

# **MID-TERM EVALUATION**

for

## **CHILD SURVIVAL IX PROJECT**

**Malawi**

**FAO-0500-A-00-3029-00**



# **ADRA**

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**Mid-term Evaluation**

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# LIST OF ACRONYMS AND ABBREVIATIONS

ADD	Agriculture Development Department
ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
CBD	Community Based Distribution (of contraceptives)
CDD	Control of Diarrheal Diseases
c s	Child Survival
DHO	District Health Office
DIP	Detailed Implementation Plan
EBF	Exclusive Breastfeeding
EPI	Expanded Program for Immunization
FP	Family Planning (also called Child Spacing)
GM	Growth Monitoring
GOM	Government of Malawi
HA	Health Assistant
HC	Health Center
HI	Health Inspector
HIS	Health Information System
HP	Health Post
HSA	Health Surveillance Assistant
IEF	International Eye Foundation
<b>KAB/P/C</b>	Knowledge, Attitude, Belief, Practice, Coverage (survey)
MOH	Ministry of Health
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PVO	Private Voluntary Organization
RHO	Regional Health Office
STD	Sexually Transmissible Diseases
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
VHC	Village Health Committee
<b>VHV</b>	Village Health Volunteer
WCBA	Women of Child Bearing Age

## EXECUTIVE SUMMARY

The mid-term evaluation of the Nsanje Child Survival XI Project operated in Southern Malawi by Adventist Development and Relief Agency (ADRA) was conducted in mid-March 1995. Evaluation was conducted by a team including members with extensive health care experience in Malawi as well as in other international projects. Evaluation included field visits throughout the project area and focus groups and interviews with community leaders, volunteers and village health committees, project beneficiaries, project staff, Ministry of Health officials and representatives of other NGO that operate in or near the project area.

Evaluation found a mature project with programs being delivered in over 180 villages of the project service area. This is an extension/expansion of a CS VI project. It has extended into some of the more remote villages that had not previously been reached. It has expanded to include interventions directed toward child spacing (family planning) and HIV/AIDS prevention.

The project uses a community development primary care model that expects mothers to be the primary care givers and supports them with an extensive network of over 450 volunteers (VI-IV), 180 Village Health and Water Committees (VHC), twenty-two health surveillance assistants (HSA) and a training and supervisory staff. Interventions are aimed at motivating recipients to use services that are available and strengthening those services rather than operating a network of services itself

The project works closely with Ministry of Health and with private health care providers in the area. Nearly everyone interviewed reported positively on these relationships.

A major development is the plan to transition employment of HSA from the project to MOH within the next few months, more than a year before the scheduled end of the project. While they will be MOH employees, they and other MOH HSA in the area will continue to receive training supplied by the project and will continue to operate the health information system established by the project. This appears to enhance the likelihood of sustainability.

A major concern about sustainability is the political climate of the area in which volunteerism is not popular. Since interventions of this type of project depend upon volunteers, solutions to this public issue are critical. They must be solutions that do not require significant recurrent costs that could not be supported by the MOH.

The project is operating at a time of very significant effective devaluation of local currency v. the US dollar which requires continuous attention to the project budget. Although there is a food crop to be harvested this year, it is not as good as normal, so hunger and malnutrition could become an increasing problem again this year.

Recommendations are being made to enhance the effectiveness of the project.

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# EVALUATION

## Introduction and Background

This project is an extension/expansion of a Child Survival VI program located in the northern half of Nsanje District, the southernmost district of Malawi. It is located in the lower Shire River valley in an area that has been heavily impacted by refugees from political instability in Mozambique which borders the project area on both east and west. The project area has also been heavily impacted by alternating years of drought and flood over the last four years. The project area is rural with several small trading centers. It is served by one major road that is partially tarmacked, a rail line with twice weekly service, and a few other unsealed roads. Travel to many parts of the district is only by motorcycle, bicycle or by foot. The project area includes the land on both sides of the Shire River and extends from Tengani to the northern boundary of the district, near Sorgin. The area includes approximately half of the district population of over 200,000.

Nsanje District is remote from the population and development centers of the country. It is generally less developed and its people have less education than the national average. Nsanje District has the highest infant mortality rate in Malawi, 191 deaths per thousand (Situational Analysis.) Most of the population of the project area are engaged in subsistence farming, growing maize, sorghum, millet and sweet potatoes. According to **WHO/MOH** estimates, over half of the existing housing provides poor protection against bad weather. The area is a low altitude river plain with surrounding foothills where daytime temperatures can reach the mid-forties (C).

Malawi is one of the least developed countries in the world. In 1991 the estimated GNP per capita was **US\$230**. Inflation rose to 22.7% in 1992 while the GDP fell 7.9%. Real income of the majority of the population has deteriorated in recent years. The rate of exchange against the US dollar has fallen from approximately 4.3 Kwacha per dollar at the start of the project to approximately 15 Kwacha per dollar at the time of the mid-term evaluation.

The national economy is predicted to grow about 4.2-4.5% annually during the life of the project. The Government of Malawi is committed to a broad-based structural adjustment program focusing on increased agricultural production, increased employment opportunities, an improved human resource development system (including universally available primary education), and increased income transfers to vulnerable groups. (Statistics from Situational Analysis of Poverty in Malawi, United Nations and GOM.)

A multi-party election held in May 1994 resulted in a change in government, the first since independence.

Although women have equal legal rights, there are many constraints to the advancement of women. Strong sociological and cultural forces maintain and enforce women's inferior position. Child bearing is considered essential and Malawi has one of the highest crude reproductive rates in the world. The illiteracy rate for women was estimated to be 71% in 1987 (compared with 52% illiteracy rate for men.) According to the Mid-Term Cluster Survey just conducted, of 278 mothers of children under the age of two years in the project area, 79.9% are illiterate. None were reported to have had more than primary school education.

The Nsanje Child Survival VI project successfully reached most objectives but its effect was constrained by severe drought followed by a season of flooding in the valley. About 20% of the villages in the catchment area, particularly those in the most remote areas, were not directly served by that project. In addition to serving these areas, the CS IX project was planned to include adding two new interventions: HIV/AIDS and Family Planning.

## **Project Design and Implementation**

The project follows a community-development primary health care model, expecting mothers to be the primary care givers for their families; focusing on educating and motivating them to use available interventions that can decrease the major causes of neonatal and infant mortality. Community-based Village Health Volunteers (VHV) have been selected and trained for service in each village of the service area. In addition, each village has selected a ten person Village Health and Water Committee (VI-K) which includes the village headman. Health Surveillance Assistants (HSA) reported that they explain to village headmen what they are going to do before beginning so that the headmen are not taken by surprise. Project liaison with the villagers is through HSA, trainers and coordinators. These are all linked together by training, supervision and monthly reporting of health data. In addition, the project has institutionalized linkages with MOH and other private agencies that function in the area. The linkages with MOH field operations are particularly important not only for project effectiveness but also for potential sustainability.

**Conclusions:** The project has been welcomed by and has coordinated well with MOH and the other private agencies in the area.

## **Accomplishments**

The project DIP projected that during the life of the project 20 ADRA HSA and 32 MOH HSA would receive training and carry primary responsibility for training 450 project VHV serving some 160 villages. The latest monthly report available, covering the period of 15 January to 14 February 1995, reported 19 HSA and 455 VHV serving 185 villages. The annual report for 1994 reported that Health Committees (VHC) had been established and at least partially trained in each of 180 villages and that all but two of those were functioning to some degree with 68% of them having met at least once a month during June-August 1994.

According to Mr Petro, the chief of Mbenji Senior Traditional Authority, "the goal of the ADRA project is simple;" he believes "It exists to improve the health standards of those who live in his villages, "

A major development has been the advancement of plans to transfer HSA from the project to MOH during the next few months. In advance of that, three project HSA who have left the project have not been replaced by the project but for the last three months their duties have been performed by MOH HSA assigned to the areas. This has provided a trial period for the major transition expected **after** the start of the GOM fiscal year in April 1995. It is planned that the transfer will be gradual over the next several months. Project HSA will be offered the opportunity for interview with MOH and those selected will be hired into newly established HSA positions in MOH. Most are likely to be hired since they are said to be better trained than most HSA and the project has encouraged them to diligence.

The tentative agreements for the transfer are that the project will continue to fund refresher training for all HSA serving villages of the area, paying the usual GOM rates for per diem during the training opportunities. The HSA will continue to provide supervision of VHV that includes collecting and compiling monthly reports from the VI-IV. Training will be done primarily by the project training staff of two, an HSA Coordinator, a staff member whose primary job is to evaluate the effectiveness of the training, and special emphasis staff in the areas of gardening, **HIV/AIDS/STD**, and family planning.

Mr. Mbengo, HSA Coordinator from MOH headquarters in Lilongwe visited the project on March 24 to collect names of and information about HSA as MOH continues with its plans to transfer them from the project to MOH employ. Although he did not and could not give assurance that all project HSA would be employed by MOH, the Ministry apparently has new establishment for many more HSA than are currently available, and the process is clearly directed toward hiring as many qualified HSA as possible. He **reaffirmed** that MOH wants them to continue serving in the same communities where they have been working with the project.

**Conclusions:** This early transfer of HSA **from** the project to MOH implies commitment, should help assure sustainability and will allow for reprogramming of some project money for use elsewhere in the project. It may mean loss of control, loss of influence of the paycheck that has been tied to monthly reporting. (See recommendation 1, 2, 3 .)

Liaison with VHC and, to some extent, supervision of VHV is done in the GOM by health assistants and health inspectors. The project does not employ any persons with these formal category of training. Thus some supervision of VHV is being done by health assistants and health inspectors employed by MOH. At the health center in Sankhulani, the HA was noted to have posted in his office a work plan that shows the project **HSAs'** whereabouts and activities. HA reported that they are often verbally invited to participate or observe project activities of their HSA.

Project HSA and some VHV participate in clinics, both mobile and those offered at health centers/health posts. There is a potential for participation in these clinics to become a greater focus of the work of the HSA than the community-based primary health care on which this project is based. This could become an even greater problem as the HSA are transferred to the MOH. (See recommendation 5 .)

A major focus of the project is to perform qualitative research to understand cultural beliefs, attitudes and practices that adversely **affect** child survival and to understand approaches to changing those problem areas. The project has used this approach particularly with HIV/AIDS and with exclusive breastfeeding. Conclusions of the qualitative research are being used to inform the messages to be given and those from the exclusive breastfeeding issue are being prepared for publication. Messages derived through this qualitative research are being presented, at least some of the time, through culturally appropriate techniques including drama and song. Evaluation team members observed a youth Anti-AIDS Club present its message through songs, poems and message cards to fellow youth in Tambo Village.

In parts of the project area near Trinity Hospital, revolving drug fund schemes have been used to provide a few medications such as aspirin, anti-malarials and eye ointment in the village. This has not been encouraged by DHO in other areas. CBD of contraceptives (contraceptive pills, foam and condoms) is being piloted in one area of seven villages near Bangula. Twenty VI-IV and two supervisors are participating in this. There seems to be good acceptance of the concept. Other villages have heard about CBD and according to one team of interviewers, “there was a request for CBD program in most villages” visited. In addition, the new District Medical Officer is more interested in revolving drug fund programs.

Conclusions: The time may be right for instituting CBD and revolving drug funds in more of the project area. (See recommendation 6, 7.)

Some specific interventions have been primarily done by single, specialist staff members. Thus child spacing’s CBD of contraceptives is being done in seven villages, gardening projects are concentrated in a few villages and **HIV/STD/AIDS** is concentrated in a few villages where the **HIV/AIDS/STD** project staff member even carries a load of case management of specific AIDS patients who have been referred to him by Trinity Hospital.. Some of the effect is being felt project wide, eg. vegetable seeds are being distributed to villages in all of the area and HIV/AIDS prevention messages and child spacing messages are given in training to all VHV, but the major effect is concentrated in limited areas.

Conclusions: Although the concentration of specific interventions in limited portions of the project area enhances those interventions in those limited areas, it is important that these be viewed as pilots and the interventions should be generalized throughout the project area. The area of effect should be expanded throughout the project area. (See recommendation 8.)

The DIP envisaged the project collaborating with an adjunct program of adult literacy. This has not been done since GOM has itself chosen to address this problem with adult literacy programs and by guaranteeing universal availability of primary education. The project has begun adjunct program that is piloting preschool programs to prepare children for primary school. This is reported to be well received, consistent with national policies and complementary to GOM programs.

**Conclusions:** If it can be structured to use health material as training media and if it can involve mothers in “parent support groups,” the preschool program could be an effective means of health promotion for mothers. (See recommendation 17.)

One of the emphases of CS VI was sanitation. The results of this are visible in some villages in the project area.

**Conclusions:** The benefits of the emphasis on sanitation are too important to be lost. Some **mechanism** of reinforcing this should be instituted. (See recommendation 16.)

At two of the health posts visited, Nchacha and Mpolo, questions were raised about the competency of VHV in doing and charting growth monitoring. The evaluation team reported this question to project staff. Without prompting, or informing the evaluation team of their plans, project **staff** immediately surveyed VHV in the area served by those health posts, using a questionnaire including a practical skills demonstration. It was determined that about half of the VHV knew what they needed to know. The staff then tried to determine why the level was so low. They found that at these two health posts, unlike most others, VHV had not been encouraged or allowed to attend “Under 5” clinics. Thus they had not been practicing their skills. Project staff and **staff** of the health posts made arrangements for VHV to be welcomed at those U5 clinics. Project staff are to monitor this agreement and the knowledge, skill and work of VHV. In addition project **staff** will sample VHV in other parts of the project area to assure that either this is an isolated problem or that a system solution is applied if required.

**Conclusions:** Project staff demonstrated readiness to attend to problems identified by evaluation; while the evaluation team was still preparing this report they confirmed a problem indicated and developed a plan for correction. This prompt use of data was an impressive demonstration of project management and relevance.

## Relevance to Child Survival Problems

Although reliable quantitative data on causes of mortality in children under the age of two are not available, there is general consensus among those interviewed in MOH, in health centers and in the villages visited, that the major causes are malnutrition, diarrhea, malaria, complications of inadequately spaced pregnancies, HIV/AIDS and acute respiratory infections. There is less agreement on the proportion attributable to each or to their order of importance.

Mrs. Mated, the enrolled nurse-midwife at Sorgin Health Center commented specifically on the increasing number of pregnant and malnourished people in the villages. She saw this as “a result of lack of child spacing which is the beginning of a cycle of poor health and deterioration,” Tetanus is said to be a problem in more remote areas. Eye problems are said to be a major cause of morbidity. The project is addressing each of these problems except for acute respiratory infections. In addition, the project is addressing eye problems due to Vitamin A deficiency that area known to be prevalent in the project area.

Conclusions: The interventions are relevant to the child survival problems of the project area.

## Effectiveness

Due to the lack of reliable morbidity and mortality data, and the resources it would have required to gather that data specifically for this project, it is difficult to measure impact of a project such as this, particularly at mid-term. The VHC at Chikunkhu Village reported, however that they have seen a decrease in diarrhea, eye diseases and bilharzia because their village members are following what they have been taught about sanitation, cleanliness and malaria prevention and treatment. They compare their village with another that has not been as active and say they see a real difference.

Comment: That perception is an important precursor for sustainability!

The project has produced lists of objectives to be accomplished by quarter and included the results of that monitoring in its Annual Report for year one. Essentially all objectives are shown to have been met. Similar results are reported for the fifth quarter.

According to the Mid-Term Cluster Sample Survey, 98.6% of children under two years have growth monitoring cards and 96.4% have immunization records. Monthly reports of **VHV** indicate that an average 75.4% have had growth monitoring each month. This is consistent with spot checks of growth monitoring cards examined in villages visited. Seven point five percent of households met the project definition of high risk. Of these, ninety-four percent received at least two VHV visits each month. A monthly average of 407 VHV report having given an average of 545 health talks each month. Fifty-nine percent report having met with their VI-K during the month. Since these reports are made through **HSA**, that would indicate that an average of at least 86% of VI-IV had contact with their HSA during the month.

Comment: The project appears to be accomplishing most of its objectives according to schedule. Nearly all high-risk households are being reached according to plan.

## Relevance to Development

The major community barriers to meeting the basic needs of children were reported to the evaluation team to be the general low economic status of the area; low literacy, particularly of women; shortages of water in many villages; inadequate food because of recurring drought; and issues surrounding volunteerism and “self help.” The CS VI project has been able to draw in a collaborative project which has rehabilitated wells and built latrines. This project is seeking another collaborative project to dig boreholes or wells. It has provided seeds and gardening expertise that has resulted not only in increased food for households but also in some cash sales of surplus vegetables. (It was reported in February that 46% of families with children under two have vegetable gardens.) It has cooperated with a pilot project of preschool/preparation for primary school. It was able to secure funding from the US Ambassador’s Fund to build two health posts at Misamvu and Kanyimbi in the more remote areas.

The UNDP Fifth Country Program is to begin operations in Nsanje District and will be working with the same Village Health and Water Committee (VHC) as does the project. That could increase the links with development.

**Comments:** Although this is not primarily an economic development project, it is community-based and fosters the community as the best source of solutions to its own problems, It has brought some limited inputs to the villages that are beyond the reach of those communities.

## Management and Use of Data

The project has developed a health information system that includes monthly reporting of activities by field staff including VHV and HSA. The project has also conducted surveys, not only Thirty Cluster Surveys as baseline and just prior to the midterm evaluation but also specific surveys regarding issues such as family planning and HIV/AIDS. These have been used as part of the qualitative research on which specific intervention strategies have been based. It was reported to the evaluation team that there have been an unusually large number of mothers dying of AIDS in the Sorgin area. A survey to determine the extent of the problem of AIDS orphans has been requested by MOH **staff** and people of the area. Field staff are much better at gathering the data than at analyzing it; they have had no background or training in data comparison and analysis.

The health information system has been designed to allow and encourage each level of field **staff to** screen the data for improbable items and question, investigate and request correction if indicated before the data are passed to the project office. Although this does not assure that all data are accurate, it should lead to cleaner, more reliable data.

**Conclusions:** The HIS system is appropriate and functional. It has been used as the source of information for designing interventions and targeting surveys. Training in simple data

comparison and analysis could be very useful for HSA and perhaps also for MOH HI and HA who work with the project. (See recommendation 15.)

## **Community Education and Social Promotion**

The project specializes in community education and social promotion of health interventions. Rather than setting up separate systems for delivery of services, the project primarily encourages beneficiaries to use services that are being supplied by MOH or other PVO. Thus rather than directly administering immunizations, the project promotes immunizations through various means including motivation of mothers, growth monitoring cards with immunization records, maintaining bicycles and supplying spares for them so that existing health centers/health posts can take mobile clinics to the villages, and assisting in operating mobile clinics.

Better nutrition of infants and young children is encouraged by promoting exclusive breastfeeding, encouraging growing of household vegetable gardens and supplying seeds for those gardens. Surveys indicate that villagers are aware of child spacing even if they are not practicing it. It was indicated to the evaluation team that although belief systems are similar throughout the project area, some communities are much more ready to consider changes in traditional practices that are putting them at risk such as “sexual cleansing” rituals that have high HIV risk. The project is conducting qualitative research to determine barriers to change and attempt to structure interventions that can overcome identified barriers. This holds promise, but it is too early to evaluate long term effectiveness in producing enduring change.

Training messages have been tested and then key messages have been printed on the reverse side of papers having drawings that illustrate the messages. VHV participate in evaluation after training to ascertain effectiveness of the training. Supervisory visits are made to monitor the messages being given.

Conclusions: The project intervenes primarily through community education and social promotion. It has been more effective at educating regarding the simple facts than in motivating people to accept the interventions. Its qualitative research may direct how to be more effective in motivation. Project **staff** assist with the services that are promoted.

## **Human Resources for Child Survival**

The primary human resources upon which the project depends for child survival are educated and motivated mothers. To achieve these the project depends upon community-based volunteers, both VHV and VHC. These are trained and supervised by HSA, HA, HI, and trainers. The VHV have had two weeks of training and continue to receive one additional day of training each quarter. HSA have had two to nine weeks of training and continue to receive one additional day of training each month. All of these work “hand-in-hand,” as it was frequently

described to the evaluation team, with clinical staff of MOH and PVO health facilities. The project does not employ a cadre of workers trained in supervision of community-based workers such as VHV.

**Conclusions:** Project staff are in place to train, motivate and support mothers, the primary care givers. Since the project staff does not have formal qualifications in supervision of community-based workers, additional training in this area, including development and use of supervisory check-lists, could improve efficacy of the staff (See recommendation 4.)

## Supplies and Materials for Local Staff

Volunteers have been supplied with simple exercise books and pens. They have been issued sets of simple drawings representing the key messages (which are printed on the back of the drawings). These drawings have been done by a local artist and are appropriate to the level and culture of the target audience. Volunteers have also been supplied with bags in which to carry their project supplies and with occasional incentives such as bars of soap at the time of training.

HSA have been supplied with bicycles, backpacks or bags to carry their project supplies, exercise books and pens monthly, a book, Malawi Prescriber's Companion, and training materials for each course. Spares and repairs for the bicycles are also supplied.

Trainers and other supervisory **staff** are supplied with motorcycles for transportation over the relatively long distances of the project and training supplies as needed.

**Conclusions:** Appropriate levels of supplies and materials are being given to VHV, HSA and other project staff.

## Quality

Primary concerns of projects of this type that depend heavily upon community-based volunteers are the quality of training, the consistency of messages received by the target audience in the villages and the quality of health information reporting. The project has employed a person whose major responsibility is to evaluate the effectiveness of the training as received in the villages. He is using focus groups and surveys to monitor this. Reporting data, suspect by some interviewees, is being routed from VHV through HSA and then through health centers/health posts prior to being received by the project office. This is being done to encourage staff at all levels to spot outlier data and question and verify it. This was seen by those interviewed as a positive step toward assuring quality of reporting. Concern was expressed by some of the evaluation team that project and MOH **staff** may not have enough practical training in data analysis to spot outliers.

**Conclusions:** The project has instituted systems to monitor and assure quality of training and reporting. (See recommendation 15 .)

## **Use of Central Funding**

The project was provided with administrative monitoring and technical support at the time of the baseline survey and in the writing of the DIP. This included management, health, and accounting support. That which was provided for the DIP was reported to be particularly helpful. PVO international office and country office have additional support available as requested.

**Project** Manager has a technical background that covers most areas required in the project. The area that appears in greatest need is in accounting and budgeting particularly as the exchange rate between the US\$ and local currency continues to change. (See recommendation 18, 19.)

## **PVO's Use of Technical Support**

The project has used external technical support from Malawian sources. This has included a local education consultant who produced art work and portions of the health curriculum; technical support in developing drama productions for health promotion; family planning and infant mortality. This was reported to have met project needs.

The project will be requesting additional technical support during the next six months in community motivation using village-appropriate techniques such as drama. A consultant has been identified and is said to be available. Training courses in supervision and communications for HSA will require technical assistance. Development and presentation of a course in simple data analysis may require technical assistance. It is planned to offer a course for TBA in some of the more remote areas; technical assistance will be required. Most of these needs can be met by locally available resource persons.

**The** project appears to have made appropriate use of technical support and does not appear to have barriers to continued assistance as necessary.

## **Assessment of Counterpart Relationships**

The only project expatriate staff are the project manager and her husband who serves as logistic manager and mechanic. These are not positions that it is expected will continue after the end of project funding. Project HSA work closely with MOH HSA and receive refresher training together. As the MOH assumes employment of the HSA, there will be no distinction

between project HSA and MOH HSA. Supervision is currently shared by project staff and MOH HA and HI. All are said to be working closely together.

Conclusions: Counterparts for project staff have been identified in MOH and are being trained in project interventions. Additional training is being planned. A whole cadre of project staff are expected to transfer to MOH employ. (See recommendation 1, 2.)

## Referral Relationships

Mothers and young children are encouraged by VHV to attend health centers or hospitals when indicated by specific symptoms which they have been trained to identify. Some health center staff observed that they may not be seeing any fewer illnesses in the target population but that mothers now know when it is necessary to bring the child to clinic. There is no formal written referral or feedback system. Apparently this has been tried in limited areas in the past and was not concluded to be useful.

Conclusions: Referral between the community-based project and clinical health facilities is occurring even in the absence of a formal, written referral system. There did not seem to be any enthusiasm for instituting such a system at this time.

## PVO/NGO Networking

The project coordinates with Trinity Hospital and Kalemba Parish Clinic in providing services. Project HSA and VHV participate regularly with **staff of** these facilities as well as with staff of MOH facilities in providing service at mobile clinics. The project has agreements with IEF, TALRES, and Marie Stopes International (family planning service provider that has been serving the area.) At the time the DIP was written, it was expected that World Vision would assume responsibility for health programs in a part of the project area in which World Vision has begun a development project. Instead WV has chosen not to enter health programs in its project area.

VI-IV that already existed in the area, whether initially part of IEF or Trinity Hospital have become part of this CS project. It is expected that at least some of these will revert to their “parent” programs after the end of his CS project.

The project collaborates with IEF on distribution of Vitamin A. IEF is willing for and requests greater collaboration on gardening for growth of vegetables rich in Vitamin A.

An Advisory Committee including other PVO working in the area was previously used and was proposed for this project, but has not met in recent quarters although this project’s management participates with many of these organizations in more general network meetings among **PVO/NGO** who work in Malawi.

Conclusions: This project has an unprecedentedly close relationship with other health provider PVO in the area. There are additional areas for collaboration. Regular participation in the advisory committees of this and various other project could identify additional opportunities for collaboration. Reactivating the CS XI Advisory Committee could be productive of advice and of coordination of programs. (See recommendation 9, 10, 11.)

## **Budget Management**

Line item comparisons of expenditures with the budgeted amounts in local currency are quite meaningless at this time because of the effective devaluation of the Kwacha v. the US\$. The exchange rate for the Kwacha v. the US\$ has changed since the beginning of this project from approximately 4.3 to approximately 15. At the same time, the relative costs of various classes of items have changed significantly depending upon whether the items are available in country such as labor or must be imported such as spare parts. Total expenditures of the project for the first sixteen months, the period for which accounting was available, were compared with the total budget for the project prorated for sixteen of thirty-six months to which gain on foreign exchange for the time period involved had been added. Total expenditures were found to be slightly below the prorated, adjusted budget.

Conclusions: It appears that the project is spending in line with real, total budget amounts. It will be important to regularly reevaluate the real budget, based upon the rate of exchange as project **funds** are exchanged for local currency and to regularly reevaluate the proportion allocated for various line items. (See recommendation 18, 19.)

It was not clear from the accounting records that **PVO's** match has been supplied to the project according to the budgeted amounts. PVO salary and OPE costs have undoubtedly been spent and should be accounted. A water project included as budgeted match has not yet been funded.

Conclusions: Since more of the match is budgeted for the second and third years of the project than the first, it is important that careful attention be given to this budget item during the remainder of the project and that accounting records reflect the match as it is supplied.

# SUSTAINABILITY

## Steps Taken

The major portions of the project that it is hoped will be sustained are the community-based focus with volunteers in the villages and a system to support that. The largest GOM requirement for this will be the employment of an adequate number of HSA to work with the volunteers and adequate numbers of health assistants and health inspectors. The move to transfer project-funded HSA to MOH over a year before the end of the project should be a positive development for sustainability since it implies the commitment of the MOH and it also provides for an orderly transition during which the project supervisory **staff** and trainers can assist in the transition and provide additional training as it is found to be necessary. Project HSA are seen by MOH to be relatively well trained and accustomed to the expectation of some diligence and thus are in demand as the MOH increases its establishment of HSA. Repair and replacement of transportation (primarily bicycles) for HSA staff is likely to be a problem just as it is for other MOH **staff**.

Conclusions: It will be important that HSA who transferred from the project to MOH be kept in the project area if at all possible and that they understand the continuing expectation that they will collect and submit monthly reports. (See recommendation 1, 2.)

Because of national shortages of trained health assistants and health inspectors, it is not likely that there will be enough of these cadres to provide adequate supervision of village volunteers so it will probably fall to the HSA to continue to provide supervision that, in the MOH scheme, should be done by HA and HI.

Conclusions: The lack of adequate numbers of HA and HI may require additional training of MOH HSA for supervision of volunteers. (See recommendation 4.)

## Volunteerism and Incentives

The issue of volunteerism, the central concept of this project and other community-based primary care projects is problematic in Malawi at present. Volunteerism acquired a connotation of enforced work without pay in the past. An issue during the recent elections was that such enforced “self help” would no longer be required. This has apparently been interpreted by many as meaning that community-based volunteerism is no longer required. Thus one of the most common themes heard on village visits was the need for more incentives for volunteers. Although few were advocating direct salaries for volunteers, the requests for more and more incentives were so extensive as to be impossible to meet out of GOM budgets.

**Conclusions:** This issue of the future role of volunteerism will have to be addressed on a much broader front than one project in one district of the country. If it is not successfully negotiated and “sold” to the villagers, no community-based programs will succeed.

Currently two separate systems of volunteers exist in the villages of the project area. The project has trained and depends upon VI-IV. The MOH has worked with villages in selecting ten member VHC. The MOH now works mostly through VHC. In some instances the VHV are members of the VHC. In others there are close relationships between them. In others there appeared to be little connection between them. VHV have received specific training in project interventions and have received minimal incentives from the project including bars of soap, pens and exercise books, and bags for carrying their supplies. They are given a small (less than **US\$1**) per diem allowance for days spent in training. During CS VI, some received a uniform and identification badge. VHC have received considerably less training in their villages, without per diems, and have not received a similar level of incentives, although they have received identification badges. Justification for the different levels of incentives is that **VHV** are expected to devote a day or more a week to their health promoting activities while VHC meet for a village meeting once a month. Evaluators heard, however, jealousy by VHC and demands for more incentives. Other PVO, including IEF, report having encountered similar challenges. There has been a conscious attempt to keep incentives consistent with GOM policy so that they can continue **after** the end of the project.

The UNDP **Fifth** Country Program will be working with the VI-K on community development issues. That could strengthen the VHC and decrease their demand for incentives from the project for health-related activities.

**Conclusions:** For the project effort to be sustained, relationships between VHC and VHV must be sorted out. (See recommendation 12.)

## **Community Involvement**

The essence of this project is community involvement. Rather than focusing on health professionals delivering clinical services, it is community-based. Volunteers are from, of and in their communities. The community has selected VHC and has been involved in choosing VHV. While community members and VHC members in focus groups almost universally felt they deserved more incentives or capital investment in infrastructure, eg. water supplies, shelters to use for clinics, road improvements, just as universally they expressed their pleasure at having the project and their sense that it is making a difference, lowering infant morbidity and mortality.

**Conclusions:** The formation of a VHC in each village, with the headman chairing the VHC, both reflects interest in the project and commitment to continuing interventions. (See recommendation 13 .)

## **Involvement of Local Organizations**

Many of the VHV on the east bank were previously volunteers in Trinity Hospital's primary health care program. They and as many as one third of those on the west bank will probably again be part of the primary health care programs of Trinity Hospital or Kalemba Parish Clinic **after** the end of the project. These local service providers stated that they see the project as effective and have been supportive of it throughout its life. Specific arrangements for transition at the end of the project have not yet been finalized. It is expected that these issues will be addressed at project Advisory Committee meetings since these organizations are part of that committee.

The project reports that it will increase its integration of other community groups into project activities, including training programs. Groups mentioned in the Annual Report are Agricultural Extension Workers, **Homecraft** Workers, and Literacy Teachers.

Conclusions: Local organizations continue to express interest in the project and to be involved in its planning and operations. (See recommendation 14.)

## **Ministry of Health Involvement**

The MOH has been directly involved in requesting, planning, implementing, and evaluating this project. MOH staff have helped train, supervise and liaise with project volunteers and VHC. As noted above, MOH expects to hire most project HSA within the next few months, more than a year before the end of the project. The project continues to invite **MOH staff** to training opportunities offered. Several MOH staff reported that the project is working much closer with them than earlier; they noted that although collaboration is not yet perfect it is much more common.

The project has maintained its own vehicles and has assisted MOH by providing maintenance and spares for its bicycles located at health centers/health posts. Maintenance of transport capability, particularly for distribution of supplies and for collection of reports will require a level of commitment by MOH that is not yet visible. While CS VI directly supplied items such as ORS to HSA and VHV, CS IX is assisting MOH with stocking and transportation and expects that all supplies will be received through the MOH system. This project was not designed with significant cost recovery or income generating activities.

Conclusions: MOH requested this project and continues to support its operation. It appears committed to sustaining the benefits to be derived from the project. Project and MOH appear to be consciously looking for opportunities to collaborate. The transfer of HSA should further that collaboration. (See recommendation 1-4.)

## RECOMMENDATIONS

1. The project should continue negotiations with DMO for transfer of project HSA to MOH.
2. The project should try to secure assurances that the HSA transferred will, as much as possible, continue serving the areas in which they currently serve in order to provide continuity for VHV and VHC.
3. The project should prepare a set of recommendations for reprogramming money budgeted for HSA salaries that will be saved by early transfer of HSA to MOH so that money can be used appropriately to strengthen the effect of the project.
4. Some of the project money budgeted for HSA salaries saved by the early transfer of the HSA to MOH should be used for increased training of HSA in supervision of VHV; this could increase the likelihood that HSA will spend more time on community-based primary health care rather than simply in clinical services.
5. The project should resist the natural attraction toward providing clinical services and always remember the public health focus on the community and its health.
6. The project should resume discussions with DMO about expanded use of revolving **fund** programs for supply of a few simple medications in the villages.
7. The project should work with the family planning service provider and the DMO to expand CBD of contraceptives to more of the project area.
8. Single specialty project training/supervisory staff should concentrate on training throughout the project area rather than on delivering services in a limited area.
9. The project Manager should reactivate the Advisory Committee, reorganizing it if necessary.
10. To enhance visibility and communications, the project Manager should visit health centers/health posts and hospitals in the project area on a regularly scheduled basis.
11. The ADRA Country Director and the project Manager should have regularly scheduled meetings, not called because of some emergent situation. They should also meet together with officers of the Malawi Union of Seventh-day Adventists to discuss the progress of the project quarterly or semiannually.
12. The relationship between VHV and VHC should be clarified and strengthened.

13. The project should consider offering training to the VHC Chairmen together with and on the same terms as that offered to VHV. This could increase understanding between them and collaboration.
14. The project should provide training in project interventions to traditional birth attendants, traditional healers and leaders of faith communities (churches and mosques) and enlist their support in communicating them to the communities served.
15. The project should develop and offer training in simple data analysis for HSA; this could be available also to HI and HA if indicated.
16. Mechanisms to reinforce the importance of sanitation, such as annual “Clean Village Competitions,” should be instituted.
17. The pilot **preschool/preparation** for primary school entry program should be structured to maximize use of health materials as media for instruction and should include organization of mothers into “parent support groups” to involve them as well.
18. The rapid and radical change in exchange rate of the Kwacha v. the **US\$** mandates that the project budget be regularly reanalyzed to keep it realistic considering the varying effect of this changing rate on various components of the budget.
19. **ADRA-International** should provide additional backup to the ADRA-Malawi accounting staff on dealing with the problems of accounting and budgeting in a time of rapid currency value change.

# EVALUATION METHODOLOGY

Members of the evaluation team spent four days talking with field project staff and in active field observations. In order to maximize the use of the time available, the team divided into three groups for one day and four groups for a second day of field site visits. Each of the teams visited health centers/health posts where they discussed the local health situation and the project with resident staff as well as visiting villages. In the villages they held discussions with village health committees (VHC) and volunteers (VHV). They did spot checks of growth monitoring/immunization cards during these visits. The villages visited were chosen to be representative of the entire project geographical area from lists of those said by HSA and trainers to be the best or most advanced in terms of the project and the worst or least advanced villages. Gardening plots and sites of community based distribution of contraceptives (CBD) were included. Two team members traveled by motorcycles to one of the most remote areas in the project service area since the track that leads there was not passable by vehicle.

Team members interviewed MOH officials at Regional and District Health Offices. They interviewed staff at Trinity Hospital on the east bank of the river in the project area, talking specifically with Dr. Peter **Cuppen** who has long acquaintance with the project and was a member of the evaluation team at midterm of CS VI. (Dr. **Cuppen** was, unfortunately not available for inclusion in this evaluation team since this was his last week in Malawi before extended leave in Europe and reassignment **after** twelve years working in primary health care in the District.)

The director and the accountant of ADRA-Malawi, the Treasurer of Malawi Union of Seventh-day Adventists, project management **staff** including the project Manager and all other supervisory staff were interviewed. Supervisory **staff** were interviewed as a group and also individually. Project HSA were interviewed in three focus groups at Ngabu. Project records and policies were reviewed at the field office at Ngabu as well as at the ADRA-Malawi office in Blantyre. Representatives of other NGO who are doing programs in the project area were interviewed.

Team members were asked to conduct semi-structured interviews using an outline questionnaire to assure that important areas were not neglected. After making its observations the evaluation team worked together with each person or group writing up a record of their observations and the team as a whole discussing major findings and recommendations.

A Thirty Cluster Sample Survey was conducted immediately prior to the evaluation and preliminary data were prepared during the field visit. That was used for comparison with baseline data.

The Chair of the Evaluation Team greatly appreciates the work of the team members who agreed to participate after only short notice and who were pushed to heavy schedules while in the field. The Project Manager and supervisory staff were particularly helpful in making arrangements for field visits notwithstanding the difficulties of communications and logistics in the project area and for being very forthcoming about project operations.

## Evaluation Team

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## APPENDICES

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## **Appendix A: Scope of Work**

# SCOPE OF WORK FOR CHILD SURVIVAL IX - MALAWI MID-TERM EVALUATION

## I. INTRODUCTION

This is a scope **of work** for the Mid-term Evaluation of **ADRA's USAID funded Child Survival IX project** **which** was signed on September 27, 1993 by Mario Ochoa, Executive Vice President of the Adventist Development and Relief Agency. The project was designed to have a three year life beginning on or about September 30, 1993 and ending September 29, 1996.

## II. THE PURPOSE OF EVALUATION

The primary purpose of the mid-term evaluation is to help **ADRA/Malawi to assess lessons** learned and identify new strategies which would eventually help the ultimate success of the Child Survival Project.

The mid-term evaluation provides an opportunity for the project leaders to be introduced to the opinion of others, learn community views on sustainability of the project activities, and familiarize key local health and development professionals with the project's effectiveness.

In a nutshell the mid-term evaluation of the Child Survival Project is expected to help adjust the direction; improve the performance; help identify what is working well; suggest areas **which** need further attention; and recommend a means of improvement for the remaining life of the project.

## III. GOALS AND OBJECTIVES

The goal of Malawi's Child Survival IX Project is to decrease morbidity mortality and improve the quality of life for low income mothers and children in the north half of Nsanje District, the southern most district in Malawi.

At the heart of ADRA's strategy is the mother as the primary care giver. As such the majority of activities will be educational and promotional in nature. This involves educating and motivating mothers to **improve their** health practices and encouraging them to increase the utilization of the existing, but enhanced, community services.

*The project objectives include:*

### **Nutrition**

1. 80% of WCBA (15,332) will have received instruction regarding nutrition during infancy, and childhood.

2. High Baseline levels of appropriate infant feeding practices have been maintained. 40% of mothers with infants less than four months (667) are practicing exclusive breastfeeding.
3. 60% of WCBA (11,499) will increase their food intake during pregnancy.
4. 80% of pregnant/lactating women (4,412) **will** receive a single dose of Vitamin A within four weeks of delivery and 80% of 6-72 months (19,238) will receive a maintenance dose of Vitamin A every six months. 50% of households with WCBA (5,000 households) will have a vegetable garden.

### **AIDS prevention**

1. 100% of **HSAs** (20) and volunteers (450) have received training in HIV/AIDS prevention and counseling.
2. 80% of **VHC's** (130) have been trained in HIV/AIDS prevention in the community.
3. 90% of target population age 15-45 knows HIV/AIDS high risk behaviors and appropriate preventive behaviors.
4. 20% of target population age 15-45 report having sex with only one partner.

### **Growth monitoring**

1. 80% of O-1 1 month old children (4,004) will participate in a monthly growth monitoring program.
2. 50% of 12-23 month old children (2,315) will participate in a growth monitoring program every three months.

### **Family planning**

- 1.: 80% of the VHCs (130) will have received instruction regarding the importance of and methods of family planning.
2. 100% of volunteers (450) trained in Family Planning counseling.
3. 25% of those desiring no more children are using a modern method of birth spacing.

## **CDD**

1. 80% of 0-23 month old children (7,708) in both remote and non-remote areas will receive appropriate home management in **diarrheal** episodes including increased fluids, increased feeding, and appropriate care seeking

## **EPI**

1. 85% of children 12-23 months of age (3,936) in both remote and non-remote areas will have been **fully** immunized.
2. **60%** of WCBA (11,499) have received at least two TT doses.

## **LITERACY (Adjunct fund)**

1. 2000 WCBA have completed the basic functional literacy course

### ***Indicators for sustainability***

According to the DIP development activities planned are not based on cash or other inputs, therefore, continued financial support will not be necessary at the end of the project. The following are the measurable objectives and indicators.

1. Volunteer activity has been institutionalized in the community.
2. Volunteer referrals are accepted by **HC/HP** staff.
3. Quality monitoring system is regularized at **HC/HP**.
4. Community level system of women's groups, **VHCs, HSAs**, and **HPs/Mobile** clinics capable of addressing other and new community health problems.
5. Following activities continue in the community, reinforced and taught through mothers' groups, and **VHCs**:
  - + CDD home management and referral for moderate/severe dehydration
  - + EPI promotion
  - + HIV/AIDS prevention education
  - + FP promotion
  - + GM Nutrition, weighing and nutrition messages
  - + Vit A distribution
  - + Vit A and iron rich vegetable garden promotion, technical help and **seed supply**.

6. For the summaries of the indicators to be monitored, refer to the attached tables at end of the Scope of Work.

#### **Iv. EVALUATION METHODS**

##### **A. Evaluation Concept**

It is helpful to remember that the process of evaluation is never far from its social setting. In view of this, the evaluating team may realize that no matter how objectively the **data was** gathered and analyzed, in the end, the final interpretation can not totally be **free** of the social and political climate of the time and the personal biases of the evaluator. Therefore, the evaluating team is expected to be unduly astute with its written presentation as this involves the lives of many whose welfare could be affected either positively or negatively. The team may keep in mind that we are social beings and as such, every assessment we do apparently takes place in a cultural context. Consequently, there are ideas that do not make sense outside their social --milieu.

This evaluation takes place in the context of two cultures, that of the **funder's** culture and that of the beneficiary's culture. The evaluating team should keep in mind that it is undertaking a major responsibility in its attempt to make a cross-cultural analysis and interpretations.

##### **B. Evaluation Activities**

The evaluation activities will focus on the guidelines designed by **USAID** for the Mid Term Evaluations of **all USAID** funded child survival projects and the supplementary questions. The evaluation team is reminded that all **USAID** funded Child Survival projects are required to respond to the sustainability questions and issues outlined in the **Child** Survival Guidelines.

It is obvious that a beneficial evaluation is a result of reliable data collection. Collection methods may include: general observations, surveys, interviewing recipients and/or **staff**, gathering information from written material, and so on.

In the preparation of the final report, the evaluating team is requested to provide the reader with, as much as **possible, accurate** sources of its information and conclusions. In fact, all evaluation statements must be backed by **existing** data. When this is not the case, the team is required to state this fact and provide a rationale for its observations and conclusions.

It goes without saying that every country is unique and Malawi is not an exception. In the event that there maybe questions which do not apply. Please, do not manipulate the questions to manufacture its applicability, but explain why the question does not apply.

Following these guidelines and taking the program objectives and the measurable objectives and

indicators for sustainability as listed above, the evaluation team is expected to perform the following.

First, the **evaluation** team should provide project **staff with** an external perspective on the progress and the potential for reaching stated objectives on the project, by reviewing project outputs and changes in health knowledge or practices.

Secondly, the evaluation team should assess whether the project is being carried out in a competent manner and make sure that priorities for action are clearly **identified**. In addition to this, the team should identify any need for further training, examine the community participation, assess the effectiveness of income generating activities, if one exists, and evaluate the adequacy of technical backstopping by **ADRA/I**.

Finally, when necessary, the team should recommend a course of action that **will** promote the highest quality performance for the rest of the life of the project.

## V. FREEDOM OF INFORMATION

The ultimate responsibility for gathering and disseminating information from all of its regional offices around the world lies within **ADRA/I**. Therefore, **ADRA/I** expects the evaluation team **particularly** the hired consultants, to turn to **ADRA/I** all the data and other information which were used as the basis of the team's final inferences.

It is **ADRA's** position that no evaluation is final until it is presented to **ADRA/I's**, discussed with the consultants in an open manner, clear understandings of **all** conclusions and any differing views are reached between the consultant and **ADRA/I** as reflected in the final document.

**ADRA/I** considers it unethical for any member of the evaluation team to use information gathered during the evaluation assignment for anything other than the evaluation under study. Should viable reason present itself for using the information obtained for other purposes, then, **ADRA/I** must be consulted and prior permission secured. This must be adhered to, **especially** when the material is of a controversial nature and exclusively involves **ADRA's** internal **affairs**.

## VI. COMPOSITION OF THE EVALUATION TEAM

The evaluation team will consist of Dr. Lester N. Wright (Independent Consultant), Dr. Gerard Latchman (**ADRA/Headquarters**), Max Church (**ADRA/Malawi** Country Director), Joy Cook (**ADRA/Malawi's** Health Coordinator), as well as one individual from **USAID/Malawi** and MOH.

## VII. CALENDAR OF EVALUATION ACTIVITIES - 1995

Travel to and from Malawi .....	March 9 - 10 and 26 - 27
Design of evaluation by Team Leader .....	March 11 pm
Malawi's Evaluation Visit .....	March 12-24
Writing of the draft MTE Report .....	March 28 - 30
Review of the draft document by ADRA/Headquarters .....	April 5 - 17
Revisions of Mid-Term Evaluation Report .....	April 18 -24
MTE Report due at ADRA for inclusion in the MTE Report .....	April 28

## VIII. REPORT FORMAT

The Mid-Term Evaluation Document will be written using the following outline:

1. **Title Page.** The title page **will** state the name and project number, names and titles of consultants, and date and name of the document.
2. **List of Acronyms.** Unusual or obscure acronyms should be identified at the beginning of the report.
3. **Executive Summary.** The executive summary synthesis should be no more than one page in length and **will** include: background of project, evaluation methodology, accomplishments and impact of the project, concerns and recommendations:
4. **Table of Contents.** Table of contents should outline each major topic section, appendices, figures, maps, tables, etc.
5. **Body of the evaluation.** The body of the evaluation report **will** include the following in sequential order:
  - *Introduction and background*  
The introduction and background will include at a minimum: justification for awarding grant, goals and objectives of the grant, implementation methods, and the purpose of the evaluation.
  - *Evaluation Methodology.*  
The evaluation methodology will include at a minimum: description of data collection and evaluation sites selection processes.
  - *Sustainability Issues:*  
The section on sustainability issues will include sequential responses to the sustainability questions and issues outlined in the Child Survival Mid Term Evaluation Guidelines.
  - *Supplementary Issues and Questions.*  
This section will address in sequence the supplementary issues and questions outlined in this Scope of Work.

6. **Appendices.** The appendices included **will** be at the discretion of the evaluation team. However, the appendices must include the scope of work, itinerary for the evaluation visit, list of individuals interviewed/surveyed during the evaluation, surveys and interviewer questionnaires, references cited, and maps. Additional appendices such as case studies, etc. may be included as determined appropriate by the evaluation team.

## **IX. BUDGET FOR EVALUATION**

The budget for the Mid-Term **Evaluation** of **ADRA\Malawi's** Child Survival IX project is attached.

The table below summarizes the indicators to be monitored, how and when.

Indicators/Data	Method of Collection	When Collected
<b>Family Planning: Effect Indicators:</b>		
1. Percent of mothers of children less than 24 months of age who desire no more children in the next two years, and are not sure, who are using a modern contraceptive method.	1. Survey	1. Baseline, EOP
<b>Family Planning: Output Indicators:</b>		
Percent of VHCs trained in family planning. Percent of volunteers trained in family planning counseling. Percent of WCBA living within 5 km of family planning commodity service provider. 163 VHCs trained. 52 HSAs trained.	1. Training Report 2. Training Report 3. survey 4. Training Report 5. Training Report	1. 2. 3. Baseline, EOP 4. 5.
450 volunteers trained. At least one key message monthly in 163 villages; 163 community FP promotional events at least quarterly. 450 vol's reviewed monthly by HSAs.	6. Training Report 7. Monthly/Quarterly Report 8. Monthly Supervision Report	3. 4. Monthly, Qtrly 5. Monthly
One home visit to each high risk woman (15-19, 35-44=9,940) at least quarterly for FP promotion. Consistent supply at HCs/HPs. Increased accessibility of FP supplies into 163 villages through CBD.	9. Monthly Report 10. Qtrly stock inventory checks 11. survey, Quarterly Reports, FP Delivery Site list	6. Monthly 7. Quarterly 8. Quarterly
<b>Nutrition: Effect Indicators:</b>		
1. Percent of mothers knowing correct time to introduce solid/semisolid foods.	1. survey	1. Baseline, EOP
2. Percent of mothers knowing which foods contain Vitamin A.	2. Survey	2. Baseline, EOP
3. Percent of mothers indicating they ate same or more than usual during last pregnancy.	3. Survey	3. Baseline, EOP
4. Percent of infants/children (under 24 months) who were breastfed within the first eight hours after birth.	4. Survey	4. Baseline, EOP
5. Percent of infants less than four months who are being given only breastmilk.	5. Survey	5. Baseline, EOP
6. Percent of infants between five and nine months, who are being given solid or semi-solid foods.	6. Survey	6. Baseline, EOP
7. Percent of children between 20 and 24 months, who are still breastfeeding (and being given solid/semi-solid foods).	7. survey	7. Baseline, EOP
8. Percent of mothers stating that they ate more food than usual during pregnancy. 9. Number of pregnant/lactating women receiving single dose of Vitamin A within four weeks of delivery and children under six years receiving Vitamin A dose in past six months. 10. Number of households growing Vitamin A and iron rich vegetables during the normal growing season.	8. Training & Monthly Reports 9. Survey 10. Monthly Report, Survey	8. Monthly 9. Baseline, EOP 10. Monthly, Baseline, EOP
<b>Nutrition: Output Indicators:</b>		
1. 52 trained HSAs, quarterly refresher training. 2. 450 vol's and 163 VHCs trained. 3. Monthly weighing of 0-11 month olds at 22 HC/HP/Mobile clinic and eight remote communities. 4. Key message communication events at: 22 monthly weighing clinics, eight CB weighing clinics, 450 monthly women's group meetings. 5. At least monthly home visits to 4000 at risk households (est. 40% of households). 6. Home visits to est. 467 LBW infants annually.	1. Training Report 2. Training Report 3. Number clinics assisted monthly 4. Monthly Report 5. Monthly Report 6. Monthly Report	1. 2. 3. 4. Monthly 5. Monthly 6. Monthly
7. Key message communication strategy specifically designed to overcome local beliefs on early introduction of solid/semisolid foods.	7. Satisfaction, KABP survey	7.

<p>8. 412 HSAs trained, quarterly refresher training.</p> <p>9. 450 vol's trained.</p> <p>10. 19,238 (80%) of children 672 months and 4,412 (80%) pregnant/lactating women receive appropriate annual Vitamin A dose(s) through 30 monthly weighing clinics or six monthly campaigns.</p>	<p>8. Training Report</p> <p>9. Training Report</p> <p>10. Clinic Records, six Monthly Census Check</p>	<p>8.</p> <p>9.</p> <p>10.</p>
<p>11. 52 HSAs thud. quarterly refresher training.</p> <p>12. 450 vol's trained in garden promotion.</p> <p>13. 150 families growing model gardens assisted by ADD technical assistance and seeds.</p> <p>14. 50 families growing model gardens from ADRA/IEF technical assistance in remote areas.</p> <p>15. Number of key message communication events by vobmteaa.</p>	<p>11. Training Report</p> <p>12. Training Report</p> <p>13. Monthly Report</p> <p>14. Moothly Report</p> <p>15. Monthly Report</p>	<p>11.</p> <p>12.</p> <p>13. Monthly</p> <p>14 Monthly</p> <p>15. Monthly</p>
<b>Growth Monitoring Effect Indicators:</b>		
<p>Percent of 611 month old children weighed in past month.</p> <p>Number d volunteers following up high risk households with home visits.</p>	<p>1. Monthly Report, Survey</p> <p>2 Monthly Report</p>	<p>1. Monthly, Baseline, EOP</p> <p>2. Monthly</p>
<p>Percent of 1223 month old children weighed in past three months.</p>	<p>3. survey</p>	<p>3. Baseline, EOP</p>
<b>Growth Monitoring Output Indicators:</b>		
<p>1. 52 HSAs trained.</p> <p>2. 450 vol's trained.</p> <p>3. 22 monthly weighing dioia.</p> <p>4. Eight commmity based weighing sights weighing 4,004 (80%) of 0-11 months md 2,315 (50%) of 12-23 months.</p> <p>5. Home visits to high risk households by volunteers.</p> <p>6. Number of volunteers following up high risk households with home visits.</p> <p>7. High risk follow- io nutrition clinics/clubs, rehab units.</p>	<p>1. Training Report</p> <p>2. Training Report</p> <p>3. No. Clinics, Monthly Report</p> <p>4. No. Clinics, Moothly Report</p> <p>5. Monthly Report</p> <p>6. Monthly Report</p> <p>7. Chic Records</p>	<p>1.</p> <p>2</p> <p>3. Monthly</p> <p>4. Monthly</p> <p>5. Monthly</p> <p>6. Monthly</p> <p>7.</p>
<b>EPI- Effect Indicators:</b>		
<p>1.Paacot of children 12-23 months who received DPT1.</p> <p>2. Paeoot Of children 12-23 months who received OPV3.</p> <p>3. Percent of children 12-P month who received measles vaccine.</p> <p>4. Paeoot change between DPT1 &amp; DPT3 doses ((DPT1-DPT3)/DPT1)x100 in children 12-23 months.</p> <p>5. Percent of mothers who received two doses of tetanus toxoid vaccine before the birth of their youngest child less than 24 months of age.</p>	<p>1. Survey</p> <p>2 survey</p> <p>3. Survey</p> <p>4. survey</p> <p>5. Survey</p>	<p>1. Baseline, EOP</p> <p>2. Baseline, EOP</p> <p>3. Baseline, EOP</p> <p>4. Baseline, EOP</p> <p>5. Baseline, EOP</p>
<b>EPI Output Indicators:</b>		
<p>1. 52 HSAs retrained.</p> <p>2. 450 vol's retrained.</p> <p>3. At least 163 communication events monthly io community groups and 30 EPI/GM clinica.</p> <p>4. Supervision of mobile clinic for accessibility coverage.</p> <p>i. Home visits to high risk.</p> <p>i. Monthly reporting of measles cases to VHC, HC.</p>	<p>1. Training Rqm</p> <p>2. Training Report</p> <p>3. Moothly Report</p> <p>4. Quarterly Supervision Report</p> <p>5. Monthly Report</p> <p>6. Monthly Report</p>	<p>1.</p> <p>2.</p> <p>3. Monthly</p> <p>4. Quarterly</p> <p>5. Monthly</p> <p>6. Monthly</p>
<p>7. Supplies in use.</p> <p>1. Cold chain monitoring verified.</p>	<p>7. Observation. Quarterly Supervision Report</p> <p>8. Observation. Quarterly Supervision Report</p>	<p>7. Quarterly</p> <p>8. Quarterly</p>
<b>AIDS Prevention Effect Indicators:</b>		
<p>1. Communities knowledgeable and increasingly practicing HIV/AIDS preventive behaviors.</p>	<p>1. survey</p>	<p>1. Baseline, EOP</p>
<p>2. Percent of target population age 15-45 correctly identifying high risk behaviors end appropriate preventive behaviors.</p>	<p>2 survey</p>	<p>2. Baseline, EOP</p>
<b>AIDS Prevention Output Indicators:</b>		
<p>1. At least quarterly focus group discussions with 163 VHCs and elders groups.</p>	<p>1. Quarterly Report</p>	<p>1. Quarterly</p>
<p>2. 10 drama teams giving at least one presentation to 130 (80%) villages at least quarterly.</p>	<p>2. AIDS IEC Events Report</p>	<p>2. Monthly</p>
<p>3. HSAs trained.</p> <p>4.450 vol's, 163 VHCs trained.</p>	<p>3. Training Report</p> <p>4. Training Report</p>	<p>3.</p> <p>4.</p>
<p>5. Key message events io 130 (80%) villages at least quarterly.</p>	<p>5. AID IEC Events Report</p>	<p>5. Monthly</p>
<p>6. Increase in numbers of testing sites offering HIV testing for public in project area (presently 0).</p>	<p>6. Hospital/HC/HP Reports</p>	<p>6. Monthly</p>
<p>7. Percent Of HSAs and volunteers receiving training in HIV/AIDS prevention and counseling.</p>	<p>7. Quarterly Training Report</p>	<p>7. Quarterly</p>
<p>8. Percent Of VHCs receiving training.</p>	<p>8. Quarterly Training Report</p>	<p>8. Quarterly</p>
<p>9. Percent Of target population age 15-45 reporting sex with only one partner.</p>	<p>9. Survey</p>	<p>9. Baseline, EOP</p>

<b>CDD Effect Indicators:</b>		
<ol style="list-style-type: none"> <li>1. Percent of infants/children (under 24 months) with diarrhea in the past two weeks who were given the same amount or more breastmilk.</li> <li>2. Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more fluids other than breastmilk.</li> <li>3. Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more food.</li> <li>4. Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were treated with ORT.</li> </ol>	<ol style="list-style-type: none"> <li>1. Survey</li> <li>2. Survey</li> <li>3. Survey</li> <li>4. Survey</li> </ol>	<ol style="list-style-type: none"> <li>1. Baseline, EOP</li> <li>2. Baseline, EOP</li> <li>3. Baseline, EOP</li> <li>4. Baseline, EOP</li> </ol>
<b>CDD Output Indicators:</b>		
<ol style="list-style-type: none"> <li>1. 52 HSAs retrained.</li> <li>2. 450 vol's retrained.</li> <li>3. At least one key message event monthly in 163 villages.</li> <li>4. Home visits to high risk families.</li> <li>5. Staff of 10 HCs/HPs perform at least quarterly self evaluation supervision reports, using commonly agreed on checklists.</li> <li>6. Distribution in selected village, particularly during rainy season.</li> <li>7. In- households with pit latrines from EOP CS IV of 43% to 65%.</li> <li>8. Experimental sand/gravel/charcoal home water filters pilot tested in 100 households.</li> </ol>	<ol style="list-style-type: none"> <li>1. Training Report</li> <li>2. Training Report</li> <li>3. Monthly Report</li> <li>4. Monthly Report</li> <li>5. Quarterly Supervision Report</li> <li>6. Distribution Log, Inventory Records</li> <li>7. Observation, Survey</li> <li>8. Observation</li> </ol>	<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3. Monthly</li> <li>4. Monthly</li> <li>5. Quarterly</li> <li>6.</li> <li>7.</li> <li>8.</li> </ol>
<b>Literacy (Adjunct fund) Effect Indicators: None</b>		
<b>Literacy (Adjunct fund) Output Indicators:</b>		
<ol style="list-style-type: none"> <li>1. GOM curriculum.</li> <li>2. Health messages included in curriculum.</li> <li>3. 10 literacy teachers trained.</li> <li>4. Teaching supplies in use.</li> <li>5. 2,000 literacy grads also exposed to CS key messages.</li> <li>6. Number of WCBA completing the basic functional literacy course.</li> </ol>	<p>Quarterly Reports, Post Test, Evaluated through other intervention evaluation methods (effectiveness of key message communication)</p>	

Project Objectives by Intervention	Measurement Method How/When (Effect indicator and SOURCE)	Major Planned Inputs and Activities	Outputs	Measurement Method & Data SOURCE - How/When
MANAGEMENT, MOE SYSTEMS & LOCAL COMMUNITY SYSTEMS STRENGTHENING				
Staff have been involved in developing, understand and are monitored by project work plans.	staff job descriptions. Quarterly work plans. Annual work plan. Signed quarterly staff reviews of work plans by position.	1. Staff participate in baseline, DIP preparation. 2. Quarterly work plans developed for each position. 3. Quarterly work plans reviewed at end of period with each staff member.	+ More efficient usage of time	+ Staff evaluations, and interviews - QTRLY STAFF EVALUATIONS, MTE, EOP
There is general participation in & satisfaction with vol by community members.	VHC meets monthly. VHC has regularly promoted vol's in community. Vol shares monthly report with VHC Community members evidence satisfaction with vol. FOCUS INTERVIEWS, MTE, EOP. Vol MONTHLY REPORT	1. VHC regularly promotes vol's in community. 2. Vol shares monthly report with VHC. 3. HSA meets Qtrly with VHCs. 4. VHC discusses monthly report with HP/HC.	+ Enhanced status of Vol in community + Satisfaction of community with vol	+ FOCUS INTERVIEWS OF MOTHERS, MTE, EOP
MOH is utilizing a service quality monitoring system for services related to project interventions.	Quarterly service quality supervisory visits HC/HP - Severe diarrhea management, EPI, FP. QUARTERLY SERVICE QUALITY SUPERVISORY VISIT RECORDS, MTE & EOP SURVEY	1. Service quality checklists developed as self evaluation instrument with HSAs and HC/HP staff. 2. Supervisory visits of HC/HP staff at least qtrly.	+ Improved service quality by HWHP	+ See column 2
HSA HC/HP staff have been given refresher training in specific interventions.	PRETEST, POSTEST, SUPERVISORY FOLLOW-UP VISITS USING CHECKLISTS	1. Refresher training for existing HC/HP staff.	+ Trained HSA's, HC/HP staff giving quality services 4 Health Centers 4 Health Posts	+ See column 2
ADRA staff are participating in regular professional upgrading activities.	QTRLY REPORTS	1. Monthly staff meetings/in-service. 2. Qtrly review sessions with staff and refresher training for HSAs. 3. Proj Manager-2 annual conf's. 4. Annual CSSP regional conf for lead staff. 5. Local agency's workshops for lead staff at least 2x yrly.	+ Improvement of professional skills of ADRA staff + Project management skills of lead staff upgraded	QTRLY REPORTS, STAFF EVALUATIONS

## Appendix B: Evaluation Visits

### Ministry of Health:

Southern Regional Office of Health

Dr. H. Bekedam, R.H.O.

Nsanje District Office of Health

Dr. P. Nkanda, D.H.O.

### Health Centers/Health Posts:

Kanyimbi Health Post

Makhanga Health Center

Masenjere Health Center

**Mlolo** Health Post

Nchacha Health Post

**Sankhulani** Health Center

Sorgin Health Center

Tengani Health Center

### Villages:

Chikungu Village

**Chitsa** Village

**Dogo** Village

**Dumba** Village

Kachere Village

Khalava Village

Mphwiri Village

Mwanavumbe Village

Ny'anga 2 Village and garden

**Siki** Village

Tambo Village

Trinity Hospital, Fatima

Kalemba Parish Clinic

Marie Stopes International Field Office

International Eye Foundation Field Office

HIV/AIDS prevention drama group at Tengani

Anti-AIDS Club at Tambo Village

U.S. AID., Malawi Mission, Lilongwe

Ken Sklaw

Laura Keams

# Appendix C: Questionnaire

**Child Survival IX  
Nsanje District Malawi  
Mid-term Evaluation Questionnaire**

Who did Interview: \_\_\_\_\_ Date: \_\_\_\_\_

**Who was interviewed:** \_\_\_\_\_ **Where:** \_\_\_\_\_

1. What relationship does this person have with the **ADRA CSIX** project?
  
2. What **does** this person know about the **ADRA CSIX** project?
  
3. **In** what ways does this person/this person's organization relate with the **ADRA CSIX** project?
  
4. What does this person think the goals of the **ADRA CSIX** project are?
  
5. What does this person think are the major health problems of women and young children in the project area?
  
6. What **does this** person know about supervision of **ADRA CSIX** project workers?
  
7. What are the best things about the **ADRA CSIX** project?
  
8. How does this person think the **ADRA CSIX** project could be improved?

Please write additional Comments on the back (use additional pages if necessary.)

# Appendix D: Mid-Term Evaluation Cluster Survey

## MID-TERM EVALUATION CLUSTER SURVEY

As part of the ADRA Child Survival IX Mid-term Evaluation exercises, March 1995, a cluster survey similar to the baseline survey was conducted. Six questions on respiratory infection were omitted since Project interventions do not target that health problem. Six additional questions on malaria were added to the original questionnaire.

A random sample of 30 villages was chosen from a total possible of 185 villages. Within each village, ten children were randomly chosen from lists of children provided by community health volunteers. Seven to ten mothers with children under two years old were interviewed per village for a total of 278 useable respondent records.

Five interviewers were trained and supervised by the Project's Coordinator of Evaluation.

1. Age of the mother  
Range: 15-52 years; Mean: 25.7; N=139
2. Age of the child under two years old  
Range: 1-23 months; Mean: 10.9 months; N=278
3. What was the highest educational level you attained? (N=278)
  - a. none 68.7%
  - b. primary, does not read 11.2%
  - c. primary, reads 20.1%
  - d. secondary & higher 0.0%
4. Do you work away from home? (N=277)
  - a. yes 22.0%
  - b. no 78.0%
5. Do you do any "income generating work"?  
(multiple answers possible; record all answers) (N=278)
  - a. nothing 21.9%
  - b. handicraft, weaving, rugs, etc 5.0%
  - c. harvesting, fruit pickers 5.0%
  - d. selling agricultural products 56.1%
  - e. selling foods, dairy products 14.4%
  - f. servant/services 2.9%
  - g. shop keeper, street vendor 2.9%
  - h. salaried worker 1.1%
  - i. other (specify) 5.0%
6. Who takes care of CHILD while you are away from home? (N=278)  
(multiple answers possible; record each one)
  - a. mother takes child with her 33.8%
  - b. husband/partner 16.9%
  - c. older children 36.7%
  - d. relatives 17.6%

- |    |                   |      |
|----|-------------------|------|
| e. | neighbors/friends | 1.4% |
| f. | maid              | 0.4% |
| g. | nursery school    | 0.0% |
7. What is the main health problem of this household? (N=226)
- |    |  |       |
|----|--|-------|
| a. | respiratory (cough, wheezing)                      | 11.5% |
| b. | fever, convulsions                                 | 51.8% |
| c. | vomiting, diarrhea                                 | 52.2% |
| d. | OB/GYN (female problem)                            | 2.2%  |
| e. | rheumatoid and joint problems<br>(aches and pains) | 3.5%  |
| f. | other (specify)                                    | 21.2% |
8. How much did the last illness in this household cost to treat (including drugs and travel costs)?  
currency amount 0.16-86.90% (N=125)

Breastfeedins/Nutrition

9. Are you breastfeeding CHILD? (N=278)
- |    |     |       |
|----|-----|-------|
| a. | yes | 95.0% |
| b. | no  | 5.0%  |
10. Have you ever breast-fed CHILD? (N=14)
- |    |     |        |
|----|-----|--------|
| a. | yes | 100.0% |
| b. | no  | 0.0%   |
11. After the delivery, when did you breast-feed CHILD for the first time? (N=278)
- |    |                                      |       |
|----|--------------------------------------|-------|
| a. | during the first hour after delivery | 71.2% |
| b. | from 1 to 8 hours after delivery     | 18.0% |
| c. | more than 8 hours after delivery     | 2.9%  |
| d. | do not remember                      | 7.2%  |
12. a. Are you giving CHILD water (or herbal teas)? (N=278)
- |    |              |       |
|----|--------------|-------|
| 1. | yes          | 80.6% |
| 2. | no           | 19.4% |
| 3. | doesn't know | 0.4%  |
- b. Are you giving CHILD cow milk, goat milk, or formula? (N=278)
- |    |              |       |
|----|--------------|-------|
| 1. | yes          | 54.7% |
| 2. | no           | 45.3% |
| 3. | doesn't know | 0.0%  |
- c. Are you giving CHILD semisolid foods such as gruels, porridge or semolina)? (N=278)
- |    |              |       |
|----|--------------|-------|
| 1. | yes          | 93.9% |
| 2. | no           | 6.5%  |
| 3. | doesn't know | 0.4%  |

- d. Are you giving CHILD fruits? (N=277)
- |    |              |       |
|----|--------------|-------|
| 1. | yes          | 75.8% |
| 2. | no           | 24.2% |
| 3. | doesn't know | 0.4%  |
- e. Are you giving CHILD carrot, squash, mango or papaya? (N=278)
- |    |              |       |
|----|--------------|-------|
| 1. | yes          | 73.4% |
| 2. | no           | 26.6% |
| 3. | doesn't know | 0.4%  |
- f. Are you giving CHILD leafy green vegetables, such as spinach? (N=278)
- |    |              |       |
|----|--------------|-------|
| 1. | yes          | 77.7% |
| 2. | no           | 22.3% |
| 3. | doesn't know | 0.4%  |
- g. Are you giving CHILD meat or fish? (N=276)
- |    |              |       |
|----|--------------|-------|
| 1. | yes          | 73.9% |
| 2. | no           | 26.1% |
| 3. | doesn't know | 0.4%  |
- h. Are you giving CHILD lentils, peanuts, or beans? (N=277)
- |    |              |       |
|----|--------------|-------|
| 1. | yes          | 68.6% |
| 2. | no           | 31.4% |
| 3. | doesn't know | 0.4%  |
- i. Are you giving CHILD eggs or yogurt? (N=276) . .
- |    |              |       |
|----|--------------|-------|
| 1. | yes          | 52.2% |
| 2. | no           | 47.8% |
| 3. | doesn't know | 0.7%  |
- j. Are you giving leafy green vegetables, such as spinach, to CHILD's food? (N=278)
- |    |              |       |
|----|--------------|-------|
| 1. | yes          | 75.9% |
| 2. | no           | 24.1% |
| 3. | doesn't know | 0.4%  |
- k. Are you adding honey or sugar to CHILD's meals? (N=278)
- |    |              |       |
|----|--------------|-------|
| 1. | yes          | 58.6% |
| 2. | no           | 41.4% |
| 3. | doesn't know | 0.4%  |
1. Are you adding fat (lard) or oil to CHILD's meals? (N=278)
- |    |              |       |
|----|--------------|-------|
| 1. | yes          | 34.9% |
| 2. | no           | 65.1% |
| 3. | doesn't know | 0.7%  |

- m. Are you adding iodized salt (local brand name) to CHILD's meals? (N=278)
- |                 |       |
|-----------------|-------|
| 1. yes          | 10.1% |
| 2. no           | 89.9% |
| 3. doesn't know | 0.0%  |
13. Health workers believe that it is very important to breastfeed during the first two years of the baby's life. What can a mother do in the baby's first four months of life to keep ON breastfeeding? (N=277)  
(multiple answers possible; record all answers)
- |  |       |
|--|-------|
| a. doesn't know  | 30.0% |
| b. breastfeed as soon as possible<br>(don't discard colostrum) | 46.9% |
| c. care of breasts, nipples                                    | 9.7%  |
| d. frequent sucking  | 12.3% |
| e. EBF during the first four months                            | 13.4% |
| f. avoid bottle feeding of baby                                | 3.2%  |
| g. relactation   | 1.1%  |
| h. other (specify)   | 5.8%  |
14. When should a mother start adding foods to breastfeeding? (N=277)
- |  |       |
|--|-------|
| a. start adding between 4 and 6 months | 65.3% |
| b. start adding earlier than 4 months  | 23.1% |
| c. start adding 6 months or later      | 1.4%  |
| d. doesn't know                        | 10.1% |
15. What should those additional foods to breastfeeding be? (multiple answers possible: record all answers) (N=277)
- |                                |       |
|--------------------------------|-------|
| a. doesn't know                | 14.8% |
| b. add oil to food             | 11.6% |
| c. give food rich in Vitamin A | 68.2% |
| d. give food rich in iron      | 24.2% |
| e. other (specify)             | 9.4%  |
16. Which Vitamin helps you prevent "night blindness"? (N=275)
- |                          |       |
|--------------------------|-------|
| a. Vitamin A             | 38.9% |
| b. doesn't know or other | 61.1% |
17. Which foods contain Vitamin A to prevent "night blindness"? (N=278)  
(multiple answers possible: record all answers)
- |                           |       |
|---------------------------|-------|
| a. doesn't know           | 38.8% |
| b. green leafy vegetables | 56.5% |
| c. yellow type fruits     | 20.1% |
| d. meat/fish              | 16.9% |
| e. breast milk            | 3.6%  |
| f. egg yolks              | 12.9% |
18. Does CHILD have a growth monitoring/promotion card? (N=278)
- |        |       |
|--------|-------|
| a. yes | 98.6% |
|--------|-------|

- b. lost card 0.7%
  - c. no 0.7%
19. Look at the growth monitoring card of the child, and record the following information: has the child been weighed in the last four months? (N=274)
- a. yes 92.7%
  - b. no 7.3%
20. Look also at the growth monitoring card, and indicate if there is a space to record Vitamin A capsules (N=269)
- a. yes 70.3%
  - b. no 29.7%

21. Amount of Vitamn A given:

AGE	DOSE	NUMBER	N/CARDS	PERCENT
6-11 months	At least one	75	103	72.8
	1	55	103	53.4
	2	11	103	10.7
	3	9	103	8.7
	4	0	103	0.0
12-17 months	At least one	55	62	88.7
	1	29	62	46.8
	2	16	62	25.8
	3	9	62	14.5
	4	1	62	1.6
18-23 months	At least one	47	51	92.2
	1	11	51	21.6 . .
	2	23	51	45.1
	3	-11	51	21.6
	4	2	51	3.9

22. Has CHILD had diarrhea during the last two weeks? (N=277)
- a. yes 33.2%
  - b. no 66.8%
  - c. doesn't know 0.4%

23. During CHILD's diarrhea did you breast-feed (read the choices to the mother) (N=90)
- a. more than usual? 56.7%
  - b. same as usual? 15.6%
  - c. less than usual? 25.6%
  - d. stopped completely? 2.2%
  - e. child not breastfed 1.1%

24. During CHILD's diarrhea, did you provide CHILD with fluids other than breast-milk (N=93) (read the choices to the mother)
- a. more than usual? 49.5%
  - b. same as usual? 22.6%
  - c. less than usual? 17.2%

- |  |    |                           |      |
|--|----|---------------------------|------|
|  | d. | stopped completely?       | 7.5% |
|  | e. | exclusively breastfeeding | 4.3% |
25. During CHILD's diarrhea, did you continue to provide CHILD with solid/semisolid foods (N=93) (read the choices to the mother)
- |  |    |                           |       |
|--|----|---------------------------|-------|
|  | a. | more than usual?          | 43.0% |
|  | b. | same as usual?            | 20.4% |
|  | c. | less than usual?          | 26.9% |
|  | d. | stopped completely        | 5.4%  |
|  | e. | exclusively breastfeeding | 4.3%  |
26. When CHILD's had diarrhea, what treatments, if any, did you use? (multiple answers possible; record all answers) (N=93)
- |  |    |  |       |
|--|----|--|-------|
|  | a. | nothing                                | 5.4%  |
|  | b. | ORS sachet                             | 67.7% |
|  | c. | sugar-salt solution                    | 28.0% |
|  | d. | cereal based ORT                       | 5.4%  |
|  | e. | infusions or other fluids              | 6.5%  |
|  | f. | anti-diarrhea, medicine or antibiotics | 18.3% |
|  | g. | other (specify)                        | 2.2%  |
27. When CHILD had diarrhea, did you seek advice or treatment for the diarrhea? (N=93)
- |  |    |     |       |
|--|----|-----|-------|
|  | a. | yes | 73.1% |
|  | b. | no  | 26.9% |
28. From whom did you seek advice or treatment for the diarrhea of CHILD? (N=69) (multiple answers possible; record each answer)
- |  |    |                             |       |
|--|----|-----------------------------|-------|
|  | a. | general hospital            | 4.3%  |
|  | b. | health center/clinic/post   | 36.2% |
|  | c. | private clinic/doctor       | 18.8% |
|  | d. | pharmacy                    | 5.8%  |
|  | e. | village health worker       | 23.2% |
|  | f. | traditional healer          | 4.3%  |
|  | g. | traditional birth attendant | 0.0%  |
|  | h. | relatives and friends       | 7.2%  |
|  | i. | other (specify)             | 1.4%  |
29. What signs/symptoms would cause you to seek advice or treatment for (name of the child)'s diarrhea? (N=277) (multiple answers possible: record all answers)
- |  |    |   |       |
|--|----|---|-------|
|  | a. | doesn't know                                      | 3.6%  |
|  | b. | vomiting  | 9.0%  |
|  | c. | fever   | 16.6% |
|  | d. | dry mouth, sunken eyes, decreased urine output    | 17.0% |
|  | e. | diarrhea of prolonged duration (at least 14 days) | 62.5% |
|  | f. | blood in stool                                    | 5.8%  |

- |    |                       |       |
|----|-----------------------|-------|
| g. | loss of appetite      | 13.7% |
| h. | weakness or tiredness | 41.5% |
| i. | other (specify)       | 12.6% |
30. What are important actions you should take if CHILD has diarrhea? (N=277)  
(multiple answer6 possible; record all answers)
- |    |  |       |
|----|--|-------|
| a. | doesn't know                               | 2.2%  |
| b. | initiate fluids rapidly                    | 7.2%  |
| c. | give the child more to drink than usual    | 34.7% |
| d. | give the child smaller more frequent feed6 | 28.5% |
| e. | proper mixing and administration of ORS    | 44.4% |
| f. | take child to the hospital/health center   | 40.1% |
| g. | feed more after diarrhea episode           | 5.1%  |
| h. | withhold fluids                            | 1.4%  |
| i. | withholds foods                            | 1.1%  |
| j. | other (specify)                            | 1.8%  |
31. What are important actions a mother should take when a child is recovering from <diarrhea? (N=277)  
(multiple answers possible; record all answers)
- |    |                                      |       |
|----|--------------------------------------|-------|
| a. | doesn't know                         | 9.7%  |
| b. | give smaller more frequent feeds     | 68.6% |
| c. | more foods than usual                | 25.6% |
| d. | give foods with high caloric content | 23.5% |
| e. | other (specify)                      | 5.8%  |

Immunization6

32. Has CHILD ever received any immunizations? (N=277)
- |    |              |       |
|----|--------------|-------|
| a. | yes          | 98.9% |
| b. | no           | 1.1%  |
| c. | doesn't know | 0.0%  |
33. At what age should CHILD receive measles vaccine? (N=185)  
in  
months, Mean=9.1 (Range=1-19)
34. Can you tell me the main reason why pregnant women need to be vaccinated with tetanus toxoid vaccine? (N=272)
- |    |   |       |
|----|---|-------|
| a. | to protect both mother/newborn VS tetanus     | 39.0% |
| b. | to protect <u>only</u> the woman VS tetanus   | 6.3%  |
| c. | to protect <u>only</u> the newborn VS tetanus | 38.2% |
| d. | doesn't know or other                         | 19.5% |
35. How many tetanus toxoid injection6 does a pregnant woman need to protect the newborn infant from tetanus? (N=277)
- |    |               |       |
|----|---------------|-------|
| a. | one           | 6.1%  |
| b. | two           | 18.4% |
| c. | more than two | 68.2% |
| d. | none          | 0.7%  |

- e. doesn't know 6.5%
36. Do you have an immunization card for CHILD? (N=277)
- a. **yes** 96.4%
  - b. lost it 3.2%
  - c. never had one 0.4%

MATERNAL CARE

38. Do you have a maternal health card? (N=270)
- a. **yes** 56.3%
  - b. **lost** it 39.3%
  - c. no 4.4%
39. Look at the maternal health card and record the number of TT vaccination<sup>6</sup> in the space below: (N=151)
- a. none 12.6%
  - b. two or more 85.4%
  - c. none 2.0%
40. Does the card have space to record ante-natal care visits? (N=154)
- a. **yes** 96.8%
  - b. no 3.9%
41. If yes, record whether the mother ever made any ante-natal visit? (N=154)
- a. one 11.7%
  - b. two or more 86.4%
  - c. none 3.2%
42. Are you pregnant now? (N=153)
- a. **yes** 3.9%
  - b. no 96.1%
43. Do you want to have another child in the next two years? (N=148)
- a. **yes** 47.3%
  - b. no 51.4%
44. Are you currently using any method to **avoid/postpone** getting pregnant? (N=92)
- a. **yes** 42.4%
  - b. no 57.1%
45. What is the main method you or your husband are using now to avoid/postpone getting pregnant? (N=36)
- a. tubal ligation, vasectomy 2.8%
  - b. norplant 2.8%
  - c. injections 44.4%

- |    |                          |       |
|----|--------------------------|-------|
| d. | pill                     | 36.1% |
| e. | IUD                      | 0.0%  |
| f. | barrier method/diaphragm | 2.0%  |
| g. | condom                   | 2.8%  |
| h. | foam/gel                 | 0.0%  |
| i. | exclusive breast-feeding | 0.0%  |
| j. | rhythm                   | 0.0%  |
| k. | abstinence               | 8.3%  |
| l. | coitus interruptus       | 2.8%  |
| m. | other                    | 0.0%  |
46. When should an pregnant women see a health proffessional (physician, nurse, midwife)? (probe for months) (N=35)
- |    |                              |       |
|----|------------------------------|-------|
| a. | first trimester, 1-3 month   | 25.7% |
| b. | middle of pregnancy, 4-6     | 62.9% |
| c. | last trimester, 7-9 months   | 8.6%  |
| d. | no need to see health worker | 0.0%  |
| e. | doesn't know                 | 2.9%  |
47. What food are good for a pregnant woman to eat to prevent pregnancy anemia? (N=150)  
(multiple answers possible; record all answers)
- |    |   |       |
|----|---|-------|
| a. | doesn't know                            | 6.7%  |
| b. | protein rich in iron (eggs, fish, meat) | 66.7% |
| c. | leafy green vegetables, rich in iron    | 72.7% |
| d. | other (specify)                         | 6.7%  |
48. How much weight should a woman gain during pregnancy? (N=151)
- |    |                     |       |
|----|---------------------|-------|
| a. | 16-12 kilos         | 5.3%  |
| b. | gain weight of baby | 4.0%  |
| c. | doesn't know        | 82.1% |
| d. | other (specify)     | 8.6%  |
49. When you were pregnant with CHILD did you visit any health site (dispensary/health center, aid post) for pregnancy/prenatal care? (N=151)
- |    |     |       |
|----|-----|-------|
| a. | yes | 92.1% |
| b. | no  | 7.9%  |
50. During CHILD'6 pregnancy, was the amount of food you ate (N=152)  
(read the choice to the mother)
- |    |                  |       |
|----|------------------|-------|
| a. | more than usual? | 20.4% |
| b. | same as usual?   | 14.5% |
| c. | less than usual? | 64.5% |
| d. | doesn't know     | 0.7%  |
51. At the delivery of CHILD, who tied and cut the cord? (N=276)
- |    |                             |       |
|----|-----------------------------|-------|
| a. | yourself                    | 19.6% |
| b. | family member               | 14.5% |
| c. | traditional birth attendant | 5.8%  |

- |            |  |       |
|------------|--|-------|
| d.         | health professional (physician, nurse<br>or midwife)                         | 55.1% |
| e.         | other (specify)  | 3.6%  |
| f.         | doesn't know   | 1.1%  |
| <b>52.</b> | <b>What is malaria? (N=270)</b>  |       |
| a          | it is a disease (dangerous disease)  | 9.3%  |
| b:         | it is fever  | 59.3% |
| c.         | it is body pain  | 34.1% |
| d.         | other wrong answers  | 9.6%  |
| <b>53.</b> | <b>Is malaria dangerous to children? (N=275)</b>                             |       |
| a.         | <b>yes</b>   | 96.4% |
| b.         | no   | 1.5%  |
| c.         | I don't know   | 1.8%  |
| <b>54.</b> | <b>What causes malaria? (N=262)</b>  |       |
| a.         | mosquito bite  | 57.3% |
| b.         | hard work in the sun   | 11.5% |
| c.         | headache   | 3.1%  |
| d.         | rainfall   | 5.0%  |
| e.         | other wrong <b>answers</b>   | 30.2% |
| <b>55.</b> | <b>Mention the ways you use to prevent malaria? (N=258)</b>                  |       |
| a.         | burning cowdungs   | 37.6% |
| b.         | burning chiguduli (rice bag strings<br>which repels mosquitoes)              | 20.5% |
| c.         | cutting grass short around houses  | 20.5% |
| d.         | keeping surrounding free from stagnant<br>water                              | 11.6% |
| e.         | bednets  | 2.3%  |
| f.         | other right answers  | 18.6% |
| g.         | other wrong answers  | 24.0% |
| <b>56.</b> | <b>What do you do for children just recovering from malaria?<br/>(N=268)</b> |       |
| a.         | give them extra foods  | 54.1% |
| b.         | give them plenty of vegetables/fruits  | 29.5% |
| c.         | breastfeed them frequently (if suckling)                                     | 17.5% |
| d.         | other right answers  | 6.7%  |
| e.         | other wrong answers  | 20.8% |

# Appendix E: Pipeline Analysis