

World Vision Relief & Development, Inc.

**WVRD/Malawi FY93
MID-TERM EVALUATION REPORT
KABUDULA CHILD SURVIVAL PROJECT
LILONGWE DISTRICT, MALAWI
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TABLE OF CONTENTS

Acronyms	4
Executive Summary	5
I. Introduction	6
II. Evaluation Process	
A. Purpose of Evaluation	
B. Composition of the Evaluation Team	7
C. Evaluation Methodology	
III. Evaluation Findings	8
A. Specified Findings	
1. Accomplishments	
2. Effectiveness	9
3. Relevance to Development	11
4. Design and Implementation	
4.1 Design	12
4.2 Management and use of data	
4.3 Community education and social promotion	14
4.4 Human resources	15
-Staffing	
- Training	
4.5 Supplies & material	17
4.6 Quality of services	
(Growth Monitoring, Immunizations, TBA, Sanitation, Malaria, CBD Agents, IGA)	
4.7 Supervision and monitoring	20
4.8 Regional & Headquarters support	21
4.9 Use of technical support	22
4.10 Counter part relationships	23
4.11 Referral relationships	24
4.12 Networking with NGO's	25
4.13 Budget management	

(Evaluation Findings, continued)

5.	Sustainability	26
	Sustainability objectives - Table 2	27
IV.	Summary of Main Findings, Conclusions & Recommendations	
A.	Specific Interventions	
	(Immunizations, Control of Diarrhea1 Diseases, Nutritional Improvement, Maternal Care, Control of Malaria, HIV/AIDS	
B.	Management and Sustainability	30
	(Sustainability, No-cost extension, Human resources, Transport) .	

V. APPENDICES

1. Itinerary for the Evaluation Team
2. Data Sources for Midterm Evaluation Report
3. Key Informants & Group discussions for Evaluation
4. Summary of findings per objective
5. Activity Achievement for the Year
6. Kabudula Child Survival Project Training for **FY94/95**
7. Monthly Reporting Forms & Tally Sheets
8. Pipeline Analysis

ACRONYMS

CBD	Community-based Distribution (of contraceptives)
CBDA	Community-based Distribution Agent
CDA	Community Development Assistant
c s	Child Survival
CSSP	Child Survival Support Program
DHO	District Health Office
EPI	Expanded Program on Immunization
GM	Growth Monitoring
HIS	Health Information System
HP	Health Promoter
HSA	Health Surveillance Assistant
KPC	Knowledge, Practice and Coverage
KCSP	Kabudula Child Survival Project
KRH	Kabudula Rural Hospital
MOA	Ministry of Agriculture
MOH	Ministry of Health
NFWCM	National Family Welfare Council of Malawi
NGO	Non-governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PM	Project Manager
PVO	Private Voluntary Organization
RHO	Regional Health Office
RNO	Regional Nursing Office
TBA	Traditional Birth Attendant
TSC	Technical Services Coordinator
UNICEF	United Nations Childrens Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
VHV	Village Health Volunteer
WFP	World Food Program
WVI	World Vision International
WV/M	World Vision/Malawi
WVRD	World Vision Relief and Development

EXECUTIVE SUMMARY

From September 19 - 29 1995, a five-person team conducted a midterm evaluation of the World Vision Kabudula Child Survival Project in Malawi. Team members were Dr. Mary Anne Mercer, team leader; Dr. Larry Casazza of World Vision Relief and Development (first week only); Mr. Genner Chipwaila, International Eye Foundation/Malawi; Ms. Anne Henderson, World Vision Relief and Development; Dr. Beatrice Mtimuni, University of Malawi; and Mr. Kibble Ngalauka, project manager. The report was drafted by the team leader, and reviewed by all team members before being put into final form. The team provided feedback to USAID and WV/M at the end of the evaluation; staff will brief project staff, volunteers, the community and the MOH on the main findings of the evaluation. The in-country costs for the evaluation totaled approximately \$5622.

The methods of the evaluation included a 30-cluster knowledge, practices and coverage (KPC) survey, carried out prior to the arrival of the evaluation team; individual interviews and group discussions with WV staff, volunteers, beneficiary groups, and collaborators; review of project records; observations of activities in Kabudula; and visits to referral sites.

The main project outcomes are: 11 of 15 objectives measured by the KPC survey showed substantial improvement over baseline levels, and for six the end-of-project targets have already been met. Immunization coverage among 12-23 month olds is 89.5% for measles and 85% for DPT3; 36% of project women are using a modern method of contraception; 60% of women know at least two dietary sources of vitamin A; and 96% of women reported at least two prenatal care visits by a trained health worker. Additional project outputs include: 10,756 vitamin A capsules were distributed; 45,831 weighings/counseling of children took place; and 1526 new pit latrines were constructed. Three new areas of activity are: community-based distribution of contraceptives; four new income-generating activity groups, also aimed at improving nutrition; and anti-AIDS clubs in the schools.

The overall quality of project services was very high. The project design includes exemplary collaboration with government and private institutions, contributing to a strong potential for sustainability. Another important lesson of the project has been the importance of flexibility of project management in responding to emerging needs and conditions in the project area.

The main recommendations are that the project: support the training of the project's 14 Health Promoters to be Health Surveillance Assistants; train one of the Senior HSAs to supervise the remaining HSAs, based at Kabudula Rural Hospital; establish the Chiwe Health Center as an outreach supervision post for HSAs and VHVs, with Nkhoma Mission Hospital maintaining the health center; establish four additional self-sustaining income generating groups; and apply for a one year no-cost extension. Additional recommendations related to human resources management were that WV make every effort to maintain a full complement of staff for the remainder of the project; formalize elements of the training and supervision that takes place; determine appropriate incentives for project volunteers; offer the HIS Coordinator further computer training; establish at the project site a resource center for HSAs and other project staff; and act on several important transportation issues that are in need of immediate action.

I. Introduction

The World Vision/Malawi (WV/M) Kabudula Child Survival Project (KCSP) is located 55 km west of Lilongwe in Kabudula Traditional Authority, Lilongwe District, in the Central Region of Malawi. The project is in a rural area of 50,202 persons living in 175 villages, 120 of which were covered by the original Child Survival project (1990-93). The bulk of the population are subsistence farmers or tenant farmers on large tobacco estates; firewood is also sold for cash income. The area is served by unimproved roads; there is no electricity, and telephone communication is essentially unavailable as well. The area continues to suffer from a severe drought that has affected Malawi for the past three years.

Lilongwe district is one of Malawi's priority areas for nutrition programs because of historically very high rates of malnutrition. The Kabudula area was known in the past for its severe measles epidemics and generally low health status. The population served by the project has extremely poor indicators of health and well-being; infant mortality is estimated to be **229/1 000** (Malawi National Health Plan, 1986-1995) and female literacy around **40%** (KPC baseline survey). The drought conditions have dramatically increased malnutrition rates in the area, and even worse nutritional deficits are anticipated before the completion of the next growing season.

This midterm evaluation of the second phase of the Kabudula Child Survival Project took place two years after the beginning of project funding.

II. Evaluation Process

A. Purposes of the evaluation

The main purpose of the evaluation is to review the progress of the project towards achievement of the objectives set out in the Detailed Implementation Plan, and to make recommendations for improvement of the project during its final phase. Specific objectives are to: review the accomplishments of the project to date; assess the effectiveness of project interventions and their relevance to development; assess aspects of the design and implementation of the project that either are beneficial to the project or in need of correction; and describe steps taken to assure the sustainability of the project following the completion of project funding. The evaluation is meant to provide concrete recommendations for steps to be taken to address the above issues during the final phase of the project.

B. Composition of the evaluation team

Mary Anne Mercer, DrPH	Team Leader Seattle, Washington, USA
Larry Casazza, MD, MPH (first week only)	World Vision Relief and Development Washington, DC, USA
Genner Chipwaila	Project Manager International Eye Foundation/Malawi
Anne Henderson, RN, MPH	World Vision Relief and Development Johannesburg, South Africa
Beatrice Mtimuni, PhD	Department of Home Economics/Human Nutrition of the University of Malawi
Kibble Ngalauka (ex <i>officio</i> member)	Project Manager World Vision/Malawi

C. Evaluation Methodology

The evaluation team was based in the Lilongwe World Vision office, making frequent field visits to the Kabudula Child Survival Project site. Part of the team traveled to Blantyre on the first day to interview the project accountant (before all of the evaluation team members had arrived in Lilongwe). There followed a one-day planning meeting with the entire team, during which the team refined the first week's schedule (Appendix 1), determined the best sources of the information requested in the midterm evaluation guidelines (Appendix 2), and developed detailed outlines for the discussions and interviews that were to take place (Appendix 3).

The next day began a series of individual interviews and group discussions with project management, WV staff, volunteers, beneficiary groups, and collaborators with the project. The team reviewed project records (including a midterm KPC survey), observed field activities, and visited referral sites.

Following the data collection activities, the team met again for one day to discuss findings and develop recommendations for future action. These findings and recommendations were presented in separate debriefings to the USAID population, health and nutrition office staff, and to World Vision staff, including the country director, regional operations director and key project staff on the final day of the

evaluation. The evaluation report was drafted by the team leader, and reviewed for revisions by all team members before being put in final form. Local costs for the evaluation totaled approximately \$5622, of which \$3379 covered **costs** of the midterm KPC survey, and \$2243 the costs of transport, local consultants and other miscellaneous local expenses,

III. Evaluation Findings

A. Specific findings

1. Accomplishments

The World Vision child survival project in Kabudula was first funded in October 1990, and this phase of the project began in October 1993 and has been in full field and general operation for 24 months. The accomplishments of the project in achieving the target outcomes for current project objectives are seen in the table in Appendix 4. The table shows that of the 15 objectives, 11 indicators showed substantial improvements from baseline levels, while the remaining four showed essentially no change from baseline. Six of the 11 objectives showing improvement have already met or exceeded the end-of-project targets.

Focusing the efforts to strengthen the messages and activities needed to meet the objectives which have not shown improvement to date will be the emphasis of the remaining project period. These areas include knowledge of mothers as to the need to refer for definitive treatment a child having bloody diarrhea; increasing the use of pit latrines and protected water wells; and increasing coverage with tetanus toxoid for pregnant women. The objective to increase the proportion of households having protected wells from **15% to 50%**, however, may well be unrealistic by the end of the project, however, since it relies on capital inputs from outside the child survival project.

One objective included in the DIP, to introduce the use of insecticide-impregnated bednets, has been dropped from the project, after an investigation into the feasibility of the plan showed that very few project families had the cash reserves to make the initial investment of the bednets. Although the bednets approach to malaria control has shown some initial success in some areas of Malawi and elsewhere, it presupposes the ability of participants to make the initial investment in bednets. The present harsh economic conditions in the project area make that condition impossible to meet. Education will continue as a malaria control intervention, and during the final year of the project a revolving drug fund for antimalarials is being initiated.

The project outputs for the first two yearshare seen in Appendix 5. e numbers of immunizations given, antenatal clinic patients seen, contraceptives distributed, weighings of children, educational sessions presented and health problems treated are taken from routine monthly tallies of village and outreach clinic activities. The numbers for the two years reflect much higher levels of activity during the second project year, after the project manager position was filled.

Additional accomplishments of the project to date are evidenced by its many training activities, seen in Appendix 6. During the period October 1993 through August 1995, project staff participated in a total of 36 formal training sessions. Participants included all levels of staff, from project management through village health volunteers, and a full range of topics, from refresher training in basic child survival interventions to learning new skills such as how to initiate and sustain income generating activities at the village level.

The wide variety of new topics introduced reflects a range of new activities that have been introduced by the project in response to community-expressed needs and local realities (e.g., economic constraints and the drought). As a result of the intensive training efforts, the project has been able to implement the following new activities:

- o Community-based distribution of contraceptives
- o Four new income-generating activity (IGA) groups, which are also aimed at improving household level nutrition, including poultry production, goat production, soya production, and a community vegetable garden.
- o Initiation of anti-AIDS clubs in the schools

2. Effectiveness

Extensive interviewing of project staff, collaborating organizations and community members provided convincing evidence of the overall effectiveness of the project. Because of its strong village presence, virtually everyone in the project area is affected by project activities. As a result of the regular outreach clinics, high risk groups, particularly children from the poorest families and those living furthest from fixed sites, benefit from project services.

There appears to be, at the same time, an increase in the number of children suffering from malnutrition in the project area, most likely due to deteriorating

food security and increased food shortages. The government's district agriculture field assistant estimated, for example, that only four months after the harvest, around **90%** of families in the Kabudula area have already exhausted their stores of food grains. It is difficult or impossible, therefore, to assess what the effectiveness of the projects nutrition-related activities would have been in the absence of the current harsh conditions.

Project effectiveness in meeting its objectives as measured by the KPC survey is discussed above. Six additional questions for which the baseline survey showed substantial need for improvement were compared with the midterm survey results; the results are seen in Table 1:

Survey question	Baseline %	Midterm %
Mother feeds child under age 2 supplementary milk	20%	20%
Mother increased fluid intake during child's recent episode of diarrhea	48%	62%
Mother gives the same or increased amount of supplementary food during diarrhea	48%	62%
Mother used antidiarrheal medication during diarrhea	11%	13%
Mother consulted VHV as source of care for child's diarrhea	12%	13%
Mothers talk to their older children about prevention of HIV/AIDS	1%	1%

Table 1

Comparison of baseline and midterm survey responses for selected indicators

For two of the six indicators, related to the mothers practice of maintaining and increasing food and fluids during her child's recent diarrhea episode, substantial improvement was seen over the baseline result, in both cases going from **48%** to 62%. For the remaining four indicators, improvement in the levels achieved was not seen. Thus at midterm, 20% of mothers still feed their children supplementary milk, which is likely to decrease the amount of their own breastmilk available (although there are likely to be individual cases where this is justified); 13% of mothers used antidiarrheal medicines for their child's most

recent episode of diarrhea; only **13%** of mothers consult the village health volunteer for care of their child's diarrhea; and less than **1%** of mothers talk to their older children about the dangers of HIV/AIDS and how to prevent it. These results indicate further areas in which the project may want to emphasize refining their messages and focusing health education efforts.

3. Relevance to Development

The overwhelming response at all levels, from DHO to community mothers, indicates that the ongoing presence and activity of the **HSAs** at the village level has dramatically improved the ability of village mothers to properly care for their children. Mothers indicated that the educational efforts of the project have led to the adoption of improved feeding practices, understanding of and compliance with immunization schedules, the proper care of sick children, and improved sanitation in the villages. In addition, they believe that current efforts to introduce income generating activities will lead to long-lasting economic benefits as well. Village health committees are clearly involved and functioning to benefit their communities.

Because mothers are being selected as volunteers to serve with the project, they become directly involved with all activities. These volunteers (**VHVs**, VHC members, **CBDAs**) make home visits, further increasing the ability of families to participate in and benefit from child survival interventions. The volunteers deliver the health education messages and serve as role models in their communities, further decreasing the gap from the community to the health messages and services. These volunteers are able to deliver the services of growth monitoring, health education, and oral rehydration therapy within the village itself. Arrangements are made, including the provision of transportation, for mothers to go from their villages to Nkhoma Mission Hospital to receive Norplant or have a tubal ligation; this service also increases the ability of villagers to participate in child spacing activities. The basic medicines utilized for the treatment of acute illnesses during outreach and nutrition clinic activities (including mebendazole, chloroquine, aspirin, antibiotics, vitamins and iron tablets) provide mothers with **access** to a wide range of services.

Another intervention that may, in the long run, make an important contribution to development in Malawi are the "Anti-AIDS Clubs" that the project has initiated in the primary schools. Youth ages 14-18 meet twice weekly to learn about HIV and AIDS, discuss what it means for them and for their communities, and develop anti-AIDS messages via dramas, art, poetry, and songs. The groups then present their work to their parents and the rest of the community in a high-profile show at the end of each of the three terms of the school year.

They also are active in teaching about AIDS in their own homes and villages. Meetings with the “patrons” (teachers sponsoring the clubs) and boys and girls groups from one school provided convincing testimonials to the dramatic changes in knowledge and attitudes that have taken place as a result of the clubs. In addition, all groups interviewed stressed that they saw evidence that there was sharply reduced early sexual activity among the target age groups. Since nearly **75%** of Malawian youth report being sexually active by age 15 (Youth and AIDS. Baseline Survey. Centre for Social Research, University of Malawi, June **1994**), an increase in the age at first sexual activity would be an important project outcome.

4. Design and Implementation

4.1 Design

There were no significant changes in the design of the project since the preparation of the DIP. Some intervention strategies have changed. The **bednet** component of the malaria control intervention was deleted. The AIDS intervention strategy was modified to emphasize the ‘anti-AIDS’ clubs, initiated by the government and supported by UNICEF, while at the same time redefining the target group from children ages 9-14 to adolescents ages 14-18. As described above, the project will introduce a pilot revolving drug scheme for antimalarial drugs in one area during the next year. The drug fund will focus on making available drug treatment for acute attacks of malaria at the village level. This initiative is to start soon and is being used as an intervention in place of the distribution of bed nets.

The projects utilization of community volunteers and the integration of activities with the existing government services is an important element of the design that appears to have facilitated the project’s progress towards meeting its objectives, especially in the area of sustainability. The decision to use students and teachers as an approach to tackle the issue of HIV/AIDS transmission is appearing to have a positive impact on the awareness of HIV/AIDS in the community. This is true both for the direct beneficiaries, students, as well as for the community at large, since students perform dramas and deliver their message to families and neighbors in their communities.

4.2 Management and use of data

When the current HIS coordinator began his work, he was stationed at the KCSP project site because of its proximity to the main data-gatherers, the

volunteers and health surveillance assistants (**HSAs**). However, since the computer had to be housed in Lilongwe, where regular electricity, was available, it was found that too little time was then available for the HIS coordinator's work on data entry and analysis. He was accordingly transferred to Lilongwe, from where he makes frequent visits to the field. This arrangement has been found to be effective, and continues to the present time.

The project now has a well-developed, computerized and fully functional health information system. It is managed by a full-time HIS coordinator, and is based almost exclusively on Ministry of Health (MOH) reporting forms. Data collection begins at the level of village health volunteers (**VHVs**), who submit reports to their supervising health surveillance assistants (**HSAs**). Detailed records of all activities are also kept at the monthly outreach clinics, and the bimonthly nutrition clinics (see Appendix 7 for the monthly reporting forms and tally sheets). The project manager submits monthly reports which summarize all areas of KCSP activity to the WV/M Health Manager (now the Regional Operations Director, Central Region), the WV/M headquarters in Blantyre, the **WVRD** home **office** in the U.S., and three copies to the District Health Office (DHO) of the MOH. Relevant reports on CBD activities are also sent to the National Family Welfare Council of Malawi. All parties indicated that the reports are provided "religiously," and that the information in the reports is useful, reliable and not redundant. Each monthly report includes an action plan for the coming month. Monthly reports are aggregated quarterly, and distributed similarly with a quarterly action plan.

The project manager uses data that are supplied him from the field in determining the areas of needed project emphasis or refresher training. For example, he carefully scrutinizes any reports of deaths in the project area, to determine age, cause, and place of death. When not satisfied with the information provided, he may ask the HSA to visit the family to get more information, or may go himself. When preventable causes of death are identified, the opportunity is taken to teach the health workers and volunteers in the area where improved services are needed.

Routine feedback on the data that are collected is provided to VHVs and **HSAs** at their refresher courses, held quarterly, and at staff meetings, held at irregular intervals. Village headmen are often included in this feedback, as well as in the training, since village compliance seems to be improved when the village leaders are well informed about the activities of the **VHVs**.

Reviews of the HIS reports sometimes leads to the flagging of special problems by WV home office staff, and this can in turn assist the project to mount

appropriate responses. A recent example was a temporary lack of DPT vaccine in the country earlier this year, which was successfully resolved. Another was noting sharp rises in malnutrition rates in the KCSP area because of the drought, which has led World Vision to initiate dialogue with CSSP staff on the need to determine appropriate responses at the field level to complex human emergencies (famine, civil disruption) that occur in the **course** of a child survival project.

All levels of staff report increased satisfaction with the sharing and feedback of information that is routinely gathered for purposes of setting targets and assessing the effectiveness of routine activities. The TSC indicated that the project manager had succeeded in greatly improving the "sense of direction of project staff" through this approach. Another important lesson learned from the project's data system is the value of using, to the extent possible, the forms and procedures of the MOH. This approach makes transfer of activities to the MOH at project closeout much easier to accomplish, and also provides information to the MOH that can be compared with other areas not covered by the PVO.

4.3 Community education and social promotion

The project has provided a mix of health education and essential service provision, linking closely with sources of referrals for services that cannot be provided at the community level. At this point in the project, staff see the need to move gradually away from service provision by project staff and towards the direction of increased capacities at village level to assess needs and mount effective responses to meet the identified needs. This appears to be taking place, as evidenced by the response of mothers when questioned about what they anticipated would happen following the departure of the World Vision project. "If World Vision must go, just be sure that the **HSAs** stay in our villages. They will continue to help us to learn what we need to learn to make our lives better."

Health messages to community mothers are the same that were used during the first phase of the project, and have not been changed during this phase. They were based on MOH health education materials and messages or on "Facts for Life," and not developed by the project staff. What has changed over time is the emphasis given to different messages, based on observations of the mothers' acceptance and comprehension, and changes in local conditions, e.g., food shortages.

The standard health education sessions make use of traditional "lecture-discussion" methods. They appear to be interactive, and conform to local styles of interaction and communication. Typically, however, the VHV involves mothers themselves by

having them deliver the key messages of the “health talk.” In that way, mothers must learn the messages well enough to teach them. Another non-traditional mode of teaching that the project uses is support for the “anti-AIDS clubs” for school-going youth, described above in Section 3. Making use of drama, the arts, poetry and song provides reinforcement and cultural meaning for the basic messages about the HIV/AIDS problem in their areas.

4.4 Human resources

Staffing

Full-time human resources for the KCSP include one project manager, technical services coordinator, HIS officer, secretary, bookkeeper and two drivers and guards. There is also one community health coordinator, who was ill in the hospital at the time of the evaluation, and thus not available for interview. Other staff include two nurses, 14 health surveillance assistants (**HSAs**), and 14 health promoters (**HPs**). Also implementing the project are 180 village health volunteers (**VHVs**), 15 community-based distribution of contraceptives agents (**CBDAs**), and 15 **TBAs** who were trained by the project. The World Vision Health Manager, Nutrition Coordinator and IGA supervisor are other WV staff not supported by the project, but do provide technical and/or managerial assistance when needed. The Health Manager, in particular, has provided regular and frequent monitoring visits to the project, particularly during the period when the project manager’s position was unfilled.

This mix of staff, when all positions are filled and functioning, appears to be adequate to meet the project’s needs. Duplication of effort does not appear to be a problem. However, serious illness among key staff members is an ongoing reality in Malawi. The seven month vacancy in the project manager position during the first year of the project placed heavy work burdens on the staff remaining and severe constraints on the completion of project activities. Compounding the problem was that the just at that time the community health coordinator, who was responsible for direct supervision of **HSAs**, was sent to be retrained for the position of HIS coordinator. The TSC was, as a result, the only regular field staff person functioning during that time.

Community volunteers are the “backbone” of the project, working in each village with the support of their supervising HSA. Workload for the volunteers is estimated to be two days weekly, which is reported to be not overly taxing, in part because of the support of the community for the volunteers’ work. Although project records do not reflect exact numbers, volunteer dropout rates appear to be currently very low, often reflecting legitimate reasons such as the family’s relocation to another area or the

volunteer's taking on other responsibilities in the village. The morale and confidence of project staff is reported, and appears to be, very good at present, in part because of the participatory approach of the project manager to program decision-making.

The question of incentives for volunteer staff was mentioned as an area in need of further discussion. Suggestions from the volunteers themselves for incentives that would please them are official badges which identify their position (these were brought up in the context of CBD agents particularly; most VHVs and VHC members already have badges); soap, so that volunteers could provide "good examples" of hygienic practices; bicycles; and uniforms. VHVs are sometimes provided soap at their meetings or refresher courses. CBD agents also received a backpack, so that they can carry their supplies of contraceptives, and a wristwatch. Other kinds of incentives have been discussed, but because of the desire to enhance sustainability, additional incentives for volunteers have not been provided.

Training

The training in which project staff have participated was seen in Appendix 6. They include both initial and refresher training for all types of worker.

Field staff express satisfaction with the quality and duration of their training. Some staff mentioned the desire for further specialized training (e.g., additional computer programming for the HIS coordinator). The schoolteachers who were trained to conduct the anti-AIDS clubs also indicated a desire for further training in this area.

Routine staff training (**HSAs, TBAs, VHVs**) was based on standard curricula developed by the MOH. Some of these curricula outline objectives and topics, but most do not include any detail on the content to be included. For project-developed training (such as that for village health committees), behavioral objectives were provided but detailed session content was not included. As a result, although the training appears to be of high based on its results (knowledgeable and skilled workers), it would be difficult to assess the quality of the training sessions per se, and impossible to replicate the content covered in any one session.

A review of the projects training records showed neatly typed reports for each training carried out by the project. The reports included, at a minimum, general background on the training, appropriate behavioral objectives, a list of participants, and a narrative summary of the sessions. Some also included a budget (mostly for those funded by outside sources). Trainee evaluation results were not found, with one exception (the CBD agent training).

4.5 Supplies and materials

The main externally-obtained supplies and materials needed for the project are health education materials; vaccines and EPI equipment; vitamin A capsules; family planning commodities; and ORS sachets, all supplied by the MOH. ORS sachets are currently out of stock, which requires that staff emphasize home available fluids or referral for children with diarrhea. Other MOH-supplied items are available in the quantities needed. Drugs are purchased by the project, or received by World Vision as gifts in kind, and reporting forms are produced by the project (based on MOH forms). Weaning food mix is currently supplied by the World Food Program, for use at the nutrition outreach clinics, held twice monthly at each site.

The storage and distribution of supplies, including drugs, from the KCSP field office appear to be well organized and the drug supplies are properly secured. For detailed comments on individual items, see the section on interventions.

Regarding other materials that might be used by the project, there appeared to be very few health education or training manuals or reference books readily available and accessible to staff in the project **office**. For example, "Nutrition Facts for Malawian Families" is a recent publication that would provide useful information regarding specific weaning food preparations that might be promoted by KCSP. Individual staff members had their own copies of several relevant books and manuals, but they were stored in files that did not make them accessible to field staff, particularly **HSAs**.

4.6 Quality of services

Staff state that they are able to monitor the quality of services provided at the most peripheral level by the results: large numbers of mothers are, for example, accepting family planning, and bringing their children to preventive care clinics. Quality is assured mostly through the regular contact that supervising **HSAs** have with the **VHVs** and **CBDAs**.

When health workers were asked how they know whether or not their messages were being well received, understood and practiced by the community, their response was that they can see a difference when they make village visits. The KPC survey conducted at midterm was also a measure of the impact the interventions of the project.

During the evaluation, many observations and interviews were held with volunteer staff and **HSAs** to assess their level of knowledge and their skills in educating and

motivating mothers. In all cases, the team was impressed with the thoroughness of the preparation of the individual carrying out the educational activity, and with their generally good grasp of the content to be transmitted. All levels of project workers (nurses, **HSAs**, Health Promoters) and volunteers (**VHVs, VHCS, TBAs, CBDAs**) interviewed appeared to have the necessary knowledge and skills to deliver a relatively high quality of health services. Interventions observed were effective, easily accessible to the target population, and were well received by the community. Follow up training, in part through supervision activities, appeared to be taking place

Growth monitoring activities observed revealed that weights were being properly measured and recorded by the health volunteers. The individual counseling provided to the mothers following the recording of the weight did not appear to be very thorough; this may have been because the counseling duties appeared to be divided between the volunteer/HSA team taking and recording the weights and the nurse who provided general health counseling. However, when individual interviews were done with the mothers following the activity, all mothers were able to report whether their child had gained or lost weight that day. They also remember most or all of the key points made in the “nutrition talk” given earlier in the morning.

The project uses the MOH reporting system that notes the numbers of children weighed and the number within the “normal” range of weight for age. It is anticipated that the MOH reporting system will be modified within the coming months, however, to allow for greater use of the data to estimate nutritional status trends in the under-five population.

Immunization activities were carried out in a fairly efficient manner. It appeared that the mothers were being informed about the type of vaccine the child was receiving and possible side effects. Vaccinations were being properly registered. The **cold** chain system was intact, with MOH policy being observed. However, the refrigerator at the **office** site was registering 10 degrees Centigrade on two consecutive visits to the project site, rather than the maximum of 8 degrees that is recommended. The injection technique of a vaccinator observed during the nutrition clinic was in need of refinement to incorporate ways to minimize pain during the injection.

The team conducted interviews and observations with one **TBA** working within a village. The TBA was able to give a very thorough description and explanation of how she conducts prenatal exams, prepares for deliveries and what types of cases she refers on the hospital. Her level of knowledge was quite impressive, except that she was uncertain as to the number of tetanus toxoid injections a pregnant woman should receive before delivery.

Sanitation assessment visits made to mothers' individual homes revealed that drinking water was being stored in a covered pot and that a 2 cup system (one for scooping out water and one for drinking) was being used. In villages where the water source was unprotected, mothers reported that they boiled their drinking water. Several latrines were also visited at these homes. Covers used for the latrines varied -- some had tight lids, others had lids with holes through which flies could enter and exit, and one latrine visited had no lid at all; their cleanliness and maintenance was otherwise exemplary. Mothers were also able to state the reasons why it is important to construct and use a latrine,

Interviews with mothers also revealed that the women knew that **malaria** is transmitted by mosquitos and were able to state some interventions for preventing malaria, such as the destruction of mosquito breeding sites. In general, the communities appeared remarkably clean and well kept.

The evaluation team observed interviews conducted by the **CBD agents** with couples who were prospective family planning clients. The agents appeared to present very thoroughly the information on the importance of and reasons for child spacing, and the various methods that were available. The CBD agents gave adequate time to the couple to ask questions and to clarify any information they did not understand.

The team visited an **income generating activities** (IGA) group involved in poultry production. The women in the group were able to state the steps necessary in **carrying** for the chickens, and the structure in which the chickens were housed was extremely clean and well kept. The women showed great pride and enthusiasm regarding the IGA approach.

Overall, the project staff appeared to have very good communication skills and open relationships with the beneficiary community. Often, however, it appeared that standardized messages were being given without adequate attention to the particular needs of the situation or group they were addressing. For example, although ORS packets were out of stock (except for a very few held back for genuine emergencies), some VHVs continued to give their standard discussion of preparation and use of ORS. More detail on alternatives, such as home available fluids and cereal-based solutions, would have been more appropriate. The project manager is aware of this issue, and has taken measures to try to assure that messages are more carefully targeted to need rather than presented as rote exercises.

4.7 Supervision and monitoring

The project has a detailed, multi-tiered system of supervision and monitoring that ends at the village level. The project manager is supervised by the World Vision Health Manager, who until the time of the evaluation had been stationed in Blantyre, some five hours drive from the project site (she has recently been relocated in Lilongwe). The project manager supervises the activities of the three senior field staff (TSC, HIS coordinator and Community Health Coordinator). The TSC and HIS coordinator work with the CHC who directly supervises the two project nurses, 14 **HSAs** and 14 HPs. The **HSAs** (who currently are nearly all men) work in pairs with the HPs (who currently are all women) to supervise the work of the 180 **VHVs**. The ratio of supervisor to supervisee at the field level is therefore approximately 14 to one, if pairs of HSA-HP supervisors are counted as a unit. In practice, however, they also do some supervisory work individually, making the effective ratio somewhat lower.

HSA supervision of VHVs and **CBDAs** takes place regularly at the outreach clinic visits, at least monthly. Additional supervision takes place monthly at the **VHV's** village. Discussions with **HSAs** and VHVs about the content of their supervision visits consistently included the following: first, the two sit together to discuss any problems that the VHV has encountered, and work together to solve those problems; second, they review together the **VHV's** records; third, they sometimes make home visits together (this seems to be not the usual practice). The VHVs interviewed were very positive about the assistance provided during their supervision visits, commenting that they usually get some "refresher training" from the visit.

Substantial supervision of village-level income generating activities is also provided by locally-based staff of two government units, the Community Development Assistant of the Ministry of Community Development, and the Veterinary Assistant of the Ministry of Agriculture. Their training, support and supervision of the four existing village IGA groups was reported to be consistent and of high quality.

Formal training in supervisory methods was not included in the 36 training sessions that were held for field staff since the beginning of the project. Senior staff also report that they were not trained by this project in supervisory skills. Supervisory checklists are available for TBA supervision (a MOH form) and for the CBD workers, although any completed forms indicating how they were used were not observed. Routine supervision records or performance evaluations for project staff and volunteers are not currently maintained. A commonly-mentioned constraint to adequate supervision even for KCSP project staff is scarcity of transport. There were two project vehicles; when one was not available due to breakdown, as was frequently the case, then only one was available for all project purposes. At the end

of the evaluation team's field visits, the older of the two project vehicles did, in fact, break down irreparably, and so will have to be replaced.

The TSC reported that she would like to spend more time on monitoring visits, but often does not have transportation available. Project nurses make use of motorcycles for their clinic activity, and **HSAs** are provided bicycles. **HSAs** mentioned the difficulty of getting to the sometimes widely scattered villages that they **cover** (ranging from 12-18) on bicycle, particularly during rainy season.

One area of apparent breakdown in the supervision plan is the supervision of **TBAs**. Some of the 15 **TBAs** who were trained by the project misunderstood the reason for the training, and expected that they would be salaried after training. Some, as it happened, were not actually "traditional" birth attendants but women who wanted to take advantage of this opportunity for training. It was planned that the project nurses should supervise the work of the 15 trained **TBAs**, but because of the misunderstandings and their own workloads this has not happened. The project manager agreed that it would be possible for the two project nurses to make a supervisory visit to the **TBAs** in the area of their outreach clinics, for purposes both of assessing their maternal care activities and to resupply their birthing kits, if needed. After this approach is implemented and the **TBAs'** involvement in service provision can be determined, the decision as to whether or not to train additional **TBAs** can be addressed, and how to best incorporate their services in the final phase of the project.

In discussing their own supervision, field staff commented positively about the project manager's participatory approach, his responsiveness to their requests for more information, and the extent to which he involved them determining the progress and direction of the project.

4.8 Regional and headquarters support

For the first two years of the project, the WV/M Health Manager was stationed in Blantyre, at the country headquarters. Communication between the WVRD central office in the U.S. and KCSP field staff, therefore, came indirectly via Blantyre. Visits to KCSP from WVRD have occurred approximately twice yearly. During the most recent visit this year, technical assistance from the WVRD international health programs director focused on preparation for the midterm evaluation; discussion and response to comments of reviewers on the detailed implementation plan and the annual report; and arranging for staff participation in the Johns Hopkins training of survey trainers.

Staff expressed satisfaction and appreciation for the level and quality of technical support and administrative monitoring that they have had from WV headquarters. The project manager, in particular, stated that Dr. Casaua's April visit brought a clarity and understanding of the child survival approach and reporting system that made his job much easier. In the future, a new position for WVRD Associate Program Manager based in South Africa will be functional, making feasible even more frequent technical assistance visits should they prove necessary.

4.9 Use of technical support

The project has made extensive use of technical support during the implementation of this phase of the project, mostly as participation in focused training programs (see Appendix 6). In addition to refresher **courses** in basic child survival activities, training was received in grant accounting, community-based distribution of contraceptives, HIV/AIDS prevention activities with adolescents, introduction of soya production and use, women's income generating activity skills, poultry production, and a US-based training of KPC survey trainers (for the HIS coordinator). A strength of these efforts has been their consistent use of training resources and curricula from the Government of Malawi whenever possible, in an effort to promote continuity and consistency with government services.

Over the next six months, the main training and technical assistance needs will probably include the expansion of CBD activities to cover the entire impact area, and further expansion of income generating groups for women that also address food security concerns. Focused efforts on better use of the nutritional data that is collected to detect trends in community-level nutritional status, and the refinement of weaning feeding messages may also require additional TA. The main constraint to obtaining such support is the identification of suitable consultants or trainers who are familiar with Malawi and who will agree to NGO fee levels.

The project manager has expressed the desire for cross-visits to other child survival projects, or with CS staff, from neighboring countries to learn about other CS projects. In addition to possible cross-visits, an Africa regional child survival workshop is to be held by **USAID** in Malawi during the final project year, which should broaden the PM's exposure to and understanding of issues in the implementation of child survival projects.

4.10 Counterpart relationships

A major strength of the project to date is its strong collaboration and integration with the MOH and other government units. The principal counterpart for all activities is the MOH, which includes District Health Office (DHO) staff and staff of Kabudula Rural Hospital (KRH). MOH counterpart staff for the TSC is a community health nurse at KRH, who is very capable and interested in outreach work, but because of three vacant posts for nurses at KRH is “swamped with curative services.” The TBA trainer and the district FP coordinator, both from the DHO, meet with the TSC every two months to review activities. The government position meant to serve as supervisor for the **HSAs** in government service is the Environmental Health Assistant, based at KRH. That individual is, however, also charged with community surveillance of large areas not otherwise covered with health services, and so is not able to take on additional supervisory responsibilities. He is meant to be supervised by a Health Inspector, a position which is currently posted at KRH but not filled.

Other groups having a counterpart relationship for some functions include UNICEF (for HIV/AIDS activities); the National Family Welfare Council of Malawi (NFWCM), for CBD activities; the Community Development Assistant, of the Ministry of Community Development, for income generating activities; the Field Assistant, Ministry of Agriculture, for soya and other agriculture-related activities. Counterpart activities largely consist of training of staff for specific activities (see 4.4, Human resources), and the provision of supplies (see 4.5, Supplies and materials). Nkhoma Mission Hospital is also a counterpart group, both because of its status as a referral point and because the Mission has agreed to take on as an outreach clinic a newly constructed (by non-CS World Vision funds) health center at Chiwe, in the KCSP outreach area.

The main activities that take place between the project and its counterpart groups are the exchange of training, supervision and supplies. Fuel and transport is provided, for example, by the project in exchange for the assistance of the CDA and VA in training and supervision **IGAs**. Emergency transport is sometimes provided by the KCSP vehicle for patients needing transfer to or from KRH. Earlier in the project life, World Vision donated to KRH a vehicle for emergency transport purposes; however, the vehicle was not allowed to remain at that post and is reported to have since broken down. The DHO, however, has stated that because of decentralization his office may be more in control of equipment such as vehicles in the future, and indicated the possibility that the vehicle could be reclaimed for KRH.

Currently the communication between project staff and their counterparts is, by all accounts, excellent. During several meetings, appreciation was expressed for the way in which KCSP staff keep their collaborators apprised of their activities and for

their generally open and helpful communication. In many cases counterpart groups, such as the DHO, seem to rely on KCSP staff to stay in touch with “what is happening” at the field level. The DHO commented specifically that he ‘wished all **NGOs** communicated as well,” and that World Vision was “a very good example of NGO collaboration” with his office. The PM noted, however, that the collaboration has been an ongoing, learning process; for example, the initial IGA groups were attempted without the assistance of the local agriculture field assistant, and were not successful. Evaluation team members who had participated in previous evaluations of KCSP noted that the degree of increased collaboration observed on this visit was substantially more than in the past.

The question of the capacity of the government health system to take on the functions of the KCSP is a difficult one. It is generally believed that KRH staff would be able to assume the key functions of the KCSP if staffing patterns and, most particularly, access to transport were improved. However, adequate resources and personnel, in particular the reliable transportation necessary to maintain supervisory relationships and staff who are mandated to carry out training and supervision, are currently not in place. These are two key requirements of sustainability that will be discussed in Section 5.

4.11 Referral relationships

Main referral sites for the project are KRH, for medical and obstetric problems that cannot be cared for at the outreach sites, including malnutrition rehabilitation, and Nkhoma Mission Hospital, for surgical methods of family planning. Access to KRH is generally good, as it is located very near the project office within the impact area. Clients wishing to undergo surgical family planning methods (sterilization or Norplant) are driven to Nkhoma Mission Hospital, which is over two hours drive from the project, by project staff in one of the project vehicles.

KRH, while it is accessible, suffers from chronic understating and lack of even basic supplies. At the time of the evaluation, three nursing posts for hospital staff were vacant. The quality of services correspondingly suffers, and transport for either routine or emergency needs is nonexistent. A nutrition rehabilitation unit, making use of MOH standards and food supplements from the World Food Program, functions satisfactorily at KRH. Quality of the care provided at Nkhoma Hospital is generally satisfactory, although access must be facilitated by the project.

Dialogue and communication between the project and each referral site was described in very positive terms by staff of each of the units. Nkhoma Hospital staff remarked also on the thoroughness with which the surgical patients referred to them

were prepared for their procedures. Staff of KRH expressed appreciation for the assistance given by project staff, such as by providing emergency transport for critically ill or injured patients. An example of this collaboration was provided during one of the site visits, when a child living nearby sustained a serious laceration to his face, requiring multiple sutures. The PM (who is well trained as a medical assistant) accompanied the child to KRH. Since the resident clinical officer was not available, he carried out the suturing himself.

4.12 Networking with NGOs

There are no other NGOs working in the Kabudula area; duplication of services is not a problem. Collaboration with NGOs, therefore, has been primarily in the form of shared training and technical assistance. The NFWCM and Nkhoma Mission Hospital are both NGOs having key roles in the project's family planning intervention. Project HOPE, a PVO with headquarters in Blantyre, played a very helpful role in orienting the new HIS coordinator to the HOPE HIS, and a former HOPE employee provided his initial HIS training.

There have been in the past coordinating meetings of NGOs in Malawi's central region that were called by the Regional Health Office, which World Vision staff attended. Only two or three have been held in the past year, however, and the RNO was unable to predict if or when further meetings would be held. KCSP staff were also represented at various coordination meetings for NGOs involved in specific activities held by UNICEF and WFP.

4.13 Budget management

The pipeline budget as of August 31, 1995 is seen in Appendix 8.

The analysis shows that of the \$591,653 for direct costs in the budget, expenditures to date total \$290, 852. This amounts to approximately half the total budgeted, although nearly two-thirds of the three-year project period has elapsed. One item is overspent to date by \$14,220, that for field in-country travel.

The **cost** overrun for field travel appears to be due to three factors. First, the **cost** of repairs to motor vehicles has increased dramatically in Malawi since the project was written, "about **500%**," according to the financial **officer**. Secondly, the price of fuel has increased approximately three times. Finally, the vehicle that was purchased for **the project, although costing far less than what was budgeted, has needed regular and frequent repairs.**

Field and accounting staff explain that the relatively low level of expenditures to date are primarily due to the vacancy in the project manager position during approximately 7 months of 1994, following the sudden death of the original project manager in April 1994. The ensuing time was the season during which most of the intensive project activities would have taken place. Although routine project activities continued, with other staff assuming parts of the project manager's duties, new initiatives could not be started. A second reason for the underspending may be that the new project manager has found other sources of funds to cover field activities to supplement the Child Survival budget. UNICEF is supporting the efforts to involve students in HIV awareness and prevention activities, and the National Family Welfare Council of Malawi has provided technical and training assistance for the establishment of community-based distributors of contraceptives. Additional funds to continue AIDS prevention activities and to expand the CBD services to other areas of the project will be applied for during the coming year.

As a result, although progress towards meeting project objectives is strong, it is unlikely that the remaining funds will be spent, at the present rate, by the end of the project year in 1996.

5. Sustainability

The main goal to promote sustainability of the project following the completion of project funding is to assure that District MOH staff take on the key community-based activities of the project. A secondary goal is to increase food security at the village level.

As mentioned above, the project has become more aggressive in searching for additional funds to supplement KCSP efforts in the area. Proposals have recently been submitted to UNICEF and to the STAPH project of **USAID** for HIV/AIDS education with adolescent groups and expansion of the pilot CBD efforts, respectively. As its expertise in health systems management becomes more recognized, the lessons learned and systems established during the project can be of use in assisting the development of District level MOH activities. For example, the DHO has requested the assistance of the KCSP HIS coordinator to refine and computerize the District's health information system.

The objectives, steps taken, and steps needed to meet the sustainability goals are seen in Table 2. The measures of the steps needed are underlined in the third column of the table, e.g., if a formal agreement is needed, the presence of the agreement is the measure or indicator to be assessed.

Table 2
Sustainability Objectives

End of project objective	Steps taken	Steps needed
1. The current complement of 14 project HSAs will be functioning and fully integrated into the MOH system	1. 14 HSAs have been trained according to MOH standards; DHO has agreed that the MOH will hire these HSAs at the end of the project	1. Formalize an <u>agreement</u> with DHO including the date at which HSAs will become formal employees of MOH
2. The 14 project Health Promoters will be trained as HSAs and will also be integrated into the MOH system	2. DHO has agreed that the MOH will also hire 14 additional HSAs if they are properly trained by the end of the project	2a. Arrange as soon as possible that the current Health Promoters are trained by MOH to be qualified HSAs 2b. Formalize with DHO the transfer to MOH, as above
3. An experienced HSA supervisor who will assure the continued quality of the basic functions of the HSAs will be based at Kabudula Rural Hospital, and will work with the Environmental Health Assistant (EHA), within the MOH system	3a. A senior HSA is currently filling some supervisory functions for HSAs 3b. An EHA is currently posted at KRH with responsibility (but without training or resources) for supervision of HSAs . A position for a Health Inspector, to supervise the EHA, is also posted but not filled.	3a. Identify and train a <u>senior HSA supervisor</u> immediately to work with the KRH EHA 3b. Within the next six months, <u>base the senior HSA supervisor at Kabudula Rural Hospital</u> 3c. Formalize an <u>agreement with DHO</u> to hire the Senior HSA within the MOH system, by October 1, 1995, at the latest 3c. Assure that a good quality <u>motorcycle</u> is left for use by the Senior HSA in his supervision 3d. Solicit the <u>commitment of DHO</u> to provide for fuel and maintenance of the motorcycle

<p>4. Nkhoma Mission Hospital will assume responsibility for Chiwe Health Center</p>	<p>4a. Nkhoma Hospital has agreed to assume responsibility for staffing and management of Chiwe Health Center, and to hire one of the project nurses for that Center</p>	<p>4a. Hold joint meetings with Nkhoma Hospital staff and produce a <u>timetable for phaseover of functions and staff</u> during the final year of the project. October 1, 1996, or before should be the target date for transfer of all staff to their new agencies.</p>
<p>5. DHO staff will be trained in the elements of KCSP's health information system</p>	<p>5. DHO has requested the assistance of the project's HIS officer to assist in developing a system for management and use of MOH data</p>	<p>5a. Project HIS coordinator and DHO should jointly determine the <u>data management and training needs</u> of the DHO 5b. KCSP should release HIS officer from some of his duties for a limited period; he should provide <u>training of DHO staff</u> in establishing and using a computerized district HIS</p>
<p>6. Four additional self-sustaining income generating activity (IGA) groups will be established</p>	<p>6. Four active and well-informed groups have been established to date; community interest is high</p>	<p>6a. The project and local MOA staff should <u>identifv 4 more villages</u> committed to establishing IGAs, and provide training and management assistance to establish the groups.</p>

III. Summary of Main Findings, Conclusions and Recommendations

A. Specific interventions

Section 4.6 outlines the team's findings regarding the generally high quality of specific child survival interventions being implemented. The following recommendations are made to further upgrade the services offered:

Immunizations

Nurses who supervise the vaccinators during the outreach and nutrition clinics should provide periodic monitoring of their technique, and assessment of the adequacy of the **cold** chain. The thermometer and/or refrigerator in the project office vaccine refrigerator should be checked for accuracy, and if necessary the refrigerator temperature adjusted, to assure that temperatures in excess of 8 degrees Centigrade are not maintained.

Control of Diarrhea¹ Disease

VHVs and **HSAs** should have refresher training in specific alternatives to the use of ORS sachets for maintaining hydration or treating dehydration in children with diarrhea (such as home available fluids and cereal-based solutions). These messages should be clear, specific, and should be used even when ORS packets are available.

Staff should review and strengthen the project messages directed towards the dietary management of diarrhea (continued frequent small feedings, extra feeding during recovery).

Nutritional Improvement

VHVs and **HSAs** need to provide more specific instructions regarding appropriate weaning foods to suggest to mothers. Recipes that include the addition of soya flour, groundnut flour and vegetables to weaning porridge should be developed and taught.

During the coming quarter the project should investigate how best to make use of the new reporting of children's weights that are expected to be announced by the MOH. In addition to the numbers of children who exhibit "normal" weight for age, it would be useful to know the numbers and proportions of children weighed who were moderately and severely malnourished, as well as the numbers and proportions of children who did not gain weight from the previous weighing. Revisions in the MOH growth cards and reporting forms should provide an ideal opportunity to develop a system that makes better use of the data on child growth that are so carefully collected at the village level. Given the likelihood of continued food insecurity at the village level, early trends in changes in nutritional status could provide useful information to guide government services.

Maternal Care

Nurses state that they need more instruments for the initial "first visit" FP exams. The project manager should explore ways to obtain the needed instruments, either through the National Family Welfare Council, Nkhoma Mission Hospital or other sources.

Project nurses should begin to provide supervision visits to the **TBA**s on the same day as they attend outreach clinics. Following two or three months of supervision visits, the project should decide whether or not to train additional **TBA**s, and how best to include those already trained in the project.

Control of Malaria

The team concurs with the decision to discontinue the bednets component and initiate a revolving drug fund for treatment of malaria attacks.

HIV/AIDS

The school-based anti-AIDS clubs should continue with full support from the project. During the coming year additional support should be sought to provide occasional educational films and other materials for the clubs and the communities in which the students live. If possible, the project should also obtain added resources for the purpose of evaluating the results of the clubs on the attitudes and sexual behavior of the students.

B. Management and sustainability

Sustainability

Most of the team's recommendations focus on ways to assure that project efforts are sustained following the end of WV project funding. The strategy for sustainability is outlined in Table 2, above. In summary, the team recommends that World Vision:

1. Support the training of the projects 14 Health Promoters to be Health Surveillance Assistants, and formalize an agreement with the District Health Office that outlines the date at which the transfer of all 28 **HSAs** to government service will take place. **The** recommended date is no later than October 1, 1996.
2. Train one of the Senior **HSAs** to supervise the remaining **HSAs**, in collaboration with the Environmental Health Assistant based at Kabudula Rural Hospital. Leave that Senior HSA Supervisor with a functioning motorcycle to facilitate his supervision of **HSAs**.
3. Establish the Chiwe Health Center as an outreach supervision post for **HSAs** and **VHVs** in that area, with one of the project nurses posted there. Formalize an understanding with Nkhoma Mission Hospital that they will assume the staffing and management of the Center as an outreach post of Nkhoma Mission Hospital at the end of World Vision project funding.

4. Provide the services of the project's HIS coordinator to assist DHO staff to further develop and computerize the District's health information system.
5. Establish four additional self-sustaining income generating groups (IGAs) in the project over the coming year, to have the joint benefit of improving household nutritional status as well as providing increased income to project families.

No-cost extension

As it appears that some additional months past September 1996 will be required to achieve project objectives and to assure full sustainability of project benefits, the team recommends that the project apply for a no-cost extension of not more than one year.

Human resources

The team has a number of recommendations regarding World Vision's management of human resources for the remaining period of the project:

1. Given that the attrition of staff due to health and other reasons is an ongoing reality in Malawi, WV personnel management should be alert to the need to act quickly to find replacements for vacant positions in as timely a manner as possible. Not more than one or two months should elapse between a vacancy and the filling of a post in the project, and the hiring of interim/temporary personnel should also be considered. Unneeded delays seriously jeopardizes the many gains made by diligent efforts of remaining staff.
2. Project management should take steps to formalize several elements of the training and supervision that takes place. Specifically, they should document the content of the training that is provided; the results of training (by means of pre- and post-tests, as a minimum); the supervision that takes place of VHV's, TBAs, and HSAs; and assure that performance evaluations of all staff are conducted. These steps will promote the continuation of the high quality of training and supervision taking place, when these functions are assumed by the MOH staff.
3. Before the end of the funding period, key project staff should discuss with the DHO and other collaborators the issue of appropriate incentives for volunteers, both CBD agents and VHV's. Low-cost, sustainable material incentives that will assist the volunteers in their work, perhaps given at regular intervals such as quarterly or annually, should be determined and provided to current volunteers.

4. The project's HIS Coordinator should be offered further computer training to assist him to broaden his computer skills; similar opportunities to improve relevant skills should be offered to other key project staff (such as a cross-visit to other child survival projects).
5. A resource center in which health education, training and other relevant materials are readily available to **HSAs** and other project staff should be established at the project office in Kabudula. Selected key materials should be left with the senior HSA supervisor at KRH when the MOH assumes responsibility for supporting the work of the **HSAs**.

Transport

Because of current needs and to enhance sustainability, several important transport issues need immediate action:

1. The project manager and regional operations director should solicit the efforts of the District Health Officer to have repaired and return to Kabudula Rural Hospital the vehicle that was previously donated by World Vision to be stationed there.
2. A second project vehicle must be purchased to replace the old four-wheel drive vehicle that was irreparably damaged at the end of the evaluation visit.
3. The project should also purchase two motorcycles to be used by the senior **HSAs** in their supervision activities.

APPENDICES

APPENDIX 1

WORLD VISION INTERNATIONAL
KABUDULA CHILD SURVIVAL PROJECT
ITINERARY FOR THE EVALUATION TEAM
17 SEPTEMBER TO 28 SEPTEMBER 1995

DATE	PLACE	ACTIVITY
September 17 (Sunday)	Lilongwe	Arrival of Dr. Mercer
18 (Monday)	Lilongwe	Arrival of Dr. Casaua + travel to Blantyre
19 (Tuesday)	Blantyre	Review of financial management and pipeline analysis; arrival of Ms. Henderson
20 (Wednesday)	Lilongwe	Arrival of remaining team members, Dr. Mtimuni and Mr. Chipwaila; evaluation planning meeting
21 (Thursday)	Lilongwe	Meetings: 9 AM: District Health Office 11 AM: USAID 2 PM: Regional Health Office 3 PM: NFWCM and
	KCSP	2-6 PM: field interviews (half team): Chief Kabudula Technical Services Coordinator Bookkeeper
22 (Friday)	KCSP	Dr. Casazza leaves; field visit AM: Nutrition clinic; individual interviews and group discussions with VHVs, HSAs , HPs, mothers and the clinic nurse PM: team meeting; interviews with CDA and Agriculture Field Assistant
23 (Saturday)	Lilongwe	9 - 12 AM: Evaluation team meets
24 (Sunday)	Lilongwe	Individual work

Page 2
 KCSP Midterm Evaluation
 Itinerary

25 (Monday)	Lilongwe	Meetings: 9 AM: UNICEF 11 AM: World Food Program (half team) and 9 AM: Nkhoma Hospital FP referral site
	KCSP	1 - 5 PM: (full team) village visit; discussions with CBD workers, TBAs , village headman
26 (Tuesday)	KCSP	Field visit: 8:30 AM: Kabudula Rural Hospital 9:30 AM: village visit; observation of growth monitoring, other VHV and HSA activities 1:00 PM: discussion on HIV/AIDS with students 3:00 PM: interviews with Veterinary Assistants and income generating activity groups
27 (Wednesday)	KCSP	8:30 AM: Team discussion of findings determination of conclusions and recommendations 4:00 PM: debriefing with USAID
28 (Thursday)	Blantyre	8:30 AM: travel to Blantyre 2:00 PM: review findings with World Vision staff 4:30 PM: external evaluators return to Lilongwe
29 (Friday)	Lilongwe	External team members depart Lilongwe

APPENDIX 2 - DATA SOURCES FOR MIDTERM EVALUATION REPORT (by section)

1. Accomplishments

KPC report

Other project documents, e.g., training reports

Interviews and observations of project staff and activities

2. Effectiveness

KPC report

Observations of implementation of interventions

Interviews: project manager (PM), technical services coordinator (TSC) and district health office (DHO) staff

3. Relevance to development; role of community

Interviews: PM, other staff

Group discussions: community groups, **VHCs, HSAs**

4. Design and implementation

4.1 Design

Interviews: PM, regional office director (central region), traditional area chief

4.2 Management and use of data

Interviews: ROD(C); PM; HIS coordinator; WVRD HQ staff; field staff; community groups

Discussions/meetings: NFWCM; DHO; **USAID**; UNICEF

4.3 Community education and social promotion

Interviews: NFWCM; MOH HIV/AIDS coordinator; field staff

Discussions: community groups; **VHVs; TBAs**

Observations of field activities

4.4 Human resources

Project staffing organogram

Interviews: PM; TSC; **CHCs; TBAs; HSAs**

4.5 Supplies/materials

Interviews: TSC; **HSAs**; nurses; bookkeeper/storekeeper; HIS coordinator; KRH staff

Observations of field office

4.6 Quality of services

Interviews: PM; ROD(C); TSC; **HSAs**

Discussions with community groups

Observations of: VHV registers, project records, service delivery (nutrition clinic, immunizations; health education; growth monitoring; "ORT **corner**"

4.7 Supervision and monitoring

Interviews: HIS coordinator; TSC; relationships shown in organogram

4.8 Regional/headquarters support

Interviews: ROD(C); PM; HQ staff

4.9 Technical assistance

Interviews: ROD(C); PM; HQ staff

4.10 Counterpart relationships:

Interviews: PM; ROD(C); MOA field assistant; CDA;

Discussions: NFWCM; Nkhoma Mission Hospital; MOH (DHO and KRH staff); UNICEF; WFP

4.11 Referral relationships

Interviews: nurses; KRH staff; Nkhoma Mission Hospital staff; **HSAs**; mothers

4.12 PVO/NGO networking

Interviews: PM; ROD(C); RHO

4.13 Budget management

Interviews: Financial officer; KCSP bookkeeper

Analysis: pipeline budget report

5. Sustainability

All interviews and discussions included the topic of sustainability

APPENDIX 3: KEY INFORMANTS AND GROUP DISCUSSANTS FOR EVALUATION

World Vision/Malawi:

Mr. Mackson Chasowa
Mr. Andrew **Pepeta**
Ms. Rose Namarika
Ms. Rabbinah Ng'ambi
Mr. Humphrey **Kalepa**

KCSP field site:

Kabudula Rural Hospital staff: PHN, MA, and Clinical Officer Mr. Mhango
Chief Kabudula
Mr. L.F. Meke, Agriculture Field Assistant (Ministry of Agriculture)
Ms. Doreen Thundu and Ms. Cecilia Chiungiza, project nurses
CDA - Mr. Masala
Veterinary Assistant - Mr. Austin Kubwalo
Headman of Kantsokwe Village
Headmaster of Kambira FP School - Mr. R. Kosimasi
Girls and boys groups and schoolteachers of Kambira FP School
VHC members, mothers groups, men's groups, **VHVs, HSAs, and CBDAs** in Kokolo, Sani, Kantsokwe, and/or Chikunkhulila villages
IGA group and TBA in Chikunkhulila village

Ministry of Health:

Dr. Brobell, DHO
Mr. Mandebvu, DHI
Mrs. T. Rashid, DNO (matron) and Mrs. Kambalame, Deputy DNO (matron)
Mrs. Chilipaine, Regional Nursing Officer

USAID:

Mr. Chris McDermott
Mr. Kenneth Sklaw

Other groups:

UNICEF - Mr. Richard Olson
NFWCM - Mr. Damaso
Nkhoma Mission Hospital - Mr. Usiwa
World Food Program - Mr. Richard Dalyrmples
World Bank - Dr. John Quinley

APPENDIX 4:

SUMMARY OF FINDINGS PER OBJECTIVE

World Vision Kabudula Child Survival Project
 Midterm evaluation knowledge, practices and coverage survey
 August 1995

Inter-vention	Objective	Base-line	Mid-term Target	Mid-term	Final Target
CDD	Increase % of mothers who continue breastfeeding during diarrhoea episodes	67%	N/A	79%	85%
	Increase % of mothers who know to refer for treatment for bloody diarrhoea	3.1%	N/A	3.3%	50%
	Reduce the number of mothers who do <u>not</u> know what to do during recovery of child with diarrhoea	28%	N/A	2%	10%
	Increase % of households whose main source is from Protected wells.	15%	N/A	17%	50%
	Increase % of households with Pit latrines	70%	N/A	71%	85%
Immuni-zation	Increase the % of Measles Vaccine coverage in children 9 months and over.	70%	N/A	09.5% (12-23 month-olds)	05%
	To maintain TT Coverage with two or more vaccines for Pregnant women at 80%.	74%	N/A	71	80%

Intervention	Objective	Baseline	MT target	MT attained	Final target
	Increase the number of completely immunized children 12-23 months	70%	N/A	85% (DPT3 proxy)	85%
HIV/AIDS	Increase the % of mothers who discuss matters related to HIV/AIDS with their husbands/partner.	39%	N/A	51%	65%
	Increase the number of school children ages 14-18 who participate in "anti-AIDS" club activities	N/A	N/A	N/A	N/A
Maternal Care	Increase the % of mothers not wanting Pregnancy in the next two years who will be using a modern method of Family Planning.	3%	N/A	36%	30%
	Maintain that 60% of Pregnant women will have two or more attendance of prenatal care by a Health Professional including trained TBAs	60%	60%	96%	60%
Malaria	By the end of the project, the % of mothers who do not know how to prevent Malaria in their children will be reduced.	58%	N/A	51%	20%
Nutrition	Increase the number of children 0-3 months exclusively breastfeeding.	5%	N/A	28%	20%
	Increase the % of mothers who [KNOW TO] Introduce supplementary foods at 4-6 months.	30%	N/A	53%	75%
	Increase % of mothers who know at least 2 food sources of Vitamin A.	32% (at least one)	N/A	60% (knew at least two)	75%

KABUDULA CHILD SURVIVAL PROJECT
ACTIVITY ACHIEVEMENT FOR THE YEAR
1993/1994 AND 1994/95

ACTIVITY ACHIEVEMENT	YEAR 1.	YEAR 2
IMMUNIZATIONS GIVEN		
Measles (O-23m)	1070	2007
DPT 1 (O-23m)	279	1397
DPT 3 (O-23m)	1188	1303
Polio 1 (O-23m)	282	1753
Polio 3 (o-23m)	1204	2005
BCG (O-23m)	404	1260
TT2 - Pregnant Women	38	186
TT3 - Pregnant Women	29	176
TT4 - Pregnant Women	40	105
TT5 - Pregnant Women	43	115
TT2 - Nonpregnant Women	175	528
TT3 - Nonpregnant Women	227	659
TT4 - Nonpregnant Women	127	427
TT5 - Nonpregnant Women	257	368
ANTENATAL		
All Pregnant Women	80	180
Pregnant Women at any ANC	811	495
Births	69	333
CHILD SPACING		
Pill - new clients	175	88
Condom - new clients	99	0
Injection - new clients	185	480
GROWTH MONITORING		
Children Weighed	10265	35566
Children w/Normal. Wt.	7528	24934

Children received Vit.A	1496	9260
Postnatal Mothers - Vit.A	292	165
EDUCATION		
Maternal Nutrition	2019	5178
Exclusive Breastfeeding	3266	7926
Nutrition (food groups)	1814	9717
Child Spacing - Men	303	1372
Child Spacing - Women	2006	7226
Malaria	2753	6949
Diarrhoea	3645	8104
HIV/AIDS	1161	9665
Sanitation	2441	10348
Immunization	1233	6613
DISEASE CASES		
Malnutrition	410	3611
Malaria	2999	3457
Diarrhoea	490	1305
Measles	22	7
DEATHS		
Under 5	17	90
5 & Over	25	64
NEW CONSTRUCTIONS		
Kitchens - new	272	209
Pit Latrines - new	907	619
Bathrooms - new	531	403
Dish Rack - new	692	516

Rubbish Pits - new	252	192
No. of Women who received Vit.A	2	149
No. of Women who attended ANC	75	508
Births	68	558
Maternal Deaths	0	0
Infant Deaths	2	14
Maternal Referrals	0	6

KABUDULA CHILD SURVIVAL PROJECT TRAINING FOR FY94/95

TOPIC/ACTIVITY	CONTENT	TEACHING METHODOLOGY	DATE	TIME	# OF PARTICIPANTS	PLACE OF TRAINING
In country CBD Managers Course (INITIAL)	CBD Approach to FP Service Delivery. Project Development and Management steps. Different approaching to Family Services Delivery in Malawi. Requirements for CBD Programme Management, Articulate and Key issues. Principals of CBD Project Design and Management .	Lecture, Group Discussions, Plenary, Brainstorming and Video	14/11/93, 10/12/93	160 hours	25	Kalikuti Hotel

VHVs Training (Re - Training)	Environmental Sanitation. Roles of VHVs. Immunization. Growth Monitor. Diarrhoea and Nutrition.	Lecture! Discussions, Demonstraatio ns and Brain Storming.	16 Feb. 1994	8 hours	25	Chiwe/Kakolo
Grant Accounting Training (INITIAL)	Partner Aid Agencies, WVRD/WVUS and MV. Budget and Grant Accounting. OMB Circulars. AID Grant.	Lecture, Discussions and Brainstoming.	9-13 May '94	40 hours	10	Multicountry Training Centre Blantyre.
Refresher Course for HPs/HSAs	Nutrition, Growth Monitor, Family Planning Motivation, AIDS Education, Care and Councelling, Sanitation, Safe drinking water, Malaria Control, Diarrhoea Diseases Control, Immunization, Cold Chain Maintenance.	Lecture, Group Discussions, Demonstration Brain Storming, and Video Film.	20-24 June 1995	32 hours	28	Nsaru RTC

Child Survival Project Seminar! Mozambique and Malawi. (INITIAL)	Improved Immunization skills, Cold Chain, Nutrition Education. STDs including HIV/AIDS Prevention, Tuberculosis and its Relation to HIV/AIDS. Malticentral Collaborative Approach with MOH, World Vision Core Values, Income Generating activities.	Lecture, Group Discussions, Preaching/Pra y ers, Field Visits, Singing, Brainstorming and Video Film	27-30 June 1994	32 hours	28	Grace Bandawe Blantyre.
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HSAs Training	Basic Principals of PHC, Basic Principals of Sanitation, Food Hygiene activities, Fami ly Health activities, Skills on Provision of Safe Water. 1st AID Technology, Disease Surveillance and Referal/Reporting Technology, Village Inspetion, Formation of VHVs and Training. Principals of Vector and Vermin Control. Basic Information, Education and Communication Technique.	Lecture Discussion Demonstration Practicals Group Discussions Field Visits.	2-22 Octob. 1994	120 hours	2	Mitundu RH, MOH.
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TOPIC/ ACTIVITY	CONTENT	TEACH METHODOLOGY	DATE	TIME		PLACE
VHVs Training (RE TRAINING)	HIV/AIDS, Control of Diarrhoeal Diseases, Immunization, Growth Monitor, Nutrition, Family Planning Motivation.	Lecture Discussions	24-25 Nov. '94	16 hours	31	Kawanga Mwendetsa and Mude
CBD Agents, Training (INITIAL)	Catchment Demography, Record Keeping, Referral System, Client Counselling, Family Planning Methods, 3 weekly workplan, Use of Checklist, CBDA Job Discription, Report writing, Distribution of Contraceptives.	Lecture Discussions Practicals Role Plays Field visits.	24 Oct. 9 Nov. 1994	80 hours	20	Chiwe

Demography Survey Staff, Feed back (INITIAL)	Demography Survey Report, Health Manager feedback report after tour, Health Promoter workload, Nutrition Education	Lecture Discussions Brainstoming	18 Feb. 1995	4 hours	28	Nsaru RTC
HSA/HP Course (Re-Training))	Environmental Sanitation, Immunization, Cold Chain (EPI), Sterilization (EPI), Family Planning, Malaria, HIV/AIDS Prevention, GrowthMonitor, Nutrition, Control of Diaarrhoeal Diseases.	Lecture Group Discussions Demonstration, Role Play and Brain Storming.	27-29 Feb. '95	24 hours	28	Nsaaru RTC
CBD Agents Course (Re-Training)	Record Keeping, Referral System, Client Councelling, Administration of FP Drugs, 3 weeks working	Lecture Group Discussion Demonstration Brain Stoming.	6-10 March 1995	40 hours	20	Chiwe

VHCS Re- Training	Roles of VHCS, Sanitation, Control of Diarrhoeal Diseases, Malaria Control, HIV/AIDS and Prevention.	Lecture Discussions Demonstrations	21-32 March 1995	16 hours	50	Kalonga
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Orienta- tion Workshop for Schools Head Masters on Formation of Anti- AIDS Clubs (INITIAL)	Basic Information of HIV/AIDS, Background of District Project Team and Youth Technical Sub Committee. The current status of HIV/AIDS in Malawi, Role of Anti AIDS Clubs, Role of Headmasters of Anti AIDS Clubs.	Lecture Discussions Brainstorming	22 April, 1995	8 hours	20	Nsaaru RTC
VHCS Training (INITIAL)	Roles of VHCS Sanitation Diarrhoeal Control, HIV/AIDS and Malaria.	Lecture Discussions	24-25 April, 1995	16 hours	80	Mguwata

<p>Training Orientation for Patrons and Matrons on Formation of Anti AIDS Clubs in Primary and DE Schools</p>	<p>Background of District Project Management Team and Technical Sub Committee, Basic Information on HIV/AIDS and Misconceptions, HIV/AIDS Current Status in Malawi</p>					
<p>Orientalion of Patrons/Matrons</p>	<p>Role of Anti AIDS Clubs, Role of Patrons, Club activires, Types of Anti AIDS Clubs, Composition of Anti-AIDS Clubs and the Constitution.</p>	<p>Lecture Discussions Brainstorming Video Film</p>	<p>29-30 April, 1995</p>	<p>8 hours</p>	<p>40</p>	<p>Nsaru RTC</p>
<p>DIP Review Workshop by Objective (INITIAL)</p>	<p>Immunization, Control of . Diarrhoeal Diseases, Vit.A Supplementation and Food Nutrients, Exclusive Breast feeding.</p>	<p>Discussions Lecture Review by Objective, Demonstration, Singing</p>	<p>31 May, 2 June, 1995</p>	<p>32 hours</p>	<p>28</p>	<p>Nsaru RTC.</p>

Soya Preparation Training (INITIAL)	Introduction, Soya Beans and its Nutrients, Preparation of Soya Snacks, Preparation of Soya Coffee, Preparation of Soya Flour (Vegetable mix), Preparation of Soya Porridge for Infants, Soya Farm Production, Application of Soya Inoculant during Plantation.	Lecture Demonstrations Discussions.	5-9 June, 1995	40 hours	17	Kamchocho
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TOPIC/ACTIVITY	CONTENT	TEACHING METHODOLOGY	DATE	TIME	# OF PARTICIPANTS	PLACE OF TRAINING
TBA RETRAINING	Conduct Physical and Practical Antenatal Care, Management of 2nd stage of Labour, Use of Delivery and Referral Record forms, Sterilization of Delivery Equipment, Signs and Symptoms of Pre Eclampsia, Environmental, Personal and Equipment Hygiene, HIV/AIDS in relation to Patients' Management, Family Planning Motivation and Benefits, Malnutrition and Management, Malaria Control and Prophylactic care for Antenatal					

TBA Refresher Course CT.	Management of Diarrhoea and Prevention.	Lecture, Discussions, Role Plays, Practicals, Field Visits.	s-10 June, '95	40 hours	20	Mitundu Rural Hospital.
VHVs Malaria Drug Revolving Fund (INITIAL)	Awareness of Malaria, Its signs and Symptoms . Improvement of Environmental Sanitation. Causes and prevention of Malaria.	Lecture Discussion Field Visit Group Discussions.	26-30 June, '95	40 hours	10	Mguwata
Womens ' I.G.A. Training (INITIAL)	Group Formation, Characteristics of Groups, Why women enter into business, Feasibility study, Business identification, Sources of capital, Business Plan.	Lecture Demonstration Singing Role Play Discussions Brainstorming.	26-30 June, '95	40 hours	20	Nsaru RTC for Chiwe
VHCs Training (Re Training)	Good Sanitation, Family Planning, HIV/AIDS prevention, Nutrition, Control of Diarrhoeal	Lecture. Discussions Field Visits	11-12 July, '95	16 hours	47	Nkhonje Primary Schoo 1

VHCs Re-Training	Roles of VHCs, Family Planning Motivation, HIV/AIDS prevention, Sanitation.	Discussions Lecture Brainstorming	12-13 July, '95	16 hours	120	Mtanda Madzidzi
VHCs Re-training	Roles of VHCs, HIV/AIDS, Diarrhoea, Immunization! Nutrition	Lecture Discussions	12-13 June! '95	16 hours	70	Kankhande
Business Management Production of Hyl ines Chickens.	Working in groups, Characteristics of Group Members, Problem solving steps, Why women enter into business. Business identification., Feasibility study, Market reserch, Business Plan, Sources of Capital, Mark'et Mix (GPs), Reord keeping.					

IGA CT.	Cash control, Pfofit and Wage sharing, System of keeping poultry, Disease Control, Egg Collecion, Marketing, Reading of chickens and growers, Housing and Feedinn.	Lecture, Demonstration, Practicals and Field Trips.	17-21 July, '95	40 hours	20	Mtanda Centre, IGAs: Chikunkhu lira, Ma'lunje.
VHCs Retraining	Environmental Sanaitation, Disease Surve i l lance, Family Planning, Control of Diarrhoeal Diseases, HIV/AIDS, Growth Monitor, Nutrition.	Lecture, Discussions, Demonstration.	1st-2nd Aug. '95	16 hours	50	Chiwe
VHVs Retraining	Malaria Control, Diarrhoea, Sanitation, Nutrition, HiV/AIDS, Rol'es of VHVs.	Lecture Discussions	2nd-3rd August, 1995	16 hours	82	Msanama

IGA Training of Womens' Clubs (INITIAL)	Business identification. Why women enter into business. Group formation. Characteristics of groups. Feasibility study. Sources of Capital. Business Plan.	Lecture, Demonstration, Singing, Role Plays, Discussions, Brainstorming.	15-19 May, 1995	40 hours	19	Msanama Mguwata
VHCs Training (Re Training)	Malaria, Diarrhoea, HIV/AIDS and Sanitation	Lecture, Discussions	5 August 1995	8 hours	10	Kalonga
Kamphata Womens' club Soya Treatment.	Introduction, Soya Bean and its Nutrients. Preparation of Soya Snacks, Preparation of Soya Coffee, Soya Flour (Vegetable Soya Porridge mix). Soya Production. Application of Soya Inoculant during Planting.	Lecture, Demonstrations and Discussions	4-5 August 1995	16 hours	34	Chiwe

TOPIC/ ACTIVITY	CONTENTS	TEACHING METHODOLOGY	DATE	TIME	# OF PARTIC IPANTS	PLACE OF TRAINING
VHVs Soya Treatment	Introduction. Soya Bean and its food vlue. Preparation of Soya snacks. Soya Coffee, Soya Flour (Vegitable mix), Soya Porridge, Soya Production, Application of Soya innoculant during Planting.	Lectur, Demonstrations, Discussions, Pratt icals.	21-22 July 1995	16 hours	19	Madzidzi
Womens' Club Soya Treatment	Soya Bean and its food value, Soya snacks, Soya Coffee, Soya Flour (Vegitable mix), Soya porridge, Soya Production, Application of Soya innoculant during planting.	Lecture, Demonstrations, Discussions, Practicals.	11-12 Aug. 1995	16 hours	50	Chiwe

VHVs Soya Treatment	Soya Bean and its food value. Soya Snacks, Soya Coffee, Soya Flour (Vegetable mix). Soya Porridge, Soya Production, Application of Soya inoculant during plantat ion.	Lecture? Demonstrations, Discussions, Practicals.	2-3 Aug. 1995	16 hours		Mtanda
CBD Supervisors Orientation Visit	CBD Programme Management CBD Activities by CBD Agents. Record keeping, Councelling, Distribution of Contraceptives. CBD Client/Agent Relationship.	Field Visit, Practicals, Discuss ions, Demonstrations.	23-29 March 1995	32 hours	6	Ekwenden i Mission Hospital.

<p>Workshop for HSA/HP on Training of Trainers.</p>	<p>Provide Trainers with information that can help them acquire a more comprehensive picture of the various aspects of the total training programmes from planning, implementation and evaluation of the activities the learner need to perform in relation to training. Enhance the development of a feeling of satisfaction among trainers derived from the knowledge that they are better able to cope with the expectations of their job as trainers.</p>	<p>Lecture, Discussions, Practicals, Demonstration and Brainstorming.</p>	<p>2s Aug. 1995</p>	<p>8 hours</p>	<p>28</p>	<p>Nsaru RTC.</p>
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APPENDIX 7: MONTHLY REPORTING FORMS AND TALLY SHEETS

World Vision (Kabudula) Child Survival Project
HSA Monthly Reporting Form

HSA Name: _____

Month of this Report: _____ Year: _____

Centre/Outreach Clinic: _____

	Village Name											
IMMUNIZATIONS GIVEN												
Measles (0-23m)												
DPT 1 (0-23m)												
DPT 3 (0-23m)												
Polio 1 (0-23m)												
Polio 3 (0-23m)												
BCG (0-23m)												
TT2 - Pregnant Women												
TT3 - Pregnant Women												
TT4 - Pregnant Women												
TT5 - Pregnant Women												
TT2 - Nonpregnant Women												
TT3 - Nonpregnant Women												
TT4 - Nonpregnant Women												
TT5 - Nonpregnant Women												
ANTENATAL												
All Pregnant Women												
Preg. Wom. at any ANC												
Births												
CHILD SPACING												
Pill - new clients												
Condom - new clients												
Injection - new clients												
Other Child Sp. - new Specify _____												

	Village Name											
GROWTH MONITORING												
Children Weighed												
Children w/Normal Wt												
Children rec'd Vit A												
Postnat Mothers-Vit A												
EDUCATION												
Maternal Nutrition												
Exclus. Breastfeeding												
Nutrition (food groups)												
Child Spacing - Men												
Child Spacing - Women												
Malaria												
Diarrhoea												
HIV/AIDS												
Sanitation												
Immunization												
DISEASE CASES												
Malnutrition												
Malaria												
Diarrhoea												
AIDS												
Measles												
DEATHS												
Under 5												
5 & Over												
NEW CONSTRUCTIONS												
Kitchens - new												
Pit Latrines - new												
Bathrooms - new												
Dish Rack - new												
Rubbish Pits - new												

Kabudula Child Survival Project (World Vision)
TBA Monthly Report

TBA Name : _____
Month of Report : _____ Year : _____
Health Centre : _____

No. of Women who Received Vit. A: _____
No. of Women who Attended ANC: _____
Births: _____
Maternal Deaths: _____
Infant Deaths: _____
Referrals: _____

REASONS FOR REFERRALS

- (1) Prolonged Labor _____
- (2) 5 or More Children _____
- (3) Handicapped _____
- (4) Too Short _____
- (5) Anemia _____
- (6) Preclampsia _____
- (7) Previous C-Section _____
- (8) Twins _____
- (9) Transverse _____
- (10) Breech Birth _____
- (11) Antenatal Bleeding _____
- (12) Labor Bleeding _____
- (13) Postpartum Bleeding _____
- (14) First Pregnancy _____

Kabudula Child Survival Project (World Vision)
HSA Tally Sheet - IMMUNIZATIONS

Center/Outreach Clinic: _____

Month: _____ Year: _____

	Village Name			
IMMUNIZATIONS				
Measles	0000 0000 0000 0000 0000 0000			
DPT 1	0000 0000 0000 0000 0000 0000			
DPT 3	0000 0000 0000 0000 0000 0000			
Polio 1	0000 0000 0000 0000 0000 0000			
Polio 3	0000 0000 0000 0000 0000 0000			
BCG	0000 0000 0000 0000 0000 0000			
TT2 - Preg	0000 0000 0000 0000 0000 0000			
TT3 - Preg	0000 0000 0000 0000 0000 0000			
TT4 - Preg	0000 0000 0000 0000 0000 0000			
TT5 - Preg	0000 0000 0000 0000 0000 0000			
TT2 - NotPreg	0000 0000 0000 0000 0000 0000			
TT3 - NotPreg	0000 0000 0000 0000 0000 0000			
TT4 - NotPreg	0000 0000 0000 0000 0000 0000			
TT5 - NotPreg	0000 0000 0000 0000 0000 0000			

Kabudula Child Survival Project (World Vision)
HSA Tally Sheet - GROWTH MONITORING/DISEASES

Center/Outreach Clinic: _____

Month: _____ Year: _____

		Village Name			
GROWTH	GROWTH MONITORING				
Children Weighed	0000 0000 0000 0000 0000 0000 0000 0000 0000 0000				
Children Norm. Wt.	0000 0000 0000 0000 0000 0000 0000 0000				
Children Rec'd Vit. A	0000 0000 0000 0000 0000 0000 0000 0000				
Postnat. Rec'd Vit. A	0000 0000 0000 0000 0000 0000				
DISEASE	DISEASE CASES				
Malnutrition	0000 0000 0000 0000 0000 0000 0000 0000 0000 0000				
Malaria	0000 0000 0000 0000 0000 0000 0000 0000 0000 0000				
Diar-rhoea	0000 0000 0000 0000 0000 0000 0000 0000 0000 0000				
AIDS	0000 0000 0000 0000 0000 0000 0000 0000 0000 0000				
Measles	0000 0000 0000 0000 0000 0000 0000 0000 0000 0000				

Kabudula Child Survival Project (World Vision)
 HSA Tally Sheet - ANTENATAL/CHILD SPACING

Center/Outreach Clinic: _____

Month: _____

Year: _____

Village Name				
ANTENATAL				
All Pregn. Women	XXXX XXXX XXXX XXXX XXXX XXXX			
Pregn. Women at ANC	XXXX XXXX XXXX XXXX XXXX XXXX			
Births	XXXX XXXX XXXX XXXX XXXX XXXX			
CHILD SPACING				
Pill - new clients	XXXX XXXX XXXX XXXX XXXX XXXX			
Condom - new clients	XXXX XXXX XXXX XXXX XXXX XXXX			
Injection - new cl.	XXXX XXXX XXXX XXXX XXXX XXXX			
Other - new clients	XXXX XXXX XXXX XXXX XXXX XXXX			

Kabudula Child Survival Project (World Vision)
 HIV Tally Sheet for EDUCATION/TRAINING

Center/Outreach Clinic: _____

Village Name: _____ Year: _____

	Month			
EDUCATION	Please count all participants in Education/Training - Men and Women			
Maternal Nutrition				
Exclusive Breast-feeding				
Nutrition (Food Grps)				
Child Spacing - Women				
Child Spacing - Men				
Malaria				
Diarrhoea				
AIDS				
Sanitation				
Immunization				

Kabudula Child Survival Project (World Vision)
VHV Tally Sheet for SANITATION/CONSTRUCTIONS/(other)

Center/Outreach Clinic: _____

Village Name: _____ Year: _____

	Month			
INSPECTION				
New Kitchens	0000 0000 0000 0000 0000 0000 0000 0000			
New Pit Latrines	0000 0000 0000 0000 0000 0000 0000 0000			
New Bathrooms	0000 0000 0000 0000 0000 0000 0000 0000			
New Dish Racks	0000 0000 0000 0000 0000 0000 0000 0000			
New Rub-bish Pits	0000 0000 0000 0000 0000 0000 0000 0000			
OTHER				
Deaths	0000 0000 0000 0000	0000 0000 0000 0000	0000 0000 0000 0000	0000 0000 0000 0000
Births	0000 0000 0000 0000	0000 0000 0000 0000	0000 0000 0000 0000	0000 0000 0000 0000
Diarrhoea Cases	0000 0000 0000 0000 0000 0000 0000 0000			

EDUCATION				
	Please count all participants in Education/Training - Men and Women			
Diarrhoea				
AIDS				
Sanitation				
Immuniza- tion				
INSPECTION				
New Kitchens	0000 0000 0000 0000 0000 0000			
New Pit Latrines	0000 0000 0000 0000 0000 0000			
New Bathrooms	0000 0000 0000 0000 0000 0000			
New Dish Trays	0000 0000 0000 0000 0000 0000			
New Rub- bish Pits	0000 0000 0000 0000 0000 0000			
WHP				
Diarrhoea cases	0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000	0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000	0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000	0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000

Kabudula Child Survival Project (World Vision)
Tally Sheet for Education/Training and Village Inspections

Center/Outreach Clinic: _____

Village Name: _____ Year: _____

	Month			
EDUCATION	Please count all participants in Education/Training - Men and Women			
Maternal Nutrition				
Exclusive Breast- feeding				
Nutrition (Food Grps)				
spacing - Women				
Child Spacing - Men				
Malaria				