CS-15 Malawi Final Evaluation

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The Partnership for Equity, Access and Quality (PEAQ) Project: *Ensuring the Pathway to Survival*

Balaka District, Southern Region, Malawi

30 September 1999 – 30 September 2003

Submitted By:

Save the Children Federation, Inc.
54 Wilton Road
Westport, CT 06880
Telephone: 203/221-4000
Fax: 203/221-4056

Contact Person:

Eric Swedberg, MPH, Child Survival Specialist

Report Prepared by Marc Debay
On behalf of the Final Evaluation Team

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Table of Contents

Acronyms List

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BA	Bicycle Ambulance
BBA	Benzyl Benzoate Application
BCC	Behavioral Change Communication
BCG	Tuberculosis Vaccine
BF	Breastfeeding
BFHI	Breastfeeding Health Initiative
CAC	Community AIDS Committee
CBDA	Community Based Distribution Agent
CHAM	Christian Hospitals Association of Malawi
CHBC	Community Home-Based Care
CMM	Community Male Motivators
CORE	Child Survival Collaborations and Resources Group
CPR	Contraceptive Prevalence Rate
CS	Child Survival
CSHGP	USAID's Child Survival and Health Grants Program
DAC	District AIDS Coordinator
DACC	District AIDS Coordination Committee
DHMT	District Health Management Team
DHO	District Health Office
DHPCC	District Health Program Coordination Committee
DIP	Detailed Implementation Plan
DRF	Drug Revolving Fund
EBF	Exclusive Breastfeeding
EPI	Expanded Program for Immunization
EPMU	Expanded Project Management Unit
FE	Final Evaluation
FP	Family Planning
GM	Growth Monitoring
GTZ	German Technical Cooperation
HBC	Home-Based Care
HBCC	Home-Based Care Counselors
HC	Health Centre
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HO	Home Office of Save the Children
HSA	Health Surveillance Assistant
HZC	Health Zone Coordinator
IEC	Information, Education, and Communication
IFA	Iron Folate
IMCI	Integrated Management of Childhood Illnesses
KAP	Knowledge, Attitudes and Practices
KPC	Knowledge, Practice and Coverage
LQAS	Lot Quality Assurance Sampling

MCH	Maternal and Child Health
MNC	Maternal and Newborn Care
MOHP	Ministry of Health and Population
MTE	Midterm Evaluation
NAC	National AIDS Committee
NGO	Non Governmental Organizations
OVC	Orphans and Vulnerable Children
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PEAQ	Partnership for Equity, Access and Quality
PLG	Program Learning Group of Save the Children
PMU	Project Management Unit
QA	Quality Assurance
SC	Save the Children Federation Inc., USA
SC/Malawi	Save the Children Federation, Inc./Malawi Field Office
SHA	Senior Health Advisor
SM	Safe Motherhood
SP	Sulfadoxine-Pyrimethamine
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TT2	Tetanus Toxoid Vaccine 2nd doses
TTV	Tetanus Toxoid Vaccine
VAC	Village AIDS Committee
VCT	Voluntary Counseling and Testing
VHC	Village Health Committee
VHV	Village Health Volunteer

A. Summary

The Partnership for Equity, Access and Quality (PEAQ) Project started in October 1999 and ended in September 2003. The total funding from USAID was $1 million from the Child Survival and Health Grants Program (CSHGP), to which Save the Children US (SC) matched $333,000. In April 2001, the USAID/Malawi mission added $200,000 to this initial funding under the Leadership In Fighting an Epidemic (LIFE) Amendment.

The Final Evaluation (FE) of the PEAQ Project was conducted by a team of ten members from SC, the Balaka District Health Office and the Mangochi District Health Office, and one external evaluator. The entire team contributed to the design, implementation and analysis of the evaluation, relying on the DIP and the MTE reports to develop the methodology and analyze their findings, and using data collected by the PEAQ Project through the baseline and final surveys, project monitoring quarterly reports, and the Balaka District HMIS.

The PEAQ Project aimed at strengthening the health system of the entire Balaka District. The district was separated from the Machinga District one year before project inception, and now has a total population of 267,512 inhabitants, the majority (94%) of which live in rural areas.

The three goals of the Balaka PEAQ Project were to:

(1) Achieve a sustainable reduction in infant, child, and maternal mortality and morbidity;
(2) Expand and refine a model for district health system strengthening; and
(3) Adapt a district-to-district model for project replication and scaling up.

The overarching approach of the PEAQ Project was one of district health system strengthening and capacity building, with an emphasis placed on community mobilization for behavior change. The PEAQ Project design included joint SC/DHO planning, the implementation of the national HMIS in the district, and intensive training activities for health workers and community members. Building on its successful experience in a similar project, the DHO staff of the nearby Mangochi District was called upon to act as a "Living University" for the Balaka DHO staff.

The FE Team found evidence of increased coverage of the following key interventions known to be effective in reducing infant, child and maternal mortality and morbidity:

- Immunization against preventable childhood diseases.
- Vitamin A supplementation of children under five.
- Iron and folic acid supplementation for pregnant women.
- Intermittent preventive treatment of malaria in pregnancy and presumptive treatment of fever among children under five with sulfadoxine-pyrimethamine.
- Assistance at delivery by qualified/trained birth attendants and early referral in case of complications.
- Exclusive breastfeeding for infants up to six months of age.
- Treatment of diarrhea with Oral Rehydration Therapy.
- Birth spacing and prevention of unwanted pregnancies.
- Early and effective treatment of sexually transmitted diseases.

The FE Team also identified that the following features of the PEAQ Project had contributed to the success of the district health system strengthening approach:

- Explicit partnership agreement with the DHO.
- Joint planning of activities by SC and the DHO.
- Focus on community mobilization and behavior change communication.
- Decentralized management of selected activities to Health Zone Coordinators covering the catchment areas of one or two health centers.
- No direct involvement of SC staff in the implementation of activities without designated MOHP counterparts.

The following lessons were learned through the PEAQ Project and were observed by the FE Team:

- With appropriate support and resources, the Balaka DHO can achieve high level of coverage of the essential interventions to reduce infant, child and maternal mortality and morbidity.
- The district-to-district Living University approach has been effective in replicating and scaling up the successful Mangochi district health system strengthening project.
- The formation and mobilization of the current District and community level HIV/AIDS structures is labor intensive and time consuming, and not as effective as expected.
- Operations research and documentation of innovative interventions require careful planning, expertise and dedicated human and other resources.

Given the success of the PEAQ Project in increasing the coverage of key interventions through a district health system strengthening approach, the Balaka DHO and SC should carefully define the human, financial, and transportation resources required to sustain these results. The DHO and SC should then develop a phase-over plan that specifies the equipment that SC can dispose of and the resources that SC can continue to provide under its other projects in the District. Through its continued presence in the District, SC should support the DHO to further develop the behavior change communication strategy and the health and management information system, strengthen the current district HIV/AIDS structures, and create new voluntary counseling and testing (VCT) centers. At the national level, the MOHP and its partners should ensure the regular supply of vaccines and other essential health products. Finally, USAID/Malawi and USAID/GH/CSHGP should consider the district health system strengthening approach and the district-to-district replication mechanism of the PEAQ Project for future health sector programs in Malawi and other countries.

B. Assessment of Results and Impact of the Program

1. Results: Summary Chart

	INDICATOR	BASE-LINE	FINAL	
			Target	Actual
	Immunization			
1	Percent of children age 12-23 months fully immunized by their first birthday (card verified)	46%	75%	50%
2	Percent of mothers of children age =< 24 months who received 2 or more doses of tetanus toxoid during their last pregnancy (card verified)	39%	90%	61%**
3	Percent of children age 6-24 months who ever received Vit A (card verified)	31%	40%	39% (p = 0.07)
	Breastfeeding Promotion			
4	Percent of children (0 – 5 mo.) who received only breast milk in the last 24 hours	28%	20%	57%**
	Maternal and Newborn Care			
5	Percent of mothers with children age =< 24 months who received iron/folate supplementation during their last pregnancy	64%	80%	87%**
6	Percent of mothers with children age 24 months or under who received at least one dose of SP during their last pregnancy	72%	80%	77%
7	Percent of mothers with children age 24 months or under who report last delivery assisted by a health worker or trained TBA	62%	75%	73% (p = 0.07)
	Child Spacing			
8	Percent of married women 15-49 years old using modern contraceptives	21%	30%	29% (p = 0.07)
	STI/HIV/AIDS Prevention			
9	Percent of women 15-49 years old who report condom use with non-regular partner	38%	50%	61%

	INDICATOR	BASE-LINE	FINAL	
			Target	Actual
10	Percent of women 15-49 years old who know of three ways to prevent STI/HIV	17%	60%	12%*
11	Percent of men 15-54 years old who report condom use with non-regular partner	25%	70%	57%*
12	Percent of men 15-54 years old who know of three ways to prevent STI/HIV	24%	60%	20%
13	Percentage of female youth 15-19 years who delay sexual debut	21%	30%	29%
14	Number of persons tested in VCT centers/month	0	350	10
15	Percent target orphans/vulnerable children (OVC) with access to community services (OVC program)	0	50%	NA
16	Percent STI cases treated according to national standards (STI treatment protocol)	19%	75%	38%*
17	Percent of households receiving help in caring for chronically ill young adults (15-49) in a population survey	0%	50%	9%
18	Percent of male youth 15-19 years who delay sexual debut	19%	30%	38%*

	INDICATOR	BASE-LINE	FINAL	
			Target	Actual
	Control of Diarrheal Disease			
19	Percent of children age 24 months or under who have had diarrhea in the two weeks prior to the survey and who have been treated with Oral Rehydration Therapy (ORT)	65%	80%	77%
20	Percent of children age 24 months or under presenting at health facility with diarrhea who were treated correctly (in accordance with the Malawi Standard Treatment Guide) at the health center level	59%	80%	Not Measured
	Control of Malaria			
21	Percent of children age 24 months or under with fever in the two weeks prior to the survey who obtained appropriate treatment	31%	50%	23%
22	Percent of children age 24 months or under presenting at health facility with fever who were treated correctly (in accordance with the Malawi Standard Treatment Guide) at the health center level	44%	70%	Not Measured
	Pneumonia Case Mgmt.			
23	Percent of children age 24 months or under with cough and difficult/rapid breathing in the two weeks prior to the survey who obtained medical care from a health facility	50%	70%	43%
24	Percent of children age 24 months or under presenting at health facility with cough and difficult/rapid breathing who were treated correctly (in accordance with the Malawi Standard Treatment Guide) at the health center level	44%	70%	Not Measured
	OTHERS			
25	50% of villages have formal alarm and transport plans	0	50%	50%
26	80% of DHMT meetings discuss current HMIS information and make management decisions based on the data	0	80%	100%
27	Each of the 9 trained HC QA teams investigate and solve at least 3 problems per year after training	0	9	0
28	A Functioning DHMT-NGO District Coordination Comm. (DHPCC)	NO	YES	NO
29	A District Fundraising Committee established and mobilizes resources for at least 2 projects per year	NO	YES	YES
30	Quarterly HMIS report produced and disseminated using computerized HMIS data	NO	YES	NO
31	80% of villages with functioning VHCs i.e. VHCs meeting at least one every two months (6 times/year)	0%	80%	91%
	Operations Research			
32	Documented results of working with Traditional Healers and initiation leaders	NO	YES	NO

	INDICATOR	BASE-LINE	FINAL	
			Target	Actual
33	Document results of Living University Approach	NO	YES	NO
34	Document Results of Birth Plan Use OR Bicycle Ambulance	NO	YES	YES

* $p < 0.05$. ** $p < 0.005$ The baseline values were recalculated to ensure that the same indicator definition was used for both baseline and final. This resulted in several changes to the baseline values and targets which are below the baseline value. For example indicator 4 on exclusive breastfeeding.

2. Results: Technical Approach

a. Overview of Project

The implementation of the Partnership for Equity, Access and Quality (PEAQ) Project started in October 1999 and ended in September 2003. The total funding from USAID was $1 million from the Child Survival and Health Grants Program (CSHGP) to which Save the Children US (SC) provided a match of $333,000. In April 2001, the USAID/Malawi mission added $200,000 to this initial funding under the Leadership In Fighting an Epidemic (LIFE) Amendment.

The goal of the PEAQ Project was to strengthen the health system of the entire Balaka District. This district was separated from the Machinga District one year before the project started this district now has a total population of 267,512 inhabitants,[1] the majority (94%) of which live in 647 villages in rural areas. At the time of the final evaluation (FE), the Balaka health system was comprised of one district hospital (84 beds; capacity to provide emergency obstetric care) and nine Health Centers (outpatient clinic with maternities; four from the Ministry of Health and Population (MOHP) and five from the Christian Hospitals Association of Malawi (CHAM). The District Health Office (DHO) personnel include six Clinical Officers (including the District Health Officer), five medical assistants, three Registered Nurses, 29 Enrolled Nurses, one Health Inspectors, ten Health Assistants, and 146 Health Surveillance Assistants (HSAs). A variety of community-based volunteers also provided health services in Balaka, including 80 trained Community Based Distribution Agents (CBDAs), 44 trained Community Male Motivators (CMMs), 90 active Traditional Birth Attendants (TBAs), 591 active Village Health Committees (VHCs—each composed of about 10 members and a chief), 888 active Village Health Volunteers (VHVs), 34 Drug Revolving Funds groups (DRFs), 58 Community-based HIV/AIDS counselors, and 80 Home Based Care counselors (HBCCs).[2]

The three goals of the PEAQ Project were to:

(1) Achieve a sustainable reduction in infant, child, and maternal mortality and morbidity;

(2) Expand and refine a model for district health system strengthening; and

(3) Adapt a district-to-district model for project replication and scaling up.

The overarching approach of the PEAQ Project has been one of district health system strengthening and capacity building, with the emphasis placed on community mobilization for behavior change. SC and the Balaka DHO worked in close partnership, with SC providing technical, managerial and financial support to the Balaka DHO and health centers staff. The PEAQ Project design included joint SC/DHO planning, the implementation of the national HMIS in the district, and intensive training activities for health workers and community members. This health systems strengthening approach also implied that the project interventions were

[1] Projection estimate for 2002 used in the Malawi Health Management Information Bulletin, Special Issue 2002.
[2] The number of community-based health workers at the beginning and at the end of the PEAQ Project is discussed in the relevant sections of the report and presented in Annex B-Methodology.

implemented according to existing MOHP policies, that they complemented other efforts and programs in the district, and that they aimed at the entire population of the district, that is, 267,512 inhabitants in 2002. Building on its successful experience in a similar project, the nearby Mangochi DHO staff was called upon to act as "Living University" for the Balaka DHO staff.

The PEAQ Detailed Implementation Plan (DIP) includes eight technical interventions: Immunization, Breastfeeding Promotion, Control of Diarrheal Disease, Pneumonia Case Management, Control of Malaria, Maternal and Newborn Care, Child Spacing, and STI/HIV/AIDS Prevention. The DIP also includes Integrated Management of Childhood Illnesses (IMCI) as a strategy to support the first five interventions cited above. The "Estimated Program Effort and USAID Funding by Intervention" table included in the DIP is reproduced below. The LIFE Amendment provided additional funding primarily to the STI/HIV/AIDS intervention.

Intervention	% of Total Effort	USAID Funds in $
Immunization	10%	$100,000
Breastfeeding Promotion	10%	$100,000
Control of Diarrheal Disease	10%	$100,000
Pneumonia Case Management	10%	$100,000
Control of Malaria	10%	$100,000
Maternal and Newborn Care	25%	$250,000
Child Spacing	10%	$100,000
STI/HIV/AIDS Prevention	15%	$150,000
Total	100%	$1,000,000

These eight interventions or Technical Approaches are discussed below in five sections covering one or several interventions. Each section begins with a summary table of the midterm and final targets for the key indicators of the interventions being discussed, and the corresponding baseline, midterm and final results. Most baseline and final result values presented in these tables were obtained from the two Knowledge, Attitude and Practices (KAP) household surveys conducted by the PEAQ Project at the beginning and the end of the project (baseline in November 1999 and final in July 2003). The midterm values come from a Lot Quality Assurance Survey (LAQS--conducted in August 2001).

Each summary table is followed by a brief discussion of the interpretation of the available data in terms of success of the project. The factors of success and the constraints identified by the Final Evaluation Team (hereafter, the FE Team) are then presented, followed by the lessons learned and the next steps.

b. Immunization

Baseline, Midterm and Final Results

	Indicator	Base-line	Midterm		Final	
			Targ.	Res.	Targ.	Res.
1	Percent of children age 12-23 months fully immunized by their first birthday	46%	55%	60%	75%	50%
2	Percent of mothers of children age =< 24 months who received 2 or more doses of tetanus toxoid during their last pregnancy (card & self report)	80%	85%	85%	90%	87%
3	Percent of children age 6-24 months who ever received Vit A	31%	20%	46%	40%	39%

The midterm and final KAP surveys demonstrate a definite increase in the immunization coverage of pregnant women. The percentage of children completely immunized by their first birthday is based on information collected from the growth monitoring card, and therefore might underestimate the true coverage. The Tetanus Toxoid Vaccine (TTV) coverage is based on information from the TTV card and from recall by the caretakers. The estimates of immunization coverage from the DHO services statistics are consistently lower than those from the KAP surveys (see section C.7). The major factors that explain the discrepancies between the two estimates seem to be underreporting of services statistics.[3]

The midterm and final KAP surveys also demonstrate a definite increase in the coverage of children 6-24 months with Vitamin A supplements. The baseline coverage of children 6-24 months was erroneously calculated as 10% at the beginning of the project and therefore the midterm and final targets were set at 20% and 40%, respectively.

Factors of Success

The PEAQ Project contributed to the above success by:

1. Increasing the number of outreach clinics from 108 to 135 through the provision of transportation to health workers (push bicycles and motorcycles).

2. Improving the cold chain through the training of six technicians and providing gas, paraffin, refrigerators, and other supplies and equipment. This support increased both the quality and accessibility of EPI services.

3. Training of 25 mid-level EPI managers, which improved the overall management of the EPI program.

4. Enhancing community mobilization though the training of the VHC members and VHVs on the importance of full immunization and the recommended immunization schedule for pregnant women and children under one year of age (see sections B.3.a and B.3.b).

The provision of Vitamin A supplements to TBAs during supervision visits may have contributed to the increase in coverage of this intervention among children under five.

[3] One source of underreporting seems to be that health workers often fail to check off the "completely immunized" column on the EPI tally sheets when appropriate.

Constraints

Throughout the duration of the PEAQ Project, the Balaka District experienced frequent stock-outs or insufficient supplies of several antigens, primarily of BCG, due to stock-outs or power shortages at the national level. Vitamin A stock-outs also occurred frequently.

Lessons Learned

With appropriate support and resources, the Balaka DHO can achieve high levels of immunization coverage. In order to reach the national target however, the DHO needs to have a constant supply of all vaccines.

Next Steps

The DHO should maintain all of the necessary cold chain equipment and means of transport to sustain the current levels of immunization services beyond the end of the PEAQ Project.

The DHO and SC should reconcile the immunization coverage estimates from the KAP surveys and the services statistics to better understand the true immunization coverage rates and related determinants to improve the monitoring of immunization activities, and to continue to increase immunization coverage.

The DHO is considering home-to-home visits to increase the immunization coverage rates in the district. An alternative strategy is to target areas known to have low coverage through the organization of periodic immunization campaigns in those areas.

c. Maternal and Newborn Care

Baseline, Midterm and Final Results

Indicator		Base-line	Midterm		Final	
			Targ.	Res.	Targ.	Res.
5	Percent of mothers with children age =< 24 months who received iron/folate supplementation during their last pregnancy	64%	75%	77%	80%	87%
6	Percent of mothers with children age 24 months or under who received at least one dose of SP during their last pregnancy	72%	75%	63%	80%	77%
7	Percent of mothers with children age 24 months or under who report last delivery assisted by a health worker or trained TBA	62%	70%	70%	75%	73%
25	50% of villages have formal alarm and transport plans	0%	25%	59%	50%	50%

The midterm and final KPC surveys demonstrate an increase in the three individual-level indicators selected for the maternal and newborn care intervention. The indicators for iron/folate supplementation and the preventive malaria treatment with sulfadoxine-pyrimethamine (SP) are based on verbal reporting and the antenatal card and the TTV card, respectively. The indicator for delivery with a qualified/trained attendant is based on the answers from the respondents.

Indicator # 25 is measured by the presence of one working bicycle ambulance (BA) for a group of about ten villages that can access it in case of medical or obstetrical emergency.

Factors of Success

The project contributed to achieving objectives #5, #6 and #7 above through:

1. Training and supervision of TBAs (34 TBAs received initial training and 29 TBAs received refresher training according to the national curriculum), and their receipt of supplies of iron/folate supplements and SP tablets (until the recent change in the MOHP policy to discontinue the practice of distributing SP through TBAs)

2. Inclusion in the VHC and VHV training curriculum of key messages on the importance of antenatal and of delivery care by trained health workers and TBAs.

3. Increase the number of outreach service delivery points offering antenatal services including provision of iron and SP tablets from 108 to 135.

The FE Team found that the PEAQ Project also improved:

4. The referral system for obstetric emergencies through establishment of alarm and transport system at the village level (see below), training of TBAs in recognition of danger signs and criteria for referral, establishment of a radio communication system in two health centers, and repair and maintenance of DHO vehicles.

5. The infection prevention practices at the health centers and the TBA levels through specific training and provision of supplies (kerosene for sterilization in the health centers; antiseptics to TBAs).

The PEAQ Project provided six new and revitalized 21 existing BAs, which together are accessible to about 300 of the most isolated villages. VHVs are typically in charge of the BA and ensuring that the community is aware of its existence and how to access it in case of medical emergency.

The FE Team also noted that health workers in all health centers received a five-day training in life saving skills as part of the safe motherhood program of the MOHP.

Constraints

There are still about 30 active TBAs who have not yet been trained.

There are still frequent stock outs of iron and SP at the national level.

There is a concern that some pregnant women receiving antenatal care services from mission health facilities fail to buy SP and iron tablets because they are too expensive.

The DHO reports late referrals by TBAs among the contributing factors of the approximately 20 maternal deaths that occurred last year in the Balaka District Hospital. However, this data should be confirmed through systematic maternal death audits.

Lessons Learned

Increasing the number of outreach service delivery points for antenatal care, training, and support of TBAs can improve the use of essential maternal and child care services.

Next Steps

Sustaining and improving the above results requires continued community mobilization and education, continued supervision and provision of supplies to TBAs, and continued availability of transport for outreach clinics.

Some mission facilities include the cost of SP and iron in their antenatal services fees so that the client does not have to pay for these items separately. Facilities with this policy do not seem to have the problem cited above.

d. Child Spacing

Baseline, Midterm and Final Results

Indicator		Base-line	Midterm		Final	
			Targ.	Res.	Targ.	Res.
8	Percent of married women 15-49 years old using modern contraceptives	21%	25%	18%	30%	29%

The baseline and final KAP surveys demonstrate a definite increase in the prevalence of modern contraception among women 15-49 years old. The Balaka health services statistics show slightly lower prevalence values by zone, probably due mainly to underreporting by some health centers and by CBDAs.

Factors of Success

The PEAQ Project contributed to the achievement of the above objective in three different ways:

1. Training of 40 CMMs and 80 CBDAs.

2. Training of 146 HSAs as co-family planning providers.

3. Increasing the number of outreach clinics offering integrated FP services from 35 to 128.

4. Mobilization of communities by trained VHCs and VHVs.

Constraints

HSAs were asked to stop providing Depo-Provera injections through an MOHP directive. If HSAs were still allowed to give Depo-Provera injections, shown by the DHS and other FP reports as the preferred contraceptive for most Malawian women, the achieved contraceptive prevalence would most likely be higher.

Five of the nine HCs in Balaka do not provide family planning services because of their religious affiliation.

Many women in the Balaka District would like to use contraceptive methods but still do not have access to family planning services.

Lessons Learned

The increase in the number of trained CMMs, CBDAs, co-family planning providers HSAs, and integrated outreach clinics has contributed to addressing the demand for family planning information and services, and increasing the utilization of modern contraceptive methods.

Next Steps

Health Center staff should support the CMMs and CBDAs in their locations through supervision and provision of supplies.

Additional CBDAs and CMMs should be trained and supervised, especially in areas covered by the five CHAM health centers.

Integrated FP outreach clinics should be maintained and new ones should be created.

The DHO should find ways to increase the number of providers of Depo-Provera, the preferred family planning method in Balaka, for instance by involving private maternity and other clinics.

e. STI / HIV/AIDS

Baseline, Midterm and Final Results

Indicator		Base-line	Midterm		Final	
			Targ.	Res.	Targ.	Res.
9	Percent of women 15-49 years old who report condom use with non-regular partner	38%	30%	NA	50%	61%
10	Percent of women 15-49 years old who know of three ways to prevent STI/HIV	17%	30%	16%	60%	12%
11	Percent of men 15-54 years old who report condom use with non-regular partner	25%	60%	NA	70%	57%
12	Percent of men 15-54 years old who know of three ways to prevent STI/HIV	24%	30%	29%	60%	20%
13	Percent of female youth 15-19 years who delay sexual debut	21%	25%	NA	30%	29%
18	Percent of male youth 15-19 years who delay sexual debut	19%	25%	NA	30%	38%

The baseline and final KAP surveys show that both indicators 9 and 11 increased. However, the sample size for these two indicators is very small, and this change is only statistically significant ($p < 0.05$) for men. The two surveys also show that indicators 10 and 12 slightly decreased during the period of the project, but this difference is not statistically significant.

Indicator		Base-line	Midterm		Final	
			Targ.	Res.	Targ.	Res.
14	Number of persons tested in VCT centers/month	0	0	8	350	10
15	Percent target orphans/vulnerable children (OVC) with access to community services (OVC program)	0%	0%	NA	50%	NA
16	Percent STI cases treated according to national standards (STI treatment protocol)	20%	20%	NA	75%	NA
17	Percent of households receiving help in caring for chronically ill young adults (15-49) in a population survey	0%	0%	NA	50%	9%

The four objectives and indicators above were added to the project key indicators with the LIFE Amendment.

HIV testing (indicator 14) was available in the Balaka hospital at the beginning of the project but primarily for inpatients and blood donor screening, and probably without proper counseling when needed. The VCT center of the District Hospital began its activities in June 2003.

As the PEAQ Project did not directly establish community services for Orphans and Vulnerable Children, this indicator (15), assumed 0% at baseline, was not measured at the end of the project.

The baseline estimate for indicator 16 came from a review of the STI registers in health centers to check the adequacy of the prescribed treatment to the recorded diagnosis. No such review was made for the final evaluation. The Balaka health services statistics show an increase in the monthly number of STIs treated in the District Hospital and Health Centers in 2002 (see Figure 2 in Annex L). This suggests that the STI training of health workers in 2001 and 2002 and the availability of STI drugs increased the coverage of STI cases treated, presumably according to the national STI treatment protocols.

The baseline KAP survey includes a question to measure indicator 17, but the value is not presented in the report. The question asked does not specify the type and source of care. The final target of 50% probably referred to the proportion of households with a chronically ill young adult who receive help in caring for that person, rather than the proportion of households receiving care for chronically ill young adults.

Factors of Success

The PEAQ Project established the foundation for increased HIV/AIDS prevention, care and mitigation activities in Balaka through:

- Formation of the Balaka District AIDS Coordination Committee (DACC) in 2000.
- Training of 36 DACC members in 2002 (Leadership training conducted by NAC trainers; Training for Transformation, a three-day course developed under the SC/Malawi STEPS (previously COPE) project).
- Sensitization of nine CACs and training of the members of four CACS in 2002;
- Initiating the training of 135 VACs.

The PEAQ Project supported the dissemination of the key HIV/AIDS messages at the community level through:

- Inclusion of these messages in the training curriculum for VHCs and VHVs;
- Various activities held during the District AIDS days.

The PEAQ Project supported the training of various community volunteers:

- 40 HIV/AIDS counselors (among the total of 80 trained counselors in the district);
- 92 Initiation counselors; and
- 80 Home-Based Care Counselors.

The PEAQ Project supported the training of health workers in;

- STI case management (two trainers; 20 trainees and seven received refresher training; another training is scheduled before the end of the project);
- HIV/AIDS counseling (12 health workers received a six-week training as Hospital Based Counselors);
- Integration of STI/HIV/AIDS into reproductive health services (68 trainees); and
- Integration of HIV/AIDS in the BFHI (two trainees).

One VCT center began its activities in the District Hospital in June 2003 when a first batch of 600 HIV tests was provided by SC to the DHO. The necessary equipment is also in place and 12 staff members have received training in counseling. Among the 33 tests already performed at the time of the FE, 12 were positive and 21 were negative.

Constraints

The District AIDS structures are composed of persons with other responsibilities and commitments, and many DACC and CAC members seek allowances or other forms of compensation. As a result, the DACC members can hardly manage to meet on a regular basis or conduct other activities expected from them such attending or conducting training events. This may slow down the overall progress on HIV/AIDS activities in the district.

The national policy to provide uniform training for DACC members resulted in such delays that this training was only conducted in Balaka in 2002. The training of some VAC members by DACC/CAC members has only recently begun.

There is no full-time HIV/AIDS coordinator at the DHO level to motivate and facilitate the work to be done by the DACC and the CACs.

As the DACC is not functional, some NGOs are conducting HIV/AIDS activities in certain areas of the Balaka District without the DHO or the DACC even being aware of their work.

The late availability and authorization to use the LIFE Amendment funds have delayed the beginning of some HIV/AIDS activities of the PEAQ Project.

The late development of the national VCT guidelines and approval of VCT activities in Balaka have delayed the establishment of VCT centers in the district.

The District Hospital is just beginning VCT activities and there is still no dedicated room for this service yet. Only one laboratory technician is trained in performing the rapid HIV tests. There is no VCT service in the health centers yet.

The Health Centers still experience (and document) stock outs of the main STI drugs.

Lessons Learned

The formation and mobilization of the DACC/CACC/VAC structure is labor intensive and time consuming, and this structure has not been as effective as expected.

The development of national policies and guidelines is a lengthy process that must be factored into projects that rely on their availability.

Next Steps

All DACC members must commit to making the DACC/CAC/VAC work despite their other non-HIV related duties.

The DACC should liaise with the NAC to get the necessary resources for intensifying HIV/AIDS activities in Balaka District.

The DHO should consider appointing a full-time coordinator for all the HIV/AIDS activities of the health sector in the district.

The DHO and the DACC should continue supporting the VCT center that was newly established in the Hospital, and establish additional centers in the health centers. Non-clinicians could be offered the necessary counseling training to avoid increasing the workload of the limited number of clinicians available in the district. Health workers should be trained in VCT testing procedures.

The DHO should ensure a continuous supply of HIV rapid tests in the VCT center(s).

The DHO should plan for training additional community-based HIV/AIDS counselors, and implement the integrated HIV/AIDS/BFHI training program in the health services.

SC and DHO should complete the planned training of health workers in HIV/AIDS case management before the end of the PEAQ Project.
SC should continue supporting the DHO HIV/AIDS activities through its other projects in the district, particularly the Adopt-a-Village project using the STEP strategy, the School Health and Nutrition Project, and the HIV/AIDS in Schools Project.

f. Breastfeeding/Diarrhea/ARI/Malaria

Baseline, Midterm and Final Results

Indicator		Base-line	Midterm		Final	
			Targ.	Res.	Targ.	Res.
4	Percent of children who received only breast milk to at least 4 months of age	28%	15%	68%	20%	57%
19	Percent of children age 24 months or under who have had **diarrhea** in the two weeks prior to the survey and who have been treated with ORT	65%	75%	59%	80%	77%
21	Percent of children age 24 months or under with **fever** in the two weeks prior to the survey who obtained medical care from a health facility	31%	40%	NA	50%	23%
23	Percent of children age 24 months or under with **cough and difficult/rapid breathing** in the two weeks prior to the survey who obtained medical care from a health facility	50%	55%	NA	70%	43%

The baseline and final household surveys show a remarkable and statistically significant ($p < 0.005$) increase in the practice of exclusive breastfeeding of infants up to four months old.

The baseline and final KAP surveys demonstrate an improvement in health care seeking behavior for children below 24 months of age for diarrhea. No improvement appears for cough and difficult/rapid breathing or for fever. Treatment with ORT for indicator 19 includes the use of Oral Rehydration Salts and Salt/Sugar Solutions. Medical care from a health facility for indicator 21 includes treatment received from DRFs.

The quality of the case management of diarrhea, fever, acute respiratory infections (indicators 20, 22, and 24 in Annex K) was not measured at the end of the project because the IMCI intervention was dropped at midterm.

Factors of Success

The training curriculum of the VHCs/VHVs, TBAs, and interactive drama groups has been expanded to include the importance of immediate and exclusive breastfeeding, and key messages about health care seeking for diarrhea and fever.

Establishing 34 DRFs in remote areas increased the availability of drugs to treat diarrhea and malaria.

Constraints

The PEAQ Project did not support IMCI training as initially planned in the DIP. This decision was made when the midterm evaluation team realized that the DIP was too ambitious for the available human and financial resources. Also, the Balaka District had not been considered by the MOHP in the first series of districts to implement IMCI.

Only two health workers were trained in "Integrated BFHI and HIV/AIDS." National BFHI master trainers were not available to conduct the training activities planned in the district.

The MOHP supported training of health workers in malaria case management, but the last training events were held in 2001 and many trainees left the district since then.

Case management of pneumonia has greatly improved at the Balaka Hospital under another project (case fatality rate decreased from 26% at the beginning of the project in 2001 to 7% currently), but this pilot project does not include health centers or the community health volunteers.

ARI was not included in the training of community volunteers provided under the PEAQ Project– this is shown in the above results. DRFs do not have drugs to treat pneumonia.

There are still 17 DRFs that were established but their members have not yet been trained. No one was available at Balaka Central to conduct this training.

Lessons Learned

The VHCs/VHVs/TBAs were effective in promoting increased care seeking for malaria and diarrhea.

The DRFs are effective in increasing the use of health services and require continued support.

BFHI master trainers are not available to meet the need for training in breastfeeding at the district level.

Next Steps

SC and the DHO will continue training the remaining DRFs as planned until the end of the PEAQ Project.

All the health workers should be trained and supervised in IMCI.

3. Results: Cross-cutting Approaches

a. Community Mobilization

Baseline, Midterm and Final Results

	Indicator	Base-line	Midterm		Final	
			Targ.	Res.	Targ.	Res.
31	80% of villages with functioning VHCs i.e. VHCs meeting at least one every two months (6 times/year)	0%	40%	NA	80%	91%

Indicator 31 above shows increased community mobilization at the village level. The final result value is that reported in the 2002 Balaka District Health and Management Information System.

Factors of Success

The PEAQ Project helped establish new or has reactivated a total of 591 VHCs in the 647 villages of the Balaka District, and trained the members of these community-based structures (11 per VHC). The project also established and trained the members of 34 DRFs among these VHCs. The formation of the DACC/CAC/VAC structure and training of its members is discussed in section B.2.e.

The PEAQ Project supported the training of various community volunteers in key BCC messages (888 VHVs, 91 CBDAs, 40 CMMs, 87 TBAs, 16 drama groups, 92 initiation counselors, 58 HIV/AIDS counselors and 80 HBC counselors).

The PEAQ helped increase the number of HSAs (from 120 to 146 currently) and their capacity to supervise community volunteers through refresher training (three days; key messages), supervision, and provision of bicycles.

The PEAQ introduced and supported Health Zone Coordinators (four DHO staff and two SC staff) to conduct and supervise the training of community volunteers, supervise the HSAs, and facilitate community mobilization activities such as the FP and the HIV/AIDS Days.

Constraints

Although about 80% of VHCs are reported to be active at the end of the PEAQ Project, the percentage of VHVs active may be lower, depending on the activity considered. For instance, VHVs often lack scales to conduct growth monitoring activities in their villages.

The QA training and subsequent follow up activities proposed in the DIP did not involve communities in the problem solving exercises conducted at the health center level (see also constraints in section B.3.c).

Lessons Learned

VHCs need stronger guidance and supervision to conduct specific and effective activities in their communities.

Next Steps

The DHO and HCs should increase the number of VHCs in underserved areas.

The Health Centers should find ways to involve HSAs in the supervision and support of VHCs and VHVs.

The DHO should support the training of Health Zone Coordinators and HSAs in community mobilization.

The QA training and implementation in health centers should include community members as part of the QA teams.

b. Behavior Change Communication

Baseline, Midterm and Final Results

About half of the PEAQ indicators related to Technical Approaches presented in Section B.2 assume some change in knowledge and behavior of the target population, and are therefore relevant to this section.

Factors of Success

The PEAQ Project established numerous community-based structures to conduct BBC activities.

The PEAQ Project trained a large number of community volunteers, who in general seem to have appropriate knowledge of most of the key messages of the project.

Constraints

The PEAQ Project used national training materials to train most VHC members and VHVs. These materials primarily include information on water and sanitation, but do not cover all of the PEAQ interventions, and do not focus on behavior change.

Many VHCs still seem to focus on water and sanitation activities (particularly cholera) although their training curriculum was modified to address this concern raised at midterm and VHC members seem to have appropriate knowledge of the key PEAQ messages.

The PEAQ Project has not had sufficient education materials to provide to health workers and community volunteers trained in key BCC messages. A review of the existing materials at the national level was made after the midterm evaluation, but most of them were too expensive for the PEAQ budget (except for a few items about FP that were available for free).

The collaboration with, and capacity building of the IEC service of the Balaka DHO has not been as fruitful as with the other DHO services.

Lessons Learned

At midterm, the PEAQ Project staff realized that the initial plans for behavior change were too ambitious and that a revision of the BCC strategy needed to include:

- Identification and prioritization of the changes in behavior likely to have the highest impact;
- Extension of the scope of activities of the VHCs from water and sanitation to a series of key behaviors to be changed with involvement of the community; and
- Evaluation of the effectiveness of the current BCC interventions including drama groups and others.

Next Steps

After the MTE, selected SC and DHO staff (program managers and zone coordinators) received training in the BEHAVE framework for planning behavior change activities. They conducted preliminary studies with four communities to identify a set of priority behaviors that they were willing to address. These findings can lead to practical plans of action involving the communities. The approach should now be presented and discussed with the EPMU and the action plans implemented as appropriate.

c. Capacity Building

Baseline, Midterm and Final Results

Indicator		Base-line	Midterm		Final	
			Targ.	Res.	Targ.	Res.
25	50% of villages have formal alarm and transport plans	0%	25%	59%	50%	50%
26	80% of DHMT meetings discuss current HMIS information and make management decisions based on the data	0%	40%	50%	80%	100%
27	Each of the 9 trained HC QA teams investigate and solve at least 3 problems per year after training	0	5	4 trained	9	0
28	A Functioning DHMT-NGO District Coordination Comm. (DHPCC)	NO	YES	YES	YES	NO
29	A District Fundraising Committee established and mobilizes resources for at least two projects per year	NO	YES	NO	YES	YES
30	Quarterly HMIS report produced and disseminated using computerized HMIS data	NO	YES	YES	YES	NO
31	80% of villages with functioning VHCs i.e. VHCs meeting at least once every two months (six times/year)	0%	40%	NA	80%	91%
32	Documented results of working with Traditional Healers and initiation leaders	NO	NO	NO	YES	NO
33	Document results of Living University Approach	NO	YES	NO	YES	NO
34	Document Results of Birth Plan Use OR Bicycle Ambulance	NO	NO	YES	YES	YES

Indicators 25 to 31 measure various aspects of the capacity of the DHO and communities in the Balaka District to implement CS activities. Indicator 25 is discussed in section B.2.c, indicator 31 is discussed in section B.3.a and indicators 26 and 30 are discussed in section C.7.

Factors of Success

The FE Team found that the PEAQ Project successfully built the capacity of the DHO and communities in Balaka to plan and implement child survival and other health activities. This result was achieved through the following main strategies:

1. The DHO and SC developed, agreed upon and updated as appropriate an explicit partnership agreement defining their respective roles and responsibilities in the implementation of the PEAQ Project.

2. The PEAQ Project created and used an effective organizational structure including direct involvement of the DHO staff in the planning and implementation of project activities through the expanded project management unit (EPMU), and decentralized management of certain activities through the Health Zone Coordinators.

3. The PEAQ Project increased the capacity of the DHO and Health Center staff to hold meetings at the district and health center levels where general management and programmatic issues are discussed.

4. The PEAQ Project increased the capacity of the Balaka District to train its health workers and volunteers by using trainers from the district for all training activities and by supporting numerous and varied training activities.

5. Specific training activities, discussed in other sections, increased capacity of health workers and volunteers to mobilize communities and deliver child survival and other interventions.

6. The PEAQ Project helped establish various community-based structures such as the VHCs, DRFs, the bicycle ambulance committees, and the DACC/CAC/VAC.

7. The PEAQ Project improved transport capacity for DHO and Health Center staff through the provision and maintenance of push bikes, motorbikes, fuel, and vehicles.

8. The PEAQ Project successfully implemented an innovative model for replication and scaling up of district-level health strengthening activities from Mangochi to Balaka District.

9. SC has identified and initiated the documentation of several activities and models of potential significance outside the Balaka District: the district-to-district Living University model, the use of bicycle ambulances as part of a community level alarm and action plans, and the promotion of individual birth plans at the community level.

10. The Hospital Advisory Committee is meeting regularly and has been successful in obtaining resources for the District Hospital.

SC/Malawi recognizes the positive effect of the PEAQ Project on its capacity to plan, implement and evaluate child survival and other projects. The various requirements of the USAID Child Survival and Health Grants Program such as the preparation of a detailed DIP and the organization of external midterm and final evaluations, improved the skills and the professional standards of all the staff involved in these exercises. This in turn improved the capacity of SC/Malawi to prepare, implement and evaluate projects in technical areas sometimes quite different from child survival.

SC/HO also recognizes that the district health system strengthening approach of the PEAQ Project and the district-to-district Living University strategy for replication and scaling up have already positively influenced other projects' design and implementation in Malawi and other countries.

Constraints

The PEAQ Project helped the formation and facilitated a few meetings of the DHMT-NGO Committee, but attendance has always been low and the last meeting of the committee was in 2002.

The existing Hospital Advisory Committee does not seek funding for public health or community health activities, and the DACC is not actively seeking additional resources for the HIV/AIDS activities in the district.

Only four Health Centers received training in Quality Assurance problem solving methods and tools but they have not regularly applied them. The two QA trainers left the district and were not available for coaching and following-up on the QA teams formed during the initial training. Some of the trained Health Center staff also left the district without transferring their skills to the replacement staff. In general, communities have not been fully involved in the problem solving exercises conducted in the Health Centers.

The PEAQ Project had difficulty with the planning and follow up on the otherwise promising documentation of innovative interventions, as proposed in the DIP. While the initial plan to work with Traditional Healers was dropped at the midterm, the Initiation Leaders were trained by the PEAQ Project but without documentation of the results of this activity. The Living University approach was "highlighted" in the MTE report and presented at a meeting of the CORE group, but not documented in a format suitable for larger dissemination within SC or with other development organizations both within and outside of Malawi. A qualitative analysis of the sociocultural determinants of the development and use of birth plans was completed and birth planning was included in the training curriculum of TBAs. However, the extent and the potential results of this intervention are not documented. Collection of data on the utilization and potential results of bicycle ambulances and community alarm plans began, but was interrupted.

Lessons Learned

Health Workers and Community Volunteers have the capacity to conduct successful child survival activities but need continued support and resources.

The district-to-district 'Living University' has been a successful approach to replicate the district health system strengthening success achieved in the Mangochi District.

Conducting operations research or full documentation of innovative interventions require detailed planning and dedicated human and other resources.

Next Steps

The DHO should maintain the now well-established Zonal and EPMU meetings.

The DHO should maintain and update health workers capacity though refresher courses.

The DHO should replace the 2 SC Health Zone Coordinators.

The QA/problem solving strategy should be revised to include a more active and effective involvement of the communities served by the Health Centers.

SC should capture the information on the PEAQ Project innovative interventions that can still be documented before the end of the project.

d. Sustainability

The strength of the design of the PEAQ Project based on district health system strengthening and capacity building is its potential for sustainable results. This is confirmed by the FE Team findings that the PEAQ successfully increased the coverage of a series of maternal and child survival interventions while building the capacity of the Balaka DHO, Health Centers, and communities to plan and implement them.

Nevertheless, the FE Team identified insufficient financial resources at the DHO level to provide the inputs necessary to sustain the PEAQ Project results, including the maintenance of vehicles and motorbikes, fuel, laboratory reagents, training and supervision.

C. Program Management

The implicit goal of the management of the PEAQ Project is the successful implementation of the planned activities and an increased capacity of the Balaka DHO and communities. In this perspective, this section examines the strengths and weaknesses of the key aspects of the management of the PEAQ Project within SC from HO to Balaka, within the DHO and its Health Centers, and at the community level. The focus is on identifying lessons learned and next steps.

1. Planning

Strengths

The joint DHO/SC planning of the PEAQ Project activities has been successful. Examples of joint planning activities are: the preparation of the DIP during a participatory workshop (a copy of the final DIP was given to all DHO and health center staff), the midterm and final evaluations, the regular meetings of the PMU and of the EPMU, the development of detailed quarterly activity plans, and the day-to-day planning of activities at the level of program managers and SC counterparts.

Weaknesses

The DIP turned out to be too ambitious, and significant adjustments of the objectives and work plan were made after the MTE (see Midterm Evaluation Action Plan, June 2002).

2. Staff Training

Strengths

The PEAQ Project provided numerous training opportunities to health workers and community volunteers. This training was conducted according to the national curriculum and guidelines. Most SC/Balaka and DHO staff received some training during the duration of the project (see Annexes I and J).

Weaknesses

The relatively high turnover of the DHO and SC staff makes it difficult to keep the specific knowledge and skills needed for project implementation.

SC and the DHO often had difficulty finding qualified trainers for the various training events that the PEAQ Project supported.

The PEAQ Project made photocopies of the MOHP recommended materials for all trainers and participants because no other material was available or affordable. This constant reproduction at the local level did not always result in good quality training materials.

The PEAQ had too small a budget to offer outside training opportunities to all SC staff, and some staff members did not benefit from having received specific, external formal training during their many years of service on the PEAQ Project.

3. Supervision of Program Staff

Strengths

The EPMU planned and conducted regular joint DHO/SC supervision visits of community volunteers.

The SC/Balaka staff in general has maintained good teamwork and collaboration, and the PEAQ Project Coordinator has provided constructive support to the professional staff.

Weaknesses

The supervision system implemented during the PEAQ Project is too costly for the current DHO budget.

4. Human Resources and Staff Management

Strengths

The PEAQ Project has provided good support to the DHO staff through training, allowances linked to specific project activities, and provision of means of transportation to conduct project activities.

The PEAQ supported the salary of two Health Zone Coordinators where no appropriate DHO staff was available. The SC and the DHO Health Zone Coordinators were supervised in the same way. As these two positions need to be filled at the end of the project, four prospective replacement persons for these two positions are currently in a 1-year training program at the Malawi College of Health Sciences.

SC personnel policies are generally clear and appropriate. The SC/Balaka team has regular "Monday meetings" that constitute a useful forum for most day-to-day project implementation issues.

Overall, the PEAQ Project benefited from qualified staff with no major extended vacancies of critical positions.

SC staff members have left the PEAQ Project for significantly higher level positions, suggesting that their time on the PEAQ helped them advance in their career.

SC has several new projects in Balaka and elsewhere in Malawi and currently examines how to provide career transition opportunities to the senior staff of the PEAQ Project who wish to continue working with SC.

Weaknesses

Both SC and the DHO experienced high turnover of staff and the consequences of having to compensate through longer hours for the vacant positions while the recruitment process was under way and to retrain the replacement staff.

The vacant positions for a second trainer during more than a year (since mid-2002) and for an office manager since March 2003 have led to work overload among the other PEAQ Project staff members.

5. Financial Management

Strengths

SC maintained full transparency with the DHO on the PEAQ budget available for program activities in the Balaka District. Typically, the PEAQ Project Coordinator would propose a budget to the DHO for agreed upon activities, which is then signed by both parties.

The PEAQ financial pipeline at the SC/HO level showed that the overall grant has been spent as expected and that there will be no significant remaining funds.

Weaknesses

There have been persistent problems with the allowances awarded to the DHO staff, which has prevented or slowed down many project activities. Many MOHP staff refuse to conduct activities with the level of allowances approved by USAID and offered by SC. The higher allowances offered by various organizations working in Balaka with the same DHO staff as the PEAQ Project create competition among them in that respect.

The SC PEAQ Project Coordinator had limited signatory power for disbursing project funds, which may have created an unnecessarily heavy managerial burden when a large number of activities were implemented at the same time.

6. Logistics

Strengths

The PEAQ Project provided various commodities and equipment to the DHO and the communities implementing project activities: TBA kits, HIV rapid tests kits, motorcycles for HZC, bicycles for HSAs, bicycle ambulances, training materials, etc.

Weaknesses

Delays in provision of some supplies (HIV tests, TBA kits, HBC kits) have slowed down the beginning of the corresponding activities.

Issues of accountability and the corresponding control procedures have sometimes delayed the maintenance of the motorbikes used by the DHO and health centers to conduct project activities.

Over the duration of the project, both SC/Balaka and the DHO have at times lacked vehicles and other means of transport to conduct project activities. Each Program Manager and Health Center should have at least one motorbike at the very minimum.

7. Information Management

Strengths

The PEAQ Project has effectively supported the implementation of the new national Health and Management Information System (HMIS) system in the Balaka District. The project supported the training of health workers and provided assistance in the use of data at the DHO and health center levels. As a result, timely and quality programmatic data have been appropriately used by the EPMU and in other training and supervision settings. Annex L presents selected HMIS data for year 2002 and the first quarter of year 2003.

TBAs, CBDAs, CMMs, VHCs report their activities to HSAs who supervise them. DHO and health center supervisors sometime use this data to give feedback to community volunteers on their work and challenges.

Health Zone Coordinators collect and report HMIS data for their zone. They have played an important role in the establishment of the HMIS and the use of the data at the health center level.

Quarterly reports of the PEAQ Project were regularly prepared by program managers and zone coordinators for the EPMU meetings. The overall PEAQ Project quarterly reports have been completed regularly throughout the duration of the project.

The PEAQ Project successfully conducted timely baseline and final KAP surveys and Health Facility Assessments, and a Lot Quality Assurance Survey at midterm.

Weaknesses

There are still delays in the transmission of the HMIS reports from the health centers to the DHO. Also, most indicators are higher in the household survey than in the HMIS, suggesting that the data in the latter are incomplete. Finally, HMIS supervisors have noted that the activity registers are sometimes not properly tallied before inclusion of the data in the HMIS reports.

There is still a need for training and supervision of health centers and DHO staff and for provision of supplies to improve quality, timeliness and completeness of the HMIS data collection, analysis and use. There is also a need for specialized technical assistance for data analysis, quality control and reporting at the district level.

The series of household, health facility, and lot quality assurance surveys are not fully documented and the comparative analyses are not complete (use of somewhat different indicators in each survey and lack of calculation of tests of statistical significance).

8. Technical and Administrative Support

Strengths

The majority of technical assistance was provided through the Living University strategy, which involved visits of the staff from Balaka DHO and SC to the Mangochi District, and technical

assistance visits from the Mangochi staff to the Balaka District. This strategy appeared very useful to both Mangochi "teachers" and Balaka "students."

SC/Balaka received frequent support from the Lilongwe offices for financial and administrative management. The SC/Malawi Senior Health Advisors and the SC Africa Regional Advisor also provided technical support on a continuous basis, and on critical areas such as the baseline and final surveys, the preparation of the DIP, the MTE and the FE evaluations, the training in the BEHAVE framework and subsequent formative research, and the establishment of VCT centers.

The PEAQ Project received continuous technical and managerial support from the SC/HO through the Child Survival Specialist, who also made a series of productive visits with extensive presence in the project site area. These visits included the DIP preparation, the MTE and FE evaluations, and the preparation of a revised work plan based on the MTE recommendations. The CS specialist also provided much appreciated assistance with the preparation of the various reports, budget allocation decisions, and identification and recruitment of consultants. The CS Specialist, as a co-facilitator of the CORE South Africa BEHAVE training in February 2002, provided technical assistance in behavior change to three of the Malawi-based project staff. This led to a revised BCC strategy for the project following the MTE.

Weaknesses

The PEAQ Project would have benefited from timely specialized technical assistance in the few areas in which it did not perform as expected. Among such areas are the implementation of the HIV/AIDS interventions and the various plans of documentation and operations research.

SC/Balaka team would have benefited from reviews of the management style and procedures by senior SC managers to ensure continuous improvement of the implementation of project activities and professional development.

9. Management Lessons Learned

The preparation, adoption and update of a clear Partnership Agreement between SC and the DHO have been effective in building capacity, mutual trust and transparent financial management.

Decentralizing the management of certain DHO activities through Health Zone Coordinators is effective. However, this organizational structure relying on the competence and attitude of the individual Health Zone Coordinators has led to project delays or poor performance in certain areas of the district where the Zone Coordinator was absent or did not cooperate.

Rigorous management of even limited financial and logistical resources allows the implementation of most of the PEAQ Project activities.

The maximum amount allowed at each level of signatory power needs to be adjusted to the actual value of the local currency to avoid delays and undue burden on the managers.

D. Conclusions and Recommendations

The PEAQ Project was implemented in the entire Balaka District (population 267,512 inhabitants in 2002) from October 1999 to September 2003. The three main goals of the project were to:

(1) Achieve a sustainable reduction in infant, child, and maternal mortality and morbidity;
(2) Expand and refine a model for district health system strengthening; and
(3) Adapt a district-to-district model for project replication and scaling up.

These goals were achieved as follows:

(1) The baseline and final assessments of the PEAQ Project show definite increases in the coverage of interventions known as effective in reducing infant, child and maternal mortality and morbidity. These include:
- Supplementation of children under five with Vitamin A;
- Supplementation of pregnant women with iron and folic acid;
- Intermittent preventive treatment of malaria in pregnancy and presumptive treatment of fever among children under five with sulfadoxine-pyrimethamine;
- Assistance at delivery by qualified/trained attendants and early referral in case of signs of complication;
- Exclusive breastfeeding up to four months of age;
- Treatment of diarrhea with Oral Rehydration Therapy;
- Birth spacing and prevention of unwanted pregnancies; and
- Early and effective treatment of sexually transmitted diseases.

(2) The PEAQ Project built on the achievements and lessons learned from a previous successful district health system strengthening project implemented by SC and the MOHP in the Mangochi District. The key features of this model that were successfully implemented in Balaka are:
- Explicit partnership agreement with the DHO;
- Joint planning of activities by SC and the DHO;
- Focus on community mobilization and behavior change communication;
- Decentralized management of selected activities to Zone Coordinators covering the catchment areas of one or two health centers; and
- No direct involvement of SC staff in the implementation of activities without designated MOHP counterparts.

(3) The PEAQ Project built upon the achievements of the previous project in the nearby Mangochi District by involving its experienced staff in formal and informal mentoring relationships with the Balaka District staff. This technical assistance was provided through two-way exchange visits and participation in project activities, primarily training and management. Staff members from both districts found their participation in this process beneficial to their work performance and personally enriching. The approach also seems to have been an efficient and time saving way to launch the PEAQ Project with the appropriate tools and know-how. A complete documentation of this approach as a strategy for replicating and scaling up successful district health strengthening projects is still warranted.

The most important achievement of the PEAQ Project is to have achieved the above results among the entire population of the Balaka District while building the capacity of the district health system. It is more significant that this was accomplished right after its constitution as a separate district. The PEAQ Project provided the DHO and Health Centers with human resources, technical and management expertise, training, transportation and various equipment and supplies. This support has improved the performance of health services and enabled communities to address their health needs through community-based structures and volunteer networks.

The PEAQ Project provides the following lessons:

- With appropriate support and resources, the Balaka DHO can achieve a high level of coverage of the essential interventions to reduce infant, child and maternal mortality and morbidity.
- The formation and mobilization of the DACC/CACC/VAC structure is labor intensive and time consuming, and it has not been as effective as expected to support intensified HIV/AIDS activities in the district.
- The behavioral change strategy and activities in the district need to focus on the behaviors most likely to have a positive impact and involve communities in this process of change.
- The district-to-district Living University approach has been effective in replicating and scaling up the successful Mangochi District health system strengthening project.
- Operations research and documentation of innovative interventions require careful planning, expertise and dedicated human and other resources.

Given the success of the PEAQ Project in increasing the coverage of key interventions through a district health system strengthening approach, the Balaka DHO and SC should carefully define the human, financial, and transportation resources required to sustain these results on the basis of the recent project experience. The DHO and SC should then develop a phase-over plan that specifies the equipment that SC can dispose of and the resources that SC can continue to provide under its other projects in the district. Through its continued presence in the Balaka District, SC should provide support to the DHO to further develop the BCC and community mobilization strategy and the HMIS, strengthen the current district HIV/AIDS structures, and create new VCT centers.

At the national level, the MOHP and its partners should ensure the regular supply of vaccines and other essential health products. The DHO should advocate for these supplies at the level of the Reproductive Health Unit of the MOHP. Finally, USAID/Malawi and USAID/GH/CSHGP should consider the district health system strengthening approach of the PEAQ Project and include its district-to-district replication mechanism for future health sector programs in Malawi and other countries.

SC will continue to use and share lessons learned from the PEAQ Project with the broader development community in Malawi through national forums with other PVOs/NGOs and the MOHP. One opportunity for sharing this experience is the MSH led health district strengthening project that will include both the Balaka and Mangochi Districts. The lessons learned will also be incorporated into the implementation of new SC health programming in Malawi. The PEAQ experience will also be shared within SC globally through presentations during the annual program learning group (PLG) meetings. The 2003 PLG focused on district health strengthening and included the PEAQ experience. Further documentation of the Living University approach used in PEAQ will be shared in the upcoming 2004 PLG. The new mini-University DIP workshop of CS grantees is another opportunity to share SC's program experience with PVOs.

E. Results Highlights

Balaka District Health Systems Strengthening

Save the Children Federation, Inc. (SC) and the Malawi Ministry of Health implemented the Partnership, Equity, Access and Quality (PEAQ) Project from September 1999 to September 2003. The project covered the entire Balaka District, which was cleaved off from the Machinga District in 1998 with a total population of about 259,664 inhabitants.

The PEAQ Project provided the Balaka District Health Office (DHO) and Health Centers with human resources, technical and management expertise, means of transportation and various equipment and supplies. This support improved the performance of the health centers and strengthened community-based structures and volunteer networks. In less than four years, the coverage of a wide range of interventions increased significantly for the following indicators:

Indicators	**1999**	**2003**
Children 6-24 months who ever received Vitamin A	31%	39%
Percent of children 0 – 5 mo. Who received only breastmilk in the last 24 hours	28%	57%
Mothers of children =< 24 months with 2 or more doses of tetanus toxoid	39%	61%
Mothers of children =< 24 who received iron/folate during last pregnancy	64%	87%
Mothers of children =< 24 with last delivery by health worker or trained TBA	62%	73%
Married women 15-49 years using modern contraceptives	21%	29%

Two other important achievements of the PEAQ Project in terms of increasing the capacity of the Balaka District are (1) the successful implementation and use of data from the new national Health and Management Information System, and (2) the regular meetings of 80% of the village health committees.

The final evaluation team identified the following factors of success of the PEAQ Project:

- Explicit partnership agreement between SC and the DHO.
- Systematic joint planning of activities by SC and the DHO.
- Strong focus on community mobilization and behavior change.
- Decentralized management of selected activities to the Health Center level.
- No direct involvement of SC staff in implementation of activities.

Also, the PEAQ Project built upon the achievements of a similar project in a nearby district by involving its experienced staff in mentoring relationships with the Balaka District staff. This technical assistance was provided through two-way exchange visits and participation in project activities. This district-to-district replication strategy has been an efficient and time saving way to launch the PEAQ Project with the appropriate tools and know-how.

Given the success of the PEAQ Project in increasing the coverage of key interventions while building the capacity of the Balaka DHO, USAID/Malawi, USAID/GH/CSHGP, SC and other PVOs should consider the health system strengthening approach of the PEAQ Project and its district-to-district replication mechanism for future health sector programs in Malawi and other countries.

ANNEXES

Annex A. Team Members and Persons Interviewed

Name	Position
Team members	
Marc Debay	Independent Consultant/Team Leader
Catherine Chiphazi	District Health Coordinator (PEAQ Project Coordinator, SC-Mal.)
Maggie Kambalame	Health Trainer (PEAQ)
Joseph DeGraft-Johnson	Africa Regional Health Advisor (SC)
David Patterson	Senior Health Advisor (SC-Malawi)
Eric Swedberg	Child Survival Specialist (SC-HO)
Emmanuel Mwale	District Health Officer, Balaka District
B.J. Miso	Healh Zone Coordinator, Balaka District
Richard Chola	AEHO, Mangochi District
Alex Nyambi	Clinical Officer, Balaka District
Teresa Mwinjiro	District Nursing Officer, Balaka District
District debriefing participants	
C.M. Kang'ombe	Clinical Officer
Hillary Mnjemu	Health Zone Coordinator
G.B. Anafi	Skin Coordinator
L. Mtemang'ombe	EN/M
O. Tonde	T.O
E. Mwambwerachaje	SEN
C. Kamende	N/Midwife
AAK Nkhoma	M/A
T.M.Mwinjiro	N/Midwife
Dubulao W. Moyo	Clinical Officer
D.G. Chando	AEHO
Rose Mbawala	N/Midwife
Joyce Chingota	N/Midwife
Banks Mateketa	CM
Blessat Mbandambanda	SECHN
Ethel Kachala	N/Midwife
Kondwani Nkanaunena	Data Officer SC
Gloria Chalira	Program Assistant SC
Master Chitabwino	Zone Coordinator SC
Mike Nkhoma	HMIS Coordinator
Thomson Kajombo	DEHO
Ruth Kasiyamphanje	AIDS Coordinator
Blessings Chitsime	MCH Coordinator
J.D. Salanaye	Accountant
USAID Debriefing participants	
Cheryl Kamin	USAID HPN Officer
Mexon Nyirongo	USAID Development Assistance Specialist/Health & Population
Alfred Chirwa	HIV/AIDS Project Management Specialist
Joseph DeGraft-Johnson	Africa Regional Health Advisor (SC)
Catherine Chiphazi	District Health Coordinator (SC-Malawi)
David Patterson	Senior Health Advisor (SC-Malawi)
Marc Debay	Independent Consultant/Team leader
Others	
Justin Okopu	SC Director of Malawi Office

Annex B. Methodology

The Final Evaluation (FE) of the PEAQ Project was conducted according to three principles of the USAID/GH/HIDN/NUT Guidelines for Final Evaluation of the Child Survival and Health Grants Program projects. The FE was:

1. Participatory

   The FE was conducted by a team of 11 members from SC, the Balaka District Health Office, the Mangochi District Health Office, and one external evaluator, Team Leader and author of the report (see team composition in Annex A). The entire team contributed to the design, implementation and analysis of the evaluation.

2. Based on the project design

   The FE Team systematically referred to the DIP and the MTE report to develop the methodology and analyze their findings.

3. Based on evidence and data

   The FE Team used the following sources of data: results from the baseline and final Knowledge, Attitude and Practice Surveys and the Health Facility Assessments conducted by the PEAQ staff; data from the Balaka District HMIS; findings from various interviews conducted during field visits; and the project monitoring data collected by the SC/Balaka.

The fieldwork of the FE lasted eight days, from Tuesday July 28th to August 7th, 2003 (see schedule in Annex D). After an orientation on the principles of the evaluation by the Team Leader, the FE Team discussed and agreed upon the final team composition and availability, and the overall schedule of work. The FE Team members also shared their personal expectations for the FE, which included obtaining the "big picture" of the overall health impact of the project, drawing lessons from the partnership and capacity building efforts with the DHO, drawing lessons from the district health system strengthening "model," documenting project highlights, innovations or successes, defining the Next Steps for Balaka, and producing a good FE report.

The FE Team then reviewed the overall progress towards the specific objectives of the project, and identified the main factors of success, the lessons learned, and the way forward. These discussions were conducted according to the list of topics adopted as outlined in the present report (sections A through C). The FE Team spent half a day on each category of topic (Technical Approach, Cross-cutting Approach, and Program Management). When appropriate, the relevant corresponding program manager for the topic discussed was invited to participate in the discussion. During these first two days of overall program review, the FE Team also noted the issues for which further information could be collected during the two days of field visits. The FE field visit guidelines were built on those developed for the MTE, but modified according to the specific target groups and the few additional questions selected by the FE (see Annex E).

For the two days of field visits, the FE Team divided into two groups with a similar number and composition of external evaluators and SC and DHO staff. Each team interviewed the same target groups in two zones tentatively selected as more and less successful on the basis of the team's

overall understanding of their ethnic composition, accessibility to health services, levels of education and wealth, and strength of the community-based activities. The target groups for the visits were the Health Center teams (including the HC In-charge, the Health Zone Coordinator, Health Surveillance Assistants, and any other health staff), members of the VHC and VHVs of two villages, members of two DRFs, two TBAs, a group of two CBDAs and two CMMs, and members of one drama group. The HC In-Charge in each zone was informed of the FE Team visit one or two days in advance and invited the selected target groups to come to the Health Center for the interview. The team agreed that the group discussions would be conducted with the representatives of the target groups available at the time of the visit. A description of the samples of sites and interviewees is presented below with estimates of the corresponding Total.

Sampling Unit	Realized Sample	Total
Zone	4	6
Health Center Team	3	9
Community Health Committee members	~10	591
Community Health Volunteer	~10	888
Drug Revolving Funds	4	34
CBDA	~10	80
Community male motivators	~6	44
TBAs (trained)	~10	90
HIV/AIDS motivator	~10	58
Drama groups	4	-

After the two days of field visits, each group summarized its findings for each zone visited according to the main topics relevant to the Technical and the Cross-Cutting Approaches of the PEAQ Project. The entire FE Team then discussed these findings once they were written up and included in one table (see Annex F). No specific conclusion was drawn from the field visit findings alone; rather, the team referred to these findings as appropriate during the various discussions that took place during the following days.

The FE Team gathered and reviewed together all the training and IEC materials available to the PEAQ Project. This exercise provided the opportunity to discuss how the training curricula and activities were developed. The FE Team also constructed the overall timeline of the main project events and activities to discuss the pace of project implementation and identify potential delays and lapses in human resources (see Annex G). The Team Leader and the representative of the Mangochi District conducted a group interview of the Balaka CS-15 staff to investigate their motivation and satisfaction with their job, and review issues that had not been addressed during the previous group discussions and field visits. The interview guidelines are included in Annex E, and the findings from these interviews are included in the various sections of the report as appropriate. The Team Leader and the representative of the Mangochi District also conducted an interview of the Balaka District Health Officer. These findings are also included in the report, where appropriate.

Prior to the FE, the PEAQ Project conducted the final household surveys and a health facility assessment, and prepared all the relevant data on project activities. These two surveys were conducted according to the same methodology as the baseline surveys. The entire FE Team discussed the preliminary results of the two final surveys and selected the key data needed for the

FE. A few FE Team members also reviewed the data available from the national and Balaka HMIS, and selected the key data directly relevant to the FE (see Annex L).

The last day of the FE Team work consisted in the presentation of the main findings and recommendations to the entire SC, DHO and Health Center staff involved in the PEAQ Project implementation (see debriefing participants in Annex A). The discussions that followed each presentation were an excellent opportunity for all the SC/Balaka and DHO staff to contribute to the FE, and also to make decisions about future activities in the district such as continuing the EPMU meetings and continuing the collaboration with Mangochi DHO as a Living University. The meeting was also an opportunity for the SC/Balaka and DHO staff to express their appreciation of their fruitful collaboration and of the results of their efforts.

At the end of the debriefing day, a rapid anonymous survey was conducted which included three simple questions: Was the final evaluation "fair"? Was the methodology "OK"? Do you have any other comment? The majority of the 29 respondents found that the evaluation was fair and appreciated the overall methodology. This evaluation of the FE also gave the opportunity to many respondents to share useful constructive feedback that was included in the final report, as appropriate.

The above FE methodology had the advantage of encouraging full participation of most PEAQ staff, giving each one the opportunity to bring valuable information and perspective to the discussions and analyses and learn about the project achievements. The methodology has limitations such as the difficulty to cover all the topics with a large group of members of different background in a relatively short period of time. Also, the sample of sites and interviewees for the field visits was not necessarily representative, and only general interview guidelines could be developed in the two days available to the entire team before conducting the field visits.

Annex C. Documents Reviewed

Detailed Implementation Plan, March 2000.

Knowledge, Attitudes and Practices in Health Survey 1999, March 2000.

Quality Assurance Assessment of Health Facilities in Balaka District 1999, March 2000.

First Annual Report, November 2000.

Midterm Evaluation Report, February 2002.

Mid-term Evaluation Action Plan, June 2002.

Third Annual Report, October 2002.

Child Survival 15 – Malawi LIFE Amendment, April 2001.

Quarterly Report - January to March 2003.

Report on EPMU meeting held from 21st to 23rd of May, 2003.

Malawi Health Management Information Bulletin. Special Issue 2002. MOHP, Planning Department, Health Management Information Unit, June 2003.

Annex D. Final Evaluation Schedule

DAY	DATE	ACTIVITY
Monday	July 27	Briefing at SC Office in Lilongwe Travel to Balaka
Tuesday	July 30	Team Meeting with District Health Office Team building and development of evaluation work plan Review of PEAQ Program Management
Wednesday	July 31	Team meeting: Review of Technical Approaches Review of Cross-Cutting Approaches
Thursday	August 1	Field visits by two groups: --Health centers and community members in Phimbi --Health centers and community members in Phalula
Friday	August 2	Field visits by two groups: --Community members in Balaka Central --Health centers and community members in Kalembo
Saturday	August 3	Team meeting Review of field visits findings and of household survey results
Sunday	August 4	Rest
Monday	August 5	Team meeting Collection and Analysis of additional data Group interview with PEAQ staff
Tuesday	August 6	Team meeting Collection and Analysis of additional data Meeting with DHO Preparation of District Debriefing
Wednesday	August 7	District-level Debriefing
Thursday	August 8	USAID Debriefing

Annex E. Group Interview Guidelines

The field visits and group interviews constitute one component of the final evaluation of the PEAQ Project. They aim at providing a snapshot of the results of the project in four of the six zones of Balaka District. Two zones are selected as the most "successful" ones while the two others are selected as being less "successful." Comparing the findings in the four zones will specify these differences and help identify the main factors of project success.

For each group interview, record:

Name of the interviewers
Date and time of interview
Name of village
Number of persons interviewed, per category

Health Center Team

1. What do you see are the greatest strengths or accomplishments of this project?
2. How have your practices or activities changed since the project started?
3. What training have you received since the project started? How did it help your work?
4. What are the key messages for each intervention?
   ARI_____

   Malaria_____

   Diarrhea _____

   Immunization _____

   Breastfeeding_____

   Family planning_____

   Safe motherhood _____

   STI_____

   HIV/AIDS _____

5. What are the main activities conducted to promote these messages and behaviors in the community?
6. What outreach activities do you conduct? Who is responsible for these activities? How often do you carry out each of these activities?
7. Who comes for supervision? Do they use a supervisory tool? When was the last time you were supervised and what problems did you discuss?
8. What outreach activities are provided in your zone by the DHO? How these outreach clinics are complementing the HC services? (Probe for type services provided; regularity; quality; any specific issues when the CS-15 ends)
9. Are the necessary drugs and supplies available? Has there been any stock out for any drugs/antigens during the past 5 months? (Probe for co-trimoxazole; SP; ORS; Vaccines; Iron/Folic Acid; condoms; pills; Depo-Provera; STI drugs)

10. Do you have DRF in your catchment area? If yes, how do the DRFs get their drug supply? What mechanisms do you have for supervision of DRF?
11. Are the fees for the drugs a constraint to their utilization? (Probe Iron/Folic Acid, SP).
12. What is the HMIS at the HC/Zone level? Who collects information, who analyzes it, who uses it, does it reflect what you are doing? (Look at some forms and reports; ask for examples of how the data are used) What are the trends in utilization of services? (Probe specifically malaria and FP).
13. Who in the communities does not access health services? What are the barriers?
14. How did the hunger last year affected the children's health? (Probe on malnutrition, breastfeeding, use of health services)
15. Do you think many women in your zone would like to use FP but do not? Why? What can be done to respond to their needs?
16. Is the HC/Zone fully staffed? What is the staff turnover?
17. What plans are there for continuing these activities beyond the end of the project? Which will be the most important activities to maintain and why? (*Observation: do they feel like the project belongs to them)*

VHCs and VHVs

1. What are the most important health problems you are addressing? Which of your activities have made the biggest difference to health in the village?
2. What are the key messages for each of these interventions?
   ARI_____

   Malaria_____

   Diarrhea _____

   Immunization _____

   Breastfeeding _____

   Family planning_____

   Safe motherhood_____

   STI_____

   HIV/AIDS_____
3. How did you learn about these messages?
4. How do you help people in your village learn about these messages and adopt the appropriate behaviors?
5. When were you last supervised and what did you discuss?
6. What kinds of health information or reports are collected in the village?
7. Is there as DRF in the village? What is your role in supporting the DRF?
8. Community AIDS support systems –What activities are done by the HBC volunteers? What support groups are available in the community and what are their roles? How are orphans taken care of and by whom?
9. How often does the VHC meet? How many times last year? When was the last meeting?
10. What plans do you have to maintain the activities we have discussed after the project ends?

DRFs

1. How were you trained in DRF? Duration of training? Content?
2. What patients (children or everybody) do you see at your DRF?
3. How do you handle patients with inadequate or no money to buy drugs?
4. What do people prefer between the health facility and DRF in relation to drugs which they dispense?
5. What types of drugs are available? How is the price determined? How many different drug dispensers have been trained in this village?
6. Who keeps the money for the DRF? Drug box? What control measures are in place for the program in terms of money and drugs?
7. How do you make sure that there is a consistent supply of drugs?
8. Where do you order drugs from?
9. How do you record and report your activities? (Look at forms and reports; discuss utilization, sales, trends)
10. What are the key messages you educate mothers on when they come to your DRF?

TBAs

1. How long have you been delivering babies? How many deliveries did you do last month?
2. Where were you trained? How long did your training last?
3. What advice and care do you give to a pregnant woman? (Probe about birth planning)
4. What advice and care do you give to a woman during labor & delivery?
5. What advice and care do you give to a woman soon after delivery? (Probe on how the cord was cut and what care was given; Immediate and Exclusive breastfeeding; counseling on STI/HIV/AIDS)
6. What kinds of medications do you give to the mother? (Probe about SP)
7. If a mother would die what would you do? (Probe for dialogue with district health personnel)
8. Which symptoms/cases would you refer to the health center? (Probe about newborn)
9. Where do you refer them? Do they go? If not, why?
10. How do they go? (Probe for alarm and transport; bicycle ambulance)
11. Can you show us your referral form and how you fill it out? What is supposed to happen with this form? In practice does this happen?
12. Do they have any feedback either from the mother or the health center?
13. How do you replenish your TBA kit?
14. What is the nearest health center? Has the nurse from the HC ever visited you? Have you been visited by any other nurse? How frequently? When was the last?
15. What challenges do you face?
16. Do you think many women in your zone would like to use FP but do not? Why? What can be done to respond to their needs?
17. Do you keep any records? Can we look at them?

CBDAs and CMMs

1. Where were you trained? How long did your training last?
2. Do you serve both male and female clients? What are the challenges associated with each?
3. What is your total number of clients? Male/female? How many new clients do you see in the last month?
4. What methods do you counsel your clients on?

5. For male motivators: What methods do you counsel men on? (Probe: vasectomy) How do you motivate other men to use modern contraceptives?
6. What contraceptives do you supply? Where do you get your supplies from? Have you had any stock outs?
7. How do you handle clients who chose methods you can't supply?
8. What are some of the side effects of oral contraceptives?
9. When and to whom do you refer clients? Do people go when referred? And do you get any feedback?
10. Please demonstrate how a condom is put on?
11. What material do you use in counseling your clients? Can we look at them?
12. What are the relationships between CBDAs and male motivators?
13. How do you work with HSAs and HC staff
14. Do you keep any records? Can we see them?
15. What challenges do you face?
16. Do you think many women in your zone would like to use FP but do not? Why? What can be done to respond to their needs?

Drama Groups

1. Training received
2. Activities conducted
3. Messages promoted
4. Response/Reaction of the community

HIV/AIDS and Initiation Counselors

1. Training received
2. Activities conducted
3. Successful results
4. Major challenges

Interview Guideline for PEAQ Staff

1. What are your main achievements since on the job?

2. Can you describe your job?

3. What are the main difficulties you are facing in your job?

4. How do you collaborate with your colleagues?

5. How does your direct supervisor help you in your job?

6. What are your plans when the project ends?

Annex F. Field Visits Findings

Phimbi	Balaka Central [Community level only]	Phalula	Kalembo
Technical Approaches			
Immunization			
Trained VHC/VHV have resulted in increased awareness and coverage of EPI/GM		VHCs have good knowledge. They involve religious and community leaders. They do not specify when the immunization needs to be completed when communicating with parents	VHCs have good knowledge Appropriate messages are communicated to the target populations
Cold chain has been strengthened at the HC level from training of technicians and provision of maintenance tools, cold chain equipment, kerosene, gas cylinders, etc		No midlevel EPI manager training	
		There are 12 outreach sites for U5 clinics conducted by HSAs once per month	There are 12 outreach sites for U5 clinics; 6 of 12 also provide family planning services
The HC experienced BCG stock outs		No vaccine stock outs reported	There have been stock-outs of some antigens from time to time. Recently, there was no vaccines for 2 months.
Maternal and Newborn Care			
Improved infection control from provision of kerosene and TBA training		TBAs are confident and have a good understanding of their work	Stronger knowledge of risk factors than danger signs at the HC
Improved referrals from community to HC from TBA training, bicycle ambulances		The TBAs expressed a need for bicycle ambulances	Birth planning messages were not mentioned at the HC
Improved referrals from HC to Hospital from provision of radio to HC by SC		Provision of radio to HC by SC	Some mothers do not deliver with trained providers because of the cost in the CHAM facility.
Increased number of deliveries at HC			

Phimbi	Balaka Central [Community level only]	Phalula	Kalembo
TBAs trained in 2000-2001 (including refresher): --know referral criterias (primi-gravidae, short height or limps, previous scar); --advise to eat well, reduce work, prepare for birth (clothes, razor blades, parafin for lamp, potential transport); --advise to stay in lateral position, eat, void, not push before being told; --advise on immediate and exclusive breastfeeding.	TBAs trained by GTZ (4 weeks) and refreshed by CS-15 (1 week) give advice: -- to pregnant women: personal hygiene, go to hospital if risk factors; --on birth plan: prepare 2 clothes; --on labor: rest on her side, eat porridge, frequent voiding, place baby to breast immediately after delivery; examines placenta --on HIV/AIDS: reduce # partners, treat STIs,		TBAs have adequate knowledge of danger signs and generally have a good understanding of their work; They counsel on HIV/AIDS, STIs, EBF, and SM
TBAs use gloves.	TBAs do 8 to 36 (exception!) deliveries per month.		
TBAs are supervised once per month and go to the Hospital every month; replenish kit (gloves, drugs) when supervised by TBA coordinator or CS-15 staff	Kit is replenish by the HC staff during meeting at HC or supervision		
TBAs report maternal death to TBA coordinator.	Report maternal death to DHO		
Refer to Phimbi or Utare; Would refer for slow progress, transversal lie, bleeding, flabby or absence/high-pitch cry newborn.	Refer to Hospital for excessive bleeding, anemia, cord prolapse, failure to deliver placenta, premature, not crying baby, jaundice, failure to suck, not passing stools. Usually get feedback from hospital on referred women; use referral form (not seen).		
TBAs used to provide SP (at 5 and 8 months); they provide IFA but there are shortages.	TBAs used to give SP at 5 and 8 months; provide iron and postpartum Vitamin A.		
TBAs keep good records.			
TBAs face problems during some deliveries from lack of water and the absence of anybody accompanying the women in labor	TBAs' challenges are they are far from HC and often lack supplies		

Phimbi	Balaka Central [Community level only]	Phalula	Kalembo
Family Planning			
Improved geographical accessibility from outreach clinics last year (1 DHO and 6 HC)		No new outreach clinics.	There are 6 outreach clinics – recently due to the ambulance and motorcycle breakdown the nurse provider used own money to get to the clinics
Male motivators trained in June 2003 know all main methods and ways to talk to men about FP; would like demonstration and education materials, and some identification sign like uniform; keep records (register of activities) and send report to HSAs; face difficulty in motivating males in using condoms and vasectomy, and in transport.	1 CMM trained in Jan 2002 Use register of activities and report of activity/supply to HSA or HSA??? Registers 10-15 activities per months (individual counseling and health talks)	One district staffed FP clinic is supposed to be held in the town on a monthly basis but has been irregular	FP messages are clear and appropriate; VHCs also had good knowledge
CBDAs trained by SC in July 2001 in FP and STI: --distribute free pills, condoms and foam tablets to women; --face problems of misconception and beliefs about FP, lack of communication with HC (lack of referral forms; no feedback; difficulty to get supplies), a too large area to cover, lack of supplies, lack of identification sign (card) and lack of incentives; --have flipchart, a demopenis, a drugbox, and umbrella.	1 new CBDA trained in June 2003 and 1 CBDA trained by GTZ in 1996: --provides pills, spermicides, condoms, and counsel on other methods and refer to hospital --serve men and women. --face some resistance from the community even though there is demand at the individual level. --is aware of misconception about contraceptives ("pill do not dissolve but accumulate in stomach") --do not give clear answer about side effects and contraindications of pills. --get supplies from MOHP; experience stock outs. --use register of activities and report of activity/supply to HSA --need demonstration and visual education materials. --"work hand-in-hand" with CMMS --will miss training, supply, and supervision at project end	Some CBDAs are quite active and competent; Other CBDAs have lacked motivation and some have stopped their activities Client compliance with referral is low – most just use the CBDA services The 14 CBDAs originally active have reduced to 9. Only 6 are very active - Generally good knowledge Good demonstration of condom use They "work hand-in-hand" with CMMs and refer clients to HSAs Challenges include lack of transport (push bicycle) and supervision	CBDA/CMM Volunteers: --Average 6-7 clients per month --Encourage male leadership and participation in FP --Stock out of condoms for two months --Generally good knowledge --Good demonstration of condom use --They work hand-in-hand and refer clients to HSAs --Challenges include lack of transport (push bicycle) and supervision

Phimbi	Balaka Central [Community level only]	Phalula	Kalembo
There are still many women who would like to use FP but do not because of the large distance to FP services; also resistance from religious beliefs and misconceptions.	TBAs do not think there is unmeet need in family planning		Many women would like to use FP but their husbands refuse Some Muslims believe FP is prohibited by their religion
Sexually Transmitted Disease			
Increased in number and quality of STI case management at HC level from training of HC staff in syndromic approach, improved drug availability, partner notification system, etc.		HC staff very appreciative of training and are very active.	Staff very appreciative of training – "I'm a STI manager"
HC documented stock outs in several STI drugs		There is an erythromycin stock out and syringes are not available – they use the EPI syringes	
		Appropriate messages	Appropriate messages
HIV/AIDS			
Recently trained HIV/AIDS counselor already sees about 14 clients a month at the HC	HIV/AIDS counselor / CHBC trained in 2001-2002 by GTZ has following activities: --was introduction by village chief as taking care of chronic diseases; --conduct group talks and house-to-house visits; --more and more people are asking for VCT and she refers them to Balaka. --if patients open: talk about VCT and how not to infect people; --currently cares for 3 patients: washing, drugs (CS-15 provided kit); --covers 4 villages, but thinks that there should be more counselors in the area; --faces challenges: transport; lack of pain killers; no education materials.	HIV/AIDS counselor: --gives talks during U5 clinics, OPD --notes that the HIV+ clients she has counseled are living positively --challenged with timely transport of VCT samples --only referred 3 clients for testing since 2001.	Counseling training resulted in a marked attitudinal change towards HIV/AIDS clients
			3-4 VCT samples sent to Balaka per month except in the last six months when reagents were not available in Balaka
		VHCs have good knowledge	VHCs have good knowledge
		Orphan care in the communities	No orphan care in the communities

Phimbi	Balaka Central [Community level only]	Phalula	Kalembo
Malaria/ARI/Diarrhea			
		ARI messages lack clarity at the HC level	ARI messages lack clarity at the HC level
			Malaria messages clear
			For diarrhea they are promoting the use of other rehydration fluids but did not mention ORS
			VHC/VHVs have appropriate diarrhea and malaria messages
Breastfeeding			
TBAs know importance of Immediate and Early Breastfeeding	TBAs know importance of Immediate and Early Breastfeeding	Messages are appropriate	Messages unclear on exclusive BF but clear on immediate BF
			VHCs have appropriate knowledge
			Some mothers fail to EBF during the hunger period last year
Cross-cutting Approaches			
Community Mobilization			
Major activities and accomplishments of VHC/VHV are in the area of cholera control (education, sanitation, epidemic surveillance) and Growth Monitoring	--Main activities of VHVs are domestic hygiene and growth monitoring. --They are doing house visiting and community meetings	VHCs have raised funds for transport and welcoming visitors through gardens or member contributions. They are very confident and clear about their activities	90% of VHCs trained 46% of VHVs trained
VHC/VHV meet regularly (average 8 times last year)			Strong support for HSAs now in the zone compared to before the project when they were working "alone"
		Have appropriate knowledge of most intervention areas	Have appropriate knowledge of most intervention areas
		Focus on sanitation is a large part of their work	Focus on sanitation is a large part of their work
BCC			
VHC/VHV and HC staff were quite knowledgeable about most key messages of the project	VHC/VHV know major messages, although not much was mentioned about SM and early malaria treatment	VHCs had a good knowledge of messages	
The main behavior change activities of VHC/VHV are: health talks and house-to-house visits			

Phimbi	Balaka Central [Community level only]	Phalula	Kalembo
HC staff are conducting health talks in HC and outreach clinics		Health workers did not have very clear messages on ARI, BF and immunization	
Drama groups (10 members) trained in interactive drama, key health messages and script are active in the area; well received by the population.	Drama group (10 members) trained in Sept 2002 on messages, script, and interactive drama: --do research in the community before developing script; --meet twice a week to prepare; perform twice a month; --currently have two plays related to health: 1 on HIV/AIDS, and 1 on marijuana; --will continue at the end of project.	Use of drama groups is important – there are two groups Drama presentations in schools The drama groups are well organized	Use of drama groups is important: Also use flipcharts Weekly drama presentations during FP clinics and U5 clinics They are well organized and have a schedule for the next six months Also have used house to house visits to spread messages
DRF			
DRF members were trained for 5 days in April 2003 in signs and symptoms and in dispensing drugs for malaria, scabies, conjunctivitis and in record keeping.	Trained in February 2003 during 5 days on malaria, scabies, conjunctivitis, diarrhea, pneumonia, AIDS.	5 DRFs in zone and are supported/supervised by the HSAs	9 DRFs were established and are supported/supervised by the HSAs Training was 6 days
DRF members see adults and children, mainly for malaria and colds; they deliver messages on hygiene, how to take drugs, and malaria prevention; they accept partial payments but always provide full treatment.	DRF see mainly children (3/4); provides health message at first visits; and refer if no improvement; provides SP, aspirin, eye ointment, BBA, ORS, paracetamol, condoms; refer to village chief if no money, but give the entire treatment.	Appropriate understanding of when to make referrals The manager interviewed only mentioned malaria	Drugs are replenished the through the district pharmacy
DRF well appreciated by the population because of the otherwise long distances to the HC.	Community appreciates DRF because it is closer than HC		Community feels SP is expensive (almost 3 K/tablet)
The treasurer keeps the money and the HSA checks during supervision visits.	One treasurer was selected but she died	DRFs are well managed – established in 2000	DRFs are well managed
DRF reorder to the DHO when ¼ of drugs remain; no drug box.	Reorder from Hospital	Drugs are replenished through the district pharmacy\	
Price of drugs determined by the committee based on cost, transport, and price in local pharmacies.	Price determined by cost and transport	Drugs are sold slightly above cost	Drugs are sold slightly above cost
DRF record on register and report on forms, but these were not properly maintained	Records well kept; mainly SP is provided.		

Phimbi	Balaka Central [Community level only]	Phalula	Kalembo
Capacity Building			
VCH/VHV have been trained in CS messages and activities		Both health workers and community volunteers benefited from numerous trainings	Both health workers and community volunteers benefited from numerous trainings
HC have increased their capacity to deliver CS interventions through training in FP, STI, cold chain, HMIS, HIV/AIDS counseling			
HC staff has also been trained and supported in implementing QA problem solving activities (last topic was low use of FP and led to opening of new outreach clinics)		The QA training helped to address the problem of women taking SP due to the cost. They decided to include the cost of SP in the initial consultation fee. They have not used QA since then due to lack of coaching and turn over of staff.	
HC has improved transport capacity (motorbikes, fuel) that allows to reach underserved areas: 6 monthly outreach clinics have recently been established			
HC has increased capacity to hold zonal meetings linked to EPMU meetings; HMIS data are used in this process.		EPMU quarterly meetings have been important to the staff to compare their work with other zones in the district and as learning opportunities	
HC has experienced stock outs (SP, Vit A, Iron, BCG, STI drugs, others) of major drugs last year as a result of problems at the national level			
DHO does not supervise the HC DHO holds a monthly outreach clinic in the zone		The zone has been supervised by the DHO and FP Coordinator but not regularly; HMIS is more regular TBAs are not regularly supervised by the nurses due to transport difficulties	The zone has been supervised by the DHO and FP Coordinator but not regularly; HMIS is more regular; Supervisors do not use checklists TBAs are not regularly supervised by the nurses due to transport difficulties but they are visited by HSAs
HSAs visit VHC/VHV every two weeks			HSAs regularly supervise the VHCs/VHVs

Phimbi	Balaka Central [Community level only]	Phalula	Kalembo
HMIS			
All HC staff trained in new national HMIS; Zone coordinator plays major role in increasing quality and use of HC data		They receive regular supervision from the district	They receive regular supervision from the district
Each staff member responsible for collecting and reporting data for its activity; all staff meets monthly to review data; report to district and review of all zones results on a quarterly basis;		The HC staff explained some trends but were unclear on decisions taken in response to these trends	The HC staff explained some trends in FP and malaria from their HIS
VHV/VHV report to HSAs on head count, diseases surveillance, households with pit latrines, etc.			VHC/VHV keep good records of vital events etc. from their catchment areas
Sustainability			
Main support needed by HC staff to continue project activities are training, transport and outreach clinics.			The HC staff feel they will be able to continue to conduct local trainings in the zone
VHV/VHV will continue their activities at the end of the project	VHC/VHV feel they can continue after project ends because they have knowledge and skills	VHCs will have fund raising activities	VHCs will have fund raising activities
Miscellaneous Observations			
Geographical barriers (river, distance) are main caused for underserved populations			
A small percentage of the population (<10%) do not use health services for religious reasons			
Food crisis last year had impact on children; HC set up feeding center, still active.			
Several positions in the HC are vacant, mainly because most MOHP staff do not want to work in remote areas.		The HC lack one medical assistant and the zone lacks one HSA; Low turn over of staff	The HC is adequately staffed According to MOHP norms the zone lacks 12 HSAs; Low turn over of staff

Annex G. Implementation Timeline – FY00 to FY03

Selected Project Activity / Landmark	Fiscal Year (October to September)															
	2000				2001				2002				2003			
	I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV
Management																
Awards	CS-15								LIFE							
SC Office operational	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Planning	KAP HFA	DIP wko	DIP App.							LQA	Act.Plan				KAP HFA	
External evaluation: Midterm / Final										MTE						FE
SC/DHO Partnership Agreement / Update		X									X					
Number of zones established		5	5	5	5	5	6	6	6	6	6	6	6	6	6	6
Human Resources[1]																
SC Senior Health Advisor	1	1	2	2	2	2		3	3	3	3	3	3	3	3	3
SC CS-15 Coordinator	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
SC Trainer	1	1	1	1	1	1	3	3	3	3					5	5
	2	2	2	2	2	2	2	2	2	2	4	4	4	4	4	4
SC Data Officer	1	1	2	2	2	2	3	3	3	3	3	3	3	3	3	3
DHO (Tamaona / Mwale)	1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2
DNO	1	1	1	2	2	2	2	2	2	2	2	2	2	2	2	2
Office manager	1	1	1	1	1	1	1	1	1	1	1	1	1			
Training of Health Workers and Community Volunteers																
VHCs/VHVs		X	X	X	X	X	X	X	X	X	X					
DRFs					X	X	X	X					X	X	X	X
Interactive drama			X	X	X	X	X	X	X	X	X	X	X	X	X	X
TBAs			X	X	X	X	X	X	X	X	X	X	X	X	X	X
CBDAs/CMMs			X	X	X	X	X	X	X	X	X	X	X	X	X	X
HIV Counselors											X	X	X	X	X	X
HBC Counselors									X							
HMIS									X	X	X					
STI							X				X					X

Selected Project Activity / Landmark	Fiscal Year (October to September)															
	2000				2001				2002				2003			
	I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV
QA						X	X									
BEHAVE												X				
DAC/CAC (Training for Transformation)												X	X			
HMIS																
National official launch										X	X	X	X	X	X	X
Quaterly Balaka District HMIS reports											X	X	X			

[1] Numbering corresponds to the successive staff members recruited for that position

Annex H. Quarterly Input Monitoring Indicators

Indicators	Baseline 1999	Final 2003	Target	
			Number	% reached
Increase the number of outreach clinics	108	135	128	105%
Train Village Health Volunteers	82	888	1140	78%
Increase number of HSAs	120	146	150	97%
HSA Refresher	120	119	120	99%
Train health center staff in monitoring and evaluation at HC level	0	9	9	100%
Train cold chain technicians	1	6	6	100%
Organize mini-immunization campaigns in all five health zones	0	?	2	0%
Train Village Health Committees	0	299	321	93%
Train Drama groups (about 10 persons/group) in interactive drama	0	16	25	64%
TOT in interactive drama	0	7	7	100%
Train TBAs				
Initial		34	32	106%
Refresher	58	87	90	97%
Establish maternal audit teams	0	2	9	22%
Train Core FP providers	0	89	150	59%
Train CBDAs – initial	3	80	121	66%
- refresher		11	No plan	
Train CBDA Supervisors		10	24	42%
TOT of CBDAs	0	3	2	150%
Train man-to-man motivators	N/A	44	75	59%
Train man-to-man motivators (Refresher)	0	20	75	27%
TOT of man-to-man motivators	0	4	4	100%
Integrate FP services into outreach clinics	35	??	128	%
Establish District AIDS Coordinating Committee	0	1	1	100%
Establish Community AIDS Committees per zone	0	4	15	27%
Establish Village AIDS Committee	0	0	120	0%
Establish voluntary counseling and testing centers in each of the five health zones	1	1	3	33%
Train clinical officers, medical assistants and nurses in syndromic management of STIs	3	20	33	61%
STI refresher	33	7	33	21%
Organize anti-AIDS days	0	3	5	60%
Organize FP days	0	1	6	17%
Train traditional healers in STI/HIV/AIDS recognition and preventive messages	0	0	0	0%
Train Anankungwis in STI/HIV/AIDS recognition and preventive strategies	0	102	75	136%
Establishment of community HIV/AIDS support groups per zone	0	0	0	0%
Establish DRFs	25	34	42	81%
Train DRF volunteers	75	297	135	220%

Indicators	Baseline 1999	Final 2003	Target	
			Number	% reached
Villages with access to functional Bicycle Ambulance	66	162	321	50%
Functioning Village Health Committees	?	591	647	91%
Sensitization of local leaders in STI/HIV/AIDS	0	150	150	100%
Train community Based HIV/AIDS counselors	0	58	140	41%
Train HBCC (Initial)		80	100	80%
HMIS Data – Jan. – Mar. 2003				
Immunization of children (U/1 year)				
BCG	77%	65.5	80%	
DPT3	63%	60.3	80%	
Polio 3	66%	52.0	80%	
Measles	52%	51.0	80%	
Fully Immunized	46%	35.4	80%	
Vitamin A given to under five children	38%	66.2	80%	
Percentage of pregnant women who received at least TT2 vaccine	80%	72.8	90%	
Percentage of pregnant women provided iron and folate (at least 1 dose)	66%	17.1 4 doses	80%	
Family Planning				
CPR	21%	11.7	30%	
Percentage of deliveries attended by trained personnel	52%	44.6	80%	
Percentage of deliveries attended by trained TBA	13%	29.3	5%	
Percent of children who received only breast milk up to at least 4 months of age	10%		20%	
Sensitization of local leaders in STI/HIV/AIDS	0	150	150	78%
Train community Based HIV/AIDS counselors	0	58	140	78%
Train HBCC (Initial)		80	100	78%

Annex I. Number of Trainees by Topic and Target Group at Midterm and Project End

TOPIC	TARGET GROUP	MID TERM		FINAL		
		Planned	Actual	Planned*	Actual	% Target
TBA Initial	Community Volunteers	18	17	32	34	106%
TBA Refresher	Community Volunteers	18	0	90	87	97%
HSA Refresher	Community Volunteers	59	62	150	146	97%
CBDA supervisors	Health Personnel	12	6	24	15	63%
CBDA Initial	Community Volunteers	35	29	121	80	66%
CBDA Refresher	Community Volunteers	14	11	14	11	79%
VHCs	Community Volunteers	321	52	321	299	93%
VHVs	Community Volunteers	840	625	1140	888	78%
STI case management	Community Volunteers	15	2	33	20	61%
STI TOT	Health Personnel	2	2	2	2	100%
Core FPP	HSA	50	43	100	89	89%
Initiation Counselors	Community Volunteers	75	40	75	92	123%
HBCC	Community Volunteers	100	80	100	80	80%
HMIS	Health Personnel	4	2	62	58	94%
HMIS TOT	Health Personnel	3	4	3	4	133%
QA TOT	Health Personnel	8	3	8	3	38%
QA teams	Health Personnel	4	4	9	4	44%
FP Providers (by MOHP)	Health Personnel	5	2	10	2	20%
DRF (Committees)	Community Volunteers	20	3	45	34	76%
CACs	Community Volunteers	20	0	40	9	23%
DACC (Sub committees)	Multisectoral	5	0	5	4	80%
CMM	Community Volunteers	30	20	75	40	53%
Cold Chain Technician	Health Personnel	5	6	5	6	120%
Drama Groups (Interactive)	Community Volunteers	12	10	25	16	64%
TOT in Interactive Drama	Health Personnel	7	7	7	7	100%
Monitoring and Evaluation	Health Personnel	9	9	9	9	100%
STI refresher	Health Personnel	15	7	15	7	47%
HIV/AIDS Counselors	Health Personnel	12	12	24	12	50%
HIV/AIDS Counselors	Community Volunteers	70	20	140	58	41%
STI/HIV/AIDS/RH Integration	Health Personnel	0	0	75	68	91%
Infection prevention	Health Personnel	0	0	75	68	91%
HMIS	Health Personnel	3	4	75	62	83%
EPI Mid level managers	Health Personnel	0	0	27	25	93%
BCC Strategy Development	Health Personnel/ CS-15 staff	0	0	18	12	67%
TFT for Zone Coordinators	Zone Coordinators	0	0	6	5	83%
DACC TFT	Multisectoral team	40	15	40	36	90%
DRF TOT	Health Personnel	11	0	11	11	100%
New FP logistic system orientation	Health Personnel	0	0	7	7	100%
Integrated BFHI and HIV/AIDS	Health Personnel	0	0	2	2	100%

* Final targets as adjusted after the midterm evaluation.

Annex J. Training Events Attended by SC Staff

DATE	TRAINING EVENT	PEAQ STAFF
April 2000	Training of Trainers	Health Trainer
January 2001	LQAS	Data Officer, Health Trainer
April 2001	Quality Assurance	Health Trainer
September 2001	Report writing workshop	District Health Coordinator
October 2001	STI Syndromic Approach	Health Trainer
February 2002	BEHAVE Framework, South Africa	District Health Coordinator, Senior Health Advisor
December 2002	Integration of Reproductive Health and STI/AIDS	Health Trainer
March 2003	Qualitative Research	Data Officer
September 2003	Community mobilization	Zone coordinator (MOHP), Health Trainer

Annex K. Objectives Monitoring Indicators

	INDICATOR	BASE-LINE	MIDTERM		FINAL	
			Target	Actual	Target	Actual
	Immunization					
1	Percent of children age 12-23 months fully immunized by their first birthday	46%	55%	60%	75%	50%
2	Percent of mothers of children age =< 24 months who received 2 or more doses of tetanus toxoid during their last pregnancy	80%	85%	85%	90%	87%
3	Percent of children age 6-24 months who ever received Vit A	31%	20%	46%	40%	39%
	Breastfeeding Promotion					
4	Percent of children who received only breast milk up to at least 4 months of age	28%	15%	68%	20%	57%
	Maternal and Newborn Care					
5	Percent of mothers with children age =< 24 months who received iron/folate supplementation during their last pregnancy	64%	75%	77%	80%	87%
6	Percent of mothers with children age 24 months or under who received at least one dose of SP during their last pregnancy	72%	75%	63%	80%	77%
7	Percent of mothers with children age 24 months or under who report last delivery assisted by a health worker or trained TBA	62%	70%	70%	75%	73%
	Child Spacing					
8	Percent of married women 15-49 years old using modern contraceptives	21%	25%	18%	30%	29%
	STI/HIV/AIDS Prevention					
9	Percent of women 15-49 years old who report condom use with non-regular partner	38%	30%	NA	50%	61%
10	Percent of women 15-49 years old who know of three ways to prevent STI/HIV	17%	30%	16%	60%	12%
11	Percent of men 15-54 years old who report condom use with non-regular partner	25%	60%	NA	70%	57%
12	Percent of men 15-54 years old who know of three ways to prevent STI/HIV	24%	30%	29%	60%	20%
13	Percentage of female youth 15-19 years who delay sexual debut	21%	25%	NA	30%	29%
14	Number of persons tested in VCT centers/month	0	0	8	350	10
15	Percent target orphans/vulnerable children (OVC) with access to community services (OVC program)	0	0	NA	50%	NA
16	Percent STI cases treated according to national standards (STI treatment protocol)	20%	20%	NA	75%	50%
17	Percent of households receiving help in caring for chronically ill young adults (15-49) in a population survey	0%	0%	NA	50%	9%
18	Percent of male youth 15-19 years who delay sexual debut	19%	25%	NA	30%	38%
	Control of Diarrheal Disease					

	INDICATOR	BASE-LINE	MIDTERM		FINAL	
			Target	Actual	Target	Actual
	Percent of children age 24 months or under who have had diarrhea in the two weeks prior to the survey	28%		41%		24%
19	Percent of children age 24 months or under who have had diarrhea in the two weeks prior to the survey and who have been treated with Oral Rehydration Therapy (ORT)	65%	75%	59%	80%	77%
20	Percent of children age 24 months or under presenting at health facility with diarrhea who were treated correctly (in accordance with the Malawi Standard Treatment Guide) at the health center level	59%	70%	NA	80%	Not Measured
	Control of Malaria					
	Percent of children age 24 months or under with fever in the two weeks prior to the survey	40%		50%		44%
21	Percent of children age 24 months or under with fever in the two weeks prior to the survey who obtained medical care from a health facility	35%	40%	NA	50%	51%
22	Percent of children age 24 months or under presenting at health facility with fever who were treated correctly (in accordance with the Malawi Standard Treatment Guide) at the health center level	31%	55%	NA	70%	23%
	Pneumonia Case Mgmt.					
	Percent of children age 24 months or under with cough and difficult/rapid breathing in the two weeks prior to the survey			5%		23%
23	Percent of children age 24 months or under with cough and difficult/rapid breathing in the two weeks prior to the survey who obtained medical care from a health facility	50%	55%	NA	70%	43%
24	Percent of children age 24 months or under presenting at health facility with cough and difficult/rapid breathing who were treated correctly (in accordance with the Malawi Standard Treatment Guide) at the health center level	44%	55%	NA	70%	Not Measured
	OTHERS					
25	50% of villages have formal alarm and transport plans	0	25%	59%	50%	50%
26	80% of DHMT meetings discuss current HMIS information and make management decisions based on the data	0	40%	50%	80%	100%
27	Each of the 9 trained HC QA teams investigate and solve at least 3 problems per year after training	0	5	4 trained	9	0
28	A Functioning DHMT-NGO District Coordination Comm. (DHPCC)	NO	YES	YES	YES	NO

	INDICATOR	BASE-LINE	MIDTERM		FINAL	
			Target	Actual	Target	Actual
29	A District Fundraising Committee established and mobilizes resources for at least 2 projects per year	NO	YES	NO	YES	YES
30	Quarterly HMIS report produced and disseminated using computerized HMIS data	NO	YES	YES	YES	NO
31	80% of villages with functioning VHCs i.e. VHCs meeting at least one every two months (6 times/year)	0%	40%	NA	80%	91%
	Operations Research					
32	Documented results of working with Traditional Healers and initiation leaders	NO	NO	NO	YES	NO
33	Document results of Living University Approach	NO	YES	NO	YES	NO
34	Document Results of Birth Plan Use OR Bicycle Ambulance	NO	NO	YES	YES	YES

Annex L. Selected HMIS Data

Figure 1. Coverage of Selected Interventions by Zone, Balaka, 2002

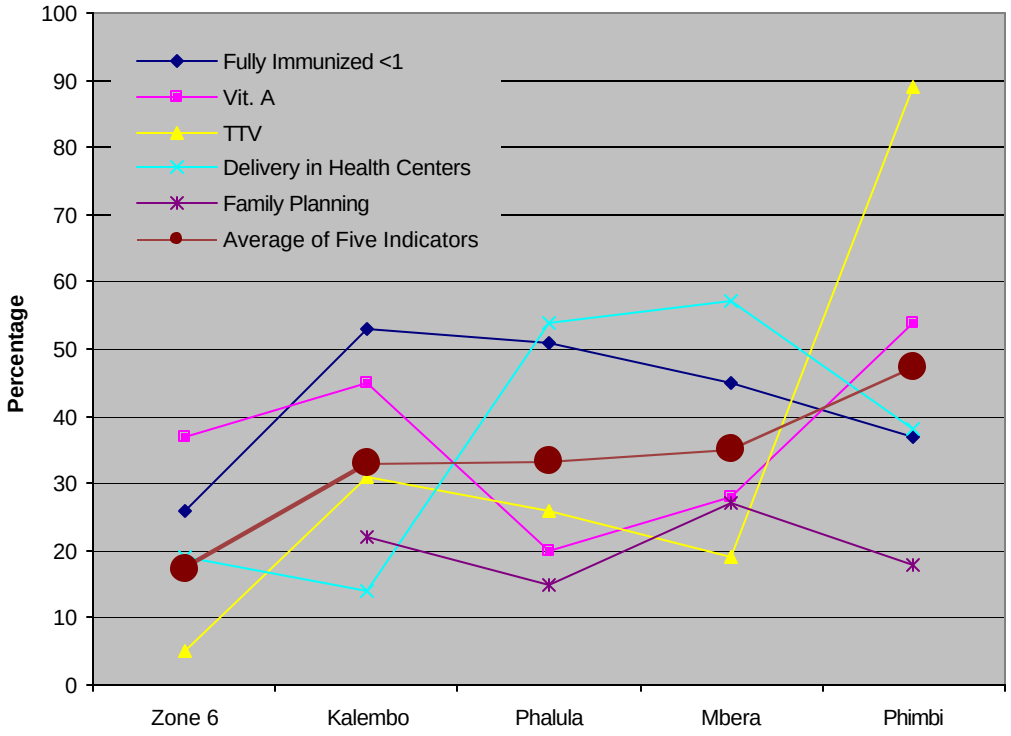

Figure 2. Monthly STI Cases Treated in Health Facilities, Balaka, 2002