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Third Annual Report**

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ACRONYMS

ADP	Area Development Program
AIDS/HIV	Acquired Immune Deficiency Syndrome/Human Immune-deficiency Virus
ANC	Antenatal Care
ASO	Auxiliary Service Officer
BDCSP	Bergville District Child Survival Project
BFHI	Baby Friendly Hospital Initiative
CBG	Community-Based Groups
CBGM	Community-Based Growth Monitoring
CBHP	Community-Based Health Programme
CBNS	Community-Based Nutritional Surveillance
CBHW	Community-Based Health Worker
CDD	Control of Diarrhoeal Disease
CDP	Community Development Project
CHC	Community Health Committee
CHESS	Centre for Health and Social Studies (University of Natal)
CHF	Community Health Facilitator
CHW	Community Health Worker
CFF	Community Field Facilitator
COA	Community Office Administrator
CPR	Contraceptive Prevalence Rate
CSP	Child Survival Project
CT	Community Trainer
DHMT	District Health Management Team
DHS	District Health System
DIO	District Information Officer
DIP	Detailed Implementation Plan
DIS	District Information System
DMT	District Management Team
DOE	Department of Education
DOH/DoH	Department of Health
ECD	Early Childhood Development
EHO	Environmental health Officer
ESATI	Eastern Seaboard Association of Tertiary Institutions
EPI	Expanded Program on Immunization
HAC	HIV/AIDS Communicators
HH/CC	Household and Community Component
HMIS	Health and Management Information System
HST	Health Systems Trust
IGA	Income-Generating Activity
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
ISDS	Initiative for Sub-District Support
KFP	Key family Practices
KPF16	The sixteen Key Family Practices
KPC	Knowledge, Practice and Coverage
KZN	KwaZulu-Natal
LAN	Local Area Network
LHC	Local Health Committee
LQAS	Lot Quality Assurance Sampling

MAP	Men as Partners
MCDI	Medical Care Development International
MCH/FP	Maternal and Child Health/Family Planning
MC&WH	Maternal, Child and Women's' Health
M&E	Monitoring and Evaluation
MHF	Municipal Health Forum
MMR	Maternal Mortality Rate
MNC	Maternal and Newborn Care
MP	Maternal Pathway
NGO	Non-governmental Organization
NPPHCN	National Progressive Primary Health Care Network
OADP	Okhahlamba Area Development Program
PEP	Peri-natal Education Programme
PHC	Primary Health Care
PPIP	Peri-natal Problem Identification Programme
PLA	Participatory Learning and Action
PLWAs	People Living with AIDS
PMTCT	Prevention of Mother to Child Transmission
PPHC/KZN	Progressive Primary Health Care Network / KwaZulu-Natal See above
PVO	Private Voluntary Organization
QI	Quality Improvement
RSA	Republic of South Africa
SCM	Standard Case Management
STI	Sexually Transmitted Infection
TA	Technical Assistance
TD	Transformational Development
TDCSP	uThukela District Child Survival Project
TH	Traditional Healer
TL	Transformational Leadership
TLC	Transitional Local Council (Municipal Government)
TVT	The Valley Trust
UNICEF	United Nations Children's Fund
UNP	University of Natal, Pietermaritzburg
UND	University of Natal, Durban
USAID	United States Agency for International Development
WCBA	Women of Child Bearing Age
WHO	World Health Organization
WVI	World Vision International
WVSA	World Vision South Africa
WVUS	World Vision United States

TDCSP'S VISION, MISSION STATEMENT AND CORE VALUES**VISION**

The District will create, and continue to re-create, a context in which *optimal health* and *well-being* are achieved and sustained.

MISSION

The TRCSP will partner with community and Department of Health in creating a well-being context for leadership, operational units and individuals in which the Child Health, Maternal Health and HIV/ AIDS interventions are developed in a holistic, integrated and sustainable manner.

CORE VALUES

The Province, District and TRCSP have committed themselves to the following core values:

- Trust, integrity and reconciliation
- Open communication
- Transparency
- Consultation
- Commitment to performance
- Courage to learn
- Change and innovation
- Valuing all people
- Striving for excellence
- Taking responsibility for oneself

EXECUTIVE SUMMARY

BACKGROUND

World Vision's uThukela District Child Survival Project (TDCSP), funded by the USAID's Child Survival Grants Program, was implemented on November 16, 1999 and will operate until September 29, 2003. This Third Annual Report informs on progress towards achieving the project objectives and implementing the recommendations of the Mid Term Evaluation held in November 2001.

The TDCSP is an expansion of the previous Bergville (Okhahlamba) District CSP (1995-1999) into the uThukela District. As such TDCSP extends coverage from 130,000 to 537,355 people. It represents a scaling-up of ongoing interventions and a testing of new approaches.

The uThukela District is divided into five municipalities, Okhahlamba (previously Bergville) Emtshezi/Estcourt, Mbabazane, Emnambithi/Ladysmith and Indaka. Each municipality is divided into a number of wards.

GOAL AND INTERVENTIONS

The TDCSP's main goal is to optimise maternal and child health status and overall well-being in the uThukela District. Linked to this is the optimisation of PHC services. In order to achieve these, TDCSP implements three technical interventions:-

- HIV/AIDS Well-being (including the Transformational Development Program);
- Maternal and Child Health (MCH); and
- Integrated Management of Childhood Illness (IMCI).

Implementation of these interventions is supported by three main cross-cutting approaches, namely:-

- Capacity building
- The development and implementation of a Health Management Information System (HMIS); which integrates community and facility level information for decision making and
- The establishment of a Learning Site.

In addition, the TDCSP has a sustainability strategy and phase-out plan to ensure that the project activities continue once the current funding grant from USAID's Child Survival Grants Program is completed.

IMPLEMENTATION

The Dept of Health district priorities have been allocated per municipality, with each of the municipalities serving as a site of Best Practice for allocated priority intervention. TDCSP has aligned the implementation of its key interventions with this allocation. As a result, the HIV/AIDS Well-being pilot project is being implemented in Okhahlamba and the Maternal Health pilot project in Mbabazane. IMCI and the IMCI household and community component is being rolled out and strengthened in all four 'new' municipalities in the TDCSP project.

ACHEIVEMENTS

TDCSP has made significant achievements during the reporting period. Chief among these are the following;-

- *HIV/AIDS Well-being: Transformational Development:* A team of people has been trained to implement a Transformational Development Program in the Pilot site (Rookdale, in Okhahlamba), and roll out training in Transformational Leadership.
- *IMCI: Facility level:* Some training of facility staff, and a focus on setting up a system to ensure sufficient, good quality supervision. *Household and community component:* Training of Community Health Committees and Community Health Workers, further development of support materials
- *Maternal Health:* Further strengthening of facility level care, development of a Mother's booklet
- *Implementation of LQAS:* An LQAS survey filled the gaps in the project baseline data and enabled the aggregation of data across the five municipalities. This provided coverage estimates for each indicator (Child Health, Maternal Health, HIV/AIDS Well-being) for the whole project area, as well as for each municipality. Targets for each key indicator were reviewed and adjusted and an action plan was co-designed with relevant stakeholders. Key indicator data in each municipality can now be monitored to determine performance of each intervention. This has contributed to the scale-up of the CSP in the uThukela District.
- *Progress towards the development of a Community Monitoring and Evaluation Framework:* A series of interviews, focus group discussions and meetings were conducted to determine the meaning of 'children at risk' and in a state of 'well-being' at community level. A measurement system with indicators for these terms was formulated and duty bearers/stakeholders who can respond to this information were identified. This research will assist in the development of a community monitoring and evaluation framework that will support community members with decision-making. In turn it will provide managers with community-based information upon which to base decisions.
- *Community Health Worker Training:* Since July 2002 TDCSP has been given access to train and ensure supervision of all the CHWs who have completed the Provincial CHW examinations. PPHCN is continuing to train all new CHWs who have entered the program This has resulted in the following spin-offs:-
 - 278 out of 320 CHWs have completed their exams and are receiving inservice training in the HH/CC of IMCI and MCH
 - The KZN provincial CHW training programme has adopted the uThukela District DoH and TDSCP-designed IMCI HH/CC training module as its child health curriculum. As a result, all CHFs and CHWs throughout the province of KZN are now being trained in the IMCI 16 Key Family Practices using the material developed by TDCSP.
- *Registration of the uThukela District Health Forum (TDHF) as a Non-profit Organisation:* the TDHF is now a legal entity, making it possible to transfer the management of the CHW program from the service provider (PPHCN) to TDHF in partnership with TDCSP and the District Management Team.
- *Building strong relationships with local (municipal) government for implementation of community-based health.* The CBHP team has facilitated the development of strong relationships and partnership with local governments at Municipal level. This is being maintained by inviting councillors to all CHC trainings and giving progress reports to local municipal councils on a 6 monthly basis.

CONSTRAINTS AND TECHNICAL REQUIREMENTS

The following constraints have been of concern during the reporting period;-

- *Insufficient Community Health Facilitators (CHF)s*: The optimal ratio is 1CHF:25CHWs, has been difficult to achieve due to the high turnover of CHF)s. Of the nine CHF)s appointed to date, four have left the programme, either through resignation or to further their education. There are therefore insufficient CHF)s available to supervise the 320 CHWs. The DMT and the provincial Director for DOH the CHW program are investigating possibilities, e.g. the upgrading the CHF position, in order to create a career path for them within the Health Services.
- *Lack of capacity to undertake supervision at an optimal level*: As a result of a shortage of CHF)s and the demands place on IMCI Supervisors, supervision has not been optimal. Plans are being put in place to streamline the supervision and support of health workers.
- *Lack of capacity to adequately address STIs*: technical assistance in appropriate message development and dissemination around STIs is required. The medical doctor who was to have worked with the intervention on this is relocating, and a new plan needs to be formulated with the DMT to address this.

Technical assistance is required with the following;-

- The evaluation of the program designed for the HH/CC, including the Monitoring and Evaluation framework;
- Assistance in developing less traditional information feedback mechanisms, such as drama, theatre and video, as well as in creative report writing skills would assist the District Information System to interact with community roleplayers in a more culturally feasible and effective manner;
- Computer literacy training for Labour Ward staff and MCH Co-ordinator;
- PPIP data capture training; and
- Appropriate message development and dissemination around STIs.

1 INTRODUCTION

World Vision's uThukela District Child Survival Project (TDCSP) began implementation on November 16, 1999, thanks to a grant from USAID's Child Survival Grants Program. This expansion grant was a follow-on to the previous Bergville District Child Survival Project, which ran from 1995-1999. It represents both a refinement as well as a scaling-up of the original program. It will run until September 29, 2003.

The uThukela District is home to approximately 585,000 people living in 155 communities that form five municipalities in the District. Each municipality is divided into a number of Wards. Ninety percent of the population are poor Africans living mainly in tribal areas (80%), but also on adjoining freehold land (10%) and white-owned farms (10%).

This area was chosen because:-

- i. The maternal/child morbidity and mortality rates of this mostly black, rural population are higher than the national average;
- ii. The District DoH has a demonstrated commitment to improving linkages with the community and strengthening primary health care;
- iii. WVSA has a 15-year history of partnership with the community and clinics in this area with nutrition education/rehabilitation programs, CHW training, youth education (health, sexuality and AIDS education); and
- iv. The area is both geographically and strategically suitable for scale-up of the original program.

Since the CSP1 project, which is what the initial Bergville District Child Survival Project is called locally, a major re-organisation of the whole district has taken place. The 'old' Bergville District is now called the Okhahlamba Municipality, which is one of five municipalities in the uThukela District. The four other municipalities are Emtshezi/Estcourt, Mbabazane, Emnambithi/Ladysmith and Indaka municipalities. The TDCSP has reorganised its activities around the new municipal boundaries. Each municipality is divided into a number of wards.

This is the Third Annual Report of the TDCSP, and follows on the Mid Term Evaluation (MTE) of the project in November 2001. The purpose of this report is to reflect on what has been and what needs to be done towards achieving the objectives of the project, and what actions have been taken in response to the MTE recommendations. As reflection and forward planning are major purposes of the report writing exercise, a workshop was held with all members of the interventions and the team leaders were asked to compile their reports. Their contributions were integrated into this overall report.

A second report on the activities of the HIV /MED Grant Amendment Project is submitted separately.

1.1 GOAL AND INTERVENTIONS

The TDCSP's main goal is to optimise maternal and child health status and overall well-being in the uThukela District. The project's sub-goal is to optimise the quality of PHC services in the District.

The TDCSP is based on three technical interventions:-

- HIV/AIDS Well-being (Transformational Development Program);

- Maternal and Child Health (MCH); and
- Integrated Management of Childhood Illness (IMCI), including health facility staff case management training; support and supervision for facilities; and a Household and Community component (IMCI HH/CC).

Implementation of these interventions is supported by three main cross-cutting approaches, namely;-

- Capacity building
- The development and implementation of a Health Management Information System (HMIS); and
- The establishment of a Learning Site.

In addition, the TDCSP has a sustainability strategy and phase-out plan to ensure that the project activities continue once the current funding grant from USAID's Child Survival Grants Program is completed.

1.2 STRUCTURE OF THE REPORT

Progress within the technical interventions and cross cutting approaches is presented in Section 2. This includes a discussion of progress towards the intervention specific MTE recommendations and highlights any other achievements and constraints. The last part of Section 2 is a discussion on the sustainability strategy and phase out plan.

Progress towards the overall MTE programmatic recommendations is presented in Section 3.

Section 4 indicates any changes from the project description and Detailed Implementation Plan (DIP), and Section 5 highlights the technical assistance that is required in the remaining year of operation.

Progress in project management is presented in Section 6. Scale-up developments, which aim at taking the project to scale within KwaZulu-Natal Province and beyond, are discussed in Section 7.

2 PROGRESS TOWARDS ACHIEVEMENT OF PROJECT OBJECTIVES

2.1 TECHNICAL INTERVENTIONS

2.1.1 HIV/AIDS WELL-BEING (TRANSFORMATIONAL DEVELOPMENT PROGRAM)

The Vision and Mission for the Well-being/HIV/AIDS component of the uThukela District Child Survival Project is the same as the Vision and Mission of the DOH in the uThukela District (Storms, 2001a, 1):

- The Vision is to achieve holistic care and wellness for all in the uThukela District.

- The Mission is to develop a well co-ordinated, affordable, easily accessible, sustainable, comprehensive and integrated service involving all sectors, and co-designed with the community.

The activities of the HIV/AIDS Well-being program are aligned with the Mission. These activities are divided into four project areas, namely;-

- Well-being pilot site (Transformational Development Program using Transformational Leadership tools)
- Control of STIs
- Men-as-Partners
- VCT.

TDCSP Transformation Development in brief

Transformational Development is a process used in the field of organizational management to facilitate change at both individual and organizational levels (Storms, 2001, 1).

Within the HIV/AIDS context it has been found that managing content (information and motivation) can improve efficiency, but can never induce total effectiveness (behavioural change) (WVSA, 2002). TDCSP has thus adopted TD as an innovative approach to behaviour change within the HIV/AIDS context. TDCSP is testing whether TD can change the way people view HIV/AIDS and thus reduce behaviours that increase risk of infection.

This program focuses on 'managing context' (WVSA, 2002). Context decides behaviour, thus the creation of a new context creates new possibilities for action and solutions. These new possibilities are transformational, not 'merely more or different ways of doing what was done before' (WVSA, 2002, p1). According to the contract between WVSA and the consultant, Futurevision, the TD Programme focuses on self-efficacy, facilitation, leadership, coaching and how to design new measures from a future perspective

This approach acknowledges that our behaviour is determined by our general mindset, or context. If our context is not changed, the acquisition of knowledge and skills has little impact on our behaviour. The basic theory of the approach is that if people are able to create a new context for themselves, a new way of seeing themselves or defining their role in a situation, they will naturally do and learn whatever is required to operate within that context (from Adams and Spencer, "Shifting Context: A Better Way of Training", quoted in WVSA, 2000a, 60).

Transformational Leadership (TL) is the basic training module explaining the theory and tools of Transformational Development.

Transformational Development (TD) is the application of TL competencies, enabling people to create a new context and future.

A number of objectives have been identified within each of the HIV/AIDS Well-being project areas. Progress towards these objectives is outlined in the following section.

2.1.1.1 Progress towards objectives

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
1. Well-being pilot site (Transformational Development Programme)		
<ul style="list-style-type: none"> Model for institutionalising TD 	Yes	A pilot site has been identified. A core team of trainers in Transformational Leadership has been trained, as have facilitators and coaches, and a Results Framework has been designed. The model /learnings will come out of this.
<ul style="list-style-type: none"> 30% of all facility PHC staff, all DoH counsellors, all CHWs and HBC givers trained in TD based coaching skills 	Partial	10 DoH and Lay HIV Counsellors were trained in Coaching and in Self Efficacy. The HBC givers and CHWs will be trained in TL when the Zulu course is rolled out in 2003.
<ul style="list-style-type: none"> Decreased perception of risk among mothers (with children <2 years of age) who feel at risk (from 62% to 20%) Emtshezi/Okhahlamba 	Yes	This will be measured with LQAS in the pilot and compared with the municipality and the district as a whole at the end of the project. A baseline survey was done throughout the District (see accompanying LQAS report).
<ul style="list-style-type: none"> Increased willingness among mothers (with children <2 years of age) in pilot site to be tested (from 35% to 70%) Okhahlamba 	Yes	This will be measured with LQAS in the pilot and compared with the municipality and the district as a whole at the end of the project. (Baseline done throughout the District)
2. Control of STIs		
<ul style="list-style-type: none"> 100% of facilities will practice SCM of STIs 	Yes/No	<ul style="list-style-type: none"> Dept of Health has been addressing this
<ul style="list-style-type: none"> 25% of Traditional Healers registered with the THs Assoc. will have attended STI management and referrals 	No	<ul style="list-style-type: none"> To be addressed in 2003
<ul style="list-style-type: none"> 40% of private practitioners will have attended CPD presentations on STI SCM 	No	<ul style="list-style-type: none"> To be addressed in 2003
3. Men-as-Partners (MAP)		
<ul style="list-style-type: none"> To develop a communication package for addressing MAP (messages, methods, and venues) 	Incorporated into Well-being pilot site objective	<ul style="list-style-type: none"> This objective has been incorporated into the Well-being Pilot Site/ Transformational Development Programme, and thus is being addressed indirectly. Many of the participants in the programme are men, and a shift in context (the desired outcome of a MAP programme) is evident among participants.
4. VCT		
<ul style="list-style-type: none"> Every facility in District will have 1 or 2 DoH staff and 5 lay 	Partial	<ul style="list-style-type: none"> The DMT has identified Okhahlamba as the municipality of Best Practice for

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
people trained in HIV/AIDS counselling packages (rotating).		<p>HIV/AIDS. This is therefore being implemented in one municipality (Okhahlamba).</p> <ul style="list-style-type: none"> • 11 DoH (6 from hospital and 1 from each of 5 clinics) and 8 lay counsellors linked to the Well Being Centre were trained in VCT counselling. Training in counselling packages (messages) will occur in 2003. • TDCSP has appointed an HIV Coordinator/manager to coach the trained counsellors
<ul style="list-style-type: none"> • Holistic service directory available at each facility for referral of clients using VCT services. 	Partial	<p>The service directory has been developed for the well being centres at ward level and still need to be shared with the facility counsellors doing VCT and PMTCT. Currently, links are being made with people and institutions to be included in the directory.</p>
<ul style="list-style-type: none"> • Nevirapine Explore possibility of having a Nevirapine pilot site (HIVAN), when counsellors are trained (Ladysmith Hospital, Emmaus Hospital + link with MNC). 	Yes	<p>The national DOH has now changed its policy and has embarked on a programme of Prevention of MTCT provincially, with all state hospitals in the District offering Nevirapine. This is a DOH Initiative with VCT and Exclusive Breastfeeding counsellors being trained by TDCSP.</p>

2.1.1.2 Responses to MTE Recommendations

MTE RECOMMENDATIONS	RESPONSE
1. Well-being Pilot Site (Transformational Development Programme)	
<ul style="list-style-type: none"> • Obtain TA from experienced professional in Child Survival indicator design to develop measurable objectives, indicators and targets for TL. Obtain baseline TL performance measures on CHWs, CHC, CHFs: Jan–Feb 2002. 	<p>A consultant, Miriam Wiltshire of Futurevision was contracted to train a team to roll out TD and TL in Okhahlamba, focusing first on the pilot site. A results framework was designed as part of her contract in order to measure whether the desired results are being achieved or not.</p>
<ul style="list-style-type: none"> • Pilot TD in selected ward in Okhahlamba or Emtshezi 	<p>The DMT chose Okhahlamba as the best practice site for HIV/AIDS; the pilot site was identified as Rookdale.</p>
<ul style="list-style-type: none"> • Local TD team 	<p>A local team of 15 people has been trained to roll out the TD/TL course and implement it in the pilot site. This team consists of Counsellors, pastors, women and youth leaders, TDCSP and OADP staff and DOH staff.</p>

MTE RECOMMENDATIONS	RESPONSE
<ul style="list-style-type: none"> Africanise/ Zulu TD language + TD in local context 	<p>The TD course is being delivered in Zulu and the training manual will be accurately translated into Zulu.</p>
<ul style="list-style-type: none"> Objectives/ indicators/ tools to assess whether concept of well-being is well understood and is effective in changing behaviour 	<p>Elaine Byrne (see HMIS Section) has researched stakeholder understanding of “at risk” and “well-being” and developed indicators for child health. This work needs to be taken further for adults and families. In order to measure these indicators, HIVAN is being engaged to work with the community in co-designing definitions of well-being in the HIV/AIDS context and how to measure the emergence of hope.</p>
<ul style="list-style-type: none"> (Training): Database on training on individual community health resources (CHWs, CHFs, CFFs, CHCs, CH forums) 	<p>A data base has been developed to track the training these categories of workers and structures by municipality, and by training received by individual within these structures.</p>
<ul style="list-style-type: none"> DoH position for someone to do TL/D training and follow up 	<p>Due to the staff shortages experienced due to nurses leaving the area and the country, the DMT has been unable to dedicate a person to this position. However DoH staff trained in TL use the tools and behaviours in their work context</p>
2. Control of STIs	
<ul style="list-style-type: none"> Training in STI for clinic sisters and Traditional Healers 	<p>This will be addressed in 2003</p>
3. Men-as-partners (MAP)	
<ul style="list-style-type: none"> Specific goals/milestones and resource requirements. 	<ul style="list-style-type: none"> It has been decided to incorporate the MAP concept within the well-being pilot. The involvement of men in the shifting context with respect to HIV will be tracked within the pilot site as a whole. Goals/ milestones for the TD programme in the well-being pilot site are being designed. Men are participants in this programme (16 men out of 40 are on the core team being trained). The initiation of a men’s movement is being explored. This will be measured with focus groups at the end of the program. The desired context is one where men and women freely participate and work towards a common vision of well-being. The Family Booklet for Child Health lists 16 key family practices; this includes the man’s role in the family.
4. VCT	
<ul style="list-style-type: none"> Train counsellors in TD coaching skills 	<p>3 of 5 nurse counsellors, and 6 of 8 lay counsellors were trained in coaching skills. 20 other community leaders and project staff were trained in individual coaching skills.</p>

MTE RECOMMENDATIONS	RESPONSE
	Some of these were also trained in group coaching skills.
<ul style="list-style-type: none"> Develop Tools to aid health workers and CHWs in TL coaching 	<p>There is a manual for TL coaching. Messages/content for coaching packages have also been developed. Community based workers will be trained in these in 2003</p>
<ul style="list-style-type: none"> Guidelines, algorithms, other HIV/AIDS /well-being job aids for facility staff and CHW in VCT 	<p>Messages have been developed by the project. The DoH has undertaken training of facility staff and counsellors around Mother to Child Transmission. Protocols for this and other information around HIV has also been developed.</p>
<ul style="list-style-type: none"> Prepare for the use of Nevirapine for prevention of MTCT 	<p>Counsellors at Emmaus Hospital and 1 maternity ward sister from each of Ladysmith and Estcourt hospitals, have been trained in Exclusive Breast feeding and PMTCT. There is a need for all VCT and PMTCT counsellors to be trained in the UNICEF Exclusive breast-feeding course, as well as in VCT and PMTCT. The training program to achieve this throughout the district is presently being planned with the DOH AIDS Coordinator.</p>

2.1.1.3 Other Achievements

- A noteworthy achievement has been the participation of many men who desire to learn how to shift the context that generates the HIV epidemic, in the TD project. This has led to the decision not to develop a separate Men-as-Partners program, rather to focus resources on the TD, where men and women work in partnership.
- The introduction of PMTCT and the provision of Nevirapine by the DoH within the past year changed the context of the project.

2.1.1.4 Constraints

- Constraint 1: Slow nature of Transformational Development.**
Transformational Development /Leadership requires personal change in individuals and is an ongoing process rather than a 'once off' acquisition of knowledge and skills. This means that the process is slow and varies for different people. The result is that planning and implementing TD project activities is dependent on individuals' personal growth and development. However, the results of participation in the programme are life changing.
- Constraint 2: Management changes.**
The HIV/AIDS Well-being intervention has had a change in management since the MTE. The leader of the intervention, a DoH staff member appointed as District AIDS Coordinator, has had many obligations to fulfil both at District and at Provincial level. In addition, the TDCSP appointed manager has left the area due to the schooling needs of her children. This has impacted negatively on the pace of project

implementation. Thus a new full time manager has been appointed by the TDCSP, whose task is to lead/manage the TDCSP HIV/AIDS Well-being intervention.

- Constraint 3: The STI activities have not been addressed.

Although the DoH has the technical expertise and plans to address STIs at facility level, the TDCSP has planned activities that target private service providers, including Traditional Healers and Private Practitioners. This requires some technical assistance in appropriate message development and dissemination around STIs. The medical doctor who was to have worked with the intervention on this is relocating, and a new plan needs to be formulated with the DMT to address this.

2.1.2 MATERNAL AND CHILD HEALTH (MCH)

TDCSP is assisting the DoH to improve the standard of maternal and neonatal health care in the district. The strategy for improving the system is to focus first on the formal health care facilities and staff, and thereafter to undertake community extension work through the CHWs and CHCs (Storms, 2001, p13).

Our experiences of the Maternal and Child Health Project

My husband put me on a horse with my suitcase and brought me across the river so I could attend the breast-feeding counselling course.

CHW from Mablessing – a remote rural community in the mountains, inaccessible when the rivers flood.

The Community Health Worker saved my baby's life by recognising the danger signs of pneumonia.

Mother, Okhahlamba.

Before you came we thought we knew everything, but you have taught us so much.

CHW, working since 1983 with the ex-KwaZulu Department of Health, to a TDCSP Community Health Facilitator.

2.1.2.1 Progress towards objectives

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
1. Monthly peri-natal mortality review meetings		
<ul style="list-style-type: none"> Monthly peri-natal mortality review meetings facilitated and data analysed for action in each Sub District / Hospital 	Yes	A monthly peri-natal mortality review meeting is held in each hospital in the district. Data is analysed using the PPIP and action is taken on the findings.
<ul style="list-style-type: none"> Identify causes of Peri-natal Deaths classifying according to caregiver, administration and client. 	Yes	Undertaken at monthly peri-natal mortality review meeting. Accumulated data in place. Ladysmith hospital is nationally recognized for using PPIP in peri-natal death analysis. Standardized peri-natal death forms used in all delivery facilities.
<ul style="list-style-type: none"> Define and implement action to address causes at monthly review meetings. 	Yes	Undertaken at monthly peri-natal mortality review meeting, effects of actions taken are also discussed.
2. Peri-natal Education Programme (PEP) self study training		
<ul style="list-style-type: none"> Obtain PEP Package 	Yes	Manuals available in all the facilities
<ul style="list-style-type: none"> Midwives completed PEP self study training 	Partially	Test done in each peri-natal review meeting. However, representatives attending the peri-natal review meetings are frequently changed, therefore progress in doing tests is slow. One test repeated more than twice.
<ul style="list-style-type: none"> Mentoring and evaluation of PEP 	Yes	Mentoring clinics during monitoring visit by the MC&WH coordinator.
3. Peri-natal problem identification programme in the whole district (PIIP)		
<ul style="list-style-type: none"> Initiate PIIP in the whole district 	Yes	The program operates in 3 labour wards of the 3 district hospitals.
<ul style="list-style-type: none"> Obtain computers for maternity wards in three hospitals 	Yes	Delivered to the Maternity Ward of each hospital.
<ul style="list-style-type: none"> Train caregivers on how to identify cause of death to primary and final cause 	Yes	Training course was delayed due to the delay in the delivery of the computers for Provincial DoH
<ul style="list-style-type: none"> Computerize the information for monthly analysis 	Partially	One hospital (Ladysmith) is on target with progress.
4. Initiate better births management in the whole district – focusing on mother and household		
<ul style="list-style-type: none"> Review CHW syllabus and MH compatibility 	Yes	Reviewed in January 2002. Found to be missing danger signs in antenatal, delivery and post delivery phases. This was addressed in the IMCI Training Manual.
<ul style="list-style-type: none"> Distribute messages and train staff in all facilities in 	Yes	CHWs have been trained on Household Messages.

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
Household Messages.		Health Committees in three municipalities have been trained on HH/CC messages linked with IMCI. A booklet on with antenatal, delivery, post-natal and neonate danger signs is in draft form. When completed it will be made available to every mother on antenatal visits.
<ul style="list-style-type: none"> Workshops for CHWs in home deliveries 	No	Planned for 2002/3
<ul style="list-style-type: none"> CHW to use Messages at HH 	Yes	In service training has been held in three out of five municipalities.
<ul style="list-style-type: none"> Supervision and evaluation of CHW (CHF) performance in client interaction and quality of health education 	Partial	PPHCN designed a field assessment tool that focuses on content and process. Difficulties in supervision arose due to the loss of four of the nine CHFs (see section 2.2.1.4 Constraints, below). As a result there has been an attempt to undertake supervision and evaluation on the days when the CHWs report to the clinics.
5. Improve working conditions including equipments, have Audit tool		
<ul style="list-style-type: none"> Meet to finalize and distribute Maternal Pathway (MP) strategy (including flowchart) 	Yes	Has been designed and finalised.
<ul style="list-style-type: none"> Delivered to all facilities 	Yes	Available at all facilities.
<ul style="list-style-type: none"> Monitoring with checklist as part of every supervision visit Once/3month per facility 	Yes	Checklist designed.
<ul style="list-style-type: none"> Facility staff to co-design MP with ANC clients 	Yes	Undertaken on a client-by-client basis.

2.1.2.2 Responses to MTE Recommendations

MTE RECOMMENDATIONS	RESPONSE
1. Monthly peri-natal mortality review meetings	
<ul style="list-style-type: none"> Monthly peri-natal mortality review meetings facilitated and data analysed for action in each Sub District / Hospital 	Yes, meetings are taking place on a monthly basis. Analysis of data takes place at the meetings and actions identified.
<ul style="list-style-type: none"> Identify causes of peri-natal deaths classifying according to caregiver, administration and client. 	Undertaken at monthly meetings.
2. Initiate better births management in the whole district – focusing on mother and household	
<ul style="list-style-type: none"> Strengthen the maternal and neonate health component in the training program of the CHWs and CHCs 	Agreement that CHW will undergo in-field training with TDCSP once the DoH training is completed (mother's antenatal booklet to be used).

MTE RECOMMENDATIONS	RESPONSE
<ul style="list-style-type: none"> Carry out performance assessments using LQAS, 6 months and 1 year after training CHWs and CHFs to determine whether training affected the level of care and counselling the CHW, CHF and/or CHC provides. 	<p>The LQAS assessment tool for HW competency in Maternal and Child Health is in the design phase. It will be tested before March 2003.</p>
3. Improve working conditions including equipments, have audit tool	
<ul style="list-style-type: none"> Focus supervision on strengthening weakest links supporting frontline health worker. 	<p>Co-ordinator undertakes M&E every three months, per facility.</p>
<ul style="list-style-type: none"> Assist medical and nursing staff members who show signs of burnout. 	<p>This is a DoH issue. TDCSP has facilitated attendance of staff members at conferences and seminars</p>

2.1.2.3 Other Achievements

- Mother's Information Card**
 A mother's card is in draft form outlining the danger signs of during the antenatal, delivery, postnatal and neonatal periods. Once the card is translated into Zulu, it will be mass produced and made available to mothers during their antenatal visits
- Best Practices in Antenatal Care**
 A focus on Best Practices in ANC includes use of a standardized antenatal care package, use of standardized equipment at facilities and the facilitation of Antenatal Care Days at facilities.

 Mbabazane has been identified as the municipality for best practice in Antenatal care. Workshops are being held with community leaders, mothers and other interest groups to redesign the antenatal services offered at the facilities to better meet client needs.
- Medication to prevent Mother to Child Transmission of HIV**
 Medication to prevent mother to child transmission of HIV (Nevirapine) is now available at all three hospitals in the uThukela District.
- Rapid Tests**
 Rapid Tests are now available at 4 facilities in the uThukela District.
- Dr Felicity Savage of WHO came to uThukela District to train in Breast Feeding Counselling for two weeks in August. The program resulted in the following:**
 - Training of eight Breast Feeding Trainers (five from uThukela and three dieticians from Ugu Municipality, Josini town and the city of Pietermaritzburg) in listening, learning, confidence and support skills to more effectively help mothers breast feed their babies;
 - Building a team of five trainers within the uThukela district in the above skills;
 - Training twenty-four participants to be counsellors, including health facility nurses based at hospitals and clinics in the district, one Community Health Facilitator, 14 Community Health Workers and one Nutrition Advisor.

2.1.2.4 Constraints

- Constraints beyond the scope of the project

The following constraints mentioned in the MTE (Storms, 2001) have not changed and are beyond the scope of the project:

All health staff clearly understood the principles of referral and expressed frustration and anxiety about the ability to do so effectively and safely. They expressed concern about a lack of transport, a lack of skilled personnel and a lack of appropriate equipment to transfer women and neonates with problems to higher levels of care. Poor transport in the referral system has also led to clinic appropriate births receiving hospital care that should be going to more risky births (Storms, 2001, 15).

A serious constraint to adequate MNC is the shortage of staff with qualifications in midwifery. In this district, as in the entire province, there has been a significant exodus of nurses and midwives to other countries because of the significant financial gain it brings. In addition, there have been staff losses due to morbidity and mortality from HIV/AIDS (Storms, 2001, 17).

However TDCSP is addressing the need to strengthen the maternal and neonatal health component in the training program of the CHWs, and in ensuring that mothers base decisions on sound information

2.1.3 INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI)

A strategy for Integrated Management of Childhood Illness (IMCI) was developed by WHO and UNICEF in 1995 to address preventable deaths in children. It was adopted by South Africa as a strategy for improving child health and survival in 1998 (Storms, 2001b, 1).

The TDCSP adopted IMCI as one of its strategies to reduce child morbidity and mortality through improving health care in health facilities and in the community. This IMCI strategy integrates the previous BDCSP interventions (acute respiratory infections, diarrhoeal diseases, and immunizations). The goal is to prevent illness and reduce deaths from common childhood conditions and to promote child health and development.

The IMCI strategy has three components:

1. Improving the case management skills of health workers
2. Strengthening the health system to better deal with child health issues
3. Improving health care practices in the home and community

The Department of Health uThukela District also adopted IMCI as its strategy to bring the vision of Primary Health Care, in particular child health, into reality. IMCI thus offers the opportunity to achieve shared governance for child health between facilities and the communities they serve.

The TDCSP has made a great deal of progress over the past year, reported in Section 2.1.3.1, below.

For the purposes of clarification, the following glossary of terms used in the IMCI intervention is provided:

ASO: Auxiliary Service Officer – a health promotion worker, employed by DoH.

C-IMCI and IMCI HH/CC: “Community IMCI” and “IMCI at the household and community level” have the same meaning.

CFF: Community Field Facilitator, employed by TDCSP to train CHCs, MHFs, local government and hospital boards and clinic committees.

CHF: Community Health Facilitator, employed by DoH to train and supervise CHWs, interacts with all community structures and clinics.

CHW: Community Health Worker, funded by DoH who contracted TVT and PPHCN to oversee training.

EHO: Environmental Health Officer.

PHC Co-ordinator: Employed by DoH, responsible for co-ordinating all primary health services within a municipality. They are senior staff members who also supervise quality of care in all PHC interventions.

PHC Trainer: Primary Health Care Trainer employed by the DoH to do all PHC related training at facility level within municipalities (nurses).

PPHCN: Primary Health Care Network; an NGO appointed by DoH to undertake the training of all CHW in KNZ.

Nurse Facilitators: DoH nurses who have been trained as facilitators for the 11-day IMCI SCM training courses. (There are also ‘In Patient Facilitators’: usually doctors).

2.1.3.1 Progress towards objectives

1. IMCI Health Facility Training & Supervision
2. Community IMCI (C-IMCI):
 - Training
 - Communication Strategy for C- IMCI
 - Monitoring & Evaluation of C-IMCI
 - Implementation of C-IMCI

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
1. IMCI Health Facility Training & Supervision:		
<ul style="list-style-type: none"> • Train PHC Nurse Practitioners in SCM: 11 day course • <i>Indicator: 75% of PHC nurses trained in IMCI SCM by end of project.</i> 	Yes	<p>62% trained to date. In order to attain the 75% target, another 20 PHC Nurse Practitioners need to be trained in IMCI SCM. However there has been a fairly high attrition rate of IMCI trained nurses (at least 15 since 1999 when training started). In order to mitigate the negative effects of this in the future 3-4 SCM courses will be held by September 2003. Next course 18th November.</p> <p>There will be particular focus on the PHC Nurse Practitioners in the Estcourt Sub-district and the mobile teams.</p>

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
<ul style="list-style-type: none"> To train IMCI supervisors <i>Indicator:</i> 80 % of Supervisors Trained in IMCI supervision by end of project 30% of Clinic Team Leaders trained 	Yes	100% of PHC Coordinators are trained in SCM & as IMCI supervisors. 9 Team Leaders are trained as IMCI Supervisors ~ 17%. Plan: 1 more Supervision Course in 2003, focusing on Team Leaders of the bigger clinics.
<ul style="list-style-type: none"> District Supervisors' Meeting 	Yes	3 District Supervisors' Meetings held in the last year.
<ul style="list-style-type: none"> IMCI participants (health facilities trainees) will have 1st follow-up supervisory visit within 6 weeks of training and thereafter once every 4 months <i>Indicator:</i> 70% of IMCI participants followed up within 6 weeks 	No	Only 40 IMCI PHC practitioners supervised in the last 4 months ~ 40%. All supervisors are aware of the need to do more supervision. The plan is to visit 5 IMCI practitioners in each municipality each month A summary of the reports will be sent to the IMCI manager at the end of every month.
<ul style="list-style-type: none"> Every facility will have a Referral system in place 	Partial	<ul style="list-style-type: none"> Referral system in place between clinics and hospitals Referral system for CHWs and clinics in place in Okhahlamba
<ul style="list-style-type: none"> To undertake IMCI Health Facility Assessments 	Yes	Health Facility assessments are conducted as part of regular supervision visits
2. Community IMCI (both the acronyms IMCI HH/CC and C-IMCI are used in community IMCI): Training		
<ul style="list-style-type: none"> ◆ To train CHF and CFFs in PLA <i>Indicator: 80% Of CHFs & CFFs trained</i> 	Yes	100% of original CFFs have been trained in PLA. 4 new CFFs still to be trained. 4 out of 5 CHFs have been trained in PLA
<ul style="list-style-type: none"> ◆ To train CHF & CFFs in IMCI HH/CC ◆ <i>Indicator: 80% Of CHFs & CFFs trained</i> 	Yes	All CHF and CFFs (100%) have been trained in IMCI HH/CC
<ul style="list-style-type: none"> ◆ To train CHWs in IMCI HH/CC <i>Indicator:</i> 80% of CHW trained 	Yes	65% of total (320) CHWs trained. 100% of CHWs trained in Ndaka, Mbabazane and Okhahlamba. Training of CHWs ongoing in the remaining municipalities of Mnambithi and Mtshezi.
<ul style="list-style-type: none"> ◆ To train CHC in IMCI HH/CC <i>Indicator:</i> Originally 50%, but new target is 90% of CHCs will be trained in HH/CC. 	Yes	CHC in 35 out of 67 Wards in uThukela District have been trained. Data Base is currently being compiled. See Annex 1.
<ul style="list-style-type: none"> ◆ Breast Feeding Counselling Course – uThukela District 	Yes	Course successfully facilitated by Dr Felicity Savage. Training of 5 Breast

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
<p><i>Indicator:</i> A 2-week Breast Feeding Counselling Course. This will support CB breastfeeding groups and the 1st KFP of the HH/CC</p>		<p>Feeding Trainers from uThukela District and 3 Dieticians from KZN. Training of 24 CHWs and Health Facility Sisters in Breast Feeding Counselling. <i>Plans:</i></p> <ul style="list-style-type: none"> ◆ Further training courses for Trainers to build a solid team ◆ Improving skills of B/F Participants presently trained. ◆ Extending training in B/F Counselling to CHF, CFF, CHW and Lay Counsellors in PMTCT programs
<ul style="list-style-type: none"> ◆ To train EHOs, EHO ASOs and Nutritionists in IMCI HH/CC 	Partial	<p>50% Environmental ASOs are trained in IMCI HH/CC Plan: Discuss with the EHOs how to be better integrated into the HH/CC</p>
<ul style="list-style-type: none"> ◆ To hold Workshops with Traditional Healers on IMCI HH/CC <p><i>Indicator:</i> 30% of registered Traditional healers will have participated in IMCI workshop by Sept 2003.</p>	No	<p>Nil participated despite approaching the Traditional Healer Organisation. Plan to approach Traditional Healers again; tools are now available, viz. Family Booklet for Child Health and IMCI video.</p>
3. Communication Strategy		
<ul style="list-style-type: none"> ◆ To develop a Communication Strategy for IMCI HH/CC 	Yes	
<ul style="list-style-type: none"> ◆ To develop a Communication Package of supportive materials with relevant messages for IMCI HH/CC <p><i>Indicator:</i> 75% of households in the uThukela District to have a copy of the Family Booklet by Sept 2003 100% of CHWs to use Flip Charts for Health Education</p>	Yes	<ul style="list-style-type: none"> • Package complete except for Flip charts and posters. • The Training Module around 16 KFPs is complete and at the printers. • The Family Booklet was field-tested and revisions made, mainly in the Zulu translations. • A training video for training community-based health is now complete. This must be translated into Zulu.
<ul style="list-style-type: none"> ◆ To document and disseminate lessons from IMCI pilot sites 	Partial	<p>A draft document is being developed by the District Medical Officer for implementation and communication of the IMCI HH/CC at the District level. See Section 2.2.2 also.</p>

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
4. Monitoring & Evaluation of IMCI HH/CC		
<ul style="list-style-type: none"> ◆ To monitor and evaluate the impact of IMCI HH/CC in the pilot sites <i>Indicators: Key indicators yet to be defined.</i> 	Yes	<ul style="list-style-type: none"> • Draft guidelines on how to develop a M&E framework are being compiled • All fieldwork is now complete. • An analysis will be completed by the end of October 2002 • The M&E Framework with the revised guidelines will be completed by the end of November • The evaluation of C-IMCI will be undertaken during the Final Evaluation of the TDCSP.
5. Implementation of IMCI HH/CC (Roll out)		
To implement the specific IMCI HH/CC strategies from pilot sites in the rest of the uThukela District	Partial	Training of Health Committees has started in all the four rollout municipalities. Developing and implementing a plan for IMCI CC/HH using a behaviour change approach.

2.1.3.2 Responses to MTE Recommendations

The mid-term evaluation team in reviewing the IMCI component of the TDCSP set priorities for the recommendations that would most likely expand the IMCI component into critical areas (particularly the community).

MTE RECOMMENDATIONS	RESPONSE
1. Training: to increase access to high quality care for children at health facilities and in the community: Shift resources to where there is the greatest need for training Community Health Workers (CHWs).	
<ul style="list-style-type: none"> • Provide training and supervision, urgently, of all CHWs who have not been trained since 1993. • To ensure that CHWs can perform their critical roles in promoting child health, focus CHW training on the 16 Key Family Practices, before conducting training on other areas, until all CHWs have taken this course and have been supervised in follow-up visits by their CHF. This will require negotiation with other partners involved in training CHWs. 	<p>This is a high priority. Training in Okhahlamba, Ndaka and Mbabazane municipalities is underway. The training is focuses on:</p> <ul style="list-style-type: none"> - the Family Booklet - the IMCI HH/CC Training Module around the 16 KFPs; and - the IMCI video.
<ul style="list-style-type: none"> • Use a team of well-trained and experienced CHF from the Bergville area to train and mentor CHF in new areas for six months of a CHW 	Three CHF are undertaking training as professional Nurses and are lost to the district as CHF. This has impacted negatively on the project. New momentum in training and

MTE RECOMMENDATIONS	RESPONSE
training cycle, providing intensive support especially at the beginning to ensure quality.	supervision of CHWs in partnership with PPHCN is required. This momentum will need to be supported by the DoH District Manager. The work of the CHWs is a good way of institutionalising the HH/CC and will provide sustainability after the TDCSP project ends.
<ul style="list-style-type: none"> • Provide the necessary materials for CHWs to carry out their tasks, including TALC weighing scales and <i>Family Booklets</i>, and train them on how to use them in their health promotion activities. 	<ul style="list-style-type: none"> • The training module is now being formally printed as a UNICEF document and is currently at the printers. • The Family Booklets are now widely available in Zulu and English. • The TALC scales have arrived for use in the whole district.
<ul style="list-style-type: none"> • Initiate a five-day IMCI course for doctors and senior management to orient them on the IMCI strategy and approach to case management. 	There is not enough training capacity in the District for this at the moment.
2. Supervision: to protect our investment	
<ul style="list-style-type: none"> • Strengthen supervision from top to bottom <ul style="list-style-type: none"> ➤ Revitalize the skills of PHC coordinators and supervisors through: <ul style="list-style-type: none"> - the planned quarterly meetings, - reviewing quarterly supervisory reports to identify strengths and weaknesses, - creating supervisory teams to focus on the weakest health facilities, - sending supervisors to other areas, as needed, and - identifying ways for supervisors to receive periodic review exercises on IMCI and supervisory skills 	<ul style="list-style-type: none"> • 19 IMCI Supervisors have been trained¹. These include all 5 PHC Coordinators (PHCC) who are the official supervisors, as well as 4 of 5 of the PHC Trainers. The others trained are Team Leaders of the Clinics. • A supervision plan has been formulated and distributed to all Supervisors (see section 2.1.3.4 below). This plan includes;- <ul style="list-style-type: none"> ➤ 5 supervisory visits per month per municipality ~ 25 visits per month; ➤ Monthly submission of summary forms by the PHCCN; ➤ Amalgamation of these reports by the IMCI manager (was Dr. Kerry and is now Sr. Buthelezi) at the end of every month; • Quarterly meetings of IMCI supervisors held during Nov 2001; March 2002; August 2002)
<ul style="list-style-type: none"> • Shift emphasis from training of primary health care workers to supervision of PHC health workers already trained. • Provide the support for supervisors to carry out regular supervision, including transportation and releasing them from more peripheral meetings and training. 	<ul style="list-style-type: none"> • A recommendation made in the MTE was to slow down on IMCI Case Management training of PHC Nurse practitioners and to focus on Supervision and Support (S/S). • This advice was followed and the course planned for February 2002 was cancelled so that the District IMCI Supervisors could concentrate on S/S. Two other Case Management Courses were cancelled during 2002. Case Management Courses

¹ The TDCSP IMCI Intervention Leader (who is also the District Medical Officer) reports that this is more than any other district in the Province and possibly the country.

MTE RECOMMENDATIONS	RESPONSE
	<p>were held in Ladysmith in April and in Estcourt in May. There will be a final SCM Course in Ladysmith on 18th Nov 2002. Therefore in comparison to calendar year 2001, where we ran 5 IMCI SCM Courses, we will have run 3 courses in calendar year 2002.</p> <ul style="list-style-type: none"> • A new supervision system has been put in place: more frequent supervisory visits and a formal reporting system.
3. Linkages within the community: to expand and strengthen support for child health	
<ul style="list-style-type: none"> • Expand IMCI community strategies and messages to other community structures. Work with community groups to increase their participation and involvement in improving the health of their children. 	<p>This is being done through the CHWs, CHFs and CFFs</p>

2.1.3.3 Other Achievements

- Overall success of IMCI

The HH/CC has been a tremendous success for a number of reasons:

- Good well trained and active CHWs with community participation;
- Good partnership between the project on the HH/CC and TDCSP; and
- Good research and useful tools developed.

The continuing work on the role of the CHW has been an excellent example to the rest of KZN of the potential of the CHWs. The HH/CC training module has been accepted by DoH as the provincial CHW training manual for Child Health. The outcome is that the Family Booklet and Module are to be used throughout KZN and South Africa. This will be a critical scale up for the project. People from the project are already doing training in HH/CC in three other provinces in South Africa.

- LQAS

The work on LQAS has stimulated interest in LQAS in DoH at both provincial and national level. See section 2.2.2 for further discussion.

- Community Monitoring and Evaluation Framework

The IMCI project has achieved significant progress towards developing a community focused monitoring and information system. See section 2.2.2.3 for a full discussion.

- Breastfeeding

Dr Felicity Savage facilitated a two-week Breastfeeding Counselling course. Five Breastfeeding Trainers from uThukela District, as well as three Dieticians from KZN were trained. Twenty-four CHWs and Health Facility Sisters were also trained. This will support community based breastfeeding groups and the 1st KFP of the HH/CC

Plans:

- Further training courses for Trainers to build a solid team.
- Improving skills of B/F Participants presently trained.

- Extending training in B/F Counselling to CHF, CFF, CHW and Lay Counsellors in PMTCT programs.

2.1.3.4 Constraints and actions during the reporting period

- Constraint 1: There are currently insufficient Nurse Facilitators.

Action: The DoH PHC Trainer for facility staff, Sr Buthelezi, is now qualified to train Nurse Facilitators. A course to train additional Nurse Facilitators, especially PHC Trainers, is planned for December 2002.

- Constraint 2: Insufficient IMCI supervision is taking place. IMCI Supervisors have a range of responsibilities of which IMCI supervision is one. It is possible that, as a result of the demands placed on them, they have failed to prioritise IMCI supervision adequately. Further, there is a perception that supervision is a form of 'policing' staff members, rather than supporting them.

Action: A supervision plan has been formulated and distributed to all Supervisors. The DHMT has been asked to ensure that reports are delivered to the DoH PHC Trainer at the end of every month. The use of the 12-page IMCI Supervision pack that was developed in the district has been very useful as it has standardized the forms used in the Supervision visit.

- Constraint 3: Problems between the Service Provider PPHCN and the DoH district management have led to a delay in training of CHWs in all CSP interventions. NPPHCN was appointed by the Provincial DoH to manage the training of the CHW programme in the uThukela District. Conflict arose when the training programme failed to adequately address CSP interventions, which are also DoH district prioritised interventions. As a result, the official DoH PHC training did not produce CHWs with adequate training in CSP interventions.

Action: In July 2002 a meeting to discuss the situation was held between the uThukela DoH District Manager, the TDCSP Manager and the CEO of PPHCN. It was agreed that once the CHWs have passed the exam for the generic CHW training course (13 modules), CSP could do in-service training of health workers according to district priorities. Since July 2002, TDCSP has had access to train 278 out of 320 CHWs. Through further negotiations with Provincial DoH CH directorate and NPPHCN it was decided to include IMCI HH/CC in the provincial CHW training curriculum. The provincial training programme subsequently adopted the module designed by TDCSP and uThukela District DoH. As a result, all health workers throughout the province of KZN are now being trained in IMCI using the material developed by TDCSP.

- Constraint 3: Delay in printing of the following tools;-
 - The Module for training Community Based Workers;
 - The printing of the Family Booklet;
 - The development of the IMCI training aid to SCM video.

Action: This issue has now been resolved. The tools are available on request.

- Constraint 4: There has been a delay in engaging with Traditional Healers, despite efforts to engage through the provincial Chairperson of the Traditional Healers Association.

Action: The tools and modules for training now exist. These will be used in approaching Traditional Healers during the coming year of operation.

2.2 CROSS-CUTTING APPROACHES

2.2.1 CAPACITY BUILDING

The capacity building program identified four main goals, namely;-

- DMT + Health forums and CHC to effectively participate in the management of health services and co-design new initiatives
- To improve the health and well-being of children under 5 and their mothers
- Share lessons learned with other ADPs in WVSA cross-project visits
- Health Messages: Promote locally adapted best practices in health messages for IMCI, HIV/AIDS and MCH

2.2.1.1 Progress towards objectives

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
Goal1: DMT + Health forums and CHC to effectively participate in the management of health services and co-design new initiatives		
1. District Manager and District Management Team to review and plan for health priorities put forward by MHF	Partial	District Health Priorities have been defined by the DMT with municipalities designated as best practice areas, but this has not been done in consultation with MHFs as these are not yet in place.
2. Finalize training package for Municipal Health Forums + Community Health Committees	Partial	The training package has been finalized for the CHC, with PPHCN/KZN defining the legal aspects and contractual supervision responsibilities. TDCSP defined the technical modules for the IMCI HH/CC, MCH, and HIV/Well-being.
3. Train 5 Municipal Health Forums + Community Health Committees in committee skills, PLAs, networking, resource mobilization, use of HMIS	Partial	Only Okhahlamba has a municipal health forum in place. The other 4 municipalities are still finalizing their structures. CHC participation in defining "well-being" and "at risk" has happened. Training of CHCs in the IMCI HH/CC and MCH has occurred in 3 of 5 municipalities. LQAS feedback is still to occur in Nov 2002.
4. Facilitate the transfer of the 200 DOH-funded CHWs in uThukela District from Valley Trust to TDCSP	Partial	<ul style="list-style-type: none"> • uThukela District Health Forum (TDHF) was registered as a legal entity on 19 September 2002. It is now possible to transfer the management of the CHW program

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
		<p>from PPHCN KZN to uThukela District Health Forum in partnership with TDCSP.</p> <ul style="list-style-type: none"> The Provincial DOH contract to PPHC/KZN for the CHW program in uThukela District has been renewed until March 2003 in order to sort out the CHWs officially on the data base. TDCSP in partnership with the TDHF is the NGO of choice for the hand over of this program.
5. - DMT to mentor PHC Coordinators in facilitating intersectoral collaboration in PLAs, health service delivery, and effective mentoring of staff	Yes	Supervision in all DOH priority areas is being tracked by the DMT during monthly meeting with program coordinators and PHC coordinators.
Goal 2: To improve the health and well-being of children under 5 and their mothers		
1. Training and mentoring of facility staff, CHCs/ CHWs giving correct health education and in the collection and use of data	Partial	CHC, and CHWs are being trained in the KFPs and in the indicators being used to track the use of health messages in surveys. The data collection tool for CHWs monthly data collection is being distributed as part of the CHW IMCI in-service training in growth monitoring and promotion
2. Mentoring all staff, including CHWs in client-centeredness and technical competence	Yes	Supervision for technical competence in facility staff has improved in IMCI and MCH in the past year. Due to the shortage of CHFs, and their heavy training schedule, little supervision of CHWs in the field has occurred. This is a priority for FY2003 now that most 278 of 330 CHWs have completed their basic training.
3. Co-design content of training package for CHCs with the TDHF	Yes	The content of the CHC training was designed in response to the needs defined by the CHCs, and the TDHF,
4. Train CHCs to become effective communicators of key health messages and danger signs	Yes	The interactive training of CHCs in the HH/CC of IMCI and MCH, in the modules most appropriate to their communities, is equipping them to be effective communicators
5. To build capacity of CHC to manage, supervise support CHWs and HBCs to sustain key health messages and practices	Yes	The CHC Management module designed by PPHC/KZN equips the CHCs with these skills
6. Train CHF to train and mentor CHWs and CHCs in	Yes	All CHFs have been trained in the IMCI and MCH messages. Training in the

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
technical aspects		HIV/Well-being messages will happen now that they have been finalized.
7. Train CHWs to become effective communicators of key health messages and danger signs	Yes	CHWs are being trained to “learn to listen to mothers” as part of their in-service training In-service trainings also focus on the key messages of the 3 technical interventions. CHWs in 3 of 5 municipalities have received in-service in HH/CC of IMCI and MCH
8 Train and equip CHWs to implement referral protocols	Partial	This is happening in Okhahlamba only. The next series of in-service training will address referrals. Attention also needs to be given to establishing the referral system through the PHC-C, in each of the other 4 municipalities.
Goal 3: Share lessons learned with other ADPs in WWSA cross-project visits	Yes	Jane Adar has been employed by WWSA as their Health Co-ordinator, TDCSP pays 25% of her package. She is responsible for this Goal and has initiated health interventions in several other ADPs since her March 2002 appointment.
Goal 4: Health Messages Promote locally adapted best practices in health messages for IMCI, HIV/AIDS and MCH	Yes	The HH/CC of IMCI has co-designed health messages for several of the 16 key family practices in the 2 pilot sites including discussing care seeking behaviours, and community definitions of Well-being and at risk for children < 5yrs of age.

2.2.1.2 Responses to MTE Recommendations

MTE RECOMMENDATIONS	RESPONSE
Goal1: DMT + Health forums and CHC to effectively participate in the management of health services and co-design new initiatives	
<ul style="list-style-type: none"> Convene, under the Learning Site, a Local Government (LG) DoH Study Group of approximately 10 persons (5 LG/ 5DoH) to review current worldwide attempts in decentralization to link local government and DoH efforts to improve people's health 	This has not progressed. See Section 2.3.1 <i>Facilitate linkage between Local Government and DoH</i>
<ul style="list-style-type: none"> Shift Project Management to a new Intersectoral Transitional Management Team (Local government, DOH, Welfare, Education, WWSA/TDCSP), with 	The strategic level project management has remained with the DMT District Manager, the WWSA Operations Director and the TDCSP Manager. Welfare and Education and Local Government are engaged with at intervention

MTE RECOMMENDATIONS	RESPONSE
district-wide representation	level within municipalities. (See also above)
<ul style="list-style-type: none"> • Compile a database in each municipality of community institutions in the district (churches, NGOs, people's organizations, etc) and community based workers that could support behaviour change activities after CS project ends; + explore ways to build capacity of these community institutions to support child protective behaviours after CS project ends 	<p>A data base is being compiled by the Community Office Administrators (TDCSP staff) at municipal level of community institutions in their municipality, their activities and contact details.</p> <p>It is planned that the HBCs will be trained in the HIV/well-being messages in each municipality. Rollout of the IMCI messages and MCH will also be considered after the full complement of CHCs, and CHWs have been adequately trained and are being coached/mentored</p>
Goal 2: To improve the health and well-being of children under 5 and their mothers	
<ul style="list-style-type: none"> • Strengthen community component in the Ladysmith and Estcourt areas; use Bergville as training site. 	<p>The CHF and CFF of Okhahlamba have been supporting the rest of the CBHP teams in the other 4 municipalities in the IMCI/MCH in-service training of the CHWs, and the training of the CHCs.</p>
<ul style="list-style-type: none"> • CSP should convene regular meetings with local and municipal governments so as to keep these officials informed of activities, as well as to remain informed about changes in administrative structures and/or responsibilities among key stakeholders. 	<p>The CBHP CFF holds meetings with municipal councillors. The COA also attends Local Government meetings relevant to CSP interventions. It is planned to have an official meeting with each of the municipal governments every 6 months to report on CSP progress in that period. Stakeholder meetings are also attended by the COA at municipal level and reported on at team meetings.</p>
<ul style="list-style-type: none"> • CSP should be actively involved in the "integrated development process" (IDP) of each of the municipalities in which it works. 	<p>The COA is responsible for obtaining a copy of each IDP document and ensuring that CSP activities align with local government priorities.</p>
<ul style="list-style-type: none"> • CSP should enhance the capacity of all the health structures within a community through cross visits, forums and workshops within and among these communities to address specific issues, 	<p>Due to the emphasis on training of CHWs and CHC in the past year, cross site visits were not possible except for subdistrict health forum members visiting each others sub-districts and the CBHP teams working in each others municipalities. These are being planned for 2003</p>
<ul style="list-style-type: none"> • Create a position for a Community Development Coordinator to lead the process of strengthening links with municipalities, facilitate community-led activities in support of CS interventions and achieve better integration with local government plans. 	<p>A Community Development Coordinator was employed and is managing the team of CFFs and COAs. She has done remarkable work in team building and developing the training capacity of these project staff members. The large number of CHCs trained in the last 3 months is largely due to her competent leadership of this team</p>
<ul style="list-style-type: none"> • Strengthen supervision of CHWs and CHCs 	<p>In 2003 a competency tool will be developed to assess the knowledge and skills of the field team in order to address training and coaching gaps</p>

2.2.1.3 Other Achievements

- *Support Messages:* Trainers identified a need for the support messages to go together with the KFP16 in order to enhance understanding the actions that communities could take to shift context. This was done and the support messages have generated great discussions with the communities. Feedback at evaluation time in each CHC training session is encouraged in the form of role-plays together with songs and poems. This proved a very effective evaluation methodology; as described below.
- *Training the CHCs: some experiences:* Commencing training with KFP16, focusing on the role of men in the family, contributed to this message being depicted in almost all the role-plays. Although this KFP somewhat clashes with Zulu culture, trainers portrayed the need for shifting the mindsets of their communities. This result was quite powerful.

CHC trainees showed overwhelming interest in breastfeeding. The use of the breastfeeding booklets on exclusive breastfeeding for the first six months of life and what to do when not at home to breastfeed proved quite effective in delivering KFP1.

A trainee by the name of Mr. Mchunu from Outer-West Ladysmith actually came forward at the end of training to request help in forming a men's support group on breastfeeding.

A lady from Indaka recited a wonderful poem on breastfeeding, encouraging early initiation of breastfeeding, the advantages of colostrums especially as a slight purgative to remove meconium as opposed to using 'umfula'. 'Umfula' is a Zulu word used for glucose water usually given as a prelacteal feed in order to 'clean out' meconium. She also discouraged the use of 'umuthi wenyoni', this is a traditional herb that is administered orally to clean the baby's stomach.

A spontaneous group of school children (boys from a local primary school called Gabangemfundo) emerged and asked to join the evaluation process. It was breathtaking when, after they had been spectators for a while, they just went on stage and performed an impromptu song on breastfeeding and its advantages.

- *Quality of training:* The Maternal Health Coordinator was impressed with the quality of training. She requested a copy of the module and she suggested that she was going to make copies of the first two pages of the module and these would be displayed in all the clinics. The first two pages KFP 16 and 15 and the relevant support messages

In order to sustain the high standard of training, and the quality of content, the following recommendation has been discussed with the trainers: in future continuous training sessions for the training team should be maintained. This will be done at least fortnightly in form of a role-play. Each trainer will handle a session on a KFP, prepare thoroughly for it including visual aids, and deliver the message to the group of trainers. Constructive criticism will follow. Specialists on the subject will be invited for comments.

2.2.1.4 Constraints

- Insufficient Community Health Facilitators (CHF)

The CHFs are tasked with training and supervising CHWs and interacting with all community structures and clinics. The optimal ratio is 1 CHF:25 CHWs, however it has been difficult to achieve this due to the high turnover of CHFs. Of the nine CHFs appointed to date, four have left the programme, either through resignation or to further their education. There are therefore insufficient CHFs available to supervise the 320 CHWs. This leaves the remaining 5 preoccupied with the training of CHWs, resulting in very little if any mentoring/supervision support of CHWs during household visits.

The DMT and the new provincial Director for the Provincial DOH CHW program are looking, among other possibilities, at upgrading the CHF position possibly to that of a Professional Nurse, in order to be able to keep committed staff in the program and allow them a career path within the Health Services.

- Too little supervision of CHWs:

Hopefully when the issues above are addressed this constraint will also be addressed. Supervision is critical to bring home the learnings in the classroom and to ensure that CHWs are having quality interactions with mothers and caregivers at household level.

CHWs are spending too much time in training sessions and too little time in the community. However, now that 278 of 320 CHWs have passed their Provincial exams, the community work and home visits will be the focus. Emphasis is on the DOH/TDCSP interventions.

2.2.2 HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)

The goal of the facility based DIS is the “development of a flexible District Information System (DIS) that is able to deliver accurate, current and integrated information, and give constant feedback to all levels and sectors, enabling decision making for quality of care”.

The overall HMIS objectives are grouped under the headings of:

- capacity development²;
- performance of the health information system;
- development of indicators for wellness; and
- information systems development for project interventions.

These objectives are similar to those of the Department of Health DIS objectives. Therefore progress towards the attainment of the objectives cannot be attributed solely to the TDCSP. However, the foundation for the development of the DIS took place through the first phase of TDCSP. In turn, the training of the CHWs has provided potential for the basis of developing a community information system (Storms, 2001c, p1).

Consequently, since the mid-term evaluation the HIMS project has been divided into two focus areas. Firstly, the facility based DIS managed by the DoH and secondly, the

² Capacity building gives the impressions that people are “empty vessels”. Capacity development will be used throughout this report to imply that we are developing the skills and knowledge that people already have (Storms, 2001c, p1).

Community Based Information System being developed by TDCSP. The present focus is on the development of an M&E framework for the HH/CC component of IMCI, with emphasis on community definitions of 'well-being' and 'at risk'. This information will be integrated into the DIS.

There have been two significant developments through the project since the mid-term evaluation. The first has been the LQAS training held in February 2002. This training targeted both district DoH and TDCSP staff. The training included the theory of LQAS, questionnaire/instrument design for the fieldwork and collecting data, followed by hand-tabulated analysis of the data (see Annex 6). The LQAS put in place a completed quantitative base-line for all technical interventions.

The second development in HMIS was the formulation of a monitoring and evaluation framework for the HH component of IMCI.

Progress towards the development of the Community Based Information System is reported in Section 2.2.2.1, which follows.

2.2.2.1 Progress towards objectives

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
1. Capacity development		
<ul style="list-style-type: none"> Providing training and input from HIS consultants, where necessary. 	Yes	See Section 2.2.2.3 LQAS
<ul style="list-style-type: none"> Assisting community organisations, committees and health forums in exploring and defining their information and research needs. 	Yes	In terms of defining information for holistic child development, focus group discussions and meetings were conducted to explore the meaning of 'well-being' and 'at risk' and how to measure them. Possible actions resulting from this information were discussed (see also section 2.2.2.3, below). As a result of this research, an understanding of the community perspective of childhood development was obtained and a minimum set of indicators established.
<ul style="list-style-type: none"> Assisting various sectors of the health department in exploring and defining their information and research needs. 	Yes	Facility staff and IMCI project staff were both included in the research clarifying the meaning of 'well-being' and 'at risk' children. Information needs (indicators and feedback mechanisms) were explored. Inclusion of this information into the DIS will be addressed in November 2002.
2. Performance of the health information system		
<ul style="list-style-type: none"> Assist in developing and strengthening the information flow between various spheres of service provision, particularly between the 	Partial	Research included identification of role players who could act to improve or maintain a child's development. Although health service personnel did feature strongly, the community adopted a multi-

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
community based programs and the facility based services		sectoral view. Thus early childhood practitioners, community forums and social workers featured prominently as key people who would need information on the population less than 5 years of age. These role players will be included in a revised information flow.
<ul style="list-style-type: none"> Facilitating the increased use of information in decision making by jointly analysing the information presented and linking it to the decision-making process 	Partial	By exploring information needs with community members and government officials and identifying who can take action based on this information, it is hoped that once this information is received by those members of the community then decisions affecting the status of children (0-5 years) will be made.
<ul style="list-style-type: none"> Developing a total quality management (TQM) approach, which is information-based and strengthens the link between information and decision-making. 	No	
3. Development of indicators for wellness		
<ul style="list-style-type: none"> Assisting in developing the new indicators and measurement methods that are in line with the new paradigm for wellness in a holistic sense. 		Various perspectives on the meaning of well-being and at risk were obtained through interviews and focus group discussions with community health workers, parents and care givers, community health committees, early childhood practitioners, social workers, traditional leaders, councillors and CSP staff. Measures on holistic child development were obtained that would assist in measuring progress towards the communities vision of holistic well-being for their children. These measures will be incorporated into the DIS.
4. Information systems development for project intervention		
<ul style="list-style-type: none"> Helping to develop the plans and define indicators for the 3 interventions and link these to service provision 	Yes	See Section 2.2.2.3 below.

2.2.2.2 Responses to MTE Recommendations

MTE RECOMMENDATIONS	RESPONSE
1. Capacity development	
<ul style="list-style-type: none"> Capacity development to move from a data culture to an information culture: There is the need for 	WVSA held a workshop on use of the Log-frame for programme implementation and monitoring. This was helpful in formulating

MTE RECOMMENDATIONS	RESPONSE
<p>capacity development with managers, within the district and within TDCSP, around use of information and indicators for management and learning.</p> <ul style="list-style-type: none"> • Within the project interventions the first step should be achieving clarity on the information needs for the project interventions and then a system to support those needs to enable vision to be translated into measurable objectives. • Clear indicators for the impact of Transformational Leadership and the measurement of well-being could be developed as pilot projects in Okhahlamba and would need to be measured separately • Key indicators that programme managers and community leaders are interested in, must be reported on in the quarterly and annual reports. The format of the feedback would need to be appropriate for the intended audience 	<p>the deliverables for the CSP, with input, output and outcome indicators.</p> <p>The LQAS has put in place complete base-line against which outcome will be measured at the end of the project. With the TD programme a results based measurement framework has been developed.</p> <p>See Section 2.2.2.3, below.</p> <p>Key indicators and feedback mechanisms for this data were obtained through the research on understanding and measuring well-being and at risk. Key role players and sectors to be included in the information flow were discussed Use of the Log-frame has clarified the key indicators that must be tracked through reporting to the various audiences.</p>
2. Performance of the Health Management Information System	
<p>Development of an integrated DIS: The use of a systems approach to the DIS should be used in determining what different people want from an information system and in the development of a minimum data set that will inform and fulfil the data and information needs of health managers in the district and within the project.</p>	<p>In determining a common understanding of 'well-being' and 'at-risk', various changes in the DIS are proposed. These changes emphasise a multi-sectoral approach, based on the community's holistic attitude towards child development. Thus a DIS that addresses the information needs of role players from community forums, early childhood development, social development and local government is envisioned.</p>

2.2.2.3 Other Achievements

- Lot Quality Assurance Sampling (LQAS)

LQAS was implemented during the reporting period. The objectives were to:-

- fill gaps in the project baseline data and enable the aggregation of data across five supervision areas (municipalities), giving coverage estimates for each indicator for the whole project area (uThukela District), as well as for each municipality;
- set targets for each key indicator, in each municipality and for the whole project area;

- compare data collected against key indicators in five municipalities to determine which interventions had acceptable levels of coverage and which were performing below expectation. As result, determine the priority interventions and municipalities where resources have to be focused; and
- simultaneously monitor the pilot municipality where the first Child Survival Grant was completed and the four new municipalities targeted during the follow-on Child Survival grant.

Survey tools were designed for three client populations, namely women of reproductive age (15–49 years), mothers of children age 0–11 months and mothers of children age 12–23 months. A parallel sampling methodology was used. Twenty-four interviews for each client population were completed in each of the five municipalities, resulting in a data set of 120 for the whole district. For the pilot area (Okhahlamba) the client population for mothers of children age 0-11 months was reduced to children age 0-5 months to ensure good data on exclusive breast-feeding.

The data was hand tabulated by the survey team, targets were reviewed and adjusted and an action plan was co-designed with relevant stakeholders.

Results showed that with LQAS, data could be collected within each municipality for each intervention. This could be aggregated for coverage estimates of the whole district. Municipalities and interventions that were performing below expectation could thus be prioritised for focused attention and resource allocation. Further, the results show that it is possible to monitor the pilot area to see if it maintains its coverage in key indicators, as measured at the end of the initial Bergville Child Survival Project, while emphasis is given to the new roll out areas.

A comprehensive LQAS report will be submitted separately.

- **Community Monitoring and Evaluation Framework**

The IMCI project has achieved significant progress towards developing a community focused monitoring and information system. More than twenty-five interviews, focus group discussions and meetings were conducted. These targeted mothers, grandmothers, fathers, teenage mothers, social workers, Early Childhood Caregivers, Traditional Leaders (Amakosi and isInduna), Community Health Committees, CHWs and Health Facility staff.

The objective of the Focus Group Discussions and interviews was to determine the following:-

- The meaning of children ‘at risk’ and in a state of ‘well-being’;
- how to measure these terms; and
- to identify the duty bearers/stakeholders who can act based on this information

As a result of these interviews and focus group discussions, greater clarity on the community meaning of meaning of ‘well-being’ and ‘at-risk’ was obtained. In addition measures/indicators of well-being and at-risk were formulated and key role players who can make effective decisions were identified.

A manual on the process undertaken in the development of this monitoring and evaluation framework for IMCI HH/CC, has been developed in draft form. The purpose of the manual is:

- to share the TDCSP experiences with other districts in South Africa and beyond our borders;
- to assist other districts in carrying out a similar process if they so desire; and
- to receive comment and advice from others with experience in this area and to learn from their input.

The research in IMCI will assist in the development of a community monitoring and evaluation framework. The primary objective of collecting information is to assist community members in their decision-making. On a secondary level it should also help project managers to use information to make good decisions and to report progress to other key stakeholders, including donors on their contribution to the situation. It is therefore envisioned that the community monitoring system will help caregivers and community members:

- manage childhood illnesses better and better attain a state of well-being for their children;
- learn from their, and other peoples, experiences
- make decisions and claim their, and their children's rights by holding duty bearers accountable.

2.2.2.4 Constraints

District Information Officer was promoted out of the District due to her good work and is now responsible for the information system in three districts. The DMT has been unable to replace her. This has negatively impacted on the facility based information system as there is no responsible person in place.

The integration of community based health information with facility based health information will be an area for priority attention in the last year of the project. This will be done by intervention within best practice areas first.

2.2.3 LEARNING SITE

This was described in the TDCSP DIP as a rural "school without walls" for Rural Health Care, PHC, DHS and Family Medicine. The Learning Site will be a place for shared learning amongst service providers and community members within the District, and also with people from other regions of South Africa and internationally. This strategy requires the development of the necessary infrastructure. The learning area will be a means through which the District will move toward its vision of scaling up the decentralized DHS. The unique contributions of this Learning Site will include:

- Create a context for reflection and new learning which can be applied to practice;
- Identifying, planning and coordinating training for all levels of health worker (including training in QI, PLA, PHC, technical training in all interventions, and training for Health Forums and Health Committees);
- Coordinating and arranging follow-up mentoring after training;
- Coordinating and running training for DMTs, as well as staff from other districts and provinces;
- Documenting PLA outcomes, other learnings and best practice; and
- Organizing study visits from public health students in South Africa and elsewhere.

2.2.4.1 Progress towards objectives

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
<ul style="list-style-type: none"> To stimulate reflective practice and research activities in the district 	Partial	<ul style="list-style-type: none"> In some sections and meetings the reflection has become part of 'business as usual'. There have also been a number of attempts to reflect on direction, current practice and expectations. The changes have mostly been at management level and to a much lesser degree at service level. Through the partnership with the University of Natal, 3 research projects have started, one of which is completed by now, there is also at least 10 other research projects running in the district that are not part of the partnership. The process of a reflective practice is a 'work culture' issue and this has not yet significantly shifted. This may be an area where technical support may be useful.
<ul style="list-style-type: none"> To develop a research agenda for the district 	Yes	<ul style="list-style-type: none"> The initial research agenda that had been developed together with the University of Natal has not been reviewed yet. A review is likely with new structures that are being proposed (see also the response to the Mid Term recommendations).
<ul style="list-style-type: none"> To support people who are doing research in the district 	Yes	<ul style="list-style-type: none"> Support is being given to people that are part of the research projects from the University of Natal. Other researchers receive some support from members of the District Research Committee in the research process. While there is support for those that are doing research, there is still limited stimulation of initiating research and reflection throughout the district (especially for the service providers)
<ul style="list-style-type: none"> To review any research proposed to be done in the district (review of protocol, including ethical review). 	Yes	<ul style="list-style-type: none"> Members of the District Research Committee are reviewing all research that is proposed in the district. This is channelled through the District Office. Comments are passed on to the researchers. A problem has been identified with the Provincial Office, who at times have given permission for research to take place, without the consent from the districts, even if it involves resources that are not controlled directly by the Provincial office. The provincial office is proposing a research committee for the whole province, but the initiative in the uThukela District has up to now been left out of these developments.

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
<ul style="list-style-type: none"> To disseminate and publish the research finding (within the district and outside of the district) 	Partial	<ul style="list-style-type: none"> The research project that has been completed is preparing to publish the findings. There have also been feed-back sessions where the projects have been discussed and presented and all staff had been invited to give comments and reviews
<ul style="list-style-type: none"> To develop and maintain relationships with research institutions. 	Yes (under review)	<ul style="list-style-type: none"> The relationship with the University via the partnership that had been initiated is currently under review as a number of new developments indicate that the current modus operandi would not be sustainable for very much longer. Developments include interest from the City University of London as well as from HIVAN to develop links and research capacity development in the district. Within the current partnership arrangements, this would have no clear structures of accountability and management. This is being reviewed currently.

2.2.4.2 Responses to MTE Recommendations

MTE RECOMMENDATIONS	RESPONSE
<ul style="list-style-type: none"> Call a breakdown and take steps to realign the key stakeholders within the district, especially community partners, around a common vision of a learning site. (This recommendation has implications for the organizational relationship between CSP and the DoH, wider than just the learning site) 	The process of calling a breakdown took some time and progress has been slow, due to other commitments of the District Research Committee.
<ul style="list-style-type: none"> Institutionalise the learning site concept within the district health office, through the establishment of a research office and the appointment of a researcher. 	The limitations of setting up a learning site within the structures of the district office have become clearer as they have been unable to employ new staff for this. Therefore the possibility of an organisation outside of the formal DoH, but with strong links with the service providers and management, fulfilling this role is being reviewed. It is likely to include the current partners within the University of Natal, as well as HIVAN (HIV/AIDS Network), and possibly the City University, London.
<ul style="list-style-type: none"> Allocate appropriate funding and resources to the establishment of the district research office, including the recruitment of an appropriate researcher, with MRC and TDCSP support for "start-up" funding 	As the structural aspects of the learning site and research office were not clear, this has not been acted on. The possibility of utilizing TDCSP resources to initiate the research / learning site structures is still a possibility.
<ul style="list-style-type: none"> Give the necessary attention to the pro-active gathering of researchable 	One of the research questions that had been identified in 2000 was taken up by one of the

MTE RECOMMENDATIONS	RESPONSE
<p>pro-active gathering of researchable questions and ideas that will lead to tangible improvements in health and well-being. Particular attention should be paid to operational research on the integration of community-based strategies for well-being into the health services.</p>	<p>teams from the University partnership (investigating Drug-use amongst teenagers in the uThukela District). However, there has not been any systematic gathering or review of possible questions. This is also in part due to the relative low profile that the District Research Committee has maintained. The research agenda had not been reviewed any further, due to the lack of credible structures.</p>
<ul style="list-style-type: none"> • Pay careful attention to the balance of control over the research agenda and processes between the district and outside bodies or individuals who might use the district as a convenient site for data collection. 	<p>As indicated above, this is being addressed within the current review of the structures and responsibilities. A likely outcome is that there will be much greater accountability and participation by District role players in the development of the research agenda.</p>
<ul style="list-style-type: none"> • Plan a long-term HRD strategy to develop analytical capacity in the district over the next 5 to 10 years. 	<p>This is not in place, but will be addressed once the new structures described above are in place.</p>
<ul style="list-style-type: none"> • Consider the following indicators for monitoring the development of the learning site: <ul style="list-style-type: none"> ➤ Health workers who recognize the opportunities for learning from each other, their patients and the literature, in their working environment ➤ Health workers and community members meet regularly at different levels to reflect and learn from common experiences, in an effort to promote better health for all in the district ➤ Health practitioners who question their routine procedures and practices and seek new ways of improving health and well-being ➤ A certain proportion of health professionals engage in post-graduate study and research ➤ A certain number of scientific research projects and publications emanate from the uThukela district ➤ A certain sustainable capacity for innovation, analysis and research into priority health issues exists within the district 	<p>To be addressed through the development of the new structures.</p>

2.3 SUSTAINABILITY STRATEGY AND PHASE-OUT PLAN

The sustainability goal of the TRCSP is to effect improved well-being through creating a well-being context for leadership, operational units and individuals in which the Child Health, Maternal Health and HIV/ AIDS interventions are developed in a holistic, integrated and sustainable manner and therefore also effect a sustainable reduction in infant, child and maternal morbidity and mortality.

The project accepts SC Foster's definition of developmentally sound sustainability as "the maintenance of individual, community, NGO, health system, private sector, and governmental capacity to continue essential promotive, preventive and case management services necessary to achieve locally established targets with minimal amount of external inputs" (quoted in WVSA, 2000a, 51)

2.3.1 PROGRESS TOWARDS OBJECTIVES

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
<ul style="list-style-type: none"> An integrated CHW program and the facility services through appropriately linked training content, effective and efficient referral and information systems, and community/ stakeholder input and feedback mechanisms 	Yes	<p>The key IMCI, MCH, and HIV/Well-being training content and messages are consistent and appropriately linked throughout the CBHP and facility services.</p> <p>The Community based information system is being developed for the TDCSP interventions and will be linked to facility information in the last year of operation. Facility staff will also attend community health days.</p>
<ul style="list-style-type: none"> Establishment of an effective and efficient referral system within and outside the DOH services 	Partial	<p>A referral system between CHWs and facilities exists in Okhahlamba. The design of a referral system in the 4 other municipalities is a priority for the last year, and will form part of the in-service training for CHWs and CHCs.</p>
<ul style="list-style-type: none"> Establishment of an effective, efficient and responsive information system that gives context appropriate information 	Partial	<p>The DOH HMIS has not progressed since the MTE due to the DHIS Manager being promoted and no longer able to give attention to one district. The development of an M+E framework for IMCI HH/CC is a step forward for collecting and analysing community based information, for action.</p> <p>Attention will be paid in the pilot sites for HIV, IMCI and MCH in linking intervention specific community and facility information, as part of the best practice in each municipality</p>
<ul style="list-style-type: none"> Formulation of a transport strategy for replacing and maintaining the transport needs of the community 	Yes	<p>The District transport Officer is prepared to take over the TDCSP vehicles within the DOH transport section and leave them allocated to the work of the CBHP, once the</p>

OBJECTIVE	PROGRESS ON TARGET?	COMMENTS
component		project is over.
<ul style="list-style-type: none"> Mentoring and coaching within the TDCSP interventions 	Partial	Supervision at all levels of health service will also be a priority in the last year of the project, now that much of the training has been completed and mentoring is needed to build the new learnings into practice.
<ul style="list-style-type: none"> Establishment of functional working partnerships between communities and facilities in operational units for service delivery according to defined health priorities 	Partial	The functional partnerships with relevant stakeholders are being developed around each intervention within the municipal best practice sites for that intervention/health priority.
<ul style="list-style-type: none"> Establishment of linkages with other stakeholders. 	Yes	One of the continuing strengths of the TDCSP is it many linkages with stakeholders, partners and interested parties within and outside the district, including at provincial, national and international levels.

2.3.2 RESPONSES TO MTE RECOMMENDATIONS

MTE RECOMMENDATIONS	RESPONSE
1. Management Transition	
<ul style="list-style-type: none"> Shift Project Management to a new Intersectoral Transitional Management Team (Local government, DOH, Welfare, Education, Ministerial Alliance, WVSA/TDCSP), with district-wide representation, that beginning in December 2001, will meet regularly every other week, to;- <ul style="list-style-type: none"> Plan how the MTE recommendations regarding community and partnerships will be implemented in the next 10 months; Develop detailed plans for sustainability of valued CSP activities Transitional Team will have broad management and decision-making authority; the TDCSP Manager will have day-to-day management authority; WVSA retains budget 	<ul style="list-style-type: none"> The strategic level project management has remained with the DMT District Manager (DoH), the WVSA Operations Director and the TDCSP Manager. Welfare and Education and Local Government are engaged with at intervention level within municipalities. Work plans with Gnat charts for each intervention, addressing the implementation of the MTE recommendations were compiled. These work plans were tracked in the monthly reports by each intervention team. Expected project outcomes have been defined in terms of health worker competency and knowledge, practice and coverage of key intervention indicators at household levels. Community competence in terms of participation, in the implementation and assessment of the interventions at community level is designed into the CBHP training component. The strategic level project management with the DMT District Manager, the WVSA Operations Director and the TDCSP Manager is undertaking broad management while the TDCSP manager makes day-to-day decisions.

MTE RECOMMENDATIONS	RESPONSE
<p>authority and accountability to donor.</p>	
<ul style="list-style-type: none"> • WVUS, WVSA, and TDCSP Manager must meet to discuss how to effect transition to new inter-sectoral management team, including securing necessary approvals from USAID/BHR/PVC. 	<ul style="list-style-type: none"> • WVUS, WVSA and TDCSP met shortly after the MTE to set in place the way forward after the MTE.
<ul style="list-style-type: none"> • Create a position for a Community Development Coordinator; job is to strengthen link with municipalities, facilitate community-led activities in support of CS interventions, and achieve better integration with local government plans—in place by February 2002. 	<p>Significant progress has been made in addressing the MTE concern that shared governance of health service delivery should be strengthened in all municipalities in the District. A position for a Community Based Development Coordinator was created and filled. The co-ordinator is managing the team of CFFs and COAs. She has done remarkable work in team building and developing the training capacity of these project staff members. The large number of CHCs trained in the last 3 months is mainly due to her competent leadership of this team. The team have built very strong relationships with local government councillors at Municipal level. This has increased acceptance of CHWs within the different communities.</p>
<ul style="list-style-type: none"> • Compile a database of community institutions in the district (churches, NGOs, people's organizations, etc) that could support behaviour change activities after CS project ends; explore ways to build capacity of these community institutions to support child protective behaviours after CS project ends. 	<p>A database is being compiled by the Community Office Administrators (TDCSP staff) at municipal level of community institutions in their municipality, their activities and contact details.</p> <p>It is planned that the Home Based Care givers will be trained in the HIV/well-being messages in each municipality. Rollout of the IMCI messages and MCH will also be considered after the full complement of CHCs, and CHWs have been adequately trained and are being coached/mentored</p>
<ul style="list-style-type: none"> • Institutionalise Transitional Leadership within the DOH by creating a position for a TD Manager in the DOH; job is to "protect the investment" by training logistics, management, etc. in TD strategy – in place by March 2002. 	<p>Due to the staff shortages experienced due to nurses leaving the area and the country, the DMT has been unable to dedicate a person to this position. However DoH staff trained in TL use the tools and behaviours in their work context</p>
<ul style="list-style-type: none"> • 2. Human resources enhancement to facilitate documentation of capacity building and sustainability of staff and volunteer capacity 	
<ul style="list-style-type: none"> • Create a position for a Human Resources Manager to compile a HR data base for staff and volunteers working in this project (CHWs, CHFs, CHCs), with information on type, dates and length of trainings; location of work, supervisory visits, length of participation in CSP, average hours 	<p>A Human Resources Administrator has been appointed. She has compiled this training database, as well as a personal file containing 6 monthly performance appraisals for each staff member. The manager uses these to track individual staff member development plans and actions. (see Annex 2)</p>

MTE RECOMMENDATIONS	RESPONSE
worked etc.	
<ul style="list-style-type: none"> Maintain a database on the trainings conducted for partners in the DOH and local government, by type, dates and length of trainings, category of person trained, etc. 	<ul style="list-style-type: none"> This database is also being compiled by the HR administrator. She is however having difficulty in tracking the supervision taking place.
<ul style="list-style-type: none"> Work with the Inter-sectoral Transition Team to find opportunities for volunteer placement after this project ends for the more than 200 persons who have been trained to work in the community in this project to date. 	<ul style="list-style-type: none"> The HBC gives in the HIV/MED amendments, receive non-financial incentives and government is looking at ways to recognise their contribution. It is hoped that further opportunities for staff placement will come available from proposals being written against expansion of various aspects of the work. . The experience gained in working for the project often leads to opportunities for employment that would otherwise not occur (some staff members have left to take up 'better' employment elsewhere).
<ul style="list-style-type: none"> Work with the Inter-sectoral Transition Team to identify and build capacity of gifted staff to assume leadership positions if the senior person (manager, coordinator, facilitator) is transferred to a new area or resigns their position during the remaining two years of CSP. 	<ul style="list-style-type: none"> Each staff member in their performance appraisal identifies someone they are grooming to fill their positions if they are unavailable for duty or leave the organization. Several CSP staff members have been identified for leadership positions, due to their excellent performance commitment to their work.
<ul style="list-style-type: none"> 3. Facilitate Linkage Between Local Government and DoH 	
<ul style="list-style-type: none"> Convene, under the Learning Site, a Local Government (LGU) DOH Study Group of approximately 10 persons (5 LGU / 5DOH) to review current worldwide attempts in decentralization to link local government and DOH efforts to improve people's health Study Group will identify key issues and questions TDCSP will send a LGU-DOH pair to each of 5 different locations now experimenting with linkage to see how working The Study Group will discuss findings and possible applications to uThukela municipalities. TDCSP will produce a "state-of-the-art" report describing issues in linking local government and DOH 	<ul style="list-style-type: none"> The establishment of a Learning Site to institutionalise reflection by health service practitioners together with the community they are serving, is a novel concept. This concept has been enthusiastically embraced by a wide range of roleplayers, including the DMT, TDCSP, Thukela District Health Forum, the Medical Research Council, and several departments within the University of Natal and HIVAN. As a consequence there has been a great deal of debate on the governance structure of the Learning Site. The structure must ensure that the community voice is included in setting research and learning priorities. The role players are currently thrashing out the mechanisms and practice of the governance structure. This has caused a delay in the implementation of the Learning Site project. For this reason, and because there has been little progress in partnership with the District Local Government and the DMT, a LGU DoH study group has not been formed, and no trips have been undertaken.

MTE RECOMMENDATIONS	RESPONSE
<ul style="list-style-type: none"> • 4. Technical Assistance 	
<ul style="list-style-type: none"> • Obtain TA from a health economist to perform a recurrent cost analysis, in order to determine the money that will be needed to sustain valued activities such as refresher training, supervision 	<ul style="list-style-type: none"> • This will be done in the last year of the project after reflection on which elements of the training introduced by TDCSP must be sustained within the DOH, and which within the community component by outside funding sources.
<ul style="list-style-type: none"> • Obtain TA from a health economist to estimate costs of a basic minimum packet for -community based HIV/AIDS workers 	<ul style="list-style-type: none"> • This study has been done independently. "Providing palliative HBC to PWAs in their last year of life costs R2840/patient/year...HBC shows considerable potential to deal cost-effectively with the growing palliative care needs in the face of the AIDS epidemic, but we need to understand better the true extent to which HBC can substitute for hospitalisation" (Uys, 2002, 624).
<ul style="list-style-type: none"> • Estimate cost of a basic minimum packet for home support of families affected by HIV/AIDS (e.g., vitamin pills, universal precautions.) 	<ul style="list-style-type: none"> • This recommendation was not carried out because such support is not yet being offered neither within the DOH nor with in the project. However an independent study is available (Uys, 2002, 624).
<ul style="list-style-type: none"> • Obtain TA from experienced African health professional to design a "reduce the stigma" campaign for the HIV/AIDS pilot in Ladysmith (Okhahlamba) 	<ul style="list-style-type: none"> • "Reduce the stigma" campaign will be addressed by creating a new context where PLWA experience love and care, because among other reasons there is no stigma experienced in the new context. People are treated as unique valued individuals, who are loved and respected and who are walking with a condition, but who are not their condition.
<ul style="list-style-type: none"> • Obtain computer training for senior management in the DOH for email communications, report generation and data base management. 	<ul style="list-style-type: none"> 14 DMT and their admin staff have all received Computer training

2.3.3 GOING TO SCALE WITHIN THE UTHUKELA DISTRICT AND BEYOND

TDCSP is the follow-on program that expands activities from the Okhahlamba Municipality into the entire uThukela District. As such TDCSP extends coverage from 130,000 to 537,355 people in approximately 155 communities (Storms, 2001, 1). TDCSP represents both a scaling-up of ongoing interventions and approaches, as well as testing of new approaches within the district (WVSA, 2000b, 6).

The initial expansion goal was to rapidly replicate the following existing TDCSP activities in the district as a whole (WVSA, 2000b, 42):

- CHW program
- IMCI training for CHWs, CHCs and facilities
- Training of Community Health Committees in governance and IMCI
- HMIS – development of the community MIS
- Maternal Health program.

Since the MTE, progress has been made in each of these aspects as outlined in the tables above. Two interventions were to be piloted in selected areas and then scaled up when the pilot objectives were reached. These were the HH/CC of IMCI and the HIV/AIDS Well-being program (WVSA, 2000b, 42). The progress with the HIV/AIDS Well-being intervention is outlined in section 2.1.1.1. The roll out of the IMICI HH/CC is discussed in the following section.

OBJECTIVES AND ACTIVITIES	ACHIEVEMENTS/ CONSTRAINTS	FUTURE PLANS
Establish an IMCI HH/CC Inter-provincial Working Group Meetings every 2 months to take forward C-IMCI nationally. Sharing experiences from pilot sites with all provinces.	Development of publications to support implementation of C-IMCI Production of Advocacy Package developed by the University of the Western Cape.	Integration of M&E framework developed in KZN, into national plans
IMCI National Workshop – Karridene KZN. Participation in workshop to share experiences from uThukela District.	Presentation of LQAS in uThukela District by Dr Tim Kerry. Presentation of progress in implementing C-IMCI in Ugu District by C Gibson	
IMCI HH/CC in KZN Province as a whole. IMCI manager rolling out C-IMCI in Ugu North and Amajuba Districts Training of CHF's in IMCI. HH/CC using KFP Training Module Family Booklet at Amatikhulu PHC Training Center, uThungulu district.	Advocacy at all levels in the districts. Establishing Inter-sectoral group (Ugu) and Task Teams (Amajuba) to take C-IMCI forward. Training of PHC trainers, CHF's and CHW's in both districts.	Distributing the Family Booklet to households in both districts. Continue training CBHW's (Traditional Healers, ECD Practitioners, CHW's and HBC's).
Presentation on the Household/Community Component (HH/CC) of IMCI to doctors from Durban City Health.	Three groups of CHF's, totalling 72 people from throughout KZN trained in IMCI HH/CC. Raising awareness as to the importance of the HH/CC of IMCI.	
C-IMCI National Input. 2 Day Workshop in Free State – March 2002	Presentation of the HH/CC of IMCI to representatives from all districts in Free State province. Assisting with Action Plans to implement C-IMCI in the province.	Possibility of C-IMCI Workshop in Northern Cape province (Dr Tim Kerry).
3-Day Workshop on C-IMCI in Limpopo Province – October 2002.	Planning objectives and Agenda for workshop. Presentation of experiences from KZN.	
Breast Feeding Counselling Course – uThukela District. Organising a 2 week Breast	Training of 5 Breast Feeding Counselling Trainers from uThukela District and 3 Dieticians from KZN.	Further training courses for Trainers to build a solid team Improving skills of

OBJECTIVES AND ACTIVITIES	ACHIEVEMENTS/ CONSTRAINTS	FUTURE PLANS
Feeding Counselling Course.	Training of 24 participants in Breast Feeding Counselling from Okhahlamba municipality – 1 CHF, 8 professional nurses and 14 CHWs and 1 Nutrition SASO)	B/F Participants presently trained Extending training in B/F Counselling to CHFs, CFFs, CHWs and Lay Counsellors in PMTCT programs.

2.3.4 CONSTRAINTS

Staff turnover has resulted in an inadequate level of supervision at facility and community levels. This is a recognised constraint to sustainability as the gain in improved quality of care that should result from putting training into practice, may be lost.

The IMCI project is addressing this through the implementation of formalised supervision and reporting procedures. The DoH is investigating the possibility of up-grading the CHF post in order to offer personnel a career path in CBH. Further, the project will make use of experienced CHW as mentors of new CHW.

3 PROGRESS TOWARDS THE OVERALL MTE RECOMMENDATIONS

The MTE made a number of recommendations with broad implications for the project. These were divided into recommendations to achieve goals of Expansion, sustainability and quality of care. The goals for expansion and quality of care are discussed in the following sections. The recommendations to achieve the goal of sustainability is discussed in Section 2.3, above

3.1 RECOMMENDATIONS TO ACHIEVE GOALS OF EXPANSION BY 09/30/2003

- *Recommendation: Strategic Targeting of Expansion Areas: Intensify efforts in Ladysmith and Estcourt area in next 10 months, including:*
 - *Initiate MH and HIV/AIDS pilot in Ladysmith;*
 - *Roll out IMCI in Escort and Ladysmith; and*
 - *Strengthen community component (HH/CC) in the Ladysmith and Estcourt areas; use Bergville as a training site.*

The TDCSP expands the original Bergville (Okhahlamba) CSP to the additional four municipalities in uThukela District. The Bergville CSP was located within the Okhahlamba Municipality. The TDCSP extends operation to Mbabazane Municipality, Ndaka Municipality, Nambithi/Ladysmith Municipality and Mtshezi/Estcourt Municipality.

In January 2002 the DMT made the decision that each of the five municipalities would serve as a site of Best Practice for one of the DoH priority interventions. The DoH district priorities were thus allocated per municipality as follows:

Maternal Health	-	Mbabazane Municipality
HIV/AIDS Well-being	-	Okhahlamba Municipality

IMCI	-	Ndaka Municipality
TB	-	Nambithi/Ladysmith Municipality
Trauma	-	Mtshezi/Estcourt Municipality

In order for TDCSP to align with the DoH priorities it was decided that the recommended HIV/AIDS Well-being pilot project would be implemented in Okhahlamba instead of in Ladysmith as recommended in the MTE. The Maternal Health pilot project would be implemented in Mbabazane Municipality. IMCI and the community would be rolled out and strengthened in all four 'new' municipalities in the TDCSP project.

Actions and Progress 1: Maternal Health Pilot Project: Mbabazane

- i. An initiative to re-design antenatal services within the municipality in accordance with client needs in the Ntabamhlope Catchment Pilot Area is underway. All role players including local government and Traditional Healers have been enrolled in the process
- ii. A mother's card highlighting key danger signs during the antenatal, delivery, postnatal and neonate periods is in draft form. When completed will be made available to all mothers during antenatal visits.
- iii. The application of LQAS has resulted in the formulation of district-wide base line information on the following indicators for women with children under the age of two years (see Annex 6):
 - knowledge of danger signs during pregnancy, during delivery and after deliver;
 - knowledge of illness in new-born babies; and
 - the presence of an Antenatal Card.
- iv. With the use of LQAS, the progress of Mbabazane in terms of these indicators will be compared to that of the district as a whole.

Actions and Progress 2: HIV/AIDS Well-being: Okhahlamba

- i. A team of people has been trained to roll-out TL and to develop the Well-being pilot site at Rookdale Ward within Okhahlamba municipality
- ii. STIs must be addressed during the final year of operation. The plan is to link with the district reproductive health initiative.
- iii. STI specific messages are being incorporated into the Well-being message package.
- iv. VCT and PMTCT councillors (DoH and lay councillors) are undergoing training at every facility in Okhahlamba.
- v. Nevirapine is available at the local hospital (Emmaus Hospital)
- vi. An Okhahlamba AIDS action team is in place to co-ordinate all AIDS related programming within the municipality, including HBC, Well-being Centre, PMTCT and VCT, orphan programmes, information about grants available from the Department of Welfare and distribution of food and clothing to the most vulnerable and youth initiatives. The AIDS action Team has also initiated a forum for sharing inter-sectoral information about HIV/AIDS programmes in a wide range of sectors, including the departments of Correctional Service, Education, Welfare, Agriculture, local government and PLWA amongst others.

Actions and Progress 3: IMCI

- i. In-service training for CHWs in Ndaka, Nmambithi and Mbabazane focussing on the KFP16 (including MCH danger signs and interventions) and on growth monitoring and promotion has taken place. During this, each of the CHWs is equipped with a TALK scale for growth monitoring and promotion.

- ii. Health Committees in the above listed municipalities have also been trained in KFP16 and the MCH danger signs and interventions. Of particular interest has been the promotion of exclusive breast feeding and Men-as-Partners.

3.2 RECOMMENDATIONS TO ACHIEVE GOAL OF SUSTAINABILITY BY 09/30/2003

Please see section 2.3 above for a discussion on progress towards the MTE recommendations to achieve the goal of sustainability.

3.3 RECOMMENDATIONS TO ACHIEVE QUALITY OF CARE OBJECTIVES BY 09/30/2003

Three main recommendations to achieve Quality of Care objectives were identified in the MTE, namely;-

- Strengthen Technical Oversight of Intervention Content
- Strengthen the Interventions of IMCI, HIV/AIDS, and Maternal and Neonatal Care
- TA to Improve Technical Content and Quality of Interventions

A number of recommendations were made within each of these. Progress towards the implementation of these recommendations is discussed below.

3.3.1 STRENGTHEN TECHNICAL OVERSIGHT OF INTERVENTION CONTENT.

- *Form technical advisory group (TAG) from the Learning Site to review technical quality of the content of HIV/AIDS and MH interventions and make recommendations to Transitional Management team to strengthen deliverables in next 10 months*

The establishment of a Learning Site to institutionalise reflection by health service practitioners together with the community they are serving, is a novel concept. This concept has been enthusiastically embraced by a wide range of roleplayers, including the DMT, TDCSP, uThukela District Health Forum, the Medical Research Council, and several departments within the University of Natal and HIVAN. As a consequence there has been a great deal of debate on the governance structure of the Learning Site. The structure must ensure that the community voice is included in setting research and learning priorities. The role players are currently discussing the mechanisms and practice of the governance structure. This has caused a delay in the implementation of the Learning Site project. Therefore a Technical Advisory group has also not yet been formed.

The following actions have been taken:

- i. WVSA has appointed a Health Advisor. Her job description includes the following:
 - the provision of technical oversight;
 - review of overall progress against indicators;
 - informing content of health messages and the process of delivery with health services; and
 - advice on the overlap and integration of messages within MCH, HIV/AIDS Well-being and IMCI.
- ii. TDCSP is contributing 25% of the cost of the Health Advisor.

3.3.2 STRENGTHEN THE INTERVENTIONS OF IMCI, HIV/AIDS AND MATERNAL AND NEONATAL CARE

- *Expand community strategies and messages to other community structures and groups. Increase their participation and involvement in improving the health of mothers, children, and families.*

The following actions have been taken to expand community strategies and messages to other community structures and groups and to increase participation and involvement:

- During the training of Community Health Committees at Ward-level, local government, Traditional Healers, CHWs, youth groups and community-based workers have been invited to participate in KFP16. See section 2.2.1.3, above.
 - Workshops and focus groups on developing an understanding of community definitions of 'well-being' and 'at risk' have been held (see section 2.2.2, above).
 - Community stakeholders are being enrolled in a process of co-designing improvement in service provision to pregnant mothers. This includes traditional leaders, local government councillors, traditional birth attendants, traditional healers, health facilitators, field facilitators and emergency services. Consultation is also taking place with Home Based Care givers, CHWs, women's groups and churches.
- *Focus supervision on strengthening weakest links supporting frontline health worker.*
 - *Carry out performance assessments 6 months and 1 year after training CHWs, CHFs, and/or CHCs to determine whether training affected the level of care and counselling the CHW, CHF and/or CHC provides.*

Within the context of losing health workers due to emigration, illness and retirement there is a growing shortage of staff at facility level. The continuing DoH training programmes have exacerbated this problem especially for the municipal trainers and senior health personnel whose responsibility it is to supervise frontline workers. In addition almost half the CHF's have left their posts, leaving five CHF's to train and supervise 320 CHWs. The ratio of CWF to CHW is thus 1:62. The desired ratio is 1:25. As a result, the desired level of supervision has not been achieved for facility staff.

The following actions and achievements are reported:

- IMCI has trained 100% of the PHC co-ordinators as IMCI supervisors, despite the problems mentioned above.
 - Only 40% of IMCI PHC practitioners were supervised in the June – September 2002 period (the target is 70%). All supervisors are aware of the need to undertake more supervision; they plan to visit 5 IMCI practitioners in each municipality each month.
 - The Community Based Health team (CHF's and CFF's) is to meet in October 2002 to discuss possibilities for improving supervision of CHWs at household level, with the limited number of CHF presently in place.
 - A supervision tool for CHWs will be designed before December 2002. This will be used to assess CHW competency and identify gaps that will inform future in-service training.
- *Shift training resources to where there is the greatest need for training CHWs*

The shifting of training resources includes:

- i. In-service training: Of the 320 CHWs, 278 have completed the generic DoH training and are currently undertaking in-service training with TDCSP. This involves training and mentorship in the priority interventions.
- ii. All CHWs will have received in-service training in the KPF16 by March 2003.
- iii. All Health Committees will have received training in the IMCI and MCH by March 2003.
- iv. In Okhahlamba the focus of CHW and CHC training is HIV/AIDS Well-being.
- v. HIV/AIDS training is prioritised in the rollout municipalities in April 2003.

3.3.3 TECHNICAL ASSISTANCE TO IMPROVE TECHNICAL QUALITY

- *Obtain TA from qualified epidemiologist to conduct a risk assessment for the DoH to determine actions most needed within DoH to move the content of the MNC and HIV/AIDS components forward – Feb 2002*
 - *HIV/AIDS component, review STI, VCT, anti-retrovirals, quality of counselling, men as partners (investigate possible pilot for men's clinic).*
 - *Maternal and Neonatal Health, review data on peri-natal mortality and birth weight, prevention of mother-to-child transmission, high risk pregnancies*

It has been ascertained that to undertake a risk assessment for the DoH would be an extensive and costly exercise. Attention has therefore focussed on the areas of risk identified by the DMT.

The DMT has identified areas of risk that must be addressed to improve quality of care, namely:

- The insufficient knowledge mothers have of danger signs during the antenatal, intra-partum and post-partum periods;
- inadequate access to facilities for delivery, due to poor transport services and limited 24 hour services (only 5 in the district).

The community aspects of the antenatal care are being addressed by the CSP. Improved access to facilities is the primary responsibility of the DoH. However this is an intersectoral problem as it encompasses issues of road access, safety and security.

With regards to peri-natal reviews, hospitals are beginning to address quality issues within the maternity wards. Post-partum issues – mothers are being educated about the importance of post-partum visits. Facility staff members are informing mothers of this need during antenatal visits.

With regard to the HIV/AIDS component, the STI concerns are being addressed through the District Reproductive Health Initiative. The project may bring in appropriate technical support to assist in addressing the STI quality of care issues.

In terms of VCT and PMTCT the quality of counselling will be improved by:-

- Training counsellors in use of the coaching packages with well-being messages (see Annexes 8, 9,10)
- Supervision/coaching support for counsellors
- Roll-out of breast feeding training linked to PMTCT

The KFP16 includes the man's role in key family practices. The application of transformational development to the Men-as-Partners project in the HIV/AIDS Well-being pilot site involves men in creating a new context where prevention and care are the focus.

- *Obtain TA from experienced professional in Child Survival indicator design to develop measurable objectives, indicators and targets for Transitional Leadership, and obtain baseline TL performance measures on CHWs, CHC, CHFs - Jan – Feb 2002.*

A consultant, Miriam Wiltshire of Futurevision was contracted to train a team to roll out TD and TL in Okhahlamba, focusing first on the pilot site. A results framework was designed as part of her contract in order to measure whether the desired results are being achieved or not.

- *Carry out delayed LQAS consultancy in February 2002.*

The LQAS consultancy was held in February 2002 as planned.

The objectives of applying LQAS in the TDCSP were as follows;-

- To fill gaps in the project baseline data and enable the aggregation of data across five supervision areas (municipalities), giving coverage estimates for each indicator for the whole project area (uThukela District), as well as for each municipality;
- To set targets for each key indicator, in each municipality and for the whole project area;
- To compare data collected against key indicators in five municipalities to determine which interventions had acceptable levels of coverage and which were performing below expectation. As result, determine the priority interventions and municipalities where resources have to be focused; and
- To simultaneously monitor the pilot municipality where the first Child Survival Grant was completed and the four new municipalities targeted during the follow-on Child Survival grant.

Survey tools were designed for three client populations, namely women of reproductive age (15–49 years), mothers of children age 0–11 months and mothers of children age 12–23 months. A parallel sampling methodology was used. Twenty-four interviews for each client population were completed in each of the five municipalities. For the pilot area the client population for mothers of children age 0-11 months was reduced to children age 0-5 months to ensure good data on exclusive breast-feeding.

The data was hand tabulated by the survey team, targets were reviewed and adjusted and an action plan was co-designed with relevant stakeholders (for LQAS results see Annex 6).

Results showed that with LQAS, data could be collected within each municipality for each intervention. This could be aggregated for coverage estimates of the whole district. Municipalities and interventions that were performing below expectation could thus be prioritised for focused attention and resource allocation. Further, the results show that it is possible to monitor the pilot area to see if it maintains its coverage in key indicators, while more emphasis is given to the new roll out areas.

4 CHANGES FROM PROGRAMME DESCRIPTION AND DIP

- There was a reduction in the scope of work to be done as outlined in the DIP. As agreed with USAID, the 1st Annual Report really took the place of the DIP.
- There has been an added advantage of having also developed the HH/CC in the District. This was a joint project between DoH, TDCSP, UNICEF and GSK.

5 REQUIRED TECHNICAL ASSISTANCE

IMCI

Technical assistance is required with the following;-

- The evaluation of the program designed for the HH/CC;
- The monitoring and evaluation (M&E) of IMCI HH/CC (Elaine Byrne who used to work for UNICEF and is doing a PhD in Community-based M&E).

HMIS

- Assistance in less traditional information feedback mechanisms, such as drama, theatre and video, as well as in creative report writing skills would assist in developing the DIS into a more culturally feasible and effective manner.

Maternal and Child Health

- Computer literacy training for Labour Ward staff and MCH Co-ordinator.
- PPIP data capture training.

HIV/AIDS Well-being

- Technical assistance in appropriate message development and dissemination around STIs is required.

6 PROGRAMME MANAGEMENT

6.1 FINANCIAL MANAGEMENT

- The MTE reported that there were problems with the programs management effecting budgeting and financial planning. The Sun System Accounting System was problematic. Addressing the situation has been ongoing;-
 - Support staff have had training in Sun Systems;
 - The financial manager received early retirement due to ill health and an interim grant accountant was brought in by WWSA;
 - The interim grant accountant is actively addressing the short-comings;
 - A new WWSA financial director has been appointed who is providing strong support and guidance to the TDCSP financial team.
- The presence of the project has assisted the District DoH financially. Funding is available for transport, food for community meetings and attendance at National IMCI meetings, conferences and seminars. Funds are also available for the development of extra tools such as the Family Booklet, IMCI HH/CC Module and video.

- The financial means to import all the required TALC scales and associated training materials has made a significant impact on the progress of the project.

6.2 HUMAN RESOURCES

- *Human Resources Administrator:* Following the MTE, a Human Resources Manager was appointed.
- *Human Resource Data Base:* The MTE identified the need for a Human Resource Data Base with files on policies, procedures, job descriptions and training statistics. It was further suggested that the database should track training and supervision of all workers (see Annex 2). The HR Manager managed this process and ensures the database is kept up to date.
- *Succession planning for key positions:* six-monthly performance appraisals have been instituted. One of the key performance areas for each staff member is the mentorship of another to ensure that job competencies are understood in the event of a staff member being absent or leaving the programme. Each performance appraisal includes a person development plan that is reviewed at the following appraisal.
- *Transfer of the management of the HW program to a District NGO:* The registration of the uThukela District Health Forum (TDHF) as a Non-profit Organisation means that it is now a legal entity and can take transfer of the management of the CHW program from the service provider (PPHCN KZN) to TDHF in partnership with TDCSP. With the program managed within the District, it will be possible to ensure that management, supervision and integration of the HW programme with the facility-based services occur.
- *Insufficient Community Health Facilitators (CHFs):* The depletion of the numbers of CHFs has been discussed at length in previous sections, as well as the possibilities for action.
- *Lack of capacity to undertake supervision at an optimal level:* As a result of a shortage of CHFs and the demands place on IMCI Supervisors, supervision has not been optimal. Plans have been put in place to streamline the supervision and support of health workers.

6.3 COMMUNICATION

- *Internet communication* has been provided to all the key intervention leaders and managers. This has greatly improved intra-project communication.
- *Management meetings;* project management meetings were replaced by District Management Meetings until it was realised that the project intervention team members needed to meet to track program performance and plan together for program implementation. As a result monthly management meetings for all interventions have again been instituted. The preparation process for writing the Third Annual Report was effective team building and communication exercise as the intervention staff reflected on their progress since the MTE.
- *Reporting:* WVSA has instituted a monthly reporting format that includes progress against indicators, activities and plans for the next month. This has helped to keep all staff focussed on the intervention deliverables. The formal reporting procedure ensures that managers receive information on a monthly basis, which they can in turn compile and report. As a result intra-project communication has improved.

6.4 LOCAL PARTNER RELATIONSHIPS

- *Local Government:* The CBHP reports on progress every six months to local government at municipal level. Health Forum meetings are held in three of the five municipalities at which the CSP reports on progress.
- *Health District Management Meetings:* The TDCSP manager attends monthly Health District Management meetings to ensure effective integration of CS interventions with district priorities and to maximise use of CSP and DoH human and financial resources.
- *AIDS Action Team:* An Okhahlamba AIDS action team is in place to co-ordinate all AIDS related programming within the municipality, including HBC, Well-being Centre, PMTCT and VCT, orphan programmes, information about grants available from the Department of Welfare and distribution of food and clothing to the most vulnerable and youth initiatives. The AIDS action Team has also initiated a forum for sharing inter-sectoral information about HIV/AIDS programmes in a wide range of sectors, including the departments of Correctional Service, Education, Welfare, Agriculture, and local government and PLWAs amongst others.
- *Interaction with external roleplayers:* Support and interaction with a variety of external roleplayers on technical input, shared learnings and advice has continued since the mid-term evaluation. This includes UNICEF, UND Department of Community Health, HIVAN, Data Research Africa, various consultants, the Provincial and National IMCI Working Group, the Child Rights Centre and MCDI.

6.5 PVO CO-ORDINATION/COLLABORATION

- WVUS and WVSA continue to provide technical and administrative support on request. The technical backstop from WVUS has changed from Tom Hall to Fe Garcia. Bill McCormick continues to provide ongoing financial management and analysis support. The Associate Programme Officer providing general management and administrative support is Tex Lanier.
- WVSA has appointed Jane Adar as the National Health Officer. She has responsibility for technical oversight of the child survival grant in South Africa.

6.6 ASSESSMENTS AND AUDITS

No assessments and audits have taken place since the MTE.

7 ISSUES WITH POTENTIAL FOR PROJECT SCALE-UP

7.1 LQAS

The implementation of the LQAS is regarded as an important new project M&E tool that has potential for supporting project scale-up in CS projects. LQAS is a sampling method that can be used locally at the level of a “supervision area” to identify priority areas or indicators that are not reaching average coverage or an established benchmark/target. It

can provide an accurate measure of coverage of health systems at a more aggregated level, for example a project catchment level or a district (Valadez, 2002).

Comparison of LQAS with 30-Cluster Sampling:

- LQAS provides a method for prioritising local areas by indicator, unlike cluster sampling;
- The sample size is smaller for LQAS (95 versus 300).

The objectives of applying LQAS in the TDCSP were as follows:-

- To fill gaps in the project baseline data and enable the aggregation of data across five supervision areas (municipalities), giving coverage estimates for each indicator for the whole project area (uThukela District), as well as for each municipality;
- To set targets for each key indicator, in each municipality and for the whole project area;
- To compare data collected against key indicators in five municipalities to determine which interventions had acceptable levels of coverage and which were performing below expectation. As result, determine the priority interventions and municipalities where resources have to be focused; and
- To simultaneously monitor the pilot municipality where the first Child Survival Grant was completed and the four new municipalities targeted during the follow-on Child Survival grant.

Survey tools were designed for three client populations, namely women of reproductive age (15–49 years), mothers of children age 0–11 months and mothers of children age 12–23 months. A parallel sampling methodology was used. Twenty-four interviews for each client population were completed in each of the five municipalities. For the pilot area the client population for mothers of children age 0-11 months was reduced to children age 0-5 months to ensure good data on exclusive breast-feeding.

The data was hand tabulated by the survey team, targets were reviewed and adjusted and an action plan was co-designed with relevant stakeholders (for LQAS results see Annex 6).

LQAS has the further advantage of being applicable to both programme intervention and HW performance assessments.

Results showed that with LQAS, data could be collected within each municipality for each intervention. This could be aggregated for coverage estimates of the whole district. Municipalities and interventions that were performing below expectation could thus be prioritised for focused attention and resource allocation. Further, the results show that it is possible to monitor the pilot area to see if it maintains its coverage in key indicators, while more emphasis is given to the new roll out areas.

Since the LQAS training in February 2002 Steve Knight from UND has trained health staff from three other districts in KZN on using LQAS for health programme monitoring. Dr Bernhard Gaede has used LQAS for quality assessment of hospital records and has introduced the concept to the National DoH are keen to explore further applications of LQAS within the national health system. PPHCN and The Valley Trust are interested in tracking CSP's application of LQAS in assessing CHW and CHF performance. WVSA is investigating LQAS as a monitoring tool within area development programme interventions.

7.2 IMCI

The household and community component of IMCI, piloted in the Thukela District has developed strategies and materials for addressing child health that are being used provincially and nationally. These include how to do a Situational Analysis, how to engage with stakeholders and roleplayers, the use of PLA techniques for community engagement, and the use of focus groups to uncover barriers to child health.

The IMCI HH/CC package of training materials that has been developed and is available for use at provincial and national levels, includes;-

- The Training Module KFP16;
- The Family Booklet; and
- A training video for training community-based health is now complete.

7.3 TRANSFORMATIONAL DEVELOPMENT TO ADDRESS THE CONTEXT OF HIV/AIDS

The pilot project for Transformational Development shows promise in being able to shift the context of HIV, and provides tools for moving beyond offering knowledge, skills and motivation in response to the epidemic. If the measurements show that indeed the context has shifted, this approach will be invaluable in addressing some of the key factors affecting child health in uThukela District.

8. CONCLUSION

Good progress has been made since the MTE in November 2002. To prepare for phase over to the DoH and local community based organisation, the project will focus on the following;-

- i. Complete roll out of CBHP and facility training according to best practice interventions in municipalities;
- ii. Deepen the culture and practice of coaching and supervision;
- iii. Roll out the TD programme pilot site and measure shift;
- iv. Engage technical assistance in the design of appropriate STI message development for appropriate management and referral;
- v. Facilitate handover of CHWs to TDHF in partnership with TDCSP and District DoH;
- vi. Complete training of CHW, CHCs and municipal health forums in IMCI HH/CC, MCH and HIV/AIDS Well-being.
- vii. Prepare for and hold end-of-project evaluation, including repeat LQAS by municipality and for the District.



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- WVSA, 2000b: uThukela District Child Survival Program First Annual report, October 2000, World Vision, South Africa.
- WVSA, 2002: Contract between TDCSP and Futurevision.

Summary of the number of Health Committee Members Trained since MTE by Municipality – October 2002

Okhahlamba Community Health Committees

In Okhahlamba there are 148 CHC members who were trained on IMCI + MCH HH/CC.

On those who were expelled there are 4 who were trained on IMCI

On the CHC modules there are 178 who were trained and on those who were expelled there are 51 who were trained.

Indaka CHC

At Indaka there are 25 CHC who were trained on the CHC module and on IMCI + MCH HH/CC there are 92 CHC members trained

Ladysmith Central

In Ladysmith Central there are 116 CHC members who were trained only on IMCI + MCH HH/CC

Ladysmith Outer West

In Ladysmith 51CHC members were trained on CHC modules and IMCI + MCH HH/CC. and those who were expelled there are 6. There are 45 new CHC Members who were trained on IMCI + MCH HH/ CC.

Emtshezi CHC

At Umtshezi there are 182 CHC members who were trained on CHC modules.

Imbabazane CHC

At Imbabazane the CHC members were trained only on CHC modules, to date there are 109 CHC members trained.

TRAINING SUMMARY TABLE

ANNEX 2

Staff Training Table October 2001 – September 2002

Topic	Facilitator/ Place	Trainee Job Title	Number of TDCSP staff and partners	Date	Hours/ Person
WV Log Frame Workshop	WVSA Operations	TDCSP Manager	1	Feb 4-8	40 hours
PLA Workshop	Rudolf, Simon, Luc	CHF, CFF, HIV/MED, WV	25	Nov 24-Dec 6	80 hours
Grant Workshop	David Sleight	Finance Officer	1	14 – 18 January	40 hours
Capacity Building Workshop	Goldwater Lukuta in Durban	Personnel Assistant for PTS.	1	07 February	1 day
Human Resource Management Course	Prof. Basson, Prof. Schaap, Prof. Uys in Pretoria	Personnel Assistant	1	18 – 22 February	5 Days
Behavior Change	Gail CSTS Johannesburg	HIV/ MED Facilitator, CHF, PN, Midwifery, PCH Coordinator	8		5 days
Community Symposium Workshop	University of Natal – HIVAN	HIV/MED HBC Coordinator	30	28 – 29 February	8 hours
LQAS	Joe Valadez Durban	HIV MED Facilitator, CFF, DOH, CHF, TDCSP interventions Leaders and Managers	30	Feb 13-1 March	3 weeks
Sun System Training	Tobias Nyondo in Durban	Finance Manager, Finance Officer, Bookkeeper	20	08-18 April	2 weeks
Monitoring and Evaluation					
Christian Listeners		CBHP Coordinator, HIV AIDS Coordinator		10-12 May	2 days
PTS & Finance Workshop	Goldwater Lukuta	Finance Manager and HR Administrator	2	27-31 May	5 days

OTHER EVENTS					
Quarterly Review for January and April, July and September 2002	WVSA NO team	TDCSP Manager	1	Quarterly	For 3 days/quarter
HIV/MED Graduation Ceremony	Mangethe Zwane& Chris Black at Bergville Farmers Hall	All MED trainees with successful Businesses got Business Certificates	300		
Orientation of sub-districts Office administration team.	Bergville CSP Manager	Community Office Administrators	5	Nov 25- Dec 06 2001	2 Weeks.
Project management /Facilitation/couching	Bergville CSP	CFF, CHF, MED team	Miriam Wiltshire	03- 15/12/ 01	2 Weeks.
Computer Training	Computer School	DOH Staff	14	June 2002	40 hours

IMCI Training Table October 2001 – April 2002

Topic	Facilitator/ Place	Trainee Job Title	Number of People	Date	Hours/ Person
Community Based Health care providers training	Tim Kerry Chris Gibson at Amatikulu PHC	Community Health Facilitators	30	March	5 days
C-IMCI	Tim Kerry & Chris Gibson at TDCSP	CHF, HIV/MED Facilitator, CFF, COA, CRS		15-17 April	3 days
CIMCI	Bloemfontein	TDCSP – IMCI Manager			
IMCI Workshop		MED Facilitator, CBHP Coordinator, CHF, CFF		29 –30 May	2
IMCI-HH/CC	Amatikulu Chris Gibon	CBHP Coordinator		13-17 May	5 days
IMCI Supervision		IMCI Leader			
IMCI	Dr. Kerry	CHF			2 weeks
IMCI	Chris Gibson Estcourt	CFF	7	1,2 August	2
Breastfeeding	Sandford Park Felicity Savege	IMCI manager, CBHP coordinator, PHC	33	August 12- 14 2002	Trainers 11 days Trainees 6 days

	Noma Mtshali	Trainers, Nutritionist, CHF Professional Nurses CHWs, Nutrition SASO			
IMCI	Amatikulu Chris Gibson	CHF	12	16-20 September	

HIV/AIDS Table October 2001 – September 2002

Topic	Facilitator/ Place	Trainee Job Title	Number of People	Date	Hours/ Person
HIV/AIDS Counseling Course	Zodwa Dladla Anwar, Humphrey Estcourt Hospital	10 DOH people/9 lay counselors	20	Feb 2002	80
HIV/AIDS Counseling Course	Zodwa Dladla, Anwar, Humphrey Emaus Hospital	10 DOH, 1 TDCSP staff, 8 community	20	March 2002	80

Maternal Health Training Table October 2001 – September 2002

Topic	Facilitator/ Place	Trainee Job Title	Number of People	Date	Hours/ Person
Midwifery Congress	Rustenburg	Midwives		5-7/12/01	3 days
Maternal Health Messages		Field Trainers			
Perinatal Mortality Review	Estcourt Hospital			May 2002	
Perinatal Mortality Review	Emmaus Hospital			May 2002	
Perinatal Mortality Review	Ladysmith Hospital			May 2002	

HIV/MED Training Table October 2001 – September 2002

Topic	Facilitator/ Place	Trainee Job Title	Number of People	Date	Hours/ Person
Training in Starting Small Businesses	Mangethe Zwane Zwelisha	Household Members with orphans and those who have taken orphans	20	November 2001	4 Weeks
Training in Starting Small Businesses	Mangethe, Bongani & Sindi Magangangozi	Household Members with orphans and those who have taken orphans		March 2002	4 Weeks
Training in Small Business Skills	Obonjaneni Bongani	Household Members with orphans and those who have taken opharns	20	May 2002	4 weeks
Training in Starting Small Businesses	Mangethe Zwane Methodist	MED Trainers and Follow up Agents	22	May 2002	4 weeks
Training in Starting Small Businesses	Bongani Bhalekisi	Household Members with orphans and those who have taken orphans	19	July 2002	4 weeks
Training in Starting Small Businesses	Mangethe Zwane Mhlwazini	Household Members with orphans and those who have taken orphans	21	July 2002	4 weeks
Training in Starting Small Businesses	Charity Ngoba	Household Members with orphans and those who have taken orphans	19	July 2002	4 weeks

Home Based Care Training Table December 2001 – September 2002

Topic	Facilitator/ Place	Trainee Job Title	Number of People	Date	Hours/ Person
Christian Listeners	B.S. Dube at Zamimpilo	Home Based Careers	64	04 – 06 February	12 hours
Christian Listeners	Ladysmith	Home Based Careers	34	14 – 15 Feb	12 hours

COMMUNITY BASED HEALTH PROGRAM

Community Health Facilitators Training Table December 2001 – September 2002

Topic	Facilitator/ Place	Trainee Job Title	Number of People	Date	Hours/ Person
Okhahlamba Sub-District					
1. Introduction to CHW Program	Phumi & Gremmah Zamimpilo	Community Health Workers	9	20/03/02 27/03/02	8 ½ hours
2. Environmental Health	May Mabaso	Community Health Workers	16	18/03/02 15/04/02	8 ½ hours
3. Mother and Child Care	Phumi & Gremmah	Community Health Workers	7	22/04/02	8 ½ hours
4. Home Visits on Module 1	Phumi & Gremmah	Community Health Workers	9	02/04/02 12/04/02	8 ½ hours
5. Home Visits on module 2	May Mabaso	Community Health Workers	9	22/03/02	8 ½ hours
6. In-service Training	May Mabaso	Repeaters CHW	12	22/03/02	8 ½ hours
7. Cholera outbreak	Phumi & Gremmah	Community Health Workers		14/01-08/02	
8. Continuous Assessment	Phumi & Gremmah	Community Health Workers		07/03/02	8 hours
9. Listing CHW for names counselors	Phumi & Gremmah	Community Health Workers		07/03/02	
10. Mapping of CHW	Gremmah & Phumi	Community Health Workers		08/03/02	
11. Review of all modules (Exams)					
12. TB – National Tuberculosis Control Program	Joyce Lotter Mark Makobelo	Community Health Facilitators		29/07/02	8 hours
13. Breastfeeding	Felicity Savege	Community Health Facilitators		11/08 & 24/08/02	12 hours
Emtshezi Sub-District					
Cholera awareness Door to door Health education Distribution of Jik.	Dudu Mazibuko "To" Mlotshwa Sizo Ndaba S'busiso Ngubane Weenen/Loskop	Community		09/01/02	2 Months
Training of CHC's	Delma Cito	Community Health Committees		February 02	5 Days.

Topic	Facilitator/ Place	Trainee Job Title	Number of People	Date	Hours/ Person
Training of CHW's on.	Dudu Mazibuko "To" Mlotshwa Roman Catholic Church Hall,Estcourt.	Community Health Workers		February /March 02	2 Weeks.
Training of CHW's in Modules 1,2,3,4 and 5.	Dudu Mazibuko "To" Mlotshwa Roman Catholic Church Hall,Estcourt.	Community Health Workers		April 02	2 Weeks.
Translation of CHC Modules	Tim, Sbu, Sizo Estcourt CSP Offices			8/02/02	2 Weeks
Compilation of CHC Modules	Tim, Sizo, Sbu Estcourt SCP Offices			April/ March	2 Days
Workshop On HIV/AIDS,ORPH— ANS,PEOPLE LIVING WITH AIDS.	Education and training Unit Estcourt Council Chambers.			11& 12 January	2 Days
Open Day for Community base projects and interventions	Department of Health Engonyameni/Loskop.				1 Day
Home base care day.	CSP/Department of Health Wembezi Community Hall.				1 Day
Breast feeding day	CSP/Department of Health Mhlungwini/Ntabamhlophe.				1 Day.
Continuous Assessment	CHF				

**Community Health Committees Training Table October 2001 – September 2002
Trainings done in the community**

Topic	Facilitator/ Place	Trainee Job Title	Number of People	Date	Hours/ Person
Okhahlamba Sub-district					
Roles and Responsibilities of CHC	May Mabaso, Happy Mohlakoana, Phumi Zondo, Gremmah Ngwenya	Community Health Committees	84	29 April – 2 May, 13 –16 May 10-14 June 20-24 May	4 weeks One week per group
IMCI	May Mabaso, Happy Mohlakoana, Phumi Zondo, Gremmah Ngwenya				

Topic	Facilitator/ Place	Trainee Job Title	Number of People	Date	Hours/ Person
Emshezi Sub-district					
Ladysmith Central					
IMCI -	Community Field Facilitators FF	Community Health Committees		09-12 September	
Ladysmith Outer West					
IMCI	Community Field Facilitators	Community Health Committees		26-29 August	
Indaka					
IMCI	Community Field Facilitators	Community Health Committees			

Transformational Leadership Trainings

Topic	Facilitator/ Place	Trainee Job Title	Number of People	Date	Hours/ Person
Transformational Development Program	Miriam Wiltshier	HIV/MED Facilitator, HIV/AIDS Coordinator, HIV MED HBC Coordinator, CFF, AIDS Counselors, Well-being core team, Pastors	30	15 – 19/07/02	5 days
Intensive Leadership Program	Miriam Wiltshier	HIV/MED Facilitator, HIV/AIDS Coordinator, HIV/MED HBC Coordinator, CFF, HIV/MED Trainer, CBHP Coordinator, HR Administrator, BBAC Administrator	30	22 – 26/07/02	5 days
Self Efficacy Program 1	Miriam Wiltshire	HIV/MED Facilitator, HIV/AIDS Coordinator, HIV MED HBC Coordinator, CFF, CRS	30	29/07– 02/08/02	5 days
Results Led Project/ Organisation	Miriam Wiltshire	HIV/MED Facilitator, HIV/AIDS Coordinator, HIV MED HBC Coordinator, CFF, CRS	30	05-08/08/02	5 days

Topic	Facilitator/ Place	Trainee Job Title	Number of People	Date	Hours/ Person
Self Efficacy	Miriam Wiltshire	HIV MED Team, TDCSP Manager, HIV MED Facilitator, HIV/AIDS Coordinator, HIV MED HBC Coordinator, CFF, CRS	51	12 – 16/08/02	5 days
Result Led Project/ Organisation	Miriam Wiltshire	HIV MED Facilitator, HIV/AIDS Coordinator, HIV MED HBC Coordinator, CFF, Well-being Core Team, Pastors, CRS	32	19-23/08/02	5 days
Coaching Program	Miriam Wiltshire	HIV MED Team, TDCSP Manager, HIV MED Facilitator, HIV/AIDS Coordinator, HIV MED HBC Coordinator, CFF, Well-being Core Team, CRS , HR Administrator, AIDS Counselors, DOH	36	26 –30/08/02	5 days
Self Efficacy	Miriam		36	05-06/09	2 days
Results Led Project	Miriam Wiltshier	HIV MED Facilitator, HIV/AIDS Coordinator, HIV MED HBC Coordinator, CFF, Well-being Core Team, Pastors, CRS	29	09–13/09	5 days
Facilitation Programme	Miriam	HIV MED Facilitator, HIV/AIDS Coordinator, HIV MED HBC Coordinator, CFF, Well-being Core Team, Pastors, CRS	39	30/09 – 04/10	5 days

The PHC Antenatal Clinic: A quick-reference guide of where and when to refer high-risk mothers

Antenatal Risk Factors	Action: Where and when to refer
Anemia - <8g/dl or - <10g/dl after 36 wks gest'n - 8-10 g/dl before 36 wks	<ul style="list-style-type: none"> • High Risk Clinic at your local hospital • High Risk Clinic • Do FBC and see visiting clinic doctor
Anti Rhesus Antibodies (If rhesus negative, test for antibodies - if antibodies are present, then refer)	<ul style="list-style-type: none"> • High Risk Clinic
Antepartum hemorrhage	<ul style="list-style-type: none"> • Immediate referral to Hospital
Big fetus	<ul style="list-style-type: none"> • High Risk Clinic or visiting doctor at 36-38 wks gestation
Birth Defects - Previous birth defect/ Downs Syndrome - Women >37yrs and book <18wks	<ul style="list-style-type: none"> • High Risk Clinic
Breech presentation	<ul style="list-style-type: none"> • High Risk Clinic at 34-36 wks
Diabetes	<ul style="list-style-type: none"> • High Risk Clinic
Eclampsia	<ul style="list-style-type: none"> • Immediate referral to Hospital . (See EDL for drug Rx)
Elderly primigravida (35 or more years old)	<ul style="list-style-type: none"> • High Risk Clinic or visiting doctor at 36 wks
Epilepsy (not eclampsia)	<ul style="list-style-type: none"> • High Risk Clinic or visiting doctor
Heart disease	<ul style="list-style-type: none"> • High Risk Clinic
Hypertension - BP 140/90 or more - SBP or DBP increased > 20mmHg since booking ----- - BP >160/100 after rest - Symptoms of imminent eclampsia - Rapid weight gain, severe edema - 2+ or more proteinuria	<ul style="list-style-type: none"> • High Risk Clinic or visiting doctor. See patient weekly (See EDL for drug Rx) ----- • Immediate referral to Hospital (See EDL for drug Rx)
Grand multipara (Para 5 or more)	<ul style="list-style-type: none"> • High Risk Clinic to plan hospital delivery
Intrauterine death - Uterus is soft, non-tender, no bleeding or pain - Recent APH or abdominal pain	<ul style="list-style-type: none"> • High Risk Clinic • Immediate referral to Hospital
Intrauterine growth retardation - Fetal movements are good - Fetal movements are poor	<ul style="list-style-type: none"> • High Risk Clinic • Immediate referral to Hospital
Kypho-scoliosis (bent spine) or deformed pelvis	<ul style="list-style-type: none"> • High Risk Clinic or visiting doctor
Mental health problems - Mental retardation - Mental confusion/ psychosis	<ul style="list-style-type: none"> • High Risk Clinic or visiting doctor • Immediate referral to Hospital
Multiple pregnancy (first assess the cervix)	<ul style="list-style-type: none"> • High Risk Clinic if not in labor • Immediate referral to Hospital if in labor
Polyhydramnios (first assess the cervix)	<ul style="list-style-type: none"> • High Risk Clinic if not in labor • Immediate referral to Hospital if in labor
Poor maternal weight gain	<ul style="list-style-type: none"> • High Risk Clinic

Antenatal Risk Factors	Action: Where and when to refer
Postmaturity > 41 wks	<ul style="list-style-type: none"> High Risk Clinic or visiting doctor
Premature rupture of membranes <ul style="list-style-type: none"> - <36 wks gestation - For > 12 hrs without contractions - Pyrexial 	<ul style="list-style-type: none"> Immediate referral to Hospital
Preterm labor (<37 wks gestation) & not about to deliver	<ul style="list-style-type: none"> Immediate referral to Hospital
Previous Caesarean Section	<ul style="list-style-type: none"> High Risk Clinic (If C/S x2, refer at 34 wks to High Risk Clinic for booking of elective C/S at 37 wks)
Previous mid-trimester abortion, neonatal death or still birth	<ul style="list-style-type: none"> High Risk Clinic or visiting doctor
Previous vacuum / forceps delivery	<ul style="list-style-type: none"> High Risk Clinic or visiting doctor at 36 wks for pelvic assessment
Small pelvis	<ul style="list-style-type: none"> High Risk Clinic or visiting doctor at 36 wks for pelvic assessment
Symptoms of AIDS	<ul style="list-style-type: none"> High Risk Clinic or visiting doctor
Unstable or abnormal lie E.g. transverse lie	<ul style="list-style-type: none"> High Risk Clinic at 36-38 wks
Urinary Tract Infection <ul style="list-style-type: none"> - Non-complicated UTI - UTI with vomiting, fever and pain 	<ul style="list-style-type: none"> Treat, do urine culture & see visiting doctor Immediate referral to Hospital
Young primigravida <ul style="list-style-type: none"> - 11-15 years - 16-17 years 	<ul style="list-style-type: none"> High Risk Clinic High Risk Clinic or visiting doctor

NB: The High Risk Antenatal Clinic should be run at your local hospital by a doctor and an advanced midwife. When referring to this clinic, please write clear notes in the antenatal card, including your assessment, why the patient should be seen at the High Risk Antenatal Clinic and any treatment that you have given. Please write your name clearly on the referral so that the doctor can reply to you.

NB: Please put this poster up in the room/s where you conduct your antenatal clinics. If clarification is needed for any of these referral criteria, look at the KZN Dept of Health Book on "Care of pregnant women and newborns at clinic and district level" or the Perinatal Education Program (PEP) Manua.

**MANAGEMENT TRAINING MODULES
FOR COMMUNITY HEALTH COMMITTEES – 2002**

Day 1

- DHS – Local government
- Organogram
- Definition of health, PHC, DHS

Day 2

- Policy / CHW contract
- Role of CHW

Day 3

- Roles of CHC – Time sheet

Day 4

- How to write a constitution

Day 5

- Role of Community Health Facilitators and Community Field Facilitators
- Mid Term Evaluation
- LQAS feedback

IMCI IMCH
Integrated Management of Childhood Illness (HEALTH)
HOUSEHOLD AND COMMUNITY COMPONENT

Key Practice 1	Breastfeeding
Key Practice 2	Complementary feeding
Key Practice 3	Micronutrients
Key Practice 4	Psychosocial & physical development
Key Practice 5	Sanitation
Key Practice 6	Malaria
Key Practice 7	Child abuse
Key Practice 8	HIV/AIDS
Key Practice 9	Feeding and fluids in sick children
Key Practice 10	Home treatment of sick children
Key Practice 11	Child injuries and accidents
Key Practice 12	Immunization
Key Practice 13	Treatment outside the home
Key Practice 14	Follow recommendations of health workers
Key Practice 15	Antenatal Care
Key Practice 16	Participation of men

Table 1: Growth monitoring, Vitamin A, Immunisations

ANNEX 6

Municipalities/ Supervision areas (SAs): 1-Mbabazane; 2-Mtshezi; 3-Ndaka; 4-Mnambithi; 5-Okhahlamba

***= Below target, ()= Below average**

Q No	Indicator	Target	Target Decision Rule	Average coverage	Average coverage decision rule	KPC 2000 TDCSP	Total Catchment area sample	SA1	SA2	SA3	SA4	SA5
Growth monitoring :0-11 months												
2	Child has a Road to Health Card			99%	N/A	93.8%	120	23	24	24	24	24
3	Child weighed at least once in the last 2 months	80%	16	72%	15	(children 0-23 mo) 67.8%	120	(13)*	17	(14)*	20	22
3A	Child weighed twice in the last 2 months	80%	16	30%	3	21.7%	120	3*	4*	6*	11*	12*
Growth monitoring 12-23 months												
1	Child has a Road to Health Card			95%	19		120	23	24	24	21	22
2	Child weighed at least once in previous 2 months	80%	16	35%	4		120	4*	9*	6*	12*	11*
Vitamin A												
1	Mother receives Vitamin A after delivery (self reported)	90%	19	57%	11		120	(5)*	(9)*	16*	22	16*
4	Mother receives Vitamin A after delivery (shown on card)	90%	19	52%	10		120	(3)*	(9)*	14*	21	15*
18	Child received Vitamin A capsule	80%	16	44%	7		120	9*	9*	8*	17	10*
Immunizations												
3	Has BCG	90%(!)	19	88% ?	19		120 (114)	(18)*	23	24	19	22
4,5,9,13	Has Polio1 + Polio2 + Polio3	90%	19	80% ?	16	93.1%	120 (114)	17*	19	22	18*	20
6,10,14	Has DPT1 + DPT2 + DPT 3	90%	19	87%	19	93.1%	120 (114)	20	21	22	21	20
8,12,16	Has Hep1 + Hep2 + Hep3	90%	19	86%	19	90.0%	120 (114)	19	22	22	20	20
17	Has measles vaccination	90%	19	77%	16	67.5%	120 (114)	17*	18*	17*	20	20

Table 2: Children 0-11 Months: Breastfeeding

Municipalities/ Supervision areas (SAs): 1-Mbabazane; 2-Mtshezi; 3-Ndaka; 4-Mnambithi; 5-Okhahlamba

***= Below target, ()= Below average**

Q No	Indicator	Target	Target Decision Rule	Average coverage	Average coverage decision rule	KPC 2000 TDCSP	Total Catchment area sample	SA1	SA2	SA3	SA4	SA5
Section 3: Breastfeeding Practice												
1	Child ever breastfed			97%	N/A	99.6%	120	23	21	24	24	24
3	How long after birth was the baby put to the breast? (Immediately/within hours)			63%	13		120	20	15	(10)	(8)	22
4	Baby the first milk (colostrum)			87%	19		120	23	(17)	22	20	22
Breastfeeding knowledge												
7	Age when child should start being given foods or liquids in addition to breast milk (supplementary feeding: At 6 months)	80%	16	38%	6	7.7%	120	6*	7*	7*	7*	18
8	Age when mother should stop breastfeeding child (weaning: 24 months or longer)			48%	9		120	18	(6)	(5)	14	15
Exclusive Breastfeeding												
2	Number of Children 0-5 months						70	13	11	11	11	24
	Exclusive breastfeeding among children 0-5 months (Children did not receive any foods or liquids listed in Q6)	45%??	6	31%	4		70	8	(2)*	(0)*	(1)*	11
6C	Baby was given commercially produced infant formula in the last 24 hours						70	9	2	5	6	17

Table 3: Knowledge and practice: Diarrhea

Municipalities/ Supervision areas (SAs): 1-Mbabazane; 2-Mtshezi; 3-Ndaka; 4-Mnambithi; 5-Okhahlamba

***= Below target, ()= Below average**

Q No	Indicator	Target	Target Decision Rule	Average coverage	Average coverage decision rule	KPC 2000 TDCSP	Total Catchment area sample	SA1	SA2	SA3	SA4	SA5
Diarrhea Knowledge: Section 2 (Mothers of children 12-23 months)												
1	Actions to take when child has diarrhea (2 or more of answers 2,3,4,5,6: Initiate fluids rapidly, ORS/SSS, more to drink than usual, continue to feed/breastfeed, home available fluids)	80%	16	88%	19		120	21	21	22	21	21
2	Danger signs for seeking treatment (2 or more)	80%	16	55%	10	39%	120	(8)*	12*	15*	17	14*
3	Mother knows how to feed a child when recovering (Ans1,2: Feed more after diarrhea, give smaller more frequent meals)	60%	11	43%	7		120	(6)*	9*	7*	20	10*
Sick child: Diarrhea Practice: Section 3 (Mothers 0-11 & 12-23 months):												
1, 2	Children 0-23months sampled (240), those with diarrhea to be assessed for treatment: Diarrhea prevalence= 29.2%						70/240	11	17	13	17	12
3	Treatment for diarrhea (Ans1,2,3: ORS, SSS, home fluids)			83%			70	11	16	12	12	7
4A	When child had diarrhea, give more liquids			44%			70	13	4	3	7	4
4B	When child has diarrhea, give same/more food			53%			70	13	12	2	4	7
6B	First place for treatment of diarrhea (Ans 1,2,3,4: Hospital/ clinic/ doctor/ CHW)			81%			70	12	14	10	12	9

Table 4: Knowledge and practice: Respiratory Illness

Municipalities/ Supervision areas (SAs): 1-Mbabazane; 2-Mtshezi; 3-Ndaka; 4-Mnambithi; 5-Okhahlamba

Q No	Indicator	Target	Target Decision Rule	Average coverage	Average coverage decision rule	KPC 2000 TDCSP	Total Catchment area sample	SA1	SA2	SA3	SA4	SA5
Respiratory infections and general danger signs: Knowledge Section 4 (Mothers of children 12-23 months)												
1	Danger signs of respiratory infection that would cause a mother to go to health facility immediately (Ans1/2/5)	60%	11	46%	9	41.9%	120	(3)*	15	10*	14	13
General Danger Signs												
1A	Danger signs that would cause mother to go to health facility immediately (2 or more signs)			33%	4		120	(2)	8	7	13	10
Sick Child: Respiratory infections Practice Section 4 (Mothers of children 0-11 & 12-23 months)												
2	Children 0-23 months sampled (240), those with Respiratory infections to be assessed for treatment : ARI prevalence: 6.3%						15/240	4	3	2	4	2
4	Mother sought treatment when child was ill with fast or difficult breathing			60%			15	1	2	2	2	2
5	Mother sought treatment on the same day			15%			15	1	1	0	0	0
6	Mother or mother & father decided to go for treatment			40%			15	1	2	0	1	2

Table 5: Maternal Health**Municipalities/ Supervision areas (SAs): 1-Mbabazane; 2-Mtshezi; 3-Ndaka; 4-Mnambithi; 5-Okhahlamba**

Q N o	Indicator	Target	Target Decision Rule	Average coverage	Average coverage decision rule	KPC 2000 TDCSP	Total Catchment area sample	SA1	SA2	SA3	SA4	SA5
Maternal Health												
1	Danger signs during pregnancy (2 or more)	80%	16	53%	10	57.4%	120	16	11*	11*	13*	13*
1A	Danger signs during pregnancy (3 or more)			21%	2		120	5	4	5	7	4
2	Danger signs during delivery (2 or more)	60%	11	36%	6		120	7*	6*	10*	11*	9*
2A	Danger signs during delivery (3 or more)			1%	N/A		120	1	1	4	4	2
3	Danger signs after delivery (2 or more)	80%	16	33%	4		120	6*	7*	7*	7*	12*
3A	Danger signs after delivery (3 or more)			7.5%	N/A		120	2	1	2	2	2
4	Danger signs that newborn baby (first 7 days after birth) is sick (2 or more)	60%	11	37%	6	35.8%	120	8*	8*	10*	8*	10*
4A	Danger signs for newborn baby (3 or more)			14%	N/A		120	2	3	4	3	5
5	First place for medical attention during pregnancy/delivery/ post partum (clinic/hospital/ private doctor)			99%	N/A		120	24	24	23	24	24
Supplementary question												
1	Mother has antenatal record			36%	6		120	10	10	(5)	(3)	15

Table 6: Women 15-49 years of age: HIV/AIDS /Well-being

Municipalities/ Supervision areas (SAs): 1-Mbabazane; 2-Mtshezi; 3-Ndaka; 4-Mnambithi; 5-Okhahlamba

***= Below target, ()= Below average**

Q No	Indicator	Target	Target Decision Rule	Average coverage	Average coverage decision rule	KPC 2000 TDCSP	Total Catchment area sample	SA1	SA2	SA3	SA4	SA5
Mother to child transmission												
1	Knows that HIV can be transmitted through pregnancy	90%	19	90%	19	86%	120	21	20	23	22	22
	Knows that HIV can be transmitted during delivery	90%	19	68%	14		120	(11)*	14*	20	18*	18*
	Knows that HIV can be transmitted through breast milk	90%	19	73%	15	66.5%	120	18*	17*	19	18*	16*
2	Knows how to reduce the risk of transmission through breast milk (EBF, heat treatment of milk Ans 1,2)	40%	6	13%/18%?	N/A		88??/120	0	0	6	6	4
Healthy Living for HIV positive people												
3	Knows how an HIV positive person can stay as healthy as possible (2 or more)			58%	11		120	(8)	14	16	15	16
3A	Knows how an HIV positive person can stay as healthy as possible (3 or more)	50%	9	20%	1		120	1*	2*	5*	9*	7*
4	Where would an HIV positive person go for treatment if they are not well (Clinic/hospital/doctor)			98%	N/A		120	24	24	24	23	22
HIV testing and VCT												
5	How a person could find out whether she/he was HIV positive			91%	21		120	22	21	21	23	22
6	The woman has heard of a Voluntary Counseling and Testing service			21%	2		120	2	6	3	12	2
8	Knows 1 or more reasons to get tested			90%	19		120	(17)	23	24	22	22
8	Knows 2 or more reasons to get tested			27%	3		120	(1)	4	12	8	7
8	Knows 3 or more reasons to get tested			6%	N/A		120	0	1	2	2	2
9	Woman would go for an HIV test herself	70%	14	73%	15	34%	120	18	20	15	20	15

10	Would talk to partner before having the test			83%	18		120	19	20	18	21	21
11	Would tell partner the results of the HIV test			86%	19		120	20	21	20	18	24
12	Feel personally at risk of getting AIDS	20%				62.2%						
14	Did use a condom at last sexual intercourse			30%	3		120	9	6	5	6	7

Table 7: Okhahlamba Municipality: Maintaining the gains of CSP1

Indicator	Target for this assessment: Results for Okhahlamba end of CSP1 KPC assessment (1999)	Decision rule for target (end of CSP1 Okhahlamba)	Number correct Okhahlamba this survey (sample size 24)	District target
Road to Health Card & Growth monitoring				
Child has a RTHC (0-11months)	98%	21	24	
Child has been weighed at least once in last 2 months (0-11months)	92.5%	21	22	80%
Child has been weighed twice in last 2 months (0-11 months)	67.5%	14	12	
Child has been weighed once in last 2 months (12-23 months)	88%??	19??	11	
Breastfeeding (0-11 months)				
Mother did breastfeed child	99.3%	21	24	
The mother put the child to the breast immediately after birth or within an hour	50.8%	10	22	
Child was given first milk from breast (colostrum)	77.1%	16	22	
Mother should start giving her child foods /liquids in addition to breast milk at age 6 months	34.6%	4	18	60%
Maternal Health				
Danger signs during pregnancy (2 or more)	46.3%	9	13	80%
Danger signs for newborn baby (2 or more signs)				60%
Immunisation and Vitamin A				
Child has a RTHC (12-23 months)	98%	21	22	
Has BCG	98.1%	21	22	90%* fully immunised by first birthday
Has Polio 1+Polio 2+Polio 3	95.3%	21	20	90%*
Has DPT1+DPT2+DPT3	96%	21	20	90%*
Has HepB1+HepB2+HepB3	94.4%	21	20	90%*

Has measles vaccination	93%	21	20	90%*
Diarrhea Knowledge (12-23 months)				
Mother knows 2 or more actions to take when child has diarrhea	55%	10	21	60%
Mother knows how to feed her child when the child is recovering from diarrhea (feed more/smaller more frequent feeds)	74%	15	10	
Respiratory Infections and Danger Signs Knowledge (12-23 months)				
Mother knows danger signs of respiratory infections (2 or more)	55%	10	13	50%
Mother knows danger signs that would cause her to take the child to the health facility	55%	10	10	50%
Indicator	Target for this assessment: Results for Okhahlamba end of CSP1 KPC assessment	Decision rule for target (end of CSP1 Okhahlamba)	Number correct Okhahlamba this survey (sample size 24)	District target
HIV /AIDS (women 15-49 years)				
Knows that the virus can be transmitted from mother to child during pregnancy	91%	21	22	
Knows that the virus can be transmitted during breastfeeding	70.3%	15	16	
Woman would go for an HIV test herself	35%	4	15	70%
Woman feels personally at risk of getting HIV/AIDS	58%	11		20%
Used a condom at last sexual intercourse	46%(used a condom every time)			

THE SICK CHILD

When a sick child should be taken to a health practitioner immediately:

1. *Child unable to drink or breastfeed
2. *Child vomits everything
3. *Convulsions in this illness
4. *Child lethargic or unconscious – seems very sleepy
5. Cough and fast breathing (>50 per minute)
6. Cough and difficult breathing, such as chest indrawing or wheeze
7. A child with diarrhea who has sunken eyes or sunken fontanelle
8. Blood in the stools of a child with diarrhea
9. Child has no energy – “ophela amandla” (& child stops playing)
10. Child under 2 months who develops a fever

[* = Danger signs taken from IMCI Chart Booklet]

UMNTWANA OGULAYO

KUNGASIPHI ISIKHATHI LAPHO UMNTWANA OGULAYO ESIWA KWABEZEMPILO

1. *Umntwana ongakhoni ukuphuza noma ukuncela
2. *Umntwana ohlanza konke akudlile
3. *Umntwana ohluthulekayo ngalesisifo esimphethe
4. *Umntwana othambayo noma oqulekile abukeke ozela kakhulu
5. Umntwana ophefumulela phezulu izikhathi ezingu 50 nge minithi
6. Ophefumula kanzima kuze kupaqake ezimbanjeni kuswininize esifubeni
7. Umntwana ophela amandla (angadlali)
8. Umntwana ashise, kakhulu abanezinyanga ezimbili
9. Indle yakhe iba negazi uma ekhishwa isisu
10. Amehlo ashona phakathi kumntwana okhishwa isisu noma angachami

[* Izimpawu eziyingozi ezithathwe encwadini

yakwa IMCI]

Thukela District Child Survival Project (MED amendment)

Home Based Care (HBC)

(Much of the following material is based on the Doctors for Life Home Based Care documents and training course – refer to acknowledgements for further details)

General

- There is a Home Based Care volunteer or a Community Health Worker trained in HBC in your community.
- Their main job in HBC is to teach families how to care for ill family members at home
- HBC givers are linked to the health system (clinics, hospitals), but also to community structures (community health committees, health forums, community based organisations, churches etc)
- HBC works towards holistic wellbeing for people:
 - Physical wellbeing: How can someone be as physically well as possible?
 - Spiritual: How can someone have a right relationship with God? How can someone's life have real meaning?
 - Psychological: How can someone have feelings of wellbeing about themselves and their situation?
 - Social: How can someone have good relationships with all those around them and important to them?
 - Developmental: How would a person like to develop themselves?
- HBC aims to give ill people and their families legitimate hope for the future

Who should be cared for at home?

- HBC can help people who are ill with HIV or AIDS, and also people who are elderly, or have other illnesses requiring care at home

What are the benefits of being in the HBC system?

- Often someone who is ill will enjoy life more if he or she is at home rather than at the hospital
- The family can provide love and physical comfort that are not available to the same extent at the hospital
- People who are with those that they love, and not isolated in the hospital, can often talk about feelings, situations and plans, which helps with wellbeing
- Often families would like to look after ill members at home, but feel they won't cope, or that they don't have knowledge and skills to do it. HBC can bridge this gap.
- Families can get information from the HBC giver about how to safely look after someone who is has AIDS: food and drink, washing, nursing
- HBC givers are taught how to develop an individual care plan for each person and family they work with.
- HBC givers can listen to the concerns of the families, and clear them where possible

What can families, friends, neighbours and communities do to help those who are ill?

- Offer care and love to ill people
- Spend time talking and doing things together
- Facilitate the ill person with making their plans for the future come into existence

- Make plans together for children's future where necessary
- Help people who are ill to maintain a healthy lifestyle
- Practical help can include the following:
 - Collecting water
 - Collecting firewood
 - Going to the shops
 - Cooking food
 - Caring for children
 - Helping in the garden/ field
 - Sweeping
 - Washing clothes
 - Helping with house maintenance

What is the role of the Dept of Health?

- It is important that the ill person be linked to the health system: the clinic or mobile clinic, and the hospital where necessary
- These can provide treatment, either on an ongoing basis (TB and blood pressure treatment) or every now and then (treatment for thrush etc)
- A person will sometimes need to be referred and admitted to hospital
- Follow up visits are necessary sometimes
- The Dept of Health provides some resources like gloves and dressings to HBC givers where necessary
- The Dept of Health plays a role in supervising the work of the HBC volunteers and CHWs.

Caring for children in the family where parents are ill or who have died

- Ill parents can spend time with their children, giving them care and guidance.
- The HBC giver can facilitate the following:
 - If parents are ill, families should try and ensure that children continue going to school, and that girls are not asked to drop out of school to care for the parents
 - All parents should choose who should be the guardians of the children when they pass away (this is not because they are planning to die, but to make provision for their children as all people will eventually pass away)
 - All parents can make sure that their children have birth certificates
 - Parents can make a will, and make sure that their children will receive the family property. (The will can be given to responsible people like the HBC giver, the CHC, community leaders etc)
 - Children whose parents are ill need lots of love and care from family and community
- If children lose their parents (through AIDS, other illnesses, accidents, or through the parent disappearing), they need their relatives, HBC givers, and other community members to care for them, and to give them hope for the future (see orphan information)

HIV/AIDS

- Some people in HBC have HIV.
- It is not the end of everything if someone tests HIV positive
- We are all affected by HIV/AIDS
- Families and communities can safely look after someone who has HIV or AIDS
- AIDS is a serious disease, it is not a curse or punishment
- HIV is a virus that makes a person's body less able to fight diseases/germs
- AIDS is a group of diseases that come after HIV has made the body weak eg diarrhoea, fever, rash etc.
- However, not all people that have these diseases eg diarrhoea, have HIV
- Some people are HIV positive for many years before they get ill

- Don't let HIV divide our families

How can families safely look after someone who has HIV or AIDS

- The HIV virus is carried in body fluids
- Blood, semen and vaginal fluids carry huge amounts of virus
- Tears and saliva carry hardly any virus. Faeces and urine also do not carry enough virus to infect anyone
- Therefore, when we care for someone who is ill with HIV or AIDS, if we avoid skin contact with blood, semen and vaginal fluids, we will likely not contract HIV
- We can safely live with HIV positive people. We **can**
 - Share cups, plates and cutlery
 - Share toilets
 - Shake hands, hug and kiss on the face, casual social contact
- It is essential that HIV positive people know that we care for them
- In our communities, HIV is usually transmitted through sex with an infected person. Therefore it is important for everyone to know their HIV status. People who are HIV negative should take care to stay negative, and HIV positive people should take care not to transmit the virus to their partners
- In HBC, to prevent transmission of HIV, we should avoid touching blood and body fluids from an HIV infected person.
- If you have a cut or a sore, you need to protect this from body fluids: cover with a plaster
- It is better to wear gloves or plastic if there is a danger of body fluid contact
- If a body fluid comes onto normal intact skin (that is, skin without cuts or sores), there should be no danger, wash with soap and water
- Aprons can be worn if there is a danger of getting body fluid on clothes
- To clean bloodstained clothes or bedding: wash with plenty of soap and water, and hang out to dry. Iron with a hot iron if necessary (the HIV virus cannot survive sunshine or dryness). Someone without cuts on their hands should deal with blood stained washing
- **Waste disposal**
 - Waste can be of 2 sorts: soft or sharp.
 - Put the soft waste eg tissues, dressings in a plastic bag and bury it
 - Put the sharp wastes eg razors, needles into a tin and bury it

How can people in HBC stay as healthy as possible

❖ Nutrition

- Eating and drinking nutritious food is the one way to strengthen your body and help protect it against infections
- Our bodies need enough of the following to maintain a good immune status:
 - energy: eg mielies, samp, rice, potatoes, bread
 - protein: eg beans, meat, fish, eggs, milk, peanuts, lentils, soya
 - fats: eg oil, margarine, fat
 - micronutrients: found in fruit and vegetables,
- Eat a balanced diet: start with what people have at home (staples), and add other foods that are affordable
- If you do not feel like eating, eat small amounts often
- If someone is HIV positive, it is very important for them to try and maintain their weight, even if they don't feel like eating
(See Nutrition information for more details)

❖ **Rest and relaxation**

- If a person is ill, they need to rest more
- Relax doing things you enjoy
- Spend time relaxing with your family and children

❖ **Spiritual help**

- Times of difficulty can be times when people draw closer to God.
- An ill person can benefit greatly from contacting a pastor or minister that can help them work towards spiritual wellbeing
- Friends can also walk with us on our spiritual path and help us pray

❖ **Work**

- People in HBC will often be too ill to work. However, sometimes they get better enough to do some work
- If the normal work is too strenuous, do lighter, less or different work
- Being able to do something may help people feel better

❖ **Taking medicines**

- Know what each medicine is for
- Know which medicines have to be taken all the time, even when you feel better
- Know when you can stop taking other medicines (often this is a while after you feel better)
- Always follow the advice of the sister / doctor
- Ask questions if you are not sure of something
- Take TB treatment after food
- If you lose a lot of weight, or feel nauseous or unwell, return to the clinic

❖ **Cigarettes, alcohol, dagga**

- These are harmful for people who are ill
- They are also expensive

How to keep the HIV positive patient safe from infection?

The HIV positive person can easily catch infections that cause sickness. Basic good hygiene can help avoid this.

- Clean environment: place where food is prepared must be kept clean, wash bed linen, towels and clothes with soap and water, use clean eating utensils that have been washed in soap and water, dispose of waste properly
- Wash hands: before cooking, eating, feeding someone else and touching medicine, after going to the toilet
- A healthy diet: use clean water for cooking and drinking, wash fruit and vegetables well before eating, eat a balanced diet of fresh food
- Use clean drinking water: boil water first, OR add 1 tablespoon JIK to 25 l water, leave to stand overnight, OR put water in clear plastic (coke) bottle and leave in the sun for 1 day
- Good habits
- Exercise: helps keep the body healthy and makes one feel good
- Early treatment of any medical problem
- Avoid contact with other sick people

What can HBC givers teach the families?

Amongst other things, HBC givers can teach families what to do with the following common symptoms and illnesses:

- Diarrhoea

- Weight loss
- Sore mouth & difficult swallowing
- Turning a bedridden person
- Fever
- Etc

Acknowledgements/ References

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Thukela District Child Survival Project (MED amendment)

Nutrition, Wellbeing and HIV/AIDS

We are in a context where many people are infected with HIV, and as a result, HIV affects us all in one way or another. People often feel hopeless and that there is not much we can do. However, we can change that by thinking creatively how we can work towards wellbeing for all: physical, psychological, social, developmental and spiritual. The information that follows is about nutrition and HIV. Good nutrition can contribute significantly to the wellness and quality of life for people with HIV.

The link between HIV and nutrition

- HIV is a virus that attacks our immune systems, which can then lead to our bodies getting other infections. Weight loss can also occur.
- Therefore when we look at nutrition and HIV, we look at ways to maintain the immune system, strengthen the immune system, and reduce the risk of getting other infections. We also look at ways to keep one's weight constant.
- Everyone's bodies need enough energy, protein, fats and micronutrients (vitamins and minerals) to maintain a good immune system
- HIV increases nutritional needs, as the body reacts to the virus with the immune response that uses more energy and nutrients, and anxiety can also weaken the immune system.
- A good diet does reduce the risk of getting any kind of infection
- A good diet can also strengthen the immune system if a person is HIV positive (this helps fight off the other infections people who are HIV positive get)
- Eating healthy food with enough energy also results in a person feeling healthier and stronger, which strengthens psychological wellbeing
- Eating enough AND a balance of different foods helps maintain body weight and muscles
- Deciding what, when and how much to eat is a complex process, and depends on lots of factors eg availability of food, taste, appetite, how much money and time we have
- Food cannot cure HIV or AIDS, nor does it treat the virus

Benefits of good nutrition

- Keep weight stable
- Prevent loss of muscle
- Replace lost nutrients
- Improve wound healing
- Recover from infections
- Deal better with medication and treatment
- Increase strength
- Improve a feeling of wellbeing

Food choices for people living with HIV: A summary

(Based on: South African National Guidelines on Nutrition for people living with TB, HIV/AIDS and other chronic debilitating conditions.)

- **Start early:** It is best to start as soon as one is aware that one is HIV positive. Once people fall behind in terms of nutrition, it gets more difficult to catch up when you feel less healthy, or have other infections.
- **Choose your own food:** Choose what is easily available and affordable
- **Eat a variety of food:** No single food is either good or bad: It is the combination of food that we eat over a long time that leads to better health
- **Make starchy foods the basis of each meal.** Starchy foods should make up the biggest part of the food intake of people with HIV. They are relatively cheap, supply lots of energy, which helps to keep the body weight stable
- **Eat lots of fruit and vegetables:** They supply vitamins and other substances that keep the immune system strong
- **Meat and dairy foods may be eaten daily:** For people living with HIV, it is important to maintain healthy and strong muscles
- **Eat dried beans, peas, lentils, peanuts or soya regularly:** This group of foods from plant sources supplies proteins needed to strengthen the immune system and muscles (more economical protein source than foods from animals)
- **Include sugars, fats and oils:** They provide energy for people. After periods of weight loss they should be included in bigger amounts to help weight gain
- **Be as active as you can:** It is important to maintain muscles in your body. Weight loss in HIV is often due to loss of weight of the muscles, and keeping them working is one way to help keep them strong.
- **Drink lots of safe clean water** (or other fluids): Diarrhoea, vomiting and night sweats can cause loss of large amounts of water that needs to be replaced. (Drink also cold drinks, milk, fruit juice etc)
- **Do not take alcoholic drinks:** alcohol is harmful to the liver, and causes the body to lose vitamins, which are important for the support of the immune system. Also the combination of some medicines and alcohol is unhealthy for the liver.
- **Check that you are not losing weight:** eg: go and weigh yourself regularly eg at the clinic, or have a particular set of clothes to wear that you can check are not getting looser, etc

The nutrients in our food

- No single food contains every nutrient that you need
- So we need to eat a healthy, varied diet (a 'balanced' diet)
- In a study done with healthy HIV positive people, it was found that a diet high in animal products, whole grains, and fruit and vegetables led to 'healthier' blood
- Maintenance of body weight is very important for wellness, and for fighting other infections. Weight loss is most often due to the fact that people do not eat enough food, rather than due to the disease itself. Make every effort to eat and keep up your energy intake.

What does this mean for us?

- **Starchy food:** The biggest part of the food intake, the basis or starting point of our meals. Provides the body with energy. Usually easy to digest, cheap. Eg mealie meal, samp, rice, potatoes, bread, jeqe, sweet potato, amadumbe, cereals
NB: *How can we use 'whole grains'?*: Use unsifted and maize meal #1 whole wheat and brown bread, cook potatoes with skins on, etc
- **Food rich in protein:** Proteins build and repair the body, and play an important role in the immune system. People should eat these as often as they can.
 - **Animal food products:** Meat (chicken, cow, sheep) and organ meat eg liver, milk and diary products, maas, eggs, fish
 - **Vegetable protein sources:** Beans, lentils, peas, peanuts/ peanut butter, sunflower seeds, pumpkin seeds, etc: should be varied or combined with other protein sources
- **Fruits and vegetables:** Food rich in vitamins and minerals, which keep the immune system strong
 - Important vitamins and minerals:
Vitamins: B Co, C, A, and E
Minerals: Calcium, zinc, iron, potassium, magnesium
 - Each one has a special use in the body
 - Our bodies need all of them: each of the vegetables or fruits is rich in only a few vitamins, so it is important to eat a variety
 - Vary in colour: dark green, orange or red, vary in shape: leaves, fruits, roots
 - Examples: Tomatoes, peaches, cabbage, oranges, bananas, lemons, pumpkin, apricots, naartjies, spinach, green beans, apples, plums, grapes, butternut, guavas, avocado pear, carrots, beetroot, lettuce
 - Preparation of vegetables is important: Eat with skins on where possible, eat them raw sometimes, don't overcook. Use the water in which vegetables are cooked in other dishes (soups, stews), as this water contains vitamins.
- **Fat and sugar:** Also rich in energy (can sometimes cause digestive problems)
eg fats: Margarine, cooking oil, mayonnaise

Guidelines for safe handling of food

It is very important to remember that:

- HIV cannot be spread by food and water
- Sharing eating utensils like cups, plates, knives and forks with HIV positive people cannot spread the virus.

General:

- Always wash your hands with soap before and after touching food
- Keep hot foods hot and cold foods cold
- Be extremely careful with leftovers. Store food for not more than 1 day, and boil before eating. Store in a fridge if possible.
- Don't eat food after the expiry date printed on the container/package

Animal products

- Cook all meat products like meat, fish, egg at high temperature till well cooked, because cooking destroys harmful bacteria. Do not eat soft boiled eggs
- Be careful to clean your cutting boards very carefully after cutting animal products

Fruit and vegetables

- Thoroughly wash fruit and vegetables that are to be eaten raw, in order to remove bacteria from the skin

About vitamin pills

- Pills cannot make up for eating well: they are an addition to a healthy eating pattern
- There is no specific vitamin that will cure HIV/AIDS: vitamins are not a treatment
- Always take vitamin pills on a full stomach: be consistent and take them regularly
- It is probably better, and cheaper, to take one multivitamin tablet with minerals daily than several pills containing different vitamins and minerals.
- Anti-oxidant preparations help your immune system. These include vitamin A, C and E and also selenium.
- More is not necessarily better: high doses can cause nausea, vomiting etc. Very high intakes of zinc and vitamin A can decrease immunity in people with HIV.
- Do not take any vitamin in amounts of more than twice the Recommended Daily Allowance (RDA) (look on the label for the RDA).
- Expensive vitamin preparations leave less money for food.

<h3>Nutrition and symptoms of HIV/ AIDS</h3>

□ **Diarrhoea:**

The main dangers of diarrhoea are dehydration and malnutrition

- **Dehydration** can be prevented by taking in extra fluids

- It is important to put back the fluid and other nutrients into the body that are lost when a person has diarrhoea
 - Additional fluids should be started as soon as the person has diarrhoea
 - Fluids are not a medicine, they are to replace lost fluids - so do not give as a medicine (not per teaspoon)
 - Fluids do not CURE diarrhoea - so diarrhoea will continue even though fluids are being given
 - Fluids are not a food (even home available fluids): they are much too dilute for this - so the person should try and eat as well as taking the fluids
 - The whole cup does not have to be drunk all at once - can be taken in small sips every few minutes
- Encourage people to **drink something every time** they have diarrhea. Some drinks are:
 - oral rehydration fluid eg. Soral, Rehydrat
 - sugar salt solution (made with 8 teaspoons sugar, ½ teaspoon salt in 1 litre of boiled water which has been cooled)
 - thin mealie meal porridge
 - soups like chicken or lentil

- broth made with stock cubes
- water used to cook rice
- juice like apple, pear, peach grape (add 1 pinch of salt to a cup of fruit juice) - not more than 2 cups per day as this can make the diarrhoea worse
- Amounts after every stool are: children under 2 years: ¼ - ½ cup, children 2 - 10 years: ½ - 1 cup, adults: 2 cups
- **Malnutrition** happens because often people **do not eat enough** when they have diarrhoea
 - As soon as the person has recovered from diarrhoea and feels better - they should try and eat more than they normally would to regain the lost weight
 - If the diarrhoea lasts longer than 2 - 3 days - the person should go to the nearest clinic to obtain medications to stop the diarrhoea - though not for children under 5 years of age
 - Try to eat small amounts of food often
 - Plain foods like phutu, mealie meal, bread, rice, potato, plain macaroni, oats, well cooked and mashed lentils, baked/poached fish, plain chicken, hard boiled eggs, cooked meat without fat are good choices.
 - Grated or mashed fruit and vegetables like peeled apple or mashed ripe banana are also good choices.
 - If the person has cramps, they should try not to eat foods which form gas like beans, cabbage, onions, broccoli, cauliflower, fizzy drinks, beer and chewing gum
 - People may find that there are some foods that make their diarrhea worse. These foods may be different for different people. Encourage people to experiment to find out which foods make their diarrhea worse. If a person thinks that a particular food does make the diarrhea worse, only cut out that one type of food at a time to see if this is really the case.
 - Large amounts of a particular food (like milk) may make the diarrhea worse, but small amounts may be fine.
 - Low fat milk, maas or yoghurt may be better than the full cream ones.
 - Greasy and fried foods are very likely to make the diarrhea worse
 - Alcohol and caffeine can also make diarrhea worse. Caffeine is found in tea, coffee, coke, cocoa and chocolate. Rooibos tea does not contain caffeine.
- **Preventing Diarrhoea**
 - Food and drinks (including water) must be as clean and safe as possible - so as to prevent diarrhoea from these
 - Drink clean water - either boiled or made safe by using bleach (Jik) - 1 teaspoon to a 25 l can of water and left to stand for 2 hours
 - Food can carry many infections as germs can grow in it. To make sure that the food eaten does not have germs in it, it is important to make sure that the food bought is safe and clean, and that it is kept this way when preparing and storing it.
 - Washing hands often with soap and water is important.
 - Proper disposal of waste - especially faeces (human and animal) - includes the area around the person who has diarrhea.
 - Do not buy or use foods after the expiry date on them has passed
 - Always wash fresh fruit and vegetables well in clean water. Take special care with those that you are going to eat raw. Use a mixture of bleach and water to wash

vegetables and fruit (1 teaspoon bleach to 1 litre of water).

- Never use cracked eggs, wash eggs before you break them, and cook eggs until they are hard
- All meat, chicken and fish must be properly cooked until it is no longer pink inside. Never eat raw or undercooked meat, chicken or fish.
- Cut meat into small pieces so that it cooks to the middle.
- Use only pasteurised milk. If this is not possible then boil the milk.
- Eat meals as soon as possible after you have prepared them. The longer the food is left standing after it has been prepared, the more chance there is that germs will get into it and grow.
- Don't let food stand at room temperature as germs grow very fast at this temperature. Hot food should be kept very hot and cold foods very cold
- Keep all foods covered. If you have leftover food, put it into clean, small, shallow, containers. Cover it with a clean cloth, which is kept damp (the evaporating water cools the cloth and the food).
- If you do not have a fridge, store it in an airy place where air can get to it but where flies cannot. If you have a fridge, put left over food into the fridge within 2 hours after it has been cooked.
- If you re-heat food, make sure that the food is made very hot (it should be boiling) and that all of the food in the container is very hot (including the middle part).
- Throw away all leftover food after 3 days.
- Do not store the food in cans, put it into another clean container
- Clean eating and cooking utensils very well as well as the area in which you prepare and cook food
- Wash utensils and cutting boards well with soap to take off any food that germs could breed in
- Air dry them on a rack, in the sun if possible
- Use a solution of 1 part bleach to 10 parts water to soak sponges or cloths used for dishwashing.
- The bleach solution can also be used for cleaning worktops and places where food is eaten.

□ **Loss of Appetite and Weight Loss**

- The main reason that people who are HIV positive lose weight is because they do not eat enough
- Weight loss may also be because of the nutrients and energy that are lost through diarrhoea and vomiting, or discomfort in their mouths and throat from thrush
- It is much easier to prevent weight loss than to try and regain it after a person has lost weight
- After a person has been sick and has been eating less, they should try and eat more than normal so that they regain the lost weight as soon as possible
- It is especially important to have enough energy in the foods that are eaten to prevent weight loss and regain lost weight
- Most energy rich types of foods are fats and sugar. These can be added to the diet as follows:
 - adding fats (margarine and oil) to porridges, phutu, potatoes, cereals, rice, vegetables
 - adding lots of fats and high fat spreads to bread eg. peanut butter, margarine
 - adding sugar and condensed milk to drinks such as tea, coffee and milo,

porridges and cereals, mashed banana

- using sugary spreads such as jam on bread
- Eating more often to ensure that a persons energy intake stays high - e.g. three meals a day and then having snacks between meals.
- Examples of snacks
 - Sandwiches or crackers (++) marg) with peanut butter, mashed avocado, jam, mashed banana with peanut butter, left-over stew (well re-heated), boiled eggs with mayonnaise, cheese, tuna
 - Full cream yoghurt, maas and milk drinks - could add sugar and/or full cream milk powder to these
 - Fruit - fresh and canned - with extra sugar added to it
 - Cheese
- Encourage people to try to eat even if they don't feel like it:
 - Try not to skip meals
 - Plan when you are going to eat - and try to eat something even if not feeling hungry
 - Eat when you feel a little better, or a bit hungry. There may be certain times of the day, for example in the mornings when you feel hungrier than at other times.
 - Keep favourite food in the house
 - Encourage people to try and eat with other people, not on their own
 - Make food look interesting - use foods with different colours and textures
 - Don't drink liquids at the same time as eating foods - these will fill the person up and then they may not feel like eating
 - Eat foods that are energy and nutrient dense. Don't fill up on non nutritious foods like chips or cold drinks
 - Whenever you have to go out, try and take some food with you that is easy to eat (e.g. sandwiches and/or fruit), otherwise you may go for a very long time without eating or drinking anything.
 - Eating fried, high fat or rich foods may make the person feel even less like eating

□ **Oral thrush**

- Go to the clinic - you may be able to get a medicine that will help the infection
- Keep the mouth clean. This will help to stop infections. Use a good mouthwash and use a soft brush to clean teeth. OR rinse out the mouth with salty water or bicarbonate of soda and water.
- Use a straw to drink for painful lips or difficulty swallowing.
- Tilt your head back to make swallowing easier.
- It may be easier to drink than to eat. The kinds of drinks that will give you nutrients are milk, maas, yoghurt or milk with milkshake powders added.
- Try sucking icicles, ice or drinking cold drinks before a meal as the cold will help to numb your mouth
- Choose soft, moist non sour foods like soft mealie meal, Pronutro, pasta, mashed potato, scrambled egg, mince, baked fish, soup, mashed pumpkin, spinach, gem squash, custard, jelly, yoghurt, ripe fruits like bananas, peaches and pears as these will be easier to eat.
- Cook foods until they are soft
- Chop, grate or mince your foods finely
- Eat food which is cold or at room temperature

- Eat small amounts of food often
- Try to avoid the following:
 - Smoking
 - Alcohol
 - Rough foods like nuts, chips, seeds, raw vegetables, maize and rice
 - Salty and spicy foods
 - Sticky and sugary foods like peanut butter, sweets and sugar
 - Sour foods and drinks like tomato, lemon, orange and grapefruit
 - Dry foods like dry bread
 - Very hot foods
- **Nausea and vomiting**
 - Just as in diarrhoea, it is important to replace the fluids and salts lost when vomiting
 - There are also drugs which can help stop nausea and vomiting
 - Often if a person is feeling nauseous and/or is vomiting they will also not feel like eating (Loss of appetite)
 - Try to eat 4- 6 meals and snacks throughout the day
 - Try to eat at the times of the day when you are feeling better (this is often in the morning)
 - Drinking liquids, which are cold or icy, may help. Drink liquids slowly (drinking through a straw may help).
 - Drink sugar salt solution after vomiting (8 teaspoons sugar, ½ teaspoon salt in 1 litre of water which has been boiled and cooled)
 - Simple, plain, soft or mashed foods are best like soups, potato, plain macaroni, rice, toast, scrambled egg, oats porridge, fruit, jelly and custard.
 - Eat foods which are at room temperature or cold rather than hot
 - Eat salty/sour foods
 - Dry meals such as toast, crackers or a plain cereal may make you feel less nauseous.
 - Ginger in foods, ginger beer or ginger biscuits may help
 - Do not eat any foods which make you feel sick when you smell or eat them
 - Get someone else to prepare foods and don't stay in the house when food is being prepared
 - Don't drink liquids for 30 minutes to an hour before and after meals
 - Rest after eating meals, but don't lie down flat for 2 hours after eating something. Keep your head up. Lie on your right hand side.
 - Don't take medicines at mealtimes unless you have been told to take them at this time by your doctor or pharmacist
 - The following foods are likely to make you feel more nauseous and should be avoided if they do make you feel worse: Fried and fatty foods, sweet or spicy foods, foods with strong tastes and smells, foods which make gas like cabbage, beans, onions, broccoli and cauliflower, very cold or hot food

Acknowledgements & References

These notes are based on workshops held in the Thukela District in 2001. The workshops were run by Fiona Ross, Dept of Dietetics, University of Natal, Pietermaritburg.

Other references:

- South African National Guidelines on Nutrition for people living with TB, HIV/AIDS and other chronic debilitating conditions. Dept of Health, South Africa. 2001.
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Thukela District Child Survival Project (MED amendment)

Orphans and Vulnerable Children

Child rights

There are a growing number of orphaned and vulnerable children in our country. This is a new situation, a new context. Together with these children (some of whom are nearly young adults), we will have to creatively design a future that will benefit us all. We can then plan what actions we need to take in order to bring that future into existence. If we commit ourselves to address the new situation, we will find possibilities and a way forward.

The Rights of Children

Children are special people, who are growing up to be the leaders and members of the communities of the future. They need healthy bodies, minds and relationships. When we talk about these things, we often refer to the United Nations Convention on the Rights of the Child, which our government has signed and promised to carry out. We talk about rights of children rather than their needs, although the two are related.

The rights of children can be grouped into 4 main categories:

- **Survival**
 - A right to life, so basic physical needs must be met: eg food and shelter, clothing and clean water
 - A right to health care, and to treatment when ill or hurt
- **Protection**
 - A right to love, care and protection, so they can be safe and know that they are cared for
 - A right to protection from abuse (physical, psychological, social etc)
- **Development**
 - A right to education, and to develop skills and talents, including the right of older children to training and help in income generating projects
 - The right to grow up to be responsible and caring citizens, and they need guidance and education from adults such as parents, care givers, guardians, other community members etc
 - A right to play and recreation, and to participate in community activities (a right to a sense of identity and belonging)
- **Participation**
 - The right to participate in decisions that affect them (This does not mean that all children make all decisions for themselves, rather, that they be consulted about things that affect them. This is especially true for older children).

There are some differences between needs and rights. Needs do not imply duties or obligations, whereas rights always imply duties or obligations. For example: *a child needs to be educated* implies that child should if possible be educated versus *a child has a right to be educated*, which implies it is someone's duty to make sure that the child gets educated. Needs can also be prioritised, whereas all rights are equally important. For example: *a child needs to be loved* versus *a child has a right to be loved*. We may prioritise the need for food and clothing above the need for love, whereas, the right to be loved and the right to food can be seen as equal.

Along with these rights, there is a corresponding set of responsibilities, eg along with the right to participation comes the children's responsibility to dialogue with other people, rather than just debate or demand things.

As children grow, their needs change, and their capacity to take on responsibilities grows.

Children in families affected by HIV and AIDS face an increased risk of losing their rights:

- Lose a stable family
- Lose their identity
- Lose their inheritance
- Emotional distress
- Increased risk of under nutrition
- Increased risk of illness and lack of health care
- Reduced likelihood of completing their schooling, (often linked to having to work for money before they are adults: child labour)
- Increased risk of becoming homeless

Who are the vulnerable children or children at risk? Who is an orphan?

In our country, many children live in poverty. This makes them vulnerable to undernutrition, lack of survival rights, lack of development opportunities, and open to abuse.

Children become orphans as a result of many different circumstances. It does not matter how a child is orphaned, the rights spoken of above are at risk. However, in our current context, children are often orphaned as a result of their parents dying of AIDS, after a parent has been ill for a while, and the family is placed under financial strain through loss of income and trying to provide health care for the ill person. Children with an ill parent are also very vulnerable.

The children most at risk are:

- Children who have experienced multiple loss of people, especially over a short time
- Children who have lost their mother
- Girls
- Children who have experienced many different types of loss (person, environment, property, status)
- Children who do not have someone they can trust
- Children who are isolated (eg orphan headed household)
- The very quiet and reserved child
- Teenagers
- Very young infants with no parents
- Children with a disability

Not all children who are orphaned are 'vulnerable' or at risk. Some live within a stable, loving family that can fulfil their rights.

What is wellbeing for an orphan or a vulnerable child?

Our dream or vision is that orphans and vulnerable children experience holistic wellbeing and can grow up to be independent. What does this mean?

Holistic wellbeing has the following components: physical, psychological, social, developmental, and spiritual.

- ❖ **Physical wellbeing:** This involves food, shelter, clothing, clean water, medical care, physical safety (eg from accidents and abuse), rest, etc.
- ❖ **Psychological wellbeing:** Orphans have a positive sense of their own identity, and a hope for the future.
- ❖ **Social wellbeing:** Children have good social relationships with the family they are living with, and with their community.
- ❖ **Developmental wellbeing:** This involves every child having the opportunity to develop his or her potential.
- ❖ **Spiritual wellbeing:** Orphans can be part of the spiritual/traditional activities of a community, and this will give them a sense of the meaning of their lives and their relationship with God.

How can we work with orphans and vulnerable children to facilitate their achieving holistic wellbeing?

In our communities, the extended family and other traditional support structures continue to care for most orphaned and vulnerable children. There is increasing strain in this system, and we need to creatively work together as community members, government service providers, NGOs and community-based organisations to find ways of making sure that all our children have wellbeing.

It is important that orphans and vulnerable children who are old enough play a role in whatever is done, as they are the 'experts' of the context, they can identify what it is time for, and above all, young people are resourceful, creative passionate and committed!

The following are some possibilities of actions that people in various roles could offer. There are many other possibilities, and the situation is different for each child, therefore there is no standard way of doing things.

Physical wellbeing:

For survival, children need food, shelter, clothing and health care. These are often scarce in situations of poverty.

- The welfare grants that are available can provide some financial help. However, accessing these grants and the necessary documents often requires some assistance. In our area few people know about these things, and we need to get information broadly available in the community.
- Families and community health workers can ensure that children receive health care when necessary, and that young children get all their immunisations.
- We need to ensure that orphans are not discriminated against within their new families that their grants are used for their benefit, and that abuse does not occur.
- Where children remain in their family homes after their parents die, community members could ensure that the houses remain in good condition so there is adequate shelter. Grannies looking after orphans also need this assistance.

Psychological wellbeing:

- If the parent of a child become seriously ill, the child may face a situation that he/she is not equipped to deal with emotionally.
- This psychological stress continues when the parent dies, and as the child faces a future without his/her parents.
- Community roleplayers like home based carers and community health workers can intervene when the parents are ill, ensuring that children do not carry the full burden of caring for ill parents.
- It is important that children have someone they trust to talk to, who can talk about hope, and how to plan and work towards the future that the child desires.

- Children also need time for play and recreation, and rest. We can ensure that all children can have these.
- We can make sure that children have a sense of identity: who their parents were, who their relations are, how they are part of the community etc.

Social wellbeing

- Orphans may lose many people who are important to them socially: first the parents, and then their brothers and sisters if they are split up and cared for in different families. We can try and make sure that siblings stay together
- All children need love and care, and moral guidance, and we can identify people who can offer these. If children are in a child headed household, this is particularly important. (Orphan children can place higher value on the love they lose when a parent dies than on things like food etc).
- Sometimes children whose parents have died of AIDS are excluded from the community. We can change this context. Everyone needs to be part of the larger community.

Spiritual wellbeing

Orphaned and vulnerable children often feel that their life has no meaning, and are not included in spiritual activities in their communities. We can assist them with spiritual guidance.

Developmental wellbeing

A consequence of having ill parents, or being an orphan in a household, or being in a child headed household is that the child often leaves school (especially girls) in order to do chores, nursing and caring for the other young children. It is critical that children remain in school.

This requires a concerted effort:

- Make sure that children's school fees are paid or that they are exempted, that they have uniforms and shoes (this may require networking with others)
- Make plans how the work the child would do at home can be covered by someone else
- Children gain social benefit and don't feel so isolated if they are able to go to school
- Grannies looking after orphans have said they need assistance with doing homework
- Older orphans and vulnerable children can be linked to skills programs, and vocational training in order to be able to become independent.

What are various possibilities for action at community level?

- Local /traditional leaders have a major role to play to safeguard the best interests of the children.
- Children who are at risk or are already orphaned are most easily identified by Home Based Care givers, or Community Health Workers.
- All parents can be encouraged to write a will and appoint a guardian for their children, so that the children can live with the guardian as soon as necessary, without a period of uncertainty. Children will get their inheritance and also be protected from property grabbing by people who do not have the children's best interest at heart. Children should be kept with their siblings as far as possible. Wills should be kept by trusted people.
- A possibility to help with food security for vulnerable children is the making of gardens to grow food (nutritious food like carrots, spinach etc). In this case, land has to be found for the garden, and help with the actual growing of food (includes seeds, access to water, implements, information etc). Networking is needed.
- Efficient school feeding schemes can be a way of ensuring that children at risk get at least one meal a day during the week.

- Organisations like NGOs can assist schools with some of the school needs in return for schools protecting the right of vulnerable children to education, and seeing to their progress.
- Elsewhere in Africa, community schools have started, where children attend for half a day, and then can do the chores they have to do at home.
- There are cultural difficulties of discussing issues of death with children. However, children have said they have a right to know of the death of their parents, and to love and care during the illness, funeral and grieving for parents. There can be dialogue around this issue.
- In some places, Community Child Care Committees or something similar have been established. These help with identifying children in need, identify existing resources to help, help care givers find extra support, work with service providers like schools, clinics and social workers etc.
- Mothers who are HIV positive often fear that their child may be HIV positive also, and abandon them. We can work against the rejection of infected mothers and children, and enable mothers and children to stay together. (Most babies born to HIV positive mothers are not infected).
- Young people are heading households can be given information on life skills and parenting skills.
- Care for guardians, those caring for the ill, and vulnerable children: these need mentors or guides to talk to, who help them look to the future, and care for them.

Labour saving

In all communities, families are experiencing 'care fatigue', which is when people are exhausted from all the care and work that is needed (during the illness of adults in the family, and then after their death, when children need care). Guardians may feel economically and emotionally unable to cope by themselves.

There are possibilities to address this:

- Guardians can engage in income generating activities. However, they need to be released from some of the household tasks.
- Community childcare can be organised. Community members contribute time regularly to care for a group of children at a central place
- Help with agricultural tasks
- Help with fetching water and fuel
- House repair

Who will care for the children?

There are many possibilities. Each situation is unique and will have its own way forward. However, some possibilities that have been tried are given below. Dept of Social Development (Welfare) is the major partner in this.

- Extended family: a family member is identified to care for orphans after the death of the parents (often the grandmother)
- Child headed household: when parents die, and there is a sibling 15 years or older, social services may work with the child to keep the family together. The younger siblings remain in their home, with the older sibling acting as the parent. They may receive support from volunteers who visit the house to ensure they are coping.
- Cluster foster care: This involves identifying a "foster mother" who is then paid to care for about 6 orphans in the community. She lives with them in a home and raises the children as her own.
- Placing adults (usually older women) in the homes of orphaned children: This often benefits the older woman (granny) and the children.

FOR REFLECTION:

What are the benefits of committing ourselves to action?

What are the costs of doing nothing?

Acknowledgements and References

This information has been compiled from a number of sources, of which the most important are:

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