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World Vision Relief & Development Inc.

MIDTERM EVALUATION
CHILD SURVIVAL PROJECT
CHANGARA DISTRICT
TETE PROVINCE, MOZAMBIQUE

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Ending Date: September 30, 1993

Submitted to:

PVO Child Survival Grants Program
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Last but not least, I would like to express my deep admiration for the resilience of the Mozambican people for tolerating such a hard life.

I have learned a lot from all of you!

Sincerely,

Thelma N.S. Leifert

ABBREVIATIONS

CB-ORS	Cereal-Based Oral Rehydration Solution
CDD	Control of Diarrheal Diseases
CSP	Child Survival Project
CSPT	Child Survival Project, Tete
CSP/DPST	Center for Statistics and Planning, Provincial Director of Health, Tete*
DIP	Detailed Implementation Plan
DDS	District Director of Health*
DPS	Provincial Director of Health*
DPPCCN	Departmento de Prevencao e Combate as Calamidades Naturais
EPI/GM	Expanded Program in Immunization/Growth Monitoring
HIS	Health Information System
HO	Health Officer
INT'L	International
KAP	Knowledge, Attitudes and Practices
LOA	Leite, Oleo e Agucar (Milk, Oil and Sugar)
MCH	Maternal Child Health
MD	Doctor
MOH	Ministry of Health
MPH	Master in Public Health
MT	Metric Tons
NRC	Nutrition Rehabilitation Center(s)
OJM	Organizacao ads Jovens de Mozambique
OMM	Organizacao ads Mulheres de Mozambique
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
RESP.	Responsavel/Manager
RN	Registered Nurse
SSS	Sugar Salt Solution
TMP/SM	Tecnico de Medicina Preventiva e Saneamento do Meio/Preventative Medicine Technician/Environmental Sanitation
TVHP	Tete Village Health Project
USAID	United States Agency for International Development
WCBA	Women of Childbearing Age
WHO	World Health Organization
WV	World Vision
WVI	World Vision International
WVM	World Vision Mozambique
WVRD	World Vision Relief & Development

*Translated from Portuguese to English

EXECUTIVE SUMMARY

The management philosophy of this project is defined as follows:

"This project is owned and operated by the Ministry of Health, Mozambique. The role of World Vision is to facilitate the MOH by providing resources, technical and administrative support to these activities. The staff of World Vision coordinates the work for the MOH with the understanding that the World Vision staff will gradually transfer the responsibilities of the project to MOH personnel."

In agreement with this philosophy, the local MOH must invest time and human resources to develop the project. Part of the institutional support that the local MOH requested was that WV assist by alleviating the pressure of rendering preventive services to the target population of the Changara District, as well as part of the suburban population of Tete City. This direct service, added with other fundamental problems listed below, caused the Child Survival Project (CSP) of WV to develop more or less independently of the MOH.

- The human resources of the MOH at the provincial and district level were not and still are not sufficient to cover the project area, which has a 40-50 km radius. Some distances are over 100 km, and the total population is 57,000 inhabitants.

- The instability caused by the war and banditry created a dense population in secure areas that exhausted the local resources and required special logistics to provide primary health care services.

- The loss of agricultural productivity caused by the lack of cultivatable land and the severe drought in the secure areas influenced motivation of the population to remain or to drop of out the project.

All of these factors contributed to the decision to give medical service to the target population in a focused manner with designated goals. It was premature to have expected that all of the services would be replicable or sustainable since the political and social stability does not exist. Adjustments in the resources and implementation of the activities have been constant during the last 24 months of the life of the project. A routine of joint planning of activities reinforces the relations that began to be established during the initiation of the project. The purpose of the meetings are to view the problems, constraints and solutions to improve the activities developed until now.

In spite of the constraints that faced the project, it has maintained a very high quality of health service to the population. During the next year the possibility of expansion of activities, training, supervision and logistics should be observed in great detail by the Provincial and District Directors of Health (DPS/DDS) with the intent of determining which interventions can be absorbed into these departments.

During the evaluation, various members of the community expressed gratitude for the benefits the project has brought to their communities. However, the non-target population expressed their feelings of exclusion from any health benefits, principally curative services, that are not available to them unless they live close to the health center. A personal observation of the author is that the community would give much more support to the project if they were not hungry and had other means of survival besides their barren fields or the insufficient food rations offered through the DPPCCN.

1. ASSESSMENT OF ACCOMPLISHMENTS

1.1 Project Background

World Vision (WV) began operations in Mozambique in 1984, distributing 5,000 metric tons (MT) of maize in the Tete Province. This province is situated in the northwest corridor of the country. It borders Zambia to the north, Malawi to the northeast, and Zimbabwe to the south. It is comprised of 12 districts and the city of Tete. Tete has an estimate of 1.2 million inhabitants; less than 500,000 live in the province; the remaining are refugees in neighboring countries.

By 1989 WV had donated in excess of 150 MT of grain and distributed AgPaks to 55,000 families. The addition of a health (child survival) component in 1989 was an essential extension of the nutritional elements of the food distribution and AgRecovery Programs.

World Vision's Child Survival Program, Tete (CSPT), a three-year project funded by USAID and WVI, was officially launched in October 1990 following the signing of a contract between the provincial MOH and World Vision Mozambique. The project services a total population of 57,000 people in the Changara District of the Tete Province. The target area stretches along the main road from the Zimbabwe border to Tete City, then continues northwest after the city limit toward the village of Boroma in the interior of the province. Travel by military convoy (1.1 hours) or small aircraft (30 minutes) is the weekly travel routine of the health staff. There is a radius of 40-50 km between the City of Tete and the villages where the target population reside (Annex 2).

The CSP Tete is an extension of the **Tete Village Health Project** (TVHP), co-funded by USAID and World Vision between October 1988 and September 1990. This two-year project witnessed a remarkable improvement in the health of the target population as a direct result of child survival inputs of nutrition, control of diarrheal disease and immunizations. Prior to WV's health interventions, coverage of this area was virtually non-existent. Many villages are distant from the health center/posts, and there is a high concentration of displaced people who have immediate and severe health care requirements which tend to overwhelm the already-overburdened health care system. In addition, this area has a high concentration of natural residents whose basic health needs were often unattended due to the lack of health personnel.

A knowledge, attitude, and practice (KAP) survey was conducted in January 1991, and implementation of the CSP interventions began in February 1991. The target population was soon expanded from the 43 barrios in and around Changara to over 90 barrios by June 1991.

The program consists of 3 localities with 17 natural villages and 1 displaced people group (deslocados) that have permanently relocated. Ninety-eight "barrios" (subsectors of villages) are the focus of the program; most of them are located along the road in secure areas of the district. These localities encompass nearly one-half of the total rural population. The target population varies in each zone from between 14,000-18,000 children between 0-3 years and women of childbearing age (Annex 3). As of August 1992, over 9,000 families with women of childbearing age and 6,330 children under three years of age were registered and matriculating through the project.

1.2 Interventions and Achievements To Date

Considering the difficulties encountered, the staff of this project have performed exceptionally and achieved a great deal in two years. To provide primary health care services to the community, it was necessary to develop special logistics which included air and ground transport that stretches an average distance of over 200 km daily. All of the materials and supplies necessary to accomplish the work in the field are carried to the villages each day by the health staff. Coordination of the staff, activities, materials and transport require a great deal of preplanning, not to mention the unexpected crises and emergencies that constantly arise in a war-ravaged country such as Mozambique.

Beyond the constant level of stress that accompanies this type of work, the stamina of the staff in the execution of these interventions has been exceptional. The need for curative health services is a constant in these villages. This need reinforces the importance of preventive health care which is promoted bi-monthly by the health teams in each village. There are, however, numerous other activities, including educational sessions, facilitator visits, supervision of the construction of latrines and the coordination of rehabilitation of local structures.

The components of the project are orientated toward child survival and include vaccinations, control of diarrheal diseases, proper nutrition during breastfeeding and weaning, growth monitoring of the child during and after birth until three years of age, prevention of malaria and environmental sanitation. The training components and health information system are directly focused on these activities. The material support and rehabilitation of physical structures are actions which complement the project

The CSP interventions focus on the particular needs of the most vulnerable in the Tete Province—children under three years and women of childbearing age. These interventions are implemented in bi-monthly rounds by the EPI/GM teams and the MOH personnel in each target village. The components of the project consist of preventive interventions, training, a health information system, material support and rehabilitation.

- **Immunizations:** Vaccination screening and injections are administered bi-monthly by each team in conjunction with the MOH. CSPT organizes and educates the community on the importance of vaccinations, provides logistical support including transportation, and assists the MOH personnel in maintaining the cold chain.

  Approximately 3,000 vaccines are administered each month; a cumulative total of more than 39,000 vaccines have been administered since the inception of the project. In addition to assisting with technical and logistical support, CSPT provides the MOH with vaccination materials including cards, syringes, needles and refrigerators.

  An **EPI cluster survey** of vaccination coverage was conducted by CSPT and the MOH in 30 barrios (village subsections) of our target villages between July 28-August 6, 1992 (Annex 13). These results were compared with results from the baseline KAP survey conducted in January 1991. Marked increases can be

seen in the DTP3/OPV3 coverage, from 65% to 83%, and the measles coverage from 53% to 90%, since WV began interventions in December 1990:

Indicators of Success 10/90-7/92:

Target Population (DIP) Registered as of 7/92 (Annex 3):

Children 0-11 months	2,884
Children 12-23 months	1,964
Children 24-36 months	1,482
Total/Children	**6,330**
WCBA	9,656
TOTAL/TOTAL POPULATION	**15,986 (29%)**

Completed Immunization 4/91-7/92 (Annex 9):

0-11 months	1,585 (78.5%)
12-23 months	700 (60.0%)
WCBA	3,587 (38.0%)

Note: The EPI survey revealed a completed vaccination coverage of 76.4% of the children below one year of age (Annex 13).

	*BCG	DTP1/OPV1	DTP3/OPV3	Measles	TT2	Completed
KAP 1/91	96%	83%/83%	65%/66%	53%	--	----
KAP 8/92	98%	87%/87%	83%/82%	90%	77%	75%

It should be noted that the percentages of the January 1991 KAP survey are calculated based on children who had vaccination cards only; since 3.5% of the children did not have vaccination cards at the time of the survey, the actual baseline percentages are lower than those listed in the table. Anti-tetanus and completed vaccines were not measured as part of the baseline KAP survey.

The KAP survey of BCG counted all vaccines regardless of whether the child had a scar showing a reaction to the vaccine. The 1992 EPI survey counted only children with scars on their arms. The actual percent of children who had received the BCG vaccine was 95%.

- **Nutrition: Thirty to fifty percent (30-50%) of all children evaluated are underweight (< 3 percentile weight/age).** Families of these children are referred to the **WV AgRecovery Program** to increase food availability in their homes. Since June 1991, over 2,400 families with wasted/underweight children from target villages have received cereal and/or vegetable seeds. Due to the severe drought and famine in Mozambique, many of these families did not plant their seeds, but ate them or saved them for the next planting season.

Indicators Towards Benchmarks 10/90-7/92:
Targeted Population (DIP) Registered as of 7/92 (Annex 3):

	Total
Total children weighed during village rounds	13,260
Number/times child detected with severe wasting (<75% W/H)	555 (4.4%)
Number/times child detected underweight (<80% W/A)	6,036
Number gained weight	1,301 (55.1%)
Number lost weight	3,231 (24.5%)

Therapeutic Feeding Centers
Indicators of Success 01/91-07/92:

	Total
Total number of admissions	772
Total number of treated children in NRC	673
Percent of children returning at least once to NRC	15%
Number of cases of Kwashiorkor	117
Number of cases of Marasmus	515
Number of cases M/K	68
Number of WCBA without breast milk	72
Number of people abandoning program before clinical discharge	112
Number of school meals per day	2,015/day

AgRecovery provided training in home gardening to mothers of children admitted to the Changara feeding center during the last quarter of 1991. The CSPT training assistant conducted a number of nutrition sessions with mothers of malnourished children as well as other accompanying family members. These sessions focused on the preparation of enriched porridge, prevention and treatment of diarrhea and the preparation and use of various types of oral rehydration fluids.

- **Oral Rehydration:** Education about the prevention and treatment of diarrhea is the objective of this intervention. The program began by teaching mothers about the preparation of a salt and sugar solution (SSS); this was followed by a cereal-based solution (CB-ORS). After the changes in MOH policy, which abolished SSS and introduced the ORS packages for home treatments, the program began to train the workers on ORS and CB-ORS exclusively.

  Instructions on the use of ORS or CB-ORS was given in group sessions and individual counseling by health technicians and community facilitators. Repeat demonstrations on the preparation of the solution were required.

  The messages of the training program for CDD are:

  1. ~~Wash hands before cooking and eating and after using latrines;~~
  2. Maintain a clean environment/community;
  3. Maintain a clean water supply in the house;
  4. Use latrines correctly/regularly;
  5. Maintain breastfeeding and solid food intake; increase liquid intake;
  6. Know how to prepare and give ORS and CB-ORS;
  7. Use boiled water to prepare ORS; and
  8. If the child does not improve, take him/her to the health center.

Indicators of Success in CDD

A KAP survey was completed in February 1991. A second KAP survey is planned at the end of the project. Indicators of impact of these activities will be determined at that time by comparison of the series analysis. The 1991 KAP survey revealed the following about a mother's treatment of a diarrheic child:

- 58% of the mothers carry their diarrheic children to the health center for treatment;
- 62.2% use ORS packets they receive from the health center;
- 21.5% increase breastfeeding when their child has diarrhea;
- 39.0% maintain breastfeeding when their child has diarrhea;
- 5.0% stopped breastfeeding their diarrheic child;
- 27.0% gave their child more fluids;
- 1.0% maintained the same quantity of fluids;
- 44.0% gave their child less fluids;
- 8.0% stopped giving their child fluids;
- 15.0% gave their child more solid foods;
- 21.0% maintained the same quantity of solid foods; and
- 17.0% stopped feeding their child solid foods.

After the interventions these values should improve. The KAP survey scheduled for 1993 will reveal how much the behaviors of the population have been modified.

- **Malaria Control and Environmental Sanitation:** Health teams are responsible for organizing and implementing two community-wide clean-up campaigns to destroy mosquito breeding sites, as well as distributing mosquito nets to pilot populations. The distribution of mosquito nets is directed by the health committees: a symbolic fee is charged for the nets and collected by the health committee and/or community facilitators.

Indicators of Success

- Distribution plan until the end of the project = 1,500 nets.

- 475 mosquito nets were already distributed in a pilot barrio, Changara Bairro 2, as of August 1992.

  The water and sanitation technician motivates and mobilizes the community to build latrines using local materials and to maintain a clean environment and water supply. When WV entered this area, less that 5% of the target population had access to pit latrines. As of August 1992, over 1,600 latrines have been constructed by the CSPT in 11 villages. Today, between 25-30% of the total target population has access to a ventilated pit latrine.

- **Training:** The training program of CSPT is the foundation of the project. It is divided into various levels:

  1. *Technical Training* for CSP and MOH personnel is conducted year round. Topics include project interventions, related health issues,

training of trainers, community mobilization and education, and managing the health information system.

2. *Training of Health Assistants* corresponds to the former Agentes Polivalent Elementares (APEs) (Basic Health Assistants) within the MOH. These assistants are trained to help the mobile team leaders (EPI/GM) in community health education.

3. *Training of Facilitators* is currently conducted by the EPI/GM team leaders. **Community facilitators are the core of the CS program.** They are non-salaried volunteers who promote health and well being in their communities. They are selected on the basis of criteria outlined by **Health Committees** in each barrio. A health committee ideally serves no more than 400-500 families.

4. *Training of Health Committees* is directed by the leaders of the barrios that were recruited for this project. Their orientation and training equips them to identify health problems in the community, prioritize the problems and mobilize the population to resolve them. This committee develops selection criteria for the community facilitators and supports and promotes good health and well being.

5. *Training of Women* is carried out during the vaccination and growth monitoring rounds and home visits by the community facilitators. In addition to having public education sessions on child survival themes before the initiation of work each day, there are also individual counseling sessions for each mother which review the growth, vaccination and nutrition status of each child. Pre- or postnatal examinations are also given to pregnant and lactating women, respectively. During home visits the facilitator reinforces the knowledge of each mother about the nutritional and immunization status of her children and the need to continue receiving the project interventions.

Indicators of Success in Training

<u>Number of People Trained</u>

# Technical Staff	28
# Assistants	18
5 Health Committees	38
# Facilitators	11
# Mothers	6,330
# WCBA	9,656
104 visits (60-100 people)	6,240-10,400

Technical training	314 hours (23 seminars)
Assistant training	46 hours (6 seminars)
Facilitators training	185 hours (37 seminars x 5 groups)
Health Committee training	30 hours (5 com. x 6 seminars)

The training assistant will help each health technician with their **health committee** and will train 15-20 facilitators himself. **The end result will be a minimal of 7 health committees and 130 community facilitators** by the end of this phase of the project. The facilitators are trained on the predominant CSP interventions including prevention and control of diarrhea, malaria, nutrition, vaccinations, and environmental sanitation, as well as problems that the health committee identifies for its respective village. The facilitator trains community members through home visits and community education sessions. It is hoped that women's groups and schoolchildren will be included in facilitation outreach in the coming year.

The facilitation program in Tete was launched in September 1991. There are currently five health committees at different stages of development and 77 facilitators in three pilot villages. Many of these facilitators have begun visiting homes of target families. An additional 50-60 community facilitators will be trained and functioning in the community by the end of September 1993.

There are three levels of health education focused toward community beneficiaries: mothers of children 0-36 months of age, women of fertile age, and the community as a whole.

More then 10,000 women and innumerable members of the target communities have received some type of primary health care education. Emphasis has been placed on modifying attitudes through increased knowledge of preventive health care practices such as immunizations, nutrition, control of diarrheal diseases, malaria prevention, and the importance of pre- and postnatal care.

At the end of the project, there will have been a total of **30 staff training** sessions made up of at least 14 week-long seminars with staff from CSPT and Zambezia together, plus 18 separate sessions with the CSP health officer, HIS and training manager and/or guest speakers. These training sessions include technical material as well as community mobilization/facilitation techniques. **Some topics include nutrition, immunization, control of diarrhea, environmental sanitation, maternal child care, community and public health work, AIDS and behavioral issues related to growth monitoring, breastfeeding and nutrition.**

2. Project Relevance to Child Survival Problems

2.1 Major Causes of Morbidity and Mortality

Malaria, diarrhea, measles, acute respiratory infection, and malnutrition are still the major causes of child mortality and morbidity in the project service area. Child health continues to be impacted by the effects of war, banditry, and the loss of agricultural productivity caused by the drought.

2.2 Child Survival Interventions and Health Promotion Activities are as follows:

2.2.1 EPI and Growth Monitoring

Vaccination screening and injections are administered bi-monthly by each team in conjunction with the MOH. CSPT organizes and educates the community

on the importance of vaccinations, provides logistical support including transportation, and assists the MOH personnel in maintaining the cold chain.

Growth Monitoring: This intervention is subdivided into growth monitoring, nutritional rehabilitation, pregnant/lactating women's nutrition, and the school feeding/nutrition program.

1. The **growth monitoring** activities are integrated with **vaccination** activities. They include weighing and measuring the height of children, educating mothers on the appropriate weaning practices, and the preparation of enriched porridge and vegetable dishes. An average of 1,500 children participate in this intervention each month. This activity is provided by the five teams led by health technicians and supported by 3 to 5 health assistants, a MOH technician and a motorist. The project is in need of a national supervisor who will oversee the day-to-day logistics and technical aspects of the project from the field. The teams have an annual plan which includes visiting each village bi-monthly (Annex 6).

   Their work routine consists of planning rounds and logistics and implementing health activities in the target village. A round lasts three days depending on the village population size. Before the visit the team leaders will go to the village to inform the leaders of the community about the days, hours and locations of the visit. Several people are contacted during this initial visit, including the administrator, chief of bairros (subdivision of a village), chief of 10 houses, health committees and community facilitators. They are responsible for mobilizing the population for a visit by the health team; however, it is still sometimes necessary to mobilize the community the first day of the visit, depending on the level of cooperation by and organization of the village leadership.

   Teams set their work stations under a tree (central to the community), next to the health post if one exists, or in another location chosen by the community. Tables and chairs are brought in by the team and the community. Depending on the size of the total population and their motivation, a round can have more than 150 people present. All other materials necessary for service delivery are carried to the field by the team. This can include village files with family registers, HIS funds, portable cold chain with vaccines, scales to weigh and boards to measure children, audio-visual materials, syringes, cotton, water, etc.

   The work starts with a health education session planned according to project themes and the number of days to be spent in this village. Following this session, which might last from 15-30 minutes, the target population is called from the family registries. The next station is the weighing and measuring of all registered target-aged children. Following this, the child health cards and HIS forms are completed. The child and WCBA is then vaccinated if necessary, and mothers with children at risk of malnutrition are counseled on good nutrition. After completion of the activities the team leader gives a list of defaulters (absentees) to the chief of 10 houses to be specifically called for the next day. The children with percentile <75% weight/height are transported to the nearest nutritional rehabilitation center.

The time and route one mother follows to get her child vaccinated and weighed (Annex 10) is outlined below:

a. Walk to the location (about 1-2 km).

b. Participate in a health education session where she learns through interesting and entertaining dramas, mimes, puppets shows, etc. about one of the health interventions. She is taught how to practice positive health behaviors during these sessions which last between 15-30 minutes.

c. Wait to be called from the population registry. This process can be rapid if her name is on the top of the list; otherwise, she may wait for 30 minutes to one hour to be called depending on the number of people registered and participating in that round in this village.

d. Weighing of the target-aged child is initiated once the mother has obtained her family register. After the child is weighed she moves to the line that measures the height of her child. These lines generally move quite rapidly.

e. The next station is where the measurements are recorded. Forms regarding the growth status of the child are completed here. The identification of malnourished children is also determined at this station.

f. If the child is at risk, the mother is instructed to go to a particular location for individual counseling on the status of her child and what might be appropriate. If the child is severely wasted, the mother is given information about the feeding centers and told to prepare to take her malnourished child (along with other children) to the closest nutrition center.

g. The final station, vaccinations, is serviced by the MOH. Both mother and child are vaccinated here. After the vaccination, if her child is nutritionally healthy, she is free to walk back home. (If she or her child do not require a vaccine, then she can return home following the recording of weight and height measurements.)

The mothers' education about EPI/GM starts with the importance of weighing her children until they are three years old, vaccinating them on schedule and maintaining the health card. The sectors of the card and some indicators to look for are also explained to her. Several songs which communicate positive health messages have been written in the local dialect for the vaccination and growth monitoring programs.

2. The **nutritional rehabilitation** of wasted children is implemented in one of the three rehabilitation centers located in Boroma, Changara and Matambo Sede. Severely wasted children (< 75% **weight/height**) detected during routine growth monitoring rounds are admitted into the center that is closest to the patient's residence. Despite the intensive coverage efforts

by the CSP EPI/growth monitoring teams, it is estimated that only 15-85% of the registered severely malnourished/wasted children are admitted into the feeding centers. Lack of complete coverage is caused by poor attendance of the severely malnourished children, the distance between the home village and the feeding centers and insecurity and fear due to the constant threat of attacks on government structures. Of those admitted for the first time, **roughly 10% abandon the program before they are clinically discharged.** Upon discharge, children are provided one month's food ration and vitamin-rich seeds.

Therapeutic Feeding Centers

Description

There are three therapeutic feeding centers in Changara Sede, Matambo Bridge and Boroma Sede that belong to the emergency program.

The nutrition team consists of one technical supervisor who makes rounds between the centers each week: one assistant in two of the centers who is responsible for the daily weighing of children, determining the quantities of food and registering the data as well as other daily functions of the center. Each center has two cooks to prepare meals. The quantity of food is pre-weighed to simplify the distribution. The kitchen is well supplied (Annex 7).

Vitamin A is given as a treatment to children in the therapeutic feeding program. The dosage of the Vitamin A is 25,000 IU. Four tablets are the necessary dosage to prevent disease. The health assistants crush the tablets and mix them with milk (LOA) and give them to the children in the centers. Other medications are also administered jointly by the MOH and CSPT.

The mother and other small children that accompany the patient are also given food by the center. Education of the mother about breastfeeding, weaning, nutrition, ORT, preparation of enriched papas, the importance of vaccinations and maternal nutrition is given by the supervisor of the centers during the patient's stay. The health assistants and cooks also assist with health education.

The control of stock is simplified and efficient and the store rooms are in good condition, as are the kitchens and the areas for weighing children. However, there is no place for the mothers and children to wash their hands before and after meals.

The NRC of Boroma and Changara are within the local health centers; this facilitates daily clinical exams of children with medical complications. These centers have covered facilities for the mothers, who accompany the children during their treatment. There is an average of 60-75 in-patients during any given week. The in-patients are malnourished children and adults including pregnant and lactating women; there is a weekly average of 5-7 out-patients.

AgRecovery provided training in home gardening to mothers of children admitted to the Changara feeding center during the last quarter of 1991. The CSPT training assistant conducted a number of nutrition sessions with mothers of malnourished children as well as other accompanying family members. These sessions focused on the preparation of enriched porridge, prevention and treatment of diarrhea, and the preparation and use of various types of oral rehydration fluids.

The program for pregnant women was reinitiated in September 1992. It is integrated with the MCH programs of the local health centers. The pregnant women have a minimal of three prenatal consultations, and they are trained about proper nutrition and supplemental feeding during their pregnancy and postpartum. Newborns are immediately registered and followed up with CSP interventions until the age of three.

The Matambo NRC is near a rudimentary health center, where there is a nurse with basic training who is both overworked and undersupplied. There are often no medications in the clinic. This, undoubtedly, signifies that the clinical treatment of these children is deficient. This center does not have a special area for the mothers to live, so they are forced to return home each night. Abandonment before clinical discharge is common in this center.

The criteria for discharge used by the centers is 85% recuperation of the weight of the child, the presence of breast milk for women diagnosed without milk, and adults, when they feel strong, who may require an average of six weeks for treatment.

Discharged children receive a food supplement from the DPPCCN that is sufficient for one month and for the entire family.

The supervisor of the nutrition team also supervises the feeding program in three primary schools in the Changara district. This program supplies a daily meal to 2,015 schoolchildren. This meal provides 35% of the calories and 50% of the protein required per day.

Malnourished adults, principally pregnant and lactating mothers, are also admitted. During any given week there is an average of 60-75 inpatients and 5-7 outpatients. Changara is the largest center, with an average of 70% of all admittances.

Since September 1991 CSPT has been negotiating with the **DPPCCN and WV commodities** for selective food distribution in area target villages: this would reduce the number of children with severe wasting (4-10%) of the target population, depending on the village and season. A strategy between involved parties has been developed and will hopefully be piloted before the end of the calendar year.

3. The **Maternal Child Health/Nutrition Program** addresses the needs of pregnant and lactating women and was reinitiated in September 1992. Pre- and postnatal examinations are carried out during the EPI/growth monitoring rounds within a given village. Pregnant women receive an average of three prenatal consultations, training in proper nutrition, vaccinations and iron supplements. High-risk pregnancies are referred by the CSP MCH nurses to the nearest health post and given special treatment by the MOH. Postpartum examinations, counseling and newborn registration are also included. Newborns are immediately registered into the child survival program and followed up by the EPI/GM teams with all interventions for the next three years.

4. The **School Feeding Program** provides one meal/day/child. The meal includes 35% of the daily required calories and 50% of the required protein. There are currently 2,015 children participating in this program.

2.2.2 Oral Rehydration Therapy (ORT)

ORT health education, appropriate preparation and utilization of ORS packets and cereal- and home-based fluids is the focus of this intervention. The health teams and/or community facilitator are responsible for educating mothers on how and when to use ORT to combat dehydration caused by diarrhea in children under three years of age.

2.2.3 Malaria Control and Environmental Sanitation

Health teams are responsible for organizing and implementing two community--wide clean-up campaigns to destroy mosquito breeding sites, as well as distributing mosquito nets to pilot populations. The money collected from the community is used to purchase equipment needed by the community for their clean-up campaign. Before the distribution of nets in the pilot areas, intensive training was essential because the population did not clearly understand that mosquitos transmitted malaria. The level of community knowledge was obtained from a malaria survey conducted in August 1992 (Annex 14).

It is hoped that the success of this program will encourage other health committees to adopt this preventive technique and to develop an acute awareness of the need to prevent malaria and maintain clean communities.

In the early stages of the project, the **environmental sanitation technician** invested time and energy in creating an awareness for the need to have latrines and discover problems that could be alleviated as a result of properly utilizing latrines. Research was done with the village leadership on types of soil found in the villages and the best latrine model to be used using local materials. An innovative method for supporting pits in petrified soil was developed by the sanitation technician and community leaders.

3. Assessment of Effectiveness

As demonstrated in the previous sections, there has been considerable progress made in a variety of areas. However, there are a number of constraints which considerably hamper progress in the following project interventions.

3.1 EPI and Growth-Monitoring Interventions

Drought, bandits, and motivation of the population already described above severely hamper the CS activities. Many health workers, on some occasions, went to the residence of a defaulter (absentee) family and took away the card of the child and asked the mother to bring the child the next day for the vaccination; sometimes he/she was successful; other times he/she was not. One health worker changed the site of the visit to the house of the president of the village to attract greater participation by the target population.

The amount of time that mothers spend in the EPI/GM process may be a major discouragement for their participation. Mothers might have to invest two to five hours of their day depending on the number of participants and the efficiency of the staff. This factor requires that health workers become creative and efficient with activities during the EPI/GM process.

Lack of MOH staff in the villages to assist with curative as well as preventive health care is a problem. The delay of the MOH staff in providing vaccines and curative care annoys the population, creating a lack of participation. There is also an irregularity in the provision of tetanus vaccines during some rounds.

Bureaucracy can inhibit the efficiency of the project. Despite the qualifications of the CSP technical staff and the lack of MOH staff to assist in vaccinations, the CSP nurses still are not yet authorized to administer vaccinations. This situation has caused extreme delays in the team's ability to administer vaccinations on schedule and is a real danger to the population.

Logistics of rounds and the HIS. The distribution of the stations (table/chairs) during the EPI/GM interventions can be confusing for a first timer. A mother can waste time lost in the system if she does not understand the flow from one station to the next. The HIS forms that the health workers are required to complete robs time from interaction between mother and workers. The recording of this information should be refocused.

Prevention of malnutrition in children at risk is not an easy task. These children are detected during rounds of the EPI/GM teams, but are being lost in the system. A regular and adequate food distribution to support the families with children at risk does not exist. Consequently, children are returning into the system as severely malnourished as the first time they were detected by the teams.

Conclusions

With the exception of the logistics of the rounds and the time needed for a mother to flow through this process, the work should continue as planned, improving techniques and efficiency over time. The messages appear to be effectively communicated, and the project can probably reach many of its goals in immuniza-

tions, growth monitoring, environmental sanitation, and the modification toward positive health behaviors.

Recommendations and Strategies

1. The population has no resources and, therefore, is dependent on the "machamba" (garden) for survival. Alternative methods of obtaining sustenance during the dry season and in a war should be discussed and built into the program before it is initiated. Income-generating strategies should also be considered. Within the village, there are other possibilities of earning money to purchase food.

   One strategy is to transform the health committees into community development committees for planing cooperatives or other forms of income generation. This can be very useful in the diversification of child survival and the well-being of families. The integration of WV's commodities and agriculture programs to the community development committees can enhance the impact of the entire project.

2. The DPS, DDS and the coordinator of the CSP should plan the monthly rounds together so that there will not be a delay in service to the population. The services rendered by the project should not lose credibility among the beneficiaries. This is the only government service given to the population in these villages.

3. Perhaps an agreement can be reached between the CSPT and the MOH regarding who collects and administers vaccines. One suggestion is for the MOH to designate a worker to this project. The other option is to create a system which gives the CSP technicians access and authority to vaccinate. This will alleviate the logistical pressures on the MOH which is already overextended.

4. The mobile filing system of the MOH should be studied and adapted by the project. A description and design of this system is attached (Annex 8). Another option is to create a system of numeration for the health cards and the family registry. Other suggestions can be found in Annex 8.1.

5. The health information system should be revised to determine what information is most relevant. This information should be collected during each round and shared with the MOH. The compilation and transferral of data should be reserved for later in the day so that this process does not consume too much of the mothers' time. With minimal adjustments this system should become more efficient, replicable and sustainable.

6. For the children at risk, the coordinator of the project and the commodities division of WV have already discussed the development of a joint food distribution system with the DPPCCN. This is similar to the children in the NRC who receive rations upon discharge.

3.2 Therapeutic Feeding Activities

The constraints found in the Matambo and Boroma NRCs continue to cause the abandoning of patients from the center before clinical discharge. The credibility of the EPI/GM worker is crucial. It can increase or decrease motivation of the population to participate in the intervention rounds. EPI/GM teams should investigate whether or not this area is indeed the most vulnerable region. It is believed that a major concentration of difficulties in a geographical area is directly related to the poverty therein.

In Changara, the number of children and accompanying mothers in the center supersede the available facilities. Besides this, the construction of the facility is somewhat closed and not ventilated; consequently, there is a high risk of the transmission of respiratory disease. During the day the in-patients were sitting under the trees, and it is believed that part of the population, despite the new structure, sleeps there also. The administration of the center does not want construction with local materials. Perhaps a review of the acceptable possibilities of the two parts might solve the problem.

Conclusions

The centers appear to function within an established routine. The district director demonstrated extreme interest in the construction of more facilities to be used by the mothers. All parties should discuss these issues and try to arrive at mutually beneficial agreements.

The nutrition team should profit from the opportunity and review general health topics with the in-patient and accompanying family members. When a patient spends more than four to six weeks in the center, gynecological exams, family planning, treatment of chronic disease, etc., can be carried out. The health card of the accompanying children should also be reviewed and a physical given in conjunction with the MOH. The malnourished child can be a symptom of a family that is not well because of lack of food or some other problem: this affords the health worker an opportunity to provide solutions to families in crisis.

Recommendations and Strategies

1. Review the functioning of the Matambo/Boroma feeding centers with the DDS, DPS and WV Commodities. Create ways to make the center more effective.

2. Review the accommodations in the center of Changara. Arrive at an agreement with the DDS as to their utilization and expansion.

3. Review the admissions of malnourished patients and clinic services of the health center. Develop a system that will review the health status of every member of the family accompanying the patient.

4. The District Director of Education expressed interest in expanding the school feeding program that exists in parts of the Changara district. Coordinators of WV commodities should study the possibilities of extending this program to all of the schools in the area. When the dry season is prolonged, the distribution of DPPCCN diminishes in frequency and quantity. Many villages are without

food stock. This program should prevent and diminish the effects of the prolonged malnutrition in the school population. The coordinator should also review the possibility of increasing the percentage of calories and daily protein. Some of these children have only one meal per day.

3.3 ORT Activities

The CSP has motivated the community to participate in training sessions and in the construction of latrines. However, the lack of water (wells), poor quality of water, and distance required to obtain water still plague the district. The majority of the villages are not visited by the water department, and many families regularly consume contaminated water.

The impact of this intervention on the decrease of the mortality rate can only be determined by survey analysis. Causes of death at the health center are not indicative of mortality in the community. Deaths and illnesses that occur in the community are not recorded by any social services entity; therefore, there is no reliable indicator of the incidence or prevalence of disease.

The community sees building latrines as a waste of their energy when they have more urgent needs. Besides, culture values require more than one latrine per family, and in some villages there is no space between houses to build a latrine.

Conclusions

Until now the packets of ORS are distributed by health services, but not the CSP. The DPS and DDS should consider distributing packets at the village level through the CSP teams who would teach the mothers how to correctly use them.

Recommendations and Strategies

1. The mother's education program must emphasize the positive health practices for the community and discuss the pros and cons of health issues.

2. The direct teaching of the mothers in the preparation of solutions should be intensified by the community facilitators. Facilitators well trained in the preparation and appropriate use of ORS should have spare packets to distribute in their work area. They should distribute ORS to mothers with diarrheic children after reviewing with them how to prepare this solution. ORS can be sold and resources put into a revolving fund. Review of the MOH policy and discussion with the DDS and DPS are necessary for this undertaking.

3. The CSP should occasionally plan and support social meetings coordinated by OMM and facilitators, in which mothers prepare enriched papas, share meals with their children, and learn about ORT and other aspects of nutrition.

3.4 Malaria Prevention Activities

The KAP survey and training sessions revealed that the population did not understand that mosquitos are the vectors that transmit malaria. Extensive training has been given to the facilitators and the general population to help them to understand these facts.

These education sessions dramatized the association of mosquito bites and symptoms of malaria, utilized other visual material and included mosquitos of different species to teach the population how to control, prevent and treat malaria.

The health committees are also extensively trained about the transmission and control of malaria and how to mobilize the community to control mosquito breeding sites. They are responsible for planning the distribution of the nets and the collection of a symbolic fee (1,000,00 metacais =.33 cents) which will provide the community with instruments for cleaning-up campaigns (Annex 7.5)*.

Constraints

The DDS, DPS and MOH do not agree on the distribution of mosquito nets and presented concerns about the efficiency and sustainability of this activity. They want to conduct a more in-depth survey that would detect cultural behavior in the use of the nets before the project continues to distribute them district-wide.

Conclusions

The work achieved by the health team and the community facilitators in educating the population is very intense and the presentations witnessed were excellent. After the health education session, the community remained excited about the distribution of mosquito nets and what effect this might have on their family's health. Some members of the population wanted to buy more than one net for their other wives.

A concern of the MOH is the sustainability of these health activities. After members of the community heard that the distribution of nets is limited, problems within the community may be created. The final analysis of the benefits and/or detriments of this distribution can be discovered from the KAP survey at the end of the project. The results from this intervention will be of scientific interest to all parties involved.

Answers to questions such as:

- Did the random distribution of nets decrease the incidence and/or prevalence of malaria?
- What type of control of variables and cultural habits are necessary to know before the initiation of the distribution of nets?
- Did the population modify their health practices with respect to the control of mosquitos?
- Is there new behavior that would prevent malaria? Did the population add a new healthy practice to their lives?
- Did a new income-generating activity sprout from the community to the local markets?

Recommendations and Strategies

1. The project should subsidize the creation of a cooperative for women to make mosquito nets. The marketing has been created by the educational campaign

and a sample distribution. If the local population can not afford to pay the real cost of the nets, the product can still be sold in the city market. This will diversify the income generation of several families, improving the quality of their lives.

2. The development of a strategy within the community that would create a cooperative with lucrative end results that can become a sustainable activity of child survival.

3. The CSP should coordinate with OMM and community facilitators in social exchanges regarding improved nutrition and ORS. Occasionally, mothers and children should be taught how to correctly prepare nutritious meals. The ingredients will be supplied by the project, and the community will supply wood, water and labor.

3.5 Environmental Sanitation Activities

The role of the environmental sanitation team is to educate and motivate the population to construct and maintain ventilated pit latrines. The type of latrines built in Tete are appropriate for the type of soil (dry and petrified). They are made of local materials; however, the iron needed for the construction of flagstones is purchased from Tete. Within each target village 20% of the latrines have cement flagstones. This is an incentive for the first families finishing their latrines. The environmental technician and his assistant make and deliver the flagstones to each site. The type of latrine constructed is a ventilated pit (VIP), and the basic requirement is that it be covered.

Constraints

Not every village recognizes the necessity of constructing latrines. Some village leaders say the time and effort used to construct VIP latrines is not worth it when one looks at the villages' desperate need for food. Communities complain that they are unable to construct latrines when "they are hungry and their children also have empty stomachs." However, some members of various communities expressed interest in learning more about the value of a latrine in the prevention of diseases.

The drought has forced the women to travel very far to collect water for family consumption. Perhaps well drilling should be considered in the next phase of the project in conjunction with another non-government organization.

Conclusions

It is surprising how the health team persuades whole communities to construct something that is not a priority of life and that has little to no cultural value. This signifies that health messages are being transmitted and received and that the community is desirous of improvement.

Recommendations and Strategies

1. One strategy for training people to make flagstones in each village might be to create diversification to assist survival capacity of the population. It is certain that the population is unable to pay 27,000,00 MT for a flagstone. At this

moment, however, when life is more stable and people return to their land, they will have had exposure to the entire process of latrine construction, which could be used as an incentive in the private sector in the future.

2. Review the construction plan for wells with Agua Rural. If possible, develop a plan that supports the construction of wells for the target areas. In addition, this team should continue teaching families about preparing and maintaining a clean water supply.

3.6 Training Activities

The constraints to training include an inability to sustain motivation and the lack of time that many of the community leaders and facilitators have. Several uncontrollable variables also influence the training component.

Drought: The absence of rain and insufficient land to produce food, and the irregularity and quantity of food distributed by the DPPCCN has forced the population to search for food in the wilderness. Hunting or gathering of wild fruits exhaust numerous; hours each day; in addition, the distance to collect water has increased due to the severity of the drought. These survival techniques confront the population on a daily basis creating stress and making it difficult for the health committee to select facilitators who are willing to work voluntarily.

Bandits: Banditry continues to disrupt community organization and stability. During and after an attack, the population (of a given village) disperses in different directions in search of security and food. This continuous movement can often last for many days or even weeks. It takes time for the community to return to its routine. It is common for people to migrate to the neighboring communities and even immigrate to neighboring countries.

Learning Capacity of the Individuals: The constant stress for survival caused by war and drought for prolonged periods contributes to intellectual stagnation witnessed in many people in the population. An interesting observation that has been noted over the last year is that each subject taught to the community facilitators consumes much more time than what was originally estimated during the planning phase. Each CSP training session must be repeated several times so that all the participants understand the lessons correctly. Consequently the training plan has been adjusted to adapt to the facilitators' learning capacity.

Motivation: Preventive health is not, at this moment, a priority in the day-to-day lives of the target population, even though they recognize its benefits and would like to have the services within their communities. During group discussions with community members, they affirmed that the priority now is to secure food, and their options are dependent on DPPCCN distribution, irrigation or income-generating projects. They strongly reiterated the need for curative and/or PHC services for the nontarget population. They vocalized their feelings of abandonment and anger concerning their painful survival.

Distance, Size and Access to the Target Area: The health workers are prohibited from living in the target villages due to security reasons. Access to these areas is along hazardous and dilapidated roads; these unfavorable conditions create delays in arrival each day. The villages cover a very large radius and require transportation between

them. Consequently, the delivery of services is a difficult process. Long hours are spent driving to and from sites.

Conclusions

1. Training of technical staff and the target population are sustainable activities of this project. Learning may be forgotten but never lost. Changed behaviors produced through acquired knowledge, positive attitudes, and appropriate practices take longer and should not be expected in the [illegible] term; however, learning builds self-reliance in people and communities.

2. The excellent quality of the training and supervision within this project has the capacity to develop a core of national technical professionals of superior quality. These professionals will eventually be absorbed into the MOH, Mozambique.

3. At the community and individual levels, the facilitators training program is creating a network of knowledgeable people with modified attitudes and practices who promote better health and well-being within their respective communities. They will be the pivotal factor in health behavior change in the community.

4. Curricula, methodology, audio-visual materials, planning and logistics training, supervision, and data collection/feedback are all well established within the project's plans and activities.

Recommendations and Strategies

1. Review the training component of the project with DDS/DPS to establish uniformity with the national training policies for the health workers in the project:

   - that have been trained through the MOH's basic training and are being trained by the project in skill development. They should become familiar with the qualifications and steps toward career development within the MOH.

   - for the assistants/community facilitators to be integrated into the APE-MOH national program.

2. The district and provincial MOH staff should become more involved with the training and supervision activities of the project. They are missing opportunities to upgrade their knowledge and acquire new skills. Project coordination should allow the development of joint plans and continue to include training for the MOH staff as well.

3. The project should expand its small library of PHC basic books in Portuguese (WHO, UNICEF), including child survival, administration of health services, and other themes the staff suggests. They will use them as references to complement their knowledge after training.

4. The training of the health assistants should include supervision of the community facilitators. Many of these assistants live in the same communities.

They can give constant and superior support to the facilitators after both groups are trained.

5. The local health structures in conjunction with CSPT should support the Changara district by revising a national training plan for APEs (through the Centro de Reciclagem-Training Center). The local structures should develop a strategy to support and accelerate that plan throughout the province.

6. The project manager and leader of the training team should consider initiating a health training center (Centro de Reciclagem) in Tete. Transferring the project's technical assistance to a Centro de Reciclagem is a viable option and should be discussed at the provincial level. The center is in need of a training specialist who will use various methodologies to promote health. A new strategy to include the training needs of project staff should be developed within the Centro de Reciclagem.

4. Assessment of Relevance to Development

The main community barriers to meeting the basic needs of children in the target area are poverty as exemplified by a per capita income of US$50.00 in some areas, continuing drought and subsequent shortage of food, political and social instability, inadequate access to health facilities, distance, size and access to target area, illiteracy, poor infrastructure, and dislocation of large segments of the population.

Community mobilization has been encouraged; an example of increased community self-reliance is the latrine construction program. Training activities among the target communities encourage self-reliance. Project interventions are taken to the communities to increase the ability of families to participate.

The political situation in Mozambique is such that serious long-term development cannot be attempted or faces many obstacles. For example, a newly opened health center may be bombed the next day. The current problems are beyond the current scope of the country to address.

World Vision Mozambique has a national development strategy on the drawing board. This strategy includes attempts to re-establish farmers under the AgRecovery plan, income-generating activities, environmental sanitation, and community mobilization.

5. Assessment of Competence in Carrying Out Project

5.1 Assessment of Design

The project's location was chosen because WVM had been operating in the area since 1984. The project is an extension of the Tete Village Health Project (TVHP) which witnessed remarkable improvement in the health of the target population as a direct result of child survival inputs. In order to respond to the high degree of migration of the population, and the lack of security in the region, the project was extended toward the northern region of the district, which increased the total population from 40,000 to approximately 57,000.

As noted in the executive summary, it was premature to have expected that all of the services would be replicable or sustainable since political and social stability does not exist. Adjustments to the project design have, by necessity, been constant.

5.2 Assessment of Management and Use of Data

Health Information System (HIS)

Description:

The information specialist developed a uniform paper-based health information system for both Tete and Zambezia child survival projects. The HIS was developed according to the needs of the project, as well as the requirements of the donors and the MOH. Data collection is completed at all levels of the project; it is compiled, analyzed and described in monthly reports.

The target population of CSPT was inherited from a previous project, the Tete Village Health Project, located in the southern part of the district of Changara. However, with the high degree of migration of this population and the lack of security in the region, the project was extended toward the northern region of the district, which increased the total population from 40,000 to approximately 57,000.

The demographics of the new target population were determined through the registration of families with the assistance of the village structures. Each chief of 10 houses brought his population to a place determined by the villagers; the teams registered the families in agreement with the formula in Annex 11. A sample of the population was compared with information from the DPPCCN through the administrators; however, they were never equivalent. After the first round in each village (which is generally a large campaign), the family registries are collected and collated; additional family registries are added during subsequent rounds.

Information is collected for each intervention from the field. There are various levels of data collection from field tallies and profiles of summary and analysis sheets. Certain forms are used exclusively in the field, while others are used to collate or analyze the collected data. This data has generated useful information for administrative and scientific interests.

The HIS includes the following forms/summaries (Annex 11):

Family:

- Child's Health Card
- Woman's Health Card

Facilitator-Community:

- Two illustrative forms marked in pink for families with children 0-11 months and green for families with children 1-3 years are used by the CF to monitor health. They are composed of 6 pages each and are used for home visits to collect data on nutrition, latrines, diarrhea, use of ORS, immunization and malaria. Beside each column there is a design which corresponds to the identity of a specific home.

Illustrative CF Training Summary:

- One kit of illustrative designs for the facilitator to use in demonstrations to educate the mother during home visits.

Archive-WV Office:

- Family Register
- Photocopy of Child's Health Card
- Photocopy of Woman's Health Card

Technician/Assistant-Village Visit:

- Inhabitants' Register
- Illustrative Family Register
- Illustrative Nutrition Profile Weight/Age
- Illustrative Register for Immunization Defaulters
- Nutritional Survey-Growth Monitoring
- Nominal list of children in need of immunization—to be given to the chief of ten houses

Technician-Nutritional Rehabilitation Center:

- Admission and periodic control form
- Malnutrition rates and compilation
- Feeding schedule for malnourished children
- Feeding schedule for malnourished adults
- Feeding schedule for family members
- Quantity of food for special feeding program
- Transference requisition
- Report for special feeding program

Technician-DPPCCN:

- List of discharged patients for DPPCCN supplement
- DPPCCN district delegation, Changara
- Daily registration of malnourished children for DPPCCN

Technician-MCH:

- Prenatal form

Technician-Environmental Sanitation:

- Water and sanitation form
- Latrine Registry

Technician-Summaries:

- Summary of home visits and training
- List of functioning health committees
- Inhabitants' Register

- Monthly report on immunizations
- Nutrition profile by age, sex, height and location
- Demonstration of growth monitoring progress
- Monthly summary of MCH interventions
- Monthly/Quarterly reports
- Quarterly Journal for interventions

Indicators of Success

Once this data is collected it is complied, analyzed and presented in report form to WVI, WVRD, USAID, MOH and local project managers. Graphics have been used for quick analysis of the project's progress (Annex 12).

Constraints

The project coordinators do not know the actual population base because a census was not conducted during the initial stages of the project. The population continues to migrate as a result of the war and drought. Consequently, the denominators used to calculate rates may vary. The numbers used for calculations are from the population that is currently registered. As a result, analysis of impact can be skewed to appear that benchmarks are not being met, but are lower than expected; this is not necessarily the case.

The forms are still being tested in the field to determine which ones are most suitable and simple.

Conclusions

After an additional field test, a review of the forms should be completed which would refine the system with objectives that are simple, complete and relevant to the sustainability of the project. For these systems to become sustainable within the health information system unit of the MOH, they should closely simulate existing HIS. Revising the forms should also keep in mind the time and personnel available to perform these tasks.

Recommendations and Strategies

1. A population census should be conducted to increase basic health information, education, economic activities and available resources. The community should be involved in this activity from the beginning to reinforce development, participation and ownership of the project. The community should participate in the gathering and analysis of the data and develop an implementation plan for the project's activities in conjunction with the leaders. If this is carried out the community will feel responsible for the implementation of the project complemented by the technical resources and material support of WV.

2. Review the forms and make the necessary adjustments. Simplify and refine them so that they can be managed easily by the MOH.

3. Monitor quantitative data for measurement of volume of services provided by the project to the target population. This data can be very useful to managers

for analyzing the quality and quantity of services as well as supporting the decision-making processes.

4. Establish a simple linear graphic analysis of data for all levels from the community to the donor. Training the community facilitators and the health committee should be oriented to interpret the most pressing needs and decision making at the community level. Perhaps simple linear graphs of progress (i.e., growth monitoring cards) can be considered.

5.3 Assessment of Community Education and Social Promotion

5.3.1 Community Health Education Activities

There are three levels of health education focused toward community beneficiaries: mothers of children 0-36 months of age, women of fertile age, and the community as a whole.

More then 10,000 women and innumerable members of the target communities have received some type of primary health care education. Emphasis has been placed on modifying attitudes through increased knowledge of preventive health care practices such as immunizations, nutrition, control of diarrheal diseases, malaria prevention, and the importance of pre- and postnatal care.

Preventive health care knowledge and practice is reinforced among the target population through presentations (dramas, mimes, etc.) given by the health teams who conduct bi-monthly visits to each village of the target area. During the absence of the teams, the community facilitators, members selected by the health committee, reinforce positive health messages and practices to the villagers through home visits.

Community meetings have been organized by the health committees to discuss population and/or the project's needs. These sessions are profitable for introducing health education themes or discussing the project with the community-at-large. Consequently, innumerable members of the community have been exposed to messages that promote positive health behavior and well-being.

The methodologies utilized in these presentations include dramas, mime, puppets, group discussions, games, inductive problem solving, visual aids (which are locally developed and culturally sensitive) and songs in the local dialect. Many health education presentations and discussions last between 20 to 30 minutes depending on the village and the topic selected.

The health presentations/messages are inclusive rather than exclusive. They do not prohibit the community from selecting any health problem that it considers important for discussion and examination. The presentations include topics such as:

- Preventable diseases and the importance of the vaccines;
- Importance of growth monitoring until three years of age;

- Importance of breastfeeding and proper weaning practices, nutrition during infancy, pregnancy, and preparation of enriched porridge;
- Importance of the pre- and postnatal care;
- Control of diarrheal diseases through prevention of dehydration using cereal-based oral rehydration solution and environmental sanitation;
- Construction of latrines and maintenance of clean water supply;
- Prevention of malaria;
- Importance of a clean community; and
- Alcoholism.

5.3.2 Testing of Material and Assessment of Learning

The following printed materials are field-tested to varying degrees:

1. Teaching materials for all aspects of basic health care (diarrhea, breast-feeding/weaning, nutrition, malaria, AIDS, vaccination) are mostly pictures with few, if any, words. Many are adaptations from MOH posters and books and were pretested/revised by the MOH before they were printed.

   Other pretesting of printed materials has taken place during Vivien Wilson's training methodology seminars: nurses design and put together teaching materials during the seminar and bring them to neighboring villages to test villagers' reactions to them.

   Finally, ongoing testing occurs during use in the field, and materials are adapted according to the community's response to them. One example is the use of a large graphic picture of the anopheles mosquito for malaria teaching. Communities often could not conceptualize the thought that the poster was depicting the tiny mosquitoes that bite at night. As a result, nurses are now either eliminating the poster or bringing jars with live mosquitoes to the field to clarify their messages.

2. Community Facilitator (CF) forms have illustrations of health care concepts to be evaluated and areas beneath each illustration to mark the number of mothers who are correctly practicing the concept. These undergo ongoing field testing as the CF's home visiting program is evaluated on a monthly basis. Numerous form updates have occurred as a result of home visiting evaluations.

The community's understanding of the materials is evaluated after each teaching session by inductive questions which are posed by the nurses. Most materials are well understood; those that are not are adapted according to suggestions from the community or from the nurses who use them in the community.

No formal learning assessment has been conducted to date. As mentioned above, communities must be able to answer inductive questions at the end of

presentations—their answers reflect some level of understanding. In addition, the teaching session given at the previous vaccination round is reviewed during the next round with inductive questions before proceeding to the next topic.

A formal evaluation of community learning will take place during the end-of-project KAP survey in June/July 1993; community knowledge of the above-mentioned health concepts will be evaluated.

5.3.3 Community Response to Health Education Activities

In the majority of these villages, the CSP is the only communication this population has with the outside world. If government services or other NGOs are working in the area, their presence is not as regular as the CSPT staff. The awareness and the importance of prevention provided to the villages during rounds is the central thrust of the project. The population as a whole is developing new attitudes and practices about their own health. During the intervention rounds, there are villagers present of every age, sex and position, even though many of them are not directly benefiting from these inputs. This participation, although indirect, has a proliferating effect to the population's KAP toward preventive health which will improve the health of the entire community over the long run.

Group discussions with the members of the target villages visited during the evaluation generated opinions and suggestions that are an integral part of this report. In all the meetings, the population vocalized their frustration at not having curative services as efficient as the preventive services. They also wanted preventive services for the non-target population (men and teens) of the impact area of the project.

The health education sessions given prior to the vaccination and growth monitoring seemed to be enjoyable for all members of the community. The dramas, puppets, songs, etc., may be the only moments of joy and escape from the frustrations and disappointments that fill their lives. The creativity used by the health workers during these presentations entertained the population; many of them responded regarding the health message communicated.

A man playing a mother's role and/or vice-versa seemed to be the most entertaining part of the presentation. The hidden messages, for example, that men should worry about family health and nutrition and that women should have the opportunity to express their expectations from men are positive aspects of the health education program. During the presentations, the population was initially inhibited about participating. When the health worker began to use gestures, moved a lot or spoke loudly, more people actively participated.

5.4 Assessment of Human Resources for Child Survival

5.4.1 Team Composition

The CSP staff consists of 7 health technicians, 18 health assistants, 4 motorists, 9 cooks, 2 administrative assistants, 1 statistics assistant, the CSP manager/HIS Officer, and the WVM health and nutrition manager.

The technical personnel of CSPT consists of six types of health teams (Annex 4):

1. Vaccination and Growth Monitoring Team: There are three EPI/growth monitoring teams. Each team services a defined number of villages, with populations ranging from 550 to 11,500 inhabitants. These teams are responsible for the mobilization of the community for immunization, growth monitoring and health education about vaccinations, nutrition, and control/prevention of diarrhea and malaria. A national health technician leads each team; he/she is responsible for the implementation of all CSP interventions and health education within his/her respective communities (Annex 5).

2. Environmental Sanitation Team: Mobilizes and educates communities about the need to build latrines and the construction and utilization of latrine covers. This team promotes safe drinking water techniques, well digging and the prevention and control of diarrheal disease.

3. Nutrition Team: Responsible for the daily operation and overall supervision of the therapeutic feeding centers.

4. Maternal Child Health Team: Provides pre- and postnatal care to pregnant and lactating women. This team also takes advantage of "missed vaccination" opportunities in pregnant women, newborns and older children who were missed during the EPI/GM rounds.

5. Training Team: Assists all teams in the formation of health latrines, training of community facilitators, and technical training on various aspects of the project.

6. Administrative Team: Responsible for the administration, logistics and daily operation of the project. Maintains a system of support for each of the technical teams. Also responsible for the analysis of data, preparation of reports and the distribution of information regarding all of the interventions of CSPT.

Each team is responsible for the administration, data collection and reporting on the CSP interventions that correspond to their job responsibilities. The Health Officer, assisted by the Administrator is responsible for the overall supervision, administration, logistical support, analysis and final drafts of reports on all project interventions.

In addition, technical assistance for the project is provided by five in-country expatriates contracted by WV:

- Doctor/MPH regional coordinator for Southern Africa health programs. This individual provides periodic assistance to the coordinators of the health project in both sites (based in Maputo).

- One doctor/national coordinator who supervises health and nutrition programs in WV Mozambique (based in Quelimane).

- One BS/MPH project coordinator/HIS specialist.

- One nurse/health educator specializing in training methodologies and primary health care (based in Quelimane).

- One administrator of finances—prepares and monitors the budget and supplies needs for the project (based in Maputo).

Administrative and support activities are provided by:

- 1 coordinator of national relations
- 1 logistics administrator
- 1 assistant administrator
- 1 statistics assistant
- 4 motorists
- 3 guards
- 15 cooks

A total of 53 salaried workers implement and monitor the project.

There are five health committees with 38 participants and 77 community facilitators who work on a volunteer basis monitoring the health interventions within their communities.

Constraints

1. The security situation in these villages is precarious. Travel along the Tete-Zimbabwe corridor is only permitted by military convoy. The danger of rebel attacks is real. Over 12 attacks were reported during the last quarter of 1991. These attacks make it difficult to travel from one location to another and sometimes cause delays in certain populations receiving child survival interventions (see Annex 6).

2. Implementing the necessary logistics is extremely difficult. Lack of security prohibits staff from living within or near target villages. The nearest village is roughly 30 km from Tete, and the furthest, Changara Sede, is over 90 km from the city. Due to poor road conditions, vehicles must travel slowly to avoid breaking springs or damaging other parts of the vehicles. CSP staff spend two to three hours each day traveling to and from target villages.

5.4.2 Human Resource Development

Training

The training unit of the project was developed by a health education/training specialist. However the health officer, H.I.S. officer and temporary consultants have been involved in different training sessions for the health workers. The unit has developed and/or adapted curricula, training methodologies and audio-visual materials appropriate for the population. These tools are designed with the health worker and project activities in mind. A sequence of training includes review of interventions, health information system (data collection), community mobilization and communication with/feedback from the community.

Training sessions are conducted on a regular basis according to the project's needs (Annex 7.2, 7.3). Uniformity of learning and follow-up supervision are the strongest characteristics of this unit. Messages are communicated in the same manner at all levels and in all sessions; the collection of data is also uniform and an essential characteristic for the maintenance of the quality interventions.

The health workers of the project receive a certificate for successfully completing training sessions (Annex 7.1).

At the time of this evaluation, a Mozambican counterpart is assuming the responsibility of training the facilitators, health latrine workers, and technical staff under the supervision of the senior trainer. In the near future he will assume the management of the training unit. His job description, along with other technical staff, is included in Annex 7.

The project has four levels of training: technical staff, assistants, health committees and community facilitators.

Technical Training: Includes training for the professionals hired by the project with a basic health background (nurses, nutritionists, preventive and/or curative health technicians, etc.). The responsibilities of these professionals are to implement project interventions in the field. The MOH personnel have also participated in these sessions and assist with field interventions. The responsibilities of these professionals are:

- Leadership of the preventive team;
- Deliver PHC-CS services to the population;
- Training and supervision of assistants/community;
- Mobilization of the communities to participate in interventions; and
- Field data collection/maintenance.

Twenty-three seminars were conducted during the period October 1990 to July 1992 for these health professionals. The MOH staff has participated in these seminars and some field work training with WV staff at this level. For 12 months the technical staff also received in-services training about project interventions (Annexes 7.1 and 7.6).

Assistants: This category of salaried employees is also pivotal to the project. They are an equivalent of the community health worker (APE) of the MOH, Mozambique. At the beginning of the project the coordinators had intentions of retraining the existing APEs; however, these workers were not found in the project areas. Each health team has one to four assistants who carry out a number of different tasks. The technical staff has gradually trained these assistants in accordance with the covering of the target area. Their responsibility is to complement the execution of the activities of the project carried out by the team leaders. During the evaluation, there were 17 assistants working with the teams. Their work consists of community mobilization for the CS interventions, weighing and measuring of children, data collection, participation in the health education sessions, making flagstones (latrine covers) and other health education materials. A training unit has given six formal

training sessions on project interventions, but there are continuous in-service training sessions and daily supervision (Annex 7.1).

Health Committee: The health committee consists of village members such as the village secretary, health worker, religious representative, rural water representative, teacher, agricultural extentionist, members of OMM and OJM and community facilitators. Each health technician will be developing at least one health committee by the end of the project life. Each committee ideally serves 400 to 500 families. The training of a committee includes sessions on its philosophy, responsibilities, the development of relationships with other structures located in the area, capacity to identify needs, ability to prioritize and solve community health problems, willingness to discover and implement solutions for these problems and to select facilitators to serve the areas. There are currently five health committees with 38 members functioning in the target area.

Community Facilitators (CF): Community facilitators are the core of the program. They are non-salaried volunteers with the primary objective of promoting good health habits and the well-being of their communities. Their task is to conduct home visits, educating the family members or the community--at-large.

The CF are selected by criteria developed by the health committee in each bairro. Training is provided by the technical staff and assistants in conjunction with the training unit. Sessions consist of training on the CSP interventions and other health themes that the health committee identifies as a priority for the community.

Seventy-seven community facilitators have been trained and are currently under supervision. They visit an average of 2,125 families each month (25% of the target families). There is an average of one facilitator for every 20-28 families. By July 1992, 5,065 mothers were trained in nutrition and oral rehydration treatment by the community facilitators (Annex 7.4). The project has a plan of training 130 community facilitators by September 1993.

Refresher Training

Needs Assessment: CSP nursing staff receive in-service training approximately every two weeks. Sessions are given by the Zambezia HO, HIS officer, therapeutic feeding center consultant, and training supervisor. During most in-services, staff are pre-tested on their technical knowledge of the subject to be taught that day or on material to be presented in the future. Based on their scores, the need for training in a particular area is assessed. In some areas (such as AIDS and Vitamin A), staff demonstrated very little knowledge, and these topics were covered in formal seminars.

Community Health Workers (CHWs) assist nursing staff during bi-monthly vaccination/growth-monitoring rounds by weighing 0-3 year olds, measuring their heights, plotting growth curves, and giving one-on-one teaching/counseling to mothers about vaccinations received and the growth curves measured on their children. Field supervision/evaluation of the CHWs is a type of "needs assessment" which has led to several CHW refresher courses in the above areas.

Appropriateness of Materials: These were evaluated as very appropriate. Standardized materials have been developed for all levels of training, from nurses to CHWs to CFs. Pre-testing, visual aids, group discussion/participation, inductive questioning, and post-testing are all used in teaching sessions.

5.5 Assessment of Supplies and Materials for Local Staff

The training unit has developed and adapted curricula for the health workers. Educational materials are provided for each worker. The majority of these are in pictorial form. Visual aids, puppets and games are available for workers.

The above materials are widely used in community preventive health care presentations, home visits and community meetings. They are locally developed and culturally sensitive, and thus they are acceptable to the community. The widespread use of pictorial materials accommodates those participants who are illiterate.

5.6 Assessment of Quality

Mozambican technicians (nurses) are employed in the project as monitors, trainers, and community mobilizers. The high-quality program of in-service training and supervision focuses on improving and increasing the skill and knowledge level of local technical staff.

Support and counsel is offered to mothers in an appropriate manner. For many mothers, the CSP activities are their only contact with the outside world, and they are encouraged to voice their opinions and concerns. The health education sessions are designed to entertain as well as inform and are an encouragement to members of the community.

5.7 Assessment of Supervision and Monitoring

Type of Supervision: Supervision is primarily field based. Monthly visits are made by the HO and HIS officer to evaluate technical aspects of the work, as well as accuracy of filling out forms. Visits by the assistant training supervisor to evaluate training sessions occur every two to four weeks, and an "evaluation form" is filled out on training sessions during visits. Additional supervision is carried out by a review of weekly and monthly statistics to evaluate the number of vaccinations, children weighed, etc.

Adequacy of Supervision: Supervision is adequate in the area of training. HIS supervision was adequate as far as the CHWs filling out forms in the field was concerned; however, it was found that the nurses were unable to accurately fill out summary statistics forms. Based on this, a full-time statistician was hired to review and fill out summary forms for monthly reports and other statistics needs. This was done prior to the MTE. At the time of the MTE, no errors were found in the filling out of any of the forms. Technical supervision was sub-optimal, mostly because of understaffing which required the HIS officer to carry out the additional function of HO. To rectify this, the Zambezia HO has been making regular visits to Tete to improve field supervision. This was started prior to the MTE and will continue until the full-time Tete HO is in place.

Health Worker Viewpoint: HIS supervision has been primarily counseling/supervision. Community training supervision is more of a performance evaluation in the field, with counseling/supervision taking place afterwards in the office. The technical supervision of the Zambezia HO is regarded by health workers as on-the-job education.

Supervision/Monitoring Needs for the Remainder of the Project: Primary needs are for (1) a full-time health officer to provide more regular technical supervision—one has been recruited and is currently finishing her language training before coming to Tete; (2) the development of a national health supervisor from within the team—this has already been done in Zambezia with great success (candidates for health supervisor are currently being screened); (3) the HIS office is currently working on a scheme to provide regular statistical feedback to nursing staff to promote a self-evaluation of monthly accomplishments.

5.8 Assessment of Use of Central Funding

The project has received administrative and technical support from WVRD headquarters in California. Since the project started, the following have visited the project to provide external support to WV Mozambique:

> Project proposal and writing of the Detailed Implementation Plan (DIP) received technical assistance from WVRD. Drs. Milton Amayun and Virginia Canlas visited Tete and assisted in writing the aforementioned documents.

In addition to the above personal visits, the following tasks have been the responsibility of WVRD headquarters in California:

- Preparation and submission of quarterly narrative reports to USAID Washington.
- Preparation and submission of contracts, financial reports, and pipeline analyses.
- Regular mailings of current public journal articles and reviews on child survival issues to assist the project's technical quality.
- Provision of materials on Vitamin A surveys which were used in the CSP Vitamin A Conference in November 1991.
- Clarification of financial, legal, and technical issues related to project implementation.

A total of $56,350 (10% of A.I.D. funding) was budgeted as headquarters costs for the above critical functions for three years. This amount has enabled the level of headquarters administrative and technical backstopping of the project to be maintained.

The allocation of A.I.D. funds to WVRD headquarters enabled WVRD to send more of what it raises privately to the project.

5.9 Assessment of PVO Use of Technical Support

5.9.1 Visits from Technical Professionals

The baseline KAP survey (January-February 1991) received technical inputs from Dr. Dennis Holdenried from Johns Hopkins University. Dr. Holdenried visited the project and trained project staff in KAP survey implementation/ analysis.

The AIDS conference received technical input from Dr. Samuel Ani, a Nigerian physician who works at the Quelimane Provincial Hospital.

WHO materials, MAP material and literature from an Africa-wide AIDS conference conducted by TALC in Zimbabwe were also utilized.

5.9.2 Out-of-Country Training Conferences

Alberto Sitoi, Liaison Officer, went to Harare, Zimbabwe, for six weeks of language training (English) between January-March 1992.

Jaime Jose Bitone, health administrator, attended a week-long management conference sponsored by MAP, Nairobi, Kenya, in April 1992.

5.9.3 In-Country Training Conferences (also see Section II A)

Francisco Milice, CSP environmental sanitation technician, attended a nation-wide water and sanitation conference in Maputo June 10-14, 1992.

Jana Webb, CSPT Health/HIS Officer, and Maria Jose, CSP maternal-child health (MCH) nurse, attended two province-wide conferences on vaccination and growth monitoring in July 1992.

Jana Webb, CSPT Health/HIS Officer, and Jaime Jose, CSPT Health Administrator, attended a two-week statistics conference for the province of Tete in June 1992.

5.9.4 Needs and Constraints

Needs over the next six months:

1. Technical support is needed to set up a computerized database for the vast quantities of statistical data being gathered on the CSP populations each day.

2. If income generation is to be included during the life of this project, some technical assistance will be necessary.

3. Ongoing technical literature updates will continue to prove useful, as they have in the past.

4. It is possible that some technical support or at least written guidelines will be needed for the upcoming KAP survey.

Constraints

1. The constraint to technical support for setting up a computerized database has been (1) lack of budget; (2) inability to locate in-country (hence, low budget) assistance. USAID has suggested that a proposal be written to fund a consultant to computerize the data. If time allows, one will be written.

2. Income-generation technical assistance will be limited by the fact that Tete CSP has no staff to receive the training or implement the project. One Australian nurse has recently been recruited who may qualify to receive the training necessary to begin implementation of this project. She is currently completing language training in Portugal.

5.10 Assessment of Counterpart Relationships

Relations, Communications, and Coordination

- **Ministry of Health**

On the national level the project communicates with the International Cooperation Department of the MOH in Maputo. However, there is not a technical section within the MOH that corresponds to the provincial and district levels through which the project can coordinate its activities. On the provincial and district level the staff relates to the MOH in respect to the planning and implementing activities, monthly reporting on the interventions, community mobilization and participation in staff training and development seminars. The project also supports the local MOH in emergencies, with materials, transport, and rehabilitation of structures as requested. Representatives of the following sectors maintain regular contact with the personnel of the project:

- Provincial Director of Health
- Provincial Medical Chief
- Provincial Director of Community Health
- Provincial Director of Nutrition
- Provincial Center for Statistics and Epidemiology - Director of Health, City of Tete
- Coordinator of EPI, City of Tete
- Head nurses of the health centers, City of Tete
- District Director of Health, Changara
- District Coordinator of EPI, Changara
- District Coordinator of MCH, Changara
- District Coordinator of Curative Medicine

Beyond having good relations with the MOH, their actual knowledge of the project is poor. One argument for this lack of knowledge might be the lack of time to learn about the project and a general ignorance on the part of the government about projects implemented by international organizations. During the negotiations of the project in the district, the administration must not have clearly understood its role in the project. There is a lack of knowledge between the project and the MOH regarding how they should achieve this work.

Support/Rehabilitation

The following materials were contributed by WV to the Ministry of Health in Tete:

1. All needles and syringes for vaccinations in CSP target villages of Changara as well as other parts of the district.

2. Vaccination cards of 0-3 year olds and women of childbearing age for the MOH for CSP target village of the Changara distinct.

3. Transportation for MOH nurse to vaccinate in CSP target villages.

4. Fuel for MOH vehicles during fuel shortages in Tete City.

5. Renovation of Changara Health Center.

6. Transport for the MOH during the cholera epidemic (August 1992)

7. Per diem for MOH staff participating in joint WV/MOH surveys.

- **Agua Rural (Ministry of Water/Sanitation)** has been a partner in the water/sanitation work of the Child Survival project. Latrine construction in CSP target villages has been divided between Agua Rural and the CSP water/sanitation technician. There is no exchange of money at this level, though transport to villages has occasionally been provided. There has been an exchange of ideas regarding latrine models/materials which took place during a national water/sanitation conference; based on this conference, Agua Rural is now expanding its guidelines for latrine construction to include a greater variety of acceptable materials and models. Because the water/sanitation work supplies essentially no materials or paid labor, Agua Rural should be able to absorb the CSP activities of water/sanitation once their infrastructure improves.

- **DPCCN (Department of Calamities)** distributes food to many of the CSP target villages. Though no exchange of money has occurred between the DPCCN and CSP, many exchanges of ideas have. The outcome of these exchanges has been (1) the DPCCN provides a one-month ration of food to families of severely malnourished children who graduate from the therapeutic feeding centers (after being referred by CSP staff during growth-monitoring rounds); and (2) a tentative plan for the CSP to assist with targeted distributions of food by identifying families with underweight or severely malnourished children for the DPCCN. As the work of the DPCCN receives no material/financial support from the CSP, its operations can continue once the CSP leaves as long as the MOH nurses are able to continue running therapeutic feeding centers and submitting lists of underweight/malnourished children each month.

5.11 Assessment of Referral Relationships

The main referral relationship exists with the MOH health posts. CSP target villages located within two kilometers of a health post are referred to the post for vaccination. Children identified during growth-monitoring/vaccination rounds as needing curative health care are also referred to health posts. All CSP therapeutic feeding centers are

run in proximity to a health post, and it is the MOH health post that provides clinical consultations and, occasionally, medicine to severely malnourished children.

These referral relationships are ongoing, as they take place during each day of the CSP and therapeutic feeding activities. The referral system is reinforced through CSP community teaching sessions that precede bi-monthly rounds to villages; the teachings reinforce visits to health posts for vaccinations and diarrhea/malaria problems. Communication between the CSP and referral sites is essentially adequate, although there are some areas of disagreement (e.g., WV supplies medicines for medical treatment of severely malnourished children; the MOH health posts prefer to control the medicines, but experience has shown that medicines disappear at an extremely rapid rate when turned over to the health posts, leaving few or none to treat the severely malnourished children; the current compromise is that the health post official supplies the diagnosis, and WV supplies the medicines directly to the patient). Occasionally there are irregularities of health post staffing (e.g., no staff at all on some days) which may also lead to difficulties. There is no exchange of money between the CSP and the MOH; however, the CSP supplies transport, needles, syringes, cotton, and some vaccination/growth-monitoring cards for MCH work in CSP target villages. It is likely that with a bit more restructuring and accountability for materials, the MOH will be able to absorb these aspects of the CSP contribution.

5.12 Assessment of PVO/NGO Networking

MSF: The CSP has worked together with MSF Belgium to evaluate the advantages/disadvantages of the inpatient milk/oil/sugar mixture versus the outpatient peanut porridge mixture for severely malnourished children. MSF has also assisted the CSP with staff medicines, and the two organizations worked together to help the MOH combat a cholera epidemic this year.

DANIDA is running an orphanage in collaboration with the government of Mozambique. The CSP assisted the orphanage by supplying formula to orphan infants less than six months of age over a period of four months. The HIS officer assisted DANIDA with a proposal for one year's funding which WV Australia accepted.

The ***Lutheran World Federation*** donated clothes to the therapeutic feeding centers of WV Tete.

The ***CSP*** and ***WV Commodities*** assist the local ***Catholic NGO Caratas*** with biscuits and dried milk for street children.

Networking at a national level has been done with Save the Children and UNICEF. WV was able to keep UNICEF accurately informed as to the stock of UNICEF vaccines distributed in the provinces of Tete and Zambezia.

Perhaps the only lesson learned through networking was at a National Convention for NGO/MOH financial accountability; there both UNICEF and Save the Children cited numerous examples of donations given directly to the MOH with very little documentation of how the money was spent, thus indicating that the MOH financial system is not yet adequately developed to directly receive large amounts of donated money.

5.13 Assessment of Budget Management

Financial monitoring has been carried out at the project level, field office level, and WVRD. The project has responsibly managed the budget, particularly in light of the restraints and disruptions which it has faced. Any overspending in programming has been more than met by World Vision contributions.

The project has enough remaining funds to carry out the third-year objectives. A.I.D. funding for year three is $209,027. World Vision will contribute an additional $54,000.

6. SUSTAINABILITY

The predetermined goals in the initial project design were extremely ambitious if one considers the unpredictable logistics, precarious security, lack of motivation and constant migration of this population. However, the project staff are conscientious, dedicated, motivated and desirous of achieving maximum results. A revision of the project goals to reflect the real situation in these communities should be carried out by the entire health staff.

Basically, the project as it stands is not very sustainable. Sustainability requires at the very least a functioning MOH infrastructure so that staffing, vaccination/patient records, health post maintenance and organization of its resources can be attained. None of this is the case.

Some aspects of the project could be considered sustainable:

Village Health Committees formed by the CSP nurses in coordination with the training supervisors are nonpaid groups of village leaders who have been taught to work together to identify village health problems, identify specific actions that can be taken to combat them, and implement actions decided upon. Several villages have experienced the benefit of health committees, and it is quite likely that these committees will continue once WV leaves.

Volunteer community facilitators have grasped the basic health concepts taught to them and have established a schedule of regular home visits to teach mothers one-on-one about practices and make sure that mothers carry them out. They have achieved a status in their community that could continue to motivate them if the MOH would continue to work with them.

Training Technical, managerial and training of trainers sessions with ongoing supervision has influenced the five CSP nurses and 25 community health workers. The nurses could easily assume leadership/management roles within the MOH. The MOH is also currently studying the CHW curriculum designed by the CSP staff to see at what level they could be integrated into the MOH.

Currently, incentives being used are (1) increased authority to those placed in supervision (e.g., health supervisors are given signing authority for small amounts of money); (2) English lessons or an out-of-country conference to those supervisors who have performed well; (3) various token items have been given to CFs during their seminars; e.g., a group photo was taken and distributed, capulanas (local skirts) with health messages were distributed; (4) meals are provided during seminars; and

(5) ongoing training and status within the community serves as an incentive at every level of worker.

Interviews during the MTE showed clearly that the community valued the regularity and consistency of CSP inputs to their villages. Unfortunately, lack of food and curative health care services were points raised by the community that prevented full participation with CSP health teachings and other activities.

The MOH participates with the project daily and sees the project as effective; however, it is by no means able to absorb it or take over operations without ongoing assistance with recurrent costs and improved infrastructure. For the mobile vaccination/growth-monitoring teamwork to be absorbed, the MOH needs to increase the number of local health posts as well as staffing and supplies to the posts.

7. Recurrent Costs and Cost-Recovery Mechanisms

A summary of recurrent costs is as follows:

Expatriate salaries: $45,000/year. (These would no longer be recurrent if the MOH assumes complete management, although so far the MOH is not interested in managing a CSP without salary supplementation or other incentives.)

National staff salaries: $67,000/year
Vehicle maintenance: $10,000/year
Vaccination/growth-monitoring supplies: $8,000/year
Ongoing training/seminars: $8,000/year

The community, with a per capita income of well under $50/year, is unable to recover any part of these costs at present. Their primary contribution is the volunteer labor of CFs and health committees. The government cannot pay its own under-staffed/over-worked employees a reasonable salary and is also not prepared to absorb recurrent costs. Recurrent cost reduction of vaccination/growth monitoring to these remote villages can only be considered when the country's civil war ends; when health posts can be constructed and maintained without regular burning and looting from bandits; when vaccine refrigerators can be put in place without having their batteries or kerosene stolen from them; when security allows nurses to stay in remote health posts for more than five hours a day; and when health staff make enough money to feel motivated to come to work daily and not demand unreasonable payments from the community. In short, Mozambique is not yet in any condition to sustain an effective preventative health program. While some aspects of the program can be sustained (see Number 6 above), the vast majority of the work requires ongoing input from external sources.

The cost per beneficiary has been high so far: about $10-15/target beneficiary/year (about $4-6/target and nontarget combined/year). Much of this is due to transport costs (flights to Changara and purchase of vehicles, both of which are necessary due to poor security of remote villages). Transport costs alone for FY92 were about $3/target beneficiary.

The possibility of income generation was investigated during the evaluations. While most communities were too busy worrying about how to obtain their food each day,

a few villages expressed great interest in income-generating activities. Two ideas under consideration are (1) collaborating with WV Agriculture to integrate their vegetable marketing program with CSP health committees; (2) supplying mosquito net material to older women of the village who could sew mosquito nets and sell them in the village.

8. Lessons Learned/Recommendations

Lesson 1: The Provincial and District MOH staff are unprepared to monitor international health projects in Tete or Zambezia.

Recommendation: A training session about the types of projects that international organizations implement in Mozambique would facilitate the existing (agency-government) relations and create efficient participation of the personnel and decision-making to achieve the goal of the project.

Lesson 2: An international organization with projects that provide direct service to the population are not sustainable because the available resources of the organization are never consistently available within the country of implementation.

Recommendation: The funder, implementer and beneficiaries of the project should jointly discuss the objectives and the sustainability of the project in the target area *before* the project is designed, the goals defined and the activities initiated.

Lesson 3: Regardless of predetermined goals, child survival programs save many lives. Future projects must be planned with the particular circumstances of the country in mind and with the contributions from the MOH and the beneficiaries themselves.

Recommendation: All target populations that participate in a child survival project should include an income-generating component administered by the population. If this component is not included, the quality of life of the beneficiaries could well be worse in the future and the benefits of the project undetectable.

Lesson 4: The CSP of WV can be a training center to teach/train Mozambicans how to implement and maintain primary health care activities during a war, with multiple logistic complications and with an unmotivated target population.

Recommendation: The next child survival project that gives institutional support should use this project as a training center.

The recommendations generated during this evaluation for each component are as follows:

1. The local MOH should participate more in the coordination and implementation of the project, so that they will not miss opportunities to learn and update themselves in the laboratory setting that the project offers.

2. An annual implementation plan of all activities within the district, including strategies and needs for their implementation, should be discussed with the coordinator of the project so that budget allocations and technical assistance can be supplied in the following fiscal year.

3. The coordinator of the project should continue to maintain formal and informal contact with the government officials at the provincial and district levels. If this is done, many administrative and budget issues can be resolved in advance.

4. The training unit of the project must plan to transfer to the MOH in Tete. Perhaps a separate intensive training center (Centro de Reciclagem—Center of Recycling/Training) like that in Zambezia should be initiated in Tete. With the project's support, the current coordinators of the training unit, a Mozambican and an expatriate, should complete an internship in the Centro de Reciclagem de Zambezia. Plans to develop the same institution in Tete should be considered. Such a center will be an intensive training unit integrating non-government organizations with the MOH.

5. The care provided by the CSP has saved many lives. A plan to create opportunities to improve the quality of life of these same children in the future must be initiated immediately. A community development strategy should be developed during the second phase of the project for the target population. The objective of community/economic development is to diversify the capacity of the community to generate income beyond what might be gleaned from their fields.

6. The health information system is functioning, but it is still in the testing/revision phase. Two objectives to be included in the analysis of the efficiency of the HIS must be simplicity and the amount of time required of the worker to collect data in the field. This system should be adjusted as necessary to correspond with the MOH's and the donor's needs.

7. The goals of the project defined by the Detailed Implementation Plan (DIP) should be revised and adjusted to the real conditions in the target areas. Some of the goals are not possible to reach due to uncontrollable variables like war, famine, drought, migration, and lack of motivation of the target population.

9. SUMMARY

9.1 Introduction

9.1.1 Evaluation Background

The goal of the Tete Child Survival Project of World Vision Mozambique is to reduce child mortality and morbidity through the integration of select primary health care interventions. These interventions include immunizations, growth monitoring, oral rehydration therapy (ORT), environmental sanitation, malaria control, and training of community workers.

The purpose of this consultancy was to provide leadership and technical assistance in the implementation of the midterm evaluation required by USAID for the Child Survival Project (CSP) of World Vision, Tete, Mozambique.

The specific objectives of the evaluation were:

1. To assess the progress of the project towards designated objectives.

2. To review the technical quality of services delivered and the appropriateness of existing process and output indicators.

3. To evaluate the effectiveness of the Health Information System in tracking progress.

4. To identify strategies that enhance the sustainability of child survival activities. Issues will include strengthening WV-MOH relationships at national and local levels, networking and coordinating with other agencies and institutions, enhancing community participation and financing, and developing the technical and managerial skills of staff.

5. To brainstorm with project staff, partners, and others about project constraints.

9.1.2 Evaluation Strategy

The evaluation included representatives from all levels of the project, including the World Vision project staff, MOH staff from the central, provincial and district levels, community workers, beneficiaries within the community, and consultants.

Planning of the evaluation was initiated and directed by the WVM Health and Nutrition Manager in coordination with the external consultant. A sequence of meetings and interviews with defined objectives were scheduled (Annex 1). Each meeting resulted in the evaluation of designated project interventions and their relationship to associated government and nongovernment sectors; they also provided recommendations that help to integrate project activities into the community, MOH, sister government structures and other WV projects. During this process each sector addressed their needs and concerns and recommended solutions to improve planning, coordination and utilization of existing resources. Preliminary strategies to reinforce sustainability of activities of these inputs and absorption of the project by the MOH were also discussed.

Briefing sessions about project activities were defined at the initial meeting which included members of the MOH, USAID and WV senior management. Specific objectives of each partner were determined during these meetings. Two MOH personnel were assigned to participate in the evaluation of the project at both sites—Tete and Zambezia.

9.1.3 Methodology of the Evaluation

The quality of services provided was observed during the performance of interventions in the field. A review of the components and implementation of these activities was conducted within group discussions which included people involved in different roles and levels of the project. Benefits, challenges, areas in need of improvement, possibilities to reproduce and expand activities, capacity of the government to absorb and sustain the interventions and the level of participation and cooperation of

involved parties represent several issues that were analyzed during these discussion sessions.

A schedule/agenda for meetings was defined to focus the discussions at each level of the project (i.e., staff, management, MOH, etc.). The idea was to orient these discussions as to what needed to be known about the project and its implementation and progress toward benchmarks. Of course, the knowledge acquired during these meetings was not limited to pre-selected questions and topics. On the contrary, more was gathered by free association about experiences and practices. A sequence of meetings and a chronology of activities to be observed were planned in advance (Annex 1). The major sequence of events were:

a. Visits to project areas where activities were being conducted.

b. Observations by the evaluators on the implementation of specific activities for the target population.

c. Discussion about the project activities with the community beneficiaries.

d. Discussions with implementors and observers about the quality, efficiency and appropriateness of the project.

e. Revision of project documents/benchmarks.

The following **project components,** implemented during the period 10/90-7/92, were reviewed to determine which actions can be improved, expanded or sustained by the DDS and DPS.

a. Health Education and Human Resources Development-Training.

b. Health Information System (HIS).

c. Interventions: MCH, EPI, CDD, Nutrition, Malaria, Environmental Sanitation

9.1.4 Participants

The following people participated in all scheduled meetings except the initial meeting with the WV Health/Nutrition manager, USAID, the MOH and the consultant. Members of other sectors of government, NGOs or WV projects also participated in some meetings and/or field trips during the course of the evaluation (Annex 1).

Team Leader:
Thelma Leifert, M.D., M.P.H., Consultant

Participants from World Vision Mozambique:
Theresa Andrews, M.D., National Manager of Health/Nutrition Projects
Jana L. Webb, M.P.H., Health Office/HIS Officer
Vivien Wilson, R.N., Training Coordinator

Hector Jalipa, M.D., M.P.H., Regional Director of Health Projects, WVI
Milton Amayun, M.D., M.P.H., Director, International Health Programs, WVRD
Alberto Sitoe, R.N., National Assistant Director of Health Projects

Participants from the MOH Mozambique:
Romao Mondlhane, National Director of Community Health
Joao Tembe, TMP/SM, MPH, Epidemiology Department
Sabadao Ntompe, RN, Provincial Director of Community Health

ANEXOS

Participantes

Annex 01

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WORLD VISION INTERNATIONAL

MOZAMBIQUE RELIEF PROGRAMME

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TELEX 6-124 W/GHV. MO
TELEFAX 42 [illegible]

REUNIAO DE AVALIACAO DOS PRJECTOS DE SOBREVIVENCIA INFANTIL NAS PROVINCIAS DE TETE E ZAMBEZIA

AGENDA

APRESENTACAO DOS PARTICIPANTES

APRESENTACAO DOS PROJECTOS

APRESENTACAO DA METODOLOGIA DE AVALIACAO

INTERVENCAO DE SEXA VICE-MINISTRO DE SAUDE

ANALISES DIVERSAS

MAPUTO 17 DE AGOSTO DE 1992

INFANTIL

INTERNATIONAL ADDRESS:
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WORLD VISION INTERNATIONAL

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Reuniao de AVALIACAO DOS PROJECTOS DE SOBREVIVENCIA INFANTIL NAS PROVINCIAS DE TETE E ZAMBEZIA

LISTA DOS PARTICIPANTES

1 -SEXA SENHOR VICE MINISTRO DA SAUDE - Ausente

2 -HERCULANO BATA -DIRECTOR N DE RECURSOS HUMANOS

3 - LUCAS CHOMERA JEREMIAS -DIRECTOR N DE SAUDE ADJUNTO

4 -JORGE F M TOMO DIRECTOR NACIONAL ADJUNTO DA COOP INTERNACIONAL

5 - DR ROMAO MONDLHANE CHEFE DO DEP DE S M I

6 -JULIO LANGA CHEFE DO DEP DE FORMACAO

7 -BONIFACIO C D COSSA CHEFE DO DEP DE COOP

8 -JOAO TEMBE DA SECCAO DE EPIDEMIOLOGIA

9 -DRA TERESA ANDREWS RESPONSAVEL DO PROGRAMA DE SAUDE

10-DR. HECTOR JALIPA RESPONSAVEL REGIONAL SAUDE WV Niua Astral

11-DRA THELMA LIEFERT - AVALIADORA (CONSULTORA)

12-ALBERTO SITOE -ASSISTENTE DO DIRECTOR DA SAUDE W. V.

13-HEATHER WAYE -HEALTH OFFICER

MAPUTO.17 DE AGOSTO DE 1992

AVALIACAO DO PROJETO DE SAUDE DE VISAO MUNDIAL (VM), MOCAMBIQUE

SOBREVIVENCIA DA CRIANCA

TETE E ZAMBEZIA

AGOSTO 19 - SETEMBRO 12, 1992

I. OBJETIVO PRINCIPAL:

Avalicao do progresso das atividades do projeto de sobrevivencia da crianca implementados nas provincias de Tete e Zambezia durante o periodo de Outuber 1990 ate Julho 1992.

II. OBJECTIVOS ESPECIFICOS:

1. Com as estruturas do MISAU Central, Provincial e Distrital, e os trabalhadores do projeto de VM, definir a estrategia da avaliacao nos locais onde atividades do projecto foram implementadas.

2. Revisao da qualidade tecnica de servicos prestados

3. Revisao se o processo de implementacao e adequado para as necessidades e condicoes locais.

4. Revisao dos "inputs/outputs" das atividades.

5. Revisao das relacoes entre VM-MISAU-Comunidade.

6. Revisao da coordenacao do projecto com outras estruturas nacionais e internacionais trabalhando nas areas do projecto.

7. Revisao do processo administrativo do projecto

9. Identificacao de strategias que possam melhorar o potencial de sustentabilidade do projeto pelo MISAU.

PRODUTO FINAL:

Dois relatorios conclusivos e com recomendacoes, respectivamente para cada projeto Tete e Zambezia.

ESTRATEGIA DA AVALIACAO:

A avaliacao sera relizada atraves de:

1. Visitas as areas do projetos onde atividades sao realizadas.

2. Observacao pelos participantes da avaliacao, de implementacao de atividades especificas na populacao alvo.

3. Discussao sobre as atividades do projecto com a comunidade beneficiaria.

4. Discussao com implementadores e observadores do projecto sobre sua efficiencia e adequacao.

5. Revisao de documentos informativos do projeto.

ATIVIDADES DO PROJETO A SEREM REVISADAS:

1. Treinamentos/Desenvolvimento de Recursos Humanos
2. Sistema de Informacao
3. Intervencoes de SMI, PAV, CDD, Nutricao, Malaria.

CRONOGRAMA DE TRABALHO:

A agenda que se segue e ainda uma tentativa. Este plano sera confirmado durante as reunioes com as estruturas Provinciais e Distritais das areas do projeto.

cc: Dr. Romao Modlhane
Joao Tembe
Lucas Chomera Jeremias
Dra. Theresa Andrews
Sro. Aberto Sitoe
Dra. Thelma Leifert

CALENDÁRIO ESPECIFICO
AVALIAÇÃO DE MEIO-TERMO
PROJECTOS DE SOBREVIVENCIA INFANTIL DA VISAO MUNDIAL
TETE, ZAMBEZIA - PROVINCIAS DE MOCAMBIQUE

Maputo:

17 Agosto: Reunioes - Vice-Ministro e MISAU no nível nacional

18 Agosto: Mesmos Reunioes

Tete:

19 " Viagem para Tete (se o tempo dar, avaliar as estatísticas/dados em Tete)

20 Agosto: Manhã: Reunioes com as estruturas provincais
Tarde: Avaliação do programa de água/saneamento (Milice)

21 Agosto: Avaliação das intervençoes de PSI/Centro da Saúde em Boroma

22 Agosto: Reunioes com a equipe de PSI (Tete)

23 Agosto: Domingo -

24 Agosto: Analise e avaliação das estatisticas/dados

25 Agosto: Changara - reunioes com as estruturas: Administrador (Nascimento) Director Distrital de Saúde (Americo) e Chefe Distrital do PAV (Tiago); avaliação das intervençoes de PSI - Ricardo

26 Agosto: Changara - avaliação de programa de facilitação; treinamento no Bairro 1 (Malária) e distribuição das redes mosquiteras.
A tarde: viagem para Quelimane.

Quelimane:

27 Agosto: Licuari - avaliação das intervençoes (Catela, Diogo, Felizardo)

28 Agosto: Manha: Avaliação do programa de SMI (Jacinta e Clarice)
Tarde: Reunioes com as estruturas: Domingos Diogo, Ausse, Miranda, Sandre, Comissão de Emergência e o Administrador de Nicoadala.

29 Agosto: Mucelo Novo: programa de ensinamento dos facilitadores sobre metodologia de treinamento.

30 Agosto: Domingo

31 Agosto: Manhã: Avaliação do programa de água/saneamento (Rafael)
Tarde: Reunioes com o equipe de PSI (Zamb)

1 Setembro: Licuari/Minhacua - facilitação (visitas das casas), comité de Saúde e casas com redes mosquiteiras.

2 Setembro: Estatisticas/Dados

Relatorio:

3-9 Setembro: Feitura dos relatórios de avaliação (Tete e Zambézia)

Informe sobre avaliação

10 Setembro: Informe sobre avaliação no nível provincial (Zamb) Domingos e Ausse

11 Setembro: Viagem para Tete e informe sobre avaliação no nível provincial (Tete) Amurane, Sábado e a Comité de Emergência

12 Setembro: Viagem para Maputo e informe sobre avaliação no nível nacional (Dr Igrejas Campo - Vice-Ministro, Directora Nacional e outras pessoas escolhidas para avaliação.)

EVALUATION DO PROJETO DE VISAO MUNDIAL (VM), MOZAMBIQUE
SOBREVIVENCIA DA CRIANCA
TETE E ZAMBEZIA

AGOSTO 17-SETEMBRO 12, 1992

Estrategia da Avaliacao

I. ENCONTROS com as organizacoes envolvidas com o projeto, para decidir o que querem como resultado da avaliacao.

1. Visao Mundial
2. USAID
3. MISAU, Maputo

II. ENCONTROS com os trabalhadores do projeto, representantes das Direcoes Provincias e Distritais, das areas do projeto para definir a estrategia e plano de visitas da avaliacao.

1. Explanacao do objectivo do encontro
2. Apresentacao dos participantes (nome, local de trabalho, relacao com o projeto, expectativas para este encontro)
3. Explanacao sobre a Avaliacao:
   - objetivos
   - methodologia
   - produto (conclusoes, recomendacoes) - Documento
4. Revisao Cronologica da implementacao do projeto
5. Definicao das:
   - Intervencoes a serem avaliadas
   - Local, data e horario de encontros para avaliacao
   - Equipas avaliadoras nestes encontros-distribuicao do trabalho
   - Metodologia a ser usada em cada encontro
   - Suporte logistico

III. IMPLEMENTACAO do plano de intervencao- encontros com estruturas e comunidades do projeto

IV. ENCONTRO Final para analise, conclusoes e recomendacoes para a avaliacao

V. RELATO informativo sobre o resultado da avaliacao para as organizacoes envolvidas com o projeto.

1. Visao Mundial
2. USAID
3. MISAU, Maputo

ENCONTRO I: DIRECAO PROVINCIAL DE SAUDE

REVISAO DAS RELACOES DA DPS COM O PROJETO

1. Quando e como foi que o DPS negociou com a VM o projeto de Sobrevivencia da Crianca?
2. Que tipo de projeto e? Emergencia, Rehabilitacao ou Desenvolvimento?
3. Quais as prioridades do DPS que determinaram as intervencoes deste projeto?
4. Quais sao as intervencoes que o projeto realiza em coordenacao com o DPS?
5. Quais sao as intervencoes que o projeto realiza sozinho?
6. Existe um plano de coordenacao de acoes na comunidade entre o DPS e o projeto?
7. O projeto cobre as acoes do DPS na area do projeto?
8. As atuais intervencoes do projeto fazem partes das prioridades do DPS?
9. Que beneficios traz este projeto na area?
   para o servico publico de saude?
   e para a populacao?
10. Quais as dificuldades que ele causa?
11. Este projeto pode ser absorvido pelo DPS? O que e necessario para tal?
12. Que estrategia, intervencoes ou apoio faria este projeto melhor do que e?

ENCONTRO II: DIRECAO DISTRITAL DE SAUDE

1. Qual e a populacao do Distrito?
2. Qual e o numero de populacao que o servico distrital atende?
3. Qual e a populacao que o projeto atende?

4. Qual e o numero de funcionarios do DDS designados para acoes preventivas comunitarias somente?

5. Qual e o numero de funcionarios do projeto designados para acao de prevencao comunitaria?

6. Que criterios de escolha determinaram os postos e os centros de saude em que o projeto funciona?

7. Quais as intervencoes de saude primaria do projeto?
8. Quais destas intervencoes sao feitas com o pessoal do DDS?

9. Quais sao as intervencoes que o pessoal do projeto faz independentemente?

10. Existe um plano de trabalho de campo coordenado? Tem copia?
11. Que tipo de relatorio ou dados o projeto fornece ao DDS?
12. Que bens materiais sao fornecidos ao DDS pelo projeto?
13. Que bens materiais sao fornecidos as comunidades pelo projeto?

14. Que tipo de apoio o projeto oferece ao sistema preventivo de saude do DDS?

15. (Competencia) Os funcionarios do projeto conhecem bem o seu trabalho?

16. Eles utilizam as tecnicas e normas do SNS nas realizacoes dos trabalhos do PAV, nutricao, controle de crescimento, saude maternal, IRO?

17. Qual e a periodicidade de visitas aos postos?
18. A comunidade esta satisfeita com o trabalho eles?

19. O DDS tem conhecimento da cobertura de populacao feita pelo projeto? Com que frequencia o projeto informa sobre estes dados? mensal, semestral, anual, ou casual?

20. O DDS tem condicoes atualmente de fornecer os servicos prestados pelo projeto? Liste o que precisa para faze-lo?

21. Existe atividades que o projeto poderia melhorar ou fornecer dentro do DDS. Liste.

22. Elabore sobre o relacionamento do projeto com o DDS e a comunidade nos niveis da gerencia e de funcionarios?

ENCONTRO III: TRABALHADOR DO PROJETO

1. Ha quanto tempo voce esta trabalhando para o projeto de VM?
2. Criterios usados para sua admicao no projeto?
3. Que areas trabalha (aldeias, piloto, nao-piloto, deslocado)?
4. Que postos trabalha?
5. Quais foram os criterios para a escolha destes postos?
6. Quais as tarefas que voce realiza?
7. Que tipos de treinamentos ja recebeu? Quem deu? E onde foi?
8. Quem e seu supervisor? Voce supervisiona? Quem e quantas pessoas?
9. Quais as estruturas do DDS com quem voce trabalha? Com que frequencia?
10. E na comunidade com quem trabalha?
11. Que tipos de treinamentos voce faz na comunidade?
12. A <u>quem</u>, o <u>que</u>, e <u>como</u> voce ensina a importancia de:
    PAV
    Nutricao (amamentacao/desmame)
    TRO
    Controle do Crescimento
    Malaria
    Saneamento/agua
13. Que tipos de dados voce registra? quem analisa? e como sao usados estes dados?
14. Com que frequencia voce visita as comunidades? Existe um plano de trabalho?
15. Voce gosta do trabalho que realiza? Quais sao as satisfacoes que este trabalho lhe oferece?
16. Voce esta satisfeito de trabalhar para a VM? Porque?
17. Que planos profissionais tem para o futuro?

OBSERVACAO DO TRABALHO DE CAMPO DO TRABALHADOR: Observar durante a realizacao das tarefas e seus componentes (intervencoes do projeto) e anotar de 0 a 5:

1. Competencia profissional (conhecimento tecnico do trabalho a ser realizado)
   0 1 2 3 4 5

2. Forma de falar/tratar com a comunidade
   0 1 2 3 4 5

3. Eficiencia/claridade nas sua explicacoes
   0 1 2 3 4 5

4. Satisfacao/atencao do(s) cliente(s)
   0 1 2 3 4 5

5. Coordenacao das atividades
   0 1 2 3 4 5

6. Preparacao do material a ser usado na intervencao
   0 1 2 3 4 5

7. Eficiencia na utilizacao do material necessario para a realizacao da tarefa
   0 1 2 3 4 5

8. Capacidade criativa/solucao de problemas
   0 1 2 3 4 5

9. Conhecimento do sistema de referencia local (locais de tratamento para mandar o cliente)
   0 1 2 3 4 5

10. Prazer na realizacao da tarefa
    0 1 2 3 4 5

Outras observacoes:

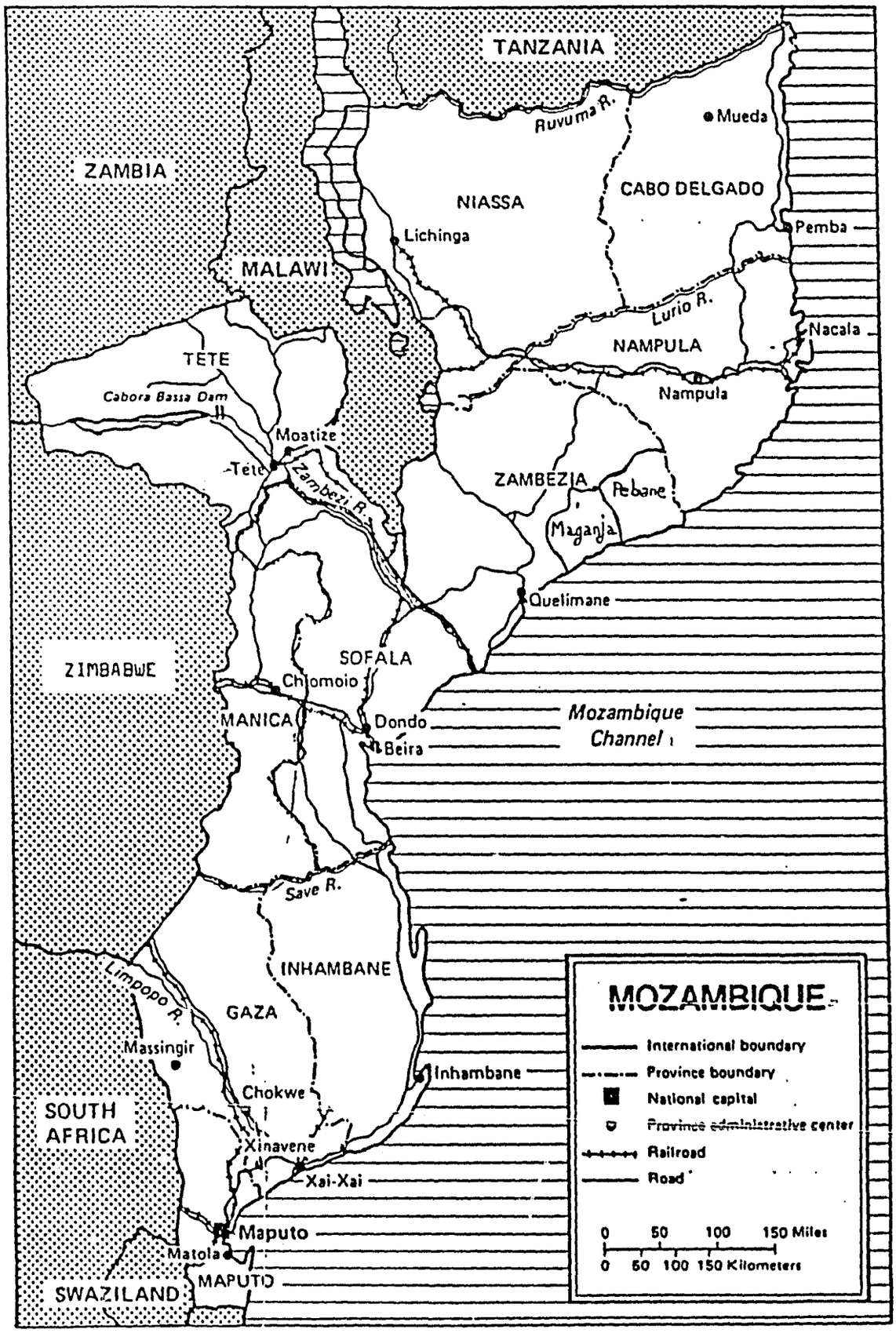
ENCONTRO IV: OUTRAS INSTITUICOES OU ORGANIZACOES COM QUEM O PROJETO SE RELACIONA (" DPCCN, MOE, SCF, DANIDA AGUA RURAL, ETC.)

1. Que tipo de coordenacao/cooperacao existe entre PSC-VM e "?
2. Qual apoio " fornece ao projeto?
3. Qual apoio o projeto oferece a " VM?
4. Quais comunidades " trabalha?
5. Que trabalhos sao realizados em cooperacao?
6. Qual sua opiniao sobre o projeto de sobrevivencia da crianca de VM? Existe alguma sugestao para novas intervencoes? (Strategias, areas de trabalho, novas populacoes)
7. Que beneficios este projeto traz para a populacao?

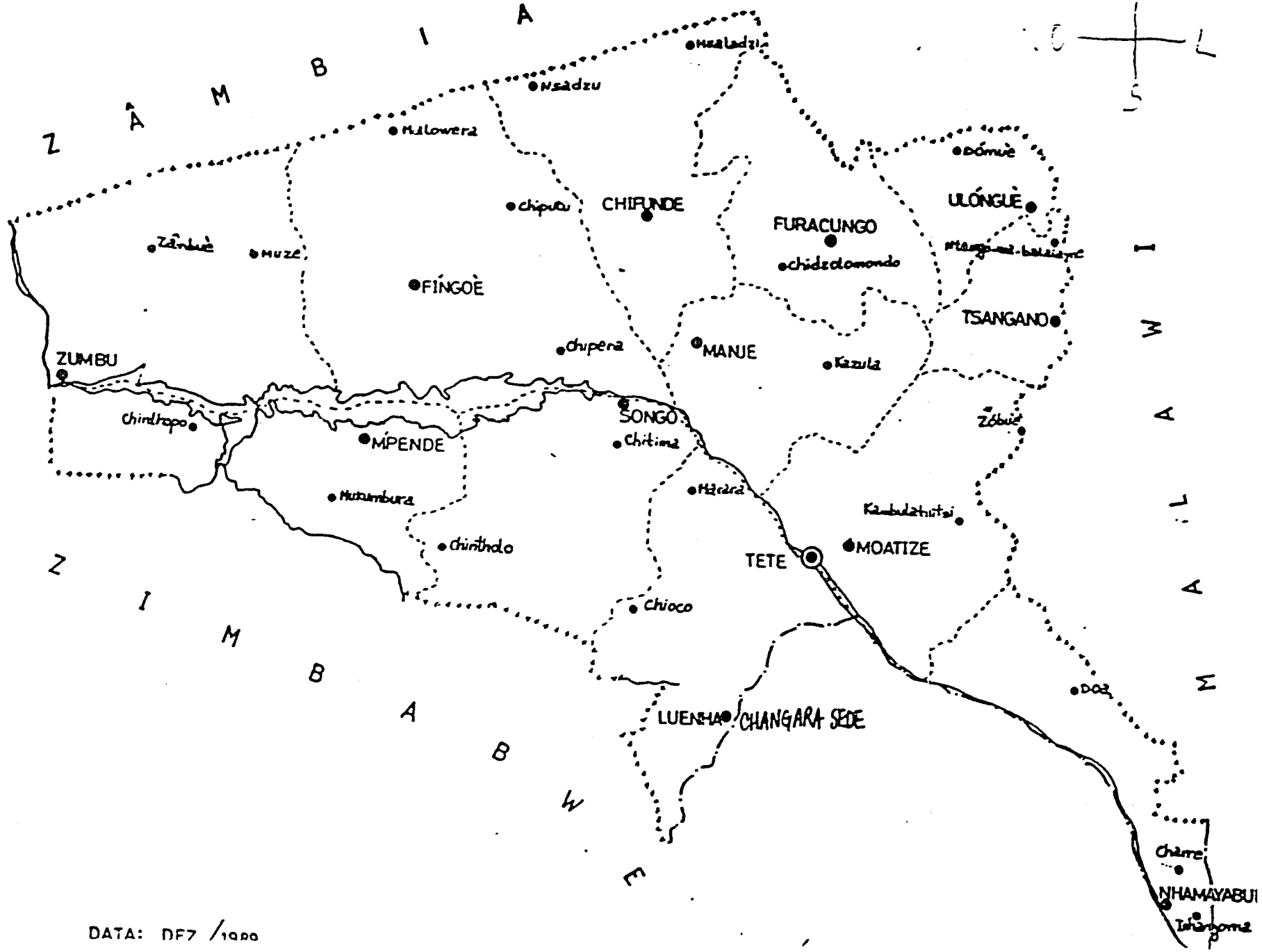
ENCONTRO V: COMUNIDADE

1. Quando foi que o projeto comecou a trabalhar aqui?
2. Quantas equipas veem trabalhar nesta comunidade?
3. Com que frequencia elas veem trabalhar aqui?
4. Quem e o que fazem quando vem aqui?
5. Ha comite de saude?
6. Ha Facilitadores?. Que fazem? Sao uteis?.
7. Ja comecou o programa de latrinas?
8. Ha distribuicao de redes mosqueteiras? Quem dorme dentro delas na familia?
9. Alem destas atividades de saude o que mais a comunidade considera necessario?

ANEXO 2: MAPAS

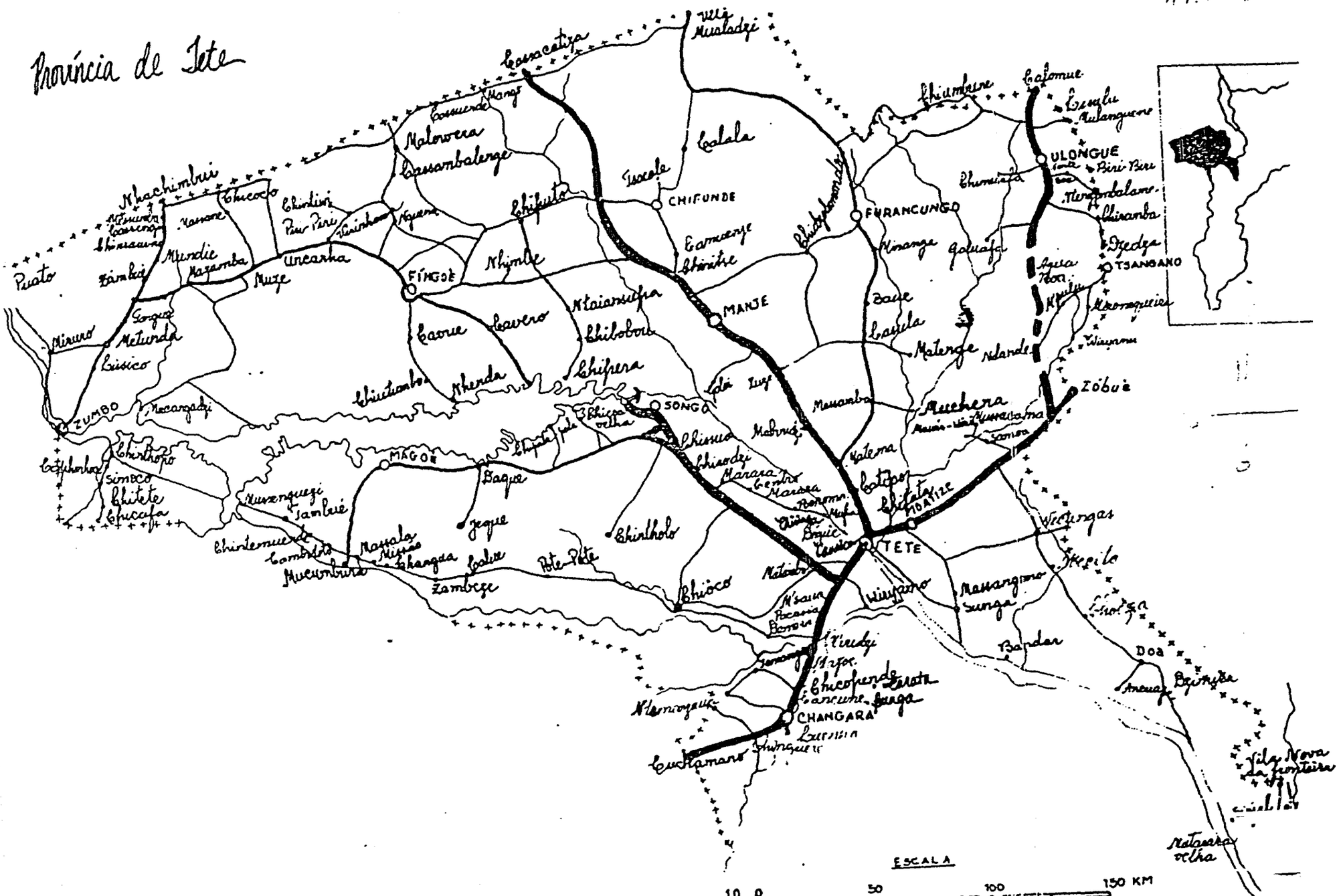

TANZANIA
ZAMBIA
MALAWI
ZIMBABWE
SOUTH AFRICA
SWAZILAND
Ruvuma R.
Mueda
NIASSA
CABO DELGADO
Lichinga
Pemba
Lurio R.
Nacala
NAMPULA
Nampula
TETE
Cabora Bassa Dam
Moatize
Tete
Zambezi R.
ZAMBEZIA
Pebane
Maganja
Quelimane
SOFALA
Chiomoio
MANICA
Dondo
Beira
Mozambique Channel
Save R.
INHAMBANE
Limpopo R.
GAZA
Massingir
Inhambane
Chokwe
Xinavene
Xai-Xai
Maputo
Matola
MAPUTO
MOZAMBIQUE
International boundary
Province boundary
National capital
Province administrative center
Railroad
Road
0 50 100 150 Miles
0 50 100 150 Kilometers

PROVÍNCIA DE TETE



DATA: DEZ /1990

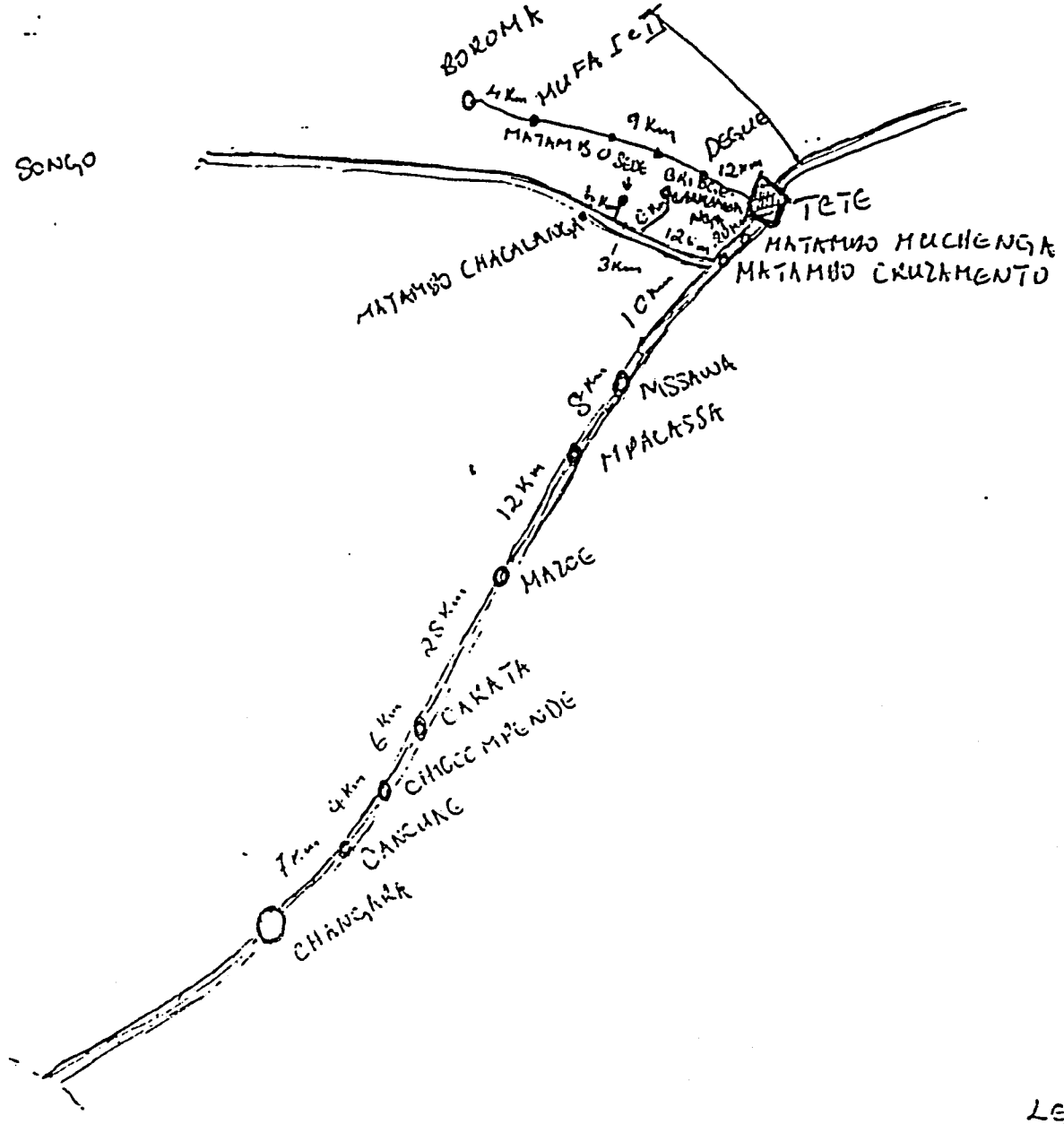
Província de Tete



ESBOÇO DE LOCALIZAÇÃO DAS ALDEIAS DO PSI de TETE/VMM

MALAWI

N



Zimbabwe

LEGENDA

- Estrada Nacional
- Estrada Secundária
- picada
- aldeia

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ANEXO 3: DISTRIBUICAO DA POPULACAO BENEFICIARIA

VISAO MUNDIAL MOCAMBIQUE - PSI TETE
ESTATISTICAS DO POPULACAO GERAL E GRUPO ALVO

ALDEIA	TOTAL HABITANT	TOTAL FAMILIAS	FAMILIAS		INDIV.	RETIR.	CRIANCAS (CUMULATIVO)				
			ALVO	NO ALVO	ALVO		0-11	12-24	25-36	TOTAL	MIF
BOROMA	3597	720	461	149	986	00	199	111	69	379	607
BUNGA	2147	628	338	186	522	05	73	70	38	181	341
CANCUNE	2111	532	612	227	1093	23	208	133	64	405	688
CARATA	1095	297	173	81	261	05	32	23	17	72	189
CHANGARA	9746	2467	2064	724	3985	100	680	347	326	1353	2632
CHIOCOMPENDE	900	131	143	88	243	10	32	30	22	84	159
DEGUE	3098	620	942	423	1811	75	216	341	297	854	957
MATAMBO BRIDGE	1999	375	319	114	551	08	109	64	50	223	328
MATAMBO CHACALANG	650*	150*	118	32	207	00	33	26	17	76	131
MATAMBO CRUZAMENT	11440	2290	665	212	1336	75	282	168	133	583	753
MATAMBO NHANGULUL	1500*	325	280	42	488	09	103	46	36	185	303
MATAMBO MUCHENGA	3558	712	282	92	477	06	88	65	32	185	292
MATAMBO SEDE	3216	581	370	235	593	04	121	67	45	233	360
MPACASSA	2420	484	267	158	524	08	111	63	38	212	312
MSSAWA	6460	1292	850	392	1693	33	359	239	157	755	938
MUFA DESLOCADOS	2131	537	417	99	790	28	166	104	87	357	433
MUFA NATURAL	711	143	123	42	272	51	49	46	41	136	136
NTEMANGRO	566	132	97	25	154	01	23	21	13	57	97
TOTAL	57345	12416	8521	3321	15986	441	2884	1964	1482	6330	9656

* APROX

**FALTA UMA

ANEXO 4: ORGANOGRAMA DO PROJECTO

Tab 4

WORLD VISION MOZAMBIQUE
TETE CHILD SURVIVAL PROGRAM
MOBILE TEAM COMPOSITION

DR. TERRY ANDREWS
Health and Nutrition
Manager

JANA WEBB

Manager of Tete CSP
Epidemiology
Statistics/ Administration
Proposal/Reports/Training

JAIME B. JOSE
Administration/Finance
Collation of Documents/
Reports

JOSE CUPERTINO
Senior Health Trainer
Supervisor of Hlth Comm
and Cmmty Facilitators
in all zones

FRANCISCO MILICE
Water and Sanitation
Technician
Water/Sanitation Trng
and Education

RITA ADRIANO
Supervisor Therapeutic
Feeding Centers (3)
and School Feeding
Programs

MARIA JOSE
Supervisor of t
Pregnant/Lactat
Women's Program

CHANGARA TEAM | MSSAWA TEAM | BORONA TEAM

POSITION DESCRIPTION

Title: Technical Training Assistant

Reports to: Health Officer

Scope of Position: To act as a counterpart to the training manager by providing technical training for the staff and community facilitators. To identify, train and supervise community health committees and to collect and assess the data on training.

Job Responsibilities:

1. To ensure uniformity in training skills and techniques of the three fixed health teams.

2. To promote the inductive method of training and evaluate the technicians use of them method in the field.

3. To initiate at least 1 health committee in each bairro including identifying, training and following up on the committee.

4. To train the health staff on a variety of community-based and primary health care topics.

5. To supervise the team leader in their administration of health committees in their areas.

6. To collect data on training components and evaluate the team leaders and their health committees.

7. To act as a back up to health committee for team members in their absence.

8. To launch and oversee the home visit facilitation program.

9. To ensure that appropriate technologies and methodologies are taught and implemented by the team leader and in the community, respectively.

10. To act as a back up supervisor to health team and assistants who oversee the severely malnourished feeding programs.

11. To design and make teaching materials to be used by the staff in health education and training sessions.

12. To orient new staff on previously taught topics.

13. To develop of the training manual on community-based and primary care topics.

TECHNICAL CONSULTANT FOR HEALTH STAFF AND FEEDING CENTERS
World Vision - CSP Mozambique

General Description: The WV technical consultant will observe CSP Health Staff and Feeding centers in Tete and discuss findings with Tete HO and Mozambique H/N manager; She/he will also provide technical training to Tete Health Staff. A written report of each consultory visit will be submitted. She will report to the H/N Manager and be in regular communication with the Tete H.O.

Required Duties:

1. Visit Tete CSP every 5-6 weeks. Each feeding center and at least one round of CSP interventions will be observed each visit.

2. During visits to feeding centers, the following will be analyzed:
   a. appropriateness of admissions, discharges, and clinical diagnoses of each patient enrolled.
   b. feeding schedules for timeliness and amounts and proper food preparation
   c. each Health Staff in charge of centers will be evaluated regarding knowledge of the patients and feeding schedules as well as supervisory abilities of local staff.
   d. other feeding center - related issues such as relationship with the MOH Health Post, changes in feeding center policies that should be made, etc.

3. At least one CSP Health Staff will be observed as he conducts CSP intervention rounds. His skills in growth monitoring, organization of target population, and community education will be observed and evaluated.

4. An in-service training will be given on a technical subject such as vaccination cold chains, malaria, AIDS, etc during each visit.

Required Education/Experience:

1. A degree in nursing is required.

2. Fluency in English and Portuguese required.

3. Must have experience in public health work and management of intensive feeding centers for the severely malnourished. Experience in a developing country preferred.

4. Mature, committed Christian required.

TRANSLATOR/TYPIST - JOB DESCRIPTION
World Vision - CSP Tete

General Description: The translator will be responsible for translating CSP documents, minutes of government and MOH meetings, project documents and current medical material from journals into Portuguese. This will be used for communication and feedback to the MOH and target villages as well as for Health Staff training.

Required Duties:

1. Translation of CSP activities such as monthly and quarterly reports and minutes from MOH and other governmental meetings.

2. Translation of some project documents such as project proposals, KAP survey results, and parts of annual reports into Portuguese.

3. Translation of current journal and WHO publications chosen by the H/N manager which apply to CSP activities. This will be used in weekly training sessions and seminars.

4. All translations will be done using Word Perfect. A minimum of 5 pages per day will be produced unless the Health Officer assigns other duties.

5. Though based in Tete and reporting to HIS Officer there, will be translating some documents that pertain to Zambezia CSP.

Required Education/Experience:

1. Must be fluent in written and oral English and Portuguese.

2. Must have completed high school through grade 12. Some university education in computers or English preferred.

3. Previous translation experience preferable.

4. Must have previous experience with computers and Word Perfect.

5. Mature, committed Christian preferred.

COMMUNITY HEALTH TRAINER - JOB DESCRIPTION
World Vision - CSP Mozambique

General Description: The Community Health Trainer will provide training to CSP and ER Health staff in areas of preventative health that apply to community teaching and mobilization. This includes problem solving, community teaching skills (drama, mime and inductive teaching), facilitator training, and village health committee formation.

Required Duties:

1. To run a week-long seminar for all WV Health staff and some MOH staff on community problem solving.

2. To launch the facilitator training and health committee formation in target villages of Zambezia; CSP staff will be trained to select and teach community facilitators, and their progress evaluated.

3. To evaluate the community facilitation and village health committee programs begun last year in Tete.

4. To evaluate and assist with a two day workshop organized by CSP Zambezia Health Staff to teach drama, song writing, inductive questioning and other community teaching skills to local hire health aides.

5. Provide one-on-one training to the CSP and ER health technicians in charge of community teaching.

6. Evaluate patient teaching sessions of ER staff in three Emergency Feeding programs.

Required Education/Experience:

1. A degree in nursing or public health is required.

2. Must be fluent in English. Additional fluency in Portuguese preferred.

3. Must have experience in community health work and community mobilization, preferably in a developing country or environment similar to Mozambique.

4. Must have had training in preventative health and community teaching.

5. Mature, committed Christian preferred.

POSITION DESCRIPTION
HEALTH DEPARTMENT
WORLD VISION MOZAMBIQUE

Title: Assistant Administrator

Reports to: Health Administrator

Scope of Position: To assist Health Officer and Health Administrator with administrative responsabilities including staff support, word processing, typing, maintenance of equipment and other duties as needed.

Required duties:

1. To assist inventorying and updating of all equipment, supplies and food stocks.

2. To maintain suffcient quantities of HIS and administrative forms.

3. To maintain an office filling system and receive, redirect and respond to incoming communications from Health/Nutrition main office and other WVM offices.

4. To schedule and follow-up all appointments for the Health Officer and Health Administrator.

5. To word process and/or type documents received from the Health Officer, Health Administrator and CSP staff.

6. To receive requests for materials and prepare requesitions.

7. To prepare mail, faxes and other parcels to be sent on behalf of Tete Health.

Knowledge/Skills/Abilities:

1. Mature and committed christian preferred.

2. Requires completion of grade nine and at least some years of University education or equivalent training.

3. Must have previous experience in administration.

4. Must be fluent in oral and written portuguese. Some knowledge of english is an advantage.

POSITION DESCRIPTION

Title: Health Assistant (Water and Sanitation)

Reports to: Health Officer

Scope of Position: To implement program interventions defined in the project document and ensure that WVM's ministry meets the needs of the neediest, efficiently and adequately.

Specific Objectives:

1. Organize, plan and coordinate the implementation of specific interventions in the area of water and sanitation.

2. Liaise with district and provincial MOH counterparts.

3. Assist the Health Officer in identifying potential water and sanitation project areas.

4. Participate in the preparation and evaluation of technical reports and recommend appropriate interventions.

Knowledge/Skills/Abilities:

1. Must be a committed Christian with sensitivity to local culture and knowlegeable of the needs and context of rural population.

2. Requires a certificate in water and sanitation, nursing or agente de medicina preventiva/curativa.

3. Must have good knowledge of local language and fluent in oral and written Portuguese. Fair knowledge of English an advantage.

POSITION DESCRIPTION

Title: Health Assistant (Nutrition)

Reports to: Health Officer

Scope of Position: To implement program interventions defined in the project document and ensure that WVM's ministry meets the needs of the neediest, efficiently and adequately.

Specific Objectives:

1. Organize, plan and coordinate the implementation of specific interventions in the area of nutrition.

2. Liaise with district and provincial MOH counterparts.

3. Assist the Health Officer in identifying potential nutrition project areas.

4. Participate in the preparation and evaluation of technical reports and recommend appropriate interventions.

Knowledge/Skills/Abilities:

1. Must be a committed Christian with sensitivity to local culture and knowlegeable of the needs and context of rural population.

2. Requires a certificate in nutrition, nursing or agente de medicina preventiva/curativa.

3. Must have good knowledge of local language and fluent in oral and written Portuguese. Fair knowledge of English an advantage.

POSITION DESCRIPTION

Title: Health Assistant (Immunization)

Reports to: Health Officer

Scope of Position: To implement program interventions defined in the project document and ensure that WVM's ministry meets the needs of the neediest, efficiently and adequately.

Specific Objectives:

1. Organize, plan and coordinate the implementation of specific interventions in the area of immunization.

2. Liaise with district and provincial MOH counterparts.

3. Assist the Health Officer in identifying potential immunization project areas.

4. Participate in the preparation and evaluation of technical reports and recommend appropriate interventions.

Knowledge/Skills/Abilities:

1. Must be a committed Christian with sensitivity to local culture and knowlegeable of the needs and context of rural population.

2. Requires a certificate in nursing or agente de medicina preventiva/curativa.

3. Must have good knowledge of local language and fluent in oral and written Portuguese. Fair knowledge of English an advantage.

POSITION DESCRIPTION

Title: Health Officer

Reports to: H/N Manager

Scope of Position: To support the H/N Manager in implementing health and nutrition program in the assigned geographical area. To include planning, designing, documentation, evaluation, research and liaising with goverment entities to ensure that WVM's ministry meets the needs of the neediest efficiently and adequately.

Critical Objective:

1. Supervise project staff.

2. Assist H/N Manager in establishing and maintaining standards for health and nutrition and ensures that project staff, partner agencies and recipient communities understand, accept and adhere to these standards,

3. Assist H/N Manager in conducting project research and liaising for the assigned project area.

4. Assist H/N Manager in planning and designing health and nutrition projects in the assigned geographical area and assist in redesigning them when necessary.

5. Ensure that assigned project adheres to WVI, GRPM and other funding agencies reporting requirements.

6. Assist H/N Manager in establishing and maintaining an evaluation system.

7. Ensure that technical information pertinent to the project are obtained, disseminated to staff and stored as required.

8. Assist H/N Manager in identifying potential health and nutrition projects in the assigned geographical area.

9. Liaise with WVM program officers for agriculture and emergency food aid in the assigned geographical area.

10. Provide technical support to WVM non-health projects.

Knowledge/Skills/Abilities:

Must be a committed Christian and sensitive to local culture and knowledgeable of context and needs of rural population. Requires a degree in Nursing, preferably with MPH or a Medical Doctor with at least 3 years experience in public health managing large community health project. Good knowledge of Portuguese or other Romance language. Must have abilities to negotiate ideas with WVM and other partners.

POSITION DESCRIPTION

Title: Liaison Officer for Health

Reports to: H/N Manager

Scope of Position: To provide the Health and Nutrition Program an official link with goverment entities (from the national to local levels) and ensure that WVM understands goverment philosophies and policies.

Critical Objective:

1. Assist H/N Manager in establishing and maintaining standards for health and nutrition and ensures that project staff, goverment bodies, partner agencies and recipient communities understand, accept and adhere to these standards.

2. To liaise with goverment entities during all stages of project development, from research to implementation to evaluation.

3. Assist H/N Manager in planning and designing health and nutrition projects making sure that goverment policies are adhered to.

4. Ensure that information disseminated by the goverment, that are pertinent to the project are obtained in a timely manner and understood by management and staff.

5. Assist H/N Manager in identifying potential health and nutrition projects.

6. Assist H/N Manager in resolving administrative issues and represent him/her in staff management as required.

7. Provide technical support to WVM non-health projects.

Knowledge/Skills/Abilities:

Must be a committed Christian and sensitive to local culture and knowledgeable of context and needs of rural population. Requires a degree in Nursing, or other health related field with at least 3 years experience as senior manager in a large community health project. Fluent in Portuguese or other Romance language. Must have excellent knowledge of goverment structure and good abilities to negotiate ideas.

JOB DESCRIPTION

TITLE: Health Information Systems Officer

LOCATION: Tete, Zambezia and Nampula Provinces of Mozambique

SUPERVISOR: Health/Nutrition Manager

PURPOSE: To assist the Health and Nutrition Manager in coordinating and managing data gathered on each of the CSP/Health interventions and to monitor and evaluate these findings with respect to the project goals and objectives. To include planning, designing, monitoring, evaluating, researching and liaising with government and non-government entities, national technicians and community health workers to ensure that there are proper reporting standards, complete documentation, periodic analysis and that World Vision's ministry meets the needs of its target population in each province.

DUTIES AND RESPONSIBILITIES:

1. Develops and maintain a health information and reporting system to be used at the community level to monitor progress toward objectives.

2. Plans, develops, implements and evaluates health surveys to be used at the community, district or provincial level.

3. Data entry, management and analysis of all CSP interventions.

4. Consolidates and submits monthly, quarterly and annual reports to WVM, WVI, WVRD, USAID and other designated parties.

5. Disseminates results of surveys and questionnaires, reports and other studies to designated entities.

6. Coordinates meeting with health staff and MOH regarding data collection and analysis.

7. Works closely with national counterparts at all levels who are responsible for disseminating information to the government and community.

8. Assist the Health Officer in developing the implementing strategies for CSP in each province.

9. Oversee administrative task related to the daily operation of the CSP projects in the absence of the Health Officer.

10. Assist in identifying new areas of intervention and developing proposals and strategies for submission to potential donors.

11. Supervise HIS staff.

12. Liaise with WVM, WVRD, WVI and Ministry of Health regarding the current status of the project as needed.

QUALIFICATIONS:

1. Must be a committed Christian and sensitive to local culture and be knowledgeable of context and needs of rural population.

2. Requires a degree in Mathematics. Biological or Physical Sciences, preferably with MPH emphasis in epidemiology and/or statistics. Must have at least 2 years of experience in Public Health to include involvement in a large community health project.

3. Must be computer literate and familiar with Word Perfect, Lotus, Harvard Graphics and Epidemiology Info or compatible program.

4. Good knowledge of Portuguese or other Romance Language.

5. Willingness of travel up to 50%.

6. Must have abilities to negotiate and implement plans and strategies with WVM and other partner agencies/organizations.

SKILLS NEEDED:

1. Management/Leadership

2. Verbal communication with staff, partners, government

3. Written communication including surveys and reports

4. Organizational skills

5. Staff training/development

6. Local government relations

7. Analytical, innovative and adaptable

8. Self-motivation

POSITION DESCRIPTION
HEALTH DEPARTMENT
WORLD VISION MOZAMBIQUE

Title: Administrative Assistant for Health

Reports to: Health/Nutrition Manager

Scope of Position: To administrate the Health and Nutrition Office to include; planning, staff support, purchasing, logistics, liaising and reporting.

Specific Objectives:

1. Receive, redirect and respond when appropriate to incoming communications from all H/N projects.

2. Provide assistance to Emergency Response Projects through purchasing of necessary supplies, and other staff support activities.

3. Manage the delivery of supplies from Quelimane to all H/N projects.

4. Assimilate statistics and assemble documents required in the preparation of all H/N reports.

5. Represent the H/N office in the absence of the Manager.

Knowledge/Skills/Abilities:

1. Must be a committed Christian with sensitivity to local culture and knowledgeable of the needs and context of rural population.

2. Requires completion of secondary school and at least some years of university education or equivalent training.

3. Must have previous experience in administration.

4. Must be fluent in oral and written Portuguese. Some knowledge of English is an advantage.

ANEXO 5: COMPOSICAO DAS EQUIPAS

Annex 5

WORLD VISION MOZAMBIQUE
TETE CHILD SURVIVAL PROGRAM
COMPOSITION OF THREE HEALTH TEAMS

CHANGARA TEAM
Vehicle MTA 11-14

RICARDO HAMILTON
Team Leader

1. Vaccinations with MOH
2. Growth Control/Monitoring Changara, Bunga, Cancune, Chiocompende‡ e Carata‡ Ntemangau
3. Health Committees-B 1-5
4. Community Facilitation
5. Supervisor-School Feeding Program
6. Supervisor-Therapeutic Feeding Program

Driver:
1. Joaquim Agostinho

Reis Simone
1. Therapeutic Feeding Program

Rui Chimica
1. Training Team
2. School Feeding Program

Joao Wassir
1. Growth Control/Monitoring

Anabela Joao
1. Growth Control/Monitoring

Auxiliaries
1. Assistance as necessary

MSSAWA TEAM
Vehicle MTA 11-13

BERNARDO CHILAMBULA
Team Leader

1. Vaccinations with MOH
2. Growth Control/Monitoring Missawa, Mpacassa‡ Matambo Cruzamento
3. Health Committees (2) Mssawa, Matambo, Mpacassa‡
4. Community Facilitation Mssawa, Matambo, Mpacassa‡
5. Supervisor-School Feeding Program
6. Supervisor-Therapeutic Feeding Program

Driver:
1. Sababo Wisque

Auxiliaries
1. 3 assistants in each area Missawa, Matambo and Mpacassa

BOROMA TEAM
Vehicle MTA 11-15

HORACIO JEMUSSE
Team Leader

1. Vaccinations with MOH
2. Growth Control/Monitoring Degue, Mufa, Boroma, Cassica Chiringa, Matambo Sede Matambo Bridge
3. Health Committees (3) Degue, Mufa e Boroma
4. Community Facilitation- Deg Degue, Mufa, Boroma, Cassica Chiringa
5. Supervisor-School Feeding Program
6. Supervisor-Therapeutic Feeding Program

Driver:
1. Jacinto Meneses

Auxiliaries :
1. 3 assistants in each area Degue, Mufa and Boroma

‡ Work depends on security situation

ANEXO 6: PLANO DE RONDAS

Annex 6

VISAO MUNDIAL MOCAMBIQUE - PSI TETE
1991-92 HORARIO DAS INTERVENCOES

EIA	10.90	11.90	12.90	1.91	2.91	3.91	4.91	5.91	6.91	7.91	8.91	9.91	10.91	11.91	12.91
OROMA											X	ATQUE		X	
UNGA	X				X			X		X				X	
ANCUNE		X				X		X		X	ATQUE		^MGRC	X	
ARATA		X										X		ATAQUE	
HANGARA	X				X			X		X	‡ATAQUE‡		X	X	
HIOCOMPENDE	X											X		ATAQUE	
EGUE									X	ATAQUE		X			X
ATAMBO BRIDGE									X				X		
ATAMBO CHACAL									X‡‡				X‡‡		
ATAMBO CRUZ	X			X			X		X				X		X
ATAMBO MUCHEN									X‡‡				X‡‡		X
ATAMBO NHANGA									X‡‡				X‡‡		
ATAMBTO SEDE	X			X			X			X			X		
UFA DESLOCADOS								ATQUE		X				X	
UFA NATURAL								ATQUE		X				X	
PACASSA						X				X	ATAQUE		X		ATQUE
SSAWA						X					X			X	
TEMANGAU											X			X	

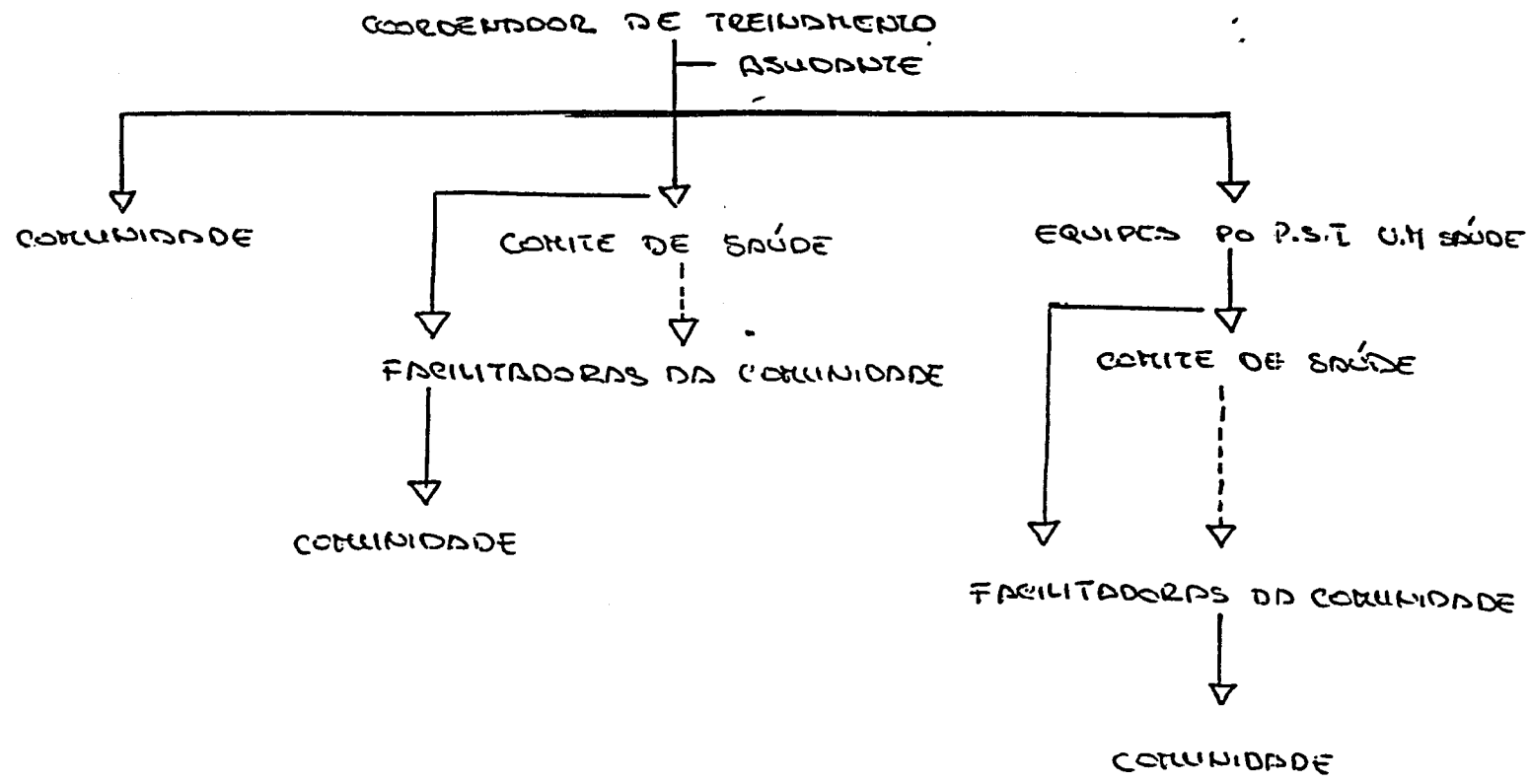
VISAO MUNDIAL MOCAMBIQUE - PSI TETE
1991-92 HORARIO DAS INTERVENCOES

MES / ALDEIA	1.92	2.92	3.92	4.92	5.92	6.92	7.92	8.92	9.92	10.92	11.92	12.92	1.93	2.93	3.93
BOROMA			X	X	ATQUE	X									
BUNGA		X		X	^MGRC	X									
CANCUNE		X		X	ATQUE	X	^MGRC								
CARATA		X		X	MINES	^MGRC									
CHANGARA	X		X		X		X								
CHIOCOMPENDE	^MGRC	X		X											
DEGUE			X			X									
MATAMBO BRIDGE		X				X	X								
MATAMBO CHACAC		X‡‡			X		X								
MATAMBO CRUZ		X		X		X									
MATAMBO MUCHEN		X‡‡		X			X								
MATAMBO NHANGA		X‡‡		X		X	X								
MATAMBTO SEDE		X		ATQUE		X	X								
MUFA DESLOCADOS	ATQUE		X			X									
MUFA NATURAL	ATQUE		X			X									
MPACASSA	ATQUE	X		X		X									
MSSANA	X		X		X		X								
NTEMANGAU		X			X										
TOTAL:	02	12	06	08	04	11	07								

‡2‡ ATAQUES ^MGRC: AUMENTO DA MIGRACAO MINE: LAND MINE. ‡‡FORMERLY INCORPORATED IN ANOTHER VILLAGE

ANEXO 7: TREINAMENTO

7.1 ORGANOGRAMA DA UNIDADE
CURRICULA
DIPLOMA
7.2 PLANO DE ENSINO PARA TREINADORES
7.3 PLANO DE TREINAMENTO PARA COMITE DE SAUDE
7.4 COMITE DE SAUDE EM FUNCIONAMENTO
7.5 PROGRAMA DE TREINAMENTO DE MALARIA PARA COMUNIDADE E INQUERITO


COORDENADOR DE TREINAMENTO
ASSISTENTE
COMUNIDADE
COMITE DE SAÚDE
EQUIPES DO P.S.T U.M SAÚDE
FACILITADORAS DA COMUNIDADE
COMITE DE SAÚDE
COMUNIDADE
FACILITADORAS DA COMUNIDADE
COMUNIDADE

Dr THELMA

CURRICULUM OF TRAINING SESSIONS GIVEN FROM THE 1ST LEVEL
UNTIL IT REACHES THE COMMUNITY LEVEL - CSP TETE

NURSING STAFF CSP TETE & ZAMBEZIA	AJUDANTES	HEALTH COMMITTEE	FACILITATORS	MOTHERS AT C.S.P ROUNDS	COMMUNITY
1.PRIMARY HEALTH CARE COMMUNITY BASED HEALTH CARE WORKSHIP. 2.SKILLS METHODOLOGY WORKSHOP 3.COMMUNICATION &TEACHING ADULTS WORKSHOP 4.PROGRAM PLANNING WORKSHOP 5.VISUAL AIDS WORKSHOP 6.VITAMIN A WORKSHOP 7.HOME VISITING PROGRAM 8.PROBLEM SOLVING WORKSHOP 9.DIARRHOEA METHODOLOGY TRAINING DAY 10.NUTRITION METHODOLOGY TRAINING DAY (14) 11.MALARIA METHODOLOGY TRAINING DAY 12.NUTRITION WORKSHOP TO C.S.P.STAFF ONLY 13 HIS (Jana) 14. BERNIE'S TECHNICAL TRAINING	1.DIARRHOCA METHODOLOGY TRAININGDAY 2.VACCINATION METHODOLOGY TRAINING DAY 3.NUTRITION METHODOLOGY 4.MALARIA METHODOLOGY TRAINING DAY 5.SKILLS METHODOLOG WORKSHOP ADAPTED TO ONLY INCLUDE a)DRAMA/MIME b)PUPPETS c)SONGS d)INDUCTIVE METHOD e)GAMES 6. HIS (Jana Weldo)	(a) 4.LESSONS TAKEN FROM THE COMMUNITY BASED HEALTH CARE C.B.H.C WORKSHOP 1.WHAT IS COMMUNITY BASED HEALTH CARE 2.WHAT IS A COMMUNITY HEALTH COMMITTEE 3.WHAT AND WHO ARE COMMUNITY HEALTH FACILITATORS 4.DISCOVERING PROBLEMS IN THE COMMUNITY MALARIA TRAINING PROGRAM	(1)1 LESSON TAKEN FROM C.B.H.C WORKSHOP - 1 2 DISCOVERING PROBLEMS IN THE COMMUNITY - 1 (3)DIARRHOEA TRAINING - 8 (4)VACCINATION-DISEASES TRAINING - 2 (5)MALARIA TRAINING - 1 (6)NUTRITION-TRAINING - 2 (7)PLUS ANY TOPIC EXPRESSED AS A FELT NEED FROM THE COMMUNITY NOT YET COVERED eg. _BILHAUZIA - 2 _NIGHT BLINDNESS - 1 _CONJUNCTWIAS-SKILLS - 1 (8)METHODOLOGY WORKSHOP - 12 ADAPTED TO INCLUDE TOPIC a.DRAMA/MIME b.PUPPETS c.SONGS. d.INDULTIVE METHOD E GAMES (h)HOME VISITING LESSON - 1 9. HIS - 5 (Jana Weldo)	(1)MOTHERS TRAINING (2)VACCINATION DISEASES TRAINING (3)DIARRHOEA TRAINING (4)MALARIA TRAINING (5)IMPORTANCE OF CONTINUED WEIGHING CHILD UNTIL 3YRS OF AGE (6)_THE GROWTH CARD CURVE INDICATES &CARE OF THE CARD	(1)ENRICHED PORRIDGE DEMONSTRATIONS (2)ORAL REHYDRATION THERRAPY (3)NEED TO TAKE THE CHILD FOR VACCINATION (4)MALARIA TRAINING (5)_IMPORTANCE OF VACCINATION

INTERVENTION: TRAINING	STRATEGY	RESPONSIBLE PART: O: R: D: J: F: M: A: M: J: J: A: S: O: N: D: J: F: M: A: M: J: J: A: S: O: N: D: J: F: M: A: M: J: J: A: S: O: N: D:	TOTAL:
Establish uniformity with the national policies of the MOH	Revise the training plan and policies		
Improve the coordination of training projects between UV and MOH	Involve the various sectors of MOH staff in the training program/project supervision		
Expand the existing library with portuguese book on primary health care	Increase the budget for educational/training material		
health assistants (CHW) responsible supervision of the facilitators	Include the supervision of the facilitators in the training of the health assistants		
lan to develop basic health be will meet the goals and support aining of health assistants	Integrate the plan for the development of AFE's with health assistants of UV		
he possibility fo creating a Center in the Province of Tete	Organize an apprenticeship for the Training Coordinator and the training team leaders in the Training Center of Zambezia		
INTERVENTION: GROWTH MONITORING/EPI		O: R: D: J: F: M: A: M: J: J: A: S: O: N: D: J: F: M: A: M: J: J: A: S: O: N: D: J: F: M: A: M: J: J: A: S: O: N: D:	
the community to create alternative nerating resources	Transform the health committees into community development committees to create cooperatives/other forms of income generation		
ordination of the activities of the ctween the MOH and UV	Plan in joint meeting the regular activities of the project		
the technical staff of the project ter vaccinations	Arrange the vaccines so that the technicians have access and can administer them		
ntegrate the mobile information system used y the MOH for organizing data	Implement mobile information filing system used by the MOH		
Revise and simplify the MIS with respect to this intervention	Determine the relevancy of the data and test this in a pilot village		
Reestablish distribution of food to the families with children at risk of malnutrition	Continue to coordinate with commodities and DPFCCH		
INTERVENTION: THERAPEUTIC FEEDING		O: R: D: J: F: M: A: M: J: J: A: S: O: N: D: J: F: M: A: M: J: J: A: S: O: N: D: J: F: M: A: M: J: J: A: S: O: N: D:	
levise the operations of the feeding center in Matambo Sede	Reanalyze the operationality of the project and and make changes as necessary		
onstruct additional accomodations for the herapeutic feeding center in Changara	Increase the budget to construction and organize and use the food for work system		
Develop a health screening system that assist all family members of the malnourished child	Initiate a system to examine all family members accompanying malnourished children		
Expand the school feeding project as feasible and possible	Examine with UV Commodities the possibility of expanding the project		
INTERVENTION: ORAL REHYDRATION THERAPY		O: R: D: J: F: M: A: M: J: J: A: S: O: N: D: J: F: M: A: M: J: J: A: S: O: N: D: J: F: M: A: M: J: J: A: S: O: N: D:	
Emphasis the positive practices of the community	Organize education seminar for mothers using the inductive method to teach about health		
Train the facilitators in the preparation and appropriate use of ORS	Intensify the training program of the facilitators in preparation/use of ORS		
Organize meeting with the community to teach them how to properly prepare enriched pepas	Select pilot villages for training seminars		
INTERVENTION: MALARIA		O: R: D: J: F: M: A: M: J: J: A: S: O: N: D: J: F: M: A: M: J: J: A: S: O: N: D: J: F: M: A: M: J: J: A: S: O: N: D:	
e the creation of a cooperative n to make mosquito nets or other es need by communities	Organize the community leaders with the facilitators: give a subsidy of materials to set up the cooperative(s)		
TION: ENVIRONMENTAL SANITATION		O: R: D: J: F: M: A: M: J: J: A: S: O: N: D: J: F: M: A: M: J: J: A: S: O: N: D: J: F: M: A: M: J: J: A: S: O: N: D:	
llagers to make latrine covers r goods: this will diversify the of community and improve survival	Assist with materials and training curriculum regarding construction methods of covers and direct training sessions		
OR: HEALTH INFORMATION SYSTEM		O: R: D: J: F: M: A: M: J: J: A: S: O: N: D: J: F: M: A: M: J: J: A: S: O: N: D: J: F: M: A: M: J: J: A: S: O: N: D:	
population census	Plan and implement a population census with the MOH		
Revise the MIS forms: simplify and adjust them as necessary for the project/MOH	Reanalize and simplify the MIS by intermatin and try to use the same categories as the MOH		
Use the data to generate the quality and quantity of service required beyond the immediate solutions for crisis situations	Expand the analysis of quantitative data to reflect the volume of services rendered by the project		
Establish a simplified system for analyzing data on the community level	Reanalysis the MIS and develop a system for presenting data to the community		

TREINAMENTO

SEMINÁRIOS

DATA	DESIGNAÇÃO	TÓPICO	DURAÇÃO	ORGANIZADOR	LOCAL
NOV. 1991	TREINAMENTO AOS AJUDANTES DO P.S.I TETE E DOIS REPRESENTANDO CHANGARA SOBRE METODOLOGIA DE ENSINO	DIFERENTES TIPOS DE ENSINO. 1- MÉTODO INDUTIVO 2-CARTAZES. 3-CANÇÃO 4-JOGOS TIPO QUEBRA CABEÇA. 5-FANTOCHES (NA BARREIRA E NA AUDIENCIA). 6-DRAMAS.	UM (1) DIA	CUPERTINO V.M. SAÚDE.	SALA DE REUNIÕES V.M. TETE.
ABRIL 1992	TREINAMENTO AS FACILITADORAS DO BAIRRO Nº2 (PILOTO) SOBRE METODOLOGIA DE ENSINO	DIFERENTES TIPOS DE ENSINO 1-METODO INDUTIVO 2-CARTAZES 3-CANÇÃO 4-JOGOS TIPO QUEBRA CABEÇA. 5-FANTOCHES (NA AUDIÊNCIA E NA BARREIRA). 6-DRAMAS.	DOIS (2) DIAS	CUPERTINO	ACAMPAMENTO DA V.M SAÚDE CHANGARA
ABRIL 1992	TREINO AOS LÍDERES DO P.S.I E SEIS AJUDANTES SOBRE DIARREIA	DIFERENTES TIPOS DE ENSINO 1-DRAMAS 2-CANÇÃO 3-FANTOCHES 4-CARTAZES 5-MÉTODO INDUTIVO.	DOIS (2) DIAS	CUPERTINO V.M. SAÚDE	SALA DE REUNIÕES V.M. TETE
JUNHO 1992	TREINO AOS LÍDERES DO P.S.I. E SEUS AJUDANTES SOBRE MALÁRIA	DIFERENTES TIPOS DE ENSINO. 1-DRAMA 2-CANÇÃO 3-FANTOCHES 4	UM (1) DIA	CUPERTINO V.M. SAÚDE	SALA DE REUNIÕES V.M. TETE

TREINAMENTO

SEMINÁRIOS E COMITÊS DE SAÚDE

----/CONTINUAÇÃO

DATA	DESIGNAÇÃO	TÓPICO	DURAÇÃO	ORGANIZADOR	LOCAL
JULHO 1992	TREINAMENTO AOS LIDERES DO P.S.T. E SEUS ASSIDANTES SOBRE VACINAÇÕES	DIFERENTES TIPOS DE CASINO 1-DRAMAS 2-CANÇÕES 3-FANTOCHES 4-CARTAZES 5-METODO INDUTIVO.	UM (1) DIA	JOSÉ CUPERTINO V.M. SAÚDE	SALA DE REUNIÕES V.M. TETE
OUT. 1990.	FORMAÇÃO DO COMITÊ DE SAÚDE EM CHANGARA SEDE BAIRRO Nº 2 (PILOTO). —u— OBS- O BAIRRO Nº2 TEM: 6-QUARTEIRÕES 30-CHEFES DE 10 CASAS 309-FAMILIAS 2.189-HABITANTES.	REUNIÃO DE INTRODUÇÃO. -CONCEITO DO COMITÊ DE SAÚDE. -CUIDADOS PRIMÁRIOS DE SAÚDE. -O QUE É UM FACILITADOR DA COMUNIDADE. -COMO RESOLVER PROBLEMAS NA COMUNIDADE.	DUAS(2) SEMANAS	VIVIAN WILSON E JOSÉ CUPERTINO V.M. SAÚDE	CHANGARA SEDE BAIRRO Nº2 POR BAIXO DUMA ARVORE. (PILOTO)
SET. 1990	FORMAÇÃO DO COMITÊ DE SAÚDE EM CHANGARA SEDE BAIRRO Nº 3 —u— OBS- O BAIRRO Nº3 TEM: 5-QUARTEIRÕES 30-CHEFES DE 10 CASAS. 496-FAMILIAS 1.985-HABITANTES.	REUNIÃO DE INTRODUÇÃO. -CONCEITO DO COMITÊ DE SAÚDE -CUIDADOS PRIMÁRIOS DE SAÚDE. -O QUE É UM FACILITADOR DA COMUNIDADE. -COMO RESOLVER PROBLEMAS NA COMUNIDADE	DUAS(2) SEMANAS	VIVIAN WILSON E BERNARDO CHILAMBULA	CHANGARA SEDE BAIRRO Nº 3 POR BAIXO DUMA ARVORE

OBSERVAÇÕES:

O BAIRRO Nº 2 (PILOTO) POSSUI NESTE MOMENTO 16 FACILITADORAS DA COMUNIDADE JÁ APRESENTADAS NA COMUNIDADE; CADA UMA RESPONDE POR 20 FAMILIAS HAVENDO ALGUMAS QUE RESPONDEM POR MAIS.

O BAIRRO Nº 3 PASSOU A SER LIDERADO POR JOSÉ CUPERTINO, TEM NESTE MOMENTO 17 FACILITADORAS.

SMA: ISTA ICIAS D

TREINAMENTO

SEMINÁRIOS E COMITÊS DE SAÚDE

----/CONTINUAÇÃO

DATA	DESIGNAÇÃO	TÓPICO	DURAÇÃO	ORGANIZADOR	LOCAL
JULHO 1992	TREINAMENTO AOS LÍDERES DO P.S.I. E SEUS ASSOCIADOS SOBRE VACINAÇÃO	DIFERENTES TIPOS DE ENSINO 1-DRAMAS 2-CONCÊTOS 3-TANTOFONES 4-CARTAZES 5-MÉTODO INDUTIVO.	UM (1) DIA	JOSÉ CUPERTINO V.M. SAÚDE	SALA DE REUNIÕES V.M. TEE
OUT. 1990.	FORMAÇÃO DO COMITÊ DE SAÚDE EM CHANGARA SEDE BAIRRO Nº 2 (PILOTO). —u— OBS. O BAIRRO Nº 2 TEM: 6-QUARTEIRÕES 30-CHEFES DE 10 CASAS 509-FAMÍLIAS 2.189-HABITANTES.	REUNIÃO DE INTRODUÇÃO. -CONCEITO DO COMITÊ DE SAÚDE. -CUIDADOS PRIMÁRIOS DE SAÚDE. -O QUE É UM FACILITADOR DA COMUNIDADE. -COMO RESOLVER PROBLEMAS NA COMUNIDADE.	DUAS(2) SEMANAS	VIVIAN WILSON E JOSÉ CUPERTINO V.M. SAÚDE	CHANGARA SEDE BAIRRO Nº 2 POR BAIXO DUMA ARVORE. (PILOTO)
SET. 1990	FORMAÇÃO DO COMITÊ DE SAÚDE EM CHANGARA SEDE BAIRRO Nº 3 —u— OBS. O BAIRRO Nº 3 TEM: 5-QUARTEIRÕES 30-CHEFES DE 10 CASAS. 496-FAMÍLIAS 1.985-HABITANTES.	REUNIÃO DE INTRODUÇÃO. -CONCEITO DO COMITÊ DE SAÚDE -CUIDADOS PRIMÁRIOS DE SAÚDE. -O QUE É UM FACILITADOR DA COMUNIDADE. -COMO RESOLVER PROBLEMAS NA COMUNIDADE	DUAS(2) SEMANAS	VIVIAN WILSON E BERNARDO CHILAMBULA	CHANGARA SEDE BAIRRO Nº 3 POR BAIXO DUMA ARVORE

OBSERVAÇÕES:

O BAIRRO Nº 2 (PILOTO) POSSUÍ NESTE MOMENTO 16 FACILITADORAS DA COMUNIDADE 5 DAS PRESENTIDAS NA COMUNIDADE; CADA UMA RESPONDE POR 20 FAMÍLIAS HAVENDO ALGUMAS QUE RESPONDEM POR MAIS.

O BAIRRO Nº 3 PASSOU A SER LIDERADO POR JOSÉ CUPERTINO, TEM APE

TREINAMENTO

SESSÕES DE ENSINO

DATA	DESIGNAÇÃO	TÓPICO	DURAÇÃO	Nº DE SESSÕES	LOCAL
	SESSÃO DE ENSINO AS FACILITADORAS DO BAIRRO Nº2 (PILOTO)	ESTUDO DA TEORIA DO SUMÁRIO TEÓRICO DA FACILITADOR DA COMUNIDADE	1 HR.	DUAS (2)	DEPARTAMENTO DA V.M. SAÚDE CRIANÇA DE SEDE
	SESSÃO DE ENSINO AS FACILITADORAS DO BAIRRO Nº2 (PILOTO)	ESTUDO DA TEORIA DO SUMÁRIO DO TREINAMENTO DAS FACILITADORAS DA COMUNIDADE.	1 HR.	DUAS (2)	DEPARTAMENTO DA V.M. SAÚDE CRIANÇA DE SEDE.
	SESSÃO DE ENSINO AS FACILITADORAS DO BAIRRO Nº2 PILOTO	ESTUDO DO MANUAL DE APOIO ÀS VISITAS DOMICILIÁRIAS.	1 HR	TRÊS (3)	DEPARTAMENTO DA V.M. SAÚDE CRIANÇA
	SESSÃO DE ENSINO AS FACILITADORAS DO BAIRRO Nº2 (PILOTO)	MANUÁRIO • TRANSMISSÃO • CAUSA • PREVENÇÃO • TRATAMENTO	1 HR	DUAS (2)	DEPARTAMENTO DA V.M. SAÚDE. CRIANÇA
	SESSÕES DE ENSINO DO BAIRRO Nº3	TODOS TÓPICOS DADOS DO BAIRRO Nº2 (PILOTO)	AS HORAS POR SESSÃO	AS REALIZADAS DO BAIRRO Nº2 C/DIFERENÇA DE DIAS.	DEPARTAMENTO, MAS DEVERIA SER BAIXADA PRIORIDADE E NO CENTRO NUTRICIONAL
	SESSÕES DE ENSINO NO CENTRO NUTRICIONAL AS MÃES PRIORIDADES	- PERDAS INFREQUENTES. - IMPORTÂNCIA DOS QUATRO GRUPOS NO NOSSO ORGANISMO. - IMPORTÂNCIA [illegible] LOA.	1 HR.	DUAS SESSÕES DE CADA TEMA X POR SEMANA.	CENTRO NUTRICIONAL.

TREINAMENTO

SESSÕES DE ENSINO

DATA	DESIGNAÇÃO	TÓPICO	DURAÇÃO	Nº DE SESSÕES	LOCAL
	SESSÃO DE ENSINO AS FACILITADORAS DO BAIRRO Nº 2 (PILOTO)	PREPARAÇÃO DA SOLUÇÃO ORAL NA BASE DE ARROZ SAL E ÁGUA.	1 HR.	DUAS (2)	CHANGARA SEDE BAIRRO Nº2 DEBAIXO DUMA ARVORE
	SESSÃO DE ENSINO AS FACILITADORAS DO BAIRRO Nº 2 (PILOTO)	- DIARREIA. • TRANSMISSÃO • CAUSAS • PREVENÇÃO • TRATAMENTO	1 HR.	QUATRO (4)	CHANGARA SEDE DE ACONTECIMENTO DE ÁGUA V.H E NA MATA.
	SESSÃO DE ENSINO AS FACILITADORAS DO BAIRRO Nº 2 (PILOTO)	PREPARAÇÃO DA SOLUÇÃO ORAL NA BASE DE CEREAIS. (FARINHA DE MILHO, FARINHA DE MANDIOCA E ARROZ).	1 HR	DUAS (2)	CENTRO NUTRICIONAL DE CHANGARA
	SESSÃO DE ENSINO AS FACILITADORAS DO BAIRRO Nº 2 (PILOTO)	PREPARAÇÃO DE ALGAS ENRIQUECIDAS (FARINHA DE MILHO MISTURADA COM FARINHA DE PEIXE UTILIZANDO LINHA OU PEIXE MOIDO).	1.30 HR	DUAS (2)	CHANGARA SEDE DEBAIXO DUMA ARVORE E NA ASSISTÊNCIA.
	SESSÃO DE ENSINO AS FACILITADORAS DO BAIRRO Nº2 PILOTO	- INTRODUÇÃO SOBRE VISITAS DOMICILIÁRIAS	30 MIN	UMA (1)	ACAMPAMENTO DA V.H. CHANGARA

DIPLOMA

TREINAMENTO DE SAÚDE

CERTIFICO QUE André Alberto ..... CONCLUIU COM SUCESSOS O SEMINÁRIO SOBRE :

- CUIDADOS PRIMÁRIOS DE SAÚDE
- CUIDADOS DE SAÚDE BASEADOS NA COMUNIDADE
- METODOLOGIA DO TREINAMENTO
4 - COMUNICAÇÃO
5 - PLANIFICAÇÃO
6 - DESENHO
7 - VITAMINA A
8 - PROGRAMA DE VISITAS DOMICILIÁRIAS

ORGANIZADO E DIRIGIDO PELA VISÃO MUNDIAL NO CORRENTE ANO
E POR SER VERDADE ASSINO E AUTENTICO COM O CARIMBO EM USO NESTA DIRECÇÃO

QUELIMANE 01 DE Novembro DE 1991

A RESPONSÁVEL DE TREINAMENTO

WORLD VISION INTERNATIONAL

EXEMPLAR DO PROTOCOLO DO MANUAL DE ENSINO
PARA TREINADORES

TOPICO E METODOLOGIA:

TEMPO:

PROPOSITO:

Até ao fim de: _____

Será capaz de:

Através de: _____

CONDUTA DE ACTIVIDADES:

FASE I:

FASE II:

FASE III: _____

MATERIAL NECESSÁRIO: _____

PÁGINA DE AVALIAÇÃO

1. TÚPICO E METODOLOGIA _____ RONDA _____

Data: _____

Sítio: _____

QUE ACONTECEU? (AVALIAÇÃ): _____

_____

_____

_____

_____

Data: _____

Sítio: _____

QUE ACONTECEU (AVALIAÇÃO): _____

_____

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_____

_____

_____

Data: _____

Sítio: _____

QUE ACONTECEU (AVALIAÇÃO): _____

_____

_____

_____

_____

_____

2ª SESSÃO DO COMITÉ DE SAÚDE

TÓPICO: METODOLOGIA: IMPORTÂNCIA DOS CUIDADOS SANITÁRIOS NA COMUNIDADE; DEMONSTRANDO TRÊS CARTAZES: DE DOIS CAMINHOS E EM TRIÂNGULO

TEMPO: 90 min.

PROPÓSITO:

ATÉ AO FIM DA 2ª SESSÃO, O LÍDER DE P.S. EM BOROMA SERÁ CAPAZ DE EFECTUAR ENSINO SOBRE IMPORTÂNCIA DE ALGUNS MEIOS DE SAÚDE NAS CASAS AOS MEMBROS DO COMITÉ, ATRAVÉS CARTAZES

FASE: DIVIR GRUPO EM (2) DOIS, QUE CADA GRUPINHO LEVA UM CARTAZ DE DIFERENTES CAMINHOS PARA SAÚDE

FASE: CADA GRUPO DESCUTE SOBRE ESSES CAMINHOS VER QUAL É BOM É MAU PARA SAÚDE

FASE: OS DOIS GRUPINHOS JUNTAM-SE E CADA MOSTRA O CARTAZ AO OUTRO E EXPLICAR

FASE: O LÍDER SUMARIZA: É MELHOR QUANDO AS PESSOAS FAZEM A SAÚDE EM CASA.

FASE: MOSTRAR O CARTAZ EM TRIÂNGULO E EXPLICAR — POUCOS NA CIDADE E MUITOS NO CAMPO. ONDE SE GASTA MAIS DINHEIRO DA SAÚDE? PORQUE É MAIS NA CIDADE? ISTO É BOM PARA PESSOAS NO CAMPO? QUE PODEM FAZER PARA NOS AJUDAR NO CAMPO? É MELHOR PREVENÇÃO OU CURAR?

FASE: EXPLICAR QUE NO FUTURO HAVERÁ ORGANIZAÇÃO DE UM GRUPO DAS MÃES E HOMENS PARA ENSINAR OUTRAS MÃES FAZER CUIDADOS DE SAÚDE EM CASA, COM NOME FACILITADORES

VII. FASE: ESCOLHA DO PROXIMO DIA PARA REUNIÃO

PESP HORÁCIO GENUSSE ZACARIAS

TESTEMUNHO 16/12/91

AVALIAÇÃO DA 2ª SESSÃO

TÓPICO: METODOLOGIA: IMPORTÂNCIA DOS CUIDADOS DE SAÚDE NA COMUNIDADE

DATA: 16/11/91

SITIO MUFA DESLOCADOS

O QUE ACONTECEU?

OS PARTICIPANTES, DEPOIS DE TEREM VISTO E DESCOTIDO OS CARTAZES QUE DEMONSTRAVAM A DIFICULDADE PARA SOCORRER UMA COMUNIDADE QUE SE ENCONTRAVA LONGE DO CENTRO DE SAÚDE QUE A AMBULÂNCIA AVARIOU NO MEIO DO CAMINHO (DA CIDADE AO CAMPO), VISTO, ELES CONCLUIRAM QUE É NECESSÁRIO A COMUNIDADE POSSUIR FACILITADORES PARA ENSINAR A POPULAÇÃO RESOLVER ALGUNS PROBLEMAS SANITÁRIOS EM CASA.

RESP. HORÁCIO GENUSSE ZACARIAS

TETE, AOS 16/12/91

P. 5.

TÓPICO E METODOLOGIA: DEHidratação com diarreia; demonstração pratica com um boneco feito de plástico fino (em saco)

Tempo: 30 MINUTOS

Propósito: Até ao fim da sessão as mães serão capazes de ver um boneco feito em plástico a demonstrar uma criança desidratada, atr de um furo no plástico.

Conduta de actividade

FASE I: Organização do grupo

FASE II: Mostrar o boneco feito de plástico e, enchê-lo d' água para ilustrar uma criança a beber líq

FASE III: Faz-se um furo com um alfinete no bonec e, a água sai através do furo. Explicar que aconteceu com o plástico depois d perder a água.

FASE IV: Repetir a operação até as mães interi rem a necessidade dos liquidos nos nosso organismos.

FASE V: Método indutivo

MATERIAL: - Um boneco feito em plástico fino
- Água
- Alfinete

Tópico e Metodologia: Desidratação com diarreia; demonstração prática com um boneco feito de plástico (fino).

Data:

Sítio:

Que aconteceu? 3 mães experimentaram a operação. Em seguida puderam ver o plástico cheio de rugas e disseram que aquelas rugas eram o resultado da falta de água no boneco. Deu-se também o exemplo de um pepino.

Bernardo Chilambula

101

TÓPICO: TREINAMENTO ÀS FACILITADORAS SOBRE PAPAS SIMPLES E RICAS

METODOLOGIA: DEMONSTRAÇÃO DE CARTAZES, EXPLICAÇÃO E PRÁTICA DE PREPARAÇÃO DE PAPAS RICAS.

TEMPO: 2 HORAS

PROPÓSITO: ATÉ AO FIM DA SESSÃO AS FACILITADORAS SERÃO PAZES DE PRATICAR E RESPONDER CORRECTAMENTE TODAS AS PERGUNTAS SOBRE AS PAPAS RICAS, ATRAVÉS DA DEMONSTRAÇÃO DE CARTAZES E PRÁTICA DE PREPARAÇÃO DAS TRÊS TIPOS DE PAPAS.

FASE 1 — MOSTRAR AO GRUPO AS FIGURAS SOBRE PAPAS, SIMPLES E RICAS UTILIZANDO FICHAS DAS VISITAS DOMICILIÁRIAS.

FASE 2 — USAR O MANUAL DA MISAU SEM LETRAS

FASE 3 — TRÊS FACILITADORAS DEVEM PRATICAR O PREENCHIMENTO DAS PRIMEIRAS TRÊS COLUNAS DAS FICHAS COM SÍMBOLOS. (JOSÉ TEMO DEVE CONTINUAR COM ESTE TRABALHO DURANTE A PRÓXIMA SEMANA JUNTO COM FACILITADORAS PASSANDO NA CASAS.)

FASE 4 — DISTRIBUIR O MANUAL DE NUTRIÇÃO A CADA FACILITADORA E EXPLICAR

FASE 5 — ENSINAR AS QUANTIDADES DE PRODUTOS PARA PAPAS

FASE 6 — PRÁTICA DE PREPARAÇÃO DAS TRÊS TIPOS DE PAPAS. FACILITADORAS DEVEM AJUDAR NA PREPARAÇÃO. ANISSE E ANDRÉ DEVEM PERGUNTAR SEMPRE ÀS FACILITADORAS SOBRE AS QUANTIDADE DA FARINHA E OUTROS PRODUTOS.

MATERIAL

- MANUAL DA MISAU SEM LETRAS SOBRE COMIDA DE ACTIVIDADE DA CRIANÇA
- MANUAL DE NUTRIÇÃO
- FICHAS DAS VISITAS DOMICILIÁRIAS
- FARINHA DE MILHO, ARROZ, MANDIOCA E DE FEIJÃO
- AÇÚCAR — 1 Kg
- SAL — 0,5 "
- COCO — 3 (LEITE DE COCO)
- OLEO — 1 L

CA

TÓPICO: TREINAMENTO ÀS FACILITADORAS SOBRE PAPAS SIMPLES E RICAS.

METODOLOGIA: DEMONSTRAÇÃO DE CARTAZES, EXPLICAÇÃO E PRÁTICA DE PREPARAÇÃO DE PAPAS RICAS.

DATA: 7 DE AGOSTO DE 1992

SÍTIO: NUNHACUA

QUE ACONTECEU? (AVALIAÇÃO)...

O GRUPO RESPONDEU CORRETAMENTE AS PERGUNTAS SOBRE AS FIGURAS DAS TRÊS COLUNAS DE FICHAS DAS VISITAS DOMICILIARES JUNTO COM MANUAL DA MISHU SEM LETRA SOBRE COMIDA DE ACTIVIDADE DA CRIANÇA.

O GRUPO NÃO TEVE PROBLEMAS RELACIONADOS COM IDADE CRIANÇA PORQUE FOI FÁCIL DISTINGUIR ATRAVÉS DOS GESTOS NAS FIGURAS.

O GRUPO PRATICOU O PREENCHIMENTO DAS PRIMEIRAS COLUNAS DAS FICHAS DAS VISITAS DOMICILIÁRIAS E SIMBOLOS, MAS APRESENTA MUITAS DIFICULDADES, PORQUE PREENCHE MUITO DEVAGAR SOBRE A QUANTIDADE DE ÁGUA ELAS PODEM USAR A MESMA QUANTIDADE QUE UTILIZAM QUANDO PREPARAM PAPAS EM CASA.

FALTARAM DUAS FACILITADORAS POR MOTIVO DE DOENÇA: { FLORINDA E RORONO

ZONA "C" ESCOLHEU UMA SENHORA DE NOME ANA CONSTANTINA PARA SER FACILITADORA E APRESENTOU SR. TOMAS PEREIRA PARA O MEMBRO DO COMITÉ DE SAÚDE.

Aurélio Gonçalves

ORGANIZAÇÃO E TREINAMENTO DE COMITÊS DE SAÚDE

7-3

MENBRO DO DE SAODE ATRAVES	TAREFA DA COMUNIDADE	PERIODO A COMPLETAR	COMO O COMITE DE SAODE REALIZAA AVALIAÇÃO	TAREFAS FORAM REALIZADAS OU NÃO

...OU ...MITE DE SAÚDE ATRAVES DE... FASE I	PROBLEMA DE TAREFA DA COMUNIDADE	MARCADO EM PERIODO A COMPLETAR	MUFA — DESCOBERTA COMO O COMITÉ DE SAÚDE REALIZAA AVALIAÇÃO	TAMBÉM FORAM REALIZADAS OU NÃO — Genuse Health Committee Tasks
...U GAMA LAZINHO AND INA FOMBE ...NTE GEMUCE ...ULANE PAUL LIA LOLE. CONSTRUIR ...INAS NAS CASAS	—	FIM DE AGOSTO 92	GEMUSSE 15 VISITAR AS CASAS JUNTAR COMITÉ DE SAÚDE FIM DE AGOSTO 92	FORAM FEITAS LATRINAS NAS CASAS DOS MEMBROS DO COMITÉ DE SAÚDE
	FASE-2: 15 PESSOAS IRÃO CONSTRUIR LATRINAS NAS CASAS DELAS	FIM DE SETEMBRO, 92	E FIM DE SETEMBRO 92	
...RMEIRO — MARIO ...AYA VAIENSI NO POSTO DE DE UMA VEZ POR ...NANA — NAS 4ª ...RAS À TARDE: CORRECTO DAS ...INAS, HIGIENE ...NTE, DO UTEN ...O DA COPA E DO AMBIENTE	OUVIR E APRENDER NO POSTO DE SAÚDE DE MUFA	ATÉ JUNHO, 92	ESCOLHA DE UM DIA, O COMITÉ DE SAÚDE IRÁ AVALIAR O ENSINO DO ELEMENTO DA SAÚDE QUARTA-FEIRA À TARDE — DIA 26.08.92	FEZ SESSÕES ATÉ, BAIRRO 1 a 7 FALTA BAIRROS
LITADORES ...ÃO ...MADAS MÃES SO ...ORS. EN CERE- • FASE I GENUSSE ...SINAR OS FACI- ...DORES. FASE II FA- ...TADORES DARÃO ...INO AS MÃES EN ...FE DE 10 CASAS	— APRENDER	FASE I — MAIO, 92 FASE II — SETEMBRO, 92	FASE I GENUSSE JÁ FEZ E OBSERVADO POR MANUEL FASE II — ESCOLHA DUM DIA COMITÉ DE SAÚDE VISITAR ENSINO EN SETEMBRO JUNTO COM GENUSSE DATA 10/09/92 INI-	FOI REALIZADO ENSINO

DE SAODE ATRAVES FASE I			REALIZAA AVALIAÇÃO	REALIZADAS OU NÃO
7.-JOÃO A REUNIÃO BAIRRO A BAIR SOBRE HIGIE DO MEIO AMBIENTE E UTENLIOS DE COPA	PARTICIPAÇÃO NA REUNIÃO. DEPOIS EFEZTUAR LIMPEZAS DO MEIO AMBIENTE, ATERROS SANITÁRIOS E LIMPEZA DOS UTENSILIOS DA COPA	ATÉ AGOSTO, 92 BAIRRO 1 B " 2 B " 3 B " 4	O COMITÉ DE SAÚ DE VISITARÃO DUAS REUNIÕES, UMA EM CADA BAIRRO E POSTERIORIMENTE EM 10 CASAS	FORAM REALIZADAS EM JULHO, 92 NOS 2 BAIRROS, ATRAVÉS DO SECRETÁRIO DA O.M. E EU VISITEI DUAS CASAS DE UM BAIRRO

ANNEX 7.7

VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANTIL
COMITES DE SAUDE EM FUNCIONAMENTO
DISTRITO DE CHANGARA

ATA DA ORMACAO	ZONA	COMPOSICAO DO COMITE DE SAUDE	FACILITAD. ESCOLHIDOS	OBSERVACOES
7/10/90	CHANGARA SEDE BAIRRO Nº 2 (PILOTO)	1-SECRETÁRIO DO BAIRRO. 2-REPRESENTANTE DE SAÚDE 3- —— " —— DE EDUCAÇÃO 4- —— " —— RELIGIOSO 5- —— " —— DA ÁGUA RURAL 6- RESPONSÁVEL DA O.M.M. 7- LÍDER DA EQUIPE DE TREINAMENTO TCTE 8-	QUINZE (15) + UM (1) TOTAL – 16	O BAIRRO Nº 2 TEM: 6-QUARTEIRÕES 30-CHEFES DE 10 CASAS 509-FAMÍLIAS – 2.189-HABITANTES.
1990	CHANGARA SEDE BAIRRO Nº 3	1-SECRETÁRIO DO BAIRRO 2-REPRESENTANTE DE SAÚDE 3- —— " —— DE EDUCAÇÃO 4- —— " —— RELIGIOSO 5- —— " —— DA ÁGUA RURAL 6- RESPONSÁVEL DA O.M.M. 7- LÍDER DA EQUIPE DE [illegible] 8-	[illegible] (9) + CINCO (5) TOTAL – 17	4-QUARTEIRÕES BAIRRO 1 20-CHEFE DE 10 CASAS 489-Nº TOTAL DE FAMÍLIAS 1.506-Nº DE HABITANTES
10.03.91 à 14.02.92	CHANGARA SEDE BAIRRO Nº 1	1-SECRETÁRIO DO BAIRRO, 2-REPRESENTANTE DE SAÚDE 3- —— " —— DE EDUCAÇÃO 4- —— " —— RELIGIOSO 5- —— " —— DA ÁGUA RURAL 6-RESPONSÁVEL DA O.M.M. 7-LÍDER DA EQUIPE DO P.S.I (CHANGARA). 8-	DOUZE (12)	5-QUARTEIRÕES BAIRRO 3 30-CHEFE DE 10 CASAS 496-Nº TOTAL DE FAMÍLIAS 1983-Nº TOTAL DE HABITANTES
22.11.91 à 13.12.91	MUFA DESLOCADOS (PILOTO)	1-SECRETÁRIO DO BAIRRO 2-REPRESENTANTE DE SAÚDE 3- —— " —— DE EDUCAÇÃO 4- —— " —— RELIGIOSO 5- —— " —— DA ÁGUA RURAL 6-RESPONSÁVEL DA O.M.M. 7- —— " —— DA O.M.M. 8-LÍDER DA EQUIPE DO P.S.I (BOLICHIA).	QUINZE (15)	4 BAIRROS 20 CHEFES DE 10 CASAS 537 FAMÍLIAS 2131 HABITANTES

VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANTIL
COMITES DE SAUDE EM FUNCIONAMENTO
DISTRITO DE CHANGARA

DATA DA FORMACAO	ZONA	COMPOSICAO DO COMITE DE SAUDE	FACILITAD. ESCOLHIDOS	OBSERVACOES
13.06.92 á 18.07.92	MSSAWA BAIRRO Nº 4 (PILOTO)	1-SECRETÁRIO DO BAIRRO 2-REPRESENTANTE DE SAÚDE 3- —— " —— DE EDUCAÇÃO 4- —— " —— RELIGIOSO 5-RESPONSAVEL DA O.M.M. 6- —— " —— DA O.J.M. 7-ELEMENTO SIMPLES DA COMUNIDADE (DETIUC) 8-LÍDER DA EQUIPE DO P.S.I. (MSSAWA).	DEZASETE (17)	BAIRRO Nº 4 TEM: — QUARTEIRÕES 9 CHEFES DE 10 CASAS 98 - FAMILIAS
		1 2 3 4 5 6 7 8		
		1 2 3 4 5 6 7 8		
		1 2 3 4 5 6 7 8		

G A DE SOBREV VIVENCIA E DE
DAS VISITAS DOMICILIARIAS E TREINAMENTO

DEIA: Changaa Sede BAIRRO: Nº 2 PERIODO DO RELATORIO: 23.8.91 a 19.3.92

NO DE ORDEM	VISITAS DOMICILIARIAS	CRIANCAS < 1 ANO	CRIANCAS 1-3 ANOS	TREINAMENTO	NO. DE SESSOES	NO. DAS PESSOAS
01	PAPAS SIMPLES	42	47	NUTRICAO	3	31
02	PAPAS RICAS	—	3	DIARREIA	5	52
03	ALIMENTOS CONSISTENTES	2	34	VACINACOES		
04	TEM LATRINAS	34	25	MALARIA		
05	TEM DIARREIA	18	12	OUTROS		
06	MUITOS LIQUIDOS	15	3			
07	SRO NA BASE DE ACUCAR SAL E AGUA	11	8			
08	SRO NA BASE DE CEREAIS	6	3			
09	VACINADAS	32	20			
10	TEM MALÁRIA	13	8			

OBSERVACOES:

Estes dados foram colhidos na primeira fase desde lugo os valores obtidos merecem muita atenção

OBSERVACOES:

Foram treinadas em média durante este período 83 mães.

N.B. Nos estão registados os dados de vacinações e malária enquanto as facilitadoras tinham registado nas suas fichas, merecem muito estudo dado que até estão continuando-se treinando as mesmas intervenções.

VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANTIL
SUMARIO DAS VISITAS DOMICILIARIAS E TREINAMENTO

April 92 - June 92

ALDEIA: Changara Sede BAIRRO: Nº 2 PERIODO DO RELATORIO: 19.3.92 A 19.6.92

NO DE ORDEM	VISITAS DOMICILIARIAS	CRIANCAS < 1 ANO	CRIANCAS 1-3 ANOS	TREINAMENTO	NO. DE SESSOES	NO. DAS PESSOAS
01	PAPAS SIMPLES	14	15	NUTRICAO	8	64
02	PAPAS RICAS	3	14	DIARREIA	12	104
03	ALIMENTOS CONSISTENTES	4	9	VACINACOES		
04	TEM LATRINAS	15	15	MALARIA		
05	TEM DIARREIA	7	22	OUTROS		
06	MUITOS LIQUIDOS	4	—			
07	SRO NA BASE DE ACUCAR SAL E AGUA	2	13			
08	SRO NA BASE DE CEREAIS	1	6			
09	VACINADAS	11	7			
10	TEM MALARIA	4	—			

OBSERVACOES:
DADOS COLHIDOS DEPOIS DE NUMEROSAS DESCÇÕES DE ENSINO COM AS FACILITADORAS REALIZADAS SATISFATÓRIOS.

OBSERVACOES:
FORAM TREINADAS EM MÉDIA DURANTE ESTE PERÍODO 168 MÃES.
É DE NOTAR QUE NÃO ESTÃO REGISTADAS AS MÃES TREINADAS SOBRE MALÁRIA E VACINAÇÃO PORQUE DEVE A DATA CONTINUA-SE A ENSINAR AS FACILITADORAS NESTAS INTERVENÇÕES.

PROGRAMA DE MALÁRIA:

A ser dado à população antes de receber a rede mosquiteira. Primeiro para ir através do comité da saúde e facilitadoras. Eles receberão em primeiro lugar para experimentar com eles. Em seguida explicações teriam lugar bairro por bairro ou zona por zona ou por cada chefe de 10 casas.

As explicações deverão decorrer como segue:

1 - Até ao fim da sessão os grupos serão capazes de ver e responder às perguntas sobre as causas, sinais, prevenção e tratamento da malária através de dramas, fantoches e uma canção.

2 - Serão capazes de comentar se querem mosquiteiro para a sua comunidade ao preço de 500,00Mt; através da escolha de 3 elementos da comunidade responsáveis pela gestão dos fundos.

3 - Serão capazes de escolher em que gostariam de utilizar o dinheiro em relação às campanhas de limpeza contra mosquitos utilizando catanas, pás ou à sua sugestão.

TEMPO = 1 HORA

MATERIAIS

1. PRÓPRIOS PARA DRAMA OU DEMONSTRAÇÃO DE FANTOCHES:
2. CARTAZES COM DIFERENTES TIPOS DE MOSQUITOS
3. CARTAZ DOS SINAIS DE MALÁRIA
4. CARTAZ DE ANÁLISE DE SANGUE
5. CARTAZ DO CICLO DE VIDA DO MOSQUITO
6. CARTAZ DE MÉTODOS PREVENTIVOS PARA ACABAR COM LARVAS E OVOS
7. CARTAZ DE PREVENÇÃO DE PICADELAS DE MOSQUITOS
8. CARTAZ DE TRATAMENTO COM MEDICAMENTOS DEPOIS DA PICADELA
9. CANÇÃO DE MALÁRIA

CAUSA E SINAIS:

1. Mostrar através de um drama ou fantoche exibindo uma pessoa a ser picada por e a seguir os sinais que ocorrem.

2. Mostrar por cartazes a diferença entre o anófeles e o mosquito normal.

SINAIS:

1. Reforçada pela demonstração da cartaz da malária em que um homem tem malária.

2. Mostrar cartaz de análise de sangue para mostrar sinal positivo.

PREVENÇÃO:

1. Perguntar " onde é que vivem desde o início do ciclo de vida até ao fim?"

2. Mostrar postal do ciclo de vida do mosquito.

3. Perguntar " Eu /nós queremos prevenirmo-nos de mosquitos; como podemos acabar com eles nas diferentes fases da sua vida?"

4. Mostrar cartaz demonstrando os métodos de prevenção na fase de ovos e larvas.

5. Mostrar cartaz demonstrando os métodos de prevenção na fase de mosquitos adultos.

TRATAMENTO:

1. Perguntar " Como é que se trata a malária?"

2. Mostrar cartaz em que alguém toma medicamentos depois de ser picado.

RESUMIR:

1. Com uma canção de malária.

TOPICS OF SEMINARS FOR CSP 3/91 - 7/79
NOTES FOUND IN TRAINING MANUAL
WORLD VISION MOZAMBIQUE

No	NAME OF TRAINING	DATE	DURATION	TOPICS COVERED	PARTICIPANTS	ORGANISED BY	REMARKS
1	NUTRITION WORKSHOP	SEP OCT/90 OVER 6 WEEKS PERIOD 3 HRS/ WK	18 HOURS	1. OBSTACLES IN NUTRITION TRAINING 2. ATTACKING THE RIGHT NUTRITION PROBLEMS 3. HOW TO MAKE FOOD MORE NUTRITION 4. HOW DO CHILREN GROW 5. THE UNDERWEIGHT 6. BREAST FEEDING 7. YOUNG CHILD'S FOOD	CSP TETE + 2 MOH TETE APROX 10	TEACHING BY VIVIEN	CHANGARA OFFICE
2	PRIMARY HEALTH CARE & COMMUNITY BASED HEALTH CARE WORKSHOP	MARCH/ 91	5 DAYS 30 HRS THIS TIME IS NEEDED SO AS TO BE ABLE TO HAVE TEA BREAKS ENERGISE INTERVALS ALSO AS EVERITHING HAD TO BE TRANSLATED	1. INTRODUCTION TO PRIMARY HEALTH CARE 2. WHAT IS COMMUNITY BASED HEALTH CARE 3. WHAT IS A COMMUNITY HEALTH COMMITTEE 4. WHAT + WHO ARE COMMUNITY HEALTH FACILITATORS 5. PREVENTATIVE HEALTH VERSUS CURATIVE 6. RELIEF REHABILITATION DEVELOPMENT 7. DISCOVERING PROBLEMS IN THE COMMUNITY 8. FORMAL + INFERMAL SURVEY	CSP STAFF FROM TETE & ZAMBEZIA + 3 MOH NURSES FROM ZAMBEZIA TOTAL= 20-25 APROX	TEACHING BY: VIVEN WILSON LOGISTICS BY: SCP , ZAMBEZIA	VENUE: ZALALA IN QUELIMANE

3	SKILS METHODOLOGY WORKSHOP	3-17 MAY/91	5 DAYS = HRS	1. DIFFERENT TEACHING STYLES 2. REMEMBER GOOD & BAD TEACHERS 3. HOW TO ASK QUESTIONS 4. INDUCTIVE METHOD 5. INTRODUCTION OF DIFFERENT SKILLS 6. PUPPETS 7. SONGS 8. STORY TELLING 9. DRAMA 10.POSTERS & FLASH CARDS 11.DEMONSTRATION 12.FLANNEL 13.MODELS 14.GAMES 15.IMPORTANCE OF PRACTICE 16.FIELD TESTING	CSP STAFF FROM TETE & ZAMBEZIA+ EMERGENCY STAFF & 3 MOH STAFF NURSES FROM ZAMBEZIA 20-25 APROX	TEACHING BY:VIVIEN WILSON & JOSE CUPERTINO LOGISTICS BY: CSP ZAMBEZIA	VENUES: ZALALA IN QUELIMANE
4	COMMUNICATION & TEACHING ADULT WORKSHOP	15-19 JULY	5 DAYS =30 HRS	1. VERBAL 2. NON VERBAL 3. BODY LANGUAGE 4. VARIOUS HABITS 5. HOW TO OVERCOME THEM 6. HOW ADULTS LEARN BEST 7. LISTENING TECHNIQUES 8. GROUP DISCUSSION 9. ~~PARENT~~, ADULT, CHILD BEHAVIOUR	CSP STAFF FROM TETE & ZAMBEZIA + 2 MOH NURSES FROM ZAMBEZIA 20-25 APROX	TEACHING BY: -VIVIEN WILSON -JOSE CUPERTINO LOGISTICS BY: CSP ZAMBEZIA	VENUE: ZALALA IN QUELIMA

No	NAME OF TRAINING	DATE	DURATION	TOPICS COVERED	PARTICIPANTS	ORGANISED BY	REMARKS
5	PROGRAM PLANNING	23-25 SEPT 91	3 DAYS 18 =HOURS	1. WHY THE NEED TO PLAN 2. USING QUESTION METHOD FROM " HELPING HEALTHE WORKERS TO LEARN" 3. PROBLEM POSING 4. 6 STEPS IN PLANNING FROM "TRAINING FOR TRANSFORMATION" 5. SETTING GOALS 6. WRITING AIMS 7. THE NEED TO EVALUATE	CSP TETE & CSP ZAMBEZIA + EMERGENCY STAFF 20-25 APROX	TEACHING BY: VIVIEN WILSON LOGISTICS BY: CSP ZAMBEZIA	VENUE: ZALALA IN QUELIMANE
6	VISUAL AIDS WORKSHOP	26-28 SEPT/ 91	2 DAYS = 12 HRS	1.WHY USE VISUAL AIDS 2.HOW TO USE VISUAL AIDS 3.USE OF COLOUR 4.USE OF LETTERING 5.USE OF SIZE 6.USE OF CULTURE 7.HOW TO DRAW FACES 8.HOW TO DRAW BODIES 9.HOW TO DRAW MOVEMENT 10.TRACING METHOD 11.GRAPHING METHOD 12.FIELD TESTING VISUAL AIDS	CSP TETE + CSP ZAMBEZIA + EMERGENCY STAFF 20-25 APROX	TEACHING BY: VIVIEN WILSON JOSE CUPERTINO LOGISTICS BY: CSP ZAMBEZIA	VENUE: ZALALA IN QUELIMANE

No	NAME OF TRAINING	DATE	DURATION	TOPICS COVERED	PARTICIPANTS	ORGANISED BY:	REMARKS
7	VITAMIN A WORKSHOP	26 OCT- 28 OCT	3 DAYS = 18 HRS	1.WHAT IS VITAMIN A 2. WHAT CAUSES VITAMIN A DEFICIENCY 3.HOW TO PREVENT VITAMIN A DEFICIENCY 4.THE COMPLICATIONS OF VIT A DEFICIENCY SHOWING DIFFERENT STAGES OF EYE CHANGESS 5. NIGHT BLINDNESS 6. THE RELATIONSHIP OF MEASLES & U.R.T.I WITH VITA. 7. FOODS RICH IN VITA 8. FOOD FORTIFICATION 9. VITAMIN A CAPSULES & DOSAGES 10. USING & PRACTICING DIFFERENT METHODOLOGY TO TRAIN THE COMMUNITY ON VITAMIN A 11. FIELD TESTING THESE METHODS	CSP TETE + CSP ZAMBEZIA + 2 MOH ZAMBEZIA 20-25 APROX	TEACHIN BY: DR TERRY ANDREWS VIVIEN WILSON LOGISTICS BY: CSP ZAMBEZIA	VENUE: ZALALA IN QUELIMANE

8	HOME VISITING PROPGRAM WORKSHOP	29 OCT -30 OCT 91	2 DAYS = 12 HRS	1. WHY HOME VISIT 2. HOW TO HOME VISIT 3. WHO HOME VISITS 4.HOW OFTEN TO HOME VISIT 5.THE USE OF THE ILLITERATE FORMS FOR THE FACILITATORS WHEN HOME VISITING	CSP TETE CSP ZAMBEZIA + 2 MOH ZAMBEZIA 20 -25 APROX	TEACHING BY: VIVIEN WILSON LOGISTICS BY: CSP ZAMBEZIA	VENUE: ZALALA IN QUELIMANE
No	NAME OF TRAINING	DATE	DURATION	TOPICS COVERED	PARTICIPA-NTS	ORGANISED BY	REMARKS
9	PROBLEM SOLVING WORKSHOP	29 JAN -3 FEB	5 DAYS = 30 HRS	1.WHY YOU HAVE PROBLEMS 2.BEHAVIOURS a) KNOWLEDGE b) BELIEFS c) ATTITUDES d) VALUES e) CULTURE 3.IMPORTANT PEOPLE 4.RESOURCES 5.CHANGES 6.READINESS FOR CHANGES 7.HELPING PEOPLE TO HEAL-THIER LIVES 8.WHAT CAN DONE ABOUT UNHEALTHY BEHAVIOURS 9.WHO SHOULD BE RESPONSIBLE FOR PROBLEM SOLVING 10.RPIORITY PROBLEMS 11.PRIORITISING MORE DEEPLY 12.HOW TO EVALU ATE PROBLEM SOLVING SUCCESS	CSP TETE CSP ZAMBEZIA + EMERGENCY STAFF 1 MOH FROM ZAMBEZIA 3 MOH FROM TETE 20-25 APROX	TEACHING By: VIVIEN WILSON LOGISTICS BY CSP TETE	VENUE: CASA AGRÁRIA IN TETE

No	NAME OF TRAINING	DATE	DURATION	TOPICS COVERED	PARTICIPANTS	ORGANISED BY:	REAMRKS
14	DIARRHOEA METHODOLOGY DAY	22.4.92	1 DAY = 6 HRS	SAME AS FOR CSP ZAMBEZIA	CSP TETE 12	TEACHING BY: VIVIEN WILSON & JOSE CUPERTINO	VENUE: HEALTH OFFICE IN TETE
15	AIDS WORKSHOP	1-5 JUNE/92	5 DAYS = 30 HRS	GROUP PRACTICE METHODOLOGIES ON AIDS	CSP TETE CSP ZAMBEZIA + 1 MOH ZAMBEZIA + 2 MOH TETE APROX 30	TEACHING BY: JANA BEBB DR.SAMUEL DR.TERRY ANDREWS ERICA DASSELAAR VIVIEN WILSON LOGISTICS CSP TETE	VENUE: CASA AGRÁRIA IN TETE
16	MALARIA METHODOLOGY TRAINING DAY	8.6.92	1 DAY 6HRS	SAME AS FOR CSP ZAMBEZIA	CSP TETE 12	TEACHING BY: VIVIEN WILSON JOSE CUPERTINO	VENUE: HEALTH OFFICE IN TETE
17	VACCINATION METHODOLOGY TRAINIGN DAY	17.7.92	1 DAY 6 HRS	SAME AS FOR CSP ZAMBEZIA	CSP TETE 12	TEACHING BY: VIVIEN WILSON & JOSE CUPERTINO	VENUE: HEALTH OFFICE IN TETE

ADJUDATES TRAINING

CHILD SURVIVAL PROGRAM - TETE PROVINCE

AME OF TRAINING	DATES	TOPICS COVERED	HOURS OF TRAINING	ORGANISER OF TRAINING	# OF PARTICIPANTS	LOCATION
orientation of P forms used in e field, andardization of owth monitoring Vaccination terventions	August 12 - 13 1992	1. CSP summary & Objectives	1 hr 10 mins	Bernie Simacio Health Officer Zambezia & Technical Person (Team leader of the group)	4 Adjudantes	TETE - Casa 1 WV Compound
		2. Forms used by CSP in the field a) Family Registry (analysis of 1 family history) b) Women's card c) Child's card	 1 hr 45mins 1 hr 45mins			
		3. Growth of a Healthy Child (analysis of 1 child's health history) -breast feeding -supplementary feeding -vaccination	6hrs			
		4. Problem of Growth - Marasmus (analysis of the growth and problems of a child with Marasmus)	4hrs			

ADJUDATES TRAINING

CHILD SURVIVAL PROGRAM - TETE PROVINCE

NAME OF TRAINING	DATES	TOPICS COVERED	HOURS OF TRAINING	ORGANISER OF TRAINING	# OF PARTICIPANTS	LOCATION
orientation of P forms used in e field, andardization of owth monitoring Vaccination terventions	August 14 - 15 1992	1. CSP summary & Objectives	1 hr 10 mins	Bernie Simacio Health officer Zambezia & Technical Person (Team Leader of the group)	5 Adjudantes (1 from training)	TETE - Casa 1, WV Compound
		2. Forms used by CSP in the field a) Family Registry (analysis of 1 family history) b) Women's card c) Child's card	 1 hr & 20mins 1hr & 15 mins 1 hr 5mins			
		3. Growth of a Healthy Child (analysis of 1 child's health history) - breast feeding - supplementary feeding - vaccination	6hrs			
		4. Problems of Growth - Marasmus (analysis of the growth and problems of a child with Marasmus)	6hrs			

ADJUDATES TRAINING

CHILD SURVIVAL PROGRAM - TETE PROVINCE

NAME OF TRAINING	DATES	TOPICS COVERED	HOURS OF TRAINING	ORGANISER OF TRAINING	# OF PARTICIPANTS	LOCATION
orientation of P forms used in e field, andardization of owth monitoring Vaccination ıterventions	August 17 -18 1992	1. CSP summary & Objectives	1 hr 40 mins	Bernie Simacio Health officer Zambezia & Technical Person (Team Leader of the group)	3 Adjudantes + 1 SMI Nurse on the first day	TETE - Casa 1, WV Compound
		2. Forms used by CSP in the field a) Family Registry (analysis of 1 family history) b) Women's card c) Child's card	 1 hr 1hr & 40mins 2 hrs			
		3. Growth of a Healthy Child (analysis of 1 child's health history - breast feeding - supplementary feeding - vaccination	5 hrs 35mins			
		4. Problems of Growth - Marasmus (analysis of the growth and problems of a child with Marasmus)	3 hrs 45mins			

TECHNICAL TRAINING

CHILD SURVIVAL PROGRAM - TETE PROVINCE

NAME OF TRAINING	DATES	TOPICS COVERED	HOURS OF TRAINING	ORGANISER OF TRAINING	# OF PARTICIPANTS	LOCATION
Reorientation of CSP forms used in the field, standardization of growth monitoring & Vaccination Intervention	August 8 - 10 1992	1. CSP summary & Objectives	1 hr	Bernie Simacio Health Officer Zambezia	6 Technical staff	TETE - Casa 1 WV Compound
		2. Forms used by CSP in the field a) Family Registry (analysis of 1 family history) b) Womens card c) Childs card	1 hr 45mins 1 hr			
		3. Growth of a Healthy Child (analysis of 1 childs health history) - breast feeding - supplementary feeding - vaccination	3 hrs & 45mins			
		4. Problem of Growth - Kwashiorkor (analysis of the growth and problems a child with Kwashiorkor)	3 hrs & 35mins			
		5. Problem of Growth - Marasmus (analysis of the growth and problems of a child with Marasmus)	4 hrs & 45mins			

VISAO MUNDIAL MOCAMBIQUE
TOPICAS DOS SEMINARIOS DE PSI, TETE

NOME DE SESSAO	DATAS	TOPICOS	HORAS DE TREINAM	ORGANIZADOR(A) DO TREINAMENTO	NUMERO DAS PARTICIPANTES	SITIO
1. PREVENCAO E TREINAMENTO DO MALARIA	AGOSTO 1992	DEFINICAO DO MALARIA TRANSMISSAO DO MALARIA PREVENCAO DO MALARIA TRATAMENTO DO MALARIA HISTORIAS DE CASOS	5.0	ORADOR: E. DASSELAAR ORGANIZADOR: JANA WEBB/ JAIME JOSE	7 CHEFES DE EQUIPAS	TETE
2. AMAMENTACAO	ABRIL 1992	PRACTICAS DE AMAMENTAR E DESMAMAR	5.5	ORADOR: E. DASSELAAR ORGANIZADOR: JANA WEBB/ JAIME JOSE	5 CHEFES DE EQUIPAS	TETE
3. SRO E DEHIDRACAO	ABRIL 1992	TIPOS DE SRO : CERAIS SAL/ACUCAR E AGUA DE ARROZ	4.5	ORADOR: JOSE CUPERTINO	50-60 FAMILIAS	TETE
4. LOGISTICAS DO PSI	MARCO 1992	LOGISTICAS INCLUI: TRANS-PORTE, COMUNICAO E APRESENTAR UM RELATORIO	2.5	ORADOR: JANA WEBB	5 CHEFES DE EQUIPAS	TETE
5. EPIDEMIOLOGIA DE SIDA	FEV 1992	EPIDEMIOLOGIA DE SIDA: GLOBAL, NACIONAL E LOCAL	3.5	ORADOR: JANA WEBB	32 PESSOA DE PSI TETE E ZAMBEZIA E MISAU	TETE
6. PREVENCAO DE SIDA	FEV 1992	PREVENCAO E TREINAMENTO SOBRE SIDA	8.0	ORADOR: E. DASSELAAR ORGANIZADOR: CSP TETE	5 CHEFES DE EQUIPAS	TETE
7. PREVENCAO DE DOENCAS DO PAV	JAN 1992	DEFINICAO, TRANSMISSAO E PREVENCAO 6 DOENCAS DO PAV	5.0	ORADOR: E. DASSELAAR	5 CHEFES DE EQUIPAS	TETE
8. RECOLHER E COMPLICAR DOS DADOS DO PSI	SET 1992	TREINAMENTO NO SISTEMA DE INFORMACAO DO SAUDE (SIS)	7.0	ORADOR: JANA WEBB	20 CHEFEES DE EQUIPAS TETE/ZAMBEZIA	TETE

ANEXO 8: ORGANIZACAO DO FICHEIRO MOVEL PARA EQUIPA DE /PAV/CC/CRN

ANEXO 8.1: RECOMENDACOES PARA CENTRO REABILITACAO NUTRICIONAL

ORGANIZAÇAO DO FICHEIRO MÓVEL

Durante a avaliação do Projecto de Sobrevivência da Criança na Provincia de Tete, ao discutir-se o circuito das mães, sugeriu-se que as fichas do registo das familias deveriam ser arquivadas em ficheiro móvel, a fim de racionalizar-se o tempo da mãe e do trabalhador.

Para organizar o referido ficheiro deverá proceder-se da seguinte forma:

(a) Dispôr de uma caixa ou de uma gaveta que pelo menos tenha a largura duma ficha de registo da família.

(b) As fichas de registo da família arrumam-se por ordem alfabetica e por mês de marcação da consulta de controlo de crescimento/vacinação.

(c) Dispõe-se-á de 4 separadores de cartolina ou de madeira, de tamanho um pouco maior do que as fichas de registo da família, com um rebordo superior onde se anotara em cada um deles o controlo a que correspondem (mês actual e mês seguinte), sendo os restantes separadores, um para as familias que faltaram a consulta de controlo/vacinação (FALTAS) e outro para as que abandonaram a consulta (ABANONOS).

(d) Após uma consulta de controle de crescimento/vacinação (seja uma primeira consulta de controlo/vacinação) a ficha respectiva deve ser arquivada no mês da proxima consulta/vacinação e portanto será colocada neste ficheiro no compartimento do mês correspondente e dentro deste mês estara por ordem alfabética.

(e) Desta forma quando uma mãe/acompanhante traz a criança a um controlo de crescimento/vacinação na data marcada a ficha procura-se por ordem alfabética no compartimento do mês actual.

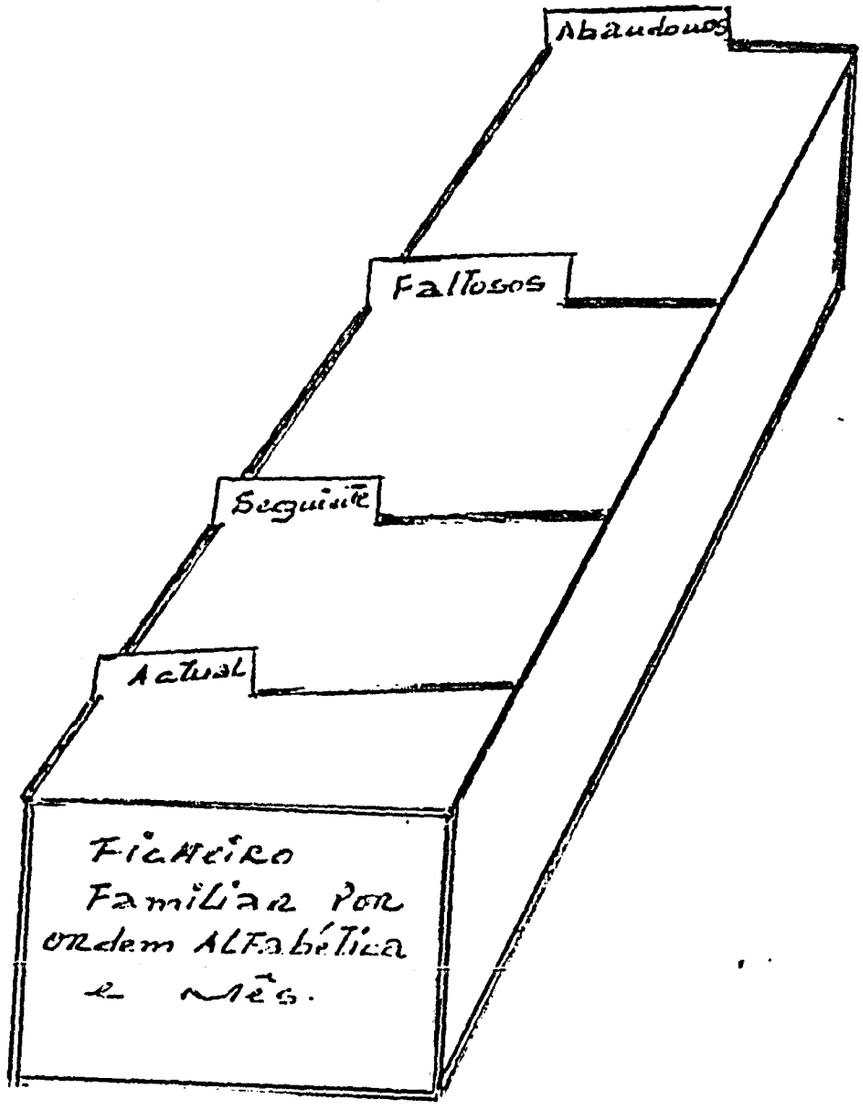
(f) No fim de cada dois meses restam no compartimento respectivo as fichas de todas as mães/acompanhantes das crianças que faltaram ao control/vacinação. Estas juntam-se e ordenam-se alfabeticamente no mesmo mês e colocam-se na divisória do arquivo que deverá estar marcada com Faltas. Estas faltantes deverão ser recuperadas com as visitas domicilárias.

(g) Se ao fim de quatro meses a mãe/acompanhante da criança não comparece deverá a respectiva ficha passar para o compartimento marcado ABANDONOS.

(H) Se uma mãe/acompanhante da criança vem ao controlo de crescimento/vacinação depois de ter faltado a marcação da consulta de control/vacinação terá de se averiguar ha quanto tempo faltou para calcular se a sua ficha esta arquivada nas FALTAS (quando faltar um periodo que não excede os quatro meses) ou ABANDONOS (se ja faltar ha mais de quatro meses).

(i) A cada mãe/acompanhante da criança quando é aberta a ficha do registo da família e entregue um cartão de controlo de crescimento da criança e no fim de cada consulta de controlo de crescimento/vacinação regista-se neste e na ficha do ficheiro a data em que será o controlo seguinte.

Ficheiro Móvel das Famílias.



AVALIACAO DOS PROGRAMAS DE CONTROLE DE CRESCIMENTO / CENTROS DE REABILITACAO NUTRICIONAL / VISAO MUNDIAL

Andrew Swiderski (NEP/DPSZ/SCF-UK)
2 Setembro 1992

Controle de Crescimento

Puntos Positivos

1. Muita boa compreensao da parte do pessoal WVI sobre o crescimento insuficiente e o preenchimento das Cartoes de Saude.

2. Bom fazer a altura alem do controle de crescimento para melhor avaliacao do estado nutricional (e se for preciso, inscricao no centro de reabilitacao).

3. Como existe um arquivo com copias das Cartoes de Saude, permite procurar as pessoas que nao se presentam no dia da pesagem.

Suggestoes

1. Mudar o fluxo das maes/criancas para diminuir confusao; arranjar se for possivel o processo numa linea ou num circulo com entrada e saida - direccao de movimento bem definida.:

a. nao chamar nomes, a vezes leva muito tempo. A mulher faz a bicha do pesagem com a Cartao de Saude no mao. Nao la entregamos o processo familiar a ela.
b. Depois ela faz a bicha do medicao.
c. Depois ela faz a bicha do registo. A Cartao de Saude tem um numero que corresponde ao processo familiar na pasta com o pessoal sanitaria. Uma vez la, fazem as percentagens nutricionais, educacao nutricional. O pessoal NAO da a mulher o processo familiar (do arquivo) mas dao este mais a Cartao da crianca ao pessoal do PAV, que estao sentados ao lado. Depois das vacinacoes a mae recebe outra vez a sua cartao e vai embora.

2. Dar retroinformacao sobre os resultados estatisticas nutricionais do dia a comunidade (que % das criancas mainutridas, etc.)

3. Tecnica da pesagem: nao subir a crianca pegando as "calcas" plasticas mas o corpo proprio da crianca para nao estragar estas calcas. Nao ter as criancas que aguardam ser pesadas/medidas em frente daqueles que estao a ser pesadas porque mete-las em panico.

4. E necessario fazer o percentile e o percentagem??? A MISAU so recolha informacao sobre o crescimento. E a WVI so precisa saber o

% peso/altura para entrar no centro nutricional. Ou pelo menos eliminar o percentile do peso/idade?

5. Incluir os adjutantes na interpretacao da informacao nutricional (no sentido comunitario- que % da populacao esta malnutrida, conclusoes, etc.)

6. As cartas de PAV precisam ser assinadas pelas pessoas que aplicam as vacinas.

7. Afestar as pessoas da mesa de registo para nao ter muita confusao/burulho la. Acho tambem que e mas facil para a mulher receber educacao sanitaria quando nao ha esta confusao e seja individual/sozinha.

Centro de Reabilitacao Nutricional

Puntos Positivos

1. Criterias de alta exigem que a crianca fica com bom peso/altura durante um tempo muito amplo.

2. A metodologia de como achar as receitas de LOA, papas, etc. amelhorou muito e é facil/simples a compreender.

3. Armazen em boa ordem, sistema de controle de stock simples.

4. Componente medica do centro permite avaliacao diaria por pessoal clinica.

5. Aberto todos os dias.

6. Bom componente de educacao sanitaria. E bom ter uma pessoa especialmente treinado para fazer isto em vez de qualquer pessoa do centro. 45 minutos pode ser muito para uma leccao!

7. Nova cozinha bem ventilada, e tem fogoes melhoradas para pouper lenha.

8. Bom ter uma pessoa responsavel para supervisar o consumo da SRO (controlar as quantidades dadas, etc.)

9. Se o periodo medio necessario para melhoramento/alta e de 6 semanas, e conforme as padroes conselhadas, e refleite um trabalho eficaz.

Suggestoes

1. **Para malnutridos e importante kcal a todas horas do dia. Depois da refeccao de 1600 ate 600 nao ha kcal significante. Uma suggestao seria de servir uma refeccao grande as 1800, e dar as bolachas aos doentes para levar e comer entre 1800 e 0600...um periodo de 12 horas!

2. Ver a ficha feita pela DPS e a MSF para a recolha da informacao dos centros nutricionais. Discutir com a Sra. Manuela sobre a maneira mais facil. A ficha de Visao Mundial

-utiliza grupos etarios diferentes
-nao tem informacao sobre tempo medio de permanendia nem ausencias
-nao tem informacao sobre estado nutricional (percentile ou percentagem/peso altura)
-nao tem numero/causas dos obitos
-nao tem informacao sobre quantos das pessoas entradas sao readmissoes
-nao tem informacao: alta por transferencia
-tabela sobre stock de material: por a coluna de existente como ultima coluna

3. Criancas que nao aceitam bem a LOA ao principio: tentar diluir.

4. Processos Clinicos Individuais:

-ter seccao/tabela pequena (como mebendez., vitamina A) para as vacinas feitas. Deixar de escrever isso no meio de texto escrito nas "observacoes". (achou dificial encontrar informacao quantitiva quando esta no meio dum paragrafo descritivo)

-preencher a "parte sobre como comeu a crianca durante a semana" ANTES da consulta/pesagem semanal para incorporar esta informacao na avaliacao total do paciente.

-aumentar o espaco para observacoes. E necessario escrever os medicamentos dados se aquilo ja esta escrito nos cardexes?

-escrever a recepcao de vitamina A so no pequeno quadro e nao no texto descritivo. (evitar repeticoes)

-ter uns quadros/uma coluna para escrever o peso/altura/% em vez de incluir no texto descritivo.

-uma ideia, em vez de medir a altura e calcular a percentagem cada semana, e de ter o peso desejado (para alta) escrito encima do processo (o peso de 85% peso/altura).

5. Um doente que quer comer duas vezes durante uma refeccao a vezes nao recebe esta segunda porcao porque nao foi calculado um "extra" na receita? Todos devem poder comer tanto quizerem.

6. Ter uma medida padronizada para servir a massa?

7. Ter agua e sabao na entrada no centro para lavagem dos maos dos doentes bem como para os accompanhantes (e tentar enforcar isto). Tambem como a maioria utiliza pratos pessoais (e nao do centro), tentar encouragar a limpeza dos mesmos antes/depois de cada refeccao.

8. Seria possivel ter esteiras de plastico (mais higenico/facil a lavar do que aqueles de material local?)

9. Seria possivel dar a cada doente um pedazo de plastico para sentar-se ?

Perguntas

1. Nao e preciso limitar os liquidos para as criancas com edemas?

2. Uma crianca que sempre esta presente nas refeccoes mas nao come bem: onde se escreve este feito?

3. Estamos seguros que os accompanhantes, que so recebem massa, nao tomam o LOA ou bolachas do paciente?

4. Os kcal em cada grupo etario vao ser suficiente para o "catch up growth" dos pacientes de maior peso?

5. 2 cozinheiros e suficiente para o volume de trabalho? No day off.

6. Um guarda e suficiente (nao da a possibilidade de descansar umas noites durante a semana)?

Comentario geral:

1. Seria boa experiencia de incluir os responsaveis provinciais de SMI/Nutricao/PAV etc. para aproveitar da experiencia de avaliacao.

2. A vezes as perguntas feitas ao pessoal de WVI pelos consultores parecia um examen/interogacao, um tribunal (como para o centro de nutricao) para o pessoal local. Responderam muito bem, nao foi facil para eles, parabens!

MEDICAMENTOS	DATA / VIA	HORAS	HORAS	HORAS	HORAS

Nome: _____ Diagnóstico _____

CARDEX

MEDICAMENTOS	DATA / VIA	HORAS	HORAS	HORAS	HORAS

MEDICAMENTOS	DATA / VIA	HORAS	HORAS	HORAS	HORAS

Nome: _____ Diagnóstico _____

CARDEX

MEDICAMENTOS	DATA / VIA	HORAS	HORAS	HORAS	HORAS

C E N T R O D E R E A B I L I T A Ç Ã O N U T R I C I O N A L

RESUMO MENSAL MES_____ de 199

PROVINCIA _____ U. SANITARIA _____
DISTRITO _____ TIPO DE U.S. _____
TIPO DE CENTRO _____ ONG ASSISTENTE _____
(Intensivo/Selectivo) (Se existe)

I - MOVIMENTO DURANTE O MES

CATEGORIA / GRUPO ALVO	N° PRESENTES NO INICIO DO MES = A	ENTRADAS			ALTAS					N° PRESENTES AO FIM DO MES = A+B-C
		Novos Casos	Readmissões	Total = B	Fim do Tratt°	Abandonos	Transf. Outr. US	Óbitos	Total = C	
1-Crianças 0-4A										
2-Crianças 5-14										
3-Homens + 15 A										
4-Mulheres+15 A										
TOTAL										

II - ESTADO NUTRICIONAL DAS CRIANCAS 0-14 ANOS

1 - NA ENTRADA

CATEGORIA / IDADE	KWASHIORKOR	MENOS OU IGUAL AO 3° PERCENTILE	MAIS QUE O 3° PERCENTILE
0 - 4 ANOS			
5 - 14 ANOS			
TOTAL			

2 - AO FIM DO MES

CATEGORIA / IDADE	KWASHIORKOR	MENOS OU IGUAL AO 3° PERCENTILE	MAIS QUE O 3° PERCENTILE	T O T A L
0 - 4 ANOS				
5 - 14 ANOS				
TOTAL				

III - DIAGNOSTICO SECUNDARIO DE ALTA (Além da manutricão)

DIAGNOSTICO	N° CASOS
1 - DIARREIA DES.	
2 - TUBERCULOSE	
3 - INF. PULMO.	
4 - MALARIA	
5 - SARAMPO	
6 - OUTROS	

IV - CAUSAS DE OBITO

CAUSA PROVAVEL	NUMERO
1 -	
2 -	
3 -	
4 -	

V - TEMPO MEDIO DE PERMANENCIA: CRIANCAS Q4 ANOS

$$\frac{\text{Total dias de participação para as crianças que acabaram o tratamento}}{\text{Numero de altas por ter curado}} = \_\_\_\_ \text{ dias}$$

VI - PERCENTAGEM DE PRESENCA: Crianças 0-4 Anos

$$\frac{\text{Numero de dias efectivos de presença, para as crianças inscritas durante o mês}}{\text{Numero de dias previstos de presença}} \times 100 = \_\_\_\_\%$$

VI - CONSUMO DE PRODUTOS (durante o mês)

PRODUTOS	CONSUMO EM KGS	STOCK EM KGS
LEITE		
OLEO		
ACUCAR		
FARINHA		
BOLACHAS		

Data: Aos__de_____199_

Responsavel

NOME: _____ Peso: _____

Endereço: _____ Altura: _____

IDADE _____ Percentagem: _____

Tipo Malnutrição: ☐ Marasmática ☐ Kwashiorkor

☐ Kwasiorkor/ Marasmático ☐ Peito Seco

Data de Admissão: _____ Data de alta: _____

VITAMINA A Crianças >seis meses de idade

DATA 1a DOSE	DATA 2a DOSE

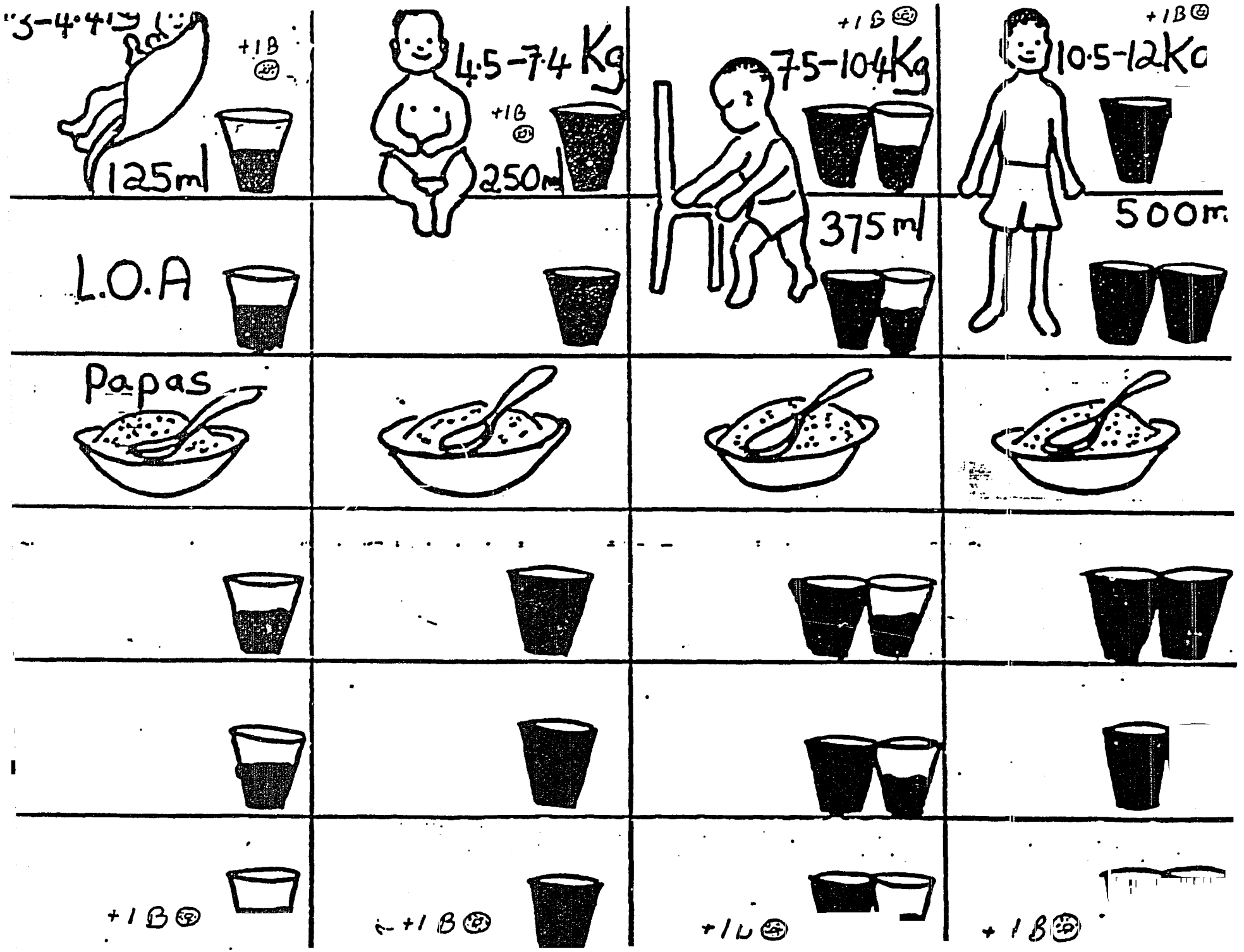
MEBENDAZOL

DATA	MANHÃ	TARDE
1o dia		
2o dia		
3o dia		

RECEBEU REFEIÇÕES NUMA SEMANA

DATA	TODAS REF.	METADE REF.	POUCAS REF	NENHUMA REF.	Observações

137


3-4.4Kg
+1B
125ml
4.5-7.4 Kg
+1B
250ml
+1B
7.5-10.4Kg
375ml
+1B
10.5-12Kg
500ml
L.O.A
Papas
+1B
+1B
+1B
+1B

ANEXO 9: DADOS ESTATISTICOS DO PROJECTO

Tete Child Survival Program
Project
Indicators
nformation based on: July 1992 totals

		Fiscal 1992				
		This Month	This Quarter	Total YTD	Target YTD	Project Target
Immunizations:						
a. Number and percent of children 0-11 months immunized by antigen	DTP/OPV1	259	595 (29.5%)	1703 (84.4%)	2018 (70.0%)	3606 (80.0%)
	DTP/OPV3	262	578 (28.6%)	1605 (79.5%)	2018	3606
	BCG	275	780 (38.7%)	1668 (82.7%)	2018	3606
	Measles	186	477 (23.7%)	1585 (78.5%)	2018	3606
b. Number and percent of children 0-11 months fully immunized		186	477 (23.7%)	1585 (78.5%)	2018	3606
c. Number and percent of women (15-49 yrs) given TT2		185	955	2758		
Cumulative total TT2 to date*				3587		
Cumulative percent TT2 to date*				(57.0%)		
ORT/CDD Practice Rate:						
a. Number of mothers with children 0-35 months receiving training in ORT cumulative individuals:		100	300	3000 (47.5%)	6275 (65.0%)	7725 (80.0%)
cumulative group* :				5380 (85.0%)		
b. Number of children 0-35 months with diarrhea in last two weeks treated with ORT**		--	--	--		
c. Number of deaths among 0-35 months secondary to diarrheal dehydration***		01	05	09		
Nutrition Improvement:						
a. Number of times/number of children 0-35 months who were weighed		1483	4826	13,268	15,921	
b. Number of times/number of children 0- 35 months where weights were	increased	1022 (68.9%)	2362 (49.0%)	7301 (55.1%)	--	
	decreased/static	288 (19.4%)	1123 (23.2%)	3237 (24.5%)	--	
c. Number of mothers who received training in breastfeeding and weaning practice		150	450	4500	6275	7725
d. Number of newborns registered and followed up every two months		195	582	2330		
e. Number of families with under-weight children referred to AgPak Program to receive vitamin A rich vegetable seeds.		60	180	1930		
Malaria Control						
a. Number of families provided with mosquito nets		475	--	475		
b. Number of anti-malaria campaigns		01	02	05		
c. Number of clean-up campaigns		--	01	03		
Community Participation						
a. Number of community health committees formed and functioning		--	01	05	08	
b. Number of health facilitators identified and functioning		--	17	77	124	
c. Total no. of latrines constructed		40	85	415	1600	3825
d. Percent families with access to latrines in 12 specific areas		--	--	--	(20.0%)	(45.0%)

ive totals; % does not reflect true rates due to previous vaccinations
ered before the project. August 1992 EPI survey revealed 77% TT2 coverage
nt tracking system does not document this information
rted by the health post; represents misdiagnosis as well as underreporting

ANEXO 10: DISPOSICAO DO PESSOAL PARA O REGISTRO FAMILIAR/RONDA

PROGRAMA DE SOBREVIVENCIA INFANTIL
DISPOSICAO DO PESSOAL PARA O REGISTO FAMILIAR

Todos machos, todas femeas > 45 anos e entre 4-14 anos ficam aqui

3

Posto de Pesagem

2

Registo Familiar

4

Centro de registo
Cartoes do MISAU
Educacao Nutricional

1

Educacao

5

Identificacao da malnutricao

Vacinacoes por MISAU

Vacinadas criancas malnutridas severamente

Casos de malnutricao severa

Severamente malnutridas nao vacinadas

7

Malnutrida < 3% nao vacinadas

Saudaveis/Nao vacinadas

6

Canalizados DPCCN

Malnutridas < 3% P/I

Malnutridas < 3% vacinadas ficam

Saudaveis/vacinadas ficam aqui

142

ANEXO 11: FIXAS DO SISTEMA DE INFORMACAO DE SAUDE DO PROJECTO

CARTÃO DE SAÚDE DA MULHER

Nº _____ DATA _____

NOME _____

_____

RESIDÊNCIA ACTUAL _____

_____

VACINA ANTI-TETÂNICA

DOSE	DATA	LUGAR
1ª		
2ª		
3ª		
REFORÇO 1		
REFORÇO 2		

- PROTEJA O SEU BEBÉ CONTRA O TÉTANO.
- GUARDE SEMPRE ESTE CARTÃO
- CUMPRA O CALENDÁRIO.

GRAVIDEZ						
CONSULTA	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
ARO? - RAZÃO						
DATA PARTO - CASA/MAT. EUT./DIST.						

Planeamento Familiar — APONTAR MÉTODOS E DATAS DE UTILIZAÇÃO

ES PARA ATENÇÃO ESPECIAL

OS QUADRADOS

PESO AO NASCER INFERIOR A 2.5KG

HEOS

MÃE AUSENTE

DESMAME PRECOCE

MALNUTRIÇÃO

MIGRAÇÃO RECENTE DA FAMÍLIA

SARAMPO OU OUTRA DOENÇA GRAVE

G COM P.T

ESCREVER NA COLUNA DO MÊS APROPRIADO

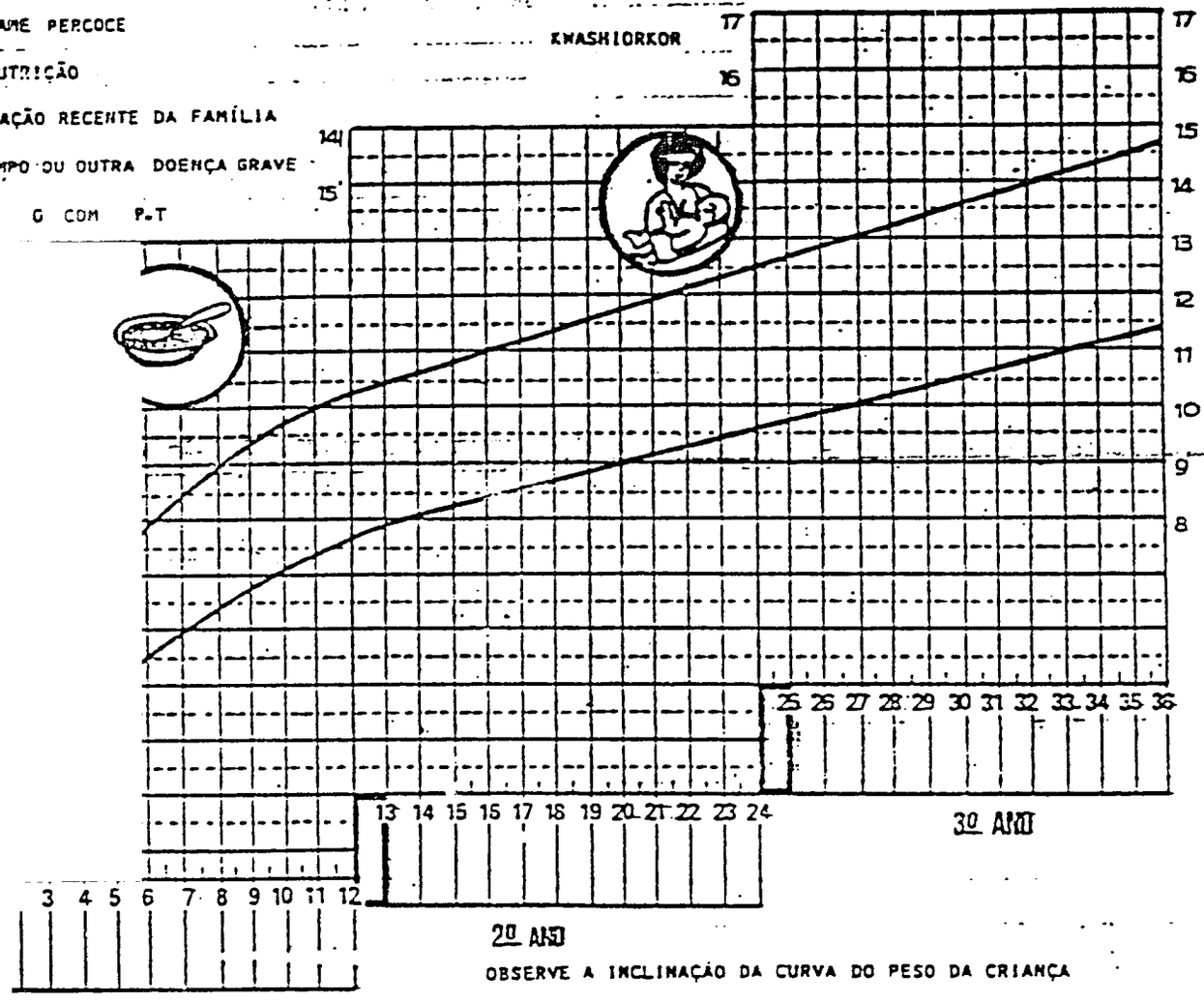
DESMAME — NOVA GRAVIDEZ DA MÃE

DIARREIA — TOSSE CONVULSA

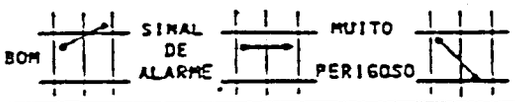
SARAMPO — ANEMIA

PNEUMONIA — OUTRAS DOENÇAS

KWASHIORKOR



OBSERVE A INCLINAÇÃO DA CURVA DO PESO DA CRIANÇA



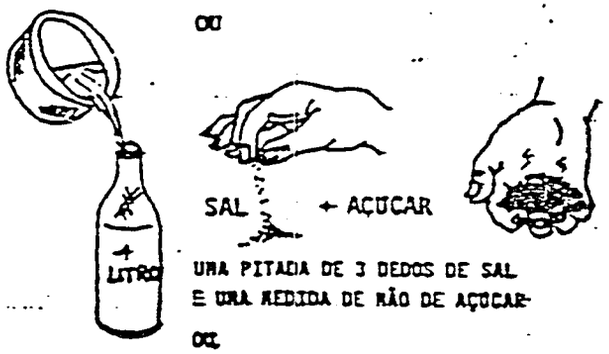
VACINAÇÕES

VACINA	DATA	LOCAL	ASSINATURA E CARIMBO
A - P à nascença			
BCG			
DTP 1ª dose			
AP 1ª dose			
DTP 2ª dose			
AP 2ª dose			
DTP 3ª dose			
AP 3ª dose			
ALS			

DIARREIA?

DAR A BEBER UMA SOLUÇÃO PREPARADA COM 1 LITRO DE ÁGUA E UM PACOTE DE SAIS.

OU



UMA PITADA DE 3 DEDOS DE SAL E UMA MEDIDA DE MÃO DE AÇUCAR

OU

DAR DE COMER PAPINHA DE ARROZ MUITO AGUADA E EM BOA QUANTIDADE E MANTER A ALIMENTAÇÃO HABITUAL

Data	Observações Clínicas	Prescrições Terapeuticas

Data	Observações Clínicas	Prescrição Terapeuticas

Data de Proxima Consulta		

República de Moçambique

Serviço Nacional de Saúde

CARTAO DE SAUDE

Nome e N.º da Unidade Sanitária

Criança SEXO .....

Nome .....

Filiação

Mãe .....

Pai .....

Residência

Local Data ..../..../....

Em casa ☐ Peso ..... Kg

Naturalidade .....

Irmãos Vivos ☐ Falecidos ☐

Causa de morte .....

Doenças Cronicas na Familia

Tuberculose .....

Outras .....

Atenção

Apresente Sempre este Cartão de Saúde nas Consultas

SUMARIO MENSAL DO FACILITADOR DA COMUNIDADE

FACILITATOR ②

REFERENTE AO PERIODO: _____ ALDEIA: _____ BAIRRO: _____ QUAT: _____ DATA: ____/____/____

1 2 3 4 5 6 7 8 9 0										
							1 LITRO			
	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000
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PROGRAMA DE SOBREVIVENCIA INFANTIL

SUMARIO MENSAL DO FACILITADOR DA COMUNIDADE

REFERENTE AO PERIODO: _____ ALDEIA: _____ BAIRRO: _____ QUAT: _____ DATA: ____/____/____

12345 67890														
	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000	00000
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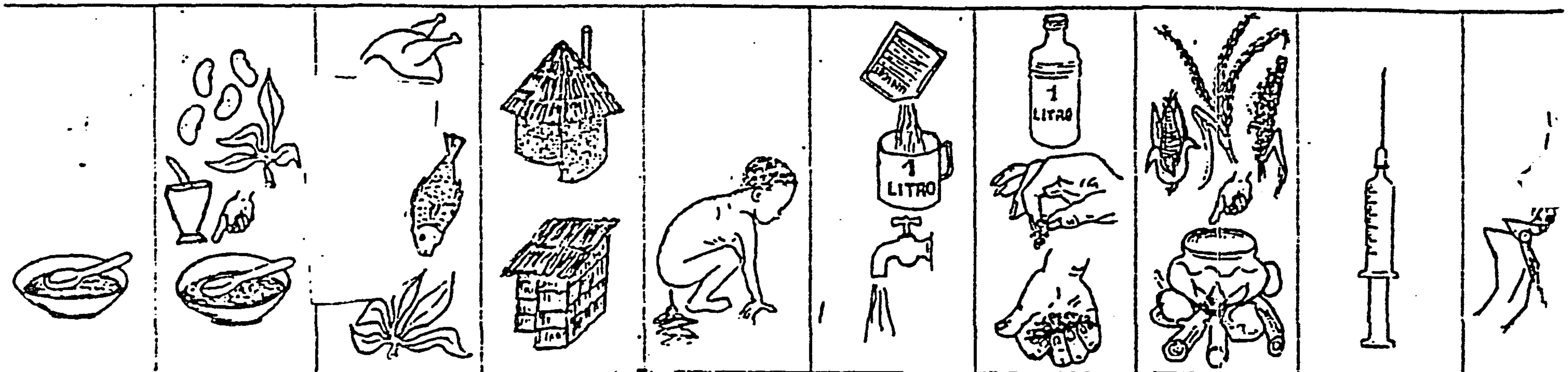
PROGRAMA DE SOBREVIVENCIA INFANTIL
SUMARIO MENSAL DO FACILITADOR DA COMUNIDADE

REFERENTE AO PERIODO: ________________ ALDEIA: ____________ BAIRRO: ________ QUAT: ______ DATA: _____/_____/_



12345 67890

(fogo)	00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 0
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(rádio)	00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 0
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(árvore)	00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 0
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(camisa)	00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000
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(calças)	00000	00000 00000	00 0 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 0
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(bicicleta)	00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 0
	00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 0

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REFERENTE AO PERIODO: _____ ALDEIA: _____ BAIRRO: _____ QUAT: _____ DATA: _____

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VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANTIL
SUMARIO MENSAL DO FACILITADOR DA COMUNIDADE

REFERENTE AO PERIODO: _____ ALDEIA: _____ BAIRRO: _____ QUAT: _____ DATA: ____/____/____

12345 67890														
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VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIAL INFANTIL -
FACILITADOR DA COMUNIDADE SUMARIO MENSAL DE TREINAMENTO

Referente ao Periodo:_____ Aldeia:_____
Data:_____/_____/_____ Bairro:_____ Quat:_____

MES:	00000	00000	00000	00000	00000	00000	00000	00000
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MES:	00000	00000	00000	00000	00000	00000	00000	00000
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MES:	00000	00000	00000	00000	00000	00000	00000	00000
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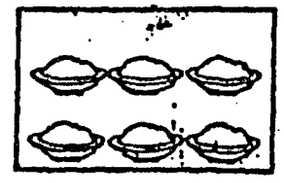
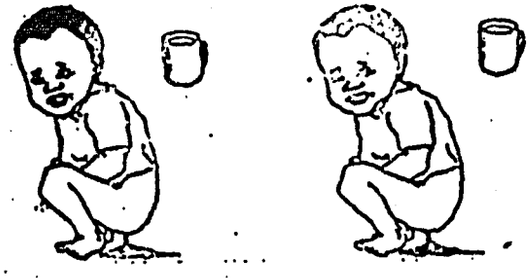
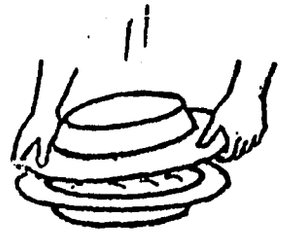
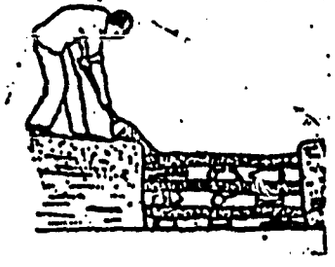
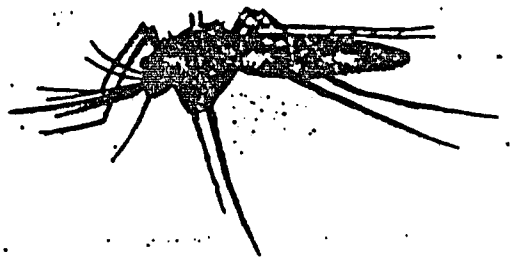
TOTAL:								

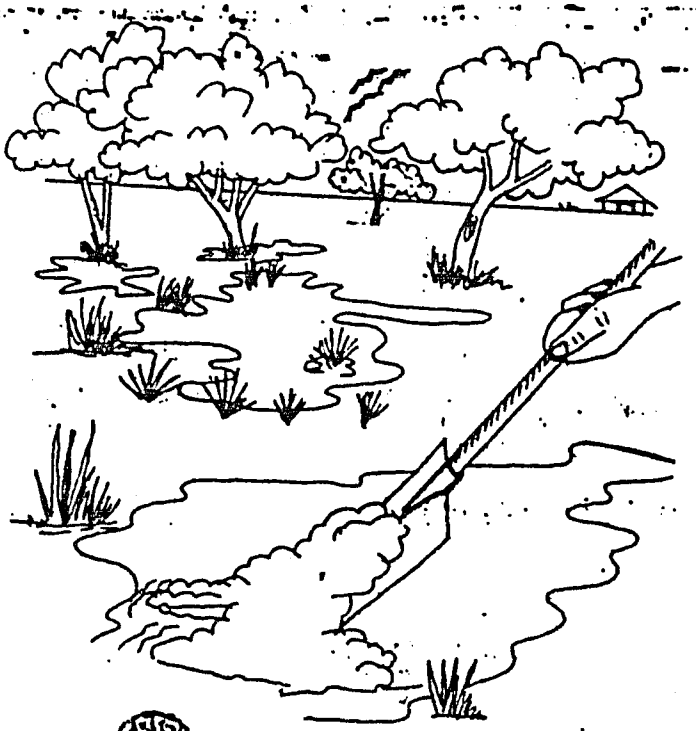


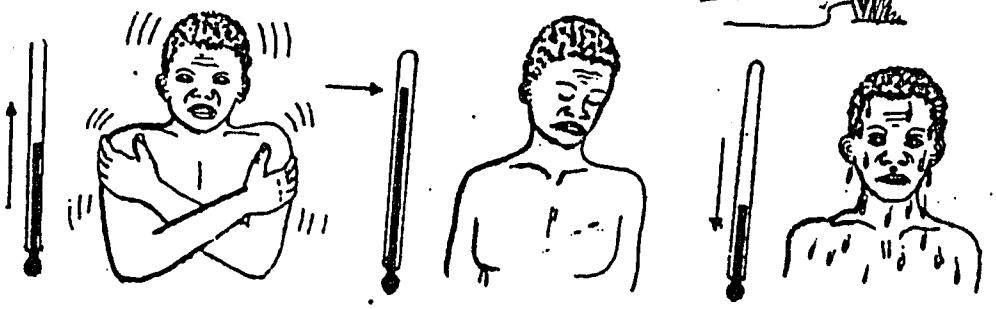












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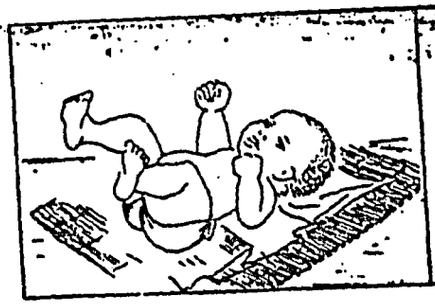

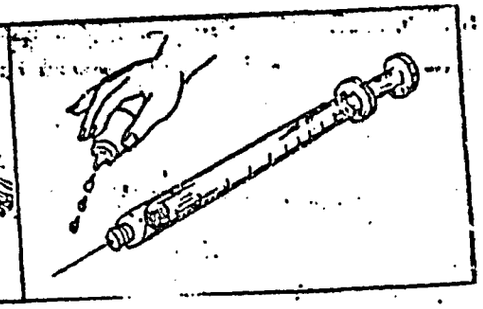

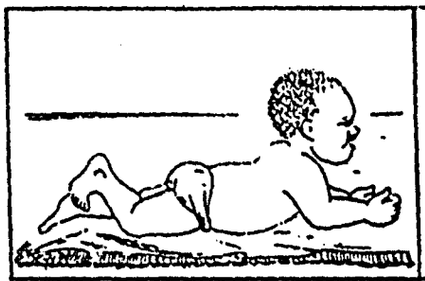

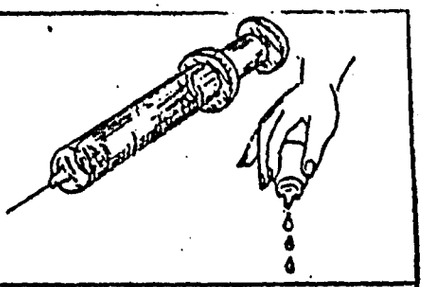

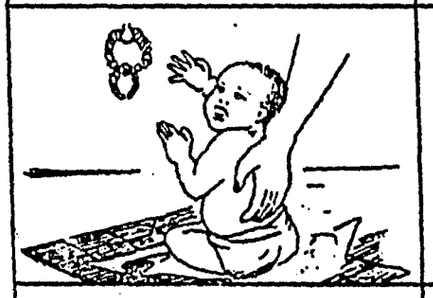

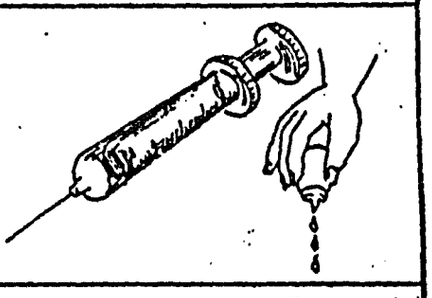

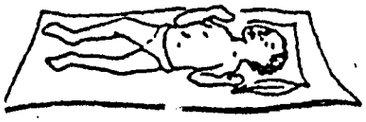

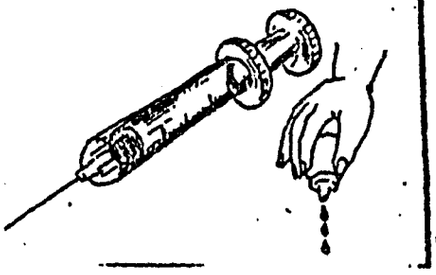

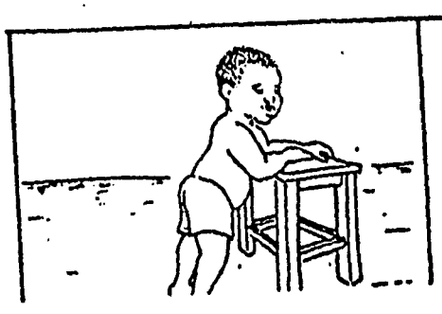

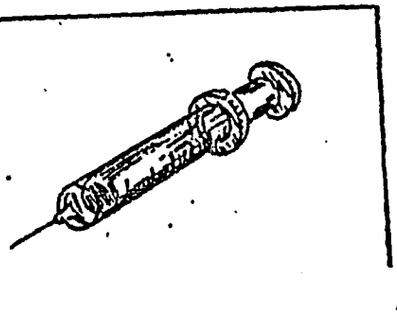

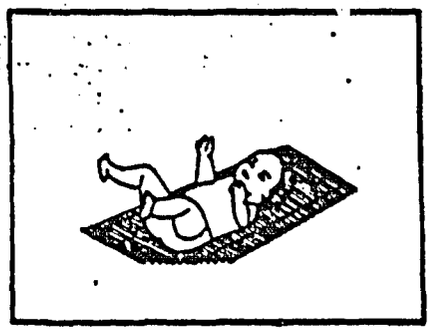

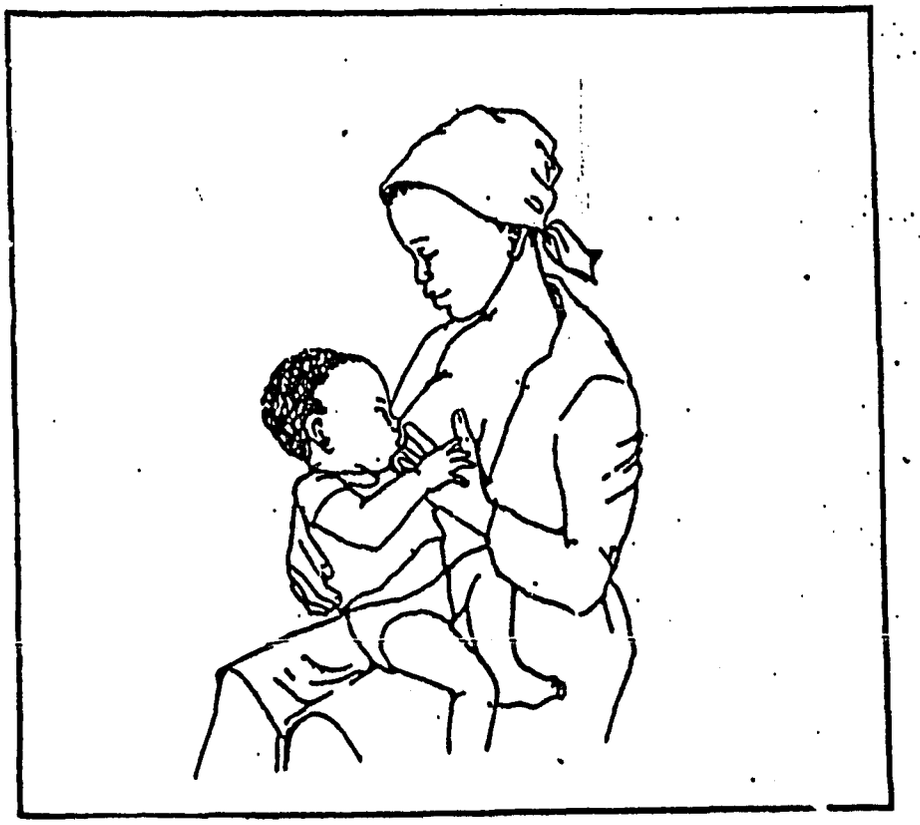

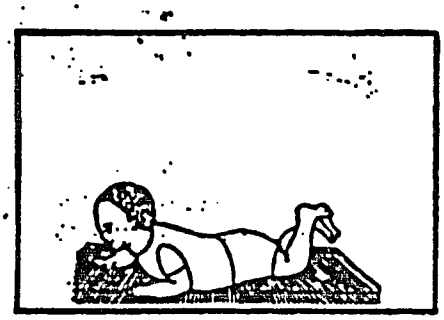

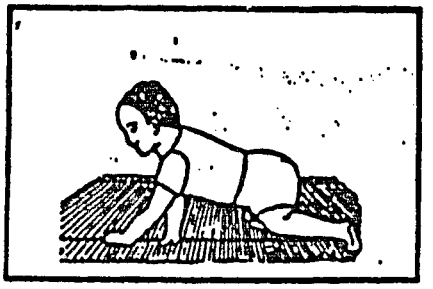

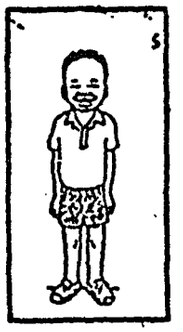

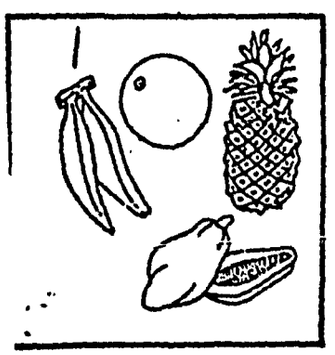

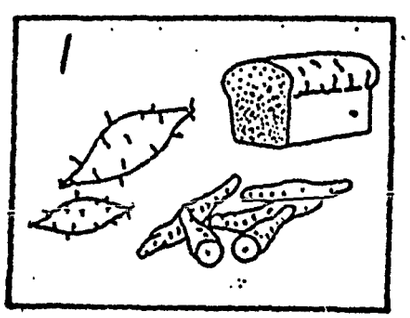

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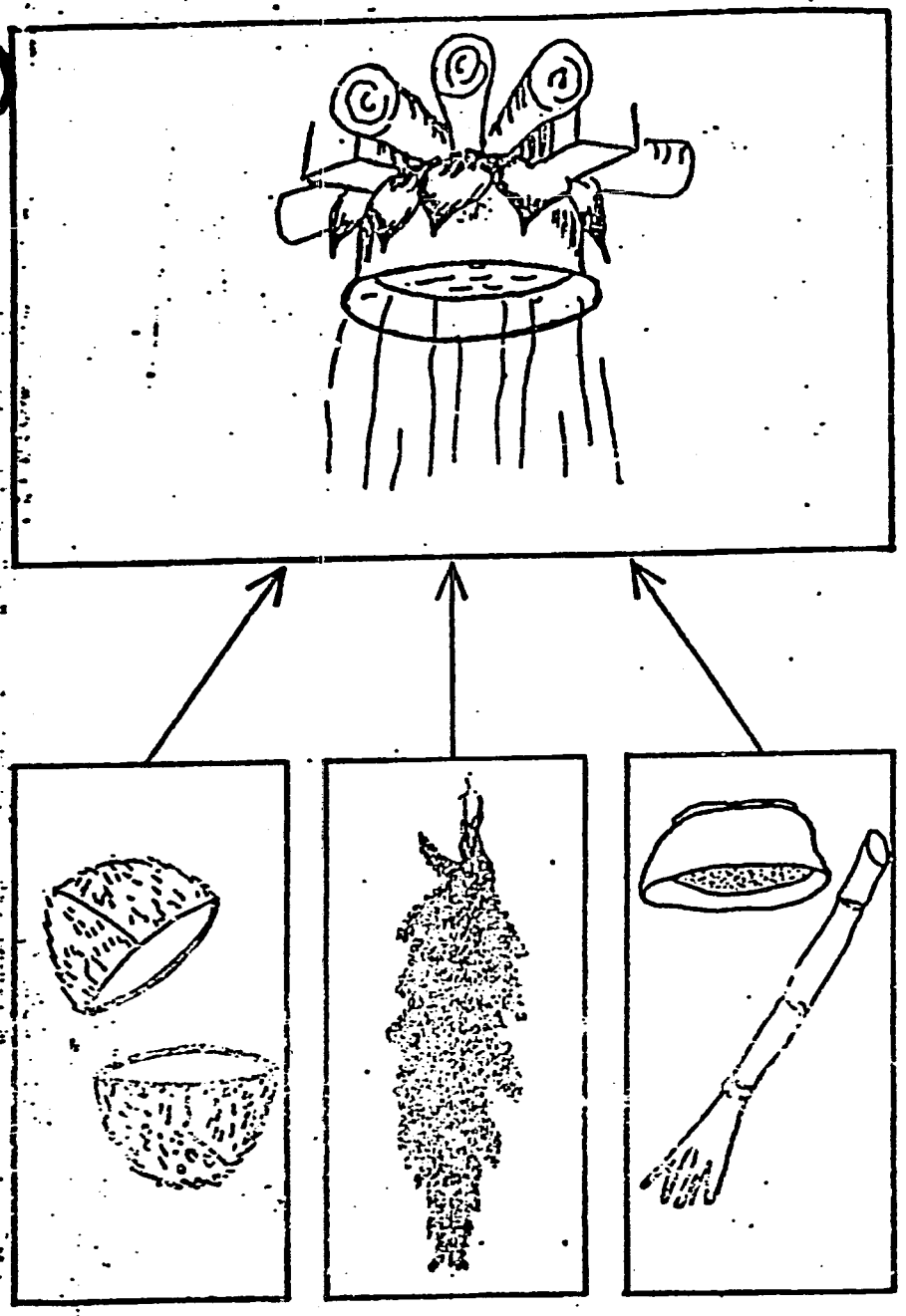

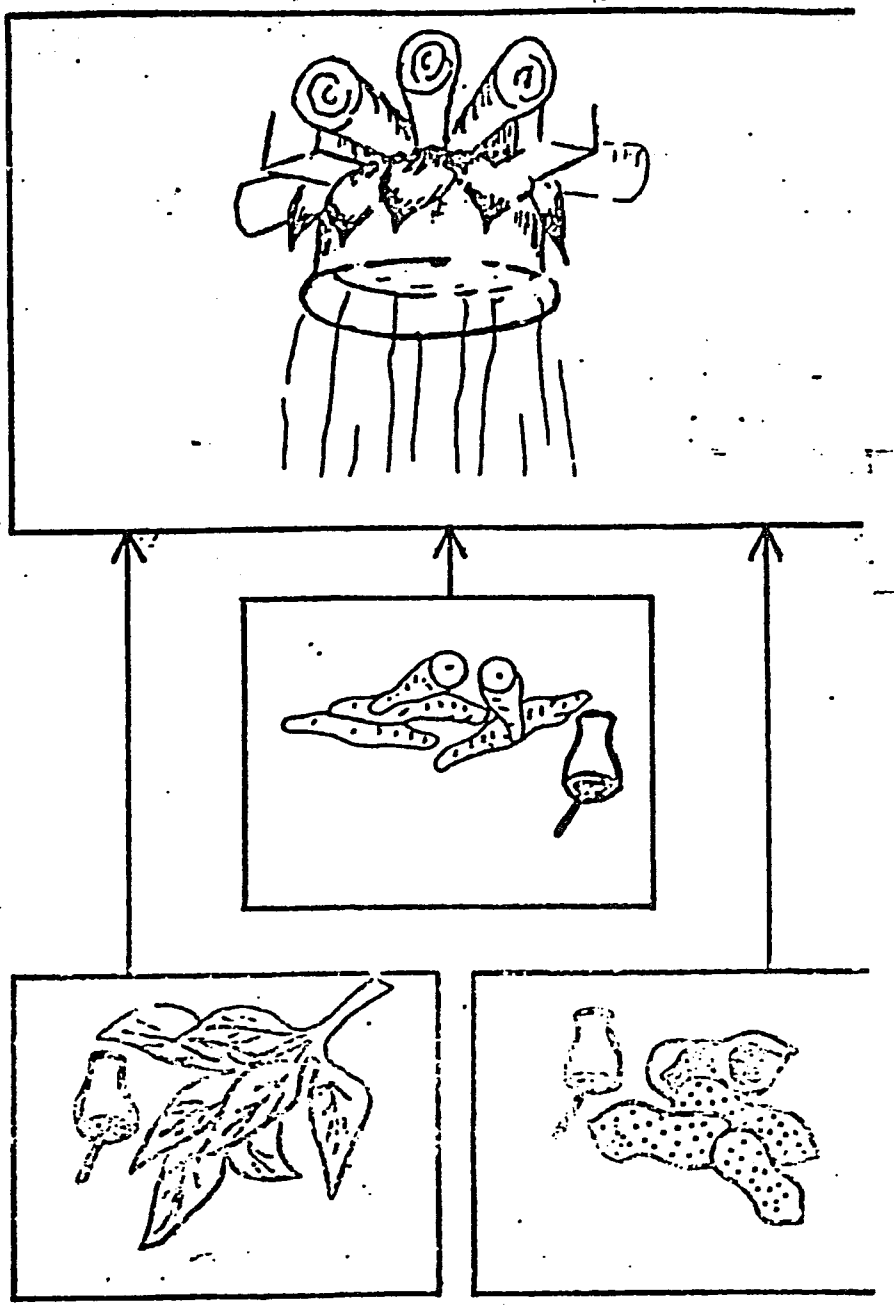

ARQUIVO

REGISTO FAMILIAR

Data: _____

Chefe da Familia: _____

Nome da Mãe: _____ Bairro: _____

Endereço: Aldeia: _____

Membro da Familia

Nome	Parentesco	Sexo	Idade ou Data de Nascimento	Situação Actual		
				Transferido	Raptado	Falecido

Nome	Parentesco	Sexo	Idade ou Data de Nascimento	Situação Actual		
				Transferido	Raptado	Falecido

VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANTIL
RECOLHA DE DADOS DE MALNUTRICAO E COMPLICACOES

CENTRO: _____ DATA: _____/_____/_____

MISSAO	KWASH	MARAS	KWH/MRS	PEITO/SECO	TOTAL	TOSSE	DIARR	PELE	OLHOS	PNEOM	TOTAL
1 YR	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000			00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
-3 YRS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000			00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
-12 YRS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000			00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
MG	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000			00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
LACT				00000 00000 00000 00000		00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
DULTOS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000			00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
LTAS											
1 YR	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000								
-3 YRS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000								
-12 YRS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000								
MG	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000								
LACT	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000							
DULTOS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000								
OTAL											

ABANDONOS	KWASH	MARAS	KWH/MRS	PEITO/SECO	TOTAL
1 YR	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000		
2-3 YRS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000		
4-12 YRS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000		
MG	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000		
LACT				00000 00000 00000 00000	
ADULTOS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000		
OBITOS					
1 YR	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000		
2-3 YRS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000		
4-12 YRS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000		
MG	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000		
LACT				00000 00000 00000 00000	
ADULTOS	00000 00000 00000 00000	00000 00000 00000 00000	00000 00000 00000 00000		
TOTAL					

Cartão de Saúde de Mulher

*N.º*_____ *Data*_____

Nome _____

_____

*Residência actual*_____

_____

Vacina Anti Tetanica

Dose	*Data*	
1.ª		
2.ª		
3.ª		
Reforço 1		
Reforço 2		

Proteja seu bebé contra o tétano

Guarde sempre este cartão

Cumpra o calendário

Gravidéz					
Consultas	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
ArO? - Razão					
Data **Parto Casa / Mat** Eut. / Dist.					

Planeamento Familiar - *Apontar método e datas de utilização*

167

Cartão de Saúde de Mulher

N.º_____ Data_____

Nome _____

_____

Residência actual_____

_____

Vacina Anti Tetanica

Dose	Data	
1.ª		
2.ª		
3.ª		
Reforço 1		
Reforço 2		

Proteja seu bebé contra o tétano

Guarde sempre este cartão

Cumpra o calendário

Gravidéz					
Consultas	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
ArO? - Razão					
Data Parto Casa / Mat Eut. / Dist.					

Planeamento Familiar - *Apontar método e datas de utilização*

PROGRAMA DE SUBSISTENCIA

FICHA DO REGISTO DO FAMILIA

ALDEIA: _____ BAIRRO: _____ QUATEIRAO: _____ PERIODO DO RELATO: _____

RND	NUMERO DAS NOVAS FAMILIAS REGISTAD · GRUPO ALVO	CRIANCAS DE 0-11 MESES	CRIANCAS DE 12-23 MESES	CRIANCAS DE 24-36 MESES	TOT	NUMERO DE M.I.F. (NOVAS)	NO. DE M.G. (NOVAS)	NO. MG SMI PGM (NOVAS)
	00000 00000 00000	00000 00000 00000	00000 00000 00000	00000 00000 00000		00000 00000 00000	00000	00000
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	00000 00000 00000	00000 00000 00000	00000 00000 00000	00000 00000 00000		00000 00000 00000	00000	00000
	00000 00000 00000	00000 00000 00000	00000 00000 00000	00000 00000 00000		00000 00000 00000	00000	00000
TOT								

PROGRAMA DE SOBREVIVENCIA INFANTIL
PERFIL DE NUTRICAO (CURVO DO PESO) POR IDADE

ALDEIA: _____ BAIRRO: _____ QUATEIRAO: _____ DATA: _____/_____/_____

AUMENTO DE PESO			TOT	PERCA DE PESO			TOT	MESMO PESO			TOT	PRIMEIRA PASAGEM			TOT	FALTAS	RETIRS
0-11	12-24	25-36		0-11	12-24	25-36		0-11	12-24	25-36		0-11	12-24	25-36			
00000	00000	00000		00000	00000	00000		000	000	000		000	000	000		00000	00000
00000	00000	00000		00000	00000	00000		000	000	000		000	000	000		00000	00000
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TAL																	

VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANTIL
REGISTO DE VACINACAO E FALTOSOS

TOTAL POPULACAO ALVO: _____ PERIODO DO RELATO: _____
ALDEIA: _____ B: _____ Q: _____ DATA: ____/____/____

VAC	IDADE DAS CRIANCAS								
	0-11 MESES	TOT	FALTA JAVAC	12-23 MESES	TOT	FALTA JAVAC	24+	TOT	FALTA JAVAC
DTP1	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 000 00000 000 00000 000 00000 000 00000 000		
2	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000	00000 000 00000 000 00000 000 00000 000 00000 000		00000 00000 00000 00000
3	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000	00000 000 00000 000 00000 000 00000 000		00000 00000 00000
APV1	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 000 00000 000 00000 000 00000 000 00000 000		
2	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000	00000 000 00000 000 00000 000 00000 000 00000 000		00000 00000 00000 00000
3	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000	00000 000 00000 000 00000 000 00000 000		0000 0000 0000
APN	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000								
BCG	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 00000 00000 00000 00000		
TOT									

VACINA	IDADE DAS CRIANCAS								
	0-11 MESES			TOT	12-23 MESES			TOT	24-36 MESES			TOT
SARAMPO	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	MULHERES IDADE FERTIL								MULHERES GRAVIDAS			
AT 1	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
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	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
AT 2	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
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	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
AT 3	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
AT 4/5	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
	00000	00000	00000		00000	00000	00000		00000	00000	00000	
TOTAL												

Visão Mundial Moçambique

Programa de Sobrevivência Infantil

Inquerito Nutricional-Controle do Crescimento

Malnutrição Crónica

P/I	M	F	TOT
<3%			
3-10			
>10			

Malnutrição Aguda

P/A	M	F	TOT
<3%			

Data:_____/_____/_____

Aldeia:_____

Bairro:_____

Quarteirão:_____

Masculino						Femenino					
Idade	Peso	% Tile	Alt	% Tile	%	Idade	Peso	% Tile	Alt	% Tile	%

TECNICO-C

5

Visão Mundial Moçambique

Programa de Sobrevivência Infantil

Ficha de Admissão e Controle Periódico

Nome: _____ Data de admissão: ____/____/____

Nome da mãe: _____ Peso: _____

Endereço: _____ Altura: _____

Data de nascimento: ____/____/____ Percentile (%): _____

Tipo de malnutrição: M K M/K P/S Data alta: _____

Data	Peso	Altura	Percentagem	Observações

174

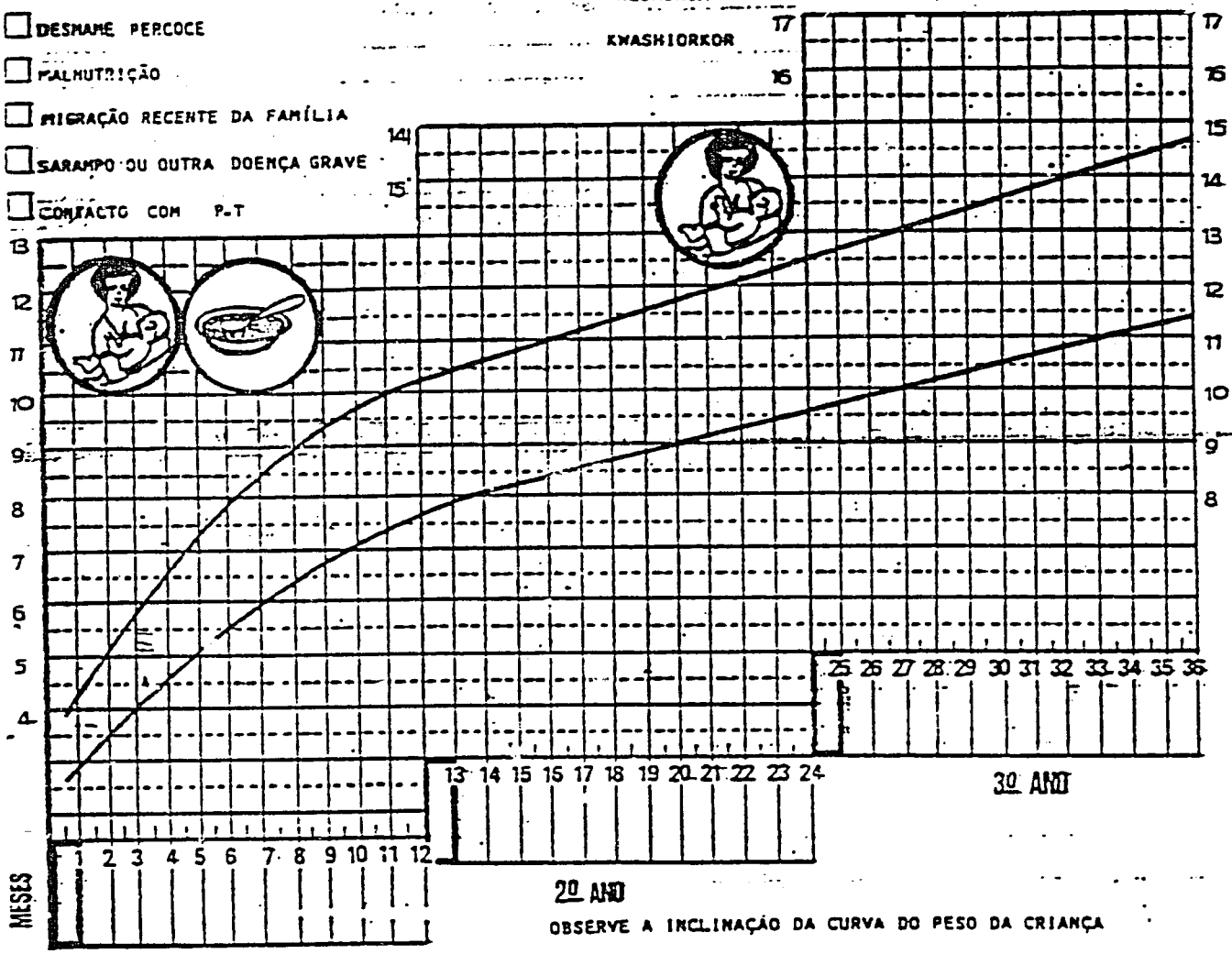
RAZÕES PARA ATENÇÃO ESPECIAL

PREECHER OS QUADRADOS

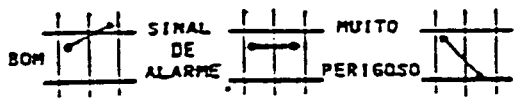
- ☐ PESO AO NASCER INFERIOR A 2.5KG
- ☐ GÊMEOS
- ☐ MÃE AUSENTE
- ☐ DESMAME PERCOCE
- ☐ MALNUTRIÇÃO
- ☐ MIGRAÇÃO RECENTE DA FAMÍLIA
- ☐ SARAMPO OU OUTRA DOENÇA GRAVE
- ☐ CONTACTO COM P.T

ESCREVER NA COLUNA DO MÊS APROPRIADO

DESMAME	NOVA GRAVIDEZ DA MÃE
DIARREIA	TOSSE CONVULSA
SARAMPO	ANEMIA
PNEUMONIA	OUTRAS DOENÇAS
KWASHIORKOR	



OBSERVE A INCLINAÇÃO DA CURVA DO PESO DA CRIANÇA



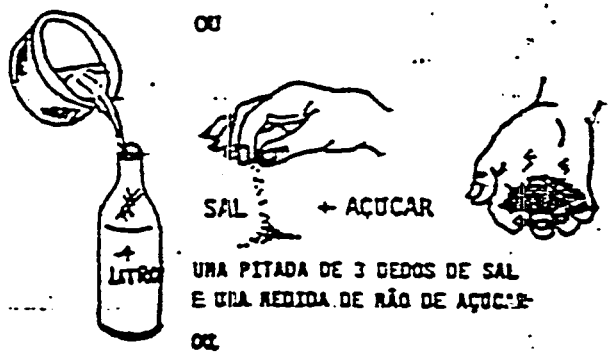
VACINAÇÕES

VACINA	DATA	LOCAL	ASSINATURA E CARIMBO
A - P & nascença			
BCG			
DTP 1ª dose			
AP 1ª dose			
DTP 2ª dose			
AP 2ª dose			
DTP 3ª dose			
AP 3ª dose			
ALS			

DIARREIA?

DAR A BEBER UMA SOLUÇÃO PREPARADA COM 1 LITRO DE ÁGUA E UM PACOTE DE SAIS.

OU



UMA PITADA DE 3 DEDOS DE SAL E UMA MEDIDA DE MÃO DE AÇUCAR

OU

DAR DE COMER PAPINHA DE ARROZ MUITO ACUIDA E EM BOA QUANTIDADE E MANTER A ALIMENTAÇÃO HABITUAL

Data	Observações Clínicas	Prescrições Terapeuticas

Data	Observações Clínicas	Prescrição Terapeuticas

Data de Proxima Consulta

República de Moçambique

Serviço Nacional de Saúde

CARTAO DE SAUDE

Nome e N.º da Unidade Sanitária

Criança *SEXO* .....

Nome .....

Filiação

Mãe .....

Pai .....

Residência

Local *Data* ...../...../.....

Em casa ☐ *Peso* ..... *Kg*

Naturalidade .....

Irmãos *Vivos* ☐ *Falecidos* ☐

Causas de morte .....

Doenças Cronicas na Família

Tuberculose .....

Outras .....

Atenção

Apresente Sempre este Cartão de Saúde nas Consultas

VISÃO MUNDIAL - MOÇAMBIQUE

Programa de Sobrevivência Infantil

Horário das Refeições para as Crianças Malnutridas

ZONA / ALDEIA _____

Período de Relato: _____

Data ____/____/____

Nome Completo	Peso	Copos por Ref.	Total copos por dia	CRIANÇAS MALNUTRIDAS															
				Data:						Data:						Data:			
				L/B	L	P	L	L	L/B	L/B	L	P	L	L	L/B	L/B	L	P	L
Total																			

VISÃO MUNDIAL - MOÇAMBIQUE

Programa de Sobrevivência Infantil

Horário das Refeições para Mulheres Grávidas e Adultos Malnutridos

E MÃES QUE AMAMENTAM DE IDADE < 6 MESES

NA / ALDEIA.....

Período de Relato: .....

Data...../...../.....

Nome Completo	Peso	Copos por Ref.	Total copos por dia	*MÃES QUE AMAMENTAM CRIANÇAS DE IDADE (6 MESES)*																
				Data:						Data:						Data:				
		1	2	L	P	M	L	*M*	B	L	P	*M*	L	*M*	B	L	P	*M*	L	M

VISÃO MUNDIAL - MOÇAMBIQUE

Programa de Sobrevivência Infantil

Horário das Refeições para as Mães Acompanhantes

ALDEIA .....

Período de Relato: .....

Data ____/____/____

ome Completo	Data:			Data:			Data:			Data:			Data:			Data:			Data:			Data:		
	P	M	M	P	M	M	P	M	M	P	M	M	P	M	M	P	M	M	P	M	M	P	M	M

VISÃO MUNDIAL–MOÇAMBIQUE

Programa de Sobrevivência Infantil

Quantidades de comida para programa de Alimentação Especial

Período do Relato: _____

Data ____/____/____

Papas – Mães = Farinha _____ Açúcar _____ _____

Loa – Crianças = Leite _____ Açúcar _____ Oleo _____ Água _____

Massa – Mães = Farinha _____ Feijão _____ Oleo _____ De manhã

E Cozinheiros = _____ _____ _____ De tarde

Papas-Crianças = F/Milho _____ Açúcar _____ Oleo _____

F/Ervilha _____

F/Verduras _____

F/Peixe _____

Data ____/____/____

Papas – Mães = Farinha _____ Açúcar _____ _____

Loa – Criaças = Leite _____ Açúcar _____ Oleo _____ Água _____

Massa – Mães = Farinha _____ Feijão _____ Oleo _____ De manhã

E Cozinheiros = _____ _____ _____ De tarde

Papas-Crianças = F/Milho _____ Açúcar _____ Oleo _____

F/Ervilha _____

F/Verduras _____

F/Peixe _____

Data ____/____/____

Papas – Mães = Farinha _____ Açúcar _____ _____

Loa – Crianças = Leite _____ Açúcar _____ Oleo _____ Água _____

Massa – Mães = Farinha _____ Feijão _____ Oleo _____ De manhã

E Cozinheiros = _____ _____ _____ De tarde

Papas-Crianças = F/Milho _____ Açúcar _____ Oleo _____

F/Ervilha _____

F/Verduras _____

F/Peixe _____

Data ____/____/____

Papas – Mães = Farinha _____ Açúcar _____ _____

Loa – Criaças = Leite _____ Açúcar _____ Oleo _____ Água _____

Massa – Mães = Farinha _____ Feijão _____ Oleo _____ De manhã

E Cozinheiros = _____ _____ _____ De tarde

Papas-Crianças = F/Milho _____ Açúcar _____ Oleo _____

F/Ervilha _____

F/Verduras _____

F/Peixe _____

Data ____/____/____

Papas – Mães = Farinha _____ Açúcar _____ _____

Loa – Crianças = Leite _____ Açúcar _____ Oleo _____ Água _____

Massa – Mães = Farinha _____ Feijão _____ Oleo _____ De manhã

E Cozinheiros = _____ _____ _____ De tarde

Papas-Crianças = F/Milho _____ Açúcar _____ Oleo _____

F/Ervilha _____

F/Verduras _____

F/Peixe _____

Programa Sobrevivência Infantil

CENTRO NUTRICIONAL CHANGARA

REQUISIÇÃO DE ADMISSÃO

Data	Nome do Doente	Diagnóstico	Observações	Nome do Clínico

O Responsável do Centro Nutricional,

VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE REPOSTA A EMERGENCIA
RELATORIO SEMENAL DO PROJECTO DA ALIMENTACAO ESPECIAL

Referente ao Periodo: ..... Data: ____/____/____

Nome do Programa: ..... Aldeia: .....

I. Alimenatacao Intensiva Estatistica:

	Rel/Ant	Admissao	Falta	Alta/C	Alta/F	Obito	TOTAL
1. (0-3 Anos)							
2. (4-12Anos)							
3. Lactentes							
4. MG							
5. Adultos							
TOTAL.....							

Tipo de Malnutricao:

a) Marasmo.....
b) Kwashiorkor.....
c) Kwashiorkor/Marasmatico.....
d) Peito Seco (sem leite).....

Refenencias Clinicas:

Causas (Diagnostico)

a) Conjuntivite.....
b) Diarreia.....
c) Malaria.....
d) Parasitosis.....
e) Sarna.....
f) Tosse.....
g) Outro.....

II. Controlo do Mensal da Mercadoria:

Data	Producto	Stock Ant	Entradas	Saidas	Existente	Estragados

Relação das Altas dadas no Cetro Nutricional para

DPPCCN

Data	Nome da Criança	Nome da Mãe	Área	DIC	AP

O Responsável do Centro Nutricional,

Direcção Distrital de Saúde de Changara

Data: .....

Delegação Distrital do DPPCCN

Changara

A pessoa abaixo mencionada recebeu alta hoje do Centro de Nutrição. Por favor providenciem uma ração completa que durará até a próxima distribulção geral ou um mês no máximo.

Nome(s) do doente: .....

Nome da mãe: .....

Nome do chefe da familia: .....

Endereço: .....

Número total dos membros da familia: .....

O Responsável do Centro de Saúde. *O Responsável do Centro de Nutrição,*

....

Direcção Distrital de Saúde de Changara

Data: .....

Delegação Distrital do DPPCCN

Changara

A pessoa abaixo mencionada recebeu alta hoje do Centro de Nutrição. Por favor providenciem uma ração completa que durará até a próxima distribulção geral ou um mês no máximo.

Nome(s) do doente: .....

Nome da mãe: .....

Nome do chefe da familia: .....

Endereço: .....

Número total dos membros da familia: .....

O Responsável do Centro de Saúde. *O Responsável do Centro de Nutrição,*

.....

Visão Mundial - Moçambique

Programa de Sobrevivência Infantil

REGISTO DIÁRIO DAS CRIANÇAS MALNUTRIDAS

(RAÇÕES DE DPCCN)

Aldeia: ____________________ Bairro: ____________________ Quart: ______________ Data: _____/_____/_____

N.º	Nome da Criança	Idade	Chefe da Familia	Deslocado	Afectado	Observ.

REPÚBLICA POPULAR DE MOÇAMBIQUE
MINISTÉRIO DA SAÚDE
DIRECÇÃO NACIONAL DE SAÚDE
SMI/PF

FICHA PRÉ-NATAL

UNIDADE SANITÁRIA .....

Nome
Data Emissão Processo/NID
B. I. (N.º, ARQ. DATA)
Data nasc./Estado/Sexo/Raça
Profissão
LOCAL DE TRABALHO
Naturalidade
Residência/Telef.
Filiação

Gesta ☐ Abortos ... ☐ Nados vivos ... ☐
Para ☐ Nados mortos ... ☐ Vivos Actuais ... ☐
Falecidos ... ☐

ANTECEDENTES OBSTÉRICOS

Partos anteriores com forceps ou ventosa? ...	☐	★★★
Complicações hemorrágicas em mais de 2 partos? ...	☐	★★★
Remoção manual da placenta em mais de 2 partos? ...	☐	★★★
N.º de cesarianas ..... (No último parto? Sim/Não)	☐	★★★
Primigesta com altura inferior a 1,5 metros? ...	☐	★★★
Primigesta com idade inferior a 16 anos? ...	☐	★★★
Primigesta com idade superior a 29 anos? ...	☐	★★★
Idade superior a 35 anos ...	☐	★★
Teve 5 ou mais partos ...	☐	★★
Última gravidez: Nado morto? ...	☐	★★
ou R. N. falecido durante a 1.ª semana? ...	☐	★★
Teve 2 ou mais abortos? ou 2 ou mais nados mortos? ...	☐	★★
Teve R. N. com mais de 4 kilos? ...	☐	★★
Teve T. A. alta ou edemas nas gestações anteriores? ...	☐	★★
Teve convulsões nas gestações anteriores? ...	☐	★★
Teve convulsões na ausência de gravidez? ...	☐	★
Tem muita fome, sêde e urina muito? ...	☐	★
Tem disuria e polaquiuria? ...	☐	★
Tem tosse e expectoração há mais de três semanas? ...	☐	★
Tem tuberculose e está em tratamento? ...	☐	

★★★ ★★★

Cuidados de Saúde Terciários
Planear parto no H. Central ou Provincial

★★

Cuidados de Saúde Secundários
Enviar à consulta de Obstetricia de Hospital Geral ou Rural

★

Cuidados de Saúde Primários
Enviar à consulta do médico ou técnico de medicina do Centro de Saúde

Vacina A. Tetânica: 1.ª dose ...../...../..... 2.ª dose ...../...../..... Reforço ...../...../.....

Análises: — V. D. R. L. Negativo ☐ Positivo ☐ Data: ...../...../.....

Hemoglobina (se menos de 8 gr. %) ... ☐ ★ Data: ...../...../.....
(pedir só com sinais de anemia)

Grupo sanguíneo (primigestas) ☐ Se Rh negativo ☐ ★★

CASOS A ENVIAR DE IMEDIATO À CONSULTA MÉDICA OU EVACUAR PARA O HOSP. RURAL, GERAL OU PROVINCIAL.

— Hemorragias evidentes e abundantes, (no 3.º trimestre não fazer toque, pois pode ser placenta prévia)
— Cefaleias fortes, perturbações da visão, dor epigástrica forte, ou convulsões no 3.º trimestre (pré-eclâmpsia, eclâmpsia).
— Dor abdominal aguda e violenta (apendicite aguda, gravidez ectópica, rotura uterina, etc.)

EVOLUÇÃO DA GRAVIDEZ ACTUAL

Data da última mestruação ...../...../..... Data provável do parto ...../...../.....

DATA										
Tempo de gestação										
Altura uterina-superior a 36 cm	★★									
Foco (Frequência cardíaca fetal)										
Movimentos Fetais										
Apresentações: Cefálica										
Pélvica	★★★									
Situações: Tranversa	★★★									
Gemelar	★★★									
Peso: Aumento superior a 2 kg p/mês	★★									
» Inferior a 45 kg ou sup. a 90 kg	★									
T. A. (superior a 140/90)	★★									
Edemas: Pés										
Mãos e face	★★									
Albumina-superior a + +	★★									
Coloração das mucosas: Coradas										
Descor. pedir Hb.										
Sal ferroso c/ácido fólico										
Cloroquina										
Assinatura										

OBSERVAÇÕES DO MÉDICO OBSTETRA: parto indicado no Hosp. Provincial ou Central. [ ] ★★★

.....

	Observações	Conduta	Ass.

OBSERVAÇÕES DA MATERNIDADE

Data do parto ...../...../..... Aborto [ ] Nado morto [ ] Nado vivo [ ]

Tipo de parto ..... Apresentação ..... Se distócico, porque? .....

Recém nascido: sexo ..... Peso ao nascer ..... Perímetro craneano .....

Anomalias ..... Reanimado? .....

Puerpério: normal, febril, com hemorragias, (sublinhe) Estado do períneo .....

Falecimento materno ..... Causa .....

Maternidade ..... Envio a P. F. .....

Assinatura .....

VISAO MUNDIAL MOCAMBIQUE

PROGRAMA DE SOBREVIVENICA INFANTIL

FICHA DE ACTIVIDADES DE AGUA E SANEAMENTO

(8)

ALDEIA: _____ BAIRRO: _____ QUAT: _____ ANO : _____

	INICIADA			EM CONSTRUCAO			CONCLUIDA				
PER	LATRINAS	POCOS	TOT	LATRINAS	POCOS	TOT	LATRINAS	POCOS	TOT	TREINAMENTO	TOT
J-N	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	
A-J	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	
J-S	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	
O-D	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	
TOT											

VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANTIL
FICHA DE REGISTO DAS LATRINAS

ALDEIA: _____ BAIRRO: _____ PERIODO DO RELATORIO: _____

O.	DATA	NOME DE CHEFE DA FAMILIA	NO PES	ADT	CRI	CHEFE DE QUARTEIRAO	CHEFE DAS 0 CASAS	LATRINAS CONSTRUIDAS T/P S/N LAG	S/N COB	PERIODO DE CONSTRUCAO 1 2 3 4 5 6 7 8 9 10 11 12					
OT															

Itenico - No (9)

VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANTIL
SUMARIO DAS VISITAS DOMICILIARIAS E TREINAMENTO

ALDEIA: _____ BAIRRO: _____ PERIODO DO RELATORIO: _____

NO DE ORDEM	VISITAS DOMICILIARIAS	CRIANCAS < 1 ANO	CRIANCAS 1-3 ANOS	TREINAMENTO	NO. DE SESSOES
	PAPAS SIMPLES			NUTRICAO	
	PAPAS RICAS			DIARREIA	
	ALIMENTOS CONSISTENTES			VACINACOES	
	TEM LATRINAS			MALARIA	
	TEM DIARREIA			OUTROS	
	MUITOS LIQUIDOS				
	SRO NA BASE DE ACUCAR SAL E AGUA				
	SRO NA BASE DE CEREAIS				
	VACINADAS				
OBSERVACOES:				OBSERVACOES:	

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VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANTIL
COMITES DE SAUDE EM FUNCIONAMENTO
DISTRITO DE CHANGARA

DATA DA FORMACAO	ZONA	COMPOSICAO DO COMITE DE SAUDE	FACILITAD. ESCOLHIDOS	OBSERVACOES
		1 2 3 4 5 6 7 8		
		1 2 3 4 5 6 7 8		
		1 2 3 4 5 6 7 8		
		1 2 3 4 5 6 7 8		

ALDEIA: _____ Q: _____

POPULACAO ALVO: 0-11 MESES: ____
12-36 MESES: ____
TOTAL: ____
M.I.F: ____

VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANTIL
RELATORIO MENSAL DE IMUNIZACOES

ANO/PERIODO: _____

DATA OU ROND	D T P									A P V									B C G		SARAMPO		AT			FALTAS			RETIR
	0-11 MES			12-23 MES			24+ MES			0-11 MES			12-23 MES			24+ MES			<11	>11	<11	>11	MG/MIF			DTP	APV	AT	
	1a	2a	3a	1a	2a	3a	1a	2a	3a	1a	2a	3a	1a	2a	3a	1a	2a	3a					1a	2a	3a				
CUM																													
VACX																													
CUM																													
VACX																													
CUM																													
VACX																													
CUM																													
VACX																													
CUM																													
VACX																													
TOT																													

VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANTIL
REGISTO DOS HABITANTES

ALDEIA: _____ BAIRRO: _____ QUAT: _____ PERIODO DO RELATO: _____

Data Ronda	Total Habitant	Total das Familias Aldeia	Fam Registradas		Criancas Registradas				Mulheres 15-45 Anos	Mulheres Gravidas Registradas	M.G. SMI consegui encontrar
			Grp Alvo	Nao Alvo	0-11	12-24	25-36	TOTAL			
a											
a		Antigos:									
		Faltas:									
		Novas:									
		Retiradas:									
		Total:									
a		Antigos:									
		Faltas:									
		Novas:									
		Retiradas:									
		Total:									
a		Antigos:									
		Faltas:									
		Novas:									
		Retiradas:									
		Total:									
TOTAL											

VISAO MUNDIAL, MOZAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANITL
PERFIL DE NUTRICAO (EM PERCENTILES) POR GENERO, IDADE, ALTURA E SITIO

MES/PERIODO: _____ DATA: ____/____/____

	IDADE					ALTURA				
	%TILE	M	F	TOT	%	%TILE	M	F	TOT	%
SITIO: _____	< 3	___	___	___	___	< 3	___	___	___	___
	3-10	___	___	___	___	3-10	___	___	___	___
DATA: _____	> 10	___	___	___	___	> 10	___	___	___	___
	TOTAL	___	___	___	___	TOTAL	___	___	___	___
SITIO: _____	< 3	___	___	___	___	< 3	___	___	___	___
	3-10	___	___	___	___	3-10	___	___	___	___
DATA: _____	> 10	___	___	___	___	> 10	___	___	___	___
	TOTAL	___	___	___	___	TOTAL	___	___	___	___
SITIO: _____	< 3	___	___	___	___	< 3	___	___	___	___
	3-10	___	___	___	___	3-10	___	___	___	___
DATA: _____	> 10	___	___	___	___	> 10	___	___	___	___
	TOTAL	___	___	___	___	TOTAL	___	___	___	___
SITIO: _____	< 3	___	___	___	___	< 3	___	___	___	___
	3-10	___	___	___	___	3-10	___	___	___	___
DATA: _____	> 10	___	___	___	___	> 10	___	___	___	___
	TOTAL	___	___	___	___	TOTAL	___	___	___	___
SITIO: _____	< 3	___	___	___	___	< 3	___	___	___	___
	3-10	___	___	___	___	3-10	___	___	___	___
DATA: _____	> 10	___	___	___	___	> 10	___	___	___	___
	TOTAL	___	___	___	___	TOTAL	___	___	___	___
SITIO: _____	< 3	___	___	___	___	< 3	___	___	___	___
	3-10	___	___	___	___	3-10	___	___	___	___
DATA: _____	> 10	___	___	___	___	> 10	___	___	___	___
	TOTAL	___	___	___	___	TOTAL	___	___	___	___
SITIO: _____	< 3	___	___	___	___	< 3	___	___	___	___
	3-10	___	___	___	___	3-10	___	___	___	___
DATA: _____	> 10	___	___	___	___	> 10	___	___	___	___
	TOTAL	___	___	___	___	TOTAL	___	___	___	___
SITIO: _____	< 3	___	___	___	___	< 3	___	___	___	___
	3-10	___	___	___	___	3-10	___	___	___	___
DATA: _____	> 10	___	___	___	___	> 10	___	___	___	___
	TOTAL	___	___	___	___	TOTAL	___	___	___	___

VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DO SOBREVIVENCIAL INFANTIL
DEMONSTRATACO DO PROGRESSO DE CONTROLE DE CRESCIMENTO

ZONA: _____
C. ALVO: 0-11 M: _____
12-23M: _____
24-35M: _____
TOTAL: _____

DE MES: _____ DE 19____

DATA	NO. DE CRIANCAS PESADAS		NO. QUE GANHARAM PESO		NO. QUE MANTERAM/ PERDERAM		PERCENTIL PESO/IDADE						FALTAS				NO. DE CRIANCAS RETIRADAS	
							< 3		3-10		> 10		NEW		RETURNS			
	NEW	OLD	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%
TOTAL:																		

VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIAL INFANTIL
SUMARIO MENSAL DO INTERVENCOES SMI

ALDEIA: _____ BAIRRO: _____ QUAT: _____ ANO: _____

MES	# REGIS	1a CONS POSTPART	# ALTAS	TOTAL	1a CONSULTAS	CONSULTAS SEGUINTES	TOTAL CONSULTAS	# VAT 1	# VAT 2	TOTAL VAT'S
JAN										
FEV										
MAR										
ABR										
MAY										
JUN										
JUL										
AUG										
SET										
OUT										
NOV										
DEZ										
TOT										

VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANTIL
RELATORIO MENSAL/TRIMESTRAL

Nome do Projecto: PSI-TETE Data: _____ Periodo:

I - Imunizacao:

	Mes Corrente	Numero Cumulativo
BCG/APO.....		
DTP 1 / AP 1.....		
DTP 2 / AP 2.....		
DTP 3 / AP 3.....		
Sarampo.....		
AT 1 (MIF/MG).....		
AT 2 (MIF/MG).....		
AT 3 (MIF/MG).....		
AT 4/5(TODAS).....		

NUMERO EM TOTAL DES VACCINAS ADMINISTRADAS...__

II- Controle de Crescimento des criancas com 0-3 anos:

	Mes Corrente	Mes Passado		Mes Corrente	Numer Cumulat.
1. Baixo de Peso (<80% peso/idade)...			Criancas Avaliada 1 vez o mais.....		
2. Malnutricao Aguda (<75% peso/alt.)...__					
3. Perderam/Manteram Peso.....			Criancas Avaliada 2 vezes o mais.....__		

III-Alimentacao Infantil:
No. da mae treinada na alimentacao infantil.....
Alimentacao Teraputica (Uso Fiche de Project da Alimentacao)

IV- Program da Alimentacao Escola:
No. das alunos alimentada no programa.....
No. das alunos pesadas.....
No. alunos ganharam peso... _ perderam/manteram peso...

V - SRO:
No. de maes treinadas na preparacao/uso de SRO.....
No. de criancas com diarreia fornecidas de SRO.....

VI- SMI:
No. de mulheres gravidas registadas..... examinadas.....

VI- Treinamento:
No. de facilitadores treinados.....
No. de facilitadores que visitaram familias.....

VII-Impacto:
No. de casos de diarreia .....
No. de casos de sarampo .....
No. de casos de malaria .....
No. de casos de kwash. o maras. (<75% P/A) ref. ao centro.....
No. de obitos por diarreia.....

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VISAO MUNDIAL MOCAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANTIL
JOURNAL TRIMESTRAL POR INTERVENCOES

Por favor sumarize os mairoes eventos/actividades que ocorreram durante o trimestre passado. Obrigada.

Agua e Saneamento: _____

Immunizations: _____

Nutricao: _____

ORT/CDD: _____

Treinamento: _____

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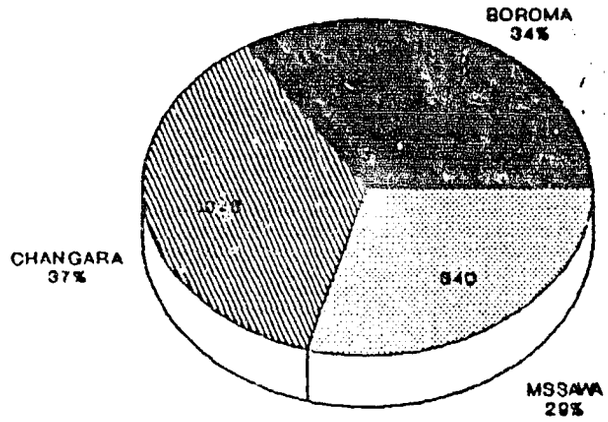
ANEXO 12: DADOS GRAFICOS

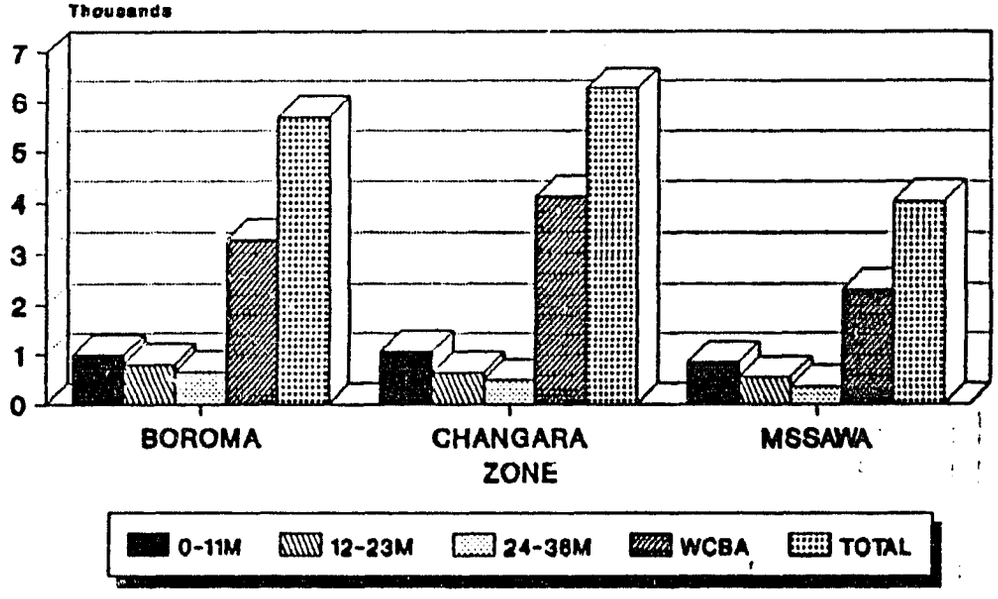
TETE CHILD SURVIVAL PROGRAM
REGISTERED POPULATION, 0-36 MONTHS
AND WOMEN OF CHILD BEARING AGE BY ZONE



EACH ZONE CONSISTS OF 4-7 SUBURBS JLW

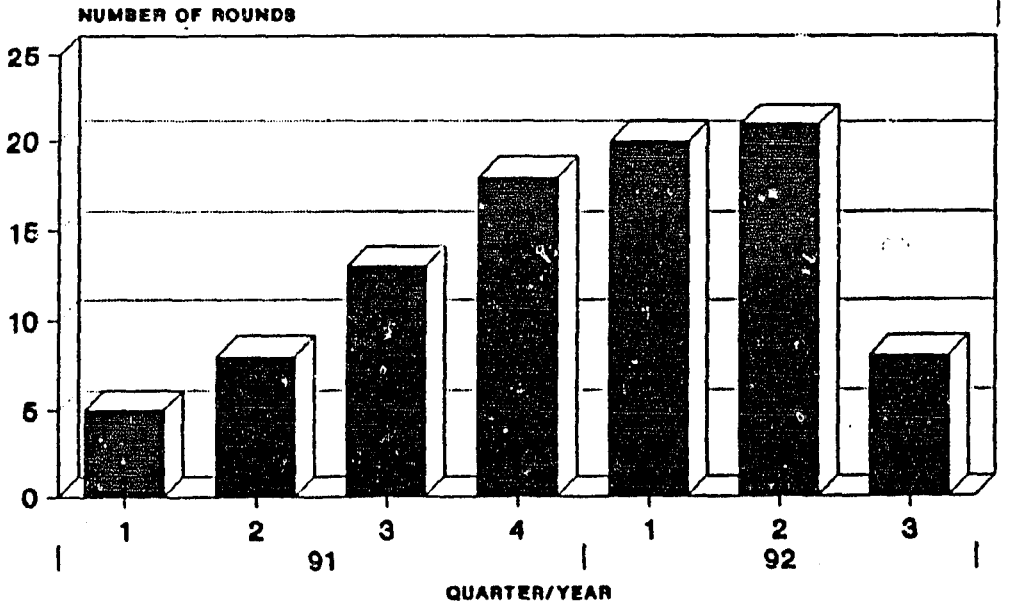
REGISTERED BETWEEN 10.90 - 7.92

TETE CHILD SURVIVAL PROGRAM
TARGET POPULATION BY ZONE/CATEGORY
JANUARY 1991 - JULY 1992



EACH ZONE CONSISTS OF 4-7 SUBURBS JLW

TETE CHILD SURVIVAL PROGRAM
COMPLETED ROUNDS OF CSP INTERVENTIONS
FIRST QUARTER 1991 - THIRD QUARTER 1992



3RD QUAT/92 INCLUDES JULY 1992 ONLY JLW

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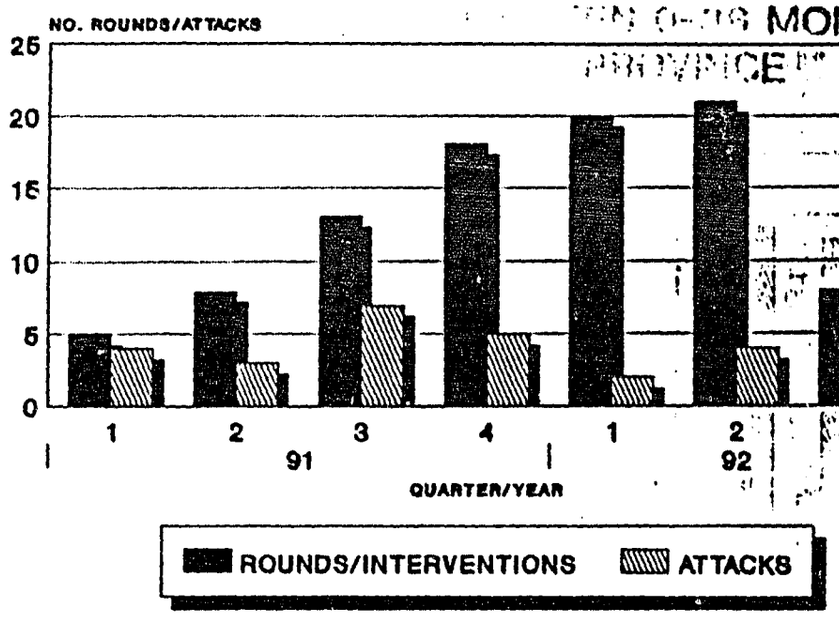
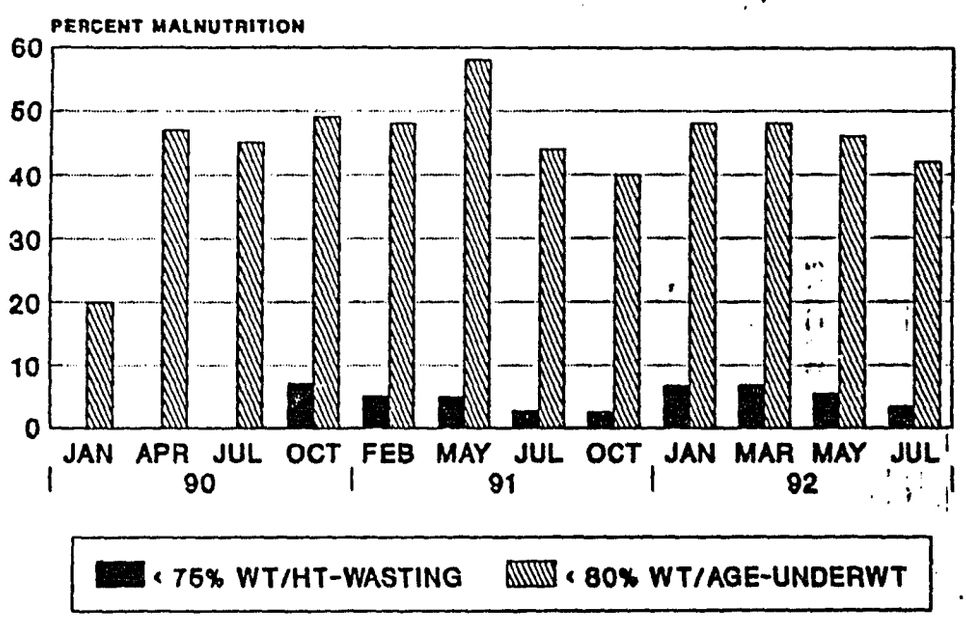
TETE CHILD SURVIVAL PROGRAM
RECORD OF INTERVENTIONS AND ATTACKS



3RD QUAT/92 INCLUDES JULY 1992 ONLY JLW

RATE OF UNDERWEIGHT AND WASTING AMONG CHILDREN BETWEEN 0-36 MONTHS CHANGARA, TETE PROVINCE



JLW

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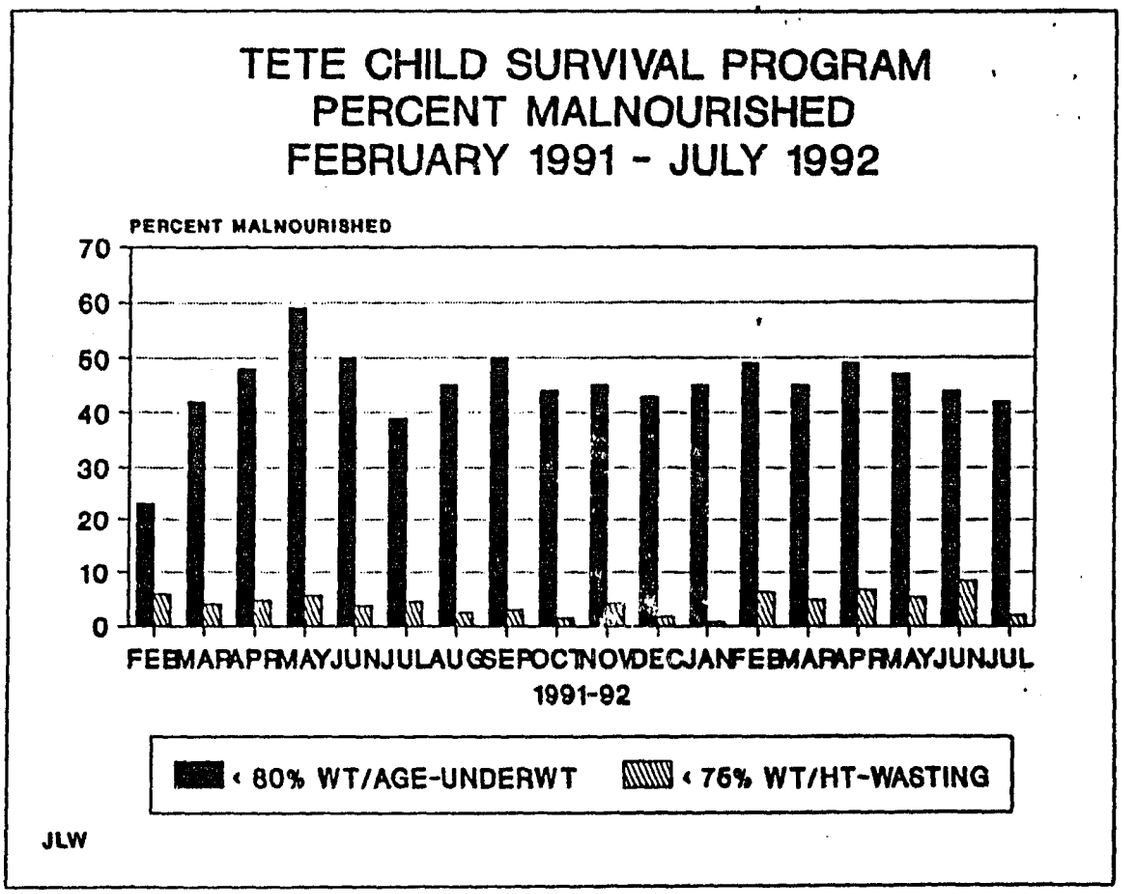
TETE CHILD SURVIVAL PROGRAM
PERCENT MALNOURISHED
FEBRUARY 1991 - JULY 1992
PERCENT MALNOURISHED
70
60
50
40
30
20
10
0
FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN JUL
1991-92
< 80% WT/AGE-UNDERWT
< 76% WT/HT-WASTING
JLW

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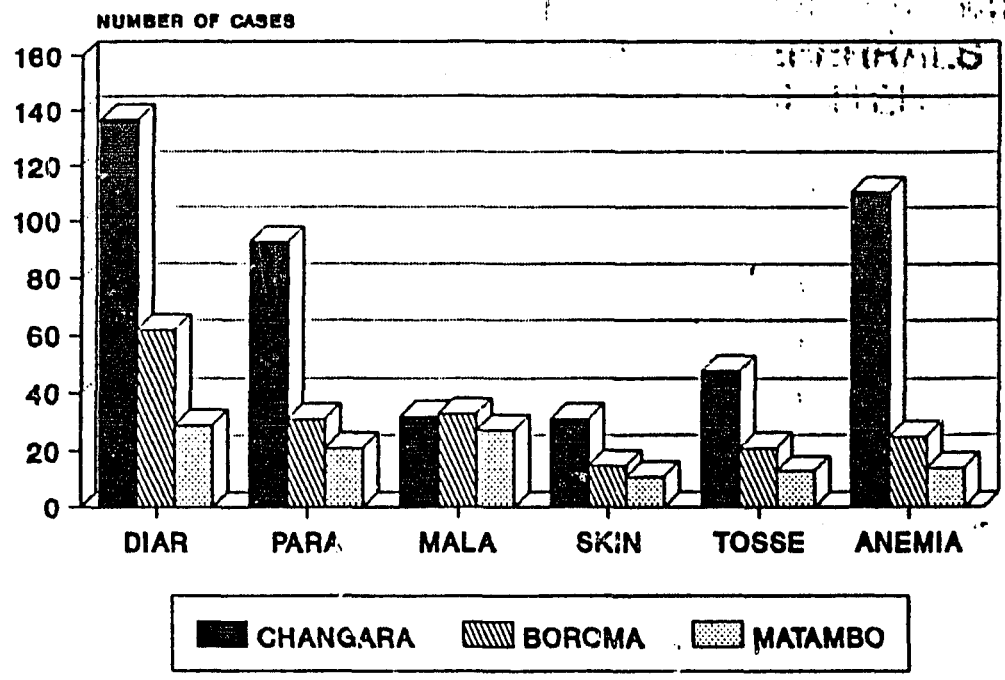
VISAO MUNDIAL, MOZAMBIQUE
PROGRAMA DE SOBREVIVENCIA INFANITL
PERFIL DE NUTRICAO (EM PERCENTILES) POR GENERO, IDADE, ALTURA E SITIO

MES/PERIODO: JULHO 1992 DATA: 01/08/92

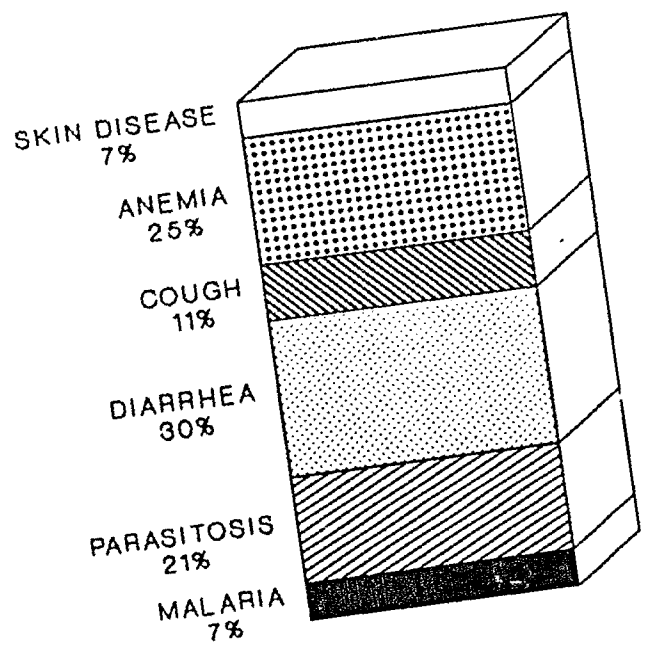
	IDADE					ALTURA				
	%TILE	M	F	TOT	%	%TILE	M	F	TOT	%
SITIO:MATAMBO BRID	< 3	31	28	59	36.2	< 3	3	7	10	6.1
	3-10	18	22	40	24.5	3-10				
DATA: JULHO 1992	> 10	42	22	64	39.3	> 10				
	TOTAL	91	72	163	100.0	TOTAL				
SITIO:MATAMBO MUCHE	< 3	31	26	57	41.6	< 3	2	4	6	4.4
	3-10	15	18	33	24.1	3-10				
DATA: JULHO 1992	> 10	28	19	47	34.3	> 10				
	TOTAL	74	63	137	100.0	TOTAL				
SITIO:MATAMBO SEDE	< 3	25	27	42	33.3	< 3	1	2	3	2.4
	3-10	10	13	23	18.2	3-10				
DATA: JULHO 1992	> 10	19	32	51	48.5	> 10				
	TOTAL	54	72	126	100.0	TOTAL				
SITIO:M.CHACALANGA	< 3	11	6	17	28.0	< 3	0	0	0	0.0
	3-10	8	10	18	30.0	3-10				
DATA: JULHO 1992	> 10	12	13	25	41.2	> 10				
	TOTAL	31	29	60	100.0	TOTAL				
SITIO:M. NHANGULULU	< 3	29	30	59	46.4	< 3	1	3	4	3.2
	3-10	20	23	43	33.8	3-10				
DATA: JULHO 1992	> 10	14	11	25	19.8	> 10				
	TOTAL	63	64	127	100.0	TOTAL				
SITIO:CHANGARA	< 3	105	117	222	41.8	< 3	11	5	16	3.1
	3-10	87	77	164	30.8	3-10				
DATA: JULHO 1992	> 10	71	74	145	27.4	> 10				
	TOTAL	263	268	531	100.0	TOTAL				
SITIO:MSSAWA	< 3	81	80	161	47.3	< 3	4	9	13	3.8
	3-10	36	39	75	22.1	3-10				
DATA: JULHO 1992	> 10	54	50	104	30.6	> 10				
	TOTAL	171	169	340	100.0	TOTAL				
SITIO: _____	< 3					< 3				
	3-10					3-10				
DATA: _____	> 10					> 10				
	TOTAL					TOTAL				

CLINICAL REFERRALS
INTENSIVE FEEDING CENTERS-TETE 1991-92

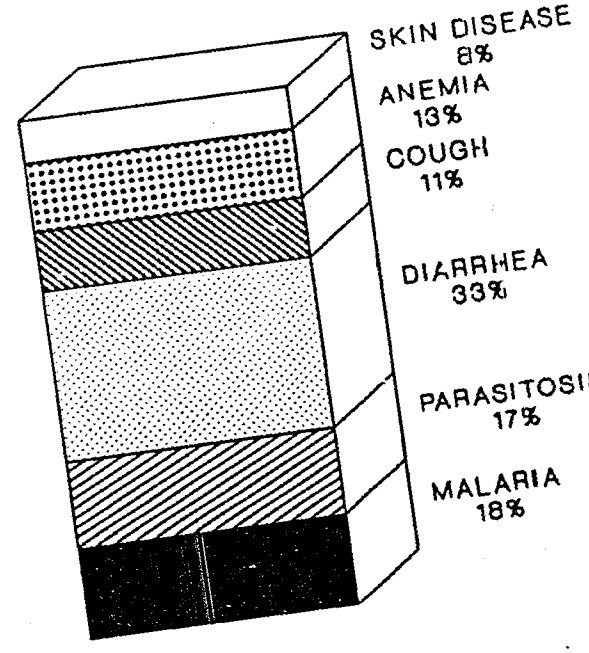


INCLUDES THE FIRST 7 MONTHS OF 1992 JLW

CHANGARA DISTRICT CLINICAL REFERRALS
CHANGARA/BOROMA FEEDING CENTERS
JANUARY 1991 - JULY 1992



CHANGARA



BOROMA

INCLUDES THE FIRST 7 MONTHS OF 1992 JLW

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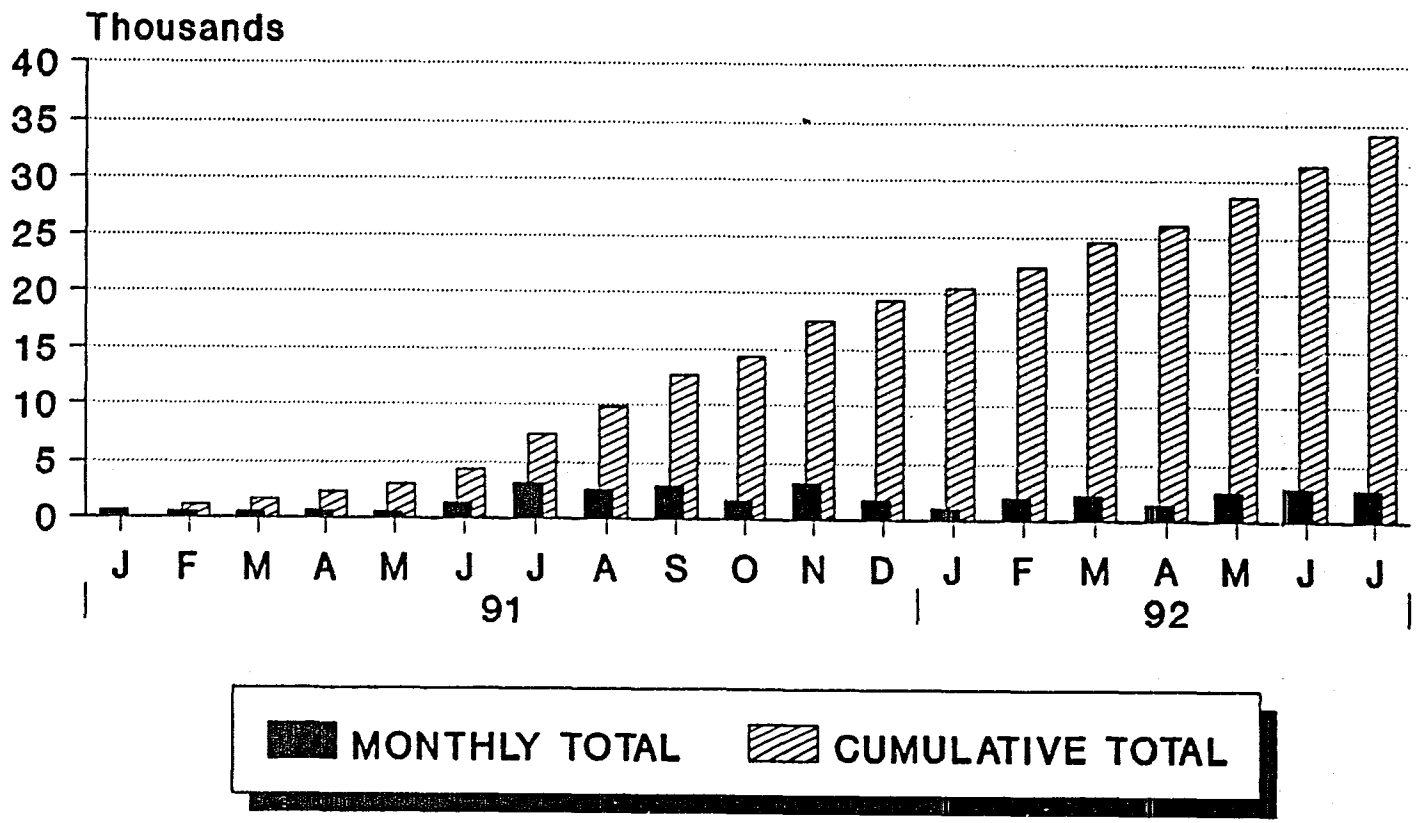
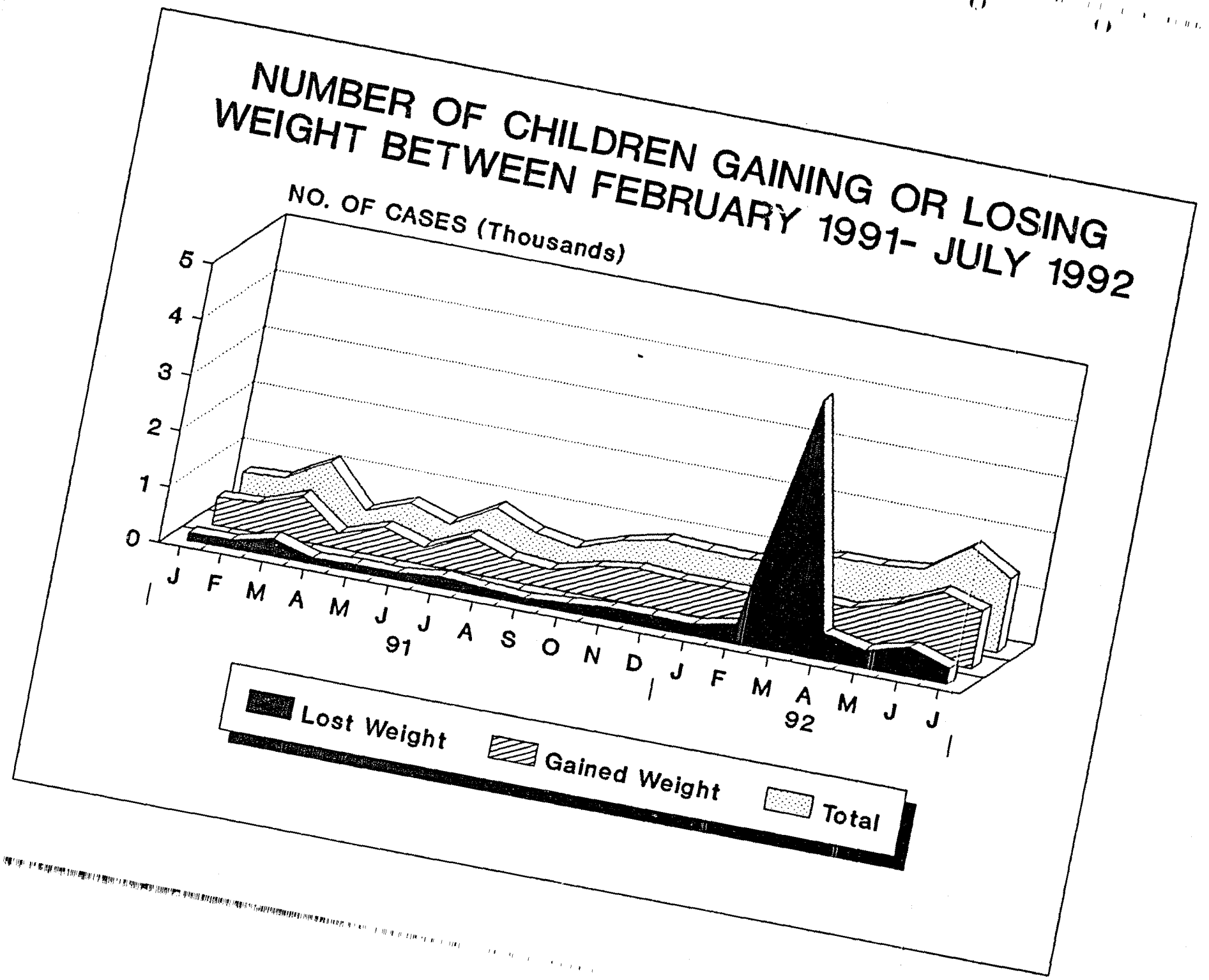
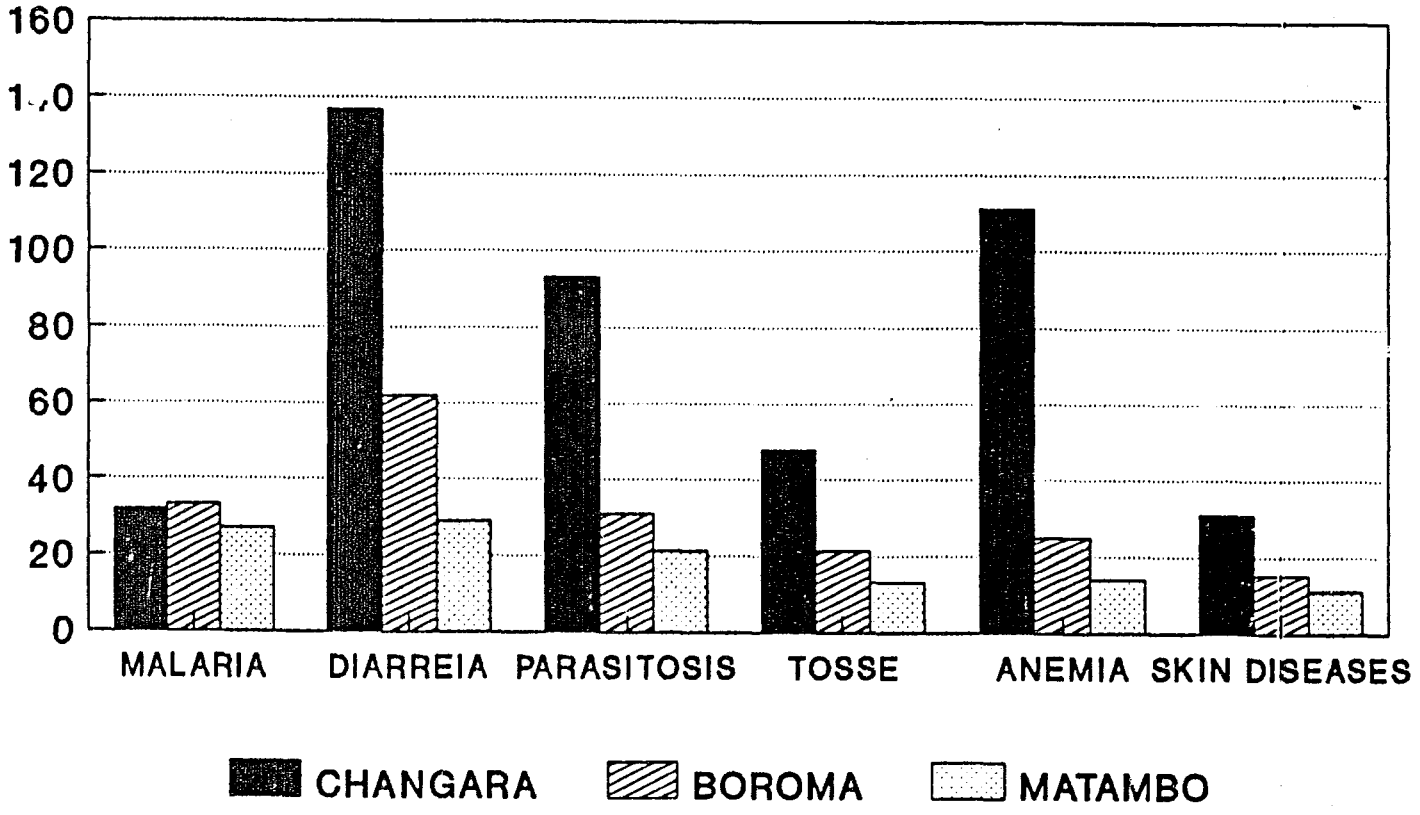
MONTHLY/CUMULATIVE VACCINATION TOTALS
TETE CHILD SURVIVAL PROGRAM
JANUARY 1991 - JULY 1992



BCG, DTP1,2,3 OPV1,2,3, TT1,2,3,4
MEASLES

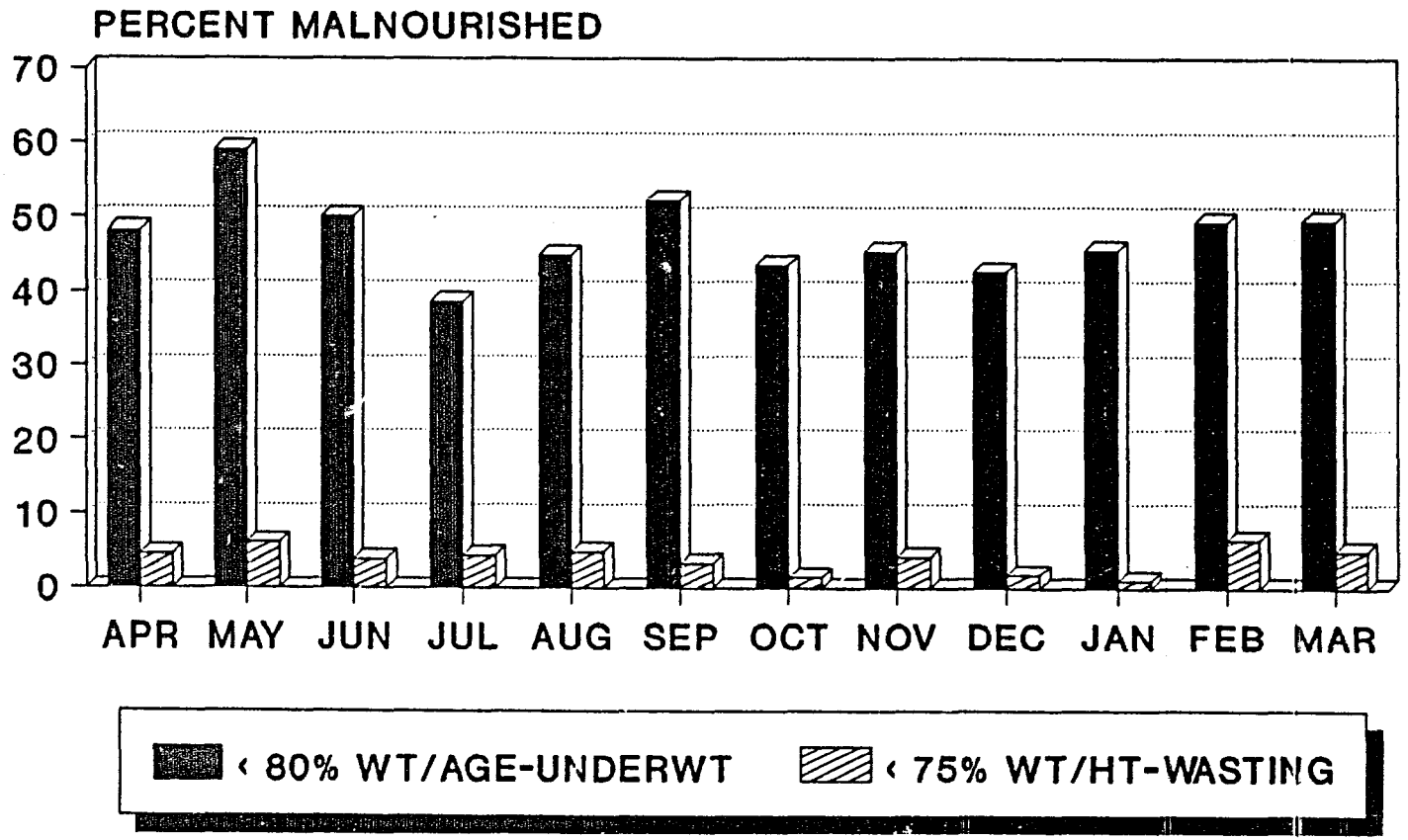

NUMBER OF CHILDREN GAINING OR LOSING WEIGHT BETWEEN FEBRUARY 1991- JULY 1992
NO. OF CASES (Thousands)
5
4
3
2
1
0
J F M A M J J A S O N D J F M A M J J
91
92
Lost Weight
Gained Weight
Total

CLINICAL REFERRALS
CHANGARA FEEDING CENTER
JANUARY 1991 - JULY 1992



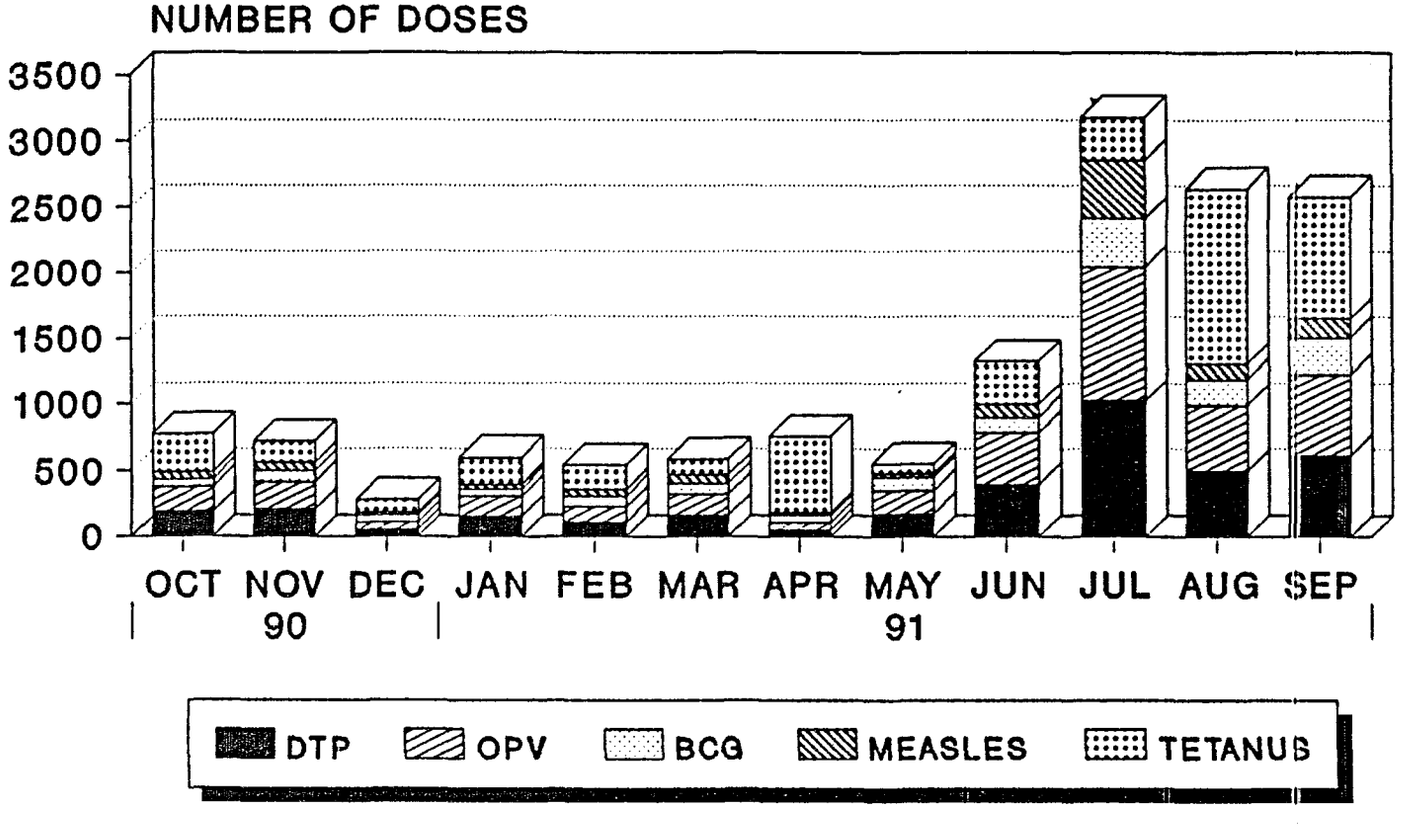
INCLUDES THE FIRST 7 MONTHS OF 1992 JLW

TETE CHILD SURVIVAL PROGRAM
PERCENT MALNOURISHED
APRIL 1991 - JULY 1992



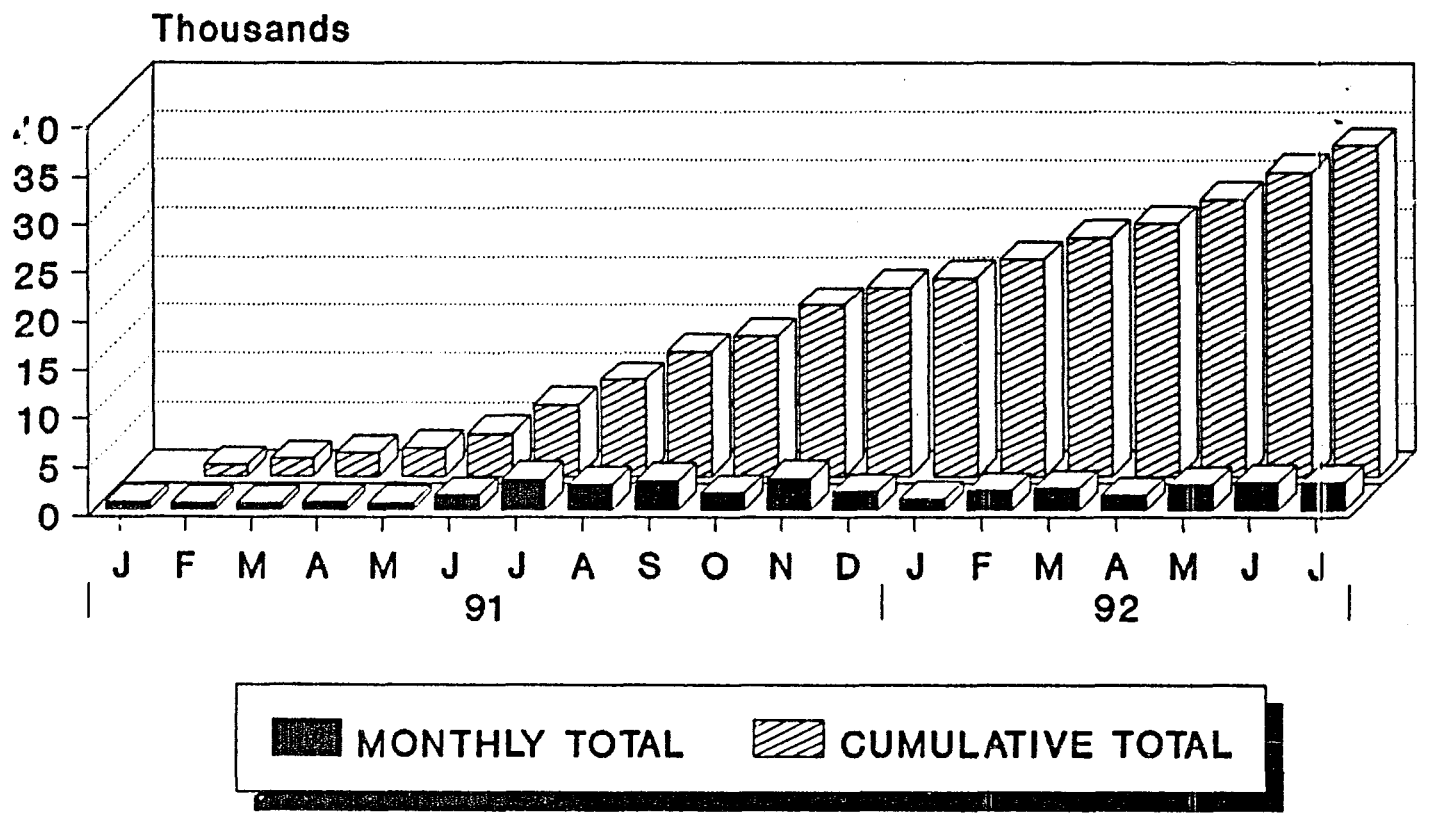
BOROMA, CHANGARA, MSSAWA ZONES JLW

TETE CHILD SURVIVAL PROGRAM
VACCINATIONS ADMINISTERED
OCTOBER 1990- SEPTEMBER 1991



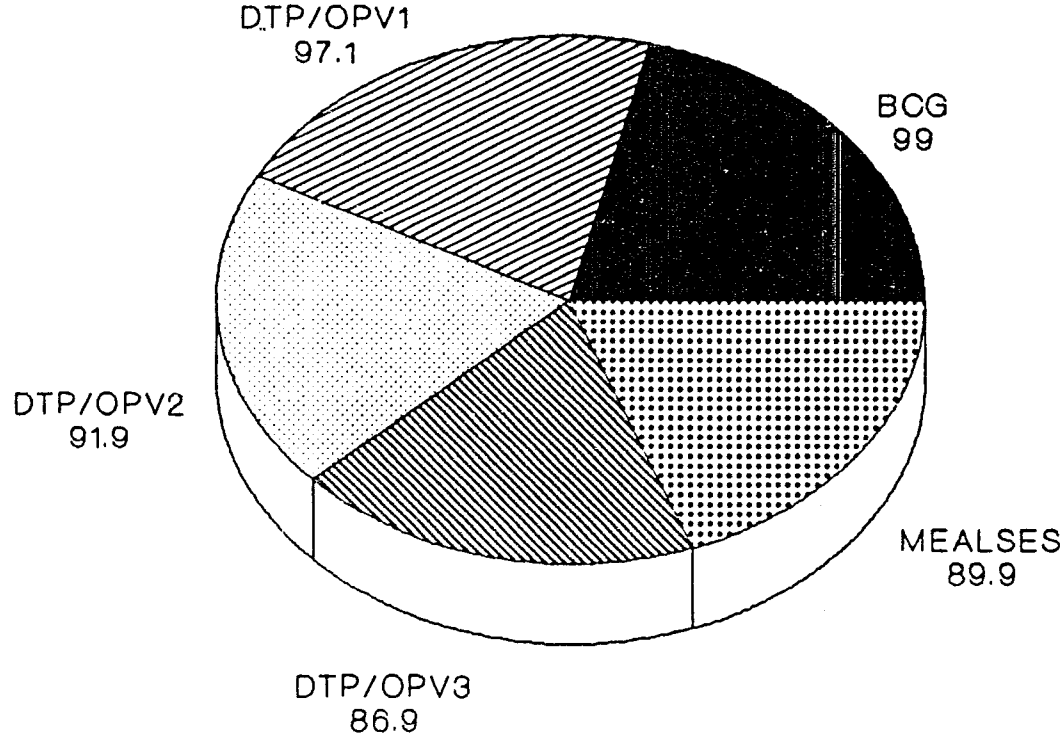
DTP/OPV 1,2,3 JLW

MONTHLY/CUMULATIVE VACCINATION TOTALS
TETE CHILD SURVIVAL PROGRAM
JANUARY 1991 - JULY 1992



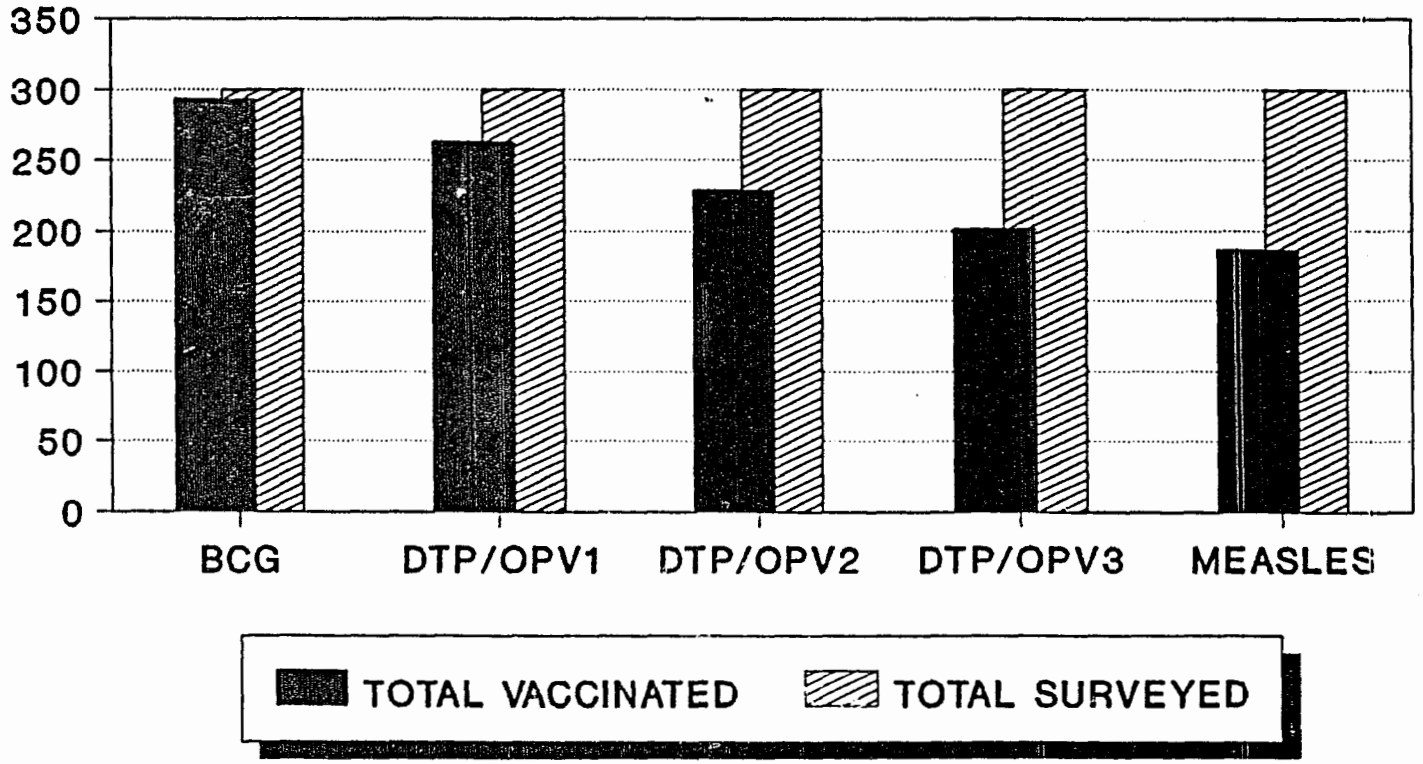
BCG, DTP1,2,3 OPV1,2,3, TT1,2,3,4
MEASLES

PERCENT VACCINATED
CHANGARA DISTRICT, TETE PROVINCE
AUGUST 1992



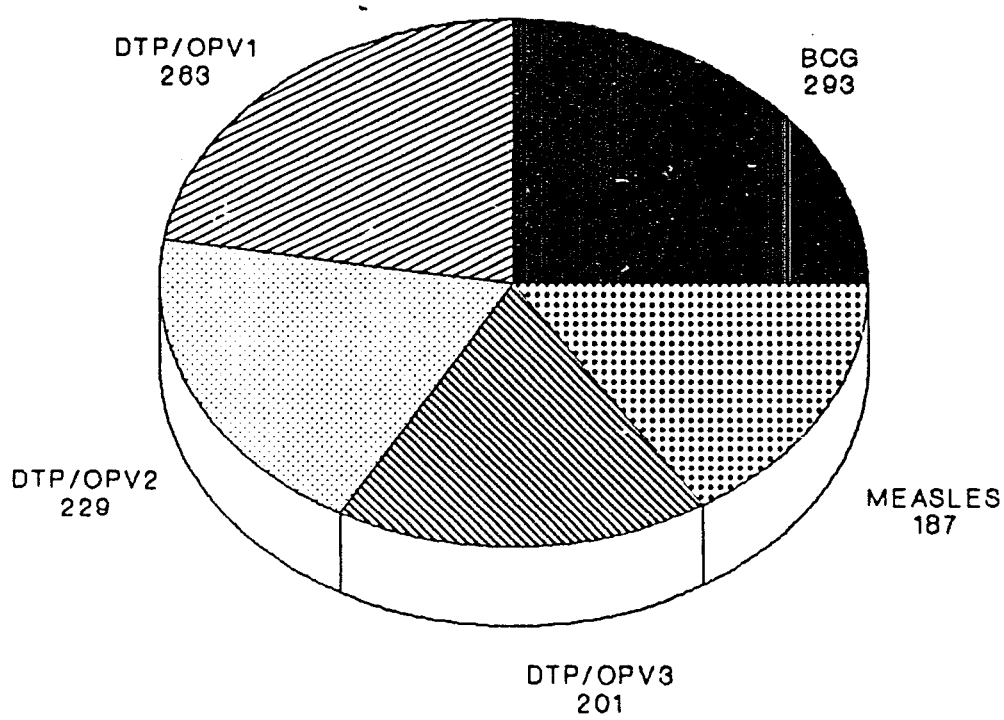
VACCINATION SURVEY CONDUCTED JOINTLY
BY THE MOH AND CSP TETE
SAMPLE: 300 CHILDREN 12-23 MONTHS

VACCINATION SURVEY RESULTS
CHANGARA DISTRICT, TETE PROVINCE
AUGUST 1992



VACCINATION SURVEY WAS CONDUCTED JOINTLY
BY THE MOH AND CSP TETE
SAMPLE: 300 CHILDREN 0-3 YEARS

VACCINATION SURVEY
CHANGARA DISTRICT, TETE PROVINCE
AUGUST 1992



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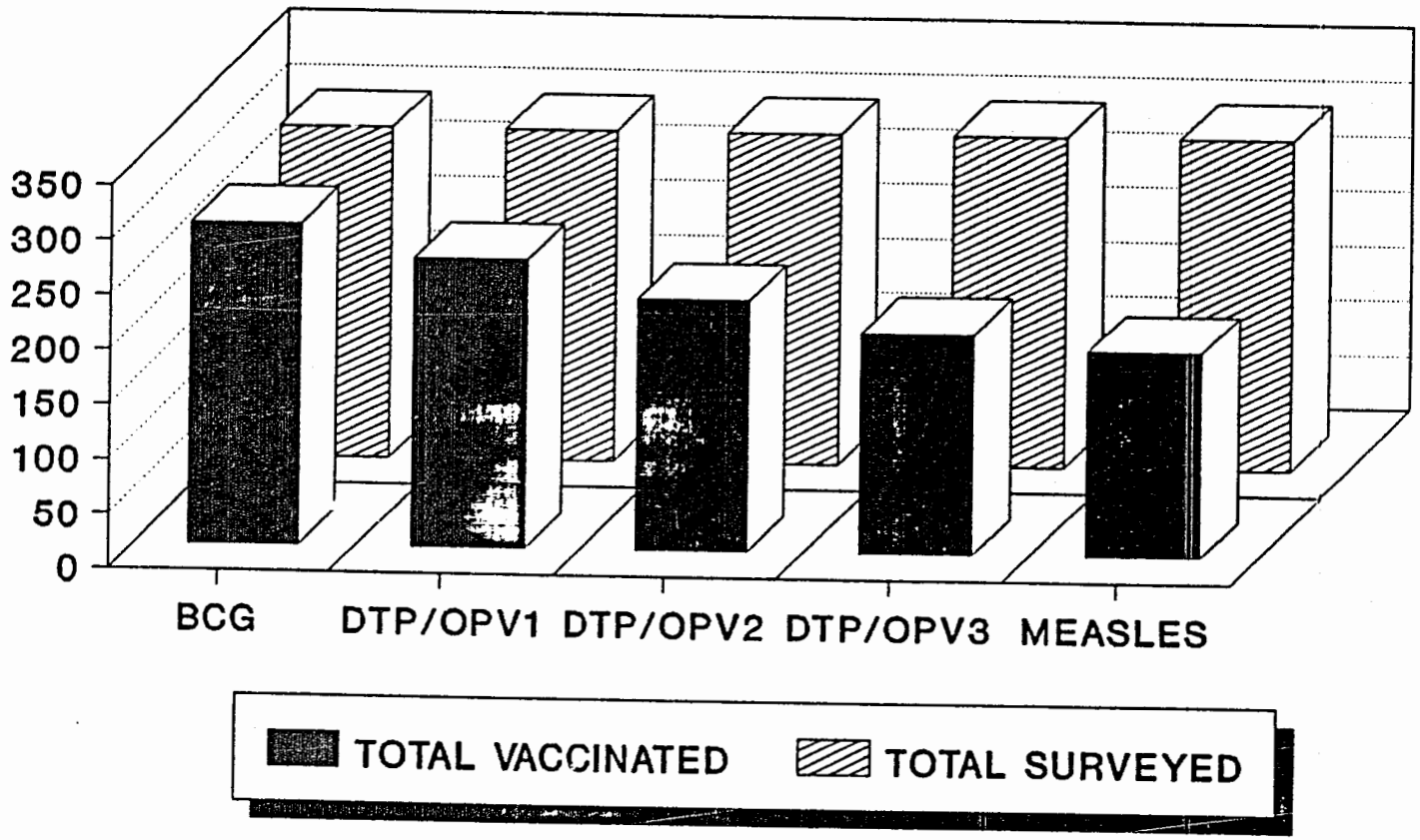
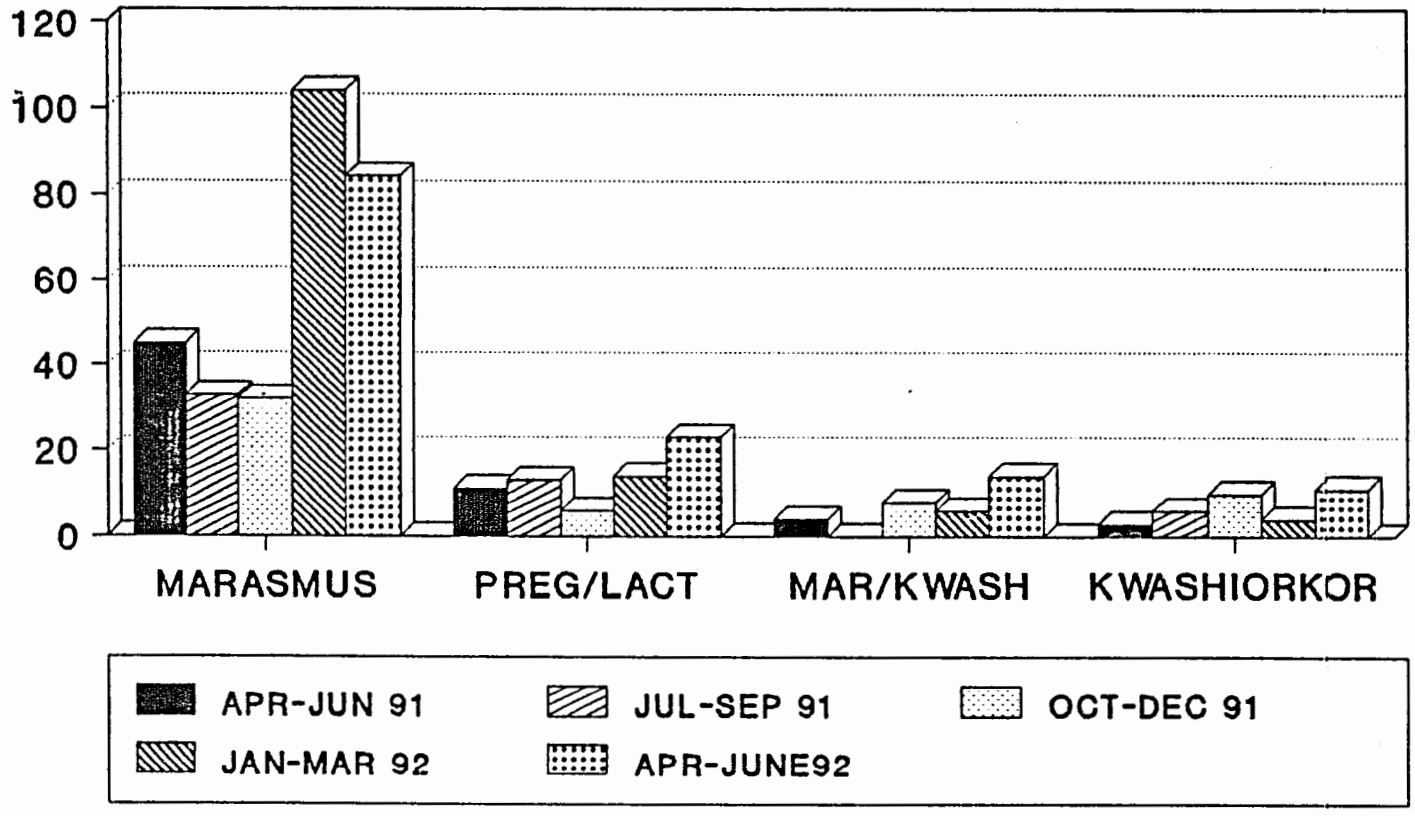
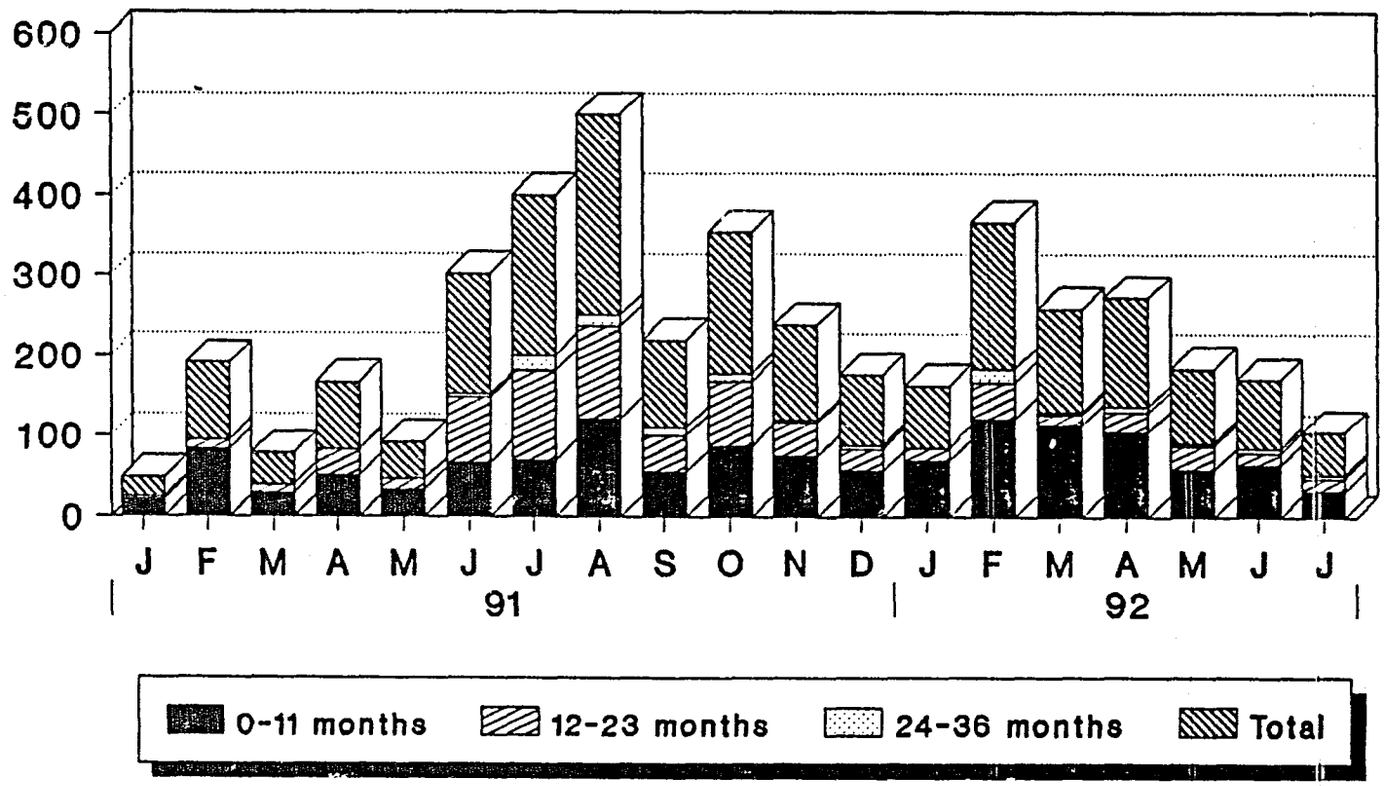


TYPES OF MALNUTRITION ADMITTED
TETE THERAPEUTIC FEEDING CENTERS
APRIL 1991 - JULY 1992



219

TETE CHILD SURVIVAL PROGRAM
COMPLETED VACCINES BY AGE
JANUARY 1991 - JULY 1992



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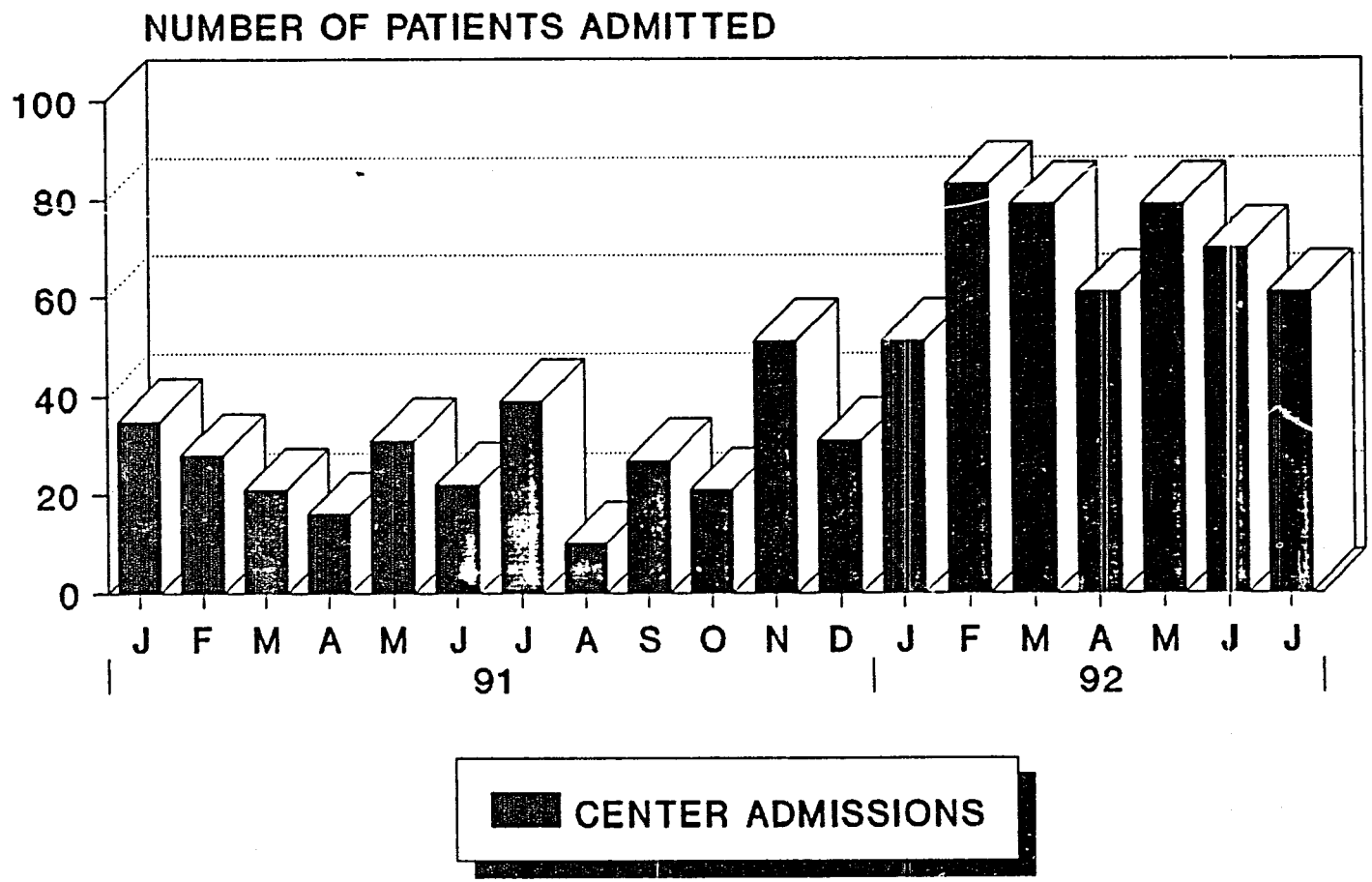
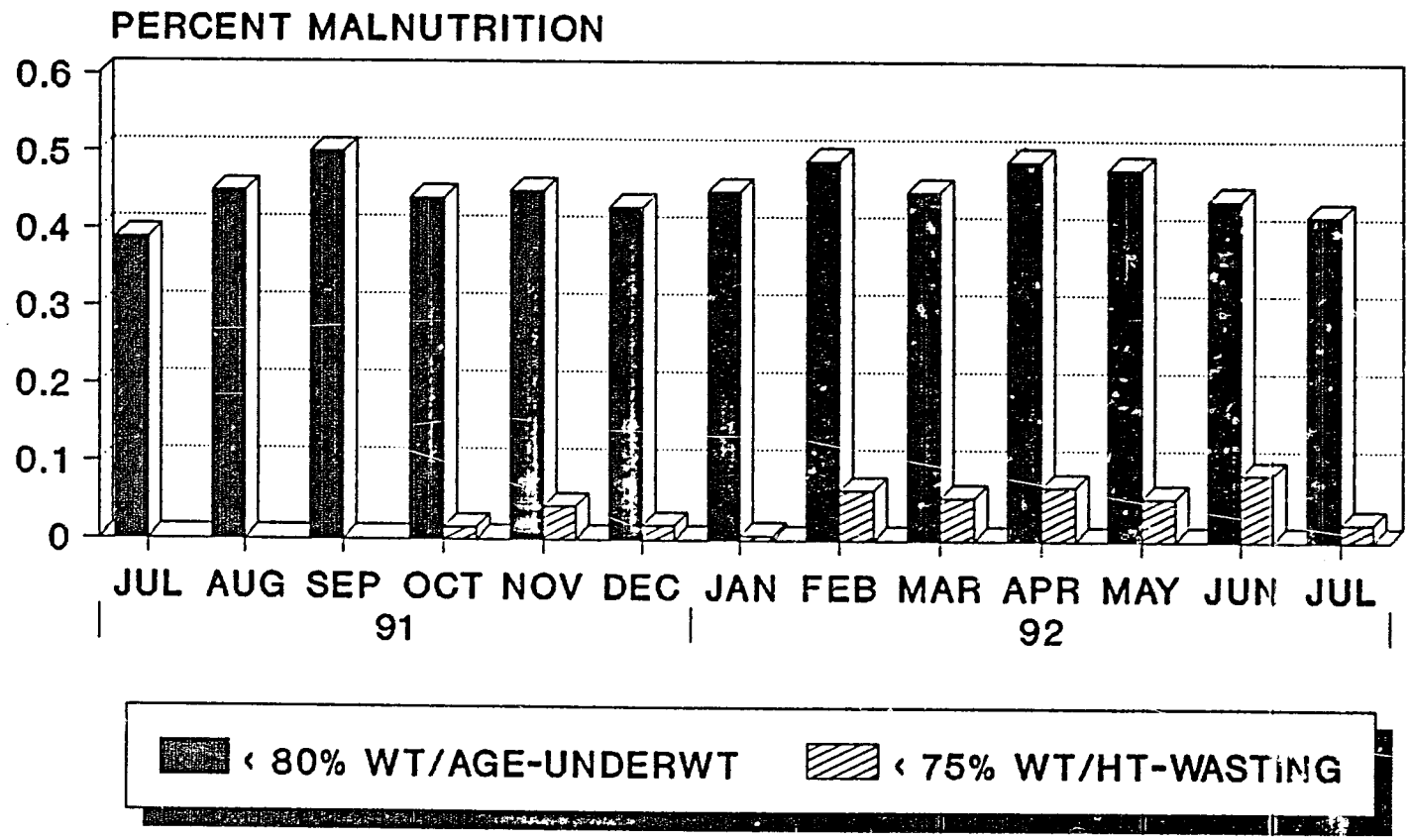
TETE FEEDING CENTERS ADMISSIONS
JANUARY 1991 - JULY 1992



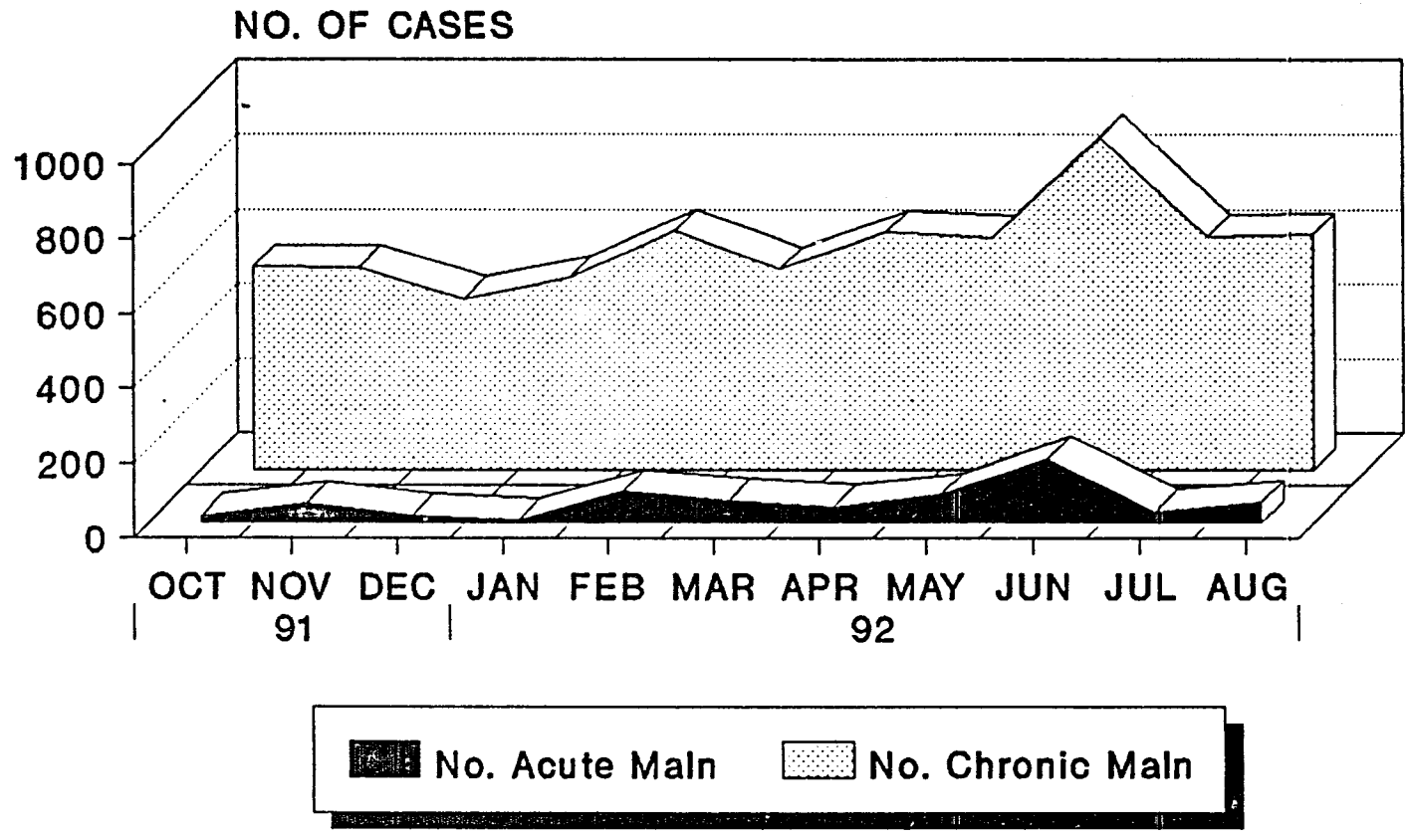
INCLUDES: BOROMA, CHANGARA, MATAMBO SEDE

RATE OF UNDERWEIGHT AND SEVERE WASTING AMONG CHILDREN BETWEEN 0-36 MONTHS CHANGARA DISTRICT, TETE PROVINCE

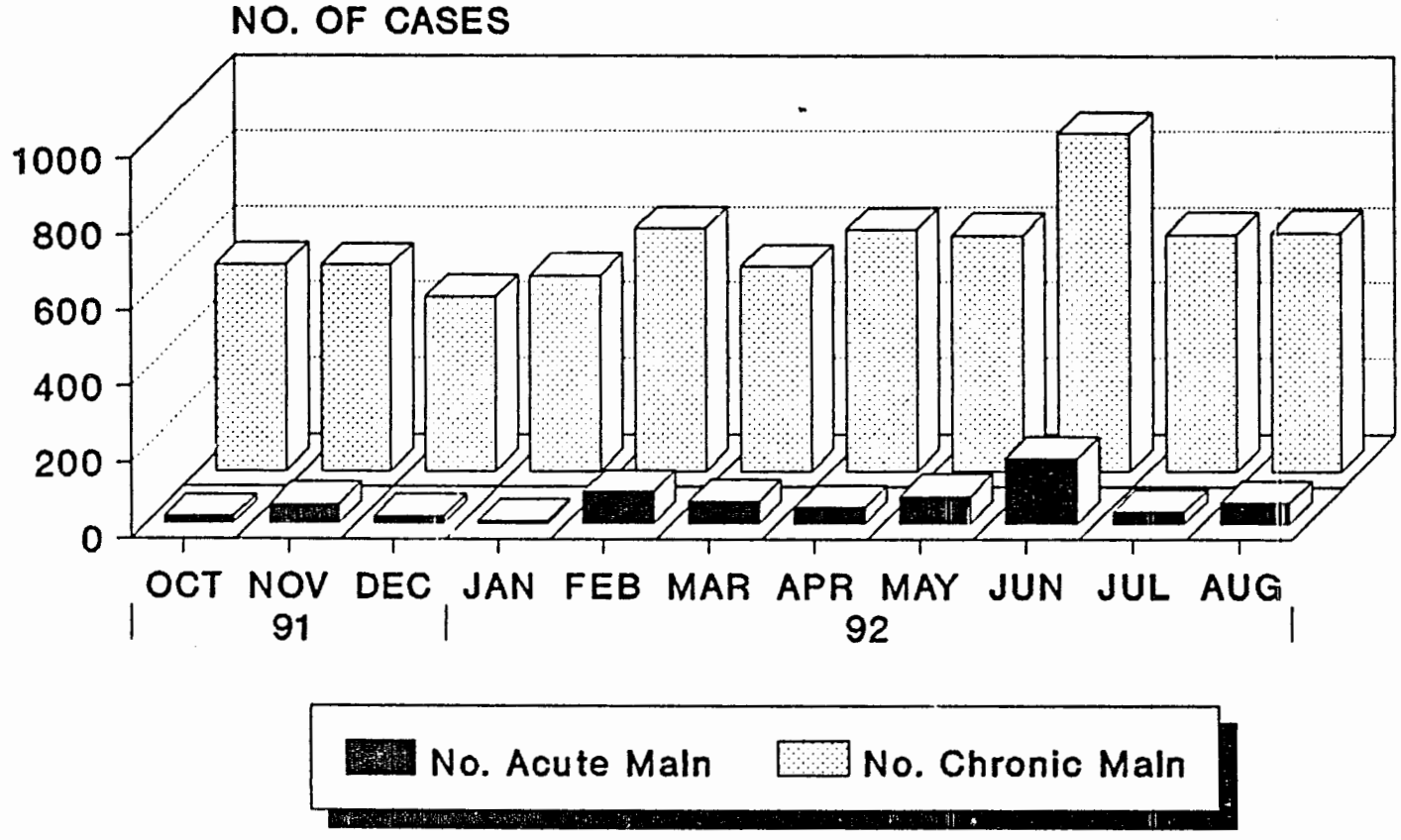


WASTING DATA BEGINS OCTOBER 1991

RATE OF CHRONIC & ACUTE MALNUTRITION
CHANGARA DISTRICT, TETE PROVINCE
OCTOBER 1991- AUGUST 1992



RATE OF CHRONIC & ACUTE MALNUTRITION
CHANGARA DISTRICT, TETE PROVINCE
OCTOBER 1991- AUGUST 1992



CLUSTER SURVEY OF EPI COVERAGE
TETE MOH - WV HEALTH
IN TARGET VILLAGES OF WV CSP TETE

Introduction

In preparation for the mid-term evaluation of WV CSP Tete, the MOH at the provincial and district levels agreed to assist WV in conducting a cluster survey of vaccination coverage in target villages covered by Tete CSP. The MOH contributed two nurses and WV contributed two nurses. The survey was conducted August 5 - 14.

Methods

In accordance with the EPI cluster survey format, 30 clusters were randomly chosen by listing the 18 CSP target villages and providing a cumulative population total after each village. The cumulative overall population (47,320) was divided by 30 to give an interval of 1.577. Villages and number of clusters per village were determined by the interval number (see appendix I for list of villages and choice of cluster areas).

The survey was conducted by four Mozambican nurses divided into two groups:

1. Eduardo Nabui - WV CSP - Boroma and Mssawa zones
   Domingos Razao - MOH - Boroma and Mssawa zones

2. Maria Jose - WV CSP - Changara zone
   Sr. Xavier - MOH - Changara zone

Prior to initiating the survey, nurses met with district and provincial MOH directors in Tete city and Changara to plan the survey schedule and receive instruction on survey methodology

Thirty clusters of 10 households each were surveyed. Only households with children 0-3 years were surveyed. If a household had a 0-3 year old but no vaccination card, the child was counted in the survey as not having been vaccinated. If the 10th household surveyed had more than one 0-3 yr old then all 0-3 yr olds in that household were surveyed and the size of that particular cluster was more than 10.

Data Analysis

Forms were analyzed for "quality criteria" (see Appendix I) and vaccinations that did not meet the criteria were excluded from the count. Percentage errors in each vaccine type were also calculated.

An age adjustment was made for all vaccines given to children 0-11 months. This was used to calculate coverage rates for children 0-11 months and overall coverage rates. See "age adjustment criteria" (Appendix II) below.

"Completed Vaccine" coverage was analyzed by observing whether a form showed that a child had received all 8 vaccines (BCG, DTP1,2,3, OPV 1,2,3, and measles). The number of vaccines given by a fixed health post vs a mobile vaccination team was also analyzed.

Results/Discussion

TABLE OF COVERAGE RATES FOR CSP TETE - AUGUST 1992

Age Group	BCG	DTP1/OPV1	DTP2/OPV2	DTP3/OPV3	Measles	Completed Vaccines	Health Post	Mobile Vacc. Team
0-3 yrs	93.0%	87.3%	86.4%	81.6%	82.1%	75.4	54.4%	54.4%
0-11 mos	95.7%	79.4%	71.3%	69.1%	74.1%	74.1%	51.5%	48.5%
12-23 mos	99.0%	97.0%	91.9%	86.9%	89.9%	80.8%	43.6%	56.4%
24-36 mos	97.4%	100.0%	98.7%	97.4%	98.7%	94.7%	39.6%	60.4%
% Errors	4.0%	2.7%	0.2%	2.5%	8.2%	10.5%		

Anti-Tetanus 2 vaccine in mothers of children surveyed:	77%

Overall vaccination rates are higher than the national average. BCG, DTP1 and OPV1 are 86% - 97%; DTP3 and OPV3 are 81.6%, and rate of measles vaccination is 82%. The fact that over half of vaccinations given were administered by mobile teams (WV nurses working with MOH nurses) shows that WV has contributed significantly to the current high rate of vaccination coverage.

The relatively low rate of TT2 coverage for mothers of children surveyed was (77%) may reflect periodic shortages of anti-tetanus vaccine which have occasionally occurred in the provinces over the past 2 years.

It should be noted that the following variations from the WHO standards of conducting and EPI cluster surveys exist:

1. Cluster sample size for the Tete survey was 10. Sample size for the WHO survey is normally 7.
2. Children aged 0-3 yrs of age were interviewed in Tete. The WHO EPI survey interviews children aged 12-23 months only.

An age adjustment was made to eliminate children who were too young to receive certain vaccinations. After the adjustment, the following numbers of children remained:

BCG - 301 DTP2/OPV2 - 264 Completed vaccines - 207
DTP1/OPV1 - 291 DTP3/OPV3 - 239 Measles - 207

Since the standard sample size for the WHO system of EPI cluster surveys is 210, and since the Tete EPI survey had children aged 0-11 mons and 12-36 mos in all clusters, the Tete EPI survey sample size is greater than the minimum WHO sample size for BCG, DTP1/OPV1, DTP2/OPV2, and DTP3/OPV3. For measles and completed vaccines, it is only 3 short of the standard sample size which makes the data relatively reliable in spite of the different technique used.

Discussion

The following table summarizes findings of a KAP baseline survey (January 1991), WV FY92 benchmarks, and Tete EPI cluster survey vaccinatio coverage results and compares them with FY92 benchmarks according to the CSP proposal:

	BCG	DTP1/OPV1	DTP2/OPV2	DTP3/OPV3	MEASLES	COMPLETED VACCINES	ANTI-TETANUS 2
KAP SURVEY - JANUARY 1991	98.2%	83.3%/83.0%	72.6%/72.4%	65.2%/65.6%	53.3%	-	-
WV DIP BENCHMARKS FY92	-		-	-	-	70%	60%
EPI SURVEY - AUGUST 1992	93.0%	87.3%/87.3%	86.4%/84.4%	82.8%/81.6%	82.1%	75.4%	77.0%

* The KAP survey of BCG counted all vaccines regardless of whether the child had a scar showing a reaction to the vaccine. The 1992 EP survey counted only children with scars on their arms. The actual percent of children who had received the BCG vaccine was 95%.

Increases can be seen in DTP3/OPV3 coverage (from 65% to 83%) since WV started CSP interventions 16 months ago and in measles coverage whic increased from 53% to 82%. It should be noted that the percentages of the Jan 1991 KAP survey are calculated based on children who ha vaccination cards only; since 3.5% of children did not have vaccination cards at the time of the survey, the actual baseline percentage are lower than those listed in the table. Anti-tetanus and completed vaccines were not measured as part of the baseline KAP survey.

Clearly the input from WV CSP has assisted in the increases seen above. As surveys were conducted in CSP target villages, and as more tha half the vaccinations were performed by mobile teams , it can be seen that WV CSP-Tete clearly has assisted in the increased vaccinatio coverage above. It is hoped that in the years to come more responsibility can be given to fixed health post to maintain the above coverag rates, to ensure sustainablility of the CSP work by the MOH.

APPENDIX I - QUALITY CRITERIA FOR PROPERLY COMPLETED VACCINES:

For a vaccine have been correctly administered, the following criteria must be met:

1. Mother must be able to show vaccination card
2. The child must have had 8 vaccines
3. There must be evidence of a BCG scar on the child's arm
4. The first DPT dose must have been received when the child was 6 weeks of age or more.
5. A minimum interval of 4 weeks between DTP or OPV vaccines must exist.
6. Anti-measles vaccine must be given when the child is 8.5 months or older.

APPENDIX II - AGE ADJUSTMENT CRITERIA

The following age adjustments were made to calculate percentage coverage of vaccines in children 0 - 11 months.

1. All children less than 2 months of age who had not been vaccinated against DTP1/OPV1, DTP2/OPV2, DTP3/OPV3, and measles wer removed from the denominator.
2. All children less than 4 months of age who had not been vaccinated against DTP2/OPV2, DTP3/OPV3, and measles were removed fro the denominator.
3. All children less than 6 months of age who had not been vaccinated against DTP3/OPV3 and measles were removed from the denominator
4. All children less than 8.5 months of age who had not been vaccinated against measles were removed from the denominator.

APPENDIX III - LIST OF VILLAGES AND SELECTION OF CLUSTERS

VILLAGE	TOTAL POP	CUMULATIVE POP	# of CLUSTERS	INTERVAL/RANDOM NO.
			1550	
Boroma	3780	3780	1	3127
Changara Sede *	1880	5660	1	4704
Cancune	3000	8660	3	6281
Carata	870	9530	1	9435
Changara Sede	13040	22570	8	14166
Chiocompende	880	23450	-	-
Degue	3950	27400	3	25205
Matambo Bridge	7700	35100	5	31513
Mufa I (afec)	3800	38900	2	36244
Mufa II (des)			-	37821
Mssawa	6000	44900	4	40975
Mpcassa	2420	47320	2	47283

Total population (47320) divided by 30 clusters = 1577

Random starting number = 1550

* formerly residents of Bunga