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FINAL EVALUATION OF THE MATERNAL AND CHILD HEALTH PROJECT PART 2

FINAL REPORT

Submitted to

Plan Malawi
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List of Acronyms and Abbreviations

ACSD	Accelerated Child Survival and Development
AIDS	Acquired Immunodeficiency Syndrome
ANC	Anti Natal Care
ARI	Acute Respiratory Infections
ART	Anti Retro Virus Therapy
ASRH	Adolescent and Sexual Reproductive Health
CBDA	Community Based Distribution Agents
CBM	Community Based Management
CBO	Community-Based Organization
CCCCDA	Community Child Centered Development Approach
CDFs	Community Development Facilitators
CDO/P	Community Development Outline/Plan
CHAM	Christian Hospital Association of Malawi
CHW	Child Health Week
C-IMCI	Community Integrated Management of Childhood Illness
CLTS	Community Led Total Sanitation
CMR	Crude Mortality Rate
CMS	Central Medical Stores
CORPS	Community Resource Persons
CPME	Corporate Planning Monitoring and Evaluation
CPO	Country Program Outlines
CSP	Country Strategic Plan
DCT	District Coordination Team
DEC	District Executive Committee
DHMT	District Health Management Team
DHO	District Health Office
DHS	Demographic and Health Survey
DIP	District Implementation Plan
DPT	Diphtheria-Pertussis Tetanus
DRF	Drug Revolving Fund
ECC-SGD	Early Childhood Care-Survival, Growth and Development
EmOC	Emergency Obstetric Care
EPI	Expanded Program for Immunization
FAO	Food and Agriculture Organization of the United Nations
FGD	Focus Group Discussion
FY	Financial Year
GoM	Government of Malawi
GUH	Growing Up Health
GVH	Group Village Headman
HIP	High-Impact Package
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
HWF	Hand Washing Facilities
IEC	Information, Education, and Communication
IMCI	Integrated management of Child Illness

IMR	Infant Mortality Rate
IPT p	Intermittent Preventive Treatment against Malaria for pregnant women
ITN	Insecticide treated Nets
LLIN	Long-Lasting Insecticide-Treated Net
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MGDS	Malawi Growth and Development Strategy
MEHN	Malawi Health Equity Network
MICS	Multiple-Indicator Cluster Survey
MIS	Malaria Indicator Survey
MMR	Maternal Mortality Rate
MNCH	Maternal, Neonatal and Child Health
MUAC	Mid Upper Arm Circumference
MOH	Ministry of Health
MP	Member of Parliament
NGO	Non-Governmental Organisation
NIDs	National Immunization Days
O&M	Operations and Maintenance
ODF	Open Defecation Free
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PMTCT	Prevention of Mother to Child Transmission
PPM	Programs and Projects Module
PRSP	Poverty Reduction Strategic Plan
PSI	Population Services International
PSM	Programme Support Manager
PU	Programme Unit
PUM	Programme Unit Manager
RBM	Roll Back Malaria
SMC	School Management Committees
SWAp	Sector Wide Approach
SWOT	Strength, Weaknesses, Opportunities and Threats
TBA	Traditional Birth Attendant
TT2	Second dose of Tetanus Immunization
TT5	Fifth dose of Tetanus Immunization
U5MR	Under-Five Mortality Rate
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
VH	Village Headman
VHCs	Village Health Committees
VHWPCs	Village Health Water Point Committees
WHO	World Health Organization
WMA	Water Monitoring Assistants

1 EXECUTIVE SUMMARY

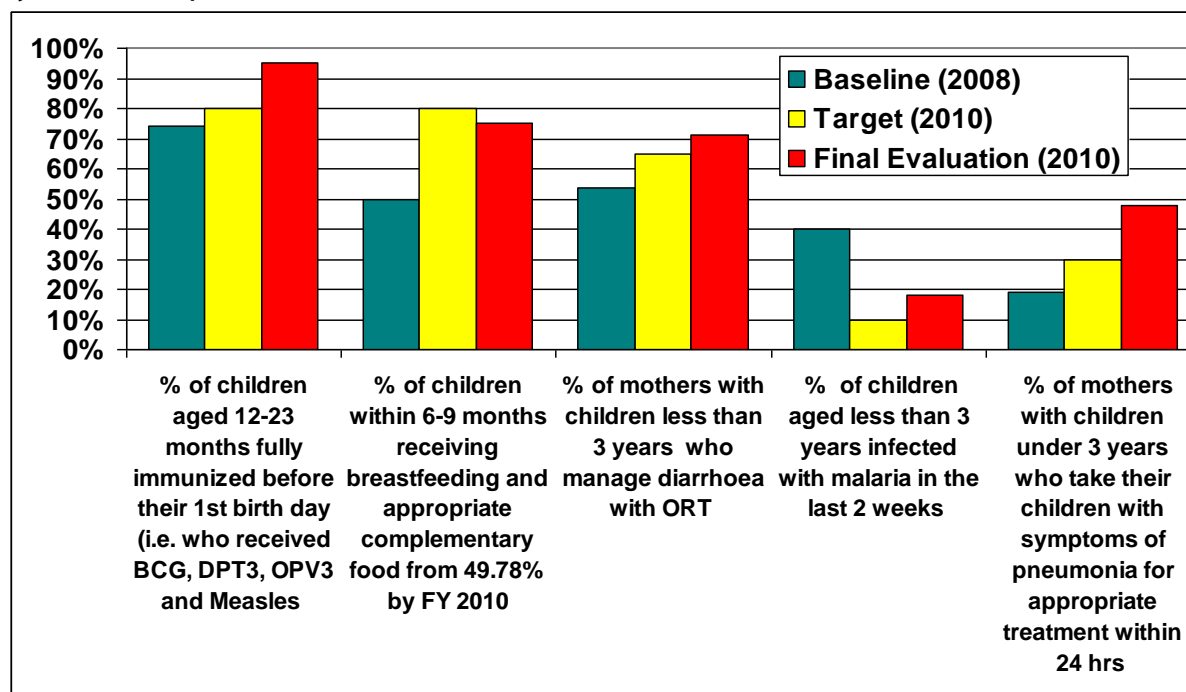
Background

Plan received funding from NORAD to implement a Maternal and Child Health (MCH) Project for 3 years (2008-2010) in Kasungu and Mzuzu Program Units (PUs). The goal of this project was to contribute to the reduction of high infant and child morbidity, mortality and malnutrition rates and to improving mother/adolescent sexual and reproductive health. The main components of the program were child health, school health promotion, maternal and neonatal health care and water and sanitation. Community and facility-based Integrated Management of Childhood Illness (IMCI) was the main strategy adopted for promoting child survival, growth and development. The final evaluation of the project was commissioned in the final year (November, 2010) to determine the level of achievement of project objectives, strategies; identify best practices, lessons learnt, weaknesses, strengths and recommendations. The evaluation also assessed the relevance, effectiveness, efficiency, & effect/outcomes and sustainability of interventions employed in the project. The evaluation was conducted among 698 sampled households out of the planned target of 600 in the 2 Program Units (Kasungu n=362, Mzuzu n=336). A total of 756 children (Kasungu n=371, Mzimba n=385) aged 1-59 months were part of the study. For anthropometry only those of the ages of between 6-59 months were included in the analysis of wasting, stunting and underweight indicators.

Key Findings against baseline and targets

Overall the project achieved most, and in some cases significantly exceeded its project targets. (Refer table 1). In cases where the final coverage fell short of project targets, significant progress was observed and important lessons were learned that will strengthen future programming.

a) Child survival/child health

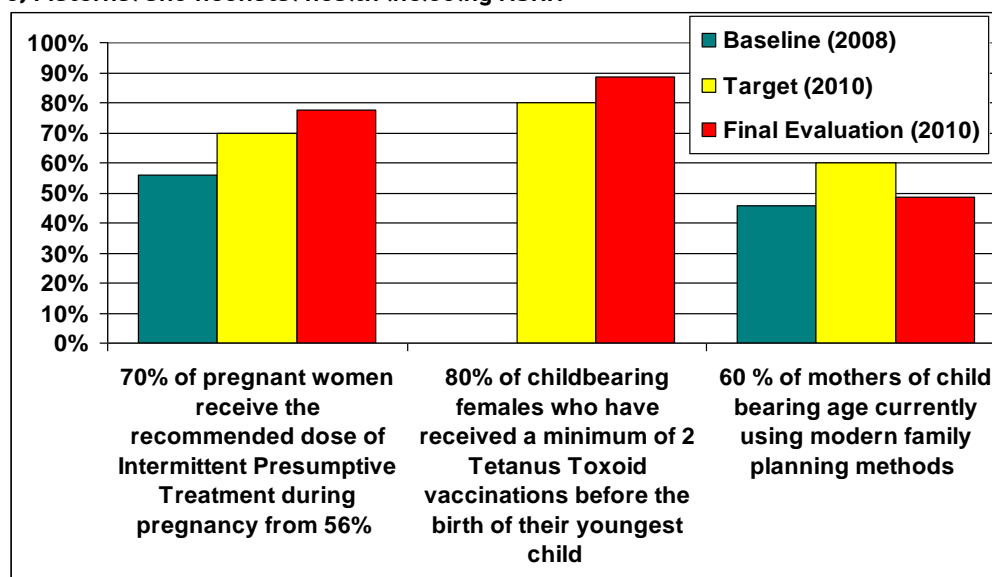


Vaccine coverage for children 12-23 months increased from the baseline of 74 % to 95.1% and above target of 80%. Some of the contributing factors include the support to integrated outreach services and the biannual child health weeks which the programme consistently supported over the duration of the project. 74.9 % of infants aged 6-9 months old from a baseline of 49.78% received complementary foods while continuing to be breastfed. These results indicate good progress on complementary feeding despite the shortfalls in meeting the target of 80%. The majority of the mothers fed their children 3 or more times a day. However despite this progress, children did not receive complementary foods of the diversity that is required. 86.7% of the children eat solid based foods. One of the key contributors to having proper nutrition is the initiation of breastfeeding within 1 hr of birth. The evaluation found out that 75.5% were able to breast their newborns within an hour of birth.

The project objective of increasing the percent of mothers using Oral Rehydration Therapy (ORT) at home during an episode of diarrhoea from 53.65% to 71.20% was exceptionally met surpassing the target of 65%. This was attributed to Plan interventions that focused on the community level training in the prevention of diarrhoeal disease, including hygiene and home-based case management through village clinics which Plan Malawi has facilitated. However in terms of knowledge most mothers failed to recognize danger signs related to diarrhoeal diseases. Only 43.8% mothers mentioned dehydration as a sign to send the child immediately to hospital. On malaria, the final evaluation results do not show major improvements in the indicators, though there was some good progress. The results indicate that 17.9% of the children had malaria in 2 weeks preceding the evaluation as compared to the project target of 10%. More cases were reported in Kasungu (26.4%) than in Mzuzu (9.4%). This shows that malaria prevention is still a major issue throughout the whole year. 71.7% of children slept under ITNs the previous night. This percentage is rather encouraging compared to the rest of the country but still needs to be improved when compared with the objective of 80%. Kasungu showed higher ITN figures at 74.1% as compared to Mzuzu at 69.3%. The findings also showed that a total 73% of the households have at least one net. This shows that there is need to implement integrated malaria prevention and control through Indoor Residual Spray (IRS) as promoted by the malaria prevention and control programme.

The rate of stunting (height for age) among all households visited was 52.1%. The results showed that only 13% were malnourished based on weight for height or underweight. These figures are also lower than the national estimates of 21% in underweight. This was attributed to male involvement in nutrition promotion, biannual deworming and integration of nutrition and food security combined with one to one counselling and conducting food and cooking demonstrations in the project area. Therefore we can conclude that the project has contributed in reducing the underweight amongst children in such PUs.

b) Maternal and neonatal health including ASRH



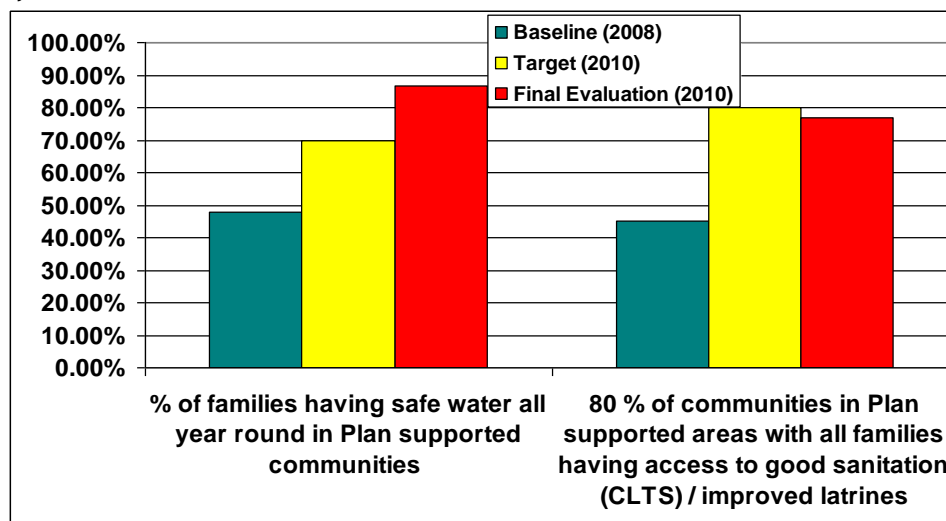
The findings show that 77.4% of mothers had received IPT during their previous pregnancy, a significant improvement from the baseline of 56.0% and meeting the target of 70%. The project provided support at various levels of the health system to strengthen IPT services and also supplied health facilities with refrigerators and health passport for keeping data. The clinicians were also trained in IMCI. At the community level CORPS were trained in EPI promotion and provided with BCC tools. The project had a family planning promotion component which resulted in the percent of mothers who desired no more children in the next two years and using a modern contraceptive method increasing from 45.78% to 48.7%. The limited increase has largely been due to absence of contraceptives at the community level. This is an area of advocacy which the programme may consider in the next country programme.

Reported coverage on mothers receiving at least 2 TTV doses was very high at 88.5%. TT2 coverage was higher in Mzuzu at 91.3% and slightly lower in Kasungu at 85.6%. The overall increase in coverage of TT immunization has contributed to better child survival in the impact areas. The project provided support at various levels of the health system to strengthen TTV vaccinations. At the health facility level, partners were supplied with refrigerators; clinicians and nurses were trained in facility

based IMCI. At the community level CORPS were trained in EPI promotion and provided with BCC tools. These activities complemented with child health campaigns.

The project had a major family planning promotional effort, resulting in a fairly high acceptance rate of modern methods. The percent of mothers who desire no more children in the next two years and are using a modern contraceptive methods increased from 45% at baseline to 48.7% at final. On type of method it was found that the injection is the most commonly used method for contraception. Through this programme Plan has managed to support the DHOs to train Health Surveillance Assistants and provide bicycles for the new Community Based Distribution Agents (CBDAs) within the program area. The district family planning coordinators and health centre supervisors are also supported with fuel and other logistics to conduct quarterly supervision of CBDAs. During these supportive visits, contraceptives and other stocks are replenished, registers and records are also reviewed.

c) Water and Sanitation



86.8% of the households were found to be drinking from safe water sources from a baseline 47.79%, highly surpassing the target of 70%. In terms of latrines, the results of the final evaluation show that 76.9% of the households have latrines from a baseline of 45% and against a target of 80%. The positive results in latrine coverage are attributed to a number of factors. Plan supported borehole drilling in some communities where it is working. In these communities village health and water point committees (VHWPCs) were trained in community-based management, resource mobilization and water point sanitation. The introduction of CLTS in these communities has also played a key role on the outcomes of this project. In terms of adoption of good hygienic practices, the results show that only 26% of households had hand washing facility. Coverage for latrine and safe water seemed very high whilst that of hand washing was exceptionally very low.

Summary of Key Lessons Learned from the project

- With proper empowerment men can equally participate in female dominated areas such as in family planning and nutrition. Men were observed taking a positive role in promoting family health care in the targeted communities.
- Local leader's involvement in promoting reproductive health is crucial in tackling key cultural beliefs and myths surrounding maternal and new born care as observed in the project areas.
- Collaboration is effective in leveraging resources and achieving objectives. Plan collaboration with government and other international donor organizations, has proven to be effective in expanding coverage since no single partner has the skills or funding to do all the child and maternal health including water and sanitation interventions
- Programs should be responsive to changing operational environment. Plan was reactive to introduce strategies, even if they did not appear initially in the original project objectives. A good example has been the introduction of village clinics and changing of TBA roles.
- Capacity building remains main tool for sustainability. Capacity building ensures that the partners retain knowledge and skills. Plan has been involved in capacity building initiatives that have worked towards institutionalizing services in partner health facilities and communities.

- Child Health Week (CHW) campaigns are highly effective ways of ensuring increased coverage of majority of IMCI indicators. CHWs have provided services at "door steps" to the child including the hard to reach areas.
- Health system strengthening is a productive portion of "Child Survival Acceleration". Investments in health system strengthening are essential complements to ACSD. The provision of infrastructure, hospital supplies, equipment and drugs by Plan helped contribute to improving under five case management.
- The quality of counselling provided to mothers by safe motherhood groups is critical to the success of an exclusive breastfeeding initiative including those mothers who are HIV positive.
- The partnership with Mission hospitals as well as government health facilities has greatly contributed to reaching out to more children in shorter period of time.
- Support to integrated outreach activities improves mothers and children access to immunization services.

Key Conclusions and Recommendations in each thematic area

CHILD SURVIVAL

Conclusion 1

Village clinics have a very good potential of contributing towards reduction in child mortality. However it was clear from all the sites visited that due to serious drug scarcity only about half of the children are actually treated at the centers. Therefore making sure that drug supply is improved, village clinics would be ideal in ensuring prompt treatment and thus saving lots of lives amongst children. The absence of zinc in village clinics is providing limited treatment alternatives. Despite the acceptance of zinc to be included among the list of drugs for community case management there has been little progress for Ministry of Health in collaboration with NGOs to provide the drug at the various village clinics. There has also been a demand among the general population for village clinics to treat adults as well. According to the design of community case management, only under five children are allowed to access treatment of services at village clinics. Due to distance factors even older people are seeing the benefits of community case management and desire to be considered for treatment.

Key Recommendations

- Improve drug management at village clinics through strengthening of logistical planning in collaboration with the District Health Offices (DHOs).
- Cautiously expand the number of village clinics whilst improving the availability of drugs in the existing clinics.
- Assess previous Drug Revolving Fund (DRF) sites and consider them as potential outlets for village clinics
- Introduce zinc at village clinics and monitor its performance.
- With the DHO, consider introducing village clinics that will also cater for the adults.

Conclusion 2

The country has been facing serious drug shortfalls which affected the performance of child health services at both health facility and village clinic level. According to the current system the districts are supposed to order drugs centrally from Government Central Medical Stores (CMS). Of late, due to logistical challenges new drug consignments have not been forthcoming on time and in the right quantities.

Key Recommendations

- Plan should engage Ministry of Health (MoH) to ensure that drug supply improves at health facilities. Plan should lobby review of the Essential Package Policy and tighten commitments to the provision of drugs including increase in financial allocation.
- Government should continue taking leading role on infrastructure provision including those related to drugs and supplies.
- Plan should seek more local and external partnerships in drug management. Leaving this for government alone to intervene means zero acceleration in lowering child mortality rates.

Conclusion 3

Despite lots of efforts in reducing malaria episodes in the PUs, results have remained low. Coverage of ITNs in the PUs is still lower than the national target of 80%. It was noted that most of the times health facilities did not stock enough nets to provide to mothers and newborn children during

delivery as per the design of the ITN policy in the country. This negatively impacted on ITN ownership as well as utilization in the targeted communities.

Key Recommendations

- Work with government to review the ITN strategy where mothers and children access nets at health facilities so that ITN availability and access is improved
- Introduce Indoor residual spraying to increase alternatives for prevention.
- Strengthen collaboration with government on monitoring efficacy of antimalarials so that resistance is tracked.

Conclusion 4

Despite some notable progress on care seeking for Acute Respiratory Infections (ARI), most mothers did not identify the danger signs requiring children to be taken to the hospital promptly. There is need for additional communication tools that address the whole ARI spectrum beginning with prevention, early recognition of signs as well as prompt treatment. The current situation showed higher coverage in prompt treatment than on preventive measures.

Key Recommendations

- Develop new messages and communication tools on pneumonia danger signs and the importance of care-seeking
- Encourage CORPS to organize additional pneumonia face to face communication with mothers.

Conclusion 5

There was evidence suggesting that nutrition groups if given some resources could help reach out to households increased number of households with seed inputs. This could in some way contribute to the reduction in malnutrition trends in the targeted area. For instance Mkopeka Nkwoya nutrition committee managed to operate a self initiated seed rotation scheme that eventually assisted many households and thus contributed to positive nutrition outcomes. There is need to encourage similar groups to take extra roles in nutrition in addition to nutrition surveillance and information dissemination. Some nutrition groups felt that the numbers of anthropometry sets were not adequate to assist them in conducting nutrition surveillance in the PUs. These equipments include scales, height boards and Mid Upper Arm Circumference (MUAC) Tapes

Key Recommendations

- Reconsider providing startup seed to nutrition groups that would sustainably manage payback schemes in order to improve results on child nutrition.
- Empower nutrition committees to manage seed systems through expanded trainings and technical supervision.
- Provide additional nutrition surveillance sets in areas where they are not adequate

MATERNAL AND NEONATAL HEALTH

Conclusion 6

Factors that contributed to pregnant women continuing having unsafe deliveries were found to be related to distance to the nearest health facility and ill treatment by health workers. In addition to this, high vacancy rate of medical personnel is affecting quality of medical care provided to mothers and newborns due to the long delays when seeking treatment and fatigue of clinical staff.

Key Recommendations

- Develop strategies of improving health worker attitudes towards patients including the strengthening of supervision and motivation of health workers.
- Improve delivery rooms so that mothers are motivated to visit the facilities for antenatal, delivery and postnatal care.
- Continue provision of equipments to health centers and lobby with central government for construction of more health facilities in order to reduce distance traveled by mothers to reach the nearest health facility. There will be need for more resources to be put into health construction through the Parliament and Government should continue taking leading role on infrastructure provision including those related to infrastructure development.
- Expand grants in size and support new partners so as to achieve acceleration in provision of MNCH care services. IMCI achieves acceleration through involvement of various players on the ground.

Conclusion 7

Despite notable improvements in family planning coverage several key issues were observed. There is shortage of family planning methods in the communities. Most of the villages visited mentioned scarcity of a diverse range of family planning methods due to reduced quantities of methods they receive on periodic basis. In addition to this, communities have fewer trained HSAs who have capacity to manage the provision family planning methods as well as supervising CBDAs.

Key Recommendations

- Train more CBDAs and HSAs in family planning
- Identify additional resources to procure family planning methods
- Improve replenishment system of family planning methods
- Ensure increased involvement of VHCs so that once trained CBDAs leave the areas someone can continue providing the service at shorter notice periods.

WATER AND SANITATION**Conclusion 8**

The provision of water showed to have contributed tremendously towards reducing diarrhea disease and child mortality. However sustainability of the water points are continuously being hampered by maintenance and operation challenges. There are also limited district supervision systems for operation and maintenance. For instance Kasungu PU has 3 WJMs who obviously cannot provide appropriate assistance in the whole district. Due to reduced management and transparency protocols by the district based system some WJMs have been indulging in unlawful charging of borehole maintenance sometimes even as high as US\$26 for routine maintenance. Local leaders have not been involved appropriately to the extent that transparency in the management of user fees is minimum. Most of the leaders met showed having no close links to the committees managing boreholes which meant that it was difficult for the committees to link very well with the fellow community members in terms of tasks like paying of monthly user fees etc. Observations showed limited linkages with the communities on how money was collected and used. There were no deliberate community meetings where the committees provided feedback to the population and sought advice for some of the critical financial decisions. In addition to this there has been an absence of skilled people in the communities to repair boreholes. Despite the committees gone through CBM training most of them have not been able to master borehole repair themselves and as a result they have been relying on other local individual experts, Water Monitoring Assistants (WJMs) for repairs which has been very costly.

Key Recommendations

- Revamp the district system for borehole operations and maintenance. This is a government led system that can be supported by all partners so that it is responsive and sustainable in helping communities manage their own water sources. The policy is already in place but its implementation has loopholes.
- Promote local leader involvement in the management of boreholes through conducting of periodic meetings.
- Put in measures to ensure total transparency in the management of funds by VHWPCs. Records needs to be in place and feedback meetings done with the general community.
- Empower communities to master repair of boreholes. Plan needs to raise capacities of the VHWPCs so that all repairs are managed internally by the committee. This will ensure instant sustainability of the boreholes as people within the village would be easier and cheaper to manage. Community Based Management (CBM)2 training of VHWPCs can be one of the strategies for achieving this in addition to introducing local village artisans who can manage repairs.
- Support District Coordination Teams (DCTs) undertake supervision of water points in the PUs.

Conclusion 9

More emphasis should be placed on improving hand washing indicators. The project managed to exceed its results on improving access to water and latrines. However hand washing indicators were observed to be very low. Promotion of soap as one of the key practices under good hygienic practices had little impact. This has been mainly due to the poverty levels in the rural communities

as most households can't afford soap for hand washing. There is need some kind of a double system where we can promote both soap at some lower cost as well as its alternative like ash so that we take into account the high poverty levels. "if people in the villages bath without soap can they really afford it for hand washing". Most likely not.

Key Recommendations

- Review and develop alternatives to soap.
- Re-strategize soap promotion principles.

SCHOOL HEALTH PROMOTION

Conclusion 10

The school health interventions have positively contributed towards the improvement of health conduction among the school going children. Key interventions included construction of school latrines, training pupils and clubs as well as provision of water points. Schools were also provided with first aid drug boxes and sanitation communication materials. Challenges included lack of water as well as soap at some of the HWFs. In addition to this most of the schools didn't have active water committees and were not collecting any user fees to aid in repairs. There was clear partnership arrangement with the community in places where they also accessing water at the school.

Key Recommendations

- Strengthen schools in the management of hand washing facilities (HWFs) so that soap and water is always available
- Revamp WPSC to improve management of school water points
- Develop a partnership agreement with surrounding communities if they are accessing water at the school
- User fees should be introduced so that quick maintenance of water points can be achieved
- School sanitation committees should be revamped in all schools
- Plan should consider introducing girls urinals in order to ease latrine congestion at latrines
- Continue adding latrine infrastructure in the schools to continue expanding Pupil: Latrine ratio

CROSS CUTTING THEMES

Conclusion 11

Overall the approach and the strategies adopted by the project have been satisfactory. The project was **relevant** from various angles. From the *community perspective*, the objectives of the project were extremely important in linking community and facility based IMCI to reduce maternal, neonatal and child health. From the *perspective of the District Council* this project was also found relevant. The project has helped initiate a fledgling movement towards reducing the rates so that women's and children's health is fulfilled. *At the national level*, the design of the Maternal and Child Health was consistent with epidemiological evidence for achieving maximum impact based on the IMCI and ACSD Concepts. The programme is in line with Sector-wide approach (SWAp) 2005 - 2011., Essential Health Package, Programme of Work, MNCH-related programmes which the government through the Ministry of Health is spearheading.

Conclusion 12

On **sustainability**, one of the important initiatives has been the direct involvement of the local district health system. Plan and the DHO have been jointly developing key action plans that are based on the needs of the district and local communities. Plan also succeeded in developing partner capacity as one of the key issue in addressing sustainability. The contribution of funds to Kasungu DHO and health facilities such as Ekwendeni Mission Hospital contributed to counterparts' continued rolling out of activities beyond the project phase. The sustainability of DHO interventions is probably the strongest that Plan achieved in the project. Plan has also been outstanding in transferring knowledge, skills and capacities in ways that enable the communities to undertake activities. Plan has successfully built upon and nurtured partnerships with local leaders and communities.

Conclusion 13

The evaluation findings show that the main focus of the project was in accordance with **CCDA**. For instance, through school clubs and community committees, children participated in the development of action plans using community IMCI approach. Children have also participated in sanitation and hygiene committees in addition to taking some roles in CLTS triggering and promotion of having

hand washing facilities. However, it was also noted that there wasn't a more established structure and support system to facilitate the implementation and monitoring of follow up activities and continuity after consultation with children. The project has facilitated good partnerships and networks at all levels as evidenced by some of the project activities being implemented by CHAM institutions/hospitals, DHOs and construction of the 6 staff houses for the two health centres which were community managed. The project also enabled other partners like UNICEF to come in and fund the scaling up of ACSD to traditional authorities outside the Mzuzu PU. Through this project Plan Malawi is a member of the national Accelerated Child Survival and Development (ACSD) networks where it participates in by giving technical input into related policies and strategic frameworks, its experiences and best practices in child health. Due to the activities/interventions that the project was able to do in malaria prevention and control, Plan is recognized technically by the national malaria control programme. In 2010, in partnership with other international NGOs, Plan participated in the Every One campaign to support newborn, child and maternal health in Malawi. This is a call to all leaders in Malawi to make sure that resources are mobilized to ensure the survival of every newborn, child and mother. The campaign will run for five years (2011-2015)

Key Recommendations

- Continuous process of engaging children needs to be developed as part of the action planning process of every key intervention.
- Use of advocacy related children initiatives should be enhanced throughout the project cycle.

Conclusion 14

Plan has been successful towards promoting **gender** in all its initiatives. Women from the PUs are active participants, agents and architects of their own development. One of the key important steps that Plan took was to involve men in interventions that are socially labelled as female dominated such as nutrition promotion. Plan also managed to mobilize male CBDAs who have been providing family planning services in the PUs. That has helped reduce gender barriers which in turn contributed to the successes of the program. Despite this cases of gender based violence are still reported.

Key Recommendations

- Plan should continue to focus its efforts in ensuring that gender based violence is reported and the perpetrators brought to justice.

Conclusion 15

Advocacy related initiatives like children's parliament have increased interest in Malawians of the value of children's views on issues that affect them including those related to child health. Plan has also been involved in other initiatives such as commemoration of Day of African Child in June every year and the Day against Child Abuse commemorated every November. Children's assemblies and children's advocacy meetings have helped increase human rights awareness among the general public including those related to health. Despite these opportunities, there are still crucial health related elements that have not been acted upon. Malawians still have to travel very long distances to access simple medical care. In addition to this the country's health facilities have been facing huge challenges related to inadequate drugs, supplies and trained staff. It is only through specialised advocacy strategies that Plan can start to face these issues.

Key Recommendations

- Due to the nature and complexity of high level issues such as drug scarcity, Plan needs to expand its links to health related alliances so that the combined forces can help improve operations of public health policies of the government
- Stronger operational agreements needs to be strengthened when engaging with District councils so that commitments are adhered by both sides throughout the implementation processes
- Plan should continue to empower communities to engage public officers when handling key strategic issues like those related to water provision

Conclusion 16

Regular planning meetings with Government, Mission Hospitals and NGO partners were conducted throughout the life of this program. In addition, child and maternal health interventions were planned together with all the partners at the district level on an annual basis. This ensured tactical coordination, supervision and leadership of the health related interventions by MoH which is crucial for sustainability. The planning of overall program direction was responsive to the perceived needs of

the partners on the ground since all of them were guided by the same National Essential Health Package. Synergies were observed in several cases. Like in Kasungu, MSH, Plan, Malawi Red Cross and MoH were coordinating very well in the areas of malaria prevention and case management with the leadership of the District IMCI coordinator. Plan has a cordial relationship with the District Health Management Teams based on mutual respect. Formal and informal coordination mechanisms are followed including consultation between project staff and DHMT members. However it has been challenging for the government partners to adhere to their side of the plans due to critical issues facing them such as inadequate staff and limited resources.

Key Recommendations

- Continuous engagement between Plan and district partners so that operational issues are discussed and work plans re-adjusted. For instance the water departments have been facing serious financial shortfalls to undertake district level supervising of water points. As an interested player, Plan would obviously consider funding such operations issues since they have a direct link to the fulfillment of the program.
- Plan should continue lobby for allocation of qualified staff in the rural areas

Conclusion 17

On phase over planning, the project was conceived with an eye towards enabling the communities and government to continue their activities and without dependence on the project staff. The project managed to facilitate creation of community groups and provided necessary capacity building for continuation of rolling out of activities. It was noted that all interventions of Plan involved discussions with local leadership, assisting communities to form voluntary groups, orientation of interested people especially in groups, among others. This ensured that participating individuals had the requisite knowledge and skills to undertake the tasks on their own. In this respect, the community at large was also given ample opportunity to participate in its development agenda. Furthermore, Plan made great efforts in building alliances through partnerships with various organizations that were deemed to have the technical know how on a particular intervention for instance mission hospitals handling safe motherhood initiatives. There was evidence of potential sources of encouragement for the community groups through Health Surveillance Assistants (HSAs) who have been actively included in almost all the trainings involving community groups. It is encouraging that Plan health related interventions are well integrated in the Health Detailed Implementation Plans (DIPs) of the District Assemblies. In terms of preparing the communities for phase out, one of the important initiatives that Plan undertook was the development of the Community Development Outlines (CDOs). These assisted in letting communities go through the process of self assessment, identify felt needs and design a plan towards implementing them. This provided a good opportunity for laying down a very good foundation for phase out planning. However some sector specific constraints remain hindering the exit plan such as limited number of water technicians to provide technical backup for water points. In addition to this availability of resources for continued rolling out of initiatives would be a huge challenge.

Key Recommendations

- Continue lobbying for fair and increased allocation of national budgets to district assemblies following the decentralised systems. This would ensure that districts plans are capable of managing implementation beyond Plan program phase.

Figure 1: Results: Summary Chart

Indicators	Baseline (2008)	Target (2010)	Final Evaluation
Child survival/child health			
% of children aged 12-23 months in Plan supported communities fully immunized before their 1st birth day (i.e. who received BCG, DPT3, OPV3 and Measles)	74%	80%	95.1%
% of children within 6-9 months receiving breastfeeding and appropriate complementary food in Plan supported communities from 49.78% by FY 2010	49.78%	80%	74.9%
% of mothers with children less than 3 years in Plan supported communities who manage diarrhoea with ORT	53.68%	65%	71.2%
% of families in Plan supported communities adopt good hygiene practices from 1.48 %	1.48%	30%	24.8%
% of children aged less than 3 years infected with malaria in the last 2 weeks in Plan supported communities	40%	10%	17.9%
% of children under five sleep under an ITN	N/A	80%	71.7%
% of mothers in Plan supported communities with children under 3 years who take their children with symptoms of pneumonia for appropriate treatment within 24 hrs of development of symptoms	18.79%	30%	47.9%
Maternal health/ safe motherhood incl. ASRH			
70% of pregnant women in Plan supported communities receive the recommended dose of Intermittent Presumptive Treatment during pregnancy from 56%	56%	70%	77.4%
80% of childbearing females who have received a minimum of 2 Tetanus Toxoid vaccinations before the birth of their youngest child in Plan supported communities	N/A	80%	88.5%
60 % of mothers of child bearing age in Plan supported communities currently using modern family planning methods	45.78%	60%	48.7%
Water and Sanitation			
% of families having safe water all year round in Plan supported communities	47.79%	70%	86.8%
80 % of communities in Plan supported areas with all families having access to good sanitation (CLTS) / improved latrines	45%	80%	76.9%

2 INTRODUCTION

2.1 Maternal and Child Health: Country Context

Child Health: Malawi has a high Child Mortality Rate (CMR) which is attributable to poor access and quality of health services, poor nutrition, respiratory diseases, malaria, HIV and AIDS, diarrhoeal diseases, among other causes. Despite this, some remarkable progress has been made to CMR. Under five mortality rate fell from 234/1,000 live births in 1992 to 122/ 1,000 live births in 2006 (MICS, 2006). Malawi has also registered a downward trend in infant mortality rate (IMR). According to the MDG Report (GoM 2009), IMR decreased from 134/1,000 live births in 1992 to 69/1,000 live births in 2006. The other indicator of progress is the increase in the proportion of one year old children immunized against measles. This proportion increased from 79 percent in 2004 to 84 percent in 2006. If the encouraging trend continues, it is projected that by 2015, an immunization rate of 100 percent will be achieved. However, the gains registered so far could also be lost due to the failure of health facilities to provide child health services. A 2007 Global Fund Health Facility Survey showed that out of 113 sampled health facilities only 8.9 percent had all basic infrastructure to provide child health services.

Malaria is a major public health problem in Malawi. It is the leading cause of morbidity and mortality in children under five years of age and pregnant women. Malaria accounts for 40 percent of outpatient visits and 18% of all hospital deaths (GoM, 2005). It is a major cause of anaemia in children. Anaemia in turn is responsible for 40% of all under five hospitalizations and 40 percent of all hospital deaths. Malawi has made great strides in prevention of malaria infection in pregnant women. Coverage of 2 SP for IPT is now at 60% (MIS,2010) from 47% in 2004 (MDHS, 2004). ITN use among pregnant women currently stands at 50% in 2010 (MIS, 2010) from 17 in 2004 (MDHS, 2004) There are however disparities in access to malaria treatment among children. Urban children are more likely to access treatment within 24 hours of onset of fever than rural children. Furthermore, children in the wealthiest quintile are more likely to access prompt treatment than their counterparts in the poorest quintile (Mathanga and Bowie -2004). The National Malaria Control Policy has adopted use of Insecticide Treated Mosquito Nets (ITNs) as one of the main strategies in the control of malaria. The coverage of ITNs increased substantially between 2000 and 2010. ITN coverage increased from 13% in 2000 to 60 % in 2010 (MIS, 2010). Almost 6% of children under five slept under an ITN at national level in the year 2000. This percentage increased to 55% in 2010. Despite remarkable increase in ITN ownership there are spatial, income and education-based disparities in ITN ownership and use.

Malnutrition is a universal, endemic and in some cases overwhelming problem that affects all districts in Malawi (MICS, 2006). The GoM has stated that nutrition is a critical factor in sustainable economic growth, and the persistent high rate of malnutrition as a silent crisis. Government has initiated substantial actions to build and demonstrate political will and commitment. The Head of State is the responsible Minister for Nutrition. A coordinating Department of Nutrition, HIV & AIDS was created in the OPC with a Principal Secretary. A "Nutrition Vote" is now established for budgetary allocation. Some of the immediate causes of chronic malnutrition are inadequate intake of calories and nutrients and high burden of infectious diseases. Underlying causes were documented to be low quantities of food available at household level, lack of food and dietary diversification, poor food processing technologies, seasonal fluctuations in food availability, lack of dietary diversification, repeated episodes of diarrhoeal disease, intestinal worms burden, post harvest losses, poor child caring practices, inadequate knowledge on appropriate care practices – including infant and young child feeding practices, work overload – women, cultural practices, poor hygiene and sanitation, poor access to safe water supply, poor access to health services, poor care seeking behaviour, traditional beliefs on illness and access to resources.

Maternal Health: Maternal mortality rate (MMR) in Malawi is one of the highest in sub-Saharan Africa. According to the annual MDG Report (GoM 2009), MMR decreased from 1,120/100,000 live births in 2000 to 807/100,000 births in 2006. It is projected that by 2015, MMR will stagger at 338/100,000 live births, which is greater than the MDG target of 155/100,000 live births. The high MMR is largely attributed to low education and literacy levels among women of child bearing age, ability to understand the cause and effect of factors contributing to maternal morbidity and mortality, early and unwanted pregnancies, and physical immaturity of women at first pregnancy, poor child spacing due to inadequate access to comprehensive family planning-services, limited access to focused antenatal and postnatal care, unsafe abortions, deteriorating quality of basic health care services, limited availability, access and utilization of emergency obstetrical care services, unsanitary conditions during pregnancy. High rates of population growth have far-reaching implications for almost all aspects of social and economic development. The 2008 Malawi Population and Housing

Census shows that the inter-censal annual population growth rate for Malawi is 2.8 percent, up from 2.0 percent in 1998 (NSO, 2008: 3), which ranks among the highest growth rates in the world.

Water and Sanitation: A high proportion of the population faces serious challenges as a result of poor access to safe domestic water supply and adequate sanitation services resulting in high prevalence of preventable diseases which contribute to poor health, loss of productivity and exacerbation of poverty. In Malawi, diarrhoeal disease is the 2nd leading cause of morbidity and mortality in children under 5 years of age. At community and household level, the poorest and most vulnerable groups, including children and women are the most affected. Improved water supply and sanitation services have direct impact of lives of women and children (particularly in rural areas), reducing the burden of water carriage (as women and children normally carry water from source to home). Time/effort in water saved in water collection has a huge potential for better child care and improved education. Use of improved sanitation facilities and safe drinking water is a fundamental right that safeguards health and human dignity. Poor hygiene, lack of sanitation, and low quantity and quality of drinking water all contribute to Malawi's poor health indicators for mothers and children, and impact negatively on the livelihood of women and children as they take on added responsibility for caring for the sick.

2.2 Project Background

With funding from Plan Norway/NORAD Framework Agreement, the Plan Malawi health programme has been implementing the 'Mother and Child Health Projects' since 2004 to date. The framework for (2004-2007) was evaluated in December 2007 and recommendations were used to develop the current program. The CY 2008-2010 framework funding supported Plan Malawi's Maternal and Child Health Country Programmes covering Kasungu and Mzuzu PUs... The goal of this project is to contribute to the reduction of the high infant and child morbidity, mortality and malnutrition rates and to improving mother / adolescent sexual and reproductive health. 1,287 children 0 to 5 years are the primary beneficiaries of the project with 597 males and 690 females. The project was also to benefit women of child bearing age including adolescents. Indirectly community members and families, government authorities at the district, national and community level as well as other NGOs will be equipped with the knowledge, skills and logistics to facilitate the process of ensuring child's right to survival and development and thus benefiting from the project.

3 PURPOSE OF THE EVALUATION

The final evaluation of the MCH Project Part 2 was undertaken to determine the level of achievement of project objectives, strategies, identify best practices, lessons learnt, weaknesses, strengths and recommendations. The evaluation was aimed at broadly assessing the relevance, effectiveness, efficiency, & effect/outcomes and sustainability of the project interventions and strategies i.e. as per the broad interventions on safe motherhood, child survival, school health, watsan.

Specifically the final evaluation was conducted in order to:

- Determine the extent to which the project has achieved its objectives.
- Assess the extent to which the Child Centred Community Development (CCCD) has been applied including elements such as partnerships, capacity building especially in strengthening Civil Society Organizations etc, accountability and community/children participation and inclusion.
- Identify the constraints and challenges faced by the project, lessons learnt and good practices.
- Assess the extent that gender was mainstreamed in the project and suggestions for improvement
- Effectiveness of the forums (quarterly reviews, annual planning etc) that the project has supported over the life span of the project.
- To come up with recommendations that could be explored to further strengthen the project and improve results in the future and also identify opportunities for advocacy and identify key aspects regarding phase out considerations for a project of this nature . The detailed TORs are presented as **Appendix 2**.

4 EVALUATION METHODOLOGY AND SAMPLE DESIGN

The evaluation was conducted using a combination of methods involving:

- Review of available literature and relevant documentation;

- Implementation of a structured questionnaire to selected households; and
- Key informant interviews and Focus Group Discussions conducted with selected officials from partners and the community.

4.1 Data Collection

Literature Review

This involved reviewing the following program documents: Project Proposal, Project Outlines and Project Completion Reports, Annual Reports to NNO, CPO midterm review and Final CPO evaluation report, PPM reports, Country Project Progress Report, Operational plans, Partner reports/records, Quarterly review reports and Documented Case studies Other documents reviewed included Malaria Indicator Survey (MIS 2010), National Water Policy, National IMCI Strategy, MDHS etc.

Self Administered Questionnaire

The primary evaluation instrument was an administered questionnaire specifically designed to solicit quantitative and qualitative responses from purposely selected households from randomly selected communities and villages. The respondents were asked to respond to a structured questionnaire designed to obtain quantitative and qualitative estimates of key MCH indicators.

Key Informant Interviews and Focus Group Discussions

Selected key informant interviews and focus groups were also conducted to supplement/validate and confirm the response from the questionnaires as well as to obtain feedback on certain issues that could not be possibly covered by the questionnaire alone.

4.2 Sampling Processes

1.1. Quantitative Evaluation

Determination of the sample size:

The quantitative assessment utilized a two-stage cluster sampling methodology in an effort to provide an unbiased and representative estimation of the information obtained. The assessment will follow the WHO/EPI 2 Stage cluster sampling technique. To determine the sample size for caregivers to be selected, the following formula will be used:

$$n = \frac{z^2 pq}{d^2}$$

where n= sample size

z= statistical certainty desired

p= estimated prevalence rate

q= 1-p (proportion without the attribute of interest)

d= degree of precision.

The desired precision (d) was set at 5% (0.05) and the statistical certainty at 95% (z = 1.96). The value of p was set at 25% (0.25). The resulting sample size of caregivers n, was 288 for 1 district and 576 for both Mzuzu and Kasungu PUs

$$n = 1.96^2 \times \frac{0.25 \times 0.75}{0.05^2}$$

$$n = 288$$

For nutrition, the prevalence of stunting was used since the other indicators (wasting, underweight) will give smaller samples which may not be representative of the severity of the problem in the areas. The prevalence of stunting among under five children in the PUs was found to be 44%-CPO Evaluation October 2010.

$$n = 1.96^2 \times \frac{0.44 \times 0.525}{0.05^2}$$

$$n = 354 \text{ HHs (354 per District and 708 HH for the whole assessment)}$$

Selection of the sample:

A list of all communities and villages was compiled by the project staff. 10 communities and 10 villages shall be randomly selected from this list by the consultants.

Selection of Caregivers and children in the clusters:

A random direction was picked by spinning a bottle. The bottleneck indicated the direction. One of the surveyors counted the number of households encountered from the centre to the border of the

village. The first household to be visited was randomly selected from among these households by drawing a random number. Subsequent households were chosen by turning to the right hand side of the surveyed house until the required number of caregivers was identified.

All eligible children in the chosen households were measured and weighed. In cases where the cluster did not have the required number of children, eligible children from the nearest villages were measured. Variables recorded for nutrition included: Date of birth, Age, Sex, Weight, Height, Presence or absence of Oedema.

1.2. Qualitative Evaluation

The Qualitative data was collected to complement the results of the quantitative survey. Information was obtained from small groups of people, representing the target population (mothers, children, youths), staff (Manager) local committees (VHWPCs), District Partners (Water Officer, DHO, Cham/Gov Health Centers) using Focus Group Discussions and key informant interviews. *Also refer to Appendix D for more details:*

4.3 Data Entry

All data was entered into EPI Info Program. The entries were then verified for accuracy with the EPI Info Validate program. This method of data entry and validation ensured that virtually no erroneously data entry was made.

4.4 Data Analysis

The information obtained from the questionnaire was analyzed using MS Excel and EPI INFO data analysis software. Descriptive analysis technique was used to find out percentages and frequencies using the software. The information collected through key informants was analyzed qualitatively. Data collected was edited, coded and analyzed using qualitative ways. Data obtained from secondary sources was analyzed using context analysis techniques. For development of training plans the data was recorded as per the findings.

4.5 Limitations on the Final Evaluation

All possible steps were taken to ensure that the results accurately represented the maternal and child health situation in the targeted communities of Kasungu and Mzuzu. However, the study faced a number of limitations:

Interviewer Bias: Assessments like this are prone to bias based on questioning techniques. In order to control this bias, interviewers were trained on how to interview without prompting, leading or guiding respondents. They were also instructed to translate one question at a time before moving on to the next question.

Subjects' Perceptions: Although our purpose was clearly defined to the community, we were at times perceived as individuals in a position to improve community issues and problems, instead of understanding our role as evaluators. In this way respondents might have chosen to provide a certain picture so that they be part of any presumed assistance.

5 ASSESSMENT KEY RESULTS AND DISCUSSIONS

5.1 HOUSEHOLD CHARACTERISTICS OF THE STUDY POPULATION

The evaluation was conducted among 698 sampled households in the 2 Program Units (Kasungu n=362, Mzuzu n=336). A total of 756 children (Kasungu n=371, Mzimba n=385) aged 1-59 months were part of the study of which 53.9% were male and 46.5% were female. For nutrition parameters only those of the ages of between 6-59 months were included in the analysis of wasting, stunting and underweight. A total of 706 children were actually assessed for nutrition indicators (Kasungu n= 355 and Mzuzu n=351). The results show that the average household size was 5.3 (Mzuzu 5.5 whilst Kasungu 5.1). The sample had 14.1% of households being headed by women with Kasungu having slightly higher figures at 19.1% than Mzuzu at 8.9%. The mean age of mothers who responded to the questionnaire was 27.3 years (Mzimba 26.7 yrs and Kasungu 27.9 years.) For further details on sample characteristics please refer to figures 2, 3 and 4 below:

Figure 2: Gender variations of the sampled Children by PU

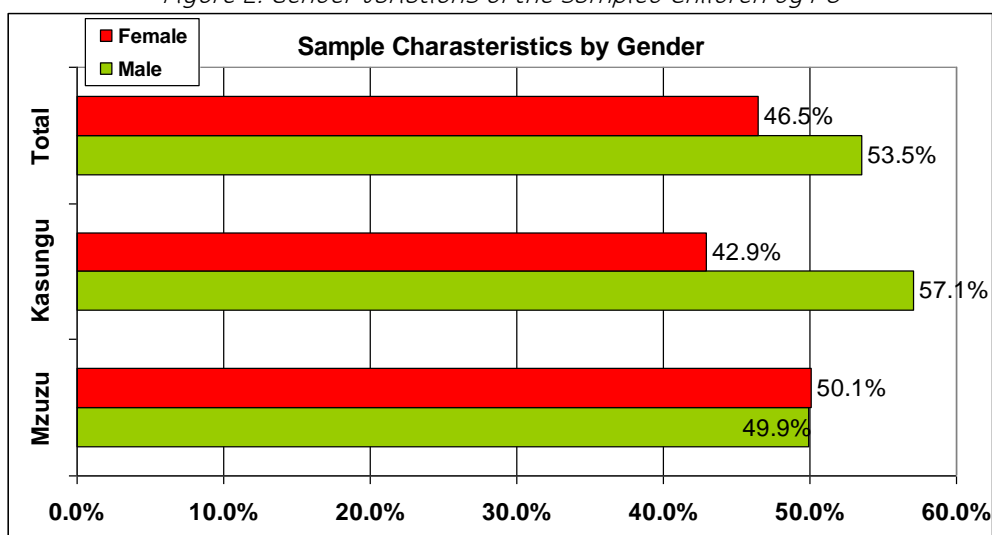


Figure 3: Gender variations for Head of Household by PU

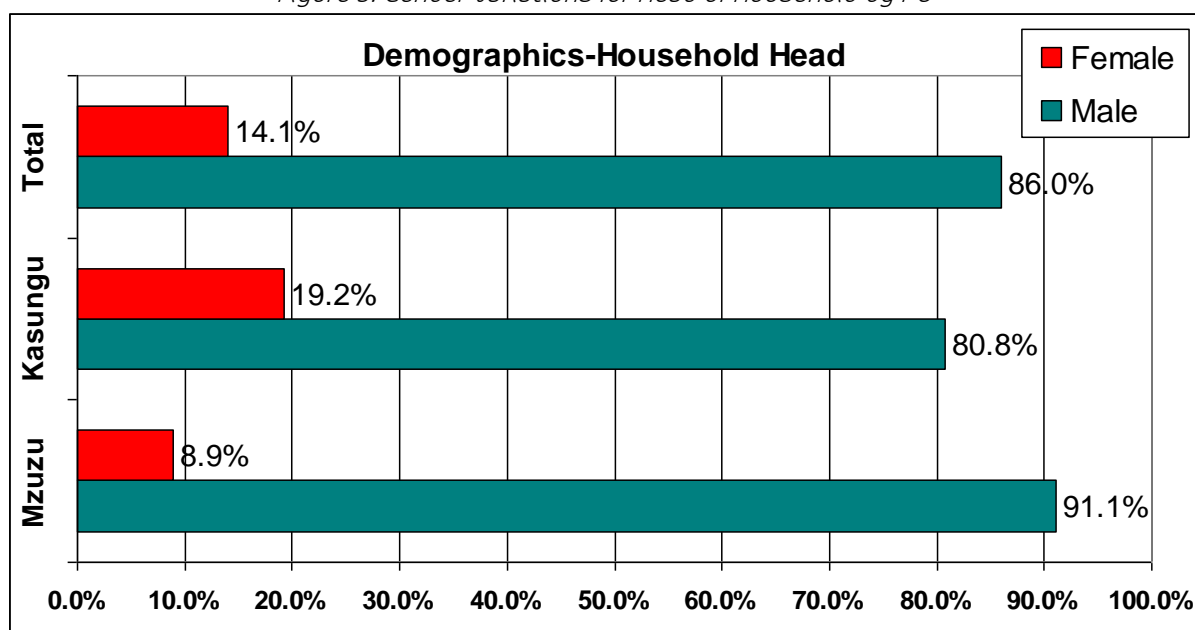


Figure 4: Age Categories for the Children assessed for Nutrition by PU

AGE RANGE	Mzuzu n	Kasungu n	Total N
6-17	105	108	213
18-29	76	88	164

30-41	74	83	157
42-53	66	52	118
54-59	30	21	51
Overall	351	355	706

5.2 RESULTS ACHIEVED PER SPECIFIC OBJECTIVE

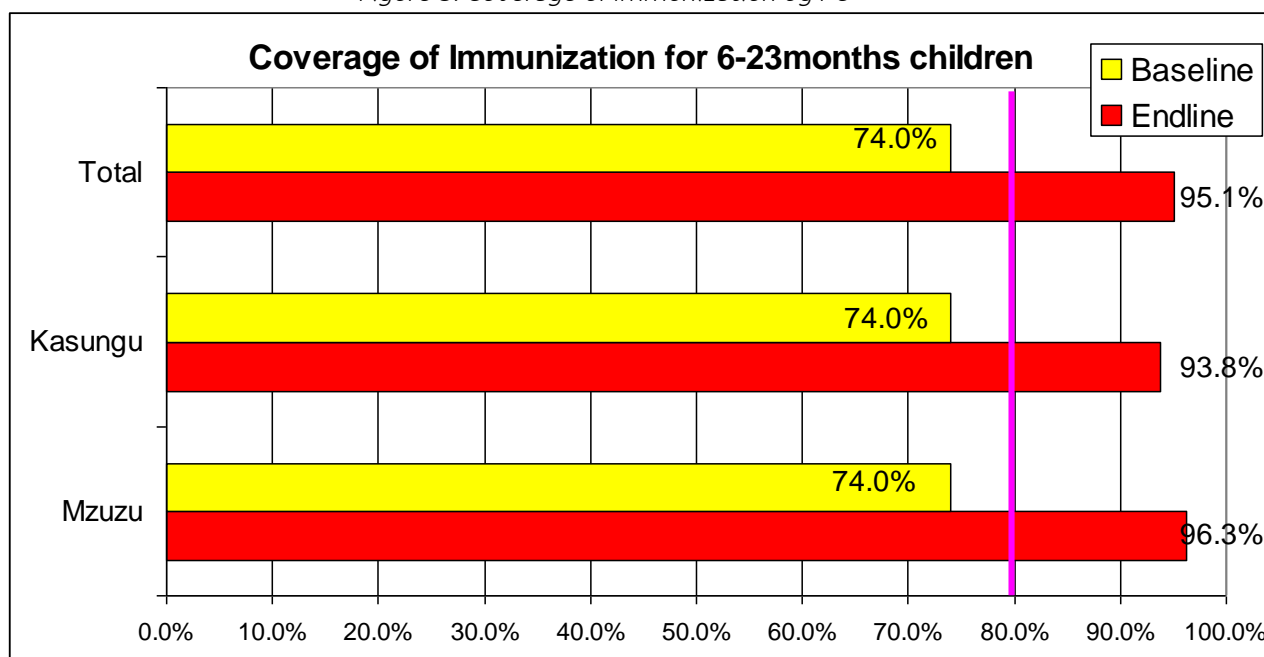
5.2.1 CHILD HEALTH

80% of children aged 12-23 months in Plan supported communities fully immunized before their 1st birth day (i.e. who received BCG, DPT3, OPV3 and Measles from 74 % by FY 2010.

Overall Assessment of the Outcomes of the Objective

Figure 5 shows the time trends in completion of vaccination among the 12 to 23 months age group. The results in the 2 PUs indicate that coverage levels increased significantly from the baseline of 74 % to 95.1% at endline. The results were well above project target of 80% vaccination coverage. Vaccine coverage tended to be higher in Mzuzu PU (96.3%) than in Kasungu PU (93.8%, although these differences were not statistically significant.) The project's very high vaccination coverage results from the project's consistent outreach services and annual health week support to both districts.

Figure 5: Coverage of Immunization by PU



Assessment of Key Strategies/Issues

Full immunization is achieved when at the age of 12 – 23 months a child has received BCG, DPT1-3, OPV1-3 and measles. Despite remoteness of the impact areas, results of immunization interventions are highly satisfactory. The results from FGDs also show that the knowledge of mothers on immunization has increased considerably. The use of safe motherhood groups has been highly productive. These groups revealed how they visited mothers in their homes to convince them to bring their children for immunization during outreach or mass campaigns organized by Ministry of Health with financial and logistical assistance from Plan. For instance in 2008, Plan participated in the National Integrated Vitamin A, Deworming and Measles campaign organized by the MOH with funding from Government of Malawi, UNICEF and WHO. The objectives of the campaigns were to eliminate measles, deworm children and increase vitamin A supplementation coverage in children aged 6 – 59 months. Children accessed the services in 13 health facilities through 120 static and outreach sites that were spread across the 2 PUs. Health workers and other community health

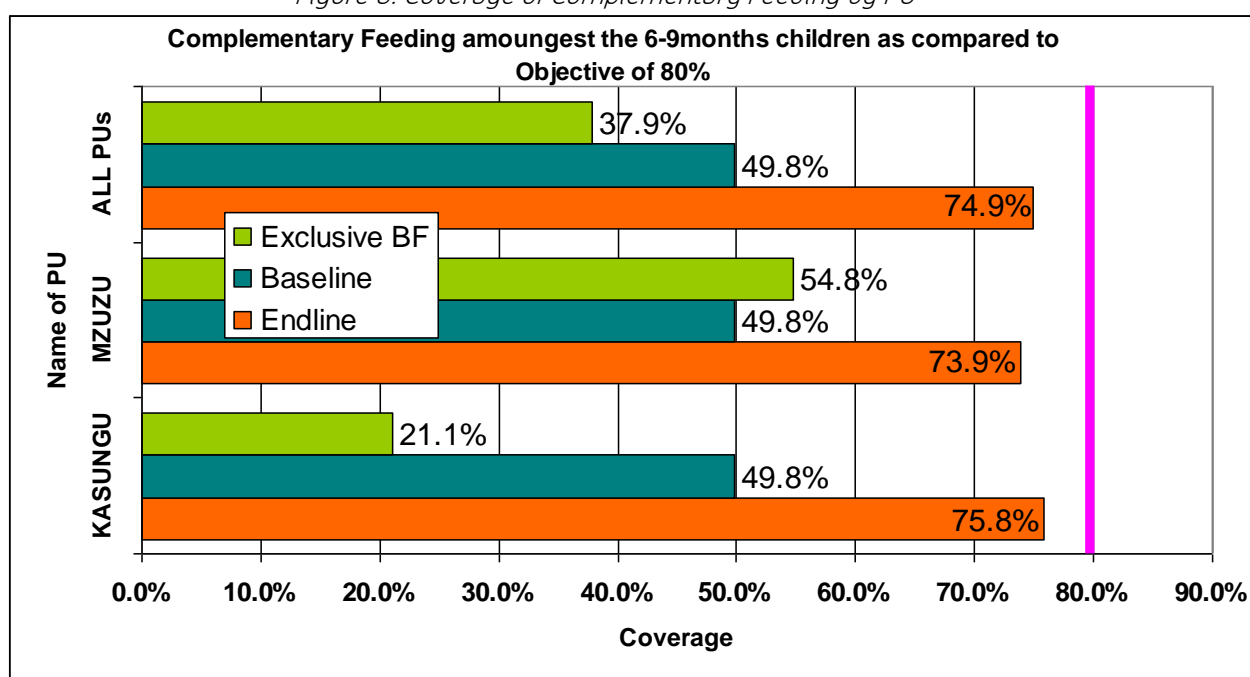
volunteers that were trained by Plan in the previous campaigns were actively involved in the campaign. Plan also supported door-to-door mop up campaigns in the hard to reach areas in order to increase coverage. Apart from this participation in 2008, Plan has been involved in other national campaigns where growth monitoring, treatment of minor ailments; other vaccinations were conducted. Plan has also been assisting Ministry of Health with logistical support in form of motorcycles and fuel in order to reach out to all corners of the PUs with services as well as information of immunizations. (NORAD Annual Report)

By FY 2010, 80% of children within 6-9 months receiving breastfeeding and appropriate complementary food in Plan supported communities from 49.78% in 2008.

Overall Assessment of the Outcomes of the Objective

The results show that 74.9 per cent of infants aged 6-9 months old received complementary foods while continuing to be breastfed. Kasungu PU had higher rates at 75.8% than Mzuzu at 73.9% although the observed variations were very marginal. These results indicate good progress on complementary feeding despite the shortfalls in meeting the target of 80%. The increasing trend from a baseline of 49.78% is positive and should be maintained. Refer to figure 6 below

Figure 6: Coverage of Complementary Feeding by PU



Assessment of Key Strategies/Issues

Complementary feeding is the most effective intervention that can significantly reduce stunting during the first two years of life. The project undertook a comprehensive approach to improving complementary feeding through counseling of caregivers on feeding and care practices and on the optimal use of locally available foods, improving access to quality foods through food security initiatives. For instance 90 nutrition promoters (community health volunteers) from nine targeted communities were trained on good nutrition and preparation of food using locally available foods. Through this training, they were equipped with skills and knowledge to effectively deliver nutritional health care services at community level like routine growth monitoring of U/5s, deworming, food processing, proper food storage, breast feeding and complementary feeding using the multimix principle of the six food groups. The promoters disseminated knowledge to communities on how they can utilize the different variety of crops like soya beans, cassava, g/nuts, sweet potatoes and hybrid maize for better yields to improve their nutritional status, follow up on malnourished children and conduct referrals to health centres/NRU. Plan also facilitated the production/printing of 57 community based teaching aids for nutrition. The teaching aids were developed in consultation with the different stakeholders at all levels and these have been distributed to all the PUs. The materials were used by the nutrition promoters during follow ups of malnourished children and nutrition sessions

The increased coverage on complementary feeding corresponds with the practices of the mothers measured during a 24 hour food recall. A majority of the mothers fed their children 3 or more times a

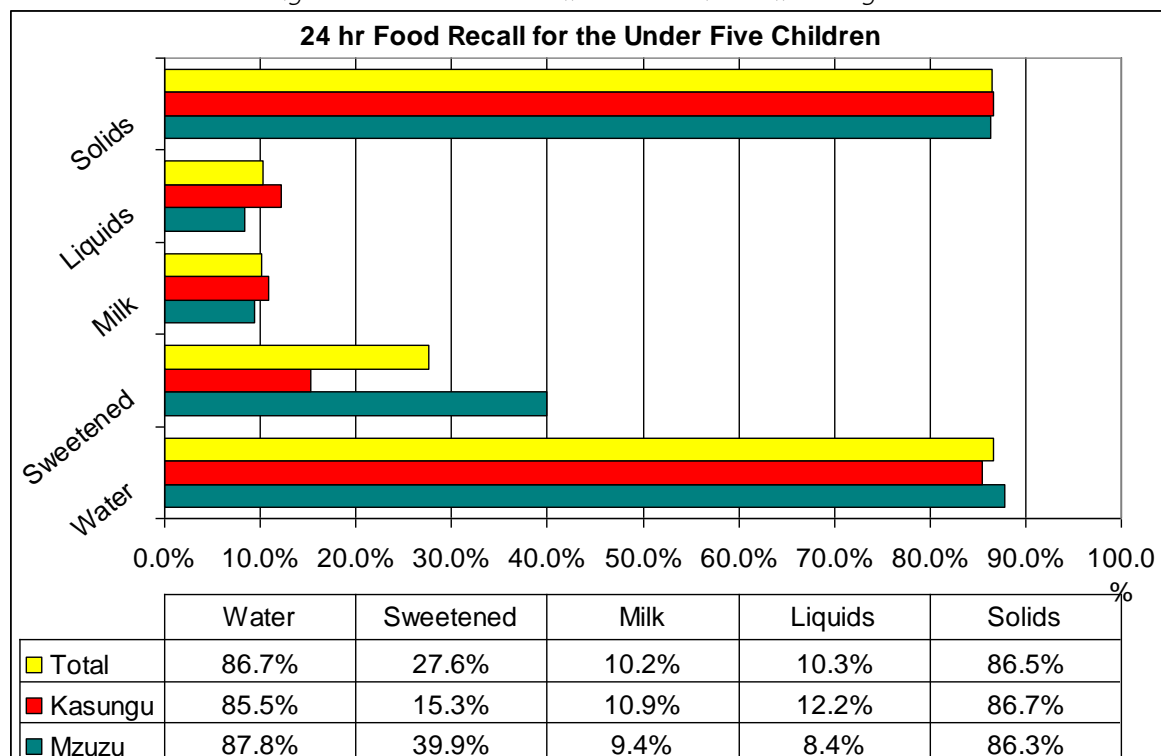
day. However despite this success on average number of meals this data do not reflect the quality of the complementary foods received. As seen from figure 8 below, children did not receive complementary foods of the diversity required. Most of the foods eaten by the children in the households were of solid base (86.3%) i.e Nsima. Milk which is highly nutritious and good for growth was only consumed by 8.4% of the children in the past 24 hours. In addition to this shortfall, the evaluation also showed low exclusive breastfeeding rates at 37.9% across the PUs (refer to figure 6). However since the sample for this category was small (n=17 in Mzuzu and n=22 in Kasungu) another comprehensive analysis is needed to triangulate the results.

In summary, the malpractices associated with complementary feeding, as identified by qualitative evaluation processes include;

- Complementary foods lacks diversity
- Foods that are given are of low nutritional value.

The program approach for teaching mothers in general on how to prepare a more nutritious meal for young children was positive but also needs to address the critical complementary feeding messages such as frequency, and preparation of foods for the more critical target age group of children of 6 – 12 months for complementary feeding. Complementary feeding is also dependent on other "hardware" that is available in the community. The combined inputs of food availability, adequate sanitation and household hygiene, clean water supply and positive feeding practices should ultimately result in improvements in the health status of the child.

Figure 7: 24 hr Food Recall for under five children by PU



Box 1: Case Study: Nkopeka Mkwoya Nutrition Committee.

Mkwoya Nutrition Committee was formed in 2008 following the shortage of food in the community that led to an increase in number of malnourished children as well as child mortality. Plan came in with teachings in good nutrition practices and associated benefits to the children and the community as a whole. Following this, the community on their own decided to elect a committee to lead in nutrition promotion in the village. The committee has 10 members with key positions of chairperson, secretary and treasure in place.

The committee manages a seed program in which households are given startup seed and later pay back to the group so that other households can also benefit. Sometimes they do borrow some good seed and plant in the group garden so that after a season they can not only pay back but also support other households. “Our support is appreciated in the community since our seed rotation ensures that more people benefit from the good seed. With the increasing population in our communities we feel this is a good strategy that should be used to reach more households. With this strategy child nutrition is improving due to the improved diversity of food.” Laments one of the group members.

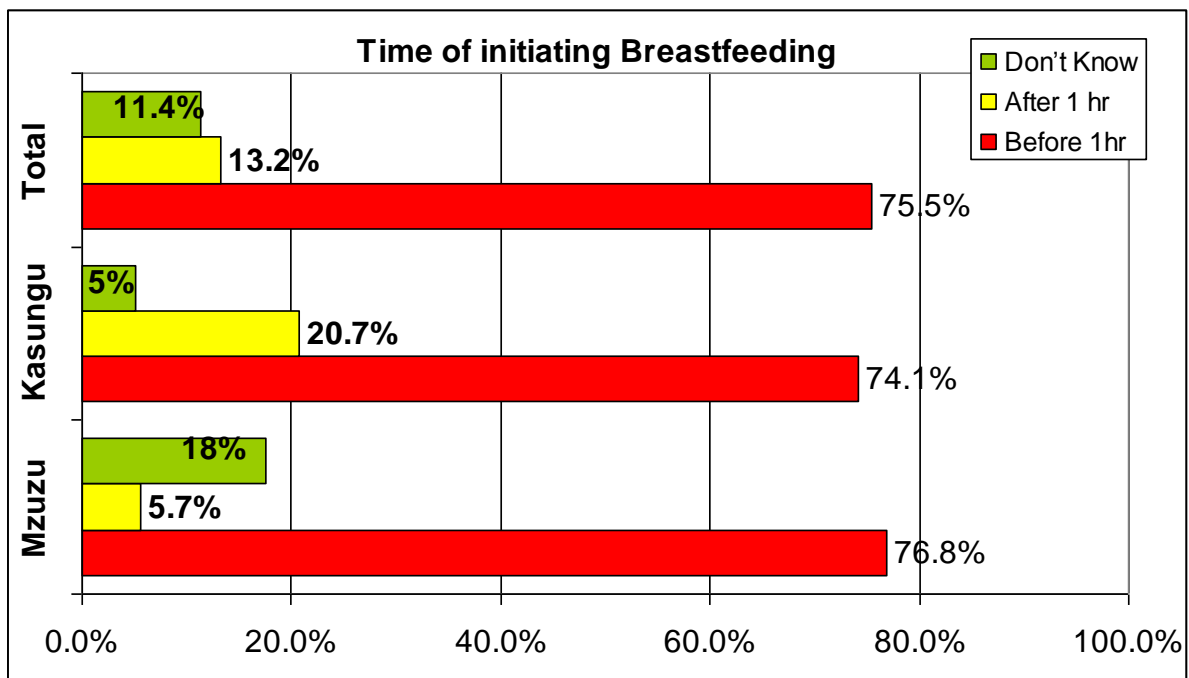
In addition to this the group teaches mothers on proper food preparation so that food retains all its nutritive value when provided to children. They also follow under five children in their homes, assess their nutritional status and provide advice or referrals if need be. In terms of community satisfaction they group had this to say, “For the past 1 year no cases of malnutrition have been spotted in the village. In addition to this no death among under fives has been reported arising from malnutrition, an indication that there is reduction in child mortality in this village”. Said one of the members of the committee. “Currently we also have about MK8, 000 from our fundraising which we will use to reach more households with startup seed. The group generates these funds through selling part of the seed. Like this money was sourced through selling g/nuts and cassava.

“One of the challenges we still face is the destruction of the crop in the field by monkeys. We also need continuous capacity building so that we master child nutrition related topics.” The group believes in supporting each other and all the original trained members are still within the committee which is outstanding performance. As a committee we link up with Ekwendeni Mission for additional technical support. We are also supported by our HSA. from Mzuzu Central Hospital who visits us at least once a month to give nutrition tips. We are also proud of our chief who also provides us opportunities to provide nutrition tips to the community members during any public events taking place in the village.” Explains the chair of the group.



Early initiation of breastfeeding: One of the key contributors to having proper nutrition is the initiation of breastfeeding within 1 hr of birth. Early initiation of breastfeeding contributes to reducing overall neonatal mortality. It ensures that skin-to-skin contact is made early on, an important factor in preventing hypothermia and establishing the bond between mother and child. Early initiation of breastfeeding also reduces a mother’s risk of post-partum hemorrhage, one of the leading causes of maternal mortality. The evaluation found out that a considerable proportion of mothers, 75.5% were able to breast their children within an hour of birth. The remaining 11.4% were unable to have their children breastfed because of various reasons including swollen breasts and not being given the baby at the right time after delivery according to the qualitative assessment. Refer to figure 8 below

Figure 8: Initiation of Breastfeeding by PU



65 % of mothers with children less than 3 years in Plan supported communities who manage diarrhoea with ORT from 53.68% by FY 2010.

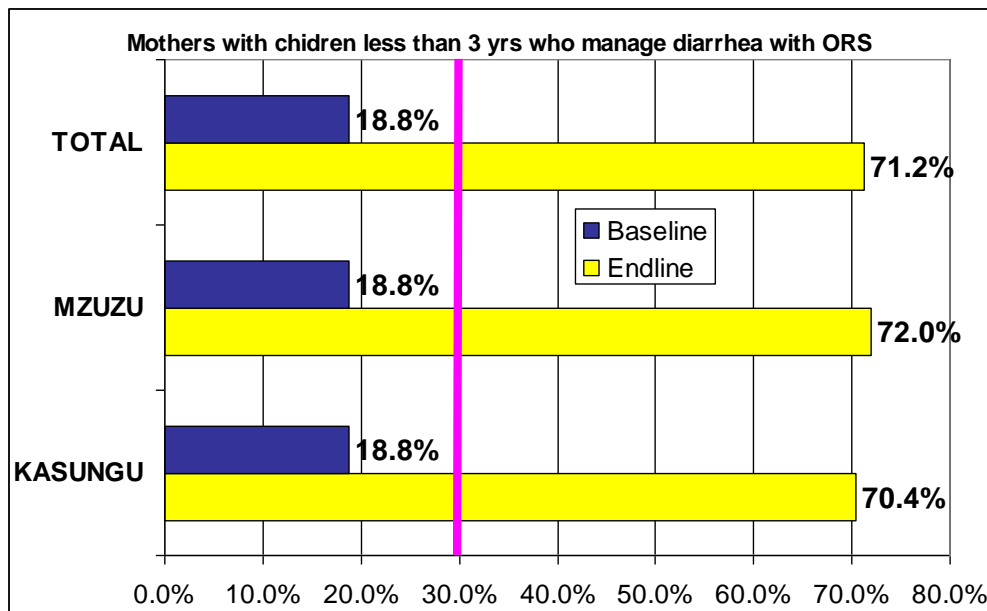
Overall Assessment of the Outcomes of the Indicator

The project objective of increasing the percent of mothers using Oral Rehydration Solution (ORS) during an episode of diarrhoea was exceptionally met. Final results show an increased use of ORS to 71.2% from a baseline of 18.8%. (Mzuzu, 72.0% and Kasungu, 70.4%). Refer to figure 9 below.

The results of evaluation highlight positive progress in the acceptance in use of ORT at home. This is attributed to project interventions that focused on the community level training of CORPS, Field Agents and Local NGOs in the prevention of diarrhoeal disease, including hygiene and home-based case management. Prevention activities carried out at the community level were combined with the clinical management. Facility-based diarrhoea case management was included in IMCI training.

However in terms of knowledge most mothers failed to recognize danger signs related to diarrhoeal diseases. Only 43.8% mothers mentioned dehydration as a sign to send the child immediately to hospital. More focus is needed to ensure that mothers recognize danger signs during diarrhoeal episodes of their babies / children. Elaborate and basic integrated messages aimed at improving knowledge and practices of mothers with ill children should focus on feeding during and after the illness. From the focus group discussion it was also clear that mothers' administration of food, fluids and breast milk during diarrhoeal illness was problematic. Most mothers mentioned of providing some of less liquids to their children during an episode of diarrhoea. With regard to these practices there is an urgent need for expanded IEC interventions. There is also a need for more collaboration with DHOs to supervise the nutrition teams more regularly.

Figure 9: Home Management of Diarrhea with ORS by PU

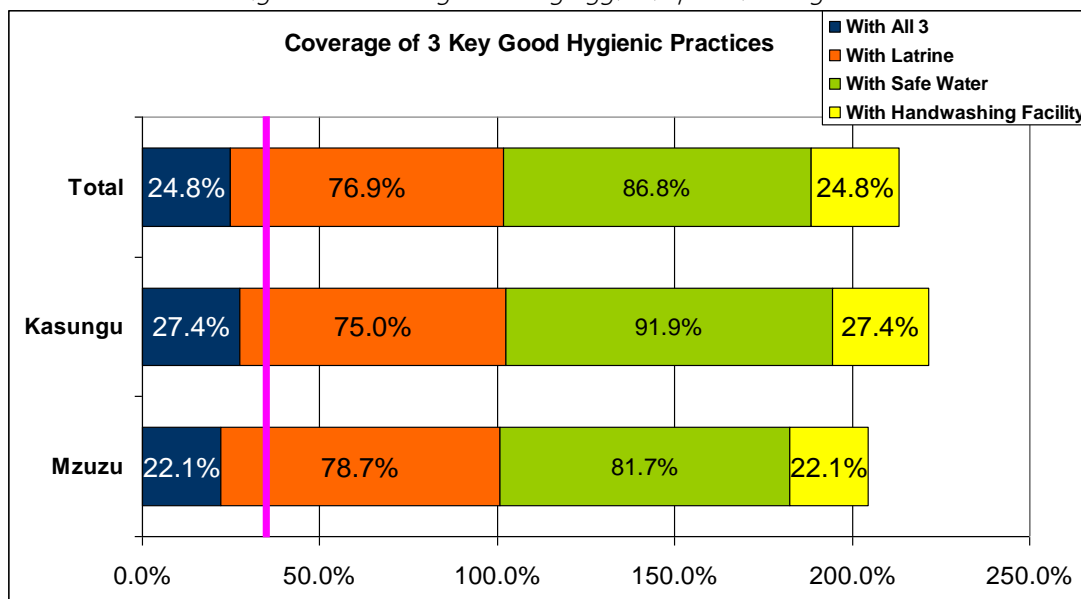


30% of families in Plan supported communities adopt good hygiene practices from 1.48 % by FY 2010.)

Overall Assessment of the Outcomes of the Objective

Overall the results show that only 26% of the caregivers adopted good hygiene practices that includes having a latrine, a hand washing facility and good water for drinking. Coverage for latrine and safe water seemed very high whilst that of hand washing was exceptionally very low. Latrine coverage was near universal. 86.8% of the surveyed households had a toilet, with or without a cover. 92% of the households also reported having access to safe water. However, only 26% of the mothers did indicate having a hand washing facility at the household. The objective therefore fell short of meeting the target by about 4 percentage points. Mzuzu had higher rates at 27.4% whilst Kasungu had 22.1% of practitioners of good hygiene. For more refer to figure 10

Figure 10: Coverage of 3 key hygienic practices by PU



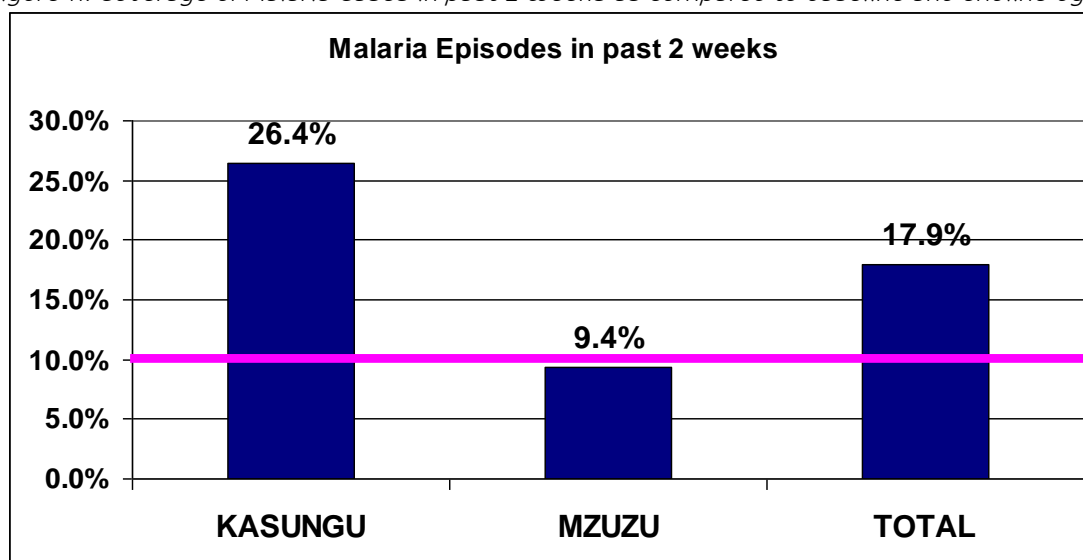
10 % of children aged less than 3 years infected with malaria in the last 2 weeks in Plan supported communities by FY 2010.)

Overall Assessment of the Outcomes of the Objective

The final evaluation results do not show major improvements in malaria indicator on reducing disease episodes. The results indicate that 17.9% of the children of less than 3 years had malaria in 2 weeks preceding the evaluation as compared to the project target of 10%. More cases were reported in Kasungu (26.4%) than in Mzuzu (9.4%). (Refer to figure 11 below). Only Mzuzu appeared to have been able to surpass the target by less than 1 pp. Annual precipitation and wet season temperature determine the distribution of mosquitoes and therefore malaria. The peak malaria season in Malawi is between December and April therefore the higher episodes could partly be due to the season. Mosquitoes also breed faster when temperatures are high (equal to or above 21 degrees Celsius). This could explain why there seemed to be more cases in Kasungu than Mzuzu PU since the latter is colder and mosquitoes are fewer.

Results also show that care seeking at the nearest health centre or village clinic for a child with malaria was found to be exceptionally very high. Plan partnerships with government and mission hospitals seem to be contributing the recorded successes. According to the project information 5 health facilities in the program area were provided with antimalarials to supplement stocks from DHO's office.

Figure 11: Coverage of Malaria Cases in past 2 weeks as compared to baseline and endline by PU



Box 2 : Case Study Providing treatment closer to the communities: A case for Sopano Village Clinic

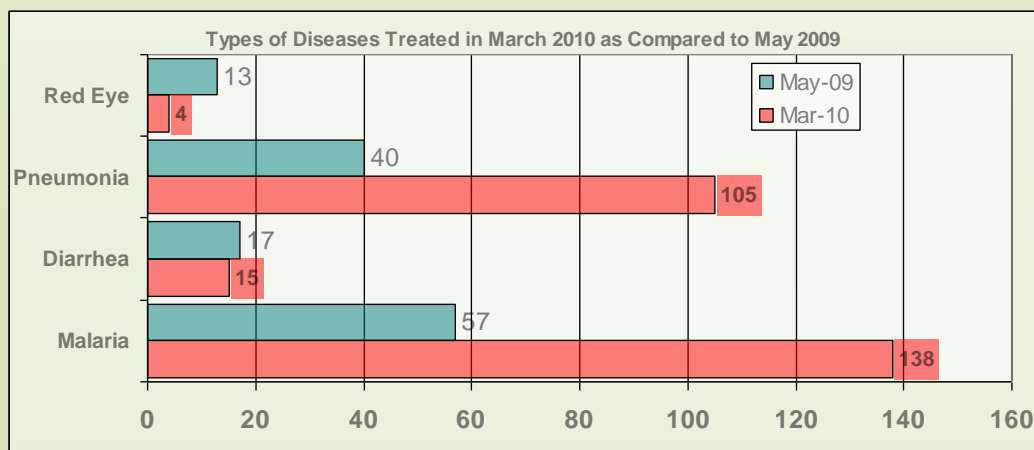
In Malawi the public sector provides 61 percent of health services. The remaining 39 percent of health services are provided by the not-for-profit Christian Association of Malawi (37 percent) and the private sector (2 percent) (MoH, 1999). Disparities exist in the availability of health facilities and trained health workers in urban and rural areas. Urban areas have more facilities and trained health workers than rural areas. These are continuing to be a major contributor to high child mortality rate in remote areas of the country.

In order to help save lives among under fives, Plan in partnership with district hospitals is promoting community case management of illnesses affecting children through Village Clinics. The purpose is to make sure that treatment of uncomplicated cases is made closer to the communities and quicker which can help save lives of under fives. The programme is in line with IMCI concept that focuses on “scaling up” of activities in the context of the Essential Healthcare Package (EHP) and sector-wide approaches. The main strategic areas that have been identified for the scale-up of IMCI activities, include, improve case management both at the community and health facility level, improve supplies and communication facilities and improve key family practices at the community and household levels.

Sopani Village Clinic in Kasungu PU is one of the centers that were opened in May 2008. The center is 20km from the nearest health facility-Kaluluma Rural Hospital and one of the 6 opened to help serve communities who are far away from the nearest health facilities within the hospitals catchment area. The center is managed by a Health Surveillance Assistant (HAS) namely, Ishmael Chisemphere. He gets support from a 10 member Village Clinic Committee that comprises of volunteers across the villages served by the center. The HSA and the committee were both trained in clinic management which has helped improve the services offered there. During each day of services, one member of the committee comes to provide logistical support to Ishmael.

The center normally opens two times a week on Tuesdays and Thursdays from 7.30am to 5.00pm and offers treatment for Malaria, Fast Breathing, Diarrhea and Red Eye. According to the plan, the Village Clinic is supposed to stock the following drugs: LA, Paracetamol, Cotrimoxazole, Zinc and Eye Ointment. However it was observed that since the clinic was opened, zinc has not yet been supplied until now. In addition to the drugs, the clinic was provided with cups and spoons that have been assisting the clinic in providing ORT services. Ishmael notes that despite the adherence to the timetable he attends to cases even at night because his role is to help save lives. “I believe in prompt treatment for under five children. So I make sure that I provide my assistance at any time that is needed.” Ishmael explains.

The clinic supports communities from 18 villages with a total population of 1665 people. However Ishmael was quick to say that communities beyond these sites also access treatment at the clinic. According to Ishmael, the number of under five children receiving treatment at the clinic has been growing ever since it was established in May 2008. “Despite challenges in drug supply the clinic has been providing exceptional treatment to the communities around this area” Ishmael explains. “The village clinic needs to have its own secure place because the under five shelter that is allocated for the facility has no burglar bars. In addition to this, restocking of drugs is difficult since we have to use about MK400/per person to travel to Kaluluma to get the drugs”. Usually we travel as a team of two. Narrates Ishmael. Lastly older people have been asking for treatment at the clinic which is not acceptable as per the design of the programme. According to community case management protocols in the country, HSAs are only allowed to treat children of less than 5 years. All cases of older people still have to be managed at the health facilities. Below is the summary of number of children treated at the clinic in May 2009 and March 2010 showing an increasing trend of curative services provided, which is a good sign for increased health seeking behaviors.



80 % of children under five sleep under an ITN by FY 2010.

Overall Assessment of the Outcomes of the Objective

The evaluation results indicate that 71.7% of children slept under ITNs the previous night. This percentage is rather encouraging compared to the rest of the country which stands at 55% but still needs to be improved when compared with the objective of 80%. Kasungu showed higher ITN figures at 74.1% as compared to Mzuzu that reported 69.3%. The higher figures in Kasungu were a result of the higher number of nets that were provided to the households in the previous years as compared to Mzuzu. On net ownership the results show that most households have 1 net at 51%, seconded by 2 nets at 37.3%, 3 nets at 7.7% and lastly 4 or more nets were found with 4.2% of the sampled household. Net retreatment was observed to be at 96%. This indicates successes in mass re-dipping campaigns that Plan had also supported in the PUs. In 2009, Mzuzu PU was able to redip over 80% ITNs during the child health week which is a positive indication that under five children and pregnant women sleep under ITNs for prevention of malaria. Plan also supported training of community health volunteers in childhood killer diseases (Malnutrition, Diarrhea, Malaria, ARI and Measles). The knowledge gained included malaria preventive measures through use of ITNs. The community health volunteers have been teaching families from their respective communities on the same. Figure 12 shows time trends in the use of ITNs.

Figure 12: ITN Coverage among under fives by PU

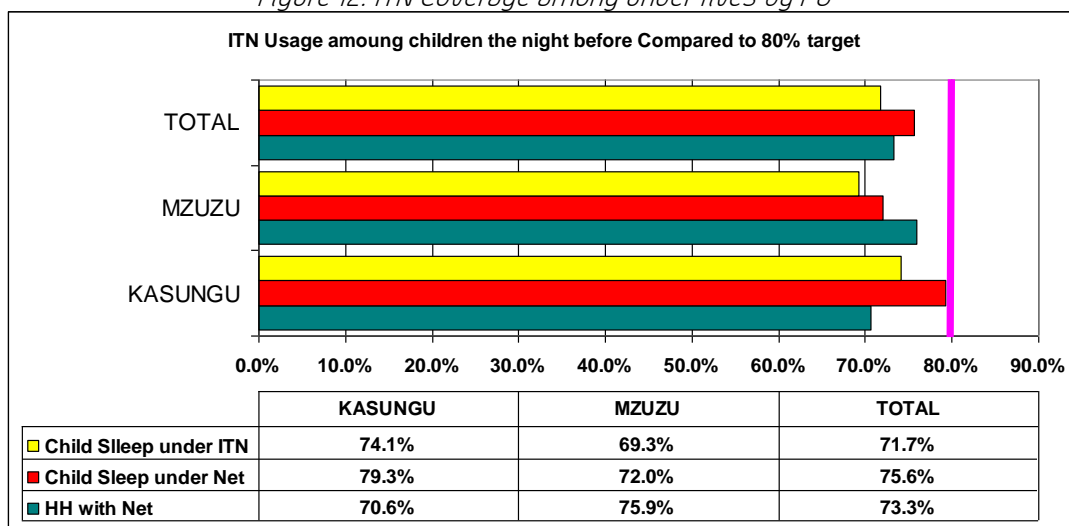
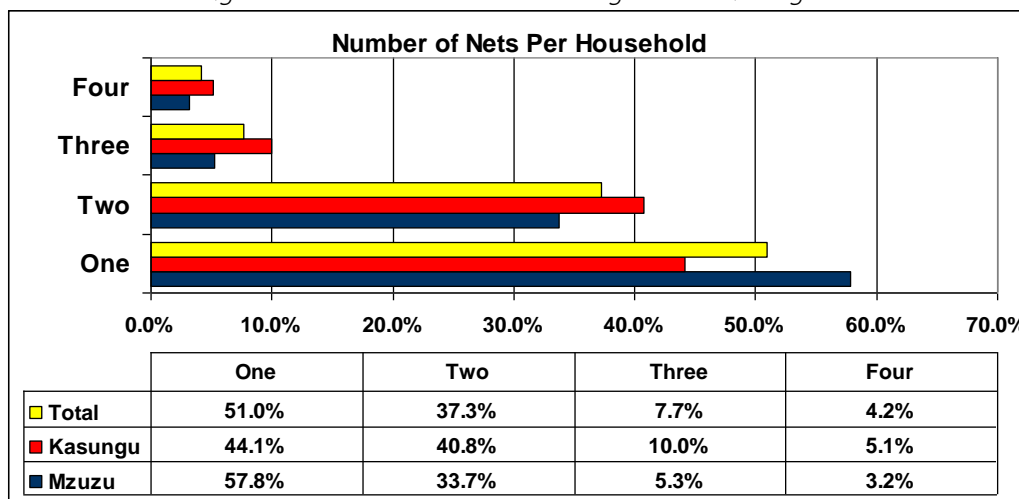


Figure 13: Number of nets owned by households by PU



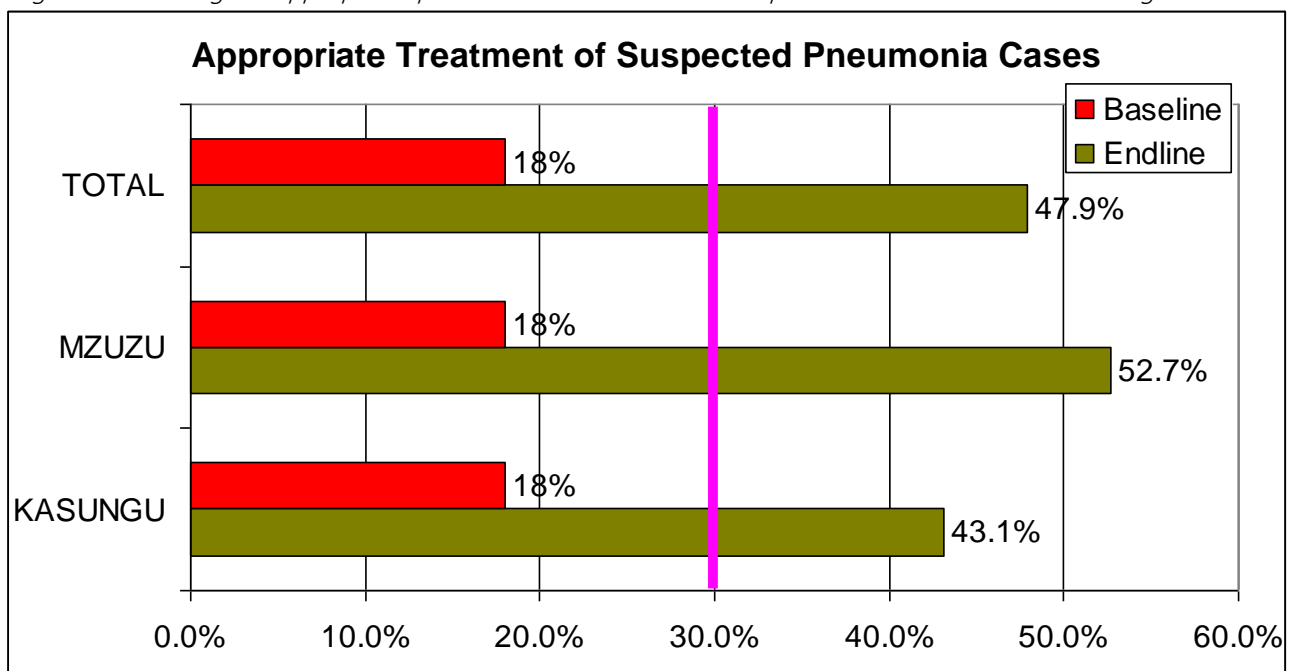
30 % of mothers in Plan supported communities with children under 3 years who take their children with symptoms of pneumonia for appropriate treatment within 24 hrs of development of symptoms from 18.79% by FY 2010.

Overall Assessment of the Outcomes of the Objective

The evaluation found increase care-seeking behaviour among mothers of children of under 3 years with pneumonia symptoms at 47.9%. Coverage was high in Mzuzu at 52.7% than in Kasungu where 43.1% of mothers went for appropriate pneumonia treatment. **Refer figure 14 below.** One of the key contributions by Plan Malawi was the support to the District Health Office with financial and material resources to train 15 professional health workers (clinicians / nurses) in facility based IMCI and 22 health surveillance assistants (HSAs) in village clinics. These trainings have helped improve case management and improved health seeking behaviours

In addition to this, another outstanding project contribution was observed to be the support on health infrastructure. Construction of health centres is in progress at Mnyanja in Kasungu PU and Matuli in Mzuzu. These health facilities will be furnished and equipped with modern medical equipment and upon completion will provide integrated static and outreach health services including treatment of ARI. The program also trained project management committees comprising of 22 people (2 group village headmen, 10 males and 10 females) on their terms of reference, project identification and cycles, resource mobilisation, leadership styles/skills, project monitoring and evaluation, functions of the project committee, conflict management, reporting and action plan development. The training has increased community's participation in project management and monitoring resulting into project ownership. However the greatest setback is the scarcity of drugs at health facilities. Although some mothers acknowledged the importance of health facilities in curing pneumonia, others admitted that they preferred to consult shop owners for pneumonia because drugs are not always available at the health facility.

Figure 14: Coverage of appropriate pneumonia treatment as compared to baseline and endline by PU



KEY LESSONS LEARNED-CHILD SURVIVAL

- **Child Health Week (CHW) campaigns** are a highly effective way of ensuring increased coverage of a majority of IMCI indicators such as Vitamin A, immunisation coverage, Net re-dipping etc. CHWs have managed to provide services at “door steps” to the child.
- **Health system strengthening is a productive portion of “Child Survival Acceleration”.** Investments in health system strengthening are essential complements to ACSD. The provision of hospital supplies, equipment and drugs by Plan helped contribute to improving under five case management which is very critical in reducing mortality. Despite the fact that infrastructure and drugs related interventions are led by Ministry of Health, support in this area seems to show quick and significant results in fostering child health.
- **The quality of counselling provided to mothers by safe motherhood groups is critical to the success of exclusive breastfeeding components.** These groups are best positioned to reach the target mothers in the PUs. Therefore their strong capacity is essential to achieving exceptional results in breastfeeding.

KEY CHALLENGES-CHILD SURVIVAL

- **Absence of zinc in village clinics providing limited treatment alternatives:** Despite the acceptance of zinc to be included among the list of drugs for community case management there has been little progress for Ministry of Health and partner NGOs to provide the drug at the various village clinics.
- **Shortage of drugs both in village clinics and health facilities:** The country has been facing serious drug shortfalls which affected the performance of child health services at both health facility and village clinic level. According to the system the districts are supposed to order drugs centrally from Government Central Medical Stores (CMS). Of late, due to logistical challenges new drug consignments have not been forthcoming on time and in the right quantities.
- **There is demand among the general population for village clinics to treat adults as well:** According to the design of community case management, only under five children are allowed to access treatment of services at village clinics. Due to distance factors even older people are seeing the benefits of community case management and desire to be considered for treatment.
- **MoH staff participation low due to the per diem modality offered by Plan:** According to partners from the District Assemblies they feel participation is hampered by modality of per diem offered by Plan. Plan usually provides for everything and only gives participants cash for incidentals. They feel they should be provided with per diem for meals and that Plan can take care of accommodation only.
- **Inadequate equipment for assessing children nutritional status by community nutrition groups:** Some nutrition groups felt that the numbers of anthropometry sets were not adequate to assist them in conducting nutrition surveillance in the PUs. These equipments include scales, height boards and MUAC Tapes

RECOMMENDATIONS-CHILD SURVIVAL

- **Provide startup seed to nutrition groups that would sustainably manage payback schemes in order to improve results on child nutrition.** Apart from taking up leading role in nutrition information dissemination, it has been observed that nutrition groups can also help managing village based seed development systems. As reflected from Mkopeka Mkowoya nutrition group they sustainably managed a local seed supply system for over two years and reached more households.
- **Work hand in hand with MOH on improving drug availability in all health facilities and village clinics.** Plan should engage government through alliances on the issue of drugs. Whilst government should still retain the leadership role in drug provision, this issue needs urgent

redress as it has a big impact in child survival interventions. Plan needs to explore new partnerships that would help address this huge challenge.

- **Cautiously expand the network of village clinics whilst improving the availability of drugs in existing clinics.** Village clinics have very good potential of helping save children and new born lives. Therefore continued support in expanding these sites would be very critical in the next stages. However drugs needs to available in all the current and expanded village clinic sites if they are going to be productive.
- **Ensure stocks of ITNs through continued collaboration with MoH:** ITN coverage in the PUs is still below the national target of 80%. Factors that contributed to this include the non availability of the nets at the health facilities.
- **Develop new messages and communication tools on pneumonia danger signs and the importance of care-seeking:** Communication tools in this area should address the whole ARI spectrum beginning with prevention, early recognition of signs as well as prompt treatment. The current situation showed higher coverage in prompt treatment other than on preventive measures.
- **Assess previous Drug Revolving Fund sites and consider them as potential outlets for village clinics**

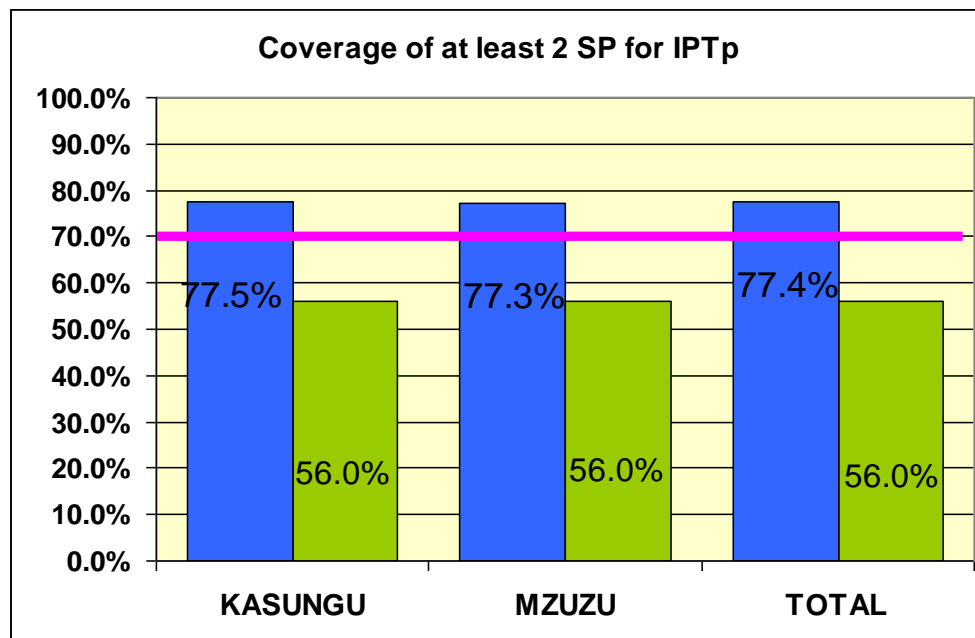
5.2.2 MATERNAL HEALTH

70% of pregnant women in Plan supported communities receive the recommended dose of Intermittent Presumptive Treatment during pregnancy from 56% by FY 2010.

Overall Assessment of the Outcomes of the Objective

The findings show that 77.4% of mothers had received at least 2 doses of IPTp during their previous pregnancy. This shows significant improvement from the baseline of 56.0% and meeting the target of 70%. Both districts had similar coverage levels (Mzuzu, 77.3% and Kasungu, 77.5%). Essentially, the number of women attending ANC is highly consistent with the number of women receiving IPTp. However some women reported unable to access SP at the health facility despite showing positive care seeking. Further attention is therefore needed to ensure that adequate drug supplies are available for IPTp to be very successful. See figure 15 below:

Figure 15: Coverage of types of SP for IPTp by PU



The sequence of training and promotion of services has contributed to more women attending ANC, more women benefiting from IPTp thus contributing to overall improvement in maternal and newborn care. However it was noted that follow up for post natal care is not routinely observed. More work needs to be done to improve functioning and delivery of services at both the pre and post natal stages to address the weaknesses in health education and clinical practices.

Traditional Birth Attendants (TBAs) still play a crucial role in delivery of maternal and neonatal health in Malawi. However, in order to reduce the high maternal and neonatal mortality rates, Ministry of Health, since 2007, has been advocating for deliveries to be undertaken by skilled health workers at health facilities. Plan has been operating based on this revised policy in 2007. For instance, Kasungu District Health Office oriented 37 TBAs and 5 HSAs with support from the project. Mzuzu PU also continued to work in partnership with Ekwendeni Mission Hospital where a total 103 TBAs and 5 HSAs were oriented on TBA new roles. In turn the TBAs have been encouraging mothers to attend ante natal care (ANC) and deliver at the nearest health facilities.

However of late, the work of TBAs across the country has been under a big debate. In October, 2010 the State President announced that TBAs will be allowed to operate in the country and that they will undergo rigorous training so that they manage the deliveries well. After this announcement the Ministry of Health has been reluctant to publicly announce a change over on policy. There seems to be major political debates going on both within government and the general public. This has created an atmosphere where there seems to be two opposing camps, one for the TBAs whilst the other against them. During the evaluation, most of the mothers met seemed to know the benefits of having deliveries at a health facility and mentioned that TBAs are not allowed to attend to deliveries. However some mothers also pointed out that some TBAs are still active within their villages. Key informant interviews with actual TBAs also showed that they were aware that Ministry of Health decision in 2007 for them to stop managing deliveries. However most of them pointed out that they were managing deliveries well and that they just needed additional technical assistance in terms of further training as well as support in delivery equipments like gloves, aprons etc. In view of this, Plan needs to undertake a special assessment of TBA work in the country and help in advising government on the best course decision to take.

80% of childbearing females who have received a minimum of 2 Tetanus Toxoid vaccinations before the birth of their youngest child in Plan supported communities by FY 2010.

Overall Assessment of the Outcomes of the Objective

Reported coverage on mothers receiving at least 2 TTV doses was very high at 88.5%. TT2 coverage was higher in Mzuzu at 91.3% and slightly lower in Kasungu at 85.6%. The overall increase in coverage of TT immunization has contributed to better child survival in the impact areas. The project provided support at various levels of the health system to strengthen TTV vaccinations. At the health facility level, partners were supplied with refrigerators; clinicians and nurses were trained in facility

based IMCI. At the community level CORPS were trained in EPI promotion and provided with BCC tools. These activities complemented with child health campaigns. The evaluation also assessed whether mothers had finished TTV before the birth of their last born. The results indicate that 67.2% were already fully protected before conceiving their last born. Refer to Figure 16 below

Figure 16: Coverage of modern family planning methods as compared to baseline and endline by PU

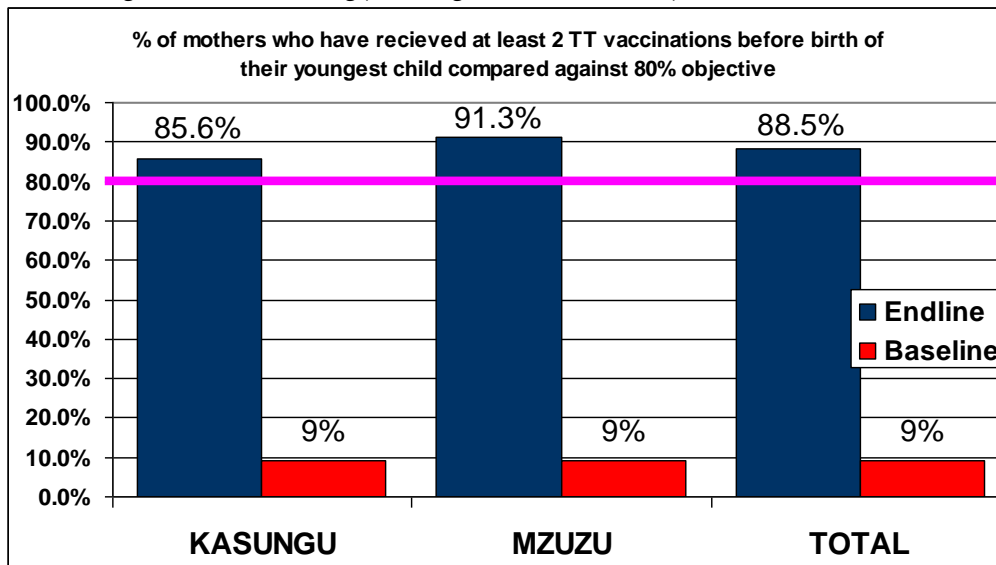
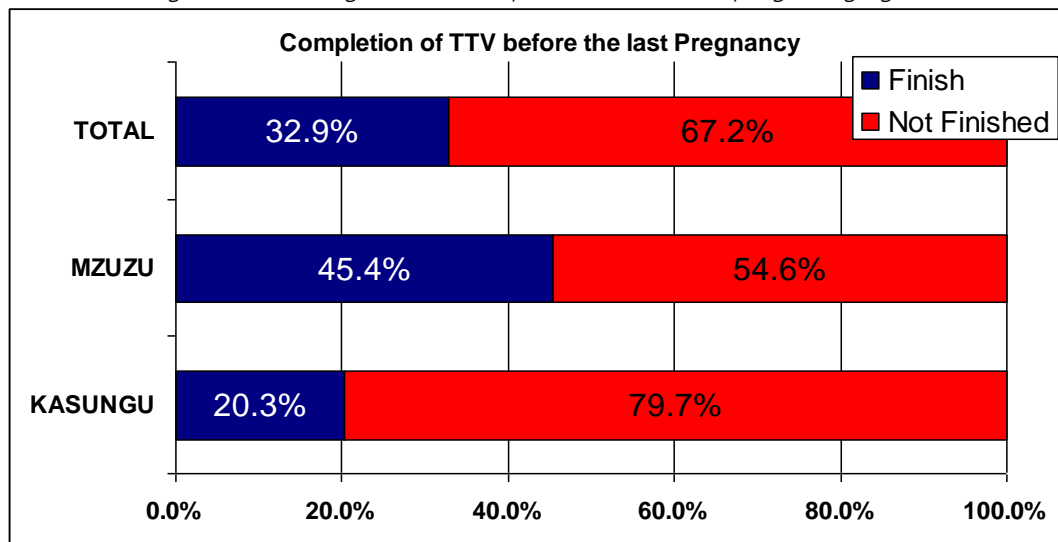


Figure 17: Coverage of TTV completion before last pregnancy by PU

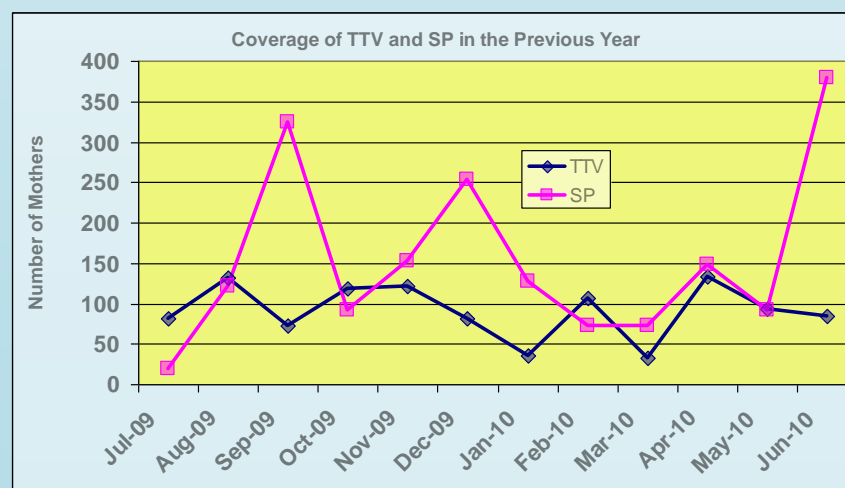
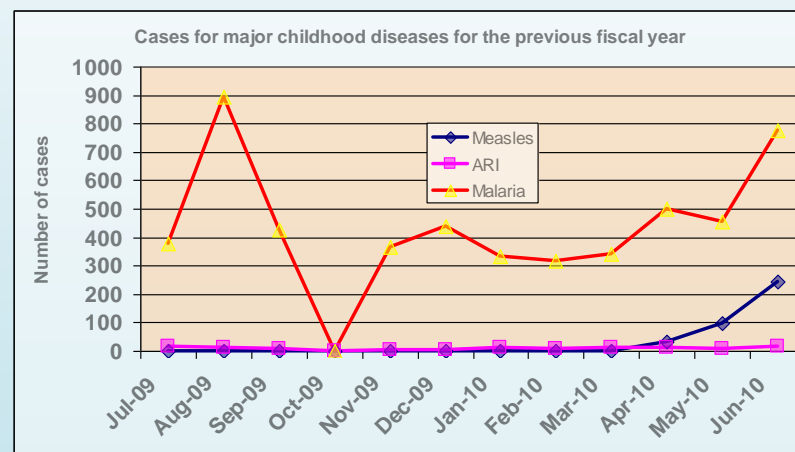


Box 3: Case Study: Kaluluma Rural Hospital

Kaluluma Rural Hospital is situated 62 km north of Kasungu Boma along M1 road to Mzimba. It was established in 1953 and certified as a rural hospital in October 2009. It serves a population of more than 32,645 from Senior Chief Kaluluma, TA Chisemphere, STA Mnyanja, Chisinga, Mabulabo in Mzimba and neighboring parts of Zambia. It also acts as a referral center for other bordering health centers of Lodjwa, Nkhamenya, Ofesi, Simulemba and Newa. The facility has 1 Clinical Officer, 1 Medical Assistant, 1 AEHO, 5 Nurses, 1 Laboratory Assistant, 34 HSAs amongst other staff.

The facility has received notable support from various stakeholders including Plan. Plan provided funds for the construction, furnishing with computer sets etc, equipping, providing piped water, electrifying of MCH unit in 2006. Plan also bought an ambulance and a motorcycle to help ease transport problems and also provided bicycles for CBDAs to enhance family planning initiatives. It rehabilitated, equipped and furnished the maternity block and constructed a shelter for adult outpatient. In addition to this Plan supported a number of curative and preventive health capacity building such as village clinic training, CLTS, CBDA, EBF and many others. On medical supplies, Plan has also been providing Iron and Albendazole Tablets which have been distributed through schools; Vitamin A, SP, iron, and health passports for children and mothers to facilitate proper record keeping.

Now the hospital is pleased since many children are being treated at the facility which is resulting in reduction in child and neonatal deaths at the facility. Refer to graph 1 below for treatment figures. The facility has also been critical in promoting TTV as seen from the graph 2 below. The facility needs additional infrastructure including a guardian shelter, kitchen, staff houses and extension of water and electricity to the other blocks. It also requires adequate medical equipment and supplies such as beds and drugs. It also feels the importance of scaling up CLTS to cover all villages in order to improve access to health.



60 % of mothers of child bearing age in Plan supported communities currently using modern family planning methods from 45.78 % by FY 2010.

Overall Assessment of the Outcomes of the Objective

The project had a major family planning promotional effort, resulting in a fairly high acceptance rate of modern methods. The percent of mothers who desire no more children in the next two years and are using a modern contraceptive methods increased from 45% at baseline to 48.7% at final. More mothers were likely to be on FP in Mzuzu at 52.8% than in Kasungu at 44.6%. (See figure 18). On type of method it was found that the injection is the most commonly used method for contraception. The Depo provera have long been the preferred method, but recently there were problems in the provision of this service at the health facilities. There have been constant stock outs of Depo at the health facilities. Through this programme Plan has managed to support the DHOs to train Health Surveillance Assistants and provide bicycles for the new Community Based Distribution Agents (CBDAs) within the program area. The district family planning coordinators and health centre supervisors are also supported with fuel and other logistics to conduct quarterly supervision of CBDAs. During these supportive visits, contraceptives and other stocks are replenished, registers and records are also reviewed.

Figure 18: Coverage of Modern Family Planning Methods by PU

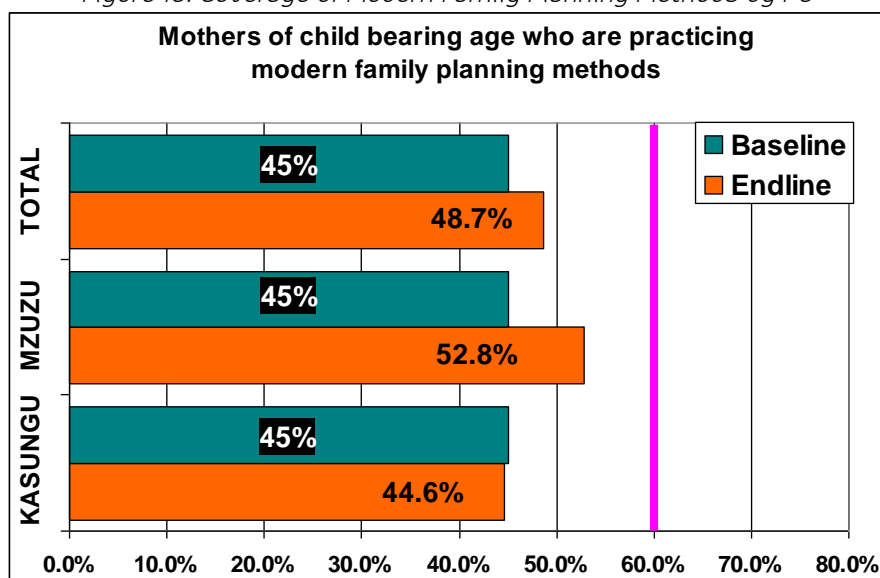


Figure 19: Contraceptive Methods by PU

#	Method	Mzuzu	Kasungu	Total
1	NORPLANT	6.1%	3.1%	4.6%
2	INJECTIONS	63.1%	74.1%	68.6%
3	PILL	17.2%	17.6%	17.4%
4	IUD/LOOP	0.5%	0.0%	0.3%
5	DIAPHRAGM	0.0%	0.0%	0.0%
6	CONDOM	0.0%	2.6%	1.3%
7	FOAM/GEL	0.0%	2.6%	1.3%
8	TUBAL LIGATION	12.1%	0.0%	6.1%
9	VASECTOMY	1.0%	0.0%	0.5%
10	LACTATIONAL AMENORRHEA	0.0%	0.0%	0.0%
11	RHYTHM	0.0%	0.0%	0.0%
12	ABSTINENCE	0.0%	0.0%	0.0%
13	WITHDRAWAL	0.0%	0.0%	0.0%

Box 4: Case Study: Enyezini CBDA Group in Mzuzu PU.

The group started in 2002 as a result of increased child and maternal mortality that was experienced at that time in the area which was contributed by low coverage of family planning services. The group which is comprised of 13 members operates in Zombwe Community which has a total number of 24 villages. Since the groups establishment they have been undertaking various awareness initiatives in the area on the benefits of family planning.

“We are empowered by the fact that family planning issues are related to development and we are happy to work hand in hand with our village headman to tackle this development issue” explains one of the members of the group. We have attended a number of trainings including HTC and family planning organized by Ekwendeni Mission Hospital and Plan. These trainings added more confidence in us to take up this role. Now people are no longer feel shy to access our services as compared to the past. Approximately each member supports about 20 clients every day. “Adolescents are also free to access services and we believe we are also playing a positive role in HIV prevention and reduction of unwanted pregnancies”

The key successes recorded are a result of the involvement of the elderly in family planning. All elderly people surrounding this area were invited at Ekwendeni where they were briefed on cultural factors that were contributing to the low utilization of family planning services in the area. Through this orientation the elderly have been advocating the benefits of having proper family planning which has enabled its coverage to increase. Currently our biggest challenge is low supplies. “Usually we run short of condoms and pills due to the inadequate supplies we receive”. Explains the chairperson of the group.



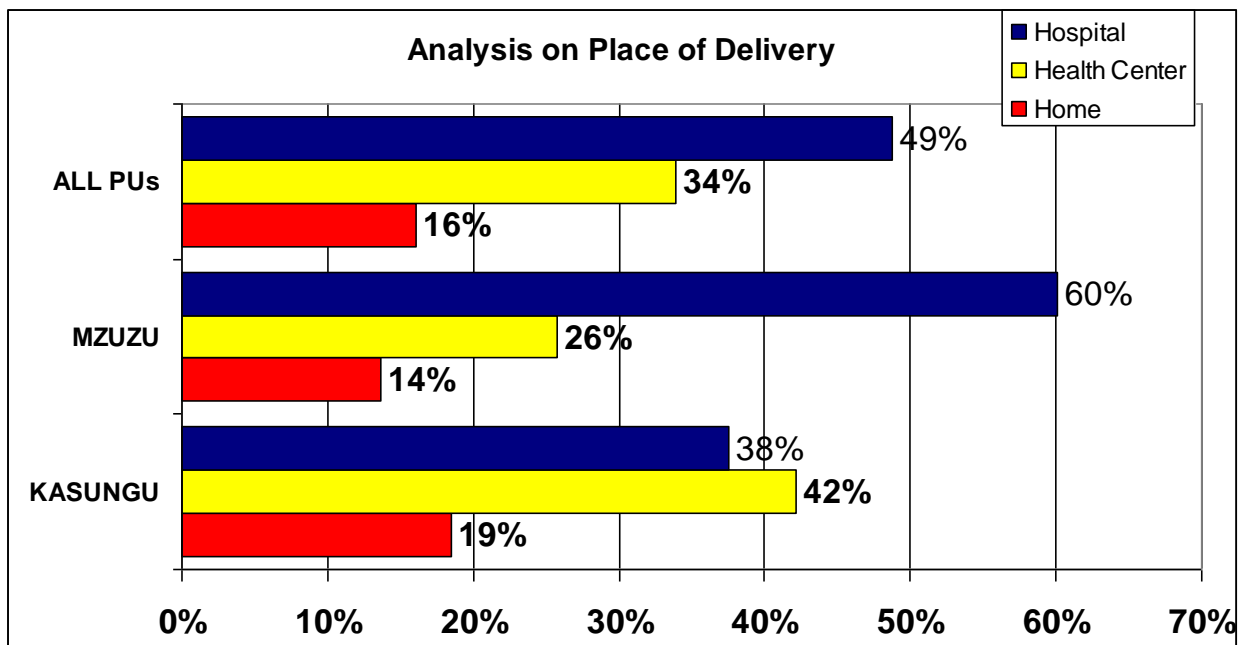
Testimonial-Yesaya Phiri, CBDA

Yesaya Phiri is one of the CBDA who started providing FP services and counseling in 1997. Plan provided him with training in addition to a set comprising of a bicycle, bag, drug box and writing pads. Since then Yesaya has been teaching people around his village on issue of family planning and providing PF services including the adolescents. “On average I provide contraceptives to over 15 youths in the village per month. I am of the opinion that ASRH interventions supported by Plan have helped in the reduction of maternal mortality as unwanted pregnancies are prevented”. Explains Yesaya. He however feels that the major setback in his role is the absence of the FP methods to the extent that clients are turned away.

Assessment of Key Strategies/Issues under the Objective

The percentage of births attended by skilled health personnel was found to be 84%. The conclusion is that care seeking on the part of the mother is on the right track. However the insufficient number of qualified personnel at the health facilities may also be a major inhibitor of success in this area. **Figure 20** shows that the percentage of children whose births were not attended by skilled health personnel was low (16%) Given this critical situation there is a need to enter into dialogue with MoH to increase the number of qualified health workers at the health facility in order to be in line with the national norms. Even though Plan mandate is not to construct health facilities, the organization helped expand coverage of health care delivery through health infrastructure development so that services are closer to the people.

Figure 20: Coverage of Place of Delivery



Testimonial: Tereza Tomoka, TBA, TA Chisemphere, Katsirizika community in Kasungu PU

Tereza Tomoka is one of the TBAs who started her operations in 1997. "Soon after finishing my initial training, Plan Malawi supported me with various items including a stretcher, a bicycle and a set of aprons". Explains Tereza. The aprons helped improve infection prevention at my clinic whilst the bicycle was used for message dissemination. The Stretcher was for emergencies in taking the mothers to hospitals if need be. Tereza used to assist many pregnant women to deliver at her clinic before government's change of decision on TBAs. "I used to charge a small token fee of MK250 per delivery just for my upkeep". Tereza is now happy to counsel women to attend ANC and delivery at the nearest clinic based on the new roles. She feels this has given her an opportunity to concentrate in her field. However she is sad to note some circumstances where deliveries do happen in the villages without any assistance from them.

Testimonial: Enyezini safe motherhood group in Mzuzu PU

The group was established in 2008 with the aim of teaching mothers on the importance of hospital deliveries and testing for HIV. In addition to this they are also involved in nutrition promotion where they advise mothers to uptake the 6 food groups. They also teach mothers on the importance of exclusive breastfeeding for the first 6 months of life of babies. They have been working hand in hand with TBAs to make sure that women are encouraged to deliver at hospitals other than at TBAs. "We are seeing positive results in this area as more ANC visits have been recorded at Ekwendeni Mission Hospital in the current year." Commented one of the ladies. They have specifically advised mothers to keep some money for hiring emergencies because most of the deliveries happening at home are a result of lack of transport to reach the nearest hospital. Apart from this the group is involved in counseling mothers on family planning and the importance of deciding how many children they want to have in the family. "We believe our roles can be better enhanced if we are given bicycles to help us in mobility. In addition to this we need exchange visits so that technically we also improve our capacities. IGA in form of pigs or diary cows could be some of the initiatives that we can undertake in order to make the group more sustainable in reaching out to more mothers".

KEY LESSONS LEARNED-MATERNAL AND NEONATAL HEALTH

- **With proper empowerment men can equally participate in female dominated areas such as in nutrition.** Men were observed taking a positive role in promoting family health care in the targeted communities.
- **Local leader's involvement** in promoting reproductive health is crucial in tackling key cultural beliefs and myths surrounding maternal and new born care.
- **Collaboration is effective in leveraging resources and achieving objectives.** Plan collaboration with government and other international donor organizations, has proven to be effective in

expanding coverage since no single partner has the skills or funding to do all the child and maternal health interventions

- **Programs should be responsive to changing operational environment.** Plan was reactive to introduce strategies, even if they did not appear initially in the original project objectives. A good example has been the introduction of village clinics and changing of TBA roles basing **changing policy**.
- **Capacity building remains main tool for sustainability.** Capacity building ensures that the partners retain knowledge and skills. Plan has been involved in capacity building initiatives that have worked towards sustaining services in partner health facilities and communities.
- **Links with the health facilities** through regular feedback, meetings, informal discussions and follow up trainings are essential to strengthen the partnership process and forge stronger links between communities and health centers.
- **Sustained health education with high levels of consistency in the messages** is key to behavior change than one-off messages via micro or mass media

KEY CHALLENGES-MATERNAL AND NEONATAL HEALTH

- **Shortage of family planning methods in the communities:** Most of the villages visited mentioned of scarcity of a diverse range of family planning methods due to reduced quantities that are given to them on monthly basis.
- **Pregnant women travel long distances to nearest health facilities for both ANC and post natal care:** Delivery at health facilities has been a very big challenge to the long distances pregnant women are expected to travel. These trips require money for transport which due to high poverty levels becomes very difficult to access.
- **Inadequate equipment in some health facilities** that provide maternity services inhibiting proper care of deliveries as well as motivation to seek deliveries at the facilities
- **High vacancy rates of medical personnel affecting quality of medical care provided to mothers and newborns:** Most of the health facilities still face huge staff shortage contributing to delays when seeking treatment and fatigue of clinical staff.
- **Few HSAs trained in family planning within the communities:** A few HSAs have the required capacity to manage the provision family planning methods as well as supervising of CBDAs.

RECOMMENDATIONS-MATERNAL AND NEONATAL HEALTH

- **Selection of community health volunteers should be undertaken in accordance with key criteria being willingness to work and not too busy with other matters.** Some of the volunteers have not been so active in supporting the family planning thematic area despite attending training supported. This in the end also affected coverage of the family planning services
- **CORPS should have clear roles and responsibilities.** It was noted that CORPS had very high expectations from their roles which in the end contributed to frustrations on their part. It seems some of the CORPS actually
- **Chief's influence on volunteer nominations needs to be checked.** There have been cases where chiefs have nominated volunteers alone in so doing choosing their relatives hoping that they will have some benefits from the roles. This again caused friction as people had limited control to the actions of the volunteers that have close ties or related to the chiefs
- **There is need to expand grants in size and to new partners to achieve acceleration in provision of IMCI services.** IMCI achieves acceleration through involvement of various players on the ground. The partnership with Mission hospitals as well as government health facilities has greatly contributed to reaching our more children in shorter period of time.

- **Lobby with central government for construction of more health facilities in order to reduce distance traveled by people to reach the nearest health facility.** Government needs to continue allocating more resources in the construction of health facilities since this has the biggest contribution to reducing maternal mortality in the PUs.
- **Develop a tool that helps to reinforce the registration system for women's vaccines. For instance** IDs for TT5 that could be used as an incentive for women and a good source of verifying immunization rates
- **Develop strategies of improving health worker attitudes towards patients including the strengthening of supervision and motivation of health workers.** One of factors that contributed to women delivering at TBAs was the issue of ill treatment by health workers.
- **Improve delivery rooms so that mothers are motivated to visit the facilities for antenatal, delivery and postnatal care.** Mothers as well as health workers complained of dilapidated infrastructure and equipment in most of the delivery rooms. This has also been one of the key factors causing low utilization of health facilities for delivery.

5.2.3 WATER AND SANITATION

70 % of families having safe water all year round in Plan supported communities from 47.79 % by FY 2010.

Overall Assessment of the Outcomes of the Objective

The survey results show that 86.8% of the households drink from safe water sources highly surpassing the target of 70%. Coverage was higher in Kasungu at 91.9% and lower in Mzuzu at 81.7%. In terms of type of water sources 8.4% of the households drink water from unprotected dug wells and unprotected springs, 4.8% from streams and rivers, 2.1% reported drinking from protected dug well/spring, 80.3% from borehole, and about 1% from pipes. The respondents were requested to estimate times they take to and from water sources. The results showed that 62% of households take less than 15 minutes from home to the water source and back to draw water, 26% of the households take 16 to 30 minutes, 9% of households take 30 minutes to one hour and 3% of households take more than one hour. The average time to and from a water source was 19.6 minutes for Mzuzu and 17.1 minutes for Kasungu. **See figure 21, 22 and 23 below for more details:**

Testimonial: WPSC at Ofesi community in Kasungu PU

Committee was formed in 1998 when Plan had sunk a borehole in the village. The committee comprise of 10 people. The group was trained but 4 people dropped out and the replaced team members are not trained. The committee is involved in management of the boreholes through supervising the cleaning and maintenance of boreholes if they require spares. The committee is successfully leading the people in taking care of the boreholes and as a result the water had been safeguarded and access is to water is always there. This has helped reduce diarrhea disease in the village than what was happening in the past. They have been taking 100% responsibility of the boreholes when it comes to repairs. They work through chiefs to make households contributions. But now they don't have any savings in case the borehole breaks down.

Figure 21: Safe Water Coverage by PU

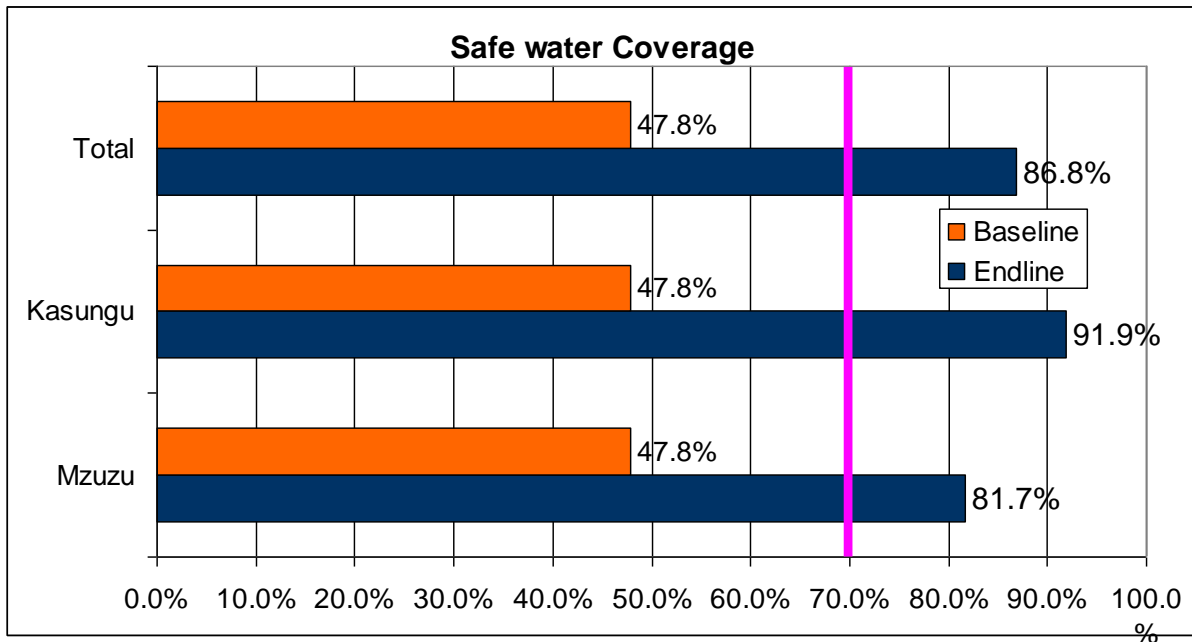


Figure 22: Main Sources of Drinking Water by PU

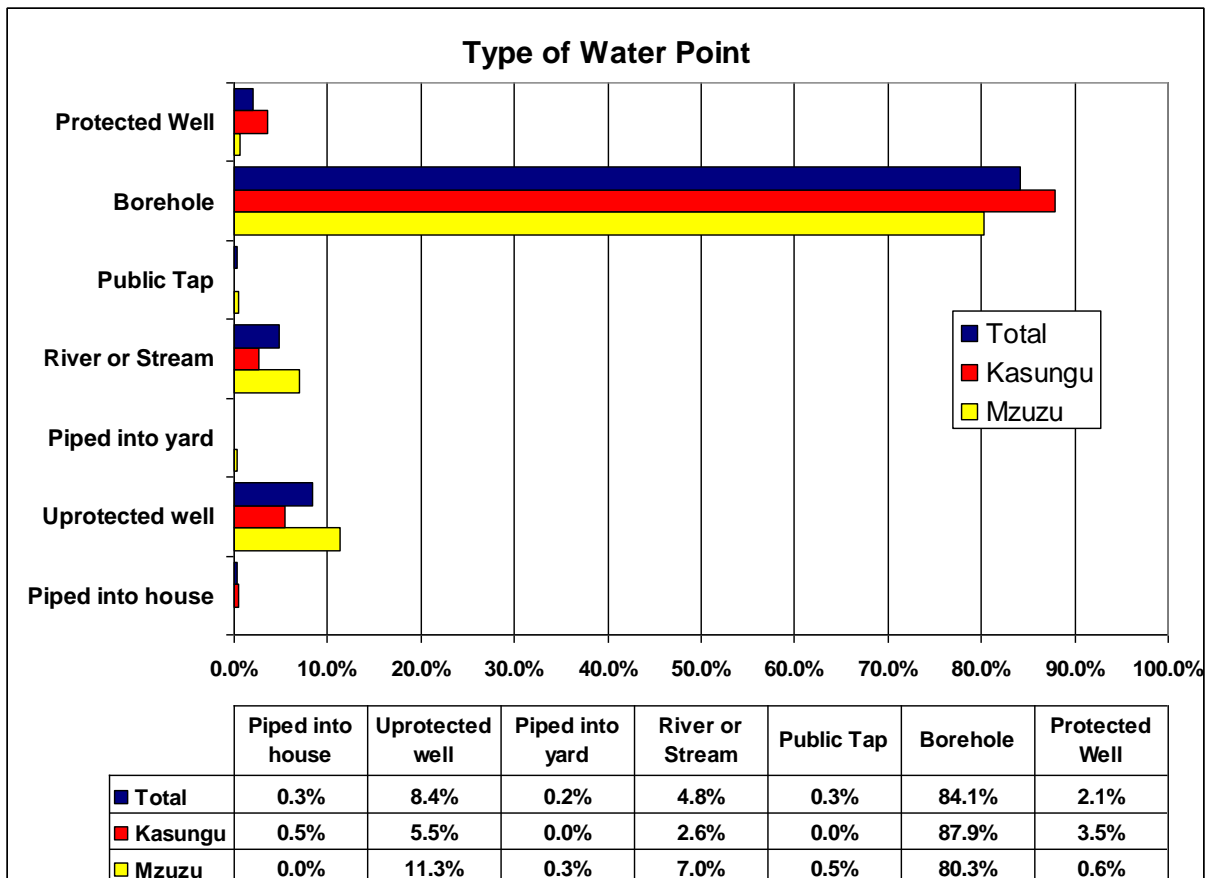
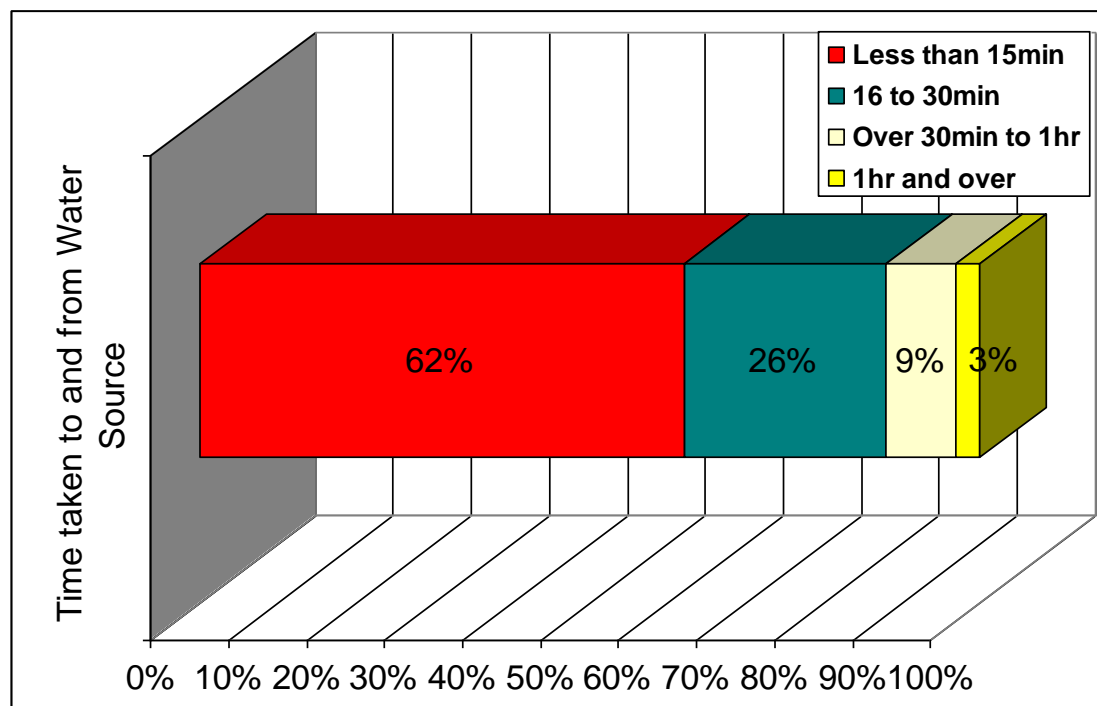


Figure 23: Time taken to and from Water Source



80 % of communities in Plan supported areas with all families having access to good sanitation (CLTS) / improved latrines from 45% by FY 2010.

Overall Assessment of the Outcomes of the Objective

The results of the final evaluation show that 76.9% of the households in the 2 PUs have latrines (Mzuzu, 78.7% and Kasungu 75.8%). In terms of type of facilities, 36.9% have got latrines with covers, 39.1% of the latrines don't have covers whilst 0.2% of the households have pipe ventilated latrines. In terms of hand washing only 24.8% of the households indicated having hand washing facilities close to their latrines. *See figure 24, 25, and 26 below for further details.* The positive results in latrine coverage are attributed to a number of factors. Firstly Plan provided boreholes in some of the communities where it is working. In these communities village health and water point committees (VHWPCs) were also trained in community-based management, resource mobilisation and water point sanitation. The introduction of CLTS in these communities have also played key role on the outcomes of this project. 25 Plan staff and 21 extension workers from ministries of Health, Gender and Water Development were trained in Community Led Total Sanitation (CLTS). The training provided knowledge and understanding on the elements and tools of CLTS approach that in turn have contributed to good progress in this area. According the project reports 12 villages were triggered in both PUs and action plans were made to clearly move the villages towards Open Defecation Free villages (ODF). 180 community health workers were also trained in good hygiene practices including the use of hand washing facilities, 2 way cup system and keeping surroundings clean just to mention a few.

Figure 24: Latrine Coverage as compared to baseline and endline by PU

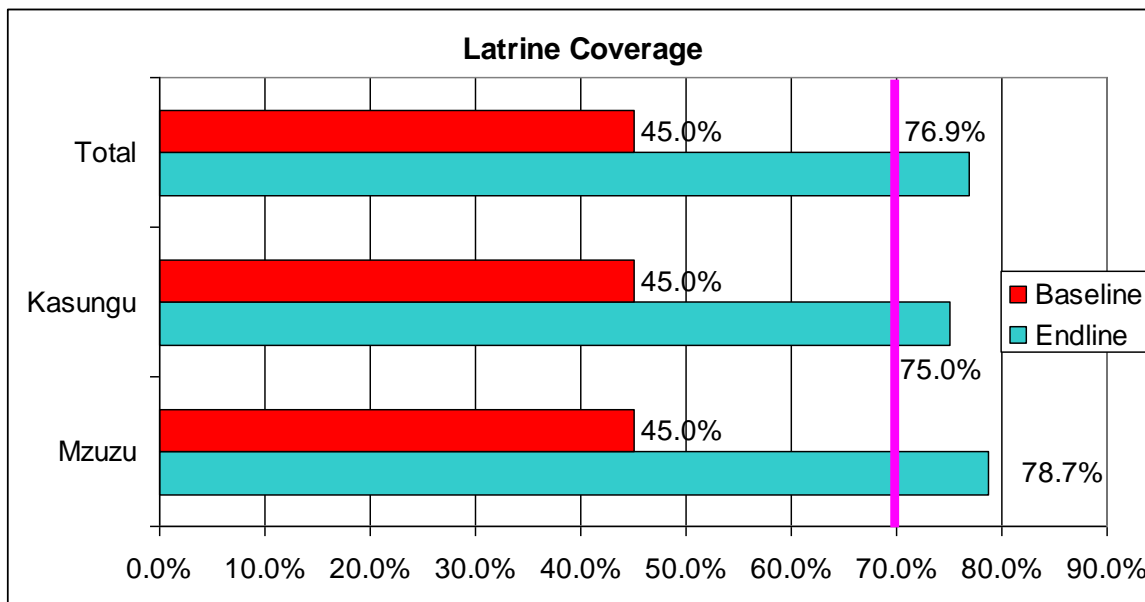


Figure 25: Type of Latrine Facility by PU

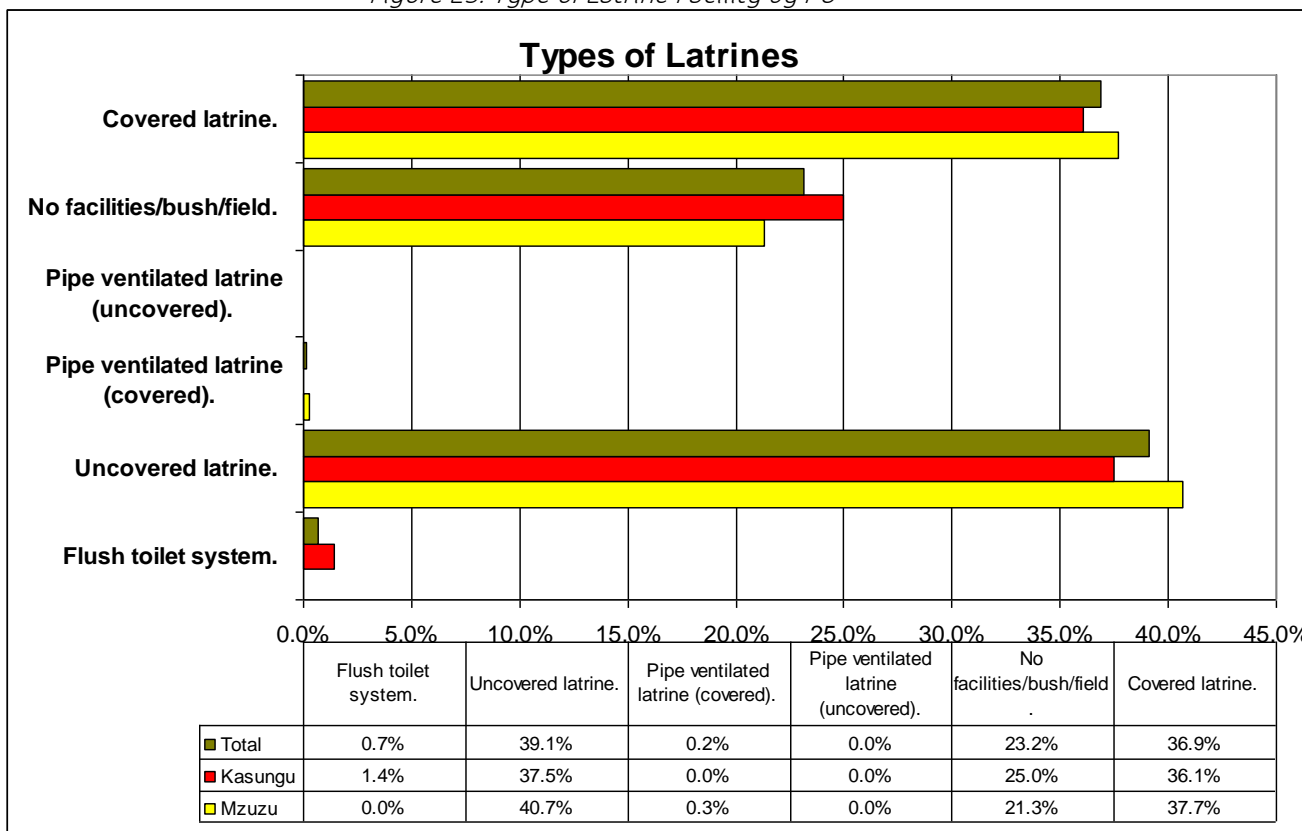
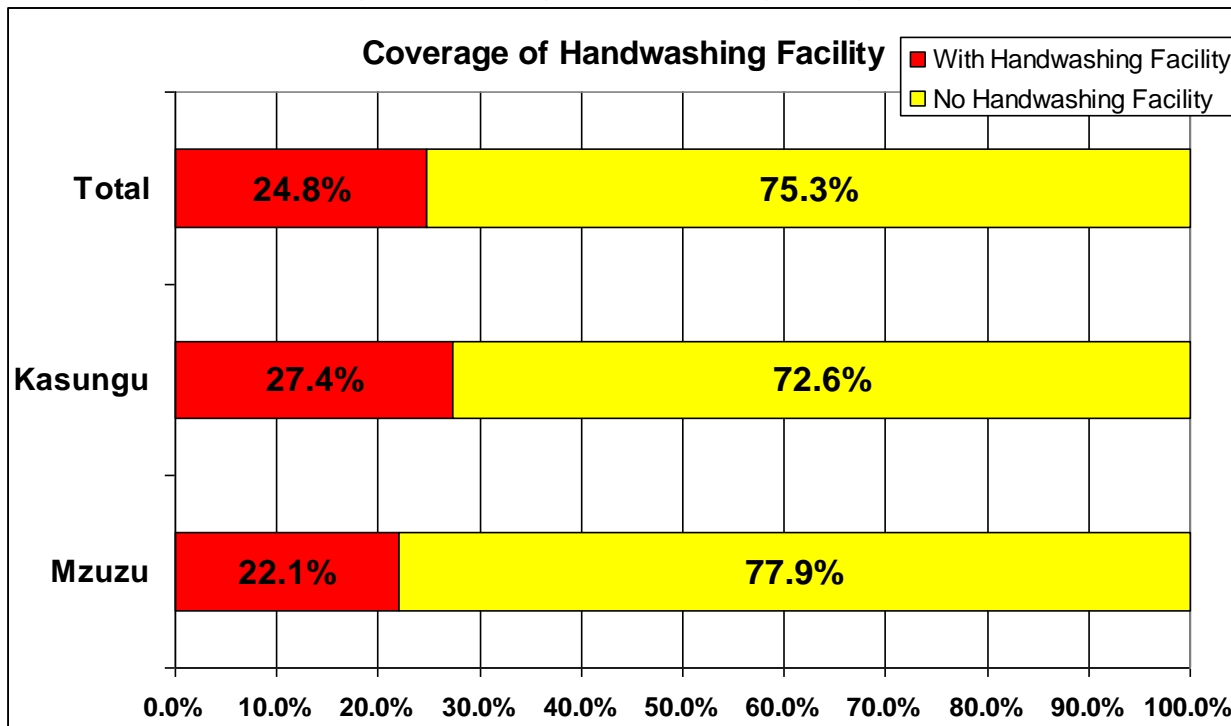


Figure 26: Coverage of Hand washing Facility



Zombe Alaki-Triggered Village

Zombe Alaki in Kasungu PU is one of the villages that were triggered with resources from the project in 2008. Before 2008 the village had 42 households with 14 latrines only. As a result of this most households experienced water borne diseases due to unsafe disposal of excreta. With the introduction of the CLTS component, the communities were motivated and have since being involved in latrine construction. Today the village is happy to note that all the households in the village now estimated at 52 have a latrine with a hand washing facility. Today they no longer hear of diarrhea episodes in the village. The achievement was made due to good partnership between their chief, the HSA of the area and Plan. Figures below the latrines built by the community and the hand washing facilities



KEY LESSONS LEARNED-WASH

- **The development of activities which respect and value the local culture have the greatest impact.** The engagement of communities through the CDO process enhances the respect of the

community in the development of priorities. Like in the above pictures the women from Zombe Alaki have used locally made bowls for hand washing.

- **Involving HSAs** in community training activities aides in enhancing sustaining and quality of health outputs.
- **Continuous follow-up and support are crucial for the development of new abilities.** The positive results observed under the CLTS component were as a result of continuous engagement with the communities and proper provision of technical support by the extension workers.

KEY CHALLENGES-WASH

- **Overcharging of borehole spare parts in some of the local shops in the PUs.** Shops in the PUs seemed to be charging for same spares as compared to other parts of the district that had the program of supporting shop owners to stock boreholes spare parts.
- **Inadequate Water Monitoring Assistants deployed in the districts.** There seemed low numbers of WJMs to adequately support community water interventions as per the design of the borehole Operations and Maintenance (O&M) protocols in the country. For instance Kasungu PU has 3 WJMs who obviously cannot provide appropriate support to the whole district.
- **Inadequate funds for supervision of water points by the water department.** There is very low government allocation of resources for supervision by the water department. This has contributed to very long period on non repair of boreholes in the targeted PUs
- **Government officers charging for repair of boreholes (US\$26 per service).** Due to reduced management and transparency protocols by the district based O&M system some WJMs have been indulging in unlawful charging of borehole maintenance.
- **Failure to collect monthly user fees for operations and maintenance of boreholes.** Overall the VHWPCs visited had very little or none of the resources collected as user fees for borehole maintenance. This is as a result of weaker mobilization strategies and low involvement of the local leadership.
- **Absence of skilled people in the communities to repair boreholes.** Despite the committees gone through CBM training most of them have not mastered repair of boreholes. They have been relying on other local individual experts, Water Monitoring Assistants (WJMs) for repairs which has been very costly
- **No transparency in the management of user fee funds by some VHWPC.** Observations showed limited linkages with the communities on how the money was collected and used. There were no deliberate community meetings where the committees provided feedback to the population and sought advice for some of the critical financial decisions
- **Chiefs involvement in borehole management is weak and unsystematic.** Discussions with both chiefs and VHWPC revealed shortfalls in the way chiefs are linked to the committees. By design the chiefs are supposed to be ex official members of the committees. However it was actually observed that almost all the chiefs never attended VHWPC meetings and didn't have any ideas of home much money was available as user fees signifying very little engagement.
- **Weak district systems for enhancing operations and maintenance of boreholes.** Overall district system for operations and maintenance not functioning well. The roles and responsibilities for NGOs, Water, Health, VHWPC seems not being adhered.

RECOMMENDATIONS-WASH

- **Empower communities to master repair of boreholes.** Plan needs to raise capacities of the VHWPCs so that all repairs are managed internally by the committee. This will ensure instant sustainability of the boreholes as people within the village would be easier and cheaper to manage
- **More emphasis should be placed on improving hand washing indicators.** The project managed to exceed its results on improving access to water and latrines. However hands hashing indicators were observed to be very low in both PUs.

- **Revamp the district system for borehole operations and maintenance.** This government led system that can be supported by all partners so that it is responsive and sustainable in helping communities manage their own water sources. Plan may support this through a refresher training, review of the roles/responsibilities and supervision.
- **Support District Coordination Teams (DCTs) undertake supervision of water points in the PUs.**
- **Promote local leaders involvement in the management of boreholes and empower communities to master repair of own boreholes.** Most of the leaders met showed having no close links to the operations and maintenance of boreholes which meant that it was difficult for the committees to link very well with the fellow villages in terms of tasks like paying of monthly user fees etc
- **New user fee collection strategies needs to be introduced.** One way of doing this would be paying of farm produce (like 50kgs of maize) at harvest period instead of cash.
- **Put in measures so as to ensure total transparency** in the management of funds collected by VHWPCs.
- **Review and develop alternatives to soap:** We need some kind of a double system where we promote both soap at some lower cost and an alternative to soap like ash so that we take into account poverty levels experienced in the communities.

5.2.4 SCHOOL HEALTH PROMOTION

The survey did find out that all pupils (boys and girls) clean up the available school toilets. 100% of the respondents mentioned that Hand Washing Facilities (HWFs) are available in their schools. In terms of availability of water at the HWFs, only 50% of the schools had water at the HWFs. In all the schools surveyed, none of the pupils agreed to availability of soap. This shows that the idea to have soap for hand washing is still far from being conceptualised in the schools. Using ash (as a traditional soap substitute) has not been reported to have been used either for hand washing or for cleaning the toilets. *See figure 27 below for further details.*

Plan has been active in school health interventions that included construction of school latrines, training pupils and clubs as well as provision of water points. According to the project reports in CY 2008, 18 teachers/ patrons and 90 pupils from 9 schools were trained in hygiene and sanitation, communicable diseases, and life skills. The 9 schools in Mzuzu PU were also provided with 9 first aid drug boxes and sanitation materials. Plan also constructed sanitary facilities in 12 primary schools in Kasungu PU where in total, 72 pit latrines, 22 urinals and 22 wash hand facilities were provided. In addition to this, Praziquantel – anti-bilharzia drug and laboratory supplies like slides were purchased for mass screening and treatment of bilharzia in 61 schools in Kasungu PU.

Figure 27: Feedback table for School Health Promotion

Name of School	Are pupils taking part in Cleaning of Latrines?	Is there enough Separation between Boys /Girls Latrines	Are Girls Urinals available?	Are Boys Urinals available?	Is there a HWF?	Any sign of Water at HWF?	Is Soap available at HWF?	Is there any WASH club?	Is the club Active?	Do pupils have Knowledge of Comm Diseases?	Is there a BH?	Is the BH User fee fund available?	Is the Borehole Working well?
Chitunda	yes	yes	no	yes	yes	no	no	yes	no	Yes	yes	No	Yes
Chisemphere	yes	yes	no	yes	yes	no	no	yes	no	Yes	yes	no	yes
Zombwe	yes	yes	no	yes	yes	yes	no	yes	yes	Yes	yes	No	Yes
Emuviyeni	yes	yes	no	yes	yes	yes	no	yes	yes	Yes	yes	No	yes

KEY CHALLENGES-SCHOOL HEALTH PROMOTION

- **Lack of water as well as soap at some of the HWFs visited:** Pupils are given roles to fill water in the HWFs but due to weaker monitoring systems by the school administration this has not worked in many schools. As for soap, the school administration is responsible for purchase. However due to limited school resources almost all the schools have not managed to stock soap at HWFs.
- **Some schools don't have active water points committees that take care of the borehole.** This means there is a weaker system for taking care of the boreholes as the school administration is expected to provide day to day management of the borehole.
- **Almost all schools visited were not collecting any user fees that would be used in repairs.** This caused significant delays in cases where the borehole needs repairs.
- **Unclear partnership arrangements** with the community in places where surrounding villages also access water at the school. Most of surrounding villages are not paying user fees as well as not involved in management of the boreholes as depicted in the policy.

RECOMMENDATIONS-SCHOOL HEALTH PROMOTION

- **Strengthen schools in the management of hand washing facilities (HWFs)** so that soap and water is always available. There will be need school water and sanitation patrons to be re-oriented on their roles.
- **Revamp WPSC in schools** to improve management of school water points. This can be done through replacement of members that left the committees and training.
- **Develop partnership agreements** with surrounding communities if they are accessing water at the school. This would include agreeing on user fee protocol, membership of the committee and meeting schedules.
- **Paying of user fees should be introduced even in schools** so that quick maintenance of water points can be achieved.
- **School based pupil sanitation committees** should be revamped in all schools. Members of the committees need to be reconstituted and trained.
- **Plan should introduce girl's urinals** in order to ease latrine congestion at latrines.
- **Continue adding latrine infrastructure** in the schools to continue expanding Pupil:Latrine ratio

Box 4: Case study: Latrines Shaping Schools For Optimum Learning

The importance of water and sanitary facilities for schools is widely acknowledged. Yet in practice, the situation in many schools, especially in rural Malawi, is far from satisfactory. Of about 248 primary schools in North Mzimba, roughly 87% have safe drinking water and 42% percent have good sanitary facilities.

The Maternal and Child Health Project Part 2 was launched with a School Sanitation and Hygiene Promotion component in 2008. The project supported the construction of latrines in targeted schools with separate units for boys and girls. Plan supported school based interventions are not just about the construction of latrines, but a package of school-centric interventions to bring about attitudinal and behavioural changes towards critical sanitation and hygiene practices among children and to empower them to lead a healthy life. In the implementation strategy, children are also used as change agents. Through this program children are motivated in creation of a healthy, clean and active learning environment in schools in addition carrying the messages back home to motivate their families to improve sanitation and hygiene habits. Zombwe is one of the targeted schools that received a set of latrines. The school was involved in the following activities: Development of action plans, Construction of child-friendly, gender-sensitive water and sanitation facilities, WASH Capacity building of teachers, School deworming and growth monitoring; Hygiene Education Activities through School Clubs

Successful and sustainable school health implementation requires a team approach and better convergence among sectors like education, health along with social welfare and rural development. The capacity building of key stakeholders to support programme implementation is crucial. In this program Plan also trained teachers and HSAs around the premises in school health promotion. Below is a school club belonging to Zombwe School and another club belonging to Emuviyeni school.

Zombwe School Club and drinking site



Emuviyeni school water buckets and hand washing facilities



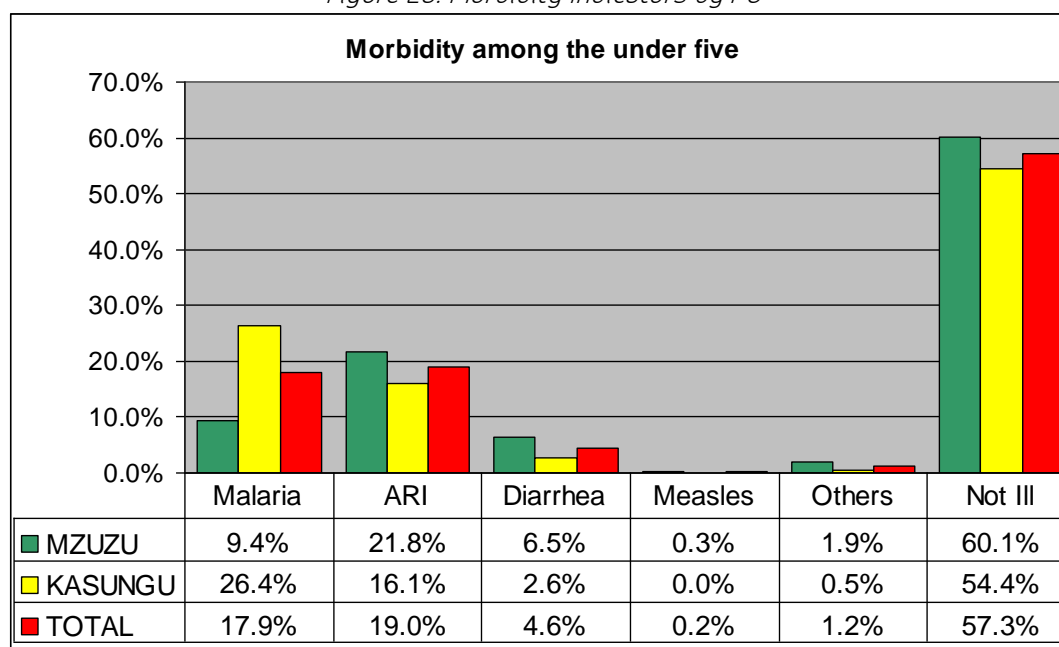
5.3 OVERALL PROJECT PERFORMANCE

5.3.1 EFFECTIVENESS OF APPROACH

Overall the approach and the strategies adopted by the project have been satisfactory. Analysis on program impact will be based on assessing variables related to reducing morbidity among the under five/pregnant women and their subsequent contributions to mortality.

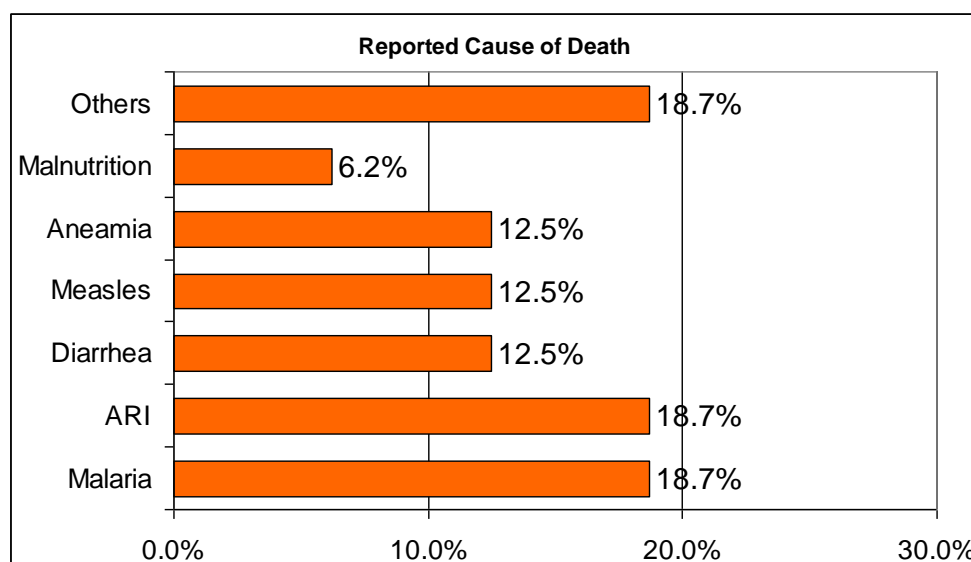
Morbidity: Households were asked what kinds of illnesses their members experienced in the last 14 days. The responses were self reported illnesses, or rather symptoms experienced in the last 14 days. 42.7% of the children had at least one illness in the last 14 days. 17.9% had malaria whilst 19.0% had a cough or difficulty breathing. Only 4.6% had diarrhoea. (Figure 28 illustrates the distribution of types of child illnesses.) Also, very few (0.2%) children were reported to have suffered from measles in the last 14 days.

Figure 28: Morbidity Indicators by PU



Mortality: Respondents were also asked if there were any deaths in their households in the past 12 months. Mortality rates are expressed in deaths per 10,000 persons per day. Kasungu had a total of 20 deaths (14 under fives and 6 over fives) from a sample of 362 households whilst Mzuzu had 4 deaths (2 under fives and 2 over fives) from a sample of 336 households. Therefore the overall crude death rate among the 2 districts was 0.92 / 10,000 / day. The death rate varied from 0.31 / 10,000 / day for household members five and older to 0.61 / 10,000 / day among under five year olds. Respondents reported the causes of death in their households. As with self-reported illness, the responses may not be completely accurate. Additionally, HIV/AIDS was expected to be grossly understated due to limited knowledge of the disease, lack of access to testing facilities and the strong stigma that it carries. The most prevalent reported causes of death in the last year among children under five years old were starvation (21.3%), malaria (19.1%) and diarrhoea (19.1%). **Figure 29** illustrates the distribution of causes of death for under five children. Overall the analysis of death figures shows lowering trends in death figures. Despite the absence of baseline data on this the qualitative information supports reducing trends in death among the under fives. However mortality in Kasungu was found to be very high as compared to Mzuzu which needs further analysis.

Figure 29: Reported Cause of Death



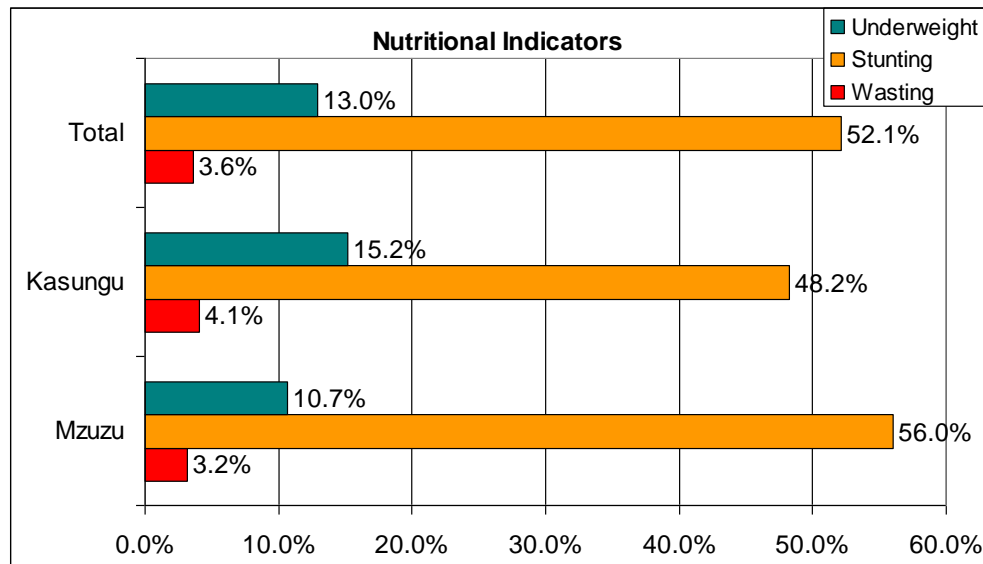
Nutrition Indicators

Acute malnutrition, also known as wasting, is an indicator of current short-term malnutrition. Wasting was quantified by weight-for-height Z-scores and oedema. The global acute malnutrition rate encompasses all children who are less than two standard deviations below a reference population of healthy children plus any oedema cases. The global acute malnutrition rate among all households visited was 3.6%. (4.1% in Kasungu and 3.2% in Mzuzu). This was lower than the typical emergency situation threshold for wasting which is over 10%.

Chronic malnutrition, also known as stunting, is an indicator of long-term malnutrition. Stunting was quantified by height-for-age Z-scores. The rate of stunting among all households visited was 52.1%. (48.2% in Kasungu and 56.0% in Mzuzu). The results are consistent with the trends in stunting in the country. Malawi has the third highest level of chronic malnutrition or stunting in all Sub-Saharan Africa at CMR 49%. In southern Africa Malawi's chronic malnutrition rates are among the highest – higher than Zimbabwe (27% - DHS 1999), Mozambique (36% - DHS 1997) and Zambia (42% - DHS 1996). Normally, high chronic malnutrition rates do not indicate an emergency or disaster, but the extremely high levels of chronic malnutrition in Malawi does indicate a serious 'vulnerability' problem which can not be ignored and needs to be investigated further. Chronic malnutrition is positively related to acute malnutrition, as those chronically malnourished are highly vulnerable to shocks leading to acute malnutrition and mortality.

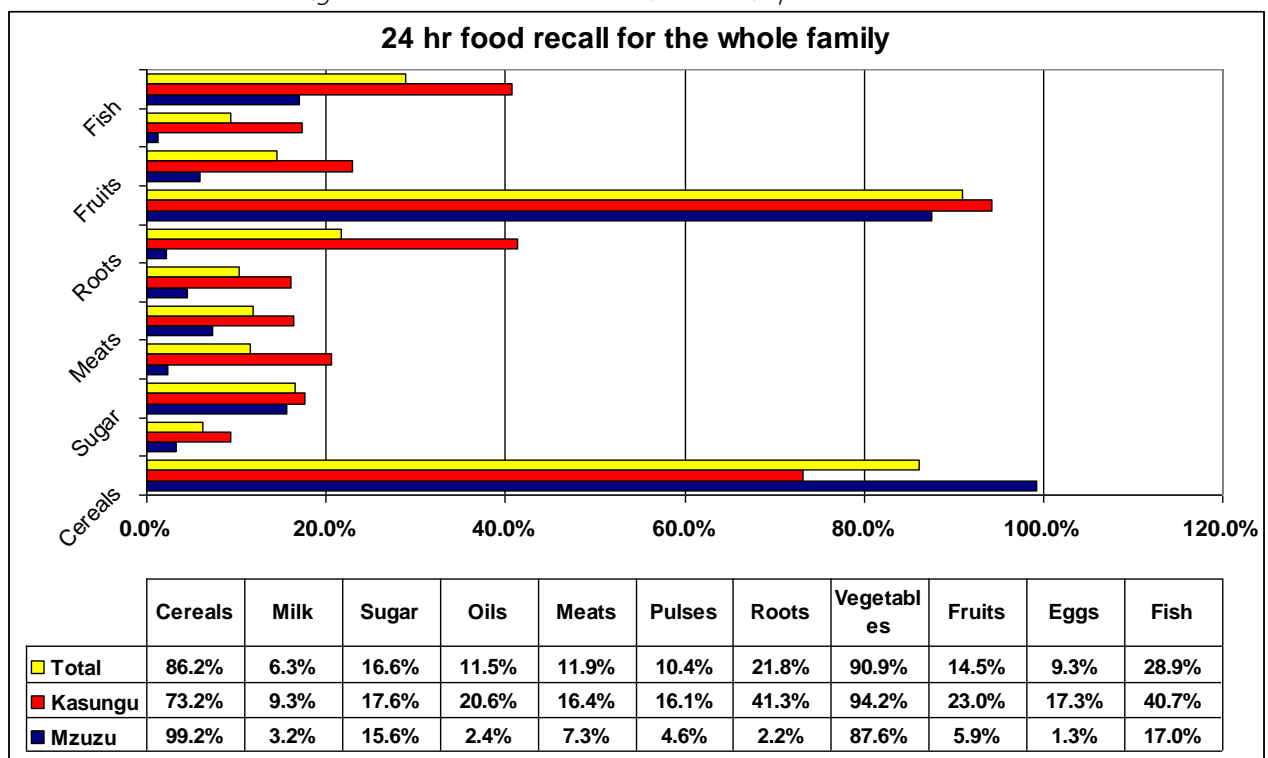
Weight-for-age, also known as underweight, illustrates a combination of stunting and wasting. A child can be underweight due to stunting and/or wasting. Underweight can be viewed as an overall indicator of nutritional status, rather than a chronic or acute look at malnutrition. Figure 31 illustrates levels of underweight. The rate of underweight among all households visited was 13.0% (15.2% in Kasungu and 10.7% in Mzuzu). According to WHO/UNICEF recommendations, if the prevalence of malnutrition in a given population of under five children exceeds 20% for Z-score of -2 SD it is concluded that the population is malnourished. The results of this study demonstrated that was only 13% were malnourished. These figures are also lower than the national estimates of 21% in underweight. Therefore we can conclude that the project interventions have in part contributed to reducing the underweight among children that would also help save lives.

Figure 30: Coverage of Nutritional Indicators



Diet diversity is one of the key strategies used in combating malnutrition. Households were asked to report the frequency with which a list of food items was consumed. The purpose of this question was to collect information on the diversity of their diets and the frequency of food consumption. Figure 31 shows that the most commonly consumed food items are: cereals, which are eaten at least every day by 99.2 percent of the households; and vegetables, which are eaten at least once a day by 87 percent of households. Animal proteins are consumed by 11.2% of the households. Fish is the most popular animal protein, with an average weekly consumption by 17% of the households. Milk, oils and eggs are consumed in smallest amount

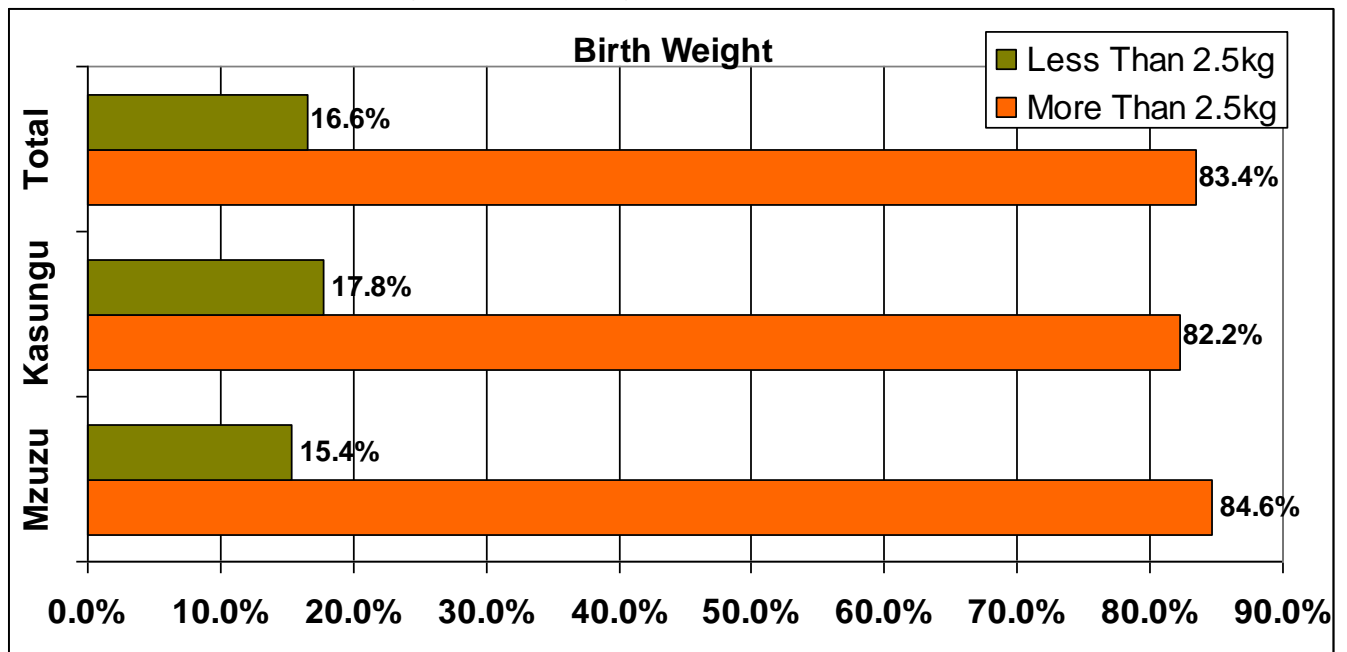
Figure 31: Assessment of meals eaten in past 24 hrs



Birth Weight: In most developing countries, it is difficult to determine gestational age, so low birth weight (< 2,500 g) is used as a proxy for intrauterine growth restriction (IUGR). The main causes of IUGR are nutritional: inadequate maternal nutritional status before conception; short maternal stature; and poor maternal nutrition during pregnancy (low gestational weight gain resulting from inadequate dietary intake). Diarrhoeal disease, intestinal parasites, respiratory infections and malaria

also impact fetal growth. Underlying causes relate to maternal care, access to and quality of health services, environmental hygiene and sanitation, household food security, educational status, cultural taboos and poverty. In order to estimate incidence of low birth weight among children in the survey sample, the questionnaire included a question taken from the MICS survey about the child's size at birth. Overall, only 16.6% of the children were of low birth weight. See figure 32 for further details.

Figure 32: Birth Weight Assessment



Summary of Effective/Ineffective Strategies in Achieving Program Impacts

Effective Strategies

Based on qualitative assessments and opinions of the author, the following are the most successful strategies observed on the comparative advantage towards contributing to the overall impacts of the program:

- Use sub grants in order to expand program reach since these partners are already with the framework and would need require of technical preparation for them to role out interventions
- Provision of boreholes seemed to have directs results in reducing diarrhea diseases and the associated child/newborn mortality.
- CLTS proved to a reliable strategy in enhancing sanitation indicators. Due to the zero subsidy strategy it's possible to reach out to more communities using fewer resources.

Ineffective Strategies

The following are the strategies that seemed to have little effect:

- Borehole maintenance by the VHWPC seemed not possible based on the level of expertise and availability of active support systems
- Use of district system for replenishing drugs for village clinics. Since even drugs for district health facilities are not adequate, relying on the same system to reach to village clinics has not been productive. As a result most of the village clinics have not been getting drugs or if they come they would be in very few quantities.
- Soap promotion strategies seemed not feasible taking into account high poverty levels in the PUs
- Malaria Prevention strategies have also been observed to have little impacts in reducing malaria episodes. It might be important explore other new strategies including use of indoor residual spraying

5.3.2 PROGRAMME RELEVANCE

From the *community perspective*, the objectives of the project are extremely important in linking community and facility based IMCI to reduce maternal, neonatal and child health. From the *perspective of the District Council* this project is also relevant. Last twenty years have seen a lot of work in the district to reduce child and maternal mortality rates. Despite notable successes, no significant movements have been noted in the rates. This project has helped initiate a fledgling movement towards reducing the rates so that women's and children's health is fulfilled. *At the national level*, the design of the Maternal and Child Health are consistent with epidemiological evidence for achieving maximum impact based on the IMCI and ACSD Concepts. The programme is in line with Sector-wide approach (SWAp) 2005 - 2011; Essential Health Package, Programme of Work, MNCH-related programmes in the Ministry of Health. The ACSD concept has links to the UNICEF Medium Term Strategic Plan (MTSP) Focus Area 1: Young Child Survival and Development; key result area 1, 2 and 3; and Focus Area 3: HIV/AIDS and Children; key result area 2. It is also consistent with the MGDS theme 2, 3 and 5. An analysis of the *macro context* also makes the objectives of the project highly relevant. The intervention contributes to the declaration of 'Millennium Development Goal' of reduction of under-five and maternal mortality.

5.3.3 SUSTAINABILITY

On sustainability, one of the important initiatives has been the direct involvement of the local district health system. Plan and the DHO have been jointly developing key actions that are based on the needs of the district and local communities. Plan also succeeded in developing partner capacity as one of the key issue in addressing sustainability. The contribution of funds to Kasungu DHO and health facilities such as Ekwendeni Mission Hospital contributed to counterparts' continued rolling out of activities beyond the project phase. The sustainability of DHO interventions is probably the strongest that Plan achieved in the project. However this has created dependency problems. Plan has also been outstanding in transferring knowledge, skills and capacities in ways that enable the communities to undertake activities. Plan has successfully built upon and nurtured partnerships with local leaders and communities.

5.3.4 CCCD COMPLIANCE

The evaluation findings show that the main focus of the project was in accordance with CCCDA. For instance, through school clubs and community committees, children participated in the development of action plans using community IMCI approach. Children have also participated in sanitation and hygiene committees in addition to taking some roles in CLTS triggering and promotion of having hand washing facilities. However, it was also noted that there wasn't a more established structure and support system to facilitate the implementation and monitoring of follow up activities and continuity after consultation with children.

5.3.5 OPPORTUNITIES FOR ADVOCACY

Overall advocacy related initiatives like children's parliament have increased interest in Malawians of the value of children's views on issues that affect them. Plan has also been involved in other initiatives such as commemoration of Day of African Child in June every year and the Day against Child Abuse commemorated every November. Children's assemblies and children's advocacy meetings have also helped increase human rights awareness among the general public including those related to health. The advocacy campaigns on child labour and child trafficking have enabled communities and partners to facilitate the reporting of cases related to child labour in particular to relevant authorities. This has resulted in some child labourers withdrawn from child labour and repatriated to their respective homes in so doing safeguarding their health. According to CPPR 2009, child advocacy activities are now being implemented at district level allowing more children to participate. In Mzimba and Kasungu district children have engaged the district assemblies on issues that affect them. This has increased interest in child participation at district level and the activities have complemented national level activities like child parliament.

Despite these opportunities, there are still crucial health related elements that have not been acted upon. Malawians still have to travel very long distances to access simple medical care. In addition to this the country's health facilities have been facing huge challenges related to inadequate drugs, supplies and trained staff. It is only through specialised advocacy strategies that Plan can start to face these issues. Due to the nature and complexity of these high level issues, Plan needs to expand its links to health related alliances so that the combined forces can help improve operations of public health policies. For instance the scarcity of drugs in the country has been linked to management inadequacies at the Malawi Central Stores. Despite revelations being made public through Global Fund spot check visits and assessments, no major changes have taken effect. Until today health

facilities still face the critical shortage of drugs. Through strong partnerships with civil society groups such as the Medical Council of Malawi, Malawi Pharmacy and Poisons Board, Malawi Health Equity Network the issues of drug mismanagement could be stopped.

5.3.6 GENDER MAINSTREAMING

Plan has been making a conscious effort towards promoting gender in all its initiatives. In the PUs women are active participants, agents and architects of their own development –not represented by someone else, but consulted and involved directly at all stages of a project cycle. The other important step that Plan took was to involve men in interventions that are labelled as dominated such as nutrition promotion. Plan managed to mobilize male CBDAs who have been providing family planning services in the PUs. That has helped reduce gender barriers which in turn contributed to the successes of the program.

5.3.7 PROGRAM PLANNING

Regular meetings with Government, Mission Hospitals and NGO partners were conducted throughout the life of this program. In addition, child and maternal health interventions were planned together with all the partners at the district level on an annual basis. This ensured tactical coordination, supervision and leadership of the health related interventions by MoH which is critical for sustainability. The strategic planning of overall program direction was responsive to the perceived needs of the partners on the ground since all of them were guided by the same Essential Health Package. Synergies were observed in several cases. Like in Kasungu, MSH, Plan, Malawi Red Cross and MoH were coordinating very well in the areas of malaria prevention and case management with the leadership of the District IMCI coordinator. Plan has a cordial relationship with the District Health Management Teams based on mutual respect. Formal and informal coordination mechanisms are followed including consultation between project staff and DHMT members.

5.3.8 PHASE-OUT PLANS

From the beginning, the project was conceived with an eye towards enabling the communities and government to continue their activities and without dependence on the project staff. The project managed to facilitate creation of community groups and provided necessary capacity building for continuation of rolling out of activities. It was noted that all interventions of Plan involved discussions with local leadership, assisting communities to form voluntary groups, orientation of interested people especially in groups, among others. This ensured that participating individuals had the requisite knowledge and skills to undertake the tasks on their own. In this respect, the community at large was also given ample opportunity to participate in its development agenda. Furthermore, Plan made great efforts in building alliances through partnerships with various organizations that were deemed to have the technical know how on a particular intervention for instance mission hospitals handling safe motherhood initiatives. There was evidence of potential sources of encouragement for the community groups through Health Surveillance Assistants who have been actively included in almost all the trainings involving community groups. Subject to adequate funding all the activities of this project will be integrated in the Health Detailed Implementation Plans (DIPs) of the District Councils.

In terms of preparing the communities for phase out, one of the important initiatives that Plan undertook was the development of the Community Development Outlines (CDOs). These assisted in letting communities go through the process of self assessment, identify felt needs and design a plan towards implementing them. This seemed to provide a good opportunity phase out planning.

6 ANNEHES

ANNEX A-TORs for the Maternal and Child Health Project Part 2 Final Evaluation

1.0 Background Information

Plan is one of the largest international development agencies in the world founded 72 years ago. Working in 49 developing countries across Africa, Asia and South America, Plan's vision "is of a world in which all children realise their full potential in societies that respect people's rights and dignity". Plan works to achieve lasting improvements for children living in poverty in developing countries, through a process that unites people across cultures and adds meaning and value to their lives. Plan Malawi was established in 1994 and is currently working in four districts, namely, Lilongwe, Kasungu, Mzimba and Mulanje. These districts rank among the poorest in the country based on a poverty score analysis. The scores which represent the percentage of people in absolute poverty are as follows, 28, 13.6, 31.8 and 33.9 respectively. (Malawi DHS, NSO Census analytical report)

In the current CSP, Plan Malawi is implementing Maternal and Child Health programme amongst others. The MCH programme is grant and sponsorship funded and it focuses on;

- Child health/child survival, growth and development for under fives
- Maternal and neonatal health including Adolescent Sexual and Reproductive health
- School health promotion
- Water and sanitation and

where deemed necessary institutional development/support is done through infrastructure, equipment, furniture and other supplies. Child Centred Community Development (CCCD) as the right based approach for Plan is the main approach/strategy which is used in the MCH programme. The aim of this approach is to build the capacity of children, their families and communities, government and other partners to actively participate in all stages of programme/project, aiming at ensuring that children benefit and develop to their full potential. The process ensures that children and communities take ownership of the programme/projects and that it creates conditions for the inclusion of marginalized groups in decision making, accessing services and participating in local governance.

With funding from NORAD, Plan Malawi health programme has been implementing the 'Mother and Child Health Projects' since 2004 to date. The framework for (2004-2007) was evaluated in December 2007 and recommendations were used to develop the current NNO framework. The CY 2008-2010 framework received funding for a Country Programme Outline (CPO) proportional funding from NORAD for 3 years (2008-2010) for Kasungu and Mzuzu PUs, called "The Maternal and Child Health Part 2" and this is the project which the TOR refers to.

2.0 Project Goal and Objectives

To contribute to the reduction of the high infant and child morbidity, mortality and malnutrition rates and to improving mother / adolescent sexual and reproductive health. This was done through developing capacity of government as primary duty bearers and other duty bearers at community and family level to ensure the right of all children to survival and development was achieved.

To achieve this goal the project planned to achieve the following targets

Child survival/child health

- 80% of children aged 12-23 months in Plan supported communities fully immunized before their 1st birth day (i.e. who received BCG, DPT3, OPV3 and Measles from 74 % by FY 2010.)
- 80% of children within 6-9 months receiving breastfeeding and appropriate complementary food in Plan supported communities from 49.78% by FY 2010.) (New but data is there!!)
- 65 % of mothers with children less than 3 years in Plan supported communities who manage diarrhoea with ORT from 53.68% by FY 2010.
- 30% of families in Plan supported communities adopt good hygiene practices from 1.48 % by FY 2010.)
- 10 % of children aged less than 3 years infected with malaria in the last 2 weeks in Plan supported communities by FY 2010.)
- 80 % of children under five sleep under an ITN % by FY 2010.)-New but data is there!!
- 30 % of mothers in Plan supported communities with children under 3 years who take their children with symptoms of pneumonia for appropriate treatment within 24 hrs of development of symptoms from 18.79% by FY 2010.)

Maternal health/ safe Motherhood incl. ASRH

- 70% of pregnant women in Plan supported communities receive the recommended dose of Intermittent Presumptive Treatment during pregnancy from 56% by FY 2010.) New-data not there!!
- 80% of childbearing females who have received a minimum of 2 Tetanus Toxoid vaccinations before the birth of their youngest child in Plan supported communities by FY 2010.)
- 60 % of mothers of child bearing age in Plan supported communities currently using modern family planning methods from 45.78 % by FY 2010.)Access to safe water and sanitation

Water and Sanitation

- 70 % of families having safe water all year round in Plan supported communities from 47.79 % by FY 2010.)
- 80 % of communities in Plan supported areas with all families having access to good sanitation (CLTS) / improved latrines from 45% by FY 2010.)-new data not there!!

3.0 Target group

1,287 children 0 to 5 years are the primary beneficiaries of the project with 597 males and 690 females. The project was also to benefit women of child bearing age including adolescents. Indirectly community members and families, government authorities at the district, national and community level as well as other NGOs will be equipped with the knowledge, skills, and logistics to facilitate the process of ensuring child's right to survival and development and thus benefiting from the project.

This will be carried out in the 2 Plan Program Units namely; Kasungu and Mzuzu PUs (and coverage was 32 and 30 communities respectively). The sample will be based on agreed criteria and ensure that it is representative both geographically, by intervention and also by actors and population groups etc.

4.0 Objectives of the Final Evaluation of the project

Broad objective

The final evaluation seeks to determine the level of achievement of project objectives, strategies, identify best practices, lessons learnt, weaknesses, strengths and recommendations.

The evaluation should thus broadly assess the relevance, effectiveness, efficiency, & effect/outcomes and sustainability of:

- Project interventions and strategies i.e. as per the broad interventions on safe motherhood, child survival, school health, watsan

Specific objectives

Specifically the final evaluation should:

- Determine the extent to which the project has achieved its objectives.
- Assess the extent to which the Child Centred Community Development (CCCD) has been applied including elements such as partnerships, capacity building especially in strengthening Civil Society Organisations etc, accountability and community/children participation and inclusion.
- Identify the constraints and challenges faced by the project, lessons learnt and good practices.
- Assess the extent that gender was mainstreamed in the project and suggestions for improvement
- Effectiveness of the forums (quarterly reviews, annual planning etc) that the project has supported over the life span of the project.
- To come up with recommendations that could be explored to further strengthen the project and improve results in the future and also identify opportunities for advocacy and identify key aspects regarding phase out considerations for a project of this nature .

5.0 Approach and Methodology

The evaluation will be conducted by an external consultant. The terms of reference will be shared with the Regional CPME and NNO for their input.

At Project Unit level, the PUM will ensure that community members in sampled communities are informed of the data collection exercise and provide the necessary support and required information to the consultant. The evaluation will participatory to enable community members, children and partners to share a true sense of ownership, contribute to the process and access the project

against their own milestone. Partners including government, mission institutions/hospitals, men, Women, children, community/village leaders/headmen, pupils, youths in and out of school, committee members, caregivers will be the key partners in the evaluation as they have been implemented the project in the communities.

The type of data to be collected will be quantitative as well as qualitative. Quantitative data will mostly come from PPM reports, such as the PO planned vs actual report, PCRs, and the beneficiary report just to mention a few. Methods of capturing qualitative information from the beneficiaries and stakeholders will be deployed for instance through focus group discussions (FGD) observations, key informant interviews (KII), case studies and most significant change stories.

Analysis of qualitative data will involve building of a logical chain of evidence. The data will be organised by clustering common themes as well as tallying and ranking of FGD responses.

6.0 Scope and Coverage

The evaluation will be conducted in the two Project Units namely; Kasungu and Mzuzu. The consultant will sample communities from all the 2 Project Units for data collection. Both purposive sampling and random sampling will be applied.

The final evaluation findings will be shared with NNO and recommendations will be used to improve the quality of the future health programmes.

7.0 Time frame

18-21 October 2010

Drafting and submission of TORs to NNO and RESA CPME for comments and incorporation of their comments

22-30 October 2010

Selection of the consultant

1-7 November 2010

Preparatory work

8-14 November 2010

Data collection

15-21 November 2010

Data analysis and report writing

22 November 2010

Submission of draft report

24 November 2010

Incorporation of comments and finalization of report

27 November 2010

Submission of final report

8.0 Source of data

Project Proposal

Project Outlines and Project Completion Reports

Annual Reports to NNO

CPO midterm review and Final CPO evaluation report

Projects and Projects Module (PPM) reports

Country Project Progress Report

Operational plans

Partner reports/records

Quarterly review reports

Documented Case studies

National level documents for example, the IMCI policy, MNH Road Map for Malawi etc.

9.0 Required expertise from the consultant

The consultant is expected to have proven working knowledge and experience in project and strategy evaluation across the whole health sector especially at district and community levels. Solid understanding of the rights based approaches to programming and the 4 thematic areas of the project. He/she will conduct the whole process of the evaluation including sampling of communities, development of tools for the evaluation, data collection, putting together all the findings of the evaluation and compiling the report. The consultant will produce one consolidated report containing a section for each thematic area including an executive summary.

The Consultant is expected to submit a technical proposal by 27th October 2010. Once the evaluation is completed, the consultant will submit for review three copies of the draft evaluation report. Plan Malawi will review the draft report and forward corrections/ observations/comments to the consultant for consideration in the preparation of the final report. It is expected that final evaluation report will be submitted in hardcopy (3 copies) and a soft copy by electronic mailing by the 30th November 2010

ANNEX B-PROPOSED SAMPLE

QUANTITATIVE DESIGN

Name of Item	Data Collection Method	Total Sample
Household survey		
Mothers of Children less than 5yrs	Questionnaires	600 (300 per district)
Nutrition		
Under Five Children	Questionnaires	712 (356 per district)

QUALITATIVE DESIGN

Name of Partner	Type of Qualitative Method	Total Number
District Level (Health, Water)		
DHO	Key Informant Interview	2
DWO	Key Informant Interview	2
PU Manager	Key Informant Interview	2
Community Level (KI) through simple random sampling		
Village Headman	Key Informant Interview	4
CDAs	Key Informant Interview	4
HSAs	Key Informant Interview	4
CHAM/HC Representatives	Key Informant Interview	6
CBDA	Key Informant Interview	4
School Representatives (Teacher/boy/girl/club)	Key Informant Interview	4
Community Level (FGD) through simple random sampling (max of 12/group)		
Mothers	Focus Group Discussions	6
Children	Focus Group Discussions	6
VHWPCs	Focus Group Discussions	6
VHC	Focus Group Discussions	4
Nutrition Promoters	Focus Group Discussions	6

ANNEX C-SCHEDULE OF THE EVALUATION

ID No	Task	Person-day	Specific dates
1	Assignment set up	Day 1	5 th Nov, 2010
2	Preparation of data collection tools	Day 2	6 th Nov, 2010
3	Literature review	Day 4	8 th Nov, 2010
4	Recruiting/training of Enumerators	Day 5	9 th Nov, 2010
5	Questionnaire pre-testing	Day 7	11 th Nov, 2010
6	Data collection(7days in parallel)	Day 8	14 th Nov, 2010
7	Data cleaning, entry and analysis	Day 15	22nd Nov, 2010
8	Draft Report writing	Day 20	28 th Nov, 2010
9	Discuss draft report	Day 23	30 th Nov, 2010
10	Final Report writing	Day 25	3rd Dec, 2010

ANNEX D-LIST OF RESPONDENTS AND VILLAGES SAMPLED

District and Community Level

Name of Respondent/Group	Position/Organization
Kasungu	
VHC	Manda
Redson Moya	Teacher-Chitunda School
Yamikani Chunga	Pupil-Chitunda School
Richard Ziwa	Pupil-Chitunda School
Mr Chirwa	Teacher-Chisephene School
WPSC	Ofesi
WPSC	Mkanda
WPSC	Petros
WPSC	Zombe
Mothers	Ofesi
Mothers	Mkanda
Mothers	Petros
CLTS	Zombe Alaki
Misheck Nyirenda	HSA/Katsirizika
Hedges Nyirenda	WMA-Kasungu Water Department
Yesaya Phiri	CBDA-Katsirizika
Stelia Chirwa	CBDA-Mwalimu
Nutrition Committee	Petros
Nutrition Committee	Ofesi
Nutrition Committee	Mkanda
Tereza Tomoka	TBA-Ofesi
Betrice Banda	TBA-Ofesi
Jacob Mberenga	Ofesi
Mrs Kanyerere	Mpepa
Catherine Yoweri	District Health Education Off Kasungu DHO
Mwalimu	Chief-Mwalimu
Sopani	Chief-Sopani
Mkanda	Chief-Mkanda
Zombe Alaki	Chief-Zombe Alaki
Mzimba	
KC Mhango	PHC Director-Ekwendeni
Boyce Msuku	H.S.A-Matuli Health Center
Grolia Phiri	H.S.A-Zombwe
Chikhomo Mvula	Chief-Chikhomo Mvula
Daniel Chima	Chief-Daniel Chima
Mkopeka Mkwoya	Chief-Nkopeka Mkwoya
Innocent Sakala	H.S.A-Mzimba
Godfry Mzima	H.S.A-Mzimba
Ishmael Chisemphe	H.S.A-Mzimba
Lazarus Chisasa	H.S.A-Mzimba
Abel Makwakwa	H.S.A-Kafulufulu
Gilbert Mtunda	Patron-Emuviyeni School
Bridget Nyambose	Pupil-Emuviyeni School
Dumisani Nkhata	Pupil-Emuviyeni School
Francis Manda	Headteacher-Zombwe School
Lusungu nyirongo	Pupil-Zombwe School
Alexander Mwangonde	DEHO-Mzimba North
Nutrition Committee	Kafulufulu
Nutrition Committee	Nkopeza Mkwoya
Mothers	Kafulufulu
CBDA Group	Enyezini
TBA Group	Enyezini
WPSC	Nkopeka Khowoya
WPSC	Andreya Mbeza
Tizithasye Safemotherhood	Enyezini

LIST OF SAMPLED VILLAGES IN KASUNGU PU

Date	Type of assessment	Name of Community/Unit	Time	Number	Community
Monday 15 th Nov	Household Survey	Village 1: Mwalimu	8.30am	30	Mwalimu
	Household Survey	Village 2: Sopani	11.00am	30	Sopani

	Key Informants	CBDA 1 Chief 1 HSA 1 CDA 1/TBA 1 Chief 2	8.30am 10.00am 1.00pm 2.00pm 3.00pm	6	
Tuesday 16 th Nov	Household Survey	Village 3: Ng`onamo	8.30am	30	Ng`onamo
	Household Survey	Village 4:Ofesi	11.00am	30	Ofesi
	KII	DWJO DEHO	9.00am 10.00am	2	
	FGDs	WPSC 1 Mothers 1 Nutrition Committee 1	2.00pm 2.45pm 3.30pm	3	
Wednesday 17 th Nov	Household Survey	Village 5: Katsirizika	8.30am	30	Katsirizika
	Household Survey	Village 6: Chinjoka	11.00am	30	Chinjoka
	Key Informants	School 1: School 2: HSA 2 CDA 2 CBDA 2/TBA2	9.00am 11.00am 1.00pm 2.00pm 3.00pm	6	
Thursday 18 th Nov	Household Survey	Village 7: Mkanda	8.30am	30	Mkanda
	FGDs	WPSC 2 Mothers 2 Nutrition Committee 2 VHC	2.00pm 2.45pm 3.30pm 4.00pm	4	
Friday 19 th Nov	Household Survey	Village 8: Zombe Alaki	8.30am	30	Zombe
	Household Survey	Village 9: Petros	11.00am	30	Petros
	KII	HC 1: Ofesi HC 2: Mpepa HC 3: Kalulumã	11.00am 1.30pm 3.00pm	3	
Saturday 20 th Nov	Household Survey	Village 10: Chisinga	8.30am	30	Chisinga
	FGD	WPSC 3 Mothers 3 Nutrition Committee 3	10.00am 10.45am 11.30am	3	

LIST OF SAMPLED VILLAGES IN MZUZU PU

Date	Type of assessment	Name of Community/Unit	Time	Number	Community
Monday 15 th Nov	Household Survey	Village 1: Daniel Cima	8.30am	30	Kafukule
	Household Survey	Village 2: Chikhomo Mvula	11.00am	30	Champhamba
	Key Informants	CBDA 1 Chief 1 HSA 1 CDA 1 Chief 2 TBA 1	8.30am 10.00am 1.00pm 2.00pm 3.00pm 2.00pm	6	
Tuesday 16 th Nov	Household Survey	Village 3: Mihla Nkosi	8.30am	30	Elangeni
	Household Survey	Village 4: Zaya Nkhoma	11.00am	30	Luvwere
	KII	DWO DEHO	9.00am 10.00am	2	
	FGDs	WPSC 1 Mothers 1 Nutrition Committee 1	2.00pm 2.45pm 3.30pm	3	
Wednesday 17 th Nov	Household Survey	Village 5: Mkopeka Khowoya	8.30am	30	Zombwe
	Household Survey	Village 6: Chinjoka Soko	11.00am	30	Tenecha
	Key Informants	School 1: Emvuyeni School 2: Zombwe HSA 2 CDA 2 CBDA 2 TBA 2	9.00am 11.00am 1.00pm 2.00pm 3.00pm 3.00pm	6	Emvuyeni Zombwe
Thursday 18 th Nov	Household Survey	Village 7: Andreyá Beza	8.30am	30	Kafulufulu
	FGDs	WPSC 2 Mothers 2 Nutrition Committee 2 VHC	2.00pm 2.45pm 3.30pm 4.00pm	4	
Friday 19 th Nov	Household Survey	Village 8: Mbená Moyo	8.30am	30	Emsizini
	Household Survey	Village 9: Kampamayiro	11.00am	30	Matuli
	KII	HC 1: Matuli HC 2: Ekwendeni HC 3: Mtwalo	11.00am 1.30pm 3.00pm	3	
Saturday 20 th Nov	Household Survey	Village 10: Mpondá Honde	8.30am	30	Ekwaiweni
	FGD	WPSC 3 Mothers 3 Nutrition Committee 3	10.00am 10.45am 11.30am	3	

ANNEX E-QUESTIONNAIRE

MCH Project Part 2 Final Evaluation (HH-QN Mother with child 0-59 Month)

QN ID	DATA ENTRY	RECORD #
INTERVIEW DATE ___/___/___ (dd/mm/yy)	TA _____	
INTERVIEWER'S NAME _____	PU NAME _____	
	VILLAGE _____	

INTRODUCTION

Hello. My name is _____. We are conducting an evaluation about the health of women and children. We would very much appreciate your participation in this survey. I would like to ask you about your health (and the health of your children). This information will help us to plan and improve existing health services. This evaluation questionnaire usually takes 20 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons. Participation in this evaluation is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this evaluation since your views are important.

NAME OF CHILD BETWEEN 0 AND 59 MONTHS
BIRTHDATE ___/___/___ CHECK CARD AGE OF MOTHER (IN YEARS) ___ # OF PEOPLE IN HH ___ DD/MM/AA
AGE OF CHILD (IN MONTHS) ___ SEX OF CHILD (PLEASE CIRCLE): M F

Instructions

1. Circle the number that applies. If the response is "yes," circle 1; if "no," circle 2; if "doesn't know," circle 9.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
Key Practice: Breastfeed infants exclusively for up to six months.			
1	After birth how long did it take to start breastfeeding?	Approx number of hours and/or minutes: ____	
2	Child was born with how much weight? <i>Check card</i>	: ____ kgs	
3	Is (child's name) still being breastfed?	YES.....1 NO.....2 DON'T KNOW.....9	
4	Since this time yesterday, did (child's name) receive any of the following? <i>Prompt and code for all items mentioned. YES 1 NO 2 DOESN'T KNOW 9</i>	Plain water.1 2 9 Sweetened, flavored water or juice ...1 2 9 Tinned, powdered or fresh milk1 2 9 Any other liquids (specify):..... .1 2 9 Solid or semi-solid (mushy) food.....1 2 9	
Key Practice: Dispose of feces, including children's feces, safely; and wash hands after defecation, before preparing meals, and before feeding children.			
5	What is the source of water for members of your household? <i>Do not prompt. Circle number to right of response given.</i> Tube well or borehole. 6 Protected dug well or protected spring.7 Other (<i>specify</i>): 8	Piped into dwelling. 1 Unprotected dug well or spring, rainwater. 2 Piped into yard/plot. 3 Pond, river or stream. 4 Public tap. 5	
6	How long does it take to get to this source, get water and come back?	Approx number of hours and/or minutes: ____	
7	What kind of toilet facility does your household use? <i>Check availability and tick where appropriate</i> No facilities/bush/field. 5 Covered latrine. 6	Flush toilet system. 1 Uncovered latrine. 2 Pipe ventilated latrine (covered). 3 Pipe ventilated latrine (uncovered). 4	
8	Is there a hand washing facility near the toilet? (Plz check) <i>Circle the number which applies. If the response is "yes," circle 1; if "no," circle 2; if "doesn't know," circle 9.</i>	YES.....1 NO.....2 DON'T KNOW.....9	37
Key Practice: Take children as scheduled to complete a full course of immunizations (BCG, DPT, OPV, and measles) before their first birthday			
9	Could you please show me the children's health cards again? <i>Tick based on card information or probing (Separately indicate card available or not)</i> OPV2 OPV3 Measles	BCG DPT1 DPT2 DPT3 OPV0 OPV1	

Key Practice : Protect children in malaria-endemic areas, by ensuring that they sleep under ITNs			
10	Do you have nets in this household? <i>Circle the number which applies. If the response is "yes," circle 1; if "no," circle 2; if "doesn't know," circle 9.</i>	YES.....1 NO.....2 DON'T KNOW.....9	37
11	If yes how many?	_____nets	
12	(If yes) Did (child's name) sleep under a mosquito net last night? <i>Circle the number which applies. If the response is "yes," circle 1; if "no," circle 2; if "doesn't know," circle 9.</i>	YES.....1 NO.....2 DON'T KNOW.....9	
13	Was this net ever treated with a product to kill mosquitoes? <i>Circle the number which applies. If the response is "yes," circle 1; if "no," circle 2; if "doesn't know," circle 9.</i>	YES.....1 NO.....2 DON'T KNOW.....9	37
Key Practice: Continue to feed and offer more fluids, including breast milk, to children when they are sick.			
Key Practice: Give sick children appropriate home treatment for infections.			
Key Practice: Recognize when sick children need treatment outside the home and seek care from appropriate providers.			
14	In the last two weeks, that is, since (current day) of the week before last, which children, if any, had any illness or health problem?	YES.....1 NO.....2 DON'T KNOW.....9	50
15	Please tell me if (children's names reported as having been ill) had any of these symptoms or illnesses in the last 2 weeks, including today. Did (children's names) have...? <i>For each child noted as having been ill within the last two weeks, prompt for all listed symptoms and illnesses mentioned below. Circle 1 for yes and 2 for no, 9 for doesn't know</i> Malnutrition.....1. 2 9 Other (<i>specify</i>):	Malaria 1. 2 9 Convulsions.....1. 2 9 Pneumonia.....1. 2 9 Cough.....1. 2 9 Diarrhea.....1. 2 9 Blood in Stool.....1. 2 9 Measles.....1. 2 9	
16	Did you seek advice or treatment for (child's name)'s illness outside the home?	YES.....1 NO.....2 DON'T KNOW.....9	65
17	(if yes) Where or from whom did you seek help? <i>Do not prompt, with exception of traditional healer (asked with sensitivity). Tick each provider mentioned.</i> Religious Leader Relative, Friend or Elder (outside household) Traditional Healer	Government Health Facility or Clinic Private Physician Community Based Practitioner including TBAs Shop or Market Village Clinic Village Health Worker	
18	Sometimes children have severe illnesses and should be taken immediately to a health facility. When should you take a sick child to a health facility right away? <i>Do not prompt – keep asking for more signs and/or symptoms until the care giver cannot recall any additional ones. Place a tick beside all signs and/or symptoms mentioned.</i>	Child not able to drink or breastfeed. Child becomes sicker. Child develops a fever. Child has fast breathing. Child has difficult breathing. Child has blood in stool. Child is drinking poorly. Other (<i>specify</i>):	
19	How much time passed between when you first recognized that the child was ill and you took him/her to the health facility? <i>Do not prompt. Write down time passed (in terms of days) under the name of each child in question.</i>	_____days	
20	During this last episode of diarrhea, did (child's name) drink any of the following? Water with feeding during part of the day. 1 2 9 Water alone. 1 2 9 Other fluids but no feeding. 1 2 9 Other (<i>specify</i>): 1 2 9 Nothing.	Breast milk. 1 0 9 Cereal-based gruel. 1 2 9 Other locally acceptable home fluids 1 2 9 ORS packet solution. 1 2 9 Other milk or infant formula. 1 3 9	
21	Was (child's name) seen at a health facility when she/he had malaria or fever? <i>If the response is "yes," circle 1; if "no," circle 2; if "doesn't know," circle 9.</i>	YES.....1 NO.....2 DON'T KNOW.....9	84
22	What medicine did (child's name) take that was provided or prescribed at the health facility? <i>Do not prompt.</i>	Paracetamol = 1 LA = 2 Quinine= 3 Other = 4 (<i>specify</i>): <i>Doesn't know = 9</i>	
23	Was (child's name) given medicine for the fever or malaria either before taken to the health facility or (if not taken to health facility) during this illness?	YES.....1 NO.....2 DON'T KNOW.....9	

24	What medicine was (child's name) given?	Paracetamol = 1 LA = 2 Fansidar = 3 Other = 4 (specify): Doesn't know = 9	
25	During (child's name)'s had diarrhea, did (child's name) was he given home treatment?	YES.....1 NO.....2 DON'T KNOW.....9	
Key Practice: Ensure that every pregnant woman receive the recommended doses of the TTV and IPTp.			
26	During your last pregnancy were you given SP for IPTp?	YES.....1 NO.....2 DON'T KNOW.....9	
27	If yes on how many occasions?.	Record the number of times: ____ Doesn't know.	
28	Did you finish TTV before your last born? (5 doses is completion)	YES.....1 NO.....2 DON'T KNOW.....9	
29	If no, How many doses of TT did you receive during your last (current) pregnancy?	Record the number of doses: ____	
Reproductive Health			
30	Are you currently doing something or using any method to delay or avoid getting pregnant?	YES 1 NO 2	
31	If yes, What is the method you or your spouse/partner are using now to avoid/postpone getting pregnant? LACTATIONAL AMENORRHEA...10 RHYTHM..... 11 ABSTINENCE 12 WITHDRAWAL..... 13 OTHER _____ 96	NORPLANT..... 1 INJECTIONS 2 PILL..... 3 IUD/LOOP..... 4 BARRIER METHOD/ DIAPHRAGM..... 5 CONDOM..... 6 FOAM/GEL 7 TUBAL LIGATION 8 VASECTOMY..... 9	
32	Where was (NAME) delivered? OTHER _____ 96 (SPECIFY)	At home.....1 In a health center.....2 In a hospital3	
33	Who assisted you with the delivery of (NAME)? OTHER _____ 6 (SPECIFY) Don't know.....9	Traditional Birth Attendant1 Medical Doctor2 Family member3 Midwife.....4 Self/No One.....5	
Mortality			
34	Was there any death in the household in the past 12 months?	YES.....1 NO.....2 DON'T KNOW.....9	
35	If yes what was the age?	: __years or __ months if less than 1yr	
36	Was there any known cause of death? If yes specify	: _____ name of disease/condition	

Anthropometry						
Date of birth	Age	Sex	Height	Weight	MUAC	Oedema
use health passport	In months	Male =M Female= F	Cm upright when >85cm	Kg (to 100g)	cm measure left arm	Yes (Y) No (N)

ANNEX F: QUALITATAIVE TOOLS

NUTRITION			
<i>Category</i>	<i>Details</i>	<i>Category</i>	<i>Details</i>
TA		Interviewer	
Village		Note taker	
Name of Group		Date	

Start Up Questions

1. When was the nutrition committee formed?
2. How did you manage to get the nutrition committee started?
3. How does it function? Who oversees? What positions are place?
4. What has been the role of committee in general?

Service Satisfaction

5. Do you believe that you are providing adequate support? Explain
6. Are you pleased with the services provided by the committee? Explain
7. Can someone explain with examples how your functions have helped improve the health of the community
8. In there an indication that there is reduction in child and maternal mortality in the village ? Explain
9. What are some of the constraints you are encountering?
10. And how do you believe that these constraints can be overcome?

Supply Management

11. Is there a record of Supplies etc?
12. are there any formal and informal links with government departments and the private sector?
Explain
13. How do you raise funds and manage it at the committee level?
14. Does the committees have any reporting forms?

Management/Capacity Building

15. How many members are available in your nutrition committee?
16. How many are trained? How are the members supported? Who facilitated and for how long?
17. Have you attended any capacity building initiatives apart from training? Explain
18. Do we still have the original number of members? If some members have left, what reasons?
19. How do you work and link up with Chiefs, Govt and community members

Child Participation

1. Do you think children were involved in full or some way in Plan Malawi project cycle?
2. If yes explain with examples (focus on design, planning, implementation, M&E).
3. Has this contributed to any successes of the program? Explain

Gender Mainstreaming

4. Do you think Plan interventions have equally involved, managed and benefitted by all gender groups (i.e men and women/boys and girls)?
5. If yes explain with examples.
6. What specific actions were undertaken by Plan to promote equal participation of men and women as well as benefits?
7. What challenges were faced in promoting gender and how were they mitigated?

VHWPC			
<i>Category</i>	<i>Details</i>	<i>Category</i>	<i>Details</i>
TA		Interviewer	
Village		Note taker	
Name of Group		Date	

Introduction

1. When was the WPSC formed? How many members are available in your committee?

2. How did you manage to get the WPSC started?
3. How does it function? Who oversees? What positions are place?
4. What has been the role of WPSC in general?

Service Satisfaction

5. Do you believe that you are providing adequate support? Explain
6. Are you pleased with the services provided by the WPSC? Explain
7. Can someone explain how your functions have helped improve the health of the community
8. In there an indication that there is reduction in child and maternal mortality in the village ? Explain
9. What are some of the constraints you are encountering?
10. And how do you believe that these constraints can be overcome?

Supply Management

11. Is there a record of Supplies etc?
12. are there any formal and informal links with gov departments and the private sector? Explain
13. How do you raise funds and manage it at the committee level? How much do have today?

Management/Capacity Building

14. How many are trained? How are the members supported? Who facilitated and for how long?
15. Have you attended any capacity building initiatives apart from training? Explain
16. Do we still have the original number of members? If some members have left why?
17. How do you work and link up with Chiefs, Govt and community members

Child Participation

18. Do you think children were involved in full or some way water supply?
19. If yes explain with examples (focus on design, planning, implementation, M&E).
20. Has this contributed to any successes of the program? Explain

Gender Mainstreaming

21. Do you think Plan interventions have equally involved, managed and benefitted by all gender groups (i.e men and women/boys and girls)?
22. If yes explain with examples.
23. What specific actions were undertaken by Plan to promote equal participation of men and women as well as benefits?

Water point

24. Is there adequate drainage?
25. Is the water point working properly ? If not what is the problem ? Is the problem being resolved?
26. Has the pump broken down in the past? Who repaired it? Parts needed? Where procured? Down time? Is the water point tidy?

Mothers			
<i>Category</i>	<i>Details</i>	<i>Category</i>	<i>Details</i>
TA		Interviewer	
Village		Note taker	
Name of Group		Date	

1. How have you received the message of exclusive breastfeeding? Do you think most women are practicing it? (Yes or no) please Explain with reasons. How has Plan supported on this area?
2. How have you received the message regarding micronutrients? Do you think children are able to get it from food or medication? (Yes or no) please Explain. How has Plan supported on this area?
3. How many people have latrines in their homes? Explain. Are they properly being used? Explain
4. Mention the correct times we need to wash hands? Do you think this is practiced in this village? Explain with examples? Do you think this has contributed to reduction in illnesses and death?
5. How about washing hands with soap? Is this being practiced in this village? Explain
6. Do you think all children in this village are immunized before they reach age of five? Please explain? How have you been received and assisted at the hospital? Do you always find the vaccination when you go to nearest hospital? How far is this nearest hospital?
7. Is this group how many do have their children sleep under a treated bed net? Explain (Probe the reasons if more or less have the children sleep under the bednet? How have Plan assisted in this area?
8. What is the feeding pattern of sick children? Explain with reasons
9. What is the name of the new malaria drug? How do you think about the new malaria drug? Probe the Perceptions.
10. When is it necessary to send child immediately to hospital? Is this being practiced? Has it helped save lives? Explain with examples?
11. How many women in this group had made 4 antenatal visits to the hospital? Why?
12. How about deliveries? Where do women give birth? And why?
13. How have all these activities helped save lives of children? Explain? How did Plan try to support in these areas?

District Partners			
<i>Category</i>	<i>Details</i>	<i>Category</i>	<i>Details</i>
District		Name of Interviewer	
Department		Date	
Name of Officer			

Introductory Questions

1. Tell us more about your specific involvement with Plan in the area of health?

2. What kinds of activities have you undertaken jointly?
3. Do you think the department/Institution has benefited from the health interventions? Explain

Partnerships/Mobilization

4. How would you characterize the partnership with Plan?
5. Have you encountered any problems in this partnership? If yes what was the problem and How did you solve that problem?
6. Have you ever had any feedback meetings on this project?
7. If yes what did you learn from those meetings? What improvements has been made with lessons from the meetings?
8. How have you assisted in mobilizing the communities for the project?
9. Did you discuss and agree on each party's role in the project?
10. Do you think that Plan is really tackling key issues in health?
11. Do you think that Plan activities fit well in the National and District Priorities?

Capacity Building

12. Have you ever attended any orientation organized by Plan? If yes in what areas?
13. How has it supported you? What improvements have been realized due to this orientation?
14. How else have you benefited in terms of acquiring knowledge?

Sustainability

15. Do you think Plan initiated/supported work in health will continue even if the organization pulls is not there? Please explain and give examples if possible

Gender Mainstreaming

16. Do you think Plan interventions have equally involved, managed and benefitted by all gender groups?
17. If yes explain with examples.
18. What specific actions were undertaken by Plan to promote gender mainstreaming?
19. What challenges were faced in promoting gender and how were they mitigated?

Challenges/Future Plans

20. Do you think Plan is tackling important health interventions? Please explain and give examples if possible
21. What were major weaknesses of this project? Please explain and give examples if possible
22. If this project was continuing, what new activities or approaches would you want to take?

Health Center Representative			
Category	Details	Category	Details
District		Name of Interviewer	
Department		Date	
Name of Officer			

Partnerships and linkages

1. In which of the Plan programme areas, does your facility play a role (Explain for each or any)
 - Child survival (malaria, ARI, Immunization, malnutrition, diarrhoea),
 - Maternal and newborn health,
 - School health promotion,
 - Water and sanitation.
2. How closely do the various components of Plan interventions link up with your organization's own strategies and programmes?

Project implementation and achievements

3. What sought of support/grants have you received from Plan in the past 2 years? Explain and provide details

4. To what extent are funds relevant to improving child, neonatal and maternal health in the areas around your catchment area?

5. At this stage, what have been the main achievements (attach any success story) of child, neonatal and maternal health interventions done through Plan funds/grants? What have been the factors contributing to these achievements?

6. Have there been any significant barriers to the effective implementation of child, neonatal and maternal health interventions using funds/grants from Plan? How might such threats to future implementation be tackled?

Coordination and Collaboration between Stakeholders

7. How effectively does your institution utilize its partnership(s) and linkages in the design, implementation and monitoring activities of its child, neonatal and maternal health interventions

8. Overall, how do you view the co-ordination child, neonatal and maternal health interventions? What more could be done?

Sustainability

9. What strategies have you put in place for enhancing sustainability in child, neonatal and maternal health interventions?

10. In your opinion, what are the main threats to the long-term sustainability of child, neonatal and maternal health? What opportunities can Plan build on to support sustainability?

11. Finally, In light of lessons learnt from current interventions, what else can be done to ensure improved child, neonatal and maternal health in line with current national and facility goals?

SEMI STRUCTURED QUESTIONNAIRE (Selected older pupils/Teachers/Patrons)

DATE:	INTERVIEWER:	PU Name:
TA:	SCHOOL:	
AGE:	GENDER:	VILLAGE:
		RESPONDENT:

INVENTORY OF PUPILS AND TEACHERS

1. No. of enrolled children, 2010, total	
	boys
	girls
No. of teachers	
No. of classes	
SANITATION	
2. What latrines are there now?	
	girls, total latrines
	girls, total latrine compartments/stalls
	boys, latrines
	boys, total latrine compartments
	teachers, latrines
	teachers, total latrine compartments
3. Total no. of pupils per latrine compartment	
	girls per latrine compartment
	boys per latrine compartment
4. No. of latrine compartments per class	
5. When were latrines completed and handed over?	
6. How long did construction take?	
7. Are they being used?	
8. Are there urinals?	
	girls, urinals
	girls, concurrent urinal spaces
	are girls using urinals concurrently
	boys, urinals
	boys, concurrent urinal spaces
9. Are there hand washing facilities?	
	Type
	Outlets (taps, hoses, basins) total
	Outlets functional
	for girls
	for boys
	Distance to latrines
	Distance to water source
	Tanks full
	Facilities used (best answer, based on pupils, teachers and observations)
	Do pupils wash their hands immediately after using latrines?
10. Is Soap/ash available in or at the latrines? (observation)	
11. Has the planned package of facilities been completed (one latrine compartment for each class of boys and girls, two urinals, hand washing stations for boys and girls)	
12. Level of privacy for boys	
	separated from girls latrines, houses, school etc.
	Doors
	blind walls
13. Level of privacy for girls	
	separated from boys' latrines, houses, school etc.
	Doors
	blind walls
14. Needs of menstruating girls taken into account (e.g. water available in the compartment)	

15 Path from the school building to the latrines?

KNOWLEDGE AND PRACTICES				
16	When do you think it is important to wash your hands? (do not	BEFORE EATING	AFTER EATING	
		BEFORE FEEDING CHILDREN	BEFORE PREPARING FOOD OR COOKING	
		AFTER CHANGING BABY	OTHER	
		AFTER DEFECATING		
17	Why is it important to wash hands with soap? (do not give answers)	PREVENT DISEASE	PREVENT DIRT GETTING INTO MOUTH	
		PREVENT DIARRHEA	PREVENT DIRT GETTING INTO FOOD	
		CLEAN HANDS/REMOVE DIRT	HEARD FROM PARENTS/OTHER FAMILY	
		BECAUSE IS GOOD HYGIENE	HEARD FROM OTHER PEOPLE	
		REMOVE GERMS	HEARD FROM RADIO/TV	
	OTHER PEOPLE DO IT	OTHER		
	Diarrhea			
18	What do you think can cause diarrhea? (do not give	BAD/DIRTY WATER	DIRTY HANDS	FAECES/DEFECATING IN THE OPEN
		BAD/DIRTY FOOD	GERMS	
		POOR HYGIENE	FLIES	OTHER
19	Do you think diarrhoea can be prevented? how			
20	If yes, how do you think diarrhoea can be prevented? (do not give answers)	WASH HANDS	BREAST FEEDING ONLY UNTIL 6 MONTHS	
		USE SOAP	USE TOILET FACILITY TO DEFECATE	
		BURY FAECES	DISPOSE CHILDREN'S FAECES IN TOILET FACILITY	
		DRINK CLEAN WATER	TREAT WATER (BOIL, FILTER, ETC)	
		STORE WATER SAFELY	PREPARE FOOD HYGIENICALLY/PROTECT	
		MEASLES VACCINATION	DISPOSE OF GARBAGE IN A PIT	
		VITAMIN A	NO OTHER FOOD/DRINK BEFORE 6 MONTHS	
		GOOD NUTRITION	OTHER	
21	Malaria	How is malaria spread? How		
22	HIV/AIDS	What is AIDS? How is it		
23	Tuberculosis	How is TB spread? How can		
24	Measles	How is measles spread? How		

SCHOOL CLUB	
Start up Questions	
1.	When was the School Club formed?
2.	How did you manage to get the club started?
3.	How does it function? Who oversees? What positions are place?
4.	What services do you provide?
Service Satisfaction	
5.	Do you believe that you are providing adequate support? Explain
6.	Can you explain with examples how the functions have helped improve the health of the pupils
7.	What are some of the constraints your are encountering?
8.	And how do you believe that these constraints can be overcome?
Management/Capacity Building	

9. How many members are available?	
10. How many are trained? How are the members supported? Was any WASH training done? Who facilitated and for how long?	
11. Do you think the club will continue after the project? Explain	

WATER SUPPLY
1. Was a water point available in the past? (before the Plan Interventions?)
2. Community or school water point?
3. If it belongs to school, does the community have access to the water point
4. What type of water point is available?
5. Is there adequate drainage?
6. Who has been trained in CBM / VLDM
7. Is the water point working properly ?
If not what is the problem ?
Is the problem being resolved?
8. Has the pump broken down in the past?
Who repaired it?
Parts needed?
Where procured?
Down time?
9. Is the water point tidy?
10. Are there co management arrangements between school and community?
11. Is there a maintenance fund?
How much and how is it managed

ANNEX G: NUTRITIONAL SURVEY GUIDELINES

METHODOLOGY

The survey we are conducting is using a two-stage cluster sampling method. This means that we need to survey a minimum of 30 children in clusters to provide us with valid estimates of the prevalence of malnutrition.

BEFORE GOING TO THE FIELD

The team should check the accuracy of the scales by using a known weight; e.g. a known 1kg weight.

ARRIVING IN THE FIELD ...

Before starting the selection of households, all the survey team must introduce themselves to the leader in the location that you will be working in. (show/ read to them the letter explaining why we are doing the survey)

Then:

- Introduce yourself
- Explain that you are here for the nutritional survey (children under 5 years)
- Explain that you have to follow a specific method. A sample only will be measured (therefore you do not need to measure everyone to get an idea of the rates of malnutrition)
- Advise that the people have to stay at their home in order to be measured.
- Define the geographical centre of the town/ village
- Ask if one member of the community familiar with the area could come along with the team.

You can now start

Objectives:

- We want to collect information on the nutritional status of the children. This survey is part of a national nutritional survey so we can assess how the different districts are doing in terms of nutrition. This information will help us assess the needs of the population.

CHOOSING HOUSES AND CHILDREN

- Go to the centre indicated by the town/ village leader and chose a random direction using the spinning pencil/ pen method.
- Draw an imaginary line between the centre and the edge of the direction. Count all the households on the right side of the direction of the pen. Go back to the middle of the area and randomly select a number between 1 and the number of houses that you have counted (e.g. let a child call a number within the range); this is the number of the house that you will go to first.
- Go to the selected house in the direction; introduce yourselves to the inhabitants of the place. Explain the purpose of your visit politely.
- For each h/h (shared cooking pot), ask the carer to call the kids under five years.
- Measure all children and check their vaccination status and vitamin A supplementation.
- Check the morbidity status of the children.
- Very careful and being sensitive ask the mortality questionnaire to the carer of the children measured.

You have now finished collecting the required data!!!...

- Before leaving the h/h check your questionnaire to see if you have forgotten anything.
- Leave the h/h and select the next household on your right-hand side. If there is no house on the right hand side then go to the middle of the area and repeat the procedure starting from spinning the pen/pencil.
- If you reach the edge of the town/ village before you have measured 33 children then go back to the centre of the town/ village and throw the pen again and follow the steps as before until you reach 33 children.
- If the last household has more children than needed to collect 33 data-sets make sure you randomly select which of the children to measure.

Special case:

If you have not completed 33 kids after trying all directions, go to the nearest town/ village. Then follow the procedure as before.

SPECIAL PROCEDURES

- In a h/h: if a child is absent, take his details and come later to measure him/her on at least 2 occasions.
- If the town/ village include several clusters, come back to the centre of the section after completing the first cluster and select a new direction by spinning a pencil. Repeat this selection method until you finish the cluster.

① Remember:

Do not make personal choice concerning the choice of houses and children. It has to be 100% random in order not to introduce a bias. The success of the survey relies on the adherence to this rule. In every situation, a solution should be sought which is appropriate to the field constraints.

DATA COLLECTION AND MEASUREMENT TECHNIQUE

Many body parameters can be used to assess the nutritional status of someone. The weight, the height, the MUAC, and bilateral oedema are the most commonly used.

WEIGHT

Children 6-59 months (65-110 cm)

- Hang the scale by its hook from a stick held up by two strong people.
- Hang the weighing pants from the scale and adjust the scale to zero. Make sure that when you are reading the scale, the needle is at eye level.
- Ask the mother to remove the clothes of the child (explaining why we need to do this) and place the child on the weighing pants. When you are measuring girls, it is more sensitive to measure them inside when removing their clothes. ALWAYS REMOVE ALL CLOTHES. If not the results will not be accurate.
- Pick up the child and hang the pants on the scale, letting the child down slowly. Make sure the child is securely inside the pants, and then let go of him. He must not be touching anything or anyone when the measurement is read.
- Read the weight of the child from the scale, making sure it is at eye level, at the nearest 100g.
- Announce the weight to the team leader, who should repeat it to the measurer and write it down clearly.
- Pick up the child, remove it from the scale and return it to its mother.

Special case:

- If the child is moving and the needle does not remain still, try to calm the child and when he is stable read the weight. If it is impossible to calm him, estimate the reading as the value at the mid point of the range of its movement.

① Remember:

Do not forget to re-adjust the scale to zero with the empty weighing pant hanging before each weighing.

Each day, all the scales must be checked by using a known weight in order to guarantee their good functioning.

HEIGHT

a) children over 2 years or between 85-110 cm

- place the measuring board upright on the flat surface
- Ask the carer to remove the child / the carer foot wear and headwear and lead the child to the measuring board. Explain to the child what is happening and reassure him that it will not be painful.

- Position the child / the carer so that the heels, buttocks and shoulder blades are touching the vertical surface of the measuring board. The feet should be flat on the floor and slightly apart, legs and back should be straight, and arms should be at the sides. Ask the child to stand tall and look straight ahead.
- Check that the child is positioned correctly. Someone can assist by holding the heels against the back of the board and the knees straight, if necessary. Make sure the child is looking straight ahead, not downwards.
- Bring the movable headboard down so that it rests firmly against the crown (highest point of the head) of the head
- Read the measurement to the nearest 0.1 cm.
- Record the measurement clearly on the recording form. Re-read it to check that it is correct.

Special case:

- If a child has poliomyelitis side-effects (physical disability), you will take his height on the longest leg.

b) Children under 2 years or less than 85 cm

- Place the measuring board horizontally on a flat piece of ground table
- Remove the baby shoes and head covering where necessary
- Place the child on the measuring board with it's head against the fixed (non-moveable) end
- Ask someone to hold the head of the baby so that the top of his head is against the board and it's eyes are pointing straight up
- Hold the baby's knees together and push them down so that they are pressing against the board. You can use your forearm to keep the baby's body in position. Then bring the footboard up so that it presses against the heels of both feet (some strength may be needed to do this if child is kicking or resisting)
- Release the child's feet while keeping the footboard firmly in place with one hand. This stops the child from kicking and moving it from the measurement reading.
- Read the measurement from directly above the tapes, to the nearest 1 mm
- Write the measurement clearly on the form
- Re-read the record value to make sure it is correct

MUAC

MUAC should always be measured at the mid-point of the **left arm**

- Ask the child to bend his left arm at the elbow and hold his hand flat against his stomach. Find the bone at the top of the arm / tip of the shoulder. Use the MUAC tape to measure from there to the tip of the elbow. Mark the middle point of the upper arm with a pen.
- Remove the tape and ask the child to let his arm hang loosely by his side
- Wrap the MUAC tape loosely around the arm at the middle point (where the pen mark is). Slip the thin end of the tape through the opening at the wider end and read the measurement in the window
- Record the measurement of MUAC between the blue arrows to the nearest 1 mm.

Special case:

- If the child has a physical disability on the left arm, you will take the MUAC on the right arm. (This must be documented)

OEDEMA

In order to determine the presence of oedema, normal thumb pressure is applied to both feet for **3 seconds** (time to say: 121 122 123). If a print persists on both feet, then the child presents oedema. Only children with bilateral oedema are recorded as having nutritional oedema.

ALL SUSPECTED CASES OF OEDEMA MUST BE VERIFIED BY THE SUPERVISOR

AGE

Only children between 6-59 months old (or more than 65cm and less than 110cm in height) will be included in the sample. If the birth date is known by the mother, determination of the age is simple. In such case, the age is recorded into the questionnaire in months.

When birth date are unknown, mothers are asked about the approximate age using the local events calendar, seasons of short / long rains etc.

VACCINATION

Ask the mother if the child has been vaccinated and check card

Morbidity Survey Guidelines

1. In the last two weeks has the child been ill? If yes from what?

Always thank the family when you leave.