



**WORLD RELIEF MALAWI
“TIWEKO TOSE ”
CHILD SURVIVAL PROJECT
THIRD ANNUAL REPORT**



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Cooperative agreement #: FAO-A-00-00-0005-000
Program Location: Mzimba and Rumphi districts, Malawi
Program Dates: September 30, 2000-September 29, 2004
Date of Submission: October 31, 2003

ACRONYMS

CBDA	Community-Based Distribution Agent
CCAP	Church of Central Africa, Presbyterian
CSP	Child Survival Project
DGMH	David Gordon Memorial Hospital
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
DRF	Drug Revolving Fund
EOP	End of Project
HIS	Health Information System
HAS	Health Surveillance Assistants
IMCI	Integrated Management of Childhood Illness
ITN	Insecticide Treated Net
KPC	Knowledge, Practice, Coverage
LRA	Local Rapid Assessment
MOHP	Ministry of Health and Population
MTCT	Mother-to-Child Transmission
PHC	Primary Health Care
SOL	Synod of Livingstonia
TBA	Traditional Birth Attendant
WR	World Relief
WV	World Vision

Program Location and Background

The *Tiweko Tose* (meaning “All of us together”) Child Survival Project (CSP) is located in Mzimba and Rumphu districts of northern Malawi. The three project areas include the health service catchment areas around the Ekwendeni, Embangweni, and David Gordon Memorial (DGM) hospitals of the Church of Central Africa, Presbyterian (CCAP) Synod of Livingstonia (SOL). The target group comprises children 0-5 year olds (36,732) and women of childbearing age (32,185).

The project goals are to 1) reduce morbidity and mortality in children under 5 and women of childbearing age; 2) strengthen the capacity of the SOL to implement Child Survival interventions; and 3) empower communities to improve their health.

The primary program strategy is to work in partnership with SOL and the Ministry Of Health and Population (MOHP) to help communities create 300 Care Groups and train 3,000 community volunteers as behavior change agents. Care Group volunteers make regular visits to more than 30,000 households to explain and promote key messages for each child survival intervention. The project intervention mix includes Nutrition (25%), Malaria control (15%), Pneumonia case management (15%), maternal and newborn care (15%), child spacing (15%), and STI/HIV/AIDS prevention (15%).

The project also includes capacity building of SOL to strengthen its organizational capacity to manage child survival activities and to increase/reinforce other community-based and health facility-based services, e.g., traditional birth attendants (TBAs), drug revolving funds (DRF) and community based distribution agents (CBDAs). These activities are conducted in collaboration with, and as part of, the MOHP district health system.

A. Progress Towards Achievement of Project Objectives

1. Program Innovations

Year three was marked by new program initiatives that evolved directly from ideas and actions of the volunteer Care Groups and project staff in response to challenges they faced.

Zone Committees: A number of zone committees have been formed to support Care Groups in their areas. Zone committees are composed of chief volunteers from the Care Groups they represent and also involve village leaders. Where zone committees exist, they serve as a mechanism for joint problem solving and encouragement to the Care Group volunteers. They are in part helping to play a support role that Village Health Committees (VHCs) should have been contributing.

Village Banks: Some care groups and communities have responded to pleas for assistance with health care fees by creating village banks that mothers can borrow from when they need urgent funds to pay either the drug revolving fund (DRF) or health facility for their child’s treatment. The banks’ conception and operation has been completely community initiated and highly successful. Details vary from bank to bank, but in general the bank’s capital has come from very small monthly contributions from care group members and village leaders.

Village gardens: Some care groups have undertaken the communal cultivation of vegetables and other crops in order to help the sick, aged and destitute, especially during a time of acute food shortage.

Poetry: The CSP is increasingly using poems and other creative forms of communication at social gatherings, meetings and under-five clinics to disseminate health messages alongside conventional methods.

Exchange visits: These visits take place between Care Group volunteers within a project area and also between project areas (hospitals). They serve to encourage the dissemination of local ideas and approaches across the project and to help the volunteers feel part of a larger whole.

Promoters Union: The promoters union is a forum comprised of promoters from across the three project areas who meet regularly to discuss issues affecting their work. The promoters also share experiences from their areas and seek ways to improve their work.

Health Information System: The Tiweko Tose CSP has succeeded in institutionalizing a health information system (HIS) that is effective in tracking progress towards DIP objectives. The local rapid assessment (LRA) surveys that are conducted every quarter provide information to the project which forms the basis for CSP monitoring and implementation and feedback to promoters, Care Groups and communities. The HIS allows the project to evaluate progress toward end of project (EOP) objectives and provides another reliable mechanism to cross check KPC survey findings.

2. Technical Interventions

The CSP has already achieved or surpassed six of its objective targets and is making progress on others. The most recent measurement of progress towards objectives was made in the July 2003 LRA and are summarized in the table below

Progress Towards Achievement of Final Project Objective Targets		
	Objectives	Progress
Malaria		
1.	Increase from 35.4% to 90% the percentage of children < 5 yrs who are treated the same day or the next day for fever (suspected malaria) at an appropriate health facility (including DRF). <i>Comment: additional DRF volunteers were trained in March of 2003, though the simultaneous food crisis inhibited DRF volunteer participation as they too were affected and needed to spend extended hours in search of food.</i>	47.1%
2.	Increase from 8.5% to 50% the number of children <5 yrs sleeping under a bed net. <i>Comment: ITNs are in short supply nationwide. Consequently,</i>	37.4%

	<i>there are ITN committees eager to sell nets without any merchandise.</i>	
3.	Increase from 8.5% to 50% the number of pregnant women sleeping under a bed net.	31%
4.	Increase from 62% to 75% the percentage of bed nets that will be retreated within the last twelve months.	YES- U/5:85.3%
		Pregnant women:77.6%
Pneumonia		
5.	Increase from 27.6% to 50% the percentage of children < 5 yrs who are treated the same day or next day for rapid, difficult breathing (with or without fever) at an appropriate health facility.	YES- 44.2%
Nutrition		
6.	Increase from 65% to 90% the number of children 0-35 months weighed regularly in growth monitoring and counseling (GMC) sessions. <i>Comment: Overall performance was negatively influenced by the floods and land slides in Livingstonia that washed out roads and bridges and resulted in a decrease in mobile clinics.</i>	72.2%
7.	Increase from 3% to 30% the percent of pregnant or lactating women who receive daily IFA supplements.	Yes- 62%
8.	Increase from 3.5% to 30% number of children 6-23 months receiving weekly iron supplementation.	Yes- 39.2%
9.	Increase from 12.9% to 50% the number of children aged 6-59 months receiving Vitamin A appropriately.	Yes- 90%
10.	Increase from 36% to 50% the proportion of mothers exclusively breastfeeding 0-6 months infants.	Yes- 73.4%
11.	Eighty percent (80%) of children who complete hearth achieve and sustain adequate (200g) or catch-up (400g) growth per month during at least 2 months after Hearth. <i>Comment: Hearth implementation was negatively impacted by famine.</i>	70%
12.	Eighty percent (80%) of children will continue to gain weight at the rate equal to the International Standard equal to their age at 6 months and one year after their participation in the hearth. <i>Comment: famine negatively impacted Hearth implementation and outcomes.</i>	70%
Family Planning		
13.	Increase from 23% to 40% the percentage of WCBA who use a modern method of contraception (pill, condom, Depo-Provera).	Yes- 60.7%
HIV/AIDS		
14.	Increase from 17.5% to 30% the percentage of sexually active women who stated they used a condom during their most recent sexual intercourse (for contraception or HIV prevention).	24%
15.	Increase to 1000 the number of people receiving VCT during prior	Yes-

	6 months in all the three areas. <i>Comment: figure does not include results from DGMH; actual figures are closer to 8000.</i>	1,552
16.	Establish 5 post-test clubs to promote healthy lifestyles and advocate VCT in each of the 3 project areas. <i>Comment: Consultation with MACRO has been made and health units informed. In Embangweni's Mabiri area – 9 AIDS TOTO Clubs have been formed in 9 schools. This has enhanced youth's willingness to undertake VCT. The activity is scheduled for 2004.</i>	9
Maternal and New Born Care		
17.	Increase to 80% the proportion of families who have an emergency transport plan in place before delivery.	70.9%
18.	Increase from 30% to 60% the number of pregnant women who receive at least 2 doses of SP during pregnancy. <i>Comment: SP is supposed to be free for women receiving prenatal care and is supplied by the MOH. However, MOH supplies are irregular and when the hospital has to purchase it independently, the cost is passed on to patients—a deterrent to following through.</i>	46.2%
19.	Of the women who do not deliver in hospital, increase from 38% to 70% those delivered by a trained and supervised TBA <i>Comment: TBA refresher trainings will be conducted in the first quarter of FY2004; currently supervision from the facilities is very poor hence reporting is not up-to-date.</i>	18%

Hearth

The project has so far implemented 5 Hearth cycles. Hearth as part of nutrition intervention was supposed to have been phased in project-wide during the second year of the program. However due to acute food shortages caused by drought it was rescheduled; it was deemed unrealistic to expect mothers to bring food when there truly was nothing to be found and in an environment when food rations were being distributed. Consequently, implementation began in just the last few months of the fiscal year. It has received very high profile support from village leaders. Rehabilitation rates were very high 70% of children admitted into the hearth achieved adequate or catch-up growth. The challenge remains sustaining the learned behaviors in order to maintain the nutrition status and prevent future malnutrition. This will be achieved by follow of mothers by hearth volunteers.

Progress on Sustainability Objectives for SOL and Health Services		
Objectives		Responsibility
1.	Ninety percent (90%) of beneficiaries in the project area will live within 5 kilometers of a trained volunteer providing health information and access to essential drugs/medical advice.	SOL PHC, CGs, VHCs, Beneficiaries

Each household is currently within less than 5Km of a CSP volunteer. A comprehensive census at the beginning of the project ensured that all households are covered and allocated to specific volunteers. Provision of adequate DRFs to meet demand due to long distances to health facility or nearest DRF however still remains a challenge. Even as 103 DRF volunteers were trained and supplied with basic treatment kits, stock-outs and food shortages (affecting volunteer availability) have inhibited the consistency and effectiveness of these services.

2.	By end of project, SOL will secure funding for interventions related to the sustainability of essential MCH interventions.	WR, CSP, SOL PHC.
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WR and SOL PHC have developed an Agriculture and Food Security proposal to scale-up some of the CSP’s proven strategies. The care groups and the health promoters already engaged in agro-related activities are the primary targets of activities intended to improve food security and thereby nutritional and economic status. Improved economic status will increase access to maternal and child health services. The main focus is on crop diversification including seed multiplication, income generation activities, environmental management and promotion of rearing small animals.

3.	Eighty percent (80%) of care groups will have met at least four times in the last six months.	CSP, Care groups, PHC
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Currently at least 70% of volunteer Care Groups meet at least once every month on their own to review their work, support each other and resolve problems. The creation of zone committees in some parts of the three project areas has been effective in ensuring that Care Groups are encouraged and continue their responsibilities. A strong indicator of sustainability within this project is that the majority of Care Groups consistently meet on their own. Part of the project’s preparation for phase out includes identifying and instituting ‘best practices’ for volunteer incentives: village banks, zone committees and introduction of a food security component in selected Care Groups.

4.	SOL PHC staff will attend at least 80% of the meetings of VHCs and District Health Management Team (DHMT).	CSP, PHC, DHMT
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SOL PHC staff have attended all DHMT meetings held; however, DHMT meetings have been inconsistent and not been held for almost one year. It is the responsibility of the DHMT to invite all health players in the district for said meetings. To compensate, the CSP has asked for meetings with the district to share reports of project activities and study findings including the First Annual Report, Nutrition Status Survey Report, DRF Assessment, Mid Term Evaluation Report, and Assessment of Volunteers.

Regular meetings do take place between the SOL PHC team, CSP and communities in order to review progress of various projects (including the CSP), problems and solutions. Such meetings are also where local support for projects is mobilized e.g. support from local leaders for Care

Groups and volunteers when doing household visits. These meetings provide valuable information for generating commitment to project activities and strategies.

5.	Eighty percent (80%) of beneficiaries will report that they are basically satisfied with their last visit to the SOL.	CSP, SOL, Beneficiaries
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According to the recent quarterly survey completed in July 2003, 90% of clients reported satisfaction with the service they received from SOL.

6.	Churches, community groups, or VHCs will approach SOL concerning disrupted or poor quality services.	Local Church, SOL, CSP, CG
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SOL PHC structures such as area boards and committees with church representation have been providing feedback about quality of service and have lobbied for introduction of new services according to need. For example, following the DRF assessment showing the important contribution DRFs are making in the areas where they exist, said committees lobbied for the hospitals to train additional DRF volunteers. Additionally, specific villages lobbied at board meetings to have community-based distribution agents for family planning in their areas and the hospitals responded by scaling up said services.

3. Capacity Building

Capacity building remains a key strategy for project sustainability. The project is involved in capacity building at varying levels with different partners and stakeholders.

Community

Households in the project area are taught simple but very meaningful health messages to practice. The one-on-one interaction between volunteers and mothers is essential to building the sense of trust necessary for desired behavior change. The project has seen transformation within communities from a culture of non-care seeking, or from seeking care with traditional healers, to one in which seeking care at a health facility is a normal, supported behavior.

Care groups

Volunteers in care groups continue to be equipped with technical messages for household visits. Care groups have now been trained in all six project interventions. The project is promoting exchange visits between care groups to further solidify support and link individual group activities to a larger, extended community effort, which also facilitates capacity building. Care groups also receive support from local leaders such as Village Headmen, who recommend and recruit replacement volunteers and are influential in reaching households who are reluctant to adopt change.

Ministry of Health and Population

The MOHP has worked closely with the project, particularly through community-based Health Surveillance Assistants (HSAs). This partnership has contributed to HSA capacity building, especially pertaining to curriculum development, Care Group training and supervision, data collection, tabulation and analysis, Health community-based nutrition rehabilitation, etc. In most areas project promoters work closely with HSAs in Care Group meetings, supervision and household visits. HSAs also have been mentored to take over CSP promoter responsibilities when promoters are absent due sickness or travel. HSAs also use the project HIS data for their work in communities.

SOL PHC Staff

PHC staff in the three hospital catchment areas where the project is being implemented are actively involved in almost all areas of project implementation. Particularly they are involved in curriculum development, data collection and tabulation, promoter training and supervision. The ultimate goal is to enhance the capacity of the SOL to assume responsibility for child survival interventions.

Project Staff

The process of project implementation is inherently capacitating for staff and stakeholders. It emphasizes the importance of teamwork, participation, reflection and learning from experience. Project staff have had effective capacity building from baseline, project implementation, MTE, quarterly surveys, community HIS, curriculum development, promoter and Care Group training. The staff has also undergone several specific trainings, the latest of which was in qualitative research in May 2003. Even after this project phase concludes the remaining staff will have sufficient capacity and experience to continue moving forward.

PVO Cooperation

The regional workshop on qualitative research methods sponsored by CSTS in Lilongwe had positive outcomes above and beyond the obvious skill building in qualitative research methods and analysis. At the end of the workshop, WR hosted participants on a site visit to the Embangweni catchment area of its CSP, fostering in-country dialogue between PVOs working in child survival. Participants met with Synod PHC staff, care groups of volunteers and zone committees to learn about WR's strategy for child survival in partnership with the SOL.

As a result of WR's role in facilitating workshop details in country, WR was asked to organize PVOs working in Malawi for country planning for household and community IMCI. The preliminary planning meeting in September 2003 was very successful and the PVOs are poised to meet with representatives from the MOHP, Unicef and USAID and others in October to coordinate strategy and approaches to implementing HH/C-IMCI in Malawi.

	Progress on Capacity-Building and Sustainability Objectives for Community Groups	Responsibility
1.	1. 95% of villages will have established VHCs by the EOP 2. 80% of VHCs will have met at least once in the last 2 months 3. At their last meeting, 75% of the VHCs address at least 3 of 5 responsibilities (specified in partnership section) <i>Staff reports, VHC meeting records, M&E</i>	CSP,SOL PHC, VHCs

Most VHCs are no longer active. In most cases the reason is that they are not adequately and regularly supervised. Ekwendeni however, has started re-training all VHCs in the catchments area.

2.	1. Church care groups will be established in 65% of the communities in the project area. 2. Leaders from 60% of the congregations in the communities in with church care groups will participate regularly (at least half of the meetings over a quarter-year) in the meetings. 3. 60% of the participating pastors will have delivered an intervention related health message from the pulpit in the previous month. 4. 65% of the churches with educational programs (Sunday Schools, etc) will deliver intervention related health messages to their learners in the previous three months. <i>Church care group meeting records, M&E results.</i>	CSP, Local Churches
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Establishing pastoral Care Groups was planned for 2004 and community mobilization has just begun.

3.	Increasing numbers of community members report instances of sickness, malnutrition, and neglect to leaders, volunteers or promoters. CSP staff or volunteers, or SOL staff address at least one non-project related village meeting each quarter in which at least two are held. Community Advisory Boards meet quarterly.	Advisory Board, CSP, SOL PHC, Care Groups.
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Incidences of morbidity and mortality are reported at all meetings including Area PHC and Advisory boards. Communities now report perceptible declines in cases of morbidity and mortality associated with Malaria, Diarrhea and Pneumonia. Hospitals also report increased numbers of mothers starting ANC by first trimester and coming early enough to “mothers’ homes” to await safe deliveries. However due to acute food shortages in the country

communities feel malnutrition especially amongst under-fives still remains a challenge. Advisory Boards continue their quarterly meetings.

B. Challenges impeding Progress towards Achievement of objectives and goals

The post MTE period to-date has been characterized by a number of events and experiences that pose obstacles to the project's activities.

Natural disasters

In March 2003 the DGMH catchment area of the project was hit by landslides and flooding that claimed five lives. There was widespread damage to property, crops and livestock and infrastructure such as roads, bridges, water sources etc. The impact of the incident on the program was overwhelming primarily because significant proportion of project volunteers and beneficiaries were victims directly or indirectly. Care Group meetings and quarterly surveys were suspended in the area as disrupted communities were fending for their livelihoods. The project responded by directly assisting the victims with food items, shelter, seed, etc and appealing to other donors such as Red Cross to intervene. The project has since resumed regular activities in the affected area.

Food shortages

Due to erratic and inadequate rainfall and premature reserve food disposal by the government during this past year, Malawi experienced acute food shortages resulting in a sharp rise in both child and adult malnutrition and deaths from related complications. This state of disaster made regular Care Group activities particularly challenging, as volunteers were at times preoccupied with securing food for their households. Often volunteers would arrive at home visits and learn that caretakers were not at home but searching for food. When volunteers were able to find mothers, the food shortages understandably dominated conversations, and mothers were not able to focus on health messages. Predictions for continued food shortages in the coming year further complicate the project schedule. While WR has partnered with other agencies to respond to the famine crisis, there still is much unmet need throughout the project area.

Transport

Transport is key to ensuring adequate community contact and the necessary support to Care Groups and promoters. The vast nature of the project areas coupled with its poorly connected feeder roads makes transportation difficult and requires constant maintenance. In addition, one of the project vehicles was damaged in an accident this year, which further complicates the transportation challenge.

Staff Turnover

In 2003 the CSP Central Office lost its Accounts Assistant who is pursuing further education in the UK and a driver. Competent replacements have been found for both positions. One promoter

died and another went for training as a nurse assistant. Replacements were made by promoting very strong volunteers. Eleven volunteers were lost to death.

HIV/AIDS

AIDS continues to thwart project progress in various ways. Funerals are commonplace in project areas, given the extended family system, which complicates the scheduling of Care Group meetings. Hospitals are also challenged by the influx of patients overstressing an already under-resourced health system and ultimately compromising the quality of care. Needless to say, there is significant felt need for the HIV/AIDS intervention activities.

Inflation and depreciation

The local currency (Malawi Kwacha) has plunged against the US dollar. At the beginning of the project the currencies were trading at MK52 to 1US\$ but today 3 years down the road the local currency has depreciated by about 100% to MK109 to 1 US\$. Most manufactured goods including fuel and spare parts are imported, so prices have skyrocketed even relative to the US dollar. Additionally, food prices have increased as a result of national shortages. This has a direct effect on project supplies and activities, transport budget and purchasing power of staff salaries (paid in local currency per SOL structures).

Politics

Experience from past election years has caused the project to be aware of potential challenges, particularly to the attitude of self-help and spirit of volunteerism upon which the project's sustainability strategy relies. Monetary handouts and other tactics of manipulation have been known to interrupt development activities and create expectations for remuneration within communities.

C. Technical Assistance

The area of technical assistance is key for program success and the project has been getting the required technical assistance in timely manner. The project continues to benefit from the WR country office in Lilongwe and Headquarters in Baltimore on technical, financial, logistical and administrative aspects of the project through visits and electronic communication.

Project staff participated in the regional training workshop in qualitative research methods sponsored by CSTS, as aforementioned. CSTS also furnishes the project with valuable technical information and new areas of knowledge and initiatives for enhancing project effectiveness.

The Deputy Director participated in the CSHGP mini-university when he traveled to the United States to present project achievements at the 30th Annual Conference of the Global Health Council. His panel presentation was titled *Reaching out to larger communities: Effective Community Mobilization for Health Action*. The presentation focused on Care Group structure as a cost-effective strategy for providing services to larger communities in underserved remote

areas. At the Child Survival and Health Mini-University at Johns Hopkins, he participated in sessions including IMCI, Immunization, Sustainability Assessment Framework, Monitoring for Effectiveness, Supportive Supervision and Organizational Capacity Assessment. This afforded the project the opportunity to network and benchmark with other organizations doing Child Survival and Health programs.

D. Program Changes Requiring Modification to Cooperative agreement

There have been no changes to the project requiring modification to the cooperative agreement. The only significant changes, in accordance with MTE recommendations, have been the revision of two indicators so that ongoing measurements are standardized with the baseline.

E. MTE Recommendations & Action Plan

The MTE was conducted in August 2002. The table below shows the progress made toward implementation of each recommendation.

MID-TERM EVALUATION RECOMMENDATIONS ACTION PLAN			
	Recommendation	Responsibility	Target Date
A	Standardization of Indicators		
1.	The CSP needs to clarify the definition of project indicators and ensure that their measurement is compatible with the baseline KPC survey.	Project staff & WRM, SOL Health/PHC Coordinator	October 31 st , 2002

Response:

This has been successfully done in collaboration with SOL hospitals.

B	Drug Revolving Funds		
2.	The three Health Units in collaboration with CSP and the MOH should evaluate the status of the DRF program to identify and correct problems with the supply of essential medicines at the community level.	DHMT, Project Staff & SOL PHC	November 30 th , 2002

Response:

An evaluation was conducted in collaboration with SOL hospitals and MOHP. Recommendations were disseminated and currently inform the DRF program implementation in the Synod hospitals. A total of 103 DRF Volunteers have since been trained and positioned (Embangweni, 40; Ekwendeni, 30; DGMH, 33).

C	Obstetrical Emergency Transportation Plans		
3.	The CSP should encourage communities to develop community-wide emergency transportation plans in addition to family-specific plans, especially for complications of pregnancy. CSP, the three health units and the MOH should also strategically place bicycle ambulances in a few communities.	Project staff & SOL PHC	March 31 st 2003

Response:

Emergency obstetrical planning among communities has been emphasized. Increasing numbers of pregnant women are making use of “mothers homes” and delivering at hospitals, indicating that the planning has been effective.

D	Incentives for Care Group Volunteers		
4.	The CSP should identify and promote best practices for incentives to Care Groups. These might include: Services provided to Care Groups from the community; Recognition of well performing Care Groups by the MOHP and Health Units; Exchange visits between Care Groups; and Income generating activities.	DHMT, Project staff, SOL PHC & Local Leaders	November 30 th , 2002

Response:

A number of best practices as elements of the incentive system have been identified and are already being implemented in some communities. Some Care Groups been rewarded through exemption from community development work, for instance building schools, upgrading roads, etc., in recognition of the valuable work they are doing. The project is currently promoting exchange visits between Care Groups within the same project area as well as between project areas, which gives the Care Group volunteers a chance to share experiences, to feel part of a larger CS community, and also to be rewarded with the chance to travel to new community areas and be recognized.

E	Behavior Change Communications (BCC) targeted to Men		
5.	The CSP should target more BCC to men and community leaders. Possible strategies include: 1.0 Special training of village leaders; 2.0 Revitalizing “Mphala,” a tradition of men to boy communication; 3.0 Encouraging men’s discussion groups; and 4.0 Team visits by volunteers to difficult households	Project staff, promoters, Care groups, HSAs, SOL PHC, Local leaders & Men	End of FY2003

Response:

Training of VHCs is underway at Ekwendeni. Although not much has been done about revitalizing 'Mphala', some promoters have been holding meetings with men. Village leaders have been very supportive to promoters and volunteers by ensuring that difficult households are accessed and by encouraging community wide pressure to change unhealthy behavior practices.

F	BCC Materials and Training		
6.	The CSP should document best practices in Behavior Change Communications materials and make these widely available. These materials might include: <ol style="list-style-type: none"> 1) Durable picture codes for Care Group volunteers; 2) Written materials in the local language for volunteers and village leaders; 3) Orientation programs for community leaders; and 4) Appropriate audio-visual equipment for Health Units 	CSP staff, WRM & MOH	End of FY2003

Response:

The project is responding to the above recommendation to the fullest extent the budget will allow, as the recommendation has significant cost implications. The project is preparing a file for volunteers with improved BCC materials including pictures and simple text in Tumbuka. This will promote internalization and learning beyond the project life. The project has benefited from WR Malawi's AIDS program materials, and the health educators are now equipped with teaching aids on HIV/AIDS.

Community leaders: 1) individual contact with promoters and volunteers and 2) in a group setting with other village leaders. Promoters are also expected to meet with headmen once a month to communicate the project's activities, messages and HIS results.

G	Program Integration CSP and Synod		
7.	The CSP and the three Health Units should consider how promoters might provide integrated, cost-effective support and supervision for all community-based Synod health initiatives.	MOH, Project Staff, SOL PHC, Local Leaders, Promoters, care groups	End of Project, 2004

Response:

This is currently underway in all 3 project areas. The process is more advanced in DGMH because PHC and CSP engage the same volunteers in all PHC work.

H	Project Expansion and Replication		
8.	The CSP, the three Health Units and the Synod	Synod	End of

	should examine the geographic reach of its current programs to: Determine how to reach inaccessible areas within the current CSP project area and Discuss options with the MOHP for expanding services to other communities and health areas.	Secretariat, MOH, CSP, SOL Health/PHC Coordinator, SOL PHC	Project, 2004
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Response:

Discussions are underway with MOHP, SOL and other key stakeholders to explore the possibility of extending certain aspects of the project to benefit other communities in need.

I	Exit Strategies and Local Sustainability		
9.	The CSP should consider diversifying strategies to sustain Care Groups. In addition to strengthening VHCs, alternatives might include: Regular meetings between Chief volunteers and village headmen; Care Group Zone Committees; and Increased links to HSAs and health centers.	MOH, Project Staff, SOL PHC, Local Leaders, Promoters, care groups	April 30 th , 2004

Response:

The project is designed in such as way that Care Group structures will continue to receive effective support from local NGOs and MOHP through Health Surveillance Assistants (HSAs). In most areas there is excellent coverage by HSAs in the absence of project promoters. Local structures such as village headmen recognize the Care Groups structure and are also supportive. Community initiatives such as zone committees in all 3 areas will ensure care groups are sustained and remain effective. This is an important part of the exit strategy. The project is also planning to integrate health and nutrition and food security in the area through. Appropriate Care Groups will be involved in food security activities, creating additional incentive to ensure the durability of Care Groups.

J	Health Information System		
10.	CSP should strengthen project monitoring and information exchange. Specifically, CSP should: 1) Adopt standardized tools to supervise promoters and Care Groups, 2) Improve information feedback to communities; 3) Increase information exchange with the MOH and within Synod Health Units; and 4) Improve the mapping of project areas and activities as part of the health district system.	Projects staff, SOL PHC, Promoters & care groups	April 30 th , 2003

Response:

The project has been successful in instituting a very comprehensive system of data collection and sharing for decision-making at different levels of the project. The elements of project HIS are as follows:

Community Health Information System

Volunteers collect information monthly and report at Care Group on various relevant indicators. Care Groups use this information to track progress of specific indicators and to identify problems and possible solutions. Care Groups and promoters also use this information to lobby for services such as ITNs and DRFs, and in discussion with local leaders, helping them remain informed about the health situation in their areas. The staff has been creative in communicating the HIS results in ways that community members can understand and connect with the results on an emotional level. For example, if 100 children were sick with malaria but only 60% went to the hospital within 24 hours, they focus on the high risk of death for the number of children whose caretakers did not take them for treatment. Appropriate delivery of the HIS results with communities and local leaders has been very effective in encouraging them to follow key family practices.

The project staff uses HIS data for activity planning, monitoring and implementation. This HIS also facilitates Care Group and promoter supervision, allowing the project to identify weak volunteers and to tailor support and supervision. The Care Groups and promoters use metaphors to describe benefits and utility of the HIS. They describe it as *light*-meaning the HIS shows where one is coming from and going. They call the HIS *supervisor*-because it provides guidance, helps to identify problems and potential solutions. They say it is a *planner*-because the HIS informs plans for project activities to be carried out each month.

Local Rapid Assessment (LRA) Surveys

LRAs capturing specific indicators are conducted every quarter to track progress. The LRAs complement the community-based HIS. CSP promoters maintain ties with HSAs to ensure that the LRA information also feeds into the MOHP health information system. The SOL Primary PHC Programs also use LRA data for effecting health actions and instituting future health plans. The project makes use of information for monitoring progress, formulating supervision and support plans and in resource allocation. Health promoters within communities are now completely responsible for data collection methods, tabulation and analysis.

F. Phase-Out Plans

From the beginning, care group training has been done with an eye towards enabling the volunteers to continue their activities and without dependence on the paid project staff. The Care Groups hold regular meetings even during off weeks when project promoters are not scheduled to meet with them to provide training. Some Care Groups will expand their portfolios of expertise to include food security, as described above

Potential sources of encouragement for the Care Group volunteers sustained activity includes the zone committees, VHCs where they exist and the government Health Surveillance Assistants who have been actively included in the training of promoters and even fill in for promoters when they are sick or unable to attend a scheduled care group meeting. The HSAs are part of the SOL PHC teams.

The specifics of how each health unit will integrate the child survival volunteers into its ongoing programs remains to be worked out in conjunction with each of the three hospital PHC teams. This is on the agenda for upcoming PHC meetings. At the time of the proposal and DIP, the vision was for each hospital to integrate its PHC activities into that of child survival. Specifically, it was anticipated that the hospitals would look to the care groups for all of their community-based volunteer needs. Unfortunately, the primary champion of this approach who would have had the position and influence to work towards this left the SOL shortly after the commencement of the CSP. In reality, the various health units have proved to be very tied to their independence as well as to their own combination of vertical programs with different managers and sources of funding. Only DGMH has streamlined its use and management of community volunteers so that all volunteer initiatives go through the care groups. The SOL health department has since revised its goal to a single approach and encourages each health unit to tailor integration and sustainability of CS activities (namely those of the care group volunteers) as it sees fit.

G. Program Management Systems

Logistic management and Procurement

At the project's central office logistical management is primarily the responsibility of the Accounts Assistant whereas at hospital level it is done between the area coordinator and accounts assistant. Efficient logistical management is important for project success given that the 3 project areas are non-contiguous and that DGMH is highly challenged by rough, seasonal roads and rugged terrain. The project also ensures timely procurement of supplies such as fuels, motor vehicle/cycle spares, stationery, training materials, volunteer incentives in line with procurement policies, standards and requirements set out.

Financial Management System

Financial management systems are adequate and appropriate. The project compiles regular monthly financial reports to periodically monitor project financial situation and expenditure. Quarterly budgets are also produced in time for planning and expenditure control. The project receives regular feedback from WR headquarters. Graham Carr, external auditors also provided policies and guidelines for project financial management. Project financial books are currently being audited.

Human Resource Management

Human resource management, including remuneration systems, are in place. Staff terms and conditions of employment are governed by SOL Health policies that are in line with the government policy requirements.

Communication System and Team Development

Although project systems and procedures postulate formal communication systems there is also increasing recognition of the importance of informal information sharing. Good relationships between team members facilitate team building and information sharing. Teamwork provides the necessary medium for project learning and reflection. It also provides an atmosphere conducive to innovation, risk taking and creativity. Personal contact is emphasized to a foster spirit of openness, trust and confidence. The project central office is well connected with the three project areas by telephone and hospital VHF radio communication.

Local Partner Relationships

There are a number of partners and stakeholders that complement the efforts of the project including the MOHP and other NGOs. Since the beginning, the project has made efforts to bolster its relationships with key partners in order to better support communities. The project does not have adequate resources to meet the “bottomless” pit of community needs and realizes that it is only through improved levels of partnerships that enough synergy can be achieved and harnessed to meet the needs of communities. For instance the project relies on MOHP and SOL to provide services such as ITNs, DRFs, and contraceptives.

PVO Coordination/Collaboration in Country

The CSP seeks to coordinate with other PVOs in every possible way, however most of the areas served by the project are the areas least served by other NGOs, except in some parts Ekwendeni where Plan International and World Vision are operational. Plan international works in the area of orphan support and water and sanitation and food security while World Vision focuses on micronutrient promotion. As mentioned, WR hosted other PVOs in Embangweni at the conclusion of the Qualitative Research Methods workshop and is the lead PVO for organizing the PVO meetings to discuss HH/C-IMCI.

Organizational Capacity Assessment

Although the project has been involved in organizational capacity assessment this has not been formal, disciplined and systematic. At the beginning of the project, the project in collaboration with the SOL conducted an informal assessment of strengths and weaknesses with regard to areas of expertise, service provision and relationships with communities. Periodic assessments since then have contributed to strengthening quality of care at the facility level and improved patient-client interaction.

Following feedback from the ISA, WR has worked to deliberately incorporate recommendations into its work. For starters, the process, originally done with the maternal and child health programs, was repeated with WR's HIV/AIDS programs, a stated objective in the ISA report.

Towards promotion of information dissemination and learning across projects, the Rwanda CS Program Manager visited the Mozambique CSP, and the Malawi and Cambodia CS managers came together at headquarters in the context of the CSHGP mini-university and Global Health Council, where both programs made presentations. These opportunities also afforded time for informal sharing and discussion of similarities and differences between respective projects. Computer and English training in the field was a request from some programs, which HQ encouraged staff to pursue locally and has happened in Rwanda, where it was of particular priority. With regard to financial management, WR has adopted upgraded financial tracking software and introduced its use to field offices. Timely financial reports from the Malawi CSP to HQ have resulted in more systematic financial tracking and timely fund transfers.

H. FY 2004 Work Plan

Planned Activities	Responsibility	Time Frame: Oct 2003-Sept 2004											
		O	N	D	J	F	M	A	M	J	J	A	S
TBA Refresher Training in the three base units	SOL PHC, CSP, Local Leaders	x	x										
Formation and Training of Pastors' Care Groups	Local Churches, CSP	x	x	x									
DRF Volunteers Refresher Training	Sol PHC, MoHP, CSP							x	x				
Care Group graduation process	Local Leaders, CSP, SoL PHC				x	x	x	x	x	x			
Strengthen Community-Based HIS in Care Groups	CSP, SoL PHC, Local Leaders, Promoters, MoHP	x	x	x	x	x	x	x	x	x	x	x	X
Baby Friendly Initiatives at DGMH	CSP, DGMH, MoHP	x	x	x	x	x	x	x	x	x	x	x	X
Retraining of Care Groups on all interventions	CSP, SoL PHC	x	x	x	x	x	x	x	x	x	x	x	x
Scale up Hearth Activities	CSP, Communities	x	x	x	x	x	x	x	x	x	x	x	x
Establish and Train 5 HIV/AIDS Post-Test Clubs	CSP, SoL PHC	x	x	x	x	x	x						
Malaria, Pneumonia, Nutrition, Family Planning, HIV/AIDS/STI, Maternal and New Born Care continues at household level	CSP, SoL PHC, Care Groups, MoHP	x	x	x	x	x	x	x	x	x	x	x	x
End of Program Evaluation	WR HQ, WRM, CSP, SoL.										x	x	
Dissemination of Evaluation Findings to stakeholders	CSP, SoL, MoHP											x	x
Conduct Project Exit Meetings	WRM, CSP, Local leaders, SoL, MoHP								x	x	x	x	x

I. YEAR 3 HIGHLIGHT: INTEGRATED ACTIVITIES IN RESPONSE TO FAMINE

In 2003 the World Relief (WR) Malawi Tiweko Tose Child Survival Program (CSP) saw tremendous innovation and commitment demonstrated by the staff, Care Group volunteers and household members in response to critical food shortages in the program area. As the crisis neared a state of disaster, the CSP expanded its activities to ensure food availability at the household level.

Tiweko Tose joined hands with communities, the Synod of Livingstonia (SOL) Development Department, SOL Primary Health Care Department and the Ministry of Health and Population (MOHP) to implement a six-month integrated nutrition program to arrest the deteriorating nutritional state among children, women of child bearing age, and the general population. The care group volunteers played a key role in ensuring that dry rations, distributed to 3000 families, were in fact received by the intended recipients. The end of the program results were very encouraging, with a measurable reduction in mortality and morbidity rates (See Annex B).

The CSP staff and volunteer Care Groups widened their scope of work beyond CSP activities in order to mobilize their communities in response to the food crisis. The Care Groups proved highly effective in this disaster situation as they mobilized families for supplementary food distributions and provided nutrition education.

The CSP's work and experience combating disease and malnutrition in this year's famine situation has enabled WR Malawi and the SOL hospitals to develop a joint agriculture and food security proposal. The proposed program will expand on the famine relief experience and empower communities to initiate crop diversification, promotion of small irrigation and livestock schemes, and income generation activities. The long-term expectation is that volunteer Care Groups will lead their communities in detecting and addressing chronic or acute food shortages, minimizing the need for outside relief and assistance. Mobilization meetings have already begun with hospitals and CSP staff.

Annex A: CSP Success stories

Changing Community Norms and Value Attributed to Healthy Behavior

From the Project Director

- Funerals are one of the most sacred cultural events in the project area. A funeral event in the village is characterized by suspension of all public events including Care Group meetings. However we have noticed that such values and norms are gradually beginning to change. In DGMH during one of the Hearth sessions, the village headmen sanctioned that mothers should continue to attend sessions with their children even when there is a death in the villages.
- One of health promoters for Embangweni who is responsible for one of the most remote areas of the project site had no place to stay overnight when traveling to the villages to facilitate care group meetings. The village headman of that area arranged accommodation with a family in the village for her, a clear indication that the promoter is valued and accepted in the area. When asked why he decided to give her the house the village headman said ‘it is in appreciation of CSP in my area’.
- Use of metaphors for community-HIS particularly in Ekwendeni reflects change of attitude. Though difficult to grapple with in the beginning promoters, Care Groups and communities appreciate the value of knowledge about health situation in their areas. Names such as *light*, *planner* and *supervisor* are used to refer to community HIS.
- Care Group volunteers are now exempted from voluntary community work in some communities in appreciation for their valuable role as village health educators.

ANNEX B

Integrated Nutrition Activities

Problems addressed: Malnutrition, Common diseases, Mortality

Target Population: 3,000 Households

Summary of Baseline results:

Morbidity: -Malaria, 31.3%, Diarrhea, 27.6%, Pneumonia, 12.6%, Edema, 5.1%
76% illness in total population

Mortality: Crude MR =1.03/10,000 persons/day U5 MR= 2.35/10,000 persons/day

Nutrition Indices: Stunting (HAZ), 57.2%, Wasting (WHZ), 2.06%, Underweight (WAZ), 20.4%

Measles and Vitamin A coverage: Measles, 90%
Vit A, 89%

CSP Project Inputs: CSP Core staff, volunteers & Care Groups, Nutrition and Health education, food items such as maize grain/flour, Likuni Phala (Porridge blend), cooking oil, training/orientation, monitoring tools, transport (Motor vehicles and motorcycles), health extension and SOL staff.

Results:

1. Morbidity Indicators

Indicator	End of Project Survey		Baseline Survey		Significance
	n	%	n	%	
Malaria	244	29.9	266	31.3	NS*
Diarrhea	115	14.1	235	27.6	p<0.001
Pneumonia	115	14.1	107	12.6	p<0.001
Edema	7	0.9	41	5.1	p<0.001

NS*=Not Significant

2. Vaccination Coverage Indicators

Antigen	CARD		RECALL		TOTAL	
	EOP Survey	Baseline Survey	EOP Survey	Baseline Survey	EOP Survey	Baseline Survey
	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)
Measles	643 (78.7)	627 (74.1)	101 (12.4)	132 (15.6)	744 (94.2)	846 (89.7)
Vitamin A	563 (68.9)	595 (69.9)	93 (11.4)	150 (17.6)	656 (80.3)	851 (87.5)

3. Mortality Indicators

	End of Project Survey		Baseline Survey	
	n	Deaths/10,000 persons/day	n	Deaths/10,000 persons/day
Crude Mortality Rate	24	0.68	36	1.03
Under Five Mortality Rate	8	0.90	22	2.35

4. Nutritional Indicators

Nutritional Indicator	End of Project Survey		Baseline Survey	
	n	%	n	%
Children with height-for-age < -2 z-score (Stunted)	462	58.0	469	57.2
Children with weight-for-age < -2 z-score (Underweight)	141	17.4	170	20.4
Children with weight-for-height < -2 z-score (Wasted)	19	2.4*	16	2.06*

*= Overall acute malnutrition

Note: During this short period, nutritional indices did not significantly improve. However, there was a reduction in underweight-for age z-score proportions from 20.4% to 17.4% including a decrease in edema, from 5.1% to 0.9%.