

WORLD RELIEF



World Relief Mozambique Expanded Impact Child Survival Program FOURTH ANNUAL REPORT



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Massangena, and Massingir districts,
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Table of Contents

Acronyms	ii
A. Main Accomplishments.....	1
<i>Strategy for contributing to scale</i>	3
<i>Progress in advancing this strategy toward objectives for scale-up</i>	3
B. Activity Status	4
C. Factors that have impeded progress	6
D. Technical Assistance	7
E. Substantial Changes to Cooperative Agreement	7
F. Sustainability Plan	7
<i>Constraints</i>	8
<i>Plans for Project Phase Out</i>	8
G. Response to MTE Recommendations	9
I. Management System.....	10
J. Local Partner Organization Collaboration and Capacity Building.....	10
K. Mission Collaboration	10
Annex 1: M&E Table.....	1
Annex 2: Work Plan.....	3
Annex 3: Budget.....	4
Annex 4: Publications and Presentations	5
Annex 5: Results Highlight.....	6
Annex 6: Monitoring and Evaluation Plan.....	7
Annex 7: CSHGP Project Data	9

Acronyms

APES	Agentes Polyvalente Elementar (Community Health Worker)
CG	Care Group
CHIS	Community Health Information System
C-IMCI	Community Integrated Management of Childhood Illness
CSP	Child Survival Project
CTO	Cognizant Technical Officer
DIP	Detailed Implementation Plan
EBF	Exclusive Breastfeeding
EPI	Expanded Program for Immunization
HC	Health Center
HF	Health Facility
HP	Health Post
HQ	Headquarters
ITN	Insecticide Treated Net
M&E	Monitoring and Evaluation
MN	Malnourished
MOH	Ministry of Health
ORT	Oral Rehydration Therapy
PVO	Private Voluntary Organization
SEED-SCALE	Self-Evaluation for Effective Decision Making and Systems for Communities to Adapt Learning and Expand
STI	Sexually Transmitted Infection
TT	Tetanus Toxoid
VHC	Village Health Committee
WR	World Relief

A. Main Accomplishments

The Vurhonga Expanded Impact CSP, now in its fourth year, continues with an impressive list of accomplishments and activities this year in accordance with last year's midterm evaluation recommendations.

1) Technical Interventions: Vurhonga is on track in accordance with the Work Plan to complete the 2nd round of technical interventions by the end of 2008. The volunteers have received training in all six technical areas, diarrhea, malaria, nutrition, HIV/AIDS, immunizations, and pneumonia and refresher trainings have been completed in all technical areas with the exception of HIV/AIDS. The HIV/AIDS refresher training is the last refresher training to take place and will be implemented by December of this year. Factors that contribute to the success of the technical interventions include highly experienced staff, utilization of a BCC saturation strategy, and strong program monitoring and evaluation. Volunteers, pastors, traditional healers, and village health committees have all received training in the same health messages to ensure individuals receive the same messages repeatedly from different sources in the community in order to ensure message uptake and encourage behavior change.

Data are collected, reviewed, and discussed with program staff on a monthly basis and used to inform program implementation. For example, there was a marked decrease in household net usage in May likely due to the end of the rainy season and the arrival of winter where the perceived threat for contraction of malaria is lowered. After staff communicated the importance of continuing net usage, data showed the usage rate return to previous levels the following month. A LRA was conducted in July of this year. (See Annex 1: M & E Table for results status). Recognition of danger signs, ITNs, and delivery by a trained health provider are three areas that are at or below indicator targets. These topics will be the foci of refresher lessons after the 2nd round of technical interventions are complete.

After the completion of the MTE last year, more emphasis was put on household visits as part of the day to day monitoring and supervision of the project. Each supervisor was given a target of 4 house visits per day. Information compiled from these visits helps identify areas needing more attention. (See Annex 6 for compilation of this data and accompanying M & E plan).

2) Animator Refresher Training: Vurhonga program animators are directly responsible for training and overseeing the Care Groups and Care Group volunteers. The animators in this EIP come from more remote areas of Mozambique and have less education than the animators in earlier child survival programs. In order to ensure fidelity of the program and its volunteers, animators received a fairly rigorous refresher training which included a pre-test in order to identify weak areas needing improvement. Supervisors and coordinators, many of whom were animators in previous CSPs, provided the refresher training to the animators. Coordinators and supervisors taught together in small groups by health topic and the animators rotated from group to group. This enabled the trainers to concentrate on a given topic area and to ensure that all the key messages were delivered to the animators fully and completely. District MOH personnel and village leaders were also present during the training which further emphasized the importance and value of the program by district and village leadership.

3) Village Leaders Training: Influential leaders play a prominent role in a community or village. Without their buy-in, support, and encouragement, mothers, volunteers, VHCs, and socorristas are less likely to be motivated to sustain positive changes in health behavior. Therefore, in order to sustain the positive gains made through the midterm evaluation and to accelerate changes that

still need to occur, a village leaders training was organized as part of the BCC strategy to increase saturation of the same health messages coming from multiple sources. In order to improve their skills as leaders in the community and to obtain buy-in by the village leaders themselves, the training included other areas in addition to the health lessons. The main topics included all health lessons (same as taught to volunteers), sustainability of the health project, community development, vision, and leadership. Each district organized their own training in coordination with the district administrator and gathered all the invited leaders in the district capital. Two active and influential leaders were chosen from each village to attend. The district administrators and district health directors were also invited and all of them attended. Some of the administrators stayed for the full duration of the 3-day seminar. The presence of the administrators and their support of the project were crucial to the success of the seminar. They provided the village leaders with a sense of duty to facilitate development in all aspects of community life, including familiarizing themselves with the content of the health lessons, and encouraging them to attend the health trainings given by the volunteers. None of the village leaders invited had any previous training on leadership and their reaction to receiving such training was overwhelmingly positive. They felt grateful to be recognized to receive such a training and a sense of responsibility to carry out what they had learned, due in part to the presence of the district administrators.

4) Operations Research on Financing Mechanisms and Impact of User Fees on Health Service Utilization and Equity: The formal public health system in Mozambique does not charge a fee for service or fee for medication to pregnant mothers or mothers of children under five. Through the Vurhonga EIP, socorristas are identified and placed in communities with more than 100 families that are at least 7 km from the nearest health center. The village raises funds to build and establish a community health post. Socorristas are quasi-private health providers that receive a fee for service established by the Village Health Committee. The objective of this operations research was to formally examine the impact of these user fees in terms of service utilization, equity and affordability. *Community health insurance schemes* have been shown to influence treatment seeking behavior, where exemptions have been shown to enhance early care seeking and compliance. The OR examined the existence and operation of community health insurance schemes or lack thereof and documents the willingness to pay and fees charged at the HP, HC and hospital for sick child visits, which includes consultation and drugs. Mechanisms for determining eligibility for exemptions to the poor were also documented and studied to ensure equitable access to services. Key Informant Interviews were conducted with 110 caregivers of children <5, socorristas, and nurses and focus groups were conducted with Village Health Committees in Chibuto district.

5) Operations Research on Effectiveness of Referral Systems: This study attempts to track referrals made at the community or primary level of care to the secondary and tertiary health facilities to determine 1) the efficacy of the referral system and 2) rates of compliance with referrals. A health record review was conducted at all first, secondary and tertiary level health facilities in Chibuto district. Key informant interviews were conducted at secondary and tertiary level health facilities with 110 caregivers of children <5. Key informant interviews were also conducted with socorristas and nurses.

Data entry into Epi Info as well as hand tabulation has been completed but data from both OR studies are still being analyzed. Dissemination of the results is planned for both the MOH and

USAID by December of 2008. Plans for wider dissemination including preparation of the results for publication will follow shortly thereafter.

Strategy for contributing to scale

The expanded impact program has expanded geographically into five new districts of Gaza with three new objectives for scaling up. They include the following objectives:

- 1) Strengthen the capacity of the health system to improve quality and coverage of C-IMCI services through training, drug management, supervision and by establishing effective health information systems.
- 2) Develop sustainable community based mechanisms to improve prevention and care seeking practices for C-IMCI and
- 3) Establish a SCALE-Squared learning center for C-IMCI training to facilitate scaling up to provincial and national implementation. The SCALE-Squared center is part of the SEED-SCALE (Self-Evaluation for Effective Decision Making and Systems for Communities to Adapt Learning and Expand) strategy developed by Dr. Carl Taylor for scaling-up community health and development projects. This methodology and its application in the Vurhonga CSP are described in detail in the DIP.

Progress in advancing this strategy toward objectives for scale-up

The CSP has contributed significantly to strengthening the capacity of the health system in expanding health services to communities that previously did not have access. Of the 71 health posts in the five districts, the Vurhonga EIP is responsible for mobilizing the community to build 55 of these health posts and staff these with trained socorristas. To date, 139 village health committees have been formed and community health information systems created whereby health information is collected on a regular basis by the volunteers and given to the Village Health Committee who meet monthly. In order to improve linkages between the CHIS and HIS, including coordination with district health personnel, a workshop was held at the SCALE-Squared Training Center. The workshop included personnel from the current five districts plus those three districts reached previously by Vurhonga 1 and Vurhonga 2, all in Gaza province. The objective of the workshop was to discuss previous and current program structure and results, as well as future directions and preparations once the EIP ends. This provided an opportunity for districts where coordination is weaker to see how utilization of the existing Care Group structure and volunteers helps the district carry out its mandated activities and community disease surveillance. It became clear at this meeting, the role that high staff turnover plays in maintaining optimal coordination with the district health system. The meeting provided an opportunity to strengthen the understanding of the community structure put in place by Vurhonga, including new district personnel in previous CS districts such as Mabalane and Guija.

In addition to the creation and establishment of village health committees, socorristas, and community health posts, the establishment of Care Groups is key to the second objective to “develop sustainable community based mechanisms.” Care Groups are based on a ratio of 1 volunteer per 10 households whereby volunteers are selected by village leaders according to criteria established by the project. This selection process helps to ensure that the health volunteer is a respected member of the community, and therefore, more likely to be influential in whatever information she passes on. The other key to ensuring success is to gain buy in from influential members of the community. Vurhonga has trained village leaders, traditional healers, and religious leaders on the same health topics as the volunteers. This also ensures that

community members hear the same health messages from more than one source, making it more likely that the new behavior is adopted.

Finally, the strategy for expanded impact is institutionalized through the establishment of a SCALE-Squared learning center. The SCALE-Squared learning center has been constructed and is in use to facilitate different trainings and workshops in the area. The learning center has been used to host an international training on Care Groups and has been used by as well as to host the district and provincial MOH and NGOs. Most recently, the training center has been used to host key meetings around national scale up of the Vurhonga community based health model, first with the local USAID mission, and secondly, with a group of individuals from MOH, USAID, CDC, and WHO. The MOH has asked USAID for assistance with Agentes Polyvalente Elementar (APEs). An APE is a basic entry level health worker trained, paid, and employed by the government health system. USAID is working with World Relief, World Vision in Zambezia province, and Food for the Hungry in Sofala province (the latter is also using our Care Group model with great success) to assist the MOH in developing a community based health model, including guidelines for APEs.

B. Activity Status

<i>Project Objectives</i>	<i>Key Activities</i>	<i>Status of Activities</i>	<i>Comments</i>
IMCI 75% of caretakers know at least 2 danger signs ¹ for seeking care immediately.	-Train volunteers and caretakers to recognize danger signs and appropriate care seeking	Completed; progress toward target on track.	2008 LRA 65%. Will be refresher focus lesson in 2009.
60% of sick children offered increased fluids	-Train volunteers and caretakers to increase fluid intake for the sick child	Completed	2008 LRA 75%
60% of sick children offered continued feeding	-Train volunteers and caretakers to continue feeding the sick child	Completed	2008 LRA 72%
CDD 50% of caretakers wash hands before food preparation, before child feeding, after defecation	-Train caretakers to wash hands before food preparation, before feeding a child and after defecation -Encourage caretakers to use latrines -Encourage caretakers to set up dish racks	Completed Completed and ongoing Completed and ongoing	2008 LRA 89%. This indicator seems to be unrealistically high and is being investigated/ re-evaluated. Caretakers are encouraged to use ash in place of soap.
70% children with diarrhea treated with ORT.	-Train caretakers to prepare and feed ORS to the child during diarrhea -Encourage HAF if ORS is not available -Ensure availability and accessibility of ORS for the caretakers -Encourage increased fluids for 2 weeks post diarrhea	Completed Completed and ongoing Completed and ongoing Completed and ongoing	2008 LRA 89%
PCM	-Train volunteers and caretakers to recognize cough	Completed	2008 LRA 100%

¹ Child not able to drink or breastfeed, child becomes sicker despite home care, fever, fast or difficult breathing, blood in stools, drinking poorly.

Project Objectives	Key Activities	Status of Activities	Comments
50% of children treated <24h for rapid, difficult breathing (suspected <i>pneumonia</i>) at HF	and fast/difficult breathing as signs of pneumonia -Train volunteers and caretakers to seek treatment in a HF within 24h for cough and fast/difficult breathing.	Completed	
Control of Malaria 75% of children treated for fever (suspected <i>malaria</i>) within 24h at a HF	-Train volunteers in recognizing signs for fever/malaria and importance of immediate treatment (within 24h)	Completed	2008 LRA 90%
70% drug compliance with chloroquine for children treated for malaria.	-Train volunteers and caretakers on the importance of full compliance to malaria treatment	Completed	2008 LRA 95%
50% of children sleep under ITN (measured if ITN is marketed)	-Train volunteers and caretakers on ITN use	Completed	2008 LRA 51%. Will be refresher focus lesson in 2009.
Immunization 80% children 12-23m fully immunized.	-Train caretakers to seek immunization for their children on schedule -Mobilize community for immunization campaigns and facilitate MOH staff -Track Vitamin A coverage	Completed, activity is ongoing Completed, activity is ongoing Completed and ongoing	2008 LRA 88%
60% of women of fertile age receiving TT	-Train caretakers on importance of immunization and mobilize community	Completed	2008 LRA 65%
EBF 40% of children EBF for 0-6m	-Train volunteers to counsel and support caretakers in EBF	Completed	2008 LRA 65%
70% of children 6-8m who received complementary feeding	-Train volunteers and caretakers on importance of appropriate and adequate complimentary feeding	Completed	2008 LRA 98%
Nutrition 80% children weighed regularly in GMC.	-Train volunteers to assist MOH staff for monthly EPI/GMC session and community mobilization -Train volunteers to counsel caretakers during home visits and GMC sessions on prevention of MN and rehab of MN children -Train caretakers on importance and preparation of enriched porridge	Completed training, activity is ongoing. Completed Completed	2008 LRA 86%
80% of caretakers of MN children who receive nutrition counseling.	-Train volunteers to counsel caretakers during home visits and GMC sessions on prevention of MN and rehab of MN children	Completed	2008 LRA 95%
70% of MN children who received nutritious weaning foods/enriched porridge after nutrition counseling.	-Train caretakers on importance and preparation of enriched porridge	Completed	2008 LRA 100%
70% of children who complete HEARTH achieve and sustain adequate (200g) or catch-up (400g) growth per month for at	-Train volunteers in HEARTH methodology -Conduct 2 HEARTH cycles in the 1 st 2 years, repeat in 3 rd and 4 th year as required	Completed Completed	No need to repeat as exceeded target after first cycle.

<i>Project Objectives</i>	<i>Key Activities</i>	<i>Status of Activities</i>	<i>Comments</i>
least 2m after HEARTH.	-Monitor coverage in bimonthly GMC sessions -Maintain HEARTH registers	Completed Ongoing	Done as part of the regular detection and surveillance by the volunteers during household visits.
STD/HIV/AIDS 50% of caretakers will know 2 ways to prevent STD/HIV/AIDS 50% of caretakers will know 2 symptoms of STD/HIV/AIDS 50% of caretakers will know 2 symptoms of HIV/AIDS	-Train volunteers and caretakers on causes and prevention of HIV/AIDS -Promote demand and utilization of VCT services	Completed first training; Refresher training to be completed by Dec. 2008. Ongoing	2008 LRA: exceeded all targets.
ANC 70% of mothers will deliver by a trained health provider	-Train volunteers and caretakers on importance of ANC and encourage delivery by trained health provider	Completed and ongoing	2008 LRA 73%

C. Factors that have impeded progress toward goals and actions being taken by project to overcome constraints

The CS project has been under financial pressure since the start of the project, due to the devaluation of the dollar against the metical by approximately 30% for about the first 9 months after which it recovered to normal. This forced us to remove certain items from the budget, adjust salaried field staff to phase out most staff even earlier than originally planned and not to increase any salaries for the first 3 years of the project. This had a negative impact on staff morale until upward adjustments were made to salaries after 3 years. To aggravate matters, the sharp rise in fuel costs over the last 18 months with the consequent rise in food and other commodities that depend on transport for its distribution further increased pressure on the project to re-adjust budgeted activities with possible negative effects on future results and impact. This affected mostly supervision and training activities, which form the core of our project. Some of the adjustments included using public transport wherever possible, rations on fuel to staff using motorbikes and vehicles, and decreasing volunteer incentives due to increased costs.

Climactic extremes of southern Mozambique have proven to be challenges to the past CSPs. Drought has afflicted the region in the current EIP for a third consecutive year. This has severe impact on both the health and income of the majority of people living in rural areas, whose subsistence relies solely on agriculture. The drought across the region continues to deter behavior change in hand-washing practices. Volunteers have found that lack of water or money to buy soap were reasons given for not washing hands after defecation or before food preparation. WR is not equipped to address the water supply infrastructure, so volunteers responded by reinforcing the hand-washing messages with households and emphasizing ash as an alternative to soap.

Net distribution and usage continues to be a challenge. World Relief was unsuccessful in its bid for the TASC 3 PMI project. The winner of the bid, Chemonics, was contacted to determine the

possibility of net distribution for children < 5 by our program staff. However, the focus of the Chemonics project is to increase capacity of health personnel in the areas of prevention, case management, BCC/IEC, monitoring and evaluation of the National Malaria Campaign Program, and leadership and management support to the DPS. It is not involved in any way with LLIN distribution. PSI was also contacted and informed us that because Gaza is designated a spray province by the MOH, net distribution for Gaza is not a priority. The number of nets available has always been and continues to be a problem. Currently nets are being distributed for < 5 distribution in Nampula province in conjunction with a measles campaign and nets are on order for Zambezia province. A proposal was submitted to the Global Fund for Round 8 and if Mozambique is successful, there should be enough nets for the whole country; however, this is unlikely to happen before the end of the EIP. Program staff can only encourage households to purchase nets in order to increase the number of nets found and used in households. In addition, PSI is helping to raise the issue during regular Malaria Prevention and Control Consortium meetings.

D. Technical Assistance

The project has benefited from the hiring of an in-country Technical Advisor, Stacy Grau, who functions as an extension of the World Relief HQ technical unit in Baltimore and as a member of the field staff. She has taken the lead in carrying out both operations research projects and enhancing networking at the national level. Stacy participated in the Technical Development Meeting hosted by USAID and CSTS in June 2008 in Washington, DC along with other members of the World Relief MCH team. She is in regular communication with Melanie Morrow, Director of MCH Programs, concerning project progress. The project does not anticipate needing technical assistance outside of World Relief in the coming year, with the exception of a Team Leader to facilitate the project's final evaluation in FY09.

E. Substantial Changes to Cooperative Agreement

World Relief would like to request a modification to its budget, to reflect a decrease in NICRA of over 4% since the DIP Budget was approved. For more information on this request, please refer to Annex 3. Budget. There are no other changes to the project requiring substantial changes to the Cooperative Agreement.

F. Sustainability Plan

The sustainability objectives for this project are as follows: 1) 80% of volunteers continue in CGs; 2) 60% of VHCs have met in the last 2 months; and 3) 60% of trained socorristas continue providing services.

The true test of sustainability objectives comes post-project. However, almost 100% of both volunteers and socorristas have continued performing their duties satisfactorily since project inception and 66% of Village Health Committees have had a meeting each month (data from the first 9 months of this program year).

The Care Group model is central to Vurhonga's sustainability plan, as discussed at length in the DIP. Experience with the CG model in previous CSPs has shown that knowledge is retained, behaviors are sustained and linkages have been maintained after CSP funding has ended.

Sustainability in taking a program to scale requires integration of services, supervision and management of resources, monitoring and evaluation, and identification of effective leaders. The EIP is tracking critical dimensions of the sustainability framework: (1) population health status; (2) organizational capacity; and (3) community capacity. Population health status is part

of routine data collection by the volunteers. The volunteers collect information on births, deaths, pregnancies, and other key health data and provide this to the Village Health Committee and the socorrista. The socorrista in turn provides the community health data to the DDS. The role of socorristas in obtaining data from CG and transmitting to the MOH ensures sustainability of the health information system after the project is terminated.

Staff performance and development has been a key element in the success of the previous CSP. After the completion of the MTE last year, much more emphasis was put on supervision of the Care Group trainings and household visits as part of the day to day monitoring and supervision of the project. Each supervisor was given a target of four house visits per day. Information compiled from these visits helps to identify areas needing more attention.

Community capacity is viewed by the program staff as the most critical dimension of the sustainability framework, and is the core foundation of Vurhonga's success. Establishing and mentoring Care Groups, CHWs, and Village Health Committees are key Vurhonga program elements. This year, community capacity has been strengthened with the village leaders training.

Constraints

Socorrista refresher trainings have been delayed due to a number of reasons. During the last few months, the MOH has added cotrimoxazole for treatment of pneumonia to Kit C, the medicine kit the socorristas use. While such changes are often necessary and positive as it allows CHWs to treat more conditions locally rather than having to refer patients to a health center which is often too far or difficult for community members to reach, such changes result in short term negative impacts. During the time it takes for the MOH to change the contents of the kits, kits have not been available at the district level for the socorristas to restock. This has caused some health posts to be out of stock of essential meds, some for as long as 4 months, virtually shutting down the work and operations of some of the health posts/socorristas. The Provincial Director has also requested that socorristas be trained on the use of rapid diagnostic tests for malaria in order to utilize a surplus stock of these tests before they expire. WR, Pathfinder, and Chemonics TASC-3 have been working together as partners involved in helping to prepare the socorrista refresher training. Unfortunately the Provincial Director still awaits central Ministry of Health approval before the training can be implemented. In the meantime, the new kits have to be opened and the cotrimoxazole removed until the socorristas receive training. The lack of a clear national policy on the use of RDTs by CHWs has contributed to the inability for provincial authority and decentralized decision making. The TASC-3 PMI project is working with the central MOH on finalization of national policies on malaria.

The DIP identified frequent MOH staff turnover as a challenge to sustainability. WR has been in discussion with the Central MOH, MOH Provincial Director, District Directors, USAID, CDC, and WHO around the need to appoint one community health officer per district to supervise socorristas, interact with volunteers, and work closely with VHCs. Vurhonga has demonstrated that community health workers do not need to be paid a salary by the MOH and communities can be mobilized to pay for and build their own health posts. This money could be used instead to provide district supervision as well as better linkages and coordination with community health activities.

Plans for Project Phase Out

It was anticipated that government roll-out of APEs was to occur in early 2008. Vurhonga was fully anticipating this and prepared to ensure that the socorristas in the WR project area were

included in training and supervision in order to become incorporated into the national APE model. However, given close discussions with the MOH and the local USAID mission, it seems unlikely that the national roll-out will occur before the end of the project. On the positive side, the government has asked the local USAID mission for help with funding of APEs and health posts. The USAID mission is extremely interested in the World Relief community health model and is working with us and two other PVOs to determine the best approach for the national government-led community health model.

G. Response to MTE Recommendations

<i>Recommendations</i>	<i>Timeframe</i>	<i>Status</i>
<p>1. Intensify efforts to hire a Deputy Director with the following key responsibilities:</p> <ul style="list-style-type: none"> a) Oversee Scale-Squared learning center b) Conduct needed operations research c) Represent the project at natl. level d) Liase with MOH for eventual reorientation of Socorristas as APE's under MOH's new community health scheme. 	<p>1. To be hired by 15 November'07</p> <ul style="list-style-type: none"> a) Ongoing b) Before September 2008 c) Ongoing d) Ongoing during MOH Provincial and National meetings. 	<p>Hired by 15 November 2007</p> <ul style="list-style-type: none"> a) Ongoing b) Both OR Topics Conducted. Analysis and Report in Progress. c) Ongoing d) Site visit by central MOH with USAID, CDC, and WHO in August.
<p>2. Streamline demands on project staff and resources to assure success of scale up in 5 districts in Gaza, specifically:</p> <ul style="list-style-type: none"> a) Prioritize 2 OR topics: <ul style="list-style-type: none"> • Financing mechanisms and impact of user fees on health service utilization and equity. • Effectiveness of referral systems (Note: this OR cannot take place until socorristas have been retrained in collaboration with MOH.) b) Refine sampling strategy used in monitoring surveys for greater consistency with KPC; reduce frequency of surveys to twice per year. c) Prioritize capacity building related to MOH for training and supervision of <i>socorristas</i>. 	<ul style="list-style-type: none"> a) OR to complete by September 2008; Original timeline delayed due to MOH policy changes affecting <i>socorrista</i> function. b) November 30, 2007 c) Ongoing 	<ul style="list-style-type: none"> a) Both OR Topics Conducted. Analysis and Report in Progress. b) Changes instituted since MTE. c) MOH has made APEs a top priority.
<p>3. Invite MOH District health directors and district community health managers to Scale-Squared learning center to disseminate and discuss MTE findings on progress in scaling up C-IMCI in Gaza Province.</p>	<p>February 2008</p>	<p>Completed.</p>
<p>4. Take a more pro-active approach to increase supply of ITNs in the project area.</p>	<p>July 2007 and ongoing</p>	<p>Ongoing (See Section C for more detail).</p>
<p>5. Conduct mid-term KPC survey to measure progress toward program objectives.</p>	<p>September 2007</p>	<p>Completed in September 2007.</p>
<p>6. Clarify program objective statements and indicator definitions in light of baseline measures, new international norms and health systems context.</p>	<p>November 30, 2007</p>	<p>Instituted with mid-term KPC completed in September 2007.</p>

7. Implement policies and put systems in place that will provide the project director timely, accurate, financial reports that enable him to better monitor expenses against the CS budget.	November 30, 2007	Began in November 2007 and is ongoing. This has improved significantly although cash flow became an issue in the last quarter.
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I. Management System

- 1) *Financial management system:* Financial management of the CSP has improved significantly. Cash flow became an issue in the last quarter of the fiscal year. Both the Project Director and Technical Advisor met with the Finance Director in the Maputo office to resolve the cash flow issue. Problem areas were identified and it is hoped that the revised amounts and schedule for reimbursement will help to improve the situation.
- 2) *Human resources:* Human resources in Vurhonga remain one of the strongest aspects of the CSP. The Project Director, who has lived in Chokwe since Vurhonga I, has been able to keep the program moving forward on schedule. There has been virtually no turnover, with the exception of the Deputy Director role. In September, a candidate was identified and began work in November. Since that time, the project has remained fully staffed. Note that the title of Deputy Director was changed to that of Technical Advisor to better reflect the capacity building relationship of the expatriate hired to fill the gap.
- 3) *PVO coordination/collaboration:* Relationships have been established with new USAID implementing partners. World Relief has been working in close coordination with Pathfinder (who has taken over for Project Hope/Save the Children in Gaza) and the recently awarded TASC-3 PMI project. There is a renewed effort for collaboration both with the MOH and between NGO/PVO partners in Gaza. Several Provincial MOH as well as NGO/PVO partners meetings have been held in Xai Xai within the last few months for which World Relief has been an active participant. Responsibility for partners meetings at district level has been designated, with World Relief responsible for partner coordination in Chibuto.

J. Local Partner Organization Collaboration and Capacity Building

The EIP is working closely with Africa Works, a local NGO, in rural enterprise development. Africa Works is providing small micro-credit loans to local farmers associations which include Vurhonga volunteers. Funds have been used for irrigation where each volunteer receives a plot to grow and produce crops. Before, volunteers had to work very hard over a large area with little result if there was no rain. The volunteers are excited at how much they can produce in a much smaller area with less time in the field. This has also helped free up more of their time to devote to giving health lessons to their households. Both the local USAID mission and World Relief see this pilot activity as promising, and opportunities are being worked on together with Africa Works to try and expand complimentary activities involving income generation with health.

K. Mission Collaboration

The addition of the Technical Advisor has added value in bringing the EIP to a national level of networking. She interacts regularly with several individuals on the SO8 Health Team at the USAID Mission, including the CTO, the Health Activities Manager, and consultant on various aspects, from MOH coordination to technical issues. The EIP has received site visits from USAID twice in the past two months to help the MOH in developing a community based health model. The second visit included representation from the central MOH, WHO, and CDC at the invitation of the local USAID mission.

Annex 1: M&E Table

Objectives	Baseline	LRA 2006	Mid Term KPC	LRA 2008	EOP Target
Integrated Management of Childhood Illness					
Caretakers know at least 2 danger signs for seeking care immediately	24%	54%	70%	65%	75%
Sick children offered increased fluids and continued feeding	3%	30%	27%		60%
Sick children offered increased fluids			38%	75%	
Sick children offered continued feeding			48%	72%	
Control of Diarrheal Disease					
Caretakers wash hands before food preparation, before child feeding, after defecation	3%	79%	16%	89%	50%
Children with diarrhea treated with ORT	54%	82%	82%	89%	70%
Pneumonia Case Management					
Children treated within 24 hours for rapid, difficult breathing (suspected pneumonia) at HF	10%	100%	50%	100%	50%
Control of Malaria					
Children treated for fever (suspected malaria) within 24 hours at HF	34%	82%	59%	90%	75%
Drug compliance with chloroquine for children treated with malaria	61%	90%	82%	95%	70%
Children sleep under ITN (measured if ITN is marketed)	14%	40%	17%	51%	50%
Immunization					
Children 12-23 months fully immunized before 1 st birthday	77%	89%	62%	88%	80%
Women of reproductive age receiving TT	34%	56%		65%	60%
Nutrition					
5-a) Percentage of children EBF for 0-6m	17%		62%	65%	40%
5-b) Percentage of children 6-8m who received complementary feeding	51%		81%	98%	70%
5-c) Percentage of children weighed regularly in Growth Monitoring Counseling (GMC)	77%		85%	86%	80%
5-d) Percentage of caretakers of Malnourished (MN) children who receive nutrition counseling	14%		81%	95%	80%
5-e) Percentage of MN children who receive nutritious weaning foods/enriched porridge after nutrition counseling	43%		84%	100%	70%

HIV/AIDS Prevention					
6-a) Percentage of mothers that deliver by a trained health provider	64%		61%	73%	70%
6-b) Percentage of caretakers who will know >2 ways to prevent STD/HIV/AIDS	10%		71%	72%	50%
6-c) Percentage of caretakers who will know 2 symptoms of STD	11%		69%	64%	50%
6-d) Percentage of caretakers who will know 2 symptoms of AIDS	25%		76%	70%	50%

Annex 2: Work Plan

Work Plan Gantt chart for October 2008- Sept 2009

Activities	2008	2009			Person responsible
	4	1	2	3	
<i>Staff recruitment & training</i>					
Staff training-camp					Supervisors/coordinators
Bi-weekly Volunteer training:					Sup/Coord/CG leaders
Annual staff vacation					Project Director
<i>Health Systems</i>					
Progr. Coordinator-MOH Director-Dist. Administrator strategic meetings					Project Director
Joint M&E with MOH					MOH/ Director/ Coordinator
<i>Monitoring & Evaluation</i>					
Continuous household evaluations					Director/ Sup/ Coordinators
Ongoing Animator supervision					Supervisors/ Coordinators
Socorrista supervision					Sup/ Coordinator/ MOH
Community-based statistics					Supervisors/ Coordinators
Under-5 mortality feedback					Supervisors/ Coordinators
FE					External Evaluator/ all staff
<i>Scale-Squared Center</i>					
Disseminate OR findings					Director/ TA/ Sup/ Coord

Annex 3: Budget

The budget included here reflects the NICRA rate at the time of the DIP (21.6%). However, the organization's NICRA has decreased 4.37% to the present rate of 17.23%. Restoring that 4.37% difference to the field would make a marked improvement in the final year operating budget. For this reason, World Relief would like to request a formal change in its project budget. If given the go-ahead, WR will gladly create and submit a budget reflecting the decreased NICRA and how the increase in available direct costs would benefit the field.

[Removed]

Annex 4: Publications and Presentations

Publications

“Mozambique: Reducing under-five mortality through a community-based programme”
The State of the World’s Children 2008, p. 59. (Results featured are from the Vurhonga 2 CSP)
Unicef, December 2007

Presentations

Annual Meeting of the Global Health Council
May 29, 2008, Omni-Shoreham Hotel, Washington, DC
“Evidence of CBIO Strategy in World Relief Programs”
Anbrasi Edward-Raj, Johns Hopkins School of Public Health
Melanie Morrow, World Relief
Henry Perry, Future Generations

USAID Implementing Partners Meeting Organized by Forte Saude
August 6, 2008, USAID Mission in Maputo, Mozambique
“WR CSP Coordination Experience with DDS and DPS”
Pieter Ernst, Child Survival Director, World Relief

USAID Site Visit
August 11, 2008, Scale-Squared Training Center in Chokwe, Gaza, Mozambique
“Socorrista Selection, Training, and Functions”
Inacio Chitlhango, Community Health Coordinator

WR Invitation to DPS/DDS Meeting
August 19, 2008, Scale-Squared Training Center in Chokwe, Gaza, Mozambique
Vurhonga Project Update, Results and Data Sharing, and Beyond EOP Discussion
Pieter Ernst, Child Survival Director, World Relief, MOH, WHO, USAID, CDC Joint Site Visit
September 10, 2008, Scale-Squared Training Center in Chokwe, Gaza, Mozambique
“Socorrista Selection, Training, and Functions”
Inacio Chitlhango, Community Health Coordinator

Annex 5: Results Highlight: Pilot project activities involving water and agriculture

Vurhonga prides itself on the depth with which it works in communities. As such, it has seen that the needs of the communities we work in are great. Not only do they go beyond health, but they also limit the project's ability to impact health outcomes. For example, it is difficult to convince a mother to wait to give birth in a "*casa de espera*" when many of these facilities lack even the basic of necessities such as ready access to clean water. Likewise, it is difficult to convince a mother to spend money to buy soap or an LLITN when there is not enough food to eat. Lack of access to clean water and ability to produce enough food to eat or provide income for a family are barriers in the communities. World Relief has been working with a local NGO, Africa Works, and other donors to fund income generating water and agriculture activities in communities within the EIP area. Such activities have been identified as possible ways to improve the sustainability of the Care Group activities.

The agriculture project was piloted in Mucatine village in Massingir district. Africa Works is providing small micro-credit loans to local farmers associations which include Vurhonga volunteers. Each volunteer received an area of 1000m² (10 x 100m) which has one row of grafted mangoes and two rows of papaya trees all irrigated with micro-sprinklers and six rows of vegetables under drip irrigation. At first, it was difficult to obtain land for the volunteers but after one year, when they had harvested two crops with very good results, obtaining more land was relatively easy. Agriculture is the main source of income for people in the communities in which we work. Before this pilot project, volunteers had to work very hard over a large area with little result if there was no rain. The volunteers are excited at how much they can produce in a much smaller area with less time in the field. They not only had enough food to eat throughout the year but they also had enough to sell to pay back all input costs for each crop as well as a portion of the original capital outlay cost. This has also helped free up more of their time to devote to giving health lessons to their households. The goal is that over time, volunteers will produce enough food to provide for their family, earn a living wage, and to share with neighboring households in need. The pilot project has resulted in the creation of small markets in these villages which benefit the greater area. Products have been made, bottled, labeled, marketed, and sold such as papaya juice, papaya chutney, papaya jam, papaya atchaar, tomato jam, tomato chutney, marula nut oil, marula jelly, and marula nut butter. The first crop of grafted mangoes will be harvested this year in December.

US church partners "adopted" five of our larger villages, none of which had a clean, safe water source. Different systems were installed, from boreholes with solar-driven pumps to electric driven pumps. These systems pump river water from crocodile infested rivers to the village and chlorinate the water before distribution. The water is sold at minimum cost per drum at distribution points in the villages. The flatbed truck from the agricultural project is also being used to transport the water tanks to neighboring communities. The project has helped neighboring communities gain access to clean water and generate income in the pilot communities. Some villages have made more than \$2,000 in 12 months, demonstrating the potential for economic sustainability of the system. Despite such encouraging results, these activities currently cover only 6 % of the total project population. The project director sees these activities as a way to improve sustainability of the Care Groups by building on the foundation created by the Vurhonga program.

Annex 6: Monitoring and Evaluation Plan

The monitoring plan includes three components: (1) HIS designed by the MOH; (2) CHIS designed by the CSP; and (3) Home Visit Monitoring Surveys.

The HIS consists of routine surveillance data collected every month by the health facilities and aggregated at the district and provincial levels by the MOH. All socorrista consultations are integrated into the HIS of the provincial MOH. Data from the midterm KPC were shared with the DDS and the data findings were compared and discussed between program and DDS staff.

The Community Health Information System (CHIS) is used to manage routine data on vital events and disease incidence that is collected by CSP volunteers during home visits. During CG meetings, volunteers report pregnancies, births, deaths, and individual women and children at risk of disease or malnutrition. The CG leader documents these in standard reporting formats and communicates the information to the socorristas and project staff. Socorristas include CG statistics from their area in monthly patient statistics and report both to the MOH. This information is shared to help the CG and VHC identify and address problems, overcome barriers and measure progress toward set objectives. It also enables volunteers and village leaders to identify households at risk and to take appropriate community action. CG data complements the existing facility-based HIS used by the MOH.

Home Visit Monitoring Surveys began after last year's midterm evaluation. Each supervisor was given a target of four house visits per day. Information compiled from these visits helps identify areas needing more attention. Supervisors identify the weakest animators and randomly select families of volunteers from the Care Groups overseen by the animator. The process is continued so that the supervisor visits at least one household per volunteer in each of the animator's care groups. Data collected from the family visits are displayed in the table below.

DATA FROM FAMILY VISITS BY SUPERVISORS

	Oct- Nov'07	Dec'07- Jan '08	Feb- Mar '08	Apr- May'08	June- July '08	Aug- Sep '08
# of families visited during time period (# is not cumulative)	758	DNC*	1,311	1,461	1,713	1,986
Knows Vurhonga volunteer	86%	DNC	92%	93%	93%	95%
Received visit from volunteer within last month	67%	DNC	71%	80%	76%	81%
Remembered last health topic	74%	DNC	75%	78%	80%	79%
Demonstrated at least 5 areas of knowledge on last topic**	59%	DNC	67%	67%	71%	74%

Has a toilet	52%	DNC	64%	62%	66%	67%
Toilet well kept*** and in good working condition	64%	DNC	63%	60%	88%	90%
Has dish rack	75%	DNC	80%	76%	79%	83%
Child <5y has an ITN	45%	DNC	61%	61%	60%	60%
Child <5y who has ITN used ITN last night ****	53%	DNC	54%	65%	70%	55%*****
Child <2y weighed in last 3m	87%	DNC	92%	90%	92%	96%
% children underweight*****	7.8%	DNC	7.2%	2.6%	2.8%	2.6%
Child 1-2 y completed immunizations	80%	DNC	87%	97%	94%	95%

* Data not collected in Dec/Jan due to staff vacation/leave

** Denominator includes everyone surveyed, not just those who remembered the last health topic

*** Well kept is defined as clean and lid is on

**** Of those children < 5 with an ITN

***** Staff communicated the importance of continuing net usage through the dry/winter months in June and usage rates increased and were maintained for three months, however, net usage rates dropped once again in September; staff will once again reiterate the importance of continued net usage, even in the dry months.

***** Rates of underweight are higher in the hungry months, usually from Oct- Jan but changes in weather patterns and less rain during the rainy season this past year has extended the hungry months.

Annex 7: CSHGP Project Data

Child Survival and Health Grants Program Project Summary

Oct-29-2008

World Relief Corporation (Mozambique)

General Project Information:

Cooperative Agreement Number: GHS A 00 04 00011
Project Grant Cycle: 20
Project Dates: (9/30/2004 - 9/29/2009)
Project Type: Expanded Impact

WRC Headquarters Technical Backstop: Melanie Morrow
Field Program Manager: Pieter Ernst
Midterm Evaluator: Muriel Klmer
Final Evaluator:
USAID Mission Contact: Dr. Titus Angi

Field Program Manager Information:

Name: Pieter Ernst
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Name: Pieter Ernst
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Cholewa
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Funding Information:

USAID Funding:(US \$): \$1,500,000 PVO match:(US \$) \$833,333

Project Information:

Description:

The goal of this expanded impact project is to scale up the Care Group (CG) model for child survival interventions.

The expanded impact program will strengthen the health system capacity to improve quality and coverage of C-IMCI services through training, drug management, supervision and by establishing effective health information systems; develop sustainable community based mechanisms to improve prevention and careseeking practices for C-IMCI; and establish a Scale 2 learning center for C-IMCI training. The major interventions are: control of diarrheal diseases, malaria prevention and case management, pneumonia case management, immunization, nutrition, exclusive breastfeeding, and HIV/AIDS.

Location:

Chibuto, Chicualacuala, Chigubo, Massangena, and Massingir.

Project Partners	Partner Type	Subgrant Amount
Ministry of Health	Collaborating Partner	

General Strategies Planned:

Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Participatory Rapid Appraisal
Lot Quality Assurance Sampling
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication
Peer Communication
Support Groups

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
CS Project Team	Networked Group	Traditional Healers	Dist. Health System Health Facility Staff Other National Ministry	Health CBOs CHWs

Interventions/Program Components:

Immunizations (10 %)

- (MCT Integration)
- (CHW Training)
- (HF Training)
- Class of Vaccines
- Vitamin A
- Serovaccines
- Mobilization

Nutrition (20 %)

- (MCT Integration)
- (CHW Training)
- (HF Training)
- Comp. Feed from 6 mos.
- Lactat
- Cont. BF up to 24 mos.
- Growth Monitoring
- (MCT Integration)
- (CHW Training)
- (HF Training)
- (MCT Integration)
- (CHW Training)
- (HF Training)

Pneumonia Case Management (10 %)

- (MCT Integration)
- (CHW Training)
- (HF Training)
- Recognition of Pneumonia Danger Signs

Control of Diarrheal Diseases (20 %)

- (MCT Integration)
- (CHW Training)
- (HF Training)
- Hand Washing
- ORS/Home Fluids
- Feeding/Re-feeding
- Case Seeking
- Case Mgmt./Counseling

Malaria (20 %)

- (MCT Integration)
- (CHW Training)
- (HF Training)
- Training in Malaria CM
- Access to providers and drugs
- ITN (Products)
- Care Seeking, Mgmt., Compliance
- (MCT Integration)
- (CHW Training)
- (HF Training)
- (MCT Integration)
- (CHW Training)
- (HF Training)

Breastfeeding (5 %)

- (MCT Integration)
- (CHW Training)
- (HF Training)
- Promote Excl. BF in 6 Months

HIV/AIDS (15 %)

- (MCT Integration)
- (CHW Training)
- (HF Training)
- Behavior Change Strategy
- Access/Use of Condoms
- ABC
- (MCT Integration)
- (CHW Training)
- (HF Training)
- (MCT Integration)
- (CHW Training)
- (HF Training)

Target Beneficiaries:

Children 0-23 months:	38,635
Children 0-59 Months	38,635
Women 15-49 years:	63,122
Population of Target Area:	227,260

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	50	299	16.7%	6.3
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	0	0	0.0%	0.0
Percentage of children age 0-23 months whose births were attended by skilled health personnel	190	299	63.5%	10.6
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	75	223	33.6%	9.8
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	19	109	17.4%	10.6
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	35	69	50.7%	20.5
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	85	110	77.3%	18.2
Percentage of children age 12-23 months who received a measles vaccine	105	110	95.5%	18.7
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	43	299	14.4%	5.9
Percentage of mothers who				

feeding children, after defecation, and after attending to a child who has defecated				
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Comments for Rapid Catch Indicators

EI not required to collect all indicators