MONKEY BAY COMMUNITY HOSPITAL PROJECT

Monkey Bay Health Zone, Mangochi District, Malawi

PROJECT DOCUMENT
January 2009- December 2011

The Government of the Republic of Malawi

The Icelandic International Development Agency

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Acronyms

AEHO Assistant Environmental Health Officer

AHSA Acting Hospital Service Administrator

AIDS Acquired Immunodeficiency Syndrome

ART Antiretroviral Therapy

CBDA Community Based Distribution Agent

CD Country Director

CHAM Christian Health Association of Malawi

CMS Central Medical Store

CO Clinical Officer

DHMT District Health Management Team

DEHO District Environmental Health Officer

DHO District Health Officer

DNO District Nursing Officer

EHP Essential Health Package

EPI Expanded Programme on Immunisation

GDP Gross Domestic Product

GoM Government of Malawi

HIV Human Immunodeficiency Virus

HMIS Health Management Information System

HSA Health Surveillance Assistant

ICEIDA Icelandic International Development Agency

IMCI Integrated Management of Childhood Illness

MA Medical Assistant

MBCH Monkey Bay Community Hospital

M/CO Co. Medical/Clinical Officer Coordinator

M&E Monitoring and Evaluation

MCT MBCH Coordination Team

MDGs Millennium Development Goals

MGDS Malawi Growth and Development Strategy

MoH Ministry of Health

NGO Non-Governmental Organisation

NRU Nutrition Rehabilitation Unit

OPD Out-Patient Department

PC Project Coordinator

PD Project Document

PIU Project Implementation Unit

PMG Project Monitoring Group

SCO Service Clerk Officer

STI Sexually Transmitted Infections

SWAp Sector Wide Approach

TA Technical Advisor

TB Tuberculosis

TBA Traditional Birth Attendant

TMT Technical Management Team

UNDP United Nations Development Programme

VCT Voluntary Counselling and Testing

Project Summary Sheet

Country:	**Malawi**
Sector:	**Health Sector**
Executing Agencies:	**Ministry of Health, ICEIDA**
Project Title:	**MONKEY BAY COMMUNITY HOSPITAL PROJECT**
Project Period:	**2009-2011**
Total Estimated Cost:	**USD 3.220.021**
ICEIDA Contribution:	**USD 2.200.000**
Government of Malawi Contribution:	**USD 1.020.021**[1]

Development Objective:
The overall objective of the Project is to support the Government of Malawi (GoM) in its efforts to achieve the Millennium Development Goals, (herein referred to as MDGs), and its national development goal of economic growth as laid down in the Malawi Growth and Development Strategy, (herein referred to as MGDS) through improved essential health service delivery in the Monkey Bay Health Zone area and adjacent health zones.

Specific Objectives:
1. Improve and upgrade infrastructure and equipment of the MBCH to progress towards standards defined by the GoM for community hospitals in order to operate as first line referral for health centres within the zone.
2. Increase operational capacity of community health related services in the zone with logistical support, training and infrastructure.
3. Provide training to health and administrative personnel in the MBCH zone based on identified needs during the project period.
4. Improve utilization of health management information systems to strengthen delivery of the essential health package in the zone
5. Facilitate collaborative approaches among stakeholders delivering essential health package in the Monkey Bay Health Zone and with the Mangochi District Health Management Team.

Expected Outputs:
In order to achieve the specific objectives the project will have to deliver the following results:

1. Monkey Bay Community Hospital provides services as first line referral hospital and progresses towards providing required service of a community hospital as defined by the GoM, through installation of new infrastructure and equipment.

2. Increased clinical and operational capacity of community clinics and outreach activities within the MBCH zone for delivery of improved health care services including the provision of components of IMCI, EPI, VCT, STI and Safe Motherhood.

[1] Based on DHO figures in 2008 taking into account budget for health workers and drugs as well as Service agreements in Monkey Bay Health Zone. Per annum: 47.601.000 MWK at the rate of 140 MWK to the USD.

3. Training of staff at MBCH and in outreach activities follows a clear policy based on needs assessment for staff and focused on on-site training when applicable during the project period.

4. Regular and increased use of statistics generated by the health services based on established guidelines.

5. Regular consultation and collaboration between stakeholders in the delivery of health care services within the MBCH zone and with the Mangochi District hospital.

SPECIFIC OBLIGATIONS AND COMMITMENTS OF THE CONTRACTING PARTIES

1. THE GOM THROUGH THE MOH CONTRIBUTION

- Provide necessary institutional/administrative support to the Project on district and ministry levels and gradually integrate project costs through governmental budget procedures and the budget of the Mangochi District Health Management Team; *and*
- Work towards financial sustainability of the project activity with cost integration in the district budget, for instance simultaneously with ICEIDA's maintainance funds phasing out.
- Provide necessary local professional, technical and support staff
- In case of up-grading of staff funded by ICEIDA, secure during the period of study substitutes with the same professional qualification;
- Secure staff who complete up-grading or diploma courses with ICEIDA's support by signing a contract to return to the health services in the Monkey Bay Health Zone Area for a defined period after the completion of the course;
- Pay the salaries of local professional, technical and support staff;
- Pay allowances and other expenses for MoH and DHMT in Mangochi for field visits and meetings regarding the Project in accordance with Malawi Government rules and regulations;
- Ensure on its behalf regular and increased use of health statistics and provide skilled staff to that end for a regular evaluation of stakeholders.

2. ICEIDA shall be responsible for:

- Finance extension, improvement and maintenance of physical infrastructures of MBCH, and clinics, and their equipment;
- Support the Health Management Team in the Monkey Bay Health Zone Area to strengthen its efficiency and effectiveness, both at the MBCH level and in the zone, in collaboration with District Health Management Team (DHMT) in Mangochi;
- Support improvements of infrastructure and activities within the Monkey Bay zone that aim to improve clinical management of out- and inpatients;
- Finance training of staff at all levels, including up-grading of staff according to needs assessment;
- Support and finance health related research in the Monkey Bay Health Zone Area in collaboration with Malawian counterparts on a mutually agreeable basis;
- Support transport and communication for relevant health activities;
- Provide laboratory materials and essential drugs to a revolving stock to use in life-saving emergency situations, if MBCH is found lacking due to temporary shortages in deliveries by Central Medical Store of Malawi.
- Provide technical advice through Icelandic and Malawian professionals; *and*
- Pay allowances and other expenses for local staff in the Monkey Bay Health Zone for meetings and other activities in support of the project based on mutual agreement according to ICEIDA guidelines.
- Provide limited funds on a monthly basis during the project period to assist in procurement of small items for maintainance and operational functionality of MBCH. This limited support will phase out during the project period with gradually decreasing monthly funds from year one to year three of the project period.

- Finance the work of a Project Coordinator on a part time basis to act as a facilitator between ICEIDA and other stakeholders and pay for non GoM personnel of the project.

Note:

- For all new major project component relevant stakeholders agree to sign a memorandum of understanding about each party's expected contribution and sustainability. This applies for instance to new buildings and operation in Chilonga, as well as to planned expansion of services at MBCH, like an X-ray facility. In those cases GoM will commit to a plan regarding staffing, operational cost and training.

Foreword

The Monkey Bay Community Hospital is a Malawi Government institution under the Ministry of Health. In accordance with this project document the GoM is responsible for meeting operational costs for the hospital including provisions of medical and laboratory supplies among other things. On the other hand ICEIDA will provide financial and technical support to some aspects in the development and operation of the hospital and community services. Specifically this will involve the training of HSAs, TBAs, structures of clinics and related logistics.

Therefore, this Project Document outlines continuous commitment and changes in support by ICEIDA to the MBCH during the period 2009-2011. By approving this project ICEIDA commits to support the MBCH to progress towards the GoM definition of a community hospital in terms of infrastructure and equipment. In addition to the provision of support to MBCH, ICEIDA will continue to support health clinics in the Monkey Bay zone with infrastructure, logistics and training to personnel.

However, a major change from earlier involvement by ICEIDA is the withdrawal of permanent Project Manager on its behalf in managing the project. Instead, ICEIDA will continue to fund the part-time position of a Project Coordinator as well as a policy implementation advisor within Malawi and consultancy from Iceland as part of ongoing monitoring process to track progress and add value to project outcomes.

The present Project Document has gone through several revisions after being circulated among the following persons who are responsible for the final version of the document: Mr. Stefán Jón Hafstein, ICEIDA's Country Director in Malawi; Dr. Geir Gunnlaugsson, consultant to ICEIDA; Dr. Guðjón Magnússon, consultant to ICEIDA; Dr. George Manjolo, ICEIDA's Project Coordinator; Dr. Guðbrandur Þorkelsson, ICEIDA's Project Manager; Dr. Mulenga, Mangochi DHO; Ásdís Bjarnadóttir, ICEIDA's Administrative Coordinator in Malawi; Gísli Pálsson, Director of Social/Energy Desk in ICEIDA Head Office; Rogers Kamanga, consultant to ICEIDA; and Kelvin Sentala, legal consultant to ICEIDA.

1. INTRODUCTION

1.1 Socio-Economic Situation in Malawi

Malawi is a small landlocked and densely populated country located in Southern Africa. Administratively, it is divided into three regions: Southern, Central and Northern Regions. These are in turn divided into 28 districts (six in the north, nine in the centre and 13 in the south). In 1998 the GoM initiated a decentralisation process with the aim of devolving administrative powers and decision-making to the districts through District Assemblies in matters that relate to governmental services including that of health care delivery. The districts are in turn divided into Traditional Authorities (TAs) made up of a group of villages which are the smallest administrative units headed by a Village Headman/woman. The TAs are active in development and social activities including community mobilization in their respective areas of jurisdiction using decentralized management structures.

In 1964 when Malawi became independent the population was estimated at 4 million. In 1998 the population was 9.9 million with 57% under the age of 20. In June 2008, Government conducted a new census and preliminary results show that the population is at 13.1 million and is expected to grow to 17 million in 2015 and 20.2 million in 2025. Malawi's fertility rates are among the highest in Africa; the total fertility rate is 5.7 births (about 6 children) per woman, and the population growth rate is 2.4%.[2]

The UNDP Human Development Report 2007/2008 rates Malawi as one of the poorest countries in the world[3]. HIV and AIDS, poverty, food security and underdevelopment remain primary development challenges. However, in the last three years food security situation has improved. According to the Annual Economic Report 2008, the 2006/2007 season maize productivity increased from 1,800 the previous season to 2,000 kg per hectare. The increase in productivity in turn led to an increase in the percentage of food secure households from 67 percent in 2005 to 97 percent during the year under review. In the same 2006/2007 there was an increase in crop production resulting in a surplus of 1,200 metric tons.

Malawi has also an extremely unequal distribution of wealth and more than 52% of the population lives below the poverty line and of these 22.4% live in extreme poverty[4]. The poor are predominantly rural smallholder households, while extreme poverty also prevails among estate labourers and the urban poor.

With a gross domestic product (GDP) per capita of US$ 667 in 2005[5], and a 39.0 Gini index, Malawi is ranked 164 out of 177 countries in terms of the Human Development Index. Industrial production is weak and for domestic requirements. The economy is predominantly agricultural which accounts for one-third of GDP and about 90% of export earnings. Agriculture is subdivided into two subsectors; smallholder subsector and estate subsector. Smallholder subsector produces various food and cash crops that include maize, rice, groundnuts, pulses, cotton, burly and flue cured tobacco. Estate subsector mainly produces agriculture products for export such as sugar, tea, burly and flue cured tobacco. Of all the crops tobacco is an important source of export revenues accounting for about 80% of export earnings but the country depends on substantial economic assistance from donor agencies. Fishing and fish-trading play an important role in the economy of lakeshore villages.

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[2] URL: http://www.census.gov/ipc/www/idb/country/miportal.html. Accessed on July 25, 2008.

[3] UNDP. *Human Development Report 2007/2008: Fighting Climate Change: Human Solidarity in a Divided World*, p. 246.

[4] National Statistic Office. 2005. *Integrated Household Survey 2004-2005,* p 61.

[5] URL: http://hdrs.undp.org/countries/data_sheets/cty_ds_MWI.html. Accessed on July 25, 2008.

Malawi's economic growth prospects for the next five years are based on the goals and objectives of the Malawi Growth and Development Strategy (MGDS) that was produced by the GoM in 2006. The main thrust of the strategy is to create wealth through sustainable economic growth and infrastructure development as a means of achieving poverty reduction. The ultimate expectation is the transformation of a predominantly importing and consuming economy to a predominantly producing and exporting economy. The MGDS's overriding philosophy is poverty reduction through sustainable economic growth and in this regard, MGDS has six key priority areas:

- agriculture and food security –increase agricultural productivity, exports of food staple, agro-processing and no food shortage even in times of disasters
- irrigation and water development – water resources are protected for domestic and agricultural use
- transport infrastructure- provide coordinated transport services and enterprises
- energy conservation and supply- reduce power blackouts, increase access to reliable, affordable electricity
- integrated rural development- promote rural growth centers
- prevention and management of Nutrition Disorders, HIV/AIDS –reduce spread of HIV and AIDS, improve quality of life, improve nutrition

Economic growth has been satisfactory in the last two years resulting in real GDP growth of 8.2 in 2006 and 7.9 percent in 2007. It is expected that in 2008 the economy will register another high growth of 7.4 percent and a decrease in inflation rate to 8.5.

1.2 The Health Situation in Malawi

The critical role played by the health sector in the development of a country cannot be overstated. A healthy population is not only essential but also a pre-requisite for economic growth and development. Hence, the health sector is a key component of the MGDS which is Malawi's medium term development framework.

Malawi's health situation based on health indicators such as maternal mortality rate, child mortality rate, child and maternal malnutrition, life expectancy, access to health facilities is generally unsatisfactory. While some achievements have been made after implementing a number of actions, some of the health indicators remain the worst in the world.

Table 1 State of Health in Malawi[6]

Indicator	Value
Infant mortality ratio per 1000 live births	72
Under-five mortality ratio per 1000 live births	122
Maternal mortality ratio per 100,000 live births	984
Children under five who are underweight	21%
Undernourished people (general population)	35%
Adult HIV prevalence	14%

The burden of disease is high due to communicable diseases and one in eight Malawi children die before they reach the age of five[7]. The disease panorama is similar to that in many other low-income countries with malaria, acute respiratory infections, diarrhea and measles in combination with malnutrition as the main contributory factors to the high child mortality.

[6] UNICEF. *Malawi Annual Report 2007*.
[7] UNICEF. *Malawi Annual Report 2007*, p. 15.

Malaria remains the largest cause of mortality and morbidity, even with the rising prevalence of HIV/AIDS. An estimated 8 million malaria episodes occur each year and in 1996 the disease accounted for 33.2% of all outpatient visits, and 18% of under-five hospital deaths. Maternal and reproductive health indicators are bleak with high maternal mortality and multiple pregnancies in combination with young age at start of sexual activity and associated teenage pregnancies. Application of Integrated Management of Childhood Illness (IMCI) and Safe Motherhood are national polices and relate to early diagnosis and improved treatment of cases.

The impact of HIV/AIDS on both individuals and population is extensive. Since 1985, there have been more than 50,000 cases of AIDS reported in the country. The estimated prevalence of HIV-seropositivity among adults (15-49 years of age) is 14. 4%. About 100.000 people are expected each year to become infected up to the year 2010. An estimated 800,000 people are currently HIV positive, of whom 30% are living with AIDS. The economic loss is devastating, through death and absenteeism (through both illness, caring for the sick, and attendance at funerals) of the productive workforce, and in the long term through reduced education and other opportunity losses suffered by orphans and other dependents. HIV infection rates are higher in urban and semi-urban areas than in rural areas. According to UNDP the estimated infection rate is 22.5% and 21.1% respectively[8]. Associated with the epidemic is increased incidence of tuberculosis. For prevention, health authorities are implementing the strategy of Voluntary Counselling and Testing (VCT)[9]. This is the process enabling the individual to make an informed choice about being tested for HIV. Full VCT services involve pre-test counselling, HIV testing and post-test counselling.

1.3 Health Care System Organisation

The organization of delivery of health care services is largely driven by GoM policy framework and strategies for the sector. Overall, the MoH is responsible for modern health services, and is the largest service provider with more than 2/3 of all reported outpatient and inpatient care. The mission sector (Christian Health Association of Malawi, CHAM) is the second largest and provides about 40% of services. Overall, CHAM coordinates 172 church related health facilities. These provide about 1/10 of all reported outpatient and inpatient care but more than 1/3 of all admissions. CHAM hospitals and health centres are in general underutilised and overstaffed compared to the facilities run by the MoH, where services are free of charge. Other non-governmental organisations are also active in the health field, particularly at community level. One national NGO, Banja La Mtsogolo, is active in family planning information. In addition, there is a large and active traditional health sector; the Herbalist Association of Malawi (HBA) which has a membership of approximately 75,000. It is estimated that there are some 5,000 traditional birth attendants (TBAs) operating and working alongside the formal system, mostly in the rural areas. Most people use the two health systems simultaneously.

Health services in Malawi are provided at three levels: primary, secondary and tertiary. At primary level, services are delivered through rural hospitals, health centres, health posts, outreach clinics and community initiatives such as drug revolving funds. District hospitals and CHAM hospitals, although some have specialist functions, provide secondary level health

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[8] UNDP. *Responding to the HIV/AIDS Epidemic through a Multi-Sectoral Approach*. UNDP Support to HIV/AIDS Response in Malawi, January 2004.

[9] *Voluntary Counselling and Testing Guidelines for Malawi. Final draft*, April 2003. Ministry of Health and Population and National AIDS Commission.

care services. The main role for the secondary level of services is to backup the activities of the primary level by providing surgical backup services, mostly for obstetric emergencies, and general medical and paediatric inpatient care for common acute conditions. At present, tertiary level hospitals provide services similar to those at the primary and secondary levels, along with a small range of specialist surgical and medical interventions.

At the community level health care services are provided through health posts, manned by Health Surveillance Assistants (HSAs) while the health centres are manned by health professionals of different categories. A medical assistant is responsible for clinical duties and is the *in-charge* of the health centre while the enrolled Nurse/Midwife is responsible for the maternal and child health services and obstetric care. An Environmental Health Assistant supervises the community-based activities. At the secondary level, the district hospitals and CHAM hospitals receive as referrals the more complicated cases for further management. There are also support services such as laboratory, X-ray and pharmacy.

1.4 The Government Policy and Strategy in the Health Sector

1.4.1 Government Health Policy

Government's policy goal for the health sector is to raise the health status of all Malawians through the development of a health delivery system that is capable of promoting health, preventing, reducing and curing diseases and reducing premature death in the population. The overall objective of the MoH is to develop a health delivery system that is pro-active and responsive to the prevailing needs and problems of the population. The objective is to be achieved by implementing an Essential Health Package (EHP) of cost-effective interventions provided free of charge at the point of delivery mainly for the poor, women and children. EHP outlines priority health activities to be implemented by the Ministry, donors and Non-Governmental Organizations (NGOs) and the private sector. EHP includes the following activities:

- Prevention and treatment of preventable diseases
- Malaria prevention and treatment - Insect Treated Nets (ITNs) promotion, Intermittent Presumptive Treatment (IPT) and case management
- Reproductive health interventions, including Safe Motherhood Initiatives, Essential Obstetric Care and family planning.
- Prevention, control and treatment of tuberculosis and related complications
- Prevention and treatment of schistosomiasis and related complications
- Management of Acute Respiratory Infections (ARI) and related complications
- Prevention and management of HIV/AIDS, sexually Transmitted Infections (STIs) and related complications, including VCT, the provision of ART and PMTCT
- Prevention and management of malnutrition, nutrition deficiencies (iodine, vitamin A and Iron) and related complications, especially those associated with HIV/AIDS
- Management of eye, ear and skin infections and related complications
- Treatment of common injuries – including emergency care for accidents and trauma and their complications.

According to the MoH Strategic Plan 2007-2011, the following support systems have been identified as key to successful implementation of the EHP interventions:

- Information, education and communication (IEC) – behaviour change interventions
- Planning, budgeting and management systems

- Monitoring and evaluation – including enhancing integrated disease surveillance and reporting activities and patient information systems
- Essential laboratory services, i.e., Central Hospital laboratories, public health reference laboratory, laboratories at district level, basic laboratories at health centre level, medical imaging and diagnostic services, including radiology, ultrasound and CT scanning
- Blood transfusion services

Agreements have been signed with CHAM to provide access to health care services free of charge at the point of delivery for maternal and neonatal care. Under the agreements, patients who can not afford to pay user charges at CHAM facilities access the services free of charge. Respective health service providers are then reimbursed for the treatment and care given to these patients by the MoH through the respective District Assemblies.

1.4.2 Strategy in the Health Sector

The health sector in Malawi is faced with numerous challenges that negatively affect implementation of programmes and delivery of health care services. Some of the challenges faced, for example by the MoH as a lead institution, include:

- Critical shortage of health workers
- A shortage and continued pilferage of drugs and essential supplies
- Increased demand for referral cases abroad
- Capacity constraints at the training institutions which limits intake thus impacting the human resources for health.
- Poor access to health care services as a result of both geographical and economic factors especially affecting women, children and the poor.

According to the MGDS improving health requires a multifaceted or integrated approach with a combination of preventive, educational and clinical measures. By this approach, the costs of interventions can be minimized and their effectiveness maximized. The MGDS which is the overarching government policy seeks this approach and the strategy for the health sector is as follows:

- Increasing the retention of qualified health workers through a targeted programme for health care workers,
- Improving working environment for health personnel,
- Increasing the availability and eliminating theft of drug supply,
- Improving health care facilities through targeted facilities infrastructure (roads, water, buildings, communication and medical equipment),
- Improving equipment at health care facilities, especially maternity services,
- Improving financial management, monitoring and supervision of health care facilities,
- Providing comprehensive health services packages that include treatment of diseases and infections, awareness programmes and education through Government and private hospitals.

Strategies outlined above have been incorporated in this project document (PD) as some of the outputs of the project. This is in line with that development effort should wherever possible be in accordance with the MGDS.

1.5 Previous and On-going Aid to the Sector

1.5.1 Previous Aid to the Sector

Over the years the health sector has benefited from various interventions supported by different development partners and NGOs operating in the sector. Targeted interventions have been at national, district, zonal and community levels in accordance with identified needs and set priorities and objectives of the health policy and strategic framework. In the project area under consideration various organizations have been involved including CHAM, World Vision (WV), World Health Organization (WHO), CARE, etc. For purposes of this PD, the previous collaboration between the Icelandic International Development Agency (ICEIDA) and the GoM through the MoH is explained in some detail under project background and justification below.

1.5.2 On-Going Aid to the Sector

As noted above the health sector is currently implementing a SWAp arrangement supported by various development partners with clearly defined coordinating and monitoring mechanisms. In receiving and implementing such support at the district and community level, the National Health Policy stipulates that the District Health Officer (DHO) with his District Health Management Team (DHMT) are the responsible authority of the health services. Therefore, the Team is responsible for delivery of health services in Mangochi District, including Monkey Bay. The MoH only lays out policy while implementation is left to the districts. One arm of the MoH is the South East Zonal Health Support Office with responsibility for Mangochi District. They do supervision and monitor implementation of national plans. In addition to these health management structures, there are health staff in each district that have zonal responsibilities within their respective zones, e.g. as in the Monkey Bay zone, and with the responsibility of reporting to the DHO. All this is in accordance with the goal of decentralization process in delivering health care services in Malawi.

In this context, Mangochi District has five health zones including Monkey Bay health zone receiving ongoing support. Several donors are supporting the District. Some of the donors and local NGOs as already pointed out operate in Monkey Bay zone. These include, among others, WHO, UNICEF, UNAIDS, World Food Programme, World Vision, Médecins sans Frontières, CARE International, CHAM in addition to SWAp pool fund and others. In addition there is a well established Traditional Authority within the Monkey Bay area who is chairman of the Area Development Programme (ADP) that is composed of 15 community members. Furthermore, there are Village Health Committees in each village that discuss health care issues, TBAs, CBDAs and home based care as well as Health Centre Committees that include representatives from several villages, including one for MBCH.

1.6 Institutional Framework for Development Efforts in the Sector

1.6.1 Institutional Framework

The health sector has clear institutional framework for delivery of health care services in Malawi. As already noted overall responsibility for delivery of health services rests with the MoH which is a leading service provider with more than two-thirds of all reported out- and inpatient care. According to 2003 health facilities study conducted by the Ministry itself, there were 617 health facilities in Malawi of which 60 percent were operated by the Ministry and the balance of 40 percent of health facilities were provided by religious organizations and the

private sector. Religious organizations that accounted for the largest share of the service provider were the mission sector, through CHAM.

According to the organisational structure of the Ministry, the Secretary for Health is the most senior official and is responsible for the overall function of the Ministry. He/she is supported by a team of senior administrative and technical officers in overseeing the operations of the Ministry. Appropriate coordination mechanisms under the health SWAp have been established in which other players including development partners within the health sector are represented and participate.

With the introduction of the decentralisation process by the GoM the Ministry has devolved some of its operations. It has created five Zone Health Support Offices that cover several districts each. At the district level, the District Health Officer (DHO) with his District Health Management Team (DHMT) is the responsible authority of the health services in district. Four Central Hospitals function as tertiary referral centres for the district hospitals and are headed by Hospital Directors. In view of this, the role of the Ministry has significantly changed from that of service delivery to policy formulation and enforcement, standards formulation and regulation and international representation.

1.6.2 Community Hospitals and Health Centres

A new initiative in the development effort of the health sector is the concept of Community hospitals. It is an improved rural hospital that is to offer more diversified secondary services, including surgical theatre and X-ray facility, and is to serve a larger population. Currently, two community hospitals have been established, one of them is the basis of this PD, the MBCH in Mangochi District.

For the MBCH Project, there is an agreement between the Government of Iceland through ICEIDA and the GoM through the MoH. The hospital is financed and operated by the GoM with the stated support of ICEIDA. For collaboration and implementation the following will be organized:

- Creation of a Project Monitoring Group (PMG) to review and monitor the progress in the implementation of the Project, as reported to it by the TMT;
- Creation of a Technical Management Team (TMT) that includes advisor provided by ICEIDA. The TMT will be expected to deliver quarterly progress reports and detailed workplans and budgets;
- Creation of the MBCH Coordination Team (MCT) to oversee implementation and meet on a monthly basis.
- An annual narrative and financial report to be produced by the PMG at the end of each financial year of the Project and presented to the MoH and ICEIDA for approval.

2. PROJECT BACKGROUND AND JUSTIFICATION

2.1. Project Background

The Government of Iceland through ICEIDA and the GoM through the MoH, hereafter called Contracting Parties, have collaborated within the health sector, more specifically in the Monkey Bay Health Zone Area in the District of Mangochi since 2000 when the Contracting Parties signed a Plan of Operations for the implementation of the project *Monkey Bay Health Care 2000-2003*. During the project period the main emphasis of activities was on the improvement of physical structures of the health centre in Monkey Bay which comprised the construction of a new health centre facility that gradually became the Monkey Bay Community Hospital (MBCH). Health zone area logistics and communication were also emphasized.

In June 2004, the Contracting Parties agreed to extend their collaboration with special emphasis on the quality of health services given in the new hospital premises in Monkey Bay as well as in the health centres in the area, outreach activities, and training of HSAs and TBAs. The extension of the collaboration intended to build on gained experience and consolidate what had been achieved. Training of human resources was an integral part of the project activities, and included short courses/seminars/training sessions for several categories of health personnel, professionals and volunteers as well as community members. Infrastructure development was continued and with rapidly growing demand on the increasingly diversified services of MBCH, it became evident that the hospital premises needed to be further expanded. On the basis of a site map identifying future buildings for the gradual expansion of service options in MBCH, the Contracting Parties agreed to construct new facilities for the laboratory and VCT/ART services as well as a surgical theatre. The building for the VCT/ART was formally taken into use in July 2007 and the laboratory in September 2007. The surgical theatre was built and equipped in October 2007 and became operational on July 1, 2008 when the first Caesarian section was performed. In addition to the construction of facilities, ICEIDA provided the MBCH with medical equipment and supplies as well as stepped in with funds because of chronic severe shortage of drugs.

Lack of qualified staff has been one of the major problems during the project implementation. ICEIDA has addressed this problem by supporting staff through non-financial incentives, such as supporting positive work environment (e.g. resources to implement health policies and better facilities at work), career and professional development (e.g. access to/support for training and education), and access to new/renovated staff houses. In total, 19 staff houses have been constructed and renovated in Monkey Bay since the year 2000.

In 2006, the GoM initiated the renovation of Nankumba Health Centre with financial support from ICEIDA and the new facility was inaugurated in March 2007. It included a new building for preventive health work for pregnant women and children, new OPD, and a VCT facility, and old buildings were rehabilitated. Later, ICEIDA funded the construction of three new staff houses, and the renovation of two old ones, taken into use in March-April 2008. In 2008 ICEIDA installed a new water point powered with solar pump at the Malembo health clinic in the zone.

In order to improve community health related services in the area, an effective operation of outreach clinics needs to be ensured. Hence, during the implementation of project activities ICEIDA purchased two ambulances and seven motorcycles. These greatly increased the capacity of the health services to reach out to the target group in the health zone area. To

alleviate difficult financial situation, ICEIDA temporarily assumed the responsibility to finance recurrent costs of vehicles since June 2003 while the Mangochi DHMT attempted to gradually integrate these costs in their district health budget. This ICEIDA support will phase out during the project period up to 2011, thereby making the counterpart responsible for the operation.

In line with national policy, since 2003 MBCH has used a special computer programme to monitor the health activities in the health zone area. With this system, the health authorities intend to collect information on a total of more than 200 indicators for the service delivery. Many of these indicators have proven not be useful to monitor the activities in the Monkey Bay Health Zone. A more limited number of indicators to monitor the health services and the impact of project activities has been discussed during project implementation.

The time frame for the extension of project activities was decided to be from July 1, 2004 to December 31, 2010. The project period was, however, divided in two distinct parts where successful implementation of project activities in Phase I (July 1, 2004 - June 30, 2007), as evaluated by a team of independent external evaluators, was to guide decision regarding the implementation of Phase II of the project. In case of a positive outcome of the evaluation and wish from both sides to continue the collaboration, it was agreed in principle the project could be extended for the period July 1, 2007 to December 31, 2010. This document extends the period throughout 2011 as an alignment to the current GoM national health policy plan which runs to the end of 2011. By that time this project automatically comes to an end. Any possible further involvement on ICEIDA's behalf will then have to be negotiated with the GoM through the Ministry of Health as a new distinct and separate project.

2.2 Project Justification

The health care delivery to the population in the Monkey Bay Health Zone Area has improved in some important aspects since the start of the project in 2000. Prior to the commitment of ICEIDA to the area, health care was rather rudimentary and services were lacking. Now, nine years later, a health institution with a wide array of services has risen and is growing fast. Despite that success, the health services in the area are still facing several challenging issues. As stipulated in the Plan of Operations, the option of a fully-fledged community hospital has continuously been discussed between the Contracting Parties. One of the difficulties has been that there was no written definition of what a community hospital should include, according to Malawian guideline. On May 24, 2006, the MoH through its Secretary of Health provided ICEIDA with a written definition of a community hospital and its proposed staffing needs. According to this official definition, a community hospital should:

- Serve a population of 60-100.000 people
- Have 80-120 beds, including medical/surgical wards for males/females, obstetrics/gynaecology, labour and delivery, paediatrics, and isolation
- Family Planning
- Operating theatre
- X-ray
- Laboratory
- Nutritional Rehabilitation Unit (NRU)
- Kitchen
- Mortuary

Currently, the MBCH does not fulfil the above criteria. In particular, it lacks an isolation ward, paediatric ward, X-ray facility as well as a Nutrition Rehabilitation Unit (NRU) and a kitchen. In addition, the maternity needs expansion and the OPD facility a renovation. However, to become a fully functioning and equipped community hospital depends not only on better physical infrastructure. It also requires adequate human resources as they are pivotal to successful operation of the hospital. A constant lack of sufficient numbers of trained staff, as stipulated by national norms for a community hospital, has been a source of concern during the whole project implementation period. Despite the number of required staff has not been reached (Table 1), the MoH through their DHO have recently succeeded to increase the number of qualified staff at MBCH. In particular, the number of Clinical Officers (COs) has increased from 0 => 4, State Registered Nurses from 0 => 2, and Nurse Midwife Technicians 2 => 7. In addition, the number of Health Surveillance Assistants (HSAs) has increased as a result of Governmental policy to improve community health services.[10]

Table 1. *National norms for staff at a community hospital and staff numbers in December 2005 and 2007.*

Post	Required	December 2005	December 2007
Chief Clinical officer	1	0	0
Senior Clinical Officer	1	1	1
Clinical officers	4	1	2
Anaesthetic Clinical Officer	1	0	1
Senior Medical Assistant	1	0	0
Medical assistants	4	2	3
Nurse-in-Charge (SRN)	2	1	2
Senior Nursing officers	7	0	4
Nurse Midwife Technicians	16	3	7
Nurse Technicians	0	2	0
Environmental Health Officers	N/A	0	1
Environmental Health Assistant	1	1	1
Health Surveillance Assistants	22	10	22
Laboratory Technicians	1	1	1
Laboratory Attendants	N/A	2	2
Dental therapist	N/A	1	1
Pharmacy Technicians	1	0	1
Pharmacy attendants	2	2	2
Hospital Attendants	19	2	18
Laundry Attendants	2	2	2
Patient Attendants	2	2	2
Mortuary Attendants	2	2	2
Messengers	1	0	1
Plumbers	1	0	0
Brick layers	1	0	1
Drivers	2	2	2
Security guards	16	4	11
Ground labourers	0	3	4
TOTAL STAFF	110	44	94
Total Clinical and Nursing staff	37	8	20

Quality of the services needs to be facilitated by more on-the job training, in particular in MBCH where ward routines need to be revised and strengthened. The greatly increased demand for OPD care has meant that the space provided within the MBCH premises is not very functional and needs to be upgraded and changed. Public health related activity has to be strengthened and integrated in the newly established water and sanitation project, funded by ICEIDA. The appropriate use of health statistics within the zone needs to be enhanced further

[10] Over 1.560 HSAs have been recruited and the Government has granted approval to recruit a further 5.961 through local assemblies. See *Ministry of Health. (2008). Mid Year Report for the Work of the Health Sector July-December 2007. Lilongwe: MoH.*

still. Lastly, financial sustainability of the services needs to be secured through collaboration with district health authorities and MoH.

An external evaluation of project activities was carried out in April to June 2007. The evaluation team consisted of Dr. Maurício Murro, an Italian physician with extensive experience from sub-Saharan Africa and Dr. Winstone Mkwandawire, a Malawian physician with several years of experience of district health work as a former DHO. The evaluation concluded that overall results of project activities were positive and suggested that ICEIDA should plan for a long-term collaboration with the MoH. The report raised several issues that were recommended for the consideration of ICEIDA in its future collaboration, e.g. further construction work in MBCH, renovation of a health post in Chilonga, top-up of salaries of health personnel, and continued technical assistance in Monkey Bay.[11] While some of these conclusions have been welcomed by ICEIDA others are not in line with current policy.

In response to the evaluation, ICEIDA decided to continue supporting project activities in the Monkey Bay Health Zone Area on the basis of the project document conceptualized and agreed upon in 2004, pending up-dated revision. Therefore, the preparation of this document defines ICEIDA's support for the MBCH zone health care services.

2.3 Target Group

The primary beneficiaries of this project are the people in the communities of the T/A Nankumba area, especially mothers and children who are among the poorest and the most vulnerable in the society.

2.4 Cross-cutting issues

Cross-cutting issues under the project include HIV/AIDS, gender, and environment. As pointed out in earlier sections of this document, HIV/AIDS is a serious challenge facing the country in general and the MoH in particular in prevention and management of the epidemic. Tremendous efforts have been made through assistance from development partners and Government resources. Some modest decline in the spread of the disease has been recorded. However, the challenge still remains in prevention and management of HIV/AIDS.

Gender issues are an integral part of the overall development agenda in Malawi and ICEIDA policy. According to the MGDS the overall priority is to mainstream gender in the national development process to enhance participation of women and men, girls and boys for sustainable and equitable development.

The Monkey Bay Community Hospital Project is committed to the achievement of greater gender equality and women empowerment. It maintains a specific focus on women and girls by emphasizing services for mothers and their children. The support of a no-fee emergency transport system enables emergency obstetric care when needed. A surgical theatre became operational in 2008 which enables women with complicated pregnancy and birth delivery to be adequately treated. The project aims to build a new facility for maternity services as well as renovating current facilities to accommodate U5-clinic and family planning services. Community health services will be improved with the focus on delivery of integrated services of antenatal care and U5-clinics at outreach clinics.

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[11] Murru M, Mkwandawire WK. Evaluation of the ICEIDA Project *Support to Monkey Bay Health Care, 2000-2007*. (2007). Lilongwe/Reykjavík: Ministry of Health and ICEIDA.

Facilitating training of health and administrative personnel in the Monkey Bay Health Zone is an integral part of the project. Training of staff at all levels, in country as well as out-of-country, including up-grading of staff, is equally offered to men and women. Training of TBAs is an important part of the project activities. Participation of women in committees and meetings is encouraged to enhance women participation in decision making.

ICEIDA plans to improve access to clean water at the MBCH. Environmental sustainability is important in providing some basic necessities of life such as water and sanitation. Improved water and sanitation facilities produce a healthy population thereby reducing the demand on health services. The MBCH Project, in cooperation with ICEIDA's Water and Sanitation Project, supports a health, water and sanitation training in the Monkey Bay Health Zone. Sustainable access to safe drinking water will be ensured by the Water and Sanitation Project which will set up an improved drinking water source in the vicinity of the hospital premises.

3. DEVELOPMENT OBJECTIVE

The overall objective of the Project is to support the Government of Malawi in its national efforts to achieve the Millennium Development Goals (MDGs) and its national development goal of economic growth as laid down in the MGDS through improved essential health care service delivery in the project area and adjacent health zones. Therefore, the main purpose of the project is to strengthen the capacity of MBCH in providing quality and sustainable health care services especially to the poor and underprivileged.

4. SPECIFIC OBJECTIVES

- Improve and upgrade infrastructure and equipment of the MBCH to progress towards the standards defined by the GoM for community hospitals in order to operate as first line referral for health centres within the zone. (See 2.2 Project Justification for the definition of a community hospital).
- Increase the operational capacity of clinics, outreach activities and work of HSAs and TBAs in the zone with logistical support, training and infrastructure based on identified needs.
- Provide training to health and administrative personnel in the MBCH zone based on identified needs
- Improve utilization of health management information systems to strengthen delivery of the essential health package in the zone
- Facilitate collaborative approaches among stakeholders delivering essential health package in the Monkey Bay Health zone and with the Mangochi District Health Management Team.

5. EXPECTED OUTPUTS

In order to achieve the specific objectives the project will have to deliver the following results:

- Monkey Bay Community Hospital provides services as a first line referral hospital and provides required service standards defined by the GoM through installation of new infrastructure and equipment. (During the project period the following will be

considered according to prioritization and financial strength: Maternity and delivery ward, kitchen, paediatric ward and male/female ward, OPD structure and the provision of NRU and basic X-ray facility explored).

- Increased clinical and operational capacity of community clinics within the MBCH zone for delivery of improved health care services including the provision of components of IMCI, EPI, VCT, STI and Safe Motherhood.

- Renovated structures at Chilonga Health Clinic making it fit for a maternity and provision of other basic services.

- Training of staff at MBCH and in outreach activities follows a clear policy based on needs assessment for staff groups and focused on on-site training when applicable.

- Regular and increased use of statistics generated by the health services based on established guidelines.

- Regular consultation and collaboration between stakeholders in the delivery of health care services within the MBCH zone and with the Mangochi District Hospital.

6. THE PROJECT STRATEGY

The strategy for the project area is to improve essential health care service delivery consistent with the overall goal of the MGDS. The aim is to strengthen MBCH through the following interrelated project components.

- Infrastructure development and small scale operational support
- Equipment
- Emergency pharmaceutical and medical supplies
- Clinical management
- Human resources training and motivation
- Administration and management through stakeholders collaboration
- Logistic support

Annex 1 outlines detailed project components and related activity details are presented in **Annexes 1a and 1b.**

7. MAIN ACTIVITIES

It is the overall purpose of this project to further strengthen the MBCH and zonal activities around Monkey Bay with new structures, equipment and training, as well as facilitating stakeholders' collaboration. Main activities constitute building of structures, support training and logistics. Detailed activities are as presented in the log-frame in **Annex 2: Project Matrix** and activity implementation plan is presented in **Annex 8**.

The project seeks to address the following concerns:

- To provide quality care to out- and inpatients in Monkey Bay Community Hospital and health centres in the Monkey Bay Health Zone

- To support services of clinics and outreach activities, as well as providing support to HSAs and TBAs
- To strengthen capacity for improved performance in delivery of health care services with training, education and health data usage
- To promote functional health management information system
- To enhance and improve collaboration among stakeholders

8. MAIN INPUTS

The GoM ensures that the MBCH is a well staffed and operational facility through its budget allocations and supervision through the DHO. ICEIDA will provide required inputs based on this PD. During project implementation, ICEIDA's support to the Monkey Bay Health Zone Area will include funds, equipment and expertise. ICEIDA will also provide technical assistance. This will involve short- and long-term consultancies by Icelandic and Malawian professionals. ICEIDA will put emphasis on staff training and motivation in Monkey Bay Health Zone Area as well as in the DHMT in Mangochi with the aim of improving sustainability of project activities. The contribution of the GoM will be consistent with its obligations under this PD.

9. ASSUMPTIONS/RISKS

During implementation that spans several years, financial and political situation is subject to change for either of the Parties. This can arise from changes of the political and socio-economic situation in Malawi, natural catastrophes that may hamper successful implementation of agreed plans, or ravaging epidemics. National policies can change in both countries, affected by deteriorating global economic situation and exchange rates that could affect the flow of funds from ICEIDA or the GoM. Both Contracting Parties agree to attend to all encountered difficulties in mutual respect, with the overarching aim to achieve the long-term developmental objective of the project, to the benefit of the target population: the poor rural population of Monkey Bay health zone area, in particular the mothers and their children.

10. ORGANISATION, ADMINISTRATION AND MONITORING OF THE PROJECT

Successful implementation of the project will also depend on the adequacy of management and monitoring arrangements put in place as well as clarity in roles and responsibilities of the various structures involved. **Annex 3** outlines terms of reference of key management structures for project coordination, implementation and supervision. Overall, the following implementation mechanisms will be in place: Programme Management Group (PMG); Technical Management Team (TMT); and the MBCH Coordination Team (MCT) which is responsible for operations on a monthly basis.

Implementation is the responsibility of the GoM with ICEIDA's support. Hence, the Ministry of Finance on behalf of the GoM will enter into an agreement with ICEIDA by signing a Memorandum of Understanding (MoU) regarding the funding, procedures and provision of project experts from Iceland. Operationally, implementation of project activities will involve the District Health Management Team under the MoH on behalf of the GoM and ICEIDA on behalf of the Government of Iceland. This will not just help to implement planned and agreed

activities but also to gain commitment and ownership of the project outputs. This approach complies with the National Decentralization Policy that aims at integrating government agencies at the district and local level into one administrative unit.

Therefore, key actors within the health zone will meet on a regular basis to discuss issues of mutual interest to foster improved collaboration and effective service delivery. The TMT and PMG constitute important structures for regular exchange of ideas and reaching mutual agreements on how to proceed with the collaboration and the use of funds. During the first year of implementation (2009) the MBCH Coordination Team (MCT) will be required to meet as often as necessary, to resume regular meetings once a month later on.
The MCT shall monitor project and health service activities and include staff in MBCH with responsibilities at zonal level as well as a representative from ICEIDA. It shall have formal meetings with agreed agenda and minutes. ICEIDA's Project Coordinator is to chair the MCT meetings. All decisions that relate to project implementation are to be taken on the basis of a mutual agreement among its members. In case of disagreement that satisfactorily cannot be resolved by the MCT, it can present the case to the TMT for decision, and as a last resort, the PMG. The TMT shall also be responsible for the preparation of the agenda for the PMG meetings.

The Project Coordinator is a part time position undertaken by a full time GoM employee at the MBCH. By virtue of his position as PC he will be accountable to ICEIDA to ensure the implementation of the actions defined in the Project Document and that outputs are successfully obtained. The PC reports to both the GoM and ICEIDA. In accordance with GoM regulations and with the written consent of the MoH, the PC will be rewarded by ICEIDA for giving him additional responsibility (see TOR in **Annex 4**).

In an effort to improve continuity in project implementation, ICEIDA will expand on gained experience with a permanent local consultancy to project activities (See **Annex 9**). It will furthermore, through contractual agreement with Reykjavík University, in Iceland, provide professional advice and support to the project. Further, a Malawian health professional is to be contracted on a part-time basis to advice on activities in the area. In addition, Icelandic and Malawian health professionals can be contracted to support and/or implement specific activities of importance to advance activities in line with the PD.

11. INDICATORS AND MEANS OF VERIFICATION

Implementation of various component activities of the project will be associated with the following indicators and means of verification.

I. Monkey Bay Community Hospital and health centres in the Monkey Bay Health Zone deliver quality care to out- and inpatients.

1.1. Physical Infrastructure Development

At the end of project activity in 2011, the indicators to be used to monitor the success of project activity regarding *physical infrastructure* include:

- MBCH is first line of referral within Monkey Bay health zone

- Hospital infrastructure has progressed towards being in line with GoM definition of a community hospital with the introduction of key infrastructure components missing in 2009.
- Key elements of a community hospital are operational and service rendered according to predefined standards (See **Annex 1 a**).
- Access to maternity and out- and inpatient services in Chilonga area are well established.
- Staff moved into new staff houses in Monkey Bay.

1.2. Clinical Management Improvement

At the end of project activity in 2011, the indicators to be used to monitor the success of project activity regarding *clinical management* include:

- Components of IMCI, TB, VCT/ART, STI, and Safe Motherhood applied within the services.
- Surgical theatre operating regularly and as need arises.
- Caesarian sections conducted according to need.
- Delivery assistance by health professionals in >60% of cases in the zone.
- Laboratory regularly offers services in line with needs assessment in >80% days/year.
- Emergency situations taken care of by means of emergency stock supplies.
- Emergency stock of supplies is refunded on a regular basis and audited by ICEIDA accountants.
- Management of endemic, maternal and childhood diseases follows official guidelines, overseen by the PC.
- Women with complicated pregnancy and birth delivery treated.
- Monitoring of outpatients and inpatients according to guidelines as reported by the PC.
- Improved response to emergency situations through use of laboratory and surgical theatre and qualified staff present at MBCH.

1.3. Administration and Management Improvement

At the end of project activity in 2011, the indicators to be used to monitor the success of project activity regarding *administration* include:

- Minutes available from meetings of different organizational components
- Supervisory reports accessible
- Monthly reports of PC to Country Director available.
- Small contingency fund for maintenance and spare parts regularly audited by ICEIDA accountants.
- Steps taken to further integrate the MBCH into the Malawian health care system, with ICEIDA support phasing out.
- Transparency and accountability of project resources
- Leadership skills provided at all levels of project implementation by means of training.

1.4. Logistical Support

At the end of project activity in 2011, the indicators to be used to monitor the success of project activity regarding *logistics* include:

- Log books for ambulances analysed and acted on.
- Vehicles and motorbikes in operational order and regular use.

- Population and health workers with access to equipment and transport.

II. Human Resources Capacity
Training guidelines are presented in **Annex 6**. Overall, at the end of project activity in 2011, the indicators to be used to monitor the success of project activity regarding *training* include:

- Report on training in compliance with agreed plans.
- Members of staff apply training received, as reported by PC.
- Retention of staff, levels of staff at least 90% of requirements at MBCH and other health centres.

III. Improvement of Outreach Services
To define this programme activity further a report will be written in 2009 to outline potential support of the project to this part of the health service. However, at the end of project activity in 2011, the indicators to be used to monitor the success of this project activity include:

- Number of outreach clinics with integrated services of the essential health package.
- More than 2/3 of outreach clinics deliver integrated services of antenatal care and U5 clinics.
- Volunteers identified and supervised in the communities.

IV. Functional Health Management Information System (HMIS)
At the end of project activity in 2011, the indicators to be used to monitor the success of project activity include:

- Health statistics are regularly collected and analysed under the supervision of PC.
- Timely communication of results to the health personnel in the zone.
- Regular use of health statistics in the delivery of essential health services
- Coordinated registration system (see **Annex 5** for recommendations concerning the coordination of patient registration at the MBCH).

V. Strengthening Collaboration of Stakeholders
At the end of project activity in 2011, the indicators to be used to monitor the success of project activity include:

- Stakeholders identified and regular contact in place.
- Regular meetings of administrative bodies have been held and minutes kept on record.
- Improved linkages and coordination mechanisms between the bodies and other stakeholders

12. MONITORING, REPORTING AND EVALUATION

Monitoring, reporting and evaluation of the project is important in that it will enable GoM, and ICEIDA as well as other stakeholders, to see whether it is being implemented as planned. In this respect, monitoring and evaluation involves systematically observing and assessing achievements or progress of the project activities, based on the Project Activity Plan and the indicators and means of verification stipulated during the planning phase. M&E mechanisms will, therefore, attempt to provide solutions to problems encountered and propose adjustment for the project to achieve its objectives. The objectives of the M&E system for the project will include the following:

- Coordinate with GoM M&E systems, procedures and units

- Enhance results based program management
- Share lessons learnt with key stakeholders
- Monitor sustainability of outputs produced
- Ensure accountability for use of funds

The following will constitute the key elements of the monitoring and evaluation system, as overseeen by the Malawian and University of Reykjavik consultants:

- Logframe analysis of the implementation/action plan every year focusing on timely completion of outputs and how they contribute to realization of reform objectives
- Annual joint reviews focusing on results of project, lessons learnt and challenges ahead
- Regular surveys, including standard checklists for key indicators in the Log Frame Matrix.
- Submission of monthly, quarterly, bi-annual and annual progress reports
- Mid-term review and end-of-program evaluations.
- A baseline study made by University of Reykjavik consultants in 2009.

In this respect, meetings of all functional structures involved with the implementation of the project are to be documented by agreed minutes. Monthly and quarterly reports, in formats agreed by the Collaborating Parties, are to be produced and forwarded to the DHMT in Mangochi and the ICEIDA office in Lilongwe and its permanent consultants. All reports and minutes on project activities shall be in English.

Supervision of project activities on behalf of ICEIDA will be done on a regular basis by a Malawian professional. Advisors at Reykjavík University will regularly follow project activities. In addition, they will visit regularly to monitor project implementation and serve on the PMG with the Country Director. Both ICEIDA and MoH can at any time ask for information on the project and visit the premises.

In 2011, the Project activities are to be evaluated by a team of external evaluators. The composition of the team should include at least one individual identified by ICEIDA and another by the MoH, and other individuals as found appropriate.

13. BUDGET

Expected contributions are presented in **Annex 7**. The expected ICEIDA contribution amounts to US$ 2.200.000 during the project period. The cost figures for ICEIDA are indicative estimates only and represent maximum contribution to the project. Due to fluctuating currency rates, inflation in both countries and rising cost of building materials in Malawi during the preparation of this document, detailed cost estimates for various components of the project are impossible at the time of preparation for this PD. More detailed estimates will be prepared during the implementation of the Project for each year in annual budgets. Costs will be established on the basis of quotations from relevant sources and suppliers. By the end of each year a revised plan and budget for the following year will be presented to the PGM.

The GoM is responsible for the operation of the MBCH, including payments of staff, recruitment and participation on its behalf in stakeholders' collaboration. The cost of this operation is a part of the total MoH budget in GoM's budget.

14. DISBURSEMENT OF FUNDS, ACCOUNTING AND AUDITING

Disbursement of funds from ICEIDA

The ICEIDA Project Coordinator and the ICEIDA Country Director shall be responsible for the disbursement of funds from ICEIDA to the Project. The funds will be provided in a timely manner.

The Project Coordinator shall, with assistance from the Monkey Bay based ICEIDA Accountant, account for the Project expenditures in accordance with ICEIDA and Icelandic Government requirements. The District Health Management Officer will be responsible for accounting for Project expenditure of funds provided by GoM in accordance with GoM requirements. Details for the annual financial report will be prepared by the MCT for approval by the PMG.

The GoM and ICEIDA will internally and separately audit each Project accounts as stated above, unless either party requests an external auditor of all the project funds. In case of such a request, the party requesting the audit will be responsible for the cost of the audit. The final audited accounts for the Project shall be available for examination and approval by GoM and ICEIDA no later than three months after the closing date of the Project.

15. PROJECT IMPLEMENTATION PLAN

The implementation of the project will start in January 2009 and will be concluded at the end of December 2011. The activities of the project are outlined in **Annex 8.** In 2009 the Project will conduct a survey to gather baseline indicators of the status of certain key services that will be monitored throughout the project period. By December 2011 this project comes to an end. Any further involvement on ICEIDA's behalf is subject to negotiation.

16. REFERENCES

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17. ANNEXES

Annex 1: Project Components

Annex 1a: Additional Information of Project Component Activities

Annex 1b: Stock Emergency Supply Details

Annex 2: Project Matrix

Annex 3: Organization, Management and Administration Structures

Annex 4: Terms of Reference for the Project Coordinator

Annex 5: Guidelines for data collection and usage

Annex 6: Training Needs Assessment and Guiding Principles

Annex 7: Project Budget Schedule

Annex 8: Activity Implementation Plan

Annex 9: Consultancy

Annex 10: Site map of MBCH

ANNEX 1: PROJECT COMPONENTS

The Government of Iceland, through ICEIDA, and the GoM, through the MoH, hereby agree to continue collaborating with special emphasis on delivery of health services in the Monkey Bay Health Zone Area. The overall and immediate objectives, as well as expected main outputs, relate to a shared vision of efficient and effective health services in the entire Monkey Bay Health Zone Area.

The time frame for the extension of Project activities is decided to be from 1st January, 2009 to December 30, 2011. An overall evaluation of project activities is to be conducted in 2011. Any further involvement by ICEIDA beyond 2011 is subject to negotiation.

1.1 Development objectives

Support national efforts in Malawi to reduce poverty and achieve socio-economic development especially among the rural poor and underprivileged within the project area

The Malawi Growth and Development Strategy (MGDS) is a national strategy that aims to reach the poor population, particularly in rural areas. The Health Sector Strategic Plan 2007-11 aims to contribute to the realization of the expected outcomes of the MGDS, which in turn will contribute to the achievement of long-term goals of the Millennium Development Goals.

Support the District Health Management Team in Mangochi to deliver the Essential Health Package in the Monkey Bay Health Zone Area and adjacent health zones.

The DHMT in Mangochi, through the District Assembly, has the devolved authority by the MoH to administer and run the health services in all of Mangochi District, of which Monkey Bay is one of five health zone areas. Successful implementation of project activities in Monkey Bay is the responsibility of the Malawian party and dependent on close collaboration of the MoH, DHMT, and health personnel in Monkey Bay with the support of representatives of ICEIDA. It is also understood that the national EHP is the main pillar on which planning of activities should be based and executed in the area.

1.2 Immediate objectives

1.2.1 Provide quality care to out- and inpatients

Monkey Bay Community Hospital and health centres in the Monkey Bay Health Zone deliver quality care to out- and inpatients.

Physical infrastructure development

During the project period the MBCH infrastructure will be upgraded in line with standards defined by GoM for a community hospital as much as financial and other circumstances allow. Priority is to be given to a new maternity, renovated OPD, U5 clinic, paediatric ward, kitchen and isolation ward at MBCH and the planned renovation of Chilonga dispensary. For each year ICEIDA budgets a maximum amount for this purpose and activities are strictly limited by the budget allocation. A specific workplan is made annually and agreed upon by stakeholders.

1. Renovated and reorganized OPD

The OPD facility will be upgraded and renovated. In 2004, the number of outpatients in MBCH was 39.619 compared to 58.855 in 2008. Considering this high number of outpatients, the current facilities are now over-burdened and patients sit on the floor in overcrowded situation. Greatly increased demand for OPD care has meant that the space provided within the MBCH premises is not very functional and needs to be upgraded and changed.

2. New maternity and paediatric wards

A new delivery room and maternity and paediatric wards constructed. Compared to the year 2005, overall bed occupancy rate has increased from 49% to 68% in 2007, based on the total number of inpatient days used, not on average bed occupancy rates for different wards. In the year 2007, 4.721 admissions were registered in MBCH compared to 4.376 in 2006. The maternity ward has the highest occupancy rate of 90-129% in every month of the year. The capacity of the paediatric ward has also been overstretched; in the first half of 2007 monthly bed occupancy rate was higher than 100%; after internal reorganisation with increased number of beds, it was about 70-120% in the last quarter of the year. Lowest bed occupancy rate is as before noticed for the male ward, around 20% in January-July 2007 and around 40% in August-December 2007 (number of beds for males was cut down during this period).

3. Present maternity ward turned into a new and reorganized facility for U5 clinics, Family Planning and pharmacy

Currently, the static U5-clinic services in MBCH are in the same building as the OPD. This mix of preventive and curative services is not desireable. With new facility for maternity services, the current facilities can be reorganised and renovated to accommodate U5-clinic and Family Planning services. The removal of U5-clinics from the OPD gives space to increase and improve the facility for pharmacy services, currently in great need for extension of space.

4. A new laundry house will be fully operational in 2009 and staff trained. A new kitchen facility can be built adjacent to it according to prioritization.

With increased activity of the surgical theatre and expected heavy load of linen to be washed it is crucial to improve the facility for the laundry services. Kitchen facility will either be an appendix to the laundry house or a stand alone structure.

5. The installation of a basic X-ray facility will be explored, and agreed to only according to MoH recommendations and standards in comparable hospitals in Malawi.

In the EHP, provision of X-ray services is envisioned. Currently there is no X-ray service in MBCH. Its availability has the potential to greatly improve quality of care and treatment options in the hospital. In 2007, purchase of a digital data processing equipment had been decided on (WHIS-RAD unit from Philips), but was later cancelled. However, the functionality and maintenance of technically advanced X-ray equipment relies heavily on prompt services when needed, as well as trained staff. It is the responsibility of University of Reykjavik consultants to address this issue during their consultancy in 2009, review options and determine with relevant stakeholders what the most appropriate solution is before commitment can be made to the provision of the service.

6. Renovated wards for post-operative and isolation patients

With increased bed occupancy rates of the available 68 beds in the wards, it is difficult to give optimal care to post-operative patients, e.g., women after Caesarian sections. Also, optimal care of HIV/AIDS and tuberculosis patients, secluded from other inpatients, is not currently available. This is a difficult problem but one that can be acted on by reorganization of the wards and renovation work.

7. New staff houses built at MBCH

During project implementation, a total of 19 staff houses have been constructed at the MBCH site. In addition, either new houses or older ones have been renovated. However, many members of staff lack adequate housing and some are renting houses at their own cost. The exact number of houses will depend on funds available and cost involved in relation to other structures that will be prioritized for each year.

8. Maintenance and renovation work will be secured with a small monthly contingency fund by ICEIDA under the supervision of the PC

The fund covers small items for day to day operations and light maintenance work such as cleaning, painting, repairs of electrical installments and the like. Maintenance crew of ICEIDA's VIN office in Monkey Bay will be available to these errands under PC's instructions. ICEIDA will budget for these operations. Nice and well maintained premises contribute to wellbeing of patients and staff alike. The oldest facilities of the MBCH have now been in use since 2002, and are beginning to get worn down. In particular, painting and floors need to be refreshed, and repairs carried out as necessary. ICEIDA plans to phase down its contribution to this part of the operation during the project period, with the explicit understanding that the DHO budget is made to include this cost at later stages.

9. Nankumba health centre. During the project period ICEIDA does not plan to build new structures.

Nankumba health centre is a busy facility judging from available health information data, for example, on OPD, maternity services and community health related activity. In 2007, outpatients' visits totalled about 40.713, compared to 26.977 visits in facilities run by all three CHAM facilities in the area. This illustrates the importance of the governmental services that do not apply user-fees. Therefore, subject to availability of funds and given other priorities the project will build only one staff house over the implementation period if circumstances allow.

10. Chilonga dispensary is renovated, a maternity ward and delivery room installed and water point renovated with solar pump.

The Evaluation Report in 2007 pointed out that Chilonga dispensary built in 2002, which is about 16 km from Nankumba health centre, had practically been left to degrade. It was recommended that ICEIDA should consider renovating the facilities. Currently, people from Chilonga attend the Nankumba health centre, despite difficult access and long distance. If access to good primary care is available in Chilonga for an area with about 10.000 inhabitants, it could alleviate somewhat the heavy workload in Nankumba health centre.

Before essential renovation of structures is undertaken ICEIDA and the DHO will sign a memorandum of understanding regarding the nature and scope of services provided at Chilonga, including the number of qualified staff the District can commit to the clinic and operational cost involved as a GoM contribution. Contribution to Chilonga structures has to be evaluated in line with other building plans, especially at MBCH, and made to fit budgetary concerns of the project as a whole.

Clinical management

Proper clinical management of out- and inpatients is of crucial importance for effective and efficient delivery of health services. The following are integral parts of this component.

1. Clinical guidelines in place and adhered to

National clinical guidelines are often available, based on international recommendations adapted to national needs. Regular use and review of the guidelines will be vital in promoting standards and consistency. The PC is to oversee that these guidelines are followed.

2. Emergency stock of pharmaceuticals maintained. Utilization defined in standard operational procedures for a revolving stock of such supplies that ICEIDA provides for use only in life saving emergency situations when MBCH is caught short. (See **Annex 1b** for procedures)

Access to pharmaceuticals is of importance for all clinical care to sick people. However, rational use and compliance to national guidelines is important. Their use has also to be complemented with good clinical care and monitoring. During project implementation access to pharmaceuticals has been severely limited, with detrimental impact on the services. An emergency stock can provide temporary relief in dire circumstances. This stock is to be kept separately from regular MBCH stock and reimbursed in kind when regular supplies are in place.

3. Essential laboratory services and materials are listed and used according to standard operational procedures for a revolving stock of such supplies that ICEIDA provides for use only in life saving emergency situations. (See **Annex 1b** for procedures)

The laboratory services are an important contribution to a fully equipped community hospital. During project implementation, lack of life-saving medical supplies has been an important factor to the detriment of the services. This includes, for example, material for hepatitis B/HIV tests, blood grouping, crossmatch and VDRL.

Administration and management

Well and transparently managed services with clear lines of command are important. Effective and efficient health services require management structure that is transparent and personnel has clear job descriptions on who is the next above them in the hierarchy.

1. Transparent project structure integrated into district organizational management

It is important that key actors within the health zone meet on a regular basis to discuss issues of mutual interest to foster improved collaboration and effective service delivery. This will

include streamlining the size of the TMT as proposed in this PD. The PMG is to convene twice a year for meetings prepared by the TMT. These meetings give ample opportunities for consultation and to review and monitor progress in the implementation of the project. Minutes of all meetings must be kept.

2. Regular meetings with minutes of different administrative structures within the zone.

Well written reports and regular minutes of meetings are one of the cornerstones for transparent management structure.

3. Financial management according to approved budget

The PC is responsible for ICEIDA's day-to-day involvement in operations. The ToR for the PC outlines specific financial responsibilities and accountability.

4. Regular supervision of services with reports

Responsibility for supervision of the health services is one important task of the DHMT in Mangochi. Further, staff in Monkey Bay also has supervisory roles within the health zone. Supervision visits should use standardized supervision checklists and provide both verbal and written feedback with well documented action points that are followed-up on.

Effective logistic support

ICEIDA will continue to provide logistical support with vehicles, motorbikes and telecommunications.

1. Ambulance that attends to patients as requested

ICEIDA will support the running of two ambulances, pay for fuel and maintenance. Both cars will be fitted with log books. MBCH will only become a first line facility of referral for the health services with access to a functional ambulance.

2. Functional motorbikes and maintenance guaranteed with funds from ICEIDA.

Motorbikes are needed for health workers for outreach activity. They need careful attention to proper maintenance.

3. Log books introduced for motorbikes and cars

The application of motor vehicles needs attention to their use.

4. Vehicle provided by ICEIDA to the DHO.

To facilitate stakeholders' collaboration and to support the DHO to that end ICEIDA contributes a vehicle to the office in 2009, under the provision that ICEIDA does not commit to maintenance or fuel cost.

1.2.2 Operational community health services

1. All HSAs are trained community health workers

One important staff group engaged in community health services are the HSAs. Many of them live in villages and know well their community. They often have home made maps and they monitor the population in each village. Recently the MoH has significantly increased the number of HSAs while their training is lagging behind.

2. Trained volunteers

ICEIDA will support the training of TBAs and CBDAs. They live and work in the villages and many enjoy trust and respect of the population. In addition to these volunteers, there are other volunteers engaged in community work in the health zone

3. Transport for community services made available

Transport for community health workers, such as TBAs, is limited. Bikes do facilitate referrals from rural villages and support health promotional activity. ICEIDA will fund the operation of bicycles for this use.

4. Estimated need for improved shelters for community services

Currently, outreach services lack proper facilities for integrated services, i.e. U5 clinics and antenatal care. Often the clinics are run under a tree or in a simple shelter. Seldom are they run in a house, e.g. church or a community facility that give a sense of privacy. This lack of facility hampers a proper integration of antenatal and family planning services during the clinic sessions. ICEIDA will explore the possibilities of ways to provide material support to outreach activities in the latter half of the project period according to a study that will be initiated in 2009.

1.2.3 Strengthening human resources capacity

1. Human resources trained and motivated according to a needs assessment

During the project period emphasis will be put on on-job training and applied training specific to the staff and facilities at MBCH according to a needs assessment. ICEIDA will fund training because quality of services is heavily dependent on trained and motivated staff. At the same time, their training cannot only be implemented at the cost of long absence from the working place with deficient and irregular service level as a result. It is also vital to find ways to avoid imbalance in the human resource management through non-transparent application of incentives to staff. The PC is responsible for implementing the training scheme based on the skeleton outline in **Annex 6.** He shall provide detailed quarterly training plans and submit for the approval of ICEIDA appointed advisor.

2. On-the-job training for improved monitoring and care of inpatients

The care of inpatients in MBCH needs special consideration, considering expansion of service options and more complicated medical problems to attend to. This underscores the value of

on-the-job training by health personnel within the zone as part of transfer of skills and knowledge that might not be possible in classroom situations.

3. Continuous training opportunities for staff at all levels of services

All categories of staff need opportunities to further their knowledge and improve service delivery. This is aimed at exposing personnel to advanced levels of knowledge but also as part of refreshing and upgrading of skills.

4. Up-grading of staff

Up-grading is a valued possibility among health professionals and important to improve the quality of the services. This has to be consistent with overall government policy and existing opportunities based on merit and fairness.

5. Staff as required by national guidelines for the level of services

Sufficient number of clinical health workers is needed to deliver quality services. This will require improvements in the recruitment system within the MoH and wide public service procedures.

1.2.4 Functional health management information system

Regular collection of health related data - and relevant analysis - is an important ingredient for good planning of health services. The computerized national HMIS has proved to be valuable to retrieve information on health service delivery in the Monkey Bay zone. Such a streamlined health information system needs a coherent and systematic approach that includes capacity building of staff.

1. Health statistics collected and analysed.

To have an impact on the local level, the health information data must be communicated in timely fashion in order to computerize such data for it to be properly analysed.

2. Results regularly discussed with health personnel in the zone and responded to.

Collection of health information is a useless endeavour if it is only collected and analysed but never reported and acted upon by those involved. Currently, the health information data have been regularly reported during annual meetings and increasingly during quarterly zone meetings.

3. A sub-set of indicators defined and regularly followed to monitor progress of services.

The national health monitoring system regularly collects data on more than 200 indicators. In addition to their questionable quality, many are not useful for planning purposes in the Monkey Bay health zone. It is the responsibility of the PC to supervise this process with the active support of the DHO.

4. Health system research conducted by students and others.

During project implementation Icelandic and Malawian university students have conducted research work that has contributed to better knowledge of the health situation in the health zone as well as on the delivery of services.

1.2.5 Collaboration among stakeholders

1. Collaboration between stakeholders within the health sector in the Monkey Bay Health Zone, in particular Mangochi District Health Management Team

According to national health policy, the DHO with his DHMT is the responsible authority of the health services in Mangochi district, including Monkey Bay. The MoH only lays out policy while implementation is left to the districts. One arm of the MoH is the South East Zonal Health Support Office with responsibility for Mangochi District. They do supervision and monitor implementation of national plans. In addition to these health management structures, there is staff in each district that have zonal responsibilities within their respective zones, e.g. as in the Monkey Bay zone, and with the responsibility of reporting to the DHO.

It is crucial that the different actors engage in continuous dialogue on ways to improve collaboration and smooth running of the system. Further, if sustainability is to be expected regarding the health services, both in scope and content, close collaboration with the Mangochi DHMT is important. In the long-term, it is crucial that the DHMT is efficient in retrieving sufficient funds for all the activities through national funds, e.g. through basket funding available by other donors.

2. Stakeholders identified and regular contact in place

Monkey Bay Health Zone Area is one of five zonal areas of Mangochi District. There are many actors within the District and some of them act in Monkey Bay, alongside ICEIDA. The District Implementation Plan for Mangochi District 2007-08 shows that there are several other donors than ICEIDA that contribute to the health services in the Mangochi district. These include, among others, WHO, UNICEF, UNAIDS, World Food Programme, World Vision, Médicins sans Frontières, CARE International and CHAM, in addition to SWAp pool fund and others. In addition to those there is a well established Traditional Authority within the Monkey Bay area who is chairman of the Area Development Programme that is composed of 15 community members. In addition, there are Village Health Committees in each village that discuss health care issues, TBAs, CBDAs and home based care as well as Health Centre Committees that include representatives from several villages, including one from MBCH.

Implementing project activity as that of ICEIDA, that aims to strengthen national health structures based on national policies and priorities, requires great deal of thoughtful insight and mutual respect from all those involved. It is evident from project history that the contacts with the DHO and his team in Mangochi have at times been strained. Future commitment is based on the understanding that both parties seek to collaborate in the most effective manner.

Annex 1a: Additional Information to Project Component Activities

Part 1: Definition of services rendered at MBCH

Monkey Bay Community Hospital is defined as a first line referral hospital for the five health centres in the Monkey Bay area of Mangochi District. The term Community Hospital is a new term in Malawian health service sector and the service level of such institution may change from time to time. The Ministry of Health in Malawi has published a list of buildings and infrastructure that such an establishment should contain indicating the scope and level of services provided. In the recommendations from the MoH, the following services are recommended at a Community Hospital and remain the frame of reference for ICEIDA's involvement in the MBCH:

A. Serve a population of 60.000-100.000.
B. Have between 80-120 beds, divided as follows:
   1. Medical/surgical – male
   2. Medical/surgical – female
   3. Paediatric
   4. Obstetric/gynaecology
   5. Labour/delivery
   6. Isolation

C. Nutritional Rehabilitation Unit.
D. Family planning unit.
E. Mortuary.
F. Kitchen.
G. Laboratory.
H. X-ray department.
I. Laundry.
J. Out Patient Department (OPD).
K. Surgical theatre.
   In the theatre clinicians perform most minor procedures (c.m) such as hernias, hydrocele, etc. Caesarean sections are performed and post-abortal care provided, as well as evacuations, repairs of ruptured uterus, etc. The theatre will also deal with minor orthopaedic procedures on extremities, fractures of extremities and most minor wounds. Additional procedures will depend on the staff capabilities to perform operations without endangering patients and staff.

Part 2: Assessment of structures and equipment at MBCH

The following structures are in place and need no further work on at the present, besides regular maintenance:

1. Laboratory.
2. Theatre.
3. Mortuary.
4. ARV/VCT building.
5. Administration.
6. Laundry (from 2009).

The following structures are in need of renovation.

1. The OPD building which includes: OPD, dentist, rehab, pharmacy and immunisation facilities. After renovation some of these activities will be in different buildings than now.
2. The maternity/delivery building. There is a plan to make this an under 5 yr. clinic and suitable for other activities, for example family planning.
3. The wards building. Will be inclusive of isolation ward.

The following structures need to be built.

1. Maternity/delivery ward.
2. X-ray facility, inclusive of dentistry, but needs more analysis during the project period.
3. Kitchen.
4. Paediatric ward.

The following equipment is needed.

1. X-ray facility: X-ray machine and related items.
2. Kitchen: cooking machinery and utensils.
3. Laundry: Minor equipment needed.

Part 3: Plan of the hospital grounds.
The attached plan has been completed and agreed upon by the partners of the project (see **Annex 10**).

Part 4: Human resources
MBCH is understaffed and it is the responsibility of the DHO in Mangochi to ensure the best possible staffing at any given time. Increased number of staff houses is essential. Currently the biggest problem is shortage of clinical officers and nurses.

Total number of posts at MBCH is 107 (2006 figures) but only about 93 are filled in 2008.
In 2008 there are three Clinical Officers but government requirements are six. The approved establishment provides for 36 positions of clinical and nursing staff but only 18 are in post.
The following benefits can be provided by the MBCH to induce increased employment:
1. Provision of more staff houses.
2. Meals during work hours.
3. Training which is optimized to MBCH actual needs.

Part 5: Training of staff
In 2008 a sum of 100.000 USD was used for training the staff at MBCH and other health personnel in Monkey Bay area. The project's parties are in agreement that training needs to be streamlined and focused to the benefit of MBCH to be directly applicable to day-to-day operation of the hospital.

1. A needs assessment of training is attached to this PD and will be reviewed on quarterly basis according to availability of funds, supply of adequate training and the ability of the MBCH to absorb this load on staff.

Part 6: Chilonga

At a meeting with stakeholders and the DHO at Chilonga on the 20th of Sept 2008 the following suggestions were made regarding further steps in the renovation of Chilonga Dispensary in order to make it a fully operational clinic. Priority was given to main building and water supply.

1. Upgrading and renovating existing main building including delivery and maternity facilities.
2. One new staff house built.
3. Three staff houses renovated.
4. Upgrading of water borehole with a solar pump.

Part 7: Nankumba.

No further additions to structures in Nankumba are planned on ICEIDA's behalf in the project period.

Part 8: Timetable for buildings:

The following structures have been prioritized, but actual building time and year may be subject to change, depending on available funds and building cost in Malawi:

1. Maternity/delivery wards: 2009.
2. OPD: 2009.
3. Reorganization of old maternity ward to house an U5 clinic, family planning and pharmacy: 2009.
4. Renovation of male/female ward: 2010
5. Paediatric ward: 2010
6. Kitchen: 2010
7. Explore the possibility of an X-ray facility: 2011
8. Staff houses: spread over project period.
9. Explore the possibility of a NRU during project period.
10. Chilonga dispensary will be scheduled with the DHO to fit into the schedule of other structures as funds allow during the project period.

Annex 1b: Stock of Emergency Supplies

The project partners agree that ICEIDA will provide a limited stock (approximately 3 days) of emergency supplies to be at hand in life saving situations when MBCH has been left short of such supplies by the Central Medical Store. These supplies are only provided on a "revolving account" basis, meaning that each item has to be reimbursed to the stock by the hospital immediately upon delivery from CMS. The PC administers this stock and is responsible for monthly auditing with ICEIDA accountant. The stock of supplies is itemized in this PD and kept separate from MBCH regular supplies. The PC keeps records of withdrawals from the stock and reports to ICEIDA accountant who checks withdrawals and refunds on a monthly basis.

The following items are deemed of essence to the operation of MBCH in emergency situations:

Laboratory items:

1. Haemoglobin
2. Blood glucose.
3. HIV test. (Determ. Test kit and Unigold).
4. VDRL test.
5. Hepatitis B test.
6. Slides for Malaria and TB investigations.
7. Staining material for Malaria and TB.
8. Blood giving sets.
9. Blood bags 250/450 ml.
10. Blood grouping sera, A, B, AB, O, and D.

Stock of drugs is divided in two categories.

1. For anaesthesia the following:
    - Suxamethonium.
    - Vecuronium.
    - Halothane.
    - Thiopentone.
    - Ephedrine.
    - Hydralazine.
    - Bupivacaine.
    - Lignocain 6% for spinals.
    - Atropine sulphate.
    - Adrenaline.
    - Pethidine.

2. Drugs for other use in the hospital:

  a) Antibiotics.
    1. Tablets
        - Amoxicillin 250 mg.
        - Penicillin 250 mg.
        - Chloramphenicol 250 mg.

- Ciprofloxacin 250 mg.
- Ketoconazol 200 mg.
- Nalidixic acid 500 mg.

2. Injectable.
    - Benzathine benzyl penicillin.
    - Chloramphenicol succinate.
    - Gentamycin.

b) Analgesics.

1. Tabets.
    - Asperin 300 mg.
    - Paracetamol 500 mg.
    - Indometacin 25 mg.
    - Morphine sulphate. 10 mg.

2. Injectable.
    - Pethedin/Morphin.

c) Other drugs.

1. Tablets
    - Aminophilline 100 mg.
    - Quinine 300 mg.

2. Injectable.
    - Aminophillin 25 mg/ml.
    - Diazepam.
    - Oxytocin.
    - Quinine.
    - Prometazine.

3. Other medicaments.
    - Dextrose 5%.
    - Ringer Lact

ANNEX 2: PROJECT MATRIX 2009- 2011

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS (OVI)	MEANS OF VERIFICATION (MOV)	IMPORTANT ASSUMPTIONS/RISKS
Goal To improve health of the population at all levels in a sustainable manner as stipulated in the Malawi Growth and Development Strategy and the Millennium Development Goals	1. Number of well qualified health personnel increased and retained; proportion of positions filled by clinical and nursing staff increased in comparison to 2008 situation up to at least 90% of requirement. 2. Improved health facilities and equipment: 2008 status compared to GoM community hospital specifications shows progress for key structures and services. 3. Improved management, monitoring and supervision of health care services through more reliable data collection as reported by the PC to the DHO and MCT.	1. Mid-term Project report, 2. National Statistical Office (NSO) reports, 3. Ministry of Health/District Hospital reports 4. Reports by PC.	1. Stable political situation & good political will **2.** Both Contracting Parties have the mutual understanding that commitment of all those involved in the project activities is a fundamental prerequisite for successful outcome
Purpose To assist the Ministry of Health through the District Health Management Team in Mangochi to deliver the essential health package in the Monkey Bay Health Zone Area and adjacent health zones.	1. Efficient and effective delivery of essential health package as reported in surveys for the project. 2. Monkey Bay Community Hospital and health centres in the Monkey Bay Health Zone deliver	1. Mid-term review report, 2. District Hospital reports, 3. Project surveys conducted in 2009, 2010 and 2011.	1. Support from all collaborating partners 2. Political and economic stability 3. Changes in policy or strategy for either of the Parties.

	quality care to out- and inpatients		4. Natural catastrophes that may hamper successful implementation of agreed plans, or ravaging epidemics. 5. Deteriorating global situation, in particular the economic situation and exchange rates that could affect the flow of funds from ICEIDA or the Government of Malawi.
NARRATIVE SUMMARY Immediate (Specific) Objectives	**OVI**	**MOV**	**Important Assumptions**
1.0. To provide quality care to out- and inpatients in Monkey Bay Community Hospital and health centres in the Monkey Bay Health Zone.	Annually increased combined number of out- and inpatients receiving care in Monkey Bay Community Hospital and health centres in the Monkey Bay Health Zone.	Evaluation reports Progress reports Data reported to DHO from MBCH and clinics	1. Good collaboration with stakeholders 2. Good working environment 3. Adequate absorption capacity of available resources
1.1 Physical infrastructure development	1.1.1. MBCH is first line of referral within Monkey Bay Health Zone 1.1.2. Hospital infrastructure is in line with GoM definition of a community hospital as measured by these indicators: • 80-120 beds, • Medical/surgical wards for males/females,	1. Programme progress reports as provided by PC. 2. Supervision Reports 3. Management Minutes provided by TMT. 4. Survey reports provided by consultants.	

	• Obstetrics/gynaecology, labour and delivery, • Paediatric ward, • Isolation beds • Family Planning • Operating theatre available for service in more than 80% of required cases • Laboratory providing required services in more than 80% of days • Kitchen • Mortuary 1.1.3. Access to maternity and out- and inpatient services in Chilonga area are established and clean water provided. 1.1.4. Staff moved into new staff houses in Monkey Bay and Chilonga		
1.2 Clinical management • *Quality clinical care to out- and inpatients* • *Good monitoring of inpatients*	1.2.1. Components of IMCI, TB, VCT/ART, STI, and Safe Motherhood applied within the services. 1.2.2. Laboratory and surgical theatre able to respond in >80% of emergency situations. 1.2.3. Caesarian and similar	1. Programme reports/ 2. Survey reports by consultants filed according to standardized checklists. 3. Management Minutes 4. ICEIDA books on emergency stock and maintainance fund. 5. In-house study and on-job	

	operations regularly and increasingly provided, in at least 120 cases annually. 1.2.4. Women increasingly giving birth with skilled birth attendants in 75% of incidences 1.2.5. Laboratory regularly offers services in line with needs assessment in >80% days/year 1.2.6. Emergency stock of supplies according to PD's specifications is refunded on a regular basis and audited by ICEIDA accountants, monthly reports kept. 1.2.7. Management of endemic, maternal and childhood diseases follows official guidelines, overseen by the PC and reported to DHO. 1.2.8. Monitoring of quality care of inpatients according to national guidelines and recommendations. 1.2.9. Monitor and evaluate the use of emergency stock.	training on national guidelines and recommendations regarding quality care of inpatients at MBCH.	

1.3 Administration • *Well and transparently managed services with clear lines of command*	1.3.1. Clear lines of administration commands in place and known to all 1.3.2. Minutes available from meetings of different organisational components 1.3.3. Supervisory reports accessible 1.3.4. Monthly reports of PC to Country Director available. 1.3.5. Small contingency fund for maintenance and spare parts regularly audited by ICEIDA accountants. 1.3.6. Proactive, efficient and effective management of the project through monthly MCT meetings. 1.3.7. Quarterly TMT meetings held and reported on. 1.3.8. PMG meetings held and reported on.	1. Programme reports 2. Management Minutes	
1.4 Logistical support	1.4.1. Logbooks for ambulances motorbikes and utilitarian vehicle analysed and acted on 1.4.2. Vehicles and motorbikes in operational order >80% of days.	Programme reports	

	1.4.3. Population and health workers with access to equipment and transport >80 % days.		
2.0. Human resources Trained and motivated staff	2.1. Report on training needs provided on quarterly basis and analyzed. 2.2. Training implemented according to plans.	1. Programme and management reports 2. Surveys reports 3. Management Minutes 4. Training reports	
3.0. To ensure community health services through outreach services.	3.1. The community provided with support to clinics and outreach with the aim of building at least 10 shelters. 3.2. Outreach clinics with integrated services of the essential health package. 3.3. Study of increased support to outreach activities conducted and acted upon to improve client satisfaction during project period. 3.4. More than 2/3 of outreach clinics deliver integrated services of antenatal care and U5 clinics. 3.5. At least 80% of outreach clinics conducted as planned	1. Programme Reports 2. Survey reports 3. Management Minutes 4. Plan to support outreach activities in place by 2009.	1. Good collaboration with stakeholders 2. Good working environment 3. Adequate absorption capacity of available resources
4.0. To ensure functional	4.1. Functional health	1. Programme reports	1. Good collaboration with

health management information system	information systems in place 4.2. Health statistics are regularly collected and analysed under the supervision of MCT/PC. 4.3. Timely communication of results to the health personnel in the zone. 4.4. Regular use of health statistics in the delivery of essential health services 4.5. Coordinated registration system	2. Supervison reports 3. Management Minutes	stakeholders 2. Good working environment 3. Adequate absorption capacity of available resources
5.0. To enhance collaboration among stakeholders	5.1. Stakeholders identified and in regular contact place 5.2. Regular meetings of Administrative bodies have been held and minutes kept on record. 5.3. Improved linkages and coordination mechanisms between the bodies and other stakeholders	Annual list of stakeholders presented to PMG meetings. Yearly reports on collaboration with key stakeholders and projects	1. Good collaboration with stakeholders 2. Good working environment 3. Adequate absorption capacity of available resources
Narrative Summary of Outputs	**Objectively Verifiable Indicators (OVI)**	**Means of Verification (MOV)**	**Important Assumptions/Risks**
1. Key structural features of a community hospital in place	1.1 Key structural features of a community hospital in place according to plan and to formal definition of a community hospital.	1. Programme progress reports 2. Supervision reports 3. Monthly reports 4. Quarterly reports	1. Availability of Funds 2. Good leadership and management 3. Reliable functional systems and guidelines

2. Appropriate and essential equipment acquired and well maintained. 3. Chilonga health centre enabled to deliver services 4. Staff moved into new staff houses in Monkey Bay and Chilonga 5. Report on training needs 6. Training implemented according to plans 7. Adequate clinical staff in MBCH as defined for a community hospital 8. Adequate staff in Chilonga health centre to conduct agreed services. 9. Proper management of endemic, maternal and childhood diseases. Women with complicated pregnancy and birth adequately treated at Chilonga and MBCH.	2.1 Essential equipment acquired and operational as reported to management structures. 3.1 Services delivered at Chilonga, supervised deliveries recorded and water provided at Chilonga. 4.1 Staff moved into new staff houses in Monkey Bay and Chilonga. 5.1 Number of reports on training needs produced. 6.1 Training reports according to plans. 7.1 Number of clinical staff in MBCH as defined for a community hospital at least 90% of requirement. 8.1 Report on staff in Chilonga by DHO to TMT. 9.1 Reports on women given treatment	5. Bi-annual reports 6. Yearly reports 7. Survey reports	

10. Monitoring of inpatients according to guidelines 11. Response to emergency situations improved. 12. Population and health workers with access to appropriate equipment and transport 13. Proper use and regular maintenance of vehicles 14. Use of health statistics.	10.1 Reports by PC. 11.1 Response to emergency situations in place as indicated by use of emergency stock. 12.1 Vehicle checklists and transport logs in order. 13.1 Records on car maintenance in place 14.1 Minutes from TMT meetings. .		
Main Activities	**Main Inputs/Resources**		**Assumptions/Risks**
As mutually agreed by the Contracting Parties and as specified in the Action Plan: **1.0 To provide quality care to out- and inpatients in Monkey Bay Community Hospital and health centres in the Monkey Bay Health Zone.** **Activities** 1.1. Renovation of the OPD 1.2 . Construction of new	• Funds and commodities • Technical assistance • Consultants • Training • Policies, systems and guidelines		1. Availability of funds 2. Collaboration among stakeholders 3. Availbility of personnel and continous skills development

maternity and children's wards 1.3. Renovation of old maternity ward to house an under-five clinic 1.4. Construction of new laundry and kitchen 1.5. Construction of an x-ray facility if deemed feasible by analysis in 2009-2010. 1.6. Renovation of wards for post-operative and isolation patients 1.7. Construction of new staff houses, funds allowing and according to prioritization. 1.8. Renovation and maintenance of current facilities in MBCH where necessary 1.9. Water provided to Chilonga. 1.10. Renovation of physical structures at Chilonga dispensary 1.11. Identify and list all current clinical guidelines of relevance for the services in MBCH 1.12. Conduct PMG meetings biannually and document meetings 1.13. Gradual integration of project costs into district			

health budget 1.14. Regular supervision of the services by the DHMT 1.15. Put in place national, routine transport administration and monitoring, including log book, for the ambulances and motorbikes **2.0. Human resources: Trained and motivated staff** 2.1. Conduct training needs assessment for staff members 2.2. Conduct on-the-job training for staff members 2.3. Conduct training for staff members according to their needs 2.4. Sending staff members for upgrading **3.0. To ensure operational community health related services** 3.1. Training of the HSAs Training of TBAs and CBDAs 3.2. Analyze and act upon the transport needs of the volunteers 3.3. Analyze and act upon the current condition of the			

outreach clinics **4.0. To ensure functional health management information system** 4.1. Seeking a streamlined system of health information that keeps all stakeholders involved and creates a basis for appropriate actions in the field 4.2. Defining a sub-set of health indicators 4.3. Conduct research on health systems **5.0 To enhance collaboration among stakeholders** 5.1. Information sharing/ sensitization of concurrent health activities within the zone 5.2. Analyze and consider expansion of project activities outside the Monkey Bay health zone			

ANNEX 3: PROJECT ORGANIZATION, MANAGEMENT AND ADMINISTRATION

Implementation of the project is the responsibility of the GoM with the support of the Government of Iceland. The actual implementation of the project will involve several bodies which shall perform roles and responsibilities as outlined below.

1. Programme Management Group (PMG)

1.1 Composition

The PMG will comprise the four members (or their represenatives) as follows:

- Secretary for Health
- District Health Officer
- Consultant to ICEIDA from the University of Reykjavik
- ICEIDA Country Director

1.2. Roles and responsibilities

The PMG will meet at least bi-annually to receive reports, deliberate on implementation progress and plans in each of the major areas of the project and clear all project implementation issues before submitting final project reports to the GoM and Government of Iceland. The PMG will be specifically responsible for:

- Overall supervision and monitoring of the implementation of the project
- Making decisions on implementation of the project
- Commissioning evaluation missions

Approving reports and major recommendations on project implementation

2. Technical Management Team (TMT)

2.1. Composition

The TMT will comprise of nine members as follows:

- The DHO in Mangochi
- Project Coordinator
- Hospital in Charge
- Representative of Country Director (CD), ICEIDA Lilongwe Office,
- Representatives of the five Health Centres in the MBCH zone.

The DHO shall chair the proceedings of the TMT and in his or her absence the Project Coordinator shall chair.

2.2. Roles and responsibilities

The TMT will meet quarterly to receive reports, deliberate on implementation progress and plans in each of the major areas of the project. Specific functions will include:

- Monitoring and reviewing progress on implementation of planned project activities as reported by the PC.
- Providing guidance to the MCT in areas of project implementation
- Making appropriate recommendations to the PMG on project implementation activities
- Review the agenda for meetings of the PMG
- Review minutes of meetings of the MCT and make minutes of the TMT meeting available to members of the PMG after each meeting.
- Review the results of data collection and analysis at MBCH as presented by representative of MBCH

3. MBCH Coordination Team (MCT)

3.1. Composition

The MCT shall comprise the following:

- Project Coordinator
- All health staff at MBCH with zonal responsibilities
- Observer on behalf of ICEIDA.

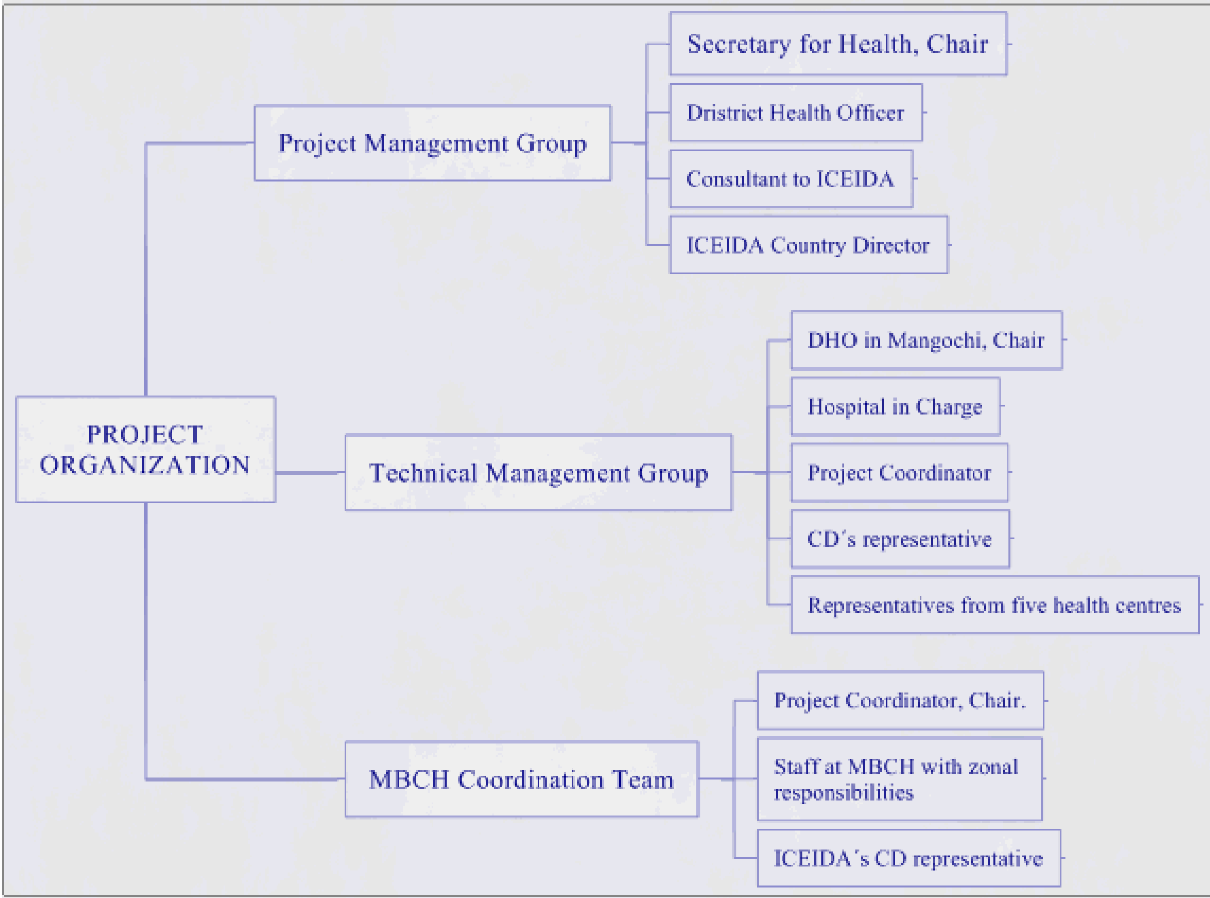
The Project Coordinator shall chair the meetings of the MCT

3.2. Roles and responsibilities

The MCT shall be required to meet once or twice a month. Specific responsibilities will include:

- Monitoring implementation of health project activities on monthly basis
- Preparing quarterly progress reports for the consideration of the TMT with specific recommendations where necessary
- Referring matters to TMT needing resolution
- Preparing the agenda for both TMT and PMG meetings
- Preparing its own agenda and minutes, under the supervision of the PC.
- Review on a monthly basis the results of data collection and analysis.

Organizational chart:



ANNEX 4: TERMS OF REFERENCE FOR PROJECT COORDINATOR

It is the duty of the Project Coordinator (PC) to conduct regular consultation and collaboration between stakeholders in the MBCH health zone and ensure the successful implementation of the Project Document of MBCH 2009-2011. The PC is a GoM employee at the MBCH. However, by virtue of his position as a part time PC he will also be accountable to ICEIDA to ensure the implementation of the actions defined in the Project Document and that outputs are successfully obtained. This is according to an agreement with the MoH. The following are the specific responsibilities of the PC.

1) The PC liaises with the District Health Officer in Mangochi, the Ministry of Health and other GoM stakeholders on issues related to the implementatation of the PD.
2) The PC supervises cooperation of MBCH with health clinics in the area and makes sure that support provided by ICEIDA is enforced.
3) The PC communicates with building contractors and providers of new equipment as advisor if needed. The PC is the day-to-day monitor of the progress of new buildings and the procurement and installment of new equipment.
4) The PC supervises MBCH staff paid for by ICEIDA.
5) On a monthly basis the PC submits a short written status and progress report to the Country Director of ICEIDA. Annually he prepares a budget for next year’s project operations and submits to the Country Director, along with a progress report for the year and next year’s workplan based on the PD.
6) The PC administers a small contingency fund provided by ICEIDA for maintainance and spare parts at the MBCH, released on monthly basis. It is the responsibility of the PC to report all cost items and provide invoices to ICEIDA´s accountant at VIN office on a monthly basis. Only upon the fullfillment of this condition next month’s contribution is released.
7) The PC is responsible for administering emergency supplies provided by ICEIDA to be used on a revolving account basis in life saving situations. The stock of supplies is itemized in the PD and kept separate from MBCH reglular supplies. The PC keeps records of withdrawals from the stock and reports to ICEIDA accountant who checks withdrawals and refunds on a monthly basis.

Note: Apart from this ToR the frame of reference is the Project Document for MBCH and the Monkey Bay health zone.

ANNEX 5: GUIDELINES FOR DATA REGISTRATION AT MBCH

Reliable information about the flow of patients going through the MBCH is imperative for good planning of health services. Following recommendations are made with special regard to registration of OPD attendance at MBCH which urgently needs improvement:

1. All relevant information, such as the date of each visit to the OPD, shall be clearly recorded in the registration book.
2. The total number of patients after every day shall be recorded in the registration book as this will reduce the risk of inaccuracy of the final counting.
3. Summary sheet after every week handed in to the Environmental Health Officers.
4. Report monthly the total number of patients attending the OPD to the Environmental Health Officer who will verify that the numbers are correct. With regard to the register clerks, the quarterly report can be used for this purpose, the important thing is to do the final counting at the end of each month instead of every three months.
5. The Environmental Health Officer computerizes the data and analyzes it in cooperation with the Project Coordinator.
6. Results are regularly discussed with health personnel in the zone and responded to. The Project Coordinator and the Environmental Health Officer report an overview of the health information data during quarterly TMT meetings.

ANNEX 6: TRAINING NEEDS ASSESSMENT AND GUIDING PRINCIPLES

ICEIDA will review training proposals made by the PC on a quarterly basis, as presented by the PC, and seek external consultancy on the issue. Funding will be released only after such review.

These are the guiding principles ICEIDA will use in evaluating support to training:

1) Training is applicable to regular work of the staff in question and will have practical implications in its role at the MBCH or in the field.
2) Training is based on the need to improve the scope of services supported in this PD. Explanation of how proposed training is expected to improve the skills of attendants is required.
3) Training is as much as possible on-the-job training, or, when external facilities are required, using ICEIDA's conference facilities in Monkey Bay whenever possible.
4) Training is based on PC's proposed plan submitted on a quarterly basis and executed only on approval by ICEIDA's consultant on the matter.

In general ICEIDA does not provide allowances or support to:

1) Regular meetings, conferences or seminars organized by the Malawian health authorities for staff within its own health system.
2) Meetings, workshops or conferences that are supported by other donors and provided for by them.
3) Training or workshops of content that does not have direct bearing on improving actual services provided by MBCH.

ICEIDA does support MBCH staff in seeking higher education and upgrade. This is under the condition that respective staff members agree to terms and conditions relating to future employment at MBCH.

ANNEX 7: BUDGET: 2009 – 2011

The Monkey Bay Community Hospital is a Malawi Government institution under the Ministry of Health. The GoM is responsible for all major operational cost, provisions of medical and laboratory supplies and the like, in order for the MBCH to function as a hospital in the Monkey Bay Health Zone.
The overall responsibility for the service as a whole is the GoM responsibility and the MBCH is integrated into the Malawian health system.

According to this project document ICEIDA will provide financial and technical support to some aspects in the development and operation of the hospital and community services. In addition this will involve the training of HSAs, TBAs, structures of clinics and related logistics. For each of the project years a detailed budget will be worked out and presented to the PMG.
A detailed annual budget will be worked out in close cooperation of stakeholders and contractors for systematic prioritization of resources, namely for infrastructure and training, the two biggest cost items.

ICEIDA estimates the total contribution from 2009-2011 to be USD 2.200.000.
For 2009 the figure will be USD 700.000.
For 2010 the figure will be USD 750.000.
For 2011 the figure will be USD 750.000.

ANNEX 8: ACTIVITY IMPLEMENTATION PLAN

To provide quality care to out- and inpatients in Monkey Bay Community Hospital and health centres in the Monkey Bay Health Zone.				
Infrastructure Development Activities	Indicators	2009	2010	2011
1. Renovation of the OPD	• Hospital infrastructure has progressed to be in line with GoM definition of a community hospital. • Key components of a community hospital are operational and service rendered according to predefined standards (See **Annex 1a**). • Access to maternity and in- and outpatient services in Chilonga area are well established. • Staff moved into new staff houses in Monkey Bay and Chilonga	x		
2. Construction of new maternity and children's wards		x		
3. Renovation of old maternity ward to house an under-five clinic		x		
5.Analysis of the provision of an X-ray facility			x	x
6. Renovation of wards for post-operative and isolation patients				
7. Construction of new kitchen and staff houses			x	x
8. Regular maintenance of current facilities in MBCH where necessary			x	x
10. Renovation of physical structures at Chilonga dispensary			x	x
11. Peadiatric ward			x	x
Clinical Management Activities	Indicators	2009	2010	2011
Identify and list all current clinical guidelines of relevance for the services in MBCH	• Components of IMCI, TB, VCT/ART, STI, and Safe Motherhood applied within the services. • Surgical theatre operating regularly and as need arises • Caesarian sections conducted according to need • Monitoring of out- and inpatients according to guidelines as reported by the PC. • Delivery assistance by	x	x	x

	health professionals in >60% of cases in the health zone. • Laboratory regularly offers services in line with needs assessment in >80% days/year • Emergency stock of supplies is refunded on a regular basis and audited by ICEIDA accountants. • Management of endemic, maternal and childhood diseases follows official guidelines, overseen by the PC. • Women with complicated pregnancy and birth delivery treated • Improved response to emergency situations by use of emergency stocks.			
Administration				
Activities	Indicators	2009	2010	2011
1. MCT meets regularly and PC reports to CD on a monthly basis. 2. Conduct PMG meetings biannually and document meetings 3. TMT meets regularly and makes minutes available to DHO, CD and consultants. 4. Gradual integration of project costs into district health budget overseen by the DHO. 5. Regular supervision of the services by the DHMT	• Clear lines of administration commands in place and known to all • Minutes available from meetings of different organisational components • Supervisory reports accessible • Monthly reports of PC to Country Director available. • Small contingency fund for maintenance and spare parts regularly audited by ICEIDA accountants. • Transparency and	x	x	x

	accountability of project resources verified by consultants. • Proactive, efficient and effective management of the project by the MCT as reported by the PC to the CD and TMT. • Number of personnel participating in leadership skills training • Budget of DHO absorbes operational cost as ICEIDA funds for operations phase out.			x
Logistics				
Activities	Indicators	2009	2010	2011
Routine transport administration and monitoring is in place, including log book for the ambulances and motorbikes	• Logistical arrangements and support in place and known to all • Log books for ambulances kept, analysed and acted on • Vehicles and motorbikes in operational order. • Population in the zone and health workers with access to transport	x	x	x
Outreach				
Activities	Indicators			
1. Needs assessment carried out to identify level of support to outreach activities. 2. Training of the HSAs 3. Training of TBAs and	• Project team makes suggestions about stronger outreach activities according to report. • The community provided with	x x	x	x

CBDAs. 4. Analyze and act upon the transport needs of the volunteers 5. Analyze and act upon the current conduct of the outreach clinics 6. If agreed by PMG material support to outreach given according to 2009 assessment.	operational health related services in clinics and outreach posts. • Outreach clinics with integrated services of the essential health package. • More than 2/3 of outreach clinics deliver integrated services of antenatal care and U5 clinics. • At least 80% of outreach clinics conducted as planned • Volunteers identified and supervised in the communities		x	x
Human Resources				
Activities	Indicators	2009	2010	2011
1. Regular training needs assessment for staff members 2. Conduct on-the-job training for staff members 3. Conduct trainings for staff members according to their needs 4. Sending staff members for upgrading	• Report on training needs • Training implemented according to plans • Members of staff utilised in line with training received • Staffing levels with minimum requirements at MBCH and other health centres at least 90% of formal standards.	x	x	x
Health Management Information Statistics				
Activities	Indicators	2009	2010	2011
1.Seeking a streamlined system of health information that keeps all relevant stakeholders involved and creates a basis for appropriate actions in the field 2. Follow data collection guidelines.	• Functional health information systems in place • Health statistics are regularly collected and analysed under the supervision of PC. • Timely communication of results to the health	x	x	x

	personnel in the zone. • Regular use of health statistics in the delivery of essential health services • Coordinated registration system			
Stakeholder Collaboration				
Activities	Indicators	2009	2010	2011
1. Information sharing/ sensitization on concurrent health activities within the zone. 2. Analyze and consider expansion of project activities outside the Monkey Bay Health Zone Area.	• Stakeholders identified and regular contact in place • Regular meetings of Administrative bodies have been held and minutes kept on record. • Improved linkages and coordination mechanisms between the bodies and other stakeholders			x

ANNEX 9: CONSULTANCY

To strengthen the project's supervision and advice on progress during the period ICEIDA provides consultancy on the following basis:

1) ICEIDA will, through contractual agreement with Reykjavík University, Iceland, provide professional advice and support to the project activities. This consultancy shall include serving on biannual PMG meetings.

2) One Malawian health professional is to be contracted on a part-time basis to regularly monitor and supervise activities in the area.

The responsibilities of the advisor include representing the CD of ICEIDA during the project's implementation period, including participating in monthly MCT meetings, and advice the PC on progress and plans. The advisor evaluates training plans submitted by the PC on a quarterly basis.
The advisor shall furthermore participate in quarterly TMT meetings.

The advisor shall act as a facilitator on ICEIDA's behalf in effective team building among MCT and TMT representatives. He or she shall advice on MBCH's progress towards greater financial and managerial sustainability and provide constructive input on how to integrate the MBCH more thoroughly into the District Health Budget.

The following are the guidelines for the advisor:

Scope of Duties and Responsibilities

(i) The advisor shall:

a) Serve as an advisor regarding the successful implementation of the Project Document (PD) for the Monkey Bay Community Hospital. The PD is the main frame of reference for his work.

b) Report directly to the Country Director of ICEIDA.

c) Attend the monthly MBCH Coordination Team (MCT) meetings which are chaired by the PC.

d) Prior to each monthly MCT meeting, have a formal meeting with the PC to be briefed and appraised on current activities and plans, for overview and consultation.

e) Attend and participate in quarterly meetings of the Technical Management Team (TMT).

f) Liaise and coordinate with the District Health Office where necessary, keeping the PC informed of the nature and scope of such activities.

g) On a monthly basis, prepare monthly reports to the Country Dircetor and meet with him for debriefing as required within the agreed framework of the services.

h) NOT have any authority over the PC or other stakeholders. In cases where crucial decisions are recommended he or she shall present such recommendations to the CD who shall in turn take necessary action as he deems fit.

(ii) The Main Areas of Operation shall be to:

a) Monitor progress of implementation of the Project Document for the MBCH

b) Assist the PC in fostering cooperation of all relevant stakeholders and provide advice on effective team building among MCT and TMT representatives and hospital staff.

c) Advise on integration process of the MBCH into the Malawian health system, including MBCH's progress towards greater financial and managerial sustainability and provide constructive input on how to integrate the MBCH more thoroughly into the District Health Budget.

d) Review training plans of the PC for the MBCH based on guidelines in the PD and evaluate their relevance and applicability before making recommendations to the CD.

e) Provide input and advice on further development of public health services in the health zone.

f) Advise and assist the CD by ensuring that the working relationship with GoM institutions is conducive.

g) Act as advisor regarding any other business related to the Project Document of MBCH.

The following is the ToR for the University of Reykjavik Consultancy:

1. Description of Assignment
The main objectives of this assignment are (i) advice the ICEIDA Country Director in supervision and monitoring of the implementation of the Project and (ii) serve on the Monkey Bay Community Hospital (MBCH) Project Management Group (PMG) as requested.
This ToR is within the *Main Contract of Work for the Years 2009 to 2011*, as agreed by ICEIDA and Reykjavík University.

2. Location and Duration
The advisor is based in Reykjavik but site visits will be made as mutually agreed, the first one in April 2009. The primary objective of the site visits is to work with the Country Director on assessing the progress of the project as described in the Project Document, and advice on issues directly related to either implementation and/or policy. To this effect the advisor takes part in meetings with stakeholders and liaises with the Country Director in evaluation of the status of the project as a whole. An agenda for each visit shall be made in advance in collaboration of the advisor and the Country Director.

3. Plan of Work and methodology

a) In preparing and conducting the assignment, the advisor will cooperate closely with ICEIDA's Country Director.
b) The advisor shall receive reports about the progress of the project and give feedback to the Country Director.
c) The advisor shall be available for long-distance conferencing with the Country Director, provide input into preparations for various project components and advice on implementation.
d) The advisor shall prepare visits to Malawi with ICEIDA office in Lilongwe by suggesting agenda for meetings and prepare for consultation on specific matters requested by the Country Director during the visit.
e) The Country Director can request advice on reports, documents or other matters pertaining to ICEIDA's support to MBCH.
f) The advisor should be available for meetings with ICEIDA staff in Iceland on an *ad hoc* basis.
g) The advisor will assist the Country Director in preparing PMG meetings on behalf of ICEIDA as well as contribute to the preparation annual reports of the PMG.

4. Specific additions to this TOR.

Any further specifications regarding the planning, timing and implementation of the consultancy for each year shall be worked out and agreed in a memo between the contracting parties.

5. Remuneration

Remuneration for the advisor is according to a contract between University of Reykjavik and ICEIDA in Iceland with reference to a special memorandum about the nature, timing and scope of the advisor's assignment each year of the project period.

ANNEX 10: SITE MAP OF MBCH AREA