Plan Malawi Maternal and Child Health (MWI 1001) Project Mid-Term Review

18th January 2006

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ANNEXES:

ACRONYMS

AIDS Acquired Human Immunodefiency Syndrome

ARI Acute Respiratory Infection

CBCC community Based Child Care Center

CBDA Community Based Distribution Agent

CBO Community Based Organization

CIMCI Community Integrated Management of Childhood Illness

CPO Country Programme Outline

HIV Human Immunodefiency Virus

IEC Information, Education and Communication

IMCI Integrated management of Childhood Illness

ITN Insecticide Treated Nets

MOH Ministry of Health

ORT Oral Rehydration Therapy

PATH Programme for Appropriate Technology in Health

PHAST Participatory Hygiene and Sanitation Transformation

PHC Primary Health Care

PMTCT Prevention of Mother to Child Transmission

SPSS Statistical Package for Social Scientists

SRH Sexual and Reproductive Health

STI Sexually Transmitted Infection

TBA Traditional Birth Attendant

VHC Village Health Committee

TABLES

EXECUTIVE SUMMARY

The aim of this evaluation exercise was to determine the effectiveness of the strategies used in implementing the project. In the final analysis the timeliness, progress and outputs delivered against the project set objectives would be outlined so as to draw recommendations that would then be fed in the last two years of the project. To achieve this aim several objectives were developed in line with the key strategic areas of the project.

Data collection was conducted in all three Plan program units of Mzuzu, Lilongwe and Kasungu from 29th August to 2nd September 2005. Six communities and a village were sampled in all these three programme units. Respondents included mothers with under-five children, youth in and out of school, members of community based organizations and institutions, village health committees and the community at large.

Community integrated management of childhood illness is the strategy that has come out very clearly as the most effective strategy at this stage of implementation e.g.

- Immunization coverage is at 72% against the set target of 80%
- The number of mothers who are able to manage diarrhoea at home using ORT has increased to 81% well above the set target of 65%.
- The incidence of malnutrition is at 06% against a set target of less than 10%%.

However the usage of insecticide treated nets, which is at 49% against 60% and accessibility of community pharmacies through PHC, which is at 19% against 80% and the percentage of new babies with normal weight, which was not assessed because of poor record keeping within the facilities posses a lot of challenges. These will require more emphasis in the next two years. Mzuzu PU is leading in performance followed by Lilongwe then Kasungu.

Safe motherhood is the second strategy that has shown effectiveness in terms of e.g.

- The rate of utilization of family planning services which has gone up to 53% against a set target of 60%.

School health promotion has also shown some achievements although there were no set targets and these are in terms of e.g.

- Support to child-to-child peer education activities, which is at 86.2%, school competitions that is at 89.2%, the giving of prizes, which is at 73.7%, and exchange visits that were assessed to be at 67.1%.
  Lilongwe PU is leading in performance followed by Mzuzu PU.

The strategies that have been identified, as being behind are safe mother hood and promotion of school health as especially in the following areas:

- Support to emergency obstetric care
- TBA and CBDA training
- Utilization of postnatal care at health facility level
- Provision of PMTCT services in the health facilities
- HIV and AIDS and STI intervention for out of school youth

- Capacity building in sexual and reproductive health issues for parents and teachers.

Limitations

- Generally the days that were planned for the exercise were not adequate, and this made the enumerators work over time. This was compounded by the fact that communication to other program units was not done as such it was very difficult to mobilize the communities. It was also very difficult to recheck the information for internal consistency because the exercises were ending very late in the evenings to carry the rechecking exercise.

- Lack of communication was worse in Lilongwe where out of the six communities only one was informed about the exercise. Focus group discussions with the members of the community were done in four out of the six communities. In one of the selected villages focus group discussions were not done because of a funeral, which occurred on the scheduled day. Similarly Mzuzu program unit had communication problems to the extent that no focus group discussions were conducted in two villages. One of the villages that were sampled was inaccessible because of bad road; a convenient sampling was then used to select another village.

- Kasungu program unit had a problem of enumerators. Out of the proposed five enumerators from Kasungu program unit only three turned up for the exercise this compromised the participatory nature of the evaluation in this program unit. Very few out of schoolgirls attended the focus group discussions and therefore this lowered the desired sample size for girl participant. Because of lack of communication focus group discussions were done only in some communities.

- The objective on the weight of new- born babies was not assessed because of lack of proper documentations in the health facilities and this was compounded by the fact that most of the health facilities have no midwives.

General Recommendations

It is therefore recommended that safe mother hood and promotion of school health strategies will require more emphasis. The issues raised above complement each other; failure in one will lead to failure in other areas even those that have been successfully implemented at this stage of the project.

To effectively use these strategies and achieve the set targets the strategies will require a proper strategic planning with clearly defined planned activities and approaches and persons responsible to carry out those activities at all levels.

In the Mother and Child health proposal, there is a proposal by Plan to contract Community Health nurses and Homecraft workers who would work with mothers in the communities.

For the successful implementation and supervision of the project at community level, it is recommended that these workers should be contracted. In addition to these, each

community should have one HSA contracted. These workers will supplement each others efforts in trying to reduce malnutrition in the children and other family key practices in community IMCI which are moving at a very slow pace in achieving the project objectives.

Specific Recommendations

1. Community dialogue and conventional IEC must be strengthened in the use of ITNs. Communities must be guided in their priorities since the nets are already subsidized. Frequent dipping of nets in insecticides should be done at every 6 months. Committees at village level e.g. the village health/ITN committee should be empowered to conduct such campaign.

2. Plans activities in PHAST are at a lower side as seen by the indicators. It is strongly recommended that Plan should make a deliberate effort to train HSAs on PHAST and these should train and supervise village health committees in carrying out PHAST activities.

3. Communities must be properly oriented to the Drug Revolving Fund and efforts by Plan must be made to maintain a constant supply.

   Committees dealing with DRF issues must undergo initial training and refresher courses.

4. Looking at the support to emergency obstetric care, low performance especially in transport for TBAs, there must be proper orientation to communities when handing over the bicycles. In some projects for example, those undertaken by UNFPA, Community Committees are chosen which include the VHC members, the village headman, church leaders if present and 1health worker say HSA or Medical Assistant/Community Nurse that frequently visits the community. These would be the overseers of the ambulance bicycles how they are used and maintained.

5. Traditional Birth Attendants and community Based Distribution contraceptive agents must have refresher courses annually. There should be good coordination and collaboration with the District Health Team which will assist in monitoring and supervision of the TBAs and CBDs.

6. Plan must support capacity building for health workers working in health facilities within the Project units so that PMTCT messages can reach the communities in order to sensitize them.

   Plan should consider integrating PMTCT within the existing VCT services which Plan is already supporting.

7. Plan activities to support men in sexual reproductive health as indicated in the project proposal.

In order to improve this situation, there is need to conduct campaigns, civic education at village level on SRH issues, this was expressed by a VHC member during focus group discussion.

Another way of encouraging men's participation in SRH issues is formation of men's clubs where men educate fellow men. Extension workers at community level can facilitate the formation of these clubs.

8. The results of the study show that access to youth friendly health services is good (70%). However, most youths confuse between youth clubs and youth friendly health services. There is need to educate them on the different activities offered by these services.

   All health workers in the 3 PUs should be trained in provision of youth friendly services.

9. Although there is some training for teachers and parents on sexual reproductive issues, there is need to intensify such training so that they are able to deal with challenging issues. The training can go along with the support to schools with different IEC materials and first aid kits.

CHAPTER ONE: BACKGROUND INFORMATION

1.1 INTRODUCTION

The health service delivery system at all levels in Malawi is still far from reaching its 11.3 million people. Currently 65% have no access to such essential services. This situation is worsened by the fact that the Ministry of health, who is the main provider of these services, does not have enough personnel and drugs to meet the needs of the community. Untrained caregivers under unhygienic conditions treat 70% of the community and especially children. Referral of serious conditions are usually done very late or not done at all because of lack of transport and other communication facilities. (**Plan-Malawi Terms of Reference for Mid-Term Evaluation).**

Plan Malawi, realizing its identity as a humanitarian, child-centred community development organization, without religious, political or government affiliation realized the importance of complementing the government's efforts in the delivery of essential health services with a purpose of achieving lasting improvements in the quality of life of deprived children as stated in its Mission statement.

Plan Malawi, started implementing this project using its two health related Country Programme Outlines (CPO) i.e. Community Health and Early Childhood Care and development which deals with health issues affecting children especially under five and women of child bearing age. In the course of the implementation, Plan evaluated its programs and in FY 2006 came up with one CPO for health issues, the Maternal and Child Health. Basically Plan plays a facilitative role in improving the health status of these members of the community. **(Plan-Malawi Terms of Reference for Mid-Term Evaluation).**

The project implementation approach was based on Plan principles that include, child centeredness integration, cooperation, gender equity, environmental sustainability and empowerment and sustainability using participatory methodologies **(Plan-Malawi Terms of Reference for Mid-Term Evaluation).** With this approach, which emphasizes ownership, sustainability was guaranteed.

In practical terms, over the last two years (From August 2003 to August 2005) Plan-Malawi maternal and child health program has worked with its partners, including communities, children, other Plan-Malawi projects domains, government, donors and other health related international organizations to achieve results in the following three key strategic areas: -

- **Under-five issues** that include high child mortality rate due to malaria, acute respiratory infection (ARI) diarrhoea, poor immunization coverage, malnutrition and HIV/AIDS.
- **Maternal health issues** that include high mortality and morbidity rates due to pregnant related complications such as anaemia, infections, emergency obstetric complications and poor antenatal and postnatal care.

- **School and out of school children issues** that include communicable diseases, early and unwanted pregnancies, child abuse, HIV/AIDS, orphan hood, and malnutrition.

1.2 PROJECT IMPLEMENTATION AREAS

The project in Malawi started in August 2003, covering mainly 4 communities in Mzuzu Program Unit. In 2004, it was rolled out to cover the program units of Lilongwe, Kasungu and the remaining communities in Mzuzu. The communities and villages in the program units are as follows: -

LILONGWE PROGRAM UNIT

COMMUNITY	VILLAGE
Sankhani	Mzungu
Mlezi	Mlezi
Chigoneka	Friday
Mwadenje	Mwadenje
Mthyoka	Mphanda
Muzu	Muzu

KASUNGU PROGRAM UNIT

COMMUNITY	VILLAGE
Khungwa	Khungwa
Khungwa	Gunthe
Katsilizika	Katsilizika
Kaongo	Galuwakuda
Mzungunika	Mzungunika
Katsilizika	Zezani
Chinjoka	Sumba
Makhangala	Makhangala
Makhangala	John Ndau
Kaluluma	Mwalimo

MZUZU PROGRAM UNIT

COMMUNITY	VILLAGE
Mlimo	James Chirwa
Kapembelwa	Sambamo Chiumia
Mphimbi	Zungwala Chima Malisawa Kumwenda
Luvwere	Zabron
Kabumba	Alufeyo
Edundu	Kantonga

	Wengani Moyo
Kabwanda	Sinya Mhoni
Zombwe	Esaya Jere Mseghere Kawelani
Ehlekweni	Fuyiwa Soko
Malivenji	Chibisa Chisi Chibula
	Kamweko Chavula

1.3 PROJECT OBJECTIVES

In order to address the key issues the following specific objectives of the project are,

1. To reduce the incidence of malnutrition amongst under -five children to less than 10%.

2 To reach 80% immunization coverage.

3 To ensure that 65% of mothers with under- five children are able to manage diarrhoea with ORT.

4 To ensure that 60% sexual active adults in Plan impact areas have access to modern family planning methods.

5 To reduce the incidence of preventable and communicable diseases in Plan supported communities by ;

To ensure that 80% of families have access to community pharmacies through PHC.

Increase the percentage of families with children less than 3 years who have been using Insecticide Treated Nets to 60%

6 To ensure that 80% of new- born babies have normal weight.

Please note;
The baseline information used to measure success or failure of each objective is based on the CPME baseline information which was done in June 2003.

1.4. KEY STRATEGIES TO ACHIEVE THE PROJECT'S GOAL, PURPOSE AND OBJECTIVES.

The implementation project as stated in the contract document specifies the following strategies: -

UNDER-FIVE ISSUES

Strategies:

- Integrated Management of Childhood Illness (IMCI) for survival, growth and development with more emphasis on Community IMCI through building capacities and supporting communities/mothers, caregivers, TBA, traditional healers and health personnel to respond to issues of under-five.

- Supporting health facilities with logistics to implement CIMCI at health facilities and strengthening out reach services for under-five.

- Working in partnership with other key organizations. E.g. Ministry of Health (MOH), Community Based Organizations (CBO), Population Services International (PSI) and Faith Based Organizations.

- Integrating with other Plan programme domains, Watsan, HIV/AIDS, Learning, Food security etc for effective implementation of a comprehensive child survival programme.

- Documentation and sharing of lessons learnt.

MATERNAL HEALTH ISSUES

Strategy: Safe motherhood through supporting

Family Planning services to prevent mistimed and unwanted pregnancies.

Ante Natal Care to administer iron tablets, Tetanus Toxoid and SP for malaria.

Emergency Obstetrics Care to provide radio messages, ambulances at all levels.

Refresher courses for Traditional birth attendants.

Training and refresher courses for CBDA.

Postnatal care training at community and health facility level.

PMTCT services to community.

Men's participation in SRH issues.

Adolescent SRH education.

IN AND OUT OF SCHOOL CHILDREN/YOUTH ISSUES

Strategies: School Health Promotion and Peer Education

HIV/AIDS interventions through youth clubs and community based organizations dealing with out of school youth issues.

Capacity building of pupils, parents through the school management committees and parents teacher associations to break the culture of silence on issues of sexual and reproductive health

Supporting schools in terms of IEC materials, first aid kits, competition prices etc.

Health education in communicable diseases.

CHAPTER TWO: MID-TERM EVALUATION OBJECTIVES

AIM AND OBJECTIVES

In line with the above terms of reference the following mid-term aim and objectives were developed to conduct the exercise: -

AIM

The aim of the evaluation exercise was to determine the effectiveness of strategies used in implementing the project, timeliness of the project, progress made against set objectives and outputs delivered against outputs planned in-order to provide recommendations that will be fed into the last two years of the project.

OBJECTIVES

1. Assess the effectiveness of Community Integrated Management of Childhood Illness in Plan Malawi programme units in terms of: -

    - Incidence and types of malnutrition amongst under-five children
    - Immunization coverage
    - Management of diarrhoea by mothers using Oral Rehydration Therapy.
    - Insecticide Treated Nets use by families.
    - How accessible Community pharmacies are to families through Primary Health Care.

2. Assess the effectiveness of Safe Motherhood In Plan Malawi programme units in terms of: -

    - Family planning services utilization by families.
    - Antenatal care services utilization by mothers.
    - Support provided to Emergency obstetric care by communities and health facilities.
    - Refresher courses provided to Traditional Birth Attendance (T.B.A.).
    - Community Based Distributor Agents (C.B.D.A.) trained and number of Community Based Distributor Agents undergone refresher courses.
    - Postnatal care services utilization by mothers at Community and health facility level.
    - Centers providing Prevention of Mother to Child Transmission (P.M.T.C.T.) of Human Immunodefiency Virus services.
    - Support to men's participation in Sexual Reproductive Health.
    - Centres providing adolescent Sexual Reproductive Health services.

3. Assess the effectiveness of School Health Promotion activities in Plan Malawi programme units in terms of: -

    - Interventions put in place to avoid the spread of Human Immunodefiency Virus and Acquired Immunodefiency Disease amongst out of school youths.
    - Capacity building of pupils and parents in dealing with sexual and reproductive health issues.

- Implementation of Participatory hygiene and sanitation transformation activities.
- Support given to schools e.g. first aid kits, IEC materials etc
- Exchange visits among the communities.
- Child to child peer education
- School competition

CHAPTER THREE: METHODOLOGY

3.1. APPROACH

The approach of the review exercise focused on coming up with reliable data that will enable Plan Malawi to improve and scale up its activities for effective implementation of the strategies and activities in the last two years.

The steps included the following:

- Developing data collecting tools
- Conducting a sampling exercise
- Training Data Collectors and Pre-testing the data collection tools by conducting a pilot survey
- Making necessary collections on the tools at the base
- Conducting the main data collecting exercise by visiting the sampled population in the project units (PUs)
- Analyzing and interpreting data at the base
- Writing a report

The mid term review describes the situation as it is from two years back to date using both qualitative and quantitative data. The study population included: the community, mothers with under-five children, caretakers, traditional birth attendants, and community based distributing agents, youths, pupils, health workers and other extension workers like teachers, Community Development Assistants etc working in all Plan Malawi program units.

3.2. DATA COLLECTION TECHNIQUES AND TOOLS

Data was collected using the following techniques and tools:

- Separate focus group discussions using small-scale flexible interview guides were conducted with adolescents and community members to ensure participation in the evaluation exercise.
- Observations were done at the health facilities in Mzuzu and Lilongwe program units and under-five and maternal cards were checked.
- Anecdotal data at health facilities, schools and communities were captured using data entry forms.
- Interviews were conducted with mothers/care takers, village health committees, health workers, community leaders and adolescents using interview schedules.
- Literature review was done by reading the Mother and Child proposal, global strategic direction of the health domain (Plan Malawi) and Plan principles, monitoring reports.

3.3. SAMPLE SIZE AND TECHNIQUES

- Probability sampling techniques was used to select the study participants in all the three Plan Malawi programme units. In Lilongwe and Mzuzu programme units six communities were randomly selected and one village was visited in each community while in Kasungu programme unit six villages were visited in respective of the communities. These villages fall in 7 communities

- Systematic sampling technique was used to select a total of 356 mothers with U/5 children (Lilongwe 119, Kasungu 119 and Mzuzu 118) and a total of 165 out of school adolescents in the households (Lilongwe 58, Kasungu 49 and Mzuzu 58).

- Simple random sampling was used to select 167 adolescents in schools in the communities (Kasungu 50, Lilongwe 57 and Mzuzu 60) and, boys and girls were given equal chance of being included in the evaluation.

- Another group of participants were 10 village leaders in each village including village health committee members and Traditional Birth Attendants (TBAs).

Total of 120 participants were included in the evaluation from the following groups:

- Extension workers
- Health workers
- Community workers

3.4. VARIABLES

OBJECTIVES	**INDEPENDENT VARIABLES**	**INDICATORS**
AREA ONE: UNDER- FIVE ISSUES.		**STRATEGY:** COMMUNITY IMCI
1. Assess the effectiveness of community IIMCI	▪ Malnutrition	▪ Incidence of malnutrition amongst Under-five children ▪ Types of malnutrition
	▪ Immunization coverage	▪ Percentage of fully immunized children ▪ Percentage of children immunized up to date

	▪ Management of diarrhoea using oral rehydration therapy	▪ Percentage of women able to manage diarrhoea using oral rehydration therapy
	▪ Use of Insecticide treated nets	▪ Percentage of families using Insecticide treated nets ▪ Percentage of families not using I.T.N.
	▪ Accessibility of community pharmacies through PHC	▪ Percentage of families accessible to community pharmacies ▪ Percentage of families not accessing community pharmacies
AREA TWO: **MATERNAL HEALTH ISSUES**. **STRATEGY: SAFE MOTHERHOOD**		
2. Assess effectiveness of safe motherhood	▪ Utilization of family planning services	▪ Percentage of women utilizing family planning services ▪ Percentage of families not utilizing family planning services
	▪ Utilization of antenatal care of services	▪ Percentage of mothers utilizing antenatal care services ▪ Percentage of mothers not utilizing antenatal care services
	▪ Provision of support to emergency obstetric care	▪ Percentage of facilities with providing support to emergency obstetric care ▪ Types of communication facilities to support emergency obstetric care
	▪ Provision of refresher courses to Traditional birth Attendance	▪ Number of refresher courses provided ▪ Percentage of Traditional Birth Attendance undergone refresher courses ▪ Percentage of Traditional Birth Attendance that have not gone under refresher courses
	▪ Provision of training and refresher course to Community Based Distributor Agents	▪ Number of Community Based Distributor Agents trained ▪ Percentage of trained Community Based Distributor Agents that have undergone refresher courses ▪ Percentage of Community Distributor Agents that have not gone under refresher courses
	▪ Utilization of postnatal care at community and health facility level	▪ Percentage of mothers utilizing postnatal care –at community & health facility level ▪ Percentage of mothers not utilizing postnatal care
	▪ Provision of PMTCT services	▪ Number of centers providing PMTCT services ▪ Number of centers not providing PMTCT services

	▪ Support to men's participation in Sexual Reproductive Health	▪ Number of centers supporting men's participation in sexual reproductive health ▪ Number of centers not supporting men's participation in sexual reproductive health
	▪ Provision of adolescent sexual reproductive health services	▪ Number of centers providing adolescent sexual reproductive health services ▪ Number of centers not providing adolescent sexual reproductive health services
AREA THREE: CHILDREN IN AND OUT OF SCHOOL ISSUES. STRATEGY: SCHOOL HEALTH PROMOTION AND PEER EDUCATION		
3. Assess the effectiveness of school health promotion activities	▪ HIV/AIDS interventions for out of school youth	▪ Number of youth clubs established ▪ Types of activities of the youth clubs ▪ Number of youth friendly health services provided
	▪ Capacity building of: - (pupils, parents through school management committees and Parents and teachers Associations dealing with sexual and reproductive health issues)	▪ Number of trainings conducted for parents on sexual and reproductive health issues ▪ Number of trainings conducted for teachers on sexual and reproductive health issues
	▪ Participatory hygiene and sanitation transformation	▪ Percentage of house holds using pit latrines with either a san-plat or dome slab ▪ Percentage of households accessing safe water ▪ Percentage of households using safe disposal methods of wastes ▪ Percentage of households using hand washing facilities
	▪ Support to schools by the project	▪ Number of schools with Information, Education and Communication materials ▪ Number of schools with first aid kits ▪ Number and types of prizes provided to schools for well kept premises
	▪ Exchange visits facilitated by the project	▪ Number of exchange visits conducted
	▪ Child to child peer education	▪ Number of peer educators trained ▪ Number of child to child peer education conducted
	▪ School competition facilitated by the project	▪ Number of competitions ▪ Type of competitions

3.5. DATA COLLECTION AND PROCESSING EXERCISE

In Mzuzu and Kasungu programme units the exercise took six days from 29th August to 2nd September 2005, while in Lilongwe programme unit the exercise took five days from 29th August to 1st September 2005. **The data collection exercise was participatory in that 87% of the data collectors were people working within the respective program units.** Data was analysed using Statistical Package for Social Scientists version 10 (SPSS).

3.6. LIMITATIONS

- Generally the days that were planned for the exercise were not adequate, and this made the enumerators work over time. This was compounded by the fact that communication to other programme units was not done as such it was very difficult to mobilize the communities. It was also very difficult to recheck the information for internal consistency because the exercises were ending very late in the evenings to carry the rechecking exercise.

- Lack of communication was worse in Lilongwe where out of the six communities only one was informed about the exercise. Focus group discussions with the members of the community were done in four out of the six communities. In one of the selected villages focus group discussions were not done because of a funeral, which occurred on the scheduled day. Similarly Mzuzu programme unit had communication problems to the extent that no focus group discussions were conducted in two villages. One of the villages that were sampled was inaccessible because of bad road; a convenient sampling was then used to select another village.

- Kasungu programme unit had a problem of enumerators. Out of the proposed five enumerators from Kasungu programme unit only three turned up for the exercise this compromised the participatory nature of the evaluation in this programme unit. Very few out of schoolgirls attended the focus group discussions and therefore this lowered the desired sample size for girl participant. Because of lack of communication focus group discussions were done only in some communities.

- The objective on the weight of new- born babies was not assessed because of lack of proper documentations in the facilities and this was compounded by the fact that most of the health facilities have no midwives.

CHAPTER FOUR: FINDINGS

In this chapter the findings of the evaluation exercise are presented and discussed in line with the evaluation objectives and the strategies used by the project addressing how Plan-Malawi faired in the implementation of the project.

OBJECTIVE ONE: Reduce the incidence of malnutrition amongst under five to less than 10%.

1.1 Incidence and types of malnutrition amongst under-five children

1.1.1 Incidence of malnutrition

Analysis of data shows that the incidence of malnutrition is at 6.48%.

1.1.2 Types of malnutrition

Table 1.1: Distribution of types of Malnutrition in the three project units

Project Units	Kwashiorkor				Marasmas			
	No of respondent		Valid %		No of respondent		Valid %	
	Yes	No	Yes	No	Yes	No	Yes	No
Lilongwe	0	119	0	100	1	118	1	99
Kasungu	13	106	11	89	3	116	3	98
Mzuzu	1	116	1	98	5	112	4	95
Total No. of respondents	**14**	**341**			**9**	**346**		
Valid percentage	**4**	**96**			**3**	**97**		

The data on table 1.1 above shows that most of the under-five children assessed had no Kwashiorkor (96%) or Marasmus (97%) However the data above also shows that there were more cases of Kwashiorkor (4%) identified than Marasmus 3%. The data also shows that out of the 14 cases of Kwashiorkor 13 were identified in Kasungu project unit and out of the 9 cases of marasmus 5 were identified in Mzuzu project unit.

OBJECTIVE TWO: To reach 80% immunization coverage.

Table 1.2: Distribution of children in Immunization coverage

Project Units	Percentage fully immunized				Percentage up to date immunized			
	No of respondent		Valid %		No of respondent		Valid %	
	Yes	No	Yes	No	Yes	No	Yes	No
Lilongwe	79	40	66	34	44	75	37	63
Kasungu	74	45	62	38	58	61	49	51
Mzuzu	104	14	88	12	107	11	91	9
Total number of respondents	257	99			209	147		
Valid percentage	72	28			59	41		

The data above shows that most of the children assessed in the three-project units were fully immunized (72%) and most of them immunized up to date (59%) with Mzuzu project unit registering more numbers 104 (88%) and 107(91%) for fully immunized and up to date immunized children respectively.

OBJECTIVE THREE: To ensure that 65% of mothers with under- five children are able to manage diarrhoea with ORT.

Table 1.3: Distribution of women in terms of ability to manage diarrhoea-using ORT

Project Units	No. Of respondents		Valid %	
	Yes	No	Yes	No
Lilongwe	92	27	77.3	22.7
Kasungu	96	23	81.4	18.8
Mzuzu	100	18	84.7	15.3
Total number of respondents	288	68		
Valid percentage	81	19		

The data on table 1.3 above shows that most mothers interviewed (81%) are able to manage diarrhoea using oral rehydration therapy with no marked significant difference among the three project units.

OBJECTIVE FOUR: To reduce the incidence of preventable and communicable diseases (malaria, diarrhoea) in Plan supported communities by ;

Increase the percentage of families with children less than 3 years who have been using Insecticide Treated Nets to 60%

To ensure that 80% of families have access to community pharmacies through PHC.

Insecticide Treated Nets use by families with children under 3 years.

Table 1.4:Percentage of families with under five children using ITNs

Project Units	Percentage families using nets				Percentage families using treated nets			
	No of respondent		Valid %		No of respondent		Valid %	
	Yes	No	Yes	No	Yes	No	Yes	No

Lilongwe	78	41	65.5	34.5	73	46	61.3	38.7
Kasungu	26	93	21.8	78.2	73	89	25.4	74.8
Mzuzu	72	46	61	39	69	49	58.5	42
Total number of respondents	**176**	**180**			**142**	**184**		
Valid percentage	**49**	**51**			**48**	**52**		

The data on table 1.4 above shows that 49% of families with under- five children are using nets. Further more the data shows that of the 176 families using nets 80.68% are using untreated nets.

Participatory Hygiene and Sanitation Transformation

Table 1.5: Sanitation and Hygiene coverage in communities

Name of a Project Area	Percentage of households using latrines				Households using hand washing				Households using safe disposal pit			
	No resp	**No**	**Yes**	**Total**	**No resp**	**No**	**Yes**	**Total**	**No resp**	**No**	**Yes**	**Total**
Kasungu		28	21	49		34	15	49		25	24	49
		17.1%	12.8%	29.9%		20.7%	9.1%	29.9%		15.2%	14.6%	29.9%
Lilongwe		50	7	57		52	5	57		34	23	57
		30.5%	4.3%	34.8%		31.7%	3.0%	34.8%		20.7%	14.0%	34.8%
Mzuzu	1	27	30	58	1	24	33	58	1	40	17	58
	.6%	16.5%	18.3%	35.4%	.6%	14.6%	20.1%	35.4%	.6%	24.4%	10.4%	35.4%
Total number	**1**	**105**	**58**	**164**	**1**	**110**	**53**	**164**	**1**	**99**	**64**	**164**
% of Total	**.6%**	**64.0%**	**35.4%**	**100%**	**.6%**	**67.1%**	**32.3%**	**100%**	**.6%**	**60.4%**	**39%**	**100%**

The data on table 1.5 above shows that most households in the project area don't use pit latrine (35.4%), hand washing facilities (32.3%) and they also don't use safe disposal pits (39%)

How accessible Community pharmacies are to families through Primary Health Care.

Table 1.6: Accessibility of community pharmacy to families through PHC

Project Units	No of respondent			Valid Percentage		
	Yes	**No**	**Undecided**	**Yes**	**No**	**Undecided**
Lilongwe	7	42	9	12.1	72.4	15.5
Kasungu	15	34	0	30.6	69.4	0
Mzuzu	8	2	48	13.8	3.4	82.8
Total number of respondents	**30**	**78**	**57**			
Valid percentage	**18.2**	**47.3**	**34.5**			

The data on table 1.6 above indicates that most families 47.3% are not accessing community pharmacies with 34.5% being not sure of the existence of community pharmacies. The problem being more marked in Lilongwe project unit (72.4%).

OBJECTIVE FIVE: Mothers of child bearing age currently using modern Family planning methods.

Table 2.1:Utilization of family planning services.

Project Units	No of respondent			Valid %		
	Yes	No	Undecided	Yes	No	Undecided
Lilongwe	79	40	0	66.4	33.6	0
Kasungu	41	75	3	34.5	63	2.5
Mzuzu	70	46	2	59.3	39	1.7
Total number of respondents	190	161	5			
Valid percentage	53	45	1			

The data on table 2.1 above shows that most of the mothers (53%) are utilizing family planning services and Kasungu is the least (34.5%) project unit in utilizing family planning services.

Antenatal care services utilization by mothers.

Table 2.2: Utilization of antenatal care services.

Project Units	No of respondent			Valid %		
	Yes	No	Undecided	Yes	No	Undecided
Lilongwe	106	13	0	89.1	10.9	0
Kasungu	98	21	0	82.4	17.6	
Mzuzu	104	12	2	88.1	10.2	1.7
Total number of respondents	308	46	2			
Valid percentage	87	13	1			

The data on table 2.2 above shows that most the mothers interviewed (87%)utilize antenatal services with no significant differences among the project units.

Support provided to Emergency obstetric care by health facilities and communities.

Table 2.3: Support to emergency obstetric care to TBAs.

Project Units	Bicycle			Radio messages			Ambulance		
	Yes	No	Undecided	Yes	No	Undecided	Yes	No	Undecided
Lilongwe	5.2	93.1	1.7	1.7	96.6	1.7	0	98.3	1.7
Kasungu	2	98	0	-	-	-	-	-	-
Mzuzu	5.2	93.1	1.7	1.7	96.6	1.7	0	98.3	1.7
Total number of respondents	12	191	3	3	293	3	0	297	3
Valid percentage	4	95	1	1	98	1	0	99	1

The data on table 2.3 above shows that most TBAs in the three project units are not given adequate support to emergency obstetric care with 95%, 98% and 99% for bicycle, radio messages and ambulance respectively.

Refresher courses provided to Traditional Birth Attendants.

Table 2.4: Traditional Birth Attendants refresher courses

Project Units	Courses			Valid %	Organ
	Trained	Not trained	Yes	No	
Lilongwe	4	2	66.7	33.3	PLAN/MOH
Kasungu	1	5	16.7	83.3	PLAN/MOH
Mzuzu	2	4	33.3	66.7	PLAN/MOH
Total number of respondents	7	11			
Valid percentage	39	61			

The data on table 2.4 above shows that most of the TBAs have never attended a refresher course and TBAs in Kasungu and Mzuzu project units were the mostly affected with 83% and 66% respectively. The few who have attended refresher courses, received the training from either Plan-Malawi or Ministry of Health.

Community Based Distributor Agents trained and or have undergone refresher courses.

Table 2.5: Distribution of CBDA trained or under gone refresher courses

Project Units	Courses		Organ	Valid %	
	Trained	Not trained	Yes	No	
Lilongwe	1	3	25	75	Plan
Kasungu	4	2	33.3	66.7	Plan
Mzuzu	4	2	33.3	66.7	Plan
Total number of respondents	9	7	92	208	
Valid percentage	56	44			

The data on table 2.5 above indicates that 56% were trained 44% were not trained. Almost all the CBDA training in most Plan project units are conducted by Plan with 66.7% for both Kasungu and Mzuzu.

Postnatal care services utilization by mothers at Community and health facility level.

Table 2.6: Distribution of utilization of postnatal care at a health facility level

Project Units	No of respondent		Valid %	
	Yes	No	Yes	No
Lilongwe	2	2	50	50
Kasungu	-	-	-	-
Mzuzu	0	5	0	100
Total number of respondents	2	7		
Valid percentage			25	75

The data on table 2.6 above shows that only 25% of the facilities provide postnatal care. This data also shows that in Kasungu programme unit no health facilities were visited. Number of facilities assessed = 9

Provision of Mother to Child Transmission of Human Immunodefiency Virus services.

Table 2.7: Distribution of centers providing PMTCT services

Project Units	No of respondent		Valid %	
	Yes	No	Yes	No
Lilongwe	2	2	50	50
Kasungu	-	-	-	-
Mzuzu	1	4	20	80
Total number of respondents	3	6		
Valid percentage			33.3	66.7

The data above shows that only 33.3% of the facilities provide PMTCT services. No health facilities were assessed in Kasungu programme unit because the communities, which were sampled, have no health facilities within 10 kilometers as required by government in the name of the Ministry of health. On average facilities are around 18 Kilometers away, so the communities sampled are normally not served by these facilities.
Number of facilities assessed = 9.

Support to men's participation in Sexual Reproductive Health.

Table 2.8: Support to men's participation in SRH issues

Project Units	No of respondent			Valid %		
	Yes	No	Undecided	Yes	No	Undecided

Lilongwe	6	52		10	90	
Kasungu	7	42		14	86	
Mzuzu	5	52	1	9	90	1.7
Total number of respondents	**of18**	**146**	**1**			
Valid percentage	**11**	**88**	**1**			

The data on table 2.8 above indicates that most communities (88%) do not support men's participation in sexual and reproductive health issues, with Lilongwe and Mzuzu at 90% respectively.

Centres providing adolescent Sexual and Reproductive Health services.

Table 2.9: Distribution of centers providing adolescent SRH services

Project Units	**No of respondent**		**Valid %**	
	Yes	**No**	**Yes**	**No**
Lilongwe	3	1	75	25
Kasungu	3	1	75	25
Mzuzu	3	2	60	40
Total number of respondents	**9**	**4**		
Valid percentage	**70**	**30**		

The data above shows that most of the centers (70%)provide adolescent reproductive health services.

In addition the effectiveness of School Health Promotion activities in Plan Malawi projects units was also assessed as it is one of the components the grant is supporting:

3.1 Interventions put in place to avoid the spread of Human Immunodefiency Virus and Acquired Immunodefiency Disease amongst out of school youths.

Table 3.1: Distribution of responses on HIV and AIDS interventions for out of school youth through youth clubs and youth friendly health services

Project Units	**Youth clubs**				**Youth Friendly health services**			
	No of resp		**Valid%**		**No respondent**		**ofValid %**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**

Lilongwe	44	14	27.7	8.5	32	26	55.1	44.8
Kasungu	11	38	6.7	23	3	46	6.1	93.9
Mzuzu	43	15	26.1	9.1	31	27	53	47
Total number of respondents	**98**	**67**	**59.4**	**40.6**	**66**	**99**		
Valid percentage							**38**	**62**

The data on table 3.1 above indicates that in most communities (59.4%)within the project units have active youth clubs for out of school youths however the health services in most of these communities (62%) are not youth friendly. (See annexes 4(a) to 4(e).

3.2 Capacity building for parents and teachers in dealing with sexual and reproductive health issues.

Table 3.2: Distribution of trainings conducted for parents and teachers

Project Units	**Training conducted for parents**				**Training conducted for teachers**			
	No of respondent		**Valid %**		**No respondent**		**ofValid %**	
	Yes	No	Yes	No	Yes	No	Yes	No
Lilongwe	2	54	3.6	96.4	7	49	12.5	87.5
Kasungu	6	44	12	88	5	45	90	10
Mzuzu	4	56	6.7	93.3	5	55	8.3	92
Total number respondents	**of12**	**154**			**10**	**149**		
Valid percentage			**7**	**93**			**37**	**63**

The data on table 3.4 above indicates that most of the parents (93%) and teachers (63%)are not trained in issues of sexual and reproductive health with the highest percentage in Lilongwe (49%)and Mzuzu (55%).

3.3 Implementation o/f Participatory hygiene and sanitation transformation.

Table 3.3: Distribution of responses in the implementation of Participatory hygiene and sanitation transformation

Name of a Project Area	**Percentage of households using latrines**				**Households using hand washing**				**Households using safe disposal of waste**			
	No resp	**No**	**Yes**	**Total**	**No resp**	**No**	**Yes**	**Total**	**No resp**	**No**	**Yes**	**Total**

Kasungu		28	21	49		34	15	49		25	24	49
		17.1%	12.8%	29.9%		20.7%	9.1%	29.9%		15.2%	14.6%	29.9%
Lilongwe		50	7	57		52	5	57		34	23	57
		30.5%	4.3%	34.8%		31.7%	3.0%	34.8%		20.7%	14.0%	34.8%
Mzuzu	1	27	30	58	1	24	33	58	1	40	17	58
	.6%	16.5%	18.3%	35.4%	.6%	14.6%	20.1%	35.4%	.6%	24.4%	10.4%	35.4%
Total number	**1**	**105**	**58**	**164**	**1**	**110**	**53**	**164**	**1**	**99**	**64**	**164**
% Of Total	**.6%**	**64.0%**	**35.4%**	**100%**	**.6%**	**67.1%**	**32.3%**	**100%**	**.6%**	**60.4%**	**39%**	**100%**

The data on table 3.3 indicates that most of the households (64%) do not use pit latrine, with Lilongwe project unit being the highest percentage of 30.5%, 67.1% do not use hand-washing facilities after using a pit latrine with again Lilongwe at 31.7% and 99% do not use safe disposal methods of waste with Mzuzu programme unit being the highest at 24.4%.

3.4 Provision of Support to schools

Table 3.4: **Distribution of responses in relation to Support to schools**

Name of a Project Area	**First aid kits**				**IEC Materials**			**Prizes**		
	No	**Yes**	**No resp**	**Total**	**No**	**Yes**	**Total**	**No**	**Yes**	**Total**
Kasungu	49	1		50	46	4	50	17	33	50
Lilongwe	51	5		56	48	8	56	10	47	57
Mzuzu	58	2	1	60	56	5	61	17	43	60
Total number of responses	**158**	**8**	**1**	**167**	**150**	**17**	**167**	**44**	**123**	**167**
Valid percentage	**94.6%**	**4.8%**	**0.6%**	**100%**	**89.8%**	**10.2%**	**100%**	**26.3%**	**73.7**	**100%**

The data on table 3.4 above shows that most of the schools are not supported in terms of first aid kits (94.6%), IEC materials (89.8%). However the data indicates favorable responses (73.7%) in terms of support of prizes given to schools.

3.5 Exchange visits.

Table 3.5: Distribution of responses in terms of support to exchange Visits

Name of a Project Area	**Number of responses**			
	No resp	**No**	**Yes**	**Total**
Kasungu		15	35	50
Lilongwe		10	46	56
Mzuzu	1	29	31	61
Total number of responses	**1**	**54**	**112**	**167**
Valid percentage	**0.6%**	**32.3%**	**67.1**	**100%**

The data above indicates that most of the schools (67.1%)are supported in terms of exchange visits to other schools.

3.6 Child to child peer education

Table 3.6: Distribution of responses as regards to Child to child peer education

Name of Project Area	Number of responses		
	No	Yes	Total
Kasungu	9	41	50
	5.4%	24.67%	29.9%
Lilongwe	8	48	56
	4.8%	28.7%	33.5%
Mzuzu	6	55	61
	3.6%	33.9%	36.5%
Total responses	23	144	167
Valid percentage	**13.8%**	**86.2%**	**100.0%**

The data above shows that in most schools (86.2%) in the programme units have child-to-child peer education activities.

3.7 School competitions

Table 3.7: Distribution of responses in terms of School competitions

Name of Project Area	Number of responses		
	No	Yes	Total
Kasungu	4	46	50
	2.4%	27.7%	30.1%
Lilongwe	5	51	56
	3.0%	30.7%	33.7%
Mzuzu	9	51	60
	5.4%	30.7%	36.1%
Total number of schools with kits	**18**	**148**	**166**
Total %	**10.8%**	**89.2%**	**100.0%**

The data on table 3.7 above indicates that most schools (89.2%) in the project units have active sporting competitions with no significant differences among the project units. Further analysis of data shows that Plan Malawi provides support in the way of giving prizes to the winning teams.

CHAPTER FIVE: DISCUSSION

5.1 UNDERFIVE ISSUES

5.1.0 COMMUNITY INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

Community IMCI is a strategy that is used to deal with issues of under five in a holistic manner. Trainers of trainers were trained on the 17 family key care practices as components of Community-based Integrated Management of Childhood Illnesses and these later trained Extension workers from different government departments such as agriculture, health, community development, and social welfare the communities where we are implementing the project. This was followed by a training/orientation of Community Owned Resource Persons (CORP's) on the same. The product of such training is a prioritized community IMCI Plan of action which the community implements with support from Plan and other extension workers. Communities conduct participatory monitoring with or without Plan as agreed during the development of the Plans of action.

5.1.1 MALNUTRITION

In the proposal Health volunteers were to identify malnourished children and provide supplementary feeding within the community. Home craft workers were to be recruited by the project to supervise mothers and conduct supplementary feeding. A community based nutritional health rehabilitation strategy was to be used for example the project had to construct a nutrition rehabilitation unit at Nkhamenya Mission Hospital in Kasungu PU. The incidence of malnutrition has increased by 0.43% as shown in the analysis of the results on table 1.1. **This increase is due to the current hunger situation. Other contributing factors are the absence of both supplementary foods and home craft workers who were supposed to supervise mothers and conduct supplementary feeding at community level.**

5.1.2 IMMUNISATION

Plan Malawi in collaboration with district health facilities and UNICEF was to organise campaign to ensure that all children under five years receive immunisation on time. The project was also to support the provision of health cards to families to monitor immunisation. The coverage of immunization in the project units has been very successful as evidenced by the results on table 1.2. Although the results are indicating coverage of 72% (fully immunized) it is anticipated that by the end of the remaining three years the 59% update will be fully immunized and therefore the target of 80% will be achieved before the end of the project. **This success is due to the immunization campaign, which was conducted during the health week of 2004 and active community participation through the involvement of community volunteers during the campaign and as an ongoing activity in the communities.**

5.1.3 DIARRHOEA MANAGEMENT

The project had planned to train extension workers in turn to train mothers on early identification of childhood illnesses, home management and prevention of diarrhoea. Transmission of messages on diarrhoea management at household has been very successful as evidenced by the numbers of mothers (81%) in all the programme units who are able to manage diarrhoea at home using ORT. The

percentage attained is well above the targeted percentage of 65% with Mzuzu programme unit having achieved 87.4%. (See table 1.3) **This success is due to the training of extension workers who in turn imparted this knowledge to mothers in the communities. Another contributing factor is the provision of logistical support such as medicines including ORS and other consumables to health facilities and as part of the DRF.**

5.1.4 MALARIA PREVENTION

To intensify efforts in Malaria prevention, Plan was to promote the use of treated bed nets and use of rapid testing at community level. Retreatment of the nets was to be managed through a drug revolving fund organized and managed by communities but facilitated by Plan. Data on table 1.4 shows that families with under five children are using nets. This is shown by the present 49% after two (2) years of project implementation. **This is a success but there is need for much more effort if the project has to meet the 60% target in the remaining two years that it set. This success is due to availability of bed nets at community level provided by the project through trained DRF committees. This slow pace in achieving the set goals is due to lack of money by most community members because of hunger. It is also noted here that out of this number of people using nets 80.68% are using untreated bed nets.**

5.1.5 PARTICIPATORY HYGIENE AND SANITATION TRANSFORMATION (PHAST)

According to planned activities, the project had to build capacity of five communities to respond to water and sanitation issues in their communities. Extension workers from departments of Health, Agriculture, Water, Gender, Child and Community Services and Education were to be trained in PHAST methodology to provide support and monitor hygiene and sanitation activities in their respective communities.

From the results on table 1.5 only 35.4% of all households visited use pit latrines without concrete slab (dome slab or san plat). Some communities in Kasungu had casted some sanplats but had not yet installed them. Most of these casted sanplats were too small in size and had cracks and not fit to be installed on pit latrines.

On the other hand 32.3% of households were recorded to be using hand-washing facilities and 39% were using safe disposal methods of refuse. All these indicators are at a lower side. This may be due to lack of participatory methodologies when introducing these activities to the communities which might lead to lack of interest by the community on project activities.

Most communities still lack wholesome water and they have either to travel long distances or go to rivers to find water.

5.1.6 COMMUNITY PHARMANCIES

The project had planned to establish and revive DRF in all project units. It also planned to support fourteen (14) DRF with training and the initial drug supplies. The data on table 1.6 as shown in this survey indicate 48% have no access to community pharmacies. R**easons given range from not being aware of their existence to lack of supplies in the existing DRF and the fact that the project started DRFs in 2005**

5.1.7 CAPACITY BUILDING TO MOTHERS ON MANAGEMENT OF CHILDHOOD ILLNESSES

Plan –Malawi was to train women in nutrition, early identification of childhood illnesses, home management and prevention of malaria, diarrhoea and acute respiratory infections (ARI).
Further analysis of the evaluation results reveal that only 34% of women were trained in the above issues.
Project reports indicate that training of caregivers was conducted in 4 communities in Mzuzu PU, 3 of which were among the sampled communities.

5.1.8 REASONS FOR ACHIEVING IN CIMCI

Engaging a CIMCI specialist to initiate the process and train the initial extension workers on the 17 family key care practices has contributed to the success. In addition Plan Malawi included a component of orienting the community resource persons on the same using the trained extension workers working in the project area. This was followed by community dialogue which is different from conventional IEC. The prioritized plans of action were written in the vernacular language for easy implementation and monitoring by the communities.
Plan responded to the plans of action and this encouraged the communities to do more and better.
Participatory monitoring has also contributed to achieving the results.
Working in partnership with the government partners all the way from the project inception to date has also created a good working relationship between Plan and the government partners. This has assured ownership and sustainability.
Exchange visits has also improve project implementation amongst implementing communities.

5.2. MATERNAL HEALTH ISSUES

5.2.0 SAFE MOTHER HOOD

5.2.1 FAMILY PLANNING

Plan-Malawi has been involved in training and providing resources to CBDAs in order to improve access to family planning services. IEC materials were provided at community level. Support was also given to CBDAs and their supervisors in form of bicycles to ease transport problems.
Coordination and collaboration with Family Planning Association, Programme for Appropriate Technology in Health (PATH), district Safe motherhood and family planning coordinators was to be emphasized. One campaign was to be conducted in Kasungu PU to sensitize men and relatives on issues of reproductive health. Fifty CBDAs in Mzuzu, Kasungu and Lilongwe were to be trained.
Results on table 2.1 show that most of the families in the project units are actively utilizing modern family planning methods, with the aim of delaying pregnancy for at least two years. The rate of utilization was assessed at 53.4% and it is positively anticipated that at the end of the project a 60% target will be achieved.
The positive indicators to this achievement might include involvement of active trained CBDAs as evidenced in table 2.5 (56% trained), who are providing family planning methods in the community.

It is expected that the use of modern family planning methods will not only increase in the mothers not wishing to have children in the next two years but also in the adolescents.

5.2.2 ANTENATAL CARE

Plan was to support health facilities with logistics to give immunizations to pregnant mothers and to administer antimalarials, and iron tablets during antenatal visits. Plan was also to encourage TBAs to inform expecting mothers about the need for Tetanus vaccination.
TBAs were to be supplied with iron tablets which they were to distribute to expecting mothers to ensure that pregnant women receive supplementary iron for at least three months.

The data on table 2.2 shows that most mothers interviewed, 87% utilize antenatal services with no significant differences amongst the project units.
Mothers have access to drugs for malaria prophylaxis and iron tablets during antenatal period in all the three PUs.

5.2.3 SUPPORT TO EMERGENCY OBSTETRIC CARE:

TBAs were to have delivery shelters improved and latrines constructed in their locations. Bush ambulances (bicycle trailers) were to be provided in order to facilitate referral of complicated cases. Emphasis was to be placed on capacity building of TBAs to identify cases that were to be referred to hospital for specialized care.

Results on table 2.3 show that most of the TBAs in the project units are not provided with adequate support to emergency care with 95%, 98%, and 99% for bicycle, radio messages and ambulances respectively.

From focus group discussions it was revealed that some village headmen received the bicycle ambulances and kept them for personal use, which made it difficult for TBAs to use when they needed them. Some TBAs further hire oxcarts whenever they have an obstetric emergency. This might be due to delivering the bicycles direct to the chief in the absence of the people who will be using the equipment or lack of orientation of communities on intended purpose for the bicycles.
Further more, most TBAs visited, lack proper delivery shelters with dilapidated or no toilets at all. They also lack safe water supply. Some TBAs travel for several kilometers to find water.

5.2.4 TBA TRAINING AND RFRESHER COURSES

Efforts to promote safe delivery at all levels especially at community level where TBAs are working were to be supported by Plan through training and refresher courses in safe motherhood. One refresher course was to be conducted in Mzuzu where 30 TBAs were targeted.

From the results shown on table 2.4, only 39% of the TBAs interviewed in all PUs, had received initial training and refresher courses. This percentage is low in relation to both the set target and the big task that these TBAs are doing in

assisting safe delivery of mothers at remote community level. What is commendable however is the fact that all these courses were offered by Plan and Ministry of Health.

5.2.5 POSTNATAL CARE SRVICES

From the evaluation findings, see table 2.6, most communities are not utilizing postnatal care services. Out of the nine health facilities that were assessed only 25% provided the service. This is attributed to lack of knowledge on the importance of postnatal care by both health workers and the communities. Another reason might be shortage of staff and long walking distances to health facilities

5.2.6 PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)

Provision of PMTCT services by health facilities in the programme units, which is at 35%, according to results on table 2.7 is very low. This is due to the fact that in most facilities the health workers in these facilities are not trained in the provision of PMTCT. Again this is attributed to lack of personnel in general. The percentage is what would be expected, as PMTCT is a new phenomenon in this country.

5.2.7 SUPPORT TO MENS PARTICIPATION IN SEXUAL REPRODUCTIVE HEALTH

Although Plan proposed to support men in SRH issues, there were no planned activities to achieve this. From the results of this study, which are on table 2.8, only 11% of the respondents said have activities in place that support men's participation in SRH. **The main reason being traditional beliefs and lack of woman empowerment in openly discussing SRH issues with their husbands and also lack of knowledge on the importance of men's participation in SRH issues.**

5.2.8 ADOLESCENT SEXUAL REPRODUCTIVE HEALTH

Counseling and family planning services were to be provided to the adolescents by the project. Use of condoms was to be promoted amongst youths in both pupils and out of school youths.
Health personnel at health facilities were to be trained on provision of youth friendly health services to increase the number of youths accessing counseling and treatment of STIs.

Results from this study seen on table 2.9, show that 70% access youth friendly health services in the health facility in all PUs. Though this is a positive achievement, most youth were unable to differentiate between youth clubs and youth friendly services as observed through the focus group discussion.

5.3 PUPILS AND OUT OF SCHOOL YOUTHS ISSUES

5.3.0 SCHOOL HEALTH PROMOTION

5.3.1 HIV/AIDS INTERVENTION FOR OUT OF SCHOOL YOUTHS

Plan Malawi through its project was to emphasize activities that could reduce the further spread of HIV amongst young people.
Life skills training for young people between 10 and 18 years of age was therefore a central component of the project.
In order to reduce boredom and divert young people's minds from thinking of indulging into casual sexual acts. Youth committees were to be formed to train in sports and recreation activities such as dancing, football and netball.
Health personnel at health facilities were to be trained to provide youth friendly services that would encourage young people to access counseling and treatment for STIs. The project was to encourage coordination and collaboration with government and mission facilities to complement these efforts.

The formation of youth clubs for the purpose of creating HIV and AIDS intervention activities at this stage of the project is, in most communities, in the right direction, which is at 59.4% see table 3.1. What these youth clubs are lacking is financial and material support for the implementation of their activities. On this same table, unlike youth clubs, youth friendly services are at lower side (38%). This is due to shortage and negative attitude of health workers towards provision of youth friendly services

5.3.2 CAPACITY BUILDING OF PARENTS AND TEACHERS

Capacity building was to be administered for parents and teachers in dealing with sexual and reproductive health issues. **From results on table 3.2, the training conducted for parents in all the project units is at 7% while training conducted for teachers is at 37%. Since most of the parents and teachers are not trained in issues of sexual and reproductive health, they may not be expected to deal with challenging issues of SRH as may be expected.**

5.3.3 SUPPORT TO SCHOOLS

Plan was to support activities in school health promotion in terms of first aid kits and IEC materials**. Most of the schools in the project units are not supported in terms of First aid kit**. **As seen in the results on table 3.3, which is at 4.8%, IEC materials, which is at 10.2%. The support to schools in terms of IEC materials is very crucial because this can go along way in improving the standard of education in the country and this will in turn promote school health and in turn have better mothers and fathers in the future.**

5.3.4 EXCHANGE VISITS

Although there are no set targets in the implementation of this strategy, the trait revealed by this evaluation is that the schools in the program units are well supported in terms of child-to-child peer education activities (86.2%), school competitions (89.2%), giving of prizes (73.7%) and exchange visits (67.1%).

Although there were no specific targets to be achieved by the end of the project but the findings indicate that the implementation of this strategy in terms of the issues stated above is in the right direction.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.1. CONCLUSIONS

Looking at the findings of the evaluation and the lessons learnt in terms of strengths and weaknesses in the effectiveness of the strategies used; **generally the performance of the project is lagging behind the timeframe.** The following conclusions are therefore presented: -

STRATEGY: Community Integrated Management of Childhood Illness

- This strategy, at this stage of the project, has been effective because out of the five objectives which relate to this strategy, three have been so far successfully implemented i.e. immunization coverage, number of mothers able to treat

diarrhea at home using ORS, incidence of malnutrition among the under fives. Those that were not successfully implemented are, utilization of ITN, access to community pharmacies and monitoring of the weight of newborn babies.

Mzuzu project unit is doing well followed by Lilongwe and Kasungu being the least.

STRATEGY: SAFE MOTHER HOOD

- Safe mother hood as a strategy at this stage of the project has not been effective because out of the seven components only one has so far been successfully implemented i.e. utilization of family planning services. Those that were not successfully implemented include support to emergency obstetric care, TBA and CBDA training, utilization of postnatal care services, provision of PMTCT services and antenatal care.

  Lilongwe project unit is performing well followed by Mzuzu and Kasungu being the least.

STRATEGY: PROMOTION OF SCHOOL HEALTH

- Out of the five specific sub-areas that were planned only one area has so far been successfully implemented**.** This indicates that school health promotion, as a strategy at this stage of the project has not been effective.

  Lilongwe Project Unit is performing well followed by Mzuzu PU and Kasungu PU being the least.

Being a mid-term review, the project is on track. The Project objectives will be achieved by the end of the project as long as the recommendations made by the team are considered and implemented.

6.2 RECOMMENDATIONS

General Recommendations

It is therefore recommended that safe mother hood and promotion of school health strategies require more emphasis. The issues raised above complement each other; failure in one will lead to failure in other areas even those that have been successfully implemented at this stage of the project.

To effectively use these strategies and achieve the set targets the strategies require a proper strategic planning with clearly defined planned activities and approaches and persons responsible to carry out those activities at all levels.

In the Mother and Child health proposal, there is a proposal by Plan to contract Community Health nurses and Homecraft workers who would work with mothers in the communities.

For the successful implementation and supervision of the project at community level, it is recommended that these workers should be contracted. These workers will supplement each others efforts in trying to reduce malnutrition in the children and other family key practices in community IMCI which are moving at a very slow pace in achieving the project objectives.

Specific Recommendations

10. Community dialogue and conventional IEC must be strengthened in the use of ITNs. Communities must be guided in their priorities since the nets are already subsidized. Frequent dipping of nets in insecticides should be done at every 6 months. Committees at village level e.g. the village health/ITN committee should be empowered to conduct such campaign.

11. Plans activities in PHAST are at a lower side as seen by the indicators. It is strongly recommended that Plan should make a deliberate effort to build the capacity of HSAs in PHAST and these should train and supervise village health committees in carrying out PHAST activities.

12. Communities must be properly oriented to the Drug Revolving Fund and efforts by Plan must be made to maintain a constant supply.

    Committees dealing with DRF issues must undergo initial training and refresher courses.

13. Looking at the support to emergency obstetric care, low performance especially in transport for TBAs, there must be proper orientation to communities when handing over the bicycles. In some projects for example, those undertaken by UNFPA, Community Committees are chosen which include the VHC members, the village headman, church leaders if present and 1health worker say HSA or Medical Assistant/Community Nurse that frequently visits the community. These would be the overseers of the ambulance bicycles how they are used and maintained.

14. Traditional Birth Attendants and community Based Distribution contraceptive agents must have refresher courses annually. There should be good coordination and collaboration with the District Health Team which will assist in monitoring and supervision of the TBAs and CBDs.

15. Plan must support capacity building for health workers working in health facilities within the Project units so that PMTCT messages can reach the communities in order to sensitize them.

    Plan should consider integrating PMTCT within the existing VCT services which Plan is already supporting.

16. Plan activities to support men in sexual reproductive health as indicated in the project proposal.

In order to improve this situation, there is need to conduct campaigns, civic education at village level on SRH issues, this was expressed by a VHC member during focus group discussion.

Another way of encouraging men's participation in SRH issues is formation of men's clubs where men educate fellow men. Extension workers at community level can facilitate the formation of these clubs.

17. The results of the study show that access to youth friendly health services is good (70%). However, most youths confuse between youth clubs and youth friendly health services. There is need to educate them on the different activities offered by these services.

    All health workers in the 3 PUs should be trained in provision of youth friendly services.

18. Although there is some training for teachers and parents on sexual reproductive issues, there is need to intensify such training so that they are able to deal with challenging issues. The training can go along with the support to schools with different IEC materials and first aid kits.

LILONGWE PU **Annex 1 (a)**

SUPPORT TO EMERGENCY OBSTETRIC CARE

NAME OF COMMUNITY	ACTION TAKEN DURING EMERGENCY OF OBSTETRIC	MODE OF TRANSPORT	WHO ELSE USES THIS TRANSPORT	PROVIDER OF TRANSPORT	MODE OF COMMUNICATION DURING EMERGENCY OBSTETRIC	PROVIDER OF MODE OF COMMUNICATION	NO. OF MODE OF COMMUNICATION	FUNCTIONAL MODE	NON FUNCTIONAL MODE	COMMENT
Sankhani Mzungu (LL/01/01)	Patient is taken to TBA then Hospital	❑ Oxcart ❑ Wheelbarrows ❑ Bicycle	❑ Farm produce ❑ Other illnesses	Hired in the village	❑ Radio messages ❑ Telephone	Ministry of Health	2	1 Radio Message	1	Need for more outreach clinics
Mlezi, Mlezi Village (LL/02/01)	Patient is taken to intended Health Center	❑ Bicycles ❑ Oxcart	❑ Used to send messages for meetings ❑ Other illnesses	❑ Bicycle - PLAN	Radio message	Ministry of Health	1	1	1	Mbadzi Health Centre has no maternity therefore the community would like to have it since it is close
Muzu (Muzu Village) (LL/03/01)	Patient is taken to TBA then to Hospital (Bottom)	❑ Bicycle Ambulance ❑ Bicycle	Other illness	PLAN	None	None	None	None	None	None
Mwadenje (Mwadenje village) (LL/04/01)	Patient is referred to hospital	❑ Oxcart ❑ Ordinary vehicle ❑ Bicycle	❑ Farm produce ❑ Other goods	Hired on a rank or community	Radio message Telephone	Ministry of Health	2	1	1	❑ The ambulance cover for 7 health centers ❑ Health Centre was promised a VCT center by PLAN

KASUNGU PU **Annex 1 (b)**

FGD FOR PROVISION OF SUPPORT FOR EMERGENCY OBSTETRIC CARE

NAME OF COMMUNITY	ACTION TAKEN DURING EMERGENCY OF OBSTETRIC	MODE OT TRANSPORT	WHO ELSE USES THE TRANSPORT	PROVIDER OF TRANSPORT	MODE OF COMMUNICATION DURING OBSTETRIC EMERGENCY	PROVIDER OF MODE OF COMMUNICATION	NO. OF MODE OF COMMUNICATIO N	FUNCTIONAL MODE	NON FUNCTIONAL MODE	COMMENT
Mankhangala	Take the patient to the hospital	Ox-cart	Transporters of farm inputs	People hire themselves	No mode of communication	No body	Zero	None	None	No safe water for TBAs PLWHs require VCT and ARVs at Kaluluma Health Centre
Zezani	Take the patient to Kaluluma Health Centre	❑ Bicycle Ambulance from TBA ❑ Ox-cart	Nobody for Bicycle Ambulance	Plan Malawi	NO mode of communication	N/A	Zero	N/A	N/A	Comment the support from PLAN Malawi Progrmme
Khungwa	Take the patient to Health Centre	❑ Ox-cart ❑ Bicycles ❑ Vehicles	Villagers taking farm produce to the market	Villagers themselves hire transport	No mode of communication	N/A	Zero	N/A	N/A	Hospital far away from community
Galuwakuda	Take the patient to office Health Centre	❑ Ox-cart ❑ Bicycles	Villagers	Villagers hire themselves	No mode of communication N/A	N/A	Zero	N/A	N/A	Nets should be made available when people harvest crops
John Ndau	Take a patient to Kaluluma Health Centre	Hired or (public transport	Villagers	Village hire the vehicles	No mode of communication	N/A	Zero	N/A	N/A	TBAs require refresher course. Nets price should be reduced for expectant mothers
Mwalilino	Take the patient to Kaluluma Health Centre	Hired a public transport	Villagers	Villager hire the vehicles	No mode of Communication	N/A	Zero	N/A	N/A	No safe water for TBAs. Hospital far from community. CBDAs require more drugs and refresher course

Annex 1 (c)

MZUZU PU

PROVISION OF SUPPORT TO EMERGENCY OBSTETRIC CARE

ZPU	1	2	3	4	5	6	7	8
MZ1	Take	Oxcart	Patient with	Community	Radio	Ministry of health	2 radio	1

	patient to hospital/health centre	Wheelbarrow Improvised stretcher	diarrhoea Patient with pneumonia Patient with any serious illness		message Telephone		messages	
MZ2	Taken to TBA Taken to Health Centre	❑ Wheel barrow ❑ Oxcart ❑ Stretcher	Bone Diarrhoea Malaria Very sick patient	❑ Plan ❑ Any kind of person	None	Nil	Nil	Nil
MZ3	❑ TBA ❑ Hospital	❑ Push bike ❑ Oxcart ❑ Wheel barrow	Any serious illness	Hiring from the members of the community	Sending a person to Ekwendeni Use of radio	Community for bikes Ministry of Health (RM)	4	All
MZ4	Taking to Health Centre/hospital	Bicycle ambulance Wheelbarrow Ox-cart Ambulance	Diarrhoea Premove Other emergencies	BA plan Community wheelbarrow/oxcart) Ministry of Health (Mz hospital)	Simply sending somebody to Ekwendeni	Nil	Nil	Nil
MZ5	❑ Call Ambulance from Ekwendeni ❑ Taking patient to TBA	❑ Ox-cart ❑ Improvised stretcher ❑ wheelbarrow	❑ Serious illnesses ❑ Diarrhoea ❑ pneumonia	Ox-cart by community Plan - oxcart Hiring by relatives	Sending somebody to get ambulance from Ekwendeni	Community	Nil	Nil
MZ6	Take patient to TBA Take patient to hospital	Wheelbarrow Oxcart Ambulance	Serious illnesses	❑ Ox-cart/wheelbarrow community ❑ Ekwendeni hospital through hiring	❑ Push bike ❑ Radio messages	❑ Community ❑ Ministry of Health	4 ox-cart/wheelbarrow and radio message	All

MZUZU PU

EMERGENCY OBSTETRIC CARE (EOC) SUMMARY **Annex 1 (d)**

REP. EOC	#	MOT	#	OTHERS USING MOT	#	PROVIDER OF TRANSPORT	#	OTHER MOC	#	PROVIDER OF MOC	#	NO. OF MOC	#	NO. OF COM/UNITY FUNCTIONING	#	NO. OF COMMUNITY NOT FUNCTIONING	#
Patient taken to:		❑ Wheel	1			❑ Communi	41	❑ Radio	3	Ministry of Health	3	Both	2	One - 3		One - 3	

❑ TBA ❑ Helath Centre ❑ Hospital	2 1 1	barrow ❑ Oxcart ❑ Bicycle Ambulance ❑ Hired vehicle ❑ Ambulance ❑ Bicycle	3 1 1 0 4			ty ❑ PLAN ❑ Hired from the rank	1	message ❑ Telephone	2	None	1	One	1				

PROVISION OF SUPPORT TO EMERGENCY OBSTETRIC CARE **Annex 1 (e)**

MZPU SUMMARY

1	%	2	%	3	%	4	%	5		6	7
❑ Take to hospital ❑ Take to health centre ❑ Take to		❑ Wheelbarrow ❑ Ox-cart ❑ Improvised stretcher ❑ Bicycle		❑ Community ❑ PLAN ❑ Some any kind of person ❑ Hiring personal		❑ Radio messages ❑ Sending somebody ❑ Telephone		❑ Ministry of Health ❑ Community		2 (MZ1) 6 (MZ26) 4 (MZ3)	1 All All

TBA		ambulance ❑ Ambulance		❑ Ministry of Health							

LILONGWE PU **Annex 2 (a)**

COMMUNITY BASED CHILD CARE CENTRES

NAME OF THE COMMUNITY	CARE GIVEN TO ORPHANS	ORPHANAGE	SUPPORT GIVEN TO ORPHANS	PROVIDER OF SUPPORT	SUPPORT GIVEN IN ADDITION TO FOOD	COMMENT
Sankhani (Mzungu)	PLAN helps a few for school fees	No orphan care/center	One donated clothes PLAN - school fees	PLAN Malawi	Fees	Nil
Mlezi (Mlezi village)	No any assistance is given	No care centers established	Maize flour Nursery	❑ HBC - Lilongwe Diocese ❑ Family church	Clothes	Community needs fertilizer loans
Muzu (Muzu village)	No any care by the community	HBC group meets the orphans and people living with HIV/AIDS	❑ Maize flower ❑ Beans ❑ Cooking oil	❑ Lilongwe Diocese the Catholic Church	None	None
Mwadenje (Mwadenje)	No any care by the community	Farmers club that has a	❑ Feeding the orphans	Community contributes monthly	Fertilizers from PLAN	❑ Social welfare has

		nursery school	with Likuni Phala	(no any organization)		❑ just donated bicycle ambulance ❑ Community would like to deal with HIV/AIDS discussions

KASUNGU PU **Annex 2 (b)**

COMMUNITY BASED CHILD CARE CENTRE

NAME OF COMMUNITY	CARE GIVEN TO ORPHANS	ORPHANAGE	SUPPORT GIVEN TO ORPHANS	PROVIDER OF SUPPORT	SUPPORT GIVEN IN ADDITION TO FOOD	COMMENT
Mankhangala	"Ndamindira" orphan organization help the orphans	No orphanage center	Soap Food Gardening Home cleaning	No organization, villagers contribute to the orphan support	Cleaning the houses for orphans	With support from PLAN Malawi - need for establishment of orphanage
Zezani	Orphans are kept in their homes by relatives	No	HBC provide food and soap	PLAN Malawi	❑ Give the soap ❑ Clothes ❑ Pay school fees ❑ Counselling services	
Khungwa	Chikwawa orphan care provide support to orphans	No	Food from villagers and village headman	MASAF PLAN Malawi	Drugs from DRF school fees to orphans at primary level only	
Galuwakuda	Villagers and chiefs take care of the	No	Food	❑	3 years ago Red Cross helped the orphans	

	orphans				with food	
John Ndau	Orphans are looked after by relatives	No	Food from villagers themselves and relatives		Nothing	
Mwalimo	Orphans are looked after by relatives	No	Food	No organization Villagers themselves	❑ Nothing	

MZU PU **Annex 2 (c)**

COMMUNITY BASED CHILD CARE CENTRES

MZPU	CARE GIVEN TO ORPHANS (CGTO) (1)	PCK (2)	TSG (3)	OPS (4)	OSPC (5)
MZ1	Establishment of HBC committee Skills training Gardening	Mphimbi CBCC (less 6 years)	Providing tool Providing clothes Fertilizer seeds	PLAN Malawi	❑ Training of care givers ❑ Playing materials
MZ2	❑ Provision of food ❑ Provision of clothes	CBCC	❑ Provision of food ❑ Cooking and eating utensils ❑ Building of toilets ❑ Seeds ❑ Desks	Plan Malawi	❑ Playing materials ❑ Provision of clothes ❑ Building of toilets ❑ Desks
MZ3	Encouraging CBCC and primary attendance	At CBCC Centres Their own Families	❑ Fertilizer ❑ seeds	❑ Plan Malawi ❑ Ekwendeni hospital	❑ Clothes ❑ School fees ❑ Vocational skills
MZ4	Establishment of CBCC Assistance by Christian Organizations and churches	CBCC (but not functioning)	❑ Food ❑ Fertilizer ❑ Seeds (given late)	❑ Plan ❑ Community	❑ Playing materials ❑ Training for care givers
MZ5	*Helped by:* ❑ Women groups	CBCC (not functioning)	Food stuffs	The community	None

	❑ HBC groups ❑ Community ❑ Guardian				
MZ6	❑ Encouraging orphans to go to school ❑ No suitable shelter for CBCC	Orphanage	Food Seeds Fertilizer	Plan	❑ Toys ❑ 3 care givers were trained

MZU PU

Annex 2 (d)

COMMUNITY BASED CHILD CARE CENTRES (CBCCCs) - SUMMARY

CARE OF ORPHANS	#	ORPHANAGE CARE CENTRE	#	SUPPORT TO ORPHANS	#	PROVIDER OF SUPPORT	#	OTHER SUPPORT IN ADDITION TO FOOD	#
School fees	1 3	No. of orphans care center	0	Funding with maize flour	2 1	❑ PLAN - 1	1 2	Clothes School fees	1 1
No care		Care from other groups	2	Soya flour Beans Likuni Phala Clothes School fees	1 1 1 1	❑ Lilongwe diocese ABC group ❑ Community	1	Fertilizers	1

COMMUNITY BASED CHILDCARE CENTRES **Annex 2 (e)**

SUMMARY

CGTO (1)	POK (2)	TSG (3)	OPS (4)	OSPC (5)
Establishment of HBC Committees = 2 Skills training = 1 Gardening = 1 Establishment of CBCC = 2 Encouraging school attendance = 3 Different forms of assistance from Christian organization = 1 Assistance from women groups = 1	CBCC = 4 In their own families = 1	Providing food = 5 Provision of fertilizer = 4 Cooking and eating utensils = 1 Seeds = 4	Plan = 5 Ekwendeni hospital = 1 Community = 2	Training of care givers = 3 Play materials = 4 Provision of clothes = 2 School fees = 1 Vocational skills training = 1

LILONGWE PU **Annex 3 (a)**

PARTNERSHIP WITH KEY ORGANIZATION (MoH, NGOs, Faith Based Organization, PSI (PART I)

NAME OF COMMUNITY	HEALTH ASSISTANTS	DRF	CHIEFS AND FAITH BASED ORGANIZED	PTA	HBC	TBAs/CBDAs	PART AFFECTED	COMMENT
Sankhani (Mzungu village)		VHC collaborating with health workers	MASAF on construction of bridges/schools	Collaborates with PLAN			Less than half of the community	❑ In need of farm clubs ❑ School's bicycle is now grounded
Mlezi (Mlezi village)	With PLAN on support to malnutrition	VHC with health workers n HIV/AIDS prevention and support	Community with PLAN on agriculture	None	None	None	of the community	None
Muzu (Muzu village)	PLAN Malawi		PLAN Malawi				Half the community is affected	None
Mwadenje (Mwadenje village)	Community		❑ Youth clubs to advise youths on HIV/AIDS Prevention ❑ Social welfare			Social welfare	of the community members	

KASUNGU PU

PARTNERSHIP WITH KEY ORGANIZATION (MoH, NGOs, FAITH BASED ORGANIZATIONS, PSI) **Annex 3 (b)**

NAME OF COMMUNITY	HEALTH SURVEILLANCE ASSISTANT	DRF	CHIEFS AND FAITH BASED ORGANIZATIONS	PTA	TBs/CBDAs	PART AFFECTED	COMMENT
Mankhangala	❑ Distribution of family planning methods e.g. condoms. ❑ Advise on antenatal issue	❑ Use of ITNS to pregnant women and children ❑ Seek early treatment e.g. S/P	❑ Advise on the good age to marry ❑ Take children to U/5 ❑ Attend antenatal clinic ❑ Dangers of unwanted pregnancy	❑ Advise pupils on dangers of early pregnancy ❑ Teach them not to go for their pupils ❑ A god age for marriage	❑ Advise on safe motherhood ❑ Attend antenatal clinic and referral to hospitals		❑ Price of nets should be reduced for pregnant women and children ❑ Need for dispensary and nurses ❑ Rradio message at Chamakala
Zezani	Provide family planning items and advise on the dangers of HIV and AIDS	Provides nutritional/education S/P to pregnant women. Advise women to go to hospital	Encourage pregnant women to go to the hospital and not to TBAs	Encourages women to attend antenatal and U/5 clinics	Refer the patient to clinics with support of PLAN bicycle ambulance		Need for nets First AID kits for the school Need for boreholes
Khungwa	IMCI team sensitize local leaders on safe motherhood and family planning Teaches on dangers of bearing children before ages 21	Advocates pm family planning for health of mother Provides S/P to pregnant women (provided by PLAN)	Teach on family planning	Advocates on family planning dangers of teen pregnancy to pupils. Need for teaching not to go for their pupils	CBDs teach women on U'5 and antenatal issue		No means of transport Offesi Health Centre is far from community (18 km away) Need of VCT and ARVs at Offesi Need of Bicycle Ambulance

KASUNGU PU CONTINUATION **Annex 3 (b)**

Galuwakuda		Advocates on marrying at a right time (18 years for girls and 20 years for boys)	Advise parents and children on dangers of early marriages	❑ Advise pupils not to rush in marriages ❑ Advise teachers not to take pupils as girlfriends ❑ Advise pupils not to go for teachers as boyfriends		Mankhangala community complained that things/projects meant for them are diverted to other areas. They are just being misused.	DRF - Drugs not enough Promised materials, pails, basin not available Teachers are looking for first AID kit and training of pupils on First Aid
John Ndau	Advise on family planning and distribution of family planning methods	Advise on sleeping in INTS for pregnant and children Price of S/P very fair	Advise on dangers of early marriages ❑ Expectant women to attend antenatal clinic		Refer patients to hospital/Health Centre Advise on postnatal hygiene		TBAs require initial training
Mwalimo	❑ Advice on family planning ❑ Distribution of F/P items ❑ Advocate on antenatal issues	❑ Makes drugs S/P accessible to pregnant women at a low price ❑ Advise people on safe sex	❑ Advise pregnant women to attend antenatal clinic ❑ Advise men to support their wives when pregnant to avoid over working		❑ Advise women on family planning ❑ Provide condoms		❑ No safe water for TBA and requires initial training ❑ PLWH – need ARVs to be at Kaluluma Health Centre ❑ CBDA – requires more drugs and refresher course. ❑ PLWH require food supplements

MZUZU PU **Annex 3 (c)**

PARTNERSHIP WITH KEY ORGANIZATIONS

MZPU	**COLLABORATION WITH OTHERS (1)**		**PORTION OF COMMUNITY AFFECTED WITH CHRONIC ILLNESSES**
	Individual	**Member (Organization)**	
MZ1	❑ Advice on abstinence ❑ Advice to go for VCT ❑ Keeping adolescent busy through clubs ❑ Involvement of youths in forming activities	Teachers - IEC on HIV/AIDS HAS/MA - Health Education Community - Psychosocial support - Vocational training	0.8%
MZ2	❑ Guidance and Counselling against HIV/AIDS ❑ Taking care of the orphans like your own kids ❑ Involving youth in forming activities	❑ *Teachers:* Counselling and guidance against school drop out ❑ *Community:* Teaching if on dangers of: ➢ Early marriages ➢ Premarital sex	13%
MZ3	❑ IEC on crop diversification ❑ Education on the advantages of VCT	❑ Encourage school attendance ❑ Robbing for school fees to support adolescents	Seven (5 women and 2 men)
MZ4	❑ Openess to cildren ❑ To stop bad traditional beliefs ❑ Educate against early pregnancy ❑ Encouraging crop diversification	❑ Topics on HIV/AIDS covered in schools (teachers) ❑ Establishment of youth clubs (community members)	67%
MZ5	❑ Counselling youth to be God fearing ❑ Abolishing bad traditional practices ❑ Counselling youth against: ➢ Bad behaviour that lead to STIs and HIV/AIDS ➢ Premarital sex ❑ Involvement of the youth in agriculture activities	❑ IEC on HIV/AIDS ❑ Crop diversification ❑ Be God fearing citizens ❑ Dimba cropping (community members) ❑ No youth clbs as such community members take the responsibilities	5%
MZ6	❑ Educate families on HIV/AIDS ❑ Educate and encourage on VCT	*School:* ❑ HIV/AIDS awareness **HSA** ❑ Preventive measures of HIV **Community** ❑ Villagers are taught on good farming practices	6 - 10

Annex 3 (d)

MZUZU PU

SUMMARY – PARTNERSHIP WITH KEY ORGANIZATIONS

COLLABORATION IN FOOD SHORTAGE, ASRH/HIV/AIDS

INDIVIDUALLY	WITH ORGANIZATION	PROPORTION OF CHRONIC ILLNESSES
❑ Keeping adolescents busy through clubs and sports ❑ Taking care of the orphans ❑ Counselling of youth to be God fearing ❑ Openness to children	*Teachers:* ❑ Counselling against school dropouts **Community** ❑ Psychosocial support ❑ Education on dangers of premarital sex ❑ Vocational training ❑ Encouraging school attendance ❑ Lobbing for school fees ❑ Be God fearing citizens	MZ1 = 0.8%
Abolishing bad traditional practices Advising against premarital sex	**HSA/M/A/NURSE** ❑ Health Education **Community:** ❑ Establishment of youth clubs ❑ Crop diversification	MZ2 = 13%
		MZ3 = 5 women and 2 men (7)
	Teachers: ❑ IEC on HIV/AIDS	MZ4 = 67%
❑ Education guidance and counselling on HIV/AIDS ❑ Involving youth in forming activities		MZ5 = 5%
		MZ6 (6 - 10) In some communities it was difficult to verify

MZUZU PU **Annex 3 (e)**

PARTNERSHIP WITH KEY ORGANIZATIONS (MoH, NGOs, FAITH BASED ORGANIZATIONS, PSI) – SUMMARY

WITH MINISTRY OF HEALTH	#	NGOs	#	FAITH BASED ORGANIZATION	#	PTA	#	HBC	#	TBAs/CBDAs		PART AFFECTED	
❑ Health centers Type of partnership: ❑ Malnutrition ❑ FP ❑ HIV/AIDS Support (prevention)	3 1 2 3	DRF MASAF Social welfare	2 1 1			With PLAN Others	1 0	None		None		Half of the community of the community	2 2

LILONGWE PU

Annex 4 (a)

HIV AND AIDS INTERVENTION

NAME OF COMMUNITY	KNOWLEDGE OF CAUSE OF HIV/AIDS	PROBLEMS ENCOUNTERED BECAUSE OF HIV/AIDS	ACTION TAKEN TO ALLEVIATE THE PROBLEMS	ACTION TAKEN TO AVOID CONTACTING HIV/AIDS	SERVICES PROVIDED FROM OUTSIDE TO AIDS AFFECTED	PROVIDER OF SERVICE	OTHER REQUIRED SERVICES FROM THE COMMUNITY

Chigoneka (Friday Village)	Poverty for girls Lack of awareness on dangers	Increase orphans Poverty Poor development	Youth club was formed to create awareness	❑ Abstinence ❑ Recreation activities	Nothing	No one	Skills course like Carpentry Recreation facilities like football/netball
Muzu (Muzu Village)	Prostitution	❑ Poverty and Hunger ❑ Increased orphans	Youth Clubs	Using condoms	❑ Counselling services ❑ Abstinence	❑ HBC ❑ Church Organizations	❑ Food for the poor ❑ Clothes
Sankhani (Mzungu)	❑ Multiple sexual partners ❑ Sharing razor blades and other sharps	❑ Increased orphans ❑ Poverty	❑ Farming clubs ❑ Small scale business	❑ Abstinence ❑ Condom use ❑ Recreational facilities	None	None	Food and clothes for the poor and HIV/AIDS patients
Mezi (Mlezi Village)	Prostitution Use of needles	Orphans increased Poverty Poor development	Drama club to create awareness	❑ Playing games ❑ Abstinence ❑ Using condoms	❑ Blackouts ❑ Food	Church organization	❑ ARVs ❑ Food and Clothing ❑ Transport e.g. bicycles
Mwadenje (Mwadenje Village)	Poverty of girls Ignorance of the dangers Prostitution	More orphans Poverty More deaths	None	❑ Abstain ❑ Use of condoms	❑ Soya flour ❑ Maize flour	❑ MoH ❑ PLAN ❑ Care intended	❑ VCT services ❑ Hall for entertainment ❑ CBCCCs
Mthyoka Mphaula	❑ Sharing needles ❑ Multiple sexual partners ❑ Blood transfusion	❑ Poverty ❑ More orphans ❑ Poor development ❑ Discrimination and stigma	❑ HIV/AIDS discussion in youth clubs ❑ Participate in building of schools	❑ Abstinence ❑ Condom use ❑ Drama ❑ Games	Feeding the orphans	Blessings Hospital (CHAM)	❑ Skill development e.g. carpentry ❑ ARVs to patients ❑ Formation of youth organizations ❑ First aid drugs

KASUNGU PU **Annex 4 (b)**

HIV AND AIDS INTERVENTION

NAME OF COMMUNITY	KNOWLEDGE OF CAUSE OF HIV/AIDS	PROBLEMS ENCOUNTERED	ACTION TAKEN TO ALLEVIATE PROBLEMS CAUSED BY HIV/AIDS	ACTION TAKEN TO AVOID CONTACTING HIV	SERVICES PROVIDED FROM OUTSIDE TO AIDS AFFECTED AND INFECTED	PROVIDER OF SERVICES	OTHER REQUIRED SERVICES IN THE COMMUNITY	
Khungwa	Poverty for girls Ignoring of advice	Poverty on the increase More orphans due to death of parents	Form clubs such as AIDS Toto Provide to orphans	Use of condoms Abstinence	Nothing	No one	❑ Establishment of ARV center ❑ Food supplements for HIV/AIDS	❑ Health center far from community (18 km,

			soap				❑ Cloths for orphans	difficult to access drugs) ❑ Need for support for HIV and AIDS from PLAN
Mankhangala	❑ Poverty for girls ❑ Unfaithfulness ❑ Lack of abstinence	❑ Increased orphans ❑ Poverty	Nothing at the moment	Abstinence Use of condoms	Nothing	No one	❑ Health to provide VCT, condoms and drugs ❑ Support for HBC	Need support for youth club formation
Zezani	❑ Poverty ❑ Lack of abstinence	❑ More orphans in the community ❑ Poverty is increasing	Food provision to orphans	❑ Abstinence ❑ Use of condoms ❑ Playing games	❑ Food from PLAN Malawi ❑ Irrigation Scheme for food security	❑ PLAN ❑ Maleza Irrigation Scheme	❑ Provision of transport ❑ Free drugs	Need for support on youth clubs
Jon Ndau	Lack of abstinence Poverty Sex for pleasure	Increased no. of orphans Poverty due to death of parents Low development	Teaching fellow youth on prevention of HIV/AIDS transmission	❑ Abstain from sex ❑ Use of condoms	Not provided	No one	❑ Formation of farm clubs ❑ Provision of farm inputs	Requires support from PLAN to support HIV/AIDS

CONTINUATION, HIV AND AIDS INTERVENTION, KASUNGU PU **Annex 4 (b)**

Galuwakuda	❑ Unfaithfulness of family members ❑ Poverty for girls ❑ Poor dressing for girls	❑ Increase of orphans ❑ Lack of parental care ❑ Poverty for remaining children	❑ Sensitize fellow youth on dangers of AIDS ❑ Help the orphans with little they get	❑ Abstinence ❑ Choose the right partner ❑ Use of condoms	❑ Not available ❑ Not yet started	No one	Provision of food supplements Formation of youth clubs	Need for support to form HIV/AIDS Clubs
Mwalimo	Poverty for girls Lack of abstinence Lack of education on HIV/AIDS	Increase in orphans Poverty Low development	Provide soap to orphans Formation of youth clubs	Keep themselves busy Abstinence Use of condoms	Not yet	No one	❑ Farm input to help orphans ❑ Starter pack for business ❑ Training on HIV/AIDS	Require support for farm inputs and training on HIV/AIDS

							awareness	

MZUZU PU **Annex 4(c)**
FGDs FOR YOUTH OUT OF SCHOOL

A. HIV/AIDS INTERVENTION

MZPU	1	2	3	4	5	6	7
Mphimbi	❑ Sexual intercourse ❑ Poverty	❑ Orphans ❑ Lack of support for the orphans ❑ Property grabbing	❑ IEC to other youth about HIV ❑ IEC to parents about HIV	❑ Youth clubs ❑ Sports ❑ Use of condoms ❑ Faithfulness ❑ IEC on AIDS through drama	❑ Provision of food ❑ Provision of clothes ❑ IEC by LISA P to community	❑ LISAP (NGO) ❑ Plan Malawi ❑ NAPHAM	❑ ARVs to the affected ❑ Vocational training ❑ Provision of food ❑ IGA seed money ❑ Exchange visits
Kapembelwa	Poverty Cultural practices Peer pressure Lack of leadership	Hunger Poverty Orphans Lack of medicines Congestion in hospitals Loss of human resources	Dissemination of HIV/AIDS messages Preaching about abstinence Distribution of condoms Helping the orphans and the needy	Sports	School fees Food Clothes Vocational training Life skills	Plan LISAP	Establishment and vocational training center Provision of sports equipment and materials Transport i.e. bicycles for ferrying the sick Film shows to keep youths busy

							Seed money for IGA
Edundu	Poverty Lack of knowledge Promiscuity Peer pressure Cultural practices Drunkardness	Number of orphans (4) Development goes down 4 in school dropouts lose of jobs 4 deaths human resources	dissemination of HIV/AIDS Sports Drama	Assisting orphans Drawing water for them Sneering houses Gondering for then	Health education Training peer educators Cooking oil Food	Plan	❑ Sports equipment ❑ Building materials ❑ IGA seed money
Ehlekweni	❑ Peer pressure ❑ Drunkardness ❑ Poverty ❑ Promiscuity	❑ Orphans ❑ Poverty ❑ Loss of human resources ❑ Development ❑ School dropout ❑ Loss of jobs	Nothing at the moment	❑ Abstinence ❑ IGAs ❑ Use of condoms ❑ Sporting activities ❑ IEC on VCT	None	None	Sports equipment Vocational training IGA seed money Transport and bicycles

Annex 4 (d)

YOUTH OUT OF SCHOOL YOUTH – SUMMARY **Annex 4(d)**

HIV/AIDS INTERVENTIONS

CAUSE OF HIV/AIDS	#	PROBLEMS ENCOUNTERED	#	WHAT TO DO TO ALLEVIATE THE PROBLEMS	#	ACTION TAKE TO AVOID CONTACT	#	SERVICES OFFERED FROM OUTSIDE	#	PROVIDERS OF SERVICES	#	WHAT OTHER SERVICES ARE PROVIDED	#
Poverty for girls	2	Increased orphans	6	Youth Clubs	4	Abstinence	5	None	2	None	2	Clothes 2	2
Lack of awareness	2	Poverty	5	Youth clubs	4	Recreational	4	None	2	None	2	Skills course e.g. carpentry	2
Prostitution	5	Poor development	4	Small scale business in the community	1	Activities	4	Counselling services	1	Church	2	VCT services	1
Sharing razor blades and other sharps	3	Discrimination and stigma	1	Drama clubs	1			Blankets	1	PLAN Malawi	1	First Aid Drugs	1
Blood Transfusion	1			Participation in developments like building schools	1			Food like Maize flour	1	CARE International	1	Transport – bicycles	1
				None	1			Soya flour	1			Youth Organization	1

								Feeding the Orphans	1			Food and Clothes	2
												CBCCCs	1

Annex 4 (e)

SUMMARY

FGD FOR YOUTH OUT SCHOOL

A. **HIV/AIDS INTERVENTION**

MZPU	1	#	2	#	3	#	4	#	5	#	6	#	7	#
	❑ Poverty ❑ Sexual intercourse = (promiscuity) ❑ Cultural practices ❑ Pressure peer ❑ Lack of leadership ❑ Lack of knowledge ❑ Drunkardness	4 3 2 3 1 1 2	Orphans Lacks of support for orphans Property grabbing Poverty Lack of medicine Congestion of hospitals Loss of human resources Development goes down School dropout Loss of jobs	4 1 1 2 1 1 3 2 2 2	IEC to other youth about HIV IEC to parents Sports Drama	2 1 1 1	Youth clubs Distribution of condoms Helping orphans IEC on HIV/AIDS IGA	3 3 2 1 3 1	Provision of food Provision of clothes IEC School fees Vocational training Life skills Training peer educators	3 2 2 1 1 1 1	Plan LISAP NAPHAM	3 2 1	ARVS Vocational training Provision of food IGA seed money Exchange visits Provision of sports equipment Transport bicycles Film shows	1 3 1 4 1 3 2 1

KEY:

1. Perceived cause of HIV and AIDS.

2. Problem encountered as a result of HIV and AIDS.
3. Action done to alleviate problems due to HIV and AIDS.
4. Activities done to avoid contracting HIV and AIDS.
5. Services provided to those infected or affected by HIV and AIDS.
6. Organization providing the services.
7. Other services required in the community.

LILONGWE PU **Annex 5 (a)**

SEXUAL AND REPRODUCTIVE HEALTH ISSUES

NAME OF COMMUNITY	**BOYS: KNOWLEDGE OF PHYSICAL CHANGES**	GIRLS: KNOWLEDGE OF PHYSICAL CHANGES	BOYS: KNOWLEDGE OF PSYCHOSOCIAL CHANGES	GIRLS: KNOWLEDGE OF PSYCHOSOCIAL CHANGES	SEXUAL AND REPRODUCTIVE HEALTH YOUTH FRIENDLY SERVICES	PROVIDER OF HEALTH SERVICES	COMMENTS
Chigoneka (Friday Village)	All boys have knowledge on physical changes	All girls have knowledge on physical changes	All showed knowledge on psychosocial changes	Al had knowledge on psychosocial changes	Services on HI/AIDS prevention	Youth Clubs initiated by PLAN	Staff are readily transferred before implementing
Muzu (Muzu Village	All boys have knowledge on physical changes	All girls have knowledge on physical changes	All showed knowledge on psychosocial changes	Al had knowledge on psychosocial changes	None	None	None
Sankhani (Mzungu)	All boys have knowledge on physical changes	All girls have knowledge on physical changes	All showed knowledge on psychosocial changes	Al had knowledge on psychosocial changes	None	None	None
Mlezi (Mlezi Village)	All boys have knowledge on physical changes	All girls have knowledge on physical changes	All showed knowledge on psychosocial changes	Al had knowledge on psychosocial changes	Advice	❑ Parents ❑ Anamkungwi	None
Mwadenje (Mwadenje Village)	All boys have knowledge on physical changes	All girls have knowledge on physical changes	All showed knowledge on psychosocial changes	Al had knowledge on psychosocial changes	Advice on dangers of early pregnancies and HIV/AIDS	Youth Alive Organization	None
Mthyoka (Mphanda)	All boys have knowledge on physical changes	All girls have knowledge on physical changes	All showed knowledge on psychosocial changes	Al l had knowledge on psychosocial changes	None	None	None

KASUNGU PU Annex 5 (b)

FGD FOR SEXUAL REPRODUCTIVE ISSUES

NAME OF COMMUNITY	BOY KNOWLEDGE OF PHYSICAL CHANGES	GIRLS KNOWLEDGE OF PHYSICAL CHANGES	BOYS KNOWLEDGE OF PSYCHOSOCIAL CHANGES	GIRLS KNOWLEDGE OF PSYCHOSOCIAL CHANGES	SEXUAL REPRODUCTIVE, HEALTH FRIENDLY SERVICE AVAILABLE	PROVIDE OF SERVICES	COMMENT
Khungwa	All boys have knowledge on physical changes	All girls have knowledge of physical changes	All boys showed knowledge of psychosocial changes	All girls showed knowledge of psychosocial changes	❑ Advice on used of condoms in family planning ❑ Use of Depo	❑ HSA ❑ CBDAs ❑ Church	❑ No organization provides sexual and reproductive health services ❑ Clinic is very far (18 km) ❑ Need for youth clubs
Mankhangala	√	√	√	√	Advice on dangers of early pregnancy and abortion	Parents and village headman	Need support for their youth club in order to advocate SRH Services
Zezani	√	√	√	√	Advice on condom use Provision of condoms Education on the use of depo	PLAN Malawi	❑ Need support from PLAN Malawi ❑ To establish youth clubs
John Ndau	√	√	√	√	Advice on dangers of early pregnancy Girls to avoid boys	Parents Church elders	❑ Need support for education ❑ Need support to have their youth clubs
Galuwakuda	√	√	√	√	❑ Abstinence ❑ Use of condoms ❑ Choice of right partner	❑ Church committee and village elders	Need support from PLAN Malawi in order to establish youth club
Mwalimo	√	√	√	√	❑ Advice on marriage after 18 years ❑ Dangers of early pregnancy	❑ Parents ❑ HSA	Youth need assistance from PLAN in order to have youth clubs

MZUZU PU **Annex 5(c)**

FGD FOR YOUTH OUT OF SCHOOL

B. **Sexual and Reproductive Health Issues**

MZPU	PHYSICAL AND PSYCHOLOGICAL CHANGES		TYPE OF SEXUAL AND REPRODUCTIVE HEALTH YOUTH FRIENDLY SERVICES PROVIDED	ORGANIZATION PROVIDING THE SERVICES
	BOYS	**GIRLS**		
Mphimbi	*Physical:* ❑ Wet dreams ❑ Grow hair to private parts *Psychosocial* ❑ Practicing cleanliness	*Physical:* Enlargement of breasts Growing of hair in private parts *Psychosocial* Practicing hygiene	Providing condoms Providing family planning services to youth	Ministry of Health CBDA
Edundu	*Physical:* ❑ Change of voice ❑ Pubic hair ❑ Pimples ❑ Wet dreams ❑ Election ❑ Ejaculation ❑ Enlargement of penis *Psychosocial* ❑ Feeling sexy	*Physical:* ❑ Pubic hair ❑ Enlargement of breasts ❑ Hip enlargement ❑ Pimples ❑ Menstruation periods *Psychosocial* ❑ Feeling sexy	❑ Provision of condoms ❑ VCT services ❑ Family planning services ❑ Treatment of STI/AIDS	❑ Ministry of Health ❑ Plan ❑ LISAP
Ehlekweni	*Physical:* ❑ Erection and ejaculation ❑ Wet dreams ❑ Pubic hair *Psycho:* ❑ Sexual feelings	*Physical:* ❑ Menstruation ❑ Breast enlargement ❑ Skin becomes soft ❑ Pubic hair *Psycho:* ❑ Sexual feeling ❑ Shyness	VCT Services	
Malivenji	*Physical:* ❑ Change of voice ❑ Beard ❑ Public hair *Psycho:* ❑ Sexual feeling	*Physical:* ❑ Public hair ❑ Menstruation *Psycho:* ❑ Feeling sexy ❑ Shyness	❑ Provision of condoms ❑ Family planning services ❑ Provision of VCT services	Ministry of Health

Annex 5 (d)

SEXUAL AND REPRODUCTIVE HEALTH ISSUES – SUMMARY

BOYS:	#	GIRLS;	#	BOYS:	#	GIRLS:	#	SEXUAL REPRODUCTIVE	#	PROVIDER OF THE SERVICES	#

KNOWLEDGE OF PHYSICAL CHANGES		KNOWLEDGE OF PHYSICAL CHANGES		KNOWLEDGE OF PSYCHOSOCIAL CHANGES		KNOWLEDGE ON PSYCHOSOCIAL CHANGES		HEALTH FRIENDLY SERVICES			
All boys have knowledge on physical changes	5	All girls have knowledge on physical changes	5	All showed knowledge on psychosocial changes	5	All showed knowledge on psychosocial changes	5	❑ HIV/AIDS prevention messages ❑ None ❑ Advice from parents	3 3 2	❑ Youth Clubs (by PLAN) ❑ Parents ❑ Anamkungwi ❑ Youth Alive Orgnaisation ❑ None	1 1 1 1 3

Annex 5(e)

B. **SUMMARY**

BOYS	#	GIRLS	#	YOUTH FRIENDLY	#	PROVIDERS	#
Physical:		*Physical:*		Provision of condoms	3	Ministry of Health	3
❑ Wet dreams	3	❑ Enlargement of breasts	3	Providing family planning	3	CBDA	1
❑ Pubic hair	4	❑ Growth of pubic hair	4	services		Plan	1
❑ Change of voice	2	❑ Enlargement of hip	1	Provision of VCT services	3	LISAP	1
❑ Erection and ejaculation	2	❑ Pimples	1	Treatment of STIs and AIDS	1		
❑ Enlargement of penis	1	❑ Menstruation	3 1				

❑ Beard **Psychosocial** ❑ Practicing cleanliness ❑ Sexual feelings	1 1 3	❑ Skin becomes soft **Psychosocial** ❑ Practicing hygiene ❑ Sexual feeling ❑ Shyness	1 3 2				

KEY:

1. Physical and Psychological Changes.
2. Type of sexual and reproductive health youth friendly services provided.
3. Organization providing the services.

Annex 6 (a)

LILONGWE PU

FOCUS GROUP DISCUSSION (FGD) WITH MEMBERS OF THE COMMUNITY AND SOME EXTENSION WORKERS

1. **Description of the sample workers**

The key informants were:

The village headmen
Members of the VHC
Traditional Birth Attendants
Teachers
Agriculture Extension workers
Health workers

PROGRAM UNIT VILLAGES	MALE	FEMALE	TOTALS
LL/04/01	6 (22.2%)	6 (29%)	12
LL/03/01	6 (22.2%)	6 (29%)	12
LL/02/01	7 (26%)	5 (24%)	12
LL/01/01	8 (30%)	4 (19%)	12
	27 (56%)	21 (44%)	48 (100%)

KEY

LL/04/01 - Mwadenje Community (Mwadenje Village)
LL/03/01 - Muzu Community (Muzu Village)
LL/02/01 - Mlezi Community (Mlezi Village)
LL/01/01 - Sankhani Community (Mzungu Village)

Annex 6 (b)

KASUNGU PU

FOCUS GROUP DISCUSSION WITH MEMBERS OF THE COMMUNITY AND SOME EXTENSION WORKERS

1. **Description of sample population:**

The key informants were:

- ❑ Village headman
- ❑ Member of VHC
- ❑ Traditional Birth Attendants (TBAs)
- ❑ Community Based Distributing Agents (CBDAs)
- ❑ Members of Drug Revolving Fund (DRF)
- ❑ Teachers

PROGRAM UNIT/VILLAGE	MALE	FEMALE	TOTALS
KU/01/01	8 (20%)	4 (13%)	12
KU/02/01	7 (17%)	5 (16%)	12
KU/03/01	8 (20%)	4 (13%)	12
KU/04/01	6 (15%)	6 (19%)	12
KU/05/01	6 (15%)	6 (19%)	12
KU/06/01	6 (14%)	6 (19%)	12
TOTALS	41 (57%)	31 (43%)	72 (100%)

KEY

KU/01/01 = Khungwa Village
KU/02/01 = Zezani Village
KU/03/01 = Galuwakuda Village
KU/04/01 = Mankhangala Village
KU/05/01 = John Ndau Village
KU/06/01 = Mwalilino Village

MZUZU PU

Annex 6 (c)

FOCUS GROUP DISCUSSION WITH MEMBERS OF THE COMMUNITY AND SOME EXTENSION WORKERS

1. **Description of the sample population**

The key informants were:

- ❑ The village headmen
- ❑ Members of VHC
- ❑ Child Care Givers
- ❑ Traditional Births Attendants
- ❑ Community Based Distributing Agents
- ❑ Members of drug revolving fund
- ❑ Teachers

PROGRAM UNIT (VILLAGES)	**MALE**	**FEMALE**	**TOTALS**
MZ1	7 (20%)	5 (13%)	12
MZ2	5 (14%)	7 (18%)	12
MZ3	6 (18%)	6 (16%)	12
MZ4	4 (12%)	8 (21%)	12
MZ5	6 (18%)	6 (16%)	12
MZ6	6 (18%)	6 (16%)	12
TOTALS	34 (47%)	38 (53%)	72 (100%)

KEY:

MZ1 = Mphimbi (Zungwala)
MZ2 = Kapambelwa (Sambamo)
MZ3 = Kabwanda (Sinya Mhoni)
MZ4 = Edundu (Zintonga)
MZ5 = Ehlekweni (Fuyiwa)
MZ6 = Malivenji (Chibisa Chisi)

Annex 7 (a)

LILONGWE PU

FOCUS GROUPS DISCUSSION WITH OUT OF SCHOOL YOUTH

1. **DESCRIPTION OF THE SAMPLE POPULATION**

PROJECT UNIT VILLAGES	MALE	FEMALE	TOTALS
LL/02/01	5 (14%)	5 (18%)	10
LL/02/01	6 (17%)	4 (14.3%)	10
LL/03/01	6 (17%)	4 (14.3%)	10
LL/04/01	6 (17%)	4 (14.3%)	10
LL/05/01	6 (17%)	7 (25%)	13
LL/06/01	7 (19.4%)	4 (14.3%)	11
	36 (56.2%)	28 (44%)	64 (100%)

KEY

LL/01/01 - Sankhani Community (Mzungu Village)
LL/02/01 - Mlezi Community (Mlezi Village)
LL/03/01 - Muzu Community (Muzu Village)
LL/04/01 - Chigoneka Community (Friday Village)
LL/05/01 - Mwadenge Community (Mwadenge Village)
LL/06/01 - Mthyola Community (Mphanda Village)

Annex 7 (b)

KASUNGU PROGRAM UNIT

FOCUS GROUP DISCUSSION FOR OUT OF SCHOOL YOUTH

Description of Sample Population

The key informants were:

- ❑ Boys and girls who are out of school.

PROJECT UNIT/VILLAGE	MALE	FEMALE	TOTALS
KU/01/01	6 (17%)	2 (17%)	12
Ku/02/01	6 (17%)	1 (8%)	12
Ku/03/01	6 (17%)	1 (8%)	12
KU/04/01	6 (17%)	3 (25%)	12
KU/05/01	5 (15%)	4 (33%)	12
KU/06/01	6 (17%)	1 (8%)	12
Total	35 (49%)	12 (17%)	72 (100%)

KEY

KU/01/01 = Khungwa Village
KU/02/01 = Zezani Village
KU/03/01 = Galuwakuda Village
KU/04/01 = Mankhangala Village
KU/05/01 = John Ndau Village
KU/06/01 = Mwalimo Village

Annex 7 (c)

MZUZU PU

FOCUS GROUP DISCUSSION WITH OUT OF SCHOOL YOUTH

1. **Description of the sample population**

MZUZU PROJECT UNITS (VILLAGES)	MALE	FEMALE	TOTALS
MZ/1	9 (28%)	1 (4%)	10
MZ/4	13 (41%)	3 (11%)	16
MZ/5	5 (16%)	4 (15%)	9
MZ/6	5 (16%)	4 (15%)	9
TOTALS	32 (73%)	12 (27%)	44 (100%)

4 out 6

FGDS were not conducted in 2 Project Units i.e. MZ2 and MZ3

KEY

MZ 1 : Mphimbi (Zungwala)
MZ2 : Kapambelw (Sambano)
MZ3 : Kabwanda (Sinya Mhoni)
MZ4 : Edundu (Zintonga)
MZ5 : Ehlekweni (Fuyiwa)
MZ6 : Malivenji (Chibisa Chisi)

WORKPLAN FOR THE MIDTERM EVALUATION **ANNEX 8(a)**

Activity	**Dates**	**Number of days**	**Responsible person(s)**
Development of data collection tools		3 days	Consultant
Translation of data collection tools into vernacular languages		1 day	Consultant
Training of 15 enumerators and pilot study		3 days	Consultant Assistants (3) Enumerators (15)
Making necessary corrections and printing of		1 day	Consultant

tools			
Data collection		8 days	Consultant Assistants (3) Enumerators (15)
Analyzing and interpretation of data		5 days	Consultant
Writing a draft report		2 days	Consultant
Editing and finalizing the report		1 day	Consultant
Submitting and presenting the main findings and recommendations		1 day	Consultant
Total		**25 days**	

Annex9 (a)

TERMS OF REFERENCE

The mid-term evaluation exercise was based on the following terms of reference:

- Determination of the effectiveness of the strategies used in implementing the project.
- Assessment of timeliness of project against the proposal time frame.
- Assess outputs delivered against outputs planned
- Determination of progress made against the project objectives.
- Development of evaluation tools.
- Determination of sample size, covering all the Program units.
- Briefing the enumerators on the data collection tools.
- Pre-testing of data collection tools.
- Conducting the evaluation exercise.
- Analyzing the data using SPSS software package.
- Interpreting the data and making recommendations.
- Presenting findings and recommendations in a workshop format to Plan-Malawi and district partners.