



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

FINAL EVALUATION

COOPERATIVE AGREEMENT # PDC-0284-A-00-1123-00

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**INTERNATIONAL EYE FOUNDATION
VITAMIN A FOR CHILD SURVIVAL PROJECT
MALAWI**

FINAL EVALUATION REPORT

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LIST OF ABBREVIATIONS

ADRA	Adventist Relief and Development Agency
A.I.D.	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	USAID centrally-funded project contracted to Family Health International
ARI	Acute Respiratory Infections
BHR/PVC	Office of Private and Voluntary Cooperation, Bureau for Humanitarian Response (USAID)
CDD	Control of Diarrheal Diseases
c s	Child Survival
CS/VA	Child Survival/Vitamin A
DHO	District Health Officer
DIP	Detailed Implementation Plan
EEC	European Economic Community
EPI	Expanded Program on Immunization
GTZ	German Development Agency
HA	Health Assistant
HCCA	Health Center Catchment Area
HI	Health Inspector
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IEC	Information, Education, and Communication
IEF	International Eye Foundation
KAP	Knowledge, Attitudes and Practices
KPC	Knowledge, Practices, and Coverage
LSV	Lower Shire Valley
MIS	Management Information System
MOH	Ministry of Health
NGO	Non-Governmental Organization (see also PVO)
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PVO	Private Voluntary Organization (see also NGO)
RHO	Regional Health Officer
SUCOMA	Sugar Company of Malawi
TA	Technical Assistance
UNICEF	United Nations Childrens Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
VHV	Village Health Volunteer

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EXECUTIVESUMMARY

The International Eye Foundation (IEF) Vitamin A for Child Survival project in Malawi was a 32-month, **\$1,095,727** program which was completed on August 31, 1994. The **USAID/BHR/PVC** Child Survival (CS) program provided \$823,107 for the project which was implemented in the Chikwawa District of the Lower Shire Valley (**LSV**) in Malawi's Southern Region. The CS interventions provided include vitamin A supplementation, nutrition and AIDS education, condom distribution and promotion of oral rehydration therapy (ORT) and immunizations. A three year extension of funding has recently been granted to the project through 1997.

The area is densely populated, with high infant (**136/1000**) and child mortality rates (**240/1000**) and a high prevalence of chronic malnutrition (49 % of children were < 90% height for age in a recent survey). The population is only now recovering from the **1991-1992** drought and is further burdened by the integration of persons displaced by the political strife in adjacent Mozambique. HIV infection is highly prevalent, especially in trade centers and among workers at the valley's sugar plantation.

The project served an estimated 77,000 children under six and 74,000 women of child-bearing age. **The** major causes of death among children under five are malnutrition, pneumonia, measles, malaria, and diarrhoea. Trachoma, vitamin A deficiency and cataracts are the leading causes of blindness, affecting 1.55% of the population. AIDS is increasingly a cause of mortality in children and adults.

Since it began its work in **the** LSV in the early 1980's, IEF has shifted its emphasis from tertiary eye care to more community-based approaches to child health and prevention of blindness. Since 1985, IEF has helped to expand and develop community infrastructure for delivery of CS interventions in the LSV through **USAID** vitamin A and CS funding. The most recent project shifted and expanded project activities from 45 villages in Chikwawa and the adjacent Nsanje District to provide services to 474 villages in Chikwawa district.

Highlights among project achievements include the development of new health infrastructure in more than 470 additional villages. Despite the demands of the ambitious efforts to expand geographically, the project also achieved impressive improvements in indicators of immunization knowledge and coverage, ORT use, vitamin A supplementation coverage, and practice of exclusive breastfeeding. The project's leadership role in national awareness and policy reform regarding infant feeding practices has undoubtedly had a far-reaching impact

beyond the project area. Project activities also led to expansion of regional AIDS control programs and influenced the development of strategies for the CS project implemented by ADRA in an area south of IEF's project area. IEF's efforts to integrate vitamin A distribution in under-fives' clinics has led to nationwide use of a simple health card-based system to remind providers to provide semi-annual supplements. The project staff have also provided leadership in coordinating PVO efforts in support of the drought relief and national AIDS prevention programs.

The extension of this project for a final three years beginning in September will offer an opportunity to consolidate these impressive gains and assure sustainability. USAID and World Bank funding will provide ongoing training and salaries for the IEF Health Surveillance Assistants (HSAs) to continue their work through the Ministry of Health (MOH). The next three years must be used to work with the district's health facilities and the beneficiary communities to assure continued support and supervision of these HSAs and the network of Village Health Volunteers (VHVs) with whom they work.

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

Al. Project Objectives

EPI :

- 95% of the children 0-23 months of age will be completely immunized by the end of the project
- 50% of women 15-45 years of age will receive three or more doses of tetanus toxoid by the end of the project
- 85% of mothers can correctly identify the months when measles vaccination should be given to children
- 65% of women can correctly identify the protective nature of **TTV** vaccination

CDD :

- 75% of children 0-35 months of age will receive ORT during episodes of diarrhoea by the project
- 75% of mothers can correctly identify one or more ORT treatment strategies for diarrhoea

Nutrition :

- 60% of lactating women will exclusively breast feed their infants up to 4 months of age
- 80% of children 6 months - 6 years of age will receive vitamin A Supplementation every 6 months
- 80% of women will receive vitamin A supplementation within two months of delivery

AIDS:

- 85% of women and their husbands can correctly identify the protective nature of condoms in AIDS prevention

Primary Eye Care (PEC) :

- 80% of the village health volunteers can correctly identify five signs of a healthy eye and will identify and refer children and mothers for treatment

A2. Accomplishments by Objective

Objectives	Indicator	Baseline (4/92)	Final (7/94)
<p>EPI :</p> <ul style="list-style-type: none"> ■ 95% of the children 12-23 mns of age will be completely immunized by EOP ■ 50% of women 15-45 years of age will receive \geq 3 doses of tetanus toxoid by EOP ■ 85% of mothers can correctly identify the months when measles vaccination should be given to children ■ 65% of women can correctly identify the protective nature of TTV vaccination 	<p>% of children 12-23 mns of age completely vaccinated</p> <p>% of women 15-49 years of age receiving 2 or more doses 3 or more doses</p> <p>% of mothers who can identify when measles vaccination should be given - 9 months 9-12 month</p> <p>% of women who can identify the protective nature of TTV</p>	<p>64.9</p> <p>62.1% 31.1</p> <p>34.6 % 48.6%</p> <p>39.9%</p>	<p>87.5%</p> <p>66.0% 40.7 %</p> <p>48.0% 65.3 %</p> <p>63.7%</p>
<p>CDD :</p> <ul style="list-style-type: none"> ■ 75 % of children 0-35mns of age will receive ORT during episodes of diarrhoea by EOP ■ 75% of mothers can correctly identify one or more ORT treatment strategies for diarrhoea 	<p>% of children 0-23 months receiving ORT for diarrhea ORS for diarrhea</p> <p>% of mothers who can correctly identify one or more ORT Tx</p>	<p>70.8% 45.7%</p> <p>62.7%</p>	<p>84.1% 78.5%</p> <p>-</p>
<p>Nutrition :</p> <ul style="list-style-type: none"> ■ 60% of lactating women will exclusively breastfeed their infants up to 4 months of age ■ 80% of children 6-71 months of age will receive vitamin A supplementation in the last 6 months ■ 80% of women will receive vitamin A supplementation within two months of delivery 	<p>% of children exclusively breastfed at 3 months of age - may get water - no water</p> <p>% children 12-23 mns. receiving vitamin A in the last 6 months (card documented)</p> <p>% women receiving vitamin A within 2 months postpartum - card documented only - cards & self report</p>	<p>9.0%</p> <p>16.9%</p> <p>----- 27.0%</p>	<p>11.5% 7.7%</p> <p>53.7%</p> <p>38.2% 43.7%</p>
<p>AIDS :</p> <ul style="list-style-type: none"> ■ 85 % of women and their husbands can correctly identify the protective nature of condoms in AIDS prevention 	<p>% women with children c 24 mns. can identify protective nature of condoms</p>	<p>58.3</p>	<p>-----</p>
<p>Primary Eye Care (PEC) :</p> <ul style="list-style-type: none"> ■ 80% of village health volunteers can correctly identify five signs of a healthy eye & will identify & refer children/mothers for treatment 	<p>% of VHVs who can identify five signs of a health eye & refer children & mothers for Tx</p>	<p>-----</p>	<p>-----</p>

A3. Constraints to Meeting Objectives

Most impressive among project achievements are those in immunization coverage (for both mothers and children), ORT treatment of children with diarrhea, vitamin A supplementation (for both children and lactating mothers) and exclusive breastfeeding. The project figure for exclusive breastfeeding among infants 0 to three months of age of 24.2% compares very favorably with the national figure of less than 5% for all children 0 to 3 months of age (Demographic and Health Surveys (DHS)).

There are the obvious cultural and social constraints to meeting objectives for knowledge and practice in such areas as infant feeding or AIDS prevention. Despite these constraints, however, the project was able to document differences, not only in the practice of exclusive breastfeeding, but also in condom use. Survey comparison of adjacent “control” (non-intervention) areas to project areas showed a significant increased use of condoms in areas reached by the project (14% compared to 8.796, $p = .05$), suggesting that AIDS prevention activities are likely to be averting AIDS deaths in the target communities.

Differences between targets and actual achievements for these objectives are due, in large part, to the exceedingly ambitious nature of the targets. Failure to achieve the proposed targets for changes in knowledge, such as of the appropriate age for measles immunization, have obviously not been barriers to achieving the more important practice objectives. For example, though less than half (48%) of mothers can correctly identify the age for measles immunization, a much larger proportion of children 12-23 months (87.5%) are completely immunized.

The survey instrument provided for the end-of-project (EOP) had been revised since the baseline data collection. Documentation of project achievements was further constrained by the changes in survey instrument design during the project period. Project staff decided to use the updated survey to facilitate central efforts in comparison of findings among CS projects and to ensure that EOP data could also be used as the baseline for the ensuing project. The resulting lack of comparability to baseline data for this project was an obstacle to evaluation. The project might have been better advised to ask both the questions from the baseline as well as the questions from the revised survey instrument in order to have more complete data for project evaluation.

Major constraints to achievement of project objectives included a shortened duration of the project (project implementation was delayed for four months due to the no-cost extension granted to the previous project), political instability with the change to a multi-party political system and the demand for emergency response to the drought which affected the project area from late 1991 to early 1993. In addition, the project was designed to serve many new villages in which IEF had not previously worked (as IEF shifted to provide fuller coverage in one district rather than serving scattered villages in two). The need to develop a new infrastructure in over 400 new, often remote, villages in Chikwawa undoubtedly diverted

project attention from efforts to increase coverage and quality of services in the new target villages.

A4. Unintended Benefits

Unintended benefits of the project included:

- Research conducted through the project on infant feeding practice created an awareness on a national level of the problem of early supplementation, the major cause of the very high prevalence of inappropriate infant feeding practice in Malawi. This awareness, along with project staff efforts to promote reform, resulted in the elaboration of a national policy and training program to promote exclusive breastfeeding through four months of age.
- IEF CS project achievements in AIDS prevention and control allowed IEF to expand these efforts by successfully competing for additional funding from Action Aid, EEC, GTZ , AIDSCAP and UNICEF.
- ADRA reports that it drew heavily upon IEF's CS project in designing its own CS strategies in the neighboring district of Nsanje. IEF has also supported ADRA CS activities through the provision of vitamin A and training of HSAs. IEF's Peace Corps volunteer has also helped ADRA in developing its gardening and solar drying activities.
- IEF's efforts to promote distribution of vitamin A at under-fives' clinics has resulted in the use of reminder stamp for children's health cards to trigger health care providers to assess vitamin A status and provide supplements every six months. This stamp is now being used throughout the 10 districts of the Southern Region, with the likely effect of increasing the quality and coverage of vitamin A distribution activities beyond the project area.
- Regional and district-level cooperation, especially among PVOs, has increased as a result of IEF leadership in coordinating efforts of PVOs and the MOH in drought response and AIDS prevention and control.
- Publications generated from the project were another contribution of IEF and its staff to Malawi. The publications are believed to have been contributing significantly to the better understanding of the health problems of the area.

A5. Final Evaluation Survey

The results of the final evaluation survey, including a summary of key indicators, are presented in appendix 6.

B. Project Expenditures

B1. Pipeline Analysis

The pipeline analysis is attached as appendix 2 .

B2. Comparison to DIP Budget

Total **USAID** project expenditures through August 31, 1994 (project completion date) were \$757,508. This total represents a 92% expenditure of the budget as presented in the DIP. There were over-expenditures in line items including equipment and supplies (8%, primarily due to the purchase of 20 rather than the planned 12 motorcycles and an underestimate of the cost of a vehicle) and other direct costs (49 % , primarily for costs of motorcycle operation). Underspent items included headquarters personnel costs (58% underspent due to reduced billing of headquarters personnel time against the project) and headquarters travel costs (50%, due. primarily to IEF staff diligence in finding reduced fare tickets and inexpensive accommodation).

Most of the budget surplus at the EOP was a result of the late project initiation date. The four-month, no-cost extension granted to the previous project reduced anticipated expenditures by reducing the duration of the project. In addition, devaluation of the local currency and a reduction of the overhead rate by 2% during the project period resulted in further reductions of planned expenditures.

B3. Handling of Finances

Handling of finances by IEF headquarters appeared, on superficial inspection (no full audit was conducted), to be appropriate. However, the IEF policy of central management of project budgets has hampered planning at the country level and has made local staff less than full participants in project implementation.

B4. Lessons Learned Regarding Project Expenditures

Chief lessons learned in the management of project expenditures include:

- Project effectiveness and capacity-building depend on empowering staff to make decisions in use of project resources to achieve the objectives. Financial control should be decentralized to the project area.
- The **PVO's** ability to take leadership roles in CS activities depends on having access to an appropriate budget for technical assistance (**TA**). While IEF effectively used TA from Wellstart and VITAP to support and promote changes in national policies for breastfeeding and vitamin A, additional TA in other areas, such as income

generation would also have been helpful. Constraints in the budget for technical assistance can prevent PVOs from having broader impact through sharing state-of-the-art solutions to emerging national problems.

C. Lessons Learned

- The decision to use MOH models for employment of HSAs, including similar training, certification and supervision by Health Assistants (HAs) in health centers, has helped to ensure their sustainability through facilitating transfer of the workers to the MOH at the end of the project.
- Investments in maintaining a good working relationship with the MOH and other collaborating institutions have been instrumental in ensuring the success of the project.
- The lack of sustained input (e.g., training, meetings, requests for action) to the Village Health Committees (VHCs) has undermined their sense of purpose, resulting in a lack of activity by these community organizations.
- Not ensuring that HSAs visit VHCs, and as a result having many HSAs directly interface with VHVs, has occasionally created resentments of the VHVs by VHC members, presenting a threat to their sustainability.
- The lack of timeliness in the availability of results from the baseline survey led to the selection of some inappropriately ambitious targets. As a result some staff were discouraged by the perceived lack of progress towards these targets.
- The orientation of traditional and religious leaders to the project prior to initiating project activities at the village level helped to develop a sense of community ownership of the CS program.
- The scaling-up of pilot projects to district-wide programs requires an enormous investment in the training of individuals and the development of infrastructure that cannot be completed in a short time period.

II. PROJECT SUSTAINABILITY

A. Community Participation

A1. Key Contacts in the Community

During semi-structured interviews in six communities, the final evaluation team obtained information from 10 members of **VHCs**, 7 other community leaders, 9 **VHVs** and 72 other members of the selected communities. Communities to be visited were selected from six of the nine health center catchment areas (**HCCAs**) within the project **area**. The specific villages to be visited for the interviews were selected by using the schedule for mobile clinics, choosing the village in each HCCA with a mobile clinic on the day of the interview visit or the next nearest day to the interview visit.

A2. Perceived Effectiveness of Child Survival Activities

The activities of the project are perceived by the community as very effective. Of the community members and leaders who were interviewed by the final evaluation team, 82% indicated that CS project activities were effective. Most often cited as key activities were the commodities distribution and primary eye care activities. Most community members (81%) reported that they perceived their VHV as being effective. Many also mentioned the effect of oral rehydration therapy (ORT) on the reduction of morbidity and mortality, and this recognition is reflected in the high rate of ORT use in the community.

A3. Activities for Empowerment of Communities

Several efforts to empower communities have been made. Chief mechanisms to promote community participation include the formation of Village Health Committees (**VHCs**) and selection of **Village Health Volunteers (VHVs)**. Although the MOH had previously formed **VHCs** in many of the district villages, IEF **HSAs** worked with these committees to strengthen them and to help them select over 650 **VHVs**. IEF and other **NGOs** are cited by the MOH as being more successful in motivating these **VHVs** to continue their work, as is evidenced by the low (3 to 6%) attrition rate among IEF volunteers. Through these mechanisms to promote community participation and improve health service delivery, nearly half of community members (49%) reported that they were better able to meet their basic health needs or to sustain CS project activities as a result of the IEF CS project.

A4. Community Participation

To ensure community involvement from the outset, the project proposal was reviewed and approved by the Primary Health Care Subcommittee of the District Development Committee. Despite this work with such a representative body, only 27% of community members who were respondents in the final evaluation interviews reported that they felt their community

had participated in the design, implementation or evaluation of IEF CS activities. VHVs, with their greater contact with the project, were more likely to report a sense of community participation in project management. Several communities were visited and focus groups were conducted with mothers, volunteers, HSAs and community leaders including VHC members during the mid-term evaluation to allow them to provide input into the evaluation and provide their ideas towards the betterment of the project, although no substantial community participation was solicited during project design or preparation of the DIP. One obstacle to community participation in project management to date has been the lack of any organizational structure which represents communities within the Chikwawa district. In the future, health subcommittees of the District Development Committee @DC) or representatives of the Area Health Committees (which have not previously been organized in Chikwawa) may be asked to assist project staff in project design, implementation and evaluation.

A5. Health Committees

Each village is expected to have a VHC. VHCs are mostly organized by the HSAs working for the MOH. Most community members and VHCs (73%) reported that the committee members are selected by the community, while others reported that they were appointed by the village headman or that the mechanism of selection was unknown. Women interviewed during under fives clinics were, however, more likely to report that the VHC members were simply “introduced” to the community, having been selected by an unknown process. All of the ten VHCs which were assessed had women members, and the average proportion of the members who were women was 40%.

One VHC reported it had met three times in the last six months, five had met twice, two had met once, while two others reported no meetings since they had been organized. It was found that VHCs are frequently bypassed by the IEF HSAs, as less than a quarter of respondents reported that the HSAs seek out members of the VHC rather than the VHV as their principal contact within each village.

A6. Issues Addressed by Health Committees

Issues addressed by the VHCs which were highlighted by their members as having been of particular importance included environmental sanitation, water supply, AIDS prevention, child spacing, and shortages of health facilities and pharmaceuticals. Three VHCs reported they had made no significant decisions or changes, though others felt their roles in promotion of latrine construction and protection of wells were particularly important.

A7. Role and Methods of Health Committees

VHCs specified their household visits and provision of health education as being most important to their work. VHC members are also trained to assist in mobile under fives’

clinics, and were observed to assist in growth monitoring and registration activities in those clinics. During home visits, VHC members may assist the Volunteer by helping to motivate families to seek appropriate services.

In some villages, however, the relationship between the VHC and the VHV has been strained, such that the Committee provides little support for the VHV in her work. IEF's tendency to bypass these committees and its provision of incentives (such as soap) for the VHV (while no compensation is provided for the VHC members) have contributed to the development of these tensions. Although there has been little solicitation of VHC input in directing the project to date, IEF plans to clarify and strengthen the role of the VHCs for the follow-on project.

A8. Contributive Participation

Few community members (27%) reported any contribution of cash, labor or materials for any health activities. One VHV reported that her VHC had provided labor to assist in supporting her, but three quarters of community members were reluctant to provide support of any kind for the VHV. Most (59%), however, indicated that they would be interested in having basic pharmaceuticals available for a fee at the time of service, and nearly all of these reported that the fees could be used to help support the volunteer.

A9. Reasons for the Success or Failure of Participation

A major constraint to contributive participation in Malawian communities at present lies in the political climate. In the past the Government forced people to work on "self-help" projects without any discussion or input from communities. Recent statements by the newly elected government have led Malawians to feel that no community participation or contributions in health should be expected from them, since they are "too poor" to pay for any services. Reliance on government for health care is actually increasing and communities are ill-inclined to take a larger responsibility for meeting their own health needs. A decision made by the MOH in April to begin a program of cost recovery has been shelved until the current political situation resolves itself.

B. Ability and Willingness of Counterpart institutions to Sustain Activities

B1. Persons Interviewed from Counterpart Institutions

The health center in each of the six HCCAs selected for the final evaluation survey was visited to assess IEF's relations with these counterpart institutions. These and other personnel from the MOH, other PVOs working in the Lower Shire Valley, Montfort

Hospital, and the sugar plantation (Sugar Company of Malawi (SUCOMA)) who were contacted and interviewed are listed in appendix 3.

B2. Linkage to Key Health Development Agencies

Because it was envisioned from the outset of the project that it would be sustained by the MOH, IEF's work with government and community organizations has been most critical. The MOH at every level describes IEF's linkages as appropriate and strong. These linkages have been evidenced by the cooperation in planning and collaboration in implementation of CS activities including training and evaluation. IEF has worked through the Primary Health Care Sub-Committee of the District Development Committee in obtaining local approval for the project. It also implements the project with the advice of a Program Advisory Committee which was organized at the request of IEF by the District Health Office (DHO), and is composed of representatives from the DHO, the Agriculture Development Division (ADD), the Sugar Company of Malawi (SUCOMA), and Montfort Hospital.

The IEF/Malawi has established such strong linkages with the key health development agencies largely because of the lead role played by the project staff in coordination of NGO activities with the MOH. The Country Directors have also provided technical assistance to NGOs in epidemiology and biostatistics, helping to further solidify collaborative relationships. The previous Country Director was also on the Advisory Committee for ADRA's CS activities. Joint operational research to examine the maintenance and motivation of VHVs has been undertaken by IEF in collaboration with SCF/UK.

The relationship with the Regional Health Office (RHO) has also been strengthened by IEF's ability to provide technical support. Both the RHO and the DHO have drawn upon IEF expertise in planning survey assessments and health interventions, particularly in response to the recent drought. Joint training activities have also been undertaken with the MOH, ADRA, Montfort Hospital and Trinity Hospital in Nsanje. AIDS prevention and control activities have elicited collaboration with ADRA, Montfort Hospital and SUCOMA. Agricultural activities and solar dryer development have been undertaken collaboratively with ADRA.

B3. Key Local Institutions to Sustaining Project Activities

The DHO and Montfort hospital are the major local institutions which are expected to sustain the project activities in the impact area. These two hospitals and their HCCAs will assume the responsibility for supporting and supervising the IEF HSAs. IEF has already started to work with these institutions in preparation for the transfer of the HSAs and the institutions are clearly willing to assume this role. Both hospitals also expressed their desire to take part in the planning of the follow-on project, to learn more about the IEF activities, and to facilitate the smooth transition of responsibilities.

B4. Perceived Effectiveness of Child Survival Activities by Key Local Institutions

All the child survival activities being carried out by the project are perceived useful in reducing morbidity and mortality in the target population. Some clinic staff credited the project with causing a shift in utilization of health services, reflecting a reduction of the number of cases of measles and diarrhea reaching the health center and an increase in appropriate consultations for severe illness. Some of the activities most frequently cited as effective include the research activities, surveys, training of the **HSAs**, facilitation of coordination among the **NGOs**, and community-based distribution of commodities.

B5. Capacity Building

The project was instrumental in the provision of nationwide training regarding exclusive breast feeding. District MOH staff collaborated in the training of IEF and MOH **HSAs** and **VHVs**. IEF has also assisted ADRA in the training of **HSAs**. Although staff at health centers have not to date been trained to supervise IEF **HSAs** in their community-based activities, the follow-on project will be largely dedicated to this activity. **More** senior management staff **will** need additional training in information management, community organization, adult education, and training skills.

B6. Key Local Institutional Capacity to Sustain Child Survival Activities

Financial resources **will** be provided through the MOH (by **USAID** and the World Bank) to sustain salaries, benefits and training for additional **HSAs**. The DHO and RHO have indicated that qualifying **HSAs** from IEF will be given special consideration in their applications for positions with the MOH. Motorcycles will be transferred to the MOH to facilitate field supervision, although efforts will be made to provide bicycles, rather than motorbikes, for most **HSAs**. Despite this “demotion” with regard to means of transportation, most (7 of 11) **HSAs** interviewed said they would accept a transfer to the MOH during the next project period. Although some financial and material problems are anticipated in motorcycle maintenance and training for senior staff, most activities will probably be continued successfully by the **local** institutions.

The largest question for sustainability relates to the **VHVs**. Although there are other volunteers within the MOH system, there is some risk that competing demands for **HSAs** time in their new roles will leave them unable to provide adequate support to sustain the **VHVs** in their current activities. The next project period will also be used to prepare the health centers where the **HSAs** will be based, ensuring that they understand the value of these **VHVs**.

B7. Perceived Effectiveness of Child Survival Activities by Counterpart Organizations

As noted in section B4 above, the project activities are perceived as effective by the key institutions. These interventions are generally accepted as the key national public health strategies.

B8. Transfer of Project Responsibilities

The project has received funding for a follow-on project for another three years. Negotiations have already begun with the local institutions to plan for the complete transfer of project responsibilities over the next three years. Although a detailed time schedule will be established in collaboration with the counterpart institutions in the preparation of the DIP, the transfer of **HSAs** will begin within the next few months. For the balance of the project period, project efforts will focus on community organization and training to ensure a smooth transition and sustainability of activities.

B9. Financial Commitments of Counterpart Institutions

The MOH had made the commitment to absorb the qualified project **HSAs** at the outset of the current project. Although the absorption of the **HSAs** has been delayed, funds have now been released and the MOH reports it is ready to begin processing of applications from IEF **HSAs** within the next few weeks.

B10. Reasons for Success or Failure in Keeping Their Commitments

Success of the MOH in keeping its commitment to accept the transfer of qualified **HSAs** may be largely ascribed to the USAID/World Bank funding in support of the salaries and training for new **HSAs**. Early decisions to train IEF **HSAs** using the MOH curriculum and to ensure their certification with the MOH were also fundamental in ensuring that they would be employable by the MOH at the end of the project. The decision to base IEF **HSAs** at health centers, as their MOH counterparts have been, has also helped to facilitate the transfer of IEF **HSAs**.

B11. Collaboration in Evaluation

Representatives from the MOH and collaborating **PVOs** participated in the design, implementation and analysis of mid-term and final evaluations, including national and district levels of the MOH, ADRA and Project Hope.

C. Attempts to Increase Efficiency

CI. Strategies to Increase Efficiency

In order to reduce costs and increase productivity, the project staff used many strategies. Trainings were shared and scheduled to reduce costs. Visits to the field were scheduled to minimize travel and complete several project tasks at one time. Equipment was purchased used and/or at reduced prices. Maintenance costs were minimized by taking great care to protect equipment from harsh field conditions. External evaluators for the mid-term and final evaluations were identified within the region to reduce travel expenses.

Headquarters costs were also kept to a minimum by such strategies as billing limited numbers of hours of staff time against the project and making extra efforts to reduce travel costs through low fares and sharing modest accommodations.

c2. Reasons for the Success or Failure in Increasing Efficiency

The success of these strategies is evidenced by the budget surplus which remains at the end of the project. Although a few line items were underspent due to the fact that the activity was not implemented (e.g., the unfilled position at headquarters), in general there were cost savings despite the fact that more activities were implemented than were promised in the DIP.

c3. Lessons Learned Regarding Increasing Efficiency

Some of the lessons learned in efforts to reduce costs and promote efficiency were as follows:

- Efforts to protect equipment sometimes made that support less available to mid-level management staff in Nchalo, making them less effective in their work.
- Although **overall** cost savings were achieved, project effectiveness suffered when staff were unaware of the levels of remaining resources which might have been expended for necessary training and technical support.

D. Cost Recovery Attempts

No cost recovery strategies have been implemented to date to offset project expenditures.

E. Household Income Generation

No household income-generating activities have been implemented by the project to date.

F. Other

F1. Sustainability-Promoting Activities

Sustainability-promoting activities carried out by the project fall into four categories, including 1) efforts to strengthen community infrastructure to sustain CS activities, 2) efforts to improve the efficiency of health service delivery systems, 3) efforts to promote community participation and demand for health services, and 4) efforts to coordinate with and strengthen the capacity of collaborating institutions.

Efforts to strengthen community infrastructure to sustain CS activities include the selection and training of VHVs and the formation and training of VHCs. Health service delivery systems have been strengthened to promote sustainability through integration of vitamin A interventions into the existing Under-Fives' Clinics, including ordering vitamin A capsules through the MOH Central medical Stores (CMS). Development of a community-based blindness prevention program in half of the villages has also helped to strengthen health service delivery.

Efforts to promote community participation and demand for health services have included health education, community organization and improvement of the Supply of key child survival **commodities** at the village level. Efforts to coordinate with and strengthen the capacity of collaborating institutions are evident in IEF's formation of NGO/MOH coordinating bodies such as the NGO CS Collaborative Group, the Drought Relief Coordinating Unit and the Regional and District AIDS Advisory Groups. Development of a Program Advisory Committee (including four collaborating institutions) to advise project planning and implementation, and in the training provided for collaborating institutions.

F2. Implementation of Sustainability Plan

Most of the IEF sustainability strategy was satisfactorily implemented. The proposed **integration of vitamin A activities into the existing Under Fives' clinic network** is largely complete, although superficial assessments at the time of the final evaluation field interviews suggested that many children "slip through" without receiving the needed doses. Initiation of some simple quality assessment and assurance measures should rectify this finding. **The ordering and supply of capsules through the Central Government Medical Stores** is also a reality, however IEF still distributes these and other commodities to the village level.

The **community-based worker system** has been established as promised with VHVs functioning in approximately 80% (474/609) of the targeted villages. The supportive relationship which was envisaged between the VHV and the VHC is, in many cases, not a reality. However, clarification and strengthening of this relationship will be a priority for the next project period.

The integration of VHVs into the MOH health delivery system was also part of the sustainability plan. The proposed MOH support and mechanisms for continuing training of these VHVs have not been created and will have to be established during the next project, as the MOH and IEF community-based infrastructures are still largely working in parallel. Over half of the VHVs have already been trained in primary eye care (PEC), as planned in the CS sustainability strategy in order to establish a community-based blindness prevention program in 50% of project villages.

The increase in community demand for CS services which was promised in order to enhance sustainability has clearly been achieved. All seven of the health centers and mobile clinics interviewed by the final evaluation team reported an increase in the perceived demand for services which was ascribed to IEF's community-based CS programs. More than half (54%) of community members interviewed reported a perceived increase in the demand for CS services due to IEF's programs.

The sustainability strategy **also specified a plan to increase MOH capacity in monitoring and evaluation and in conducting operational research.** Some progress is evident in achieving this sustainability objective. Although MOH personnel have been involved in planning and conducting periodic evaluations of the IEF project and several health surveys have been conducted in collaboration with the MOH, an even closer relationship planned for the next project will make this technology transfer more complete.

As part of the sustainability plan, the DIP specified that certain sustainability indicators would be monitored to track progress in implementing the sustainability strategy. Data regarding one of the five proposed indicator (the attrition rate among volunteers) was recorded, analyzed and reported periodically in project documents. Data for a second indicator (the number of health centers supervising volunteers) were available, but since the total remained zero, the figures were not routinely reported. Some figures (regarding supplies of vitamin A available in health centers) were used as a basis for action (providing supplies to health centers), though no records were kept or reported to summarize the data. No data were recorded for two of the indicators, one because it was not practical (number of VHC meetings held), and the other (MOH ability to design, implement and analyze surveys) because it was not feasible to measure the indicator.

F3. Changes in Sustainability Potential

The MOH at central, regional and district levels is currently addressing the key barriers to sustainability. The fact that efforts are now underway within the MOH to improve strategies to sustain the VHCs, the VHV, community-based distribution systems, and an HIS, suggests that there is considerable sustainability potential in project benefits. Agreements have been solidified to transfer project activities to the MOH as soon as possible within the next few months. The next three year project period will, therefore, provide an opportunity to focus on identifying areas where additional support and training may be needed in order to successfully sustain those activities which had previously been implemented by IEF.

III. EVALUATION TEAM

A1. Members of Evaluation Team

The evaluation team included two external evaluators from the Evaluation Unit of the Department of Community Health at Addis Ababa University (AAU), one representative of IEF/Bethesda, the IEF/Malawi Country Director, four senior staff members of the CS project, a representative of the MOH from the national level and one from the district level, and representatives from each of two other NGOs (ADRA and HOPE) working in CS in the Southern Region.

The specific names and titles of the evaluation team members are as follows:

<u>Name</u>	<u>Title/Position</u>
Mathews D. Alifinali	Training and Supervision Assistant/IEF
Theresa W. Banda	Senior nutritionist/MOH
Yemane Berhane	Assistant Professor, AAU
Jeffrey Brown	CS Coordinator, IEF/USA
Joe Canner	IEF Country Director, Malawi
Henderson L. Chikhosi	Project Director/IEF
Watson Chikopa	Training Coordinator/ADRA
W. C. Chimwaza	A.E.H.O./MOH
James Lusantha	Field supervisor/Project Hope
Richard Mmanga	Training and Supervision Coordinator/IEF
George Mekiseni	Information Coordinator/IEF
Sally Stansfield	Assistant Professor, AAU

A2. Authors of the Final Evaluation Report

Drs. Yemane Berhane and Sally K. Stansfield were the authors of the final evaluation report. The draft report was circulated to all evaluation team members and project staff for review

and revision. After their comments were incorporated, the report was forwarded to IEF for final preparation and submission to USAID and circulated to interested agencies within Malawi.

Iv. RECOMMENDATIONS

A. Sustaining Health Service Delivery Systems

- In view of the need, over the next three years, to transfer the IEF HSAs and VHVs to the hospitals in Chikwawa District's new Health Delivery Areas (Chikwawa District Hospital and Montfort Hospital), IEF will need to involve the staff of these institutions in planning for the upcoming project and development of the DIP.
- The project should seek ways to enhance the perceived utility of outreach activities to clinical staff, such as through documenting changes in health center service utilization patterns and assisting health centers in locating and motivating defaulters from tuberculosis treatment.
- A project status report should be prepared for dissemination to both communities and collaborating institutions, describing the achievements of this project and the issues to be addressed in the new project.
- The project HIS must be reviewed in light of national, regional, and district initiatives in information systems, revising the system to retain only those components which are likely to be sustained after the end of the project.
- IEF staff should work with the new District Health Education Officer in efforts to improve DHO capacity for health education and to strengthen IEF's IEC components.

B. Community Organization and Development

- The project should proceed with its plans to involve communities in planning for the next three years. Identifying an appropriate interface with the community would be facilitated if IEF can work with a district level representative organization such as the Primary Health Care subcommittee of the DDC (District Development Committee) or with Area Health Committees.
- VHVs and VHCs should be reoriented to ensure that VHVs report to the health committee in their village (with only technical supervision provided by the HSAs) and those health committees are equipped to support and supervise their volunteers.

- The project should collaborate with selected VHCs and VHVs in pilot efforts to develop small-scale income generating activities (IGAs) which may be used to support health activities at the village level.
- With the consent of VHCs, more remote villages may be selected to assess the feasibility and effectiveness of using VHVs to recover costs of selected pharmaceuticals such as aspirin, paracetamol, and sulfadoxine/pyramethamine.

C. Strengthening the Quality of Health Services

- IEF should work to enhance sustainability by increasing the reliability of commodities supplies, including vitamin A, ORS, condoms, and tetracycline ointment at the village level.
- Support and supervision to VHVs should be strengthened, such as through quarterly meetings of clusters of VHVs, continuing education programs, and efforts to train the VHCs to provide on-site support for VHV activities.
- Team approaches to quality assurance (QA) or continuous quality improvement (CQI) should be considered as a strategy to enhance team-building, improve performance, and increase the sustainability of HSA and VI-IV activities.
- Fortification of sugar as a more long-term solution to endemic vitamin A deficiency deserves further exploration. IEF should work with the MOH to further explore the feasibility and expected effectiveness of sugar fortification, including through documenting the prevalence of sugar consumption among high risk children.
- Vitamin A and IGA interventions can be strengthened through promotion of the use of solar dryers, especially to preserve vitamin A-rich fruits and vegetables to enhance food security and/or generate income. Project staff would profit from an opportunity to visit other projects with IGA activities, either nationally or regionally
- IEF should proceed with its plans to extend services to SUCOMA. Home Craft Workers already in place might be trained as HSAs, who could work with volunteers who are already active there. These efforts should proceed with the full participation of the DHO to ensure continued support after the end of the project.
- Further training should be provided to HSAs, VHCs, and VHVs regarding family planning and AIDS control. Community-based distribution of condoms is clearly desirable to communities but requires further support to be effective.

D. Human Resources Management and Development

- IEF should prepare a human resources development plan as part of the DIP for the next project which addresses the needs for training (such as in supervisory skills, information systems, community organization, income generating activities, and adult education) within the MOH and Montfort Hospital, so that these institutions may better sustain IEF's community-based programs.
- In collaboration with the DHO, IEF should develop a training program for VHCs and VHVs designed to prepare VHVs to report to the VHC and VHCs to better supervise their VHVs.
- All health training provided within the district should be coordinated to ensure that IEF, Montfort Hospital and MOH staff profit from all training opportunities and are encouraged to integrate health activities.
- **HSAs** working for IEF should be promptly- assessed and encouraged to apply for transfer to the MOH as soon as possible. Personnel cost savings from early transfer should be invested in training for DHO or other MOH staff who will be instrumental in sustaining community-based activities.
- The HAs (and/or MAs) in health centers with IEF **HSAs** should receive orientation and training regarding the nature of the **HSAs** community-based activities and in supervisory skills appropriate to better supervise those activities.

E. Project Management and Administration

- IEF needs to reduce or eliminate its role in program implementation and take a role in technical support during the next project period. This shift would be greatly facilitated by moving the project office to close proximity with the DHO in Chikwawa.
- In view of the importance of the CS project in IEF's activities in Malawi, the Country Director should spend approximately half of his time working with project staff in the field. Efforts should be made to ensure frequent consultations with senior project staff in order to improve the transparency of management practices, both in IEF/Malawi and IEF/Bethesda.
- IEF/Bethesda should decentralize financial control to Nchalo for the **Malawi/CS** programs. Periodic transfers of data by electronic mail might be used to ensure that both Bethesda and Nchalo have up-to-date financial information to facilitate planning.

- The DIP should be drafted in Nchalo, ensuring that each member of senior project staff takes responsibility for program planning within his own area of expertise. The long “lead time” before the DIP is due should also permit substantial involvement of community members and collaborating institutions in selecting key strategies for sustainability.
- Project equipment, including the photocopier and third computer, should be moved to the project office in Nchalo. If necessary, the budget may be adjusted to assure adequate resources to cover the anticipated increased costs of maintenance and repair in the harsher conditions in Nchalo.
- To ensure sustainability of project activities after the next three years, IEF should facilitate regular management meetings which include both the MOH and Montfort Hospital personnel.

SCOPE OF WORK
MALAWI END OF PROJECT EVALUATION
CHILD SURVIVAL FOR VITAMIN A PROJECT
CHIKWAWA DISTRICT, LOWER SHIRE VALLEY
AUGUST 15th - 25th, 1994

1. INTRODUCTION

The purpose of the End of Project (EOP) Evaluation is to review the IEF-Malawi Child Survival for Vitamin A Project in the Lower Shire Valley of Malawi. The EOP Evaluation is a requirement of the United States Agency for International Development, Bureau for Humanitarian Response/Child Survival and Health funded Cooperative Agreement No. PDC-0284-A-00-1123-00. The life of the project extends from January 1st, 1992 through August 31st, 1994.

The EOP Evaluation is estimated to require 15 days from an external evaluator. The dates of the required field visit are tentatively scheduled for August 15 - August 24th, 1994.

2. **OBJECTIVES**

The requirements of BHR/PVC for the final evaluation are:

- a. A narrative report (English), addressing effectiveness and project sustainability (AID guidelines provided);
- b. Results of a knowledge and practice standardized survey, covering each project intervention (will be completed in advance of evaluation);
 - i. assess the degree to which project objectives were achieved through:
 - (1) comparison of the baseline and final survey results;
 - (2) review of available H/MIS data;
- c. A final financial pipeline analysis (completed with assistance from Bethesda headquarters in advance).

Additional requirements of IEF for the final evaluation are:

- d. Assess the implementation process since the mid-term-evaluation and identify common constraints that have impeded effective implementation;

- e. Summation of other relevant IEF activities related to project development (with assistance from IEF).

Specific guidelines are provided from **USAID BHR/PVC/CSH** for this purpose. Additional questions for consideration will also be provided by IEF. The EOP evaluation will be made available to IEF (headquarters and country staff), **USAID** (Washington and Mission), and others (Ministry of Health, WHO, UNICEF). The document will serve as the required **USAID** EOP report.

3. ACTMTIES

The evaluator will lead a team consisting of the IEF-Malawi staff (Country Director, Project Director, Supervisors, and Health Surveillance Assistants) and IEF-Headquarters Child **Survival/Public** Health Manager; an official from the Ministry of Health (to be designated); and a representative from a sister PVO (to be identified). Major tasks are:

- a. Review documentation (1 day)

Review all project related documentation (proposal, detailed implementation plan, annual report, baseline survey, mid-term evaluation and quarterly reports) This information should be reviewed in advance of arrival.

- b. Orientation (1 day)

Meet with **USAID**, Ministry of Health National Officials, the Southern Regional Health Officer, other pertinent agency representatives and project staff to discuss and provide input into the design of the evaluation.

- c. Preparation of interview forms (1 day)

Qualitative data will be collected through a combination of key informant interviews, focus groups, and inspection of volunteer registers. To prepare for ***this, BHR/PVC Guidelines*** will be used to develop a specific set of interview questions to interview: i. community members; ii. local leaders; iii. project volunteers; iv. project **staff**; and v. Ministry of Health staff (district and regional).

- d. Data Gathering (4 days)

Team members will be divided into groups each consisting of one IEF staff person paired with either a PVO or MOH representative. In a sample of project communities (6-10), teams will complete structured interviews and focus groups with: i. community members; ii. local leaders; iii. project volunteers; iv. project **staff**; and v. Ministry staff (district

and regional). Project staff interviews and focus groups will be limited to i., ii., and iii only; the Team Leader will conduct interviews of all above levels. The total number of interviews and focus groups will be determined in-country.

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

e. Analysis (1 day)

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

f. Recommendations & Lessons Learned (1 day)

One day is required to process major recommendations and lessons learned from all interviews and focus groups following the AID guideline headings. Recommendations and lessons learned will follow the “Findings” from the previous day.

g. Debriefing (1 day)

Debriefing and presentations to the MOH (regional, central) and **USAID** will be conducted (and if time allows other institutions ‘may also be included’). The **debriefing** will consist of a review of the evaluation process, and the draft findings and recommendations.

h. Report Writing (3 days)

- i. The Team Leader will write a **first** draft report (conclusions and recommendations) for debriefing and for presentation to IEF for comments and suggestions prior to departure. Preparation of the report will be a continuous daily process of typing interview forms, interviewee lists, findings and recommendations lists. A secretary will be provided for this purpose.
- ii. The second draft will require additional time (1 day), incorporating staff comments from the first draft. Upon completion staff will have the opportunity to make final comments on the second draft before the final report is completed.
- iii. The **final** report in English will require 1 day. This report will be delivered to IEF Headquarters for submission to **HR/PVC/CSH**. Final

write-up may be completed outside Malawi. The final report must be delivered by October 15th, 1994.

4. SCHEDULE

See attached.

5. REQUIREMENTS

IEF is seeking an evaluator with proven skills in program evaluation, familiarity with USAID Child Survival program and private voluntary organizations, and preferably the country of Malawi.

6. ATTACHMENTS

AID Guidelines
IEF Additional Questions
Schedule
Report Outline

J:VEPPAD-MALSOW

Appendix 3

PRINCIPAL CONTACTS

IEF

Henry Kalavina	Health surveillance Assistant Supervisor
Golden Makata	Accounting-Administration
Mathews D. Alifinali	Training and Supervision Assistant
M. Kuthewela	Health Surveillance Assistant
J. Kapenga	Health Surveillance Assistant
J. Mpende	Health Surveillance Assistant
Mr. Helvrick Lockie	Health Surveillance Assistant
E. Gombeza	Health Surveillance Assistant
Gombeza Maperera	Health Surveillance Assistant
Jim Chiosa	Health Surveillance Assistant
B. Kabualo	Health Surveillance Assistant
L. Cholokhoto	Health Surveillance Assistant
J. Chisenga	Health Surveillance Assistant
J. Naraya	Health Surveillance Assistant
M. Thoyo	Health Surveillance Assistant
Chris Nsona	Health Surveillance Assistant
F. Kupheka	Health Surveillance Assistant
Onita Misonswe	Village Health Volunteer
Ms. Dorothy Alumewda	Village Health Volunteer
Ms. Rebecca John	Village Health Volunteer
Ms. Mary Chipaliwali	Village Health Volunteer
Ms. Eunice Macfield	Village Health Volunteer
Noinenenji Tinneron	Village Health Volunteer
Matialiya Nsabwe	Village Health Volunteer
Patrick Magauizo	Village Health Volunteer
Ms. Hilda Stephen	Village Health Volunteer
Ms. Lucy Belief	Village Health Volunteer
Ms. Mary Chigudu	Village Health Volunteer

Montfort Hospital

Sr. M.B. Mkoka	Matron
Dr. Van Aalen	Medical Officer
Dr. P.C. Masache	Senior Medical Officer
A.F. Salamu	Administrator

SUCOMA Medical Office

Mr. Rowland Gondwe	Medical Technician
Mr. Bernard M. Kachale	Estate Health Officer
Mr. A.J. Kapeta	Environmental Health Inspector
Ms. Ellen F. Kebbie	Estate Matron

MOH

Dr. Henk Bekedam	Regional Health Officer
Mr. E.P. Iumula	Regional Health Inspector
Mrs Violet Kamfose	Family Health Officer, MOH, Blantyre
Ms. Lucrezia Kuchande	PHC Program Assistant, CPAR
Mr. Mabwera	Senior Medical Assistant, Maperera HC
Mr. Mtambalika	Health Assistant/Maperera HC
Dr. D.S. Nyangulu	Controller, Preventive Health Svcs.
Ms. Lilian Selenje	Project Officer, UNICEF
Dr. H.M.J. Shaba	National PHC Coordinator
Dr. E.F. Venemans	Chikwawa District Health Officer
Mr. Mabwera	Senior Medical Assistant, Maperera
Mr. Mtambalika	Health Assistant, Maperera
Mr. Munthali	Health Assistant, Ndakwera
Mrs. Mero	Do10 Health Center
Mrs. Misasi	Nurse, Ndakwera HC
Mr. Gobede	MCH Coordinator, Chikwawa

PVOs

Dr. Joyce Cook	CS Project Director, ADRA
Mr. P.S.R. Kantunda	PHC Coordinator, CHAM

USAID

Mr. Chris McDermott	Chief, Health and Population
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Appendix 4

MALAWI END OF PROJECT EVALUATION OF IEF CHILD SURVIVAL PROJECT
 CHIKAWA DISTRICT, LOWER SHIRE VALLEY
 AUGUST 15th - 25th, 1994

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7	8	9	10	11	12	13 Trip to Blantyre
14 Discussion with IEF field director	15 Meeting - RHO - staff	16 Interview form development Meetings - ADRA - DHO	17 Field Interview	18 Field Interview	19 Meetings	20 Data Analysis
21 Draft writing	22 Discussion with project staff	23 Debriefing	24	25	26	27

Appendix 5

Documents Reviewed

IEF Malawi Vitamin A for Child Survival Project. Country Proposal. December 1990 .

IEF Malawi Vitamin A Project. Final Evaluation Report. January 1992 .

IEF Malawi Vitamin A for Child Survival. Baseline Survey Results. August 1992.

IEF Malawi Vitamin A for Child Survival. Detailed Implementation Plan. June 1992.

IEF Malawi Vitamin A for Child Survival Project. Mid-term Evaluation Report. December 1993.

IEF Malawi Vitamin A for Child Survival. Quarterly Progress Report # 7 . July - September 1993.

IEF Malawi Vitamin A For Child Survival. Project Proposal January 1994.

Appendix 7

VITAMIN A FOR CHILD SURVIVAL

IEF PROJECT

Chikwawa District, Lower Shire Valley, Malawi

FINAL EVALUATION

FIELD INTERVIEW RESULTS

AUGUST 15 - 25, 1994

DISCUSSION GUIDE FOR COMMUNITY MEMBERS

of interviews = 11

Are you aware of the IEF Vitamin A/CS programs?

Yes=11 No = 0

Has the VHC made any decisions or changes which you feel have been particularly important?

Yes = 8 No = 2 DK = 1

How are VHC members chosen within this community?

Community = 7 Chief = 1

HSA/VHV = 1 DK = 2

When the HSA comes to your village, does (s)he go first to see the members of the VHC or first to see the VHV?

VHC = 2 VHV = 6 DK = 3

What is the VHC's relationship with the VHV?

Good = 7 **Bad = 1** DK = 3

Do the members of the VHC **assist** the VHV in motivating community members to seek necessary health services?

Yes = 7 No = 2 DK = 2

Does the VHV in this village receive any compensation or "incentives" for her work? **Yes [1** **No []**

Yes = 2 No = 6 DK = 3

Does the VHC help to provide or obtain money/labour/material support for the VHV?

Yes = 1 No = 7 DK = 3

What kind of support for the VHV could be provided in the future to help to motivate the VHV?

Money, helping in their garden, draw water for her, help in the household activity, provide maize

Nothing = 6

Has the VHV in this community been trained in primary eye care? Does she provide ointment for eye infections?

Yes = 7 No = 2 DK = 2

Have IEF CS/Vitamin A programs made any differences in your community?

Probe for: perceived effectiveness of CS?

Perceived as effective 8
 Not perceived as effective 0
 Difficult to comment 3

Probe for: **any** changes in the ability of communities to meet their own health needs and/or sustain CS activities?

Change observed 2
 No change observed 2
 Difficult to say anything 7

Probe for: any change in demand for services?

Demand increased = 2 No change observed = 9

Probe for: perceived effectiveness of the VHV?

Effective = 8 Not effective = 3

Have you received health education from your VHV/ HSA?

Yes = 3 No = 8

Has the community participated in the design/implementation/evaluation of the IEF project?

Yes = 3 No = 8

Has the community helped to provide any **financial/labour/material** contributions in support of project efforts?

Yes = 3 No = 8

Are any other kinds of health services needed in your community?

AIDS prevention (condom **distribution**), **family planning**, home craft, hospital, school, **malaria** treatment, food preservation, diarrhea treatment, food supplementation, schistosome treatment

Would you and your community be interested in basic curative services (**antimalarial/antipyretics**) available within your village for a small charge at the time of treatment?

Yes = 5 No = 6

Could proceeds be used to support the volunteer?

Yes = 5 NA = 6

Any other issues to discuss; Suggest ways to improve program?

Inclusion of curative services

DISCUSSION/OBSERVATION GUIDE FOR HEALTH CENTERS/MOBILE CLINICS

interviewed = 7

Is vitamin A available in Under-Fives clinics for distribution in conjunction with clinical and preventive services?

Yes = 7 No = 0

Is vitamin A available in Under-Fives clinics actually provided to all eligible children who have come for clinical and preventive services? (Exit interviews and review of u-5s' cards.)

Yes = 2 No = 1 Not observed = 3

Have there been any periods in the past year when the clinic has had no supplies of vitamin A (estimate number of weeks)?

Yes = 0 No = 7

How often are stock of vitamin A monitored? reordered?

No regular **monitoring** 4
Order monthly with other drugs 2
Not ordered, supplied **with** vaccines 1

Assess the awareness of the HC staff of IEF Vitamin A/CS programs.

Aware = 7 Not aware = 0

Does the HA have any role in supervision of the IEF HSAs?

Yes = 3 No = 2 Collaborate = 2

Have IEF CS/Vitamin A programs made any differences in your community?

Probe for: perceived effectiveness of CS?

Perceived as effective 6
Difficult to comment 1

Probe for: any changes in the ability of communities to meet their own health needs and/or sustain CS activities?

Change observed 3
No change observed 2
Difficult to say anything 2

Probe for: any change in demand for services?

Demand increased = 7 No change = 0

Probe for: perceived effectiveness of the VHV?

Effective = 6 Some are effective 1

Does the clinic staff ever use the HSAs and/or VHVs to follow-up patients (such as TB defaulters) from the Health Center?

Yes = 1 Occasionally = 1 No = 4

DISCUSSION GUIDE FOR HEALTH COMMITTEE MEMBERS

interviewed 10

How many meetings has the VHC had within the last six months?

None = 2 One = 2
Two = 5 Three = 1

How many members are on the VHC?

Five = 1 Nine = 1 Ten = 8

Proportion of Women on VHC?

20% = 2 30% = 3 40% = 2
 50% = 1 60% = 1 80% = 1

When was the last routine meeting of the VHC?

1 day ago = 1 2 wks ago = 1 4wksago = 2
2 mns ago = 2 4 mns ago = 2 Don't meet = 2

How many members attended the last meeting?

80% = 4 30% = 1 Don't remember = 3

What issues does the committee address during its discussions?

Environmental sanitation, water supply, AIDS prevention, child spacing, shortage of drug and lack of health facility

Two VHC have done nothing

What methods/activities does the VHC use in doing its work?

Households visit and health education

Has the VHC made any decisions or changes which you feel have been particularly important?

Improved sanitation: latrine construction and water protection

Three VHC made no significant change

How are VHC members chosen within this community?

By community = 8
 By the chief = 1
 By HSA/VHV = 1

Is your VHV a member of the VHC? Yes [7] No [3]

Does s/he come to the meetings? Yes [7] No [1] NA [2]

Does the HSA attend the VHC meetings? Yes [4] No [2] NA [2]

When the HSA comes to your village, does (s)he go first to see the members of the VHC or first to see the VHV?

Chief = 2 VHC = 2 VHV = 6

What is the VHC's relationship with the VHV?

Good = 9 Bad = 1

Does the VHV report her findings regarding coverage (or other indicators) to the VHC on a regular basis?

Yes = 4 No = 6

Do the members of the VHC assist the VHV in motivating community members to seek necessary health services?

Yes = 5 No = 5

If yes, specify How.

Health education through household **visit**

Does the VHV in this village receive any compensation or "incentives" for her work? Yes [] No []

Yes = 6 No = 4

Does the VHC help to provide or obtain money/labour/material support for the VHV?

Yes = 2 No = 8

What kind of support for the VHV could be provided in the future to help to motivate the VHV?

Money contribution = 1

Assist in activities = 1

None = 8

Does she provide ointment for eye infections?

Yes = 6 No = 3 Dk = 1

Have IEF CS/Vitamin A programs made any differences in your community?

Probe for: perceived effectiveness of CS?

Perceived as effective = 9

Not perceived as effective = 1

Probe for: any changes in the ability of communities to meet their own health needs and/or sustain CS activities?

Change observed = 8

No change observed = 2

Probe for: any change in demand for services?

Demand increased = 6

No change observed = 4

Probe for: perceived effectiveness of the VHV?

All are effective = 8

Some are effective = 1

Not effective = 1

Has the community participated (through the VHC or other mechanism) in the design/implementation/evaluation of the IEF project?

Yes = 2 No = 8

Has the community helped to provide any **financial/labour/material** contributions in support of project efforts?

Yes = 3 No = 7

Are any other kinds of health services needed in your community?

Sanitation; Family planning, AIDS, Drugs, Hospital/clinic, water, school, malaria treatment and first aid

Would you and your community be interested in basic curative services (antimalarial/antipyretics) available within your village for a small charge at the time of treatment?

Yes = 4 No = 6

Could proceeds be used to support the volunteer?

Yes = 3 No = 1 NA = 6

Any other issues to discuss; Suggest ways to improve program?

Transport for labouring women

DISCUSSION GUIDE FOR VILLAGE HEALTH VOLUNTEERS

interviewed = 9

What activities do you engage in as a volunteer?

Vitamin A distribution, ORS distribution, eye treatment, registration of families, assist in under 5 clinic, health education

Time spent on voluntary work = range 3 - 15 hours/week, majority 3-4 hours/week

Are you satisfied with your job? Yes = 6 No = 3

How long will you continue as a volunteer?

Until the end of the project = 3
For life/for long time = 6

How often are you visited by you HSA for supervision

1-2 **times/ week**

Do you participate in the meetings of your VHC?

Yes = 4 No = 5

Are you a member of VHC?	Yes = 3	No = 6
Does the HSA attend the VHC meetings?	Yes = 3	No = 6
Do you attend under fives' clinics?	Yes = 6	No = 3

When the HSA comes to your village, does (s)he go first to see you or first to see the VHC members or other community leaders?

VHC = 4 VHV = 5

How many meetings has the VHC had within the last six months?

None = 3 One = 3
Two = 2 DK = 1

How many member-s a report the VHC?

Ten = 4 Seven = 1 DK = 4

What is the proportion of women on the VHC?

10% = 1 20% = 1 40% = 2
60% = 1 DK = 4

When was the last routine meeting of the VHC ?

2 wks = 1 4 wks = 2 12 wks = 2
DK = 1 Doesn't meet = 3

How many members attended the last meeting?

80% = 3 70% = 1 **DK = 2**

What issues does the committee address during its discussions?

Sanitation, need for health services, under-five clinic, protection of water source, digging latrine and family planning

What methods/activities does the VHC use in doing **its** work?

Households visiting

Has the VHC made any decisions or changes which you feel have been **particularly** important?

Yes = 6 No = 3

How are VHC members chosen within this community?

By community = 6 Dk= 3

Are **you** a member of the VHC? Yes = 2 No = 7

Do you go to the meetings? Yes = 3 No = 6

Does the HSA attend the VHC meetings? Yes = 0 No = 9

What is your relationship with the VHC?

Good = 7 No communication = 2

Do **you** report your Findings regarding coverage (or other indicators) to the VHC on a **regular** basis?

Yes = 5 No = 4

Do the members of **the** VHC assist you in motivating community members to seek necessary health services?

Yes = 7 No = 2

Do you receive any compensation or "incentives" for your work?

Yes = 8 No = 1

If yes, would you continue without incentives?

Yes = 6 No = 2

Does the VHC help to provide or obtain **money/labour/material** support for the VHV?

Yes = 2 No = 7

If yes, specify: **labour**

Has the community participated (through the VHC or other mechanism) in the design/implementation/evaluation of the IEF project?

Yes = 4 No = 5

Has the community helped to provide any financial/labour/material contributions in support of project efforts?

Yes = 3 No = 6

What kind of support could be provided in the future to help to motivate you to continue your work?

Improve drug supply, money, supply uniform, continue giving soap, supply oil, supply shoes and supply stationery

Have you been trained in primary eye care? Yes = 8 No = 1

Have IEF CS/Vitamin A programs made any differences in your community?

Yes = 8 No = 3

Probe for: any changes in the ability of communities to meet their own health needs and/or sustain CS activities?

Yes = 5 No = 4

Probe for: any increased demand for services?

Yes = 8 No = 1

Are any other kinds of health services needed in your community?

AIDS prevention activity, Family planning, nutrition clinic, malaria treatment and curative services

Would you and your community be interested in basic curative services (antimalarial/antipyretics) available within your village for a small charge at the time of treatment?

Yes =7 No = 2

Have you had adequate supplies of vitamin A?	Yes = 7	No = 2
O R S ?	Yes = 2	No = 7
Condoms?	Yes = 1	No = 8
Tetracycline?	Yes = 0	No = 9

Any other issues you would like to discuss?

Hand bags, road construction is needed, want HSA to be based in the villages, **provide** VHVs with more drugs, want health workers **at the health** post, more soap, boreholes, schools

DISCUSSION GUIDE FOR VILLAGE LEADERS

interview = 7

Are you aware of the IEF Vitamin A/CS programs?

All yes

Has the VHC made any decisions or changes which you feel have been particularly important?

Yes = 6 No = 1

How are VHC members chosen within this community?

By community 7 (all)

When the HSA comes to your village, does (s)he go first to see the members of the VHC or- first to see the VHV?

Village headman

What is the **VHC's** relationship with the VHV?

Have good **relationship**

Do the members of the VHC assist the VHV in motivating community members to seek necessary health services?

Yes = 4 No = 3

Does the VHV in this village receive **any** compensation or "incentives" for her work?

Yes = 0 No = 7

Does the VHC help to provide or obtain money/labour/material support for the VHV?

Yes = 0 No = 7

What kind of support for the VHV could be provided in the future to help motivate the VHV?

Yes: helping in his/her garden
building/repairing his/her house
helping on his/her problem
visiting him/her when sick

Nothing: the community is poor (said by 4 leaders in interview)

Does the VHV provide ointment for eye infections?

Yes = 2 No = 4 Dk = 1

Have IEF CS/Vitamin A programs made any differences in your community?

Probe for: perceived effectiveness of CS?

Perceived as effective = 7
Not perceived as effective = 0

Probe for: **any** changes in the ability of communities to meet their own health needs and/or sustain CS activities?

Change observed = 6
No change observed = 1

Probe for: any change in demand for services?

Demand increased = 7
No change observed = 0

Probe for: perceived effectiveness of the VHV?

Effective = 7
Not **effective** = 0

Has the community **participated** (through the VHC or other mechanism) in the design/implementation/evaluation of the IEF project?

Yes = 1 No = 6

Has the community helped to provide any **financial/labour/material** contributions in support of project efforts?

Yes = 1 No = 6

Are any other kinds of health services needed in your community?

Family planning, Eye treatment, AIDS prevention, **health post**

Would you and your community be interested in basic curative services (antimalarial/antipyretics) available within your village for a small charge at the time of treatment?

Yes = 7 No = 0

Could proceeds be used to support the volunteer?

Yes = 7 No = 0

DISCUSSION GUIDE FOR HEALTH SURVEILLANCE ASSISTANTS

interviewed = 11

Assessment of issues concerning the role of HSAs after the end of the next project:

Will you and other HSAs accept transfer to the MOH at the end of the next three year project?

Yes = 7 No = 2 Not sure/reluctant = 2

Will HSAs be willing to take on a smaller catchment area and use a push-bike instead of the motor bike?

Yes = 7 No = 0 NA = 2

What are your concerns and ideas about sustaining project activities at the end of the next three years?

sustaining **incentive** for VHVs = 5

training & supervision = 3

no cancer n = 3

Are you satisfied with the amount and-quality of your training?

Amount: Enough = 3 short = 8

Quality: Good = 11 Bad = 0

Are you satisfied with the amount and quality of your supervision?

Amount: Satisfactory = 10 No answer = 1

Quality: **Good** = 9 Bad = 1 No answer = 1

Who supervises you? Are you also supervised by the HA?

IEF = 5

IEF & MOH = 4

IEF & occasionally MOH = 2

How often (specify number of times per month)?

1 - 2 times per week

Can we see your (specify whether seen, completeness, etc):

Commodity Distribution Form? { good }

VHV Supervisory Checklist? { good 3 }

Health Education Report? { good }

General comment: over worked