



## World Relief Mozambique Expanded Impact Child Survival Program FIRST ANNUAL REPORT



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**Project Location:** Chibuto, Chicualacuala, Chigubo, Massangena,  
Massingir districts, Gaza Province, Mozambique

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## ACRONYMS

|                |   |
|----------------|---|
| <b>CHIS</b>    | <b>Community Health Information System</b>                      |
| <b>CSP</b>     | <b>Child Survival Project</b>                                   |
| <b>CTO</b>     | <b>Cognizant Technical Officer</b>                              |
| <b>DIP</b>     | <b>Detailed Implementation Plan</b>                             |
| <b>EBF</b>     | <b>Exclusive Breastfeeding</b>                                  |
| <b>EPI</b>     | <b>Expanded Program for Immunization</b>                        |
| <b>HC</b>      | <b>Health Center</b>  |
| <b>HF</b>      | <b>Health Facility</b>  |
| <b>HP</b>      | <b>Health Post</b>  |
| <b>HQ</b>      | <b>Headquarters</b>   |
| <b>C-IMCI</b>  | <b>Community Integrated Management of<br/>Childhood Illness</b> |
| <b>ITN</b>     | <b>Insecticide Treated Net</b>                                  |
| <b>M&amp;E</b> | <b>Monitoring and Evaluation</b>                                |
| <b>MN</b>      | <b>Malnourished</b>   |
| <b>MOH</b>     | <b>Ministry of Health</b>                                       |
| <b>ORT</b>     | <b>Oral Rehydration Therapy</b>                                 |
| <b>PVO</b>     | <b>Private Voluntary Organization</b>                           |
| <b>STI</b>     | <b>Sexually Transmitted Infection</b>                           |
| <b>TT</b>      | <b>Tetanus Toxioid</b>  |
| <b>VHC</b>     | <b>Village Health Committee</b>                                 |
| <b>WR</b>      | <b>World Relief</b>   |

## **A. Main Accomplishments of the Program**

In its first year, the Expanded Impact Child Survival Project made significant progress toward its goals by completing ground work needed for full-scale implementation: establishing the Care Group infrastructure, training all staff and volunteers, and developing the Scale<sup>2</sup> learning center. A total of 129 Animators have been trained in the health education curriculum, and 4054 volunteers in 408 Care Groups are currently being trained. The number of volunteers is significantly higher than the 3600 that were planned for, as the project is reaching both a higher number of households and households that are more remote and disparate than were initially planned. The first lesson, diarrhea/hygiene was implemented at the household level in September 2005. The Project achieved numerous other successes, including completing a census of villages in the catchment area, modifying the health curriculum and translating it into Portuguese (from Shangaan, the local language from the last project), and effectively coordinating with the Ministry of Health to implement a vaccination campaign.

First year activities went very smoothly at least in part due to the fact that the process was facilitated by a group of core staff members who have 10 years of experience in successful Care Group implementation in Mozambique. The excellent relationships World Relief has built over the years with communities, the Ministry of Health, and other NGOs also contributed to the accomplishments of the first year.

The overarching goals of the project to achieve the ultimate goal of reducing disease burden in women and children under 5 years are: 1) strengthen the capacity of the health system to improve quality and coverage of C-IMCI services through training, drug management, supervision and by establishing effective health information systems, 2) develop sustainable community based mechanisms to improve prevention and care seeking practices for C-IMCI and 3) establish a Scale<sup>2</sup> learning center for C-IMCI training to facilitate scaling up to provincial and national implementation.

The Care Group (CG) model addresses C-IMCI by strengthening the health infrastructure through training of health providers, improved drug supply and management and increasing access to health services to the population. Training is conducted through a cascade training approach through skilled health personnel trained in C-IMCI using standard protocols endorsed by the MOH. The CG model facilitates the development of effective community based health infrastructures by developing village health committees (VHC), care groups of pastors and traditional healers, and an extensive network of community based volunteers who provide educational health services to the population. Mechanisms that will be instituted for the community health information system (CHIS) facilitated an effective surveillance for childhood illnesses and recording of vital events.

The Scale<sup>2</sup> learning center with accommodation facilities has been developed and has been very useful for training people (like the Animators) from outside Chokwe. This has reduced per diems and accommodation costs significantly. (Note: No USAID funds were used for infrastructure costs.) Staff are in the process of finishing the library next to the

training center that will serve as a resource for materials in C-IMCI related subjects for this project and for outside agencies. The facility will be used to provide training on the Care Group method for other agencies and the Ministry of Health. The first of such trainings is tentatively planned for March 2006.

### Progress Toward Project Objectives: End of Year 1

| Project Objectives/<br>Technical Intervention   | Key Activities  | Status of<br>Activities   | Comments:  |
|---|---|---|--|
| <b>Control of Diarrheal Disease</b>   |   |   |  |
| 75% of caretakers know at least 2 danger signs <sup>1</sup> for seeking care immediately        | Select and train Animators.<br>Select Volunteers.<br>Establish Care Groups.<br>Train volunteers for household level implementation. | All 129 Animators have been trained. Care Groups have been established and 4054 volunteers are being trained and have begun implementing health education lessons at the household level. | Implemented in September 2005  |
| 60% of <i>sick children</i> offered increased fluids  |   |   |  |
| 60% of <i>sick children</i> offered continued feeding   |   |   |  |
| 50% of caretakers wash hands before food preparation, before child feeding, after defecation    |   |   |  |
| 70% of children with diarrhea treated with ORT  |   |   |  |
| <b>Pneumonia Case Management</b>  |   |   |  |
| 50% of children treated <24h for rapid, difficult breathing (suspected <i>pneumonia</i> ) at HF | See above.  | See above.  | To be implemented: 1 <sup>st</sup> quarter 2007                        |
| <b>Control of Malaria</b>   |   |   |  |
| 75% of children treated for fever (suspected <i>malaria</i> ) within 24h at a HF                | See above.  | See above.  | To be implemented: 4 <sup>th</sup> quarter 2005                        |
| 70% drug compliance for children treated with chloroquine for malaria.                          |   |   |  |
| 50% of the children <2y sleep under ITN (measured if ITN is marketed)                           |   |   |  |
| <b>Expanded Program for Immunization</b>  |   |   |  |
| 80% children 12-23m fully immunized   | See above.<br><br>Also, assist MOH with immunization campaign.  | See above.<br><br>Assisted MOH with immunization campaign in September 2005.  | To be implemented at the household level: 4 <sup>th</sup> quarter 2006 |
| 60% of women of fertile age receiving TT  | See above.  | See above.  | To be implemented: 4 <sup>th</sup> quarter 2006                        |
| <b>EBF &amp; Nutrition</b>  |   |   |  |
| 40% of children EBF for 0-6m  | See above.  | See above.  | To be implemented: 1 <sup>st</sup> quarter 2006                        |
| 70% of children 6-8m who received complementary feeding   |   |   |  |

|  |  |   |   |
|--|--|---|---|
| 80% children weighed regularly during growth monitoring  |  |   |   |
| 80% of caretakers of malnourished children receive nutrition counseling  |  |   |   |
| 70% of MN children receive nutritious weaning foods/enriched porridge after nutrition counseling   |  |   |   |
| 70% of Children who complete HEARTH achieve and sustain adequate (200g) or catch-up (400g) growth per month for at least 2m after Hearth |  |   |   |
| <b>Reproductive Health and HIV/ AIDS Prevention</b>  |  |   |   |
| 70% of the mothers will deliver by a trained health provider   | See above.   | See above.  | To be implemented: 3 <sup>rd</sup> quarter 2006   |
| 50% of caretakers will know 2 ways to prevent STI/HIV/AIDS   |  |   |   |
| 50% of caretakers will know 2 symptoms of STI  |  |   |   |
| 50% of caretakers will know 2 symptoms of HIV/AIDS   |  |   |   |
| <b>Strengthening Health System Capacity for IMCI Implementation</b>  |  |   |   |
| % of providers who have training IMCI/C-IMCI   | Training and supportive supervision of socorristas. Joint M&E with MOH.  | Refresher trainings have been conducted with Socorristas in areas from the previous project (Massingir district). New Socorristas will be selected after VHCs have been established in the new areas. | Socorrista recruitment and training are scheduled for the 1 <sup>st</sup> & 2 <sup>nd</sup> quarter of 2006.                          |
| % of socorristas comply to standard case managements practices and provide services  | Training and supportive supervision of socorristas. Joint M&E with MOH.  | New Socorristas will be selected after VHCs have been established in the new areas.   | Joint M&E with MOH is ongoing through the end of the project.   |
| 60% of HC/HP have essential drugs for IMCI   | Train in creating and maintaining records. Monitor system for procurement of essential drugs. Support of VHC to monitor user fees. | VHCs are currently being formed, to be functioning in the 1 <sup>st</sup> quarter of 2006.  | More will be known about activities related to essential drugs after the health facility assessments are completed in November, 2005. |

|  |   |   |  |
|--|---|---|--|
| 75% of target population has access to health services (<5km)                            | Support outreach activities.<br>Training of socorristas and support establishment of HP.                        | New Socorristas will be selected after VHCs have been established.  | Socorrista recruitment and training are scheduled for the 1 <sup>st</sup> & 2 <sup>nd</sup> quarter of 2006. |
| % HP provide monthly CHIS data to HC   | Design and institute CHIS.<br>Create and train VHC to support volunteers.                                       | VHCs are currently being formed, to be functioning in the 1 <sup>st</sup> quarter of 2006.  | CHIS is scheduled to be implemented in June/July 2006.   |
| <b>Sustainability and Capacity building for improved support systems</b>                 |   |   |  |
| 60% of VHC meet in the last 2m   | Establish VHCs.<br>Training and supportive supervision of VHC members.  | VHCs are currently being formed, to be functioning in the 1 <sup>st</sup> quarter of 2006.  | Supportive supervision of VHCs is ongoing as needed until the end of the project.                            |
| 80% of volunteers continue providing services  | Training and supervision of Care Groups.  | Care Groups have been formed and are currently being trained and supervised.  | Care Group training and supervision is ongoing until the end of the project.                                 |
| 60% of trained Socorristas continue providing services                                   | Training and support of Socorristas.<br>Establishment and support of health posts.                              | Refresher trainings have been conducted with Socorristas in areas from the previous project (Massingir district). New Socorristas will be selected after VHCs have been established in the new areas. | Socorrista recruitment and training are scheduled for the 1 <sup>st</sup> & 2 <sup>nd</sup> quarter of 2006. |
| 80% of pastors/traditional healers receive training in C-IMCI                            | Training and supportive supervision of pastors, traditional healers.  | Pastor/traditional healer Care Groups will be formed in December in the same communities as the main Care Groups.   | Training and supportive supervision of pastors/traditional healers continues for the life of project.        |
| <b>Establishment of resource center for training and dissemination of best practices</b> |   |   |  |
| Functioning resource center for training on C-IMCI.                                      | Establish training center.<br>Development of training curriculum, supervision guidelines, M&E Performance plan. | Training center has been established.<br>Library for C-IMCI materials is being developed.   | The first training workshop (on health facility assessments) will take place in November 2005.               |
| 50% of district MOH participated in at least one workshop.                               | Joint planning with MOH, PVO and donor community.<br>Training and dissemination workshops.                      | Planning for workshops involves MOH, PVO and donors.  | The second workshop is tentatively scheduled for March 2006.   |

## **B. Factors that have Impeded Progress**

As part of its EPI efforts, the project assisted the MOH with an intensive immunization campaign for about one month. As a result, some activities were delayed. The health facility assessments will be conducted a month later than they were originally scheduled, and Socorrista recruitment and training will take place in the first 2 quarters of 2006, rather than the last 2 quarters of 2005.

During August, the new provincial governor transferred all district administrators in the target areas to new districts. This meant that project staff had to start from scratch explaining the program to them. Fortunately, this has not delayed project activities. The project's district coordinators will continue to meet with their respective district administrators and MOH directors on a monthly basis to ensure good communication.

## **C. Areas Requiring Technical Assistance**

World Relief's former Director of Maternal and Child Health and Johns Hopkins School of Public Health faculty member, Dr. Anbrasi Edward, will be providing technical assistance to the project for health facility assessments, to be conducted in November/December 2005. The project currently has no other needs for technical assistance.

## **D. Substantial Changes Requiring Modification of Cooperative Agreement**

The project is exploring the possibility of considering documented volunteer hours part of the PVO match and is currently waiting for a response from its CTO regarding this matter. Regardless, project objectives and activities will not be altered, but will remain consistent with what was described in the DIP.

## **E. Sustainability**

A detailed discussion of sustainability was included in the DIP, and is repeated here:

The CG model has demonstrated sustainability in several aspects of both community behaviors and linkages with the health system. 1) Twenty months after the completion of the CSP in Guija and Mabalane, 93% of the volunteers continued providing services at the households, 2) 77.5% of the VHC had met in the previous quarter and 90% of the communities reported an active *Chefe de Saude*. 3) Retention rate of the 2300 volunteers was 98% at the end of the project, 4) Linkages with the MOH and the community were evident. Four years after the completion of the CSP in Guija and Mabalane, four of the eight indices used to evaluate impact (ORT use for children with diarrhea (83%), malaria treatment within 24 hours for children 1-5 (80%), use of modern family planning methods (22%), and completed immunizations (89%)) depended directly upon the accessible and responsive provision of MOH services.

Aspects of sustainability need to be carefully examined to ensure sustained quality and coverage of implementation by the community and MOH systems when the project phases out. MOH staffing problems have been identified as a major challenge to program sustainability, but WR has been in discussion with MOH Provincial Director to advocate for the appointment of one community health officer per district to supervise Socorristas, relate to volunteers, and work closely with VHCs. The dimensions of the sustainability indices will be integrated in the program to ensure long term impact in the project areas<sup>ii</sup>. Sustaining and improving the health status with the district health systems, and building community competency and capacity through training of VHC, Pastors, traditional healers and the volunteer CG will ensure momentum and achieve impact. Sustainability in going to scale requires integration of services, supervision and management of resources, monitoring and evaluation, and identification and nurture of effective leaders.<sup>iii</sup> The program in Gaza, has already tracked critical dimensions of the sustainability framework, 1) population health status, 2) organizational capacity and viability, and 3) community capacity; these will continue to be tracked during the expanded project.<sup>iv</sup>

Changes in *population health status* have been sustained in the CG model. Four years following the end of Vurhonga 1, all of the measurable health indicators used to evaluate project impact remained above the EOP goals. Vurhonga 2 demonstrated a 62% decrease in under-five mortality over three years of the program from 2000 to 2002; which has been supported by a recent research study using retrospective pregnancy history surveys. Supervision and training of the CG volunteers is ensured through established linkages of the Village Health Committee (VHC), pastoral care groups and MOH. Previous CSP districts will receive ongoing support from WR by including district MOH directors in trainings at the Scale<sup>2</sup> center. In addition, these districts will be included in household surveys at midterm and final evaluations of the current program.

IMCI implementation has faced enormous challenges both at the facility and community levels. Its introduction in the community requires strategic partnerships and added costs. In a joint DFID/USAID evaluation of IMCI projects, the investigators acknowledged that effectiveness was being achieved with IMCI but it was costly and did not achieve acceptable coverage rates<sup>v</sup>. The previous CSP have illustrated considerable impact with relatively few resources at lower costs. Average annual cost per household of \$23 (\$1.33 million/14,570 households/4 years) was required to establish the C-IMCI program in the first CSP, which declined to \$14 (\$1.33/23,610 households/4 years) in the second CSP very close to the projected cost of approximately \$14.50 (\$3.3 million/45,450 households/5 years) in the present proposal. The CG model provides no continuing funding to the community or MOH workers beyond the EOP. The partnership to institute comprehensive C-IMCI becomes affordable when seen as a one-time establishment cost rather than an annual operating expense. The administrative model of the CG also facilitates the effective integration of other programs and interventions. WR is also engaged in emergency famine relief and agriculture development in some of the targeted districts, to improve food security and economic viability of the population.

## F. Responses to DIP Consultation

Responses to comments from those who reviewed the DIP were included in the final DIP, submitted June 30, 2005. Those responses are repeated here:

*Proposal Reviewer Comments:* The expanded impact program focuses on scaling up child survival activities through all districts within Gaza province, advocating for sustainable change in the communities and building capacity within the health system. The project will therefore monitor information on several of the indicators and issues highlighted by the reviewers, but would not be included in the list of interventions to be implemented by the project. Considerable effort will be made in establishing the Scale<sup>2</sup> Center for national and regional training on community based health interventions, and therefore has been prioritized as a major effort for the expanded impact program. The comments of the reviewers (in italics) and responses have been illustrated below:

*Since deaths in neonatal period may represent a high proportion of all infant deaths, it would be useful to articulate why activities to target this period are not more overtly addressed as part of project activities.*

The project recognizes that a high proportion of U5 deaths are due to neonatal causes, and will continue to track neonatal deaths through established CHIS, but this will not be a EOP objective because of resource constraints and project priorities for increased efforts in behavior change. However, the CSP will continue to promote activities that improve pregnancy outcome, such as prenatal care, TT and iron supplementation in pregnancy, and delivery by trained provider, appropriate postnatal care and nutrition for women and essential actions for neonatal care at the household level.

*No data are presented on rates of anemia in women and children. What is the national policy on iron supplementation/periodic de-worming for children?*

Anemia in U5 is estimated to be about 75%<sup>vi</sup>, and the receipt of iron supplements by pregnant women was reported to be about 60% in the recent DHS (2003). In pregnant women a 60% anemia prevalence has been reported although no recent studies have been done in the project site. National policies advocate for 30 iron tablets every month from the first Antenatal Care (ANC) visit till delivery. Clinically anemic children and those with malnutrition during the rehabilitation phase are supplemented with iron according to the national policy. De-worming in children has been initiated as a pilot program in certain districts and certain schools for first year primary school children. Although there is no national policy, deworming is frequently prescribed by health workers for almost any abdominal symptoms for children U5.

*Are data available from previous CS focus districts on EBF rates, initiation of BF, or complementary feeding practices?*

EBF rates for the first four months of life was 55% in the first project, but EBF rates, initiation of BF and complementary feeding practices were not tracked in the second project.

*How are vaccines delivered – is outreach included? What are barriers to improving coverage rates? Are there problems on the supply/demand side? What has the project done in the CS program to strengthen immunization activities?*

Complete child immunization coverage increased from 37% to 93% during the life of Vurhonga 1 and throughout Vurhonga 2 ranged from 89-91%. EPI and outreach activities are primarily the responsibility of the MOH, to maintain the cold chain, procure vaccines, and conduct daily vaccinations at health posts equipped with the cold chain and outreach activities to villages for community-based vaccination at health posts that have no refrigerators. The project works closely with the MOH in creating demand for immunization services, through education on the importance of immunization in pregnancy and for children, explaining side effects, and appropriate treatment; and mobilizing mothers to access immunization services during MOH EPI outreach.

*How are essential supplies currently budgeted and delivered? Will the system be able to manage with the increased demand that will occur? What are the important barriers to maintaining adequate supplies? Are data available for current supervisory practices at health facilities?*

No major issues of stock outs for essential drugs were reported in the health facilities of the districts in the project area. Accessibility is a major barrier to some of the remote health posts and therefore will need to be monitored to ensure adequate supplies. The HFA recently conducted by the MOH would provide more accurate data on current status. The project plans to conduct quality assessments to measure and monitor essential drug supply. The increased demand for medicines administered by socorristas is not a major barrier as “Kit C” is available if requested in time at the Provincial level.

*Are data available on current referral practices and barriers to referral?*

Information from the MOH at the national and provincial level indicated very low referral rates especially from the HP/HC to the hospital, and has been included as one of the operations research priorities in the project. The major barrier is access to the HP/HC although cost was not reported to be a barrier in the previous projects as the fees are jointly determined by the VHC and the MOH, and free to those who cannot afford it. Knowledge of danger signs is also low among the mothers and caretakers and likely to affect timely referral for fever and symptoms of pneumonia. A common barrier in previous districts was the lack of emergency transport systems, which was overcome by developing emergency transport plans at village level through the VHC.

*Are data available on use of drug sellers from previous project sites, and possible approaches to improving their practices; limiting their use by caretakers? Is this a problem?*

The practice of accessing drug sellers is not common in the project area although most access care from traditional healers and pastors, who will be targeted for training during the project. In the previous CSP, training of these indigenous providers resulted in higher utilization of formal health services, and improved health status, which improved the credibility of the counseling provided by the pastors and traditional healers. Training of volunteers and caretakers includes the dangers of obtaining drugs and injections from unregistered providers.

*Work plans show programmatic phases, but not the geographic expansion plan.*

Revised work plan demonstrating the expansion has been provided in Annex K. Training will be phased into the districts, the proximal ones receiving training prior to the more remotely located districts. The whole project area will be treated as one area and the interventions will be phased in one at a time in all the districts at the same time. The initial training of the Animators will be phased in starting with Chibuto, followed by the rest of the districts due to the large number of animators. Those not participating in training will be engaged in conducting the census.

*Clarify why anemia is not an element of nutrition activities*

Iron supplements during pregnancy will be promoted during the health education sessions, to access ANC and ensure compliance to at least 60 tablets of iron supplements. Although iron supplements will be provided for children enrolled in the Health sessions it will not be promoted universally in compliance with national guidelines.

*Are data available on deficiency rates? What is the national policy? Should HH messages include the importance of using iodized salt?*

According to UNICEF, 62% of the households surveyed in Mozambique consumed iodized salt<sup>vii</sup>, and reported to have a prevalence of 17% goiter rate<sup>viii</sup>. The selling of iodized salt is promoted nationally and shops are inspected by health officials periodically. A recent study indicated that iodine deficiency was not prevalent in the South, and only evident in Niassa and Tete provinces in the North. The provincial MOH has confirmed that it is not a priority for Gaza.

*PVO might consider including OR on implementation issues surrounding zinc supplementation during and after a diarrhea episode.*

Although the project recognizes the critical contribution of zinc supplementation, it has not been included as one of the interventions due to resource and budget constraints as supplies have to be ensured for the all the 5 districts for the duration of the project.

*Clarify the technical content of socorristas training – including how they are taught to assess and classify children with possible malaria or pneumonia.*

The IMCI guidelines will be adapted and used for training the socorristas. Four videos developed by PAHO have been translated into Portuguese and will be used during the training for identifying children with danger signs for malaria and pneumonia and highlighting the importance of an immediate referral to the HC. The training will be conducted jointly by the MOH and the project staff using national guidelines and protocols. Socorristas will be trained to treat all children with a fever as malaria but also to detect signs of pneumonia, (rapid, difficult breathing, subcostal retraction) malnutrition, anemia and meningitis that may indicate a need for referral to a hospital or health center.

*Clarify whether QOC assessments will include observations of practice, and whether routine supervision by MOH staff to monitor QOC is feasible in the longer term.*

Case management observations have been conducted as part of the National HFA and the project will monitor the performance of the socorristas at the HP level. However the performance of the providers at the HC level will be reassessed after the training on QA and problem solving to ensure improved quality. Since the MOH has initiated the HFA as a first step to assess quality, efforts for quality improvement are being considered at the national level and therefore sustainable in the longer term. MOH directors in the previous districts have already taken initiative to supervise each socorristas post every 3 months.

*Clarify whether simple nutrition/immunization data can be added to the CHIS*

Currently, weight of U2 children is measured and monitored by the volunteers to enroll malnourished children for the Hearth program and reported to the leader during the CG meeting. CHIS data on immunization includes children 12-23 months.

*Consider reviewing the following indicators:*

Indicators for monitoring care seeking behavior for pneumonia and nutrition have been included. Caretakers accessing care from the HP/HC for children with rapid/difficult breathing will be recorded for the pneumonia indicator. Nutrition: Rapid Catch complementary feeding indicator has been included in the baseline survey. The proportion of U2 children who are underweight is already collected through CHIS.

*Quality of child care for facility-based health workers: is it feasible to include the suggested indicators in the proposed HFAs? Would this be beyond the scope of the project?*

Improved quality of care at the HP operated by the socorristas will be closely monitored by the project staff to determine compliance to standard protocols, which will be facilitated by supportive supervision, job aids and quality of counseling through exit interviews. These approaches have been tested and found effective in the previous CSP, except for the introduction of job aids, which will be examined in the current CSP.

## **G. For Programs receiving Family Planning support: Not Applicable**

## **H. Program Management System**

The project's management system has facilitated a very successful first year. The only significant management challenge of note is the absence of a deputy director during year one. Although the project had proposed a full time deputy for the life of the project, the Director has realized that significant efforts will be required for developing initiatives for capacity building within the health systems which will require close monitoring and strategic meetings to ensure validity and develop working relationships between the various stakeholders. Therefore a technical advisor with a higher technical and communication competency has been hired for two years in place of the deputy (to start in January 2006). The technical advisor will help to establish the Scale<sup>2</sup> learning center as a training resource and to facilitate the capacity building process with the district MOH and program staff. The technical advisor's roles and functions will be phased out and assumed by program supervisors and district coordinators.

The communication system has been greatly improved with the introduction of a satellite dish for continual email contact. Similarly, satellite phones allow staff to contact the project office even from remote villages.

The Scale<sup>2</sup> learning center facilitated team building by making it possible for large numbers of Animators to be trained together. The staff have developed a strong vision for the project during the time they spent together in training. This is especially important because the size of the project area limits the amount of time staff will be able to interact with each other.

The project maintains very good relationships with the Ministry of Health and with other PVOs, and actively seeks to collaborate with them when possible. For example, the project recently worked with the MOH on an immunization campaign, and has met with Save the Children to discuss possible cooperative efforts in the future. In addition, each project coordinator meets with her respective district director monthly to improve the coordination of the project.

## **I. Mission Collaboration**

The project maintains an excellent relationship with the USAID Mission, having attended USAID trainings and having been privileged to host Dr. Titus Angi from the Mission several times and recently Ms. Jill Boezwinkle from USAID Washington, DC (October 11-13, 2005). At a training on PD/Hearth in September 2005, the project was identified as a leader in Hearth implementation.

During their visits to Chokwe, both Dr. Angi and Ms. Boezwinkle appeared to be pleased with the project. One aspect of note was the high level of health knowledge demonstrated by community members and project volunteers. In addition, the clear

structure of Care Groups, which is well linked to the Ministry of Health and sustainable even after the project ends, was also seen as a positive characteristic of the project.

Table 6 (taken from the DIP) provides a brief overview of the GRM strategy, USAID Priorities and the conformance of WR strategic plan for the proposed CSP. The SO8 proposes to expand the delivery for C-IMCI through community health agents and traditional healers who will be trained in the guidelines to provide first-line health care to the communities for malaria, diarrhea, hygiene and sanitation.

Table 6: MOH, USAID, CSP Program Priorities

| <i>GRM Strategy</i>  | <i>USAID Strategic Plan</i>  | <i>WR CSP</i>   |
|--|--|---|
| Focus on PHC to reduce disease burden of malaria, TB, diarrhea, ARI and vaccine preventable diseases.  | SO8: Increase use of CS and reproductive health services in the target areas: malaria, pregnancy and perinatal complications, vaccine preventable diseases, and diarrheal diseases   | Support implementation of IMCI interventions of diarrhea, malaria, ARI, nutrition and vaccine preventable diseases.   |
| Increase health system capacity  | IR1. Increase access to quality CS and reproductive health services  | Improve health system capacity: training, drug management and supply  |
| Increase role of individuals and communities in health promotion through improving sanitation, water supply, nutrition, female education and woman's status in society | IR1. Increase access to quality CS and reproductive health services<br>IR2. Increase demand at community level for child and reproductive health services and adoption of healthy behaviors. (Creation and empowerment of community leadership council)<br>IR3. More accountable policy and management: Investigate and test new approaches to service delivery, financing decentralization and promising models of community involvement. | Create extensive community based mechanisms for improved preventive and care seeking behavior for maternal and child health. Empower CG and VHC to identify and address problems and create effective links with the health system. |

## J. Timeline

In FY06, the program will follow the timeline described the original workplan, with a few minor changes. The Health Facility Assessments, which were scheduled to be completed during the 3<sup>rd</sup> and 4<sup>th</sup> quarter of 2005, will be conducted in the 4<sup>th</sup> quarter of 2005 and the 1<sup>st</sup> quarter of 2006 and Socorrista recruitment and training will take place in the first 2 quarters of 2006, rather than the last 2 quarters of 2005. The schedule changes are due to the project's involvement with the MOH intensive immunization campaign in September which interrupted project activities. The Health Facility Assessments and Socorrista recruitment and training are the only activities affected by the interruption that require a deviation from the DIP workplan.

|   | 2005 | 2006 |   |   |
|---|------|------|---|---|
| Quarter   | 4    | 1    | 2 | 3 |
| <b>Activities</b>   |      |      |   |   |
| <b>Staff recruitment &amp; training</b>                                 |      |      |   |   |
| Recruitment of new district Animators                                   |      |      |   |   |
| Recruitment of village volunteers                                       |      |      |   |   |
| Staff training-camp   |      |      |   |   |
| Staff orientation seminar   |      |      |   |   |
| Motorbike training and exams  |      |      |   |   |
| Initial Animator training   |      |      |   |   |
| Animator training-camps   |      |      |   |   |
| Formation of Volunteer groups   |      |      |   |   |
| Formation of health committees  |      |      |   |   |
| Bi-weekly Volunteer training:   |      |      |   |   |
| Diarrhea  |      |      |   |   |
| Malaria   |      |      |   |   |
| Nutrition   |      |      |   |   |
| HIV/AIDS  |      |      |   |   |
| Immunizations   |      |      |   |   |
| Pneumonia   |      |      |   |   |
| Recruitment of Socorristas  |      |      |   |   |
| Socorrista Training   |      |      |   |   |
| Placement of Socorristas to relevant communities                        |      |      |   |   |
| Socorrista refresher training   |      |      |   |   |
| Annual staff vacation   |      |      |   |   |
| <b>Health Systems</b>   |      |      |   |   |
| Strategic meeting with district Administrators and health directors     |      |      |   |   |
| Progr. Coordinator-MOH Director-distr Administrator strategic meetings. |      |      |   |   |

|   |  |  |  |  |
|---|--|--|--|--|
| Baseline Integrated KPC/RC survey & data analysis |  |  |  |  |
| Preparation of SS training center                 |  |  |  |  |
| Health Facility Assessments                       |  |  |  |  |
| Joint M&E with MOH                                |  |  |  |  |
| <b>Monitoring &amp; Evaluation</b>                |  |  |  |  |
| Quarterly evaluation (mod LQAS)                   |  |  |  |  |
| Ongoing Animator supervision                      |  |  |  |  |
| Socorrista supervision                            |  |  |  |  |
| Community-based statistics                        |  |  |  |  |
| Under-5 mortality feedback                        |  |  |  |  |
| MTE   |  |  |  |  |
| FE  |  |  |  |  |
| <b>Operations Research</b>                        |  |  |  |  |
| OR planning & evaluation:                         |  |  |  |  |
| Job Aids  |  |  |  |  |
| Referral systems                                  |  |  |  |  |
| Village Health Insurance Scheme                   |  |  |  |  |
| OVC care-seeking pattern                          |  |  |  |  |
| <b>Scale<sup>2</sup> Center</b>                   |  |  |  |  |
| Preparation and Stocking of SS center library     |  |  |  |  |
| SS center workshops:                              |  |  |  |  |
| Workshop on HFA & QA introduction                 |  |  |  |  |
| Care Group Model                                  |  |  |  |  |
| Community HIS                                     |  |  |  |  |
| OR findings                                       |  |  |  |  |

Key:

HFA - Health Facility Assessments

HIS - Health Information System

OR - Operations Research

OVC - Orphans and Vulnerable Children

QA - Quality Assurance

SS - Scale Squared

TA - Technical Advisors

TE -Technical Expert

**Note: Project staff will be on part time schedule to facilitate the phasing our process that will occur in the 5th year of the program.**

### K. Scale Up Methodology

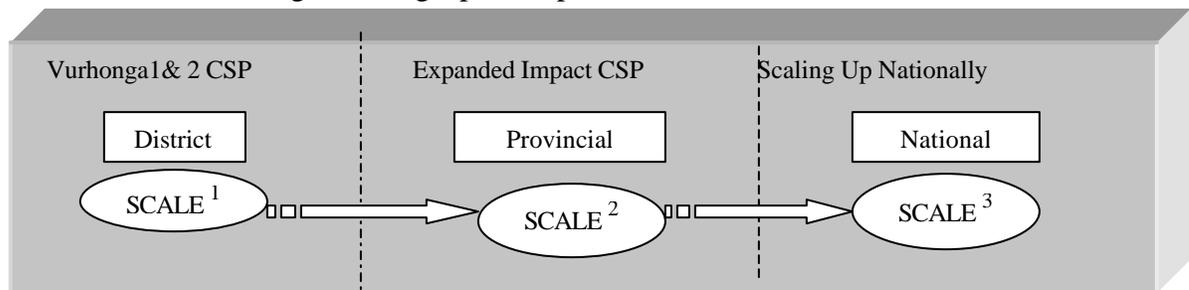
The main purpose of the project is to scale up the Care Group model for child survival interventions through direct implementation in 5 new districts in Gaza Province and by establishing a Scale<sup>2</sup> learning center for C-IMCI training to facilitate scaling up to provincial and national implementation. A description of the SCALE Model of Expanded Impact, included in the project’s original proposal, follows:

#### *The SCALE Model of Expanded Impact*

Drawing upon decades of experience that began before primary health care was embraced at the Alma Ata conference, Dr. Carl Taylor recognized that many community-based projects that are successful among a small population fail when they are scaled up to larger levels. Among the handful of projects that have been successful in scaling up, he and his son discerned an emerging model that they describe as SCALE (System for Communities to Adapt Learning and Expand).<sup>ix</sup> The three basic principles of the SCALE model include 1) establishing three way partnerships with the community, government and technical experts, 2) taking action based on locally obtained data, and 3) demonstrating change in community behavior. When Dr. Taylor conducted the final evaluation (FE) of Vurhonga 2, he recognized these elements and challenged WR to pursue scaling-up in this proposal.

Under Dr. Taylor’s model, *Vurhonga 1 and 2* comprised *Scale<sup>1</sup>: Successful Change as Learning Experiences* - district level programs that were successful in improving health and also in establishing health information systems and community/MOH partnerships that have continued beyond the End Of Project (EOP). WR acted in an enabling but time-limited technical role. The expanded impact CSP will enable *Scale<sup>2</sup>: Self-help Centers for Action Learning and Experimentation*, expanding the impact of the program to a provincial level and setting up a Scale<sup>2</sup> training center at the *Vurhonga 2* site in Chokwe for other districts in Gaza and throughout the country. Developing *Scale<sup>3</sup>: Systems for Collaborative Adaptive Learning and Extension* will require investments from the national MOH and depends upon the success of Scale<sup>2</sup>. The Scale<sup>2</sup> center lays the foundation for the final step by building upon models of proven effectiveness and a critical mass of trained leaders within the MOH.

Fig 1: Scaling Up for Implementation of C-IMCI



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<sup>i</sup> : child not able to drink or breastfeed, child becomes sicker despite home care, fever, fast or difficult breathing, blood in stools, drinking poorly.

<sup>ii</sup> The Child Survival Sustainability Assessment. Eric Sarriot 2002

<sup>iii</sup> Community Based Health Care: Lessons from Bangladesh to Boston. Eds Johns Rhose and John Wyon, 2002.

<sup>iv</sup> The Child Survival Sustainability Assessment. Eric Sarriot, CORE, 2002

<sup>v</sup> Meek, S, *Joint DFID/USAID Evaluation of Integrated Management of Childhood Illness (IMCI)*, Malaria Consortium, [www.malariaconsortium.org/mcproject7.htm](http://www.malariaconsortium.org/mcproject7.htm)

<sup>vi</sup> 3 Repartição de Nutrição. Instituto Nacional da Saúde. Ministerio da Saúde de Moçambique. Evaluation of micronutrient deficiencies in Cabo Delgado, Manica, Gaza, and Maputo Provinces in Mozambique. Nutrition Department, Ministry of Health. Maputo, Mozambique. 1999

<sup>vii</sup> UNICEF, 2003

<sup>viii</sup> Micronutrient Initiative, 2004

<sup>ix</sup> Taylor-ide and Taylor Just and Lasting Change: When Communities own their Future. Johns Hopkins University Press 2002.

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## **Child Survival and Health Grants Program Project Summary**

**Oct-28-2005**

### **World Relief Corporation (Mozambique)**

#### **General Project Information:**

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

**WRC HQ Backstop:** Olubukola Ojuola

#### **Field Program Manager Information:**

**Name:**  
**Address:**

**Phone:**  
**E-mail:**

#### **Alternate Field Contact:**

**Name:** Pieter Ernst  
**Address:** CP 40  
Chokwe  
**Phone:** 258-21-20154  
**E-mail:** pemst@wr.org

#### **Funding Information:**

**USAID Funding:(US \$):** \$2,500,000

**PVO match:(US \$)** \$833,333

#### **Project Information:**

**Description:**

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

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

### **General Strategies Planned:**

Strengthen Decentralized Health System

### **M&E Assessment Strategies:**

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

### **Behavior Change & Communication (BCC) Strategies:**

Interpersonal Communication  
Peer Communication  
Support Groups

### **Groups targeted for Capacity Building:**

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

### **Interventions/Program Components:**

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## **Immunizations (10 %)**

(IMCI Integration)

(CHW Training)

(HF Training)

- Classic 6 Vaccines
- Vitamin A
- Surveillance
- Mobilization

## **Nutrition (20 %)**

(IMCI Integration)

(CHW Training)

(HF Training)

- Comp. Feed. from 6 mos.
- Hearth
- Cont. BF up to 24 mos.
- Growth Monitoring

## **Pneumonia (10 %)**

(IMCI Integration)

(CHW Training)

(HF Training)

- Recognition of Pneumonia Danger Signs

## **Control of Diarrheal Diseases (20 %)**

(IMCI Integration)

(CHW Training)

(HF Training)

- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding
- Care Seeking
- Case Mngmnt./Counseling

## **Malaria (20 %)**

(IMCI Integration)

(CHW Training)

(HF Training)

- Training in Malaria CM
- Access to providers and drugs
- ITN (Bednets)
- Care Seeking, Recog., Compliance

## **Breastfeeding (5 %)**

(IMCI Integration)

- Promote Excl. BF to 6 Months

## **HIV/AIDS (15 %)**

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(CHW Training)

- Behavior Change Strategy
- Access/Use of Condoms
- ABC

### Target Beneficiaries:

|                                   |                |
|-----------------------------------|----------------|
| <b>Children 0-23 months:</b>      | <b>38,635</b>  |
| <b>Women 15-49 years:</b>         | <b>63,122</b>  |
| <b>Population of Target Area:</b> | <b>227,260</b> |

### Rapid Catch Indicators:

| <b>Indicator</b>  | <b>Numerator</b> | <b>Denominator</b> | <b>Percentage</b> | <b>Confidence Interval</b> |
|---|------------------|--------------------|-------------------|----------------------------|
| Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population) | <b>50</b>        | <b>299</b>         | <b>16.7%</b>      | <b>6.3</b>                 |
| Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child  | <b>0</b>         | <b>0</b>           | <b>0.0%</b>       | <b>0.0</b>                 |
| Percentage of children age 0-23 months whose births were attended by skilled health personnel   | <b>190</b>       | <b>299</b>         | <b>63.5%</b>      | <b>10.6</b>                |
| Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child    | <b>75</b>        | <b>223</b>         | <b>33.6%</b>      | <b>9.8</b>                 |
| Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours  | <b>19</b>        | <b>109</b>         | <b>17.4%</b>      | <b>10.6</b>                |
| Percentage of infants age 6-9 months receiving breastmilk and complementary foods   | <b>35</b>        | <b>69</b>          | <b>50.7%</b>      | <b>20.5</b>                |

|   |     |     |       |      |
|---|-----|-----|-------|------|
| Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday  | 85  | 110 | 77.3% | 18.2 |
| Percentage of children age 12-23 months who received a measles vaccine  | 105 | 110 | 95.5% | 18.7 |
| Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)  | 43  | 299 | 14.4% | 5.9  |
| Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment   | 71  | 299 | 23.7% | 7.3  |
| Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks   | 5   | 171 | 2.9%  | 3.6  |
| Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection  | 27  | 262 | 10.3% | 5.4  |
| Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated | 9   | 299 | 3.0%  | 2.8  |

### Comments for Rapid Catch Indicator