PVO CHILD SURVIVAL GRANTS PROGRAM, 1992

PRIVATE SECTOR INITIATIVE TO EXPAND CHILD SURVIVAL SERVICES FOR TEA AND COFFEE ESTATE WORKERS AND THEIR FAMILIES IN THE THYOLO DISTRICT OF MALAWI

ANNUAL REPORT -- YEAR 1

Submitted to:

AID/FVA/PVC/CSH

Room 103, SA-2
Agency for International Development
Washington, D.C. 20523

Submitted by

THE PEOPLE-TO-PEOPLE HEALTH FOUNDATION, INC.
(PROJECT HOPE)

MILLWOOD, VIRGINIA 22646

(703) 837-2100

OCTOBER 7, 1992

Project Manager, U.S.A.: **Bettina Schwethelm, Ph.D., M.P.H.**
CS Coordinator, Malawi: **Catherine Thompson, B.S.N., M.P.H**

TABLE OF CONTENTS

APPENDICES

ACRONYMS

ADRA	Adventist Development and Relief Agency
APHA	American Public Health Association
ARI	Acute Respiratory Infection
CAC	Central Africa Company, Ltd.
CBD	Community Based Distribution
CONGOMA	Council of NGOs in Malawi
DD	Diarrheal Disease
DHO	District Health Officer
DRCU	Malawi Drought Response Coordinating Unit
HIS	Health Information Specialist
HSA	Health Surveillance Assistance
IEF	International Eye Foundation
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organization
PCV	Peace Corps Volunteer
RHO	Regional Health Officer
ZOA	ZUD OST ASIA (Dutch Christian Refugee Organization)

1. RESULTS IN YEAR ONE

1.1 Major Results

a. Training:

Health Surveillance Assistants (HSAs). In the first year pilot project, Project HOPE trained seven HSAs from one estate company, the Central Africa Company, LTD., in a two-week intensive course, and 23 additional HSAs from the remaining estate companies were trained in this two-week course in September 1991. In February 1992 the entire group received the final four weeks of training, leading to a Health Surveillance Assistant certificate from the MOH. This training included information on AIDS, child spacing, nutrition, Vitamin A, sanitation, diarrheal diseases, ORT, ALRI, malaria, and EPI

Volunteers. The volunteers were recruited in March of 1992 over a two month period after the completion of the final HSA training. The 269 volunteers received a one-day module on ARI and Malaria. The training was delayed by the unrest in the country and the closing of some of the estates for a few weeks. During the next year, they will receive training on nutrition, diarrheal disease control (DDC), sanitation, HIV/AIDS, child spacing, and EPI.

b. Workshops:

Training of Trainers. Project HOPE contracted with DMN Consulting (Dr. Nahid Mazloum) for a two-day workshop for the medical assistants on the estates and Project HOPE's professional staff. This workshop focused on how to teach adult volunteers with emphasis on alternative methods of learning, (e.g., use of audio-visual aids, role play, group discussion, etc.).

c. Ongoing activities:

HSA Supervision. Project HOPE's field trainers supervise the HSAs at least once a month in their activities and assist with any problems. These visits monitor project progress and stress the importance of reporting.

HSA Meetings. Every quarter since the completion of training, meetings are held with the HSAs to discuss mutual problems and successes and to educate them on the use of the HIS forms and the importance of reporting.

Management Reports. Every quarter, the Project CS Coordinator sends reports to the estate managers to review progress and share the successes of the project. This keeps the managers involved in the project.

Condom Distribution. Project HOPE is assisting the estates in the distribution of condoms for AIDS prevention. This has been very successful, as the estate clinics are able to maintain a stock of condoms.

Child Spacing. Project HOPE has assisted one estate to open a child spacing clinic and provided some essential equipment and technical advice. At the opening of the clinic, which was attended by 200 men and women, a video was shown and a play given on child spacing.

HIS. The HIS has been developed with the assistance of an expatriate consultant and the project's PCV. This has enabled us to track activities at the compound, estate, and company level.

NGO/PVO Cooperation - Project HOPE has been very involved in the quarterly meetings of the USAID sponsored child survival projects in Malawi. These include IEF, ADRA, Save the Children, U.S.A., and WorldVision. The PVOs have met three times this year to discuss mutual problems and lessons-learned and to share resources.

Another NGO activity has focused on the drought in Malawi. Project HOPE worked with the other NGOs to coordinate relief activities on the regional and district level. The Child Survival Project Coordinator is a member of the Regional Health Subcommittee for the Drought and the District Drought Relief Committee on the Drought, which are working to standardize nutritional surveillance activities and reporting and serves as technical advisor to ZOA Refugee Care, an organization that is responsible for nutritional surveillance in Thyolo. Project HOPE has received a PCV to assist with nutritional monitoring in Thyolo and is in the process of obtaining essential drugs for Malawi, earmarked for Thyolo.

Overall, this year has been very productive, focusing on infrastructure building through the training of HSAs and volunteers and the development of the HIS. The problems of the drought have taken much of the time of our CS Project Coordinator and the professional staff, but has not impacted negatively on the progress toward achieving project objectives.

1.2 Change in Approach to Individuals at Higher Risk

Since the DIP, the MOH has made two decisions that change the project's approach to child spacing and vitamin A. The MOH has given Project HOPE permission to initiate community-based distribution system (CBD) for oral contraceptives in Thyolo (See letter, Appendix A) The project's Maternal

Specialist, Mrs. Liwonde, will be participating in a SEATS-sponsored training-of-trainers course for this program, held at the Malamulo Hospital. Project staff will start training volunteers on one estate in January, 1993, and then assess these activities before initiating them at the other estates. The MOH has also changed its position on Vitamin A and is mandating supplementation for all children from six months to six years with Vitamin A capsules every 5 months. Project HOPE will assist with this distribution on the estates. The project discussion with IEF to assist in conducting a training-of-trainers program for the HSAs to train the volunteers as distributor of Vitamin A.

1.3 Staffing

The organizational chart, position descriptions, and CVs are attached in Appendix B. New staff this year are the following:

Mr. Henry Gondwe HA - Field Trainer, November 1991

Mrs. Harriett Liwonde, ENM - Maternal Care Specialist, June 1992

Ms. Leigh Anne Shafer, PCV - HIS Specialist, January 1992

Ms. Michele DiTomas, PCV - Drought Relief Administrator (new since the DIP).

1.4 Continuing Education

Mr. Gondwe, Field Trainer:
- o HSA Curriculum Workshop (national) - March 1992 for five days
- o Southern Region Health Seminar - June 1992 for four days
- o Training of Trainers Workshop - (Thyolo) April 1992 for two days

Mrs. Liwonde, Maternal Care:
- o CONGOMA Management Workshop for Famine Programs (national) - July 1992 for five days

Mrs. Chunga, Field Trainer:
- o Training of Trainers Workshop - April 1992 - for two days

Catherine Thompson, Project Coordinator:
- o Nutritional Surveillance Workshop - Sept 1992- for two days

1.5 Technical Support

PVO Headquarters - Marguerite Farrell, Assistant Director, MCH programs conducted a two-week site visit-January 1992.

Consultant - Hubert Allen, HIS Consultant, assisted the project for five days in July and August in the review and modification of the HIS.

Workshop - DMN Consulting provided a local consultant, Dr. Nahid Mazloum, to train the volunteer trainers in alternative methods of adult education.

Ethnographic Study - Local consultants, Dr. Joan Davison of Chancellor College and a graduate student, conducted a two-week ethnographic study.

The project continues to receive technical input from other CS projects in the country, particularly Dr. Paul Courtright, Director, IEF, who provides ongoing information on Vitamin A. Save the Children Fund, UK, brought in a nutritionist specialist in the drought, Jane Macaskil who conducted a two-day workshop on conducting nutritional surveillance.

1.6 Community Participation

Presently, there are 29 active health committees on the estates which deal with their respective HSAs. The community participation levels are monitored through the HIS. The following activities were reported by the HSAs (volunteer data are just beginning to be collected (See Appendix C for HSA and Volunteer reporting forms).

Health Education	Talks Given	Attendance
Diarrheal Diseases	322	8,351
Nutritional Talks	201	5,013
Immunization	263	6,973
Malaria	275	6,578
Respiratory Infections	174	3,584
Child Spacing	176	4,791
AIDS Education	188	4,979
Hygiene	777	5,478
Sanitation	193	5,035

Activities Generated:	No. of Activities	Attendance
House smearing	390	880
Rubbish pits dug	123	1,325
Surroundings cleared	392	17,293
Pit latrines dug	125	806

Patients Referred to the Clinics:	Number
Measles	180
ARI	2,878
Chicken Pox	39
Diarrheal Diseases	2,085
Malaria	3,401
Malnutrition	652

1.7 Linkages to Other Health and Development Activities

- o USAID CS projects. The CS projects funded by USAID in Malawi (IEF, ADRA, World Vision, and Save the Children, USA) meet quarterly to discuss mutual problems and lessons-learned and to share resources.

- o NGO Drought Relief. Malawi is experiencing a severe drought which threatens to undermine all CS activities. The NGOs in the country have formed a Drought Relief Coordination UNIT (DRCU) to coordinate all NGO activities. Under this umbrella, Project HOPE in Thyolo is working with ZOA Refugee Care to conduct nutritional surveillance activities in the district in order to assist with targeting of food distribution and essential drugs. The CS Project Coordinator has also been involved in the district and regional drought health committees.

- o MOH. Project HOPE continues to work closely with the DHO, RHO, and the MOH in Lilongwe to coordinate all activities under the policies of the MOH in Malawi.

2. CONSTRAINTS, UNEXPECTED BENEFITS, AND LESSONS-LEARNED

2.1 Constraints

Drought - Malawi is experiencing a severe drought with up to 100% crop failure in some areas. Thyolo has also been affected. The drought has decreased the amount of tea in the fields to be picked, leading to massive layoffs of estate workers. Although July and August are usually layoff times for the estates, this year they have cut back even more. As a result, about 40% of the project volunteers have left the estates. Additional volunteers were recruited and will be trained in ARI and Malaria next year. It is possible that the volunteers who left will return when the rainy season begins.

Child Spacing Policy - The MOH has a policy that child spacing providers need to participate in a three-months training course. Only one of the estate nurses has had this training and no further training is being provided in Thyolo this year. Therefore, the project has decided not to hire a nurse to replace the estate nurses during this training due

to the lack of training opportunities and the inability of finding a replacement nurse. Also, the MOH is in the process of reevaluating the length of training required and, hopefully by next year, will have reduced the time length. Instead, Project HOPE has transferred a highly qualified nurse from the former Safe Mother-hood project, Mrs. Liwonde, who will assist the existing child-spacing clinic and be prepared to assist others when the training has been reduced. To promote child spacing, the project received a letter dated September 2, 1992, giving Project HOPE permission to initiate a CBD program for oral contraceptives in Thyolo. We have plans to work with the SEATS project at Malamulo Hospital who will be training the trainers of the volunteers in October 1992. Mrs. Liwonde will be participating in the training

2.2 Unexpected Benefits

The HSA training was expected to generate limited community activity. However, in fact, vast improvements were found in the compounds through HSA efforts (see also Section 1.6): Latrines and rubbish pits have been dug, houses smeared, and wells cleaned. All these activities have taken place through community participation. Also, the HSAs have recommended to their estate managers the need for home gardens and repairs, and many estates have complied with their requests.

2.3 Institutionalization of Lessons Learned

Communication - We have found that proper communication with the private sector managers is very important. Project HOPE is working with 11 different companies and 11 different managers and communications systems. Each HSA must work within the organizational structure of the company that has hired him. Project HOPE has had to adapt to each company in its activities, i.e., one estate expects our field trainers contact them before going on to the estate. Other estates have given open access to the project staff. We have had to work with the HSAs to recognize the particular command structure on their estate and work within that structure to assure sustainability of their role.

Community Mobilization - HSAs have had success in generating activities on the compounds. These activities are now a yearly part of the program. To institutionalize these activities, it helps to have a concrete reason for them, i.e., the "rainy season clean-up."

3. CHANGES MADE IN PROJECT DESIGN

3.1 Change in Perceived Health Needs

The drought has led to a new focus on the nutritional aspect of child survival. To respond to this situation, a nutritional survey as outlined by the NGO DRCU (Drought Relief Coordination Unit) on the estates, will be conducted in September 1992, January 1993, and March 1993. If Project HOPE finds an increase in malnutrition above that of the district overall, it will assist estate clinics to establish supplementary feeding nutrition clinics.

3.2 Changes in Project Objectives

An activity to support the child-spacing objective, i.e., training of six estate nurses in the three-month child spacing course, was changed. Since the availability of training activities is limited and the MOH may change the content and length of the training, this activity was not initiated. Instead, Project HOPE will wait for the new training plan and send one or two nurses to the training next year. All other activities remain the same.

3.3 Changes in Planned Interventions

There are no changes since the DIP, except in the above-mentioned child spacing and nutritional surveillance activities.

3.4 Change in Potential and Priority Beneficiaries

No changes were made since the DIP was submitted.

4. PROGRESS IN HEALTH INFORMATION DATA COLLECTION

4.1 Characteristics of the Health Information System

4.1.1 The project HIS does not maintain family or individual records. Project staff only refers individuals to clinics and keep track of numbers referred and numbers of diseases found. The HIS collects information about the daily activities of the HSAs and the volunteers.

4.1.2 The project HIS uses the compound as the lowest level of data collection. A compound is comparable to a small village on the estate. The HSAs report at this level and try to refer patients to the clinics on a more timely basis (See Section 1.6 for the numbers of individuals referred by the project.). In addition to the referrals, the HSAs and volunteers also provide follow-up to these women and

children. The system has been refined this year, to see what understanding the HSAs have of the reporting process and to work with the volunteers to initiate their reporting process. Staff meet quarterly with the HSAs to review any problems and to fine-tune the HIS.

4.1.3 The estates run clinics on a regular basis, including Under Five, and Nutrition clinics along with the daily operation. The information they collect does not change. One nutrition clinic and one child-spacing clinic have been added since the DIP, and the project will assist other estates to add specialty clinics during the next year. At present, the HIS is keeping track of the patients the HSAs refer to the clinics. The HSAs follow up on the children they refer to the clinics to see if they attended.

The next step in the development of the HIS is to collect the monthly reports given to the MOH on the number of patients seen and the type of problem. These data are kept by the clinics, and the project, in process of collecting them and inputting them into the computer. The project education activities will then be compared to the numbers of patients seen at the clinics last year.

4.1.4 Community Health Workers (HSAs and volunteers) submit monthly reports recording their daily activities. This information is the basis of the project HIS. The HSAs have remained active. The volunteers are just now beginning to submit reports. The information is used as a management tool to determine if the HSAs are focusing on the correct interventions, to monitor progress toward achieving the project objectives, and to provide feedback to HSAs, volunteers, USAID Malawi, the MOH, estate managers, and HOPE Center.

4.2 Special Capacities of the HIS

4.2.1 The project monitors service standards of the HSAs and volunteers, e.g., the number of talks given on a CS topic each month. The estate clinics have standard work loads and do not change.

4.2.2 Since each volunteer submits monthly reports to their respective HSAs, the project can track active volunteers. Presently, the HSAs are all active and are reporting with increasing quality. Project staff keep track of active volunteers and the training they have received, using an updated roster. For example, many volunteers were laid off from the estates and have left. They have been replaced by the project. The replacements have not yet been trained in the first module, but will receive the second module first. Later on they will be trained in the first module. Also,

the laid-off volunteers may be rehired by the estates during the rainy season. If they are still interested in working in CS, they can return to the program, and will not require further training in the modules they have already received.

4.2.3 The project monitors the usual child survival interventions (DDC, malaria, ari, etc.). Any unusual cases, such as acute paralysis will be referred to the clinics on the estates. In the case of an acute problem, such as polio, measles, or cholera, the HSAs will report a case immediately to the clinic which then reports it to the district hospital for action. All immunizable diseases, cholera and TB are under active surveillance and have emergency procedures worked out with the DHO. Project HOPE will assist where needed in these situations. The monthly reports and clinic reports to the MOH will be the main data base for this information and be included in the HIS.

4.2.4 The amount of training received by the community health workers as a part of the ongoing project is tracked by the HIS.

4.2.5 Volunteer forms are the most difficult to collect. There are many volunteers and the system is new. It will take some time for the volunteers to get used to the reporting forms. Some modifications in the form were already made to help the volunteers understand them better.

4.3 Management of the HIS

4.3.1 The following resources have been allocated for the HIS form August 1991 - July 1992, 10% of Project Coordinator time, 15% of field trainer time, rent of the PCV, fee for a five-day expatriate consultant, and computer equipment and software. The total amount is approximately $22,610.

4.3.2 Indicators are reviewed on a monthly and quarterly basis. At that point, we compare past outputs and make changes in the program as needed.

4.3.3 The last time information was shared was on September 4th during the last HSA meeting. Each HSA received graphs outlining his reported activities. At the same time, the managers of the estates received quarterly reports on the project's CS activities, with specific information about their respective estate. The MOH receives quarterly reports as well.

4.3.4 The field trainers collect the HSA and volunteer reporting forms and analyze and monitor the quality of the data. The forms are compiled by the data entry clerk and entered into the computer program developed by the PCV. The

final information is analyzed by the Project CS Coordinator in consultation with the entire professional staff.

4.3.5 At the quarterly HSA meetings, the importance of the information they collect is discussed. Now that the HSAs are receiving graphs about their activities, they are more motivated to submit accurate reports. The HIS allows for quick summary and feedback of the data and easy access to information for decision-making. The project can, therefore, share the information received easily and in a timely manner.

5. SUSTAINABILITY

5.1 Recurrent Costs

5.1.1 The project is designed to have a minimum of recurrent costs. The HSAs are already paid estate employees. The recurrent costs for the estates are their salaries ($50 per month per HSA already in operation), bicycle maintenance, and ongoing HSA and volunteer training. While Project HOPE is responsible for the volunteer training, only the minimum amount of money needed to buy lunch in Thyolo is provided (approximately $525 per training session for 300 volunteers). When the estates take over, they will have to provide lunch to the volunteers. Since all training is organized in one day modules, overnight expenses are not a problem. According to the UNICEF guidelines for per diems, this is acceptable. (Either lunch is provided or funds given for lunch).

The HSAs will need ongoing continuing education which the project has provided on a quarterly basis for four hours. The HSAs receive light refreshments at about $25 per session). The MOH, through USAID, is training HSAs in the country. Therefore, when an HSA leaves, the estate will not need to retrain a new HSA but can recruit an HSA who is already trained. The field supervisors work with the estate medical assistants as their counterparts. At the end of the project, the latter will be responsible for the supervision of the HSAs. Once Project HOPE leaves, the Agricultural Employers Association (AEA) will be responsible for the project. The mechanism for this is under discussion. Either a health committee will be formed, and/or a coordinator hired.

5.1.2 Most of the recurrent costs will be assumed by the estates.

5.2 Strategies for Increasing Post-Project Sustainability

5.2.1 Estate Cooperation - At the moment the cooperation

among the various estates is through Project HOPE. We are trying to develop a health committee to play that role. Before Project HOPE initiated work with each estate company, estate management had to commit to hiring the necessary number of HSAs. As a result, the HSAs are already paid estate employees and will remain so once the project has ended. This strategy was accepted by the management and substantially reduces project cost.

Volunteers - The volunteers are supervised by the HSAs and the medical assistants on the estates. The role of the HSAs and medical assistants needs to be continued by each estate. Each estate will have to keep up the necessary ongoing volunteer training with the assistance of the health committee. The volunteers received a waterproof bag for holding their teaching materials as the only incentive. The project follows MOH guidelines of not paying volunteers. Project staff and HSAs are working to strengthen the compound health committees to provide further incentives for the volunteers.

5.2.1 The project's continuing supervision and training of the HSAs and medical assistants to enable them to train volunteers, will in the long run cut down any costs to the companies to maintain volunteer training. Estates have already employed the HSAs and medical assistants who will be the trainers.

5.3 Cost Recovery

Project HOPE does not have any cost recovery program at present.

6. PROJECT EXPENDITURES AND JUSTIFICATION FOR BUDGET CHANGES

6.1 Pipeline Analysis (See Appendix D)

6.2 Justification of Budget Changes

There are no major changes in the project budget since the DIP.

7. 1992/93 WORK SCHEDULE AND BUDGET

See Appendix E for the 1992/93 Budget

SCHEDULE OF ACTIVITIES

1.	Nutritional Surveillance Surveys to monitor the impact of the drought on child nutritional status:	
	September 14-24	First Survey
	January 11-19	Second Survey
	May 10-18	Third Survey
2.	September 28 - December 15	Volunteer training - two modules: DDC and nutrition
3.	Deputy Coordinator: December	Advertise for the position in December, interview in January and hire by February 1992
4.	February 1-25	Volunteer training in HIV/AIDS
5.	April 5-29	Volunteer training - child spacing motivation
6.	March 8-19	Midterm KAP Survey
7.	June 1-24	Volunteer training - EPI
8.	July 6-17	Midterm Evaluation

ADDITIONAL ACTIVITIES:

Child Spacing

- o Increase education activities of Mianga (monthly videos and child spacing talks and videos). Go to different compounds with the video, once each month. CBD of contraceptives as described earlier.

- o Increase the number of child spacing clinics of the estates. Look into training opportunities in child spacing for two estate nurses next year.

Malaria

- o Investigate existing operations research on bed nets or alternative methods of prevention. (Additional funding may be available from the local mission to assist with additional malaria activities).

Drought

- o In cooperation with ZOA Refugee Care (a PVO), continue with ongoing nutritional surveillance activities in the

district from September 1992 to March 1992. Mrs. Liwonde will assist with the supervision of the telams, as well as the utilization of an additional PCV, Michele DiTomas. Ms. DiTomas will begin to assist with drought-related activities in the district and on the estates on September 14, 1992. Project HOPE will compile the weekly and monthly reports for the DHO, RHO, and DRCU on drought-related activities.

AIDS

- Organize additional AIDS workshops for estate personnel.
- Conduct a rapid assessment of AIDS attitudes
- Work with UNICEF's Social Mobilization Officer to establish AIDS drama groups on the estates.

Presentation

The project activities will be presented during a round-table session at the annual APHA meeting in Washington in November 1992 by the CS Project Coordinator, Catherine Thompson.

APPENDIX A

LETTER FROM THE MOH GIVING PERMISSION FOR CBD DISTRIBUTION OF CONTRACEPTIVES

Telegrams: Ministry, Lilongwe
Telephone: Lilongwe 730 099

Communications should be addressed to:
The Secretary for Health

In reply please quote No. ADM/13/31

MINISTRY OF HEALTH
P.O. BOX 30377
CAPITAL CITY
LILONGWE 3
MALAWI

Ms Catherine Thompson, BSN, MPH
P.O. Box 219
THYOLO

2 September 1992

RE: PROJECT HOPE SAFE MOTHERHOOD INITIATIVE IN THYOLO

Thank you for your regular reports on the above project. We note with satisfaction the achievements being made in manpower development, service expansion and communication/transport support.

As regards the use of TBAs/Village Volunteers in child spacing service delivery you may feel free to emulate Ekwendeni Hospital who are using similar personnel, after requisite training, to provide the first cycle of oral contraceptive pills on the basis of the WHO personnel check list a copy of which is attached. The supervisors of the project in Ekwendeni are satisfied with the progress made over the last 5 months.

Clients are required to obtain medical check up at health facility before they can obtain further supply of oral contraceptives from the TBA/Village Volunteer.

We look forward to continued collaboration with you in the promotion of the health of the people of Malawi.

Best regards

Dr J S Kure
FOR THE PRINCIPAL SECRETARY

Att a.

17

PROJECT HOPE
THE PEOPLE-TO-PEOPLE HEALTH FOUNDATION, INC., P.O. BOX 219, THYOLO, MALAWI
Child Survival Programme

FAX Attention: Laura Kearns

September 15, 1992

Laura,

The following two pages is my letter from Dr. Kure about CBD of oral contraceptives through Project HOPE that I spoke to you about. We will be working with Malamulo Hospital program on this in the estates and with TBAs already trained by our Safe Motherhood programme. I thought you and Chris would be interested in this.

Talk to you soon.

Cathy

ANNEX 1

CHECKLIST FOR COMMUNITY BASED HEALTH WORKERS FOR THE PRESCRIPTION OF ORAL CONTRACEPTIVES TO ELIGIBLE WOMEN.

Check the following by history and examination:

	YES	NO
Above 40 years of age	...	...
Above 35 years of age and a heavy smoker	...	...
Seizures	...	...
Severe pain in the calves or thighs	...	...
Symptomatic varicose veins in the legs	...	...
Severe chest pains	...	...
Unusual shortness of breath after exertion	...	...
Severe headaches and/or visual disturbances	...	...
Lactating (Yes = for less than 6 months)	...	...
Intermenstrual bleeding and/or bleeding after sexual intercourse	...	...
Amenorrhoea	...	...
Abnormally yellow skin, eyes	...	...
Mass in the breast	...	...
Swollen legs-OEDEMA	...	...
Blood pressure (Yes = above 140 mm Hg (18.7 kPa) systolic and/or 90 mm Hg (12 kPa) diastolic)	...	...

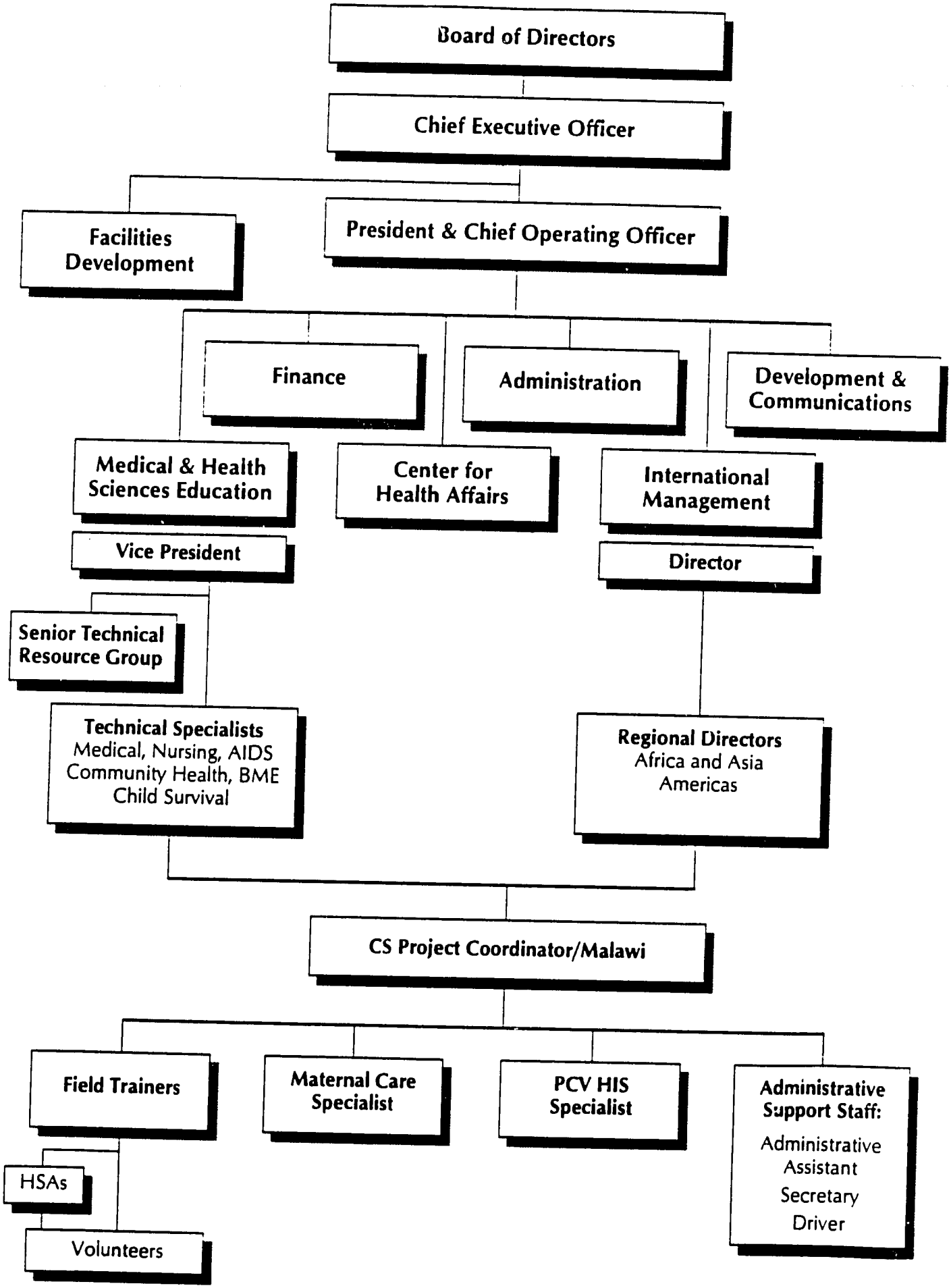
INSTRUCTIONS;

If all the above are negative the women may be given oral or injectable contraceptives. If any are positive, she must first be seen by a doctor.

Source: *WHO Offset Publication No.65,WHO Geneva 1982.*

APPENDIX B

ORGANIZATIONAL CHART


Board of Directors
Chief Executive Officer
Facilities Development
President & Chief Operating Officer
Finance
Administration
Development & Communications
Medical & Health Sciences Education
Center for Health Affairs
International Management
Vice President
Director
Senior Technical Resource Group
Technical Specialists
Medical, Nursing, AIDS
Community Health, BME
Child Survival
Regional Directors
Africa and Asia
Americas
CS Project Coordinator/Malawi
Field Trainers
Maternal Care Specialist
PCV HIS Specialist
Administrative Support Staff:
Administrative Assistant
Secretary
Driver
HSAs
Volunteers

CURRICULUM VITAE

CATHERINE LARIVEE THOMPSON
P.O. BOX 219
THYOLO, MALAWI
Tel. and Fax: (265) 472438

CURRENT POSITION:

Child Survival Coordinator
Project HOPE
Malawi
November 5, 1990 - present

EDUCATION:

Master of Public Health

Columbia University, School of Public Health, NYC
Focus: International Population and Family Health, 1987

Bachelors of Science in Nursing
New York University, NYC, 1982

PROFESSIONAL EXPERIENCE;

November 1990 - Present

Child Survival Coordinator, Project HOPE, Thyolo, Malawi

Direct, supervise, and assist the implementation of the Project HOPE Child Survival and Safe Motherhood programs in Malawi in accordance with Project HOPE, USAID, and MOH guidelines.

Develop training materials for Health Surveillance Assistants (HSA) and volunteers in AIDS, Child Spacing, ORT, Sanitation, EPI, Nutrition, Malaria, and ARI. Direct and assist in the training programs.

Developed and implemented an ethnographic/baseline survey on the private sector tea estates in Thyolo. Prepared data analysis and survey report. Integration of baseline data into the project initiatives.

Direct all aspects of program, financial, administrative, logistical, and personnel. Supervise and train field staff, health surveillance assistants, volunteers, and office personnel.

Assist with proposal writing according to Project HOPE and USAID guidelines.

January 1990 - November 1990

U.S. Embassy Nurse, Mbabane, Swaziland

Independent health consultation to the American Mission. Coordination of health care in liaison with local physicians, pharmacists, and hospitals. Determination of need for medical evacuation and coordination of same.

Education of community in disease prevention, emergencies, first aid, and childbirth. Emphasis placed on AIDS, malaria, and parasitic diseases. Planning and implementation of immunization programs according to the State Department guidelines.

Administration of health unit, determination of essential drugs, supplies and educational materials, and budgeting for same. Computerization of the health unit utilizing the Wang Computer.

January 1989 - December 1990 (full time)
January 1990 - November 1990 (part time)

Lecturer, Swaziland Institute of Health Sciences, Mbabane, Swaziland

Lecturer in public health, tropical diseases, and epidemiology to the nursing and midwifery program. Preparation of lectures, practicums and teaching aids. Collaboration with Swazi lecturers and assistance with lecture preparation for public health, family planning, and AIDS.

May 1987 - May 1988

Public Health Officer, Baha'i International Community, Haifa, Israel

Initiation, planning, and implementation of first full time health position. Independent health consultation to staff of 450 from 36 countries. Health education programs in disease prevention, emergencies, first aid, and immunizations.

Research of potential health hazards such as pollution of air, water, food, and war threats and presentations of new policy guidelines.

Design of five health care stations and training and supervision of fifty professional and volunteer staff to provide emergency care for 1200 delegates from 136 countries at an international convention.

May 1985 - April 1987

Home Health Intake Coordinator, Visiting Nurse Service of New York City

Development and implementation of a new position as liaison/consultant for the Visiting Nurse Service of New York City to Columbia Presbyterian Medical CEnter, Center for Women and Children, and at Harlem Hospital.

Staff education, coordination of patient discharge from the hospital and admission to Visiting Nurse Service Home Care. Special attention paid to AIDS patients home care needs, since Visiting Nurse Service had the contract for all AIDS patients in New York City.

December 1983 - May 1985

Public Health Nurse, Visiting Nurse Service of New York City

April 1982 - August 1983

Statistics Research Assistant, Baha'i International Community, Haifa, Israel

November 1981 - April 1982

Staff Registered Nurse, U.S. Army Field Hospital, Berlin, Germany

PRESENTATIONS

Schwethelm, B., Thompson, C., (1991). Developing Child Health Activities with Private Sector Tea and Coffee Estates in Thyolo, Malawi: Problems and Issues. Presented at the Annual Meeting of the National Council for International Health.

PROFESSIONAL ORGANIZATIONS

American Public Health Association
National Council for International Health

CURRICULUM VITAE

SURNAME:	Gondwe
OTHER NAMES:	Henry Ashrust
DATE OF BIRTH:	
SEX:	Male
MARITAL STATUS:	Married
DISTRICT OF ORIGIN:	Rumphi
NATIONALITY:	Malawian
DENOMINATION:	Anglican
PRESENT ADDRESS:	Project HOPE, Box 219, Thyolo, MALAWI
EDUCATIONAL DETAILS:	"O" Levels - Malawi Certificate of Education at Mzuzu Sec. School in 1974
PROFESSIONAL EDUCATION:	Certificate in Public Health - Zomba School of Hygiene 1978

WORKING EXPERIENCE:

Working Experience with Project HOPE. Trainer and Field Supervisor since 1st September, 1991.

Attended Volunteer Training Workshop by Dr. M. Nahid (Education Consultant) from 9 April to 10th April, 1992.

Took part in Health Surveillance Assistant Trainers Workshop where we improved and developed a curriculum for the HSAs Training Program in Malawi. From 22nd March to 28th March, 1992.

Trained 30 HSAs who belong to the Tea Estates in Thyolo - 2nd February - 28th February, 1992.

WORKING EXPERIENCE WITH MINISTRY OF HEALTH

District TB Officer - Thyolo District Hospital until 31 August, 1991. Promoted to Senior Health Assistant in February, 1991.

Attended AIDS Workshop from 6th Feb. to 14th Feb. 1992

Attended Tuberculosis Workshop from 16th Dec. to 24th Dec. 1989.

Trained 20 Health Volunteers on community based Health Activities from 12th June to 18th June 1989.

Protected 6 wells and springs in 3 villages from 4th May 1988 to 18th May 1988.

Attended 2 week Primary Health Care Workshop from 12th July, 1988 to 27th July, 1988. Took part in Immunization Coverage Survey (Maching and Thyolo). Attended a one week Evaluation EPI Workshop from 11th September to 18th September, 1988.

Advance Publicity Officer for Polio Campaign (Kasungu) April to June 1986. Took part in Tuberculosis Survey conducted by Mendicus Mundi (French Organization) June 1986. Took part in goiter Survey in Mwanza - October 1986; INTERSECTRAL COORDINATOR and TB Officer for Mwanza in 1986.

Cholera control Supervisor and TB Officer for Chikwawa District Hospital in 1985.

District TB Officer and Cholera control Supervisor 1978 - 1979. Attended a one week National Seminar on the Implementation and Interpretation of Primary Health Care Delivery System by Dr. Yun WHO Representative to Malawi, June 3 to 11, 1979.

CONTRIBUTIONS:

Co-writer of an Article called "Encouraging Community Participation in the Private Sector Tea Estates in Malawi" to be presented at ALPHA 120th Annual Meeting - Washington DC - November 8 to 12, 1992.

Took part in the Registration and resettling of Mozambican Refugees at Chipho camp under the ZOA Refugee Care in 1989.

Sole Public Health member present during the review of Child Survival by Dr. Thom Kenyon of Project HOPE. I used to take him around in problem areas from 8th February to 10th February. This enabled **Project HOPE** to establish a Child Survival Project in Thyolo - Malawi.

I managed to mobilize most communities in all the district I have worked for Public Health Actions.

HOBBIES: Reading professional journals, novels and magazines, watching soccer and listening to pop and reggae music.

CS Field Trainer/Supervisor

NAME: Mrs. M. Chunga
P.O. Box 219
Thyolo, Malawi

QUALIFICATIONS:

1962-1966 Harare Hospital School of Nursing, Zimbabwe
Degree: State Registered Nurse

EXPERIENCE:

1966-1968 AIDS Counsellor trained by MOH
Queen Elizabeth Central Hospital, Blantyre, Malawi; Female surgical ward doing general duties (e.g. giving oral medicine, injections, dressing wounds, general nursing care of patients and writing ward reports).

1968-1972 Oedza District Hospital, Malawi, Staff Nurse in charge of arranging weekly duty roster for junior staff, plus leave roster. Theatre work, supervising health centres in the District;

1973-1976 Zomba General Hospital, Malawi, Theatre work, scrubbing, staff nurse for 11 months.

1976-1978 Queen Elizabeth Central Hospital Training School; Midwifery.

1978-1990 Thyolo District Hospital; Sister-In-Charge, supervising junior staff, writing weekly duty roster, leave roster, supervising food for patients, theatre nurse scrubbing for operations. In charge of maternity ward. Supervising in health centres. Inservice education for counselling AIDS patients.

References: Dedza District Hospital - Dr. J. Chiphazi
Regional Medical Officer - Dr. A. Oonkmann

CURRICULUM VITAE

NAME:	Mrs. Harriet Liwonde
NATIONALITY:	Malawian
MARITAL STATUS:	Married
NUMBER OF CHILDREN:	five
ACADEMIC QUALIFICATION:	Junior Certificate
PROFESSIONAL QUALIFICATION:	Enrolled Nurse/Midwife and Enrolled Public Health Nurse.
PLACES TRAINED:	Queen Elizabeth Central Hospital from 1960 - 1963 as enrolled Nurse Zomba School of Nursing from 1965 -1967 as Enrolled Nurse Zomba School of Nursing from 1970 - 1971 as Enrolled Public Health Nurse
PLACES OF WORK:	Queen Elizabeth Central Hospital from 1967- 1970 doing General Nursing in Pediatric Ward and few months in Maternity. From 1971 - 1972 December Ngabu Rural Hospital doing Community Nursing From 1972 - 1975 Chintheche Rural Hospital doing Community Nursing in the wards From 1975 - 1978 Worked at Mzimba District Hospital General Nursing and little of community nursing 1978 - 1980 Worked at Balaka General Nursing and partially Community Nursing and was promoted to Senior Enrolled Nurse in 1980 From December 1980 Posted to Thyolo District Hospital worked in the Pediatric ward as Ward Incharge for 3 years; then in 1985 I was shifted to Maternal and child health Department worked as community Nurse and in 1986 I was appointed as a District Maternal and child Health Coordinator for the District

and the same year I was promoted to Principal Enrolled Public Health Nurse. I was also engaged in Traditional Birth Attendant Trainer from 1982 up to the date of my retirement from the Ministry of Health, December, 1990. I have worked with the Ministry of Health for at least 25 years.

REFEREES: Ministry of Health, BOX 30377, Lilongwe 3.

CURRICULUM VITAE

Curriculum Vitae

MICHELE ELISE DITOMAS

ADDRESS:

PERSONAL:

EDUCATION: Bachelor of Science, Biology, May 1990
Marquette University, Honors Program
Milwaukee, Wisconsin

EXPERIENCE:

October 1990 - Present

Peace Corps Volunteer Secondary School Teacher

Taught biology at the Luchenza Secondary School at JCE and MSCE levels. Organization of the school library into the Dewey Decimal System and served as the school librarian.

Peace Corps Secondary Projects

Project HOPE - assisted community health volunteers in conducting a health survey for the Project HOPE Child Survival Project on the Thyolo tea estates.

VAC Funded Well Project - assisted in the construction of wells in areas which the above survey revealed to have the poorest water sources. Promoted community participation.

January 1990 - May 1990

High School Tutor - tutored high school students at University in Biology as part of an effort to give minority students in Milwaukee opportunities for higher university education.

January 1989 - January 1990

Tutor - responsible for tutoring college athletes in biology, chemistry, physics, and English at Marquette University.

PROFESSIONAL PROFILE
KWAME ASIEDU

PERSONAL Associate Program Officer, PATH

EDUCATION

M.P.H. - Columbia University School of Public Health, 1986
B.A. - Baruch College, New York, 1981

LANGUAGE PROFICIENCIES English, Twi. and Ga (Ghana), Creo (Sierra Leone)

EXPERIENCE

1989-present — AIDS Control Program Manager, Project HOPE Malawi

1988-89 — Associate Program Officer, PATH, Washington,D.C. Monitor and provide technical assistance in program planning, management, training, evaluation and curriculum to Family Planning/Information, Education and Communication, and health projects in Ghana. Developed FP/IEC training curriculum to train NORPLANT health workers. Provide assistance to Manage FP/IEC projects in developing countries, and co-author proposals. Supervised a staff of three.

1987-88 — Public Health Educator, Office of Health Promotion and Disease Prevention, Washington, D.C.

Planned and developed health promotions activities for special populations that are at risk for certain preventable diseases and injuries. (Teen pregnancy, infant mortality, sexually transmitted diseases, cardiovascular disease, alcohol and drug abuse, cancer, etc.)

1987-88 — Consultant, Johns Hopkins University/Population Communication Services, Baltimore, Maryland

Principal Trainer for JHU/PCS and Ministry of Health/Health Education Division of Ghana, USAID funded workshop in Ghana. Trained 38 Regional Health Education Officers and District Health Management Teams in family planning, interpersonal communication and counseling training. Developed information, education and communication manual for training of clinic staff.

1987 — Primary Health Care Consultant, Donnelly Roark and Associates, Inc., Washington, D.C.

Developed primary health care project proposal for Donnelly Roark and Rutgers University for a project in Burkina Faso.

1987 — Group Leader/Teacher, Congressional Youth Leadership Council, Washington, D.C.

Taught and supervised 22 high school seniors (Congressional Scholars) for a period of one week at a time.

AFFILIATIONS

American Public Health Association

National Council for International Health

Institute of Society, Ethics, and Life Sciences

CURRICULUM VITAE
HUBERT A. ALLEN, JR.

Nationality: American
Dependents: Wife-Deborah
Child: Child-Nyika

EDUCATION

1985 **Master of Science**, Biostatics, Johns Hopkins University, School of Hygiene and Public Health, Baltimore, Maryland, September 1985. Thesis: Methods of Band Survival Analysis: Applied to Studies of the Tundra Swan (Cygnus columbianus columbianus).

1980 **Bachelor of Science**, Applied Math-Biology, Brown University, Providence, Rhode Island.

INTERNATIONAL HEALTH CONSULTING

HEALTH INFORMATION SYSTEMS:

Feb.-May 1992 **The Expanded Program on Breastfeeding Promotion, Wellstart, Washington, D.C.** Developed a user-friendly Global Breastfeeding Trends Monitoring System using Epi Info software, and a core of DHS data.

January 1992 **The Romania Family Planning Project, The Centre for Development and Population Activities, Romania.** Designed the forms for a clinic-based family planning information system.

October 1991 **The Adventist Development and Relief Organization, Malawi.** Developed a comprehensive Child Survival Health Information System for the ADRA Child Survival Project, using Epi Info software for a community registration of 100,000 people.

May 1991 **U.S. Peace Corps, Office of Medical Services, Washington, DC.** Consultant to University Research Corporation. Reviewed the OMS health information systems and proposed an umbrella information system for use in Quality Assurance.

March-April 1991 **The Foundations for the Peoples of the South Pacific, Vanautu.** PVO Child Survival Operations Support Project, Johns Hopkins University, Institute for International Programs. Developed a comprehensive Island Health Information System for the Vanautu Child Survival Project using Epi Info

POSITION DESCRIPTION

Catherine L. Thompson, B.S.N., M.P.H.

PROGRAM: Malawi Child Survival

POSITION: Child Survival Coordinator

DURATION: November 1, 1990 - June 30, 1991

REPORTS TO: Malawi Country Manager, HOPE Center

REPORTING TO THIS POSITION: Field Staff

BASIC FUNCTIONS:

1. Assure compliance of the CS project with the A.I.D. grants requirements particularly the Detailed Implementation Plan.

2. Plan, direct, supervise, and participate in the implementation of the Project HOPE CS project in Malawi in accordance with the philosophy and guidelines established by the Medical Director and the Board of Directors of the Foundation.

3. Represent the Foundation before Malawian authorities as required for the day-to-day operation of the CS project.

4. Investigate locally available funding opportunities for CS projects and prepare grant proposals in coordination with Project HOPE.

PRINCIPAL DUTIES:

1. Direct, supervise, and assist the implementation of the Project HOPE CS project in Malawi in accordance with the Detailed Implementation Plan, utilizing the expertise of the on-site faculty and staff. It is understood that this plan is to be prepared utilizing Project HOPE, A.I.D., and MOH guidelines.

   - Develop and implement an ethnographic/baseline survey in the tea estates in the target area.

   - Assure that appropriate curriculum is developed for the selected CS project components.

   - Assure that the data from the survey is analyzed quickly and integrated into program planning.

   - Train and supervise the field trainer/supervisor and the health surveillance assistants.

software, involving eleven modules, with routine reporting from 17 districts. January, September 1991. USAID funded.

Sept. 1991 **Ministry of Health, Mozambique.** Developed a comprehensive health information system in the Zambezi Pilot using Epi Info software, involving six modules, with routine reporting from 17 districts. Johns Hopkins University Institute for International Programs. USAID funded.

Save the Children Federation. Computerized Mbalachanda, Malawi, census of 40,000 individuals for Primary Health Care Information.

United Nations High Commissioner for Refugees. Computerized census of 277,000 Mozambican Refugees in Malawi.

Ministry of Education and Culture. Secondary School Location Study involved data entry of 10,000 questionnaires, Malawi. IDA Education project.

November 1991 **The Nigeria Family Planning Monitoring System.** Population Communication Services. Johns Hopkins University. Developed a demonstration family planning

POSITION DESCRIPTION

PROGRAM: Malawi Child Survival

POSITION: Health Information Specialist

REPORT TO: Program Coordinator

BASIC FUNCTIONS:

1. Assist the Program Director in the monitoring requirements of the child survival project and develop the necessary systems for data management.

2. Train project staff in data management and computer use, as appropriate.

PRINCIPAL DUTIES:

1. Assist the Program Director in the development of a manual or computerized system of monitoring project inputs and outputs.

2. Assist in the development and analysis of needs assessment surveys and training evaluation instruments.

3. Train project and CS staff in the use of word processing, management, and data analysis software, as needed.

4. Assist the Program Director in the development implementation and evaluation of MIS workshops.

5. Develop training modules, materials, and audiovisual resources for CS program trainees.

6. Submit reports of activities to the program director.

REQUIREMENTS:

1. Monitoring and evaluation skills and experience and the analysis of qualitative data.

2. Proficiency in computer usage (hardware and software-Wordperfect, dBase, Lotus 1-2-3).

POSITION DESCRIPTION

PROGRAM: Malawi Child Survival

POSITION: Area Supervisors

REPORTING TO THIS POSITION: Health Surveillance Assistant

PRINCIPAL DUTIES:

1. Assist the Project Coordinator in the training and supervision of the Health Surveillance Assistants, and provide technical assistance to their activities with the communities.

2. Promote the project objectives at the community level during the project start-up phase.

3. Assist the Project Coordinator in the development and implementation of training curricula for the community volunteers and/or TBAs.

4. Conduct home visits to at-risk families identified by community volunteers and staff and utilize these visits also to provide in-service training to the Health Surveillance Assistants.

5. Supervise the collection of data of the Health Surveillance Assistants and the community volunteers to the project MIS.

6. Coordinate and assure the regular supply of basic materials to the Health Surveillance Assistants and the community volunteers.

7. Coordinate project activities with local health centers and health posts.

8. Assist the Project Coordinator in the development of sustainability strategies.

9. Submit monthly reports on activities completed.

10. Fulfill other responsibilities as requested by the Project Coordinator.

QUALIFICATIONS:

1. Minimum of 3-5 years experience in primary health care or maternal and child health at the community level.

2. Diploma in public health nursing, health inspection, health assistant, or equivalent.

POSITION DESCRIPTION

Program: Malawi Child Survival

Position: Maternal Care Specialist

Reports to: Child Survival Coordinator

PRINCIPLE DUTIES:

1. Assist with the technical component of all training concerning maternal care (i.e. child spacing, nutrition, antenatal, and postpartum care).

2. Assist with the establishment and ongoing support of child spacing clinics.

3. Advise field trainers on the child spacing components of all training of volunteers.

4. Coordinate and assure the regular supply of basic materials for child spacing clinics.

5. Coordinate project activities with the MOH district health team.

6. Supervise the collection of data on the child spacing clinics and on maternal care.

7. Assist the Project Coordinator in the development of sustainability strategies.

8. Submit monthly reports on activities completed.

9. Fulfill other responsibilities as requested by the Project Coordinator.

QUALIFICATIONS:

1. Minimum of 5 years experience in primary health care or maternal and child health at the community level.

2. Diploma in nursing with community and child spacing certificates.

3. Proven excellent supervisory skills and ability to work in teams.

4. Experience in community development activities.

POSITION DESCRIPTION

Program: Malawi Child Survival

Position: Drought Relief/Nutrition Coordinator

Reports to: Child Survival Coordinator

PRINCIPLE DUTIES:

1. Assist Project HOPE Child Survival Coordinator with the logistics and administration of nutritional surveillance in Thyolo district in cooperation with ZOA Refugee Care.

2. Assist with supervision and training of nutrition volunteers on the tea estates and for the MOH.

3. Coordinate transportation of likuni phela with the MOH and with estate vehicles as needed.

4. Submit weekly reports on the nutrition surveillance to the Child Survival Coordinator, ZOA Refugee Care, DHO, RHO, and the DRCU (Drought Relief Coordination Unit.)

5. Represent Project HOPE at famine relief meetings as requested by the Child Survival Coordinator.

6. Fulfill other duties as requested by the project coordinator.

QUALIFICATION:

1. Peace Corps Volunteer with two years experience in Malawi.

2. University degree.

3. Ability to work with the community and with other organizations.

4. Leadership and supervisory skills and the ability to work with a team.

APPENDIX C

HSA AND VOLUNTEER REPORTING FORMS

HSA MONTHLY CONSOLIDATED FORM

NAME OF HSA ..... ESTATE/DIVISION .....

DATE SUBMITTED ..... YEAR .....

ACTIVITY	NAME OF COMPOUND													TOTAL
VOLUNTEER SUPERVISED														
HEALTH EDUCATION ATTENDANCE														
(a) Diarrheal Diseases														
(b) Nutrition														
(c) Immunization														
(d) Malaria														
(e) Respiratory Infections														
(f) Child Spacing														
(g) Aids Education														
(h) Hygiene														
M.C.H. ACTIVITIES ATTENDED														
(a) U/5 Clinic														
(b) U/5 Outreach Clinic														
(c) Nutrition Clinic														
REFERRALS TO DISPENSARY														
(a) Measles														
(b) Respiratory Infections														
(c) Chicken Pox														
(d) Diarrhoea Diseases														
(e) Malaria														
(f) Malnutrition														
PATIENTS RECEIVED AT CLIN														
(a) Measles														
(b) Respiratory Infections														
(c) Chicken Pox														
(d) Diarrhoea Diseases														
(e) Malaria														
(f) Malnutrition														

ACTIVITY	NAME OF COMPOUND														TOTAL
INSPECTIONS															
(a) No. of houses satisfactory															
(b) No. of houses unsatisfactory															
(c) No. of pitlatrines satisf.															
(d) No. of pitlatrines unsatisf															
(e) No. of Rubbish pits															
(f) No. of racks															
(g) No. of Bathrooms															
WATER SUPPLY															
(a) Wells Protected															
(b) Wells unprotected															
(c) Springs protected															
(d) Springs unprotected															
(e) No. of Boleholes															
(f) Boleholes not functioning															
(g) Water Sources Chlorinated															
(h) Aprons Installed															
(i) Soakway Installed															
INFESTATIONS															
(a) Mosquitos															
(b) Lice															
(c) Rodents															
(d) Cockroaches															
(e) Bed bugs															
ACTIVITIES GENERATED															
(a) House Smearing															
(b) Digging of Rubbish pits															
(c) Clearing Surroundings															
(d) Digging of Pitlatrines															
(e) Demonstrations															
(f) Role Plays															
OTHERS															

MAREKODIA NTCHITO

RECORD OF WORK

A ODIPELERKA KUGWIRA NCHITO YA ZAUMOYO

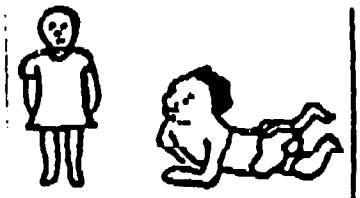
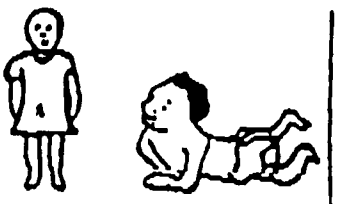
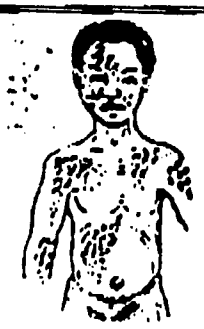
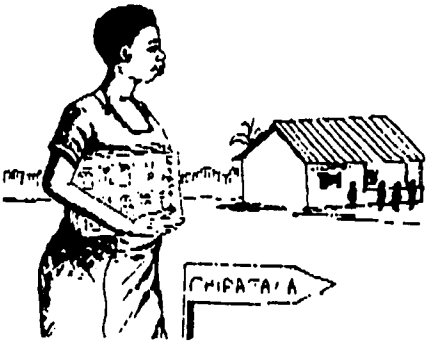
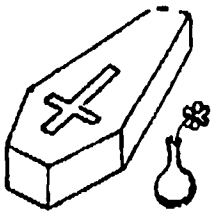
HEALTH VOLUNTEERS

NAME
DZINA_____

COMPOUND/VILLAGE
KAMPOUNDI/MUDZI_____

MONTH
MWEZI _____

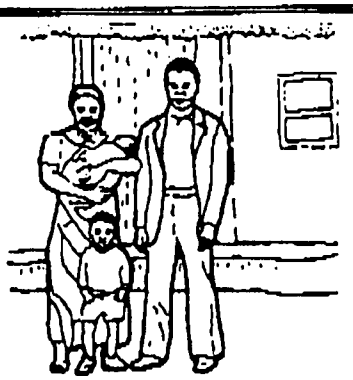
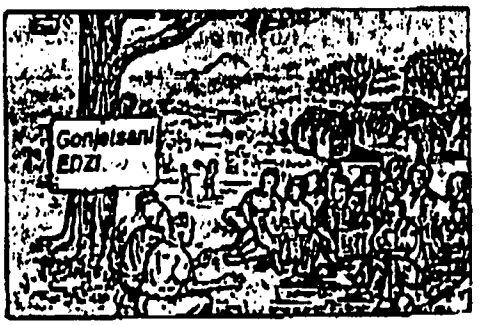
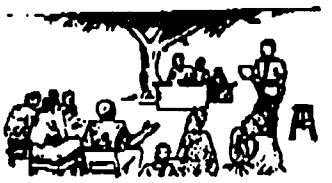
YEAR
CHAKA____

	ANA OCEPELA ZAKA ZISANU INFANTS AND UNDER FIVE YEARS 	TOTAL		**ANA OCEPELA ZAKA ZISANU** 	TOTAL
KUSEGULA M'MIMBA DIARRHEA 	00000 00000 00000 00000 00000 00000		**KUTSOKOMOLA** ARI 	00000 00000 00000 00000 00000 00000	
CHIKUKU MEASLES 	00000 00000 00000 00000 00000 00000		**MALUNGO** MALARIA 	00000 00000 00000 00000 00000 00000	
UTUMBIDWA MALNUTRITION 	00000 00000 00000 00000 00000 00000		**KUTUMIZA KUCHIPATALA**  REFERRAL TO HEALTH CENTER	00000 00000 00000 00000 00000 00000	
INFA DEATH 	00000 00000				

MAREKODIA NTCHITO

KUBELEKA		LIVE BIRTHS KUBEKEKA WAMOYO	STILLBORN KUBELEKAWA KUFA	INFA DEATH
BIRTH		UUUUU 00000 00000 00000	UUUUU 00000 00000 00000	00000 00000 00000 00000

MAPHUNZIRO A ZAUMOYO HEALTH TALKS

KULERA CHILD SPACING		00000 00000 UUUUU 00000	**UKHONDO** SANITATION	00000 00000 00000 00000
EDZI AIDS		00000 00000 00000 00000	 HYGIENE	
MISONKHANO YA BUNGWE LA UMOYO MMIDZI VILLAGE HEALTH COMMITTEE		00000 00000 00000 00000	**ZAKUDYA ZA BWINO** NUTRITION	00000 00000 00000 00000
KKUYENDELA MMIDZI HOME VISITS		00000 00000 00000 00000		

APPENDIX D

PIPELINE ANALYSIS

1992 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
PVO/COUNTRY PROJECT: MALAWI CHILD SURVIVAL-CSVII

HEADQUARTERS

	Actual Expenditures To Date (08/01/91 to 08/31/92)			Projected Expenditures Against Remaining Obligated Funds (09/01/92 to 08/31/94)			Total Agreement Budget (Columns 1 & 2) (08/01/91 to 08/31/94)		
COST ELEMENTS	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
I. PROCUREMENT									
A. Supplies	0	10	10	243	71	314	243	81	324
B. Equipment	0	0	0	0	0	0	0	0	0
C. Services/Consultants									
1. Local	0	0	0	0	0	0	0	0	0
2. Expatriate	0	0	0	0	0	0	0	0	0
SUB-TOTAL I	0	10	10	243	71	314	243	81	324
II. EVALUATION/SUB-TOTAL II	0	0	0	0	0	0	0	0	0
III. INDIRECT COSTS									
Overhead on HQ/HO (55%)	6,664	2,213	8,877	11,336	3,787	15,123	18,000	6,000	24,000
SUB-TOTAL III	6,664	2,213	8,877	11,336	3,787	15,123	18,000	6,000	24,000
IV. OTHER PROGRAM COSTS									
A. Personnel (List each position & total person months separately)									
1. Technical	6,730	2,243	8,973	16,148	5,383	21,531	22,878	7,626	30,504
2. Administrative	3,149	1,049	4,198	7,554	2,518	10,072	10,703	3,567	14,270
3. Support	2,226	742	2,968	4,024	1,342	5,366	6,250	2,084	8,334
B. Travel/Per Diems									
1. In-country	853	284	1,137	1,397	466	1,863	2,250	750	3,000
2. International	5,499	1,833	7,332	8,217	2,739	10,956	13,716	4,572	18,288
C. Other Direct Costs (Utilities, printing, rent, maintenance, etc.)	1,554	518	2,072	14,406	4,802	19,208	15,960	5,320	21,280
SUB-TOTAL IV	20,011	6,669	26,680	51,746	17,250	68,996	71,757	23,919	95,676
TOTAL HEADQUARTERS	26,675	8,892	35,567	63,325	21,108	84,433	90,000	30,000	120,000

9/28/92
11:50

FIELD

COST ELEMENTS	Actual Expenditures To Date (08/01/91 to 08/31/92) AID	PVO	TOTAL	Projected Expenditures Against Remaining Obligated Funds (09/01/92 to 08/31/94) AID	PVO	TOTAL	Total Agreement Budget (Columns 1 & 2) (08/01/91 to 08/31/94) AID	PVO	TOTAL
I. PROCUREMENT									
A. Supplies	0	4,657	4,657	4,947	28,708	33,655	4,947	33,365	38,312
B. Equipment	0	44,207	44,207	0	12,524	12,524	0	56,731	56,731
C. Services/Consultants									
1. Local	1,305	0	1,305	2,695	1,000	3,695	4,000	1,000	5,000
2. Expatriate	0	0	0	1,060	7,060	8,120	1,060	7,060	8,120
SUB-TOTAL I	1,305	48,864	50,169	8,702	49,292	57,994	10,007	98,156	108,163
II. EVALUATION/SUB-TOTAL II	0	0	0	34,056	0	34,056	34,056	0	34,056
III. INDIRECT COSTS									
Overhead/Field (55%)	38,642	312	38,954	81,709	19,875	101,584	120,351	20,187	140,538
SUB-TOTAL III	38,642	312	38,954	81,709	19,875	101,584	120,351	20,187	140,538
IV. OTHER PROGRAM COSTS									
A. Personnel (List each position & total person months separately)									
1. Technical	15,473	109	15,582	23,301	7,101	30,402	38,774	7,210	45,984
2. Administrative	49,231	347	49,578	76,215	17,769	93,984	125,446	18,116	143,562
3. Support	5,626	40	5,666	8,166	2,152	10,318	13,792	2,192	15,984
B. Travel/Per Diems									
1. In-country	13,987	99	14,086	39,175	5,403	44,578	53,162	5,502	58,664
2. International	0	0	0	57,548	10,446	67,994	57,548	10,446	67,994
C. Other Direct Costs (Utilities, printing, rent, maintenance, etc.)	25,590	180	25,770	31,274	8,011	39,285	56,864	8,191	65,055
SUB-TOTAL IV	109,907	775	110,682	235,679	50,882	286,561	345,586	51,657	397,243
TOTAL FIELD	149,854	49,951	199,805	360,146	120,049	480,195	510,000	170,000	680,000

9/28/92
11:56

TOTAL - FIELD & HEADQUARTERS

	Actual Expenditures To Date (08/01/91 to 08/31/92)			Projected Expenditures Against Remaining Obligated Funds (09/01/92 to 08/31/94)			Total Agreement Budget (Columns 1 & 2) (08/01/91 to 08/31/94)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
TOTAL HEADQUARTERS	26,675	8,892	35,567	63,325	21,108	84,433	90,000	30,000	120,000
TOTAL FIELD	149,854	49,951	199,805	360,146	120,049	480,195	510,000	170,000	680,000
TOTAL	176,529	58,843	235,372	423,471	141,157	564,628	600,000	200,000	800,000

9/28/92
11:58

APPENDIX E

1992/93 BUDGET

RUN DATE 10/01/92
FOR THE FYE JUNE 30, 1993
Malawi Cooperative Child Survival 18311
0575310000

	U.S. CURRENCY	LOCAL CURRENCY	GIK	TOTAL
SALARIES AND WAGES	66,104	19,380		85,484
EMPLOYEE BENEFITS	28,391	3,876		32,267
PAYROLL TAXES	1,728			1,728
SUPPLIES	8,422	4,620		13,042
OCCUPANCY	1,000	3,420		4,420
COMPUTER SERVICES				
PROFESSIONAL FEES/SERVICES	200	4,500		4,700
HOSPITAL CONSTRUCTION				
POSTAGE AND SHIPPING	3,200	1,620		4,820
AWARDS AND HONORANIUMS				
BOOKS AND PUBLICATIONS				
PRINTING AND ARTWORK				
TRANSPORTATION	10,766	31,032		41,798
TELEPHONE AND TELEX	4,200	3,750		7,950
MISCELLANEOUS				
TOTAL DIRECT EXPENSES	124,011	72,198		196,209
DIRECT EXPENSES	124,011	72,198		196,209
INDIRECT CHARGES (RATE = 55%)	52,923	12,791		65,713
	176,934	84,989		261,922

RUN DATE 10/01/92
FOR THE FYE JUNE 30, 1993
Malawi Cooperative Child Survival 28111 (EVALUATION)
0575310000

	U.S. CURRENCY	LOCAL CURRENCY	GIK	TOTAL
SALARIES AND WAGES				
EMPLOYEE BENEFITS				
PAYROLL TAXES				
SUPPLIES				
OCCUPANCY				
COMPUTER SERVICES				
PROFESSIONAL FEES/SERVICES	5,880	2,100		7,980
HOSPITAL CONSTRUCTION				
POSTAGE AND SHIPPING				
AWARDS AND HONORANIUMS				
BOOKS AND PUBLICATIONS				
PRINTING AND ARTWORK				
TRANSPORTATION	10,003	1,360		11,363
TELEPHONE AND TELEX				
MISCELLANEOUS				
TOTAL DIRECT EXPENSES	15,883	3,460		19,343
DIRECT EXPENSES	15,883	3,460		19,343
INDIRECT CHARGES (RATE = 55%)				
TOTAL	15,883	3,460		19,343

APPENDIX F

RESPONSE TO TECHNICAL REVIEW OF DIP

TECHNICAL REVIEW OF CS VII DIP: HOPE/Malawi (E)

Overall Impression: Good DIP, but a few areas need more work. It is suggested that field staff clarify the "who, what, when and how" of project implementation, and/or set more measurable objectives.

STRENGTHS

The DIP clearly outlines the strategies HOPE intends to follow to achieve the stated objectives, the personnel required to implement the activities, and the data that the project needs to measure progress over time.

Hope's plan is to maintain the existing high level of immunization coverage by a mixed strategy of fixed and outreach sites and HSAs trained to administer vaccines.

It is a strength that HOPE has initiated active surveillance for measles.

The project is promoting a TT5 schedule.

HOPE has added vitamin A capsule distribution in response to the current drought and will collaborate with IEF in vitamin A activities.

The project plans to raise awareness of parents and HSAs to the signs and symptoms of acute lower respiratory infection. The project will support the estate clinics and upgrade the ability of clinic staff to provide proper treatment for respiratory infections.

The project plans to have a rigorous in-service training program.

Collaboration among project staff, the MOH, and the estates on the baseline survey; training; and data collection activities fosters closer cooperation between the public and private sectors.

CONCERNS AND RECOMMENDATIONS

The baseline survey was conducted during the pilot study phase of the project on eight estates of one of the fourteen companies. It is not clear from the information in the DIP that the data obtained from the baseline survey can be projected to the population living on the estates of other companies. The health services of the various companies seem to vary considerably.

HOPE has not identified priority behaviors for change through its information, education and communication efforts. Reviewers

believe that the project has too many messages, and needs to better focus its messages.

Immunization

Objectives for immunization should not be number of children or women immunized, rather it should be a percent of the target population. (For example: "percent of children 12-23 months who have received their DPT3" or "percent of births that are fully covered by tetanus toxoid".) Revise the immunization objectives.

Management of Diarrheal Diseases

The CDD component targets educational sessions for 40% of mothers in first year and 60% in second. The target, however, is 70-80% for using ORT in the first and second year of the project. How will this target be achieved if fewer women are to be educated than will use ORT? HOPE will have to reach more mothers with education.

Pneumonia Control

Is chloramphenicol justified in this setting? Ampicillin should be considered first, then perhaps erythromycin.

AIDS/HIV

The target population listed for the HIV/AIDS component varies. The DIP states in Table A that 163,963 persons, of all age groups, will benefit from AIDS interventions. Yet, the two objectives for the program address a smaller number. The DIP text states that HIV/AIDS education messages are targeted to men and women of fertile age. Please clarify these inconsistencies.

According to the baseline survey, condom use is very low (7%) making the target of 20% condom use questionable. Condom use is a method over which many women in African societies have little or no control. HOPE should expand their strategies and help women gain greater control over their own reproductive health.

Maternal Care

It is clearly stated in the DIP that high risk pregnancy is not included in the child survival project at this time. Nevertheless, reviewers feel strongly that HOPE should include the identification of high risk pregnancies and timely referral to an appropriate health facility as an integral component of the project. The timing seems right. The DIP states that a Safe Motherhood project has provided equipment to the district hospital in Thyolo, an area with a maternal mortality rate of

474/100,000. HOPE has already trained 30 HSAs to promote child spacing, and the plan is to have the HSAs address the nutritional needs of pregnant and lactating women. Furthermore, six nurses from estate clinics will participate in a three month long child spacing course. Thus, it seems appropriate for HOPE to develop some formal link between child survival and maternal health.

The malaria component should promote and provide prophylaxis for pregnant women.

Contraceptive use is very low, although the baseline survey indicates women are interested in spacing births. Is there any way to improve contraceptive supply and distribution?

Budget and Sustainability

What is the $120,000 described as "minor computation differences"? This does not seem minor. Clarify.

Will estate managers continue to support child survival activities and personnel after funding ends? HOPE should involve managers more; inform them of problems and progress; and develop a system to continue. Reviewers suggest starting a competition among estates for best performance in an intervention (percent of immunization coverage, percent of ORT use, etc.).

Too many tasks have been given to the Child Survival Coordinator. HOPE should rethink this position and the phase-over of responsibilities to the Malawian who will run the effort in the third year.

The DIP does not describe the phase-over to estate management in any detail. Present a detailed plan of phase-over in the next project document.

RESPONSE TO THE TECHNICAL REVIEW OF THE DIP

1. Baseline - The baseline was conducted on eight estates, which are representative of the rest of the estates. In reality, the health services do not vary from estate to estate. They all have clinics run by medical assistants, and the larger estates have outreach dispensaries similar to the ones on the individual estates of the Central Africa Company, Ltd.

2. Project staff disagree with the reviewers that there are too many messages. There are seven areas of concentration; AIDS, Child Spacing; DDS/ORT, Malaria, ARI, Nutrition, and EPI. The messages are focused on major aspects of each area of concentration using the Facts for Life booklet and MOH materials.

3. Immunizations - The project objectives will be revised to reflect the comment of the reviewers.

4. Diarrheal Disease - The objective will be adjusted to reflect the comments of the reviewers.

5. Pneumonia Control - The project follows MOH treatment protocols.

6. AIDS/HIV:

Point 1 - The messages are focused on those individuals who are sexually active, but the total population will benefit if the sexually active individuals do not contract HIV. This includes children and older family members who would have to deal with orphans and other issues related to deaths in the family.

Point 2 - This refers to AIDS and not birth control. Project staff are distributing condoms on the estates in very large numbers, where they were not available at all before. The men appear to use the condoms. This activity is directed at decreasing HIV transmission and may or may not have an impact on child spacing.

7. Maternal Care - Including an expanded maternal care component would require additional program funds. Unless additional funds become available only child spacing activities will be implemented. Because of its experience with Safe Motherhood activities and the extensive local need, the project would welcome including additional maternal care activities.

8. Malaria - Prophylaxis for pregnant women in Malawi is under study, and the available method, Chloroquine, has been found ineffective. Project staff will make further investigations to address this issue.

9. Project HOPE now has permission to distribute oral contraceptives through community-based distribution. Mrs. Liwonde starts the TOT course in October and training of volunteers in January, 1993.

10. $120,000 minor computation difference. This refers to the budget overall and was misinterpreted by the technical reviewers (see attached budget).

11. The CS Project Coordinator is constantly in touch with the managers about the progress of the project. They receive written quarterly reports and information through these personal contacts. The competition idea is interesting and will be discussed with the staff. The project is already considering identifying the "HSA of the Month" based on good performance.

12. The deputy coordinator will learn to assume the roles of the CS Project Coordinator to be able to take over in the final year.

13. Phase-over is a concern. More time is needed than the remaining two years to do it. The CS Project Coordinator spoke with the AEA chairman about it, and he said they would be interested in hiring a coordinator (local) to oversee the projects in each district (if Project HOPE expands its activities), but the present financial crunch, due to the drought, would not make it possible in the next year or so.