Final Evaluation of the
Tiweko Tose Child Survival Project
July 26 – August 5, 2004

World Relief Malawi/CCAP Livingstonia Synod Hospitals
Tiweko Tose Child Survival Project

“Tiweko Tose” means “All of Us Together”

This Final Evaluation was completed in compliance with
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Executive Summary

The Tiweko Tose Child Survival Project (2000-04) works in Mzimba and Rumphi districts of N. Malawi. The project areas include the three catchment areas of Ekwendeni, Embangweni, and David Gordon Memorial hospitals of the CCAP Synod of Livingstonia (SOL). The target group comprised children 0-5 year olds (36,732) and women of childbearing age (32,185).

The project goals are to 1) reduce morbidity and mortality in children under 5 and women of childbearing age; 2) strengthen the capacity of the SOL to implement Child Survival interventions; and 3) empower communities to improve their health.

The major project strategy helped communities create 230 Care Groups and train 2,300 volunteers as behavior change agents. Care Group volunteers regularly visited more than 23,000 households to promote key child survival messages. The project intervention mix included Nutrition (25%), Malaria control (15%), Pneumonia case management (15%), maternal and newborn care (15%), family planning (15%), and STI/HIV/AIDS prevention (15%).

The final evaluation took place from July 26 to August 5, 2004 to 1) determine whether the project met its goals and objectives; 2) assess the effectiveness of project interventions; 3) identify Lessons Learned; and 4) propose a dissemination plan. The evaluation team of 14 persons included a USAID representative; three MOH district staff, three SOL PHC personnel, three project area coordinators, the project director and deputy director, the WR country deputy director, and the team leader.

The evaluation team reviewed project documents, e.g., the final KPC survey and project responses to MTE recommendations. The team also conducted a SWOT assessment of Strengths, Weaknesses, Opportunities and Threats. Teams visited the three project areas for discussions with District Health Management Teams, SOL Management, health center staff, health promoters, mothers’ groups, community leaders, and Care Group volunteers.

The evaluation team found that the project had achieved or surpassed eleven of its twelve primary objectives. For example, prompt treatments for fever and rapid, difficult breathing more than doubled, increasing from around 30-35% to more than 70%. 60% of women and children now sleep under bednets (ITNs). The percentage of pregnant women receiving two doses of SP at prenatal clinics increased from 30% to 60%. The use of modern contraception by married women increased from 20% to 60%. These interventions appear to have contributed to reductions in mortality and morbidity.

Care Groups are well established in the three project areas, and recognized as effective BCC agents by both SOL and MOH. While the “graduation” of Care Groups and their transitioning their support to SOL has not yet occurred, discussions with the MOH and SOL indicate that this will not be difficult as HSAs will help supervise and link Care Groups to health centers. A detailed transition plan to make this happen by September 30th has been prepared.

The evaluation team identified nine “Lessons Learned” from this project. These are summarized on the following page.
Nine Lessons Learned

LL1: A BCC intensive project requires an effective service delivery partner to achieve its objectives. The Tiweko Tose project worked hand in hand with the service delivery system and supplies of the Synod of Livingstonia and the Ministry of Health to realize most of its objectives. As a Malawian proverb aptly states, “One head cannot carry a roof.”

LL2: Action-oriented training and structure of Care Groups encourages effective, empowered teamwork for Behavior Change Communications (BCC). Care Groups organize a community of adults around actions (Behavior Change Communications) and encourage teamwork for the common good of the community.

LL3: Interactions between Care Group volunteers and their households are models of love and shared security for the community. Care Groups have become a source of shared social support and encouragement for volunteer mothers. This has also become a model for the whole community.

LL4: Knowledge empowers people to action. One-on-one behavior change communication results in not only in improved health behaviors, but also in community-wide actions like group gardens and IGAs. Women, in particular, have been empowered to openly discuss health matters and make decisions with their husbands, e.g. about family planning.

LL5: BCC is a powerful force for community redefinition of acceptable behavior. BCC campaigns have created a community-wide standard for acceptable behavior, and provided peer pressure to bring about behavior change among those who initially rejected the messages. For example, it is no longer acceptable behavior to use a bed net as a fishing net.

LL6: Women are more enthusiastic, effective BCC agents than are men. Care Groups often include an equal number of women and men volunteers. Women, however, attend meetings more regularly, and are more enthusiastic about BCC, especially drama and music.

LL7: A project is more easily sustained if it is planned and implemented as part of an existing program, rather than as a standalone project. Working through the Synod of Livingstonia health system made it much easier to plan and provide support structures for the continued work of Care Groups, i.e., as part of the SOL Primary Health Care program. However, capacity building does not happen automatically. It requires a conscious strategy and resources.

LL8: Sustainability activities programmed near the end of a project may be negatively associated with phasing out. The graduation of Care Groups was (and still is) intended as a celebration of their independence and maturity. However, because this event is coming so close to the end of project, some communities have associated it negatively with phasing out.

LL9: Phasing out indicators should be included and featured prominently in project monitoring. The project would probably have advanced further with phasing out and sustainability had a specific indicators, like graduation of Care Groups, been tracked “up front” as part of the project monitoring system.
Figure 1: Map of the TTCSP Project Area
Abbreviations and Acronyms

AIDS  Acquired Immune Deficiency Syndrome
ARI  Acute Respiratory Infection
BCC  Behavior Change Communication
C-IMCI  Community-Based Integrated Management of Childhood Illness
CBDA  Community Based Distribution Agent
CCAP  Church of Central Africa Presbyterian
CG  Care Group
CSP  Child Survival Project
DGMH  David Gordon Memorial Hospital
DHMT  District Health Management Team
DHO  District Health Officer
DIP  Detailed Implementation Plan
DRF  Drug Revolving Fund
EBF  Exclusive Breast Feeding
EOP  End of Project
EPI  Expanded Program on Immunizations
GMC  Growth Monitoring Clinic
HC  Health Center
HH  House Hold
HIS/MIS  Health Information System/Management Information System
HIV  Human Immunodeficiency Virus
HQ  Headquarters
HSA  Health Surveillance Assistants
IEC  Information, Education and Communication
IFA  Iron Folic Acid
IMCI  Integrated Management of Childhood Illness
ITN or ITM  Insecticide-Treated Nets (or Materials)
KPC  Knowledge, Practice and Coverage Survey
MCH  Maternal and Child Health
MOH  Ministry of Health
MTE  Mid – Term Evaluation
ORS (ORT)  Oral Rehydration Solution (and Therapy)
PCUSA  Presbyterian Church United States of America
PHC  Primary Health Care
PVO  Private Voluntary Organization
SOL  Synod of Livingstonia
SP  Sulfadoxine Pyrimethamine (Fansidar)
STI  Sexually Transmitted Infections
TA  Technical Administrative support
TBA  Traditional Birth Attendant
TTCSP  Tiweko Tose Child Survival Program
USAID  United States Agency for International Development
VCT  Voluntary Counseling and Testing
VHC  Village Health Committee
WatSan  Water and Sanitation
WCBA  Women of Childbearing Age
WR  World Relief
Table of Contents

Executive Summary
Major Recommendations
Map of project area
Abbreviations and Acronyms
Tables and Figures

I. Introduction ........................................................................................................................................................................ 1
   A. Brief overview of the project
   B. Project Complexity
   C. Scope of Work and Final Evaluation Methodology

II. Assessment of Results and Impact of the Program ........................................................................................................ 3
    A. Results: Summary of Baseline, Mid-Term, EOP KPC & Quarterly Surveys
    B. SWOT: An Analysis Strengths, Weaknesses, Opportunities and Threats
    C. Progress Report by Intervention Area
    D. New tools and innovative approaches

III. Cross Cutting Approaches ............................................................................................................................................. 13
      A. Community Mobilization
      B. Communications for Behavior Change (BCC)
      C. Capacity Building
      D. Sustainability and Exit Strategies

IV. Program Management .......................................................................................................................................................... 24
    A. Planning
    B. Human Resources and Staff Management
    C. Financial and Logistics Management
    D. Information Management (Health Information System)
    E. Technical and Administrative support
    F. Response to MTE Recommendations

V. Conclusions and Lessons Learned ........................................................................................................................................ 28
    A. Conclusions
    B. Summary of Lessons Learned
    C. Results Highlight: TTCSP & C-IMCI

Attachments:
    A. Evaluation Team Members and Resource Persons Contacted
    B. Final Evaluation Scope of Work
    C. Questionnaires for Field Visits
    D. SWOT Questionnaire and Results
    E. Project Responses to the MTE Recommendations
Tables and Figures

**Figures:**
- Figure 1: Map of Project Area
- Figure 2: TTCSP Achievement of Primary Project Objectives
- Figure 3: The Care Group Structure
- Figure 4: The BCC Learning Cycle
- Figure 5: Project, Partner and Community Structures
- Figure 6: Links from Care Groups to HSAs and Village Headmen
- Figure 7: Project Organizational Chart

**Charts:**
- Chart 1: Children <5 yrs. treated same/next day for fever
- Chart 2: Children < 5 yrs. treated same/next day for rapid, difficult breathing
- Chart 3: Children < 5 yrs. & Pregnant Women sleeping under a bednet (ITN)
- Chart 4: Bednets (ITNs) retreated within last 12 months
- Chart 5: Children < 36 months weighed at GMC sessions
- Chart 6: Pregnant women receiving Iron Folic Acid (IFA)
- Chart 7: Mothers exclusively breastfeeding 0-6 mos. infants
- Chart 8: Married women using modern contraception
- Chart 9: Married women using condom during last intercourse
- Chart 10: Families who have an emergency transport plan
- Chart 11: Pregnant women receiving 2 or more SP doses
- Chart 12: Malnutrition in 0-3 yrs. old and impact of HEARTH - DGMH

**Tables:**
- Table 1: Summary of Field Visits to the Three Project Areas
- Table 2: KPC and Quarterly Survey Results
- Table 3: SWOT Analysis of Strengths, Weaknesses, Opportunities & Threats
- Table 4: Key BCC Messages
- Table 5: Suggestions for Supporting the Work of Care Groups
- Table 6: Draft DGMH Transition Plan
- Table 7: Illustrative Care Group Data for the DGMH Program Area
I. INTRODUCTION

A. Brief overview of the project

The Tiweko Tose Child Survival Project (2000-2004) is located in Mzimba and Rumphi districts of northern Malawi. The three project areas include the health service catchment areas around the Ekwendeni, Embangweni, and David Gordon Memorial hospitals of the CPAP (Central Church of Africa, Presbyterian) Synod of Livingstonia (SOL). The target group comprises children 0-5 year olds (36,732) and women of childbearing age (32,185).

The project goals are to:

1) Reduce morbidity and mortality in children under 5 and women of childbearing age;
2) Empower communities to improve their health; and
3) Strengthen the capacity of the SOL to implement Child Survival interventions.

The project strategy is, in partnership with SOL and the MOH, to help communities create Care Groups and train volunteers (one per ten households) as behavior communication change agents. Care Group volunteers regularly visit more than 23,000 households to explain and promote key health messages. The project intervention mix includes Nutrition (25%); Malaria control (15%); Pneumonia case management (15%); Maternal and newborn care (15%); Child spacing (15%), and the prevention of STI/HIV/AIDS (15%). The project also includes capacity building of SOL to prepare and manage child survival grants.

B. Project Complexity

It is interesting, and important, to note the geographic and partnership complexity of this project.

First, most child survival projects concentrate efforts in one geographic area. TTCSP is working in three separate geographic areas, each under a different management unit of SOL.

Second, most child survival projects, and the PVOs that manage them, work with one or two local partners for implementation, i.e., usually the beneficiary communities and the Ministry of Health. TSCSP, however, is working in collaboration with the SOL, communities and the MOH. These complexities of relationships are in turn multiplied by three geographic areas.

Third, most child survival projects are implemented in communities where there is little in the way of existing community-based interventions. In the case of TTCSP, however, the SOL has an existing network of community-based service providers. In addition, the MOH has well-established outreach into most communities through Health Surveillance Assistants.

These complex dimensions have created a project dynamic and network of relationships that have been a challenge to implement and manage. At the same time, however, they also provide some unique opportunities and potential for sustainability and development of a model for Community-based IMCI programs (see Results Highlight: TTCSP & C-IMCI).
C. Scope of Work and Final Evaluation Methodology

The final evaluation is an opportunity to answer four (golden) questions:

1) Did the project meet its objectives?
2) Were the interventions effective?
3) What are the Lessons Learned from this project?
4) How can we share this project and Lessons Learned?

This final evaluation took place from July 26 to August 5, 2004. The evaluation team consisted of 14 persons, including a USAID representative; three MOH district staff, three SOL PHC personnel, three project area coordinators, the project director and deputy director, the WR country deputy director, and the team leader.

The assessment methodology, as summarized in Annex C, followed USAID guidelines for final evaluations. The evaluation included the following activities:

- Review of KPC and quarterly LRA (Local Rapid Assessment) surveys;
- Responses to the MTE recommendations;
- SWOT assessment of project Strengths, Weaknesses, Opportunities and Threats;
- Visits to the three project areas (see Table 1) for discussions (see Annex D for questionnaires) with District Health Management Teams; SOL Health Management; Health center staff; Health Surveillance Assistants (HSAs); Health promoters; Groups of Mothers; Community leaders; Church Care Group members; and Care Group volunteers;
- Compilation and discussion of field visit reports;
- Formulation of Conclusions and Lessons Learned;
- Presentation to local stakeholders in Mzuzu (Aug. 4)
- Presentation to USAID and UNICEF in Lilongwe (Aug. 5)

| Table 1: Summary of Field Visits to the Three Project Areas |
|----------------|----------------|----------------|
| **MOH SOL**    | **DGM**        | **Embangwenci** | **Ekwendeneni** |
| **Health Facilities Staff & HSAs** | **DGM Mgmt Team** | **Mzimba DHMT** | **Emb Mgmt Team** |
| **Community: CGs, leaders, & mothers** | **Mlowe HC Chitimba** | **Mabiri HC Mharaunda HC** | **Ekwendeni Hosp. (no HCs in this area)** |
| **Community: CGs, leaders, & mothers** | **Luwuchi Chihanga** | **Chitembeya Makhosikazi** | **Ekwaiweni Baula & Chilida** |

The group discussions typically concentrated on these questions (see Annex D for details):

1) How effective has TTCSP been in improving community health?
2) What lessons have you learned through this project?
3) What problems did you encounter? What did you do to try to resolve them?
4) What assistance would be required to ensure that Care Groups continue to function?
### II. ASSESSMENT OF RESULTS AND IMPACT OF THE PROGRAM

#### A. Results: Summary of Baseline, Mid-Term, EOP KPC & Quarterly Surveys (Table 2 and Figure 2)

<table>
<thead>
<tr>
<th>PROJECT OBJECTIVES</th>
<th>KPC 2000</th>
<th>1st Survey Sep 01</th>
<th>2nd Survey Dec 01</th>
<th>3rd Survey May 02</th>
<th>MTE Survey Jul 02</th>
<th>MTE Target</th>
<th>5th Survey Oct 02</th>
<th>6th Survey Feb 03</th>
<th>7th Survey Jul 03</th>
<th>8th Survey Oct 03</th>
<th>9th Survey May 04</th>
<th>EOP KPC Jul 04</th>
<th>EOP Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase from 35.4% to 90% the percentage of children &lt;5 yrs treated the same or next day for fever at an appropriate health facility</td>
<td>35.4</td>
<td>52.0</td>
<td>56.2</td>
<td>56.0</td>
<td>52.1</td>
<td>45</td>
<td>56.2</td>
<td>58.0</td>
<td>47.2</td>
<td>60</td>
<td>62</td>
<td>73.8</td>
<td>90</td>
</tr>
<tr>
<td>2. Increase from 27.6% to 50% the percentage of children &lt;5 yrs who are treated the same or next day for rapid difficult breathing at an appropriate health facility</td>
<td>27.6</td>
<td>52.0</td>
<td>42.7</td>
<td>65.0</td>
<td>55.0</td>
<td>30</td>
<td>42.7</td>
<td>65.2</td>
<td>44.2</td>
<td>59</td>
<td>58</td>
<td>63.6</td>
<td>50</td>
</tr>
<tr>
<td>3. Increase from 8.5% to 50% the number of children &lt;5 years and pregnant women sleeping under bed net</td>
<td>8.5</td>
<td>15.0</td>
<td>Under Fives</td>
<td>13.8</td>
<td>26.1</td>
<td>23.1</td>
<td>15</td>
<td>13.8</td>
<td>26.1</td>
<td>37.4</td>
<td>35</td>
<td>51</td>
<td>60.3</td>
</tr>
<tr>
<td>4. Increase from 62% to 75% the percentage of bed nets that will be retreated within the last 12 months</td>
<td>62</td>
<td>63.0</td>
<td>39.2</td>
<td>55.0</td>
<td>62.2</td>
<td>65</td>
<td>39.2</td>
<td>55.0</td>
<td>79.2</td>
<td>79</td>
<td>92</td>
<td>96.9</td>
<td>75</td>
</tr>
<tr>
<td>5. Increase from 65% to 90% the number of children 0-35months weighed regularly in GMC sessions</td>
<td>65</td>
<td>61.0</td>
<td>59.8</td>
<td>74.0</td>
<td>65.2</td>
<td>75</td>
<td>59.9</td>
<td>90.1</td>
<td>72.2</td>
<td>74</td>
<td>79</td>
<td>97.2</td>
<td>90</td>
</tr>
<tr>
<td>6. Increase from 3% to 30% the proportion of pregnant women who receive daily IFA supplements</td>
<td>3</td>
<td>NA</td>
<td>Under Fives</td>
<td>66.0</td>
<td>58.0</td>
<td>5.1</td>
<td>10</td>
<td>66.0</td>
<td>58.2</td>
<td>39.2</td>
<td>44</td>
<td>70</td>
<td>75.9</td>
</tr>
<tr>
<td>7. Increase from 36% to 50% the proportion of mothers exclusively breastfeeding 0-6 months infants</td>
<td>36</td>
<td>76.0*</td>
<td>80.7*</td>
<td>72.4*</td>
<td>82.1*</td>
<td>40</td>
<td>NA</td>
<td>69.4</td>
<td>75.9</td>
<td>69</td>
<td>80</td>
<td>95.4</td>
<td>50</td>
</tr>
<tr>
<td>8. Increase from 23% to 40% the percent of married women who use a modern method of contraception</td>
<td>23</td>
<td>36.0</td>
<td>47.7</td>
<td>50.3</td>
<td>50.1</td>
<td>25</td>
<td>47.7</td>
<td>50.3</td>
<td>60.0</td>
<td>55</td>
<td>63</td>
<td>61.0</td>
<td>40</td>
</tr>
<tr>
<td>9. Increase from 17.5% to 30% the percent of sexually active married women who state using a condom during their most recent sexual act</td>
<td>27.5</td>
<td>12.0</td>
<td>21.4</td>
<td>17.1</td>
<td>22.0</td>
<td>20</td>
<td>21.4</td>
<td>17.1</td>
<td>24.0</td>
<td>39</td>
<td>22</td>
<td>38.2</td>
<td>30</td>
</tr>
<tr>
<td>10. Increase from 9.5% to 90% the percent of families who have an emergency transport plan in place before delivery</td>
<td>9.5</td>
<td>NA</td>
<td>75.2*</td>
<td>84.1*</td>
<td>86.3*</td>
<td>10</td>
<td>75.2</td>
<td>84.1</td>
<td>71.0</td>
<td>80</td>
<td>84</td>
<td>84</td>
<td>80</td>
</tr>
<tr>
<td>11. Increase from 30% to 60% the percent of pregnant women who receive at least 2 doses of SP during pregnancy</td>
<td>30.6</td>
<td>NA</td>
<td>66.7</td>
<td>56.0</td>
<td>63.0</td>
<td>40</td>
<td>66.7</td>
<td>55.5</td>
<td>46.2</td>
<td>62</td>
<td>70</td>
<td>61.3</td>
<td>60</td>
</tr>
</tbody>
</table>

Notes: NA = Data not collected during survey

* = Methodology used during these surveys was different from the baseline KPC
B. SWOT: An Analysis of Strengths, Weaknesses, Opportunities and Threats

A SWOT analysis of project Strengths, Weaknesses, Opportunities and Threats was conducted on the first day of the evaluation in order to assess the opinions of evaluation team members. The complete results of this survey, with more than 200 pieces of information, were compiled to identify areas where people held similar views.

An initial compilation of the results (see Annex D for details) was presented and discussed with the team members. Based on this discussion further clarifications and consolidation of opinions resulted in the major areas of agreement.

<table>
<thead>
<tr>
<th>STRENGTHS (What does this program do well?)</th>
<th>OPPORTUNITIES (Possibilities to continue this work?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Care Group Structure for Households</td>
<td>1) Existing supportive PHC programs</td>
</tr>
<tr>
<td>2) HIS: Health Information System</td>
<td>2) Donor’s willingness to support</td>
</tr>
<tr>
<td>3) BCC: Participatory Approach</td>
<td>3) CGs are strong - no backsliding</td>
</tr>
<tr>
<td>4) Community Mobilization &amp; Empowerment</td>
<td>4) SOL Health System existing</td>
</tr>
<tr>
<td>5) Interactions with other stakeholders</td>
<td>5) Involve other stakeholders</td>
</tr>
<tr>
<td>6) Committed Staff, Leadership, Team Spirit</td>
<td>6) Structures available for scaling up</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WEAKNESSES (What did the program not do so well?)</th>
<th>THREATS (What might hinder continuation?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Not a provider of Services</td>
<td>1) HIV-AIDS could comprises gains</td>
</tr>
<tr>
<td>2) Integration with Health Facility programs</td>
<td>2) Dropout rate after taken off incentives</td>
</tr>
<tr>
<td>3) Jobless after program ends</td>
<td>3) Insufficient supervision when program ends</td>
</tr>
</tbody>
</table>

Not surprisingly, the Care Group structure, HIS and BCC were identified as the greatest strengths of the project. The most important weaknesses were that the project was not itself a provider of services, making it dependent, for the most part, on services and supplies provided by the MOH and SOL health facilities. There was also a recognized weakness in the integration of the BCC services with health facility programs.

The evaluation team identified a number of opportunities that could contribute to the continuation of this work. Most notably were the existing supportive PHC programs of SOL, the possibility of donor support, and the strength of the Care Group structures. The greatest threats, on the other hand, were thought to be that HIV-AIDS might compromise the gains of the project and the Care Group volunteers might drop out due to lack of motivation and supervision.

The SWOT analysis and discussion tentatively put a number of key issues and potential lessons learned on the table for discussion at the very start of the evaluation process. These comments help shape the types of questions that were asked during the field visits and ultimately re-emerged as part of the Lessons Learned.
C. Progress Report by Intervention Area

1. BCC at the primary intervention

The primary intervention of TTCSP is Behavior Change Communications. BCC is normally discussed later as a cross-cutting activity. However, it is important to note that in this project BCC is the primary (and only) service provided. The service delivery health technical interventions were provided by the SOL and MOH health facilities, health surveillance assistants and SOL community-based volunteers, e.g., drug revolving fund and bednet volunteers.

The resources of TTCSP have concentrated on providing BCC at the community level through Care Group volunteers. Project resources have provided very little in the way of training, supplies or equipment at the health facility level. For example, TTCSP did not procure and distribute bednets, SP, immunizations, cold chain equipment, ARI timers or any of the typical inputs that are associated with those interventions.

It is important to note, and to give credit to the work of the local partners, that when one examines the eleven primary indicators listed below that their achievement depends largely on services provided outside TTCSP. In fact, only two of the objectives (exclusive breastfeeding and emergency transport system) might be considered primarily dependent on BCC alone.

1. Children treated same/next day for fever at an appropriate health facility
2. Children treated same/next day for rapid difficult breathing at a health facility
3. Number of children and pregnant women sleeping under bed net
4. Bed nets retreated within the last 12 months
5. Children 0-35months weighed regularly in GMC sessions
6. Pregnant women who receive daily IFA supplements
7. Mothers exclusively breastfeeding 0-6 months infants
8. Married women who use a modern method of contraception
9. Sexually active married women who used a condom during their most recent sexual act
10. Families who have an emergency transport plan in place before delivery
11. Pregnant women who receive at least 2 doses of SP during pregnancy

This is not meant to be a criticism of TTCSP. This is the way the project was designed and faithfully implemented. This type of project is very dependent on the work of the local partners. The importance of those contributions were noted early in the evaluation process and formulated into the first Lesson Learned.

Lesson Learned #1: A BCC intensive project requires an effective service delivery partner to achieve its objectives.

TTCSP worked hand in hand with the service delivery system and supplies of the Synod of Livingstonia and the Ministry of Health to realize most of its objectives. As a Malawian proverb simply and aptly states this lesson learned, “One head cannot carry a roof.”
The project emphasized key messages at the household level for all child survival interventions. These interventions were introduced in phase. Each phase included a training of trainers that included the health promoters and selected HSAs. These trainers in turn simultaneously trained their Care Groups in the key messages for those interventions and to implement a community wide campaign according to the following schedule:

- Malaria and Pneumonia (April 2001)
- Nutrition and Exclusive Breastfeeding (August 2001)
- HIV/AIDS and Child Spacing (April 2002)
- Maternal and Newborn Care (Oct-Dec 2002)

This strategy provides volunteers an opportunity to fully learn the material and to concentrate on training households for those messages. World Relief has found that by teaching in smaller units, people have sufficient time to internalize and put into practice the information they are learning. Also, interventions can be timed during their greatest need, e.g., introduce malaria training at the beginning of the malaria season.

2. Malaria and Pneumonia

Malaria and pneumonia together are the major cause of under-5 mortality, accounting for over half of the deaths of children nationwide (malaria/anemia, 35%; pneumonia, 16%). The project baseline KPC survey found that 35.4% children <5 yrs were treated the same or next day for fever at an appropriate health facility. Similarly 27.6% were treated the same or next day for rapid difficult breathing.

TTCSP introduced malaria control and pneumonia case management in April 2001 as one intervention because they share a similar symptom (fever) and primary strategy (rapid recognition and treatment of suspected cases). The key messages encouraged caregivers to 1) identify adverse effects and provide care seeking same next day; 2) encourage children and pregnant mothers to sleep under bed nets; and 3) encourage retreating bed nets.

The results in achievement of these objectives are show in Charts #1 and #2.
The final KPC found that 73.8% of the end of project objective (EOP) of 90%. This is the only objective for which the project did not meet or surpass its end of project objective. As shown in charts #3 and #4, the project met its target for bednets, with utilization increasing from 8.5% to an impressive 60% for both children pregnant women. This achievement is in due in part to the contributions of UNICEF and PSI who during the past year have provided large numbers of bednets in the targeted areas. Re-dipping campaigns have also surpassed the EOP objective.

3. Nutrition and Exclusive Breastfeeding

The objectives for this component were to increase the number of:

- Children 0-35 mo. weighed regularly in growth monitoring and counseling;
- Pregnant women receiving iron/folate supplementation;
- Children 6-59 months old receiving Vitamin A capsules; and
- Mothers exclusively breastfeeding 0-6 month infants.

The nutrition intervention has influenced some longstanding socio-cultural issues underlying malnutrition e.g. breast-feeding while pregnant, taboos on eating eggs, and breastfeeding first colostrums. Attendance at growth monitoring clinics had improved to surpass the EOP objective. Nutritional supplementation of pregnant women with Iron Folic Acid (IFA) has improved dramatically and surpassed the EOP objective. This positive result appears to be largely dependent on whether IFA is in stock at the MOH and SOL health facilities.
The EOP objective for Exclusive Breastfeeding (EBF) was also surpassed (see Chart 7). However, it is probable that these results have been skewed by the increased knowledge of mothers, i.e., mothers may be responding to survey questions with the correct answer that they feel interviewers want to hear. This is simply a limitation in the survey methodology. An alternative approach for future consideration might be to use Care Group volunteers as key informants to assess (or double check) what they feel is the level of EBF in households. There is, however, little doubt that the project has increased exclusive breastfeeding in the targeted communities to at least 50%.

TTCSP has found that community-based nutrition management approach using the HEARTH model is an effective and sustainable way of curbing malnutrition in the villages. Two communities participated in HEARTH from January 2002 through December 2003. Children’s weights were monitored for 12 months. Of the 38 children admitted to hearth, 33 successfully participated until the assessment time representing 87% attendance rate. All of the children gained weight tremendously doubling at half a year and at the end of the one year (see Charts #12 and #13).

The HEARTH experience is documented in a separate report entitled “Making a Difference - Best Practices.” Based on the success with HEARTH, the project has recommended that it be scaled up to more reached areas, perhaps through MOH and SOL PHC structures. However, given the intensive nature of this intervention and the current workloads of health facility personnel it is doubtful that there will be much interest.
4. HIV/AIDS and Child Spacing

The objectives of this component, which began in May 2002, were to increase the number of:

- Married women who use a modern method of contraception;
- Married women using condoms during sexual intercourse;
- People taking Voluntary Counseling and Testing (VCT); and
- Post-test clubs to promote healthy lifestyles and advocate VCT.

It should be noted that these objectives and indicators were originally stated incorrectly in terms of Women of Child Bearing Age (WCBA). However, WR and SOL opted to limit BCC for this component to only married women/couples.

The key messages for this component were:

- Know your HIV status through Voluntary Counseling and Testing (VCT);
- Know five signs of Sexually Transmitted Infections (STIs) and seek medical treatment
- Local Injections and bathing dead bodies promote the spread of HIV/AIDS.
- Mothers who are HIV positive and choose to breastfeed should breastfeed exclusively
- Married couples should use condoms for STI/HIV/AIDS prevention and contraception
- Using modern family planning methods improves health, economic and social status
- Condoms can effectively prevent HIV/AIDS and pregnancy.

Progress for these project components is shown in Charts 8 and 9. The increase in modern contraception among married women from 23% to 61% is very impressive. It is also noteworthy that since most Women of Child Bearing Age (WCBA) are married women, the project approach of limiting BCC to married women has still been very effective. One might also assume, although it is unknown through the KPC results, that a significant numbers of non-married WCBA may also be obtaining modern contraceptives from health facilities.
5. Maternal Health and Newborn Care

The objectives of this component were to:

- Educate families about maternal risks;
- Increase the number of deliveries by trained personnel, including trained TBAs;
- Ensure that families have an emergency plan for referrals.
- Increase the number of pregnant women receiving SP and Iron Folic Acid

The provision of SP (Sulfadoxine Pyrimethamine, Fansidar) during pre-natal clinics as a malaria prophylaxis for pregnant women progressed well as shown in Chart 11. It is noteworthy that the project first surpassed its EOP objective by the MTE before this component was officially introduced. This would appear to indicate that Care Groups are providing “enriched” messages during their household visits and that the success of this component, like that of IFA distribution, is largely dependent on the availability of these products at the MOH and SOL health facilities.

![Chart 10: Families who have an emergency transport plan](image)

![Chart 11: Pregnant women receiving two or more SP doses](image)

The objective with regards to emergency transport plans was achieved before the official BCC campaign even began in late 2002. These results, similar to those for exclusive breastfeeding, are probably skewed by increased knowledge of mothers who are eager to give the correct response.

The term “emergency transport plan” generally means that a pregnant woman has received pre-approval from her husband, grandmother and TBA to go to a health facility in case of an obstetrical emergency. This shortens the traditional approval process which typically requires five steps – 1) A pregnant woman tells her husband that she suspects a problem; 2) the husband tells the grandmother; 3) the grandmother tells the TBA; 4) the TBA decides whether referral to the hospital is needed; 5) if approved, the husband arranges the transportation.

Unfortunately “preapproval” does not guarantee that emergency transportation is locally available. The MTE recommended that TTCSP discuss the need for community-wide emergency transportation plan with VHCs, and consider the strategic placement of bicycle ambulances in selected communities. Since the MTE, emergency obstetrical planning among communities has been emphasized. Increasing numbers of pregnant women are making use of “mothers homes” and delivering at hospitals, indicating that the planning has been effective. While no bicycle ambulances have been provided, this has been discussed with communities.
6. Special outcomes, unexpected successes or constraints

Special outcomes and successes of this project have included:

- Care Groups mobilizing communities for other development activities, e.g. communal gardens, and other income generating activities.
- Village banks to support families to access treatment at the hospital when they do not have money and they repay afterwards.
- Care Groups Zonal committees that oversee the activities of individual Care Groups in their respective areas.
- Exchange visits between Care Groups and between promoters for problem solving and information sharing.

7. How Lessons Learned will be applied

World Relief has prepared a new Child Survival project for Chitipa district. This projected was submitted to USAID in Nov. 2003, but unfortunately narrowly missed being funded. The project will be re-submitted for funding this year. The Lessons Learned from the TTCSP final evaluation will be incorporated into the revised proposal.

The results of the final evaluation and Lessons were shared with local stakeholders in Mzuzu and during a joint debriefing with USAID and UNICEF. It is also planned to make similar presentations to DHMTs and SOL health unit personnel in each of the project areas.

D. New tools and innovative approaches

The implementation of this project in partnership with the CCAP Synod of Livingstonia is an innovation for child survival projects. The project builds on the existing infrastructure and service history of health services of the church.

One of the Lessons Learned, based on this innovation is that “A project is more easily sustained if it is planned and implemented as part of an existing program, rather than as a standalone project.” Working through the Synod of Livingstonia health system made it much easier to plan and provide support structures for the continued work of Care Groups, i.e., as part of the SOL Primary Health Care program. However, capacity building does not happen automatically. It requires a conscious strategy and resources.

The Care Group structure represents a new and innovative approach to community organization in Malawi. While the TTCSP project and Care Groups were not specifically designed as a C-IMCI project, the Care Group links together the three elements of C-IMCI, i.e., 1) links between communities and health facilities 2) community-based service providers; and 3) promotion of key behaviors at the household level. This could be one model for C-IMCI programs in Malawi, especially those in which SOL, or other NGOs, have trained volunteers for community-based service delivery (see Results Highlight: TTCSP & C-IMCI).
III. CROSS CUTTING APPROACHES

A. Community Mobilization

1. Care Groups

This project is based on the Care Group model that World Relief has pioneered and used in a number of Child Survival Projects. Community volunteers, each with a responsibility for ten households, are organized into Care Groups (10-12 per group) for mutual support and for training, supervision by project-paid health promoters and health educators.

TTCSP originally estimated a need for 300 Care Groups and 3,000 volunteers. However, the project found that 230 groups were sufficient for 100% geographic coverage of the three targeted areas. Each Promoter works with five to eight Care Groups of 10-15 volunteers each. The project trained approximately 2,300 volunteers. The volunteers make weekly visits to ten households for behavior change communications, i.e., a total of 23,000 visited each month (see Figure 15):

During the MTE Care Groups were asked how they would sustain their work. Strong Care Groups responded, "We are volunteers, our role is to help, we cannot stop." On the other hand, weaker Care Groups begged the question by responding that they would "form a committee to discuss the issue when the project ends." See “Sustainability and Exit Strategies.”

A MTE recommendation encouraged TTCSP to identify best practices for incentives to sustain Care Groups, e.g., services provided to Care Groups from the community and health facilities; recognition of well performing Care Groups by the MOH and Synod Health Units; exchange visits between Care Groups; and income generating activities. The final evaluation team found that a number of best practices as elements of the incentive system have been identified and implemented, e.g., some CGs are exempted from community development work. Exchange visits
between Care Groups have also been implemented. These exchange visits seem to be quite popular and might be a contributing strategy for sustaining the program and having strong CGs visit weaker CGs (or vice versa).

The evaluation team identified two closely related lessons learned with regards to Care Groups.

**Lesson Learned #2:** Action-oriented training and structure of Care Groups encourages effective, empowered teamwork for Behavior Change Communications (BCC).

**Lesson Learned #3:** Interactions between Care Group volunteers and their households are models of love and shared security for the community.

Care Groups organize a community of adults around actions (Behavior Change Communications) and encourage teamwork for the common good of the community. TCare Groups also become a source of shared social support and encouragement for volunteer mothers. This has also become a model for the whole community.

The Care Group structure has demonstrated that organizing adult people in a community around an action encourages teamwork and effectively empowers them to carry out activities that are of common good to the whole community. Care Group volunteers are trained and charged with specific tasks to regularly visit households to monitor the implementation of the BCC key messages. In this way, each of the volunteers felt personally responsible for their ten assigned households, and to report on their progress at Care Group meetings.

The teaching method was also action oriented. Lessons were delivered to the community through drama, music and other demonstrative ways rather than by lecturing. These were imaginatively created by the Care Group volunteers and tailored specifically to their communities. Communities found this approach to be both entertaining and educative, and ultimately more effective. This positive action-oriented approach also provided a feedback mechanism to CG volunteers that gave them more confidence for continuing and increasing these activities.

The story of one health promoter is a good example of this action-oriented training in work:

*Ping Nkwazi, a TTCSP health promoter, says that he was one of the first persons to be transformed by the power of BCC action-oriented training. Prior to TTCSP he would regularly take his seven children to the health facility, at least every other month. However, since learning the key messages of BCC and taking them to heart, he has had to take his youngest child of five years to the health center only one time. Now, as Ping teaches and supervises his Care Groups he offers the example of this own family’s experience. He also sincerely thanks TTCSP for bringing BCC action-oriented health messages to his community.*
B. Communications for Behavior Change (BCC)

TTCSP recognizes that effective BCC must be taught in easily digestible messages, and has appropriately formulated BCC messages from community focus group discussions. These messages, shown in Table 6, are in keeping with MOH policies and technical guidelines.

<table>
<thead>
<tr>
<th>Table 4: Key BCC Messages</th>
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<tbody>
<tr>
<td><strong>Malaria and Pneumonia</strong></td>
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<tr>
<td>1) Identify adverse effects of fever (Malaria).</td>
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<tr>
<td>2) Explain the importance of care seeking same day or next day.</td>
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<tr>
<td>3) Explain the importance of children under five and pregnant mothers sleeping under bed nets.</td>
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<tr>
<td>4) Explain the importance of retreating bed nets.</td>
</tr>
<tr>
<td>5) Identify adverse effects of pneumonia.</td>
</tr>
<tr>
<td>6) Explain the importance of care seeking same day or next day.</td>
</tr>
<tr>
<td><strong>Nutrition and Supplementation</strong></td>
</tr>
<tr>
<td>1) Pregnant/lactating women and children under age of five should take adequate nutritious foods such as Yellow, Greens, Brown and White foods.</td>
</tr>
<tr>
<td>2) Pregnant/lactating women and under five children should take adequate iron and Vitamin A.</td>
</tr>
<tr>
<td>3) All women of childbearing age, men and grannies should know the nutrition related complications in pregnancy/lactating and under fives.</td>
</tr>
<tr>
<td><strong>Exclusive Breast Feeding</strong></td>
</tr>
<tr>
<td>1) Babies should exclusively breastfeed from soon after birth until six months</td>
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<tr>
<td>2) Breast milk contains all the nutrients required for a child from birth to six months</td>
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<tr>
<td>3) Colostrum protects the baby from infections from birth up to later stage.</td>
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<tr>
<td>4) Introduce solid foods after six months and continue breast-feeding for a minimum of two years whether mother is pregnant or not.</td>
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<tr>
<td><strong>Growth Monitoring and Counseling</strong></td>
</tr>
<tr>
<td>1) All children under five should be weighed each month. High risk if no weight gain for 2 consecutive months.</td>
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<tr>
<td>2) All at risk children should receive special care.</td>
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<tr>
<td>3) Parents and guardians should attend the under-5 clinics to be counseled on childcare.</td>
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<tr>
<td><strong>Disease Control</strong></td>
</tr>
<tr>
<td>1) Sick or recovering children should be given food and breast milk more than usual.</td>
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<tr>
<td>2) Children with diarrhea should be given fluids/ORS frequently,</td>
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<tr>
<td>3) Wash hands after contact with faces and before handling foods.</td>
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<tr>
<td>4) All immunizations should be completed by the child's first birthday.</td>
</tr>
<tr>
<td><strong>HIV/AIDS and Child Spacing</strong></td>
</tr>
<tr>
<td>1) Knowing ones HIV status through Voluntary Counseling and Testing (VCT) helps to reduce further HIV transmission and prolongs life.</td>
</tr>
<tr>
<td>2) Men, Women, Boys and Girls should know at least 5 signs of Sexually Transmitted Infections (STIs) and upon seeing them they should seek medical treatment immediately.</td>
</tr>
<tr>
<td>3) Local Injections and bathing of dead bodies are traditional practices that promote the spread of HIV/AIDS</td>
</tr>
<tr>
<td>4) Mothers who are HIV positive and choose to breastfeed should breastfeed exclusively</td>
</tr>
<tr>
<td>5) Married couples should use condoms for STI/HIV/AIDS prevention and contraception</td>
</tr>
<tr>
<td>6) Using modern family planning methods improves health, economic and social status of individuals/families.</td>
</tr>
<tr>
<td>7) Condoms when properly stored and used can effectively prevent HIV/AIDS and pregnancy.</td>
</tr>
</tbody>
</table>

The fact that the project has surpassed almost all of its primary objectives is, of course, a demonstration of the effectiveness that these BCC messages have had in increasing demand for services. There is also ample anecdotal evidence from the communities and health facilities that BCC messages are resulting in new ways of doing things:

- Increased attendance at health facilities and for antenatal care;
• Volunteers referring mothers to the hospital even when they can only pay in kind;
• Mothers refusing to go to traditional healers;
• Traditional Healers bemoaning their dwindling market;
• Traditional healers who become volunteers.
• Openly breastfeeding child even when mother pregnant;
• Increasing attendance at growth monitoring clinics; and
• Couples opting for Voluntary Counseling & Testing.

The MTE recommended that TTCSP target men and community leaders with BCC. Possible strategies included 1) special training of village leaders; 2) revitalizing “Mphala,” a tradition of men to boy communication; 3) encouraging men’s discussion groups; and 4) team visits by volunteers to difficult households. The final evaluation team found that while the project had not pursued a systematic revitalization of “Mphala,” some health promoters have done so. Similarly, organized orientation programs for community leaders have been left to the initiative of health promoters. Promoters are expected to meet with headmen (and other community leaders) to communicate project activities, messages and HIS results. Village leaders have been generally supportive of promoters and volunteers. However, given the Lesson Learned #6 (see below), it would seem that something more should have (and still could be) pursued with BCC for men.

The MTE also recommended that TTCSP document best practices in BCC materials and make them widely available, e.g., durable picture codes for Care Group volunteers. TTCSP has prepared a file of improved BCC materials with pictures & simple text in Tumbuka. However, the project felt that they were too expensive to print in sufficient numbers. The project has, however, benefited from WR AIDS IEC materials for HIV/AIDS. The project has also summarized its approach to BCC in “The BCC Learning Cycle” (Figure 4).

The final evaluation team identified three Lessons Learned in the area of BCC:

**Lesson Learned #4: Knowledge empowers people to action.**

One-on-one behavior change communication results in not only in improved health behaviors, but also in community-wide actions like group gardens and IGAs. A few of the empowered activities that were noted include:

- Protecting family against malaria & other preventable diseases;
- Spacing children or limiting the number of children;
Promoting good hygiene and sanitation in the home;
- Organizing group gardens as an IGA for social assistance activities;
- Developing nursery schools in the community; and
- Beginning initiatives to raise funds to purchase a bicycle.

It is particularly noteworthy that time and time again, that women, in particular, mentioned that their increased knowledge has empowered them to more openly discuss health matters and make joint decisions with their husbands, e.g. about family planning. This may, in effect, be one of the most important and sustainable contributions from this project.

**Lesson Learned #5: BCC is a powerful force for community redefinition of acceptable behavior.**

BCC campaigns have created a community-wide standard for acceptable behavior, and provided peer pressure to bring about behavior change among those who initially rejected the messages. For example, it is no longer acceptable behavior to use a bednets as fishing nets.

As more community members accept and begin to practice BCC and discern the benefits more pressure tends to mount on those who have not embraced the BCC to comply. And as village leaders get inspired to openly talk about BCC and pastors through Pastors’ Care Groups encourage youth leaders to teach fellow youths, non-compliance with BCC gradually becomes unacceptable deviant behavior. For instance less and less people in the project area seek treatment for fever and convulsions from traditional healers now than before the project and much less people reveal they visited a traditional healer for fear of stigma and ridicule that now comes with such care-seeking behavior.

Conversely, there has been an upsurge of good practices that communities previously deemed unacceptable. With BCC more pregnant mothers now ‘openly and defiantly’ continue breastfeeding their children and much more pregnant mothers and children eat eggs. Community norms are gradually but steadily being re-shaped and re-aligned with BCC thereby setting standards for acceptable behavior.

**Lesson Learned #6: Women are more enthusiastic, effective BCC agents than are men.**

Care Groups often include an equal number of women and men volunteers. This resulted by chance rather than by specific design. Women, however, attend meetings more regularly, and are more enthusiastic about BCC, especially drama and music. Perhaps this is because the project addresses issues and key messages primarily to women and children where child care is still considered a women’s job, and the husband’s influence is more indirect.

While the drop out rate is greater for men than women, men are generally recognized, by tradition at least, as being more persuasive communicators in village groups. Their presence in the Care Group, even in small numbers, helps legitimize the function of the Care Group.
C. Capacity Building

1. Capacity Building of World Relief

World Relief has considerable experience of implementing in implementing simultaneously more than a dozen Child Survival programs. Each CS project adds something new to that experience. WR is currently drawing on the experience of the Tiweko Tose project, and other projects, to prepare a manual on Care Groups.

2. Capacity Building of the Synod of Livingstonia (SOL)

The third major objective of TTCSP was to “Strengthen the capacity of the SOL to implement Child Survival interventions.” Capacity building of SOL is not straightforward since each of the three hospitals has a unique history of community project development with different core competencies and different community-based programs. As the DIP aptly noted, “The project is not working in an organizational and program vacuum but rather in organizational and community settings that are richly diverse.”

This diversity of SOL’s programs is apparent in Figure 5, which also shows the position of community leadership and Village Health Committees in coordination of these activities. SOL has a long history of community-based initiatives including drug revolving funds (DRFs), bednet sales, community-based distribution agents, and water/sanitation committees.

**Figure 5: Project, Partner and Community Structures**
The SOL PHC staff are involved in project implementation, especially curriculum development, data collection, promoter training and supervision. The goal is to enhance their capacity to assume responsibility for child survival interventions. The key indicator for SOL capacity building was that “by end of project, SOL will write and have funded from outside donors a grant proposal for interventions related to the sustainability of essential MCH interventions.”

WR and SOL PHC did jointly develop and currently implement an Agriculture and Food Security proposal that works through Care Groups and health promoters. It is anticipated that this project may serve as an Income Generating Activity for Care Groups. However, while this initiative is to be commended it does not really satisfy the objective of a “grant proposal for interventions related to the sustainability of essential MCH interventions.” Meanwhile, World Relief has independently prepared a CS proposal for Chitipa district that is based on the TTCSP experience and which includes SOL only as one of several local partners.

Dr. Ngwira, the Synod Health Director feels that SOL has a stronger capacity today to provide PHC and CS services, especially for BCC at the community level. However, he also recognizes that the project did not do any specific capacity building activities with SOL or bring in any specific technical assistance to help SOL with proposal writing. The project’s approach for capacity building of SOL has been more of absorption from the bottom up, rather than provision of technical assistance to Synod PHC directors.

Another indicator of SOL capacity building was that “SOL PHC staff would attend at least 80% of the meetings of VHCs and District Health Management Team (DHMT).” SOL PHC staff have attended all DHMT meetings held; however, DHMT meetings have been inconsistent and not been held for almost one year. According to TTCSP, it is the responsibility of the DHMT to invite all health players in the district for said meetings. However, to compensate, the CSP has asked for meetings with the district to share reports of project activities and study findings including the First Annual Report, Nutrition Status Survey Report, DRF Assessment, Mid Term Evaluation Report, and Assessment of Volunteers.

It was also the intention of both WR and the Synod to use TTCSP as a “unification” project, i.e. a project in which the three disparate geographic programs would work in a more integrated fashion. More specifically, the MTE recommended that CSP and the three Health Units consider how the TTCSP health promoters might provide integrated, cost-effective support and supervision for all community-based Synod health initiatives.

This is being tried in DGMH areas where PHC and CSP engage the same volunteers in all PHC work. However, the idea of having TTCSP health promoters and Care Groups expand and continue their work to provide support to other Synod volunteers has not been well received. Both health promoters and Care Groups have been perceived as threats by the other SOL programs. Some people feel that Care Group volunteers might want to take over the health service provision that other SOL volunteers are doing, e.g., to be drug revolving fund volunteers selling essential medicines and/or bednet volunteers to sell bednets within the community. TTCSP has not (yet) convincingly been able to explain the advantage of using CG volunteers as the BCC agent for the other SOL volunteers.
The Lesson Learned from capacity building of SOL is as follows:

**Lesson Learned #7:** A project is more easily sustained if it is planned and implemented as part of an existing program, rather than as a standalone project.

Working through the Synod of Livingstonia health system made it much easier to plan and provide support structures for the continued work of Care Groups, i.e., as part of the SOL Primary Health Care program. However, capacity building does not happen automatically. It requires a conscious strategy and resources.

3. Capacity Building at the Community Level

The second major project objective was to empower communities to improve their health. The achievements to date demonstrate what is possible when there is good collaboration between a BCC project to create demand and functioning health facilities to satisfy that demand.

The key issue then becomes how to sustain the work of Care Groups once the project ends. The project at first focused on reinforcing Village Health Committees to supervise Care Groups. The MTE, however, raised doubts as to whether that strategy would be most effective, and recommended diversifying strategies, e.g. meetings between Chief volunteers and village headmen; Care Group Zone Committees; and increased links to HSAs and health centers.

The final evaluation found that most VHCs are no longer active, and that the other recommended options have been pursued only informally. This became, therefore, a key topic for discussions with the field visits. All interview included the question, “How can you support the continued work of Care Groups?” A sampling of results from these discussions are shown in Table 5.

<table>
<thead>
<tr>
<th>Group</th>
<th>How can you support the continued work of Care Groups?</th>
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<tbody>
<tr>
<td><strong>District Health Mgmt Teams</strong></td>
<td>- More HSAs could be trained to supervision Care Groups</td>
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<tr>
<td></td>
<td>- Care groups are participatory, democratic and transformative</td>
</tr>
<tr>
<td></td>
<td>- CGs focus much at community much more than VHC</td>
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<tr>
<td></td>
<td>- MOH would continue supporting care groups</td>
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<tr>
<td></td>
<td>- HSAs are an ideal structure for the support but are overloaded</td>
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<tr>
<td></td>
<td>- Need for gradual phasing out</td>
</tr>
<tr>
<td><strong>SOL Health Unit Teams</strong></td>
<td>- Hospital through PHC will provide supervision and support.</td>
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<tr>
<td></td>
<td>- TTCSP Area Coordinator could continue working as CG Coordinator</td>
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<tr>
<td></td>
<td>- Some TTCSP volunteers are part of PHC programs. Easy to supervise.</td>
</tr>
<tr>
<td></td>
<td>- Supervision from PHC office for CGs, HSAs in the communities</td>
</tr>
<tr>
<td></td>
<td>- Local leaders already mobilized to give support to CGs</td>
</tr>
<tr>
<td><strong>Health Promoters</strong></td>
<td>- We will continue to work as volunteers. We started as volunteers</td>
</tr>
<tr>
<td></td>
<td>- Continue working in community as volunteers. Need IEC materials</td>
</tr>
<tr>
<td></td>
<td>- Promoters are already volunteers and will go back to volunteerism</td>
</tr>
<tr>
<td></td>
<td>- High potential for some (4) promoters to seek paid jobs</td>
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<tr>
<td></td>
<td>- Need for additional six months to support weak care groups</td>
</tr>
<tr>
<td></td>
<td>- Need for a new push bicycle to sustain the activities</td>
</tr>
<tr>
<td>Group</td>
<td>How can you support the continued work of Care Groups?</td>
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</tbody>
</table>
| **Health Facility Staff** | - Promoters will work as volunteers after the program  
- HSAs will continue to collect HIS info from CGs  
- CGs which are already trained will train newly formed CGs  
- VHCs & CGs will work together with support from HSAs  
- Health facilities will continue to support CG innovations |
| **Community Leaders** | - Village headman spreads health messages to other places  
- Drop-out replacement of CG volunteers by village leaders.  
- Gradual graduation of care groups  
- Village Headmen and VHC will supervise Care Groups  
- Meet with CGs monthly and get reports. |
| **Care Group Volunteers** | - Well trained highly motivated CG which is ready to train others  
- Innovations like IGAs which motivates team building  
- Others are motivated to join the CG  
- Train volunteers to train others  
- Exchange visits between active and non active CGs  
- Continue and increase good liaison with Health Center staff  
- Continue meeting as Care Group and provide BCC to households  
- Formed and strengthened zonal committee  
- Engaged/elected zonal sectoral heads to supervise CGs.  
- Recognize VHC and village headmen to support them. |
| **Mothers** | - Encourage Care Groups  
- Demand from village headmen to support the Care Groups.  
- Effective gradual weaning is much better abrupt phasing out  
- Mothers will continue to encourage them so that they learn more |

50% of CGs are linked to an active “engaged” HAS. However, these relationships have not been closely monitored by the project (see Transition Planning in *Conclusions*). It is probable that some Care Groups will continue to receive support from HSAs. Local health facilities of the MOH recognize the Care Group structure and are supportive of this approach. Zonal committees have been also organized in some project areas to sustain the work of Care Groups.

The graduation of Care Groups is probably the most significant element of capacity building at the community level. It was (and still is) intended as a celebration of their independence and maturity. Based on the Vurhonga project model, a Care Group was to graduate when 60% of its members passed an oral test. The objective is to make Care Groups as independent as possible, with the “Chief Volunteer” becoming the internal “promoter” of the Care Group. However, while some Care Groups were already to graduate a year ago or more, this process, for a number of reasons, had not yet been implemented. During the final evaluation, Area Coordinators estimated that 50% of Care Groups are ready to graduate.

As the possibility and conditions for Care Group graduation were discussed during the final evaluation, it became apparent that this event was now being closely associated with (and synonymous to) the end of the project. This has there created a dilemma for the project, and resulted in an interesting difficult Lesson Learned.

**Lesson Learned #8:** Sustainability activities programmed near the end of a project may be negatively associated with phasing out.
D. Sustainability and Exit Strategies

The exit strategies for this project naturally focus on how best to support the work of Care Group volunteers. However, because the SOL has its own community-based activities in the project area, the question has been how to phase-in support for Care Groups into ongoing PHC programs and SOL structure.

An important first level sustainability strategy, as previously discussed, is directed at Care Groups and their eventual “graduation.” A second level sustainability strategy is directed at health promoters. The project hopes that since promoters were recruited locally, that they will stay in their communities and continue supporting Care Groups after project completion. Some of them would be qualified to become HSAs should that training opportunity be provided.

Because of the dubious status of Village Health Committees the MTE suggested that links between Care Groups and the village headman and HSAs (see Figure 6) might, in fact, be an acceptable substitute for the VHC. Some “engaged” HSAs are already seen as an important source of technical information and supervision from the health center. Therefore, one exit strategy scenario would be for the project to transfer the “moral encouragement” support for Care Groups to village headman, and the “technical support” for Care Groups to HSAs.

Figure 6: Links from Care Groups to HSAs and Village Headmen

The initial response to reinforcing these links was that adding tasks of supervision and support of Care Groups by HSAs would overburden their job description. However, upon further discussion it became apparent that Care Groups could help unburden the work of HSAs by taking over (and performing more effectively) the BCC tasks that HSAs are expected to complete.

The discussions with MOH and SOL representatives were very positive. In addition, during the debriefing with USAID, the team learned that the MOH is working on a new HSA curriculum which includes a module of what HSAs do at the household level. This would be a great opportunity to explain how HSAs might provide BCC to households through the Care Group structure (or other community-based BCC volunteers) should they exist in the area where an HAS is working. TTCSP could be written up as a case study as part of this curriculum.
According to the DIP, most of the capacity-building and sustainability objectives were to be implemented during the last two project years. However, some of the indicators were overly complex and almost impossible to measure, e.g., “At their last meeting, 75% of the VHCs address at least 3 of 5 responsibilities.” On the other hand, the graduation of Care Groups which is an extremely important and relatively easy to measure capacity-building indicator was not included as a capacity-building or sustainability indicator. The project would probably have advanced further with phasing out and sustainability had a specific indicators, like graduation of Care Groups, been tracked “up front” as part of the project monitoring system. This observation led to the formulation of another Lesson Learned.

Lesson Learned #9: Phasing out indicators should be included and featured prominently in project monitoring.

It was encouraging to note, however, during the Final Evaluation that the TTCSP area coordinators estimated that:

- 50% of Care Groups are ready to graduate;
- 42% of CGs are working with an “engaged” (trained and active) HAS;
- 42% of CGs have organized Zonal Committees for support;
- Many Health Promoters have promised to continue working as volunteers; and
- SOL & MOH indicate a strong desire to continue support to Care Groups.

It is also noteworthy both MOH and SOL authorities are enthusiastic about the possibility about increasing the role of HSAs in serving as a link to Care Groups. Dr. Ngwira, the SOL Health Director, feels that HSAs working in synod health facilities are informally seconded to SOL. This means that the SOL PHC director should have considerable authority to using them become as the transmission link for reports from Care Groups to health facilities and onward to the CG coordinator and PHC director in their respective program regions.

Based on these results and in order to maintain Child Survival activities after the current CSP grant funding ends, the evaluation team has recommended that each of the SOL Management Unit prepare a transition plan for phasing over from project to program management. The evaluation team took advantage of the presence of the PHC director from DGMH to prepare a draft DGMH Transition Plan (see Table 6).

<table>
<thead>
<tr>
<th>Table 6: Draft DGMH Transition Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Activities</strong></td>
</tr>
<tr>
<td>Prepare Map of Care Groups &amp; HSAs</td>
</tr>
<tr>
<td>Staff Transition from TTCSP to SOL</td>
</tr>
<tr>
<td>(Area Coordinator, Health Educator, Driver)</td>
</tr>
<tr>
<td>Discuss HSA role with DHO</td>
</tr>
<tr>
<td>Briefing of HSAs</td>
</tr>
<tr>
<td>HSA orientation on Care Groups</td>
</tr>
<tr>
<td>Area PHC Committee briefings</td>
</tr>
<tr>
<td>Care Group Graduation</td>
</tr>
</tbody>
</table>
IV. PROGRAM MANAGEMENT

A. Planning

The original planning process for the project and the Detailed Implementation Plan (DIP) was quite inclusive, including both the SOL and MOH representatives. Project direction found the DIP preparation process to quite practical and was used for project implementation. However, they also feel that the number of interventions might have been too numerous.

Planning and review meetings during the implementation process, especially those called by the District Health Management Team (DHMT), did not occur as frequently as originally intended. Had these meetings occurred as planned, and had TTCSP project direction been a bit more assertive in making those meetings happen, the transition process would probably be further advanced than it is today.

B. Human Resources and Staff Management

Staff supervision is structured and provided according to the organizational chart (Figure 18).

Since the MTE, selected project staff, the project deputy director and two health educators, received training in C-IMCI from CORE group. They found one week to be too short for this training as the development of a strategy was not really done. They found this training to be useful in understanding PHC is organized at the community level and how it can be part of a C-IMCI approach.

Other training included one week of qualitative research for four project staff where they learned more about participatory research tools, such as focused group discussions, free listing and positive deviancy.

Finally, the deputy director was able to complete a long distance learning “Masters in Rural Development” through the University of London. Appropriately, his thesis work examined the impact of a volunteer network on behavior change communications specifically looking at issues of attendance, gender, and mutual support. He was also able to present the work of the project at Global Health Conference (2003) and attend the Child Survival Mini-University at Johns Hopkins, which he found to be extremely useful.

One of the challenges of this project was that in working in partnership with SOL, that the project “inherited” SOL personnel for key project positions, e.g., Area coordinators. In some cases these personnel were less qualified than personnel recruited from the outside. There was also a training gap at the level of the SOL PHC directors. The project assumed that a close working relationship would automatically develop with these PHC directors as Area Coordinators reported both to their PHC director and to TTCSP project direction. This did not happen, and, in fact, became a point of tension. In retrospect, the project should perhaps have made more effort for capacity building of PHC directors and to develop a better (and sustainable) working relationship with them.
The supervision of project personnel, especially the area coordinators, health educators and health promoters, was intended to depend primarily on supervision from PHC directors. However, this did not develop as well as planned, perhaps in part because of a lack of capacity building for those individuals. Also, and perhaps more importantly, the natural tendency of personnel to be linked to the “resource-rich” project office, probably explains why the project took on more responsibility in this area than they originally intended.

Two of the three area coordinators were SOL employees before the project began. Dr. Ngwira, the SOL health director feels that it should not be difficult for those persons to be reabsorbed by the system and continue their work as Care Group coordinators. He is also prepared to offer a position to the third area coordinator who was “market hired.” However, since this has not yet occurred, it is not possible to say that the “supervisory system fully institutionalized.”

noted that two of the current area coordinators were formerly SOL employees and that they are to be “reabsorbed” into the system. He is open to the idea that these persons might become the CG coordinator under the director of the PHC director.

The MTE recommended that the supervision system be improved with more quantitative monitoring of volunteers and promoters using information that is already available. It was also recommended that the project seek technical assistance in this area. This did not happen, and while the supervision of health promoters appears adequate, the project has not taken advantage of this potential strength. For example, it would not be difficult for the project to monitor the performance level of health promoters and Care Groups, but the system has never been developed to do this. This could have been particularly helpful in advancing the phasing out of the project.
C. Financial and Logistics Management

As the DIP so aptly states, “The project is person-intensive, not commodity-intensive.” Given the three project areas and the large number of personnel involved in this project, logistics are very important to maintaining a smoothly operating project. Vehicles and motorbike have facilitated provision of extension. All necessary personnel were provided two weeks of motorcycle training and exams.

Each promoter is provided a pushbike with the understanding that ownership remains with the project. The promoters are responsible for minor repairs. Major repairs, especially new tires, are provided by the project. This system has worked quite well, especially in the flatter terrain of Ekwendeni and Embangweni.

D. Information Management (Health Information System)

The quarterly surveys have provided an excellent means of monitoring project activities. In addition to the quarterly surveys, chief volunteers keep Care Group registers and submit monthly reports to their respective promoters. Promoters on their Friday meetings give reports and submit them to Area Coordinators and Health Educators who in turn serves as inputs into monthly reports submitted to central office by hospitals. These data have also been used to report to local leaders and solicit their support to mobilize communities. As noted above, however, there is a need to improve the HIS and monitoring system by using this information to compile performance indicators for volunteers and promoters.

The MTE recommended that CSP should 1) adopt standardized tools to supervise promoters and Care Groups, 2) improve info feedback to communities; 3) increase info exchange with MOH and within Synod Health Units; and 4) improve mapping of project areas and activities.

Since the MTE the project improved its comprehensive system of data collection and sharing for decision-making at different levels of the project. The elements of project HIS include the Community Health Information System and Local Rapid Assessment (LRA) Surveys. However, the adoption of standardized tools to supervise promoters and Care Groups have not been developed. Info exchange with Health Centers has been improved reinforced links to HSAs.

The project could also have made more use of mapping to monitor project activities and to develop project exit strategies. For example, a key element of the newly proposed transition plan for DGMH will be to “map out” the current support links between Care Groups and their graduation potential, engaged HSAs, zonal committees and health promoters who are likely to continue working as volunteers. Optimally, each Care Group will require one or more support links ensure that they continue to receive technical and motivational support. Table 7 shows the type of information that will be collected to assess these support links. An additional step to geographically map these links on a map could help guide the transition process.
Table 7: Illustrative Care Group Data for the DGMH Program Area

<table>
<thead>
<tr>
<th>Care Group</th>
<th>Community</th>
<th>Health Center Catchment Area</th>
<th>Care Groups Ready to Graduate?</th>
<th>HSAs Already Engaged?</th>
<th>Health Promoters Very Active?</th>
<th>Zonal Committee Exists and Active?</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zwangendaba-1</td>
<td>Zwangendaba</td>
<td>Mabiri</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>4</td>
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<tr>
<td>Saswa-1</td>
<td>Saswa</td>
<td>Mabiri</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>3</td>
</tr>
<tr>
<td>Chikande-1</td>
<td>Chikande</td>
<td>Mabiri</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td>Chikande-2</td>
<td>Chikande</td>
<td>Mabiri</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td>Mabiri-1</td>
<td>Mabiri</td>
<td>Mabiri</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td>Mabiri-2</td>
<td>Mabiri</td>
<td>Mabiri</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td>Muzozu-1</td>
<td>Muzozu</td>
<td>Mabiri</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>2</td>
</tr>
<tr>
<td>Viwangalala-1</td>
<td>Viwangalala</td>
<td>Mabiri</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>1</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>

E. Technical and Administrative support

Project staff found technical assistance from World Relief to be “quite beneficial, expeditious and timely.” Most of the supplemental TA that was recommended during the MTE was obtained, e.g., formation of HIV/AIDS post-test clubs, follow-on grant proposal writing, and end-of-program evaluation.

However, the grant proposal writing TA concentrated on the development of a new Child Survival proposal in a new geographic area (Chitipa) that is not in direct partnership with SOL. The objective of capacity building of SOL to prepare a Child Survival proposal was not, therefore, realized. Also, during the MTE it was suggested that the project seek TA for improving it supervision and monitoring tools. While a visit to World Relief’s Vurhonga project in Mozambique was made, this did not result in any marked improvement in the project personnel monitoring system.

F. Response to MTE Recommendations

Annex E summarizes the MTE recommendations, the status of project actions/responses to those recommendations in October 2003, and the assessed status of the implementation of recommendations at the time of the final evaluation. In general, the project, for a number of reasons, did not implement the recommendations as fully as they had hoped, especially with Recommendations 7, 8, 9 and 10 dealing with program integration with SOL, program expansion with the MOH, exit strategies and sustainability, and adoption of improved HIS tools. Discussions with SOL and the MOH during the final evaluation indicate good potentials for sustainability. However, these discussions and plans should have been formulated and implemented months ago. The project really needs another year to phase over support to SOL and the MOH.
V. CONCLUSIONS AND LESSONS LEARNED

A. Conclusions

TTCSP is a very complex child survival project because it: 1) is essentially three projects areas combined into one project; 2) is implemented through the health services of the Synod of Livingstonia; and 3) is introducing a new concept in community-based BCC in an environment that is already historical rich with community initiatives.

The project is to be commended for achieving eleven of its twelve primary objectives due, in part to its collaboration with services provided by SOL and MOH health facilities. Care Groups are well established and recognized as effective BCC agents by both SOL and MOH.

It is encouraging to learn that 50% of Care Groups are ready to graduate and that 42% have a trained and active HSA. While the “graduation” of Care Groups has not yet occurred, discussions with the MOH and SOL indicate that this will not be difficult as HSAs will help supervise and link Care Groups to health centers.

In order to sustain BCC and Care Group activities after the current CSP grant funding ends, it is important that each of the SOL Management Units prepares a transition plan for phasing over from project to program management (see Table 6 for the draft plan from DGMH). However, it would also be of interest to WR and SOL to seek some additional funding adequately support the phasing out/over process and in documenting the “phasing in” of HSAs.

B. Summary of Lessons Learned

The evaluation team identified the following nine Lessons Learned:

LL1: A BCC intensive project requires an effective service delivery partner to achieve its objectives.

LL2: Action-oriented training and structure of Care Groups encourages effective, empowered teamwork for Behavior Change Communications (BCC).

LL3: Interactions between Care Group volunteers and their households are models of love and shared security for the community.

LL4: Knowledge empowers people to action.

LL5: BCC is a powerful force for community redefinition of acceptable behavior.

LL6: Women are more enthusiastic, effective BCC agents than are men.

LL7: A project is more easily sustained if it is planned and implemented as part of an existing program, rather than as a standalone project.

LL8: Sustainability activities programmed near the end of a project may be negatively associated with phasing out.

LL9: Phasing out indicators should be included and featured prominently in project monitoring.
C. Results Highlight: TTCSP & C-IMCI

Community-Based Integrated Management of Childhood Illnesses (C-IMCI) includes, by definition\(^1\), three elements:

- **Element 1**: Links between communities and health facilities that serve them;
- **Element 2**: Community-based service providers, e.g., TBAs; and
- **Element 3**: Promotion of key behaviors, especially at the household level.

The Tiweko Tose Child Survival Project has trained more than 2,300 Care Group volunteers in Behavior Change Communications, with each volunteer responsible for ten households. This approach represents Element 3 of C-IMCI. At the same time, the presence of Synod of Livingstonia (SOL) community-based volunteers for service delivery represents element 2, e.g., TBAs, Drug Revolving Funds, and Bednet volunteers, etc. Finally, Element 1 reaches into these same communities from health centers, both SOL and the MOH, with Health Surveillance Assistants (HSAs).

While the TTCSP project was not specifically designed as a C-IMCI project, the resulting project (after the transition phase is completed) will link together these three elements as shown in the figure below. This could be one model for C-IMCI programs in Malawi, especially those in which SOL, or other NGOs, have trained volunteers for community-based service delivery.

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1 As described, for example, in “Reaching Communities for Child Health and Nutrition: A Proposed Implementation Framework for HH/C IMCI,” published by BASICS and CORE, Jan. 2001.