

VITAMIN A FOR CHILD SURVIVAL PROJECT
Chikwawa District
Lower Shire Valley, Malawi

MID-TERM EVALUATION
October 17 - 31, 1993

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MALAWI

MID-TERM EVALUATION

for

VITAMIN A FOR CHILD SURVIVAL PROJECT
Chikwawa District
Lower Shire Valley, Malawi

Submitted to:

The International Eye Foundation
Bethesda, Maryland, USA

Written by: M.P. Selvaggio
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ACRONYMS

ADRA	Adventist Relief and Development Agency
A.I.D.	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
ALRI	Acute Lower Respiratory Infections
ARI	Acute Respiratory Infections
CDD	Control of Diarrheal Diseases
CDIE	Center for Development Information and Evaluation (within A.I.D.)
DIP	Detailed Implementation Plan
EEC	European Economic Community
EPI	Expanded Program on Immunization
GOM	Government of Malawi
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IEC	Information, Education, and Communication
IEF	International Eye Foundation
I.U.	International Units
KPC	Knowledge, Practices, and Coverage
MA	Medical Assistant
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organization (see also PVO)
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PACD	Project Assistance Completion Date
PCV	Peace Corps Volunteer
PHC	Primary Health Care
P _m	Person-Months
PVO	Private Voluntary Organization (see also NGO)
TA	Technical Assistance
ToT	Training of Trainers
VHC	Village Health Committee
VHV	Village Health Volunteer
USAID	United States Agency for International Development

MAP OF MALAWI

DISTRICTS OF MALAWI

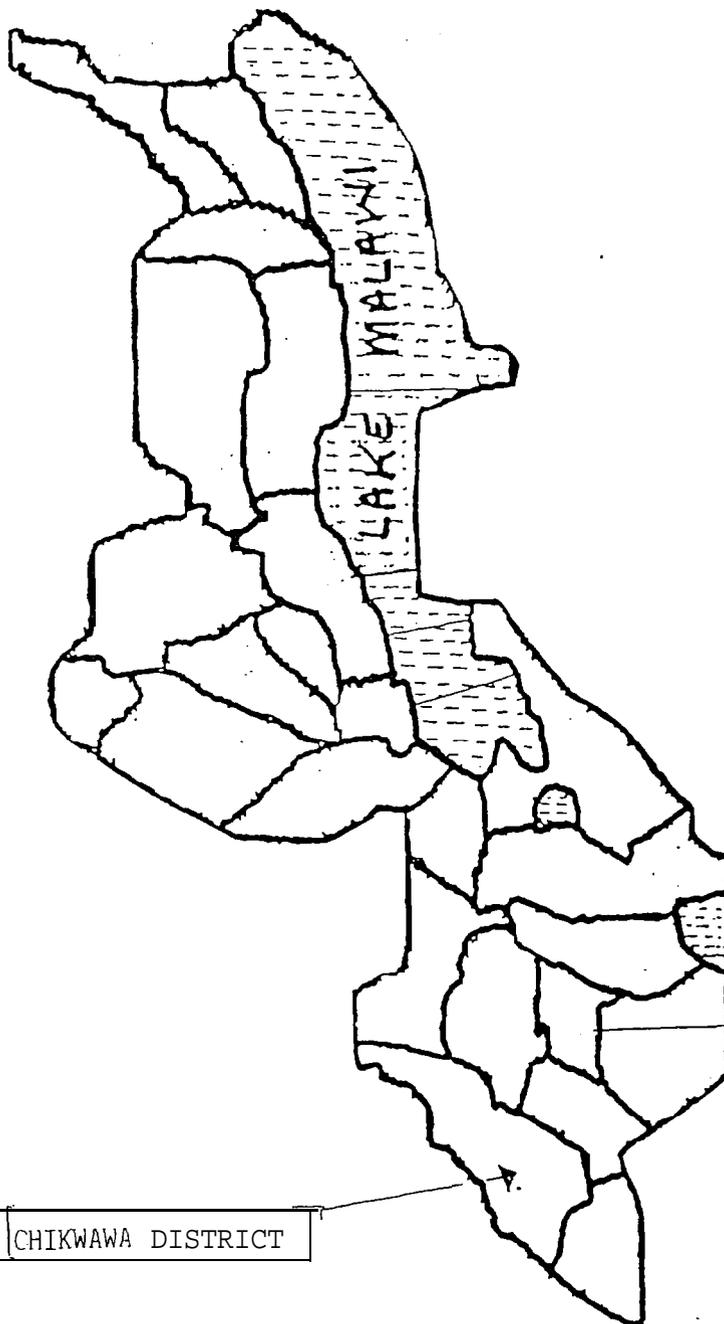


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BACKGROUND

The International Eye Foundation (IEF), a non-profit private voluntary organization (PVO) based in the U.S., has a long history of assistance to the health sector in Malawi. IEF first started working in Malawi in the early 1970's, fielding ophthalmologists to establish and deliver ophthalmological services in the southern region of the country. Support for vitamin A distribution was also part of this assistance.

In the late 1980's, IEF received funding from A.I.D./Washington to implement a two-year (1989-1991) pilot program for community-based vitamin A distribution in rural Chikwawa and Nsanje Districts. The project worked in forty-five villages and distributed vitamin A capsules and information on a campaign basis. An evaluation of that project (3) found that the use of village volunteers to promote vitamin A supplementation was successful, although stronger health education services would have contributed to even greater success. The campaign approach was found to not be sustainable.

The "Vitamin A for Child Survival Project", the focus of this evaluation, is also funded by A.I.D./Washington and is a three-year (1991-1994) follow-on effort building on the experiences of the first pilot project. The Vitamin A for Child Survival Project expands both the number of interventions to be delivered as well as the size of the population to be targeted. This project works in nearly 400 villages in Chikwawa District, promotes a wide range of child survival services and collaborates closely with all MOH services in the district.

At the time of this mid-term evaluation, the project had been operational for 21 months, since January 1992, although funding was available from September 1991. Project implementation was delayed for four months until January 1992 because a no-cost extension (through December 1991) was granted to the previous project. Approximately ten months remain until the Project Assistance Completion Date (PACD) which is scheduled for August 1994. At the PACD, the project will have been implemented for only 31 months, not the 36 months usually allocated for child survival projects.

This evaluation report documents the accomplishments and achievements of the IEF/Malawi Vitamin A for Child Survival Project in thus far achieving its objectives, as well as to recommend areas of improvements or further attention. The organization of the following discussion follows the outline and questions set forth in the " 1993 FHA/PVC Child Survival Mid-Term Evaluation

¹ Chikwawa District, situated in the southern tip of Malawi in the Lower Shire Valley, is famous for its high temperatures and dry climate. An estimated 400,000 people live in the district, of which 22 percent are women of child bearing age and 21 percent are children under five years of age. Infant mortality is higher in the district than for the nation as a whole (174 in the district vs. 151 in Malawi). Water is generally a problem for the area, and only half the population have access to potable water supplies and sanitation facilities (8).

Guidelines” developed in A.I.D./Washington.

The evaluation team was comprised of one IEF/US representative (J. Brown), an external evaluator (M.P. Selvaggio), five IEF/Malawi staff (H. Chikhosi, R. Mmanga, M. Alifinali, H. Kalivina, and R. Berger), one representative from the regional office of the Ministry of Health (M. Bokosi) and a representative from Project HOPE (H. Gondwe), another PVO working in Malawi. The **full** names and titles of these individuals are found in Annex B. The team conducted interviews with IEF field staff, mothers from targeted communities, community representatives, project-supported Health Surveillance Assistants and Village Health Volunteers, and representatives from MOH health centers. In addition, information for this report was also obtained from project documents, from interviews with district and regional MOH staff, and from interviews with ADRA (a collaborating NGO). In-country interviews and data collection took place between 17 and 31 October 1993.

EXECUTIVE! SUMMARY

The IEF/Malawi Vitamin A for Child Survival Project was evaluated in October 1993 by a group of external and project personnel. The project, operational for 21 months at the time of the evaluation, was present in nine (of eleven total) health catchment areas of Chikwawa District and had established a village-level health infrastructure where none previously existed. This infrastructure, comprised of personnel, commodities (vitamin A, ORS, and condoms), and information for child survival is credited with extending critical child survival services to a needy and vulnerable population. The village-level health infrastructure was also designed to compliment the services provided by the MOH at its clinics and rural hospitals in the district.

Of many notable project accomplishments, IEF is highly recognized throughout Malawi for successfully establishing commodity distribution at the community level, making it a leader in village-level health promotion. The establishment of this community-based supply system appears to have contributed to an increased demand for ORS, vitamin A and condoms. IEF is also regarded as a leader in Malawi for having fostered effective and vital NGO-NGO and NGO-GOM collaboration where little or no collaboration earlier existed. Finally, IEF staff and project consultants have conducted considerable scientific research (on breastfeeding, vitamin A, use of volunteers in village health programs, eye disorders and blindness, and the extent of malnutrition during drought) which has strengthened the project itself and has assisted the Malawian MOH in their policy making efforts.

In the coming year, the project needs to strengthen its IEC efforts at the community level to return to the strong IEC emphasis of the project as presented in project proposal and DIP. The use of alternative IEC materials or modalities (radio, drama, group sessions) should be explored to compliment the present emphasis on one-on-one talks. Other recommendations for the remainder of the project concern the need to provide project management staff and HSAs with supervisory training, and revising the project's information system to include data on IEC and commodity flows.

1. **ACCOMPLISHMENTS**

The IEF/Malawi “Vitamin A for Child Survival Project” has been operational for 21 months, since January 1992. Table 1 provides a summary of the numerous inputs which have been financed by the project, and the measurable outputs which have occurred as a result of project efforts.

IEF has established its program in nine of 11 targeted catchment areas in the district. In the nine areas where IEF is currently operating, an estimated 70% of women and children (or an estimated 127,000 of total project target of 222,000) are now believed to be beneficiaries of some or all project inputs and outputs.

To date, the most significant project achievement has been the establishment of a strong village-level distribution system for vitamin A and ORS. In each and every interview conducted during this evaluation -- whether with mothers, community leaders, Ministry of Health staff, or other NGO representatives -- the distribution of vitamin A and ORS was mentioned as the single most effective and successful project activity. As condom distribution has recently been added to the project, it is expected that this will also prove to be successful in the coming months. As a result of establishing this community-based supply system, the project appears to have contributed to an increased demand for ORS, vitamin A and condoms.

Another project accomplishment is the training and deployment of more than 500 health care staff (volunteers and health surveillance assistants [HSAs] for the delivery of health education and commodity services at the community level. These individuals are providing information, education, commodities and referral services to village residents where little outreach had previously occurred. MOH health personnel working in the district (less active at the village level due to transportation constraints) were particularly satisfied with the referrals made by project volunteers, as well as the information sharing which takes place between village-level IEF personnel and their facilities. The success of the recently launched AIDS control activities at the village level (condom distribution and AIDS education) is a result of this deployment.

IEF is also to be credited for facilitating the development of a national vitamin A policy. Until IEF's involvement, the MOH protocol for vitamin A supplementation was not fully understood or effectively implemented. Following the visit of a project-sponsored consultant from Helen Keller International (HKI/VITAP) who examined the use of vitamin A in drought relief programs, a national vitamin A policy was prepared (with IEF collaboration with UNICEF) and has been distributed nationwide.

Table 1
IEF/Malawi Vitamin A for Child Survival Project: Mid-Term Evaluation
MEASURABLE INPUTS, OUTPUTS, AND OUTCOMES (as of October 1993)

INPUTS** (estimated total cost: \$ 516,000)	OUTPUTS	OUTCOMES
<p>EXPATRIATE STAFF 21 person-months)</p> <p>TECHNICAL ASSISTANCE 32 person weeks short-term)</p> <p>LOCAL STAFF (80 pm Technical Support; 105 pm Administrative Support; 42 pm Peace Corps Volunteers; 216 pm HSA support)</p> <p>TRAINING (46 pm for 22 HSAs; 160 pm for 505 village health volunteers; 300 pm for 3000 village health committee members; 9 pm for other non-IEF health workers; 2.5 pm for IEF staff development)</p> <p>REHABILITATION of Chikwawa Office and House</p> <p>SURVEYS/RESEARCH: 1 Baseline KPC; 3 Nutrition Surveys for Drought Monitoring; participation in 4 other nutrition surveys; technical support given for 6 other surveys: focus groups with MOH staff and mothers on breastfeeding.</p> <p>COMMODITIES: 220,000 Capsules Vitamin A; 3 Vehicles, 12 motorcycles, and 10 bicycles (for HSAs)</p> <p>Office Furniture: (desks/chairs for 9 IEF staff and 14 HSAs; 1 photocopier: 1 fax machine)</p> <p>Computer equipment: (2 PCs, 2 printers)</p>	<p>Functioning commodity distribution system in place at village level.</p> <p>26 community oriented individuals trained in basic HC services delivery (volunteers, HSAs, community leaders).</p> <p>38 MOH Nurses and Medical Assistants trained in exclusive Breastfeeding (38 at district level + 20 at regional level)</p> <p>Assisted with development of a national vitamin A policy.</p> <p>Assisted with development of vitamin A poster for national distribution (but printing not yet completed).</p> <p>Publication of a nationally-distributed newsletter issue on exclusive breastfeeding.</p>	<p>Changes in morbidity and mortality not yet possible to measure.</p>

Inputs refer only to the resources provided by A.I.D. and IEF and do not reflect the MOH's in-kind contribution to the project (mostly staff salaries) or contributions by other donors such as UNICEF and EEC for related health activities.

A fourth accomplishment is project's role in promoting exclusive breastfeeding in Malawi. IEF undertook a series of investigations (analyzing baseline data, conducting focus groups, and sponsoring an infant feeding consultant from Wellstart International) to document the extent of poor feeding practices. Through this process, IEF noted that MOH personnel at the clinic level were significantly contributing to poor feeding practices through detrimental advice they were offering to mothers of newborns. IEF launched an intensive training effort aimed at MOH staff as well as providing IEC at the community level. IEF also wrote an entire issue of a local health newsletter (EPI Bulletin) devoted to the topic of breastfeeding. This newsletter is distributed nationwide to all health officials in the public and private sector. While the full impact of IEF's efforts in promoting exclusive breastfeeding will not be known until the end of the project, IEF is credited with stimulating broad awareness of the need for improved infant feeding in Malawi.

A fifth project accomplishment is the IEF's contribution to developing nutritional assessment skills among MOH and NGO staff at regional and district level. This occurred in the early months of the drought when it became clear that there was no effective mechanism for targeting food and other drought relief services to the most vulnerable populations. IEF took the lead in training government and NGO staff in nutritional assessment. This data was then used for broad ranging drought relief interventions.

The project director and the project ophthalmologist have directed considerable effort toward the publication of numerous scientific articles related to the project (see Annex H). These have concerned the role of village health volunteers, malnutrition during drought, and studies related to eye **diseases** and disorders. The on-going studies of village **health** volunteers have been supported by the Malawian MOH and other **NGOs**, such as ADRA, Project HOPE, and Save the Children (**UK**).

Finally, largely as a result of IEF's work on drought and breastfeeding issues, a significant accomplishment is the establishment of productive working relationships with the regional MOH, district MOH, **and** other **NGOs** working in the **southern** region of Malawi. As a result of the considerable efforts of the country director, IEF has been very instrumental in establishing **an** effective forum for NGUMOH collaboration which did not exist prior to this project, but which were initially established to coordinate drought response. Now, regular meetings are now held between the MOH and all **NGOs** working in the **health** sector in southern Malawi and these meetings have evolved from a focus on drought relief to general development. The country director, in coordination with the Regional Health Officer, coordinates and manages the **MOH-NGO** collaboration sets the agenda of these meetings. The country director's strong leadership role has contributed to enhanced **NGO-MOH** relations throughout the region.

2. RELEVANCE TO CHILD SURVIVAL PROBLEMS

“Relevance” refers to the appropriateness of interventions given the needs of the beneficiary population. **A.I.D./CDIE** states that to be relevant in health terms, a program or project should allocate its resources in proportion to the seriousness of the varied health problems affecting the population.

In Malawi, the leading causes of both morbidity and mortality among hospitalized inpatients and outpatients are malaria, respiratory infections, undernutrition, AIDS, diarrheal diseases, and anemia (1). In Chikwawa District, the main causes of morbidity among children are: malaria, diarrhea, and upper respiratory infections (8). The absence of adequate water supplies contributes greatly to the very high prevalence of water-borne diseases. An estimated 30 percent of all children are underweight. The main causes of child mortality, however, are: malnutrition and anemia, **AIDS**-related complaints, and malaria (8).

For all **health** problems, women and children are the most vulnerable groups in the country. Although physical accessibility to health services is not a constraint in Malawi, as most Malawians live within 8km of a health facility, most MOH services are limited and lack effective outreach into their communities.

IEF presented its proposed technical approach to address these health problems in both the Project Proposal (4) and the Detailed Implementation Plan (DIP)(S). The project is designed to build a service delivery **infrastructure** at the village level which complements **Ministry** of Health services and which can be easily integrated into MOH structures for sustained program impact. The project also aims to increase demand for child survival services through directly involving and supporting volunteers and village health committees. This project consists of: (1) promoting utilization of certain MOH services (EPI and primary eye care); (2) delivering key commodities at the community level (vitamin A, ORS, and condoms); and (3) educating the general public on healthy practices to promote child survival (**breastfeeding/weaning**, basic hygiene, and HIV/AIDS). The MOH is generally not providing these services at village level.

As presented in the project proposal and DIP, the mix of IEF project interventions is appropriate for meeting the common health problems in Chikwawa District. **EPI** coverage is monitored through a household register, and mothers are encouraged to take their children for vaccinations at the appropriate time. IEF **HSAs** also assist MOH staff in delivering immunizations in under-five clinics. Control of diarrheal diseases is addressed through distribution of ORS packets to diarrhea patients, and in hygiene/sanitation education. Construction of water supplies is not a component of this project, because other organizations are involved in this. Improved child nutrition is promoted through vitamin A supplementation, educating mothers on exclusive breastfeeding, and demonstrating how to prepare appropriate weaning foods. HIV/AIDS control is addressed through distribution of condoms at village-level and IEC on AIDS for village residents and traditional

Table 2
IEF Vitamin A for Child Survival Project
Mid-Term Evaluation
PLANNED, ACTUAL, AND TARGETED ALLOCATION OF A.I.D. RESOURCES

INTERVENTION	PLANNED use of A.I.D. funds (percent)	ACTUAL use (by mid-term) of A.I.D. funds (percent)	REVISED TARGETED use of A.I.D. funds by PACD (percent)
	June 1992 (DIP)	October 1993	September 1994
A. ORT	25 %	25 %	25 %
B. Immunization	20 %	15 %	15 %
C. Nutrition (sum of 1,2,3 below)	45 %	40 %	45 %
1. Breastfeeding	(15 %)	(15 %)	(17.5 %)
2. Weaning process	(15 %)	(15 %)	(17.5 %)
3. Maternal Nutrition	(15 %)	(10 %)	(10 %)
D. ALRI	0 %	0 %	0 %
E. Family Planning/Maternal Care	0 %	0 %	0 %
F. Other (sum of 1 and 2 below)	10 %	20 %	15 %
1. HIV/AIDS	(5 %)	(15 %)	(10 %)
2. Primary Eye Care	(5 %)	(5 %)	(5 %)
TOTAL	100 %	100 %	100 %

healer?. Primary eye care is addressed through distribution of vitamin A, education on face washing, and referrals to MOH for eye infections and injuries.

“Relevance” also refers to the appropriateness of the strategies employed to improve health status.

² IEP has also received additional funding totalling K160,000 (or approximately \$38,000 at current exchange rates) from UNICEF, Action Aid, and the EEC to implement complementary HIV/AIDS activities in Chikwawa. These supplemental funds are used for educating groups which are outside the focus of this child survival project (i.e. bar girls, youth, some traditional community leaders, horecraft extension workers), and for developing peer educator programs.

The project is designed to work closely and collaboratively with **all** Ministry of Health structures and personnel in order to enhance future sustainability of project activities. This is relevant, given the limited resources available to the district. In addition, the project's focus on village-level personnel (health committees and volunteers) to increase accessibility to health information and basic services is also relevant.

Table 2 above presents the planned allocation of A.1 .D. contributions (as presented in the project DIP) compared to the actual allocation to date and the targeted allocation by the end of the project. The slight differences between planned and actual targeted allocation of project resources are attributed to an overstatement of maternal nutrition activities in the **DIP**, and the fact that EPI coverage was **already** quite high in Malawi at the start of the project. Thus, slightly greater emphasis is given in the project to HIV/AIDS interventions, and **breastfeeding/weaning**.

3. EFFECTIVENESS

“Effectiveness” refers to the extent to which services are reaching the intended beneficiaries. Effectiveness has two dimensions -- **coverage** of services (a quantitative measure of project performance) and **quality** of services (how well the services meet the needs of the beneficiaries).

3 . 1 Coverage

At the time of this evaluation, coverage information was available from the project's information system for vitamin A capsule distribution and EPI services. Among children between 12 and 23 months, EPI coverage has increased from 67 percent at baseline to 70.8 percent at mid-term. Among children 6 months to 6 years of age, vitamin A supplementation increased from 13.9 percent at the baseline to 72 percent at mid-term, exceeding the end-of-project target of 60 percent for this intervention. Coverage rates for other project interventions will be measured at the end of the project.

In terms of general project activities, IEF is now operating in nine of eleven targeted catchment areas in the district. In the project's final year, IEF plans to include the remaining two catchment areas in the program by training **HSAs**, village health committees and volunteers to establish services there. However, the evaluation team recommends that IEF not invest further effort into this expansion because these areas will have less than nine months of support from IEF before the end of the project. Rather, **IEF** should spend the coming year focusing on strengthening the quality of services being delivered in the nine catchment areas where the project is operating. While this recommendation undoubtedly means that the overall beneficiary target will not be met, the chances for sustainability in those catchment areas where **the** project is established will be greatly enhanced if strengthening existing operations is given priority.

Overall project implementation has been slower than expected, particularly in **year** one. This is largely attributed to: (1) a four-month postponement in project start-up (from September 1991 to January 1992) due to a no-cost extension through December 1991 which was given to the previous project; (2) the prolonged 1991-92 drought which severely affected Chiksvawa District and generally all countries in southern Africa; and (3) the unstable political situation in the country. The four-month postponement in project start-up contributed to implementation delays in the first year.³ The drought diverted the attention of project volunteers away from implementation of project activities at village level to attending to their own survival. This had the effect of delaying and postponing many village-level activities until the drought had passed. The drought also prompted many PVOs, including IEF, to undertake nutritional assessments to target food relief and to construct water points -- activities which became priorities and thereby delaying the implementation of other child survival interventions in the project. The issue of political instability and its role in slowing project implementation is further discussed in section 4 below, "Relevance to Development". These factors will affect the project's ability to successfully achieve all of the project objectives.

3.2 Quality

For those project components which are being fully implemented, such as commodity distribution, the quality of service delivery is good. Vitamin A and ORS are in good supply and rarely suffer from stockouts. "Market penetration" of the commodities to the targeted communities is good. The project needs, however, to more closely monitor the flow of commodities at the village level, with stock control sheets or a **similar** system.

It was not possible to assess **the** quality of those project components which are not fully implemented (such as IEC, condom distribution, and primary eye care). The absence of an IEC strategy or system to ensure quality control of messages being disseminated may be affecting the quality of all IEC activities in the project- Section 5.3 below, "Community Education and Social Promotion" more thoroughly discusses how IEC can be improved in the project.

4. RELEVANCE TO DEVELOPMENT

There are numerous community barriers to the successful implementation of project objectives and the successful improvement of child health. The most profound of these is Malawi's current transition from an authoritarian government to a more democratic system which has created great political instability in the country. Now, with the sense of liberation which has accompanied

³ This means that the project will only be implemented over a thirty-two month period, rather than the full three years normally allocated to NGO health projects, and that the project may have difficulty in fully reaching its objectives in this reduced length of time.

political change, many communities are now less willing to commit to voluntary activities, preferring instead to attend to their own economic survival (unless compensated for any or all activities related to community development).

For IEF, this has meant that village-level mobilization has become increasingly difficult. The task of motivating volunteer participation (both for village health volunteers [VHVs] and village health committees [VHCs]) is complicated by some communities' resistance to holding community meetings and VHV and VHC ever-increasing requests for salaries or compensation for any project related work. While IEF staff report that poor community spirit affects only 30 percent of villages in the project, the problem could grow further and this could affect the project's ability to reach broad coverage of all its objectives.

Another community constraint is widespread illiteracy which makes educating mothers difficult and which contributes to lower health status among children. Poverty also contributes to difficulties in changing mother's knowledge and behaviors, since insufficient resources impact heavily on the family's ability to adopt recommended practices. Finally, a deeply rooted cultural preference for traditional medicine over modern health care constrains the ability of the project to promote greater utilization of MOH and village-level child survival services.

5. DESIGN AND IMPLEMENTATION

5 . 1 Design

The project is designed to establish a village-level health **infrastructure** (defined as **personnel**, commodities, and information) in eleven MOH catchment areas in Chikwawa District. The village-level infrastructure complements **the** Ministry's **infrastructure** which typically does not extend beyond the health center of **the** catchment area. Therefore, the project is designed to establish outreach and services to **the** village level.

The DIP indicates that the project will begin in three catchment areas and enter the remaining eight areas in a phased **manner** during the first, second, and **third** years of operation. There has been no change to this plan, and indeed **the** project is largely being implemented as it was designed, albeit with some delays in implementation. A goal in project design was to scale up from a pilot project focusing on a limited geographical area (only 45 villages) and providing limited services (only vitamin A and ORS) to a district-wide project delivering many more interventions. The belief by some IEF staff that the project now may have "too much on its plate" indicates that the project may have been too ambitious in its design or that management systems are needed to ensure efficient and effective implementation of project activities. In addition, some of the project's difficulties in implementation are explained by numerous environmental, political and cultural constraints discussed above.

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5.2 Management and Use of Data

The project's Information System (IS) consists of six components: (i) a **Village Roster Book**; (ii) an **HSA Semi-Annual Report**; (iii) monthly **HSA narrative reports**; (iv) occasional **special surveys/assessments** to measure skills and knowledge among IEF HSA or volunteer staff; (v) **Supervisory Checklists**; and (vi) **AIDS Training Reports**. Annex F contains samples of most of these forms.

The Village **Roster Book** is a system developed in the previous pilot project (for recording vitamin A distribution) and adapted for use in this project by the addition of EPI and ORS information. The purpose of the roster book, completed and maintained by the village health volunteer (VHV), is to enable the VHV to monitor the coverage of EPI services for children and women (for tetanus) and to record when vitamin A capsules and ORS sachets are dispensed.

Some weaknesses with the roster book have been identified. First, as was noted in the project's annual report (7) many VHVs have had trouble learning the proper use of the roster book, ' indicating that errors may be present in the data as a result of VHV difficulties in using the system. Second, the roster book does not include any record of other project activities which are being implemented by VHVs such as IEC activities conducted in village, or distribution of other project commodities (i.e. condoms)'. Third, it is not clear whether all the vitamin A data in the roster book relates only to vitamin A dispensed by IEF or whether the information also includes coverage of vitamin A supplementation by the MOH. If the overall goal of the roster book is to monitor overall coverage of vitamin A supplementation or ORS use, irrespective of where the commodities originate, then the roster book should clearly include both MOH and IEF commodities distributed. At the present, however, it is unclear if all VHVs are recording the same vitamin A. Such gaps and points of confusion mean the roster book has limited usefulness for measuring overall project performance.

There is not enough time left in this project to refine **the** roster book. However, in **the** event of a **follow-on** project, it is recommended that the village-level data system be simplified so it is easier to use by the VI-IV, can convey monthly activity information, **and** includes all project components.

The information from the Village Roster Book is aggregated every six months onto the **HSA Semi-Annual Report**, a form which was also adapted from **the** previous pilot project and carried over into this project. The purpose of the form is to calculate the coverage of vitamin A supplementation among children and ORS usage rates in each village. The HSA Semi-annual Report is completed by HSAs through visiting each of their volunteers **every** six months and counting the vitamin capsules and ORS sachets disbursed, as well as any new births which occurred during the quarter. This information is then sent to IEF managers for analysis. Data from this report provided the

⁴ IEF restricted the number of variables included in the roster book because it wanted to streamline and simplify the work for volunteers who have limited literacy.

evaluation team with coverage information on Vitamin A and EPI which was presented in section 3.1, "Coverage".

Three **special surveys/assessments** were recently added to the Information System. In June, a special survey was conducted among VHV's on their knowledge of exclusive breastfeeding, weaning, child spacing and HIV/AIDS. In August a special survey was conducted among VHV's to measure their knowledge of vitamin A rich foods, sanitation, and eye diseases. In September, a special survey was conducted among volunteers to measure their relationship with the village health committees and EPI coverage in their village. The purpose of these surveys is to determine if VI-IV training was adequate and if VHV working knowledge is sufficient for community-level work. IEF also uses these surveys to identify where VHV knowledge is poor and where additional attention is required. IEF plans to repeat these surveys every six months, but the evaluation team recommends that the surveys be collected only once each year since VHV knowledge may change very little over a six month period. These surveys are a positive addition to the IS in that they provide critical information on the effectiveness of training. (No other training evaluations were conducted prior to the initiation of these surveys.)

The **data** from **the HSA Semi-Annual Report** (report #1) and **the three special surveys/assessments** (reports #2, 3, and 4) are published semi-annually as routine project reports which are shared with the MOH. Several MOH officials stated that IEF's village-level information is a good input for the health sector, since it provides village-level coverage information not available within the MOH's own information system.

IEF recently added two Supervisory **Checklists** (one for HSAs and one for VHV's) to the HIS to identify whether sufficient commodity supplies exist at the VHV and HSA level, and to identify any job difficulties. The VHV Checklist is completed monthly by the HSA supervising that volunteer. The HSA checklist is completed monthly by the IEF supervisor. The checklists are a positive addition to the HIS. Prior to September, supervision of HSAs and VHV's was ad hoc and unstructured, but now the checklists help IEF to focus on issues related to field operations. A few modifications, however, are recommended to facilitate better monitoring of HSA and volunteer performance. The VHV checklists should ask information on all IEC activities (only AIDS is mentioned), and clarification should be obtained on the nature of these IEC activities -- whether they were household visits, group discussions, etc. The numbers of persons present at the IEC activities should be sought. On the HSA Supervisory Checklist, questions should also be added related to IEC, and the frequency, topic, and attendance of each IEC activity. These additions should enable IEF to more effectively monitor the performance of the HSAs and VHV's in conducting their day-to-day tasks

Each month, IEF HSAs prepare a *Narrative Report* which details each HSA's activities throughout his catchment area, and which lists problems encountered during the month. The reports do not appear to be very useful either for program management or evaluating the HSAs' performance.

Finally, **ADS Training Reports** are being completed by VHVs for all AIDS educational activities conducted at the village level. The AIDS Reports consist of a list of all persons who attended an AIDS talk. The information is being used to track the coverage of AIDS information at the community level, as well as the level of effort given to AIDS training compared to the expected level of effort.

The evaluation team was concerned about two major gaps in the information system. First, aside from the AIDS Training Report, no data on IEC activities is being collected on a regular basis, despite the fact that IEC is fundamental to all project activities. It is highly recommended that VHVs and HSAs begin to keep records on all IEC activities conducted at the village level, including the numbers of persons who attend (names should not be necessary) and the topics discussed. This data will assist IEF in tracking the overall level-of-effort at the village level which is being expended toward education, and will assist in demonstrating at the end of the project the effectiveness of this. Second, **no** program data is being submitted to IEF program managers on a monthly basis. Neither the HSA narrative monthly reports nor the supervisory checklist include usable information on the program's or staff's level of effort (i.e. commodities dispensed, IEC talks given, etc). No stock control system is in place at the village level for monitoring the movement of commodities. The best program level data is in the roster book, but it is compiled only semi-annually and does not represent the full range of project interventions. The lack of monthly program data makes it very difficult for IEF managers to monitor the performance of the program (in terms of education activities as well as commodity distribution activities). At a minimum, IEC and stock control information at HSA and VHV level should be collected monthly and submitted to IEF.

5.3 Community Education and Social Promotion

The project has a two-pronged approach to social promotion: (i) mobilization of community groups (village health committees) to promote community involvement, and (ii) IEC of mothers and other community members on child survival interventions.

Community mobilization is largely taking place through formation and training of **village health** committees (see section 5.4.4 below for details on VHC training). In theory, these committees are responsible for support and "oversight" of the work of the village health volunteer. Many VHCs, an estimated 70 percent of all communities where IEF operates, function well and provide critical support to the project. However, 30 percent of the committees have little involvement in project activities at the village level. While the poor performance of these committees may constrain the project's ability to reach its objectives by the PACD, the value of IEF's community involvement efforts should not be understated. Enabling communities to take more responsibility for their welfare is a difficult but critical process for the long-term sustainability and success of all development efforts. While results are not yet visible, this is an important part of the project and must continue to have the attention of program managers.

The second component of social promotion, IEC of mothers and community members, is presented in the DIP as a fundamental project component for achieving project objectives. Indeed, five of eleven project objectives are related to increasing knowledge levels among mothers and their husbands. Unfortunately, this is the most weakly implemented component of the project. Only minimal IEC is evident at the village level and few materials are used when IEC activities do occur. The volunteers are expected to provide health education on an informal basis, i.e. when drawing water at the well and during field work, but this appears to occur only on an ad hoc basis. Community talks are by and large not taking place, although one-on-one education results when the volunteers visit households for vitamin A or ORS distribution.

An exception to this is evident where IEC is highly structured -- as occurred for HIV/AIDS education when during the months of August and September VHVs were expected to give at least one AIDS talk per week, and attendance at these talks was recorded and submitted to IEF project managers. Attendance at these talks was reportedly high and anecdotal information suggests that demand for condoms is increasing as a result of these IEC efforts. Because IEC for other interventions (such as education for nutrition/weaning, EPI, or CDD) was not as structured or formalized, it appears that little IEC has occurred in these areas. The evaluation team recognizes the present difficulties in mobilizing communities for IEC, but the apparent success of HIV/AIDS efforts demonstrate that more structured IEC activities, along with performance expectations from program managers (i.e. once per week), can overcome many of the barriers to educating the community.

The project conducted formative research on infant feeding practices in order to establish the nutrition messages. This research was undertaken by (i) IEF staff who conducted focus groups of mothers and health workers and (ii) a consultant from Wellstart (10) who investigated even further the nature of infant feeding in Chikwawa. Numerous nutrition messages were formulated based on the results of these data. Focus groups were also conducted for formulating AIDS messages. Aside from researching nutrition and AIDS, however, it is not apparent that KPC data collected during the baseline or other behavioral research results were utilized to formulate messages or strategies for other IEC areas (EPI or ORT education).

Limited educational materials are being used in the project. Some materials have been distributed to the volunteers and HSAs for use in their IEC work, but no materials are distributed directly to the community. IEF assisted the MOH and UNICEF in pre-testing some "posters" (actually A4-sized flyers), which are now used by VHVs and HSAs in their IEC efforts -- one sheet for vitamin A, two sheets for CDD/ORT, one for breastfeeding, and a packet of seven sheets on HIV/AIDS. Only the HIV/AIDS packet is completely pictorial. The other posters have written messages in Chichewa or Sena, the local languages used in the district. IEF also assisted UNICEF with the development and pre-testing of a vitamin A poster which is now being printed. The project has not conducted any evaluation on the use or impact of the various posters.

The project needs to intensify IEC activities in order to ensure that educational objectives under the

project will be met. A variety of modalities should be explored such as group talks, printed materials, drama groups, even radio (if feasible). Indeed, the DIP notes that educational messages will be promoted using a variety of presentation materials (flip charts, drama, small group sessions, and inter-personal communication). At the present, however, only the inter-personal approach (i.e. one-on-one) is being employed and it is not evident that alternative approaches were earlier tried and rejected. The evaluation team recognizes that some IEC activities, such as group talks, are problematic at the present time in view of the changing political situation. But every effort should be made to employ alternative approaches.

There is also need to incorporate more materials into the IEC work of both the volunteers and the HSAs. More structured materials could contribute to better quality control in message dissemination. For example, on the reverse side of each poster or flyer, the main message can be printed in order to guide the talk of the HSA/volunteer. While there is little time to create new materials, the MOH Health Education Unit most certainly has additional materials which could be of use to the project. Using materials from other NGO child survival projects in the southern region is another option which the project may wish to explore.

In the absence of a household survey at this time, it is not possible to say what progress has been made in IEC. But it is unlikely that all project IEC objectives will be achieved by the PACD without a greater emphasis in the project toward IEC. It is thus recommended that IEF recruit a short-term consultant to assist in developing an IEC strategy, including any refresher HSA/volunteer training in IEC which may be required.

5.4 Human Resources for Child Survival

The IEF Project comprises three types of personnel: (i) IEF project managers who train and supervise the HSAs, maintain the HIS, and coordinate all project activities; (ii) health surveillance assistants (HSAs) and village health volunteers (VHVs), trained and employed by IEF, and responsible for providing preventive health services at the village level; and (iii) village health committees (VHCs). These are more fully discussed below.

5.4.1 IEF Project Managers

Annex E contains an organ&ram for IEF Project staff involved in implementing this project. These staff have been responsible for program start-up; liaising with 300 communities and the MOH; training 9 HSAs, 505 volunteers, and 300 village health committees; and monitoring/supervising the performance of HSAs, VHVs, VHCs, and the implementation of project activities. Two expatriate positions are part-time --- the country director is employed half-time by the project, as is the ophthalmologist. Of eight Malawian staff, three are administrative/financial,

two are clerical/drivers, and three are program managers/supervisors. Two project staff are full-time expatriate Peace Corps Volunteers.

Although the Country Director and the Ophthalmologist are half-time IEF employees, it appears that the Director dedicated more than 50 percent of his time to the project and he is credited with contributing significantly to the project accomplishments thus far. A new country director is being hired beginning January 1994 and he will be employed full time by this project. While the ophthalmologist's responsibilities mostly concerned tertiary care, she provided critical input into developing primary eye care activities and developing eye treatment capacity at the district level.

Counterparts for IEF project managers consist of district and regional MOH staff. The MOH supports IEF in technical areas, but IEF undertakes all coordination and monitoring/supervisory functions for the project.

There is some evidence that the project's utilization of Peace Corps Volunteers without assigning counterparts has not been effective. Only half the PCVs working under the project have had counterparts. The concern is that when the PCV departs, their activities are fully sustained by any one individual. The evaluation team recommends that the project review its use of PCVs and considers matching each volunteer with a Malawian IEF counterpart in order to develop Malawian capacities to sustain the inputs of the PCV.

Several IEF staff have benefitted from staff development opportunities, such as attending workshops, seminars, or conferences. These are listed in Annex D. There is need however, to provide the Training and Supervision Coordinator and his two subordinates with supervisory training. This would strengthen supervision of HSAs and the monitoring of project activities. The project director has also requested short-term training in public health, as his training and experience lie more in administration.

Given the present project's level of effort, the existing staff complement at the management level is sufficient to meet **all** administrative and programmatic responsibilities of the project. However, in the event that the project is extended or expanded, additional program personnel may be required to manage and supervise any additional HSAs and volunteers added to the program.

5.4.2 Health Surveillance Assistant (HSAs)

The project employs 17 HSAs for supervising and monitoring the implementation of project activities at village level. HSAs are the lowest level health staff in the Malawian health care system, working either in the government or with the private sector (both for-profit and not-for-profit) to provide the critical functions of health promotion and delivery of preventive health

services. In Chikwawa, IEF-employed HSAs are based at MOH health center⁵, where they assist in giving morning health talks at the health center and in giving immunizations at under-five clinics. But IEF HSAs are far more outreach oriented than MOH HSAs, mostly because the Ministry HSAs do not have transport and little emphasis is given to their outreach into communities. Most IEF HSAs have a motorcycle which is fully financed under the project (for purchase, maintenance and operation costs). IEF HSAs emphasize community education on vitamin A supplementation, CDD/ORT, and nutrition whereas the MOH HSAs focus more on monitoring disease outbreaks and delivering EPI and growth monitoring services. A chart depicting the differences in work responsibilities between Ministry and IEF HSAs is found in Annex G.

IEF directly recruited the 17 HSAs (12 men and 5 women) but received MOH concurrence on all candidates. The IEF Training/Supervision Coordinator trained half the HSAs using the MOH's six-week HSA curriculum (but modified slightly to include additional days on vitamin A and Breastfeeding which were not included in the MOH curriculum)⁶. The MOH pre-service curriculum consists of four weeks of classroom work and two weeks of field work. The other HSAs trained earlier in the project followed a four-week curriculum which concentrated on vitamin A, CDD, EPI, and nutrition. All seventeen IEF HSAs have benefitted from frequent and regular in-service training provided by IEF in selected technical areas (see Annex D), most of which has been provided as part of project staff meetings.

Technical training appears to have been sufficient to prepare HSAs for their technical duties. However, while the HSAs' primary responsibility is to supervise the VHVs and the implementation of project activities at village level, only minimal supervisory training was included in their pre-service training. The evaluation team believes that HSAs require additional in-service supervisory training in order to upgrade skills and make each contact with their subordinates (the volunteers) even more productive. It is recommended that the project provide the HSAs with further in-service training in supervision as soon as possible.

Each IEF HSA supervises an estimated 40 volunteers, each who in turn serve an estimated 50 families (depending on the size of the village). While on average, IEF HSAs supervise 28 volunteers, there are some IEF HSAs who supervise more than 50-60 volunteers -- a ratio which the evaluation team believes minimizes their effectiveness. The evaluation team suggests that the project investigate a redistribution of HSAs so that each individual is responsible for supervising no more than 30 volunteers -- a more reasonable workload which would enable each HSA to

⁵ This close working arrangement was deliberate in the design of the project so as to promote sustainability. The IEF HSAs are meant to be transferred to the MOH once the project ends and have been selected, trained, and paid according to MOH criteria.

⁶ IEF also provided a collaborating NGO, ADRA, with pre-service training for four of its HSAs. Project funds were not used for these individuals.

concentrate on monitoring the quality of all project services delivered.

5.4.3 Village Health Volunteers (VHVs)

The project's 505 village health volunteers (predominantly female), selected by their communities have received five days of pre-service training in vitamin A, nutrition, primary eye care, CDD, EPI, and the structure of the health system. The volunteers were trained by the HSAs with support from IEF HSA Supervisors. Most volunteers have basic literacy skills, but in those villages where no literate women could be identified, a male member of the village health committee was assigned to assist the illiterate volunteers. An estimated 10 percent of VHVs are illiterate and require assistance.

An exception to this is in the seven catchment areas where IEF has introduced AIDS activities. Each female volunteer is matched with a male counterpart, and they both have received in-service training (one day) on HIV/AIDS. Each are expected to provide AIDS information to their communities -- the men teach the men and the VHVs teach the women.

Pre-service training appears to be adequate to enable the volunteers to do their jobs. Although some individuals have trouble learning the correct use of the roster books, this has been addressed through HSA supervision. In-service training has been provided to volunteers in eye care, cataract recognition, breastfeeding and HIV/AIDS (see Annex D for a list of in-service training provided to volunteers).

Each volunteer is largely responsible for distributing vitamin A, ORS, and condoms, and maintaining the roster book which lists all target families, their EPI status, and all vitamin A and ORS which has been distributed to the families- Volunteer are also expected to educate their constituents on child survival issues -- through **one-on-one** education or through group sessions. Only HIV/AIDS education appears to be taking place in group settings.

Based on two studies conducted in the project, the attrition rate for volunteers is estimated to be between 3 and 6 percent. This correlates with the rate found in the previous project (5 percent). There are reportedly some cases of volunteers being forced to quit as a result of pressure from their husbands who did not approve of their unpaid status. In other cases, volunteers have moved away from the district with their families (and on occasion taking their roster books with them!).

During the evaluation, interviews were held with volunteers to solicit their perspectives on their work. While volunteers cited stockouts of "drugs" as problems in conducting their work, it is not clear whether they were referring to the need for more project **commodities** or their desire to have additional items to offer to the communities. There is no evidence that volunteers are attempting to sell any of the commodities which they distribute.

As is typical in volunteer-driven programs worldwide, many VHV and VHC members initially agreed to participate as volunteers, but now are pressuring IEF for salaries or in-kind remuneration (clothes, soap, or other incentives). In the previous project, volunteers received numerous incentives: a uniform, badge, bag, shoes, and monthly soap allowance. In this project, all incentives except for monthly soap allowances were abolished in order to conform with new regulations within the Ministry of Health. IEF volunteers now are supposed to receive monthly soap allowances, although there are reportedly some cases where volunteers do not receive their allowance. This has contributed to dissatisfaction among some volunteers with the program. IEF should investigate why soap is not being distributed to volunteers, and make every effort to resolve this issue.

Although the project has strictly followed MOH policies for volunteer remuneration, volunteers themselves are demanding much more compensation for their work. To conform with MOH norms, IEF will provide only soap. This frustrates some volunteers who appear to believe that once they were part of the program additional incentives would be awarded. Dealing with these demands has been difficult for IEF staff, including HSAs, but considerable effort has been made to keep the VHVs involved in the project and to remind them of the nature and purpose of volunteerism. If the project were extended beyond the PACD, it is recommended that IEF continue to explore alternative approaches to volunteer compensation for enhanced sustainability of services delivery at the village level.

Finally, the project is investigating the determinants of volunteer performance and motivation. IEF is interviewing VHVs themselves, a neighbor of the volunteers, and the volunteers' HSA supervisor to evaluate their performance and the factors which appear to contribute to successful VHVs. The volunteers' performance in delivering services (Vitamin A capsules and ORS distributed; communities' EPI status; child mortality status) will also be examined in the study to identify distinguishing factors for good or poor performance. The results of this review, expected in 1994, is expected to benefit all projects in Malawi utilizing village volunteers as well as **benefiting** the MOH in formulating their policies regarding volunteers.

5.4.4 Village Health Committees (VH)

Each village where IEF operates has established a health committee consisting of ten members (usually seven men and **three** women). While VHCs are not direct "employees" of the project, their participation is important because they are meant to support the VHV to enhance her effectiveness. IEF had not worked with VHCs in the previous project, but included this into the current project as a result of recommendations made in the evaluation of the previous project.

Each village health committee received one day of training in vitamin A, **water/sanitation**, and roles/responsibilities vis-a-vis the volunteer. The training was conducted by the HSAs in collaboration with the MOH District Health Inspector. Refresher training in HIV/AIDS was

recently provided to many VHCs in the areas of HIV/AIDS.

The issue of VI-K community support for volunteers was explored by the evaluation team. No VHCs support the volunteers aside from offering some moral encouragement. When asked what kind of material support the committee should or could provide the volunteer, most VHCs said “none”, although one community offered to assist in preparing her fields, and another offered to assist in drawing water for her. This was a discouraging finding for project staff, but not totally unexpected since the project is still in the process of promoting the sustainability of volunteers at community level.

Like some volunteers, some VHCs have recently started asking for IEF salaries or compensation. They believe that the volunteers are paid (despite IEF explanations to the contrary) and they claim that their contribution to health activities should also be compensated. IEF is making efforts to address these issues.

5.5 Supplies and Materials for Local Staff

HSAs use motorcycles (some use bicycles) to enable them to visit all their villages and provide commodity and technical support to volunteers. This is a relatively expensive input to the project, but it greatly enhances IEF’s activities at the village level.

IEF volunteers and HSAs are provided vitamin A, ORS, and condoms for distribution to village mothers. Most vitamin A capsules provided in the project have been purchased by IEF or obtained as a donation from Hoffman LaRoche’s “Sight and Life Program”. ORS and condoms for distribution in the project are obtained from national MOH supplies.

Volunteers are supplied on a monthly basis from stocks held by HSAs. HSAs are supplied from IEF, but when IEF stockouts occur, MOH clinic supplies are reportedly used. The MOH at the district and village level have no objections to providing IEF with commodities, as they claim to have adequate supplies of all items. On the other hand, IEF receives most its supplies from the MOH itself, indicating that problems with MOH supply and distribution systems have necessitated IEF’s involvement in transporting ORS and condom supplies directly to their **catchment areas**⁷. **Unfortunately**, IEF’s assistance in ensuring supplies for HSAs and volunteers is not sustainable beyond the end of the project, and there is need to transfer the responsibility for commodity

⁷ Although the project uses MOH supplies of ORS and condoms, IEF attempts to utilize vitamin A capsules from the MOH Central Medical Stores (CMS) have been fraught with difficulties. CMS took more than a year to obtain their supplies, and when the capsules arrived they were the incorrect dosage needed for child supplementation programs (15,000 1.0. instead of the 200,000 1.0. dosages used for supplementation programs). As a result, most the vitamin A supplies used in this project have been provided directly by IEF.

logistics to the MOH. But MOH supply logistics problems are a nationwide problem, and IEF will not be able to affect an improvement in the life of this project. As such, USAID/Malawi should initiate a dialogue with the MOH to promote improvements in supply logistics throughout the health sector.

Only few rudimentary IEC materials are used at the village level. The absence of good quality IEC materials hampers the VHVs ability to conduct IEC and to promote certain behaviors at village level. This in turn hampers the project's ability to reach project objectives. It is recommended that the project attempt to obtain more and better IEC materials for all IEC topic areas. These materials should minimize wording and should consist of easily understood pictures. If feasible, the project should explore the distribution of materials to the community itself (such as flyer or brochures). Leaving materials with a mother or family could enhance the learning process.

IEF maintains an "office" in the home of the country director in Blantyre, and another office in Nchalo, Chikwawa district. The IEF office in Nchalo has no photocopier and is in need of another computer. The absence of a photocopier is a major constraint to effective program management. Most photocopying must be taken to the country director in Blantyre or to a commercial outlet in Blantyre. There are no commercial photocopying services in Chikwawa. An additional computer would greatly assist in all program management activities in Nchalo.

5.6 Quality

IEF/Malawi staff embody a wide variety of technical and administrative skills and knowledge to implement the project. Nevertheless, there is a need to supplement these skills with IEC expertise to ensure effective implementation of IEC activities. No staff members have any IEC training, and consequently, little strategizing or emphasis has been given to project IEC work. As a result, it appears that not all the information necessary for behavior change is being disseminated. Nor is it clear that VHVs have sufficient adult education skills to effectively impart their child survival knowledge. It is thus recommended that IEF recruit a short-term consultant to assist in developing an IEC strategy, including any refresher training in IEC which may be required.

As mentioned earlier, IEF project management staff and IEF HSAs also require additional **training** in supervision.

The ophthalmologist working under the project appears to have contributed to establishing secondary and primary ophthalmological services in the district and southern region. There are also numerous IEF activities which are being implemented outside this child survival project which have had a positive impact on project activities. Research conducted on traditional healers and their treatments of eye and other diseases have provided this child survival project with additional skills and knowledge to address child health problems at the community level.

5.7 Supervision and Monitoring

Volunteers are supervised by HSAs. HSAs visit each volunteer monthly to identify any problems the volunteer is having with her work, and to resupply her with any needed commodities. In some cases, volunteers are visited more frequently. Transport is not a constraint to volunteer supervision. HSA supervision of volunteers is mainly oriented toward administration and counseling/support. With the recent introduction of checklists, performance evaluation is now a more formal part of the supervisory process. HSAs conduct little, if any, on-the-job training as part of their supervisory visits.

The HSAs themselves are supervised by two IEF HSA Supervisors. Each HSA submits a monthly workplan which is then used by the supervisors in conducting their visits. The HSA supervisors visit each HSA once per month to provide them with commodities and to assist in resolving any identified problems in their work. HSAs also have the opportunity to meet their supervisors twice monthly at the IEF office when they attend staff meetings and collect their salaries. The frequency of contact between HSAs and their supervisors is therefore three or more times per month. The majority of contact between the supervisors and HSAs consist of administration and support, although with the recent addition of the Supervisory Checklist, performance evaluation is now a more structured part of the supervisory process. On-the-job training is not a critical part of HSA supervision, because a great deal of in-service training occurs during the twice-monthly meetings at the IEF Office.

The two HSA Supervisors are supervised by the IEF Training and Supervision Coordinator. Each HSA Supervisor prepares a monthly workplan, but this does not seem to be utilized by the Training and Supervision Coordinator for effective supervision and monitoring of their work. The work of the HSA Supervisors is the most substantive program work being conducted by all IEF program managers- Monitoring their work more closely will enable IEF to more closely monitor the performance of the project.

5.8 Use of A.I.D. Central Funding

IEF/Malawi receives administrative and technical support from IEF home office in the USA. Home office support has been provided for project planning (proposal and DIP preparation), administrative backstopping, liaising with AID/Washington and Johns Hopkins University on behalf of the Malawian program, procurement of commodities and supplies, and providing technical support (literature requests, etc). 30 percent of the salary of an IEF Technical Support person was allocated to the project. One-third time is a realistic level of technical support for the project.

IEF/USA receives administrative and technical support from the A.I.D./Washington PVO Child Survival Support Project (PCSSP). By and large, IEF home office staff find the regional

workshops, technical reviews, and technical bulletins useful in implementing the project. Two IEF/Malawi program managers benefitted from a PCSSP regional workshop held in Africa. At a technical level, PCSSP sampling guidelines for the baseline survey were modified as they were too narrow to ensure acceptable confidence intervals for the size and scope of this project. In addition, PCSSP's sampling frame guidelines do not include children over two years of age, although the project wanted to sample all children under six to measure the impact of vitamin A supplementation. For this reason, IEF chose to use other sampling parameters.

5.9 IEF's use of Technical Support

To date, approximately 32 person-weeks of external technical assistance* were obtained for: (1) a review of vitamin A in drought relief programs (1 person week) conducted with assistance from Helen Keller (HKINITAP); (2) a review of Breastfeeding and early child supplementation in Chikwawa District (4 person weeks) conducted in conjunction with Wellstart International; and (3) refinement of the HIS and supervision systems for HSAs and volunteers (an on-going 7 person-month consultancy from August 1993 through February 1994).

The first two consultancies assisted in strengthening certain aspects of the program. First, the review of vitamin A in drought relief programs (a consultancy conducted **with the** assistance of Helen Keller International (HKI/VITAP)) resulted in the development of a national vitamin A policy. Prior to the consultancy, MOH protocols for vitamin A distribution existed but were not widely used in the health sector. The consultancy, however, highlighted the need to have vitamin A more firmly integrated into community health programs. IEF and UNICEF both assisted the MOH in developing a national vitamin A policy which addressed these issues. The policy has been widely disseminated throughout **the** country, but IEF believes that the MOH **still** requires assistance in getting it implemented nationwide. IEF's considerable success in establishing village-level vitamin A supplementation programs during this process makes them the logical and ideal partner to assist the MOH in this effort.

Second, the data from Wellstart's breastfeeding review was utilized for developing various nutrition messages at village level and in raising awareness at regional and national level of breastfeeding issues. The breastfeeding IEC effort was a strong project component in the first **half** of project implementation and has positively influenced MOH policy.

The project has needed a skilled and experienced IEC Specialist and to assist in strategizing and systematizing IEC activities. External technical assistance however, was not obtained because of

⁸ The HKI/VITAP consultancy was funded directly by Helen Keller, but IEF requested the assistance and managed her consultancy. Funding for the Wellstart consultancy was shared between the project and Wellstart International.

limited budgetary resources to finance external technical assistance. Rather, IEF/US staff have attempted to obtain expertise from Washington-based groups and then passing that information on to the IEF/Malawi staff. This has not been as successful as it could have been, given that there is no substitute for on-the-ground support. It is recommended that IEF obtain qualified expertise in IEC for assisting in the launch of these activities in the remainder of the project.

5.10 Assessment of Counterpart Relationships

The chief counterpart for this project is the Ministry of Health at the district-level. For broader collaboration and networking, the Regional MOH is a secondary counterpart. Regular meetings are held between IEF program managers and the District Health Officer and the Regional Health Officer. Relationships are very productive and cordial. IEF staff in Chikwawa work closely with the District Health Inspector (the supervisor for all MOH HSAs in the district) and with the District Health Officer. At the regional level, a strong professional and personal relationship was forged between the IEF country director and the Regional Health Officer. This enabled IEF to play a strong and effective leadership role in NGO-MOH coordination (see section 5.12 below). The IEF ophthalmologist's counterpart is an ophthalmological medical assistant and their relationship is also production and effective.

A new Regional Health Officer has recently started work in the southern region. He is particularly interested in his own staff development and has requested IEF (as well as all other NGOs) to work even more closely with regional departments. In this case, the Regional Family Health Office and the Regional Health Education Office are the departments which IEF should forge even closer relations. IEF states that past efforts to involve these offices have been frustrated. With new Regional Health leadership, however, more emphasis may be placed on building closer working relations with NGOs. For this reason, IEF should renew its efforts to involve these two offices even more closely in all its work.

At the health center level, IEF HSAs and MOH HSAs work closely. As mentioned earlier in this document, IEF HSAs regularly participate in morning health talks at the health center and in delivery of EPI services at under-five clinics. Relationships between the Ministry HSAs and the IEF HSAs appear to be good. Health Center managers (i.e. medical assistants and nurses-in-charge), however, have little professional interaction with IEF HSAs. This appears to be due to the direct supervision of IEF HSAs by IEF staff, with little health center staff involvement. Consequently, health center staff do not appear to fully understand the unique talents of IEF HSAs and their contribution to the health care system. When asked about integration of IEF HSAs into their own HSA staff, health center managers generally cited barriers or deficiencies in the IEF HSAs work responsibilities which would make the hand-over problematic -- in particular, IEF's

minimal emphasis given to EPI and sanitation work as compared to MOH HSAs⁹. This suggests that there is little appreciation at the MOH service delivery level of IEF's unique contribution to village-level health promotion. Because the project plans to transfer the HSAs to the MOH once the project ends, there is need to involve health center managers in better understanding and support of the community-level work of the IEF HSAs. This could enhance sustainability of the project's village-level work.

5.11 Referral Relationships

The referral care sites for all village-level health work is the MOH health center in that catchment area. Health posts, which are theoretically the closest facility to the villages, largely only offer under-five clinic preventive services. As a result, most individuals tend to travel to health centers for their care, as a wider range of services is available at these facilities. However, many health centers appear to be somewhat underutilized as patients bypass the centers to utilize the services of rural and district hospitals. One explanation is that because communities believe that health centers lack sufficient supplies of medicines or other items, rural hospital services are sought out. Because there is no charge for health care in Malawi, there are no disincentives for bypassing the referral chain.

As mentioned previously, IEF supplies its field staff with ORS and condom supplies which originate from the MOH. IEF transports these supplies directly to their staff because of occasional shortages at MOH facilities. IEF says that without their facilitation in transporting supplies, the community would have little access to commodities at health centers or village level.

IEF is not directly taking steps to strengthen access to referral sites, although volunteers are responsible for encouraging mothers to seek out EPI services and CDD services, in the case of prolonged and severe diarrhea. There is evidence that this is working well, as many health center staff cited their satisfaction with increased utilization of MOH services as a result of village-level IEF promotion of health care.

5.12 IEF Networking with Other NGOs/PVOs

IEF is a leader in the NGO community of Malawi, mostly due to the country director's considerable effort in forging NGO-NGO and NGO-MOH coordination. During the drought, he

⁹ Most MOE ESAs work more in static health facilities than at the village level. They are largely involved in assisting with the delivery of EPI and growth monitoring services in under-five clinic services at health centers and with mobile clinics, rather than village-level health promotion or social mobilization. Those who do work at the village level tend to focus more on sanitation.

initiated coordination meetings with the MOH and all NGOs working in the southern region. The meetings served as the foundation for the first ever collaborative efforts between the Government and the NGO community. Now that the drought has passed, these meetings have evolved into NGO-MOH health sector coordinating meetings. These are the forums through which a great deal of NGO-NGO collaboration takes place.

The project proposal and DIP outlined the working relationship between IEF and ADRA. Indeed, the project has worked closely with ADRA -- providing assistance in pre-service and in-service training for ADRA HSAs and in distribution of vitamin A. ADRA has relied heavily on IEF for technical and professional support -- support which ADRA states has been immeasurably helpful. IEF has also worked very closely with Montfort Hospital, a Catholic Hospital in Chikwawa District, providing training assistance to their staff and developing collaborative relationships. IEF has also worked closely with UNICEF and Save the Children (UK) on numerous nutrition and child survival issues. Other NGOs working in Malawi also have very positive views of IEF. Project HOPE cites IEF's work with village volunteers in Malawi as having great applicability to other NGO and community health projects.

IEF cites two lessons regarding their collaboration with other NGOs/PVOs. First, with reference to the drought or other disasters, NGO-NGO collaboration can effectively mobilize government action and resources to quickly respond to the emergency. In this case, the mobilization of IEF and other NGOs in southern Malawi to conduct rapid nutrition surveys enabled food relief to be targeted to the most needy Malawian children and their families. A second lesson is that NGO-NGO collaboration allows the health system to more easily and effectively learn what works for future integration into the health system. In this case, the standardization of volunteer compensation and nutritional surveillance has benefitted the MOH and NGOs alike.

5.13 Budget Management

As of June 1993, overall project expenditures to date were largely on target, although some line items were either slightly over-expended or under-expended. In particular, in-country costs (such as Malawian salaries and supplies) are only 30 percent expended to date due to devaluation of the Malawian Kwacha. Although significant savings are realized in some line items (Malawian salaries/benefits, and in-country travel/per diem) other items, such as procurement of equipment and supplies, are somewhat overexpended. In total, fifty percent of the project budget was expended as of June 1993 (the 18th month of project implementation).

The project may accumulate some savings by the PACD since a sizeable portion of expenditures thus far were for one-time equipment and vehicle purchases. It is recommended that these assumed savings be used to finance the costs associated with the launch of the IEC effort. The project budget does not specifically set aside funds for IEC, but the costs of a consultant and possibly for

materials development/printing could be sizable. There should be sufficient savings in the budget to cover the costs of this and the costs of extra computing and photocopying equipment.

6. SUSTAINABILITY

The DIP cites six sustainability goals for the project. Progress toward achieving these is mixed:

1. ***Integrate vitamin A interventions into the existing EPI and under-five structure, including the ordering and supply of capsules through the Government's Central Medical Stores.*** This goal has been partially achieved, as vitamin A **is** now distributed at most under-five clinics. However, the Government is not directly financing vitamin A supplies, but rather depends heavily on UNICEF donations.
2. ***Establish a community based worker system supported by village health committees in 90 percent of villages in the district.*** Through project efforts, nearly 300 villages (of 475 in the district) now have village-based health infrastructure (personnel, information, and commodities). This represents 63 percent of the villages in the district. In the remaining months of the project this should increase to more than 80 percent of the villages in the district. Roughly 70 percent of the project's volunteers operating in these villages are well received and supported/encouraged by their communities (30 percent are not well supported and receive no moral or material support).
3. ***Integrate VHVs into the MOH delivery system and standardize their training and support mechanisms.*** Volunteers are not yet integrated into the MOH delivery system although standardized training and support levels have been established.
4. ***Increase community demand for child survival services through more direct support of VHVs and VHCs.*** The project has contributed to a significant increased demand for ORS, vitamin A and condoms by establishing a supply systems at community level.
5. ***Establish a community-based blindness prevention program in 50 percent of villages.*** The project's primary eye care activities have been established in two of nine catchment areas and in 20 percent of all villages in the district.
6. ***Increase the MOH capacity in monitoring, evaluation, and conducting operations research.*** The project has successfully trained MOH staff in how to conduct nutritional assessments, and how to conduct research on breastfeeding practices.

While these are very ambitious sustainability goals for a three year project, especially in Malawi's politically and economically unstable environment, IEF has made good progress toward establishing sustained child survival programs at community level in the district. The project's strength is its establishment of village-level infrastructure and operations which compliment the more static MOH facilities in the district. The MOH lacks the ability and resources for providing transport, pharmaceutical supplies, and village-level staff to undertake sound outreach into the communities

surrounding their clinics. IEF's contribution to the project has been to address these constraints by establishing a complimentary services and infrastructure. For sustainability, two of the project's main inputs (HSAs and vitamin A) have the best chances for effective sustainability because they are consistent with the Ministry's emphasis on HSAs¹⁰ (with USAID and World Bank funding) and with recently formulated policy on vitamin A. However, it is unlikely that the MOH will have the human, material and financial resources to assume the IEF model in its entirety. But the project's strong outreach and village level work may be weakened once IEF transferred project activities to the government due to insufficient MOH resources to sustain these activities.

The project planned for HSA sustainability since the design. HSAs were trained using the most recent MOH curriculum, and IEF is in the process of investigating whether MOH certificate can be obtained for their HSAs. If the project were extended for an additional 3 years, or if a follow-on project were funded, IEF could more successfully work toward the above sustainability goals, particularly those related to volunteers and village health committees. In the remaining months of this project, however, only the HSA staff will realistically carry on following the PACD.

Commodity distribution, the most successful portion of the project, could possibly be sustained following the PACD. It appears that IEF has increased demand for vitamin A supplementation and ORS (and most likely condoms in the coming year). If the communities were able to receive all their supplies through the MOH system, the project's high coverage levels could be maintained. If this project were to end, however, without sufficient MOH commitment to meeting the commodity needs of these communities, coverage levels could fall.

In the design of the project, IEF expected that volunteers could be directly compensated by their communities. As was discussed above, there has been disappointly progress in this area. It is possible that the on-going study of volunteer performance will shed some light on how volunteers might be **sustained** in the absence of an external donor organization or the government. Village health committees are a well established tradition in Malawi, and perhaps through revitalizing these groups can the village level work of the project be more successfully sustained.

Alternatives to a MOH handover are not available in Chikwawa district. The only other established organization in the health sector is Montfort Hospital, a Catholic-run facility with a catchment area covering ten percent of the district population- Their limited coverage makes them an unlikely option for sustaining this district-wide project. Given this, the MOH is the only institution capable for maintaining and sustaining project activities.

¹⁰ The Ministry of Health has established between 3,000 and 4,000 HSA positions, of which less than half are filled. A budget exists for paying their salaries also exists, so financial resources are available to absorb them into the MOH personnel structure.

7. RECURRENT COSTS AND COST RECOVERY MECHANISMS

The recurrent costs to the program consist of HSA Salaries; the cost of operating and maintaining vehicles and HSA motorbikes; program management costs; head office program support; and general operating expenses. These are estimated as follows:

(a) HSA/volunteer compensation: IEF pays each HSA K151.00 per month plus a 10 percent housing allowance (for a total K166 per month per HSA). The salary of K151 is calculated to include a 50 percent differential over the amount the GOM provides its HSAs (average K100.00 per month) in lieu of GOM retirement and other benefits. The total HSA salary cost to IEF (including a 13th month Christmas bonus) is calculated at K2,158 per HSA per year or K36,686 for 17 HSAs. At current exchange rates (K4.2 = \$1.00) this amount to \$8,750 per year for all HSA salaries.

Volunteers receive a monthly allowance of soap which costs K1.29 per volunteer per month. For 505 volunteer this total K7,817 per year or \$1,860 annually at current exchange rates.

(b) Vehicle/Motorcycle Operation and Maintenance: It is not possible at this time to disaggregate HSA transport from program management transport. From data for the first nine months of 1993, total petrol cost was K47,600, total service cost was K18,500, and maintenance was K28,800. Extrapolating from this data, annual petrol costs are an estimated K63,500, annual service costs are K24,600, and annual maintenance is K38,400, or a total vehicle O&M cost of K126,500 per year or \$30,100 at current exchange rates.

(c) Program Management: Excluding expatriate costs, annual salary costs for Malawian program management staff is calculated at \$22,800 per year. Exact costs for office operations at the Blantyre and Nchalo offices were not available at the time of the evaluation, but the pipeline analysis shows an estimated \$18,000 per year was expended for these activities.

(d) Total IEF/Malawi local costs (sum of a, b, and c above): Excluding expatriate costs, the total annual recurrent costs for the above items is calculated at \$81,510. Over a three-year project implementation period, this would account for \$244,530 or approximately 24 percent of total project costs.

(e) IEF Home Office and IEF Expatriate Salaries: IEF Home Office recurrent expenses have accounted for only \$52,000 over the first half of the project, giving a total home office expenditure rate of \$104,000 over the life-of-the project, representing only 10 percent of total project costs. In-country expatriate costs are budgeted at \$184,700 over the life-of-the project.

Total project recurrent costs (sum of d and e above): Over a three year period, both in-country (Malawian) and U.S. recurrent costs are calculated to be 53 percent of total project costs, over

\$533,230 over a three year period.

No local contribution is being made by the Government or communities to cover any recurrent costs, nor is it realistic at this time to expect that recurrent costs could be covered by resources outside the project.

The project has not calculated the recurrent cost burden to the MOH following the PACD, but the costs of HSA salaries is the only expense which the MOH would assume. Other program activities and their associated costs (such as the operating and maintenance costs of their motorcycles; and the costs of program management salaries, transport, and operating expenses) will not be assumed by the MOH. The Ministry provides benefits to their employees, and because IEF HSAs would receive these as well, their monetized IEF benefits would not be included in their MOH salaries. Therefore, the recurrent costs to the MOH would be an estimated K 100 per month per HSA or K1,200 per year per HSA or K20,400 for all 17 HSAs. At current exchange rates this is only \$4,8500 per year for 17 HSAs. It is not possible at this time to calculate non-monetized GOM benefits (such as government housing, retirement priveleges, etc).

As of June 1993, the project was 50 percent expended. Assuming 127,000 women and children are now beneficiaries of project activities, this gives a current per capita project cost of \$4.06 per beneficiary. This is only slightly higher than the \$3.60 calculated in the DIP.

8. **RECOMMENDATIONS**

General:

IEF should continue to explore mechanisms for sustaining **health** activities at the village level.

JEF should continue to develop collaboration between NGOs and the MOH and continue to contribute to national policy formulation regarding **health** activities in the country.

JEF should not expand its program to the two remaining catchment areas, but rather focus on strengthening the quality of services delivered in the existing nine areas where it is currently operating .

JEF should involve MOH **health** center managers in better understanding and supporting the community-level work of the project HSAs. This could enhance sustainability of the project's village-level work.

IEC:

It is recommended that JEF obtain qualified expertise in IEC through a short-term **consultant** for defining the IEC strategy for the remainder of the project and to develop any refresher

- training in IEC which may be required.
- Launch a vigorous IEC effort for the remainder of the project. Every effort should be made to employ a multitude of IEC activities, such as individual and group talks, drama, printed materials, etc.
Incorporate more educational materials into the IEC work of both the volunteers and the HSAs. More structured materials will contribute to better quality control in message dissemination. Procure additional IEC materials from the Health Education Unit, other NGOs, or other development agencies, such as UNICEF.

Personnel :

Get Government certificates for all IEF HSAs who have completed 6 week training.
Provide supervision skills training for all project HSAs, the Training and Supervision Coordinator and his two assistants.
All Peace Corps Volunteers working in the project should be assigned full-time Malawian counterparts .

Information System:

At a minimum, commodity flow information and all IEC information at the HSA and VHV level should be collected monthly and submitted to IEF.
The VI-IV and HSA supervision checklists should be revised to include variables on IEC activities including the frequency, topic, and attendance of each IEC activity; and whether they were household visits, group discussions, etc. These additions will enable IEF to more effectively monitor the performance of the HSAs and VHVs in conducting their day-to-day project tasks.
The three special surveys recently introduced to the information system should be repeated only annually (rather than semi-annually as planned).

Recommendations for A. I. D.:

AID/Washington: survey guidelines should not be required but only recommended, so that projects which contain interventions for groups over two year of age will be able to document the impact of the additional interventions by using alternative sampling frames.
AID/Washington: DIP guidelines should be revised so that the document is a more useful implementation tool (a “workplan”) for program recipients.
USAID/Malawi: Because MOH supply logistics problems are a nationwide problem, USAID/Malawi should initiate a dialogue with the MOH to promote improvements in supply logistics throughout the health sector.

ANNEX A

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ANNEX B

MEMBERS OF THE DATA COLLECTION TEAM FOR THE MID-TERM SURVEY

Ms. Martha Bokosi, Family Health Officer, MOH Regional Health Office, Blantyre
Mr. Henry Gondwe, HSA Supervisor, Project HOPE, Thyolo, Malawi
Mr. Henderson Chikhosi, IEF Project Director, Chikwawa
Mr. Richard Mmanga, IEF Training and Supervision Coordinator, Chikwawa
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Mr. Henry Kalavina, IEF Training and Supervision Assistant, Chikwawa
Mr. Rene Berger, IEF Project Consultant, Chikwawa
Mr. Jeff Brown, IEF/US Child Survival Program Manager, Bethesda, USA
Ms. Mary P. Selvaggio, Independent Consultant, Mbabane, Swaziland

ANNEX C
PERSONS CONTACTED

Page 1 of 2

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Ms. B. Makhori, Nurse/Midwife, Kakoma Health Center
Mr. Ngayiye, Senior Health Assistant, Makhwira Health Center
Mr. Ndapwanga, HSA, Makhwira Health Center
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Mr. B. Thondoya, Medical Assistant, Chipwaila Health Center
Mr. A. Bodza, HSA, Chipwaila Health Center
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Mr. F. Munthari, Health Assistant, Ndakwera Health Center
Mr. L. Seven, HSA, Ndakwera Health Center
Ms. P. Navicha, HSA, Ndakwera Health Center
Mr. J. Mugawa, Medical Assistant, Ndakwera Health Center

OTHER

Dr. Joyce Cook, ADRA Health Project Director
Mr. J. Canner, IEF Country Director Designate
Dr. Stewart Tyson, UNICEF Representative

ANNEX D

Comprehensive List of Pro&t-Financed Training Activities (as Of October 1993)

I. PRE-SERVICE TRAINING

HSAs: (9 persons x 6 weeks) + (9 persons x 4 weeks)
VHVs: 505 persons x 5 days
VHCs: 297 committees x 10 members/committee x 1 day
ADRA: 4 HSAs x 6 weeks (NB: ADRA reimbursed the project for this training)

II. IN-SERVICE TRAINING

HSAs: **Vegetable Gardening:** 9 persons x 3 days
Breastfeeding: 13 persons x 3 days
Cholera: 13 persons x 3 days
Water/Sanitation: 13 persons x 1 day
HIV/AIDS: 13 persons x 3 days
Cataract Recognition: 18 persons x 3 days
Nutrition Assessment: 24 persons x 1 day
Use of HIS: 18 persons x 1 day
General training in staff meetings: 18 persons x 6 days
W Assessment Baseline: 5 persons x 1 day

Volunteers: **Eye Care:** 505 volunteers x 1 day
Cataract Recognition: 184 volunteers x 1 day
Breastfeeding: 400 volunteers x 1 day
HIV/AIDS: 400 volunteers x 1 day

Village Health Committees: **HIV/AIDS:** 297 committees x 1 day

ADRA: **Vitamin A & Diarrhea:** 18 HSAs x 0.5 days

Montford Hospital: **Vitamin A:** 13 volunteers x 1 hour

Ministry of Health: *Breastfeeding*: (18 nurses/MAs x 1 day) + (22 nurses/MAs x 2 days)
Nutritional Assessment (20 MOH staff x 1 day)
Primary Eye Care (12 MOH staff x 1 day)
Vitamin A (112 MOH staff x 1 day)

Other NGOs: *Nutrition Assessment*: (20 persons x 1 day)

Traditional Healers: *HIV/AIDS* (300+ persons x 1 day)

Religious Leaders: *HIV/AIDS* (102 persons x 1 day)

III. IEF STAFF DEVELOPMENT

Computer Literacy: 2 weeks x 2 persons

IVACG Vitamin A Seminar: 1 person x 1 week

Contraceptive Community Based Distribution/ToT: 1 person x 1 week

IEF staff also attended the following courses/seminars, but financing came from other sources:

AIDS: 1 person x 1 week (AID/Washington CSSP-funded)

CCCD Child Survival Seminar: 1 person x 1 week (AID/Washington CCCD-funded)

AIDS: 1 person x 1 week (Peace Corps funded)

INTERNATIONAL EYE FOUNDATION / MALAWI -- Organigram

