

Executive Summary	1
A. MAJOR ACCOMPLISHMENTS OF THE PROJECT	2
TECHNICAL INTERVENTIONS	2
HIV/AIDS	2
<i>HIV/AIDS Counseling Training of Health Facility Nurses</i>	2
<i>Counseling Training for PMTCT Implementation for Lay Counselors</i>	3
<i>Supply of Rapid tests to Ndwedwe District Health Facilities</i>	3
<i>Status of introduction of cotrimoxazole prophylaxis for PLWA</i>	3
<i>Establish a Home Based Care System for Ndwedwe Sub-District</i>	3
<i>HIV/AIDS Faith-Based Initiatives</i>	4
<i>Traditional Healers Workshop</i>	4
<i>Care of HIV/AIDS Orphans and Vulnerable Children</i>	5
<i>Develop and introduce an orphan register</i>	5
<i>Institute Income Generating Programs</i>	6
<i>Youth Clubs and Peer Education Strategy and Work of DramAide</i>	6
CONTROL OF DIARRHEAL DISEASES	7
<i>Developing a behavior change strategy</i>	7
<i>Community behavior change activities</i>	7
<i>Training for community health workers</i>	8
IMMUNIZATION	8
<i>Training of clinic based staff</i>	8
<i>Developing a behavior change strategy</i>	8
PNEUMONIA CASE MANAGEMENT	8
<i>Training and supervision of clinic staff in IMCI/pneumonia case management protocols</i>	9
<i>Developing a behavior change strategy</i>	9
MATERNAL AND NEONATAL CARE	9
<i>TBA training on maternal and newborn care</i>	9
<i>Assistance for Facility Nurses on PEP Maternal and Neo-natal module</i>	9
IMCI	10
<i>Community/household IMCI</i>	10
<i>Support IMCI monitoring and supervision</i>	10
<i>Training for project staff and community based health workers</i>	10
MONITORING AND EVALUATION	10
Accomplishments include the following:	11
<i>Health situational and health facility assessments</i>	11
<i>Other routine monitoring and evaluation activities</i>	11
<i>Finalizing DIP and presentation to USAID</i>	11
BEHAVIOR CHANGE COMMUNICATION	12
<i>GAPS analysis for identification of common IMCI key family practices and interventions</i>	12
SUSTAINABILITY AND CAPACITY BUILDING	13
<i>Project Management training for MCDI staff</i>	14
<i>Community entry and introduction of the project activities in the new expanded area</i>	14
<i>Strengthening Community Health Committees' Organizational Capacity</i>	14
B. CHALLENGES AND IMPEDIMENTS TO PROGRESS	14
<i>Absence of Functional District Health System and Fragmentation of Services</i>	14
<i>Shortage of Professional Nurses at PHC and hospital level</i>	15
<i>The HIV/AIDS Epidemic</i>	15
C. AREAS OF REQUIRED TECHNICAL ASSISTANCE	16
<i>Technical Assistance Received</i>	16
D. CHANGES FROM THE PROGRAM DESCRIPTION AND DIP	17
E. MANAGEMENT SYSTEM	17
F. OTHER RELEVANT ACTIVITIES	25
G. RECOMMENDATIONS AND RESPONSES TO THE DIP REVIEW	26
H. ANNEXES:	35

Executive Summary:

In October 2001, MCDI was awarded a four-year cost-extension to continue its Ndwedwe District Child Survival Program (NDCSP). This report covers the period of October 2001 to September 2002, the first annual report for this cost-extension grant. NDCSP is focusing on five key intervention areas: HIV/AIDS (30%), control of diarrheal disease (20%), immunization (20%), pneumonia case management (15%), and maternal/neonatal care (15%)

Over the past year, the NDCSP has made significant progress in carrying out a range of HIV/AIDS activities. These include providing counseling skills training to health facility nurses and lay personnel from both the Department of Health (DOH) and the community in support of the DOH strategy to provide VCT and PMTCT services in the District, supplying HIV/AIDS rapid test kits to hospitals, establishing a home-based care system for HIV/AIDS affected individuals; training home-based care workers in TB-DOTS therapy, developing and introducing an orphan register, building the capacity of CHCs to institute income generation programs, working with DramAidE to establish youth health clubs and enhance peer education programs, organizing inter-faith AIDS prevention workshops, and training traditional healers on infection control and AIDS prevention.

The project has also made progress in establishing supervisory systems to support clinical case management for diarrheal disease and pneumonia, and monitoring of immunization activities. Maternal and neo-natal care interventions have included assisting additional nurses to complete the PEP training program and providing refresher training for TBAs on maternal and neo-natal care.

In order to support target interventions, the NDCSP field team, with expert assistance, conducted a GAPS Analysis, which is now being used to develop a behavior change strategy. Initial strategies and behavior change targets have been identified and the project team is beginning the process of adapting and developing appropriate messages and interventions. The project is on track in implementing interventions in each of these areas and is making progress in meeting its objectives.

A number of district-wide initiatives for the integration and improvement of clinic and community linkages have been introduced with the assistance of NDCSP. Additional IMCI in-service training for clinic staff was conducted by the team. An IMCI supervisory plan is in place and being implemented using supervisory tools developed by DOH. With the encouragement of the Project team, clinic supervisors have taken on added responsibility in the implementation of HH/C IMCI. The project has trained 120 community outreach personnel (44 CHWs, 28 TBAs and 48 HBCVs) to promote IMCI key family practices.

During this first year of the extension phase, NDCSP has completed a final/baseline KPC, four new health facility assessments, a final evaluation, a GAPS analysis, qualitative analysis, a number of focus group discussions, and a DramAidE evaluation and baseline analysis and has been actively introducing project activities into the new project area. The Project has also assisted the DOH in establishing a community health information system and publishing a quarterly epidemiological report. The Project continues to work closely with a large number of

communities, local NGOs and the KZN District Health Management Team to implement program interventions.

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A. MAJOR ACCOMPLISHMENTS OF THE PROJECT

TECHNICAL INTERVENTIONS

HIV/AIDS

The overall objectives of this intervention are to increase awareness among mothers/caregivers of symptoms of STIs other than HIV/AIDS, to encourage use of condoms during intercourse to prevent HIV transmission, increase awareness of ways in which a mother can transmit HIV/AIDS to her child, and to reduce stigmatization. In terms of institutional support, the Project is assisting (1) DOH health facilities to provide appropriate HIV/AIDS/STIs prenatal screening and counseling and (2) households caring for OVCs to access DSW grants and services. The Project's objectives also include working with adolescents to prevent HIV/AIDS transmission through assuring that secondary school students have adequate knowledge of HIV/AIDS prevention strategies and encouraging them to adopt sexual practices that prevent the transmission of the HIV/AIDS virus. All activities set forth in the Detailed Implementation Plan (DIP) for the first year have been carried out by the project team and the following accomplishments reflect NDCSP progress toward achieving these objectives:

Institutional Support: The NDCSP team has actively supported a number of initiatives to increase institutional support for both AIDS prevention and care in Ndwedwe District. These activities not only support care at the facility and household levels, but also promote the transfer of knowledge and reduction of stigma to not only mothers but also other community members. In addition to training clinic-based personnel on testing, diagnosis, and prenatal screening, the NDCSP team has been very active in supporting a new DOH strategy to establish PMTCT and VCT activities in the area. The DOH is committed to roll out this strategy in all potential facilities. Accomplishments include:

HIV/AIDS Counseling Training of Health Facility Nurses

A ten day workshop on AIDS counseling was jointly organized by the DOH and MCDI staff to train eleven PHC nurses from Ndwedwe health facilities. Performance of trained counselors has been assessed by MCDI trainers during routine supervision. It is critical that MCDI continue to support and mentor all the nurse counselors as the DOH has not yet established a proper supervisory system. These trained professional nurses have assumed responsibility for HIV counseling activities in their respective facilities. These include two VCT sites in Osindisweni and Montebello hospitals and the PMTCT site in Montebello hospital

Counseling Training for PMTCT Implementation for Lay Counselors

In the light of the shortage of professional nurses and the increased burden on the health care system due to rising HIV/AIDS epidemic, the Department of Health AIDS Program requested MCDI's assistance in training a group of lay counselors in the greater Ilembe District as HIV/AIDS counselors. Following planning meetings with District and Regional health authorities and identification of the appropriate individuals, MCDI trained thirty three lay counselors to start a PMTCT counseling program in 4 hospitals- Montebello, Ntunjambili, Maphumulo and Stanger- within Ilembe district. Of these hospitals, only Montebello hospital is located in Ndwedwe. These trained counselors will enable the DOH to initiate MTCT and VCT activities in hospitals of Ilembe District.

The training was organized in two workshops of two weeks each and included the following modules: Introduction to HIV/AIDS; Self Awareness; Attitudes; Introduction to the TASO model of counseling; Stages of HIV infection and sexually transmitted infections; Management of HIV and opportunistic infections including TB management and DOTS; Children and HIV/Aids; Prevention of infection through blood; Sexuality and safer sex; VCT, Legal and ethical issues; Behavior change; Principles of HIV/AIDS Counseling including: Verbal Counseling, Pretest Counseling, Post-test Counseling; Stress and burnout; Crisis counseling; Resources for HIV/AIDS services; Practical Counseling; PMTCT; and Nevirapine¹. Following training, these lay counselors were employed by the DOH at PMTCT pilot sites in four abovementioned hospitals.

Supply of Rapid tests to Ndwedwe District Health Facilities

MCDI supplied the DOH with 2488 HIV/AIDS rapid test kits. These tests kits are being used by Osindisweni and Montebello hospitals which are both VCT and PMTCT sites. MCDI also assisted in training four laboratory and four PHC nurses in these two hospitals on use of HIV/AIDS rapid test kits in July 2002. As requested by DOH, future HIV rapid tests training for clinic nurses has been postponed, pending identification of the clinic VCT sites. MCDI has been one of the pioneers in introducing HIV rapid tests in KwaZulu Natal.

Status of introduction of cotrimoxazole prophylaxis for PLWA

Currently there is no government policy on the use of cotrimoxazole as a prophylactic for opportunistic infections for PLWA in South Africa. However, the DOH has not objected to this strategy and MCDI plans to train clinic nurses in use of cotrimoxazole in the second year of the project.

Establish a Home Based Care System for Ndwedwe Sub-District

The DOH requested MCDI to carry out activities related to home based care (HBC) for HIV/AIDS patients, including; training and supervision of HBC activities in the project area. Following an assessment of the HBCVs in the project area trained either by the DOH or other NGOs, the following needs were identified: additional volunteers to be trained, a comprehensive supervision system, and upgrading the knowledge of the HBCVs in the DOTS TB treatment strategy. Based on this assessment, MCDI is assisting the DOH with the establishment of a District Home Based Care system, including supervision and training of HBCVs, and

¹ Nevirapine is only being used in Montebello Hospital on a pilot basis and is still under consideration by DOH for wider use.

implementation of a community DOTS strategy. These trained HBCVs are currently monitoring and providing home-based care to 188 patients. This effort, although limited in the early stages of the project, is encouraging given that it is still difficult to identify PLWA and that the DOH is still developing supervisory systems for HBC workers.

MCDI trainers, in collaboration with trainers from Sinisizo, a local catholic NGO with expertise in HBCV and TB DOTS training, organized training workshops for the HBCVs from fourteen different tribal authorities. This training provided information and skills for the HBCVs to:

1. Demonstrate a knowledge and understanding of the progression of HIV infection
2. Recognize problems associated with the home care for people with AIDS – poverty, poor nutrition, elderly caregivers etc.
3. Demonstrate that they had acquired the basic skills needed to care for a person with AIDS in the home.
4. Access different government grants for AIDS patients and the orphans and vulnerable children.
5. Supervise community DOTS TB activities at the household level

Presently, there are 214 HBCVs functioning in Ndwedwe, 150 of whom have been trained by MCDI to provide services to a large number of families and households affected by AIDS. Establishment of a supervision and a referral strategy is a serious challenge for the effective implementation of a comprehensive home based care system in Ndwedwe. The project is trying to bring mobile clinics on board for support and supervision of the HBVCs. Clinics serve as formal referral points for this system.

Additional local activities for addressing awareness, prevention, and stigma:

HIV/AIDS Faith-Based Initiatives

Faith-based initiatives in public health for implementing HIV/AIDS projects at community level have recently been given lot of attention by the Government of South Africa and, in particular, KwaZulu Natal, the area with the highest HIV prevalence in this country. MCDI has been active in different provincial, national and international forums, e.g. Provincial Inter-Faith HIV/AIDS Forum, Provincial HIV/AIDS Action Unit (Religious Leaders Forum) and the World Conference of Religion and Peace.

MCDI and the Diakonia Council of Churches, an umbrella body for the local churches, jointly organized three one-day interfaith workshops followed by two three-day workshops in the project area and conducted fifteen focus group discussions for religious leaders and the interfaith community. The main strategy was to form focal groups among religious communities to spearhead HIV/AIDS interventions in their respective communities. The workshop covered the following subjects : prevention, care and support of the patients and care of HIV orphans and other vulnerable children and defining the role of the faith-based organizations and religious leaders in addressing this pandemic.

Traditional Healers Workshop

In April 2002, the project sponsored a 3-day workshop for Traditional Healers (TH) at Osindisweni Hospital. The workshop trained 15 THs from Ndwedwe Central with the aim of

organizing and empowering this important group of community leaders around issues of HIV/AIDS/STIs and TB. Yet another objective was to educate them on infection control measures, especially related to the utilization of sharp objects in their daily practice. A pre-course evaluation showed that the understanding on AIDS issues was minimal and in some instances non-existent among the THs. These traditional healers are encouraged to disseminate information acquired in this workshop to their colleagues in other areas of Ndwedwe. By training TH, this workshop has created an additional group of community based providers to be part of the existing network of community based workers/facilitators. This will help the project to effectively implement C/HH-IMCI and other community interventions.

Orphans and Vulnerable Children: During this first year of project implementation project staff have completed a number of tasks relative to institutionalizing support for orphans and vulnerable children. All of the activities planned for in the detailed implementation plan have been accomplished, as follows:

Care of HIV/AIDS Orphans and Vulnerable Children

The Government of South Africa is seeking viable means of meeting the needs of increasing numbers of orphans and children affected by AIDS. It is preferred that these children remain in their home communities, but some do not have a capable full-time caregiver within their immediate kin network. There are an increasing number of child headed-households in the project area. To meet this growing demand a system of care and support of orphans was developed by MCDI in collaboration with the Department of Health, Department of Social Welfare, Department of Home Affairs, and local governments, local partners and the community.

A pilot Wealth Ranking exercise was conducted in two tribal authorities to identify the most needy communities and households. Based on the findings of this exercise, the communities in two tribal authorities of Qadi and KwaNyuswa have identified two sites for the establishment of a model crèche. Two potential partners have shown interest in the implementation of this project: CHF (Community, Habitat and Finance) which is a US based PVO and the KZN Interfaith AIDS Forum (eKhaya Project). A preliminary assessment of the communities and sites has been completed by MCDI, eKhaya, and CHF, and agreements with communities have been reached.

Develop and introduce an orphan register

MCDI also developed and introduced an orphan register. This register is being continuously updated by the CHWs and HBCVs, and is being used to collect information on orphans and their families. The CHCs, CHWs and HBCVs have all been trained to gather information on orphans and vulnerable children.

Based on information collected using the orphan register, it is understood that Qadi and KwaNyuswa tribal authorities have the highest number and concentration of OVCs in Ndwedwe. For many of these children, the day-care arrangement that will be pilot tested by the NDCSP, in collaboration with other NGOs, could make it possible for a neighbor or elderly relative to assume responsibility for them. If the model crèches established in Ndwedwe prove to be successful in this regard, MCDI will develop a formal model plan that can be applied throughout the province.

Institute Income Generating Programs

In-order to facilitate income generation activities for communities and to build the capacities of community based institutions and workers - such as the CHCs, CHWs, and HBCVs - to be able to assist OVC/PLWA families, the project conducted a two and a half day workshop on Social Grant programs. This workshop was attended by 44 CHC members, other community leaders and Chiefs from four tribal authorities, as well as representatives from the DOH, Home Affairs, Welfare, Social Justice and local government entities.

The training methodology consisted primarily of group discussions, identifying the reasons preventing CHCs from applying for social grants, and ways to overcome these obstacles to better assist their communities. The group discussions focused on ways to:

- link the community through CHCs with District government officials in addressing community problems.
- help CHCs link with relevant people for advocacy in matters that concern them.
- develop a common vision amongst all parties regarding HIV/AIDS as a problem of the entire community, and that the problems of orphans and other vulnerable children can be addressed through community participation and ownership.

A user-friendly manual “Applying for Grants for Orphan and Vulnerable Children” developed by NDCSP was used to orient them on ways to access resources.

Following the introduction of orphan registers and training on ways to access grants for orphans and vulnerable children, approximately 300 orphans and vulnerable children in two tribal authorities (Nyuswa, Mavela/Ngongoma) have been identified by CHWs, CHC’s members, HBCVs and TBAs. Although some of the information is still unclear, the efforts of these volunteers, who are mostly illiterate, have been encouraging. A monitoring form has also been developed that will help monitor the volunteers’ activities.

A large number of OVCs in Ndwedwe are in the process of acquiring relevant documents necessary for government grant application. In October 2002, the MCDI social worker held a meeting with officials from the Department of Home Affairs, the District Councilor, the Inkosis (local leadership), and the CHC members to formalize a partnership with the government departments and facilitate the process of accessing grants for OVCs.

The project has yet to initiate a model crèche, which was planned during the first year. However, with the identification of two partners, CHF (Community, Habitat and Finance), a US based PVO, and the KZN Interfaith AIDS Forum (eKhaya Project), MCDI will carry out this activity in the second year of the project.

Focus on Adolescents: The NDCSP has actively supported a set of activities directed at improving the awareness and safe sex practices of adolescents in the District. The Project team has worked closely with its local partner, DramAide, to accomplish the following:

Youth Clubs and Peer Education Strategy and Work of DramAide

One of the strategies adopted by NDCSP has been to promote peer education activities among the youth in Ndwedwe. DramAide, a local NGO affiliated with the University of Natal and

specializing in performing drama as a medium of education, was subcontracted to implement a school peer education project in Ndwedwe. The first intervention phase ran from January 2000 until October 2001. Its primary goal was to establish Health Clubs in secondary schools spread across the AIDS-ravaged Ndwedwe rural and deep rural areas of Kwazulu-Natal. These Clubs were initiated by the DramAide facilitators, with the concurrence of the relevant regional educational authorities. Secondary school students were exposed to a range of key AIDS messages using drama and self exploration and other Life Skills techniques, designed to change attitudes and behavior regarding the virus. Communication of the AIDS messages from Club members to other learners, at the same and other schools, was key. In an evaluation of this initiative it was noted that many of the goals had been achieved and that a significant positive change in attitudes and expressed practices had occurred regarding HIV/AIDS at the target schools. The evaluation recommended that more effective methods be used to cascade the initiative to nearby schools, a goal of the intervention that has not yet achieved the same level of success.

As set forth in the work plan, the project established eight school health clubs in secondary schools with the intention of cascading this initiative into primary schools. One of the main aims of the project for this year was to link school clubs with other community resources, like local youth groups/clubs, youth outside schools and the CHCs, to provide further training for clubs to help them fulfill the requirements of the National HIV/AIDS youth policy which provides a framework for youth development across the country. These activities are in process.

Facilitating factors include strong support and active partnership with the DOH and identification of new potential partners in scaling up HIV/AIDS activities.

CONTROL OF DIARRHEAL DISEASES

Project objectives for this intervention include improving mother and caregiver practices relative to adequate provision of ORT and other liquids to children during diarrheal illness as well as their adoption of good household practices such as hand washing. These objectives focus primarily on changing behaviors; therefore, primary effort has been placed on developing a behavior change strategy to address these practices, as follows:

Developing a behavior change strategy

In August, 2002, the project conducted a Gaps Analysis focusing on the key family practices, including diarrheal disease control. The results of this analysis are currently being used in group discussions and workshops with community members and District Health officials to help NDCSP staff to identify key behavior change strategies, messages and interventions. Based on the outcome of this exercise the project will review and adapt existing behavior change materials in the second year of the project. The project is currently using material developed by DOH, WHO and Tugella World Vision CSP.

Community behavior change activities

Cholera behavior change activities were undertaken at clinic outpatient departments and cholera tents. The project used behavior change materials developed by WHO/DOH to train communities. The project also assisted the DOH in distributing chlorine in communities.

Training for community health workers

In order to supplement previous clinical IMCI training provided to health facility staff, additional training on diarrheal diseases prevention and care, with special emphasis on control of the cholera epidemic, was conducted in five tribal authorities during the cholera epidemic.

IMMUNIZATION

The objective of this intervention is to ensure that children in the target area receive, in a timely manner, all childhood immunizations. In order to address this objective the project's first year activities and accomplishments have included:

Training of clinic based staff

MCDI is an active member of the District Health Management Team (DHMT), supervising quarterly EPI program activities at all PHC facilities, including support for DOH activities in immunization mass campaigns, cold chain monitoring and stock management of vaccines. Staff of all nine clinics, three hospitals, and the community health center in Ndwedwe have been trained in immunization in accordance with the IMCI strategy. In addition, staff skills have been enhanced by in-service training sessions conducted by the MCDI trainer during quarterly supervisory visits. During routine supervisory visits, it has been noted that the immunization services do maintain quality services in terms of maintenance of cold chain and availability of vaccines.

Developing a behavior change strategy

During this year, the project was to develop a BCC strategy as defined by the BEHAVE Framework, and adapt, reproduce and disseminate BCC materials on immunization. The project conducted a Gaps Analysis, the results of which are being used in group discussions/workshops with members of the communities, District Health and NDCSP to identify key behavior change strategies, messages and interventions to address immunization-related behaviors. During the second year of implementation, the project will review and adapt existing BCC materials to support the strategy.

Routine supervision by the NDCSP trainer has contributed substantially to the progress in achieving this objective.

PNEUMONIA CASE MANAGEMENT

The overall objectives of this intervention area are to assure that clinics in the project target area are correctly implementing IMCI protocols for pneumonia diagnosis and treatment and that mothers/caregivers demonstrate improved care-seeking practices for pneumonia, resulting in prompt medical attention. The activities set forth in the implementation plan for year one have been accomplished as follows:

Training and supervision of clinic staff in IMCI/pneumonia case management protocols

All health care facility workers in the project area have now received training in appropriate case management using the IMCI approach. Regular supervision by the NDCSP staff, using supervisory protocols developed by DOH, has allowed the project to monitor the effectiveness of this training and be assured that clinic staff are correctly implementing those protocols.

Developing a behavior change strategy

During the first year the project team was scheduled to develop a BCC strategy as defined by the BEHAVE Framework and adapt and reproduce existing BCC materials on PCM. In addition, the project was to train CHCs, HBCVs, CHWs, TBAs and traditional healers on PCM behavior change messages. Using the GAPS Analysis, conducted in August 2002, and subsequent group discussions with members of the communities and District Health Management Team, NDCSP staff is currently identifying a behavior change strategy, messages and proposed interventions. Based on the outcome of this exercise the project will implement the strategy and review and adapt existing BCC materials in the second year of the project.

MATERNAL AND NEONATAL CARE

The objectives of this intervention are focus on assuring that neonates exhibiting recognized danger signs receive timely medical attention, that CHCs make commitments to respond to priority health concerns in their communities, including obstetric emergencies, that mothers receive four antenatal checkups during their last pregnancy, and that clinic nurses in the project target area, who provide maternal and neonatal care, are trained using the PEP modules. Accomplishments include the following:

TBA training on maternal and newborn care

As planned in the DIP work plan, the MCDI training coordinator conducted refresher training for 37 TBAs on maternal and neonatal care. As a result of this training, TBAs are better aware of obstetric and neonatal danger signs, have confidence to handle obstetric cases, have increased their referrals of pregnant women to the health facilities, and are encouraging pregnant women to receive four antenatal checkups. TBAs have also been able to organize health education sessions in the communities for mothers and caregivers. The MCDI training coordinator regularly supervises these TBAs. There is evidence that previously trained TBAs now have enhanced skills and this training has facilitated increased numbers of women delivering at health centers.

Assistance for Facility Nurses on PEP Maternal and Neo-natal module

The MCDI Training Coordinator conducted a needs assessment and then assisted willing and interested nurses from Ndwedwe clinics to enroll in the PEP course. The training coordinator facilitated the purchase of the manuals from the PEP Department of Grootteschuuser Hospital in Cape Town, mentored their studies and was a final examiner for this course. With the help of MCDI, five professional nurses in Ndwedwe received their certificates during this current year. The training has helped them to manage difficult obstetric and neonatal cases more effectively. Moreover, three professional nurses have also enrolled in the advanced diploma in midwifery program.

IMCI

Activities proposed under IMCI include: training a cadre of IMCI supervisors and other clinic staff, and supporting IMCI monitoring, supervision and guidance.

Accomplishments include the following:

Community/household IMCI

A number of district-wide initiatives for the integration and improvement of clinic and CHC linkages have been introduced with the assistance of the NDCSP. NDCSP staff members are providing technical assistance to the IMCI District Task Team and the Ndwedwe District HIV/AIDS Task Team. With the encouragement of MCDI, clinic supervisors for the District have taken on added responsibility of playing an active role in the implementation of the C/HH-IMCI.

Support IMCI monitoring and supervision

According to DOH supervisory plans, IMCI supervision takes place once every quarter. MCDI's training coordinator, authorized by the DOH to assist in IMCI clinical/facility training and supervision of IMCI activities at the health facility level, is routinely conducting supervisory visits. The project uses supervisory tools developed by DOH, which includes manuals/protocols and checklists. These visits are part of clinical IMCI in-service training for the professional nurses. After each supervisory visit, a report of the observations, outlining the weakness and strengths of the clinic nurses and facilities, and recommendations is sent to the Regional IMCI Coordinator. It is expected that at the PHC level, all childhood illnesses will be managed according to IMCI guidelines and protocols.

Training for project staff and community based health workers

The project trained 44 CHWs, 28 TBAs and 48 HBCVs on IMCI key family practices, which includes pneumonia case management, control of diarrheal diseases, immunization, and on the conduct of behavior change activities in their communities. Recently, MCDI's AIDS/PHC Supervisor was trained in Clinical IMCI by attending a course organized by the Department of Health. The supervisor was also trained on new breast feeding techniques, in a course organized by UNICEF. The project's training coordinator who has also been trained in Clinical IMCI supervises clinic nurses. With the availability of two trained IMCI supervisors, MCDI is well positioned to play a more active role in the implementation of IMCI in Ndwedwe. MCDI will facilitate the next round of training for the IMCI supervisors that will be conducted in 2003, based on the DOH work plan.

MONITORING AND EVALUATION

Activities to be accomplished under health situational and health facility assessments include: baseline KPC surveys, health facility assessments in the new areas, focus group discussions and GAPS Analysis. Other planned routine monitoring activities include developing GIS and demographic maps locating CHWs, TBAs, HBCVs, establishing a community-based health information system, and reviewing and adapting existing community-based health information systems and materials. Planned activities also include monthly OVC register review meetings,

monthly reporting by HBCVs on status of patients under their care, training CHCs, HBCVs, CHWs and TBAs in household level health information collection and expanding facility based HIS to include new facilities. Planned special studies include examining reasons for community resistance to IMCI implementation and a cost effectiveness study of HBCVs. Except for review and adaptation of existing community based health information systems (CBHIS) and training of community based volunteers in CBHIS, the project has accomplished all activities planned for the first year of the project. Activities such as developing the GIS and demographic map, focus group discussions and conduct of a qualitative study to further identify barriers to behavior change have already been initiated and will be completed in the second year of the project.

Accomplishments include the following:

Health situational and health facility assessments

The NDCSP project conducted a final KPC survey in December 2001 to provide data for the final evaluation of the project, as well as the baseline for the cost-extension phase of the project. Following the final KPC survey, a final evaluation was also conducted, and the results of this evaluation were used in preparing the cost-extension's detailed implementation plan. Health Facility Assessments were also carried out in the new area during May- June 2002. (See Annex d for the results of this assessment for the new facilities)

A study was commissioned by MCDI to provide baseline information upon which the DramAidE interventions will be based. This study was conducted by June Kelly, a clinical psychologist/counselor and consultant attached to the University of Natal. (Refer to Annex c for the executive summary of this study).

Other routine monitoring and evaluation activities

The Chief of Party, Dr. Farshid Meidany, assisted the KwaZulu-Natal Provincial DOH in analysis of the Annual Antenatal HIV Survey epidemiological data and cholera data for KwaZulu-Natal. He also helped the newly appointed Director of Epidemiology in setting up a committee for the regular publication of a quarterly epidemiological bulletin. MCDI will print the first issue of this publication in November 2002. Other contributors to this work include an epidemiologist and a public health specialists from DOH, WHO, Italian Cooperation and Cuban Cooperation.

In addition, MCDI is assisting the DOH in establishing a community health information system and in identification of a minimum set of data and indicators. The Provincial Epidemiology Unit and other stakeholders are involved in this effort.

The project is also developing coordinates to map the community CHWs and HBCVs using the GIS package, which will be used to facilitate formation of supervisory units and systems as well as establishing links for referrals to health facilities.

Finalizing DIP and presentation to USAID

Design of the Phase II project DIP included involvement of all project staff, key local project partners, as well as MCDI Home office staff. In addition, the findings of the Phase I final KPC and Final Evaluation provided a substantial base of information upon which the Phase II DIP was based. During DIP preparation, the Project Manager consulted key DOH personnel at both

the district and provincial levels, including the District Health Manager, the Regional AIDS Coordinator, the Provincial IMCI Manager, the Provincial MCH Coordinator, the Assistant Regional Director for Adolescent & Child Health, the Assistant Regional Director for EPI/IMCI, the Provincial Chief Pharmacist, the District Municipal Manager, and the Regional Health Information Manager.

In-depth interviews were also conducted with relevant health facility staff from both old and extended project areas as well as traditional leaders (Amakosi) residing in the District in order to obtain their inputs on the district health needs. Finally, intensive discussions were held with the Project's partners, including the Director of Valley Trust, the Manager of TREE, the Director of DramAIDE, the Programme Manager of Diakonia, the AIDS Network Coordinator at Diakonia, and representatives of the Natal University Centre for Rural Development, the Provincial Interfaith AIDS Forum, the Natal University Institute of Virology, and staff from Doctors for Life.

Prior to the submission of the DIP, all project staff and key project partners at the local level were consulted to ensure their full support and agreement with the NDCSP's plans for Phase II. The DIP was presented to USAID by the Project Manager and MCDI Home Office staff on 10 June 2002.

Subsequent to the DIP approval, a workshop was organized with the participation of all field staff and DHMT. The main objectives were to study the DIP and to identify individual roles/tasks. Later, each staff member produced a first year work plan. Based on this individual work plan the project's first year plan was developed. This plan is being used at the weekly staff meetings to monitor activities and plan for future activities. Some relevant parts of the DIP have been translated into Zulu and are being used by the staff members in discussions with the CHCs, Chiefs and the communities.

Two special studies that were planned for the first year (community resistance to IMCI implementation and cost effectiveness study of HBCVs) will be carried out after the project has implemented these activities in all communities in Ndwedwe.

CROSS CUTTING APPROACHES

BEHAVIOR CHANGE COMMUNICATION

Activities to be accomplished in the first year of the project include: conducting a qualitative GAPS analysis to identify gaps in current strategies, conducting a workshop to define the BCC strategy using the BEHAVE Framework, adapting BC materials used by other PVOs, and conducting behavior change activities targeted at mothers and non-maternal caregivers. Except for behavior change activities targeted at mothers and non-maternal caregivers, the project has carried out all activities and is in the process of reviewing behavior change materials developed by other PVOs and the DOH for adaptation and use in the project area.

GAPS analysis for identification of common IMCI key family practices and interventions

In August the project conducted an IMCI Key Family Practices GAPS Analysis. The purpose of this GAPS Analysis was to provide an assessment, based on discussions with community

members, of the degree to which household and community practices match the ideal behaviors described by the Key Family Practices (KFP) and to identify barriers/benefits to adopting these desired behaviors. This methodology was utilized as a simple tool to identify program priorities and will be used to identify the most appropriate behavior change interventions.

This qualitative survey was developed based on the Key Family Practices identified as essential to the health of children by the South African Dept. of Health on the basis of guidelines from WHO and UNICEF.

In preparation for this exercise, the project's Home Based Care Trainer attended a Behavior Change workshop conducted by the Academy of Educational Development in February 2002. The NDCSP project also trained all project staff and the DOH counterparts, the District Health Coordinator, Regional Health Information Officer and Health Facilitators on GAPS analysis, and finalized a GAPS Analysis instrument and Guidelines that can be used by MCDI's other child survival projects. This process was facilitated by Consulting Anthropologist, Dr Barbara Parker.

The results of this GAPS Analysis were later used as the basis for a group discussion/workshop, involving the communities, District Health and NDCSP, to identify key behavior change strategies, messages and interventions.

The next step will be to use the results of this exercise in the implementation of C/HH-IMCI in the project area. A number of behavior change messages and interventions have been identified and will soon be developed. The project also collected IEC/BC material from the DOH, the Equity Project, and World Vision. In a meeting with DramAidE a number of messages have been identified which should be included in youth club activities.

A committee comprised of DOH, DOE, MCDI and community members will select appropriate materials for use in the project. These materials will also be field tested at the community level and then reviewed and adapted for use by the end of the second quarter of the second year.

SUSTAINABILITY AND CAPACITY BUILDING

The Project team is working closely with a number of local organizations to expand their organizational capacity to develop and manage a number of HIV/AIDS and child survival interventions. Their continued participation in these areas throughout the extension period enhances the prospects for sustainability of project interventions in these areas. These organizations include the Department of Health, DramAidE, TREE, Sinosizo, Valley Trust, eKhaya, Diakonia Council of Churches. The Project is supporting the activities that are important to these institutions, all of which will contribute to achieving the goals of the NDCSP.

In terms of capacity building, the Project team conducted a capacity assessments with DramAidE and TREE (the largest early childhood resource and training organization in KZN), measuring the following areas: governance and organizational environment, financial management, and management systems, using an evaluation guide developed by USAID/South Africa. Areas to be strengthened include strategic planning, developing monitoring and evaluation systems, developing management and administrative skills of staff. Capacity assessments have yet to be conducted with the other project partners. These assessment will be carried out in year two.

The Project has reviewed and is currently using the DOH-developed IMCI monitoring tools to measure case management practices and quality of services. Specific capacity building activities include the following:

Project Management training for MCDI staff

The field office PHC Supervisor and Home Based Care Trainer participated in a five day course on Project Management, organized by Liberty House. It is expected that they will apply the skills learned in planning, implementation, supervision/monitoring and evaluation in program implementation. Field office community organizer participated in a course on Financial Sustainability, jointly organized by Non-Profit Partnership (NPP), a local NGO, and the Provincial Parliamentary Programme (PPP), a government program. It is expected that he will apply the skills learned in this course to strengthen an intervention focusing on financial sustainability in the project area. All the project staff were also trained on basic computer applications and use of internet and e-mail, to facilitate day-to-day functioning. The project team was also trained in KPC surveys and data analysis.

Community entry and introduction of the project activities in the new expanded area

New project areas were visited by the Project Manager and the training coordinator, accompanied by the DOH District Coordinator and other staff members, to introduce MCDI and our activities to the CHCs and the community members. Later the project community organizer and a health facilitator from DOH visited each new tribal authority to conduct PLA activities on prioritization of health conditions, identifying community resources for two CHCs and establishing a plan of action for one of the CHCs. The project plans to train CHC members on organizational skills in the second year, in collaboration with DOH and Valley Trust facilitators.

Strengthening Community Health Committees' Organizational Capacity

Community mobilization of all Tribal Authorities in the extended project area has been successfully completed by MCDI staff. MCDI met with all chiefs, indunas and counselors from these areas and identified those HBCVs to be trained from each new tribal authority. Subsequently, MCDI's Community Organizer, in collaboration with Valley Trust, a local partner NGO working with the DOH in strengthening CHCs and CHWs, and DOH, conducted Participatory Learning Exercises (PLA) with each of these tribal authorities to initiate formation of Community Health Committees. These CHCs are regularly visited by MCDI staff, Valley Trust and DOH during which time relevant PLA activities and capacity building in the following areas have been undertaken: project management (to identify their problems, priorities and make their own action plans), roles of committee members, constitution writing, needs analysis and prioritizing problems and activities, proposal writing, fundraising skills, basic financial management skills, business management skills, and lobbying and advocacy. The resulting behavior change strategy will be addressed through these community organizations.

B. CHALLENGES AND IMPEDIMENTS TO PROGRESS

Absence of Functional District Health System and Fragmentation of Services

KwaZulu Natal still does not have a functional District Health System. During this first year of the cost extension period of the project (as well as in previous years), the primary impediment

faced by the program has been the fragmented system of services, reporting, supervision, supply and administration that has characterized the Ndwedwe Magisterial District.

Community health services in Ndwedwe are provided through nine clinics, one community health center and one District Hospital. These clinics report to four different administrative centers or hospitals, only one of which is actually within the official boundaries of Ndwedwe. In some cases, the facility responsible for supervising and supplying a clinic differs from its designated referral hospital.

In June 2002, the DOH officially announced that new Health Districts would be established according to the recent Local Government municipal demarcations. This means that Ndwedwe is now part of a large Municipal District called Ilembe. Ilembe consists of four local municipalities, including Ndwedwe. The capital of this new Health District is Stanger, about 160km from Ndwedwe.

Response: The Department is now in the process of establishing a District Health Office in Stanger, appointing a District Manager and other staff for this office and delinking the facilities in this new district from supervisory authorities in Durban and Pietermaritzburg. Previously, MCDI helped the Ndwedwe District Manager to establish a functional Interim District Management Team (IDMT), but due to the fragmentation of services it could not function optimally. This transitional period in the establishment of the District Health System is a crucial time for the field team to build linkages with the new District Office to be able to influence management decisions. Unfortunately NDCSP has very limited resources that can cover only the Project area and not the greater Ilembe District.

Shortage of Professional Nurses at PHC and hospital level

Department of Health facilities are the major clinical partners of NDCSP. Shortage of trained health workers remains a major barrier for the effective implementation and sustainability of the project activities. This problem is a national issue and needs major attention. Professional nurses are leaving the country on a huge scale. This problem is more serious in rural areas, due to unfavorable living conditions and lack of monetary incentives to encourage health professionals to remain in rural areas. In the past, the clinic nurses received a rural allowance.

Response: For the sake of the sustainability of the NDCSP activities and transfer of skills to local partners, a number of DOH trained staff should be assigned to work with the NDCSP staff on a regular basis. Unfortunately this has not yet happened. Establishment of a supervision and referral strategy for the effective implementation of a comprehensive home based care system in Ndwedwe will be seriously challenged if DOH supervisory personnel are not made available. MCDI has tried to bring mobile clinics on board for support, supervision of the HBVCs. Clinics serve as formal referral points for this system. The DOH does not have enough professional health workers to assume the supervisory role currently undertaken by MCDI staff when the project phases out. This same problem exists for IMCI supervision and HIV/AIDS counseling.

The HIV/AIDS Epidemic

The dramatic surge in the rate of HIV infection in South Africa and especially in KZN has been the greatest public health threat in the history of this region. According to the Children in

Distress (CINDI), four out of ten young adults in KZN are expected to die of AIDS in the next 15-20 years. Sentinel surveillance from antenatal clients in KZN indicated that about 33 percent of all pregnant women were testing positive for HIV in 2001. For the same year this figure was above 41% for Region F of KwaZulu Natal, the highest in KZN (Ndwedwe is situated in Region F). In response to the increasing awareness of the severity of the HIV/AIDS epidemic, MCDI proposed new activities in the current phase of the project in addition to the previous child survival strategies. These activities fall under four main intervention areas:

- Strengthening the capacity of families affected by HIV/AIDS to cope with the epidemic through training in community and home base care and exploring income-generation activities;
- Stimulating and strengthening a community response to ensure the protection of the most vulnerable children and provide essential services.
- Behavior change activities targeted at the youth and school children using peer education models; and.
- Recently, because Ndwedwe has been chosen as the only rural pilot site for the implementation of PMTCT sites in KZN, the project team has been actively involved in the implementation of this strategy in the District Hospital (Montebello Hospital) training professional nurses and lay counselors in counseling, and assisting with the supervision of the antenatal clinic PMTCT activities.

Response: Our involvement in these activities needs more resources, financial and human. Regrettably the present resources of the NDCSP cannot cover the mammoth task of taking on the burden of HIV in the project area. NDCSP has trained a large number of HBCVs that provide crucial services to the community. However, the question remains: how long will these trained professionals remain as **volunteers**? The DOH does not have a clear vision on this issue. MCDI is currently exploring ways and means of enhancing community participation through poverty alleviation strategies and empowering communities in Ndwedwe to take charge of their own basic health needs. In addition, supplementary funding opportunities to address HIV/AIDS issues are being explored from multiple sources, including the USAID Mission in South Africa.

C. AREAS OF REQUIRED TECHNICAL ASSISTANCE

MCDI has identified three areas in which technical assistance is planned for the second and third years of Phase II: First, MCDI wishes to conduct an evaluation of our Home Based Care Volunteer training and supervision program, including a cost effectiveness analysis of this system. Part of this evaluation should include the development of practical guidelines for the DOH on how to deal with the issue of voluntarism. Technical assistance is also needed to assist communities and local partners to identify income generation opportunities, poverty alleviation strategies, and sustainable community projects. A consultant from the University of Natal Center for Rural Development has been identified to work with MCDI Community Organizer on this initiative. Technical assistance will also be required to initiate a regular LQAS as a monitoring and supervisory tool for IMCI and other strategies of the project.

Technical Assistance Received

The Senior Program Officer (SPO) visited the field in the months of October 2001 and February 2002. The previous Project Manager left the project in October 2001. The SPO's first

visit was necessary to ensure smooth transition of the project from the first to the second phase. She prepared the project staff for the KPC. She also interviewed the new project manager. Her second trip's main objectives were to orientate the new project manager and to prepare the ground for the final evaluation of the project.

The Child Survival Coordinator from the Home Office Child Survival Support Team visited the field in the month of April to provide technical support as well as to assist the field team in preparing the DIP. On-going technical backstopping to the project is provided by sharing current child survival/HIV/AIDS literature and through constant communication via e-mail and telephone.

Ms. Gita Gidwani, a Social Scientist from Johns Hopkins University assisted with the final KPC. In-addition, technical assistance was provided by Barbara Parker, Consulting Anthropologist, in conducting GAPS Analysis exercise and behavior change assessments. Consulting Psychologist, June Kelly, assisted the team in evaluations of DramAidE and finalized the key family practice messages for IMCI.

D. CHANGES FROM THE PROGRAM DESCRIPTION AND DIP

There are no major changes to the DIP, that will require modification to the current agreement with USAID. Changes have occurred in the proposed partnership with Sichu Foundation (a Taiwanese Buddhist Organization) and Doctors For Life (a South African NGO working with OVC and HBCVs) for OVC initiatives. Both were unavailable to participate. Instead, the project embarked on a more significant relationship with eKhaya Project (Provincial Inter-Faith AIDS Forum) and CHF (Community, Habitat and Finance--a US-based PVO).

E. MANAGEMENT SYSTEM

1) Financial Management

The financial management activities carried out by the Child Survival Project are consistent with the activities outlined in the DIP. At the home office, MCDI has a financial management system that is overseen by the Chief Financial Officer and is regularly audited. In the field, the Administrator has the responsibility for implementing MCDI management protocols for field accounts. This protocol consists of a manual that outlines standard procedures for tracking all field expenditures and income fund transfers authorized by the Project Manager and the Director of the Division. All program expenditures are entered onto an Excel spreadsheet and aggregated monthly. Field office expenditure reports are submitted on a monthly basis to MCDI HQ in Washington where they are reviewed and forwarded to the office of the CFO in Augusta, Maine. Field expenditures are tracked using a coded chart of accounts that corresponds to project grant line items. All accounts are reviewed and entered into an automated system and later merged with the main corporate system in Maine.

In the field office, NDCSP operates a local expenditure account and payments are authorized by the Project Manager. Comprehensive financial reports are routinely compiled and forwarded from the field office to the Washington office where they are reviewed. MCDI Home Office submitted all (four) financial reports to USAID.

The Project's financial management and accountability for project finances and budget have been adequate and no budgetary adjustments have been required. The project appears to be approximately on-target with expenditures, neither over nor under budget. No financial irregularities of any degree were apparent during this first year of Cost Extension Grant. Budgeting skills appear to be well developed and adequate supervision and support was provided from Home Office. No provision has been made to date for activities beyond the extended cooperative agreement but plans are in place to engage with new partners in intervention areas which will need on-going financial support e.g. care of OVCs, VCT/PMTCT and poverty alleviation and sustainability initiatives.

2) Human Resources

Recruitment and orientation of the new Project Manager

The CS Project Manager position is filled by Dr Farshid Meidany, a Community Health Specialist and Epidemiologist who previously worked as the Provincial Epidemiologist with the Health Department in the Eastern Cape, South Africa and National AIDS/STD Control Program Director in Equatorial Guinea. He has overall responsibility for Child Survival Grant management activities in the field to include the supervision of project staff and the oversight of work plan activities, liaison with national, regional and district-level DOH authorities, and coordination of activities with all local partners. He works directly with the DHSMT to strengthen its capacity to manage the new district health system, and with partner organizations. The Project Manager is in routine contact with the Home Office which consists of the Child Survival Coordinator, Dennis Cherian, CS Support Staff and the Administrator.

CORE NDCSP team and their functions

In addition to the Project Manager, the core NDCSP team consists of five key field positions directly supported by the project: (i) Training Coordinator: Thuli Ngidi, an experienced psychiatric and community health trainer nurse, has overall responsibility for coordinating all training activities of NDCSP, including clinical training of DOH facility based staff. She is also supervising the implementation of the IMCI and PEP programs in the clinics and hospitals serving the Sub-District. She monitors the quality of care and, based on systematic observation, suggest additional or refresher training as needed to improve it. She is also responsible for developing and implementing a training program to improve counseling skills in clinic-based nurses, and to introduce HIV/AIDS counseling to additional facilities as deemed appropriate by the DOH. (ii) AIDS/Primary Health Care Supervisor: Thoko Radebe, is a nurse with experience in training Home-Based Care Volunteers, TB DOTS strategy and IMCI . She supervises, with DOH participation, the HBCVs activities in the field and implements refresher training for them as needed. She is also supervising the HIV/AIDS-related activities of the CHCs and CHWs, and oversees the NDCSP's collaboration with local partners. She is also responsible for the implementation of the C/HH-IMCI in the project area. (iii) Community Outreach Organizer: Christopher Mohatsela coordinates the activities of the Community Health Committees, with assistance from the Project Manager and AIDS/PHC supervisor. Mr. Mohatsela is responsible for the organization of the new CHCs, including facilitation of PLA/PRA exercises, identification of health priorities and development of an action plan for each CHC. He assists the Project Manager to provide technical assistance to the CHCs in designing BCC campaigns, developing child

survival messages and disseminating them to the community. He will also oversee and facilitate income-generating activities, such as facilitating work of the Center for Rural Development of the University of Natal in Ndwedwe District in activities regarding sustainability of the NDCSP project strategies and community self sufficiency. iv) Social Worker: Zanele Buthelezi, works with the CHCs on development and updating of the OVCs Registers and on monitoring the condition of children in the Registers. She establishes liaison between the CHCs and governmental agencies (such as the Dept. of Welfare, Dept. Home Affairs and Dept. Local Government) to facilitate foster care grants and other benefits to households affected by HIV/AIDS, in order to ensure that all those who are eligible have assistance in accessing these resources. She is also overseeing and facilitating creation of model crèches coordinating activities of by eKhaya project, CHF, MCDI, the communities and other partners. v) Project Administrator/Bookkeeper: Zandile Myeza assists the PM in all administrative, logistics and financial management of the field office.

All staff reports directly to the Project Manager. In the absence of the Project Manager, the Project Training Coordinator acts as the PM. Each staff member submits a quarterly report and an annual report. All staff participate in a weekly planning/monitoring meeting to report on their activities and plan for the future activities based on the DIP.

Currently the CHWs are supervised by mobile and fixed clinics nurses on a monthly or bimonthly basis. HBCVs and TBAs are supervised by MCDI staff on a monthly or bimonthly basis.

The services of our short term home-based care trainer, Esmé Cakata will be terminated towards the end of November. She was employed to assist the PHC/AIDS Supervisor to train a certain number of HBCVs for the project area. Much of this has been achieved. The future planned trainings of HBCVs will be conducted by the MCDI Training Coordinator and the PHC/AIDS Supervisor together with Sinosizo, a local NGO with expertise in HBCV and DOTS training.

3) Communication systems and team development

The field office uses telephone fax and e-mail to communicate with the Home Office on a regular basis. At the minimum, weekly communications are maintained between the Home Office and the Field Team to discuss and update on program activities.

Since the beginning of this phase of the project, field staff have been involved in all the planning activities of the project, including design and development of the DIP and development of the project work-plan. Weekly staff meetings are appropriate platforms for solving inter-personal problems and stimulate team spirit among the field staff. We are planning to have a retreat in the second year of the project.

4) Relationship with local partners

MCDI enjoys good relationship with the Department of Health authorities at different levels; provincial, district, sub-district and at each health facility. The NDCSP has established an excellent cross-sectoral collaboration with a number of South African NGOs; such as Sinosizo,

DramAidE, eKhaya Project, Tree and Valley Trust, etc. MCDI was invited to become a member of an NGO coalition group in KwaZulu Natal (Collaborative Group). We are very well known by the communities and community based structures and have excellent relationship with CHCs.

5) PVO Coordination/collaboration with other PVOs, USAID Mission

NDCSP has excellent relationships with other PVOs functioning in KwaZulu Natal, such as, World Vision, Salvation Army and CHF (Community, Habitat and Finance). World Vision has developed a manual for the training of IMCI key family practices, which is being used by our MCDI trainers. Recently, the Salvation Army Country Administrator and a Senior Advisor visited our office and requested assistance for their new Child Survival Project in the Zulu Land. Currently, we are working on a model of care for HIV/AIDS Orphans with CHF.

NDCSP has the benefit of exceptional relationship with US AID Mission in Pretoria. In response to the increasing awareness of the severity of the HIV/AIDS epidemic, MCDI received additional funding from the AID Mission in 2000 to add new activities to the previous child survival project. In September 2002, Dr Anne Peterson, Assistant Administrator of the AID Bureau for Global Health, visited the project area. She was accompanied by the Country Mission Project Specialist, Ms. Anita Sampson and the Mission's Senior Technical Advisor for AIDS and Reproductive Health, Dr Melinda Wilson. MCDI organized a meeting, which was held at Ndwedwe Community Health Center. Ndwedwe District Coordinator, Regional AIDS Coordinator, Regional and District AIDS/Life Skills Coordinator from the Department of Education, CHC members, HBCV, TBA and CHW representatives, DramAidE trainers and MCDI staff participated. The impact of HIV/AIDS in Ndwedwe is a major concern.

Recently, the NDCSP Project Manager visited Country AID Mission to discuss possible supplementary funding for expanding HIV/AIDS activities in the project area.

MCDI is also exploring partnerships with a USAID-funded project of the University of Witwatersrand, Reproductive Health Research Unit (RHRU). RHRU has expressed interest in collaborating with MCDI on different activities, namely, STD training and research and youth and adolescent health.

MCDI is also collaborating with the Department of Virology of the University of Natal for quality control of HIV rapid tests in Ndwedwe. We have also initiated dialogue with a consultant from the Center for Rural Development of this university for implementing poverty alleviation projects.

MCDI also entered into discussion with the Horizons Project, a joint project of the Population Council and the University of Natal, concerning collaboration on youth and adolescent health. Lessons learned from the Horizons project will be incorporated into DramAidE activities. The project is also engaged with a consultant from the Department of Anthropology of University of Durban Westville on a research exploring the role of traditional healers in modern health care.

Recently, the NDCSP Project Manager visited the World Health Organization representative in South Africa, Prof. Welile Shasha. He expressed interest in visiting the project area in the near future and providing some assistance for PMTCT and TB control activities.

6) Organizational Capacity Assessment/Audit

An Institutional Strengths Assessment was conducted by MCDI with support from the CSTS in March, 2002. During the preparation phase of this Institutional Strengths Assessment, MCDI's leadership in Maine and Washington requested that the design of the ISA process be modified to allow MCDI to approach this assessment as a capacity building activity. MCDI asked to have designated staff involved in the facilitation of the self-assessment meeting, analysis of field and HQ data, and preparation of the ISA report so that the organization would be well-positioned to replicate the ISA process in the future, or to adapt the ISA tools to field programs or local partners.

The exercise assessed MCDI's institutional capacities along the following six categories:

Use of Technical Knowledge and Skills

Areas of strength:

- ❖ Use of Technical Knowledge and Skills is the strongest capacity area overall for MCDI, receiving the highest average score from both home office staff and field staff
- ❖ Project interventions are regularly based on recognized national or international standards, and International Division staff report that they consult a diversity of quality resources to keep informed of state of the art information in the health arena.
- ❖ MCDI encourages the development and implementation of projects with high levels of community involvement.
- ❖ Note: Self-Assessment Meeting participants identified Emergency Medical Services and Community-based Health Care Financing Schemes were two areas of technical strength that had not been included in the ISA tool.

Challenges:

- ❖ Scores from field staff suggest that monitoring and evaluation; behavior change communication; and the conduct of organizational capacity assessments are the areas in which technical backstop support might be improved/increased.
- ❖ There appears to be no formal mechanism at present for International Division staff to tap into the expertise of the Maine-based Child Survival Technical Advisory Group, or for Maine-based staff to learn from the technical expertise of the D.C.-based staff. Finding a way to address this challenge could lead to increased technical capacity of both groups and the organization as a whole.

Addressing challenges:

The Home Office Child Survival Coordinator will provide technical support and train project staff in monitoring and KPC surveys. The CS Coordinator was recently trained by CORE/CSTS

in KPC 2000 Training of Survey Trainers. The project has trained one field staff and one Home Office staff in the BEHAVE Framework, organized by AED. Recently, the field office staff were trained and assisted by an external consultant in conducting the GAPS Analysis. A Behavioral Analysis was performed by the field team based on the results of the GAPS Analysis, the results of which will be used by the team in developing a behavior change strategy and interventions for the project.

Administrative Infrastructure and Procedures

Areas of Strength:

- ❖ Field staff access to an Internet connection should facilitate communication between the U.S.-based offices and field programs.
- ❖ There is relatively strong agreement that regular progress reports are submitted to backstop staff from field programs on a regular basis.

Challenges:

- ❖ Self-assessment discussions suggest a need to have annual reviews of hardware and software.
- ❖ Self-assessment discussions suggest a need for improved security of computer systems.
- ❖ Self-assessment discussions suggest a need for better off-site back up of data.
- ❖ There is a high level of disagreement between HQ and field staff regarding the existence and regular updating of administrative procedures. Several field recommendations request information on administrative procedures.
- ❖ There is a high degree of disagreement between HQ and field staff regarding the timely procurement and delivery of supplies to field programs, wherein the field perceives this process to be slower than it could be.

Addressing challenges:

The field staff have been updated on the administrative procedures. Field teams are now routinely supplied with hard copies of policy manuals, Title 22-Part 226 of the USAID CFR, and the MCDI financial management manual. Additionally, in response to a specific recommendation to make relevant reference materials, child survival technical documents and other materials accessible through the MCDI website, these documents and relevant linkages to other websites have been placed on a password protected section of the MCDI website.

Organizational Learning

Areas of strength:

- ❖ There is a high level of agreement between field and Home Office respondents that the organization's health projects fit well within MCDI's vision and mission.
- ❖ Both field and home office respondents feel that the organization provides appropriate support if/when issues of conflict or disaster disrupt program operations.

Challenges:

- ❖ Field recommendations suggest a need for clarity regarding reporting relationships and lines of communication, organizational structure, and delegation of authority.
- ❖ There seem to be opportunities for enhanced collaboration and cross-learning between the Maine staff and the Washington-based staff in the International Division.

Addressing challenges:

In response, MCDI has scheduled and implemented annual visits by field managers to the home office and the home office child survival coordinator to the field office to share lessons learned and to provide the home office with a firm understanding of field implementation issues. Field manager visits are scheduled to coincide with the annual Global Health Council Conference.

Financial Resources Management

Areas of Strength:

- ❖ There is agreement between HQ and field respondents that financial resources are transferred from HQ to the field in a timely manner.
- ❖ Both HQ and field staff agree that the organization encourages and supports the identification of new/emerging funding sources for its programs/projects. This is reinforced by the information reported on the organizational profile which suggests that the organization has a diverse array of funding sources for its international projects.

Challenges:

- ❖ Self-assessment discussions as well as ISA field data suggests a need to develop a system that improves access to current financial data.
- ❖ ISA discussions suggest a need to streamline entry of cost data and processing of funds transfer—the current system appears to have too many opportunities for problems and errors.
- ❖ Field recommendations and ISA scores suggest a need to examine communication between HQ and field regarding financial reports and related data. Some field respondents report confusion or problems with financial information sent by HQ, others request clarity on protocols regarding budget modifications.

Addressing challenges:

In collaboration with its head office in Maine, MCDI has transitioned to a new web-based financial management system that permits all field managers password protected access to line item expenditure summaries that are updated monthly.

Human Resources Management

Areas of strength:

- ❖ MCDI field staff have presented and/or participated in regional meetings/workshops related to Child Survival, as well as annual meetings of the Child Survival Collaborations and Resources Group (CORE).

Challenges:

- ❖ Self-assessment discussions and ISA data suggest a need to share knowledge and experience in a more formal manner at multiple levels: between international projects and between Washington and Maine staff. This includes the sharing of special skills and capabilities (GIS, Public Health, Epidemiology, Healthcare Financing).
- ❖ Self-Assessment discussions suggest that the MCD website could possibly be used for increasing staff interaction, and that the organization might learn from websites it has designed for other customers.
- ❖ There is a high degree of disagreement as to whether visits from health backstop staff are used as opportunities to motivate and encourage the project team in the field.
- ❖ Like many other PVOs, MCDI faces the challenge of finding creative ways to document its lessons learned and share information to promote cross learning, while managing its overhead costs and recognizing that it is not practicable to designate the responsibility for this task to any one individual.

Addressing challenges:

MCDI has gained experience during implementation of current projects, for example, in community-based health care financing, community mobilization, and strengthening the organizational capacity of partners such as local NGOs and the district ministry of health offices. In order to share these lessons learned, it has been suggested that MCDI institutionalize a quarterly child survival newsletter through its website. The first issue of the newsletter was developed and disseminated. However, MCDI is still working to institutionalize and regularize this medium to disseminate these results among all partners and stakeholders. In addition, the lessons learned will be shared not only with PVO and NGO partners, but also with CORE Group members during the annual CORE Group meeting and presentations that MCDI will make during annual meetings of the Global Health Council. CSP updates are also posted on MCDI's website.

To enhance and further develop field office capacity, MCDI supports field staff participation in various national workshops and international meetings and will continue to promote staff involvement in the various fora related to child survival and maternal health, viz, CORE group annual meetings and CSTS and BASICS training activities. The skills, tools and information gained from these activities are routinely shared with other members of the MCDI team. Over the past two years MCDI staff have participated in workshops focusing on KPC, LQAS, BEHAVE Framework, sustainability, monitoring and evaluation (M&E), and HH/C IMCI.

F. OTHER RELEVANT ACTIVITIES

Sanger Project (Traditional Healers Bio-Medical Research Project)

Traditional healers are very influential in different aspects of community life in KwaZulu Natal in general and in Ndwedwe sub-district in particular. A large number of HIV/AIDS patients go to the traditional healers with the hope of receiving care and support. MCDI is currently completing a study, funded by Margaret Sanger Center, to better understand the knowledge, attitude and current practices of South African traditional healers on HIV/AIDS, STIs and reproductive health. This research was being carried out in three provinces of KwaZulu Natal, Gauteng and Mpumalanga. Ndwedwe was chosen as the KZN site for this research.

In Ndwedwe, a researcher from the University of Durban Westville's Department of Anthropology performed this research with active participation of MCDI staff in all tribal authority areas. Results of focus group discussions and individual in-depth interviews are currently being analyzed. MCDI hopes to use the findings of this research in planning activities targeted at the traditional healers in the future.

Following from this initiative, a number of workshops and meetings for Traditional Healers were held, with 15 THs from Ndwedwe Central participating. The objective of this activity was to increase the knowledge and awareness of these community leaders about AIDS/HIV & STIs and TB. Another objective was to educate them on infection control measures, especially related to the utilization of sharp objects that they use in their daily practice. A pre-course evaluation indicated that the understanding of AIDS issues was minimal and in some instances non-existent, demonstrating the importance of targeting such training at this group of people

USAID Visits

In the month of September, the MCDI project was visited by Dr. Ann Peterson, Assistant Administrator, USAID/GH and Anita Sampson, PHN Officer USAID Mission. Meetings were organized with the DOH officials and other partners. Subsequent to this visit, the MCDI Chief of Party, Dr. Farshid Meidany, also met with PHN Officers Anita Sampson and Dr John Crowley, and with the Senior Technical Advisor for AIDS and Reproductive Health, Dr Melinda Wilson, to discuss potential collaboration.

G. RECOMMENDATIONS AND RESPONSES TO THE DIP REVIEW

As agreed at the DIP review, MCDI is submitting clarifications and revisions of items in the DIP as per the recommendations of the reviewers. Each of these recommendations and their responses are described in detail below:

1. UPDATE INDICATORS CHANGED SINCE THE DIP SUBMISSION

In response to the recommendations of the DIP review team, the project has updated the objectives and indicators for each intervention and incorporated new indicators. A detailed list of the objectives and indicators are given below.

Cost extension objectives and indicators

HIV/AIDS/STIs (LOE 30%)

Objectives

1. At least 65% of mothers/caregivers are aware of at least 3 symptoms of STIs other than HIV/AIDS in females
2. At least 50% of the mothers use condoms on last act of intercourse for prevention of HIV transmission
3. At least 90% of the mothers recognize three known ways in which a mother can transmit HIV/AIDS to her child
4. 90% of the mothers/caregivers will not stigmatize HIV affected families
5. 100% of all appropriate health facilities provide HIV/AIDS/STIs prenatal screening and counseling
6. At least 75% of the households caring for OVCs are aware of and know how to access DSW grants and services
7. At least 85% of high school students in active school health clubs have adequate knowledge of HIV/AIDS prevention strategies
8. At least 60% of high school students in active school health clubs adopt sexual practices that prevent the transmission of the HIV/AIDS virus

Indicators

1. Increase from 26% to 65% the percentage of mothers/caregivers of children aged 0-59 months who are aware of at least three symptoms of STIs other than HIV/AIDS in females
2. Increase from 30% to 50% the percentage of mothers of children aged 0-59 months who report use of condoms on last act of intercourse
3. Increase from 54% to 90% the percentage of mothers of children aged 0-59 months who can recognize the three known ways in which a mother can transmit HIV/AIDS to her child
4. Increase from 68% to 90% the percentage of mothers/caregivers of children aged 0-59 months who will be willing to allow children under their care to play with an HIV-positive child from an AIDS-affected family

5. 100% of the appropriate health facilities in the project area will provide continuous HIV/AIDS/STI VCT services according to protocols
6. 75% of households caring for OVCs will be aware of and know how to access DSW grants and services
7. 85% of high school students in which School Health Clubs (SHCs) are active will have adequate knowledge of HIV/AIDS prevention as demonstrated in their ability to name at least two strategies of prevention
8. 60% of high school students with active SHCs will report adoption of one of three strategies of HIV/AIDS prevention (abstinence, being faithful, condom use).

Control of Diarrheal Diseases (LOE 20%)

Objectives

1. At least 90% of the mothers/caregivers with children age 0-23 months will provide ORT to their child during diarrheal illness
2. At least 50% of the mothers/caregivers with children age 0-23 months will increase liquid intake for their child during diarrheal episodes
3. At least 50% of the mothers/caregivers of children aged 0-23 months will adopt good household practices of hand washing

Indicators

1. Increase from 74% to 90% the percentage of mothers/caregivers of children aged 0-23 months who provide oral rehydration therapy (ORS, SSS or available home fluids) to the child under their care during diarrheal episodes
2. Increase from 7% to 50% the percentage of mothers/caregivers of children age 0-23 months who give increased liquids during diarrhea episodes
3. Increase from 15% to 50% the percentage of mothers/caregivers of children aged 0-23 months who report that they wash their hands before feeding the child under their care

Pneumonia Case Management (LOE 20%)

Objectives

1. 100% of the clinics in the project target area will correctly implement IMCI protocols for pneumonia diagnosis and treatment
2. At least 45% of the mothers/caregivers will have improved care-seeking practices for pneumonia, resulting in prompt medical attention.

Indicators

1. 100% of clinics in the project target area will have had no stock outs of essential IMCI drugs in the last 3 months
2. 100% of the trained clinic staff in the project target area will correctly diagnose and treat pneumonia cases according to IMCI protocols

3. Increase from 10% to 45% the percentage of mothers/caregivers of children aged 0-23 months with cough and rapid or difficult breathing who seek medical attention within 24 hours after the onset of symptoms.

Immunization (LOE 15%)

Objectives

1. At least 80% of children in the target area will receive timely and all childhood immunization services

Indicators

1. Increase from 51% to 70% the percentage of children aged 12-23 months who are fully immunized against the five vaccine preventable diseases as per RTH card, before the first birthday
2. Increase from 61% to 80% the percentage of children aged 12-23 months who have received a measles vaccination as per RTH card.

Maternal/Neonatal Care (LOE 15%)

Objectives

1. At least 60% of neonates exhibiting recognized danger signs receive timely medical attention
2. At least 40% of the CHCs will make a commitment to respond to priority health concerns in their communities, including obstetric emergencies
3. At least 50% of the mothers will have received 4 antenatal checkups during their last pregnancy
4. At least 80% of the clinic nurses in the project target area providing maternal and neonatal care are trained using the PEP modules.

Indicators

1. Increase from 41% to 60% the percentage of mothers/caregivers of children age 0-23 months who know two or more of the danger signs in newborns that indicate the need for immediate treatment
2. 40% of the CHCs will have a cost recovery/financial system or loan system for their priority PHC activities (e.g., transporting obstetrical emergencies, incentives for CHWs, HBCVs, etc.), and guidance for accessing social welfare grants
3. Increase from 20% to 50% the percentage of mothers who will have made an antenatal visit during the first trimester and at least three antenatal visits thereafter, during their last pregnancy
4. Increase to 80% the percentage of PEP-trained midwives in program area health facilities providing maternal and neonatal care according to PEP modules.

2. REVISE DIARRHEAL INDICATORS BASED UPON CHRIS MCGAHEY'S COMMENTS.

It was recommended during the DIP review that the project incorporate indicators on hand washing, use of hygienic latrines, quantity of water use per capita per day, maternal recall of diarrheal diseases in their children in the previous two weeks.

The CDD household management strategies are consistent with household administration of ORT, increased fluid intake, continued feeding and proper hand washing prior to feeding the child. In addition to hand washing behavior, mothers will be educated to adopt and practice other key household practices such as safe disposal of feces, use of latrines and clean water. While we think the recommendations of including additional indicators to monitor water and sanitation factors are beneficial, these aspects are not included as direct interventions of the child survival project. The project supports the DOH for cholera preparedness through multiple strategies such as establishing cholera/rehydration tents.

Please note that the reference to ORT corners for cholera management in the DIP is an error. The MCDI team has produced a "Cholera Preparedness" statement that should replace these references.

3. REVISE CHOLERA CASE MANAGEMENT STRATEGIES IN ACCORDANCE WITH WHO GUIDELINES

As cholera outbreaks have occurred in the project area following the submission of the cost-extension proposal, it is important to note that the project will support the DOH cholera strategy, preparedness and response plan. The activities will include the following:

1. Use of Temporary Treatment Centers (cholera tents) to provide rapid and efficient treatment for many patients. Treatment Centers will be set up in an area (or building) with the following characteristics:
 - a) An adequate water source
 - b) Good drainage away from the site
 - c) Easy to clean
 - d) Provisions for disposal of excreta, vomit, and medical and other waste
 - e) Convenient hand washing facilities
 - f) Good access for patients and supplies
 - g) Adequate space (divided into separate areas for patient care, kitchen, stores, staff area, etc.)

2. Mobilize the mobile control team to assist during an outbreak of cholera in the project area. The team will be composed of trained personnel to:
 - a) Establish and operate Temporary Treatment Centers
 - b) Provide on-site training in case management for local health staff
 - c) Supervise environmental sanitation measures and disinfection
 - d) Carry out public education and give information to the public

- e) Arrange research to determine transmission modes
- f) Collect specimens for submission to laboratories, and provide logistical support, such as the delivery of supplies, to health facilities and laboratories.
- g) Assist in active and passive surveillance activities.

Finally, the measures that will be promoted to prevent and control cholera and other diarrheal diseases will include: health education messages, food safety, hand washing, surveillance, environmental sanitation, disinfection, and safe practices at funerals.

4. ENSURE CONSISTENCY OF MESSAGES BETWEEN BREASTFEEDING AND MTCT PREVENTION, AND HOUSEHOLD CASE MANAGEMENT OF DIARRHEA. ADDRESS INCONGRUENCE BETWEEN THE BEHAVE FRAMEWORK, AND DIARRHEAL DISEASE CONTROL

Based on the recently conducted GAPS Analysis, MCDI is developing a key set of messages and behavioral change intervention strategy to ensure consistency of messages in household case management of diarrhea and diarrhea control intervention, as well as for consistency in messages between breastfeeding and MTCT prevention. The messages will also be reviewed to ensure consistency with the current National policy on breastfeeding in HIV. The project is currently using the BEHAVE Framework to conduct the behavioral analysis and develop behavioral change approaches for interventions.

5. DEVELOP A CONTINGENCY PLAN

Introduction

Potential problems: MCDI's experience to date in Ndwedwe has been free of any overt security risks. However, the presence of endemic political violence (between rival political parties), and well as the potential for economically motivated violence, has characterized the area for many years and limits the mobility of both service providers and their clients, as well as project team members, especially at night. Although political violence is endemic in South Africa, all project activities are located in Ndwedwe District, most of which is composed of quiet, rural townships where violence and unrest are uncommon. Specific problems identified by the staff include vehicle breakdown in isolated areas, health emergencies, and interpersonal violence, which is a problem throughout South Africa. No significant crises are anticipated in South Africa based on the latest State Department reports.

Persons responsible for development, review and updating the security plan: This security plan was developed with the collaboration of all field team and home office team members. The field team participated in plan development and are thoroughly familiar with procedures. Home office responsibility for overall security planning is assumed by the International Division Director and the President of MCD. Country responsibility is assumed by the Child Survival Project Manager in South Africa.

Copies of this plan are available at the MCDI International Division Office: 1742 R. Street, NW, Washington, D.C. 20009 and at the MCDI Field Office: 1401 Maritime House, 143 Victoria Embankment, Durban, Republic of South Africa

Standard Operating Procedures

Site selection and access (office and residences): The project team in KwaZulu Natal is composed of seven individuals that work out of an office on the 14th floor of Maritime House, 143 Victoria Embankment, in Durban, South Africa. This is secure office space in a modern business district of downtown Durban with 24 hour security. As in other major urban centers, there is the ever present threat of street crime and safety after night fall. For this reason staff hours are set to allow personnel to depart the office and arrive home before dark. The office suite door is kept locked at all times and window blinds have been installed to maintain privacy and security of equipment.

There has been some discussion of locating a satellite office (training center) closer to the Ndwedwe district. The proposed new site is located at Ndwedwe Community Health Center with 24 hour security guards. The current office in Durban is 50-80 km outside of the Ndwedwe district. Should the team work from this location, a new security plan will be developed. Rules governing personal safety will apply to personnel working at this location.

Movement and transport (vehicles): The project owns and maintains two four-wheel drive vehicles. These vehicles are maintained on a regular schedule and are equipped with anti-theft devices (alarms) as well as GPS units so that they can be located if broken down in the field or stolen. The project replaces problematic vehicles to assure the safety of the field team. It is project policy that project staff travel in pairs and that no staff are in the field after dark. The four-wheel drive capacity of the vehicles assures that staff can return to Durban during the rainy season when many roads are impassable. The project vehicles are garaged at the office building which has secure access when not in use. The project manager's vehicle is also equipped with antitheft built-in tracking devices. At night it is kept in a locked garage at his residence.

Telecommunications (regular use and during emergencies) : There is daily communication via e-mail or telephone calls between the MCDI HQ and the field office. All project staff carry cellular telephones for emergency and normal work requirements. This allows them to contact the project whether they are in a project vehicle or using public transportation to carry out field assignments. The project is also equipped with an IRIDIUM satellite phone that MCDI (HQ) has supplied to all its CS projects. The phone ensures 24-hour contact with local authorities in KwaZulu Natal, with the US embassy in Pretoria, and MCDI's Washington office.

Post-incident actions: The Project Manager is responsible for notifying and formally reporting to USAID, MCDI Home Office, and Department of Health counterparts any threats or incidence of violence involving staff members. On issues of personal security, the field team member contacts the local authorities and the project manager determines on a case-by-case basis whether to involve other staff in the emergency or incident.

Contingency Plans

Plans to maintain program continuity in the face of threats or crises: In the event of violence, personal security of the staff is the first priority and the project will take all necessary steps to remove its personnel from harm. In consultation with local partners, the project team will determine alternative sites for the delivery of training programs and for holding meetings. All project team members are either citizens or permanent residents of the Republic of South Africa. It has been an MCDI strategy to hire qualified local personnel from the target communities in order to maintain an operational presence during times of local unrest. If the project manager, who is a permanent resident of South Africa, must leave the project for any reason, including routine travel, Thuli Ngidi, the senior training coordinator is responsible for project management decisions and actions.

Evacuation: In the event of an evacuation, the UN has offered to coordinate security arrangements with NGOs. MCDI will further explore this arrangement.

In the event of any social, political or natural upheavals the project will adopt different measures in proportion to the severity of the event. These will include the following range of measures: tighter personal security procedures, stopping field work, temporary closing of the office, relocation of the field office and permanent closing down of the project.

Medical evacuation: South African health facilities are among the best in Africa. Personnel requiring medical care will be admitted to appropriate private or public free access health care facilities in Durban, based on their personal wishes and no medical evacuation to a second country will be required.

Death of staff: All field staff are South African citizens and residents. The death or injury of any staff member will be reported to all concerned parties (MCDI, USAID, DOH counterparts), after having notified appropriate family or next of kin. All arrangements thereafter will be handled by the family.

Other high risk, foreseeable events: Due to its past history, South Africa is still a socially turbulent area and there is the potential for unrest in this country. However, we do not foresee risks of any serious or critical events in the near future.

Supporting Information

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6. INCORPORATE BIRTH PLANNING INTO ANTENATAL INTERVENTIONS

The NDCSP's birth planning approaches aim to decrease delays in deciding to seek care, reaching care and receiving care that contribute to the death of pregnant and postpartum women and their newborns. To achieve this the project has initiated multiple level interventions focused at the health facility, community and household level.

Activities promoted at health facilities include routine antenatal checkups, provision of iron/folate tablets and tetanus toxoid injections, counseling and educating on HIV/AIDS and maternal and newborn danger signs, prevention of MTCT, and voluntary testing and referrals to higher level of care when appropriate.

Activities at the community and household level include training TBAs to recognize danger signs, and educating mothers and households to seek timely care. The TBAs are also trained to ask the mother to assemble required supplies (a new razor blade, clean thread. etc.) prior to the delivery, and to discuss transport plans in case of emergency. All pregnant women are issued a maternal card. The TBAs assist in deliveries for only those pregnant women who carry a card;

the rest are referred. In addition, all maternal cards that are marked red are recognized as needing referrals. All these activities help to enable more mothers to seek antenatal care, deliver at hospitals and increase the number of early and appropriate referrals.

Discussions have been held with the District Manager of the DOH to train additional community-based workers (CHWs, HBCVs,) to recognize maternal and newborn care danger signs, thus enabling them to advise mothers to seek early medical care and provide health education.

In addition, the CHCs that are being formed in each village will form the central community decision-making body and will be linked with the DOH. PLA exercises with the CHC and the community will be conducted to explore the potential of mobilizing a transport system at the respective communities, i.e., for obstetrical emergencies or to transport sick children.

H. ANNEXES:

The following reports are included as Annexes:

- a) Summary of the GAPS Analysis for identifying the IMCI key family practices for Ndwedwe**
- b) Summary of the Dram Aide Baseline Report of the NDCSP Cost-extension**
- c) Summary of Health facility Assessments in the new area May 2002**

Annex A: Summary of the GAPS Analysis for identifying the IMCI key family practices for Ndwedwe

Conducted by Barbara Parker, Consulting Anthropologist
for Medical Care Development International(MCDI) South Africa
August 5-7, 2002

Background

The consultancy began in July, 2002, with the development of implementation guides to accompany two Participatory Learning and Action (PLA) exercises: the IMCI Key Family Practices (KFP) GAPS Analysis and the Wealth Ranking Exercise. The GAPS Analysis and Wealth Ranking exercises had first been pilot tested in 2001 in the Mohlokohlo and Shangase communities, respectively. Both had yielded a fund of useful information, so MCDI decided it would be productive to refine the two instruments and develop standardized implementation guides that would permit them to be applied more widely within Ndwedwe District and in other contexts and program areas as well. Plans for further developing the GAPS Analysis and Wealth Ranking exercise were therefore included in the NDCSP's Detailed Implementation Plan (DIP) for the program's cost extension. The instruments and guidelines were prepared by the end of July, and a staff training and field test of the instruments was scheduled for August 5-7.

During the review of the DIP at USAID in Washington DC, it was suggested that these exercises should not stand alone but should instead be part of the development of a comprehensive behavior change strategy. The training and field test, therefore, were carried out in such a manor as to constitute one component of the formative research needed to carry out a Behavioral Analysis. Other components will include the results of the baseline KPC survey and small-scale qualitative assessments. The purpose of the Behavioral Analysis is to serve as the basis for the development of a systematic Behavior Change Strategy (BCS). The final BCS will be a framework for planning all behavior change interventions related to the Community Component of IMCI. The framework will include a series of interventions and activities that are aimed at overcoming the barriers that prevent community members from following the KFPs.

The IMCI Key Family Practices GAPS Analysis

The IMCI Key Family Practices GAPS Analysis is a qualitative baseline assessment of household and community practices that may be carried out in preparation for the introduction of the Community Component of the Integrated Management of Childhood Illnesses (IMCI). The IMCI Community Component complements the Facility and Health System components of IMCI. It is aimed at initiating, reinforcing and sustaining family practices that foster child survival, growth and development. The GAPS Analysis instrument developed for the NDCSP was based on 18 Key Family Practices identified as essential to the health of children by KwaZulu-Natal's Dept. of Health IMCI Task Force in 2001, on the basis of guidelines from WHO and UNICEF. The Key Family Practices are those household behaviors that, if followed

systematically, can improve child survival rates and protect children against preventable diseases.

The GAPS Analysis exercise was introduced to KZN in 2001 by the Dept. of Health and the Tugela District Child Survival Project. It was subsequently revised by MCDI to meet the specific conditions and needs of Ndwedwe District. The purpose of the GAPS Analysis is to provide an assessment, based on discussions with community members, of the degree to which household and community practices match the ideal behaviors described by the Key Family Practices (KFP). The GAPS Analysis can be utilized as a simple tool to identify program priorities by scoring each KFP in terms of whether “all,” “most,” “some,” “few,” or “none” of the members of the community currently practice it. Roughly, KFPs that are practiced by “few” or “none” of the community should receive higher priority than those that are currently practiced by “all” or “most;” however, exceptions may be made if the practice is not followed due to factors that are outside the control of the family or beyond the scope of the NDCSP.

In this instance, the purpose of the GAPS Analysis was not simply to assign priorities to interventions within the program, but to prepare for the development of a comprehensive behavior change strategy. The NDCSP team’s analysis of results, therefore, included an examination of existing barriers to introducing the desired behavior, and motivators or incentives that might facilitate behavior change.

Conclusion

The two-day field test revealed that the IMCI Key Family Practices GAPS Analysis is productive tool that the field team is easily able to execute. It yielded a useful body of data that the team was able to apply to its task of developing a baseline behavioral assessment. The GAPS Analysis, then, constitutes the second step (following the Baseline Survey in the last quarter of 2001) in the design of a comprehensive behavior change strategy for Ndwedwe District. The team initially feared that the length of the exercise would strain the patience of the participating community members. In the field test, however, the exercise was completed in about two hours, and participants were willing to stay the course. As the team gains experience with the instrument, the exercise may proceed more quickly.

Although no conclusions are possible without consulting the Baseline Survey results as well as qualitative data collection that is to come, the results of the field test suggest certain priorities for behavior change interventions. In particular, the participating mothers in Ndwedwe estimated that the community’s knowledge of the danger signs of childhood illness – lethargy, fast and difficult breathing, sunken eyes and fontanelle, etc. – is weak. If, as they suggest, most community members would consult a traditional healer instead of going immediately to a health care facility, then it may be advisable for the NDCSP to solicit the participation of traditional healers in the program. Traditional healers can be trained to refer mothers immediately to the health care worker when danger signs are evident, and they can instruct mothers on home care of illnesses that do not require urgent medical care. In addition, any training programs that are planned for CHWs, CHCs, or community volunteers should include the danger signs of childhood illness and the importance of referring a child with any of these signs to a health worker immediately.

Other areas in which community practice appears to diverge significantly from the desired behaviors are HIV/AIDS prevention and hand washing. Promoting behaviors that protect individuals and families against the HIV virus – abstinence, faithfulness to one partner and condom use – requires a complex and multi-faceted behavior change strategy in itself. Developing and implementing such a strategy may be beyond the scope of the Community Component of IMCI (although the NDCSP may wish to do so in connection with its HIV/AIDS intervention as described in the DIP). Hygienic hand washing with soap, on the other hand, is a discrete and definable behavior that can be promoted with a more limited set of activities. The fact that most mothers believe hands must be visibly dirty to merit the use of soap, suggests that a well-designed communications campaign should be a central feature of the program’s approach to changing hand-washing and personal hygiene practices.

A full copy of the GAPS Analysis Report, including guidelines for implementation, is available upon request from MCDI

Annex B: Summary of the Dram AidE Baseline Report of the NDCSP Cost-extension

Conducted by June Kelly, Child Development Unit
for Medical Care Development International(MCDI) South Africa
August 2002

The purpose of this study is to provide baseline information upon which the proposed DramAidE interventions for the Ndwedwe Child Survival Project (NCSP) will be based. The first intervention phase ran from January 2000 until October 2001. Its primary goal was the establishment of Health Clubs in eight secondary schools spread across the AIDS-ravaged Ndwedwe rural and deep rural area of Kwazulu-Natal. These Clubs were initiated by a DramAidE facilitator, with permission from the relevant regional educational authorities. Learners were exposed to a range of key AIDS messages. Drama and self exploration techniques aimed to achieve an internalization of these messages in order to change attitudes and behavior regarding the virus. The ultimate aim was a reduction in the spread of the virus, in addition to the removal of the stigma associated with the disease. Communication of the AIDS messages from Club members to other learners at the same, and other schools, was key for this aim to be achieved. A school teacher acted the 'Club teacher' who ran the Club on a regular basis.

In an evaluation of the success of this initiative it was found that many of the goals had been achieved and that a significant positive change in attitudes and expressed practices had occurred regarding HIV/AIDS at the target schools. The evaluation recommended that more effective methods be made to cascade the initiative to nearby schools, a goal of the intervention that had not achieved the same level of success. The intention was that DramAidE would follow up recommendations made in this evaluation with a further intervention phase in the near future. Administrative delays resulted in the planned further intervention beginning in the second half of 2002, nearly 12 months after conclusion of the initial phase. Given this delay, MCDI felt the current interim report was required to assess the status of the initiative in order to facilitate a more effective follow-up intervention programme.

In the current study, qualitative data was gathered at four representative schools chosen from the initial target schools. Focus group and interview techniques were used to gather information on the prevalent level of knowledge, attitudes and practice about HIV/AIDS and related issues in these schools. Views of three different groups were obtained, namely Health Club group members; a governing body/senior staff/parent group, and Club teachers.

The current research concludes that the Health Clubs continue to function despite the absence of a DramAidE facilitator for a prolonged period. Club teachers and members remain motivated. However, a range of obstacles, including parental attitude, school policy and financial restrictions have resulted in most Clubs loosing some of their vibrancy. In order to remedy this it is recommended that some follow-up visits be made to all the initial first phase target schools by the DramAidE facilitator to improve motivation and to clarify and remedy, where possible, particularly obstacles faced by a Club.

Certain key recommendations made in the evaluation of the first phase of the intervention have not been implemented as yet. These issues continue to impede the progress of the Health Club initiative in the original target schools, and are likely to impact negatively on the long term success of new Clubs formed. Recommendations in the current study that echo these earlier injunctions are:

- Senior staff, governing bodies and parents need to attend workshops facilitated by DramAidE to gain insight into HIV/AIDS facts and to garner support for the Health Clubs.
- Networking with local educational and health authorities continues to be important to provide policy and practical support for the AIDS initiative. In particular, the educational authorities may need to use some ‘carrot and stick’ methods to motivate school management of the value of the Health Club initiative.
- DramAidE should include an entrepreneurial module in their workshops with learners and Club teachers, with the aim of developing ways of fund raising for transport of Clubs to other schools and to provide materials for basic health.(such as a First Aid Kit). This step is intended to make schools less dependent on outside funding to carry the AIDS messages to other schools and to their own learners.
- Local health authorities, including local clinics, need to address the lack of basic health equipment at the schools (such as condoms, gloves and disinfectant). These are tools that play a role in preventing transmission of the virus.
- While cascading remains a meritorious target for Health Clubs, it has not proved effective up to this point. Reconsideration of an out-of-school, paid, youth group for large scale development of Health Clubs at schools is suggested. A more proactive attitude by individual Clubs and better support from school principals and senior staff would also assist the success of cascading to other schools.

In addition to a continuation of the establishment of further Health Clubs, the DramAidE intervention proposal aims to address new issues arising from the progression of HIV/AIDS over time in the learner community. These relate to the development of a school’s policy on dealing with infected learners and teachers, and affected learners who have lost caregivers to the virus and are essentially orphans. The current study highlights the absence of such policy, to the extent that some governing body groups are ignorant of educational policies that already exist and which place the rights of HIV/AIDS infected and affected learners and teachers into law. While the evaluation indicates a positive stance towards affected and infected individuals by the school authorities, the absence of clear cut, applicable, policy leaves the way open to neglect, and even abuse, of these individuals by the school system. The current lack of support for the Health Club initiative in the target schools by the authorities is already evidence of this.

Annex C: Summary of Health Facility Assessments in the new area May 2002

Clinic Assessments (expansion areas) for the Ndwedwe District, South Africa

Health Facility Assessments of three clinics in the expansion area were carried out by the project in the month of May, 2002. These clinics are Kearsney, Esidumbini and Cibini which are under the supervision of Stanger and Applesbosch hospitals. These clinics have 7, 11, and 10 staff respectively. All the clinics were remote and rural and served populations in the range of 1000-1500 population. The nearest referral hospitals for these clinics are Stanger and Applesbosch hospitals. All have access to government ambulances for transport of referred patients.

Although varying in number of trained personnel available, all three clinics have staff trained in HIV/AIDS clinical diagnosis, counseling, psychological support and coping with PLWA, infection control measures, care of pregnant women and children, EPI, basic and comprehensive essential obstetric care and post abortion care. On average, all three clinics had monthly supervisory visits in the last six months.

Apart from Cibini, which recommended two, the other clinics both recommended at least 4 antenatal visits. Esidumbini and Cibini stated that they delivered 20 and 2 babies, respectively, in the last 12 months, with all of them stating that most pregnant women delivered at hospitals. None of the clinics supervised TBAs nor had their nurses participated in PEP training courses. All of the clinics had integrated HIV/AIDS/STI/RTI counseling with ANC activities and had access to a range of family planning services, including access to pills, injectables and condoms. Limited emergency obstetric care was provided at Esidumbini and Cibini clinics, including post-abortion care. Clinic staff interviewed at all three clinics knew of the key signs and symptoms during pregnancy that would prompt referrals. Similarly, Esidumbini and Cibini clinic staff interviewed were aware of symptoms and signs after delivery that would prompt referrals.

At all clinics antibiotics used in shigella dysentery include co-trimoxazole, nalidixic acid and metronidazole. All clinics refer children less than 2 months with pneumonia to the referral hospitals. Voluntary STI testing, counseling and treatment are available at these clinics and all clinics draw blood, however, screening of blood drawn is carried out at the referral hospitals. None of the clinics use cotrimoxazole as a prophylactic for treatment of opportunistic infections. The interviewers also stated that support groups for PLWA are unavailable in the community.

On review of infrastructure and equipment availability, all three clinics have access to protocols for care of pregnant women and newborns as well as protocols for HIV/AIDS testing and counseling. In addition, ORS packets, and equipment to measure, mix and prepare ORS were also available. Other equipment such as the otoscope, infant weighing scale, educational materials for maternal/antenatal and newborn health and instruments to perform obstetrical and gynecological functions as well as protective clothing for newborn are available in all the clinics. Clinics, with the exception of Kearnsey, had access to most of the essential drugs, and all had access to essential medical and surgical equipment and supplies.

Hospital Assessment (expansion areas) for Ndwedwe District, South Africa

Of the two referrals hospitals, Stanger and Applebosch, the latter was surveyed, as it serves the project's expanded area in Ndwedwe district. Applebosch hospital serves six clinics, of which only two, Cibini and Esidumbini, fall within the new expanded project area. This hospital has a total of 181 beds, with 48 maternity and 26 pediatric beds for a population of 53,000. The nearest referral hospital is Northdale, located 38 miles away, and has access to regular ambulance services for transporting referred patients. The hospital functions 24 hours.

The hospital has a total of 162 staff, including doctors, nurses and other paramedical professionals. Varying number of nurses, doctors and paramedical staff have been trained in HIV/AIDS clinical diagnosis, counseling, psychological support and coping with PLWA, infection control measures, care of pregnant women and children, EPI, basic and comprehensive essential obstetric care and post abortion care. One staff member has also been trained in IMCI protocols.

Applebosch hospital recommended at least 4 antenatal visits. The hospital also conducted 1085 deliveries in the last 12 months. Hospital nurses did not have access to the PEP training course. The hospital also provided HIV/AIDS/STI/RTI counseling integrated with ANC activities and had access to a range of family planning services, including access to pills, injectables and condoms. In addition, emergency obstetric care, including post-abortion care was readily available. Clinic staff interviewed at the hospital knew the key signs and symptoms during pregnancy and after delivery that would prompt referrals.

At the hospital antibiotics used in shigella dysentery include co-trimoxazole and nalidixic acid and all children less than 2 months with pneumonia were treated as an outpatient with antibiotics. This conforms to the KwaZulu Natal IMCI guidelines for pneumonia which prescribes amoxicillin for 5 days. The hospital has also been challenged with difficulties of not being able to make timely and appropriate referrals. Other services such as ELISA HIV tests, cotrimoxazole for treatment of opportunistic infections and support groups run by CHWs are available for communities.

Infrastructure and equipment were also available and satisfactory. Essential drugs and consumable supplies such as nalidixic acid, ceftriaxone, hexaprenaline IVI (for asthma), calcium gluconate, Vitamin A (capsules), cotrimoxazole were available; syphilis testing kits were mostly out of stock.

HEALTH FACILITY ASSESSMENT - CLINICS AND HOSPITAL IN EXPANDED AREA

1- Ndwedwe District Clinics (New Expanded Area)			
	Kearsney	Esidumbini	Cibini
GENERAL INFORMATION			
Staff member interviewed	SPN F Dlamini	PN NC Tom	CPN TN Blose
Comments:	- Remote clinic -Under Stanger Hospital -No deliveries in the last year -Serving small farm population	Very remote and rural, bad roads	Remote and rural
Clinic under	Stanger Hospital	Applesbosh Hospital	Applesbosh Hospital
Total Staff	7	11	10
Total # of beds	0	4	3
• Maternity beds	0	2	2
• Pediatric beds	0	2	1
Estimated population served	Total : 1270 0-11: 210 >5: 562 W (15-49): 468	Total : 1593 0-11: 526 >5: 643 W (15-49): 424	Total : 1115 0-11: 130 >5: 485 W (15-49): 300
Estimated area served by this facility	Maphumulo TA: Nothmati, Maqambe, Hlatswayo, Kwa Jinu, Mbekaphasi, Mabholvane Mambedu, Kransdorp, Mtandusi, Lot 14 Compends, Stanger, Groutnile, Melville Maphumulo, Derdethu	Nyuswa Tribal Authority:	Mlamula TA
Hours facility open	7:30 – 16:00, M-F	07:00 – 16:00 M- F	7:00 – 16:00 M-F
Functional waste disposal area/pit?	Yes, collected by Stanger	Yes, burnt once a week	Yes, burnt once a week
Nearest Referral facility	Stanger Hospital	Applesbosh Hospital	Applesbosh Hospital
How is transport handled for referrals?	Government ambulance services from Stanger Hospital.	Government ambulance services from Applesposh Hospital.	Government ambulance services from Applesposh Hospital.
STAFFING, TRAINING AND SUPERVISION			
Number of:			
Doctors	0	0	0

Professional Nurses (PN)			
-PN/ Midwife	3 (All PNs)	3 (all PNs)	2
Enrolled Nurses (EN)	2	2	2
Enrolled Nursing Auxiliary (ENA)	0	1	1
ADMs	2	2	0
AIDS Counselor	1	2	1
Medical Social Worker	0, refer to Stanger	0	0
Staff trained in:			
HIV/AIDS clinical diagnosis	1	2	1
Counseling, psychological support, and coping w/ PLWA	2	2	1
Universal Precautions, Asepsis/Antisepsis Procedures	7	7	5
Care of Pregnant Women and Children (KZN DOH protocol)	3	3	1
IMCI protocol	0	0	0
EPI	2	2	2
Basic Essential Obstetric Care	3	3	1
Comprehensive Essential Obstetric Care (blood transfusion, C-section)	3	3	1
Refresher training in essential OC?	0	1 (Oct 2001)	0
Post-abortion care services	3	3	1
Number of supervision visits in last 6 months	6	6	5
ANTENATAL/MATERNAL HEALTHCARE			
At least 4 antenatal care visits recommended	Yes	Yes	Yes

Do you recommend pasteurization of breastmilk for HIV + mothers?	No	No	No
All ANC activities performed during a visit	Yes	Yes	Yes
Do deliveries occur at this facility? If so, how many?	No	Yes (20 during past 12 months)	Yes (2 during past 12 months)
If not, where do they occur?	Stanger Hospital	Applesbosh Hospital	Applesbosh Hospital
How many deliveries occurred in this facility in the past year?	0	About 20	2
ADM present?	No		
Are TBAs in the community supervised?	No	No	No
PEP program in place?	No	No	No
HIV/AIDS/STI/RTI counseling integrated w/ ANC activities?	Yes	Yes	Yes
How long after delivery does F/U in facility occur?	After 6 weeks earlier	N/A	For 12 months
What family planning services offered?	Pill Injectibles condoms	Pill Injectibles condoms	Pill Injectibles Condoms
Emergency obstetric care provided?	No	Limited care	Limited care
Post-abortion care services offered?	No	Yes	Yes

<p>Symptoms & Signs during pregnancy that would prompt referral</p>	<p>-previous bad obstetric history/abdominal scars/ previous stillbirth -hypertension/ headache/ swelling/fits -anemia/pallor/ fatigue/shortness of breath -cessation of fetal movement/baby does not move -abnormal lie/position of fetus -sepsis /foul smelling discharge -hemorrhage/ heavy bleeding -multiple pregnancy/ large abdomen -obstructed/ prolonged labor</p>	<p>-previous bad obstetric history/abdominal scars/ previous stillbirth -hypertension/ headache/ swelling/fits -anemia/pallor/ fatigue/shortness of breath -cessation of fetal movement/baby does not move -abnormal lie/position of fetus -sepsis /foul smelling discharge -hemorrhage/ heavy bleeding -multiple pregnancy/ large abdomen -obstructed/ prolonged labor</p>	<p>-previous bad obstetric history/abdominal scars/ previous stillbirth -hypertension/ headache/ swelling/fits -anemia/pallor/ fatigue/shortness of breath -cessation of fetal movement/baby does not move -abnormal lie/position of fetus -sepsis /foul smelling discharge -hemorrhage/ heavy bleeding -multiple pregnancy/ large abdomen -obstructed/ prolonged labor</p>
<p>Symptoms & Signs during delivery that would prompt referral</p>	<p>N/A since no deliveries occur here</p>	<p>previous bad obstetric history/abdominal scars/ previous stillbirth -hypertension/ headache/ swelling/fits -anemia/pallor/ fatigue/shortness of breath -cessation of fetal movement/baby does not move -abnormal lie/position of fetus -sepsis /foul smelling discharge -light bleeding/spotting -hemorrhage/ heavy bleeding -multiple pregnancy/ large abdomen -obstructed/ prolonged labor</p>	<p>previous bad obstetric history/abdominal scars/ previous stillbirth -hypertension/ headache/ swelling/fits -anemia/pallor/ fatigue/shortness of breath -cessation of fetal movement/baby does not move -abnormal lie/position of fetus -sepsis /foul smelling discharge -light bleeding/spotting -hemorrhage/ heavy bleeding -multiple pregnancy/ large abdomen -obstructed/ prolonged labor</p>

Symptoms & Signs after delivery that would prompt referral	N/A	-hypertension/ headache/ swelling/fits -anemia/pallor/ fatigue/shortness of breath -sepsis /foul smelling discharge/ -postpartum abdominal pain -hemorrhage/ heavy bleeding	hypertension/ headache/ swelling/fits -anemia/pallor/ fatigue/shortness of breath -sepsis /foul smelling discharge/ -postpartum abdominal pain -hemorrhage/heavy bleeding
How many cases of obstetric emergencies have occurred in this facility in past year?	0	1	0
How many deaths from obstetric emergencies have occurred in this facility in past year?	Not in questionnaire	0	0
CHILD HEALTHCARE			
What antibiotic would you choose in the case of dysentery from Shigella?	Co-trimoxazol, Metronidazol	Co-trimoxazol, Nalidixic Acid	Nalidixic Acid, Metronidazol
What would you do w/ a child < 2 months w/ pneumonia?	Refer	Refer	Refer
Ever unable to refer a child?	No	No	No
Why?			
Are STI tests provided, w/counseling and treatment?	Yes, voluntary	Yes, voluntary	Yes
Are HIV tests and counseling provided?	Counseling done and blood taken and sent to Sanger Hospital	Counseling done and blood taken and sent to Applesbosh Hospital	Counseling done and blood taken and sent to Applesbosh Hospital
Is Cotrimoxazole used as preventive therapy for OIs in people with HIV?	No	No	No
Is there any support group in the community for PLWA?	No	No	No
INFRASTRUCTURE AND EQUIPMENT			
“Care for Pregnant Women & Newborns at Clinic and District level” Protocols from KZN DOH	Available	Available	Available

Protocols for HIV/AIDS testing	Present	Available	Available
Protocols for HIV/AIDS counseling	Present	Available	Available
Measuring and Mixing Utensils to Prepare ORS	Available	Available	Available
Cups & Spoons to administer ORS	Available	Available	Available
Otoscope	Available	Available	Available
Delivery or Labor Room w/ Bed & Lightening	N/A	Available	Available
Infant weighing scale	Available	Available	Available
Table & Stool for GYN Exams	Available	Available	Available
Protective Clothing (Shoes, /boots, gowns, plastic aprons)	Available	Available	Available
Cloth/Towel to Dry Baby	N/A	Available	Available
Blanket to wrap baby	Available	Available	Available
Educational Materials related to Maternal/antenatal and newborn health	Available	Available	Available
ESSENTIAL DRUGS & CONSUMABLE SUPPLIES			
Paracetamol	Available	Available	Available
Paracodol	Not available	Available	Available
Pethidine	Not available	Available	Available
Amoxicillin	Not available	Available	Available
Ceftriaxone	Not available	Not available	Not available
Cotrimoxazole	Available	Available	Available
Nalidixic Acid	Not available	Available	Available
Procain Penicillin (IMI)	Available	Available	Available
Erythromycine	Available	Available	Available
Praziquantel (Biltricide)	N/A	N/A	N/A
Piperazine	Not available	Not available	Not available
Mebendazole	Available	Available	Available
Niclosamide (Yomesan) tablets	Available	Not available	Not available
Diazepam (Valium)	Available	Available	Available
Phenobarbital (Gardinal)	Don't keep in stock. Order per doctor's order	Available	Available
Naloxone (Narcan)	Not available	Available	Available
Dihydrallazine (Nephrosol)	Not Available	Available	Available
Aminophyllin	Available	Available	Available
Hexoprenaline IVI (for asthma)	Not Available	Not available	Not available

Salbutamol	Available	Available	Available
Prednisone	Not available	Available	Available
Calcium gluconate	Not available	Available	Available
Ferrous Fumarate	Available	Available	Available
Folic Acid	Available	Available	Available
Pregamal	Not available	Not available	Not available
Multivitamin tablets	Available	Available	Available
Vitamin A (capsules)	Available	Available	Available
ORS Packages	Available	Available	Available
4,2% Sodium Bicarbonate	Not Available	Available	Available
Haemacel or 4% Albumin	Not Available	Not available	Not available
Syntocinon (Oxytocin)	Not Available	Available	Available
Gentian Violet	Available	Available	Available
Nystatin	Available	Available	Available
Econazole Pessaries	Not available	Not available	Not available
Syphilis Test Kits	Not available	Not available	Not available
Blood transfusion tubing	Available	Available	Available
MEDICAL/SURGICAL EQUIPMENT AND SUPPLIES			
Adult ventilator bag and mask	Available	Available	Available
Equipment and supplies for cross-matching blood	Available	Available	Available
Equipment and supplies for collection of blood	Available	Available	Available
Hemoglobinometer	Available	Available	Available
Long dressing forceps	Available	Available	Available
Obstetric Forceps	Available	Available	Available

2- Hospital Serving Ndwedwe New Extended Area	
APPLESBOSH HOSPITAL	
GENERAL INFORMATION	
Staff member interviewed	Matron Gloria Bolayo, CPN
Comments:	-No children present w/ dysentery from shigella or measles anymore -No syphilis test kits
Total # of beds	181
• Maternity beds	48
• Pediatric beds	26
Estimated population served	53,000
Estimated area served by this facility	Cibini (in Ndwedwe Sub-district) Bambanani Emtulwa Icumisa Esdumbini (in Ndwedwe Sub-district) Ozwatini
Hours facility open	24 hours
Functional waste disposal area/pit?	Yes
Nearest Referral facility	Northdale Hospital (66 km; 45 minutes away)
How is transport handled for referrals?	METRO ambulance (DOH contract with a private company)-toll free call 10177
STAFFING, TRAINING AND SUPERVISION	
Number of:	
Doctors	5
Professional Nurses (PN)	34 total
-PN/ Midwife	33
Enrolled Nurses (EN)	27
Enrolled Nursing Auxiliary (ENA)	44
ADMs	2
AIDS Counselor	2 + 2 lay counselors
Medical Social Worker	1
Laboratory tech.	3
Radiographer	3
Pharmacist	3
Pharmacy Assistant	3
Total Staff	
Total Staff treating children	5 nurses and 3 doctors
Staff trained in:	
HIV/AIDS clinical diagnosis	106
Counseling, psychological support, and coping w/ PLWA	4
Universal Precautions & Asepsis/Antiseptic Procedures	All doctors, PNs, ENs, ENAs, GAs, porters, and messengers
Care of Pregnant Women and Children (KZN DOH protocol)	34 PN Midwives

IMCI protocol	1 PNs
EPI	
Basic Essential Obstetric Care	All PN Midwives
Comprehensive Essential Obstetric Care (blood transfusion, C-section)	All PN Midwives, but only in blood transfusion, and not in C-section.
Refresher training in essential OC?	No
Post-abortion care services	2 PN
Last in-service training and date	AIDS counselors, 13 May 2002
ANTENATAL/MATERNAL HEALTHCARE	
At least 4 antenatal care visits recommended	YES
Do you recommend pasteurization of breastmilk for HIV + mothers?	NO
All ANC activities performed during a visit	YES
Number of Deliveries in last year	1085
ADM present?	YES-2
PEP program in place?	N
HIV/AIDS/STI/RTI counseling integrated w/ ANC activities?	YES
How long after delivery does F/U occur?	6 weeks
What family planning services offered?	Pill, injectibles, condoms
Emergency obstetric care provided?	YES
Post-abortion care services offered?	YES
Symptoms & Signs during pregnancy that would prompt referral	-previous bad obstetric history/abdominal scars/previous stillbirth -hypertension/headache/swelling/fits -anemia/pallor/fatigue/breathlessness -cessation of fetal movement/baby does not move -abnormal lie/position of fetus -hemorrhage/heavy bleeding -multiple pregnancy/large abdomen (if it risky) -obstructed/prolonged labor
Symptoms & Signs during delivery that would prompt referral	hypertension/headache/swelling/fits hemorrhage/heavy bleeding Obstructed/prolonged labour
Symptoms & Signs after delivery that would prompt referral	hemorrhage/heavy bleeding
How do you treat a pregnant woman with heavy bleeding?	Not in questionnaire
How many cases of obstetric emergencies have occurred in this facility in past year?	3
How many deaths from obstetric emergencies have occurred in this facility in past year?	0
CHILD HEALTHCARE	
What antibiotic would you choose in the case of dysentery from shigella?	Co-trimoxazol Nalidixic Acid

What would you do w/ a child > 2 months w/ pneumonia?	Outpatient treatment with antibiotics Home care
Ever unable to refer a child?	Yes
Why?	N/A
Are STI tests provided, w/counseling and treatment?	Yes, voluntary
Are HIV tests and counseling provided?	Yes, Elisa (blood sent to Virology Dept. Univ. Natal)
Is Cotrimoxazole used as preventive therapy for OIs in people with HIV?	Yes
Is there any support group in the community for PLWA?	Yes. "OGUNTINI" is a home based care group in the community run by CHWs
INFRASTRUCTURE AND EQUIPMENT	
Table & Stool for GYN Exams	Available & satisfactory
Delivery/Labor Room w/ Bed & Lightening	Available & satisfactory
Ambulance/Vehicle for Emergency Transfer	Available & satisfactory
Cloth/Towel to Dry Baby	Available & satisfactory
Blanket to wrap baby	Available & satisfactory
Educational Materials related to Maternal/antenatal and newborn health	Available & satisfactory
ESSENTIAL DRUGS & CONSUMABLE SUPPLIES	
Ceftriaxone	Available
Nalidixic Acid	Available (tablets & mixture)
Nitrofurantoin	Out of stock for 2 weeks, on order now
Piperazine	Do not stock
Niclosamide (Yomesan) tablets	Do not stock
Hexoprenaline IVI (for asthma)	Available (injection, for infusion)
Calcium gluconate	Available
Vitamin A (capsules)	Tablets available
Econazole Pessaries	Do not stock; stock clotrimazole instead
Syphilis Test Kits	Out of stock