FINAL EVALUATION – STAFH PROJECT

MIDTERM EVALUATION – CHAPS PROJECT

INTERNATIONAL EYE FOUNDATION
CHIKWAWA DISTRICT, MALAWI

Sept 12 – 30, 1999

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APPENDICES

LIST OF ABBREVIATIONS

ARI	Acute Respiratory Illness
CBD	Community Based Distribution (of contraceptives)
CPR	Contraceptive Prevalence Rate
DEHO	District Environmental Health Officer
DHMT	District Health Management Team
DHO	District health officer
DRF	Drug Revolving Fund
FP	Family Planning
HBC	Home-Based Care
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
HSA	Health Surveillance Assistant
IEC	Information, Education and Communication
IEF	International Eye Foundation
IMCI	Integrated Management of Childhood Illness
IPCC	Interpersonal Counseling and Communication
MCH	Maternal Child Health
MOH	Ministry of Health
NRH	Ngabu Rural Hospital
ORS	Oral Rehydration Solution
PAC	Project Advisory Committee
PEA	Primary Education Advisor
QA	Quality Assurance (and Problem Solving process)
STAFH	Support to AIDS and Family Health Project
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
TH	Traditional Healer
VHC	Village Health Committee

I EXECUTIVE SUMMARY

The evaluation covered two projects providing the final assessment for the STAFH (Integrated AIDS and Family Planning) project and the midterm assessment for the CHAPS (Community Health Partnerships) project The STAFH project ran from 2/96 - 9/99, while the CHAPS project is scheduled to run from 4/98 - 6/01 The evaluation took place from September 13 – 30, 1999, with a team that included IEF staff from both projects the Maternal Child Health (MCH) and Family Planning (FP) Coordinators from the Ministry of Health (MOH) and an external evaluator

The STAFH project was largely a mobilization, behavior change project balanced by an effort to assure the availability of services once demand was mobilized It had a relatively narrow technical focus on HIV/AIDS prevention and family planning The project covered a broad sweep of the District, including a variety of target groups and a variety of partners for reaching these groups

By contrast, CHAPS works exclusively through the MOH with a focus on capacity building and assuring service availability at the community level The range of potential interventions is as wide as the activities of the MOH itself, but the strengthening of management and support systems for these interventions provides the framework for these activities The project design outlines objectives for both the capacity building and the actual service delivery interventions

STAFH was a competently implemented project that made good progress towards all of its objectives Highlights of these achievements include

- Increased contraceptive prevalence rate (CPR) in the District as a whole and in villages with community based distribution (CBD) of contraceptives in particular
- Increased competency of clinical staff in the appropriate treatment of sexually transmitted diseases (STDs) and in the supervision of CBDs
- Increased access to FP methods – both in the community, and with respect to reliable supplies at the health centers
- Increased depth and breadth of knowledge about AIDS and FP

Points where the project fell short are due more to the gaps in the design of the project particularly regarding unclear definition of objectives and lack of support systems for activities rather than to the implementation of project activities themselves

Significant accomplishments with respect to specific STAFH activities include

- CBDs trained and active in community distribution of pills and condoms
- Providers trained and retrained in STD syndromic management
- Health Surveillance Assistants (HSAs) trained in HIV/AIDS and FP, including supervision of CBDs
- Traditional healers trained in HIV/AIDS prevention and modern FP
- Partnerships supporting peer educators in Sucoma and home-based care (HBC) volunteers and counseling at Montfort Hospital
- Pilot efforts in training traditional initiation counselors (nankungwis) and educating politicians on HIV/AIDS prevention

The fourth year no-cost extension under STAFH allowed for a seamless transition of STAFH activities into CHAPS More importantly however, it allowed for the STAFH design to transition to the system strengthening model in partnership with the Ministry of Health (MOH) of CHAPS The key activities for increasing FP use and access as well as those for improved clinical capacity are now firmly established under CHAPS

For the midterm evaluation of CHAPS, the early phases of implementation for such field activities as drug revolving funds(DRFs), CBDs communal gardens and work with village health committees (VHCs) were assessed, in addition to assessing the quality assurance/problem solving process (QA) for improving services at the health center level While specific recommendations for each intervention area are elaborated in the body of the report the more generalized conclusions about the CHAPS process are probably more significant

- The first year of the project was frustrating for everybody - the District Health Management Team (DHMT) was not functioning and IEF staff had no authority in the District Without MOH leadership in the District, it was extremely difficult for the project to move forward
- This project demonstrates a strong sense of ownership on the part of MOH and the DHMT really 'gets it" that CHAPS is a participatory team process
- The project has focused significantly on DHMT and community level inputs, but has not addressed the problem of DHMT attrition and turnover
- Most all community level activities are well under way with concurrent efforts to address supervision and supply systems
- Given the decentralization process occurring in Malawi the CHAPS design (PVO/MOH partnership, mixed community and system level interventions and mixed process and material inputs) works well and is very appropriate
- The CHAPS objectives are appropriate for a project such as this but the three year time frame is too short for a project with this scope and effecting this level of change

As part of the systems approach taken by CHAPS, the evaluation team recommended significant strengthening and expansion of the quality assurance/problem solving approach recently initiated in the District This has the potential to provide strengthening and capacity building at the health center and community levels as a balance to the efforts underway at the DHMT level It can also assure continuity in the face of turnover at more senior levels

While this process was originally conceived as an approach to improve health center leadership and accountability for quality services the team also saw it as a potential tool that could be adapted for community mobilization and organization Specific recommendations include

- Explore ways to extend the team problem solving approach to supervision of HSAs and to the HSA supervising the community
- Strengthen the supervision and support role between the secondary supervisors at the health centers, the HSAs, and the community volunteers
- All health centers and Ngabu Rural Hospital need to put a management structure (health center management team) in place to oversee day to day operations and resource allocation

The biggest constraint faced by CHAPS is the extreme shortage and turnover of human resources in the District particularly in leadership positions While the project can work to offset this disadvantage through strengthening management systems and policies as well as through strengthening the management functions of the District Coordinators and health center level staff, it can't function in a vacuum The larger human resource needs also need to be taken into consideration at the national level when assigning personnel

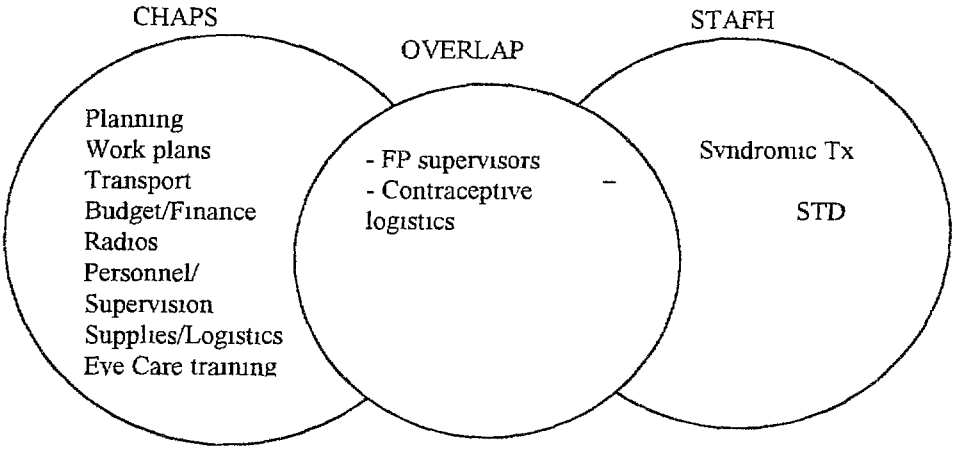
II OVERVIEW OF PROJECT DESIGN - STAFH AND CHAPS

These two projects had very different designs and emphases The STAFH project focused strictly on HIV/AIDS prevention and family planning, with most of its activities and objectives centering on community mobilization and behavior change It began in Feb 1996 and was granted a fourth year no cost extension The CHAPS project is balanced between an orientation towards District level capacity building focusing on management systems and resource provision and assuring delivery of health services and improved health at the health center and community levels This project began in April 1998 and is funded through June 2001

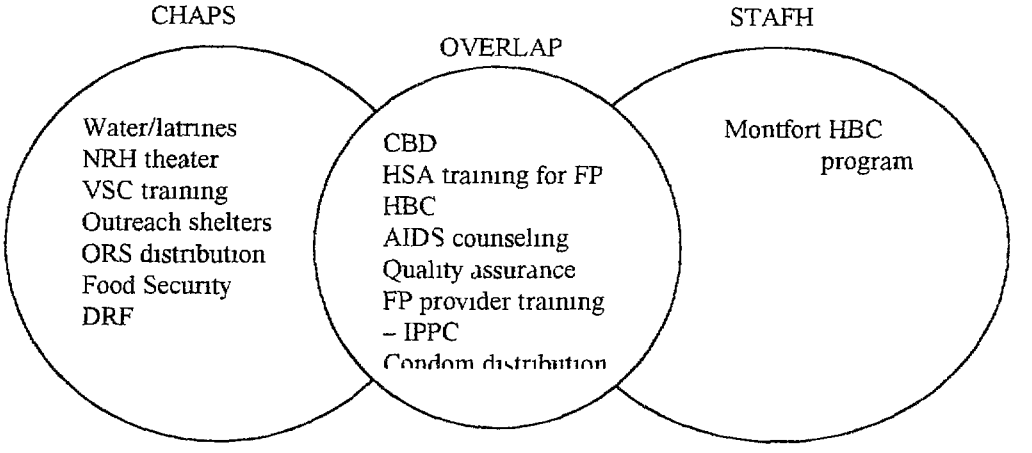
The following schematic represents the relative emphases of each project as well as the points of overlap with respect to capacity building service delivery and community mobilization/demand creation

SCHEMATIC REPRESENTATION OF RELATIONSHIP BETWEEN STAFH AND CHAPS PROJECTS

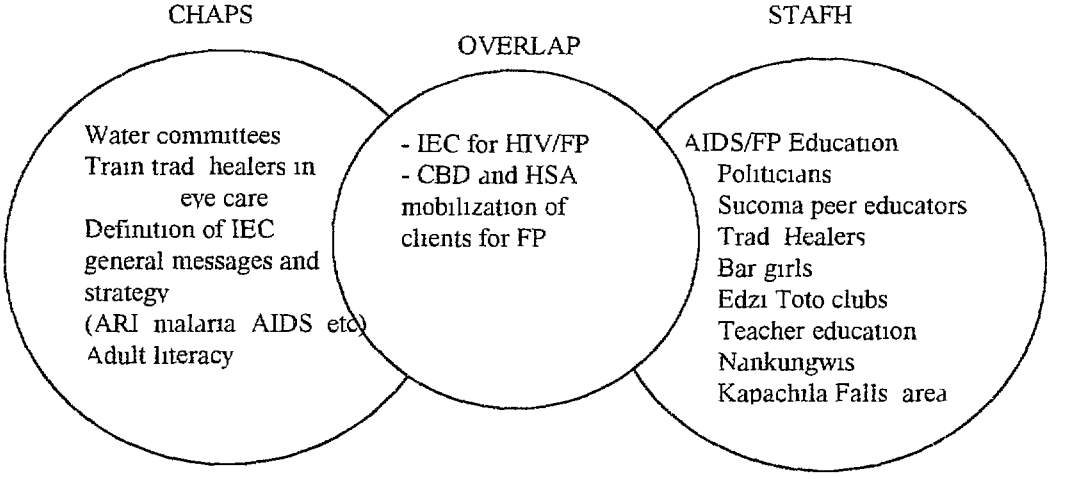
CAPACITY BUILDING



SERVICE DELIVERY/ACCESS



DEMAND CREATION/COMMUNITY MOBILIZATION



Many of the STAFH activities fell into the areas of community mobilization The original RFA for the project emphasized a broad sweep of IEC and service strengthening activities but with the very specific focus of HIV/AIDS prevention and family planning A variety of partners was encouraged rather than working primarily with the MOH As a result, STAFH included activities targeting schools special groups such as bar girls, peer educators and employees of Sucoma contract laborers and surrounding villages for the Kapachila Falls project traditional healers and nankungwis for village education and home based care volunteers (HBC) working with Montfort Hospital STAFH staff trained and followed up all these groups in HIV/AIDS prevention as well as family planning

While CHAPS has a few activities with community mobilization, they fall under the general IEC strategies being developed by the MOH They cover the full range of primary care activities supporting the service delivery activities for which MOH is responsible CHAPS is not picking up the special target groups that were covered under STAFH

With respect to increasing access to reproductive health services, the STAFH project trained and supported community based distributors (CBDs) for family planning HSA capability to supervise CBDs as well as to distribute FP methods themselves were also covered Condom distribution was emphasized through every possible outlet These included supporting the sale of Chishango condoms through Sucoma and local groceries and bars as well as assuring the free distribution of MOH condoms through MOH distribution systems By design CHAPS is picking up most of these activities through its support of MOH service delivery

STAFH began addressing quality assurance in a small way through the training of FP providers in interpersonal communication and counseling (IPCC) as well as supervision and support for appropriate STD treatment However this is being much more comprehensively addressed through the CHAPS project as an intervention at several levels It becomes part of the capacity building approach that will lead to improved sustainability for the training and interventions introduced

In addition to the reproductive health service delivery, CHAPS is also supporting service delivery activities for a variety of other child survival activities These include

- drug revolving funds (DRF) for improved village access to malaria and pneumonia treatment (among others)
- renovation of the Ngabu Rural Hospital operating theater to improve access for surgical contraception and Caesarian sections
- construction of outreach shelters to provide a private place for FP counseling,
- facilitation of village based ORS distribution
- and implementation of a food security component through seed distribution and establishment of communal gardens

Like with other CHAPS activities, these interventions are implemented by MOH staff but resources training, and systems support are provided by the project In the project design documents, these are referred to as the "Part B" interventions

The STAFH project focused less on long term capacity building since it was primarily designed as a community mobilization project and the partnership with the MOH was less emphasized This area is, however strongly emphasized in the CHAPS project While there are a significant number of activities occurring to assure delivery of services in the periphery, the capacity building activities provide the framework which holds the project together These include developing management structures establishing systems such as supervision, communication and logistics/transport for supporting day to day operations, maintaining information, and planning/review activities

It is these activities combined with some significant and jointly prioritized material inputs that complement the health center and community level activities They give the project a balance that is appropriate for supporting day to day operations as well as for increasing the sense of ownership on the part of MOH This will ultimately improve the chance for sustaining these activities after the end of the project In the project design documents, these are referred to as the "Part A" interventions

The fourth year extension for the STAFH project allowed staff to continue to expand the coverage for the key interventions However more importantly, it also allowed the project to begin to function in the capacity building mode undertaken by CHAPS As such, the line between the two projects became a moving target as IEF s implementation of STAFH activities began to roll over into activities supporting MOH's implementation role

III EVALUATION METHODOLOGY

The evaluation process was a participatory one, complemented by results from several surveys and a review of reports and activity data It was the final evaluation for the STAFH project and the midterm evaluation for the CHAPS project The integration of these two evaluations was justified for several reasons

- Both projects had a strong reproductive health focus and it was hoped that a single evaluation would reinforce the integrated and overlapping components of the two projects
- At the community level the activities are not distinguished between projects
- With the fourth year no-cost extension for STAFH many of the STAFH activities were already transitioning into CHAPS such that even at the management level there was already a significant level of integration

As the final evaluation for the STAFH project this evaluation focused on accomplishments relative to objectives and planned activities as well as lessons learned Because the CHAPS project is still ongoing in the District it also addressed recommendations regarding the continuation or otherwise handing over of specific activities implemented under this project

As the midterm evaluation for the CHAPS project, this evaluaion focused on assessing progress to date and making recommendations Due to its dual nature, the main emphasis for CHAPS was on the field (PartB)activities CBD, DRF home based care (HBC) gardens, and village health committees (VHCs) These were assessed in detail and activity specific recommendations were made The adult literacy and primary eye care activities were still too recently initiated to assess progress and the water activities with the sub-contract to Concern Universal, required more assessment than was feasible during the time allowed

With respect to the capacity building activities at the District level (Part A) people were interviewed and a general sense of progress and satisfaction was assessed However the specific details of each intervention (e g the accounting system or transport log) were not reviewed

The core evaluation team was made up of two representatives from the MOH (the FP and MCH Coordinators) the two project managers the IEF Country Director and the external evaluator They were assisted with both the field work and the discussion/drawing of conclusions by several project coordinators from both projects The process involved

1 Meeting as a team to define priority issues determine evaluation schedule and list of interviewees, and develop question guides

2 Field visits to meet with
- teachers and students in three schools,
- HSAs CBDs, DRF volunteers, farmers traditional healers, and village health committees in ten villages,
- health center staff in two health centers and Ngabu Rural Hospital, and
- management and program staff at Montfort Hospital and Sucoma Sugar Plantation
- The external evaluator also met with the District health management Team (DHMT) and the CHAPS Systems Advisor

3 Meeting as an expanded team to analyze findings and develop recommendations

4 Presentation of results to the District USAID and the CHAPS quarterly meeting

The list of team members of priority issues identified by the team the question guides and the evaluation schedule with a list of people contacted as well as and a map of sites visited are included in the appendix

The participatory evaluation process was supplemented by a significant amount of data from a variety of surveys

1 CS Mid-term evaluation KAPC survey July 1996 (→ baseline data STAFH)
2 STAFH school baseline KAPB survey September 1996 (→ baseline data STAFH)
3 STAFH CBD villages baseline KAPB survey October 1997 (→ baseline data STAFH)
4 CHAPS baseline KAPC survey for men October 1998 (→ EOP data STAFH baseline data CHAPS)
5 CHAPS baseline KAPC survey for women October 1998 (→ EOP data STAFH baseline CHAPS)
6 STAFH school final KAPB survey September 1999 (→ EOP data STAFH)
7 STAFH CBD villages final KAPB survey (incl Non-CBD villages), August 1999 (→ EOP data STAFH)

Lastly, quarterly reports and a variety of special assessments carried out by the project also provided significant information on the activities which were completed and a sense of intervention specific issues or concerns which were taken into account during project planning and implementation

IV SUMMARY OF RESULTS – STAFH PROJECT

The STAFH project was well executed completed nearly all the activities suggested in the proposal, and achieved or made significant progress towards the achievement of all of its objectives While tables for each project objective with the specific numerical results from the various surveys are included in the appendix, the conclusions by objective are summarized here

1 Increase the contraceptive prevalence rate by 50% by EOP

There was a definite increase in contraceptive prevalence throughout the District with a more significant increase in villages with CBDs The District wide increase was by 24% while the increase in CBD villages was by 70%

2 40 villages have at least one CBD for FP methods

A total of 66 villages had CBDs at the end of the project with 88 active CBDs

3 In villages with CBDs, increase to 50% the level of men/women, 15-49 years, who have received information from a CBD

This specific objective was not measured during the survey However qualitative information collected during the evaluation indicates that CBDs do talk with their friends about family planning and they are seen by both men and women as a resource in the village for family planning information In CBD villages 25% of all contraceptive users, and 65% of all pill or condoms users cited the CBD as their source of contraceptive supplies This would indicate that the CBDs do significantly increase access in villages where they work The difference between the two numbers is due to a generalized preference for injectable contraceptives which are not available at the village level

4 75% of all clinical staff have adequate knowledge about AIDS, FP and STDs

While it is difficult to assess what 'adequate means, the average score on post training tests was 87% These tests covered all three information areas

5 75% of the health centers that have adequate drug supplies correctly manage STD cases

Assuming the correct diagnosis, 413/469 or 88% of identified STD cases were correctly treated This was drawn from a review of STD registers for the past 2-3 months in seven health centers It does not assess whether the diagnosis was correct, since this would have required direct observation of provider/patient interactions, but does review the drugs prescribed and dosage levels for each diagnosis

6 Increase to 50% the proportion of men/women, 15-49 who know 1/ modes of transmission of HIV, 2/ methods of HIV/AIDS prevention 3/ correct condom use, and 4/ four or more methods of family planning

There are several reasons why this is a difficult indicator to assess The baseline for the first two points was already well above the 50% mark indicated in the objective There is no very good way to measure correct condom use and so it was not measured Lastly, the ability to list four family planning methods really tells very little about a person s understanding of family planning, nor is it an indicator of whether they have the essential information for using family planning

That said the surveys indicate that people were more educated about HIV/AIDS at the end of the project There are fewer misconceptions as measured in CBD villages with a 5 7 fold decrease in women and a 3 3 fold decrease in men who had at least one misconception about how one contracts AIDS Although incrementally small because of the high baseline rates, there were also increases particularly among women, in knowledge of transmission

With respect to family planning, the general conclusion is that most people do know about family planning and are familiar with at least two methods A significant number also know a third method representing an increase of more than double from baseline in CBD villages While not reaching 50% for knowing four methods there was an increase of 150% from baseline in the ability to name four methods - also as measured in the CBD villages The increases in knowing three and four methods might indicate that people have now have a wider knowledge of family planning than previously District wide while not assessed at baseline 63% of people knew 2 methods but only 10% knew four The difference between CBD villages and the District as a whole also corroborates the hypothesis that CBDs have a positive impact on people s family planning knowledge

7 **80% of adolescents participating in anti-AIDS clubs know 1/ modes of transmission of HIV, 2/ methods of HIV/AIDS prevention, 3/ correct condom use, and 4/ four or more methods of family planning**

With the same constraints for this objective as the previous one, it is clear that, even at baseline the knowledge level of students in school was nearly 100% Again there were very few misconceptions about AIDS transmission and when stratified by those participating in Anti-AIDS clubs, there seemed to be no difference

With respect to family planning knowledge levels were also high with 98% of all students knowing at least one method of family planning and 60% knowing three It then dropped to only 24% who knew four methods Participation in the Anti-AIDS club did seem to make a positive difference for those who knew more than two different methods of family planning

8 **Increase to 50% the number of prostitutes employed at commercial center who report use of condoms during last sexual act**

This was not measured quantitatively However when this issue was raised during focus groups with bar girls many indicated they could still be convinced not to use a condom when offered a high price They all knew they should be using condoms but the economic pressure of the present tended to override their concern about the future

9 **Increase by 25% the proportion of men/women, 15-49 years, reporting use of condoms during their last sexual act**

District wide 8% of women and 16% of men reported ever having used a condom to avoid getting or transmitting AIDS Also District wide 36% of men who reported having casual sex during the last 12 months reported using a condom during their last sexual act with a non-regular partner In the CBD villages, of those who reported ever having used a condom, 31% of women and 61% of men reported using a condom with their regular partner, and 60% of women and 84% of men reported using a condom with their last non-regular partner Although numbers are small it seems these are quite significant increases over baseline However staff feel there was probably a significant amount of over reporting of condom use

At least the project can conclude that people know what they're supposed to do even if it leads to over reporting of the actual behavior

10 Increase by 50% condom distribution to men/women, 15-49 years

Overall condom distribution in the District (all sources) nearly doubled between 1996 and 1998 However there seems to have been a drop in distribution in 1999 Reasons for this need to be explored further

SPECIFIC PROJECT ACTIVITIES

Again while there is a table in the appendix outlining all the project activities related to the initial targets highlights of the specific activities accomplished under the STAFH project include

- Trained 73 CBDs to make a total of 93 CBDs – 88 of whom who are active in the District 32 HSAs were trained in CBD supervision and support, and 18 health center staff were trained as secondary supervisors (reached 78% of target – then shifted to working on the supervisory support structures)
- Trained 45 clinic staff, representing a minimum of two staff from each health center in the expanded two week training for syndromic management of STDs (100% of target)
- Trained 80 HSAs in FP promotion and HIV/AIDS education (60% of target) 30 HSAs were also trained as core FP providers
- Established 132 active anti-AIDS clubs out of a total of 157 schools 264 patrons and headmasters were trained in the necessary information to support these clubs and 12 Primary Education Advisors (PEAs) were trained to supervise them A sub-group of 150 patrons in 75 schools were also trained in basic FP information which was then introduced into the anti-AIDS club activities (85% of target but it must be noted that the number of schools in the disctrict has been increasing steadily, i e reaching 100% was a moving target in 1996 there were a total of 97 schools in the district)
- Renovated Montfort counseling center and provided salary support for counselor/supervisor for the duration of the project Responsibility for both has now been assumed by Montfort Hospital
- 32 home-based care volunteers were trained and refreshed to assist with terminal patients at home as part of a Montfort Hospital program (40% of target due to needing to follow Montfort s lead)
- 514 peer educators and a sub-group of 40 peer educator supervisors were trained in basic HIV prevention and family planning for Sucoma Sugar Company (no specific target)
- Trained 210 bar girls as peer educators (no specific target)
- Trained approximately 600 traditional healers in AIDS prevention and family planning (no specific target)
- Additional activities included targeting politicians for HIV prevention training care counseling training for IEF Montfort and Sucoma staff man to man training for 18 HSAs and printing of FP record cards and hormonal check lists to assist the MOH activities

Although several of these activities appear to fall short of their targets this is largely due to the overly ambitious setting of targets for the extension year of the project During the last year the project was already shifting its focus towards the more comprehensive CHAPS approach with higher MOH ownership This meant less training was done than was projected

V SUMMARY OF PROGRESS / GENERAL CONCLUSIONS – CHAPS PROJECT

As indicated under the section on methodology, this evaluation focused more on the specifics of the community level interventions and on the general process and lessons learned for the capacity building/partnership aspect of the project There are several general conclusions to be drawn about the progress of the CHAPS project before going into the details of the specific interventions

- **Even in a district that has had a large number of problems with turnover, unfilled positions and management, CHAPS - as a process for building capacity balanced with assuring access to services and information at the community level - seems to be working There is currently an overwhelming sense of satisfaction with the project and its progress on everybody's part** (Note Capacity building doesn t mean just training, but also building systems and developing and implementing policies)

- **The first year of the project was frustrating for everybody - the DHMT was not functioning and IEF staff had no authority in the District**

Because the PVO is not the implementing agency it depends on a certain level of function on the part of the MOH if activities are to be implemented and money is to be effectively spent The presence of the PVO helps assure money is spent appropriately in a District where other controls may not be in place but if there is no functional partner then not much can happen

In the case of Chikwawa, the IEF team spent the first year working mostly with program coordinators on community level interventions Once MOH placed an effective leader in the District the groundwork laid by the project allowed the project to move forward quickly on many levels

- **This project demonstrates a much stronger sense of ownership on the part of MOH than many PVO projects where the PVO is the primary implementer**

In the case of CHAPS the MOH is the primary implementer, and many MOH staff at different levels indicated they saw this as *'their project* Their involvement from the beginning in developing work plans reviewing progress and budget development and review contributes The transparency of the budget process seems to be particularly significant

- **The DHMT really "gets it" that CHAPS is a participatory team process**

When asked what advice they would give to new CHAPS districts, members of the DHMT responded

- ' CHAPS depends on a participatory approach at all levels It does not implement new activities but reinforces existing services
- ' CHAPS encourages a team management approach and they need to support that
- They should focus more on areas they are failing to address – on the needy, neglected areas – since CHAPS can help them do a better job '
- They should pick up on the objectives right from the beginning and learn quickly what CHAPS is all about in order not to lose time like we did'

- **The project has focused significantly on DHMT and community level inputs, but has not addressed the problem of DHMT attrition and turnover**

During the evaluation, this observation led to recommendations for further strengthening of middle management levels In addition, although not directly related, it was recognized that a FH Coordinator would normally be on the DHMT The lack of a FH Coordinator in the District has meant the activities that would fall under this person (FP, MCH etc) depend on the District Environmental Health Officer to represent them on the DHMT It was also recommended that interim representation by one of the program coordinators (MCH or FP) be considered pending appointment of a FH Coordinator

Related to this issue is the key role the central MOH plays in supporting or not supporting these projects through the assignment of personnel While the author recognizes the severe human resource constraints the MOH is facing transferring away staff who have been trained and are involved with implementing the CHAPS project, or delaying the filling key leadership vacancies in the district such as the DHO or District Administrator, severely hampers the project's ability to function

- **Most all community level activities are under way with concurrent efforts to address supervision and supply systems** (see following list of achievements)

While there has been some concern that CHAPS is trying to cover too many interventions, it is important to remember that with MOH as the primary implementer CHAPS is only supporting the activities the MOH or other ministries are already doing There are not new interventions in CHAPS but rather technical and system support for interventions that are already on the ground

- **Given the decentralization process occurring in Malawi, the CHAPS design (PVO/MOH partnership, mixed community and system level interventions, and mixed process and material inputs) works well and is very appropriate**

Specifically the level of partnership implied in a project such as this means that sustainability with respect to MOH absorption and ownership of the activities is not an issue although reduced resource levels will need to be planned for during the second phase of the project Secondly, the mixed community and system level interventions provide the glue ' that holds a variety of community level interventions in place Without intervention to assure the systems are in place for continued logistic and supervisory support of community interventions, training occurs in a vacuum and activities fall short Lastly the significant level of material inputs has provided credibility to the project and significantly improved the acceptability of the partnership in the eyes of MOH staff

- **The CHAPS objectives are appropriate for a project such as this but the three year time frame is too short for a project with this scope and effecting this level of change**

In spite of the significant delays and frustrations early in the project the CHAPS project is essentially on track in the implementation of their objectives and planned activities However it is behind schedule This is partly due to the delays in getting started but it is also due to overly ambitious objectives given the depth and breadth of change expected – both in behaviors at the household level and in service delivery systems Particularly the behavior change objectives are delayed because the community mobilization systems (IEC HSAs, VHCs, supervision etc) have to be put in place before the intervention can take place and behavior change can occur

While a detailed report of progress against objectives is included in the appendix, specific CHAPS project achievements include

Part A – Capacity Building

- District office space renovated to accommodate IEF CHAPS staff on the hospital grounds as well as to accommodate the hospital accounts office and to provide the hospital with an airconditioned computer room
- Fleet management system implemented transport committee established, 12 vehicles repaired policies for use of cars and motorcycles in place, 15 motorcycles and large truck procured, and motorcycle riders trained The need for procuring and maintaining HSA bicycles is still to be addressed and a transport officer needs to be recruited
- An accounting computer has been purchased and use of the Quicken accounting package has been temporarily implemented A scope of work for an accounting consultant has been finalized and arrangement of the consultancy is in progress The IEF Systems Advisor is working with MOH accounts office for on the job training and budget review Monthly MOH budget review meetings are taking place
- The storekeeper has been trained in a manual system for stock control Initial cleaning and reorganizing of store was accomplished and kitchen stores management was reorganized
- Regular DHMT meetings general staff meetings and CHAPS Coordinators meetings are taking place IEF and MOH staff jointly developed two annual work plans which also included a detailed review of progress Monthly work plans for DRF, outreach shelter construction CBD QA, and primary eye care activities are also developed Management team meetings for Ngabu Rural Hospital still need to be implemented
- A quality assurance/problem solving process (QA) has been initiated as a means to improve management and supervision QA training of trainers was completed for a team of four trainers and training has taken place at Ngabu Rural Hospital and two health centers A quality baseline assessment was carried out and analyzed Job descriptions for most cadres are in place and a transparent staff evaluation process is being considered
- Supervision for quality and effectiveness has not yet been considered in depth except for providing radios to health centers for improved communication This will be covered in depth as part of rolling out the QA problem solving process With radios now in place and improved availability of transport supervision is occurring more regularly than previously and the District QA team is using radios to monitor the progress of the QA teams at the health centers
- A team is reviewing the HIS They have agfeed on a plan for collecting processing and using information
- A District cost sharing account was opened and sources for cost sharing funds under discussion The integration of cost sharing systems with re-supply for the DRFs has not yet been addressed
- A consultant worked with a District team to review IEC activities in the District and to develop possible messages and strategies A plan for implementation still needs to be elaborated
- Equipment has been ordered for new Ngabu Rural Hospital theater including equipment for voluntary surgical contraception (VSC)
- One MOH Clinical Officer was trained in Integrated Management of Childhood Illness (IMCI) Two Clinical Officers and one nurse were trained in VSC, the District AIDS Coordinator attended the international HIV/AIDS conference in Zambia thirteen health officers were trained in IEC, and four management staff were trained in computers

(Note the above achievements were taken by verbal report during conversations with project and MOH staff and from quarterly reports The actual implementation of these activities was not reviewed during the evaluation process)

Part B – Health Interventions

- A needs assessment was done to determine needs for outreach shelters This resulted in the organization of communities and the initiation of construction for eight shelters
- Health center family planning providers were trained as secondary supervisors for CBDs
- Renovation of the operating theater at Ngabu Rural Hospital was begun
- 46 CBDs were refreshed An assessment of CBD supervisors was completed in preparation for training CBDs as well as to identify needs for strengthening supervision
- The adult literacy curriculum was reviewed and adapted to include more reproductive health content 20 instructors and 10 VHC members were trained in the new approach 317 women started classes in August
- A DRF needs assessment was carried out and community mobilization in 10 villages with non-active DRFs was completed Training of VHCs/DRF volunteers for 2 villages was done
- Soya and groundnut seed distribution was piloted in 30 households during the 1998 growing season 100% of farmers who had a good yield of groundnuts returned their 12 kilograms of loan seed at the end of the season Fifteen communal gardens were also piloted, with nine of those gardens producing a reasonable yield
- A sub-contract for water and sanitation is being implemented by Concern Universal
- 60 teachers from 41 schools and 27 health workers were trained in primary eye care screening, preventive care, and management of basic problems A health worker training needs assessment done in preparation for their training

VI OBSERVATIONS, LESSONS LEARNED, RECOMMENDATIONS – SPECIFIC INTERVENTIONS

A Community Based Distribution of Contraceptives (STAFH and CHAPS)

Both projects have invested significantly in this intervention, and the evaluation assessed it carefully

Observations

- All the clients interviewed appreciated the work of their CBD and appreciated having contraceptives available in their village Several village CBD clients indicated they were using pills because they were available in the village, although they would prefer injectable contraceptives
- Several CBDs indicated that women who use Depo Provera may come to them for pills during the rainy season when access to the health center is more difficult and outreach activities are less regular The health center indicated they have no new clients coming to them for pills since all prefer Depo Provera The only client they have on pills are those who had difficulties with the injection
- Clients feel they can help mobilize others to use FP
- One client mentioned it is hard for her to make appointments for follow up at the health center, but since the CBD is in her village she doesn t have problems getting re-supplied with pills
- CBD volunteers are generally hard working and like their work, although they mentioned training and the opportunity to learn more provides them motivation to continue While some other incentives such as umbrellas boots etc were mentioned, the request for additional incentives was not overwhelming
- CBDs are generally working 2-3 afternoons/week Some CBDs have difficulty maintaining a regular supply of contraceptives This usually seems to depend on the level of activity of the supervising HSA although some CBDs seek supplies directly from the health center on their own initiative
- Those CBDs who were active and seemed to care about their work seemed well trained – many were able to mention side effects and their management Registers were generally well maintained and showed signs of regular use
- Gola CBD – counseling means giving the necessary facts and information so FP clients can make a choice
- It seems male CBDs are able to work effectively with both men and women They feel they might have an advantage when dealing with husbands who are difficult to convince of the benefits of FP
- There seemed to be a steady trickle (3-5/week average) of tubal ligation clients that were motivated by CBDs The CHAPS project works with the FP Coordinator to provide transport for these clients
- One CBD was serving four school girls since ' they were shy to go to the health center
- One health center supervisor was concerned that the main problem with the CBD program was lack of supervision and he hopes the secondary supervisor system will improve things

Lessons Learned

1 The long distances required to cover several villages make mobilization and follow-up of clients difficult for CBD volunteers
2 CBD volunteers do increase access to family planning and users appreciate the availability of methods at the village level However, several users indicated they were using pills because they were available in the village while they would prefer injectable contraceptives
3 Trained village volunteers are capable of delivering essential family planning information and services
4 Male CBD volunteers are able to provide family planning services to both male and female clients
5 Although important the idea of reproductive goals is still far from the understanding of village clients
6 CBD mobilization positively influences the acceptance of tubal ligations

Recommendations

1 Continue to strengthen the secondary provider (family planning providers at the health center) role as a means to assure support for CBD activities even if the supervising HSA may not be strong
2 Complete the CBD training as planned under STAFH and CHAPS with the addition of at least 28 more CBD volunteers
3 Encourage CBD clients to also be family planning motivators

B Syndromic Treatment of Sexually Transmitted Diseases (STAFH)

Observations

- Contact tracing appears good at Ngabu Rural Hospital– over 50% of patients in the STD register had brought partners However others say it is difficult when anonymity isn t assured or when HSAs are not interested in assisting with tracking down partners
- Since 5/99 STD drugs have been in short supply at Makhwira HC – especially erythromycin
- Montfort – 4 technicians and 4 nurses were trained in 1998 for 2 weeks
- Health education and counseling is reportedly done for STD patients at Ngabu Rural Hospital
- Drugs seem to be effective – providers reported there were no return clients at Ngabu Rural Hospital
- Training has prepared the clinician to treat cases well without having to figure out the exact diagnosis
- Registers seem to indicate a high rate of appropriate treatment, which was corroborated during interviews

Lesson

Clinicians appreciated the syndromic management training and recognize its importance The three total weeks of syndromic management training (one week initially then two weeks expanded sundromic management training) seems to have been enough to achieve appropriate treatment (drug selection and dosage) assuming correct diagnosis Providers also understood the counseling, values implications, and partner identification issues that come with the problem

Recommendation

Include review of STD drug stocks and STD registers as part of routine supervision of clinical practice No additional vertical training is recommended at this time except to replace staff lost through attrition

C Home Based Care / HIV/AIDS Counseling (STAFH and CHAPS)

- HBC clients appreciate the support their guardians receive from the volunteers No other health workers visit them
- HBC volunteers have never been provided with gloves or other supplies The program tries to stay within the locally available supplies but some clients refuse to be seen because the volunteer does not have any essential drugs such as aspirin and eye ointment
- Volunteers render physical support to their clients such as water collection and sweeping houses
- Volunteers are covering a wider area (several villages) and as a result transport remains a problem
- Transport is not a problem for the HBC supervisor because IEF/STAFH supplied and maintained the motorcycle
- The supervisor for Montfort counseling center counsels patients both in the hospital and villages However, blood testing is currently not available at the counseling center and she feels people are not coming for counseling because testing is not available
- The supervisor was trained in HBC and Care Counseling in 1994 and 1995, and refreshed in 1999
- Montfort clinicians appreciate being able to refer to the HBC supervisor when they are discharging sick patients

Lessons

1 The STAFH inputs appear sufficient to leave a sustainable HBC/counseling intervention within the Montfort Hospital context

Recommendations

1 HBC volunteers should be provided with personal protection (e g soap and gloves)
2 CHAPS with the DHMT should identify and support a HBC committee to recommend and pilot a feasible HBC delivery model including provision of minimal supplies Lessons learned from the Montfort experience should be considered

D School – Based Activities (STAFH)

Observations

- Primary Education Advisors (PEAs) and Patrons were observed to have more interest in Edzi Toto clubs than teachers Other teachers have less interest in club activities despite good things the club is doing
- The club members know most of the important points of HIV/AIDS and FP but not STDs Their activities focused on AIDs and FP transmission and prevention of HIV, partially on home care and on FP information
- Teachers at Phwadzi Secondary School felt that the least sustainable activity is the organization of extension activities The main support needed is transport for club members The club lacks strong leadership The Ministry of Education doesn t support the club in any way
- It was suggested that other related lessons such as First Aid, tuberculosis, cancer, diabetes, deforestation and others might add interest One club suggested bringing in guest speakers
- Phwadzi Secondary School Patron feels that the introduction of FP boosted the group He also suggested HBC activities could be introduced
- Problems with the cascade training model and the expectations for allowances make it difficult for PEAs visiting schools to train teachers
- Pupils meet on their own without patrons – He makes them meet but he doesn't come '
- Students complained that Edzi Toto Clubs do the same thing again and again
- Pupils requested T-shirts as ID and denied having membership cards They suggested something be done for motivation e g incentives transport, certificates etc
- Supervision of Edzi Toto activities is not usually included in PEA visits

Lessons

1 Addition of family planning information increased participation at the club level
2 Lack of Ministry of Education and District Education Office ownership for the Anti AIDS club program makes sustainability difficult
3 Involvement of the Primary Education Advisors in the Anti-AIDS club program created a potential linkage for sustainability

Recommendation

IEF should hold a "Change of ownership ' meeting for all PEAs representatives from health centers and DHO/DEO representatives to

a Discuss findings from the final evaluation
b Give participants an assignment to meet together and develop a work plan for the Anti-AIDS clubs and other school based activities for the coming year and
c Offer them a fixed amount of support funds per school (to be determined by the DHMT working from the CHAPS budget) which they could use to support their activities These funds would only become available upon submission of a proposal for activities with a means for monitoring their implementation

E Special Target Groups (STAFH)

1 Traditional Healers / Nankungwis

Observations

- Most traditional healers reported changing their behavior as a result of what they learned regarding HIV prevention They still remember important information eg modes of transmission and preventive measures such as avoiding sharing razor blades and using a different medicine stick for each person
- They were willing to give out condoms but hadn t been re-supplied after the first batch
- The impact of the Nankungwis is difficult to assess in a village as there are several of them They have both religious and traditional affiliations
- The in -charge of Makhwira HC thinks there is need for traditional healers and community to be trained on malaria as a cause of convulsions He sees too many kids dying because they were held up with the traditional healer for too long
- Traditional healers would like health workers to visit them in order to educate them on new issues They don t know what is going on in the village with health activities because they are not involved with or visited by health personnel
- There is good collaboration between them (healers) and government (hospital) compared to the past years If they have failed to cure a certain disease, they send the patient to the hospital One refers STD clients to the hospital after they have been on his treatment for three days with no improvement The chances for cure of an STD is 50/50 in the case of one traditional healer
- Another healer feels he is in partnership with the HSA because both are doing health related issues
- The traditional healers are supervised by nobody apart from their chairman who stays in the same area The traditional healer in Jakobo received HIV/AIDS messages from traditional healer committee (e g not to share razor blades use condoms, etc) but no explanation of reasons
- All treated STD cases are encouraged to bring their partners for treatment

Lesson

Traditional healers are interested in learning about Western views of medicine and are willing to change their behavior They are also willing to promote healthy behaviors in the community

Recommendations

- Traditional healers should be considered as part of the community's health team As such regular contact between them and HSAs, health committees and MOH staff should be encouraged
- Traditional healers should be supplied with free condoms for distribution
- The project should carry out a simple assessment of the nankungwi intervention and apply for separate follow-on funds if the assessment shows the intervention works well

2 Sucoma Peer Educators

This was an intervention that was begun by Project Hope and taken over by IEF under the STAFH project The initial training was done by Project Hope, while refresher training and supervision were subsequently provided by IEF Training of 40 peer educator supervisors out of the group of peer educators was also added by IEF

Observations

- As peer educators they are not doing much on counseling since they seldom visit people in their homes
- A lot of people request condoms from these volunteers
- Some members of the community insult these volunteers – they get tired of the same old community education meetings

- All peer educators had to be employees or spouses of employees in order to avoid problems with incentives
- The Sucoma Medical Officer is willing to sustain activities, but is concerned that he doesn't have enough internal trained trainers and the Sucoma management doesn t support training costs Sucoma communication between medical staff and senior management seems limited

Lesson
The requirement that the peer educators be Sucoma employees or their spouses is a significant advantage for sustainability

Recommendations
- De-emphasize the community meeting/group education component of their responsibilities and strongly emphasize their distribution of condoms
- IEF staff should meet with the Sucoma staff who are involved with the peer educator program to hand over STAFH activities and to assist with development of the next year's work plan (Note this may also include joining the medical officer in a meeting with senior Sucoma staff if he thinks it would be helpful)

3 Bar Girls

The project did an assessment of the training program in mid-1999 using a focus group of women from each of the three trading centers in the District They asked about safe sex behaviors, knowledge about AIDS and FP and impressions of the training done by the project The conclusion was that knowledge levels were high, people appreciated the training and the training didn't necessarily lead either to increased education activities with peers or changed personal behavior

Recommendation
Although potentially an important intervention, there is increasing recognition that all women/people are at risk, and specially targeting commercial sex workers may not be the most effective use of resources for AIDS prevention The CHAPS project should continue to assure condom availability at bottle stores and trading centers, but should probably not continue to spend resources on special trainings for bar girls unless additional funds for that purpose are procured

4 Kapachila Falls Workers and Surrounding Villages

Although a significant amount of effort was put into working with the construction company on HIV/AIDS prevention and family planning, very little progress was made As a short term contracting company they felt little or no responsibility either for their workers or for the area and they were unwilling for any activities to take place during work hours There was also a fair amount of tension between labor and management, with the project perceived as associated with management

An income generation intervention in the Kapachila villages was also planned to provide an alternative to the commercial sex work available with the construction workers Unfortunately a feasibility review indicated the project would have needed to make a significantly larger investment than they had planned, including employment of a staff person for micro-enterprise in order for such an intervention to be successful As a result, this was never started This decision did not impact the implementation of the other District health activities such as drama group support and CBD in the Kapachila area

Lessons
When dealing with short term contractors, it is difficult to get management support for health activities There is a limit to how much you can work directly with workers who are often displaced and disenfranchised in these settings

Recommendation
- Continue to consider the Kapachila area for community level interventions like any other underserved area of the District
- Encourage the Impregilo Company doctor to include and expand the partner identification and treatment component of his STD program Provide the necessary advice and training for this effort

5 Politicians

Taking the observation that political commitment in Uganda seems to have contributed significantly to the decrease of HIV transmission in that country, the project decided to try working with politicians in Chikwawa District during its extension phase Thirteen politicians were trained in HIV prevention and family planning with the hope they would then incorporate these messages in their work However, the agency's need to remain non-sectarian has made follow up complicated

Recommendation
While political leaders are interested in health issues and are potential allies for health interventions a formal relationship with them through provision of training is potentially complicated IEF could support non-partisan efforts at the national level

F Drug Revolving funds (CHAPS)

Observations
- The DRF has strong management systems in place the VHC monitors drug stocks and money (Gola)
- Drug prices are set by the VHC to be slightly less than grocery prices (Replacement cost not considered)
- The MOH drug supply system for the DRFs is not working at all
- In Gola village there is one DRF volunteer and the community has difficulties when he is out of the village for a few days
- Their DRF has difficulties with the community on the issue of purchasing and/or completing the course of treatment
- The volunteers were observed to be hard working and cooperative Sometimes they reported meeting Mr Gobede, the MCH Coordinator, at Chikwawa for purchasing drugs

Recommendation
1 The District DRF committee, which is already in place, should continue working on
   a The Drug re-supply system so that it is functional at the health center level This will need to take some kind of cost sharing accounting system into account
   b Ways to train volunteer replacements when original DRF volunteers leave
   c The community system for oversight and ownership of the intervention
   d Ways to educate the community on appropriate drug use

G Seed Distribution / Communal Gardens (CHAPS)

This project has two agricultural interventions for the purpose of improving food security It is distributing soy and groundnut seeds to individual farmers and is also attempting to organize communal gardens in order for the community to have a means to provide supplemental food for malnourished children

- The community in Pende harvested soya in March and ate it for three months immediately after harvest They made Likuni Phala to feed the entire family - not just the children
- Farmers in Gola indicate seed availability (like pigeon peas) is the main limiting factor for increasing production
- Last year they had a poor yield of soya because they planted late Despite low production from soya/groundnuts they are still willing to grow these crops They would also like assistance with pigeon pea seeds
- Farmers in Gola do not appreciate the nutritional value of pigeon peas or know how to make porridge with them
- The community has been discouraged because no extension workers have been supervising them

Lesson

Seed distribution, even if with limited other inputs, can be well accepted and sustainable

Recommendations

- The seed distribution should be expanded, but substituting other protein foods such as increased ground nuts or pigeon peas for soya should be considered Farmers also need to be trained to use these in making porridge for young children
- Even though this is a difficult intervention the project should select the successfully producing villages (those where the cooperative gardening is working) but place a much stronger emphasis on the goal of malnutrition prevention (as contrasted to just communal production) Lessons learned should be documented and used to develop recommendations for continuation of the program (or not) next year

H Water/Sanitation, Adult Literacy, and Primary Eye Care

These interventions were not assessed in detail during the evaluation Adult literacy and primary eye care were only initiated within the last couple of months although in both cases curricula have been developed and trainers trained It was felt it was too early to assess the effectiveness or progress of these interventions

The water and sanitation component of the project is covered by a sub-contract to Concern International a PVO that has been working on water in the District for many years While they are well underway with their work the time allowed for the evaluation did not allow for a full assessment of the progress on this sub-contract

Recommendation

A couple of representatives from CHAPS (e g District Environmental Health Officer, IEF) should go through a simplified midterm evaluation process with Concern Universal to assess progress and to assure collaboration and consistent messages between the different components of the CHAPS project at the community level

I Integrated Management of Childhood Illness (IMCI), Support for Traditional Birth Attendants (TBAs)

These are interventions with which the project has done little or nothing to date but which the team thought should still be considered They are activities which the MOH is already implementing or undertaking so the addition of project support to these activities is only providing the same kind of system support it is providing to other interventions

Recommendations

- Continue the process of implementing IMCI in the District by training a Chikwawa Clinical Officer as an IMCI trainer and by encouraging its implementation in the District
- Although TBAs did not originally figure in the CHAPS proposal and work plan, the MOH is actively working to increase the training and supervision of TBAs in the District With this in mind the CHAPS project should use its resources to
    - Add TBAs to the supervision and support structure already established to support the DRF and CBD activities in villages (VHCs, HSA primary supervisors, and health center secondary supervisors)
    - Review 1/ the criteria for selection, 2/ the mechanism for replacing those lost through attrition and 3/ the content of the curriculum to be sure it reflects the state of the art for maximizing the effectiveness of TBAs in preventing maternal mortality and promoting maternal health in the community

VII OBSERVATIONS, LESSONS LEARNED, RECOMMENDATIONS – CROSS-CUTTING INTERVENTIONS

A Capacity Building – District Level (CHAPS)

The main activities undertaken by the project to address this level are re-initiation of regular management meetings for both administration and budget review, improvements on the fleet management storekeeping and accounting systems and some effort to increase both frequency and effectiveness of supervision While the specific details of these interventions were not assessed during the evaluation the external evaluator met with the District Health Management Team (DHMT) and the IEF Systems Advisor and made the following

Observations

- The DHMT recognized a wide variety of benefits While most of them were material, the assistance from the transport and QA consultants the re-initiation of DHMT and budget meetings and the annual planning meeting were also mentioned
- The DHMT mentioned concern about sustainability and whether there was a possibility of continued funding beyond 6/01 While initially this meant availability of funds to continue with the activities they have started they also made some behavioral recommendations for sustaining the changes made (see below)
- The DHMT indicated there was already a recommendation to include a Family Health Coordinator on the team to represent the concerns of MCH and FP in the decision making The lack of a Public Health Nurse in this position in the District is the reason they are not currently represented
- The DHMT felt the partnership between IEF and the MOH was generally going well They feel listened to and supported in their efforts, although they had several suggestions (see below)
- While they recognize that the allowance issue continues to create tension they were aware of and accept the written Memorandum of Understanding that was developed They suggested it would be helpful if MOH Program Coordinators were briefed more thoroughly on its contents
- The IEF CHAPS team has provided a sense of vision and leadership that significantly helped the DHMT move forward
- The Systems Advisor has reviewed the District HIS with DHMT members The general conclusion was that the system design is generally all right and has limited flexibility due to requirements at the national level However, work needs to be done to improve the quality and consistency of the information reported as well as use of the information

Lessons

- Improvement of the transport system has positively impacted morale and supervision at all levels of the District
- The design for CHAPS provides a coherent focused framework for whatever interventions were/are prioritized in the District By contrast STAFH by design had a more narrow technical focus for its interventions that resulted in more of a list of interventions with less concern for the system relationships between them
- The MOH s direct involvement in the development of the CHAPS work plans, budgets, and budget decisions has led to a significantly different sense of ownership with the CHAPS project than with other PVO projects

Recommendations

Following are suggestions that came from the DHMT members themselves, but supported by evaluator

- Continue to emphasize the implementation and enforcement of policies and systems even when individual personnel change, as a means to maintain activities which have been initiated
- In order to maintain newly initiated activities, specific plans for their continuation should be included during the development of annual and quarterly work plans – not only plans for new activities
- It would be more helpful for all the JEF CHAPS staff to have offices in Chikwawa so they would be more accessible to each other
- They would like to continue to be involved with selection of CHAPS staff when people are hired from outside They are also interested to know the qualifications of the technical staff with whom they are working

B Capacity Building – Peripheral Levels

Recommendation

Although the CHAPS project has put a lot of energy into capacity building of the DHMT, the considerable turnover of staff makes it difficult to establish institutional memory at that level The project should balance these efforts with strengthening and capacity building at the health center and community levels for increased sustainability

There are already specific interventions in progress to address this but the evaluator felt it was important to elaborate the overarching recommendation emphasizing the need to address capacity building activities at all levels Activities are underway to address supervision and supply systems at the health center and community levels, as well as to strengthen the roles of the HSAs and the VHCs A key strategy to do this is the implementation of a quality assurance/problem solving process that empowers personnel at each level to identify their problems and constraints and to work collectively to resolve them

1 Quality Assurance / Problem Solving Approach

This is also an intervention that is still in its early phases, but is central enough to the overall project goals that the evaluation team did a preliminary assessment Two health centers where staff had been trained in the process were visited and two members of the training team at the District level were interviewed

Observations

- Chapananga
  - Health workers ' work as a team and hold staff meetings now as a result of their QA training" but they had a difficult time defining quality services They reported working together to repair their sterilizing stove, and they are meeting together to identify and discuss problems
  - "The benefits of QA is it allows staff to identify problems and their solutions before seeking external assistance'
- Ngabu Rural Hospital
  - They don t see health center reports as they are sent directly to the District This makes it difficult to support the health centers in their catchment area
  - At Ngabu Rural Hospital the QA process is not going well because the members are too busy with other activities People are absent (workshops) so it is hard to get together for a meeting
  - There is no proper coordination between departments at the hospital – e g no planning for transport use Staff don't see themselves as a team responsible for managing their health center
- They will need follow-up and reinforcement of problem solving process They had a tendency to slip back into the pattern of expecting external solutions of their problems

- QA Training Team
  - The team reported a very thorough training process whereby they were first trained in the process then supervised while they facilitated a training and finally carried out training on their own By the third time through they felt confident in the process
  - While they indicated they are prepared to provide follow up supervision to the health centers that were trained in the QA process, they may not be so clear on the next steps necessary to keep the process moving forward
  - They initially had a difficult time imagining how the process might be applied at the community level - particularly since it implies such a large scale However when offered the suggestion that HSAs might be trained to implement the process they seemed to think the adaptation to achieve this would be quite feasible

Lesson
The thorough planning and training for the implementation of this process means the quality asssurance team feels well trained and competent in training health center staff and in pushing the process forward

Recommendation
This is a promising process that is recommended for expansion at the health center and even community level However, solid follow up should be emphasized and reinforced
- for the QA core team so they are clear on their support role
- and for the health centers and community committees by the QA core team and staff supervisors

2 Management and Supervision

Observations
- The in -charge of Makhwira Health Center complains that many staff members are sent to his area without receiving any training In addition he is interested in HBC and would like to receive training in Care Counseling
- The in- charge of Makhwira Health Center claims that the health center management team (MA, Nurse, HA) meets about every other month The last meeting was July 19, 1999 but the next meeting has not yet been scheduled In general, health center staff don't see themselves as managers
- Makhwira Health Center doesn t get supervision support for administration and management – only the DHO visits and his visits are generally oriented towards technical issues and troubleshooting
- The in- charge of Makhwira Health Center states that transport is not the main reason why he is not making so many supervision visits, rather he is too busy at the health center
- Routine visits by DHO improved soon after CHAPS came into the District
- Health Assistant was concerned that he can't supervise HSAs on CBD if he hasn t also been trained on CBD
- The FP Coordinator felt the interpersonal counseling training has made a significant difference both in her ability to assist staff technically with family planning counseling, but also in her ability to effectively supervise and manage her staff

Recommendations
1 Supervisors need to be trained in the responsibilities of their subordinates (CBD, QA, etc)
2 All health centers and Ngabu Rural Hospital need to put a management structure (health center management team) in place to oversee day to day operations and resource allocation (e g transport, outreach activities, supervision reporting etc) CHAPS/District MOH should assist with this process

3 Reinforce relationships between secondary supervisors (health center staff) and village volunteers (for CBD DRF etc) particularly when there may be difficulties in getting supplies into the hands of the volunteers

3 Strengthening of HSAs

The HSA is a key link between those who are involved with community level activities and their supporting health center In areas where there were strong HSAs, community activities seemed to be going well and volunteers felt good about their work In areas where the HSA was not strong the evaluation team found reports of supply stock outs at the community level, frustrated volunteers, and limited activities actually occurring

Observations

- The HSA in Pende village is not aware of health activities in his village Many problems in the village appear to be due to the lack of supervision by the HSA
- The Dausi HSA refers clients with normal Depo-Provera side effects to the health center even when they should be managed at the village level
- The HSA in Mchacha shows that an HSA s work in a village need not depend on an active VHC - he works directly with volunteers
- HSA has problems in keeping his bicycle in running condition as the hospital rarely gives spare parts
- HSA is only being supervised during normal under-five outreach once a month Hence the outstanding problems are not sorted properly

Lessons

1 HSA supervision of CBDs in the current system depends too strongly on the quality of the individual HSA
2 Transfer of HSAs make it necessary to plan for regular training systems (even if it is on the job training) for special HSA programs (such as CBD, water maintenance, DRF etc) to assure continued supervision of these programs by incoming replacements

Recommendations

1 Explore ways to extend the quality assurance / team problem solving approach to supervision of HSAs and to the HSA supervising the community
2 As CHAPS activities are depending on effective HSAs, the problem of HSA transport (bicycle distribution and maintenance system) needs to be urgently addressed
3 Since HSAs are crucial for the success of community activities an effort should be made to pull weak ones to posts where they can be supervised, and fired if necessary

4 Strengthening Village Health Committees (VHC)

Observations

- Gola and Mvula – The VHC encourages mothers to attend both ante-natal and under five clinics (mobilization) They also motivate ill people to go to the DRF and mothers to go to CBD and communities to go to communal gardens One CBD (Makhula) has difficulty mobilizing older women and men and thought the VHC might be able to help with mobilization
- Members pointed out clearly that CBD, DRF and gardens were for their own benefit (Gola)
- There is need to provide refresher course to those who were trained in 1997 in order to boost their morale It was observed the committee was only supervised once (Dausi) There is also a need to replace the drop out members as there is no system to address attrition

- VHC members in Mchacha said they supervise the CBD/DRF volunteer regularly but they didn t seem clear on what supervision meant
- The Nyalugwe VHC is distorted and falling apart – 'the Village Headman (VHM) is a dictator In Lazo, the VHM was not represented at all Volunteers are not represented on the VHCs
- The HSA in Mchacha thinks VHCs do not understand their role as responsible for health activities in their village
- Members of the Outreach Shelter Committee appear to be confused regarding their role and the overlap with the VHC They complain about "too little sand and too many supervisors' - District and health center supervisors are confusing the builder, the community and the HSA on the plan for the shelter

Recommendations

1 VHCs need training including implementation of a system for training replacements when attrition occurs
   a All PHC activities occurring in their particular village (CBD DRF, water, gardens, growth monitoring, etc)
   b How to provide oversight and support to village volunteers
   c How to organize regular community meetings on health in order to increase general community participation and ownership
2 Train and work with all District HSAs to apply the problem solving process (as initiated under the quality assurance intervention for CHAPS) in organizing and training VHCs
3 Select 10-20 very active VHCs to focus on strengthening the community/VHC/HSA/health center relationships and collaboration through more active implementation and supervision of the problem solving process Document the experience and lessons learned

C Supply systems

Observations

- Both the HSA and in-charge for Makhwira Health Center say there are never any problems with contraceptives supplies but the CBD from Machacha says she often does not get enough contraceptives from HSA
- The FP logistic information system has decreased contraceptive stock outs at Ngabu Rural Hospital The in-charge of Makhwira Health Center reports that he gets contraceptives soon after he sends his FP reports and the same is true for vaccines
- Condoms are not adequate at the HC The staff feel that they are only supplied for FP and not for casual use
- Sucoma – The STAFH project assisted in transporting supplies from the MOH in Chikwawa
- The Sucoma Matron is concerned that the STD/FP equipment she requested (through IEF to be procured by JSI/STAFH) was never received and the now the project is ending

Lessons

- The recently introduced contraceptive logistic system (CDLMIS) made a difference in contraceptive availability in the periphery
- The splitting of condom distribution responsibility between family planning and AIDS sections has resulted in problems with condom availability at the health center level and below

Recommendations

- The *perception* of adequate supply at the health center and community levels needs to be considered when distributing contraceptives (If providers perceive their supplies to be few they sometime under - distribute supplies to clients or volunteers - even if their actual supplies are adequate)

- CHAPS should provide the FP/STD equipment that was identified as needed but not supplied by the JSI/STAFH project
- CHAPS should facilitate problem solving between the FP and AIDS Coordinators at the District level for efficient condom distribution Advocacy for changing the system at the national level should also be considered

D Other Partnerships

The MOH is the primary partner/lead player for the CHAPS project However both Sucoma and Montfort Hospital were important partners under the STAFH project As significant health service providers in the District they also need to be considered under CHAPS

Observations

- The Montfort Medical Officer did not seem to realize that STAFH funds were paying the counselor – he thought Montfort was paying her
- The Montfort motorcycle is regularly maintained by STAFH
- Montfort feels awkward using MOH HSAs and HC staff to support their community activities There seems to be confusion over the health delivery area and the role of MOH for supervision and follow-up in that area
- Sucoma management didn t know the project was ending although there are multiple reasons (staff turnover, misunderstanding, independence) why the phase over process may not have been clear to everybody

Lessons

- Early in the STAFH project, the project advisory committee (PAC), which was made up of MOH IEF Montfort and Sucoma provided a forum for addressing program implementation and management in general The dissolution of this group may have led to a loss of clarity regarding specific project activities and the plans for handover among these participants
- Montfort Hospital s responsibility for the recruitment and payment of the HBC supervisor even though it was with STAFH funds, improved their ownership of the HBC program

Recommendations

- Do formal handover including written letters and meeting with management to assure details (e g payment of HBC supervisor salary, continued condom supply etc) are not dropped in the process of phasing out (see also specific recommendation for Sucoma peer educators)
- Review and strengthen the role of the District Health Technical Coordinating Committee (DHTCC) or other District structures to assure a forum for communication and problem solving of technical as well as management and supervision issues for all health players in the District

E IEC Strategy / Community Mobilization

The STAFH project was primarily an IEC project, focusing on a variety of target groups with focused messages around HIV/AIDS prevention and family planning Drama groups, competitions wall murals peer education, videos, and discussion groups were all used to convey these messages More in line with its approach to strengthening systems, the CHAPS project is taking a District wide focus to defining an overall IEC strategy It includes specific behavioral messages that reflect the project objectives but is also trying to provide staff with a more effective framework for their health education activities

Lessons

- There has been an increase in the depth and breadth of people s knowledge about HIV transmission and family planning since the inception of the project that may have been encouraged by the wide variety of IEC activities that occurred throughout the District
- The knowledge changes (particularly for FP) were greater in the CBD villages than in the District as a whole This might indicate that the individual peer counseling mode may be more effective than a generalized IEC campaign, or at least effective as an enhancer of such a campaign

Recommendation

Although the IEC consultant outlined a comprehensive list of potential target groups and IEC strategies, the messages and activities should be prioritized to a few key messages and strategies - keeping in mind that the final impact has to be the absorption of the messages for behavior change by individuals and families in communities

VIII PROJECT MANAGEMENT

Both projects were/are generally well managed with respect to resources personnel, planning, information monitoring and technical support

A Project Planning and Monitoring Process

The STAFH project was largely designed by IEF staff with input from the MOH and the Project Advisory Committee (MOH, Montfort Hospital, Sucoma and IEF) The committee served as a forum for coordinating activities and exchanging ideas The nature of the design was quite concrete with a clear outline of activities to be completed As a result, although staff went through the process of developing an implementation plan, it was never finalized nor did it become a document that was used as a management tool Additionally, while quarterly reports were done the project did not follow an annual reporting or review process When questioned, staff did not report missing the implementation plan with respect to keeping track of project deliverables However it is likely that the lack of this document affected the ability of staff to share the project with others, and it certainly made it more difficult for the evaluator (or others) to assess its status It is also open to discussion whether the project activities might have had more coherence if they were implemented in the context of an overall work plan

Monitoring for the STAFH project was by survey, and by monthly activity reports that were tracked by Project Coordinators Baseline surveys were done in the Kapachila Falls area, in schools, and in CBD villages A final child survival survey carried out in August, 1996 also contributed significant baseline information Final surveys were done in the CBD villages and in schools The baseline survey for CHAPS also contributed to an estimate for some final STAFH indicators for the District as a whole

The project effectively used simple informal assessments to determine program strengths, weaknesses and contextual information This information was then used to plan training and make program decisions Examples of assessments carried out include

- CBD Supervisors – Training needs assessment and review of constraints prior to refresher training
- Peer educators – bar girl focus groups to review knowledge and practices prior to refresher training
- Nankungwi initiation advisors – assessment of practices roles and AIDS/FPknowledge prior to initiating intervention
- Traditional healers – training needs assessment prior to refresher training

These assessments were simple and did not take a lot of time and resources but they provided good information on which to base subsequent project activities A disadvantage however to the limited emphasis on formalizing these assessments is the lack of accessibility of the information to others – either for use by other IEF staff, or by other projects in the country

In contrast to STAFH, the CHAPS project has been planned extensively from the beginning in a participatory way with the MOH Several people cited the value of the annual review and work plan development process stating they had learned a lot about program planning and management by going through it

In addition to the quantitative baseline survey carried out in October 1998, the project carried out a baseline quality assessment with technical assistance from University Research Corporation (URC) This assessment included a variety of measures for health facilities as well as technical competency in order to provide a baseline for many of the health center level capacity building interventions that are proposed under CHAPS With respect to the capacity building interventions at the District level the Systems advisor carried out a preliminary review, with the specialized consultants doing more in-depth assessment as part of

developing an intervention plan However, because this kind of capacity building is a new area of focus there are not yet either elaborated tools or defined indicators for progress for many of these activities

In keeping with its commitment to putting MOH in the lead implementation position the project has not developed an information system beyond that already utilized by the MOH It is focusing instead on improving the quality and flow of information within that system Project Coordinators track activities on a monthly basis and this provides information for the Project Manager to monitor progress

While in principle this should be adequate the evaluator is concerned that there are some key performance indicators that may fall between the cracks unless additional effort is made to track them or at least to pull the specific information out of the MOH information system Examples of these might be 75% of activities on the work plans are completed, health center stock levels of essential drugs or tracking of supervision activities

Recommendation
Project staff should review the available information relative to the specific performance indicators listed in the proposal log frame to be sure they are monitoring the necessary information for measuring project progress

B Internal Project Management – IEF

IEF as an organization has the basic structures in place for effective management These include job descriptions, annual staff evaluations performance review during the first three months of employment, generation of monthly finance expenditures against projections and efficient procurement As a result, project staff is generally free to focus their effort on project implementation

The evaluator met formally with both project managers, the Country Director, and the CHAPS Systems Advisor to assess their view of project management In addition, she was available throughout the evaluation for informal comments from more junior staff Following are some of her observations

Observations
- With the emphasis on MOH capacity building IEF staff (QA PM) are concerned that they too need staff development if they are to be effective advisors
- Staff appreciate the open, participatory management style practiced at IEF They feel listened to and supported
- The Systems Advisor has the double role of project administrator and counterpart for MOH administration and finance This is a big job He likes being involved and really working with systems - getting his hands dirty and not just working them out theoretically
- Everyone feels there has been good support from both Blantyre and US offices in logistics procurement, finance tracking, administration etc
- Spending for both projects was on track and consistent with budget projections

Recommendation
- IEF should try to assure training opportunities for IEF advisors to complement training received by MOH counterparts in order to assure their continued credibility
- Everyone needs to be sure both the IEF management and the MOH Systems Advisor components of the Systems Advisor's job are adequately addressed Delegating some of the day to day errands he does (for both the project and MOH) to others leaving him free to focus on the systems management would help

C Technical Assistance

Because of the capacity building and advisory nature of CHAPS with its focus on strengthening management systems, the project has depended fairly heavily on outside technical assistance A lot of this has come through the umbrella agreement with URC that was arranged at the beginning of the project Others have come independently

- URC on Quality Assurance –
  - Ms Lynette Malianga came a total of five times with a duration varying from 3-10 days to assist with the baseline assessment and training in the quality assurance/problem solving process
  - Ms Jolee Reinke came once for 5 days to assist with QA training
  - Ms Mellina Mchombo came once for 5 days to assist with QA training
- URC on Fleet Management – recruited Mr Tobias Harwa from Zimbabwe to develop fleet management plan
- Mr Gilbert Mwakanema, Adult Literacy Consultant – came from Lilongwe to assist with adaptation of and training for adult literacy curriculum
- Mr Daudi Nturibi IEC Specialist – Came from Nairobi to review and develop IEC messages and strategies with District team
- Mr Precious Givah, Planning Specialist – Came from Malawi Institute for Management in Lilongwe and assisted with workshop for the development of the annual work plan

URC was hired by all the CHAPS projects to provide a framework and technical assistance for the management training component of these projects This has been an innovative, although relatively expensive input, and indications from staff are that some elements have been more helpful than others

Recommendation
Evaluate the costs and benefits associated with the technical support model offered by URC to determine if this kind of assistance model is helpful as PVOs move toward increased systems support and advisory roles

D Impact of the Projects on IEF

The STAFH project provided the opportunity for IEF to apply its child survival experience in the District to the more technically focused interventions of HIF/AIDS prevention and family planning They were able to expand and strengthen their CBD interventions as well as raise the general profile and awareness regarding reproductive health both internally as well as in the District

Implementation of the CHAPS project has entailed a shift in role for IEF from one of doing direct implementation of programs to one of advising They are now working in partnership to assist MOH in improving health in the District The technical assistance brought in to support this new role has positively affected the way the agency has carried out the planning and management of this project – both internally and in relation to the MOH It is hoped that this perspective will be maintained with the turnover of project leadership to the STAFH Project Manager

IX SUSTAINABILITY IMPLICATIONS

With respect to the STAFH project, the fourth year extension allowed for more limited and prioritized activities With the CHAPS project in place the continuation of those interventions which contribute to the larger District vision for health is possible As such, some activities are being phased out, some are being phased over to other partners such as Montfort Hospital and Sucoma, and those which fit in with the MOH vision for health in the District will continue to be supported by MOH under CHAPS

Sustainability with respect to CHAPS entails two elements resources – both financial and human and ownership With respect to resources, the current activities have all been planned with consideration to the resource constraints of the MOH, but realistically they have also benefited from the additional resources of CHAPS Some level of the current activities would be sustainable without outside resources but they would not include the level of training and support they are currently receiving

With respect to ownership, the design of the CHAPS project with the MOH as the primary implementer of all activities, essentially makes this a non-issue As a result, in spite of the ending of the STAFH project and the general need to consider sustainability during an evaluation process the issue of sustainability in this evaluation tended to slide into the background

X CONCLUSIONS

In conclusion, the STAFH project was a well executed project targeting most of Chikwawa District with a wide variety of interventions designed to improve awareness and lead to changing behaviors with respect to AIDS prevention and family planning utilization The availability of funding under the CHAPS project allows for the continuation of some activities – particularly those contributing to improved access for family planning

It was certainly the feeling of all parties consulted that the CHAPS design is working very well in Malawi at this time It provides a framework for strengthening systems while at the same time implementing activities designed to improve health at the household level The District focus is large enough to make a significant difference in health as well as to have some impact on national policy while at the same time it is small enough to get something done The true partnership undertaken in this project has led to a significant level of ownership on the part of MOH for the project activities and interventions It has also led to an effective balance between institutional capacity building and community level implementation of interventions such that the community level activities are occurring in the context of sustainable support systems

APPENDIX A

Evaluation Team Composition, Schedule, and Contacts

EVALUATION TEAM

Marcie Rubardt Team Leader
Joyce Naisho, CHAPS Project Manager
Mercy Kampinda MOH FP Coordinator
Christine Witte IEF Country Director
Tommie Mpetheya STAFH Project Manager
Nelson Gobede MOH MCH Coordinator

EVALUATION SCHEDULE AND PERSONS CONTACTED

Sun 12 Sept	Arrive Blantyre
Mon 13 Sept	Met with core evaluation team Joyce Naisho IEF CHAPS Project Manager Tommie Mtepheya IEF STAFH Project Manager Christine Witte IEF Country Director Mercy Kampinda, MOH FP Coordinator - Chikwawa Nelson Gobede MOH MCH Coordinator - Chikwawa Reviewed project progress to date
Tues 14 Sept	Met with expanded evaluation team including George Meksem IEF CHAPS QA/Training advisor Elton Chiumia, IEF STAFH FP Coordinator Paul Chibisa IEF STAFH Asst HIV/AIDS Coordinator Defined evaluation issues, outlined schedule Met with Dr Esther Ratsma outgoing District Health Officer Chikwawa
Wed 15 Sept	Finalized interview tools and evaluation schedule
Thurs 16 Sept	Field visits - Matengambiri Chambuluka and Paiva villages Konzere Primary School Ngabu Rural Hospital
Fri 17 Sept	Field visits - Pende and Dausi villages
Mon 20 Sept	Field visits - Makhula Nguleti and Mchacha villages Phimbi Primary School Makhhwira Health Center
Tues 21 Sept	Field visits - Chipakuza and Thomu villages Montfort Counseling center and Montfort Management Sucoma - peer educators and clients Sucoma Health Center and Sucoma management
Wed 22 Sept	Field visits - Gola and Mvula villages Chapananga Health Center Phwadzi Secondary School
Thurs 23 Sept	Organization of observations Develop Recommendations
Fri 24 Sept	Develop Recommendations Meet with 2 QA team members Mr Mulenga and Mrs Chikopa Meet with DHMT Mr Chinkonde Acting DHO Mr Chunga - DEHO (on study leave) Mr Mulenga Acting DEHO Mr Semu, District IEC Officer Mrs Phiri Clerk/Administration
Sat /Sun 25-26 Sept	Complete recommendations Review numbers and accomplishments re activities completed and survey results related to objectives
Mon 27 Sept	Finalize recommendations Presentation to results to Chikwawa District representatives from District Commissioner, District Education Office DHMT Sucoma IEF staff
Tues 28 Sept	Presentation of results to USAID - Mexson Nyirongo and Kalinde Chindehu
Wed 29 Sept	CHAPS quarterly meeting Presentation of results
Thurs /Fri 30 Sept /1 Oct	Travel home

APPENDIX B

Key Evaluation Isues (identified by team)

PRIORITY ISSUES IDENTIFIED BY EVALUATION TEAM

- CBD -
  - how does the community benefit from the CBD
  - client satisfaction with the service
  - what kind of support do they get from the project/MOH and the community (not just allowances but also supervision, supplies etc
  - what constraints do they experience - are there ways the project could improve to diminish these

- Home-based Care
  - What role does the HBC volunteer have in the community (what model makes sense for delivery of HBC
  - what to do about kits or supplies (gloves, pain medicines soap etc)
  - what constraints do they face and how might the project address these (improve)
  - the impact of HBC in the community, what is the connection of the community level with the hospital level (referrals follow up etc)
  - Is it feasible?

- Counseling and Testing - What is the quality of counseling for FP STD, HIV? How do you train for or achieve good interactive counseling?

- STD syndromic management
  - How well is it done in reality (check post tests for knowledge treatment register for practice)
  - What is the community perception of the need to seek treatment at the health center (survey)
  - How is partner identification working What are problems Are there creative approaches to encouraging partner participation

- Nankungwi/Traditional Healers
  - What is their perception / the communities perception (including youth and parents) of their role in the community - do people listen to them and follow what they say
  - Do the healers appreciate what they learn - does it make a difference

- What role does the community play in supporting the health activities?

- Schools / Edzi Toto Clubs
  - What next?
  - What is the level of appreciation of the students and the teachers

- Commercial sex workers - what is the effectiveness, what next
- Sucoma peer educators - what next?
- Kapachila - what next?
- Food security model - community gardens and subsidized crops
  - Is it doing what it s supposed to
- IEC - has been covered by the recent consultant visit
- Condom distribution - PSI CSW MOH
- QA process
- politicians - what next?
- partnerships
- the number and breadth of the CHAPS interventions

COMMUNITY QUESTIONNAIRE

HEALTH COMMITTEE - (Group)

1 What health activities are occurring in your community? Prompt FP/CBD? Health education? DRF? Condom distribution? Water and Sanitation? - what specific activities in each of these areas and by whom?

2 How are these activities going on? - What is working well? Why? What isn't working so well? Why not? (strengths and constraints)

3 What do you do to support these activities? (health committee role) How do you know what needs to be done? What are difficulties you find in making sure these activities happen and can continue? (Whose activities are they?)

4 How has the project/MOH supported or helped with these activities in your community? When was the last time someone from the project/MOH visited here to see how the work was going? What did you discuss?

5 What health education activities have taken place here in the village? (all IEC activities - not just health talks What have you learned? What activities do you see as most effective for helping people understand about health and ways they can improve their health?

Have you or friends of yours received specific services in the community? (such as CBD HBC health education, drugs from DRF, sanitation activities home visit etc) What was your/their experience Was it helpful? - If so, what was helpful? Are there things you wish had been done differently? - If so what? Are you doing anything differently as a result of this project? (has behavior changed?)

After the project finishes what are ways you can think of to encourage these people to continue providing services in the village? (sustainability)

6 Were traditional healers (or nankungwis - Paiva) in your community trained by the project? Do you know what that training was? What, if anything have you noticed they are doing differently as a result of that training? (Paiva - How do you feel about nankunwis passing on this kind of information to your children? - Do your children listen or do anything different as a result of it?)

7 If you need condoms here in the village, where can you go to find them? Are they always there?

HEALTH CENTER/NRH

MEDICAL ASSISTANT/NURSE (Clinical Officer at Ngabu?)

1 What experience have you had with the MOH efforts to assess and improve quality of services in your facility? What kinds of components do you think contribute to good quality services? (what are the elements of quality what is the definition of quality) How are ways you see that you can improve the quality of service at your facility?

2 What training have you had recently in FP? What do you know about what the CBDs are doing? How many CBDs do you have in your area? What contact have you had with them? What do you see as the benefits of having CBDs? What are some of the difficulties you see with working with CBDs?

3 What training did you have in STD treatment? Describe what you do when someone comes to you with symptoms of an STD Do you feel comfortable in the way you are able to treat STDs? Why or why not? What do you do to identify partners of STD patients? How well is this working? What are your difficulties with this? May we review your STD register to see what patients you have seen in the last two months and how they have been treated (copy Diagnosis treatment and doses for each patient in last two months)

What kinds of things do you discuss with your FP patients? Your STD patients? Any HIV patients? What are the concerns these patients bring up with you? (counseling)

4 What do you find most satisfying about your job? Why? What do you find most difficult about your job? Why?

5 What support have you had from the project/MOH over the past 6 months (supervision supplies training etc) Are there ways this support could be improved?

What are ways you provide support to volunteers in the field? What do you need to do this better?

6 How do your supplies and drugs systems work? Have you had any stock outs in STD drugs family planning supplies or condoms in the past six months? If yes do you know why? How do you account for FP supplies and/or condoms that are given to others (CBD TH etc) to distribute?

WARD ATTENDANT/CLEANER (Chapananga HC)

1 What training did you receive from the project/MOH?

Are you doing anything different at your work as a result of this training? What?

SCHOOLS

PEAs, TEACHERS, PATRONS, STUDENTS

1 What do you see as the main benefits that Edzi Toto clubs have to offer? What are the most successful activities your club has done? Can you describe how things have changed (if they have) as a result of some of these activities? What are other things the club might do?

What are some of the effective health education activities? (if the murals are part of the school - How have the murals been used/made a difference?)

What difficulties do you find in doing your activities? What are ways the project could better facilitate these activities?

COMMUNITY VOLUNTE _RS (CBD, HBC, DRF, (GMV, TBA,)Water and sanitation Sucoma peer educators)

1 What kinds of things do you do as a volunteer? How often? What do you like best about your job? Why?

2 What is going well in your job? Why? What do you find difficult? Why?

3 How has the project/MOH facilitated your doing your job? What could be done to help you as a volunteer? How about the community or the health committee?

4 Is what is expected of you reasonable? Is there a reasonable amount of work? Do you feel competent in doing what you are expected to do?

How have things changed in the community with respect to (FP/HBC/Drug availability/Water and Sanitation etc) How are things different as a result of your work?

(man to man village - Gola) CBDs - What is your success with reaching men? To what do you attribute the success or difficulty?)

CBD,HBC CLIENTS

Ask questions #6 and #5 from health committee list

NANKUNGWI/TRADITIONAL HEALER

1 What is your role with respect to health in this community? When are you consulted? How do you influence peoples actions or behaviors with respect to their health? Do you feel people listen to and follow what you say ? Why or why not?

What kind of training did you receive from the project? What was helpful about it? What do you wish might have been done differently? Are you missing information you wish you had? What? Are you doing anything differently (either in your own life or with your clients) as a result of what you learned in training? What?

Nankungwi Youth - Ask health committee questions # 5 and #6

HSA

1 What are the activities in the community that take most of your time? Which ones are going the best? Why? Which ones are you having the most difficulty with? Why? What do you like best about your job? Why?

2 What kind of support from the project/MOH have you had to do your job? (training supervision transport supplies etc) How did it help you? What more could be done to help you do your job better?

3 What do you see as the strengths of your volunteers/committees? (all cadres) Of their programs? - (CBD HBC DRF Water etc) Are the ways these activities could be carried out more effectively in the communities?

1 What kind of training and other support has this intervention received from the STAFH project (training supplies reimbursements transport etc) How did it help your program? Are there ways it could have been improved?

PEAs - has the project had an impact on the capacity of the MOE to address the problem of teen pregnancy and HIV? In what way?

TEACHERS - Describe how if in any way the training on the AIDS curriculum influenced what you do in the class room

2 With the end of the STAFH project what kind of inputs will be needed to continue the Edzi Toto activities Do you have any ideas where this support might come from? What?

3 (TEACHERS/PEAS) Have you had any training regarding primary eye care? What is the benefit of this training? Do you see this as an important problem that teachers should be addressing? Why or why not?

MISC INTERVIEWS

POLITICIAN

1 What training did you receive from IEF/STAFH regarding HIV/AIDS prevention? Did you learn anything new or different from what you knew already? Are you doing anything different as a result of your contact with IEF?

2 Do you have suggestions of what role NGOs might play in advocating for health issues (AIDS prevention HBC safe motherhood etc) through the political system?

SUCOMA/MONTFORT

Volunteers - (peer educators HBC volunteers) - see volunteer questions under community
Health staff - See questions under health center

Management Staff

1 What has been the benefit you have seen to working with the IEF STAFH project? How has your organization capacity increased (if it has) as a result of this collaboration (training new programs personnel etc)

2 What difficulties have you experienced with this partnership? Why do you think this was? Knowing what we know now are there ways these could have been alleviated or better addressed (lessons learned)

3 Are there ways the project could better have helped you overcome the constraints and difficulties you experience in implementing family planning and AIDS preventions interventions?

4 How do you plan to continue the activities that have been supported by the project? What difficulties do you foresee in doing this?

FOOD SECURITY

Communal Garden - Participants

1 Explain to us how you have the garden set up who does the work who keeps track of the inputs and outputs, who supervises etc? Whose garden is it?

2 What do you see as the benefit to having a garden like this? Is this the best way to reach this benefit?

3 What difficulties do you encounter in managing a garden like this? Is there a better way to do it?

4 What actually happened to the food that was harvested last year? Sold? Eaten? By whom? Is this what was supposed to happen If not, why did it get allocated the way it did?

Soy/Groundnut Farmers

1 What convinced you to plant soy/groundnuts?

2 What has been your experience with this crop? Did you get a good harvest? Why or why not? What did you do with the harvest - eat it? Sell it? To whom?

3 Do you expect to continue planting it? Why or why not?

PROJECT MANAGEMENT (IEF AND MOH/CHAPS)

1 Human resource management - personnel policies staff development plan annual appraisals supervision (checklists?) etc
(IEF staff progress on CHAPS/MOH)

2 Planning process - participatory use of data dynamic, ownership (both projects)

3 Financial reporting awareness of expenditures against budget

4 Increase in IEF capacity as a result of project(s) Ways to measure change in capacity

5 HIS system

6 Lessons learned

APPENDIX C

Discussion Guides for Field Visits

COMMUNITY QUESTIONNAIRE

HEALTH COMMITTEE - (Group)

1 What health activities are occurring in your community? Prompt FP/CBD? Health education? DRF? Condom distribution? Water and Sanitation? - what specific activities in each of these areas and by whom?

2 How are these activities going on? - What is working well? Why? What isn t working so well? Why not? (strengths and constraints)

3 What do you do to support these activities? (health committee role) How do you know what needs to be done? What are difficulties you find in making sure these activities happen and can continue? (Whose activities are they?)

4 How has the project/MOH supported or helped with these activities in your community? When was the last time someone from the project/MOH visited here to see how the work was going? What did you discuss?

5 What health education activities have taken place here in the village? (all IEC activities - not just health talks What have you learned? What activities do you see as most effective for helping people understand about health and ways they can improve their health?

Have you or friends of yours received specific services in the community? (such as CBD HBC health education drugs from DRF, sanitation activities home visit etc) What was your/their experience Was it helpful? - If so, what was helpful? Are there things you wish had been done differently? - If so what? Are you doing anything differently as a result of this project? (has behavior changed?)

After the project finishes what are ways you can think of to encourage these people to continue providing services in the village? (sustainability)

6 Were traditional healers (or nankungwis Paiva) in your community trained by the project? Do you know what that training was? What if anything have you noticed they are doing differently as a result of that training? (Paiva - How do you feel about nankunwis passing on this kind of information to your children? - Do your children listen or do anything different as a result of it?)

7 If you need condoms here in the village where can you go to find them? Are they always there?

COMMUNITY VOLUNTEERS (CBD, HBC, DRF, (GMV, TBA)Water and sanitation Sucoma peer educators)

1 What kinds of things do you do as a volunteer? How often? What do you like best about your job? Why?

2 What is going well in your job? Why? What do you find difficult? Why?

3 How has the project/MOH facilitated your doing your job? What could be done to help you as a volunteer? How about the community or the health committee?

4 Is what is expected of you reasonable? Is there a reasonable amount of work? Do you feel competent in doing what you are expected to do?

How have things changed in the community with respect to (FP/HBC/Drug availability/Water and Sanitation etc) How are things different as a result of your work?

(man to man village - Gola) CBDs - What is your success with reaching men? To what do you attribute the success or difficulty?)

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What kind of training did you receive from the project? What was helpful about it? What do you wish might have been done differently? Are you missing information you wish you had? What? Are you doing anything differently (either in your own life or with your clients) as a result of what you learned in training? What?

Nankungwi Youth - Ask health committee questions # 5 and #6

HSA

1 What are the activities in the community that take most of your time? Which ones are going the best? Why? Which ones are you having the most difficulty with? Why? What do you like best about your job? Why?

2 What kind of support from the project/MOH have you had to do your job? (training supervision transport supplies etc) How did it help you? What more could be done to help you do your job better?

3 What do you see as the strengths of your volunteers/committees? (all cadres) Of their programs? - (CBD HBC DRF, Water etc) Are the ways these activities could be carried out more effectively in the communities?

HEALTH CENTER/NRH

MEDICAL ASSISTANT/NURSE (Clinical Officer at Ngabu?)

1 What experience have you had with the MOH efforts to assess and improve quality of services in your facility? What kinds of components do you think contribute to good quality services? (what are the elements of quality, what is the definition of quality) How are ways you see that you can improve the quality of service at your facility?

2 What training have you had recently in FP? What do you know about what the CBDs are doing? How many CBDs do you have in your area? What contact have you had with them? What do you see as the benefits of having CBDs? What are some of the difficulties you see with working with CBDs?

3 What training did you have in STD treatment? Describe what you do when someone comes to you with symptoms of an STD Do you feel comfortable in the way you are able to treat STDs? Why or why not? What do you do to identify partners of STD patients? How well is this working? What are your difficulties with this? May we review your STD register to see what patients you have seen in the last two months and how they have been treated (copy Diagnosis treatment and doses for each patient in last two months)

What kinds of things do you discuss with your FP patients? Your STD patients? Any HIV patients? What are the concerns these patients bring up with you? (counseling)

4 What do you find most satisfying about your job? Why? What do you find most difficult about your job? Why?

5 What support have you had from the project/MOH over the past 6 months (supervision supplies training etc) Are there ways this support could be improved?

What are ways you provide support to volunteers in the field? What do you need to do this better?

6 How do your supplies and drugs systems work? Have you had any stock outs in STD drugs family planning supplies or condoms in the past six months? If yes do you know why? How do you account for FP supplies and/or condoms that are given to others (CBD TH etc) to distribute?

WARD ATTENDANT/CLEANER (Chapananga HC)

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Are you doing anything different at your work as a result of this training? What?

SCHOOLS

PEAs, TEACHERS, PATRONS, STUDENTS

1 What do you see as the main benefits that Edzi Toto clubs have to offer? What are the most successful activities your club has done? Can you describe how things have changed (if they have) as a result of some of these activities? What are other things the club might do?

What are some of the effective health education activities? (if the murals are part of the school - How have the murals been used/made a difference?)

What difficulties do you find in doing your activities? What are ways the project could better facilitate these activities?

COMMUNITY VOLUNTEERS (CBD, HBC, DRF, (GMV TBA,)Water and sanitation, Sucoma peer educators)

1 What kinds of things do you do as a volunteer? How often? What do you like best about your job? Why?

2 What is going well in your job? Why? What do you find difficult? Why?

3 How has the project/MOH facilitated your doing your job? What could be done to help you as a volunteer? How about the community or the health committee?

4 Is what is expected of you reasonable? Is there a reasonable amount of work? Do you feel competent in doing what you are expected to do?

How have things changed in the community with respect to (FP/HBC/Drug availability/Water and Sanitation etc) How are things different as a result of your work?

(man to man village - Gola) CBDs - What is your success with reaching men? To what do you attribute the success or difficulty?)

CBD,HBC CLIENTS

Ask questions #6 and #5 from health committee list

NANKUNGWI/TRADITIONAL HEALER

1 What is your role with respect to health in this community? When are you consulted? How do you influence peoples actions or behaviors with respect to their health? Do you feel people listen to and follow what you say? Why or why not?

What kind of training did you receive from the project? What was helpful about it? What do you wish might have been done differently? Are you missing information you wish you had? What? Are you doing anything differently (either in your own life or with your clients) as a result of what you learned in training? What?

Nankungwi Youth - Ask health committee questions # 5 and #6

HSA

1 What are the activities in the community that take most of your time? Which ones are going the best? Why? Which ones are you having the most difficulty with? Why? What do you like best about your job? Why?

2 What kind of support from the project/MOH have you had to do your job? (training supervision transport supplies etc) How did it help you? What more could be done to help you do your job better?

3 What do you see as the strengths of your volunteers/committees? (all cadres) Of their programs? (CBD, HBC, DRF, Water etc) Are the ways these activities could be carried out more effectively in the communities?

1 What kind of training and other support has this intervention received from the STAFH project (training supplies reimbursements transport etc) How did it help your program? Are there ways it could have been improved?

PEAs - has the project had an impact on the capacity of the MOE to address the problem of teen pregnancy and HIV? In what way?

TEACHERS - Describe how if in any way the training on the AIDS curriculum influenced what you do in the class room

2 With the end of the STAFH project what kind of inputs will be needed to continue the Edzi Toto activities Do you have any ideas where this support might come from? What?

3 (TEACHERS/PEAS) Have you had any training regarding primary eye care? What is the benefit of this training? Do you see this as an important problem that teachers should be addressing? Why or why not?

MISC INTERVIEWS

POLITICIAN

1 What training did you receive from IEF/STAFH regarding HIV/AIDS prevention? Did you learn anything new or different from what you knew already? Are you doing anything different as a result of your contact with IEF?

2 Do you have suggestions of what role NGOs might play in advocating for health issues (AIDS prevention HBC, safe motherhood etc) through the political system?

SUCOMA/MONTFORT

Volunteers - (peer educators, HBC volunteers) - see volunteer questions under community
Health staff - See questions under health center

Management Staff

1 What has been the benefit you have seen to working with the IEF STAFH project? How has your organization capacity increased (if it has) as a result of this collaboration (training new programs personnel etc)

2 What difficulties have you experienced with this partnership? Why do you think this was? Knowing what we know now are there ways these could have been alleviated or better addressed (lessons learned)

3 Are there ways the project could better have helped you overcome the constraints and difficulties you experience in implementing family planning and AIDS preventions interventions?

4 How do you plan to continue the activities that have been supported by the project? What difficulties do you foresee in doing this?

FOOD SECURITY

Communal Garden - Participants

1 Explain to us how you have the garden set up who does the work who keeps track of the inputs and outputs who supervises etc? Whose garden is it?

2 What do you see as the benefit to having a garden like this? Is this the best way to reach this benefit?

3 What difficulties do you encounter in managing a garden like this? Is there a better way to do it?

4 What actually happened to the food that was harvested last year? Sold? Eaten? By whom? Is this what was supposed to happen If not why did it get allocated the way it did?

Soy/Groundnut Farmers

1 What convinced you to plant soy/groundnuts?

2 What has been your experience with this crop? Did you get a good harvest? Why or why not? What did you do with the harvest - eat it? Sell it? To whom?

3 Do you expect to continue planting it? Why or why not?

PROJECT MANAGEMENT (IEF AND MOH/CHAPS)

1 Human resource management - personnel policies staff development plan annual appraisals supervision (checklists?) etc
(IEF staff progress on CHAPS/MOH)

2 Planning process - participatory use of data dynamic ownership (both projects)

3 Financial reporting awareness of expenditures against budget

4 Increase in IEF capacity as a result of project(s) Ways to measure change in capacity

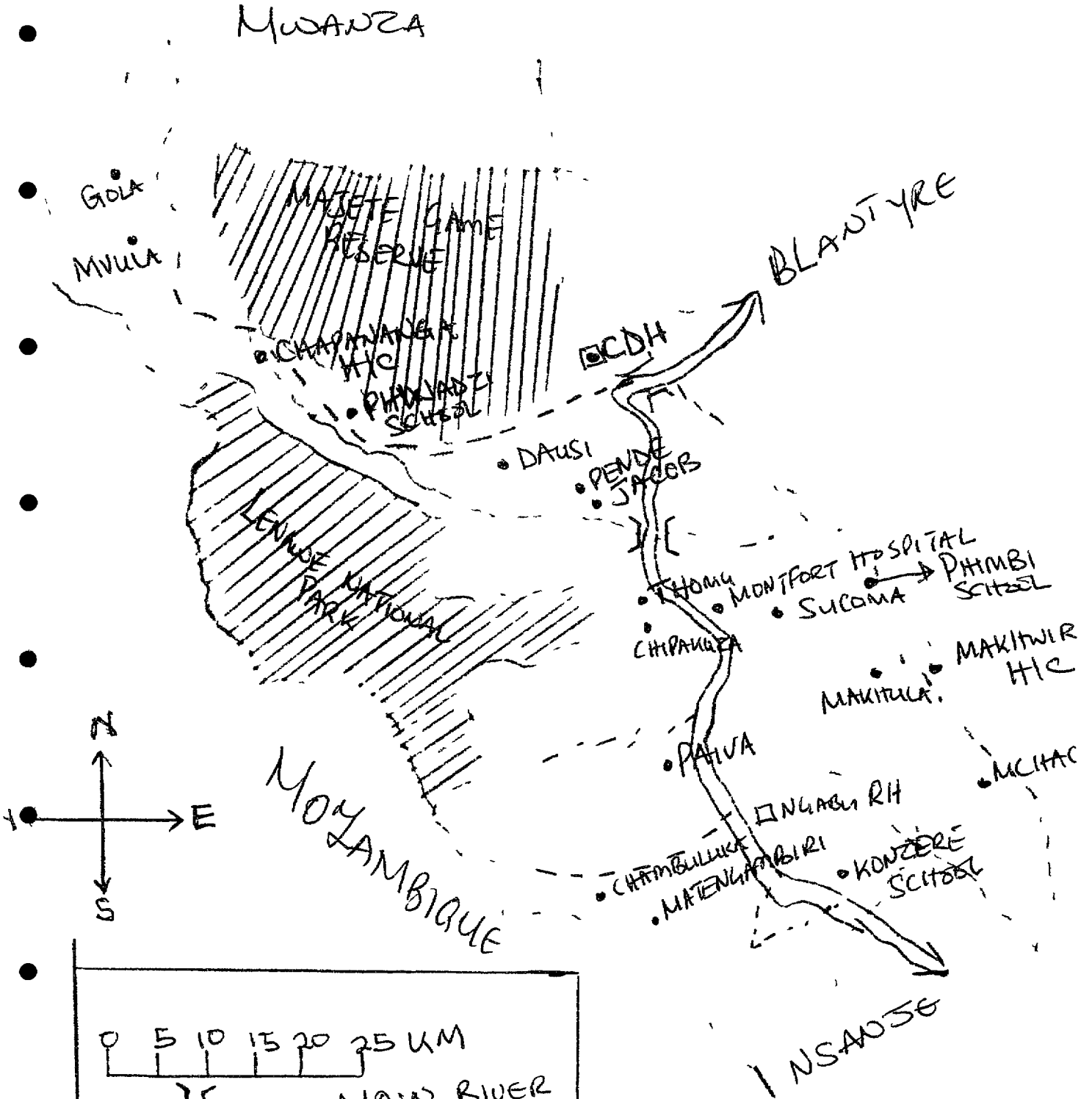
5 HIS system

6 Lessons learned

APPENDIX D

Map of Project Area (evaluation visits noted)

MAP OF CHIKWAWA DISTRICT



BY G KUTHOK

APPENDIX E

Evaluation Observations

EVALUATION OBSERVATIONS

NOTE The following observations reflect contributions from all evaluation participants They are essentially the raw data the team worked for the development of recommendations and have not been extensively edited

SCHOOLS

- It was also observed that PEAs and Patrons were on the great demand of refresher courses
- The murals are not used very much by pupils or teachers in class when discussing about HIV/AIDS and FP issues
- The club feels it has not benefited much from the project
- The club feels the Patron is a contributing factor to their failure of activities
- Female members are shy to contribute ideas
- The club members know most of the important points of HIV/AIDS and FP and not STDs Their activities focused much on AIDs and FP e g
    - Mode of transmission of HIV/AIDS
    - Prevention measures of HIV/AIDS
    - Partially, home care
    - Importance of FP and points of FP

OBSERVATION OF PEAs TEACHERS AND PATRONS

- Teachers are interested in learning FP/STD/HIV/AIDS activities to have more knowledge
- PEAs and Patrons were observed to have more interest with EDZI TOTO CLUBs as compared to teachers
- When asked about other things to be included in clubs the H/Master as well as teachers were observed to request IEF to include 'Malaria disease in the program
- Patrons were interested in Edzi Toto before they were chosen by H/Master
- Other teachers have less interest in club activities despite good things the club is doing
- Their support to club patron is inadequate that makes club/patron not to think of sustaining ability It's a one man operation and in addition to that the school has the problem of under staff
- It s difficult to measure the behavior change but it s there indirectly They re comparing these days to the past They indicate drop outs and expulsion due to pregnancies are not happening as it used to
- Teachers at Phwadzi Secondary School felt that the least sustainable activity is the organization of extension activities The main support needed is transport for Edzi Club members The club lacks strong leadership The MOE doesn't support the club in any way
- In Primary Schools club activities will be a bit sustainable with problems due to lack of things which can motivate them
- Other related lessons added to boost the club members morale could be First Aid TB Cancer Diabetes, Deforestation and others
- Phwadzi Secondary School Patron feels that the introduction of FP boosted the group
- Patrons in Phwadzi Secondary School suggested HBC activities could be introduced
- Problems with the cascade training model due to expectations for allowances make it difficult for PEAs visiting schools to train teachersThis could also be due to IEF not training deputies as promised
- Pupils meet on their own without patrons - He makes them meet but he doesn t come
- Edzi Toto Clubs do the same thing again and again
- Pupils requested T-shirts as ID deny having membership cards

- Students misinterpret the name of club, thus other students think that members of the club have AIDS
- Something has to be done for motivation e g incentives transport certificates etc
- Junior Primary Schools do not have EDZI TOTO - maybe more attention goes to Senior Primary Schools
- Patrons did not remember to mention zone competition even though they were number one (Phimbi)
- Competition prizes were for benefit of school Students appreciate prizes as an incentive
- Toto clubs also know pills and condoms for FP They mentioned avoiding teen pregnancy as a means to prevent mortality - body not ready (marriage girls 15/18 yrs boys 21 yrs)
- Supervision of Edzi Toto not usually included in PEA visits
- No system for briefing other teachers after training (no allowance) PEAs say they do not have transport for supervision even though they have motorcycles

D R F

- DRF has strong systems VHC measures stocks and money
- Drug prices set by VHC to be slightly less than grocery prices (Replacement cost not considered)
- MOH drug supply for DRF not working at all
- Makhula had 2 false starts (stolen money) but VHC recommended new drug stock
- Farmers in Gola said that this DRF usually only has Aspirin and Fansidar
- It was observed that the DRF in both villages are very active and cooperative Above all it was noted that they have enough drugs such as aspirin bactrim TEO fansidar and albendazole
- Farmers in Gola would like to have more than one DRF volunteer as they often find it hard to get drugs when he is away All farmers (10) reported using the DRF indicated medicine for the DRF can be purchased by themselves at Chipiku
- In Gola village there is one DRF volunteer and community has problem when he has gone out to the village for a few days
- Their DRF has difficulties with the community on the issue of completing the course of treatments
- People don't respect volunteer - think he is stealing money Gola DRF difficulty getting people to buy the full course of drugs
- It was noted that there was a long delay in receiving the drugs when they purchased an order at Ngabu Rural Hospital
- They were observed to be hard working and cooperating Sometimes they reported meeting Mr Gobede at Chikwawa for purchasing drugs
- It was observed that the volunteers were of importance to their community because of services they rendered

HC CAPACITY

- In charge of Makhwira HC complains that many staff members are sent to his area without having received any training
- In charge of Makhwira HC would like to receive training in care counselling Last time he got on HIV/AIDS was in 1992
- In charge of Makhwira HC claims that HC management team (MA Nurse HA) meets about every other month Last meeting was July 19 1999 but the next meeting has not been scheduled yet
- 3 clients referred to the HC were not assisted
- It seems his juniors are unruly as he kept complaining about them
- (Ngabu Rural Hospital) CHAPS/STAFH has really assisted in performing their work well

- -Tr ning (STDs OBD USC DA)
- -Transport
- -Renovations

- Makhwira HC don t get supervision support in administration and management e g Full DHMT support
- In charge of Makhwira HC states that transport is not the main reason why he is not making so many supervision visits rather he is too busy at the HC
- Health centers don't see themselves as managers Makhawira NRH
- Sucoma - 10 FP providers trained in IPPC and 7 in FP logistics management

CBD

CBD VOLUNTEERS

- He doesn t do a follow up on client who choose other methods e g Deco
- Dausi village CBDs were both hard working and proved to like their work They said they needed some more training to refresh them
- Dausi CBD- One is using pills but the other is using natural FP (I feel she is on traditional method)
- He feels refresher courses are the only remedy for problems e g CBDs report system
- CBD- Even though very elderly but seems dedicated and knows what she is supposed to do Works 3 days in a week
- The CBDA in Makhula village was observed to be a dedicated and alert Above all she was observed to be a good motivator
- He has managed to counsel 4 men on condoms as their method of contraception
- She acts as TBA as well (gathered from the VHC) Her main problem which she kept mentioning is that she inadequate supply of contraceptives
- It seems the CBDA under reports (improper use of tally sheet) that s why she gets in adequate supply of contraceptives
- He has too many activities ie CBD DRF and VHC which can eventually lead to poor performance
- People don t like foam Prefer Depo but use pills because of local availability Depo users try to convince them on benefits of Depo
- CBDs in Pende were selected by the headman who called them to his hut and told them that they are volunteers They were not told what they were volunteering for
- Refresher courses seems to him as a motivation in CBD works as allowances received was cited as an encouragement
- CBD Gola knew side effects & management / advice to give Knew advice for missed pills including need for using condoms as backup
- CBD want incentives such as T-shirt umbrella also refresher course
- Gola CBD thinks a male CBD is more effective since he can speak strongly and convince people in difficult areas
- The are some new developments in family planning which should be covered during refresher
- Registers generally well maintained and well used (to keep records of when people had appointments) First person in Makhula register was CBD herself
- CBD serving 4 school girls because they are too shy to go to HC Needed coaching to give both pills and condoms to school girls for protection as well as contraception - didn t seem to know much at HIV prevention

CBD CLIENTS

- Client doesn t know what to do in case of missed pills (especially 2)
- The clients were satisfied and their CBD even though some were after depo

- Sometimes was no possible for her to fulfil HC appointment dates but since the CBD is at easy reach there is no r oblem in getting re-supply of pills
- CBD Clients- Hs been on lofer for 4 years It was further observed that the client motivated his in-law who is currently using family planning (pills)
- Eight out of nine farmers in Gala report learning FP messages from their CBD The ninth person was a very old man

SUPERVISOR/COMMUNITY SUPPORT

- Support from the programme Training on DRF CBD communication garden and soya utilization
- Clients can help mobilize others CBD feels commitment to her clients can continue without allowance but does feel need for continued learning
- In charge of Makhwira HC thinks the main problem with the CBD is lack of supervision by the HSAs Hopes that the secondary supervision will improve things
- The community is not prepared to assist with CBDA in cultivating his/her garden on any other piece of work but they are willing to thank the services through token gifts
- Observed to lack contraceptives in some months of the year
- Observed to be supervised mostly by MOH HSA rather than an IEF member who goes there only once a month
- (Chapananga) Health Assistant was not oriented on CBD/FP and cant supervise HSAs/CBD on these activities
- He gets supervision frequently since he is near with his supervisor
- Supervision of Makula is a problem because the supervisor (HSA) was transferred to Chikwawa District Hospital and secondary supervisor (MA) too busy
- HSA knows the activities which are taking place in his catchment area as he was able to list them all
- CBDs should only be assigned to one village as they have other things to do to support their families
- CBDs in Pende appreciate the referral visits by the IEF
- Volunteer mentioned that supervisory visits from Chikwawa provide significant motivation
- NRH has two good motorcycles grounded which could be used in the field activities Transport organization very poor
- No transport for 2 CBD supervisors
- Gola CBD covers 3 villages - distance is a significant constraint (transport)

SUPPLY SYSTEMS

- The new reporting system for FP allows NRH to have adequate supplies of contraceptives
- CBDs in Pende and Fakolo villages have few clients and complain about long periods of stock outs
- Both HSA and HC in-charge for Makuwira HC say there are never any problems with contraceptives supplies but the CBDA of Machacha says she often does not get enough contraceptives from HSA
- Sucoma equipment for FP/STD not available (was supposed to come from JSI/STAFH)
- The Chapananga HC members reported to have enough contraceptives but they ran short of condoms in May June and July last year It was reported that they were stuck at Kukoma Health Center
- The FP logistic information system has assisted in easing stock outs of FP methods at Ngabu RH
- Necessary condoms were out of stock 6 out of the last 12 months hence few men using condoms regularly

- In-charge of Makb ,ira reports that he gets contraceptives soon after he sends his FP reports The same is true for vaccines
- HSA in Mchacha likes M4E - he makes up his own forms as there is a shortage of forms
- Condoms are not adequate at the HC The staff feel that they are only supplied for FP and not for casual use
- Chapananga HC complained of stock outs - condoms Gentamycin and Erythromycin - it wasn t clear why - They stated Chikwawa pharmacy had no antibiotics in August there was some problem with expiration?) Condoms went to Kukoma H/C They don t get enough condoms for both FP and AIDS prevention
- Sucoma - STAFH project assists in transportation of supplies
- Matron concerned that STD/FP equipment requested was never honored (JSI/STAFH)& project already ending
- Sucoma - logistic training assisted with decreasing stock outs

HSA - ROLE / CAPACITY

- HSA in Pende village is not aware of health activities in his village Many problems in the village appear to be due to the lack of supervision by the HSA
- Dausi HSA refers clients with normal Depo side effects to HC
- The HSA had a few problems compiling reports from the CBD
- HSAs said they liked their sanitation activities but communities visited didn t have adequate pit latrines
- HSA in Mchacha shows that HSA work with the village does not differ whether there is an active VHC or not - he works directly with volunteers
- He seems to know his job description well
- HSA was able to answer what he does, but he knew his job lacked guidance from his supervisors
- HSA has problems in keeping his bicycle in running condition as the hospital rarely gives spare parts
- HSA of Mchacha was last visited by his supervisor (HA) on August 17 1999
- HSA - Gola The HSA is a hard worker even though there are down falls in other activities conducted in that area The HSA has been assigned more work to be done in his area Hence others such as the U/5 clinics are not doing as well due to lack of supervision
- HSA is only being supervised during normal u/5 outreach once a month Hence the outstanding problems are not sorted properly while made other activities not to move well

PEER EDUCATION

- As peer educators they are not doing much on counselling since they seldomly visit people in their homes
- A lot of people request condoms from these volunteers
- Peers feel the trainings they have had has benefited them and more people are saved from HIV by use of condoms and unwanted pregnancies by use of FP
- Some members of the community insult these volunteers - get tired of the same old community education meetings
- Peer Educators - These peer educators are committed to their work because they combine their paid job with their health activities
- All peer educators had to be employees or spouses of employees in order to avoid problems with incentives

TH NANKUNGWI

- Willing to give out condoms but didn t get resupplied after the first batch

- Impact of Nankunf vis can not be assessed in a village as there are several of them They have both religious and raditional affiliations
- In charge of Makhwira HC thinks there is need for THs and community to be trained on malaria as a cause of convulsions as he sees too many kids dying because they were held up at the TH for too long
- TH Dausi willing to distribute free condoms especially to young men for protection against HIV/AIDS and STDs
- Traditional healers ask that health workers should visit her in order to educate her on new issues
- They requested refresher course to remind them on the information they learned
- He doesn t know what is going on in the village and health activities because he is not involved or visited by health personal
- TH in Jakobo received HIV/AIDS messages from TH committee (ie do not share razor blades prevent condoms) but no explanation why Says she would like to learn more abou HIV/AIDS
- He refers STD clients to the hospital after they have been on his treatment for three days and no improvement
- There is a good colaboration between them (healers) and government (hospital) compared to the past years If they have failed to cure certain disease they do send the patient to the hospital They do work together with others eg VHC TBAs CBDs DRF and HSA though these others are not supervising them
- The traditional healers are supervised by nobody apart from their chairman who stays in the same area
- On HIV/AIDS, the traditional healers still remember some of the important points eg mode of transmission On this one the mentioned sexual intercourse Preventive measures mentioned included avoiding sharing razor blades and using a stick per person to apply medicine
- He feels he is in partnership with the HSA because both are doing health related issues
- All treated STD cases are encouraged to bring their partners for treatment
- He cited Kulowa Kufa as one of the cultural behavior promoting the spread of HIV/ AIDS
- TH Makhula was able to mention all topics covered initial training HIV/AIDS, Family palnning, STDs and Primary Eye Care
- Patients refered are willing to go to the health facility for further management after seeing the TH
- Traditional healer Makhula remembered some modern family planning methods mentioned some common STDs and some common eye problems
- STD patients are treated for three days and if not better referred to a health centre
- TH were supplied with condoms during their initial training Since then no supply They are willing to distribute them to the community
- The chances of STD cure is 50/50 in his case as a TH
- Requested for refresher course to remind them what they have forgotten and new information
- Changed then practice ie one razor blade per patient No more injections from local people
- No more applicationfor local tropical drugs to the cornea Patients with blurred vision one refered to health facility
- He is looking for future training with much emphasis on HIV/AIDS & primary eye care
- Mentioned some signs & symptoms of a client with STDs (GC Syphilis)
- TH and health center staff in Mchacha consider their relationship as a partnership since they bothe deal with health

SUPERVISION /MANAGEMENT

- The secondary supervisor from the HC in assisting me too on top of the primary supervisor
- What to do when training of supervisors is wanted ' but supervisor staff is too weak (e g HSA)
- Routine visits by DHO improved soon after CHAPS came into the District

GARDENS / FARMERS

- 1/4 of germinated soya seeds is destroyed by worms and grasshoppers while 1/3 of groundnuts is destroyed from moisture They harvest soya in March and feed on it for three months After that ey are left with nothing They make Likuni Phala to feed the entire family - not just the kids
- Farmers in Gola say that their main limiting factor to increase production is seed (liked seeds of pigeon peas)
- Despite low production from soya/groundnuts they are still willing to grow these crops and would also like assistance with pigeon peas seeds
- Farmers in Gola do not appreciate the nutrition value of pigeon peas and how to make Likuni Phala with pigeon peas
- The community has been discouraged because no extension workers has been supervising them
- Last year they had a poor yield of soya because they planted late
- Client produced 3 bags peanuts (seeds not from project) and plans to sell 50% Doesn t know about adding peanuts to phala but does add to relish

COMMUNAL GARDEN

- Garden imput given to Pende village all went to the headman Some villages considered the community garden 'the chief's property
- People of Pende village did not appear to have a clear and realistic picture of how many people benefit from the community garden
- Soya and maize will be utilized to feed children and even parents to 470 families from a field of one hectare
- Most men are not taking part in communal garden

HBC/ COUNSELLING

HBC VOLUNTEER

- HBC volunteer has never been provided with condoms / gloves
- New the disease affecting people - volunteer renders physical support to her clients ie water collection and sweeping houses of pts
- Volunteers covering a wider area as a result transport remains a problem
- They require an identity such as a badge or uniform
- They should be given protective wears such as aprons gloves and masks just to protect themselves
- They require bicycles as an incentive but also to ease their problem of transport
- Had a wide area to cover but lacks transport
- Some clients refuse to be seen because the volunteer does not have any essential drugs as aspirin eye ointment

HBC SUPERVISOR

- Transport is not a problem to her because of the IEF staffh motor bike she was given but her volunteers have a problem of this issue
- Monfort counselling centre HBC supervisor counsels patient both in hospital and village
- Blood testing is not available at the counselling centre
- Monfort supervisor may be undercounting her clients
- HBC supervisor feels people are not coming for counseling because testing not available
- She was trained in HBC are care counselling in 1994 and 1995 Refreshed in 1999
- Advice for expanding HBC model
    - Build on existing programs
    - Keep it simple and basic using existing resources
    - Volunteers may be easier for MF to recruit than for govt

- She needs more support from the MOHP on terms of supervision and material support ie stationery and spare parts for her motorcycle
- Follow up of patients some times is a problem because it is a problem to identify homes
- HBC emphasis on the use of local available resources in communities and household of patient
- No coordination between Chikwawa diocese HBC programs and Monfort hospital despite Monfort being a Catholic institution
- She is working in 60 villages but has 32 volunteers from 30 villages
- HBC volunteers have no supplies, medical officer acknowledges this may be something they should consider Need to assess cost
- In charge of Makhwira HC thinks one HBC/village would be good but supervision of that many volunteers would exceed his HC s supervisory capacity
- HBC volunteer supervisor makes follow up of her 32 volunteer in 30 villages every month
- MF clinicians appreciate being able to refer to HBC when they are discharging sick patients
- She gets other support from Action Aid

HBC CLIENT

- HBC Volunteer has assisted me to improve my health though I am sick
- No health worker assisting me excluding the HBC volunteers
- I am getting a good support from my guardians because of the HBC volunteers advises
- Visited several times by volunteers appreciates the volunteers' support She lacks money to pay Monfort hospital for medical services

Village Health Committees

- Carries out home hygiene disease surveillance and Under five shelter construction
- Observations from Gola and Mvula - VHC encourages mothers to attend both ante-natal and under five clinics (mobilization)
- Members pointed out clearly that CBD DRF and gardens were for their own benefit (Gola)
- There is need to provide refresher course to those who were trained in 1997 in order to boost their morale It was observed the committee was only supervised once (Dausi)
- Suggestion to integrate the TH into village health activities - get HSA and VHC recognition
- Farmers in Gola see the HSA as one of their own - see him as a partner with the VHC (they think the MCH coordinator (who visits regularly) is the supervisor
- VHC members in Mchacha said they supervise the CBD/DRF volunteer regularly But they didn t seem clear on what supervision meant
- VHC in Gola and Mvula encourage mother to concentrate on FP methods in order to save their lives and have a better life for their children and themselves
- Lazo VHC presented themselves and the water committee (recently trained by Concern) but had no representation from the Village Headman
- Dausi committee secretary seemed to take a leadership role - might be better utilized even though he isn t the chairman
- CBD has difficulty mobilizing older women, and men - she thought the VHC might be able to help with mobilization (Makula)
- Nyalugwe VHC is distorted and falling apart - VHM is a dictator
- VHC in Pende is not well organized and does not assist the CBD
- CBDs in Pende have been without contraceptives for 6 mos
- There is a need to replace the drop out members of the VHC (Dausi) - no mechanism to address attrition
- Volunteers are not represented on the VHCs
- HSA in Mchacha thinks VHCs do not understand their role as responsible for health activities in their village

- Community Health Cente Committee is not functioning for Chapananga HC They need latrines and there is no way to mobilize self help for that task
- The VHC motivates ill people to go to the DRF and mothers to go to CBD and communities to go to communal gardens

Project committee - Sub-Cimmittee for Outreach Shelter - Mchacha

- Members were open (males) while females were unable to speak
- Questions meant for VHC committee were wrongly forwarded to project committee
- Members of the outreach shelter project committee appear to be confused regarding this role and the overlap with the VHC
- Outreach shelter committee members for Mchacha complains about too little sand and too many supervisors '
- Role of Project Committee - Provision of cheap labor for collection of sand bricks and water for construction
- Under five shelter getting assistance with cement, window and door frames Vehicle to assist in collection of bricks and sand
- District and HC supervisors confusing the builder community and HSA on the plan for the shelter

IEC Strategies

- Teachers have recommended drama as the best and most reliable way to teach others because it tackles the real situation – what is acutally happening in a day to day life
- Peers expressed that use of films and visual aids would help more in educating the community
- They also requested bringing Chewa videos for community education – suggested the local priest has a video machine
- Gola CBD – counseling means giving the necessary facts and information so FP clients can make a choice
- Ways of imparting knowledge for Edzi Toto groups include drama lecture questions and answers guest speakers, video shows
- A FP client managed to motivate four of her friends
- Pupils request exchange visits and guest speakers e g from the MOH
- Two messages on the murals are a supplement to material already in their syllabus
- The murals assist teachers and pupils as a discussion point for AIDS and FP

Politicians

- Politician suggested he could assist in gathering people together while the NGO could assist with disseminating information and transport
- (staff) concern that NGO affiliation with politicians could be taken wrongly

Sustainability

- Farmers in Gola say they intend to continue farming soya and groundnuts even though they did not have a good harvest this year
- Suggested sustainability for the E T club in the future might be through a communal garden or other IGA
- Sustainability of the clubs will obviously go down since they re used to getting something from IEF e g exchange visits, competitions, and regular supervision
- HSA collaborates with other exchange workers in his area (Gola)
- DRF is also keeping goats to support shortfalls but difficult because the person keeping the goats has become employed and not keeping them well
- Gola – the community can continue with activities when the project ends because they now have their own seeds and goats to support the DRF

Partnerships

- Sucoma – there are multiple reasons (staff turnover misunderstanding independence) why the phase over process may not be clear to everybody
- Sucoma management didn't know the project was ending, was concerned about continuing training and getting supplies regularly from MOH
- Sucoma is willing to sustain activities but is concerned because the Sucoma management doesn t support training costs and they feel they don t have enough internal trained trainers
- Sucoma communication between medical staff and senior management seems limited
- Sucoma reports no MOH supervision of FP or STD
- Montfort – the HBC supervisor didn t know here status upon the phasing out of STAFH
- Montfort was concerned there was no memorandum of understanding – the level of collaboration was implied but not defined
- Montfort was concerned that collaboration meetings with STAFH had fallen off since 1997
- The Montfort motorcycle is regularly maintained by STAFH (the supervisor salary also paid by STAFH – but the Montfort medical officer didn t realize it)
- Montfort feels awkward using MOH HSAs and HC staff to support their community activities – confusion over the health delivery area and what is the role of MOH in that area

Quality Assurance

- Makuwira – the in charge requires information on QA since he didn t know anything about it (HA has not been trained, but one of the QA team is at his HC)
- The FP Coordinator is concerned the numbers from their registers aren t reflected in their monthly reports
- Chapananga – health workers work as a team and hold staff meetings now as a result of their QA training
- People off to an excellent start at Chapananga, but had a difficult time defining quality services
- Chapananga sited they worked together to repair their sterilizer stove, and they are meeting together to identify and discuss problems
- They will need f/u and reinforcement of problem solving process
- The benefits of QA is it allows staff to identify problems and their solutions before seeking external assistance
- NRH doesn t see HC reports as they are sent directly to the District
- At NRH the QA process is not going well because the members are too busy with other activities People are absent (workshops) so it is hard to get together for a meeting
- There is no proper coordination between departments at NRH – e g no planning for transport use

<u>Sydromic Management of STD</u>

- Sucoma refresher course for syndromic management is a priority for continuing activities
- Problem that Sucoma doesn t seem to treat many patients – it may be a problem of confidentiality in the company clinic
- Sucoma – partner tracing is difficult because patients deny the proximity of the partners
- One health center lost their partner stamp – doesn t know how to do partner tracing now
- Montfort concerned that 100 STD pts /mo is few relative to their target population
- Contact tracing appears good at NRH – over 50% had brought partners
- Since 5/99 STD drugs have been in short supply at Makuwira HC – especially erythromycin
- Makuwira claim he and the nurse are trying to find aprtners but returns are low and HSAs not interested in assisting with tracking down partners
- Montfort – 4 technicians and 4 nurses trained in 1998 for 2 weeks
- Health education and counseling done for STD pts At NRH
- Drugs seem to be effective – no return clients at NRH
- Training has prepared the clinician to treat cases well without having to figure out the exact diagnosis

Misc

- Parva religious groups take a role in advising youth on HIV/AIDS
- Water - community didn t participate in siting the borehole
- Community needs a hand with spare parts – hasn t had them since they ere trained
- 3 teachers had eye training – PEAs knew nothing about it
- Community nurse wrote proposal to introduce CBD at Montfort, but not clear where that is now The nurse is transferred
- HC does 10 depo clients/mo at Gola
- Gola CBD has 34 active pill clients
- Chapananga – all new FP clients start with Depo – only on pills if Depo didn t work out
- There appears to be a discrepancy between the number of actual clients and the expected number at Makuwira
- Orphan care and youth activities are additional concerns not currently addressed by Montfort

APPENDIX F

Results of KAP Surveys Pertaining to STAFH Objectives

STAFH Project Final Evaluation

Key Project Objectives

1 Increase the contraceptive prevalence rate by 50% by EOP

Indicators measured

a 1) Women reporting using a contraceptive at the time of the survey (CBD villages)

Baseline (N=232)	EOP (N=207)	Increase from Baseline to EOP
24% [C I 17% - 33%]	41% [C I 31% - 51%]	+70%

a 2) Interviewees reported use of contraceptive at the time of the survey (District-wide)

Baseline (N=594)	EOP (N=289)	Increase from Baseline to EOP
24% [C I 19% - 29%]	30% [C I 23% - 39%]	+25%

* from survey for CS mid-term evaluation, July 1996
** from CHAPS baseline survey, October, 1998

b 2) Interviewees who do not plan to have a child in the next two years reported use of contraceptive at the time of the survey (District-wide)

Baseline (N=490)	EOP (N=242)	Increase from Baseline to EOP
29% [C I 23% - 35%]	36% [C I 28% - 46%]	+24%

* from survey for CS mid-term evaluation, July 1996
** from CHAPS baseline survey, October, 1998

2 40 villages have at least one CBD for FP methods

Indicator		
	# villages with at least one CBD	66
	total # of CBDs active at EOP	93

3 In villages wit CBDs, increase to 50% the level of men/women, 15-49 years, who have received FP information from a CBD

Indicator

a 1) Percentage of all current contraceptive users who give "CBD" as the source of their current method used (CBD-villages)

Baseline (N=56)	EOP (N=84)	Increase from Baseline to EOP
0%	25% [C I 13% - 41%]	N/A

b 1) Percentage of current users of the Pill or Condoms for FP who give the CBD as their source of contraceptive at EOP (CBD-villages)

Contraceptive	Women	Men
Pill	20/31 = 65% [C I 37% - 85%]	54%
Condom	0%	11/21 = 52% [C I 22% - 81%]

4 75% of all clinical staff having adequate knowledge about AIDS, FP and STDs

Indicator # health center staff having adequate knowledge about AIDS, FP and STDs

Post training tests (average score) 87%

5 75% of the health centers that have adequate drug supplies correctly manage STD cases

Indicator # STD cases correctly managed at health centers 413/469 = 88%

Sample analyzed records from 7 health centers for 2 - 3 months (i e Jun - Aug, 99)

6 Increase to 50% the proportion of men/women, 15-49 years, who know
1) modes of transmission of HIV
2) methods of HIV/AIDS prevention
3) correct condom use
4) four or more methods of family planning

Note 1) and 2) address the same issue as a person who knows how to get HIV/AIDS knows what to do to prevent infection with HIV

3) is very difficult to measure and the project did not attempt to do so

Indicators

a 1) Interviewees who could correctly identify AIDS (open question) (CBD villages)

BASE LINE		EOP	
Women	Men	Women	Men
90%	97%	92%	98%

a 2) Interviewees who had ever heard of AIDS (district-wide)

BASE LINE		EOP**	
Women	Men	Women	Men
N/D	N/D	88%	90%

* from survey for CS mid-term evaluation, July 1996
** from CHAPS baseline survey, October, 1998

b 1) Interviewees who knew what AIDS is and who knew at least one correct way of
getting AIDS (CBD villages)

BASE LINE		EOP	
Women	Men	Women	Men
88%	99%	98%	98%

b 2) Interviewees w o had heard of AIDS and who knew at least one correct way of getting AIDS (district-wide)

BASE LINE*		EOP**	
Women	Men	Women	Men
N/D	N/D	85%	96%

* from survey for CS mid-term evaluation, July 1996
** from CHAPS baseline survey, October, 1998

c 1 Interviewees who knew what AIDS is and who had at least one misconception about
how to get AIDS (CBD-villages)

BASE LINE		EOP	
Women (N=284)	Men (N=73)	Women (N=200)	Men (N=173)
17% [C I 11% - 24%]	20% [C I 7% - 36%]	3% [C I 1% - 9%]	6% [C I 2% - 14%]

	Decrease from Baseline to EOP in CBD villages
Women	5 7-fold decrease (-470%)
Men	3 3-fold decrease (-230%)

c 2) Interviewees who had at least one misconception about how to get AIDS (District-wide)

BASE LINE		EOP**	
Women	Men	Women (N=218)	Men (N=266)
N/D	N/D	4% [C I 1% - 10%]	3% [C I 1% - 8%]

* from survey for CS mid-term evaluation, July 1996
** from CHAPS baseline survey, October, 1998

d 1) Interviewees named methods of modern FP (CBD villages)

# FP methods known	BASE LINE			EOP		
	Women	Men	Total	Women	Men	Total
at least one	74%	85%	77%	90%	82%	86%
at least two	58%	62%	59%	87%	79%	84%
at least three	23%	24%	24%	56%	47%	52%
at least four	8%	7%	8%	23%	15%	20%

# FP methods known	**Increase from** Baseline to EOP		
	Women	Men	Total
at least one	+ 21%	- 3%	+ 11%
at least two	+ 50%	+ 27%	+ 42%
at least three	+140%	+ 95%	+116%
at least four	+187%	+114%	+150%

d 2) Interviewees named methods of modern FP (District-wide)

FP methods known	BASELINE	EOP **	
		Women	Men
at least one	N/D	71%	71%
at least two	N/D	67%	61%
at least three	N/D	39%	32%
at least four	N/D	12%	9%

* from survey for CS mid-term evaluation, July 1996

** from CHAPS baseline survey, October, 1998

7 80% of adolescents participating in anti-AIDS clubs know
1) modes of transmission of HIV
2) methods of HIV/AIDS prevention
3) correct condom use
4) four or more methods of family planning

Note 1) and 2) address the same issue as a person who knows how to get HIV/AIDS knows what to do to prevent infection with HIV

3) is very difficult to measure and the project did not attempt to do so

Indicators

a) Students who could correctly identify AIDS
Note as overall levels were above target, no breakdown by membership in EDZI TOTO clubs was done

BASE LINE		EOP	
Girls	Boys	Girls	Boys
96%	92%	99%	99%

b) Students who could name at least one correct way of getting AIDS
(Note as overall levels were above target, no breakdown by membership in EDZI
TOTO clubs was done)

BASE LINE		EOP	
Girls	Boys	Girls	Boys
96%	89%	100%	100%

c 1) Students who have at least one misconception about how to get AIDS

BASE LINE		EOP	
Girls	Boys	Girls (N=188)	Boys (N=192)
N/D	N/D	10% [C I 5% - 18%]	7% [C I 3% - 14%]

c 2) Students having ever belonged to an EDZI TOTO Club who know what AIDS is and who have at least one misconception about how to get AIDS

BASE LINE		EOP	
Girls	Boys	Girls (N=69)	Boys (N=78)
N/D	N/D	13% [C I 5% - 30%]	5% [C I 1% - 19%]

d) Students who named modern methods of FP

# FP methods known	BASELINE	EOP			
		Girls	Boys	Total	Total TOTO Club
at least one	N/D	97%	98%	98%	99%
at least two	N/D	83%	84%	83%	90%
at least three	N/D	57%	63%	60%	71%
at least four	N/D	23%	25%	24%	33%

8 Increase to 50% the number of prostitutes employed at commercial centers reporting use of condoms during last sexual act

N/D

9 Increase by 2[F] % the proportion of men/women, 15-49 years, reporting use of condoms during their last sexual act

Indicators

a 1) Reported having ever used a condom (CBD villages)

BASE LINE		EOP	
Women (N=232)	Men (N=74)	Women (N=185)	Men (N=171)
12% [C I 7% - 20%]	28% [C I 15% - 46%]	12% [C I 6% - 21%]	41% [C I 31% - 52%]

	Increase from Baseline to EOP in CBD villages
Women	0%
Men	+46%

a 2) Reported having ever used a condom (District-wide)
Note this question was not asked in the CHAPS baseline survey, see below for variation

a 2 1) Reported knowing that condoms prevent the spread of HIV/AIDS (District-wide)

BASE LINE		EOP	
Women	Men	Women	Men
N/D	N/D	87%	96%

** from CHAPS baseline survey, October, 1998

a 2 2) Reported havir ʒ ever used a condom to avoid getting or transmitting HIV/AIDS
(District-wide)

BASE LINE		EOP	
Women	Men	Women (N=253)	Men (N=295)
N/D	N/D	8% [C I 4% - 14%]	16% [C I 10% - 23%]

** from CHAPS baseline survey, October, 1998

b 1) Reported using a condom during last sexual act with regular partner (CBD villages)
Note of those who reported having ever used a condom (see 9 a above)

BASE LINE		EOP	
Women	Men	Women (N=42)	Men (N=74)
0%	0%	31% [C I 14% - 55%]	61% [C I 43% - 76%]

c 1) Reported using a condom during last sexual act with non-regular partner (CBD villages)
Note of those who reported having ever used a condom (see 9 a above) AND excluding those who gave "no non-regular partner" as reason for not having used a condom, those who responded "don't know" were included in the denominator

BASE LINE		EOP	
Women (N=49)	Men (N=44)	Women (N=5)	Men (N=45)
24% [C I 10% - 46%]	40% [C I 21% - 63%]	60% [C I 7% - 98%]	84% [C I 62% - 95%]

	Increase from Baseline to EOP in CBD villages
Women	+ 50%
Men	+110%

c 2) Reported usin a condom during last sexual act with non-regular partner (District -wide)
Note of those who reported having had casual sex during the last 12 months

BASE LINE		EOP *	
Women	Men	Women (N=5)	Men (N=28)
N/D	N/D	0%	36% [C I 14% - 64%]

** from CHAPS baseline survey, October, 1998

10 Increase by 50% condom distribution to men/women, 15 - 49 years

Indicator # condoms distributed in project area

Supplier	1996	1997	1998	1999 (Jan - Aug) [prorated for 12 months]	To
PSI	299,268	233,352	382,032	160,200 [240,300]	1,07
SUCOMA	N/A	222,486	180,000	77,652 [116,478]	48
IEF (MOHP)	48,000	68,200	80,200	14,210 [N/A]	21
IEF (PSI)	52,000	65,000	96,000	28,920 [N/A]	24
MOHP/FP	1,700	23,300	36,000	22,000 [33,000]	83
MOHP/AIDS	N/A	N/A	N/A	N/A	-
TOTAL	400,968	612,320	774,232	302,982 [393,877]	2,09

APPENDIX G

STAFH Achievements compared to Proposed Activities

STAFH ACHIEVEMENTS

INITIAL TARGET	ADDED TARGET WITH EXTENSTION	ACHIEVEMENTS
Condoms distributed throughout project area by PSI MOH CBDs traditional healers peer educators and village health committees Identify individual or agency to become official Chishango distributor		- Condoms distributed throughout district by PSI - this distribution system is probably more sustainable than developing an independent person/agency for Chishango distribution - Some condom shortages at health center level due to confusion in ordering between condoms for FP and condoms for AIDS prevention - CBDs distribute condoms regularly THs distributed once but are interested in continuing VHCs not well developed under this project - Sucoma peer educators each distributing up to 2 cartons of Chishango /month
HSAs and 120 CBDs will be trained in AIDS education and FP promotion	Remaining CBDs to be trained under CHAPS after supervision and supply systems have been strengthened - Train remaining 69 new HSAs for a new target of 134 total HSAs trained in FP promotion and AIDS prevention	- 65 HSAs received initial training in FP promotion and HIV/AIDS education as well as refresher training which also included reporting issues - 32 HSAs (those in CBD areas) received additional training in CBD management and supervision - STAFH trained 73 CBDs to make a total of 93 CBDs in the district It has provided ongoing refresher and supervision for all 93 CBDs These are working in a total of 66 villages (about 10% of the District) selected in clusters of underserved areas - 15 Additional HSAs trained for HIV/FP under the extension phase The one year extension was short to catch all 69 new HSAs
Train clinic staff in STD management and HIV prevention counseling using standard MOH protocol	Train 2 staff members per health center (total of 44 including 22 newly trained) in expanded training for syndromic management Assessment of training quality to be considered	- 44 clinic staff representing all one each from 11 health centers and 3 hospitals received initial 1 week training - 45 clinical staff representing at least two from each HC- majority but not all had been previously trained- received expanded 2

		week training in syndromic management and HIV prevention - STD training assessment carried out in Feb in all District HCs
Nurses from all District health centers except Montfort will be trained in FP provision and use of the hormonal check list	District MOH tak	- District MOH taking lead on FP provider training including use of hormonal check list - Trained 13 FP providers in interpersonal communication and counseling skills (IPCC) - Trained 30 HSAs (in additiona to those trained as CBD sueprvisors)as core FP providers able to administer the hormonal check list and distribute pills - Project trained 18 health center and hospital nurses representing 100% of health facilities as secondary supervisors for managing CBDs
BLM will provide TA to health centers on quality assurance for FP services	CHAPS will carry out quality assurance exercies including FP and STD treatment services	QA assessment carried out in 11/98 and initiation of participatory QA process at health center level underway under CHAPS
4 individuals to be trained in male sterilization techniques (2 Sucoma 2 MOH)	to be carried out under CHAPS	2 clinical officers and 1 nurse trained in VSC techniques for both men and women
Montfort also providing free STD treatment in spite of being paying hospital		Montfort receiving STD drugs from MOH and providing free STD treatment
Equip teachers at every primary and secondary school in the District to initiate anti-AIDS clubs	Extend coverage to new schools in District to include total of 157 schools (133 primary 3 secondary 6 private and 15 distant education centers)	- 132 active anti-AIDS clubs out of 157 schools - 264 headmasters and patrons trained in 132 schools 392 teachers in 131 schools trained in teaching AIDS curriculum - All 12 PEAs trained as trainers for supervising and supporting anti-AIDS clubs - 150 patrons from 75 schools trained in FP messages and ways to introduce them in the anti-AIDS clubs
Strengthen Montfort counseling center (Montfort was to) Recruit and train an additional 80 HBC volunteers beyond the 30 already trained by IEF	Same	- Center renovated - money provided to Montfort to pay salary of HBC/counseling supervisor - 32 HBC volunteers trained and refreshed and working in

		approximately 60 different villages They cared for a total of 240 patients and registered 1665 orphans Additional volunteers not trained due to lack of Montfort mobilization
Train and support peer educators for AIDS education and condom distribution activities		- 514 peer educators and a sub group of 40 peer educators supervisors were refreshed and supervised - Sucoma supervisor indicates there are currently approximately 120 active peer educators
Kapachira Falls community education and mobilization efforts in IGAs and AIDS prevention	Dropped out because IGA intervention because micro-enterprise perspective to IGAs was beyond the scope of STAFH	Project trained 6 CBDs and supported 2 drama groups in the area as part of their general District-side efforts
Emplovee HIV/AIDS education and condom distribution program for Impregiloat Kapachirla Falls	Dropped out due to tension between Group Five management and staff Working environment did not allow for effective occupational health intervention	Trained 1 nurse at Impregilo in syndromic management for STDs IEC activities were limited to employees during off-hours and to camp residents These activities were poorly attended due to the working atmosphere
Special health education targeting bar girls		- 162 bar girls originally trained as peer educators with emphasis on negotiation for safe sex condom use and seeking treatment for STDs - 48 bar girls (mostly new ones) were trained under the extension phase
Formative research to determine role of traditional advisors (nankungwis) in sex education and initiation of education program to target young women through these advisors	Had not been done at time of extension but kept as intervention	- Qualitative assessment done on role attitudes and practices of nankungwis - 281 nankungwis in eastern bank area of the district trained in AIDS prevention and FP
No initial plan to train traditional healers in proposal?	Plan to train 400 new traditional healers during extension project Explore involving them in condom distributon	- 633 traditional healers initially trained in HIV prevention under shilc survival and refreshed (with the addition of FP and eye care)under STAFH - 150 additional new traditional healers trained under STAFH (time ran short in one year to train all 400)
IEC Campaign for AIDS prevention and FP promotion to include drama groups, video shows sports activities music events etc		Multiple IEC activities including drama groups competitions Chishango night music shows etc - 150 murals depicting AIDS prevention and family planning

		messages have been painted on walls of 25 schools
Train VHCs and TBAs in addition to CBDs and traditional healers in community based education for AIDS prevention and FP promotion	Not done under STAFH because these are weak structures and require more inputs than were available under the project CHAPS will pick up the VHCs as part of overall community strengthening of health activities	TBAs still to be discussed
MISC ADDITIONAL ACTIVITIES	Train 11 political leaders as trainers for AIDS prevention in order for them to conduct educational sessions in their areas	- 13 political leaders trained but no apparent follow on activities have occurred - Project continues to pursue participatory interventions such as Stepping Stones gender training and Care Counseling training to encourage behavior change - Printing of FP cards and laminated hormonal check lists to assist with District supplies - Trained all 19 homecraft workers in FP motivation and HIV prevention - Trained18 HSAs in man to man" (some of these were already CBD supervisors or FP providers)

APPENDIX H

Summary of CHAPS Achievements
April 1998 - September 1999
(prepared by Joyce Naisho, CHAPS PM)

CHIKWAWA DISTRICT CHAPS SUMMARY REPORT FROM APRIL 1998 TO SEPTEMBER 1999
PREPARED IN SEPTEMBER 1999 BY JOYCE NAISHO

1 CAPACITY BUILDING

Planned Activity	Progress this quarter	Progress prior to this quarter	Plans for October/Dec 1999	Remarks
1 Project staff recruited	Project secretary hired	Project Manager, System Advisor, Training/QA Advisor, Community Health, DRF, PEC and Adult Literacy Coordinators and other project support staff hired	Two extra guards to be hired	Some members of staff from STAFH project will be transferred to CHAPS These are the HIV/AIDS FP supervisors and support staff N B these were not originally budgeted but project funds could adequately cater for their expenses
2 Office allocation for CHAPS Project	DHI, Accounts and CHAPS office complete and occupied	Not applicable (N/A)	1 Purchase any additional furniture required 2 All Coordinators and supervisors will move to the former STAFH office	List has already been prepared

Planned Activity	Progress this quarter	Progress prior to this quarter	Plans for October/Dec 1999	Remarks
3 CHAPS Project fleet	1 One four wheel double cabin pickup 2 Four motorcycles	1 Vehicle and motorcycles in good shape The vehicle is regularly serviced at Toyota motors 2 All riders have been taught on daily, weekly & monthly checks, and all motorcycles are serviced at Stansfield motors or by the Hospital mechanic	Project will need two office bicycles These were not planned for before but found necessary later	1 To be used for short errands 2 Mr F Chola takes the general management for all IEF CHAPS fleet 3 The accounting system for all ministries may change once the policy for decentralization is started

Planned Activity	Progress this quarter	Progress prior to this quarter	Plans for October/Dec 1999	Remarks
4 Project Management	1 IEF CHAPS Project Coordinators meeting	1 All coordinators meet with the Project manager monthly to discussions either technical and/or administration	1 75% of all the times and dates set for numbers 1, 2 3 and 4 have been successfully carried out	1 Although most of these meetings have been held regularly the CHAPS Project Manager will need to keep reminding the DHC and the hospital administrator Assist in drawing the agenda that will include project and general district issues
	2 Expanded DHMT meetings	2 MOHP & CHAPS Project issues are discussed in this meeting held regularly once a month		
	3 Expanded government and CHAPS budget meetings	3a Once or twice a month governed by time the HQ sent in funds for the district expenditure 3b CHAPS budget held every six months		
	4 Hospital general staff meeting	4 Once every three months for staff welfare and dissemination of new government policies and/or circulars		
	5 Ngabu Rural Hospital Health Management meeting	5 No regular meetings have been planned at NRH yet	5 NRH will need to be assisted to plan for regular monthly meetings for them to begin seeing themselves as a cohesive team	5 The NRHMT

Planned Activity	Progress this quarter	Progress prior to this quarter	Plans for October/Dec 1999	Remarks
5 Accounting System improved and computerized	1 Discussions with URC continued and a revised scope of work sent to Partnership for Health Reform Project (PHR) This project have now taken the task for financial management for all CHAPS Projects 2 Chikwawa expanded CHAPS team expressed the need for the TA to be available in the next quarter 3 The second computer has been ordered	1 The first accounting computer purchased 2 The accounting package that IEF for its accounts was installed This facilitates CHAPS Project accounts reporting system 3 Internal needs assessment for the government accounting system was done 4 Results discussed during QA meeting/workshop in May 1999 These gap in the findings was used to develop the scope of work for TA done 5 On job training for the Accounts clerk started and is being continued	1 Follow-up the purchase of the second accounting computer 2 Continue discussion with URC to put pressure on PHR for the accounts TA 3 Chola to develop a plan for training and on job training to be continued 4 PHR and QAP supplemental questions for financial management for CHAPS quality assessment to be completed and sent to QAP	

Planned Activity	Progress this quarter	Progress prior to this quarter	Plans for October/Dec 1999	Remarks
6 Stock control improved and computerized	1 Manual system was for stock control, was discussed by the management The store keeper was trained for stores and he, under the DHO's supervision started cleaning and reorganising stores	1 Kitchen stores management reorganised Two different staff members were assigned to receive and supply items for the day use	1 Close supervision for these two section need to be continued 2 A second store keeper has been posted to the District Follow-up needed	1 The DHMT had decided not to computerized its stock control system It was thought that it might be too complex
7 Detailed implementation plan (DIP), annual and monthly plans exist	1 Monthly plans for CBD program 2 Monthly plans for DRFs program 3 Monthly plans for outreach shelters constructions 4 Plans for primary eye care survey and training 5 Plans for Quality Assurance by the QA Core Team 6 Training Plans for various areas e g VSC, laboratory, adult literacy, etc	1 Detailed Implementation Plan in place 2 Annual for April 1998 to March 1999 exist and most activities planned were carried out within the year 3 Annual plan for April 1999 to March 2000 exist and activities are still being implemented 4 Program managers and coordinators use the annual plans to draw out monthly plans These help management in budgeting	1 Planned activities to be continued 2 Budgeting for planned activities	1 Some activities may flow into next planned This should be considered when plans for April 2000 to March 2001 will be developed

Planned Activity	Progress this quarter	Progress prior to this quarter	Plans for October/Dec 1999	Remarks
8 Government vehicle management plan exists and is implemented	1 Continued repairs and regular service for all vehicles and motorcycles 2 Discussion and planning for retraining for Chikwawa District Hospital motorcycles riders 3 Continue the monthly transport committee meetings 4 Site for vehicle repair shade have been identified and plans have been drawn	1 Plans for getting technical assistant for the fleet management were developed TA procured and fleet management plans developed 2 Fifteen motorcycles ordered and received 3 Four tone track purchased and in full use	1 Shade for repairing vehicles at the hospital to be built 2 Reinforcement of the plans laid down for fleet management This could well be done through discussions and regular meetings by the transport committee	1 The current cost for vehicle maintenance is extremely high This is because of the age of the vehicles and lack of maintenance before the start of the project 2 Continue support for fleet (monitor implementation for plan, use of the supplementary fuel)

Planned Activity	Progress this quarter	Progress prior to this quarter	Plans for October/Dec 1999	Remarks
9 Personnel management plan including a QA plans exists and is implemented	1 Four staff members trained as QA Trainers and Coaching 2 QA Teams trained in MRH, Gaga H/C and Chapananga H/C	1 Former DNO, DHI and late Ms Jamu were trained in QA District education Officer, Current DHI and MCH Coordinator, the CHAPS Training/ QA Advisor and the CHAPS Project Manager were trained in QA too 2 Quality Assurance assessment was carried out The report was written, recommendations drawn, priorities set and interventions started	1 Discussions held with QAP to help train replacements 2 Continue support for QA Core Team 3 QA Core Team continue training health centre QA teams 4 Train supervisors, implement and monitor supervisory system 5 Train incoming CHAPS Project Manager and Training/QA Advisor in QA	1 Most of those trained in QA have been transferred Therefore need to train others 2 QA training strategy to be extended to the HSA level 2 Middle level management to be strengthen as advised after the mid term evaluation

Planned Activity	Progress this quarter	Progress prior to this quarter	Plans for October/Dec 1999	Remarks
9b Staff development	1 Clinical officer completed IMCI training 2 Two clinical officers finished VSC theory and are doing practicals One Registered Nurse completed VSC support training and is undergoing practical training 3 Mr K Chikonde, Senior CO and Acting DHO has had an orientation on HIV/AIDS in Zambia 4 Thirteen health officers from Chikwawa district Hospital, Ngabu Rural Hospital, IEF MICAH and CHAPS had a two week training in IEC The training covered the process for IEC and development for the District	1 Mr Mgeni, Accounts Assistant on job computer training continuing 2 Mrs Y Uzamba and Mrs Harawa on job computer training continuing 3 Mr Semu trained on spreadsheet 4 Electrician trained on radio maintenance 5		

Planned Activity	Progress this quarter	Progress prior to this quarter	Plans for October/Dec 1999	Remarks
10 HIS exist that satisfies the information needs at all level of MOHP and the communities	1 HIS workshop carried out and a plan for collecting, processing, reporting and using the health information was set 2 A planned for monitoring HIS was set 3 Information for writing the 1998 District Annual report was collected analysed and the report completed	1 All HSA reporting forms collected for review 2 Data for developing the five years District planned collected and a plan developed in collaboration with the national planning unit	1 Possible review of the HSA reporting forms 2 Continue assisting the District in collecting all the activity data	1 This was one of the very weak areas A lot will still need to be done to improve the recording system
11 Cost sharing plan is developed and implemented	2 District cost sharing account opened	1 Discussions for ways of raising funds for cost sharing discussed at DHMT 2 Preparation for cost sharing carried out (application and discussions with headquarters done)	1 Develop the plans discussed for raising cost sharing funds	1 Private ward not yet possible It was found to be too demanding The District might not adequately manage
12 District IEC is developed and successfully implemented, with emphasis on community education	1 Competent IEC consultant to be identified 2 Some IEC materials available e g for FP, HIV/AIDS, TB Bilharzia, Health Education Calenders and Nutrition posters with messages collected	1 IEC needs assessment to be carried out The results were then used to develop the scope of work for the IEC TA	1 Complete the IEC report 2 Develop any necessary IEC materials 3 Put into practice the plans developed	

Planned Activity	Progress this quarter	Progress prior to this quarter	Plans for October/Dec 1999	Remarks
13 Health facilities and equipment have been assessed and improved with focus on NRH	1 IEF USA office organising for shipment 2 Eight VCS kits added to the original equipment orders	1 Theatre equipment for NRH and CDH ordered 2 IEF USA office received quotations that were then approved by DHMT	1 Follow-up on equipment ordered through IEF USA office	

PROJECT INTERVENTIONS

Objective 1 Increase Access to Reproductive Health

Objective 2 Increase HIV/AIDS Awareness and Prevention through Condom Promotion and Female Adult Literacy

1 Provision of centers for reproductive health care services	1 Construction and/or renovation for eight outreach shelters started	1 Needs assessment for outreach for seventeen outreach centres carried out	1 Continue and complete renovation/building for the eight completed shelters	1 Report for needs assessment available 2 Constructions are at different stages for the different shelters 3 The costs for the renovation are shared between the community and the project

2 Increasing of family planning providers at the health centres level	1 Four Family planning providers trained in IEC 2 Three FP providers trained as trainers for CBDAs and HSA supervision	1 MOHP has posted four community nurses with FP training to District One is based at CDH and three at H/Cs 2 Seventeen Family planning providers trained for CBD program		1 Regular follow up for FP providers needed 2 Training on supervision for FP providers 3 See other needs from QA assessment report
3 Providing tubal ligation and vasectomy at NRH and CDH	1 Staff for VCS are still undergoing practical training at BLM These are done twice a week	1 Two COs and one SRN had theory and some practical training in VSC	1 The three staff members to complete the training and examined by Prof Lema (BLM will arrange and inform on date for examination)	1 SRN or Community Nurse from NRH to be trained in VSC 2 Anaesthetist for NRH hospital to be identified and trained

4 Enabling NRH to handle minor surgeries including caesarian sections	1 Renovation of former stores, kitchen and laundry for theatre started on 15th September 1999 2 Eight VSC kits added to original equipment list IEF USA office is organizing for equipment shipment	1 NRH visited, state of buildings checked, and identify one suitable for a theatre 2 Committee for renovation set 3 Current kitchen/store earmarked for renovation 4 Plans for new stores, kitchen and laundry drawn 5 Search for quotations carried out and two contractors identified	1 Close supervision for construction for DHO and PM at least once every two weeks 2 DHI to visit work once a week	1 Malnourished children had no place for feeding, therefore a space for them will be provided at the renovated structure
5 Increasing the number of CBDAs	1 Forty six (46) CBDAs and 14 primary supervisors had refresher training 2 Needs assessment carried out two days prior to CBDAs refresher course Combined findings i e HSAs and CBDAs identified problems were then used to determine refresher courses content	1 Needs assessment for primary supervisors was carried out The report was used to bridge the missing gaps on CBD	1 The CBD program in Eastern Bank and Chikwawa has unique problems Therefore focus group discussions in 10 villages in these areas will be carried out 2 This FGD will give direction for appropriate intervention	1 The additional CBDAs will be trained in Dec 1999/Mar 2000 quarter

6 Offering Norplant at CDH and NRH				1 Awaiting MOHP policy for Norplant at district level
7 Empowering women in negotiation skills through adult literacy	1 Searched and reviewed six available training adult literacy training materials 2 Six supervisors trained in LePSA method 3 Twenty instructors (20) trained on Learner-centred, Problem Posing, Self discovery, Action planning (LePSA) method of teaching 4 Ten VHC members from the 20 villages where the women were selected for adult literacy have been trained in the new approach for adult literacy 4 317 women started literacy classes in August	1 Coordinating committee set (Members from MOHP/CHAPS, MOWA&Y and MOE) 2 All manuals, curricula collected 2 Supplementary materials for family planning and HIV/AIDS developed 3 Stationery, blackboards & chalk purchased and distributed to all instructors	1 The ongoing classes will complete in May 2000, therefore these classes will continue till then 2 Adult literacy instructors will be trained as trainers (TOTs) in Family planning and HIV/AIDS in October 1999	1 Progress so far is good Strong team from MOHP, MOWY&CD and CHAPS 2 Classes take 10 months

8 Providing IEC services to child bearing women	1 Four FP providers trained in IEC 2 Safe motherhood Coordinator trained in IEC 3 Available materials reviewed and field tested 4 Three appropriate video tapes on FP and HI/AIDS counselling have been ordered	1 IEC needs assessment was carried out 2 Report being used for IEC needs 3 Plan for revised health talks	1 Develop new IEC materials as identified during the IEC workshop	1 Safe motherhood Initiative (SMI) unit from HQ have promised to support a video tape to be developed at district level Need to follow-up
9 Distributing condoms at rest houses and bars, at health facilities and traditional healers	1 Needs assessment questionnaire revised	1 First draft for needs assessment developed	1 Carry out needs assessment	1 Needs assessment may not be necessary, (see mid term evaluation report)
10 Allowing volunteers to sell MOHP condoms	Nothing done yet	same	1 Nothing planned for this period	1 Need discussion at DHMT level (Note reason for this suggestion was for volunteers to have some little source of income)

Objective 3 Increase the Participation of Community Members in the care for AIDS Patients

1 Promoting Home Base Care (HBC)	1 A working committee was set (members from IEF STAFH Project and MOHP/CHAPS) 2 Malawi study on AIDS and HBC literature reviewed		1 Explore means and ways for HBC	1 HBC is still a grey area, nothing much was done (Note some suggestions from mid term evaluation)

Objective 4 Increase Access to Drugs for Community-Based Treatment of Malaria, ARI & Diarrhea

Objective 5 Increase Access to and Acceptance of ORT, Diarrhea Prevention and Exclusive Breastfeeding Messages

1 Reviewing and mapping out the current DRFs	1 Community awareness has been raised in ten (10) villages with non-active DRFs 2 Communities in these villages were assisted with guidelines for selecting volunteers for DRF management training	1 Needs assessment carried out 2 Map for existing DRFs prepared 3 Plans for DRFs activities developed	1 Ten (10) members from each of the first 8 non-active DRFs will be trained in October 1999	
1 Regularization of the supply of ORS to GMVs	1 Nothing this quarter	1 List of active and non-active GMVs established There are --- active and --- non-active GMVs 2 ORS has not been available at CMS		1 Continue support for GMVs

2 Providing IEC using relevant materials	1 Relevant IEC materials for Diarrhea prevention and Exclusive B/F were include in the master IEC plan		1 Assist in procurement or development of the planned IEC messages	

Objective 6 Improve Access and Acceptance to Consumption and Preservation of Protein, Oil and Micronutrient Rich Foods

1 Increasing the number of farmers growing protein, oil and micronutrient rich foods	1 Thirty two percentage of farmers grew groundnuts, 61% grew sorghum, only 3 4% had soya and 50% grew pigeon peas (Baseline survey results) 2 Plans for 1999 season have been developed 3 75% of farmers and household who were involved in either individual or communal farms have been trained on soya utilization	1 Baseline survey carried out 2 Data entry and analysis completed 3 30 household in Gola area issued with groundnuts and soya seeds October 1998 4 100% yield for cassava 5 20% yield for soya 6 Soya seeds and groundnuts have already been purchased for 1999 season 7 In response to MOHP nutrition unit, 15 communal gardens were set Nine were successful 8 All the farmers who harvested had a good groundnuts harvest returned 12kgs each This will be distributed to other farmers interested in growing groundnuts	1 Finalize report	

Objectives 6 Increase Access to and Acceptance of Preventive Eye Care Services in the Community

1 Expanding and providing training to Traditional Healers (THs) on primary eye services	1 No baseline done 2 No training done yet and so supervisory plan yet			1 This was found not to be necessary 2 Training to be planned for next quarter
2 Increasing the number of schools screening primary one entries and any other children transferring to the school	1 No teachers trained during this period 2 Fifteen health (15) workers trained in July 1999	1 Sixty (41) teachers trained in from 25% of 130 schools a basic eye problems b Their role for preventive care for pupils c Techniques in vision screening and low vision 2 Twenty seven (27) health workers trained in April/May 1999		1 Although not in the original plan it was found necessary to train health workers in preventive eye care especially from H/C They will be the TH supervisors 2 Before training a need assessment was done with the following findings, 72% heard about PEC but only 32% trained Less than 20% knew of s&s for trachoma and corneal ulcer Most did not know Vit A dosages 3 Training was then done
3 Chikwawa cataract & trachoma survey	1 Completed in August/Sept 1999 Data entry complete			1 This was not in the original plan but was found to cover the baseline that was planned for THs, school teachers and pupils Result will be used for PEC and rehabilitation for cataract blindness and any other necessary intervention

APPENDIX I

Recommendations and Lessons Learned

RECOMMENDATIONS AND LESSONS LEARNED

INTERVENTION SPECIFIC RECOMMENDATIONS

SCHOOL PROGRAM (STAFH)

Lessons

1 Addition of family planning information has increased participation at the club level
2 Lack of Ministry of Education and District Education Office ownership for the Anti AIDS club program makes sustainability difficult
3 Involvement of the Peer Education Advisors (PEA) in the Anti-AIDS club program created a potential linkage for sustainability

Recommendation

IEF should hold a Change of ownership' meeting for all PEAs representatives from health centers and DHO/DEO representatives to

a Discuss findings from the final evaluation
b To give participants an assignment to meet together and develop a work plan for the Anti-AIDS clubs and other school based activities for the coming year and
c To offer them a fixed amount of support funds per school (to be determined by the DHMT working from the CHAPS budget) which they could use to support their activities These funds would only become available upon submission of a proposal for activities with a means for monitoring their implementation

COMMUNITY BASED DISTRIBUTORS FOR CONTRACEPTIVES (STAFH, CHAPS)

Lessons

1 Long distances required to cover several villages make mobilization and follow-up of clients difficult for CBD volunteers
2 CBD volunteers do increase access to family planning Availability of methods at the village level is appreciated by users However several users indicated they were using pills because they were available in the village while they would prefer Depo Provera
3 Trained village volunteers are capable of delivering essential family planning information and services
4 Male CBD volunteers are able to provide family planning services to both male and female clients
5 Although important the idea of reproductive goals is still far from the understanding of village clients
6 CBD mobilization positively influences the acceptance of tubal ligations

Recommendations

1 The *perception* of adequate supply at the health center and community levels needs to be considered when distributing contraceptives (If providers perceive their supplies to be few they sometime under -distribute supplies to clients - even if their actual supplies are adequate)
2 Continue to strengthen the secondary provider (family planning providers at the health center) role as a means to assure support for CBD activities even if the supervising HSA may not be strong
3 Complete the CBD training as planned under STAFH and CHAPS with the addition of at least 28 more CBD volunteers
4 Encourage CBD clients to also be family planning motivators

HOME-BASED CARE / HIV-AIDS COUNSELING (STAFH, CHAPS)

Lessons

1 The STAFH inputs appear sufficient to leave a sustainable HBC/counseling intervention within the Montfort Hospital context
2 Montfort Hospital s responsibility for the recruitment and payment of the HBC supervisor even though it was with STAFH funds improved their ownership of the HBC program

Recommendations

1 HBC volunteers should be provided with personal protection (e g soap and gloves)
2 CHAPS with the DHMT should identify and support a HBC committee to recommend and pilot a feasible HBC delivery model including provision of minimal supplies Lessons learned from the Montfort experience should be considered

SYNDROMIC MANAGEMENT FOR STD TREATMENT (STAFH)

Lesson

Clinicians appreciated the syndromic management training and recognize its importance The three total weeks of syndromic management training (one week initially then two weeks expanded sundromic management training) seems to have been enough to achieve appropriate treatment (drug selection and dosage) assuming correct diagnosis Providers also understood the counseling value and partner identification issues that come with the problem

Recommendation

Include review of STD drug stocks and STD registers as part of routine supervision of clinical practice No additional training recommended at this time except to replace staff lost through attrition

TRADITIONAL HEALER TRAINING (STAFH, CHAPS - eye care)

Lesson

Traditional healers are interested in learningabout Western views of medicine and are willing to change their behavior They are also willing to promote healthy behaviors in the community

Recommendations

1 Traditional healers should be considered as part of the community s health team As such regular contact between them and HSAs health committees and MOH staff should be encouraged
2 Traditional healers should be supplied with free condoms for distribution

NANKUNGWI TRADITIONAL ADVISOR TRAINING (STAFH)

Recommendation

Carry out a simple assessment of the nankungwi intervention Apply for separate follow-on funds if determined that it did work well

PEER EDUCATORS - SUCOMA (STAFH)

Lesson

The requirement that the peer educators be Sucoma employees or their spouses is a significant advantage for sustainability

Recommendations

1 De-emphasize the community meeting/group education component of their responsibilities and strongly emphasize their distribution of condoms
2 IEF staff should meet with the Sucoma staff who are involved with the peer educator program to hand over STAFH activities and to assist with development of the next year s work plan (Note this may also include joining the medical officer in a meeting with senior Sucoma staff if he thinks it would be helpful)

POLITICIAN EDUCATION (STAFH)

Recommendation

While political leaders are interested in health issues and are potential allies for health interventions a formal relationship with them through provision of training is potentially complicated IEF could support non-partisan efforts at the national level

DRUG REVOLVING FUNDS (CHAPS)

Recommendation

1 The DRF committee should continue working on
   a The Drug resupply system so that it is functional at the health center level This will need to take some kind of cost sharing accounting system into account
   b Ways to train volunteer replacements when original DRF volunteers leave
   c The community system for oversight and ownership of the intervention
   d Ways to educate the community on appropriate drug use

SEED DISTRIBUTION (CHAPS)

Lesson

Seed distribution even if with limited other inputs can be well accepted and sustainable

Recommendation

The seed distribution should be expanded but substituting other protein foods such as increased ground nuts or pigeon peas for soya should be considered Farmers also need to be trained to use these in making porridge for young children

COMMUNAL GARDENS (CHAPS)

Recommendation

Even though this is a difficult intervention the project should select the successfully producing villages (those where the cooperative gardening is working) but place a much stronger emphasis on the goal of malnutrition prevention (as contrasted to just communal production) Lessons learned should be documented and used to develop recommendations for continuation of the program (or not) next year

SPECIFIC INTERVENTIONS - not addressed in depth during the evaluation

WATER AND SANITATION (CHAPS)

Recommendation

A couple of representatives from CHAPS (e g DHI IEF) should go through a simplified midterm evaluation process with Concern Universal to assess progress and to assure collaboration and consistent messages between the different components of the CHAPS project at the community level

PEER EDUCATION FOR COMMERCIAL SEX WORKERS (STAFH)

Recommendation

Although potentially an important intervention, there is increasing recognition that all women/people are at risk and specially targeting commercial sex workers may not be the most effective use of resources for AIDS prevention The CHAPS project should continue to assure condom availablility at bottle stores and trading centers but should probably not continue to spend resources on special trainings for bar girls unless additional funds for that purpose are procured

ADULT LITERACY, TRAINING OF TRADITIONAL HEALERS AND TEACHERS IN PRIMARY EYE CARE AND SCREENING (CHAPS)

Too early in these interventions to assess or make recommendations

INCOME GENERATION AND HEALTH EDUCATION ACTIVITIES FOR KAPACHILA FALLS

Recommendation

1 Continue to consider the Kapachila area for community level interventions like any other underserved area of the District
2 Encourage the Escom doctor to include and expand the partner identification and treatment component of his STD program Provide the necessary advice and training for this effort

WORK BASED AIDS PREVENTION INTERVENTION WITH KAPACHILA FALLS PROJECT

Lessons

When dealing with short term contractors it is difficult to get management support for health activities
There is a limit to how much you can work directly with workers who are often displaced and disenfranchised in these settings

ADDITIONAL CHAPS INTERVENTIONS

IMCI

Continue the process of implementing IMCI in the District through the training of the Chikwawa clinical officer as an IMCI trainer and encouraging its implementation in the District

TBAs

Although this did not originally figure in the CHAPS proposal and work plan the MOH is actively working to increase the training and supervision of TBAs in the District With this in mind the CHAPS project should use its resources to

- Add TBAs to the supervision and support structure already being established to support the DRF and CBD activities in villages (VHCs HSA primary supervisors and health center secondary supervisors)
- Review 1/ the criteria for selection 2/ the mechanism for replacing those lost through attrition and 3/ the content of the curriculum to be sure it reflects the state of the art for maximizing the effectiveness of TBAs in preventing maternal mortality and promoting maternal health in the community

CROSS-CUTTING ISSUES

MANAGEMENT AND SUPERVISION

Lesson

Improvement of the transport system has positively impacted morale and supervision at all levels of the District

Recommendations

1 Supervisors need to be trained in the responsibilities of their subordinates (CBD QA etc)
2 All health centers and Ngabu Rural Hospital need to put a management structure (health center management team) in place to oversee day to day operations and resource allocation (e g transport outreach activities supervision reporting etc) CHAPS/District MOH should assist with this process
3 Reinforce relationships between secondary supervisors (health center staff) and village volunteers (for CBD DRF etc) particularly when there may be difficulties in getting supplies into the hands of the volunteers

SUPPLY SYSTEMS

Lessons

1 The recently introduced contraceptive logistic system (CDLMIS) made a difference in contraceptive availability in the periphery
2 The splitting of condom distribution responsibility between family planning and AIDS sections has resulted in problems with condom availability at the health center level and below

Recommendations

1 CHAPS should provide the FP/STD equipment that was identified as needed but not supplied by the JSI/STAFH project

2 CHAPS should facilitate problem solving between the FP and AIDS Coordinators at the District level for efficient condom distribution Advocacy for chanign the system at the national level should also be considered

CAPACITY BUILDING

Recommendation

Although the CHAPS project has put a lot of energy into capacity building of the DHMT the considerable turnover of staff makes it difficult to establish institutional memory at that level The project should balance these efforts with strengthening and capacity building at the health center and community levels for increased sustainability More specific recommendations have been outlined in the sections on HSAs and management and supervision

OTHER PARTNERSHIPS

Lesson

Early in the STAFH project the project advisory committee (PAC) which was made up of MOH IEF Montfort and Sucoma provided a forum for addressing program implementation and management in general The dissolution of this group may have led to a loss of clarity regarding specific project activities and the plans for handover among these participants

Recommendations

1 Do formal handover including written letter and meeting with management to assure details (e g payment of HBC supervisor salary continued condom supply etc) are not dropped in the process of phasing out (see also specific recommendation for Sucoma peer educators)
2 Review and strengthen the role of the District Health Technical Coordinating Committee (DHTCC) or other District structures to assure a forum for communication and problem solving of technical as well as management and supervision issues for all health players in the District

QUALITY ASSURANCE INTERVENTION

Lesson

The thorough planning and training for the implementation of this process means the quality asssurance team feels well trained and competent in training health center staff and in pushing the process forward

Recommendation

This is a promising process being recommended for expansion at the health center and even community level However solid follow up is should be emphasized and reinforced

- for the QA core team so they are clear on their support role
- and for the health centers and community committees by the QA core team and staff supervisors

HSA ROLE

Lessons

1 HSA supervision of CBDs in the current system depends too strongly on the quality of the individual HSA
2 Transfer of HSAs makes it necessary to plan for regular training systems (even if it is on the job training) for special HSA programs (such as CBD water maintenance DRF etc) to assure continued supervision of these programs by incoming replacements

Recommendations

1 Explore ways to extend the team problem solving approach to supervision of HSAs and to the HSA supervising the community
2 As CHAPS activities are extended to the health center level and HSAs the problem of HSA transport (bicycle distribution and maintenance system) needs to be urgently addressed

3 Since HSAs are crucial for the success of community activities as effort should be made to pull weak ones to posts where they can be supervised and fired if necessary

VILLAGE HEALTH COMMITTEES

Recommendations

1 VHCs need training including implementation of a system for training replacements when attrition occurs
   a All PHC activities occurring in their particular village (CBD DRF water gardens growth monitoring etc)
   b How to provide oversight and support to village volunteers
   c How to organize regular community meetings on health in order to increase general community participation and ownership
2 Train and work with all District HSAs to apply the problem solving process (as initiated under the quality assurance intervention for CHAPS) in organizing and training VHCs
3 Select 10-20 very active VHCs to focus on strengthening the community/VHC/HSA/health center relationships and collaboration through more active implementation and supervision of the problem solving process Document the experience and lessons learned

IEC STRATEGY

Lessons

1 There has been an increase in the depth and breadth of people s knowledge about HIV transmission and family planning since the inception of the project which may have been encouraged by the wide variety of IEC activities which occurred throughout the District
2 The knowledge changes (particularly for FP) were greater in the CBD villages than in the District as a whole, which indicates that the individual peer counseling mode may be more effective or at least effective as an enhancer of a generalized IEC campaign

Recommendation

Although the IEC consultant outlined a very comprehensive list of potential target groups and IEC strategies the messages and activities should be prioritized to a few key messages and strategies - keeping in mind that the final impact has to be the absorption of the messages for behavior change by individuals and families in the communities

CROSS - CUTTING INTERVENTIONS - not assessed in detail, but seem to be on track.

HIS

ACCOUNTING SYSTEM AND STOCK CONTROL - MOH

FLEET MANAGEMENT

PROJECT MANAGEMENT

Lessons

- The MOH s direct involvement in the development of the CHAPS work plans budgets and budget decisions has led to a significantly different sense of ownership with the CHAPS project than with other NGO projects
- The design for CHAPS provides a coherent focused framework for whatever interventions were/are prioritized in the District By contrast STAFH by design had a more narrow technical focus for its interventions that threrefore resulted in more of a list of interventions with less system relationships between them
- Given the decentralization process occurring in Malawi the CHAPS design (PVO/MOH partnership mixed community and system level interventions and mixed process and material inputs) works very well

Recommendations

Following are suggestions that came from the DHMT members themselves but the evaluator agrees with them

- They see emphasis on the implementation and continued enforcement of policies and systems even when individual personnel change as a means to maintain activities which have been initiated
- In order to maintain newly initiated activities specific plans for their continuation should be included during the development of annual and quarterly work plans in addition to planning for new activities
- It would be more helpful for all the IEF CHAPS staff to have offices in Chikwawa so they would be more accessible to each other
- They would like to continue to be involved with selection of CHAPS staff when people are hired from outside They are also interested to know the qualifications of the technical staff with whom they are working
    - Although in the general plan for the DHMT the absence of a Family Health Coordinator in Chikwawa should not preclude representation for FP MCH and community level activities on the DHMT by more than the DEHI

Other Recommendations – Internal Project Management

- Project staff should review the available information relative to the specific performance indicators listed in the proposal log frame to be sure they are monitoring the necessary information to measure project progress
- IEF should try to assure training opportunities for IEF advisors to complement training received by MOH counterparts in order to assure their continued credibility
- Everyone needs to be sure both the IEF management and the MOH Systems Advisor components of the Systems Advisor s job are adequately addressed Delegating some of the day to day errands he does (for both the project and MOH) to others leaving him free to focus on the systems management would help
- Evaluate the costs and benefits associated with the technical support model offered by URC to determine if this kind of assistance model is helpful as PVOs move toward increased systems support and advisory roles

REVIEW OF OBJECTIVES

- CHAPS objectives may be valid, but the time frames are probably too ambitious Three years is a totally unrealistic time frame for a project with the scope and system orientation of this one
- The rolling over of STAFH into CHAPS and the inherent sustainability of the CHAPS design means specific sustainability recommendations were not seen as necessary at this time