



***Achieving Equity, Coverage, and Impact
through a Care Group Network***

**Sofala Province, Mozambique
October 1, 2005 – September 30, 2010
Cooperative Agreement No. GHS-A-00-05-0014-00**



FY07 Annual Report

Submitted by:

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October 31, 2007

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ACRONYMS AND ABBREVIATIONS

ABY	Abstinence, Being Faithful program for Youth (PEPFAR funded)
AFASS	Acceptable, Feasible, Affordable, Sustainable, Safe
AISPO	Italian Association for Solidarity Among People
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavior change communication
BF	Breastfeeding
BMI	Body mass index
CED	Chronic energy deficiency (BMI<18.5)
CG	Care Group
CI	Confidence Interval
CQI	Continuous quality improvement
CS	Child Survival
CSHGP	Child Survival and Health Grants Program
CSNPC	Child Survival and Nutrition Program Coordinator (the HQ backstop)
CSP	Child Survival Program / Project
CSP Manager	Child Survival Program Manager (Mozambique)
CSTS	Child Survival Technical Support program
CORE	Child Survival Collaborations and Resources Group (an umbrella group of PVOs involved in child survival projects)
CUAMM	Doctors with Africa (Italian NGO)
DAP	Development Activity Proposal
DHP	Director of Health Programs
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DPT	Diphtheria Pertusis Tetanus vaccine
EPI	Expanded Program of Immunization
FAM	Food Aid Management
FFP	Food for Peace
FH	Food for the Hungry International
FH/M	Food for the Hungry Mozambique
GM/P	Growth Monitoring/Promotion
HAI	Health Alliance International
HFA	Health Facility Assessment
HH	Household
HH/C IMCI	Household and Community Integrated Management of Childhood Illness
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HNP Manager	Health and Nutrition Program Manager (Mozambique)
HPSO	Health Program Support Official (formerly “District Coordinator”)
HQ	Headquarters
IMCI	Integrated Management of Childhood Illness
IMR	Infant mortality rate
IR	Intermediate Results
JHU	Johns Hopkins University
KPC	Knowledge, Practice, and Coverage
LBW	Low Birth Weight

LM	Leader Mother
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MEWG	CORE's Monitoring & Evaluation Working Group
MCH	Maternal and Child Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
NCR	Nutritional Rehabilitation Center
NGO	Non-governmental organization
NO	National Organization
NR	Nutritional Rehabilitation
NRC	Nutritional Rehab Center
ORS	Oral Rehydration Serum
ORT	Oral Rehydration Therapy
PD	Positive Deviant
PVO	Private and Voluntary Organization
PWCSA	Provincial Women's Committee for Social Action and Coordination (Direcção Provincial da Mulher e Coordenação da Acção Social)
QI	Quality Improvement
QIVC	Quality Improvement and Verification Checklist
RHFs	Recommended home fluids (for use during diarrhea)
RBM	Roll Back Malaria
SBCWG	CORE's Social and Behavior Change Working Group
SO	Strategic Objective
STI	Sexually transmitted infection
TBA	Traditional Birth Attendant
TIPs	Trials of Improved Practices
TOST	Training of Survey Trainers
TOT	Trainer of Trainers
U5MR	Under five mortality rate
UNDP	United Nations Development Program
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VAD	Vitamin A deficiency
VCT	Voluntary Counseling and Testing
WAZ	Weight for Age Z-score
WDC	Washington, DC
WFP	World Food Program
WHO	World Health Organization
WR	World Relief
WRA	Women of reproductive age
WV	World Vision

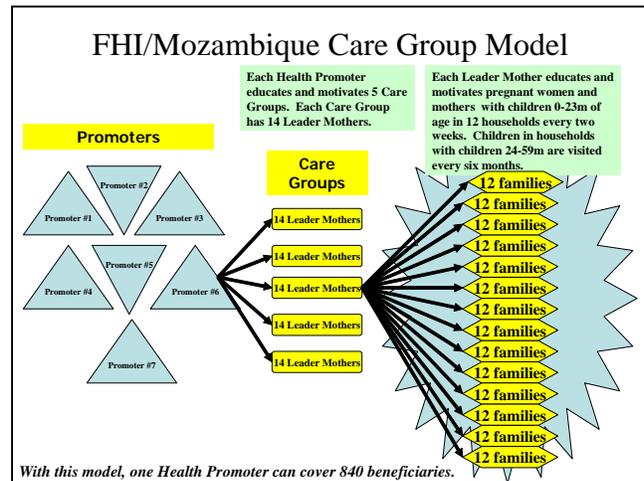
Executive Summary:

To improve the health and nutritional status of children in Sofala, Food for the Hungry (FH) is currently implementing a five-year (October 1, 2005- September 31, 2010) \$3.3 million¹, Expanded Impact Child Survival Project utilizing the Care Group (CG) model.

Care Group Methodology

This project is expanding FH's successful Care Group model into ten districts in Sofala province. The CG methodology helps mothers to learn how to help their children survive and thrive, and to adopt new behaviors. In FH's methodology, an initial census is done to divide households with children under two years of age or pregnant women into groups of twelve. Each twelve-household group elects a LM under the guidance of the Promoter. A group of 14 LMs forms a

Care Group. Each Promoter serves five Care Groups, and meets with the LMs in each Care Group every two weeks for two hours. During Care Group meetings, Promoters teach LMs weekly health messages using small flipcharts and other educational materials and methods. LMs discuss the health lesson, report on illnesses of children in the households they serve, discuss problem cases (e.g., in terms of behavior change), and report on vital events. LMs practice health promotion in pairs, and are supervised and coached by the Promoter. During the two weeks between Care Group meetings, each of the LMs does health promotion through home visits to each of the twelve women/mothers that she serves (households with pregnant women or children under two). Children 24-59m of age are seen every six months and receive vitamin A, deworming drugs, and are screened for malnutrition.



Zinc Operational Research

In 2007, the Mozambique MOH approached USAID requesting assistance with operational research to evaluate the practicality and sustainability of community strategies to access and utilize zinc in the treatment of diarrhea for children under five years of age. USAID has invited FH to be the implementing partner and in addition to determining best practices and disseminating lessons learned this will be an opportunity for FH to showcase the effectiveness of Care Groups in providing community level health care and education. This work is scheduled to begin in November 2007.

C-IMCI

During the second year of program implementation, FH continued to work with 150 Care Groups, a monthly average of 1,985 Leader Mothers (LMs) and 24,000 Beneficiary Mothers (BMs). One hundred and sixty LMs were trained in C-IMCI (one from each

¹ \$2,499,910 USAID funds and \$847,653 Match funds

Care Group plus ten additional LM trained in a refresher course to account of volunteer turnover and low performance), and each trained LM received a bicycle to enable her to offer referral and sick child evaluation services to her community. The average post-test score for LMs trained in C-IMCI was 79%. QIV Checklists will be used to help C-IMCI trained LMs improve their IMCI skills over time.

Module II & III Training

LMs and BMs received training using pictorial flip-charts designed to be used by both literate and illiterate leaders, based on barrier analysis results and field tested prior to printing. The two training modules covered were Module II: Sanitation & Hygiene and Module 3: Prevention of Diarrhea. Dramatic increases in diarrhea-related behaviors have been seen as a result of this training. Both modules were shared with the MOH and used during the cholera epidemics in Caia and Marromeu.

Additional Trainings Conducted by FH

FH also conducted several trainings and workshops during year two. These included Mini-KPCs, LQAS, Verbal Autopsies, Health Facility Assessment, Motivational Interviewing, and How to Work Effectively with Community Development Committees.

Zambezi Flood Response

During the Zambezi Floods, CS activities were suspended in flood affected communities in the districts of Chemba, Caia, and Marromeu during the months of February, March, and April. FH Child Survival officials and facilitators in these areas were involved in relief activities which included nutritional surveillance and health promotion in IDP camps, supplementary feeding for malnourished children and referral to therapeutic feeding centers.

This annual report provides further details regarding program accomplishments, challenges, the year three work plan and our program management systems.

A summary of the success to date on project indicators is given on the following pages.

#	Project Indicators	Baseline Feb. 2006				May 2006 mini-KPC				September 2007 mini-KPC				EOP Target	EOP Target Already Achieved (Phase I Communities)	Percent Change since baseline
		Num	Den	%	CI	Num	Den	%	CI	Num	Den	%	CI			
1	% of children 0-23 months who are underweight (WAZ<-2.0)	146	557	26%	22.6-30.1%			NM		78	378	21%	16.6-24.7%	18%	x	19.2% improvement (decrease)
2	Percentage of infants aged 0-5 months who were fed breastmilk only in the last 24 hours	9	52	17%	8.2-30.3%	65	95	67%	57.9-76.8%	87	95	92%	86.0-97.2%	60%	✓	412% increase
3	Percentage of children 9-23m who receive food other than liquids at least three times per day	40	123	33%	24.4-41.6%	92	93	99%	96.8-101.0%	62	95	65%	55.7-74.8%	65%	✓	97.0% increase
4	Percentage of children 6-23 months of age with oil added to their weaning food [1]	50	142	35%	27-43%	71	94	76%	66.8-84.2%	83	95	87%	80.7-94.0%	80%	✓	149% increase
5	Percentage of children 12-23 months of age who have received one	83	101	82%	73.3-89.1%	63	82	77%	67.7-86.0%	78	88	89%	82.0-95.3%	95%	x	8.5% increase

#	Project Indicators	Baseline Feb. 2006				May 2006 mini-KPC				September 2007 mini-KPC				EOP Target	EOP Target Already Achieved (Phase I Communities)	Percent Change since baseline
		Num	Den	%	CI	Num	Den	%	CI	Num	Den	%	CI			
	Vitamin A capsule in the past six months (card or mother's report)[2]															
6	Percentage of children 6-23m who have consumed at least one Vitamin A rich food in the previous day	42	147	29%	21.4-36.6%	76	92	83%	74.9-90.4%	83	95	87%	80.7-94.0%	80%	✓	200% increase
7	Percentage of children 12-23 months who received deworming medication in the last six months	24	99	24%	16.2-33.9%	51	75	68%	57.4-78.6	52	63	83%	73.2-91.9%	75%	✓	246% increase
8	Percentage of children aged 0-23 months who were weighed in the last four months (card-confirmed)	129	184	70%	63-77%	77	90	86%	78.3-92.8%	82	92	89%	82.8-95.5%	90%	x	27.1% increase

#	Project Indicators	Baseline Feb. 2006				May 2006 mini-KPC				September 2007 mini-KPC				EOP Target	EOP Target Already Achieved (Phase I Communities)	Percent Change since baseline
		Num	Den	%	CI	Num	Den	%	CI	Num	Den	%	CI			
9	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF)[3]	57	80	71%	60-81%-	76	92	83%	74.9-90.4%	90	94	96%	91.7-99.8%	90%	✓	35.2% increase
10	Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness	25	80	31%	21-43%			NM		64	92	70%	60.2-79.0%	60%	✓	125% increase
11	Percentage of mothers of children 0-23m who can correctly prepare ORS	88	199	44%	37.2-51.4%	75	95	79%	70.7-87.1%	86	95	91%	84.6-96.4%	80%	✓	107% increase

#	Project Indicators	Baseline Feb. 2006				May 2006 mini-KPC				September 2007 mini-KPC				EOP Target	EOP Target Already Achieved (Phase I Communities)	Percent Change since baseline
		Num	Den	%	CI	Num	Den	%	CI	Num	Den	%	CI			
12	Percentage of mothers of children age 0–23 months who know at least <u>three</u> signs of childhood illness that indicate the need for treatment	58	199	29%	22.8-35.5%	89	95	94%	88.8-98.6%	82	95	86%	79.4-93.2%	75%	✓	197% increase

USAID Report-Out Indicators	FY06 Baseline*	FY07 Target**	FY07 Results	FY08 Target**
5. Number of people (health professionals, PHC workers, CHWs, volunteers, non-health personnel) trained in child health care and child nutrition through CSHGP-supported programs.	26,969 ALL FEMALE	26,969 ALL FEMALE	26,022 ALL FEMALE	62,790 ALL FEMALE
9. Number of children reached by programs that promote good IYCF and/or growth promotion programs.	49,361	50,988	58,417	169,426
12. Number of children under 5 years of age who received Vitamin A from CSHGP-supported programs.	0	43,595	39,918	144,859
17. Number of people (medical personnel, health workers, community workers, etc.) trained in malaria treatment or prevention. <i>(these numbers are for individuals trained in C-IMCI)</i>				
	Males	21	13	
	Females	10	163	384

**CSHGP Data Sheet: Child Survival and Health Grants Program Project Summary
Sep-06-2006**

Food For The Hungry, International (Mozambique)

General Project Information:

Cooperative Agreement Number: GHS-A-00-05-00014 21

Project Grant Cycle:

Project Dates: 9/30/2005 - 9/30/2010

Project Type: Expanded Impact

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Field Program Manager: Emma Hernandez

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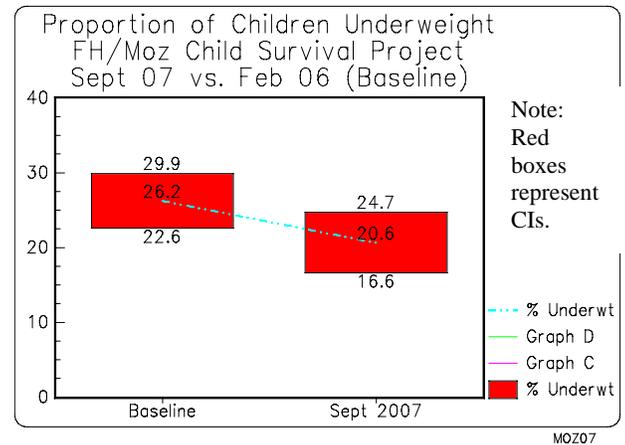
Funding Information:

USAID Funding:(US \$): \$2,499,910 PVO match:(US \$) \$847,653

A. Main Accomplishments:

21.4% Reduction in Malnutrition (WFA)

A Mini-KPC study that was done in September 2007 found that – of 378 children assessed – the percent of underweight children had dropped from 26.2% in February of 2006 to 20.6% in September of 2007, a 21.4% decrease. Due to the small number of children evaluated during routine monitoring, this difference is not statistically significant, but it indicates a positive trend that is reflective of the behavior change seen in project areas. See section O, Results Highlight for further information about the September mini-KPC results.



96% Average Monthly Attendance at Care Group Activities

During year one of the project, 150 Care Groups were formed involving a targeted 27,072 mothers, of which an average of 91.5% (2016) of ML and 86% (23075) of MB were active on a monthly basis. This high level of attendance can be accredited to a long chain of quality people, processes and tools that have created a dynamic training system that provides health promotion information and stimulates behavior change within a large network of households. The following programmatic aspects created this success:

1. The Care Group model itself, which brings mothers with similar interests and challenges together on a biweekly basis to learn from other mothers about topics that are relevant to their daily lives and presented in appropriate and dynamic manner.
2. Leader Mothers, responsible for training beneficiary mothers, were selected by Community Development Committees and orientated as volunteers, with the aim of reducing infant and child mortality and morbidity in their own communities, not for the MOH or FH, but for the benefit of their own children and families. These mothers, most of whom are illiterate, were selected because they were respected individuals who were already advising the community about pregnancy and child rearing practices.
3. Each Leader Mother is equipped with a large, color, pictorial flip-chart encased in plastic, developed using results of behavior change research, such as studies done by FH on positive deviance, the KPC survey, and Barrier Analysis, and the input of the provincial and district MOH, HQ backstop, CS Project Manager, a skilled local artist, and a printing company dedicated to assuring quality. The material is pretested prior to printing to assure images accurately convey key messages to an illiterate population.
4. Facilitators (a.k.a “Promoters”), responsible for teaching LMs, are individuals who already resided in the area of project implementation, assuring they spend the majority of their time in the communities, with the project beneficiaries, and speak the local language. Facilitators receive five days of training for each module, and training is reinforced in monthly refresher trainings. Trainings are given in participatory manner using principles of adult education, including stories, games, and lesson review.
5. Five to ten Facilitators are supervised by trained nurses (Supervisors), equipped with motorbikes, that in addition to leading the monthly refresher trainings visit Facilitators on a weekly basis, using QIVC checklists to assure that Facilitators are training their LMs in the correct health promotion content in a participatory manner.
6. Nurses are supervised by a CS Trainer, CS M&E staff, and CS Project Manager, who coordinate with FH procurement, HR, logistic, and other departments to assure the appropriate staff are well trained and equipped to carry out their roles.

C-IMCI

In year one, FH assisted the Sofala Province MOH to locate the C-IMCI training materials (that had been approved by the Ministry but were no longer available in the province), reproduce them, and facilitate the training of 13 MOH MCH nurses. In year two, MOH MCH nurses trained three HPSO's and one hundred and fifty LM in C-IMCI by November 2007. This training was done using small class sizes of 25 or less and included practicum's where LM practiced using the skills they were learning.

C-IMCI Pre and Posttest scores:

Category of Staff	Number Trained, C-IMCI	Pretest Score	Posttest Score	Change in Score
MCH nurses	13	43%	64%	48.8%
HPSOs	3	42%	80%	64%
LMs	160	57%	79%	38.6%

C-IMCI trained LM are recognized by the MOH and fit into the MOH's system of "Community Health Agents" (known as "ACs" in Portuguese). ACs are active in their communities, visiting sick children, identifying danger signs, referring children to the health facility, visiting children within one week after returning from the health post, or visiting the child daily for follow-up if he/she is not referred. Although the Mozambique MOH, does not allow ACS to administer medications, they do provide ORS to ACSs and use the ACSs to assist mothers to correctly control medication regimens. ACSs have been so effective in their role that district officials have reported to CS project officials a notable increase in patient numbers at health centers and hospitals.

During the **Verbal Autopsy** practicum, 22 verbal autopsies were conducted in Manga district. We found during that experience the following care seeking problems:

- Delays in detecting the illness by the mother (27% of cases)
- Delays in deciding when to seek care for a sick child (23% of cases)
- Delays in reaching a health facility in a timely manner (32% of cases)
- Delays in being attended in a timely manner once the child reached a health facility (18% of cases)
- Delays in following-up care (e.g., returning to the clinic when the child did not improve; 30% of cases)

We expect these staff and volunteers who were recently trained in C-IMCI to help reduce many of these delays in care that leads to child deaths.

Trainings Done with Partners, Staff and Beneficiaries

In year two of the project, trainings were completed on Module II on Sanitation and Hygiene, and Module III on the Prevention of Diarrhea. Module IV on Breastfeeding and Complementary Feeding was started in Sept. 2007. Trainings for partners and

program staff were also done on LQAS, Verbal Autopsy, and Health Facility Assessments.

Training Topic	Category of Staff	NºTrained	Pretest Score	Posttest Score	Change in Score
Module II: Sanitation & Hygiene	HPOS, Trainer, MOH Facilitators	39	53%	91%	72%
Module III: Diarrhea	HPOS, Trainer, MOH Facilitators	40	63.5%	90%	44%
Module IV: BF and Complementary Feeding	HPOS, Trainer, MOH Facilitators	40	50.5 %	85.5%	69%
Mini- KPC & LQAS (TOT)	CS Manager, M&E, HPSOs, Trainer	15	50%	84%	68%
Mini- KPC & LQAS (TOT)	Facilitators	39	20%	80%	300%
Verbal Autopsies and Health Facility Assessment (TOT)	CS Manager, M&E, HPSOs, Trainer	12	58%	89%	53%
Verbal Autopsies (Field Training, cascaded)	HPOS, Trainer, MOH Facilitators	39	20%	90%	350%
Health Facility Assessment (Field Training, cascaded)	HPOS, Trainer, MOH Facilitators	40	50%	80%	60%

Scaling-Up Care Groups

In 2007, the Mozambique MOH began to discuss internally and with NGO partners the best way to implement health care and prevention at the community level. The provincial MOH in Sofala is interested in using FH's (and WR's) Care Group model to implement community level health care. The Mozambique USAID mission, represented by Dr. Angi Titus, is advocating with the MOH to consider the Care Group model, being used by both World Relief and Food for the Hungry in CS and Food Security projects in the south and central areas of the country.

Partners are realizing that the extensive and easily-accessible communication network created by Care Groups can easily be used to offer a variety of health care services to the community. CUAMM, a partner of FH in the CS project, used the FH established Care Group network to identify and treat malnourished children in the Manga (Beira district). USAID has requested that FH use the Care Group network to pilot community-level zinc treatment for preschool children with diarrhea. The provincial ministry has approached FH and requested we implement a "Community Kitchen" program through the Care Groups, as well.

Part II: Project Objective Table

Project objectives	Key Activities (as outlined in the DIP)	Status of Activities	Comments
Improve Child Nutritional Status	<ul style="list-style-type: none"> • BCC and nutrition promotion via CGs • Bi-weekly home visits • Technical training of partner staff in nutrition • Community IMCI training of LM's and Promoters • PD/Hearth • Barrier Analysis to improve nutritional messages • Integration of Motivational Interviewing into CG curricula • Promotion of the production so Vit A rich foods • Vit A supplementation • Deworming of children >12m • Malnutrition Screening as part of Hearh 	<ul style="list-style-type: none"> • Ongoing 	<ul style="list-style-type: none"> • Training of partners, program staff, LMs, and BMs on modules II and III completed. Module IV, Promotion of Breast Feeding and Complementary Feeding was started in September 2007. • LMs are conducting bi-weekly home visits to their beneficiary households. • Hearh activities will start in year 3 of the program to reach both Phase I and Phase II districts. • A BA study was conducted to analyze the barriers to exclusive breastfeeding in preparation for module IV. • In September of 2007, HPSOs were trained in Motivational Interviewing, giving them the behavior change counseling skills to share with Facilitators and use in their contact with beneficiaries. • In April and May 2007 a vitamin A, de-worming, and GM/P campaign was carried out in all five districts in partnership with the MOH. 10,975 children were dosed with vitamin A, 12,000 with Mebendazole, and 9,417 received GM/P. • In September 2007, a mini-KPC was done that included anthropometry.
Assure Appropriate Diarrheal Case Management	<ul style="list-style-type: none"> • BCC on diarrhea management including ORT in CGs • Technical training of partner staff in diarrhea and C-IMCI training • ORS stocks provided to LM's • Demonstration of preparation and use ort ORS through CGs and home visits. 	<ul style="list-style-type: none"> • Ongoing 	<ul style="list-style-type: none"> • Training of partners, program staff, LMs, and BM on Module III: Prevention of Diarrhea was done from June – August 2007. • Training of HPSOs, Facilitators and 150 LMs on C-IMCI was completed in November 2007, using MOH MCH Nurses as trainers. • In September, a follow-up C-IMCI training was conducted for new FH staff and 10 LMs. • In coordination with the MOH, LMs trained in C-IMCI are receiving ORS from the health facility and treating children with diarrhea. • In March 2007, partners and program staff were trained in Health Facility Assessments (HFA). • HFAs were conducted once every two months at different HFs to assure that children referred to HFs receive complete care according to IMCI protocols. Monthly reports were prepared for health posts and shared personally with HP directors. A copy of the report was also given to the District Director of Health

Project objectives	Key Activities (as outlined in the DIP)	Status of Activities	Comments
			Services.
Increase the proportion of mothers of young children who have access to an IMCI-Trained Provider within one hour of their Home	<ul style="list-style-type: none"> • Technical training of partner staff in C-IMCI training • Development of C-IMCI education modules for use by CGs • Training of selected LMs in C-IMCI 	<ul style="list-style-type: none"> • Ongoing 	<ul style="list-style-type: none"> • In project year 2, HPSOs and 13 district MOH nurses received C-IMCI trainings facilitated by the MOH. • Training of HPSOs, Facilitators and 160 LMs on C-IMCI was completed in November 2007, using MOH MCH Nurses as trainers. • In September, a follow-up C-IMCI training was conducted for new FH staff and LMs. • MOH approved and developed C-IMCI materials were used and made available by FH for MOH facilitated C-IMCI trainings. One LM from every CG was trained in IMCI and equipped with a bicycle. • All LMs and BMs were educated about the role of C-IMCI trained LMs to visit sick children, identify danger signs, refer children to the HF, make control visits after a child returns from the HF, or visit daily for follow-up if child was not referred.
Assure the sustainability, quality & expansion of the CG model in Mozambique	<ul style="list-style-type: none"> • Operations Research on the reasons for CG effectiveness • Presentations of FH model with MOH leader in 2 adjacent provinces • Advocate for CG model in international, national, and provincial meetings • Training of selected LMs in C-IMCI • Regular supervision of LM and the use of QIVCs to improve LM health promotion • Training of HPSOs and partner representatives in high quality health promotion 	<ul style="list-style-type: none"> • Ongoing 	<ul style="list-style-type: none"> • OR and presentations of FH model in adjacent provinces is scheduled for the final year of the program • FH frequently communicates the results of the CG model with provincial MOH officials and has unsuccessfully attempted to schedule a meeting at the national level. Dr. Titus Angi (USAID) has advocated on behalf of the CG model to the national MOH as the ministry has been reviewing their community health strategy and C-IMCI. • USAID, doing OR on Zinc for the treatment of diarrhea on behalf of the MOH, has asked FH to be their implementing partner, recognizing that the Care Group structure will allow for easy identification of diarrhea cases, rapid community based treatment, and monitoring and evaluation of the activities. • In September 2007, the provincial MOH requested that FH implement their “Community Kitchens” strategy through the Care Group model. • In February 2007 partners and program staff were trained in LQAS, Verbal Autopsy, and Health Facility Assessments by CS HQ staff. • Facilitators and LMs are supervised monthly using QIVCs during their CG trainings.

B. Challenges and action taken to overcome constraints:**Memorandum of Understanding with MOH**

The Mozambique MOH would like all partner NGOs to sign a MOU. A consortium of NGOs in Mozambique (led by NIAMA) have been in discussion with the MOH regarding this MOU as it requires of NGO's to commit to certain activities that may be in conflict with the commitments they have made to their donors and to project communities. For example, NGOs implementing projects with total budgets in excess of one million dollars would be required to equip, rehabilitate, or construct health posts. We feel that this activity should not use up valuable program funding, and that our CG project (as written) and involvement in the zinc OR and scale-up is more than adequate in terms of helping the MOH to accomplish its objectives in Sofala. FH is advocating along with other NGOs to change the wording on the document so that we would be able to create the MOU.

Training the Right People from the MOH

All project activities are done in partnership with the MOH Nutrition and MCH departments. When trainings and meetings are held in order to carry out the Care Group and IMCI activities in a well-coordinated manner with a high level of quality, the MOH tends to send high level officials instead of the field-level staff who we have invited. FH is clear in organizational meetings with department heads and invitations as to who should attend trainings. FH has considered making per diem payment dependent on passing tests, but feel that as yet the relationship with the MOH is not strong enough to implement measures that would be sure to create high levels of conflict. We are open to suggestions from USAID as to how to resolve this challenge.

Zambezi Floods place Care Group Meetings on Hold

Some of the Care Groups were scattered during the Zambezi floods in Caia and Marromeu and the Care Group teaching was put on hold. After two months, Care Groups members returned to their villages and resumed work.

CD Committees and LM Expectations regarding Incentives

Some of the Community Development Committees (CDC) and Leader Mothers involved in the program continue to expect incentives from FH such as T-shirts, hats, bicycles, and salaries. To respond to this, FH Facilitator (Promoter) level staff who work closely with these committees were retrained, with assistance from FH's Food Security program staff. This retraining focused on the basic concepts of community development, the committee's role, and how to help committees and individual volunteers understand that they are serving their own families and community by reducing child mortality and morbidity and not as employees of FH.

Staff time lost to Sickness and Funerals

Working in a province with a 26% HIV prevalence rate creates difficulties as staff illness and family deaths create immense constraints on the ability of

staff to work full time. The expectations and demands placed on staff by their extended families are multiplied beyond the norm by the fact that they hold position considered to be prestigious by working in an NGO. The expenses, justified absences, and the preoccupation that dealing sick family members creates interferes with staff performance. This is especially critical when staff hold roles of management and coordination. One solution has been to hire a “floater” supervisor who can step in when staff fall sick or need to be absent for extended periods of time to deal with sick family members.

Delays in the Preparation of Flipcharts

The preparation of training materials is taking more time than was programmed due to logistical and administrative constraints. In September of 2007 a solution was found to the principal obstacle of obtaining three quotations and samples from printing companies. A contract was drawn up with the only printing company with on-site printing services in Beira, Mozambique for future flip-chart preparation. This contract was approved by FH's finance department.

Formal MOH approval of Educational Material not possible within Project Time Frame

Obtaining formal approval from the MOH for the educational materials produced by FH from the MOH has been impossible in the program time frame as the process takes approximately one year for each flipchart. The solution has been to assure educational messages are inline with MOH policies and guidelines. This strategy has worked out well for both parties. The MOH and other NGO partners ask for and use educational material produced by FH, despite the lack of formal MOH approval.

Rural areas create Project Delays

Training of Facilitators (Promoters) is taking more time than originally planned because most of the communities where the project is being implemented are some of the most rural and isolated in the country. These Facilitators who teach the groups must take one week a month to travel to the project training and reporting site, prepare their report, meet, and travel home again, giving them less time for training in the Care Groups each month. In other rural, but more accessible areas, Facilitators can travel to (and attend) the training and reporting meetings all in the same day and modules can be covered in one-third less time. To resolve this problem, FH has combined some of the modules so that fewer modules are conducted during the project cycle, while still including all key messages.

C. Required Technical Assistance

CS HQ: Technical assistance has been provided by FHUS to the CS Mozambique staff in training, answering questions, and reviewing survey and result reports in the following activities: Barrier Analysis of exclusive breastfeeding and hand washing,

mini-KPC Methodology including LQAS, Health Facility Assessment, and Verbal Autopsies. No outside consultants were used for this.

MOH: The Mozambique MOH trained FH staff in IMCI for both the health center and community levels.

CUAMM: CUAMM has Nutritionists and Pediatric doctors that are specialists in nutritional rehabilitation, especially in the clinical setting, and have provided advice and support to FH field staff in this area.

D. Substantial Changes from the DIP

New Date for entering 2nd Cohort Communities

Instead of entering new communities in April of 2008 as originally planned the CS program will enter new areas in June 2008. This change in plans is due to the difficulties discussed in section II.B. Challenges (including the 07 Zambezi Floods).

Some of the Original Project Partners no longer share Project Goals

Three of the original CS project partners are no longer actively participating in project trainings and activities. AISPO is no longer working in the Sofala province. Esmabama, a Catholic NGO running two hospitals and providing assistance to the MOH in 2nd cohort districts, declined at project start-up to partner with FH and use Care Groups to expand the secondary and tertiary health care services they offer to the community level and was not included in the DIP. HAI, while still coordinating with FH, focuses almost exclusively on HIV/AIDS related programming and has little incentive to attend trainings and learn about tools that deal with community health related to nutrition and childhood diseases. FH has been able to add CUAMM as a partner, an Italian NGO operating in Manga in the areas of nutrition and health. Successful coordination with the MOH has enabled FH to progress toward its scale-up objectives despite the bowing out of original partners, especially as regards the scale-up of zinc nationally, and FH's participation in those plans.

Added position: Child Survival Trainer

In 2007 the position of a Child Survival Trainer was added. This position was deemed necessary because of the repeated and continuous trainings that required the CS Project Manager to be out of the office and unable to attend to project administrative and scale-up needs.

Verbal Autopsy Data to be collected for one Care Group of each Facilitator (Promoter)

Collecting of Verbal Autopsy data was originally planned to be done for all children who died within the Care Group network, but during the verbal autopsy training, staff realized the amount of data that would be generated would be onerous and unnecessary to get a good idea of causes of child deaths and opportunities for improvement in the program. The decision was made to select at random one of each facilitator's five Care Groups, and only perform

verbal autopsies on children who died within that Care Group. This sample will still provide useful program and management data. Data (counts) of all deaths of children will still be carried out, but without the longer verbal autopsy interview being done. (See Annex 1 for the updated VA questionnaire.)

More Health Facility Assessments to be Routinely Conducted

FH originally planned to do one **abbreviated HFA** in Manga district (using QIV checklists) focusing on two key interventions – GM/P and diarrhea case management. Since that time, FH decided to use two of the main tools in the more robust **BASICS HFA**. An HFA was done in Manga district during training. Now each Supervisor is also responsible for conducting one HFA in the district(s) that they supervise every 2 months with the help of Facilitators under their charge and MOH staff. Results from the HFA are immediately explained to health facility staff for their use and will be compiled for a more systematic review after approximately one year of data collection. We believe this more intensive use of the HFA will result in better clinical outcomes, better information on problems being provided to C-IMCI trained LMs, C-IMCI trainers, and MOH supervisory staff, and other positive outcomes.

E. Monitoring Plan

Monitoring & Evaluation Activities done in Year One and continued through Year Two:

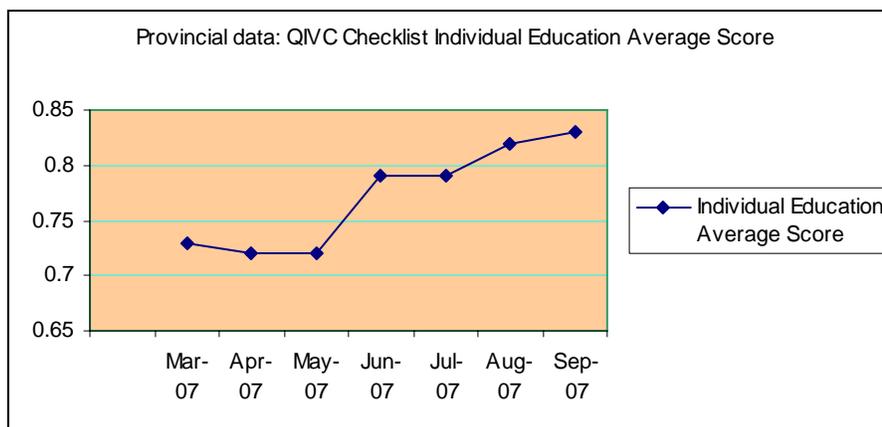
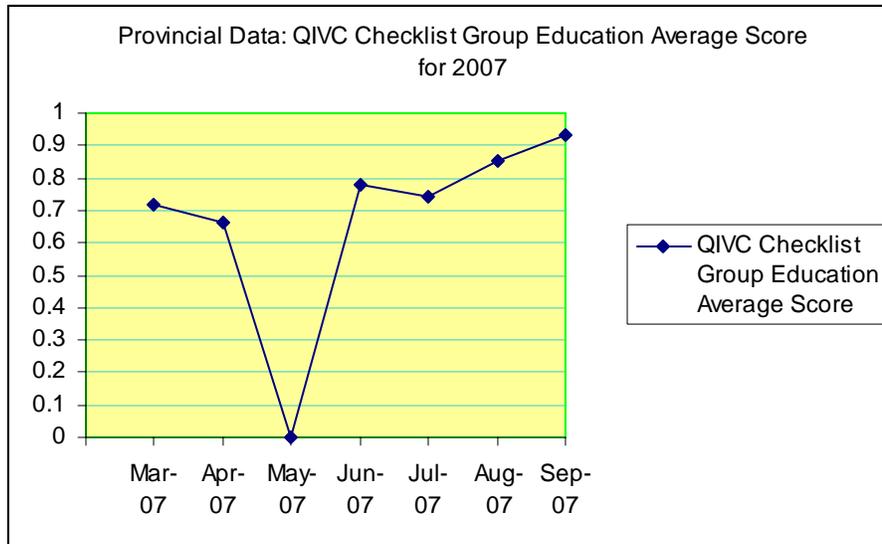
- **Community-level Information System:** Every two weeks during the Care Group meetings, each Leader Mother verbally reports on the status of the women and children in her twelve-group of households. One Leader Mother from each group was chosen to be the President and is responsible for filling in the group's copy of the Care Group Report Form. The Promoter keeps a copy of this information in a duplicate Care Group Report Form (for each group). A tally sheet is used to keep track of the current month's events and situations, and this information is reported to the HPSO during monthly meetings. HPSOs report to district-level MOH representatives and the CS Program Manager in Beira who then provides monthly reports to the FH HQ backstop in Washington DC. The information is also aggregated and reported during quarterly Coordination Team Meetings.
- Program Staff and LMs received training in the use of a **Verbal Autopsy form** in February 2007 (see Annex 1). A Verbal Autopsy is an interview done by a community health worker or nurse with a parent of a child that has died concerning the circumstances surrounding the child's death. It is completed in order to better understand the reasons that children are dying so that more deaths can be prevented. The CHW or nurse determines the likely cause of the child's death based on the information provided by the parents. Verbal autopsy data collected over a period of time will allow for better understanding of the age at which children are dying, causes of death, delays that may have contributed to some deaths, home care provided to the child, and

follow-up. In addition, it provides staff with an opportunity to offer condolences and compassion to the family.

When FH started to report the results of the verbal autopsies to the MOH, it was difficult for the Ministry to accept the validity of the data that indicated that many child deaths were occurring even in areas like Manga, where health posts can be easily accessed by the population. Lately, the MOH has become more interested in FH's community-level mortality data and has requested that FH make projections from their district-level data to reflect the situation at the provincial level. The MOH only has data for clients who have accessed the health care system at the health post or hospital level. With the increased focus on community level health care in the country, a need is arising for community-level data. FH will be using this recent demand for community-level data to make the case to the MOH for using Care Groups more routinely in their system.

- Program staff received training in the use of **Quality Improvement and Verification Checklists (QIVCs)**. These checklists are used by the HPSO's in their supervision of Promoters, and by the Promoters in their supervision of Leader Mothers. QIVCs provide a detailed check of health workers' performance on their key processes in order to monitor and improve their performance, identify "system problems," and to encourage them. QIVC consistent use needs to be improved, as this provincial data below indicates. A total of 30 CS Facilitators should be observed on a monthly basis doing Group Education and 150 ML should be observed doing individual education. The gradual improvement in scores is evidence to how helpful the tool can be in identifying weaknesses and improving education offered.

QUALITY IMPROVEMENT CHECKLISTS for OCTOBER 2006- SEPTEMBER 2007				
Provincial Data from Manga, Caia, Marromeu, Maringue, and Chemba project communities				
Month/Year	No. of Staff Observed doing Group Education	Group Education Average Score	No. of Staff Observed doing Individual Education	Individual Education Average Score
Mar-07	12	72%	48	73%
Apr-07	6	66%	91	72%
May-07	0	0%	133	72%
Jun-07	9	78%	115	79%
Jul-07	8	74%	139	79%
Aug-07	11	85%	131	82%
Sep-07	2	93%	78	83%



- Barrier Analysis (BA)** has been conducted before the development of most Care Group educational modules, such as the modules dealing with Sanitation and Hygiene, Diarrhea, and Breastfeeding/Complementary Feeding. BA was conducted in 2006 to identifying the barriers to hand washing with soap or ash to provide insight when developing the BCC messages and activities related to diarrhea. In 2007, BA was conducted to identify mothers' barriers to exclusive breastfeeding to provide insight when developing the BCC messages and activities related to breast feeding and complementary feeding. The BA questionnaire used for exclusive breastfeeding is found in Annex 2, the results of this BA and implications for program planning can be found in Annex 3 and 4. (The results of this study have been submitted for presentation at the 2008 Global Health Council as part of a preformed panel on BA & Doer/NonDoer Analysis.)
- Pre- and posttests** are used in all trainings of HPSO's and Promoters. This data is used to measure the quality/effectiveness of trainings and to discover where further on-the-job training is needed. (See Section A, Main Accomplishments, for pre/posttest scores.)

- **Oral Testing in Care Groups:** As interventions are phased in, Leader Mothers are to be orally tested on their knowledge of key project messages during their biweekly Care Group meetings in order to reinforce their current learning and assess whether the group is able to carry out health promotion without further extensive involvement of the Facilitator. Facilitators are often reticent to use the oral test tool because they do not want to keep the Care Group atmosphere friendly and informal. In the following year, oral test questions will be included in Module trainings and Facilitators will be taught creative games to make oral a fun, interactive part of the training.

Monitoring and Evaluation Tools used in year 2:

- **Rotating Mini-KPCs.** With this methodology, a two-paged KPC-type questionnaire is administered after each module to a sample of mothers of children less than two years of age (all mothers from one Care Group per Promoter, chosen without replacement). Two such mini-KPCs were carried out this year. Annual anthropometry is also done for these – and an over sample of – children selected at random, and weight-for-age is assessed. The mini-KPC questionnaire currently being used for children age 0-5m is found in Annex 5 and for children age 6-23m in Annex 6. The results of this mini-KPC and implications for program planning can be found in Section O. Staff have found this regular reporting out of behavior change – with data on successes and deficiencies by supervision area – to be very helpful in program planning.
- As described above, **abbreviated health facility assessments** are done on a monthly basis by HPSOs of different health posts to assure that clinical management of childhood diseases is provided correctly and completely. A health worker observation tool and mother's exit interview tool are used. The objectives of the HFA are to assess the knowledge and practices of health workers in outpatient settings on classification and management of childhood illnesses, the principle barriers to good and effective case management practices, the quality of the advice provided to health workers on prevention and treatment of childhood illnesses, and to see if the caregivers of those children understand what they need to do in the household. After the assessments are done, meetings are scheduled with health facility staff to review the results and a copy of the report is also provided to the district health director. During the post-assessment meetings, improvements are prioritized and planned in the quality of care in health facilities, including communication skills and standardized case management practices. A yearly review of HFA data (from all HFAs conducted) is also planned for the upcoming year.

HFA's have had a positive influence on many health posts and improved the care children are receiving. In program operation areas there is now at least one technical nurse trained in IMCI who is responsible for triaging and

performing the assessment of pediatric patients. It has also been recognized that it takes at least 15 minutes to do a complete evaluation of a pediatric patient if the IMCI guidelines are followed. While many health post staff members argue that patient load doesn't allow for 15 minutes per patient, the discussion allowed for many to realize that taking an extra 5 to 10 minutes during the initial visit can decrease the need for follow-up visits or the child's situation worsening and requiring additional time from health professionals. District directors now also have added justification for petitioning higher staffing levels for health posts. Please see Annex 7 for the results of HFA study carried out during the HFA training. Annex 8 shows the results of HFAs done in project districts during July 2007.

F. Sustainability

Studies find Care Groups Continue to Meet after Project Finishes in Mozambique

Sustainability will rely heavily on the continuation of the Care Groups themselves, and studies in Mozambique have shown that Care Groups continue to meet and do health promotion long after project funding has ended. Studies conducted by World Relief in Gaza province found that of the 1,457 volunteers active at the end of a Care Group project, 1,361 (93%) were active twenty months later. Of the original number, 92 LMs had left their post or moved out of the area and 44 had died. Out of these 132 vacant roles, the communities had selected 40 replacements, and other volunteers trained their new colleagues and entrusted them with the educational materials of their predecessors. Furthermore, the changes brought about in the original program – similar to FH's dramatic changes with its Title II Care Group project – were maintained during this period, as well. A full thirty months after the end of the project, final program goals on eight key indicators continued to be exceeded. While FH has not yet pulled out of the communities in Sofala where Care Groups have been established (using Title II funds), FH has seen the same low turnover rate and exceptional impact and changes in results-level indicators that are associated with a successful, community-supported project.

Hand-over and Training of Care Group Presidents and C-IMCI LM

FH is preparing over the coming year to move into Phase II districts (the remaining five districts in the project) and to reduce the number of meetings held each month with our current Care Groups as that is done. As that happens, FH will spend more time preparing Care Group Presidents and C-IMCI trained LMs (sometimes the same person) to take more leadership in their Care Group and to understand what is necessary to keep the group morale high, health promotion continuing, and the gains made in their communities to last.

LM and BM Turnover

During the second year of the program, FH worked with 2,079 LM's, 91.5% of LM's participated in training and 5% of LM's dropped out. The principle causes of project abandonment were change of residence, illness, and death

Fostering the Ethic of Development within Communities

Another aspect of the CS project that ensures sustainability is the use of Community Development Committees (CDC) to form, supervise, and manage the Care Groups and community level project activities. At project start-up, these CDCs were formed using existing groups of leaders who were already actively governing the community when possible. The objectives of the project were explained to the CDCs as well as what their role would be. However, in a post-colonial, post-socialist society that is accustomed to receiving donations from NGOs, it has often been difficult for CDC members to understand their role in community development. History has taught them that they can and should expect to be paid, or at least to be provided with incentives to develop their community. This mentality is not only firmly held by the CDC members, but also staff members, hired and trained to work with CDCs.

The CDCs started with 15 members, but at present the average membership is four committee members per community. The process, while not easy, has helped project staff and communities to grapple with the question of who benefits from this project and – if they should choose to not participate because of lack of incentives – who will ultimately suffer the consequences of their lack of participation.

FH has a Title II project operating in different communities, but many of the same districts where the CS project is operating. The Title II Food Security project has a formal training program and staff dedicated to working with CDCs, providing training about community development, and small project management. Title II staff were invited to train CS staff and share from their own experiences of working with CDCs. Changing a culture and a mentality that has been held since Portuguese colonialism and is reinforced with every disaster and poorly-done development/relief project is a long process, but inroads are being made. FH will attempt to do a small positive deviance type study this year on effective CDCs and use that information during formation of CDCs in Phase II districts.

G. DIP Consultation Responses:

N/A – our DIP was approved in June 2006. There are no additional responses that need to be addressed in this annual report.

H. Projects in the First Year - Social and Behavioral Change Strategy:

N/A our SBC strategy was clearly outlined in our approve DIP and there have not been modifications to this strategy. (See **Annex 3** for a copy of our BEHAVE framework for exclusive breastfeeding – additional plans that we have developed for

supporting that behavior.)

I. Projects in the Final Year

N/A this program just completed its first year of activities.

J. Programs Receiving FP Support:

N/A this program does not receive FP support

K. TB Programs:

N/A this is not a TB program.

L. Management System:

The FH Mozambique financial department used the “SUN” system to enter expenses and provide monthly reports to program managers. The SUN system allows FH to track funds received from donors separately. On the 20th of every month a draft report is prepared for program managers to review and verify. Based on comments received from program departments a final report for the previous months spending is produced on the 25th of the following month. These reports are submitted to FH headquarters in Phoenix and used to compile quarterly USAID financial reports. Headquarters expenses are tracked using the Forecaster system and closely monitored by the CSNPC.

In September 2007 FH upgraded the “SUN” system to a newer version. The benefits of this upgrade are:

- Upgraded SUN financial software is easily compatible with Windows operating system and other recently developed software. This is an improvement from earlier DOS version we have used for years which had a very limited interface with other software and therefore limited capabilities.
- Vision XL and Executive modules are being implemented alongside the new upgraded SUN. This provides excellent reporting tool and extensive interface with MS Excel / Word software. Ability to design reports that will suit our diverse donor needs is a great advantage. Finance and management staff can access required financial reports and analysis and this capability is both at the field and HQ level.
- Data entry process will be much faster and enhanced through use of Vision excel. Data processing time will be reduced as we can upload data straight from excel with preset definitions.
- Data is centrally accessed through a Citrix server in Phoenix. Authorized personnel can access real time data any time after it is processed. Being a web-based system, no transfer of data needed from field office to HQ will be necessary, and vice versa.

- Financial data security is greatly enhanced. Required backups at the field level are not required, there are no worries should a computer in use in the field office crash since the data is still intact in the server.

Human Resources:

Organizational Structure: FH directs, mentors and works through its partners in Mozambique, to build their capacity to administer and technically manage the health activities conducted through the Care Group structure established by each district office. FHUS maintains close contact with the USAID Child Survival office, provides project guidance and backstopping, manages the US-portion of the budget, and oversees the completion of USAID narrative and financial reporting requirements. FHUS is also responsible for receiving/dispersing all funds.

A **CS Coordination Team** is meeting each quarter to coordinate and plan activities in each district. This team is comprised of FH staff, provincial MOH representative, representatives from HAI, CUAMM, and PWCSA. Once activities for the upcoming period have been decided upon by the CS Coordination Team, the CSP Manager is responsible for communicating them to all Health Program Support Officials (HPSOs) twice a week via cell phones, and during monthly visits to each district. Monthly **District Coordination Meetings** that are attended by HPSOs, Promoters, and representatives from district level MOH also facilitate communication and coordination.

During the second year of the program, FH/Moz had to replace two of the three HPSOs and one was promoted to the position of CS Trainer. Turnover was due to a fatal illness, recall of one HPSO back to the MOH, and promotion. The three HPSOs are responsible for the five districts currently covered by the program, and a fourth “floating” HPSO has recently been hired to cover a HPSO while on maternity leave and when other HPSO’s are sick or unable to perform their duties for various reasons. In the second year of the project, 9 of the 38 Facilitators were replaced due to poor performance. Frequent illness and deaths in staff’s families have been a constant challenge since the project started and has led to delays and difficulties in completing activities in a timely and quality manner. Training three new HPSO has been a challenge for the project manager and has meant a loss of institutional capacity and memory.

Due to the lack of training programs available in the country, it is difficult to obtain staff with formal education in biostatistics, epidemiology, or public health. Staff applying for M&E positions or higher-level coordinator positions with this type of training can demand extremely high salaries beyond FH’s salary scale as they are in short supply and will have studied abroad. Due the lack of formal training within the FH/M M&E staff, a high level of M&E support is required from the DHP and CSNPC.

The CSP Manager and Provincial MOH representatives coordinate together to supervise technical aspects of their work related to this project. The HPSOs are responsible for biweekly supervision of ten Promoters per district. During FY07, the MOH district staff began, on a quarterly basis, to join the HPSOs in their supervision of the Facilitators as time allowed. The HPSOs are accountable to the CSP Manager. Each Facilitator, in turn, is responsible for educating and supervising the work of the LMs in the five Care Groups that they serve.

Leader Mothers currently spend about two hours every other week participating in Care Group meetings and another 8 hours a week conducting home visits to the 12 beneficiary mothers they serve.

Carolyn Wetzel, MPH/TM is FH's Child Survival and Nutrition Programs Coordinator, and serves as the primary technical and administrative backstopping to the field staff. (She replaces Lauren Erickson-Mamane, who left FH in July 2007 and took a job with the Peace Corps in Benin.) She is supported by Tom Davis, MPH, FH's Director of Health Programs (DHP). Emma Hernandez Avilan, BSN is FH/Mozambique's full time Child Survival Program Manager and is responsible for managing the CS team in Mozambique. Mr. Tesfaye Legesse, M&E Program Manager for FH/Mozambique and Derrick Kapuara, M&E technician, work closely with the CS Project Manager in coordinating M&E activities and measuring progress toward objectives at the community level.

Communication system and team development:

Monthly project technical and quarterly financial reports sent from the CSP Manager to FH's DHP and constitute the basis of FH's quarterly and annual reporting to USAID.

Internet service for the project office in Beira is reliable, and is used for frequent communications and document transfer. Shortwave radio communication is used for communication where cell phone coverage is limited and to reduce costs related to cell phone usage. All HPSOs have cell phones and are issued credit on a biweekly basis. Many Facilitators also have cell phones that they can use when in areas with cell phone coverage that allows for improved communication among project staff.

The DHP and CSNPC are ensuring transfer of skills through several mechanisms. (1) The DHP and CSNPC are conducting trainings and participating in curricula development with field staff in Mozambique. During the second year of program implementation, both the DHP and CSNPS traveled to Mozambique to conduct a training on Mini-KPC Surveys, Verbal Autopsy, and Health Facility Assessments. The CS Project Manager and Mozambique Health Programs Manager were also able to travel to the US to attend the CS Mini-University and meet with the CSNPS. (2) The CSNPC provides summaries of relevant information from the CORE listserv and working groups, technical newsletters, USAID correspondences, and relevant training opportunities to project staff members. (3) The DHP and CSNPC provide technical updates and lessons learned during CS meetings in Washington to the CSP Manager and HNP Manager.

Local Partner relationships & PVO Collaboration:

FH’s strategy is partnering with the **Sofala provincial MOH, PWCSA, CUAMM, HAI**, and other partners to implement FH’s highly successful Care Group model for improvements in nutrition, diarrhea, and household and community IMCI throughout Sofala province. During the second year of implementation, FH implemented all activities in close collaboration with the MOH, including trainings, campaigns, emergency relief, and creating provincial reports. In Beira (Manga), FH worked closely with CUAMM in the identification of cases of malnutrition, and malnourished children found in the community were sent to MOH health posts, supported by CUAMM with food rations, materials, and technical advice. At the district level, HAI collaborates by building the capacity of the District health team. The AISPO project ended in 2006 and was not renewed. AISPO is no longer present in the Sofala region. PWCSA is invited to attend all trainings, but to date has not been present at any trainings. A new partner relationship has been developing with the Catholic University in the later half of the 2007 FY. They have requested copies of the Module III: Diarrhea flip-chart, requested information about project monitoring and evaluation tools, and invited the Health Programs Manager to teach Year 1 medical students about issues of nutrition and public health.

M. Mission Collaboration:

FH has worked closely with the USAID mission as evidenced by the mission’s invitation to FH/M to pilot the Zinc operational research project. Nationally and provincially, it has been recognized that FH’s Care Group network is a methodology that effectively allows the MOH’s services and information to reach the community, where current health systems are not able to provide complete coverage.

N. Activity Timeline:

Activity	Year 3, FY08			
	Q1	Q2	Q3	Q4
Vitamin A and Deworming Campaigns				
Annual review meeting of Project Partners & Devel. of Year #3 Annual Implementation Plan				
Phase I Promoters teach LMs on Module #4/5 (combined), Breastfeeding and Complementary Foods				
LMs do health promotion on Module #4/5				
Zinc OR: Advocacy and announcement of the zinc OR project in two project districts; Identification of communities and partners for project implementation; update community mapping; Identification of existing training and BCC materials				
Zinc OR: Formative research on the level of diarrhea, KPC and use of health services with diarrhea, including submitting the plan to an ethics panel and implementation				

Zinc OR: Designing BCC materials (w/training materials furnished by MOH); Development of M&E and reporting forms and system changes for Zinc OR				
Zinc OR: Pretesting of training and BCC materials; Printing/copying of BCC, reporting, and M&E forms and materials; Training of CHAs (FH/MOH), C-IMCI LMs, & MOH HF staff				
Mini-KPC, Module #4/5				
Revision and pretesting of Care Group Module #6/7 (combined): Micronutrients and Nutrition & Care for Pregnant Women				
Training of Phase I District Coordinators and Promoters in Care Group Module 6/7				
Phase I Promoters teach LMs on Module #6/7; LMs do health promotion on Module #6/7				
FH HQ Backstop visit (CSNPC and DHP): Program monitoring, management audit, Mortality Review Meeting, follow-up on HFAs				
Zinc OR: Implementation of field activities; Supervision of field activities; Documentation of best practices and dissemination of lessons learned; Zinc OR M&E				
Zinc OR: Training of community/other leaders and LMs				
Mini-KPC, Module #6/7				
Catch up on modules (for CGs that repeated lessons)				
Midterm evaluation (including anthropometry)				
PHASE II DISTRICTS IN SOFALA				
KPC, FGDs, and Barrier Analysis studies.				
Selection of Phase II Promoters and formation of Community Development Committees				
Community mapping and census activity				
Identification of Leader Mothers and formation of Care Groups				
TOT for District Coordinators and Promoters on Heathh Nutritional Rehabilitation Methodology				

O. Results Highlight

Problem Addressed: Monitoring project indicators during a five year project at start-up, midterm, and end-of-project can result in discovering problems or ineffective strategies at the end of year two or even in year three, depending on the survey analysis time frame.

Project's Input to Address Problem: Annual rotating mini-KPCs are planned in project communities. A short KPC-type questionnaire is administered yearly to a sample of mothers of children less than two years of age. Anthropometry is done regularly, Weight-for-age assessed at baseline, yearly during the mini-KPCs, and at final. Data from these surveys helps project staff/partners to monitor progress towards meeting targets (especially in terms of behavior change), and to identify problem areas. For a full description of the mini-KPC methodology, see the Title II Monitoring Toolkit produced by FH technical staff at: Main body:

<http://gme.fhi.net/fse/isapr/docs/TIIMonitoringToolkitfinal.doc> Annexes:
<http://gme.fhi.net/fse/isapr/docs/FAMTIIMonitoringToolkit%5B1%5D.ZIP>

Magnitude of the Intervention: All 1,076,055 targeted beneficiaries benefit from adapting the project on a regular basis to meet identified needs and changing circumstances.

Quantifiable or Specific Results: The results of the September 2007 KPC are found below:

Round #2 of CS Mini KPC (19/20/22/26-9-2007)

Survey Purpose:

The main aim of the survey was to collect data on the project indicators that serve as a point of measurement of change in behavior of mothers in the project areas. Furthermore, collecting information on mothers' knowledge and practices was part of the purpose of this survey. Areas of study in this survey were: Water and Hygiene Behaviors; Coverage Indicators measuring Visits by Leader Mothers; Vitamin A and De-worming; Other Knowledge and Behaviors Measured that include Exclusive Breastfeeding; Diarrhea and IMCI.

Location & Supervision Areas:

Five Supervision Areas were involved in the collection of data. The first Supervision Area to conduct the survey was Manga. The survey took place on the 19th of September, a day after the survey training session had taken place. Other Supervision areas were; Caia District (survey conducted on the 20th of September), Marringue District (surveyed on the 22nd of September), and Chemba and Marromeu Districts (surveyed on the 26th of September).

Methodology:

LQAS was used in the five Supervision Areas with parallel sampling of 0-5 months olds and 6-23 months olds. Each age group had its own questionnaire. We used 19 questionnaires for each age group in each Supervision Area. A total of 38 questionnaires were completed in each Supervision Area. All five Supervision Areas had a total of 190 questionnaires completed. Each questionnaire had anthropometry questions added to them. The 0-5 months questionnaire required only one child to be weighed and the 6-23 months required 3 children to be weighed. Weights were collected and a total of 378 children were weighed in all 5 Supervision Areas.

KPC training took place in Manga first. The other four districts received their training in Caia. Interviewers were FH Promoters working in those districts. Each promoter interviewed mothers that belonged to the second promoter to avoid likely bias. Supervisors were FH staff including CS manager and M&E member.

Data Analysis:

LQAS Tabulation tables were used to enter data and automatic data analysis was done. All Tabulation tables had targets for each indicator, and calculated average coverage, and whether each district was under average coverage and under the target for each indicator. A narrative of the analysis was prepared in Mozambique and finally checked by Tom Davis, FH Director of Health Programs. Anthropometry data was entered into Epi-Info 6.04 version by M&E staff members and analysis was done by Tom Davis using a program written for FAM. The first data was analyzed and was completed on the 19th of October. Anthropometry data was analyzed and completed on the 29th of October.

Water and Hygiene Behaviors (covered in Module #2)

- a. **Water purification:** 94% average coverage, all districts at above project target of 75%.
Conclusion: Target surpassed, with **Chemba** and **Marringue** well improved this time when compared to Round #1 results.
- b. **Defecated proper place:** 79% average coverage, above project target of 70%.. Caia, Chemba, and Marringue districts are no longer below project target and below average coverage. *Conclusion:* Overall target surpassed in all districts.
- c. **Hand washing proper times:** 79% average coverage, surpassed project target (of 40%). Chemba, Marringue and Marromeu districts did particularly well, and Marringue is now above the project target. Manga and Caia districts are below average coverage but above the project target.
Conclusion: Overall target surpassed, but needs more work in **Manga and Caia**. Manga has been below target for two consecutive periods. Consider doing more activities there to boost results. (Caia remains above the project target, but below average coverage.)
- d. **No diarrhea last two weeks:** 64%, below project target of 70% without diarrhea. Manga, Marromeu and Marringue are above both Average coverage and Project target while Caia and Chemba are below Project target.
Conclusion: Failed to achieve the overall target which may be due to seasonal variations with this indicator – continue to monitor. **Chemba and Caia are below the project target**, so continue to devote effort to this indicator there. Poorer handwashing practice in Caia (relative to other districts) may be linked to diarrhea.

Overall Results, Water and Hygiene Behaviors: Good results on most water and hygiene indicators used in this survey, and most districts surpassing project targets on 3 of 4 indicators. No diarrhea last two weeks is still below target in two of five districts: Continue to explore barriers and give appropriate advice. Other promoted practices in future modules (e.g., exclusive breastfeeding) will probably help improve this indicator.

Coverage Indicators:

- a. **Infants visited by LM:** 94% average coverage, surpassed project target of 90%. No districts below average coverage or below target.
Conclusion: Surpassed target. Maintain the coverage.
- b. **Children 6-23m, visited by LM:** Average coverage = 95%, above project target of 90%. No districts below average coverage or below target. Caia district has now improved coverage.
Conclusion: Above the target. Maintain the coverage.
- c. **Weighed at least once during last 4 months:** 89% average coverage, just below project target of 90%. Marromeu continues to be below the project target and below average coverage.
Conclusion: Below target, more work needed in **Marromeu** to achieve equity and to stay above target. Look into reasons for low GM/P coverage in Marromeu and develop plans to address this problem.
- d. **Child dewormed:** 83%, above project target of 75%. Below project target in Caia and Marromeu where coverage has dropped below target. On target in Manga, Chemba, and Marringue. Manga and Chemba have improved compared to the last mini-KPC.
Conclusion: Above overall target, but Caia and Marromeu are below target. Find out why coverage for deworming has worsened in these two districts – during last round, these two were above project target.
- e. **Vitamin A supplementation:** 89% average coverage, below project target of 95%. Project is below target and below average coverage in **Marromeu**. All other districts are above target.
Conclusion: Below project target. More work needed, especially in **Marromeu**.

Overall Results, coverage indicators: Surpassed targets on 3 of 5 coverage indicators, but need more work on GM/P and Vitamin A. Districts need to explore reasons why coverage is still below target, especially in Marromeu. Vitamin A supplementation and deworming is expected to be better in all districts. Look for ways to improve GM/P and Vit.A supplementation, especially.

Other Knowledge and Behaviors Measured

- a. **Exclusive BF:** 75%, all districts surpassed project target of 60%.
Conclusion . Consistent with previous findings, but suspicious since we have not done much work here. Suggest that you conduct some focus groups to find out if mothers are truly exclusively breastfeeding or if the way the question is worded in the mini-KPC leads to “false positives.”
- b. **BF both breasts:** 92%, surpassed project target of 75% in all districts. One district (Manga) is below average coverage but above project target.
Conclusion: Same as above – excellent, but suspicious. Ask about this during FGDs, as well. Also ask who – if anyone – has promoted this practice and exclusive BF with them. (C-IMCI trained LM? Health facility staff?)

- c. **Completely empties both breasts:** 59% average coverage, below project target of 80%. Below average coverage and target in Manga and Marringue. Above target and average coverage in Marromeu and Chemba. Caia is below target but achieved the average coverage.
Conclusion: We will be teaching more on this in the next module. Expected to be low at this point.
- d. **Consumption of vitamin A foods:** 87% average coverage, surpassed project target of 80% in all districts. Only Marringue district is below average coverage.
Conclusion: Good achievement on this indicator. (Was this taught in one of the previous modules? If not, to what do you attribute the change?)
- e. **Child ate solid or semi-solid foods:** 65% average coverage, below project target of 95%. All districts below target except Marromeu.
Conclusion: We have not worked on this behavior yet, but will be part of the next module. It would be worthwhile to find out why mothers in Marromeu are doing the practice. This could inform health promotion in the other districts. If BA is done on this practice, be sure to include Marromeu mothers in the sample.
- f. **Mother adds oil to child's food:** 87% average coverage, above project target of 80%. Marromeu district is still below target (see previous results) and below average coverage.
Conclusion: Same comments apply as for “e” above. Marromeu is already above target.
- g. **Gave ORT to prevent dehydration:** 96% average coverage, all districts above target of 90%.
Conclusion: Excellent achievement. Up from 71% at baseline. This is one of the most important behaviors for avoiding child deaths.
- h. **Mother knows how to make ORS:** 91%, above project target of 80%. Marromeu district is below average coverage.
Conclusion: Good results. Even though target was 80%, every mother should know how to make ORS. Remind mothers of process during upcoming meetings, and ask for return demonstrations.
- i. **Mother knows child danger signs:** 86%, surpassed target of 75%. Only Caia is below average coverage.
Conclusion: Good results. Continue to reinforce knowledge of these signs in future CG meetings, and test mothers knowledge.
- j. **Mother knows maternal danger signs:** 55% average coverage, below target of 80%. Marromeu and Chemba are below average coverage and project target. Caia is below average coverage.
Conclusion: We have not taught on this yet. This will be covered in the last CG module.

<p>Overall Results, other indicators: We have taught on some of these topics in the Care Groups. C-IMCI Leader Mothers have learned most of these behaviors and are promoting</p>
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them. We have surpassed the project target in more than *half* of them (7 of 10). You should explore if the MOH is teaching on these things more than FHI staff to verify efforts in the field by our staff.

District	Main Focus Area (Below Project Target) for Behaviors that We have Promoted So Far
Manga	<ul style="list-style-type: none"> • Handwashing
Caia	<ul style="list-style-type: none"> • No diarrhea last two weeks • Deworming • Handwashing
Marromeu	<ul style="list-style-type: none"> • Weighed at least once during the last 4 months • Vitamin A supplementation • Deworming
Chemba	<ul style="list-style-type: none"> • No diarrhea last two weeks
Marringue	<ul style="list-style-type: none"> • (No deficiencies)

Q. Child Survival Related Presentations by Food for the Hungry Staff

Lauren Erickson-Mamane, FH's child survival backstop up to July 2007, presented at the June 2007 Mini-University on *Using Formative Research to Inform Program Design: Barrier Analysis*.

Tom Davis, Director of Health Programs for FH, made the following child survival related presentations during the year:

- a. **Health Behavior Health Education Global Health Roundtable at the UNC-Chapel Hill** in October 2007: Mr. Davis presented on the Barrier Analysis tool for graduate students in this group featuring FH's work in child survival.
- b. **2007 Christian Connections for International Health conference:** Presentation on Child Survival advocacy. During this session, participants learned easy-to-use tools to change policy that affects the people that they are called to serve (e.g. mothers and children). The workshop focused on equipping participants with tools, using exercises to practice using these tools, and advocacy action ideas to take home with them to generate action in their communities and the world.
- c. **CORE Spring and Fall meetings in 2007:** In the Spring Meeting, Mr. Davis presented on Barrier Analysis results on AIDS prevention in four countries. He also presented the opening and closing sessions on child survival as Chairman of the Board of the CORE Group, including a discussion of the "last mile" problem and how PVOs have taken the lead in solving this problem.
- d. **International Food Aid Conference** in Kansas City, April 2007: Our presentation included information on mortality declines using FH's Care Group model (which is currently part of our child survival project in Mozambique).
- e. **January 2007 Food for the Hungry Launch** conference in the Dominican Republic: We featured FH's USAID-sponsored child survival and Title II health work.

- f. **2007 APHA Conference**, session entitled, “*Care Groups significantly reduce child mortality in Mozambique*” as part of the preformed panel session, “*Community-based Approaches Are Essential in Global Fight to Increase Child Survival*” and is scheduled for Monday, November 05, 2007: 8:30 AM-10:00 AM in Room 158A. The abstract is provided below:

Food for the Hungry/Mozambique’s (FH/M) Expanded Impact Child Survival project in Mozambique is covering 10 districts in Sofala Province. This program is based on FH’s Title II health program, which has outpaced all other Title II PVOs in Mozambique in terms of reductions in child malnutrition and speed of behavioral change. The analysis described at the 2004 APHA conference was extended to include measurement of child mortality changes.

FH’s health and nutrition interventions are implemented via Care Groups, a multiplier model where thousands of mothers are taught in groups to promote behavior change with nine of their neighbors.

An assessment of mortality was conducted using pregnancy histories conducted by interview teams with members of the National Institute of Statistics, personnel from the provincial/district health systems and NGOs. The survey instruments used in the Demographic Health Survey (DHS) 2003 and standard Verbal Autopsy instruments were adapted for the study.

From 1998 to 2001, FH/M decreased the proportion of children 6-23 months who had moderate/severe stunting by 40% (from 50.4% to 30.3%, $p < 0.05$, $n = 2,337$). The current study found a 62% reduction in the under-five mortality rate and a 94% reduction in the CMR. The cost-per-beneficiary was \$4.50. Other studies on this model (as applied by World Relief) have found similar reductions in the under-five mortality rate and evidence of high sustainability of results.

Title II health programs – using effective methods such as Care Groups – should be mobilized to help achieve MDG #4, since they can achieve significant improvements in child survival in addition to their impact on childhood malnutrition.

Annex 1: Child Verbal Autopsy Form

FOCAS Child Verbal Autopsy Form

Tell the family the purpose of your visit:

- To talk with them about the child who died in their family.
- To better understand why he or she died so that FOCAS might be able to prevent other children from dying.
- To offer our condolences to the family.
- Mention that – while it is important for us to get information – at any point the family wants to take a break and not talk about it for a few minutes, they should feel free to do so.

1. Person completing form: _____ 2. Date of verbal autopsy: ___/___/___

3. Suspected cause of death listed on Vital Events Registry:

4. Name of child who died: _____

5. Child's age at death: _____ months. If the child died before the 41st day of life then how many days after delivery did the child die? (Note: Put 0 if on day of delivery)

6. Child's date of birth: ___/___/___ 7. Child's Date of death: ___/___/___

8. Address: _____

9. Mother's /caregiver's name: _____

10. Person responding to questions: _____. 11. Relationship to child:

12. **Nutritional Status.** Indicate the date of the child's last growth monitoring check and place an "X" beside the child's nutritional status at last growth monitoring check:

Date: ___/___/___ Nutritional Status: M1:___ M2:___ M3: ___ .

13. If the child was under 41 days old, was the child **low birth weight**?

Yes:___ No: ___ Child was 41 or more days old: _____

14 . **Education of Mother / Caregiver.** Indicate "**yes**" or "**no**" if the child's mother or primary care giver was educated on each topic and write the **date** of each education session given.

Breastfeeding (0 m) No__ Yes: ___/___	Post natal care & danger signs (0 m) No__ Yes: ___/___	Pneumonia danger signs (1 m) No__ Yes: ___/___	Oral rehydration therapy (2 m) No__ Yes: ___/___	Pneumonia danger signs (refresher) (16 m) No__ Yes: ___/___
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15. **Acute Respiratory Infection** Did the child have Acute Respiratory Infection within 30 days before death? Yes:___ No: ___ If "yes" then continue with 15.a., if "No" then skip to Question 16.

15.a. Did the child have pneumonia? Yes:___ No: ___

15.b. If the child had pneumonia was the child followed up with 48 hours after beginning treatment? Yes:___ No: ___

16. Did the child have Diarrhea within 30 days before death? Yes:___ No: ___

If "No" then skip to Question 17.

16.a. Did the child receive a follow up visit with 24 hours after the first visit? (Recommended if the child has signs of dehydration, severe disease, has diarrhea and vomiting, or if the child was referred). Yes:___ No: ___

17. Social status of family: Above average resources Average Below Average

18. Family members, neighbors, and others attending to the child or nearby at time of death (list all):

19. Indicate below who attended the child (check all):

CHA Mother Grandmother Other family
 Nurse Doctor Other_____

20. If CHA, doctor, or nurse, indicate the name of the person(s) attending the birth:

21. Location of death: Home Relative's house Hospital Clinic Other

22. How old is the next oldest sibling to the child that died? _____ months.

23. Has the child's mother had any other child deaths before this one? Yes:___

~ If so, how many? _____ No: ___

24. **NARRATIVE**

(Tell the person:) I need you to tell me now exactly what happened from the time that you noticed that (NAME) was sick until the day that he / she died. It is important that we know all the details so that we can try to prevent similar deaths from happening in the future. So please take your time and be sure to mention on what days and times the different things happened that led up to (NAME's) death. Remember that if at any point you want to take a break and not talk about it for a few minutes, you are free to do so. (WRITE FULL NARRATIVE BELOW. BE SURE TO ASK ABOUT AND INCLUDE:)

- **Dates and times** when each event happened.
- **Signs and symptoms** seen at each point in time.
- **Problems with the child eating or drinking** during the illness, and **problems** found during rally post visits
- **Any other health problems** the child had, especially within the last month before death.
- **Details on any delays** that occurred that could have possibly been associated with the death (e.g., delay in recognizing the problem, delay in making a decision about care, delay in getting transport to the clinic or hospital, delays in receiving care once at facility).
- **WHO** made or contributed to each decision mentioned.
- **Once care was received, were there any problems with follow-up care or home care** of the child that could have possibly been associated with the death? (e.g. did the caregivers know how to properly administer any prescribed treatments?, did they know how quickly the child should have improved and what to do if the child did not improve?, did they know the danger signs and where they should seek help?, did they know when to return to the clinic?, did the health agent make follow-up visits if this was indicated?).

• **Any health history or background information** that could possibly be important (e.g., that the child had asthma, had parasites, had malaria)
(Write the full narrative below. Use the back if more space is needed. Be prepared to relate the entire story of this woman's death in detail during the next Mortality Review Session:)

25. **At what time – day and hour – did the caregiver recognize that the child had a problem requiring medical attention (from CHA, Health Center, Clinic or Hospital) ?** _____

26. Were delays in **recognizing the problem** found? Yes No

- If yes, please explain the nature of the delay:

27. **At what time – day and hour – did the caregiver decide to seek medical attention?** _____

28. Were delays in deciding **to seek medical attention** found? Yes No

- If yes, please explain the nature of the delay (e.g., cost, distance):

29. At what time – day and hour – did the child reach a health facility?

30. Were delays in **reaching a health facility** found?Yes No

31. ***If there was a delay in reaching a facility***, was the delay related to:

- Distance to health facility.....Yes No
- Availability of moneyYes No
- Knowledge of where to goYes No
- Problems with health facility personnelYes No

If there were any delays in reaching a facility, please explain the nature of the delay:

32. **At what time – day and hour – did the child reach the health facility?**

33. **At what time – day and hour – was treatment begun** by a health professional at the health facility?

33. Delays in **receiving care once at a health facility** found?.Yes No

If yes, please explain the nature of the delay:

34. Were problems with **follow-up care or home care after receiving medical care** found? Yes No

35. Was the problem related to how the caregivers were oriented? Did the caregiver(s) know:

- How to administer prescribed treatment. Yes No
- What to do if the child did not improve? Yes No
- The danger signs? Yes No
- When to return to the clinic or find the health agent? Yes No

36. Was a follow up visit from the health agent indicated? Yes No

If "yes" did the health agent make the visit within the indicated time? Yes

No

If "no" then why not? _____

37. If there were any other problems with follow-up or home care **after receiving medical care**, please explain the nature of the problem:

38. Supervisor's Signature: _____

Annex 2: Barrier Analysis Questionnaire on Exclusive Breast-Feeding

**Barrier Analysis Questionnaire on
Exclusive Breast-Feeding
Mothers of Children 0-11m, Sofala Province**

Interviewer's Name: _____ Questionnaire No.: _____

Date: ____/____/____ Community: _____ GROUP: Doer NonDoer

Age of Mother Interviewed: ____ years Age of mothers youngest child: ____ months

Main language mother speaks: _____ Language of Interview: _____

First NAME of youngest child between 0-11 months of age: _____

REFER TO THIS CHILD THROUGHOUT THE INTERVIEW

Discuss CONFIDENTIALITY:

- *Purpose of study*
- *They can choose to participate or not participate in the study. No services will be withheld nor will they be discriminated against if they choose not to participate.*
- *Everything they say will be held in strict confidence and will not be shared with anyone else.*
- *Ask the person if they wish to participate. If not, thank them for their time.*

(Screening Questions for Respondents whose youngest child is between 0-5 months of age)

1. What is your relationship to this child (If mother prompt biological or adoptive)
 - 1. Biological mother
 - 2. Adoptive mother>end questionnaire
 - 3. Grandmother>end questionnaire
 - 4. Aunt>end questionnaire
 - 5. Other (Specify:-----)>end questionnaire

2. Are you currently breastfeeding (NAME)?
 - a. Yes
 - b. No →**Non Doer**
 - c. Don't know/No Response→**Non Doer**

3. Are you currently giving (NAME) anything other than breast milk, including water, other liquids or other foods?
 - a. Yes →**Non Doer**
 - b. No → **Doer**

c. Don't Know / No response → **Non Doer**

- **If #2 = YES and #3 = No then mark the respondent as a DOER at the top of page one.**
- **If #2 is NO or Don't Know/no response then mark the respondent as a NONDOER at the top of page one.**
- **If #3 is YES then mark the respondent as a NONDOER at the top of page one**
- **GO TO QUESTION # 7**

*(Screening Questions for Respondents whose youngest child is **between 6-11 months of age**)*

4. What is your relationship to this child (If mother, prompt biological or adoptive)
- 1. Biological mother
 - 2. Adoptive mother>end questionnaire
 - 3. Grandmother>end questionnaire
 - 4. Aunt>end questionnaire
 - 5. Other (Specify:-----)>end questionnaire
5. How old was your (NAME) when you first gave him/her something to drink other than breastmilk?
 _____ months
6. How old was your child when you first gave him/her something to eat other than breastmilk?
 _____ months

- **If response to questions #5 and #6 are BOTH 6 months or greater then mark the respondent as a DOER at the top of page one.**
- **If response to either question #5 or #6 is less than 6 months, then mark the respondent as a NONDOER at the top of page one.**

EXPLAIN: We are conducting this study to better understand why some mothers exclusively breastfeeds their children and others do not. Explain that exclusive breastfeeding mean giving ONLY breastmilk, no other types of food or liquids, including water, until the child is 6 months of age.

(Perceived Susceptibility)

7. How serious a disease/problem is malnutrition: Very serious, somewhat serious, a little bit serious, or not serious at all?
- a. Very serious
 - b. Somewhat serious
 - c. A little bit serious
 - d. Not serious at all

8. Do you think a child who is less than 6 months old could become malnourished if they are not exclusively breastfed?
- a. Yes
 - b. Possibly
 - c. No
 - d. Don't know
9. Do you think (NAME) could become malnourished if he/she is/was not exclusively breastfed?
- a. Yes
 - b. Possibly
 - c. No
 - d. Don't know

(Perceived Self Efficacy)

10. What would make **(or would have made)** it easier for you to exclusively breastfeed (NAME)?
11. What would make it **(or have made it)** more difficult for you to exclusively breastfeed (NAME)?
12. Do you think exclusively breastfeeding (NAME) until s/he is/was 6 months old would avoid (NAME) becoming malnourished?
- a. Yes
 - b. Possibly
 - c. No
 - d. Don't know

(Perceived Social Acceptability/Social Norms)

13. Would most of the people that you know approve **(or would have approved)** of you exclusively breastfeeding (NAME)?
- a. Yes
 - b. Possibly
 - c. No
 - d. Don't know

14. Who are the people that would approve (**or would have approved**) of you exclusively breastfeeding (NAME)?
15. Who are the people that would disapprove (**or would have disapproved**) of you exclusively breastfeeding (NAME)?
16. If you wanted to exclusively breastfeed (NAME) until s/he is/was 6 months of age, how difficult would it be for you to remember **not** to give (NAME) anything other than breastmilk, including water, during the day? Very difficult, somewhat difficult, a little bit difficult, or not difficult at all?
 - a. Very difficult
 - b. Somewhat difficult
 - c. A little bit difficult
 - d. Not difficult

(Perception of Divine Will)

17. Do you think that **God approves** of mothers exclusively breastfeeding their children until they are 6 months old?
 - a. Yes
 - b. Possibly
 - c. No
 - d. Don't know
18. Do you think that **God approves (or would approve)** of you exclusively breastfeeding (NAME) until s/he is/was 6 months old?
 - a. Yes
 - b. Possibly
 - c. No
 - d. Don't know

(Positive and Negative Attributes of Action)

19. What are the advantages (or would be advantages) of exclusive breastfeeding your child until he/she is 6 months old? (Write all responses below)
 - a.-----
 - b.-----
 - c.-----
 - d.-----
20. What are the disadvantages (or would be disadvantages) of exclusively breastfeeding your child until he/she is 6 months old? (Write all responses below) a.-----

Annex 3: Results of Barrier Analysis Exclusive Breastfeeding Study

Barrier Analysis Results Reporting Form:

Exclusive Breastfeeding

May-07

Total NonDoers	45								
Total Doers	45								
Determinants	NonDoers: + Exp. (A)	Doers: +Exp. (B)	Doers %	NonDoers %	Diff.	Odds Ratio	Conf. Interval		p-value
							Lower limits	Upper limits	
Q12. Things that make it easier									
<i>Mother takes balanced diet</i>	22	38	84%	49%	36%	0.18	0.07	0.48	0.0003466
<i>When the child has appetite</i>	3	3	7%	7%	0%	1.00	0.19	5.24	1.0000000
<i>Nothing</i>	20	4	9%	44%	-36%	8.20	2.51	26.77	0.0001368
Q13. Things that make it more difficult:									
<i>Lack of balanced diet</i>	10	6	13%	22%	-9%	1.86	0.61	5.64	0.2701047
<i>Mother going without food</i>	15	13	29%	33%	-4%	1.23	0.50	3.01	0.6488340
<i>When child is sick</i>	9	11	24%	20%	4%	0.77	0.28	2.10	0.6120899
<i>Lack of knowleldge</i>	11	15	33%	24%	9%	0.65	0.26	1.62	0.3522362
Q16. Who would approve:									
<i>Husband</i>	8	9	20%	18%	2%	0.86	0.30	2.49	0.7876993

Q18. Thinks he/she can remember to do the preventive action most of the time									
Very difficult	18	13	29%	40%	-11%	1.64	0.68	3.95	0.2673721
Somewhat difficult	10	7	16%	22%	-7%	1.55	0.53	4.52	0.4191492
A little bit difficult	1	1	2%	2%	0%	1.00	0.06	16.50	1.0000000
Not difficult at all	16	24	53%	36%	18%	0.48	0.21	1.12	0.0896860
<i>(Very / Somewhat difficult [calc.]</i>	0	0	0%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Missing									
Perceived of Divine will									
Q19. Thinks God approves of people doing the action									
Yes	16	32	71%	36%	36%	0.22	0.09	0.54	0.0007232
Possibly / sometimes	2	0	0%	4%	-4%	#DIV/0!	#DIV/0!	#DIV/0!	0.1526614
No	20	10	22%	44%	-22%	2.80	1.12	7.00	0.0253473
Don't know	7	3	7%	16%	-9%	2.58	0.62	10.69	0.1797126
<i>(Yes / Possibly [calculated])</i>	0	0	0%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Missing									
Q20. Thinks that God approves/would approve of <u>him/her</u> doing the action									
Yes	13	31	69%	29%	40%	0.18	0.07	0.45	0.0001472

Possibly / sometimes	3	0	0%	7%	-7%	#DIV/0!	#DIV/0!	#DIV/0!	0.0781267
No	22	11	24%	49%	-24%	2.96	1.21	7.25	0.0161224
Don't know	7	3	7%	16%	-9%	2.58	0.62	10.69	0.1797126
(Yes / Possibly [calculated])	0	0	0%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Missing									
Q23. How important do you think the preventative action is?									
Very important	24	40	89%	53%	36%	0.14	0.05	0.43	0.0001984
Somewhat important	7	1	2%	16%	-13%	8.11	0.95	68.88	0.0262569
A little important	1	1	2%	2%	0%	1.00	0.06	16.50	1.0000000
Not Important at all	7	2	4%	16%	-11%	3.96	0.78	20.23	0.0789484
Don't know	6	1	2%	13%	-11%	6.77	0.78	58.73	0.0490795
Missing	0	0	0%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Annex 4: Exclusive Breast Feeding Barrier Analysis Important Findings and BEHAVE framework

People who	Were x times more likely to EBF
Did not say <i>Nothing makes it easier to EBF</i>	8.2
Said <i>I can EBF with my current knowledge and skills</i> [perceived self-efficacy]	7.4
Said <i>EBF is very important</i>	7.0
Said <i>Having a balanced diet makes it easier to EBF</i>	5.7
Said <i>God approves of me EBF</i> [perceived divine will]	5.0
Said <i>EBF is less expensive</i>	4.5
Said <i>friends/extended family approve/would approve of me EBF</i> (& for NonDoers: Nobody approves of me EBF) [Social acceptability (open ended)]	4.2
Said <i>Most people approve / would approve of me EBF</i> [social acceptability (closed ended)]	3.4

FH/MOZ BEHAVE Framework			
Behavior: Exclusive Breast Feeding for 0-6 months			
Priority Group	Behavior	Key Factor	Activities
In order to help:	To:	And knowing that:	We will:
Mothers of children 0-5 months	Exclusively breastfeed to the child's six month of life	<p>Mothers do not:</p> <ul style="list-style-type: none"> • believe that they can exclusively breastfeed, especially if they have a child who is sick or if they are not eating a balanced diet; • realize that exclusively breastfeeding can save them money; • believe that their extended family members support them in exclusively breastfeeding; • believe that God is in favor of their exclusively breastfeeding; • realize that exclusively breastfeeding will help their child to avoid diarrhea; • believe that exclusive breastfeeding is important. 	<p>Use <u>messages</u> (via 4,830 <u>Leader Mothers</u>): EBF is important (e.g., disease prevention / immune effects, mental devel.); you can EBF successfully even if you do not change your diet; EBF can save you money; EBF is a good idea, even for mothers who do not have a perfect diet; you can improve your nutrition during nursing (ex.).</p> <p>Use <u>strategies</u>: Convince extended family members of the value of EBF; have them encourage mothers to EBF; show community support for EBF (e.g., declarations); have clergy promote EBF ("God gives us what we need; EBF is honoring to God"). "You can do it!" posters</p>

Annex 5: Mini-KPC 0-5 month old questions:

**Mozambique Expanded Impact Child Survival Project
Mini-KPC Survey Questionnaire
FOR MODULE 2 : HYGIENE AND SANITATION
For infants aged 0-5 months**

**Lauren Erickson, MPH
Emma Hernandez Avilan, RN
Tom Davis, MPH**

11/2/2007 8:47:51 AM

INTERVIEWER INSTRUCTIONS:

- A. HAVE ALL THE MOTHERS – BOTH LEADER MOTHERS AND BENEFICIARY MOTHERS – ASSOCIATED WITH ONE CARE GROUP FOR THIS PROMOTER MEET AT A COMMON MEETING PLACE. ASK THEM TO BRING THEIR GM/P AND/OR IMMUNIZATION CARDS WITH THEM.
- B. ASK MOTHER IF SHE HAS A CHILD UNDER TWO. IF MOTHER HAS MORE THAN ONE CHILD 0-23M, RANDOMLY SELECT ONE CHILD TO SERVE AS INDEX CHILD (NAME) ON QUESTIONNAIRE

IF (NAME) IS 0-5 MONTHS OF AGE USE THIS QUESTIONNAIRE AND INTERVIEWN THE MOTHER. [If (NAME) is 5 months and 30 days s/he is considered 5 months.] THEN ASK THE NEXT MOTHER THE AGE OF HER CHILD UNTIL YOU FIND A 6-23M OLD.

IF (NAME) IS 6-23M OF AGE USE OTHER QUESTIONNAIRE AND INTERVIEW THE MOTHER. THEN ASK THE NEXT MOTHER THE AGE OF HER CHILD UNTIL YOU FIND A 0-5M OLD

AFTER YOU HAVE COMPLETED 19 QUESTIONNAIRES FOR EACH RESPONDENT TYPE (0-5M OR 6-23M) STOP USING THAT QUESTIONNAIRE. WE ONLY NEED 19 QUESTIONNAIRES FOR EACH TYPE OF RESPONDENT.

Selection of Respondent: For the first mother selected among Care Group participants, ask how many children who live in her house that are under two years of age. Ask for the names and ages and select one of those children at random this child will serve as (NAME) on the questionnaire. CHOOSE THE CORRECT QUESTIONNAIRE TO USE BASED ON (NAME'S) AGE. This questionnaire is for children 0-5 months only. Verify that the child is the age that you were originally told and begin the consent process below.

We want to interview the biological mother if at all possible. Only interview someone other than the biological mother if the child has been adopted. You can then interview the adopted mother. Any other type of caregiver will not be interviewed.

INFORMED CONSENT

Before interviewing a mother or chief caregiver, you must get her/his consent to conduct the interview. Please read the informed consent exactly as it is written. This statement explains the purpose of the survey and the voluntary nature of the respondent's participation, then seeks her/his cooperation. After reading the statement, you (not the respondent) must sign the space provided to affirm that you have read the statement to the mother/chief caregiver. Circle "1" if the mother/chief caregiver agrees to be interviewed and proceed to the modules. If the mother/chief caregiver does not agree to be interviewed, circle "2", thank her/him for her/his time, and end the interview.

INFORMED CONSENT STATEMENT

Hello. My name is _____, and I am working with Food for the Hungry. We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of one of your children. This information will help (Food for the Hungry) to plan health services and assess whether it is meeting its goals to improve children's health. The survey usually takes _____ minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey? [*Answer any questions the mother/chief caregiver has.*]

Do you agree to be interviewed?

RESPONDENT AGREES TO BE INTERVIEWED 1 → **DO INTERVIEW**

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED...2 → **END INTERVIEW**

Signature of interviewer: _____

Date: ____ / ____ / ____
 dd mm yyyy

Questionnaire Number: _____

Care Group #: _____ **Leader Mother #:** _____ **Beneficiary Mother #:** _____

Is respondent a Leader Mother (circle) Y N

Interviewer's Initials: _____

Interview Date: ____/____/____

1. What is your relationship to this child [IF mother prompt biological or adoptive]

- 1. Biological Mother
- 2. Adoptive Mother
- 3. Biological Father →end questionnaire
- 4. Adoptive Father →end questionnaire
- 5. Grandmother →end questionnaire
- 6. Aunt →end questionnaire
- 7. Other (Specify: _____) →end questionnaire

2. How old are you?

_____ Years

3. What is (NAMES's) date of birth? (COMPARE WITH GM OR IMMUNIZATION CARD)

__ __/ __ __/ _____ [NOTE - If the child is ≥ 6 months of age, END SURVEY]
 dd mm yyyy

QUESTIONS #4-9 NOT ASKED OF MOTHERS OF CHILDREN 0-5 MONTHS

10. Are you currently breastfeeding (NAME)?

- 1. YES
- 2. NO →skip to Q. #24
- 9. DON'T KNOW/NO RESPONSE →skip to Q. #24

11. Are you currently giving (NAME) anything other than breast milk, including water, other liquids or other foods?

- 1. YES
- 2. NO
- 9. DON'T KNOW/NO RESPONSE

12. When breastfeeding (NAME) do you offer both breasts?

- 1. YES

- 2. NO→skip to Q. #24
- 9. DON'T KNOW/NO RESPONSE→skip to Q. #24

When breastfeeding (NAME) do you usually completely empty both breasts?

- 1. YES
- 2. NO
- 9. DON'T KNOW/NO RESPONSE

QUESTIONS 14-23 NOT ASKED

GROWTH MONITORING AND CHILD ANTHROPOMETRY

- 24. Was (NAME) have a growth monitoring card? IF YES: May I see it please?**
- 1. YES, SEEN
 - 2. NOT AVAILABLE / CARD MISPLACED → skip to Q#26
 - 3. NEVER HAD A CARD → skip to Q#26
 - 9. DON'T KNOW/NO RESPONSE → skip to Q#26
- 25. LOOK AT (NAME) GROWTH MONITORING CARD AND SEE IF (NAME) HAS BEEN WEIGHED IN THE LASTS FOUR MONTHS**
- 1. YES
 - 2. NO
 - 9. CANNOT DETERMINE FOR SURE
- 26. During the past two weeks, have you received a visit from you Leader Mother?**
- 1. YES
 - 2. NO
 - 3. RESPONDENT IS THE LEADER MOTHER
 - 9. DON'T KNOW/NO RESPONSE

**END OF QUESTIONNAIRE
THANK RESPONDENT FOR HER TIME**

Annex 6: mini-KPC questionnaire for 6-23m olds:

**Mozambique Expanded Impact Child Survival Project
Mini-KPC Survey Questionnaire
FOR MODULE 2 : HYGIENE AND SANITATION
For children 6-23 months**

**Lauren Erickson, MPH
Emma Hernandez Avilan, RN
Tom Davis, MPH**

11/2/2007 8:47:51 AM

INTERVIEWER INSTRUCTIONS:

- C. HAVE ALL THE MOTHERS – BOTH LEADER MOTHERS AND BENEFICIARY MOTHERS – ASSOCIATED WITH ONE CARE GROUP FOR THIS PROMOTER MEET AT A COMMON MEETING PLACE. ASK THEM TO BRING THEIR GM/P AND/OR IMMUNIZATION CARDS WITH THEM.
- D. ASK MOTHER IF SHE HAS A CHILD UNDER TWO. IF MOTHER HAS MORE THAN ONE CHILD 0-23M, RANDOMLY SELECT ONE CHILD TO SERVE AS INDEX CHILD (NAME) ON QUESTIONNAIRE

IF (NAME) IS 0-5 MONTHS OF AGE USE OTHER QUESTIONNAIRE AND INTERVIEWN THE MOTHER. [If (NAME) is 5 months and 30 days s/he is considered 5 months.] THEN ASK THE NEXT MOTHER THE AGE OF HER CHILD UNTIL YOU FIND A 6-23M OLD.

IF (NAME) IS 6-23M OF AGE USE THIS QUESTIONNAIRE AND INTERVIEW THE MOTHER. THEN ASK THE NEXT MOTHER THE AGE OF HER CHILD UNTIL YOU FIND A 0-5M OLD

AFTER YOU HAVE COMPLETED 19 QUESTIONNAIRES FOR EACH RESPONDENT TYPE (0-5M OR 6-23M) STOP USING THAT QUESTIONNAIRE. WE ONLY NEED 19 QUESTIONNAIRES FOR EACH TYPE OF RESPONDENT.

Selection of Respondent: For the first mother selected among Care Group participants, ask how many children who live in her house that are under two years of age. Ask for the names and ages and select one of those children at random this child will serves as (NAME) on the questionnaire. CHOOSE THE CORRECT QUESTIONNAIRE TO USE BASED ON (NAME'S) AGE. This questionnaire is for children 6-23 months only. Verify that the child is the age that you were originally told and begin the consent process below.

We want to interview the biological mother if at all possible. Only interview someone other than the biological mother if the child has been adopted. You can then interview the adopted mother. Any other type of caregiver will not be interviewed.

INFORMED CONSENT

Before interviewing a mother or chief caregiver, you must get her/his consent to conduct the interview. Please read the informed consent exactly as it is written. This statement explains the purpose of the survey and the voluntary nature of the respondent’s participation, then seeks her/his cooperation. After reading the statement, you (not the respondent) must sign the space provided to affirm that you have read the statement to the mother/chief caregiver. Circle “1” if the mother/chief caregiver agrees to be interviewed and proceed to the modules. If the mother/chief caregiver does not agree to be interviewed, circle “2”, thank her/him for her/his time, and end the interview.

INFORMED CONSENT STATEMENT

Hello. My name is _____, and I am working with Food for the Hungry. We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of one of your children. This information will help (Food for the Hungry) to plan health services and assess whether it is meeting its goals to improve children’s health. The survey usually takes _____ minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey? [*Answer any questions the mother has.*]

Do you agree to be interviewed?

RESPONDENT AGREES TO BE INTERVIEWED 1 → **DO INTERVIEW**

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED...2 → **END INTERVIEW**

Signature of interviewer: _____

 Date: ____ / ____ / ____
 dd mm yyyy

Questionnaire Number: _____

Care Group #: _____ **Leader Mother #:** _____ **Beneficiary Mother #:** _____

Is respondent a Leader Mother (circle) Y N

Interviewer's Initials: _____

Interview Date: ____/____/____

4. What is your relationship to this child [IF mother prompt biological or adoptive]

- 1. Biological Mother
- 2. Adoptive Mother
- 3. Biological Father →end questionnaire
- 4. Adoptive Father →end questionnaire
- 5. Grandmother →end questionnaire
- 6. Aunt →end questionnaire
- 7. Other (Specify: _____) →end questionnaire

5. How old are you?

_____ Years

6. What is (NAME'S) date of birth?

__ __/ __ __/ _____ [NOTE - If the child is <6 months or >23m of age, END SURVEY]
 dd mm yyyy

7. In the past week, did you do anything to the water given to (NAME) to make it safer to drink? If so, what? (What else?) [MULTIPLE ANSWERS ALLOWED]

- A. DID NOTHING / DID NOT TREAT THE WATER
- B. BOILED THE WATER
- C. ADDED BLEACH / CHLORINE TO THE WATER
- D. USED A COMMERCIAL WATER PURIFICATION PRODUCT (e.g., PUR)
- E. SIEVED IT THROUGH A FINE CLOTH
- F. USED A WATER FILTER (ceramic, sand, composite)
- G. USED SOLAR DISINFECTION (left it in the sun)
- H. USED SEDIMENTATION (left it so sediment falls to the bottom)
- X. OTHER (Please specify:) _____

8. The last time (NAME) passed stool, where did he/she defecate?

- 1. USED A LATRINE, TOILET, OR IN A SPECIALLY DUG HOLE IN THE GROUND
- 2. USED POTTY (INDOOR POT OR PAN)
- 3. USED WASHABLE DIAPERS
- 4. USED DISPOSABLE DIAPERS
- 5. WENT ON FLOOR IN HOUSE
- 6. WENT OUTSIDE OF HOUSE ON THE GROUND (BUT NOT IN A DUG HOLE)
- 7. WENT IN HIS / HER CLOTHES
- 8. OTHER (SPECIFY): _____
- 9. DON'T KNOW

9. Does your household have a special place for hand washing?

- 1. YES
- 2. NO → skip to Q. #9
- 9. DON'T KNO W/NO RESPONSE → skip to Q. #9

10. ASK TO SEE THE PLACE USED MOST OFTEN FOR HAND WASHING AND OBSERVE IF THE FOLLOWING ITEMS ARE PRESENT:

- A. SOAP AND WATER
- B.. ASHES (with or without water)
- C. OTHER → Skip to Q. #9

11. When do you wash your hands with soap/ash? (When else?)*[MULTIPLE ANSWERS ALLOWED]*

- A. DON'T KNOW/NO RESPONSE
- B. NEVER
- C. BEFORE FOOD PREPERATION
- D. BEFORE FEEDING CHILDREN
- E. AFTER DEFECATION
- F. AFTER ATTENDING TO A CHILD WHO HAS DEFECATED
- X. OTHER (SPECIFY) _____

12. HOW DO YOU KEEP FOOD AFTER YOU PREPARE IT?

- 1. MENTIONS COVERING IT OR REFRIGERATING IT
- 2. DOES NOT MENTION COVERING IT OR REFRIGERATING IT
- 9. DON'T KNOW/NO RESPONSE

14. I would like to ask you about the food (NAME) ate yesterday during the day and at night, either separately or combined with other foods.ⁱ Did (NAME) eat any of the following foods yesterday during the day or at night? Anything else?

[READ THE LIST OF FOODS. CIRCLE THE LETTER IF CHILD ATE THE FOOD IN QUESTION -- MULTIPLE RESPONSES ALLOWED]

- A. Any pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside?ⁱⁱ
- B. Any dark green leafy vegetables?ⁱⁱⁱ
- C. Any ripe mangos?
- D. Any liver or ucimbo?
- E. NO RESPONSES GIVEN

15. How many times did (NAME) eat solid, semi-solid, or soft foods other than liquids yesterday during the day and at night? (What type of food did he/she eat?)

NOTE!:

- WE WANT TO FIND OUT HOW MANY TIMES THE CHILD ATE ENOUGH TO BE FULL.
- SMALL SNACKS AND SMALL FEEDS SUCH AS ONE OR TWO BITES OF MOTHER'S OR SISTER'S FOOD SHOULD NOT BE COUNTED.
- LIQUIDS DO NOT COUNT FOR THIS QUESTION.
- DO NOT INCLUDE THIN SOUPS OR BROTH, WATERY GRUELS, OR ANY OTHER LIQUID.

[USE PROBING QUESTIONS TO HELP THE RESPONDENT REMEMBER ALL THE TIMES THE CHILD ATE YESTERDAY]

___ ___ Number of times child ate

9. Don't know/No response

16. Do you add oil to the food prepared for (NAME)

1. YES
2. NO
9. DON'T KNOW/NO RESPONSE

17. When (NAME) last had diarrhea, what did you give (NAME) to prevent dehydration? (Anything else?)

- A. DON'T KNOW / NO REPOSE
- B. ORAL REHYDRATION SOLUTION (FROM PACKETS)
- C. ORAL REHYDRATION SOLUTION (HOME MADE)
- D. RECOMMENDED HOME FLUIDS – WATER, JUICE, ETC.
- E. OTHER (SPECIFY:)
-
- F. NOTHING
- G. NEVER HAD DIARRHEA
- H. DON'T KNOW / NO RESPONSE / DOESN'T UNDERSTAND "DEHYDRATION"

18. Has (NAME) had diarrhea in the last 2 weeks? ^{iv}

- 1. YES
- 2. NO
- 9. DON'T KNOW/NO RESPONSE

19. Have you heard of ORS?

- ***IF YES, ASK MOTHER TO DESCRIBE ORS PREPARATION FOR YOU.***
- ***IF NO, CIRCLE RESPONSE 4 (NEVER HEARD OF ORS).***

[ONCE MOTHER/CHIEF CARE PROVIDER HAS PROVIDED A DESCRIPTION, RECORD WHETHER S/HE DESCRIBED ORS PREPARATION CORRECTLY OR INCORRECTLY.]

CIRCLE 1 [CORRECTLY] IF THE MOTHER/CHIEF CARE PROVIDER MENTIONED THE FOLLOWING:

- USE 1 LITER OF CLEAN DRINKING WATER (1 LITER=3 SODA BOTTLES)
- USE THE ENTIRE PACKET
- DISSOLVE THE POWDER FULLY

- 1. DESCRIBED CORRECTLY
- 2. DESCRIBED INCORRECTLY
- 3. HEARD OF ORS BUT MOTHER REFUSES TO DESCRIBE PROCESS
- 4. NEVER HEARD OF ORS

20. Do you have a card where (NAME'S) vaccinations are written down? IF YES, ASK: May I see it please?

- 1. YES, SEEN BY INTERVIEWER
- 2. NOT AVAILABLE/LOST / MISPLACED → skip to Q. #22
- 3. NEVER HAD A CARD → skip to Q. #22
- 9. DON'T KNOW / NO RESPONSE → skip to Q. #22

21. (1) COPY DATE FROM THE CARD

(2) CHECK "NO DATE" BOX IF CARD SHOWS THAT A VACCINATION WAS GIVEN BUT NO DATE IS RECORDED

(3) FOR DEWORMING PLEASE INDICATE IF CHILD IS LESS THAN 12 MONTHS OF AGE

(4) FOR VIT A PLEASE NOTE IF CHILD IS LESS THAN 6 MONTHS OF AGE

VACCINE	DAY/MONTH/YEAR		
Dewormed?	____ / ____ / ____ MONTHS OF AGE	<input type="checkbox"/> NO DATE	<input type="checkbox"/> NO VACCINE <input type="checkbox"/> < 12
VITAMIN A (MOST	____ / ____ / ____ MONTHS OF AGE	<input type="checkbox"/> NO DATE	<input type="checkbox"/> NO VACCINE <input type="checkbox"/> < 6

RECENT)	
---------	--

22. Sometimes children get sick and need to receive care or treatment for illnesses. What are the signs of illness that would indicate your child needs treatment? (Any other signs?)

[MULTIPLE RESPONSES ALLOWED]

- A. DON'T KNOW/NO RESPONSE
- B. LOOKS UNWELL OR NOT PLAYING NORMALLY
- C. NOT EATING OR DRINKING
- D. LETHARGIC OR DIFFICULT TO WAKE
- E. HIGH FEVER
- F. FAST OR DIFFICULT BREATHING
- G. VOMITS EVERYTHING
- H. CONVULSIONS
- J. OTHER (SPECIFY)_____
- K. OTHER (SPECIFY)_____
- L. OTHER (SPECIFY)_____

23. What are the signs of danger after giving birth indicating the need for you to seek health care?

[MULTIPLE ANSWERS ALLOWED]

- A. FEVER
- B. EXCESSIVE BLEEDING
- C. SMELLY VAGINAL DISCHARGE
- D. DON'T KNOW/NO RESPONSE
- X. OTHER (SPECIFY)_____

GROWTH MONITORING AND CHILD ANTHROPOMETRY

24. Was (NAME) have a growth monitoring card? IF YES: May I see it please?

- 1. YES, SEEN
- 2. NOT AVAILABLE / CARD MISPLACED → skip to Q. #26
- 3. NEVER HAD A CARD → skip to Q. #26
- 9. DON'T KNOW/NO RESPONSE → skip to Q. #26

25. LOOK AT (NAME) GROWTH MONITORING CARD AND SEE IF (NAME) HAS BEEN WEIGHED IN THE LASTS FOUR MONTHS

- 1. YES
- 2. NO
- 9. CANNOT DETERMINE FOR SURE

26. During the past two weeks, have you received a visit from you Leader Mother?

- 1. YES
- 2. NO
- 3. RESPONDENT IS THE LEADER MOTHER
- 9. DON'T KNOW/NO RESPONSE

**END OF QUESTIONNAIRE
THANK RESPONDENT FOR HER TIME**

Annex 7: Health Facility Assessment February 2007 Results

Overall Findings, Health Facility Assessment FH/Mozambique, February 2007

Positives:

- Good advice given on medications, diarrhea, nutrition, and fever/malaria.
- In general, very good communication with patients; very courteous and used the right language.
- All children were weighed.
- Checked vaccination data on majority of the children (75%).
- Gave first dose of medicines in the clinic and showed mother how to do it.
- For chief presenting illness, good advice was generally given
- Nurses sometimes checked all danger signs, and usually checked a few of them
- Screened children to look for most severe cases to see first
- Sometimes used open-ended questions on medication dosing
- Sometimes gave ORS in the clinic
- Sometimes took weight into account when calculating dosage.

Opportunities for Improvement:

- Need to assess breathing (listening for stridor, looking for chest indrawing) and respiratory rate on all children with respiratory symptoms. It's easy to miss a case of pneumonia when you do not count respirations.
- Need to assess for all four IMCI illnesses; not just presenting complaint.
- Do assessment of all danger signs on all children.
- In general, assessments should be more thorough. Use the IMCI chart to help.
- Assess home feeding and give every parent advice on home feeding (more liquids/breast milk, continued feeding).
- Use thermometer on every child with a history of fever.
- Need to find ways to give medicine to children without having them choke on it (and possibly aspirate on the medicine).
- Do malaria tests on all children with fever.

Indicator Results from FH/Moz Health Facility Assessment (Feb 07)

	Indicador	Proportion
A	Proportion of children evaluated for the four danger signs (Lethargic/difficult to awake, unable to drink/breastfeed, vomits everything, convulsions)	20%
B	Proportion of asleep/unconscious children who were evaluated for lethargy: (no children were asleep/unconscious)	-
C	Proportion of children evaluated for all four IMCI diseases (cough/difficult breathing, ear problems, diarrhea, fever/malaria)	0%
D	Of children with cough/difficult breathing, the number of classification steps (of 5) done properly	1.1 steps; 22% of process
E	Of children with ear problems, the number of classification steps (of 1) done properly	1 step; 100% of process (n=1)
F	Of children with diarrhea, the number of classification steps (of 5) done properly	1.0 steps (20% of process)
G	Of children with fever, the number of classification steps (of 3) done properly	1.8 steps (60% of process)
H	Proportion of children with fever who received a calmativ	100%
I	Proportion of cases where the health worker mentioned the majority of danger signs to the caregiver that should have been mentioned	30%
M	Proportion of children whose vaccination card was checked for completeness	75%
S	Proportion of children who were underweight who were correctly evaluated (checking on breastfeeding, other foods given, and feeding during illness) by the health worker	0%
T	Proportion of caregivers of children 0-23m who were asked about feeding/breastfeeding	20%
U	Of children who were given an antibiotic, proportion who received appropriate instructions on dosing	75%
V	Of children who were given an antimalarial, proportion who received appropriate instructions on dosing	100%
W	Proportion of children who needed referral to a higher level of care who were referred appropriately: (<i>No children needed referral.</i>)	-
GG	Proportion of mothers who were told to give more liquids and to continue breastfeeding their sick child	38%
HH	Proportion of children with cough / rapid breathing / difficult breathing whose respiratory rate (breaths/minute) was evaluated	0%

Annex 8: One example of the April 2007 District Health Facility Assessment.**MARROMEU****CS-Indicator Results from FH/Moz Health Facility Assessment
(APRIL 2007)**

	Indicador	Proportion	Processes that need improvement
A	Proportion of children evaluated for the four danger signs (Lethargic/difficult to awake, unable to drink/breastfeed, vomits everything, convulsions) <i>(No. of chdn evaluated for 4 danger signs/Total chdn evaluated)</i>	0/10 0%	All children to be evaluated and checked on the 4 danger signs.
B	Proportion of asleep/unconscious children who were evaluated for lethargy: <i>(no children who were asleep or unconscious/Total chdn observed)</i>	9/10 90%	Excellent
C	Proportion of children evaluated for all four IMCI diseases (cough/difficult breathing, ear problems, diarrhea, fever/malaria) <i>(No. of chdn. evaluated for all 4 IMCI diseases/Total chdn evaluated)</i>	0/10 0%	IMCI diagnosis is a clear way to evaluate a child's health.
D	Of children with cough/difficult breathing, the number of classification steps (of 5) done properly <i>(No of classifications completed properly/Total chdn observed)</i>	7/60 steps; 12% of process	Must improve in evaluation of respiratory problems in children
E	Of children with ear problems, the number of classification steps (of 1) done properly <i>((No of classifications completed properly/Total chdn observed)</i>	2/30 step; 7% of process (n=)	A very weak evaluation.
F	Of children with diarrhea, the number of classification steps (of 5) done properly <i>((No of classifications completed properly/Total chdn observed)</i>	15/70 steps (21% of process)	Pay attention on diarrhea episodes in children.
G	Of children with fever, the number of classification steps (of 3) done properly <i>((No of classifications completed properly/Total chdn observed)</i>	13/50 st eps (26% of process)	Encourage the use of thermometers
H	Proportion of children with fever who received a calmative <i>(No. of chdn with fever/ Total chdn observed)</i>	4/10 40%	Not all those who had fever received medicines and thermometers were not used.
I	Proportion of cases where the health worker mentioned the majority of danger signs to the caregiver that should have been mentioned <i>(No of cases mentioned/Total cases)</i>	0/10 0%	Must encourage the use of thermometers
M	Proportion of children whose vaccination card was checked for completeness <i>(No. of vaccination cards checked/Total chdn with vaccination cards)</i>	1/10 10%	Must always check with the card for the child when brought to the clinic.

			Processes that need improvement
S	Proportion of children who were underweight who were correctly evaluated (checking on breastfeeding, other foods given, and feeding during illness) by the health worker (<i>No. of children evaluated/Total chdn attended to by the technician</i>)	0/10 0%	A good chance to monitor nutritional status of children.
T	Proportion of caregivers of children 0-23m who were asked about feeding/breastfeeding (<i>No of caregivers asked/Total caregivers observed</i>)	1/10 10%	Important to know feeding customs and practices of mothers.
U	Of children who were given an antibiotic, proportion who received appropriate instructions on dosing (<i>No of chdn given appropriate instruction on dosing/children attended to</i>)	7/10 70%	Better understanding of the mother when she comes from the exit point, therefore good checks should be made.
V	Of children who were given an antimalarial, proportion who received appropriate instructions on dosing (<i>(No of chdn given antimalarial with appropriate instructions/No of chdn observed)</i>)	7/10 70%	The same as above
W	Proportion of children who needed referral to a higher level of care who were referred appropriately: (<i>No children needed referral.</i>)	0/10 0%	Not many transfers were effected from the HF
GG	Proportion of mothers who were told to give more liquids and to continue breastfeeding their sick child (<i>No of mothers communicated on liquids in times of diarrhea/ Total mothers observed</i>)	0/10 0%	Teach mothers that children lose liquids and must be given more to replace lost liquids
HH	Proportion of children with cough / rapid breathing / difficult breathing whose respiratory rate (breaths/minute) was evaluated (<i>No of chdn evaluated on respiratory rates/ Total chdn observed</i>)	0/10 0%	Technicians should remember that cold can be pneumonia in children therefore a close check should be done

Annex 9: Consolidated Mortality Data by Cause October 2006 to September 2007**VA by DISTRICT, DISEASE, AGE & SEX- October 2006 to September 2007**

District	Disease	Age			Age			Total	% Cause of Death
		Male			Female				
		<1month	1-11months	12-23months	<1month	1-11months	12-23months	Deaths	Death
ALL Districts	Diarrhea	0	3	0	0	5	2	10	24%
	Malaria	0	4	3	0	4	0	11	26%
	Malnutrition	0	1	0	2	0	0	3	7%
	Fever	1	3	0	1	3	1	9	21%
	Pneumonia	2	1	0	0	2	0	5	12%
	Convulsions	0	0	1	0	2	0	3	7%
	Asfixia	0	0	0	1	0	0	1	2%
	Stil-birth	0	0	0	0	0	0	0	0%
	Other	0	0	0	0	0	0	0	0%
	Total	3	12	4	4	16	3	42	100%

District	Disease	Age			Age			Total	% Cause of Death
		Male			Female				
		<1month	1-11months	12-23months	<1month	1-11months	12-23months	Deaths	Death
Manga	Diarrhea						1	1	8%
	Malaria			1				1	8%
	Malnutrition		1					1	8%
	Fever	1	1			1	1	4	31%
	Pneumonia	1				2		3	23%
	Convulsions			1		1		2	15%
	Asfixia				1			1	8%
	Stil-birth								
	Other								
	Total	2	2	2	1	4	2	13	100%

District	Disease	Age			Age			Total	% Cause of Death
		Male			Female				
		<1month	1-11months	12-23months	<1month	1-11months	12-23months	Deaths	Death
Chemba	Diarrhea		1			1	2	33%	
	Malaria		1				1	17%	
	Malnutrition				2		2	33%	
	Fever								
	Pneumonia	1					1	17%	
	Convulsions								
	Asfixia								
	Stil-birth								
	Other								
	Total	1	2	0	2	1	0	6	100%

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- ⁱ A separate category for any foods made with red palm oil, palm nut, or palm nut pulp sauce must be added if these items are fed to young children. A separate category for any grubs, snails, insects or other small protein foods must be added if these items are fed to children. Items in each food group should be modified to include only those foods that are locally available and/or consumed in country.
- ⁱⁱ Items in this category should be modified to include only vitamin A-rich tubers or vitamin A-rich red, orange, or yellow vegetables that are consumed in the country
- ⁱⁱⁱ These include cassava leaves, bean leaves, kale, spinach, pepper leaves, taro leaves, amaranth leaves, or other dark green leafy vegetables
- ^{iv} The term(s) used for diarrhea should encompass the expressions used for all forms of diarrhea, including bloody stools (consistent with dysentery), watery stools, etc.