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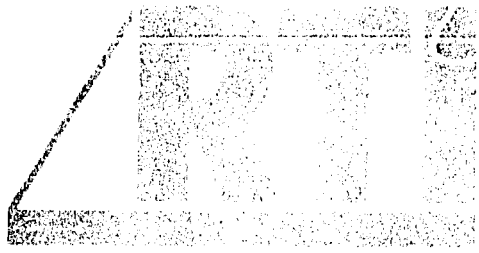

RESEARCH TRIANGLE INSTITUTE

CHILD SURVIVAL IN MALAWI: BACKGROUND REPORT FOR THE FIELD STUDY

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Introduction

Child survival has remained a priority area of assistance of the Agency for International Development (A.I.D.) for the past decade. Given its importance, the child survival program has been selected for assessment by the Center for Development Information and Evaluation (CDIE) as one of three sectors of focus for A.I.D./CDIE's reinitiated Impact Evaluation Series which was pioneered over a decade ago. As in the past Impact Evaluations, the assessments are intended to document development results-- program and project impacts and trends, program performance and implementation-- and derive operationally useful lessons about future program and policy strategies.

Implementation of CDIE's child survival program assessment began in 1989. Four of six planned country studies have been completed: Egypt (1989), Indonesia (1990), Haiti (1990), and Morocco (1991). While the focus of the Impact Evaluation Series under which these studies were conducted remains the same, greater emphasis is now being placed on more rigorous evaluation methodology which highlights greater objectivity of the process and relies on more empirical data collection and analysis. The two remaining country studies, Bolivia and Malawi, are being conducted following this new approach. A recent review of conceptual and program issues in A.I.D.'s child survival program has been completed and appropriate evaluation methodologies and tools have been defined and developed. They are being applied in the Bolivia field study which is currently underway. Upon completion of the Malawi field study, a final Impact Evaluation report will be prepared for A.I.D. senior management to summarize and synthesize the impact and performance of A.I.D.'s overall Child Survival Program.

Purpose of This Report

This report is designed to provide background information to the field study team that will be conducting the Impact Evaluation study of A.I.D.'s child survival program in Malawi. Information pertinent to child survival in Malawi is included: demographic and socioeconomic characteristics; child health characteristics; description of the health delivery system; overview of A.I.D.'s strategies for child survival; and, details of USAID/Malawi

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child survival activities since 1985. The intent of this paper is to summarize succinctly topics and issues relevant to child survival in order to facilitate the planned field study in Malawi rather than to serve as a comprehensive desk study.

This report was prepared from a review of relevant documents that were identified through computer-based information searches of the CDIE and POPLINE databases. Documents from the World Bank, UN, WHO, Malawi Government, A.I.D./CDIE, A.I.D./R&D/Health, USAID/Malawi, and the scientific literature were reviewed. Valuable assistance was provided by the Center for International Health Information and the A.I.D. Health Information System. In addition, the field assessment team coordinator visited Malawi on 27th January - 31st January, 1992, to prepare for the planned field study and obtain additional information from USAID/Malawi on current and recently implemented projects.

The report is organized in the following chapters:

Introduction
The Malawi Setting
Child Health and Survival in Malawi
Health Policy and Health Care Delivery in Malawi
A.I.D. Child Survival Strategy
USAID/Malawi Child Survival Program

Selected References

In a separately bound document:

Appendix A: Summaries of USAID/Malawi Child Survival Projects from 1985 to the Present.

Appendix B: Project Summary Tables: Project Activities by Program Area.

The Malawi Setting

Malawi is a small landlocked, sub-Saharan African country bordered by Mozambique on the south and east, Zambia on the west, and Tanzania on the northeast. About 20% of country's 45,750 square miles comprises water, mostly in Lake Malawi along the eastern boundary. The topography is diverse, with elevations ranging from low flood plains to averages of over 4,000 feet on extensive plateaus in the central and southern regions, but dominated by rolling plateaus and eroded escarpments. There are three distinct geographical and administrative regions: the Northern Region, the Central Region, and the Southern Region. These regions are important not only for their climatic and topographical differences, but also because of demographic and socioeconomic differences. (Figure 1)

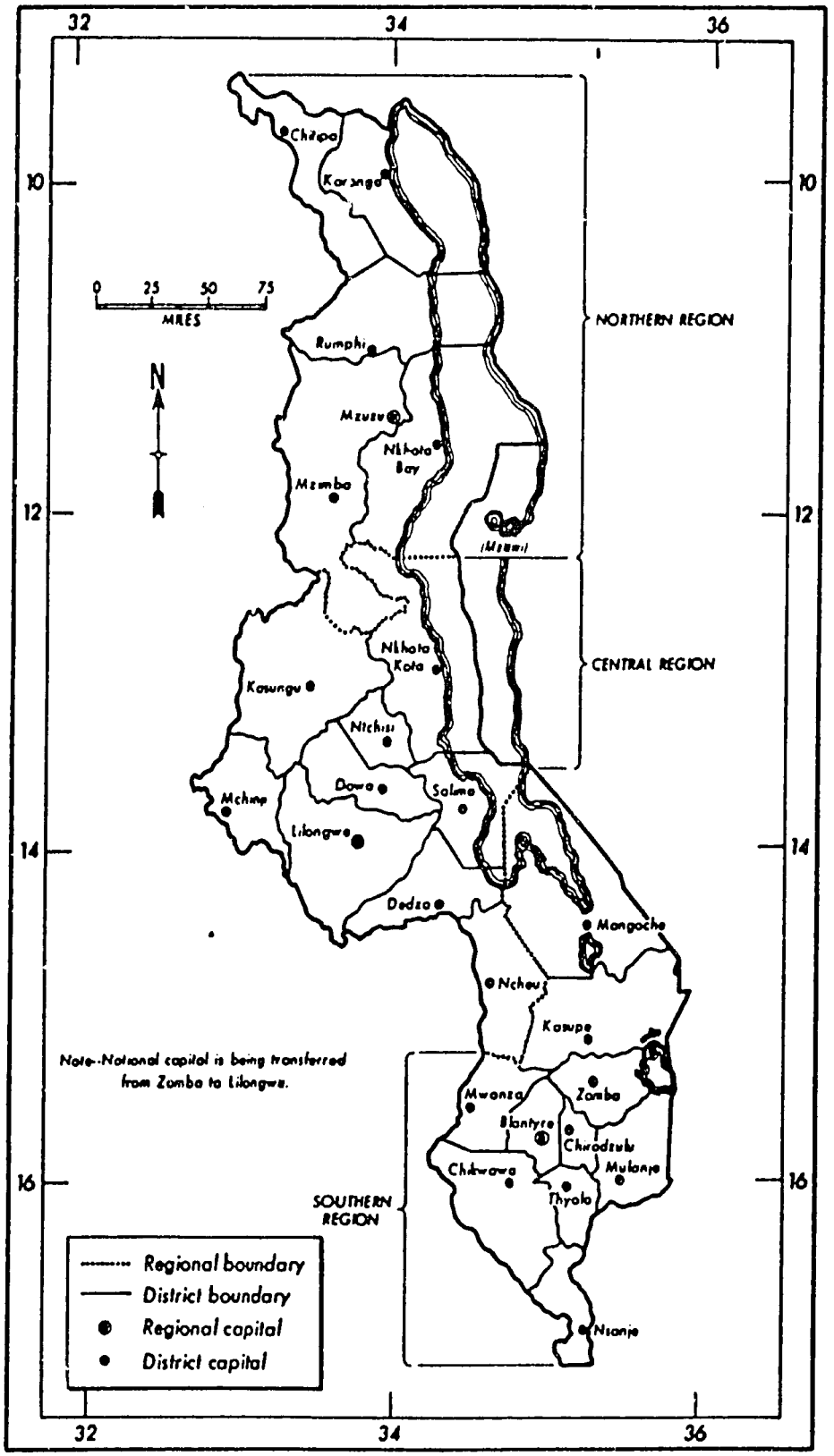
Members of nine different tribes compose the population of Malawi resulting in linguistic diversity in many areas. Chichewa, spoken by 75% of Malawians, and English are the two official national languages and both are taught in schools.

Since independence in 1964, Malawi has remained a unitary, one-party republic governed by Life President Dr. H. Kamuzu Banda. In 1975, the capital and government offices were moved from Zomba in the south to Lilongwe in central Malawi.

Population Size and Distribution

In 1987 when the most recent population census was conducted, Malawi's population was 7.98 million. This figure includes Mozambican refugees who at the time numbered about 250,000. Since 1987 the influx of refugees has grown dramatically with over 900,000 registered as of early 1991. (Figure 2)

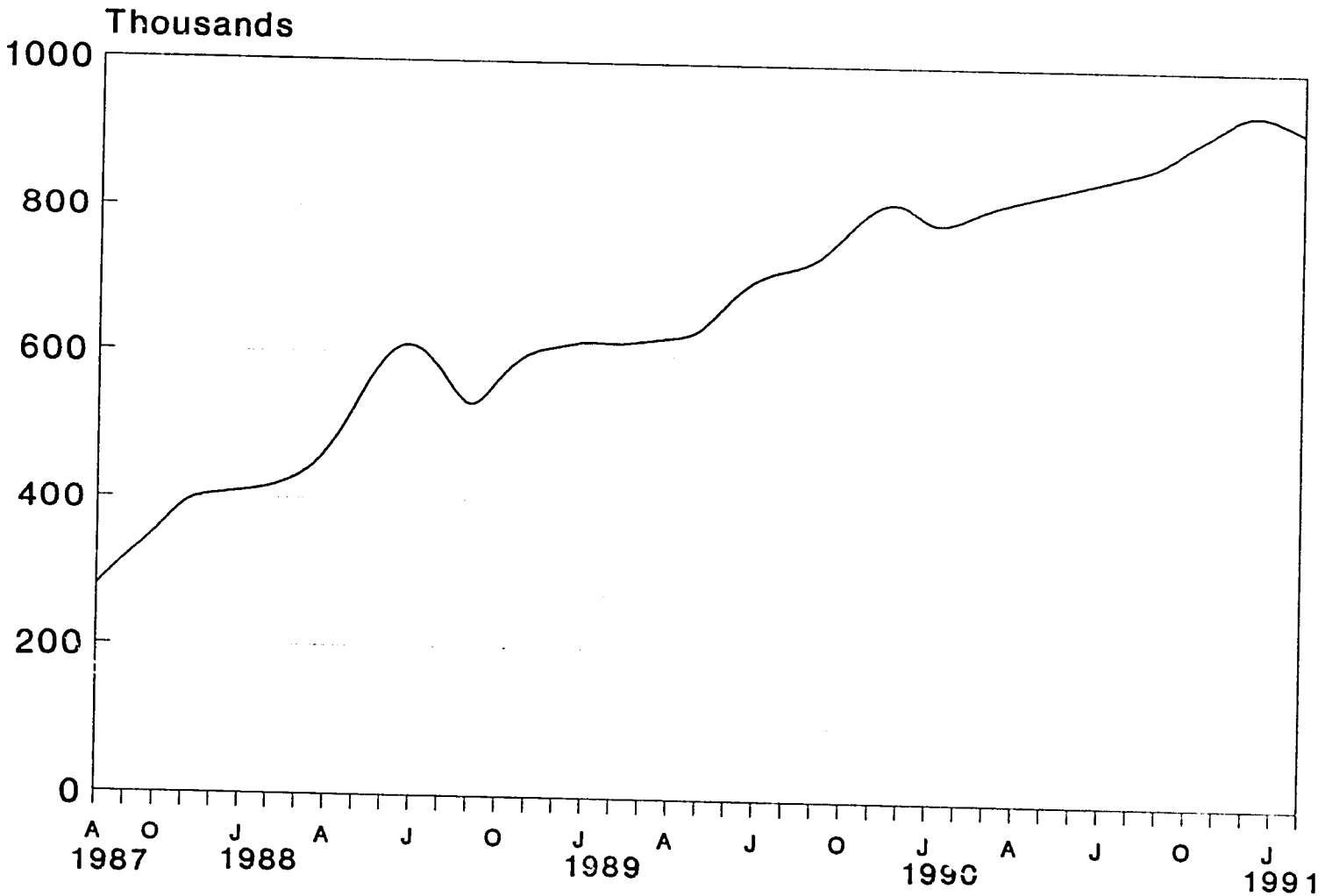
Malawi's population grew at about 2% annually from the turn of the century to 1945, after which time population growth accelerated to about 2.9% annually for the next 30 years. The rate of population growth continued to increase from 1977 to 1987, when it was estimated at 3.7% per annum. (Figure 3) This latest intercensal growth rate includes the refugee population; with refugees excluded, population growth is estimated



Source: Adapted from Malawi, Department of Census and Statistics, *Malawi Population Census, 1966: Final Report*, Zomba, 1970.

Figure 1. Administrative Regions and Districts, Malawi, 1974

Figure 2.
Mozambican Refugees in Malawi



Source: Food Security and Nutrition Bulletin, GOM, 1991

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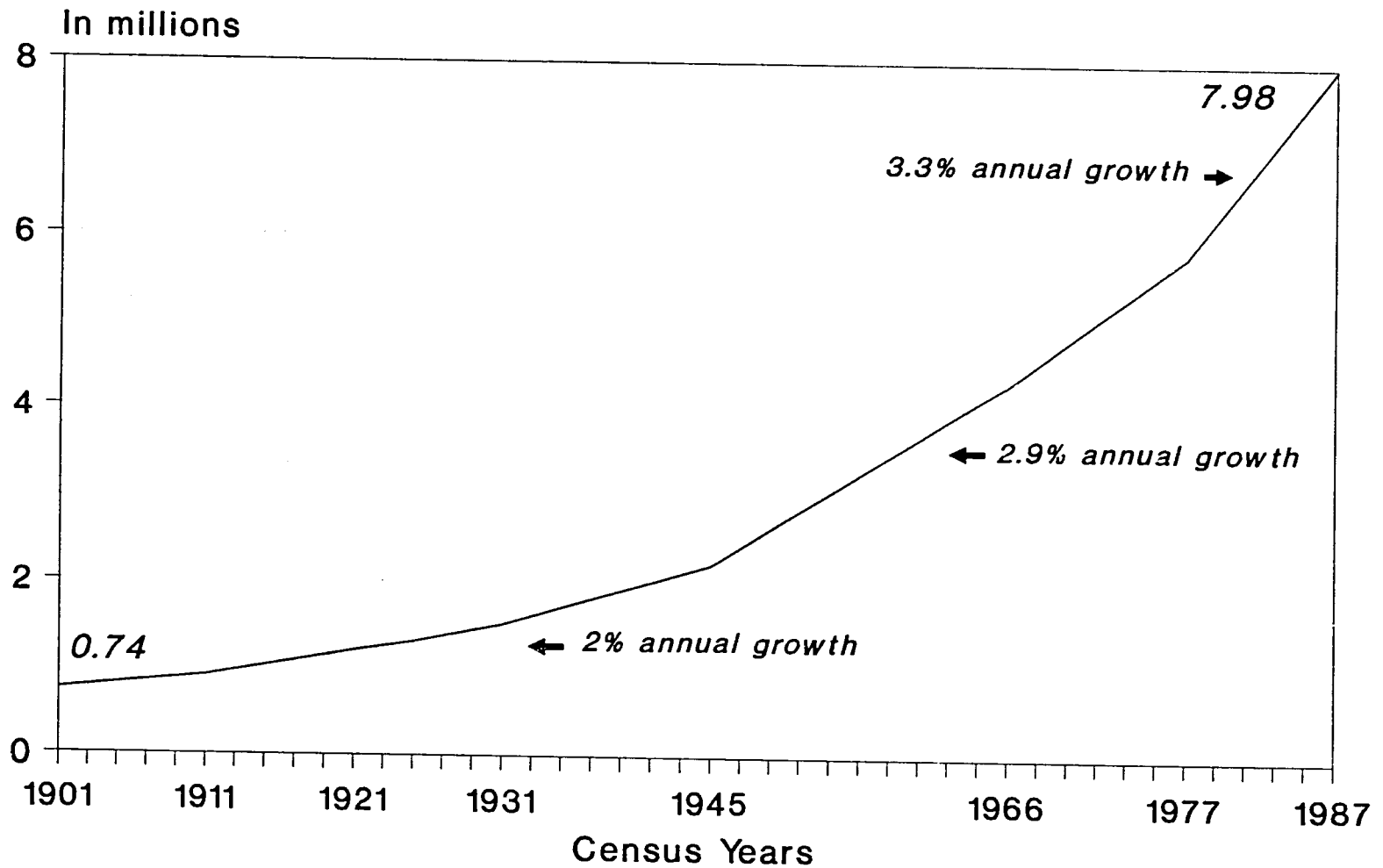
Figure 3.
Historic Population of Malawi



at 3.3%. Even without the influx of refugees, Malawi's population is one of the fastest growing in the world and in the region. Depending on how fertility changes in the future, Malawi's population will more than double in the next 20 to 30 years.

Population density nearly doubled between 1966 and 1988, from 43 to 85 persons per square kilometer, making Malawi the third most densely populated country in Africa following Rwanda and Burundi.

Malawi's population is predominantly rural with 88% living in rural areas. The population is dispersed unevenly among the three regions. (Figure 4) The Shire Highlands in the Southern Region, as well as southern parts of the Central Region, have population densities ranging from 230 to 4460 persons per square kilometer. Blantyre, the principal commercial center located in the south, is the largest city with a population of 332,000, followed by Lilongwe City with 234,000 and Zomba Municipality with 43,000.

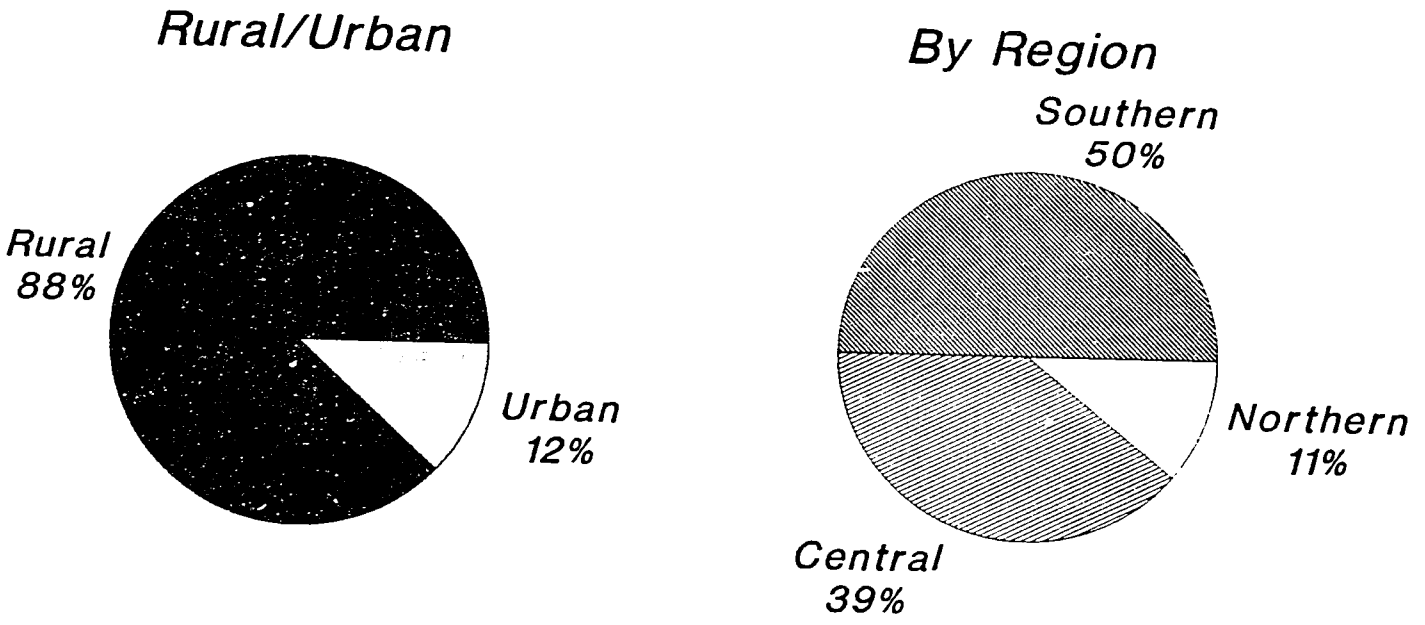
Fertility

The primary cause of rapid population growth in Malawi is high fertility. Based on the 1977 census (the most recent data source), the crude birth rate is estimated at 54 births per 1000 population. The most recent estimate of the total fertility rate (TFR) comes from the 1984 Family Formation Survey when it was 7.6; that is, on average each woman has about 7.6 births in her lifetime. In comparison, the total fertility rate is 6.7 in Burundi, 6.4 in Kenya, 5.0 in Botswana, 4.4 in Egypt, and 2.9 in Indonesia. The TFR is slightly lower in urban Malawi, about 7.2, and there are regional differences, with ranges from 5.8 to 9.6 in the Central Region, 6.8 to 8.3 in the Northern Region, and 7.1 to 8.3 in the Southern Region.

There is some evidence to suggest that fertility may have begun to decline in the past 8 years, but the use of family planning services remains low, with an estimated contraceptive prevalence rate (CPR) of about 5%. In comparison, the CPR is 7% in Burundi, 27% in Kenya, 33% in Botswana, 38% in Egypt, and 48% in Indonesia.

The other reason for high fertility is that marriage is nearly universal and occurs at an early age. Nationally, the median female age at marriage is 17.4 years. It ranges from 16.9 in the Southern Region to 18.3 in the

Figure 4.
Population Distribution



Source: 1987 Census

Northern Region, possibly providing some explanation for the regional differentials in fertility. Early marriage means that women are exposed to longer periods of risk of conception during their reproductive years and, in the absence of family planning, contributes to the large number of children born.

Mortality

Malawi has experienced a long term trend of declining mortality as health services have expanded and health conditions have improved. The crude death rate has fallen from about 27 deaths per 1000 population in the 1960's to an estimated 21 in 1987. The most recent estimate of life expectancy at birth is from the 1977 Census when it was 41 years. It is likely that life expectancy has continued to increase and some estimates suggest that it may have risen to near 47 today. However, during the past few years there are indications that due to a resurgence of malaria and the rapid spread of AIDS, the declining trends in mortality may have slowed down or even reversed. The first reported AIDS death occurred in 1985, but by 1990 AIDS had become the leading cause of death among people aged 20-40 years (AIDS Secretariat, MOH).

Although there have been modest declines in the observable past, infant and child mortality rates remain extremely high and are among the highest in Sub-Saharan Africa. The latest national level estimate of infant mortality rate is from the 1984 Family Formation Survey when it was estimated at 151 infant deaths per 1000 live births. Estimates today range from 140 to over 170 and vary according to assumptions about the persistence of malaria and the prevalence of HIV/AIDS. During the 1960's an estimated one third of all children died before their fifth birthday. Today it is estimated that 25% die before age five. Infant and child mortality are discussed in greater detail in the following chapter.

Economy

Since independence in 1964, Malawi has achieved impressive economic growth. Gross Domestic Product (GDP) has grown at nearly three times the rate of Sub-Saharan Africa as a whole. Between 1967 and 1979 GDP grew at an annual average rate of 5.5%. Since 1981 Malawi has been successfully implementing stabilization and structural adjustment programs with the IMF and World Bank. As a result, Malawi became the first

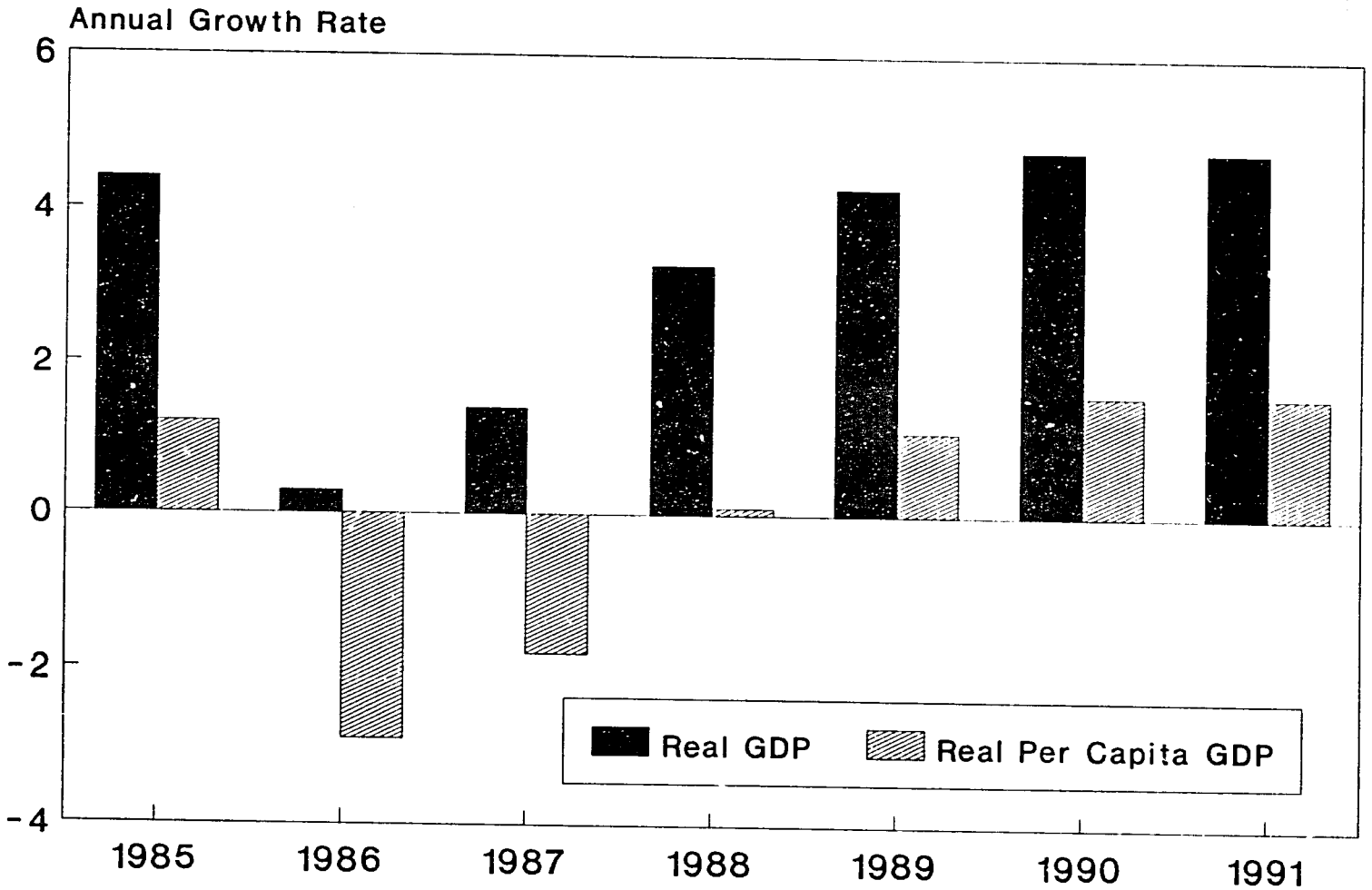
country to qualify for the IMF's Enhanced Structural Adjustment Facility in 1988. However, economic growth during the 1980's was not as stable and GDP has shown an upward trend only in recent years. (Figure 5) The rate of economic growth has not kept up with the rate of population growth, resulting in a decline in real per capita income. In the early years of independence per capita income grew at about 3% annually; in the past several years GDP per capita has grown at about half that rate. In 1988 Malawi was considered the sixth poorest country in the world with a per capita income equivalent to about $US 170.

A number of external factors have heavily influenced the economy--oil shocks, closure of international transportation links, deteriorating trade terms and markets, and recently the influx of refugees. Although positive economic growth is evident in recent years, there is reason to believe that this is not due to true structural adjustment, but rather donor in-flows. A primary concern is that growth to date has not been sufficiently broad-based to promote sustainability.

The economy is highly dependent on agriculture which is the major source of income and employment in Malawi. Approximately 90% of the population depends on subsistence farming. Crop production continues to fluctuate with changing weather conditions and rapid population growth is placing increasing pressure on arable land. By the early 1980's most of the best land was already under cultivation, forcing farmers to move to more marginal lands and to reduce fallow periods, resulting in declining yields. Rural wage rates also declined in the late 1980's and there are insufficient job opportunities for the increasing number of rural Malawians who cannot be employed productively on their own farm plots.

Despite a history of pragmatic, market-oriented economic policies, Malawi faces critical constraints to sustainable economic growth. These include rapid population growth, low productivity, costly transportation disruptions, and inadequate domestic and external resources.

Figure 5.
Recent Economic Growth



Source: USAID, API FY91

Education

In 1989 only about 32% of the population was literate (defined by the Ministry of Education and Culture as the percent of the population ages 10 and above who completed Primary Standard 4). There are also striking gender differences with female literacy much lower than male literacy. Although the number of primary school students has grown rapidly over the past decade, enrollment rates have not increased. During the 1988/89 school year an estimated 43% of primary school age children were actually enrolled in school. There are very limited opportunities for education beyond the primary level. Less than 5% of eligible children go on to attend secondary school.

Educational attainment varies widely among the regions with the Northern Region showing higher rates of primary education compared to the Central and Southern Regions. (Figure 6)

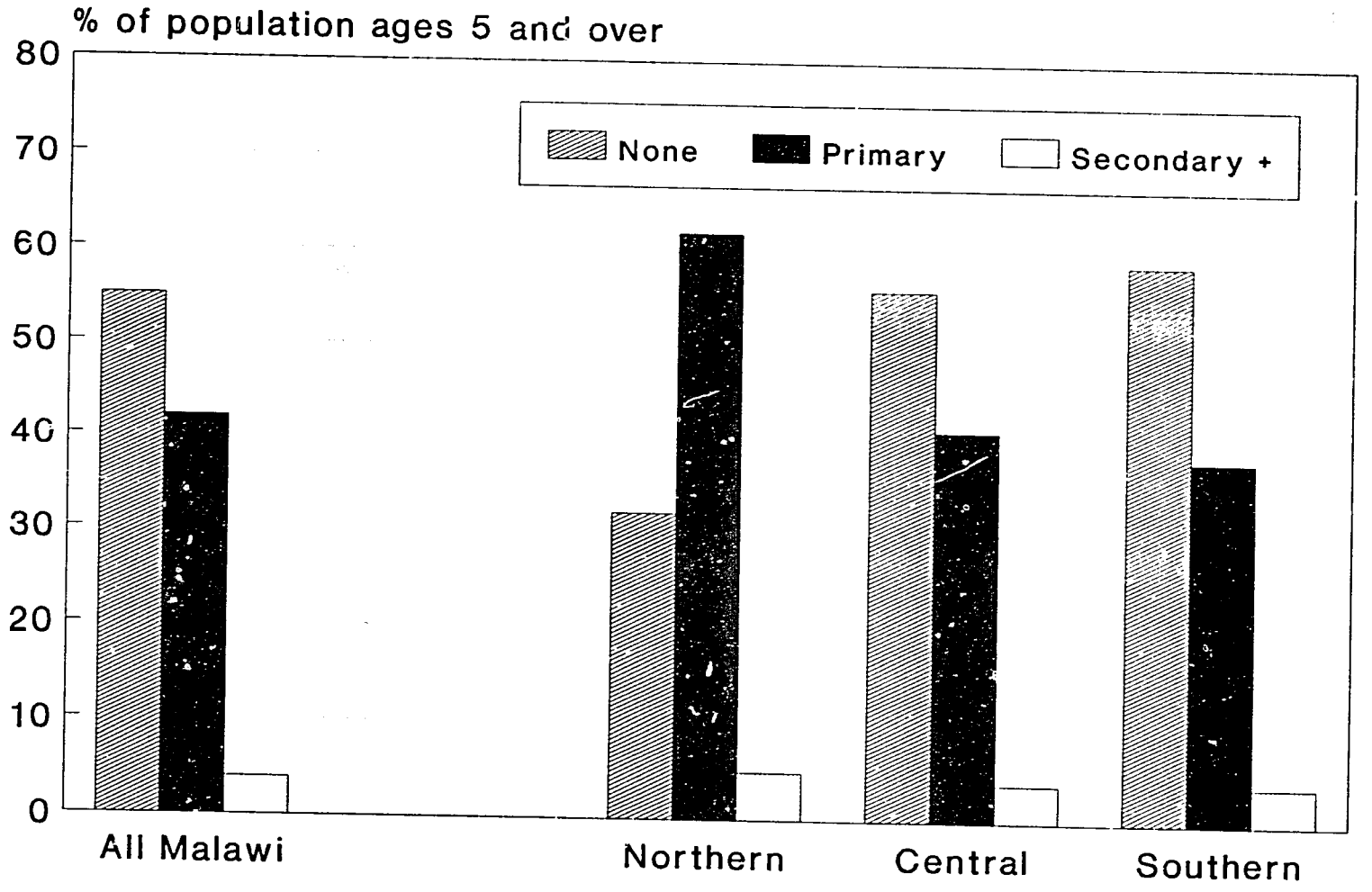
In 1991 recurrent education expenditures represented about 12% of the total Malawi Government budget. In addition to the long range goal of universal primary education, there is need for improved quality of education. In 1987/88 the average number of students per classroom was 68.

Water, Sanitation and Housing

Malawi has placed major emphasis on the development of an adequate water and sanitation system. By mid-1990, the rural water supply consisted of about 7,500 bore holes and 3,500 hand-dug wells with pumps, in addition to 55 piped water schemes. Taking into account that these are not fully operational at any one time throughout the year, it is estimated that about 40% of the rural population has access to safe drinking water. Due to rapid growth of urban areas, main-piped water systems are presently inadequate to serve population needs. In Lilongwe 30-40% of the population do not have access to the main water system and these areas suffered a severe cholera outbreak in 1989. In Blantyre lack of access to potable water is a serious problem, but no statistics are available on water coverage.

It is estimated that 64% of all households have some form of toilet (94% of urban households and 61% or rural households). In rural areas these are primarily unimproved pit latrines. In urban areas, about 15% of these are

Figure 6.
Educational Attainment by Region



Source: 1987 Census

through a waterborne sewage system, while the others are pit latrines, many of which are shared. Hygiene education has lagged behind technical advances with most of the efforts directed to the rural population.

In 1990 there were an estimated 299,000 urban households, over half of which were located in unplanned or squatter locations. Among the planned sites, the upper and middle income households have access to public housing programs, while the low income households are in site and service schemes referred to as Traditional Housing Areas. The majority of the 1.6 million rural households are housed in traditional structures made of rammed-earth or burnt brick walls with grass thatch roofs.

Child Health and Survival in Malawi

High fertility over the past decades has resulted in a very young Malawi population. Approximately half of the population is under 15 years of age. (Figure 7) In 1987, there were 1.65 million children under age five and 1.77 million women of reproductive age, representing 43% of the total population. Even if population growth begins to slow in the near future, the population of children under age 5 will number over 3 million in just 20 years.

Infant and Child Mortality

In the 1986-1995 Health Plan, the Ministry of Health estimated that while children make up about 20% of the population they account for about 57% of all deaths. In 1984 the infant mortality rate was 151 and the under-five mortality rate was 258 deaths per 1000 live births. Although precise and up to date estimates of infant and child mortality are not available it is certain that child survival since the mid-1980's is not continuing the improving trend seen in the 1960's and 1970's. Due to the advent of the AIDS epidemic and the spread of chloroquine-resistant malaria, some estimates place the infant mortality rate today as high as 178. A more recent national level estimate will be available soon, following analysis of the 1987 population census.

Regardless of the actual current rate, regional differences are apparent. In 1984 the Central Region had the highest IMR of 169, while the Southern Region had the lowest at 138. (Figure 8) It is estimated that 25% of deaths in children under age five occur in the first month of life, 25% occur in months 2-12, and 50% occur in years one through four.

Causes of Childhood Morbidity and Mortality

The most prevalent disease among all age groups of the population is malaria and it is the number one cause of morbidity and mortality among children as well. In 1988, Malaria accounted for 35.8% of all child outpatient cases, 30% of all inpatient cases, and 19.4% of all child deaths. (Exhibit 1) Anemia, very highly associated with malaria, is the second most important cause of morbidity and mortality in children, and together

Figure 7.
Population Age Distribution
1987

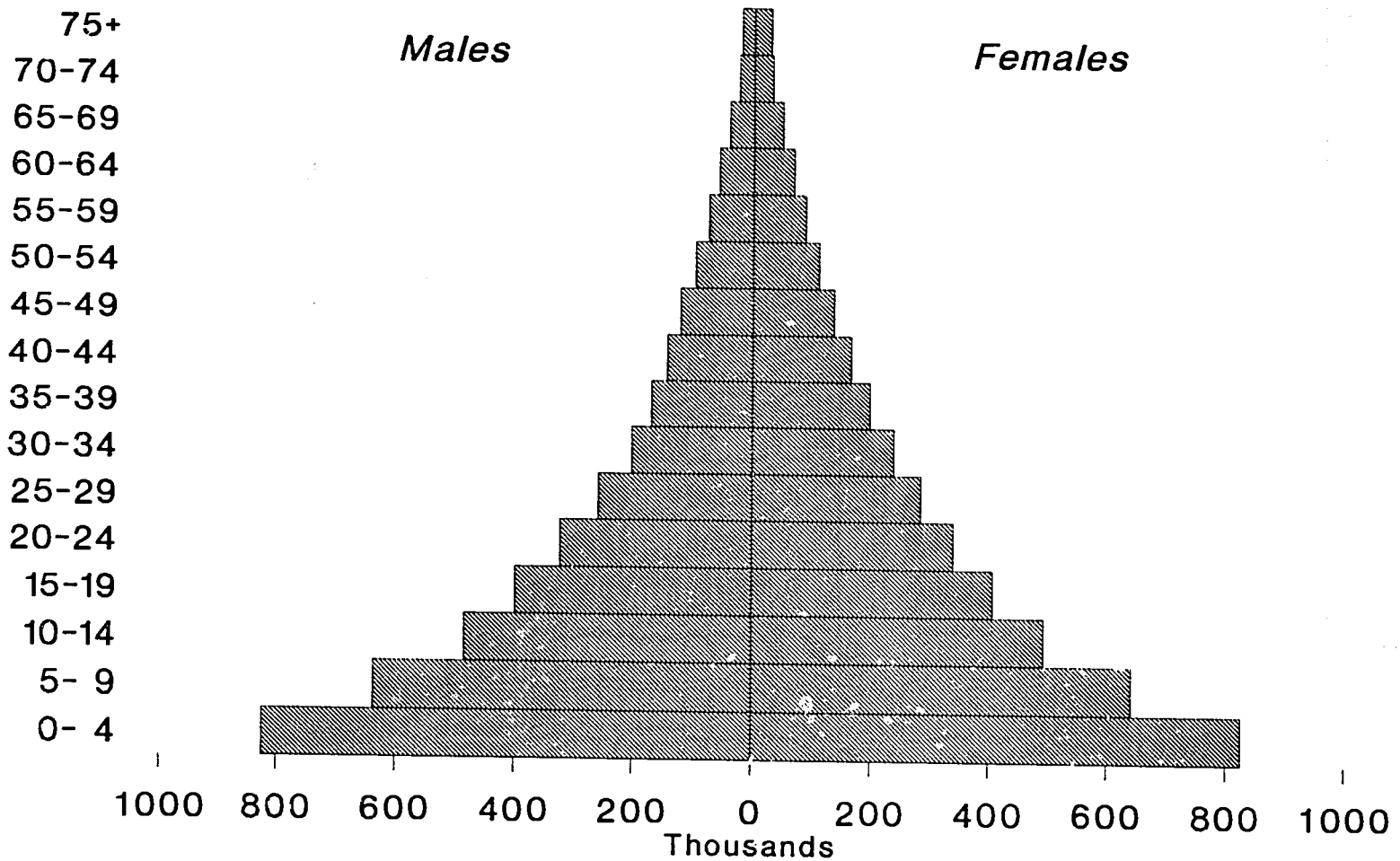
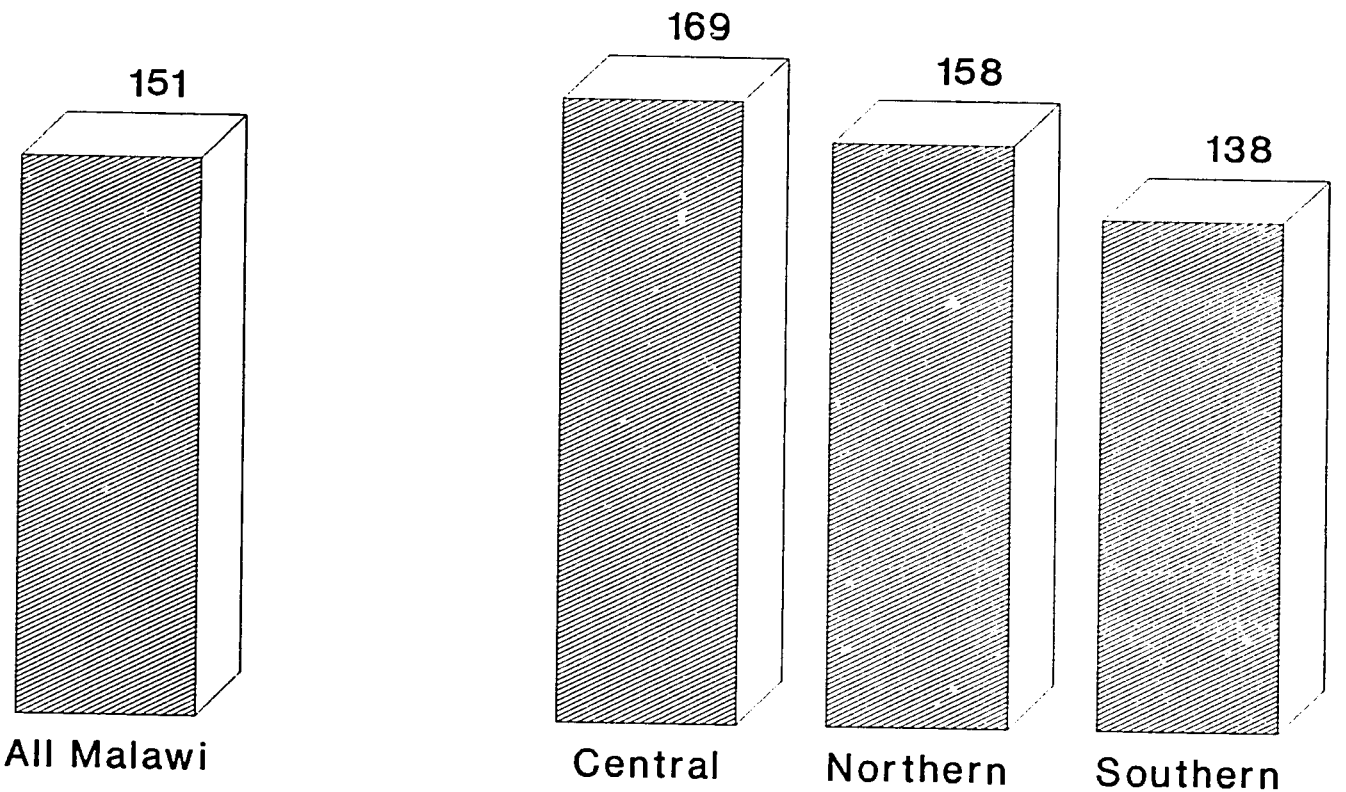


Figure 8.
Infant Mortality Rates by Region
1984

Infant deaths per 1000 births



Source: Family Formation Survey

Exhibit 1. Major Causes of Morbidity and Mortality in Children Under Age Five, 1988

	Outpatients		Inpatients			
	Number of Cases	Percent of Total	Number of Cases	Percent of Total	Number of Deaths	Percent of Total
Malaria	1,700,734	35.8	25,155	30.0	1,544	19.4
Anemia	865,342	18.2	10,997	13.1	983	12.4
Pneumonia	326,321	6.9	9,574	11.4	958	12.1
Measles	326,823	6.9	5,900	6.6	542	8.0
Diarrhea	323,372	6.8	6,301	7.5	637	8.0

Source: Ministry of Health

they represent 32% of all child deaths. Pneumonia, measles and diarrheal diseases each accounted for about 7% of outpatient cases, but had a slightly greater impact on mortality. In particular, pneumonia is more fatal, accounting for 12.1% of all child deaths in 1988.

Absent from these 1988 statistics is the sixth leading cause of death, avitaminosis, which accounted for about 15% of all inpatient child deaths in 1987. (The total distribution of child deaths is presented for 1987 because this information was not available to us for more recent years.) (Figure 9)

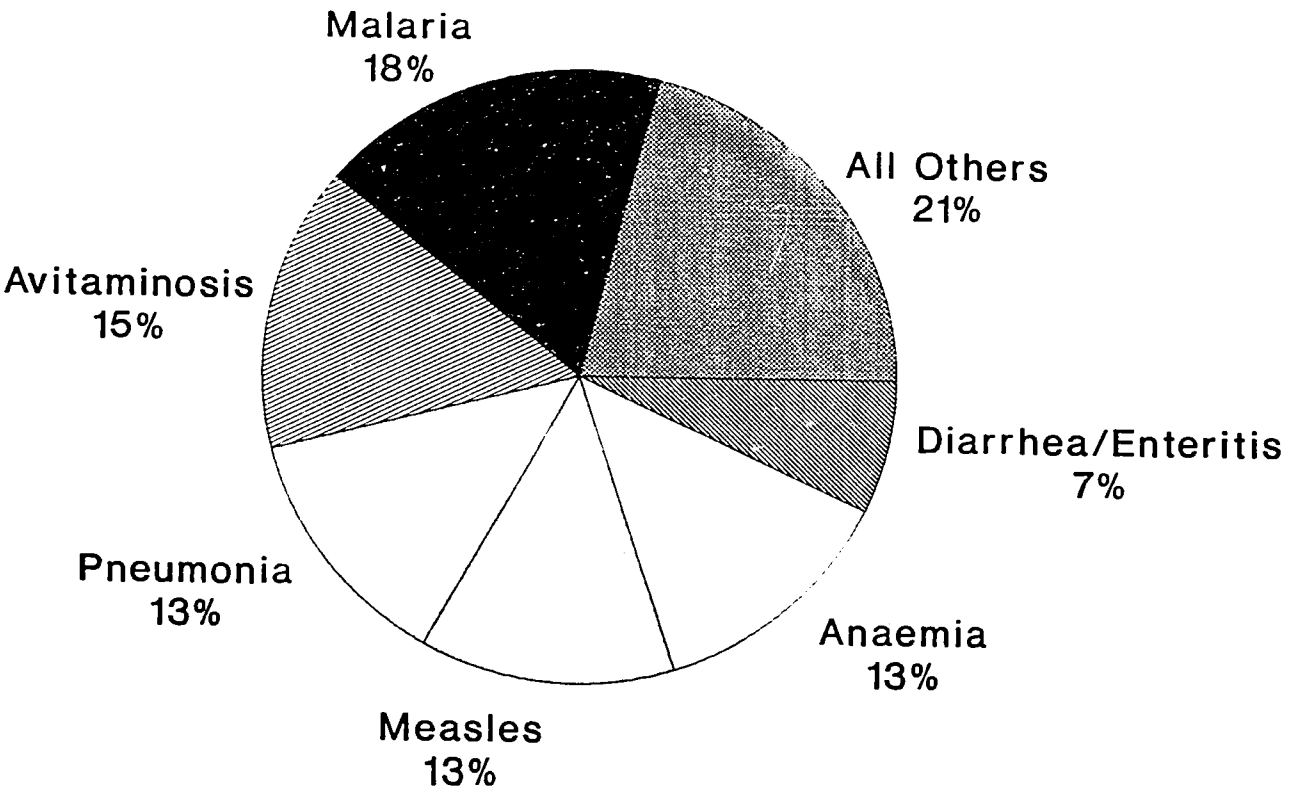
The pattern of childhood diseases serious enough to require hospitalization appears to have remained relatively unchanged in the most recent years. In 1990, malaria and anemia together accounted for over 40% of admissions, followed by acute respiratory infections, diarrheal diseases, nutritional deficiencies and measles. (Figure 10) However, the pattern of childhood diseases *has* changed rather dramatically since the mid-1980's. (Figure 11) Of particular importance is the increase in child mortality from malaria, going from 11% of child deaths in 1985 to over 19% in 1988. The percentage of deaths from related anemia has shown a small increase, while pneumonia and measles have declined, and diarrheal diseases show no consistent trend.

It should be noted that these statistics were obtained from data collected by the Ministry of Health for their Health Information System and rely on officially reported cases only. The Family Formation Survey in 1984 found that only about 25% of all child deaths occur in, or enroute to the hospital, while the other 75% occur in the household and may, or may not, be officially reported.

In 1990 approximately 130 cases of AIDS were reported among children under age five, representing about 5% of the total number of reported AIDS cases. Although this number is relatively small at this time, it will continue to increase dramatically in the future, and each case will result inevitably in death. Additionally, by the year 2000 it is projected that several hundred thousand children may be orphaned by AIDS, producing serious consequences for the health and well-being of Malawi's children.

Figure 9.
Distribution of Child Deaths by Cause
Inpatient deaths of children under 5

1987



Source: Ministry of Health

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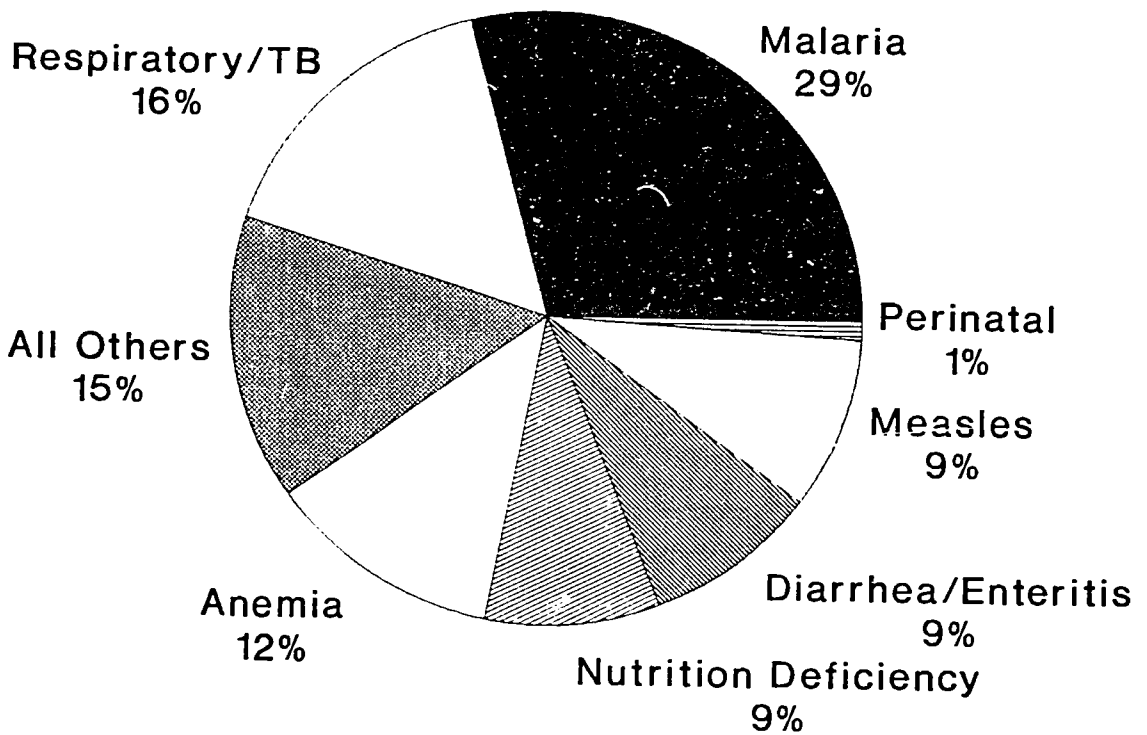
Figure 10.
Distribution of Child Hospitalizations by Cause

1990



Source: Ministry of Health

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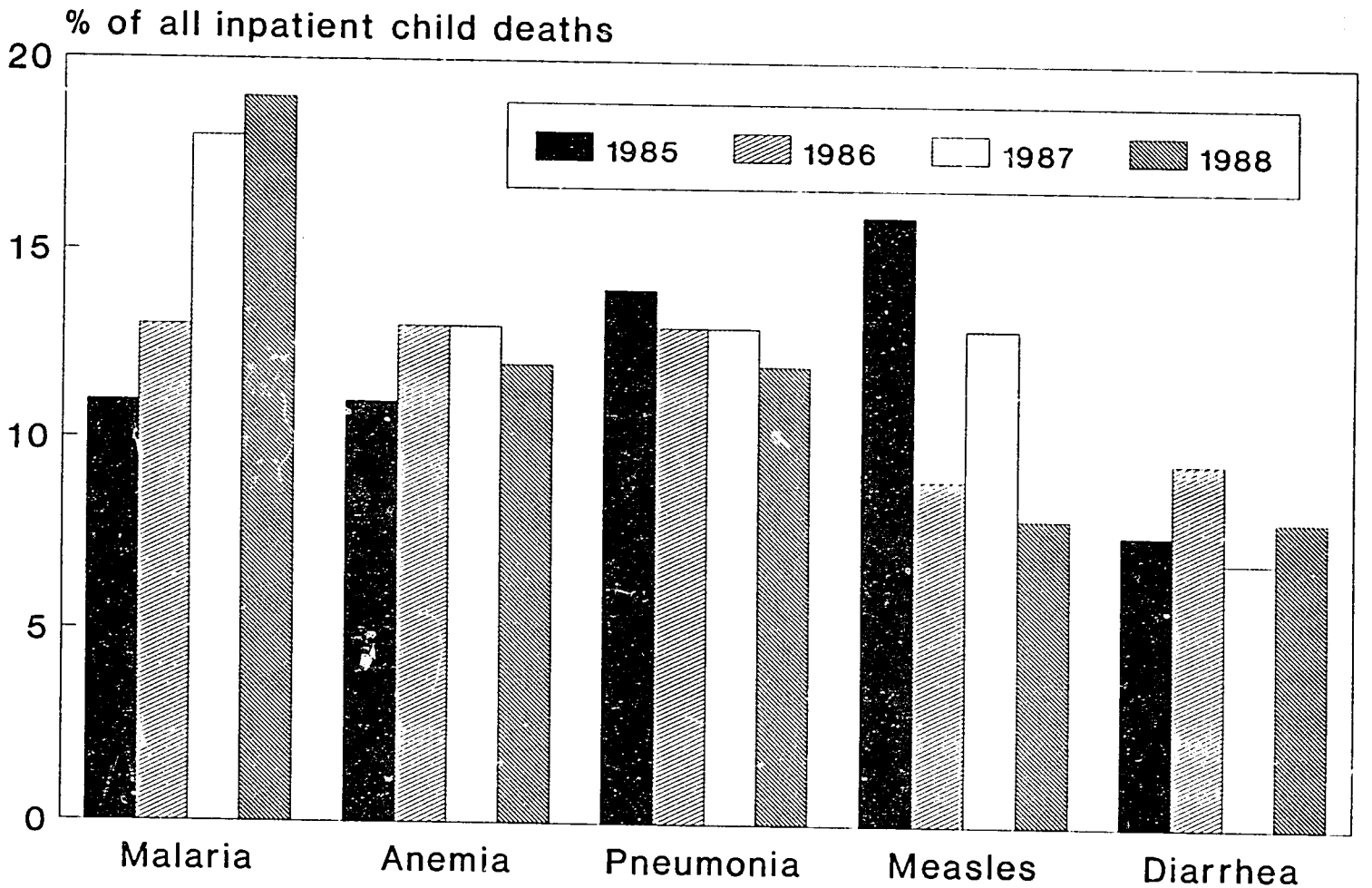
Figure 11.
Causes of Mortality Among Children



Source: Ministry of Health

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The major causes of childhood disease are discussed in more detail below:

Malaria

Malaria contributes to mortality in three distinct ways: 1) causing acute fever illness which progresses to severe disease and death; 2) causing chronic debilitation characterized by anemia and malnutrition which leads to death or contributes to other infectious agents causing death; and, 3) causing placental infection in pregnancy leading to low birth weight which is the most important risk factor for neonatal mortality. Even with appropriate care, the case fatality rate for cerebral malaria is about 30% for children under age five.

Before 1980 malaria control activities included case management through health facilities and chemoprophylaxis (primarily chloroquine) for pregnant women and children attending clinics. In the early 1980's it was observed that some malaria cases were failing to respond to chloroquine treatment and in 1984 chloroquine resistant strains of malaria were confirmed. Attempts to treat and prevent malaria through the end of the 1980's clearly were inadequate. It has been demonstrated that chloroquine prophylaxis is of limited benefit in preventing malaria in pregnancy and that chloroquine can no longer be relied upon to treat severe infection. Alternative drug treatments are under consideration, but none is entirely satisfactory. The Ministry of Health has developed a second 5-year plan (1990-1994), which among other objectives, emphasizes the importance of recognition by mothers of febrile illness in children, and prompt treatment. This, of course, assumes that an effective treatment exists and is available, while at present this is not often the case.

Malnutrition

Although agriculture and food production is the primary occupation and source of income in Malawi, malnutrition is highly prevalent. The National Sample Survey of Agriculture (NSSA) for 1980/81 revealed that approximately 56% of children under age five in rural Malawi suffer from chronic malnutrition as measured by stature, or height by age. Although there has not been a more recent nation-wide survey, later smaller surveys suggest the problem has not diminished. A 1989 survey in Ntchisi, for example, showed that 70% of children surveyed suffered from chronic malnutrition. Malnutrition is seen among the urban poor as well. A recent

study estimated that 42% of children surveyed in Blantyre and 35% of children in Lilongwe were chronically malnourished. (Figure 12)

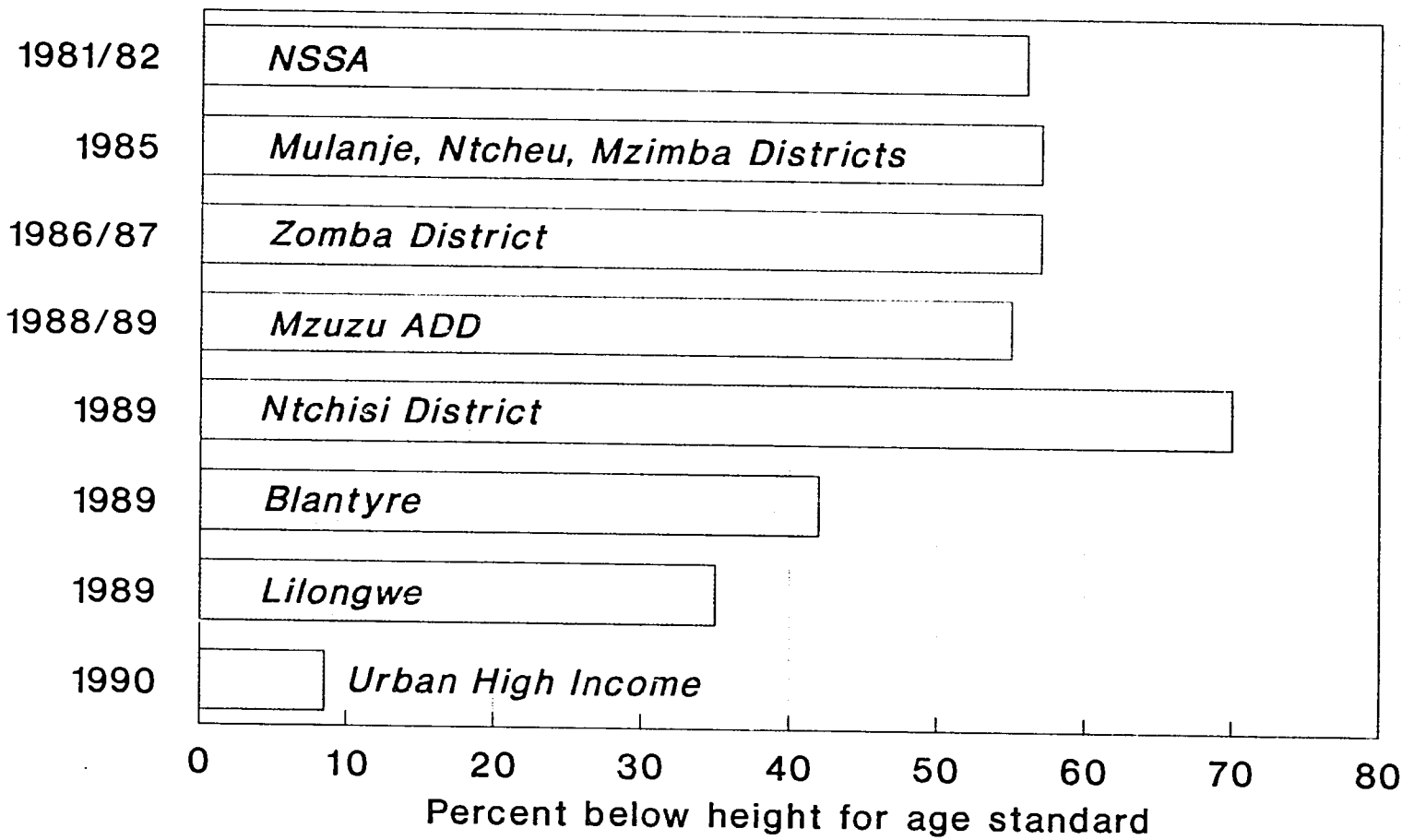
The short stature of Malawian children consistently found in past studies led to investigations concerning the appropriateness of the standard against which stature was compared. It was felt that perhaps the observed low height for age may be the result of genetics rather than poor nutrition and health. A 1990 study, however, provided evidence to refute this hypothesis. A sample of urban Malawian children from high income families compared favorably with the established standard of U.S. children of the same ages, whereas rural Malawian children were on average about 10 cm (4 in) shorter. (Figure 13)

Protein-energy malnutrition is the primary nutritional problem, although specific nutrition deficiencies have been identified. Iron-deficiency anemia is the most commonly reported nutritional problem among women and children, contributing to low birth weight, perinatal problems in pregnant and lactating mothers, and chronic fatigue and ill health. Important causes are poor nutritional intake of iron accompanied by increased blood destruction and loss, particularly from malaria and schistosomiasis.

Vitamin A deficiency is a public health concern in the Lower Shire. A 1988 survey in Salima and Dedza East estimated that 22% of the sampled population showed signs of Vitamin A deficiency. Children suffering from Vitamin A deficiency have more attacks of diarrhea and respiratory infections, while severe deficiency causes blindness and death.

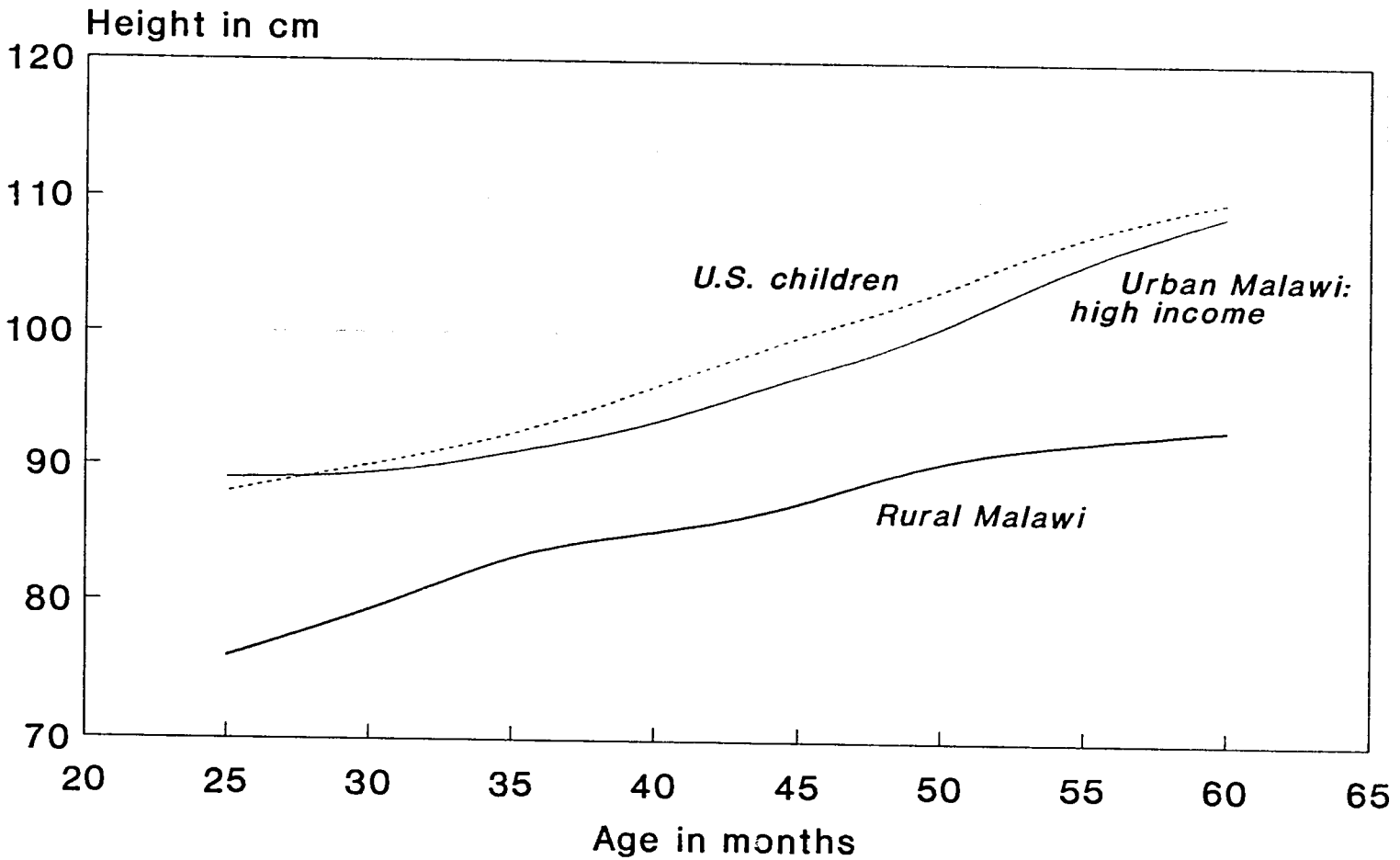
The immediate cause of malnutrition is that people, especially children, are not getting adequate food to satisfy their body's requirements. In Malawi, there are several reasons for this: lack of food availability at the household level, poor feeding and childrearing practices, and the effects of disease. The important relationship between nutrition and infection particularly affects children. Poor nutrition lowers the body's resistance to infection, leading to more frequent infection and slower recovery so that diseases such as measles and diarrhea which are rarely fatal in developed countries, become major childhood killers. At the same time, infection can also interfere with food intake and absorption, thus potentiating the effects of poor nutrition.

Figure 12.
Nutritional Stunting Among Groups of Malawi Children



Source: Food Security and Nutrition Bulletin, March 1991

Figure 13.
Nutritional Status of Children
Average height by age



Source: Food Security & Nutrition Bulletin, GOM, 1991

On average (in 1984) children are breastfed for 17.4 months, with somewhat shorter durations in urban areas. However, closely spaced births often lead to early and abrupt termination of breastfeeding. A 1989 study showed that 38% of urban mothers stopped breastfeeding because of another pregnancy. In addition, many early teenage pregnancies are unwanted and young mothers commonly give their young children to grandmothers for care in order to finish school or work, depriving the child of breastfeeding.

Measles and Other Vaccine Preventable Diseases

Measles has declined as a cause of both morbidity and mortality over the past two decades, but still remains a significant cause of child mortality. Rates of infection among children under five halved from 1985 to 1989, from 707 cases/10,000 to 327 cases/10,000, as a result of increased immunization coverage from about 65% in 1981 to 80% in 1990. (Figure 14a)

Most children in Malawi are currently immunized against the primary vaccine preventable diseases. Rates of immunization have consistently increased since the early 1980's when 65% of children were fully immunized. In 1990 it was estimated that immunization coverage was over 90% for BCG, about 80% for DPT and polio (3 doses); and, 72% for tetanus (2+ doses) in 1989. (Figure 14b) These rates are higher than those found in most of East Africa.

Diarrheal Diseases

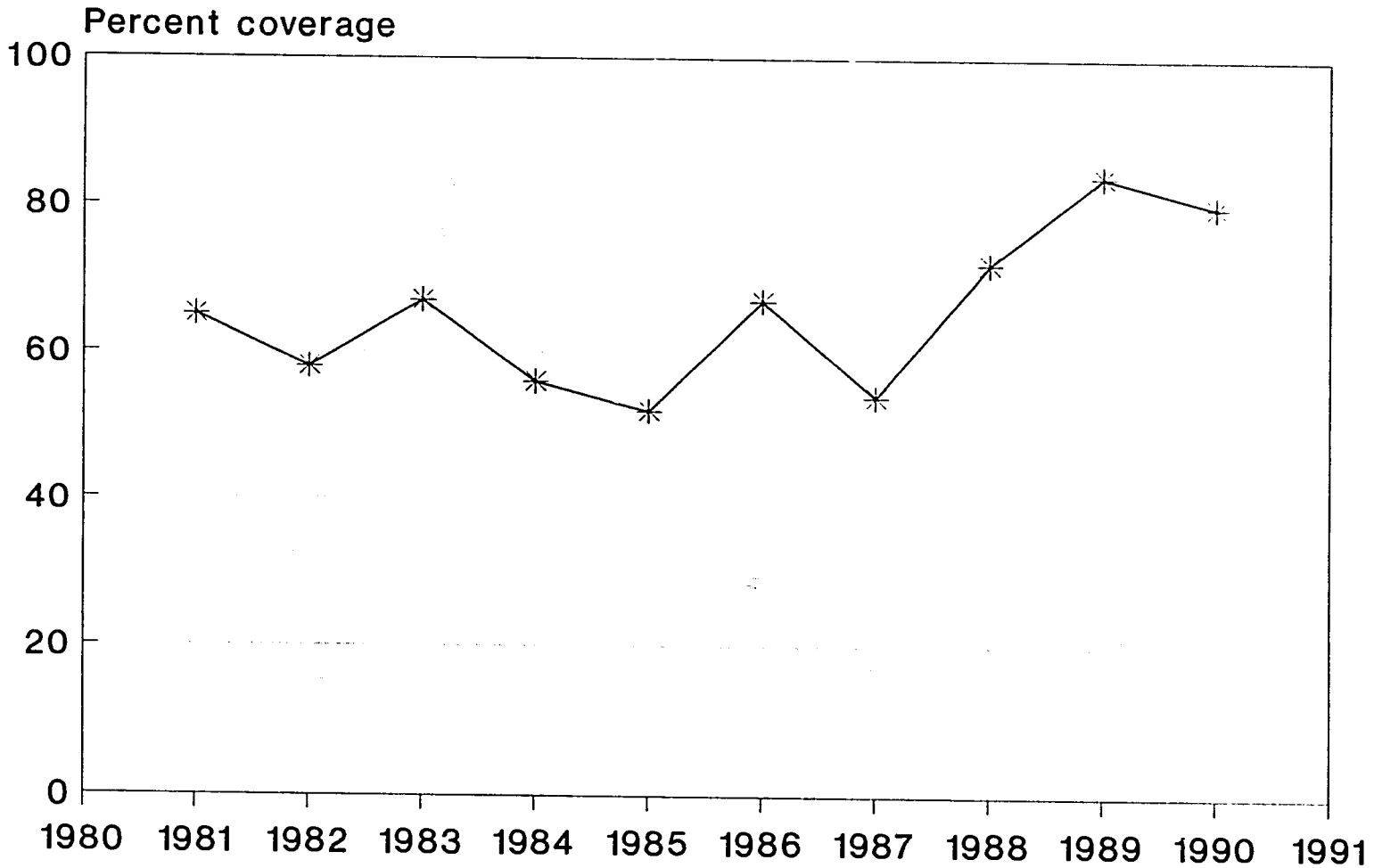
In the overall population, morbidity rates from diarrheal diseases showed a 50% decline from 1980 to 1989, although they still represent 9% of all child hospitalizations and 7% of all inpatient child deaths. Although access to oral rehydration therapy (ORT) was estimated at 56% in 1989 (from 25% in 1985), oral rehydration salts are estimated to be used appropriately in less than 20% of diarrheal cases. These rates are considered low in comparison with other countries in East Africa.

AIDS

HIV/AIDS affects the young and middle-aged sexually active population who are primarily the economically productive members of society, but the

31

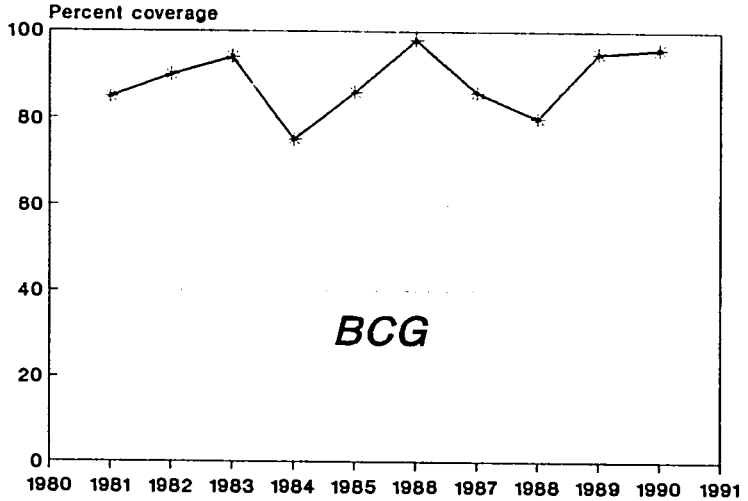
Figure 14a.
Measles Immunization Coverage Rates

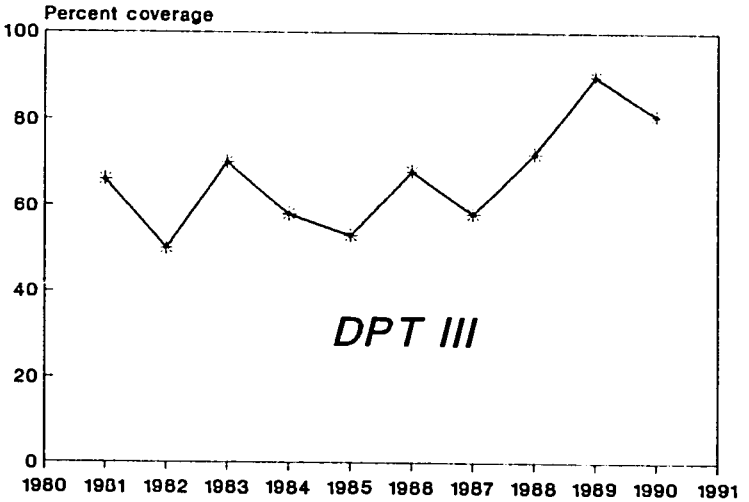


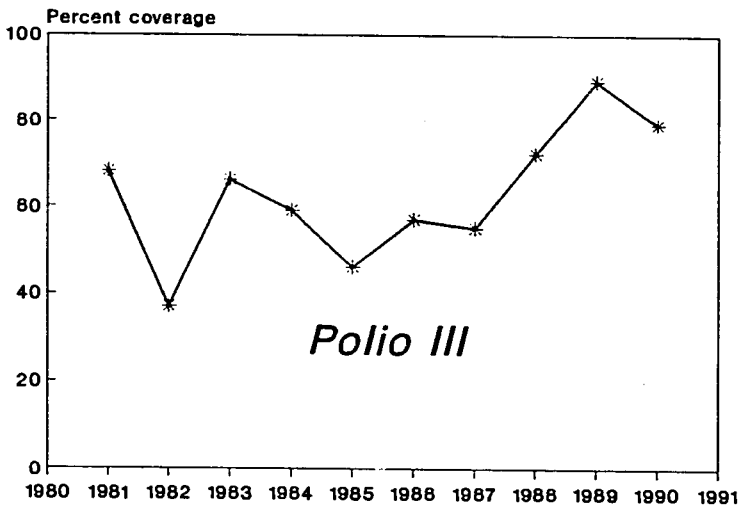
Source: CIHI, ISTS; June 1991

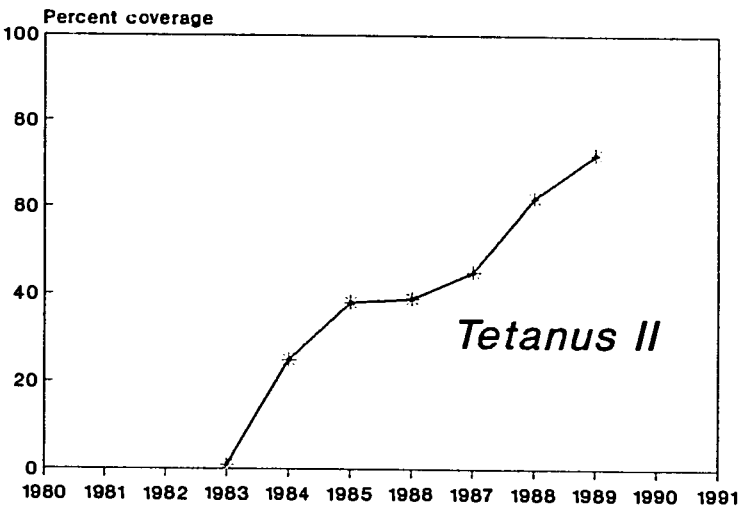
22

Figure 14b. Immunization Coverage Rates









Source: CIHI, ISTS; June 1991

impact on children is grave. It is estimated that women with the HIV virus pass it on to their children in about 30% of cases, and progression of the disease is more rapid in children. Some studies estimate that due to HIV, infant mortality rates may increase by as much as 50% over the next ten years. Other estimates project a continued but more gradual decline in infant and child mortality rates than would have been anticipated without the advent of AIDS. (Figures 15a and 15b) These latter estimates do not take into account the impact on children of being orphaned by parents who succumb to AIDS.

HIV prevalence among adults was estimated at about 10% (range 3% - 20%) nationally in 1990, but this is based on two healthy adult populations: blood donors and women attending antenatal clinics. HIV prevalence is thought to be lower among the rural population, but no studies have been conducted. Among those populations that have been sampled, the prevalence rate is climbing rapidly. Seroprevalence among urban women of reproductive age seen at Queen Elizabeth Hospital in Blantyre rose from 2% in 1985 to 26% in 1991. (Figure 16)

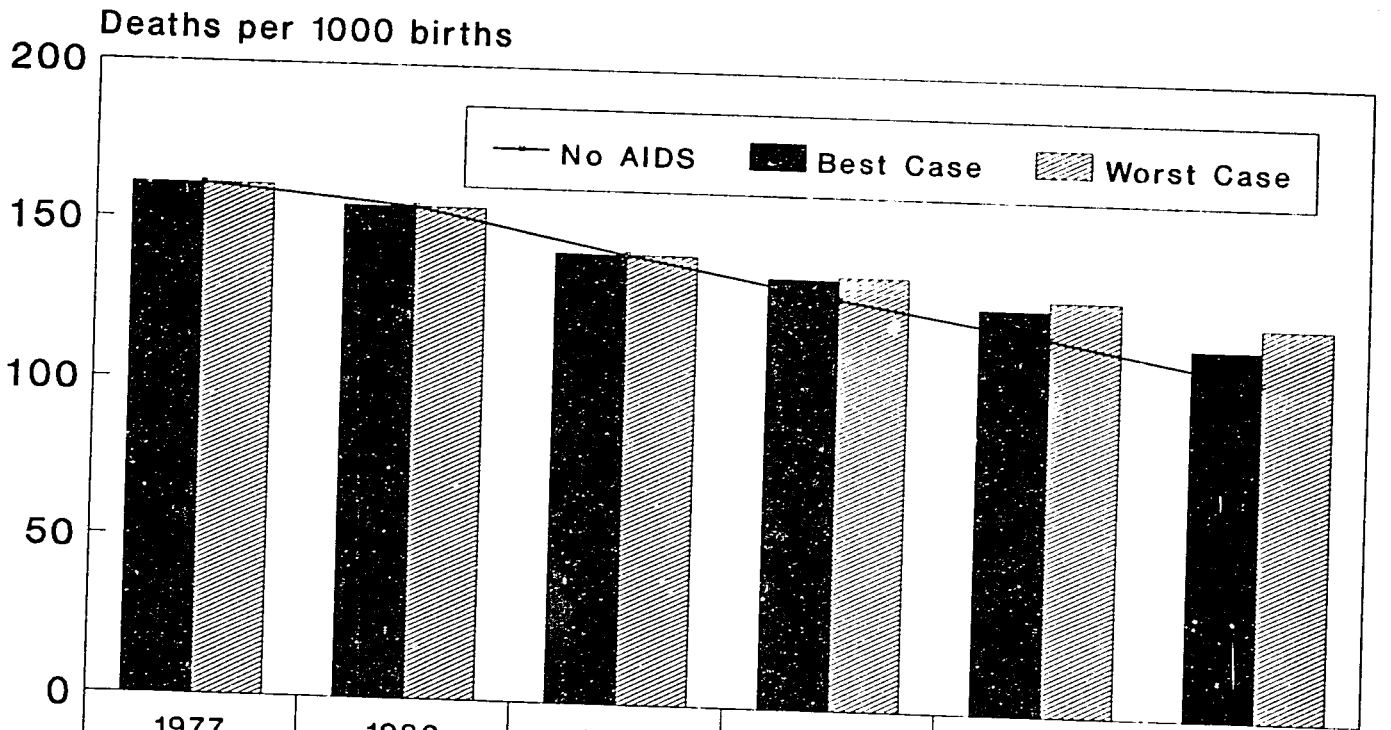
In 1995, the Ministry of Health projects that AIDS will kill 40,000 adults and the annual toll is expected to climb sharply thereafter. (Figure 17) Estimates of projected child deaths are not available. The distribution of AIDS cases by age differs by gender with female cases outnumbering male cases in ages 15-24, but with males outnumbering females at ages 30 and above. (Figure 18)

The full impact of the AIDS epidemic is difficult to predict, although evidence is clear it will affect virtually all aspects of society. The pool of talent in government, industry and academia is being thinned; and productivity in the agricultural labor force is expected to decline. The health sector is already experiencing a strain. Up to one-third of all hospital admissions are due to HIV-related diseases with AIDS-related TB also showing dramatic increases. It is placing enormous demands on the health care system, consuming scarce resources that otherwise might be allocated to primary health care.

High Fertility and Maternal Health

The fertility behavior of Malawian women places them and their children at increased risk of morbidity and mortality. Worldwide research has

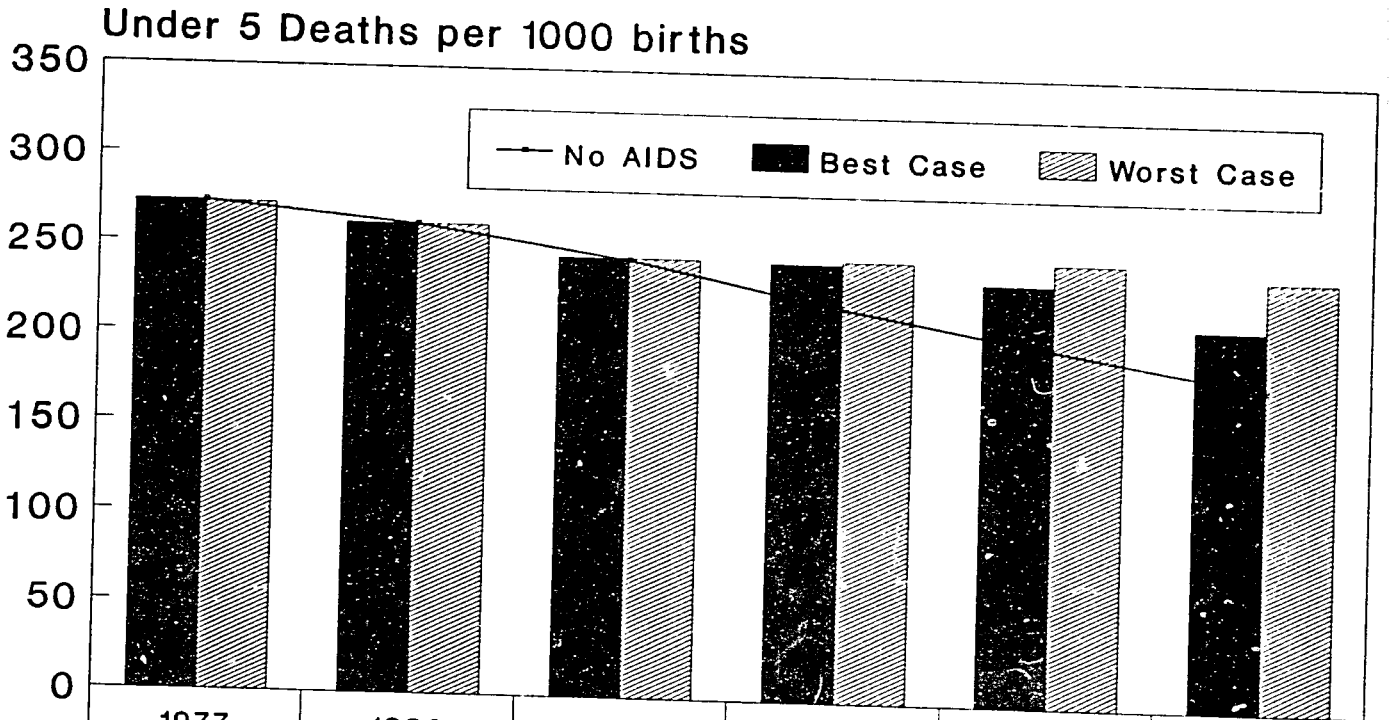
Figure 15a.
Projected Infant Mortality Rates With and Without AIDS



	1977	1982	1987	1992	1997	2002
No AIDS	161	155	142	130	119	107
Best Case	161	155	142	136	128	117
Worst Case	161	155	142	137	131	124

Source: MOH/AIDSTECH, October 1991

Figure 15b.
Projected Child Mortality Rates With and Without AIDS



	1977	1982	1987	1992	1997	2002
No AIDS	273	262	244	220	199	179
Best Case	273	262	245	244	235	212
Worst Case	272	262	245	246	247	240

Source: MOH/AIDSTECH, October 1991

Figure 16.
HIV-1 Seroprevalence Among Women
Antenatal Clinic
Queen Elizabeth Hospital, Blantyre

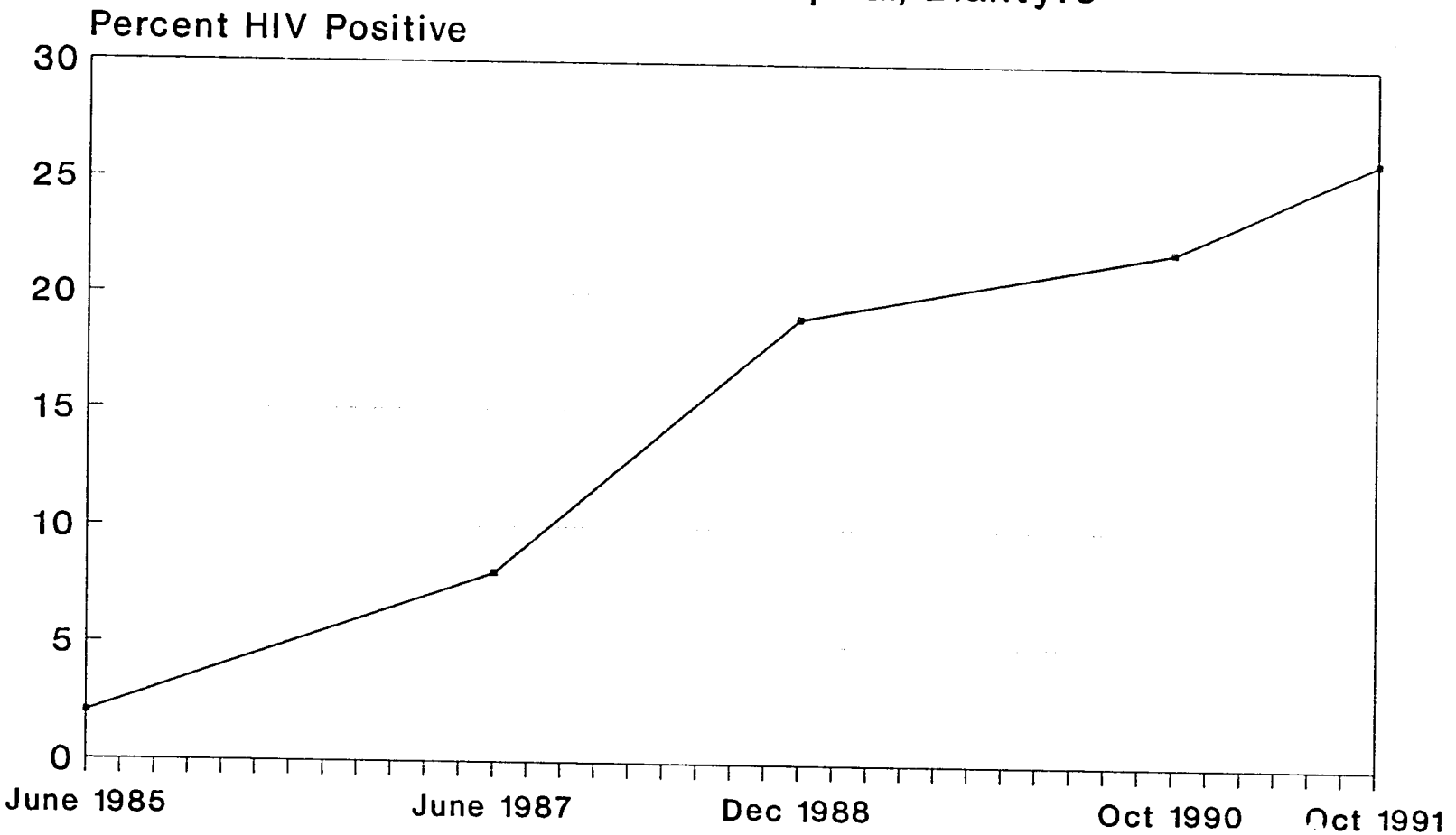
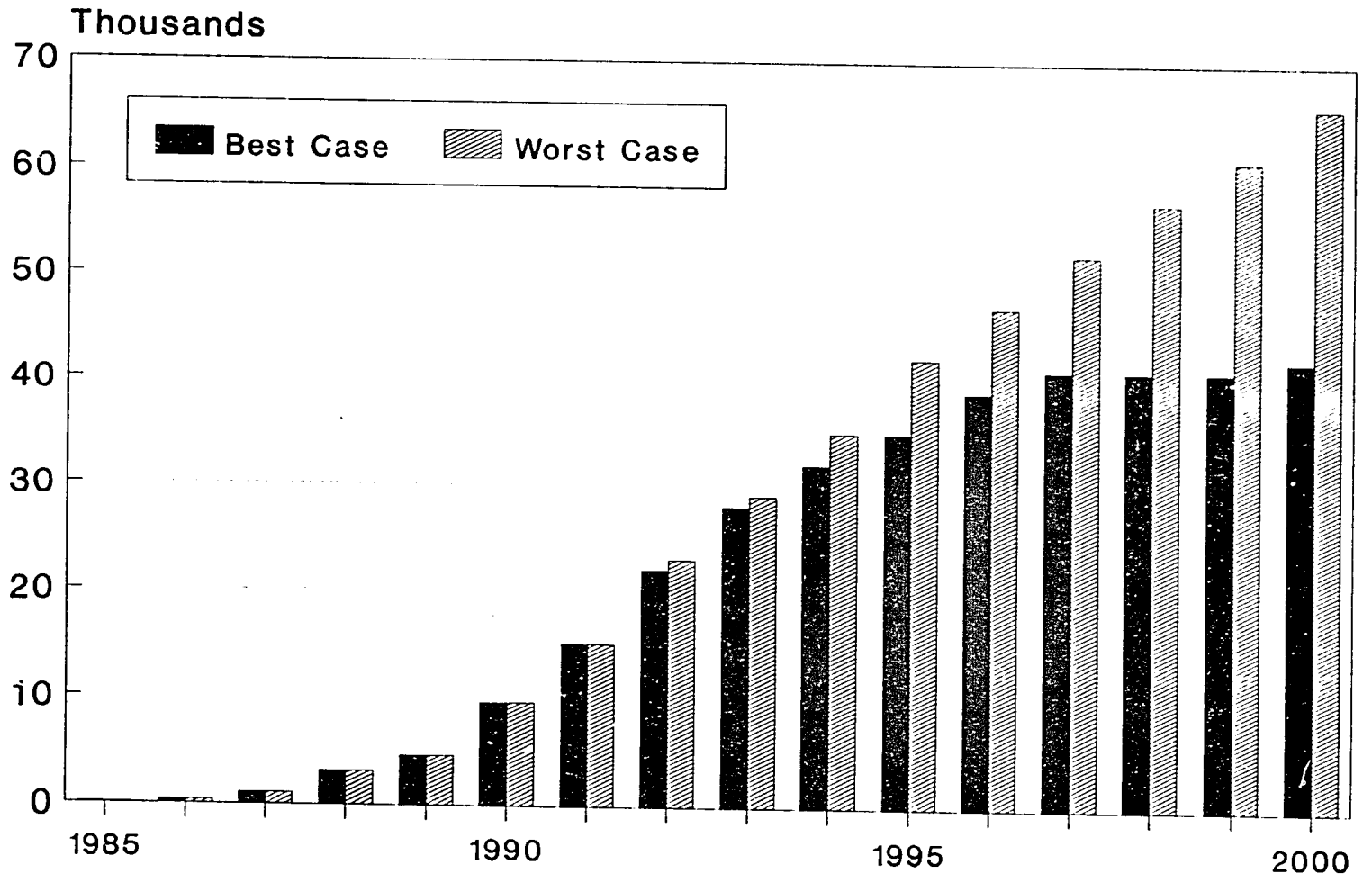
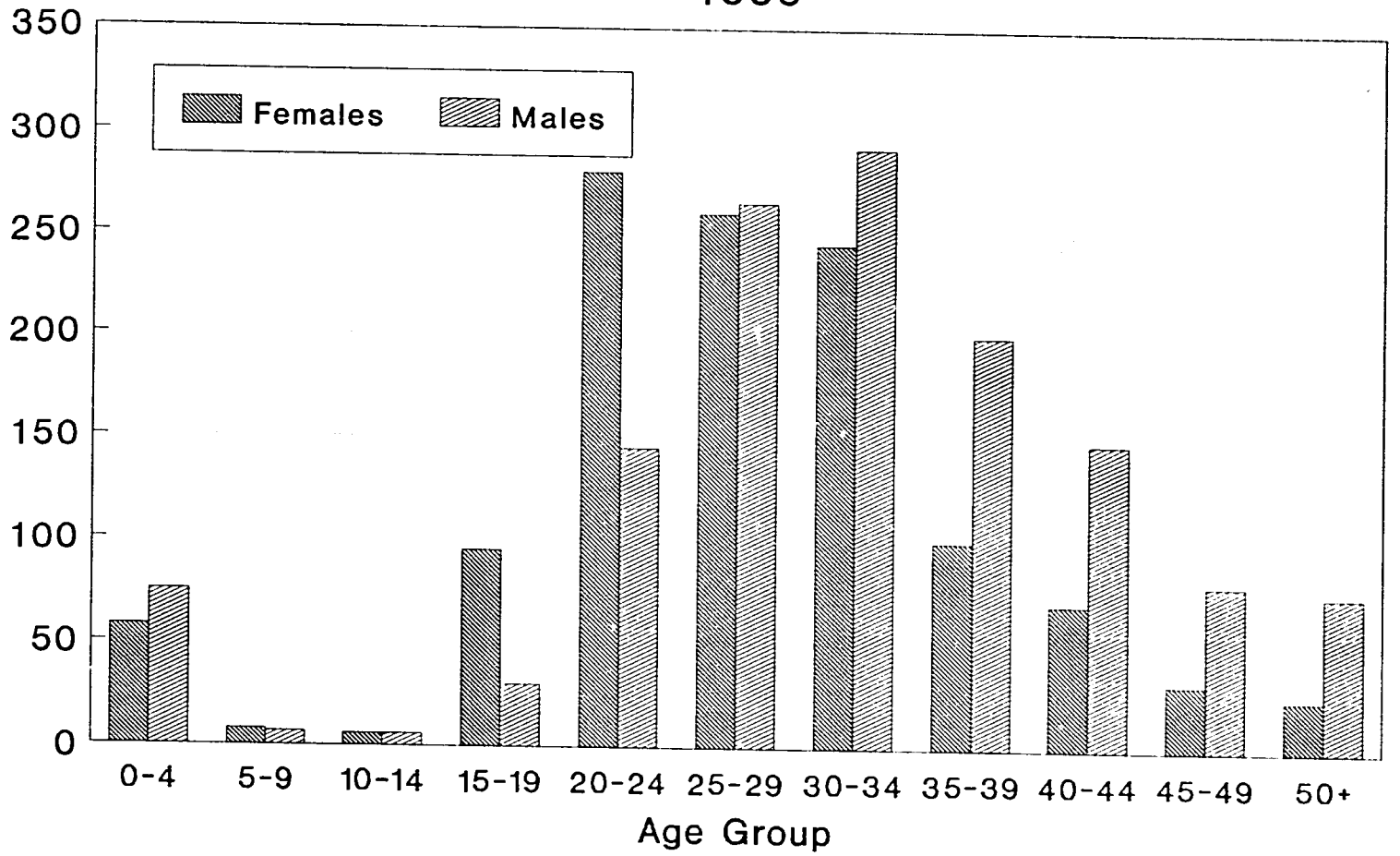


Figure 17.
Annual Adult AIDS Deaths



Source: MOH/AIDSTECH, March 1991

Figure 18.
Age and Gender Distribution of AIDS Cases
1990



Source: AIDS Secretariat, MOH

demonstrated that closely spaced births, births to very young and very old mothers, and high parity births increase risks for both mothers and children. In Malawi, nearly one-fourth of all births occur within two years of a previous birth, with an average interval of 2.3 years; 14% of all births occur to teenage mothers, 7% occur to mothers over age 40; and, over half the births to women over age 40 are parity 7 and higher. High fertility is in part response to high rates of infant and child mortality-- almost every family experiences the death of a child and the birth of another child is some compensation. However, this pattern of fertility is itself contributing to elevated mortality.

Access to family planning services, referred to as child spacing services in Malawi, has improved over recent years, but in 1990 only 200 out of 748 health facilities offered such services. In 1984 about 1.6% of women of reproductive years were currently using modern contraception; this figure was estimated at about 3.4% in 1989. The Demographic and Health Survey (DHS) scheduled to be conducted later this year will provide much needed current information on fertility and child spacing practices, in addition to infant and child morbidity and mortality estimates.

Maternal mortality has been estimated at 133 maternal deaths per 100,000 births on the basis of hospital records and 474 per 100,000 based on the sisterhood estimation method in a community study. In 1989 the MOH estimated that only 41% of births were attended by health workers or trained birth attendants (TBAs), although this figure was 69% from the 1984 Family Formation Survey. In 1989, 76% of women received antenatal care at least once. In 1984 only 29% of mothers attended clinics for postnatal care.

High fertility and a young population mean that a large number of women are pregnant most of their reproductive lives. They require antenatal, perinatal, and postnatal care for themselves and their children. Mothers and children are at elevated risk of disease and mortality and their large numbers place great demands on the fragile health care system and make improvements very difficult.

Health Policy and Health Care Delivery in Malawi

Evolution of Health Policy in Malawi

Since independence in 1964, the Government of Malawi has been committed to improving the health status of the population. The focus of this commitment has evolved gradually from a curative approach toward a more recent emphasis on primary health care.

From 1965 to 1969 the Government of Malawi emphasized the construction of health care facilities with concurrent manpower development to staff the new facilities. Resources were devoted mainly to curative services. A fifteen year plan devised in 1973 articulated initial development of basic health services with a concerted effort to control communicable diseases. A "mini-plan" that accompanied the fifteen year plan addressed maternal and child health issues. The objectives of the mini-plan included establishment of a countrywide basic health care system; reduction in morbidity and mortality from malaria, diarrheal diseases, tuberculosis, and schistosomiasis; provision of safe water and sanitation; nutrition education; and, prenatal and postnatal care. In 1982, the Government of Malawi through the Ministry of Health reiterated its commitment to primary health care and the provision of maternal and child health services.

The current 1986-95 Health Plan continues this approach. Its objectives are to establish a national network of health facilities and services accessible to the Malawi population; to continue manpower development to staff the facilities; to improve the managerial process currently in use in health facilities; to expand maternal and child health services; and, to improve the nutritional status of mothers and children.

The Malawi Government's commitment to population concerns has been less proactive. A child spacing program, first introduced in the early 1960's, was soon terminated due to opposition and misunderstanding concerning its objectives. In 1982, "child spacing" was reintroduced with slow but steady progress. Until recently the government has been reluctant to advocate aggressive interventions to slow population growth and reduce fertility. Although there is no explicit population policy, official support to strengthen the child spacing program has grown markedly over the past five

years. In particular, in 1989 Life President Banda formally approved child spacing and the launching of a social marketing program for condoms. In November 1990 Parliament formally established a national parastatal organization, the National Family Welfare Council, to coordinate and advocate child spacing activities. In June 1990 the Ministry of Health drafted a new five-year child spacing plan for 1990-1995. Within the past several months, government officials have begun to refer publicly to child spacing programs as family planning programs.

Health Care Delivery System

Health care in Malawi is provided by three major agencies. The Ministry of Health (MOH) has primary responsibility for developing policies, strategies, and programs for health care as well as service provision. Additionally, the Private Hospitals Association of Malawi (PHAM), comprising religious and other private volunteer agencies, operates nationwide hospitals, rural hospitals, and health centers. The Ministry of Local Government (MOLG) operates health facilities in 22 out of the 24 districts and in the four major cities. In 1985, 744 health facilities were operated by these three agencies and miscellaneous smaller groups. These figures remained approximately the same in 1990.

Ministry of Health

In the mid-1970's, the MOH adopted a primary health care approach designed to provide integrated health services throughout the country. The MOH operates a three tier health care system that includes central, district and specialized hospitals at the tertiary level; rural hospitals and health facilities at the secondary level; and community dispensaries, mobile clinics, health posts, and maternity clinics at the primary level.

Services at the primary level emphasize activities and interventions associated with maternal and child health care (health education, environmental sanitation, diarrheal disease control, immunization and growth monitoring) through a rather extensive network of outreach programs and fixed facilities. Much of the work is carried out by the 550 Health Surveillance Assistants (HSAs), most of whom are men. They are supervised by Health Assistants at the nearest fixed facility. It is estimated that most Malawians live within one hour of a health facility.

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At the secondary level, the MOH provides curative care; prenatal, natal and postnatal care for mothers; infant and child care; and, community health services through the following facilities:

20 rural hospitals,
9 maternity units,
113 dispensary/maternity centers,
93 dispensaries, and
15 health posts.

At the primary level, the MOH has 24 district hospitals serving as referral hospitals for their respective districts, and three central hospitals: Kamuzu Central Hospital (KCH) in Lilongwe, Queen Elizabeth Central Hospital (QECH) in Blantyre, and Zomba General Hospital. Together these hospitals provide a total of 6,815 beds, or just less than half of all beds in Malawi. Utilization of hospital services, both in-patient and out-patient, is very high. QECH has an in-patient capacity of 892 beds, but in-patients number between 1200 and 1500 daily. About 1000 out-patients are seen daily in addition to about 700 children at the Under-five clinics. At KCH the situation is even more crowded. Most of the hospitals' users come from cities where the hospitals are located; only a small percentage come from surrounding or further districts.

Private Hospital Association of Malawi (PHAM)

PHAM facilities provide services to about 1.3 million patients annually, close to half of Malawi's health services, including just over one-third of all hospital admissions. The types of services offered by PHAM are similar to those of the MOH, with the exception that although preventative services are available free of charge, user fees are charged for curative services. PHAM facilities are incorporated into the MOH's three tier system of care and thus include district hospitals, rural hospitals and health centers. PHAM operates 150 facilities with approximately 5,000 beds. PHAM institutions train almost 70% of the country's enrolled nurses.

The MOH provides about one third of the funding for PHAM facilities through an annual subsidy. Due to financial difficulties several PHAM units have requested the MOH to assume their operations, but due to lack of resources the MOH has not done so.

Ministry of Local Government (MOLG)

District councils, through the MOLG operate more than 100 health units: 19 dispensaries, 76 maternity units, and 9 health centers. About half of these units are adjacent to MOH facilities. These facilities provide about 660 beds, most of which are maternity beds. In general, the MOLG facilities are poorly financed and ill equipped compared to MOH and PHAM facilities.

Other Health Care Providers

There are miscellaneous other health care providers (curative and preventative) in Malawi including city governments; army; police; company and estate financed health facilities for employees; and, a small number of private practitioners. Together about 200 facilities are operated by these providers with about 600 beds. There are also approximately 1800 traditional health practitioners and 1000 traditional birth attendants, primarily in rural Malawi.

Personnel

Inadequate human resources severely constrain the delivery of health care and child survival services in Malawi. The ratio of one physician for every 60,000 population is the lowest in Africa. In many respects, Medical Assistants and Clinical Officers function as physician substitutes, but the ratio of one per more than 11,000 population makes them more thinly distributed than physicians in most countries. Coverage by lower level health personnel is also sparse: one registered nurse per 12,000 population, one enrolled nurse per 4000, one Health Inspector per 75,000, and one HSA per 25,000. In 1989, 75% of all service delivery staff were hospital based, three-fourths of which were deployed at referral and special hospitals.

Financial Resources

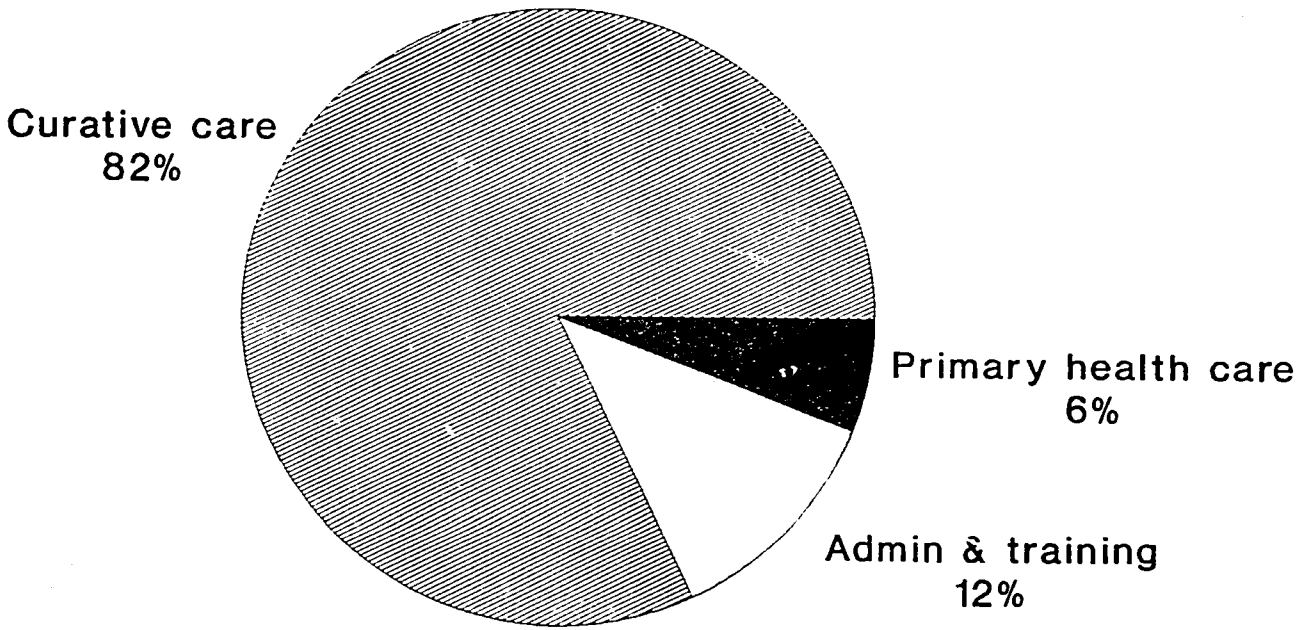
A major constraint to development of an adequate health care system in Malawi is lack of adequate financial resources. Throughout the 1970's, about 5% of the total GOM budget was allocated to recurrent health costs through the MOH. Since that time the proportion has increased slightly reaching about 7.2% in the past several years. The MOH budget for

1990/91 was K66.8 million, or approximately K7 (about US $2-3) per capita. This amount is inadequate to cover the full operating costs of existing services, let alone pay for recurrent costs of new projects.

Malawi has consistently devoted a large proportion of its health expenditures to curative care. Between 1983/84 and 1986/87, only 6% of the MOH recurrent budget was devoted to primary health care. (Figure 19) The MOH has a history of cost overruns of budget estimates resulting from a serious lack of financial control in many facilities. Recent studies have helped to identify ways in which expenditures could be reduced without sacrificing quality of services, estimating that as much as K4-5 million could be saved annually with better financial management.

All public health services, except in the paying wards of the central hospitals, are provided free. Private patients in MOH facilities pay fees (amounting to about 1% of the MOH budget), but they are heavily subsidized and do not cover the costs of services provided. Major demands on limited financial resources arise from the following: high cost of medicines and equipment due to inflation; the need for equitable, nationwide distribution of services and resources; expenses incurred in efforts to respond to epidemics such as AIDS; and the rapid increase in population.

Figure 19.
Ministry of Health Recurrent Budget
1983/84 - 1986/87



A.I.D. Child Survival Strategy

A.I.D. Program Strategy

In 1985 A.I.D. launched a major child survival initiative to reduce significantly the number of preventable child deaths in the developing world. Between FY85 and FY90 over one billion $US were committed to the Child Survival Program.

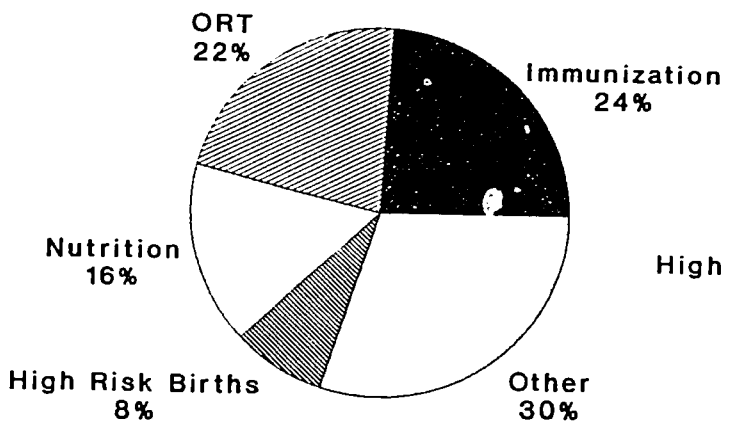
The foundation of the Agency's strategy has been promotion of two core interventions, immunization against childhood diseases and oral rehydration therapy (ORT) for diarrheal diseases. The implementation of this "twin engine" approach is expected to break the cycle of disease, malnutrition and death thereby allowing for further development of health care systems. Nearly half of all child survival funding from 1985 to 1990 was allocated to these two interventions. In addition to immunization and ORT, nutrition and high risk births have been important program areas. The distribution of funding by intervention for FY90 indicates a recent shift away from the twin engines toward expansion in other areas. (Figure 20)

While the Agency's focus has begun to broaden within the past several years in response to the changing needs and environment of child health in the developing world, a number of key strategies have continued to underlie A.I.D.'s child survival program:

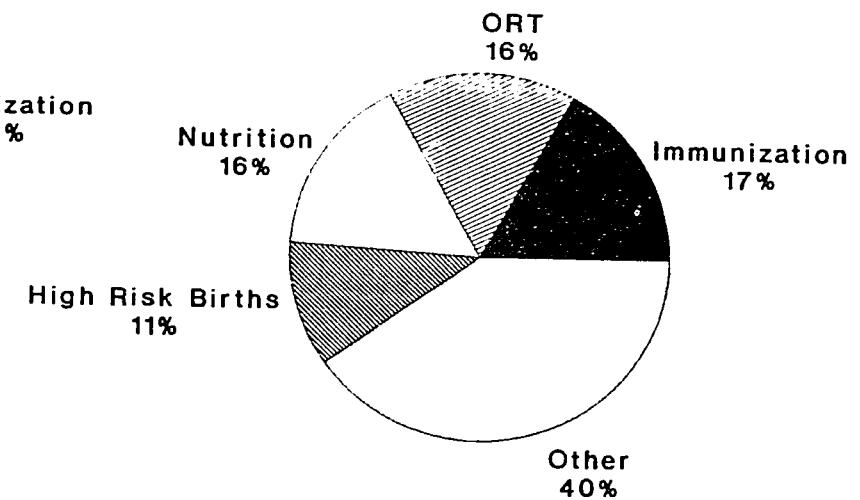
- Focus on a few relatively simple, proven technologies;
- Concentrate on countries with high infant and child mortality rates and in which the greatest impact can be made;
- Collaborate with other donors and agencies such as the World Health Organization, the United Nations Children's Fund, universities and host country institutions;
- Mobilize and work closely with the private sector, both private voluntary organizations and for-profit organizations;
- Provide technical assistance to field programs;
- Promote the development of sustainable services;
- Increase program effectiveness through problem-solving applied research; and,
- Monitor, evaluate, and refine program services.

Figure 20.
Total A.I.D. Funding for Child Survival by Intervention

FY85 - FY90



FY90



Source: Child Survival 1985-1990: A Sixth Report to Congress on the Program, 1991

[From *Child Survival 1985-1990: A Sixth Report to Congress on the USAID Program*, May 1991, p. 5.]

A.I.D. Child Survival Program Model

While emphasis has been placed on low-cost, simple, and proven preventative and curative child survival interventions, A.I.D.'s child survival program in practice is extensive and multidimensional. For the purpose of assessing the Agency's overall child survival program, we have developed a conceptual program model of child survival to better understand how the many dimensions of the program fit together. It was designed to be descriptive and comprehensive, providing a framework for looking at the many child survival interventions worldwide. In that respect, it communicates little about the various strategies that have been adopted and rejected, but provides a framework for examining different areas of emphasis within country-specific programs.

A survey of A.I.D. child survival programs in countries throughout the world has identified a comprehensive set of major *program areas*, categorized as follows:

- Immunization against childhood diseases: tetanus, polio, DPT, measles, BCG;
- Control of diarrheal diseases, including prevention and case management;
- Control of acute respiratory infections (ARI), primarily through case management;
- Control of malaria, including prevention and case management;
- Contr ol of AIDS, primarily through prevention;
- Nutrition programs, including Vitamin A and other micronutrient supplements, breastfeeding, growth monitoring;
- Promotion of healthy fertility behavior, with emphasis on family planning services;
- Maternal health and prenatal care;
- Primary health care;
- Water supply and sanitation; and
- Other disease control.

Within each of these program areas, a variety of activities may have been implemented. Some program areas may include a full spectrum of activities, while others include only one or several. For summary purposes, these *activity areas* have been categorized as follows:

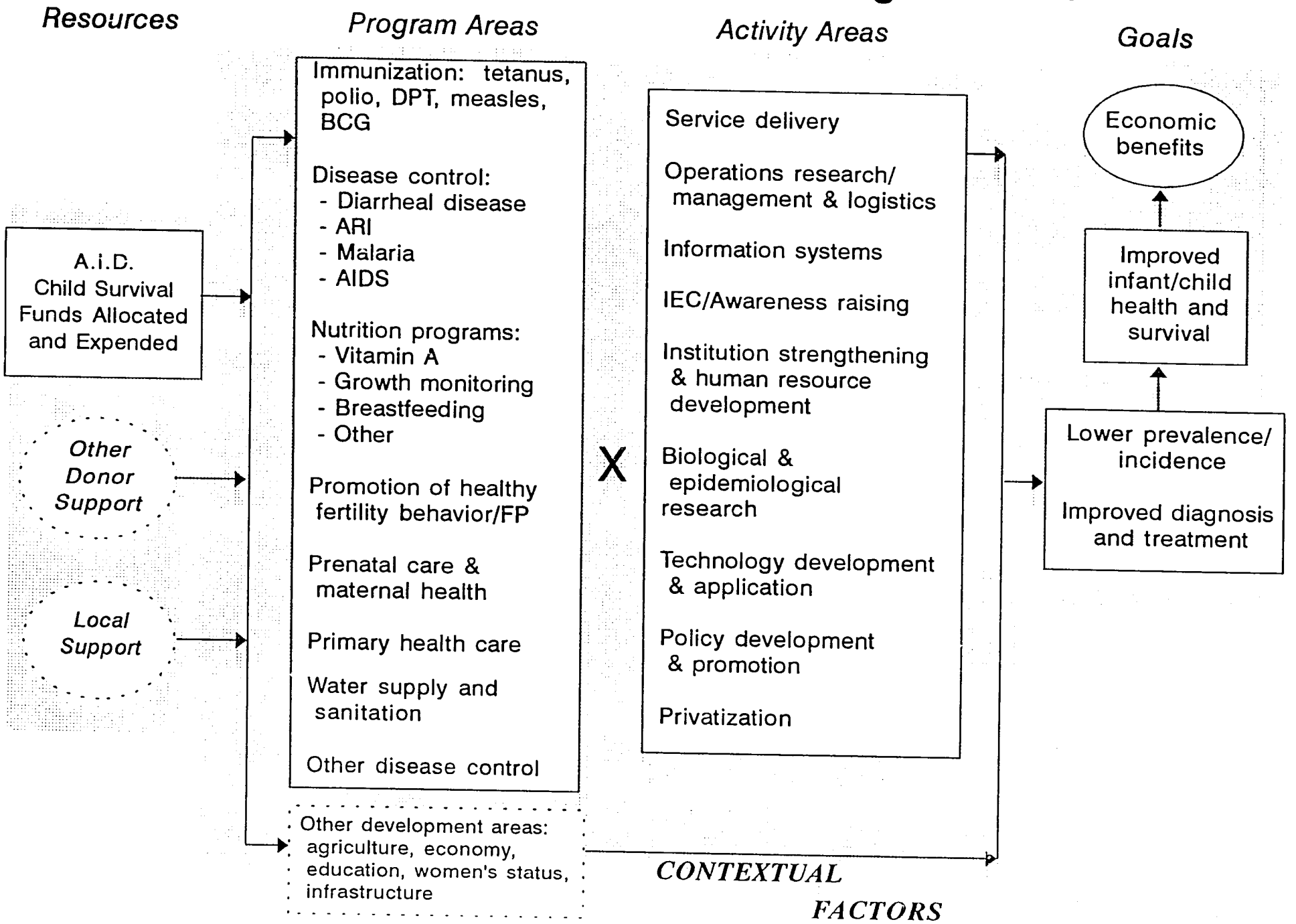
- Service delivery, including a broad spectrum of activities;
- Operations research, including logistics and management;
- Information systems for management, surveillance, monitoring and evaluation, etc;
- Information, education and communication (IEC) and awareness raising;
- Institution building/capacity strengthening and human resource development/training;
- Biological and epidemiological research;
- Technology development and application;
- Policy development assistance and promotion, including resource allocation and financing; and
- Privatization/assistance in developing and promoting the private sector involvement.

For example, a program in malaria control may encompass several activities such as implementation of an information surveillance system, biological research, IEC, and institutional strengthening; while a program in promotion of breastfeeding may comprise only IEC activities. These configurations vary among country-specific programs and projects.

The full spectrum of A.I.D.'s child survival program can be represented by a matrix of program areas crosstabulated by activity areas. Figure 21 describes how A.I.D. funds and other support operate through this program matrix to impact on child health and survival. The child survival program impacts on the final goals in conjunction with development assistance in other areas (such as agriculture, the economy and education) against a background of myriad contextual factors which may be either facilitative or constraining.

This conceptual model is provided to assist in describing the country-specific child survival programs of the six case studies included in the A.I.D. program-wide assessment and facilitate comparisons among

Figure 21. A.I.D. Child Survival Program Model



countries. It will be used to articulate Malawi's child survival program in the following chapter.

Bureau for Africa's Child Survival Action Plan

Today there is much geographic variation in child survival issues and the regional bureaus play an important role in defining areas of concern. Infant mortality rates in Africa are the highest of any region in the world. As one of three regions, about 24% of total A.I.D. funds for child survival were allocated to Africa from 1985-1990. The Bureau began targeting improved health for infants and children in 1981 with the initiation of the Africa Child Survival Initiative-Combatting Childhood Communicable Diseases project in 13 participating countries. The project focused on increasing immunization coverage, controlling diarrheal diseases, and combatting malaria.

While the Bureau for Africa follows closely the agency-wide child survival policy, conditions in Africa have necessitated modifications to the worldwide child survival strategy. In particular, in addition to the "twin engines" approach, the Africa Bureau strategy places special emphasis on interventions to address the following conditions:

- Very high fertility and closely spaced births;
- Prevalence of major diseases, including AIDS and malaria;
- Malnutrition resulting from inadequate food supplies and famine; and,
- Inadequate human resources to develop and maintain a health care delivery system.

In 1985 the Bureau for Africa identified eight African emphasis countries (Kenya, Malawi, Mali, Niger, Nigeria, Senegal, Sudan, Zaire), in which to focus special child survival efforts. Within these countries it is the responsibility of the USAID mission to develop country-specific child survival objectives that are consistent with and build upon the Bureau's Child Survival Action Plan.

In January 1991 a presidential mission of delegates from A.I.D. and the U.S. Department of Health and Human Services visited seven countries in Africa, including Malawi, to assess the situation of child survival. The

following conclusions and recommendations were made with regard to improving the survival of African children:

- Healthy economies provide resources for healthy children. U.S. policy should continue to emphasize broad-based economic growth to help create an environment in which health programs will be sustainable and effective;

- Strong primary health care policies and systems must undergird health interventions. U.S. assistance should continue to support targeted child survival activities while promoting policies to advance primary health care and integrated approaches to prevention;

- U.S. assistance in helping to combat malaria should be intensified, helping to develop more integrated approaches to applied and basic research and malaria control programs;

- Behavior change is the key to breaking the AIDS transmission chain. U.S. programs should support additional interventions to promote behavior change, encourage social marketing of condoms and control of sexually transmitted diseases, and support research on other means to reduce HIV transmission, including vaccines;

- Rapid population growth can overwhelm health care efforts. The U.S. should intensify assistance for improved reproductive health and family planning and should include efforts to increase the range of choice of contraceptive methods;

- Information technology can be more effectively harnessed in the battle to save children's lives. The U.S. should explore additional means to ensure that African professionals have access to public health information, technical assistance and training in epidemiology, disease surveillance, computer science, and data use.

[From *Child Survival and AIDS in Sub-Saharan Africa: Findings and Recommendations of the Presidential Mission to Africa*, January 4 - 18, 1991]

USAID/Malawi Mission Strategy

As a designated priority country for child survival in Africa, Malawi's funding for child survival represented about 11% of all child survival funds for Africa in FY90. Over the years there has been a gradual evolution of mission child survival priorities to reflect changing conditions within Malawi. These priorities parallel closely those outlined by the Bureau for Africa Child Survival Action Plan.

In fiscal years 1987 and 1988, USAID/Malawi articulated the following priorities for its "Second Generation Programs". These are to:

- Increase the percentage of health care facilities with ORT centers;
- Initiate a community based ORT education program;
- Increase immunization coverage of children under age five;
- Provide vitamin A supplements;
- Increase the number of Malawians with access to potable water;
- Increase the number of Malawians trained in sanitation and hygiene; and,
- Improve the capability of maternal and child health and family planning programs to be self-sustaining.

By 1991 USAID/Malawi had expanded its focus to include a response to the newly developing AIDS epidemic, while continuing to support implementation of its two core interventions, immunization and ORT. Its priorities for this year were to:

- Improve access to primary and preventive health services;
- Improve the monitoring and treatment of malaria;
- Reduce deaths due to diarrheal diseases;
- Reduce fetal AIDS transmission;
- Improve immunization coverage;
- Improve nutrition;
- Establish and strengthen health institutions' capabilities to plan and implement an AIDS control program; and,
- Increase knowledge of AIDS prevention in school age children.

USAID/Malawi's child survival strategy is fully integrated within the current overall health office objective to help combat three national public health emergencies: the AIDS and malaria epidemics, and extremely high

fertility and population growth rates. Two key strategies to meeting this objective are: to increase the numbers of health personnel in the public sector who provide AIDS, malaria, and family planning services; and, to lessen the public sector's burden for health care provision by developing private sector health services. Thus, a primary concern of the health program, including child survival, is one of institution strengthening and capacity building to promote longer term sustainability of programs and services.

USAID/Malawi Child Survival Program

Portfolio of Projects

USAID/Malawi views child survival as an integrated component of its broader health, population and nutrition (HPN) program. Although many of the past and ongoing projects have a singular child survival focus, others are multidimensional in design and implementation reflecting a philosophy that many child survival issues are better addressed from a broader approach. Because it is difficult to isolate the child survival components of many projects without an in depth study of the individual projects, we present in this section an overview of HPN projects both directly and indirectly related to child survival. Most of these projects are exclusively health-related projects for which HPN has primary management responsibility. However, HPN shares management responsibility for multisectoral projects and many centrally-funded projects are more or less outside the purview of HPN management.

Exhibit 2 presents a comprehensive list of these projects from 1985 to the present. Project periods and durations are indicated by the shaded time lines. Overall 12 bilateral projects, 3 regional projects, 25 centrally-funded projects, and 9 technical assistance projects have been identified. In more recent years there has been a shift toward bilateral project funding involving the Government of Malawi.

Summary information on these projects is provided in Exhibit 3. Information is included on budgeted funding, the area or locality served by the project, the target population, and the implementing institutions. Among the projects for which the locality of the intervention is known, approximately half of the projects are focused in specific districts, while the other half are intended to provide services in rural areas or nationwide.

The target population of a project is often difficult to specify. Many projects target services to women of reproductive age, mothers, and children. However, in recently implemented projects such as PHICS, although the ultimate objective of the project is to improve child survival,

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Exhibit 2
TIMELINE: USAID Funded Activities Related to Child Survival and Health in Malawi
FY 1980 to 1995

FY	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95
BILATERAL PROJECTS																
Self-Help Rural Water Supply																
Rural Development Linkages																
Health Institutions Development (HID)																
Human Resource/Institution Develop																
Family Health Initiatives																
Promoting Health Interventions for Child Survival (PHICS)																
Services for Health, Agriculture, Rural Enterprises (SHARED)																
Demographic and Health Survey (DHS)																
Child Spacing Commodities and Logistical Support																
Project HOPE AIDS																
Condoms for AIDS/STD Prevention																
Phalombe disaster assistance																
REGIONAL PROJECTS																
Africa Child Survival Initiative (CCCD)																
Africa Child Survival Initiative (CCCD)																
HIV/AIDS Prevention in Africa																
CENTRALLY FUNDED PROJECTS																
Community Organization of Primary Health Care: PRICOR																
Cornell Nutrition Surveillance																
CS Grant to ADRA																
CS Grant to IEF																
HEALTHCOM																
CS Grant to SCF																
PATH																
FY87 Vitamin A Grant to ADRA																
FY87 Vitamin A Grant to SCF																
FY88 Vitamin A Grant to SCF																
FY88 Vitamin A Grant to HK																
Improvement of Maternal and Infant Diet Project																
CS Grant to SCF																
CS Grant to IEF																
Vitamin A Grant to IEF																
Association for Voluntary Surgical Contraception (AVSC)																
SOMARC																
Johns Hopkins University AIDS Research																
WHO Global Program on AIDS																
A.I.D. support to UNICEF for E.P.I.																
American Schools and Hospitals Abroad (ASHA) Grants to Malamulo Hospital																
SEATS																
CS Grant to ADRA																
CS Grant to WVRD																
Project HOPE Child Survival																
TECHNICAL ASSISTANCE																
AIDSCOM (Mission Buy-in)																
ORT-HELP																
REACH																
WASH II																
AIDSTECH (Mission Buy-in)																
PRITECH																
Vector Biology Control																
Mangochi Malaria Research Project																
RAPID																
FY	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95

Exhibit 3. A.I.D. Child Survival Projects in Malawi

PROJECT NAME	NUMBER	TIME PERIOD	BUDGET (THOUSANDS)	AREA/ LOCALITY	TARGET POPULATION	INSTITUTION
BILATERAL PROJECTS						
Self-Help Rural Water Supply	612-0207	1980-88	$ 5,925	Women in rural communities	Rural population	Government of Malawi (GOM)
Malawi Rural Development Linkage (PVO)	612-0220	1983-89	$ 1,370	Mzimba and Kasungu District	General population	Save the Children Federation and GOM
Health Institutions Development	612-0211	1984-90	$ 8,700	Rural areas	Women and children	Ministry of Health and Howard University
Human Resources/Institution Development (HRID)	612-0230	1987-95	$18,000 T $ 1,309 H	Malawi	Professional and technical employees/women	Academy for Educational Development
Family Health Initiatives	612-AFHI	1988-	$ 660	--	--	--
Promoting Health Interventions for Child Survival (PHICS)	612-0231	1989-97	$20,443 T $15,000 H	Mzimba, Salima, Dedza, Dowa, Machinga, Mangochi, Mulanje	Rural population and children	Government of Malawi
Services for Health, Agricultural, Rural Enterprise Development (SHARED)	612-0232	1990-2000	$15,000 T $ 3,750 H	Essential rural areas	Malawian NGOs and US/International PVO's	The Experiment in International Living
Demographic and Health Surveys (DHS)	936-3023	1991-	$ 445	Malawi	Women of reproductive age	Macrosystems
Child Spacing Commodities and Logistical Support Program	--	Annual	$ 450	Malawi	--	--
Project HOPE/AIDS	--	1990-93	$ 722	--	--	PHAM and religious community
Condoms for AIDS/STD Prevention	--	Annual	$ 485	Malawi	--	--
Phalombe Disaster Assistance	--	1991-	$ 340	--	--	--

-- No information available

Budget: T = Total
H = Health Component

Exhibit 3. A.I.D. Child Survival Projects in Malawi

PROJECT NAME	NUMBER	TIME PERIOD	BUDGET (THOUSANDS)	AREA/ LOCALITY	TARGET POPULATION	INSTITUTION
REGIONAL PROJECTS						
Africa Child Survival Initiative Subproject 12: Malawi	698-0421	1985-89	--	Malawi	Children under age 5	--
Africa Child Survival Initiative Combatting Childhood Communicable Disease	612-CCCD	1981-88	--	Sub-Saharan African Countries	Children under age 5	Centers for Disease Control
HIV/AIDS Prevention in Africa	698-0474	1991-92	$ 800	--	General population	--
CENTRALLY FUNDED PROJECTS						
Community Organization of Primary Health Care: PRICOR	936-5920	1982-85	--	--	Primary health care program donors and planners	--
Cornell Nutrition Surveillance (Nutrition and Dietary Surveys)	931-1064	1984-89	--	Malawi	Institutions/ governments	Cornell University
Child Survival Grant to Adventist Development Relief Agency (ADRA)	938-0508	1985-88	$ 308	15 Clinics throughout Malawi	Women and children	Adventist Development Relief Agency
Child Survival Grant to International Eye Foundation (IEF)	938-0501	1985-88	$ 442	Lower Shire, Valley Eastern Malawi	Women and children	International Eye Foundation
HEALTHCOM (Communication for Child Survival)	931-1018	1985-88	--	--	Mothers	Academy for Educational Development
Child Survival Grant to Save the Children Federation (SCF)	938-0524	1986-89	$ 280	Nzimba District, Northern Region	Women and children	Save the Children Federation
Program for Appropriate Technology in Health (PATH) for HEALTHTECH Technologies for Child Health	936-5968	1987-91	--	Malawi	Women and children	Programs for Appropriate Technology in Health

-- No information available

Budget: T = Total
H = Health Component

Exhibit 3. A.I.D. Child Survival Projects in Malawi

PROJECT NAME	NUMBER	TIME PERIOD	BUDGET (THOUSANDS)	AREA/ LOCALITY	TARGET POPULATION	INSTITUTION
FY 87 Vitamin A Grant to Adventist Development Relief Agency	931-0045	1987-91	$ 100	--	--	Adventist Development Relief Agency
FY 87 Vitamin A Grant to Save the Children Federation	931-0045	1987-90	$ 127	--	--	Save the Children Federation
FY 88 Vitamin A Grant to Save the Children Federation	931-0045	1988-91	$ 500	--	--	Save the Children Federation
FY 88 Vitamin A Grant to Helen Keller International	931-0045	1988-91	$ 1,256	--	--	Helen Keller International
Improvement of Maternal and Infant Diet Project	931-1101	1988-89	$ 56	--	Women and children	--
Child Survival Grant to Save the Children Federation	938-OSCF	1989-92	$ 600	Mbalachanda and Mkota Districts in Central Region	Women and children	Save the Children Federation
Child Survival Grant to International Eye Foundation	938-OIEF	1989-94	$ 1,330	Lower Shire in Southern Region	Women and children	International Eye Foundation
Vitamin A Grant to International Eye Foundation	938-OIEF	1989-91	$ 415	--	--	International Eye Foundation
Association for Voluntary Surgical Contraception (AVSC)	--	1990-92	$ 71.4	--	--	PHAM
Malawi Health Social Marketing Project (SOMARC)	--	1990-93	$ 600	Malawi	--	--
Johns Hopkins University AIDS research	--	1989-91	$ 200	Queen Elizabeth Hospital in Blantyre	--	NIH and John Hopkins University
WHO Global Program on AIDS (GPA)	--	1989-90 1991	$ 600 $ 400	--	--	--
AID Support to Malawi EPI	--	1991	$ 500	--	Women and Children	UNICEF/Malawi

-- No information available

Budget: T = Total
H = Health Component

Exhibit 3. A.I.D. Child Survival Projects in Malawi

PROJECT NAME	NUMBER	TIME PERIOD	BUDGET (THOUSANDS)	AREA/ LOCALITY	TARGET POPULATION	INSTITUTION
The American Schools and Hospitals Abroad (ASHA)	--	1980-90	$ 3,000	Malamulu Hospital in Thyolo District	--	--
Family Planning Service Expansion and Technical Support (SEATS)	--	1990-94	$ 500	Malamulo Hospital; National Family Welfare Council; Ekwendi Hospital	--	--
Child Survival Grant to Adventist Development Relief Organization	--	1990-93	$ 550	Nsange District in Southern Region	Women and children	Adventist Development Relief Organization
Child Survival Grant to World Vision Relief and Development	--	1990-93	$ 475	Lilongwe District in Central Region	Women and children	World Vision Relief Organization
Child Survival Grant to Project Hope	--	1991-94	$ 575	Estate Section in Thyolo District	Women and children	Project Hope
TECHNICAL ASSISTANCE						
AIDSCOM	538-0161	1989-92	$ 800	--	High risk groups, decision makers, health professionals	--
ORT-HELP	936-5939	--	--	--	--	--
REACH	936-5927	--	--	--	--	John Snow, Inc.
WASH II	936-5942	1984-89	$19,700	--	General population	Camp, Dresser and Mckee
AIDSTECH	936-5972	1989-97 1990-92	$127,227 $ 200	--	High risk groups, decision makers, health professionals	Family Health International
PRITECH I PRITECH II	936-5927 936-5696	1983-88 1987-92	$ 410 --	--	--	Management Services for Health
Vector Biology and Control (Malaria Control in Malawi)	936-5948	1985-95	$ 19,880	Malawi	General population	Medical Science Corporation International

-- No information available

Budget: T = Total
H = Health Component

Exhibit 3. A.I.D. Child Survival Projects in Malawi

PROJECT NAME	NUMBER	TIME PERIOD	BUDGET (THOUSANDS)	AREA/ LOCALITY	TARGET POPULATION	INSTITUTION
Mangochi Malaria Research Project (MMRP)	--	1987-90	$ 500	Mangochi District	Pregnant women	CDC and Malawi Government
Population, Health, and Development Project (RAPID)	--	Annual 1989-92	$ 50	—	Decision makers, host institutions	Research Triangle Institute and the Futures Group

-- No information available

Budget: T = Total
H = Health Component

the immediate target population could be considered health institutions and manpower, thus blurring the interpretation of who is the actual target population.

The implementing institutions for A.I.D.-supported activities include a variety of public and private entities such as the Malawi Government, U.S. and Malawian Private Voluntary Organizations and Non-Governmental Organizations, religious groups, universities, and private contractors.

More detailed project summaries were prepared for each of the identified projects and are bound separately from this report in Appendix A. In addition to the information presented in Exhibit 3, each summary provides a brief statement on the project purpose or objectives, history or background, accomplishments, issues, and evaluation results.

Sources of Information

Project information was obtained from project papers, logframes, project abstracts, project renewal documents, and mid- and/or final evaluations. Sources of information available to us for compiling this summary of projects are identified in Exhibit 4. The project paper provides a comprehensive description of initially proposed project activities. Evaluations present a more accurate picture of what actually was implemented at various stages throughout the project. It was rare, however, to have both project paper and evaluation for a given project, thus making a comparison of planned activity to implemented activity impossible in most cases. In some instances, mainly for centrally funded projects, only a project abstract or logical framework (logframe) was available. The abstract presents a concise summary of planned project activities. The logframe summarizes the goal, purpose, inputs, and outputs for a planned project. In these cases, it is important to note that the presented data reflect the limited available information from these summary sources.

Current Projects

The current portfolio of A.I.D.-funded health projects in Malawi includes 23 activities with combined funding of almost $US 38 million, approximately 75% of which is bilateral aid. These projects are listed in Exhibit 5 by topic area: integrated and multisectoral, PVO/NGO child survival, population and family planning, AIDS prevention, and other.

Exhibit 4. Information Sources: A.I.D. Child Survival Projects in Malawi

PROJECT NAME	NUMBER	PROJECT PAPER	LOG FRAME	ABSTRACT	EVALUATION	OTHER
BILATERAL PROJECTS						
Self-Help Rural Water Supply	612-0207		X	X	Mid Year	Brief Reports
Malawi Rural Development Linkage (PVO)	612-0220			X	Final	
Health Institutions Development	612-0211	X	X	X		
Human Resources/Institution Development (HRID)	612-0230	X	X	X	Mid Year	
Family Health Initiatives	612-AFHI					
Promoting Health Interventions for Child Survival (PHICS)	612-0231	X	X	X		
Services for Health, Agricultural, Rural Enterprise Development (SHARED)	612-0232	X	X (in PP)	X		
Demographic and Health Surveys (DHS)*	936-3023	X	X	X		
Child Spacing Commodities and Logistical Support Program	--			X		
Project HOPE/AIDS	--			X		
Condoms for AIDS/STD Prevention	--			X		
Phalombe Disaster Assistance	--					
REGIONAL PROJECTS						
Africa Child Survival Initiative Subproject 12: Malawi	698-0421	X		X	Economic	
Africa Child Survival Initiative Combatting Childhood Communicable Disease	612-CCCD	X			Fifth Year	
HIV/AIDS Prevention in Africa*	698-0474	X		X		

*Overall project information - not Malawi specific.

Exhibit 4. Information Sources: A.I.D. Child Survival Projects in Malawi (continued)

PROJECT NAME	NUMBER	PROJECT PAPER	LOG FRAME	ABSTRACT	EVALUATION	OTHER
CENTRALLY FUNDED PROJECTS						
Communi8ty Organization of Primary Health Care: PRICOR	936-5920		X	X		
Cornell Nutrition Surveillance (Nutrition and Dietary Surveys)	931-1064		X	X		
Child Survival Grant to Adventist Development Relief Agency	938-0508			X		Contract
Child Survival Grant to International Eye Foundation	938-0501			X		Contract
HEALTHCOM (Communication for Child Survival)	931-1018		X	X	Mid Year*	
Child Survival Grant to Save the Children Federation	938-0524			X		Contract
Program for Appropriate Technology in Health (PATH) for HEALTHTECH Technologies for Child Health	936-5968			X	Mid Year	Final Report
FY 87 Vitamin A Grant to Adventist Development Relief Agency	931-0045		X	X		
FY 87 Vitamin A Grant to Save the Children Federation	931-0045					
FY 88 Vitamin A Grant to Save the Children Federation	931-0045					Overall Grant
FY 88 Vitamin A Grant to Helen Keller International	931-0045					
Improvement of Maternal and Infant Diet Project	931-1101				Evaluation of 931-1010	
Child Survival Grant to Save the Children Federation	938-OSCF					
Child Survival Grant to International Eye Foundation	938-OIEF					
Vitamin A Grant to International Eye Foundation	938-OIEF				Mid Year	Directory
Association for Voluntary Surgical Contraception (AVSC)	–			X		
Malawi Health Social Marketing Project (SOMARC)	–			X		
Johns Hopkins University AIDS research	–			X		

*Overall project information - not Malawi specific.

Exhibit 4. Information Sources: A.I.D. Child Survival Projects in Malawi (continued)

PROJECT NAME	NUMBER	PROJECT PAPER	LOG FRAME	ABSTRACT	EVALUATION	OTHER
WHO Global Program on AIDS (GPA)	--			X		
AID Support to Malawi EPI	--			X		
The American Schools and Hospitals Abroad (ASHA)	--			X		
Family Planning Service Expansion and Technical Support (SEATS)	--			X		
Child Survival Grant to Adventist Development Relief Organization	--			X		
Child Survival Grant to World Vision Relief and Development	--			X		
Child Survival Grant to Project Hope	--			X		
TECHNICAL ASSISTANCE						
AIDSCOM	538-0161		X	X		
ORT-HELP	936-5939					
REACH	936-5927					
WASH II	936-5942			X		
AIDSTECH	936-5972		X	X		
PRITECH I PRITECH II	936-5927 936-5696	X	X	X		
Vector Biology and Control (Malaria Control in Malawi)	936-5948		X	X		Report
Mangochi Malaria Research Project (MMRP)	--			X		
Population, Health, and Development Project (RAPID)	--			X		

*Overall project information - not Malawi specific.

Exhibit 5. Summary of Current USAID Support to the Health and Population Sector in Malawi as of October 1991

	Period	Amount
Integrated and Multisectoral Projects		
	1989-1997	$20,400
Promoting Health Interventions for Child Survival (PHICS)	1987-1995	1,300
Human Resources and Institutional Development (HRID)	1990-2000	3,750
Services for Health, Agriculture and Rural Enterprise Development (SHARED)		
PVO/NGO Child Survival Projects		
Save the Children Federation (SCF)	1989-1992	600
International Eye Foundation (IEF)	1989-1992	1,330
Adventist Development and Relief (ADRA)	1990-1993	550
World Vision Relief and Development (WVRD)	1990-1993	475
Project HOPE Child Survival	1990-1992	150
Population and Family Planning		
Child spacing commodities	Annual	450
Demographic and Health Survey (DHS)	1991-1992	445
Association for Voluntary Surgical Contraception (AVSC)	1990-1992	150
Family Planning Service Expansion and Technical Support Project (SEATS)	1990-1994	500
Health Social Marketing Project (SOMARC)	1990-1993	660
Resources for Awareness of Population Impacts on Development (RAPID)	1989-1991	100
AIDS Prevention		
AIDS Communications Support (AIDSCOM)	1989-1992	800
AIDS Technical Support (AIDSTECH)	1990-1992	200
Project HOPE AIDS	1990-1993	720
Johns Hopkins University AIDS Research	1989-1991	200
Condoms for AIDS/STD prevention	Annual	485
WHO/Global Program on AIDS (GPA)	Annual	400
Other Health Activities		
A.I.D. support to UNICEF for E.P.I.	1991	500
American Schools and Hospitals Abroad (ASHA) Grants to Malmulo Hospital	1980-1990	3,000
Phalombe disaster assistant: rehabilitation of piped water scheme	1991	340
	Total	$37,930

Most of these projects began between 1989 and 1991 with durations ranging from one year to ten years. The most significant future activity is the proposed $US 40 million Family Health and AIDS Control Support project planned for 1992-2000.

In addition to broadening program areas over the past few years, USAID/Malawi has also developed a program strategy that emphasizes human resource development and institution building in the health sector. A look at the major currently funded projects (PHICS, Self-Help Rural Water, and Health Institutions Development) reveals this focus. In an effort to address the severe health manpower shortages and the inadequate health infrastructure, these projects promote activities in information and education, human resource development, and sustainability.

Program Model

It is difficult to summarize the child survival program in Malawi based on this survey of health and population projects because of differing characteristics among the projects, i.e. scope, level of effort and funding, and the multisectoral approaches of many of them. For example, it is not possible to calculate the distribution of allocated funds by program area (i.e., immunization, nutrition, family planning, etc.) or by activity area (i.e., service delivery, IEC, policy promotion, etc.) with any degree of accuracy. Nevertheless, we reviewed the projects with reference to the A.I.D. Child Survival Program Model that was developed to help describe the agency-wide child survival program, and crosstabulated program areas by activity areas for each project when sufficient information was available to do so. A summary table of activities by program area was prepared for each project. These are provided in Appendix B.

An analysis of these summary tables shows the following:

- The full array of program areas are represented in the portfolio of projects. Areas with the greatest concentration of projects include: immunization, nutrition (including Vitamin A), family planning, and recently AIDS. Areas with least representation include acute respiratory infections and prenatal care. Again, this is based on number of projects, not funding level.

- The program is comprised of both single- and multi-focus projects. Of the 35 projects for which we have information, half had a single program area as their focus, while the other half addressed multiple program areas.

- Almost all (over two-thirds) projects had activities in institution building and/or human resource development. While this has been articulated recently as a priority, it was an integral activity in many of the earlier projects as well.

- Except among projects whose primary focus is institution building, a spectrum of activities is usually undertaken within each program area. In particular, service delivery is rarely provided without an IEC and/or information systems component.

- Policy efforts and privatization are the two most under represented activity areas. Policy activities have been in AIDS and population only, while recent privatization efforts include social marketing of condoms and assistance to develop employer-based health care services.

Undoubtedly, certain combinations of activities and program areas work more, or less, effectively and efficiently to achieve sustainable program impacts. Finding optimal solutions to child survival problems based on review of past programs and strategies is a major challenge of the child survival program assessment.

Selected References

In addition to the specifically referenced A.I.D. project documents obtained through A.I.D./Washington, information for this report was obtained from USAID/Malawi HPN file materials and the following influential reports:

Poverty in Malawi: A Situation Analysis, United Nations, January 1991.

Child Survival 1985-1990: A Sixth Report to Congress on the USAID Program, U.S. Agency for International Development, Washington, DC, may 1991.

Child Survival and AIDS in Sub-Saharan Africa: Findings and Recommendations of the Presidential Mission to Africa, U.S. Agency for International Development and the Department of Health and Human Services, January 1991.

RESEARCH TRIANGLE INSTITUTE

CHILD SURVIVAL IN MALAWI: BACKGROUND REPORT FOR THE FIELD STUDY

APPENDIX A:
Summaries of USAID/Malawi Child Survival Projects

APPENDIX B:
Project Summary Tables

Submitted to

Center for Development Information and Evaluation
U.S. Agency for International Development
AID/CDIE/POA/E
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Washington, DC 20523

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Child Survival Analytical and Design Work

Prepared by

Research Triangle Institute
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February 13, 1992

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APPENDIX A

Summaries of USAID/Malawi Child Survival Projects: 1985 to Present

CURRENT PROJECTS

This summary of current health and population projects was prepared by the HPN Office, USAID/Malawi.

Summary of Current and Planned USAID Support
to the Health and Population Sector in Malawi
(as of October 1991)

			Amount
I.	Current		
A.	Integrated and multi-sectoral projects	Duration	($000)
1.	Promoting Health Interventions for Child Survival (PHICS)	1989-1997	20,400*
2.	Human Resources and Institutional Development (HRID)	1987-1995	1,300*
3.	Services for Health, Agriculture and Rural Enterprise Development (SHARED)	1990-2000	3,750*
B.	PVO/NGO child survival projects		
1.	Save the Children Federation (SCF)	1989-1992	600
2.	International Eye Foundation (IEF)	1989-1992	1,330
3.	Adventist Development and Relief (ADRA)	1990-1993	550
4.	World Vision Relief and Development (WVRD)	1990-1993	475
5.	Project HOPE Child Survival	1990-1992	575
C.	Population and family planning		
1.	Child spacing commodities	annual	450*
2.	Demographic and Health Survey (DHS)	1991-1992	445*
3.	Association for Voluntary Surgical Contraception (AVSC)	1990-1992	150
4.	Family Planning Service Expansion and Technical Support Project (SEATS)	1990-1994	500
5.	Health Social Marketing Project (SOMARC)	1990-1993	660
6.	Resources for Awareness of Population Impacts on Development (RAPID)	1989-1991	100
D.	AIDS prevention		
1.	AIDS Communications Support (AIDSCOM)	1989-1992	800*
2.	AIDS Technical Support (AIDSTECH)	1990-1992	200*
3.	Project HOPE AIDS	1990-1993	720*
4.	Johns Hopkins University AIDS Research	1989-1991	200
5.	Condoms for AIDS/STD prevention	annual	485*
6.	WHO/Global Program on AIDS (GPA)	annual	400
E.	Other health activities		
1.	A.I.D. support to UNICEF for E.P.I.	1991	500
2.	American Schools and Hospitals Abroad (ASHA) Grants to Malamulo Hospital	1980-1990	3,000
3.	Phalombe disaster assistance: rehabilitation of piped water scheme	1991	340*
		Sub-total	$37,930

II. Planned and proposed

A.	Family Health and AIDS Control Support Project (FHACS)	1992-2000	40,000*
B.	PHICS Water and Malaria Amendment	FY 1992	6,300*
C.	AFRICARE Matching grant proposal for water scheme development	1992-1997	690
		Sub Total:	$46,990
		Total:	$84,920

* Bilateral funds.

A. Introduction: The A.I.D.-funded portfolio of health projects in Malawi consists of the 23 activities listed on page one. The listing does not include many one-time only A.I.D.-funded health activities such as attendance at international conferences, small grants, and technical assistance outside the context of a project.

B. Objectives: The portfolio is intended to address three strategic objectives:

a. To reduce fertility and population growth rates.
b. To reduce infant and child mortality and morbidity rates.
c. To control the spread of HIV/AIDS.

C. Value of assistance: Grant assistance to the health sector in Malawi is valued at approximately $38 million for on-going projects, approximately 75% of which is in bilateral support. In addition, another $46 million worth of new bilateral health activities are under design. With the expiration of the HAPA-funded Johns Hopkins University AIDS research project at the end of December 1991, there will no longer be any activities supported with Africa Bureau regional funding.

D. Project type: Most activities are exclusively health-related "projects" for which HPN has primary management responsibility. Others are components of Mission-funded multi-sectoral projects such as HRID (minimum of $1.3 million for health) and SHARED (approximately $3.7 million for health) for which HPN management responsibility is shared with the HRDO and AFS. HPN control and management responsibility for some projects is either limited (e.g. the five centrally-funded child survival projects) or non-existent (A.I.D. support to WHO/GPA and UNICEF/EPI).

E. Implementing agent: A.I.D.-supported activities are implemented by a variety of public, parastatal and private sector entities such as the Malawi Government (MG); U.S. and Malawian Private Voluntary Organizations (PVOs) and Non-Governmental Organizations (NGOs); church groups; universities; and private contractors and private sector firms.

F. Summary report on HPN activities: On the following pages, there are capsule summaries of HPN activities on the list, indicating implementation status and actions as of October 1991.

A. Promoting Health Interventions for Child Survival Project (PHICS):

1. Summary:

a. Introduction: An 8-year (1989-1997), $20.4 million bilateral grant to the MG, of which $15 million is for the Ministry of Health (MOH) to improve and expand primary health care (PHC) services, and $5.4 million is for the Ministry of Works (MOW) to extend the rural piped water system.

b. Project's ancestry: PHICS provides continuation support to address needs previously met by four separate USAID-funded projects; Rural Piped Water, Combatting Childhood Communicable Diseases (CCCD), the Mangochi Malaria Research Project (MMRP), and the Howard University-implemented Health Institutions Development Project (HID). PHICS also adds a major new focus on instititutional and human resource development and on AIDS. A.I.D. support for priority PHC activities consolidated under a single bilateral grant is expected to facilitate program integration, efficiency and sustainability.

c. PHICS and Health Manpower: On 30 September 1990, the 6-year (1984-1990), $8.7 million Howard University-implemented Health Institutions Development (HID) Project came to an end. On 25 September 1990, a $5.4 million amendment to the PHICS Project Grant Agreement was signed which will help address the following priority health manpower needs: the establishment of a new pre-service training program for community health workers (Health Surveillance Assistants); the completion of ongoing Health Assistants' (HAs), Family Health and AIDS in-service training programs; the establishment of an MOH health manpower planning and development unit; the further strengthening of the capacity of the Lilongwe School for Health Sciences to plan and conduct expanded training programs for the nation's paramedics; and the design and implementation of a new national integrated program of in-service training for MOH personnel.

d. PHICS and Malaria Control: The MMRP was a 3-year (1987-1990), $500,000 Limited Scope Grant Agreement with the MG for the local costs of malaria research in Mangochi District conducted by the U.S. Centers for Disease Control (CDC) in collaboration with the MOH. On 30 June 1990, the MMRP was completed on schedule. Malaria in pregnancy research goals were met and findings are being incorporated into MOH malaria policies and programs.

PHICS is helping to meet a second MMRP/MOH goal: to retain and continue research capability developed under the MMRP and incorporate this capability into the MOH as their first field research station under the Community Health Sciences Unit (CHSU)/Epidemiology Section. PHICS supports certain core costs of the research station. CDC and USAID provided TA to the MOH to assist with the development of its new 5-year national malaria control plan. At the request of the MOH, PHICS is meeting long- and short-term TA needs identified in the new plan via three mechanisms: a Mission PASA with CDC, a buy-in to the VBC Project, and a buy-in to the TAACS program for a LT malaria advisor.

e. PHICS and AIDS Control: PHICS supports specific AIDS activities such as in-service training for health workers, as well as activities considered essential for the successful implementation of the AIDS control program such as the strengthening of the MOH Health Education Unit (HEU) and support to MOH health research, epidemiology, and information units which support the AIDS program.

f. Project objectives:

(i) Institutional and Human Resource Development: To strengthen the capacity of MOH training institutions and service delivery support units to plan, implement, and evaluate an expanded PHC service delivery system including a new AIDS component and enlarged malaria and child spacing components.

(ii) Service Delivery: To increase the supply and utilization of preventive health care services among rural Malawians by expanding and decentralizing the national health education program; hiring new community health workers and support staff; providing pre- and in-service training in priority subjects such as child spacing and malaria; and providing access to an additional 250,000 people to potable piped water and hygiene education and sanitation services.

(iii) Sustainability: To sustain PHC services by supporting policies and program strategies which promote institutionalization; supporting increases in the relative and absolute level of human and financial resources committed to PHC; and ensuring the recurrent costs of an expanded PHC program are assumed by the MG.

2. and 3. Implementation status and Actions/issues:

Please refer to the PHICS Project Implementation Report (PIR) for the period 1 April 1991 through 30 September 1991 for a summary of the Project's implementation status, accomplishments to date, and main issues and actions.

B. Human Resources and Institutional Development Project (HRID):

1. Summary: An 8-year (1987-1995), $18 million grant under which $1.3 million have been earmarked for health sector human resource and institutional development activities.

2. Implementation status:

a. To strengthen training capacity at Kamuzu College of Nursing (KCN), 3 faculty members have been sent to the U.S. to earn Master's degrees. Two will return in the summer of 1992 and one in 1993.

b. To clarify the optimal allocation of HRD activities between HRID and PHICS, a review of planned support to the 5-year National Health Manpower Plan was undertaken. The review reconfirmed the plan to support health management training activities and the strengthening of KCN under HRID, while PHICS would focus on support to the Lilongwe School for Health Sciences and the Ministry of Health's Manpower Planning and Development Unit.

c. In March 1991, Delivery Order No. 45 was approved, earmarking $753,000 for the implementation of priority HRID health project activities, including the following:

Master's Level Training: 3 PHAM and 4 MOH staff members will earn Master's degrees between 1991 and 1994. Of the seven candidates, 2 will be trained in Nursing (KCN), 2 in Hospital Administration and 3 in Health Administration.

KCN: One faculty member is being sponsored to earn a Bachelor's degree at KCN. Recruitment of a long-term Technical Advisor for KCN was resumed after the primary candidate was disqualified by the University of Malawi on the basis of age. Instructional commodities worth $20,000 are being procured.

d. Of the remaining funds earmarked for HRID project health activities, it is anticipated that approximately $25,000 will be used for short-term training at the Malawi Institute for Management and approximately $200,000 will be used to procure additional instructional commodities for KCN. KCN's educational material and equipment needs are currently being costed in detail.

3. Actions/Issues:

a. Develop plan for HRID support for MIM-implemented activities.

b. Review final KCN equipment list and costing; proceed with procurement.

C. Services for Health, Agriculture, Rural and Enterprise Development Project (SHARED):

1. Summary: A 9-year (1991-2000), $15 million bilateral project to strengthen and expand the capacity of Malawian and U.S. PVOs to contribute to the attainment of key development objectives. Under this multi-sectoral "PVO Umbrella" project, USAID will support PVOs to strengthen and expand social services including PHC, child spacing and AIDS services. The initial Project design envisions roughly 25% of Project resources ($3,750,000) being devoted to HPN.

2. Implementation status: On 29 July - 2 August, 70 participants representing NGOs, government, the university, USAID/HPN and other health institutions attended the SHARED Project HPN Sector Workshop in Mzuzu. One outcome of the workshop was the formation of a NGO Technical Committee on PHC. This body will represent NGOs on relevant committees of the GOM/MOH, MOCS and CSWS. On 13-15 August, a PHAM diagnostic workshop was held in Lilongwe. Attended by 30 participants representing 23 churches, the workshop served as one step in a process designed to strengthen PHAM's institutional capacity. By way of self-evaluation, workshop participants identified constraints, formulated strategies and developed action plans to improve PHAM. Through these two workshops, the groundwork has been laid for eventual SHARED grant awards in the health sector.

3. Actions/issues: HPN continue dialogue with AFS and mission management regarding SHARED Project relationship with HPN sector in general and the new population and AIDS bilateral project in particular. Maintain mission consensus on magnitude, type and timing of SHARED Project support to the health sector. Establish coordination mechanisms between EIL and Mission/HPN to ensure sufficient degree of HPN control over health project identification, and proposal review and approval process to help ensure maximum coordination. By end-November, finalize letter updating EIL on mission funding strategy for health sector.

D. Five U.S. PVO Child Survival (CS) Projects:

1. Summary: The following five U.S. PVOs were awarded a total of $3.53 million in FY 1989-1991 central funding through the annual FVA/PVC competitive CS grants program to implement CS projects in Malawi. PVO and Malawian cash and in-kind contributions are additive to the A.I.D. grant awards.

a. Save the Children Federation (SCF): A 3-year (1989-1992), $600,000 grant to supplement MOH PHC/CS services in Mbalachanda and Mkota in the Central Region. Through Village Health Volunteers (VHVs) and Health Surveillance Assistants (HSAs) the project promotes EPI, ORT, nutrition, birth spacing information, condom promotion, AIDS/STD education, malaria and ARI treatment and the establishment of drug revolving funds.

b. International Eye Foundation (IEF): A 5-year (1989-1994), $1,330,000 grant to supplement MOH PHC/CS services in the Lower Shire Valley in the Southern Region. Through VHVs and HSAs, the project promotes Vitamin A supplementation, blindness prevention, EPI, ORT and the prevention and control of AIDS.

c. Adventist Development Relief Agency (ADRA): A 3-year (1990-1993), $550,000 grant to supplement MOH PHC/CS services in Nsanje District in the Southern Region. Through Volunteer Mother Visitors, HSAs and two employed Health Inspectors, the project promotes EPI, nutrition, ORT, vitamin A supplementation, food production, child spacing promotion, malaria prevention and treatment, sanitation and AIDS education.

d. World Vision Relief and Development (WVRD): A 3-year (1990-1993), $475,000 grant to supplement MOH PHC/CS services in Lilongwe District in the Central Region. Through Nutrition Promoters and VHVs, the project promotes nutrition, EPI, ORT, environmental and housing sanitation and the treatment and prevention of malaria. The project uses social mobilization and marketing to ensure community-level sustainability.

e. Project HOPE: A 3-year (1991-1994), $575,000 grant to supplement CS services in the estate sector in Thyolo District in the Southern Region. Through VHVs and HSAs, the project promotes EPI, ORT, growth monitoring, nutrition, vitamin A supplementation, child spacing, AIDS/STD prevention and the treatment and control of malaria and ARI. The project aims to demonstrate the cost-effectiveness of private sector CS service provision.

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2. Implementation status:

HPN staffing constraints continue to limit the Mission's involvement with and knowledge of the PVO projects. However, during the reporting period, the Mission did manage to visit four of the five PVO projects at least once and found implementation progressing well.

In March, USAID/HPN attended a workshop conducted by IEF and ADRA on the issue of volunteerism in the health sector. All AID-supported NGO CS projects were represented at this workshop which produced an excellent report based on which IEF and ADRA are designing operations research projects to address key question related to volunteerism: e.g. training, motivation, retention, and reward.

In August, the HPN graduate student intern participated fully in an evaluation of the SCF project and produced a useful report on the project. Also in August, the Mission requested PVO Project Coordinators to submit status updates on their projects. Below are some highlights from PVO reports.

> Both World Vision and Project Hope have completed KAP baseline surveys of their target communities. World Vision has opened 10 growth monitoring centers and trained 50 volunteers.
>
> Drug revolving funds have been established in 131 (90%) of SCF's 145 target communities. Increased demand for child survival and child spacing services in one target community led the MOH to post a full-time service provider there.
>
> ADRA reports that, although the project has ended, more than 60% of the volunteers involved in their first A.I.D.-funded CS project are still actively working in their communities. Since that project's inception, 16 clinics have reported a 50% or more decrease in the under-five mortality rate.

The PVO status updates included several lessons learned, many related to volunteerism, sustainability and project impact. The Mission is summarizing these lessons learned for distribution.

3. Actions/issues:

a. Coordination/integration of PVO CS projects with Mission health portfolio: With additional staff, Mission could play a more dynamic role in the design, monitoring and support of PVO CS projects, for example: improving interaction and coordination among US PVOs and between the MG and the PVOs; and, helping to disseminate and utilize CS service delivery lessons learned. HPNO meet with five PVOs in Jan.1992 to update on mission funding strategy for health sector and new bilateral project.

b. Standardize PVO reporting: Request PVOs to submit a summary status and lessons-learned report to Mission at least once annually in time to factor into the PIR and API.

c. Evaluate CS PVOs: Ongoing assessment of the PVO CS portfolio to:

... identify achievements worth publicizing and expanding;
... identify areas where FVA/PVC CS policies and program guidance may impede, or at least not advance attainment of Mission health sector objectives.
... develop explicit Mission policy on US CS PVO programs to communicate to FVA/PVC and PVOs in an effort to more efficiently influence the design of projects and to then apply as Mission review criteria to future PVO project proposal submissions.
... identify projects which merit continuation with USAID bilateral financing and via which grant mechanism (e.g. FHACS, SHARED);
... recommend whether and how consolidation of the PVO portfolio is advantageous and possible (e.g. combine HOPE AIDS and CS projects);
... recommend ways to improve Mission support, management, and utilization of PVO CS projects (e.g. add staff to HPN office).
... ensure current and future PVO projects complement the Mission's bilateral health portfolio, and address directly the CDSS objectives.

E. Child Spacing Commodities and Logistical Support Program:

1. Summary: Bilateral support in the range of $450,000 annually to meet national child spacing program needs for all contraceptive commodities with the exception of injectable contraceptives which are supplied by UNFPA (and recently ODA, due to UNFPA funding constraints). Commodities are accompanied by TA and training from the AID-funded JSI/Family Planning Logistics Management (FPLM) Project to enhance GOM capacities to forecast contraceptive needs, to improve the procurement and distribution system, and to design and implement quality assurance systems.

2. Implementation status: Commodities ordered via Lilongwe 06077 (Nov. 1989) to meet contraceptive needs through mid-1992 with FY90 and FY91 Mission bilateral funding, are arriving in-country on schedule. MOH and Central Medical Stores (CMS) staff in Blantyre reported to USAID/HPN during August 1991 field trips that USAID-funded contraceptive commodities are arriving in-country on time, on schedule and in the correct quantities. To the extent that there are logistical problems, they are related to the distribution of commodities from the CMS to the district level.

3. Actions/issues:

a. ST TA from JSI/FPLM Project: Mission requested TA from the JSI/FPLM Project to help forecast and cost contraceptive needs (including AIDS condoms) for 1992/93, assess status of in-country logistics and recommend ways to improve, draft documentation necessary to implement procurement plan, and outline contraceptive and condom commodities component of new bilateral project (FHACS) to meet longer-term national commodities, TA, and training needs.

Mission was informed that Brice Atkinson is available for this assignment in Jan/Feb 1992. Mission is coordinating this TDY with next RAPID Project TDY to utilize the Malawi "FAMPLAN" model to be developed in Jan/Feb 1992 for projecting and costing commodities.

b. HPN staffing: Training/orientation is needed for the new HPN FS-08 FSN (to begin work O/A 1 Dec 1991) whose responsibilities will include the management and monitoring of contraceptive and condom procurement program. Ideal orientation will be to work full-time with Atkinson during Jan 92 TDY.

c. FHACS and local manufacture of condoms: PATH/PIACT responded to Ministry of Trade enquiry regarding a study of the feasibility of developing local condom manufacturing capability in Malawi. HPN to review the issue in connection with FHACS design.

F. Demographic and Health Survey (DHS):

1. Summary: USAID obligated $445,000 in bilateral funding for a Demographic and Health Survey (DHS) to be conducted in Malawi to furnish planners and policy-makers with updated, national-level data on fertility, mortality, child spacing knowledge and practice, malaria, AIDS and other priority public health issues with which to evaluate progress and design new program approaches.

2. Implementation status: In August 1991, the Government gave written approval for the DHS. Anne Cross of the DHS Project is in Malawi 3-16 Nov 1991 to prepare the grant agreement and work with the GOM to finalize the scope and content of the DHS.

3. Actions/issues: Expedite implementation of survey. Ensure MOH decides to include as many supplementary modules as is feasible, especially the modules on AIDS and malaria.

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G. Association for Voluntary Surgical Contraception (AVSC):

1. AVSC PHAM Project

a. Summary: A 3-year (1990-1992), $71,400 centrally-funded project with the Private Hospital Association of Malawi (PHAM) to improve the quality and safety of surgical contraception, counselling, service delivery and training at selected PHAM medical facilities.

b. Implementation Status: Initial $21,000 grant for 3 PHAM hospitals has been expanded and extended to 3 more PHAM hospitals.

2. PHICS buy-in to AVSC

a. Summary: An 18-month (4/91-9/92), $77,500 buy-in through PHICS to expand and improve MOH surgical contraception and counseling services by training physicians and nurses from three major hospitals, and providing necessary supplies and equipment.

b. Implementation status: The PIO/T was completed in May 1991. The contractual work between AID/W and AVSC/NY was not completed until the end of FY 1991. The first training will take place in Kenya during November. The next AVSC TDY Malawi (probably November) is expected to expedite implementation.

3. Actions/issues:

a. HPN staffing: With additional staff, Mission could strengthen monitoring and support for this innovative project, expediting both the expansion of VSC in the private and public sectors and the introduction of NORPLANT.

b. VSC and PHICS: Ensure AVSC's Dr. Lynam helps with commencement of mission-funded buy-in activities during Feb 92 TDY.

c. VSC and FHACS: During next AVSC TDY, obtain assistance in forecasting longer-term national needs for expanding and improving VSC services in the private and public sector for possible support under FHACS, and begin consultations regarding possible AVSC role in introducing NORPLANT.

d. AVSC and the NFWC: During next AVSC TDY, explore possibility of AVSC support to the NFWC to develop in-house expertise in VSC IEC, counseling and service delivery.

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H. The Family Planning Service Expansion and Technical Support Project (SEATS):

1. SEATS/Malamulo Hospital Community Based Distribution Project:

a. Summary: On 1 Nov 1990, at the conclusion of support from the AID-funded Family Planning International Assistance Project (FPIA), the SEATS Project entered into a subagreement with Malamulo Hospital to provide $39,831 for a six-month (11/90-4/91) pilot project to deliver child spacing services at the community level in Thyolo district. The project received a no-cost extension through Dec 1991 to continue current activities while allowing time for SEATS to complete and negotiate a proposal for project expansion.

b. Implementation status: SEATS sent an evaluation team to Malawi in April/May 1991 to review the SEATS-funded pilot project The team identified areas for improvement but overall found the pilot project progressing well, even exceeding targets in some instances (e.g. service delivery sites established, number of VSC acceptors). The team recommended the project be expanded to include: (a) the integration of child spacing services at all 18 Adventist Health Service (AHS) dispensaries nationwide and; (b) the provision of services to clients motivated through the ADRA Child Survival project. This expansion is expected to generate an estimated 50,000 couple years of protection (CYP) by 1994. Over the next few months the pilot project evaluation recommendations will be implemented and the multi-year proposal for project expansion will be finalized.

c. Actions/issues: Review and comment on the first draft of a $700,000 SEATS proposal for a 30-month project -- Jan 1, 1992 to June 30, 1994.

2. SEATS/National Family Welfare Council (NFWC):

a. Project Summary: In 1990-91 the SEATS Project provided technical assistance with the design of a NFWC - Malawi's first organization to focus exclusively on child spacing coordination, service delivery support, and advocacy at the national level.

b. Implementation status: The NFWC was formally established and approved by Parliament as a parastatal in Nov 1990. With TA from local donors, the NFWC proposal was finalized in April 1991. A donors meeting was held 22 May 1991 to solicit support for NFWC. Donors pledged sufficient funds for the first two years of NFWC operations. USAID pledged $350,000 to the NFWC for activities to be implemented by SEATS. In addition, the MG has made a subvention grant to the NFWC from the revenue budget. An acting NFWC executive secretary began 1 Sept 91. Interviews are being conducted for a permanent Malawian executive secretary and other key NFWC staff, and a long-term resident advisor. A SEATS-funded interim advisor arrived Nov 2, 1991 for approximately six weeks.

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c. Actions/issues: Coordinate with interim resident advisor to expedite operationalization of NFWC.

3. SEATS/Ekwendeni Hospital Community Based Distribution (CBD) project:

a. Summary: Ekwendeni hospital developed a CBD proposal with TA from WHO for possible support from UNFPA. The project is important because it is the first to involve the CBD of oral contraceptive pills in Malawi. UNFPA funding constraints led USAID to request SEATS to consider supporting the proposal. SEATS staff worked with Ekwendeni to revise the proposal. A contract is due to be signed on 5 Nov. 1991 with implementation to begin shortly thereafter.

b. Implementation status: SEATS staff conducting initial training and project start-up activities in -country in Nov 1991.

c. Issues: Receive, review and approve the final proposal.

4. New project ideas for SEATS support: During SEATS May and August TDYs, additional short-term child spacing service delivery project ideas were discussed with the Mission. Review these ideas in connection with the FHACS PID design and communicate optimal short-term role of SEATS Project in population sector in Malawi.

I. Malawi Health Social Marketing Project (SOMARC):

1. Summary: The first nationwide program to market and sell health products at subsidized prices throughout Malawi's private retail sector.

2. Implementation status: An initial grant of $600,000 in central funding for local costs allocated for 3-years (1990-1993). In addition, central funds will support the costs of condoms and other contraceptive commodities. Lever Brothers/Malawi has been contracted as the implementing agency, a Malawian project coordinator has been hired, a project office established, an advisory group formed and active, preliminary market research and baseline survey complete, project launched 2 August 1991, Protector brand condoms on the shelves in mid-August, condom ad campaign approved by National AIDS Committee 16 August 1991, four radio spots per day began early September 1991. Over 100,000 condoms sold to retailers to date. Initial data collection and plans have begun for the introduction of additional health products -- probably the pill and an anti-malarial.

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3. Actions/issues:

a. Free vs. subsidized condoms: Reach agreement with the MOH on a condom procurement plan and strategy for the next several years which would maximize the sale of subsidized "SOMARC" Protector brand condoms, maximize reliance on less expensive condoms purchased by multi-laterals, and minimize reliance on more expensive Sultan brand condoms supplied by USAID. This plan should be completed no later than the conclusion of the JSI/FLMP TDY in Jan/Feb 1992 and incorporated into the FHACS design and PP.

b. Focus sale of Protector brand condom more on high risk groups: Obtain agreement to distribute the Lever/Protector condom through Chibuko (LONRHO owned) and Carlsburg networks to bars, restaurants and bottle shops. The objective is to resolve this issue during the Nov 1991 SOMARC TDY.

c. SOMARC and FHACS: Determine when bilateral support under FHACS will be needed, for what, and at what levels for continuation of social marketing activities.

J. Population, Health, and Development Policy (the RAPID Project):

1. Summary: A program of activities which began in 1989 for which approximately $50,000 in central funding has been available annually from the USAID-funded RAPID Project for TA, training, and computer hardware and software with which to strengthen EP&D, MOH, NSO, and University of Malawi capacity to analyze population, health (including AIDS), and development problems and to utilize analytical findings to plan, to allocate resources, and to formulate population, health, and development policies.

2. Implementation status: The first phase of this program is complete with the development of a RAPID model for Malawi which includes an AIDS component. Both the hard copy and the software version of the RAPID Malawi were presented to senior government officials at a population workshop in early Oct 1991.

3. Actions/issues:

a. Utilization: EP&D is implementing a plan to utilize the RAPID model at central and district levels. Current HPN staffing constrains the Mission's ability to closely monitor and/or participate in this activity, and constrains the extent to which we might utilize the model for in-house purposes and policy/advocay work with other donors.

b. Priority request for RAPID IV TA: Follow-up on the Mission's Oct 91 cabled request for TA in Jan/Feb 92 with the development of a "FAM PLAN" model for Malawi with which to project national contraceptive needs and costs in relation to the FHACS design.

c. RAPID and FHACS: Undertake needs assessment to determine longer-term population policy analysis needs and whether a population policy component should be included in the new FHACS Project, and if so, outline the size and shape of the component. In this connection review the idea of RAPID support to equip the NFWC to make full and effective use of RAPID and FAMPLAN presentations in their child spacing advocacy and policy work.

K. The AIDSCOM Project:

1. Summary: Since Jan 1989, the AIDSCOM Project has been providing short and long-term TA, training, and commodities, to implement a series of priority activities related to AIDS policy and IEC program development in Malawi. The focus of AIDSCOM's work with the MOH AIDS Control Program (ACP) is on AIDS/HIV information, education, and communication (IEC).

2. Implementation status: AIDS IEC activities implemented between Jan 1989 and March 1990 were supported with $200,000 of AFR bureau HAPA funds. USAID provided an additional $200,000 in FY90 bilateral funding and $400,000 in FY91 funding to support a continuation and expansion of these activities including a long-term resident AIDS IEC advisor and costs related to the development and implementation of an AIDS education program for the schools and other AIDS IEC activities. The advisor has been in place since Nov 1990. AIDS education materials have been developed, field-tested, revised and finalized. Materials are being printed overseas and are expected to be available in the first quarter of 1992. Plans proceed for the nationwide introduction of AIDS education in schools in early 1992.

3. Actions/issues:

a. Workplan review: Review and finalize the updated workplan for the AED/AIDSCOM resident advisor.

b. Reporting: Mission receives monthly financial reports from AED/AIDSCOM for administrative approval. However, reports are received late and in a format which makes it difficult to relate expenditures to specific activities requested in the Mission PIO/T scope of work. Reporting of project implementation needs strengthening, particularly to align with the PIR and API.

c. AIDSCOM and FHACS: FY92 is the last year AFR/HAPA can be used for buy-ins to AED/AIDSCOM. State 129143 encourages missions to begin to explore alternative funding mechanisms. Mission intends to channel all or most support for AIDS prevention through a new bilateral project. Assess the need for continuation funding under FHACS for the activities currently implemented by AIDSCOM.

L. The AIDSTECH Project:

1. Summary: Beginning in Jan 1989 with central funds, and now under a $200,000 FY90 mission buy-in, the AIDSTECH project provides short and long-term TA, training, and travel support for activities related to AIDS policy and program development in Malawi. The focus of AIDSTECH work with the MOH/ACP is on forecasting, research, surveillance and to a lesser extent, blood screening.

2. Implementation status: The ACP is now routinely tracking confirmed AIDS cases and certain measures of HIV seroprevalence. Projections of AIDS cases, deaths and orphans developed and periodically updated with AIDSTECH support, are now being used in major policy forums such as the Oct 1991 Principal Secretaries workshop on population. Plans and funding are in place to implement three pilot surveillance surveys of HIV and STD status among STD patients, rural ante-natal clinic attenders and adolescents. The Red Cross study on attitudes towards donating blood is underway. Final approval is still pending for a study of the direct costs of AIDS to the national health care system.

3. Actions/issues:

a. Blood donor study: HPN staffing constraints have made it difficult to closely monitor this Malawi Red Cross-implemented study.

b. Economic Impact of AIDS study: Subagreement formally reviewed in April 1991 by HPN, AIDSTECH and the MOH/ACP. MG written comments and approval to proceed is still pending. Expedite MG approval.

c. Rural seroprevalence survey: Expedite MG approval of the survey and its implementation. Consider raising as a condition of further USAID support to the ACP at the 2 Dec 1991 donors meeting.

d. Reporting: Mission rarely receives monthly financial reports from FHI/AIDSTECH for administrative approval. Reporting of project implementation needs strengthening, particularly to align with the PIR and API.

e. AIDSTECH I, "AIDSTECH II", and FHACS: FY92 is the last year AFR/HAPA can be used for buy-ins to FHI/AIDSTECH. State 129143 encourages missions to explore alternative funding mechanisms. Mission intends to channel all or most support for AIDS prevention through the FHACS project. Assess the need for continued funding under FHACS for activities currently implemented by AIDSTECH. Determine specific implications of priority status under new "AIDSTECH II" project; decide whether to accept priority status; if accept, obtain MG/MOH informed consent; confirm that the proposed RD/H/AIDS Jan 92 TDY to Malawi to develop a comprehensive AIDS control strategy would be part of the FHACS PP design; confirm that the mission would control "AIDSTECH II" inputs into the national ACP; e.g. the decision as to the need for a resident advisor.

M. Project HOPE/AIDS:

1. Summary: Beginning in 1990 with $322,000 AFR/HAPA-funds and now under a two year (1991-1993) bilateral cooperative agreement tentatively budgetted at $400,000, Project Hope works with PHAM and the Malawian religious community to design, implement, evaluate and institutionalize AIDS counselling and IEC programs. The cooperative agreement will expand HOPE AIDS activities in the private sector.

2. Implementation status: By late Sept, 15,000 copies of the booklet "What is AIDS?" and 1,000 copies of "AIDS - A Christian Response" had been produced and distributed. More than 1,500 people from the nation's religious community were trained and many have begun training their peers and including AIDS information in their religious activities. Trained trainers include pastors, nuns, muslim sheikhs, Women's Guild and youth leaders, etc. Project Hope also collaborated with the MOH ACP on three major workshops -- an inter-country workshop on HIV/AIDS prevention, a workshop for the development of AIDS policies and guidelines and a workshop on AIDS in the workplace. $200,000 of FY 91 funds were obligated under the bilateral cooperative agreement in Sept 1991.

3. Actions/issues:

a. Coordination with HOPE CS Project: Encourage and facilitate further coordination between HOPE AIDS and HOPE Child Survival Projects to expedite the provision of AIDS/HIV IEC services to estate workers and families in Thyolo district.

b. Reporting and coordination: Mission does not receive any financial reports on this project. Reporting on implementation needs strengthening, particularly to align with the PIR and API. Monitor compliance with reporting requirements under the bilateral buy-in; e.g. the review and approval of a workplan for year one.

c. HOPE and FHACS: In connection with the design of FHACS, identify longer-term national ACP needs which HOPE might meet.

N. Johns Hopkins University (JHU):

1. Summary: A 2-year (1989-1991), $100,000 AFR/HAPA-funded grant to implement a sexually-transmitted diseases (STD) prevention and treatment pilot project entitled, "Prevention of HIV transmission in Malawi by reduction of genital ulcer disease" at Queen Elizabeth Central Hospital (QECH) in Blantyre in conjunction with ongoing AIDS medical research funded under the International Collaboration for AIDS Research (ICAR) Program of the U.S. National Institutes of Health (NIH) at $1,500,000 for 4 years (1988 - August, 1992).

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2. Implementation status: HAPA support for selected costs of "model" STD clinic at QECH. STD data being analyzed. No-cost extension through 31 Dec. 1991. Final evaluation being planned and to take place in Dec. 1991 or Jan. 1992. STD patient diagnostic and treatment guidelines developed. See 3.b. below.

3. Actions/issues:

a. Reporting: JHU in-country staff readily share information from both the NIH/ICAR AIDS research project and the HAPA-funded component with the Mission. It is difficult to discern HAPA-funded inputs and findings in the ICAR context. Reporting needs to be aligned with the PIR and API.

b. Longer-term needs: HAPA funding ends in 1991. Ascertain JHU longer-term research plans and funding status and needs.

O. Condoms for AIDS/STD Prevention:

1. Summary: A program to increase the use of condoms for AIDS/STD prevention.

2. Implementation status: USAID anticipates providing 11 million condoms ($483,000) to the MOH/ACP in 1990 and 1991. In addition, USAID anticipates supplying 5 million condoms ($220,000) in 1990/91 to the MOH for the child spacing program, and 2.3 million condoms ($62,000) to the SOMARC Project for sale in the private sector beginning in August 1991. Condoms are arriving in-country according to Mission cabled request (Nov. 1989). The MOH ACP implemented the recommendation that AIDS condoms be handled and distributed like contraceptives by the MG CMS. Mission receives information on condom distribution sporadically. An April 1991 SOMARC baseline survey suggests that up to 9% of men may be currently using the condom primarily for STD/HIV prevention (up from zero in 1984).

3. Actions/issues:

a. JSI/FPLM TDY: Include in Atkinson Jan/Feb 92 scope of work the development of a long term multi-donor, cost-efficient condom procurement plan; means to improve reporting of condom receipt and distribution; ways to ensure coordination and complementarity with the SOMARC project; pursuing the idea of establishing local condom manufacturing capability; improving condom logistics management; and helping to establish a quality control program.

b. Funding: In July 1990, HPN met with ST/Pop and ST/H to discuss funding for AIDS condoms. It was agreed that AID/W would provide central funding for one last year to meet Malawi's AIDS condom needs. As of FY92, the Mission has budgeted bilateral funds to purchase condoms. Upcoming JSI/FPLM TDY will assess future needs, other donors' plans, prepare cost estimates (include in FY94 ABS), prepare shipment schedules, draft request cable, etc.

P. AID Support to the WHO Global Program on AIDS (GPA):

1. Summary: Annual AID/W grant to WHO/GPA Geneva for AIDS control program activities worldwide.

2. Implementation status: A.I.D. contributes approximately $25 million annually to the WHO/Global Program on AIDS/GPA. The portion allocated for Malawi has been steadily increasing. Out of the FY 1989, 1990 and 1991 contributions, $250,000, $350,000 and $400,000 respectively were attributed to support the Malawi ACP.

3. Actions/issues: Include FY 91 $400,000 grant in Mission pledge at Dec. 2, 1991 donors meeting.

Q. AID support to the Malawi Expanded Program for Immunization (EPI):

1. Summary: In FY91, AID gave a one-time emergency grant to UNICEF/NY to cover a shortfall in funds from the government of Italy. The emergency grant included $500,000 for the immunization program in Malawi.

2. Implementation status: UNICEF/Malawi is the implementing agent. Funds are being expended for routine immunization needs. To ensure complete expenditure of funds, AID approved a no-cost extension of this grant through September 30, 1993.

3. Actions/issues: USAID does not receive reports from UNICEF on the local EPI program. Reports must be requested.

R. The American Schools and Hospitals Abroad (ASHA) Program:

1. Summary: Malamulo Hospital, an American Adventist Hospital in Thyolo district, has received approximately $3 million in grant aid over the course of the last ten years from the USAID-administered ASHA program to strengthen and expand the hospital's curative and preventive health care services and its teaching programs.

2. Implementation status: In Dec 1990, Malamulo opened and inaugurated its new ASHA-funded Medical Assistants Training School facility. Since December, there have been significant staff changes the most notable being the departure of the American Medical Director Gil Burnham and two other American doctors. It seems unlikely they will be replaced by Americans.

3. Actions/issues: Confirm that implementation of all ASHA grants is now complete.

VS 0637D gwn 10/29/91
GN update 11/08/91

PAST PROJECTS

Information for these project summaries was obtained from ISTI information unless noted otherwise. The following abbreviations are used to reference alternative information sources:

L= Logframe
P= Project paper
M= Mid-term evaluation
E= Evaluation document
C= Contract document

SELF-HELP RURAL WATER SUPPLY

DURATION: 1980-1988; 1980-1989(L)

PROJECT NO: 612-020

FUNDING AMOUNT: $5,925,000

TYPE & WITH WHOM: Bilateral with GOM

PURPOSE/OBJECTIVE: Assist GOM in its rural piped water program which, in turn, will provide safe water to a significant percentage of Malawi's rural population.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: Despite abundant indigenous water supplies, rural areas in Malawi lack access to safe water, leading to a high incidence of water-related diseases. The GOM, however, lacks the resources needed to construct the system, to educate rural beneficiaries in the link between safe water and health, and to institutionalize an information system to monitor and evaluate the program.

ACCOMPLISHMENTS: By the end of the project, the Ministry of Works (MOW) with USAID financing had undertaken 22 new schemes serving 314,000 people (exceeding significantly the design population of 241,000), while the Ministry of Health (MOH) had provided Hygiene Education and Sanitation Promotion (HESP) services reaching an estimated 270,000 people. USAID mid-term (1983) and final (1986) project evaluations found the program in both ministries to be effectively implemented and, in general, to have achieved more than anticipated.

ISSUES: Of particular interest was the development within rural communities of widespread demand for HESP services as well as water supply services. Although HESP had received only 5 per cent of the original USAID grant, MOH has now significantly improved their provision of focused hygiene and sanitation guidance to rural communities. Moreover, both the MOH and the MOW are pleased with the interministerial involvement created under the USAID Grant and both have expressed strong interest in expanding the HESP component in order to fully complement the well established water program.

EVALUATION: No Information Available

MALAWI RURAL DEVELOPMENT LINKAGE PROGRAM (MRDLP)

DURATION: 1983-89; 1983-88(E)

PROJECT NO: 612-0211

FUNDING AMOUNT: $1,370,000; $1,250,000 (E)

TYPE & WITH WHOM: Bilateral with Save the Children Federation and GOM

PURPOSE/OBJECTIVE: This project aims to help the GOM strengthen community infrastructure and help villagers identify and implement development activities by establishing linkages between 68,000 people in Mbalachanda and Mkhota and existing government services. The project is being implemented by the SCF/US.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: MRDLP was implemented in two isolated areas extending a radius of 15 kilometers around two Rural Growth Centers (RGC) built with German Support. The first was Mbalachandra (approximately 37,000 people) in the Mzimba District of northwestern Malawi, and the second areas was Mkhota (approximately 31,000 people) in the Kasungu District of central western Malawi. The original goals of the RGCs were to create focal points of development in remote, underdeveloped areas of Malawi through provision of infrastructure and integrated services to the rural population; 2) contribute to the decentralization of administration; and 3) contribute to the integration of development activities of the various Ministries in the rural areas.

ACCOMPLISHMENTS:

- Creation of Area Development Committees (ADCs);
- Sustainable development activities at Mblachanda and Mkhota;
- Infrastructure at Mblachanda;
- Community mobilization; and
- Training of a cadre of dedicated, expert Malawian community development professionals.

ISSUES: Problems in the vertical and horizontal integration of community services.

EVALUATION: The Linkage Program has demonstrated significant achievement in creating credible ADCs capable of addressing the development priorities of their communities and has trained a cadre of dedicated, expert Malawian community development professionals. However, the following weaknesses were also cited:

- lack of long-term planning;
- lack of crucial upward linkages to the District Development Committees; and
- dependence on SCF for financial and technical resources and authority.

Lessons learned:

- Avoid excessive emphasis on infrastructure;
- Develop ADC's as repositories for long-term area planning. Institutionalize ADC's and integrate MRDLP staff into existing GOM community services.;
- Increase income generating activities.

HEALTH INSTITUTIONS DEVELOPMENT

DURATION: 1984-1991; 1984-1992(L)
PROJECT NO: 612-0211

FUNDING AMOUNT: $8,700,000 T

TYPE & WITH WHOM: Bilateral with GOM/MOH and Howard University

PURPOSE/OBJECTIVE: This project is a manpower development initiative conceived by GOM/MOH in support of MOH activities. Specifically the project will: 1) train personnel to improve MCH services, 2) train personnel to provide child spacing services to Malawian families, 3) train and retrain mid-level health workers in primary health care, and 4) establish within MOH the institutional capability to train Community Health Nurses, MCH/CS Enrolled Midwives, and PHC-ready Medical Assistants and Health Assistants.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: The rural poor in Malawi are underserved in health. Mothers and children are the group suffering the greatest morbidity and mortality. The Government of Malawi has determined that the most effective intervention strategy is the improvement of MCH services with the integration of CS within the PHC context, especially in rural areas. The lack of appropriately trained mid-level health personnel hampers the achievement of the primary health care strategy.

The project aims at fulfilling a dual need. On the one hand, health personnel will be trained and retrained to implement the PHC strategy of the MOH. Simultaneously, health manpower institutions will be strengthened so that they will have the capability of preparing health workers beyond the life of the project.

ACCOMPLISHMENTS: No Information Available

ISSUES: No Information Available

EVALUATION: No Information Available

AFRICA CHILD SURVIVAL INITIATIVE: COMBATTING CHILDHOOD COMMUNICABLE DISEASES

DURATION: 1981-1988

PROJECT NO: 612-CCCD

FUNDING AMOUNT: $47,000,000 (P)

TYPE & WITH WHOM: Regional(?) with the Centers for Disease Control

PURPOSE/OBJECTIVE: Increase the ability of African governments to: 1) control measles, polio, tuberculosis, diptheria, pertussis, and tetanus (through enhancing their capacities to develop and administer immunization programs); 2) provide simple and effective treatment for the control of diarrheal disease; and 3) control disease of local importance, such as yaws and yellow fever.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: This project is targeted at all of sub-Saharan Africa. The target population for vaccine preventable diseases includes all children under one year of age and all pregnant women. This project was conducted in Malawi under Subproject 12 (698-0421) from 1985-1989.

ACCOMPLISHMENTS: No Information Available

ISSUES: No Information Available

EVALUATION: No Information Available

HIV/AIDS PREVENTION IN AFRICA

DURATION: 1988-1992

PROJECT NO; 698-0474

FUNDING AMOUNT: $20,500,000 (P); $20,858,000 (L)

TYPE & WITH WHOM: Regional, institution not known.

PURPOSE/OBJECTIVE: Provide Africa Bureau support for national and regional HIV/AIDS prevention and control activities in African countries. In-country subprojects completed by USAID and implementing public or private sector institutions to assist with IEC activities, epidemiological, behavioral, and operations research in implementation of national AIDS control plans.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: The problem of AIDS is particularly serious in Africa, where in several sub-Saharan countries deaths from AIDS and AIDS-suspect diseases will approach epidemic proportions in the near term.

ACCOMPLISHMENTS: No Information Available

ISSUES: Do not have any Malawi specific details for this project. Project 612-HAPA may be the Malawi AIDS project, but no project information was found.

EVALUATION: No Information Available

COMMUNITY ORGANIZATION OF PRIMARY HEALTH CARE (PRICOR)

DURATION: 1982-1985; 1981-1991 (L)

PROJECT NO; 936-5920

FUNDING AMOUNT: $20,053,000 (L)

TYPE & WITH WHOM: Centrally-funded, institution not known

PURPOSE/OBJECTIVE: To resolve issues, program policy, and design questions which impede the successful implementation, sustainability, or extension of primary health care programs.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: Primary Health Care programs appear capable of effectively addressing growing health care needs of the world's poor. However, decisionmakers have repeatedly discussed that LDCs lack the information necessary to weigh the cost and benefits of alternative program designs and implementation strategies and that this absence of concrete standards by which to judge program performance is a major constraint to the successful development of PHC programs.

ACCOMPLISHMENTS: No Information Available

ISSUES: Do not have any Malawi specific details for this project.

EVALUATION: No Information Available

CORNELL NUTRITION SURVEILLANCE (Nutrition and Dietary Surveys)

DURATION: 1984-89; 1977-1989 (L)

PROJECT NO; 931-1064

FUNDING AMOUNT: $6,083,000 (L)

TYPE & WITH WHOM: Centrally funded with CDC and Cornell Nutritional Surveillance Program at Cornell University

PURPOSE/OBJECTIVE: To develop and refine rapid, simple, low-cost procedures for:

- assessing the nature, magnitude, and regional distribution of malnutrition in populations;
- determining patterns of family food consumption and individual dietary intake; and
- maintaining a nutritional surveillance system capable of early warning of nutrition problems; and
- to assist selected LDCs in the implementation of these procedures.

The "implied" objective was to provide core support to a scientific center of excellence. The main objective for CNSP was the promotion of the multisectoral approach to nutritional surveillance.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: Conventional methods for determining nutritional status, dietary intake, and food consumption patterns are costly, time-consuming, and complex. Methods for maintaining nutrition surveillance are essentially non-existent. The lack of rapid, low-cost, and reliable methods of measuring dietary intakes and nutritional status is therefore an impediment to effective nutrition planning and program implementation in LDCs.

ACCOMPLISHMENTS: No Information Available

ISSUES: (Issues described in mid-term evaluation of overall project.) Project resources in Malawi have been used principally for data processing aspects of nutrition surveys. As such, much of the effort has concentrated on nationwide surveys to serve as baseline data for nutritional surveillance systems. Issue of political sensitivity to reporting the extent of nutritional problems.

Mid-term evaluation issues of the usefulness of a nutritional surveillance system as opposed to other forms of information collection and analysis.

EVALUATION: No Information Available

CHILD SURVIVAL GRANT TO ADVENTIST DEVELOPMENT RELIEF AGENCY

DURATION: 1985-1988; 1985-1991 (L)

PRODUCT NO: 938-0508

FUNDING AMOUNT: $308,000; $948,000 (L) (overall funding); $887,500 (C) (overall funding)

TYPE & WITH WHOM: Centrally funded with Adventist Development Relief Agency (ADRA)

PURPOSE/OBJECTIVE: In Malawi, ADRA will train 20 village health workers (VHWs) at a 6 week hands-on course in epidemiology, training skills, nutrition, and methods of monitoring and reporting. When the VHWs return to their own villages, they will set up village health committees to identify the health needs of the communities. The project will respond to these needs by completing 15-25 primary health care interventions including delivering and promoting immunizations and tracking high-risk children and program dropouts through surveys and disease surveillance activities.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: No Information Available

ACCOMPLISHMENTS: No Information Available

ISSUES: No Information Available

EVALUATION: No Information Available

CHILD SURVIVAL GRANT TO INTERNATIONAL EYE FOUNDATION

DURATION: 1985-1988; 1985-1989 (L)

PRODUCT NO: 938-0501

FUNDING AMOUNT: $442,000

TYPE & WITH WHOM: Centrally funded with the International Eye Foundation (IEF)

PURPOSE/OBJECTIVE: Comprehensive child program in the Lower Shire Valley in eastern Malawi including such elements as provision of vitamin A, oral rehydration therapy, immunization and nutrition education. Other project activities include:

- training medical and health professionals in the provision of EPI services;
- promoting immunization through training of traditional birth attendants;
- develops and implements monitoring capacity for EPI vaccine coverage and disease surveillance.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: No Information Available

ACCOMPLISHMENTS: No Information Available

ISSUES: No Information Available

EVALUATION: No Information Available

HEALTHCOM (COMMUNICATION FOR CHILD SURVIVAL)

DURATION: 1985-1988; 1978-1993 (L) (M)

PRODUCT NO: 931-1018

FUNDING AMOUNT: $18,527,000 (L); $17,145,000 (M)

TYPE & WITH WHOM: Centrally funded with Academy for Educational Development (since 1985)

PURPOSE/OBJECTIVE: The purpose of Phase II of the project (1985-1990), the demonstration phase,is to complete the development and application of a health education methodology that has thus far evolved in two phases:

Phase I - was largely trial and development in two countries of communication and social marketing methods to diarrheal disease programs;

Phase II - has emphasized mass media campaigns to reach large numbers of mothers quickly an has devoted proportionately fewer resources to the institutionalization process.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: Acute diarrhea is a major cause of infant mortality in developing countries. Although both prevention and treatment can be achieved in the home, widespread educational efforts have not yet been made among rural LDC populations. Inadequate instruction in basic home health measures results in the continued prevalence of acute diarrhea and other communicable diseases.

ACCOMPLISHMENTS: Mid-term: concentrated mostly on audiences, mass-media and campaigns.

FINAL ACCOMPLISHMENTS: No Information Available

ISSUES: Should stress simultaneous institutionalization efforts with audience-change activities over a more realistic 15-20 year period.
Final issues n/a.

EVALUATION: No Information Available

SAVE THE CHILDREN FEDERATION CHILD SURVIVAL GRANT

DURATION: 1986-1989; 1986-1991 (L)

PROJECT NO:

FUNDING AMOUNT: $280,000; $230,000 (C); $1,485,000 (L) for full project

TYPE & WITH WHOM: Centrally funded with Save the Children Federation

PURPOSE/OBJECTIVE: To train families in practices which will protect child health and to support child protective behavior by assisting communities to organize, implement and monitor primary health care. In Malawi, SCF will integrate CS activities into its existing integrated community development program in Mbachanda, northern Malawi. The program will focus on vaccination, ORT, clean water, malaria treatment, detection and prevention of nutritional deficiency disease, training in child feeding, pneumonia treatment, development of a community-based information system, and ante-natal care and birth spacing.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: No Information Available

ACCOMPLISHMENTS: No Information Available

ISSUES: No Information Available

EVALUATION: No Information Available

PROGRAM FOR APPROPRIATE TECHNOLOGY IN HEALTH (PATH) FOR HEALTHTECH: TECHNOLOGIES FOR CHILD HEALTH

DURATION: 1987-1991; 1987-1995 (L)

PROJECT NO: 936-5968

FUNDING AMOUNT: $6,000,000(P) $14,100,000 (L)

TYPE & WITH WHOM: Centrally funded with Program for Appropriate Technology in Health (PATH)

PURPOSE/OBJECTIVE: HealthTech is designed to develop a mechanism for promotion of the development, testing, introduction and local manufacture of child survival technologies to support the child survival strategy of A.I.D. Particular emphasis is on single use injectors for immunization.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: One of the primary goals of A.I.D.'s health strategy is to improve child survival through the application of effective and affordable technologies. The Office of Health has endorsed this strategic approach and has developed projects to improve vaccine efficacy and delivery, provide better ORT outreach and use, promote improved maternal and child nutrition, and encourage effective voluntary family planning.

ACCOMPLISHMENTS: From 1987-90, accomplishments included (for the overall project):

- The infrastructure for HealthTech was established;
- Over 30 technologies have been examined and screened for possible inclusion in the program;
- Sixty unsolicited project ideas have been received and logged into a database for technology ideas;
- Work plans for 24 different technologies have been prepared and submitted to USAID for approval.
- The approved projects include four injection technologies, five adjunct technologies for immunization/vaccination, five maternal care technologies, three newborn care technologies, and three primary health care technologies;
- Design-stage field trials in developing countries have been conducted for several technologies;
- Introductory field trials of three different technologies are occurring in five countries;
- HealthTech currently has activities ranging from information dissemination to field trials to technology transfer in over 50 developing countries; and
- Collaborations with 12 private sector organizations have been established.

The technology listed for Malawi was the BIRTHWeigh, a low birthweight indicator. It is not clear which other accomplishments apply to Malawi.

ISSUES: Through an unsolicited proposal in March, 1990, The HealthTech program was renewed for five years.

EVALUATION: Mid-term: Found that HealthTech has made major strides in encouraging private/public sector technology. The team found no evidence of pursuing PATH-owned technologies when better alternative existed. PATH has procedures in place that provide for continuing re-evaluation of alternative to technologies under development. HealthTech has been incredibly successful in moving new technologies for primary care through various stages of development. Personnel are well organized, professional, enthusiastic and dedicated to the success of the project.

VITAMIN A DEFICIENCY PROGRAM SUPPORT

PROJECT NO: 931-0045

FY87 VITAMIN A GRANT TO ADVENTIST DEVELOPMENT RELIEF AGENCY
DURATION: 1987-1991
FUNDING AMOUNT: $100,000

FY87 VITAMIN A GRANT TO SAVE THE CHILDREN FEDERATION
DURATION: 1987-1990
FUNDING AMOUNT: $127,000

FY88 VITAMIN A GRANT TO SAVE THE CHILDREN FEDERATION
DURATION: 1988-1991
FUNDING AMOUNT: $500,000

FY88 VITAMIN A GRANT TO HELEN KELLER INTERNATIONAL
DURATION: 1988-1991
FUNDING AMOUNT: $1,256,000

VITAMIN A GRANT TO INTERNATIONAL EYE FOUNDATION 938-OIEF
DURATION: $1989-1991
FUNDING AMOUNT: $415,000

TYPE & WITH WHOM: Centrally Funded

PURPOSE/OBJECTIVE: The vitamin A deficiency program serves as the Office of Nutrition's mechanism for assisting developing countries in the prevention and control of vitamin A deficiency.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: No details available on the individual grants to PVOs or for work specific to Malawi.

ACCOMPLISHMENTS: No Information Available

ISSUES: No Information Available

EVALUATION: No Information Available

IMPROVEMENT OF MATERNAL AND INFANT DIET PROJECT

DURATION: 1988-1989

PROJECT NO: 931-1101

FUNDING AMOUNT: $56,000

TYPE & WITH WHOM: Centrally funded, institution not known

PURPOSE/OBJECTIVE: No information found on this project. Project 931-1010 may be the precursor for this project.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: No Information Available

ACCOMPLISHMENTS: No Information Available

ISSUES: No Information Available

EVALUATION: No Information Available

SAVE THE CHILDREN USA

DURATION: 1989-1992

PROJECT NO:

FUNDING AMOUNT: AID $600,000 over three years
SCF $185,274 over three years

TYPE & WITH WHOM:

PURPOSE/OBJECTIVE: This is SCF's second child survival project in Mbalachanda district and first in Mkhota district aimed at a total target population of 187,000. The project goals are to improve the health status of children under five and of women of child bearing age as well as to ensure the integration of the program into the MOH structure by the end of the grant period.

Specific activities include: immunization, ORT, nutrition monitoring and education, birth spacing information and condom promotion, AIDS/STD education, and Malaria and ARI treatment.

The above interventions will be carried by SCF trained VHPs and monitored by HSA-level supervisors in close collaboration with the MOH. It is hoped that these supervisors will be absorbed by the MOH at the end of the project.

Drugs are distributed through drug revolving funds (DRFs) which are designed to operate at a small profit. These profits may be used to finance current VHP incentives beyond the life of the project.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT:

ACCOMPLISHMENTS: SCP has been successful in generating considerable demand for health services provided by the VHPs. In Mkota, by volunteering her child spacing expertise one day a week in the local health clinic, the health coordinator created sufficient demand for child spacing services that the MOH was compelled to post a child spacing nurse there.

In Mbalachanda 131 out of 145 DRFs are operating and generating enough cash to purchase replacement supplies. Some DRFs are beginning to express a demand for a wider variety of drugs such as eye ointment and ORS packets.

SCF has succeeded in generating considerable enthusiasm among village leadership for the VHP program as well as for DRFs.

Once incentives have been used to motivate volunteers it is nearly impossible to withdraw them.

The act of being selected by the community and the support of the community leaders for the VHPs serves as a considerable source of honor and prestige for a volunteer. These are important ingredients in volunteer motivation.

Frequent supervision helps reinforce what VHPs have learned and acts as a source of encouragement.

The support of community leaders for the VHPs is an important ingredient in the volunteer motivation.

There is large demand for the local supply of medicines. People express a willingness to purchase chloroquine since local health centers tend to run out mid-month or may be too distant.

ISSUES:

EVALUATION:

INTERNATIONAL EYE FOUNDATION

DURATION: 1992 - 1994

PROJECT NO:

FUNDING AMOUNT: AID to be determined
IEF to be determined

TYPE & WITH WHOM:

PURPOSE/OBJECTIVE: This is IEF's second child survival project in the Lower Shire Valley of Southern Malawi. Based in the district of Nsanje and Chikwawa the project aims to reduce infant/child mortality and morbidity by focusing on both health service delivery and management infrastructures. The service delivery component emphasizes semi annual Vitamin A supplementation; blindness prevention; EPI and ORT promotion and monitoring; as well as AIDS prevention and control among a target population of 265,000.

In the area of intrastructure building IEF will focus on training, developing community-based management structures, and increased coordination of NGO and MOH activities. The development of a large cadre (1,300) of Village Health Promoters (VHPs) who will be supervised by MOH HSAs figures prominently in this strategy.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT:

ACCOMPLISHMENTS: IEF's evaluations and measures of achievement have emphasized meeting or exceeding targets for people trained and Vitamin A, ORT, EPI coverage etc. rather than measuring changes in mortality and morbidity statistics. In fact, as a result of AIDS the IMR -- which IEF estimates at 205/1000 in the project area -- may be on the increase. IEF is going to try and measure deaths due to AIDS and include it in its reporting system.

A viable community-based health management system has been established in which additional health promotion activities can be included.

LESSONS LEARNED: The persistent lack of health infrastructure at the community level in rural Malawi has forced IEF to encourage communities to recognize health as important and to accept some individual responsibilities for better health.

Using village health volunteers has proved to be successful approach to IEF activities although there is considerable fragility to a system that relies upon volunteers. For this reason, IEF is working with other NGOs to investigate the role of volunteers in village health.

To sustain vitamin A and blindness prevention activities it is vital to ensure that the MOH is involved in all aspects of planning, implementation, and appraisal of the work. Upcoming project activities will be completely integrated within MOH structures.

While the IMR in the villages that IEF has been working in for the past two years in considerably lower than the Lower Shire Valley as a whole the increasing impact of AIDS on the rural population will likely contribute to an increase in infant mortality.

ISSUES:

EVALUATION:

ADVENTIST DEVELOPMENT AND RELIEF AGENCY

DURATION: 1990 - 1993

PROJECT NO:

FUNDING AMOUNT: AID $371,494 over three years
ADRA $99,557

TYPE & WITH WHOM:

PURPOSE/OBJECTIVE: This is ADRA's first child survival project in Nsanje District. Previously ADRA conducted Child Survival I and a nationwide basis, involving sixteen Primary Health Care Clinics under the Aventist Health System. The goals of the current project are to improve the health status of high-risk children under three and their mothers through coordinated efforts with existing MOH and NGO agencies, most notably the IEF Vitamin A program. ADRA currently estimates the U5MRF in Nsanje at 350/1000 which is 30% above the national average.

Specific interventions among the target population of 46,000 include EPI, nutrition, CCD/ORT, Vitamin A supplementation and food production, child spacing promotion, malaria prevention and intervention, sanitation and AIDS education. Among their targets is a forty percent reduction in deaths due to malaria of mothers and children under three in one pilot village.

In order to improve their service delivery and health education capabilities ADRA will employ two qualified Health Inspectors, and train HSAs and Volunteer Mother Visitors in addition to organizing Village Health Committees. ADRA will also conduct limited operations research with a special emphasis on volunteerism to determine models which work well.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT:

ACCOMPLISHMENTS: Since the end of CS I project over 60% of the volunteers are still working, long after any incentives have been discontinued. This level of success is very unusual.

LESSONS LEARNED:

1. From previous child survival projects ADRA has concluded that it is better to concentrate efforts in a small geographic areas rather than spread them thinly.

2. Prejustice against religion or a specific denomination can affect health programs operated out of church facilities.

3. The HIS must be kept as simple as possible. It was found that workers interpreted terms on the forms differently and over 50% of the forms contained gross mistakes putting into

question the entire database. Key indicators must be identified and emphasized while more peripheral albeit interesting information should be omitted.

4. It is difficult to get good baseline data from sample surveys. ADRA has found it more useful to use population requisition with village household registers which can provide initial benchmarks as well as ongoing monitoring information at much reduced cost.

5. It is impossible to provide home visits to the entire target population. Emphasis needs to be on the high-risk families to use resources more efficiently.

6. External technical assistance and consultation need follow-up visits to assure maximum success. One-time visits were of marginal value and the quick fixes often did not last.

7. At least three quarters of a year has been required in Child Survival VI to lay the foundation for interventions to begin in Nsanje district. This foundation includes developing partnerships with other NGOs and the MOH; acquiring equipment, materials and supplies; recruiting staff and training others; allocating office space and staff housing.

ISSUES:

EVALUATION:

WORLD VISION RELIEF AND DEVELOPMENT

DURATION: 1990 - 1993

PROJECT NO:

FUNDING AMOUNT: AID $426,093
WVRD $218,590

TYPE & WITH WHOM:

PURPOSE/OBJECTIVE: WV's approach focuses on social mobilization with an emphasis on social marketing strategies such as drama, story telling, and songs in a effort to enable communities to assume responsibility for their own health. Communities form Village Health Committees and select trainees to become Nutrition Promoters and Village Health Workers. WV has recruited health surveillance assistants and homecraft workers who work with village health committees. The committees will be able to sustain project activities after WV phases out. The malaria control program is conducted entirely within the MOH infrastructure with WV providing training, lab equipment and supplies.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: WVRD has been working in Kubudula District since 1985. Their current AID funded child survival project serves a population of 54,000 with the foal of reducing child and infant morbidity and mortality by providing services in nutrition, immunization, ORT, environmental and housing sanitation, and malaria treatment and prevention.

ACCOMPLISHMENTS: A KAP survey was conducted in January of 1991 in the impact area and provided considerable baseline data pertinent to the main interventions. Ten growth monitoring centers have been established and 50 growth monitoring volunteer have been selected and trained.

LESSON LEARNED: A funding period of at least five years is necessary for significant impact. The active involvement of the community in identifying their own health problems helps in solving some of the problems locally. Village Health Committees/Volunteers are very instrumental in mobilizing the community and in the delivery of health messages. Their momentum tends to diminish over time but regular short training courses and follow-up have proved useful in retaining their enthusiasm. However, an incentive system that does not jeopardize project sustainability needs to be developed.

Much of the first year of a project is taken up in training in order to improve the level of understanding and acceptance of the project goals by the community and service providers.

No child survival project is complete without addressing the problems of safe water supply and malaria.

Addressing malnutrition is not merely a matter of education. Income generating activities play an important role in addressing it.

The MOH has very limited resources and sustainability issues need to be discussed before committing outside resources.

ISSUES:

EVALUATION:

PROJECT HOPE CHILD SURVIVAL

DURATION: 1991 - 1994

PROJECT NO:

FUNDING AMOUNT: AID $601, 779 (over 3 years)
HOPE $245, 232 (over 3 years)

TYPE & WITH WHOM:

PURPOSE/OBJECTIVE: Project HOPE's current efforts involve the continuation and expansion of a one year pilot project which initiated the provision of child survival services in private sector estates in the Thyolo District. The project has two goals: to reduce morbidity and mortality among children under five and in mothers of child bearing age as well as to demonstrate the cost effectiveness of private sector CS service provision.

The project will work with 39 estates with a target population of 45,600 employees (x 5 = dependents). Specific project foci include in order of priority: immunization, ORT, growth monitoring, nutrition, child spacing, AIDS/STD prevention, as well as Malaria and ARI treatment and control.

The project has a large training component for HSAs and Village Health Volunteers. The estates will be responsible for the salaries of these trainees as well as all other recurrent costs including transportation, pharmaceuticals and accommodation. This project will collaborate closely with Project HOPE's Safe Motherhood and HIV/AIDS Prevention projects.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT:

ACCOMPLISHMENTS: A comprehensive ethnographic and health baseline/KAP survey has been conducted. Surveys at mid project and upon project completion will give a measure of impact.

The pilot project has succeeded in generating considerable interest among estate management for private sector involvement in CS service provision. The main interests of the estate managers are AIDS prevention and child spacing.

LESSONS LEARNED: Estate management is concerned with workforce welfare but lacks guidance on effective measures to improve it. Results from the pilot project indicate that estate managers will support increased CS services as they are exposed to options and are allowed to make independent decisions.

ISSUES:

EVALUATION:

REACH

DURATION: Unable to locate any information on this project.

PROJECT NO: 936-5927

FUNDING AMOUNT:

TYPE & WITH WHOM: John Snow, Inc.

PURPOSE/OBJECTIVE:

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT:

ACCOMPLISHMENTS:

ISSUES:

EVALUATION:

WATER AND SANITATION FOR HEALTH (WASH) II

DURATION: 1984-89

PROJECT NO: 936-5942

FUNDING AMOUNT: $19,700,000 Total

TYPE & WITH WHOM: Technical Assistance with Camp, Dresser & McKee

PURPOSE/OBJECTIVE: No Information Available

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT:

ACCOMPLISHMENTS:

ISSUES:

EVALUATION:

PRITECH I and II

DURATION: 1983-1988, 1987-1992

PROJECT NO: 936-5927; 936-5969

FUNDING AMOUNT: I- $59,700,000 (L)
II- $45,750,000 (L)

TYPE & WITH WHOM: Technical Assistance with Management Sciences for Health

PURPOSE/OBJECTIVE: I - To make primary health care systems more effective by introducing improved disease control technologies, particularly oral rehydration therapy and immunizations, and by improving management and training. No specific information on activities in Malawi.

II- To strengthen diarrhea disease control/oral rehydration therapy and child survival programs in LDCs through appropriate case management, including feeding, fluids, and referral; promotion of preventive hygienic and sanitation practices; and other health related interventions. Also to develop a repository of state-of-the-art information, research results, and technical expertise to serve AID. No specific information on activities in Malawi.

HISTORY/BACKGROUND/MOTIVATION FOR PROJECT: No Information Available

ACCOMPLISHMENTS: No Information Available

ISSUES: No Information Available

EVALUATION: No Information Available

APPENDIX B

Project Summary Tables: Project Activities by Program Area

Project Summary Table: Activities by Program Area

Title: Self-Help Rural Water Supply
Number: 612-0207
Period: 1980-1988

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation	✓	✓		✓	✓				
Other:									

Project Summary Table: Activities by Program Area

Title: Malawi Rural Development Linkage Program
Number: 612-0220
Period: 1983-1989

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization	✓				✓				
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP					✓				
Prenatal Care									
Water/ Sanitation									
Other: Area Develop. Comm.		✓	✓	✓	✓				

Project Summary Table: Activities by Program Area

Title: Health Institutions Development
Number: 612-0211
Period: 1984-91

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Management	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition				✓	✓				
Population/FP	✓		✓	✓	✓				
Prenatal Care	✓		✓	✓	✓				
Water/ Sanitation									
Other: Primary Health Care	✓		✓	✓	✓				

Project Summary Table: Activities by Program Area

Title: Human Resources Institutional Development
Number: 612-0230
Period: 1987-95

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition					✓				
Population/FP					✓				
Prenatal Care									
Water/ Sanitation									
Other: Health					✓				

Project Summary Table: Activities by Program Area

Title: Family Health Initiatives
Number: 612-AFHI
Period: 1988-Cont.

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Promoting Health Interventions for Child Survival (PHICS)
Number: 612-0231
Period: 1989-97

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization	✓	✓	✓	✓	✓				
Diar. Diseases (ORT)	✓	✓	✓	✓	✓				
ARI	✓	✓	✓	✓	✓				
Malaria	✓	✓	✓	✓	✓	✓			
AIDS			✓	✓	✓	✓			
Vitamin A									
Growth mon.	✓	✓	✓	✓	✓				
Other Nutrition	✓	✓	✓	✓	✓				
Population/FP	✓	✓	✓	✓	✓				
Prenatal Care									
Water/ Sanitation	✓	✓	✓	✓	✓				
Other:									

Project Summary Table: Activities by Program Area

Title: Services for Health, Agricultural, Rural and Enterprise Development (SHARED)
Number: 612-0232
Period: 1990-2000

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria					✓				
AIDS					✓				
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP					✓				
Prenatal Care									
Water/ Sanitation									
Other: Primary Health Care					✓				

Project Summary Table: Activities by Program Area

Title: Demographic and Health Surveys
Number: 936-3023
Period: 1991-92

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other: Survey			✓		✓				

Project Summary Table: Activities by Program Area

Title: Child Spacing Commodities and Logistical Support Program
Number:
Period: annual

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP	✓	✓	✓		✓		✓		
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Project Hope/AIDS
Number:
Period: 1990-93

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS	✓			✓	✓				
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Condoms for AIDS/STD Prevention
Number:
Period: annual

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS	✓	✓	✓						
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP	✓	✓	✓						
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Africa Child Survival Initiative - subproject 12: Malawi
Number: 698-0421
Period: 1985-89

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization	✓		✓	✓	✓				
Diar. Diseases (ORT)	✓		✓	✓	✓				
ARI									
Malaria	✓		✓	✓	✓				
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition	✓			✓	✓				
Population/FP									
Prenatal Care									
Water/ Sanitation	✓		✓	✓	✓				
Other: Linkage Support	✓		✓	✓	✓				

Project Summary Table: Activities by Program Area

Title: HIV/AIDS Prevention in Africa
Number: 612-HAPA
Period: 1991-92

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS		✓	✓	✓	✓				
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: HIV/AIDS Prevention in Africa
Number: 698-0474
Period: 1988-92

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Community Organization of Primary Health Care: PRICOR
Number: 936-5920
Period: 1982-85

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other: Primary Health care		✓	✓					✓	

Project Summary Table: Activities by Program Area

Title: Cornell Nutrition Surveillance (Nutrition and Dietary Surveys)
Number: 931-1064
Period: 1984-89

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition			✓		✓				
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Child Survival Grant to Adventist Development Relief Agency
Number: 938-0508
Period: 1985-88

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization	✓			✓	✓				
Diar. Diseases (ORT)					✓				
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition				✓					
Population/FP					✓				
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Child Survival Grant to International Eye Foundation
Number: 938-0501
Period: 1985-88

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization	✓		✓	✓	✓				
Diar. Diseases (ORT)	✓			✓					
ARI									
Malaria									
AIDS									
Vitamin A	✓			✓	✓				
Growth mon.									
Other Nutrition				✓					
Population/FP									
Prenatal Care									
Water/ Sanitation				✓					
Other:									

Project Summary Table: Activities by Program Area

Title: HEALTHCOM (Communication for Child Survival)
Number: 931-1018
Period: 1985-88

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization				✓	✓				
Diar. Diseases (ORT)				✓	✓				
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition				✓	✓				
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Description is from overall project information - not Malawi specific.

Project Summary Table: Activities by Program Area

Title: Child Survival Grant to Save the Children Federation
Number: 938-0524
Period: 1986-89

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization	✓		✓	✓	✓				
Diar. Diseases (ORT)	✓		✓	✓	✓				
ARI	✓		✓	✓	✓				
Malaria	✓		✓	✓	✓				
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition	✓		✓	✓	✓				
Population/FP	✓		✓	✓	✓				
Prenatal Care									
Water/ Sanitation	✓		✓	✓	✓				
Other:									

Project Summary Table: Activities by Program Area

Title: Program for Appropriate Technology in Health (PATH) for HEALTHTECH Technologies for Child Care
Number: 936-5968
Period: 1987-91

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization		✓			✓				
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other: Technology Develop.		✓	✓		✓				

Information is from overall project - not Malawi specific

Project Summary Table: Activities by Program Area

Title: FY 87 Vitamin A Grant to Adventist Development Relief Agency
Number: 931-0045
Period: 1987-91

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: FY 87 Vitamin A Grant to Save the Children Federation
Number: 931-0045
Period: 1987-90

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: FY 88 Vitamin A Grant to Save the Children Federation
Number: 931-0045
Period: 1988-91

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: FY 88 Vitamin A Grant to Helen Keller International
Number: 931-0045
Period: 1988-91

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Improvement of Maternal and Infant Diet Project
Number: 931-1101
Period: 1988-89

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition		✓			✓				
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Information from overall project - not Malawi specific

Project Summary Table: Activities by Program Area

Title: Child Survival Grant to Save the Children Federation
Number: 938-OSCF
Period: 1989-92

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Child Survival Grant to International Eye Foundation
Number: 938-OIEF
Period: 1989-94

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Vitamin A Grant to International Eye Foundation
Number: 938-OIEF
Period: 1989-91

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Association for Voluntary Surgical Contraception (AVSC)
Number:
Period: 1990-92

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP					✓		✓		
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Malawi Health Social Marketing (SOMARC)
Number:
Period: 1990-93

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP	✓			✓					✓
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Johns Hopkins University (JHU)
Number:
Period: 1989-91

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS	✓		✓			✓			
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: AID Support to the WHO Global Program on AIDS (GPA)
Number:
Period: annual

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: AID Support to the Malawi EPI
Number:
Period: 1991

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization	✓								
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: American Schools and Hospitals Abroad Program
Number:
Period: 1980-90

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other: Health					✓				

Project Summary Table: Activities by Program Area

Title: Family Planning Service Expansion and Technical Support (SEATS)
Number:
Period: 1990-94

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP	✓		✓				✓		
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Child Survival Grant to Adventist Development Relief Organization (ADRA)
Number:
Period: 1990-93

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization	✓								
Diar. Diseases (ORT)	✓								
ARI									
Malaria	✓			✓					
AIDS				✓					
Vitamin A	✓								
Growth mon.									
Other Nutrition	✓								
Population/FP				✓					
Prenatal Care									
Water/ Sanitation				✓					
Other:		✓							

Project Summary Table: Activities by Program Area

Title: Child Survival Grant to World Vision Relief and Development (WVRD)
Number:
Period: 1990-93

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization	✓			✓					
Diar. Diseases (ORT)	✓			✓					
ARI									
Malaria	✓				✓				
AIDS									
Vitamin A									
Growth mon.	✓				✓				
Other Nutrition				✓					
Population/FP									
Prenatal Care									
Water/ Sanitation				✓					
Other:									

Project Summary Table: Activities by Program Area

Title: Child Survival Grant to Project Hope
Number:
Period: 1990-92

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization	✓								✓
Diar. Diseases (ORT)	✓								✓
ARI	✓								✓
Malaria	✓								✓
AIDS				✓					
Vitamin A	✓								✓
Growth mon.	✓								✓
Other Nutrition	✓								✓
Population/FP				✓					
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: AIDSCOM
Number: 538-0161
Period: 1989-92

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS				✓	✓				
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: ORT-HELP
Number: 936-5939
Period:

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)				✓					
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Information from overall project - not Malawi specific.

Project Summary Table: Activities by Program Area

Title: REACH
Number: 936-5927
Period:

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization			✓	✓					
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: WASH II
Number: 936-5942
Period: 1984-89

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: AIDSTECH
Number: 936-5972
Period: 1987-97

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS						✓	✓	✓	
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: PRITECH I
Number: 936-5927
Period: 1983-88

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: PRITECH II
Number: 936-5696
Period: 1987-92

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Vector Biology and Control (Malaria Control in Malawi)
Number: 936-5948
Period: 1985-95

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria						✓			
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP									
Prenatal Care									
Water/ Sanitation									
Other:									

Project Summary Table: Activities by Program Area

Title: Population, Health, and Development Policy (RAPID Project)
Number:
Period: 1989-91

PROGRAM AREA	ACTIVITY AREAS								
	Service Delivery	Operations Research	Information Systems	IEC	Institution Building Training	Biological/Epi Research	Technology Development & Application	Policy	Privatization
Immunization									
Diar. Diseases (ORT)									
ARI									
Malaria									
AIDS									
Vitamin A									
Growth mon.									
Other Nutrition									
Population/FP			✓				✓	✓	
Prenatal Care									
Water/ Sanitation									
Other:									