

World Vision Relief & Development, Inc

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WVRD/Malawi FY93
FINAL EVALUATION REPORT
KABUDULA CHILD SURVIVAL PROJECT
LILONGWE DISTRICT, MALAWI
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ACRONYMS

ADRA	Adventist Development and Relief Agency
CBD	Community-based Distribution
CBDA	Community-based Distribution Agent
CDA	Community Development Assistant
CIDA	Canadian International Development Agency
CHAM	Christian Hospital Association of Malawi
c s	Child Survival
CSSP	Child Survival Support Program
DHO	District Health Office
EOP	End of Project
EHA	Environmental Health Assistant
EPI	Expanded Program on Immunization
GM	Growth Monitoring
HIS	Health Information System
HP	Health Promoter
HSA	Health Surveillance Assistant
IGA	Income Generating Activity
JHU	Johns Hopkins University
KPC	Knowledge, Practice and Coverage
KCSP	Kabudula Child Survival Project
KRH	Kabudula Rural Hospital
MOH	Ministry of Health
NFWCM	National Family Welfare Council of Malawi
NGO	Non-governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PM	Project Manager
PVO	Private Voluntary Organization
SCF	Save the Children Foundation
TBA	Traditional Birth Attendant
TSC	Technical Services Coordinator
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
VHV	Village Health Volunteer
WFP	World Food Program
WV/M	World Vision/Malawi
WVRD	World Vision Relief and Development

EXECUTIVE SUMMARY

An end-of-project (EOP) evaluation of the World Vision Kabudula Child Survival project in Malawi was conducted September 2-13 by a six-person team. The team consisted of Dr. Gordon Buhler, team leader; Dr. Beatrice Mtimuni, Head of Human Nutrition Department, University of Malawi; Mrs. Priscilla Masepuka, Family Planning Manager, MOH/GOM; Mr. Genner Chipwaila, Project Manager, International Eye Foundation, Malawi; Ms. Anne Henderson, Health Manager, WVRD, Southern Africa; Mrs. Regina Mandele, Senior Nutritionist, WV Malawi; Mr. Kibble Ngalauka, CS Project Manager, Kabudula. The report was drafted on site and reviewed by team members before revision to final form. The team briefed USAID in Lilongwe and WV Malawi management in Blantyre at the end of the evaluation visit. The project has been granted a one-year no-cost extension for FY97.

A 30-cluster knowledge, practice and coverage survey (KPC) was done prior to the arrival of the evaluation team. During the evaluation visit, interviews and discussions with CS project staff, volunteers, community leaders, clients and representatives of collaborating organizations were carried out. Project records were reviewed, observations of activities made and referral sites visited.

Highlights of project achievement were: Immunization coverage among 12-23 month old children (89.4% for DPT3, 87% for measles) exceeded targeted levels. Among mothers of children age 0-23 months, 76.7% had received TT2, just short of the 80% targeted. Remarkable achievement in maternal care took place with 40.8% of women not wishing to have a child in the next two years using a modern contraceptive method and 94.6% of mothers reporting at least one ante-natal visit. Control of diarrheal disease objectives were not all achieved. Continued feeding was targeted for 85% of mothers but only 55.9% of those giving solid foods continued to do so during diarrhea and 70.9% of those breast feeding continued to give the same amount or more. Protected wells served 40.3% of the population and 62.3% lived in households with a pit latrine; both outcomes below the objectives, 50% and 85% respectively. HIV interventions were primarily implemented through school-based anti-AIDS clubs and this population was not surveyed. Qualitative evidence suggests that discussion of the topic is more open among this group as well as among mothers surveyed. Of the latter, 48.3% reported discussing HIV/AIDS with their husband/partner, less than the 65% target but considerable improvement in a difficult area.

Outputs increased substantially in all interventions over the life of the project. Children weighed went from 10,279 in year one to 40,833 in year three; Vitamin A capsule distribution from 1,500 in year one to 11,789 in year three. Antenatal care visits fell from 811 in year one to 548 in year two and back up to 942 in the final year. These apparent changes may be due, in part, to more complete reporting as the project matured.

This project has shown particular strength in two areas: service delivery interventions such as immunization and antenatal care, and collaboration with government and other institutions. It is less clear that information, education and communication interventions were as effective. There is potential for sustainability in the strong relationships developed with community leaders and DHO management. Valuable referral patterns are in place with Nkhoma Mission Hospital which supports the Chiwe Health Center in the project area.

Principal recommendations for the extension period are to proceed immediately to transfer the **HSAs** to the DHO while continuing to provide logistic and supervisory support to them (in process at the time of the evaluation); give a motorcycle in good condition to the DHO for supervision when the **HSAs** are employed and a four-wheel drive vehicle at the end of the extension period; make the Project's HIS coordinator available as much as possible to the DHO to develop their HIS; employ an IGA worker to initiate 45 new IGA projects; The importance of maintaining continuous project staffing and leadership and the value of a close working relationship to the DHO from the early planning stage and throughout the project are among the lessons learned.

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

I.A. Project Accomplishments

IA. 1. Accomplishments and Objectives

This project has been in operation since October 1993 when it began as an expansion and continuation of World Vision's Child Survival VI project in the Kabudula area. This is an end-of-project evaluation, however a one year no-cost extension has been approved and funds remain to support continuation of Child Survival activities. Emphasis in this report will be on achievements that appear to be sustainable and potential for strengthened sustainability that can be realized in the remaining extension year.

Accomplishments of the project in terms of the DIP objectives are shown in Table 1. In Table 2 KPC measures of the Key Child Survival Indicators as defined in the Survey Trainer's Guide published by Johns Hopkins University/Child Survival Support Program (CSSP) are shown. Activities and services, as recorded in the HIS, are summarized in Table 3. Reporting of births, deaths and selected diseases is found in Table 4. The activities of the Community Based Distribution Agents (CBDAs) are summarized in Table 5 and Training Activities shown in Appendix F.

The DIP stated five objectives related to Control of Diarrheal Disease: one related to practice, two knowledge-related and one each related to protected wells and latrines. Continued feeding during episodes of diarrhea, which the DIP stated would be practiced by 85% of mothers, was taken to include both breast feeding and giving solid foods. Indicators five and seven in Table 2 estimate achievement of this objective and suggest that it was less than targeted -- 70.1% continued to breast-feed and 55.9% gave the same amount or more solid food. This was virtually the same as the baseline and well short of the 85% objective. ORT use, while not a stated objective of the DIP, was high at 82.6%. The objectives for wells and latrines were not met. Although there has been considerable activity in this sphere, very heavy rains earlier this year caused many of the latrines to collapse. Wells considered "protected" have been lined and have drainage channels to take water away from the well, but are open and use a bucket, sometimes placed on the ground, for drawing water. Further refinement of this component is needed.

Immunization objectives for children were achieved. This achievement must be viewed as one of the most important things done and was much appreciated by community leaders and mothers. The system of outreach clinics, Health Surveillance Assistants (HSAs) and Village Health Volunteers (VHVs) has been the key to promotion and delivery of this service. Other very important functions have grown along with immunization but it remains a core function of the team and a critical element to be sustained. Tetanus toxoid for women did not quite reach the objective set, but with 77% coverage achieved versus 80% targeted this is well on its way to the objective. More focus now needs to be placed on reaching TT5 for all CBA women in addition to immunizing pregnant women.

The project has been very active in HIV/AIDS education through the schools and through the VHVs. The only objective measured was the percent of women in the sample who reported speaking to their

husband/partner about HIV/AIDS. This reached 48.3%, short of the targeted 65%, but is real progress in an area that seems to very sensitive. The survey did not measure knowledge of HIV/AIDS in school children but group interviews and the activity reports of these clubs indicate that there is widespread knowledge of the modes of transmission and means of prevention among the EDZI TOT0 (anti-AIDS) club members, (Report of Anti-AIDS club activities available upon request.)

One of the most outstanding achievements of the project is the acceptance of modern methods of child spacing. The 40.8% use of modern contraceptives exceeded the ambitious target of 30%. This has been accomplished through a collaborative effort using Community Based Distribution Agents (CBDAs) initially trained and supported by National Family Welfare Council of Malawi with further funding made available through JSI/STAFH. Consistent availability of supplies and the couple-counseling done by the CBDAs seem to have been the keys to this remarkable achievement. Clearly, maintaining this level of acceptance will require a continued supply system. Table 5 documents the number of new acceptors each year by method that have been served by the CBDAs.

The objective for antenatal care in the DIP was to have 60% of mothers make at least two visits during the most recent pregnancy according to the card record. However, only 89 of the 249 cards reviewed had spaces for recording antenatal visits. The resulting estimate of 27.3% (82/300) coverage (two visits) is probably significantly lower than actual coverage. Self reporting of at least one visit to a health professional or trained TBA was 94.7% (284/300). This is very much in line with observations of the nurse midwives who state that, while almost all women come for one antenatal check, these single visits often come late in the pregnancy. According to the survey, the cord was cut by a health professional in 52% of deliveries and by a TBA in 18%. Earlier antenatal visits and quality of care need to be addressed in the extension period.

Two objectives were included in the DIP for malaria control, one related to knowledge of preventive measures and one to the distribution and use of impregnated nets. The second was discontinued as it was not feasible in the project area. Knowledge of appropriate preventive action was improved with 56.7% of mothers surveyed able to mention at least one appropriate action, less than the 80% objective stated in the DIP. Also from the survey it should be noted that 90.3% of mothers recognize fever as a sign/symptom of malaria that would cause them to seek treatment and of the 149 mothers whose children had a fever during the previous two weeks, 132 or 89.2% actually sought treatment. Of these, 82 or 62% went to a hospital or health center.

Exclusive breastfeeding during the first four months of life was done by only five percent of mothers at baseline. This rose to 45% by EOP, exceeding the targeted 20%. Breastfeeding is virtually universal in this population but water and other fluids are also generally given, This much change in practice must be viewed as a very successful communication effort.

Outcomes related to the other nutrition objectives showed less change. The percent of mothers who knew when to introduce supplementary foods rose from 38% at baseline to 50.3%, a marginal increase given the confidence limits of the survey and well short of the 75% targeted. Knowledge of at least two sources of vitamin A was reported by 62.3% of the sample, a considerable improvement over the 30% baseline figure, but again short of the targeted 75%.

In summary it seems fair to say that delivery of immunization and maternal care has been very successful, The outstanding achievement is the use of a modern contraceptive method by 40% of the mothers surveyed. ORT has been successfully promoted, but other messages related to CDD not as widely accepted. Refinement in the implementation of water and sanitation interventions is needed. Efforts in HIV/AIDS have raised awareness of the issue and brought it to the point of open discussion in schools and, to some extent, at home. However this intervention was not thoroughly assessed, nor were the malaria interventions, Prompt treatment seems to be the best line of defense against this disease in Malawi and more widespread access to medications and training of outreach personnel is a continuing need. Nutrition education has effectively improved the level of exclusive breast feeding, but other targets in this area were not reached. Service delivery has been the strength of the project, communication apparently somewhat less effective.

Table 1
DIP Objectives and Achievements

<u>Objective</u>	<u>Indicator</u>	<u>Baseline</u>	<u>Target</u>	<u>EOP Achievement</u>
CDD 1.	Percent of mothers who continue feeding during child's acute episodes of diarrhea from 66% to 85% by 1996.	66%	85%	Measured by KPC key indicators #5 and #7 in Table 2
CDD 2.	Percent of mothers who did <u>not</u> know what to do during recovery of child with diarrhea from 30% to 10% by 1996	28%	10%	61300 = 2.0%
CDD 3	Percent of mothers who mentioned that blood in the stool would cause them to seek advice or treatment.	3.1%	50%	91/300 = 30.3%
CDD 4.	Percent of households whose main source of drinking water was a protected source.	15%	50%	44 boreholes + 77 protected wells 121/300 = 40.3%
CDD 5.	Percent of households with pit latrines.	70%	85%	187/300 = 62.3%
IMM 1.	Percent of children 12 to 23 months of age who have had measles vaccine.	70%	85%	107/123 = 87.0%
IMM 2.	Percent of children 12 to 23 months of age who had completed the immunization series.	70%	85%	110/123 = 89.4%
IMM 3	Percent of mothers of children age 0-23 months who had received at least two doses of tetanus toxoid.	74	80%	230/300 = 76.7%

<u>Objective</u>	<u>Indicator</u>	<u>Baseline</u>	<u>Target</u>	<u>EOP Achievement</u>
HIV 1.	Percent of mothers who reported discussing matters related to HIV/AIDS with their husband/partner.	39%	65%	145/300 = 48.3%
HIV 2.	Percent of school age children (9- 14 years) able to list at least two modes of HIV transmission.		30%	Not measured. Please see attached report of Anti-AIDS clubs.
Maternal Care 1.	Percent of mothers not wanting more children in the next two years using a modern method of child spacing 1996.	3%	30%	96/235 = 40.8%
Maternal Care 2. (Card based)	Percent of women who had two or more attendances by a health professional or trained TBA during their most recent pregnancy.	N/A	60%	Not adequately measured since only 89 of the 249 cards seen had space to record ante-natal visits
Maternal Care 2. (Self report)	Percent of mothers (of children 0-23 months) who had at least one visit to a health professional or trained TBA during their most recent pregnancy.			284/300= 94.6% This finding suggests that the DIP objective was substantially met
Malaria 1.	Percent of mothers who mentioned at least one appropriate action to prevent malaria.	40%	80%	170/300 = 56.7%
Nutrition 1.	Percent of children 0-3 months of age who were exclusively breast-fed.	5%	20%	20/44 = 45%
Nutrition 2.	Percent of mothers who stated that supplementary foods should be introduced when a child is 4-6 months of age.	38%	75%	151/300 = 50.3%
Nutrition 3	Percent of mothers who could name at least two food sources of Vitamin A.	30%	75%	187/300 = 62.3%

* DPT3 was used as a proxy for completion rather than OPV3 since DPT3, in short supply at times, was considered the limiting factor.

Table 2
Key Child Survival Indicators

No	<u>Indicator</u>	<u>Target</u>	<u>EOP</u> <u>Achievement</u>
1	Appropriate Infant Feeding Practices: Initiation of Breastfeeding. Percent of children (less than 24 months) who were breast-fed within 8 hours of birth.		2701300 = 90.0%
2	Appropriate Infant Feeding Practices: Exclusive Breastfeeding. Percent of infants less than four months who are being given only breast milk.	20%	20144 = 45.4%
3	Appropriate Infant Feeding Practices: Introduction of Foods. Percent of infants between 6 and 10 months who are being given solid or semi-solid foods.		75/78 = 96.1%
4	Appropriate Infant Feeding Practices: Persistence of Breastfeeding. Percent of children between 20 and 24 months who are still breastfeeding.		35143 = 81.4%
5	Management of Diarrheal Diseases: Continued Breastfeeding. Percent of children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more breast milk.	85%	78/110 = 70.9%
6	Management of Diarrheal Diseases: Continued Fluids. Percent of children (less than 24 months) with diarrhea in the past two weeks who were given the same or more fluids other than breast milk.		76/107 = 71.0%
7	Management of Diarrheal Diseases: Continued Foods. Percent of children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more food.	85%	571102 = 55.9%
8	Management of Diarrheal Diseases: ORT Usage. Percent of children (less than 24 months) with diarrhea in the past two weeks who were treated with ORT.		95/115 = 82.6%
9	Pneumonia Control: Medical Treatment.		This intervention was not part of the project
10	Immunization Coverage (Card): EPI Access. Percent of children age 12 to 23 months who received DPT1.		117/123 = 95.1%
11	Immunization Coverage (Card): EPI Coverage. Percent of children 12 to 23 months who received DPT3*.	85%	110/123 = 89.4%

No	Indicator	Target	EOP Achievement
12	Immunization Coverage (Card): Measles Coverage. Percent of children 12 to 23 months who received measles vaccine.	85%	107/123 = 87.0%
13	Immunization Coverage (Card): Drop Out Rate. Percent of 'drop-outs' between DPT 1 and DPT3.		(117-110)/117 = 6.0%
14	Maternal Care: Maternal card. Percent of mothers with a maternal card.		2491300 = 83.0%
15	Maternal Care: Tetanus Toxoid Coverage (Card). Percent of mothers who received two doses of tetanus toxoid vaccine (card).	80%	230/300 = 76.7%
16	Maternal Care: One or More Ante-Natal Visits (Self Report**). Percent of mothers who had at least one prenatal visit prior to the birth of the child.		2841300 = 94.6%
17	Maternal Care: Modern Contraceptive Usage. Percent of mothers who desire no more children in the next two years, or are not sure. who are using a modern contraceptive method.	30%	961235 = 40.8%

* DPT3 was used as a proxy for completion rather than OPV3 since DPT3 was in short supply at times, making this vaccine the limiting factor in completing the series.

** Most maternal cards did not have a space to record ante-natal visits hence this indicator is self report data.

Table
Activities Reported for the Period of
October 1993 to August 1996

<u>Activities and Services</u>	<u>Number of Clients Served</u>		
	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
<u>Immunizations</u>			
Measles (0-23mos.)	1070	2154	1747
DPT1 (0-23mos.)	279	1508	1748
DPT3 (0-23mos.)	1188*	1444	2051
Polio 1 (0-23mos.)	283	1833	1601
Polio 3 (0-23mos.)	1204*	2113	1811
BCG (0-23mos.)	405	1344	1214
TT2-Pregnant women	38	194	226
TT3-Pregnant women	29	180	253
TT4-Pregnant women	40	114	183
TT5-Pregnant women	43	128	141
TT2-nonpregnant women	175	551	443
TT3-Nonpregnant women	227	698	470
TT4-Nonpregnant women	127	444	329
TT5-Nonpregnant women	257	383	373
<u>Antenatal</u>			
Pregnant women at any ANC	811	548	942
<u>Child Spacing</u> (Done at the outreach clinics. Please see Table 4 for CBDA activity.)			
Pill-new clients	175	90	107
Condom-new clients	99	0	1
Injection-new clients	185	499	307

* The excess of DPT3 and OPV3 over DPT1 and OPV1 is due to the emphasis on recording only the completⁿ of a series during the initial phase of the project; this was later corrected in HIS.

Table 3 - Continued

<u>Activity</u>	<u>Number of Clients Served</u>		
	<u>Year</u>	<u>Year</u>	<u>Year</u>
<u>Growth Monitoring</u>			
Children weighed	10279	39266	40833
Children with normal weight	7537	27603	29588
Children receiving Vit.A capsules	1500	10207	11789
<u>Education</u>			
Maternal Nutrition	2024	5715	4705
Exclusive Breastfeeding	3266	8486	7348
Nutrition (food groups)	1828	10481	13513
Child Spacing-men	308	1421	1217
Child Spacing-women	2024	7879	9928
Malaria	2757	7398	8164
Diarrhoea	3645	8693	10440
HIV/AIDS	1161	10277	5142
Sanitation	2472	11486	11641
Immunization	1233	7461	7007

Table 4
Reporting of Selected Diseases, Births and Deaths

<u>Disease Cases</u>			
AIDS	0	5	4
Malnutrition	410	3766	1449
Malaria	3002	3600	2815
Diarrhea	491	1361	1009
Measles	22	7	30
<u>Births</u>	69	349	693
<u>Deaths (total)</u>	42	155	163
Under Five	17	90	95

Five and above	25	65	68
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Table 5
Activities of Community Based Distribution Agents

<u>Activity</u>	<u>Number of Clients Served</u>		
	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
Overette Pill	0	32	16
Lofeminal Pill	0	91	46
Condom	0	157	83
Foam Tablets	0	17	3
<u>Reason for Referral</u>	<u>Number of Clients Referred by CBDAs</u>		
Pelvic Examination	0	144	67
Invasive Methods - Tubal Ligation, Norplant, Depoprovera and Vasectomy	0	246	178
Side Effects	0	28	35
<u>Voluntary Surgical Contraception Done by Nkhoma Mission Hospital</u>			
Tubal Ligation	0	84	40
Norplant	0	22	4
Vasectomy	0	1	0

Tables 3, 4 and 5 above are summaries of the data collected through the HIS. Records of community and outreach clinic activities in Table 3 seem to be quite complete, particularly after mid term. The dramatic increase between year one and year two in the number of clients probably reflects both more complete reporting and enhanced service delivery as the project got underway. Table 5 shows the activities of the CBDAs which began in the second year of the project. These records are congruent with the survey finding that 40.8% of women who do not wish to have a child in the next two years are using a modern contraceptive method.

Table 4 is an attempt to record surveillance data, however completeness should probably be questioned, since the number of births and deaths is obviously incomplete. The population census done by the project in year two found approximately 2000 infants born within a one year period while only 69, 349 and 693 in years one, two and three respectively were recorded. Annual surveys have been the primary measures of achievement rather than a focus on a community level record keeping system. Nonetheless, this HIS has potential for leading the way toward stronger data collection in the District.

Appendix F summarizes training activities. It should be noted that the project has used DHO personnel in much of its training and, in turn, has actively participated in curriculum development with the DHO's office and other agencies.

I.A.2. Unintended effects

Some of the positive unanticipated effects of the project include:

The synergy created by the Community Based Distribution system for child spacing promotion and distribution of contraceptives has enhanced both of these projects' effectiveness. The initiative of the project management and the involvement of the HSAs in CBD substantially enhanced the CS project's efforts to promote child spacing. Collaboration with the National Family Welfare Council of Malawi (NFWCM) and JSI/STAFH has led to new funding for WV/M activities in the project area and demonstrated the effectiveness of using HSAs to supervise the CBDAs.

The anti-AIDS initiative, EDZI TOTO, has been made possible by the management and logistical support of the CS project again done in collaboration, in this case, with UNICEF.

The acceptance of Child Spacing was not unintended, but the degree to which it was accepted went far beyond anyone's expectations.

Because of its local contacts and expertise in the organization, WV/M was requested by World Food Program (WFP) to do a soy flour utilization trial in the project area. There was apparently quite a high level of acceptance of the soy products which led to introducing soy beans as a crop for local consumption, a successful income generation activity.

Another example of successful collaboration is the arrangement made on the recommendation of the DHO for placement of a United Nations Development Program (UNDP) volunteer through the World Food Program WFP to work as a Food Security Mobilizer in the project area.

There were also a number of unanticipated obstacles to implementation that bear on the effectiveness of the project. Some of these include:

Despite intensified implementation efforts, the number of households with pit latrines decreased due to unusually heavy rains in early 1996 washing away pits and destroying the latrines.

Malawi experienced inflation and devaluation of its currency, the Kwacha. For example, the budget for bore hole wells was \$5,000 per year. By year three this was only enough to rehabilitate one bore hole whereas in the first year it could have done four or five.

Key personnel became ill or died. The Project Manager who began the project died before

the mid term and a Community Health Coordinator who had worked for only three months was released for medical reasons and subsequently died. Both of these events unsettled project operations for some time afterward. Delays in replacing these people and in hiring nurses were unintended but might have been reduced with more expeditious recruiting.

I.A.3. The Final Evaluation KPC Survey Report is attached. A summary of key Child Survival indicators is included in Table 2 above.

I.B. Project Expenditures

The pipeline budget as of July 31, 1996 is attached in Appendix C. As of that date, actual expenditures for direct costs in the budget totaled \$460,798 out of a budget of \$591,653. It was projected that by the end of September 1996, a total of approximately \$120,000 would remain for the project extension until September, 1997.

Underspending (approximately 20%) occurred in the personnel line item which includes salaries, wages and benefits. The main reason for this variance is that salaries budgeted are almost double the amount the staff actually receive. The project has made an effort to offer salaries which are comparable to those received by counterpart MOH staff to avoid disparity between NGO and government positions. WV Malawi, which has numerous projects in operation, has a standard compensation policy based on grade and applied to all projects. The project activities are supported by 172 village volunteers, working without salary while significantly extending the outreach and impact of the project.

The travel/per diem line item has been overspent (by approximately 90%) with actual expenditures of \$89,612 at the end of July 1996 as compared to a total project budget of \$47,650. The factors contributing to over expenditure on this line item include: 1)300% inflation in the price of fuel which is expected to continue to rise; 2) The oldest vehicle in the project has required numerous repairs and maintenance. The roads to the project site are in bad condition and cause much "wear and tear" on the vehicles. Repair of vehicles in Malawi is very expensive as most car parts must be imported. The original budget planned for the use of only one vehicle, but the project has two vehicles in operation to facilitate the rather difficult logistics of the area and ensure that at least one is roadworthy at all times.

Underspending (approximately 50%) also occurred in the consultant line item with actual expenditures for the three year project period being approximately \$30,000 as compared to the budgeted \$70,742. The most significant reason for the underspending is that all training was done by locally available consultants who were able to be hired at a much lower rate. The project originally planned to bring in an external consultant for quality assessment, but was able instead to send the project manager to a two week course to learn key principles of quality assurance.

The procurement line item, including supplies, equipment and training, was spent very nearly as planned. Expenditures for procurement at the end of July 1996 were \$13 1,473 as compared to the budgeted \$141,830.

Other direct costs, including communications, facilities and income generating activities, were underspent (by approximately 50%) with actual expenditures at the end of July 1996 totaling \$38,251 as compared to the budgeted \$94,093. During the remaining extension period, plans call for more intensive IGA activities which will bring this expenditure into line with the budget.

The grant accountant who provides 50% of his time monitoring the Child Survival grant was able to very adequately explain and provide records of the monthly tracking system used to monitor project expenditures. The grant accountant has undergone regional training within WV on the management and monitoring of USAID field grant requirements and has regular contact with WVRD's grant accountant based in Washington, DC. A monthly meeting is held between the grant accountant and the project manager to review and discuss monthly expenditures and management of remaining grant funds.

The grant accountant and project manager have initiated discussions for planning the budget for the one-year no-cost extension to begin in October 1996. Plans are to spend less money on salaries as the DHO absorbs the salaries for HSAs presently employed by the project. Some of the conserved resources will be spent on the strengthening and expansion of IGA activities and water and sanitation interventions.

I.C. Lessons Learned

1. Coordinate, at the planning stage, with involved government offices in order to facilitate transfer of project operations to them at the end. Formalize a written agreement which defines responsibilities of the NGO and the government and the time line for activities. Continue an active dialogue with district level health team and project area representatives throughout the project cycle (quarterly meetings).

2. Active participation in coordinating efforts with donors, other implementing agencies and technical support groups enables the PVO to take advantage of opportunities and cooperate with initiatives that enhance CS effectiveness (i.e., the anti-AIDS club and community-based distribution of contraceptives). Learn from other organizations and supplement project activities with their programs.

3. It is important to listen to the community's definition of its own problems, recognize the value of its understanding and encourage them to take responsibility for finding solutions. For example, in talking with women, staff learned that malnutrition often seen among toddlers is called "tsempho", a term which refers to the father's infidelity. This often occurs after tobacco harvest when the father leaves for the city with the money earned at harvest to spend it on other women. The community identified the problem, defined it in their terms and is searching for their own solutions.

4. Beware of creating a "Santa Claus" image through such things as giving feasts; rather let the staff accept the hospitality and contributions of the communities and share their skills and energy with the community.

5. Communication/education is of vital importance. Delivering services is essential, but for true change at the community level, take time to listen and inform. The deadlines of a rigid plan of action sometimes make the pressure to short circuit this process irresistible. The result is too often miscommunication and lost opportunity.

6. CS objectives are specific and limit activities within a project. Where communities express needs outside these objectives such as literacy education, the PVO needs to be able to marshal other resources and establish linkages to meet expressed needs with other programs coordinated with CS interventions. This project has done particularly well in this respect by obtaining supplementary resources for HIV/AIDS education and linking with the Community-Based Distribution program for child spacing.

7. The level of community involvement in decision making about interventions which require their resources and changes in their practices is much higher than for interventions that primarily deliver services to them. For example, pit latrine construction had been quite slow until mid-term when a concerted effort was begun to consult with community leaders to gain their support. This took the form of discussion with communities in which project management gave community leaders more insight into the progress of the project and sought their advice on how to address areas where there had been little progress. Following these discussions, more construction was done in three months than in the previous year. Immunization and antenatal care, on the other hand depended more on making the services acceptable and available.

8. It is necessary to focus the health education messages to be conveyed by the HSAs, VHVs and TBAs and monitor their reception and uptake in the community. For example, HSAs should check households (randomly) to verify what messages have been understood by mothers in regard to diarrhea management, breastfeeding, etc. Interviews with these workers suggest good general knowledge about these interventions but somewhat vague expressions of the health messages to be delivered.

9. Having a Health Manager at the national office level of WV/M gives valuable coordination and communication to the project, enabling personnel and projects to share their learning, technical assistance, and providing liaison with other offices of World Vision and WVRD.

10. Filling staff positions, particularly leadership roles is critically important to a CS project with its time-bound objectives. Personnel recruitment procedures need to facilitate this process. The project went for seven months without a Project manager and had a full complement of three nurses for only about three months of the 36 months it was in operation. Recruitment is not easy for these positions but some solution needs to be found, perhaps the use of temporary/contract people for the interim until permanent staff can be recruited.

II. PROJECT SUSTAINABILITY

II.A. Community Participation

Delivery of preventive health services has been the primary focus of this project. Training and communication have supported and enhanced these services. The community's role in these activities has been both that of beneficiary as well as a source of support. They have contributed materially to some of the project's work, especially the IGA activities and the soya bean production effort, and have actively participated in service delivery and communication through the TBAs and VHV's. These volunteers have been responsible for assisting at outreach clinics, following up to encourage completion of immunization series, growth monitoring and visiting homes to communicate health messages.

The communities have also contributed to construction projects by providing labor, bricks and sand. The estimated value of these is \$4,200 for building outreach clinics, \$677 for construction of poultry enclosures as part of the IGA component, and \$2,240 for protection of shallow wells. These contributions represent significant effort on the part of the client communities but also demonstrate the limited capacity of these communities to carry on this type of project without external assistance.

II.B. NGOs

The principal NGO with which the project has collaborated is the Nkhoma Mission Hospital (NMH) through an arrangement whereby WV/M built a Health Center (HC) at Chiwe and NMH provides medicines, supervision, referral services and staff salaries paid through the Christian Hospital Association of Malawi (CHAM) with funds from the MOH. Referral is effective for cases that do not require immediate attention but transport is difficult to arrange and quite expensive for most of the rural population. This center was opened in December 1995 and is staffed by a Medical Assistant, one full time nurse and a second nurse from Nkhoma on a rotating basis. A project HSA and a Health Promoter are also based there and will continue when the HSAs become DHO personnel. The HC personnel provide services only on site and are not involved in the outreach activities nor are they prepared to assume responsibility for them as the CS project is concluded. These activities will become the responsibility of the DHO as WV/CS activities are phased over to them. NMH has been particularly valuable to the people of the project area in providing surgical referral services including referrals from the CBDAs for tubal ligations and Norplant insertion, This service will continue to be available.

The CSP has developed relationships with a number of programs which are synergistic to the Child Survival activities and are supported by other organizations which, while they are not NGOs, are effective partners of World Vision and are committed to supporting health activities beyond the project time frame. These will be described here although they are funded by governments:

- ▶ John Snow International (JSI) through its Support To AIDS and Family Health (STAFH) acts as a contractor to USAID, supporting PVOs in their child spacing and STD control activities. World Vision has received a grant from STAFH for \$8 1,504 to which they have added an in-

kind contribution valued at \$79,963. This grant is to support the training of CBDAs and their HSA supervisors in the Kabudula area. The project is scheduled to operate until June 1998.

- ▶ The National Family Welfare Council of Malawi (NFWCM) has provided trainers and a budget of \$3,000 to train CBDAs and, through the Technical Services Coordinator (TSC), to monitor their activities in the Kabudula area.
- ▶ UNICEF has committed \$4,800 to support the anti-AIDS clubs through June 1998. This provides teaching materials and some support for club activities. UNICEF has also supplied tee shirts and footballs to the clubs.
- ▶ A proposal has been submitted to the Micronutrients and Health (MICAH) project, presented by WV/Canada, a contractor to the Canadian International Development Agency (CIDA). This will fund a fortification and supplementation project with \$134,000 to benefit the Kabudula area and beyond.

The CSP staff have also had regular contact with Save the Children Foundation (SCF), Project HOPE, International Eye Foundation and the Adventist Development and Relief Agency (ADRA), all of whom are currently operating CS initiatives in Malawi. There is a bi-monthly coordination meeting between these groups. WV/CSP staff have also participated in two CSSP workshops hosted by SCF-US/Malawi on malaria interventions and pneumonia case management, where these other organizations were present as well.

II.C. Ability and Willingness of Counterpart Institutions to Sustain Activities

This project was conceived and designed to be compatible with the MOH patterns of staffing and services. The HSAs have been trained by MOH trainers as have the VHVs. The principal contacts for collaboration have been the DHO and the staff of the KRH. Changes in leadership at the office of the DHO and at KCSP have created discontinuity in collaboration at times but the present working relationship at the management level appears to be excellent.

Kabudula Rural Hospital (KRH) is seriously understaffed with only seven of its 13 listed positions actually filled. This leaves virtually no time free for staff to actively engage in outreach supervision. The Environmental Health Assistant who has overall responsibility for preventive services is unable to take direct responsibility for supervising the HSAs and the post of Health Assistant, who would normally have direct responsibility for the HSAs, is vacant. When the staff at KRH was asked how they would sustain the project's activities, one of the nurses responded candidly: "We will be in trouble." The Kabudula Traditional Authority's assessment was that activities will continue but at a less intense level. Clearly staffing levels at KRH are not currently adequate to supervise project activities. Hopefully they may be at the end of the extension period. It is also clear that curative services both at KRH and Chiwe Health Center will continue to absorb all resources available for some time to come.

MOH representatives are more confident of their ability to sustain activities provided they are given

a four-wheel drive vehicle, a motorcycle and bicycles to provide logistic support. Their willingness is apparent as is that of the project management to collaborate in the transfer of responsibilities to the DHO and KRH. The vehicle previously transferred to the DHO for KRH was used by the Central Hospital in Lilongwe until it broke down and has been out of service now for more than a year. The DHO has assured WV that when the next vehicle is handed over it will be used at Kabudula. The most positive aspect of the transfer of resources and responsibilities to the DHO is the openness of communication between that office and the KCSP management. Section 11.D. below details the steps to be taken in this transfer.

11.D. Sustainability Plan, Objectives, Steps Taken, and Outcomes

With the exception of objective six below, all sustainability objectives are focused on the counterpart's (MOH) ability to sustain activities. This is unquestionably important, However more attention to institutionalizing health practices in the areas of nutrition, family planning, diarrheal disease control when establishing sustainability objectives could be expected to focus more project energy and resources on strengthening health care at the household and community level. The acceptance of the CBDAs and the apparent success of their work illustrates the potential for more focus on the community while continuing to support the clinical health care system. Table 6 includes the objectives for sustainability from the DIP, the steps to be taken as outlined in the Midterm Evaluation Report, a summary of follow-up activities done since the midterm and steps recommended for the extension period.

Table 6
Sustainability Objectives

<u>End of project objective</u>	<u>Steps needed identified at midterm</u>	<u>Steps taken since midterm</u>	<u>Steps needed during extension</u>
<p>1. The current compliment of 14 project HSAs will be functioning and fully integrated in the MOH system.</p>	<p>1. Formalize an agreement with DHO including the date at which HSAs will become formal employees of MOH</p>	<p>Two day workshop (Feb. 96) at project site held with DHO where agreement was made to employ 14 HSAs plus 14 HPs to be trained by WV from June 1996. The DHO received approval for this agreement from the MOH in Aug. 96.</p> <p>EOP Evaluation team meeting (9/96) with DHO agreed that the MOH will now accept applications from all trained HSAs (request made for 21 positions) and from those employed as HPs (still waiting to be trained as HSAs) who meet the academic qualifications.</p>	<p>Submit applications of HSAs and HPs to DHO personnel officer and continue to negotiate with the Principal Environmental Officer.</p> <p>Enroll academically qualified HPs in HSA training.</p> <p>Prepare a memo of understanding to the Deputy DHO regarding discussions and verbal agreements of 9/9/96.</p>

<p>2. The 14 project Health Promoters will be trained as HSAs and will be integrated into the MOH system.</p>	<p>2a. Arrange as soon as possible that the current health promoters are trained. 2b. Formalize with DHO the transfer to MOH, as above.</p>	<p>Applications were submitted to the DHO during the evaluation with an agreement to take the 14 HSAs who have been trained by the MOH on staff within the next quarter and to review and process the applications of the HPs, taking those who are suitably qualified for training.</p>	<p>Continue to work with the DHO on this aspect of the transition.</p>
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<p>3. An experienced HSA supervisor who will assure the continued quality of the basic functions of the HSAs will be based in Kabudula Rural Hospital, and work with the Environmental Health Assistant (EHA) within the MOH system.</p>	<p>3a. Identify and train a senior HSA supervisor immediately to work with the KRH EHA.</p> <p>3b. Within the next six months, base the senior HSA supervisor at KRH.</p> <p>3c. Formalize an agreement with the DHO to hire the Senior HSA within the MOH system by October 1, 1995 at the latest.</p> <p>3d. Assure that a good quality motorcycle is left for use by the Senior HSA in his supervision.</p> <p>3e. Solicit the commitment of the DHO to provide for fuel and maintenance of the motorcycle.</p>	<p>3a, b & c. Senior HSA was trained as a supervisor and begin supervising HSAs based out of the CS project office but in collaboration with the KRH EHA. (The senior HSA will be unable to supervise other HSAs within the MOH system as only Health Assistants are qualified to carry out this role.)</p> <p>3d. Motorcycle has been purchased and is in use by project manager based at the Kabudula CSP office.</p> <p>3e. The DHO will assume responsibility for the fuel and maintenance of the motorcycle once it is registered with the DHO.</p>	<p>3a, b & c. DHO has agreed to employ the senior HSA (now a supervisor) but only at the level of an HSA. In order for a senior HSA to become a supervisor they must receive training to be upgraded to a Health Assistant level. The project senior HSA will need to apply for an HSA position with the DHO. Continue dialogue with DHO regarding child survival activities and between the Community Health Coordinator and the DHO Health Assistant to follow up supervision of HSAs.</p> <p>3d. Motorcycle will be given to the EHA at KRH for use in HSA supervision activities when the DHO has employed the HSAs (plans are for 10/96).</p> <p>3e. When the motorcycle has been handed over to the DHO, WV/CS will provide an agreed upon amount of fuel each month until Sept. 1997. Maintenance will be the responsibility of the DHO.</p>
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<p>4. Nkhoma Mission Hospital (NMH) will assume responsibility for Chiwe Health Center.</p>	<p>4a. Hold joint meetings with NMH staff and produce a timetable for phase over of functions and staff during the final year of the project. October 1, 1996, or before should be the target date for transfer of all staff to their new agencies.</p>	<p>4a. Phase over has been completed (Nov. 1995) and the Chiwe Health Center is now the responsibility of the NMH and is fully operational. Salaries, medicines, supervision, etc are provided by NMH. The center serves as a project base for the HSAs serving in the area.</p>	<p>4a. Completed - no further interventions required.</p>
<p>5. DHO staff will be trained in the elements of KCSP's HIS.</p>	<p>5a. Project HIS coordinator and DHO should jointly determine the data management and training needs of the DHO. 5b. KCSP should release HIS officer from some of his duties for a limited period; he should provide training of DHO staff in establishing and using a computerized district HIS.</p>	<p>5a. Duties within WV/M have kept the HIS Coordinator from spending time with the DHO.</p>	<p>5a. During the extension period, the HIS coordinator will be made available to the CS project full time and will spend as much time as his CS responsibilities permit with the DHO's office collaborating on the development and use of their HIS.</p>
<p>6. Four additional self-sustaining income generating activity groups will be established.</p>	<p>6a. The project and MOA staff should identify four more villages committed to establishing IGAs, and provide training and management assistance to establish the groups.</p>	<p>6a. Four more villages have been identified. IGAs have been established in each of them and appear to be functioning well.</p>	<p>6a. Employ a trained IGA worker to train village volunteer groups to initiate at least 45 new community IGA projects (40 new soya bean production groups, 4 new poultry groups, one new piggery) and strengthen the existing soya bean (50 groups) and poultry (4 groups) projects by Sept. 97.</p>

III. EVALUATION TEAM

1III.A. Members of the final evaluation team were:

Dr. Gordon Buhler, Team Leader, Independent consultant
Dr. Beatrice Mtimuni, Head of Human Nutrition Department, University of Malawi;
Mrs. Priscilla Masepuka, Family Planning Manager, MOWGOM;
Mr. Genner Chipwaila, Project Manager, International Eye Foundation, Malawi;
Ms. Anne Henderson, Health Manager, WVRD, Southern Africa;
Mrs. Regina Mandele, Senior Nutritionist, WV Malawi;
Mr. Kibble Ngalauka, CS Project Manager, Kabudula.

Documents outlining the evaluation process are included in Appendix A. Field notes which provide a record of interviews and observations are in Appendix B.

APPENDIX A

Evaluation Planning Worksheet

Schedule

Interview Guides

INFORMATION NEEDS WORKSHEET

Sec.	Information needed	Sources	Method	Tables to construct	Draft
I.A.	KPC results Service and activities Issues ? ? ? ?	KPC report Project records	Document review	1. Project Objectives and Achievements 2. Project Activities and Services Others?	GB KN
	Unintended + & - of project activity	Eval. team	Daily and wrap-up discuss.	none	GB
I.B.	Pipeline	Proj. act.	dot review	Pipeline Analysis	AH
	Project expenditures and budget	"	"	1. Statement of Expenditures by Budget Category	AH
C.	Lessons Learned	Eval. team	Daily & wrap-up discuss	none	GB

IA	<p>Community participation and contributions Issues ?Support for VHVs ?Selection of committies ?Function and regularity of Community health committies ?Issues discussed at mtg. ?Activities undertaken, ?Contributions ?Support of HSA ?What will continue without WV funds? ?IGAs established</p>	<p>Project records, field staff & key community leaders</p>	<p>Dot review & interviews</p>	<p>1. Estimated Value of Community Contribution Others</p>	<p>KN AH</p>
II.B	<p>Ability of NGO partners to sustain Chiwe Health Center established as outreach post of Nkhoma Hosp.? Chiwe hospital willingness to support HSAs JSI support for some CS type activities Nkhoma hosp. referral service</p>	<p>Project management Nkhoma Mission Hospital management</p>	<p>Interviews document review</p>		<p>Prisca</p>
II.C	<p>Ability and willingness of Counterpart Institutions to Sustain Activities MOH hiring HSAs? Training Senior HSA? Motorcycle for supervisor CBDA support & supervision HIS Director assisted DHO in computerization?</p>	<p>DHO HSAs NFWCM WFP UNICEF</p>	<p>Interviews</p>		<p>GB KN</p>
	<p>Formalize supervision and training procedures? Resourse Center established?</p>			<p>Training Table</p>	<p>Rebeana GB</p>
II.D	<p>Sustainability Plan -</p>	<p>DHO Community laders PM & staff</p>	<p>Interviews Team discussion</p>	<p>1. Sustainability Goals, Objectives, Steps Taken and Outcomes</p>	<p>GB</p>

Village Health Committees

1. How long has the committee been in operation?
2. How often does the committee meet and for how long?
3. What are the topics of discussions during the meetings?
4. What activities has the committee undertaken within the village?
5. What changes have you seen since your committee has been functioning within the community?
6. What contributions has the community made to the project activities?
7. What activities that have been initiated by the committee will continue after the end of the project?
8. How often are you visited by an HSA - and what happens during these visits?
9. What services do you get from the nearby health clinic?
10. What advice would you have for World Vision if they were to do another project like this?

Village Health Volunteers

1. How long have you served as a VHV?
2. What are your main activities within the community?
3. How much time in a week do you spend in your volunteer work?
4. How do you fit your volunteer work into your other household/community responsibilities?
5. What is your role within the community?
6. What are the key health messages which you promote within the community regarding diarrhea prevention and control, immunization, nutrition and HIV/AIDS.
7. How often does the supervisor visit you and what happens during these visits?
 - a. What training needs do you have?

Questions for UNICEF, USAID, WFP, and STAPH

1. Can you tell us about WV's work in Kabudula District?
2. What are the current linkages between WV and your organization?
3. What have been the significant contributions of the WV project and what are the potential long term effects?
4. What are some of the lessons your organization has learned from collaboration with WV on this project?
5. What elements of WV's CS project would your organization support beyond the end of the project.
6. What are your organization's priorities and strategic objectives in the area of child survival / primary health care for women and child?
7. Are there additional points for collaboration which would be useful in the upcoming year?

Questions for the DHO?

1. Can you tell us about WV's work in Kabadula District?
2. What are the current linkages between WV and your organization?
3. What have been the significant contributions of the WV project and what are the potential long term effects?
4. What are some of the lessons your organization has learned from collaboration with WV on this project?
5. What elements of WV's CS project would your organization support beyond the end of the project.
- 5a. In the original agreement it was understood that the HSAs would be absorbed into the DHS and that the 2 key supervisors along with motorcycles would go along with them - How soon are you prepared to assume this responsibility?
- 5b. Is the donated ambulance in operating condition and has it been useful and has it been useful for transport of referrals?
6. What are your organization's priorities and strategic objectives in the area of child survival / primary health care for women and child?
7. Are there additional points for collaboration which would be useful in the upcoming year?
8. What are some of the significant constraints you have encountered in health care delivery within Kabudula District? Has the project assisted you in dealing with any of these problems?

Traditional Birth Attendants

1. How long have you served as a TBA?

2. What are your main activities within the community?
3. How much time in a week do you spend in your work? How many deliveries do you assist each month?
4. How do you fit your volunteer work into your other household/community responsibilities?
5. What is your role within the community?
6. What are the key health messages which you promote within the community regarding prenatal care and needs of the pregnant women?
7. How often does the supervisor visit you and what happens during these visits?
8. What training needs do you have?
9. Where do you send women with complications of pregnancy/delivery?
10. What are complications for which you would refer a pregnant woman?
11. Do you have a delivery kit? (Observe the kit to see if it is clean and also if it is being used)

CBD Agents

1. How long have you served as a CBD agent?
2. What are your main activities within the community?

3. How much time in a week do you spend in your volunteer work?
4. How do you fit your volunteer work into your other household/community responsibilities?
5. What is your role within the community?
6. What are the key health messages which you promote within the community regarding child spacing and STDs/HIV/AIDS.
7. How often does the supervisor visit you and what happens during these visits?
8. What training needs do you have?

Health Surveillance Assistants

1. How long have you been serving as a HSA?
2. Will you continue to serve as a HSA under the MOH system (target issue of lower salary -will they accept this)? (Discuss WV 1 year extension and fact that during this year they will become government salary)
3. What are your main activities?
4. What support have you received from the project?
5. What is your reporting system? What data are you collecting - ask to see the forms? How do you use this data?
6. How would you manage a mother who has a child presenting with diarrhea? (What actions would they take - see if there is a knowledge of cereal based ORT.)
7. What are the correct dosages for Fansidar(SP)? When would a child or mother need to receive this drug?
8. What health education materials do have are? Are they sufficient? (Ask to see the materials - and assess their understanding of these materials.)
9. What project activities will be sustainable once the project comes to an end?

INTERVIEW GUIDE FOR SUPERVISORS

1. How long have you served as a supervisor?
2. What training did you receive to become a supervisor?
3. How many people do you supervise? What are their jobs?
4. What do you see as your most important responsibilities in your role as a supervisor?
5. What takes place during a typical supervisory visit?
6. What changes do you see in your job when the Child Survival project ends?
7. What problems do you encounter among the people you supervise?
8. What further training do you need?

APPENDIX B

Field Notes

FIELD NOTES

Sent. 3 Kabudula

The field office of the project is in a rented brick building with two rooms. One a larger more open office with desks for HSA supervisors, places to keep records and supplies for each of the 14 HSAs and two refrigerators. The other room serves as an office for the manager and the trainer. The refrigerator log was current and showed only one reading of 10 degrees.

The project has also built four houses for staff which are to be turned over to the Rural Hosp when the project ends. They are among the better houses in town.

Nsanama

An Outreach clinic in progress in a community center building built by the MOAg. About 200 women seated on the ground were listening to the HP. After the ed. session, they went through the stations of the clinic-- ORT corner, GM, Vit. A, immunization & antenatal care with child spacing. Crowded but organized. There are 14 such centers, each has a monthly outreach clinic staffed by a nurse, usually a couple of HSAs & HPs and several VHVs. The VHVs are to follow up on any children who do not appear for immunizations in their villages. A project tally sheet (HSAs keep a MOH tally sheet) to record the number of children vaccinated in each village is used and the numbers given to the VHV and used by the HSA to make his report. The VHV then goes back to the village, collects the cards, enters the vaccination record in the register, sees who did not get vaccines at the last session and pays a reminder visit to those homes. Prior to the next session the VHV informs every one in the community and particularly those who are delinquent. They do this through checking the cards at GM sessions in the village. When activities are taken over by MOH HSAs the project tally sheet and follow up system will fall by the way and only the MOH tally sheet will be used. This will not facilitate follow up. Pressure is brought on families to get immunization done through the chief who tells them that they better do it or will not be allowed to attend funerals which means that no one will attend theirs. HSAs keep in touch with the VHVs to monitoring any disease outbreaks, particularly measles, conjunctivitis and severe diarrhea. There have been a couple of measles outbreaks which were followed by campaigns.

Chiwe Health Center

The center was built by WV, opened in Dec.95. Staffed by 1 MA (Mr. Mataya, not formally trained but experienced), 1 FT nurse, 1 rotating nurse from Nkhoma Mission Hospital (NMH), and Mrs. Mattaya who does registration and clerical work. These are paid by MOH through CHAM to Nkhoma. There are also 2 HSAs based here one paid by DHO and one by the project. If DHO takes on the second HSA they will continue to base him at Chiwe.

Transport for emergencies is by locally hired vehicles, referrals can be transported by the DHO vehicle with advance notice.

Meds are supplied by Nkhoma. Cost recovery is done to defray most of the cost of medicines but no one is refused services for lack of money. Housing is not satisfactory and application has been made to the GOM Social Activities fund for building.

They will continue to do immunizations at Chiwe but no outreach clinics after EOP.

Nkhoma Mission Hosuital

Met with Dr. Van Velden, a general physician and surgeon who is the hospital superintendent. Staffed by five dots one his father who is an ophthalmologist. 220 beds and a nursing school. A new unit for surgical FP. Tubal ligations and some elective surgery from the Kabudula area is done here. They run 9 other scattered HCs besides Chiwe. Interaid does a CS type project in their **catchment** area. NMH trains **CBDAs** and does referral tubal ligations funded by CIDA and STAFP (not real clear).

Van velden says MOH has many open positions but no money to pay for them. Also that DHO is reluctant to staff outreach programs. "Primary Health care is not cheap". He is quite focused on curative care at the hospital. "If we get a free ambulance , we won't take it". Asked about supervising **HSA**s around Chiwe, he explained that their commitment was to staff and supply a health center and they really did not feel able to reach beyond that.

Kabudula Rural Hospital

Staffed by an MA, 2 nurse midwives, 1 PH nurse and menial staff, Sanctioned for CO, 2 **MAs**, 7 nurses, health inspector, environmental health assistant. Understaffing due to lack of housing, poor school. serves a pop of 55,000

Says: WV project has reduced their workload, raised immunization coverage, unproved FP acceptance and done nutrition ed and supplementary feeding; the former project vehicle is theirs but the driver works directly for the DHO and it is currently disabled;

Asked what will happen as WV project phases out the PH nurses responded without hesitation; "we will be in trouble." It seems an accurate assessment.

Kabudula Traditional Authority

The chief was ill but came out to the veranda to talk with us. Says WV has worked smoothly with him, good communication (they have also hired his son) Most important contribution of the project: Increased immunization, health education. What will remain when project phases out? Volunteers will still need supervision but level of supervision will decline, OCs will not be run

Kabudula Traditional Authority

The chief was ill but came out to the veranda to talk with us. Says WV has worked smoothly with him, good communication (they have also hired his son) Most important contribution of the project: Increased immunization, health education. What will remain when project phases out? Volunteers will still need supervision but level of supervision will decline, OCs will not be run by KRH, things will fall apart after a year or two without WV. He has tried through the District Development Council to get more staff at the hospital but without success. Wish list: WV should build a hospital in the area and do PHC as well.

HSA Interviews (2)

#1 6 years with CS (Senior HSA)

Will accept MOH salary--security and enjoys the job

Main Activities: He supervises nutrition and JGA in all 14 centers. Distributes WFP food and does reporting--about 10 bags/month/center

Support from project: Has received training in nutrition from the project as well as other workshops--trained in poultry and piggeries by MOAg Reports and gets supervision from Rabbina

Able to explain reporting system

Diarrhea management--hesitant and uncertain) actions to take for a child with diarrhea “we give health talks, encourage latrines & hand washing” asked again about managing a case “increase fluids” Knew proportions for SSS

Dosages for fansidar “use nets if they can get them, burn cow dung or use leaves” Fansidar available only at HC Under 3 months 1/2 tab, 4-7 mos. 1 tab, 8-14 mos. 2 tabs., 15 mos.+ 3 tabs. Asked if months or years, he asserted it was months. Overall not sure in this area.

Materials available: Facts For Life, sometimes a few posters

Sustainable activities: MOH will do under 5 clinics, supplementary feeding will continue on a smaller scale, HSAs may use bicycles to do a smaller number of villages. VHV and VHCs will continue. Quite optimistic.

#2 S A

One year service untrained

Would like very much to work for MOH even at lower salary
Main Activities: Supervise GM clinics (11 VHV), 6 CBDAs does immunization at OCs, most exited about soybean seeds (30 Kg. yielded 420 Kg.), does well protection & pit latrines, communicates health messages to community

Able to describe reporting system

Diarrhea treatment: “we do health education, advise exclusive breastfeeding, suggest they go to nearest clinic, if under 4 months, give watery food and go straight to hospital” Spoke english very well, but seemed quite confused on this topic.

Malaria treatment: “advise good sanitation, empty water containers, cut grass and use herbs in the house.” Asked again about treatment--“first use cold compress, then go to hospital” Fansidar is available only at OC or HC Dose schedule: give once a month, to adults 2-3 tablets/month. 0-4 mos.--1/4 tab; 6-12 mos--1/2 tab; 1-4years--1 tab; 4-12--2 tabs; 12+--3 tabs..

Ed. materials: posters (not at the HC); textbook for HSAs; demonstrations such as burning cow dung, herbs, condom instructions.

Sustainable interventions: CBDAs will function; Ocs as before the project under the MOH (here and there and once in a while); IGAs skills will remain.

VHV Nsanama

worked 3 yrs

Support from project: Has received training in nutrition from the project as well as other workshops--trained in poultry and piggeries by MOAg Reports and gets supervision from Rabbina

Able to explain reporting system

Diarrhea management--hesitant and uncertain) actions to take for a child with diarrhea “we give health talks, encourage latrines & hand washing” asked again about managing a case “increase fluids” Knew proportions for SSS

Dosages for fansidar “use nets if they can get them, burn cow dung or use leaves” Fansidar available only at HC Under 3 months 1/2 tab, 4-7 mos. 1 tab, 8-14 mos. 2 tabs., 15 mos.+ 3 tabs. Asked if months or years, he asserted it was months. Overall not sure in this area.

Materials available: Facts For Life, sometimes a few posters

Sustainable activities: MOH will do under 5 clinics, supplementary feeding will continue on a smaller scale, HSAs may use bicycles to do a smaller number of villages. VHV and VHCs will continue. Quite optimistic.

H S A

One year service untrained

Would like very much to work for MOH even at lower salary

Main Activities: Supervise GM clinics (11 VHV), 6 CBDAs does immunization at OCs, most exited about soybean seeds (30 Kg. yielded 420 Kg.), does well protection & pit latrines, communicates health messages to community

Able to describe reporting system

Diarrhea treatment: “we do health education, advise exclusive breastfeeding, suggest they go to nearest clinic, if under 4 months, give watery food and go straight to hospital” Spoke english very well, but seemed quite confused on this topic.

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Ed. materials: posters (not at the HC); textbook for HSAs; demonstrations such as burning cow dung, herbs, condom instructions.

Sustainable interventions: CBDAs will function; Ocs as before the project under the MOH (here and there and once in a while); IGAs skills will remain.

VHV Nsanama

worked 3 yrs

Main activities: keeps register (32 children U5 for imm. Gm, TT, antenatal, vitA) At OC clinics he registers and weighs kids, gives Vi A, eye ointment, ORS, health ed. After OC reviews tally sheet with nurse finds villages with poor attendance then goes back to chief to get him to prod delinquent families, Works with VHC to do wells raises funds for bricks etc, organizes labor and connects with the project HSA to get assistance

Time spent: parts of five days maybe 10 hours/wk

vol work does become difficult when planting and harvesting.

Key Messages: for diarrhea--hand washing and exclusive BF; HIV/AIDS--take your own blade for tattoos, avoid injections from nonmedical people, abstinence from sex. Immunization--get started on BCG immediately after birth.

Supervisor: visits weekly at least

Training needs: has missed 4 training sessions needs to catch up; needs training in use of record cards

DHO

Present: Evaluation team: GB, AH, Kibble, Regina, Genner, Rabbina

DHO: Dr. Masache (Deputy DHO), Mr. Lukhele (Sr. Environmental Health Officer), Mrs. Mwenye (Personnel Officer), Mrs. Chinula (Matron), Mrs. Kabalame (Matron)

Current Linkages:

WV/CS is doing most preventive services in Kabudula; WV HSAs also o typical MOH services such as malaria treatment; Outreach clinics and monitoring of health statistics

Potential log-term effects:

Health conditions will be improved--that's positive; a negative effect is that a need has been created--there will be more pressure on us.

Elements to be supported in Kabudula TA:

strengthen KRH, posting a Clinical Officer, provide an ambulance, upgrade hosp to provide surgical capacity especially for C-sections, recruit WV HSAs to work in their own areas but may have to adjust some of these areas since WV/CS has been able to have better ratio of HSAs to population than most districts. Need to have the HSAs formally apply, they will be taken according to their academic qualifications. Senior HSA will just be HSAs. Reporting will be only through the DHO system, Will be on DHO salary scale and under their supervision. Kibble asked for 14 HSAs + 7 home craft workers to be taken on. Did not commit to a fixed number but to taking all academically qualified HSAs and even some who are as yet untrained up to the usual number for a district like Kabudula--may have to relocate some to less well-served areas.

WV Ambulance donated:

Not in service due to breakdown--was with the central hospital and had high maintenance costs.

Lesson learned:

NGOs should liaise with planning unit of MOH when starting a project so that phase over can be budgeted on its completion. That means building to their specs, staffing with their certified people, sometimes NGOs are discouraged since they will also want them to go where they want them. The DHO may have other priority areas and be more flexible on specs so they are not always in agreement, NGOs need to get them both on board before starting.

JSVSTAFP

Linkages:

STAFP goal is to decrease HIV spread and fertility, has a TA team that works with gov and NGOs, also gives grants to PVOs (24 thus far); works with MOH on curriculum through NACP. Works with NFWC and NGOs or MOH to implement AIDS ed. and develop new approaches such as using HSAs to supervise CBDAs. Does policy dialogue i.e. to encourage MOH to use syndromic approach to STD management and train nurses to do it. Also to integrate all reproductive health services

Introducing STD management into FP services. Half of HIV is contracted within marriage (estimate). 30% of adults in Blantyre are HIV pos. Has moved MOH and NFWC to promote condoms on equal basis with other methods not just a temporary measure as before. But would like to see the advantage of condoms as a prophylactic emphasized more. Much FP programming is not male-friendly. Condom use in marriage study showed both males and females reluctant to talk with partners for fear of arousing suspicion or expressing distrust.

NGOs have initiated using HSAs to supervise CBDAs. there are about 2000 HSAs in Malawi whose training has included very little FP. JSI would like to see them trained for FP but there are already about 23 programs that use them for implementation, A study of CBDAs showed now link between supervision and quality of their work. Outputs are measured need to do some outcome evaluation as well. Concerned about phase-out of CS, but with WB paying for HSAs through MOH something may continue to happen.

National Family Welfare Council

Present : WV--GB,AH, Regina, Rabbina, Genner
NFWC--Dr. Palamuleni (Director of Programs), Mr. D.E. Banda (Deputy Director, Research and Evaluation), Mrs. E. Perekamoyo (Deputy Service Delivery Officer)

Contributions of WV:

Expand services beyond NFWC's capacity. Use of HSAs as supervisors shown to work in WV project.

Current FP Programming:

7% contraceptive prevalence rate in 1992, up to 9.6% in 94, 40% in WV area is phenomenal, if true. CBDA to serve 50 houses some more some less. NFWC is part of **MOcommunity** services but is part of numerous coordinating committees. FP and STDs used to be part of same curriculum until 86-87 when a separate STD program was set up may be time to integrate again. Now works though both vertical program and PHC or outreach clinics. Closely involved with DHO would integrate HIS more with them.

Advice to NGO:

Work in areas of particular need. Consult the Council and DHO to identify areas. Planning unit in MOH is mostly concerned with facilities not so much with community based programs.

APPENDIX D

Summary of Training Activities

Summary of Training Activities

TRAINING DATES	TRAINING PLACE	TRAINING TOPICS	HOURS	TRAINING METHOD FOR TOPIC(S)
PART 1 3 to 27 Oct. '95	Mitundu Rural Hospital, Primary Health Care Center	<u>HSA TRAINING</u> . Planning of health activities . Immunization . Disease surveillance . Cold Chain . Sterilization of vaccine instruments . Primary Health Care components . Sanitation . Water source protection . Village inspection . Nutrition . Growth monitoring . Vitamin A . Supplementary feeding . Family planning . Food hygiene . Report writing	260 hours	• Lecture . Discussion • Field Visits • Role Play • Demonstrations
13 Oct. '95	District Health Office Conference Room, Lilongwe	• Antenatal Care . Management of women in labor . Postnatal Care . Exclusive breastfeeding . Inter-personal communication	8 hours	. Lecture . Group Discussion . Practice

1 to 7 Nov. '95	Chiwe Health Center	<u>CBD REFRESHER COURSE</u> . Conducting needs assessments . IEC for family planning, HIV/AIDS and STD prevention . Anatomy and physiology of reproduction . Primary Health Care . Counseling . Record keeping . Contraceptive distribution and storage	40 hours	. Lecture . Discussion • Field Visits • Practice
6 to 9 Nov. '95	Lilongwe Hotel	. Monthly Report (PMU) . PMU Monthly Stock Sheet . Quarterly Report . Beneficiary attendance roster	40 hours	. Lecture . Discussion • Practice
23 Feb. '96	DHO Conference Room, Lilongwe	. Health education on family planning . Who is a TBA? . Revised WHO/EPI policy . Types of mental illness . Management of psychiatric patients . Follow-up cases	8 hours	. Lecture . Group discussion
26 Feb. to 1 Mar. '96	Kalonga Center	<u>IGA</u> . Working in groups . Characteristics of group members . Khola construction . Division of labor . Piggery and poultry management . Problem solving . Business management	40 hours	• Lecture • Role Play . Group discussion • Demonstrations

29 Feb. to Mar. '96	Nsaru RTC	<u>STAFF REFRESHER COURSE</u> . Environmental Sanitation . Family planning Control of diarrheal diseases . Primary health care . Health information system . Supervision	20 hour:	Lecture Discussion Demonstrations Practice
27 to 29 Feb. '96	Mponela Primary Health Care Center	<u>TBA REFRESHER COURSES</u> . History-taking . Physical exams . Management of minor disorders of pregnancy . Selective prophylactic treatment . Management of labor . Management of abnormal labor . Post-partum care . HIV/AIDS prevention . Neonatal tetanus prevention . Family planning motivation . Exclusive breastfeeding . Care of delivery instruments . Primary health care concepts . Environmental health . Control of diarrheal diseases	80 hour	. Lecture . Discussion . Songs . Illustrations . Demonstrations . Practice . Field visits
25 Mar. to 4 Apr. '96	Nkopola Lodge, Mangochi	<u>COMMUNITY-BASED DISTRIBUTION OF CONTRACEPTIVES CURRICULUM DEVELOPMENT WORKSHOP</u>	80 hour	. Lecture . Group plenary session . Brainstorming

16 to 18 Mar '96	Multi-country Training Center, BT	<u>FAMILY PLANNING PROVIDERS COURSE</u>	160 hours	. Lecture . Group discussion . Practice
1 to 4 Apr. '96	LADD Staff Training Center, Lilongwe	<u>MALNUTRITION MANAGEMENT</u> . Soya bean production, utilization and processing . Soya bean recipes . Plan of action for village training	32 hours	. Lecture . Practice . Demonstration
15 Apr. '96	Nsaru RTC	<u>HIV/AIDS UPDATE</u> . Basic information on HIV/AIDS . Reporting system . Lessons learned . Journaling	8 hours	. Lecture . Discussion
20 to 21 Apr. '96	Nsaru RTC	<u>HIV/AIDS UPDATE</u> . Basic information on HIV/AIDS . Plan of Action . List of activities for FY96 reporting system . Lessons learned . Journaling	16 hours	. Lecture . Discussion

15 Apr. to 10 May, '96	Mponela Primary Health Care Center	<u>TBA INITIAL TRAINING</u> <ul style="list-style-type: none"> . History-taking . Physical exams . Management of minor disorders of pregnancy . Selective prophylactic treatment . Management of 1st, 2nd and 3rd stages of labor . Post-partum care . HIV/AIDS prevention . Neonatal tetanus prevention . Family planning motivation . Exclusive breastfeeding . Care of delivery instruments . Primary health care concepts . Environmental health . Control of diarrheal diseases . Neonatorum Ophthalmia 	160 hours	<ul style="list-style-type: none"> . Lecture . Songs . Illustrations . Demonstrations . Practice • Field visits
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6 May to 17 May, '96	Kalikuti Hotel	<u>INTRODUCTION TO LOTUS 123</u> The @ Function, Range names, Consolidation, Worksheet techniques, entering data, editing data, changing the appearance of data, printing a worksheet, formatting a worksheet with WYSIWYG, copying contents of a cell, creating graphs.	80 hours	• Lecture . Assignments . Demonstrations . Practice
31 May '96	Regional Health Office, Lilongwe	<u>MOH/NO MEETING ON POLIO NATIONAL DAYS AND VITAMIN A CAMPAIGN (NIVACs)</u>	8 hours	. Lecture • Discussion
27 May, '96	Kalikuti Hotel	<u>WFP</u> . Malnutrition and feeding U/5 children . Likuni Phala (homemade) • How to make soy flour at home . Soya nutrients . IEC materials and messages to mothers of malnourished children	8 hours	. Lecture . Discussion . Demonstration
4 to 7 June, '96	Nsaru RTC	<u>SYNDROMIC MANAGEMENT OF STDs</u>	32 hours	• Lecture • Group discussion • Role plays

3 to 7 June '96	Chiwe Health Center	<u>CBD REFRESHER COURSE</u> . Conducting needs assessments . IEC for family planning, HIV/AIDS and STD prevention . Anatomy and physiology of reproduction . Primary Health Care . Counseling . Contraceptive distribution and storage	40 hours	. Lecture . Discussion . Illustration . Field Visits • Practice
10 to 21 June, '96	Nsanama Center	<u>CBD FIRST INITIAL COURSE</u> . Conducting needs assessments . IEC for family planning, HIV/AIDS and STD prevention . Anatomy and physiology of reproduction . Primary Health Care . Counseling . Contraceptive distribution and storage . 3-week work program plan	80 hours	. Lecture . Discussion • Illustration • Field Visits • Practice
24 to 26 June, '96	Nsanama Center	<u>CBD SUPERVISOR COURSE</u> . Record keeping . Supervision . Contraceptive logistics . Distribution of equipment and supplies . Report writing	24 hours	. Lecture • Discussion • Illustration • Field Visits • Practice

27 July to 2 Aug. '96	DAC Office, Kabudula	<u>2ND INITIAL CBD COURSE</u> <ul style="list-style-type: none"> . Conducting needs assessments . IEC for family planning, HIV/AIDS and STD prevention . Anatomy and physiology of reproduction . Primary Health Care . Counseling . Record keeping . Contraceptive distribution and storage . 3-week work program plan 	80 hours	<ul style="list-style-type: none"> . Lecture . Discussion . Illustration . Field Visits . Practice
5 to 7 Aug. '96	DAC Office, Kabudula	<u>CBD SUPERVISOR COURSE</u> <ul style="list-style-type: none"> . Record keeping . Supervision . Contraceptive logistics . Distribution of equipment and supplies . Report writing 	24 hours	<ul style="list-style-type: none"> . Lecture . Discussion . Illustration . Field Visits . Practice

RECOMMENDATIONS

1. IMMUNIZATIONS

Quality assurance should be put in place / by conducting refresher courses for HSAs/HAs/Nurses.

During the trainings much emphasis should be put on interval given vaccinations and vitamin A.

2. IGA

(a) Establish ^{other} few more (2-4) poultry keeping clubs in order to respond to community demands.

(b) Poultry club members should in the near future start processing purchasing by themselves using their own funds.

(c) Develop proper mechanism on how poultry club members are going to use profits obtained from sales.

3. DIARRHOEAL CONTROL/HIV/AIDS

(a) Conduct short courses for VHCS/VHVs on the care of drinking water supplies and ORS use.

(b) Intensify community awareness on HIV/AIDS. Involve more men.

PLACES VISITED AND NAMES OF PEOPLE INTERVIEWED

1. Msanama outreach clinic: 03/09/96
HSA
2. Chikumbulira Poultry Club: 03/09/96
Mr. Mpunga - HSA
and the club members
3. Chinese Health Centre: 04/09/96
Mr. Mataya - MA
Mrs Mataya - HCW
Mr. J.B. Chilala - HSA
Mr. Alix Mtamangi - Volunteer
Mr. Jonathan Jimu - "
4. Kabuthu Disrupt Education Centre: 09/9 6
Mr. M.M.C. Josingwa - Teacher
Mr. I.M. Chimbayo - Teacher
5. Mkwawa Village: 05/09/96
Mr. Felix Chipewa - VHC Chair
Mr. Bwanali - VHC Secretary
Mr. Chagwa - VHC Treasurer
6. Then Village: 05/09/96
Mrs Mgwata - Volunteer
7. Kabumbula Rural Hospital: 05/09/96
Ms. Era Chikopa - Com. Health Nurse
Mrs. E. Machona - Nurse

WVI - CS - EVALUATION - FINDINGS

By GEMNER CHAWAHA

EXECUTIVE SUMMARY:

The project evaluation methodology included a KIC survey, record reviews and field observations of health facilities and income generating activities. There were individual and group meetings on site with project staff, village health committees, volunteers, youth clubs and supportive health staff from other organizations/departments.

Semistructured questionnaires were developed and used to ensure that key topics were covered. Health sites, schools and villages visited were representative and widely distributed throughout the project area.

The project has had a positive impact on the health of the target population. There is increased awareness of health and nutrition issues. Achievements have been made on immunizations, HIV/AIDS, sanitation and IGA. These achievement were clearly relevant for overall developments.

Lessons Learnt

IMMUNIZATIONS

The visit of 3rd September 1996 to Msanama outreach clinic revealed high achievements in many areas.

According to the observations made cold chain was properly maintained for the fact that health workers used hard frozen ice packs with correct immunization techniques.

At every step health workers were able to tell mothers the type of vaccine, importance of vaccination and when to return for the next one.

At least 10 health record cards (4/5 and TTV cards) were checked with a view to study Vit A and vaccination intervals. From the 'immediate anal^x', it was found out that about 90% of children received Vitamin A twice/a^a ear, 65% of children received measles vaccinations at the right time whereas 40% 4 mothers received 3rd TTV very early (by 4th-5th month from the 2nd dose)

The outreach clinic services were greatly participated by growth monitoring workers (community volunteers) who according to interview knew community health requirements.

Lessons Learnt

HIV/AIDS

All along the places visited HIV/AIDS was another element of great importance.

Health workers/volunteers at Msanama Outreach clinic, Chiwe health centre, Kabuthu District Education Centre [DEC], Nkhoma Mission hospital and Kabindula Rural hospital ~~and also~~ expressed their concern on AIDS. Fortunately, there is a joint effort in the control of the situation.

Evidence of Anti AIDS club was witnessed at Kabuthu school where interviews were made to school teachers and students.

The club formulated by the school under the initiative of Child Survival Project was found to be familiar to control of AIDS in the community.

The project staff, volunteers, VHTs and other health workers of Mott have a task of educating the community about HIV/AIDS.

Women are always at risk because men are most of times in towns where chances of collecting HIV and pass to women are great.

Lessons Learnt

Income Generating Activities [IGA]

Chikankhulira Village was visited on 3rd September, 1996... with a view to learn IGA through soyce and poultry keeping clubs.

A club mostly composed of women made sales costing about K 330 and were with support from child survival project started poultry keeping club in December, 1995.

The chicken club started with 100 chicken and by then made sales from chicken and eggs which gave about MK 8,580. At the time of visit the club had 0 old and 11 chicken and were expecting to purchase some chicken through the project.

On the profits to be made in future the club members indicated that they were to provide loans to the members only, and to be paid back with about 10% interest.

Three other areas visited during the evaluation period expressed their great interests in starting IGA through poultry keeping.

Lessons learnt

CONTROL OF DIARRHOEAL DISEASES

Project health workers joined by VHC^s/VHV^s were during the evaluation found to be working hard in the control of diarrhoeal diseases.

As witnessed at Msanang outreach clinic and Chime health centre diarrhoea cases are being treated by ORS. The treatment of diarrhoea is also being participated by volunteers in all outreach clinics.

The other control of diarrhoeal diseases within the project area was done by protection of drinking water supplies and improvement of pit latines in the households. New pit latines were greatly appreciated at Mkwawa and their villages which revealed about 70% of households having pit latines.

However, communities needed to be educated on how to make protected well safe.