FOURTH ANNUAL REPORT

Chikankata Child Survival Project

(Mazabuka and Siavonga Districts,
Southern Province, Zambia)

THE SALVATION ARMY WORLD SERVICE OFFICE

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Acronym List

ANC	Ante-Natal Care
CDKs	Clean Delivery Kits
CGs	Care Groups
CGVs	Care Group Volunteers
CHW	Community Health Worker
CH&D	Community Heath and Development
CPT	Care and Prevention Team
CCSP	Chikankata Child Survival Project
DHMT	District Health Management Team
EmONC	Emergency Obstetric and Neonatal Care
EOP	End of Project
FANC	Focused Antenatal Care
GMP	Growth Monitoring Promotion
HC	Health Center
HH	Household
ITN	Insecticide Treated Net
KPC	Knowledge Practice and Coverage
M&E	Monitoring and Evaluation
MCH	Maternal Child Health
MNC	Maternal and Newborn Care
MPH	Master in Public Health
MoH	Ministry of Health
MTE	Midterm Evaluation
NHC	Neighborhood Health Committee
NFNC	National Food and Nutrition Commission
NMCC	National Malaria Control Center
PAC	Post-abortion Care
PD	Positive Deviance
RHC	Rural Health Center
SAWSO	Salvation Army World Service Office
TSA	The Salvation Army
TTBAs	Trained Traditional Birth Attendants
WHO	World Health Organization

BACKGROUND

The Chikankata Child Survival Project (CCSP), implemented jointly by The Salvation Army (TSA) World Service Office (SAWSO) and TSA Chikankata Health Services (CHS), is a five-year project that aims to reduce maternal and under-five child mortality for 50,593 direct beneficiaries (4,620 children under 12 months; 4,353 children 12-23 months, 13,146 children 24-59 months, and 28,474 women of reproductive age) in the Mazabuka and Siavonga Districts of Zambia's Southern Province. The effective collaboration between US-based SAWSO, TSA, and Zambian Ministry of Health (MOH) includes all primary service providers within the Mazabuka and Siavonga Districts and influential maternal and child health advocates at the national level. The CCSP works in a rural area with limited infrastructure and extreme poverty and will benefit 123,613 people.

Mazabuka and Siavonga Districts have unacceptably high levels of maternal and child mortality. The under-five mortality rate is 182/1000, and the infant mortality rate is 103/1000—both primarily caused by malaria and malnutrition. The maternal mortality ratio is estimated to be 729/100,000, and the newborn mortality rate is 35/1000. The CCSP endeavors to achieve the following results, through innovative community-based strategies, building on TSA's presence at the local level.

Result 1: Improved malaria prevention and treatment practices (40%)
IR 1.1: Increased insecticide-treated net use among pregnant women and children under five
IR 1.2: Increased appropriate care-seeking for danger signs
IR 1.3: Continued high coverage of intermittent preventive treatment in pregnant women

Result 2: Increased immunization coverage in children (10%)

Result 3: Improved nutritional status of children and pregnant women (30%)
IR 3.1: Improved child feeding practices
IR 3.2: a) Improved detection of malnutrition b) Improved community treatment of malnutrition
IR 3.3: Increased exclusive breastfeeding up to six months of age
IR 3.4: Increased coverage of micronutrient supplementation (Vitamin A and iron/folic acid)

Result 4: Improved maternal and newborn care practices (20%)
IR 4.1: Increased deliveries by trained providers, improved birth preparedness, and improved home practices related to pregnancy and birth
IR 4.2: Improved quality of maternal and newborn care in health facilities
IR 4.3: Increased coverage of postpartum care

A. MAIN ACCOMPLISHMENTS

During the fourth year of implementation, the CCSP focused mainly on improved maternal and newborn care practices by carrying out a health worker training on Focused Antenatal Care (FANC), establishing a community-based emergency transport system, as well as doing refresher trainings for Care Groups (CGs) and Trained Traditional Birth Attendants (TTBAs) on antenatal and postnatal care. The CCSP continued to carry out cross-cutting capacity building activities as well as the highly successful malaria, nutrition and immunization activities, which showed outstanding results. The team also focused on addressing key recommendations from the Midterm Evaluation (MTE).

Cross-cutting Capacity Building Accomplishments

- *Refresher training for CGs, TTBAs and Community Health Workers (CHWs):* At the start of year four, the CCSP conducted refresher trainings for the 63 CHWs and 91 TTBAs using MOH facilitators. Under the CHW training, relevant topics included the role of CHWs and Neighborhood Health Committees (NHCs); community empowerment and counseling; management of malaria, acute respiratory infections, and diarrheal disease; nutrition; immunization; safe motherhood; and water and sanitation.

  Trainings for TTBAs included the following: anatomy of the female reproductive system; antenatal care (ANC); nutrition during pregnancy; danger signs during pregnancy; signs, stages and management of labor; care of the newborn; infection prevention; immunization; causes and management of low birth weight babies; post-abortion care (PAC); postnatal care; birth planning; breast feeding; nutrition during breastfeeding and harmful traditional practices.

  Field Facilitators led refresher trainings for over 196 CGs on all intervention areas during their regular visits three times a month. The Care Group curricula for both the maternal and newborn care and malaria interventions were improved by MPH students from Emory University Rollins School of Public Health. (See intervention-specific sections below for details.)

- *Expansion of men's groups:* This project initiative was developed in an effort to increase men's involvement in women's and children's health by tapping into the already existing Salvation Army Men's Fellowship Groups found in local Corps (Salvation Army churches). To date, a total of 20 men's groups (each with an average of 10 to 12 members) have been established in the Mazabuka district. Project staff did initial trainings using CG curricula introducing topics which men then discuss during regular meetings, which have been well-attended due to their following weekly church services. The men then communicate health messages to others in the community. The local Corps officers keep attendance and compile reports of what goes on during these meetings. A report from the MCH department states that there are now more men bringing children to under-five clinics, and a number of women report that they no longer have problems in telling their spouses they want to start family planning.

Improved Maternal and Newborn Care Practices

- *Health worker training on FANC: The* CCSP held a FANC workshop on April 20 to 25 at Chikankata Health Services for 14 clinical health workers from rural and urban HCs in Mazabuka. They were given a pre-test to assess their knowledge of FANC and assessed at the end of the training. Almost half the participants failed the pre-test, but all participants passed the post-test, a testament to the effectiveness of the training.

- *Refresher training for CGs on MNC:* Per MTE recommendations, the CCSP retrained Care Group volunteers (who in turn retrained their households) on maternal and newborn care which included the importance of knowing danger signs that may occur during pregnancy, postnatal checkups (with an emphasis on timing and intervals of visits), antenatal checkups by skilled attendants, skilled attendance at delivery, place of delivery, and owning and utilizing a CDK. As mentioned above, Field Facilitators led trainings for over 196 CGs. In addition, the CG curriculum for maternal and newborn care was improved by an MPH student from Emory University Rollins School of Public Health.

- *Community-based emergency transport system with CPTs/NHCs:* Because a Doer/Non-Doer survey found that long distances to health facilities is the primary barrier to facility delivery, the project worked with the most remote villages to establish community-based emergency transport systems (see pg. 5). Using the example of an existing community-developed system, the CCSP contributed 10 donkeys to five communities. The donkeys were chosen for their resistance to disease and their ability to survive in the harsh weather conditions of the Zambezi Valley (Siavonga). These communities were chosen because of distance from health facilities, their high incidence of maternal deaths and their poor road networks. Five two-wheeled ox carts were constructed; the community provided wood while the project constructed the frames with wheels. Local communities decided that as donkeys continue to reproduce, their offspring will be passed on to other communities with similar transport problems until all isolated communities have at least a functional community transport system. Communities are responsible for the safe-keeping of these animals, providing them with medication should the need arise, and maintaining the donkey carts. This is entirely community-owned, meaning that communities will be responsible for sustaining the system. The project staff will only offer technical assistance and advice.

- *Refresher trainings for TTBAs:* Per MTE recommendations, a total of 91 active TTBAs from Mazabuka and Siavonga attended refresher trainings in year four. Refer to page three for a list of topics covered in this training.

Improved Malaria Prevention and Treatment Practices

- *Improved record keeping and distribution of ITNs:* During the MTE, it was recommended that the project, DHMT and USAID/Zambia collaborate to identify bottlenecks in the distribution of ITNs. With support from an Emory University intern, the CCSP conducted a baseline of all the ITNs in the project area, counting the total number of sleeping spaces, the number and conditions of ITNs per household, and who slept under them. These results have since been circulated to all health facilities for use as a reference point for ITN distribution in the future. The baseline revealed that duplication or inappropriate distribution of ITNs caused by a lack of data on how many households have ITNs and the lack of community participation in the distribution process have been significant problems.

  After looking at the baseline results, the Emory intern and CCSP staff recommended a new distribution system, further integrating CPTs, NHCs and other community leadership such as the headmen to act as community point people for distributions. CG volunteers will continue to collect household statistics on the people that need ITNs and submit these statistics to the CPT/NHC who then pass this information on to the health centers. The various health centers will then sit with CPTs and NHCs to determine ITN eligibility.

  The new system enables communities to identify gaps in ITN supply at the community level. Care Group volunteers (as part of NHCs/CPTs) will continue to collect household data which they will present at each month's meeting. The NHCs/CPTs will present the same data at Health Center meetings. The baseline data will also be used as a resource to request more ITNs either from donors or the National Malaria Control Center, while health facilities and CPTs/NHCs will use it to better allocate ITNs. The baseline also creates a better way of determining the pattern of distribution of ITNs per age group. At each of the Health Facilities in the project area, a database of all the households has been developed. These databases will be updated by a CHW or another volunteer after ITN distributions or when six months have passed from the last update.

- *Refresher training for CGs on malaria:* Refresher trainings were carried out emphasizing malaria signs and symptoms and ITNs (per MTE recommendations). This training helps to reinforce significant gains achieved in year one. As mentioned above, Field Facilitators led trainings for over 196 CGs. An MPH student from Emory University Rollins School of Public Health also improved the CG malaria curriculum.

Improved Nutritional Status of Children and Pregnant Women

- *Expansion of PD Hearth:* PD Hearth continues to carry out screening of the children for malnutrition at the community level in order to put those identified to be malnourished on a feeding program for two weeks using locally available foods contributed by mothers of the malnourished children. At the end of two weeks children are re-weighed and compared with their entry weight. This year, the project expanded Hearth from three villages to ten, reaching a total of 83 children from January to August, 2009.

- *Training of Care Groups in Hearth messages:* Per MTE recommendation, Field Facilitators continue to teach CG volunteers Hearth program messages such as the importance of observing high standards of hygiene and feeding children sufficient food in proportional amounts with the child's age and status.

- *Collaboration of Field Facilitators, CHWs and RHC staff for recuperation of underweight children:* Per MTE recommendation, at each month's GMP session, children that are identified to be underweight are selected to be included in the next Hearth session. At the end of the following month, these children are re-weighed to ascertain malnutrition levels. The RHC then makes plans for the level of effort that needs to be put into combating malnutrition at the community level.

Monitoring and Evaluation

- *Maternal and newborn care mini-KPC survey:* The results of the mini-KPC survey showed that the project has made significant progress on most indicators except for immediate breastfeeding and skilled birth attendance. Of the seven indicators measured, TTBA-attended home births, child being place with mother immediately after birth, and use of CDKs showed the greatest improvement, by increasing over twenty percentage points. Post-partum visits, TTBA-attended home births, and CDK use have already surpassed EOP targets. (See Annex 1, Result 4)

- *Conducted Doer/Non-Doer survey on key factors for using a health facility for delivery:* As was seen from the mini-KPC data, skilled birth attendance has barely improved in the project area. In response, the CCSP did a Doer/Non-Doer survey to explore reasons for low utilization of health facilities at delivery. The survey revealed three major action points for the CCSP: 1) Since advanced preparation is a major key factor for Doers, Care Group Volunteers and TTBAs should continue to focus efforts on helping families with birth planning. (The refresher training conducted this year for these groups concentrated on birth planning.) 2) TTBA training and supervision should continue to emphasize the role TTBAs play in increasing facility births, since Doers reported that they were important in helping women/families reach facilities. Again, Year Four refresher training for this cadre covered this topic. 3) Since Non-Doers mentioned distance to the facility as the primary challenge to facility delivery, the project should look for creative, inexpensive ways to overcome geographical barriers. The CCSP has since put in place a local solution involving donkeys and carts which will eventually be expanded to some of the most remote villages.

B. ACTIVITY STATUS

Related Key Activities (as outlined in DIP)	Status of Activities	Comments
General Management		
Conduct refresher training for CHWs and TTBAs	Completed	Five day refresher course for 63 CHWs and 91 TTBAs which included birth planning for pregnant women.
Establish village- based men's groups	On target	20 men's groups meet with project staff for supervision and reporting weekly; Men are beginning to get involved in women's and children's health.
Facilitators meet with Care Groups two times a month	On target	Facilitator meetings with CGs have been increased from the initial 2 to 3 times per month resulting in improved meeting attendance and reporting.
Supervision of Facilitators	On target	Supervisors spend one day every week working with each Facilitator and occasionally accompany the Facilitators for supportive visits.
Support monthly NHC/CPT meetings	Not yet on target	Supervisors, CGVs, and Facilitators attend monthly meetings to present on CSP's vital statistics, but meetings have been erratic.
Participate in quarterly DHMT meetings	On target	CH&D manager attends these meetings and reports on CSP intervention progress.
Task Force meetings	Completed	Conducted one task force meeting in year four with TSA Siavonga, RHC's, DHMT, CHS, and Plan International to share achievements and address challenges.
Monitoring and Evaluation		
Conduct Mini-KPC on maternal and newborn care	Completed	Conducted a mini-KPC on maternal and newborn care in February, 2009; the results show that CCSP is making steady progress on most indicators.
Compile and analyze Care Group and Hearth data	On target	Project M&E coordinator compiles project-wide reports on a monthly basis and sends these reports to SAWSO once per quarter. Volunteers will continue to collect HH data to ensure continuity even after the end of the project.
Conduct Doer/Non-Doer survey on key factors for using a heath facility for delivery	Completed	Results showed that distance to facilities is the primary challenge to facility deliveries.
Result 1: Improved Malaria Prevention and Treatment		
Support ITN re-treatment activities at health facilities and communities	On target	Volunteers inform mothers of actual re-treatment dates. Supervisors carry retreatment supplies. Facilitators and volunteers conduct the actual re-treatment of ITNs. RHC staff order supplies from DHMTs. Sometimes there is a shortage of retreatment drugs.
Work with DHMTs and RHC staff to improve record-keeping of ITNs/identify ITN distribution problems and set goals to rectify them	Completed	Interns from Emory University helped complete this activity. Baseline of ITNs was done and results have been shared with RHCs and hospitals. A new distribution system was recommended that includes CPTs/NHCs and Care Groups.
Refresher training for Care Groups on malaria signs and symptoms and reinforcing the importance of using ITNs	On target	Facilitators reviewed first year health messages. CGVs passed on these messages to households. A new CG curriculum was developed. There is increased ITN utilization among pregnant women and children.
Result 3: Improved Nutritional Status of Children and Pregnant Women		
Conduct PD inquiry; develop Hearth sessions/conduct Hearth cycles	On target	Daily food contributions may sometimes be erratic or nonexistent in parts of the Siavonga district. The area is characterized with little to no rain in some places; the soil is poor and does not support crop growth.

Train Care Groups in messages that were developed in the Hearth program	On target	Teach mothers about the importance of good hygiene, feeding children at least four times a day, and feeding children with protein dense foods. There is increased knowledge among mothers about nutrition, and more mothers are willing to enroll their children in the PD Hearth program.
Field Facilitators meet with their CHWs and RHC staff to develop goals for recuperating underweight children	On target	Facilitators and CHWs take part in community-led GMP activities. Facilitators plan upcoming sessions with RHC staff.
Result 4: Improved Maternal and Newborn Care		
Refresher training for TTBAs on birth planning; danger signs during pregnancy, labor and the postnatal period; postnatal care; and the importance, utilization and price of CDKs	Completed	Conducted a five-day refresher training for 91 active TTBAs in Mazabuka and Siavonga, training them on the importance of ANC and birth planning. TTBAs are conducting most home deliveries, and CDKs are not supplied to RHCs any more from the central stores due to a change in DHMT policy.
Refresher training for CGs on ANC (including CDK promotion and birth planning), danger signs in pregnancy, postnatal check-up schedule and care for postnatal women	On target	Facilitators teach volunteers on danger signs associated with pregnancy and the importance of using CDKs. Volunteers learn postnatal schedules and the importance of these time intervals. Most volunteers and mothers know why they should have a post natal checkup after delivering. A new MNC curriculum was developed.
Additional Recommendations from the Midterm Evaluation		
Result 1: Improved Malaria Prevention and Treatment		
Procure IEC materials with magnified pictures in all 4 interventions	Not yet on target	Because Care Groups are already so effective (per mini-KPC results), the project decided to put resources towards health worker trainings instead.
CCSP to collaborate with DHMTs and other stakeholders (USAID and PMI) to identify ITN distribution problems and set goals to rectify them	Completed	This activity was carried out by an intern from Emory University. She identified ITN distribution gaps using a baseline and met with stakeholders to discuss solutions.
Result 3: Improved Nutritional Status of Children and Pregnant Women		
Procure IEC materials with magnified pictures in all 4 interventions	Not yet on target	Because Care Groups are already so effective (per mini-KPC results), the project decided to put resources towards health worker trainings instead.
Develop checklists for CHW growth promotion counseling (jointly with CHWs and RHC staff) and implement during GMP sessions[1]	Not yet on target	This has not been completed in its entirety due to unavailability of RHC staff. Growth promotion counseling skills, however, have been newly incorporated into CHW refresher trainings.
Result 4: Maternal and Newborn Care Activities		
Procure IEC materials with magnified pictures in all 4 interventions	Not yet on target	Because Care Groups are already so effective (per mini-KPC results), the project decided to put resources towards health worker trainings instead.
Train health workers in emergency obstetric and neonatal care (EmONC)	On target	At the time of writing of this report, the EmONC training was in process to be completed Oct. 23, 2009.
Train health workers in Focused Antenatal Care (FANC)	Completed	Carried out from April 20-25th, 2009 for 14 nurses and health technicians from 12 RHCs in Mazabuka.
Review and revise referral protocols jointly with RHC and DHMT staff	Not yet on target	The MOH has developed new referral forms which must be used exclusively. Health worker trainings on EOC and EmONC focus on referral.

[1] The project will use the following document to develop and use checklists: Supervision and Support of High-Quality Group-Based Nonformal Education Services: The Use of Observation Checklists. Prepared for the Food and Nutrition Technical Assistance Project by Freedom from Hunger.

Community Mobilization		
Training of Super Care Group Leaders in Facilitation skills	Completed	Super Care Group leaders were selected and are successfully supervising their Care Groups.
Facilitators work with CGs to set goals for membership attendance and home visitation then CGs make plans to reach their goals	Completed	SAWSO developed meeting attendance tracking forms to track meeting attendance.
Monitoring and Evaluation		
Orientation of CCSP on new U-5 Cards and training of CCSP staff on data management-using data for action	Completed	Facilitators have been making more decisions based on data collected. (i.e. referring underweight children to Hearth sessions, taking immunization coverage statistics to RHC staff).
Help TTBAs and CHWs to improve record keeping of GMP data and Maternal and Newborn Care statistics	On target	CCSP is continually engaging with TTBAs and CHWs in assisting them with their record keeping.
Help CPT/NHCs improve scheduling of meetings and using data for action	On target	Engaging with CPTs/NHCs has been challenging due to time constraints. A CPT/NHC organizational capacity survey was conducted which should inform CPTs/NHCs on what to improve.
Develop project-wide indicator graphs and zonal graphs for illustrating progress over time	On target	Graphs have been completed and are on display in the CCSP office.
Disseminating of Mid-Term Evaluation findings/ PD results to stakeholders	Completed	This was completed shortly after the Midterm Evaluation.

C. FACTORS IMPEDING PROGRESS

- *MOH Policies on MNC*: The most significant problem facing the CCSP is the MOH's revision of its policy towards TTBAs, CDKs, and home births in general. Recently, the central MOH has removed support for TTBA training programs and has discontinued supplying CDKs to districts, emphasizing the need to increase facility births. While the CCSP agrees with this goal, the factors that inhibit facility birth (understaffed, undersupplied, and insufficient RHCs) have not changed. Until these barriers are removed, the CCSP does not expect dramatic changes in decision-making related to place of birth.

  The project has been in discussions with the district-level MOH (DHMTs), which better understands the reality of the situation in the project area. The CDK supply is the most pressing issue: while the project increased use of CDKs at home births from 55.8% to 75.6% in February of this year, Care Group Data from July-September show that figure falling back to 61.3%. The project is currently exploring other means of procuring or producing CDKs to ensure that TTBAs and families are able to support clean births. Additionally, the project worked with a graduate student to explore the role of TTBAs and try to find ways to use them to increase facility births despite the challenging environment. Once the results are available, the project will attempt to implement adjustments accordingly. Finally, the project is investing considerable resources to improve the skills of health workers at Chikankata Hospital and the RHCs in both essential obstetric and emergency obstetric care.

- *Hearth Attendance:* Although the project has taken steps to scale up Hearth to the whole project area, results have not been as good as expected, leading to concerns about the quality of implementation in these new areas. The most significant problem noted is lower than desired attendance and contribution rates. To address this issue, the project will conduct a Doer/Non-Doer analysis of mothers who complete the Hearth session and those who do not. With that information, the project will make necessary adjustments to

increase attendance. The Program Manager and M&E Coordinator will also work closely with Supervisors to visit Hearth sessions and help Facilitators and Care Group Volunteers to improve the quality of the sessions. Until sessions reach the desired level of quality with better results, Facilitators and Supervisors will closely supervise sessions.

- *Monitoring and Evaluation:* The project has been having difficulties with follow-up of Hearth attendees to ensure continued positive weight gain. While these children are participating in GM/P activities and are being weighed as planned, the data is not being transferred to Hearth records. The project is in the process of developing a more streamlined system that allows for quick, simple calculation of indicators to assess progress. This system is particularly important for the sustainability of Hearth after the project, as communities will need to manage the data themselves.

  The project has also encountered problems monitoring Care Group attendance and home visits due to the increased data collection burden on volunteers. Because the project needs to know how well Care Groups are functioning in order to know how effective the strategy is, the final year will focus solely on monitoring Care Groups themselves and not on monitoring interventions. (The final KPC will be conducted in July, leaving only a few months in which indicators are not being tracked directly.)

D. TECHNICAL ASSISTANCE NEEDED: N/A

E. SUBSTANTIAL CHANGES FROM DIP: N/A

F. SUSTAINABILITY PLAN

The CCSP has taken a four-fold approach to sustainability: 1) Care Groups of local mothers as key change agents, 2) increasing capacity of existing health service providers, 3) working with local community groups to develop leadership for health, and 4) community-based monitoring and evaluation systems that build motivation and capacity to bring about positive health outcomes. Progress on these four strategies is detailed below:

1) Much of the progress to date on project interventions can be attributed to the Care Group model. Facilitators and volunteers meet on a regular basis and volunteers are successfully communicating with their households for behavior change. The CCSP's challenge thus far has been documenting the implementation of the Care Group model (attendance and home visits, for example). In the final year, this monitoring will be a major focus in order better support less successful groups and to help more advanced groups begin working independently of project staff.

2) The strategy for increasing capacity of health service providers involves both training and joint activity planning to better link services and communities. Trainings in the project interventions are on track, although MNC has been more challenging than expected and is slightly behind schedule. Facilitators work closely with CHWs and HC staff to plan outreach activities, such as growth monitoring and immunizations. In addition to completing health worker trainings on Essential Obstetric Care and Emergency Obstetric and Neonatal Care, the project will focus on system and policy issues such as strengthening emergency referral protocols and ensuring supervisory checklists and MNC protocols include the most up-to-date standards of care.

3) Facilitators and Care Group leaders meet regularly with CPTs/NHCs. Capacity of these groups varies widely, however. The most important contribution of the project is the integration of Care Groups (through leaders) into CPTs/NHCs and their presentation and analysis of household level health data.

Additionally, the project is working to improve linkages between RHCs and CPTs/NHCs. An example of this effort is the recommendations for improved local ITN distribution, which involves these groups in determining ITN needs rather than depending solely on HC staff.

Additionally, the project is using existing men's groups in TSA churches to increase support for healthy family behaviors from fathers and grandfathers. The initial stages have involved project staff conducting trainings for the men, but in year five, this will transition to building leadership from within the church to allow for continuation and expansion of the strategy.

4) Community-based monitoring and evaluation is taking place in most communities, but not to the level and extent planned for originally. The project does not want to place undue data collection burdens on volunteers and is looking for ways to balance information needs with realistic expectations. As mentioned previously, the CCSP will focus on assisting CGs in monitoring their activities in the final year to help with sustainability of these groups after the end of the project. Hearth data, as well, is not regularly analyzed by communities themselves, and the project will work to facilitate such as system to strengthen community capacity to continue Hearth independently.

G. SPECIFIC INFORMATION FROM MIDTERM EVALUATION

The project has made great strides towards implementing recommendations from the MTE. Immediately after the MTE, findings from the evaluation and PD results were distributed to stakeholders. The CCSP also collaborated with the DHMT and other stakeholders in such activities as identifying ITN distribution problems, improving linkages among stakeholders, and using project data to make informed decisions. Per MTE recommendation, the CCSP trained Super Care Group leaders on facilitation skills and health workers on Essential Obstetric Care and Focused Antenatal Care. CCSP staff were also oriented on the new U-5 Cards and trained on data management in order to use the data for action. Lastly, TTBAs and CHWs were trained to improve record keeping of GMP and MNC data. (Refer to Section B for activity status of specific MTE recommendations).

H. EXPECATIONS FOR FINAL YEAR See section F.

I. MANAGEMENT SYSTEM

- *Financial management system:* Financial aspects of the project are managed by the book keeper who compiles each month's expenses and prepares monthly financial reports with the assistance of the Senior Accountant and Project Manager. The field office also anticipates project expenditures for approval by SAWSO. The Hospital Accountant is responsible for approving all financial requests which are then sent to SAWSO for review. All expenses are documented with receipts, and then submitted to accounts for preparation of financial reports.

- *Human resources:* CCSP has 30 employees, all of whom are incorporated into the CHS Community Health and Development Department (CH&D). In June, 2009 the CCSP's Project Manager left and was replaced. The project also promoted six Care Group leaders to become Super Care Group leaders to more evenly distribute the workload.

  CCSP has a total of 196 Care Groups supervised by 21 Facilitators. The Facilitators train Care Group volunteers, men's groups, and CPTs/NHCs on health topics. Field Facilitators meet with each Care Group three times a month. During these meetings CG volunteers compile and submit reports, receive health messages and share experiences from day-to-day activities. The Facilitator gives feedback on the previous

month's report, provides technical assistance to volunteers who may have encountered problems, and may also accompany them during household visits. Facilitators also train volunteers on data collection of vital statistics (deaths, births, and illnesses); and assist CPTs/NHCs in compiling and analyzing data to make decisions. They also improve the link between the community and health centers. Mobility of the Facilitators has been made easier through the procurement of bicycles as some Facilitators cover long distances of about 25 kilometers per day.

Each Field Supervisor looks after four Facilitators except for one who manages five. Supervisors oversee community-level activities; hold meetings with CPTs/NHCs; coordinate activities with HC staff; and help with training, home visits, GMP sessions, and Hearth sessions. Field Supervisors receive oversight from the Project Manager.

- *Communication system and team development:* The CCSP has an effective communication system in place. The project management's access to email has facilitated reliable communication with the SAWSO Health Advisor, also enabling them to submit timely quarterly narrative and financial reports. Team development at the field level is ongoing, with the staff having been trained in all intervention areas. The CCSP Manager, M & E Officer, and Administrative Assistant hold weekly meetings with the field team, during which staff members discuss achievements and challenges encountered during the previous week and focus on the planned activities for the upcoming week. CCSP management makes frequent spot checks in the field to monitor project implementation and listen to staff and volunteer concerns.

- *Other relevant management systems:* SAWSO's Health Technical Advisor conducts country visits for technical assistance as needed.

J. LOCAL PARTNER ORGANIZATION COLLABORATION AND CAPACITY BUILDING

The project has a positive relationship with its local partners—Harvest Help/Zambia, DHMTs (Siavonga and Mazabuka), Plan Zambia, Churches Health Association of Zambia (CHAZ), Centers for Disease Control (CDC), Center for International Health under Boston University, Emory University Rollins School of Public Health, National Food and Nutrition Commission (NFNC), Riverside Mission Seventh day Adventist (SDA), and Mtendere Roman Catholic Mission Hospital. CCSP participates in quarterly DHMT meetings, and DHMT members attend the project stakeholder meetings. Both the FANC and EmONC (being done at the time of writing) trainings were carried out in collaboration with the MOH in an effort to improve the skill set of health workers in the Mazabuka and Siavonga Districts.

K. MISSION COLLABORATION

The project works very closely with the USAID country office. The CCSP Manager participates in quarterly meetings in the Population, Health, and Nutrition Office. President's Malaria Initiative, Resident Advisor, Dr. Allen Craig advised CCSP on ITN activities, and Dr. Oliver Lulembo, Senior Health Advisor for USAID Zambia met with CCSP staff, to advise CCSP activities. CCSP plays an important role in contributing to the USAID Mission's overall health objectives such as improved immunization coverage in children; improved nutritional status of children and pregnant women; improved child feeding practices; improved detection of malnutrition; improved treatment of malnutrition; increased exclusive breastfeeding up to six months; and increased coverage of micronutrient supplementation (vitamin A, iron and folic acid).

Annex 1: M&E Table

Result 1: Improved malaria prevention and treatment

Objectives	Baseline Jan 06	Mini-KPC Feb 07	CG Records Ave. July-Sept. 09	Target	Target Achieved (per KPC and CG data)
% of children 0-23 months who slept under an ITN the night before	21.8	66.2	82.3	60.0	Yes per both sources
% of pregnant women who slept under an ITN the night before	Not established	Not measured by KPC	83.9	60.0	Yes per CG data
% of children 0-23 months with a febrile episode that ended during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	10.5	25.0	Not tracked by Care Groups	65.0	Not yet
% of mothers of children 0-23 months who received IPT for malaria during their last pregnancy	83.8	94.9	86.3	70.0	Yes per both sources

Result 2: Increased immunization coverage in children

Objectives	Baseline Jan 06	Mini-KPC Feb 08	CG Records Ave. July-Sept. 09	Target	Target Achieved (per KPC and CG data)
% of children 12-23 months who are fully vaccinated before the first birthday	35.2	55.5	90.1	70%	Yes per CG data, No per KPC
% of children 12-23 months who received a measles vaccine	54.6	75.6	94.2	80%	Yes per CG data, No per KPC

Result 3: Improved nutritional status of children and pregnant women

Objectives	Baseline Jan 06	Mini-KPC Feb 08	CG Records Ave. July-Sept. 09	Target	Target Achieved (per KPC and CG data)
% of children 6-23 months who ate a Vitamin A-rich food, a high protein food, and an iron-rich food in the last 24 hours	27.2	25.0	Not tracked by Care Groups	50%	No per KPC
% of children 12-23 months who ate semi-solid food at least four times in the past 24 hours	21.1	36.7	Not tracked by Care Groups	50%	No per KPC

Objectives (Result 3 continued)	Baseline Jan 06	Mini-KPC Feb 08	CG Records Ave. July-Sept. 09	Target	Target Achieved (per KPC and CG data)
% of children 0-23 months who were weighed at least once in the past two months	69.4	69.4	87.1	90%	No per either source
% of children 0-23 months are above -2 standard deviations for weight for age	87.4	88.9	Not tracked by Care Groups	95%	No per KPC
% of infants 0-5 months who received nothing except breastmilk in the past 24 hours	43.8	67.9	96.6	70%	Yes per CG data, No per KPC
% of children 12-23 months who have received a dose of Vitamin A in the past six months	37.3	50.2	96.8	75%	Yes per CG data, No per KPC
% of mothers of children 0-23 months who report taking at least 90 days of iron/folic acid supplements during her last pregnancy	24.5	66.3	Not tracked by Care Groups	50%	Yes per KPC

Result 4: Improved maternal and newborn care practices

Objectives	Baseline Jan 06	Mini-KPC Feb 09	CG Records Ave. July-Sept. 09	Target	Target Achieved (per KPC and CG data)
% of mothers of children 0-23 months whose last birth was attended by a health professional	44.2	48.4	64.8[2]	55	Yes per CG data, No per KPC
% of mothers of children 0-23 months who did not give birth in a health facility whose birth was attended by a TTBA	13.4	43.0	71.6[1]	30	Yes per both sources
% of home deliveries in which a clean birth kit was used	55.8	75.6	61.3	70	Yes per KPC No per CG data
% of mothers of children 0-23 months whose child was placed immediately with her after birth	15.3	57.3	93.1	60	Yes per CG data, No per KPC
% of children 0-23 months who were breastfed within one hour of birth	43.8	41.3	89.9	75	Yes per CG data, No per KPC
% of mothers of children 0-23 months who had at least one postpartum check-up after the birth of her last child	18.7	64.0	85.1	50	Yes per both sources
% of mothers of children 0-23 months who received a postpartum dose of Vitamin A during the first two months after delivery (card confirmed)	6.3	22.1	68.7	50	Yes per CG data, No per KPC

[2] Indicator differs slightly as Care Group data is only for births in the reported period, not for mothers of children 0-23 months. (Data for all under-twos would not be expected to vary greatly from month to month.)

Annex 2. Work Plan FY10

Work Plan for Year Five October 2009-September 2010					
Activities	**Personnel**	**1**	**2**	**3**	**4**
General management					
Refresher training for existing CHWs and TTBAs, initial training for new ones	CH&D Manager	X			
Facilitators meet with Care Groups bi-weekly	Facilitators	X	X	X	X
Supervision of Facilitators	Supervisors	X	X	X	X
Support monthly NHC & CPT meetings, provide refresher training	Supervisors, Facilitators, Project Mgr.	X	X	X	X
Participate in quarterly DHMT meetings	CH&D Manager	X	X	X	X
Task Force Meeting	All	X		X	
Give Annual Volunteer Incentives	Facilitators				X
Training of church leaders in Men's Groups activities	Supervisors, Facilitators, Project Mgr.		X	X	X
Monitoring and evaluation					
KPC Survey/Anthropometric Survey	SAWSO, CSP Team			X	
Conduct final evaluation	Consultant, CSP Team				X
Mini-KPC surveys	Supervisors, Facilitators	X			
Monitor frequency of Care Group meetings and track attendance	Supervisors, Facilitators, Project Mgr., M&E Coordinator	X	X	X	X
Develop streamlined data collection system for Hearth records	Supervisors, Facilitators, Project Mgr., M&E Coordinator	X			
Doer/Non-Doer Survey on Immediate Breastfeeding	Supervisors, Facilitators, Project Mgr., M&E Coordinator, SAWSO	X			
Doer/Non-Doer Survey on Mothers Completing Hearth	Supervisors, Facilitators, Project Mgr., M&E Coordinator, SAWSO	X			
Result 1: Improved malaria prevention and treatment					
Support re-treatment activities at health facilities and communities	Supervisors, Facilitators				X
Result 3: Improved nutritional status of children and pregnant women					
Monitor Hearth sessions to improve quality	Supervisors, Facilitators	X	X	X	X
Result 4: Improved maternal and newborn care practices					
Train health workers in emergency obstetric and neonatal care (EMONC)	MOH, Jhpiego, CHS	X			
Refresher training on emergency obstetric care, focusing on AMTSL and infection prevention	MOH, CHS		X		
Strengthen emergency referral protocols	DHMT, Project Mgr., M&E Coordinator	X	X		
Ensure supervisory checklists and MNC protocols are up-to-date	DHMT, Project Mgr, M&E Coordinator	X	X		

Child Survival and Health Grants Program Project Summary

Oct-29-2009

Salvation Army World Service Office (Zambia)

General Project Information:

Cooperative Agreement Number: GHS-A-00-05-00033
Project Grant Cycle: 21
Project Dates: (9/30/2005 - 9/30/2010)
Project Type: Standard

SAWSO Headquarters Technical Backstop: Claire Boswell
Field Program Manager: Portipher Pilingana
Midterm Evaluator: Richard Crespo
Final Evaluator:
USAID Mission Contact: William Kanweka

Field Program Manager Information:

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Funding Information:

USAID Funding:(US $): $1,476,719 **PVO match:(US $)** $502,622

Project Information:

Description:

Program Goal:
To reduce maternal and under-five mortality through innovative community-based behavior change strategies and improved health services.

Interventions:

-Malaria
-Immunizations
-Nutrition
-Maternal and Newborn Care

Strategies:

1) The Care Group model
2) Positive Deviance/ Hearth model
3) Care and Prevention Teams
4) Men's Groups

Location:

The project area includes two districts in Zambia's Southern Province, about 130 miles southwest of Lusaka. The area is rural with few roads, limited transportation, and almost no infrastructure. The CCSP area includes all of Siavonga District and the part of Mazabuka District that falls within Chikankata Health Services catchment area.

Project Partners	Partner Type	Subgrant Amount
Ministry of Health - Mazabuka District	Collaborating Partner	
Ministry of Health - Siavonga District	Collaborating Partner	
Harvest Help Zambia	Collaborating Partner	
Mtendere Mission Hospital	Collaborating Partner	
Churches Health Association of Zambia	Collaborating Partner	
Plan Zambia	Collaborating Partner	
The Salvation Army Chikankata Health Services	Collaborating Partner	

General Strategies Planned:

Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Organizational Capacity Assessment with Local Partners
Participatory Learning in Action
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

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
Field Office HQ CS Project Team	Local NGO	(None Selected)	Health Facility Staff	Health CBOs CHWs

Interventions/Program Components:

Immunizations (10 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Classic 6 Vaccines
- Vitamin A
- Mobilization

Nutrition (30 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- ENA
- Hearth
- Growth Monitoring

(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)

Malaria (40 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Antenatal Prevention Treatment
- ITN (Bednets)
- Care Seeking, Recog., Compliance
- IPT
- ACT

Maternal & Newborn Care (20 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Emerg. Obstet. Care
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Integr. with Iron & Folate
- Normal Delivery Care
- Birth Plans
- Control of post-partum bleeding
- PMTCT of HIV
- Emergency Transport

(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)
(IMCI Integration)
(CHW Training)
(HF Training)

Target Beneficiaries:

Infants < 12 months:	**4,620**
Children 12-23 months:	**4,353**
Children 0-23 months:	**8,973**
Children 24-59 months:	**13,146**
Children 0-59 Months	**22,119**
Women 15-49 years:	**28,474**
Population of Target Area:	**124,613**

Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	**21**	**188**	**11.1%**	**4.7**
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-23 months whose births were attended by skilled health personnel	**44**	**95**	**48.4%**	**10.4**
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	**0**	**0**	**0.0%**	**0.0**
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	**35**	**49**	**67.9%**	**12.3**
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	**54**	**95**	**55.5%**	**10.2**
Percentage of children age 12-23 months who received a measles vaccine	**72**	**95**	**75.6%**	**8.7**
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	**126**	**190**	**66.2%**	**6.9**
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	**0**	**0**	**0.0%**	**0.0**
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	**0**	**0**	**0.0%**	**0.0**
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	**0**	**0**	**0.0%**	**0.0**

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	**0**	**0**	**0.0%**	**0.0**

Comments for Rapid Catch Indicators

The malaria indicator (bednets) was collected in February 2007. Vaccination (full and measles), weight for age, and exclusive breastfeeding data were collected in February 2008. The data for skilled delivery were collected in February 2009.