# REPUBLIC OF MOZAMBIQUE
## NAMPULA PROVINCE
## NACALA VELHA AND MEMBA DISTRICTS

# STRENGTH PROJECT
# CS-16

Cooperative Agreement Number is FAO-A-00-00-00036

# MID-TERM EVALUATION

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**SUBMITTED TO**
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My praise to all for believing that empowered we can change the future!

**LIST OF ACRONYMS**

| | | Portuguese Acronym |
|---|---|---|
| | Lowest cadre in the MOH health workers structure | APEs |
| | MOH Weekly Epidemiological Bulletins | BES |
| | Monthly Health Days (Strategy to provide health services) | DMS |
| | Traditional Medicine Study Cabinet | GEMT |
| ANC | Ante-natal Care | CPN |
| ARI | Acute Respiratory Illness | IRA |
| BCC | Behavior Change Communication | |
| BF | Breast Feeding | AM |
| CBDA | Community-Based Distribution Agent (for contraceptives) | |
| CDD | Control of Diarrheal Disease | |
| CBSD | Cassava Brown Streak Disease | |
| CHT | Community Health Team | CLCS |
| CS | Child Survival | SI |
| DHMT | District Health Management Team | EGP |
| DHO | District Health Office | DDS |
| DIP | Detailed Implementation Plan | PID |
| DRF | Drug Revolving funds | |
| EPI | Expanded Program for Immunization | PAV |
| FP | Family Planning | PF |
| GAS | Swedish Support Group | GAS |
| HBC | Home-Based Care | |
| HC | Health Center | CS |
| HFA | Health Facilities Assessment | |
| HIS | Health Information System | SIS |
| HMIS | Health Management Information System | |
| HP | Health Post | PS |
| HT | Health talks | *palestras* |
| IMCI | Integrated Management of Childhood Illness | AIDI |
| KPC | Knowledge, Practice and Coverage (survey) | |
| LQAS | Lot Quality Assessment Survey | |
| MB | Mobile Brigade | |
| MCH | Maternal and Child Health | SMI |
| MOH | Ministry of Health | MISAU |
| MTE | Midterm Evaluation | |
| NaV | Nacala-Velha District | |
| PHO | Provincial Health Office | DPS |
| QC | Quality Control | |
| SC/US | Save the Children Federation/US | SC |
| SP | Strength Project | PF |
| TBA | Traditional Birth Attendant | PT |
| TH | Traditional Healers | *Curandeiros* |
| TOT | Training of Trainers | |
| TT | Tetanus Toxoid | |
| VHV | Village Health Volunteer | *Activistas* |

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## Appendixes

## *Executive Summary*

The Strength Project in the impoverished districts of Nacala-Velha and Memba, in Nampula province, northern Mozambique, seeks to: (1) sustainably reduce MMR, and U5MR; (2) sustainably improve the capability of DHOs and communities to respond to health needs; and (3) develop innovative approaches to inform policy and practices of SC and other partners. The main strategies are: (1) Partnership and institutional development for district health system strengthening through a **Program Management Team (PMT**) to enhance SC-DHO partnership for program planning, monitoring and evaluation, capacity-building and sustainability of program activities, and (2) Strengthening community component of maternal and child health through support for **Community Health Teams (CHTs)** that would monitor and support the activities of community health workers in the *Regulados*.

The districts have an official population of 286,814 including a CS16 beneficiary population of 134,229 (47,324 children 0-59 months, 21,511 births, and 65,394 women of reproductive age). The under-five mortality rate of 315/1000 is almost 50% higher than the national average of 219/1000. DDS are the main implementers of the six **project interventions** that support the MISAU's **district-level essential health package** and include: Immunization (15%), Control of Malaria (15%), Pneumonia Case Management (15%), Control of Diarrheal Disease (10%), Maternal and Newborn Care (30%), and Child Spacing (15%). The role of SC/US is capacity building, technical assistance, management support, and fiduciary responsibility.

Main accomplishments of the program include opening the communication channel with districts and with THs, improving the quality and skills of the trainers, and the perceived changes in the behavior, knowledge and assertiveness of mothers. CLCS are well developed in all *Regulados* and support outreach services by Mobile Brigades. Training of community-based providers (APEs and socorristas), Activistas, TBAs, and other CLCS members, as well as dialogue with traditional healers has led to community mobilization for responsive and appropriate behavior change communication (BCC) for caregivers, community leaders, and mothers.

Overall progress towards achieving program objectives can be summarized by a short analysis of achievement of each of the results and intermediate results set up in the DIP:

**Improved Capacity of two health districts to implement CS approaches and support community structures** is the weakest achieved at this point. All the intermediary results need focus and emphasis in use and management of technical skills such us supervision, data analysis,and decision-making.

**Improved capability of communities to identify and respond to their health needs** is one of the strongest. CLCS and all its members have received training and seem very committed working for their community's improvement. CLCS and mothers are assertive and demand more services that will benefit them such as

more TBAs, more HP and more MB visits. DDS-CLCS links are emerging but are still weak.

**Increased use of key health services and improved CS practices at the household level** has mixed results. Availability of CS services has not increased, due to lack of personnel and conflicting MISAU strategies (MB and DMS). Health facilities cannot respond to community demands due to lack of HR, fluctuation of supplies, and geographic spread of facilities. Lack of vehicles reduces MB and other service delivery opportunities. Quality of services is not being monitored due to lack of supervision. However, there seems to be increased caregiver knowledge of selected CS issues, which will be more fully assessed in the final evaluation.

**Increased capability of SC to achieve large scale, innovative CS programs in the Southern Africa setting** is on a good track. CLCS work can be considered a success especially if the trainings are refined and follow-up is implemented. The experience with TH needs to be reported and shared with other provinces, NGOs and at the Africa regional level. Capacity building at district level has not yet been achieved. Since the communication channels between SC and DDS staff has finally opened, an intense transfer of management skills can be hopefully achieved by the end of the project.

**Inform Nampula Province Health Office on innovative CS strategies** is also on a good track. DPS members have been steady participants of EGP meetings where there are opportunities to share strategies and improve implementation. The approaching *Conselho Coordenador de Saude* de Nampula is another chance to share project successes and difficulties.

Main constraints have been small representation of each district at EGP meetings; inadequate nursing staff in the two districts due to absolute lack of skilled personnel in Nampula province; facilitation of community Alarm and Transport (A&T) and provision of bicycle ambulances as part of A&T due to failure of community to take on their part of the agreement and to the slow motion of logistics both for the bicycle ambulance and the equipment for the maternities. Other constraints are not including the data analysis component in CLCS trainings, shifting from MB to DMS; lack of district perdiems for supervision; old vehicles that delay field activities; food crisis due to drought and CBSD that interfere with health activities; and very low advances in FP education and use. The production and promotion of clean birth kits was abandoned as a strategy due to the local industries' impossibility of supplying the components of the kit. Efforts will focus on health education of mothers on clean delivery.

Prospects for sustainability depend on the successful transfer of capacity building skills. Institution of monthly management meetings at district level to plan and budget activities and coordinate use of resources, will reinforce a management attitude adequate for sustainability. Devising an exit strategy that will leave the districts and CLCS strengthened is crucial, including lobbying the DPS at the appropriate level to ensure existence of resources after the life of the

project. Institution of supervision would be one of the most important achievements.

Priority recommendations resulting from this evaluation are:

1. Improve the general Strengthen Project and EGP management starting by finalizing the Plan of Action with each of the DDS and actively disseminating LQAS and MTE results to DDS, DPS, HC and CLCS.
2. Implement monthly meetings in each of the districts with the technical team for the remainder of the project.
3. Discuss the exit strategy of the project, so DDS directors and staff gradually TAKE OVER all the activities and leadership.
4. Implement supervision visits from DDS to Health Centers and CLCS by immediately setting up a workshop to rapidly provide staff and DDS trainers and others with supervisory skills. A checklist directed to all components and cadres to be supervised, and a real supervision plan with places, dates, use of resources, and responsibilities should be the outputs of such workshop.
5. Re-plan the Mobile Brigades to achieve five annual visits per community, to become more regular, to arrive early, and to coordinate with Monthly Health Days, supervision, and supply activities. Include Logistics (SC and district) in the elaboration of the plan.
6. Organize specific refresher training of TBAs in Lurio, refresher trainings of APEs in distant areas, and training of DDS and SC staff in basic management, data management, resources management and basic epidemiology and statistics.
7. Improve purchasing procedures for bicycle-ambulances in Memba, and reactivate the A&T system in NaV. Expedite purchasing procedures for material and equipment destined to maternities and reference hospitals and for two-way radios to districts.
8. Improve vehicle maintenance procedures to allow increase of supervision and Mobile Brigade activities.
9. Exchange and review BCC materials and messages with SC Gaza Project and other experts in this matter. With DPS and DDS acquire, produce and distribute IEC materials for all levels of the community and the health system.
10. Expand FP training to *Tecnico de Saude* in all health facilities and to all members of CLCS.
11. Discuss with DPS the feasibility of a pilot study of CBD FP methods in a remote community as has recently been piloted in the Bridges project and the feasibility of a pilot study of Immunization practices by APEs.
12. Dialogue with GEMT to improve THs procedures on the referral of sick children and women
13. EFFECTIVELY improve the EPI situation by addressing management of the cold chain, supply of EPI materials and vaccines, and Mobile Brigades planning at every monthly meeting.

# *I. Assessment of Progress Towards Achieving Program Objectives*

## 1. Technical Approach

### 1.1 Project Overview

The Save the Children Federation/USA (SC) STRENGTH PROJECT (SP) is located in Nacala-a-Velha (NaV) and Memba Districts, in northern Mozambique. These are two of the most poor and inaccessible districts in Mozambique with an official population of 286,814 including a CS16 beneficiary population of 134,229 (including 47,324 children 0-59 months, 21,511 births, and 65,394 women of reproductive age). The under-five mortality rate of 315/1000 is almost 50% higher than the national average of 219/1000 (See Appendix 1). The Strengthen Project has a three-year (September 2000 – September 2003) life and a combined budget (USAID and SC/US in a 25% match) of US $933.300, for an annual cost per beneficiary of $2.32. The ultimate goals are to (1) Sustainably reduce MMR, and U5MR; (2) Sustainably improve the capability of DDS and communities to respond to their health needs; and (3) Develop innovative approaches to inform policy and practices of SC and other development partners.

The project responds to the needs and priorities of constituent communities, Ministry of Health (MISAU) and USAID/Mozambique; all seek reduced under-five and maternal mortality and morbidity through a **strengthened health system**. Between July 2000 and March 2001 baseline studies were conducted in preparation for detailed implementation planning. In February, 2001 a five day project planning meeting was held with district and provincial health office representatives, community leaders, and SC technical staff Project; it led to the DIP, the project blueprint whose results framework and indicators are presented at the end of this section. In July- August 2002 an LQAS survey was conducted and data was compared to the baseline studies. The results were used to prepare the qualitative midterm evaluation that took place in September 2002, whose report is presented here and whose outcome is a Preliminary Action Plan.

The DHO (DDS) are the main implementers of the **six project interventions** that support the MOH's **district-level essential health package** and include: Immunization (15%), Control of Malaria (15%), Pneumonia Case Management (15%), Control of Diarrheal Disease (10%), Maternal and Newborn Care (30%), and Child Spacing (15%). The role of SC/US is capacity building, technical assistance, management support, and fiduciary responsibility.

The two major implementation strategies for each of the districts are:

(1) Partnership and Institutional Development for District Health System Strengthening through:

- Program Management Team (PMT), called EGP, to enhance SC-DDS partnership for program planning, monitoring and evaluation, capacity-building and sustainability of program activities.
- Support of additional staff for DDS to address the constraint of inadequate nursing staff in the two districts by recruiting three MCH (SMI) nurses for NaV and three nurses for Memba. The salaries of these nurses will be supported by the Strength Project for the first two years of the program. The Nampula Province PHO (DPS) will take over the salary payment in the third year. The MCH nurses are essential for increasing the number of mobile brigades outreach conducted in a month, especially in terms of prenatal care and family planning services.
- Upgrade emergency obstetric health facilities and services. The two CS-16 districts do not have a comprehensive emergency obstetric care (CEOC) facility. Women needing CEOC services are referred to the neighboring districts of Monapo and Nacala Porto. CS-16 works with Monapo and Nacala Porto DDS and hospital Directors to streamline the referral systems, as well as upgrade the maternity wing of their hospitals.

(2) Strengthening the community component of maternal and child health through:

- Support for Community Health Teams (CHT), called CLCS, that monitor and support the activities of community health workers in the Regulados.
- Support of outreach services by Mobile Brigades.
- Facilitation of community Alarm and transport (A&T)
- Provision of bicycle ambulances as part of A&T
- Production and promotion of clean birth kits.
- Training of community-based providers (APEs and socorristas)
- Training of Activistas and TBAs
- Training and dialogue with traditional healers
- Support of community mobilization for responsive and appropriate behavior change communication (BCC) for caregivers, community leaders, and male and female decision makers.

A set of measurable indicators established during the DIP was used to monitor progress and is described in following page. In addition EGP also monitors DDS generated data that is part of the national HIS (SIS). Strengthen Project also uses others sources of information such as KPCs and LQAS surveys.

As outlined in the DIP, SC works most closely with its current partners, the DDS, in close collaboration with the DPS and the communities of NaV and Memba, as well as the referral hospitals in Nacala Porto and Monapo.

## PROJECT KEY RESULTS
## These indicators were adapted from the DIP.
## Indicators related to QC were excluded in the MTE.

**Maternal and Newborn Care (30%)**

- 85% of women will have at least two antenatal care (ANC) visits with trained health personnel during their last pregnancy.
- 80% of women will receive two doses of tetanus toxoid during their last pregnancy.
- 50% of women will be attended by trained personnel during their last delivery.
- 10% of women will have birth plans (3 of 5 components) during their last pregnancy
- 90% of *regulados* will have formal alarm and transport plans.
- 50% of women 15-49 will know at least three pregnancy-related danger signs.

**Child Spacing (15%)**

- 25% of mothers with children under 24 months old, who do not desire to have a child in the next two years, will use a modern family planning method.
- 50% of women with children under 24 months old, will know at least two modern methods for child spacing.

**Immunization (15%)**

- 55% of children age 12-23 months will be fully immunized by the age of 12 months.

**Malaria Control (15%)**

- 80% of mothers with children < 24 months with fever in previous two weeks will seek care within 48 hours.

**Diarrhea Case Management (10%)**

- 80% of mothers with children 6 < 24 months with diarrhea in previous two weeks will manage the diarrhea with Oral Rehydration Therapy (oral rehydration solution or community-based oral rehydration fluids such as watery porridge).

**Pneumonia Case Management (15%)**

- 85% of mothers with children < 24 months with cough and difficult/rapid breathing in previous two weeks will seek care from a health facility.

**Capacity Building**

- SC/HQ: At least 2 SC Field Offices and/or other organizations will develop a plan for adopting successful CS16 approaches.
- SC/M: SC/Moz staff will participate in policy forums at the provincial level advocating for changes in policy based upon CS16 strategies.
- DHOs: Presence of annual workplan specifying activities, persons responsible, date and resources available/monitoring and supervisory tools for each capacity.
- Presentation of HIS reports during quarterly PMT meetings.
- Communities: (1) 75% of *regulados* will be able to identify 2 or more priority maternal/child health problems to be addressed through an action plan; (2) 70% of *regulados* will have formed CHTs and members will know the roles and responsibilities; (3) 80% of CHT members will be able to cite five approaches to increase community participation in health activities; (4) 75% of CHT members will understand numerical trends of HIS and use for health planning.

**Sustainability**

- 2 DHOs will prepare an annual health work plan indicating efficient use of resources.
- 75% of CHTs at *regulado* level will attend meetings regularly.
- 2 DHOs will have supervisory and monitoring systems for QOC and peer review.
- DHOs will regularly share lessons learned at provincial and national MOH levels.
- DHOs commit to sustaining CHT training and formation by inclusion into yearly DHO plans.

# PROGRAM DESIGN

## Results Framework: Goals, Results, and Intermediate Results

**Goal: Sustained reduction in under-five and maternal mortality and morbidity in two health districts of Mozambique**

| R-1: Improved Capacity of two health districts to implement CS approaches and support community structures | R-2: Improved capability of communities to identify and respond to their health needs | R-3: Increased use of key health services and improved CS practices at the household level | R-4: Increased capability of SC to achieve large scale, innovative CS programs in the Southern Africa setting | R-5: Inform Nampula Province Health Office on innovative CS strategies |
|---|---|---|---|---|
| IR1: Improved strategic mgmt. practices<br>IR2: Improved organiz. learning<br>IR3: Impr. use and mgmt. of tech. skills<br>IR4: Improved fin. resource mgmt.<br>IR5: Impr.HR mgmt.<br>IR6: Improved support for community | IR5: Increased ability of comm. institutions to analyze health trends and needs<br>IR6: Improved organization of community to address health needs<br>IR7: Increased links between community and the DHOs | IR8: Increased availability of CS services<br>IR9: Improved quality of selected CS services<br>IR10: Increased caregiver knowledge of selected CS issues | IR11: Improved skills of SC staff in a capacity building role at the district level | IR12: Documenting and disseminating the feasibility and results of implementing the CS-16 approaches |

## 1.2 Maternal and Newborn Health

The following sections will describe for each intervention area the objectives, key activities and technical approaches as described in the DIP, as well as the project activities and MTE results with emphasis on project outcomes and challenges, followed by recommended next steps. A complete Table of Indicator Results from the LQAS is in Appendix 2.

Maternal and Newborn Care (30%)

Objective End Results

- 85% of women will have at least two antenatal care (ANC) visits with trained health personnel during their last pregnancy.
- 80% of women will receive two doses of tetanus toxoid during their last pregnancy.
- 50% of women will be attended by trained personnel during their last delivery.
- 10% of women will have birth plans (3 of 5 components) during their last pregnancy
- 90% of *regulados* will have formal alarm and transport plans.
- 50% of women 15-49 will know at least three pregnancy-related danger signs.

This intervention was targeted towards mothers and their newborns. It sought to increase pregnant women's utilization of antenatal and delivery services provided by professional and trained community-based workers. To facilitate use of these services, the project sought to increase mothers' knowledge on pregnancy-related danger signs, improve birth planning by pregnant women, and improve community referral systems to the health facilities. The key project activities proposed to support this intervention in the two districts were;

- to improve knowledge and behavior of pregnant women through carefully designed key BCC messages,
- to train traditional birth attendants (TBAs) in clean and safe deliveries,
- to increase access to prenatal services by increasing the number of Mobile Brigade outreach points and number of SMI nurses,
- to enhance community capacity for establishing and managing alarm and transport systems, and
- to strengthen the DDS referral system for pregnant women.

<u>Activities and MTE Results</u>

The project has trained teams of volunteers in each of the 46 regulados to educate pregnant women and their families on the need for regular antenatal care and to deliver with a trained attendant. In addition, the team of volunteers educates the mothers on pregnancy-related danger signs that require immediate referral to a health facility. The team consists of*, regulos, activistas, apiamwene*, traditional healers, TBAs, APEs, and *Socorristas*, that forms the Community Health Team (CHT), known as CLCS. Overall the project has trained the

members of 46 CLCS, 13 in NaV and 33 in Memba district, according to the number of Regulados in each district. All CLCS are active and performing their role of educating the community on maternal and newborn issues. The education is conducted using *palestras* (health talks), and songs. BCC materials used include posters, flip-charts (*albums seriados*), and pamphlets. Most CLCS have also established Alarm and Transport Systems with and without bicycle ambulances in their Regulados.

One hundred and sixty-four (167) TBAs have been trained by the project. This has increased the baseline number of trained TBAs from 75 (NaV 35 and Memba 40) to 142. Two more trainings are currently taking place (11 in NaV and 15 in Memba). Two SC/US trainers and two DDS trainers jointly carry out the TBA training using the national TBA curriculum. All the trained TBAs received re-usable delivery kits assembled by the project based on MOH recommendations. The TBAs have also been linked to the nearest health centers so that they can receive re-supply of perishable items such as cotton wool, bandage and gloves. Four MCH (SMI) nurses, 10 elementary midwives (PE) and three of SC/US trainers received in-service training on prenatal, delivery, postnatal and newborn care, and family planning from the DPS SMI trainers.

The effectiveness of the BCC component of this intervention is manifested in the increase of percent of women who knew at least three pregnancy-related danger signs from a baseline average of 31% (NaV 18% and Memba 44%) to a MTE average of 75% (NaV 95% and Memba 57%). However, indicators for maternal practices including the utilization of maternity services did not show similar impressive increases, with the exception of prenatal tetanus immunization. Percent of pregnant women who received at least two doses of tetanus toxoid increased from a baseline average of 46% to 57%. This number fell in Memba (62% to 42%) but increased in NaV (30% to 74%). Although antenatal care coverage is quite high, and TT vaccination can be achieved with only two contacts, overall the percent of women who reported that they had at least two antenatal visits decreased from 75% to 64%. The decrease was more pronounced in Memba, 74% to 55%, compared to a drop from 77% to 74% in NaV (see Graph 1.)

The percent of women who reported having had three of the five components recommended for a birthplan increased only slightly from 0% to 3%. The average percent of women who were attended by a trained provider during delivery showed no significant increase. It actually dropped from 38% to 28% for Memba but increased from 34% to 51% for NaV.

Challenges and Outcomes

Two approaches in the DIP under this intervention that have been hindered by severe constraints are (a) the planned increased access to prenatal services by

increasing the number of Mobile Brigade outreach points and number of MCH nurses in the two districts, and (b) strengthen the DDS maternal referral systems. The Mobile Brigade outreach has not been regular. A review of the transport log for Mobile Brigade by the MTE review team for the period January – June 2002 showed that outreach services have been limited in the number of sites visited as well as the frequency of visits to same sites (Appendix 3). The few sites that were visited by the Mobile Brigades were visited only once in the six-month period. The visits were more limited in Memba than NaV. This explains the drop in the percent of women who reported attending ANC (CPN) at least twice in their last pregnancy. The project had experienced difficulty recruiting SMI nurses through the DPS. This is due to the limited number of SMI nurses in the country, and the agreement to pay them MISAU salaries. Other constraints identified during the MTE include lack of adequate pregnancy-related BCC materials such as non-literate flip-charts, pamphlet and posters, and the limited number of individuals trained in the use of drama for educating community members. The BCC related constraints are elaborated further in the BCC section below.

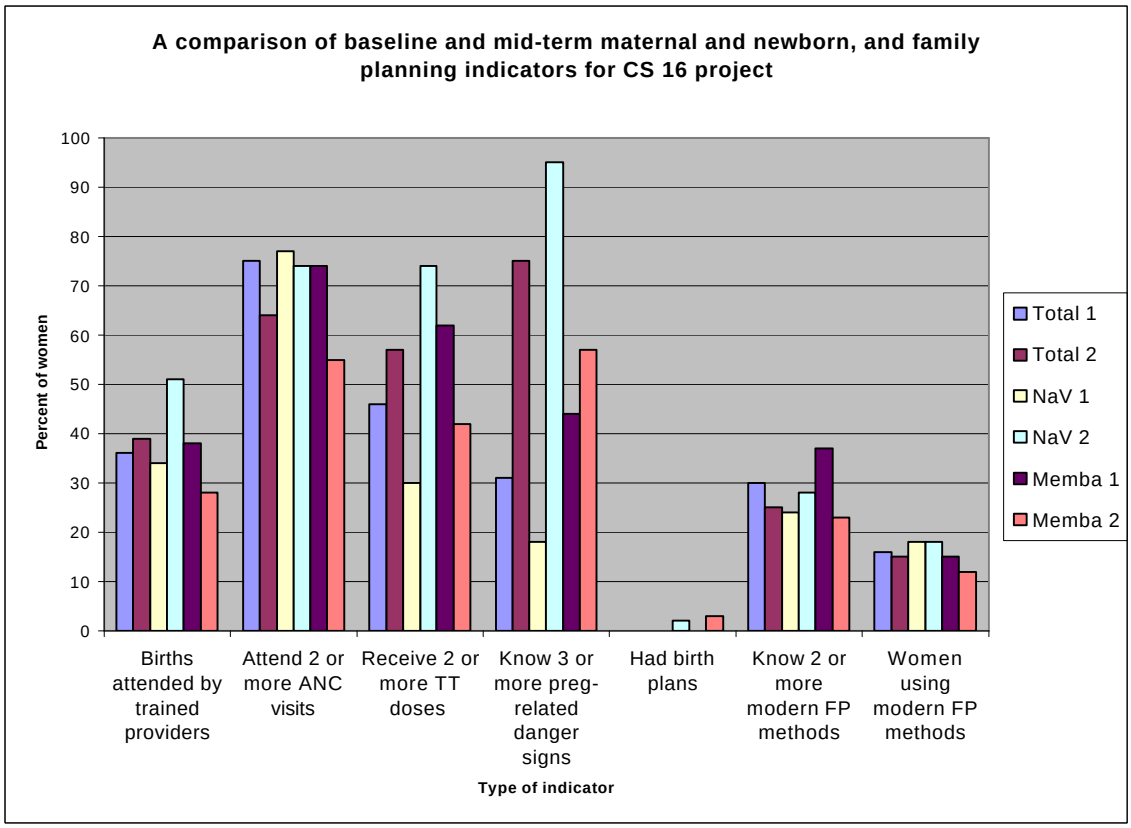
Despite assurances from community leaders in NaV at the beginning of the project to establish a mechanism to maintain bicycles ambulances given to them under CS-12, bicycle ambulances in all the Regulados visited by the MTE team were broken and the community had no plans to maintain them. The reason given for this state of disrepair was that the community was too poor to contribute the required money to have the bicycle ambulances repaired. Women with danger signs are carried on make-shift stretchers carried by community members to the nearest health center. Memba has received 17 bicycle-ambulances distributed to the southern part under CS-12 and the project is yet to supply the northern regulados. Equipment needed for improving maternity services at the health centers in the two project districts, and the two referral hospitals at Monapo and Nacala-Porto, have not been purchased.

An assessment on the availability of materials needed to make clean delivery kits for pregnant women found that apart from soap and razor blade none of the other items are available in Nampula. The project therefore decided not to produce and distribute clean birth kit but to focus on the promotion of clean delivery based on the use of new razor blade and soap. Lastly, TBAs reported not receiving any financial or material appreciation from their clients even though Traditional Healers (curandeiros) do get these “payments” from their clients. They attributed this to misunderstanding on the part of the community that TBAs are paid by SC/US or MISAU, since they were trained by them.

Next Steps

To reach its objectives, the project will have to:

1. Increase access to prenatal services by making the Mobile Brigade outreach more regular. Better planning of the movement of available district vehicles and those of the project could assist in improving the MB.
2. Re-train more practicing TBAs, in selected areas of Memba based on analysis of the distribution of current trained TBAs, in order to meet its objective of improving access to delivery by trained providers.
3. Priority should, however, be given to regular supervision of the currently trained TBAs.
4. Improve purchasing procedures to shorten the time it takes to purchase project items such as the maternity equipment and bicycle ambulances.
5. Initiate dialogue with the CLCS that have bicycle ambulances to develop plans for getting the broken down bicycle ambulances repaired.




## 1.3 Child Spacing

**Child Spacing (15%)**

Objective End Results

- 25% of mothers with children under 24 months old, who do not desire to have a child in the next two years, will use a modern family planning method.
- 50% of women with children under 24 months old, will know at least two modern methods for child spacing.

The project sought to increase the percent of women of reproductive age and men using modern contraceptives to space the births of their children. The intervention includes:

- Use of multi-channel BCC strategy to motivate women and men to use modern contraceptives
- Increase access to family planning methods through integration of FP services with immunization, prenatal and postnatal services provided through the Mobile Brigades, and distribution of pills and condoms by APEs and *Socorristas*
- Community-based distribution of condoms through TBAs and *Activistas*
- Improving the FP counseling skills of health personnel

Activities and MTE Results

There has been limited implementation with this intervention with the exception of the BCC activities and in-service training for health center MCH staff and SC/US trainers. Similarly to the mobilization of pregnant women to use maternity services, CLCS members have been trained and are responsible for the education and motivation of women and men to use modern contraceptives. As mentioned earlier under the maternal and newborn section, FP was also part of the in-service training conducted by the DPS for health center MCH staff and SC/US trainers.

No progress has been made towards achieving the objectives set for this intervention. The percent of women with children under two years who reported knowing at least two modern FP methods decreased from a baseline average of 30% to 25% in NaV, with Memba experiencing the most drop in coverage, from 37% to 23%. Modern contraceptive use by women not wishing to have another child in the next two years remained almost the same at baseline average of 16% compared to MTE value of 15%. (See Graph 1)

Challenges and Outcomes

The main constraints in implementing activities planned for this intervention has been the low priority given to FP-related BCC activities by CLCS. CLCS members did not spontaneously mention FP BCC as one of the activities that they implement. Lack of carefully designed strategies for negotiating with women and men to use modern FP methods was another constraint identified. The CLCS lack BCC materials and samples of modern contraceptives for educating the community. FP methods other than condoms are only available at HC where there is a SMI nurse or elementary midwife. The number of such facilities is quite low and far away from most communities. Non-SMI nurses at health facilities reported counseling women on FP but they also lack BCC materials and FP

samples. APEs continue to distribute only condoms and not pills as was envisioned in the DIP. *Activistas* and TBAs are also not distributing condoms. Lastly, project staff seems not to be aware of all the activities planned in the DIP, especially the distribution of condoms by TBAs and *Activistas*, and pills by APEs and *Socorristas*.

Next Steps

To reach the objectives:

1. The project and DDS staff will have to become familiar with the planned activities for this intervention, and revise the work plan to accomplish these activities.
2. CLCS will have to give FP BCC activities the same level of priority they have been giving to the other interventions. Strategies have to be developed in partnership with the CLCS to engage women and men to dialogue on FP use.
3. The project should contact their colleagues in Gaza Province, where SC/US piloted a community-based distribution of condoms and pills, to learn from their experiences
4. Meet with the Gaza office staff to ascertain whether there are BCC materials that could be appropriate for the project to use.
5. Discussions should be held with the DDS and DPS staff to immediately train and initiate supply of contraceptive pills to the APEs and *Socorristas*, and condoms to TBAs and *Activistas*.
6. To increase access to FP methods at the health centers, the project should discuss with the DPS and DDS a strategy to avoid stock outs and the feasibility of providing FP methods through the outpatient department by the *Tecnicos de Saude*. At least *Tecnicos de Saude* should have FP BCC materials and samples to use in counseling potential FP clients.

### 1.4 Child Health (Immunization, Malaria, Diarrhea, Pneumonia)

Immunization (15%)

| Objective End Results |
| --- |
| • 55% of children age 12-23 months will be fully immunized by the age of 12 months. |

The program approach to improvement of district immunization coverage has been through the following activities:

(1) multi-channel targeted BCC to motivate mothers to attend vaccination sessions;

(2) collaborative MOH-SC village-based vaccination sessions;
(3) support of continued facility-based vaccine-preventable disease surveillance by MOH

The project was to provide:
(1) service quality assurance emphasizing coverage by geographic locale through mobile brigades;
(2) Cold chain equipment at selected health posts and centers;
(3) Train district staff in logistic management to improve drug supply at the health facilities;
(4) Bicycles to selected members of the CLCS to use for mobilization.

Activities and MTE Results

The MOH provides year-round services, vaccines, and supplies as well as conducting facility-based surveillance for polio, measles, and neonatal tetanus. All 46 CLCS engage to mobilize their communities, prepare sites for DDS Mobile Brigades, and assist during the brigades. CLCS use health talks and home visits to teach mothers about immunization. Focus group discussions with mothers revealed they know vaccine importance and they know that five visits are necessary to complete child immunization.

Percent of children 12-23 months fully immunized by age 12 months has fallen more than 50% from the baseline (NaV 32% to 12% and Memba 34% to 13%)[1]. Results of LQAS survey on immunization indicators are shown in Graph 2.

Challenges

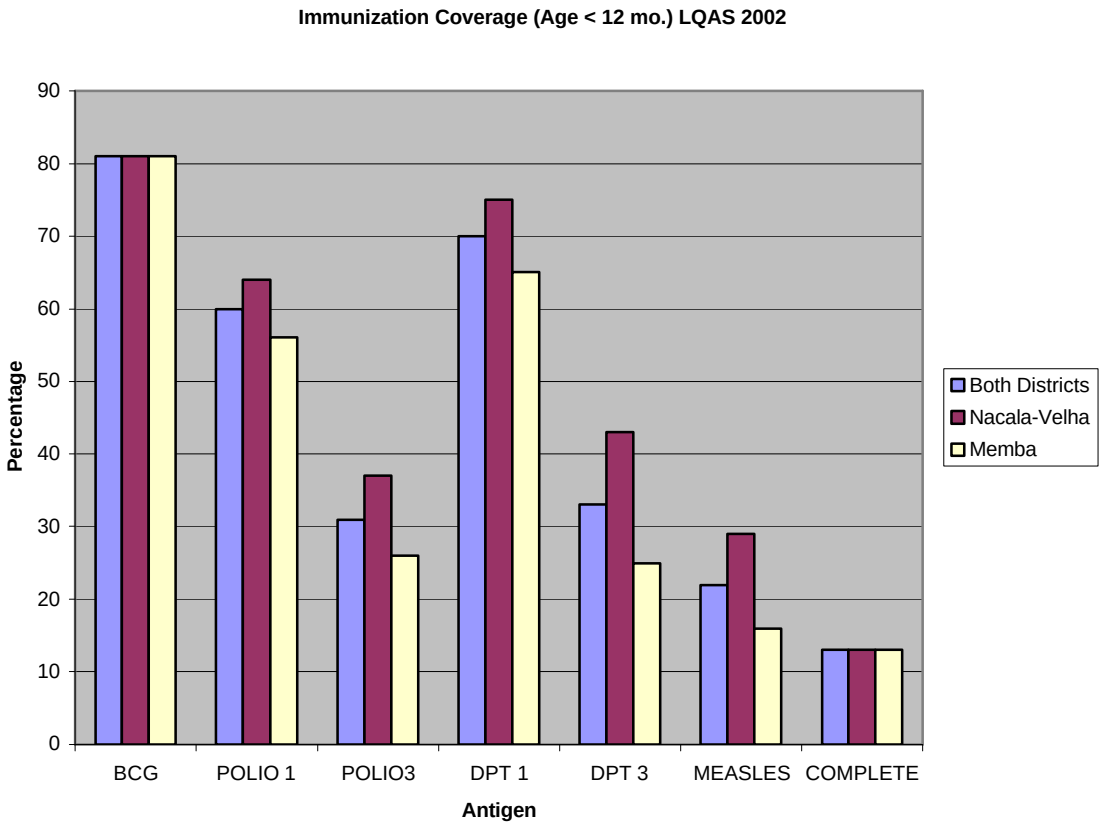
Due to the limited vaccination coverage of the fixed health centers the majority of immunization needs to be obtained through the mobile brigade strategy. However an analysis of the frequency and distribution of mobile brigades in the two districts reveals that the quality of DDS Mobile Brigade service delivery has not been improved in CS16. Although SC provides a vehicle and driver for each district the frequency of mobile brigades in the targeted *regulados* is not sufficient to completely immunize children by their first birthday. In the period of Jan. through June 2002 only a few mobile brigade posts had been visited more than once (Appendix 3). In NaV district there was a long period in which no brigades were executed due to district personnel problems. In Memba the communities are spread out and not accessible during the rainy season. In both districts political unrest due to the cholera epidemic prohibited the visits of

[1] The midterm LQAS survey included a complete sampling of Memba district not possible during the baseline Memba KPC due to the inaccessibility of a number of areas due to impassable roads during the rainy season. Thus the Memba midterm results are not directly comparable to the baseline and include communities which do not receive mobile brigade services in the rainy season.

mobile brigades in several areas from February through April 2002. It was reported that sometimes mobile brigades arrive so late that community disperses to their daily tasks, after a morning wait. Some health centers are also not implementing the policy of providing immunization services five days a week. Vaccine stock-outs have also continued to be an issue at times for the districts. In one health center (Baixo Pinda) the cold chain was established but the district had not provided the necessary kerosene supply in spite of an existing budget line. The tentative initiative on the part of the MOH to shift from a Mobile Brigade strategy to the Monthly Health Days (DMS) seems to have led to the disruption of the former, without really having started the latter.

Next Steps

1. Alternatives for immunization services to cut-off areas during the 8 months of the rainy season need to be discussed by the DDS Directors, EPI Officers and SC Coordinator.
2. The mobile brigades require better planning to ensure adequate frequency (five visits/community per year) and coverage in the districts.
3. DDS and SC need to ensure that the MB team arrives early in the communities, to avoid missed opportunities.
4. Determine how the monthly health day (DMS) strategy will complement the mobile brigades.
5. Ensure the availability of EPI material.
6. Verify that the fixed posts are established and functioning
7. Supervision of activities.




Graph 2. Results of LQAS survey regarding Immunization Indicators for Nacala Velha, Memba and both districts

Malaria Control (15%)

Objective End Results

- 80% of mothers with children < 24 months with fever in previous two weeks will seek care within 48 hours.

Diarrhea Case Management (10%)

Objective End Results

- 80% of mothers with children < 24 months with diarrhea in previous two weeks will manage the diarrhea with Oral Rehydration Therapy (oral rehydration solution or community-based oral rehydration fluids such as watery porridge).

Pneumonia Case Management (15%)

Objective End Results

- 85% of mothers with children < 24 months with cough and difficult/rapid breathing in previous two weeks will seek care from a health facility.

To date the program approach to obtaining these objectives has been:

(1) training clinicians at health posts and centers in the MOH IMCI protocol (10 were trained);
(2) All CLCS educating women and other community members on the importance of early treatment for fever;
(3) Refresher training for APEs to manage uncomplicated fever at the community;
(4) Train *socorristas* to refer fever patients to nearest health facility;
(5) Training CLCS to educate women and other community members on importance of increasing children's fluid intake when they develop diarrhea;
(6) Promote the use of community-based oral rehydration therapy by mothers and community service providers for management of children with diarrhea.
(7) Refresher training for APEs and *socorristas* on the management of diarrhea;
(8) Train traditional healers to recognize pneumonia and refer clients with suspected ARI to the nearest health facility.
(9) Refresher training for APEs and *socorristas* to diagnose and refer children with pneumonia to the nearest health post or center
(10) Conduct *palestras* at health facilities and Mobile Brigade outreaches on recognition of signs and symptoms of pneumonia and the need to refer immediately.

The project has not yet provided the following three inputs:
(1) Training DDS staff in supportive supervisory skills;
(2) Training DDS staff to improve the logistics of drug supply at the health facilities and supply of drug kits to APEs (after assessment of the district logistic system);
(3) Dialogue with GEMT and traditional healers to explore the possibility of using them to manage uncomplicated fever.

Activities and MTE Results

The percentage of mothers with children < 24 months with fever in previous two weeks who sought care within 48 hours has decreased considerably from baseline in both NaV and Memba districts; Nacala 57% to 30% and Memba from 66% to 34%.

The percentage of mothers with children < 24 months with diarrhea in previous two weeks who managed the diarrhea with ORT (ORS or community-based oral rehydration fluids such as watery porridge) has showed little change in both NaV and Memba districts; Nacala from 66% to 67% and Memba from 67% to 62%.

The percentage of mothers with children < 24 months with cough and difficult/rapid breathing in previous 2 weeks sought care within 48 hours has showed a slight decrease in both NaV and Memba districts; Nacala from 64% to 54% and Memba from 73% to 67%.

This project has combined IMCI training for health center providers as a support for the community level mobilization for appropriate homecare and timely care-seeking for malaria, diarrhea, and pneumonia. Ten nurses received the facility-based IMCI training and the ones we interviewed felt it had particularly improved their assessment skills and treatment due to the existence of a protocol that is easy to follow.

Focus group discussions with mothers revealed they receive health education through *palestras* carried out by all 46 CLCS and at HC and have good knowledge of:

- How to prepare household ORS and give plenty of fluids child with diarrhoea
- When to take their children to HF for diarrhoea, pneumonia and fever
- The danger signs of diarrhoea
- How to prevent diarrhoea
- Signs of pneumonia
- How to reduce fever at home and during referral transport
- Malaria symptoms and signs
- How to prevent malaria

The training of traditional healers has improved the safety of their treatment practices. They now report using one blade for each person and they sterilize their knives and other cutting materials. THs state that they do prefer to refer to the nearest health center, cases of diarrhoea, malaria, IRA, meningitis, measles and tetanus.

Fourteen APEs and Socorristas also provide services in the communities and were trained in simplified IMCI. APEs when they have medicines available are able to treat malaria, transfer severe cases to the health centers and educate mothers on appropriate referral.

Challenges

The major challenges for appropriate homecare and case management of diarrhea, pneumonia, and malaria in CS16 are:

- Recognition of danger signs by families and traditional healers: Families are delaying referral to the HC because the illness is not considered serious (for example if the child can play).
- THs also do not always transfer children in a timely manner, preferring to try treatments three times or wait two days.
- Behavior Change Communication Approach: CLCS are not clear on child health messages and behaviors. In many CLCS there is emphasis on water and sanitation – both in terms of messages and in terms of their understanding of their role. The messages are generalised and the key messages are not well described. For example mothers consider fever as a danger sign but because there is a distinction between "normal" malaria and "severe" malaria they might delay care seeking.
- The CLCS in most of Memba do not have trained *activistas* from previous CS projects, so they have less manpower for health education.
- Some APEs in NaV could not clearly identify danger signs and failed to refer when a child should be transferred.
- Important barriers to seeking referral care in health facilities: lack of money, lack of medicines at HC and with APEs (for example chloroquine stock outs discourage mothers from seeking care), belief in effectiveness of TH for certain diseases, and the fear of their children dying at the HC.

Next Steps

1. Training DDS staff in supportive supervisory skills to be able to follow up HC staff activities, and APEs performance.
2. Training DDS staff, especially trainers in supportive supervisory skills to be able to follow up CLCS educational activities in the community with *activistas*, TH, TBAs and others.
3. Improve key messages in the modules and sessions delivered by the educators at all levels.
4. Follow-up of community-based *palestras* and other BCC activities.
5. Distribution of IEC materials.
6. Refresher training for APEs and/or on-the-job training during supervisory visits.
7. Working with DDS staff to improve the logistics of drug supply at the health facilities and supply of drug kits to APEs[2].
8. Dialogue with GEMT and traditional healers to improve the promptness of referrals.

[2] Consult document "Avaliação da Gestão do Sistema de Logística, nas Provincias de Nampula e Zambézia – Medicamentos, Vacinas, Anticonceptivos" por A.P. de Morais Oppenheimer et al., JSI, HSDS Moçambique, Set 2001.

## 2. Cross Cutting Approaches

### 2.1 Community Mobilization and Behavior Change Communication

Activities

Community mobilization (CM) and behavior change communication (BCC) are the key approaches for creating awareness and demand for maternal and child health services in the project. CM is also the vehicle for getting the community to setup appropriate referral systems for pregnant women with danger signs or complications, and sick children. The CLCS are responsible for conducting the activities associated with both of these approaches in their communities. The project has facilitated the establishment of, and provided training to the CLCS in all the *Regulados* in the two districts. All CLCS members have been trained in health talk and community mobilization techniques. The training was done using a manual developed by the project. The BCC approaches used by the CLCS include group and one-on-one (including house visits) counseling using flip-charts, posters and pamphlets. Working with members of the community, CLCS members have developed songs based on the project's six intervention themes. Staff at the health facilities also provides group and one-on-one counseling for clients attending these facilities and at Mobile Brigade outreach.

There are approximately equal numbers of men and women on the CLCS. The Regulos are the chairpersons of the CLCS. They are responsible for calling, and leading discussions during the monthly CLCS meetings. Other members include Apiamwenes, *Activistas*, TBAs, *Socorristas*, APEs and Traditional Healers. There is regular attendance of, and active participation by all the CLCS members at meetings. Interviews with mothers confirmed that the CLCS members are truly conducting the health talks and mobilizing communities to respond to the needs of pregnant women and sick children. They, also, assist in mobilizing the communities for the Mobile Brigade outreach services. All the CLCS visited did not have written work plans but relied on members remembering assignments given to them during the meetings. The CLCS members have specific data collection assignments that they present at each meeting for discussion and decision-making. The section on HIS provides further information on the type of data collected and by whom.

Community mobilization and BCC are other major accomplishments by the project. CLCS monthly meetings were fairly regular in NaV where the frequency of meetings ranges from 8-12 times (monthly) in the past year compared to an average of 3 meetings (quarterly) in Memba. Use of community data for decision-making is more limited in Memba district. Mothers interviewed demonstrated adequate knowledge in pregnancy-related and sick child danger signs, components of birth planning, what action to take for pregnant women or sick children with danger signs and how to manage a child with diarrhea. The

progress towards achieving the set CM/BCC objectives is discussed under the specific technical interventions.

Challenges

- Some CLCS in both districts reported not having a good relationship with health center staff. Twice they mentioned that patients who delivered outside the facility were afraid of going to the center for postnatal services or were refused services or not treated with respect by the nurses/midwifes. In another health center the *Tecnico de Saude* did not even know which community members he should be working with.

- There is lack of communication between some DDS staff and CLCS. CLCS members are not treated with respect when they accompany community members to health facilities and are afraid of reporting the situation to DDS. The DDS staff has never supervised any of the CLCS in the two districts. In the DIP, the plan was for the CLCS to be supervised every quarter by a joint SC/US and DDS team.

- Lack of focus on key messages is also a constraint. Health talks provided by CLCS members tend to cover broad areas and are not limited to the key messages that mothers need to know in order to take action to prevent or seek early treatment for a particular disease. There is over-reliance on health talks as the panacea to get community members to change their practices with regards to use of health services or taking preventive actions. When asked what they will do to get mothers to take their children for immunization or use FP, almost all the CLCS visited mentioned they would conduct more health education talks. CLCS members agreed that more community members would participate in BCC activities if interactive drama was used as the channel for providing key BCC messages. The project trained one person from each of the CLCS in each district in drama for health education. The trained persons were expected to train other members of the CLCS. At the time of the MTE, none of the trained CLCS representatives have conducted the drama training for their colleagues.

- A major constraint to BCC is the general lack of BCC materials at both community and health facility level.

- Lastly, the CLCS members reported that community members do not fully trust them, and think SC/US pays them for the activities they undertake. An example was given of this distrust that apparently reached crisis level during the cholera epidemic. Community members accused the CLCS members of causing the epidemic by deliberately putting cholera vibrios (the chlorine pills) in the wells. The lack of financial contribution by community members

towards the maintenance of bicycle ambulances was also attributed to this distrust.

Next Steps

1. Improve the supervisory skills of DDS and its trainers towards health facilities services and staff, emphasizing the importance of the relationships with the community.
2. Improve the supervisory skills of DDS and especially its trainers to conduct regular visits to CLCS meetings. They should invite themselves to attend the CLCS meetings to be able to guide part of the discussion, address the weaknesses (use of data, A&T systems, trust issues, including clarification on the roles of TBAs and relationships with both SC and MOH.) These issues should also be directly discussed with the mothers.
3. Diversify BCC approaches by continuing the development of local theater and drama groups in each of the regulados.
4. Review BCC key messages to be delivered by CLCS members to mothers and incorporate them into a revised training curriculum.
5. Plan a massive distribution of appropriate, non-literate BCC materials to the communities and health centers.

## 2.2 Capacity Building Approach

**Capacity Building**

- SC/HQ: At least 2 SC Field Offices and/or other organizations will develop a plan for adopting successful CS16 approaches.
- SC/M: SC/Moz staff will participate in policy forums at the provincial level advocating for changes in policy based upon CS16 strategies.
- DHOs: Presence of annual work plan specifying activities, persons responsible, date and resources available/monitoring and supervisory tools for each capacity.
- Presentation of HIS reports during quarterly PMT meetings.
- Communities: (1) 75% of *regulados* will be able to identify 2 or more priority maternal/child health problems to be addressed through an action plan; (2) 70% of *regulados* will have formed CHTs and members will know the roles and responsibilities; (3) 80% of CHT members will be able to cite five approaches to increase community participation in health activities; (4) 75% of CHT members will understand numerical trends of HIS and use for health planning.

The essential aim of the CS-16 Project is to build capacity in the DDS and the communities for long-term access, coverage, quality, and sustainability. The Project addresses capacity building on three **systems levels**: **the household**, **the community**, and **District Health** levels as well as the field office. The goal is to provide organizations (families, communities, DDS) with the tools and skills they need to promote their own ongoing development.

CLCS members were to receive training necessary for: (1) developing care-seeking and transport plans for pregnant/postpartum women and sick children; (2) data-driven decision-making with regard to community health; and (3) mobilization to reduce barriers to and increase use of existing health services. They were to work at the community level to promote child survival through community mobilization and BCC focusing on prevention, caregiver practices, and appropriate care-seeking aimed at mothers and caregivers, decision makers, and community leaders who influence behaviors at critical points (during pregnancy, delivery, postpartum, childhood illnesses.)

The February capacity assessment identified four capacity areas the DDSs wished to improve, which are expressed in the following objectives: (1) Improving the distribution and delivery of services and benefits, (2) Improving needs assessment and planning, (3) Improving financial management and (4) Improving organizational learning. These were to happen through the joint Program Management Team (EGP).

Capacity building of SC headquarters and field staff emphasizes strengthening systems to support organizational learning and experience-based advocacy through the annual "program learning group" (PLG) meetings in which SC health staff from headquarters and the field share lessons learned from field experience and participate in technical updates on "state-of-the-art" practices in health. One anticipated innovation is the approach to working with traditional healers that SC Mozambique will document and share at the PLG as well as in international forums such as workshops on HH/C-IMCI approaches. SC/Mozambique staff identified the need to increase their capacity in needs assessments and planning and that was to be given in a practical fashion such as what has occurred during the DIP preparation. SC/Mozambique also is to strengthen staff skills to advocate at the provincial level based on experience gained through implementation of the project.

Activities and MTE Results:

This section is complemented by the Program Management (section 3) below, where project activities regarding capacity building are described in more detail.

SC HQ have conducted an Institutional Strengths Assessment in Feb 2002 and as a result the Office of Health (OH) has developed capacity building plans for four current SC initiatives that include immunization; community case management of childhood malaria, pneumonia, and diarrhoea; safe motherhood; and adolescent sexual and reproductive health. OH also developed a draft advocacy plan for health. Contacts between HQ and SC Nacala, besides the DIP, have been the revision of 1$^{st}$ year annual report, preparation for the midterm studies and evaluation, and financial and administrative backstopping.

SC Nacala participated in an international forum in NY April-May 2002 where one of the staff shared the life and challenges of Mozambican mothers. Unfortunately Dra. Catarina Regina, the Bridges coordinator had to cancel her planned trip to participate in the PLG this year and the documentation of the work with THs has not been done. However, the work with THs, *curandeiros*, has made important progress. The staff considers being able to communicate and exchange with such an icon of traditional health care a huge step. As mentioned earlier, THs now report changed practices of using one blade per person and sterilizing their cutting instruments by boiling. They also clearly identified the illness symptoms which they refer immediately to a health facility. In one *regulado* a TH explained how his prompt transfer of a child with rapid and difficult breathing saved her life. Some days after the mother had returned home with the cured child she approached him to express her deep gratitude for his action. However, most of them confessed to keep the child for some time before transferring.

The DDS director in NaV has presented a summary of the project to the local government Administrative Council. The quarterly joint management meetings with Bridges have been opportunities to share project developments with DPS.

The SC lead trainer started using a supervisory checklist for the first time this May. She attended three TBA trainings and assessed the following: training methodology, communication skills, knowledge and presentation style of the subject, including ability to answer questions and clarify doubts, use of BCC materials and motivation of the audience. With this tool and improved curricula the quality of the trainings will certainly improve.

Challenges

HQ and the Strengthen Project need to have more communication and exchange of reports to ensure the quality of the planned activities. This may have helped detect the need to work even more closely with DDS directors and might have steered EGP activities in the right direction.

DDS directors did not produce annual work plans and/or monthly action plans. In NaV, the secretary keeps the director's meeting agenda and that is what is followed as a plan. The SC program manager explained that in spite of these shortfalls a huge gain has been achieved in the collaboration between districts and SC, and the staff corroborated this opinion, stating that before it was almost impossible to work collaboratively with district directors. This effort has been accomplished in the joint management meetings. Objective assessment of district management, however, showed that SC project documents were filed away and not at their fingertips, Mobile Brigades were not planned properly, EPI and FP indicators fell since baseline and there was no supervision either to the HC or to CLCS. NaV DDS holds a monthly meeting with all technical staff and Memba DDS holds a similar meeting on a quarterly basis. These opportunities to work more closely with the districts and build their capacity in terms of planning

and monitoring have not been explored. DDS directors complained that the contacts with the program manager have been only through the telephone. Management of the HIS seems to have improved only slightly. We saw rudiments of data analysis and no use in decision-making. Please refer to the section 2.3 Health Management Information System for more details.

CLCS are active and engaged in their work of mobilizing and educating communities to the extent they were trained to. The MTE team noticed that CLCS tend to perform activities they were trained to, but not activities that were left to their own initiative. For example, the *regulo* performs as a key element of the Alarm System as it was oriented to do, but still today nobody is in charge of the bicycle maintenance. This decision was not scripted. TBAs collect information related to maternal and newborn care and the *activista* compiles them in the tally forms. TBAs carry this information to the HC or to the trainer in the district, but CLCS do not know how to effectively use the data to make decisions. Management of information at this level was cut from the training curriculum. More assertive *regulos* demand collaboration with DDS but district and health center staff have not yet received sufficient training to answer those demands.

There are trust issues between *regulos* and the community that need to be addressed in public meetings. An example is the fact that the community does not wish to contribute for a cash fund to maintain the bicycle-ambulances because they do not trust their money with the *regulo* and believe that the *regulo* is also receiving money from SC to maintain the bicycles. The bicycles might be used for other activities to generate income, but they have not come up with mechanisms to manage this. There is clearly a need to improve knowledge and skills of CLCS members in specific management areas.

Regarding delivery of BCC messages, CLCS were not taught the Community Action Cycle (CAC) which is an alternative to the traditional “talk” or lecture-style approach for delivery of BCC messages, drawing on basic concepts of facilitating critical reflection and exploration of experiences, attitudes and practices. It allows both the community and the field staff to learn about how caregivers perceive problems and how they respond to them. Together community and field staff can then plan for, implement and evaluate improved behaviors in IMCI, MNC, EPI, and especially FP.

As stated earlier in the document mothers became very active, assertive and gained knowledge through the educational contacts with CLCS, health workers and others. All six groups of mothers we interviewed showed these characteristics. Their knowledge on fever management, diarrhea management and pneumonia management has increased, as well as immunization, pregnancy danger signs and even clean delivery and birth plan. Currently the health services have not adapted to meet this increased demand.

## Training

Training has been the strongest capacity building component of the Strengthen Project. The project has a core of ten Trainers, four from SC and six in the districts. They were prepared by provincial TOT and have carried out trainings of CLCS, TH, TBAs, and APEs. HC personnel training in IMCI is carried out by provincial trainers. As of June 2002, 688 people have been trained.

Training and refresher for 14 APEs, 7 *socorristas*, 4 SMI nurses, 10 Elementary Midwifes, and 9 nurses or *Tecnicos de Saude* were all carried out by DPS. SC staff participated in some of these trainings to increase their skills as TOT. These trainings facilitated the transition to IMCI strategy adopted by the country. Interviews during the MTE revealed the trained technician had more educational materials on hand, they had protocols and reported making more accurate diagnosis and prescribing better treatments versus the non-trained technicians. The final evaluation with its facility assessment will objectively measure these advances. The best example of successful training we found in the field was of a male nurse who not only used the IMCI protocol but helped the fellow MCH nurse with prenatal visits and deliveries, studied her manual to help her understand more difficult subjects, offered FP education to his adult patients, analyzed his registry for disease trends and contacted the respective CLCS to discuss possible solutions to the respective communities.

All information on training was obtained from SC office and none from the districts. NaV had a dossier with modules but they are not using statistical information to track their work.

However DDS health technicians have yet to be trained in specific areas such as the use of the HIS for planning, monitoring and support-a-vision, logistical and resource management especially for EPI and family planning. The current model of EGP meetings seem not to be appropriate to help capture the essence of planning and follow-up.

SC staff has not received training on needs assessment and planning. Through participation in EGP with Bridges to Health Project meetings, the Lead Trainer especially had a chance to receive on-the job training on some managerial skills and share lessons learned. The participatory and formative approach of the MTE was considered by the staff and by the district representatives as a very helpful learning opportunity. Lastly, advocacy efforts are a weak area both at provincial and national level.

<u>Next Steps</u>

The project needs to emphasize more follow-up to guarantee a level of performance according to the training efforts. Both DDS staff and SC staff need to:

1. Acquire management, supervisory, data management and resource management skills. These are to be transferred in working sessions with each of the districts. The EGP meetings might continue until the end of Bridges in April 2003. Additional monthly meetings should take place at each of the districts with the district technical staff including the director. From statistical information presented, communities and health facilities are targeted to specific activities, a work plan is drafted and resources are made available to execute the activities. These resources may continue to come from SC as it has been, but emphasis should go on to drawing more and more district and provincial resources keeping capacity building and sustainability strategies in mind and the end of the project at sight. These FORMATIVE meetings will create abilities to analyze data, lead to quality improvement, manage resources and personnel, manage the budget, and address community needs, and strength districts, staff and communities. Objectives and strategies of the Strengthen Project should be the starting point in all meetings, so participants internalize them.
2. Acquire new skills to advocate for the district needs and plans. Once they learn to use data that can be used also to better advocate the needs and draw more resources to the district. The vehicles need to remain in the districts after Strengthen Project ends.
3. Trainers need to learn new skills to use statistical information to increase performance and monitor trainees.
4. Follow-up CLCS meetings. The HC and health workers should be encouraged to participate in these meetings and receive community-based monitoring reports from these meetings. Through this mechanism facility-based health workers will improve their relationships with community leaders, respond to their health needs and gain more respect and status at the community level
5. Increase supervision to Activistas, CLCS, APEs, TBAs, by using a specific checklist for each of the cadres. This list will be the output of short-term training on supervisory skills directed to staff and districts as it is envisioned in the Action Plan.
6. Present results of the LQAS survey and MTE results to all HC and CLCS as feedback information and to foster “information for action” attitude.

## 2.3 Health Management Information System

The CS16 project results are being monitored and evaluated through the use of community data, service statistics, qualitative studies, supervisory checklists, LQAS, KPC surveys, and Health Facility Assessments. For evaluation purposes household and facility assessment surveys (both 30 cluster surveys and LQAS) and project training records have been used at baseline and midterm. Project activities are jointly monitored by SC, DDS, and CLCS.

**SC Level:** Rather than establishing a parallel system SC works with the DDS to prepare quarterly reports of district service delivery. The project staff also prepares separate quarterly and annual reports to describe the key activities of the project including trainings, mobile brigades, supervision visits, meetings attended, challenges and proposed solutions. This report is shared with the SC/US Mozambique Office in Maputo and the SC/US HQ. This report is used to monitor the progress of the Strengthen Project and report on its accomplishments to USAID.

**District Level:** DDS undertakes routine SIS data collection to monitor district service delivery including EPI, family planning, sick child consultations, antenatal, delivery and postnatal coverage. MOH Weekly Epidemiological Bulletins (BES) keeps track of immunization-preventable diseases. Community level information is to be incorporated into these service statistics. The M&E skills of local staff and partners are to be strengthened primarily through in-service training and supervision. The SC M&E Specialist works with the DDS and specifically with the District Preventive Medicine Officers to strengthen the quality of their reporting. Consistent supervision at all levels is critical to reinforcing the monitoring skills of the volunteers and the health workers.

During the quarterly EGP meetings, DDSs make presentations on the coverage of their services in the preceding quarter and discuss implementation challenges. Thus the DDSs are tracking the progress of MOH indicators, and meetings are used as a forum for reviewing reports. However the quantity and quality of data included in the quarterly report is quite limited. The evaluation found that data analysis for decision making and planning is also limited at the district level. Computers were given to the districts in July 2002. However there is not a training plan or a clear definition of use and responsibilities. The SC M&E Specialist does not have the requisite background and training to conduct data analysis and provide sufficient training of the district officers.

The community-based information system has been partially incorporated into the districts' health information systems. The information collected by CLCS from the TBAs at the community level (*regulado*) is being given to the SMI nurse of the health facility nearest to the *regulado*. The SMI nurses are then including this community information in their monthly report to the DDS.

Beyond the routine monitoring system, the project used a lot quality assessment sampling technique for a midterm monitoring survey. It took four weeks to provide an estimate of whether the project was on track relative to its objectives. This survey was reviewed as part of the MTE and its results are in Appendix II.

Quality of services at the health facilities and community-based service points is to be monitored by the DDSs through supportive supervision using standardized

checklists. These supervisory checklists which were to be developed by JSI in 2001 have not yet been done.

**Community Level:** CLCS have been trained to monitor their activities during their regular meetings. The use of data collection instruments is a component of the trainings with the CLCS, APE/*socorrista*s, and the TBAs. During regular forums (monthly or quarterly) these community providers share the results of their work with other community leaders and the information is summarized in monthly tally forms. This forum is intended to provide greater feedback of information to the wider community so that "social pressure" will stimulate behavior change for improved health.

The evaluation team found the completeness and quality of the community information inconsistent. The majority of CLCS are collecting information on the use of trained and untrained TBAs as well as the number of maternal and child deaths. However few are collecting other information on the number of cases of specific diseases. The training on the use of this information at the community level was insufficient.

Next Steps

1. Provide technical assistance on data analysis and applied epidemiology. Local resources can be used, for example Victorino from the Gaza office and the statistician in Nacala-Velha.
2. Refresher training of CLCS members in data-driven decision-making based on the CLCS monthly return form is required. Use the monthly meeting report form developed by the Bridges project in Nampula.
3. Revise the SC quarterly report to include other process indicators to measure project progress.
4. Increase regular supervision of CLCS and service providers focusing on the quality and use of data

## 2.4 Sustainability Strategy

Sustainability

Objective End Results

- 2 DHOs will prepare an annual health workplan indicating efficient use of resources.
- 75% of CHTs at *regulado* level will attend meetings regularly.
- 2 DHOs will have supervisory and monitoring systems for QOC and peer review.
- DHOs will regularly share lessons learned at provincial and national MOH levels.
- DHOs commit to sustaining CHT training and formation by inclusion into yearly DHO plans.

The weaknesses of the capacity building assessment reflect on the potential sustainability of activities beyond the life of the project. Neither DDS had annual work plans or even quarterly work plans in addition to the SC training plans. Monitoring systems for health workers, quality control of services and for CLCS do not exist. It is necessary that districts and province commit time and resources to continue monitoring CLCS beyond the life of the project to keep them motivated. With the interest fostered by the MTE, we expect that the relationship of the DDS and CLCS to improve. District financial and budget management issues need to be addressed. The periodic unavailability of the MOH vehicles assigned to each district will further strain the ability to carry out supervisory activities. Finally a huge challenge is the destiny of the cars currently working in the districts. These two vehicles might not be kept in the districts after the end of the project and this is a major obstacle to continuation of activities.

Next steps

In order to ensure continuation of activities SC and DDS staff have to:

1. Institute the monthly meetings at district level and jointly plan and budget activities. This exercise for the remainder of the project will consolidate a management attitude adequate for sustainability purposes. An example could be:
    a. Always start with a clear presentation of the project objectives and strategies to keep them in mind.
    b. Data presentation by intervention area. Compare with last report. Discuss trends, why or why-nots of data, quality aspects. Ask justifications, teach data analysis, and stress formative character of meeting. Identify problems and problem-*regulados.* Discuss solutions; identify responsible, make clear guidelines and actions. Jot down to follow-up accomplishment in the next meeting. Be consistent and comprehensive.
    c. Study DIP work plan and MTE Action Plan for activities that are planned for the period. Discuss with persons responsible, how to accomplish activities, spell out straight guidelines, and confront every lack of accomplishment in a constructive way, so difficulties are surpassed. Find solutions.
    d. Coordinate use of resources, especially vehicles and personnel, so several activities are accomplished in one trip. (1 supervisor to community activities, 1 or two MB nurses, 1 supervisor for the HC or HP).
    e. EPI management: have or prepare list of all health facilities and their cold chain status. Look at vaccine supplies to each, compare with immunization numbers and targets, find disparities in all logistic management information, ask questions, uncover problems,

find solutions, assign responsibilities, and follow up on next meeting. Look at QC of immunization data including MB and CIC per facility. Discuss trends. Disparities have to be discussed with the EPI person and responsible of the health facility and follow-up recommended orientations. Look at number of days the facility provided immunization, compare well-children visits + sick children visits and immunization numbers, find reasons for the disparities. Finally, study the feasibility of opening more vaccination posts. Create the conditions if they within reach. Make proposals to DPS if not. Follow-up on the requests. Instill urgency.

2. Devise an exit strategy that will leave the districts strengthened.
3. Elaborate a plan for supervision that covers all the follow-up needs at the community level, including health workers, CLCS, theater groups, *Activistas* e APEs, TBAs, etc, emphasizing on-the-job training and sharing of resources such as time, vehicles and activities such as mobile brigade or DMS. It is only necessary that each member has one or more attributed responsibility.
4. Lobby the DPS at the appropriate level, using statistical information analysis, to ensure that the vehicles stay in the districts after the en of the project and that a vehicle maintenance budget is executed appropriately.
5. Use the opportunity of the *Conselho Coordenador Provincial* to present the LQAS, MTE results, the Action Plan, and a clear outline of the district sustainability needs.
6. Discuss with CLCS the need to continue the activities in the absence of sponsorships.

## II. Program Management

### 1. Planning

The basic constitution of the PMT (EGP) for both Districts includes the DDS director, or a representative when he cannot attend, the SC Strength Project program manager, Bridges Project staff, and representatives of the DPS, especially the SMI Coordinator and the NEP Coordinator and JSI Coordinators from Nampula and Maputo. Several other people have been invited and attended, such as other SC staff, district trainers. Local NGOs (GAS, ADPP and MS) are always invited but their attendance is rare.

The Bridges Project, which has similar objectives in terms of capacity building works in four other districts of Nampula. The Strength Project manager also manages the Bridges Project. That meant that the EGP became a bigger meeting with representatives of six districts and about 12 to 20 people. Representation at those meetings ranged from 21% to 35% for DPS, 10% to 18% for SC and from less than 1% to 21% for DDS. EGP meetings are called and prepared by SC following the schedule. Different districts hosted the meeting if there were conditions to lodge all the participants. Neither Memba nor Nacala Velha hosted an EGP meeting due to lack of those conditions. District directors and SC present their reports in a plenary session. Then the participants divide in two groups, the Strength and Bridges groups, to discuss issues in more detail.

EGP was scheduled to meet regularly every trimester, what would be six meetings so far. We found minutes of only 4 ($2^{nd}$ to $5^{th}$) meetings. The agenda includes meeting objectives, report presentations by districts and by SC, reports on visits made to health facilities, data presentation, discussion and recommendations, and a work plan for the coming trimester. However the minutes do not reflect the improvements expected at this point. The description of the problems is not quantified, do not clearly indicate to which facilities they refer to, and the recommendations are too general. The appendixes of the meetings are listed but not annexed to the minutes, making it difficult to analyze its content. In meetings $3^{rd}$ and $4^{th}$ for example problems such as elaborate a DDS/SC joint work plan; identify problems with the cold chain; inventory of bicycle-ambulances) were discussed and recommendations were made but the accomplishment of these recommendations were not tracked down in the following meetings. The recommendations are not specific enough (who, when, how) and that makes it difficult to track the accomplishments. The report of last meeting that took place in Ribawe in July 2002, recommended a reporting format that allows tracking accomplishments of meeting recommendations. It also showed a novel analysis of the data, comparing data of the first semester of two consecutive years and what indicators went down or up. However no decisions were recorded from this comparison.

In preparation for the EGP meetings, the SC M&E officer goes to the district, collects data and returns to the office to prepare tables and graphs. SC presents a proposal of the work plan, mainly trainings as planned for in the DIP. Districts and DPS agree on the calendar of activities according to the availability of the trainers and this represents SC quarterly plan. District problems or activities are not reflected in that plan. The meeting minutes are prepared by the project coordinator aided by a participant. The districts could not show their copies of those minutes, nor of the quarterly work plans.

Training activities followed closely the DIP schedule adjusted to availability of DPS trainers when needed. Trainings only dependent on SC and district trainers took place as scheduled. On the logistics side the procurement of supplies for the maternities, bicycle-ambulances, two-way radios and others have been delayed by six to 9 months. Computer equipment only arrived in the districts about two months ago but has been locked, due to lack of trained district officers to use them. Explanations for these delays seem to be "things in Mozambique are slow "and that logistical procedures in Nacala and Nampula are slow-moving.

The staff does not know all the program objectives and were not too clear on the cross cutting approaches. They know the intervention areas, perhaps because most are MCH nurses and are very much engaged in the activities. Staff says they all have a copy of the DIP but could not produce it easily. Only one copy in Nacala was available throughout the evaluation. That copy is translated to Portuguese, but not complete, and written in a heavy format that does not facilitate reading. We do not know if translation was cross-checked for accuracy but some acronyms were not translated at all e.g. MNC. There is not a comprehensive monitoring and evaluation plan. The M&E specialist needs further training to prepare one on her own.

Regarding the use of health information, there is graph frenzy. Graphs are generated with MOH data but their quality needs to be improved. They lack proper labeling of place, time frame, and source references. Some tend to aggregate such a number of variables and bars that they become difficult to understand. In addition there appeared to be little use of this information in specific decision making. The team leader assessed the set of graphs from Memba for the period of Jan-Jun 2002 and made comments that will help guide the M&E person to improve the presentation, analyze the information she collects and promote discussion around problems identified by the data during the monthly meetings with the districts. A copy of this is in Appendix XI.

The hiring of six local MCH nurses did not happen due to lack of skilled personnel in the Province, the low MISAU salaries, and the remoteness of the

Districts. Only five months ago, the DPS hired two general medicine nurses under that agreement.

Planning of field activities has improved. Initially the training team packed foodstuffs and other items to the field, as trainings were never shorter than one day. They hired local cooks to prepare the meals for all participants. Participants, however, proposed to receive cash instead of the meals, as that could be taken home and cover family needs dependent on their income. That decision happened at the management level with no advanced notice to the trainers in the field. The logistic staff went to the field with the new rules without properly communicating these changes. Their lack of training on how to deal with the community clashed with the traditional authorities and impacted negatively on the community. Finally a solution was worked out over the phone with the manager. A discussion of the problem on following Monday meeting generated a wave of open animosity of one member of the logistics team towards the technical staff. It remains till now. This impacts the processing of operational budgets, letters and other dispatches which leads to unnecessary delays of activities.

Technical staff in the field or at least the lead trainer does not handle any financial operations at all. Usually training sessions are visited by the logistics personnel to pay per-diems. Those extra trips to the field that could mean also supervision opportunities but this option was never explored.

### 2. Staff Training and Supervision and Technical Support

The staff has received training in many areas, especially on TOT, health education, curricula preparation, programming, clean birth, and computing. Beside most have a health background (see Appendix IV). However, in view of the results, more formal training on management skills is needed for both the staff and DDS partners. BCC training has relied on the traditional health talks. Only recently were theater and drama introduced and the CAC approach was not emphasized. Basic epidemiology and statistics skills are necessary to enable a better M&E performance and transfer of skills to district personnel.

The Strengthen Project has received technical support from overseas, for example a consultant that carried out the LQAS, trainings on CLCS and Clean Delivery, and the study on the feasibility of selling clean birth kits. Opportunities of using local expertise in epidemiology and statistics, exchange of experience with Gaza on CBD of FP methods, review and update of BCC messages and A&T systems need to be explored. During the evaluation a nurse trained in IMCI

in the Geba HC, Epuite, Memba was identified who could be an example to other health workers.

Recently, for the first time the Lead trainer supervised training sessions conducted by her staff 3 times this year. She has developed a supervisory checklist to help her achieve the supervisory objectives. Problems pinpointed were discussed with the supervised trainers.

The evaluation team did not discuss the program budget in the absence of the Program Manager. During debriefing with the Country Director a budget tracking tool was made available but the evaluation team did not have enough time to discuss it in more detail. The budget will require some adjustments to respond to identified training needs including the need for one more TBA training for the Lurio area, training/refreshers to selected APEs and management and epidemiology training to staff and district personnel.

It was not possible to evaluate supervision of program staff, in the absence of the Program Coordinator and Manager. The MTE team learned that the manager held meetings every Monday of about 2-3 hours. These meetings included the technical and logistics staff. Discussion of the work schedule and report of field activities of the ending and starting weeks were the focus of the meetings. The staff expressed that they felt sufficiently guided in their activities.

The program has always been understaffed, as a national coordinator was never hired due to the shortage of skilled available national workers. Now there is an urgent need not only for a coordinator but a new program manager, according to the organizational chart Appendix VIII of the DIP. The external evaluators had a chance to interview two strong candidates for the coordinator position. Reports of these interviews were left with FOD. The lead trainer is filling for both now and she herself recognizes not having the necessary management skills. Project logistics and operations are staffed with three people who were not interviewed.

### 3. Human Resources and Staff Management

Some complaints were made in terms of lack of communication related to the management of human resources in the prior CS-12 project. For example some people being fired without notice and just plainly disappearing from the office with no chance to bid farewell. This makes the staff uneasy and fearful that they would be next ones. They understand they are under contract and that their terms are finite, but feel unstable during the contract period.

Technical staff turnover has been low in CS-16. No staff has left the program so far and another trainer joined the NV team two months ago. The greater challenge has been recruitment at appropriate skill level.

Usually when a contract ends the staff is given opportunities to apply for positions in a new project if one is to come. Otherwise they will engage in other projects or other NGOs given their training, skills and experience. Going back to work in MOH was not mentioned as an option.

We were told that all staff has job descriptions, although we did not see them. However due to the performance of certain elements, for example the district directors, there is a need to make sure the job descriptions are detailed enough to ensure their performance. The new director should understand the need to travel monthly to and work in each of the districts, in order to accomplish transfer of management skills and data analysis and lay the groundwork for sustainability.

The technical staff is cohesive, committed and enjoy their work. They are very much engaged in the activities and truly believe on what they are doing. All are skilled in their dealings with the community and easily establish rapport with them. They feel the need for leadership especially since the Program Manager left two weeks prior to the evaluation. The relationships with district and CLCS members is excellent and that impacts positively the program and on the organization. They seemed to quickly absorb more new skills and perform better when they have direct guidelines. The ability to work independently can be build over time if they are given proper responsibilities.

## 4. Financial Management, Administration and Logistics

It was not possible to discuss this in any detail because the responsible person was away in a mission in a SC province. We really did not have leaders at all to discuss details of the Strengthen Project. However we were informed especially by the district directors of the difficult relationships with the Chief of Operations and of the problems with the logistics staff.

Procurement of local supplies for the birth kit has proven very difficult and non-viable at this point. That was reported by a consultant who visited the field in preparation of the LQAS survey, right before the MTE. That caused a step back from the planned supply of birth kits to TBAs. Communication on this change has not been clear enough and some TBAs still reported an expectation that cannot be fulfilled. CLCS and TBAs should be informed and clarified as soon as possible. The impossibility of supplying birth kits gave way to improve education of TBAs and mothers in clean births. As proposed and elaborated by the consultant, the management was ready to carry out a study protocol on the

impact of health education alone. The objectives and feasibility of such a protocol should be discussed with the regional advisor before it is started, given the shortage of personnel and considering other more imperative project priorities.

Certain equipment and materials for maternities were to be distributed in Q5 and Q6 of the project. In April the lists were presented to the project manager and six months later the materials have not been purchased. Bicycle-ambulances for Memba should have been distributed this last quarter, but apparently purchasing orders haven't been issued yet.

Vehicles are a concern. The current vehicles, with permission from USAID, will be transferred to the DPS at the end of CS16. They were originally purchased for CS-16. It is possible that the DPS will allocate the vehicles to other districts that currently have more severe vehicle needs. The two vehicles are stationed one per district, Tuesday through Thursday and under a careful plan support mobile brigades, distribution of supplies, and transportation of emergency cases to the closest health facility and reference hospitals. Sustainability of activities, once CS-16 is over, is totally dependent on these vehicles. Advocating for this and other issues is clearly needed.

DDS directors also mentioned some unfinished construction promised by the Strengthen Project. This includes the kitchen to support the TBA training gazebo in Memba, and the completion of the kitchen, W.C. and the training gazebo in Nacala-Velha. However they were also quick to recognize the important aid provided by SC/US, supplying vehicles for example, and the supporting role in the partnership and training of personnel.

The main logistic challenges of the project are:

1. Purchasing and distribution of bicycle-ambulances to Memba, including all the necessary steps to guarantee compliance towards a local maintenance system.
2. The reactivation of the bicycle-ambulances in NaV and Southern Memba *regulados* might prove challenging since it is necessary to meet often with CLCS to reopen the issue of the agreement and the maintenance and, if the community assumes its responsibilities, to help with some of the repair costs.
3. The procurement and immediate supply of some or part of the equipment and material for the maternities, both in the districts and in the reference hospitals according to what was set in the DIP.
4. Systematically inform all TBAs and CLCS of the shift from the distribution of clean delivery kits to the education of mothers on clean delivery as a result of the consultants' appraisal.
5. Programming supervision visits with DDS in a way that enables them to continue the activities after the life of the project.

6. Keep and increase the number of Mobile Brigades to the field and coordinate in addition supervisory visits and meetings with CLCS.
7. Keep the vehicles in the districts and set up a maintenance budget to allow them a longer life. For now increasing the number of days vehicles work in the districts will allow increase in the number of Mobile Brigades and support beginning of supervisory visits.
8. Finish all construction that was promised in the beginning of the project.

## III. Recommendations

These recommendations are a summary of the recommendations indicated in each area.

1. Program Management:
    - Adjust job descriptions to new tasks, for example project manager have to travel to the districts often, DDS directors need to take in leadership and not act as the receiving end only.
    - Expedite hiring of manager and coordinator
    - Revise DIP work plan to make sure that strategies and activities are followed as set in the beginning of the project.
    - Finish the Plan of Action in a larger workshop with DDS directors and their technical teams. Discuss in detail the allocation of resources, especially the ones coming from DDS, and responsibilities.
    - Implement immediately monthly meetings in each of the districts with the technical team. These meetings should be working meetings, so protocol is left out. DDS directors should lead the meetings and SC staff act as counselor and mentor. In preparation to the meeting some ground work might need to be done in order to enable directors to lead. Adding on to his comments, correct view-points, stimulate problem solving, not taking laxity and accommodation are some recommended strategies.
    - Shadow directors in final evaluation, so they take a leading role
    - Discuss with all stakeholders the exit strategy of the project, so SP activities are phased out but not over. DDS directors and staff should gradually TAKE OVER all the activities and leadership.
    - Stress the implementation of supervision visits from DDS to HCs and CLCS.

2. Staff Supervision:
    - Supervision should be the main activity for the remainder of the project, to allow follow-up of personnel trained during the first half of the project. Supervision should underscore on-the-job training and formative characteristics.
    - Set up a workshop to rapidly provide staff and DDS trainers and others with supervisory skills, according to what is delineated in the Plan of Action. The outcomes of such workshop are: 1) a checklist directed to all components and cadres to be supervised, 2) a real supervision plan with places, dates, use of resources,

and responsibilities. Such plan can be periodically self-repeated. Include Logistics (SC and district) as part of the plan elaboration.

3. Logistics:
   - Help DDS to re-plan the Mobile Brigades to increase total number of times, to achieve 5 times to same community, to become more regular, to arrive early, and to find coordination with Monthly Health Days and supervision and supply activities. Invite other holders of resources to join in efforts. Include Logistics (SC and district) as part of the plan elaboration.
   - Discuss wit *regulos* closer to HCs taking their community to the HC, so Mobile Brigade can cover distant areas with no HCs.
   - Improve purchasing procedures for bicycle-ambulances in Memba, and reactivation of A&T system in NaV.
   - Expedite purchasing procedures for material and equipment destined to maternities and reference hospitals.
   - Reactivate allocation of two-way radios to districts.
   - Improve vehicle maintenance procedures to allow increase of supervisory and Mobile Brigade activities
   - Finish all construction activities undertaken in the beginning of the project

4. Training:
   - Training of TBAs in Lurio, making sure that they will be supplied for a period equivalent to the rainy season and visited as soon as roads are transitable again every year.
   - Refresher trainings of APEs of more distant areas, such as Lurio, Mezope and others.
   - Training of DDS and SC staff in basic Management, data management, resources management and basic epidemiology and statistics, in a practical way based on the data and resources of the districts (for example Memba data practical analysis example in appendix XI).
   - Quick set up and computer training for selected members in each district (director, NEP, statisticians, SMI responsible).

5. Capacity Building:
   - Dissemination of LQAS and MTE results to DDS, DPS, HC and CLCS, as these places are being visited. Adjust the reporting to each audience, stressing on the key points.
   - Present LQAS and MTE results and Action Plan to *Conselho Coordenador de Saude* de of Nampula Province.

- Exchange and review BCC materials and messages with SC Gaza Project and other experts in this matter.
- With DPS and DDS acquire, produce and distribute IEC materials to all levels of the community and health system.
- Expand FP education and demonstration to *Tecnico de Saude* in all health facilities and to all members of CLCS.
- Spread the positive experience of the nurse in Geba HC, who successfully attempted to link the triangle of HC, community and DDS. The community needs to know his every day heroes.
- Share the positive story of how a TH saved a child's life by promptly referring her .
- Share lessons learned and experience with SC in Gaza on CBD contra-conceptive pills.
- Discuss with DPS the feasibility of a pilot study of CBD FP methods in a far-way community.
- Discuss with DPS the feasibility of a pilot study of Imunization practices by APEs, drawing on the experience of other African countries. Such strategies might greatly improve immunization coverage in distant and inaccessible areas.
- Dialogue with GEMT to improve THs procedures on the referral of sick children and women
- Strongly advocate for the districts to keep the vehicles in the districts. Use statistical data to prove the point (immunization and CPN coverage, supervision coverage activities, number of contacts with CLCS and problems solved due to those contacts.

## IV. Results Highlight

The Strength Project in the impoverished districts of Nacala-Velha and Memba, in Nampula province, northern Mozambique, has set to contribute to: (1) sustainably reduce MMR, and U5MR; (2) sustainably improve the capability of DHOs and communities to respond to health needs; and (3) develop innovative approaches to inform policy and practices of SC and other partners. The main strategies are: (1) Partnership and Institutional Development for District Health System Strengthening through a **Program Management Team (PMT**) to enhance SC-DHO partnership for program planning, monitoring and evaluation, capacity-building and sustainability of program activities, and (2) Strengthening community component of maternal and child health through support for **Community Health Teams (CHTs)** that would monitor and support the activities of community health workers in the *Regulados*.

The institutional capacity building approach is not novel in Mozambique and many attempts have been tried at national, provincial and lately district level with somewhat uncertain results. However, **capacity building at the community level** is unique in Mozambique and Nacala-Velha and Memba are the pilot districts. In here, 46 *regulados*, geographic and traditional authority areas, were identified, with a beneficiary population of 134,229 reproductive age women and children under five. Contacts were made with the *regulo* and his advisor, the apiamwene, to create a CHT that includes respectable members of the community such as traditional healers, traditional birth attendants, religious leaders, teachers, health activists and mothers. These 46 CHTs, totaling a total of 332 people with balanced gender participation, have received training to provide the communities with the tools and skills they need to promote their own ongoing development, including leadership, organizational skills, health education, behavior and information. CHT have been active since and are well on their way to effectively discuss and solve their health problems. As it was stated by the staff “they see change happening”. A spillover of this democratic approach is empowerment of women. Women now speak in public when before they would not dare, limiting themselves to silent listening during *palestras* or health talks. Now they are active, ask more questions and have started demanding services from the district health authorities especially for more traditional birth attendants and more FP services. They also attend more preventative services than before. The understanding of the causes of disease is also gaining new levels, moving more and more away from supernatural to controllable causation.

Being able to communicate with Traditional Healers or *curandeiros*, the icons of traditional health care has been another highlight of the project. THs are very well regarded in the community and sometimes are the first to be contacted in case of disease. Their practices apparently improved in terms of sterilization techniques and referral services, after training as members of CHTs. A *curandeiro* approached the evaluation team and told us that a seriously ill patient

he had referred promptly to a health care facility with rapid and difficult breathing recovered after modern treatment. Upon return to the *regulado* the mother went up to him and expressed her gratitude for having saved her child. His status was kept, a child is alive. He was very proud of it.

## V. Action Plan

The methodology used to elaborate the Action plan is described in the MTE Assessment Methodology (Appendix 5).

DDS directors and DPS representatives were invited to participate in the activities from the beginning of the evaluation. Both appointed somebody else and excused themselves due to being involved in local and provincial government activities, followed by preparation of the Provincial Health Coordination Counsel. NaV representative, the District Administrator, had participated before in EGPs and had a better understanding of the project. Memba representative was a curative nurse, *Tecnico Medio de Saude*, who did not know about the project. DPS representative, a member of the Provincial SMI, had not participated before either in any of the project joint activities and could only stay for one day of the nine working days of the evaluation.

It is worth mentioning that DDS directors took this evaluation as a SC activity. A better approach to capacity building might have been allowing them to substitute the project absent leadership, and to take active roles instead of letting them assume an observer role. They think they are expected to only "join" in. This approach can be surely tried in the final evaluation. Application of BCC strategies targeting communities and health workers should also be tried with DDS directors and other decision-maker levels.

Given the above, the Action Plan MUST be completed using the same methodology of the MTE, with the participation of District Directors and their teams, including the administrator, the responsible for statistical information (NEP), the responsible for Community Health (either EPI, SMI or both), the responsible for the district budget, and other local partners such as MS. This is to ensure that the final Action Plan is their own, and not one made for them, and the availability of necessary and existing resources is better analyzed and planned. The Action Plan must not only express the activities needed to achieve the expected results at the end of the project but should be seen as another valuable chance to transfer capacity building and ensure sustainability.

This Action Plan section includes:
- An analysis of the quantitative results of LQAS, seen in Appendex 15,

- The Preliminary Action Plan. The plan was developed by using a modification of the Logic Framework where the CHALLENGES were the basis to brainstorm appropriate solutions and develop a set of activities leading to solve the challenges. (Appendix 14)

The final action plan developed by SC and the MOH will be translated into English and submitted to USAID.

# APPENDIX 1A

## Child Survival Grants Program Project Summary

*The Strength Project*
*DIP Submission: Apr-16, 2001*
*SC Mozambique*

*Field Contact Information:*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*Project Information:*

| | |
|---|---|
| **Project Description:** | The Save the Children Federation/USA (SC)STRENGTH project is in Nacala-a-Vehla and Memba Districts, in northern Mozambique. These are two of the most poor and inaccessible districts in Mozambique with an official population of 286,814 including a CS16 beneficiary population of 134,229 (including 47,324 children 0-59 months, 21,511 births, and 65,394 women of reproductive age). The under five mortality rate of 315/1000 is almost 50% higher than the national average of 219/1000. The project responds to the needs and priorities of constituent communities, Ministry of Health and USAID/Mozambique; all seek reduced under five and maternal mortality and morbidity through a strengthened health system. Between July 2000 and March 2001 baseline studies were conducted in preparation for detailed implementation planning. In February, 2001 a five day project planning meeting was held with district and provincial health office representatives, community leaders, and SC technical staff Project. The DHOs are the main implementers of the project interventions; the role of SC/US is capacity building, technical assistance, management support, and fiduciary responsibility. Major interventions support the MOH's district-level essential health package and include: Immunization (15%), Control of Malaria (15%), Pneumonia Case Management (15%), Control of Diarrheal Disease (10%), Maternal and Newborn Care (30%), and Child Spacing (15%). All interventions are consistent with MOH policy. The ultimate goals are to: (1) sustainably reduce MMR, and U5MR; (2) sustainably improve the capability of DHOs and communities to respond to their health needs; and (3) |

| | |
|---|---|
| | develop innovative approaches to inform policy and practices of SC and other development partners. The two major implementation strategies for each of the districts are: (1) Partnership and Institutional Development for District Health System Strengthening through: · Program Management Team (PMT) to enhance SC-DHO partnership for program planning, monitoring and evaluation, capacity-building and sustainability of program activities. · Support of additional staff for DHO to address the constraint of inadequate nursing staff in the two districts. The Nampula Province and SC will recruit three MCH nurses for Nacala-a-Velha and three nurses for Memba. The salaries of these nurses will be supported by the Strength Project for the first two years of the program. The Nampula Province PHO will take over the salary payment in the third year. The MCH nurses are essential for increasing the number of mobile brigades outreach conducted in a month, especially in terms of prenatal care and family planning services. · Upgrade emergency obstetric health facilities and services. The two CS-16 districts do not have a comprehensive emergency obstetric care (CEOC) facility. Women needing CEOC services are referred to the neighboring districts of Monapo and Nacala Porto. CS-16 will work with Monapo and Nacala Porto DHOs and hospital Directors to streamline the referral systems, as well as upgrade the maternity wing of their hospitals. (2) Strengthening community component of maternal and child health through: · Support for Community Health Teams (CHTs) that would monitor and support the activities of community health workers in the Regulados. · Support of outreach services by Mobile Brigades. · Facilitation of community Alarm and transport (A&T) · Provision of bicycle ambulances as part of A&T · Production and promotion of clean birth kits. · Training of community-based providers (APEs and socorristas) · Training of Activistas and TBAs · Training and dialogue with traditional healers · Support of Community mobilization for responsive and appropriate behavior change communication (BCC) for caregivers, community leaders, and male and female decision makers. |
| **Partners:** | SC will collaborate with other NGOs working in the area including the People to People Development Association (ADPP), Grupo Africano de Suecia (GAS), and AMETRAMO the professional organization of traditional healers who will provide expertise in training with traditional healers. SC will work most closely with its current partners, the District Health Offices, in close collaboration with the Provincial Health Office and the communities. |
| **Project Location:** | SC will work in all communities of Nacala-a-Velha and Memba Districts as well as the referral hospitals in Nacala Porto and Monapo. |

*Grant Funding Information:*

| | | | |
|---|---|---|---|
| **USAID Funding:(US $)** | $ 700,000 | **PVO match:(US $)** | $ 233,000 |

*General Strategies Planned:*
Private Sector Involvement
Advocacy on Health Policy
Strengthen Decentralized Health System
*M&E Assessment Strategies:*
KPC Survey
Health Facility Assessment
Organizational Capacity Assessment with Local Partners
Organizational Capacity Assessment for your own PVO
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
*Capacity Building Targets Planned:*

| PVO | Non-Govt Partners | Other Private Sector | Govt | Community |
|---|---|---|---|---|
| US HQ (CS unit)<br>CS Project Team | (None Selected) | Traditional Healers | Dist. Health System<br>Health Facility Staff | Other CBOs<br>CHWs |

*Interventions:*

| |
|---|
| **Immunization** 15 **%** |
| ** IMCI Integration |
| ** HF Training |
| *** Classic 6 Vaccines |
| *** Vitamin A |
| *** Surveillance |
| *** Cold Chain Strengthening |
| *** Injection Safety |
| **Acute Respiratory Infection** 15 **%** |
| ** IMCI Integration |
| ** CHW Training |
| ** HF Training |
| *** Pneumonia Case Management |
| *** Case Mngmnt./Counseling |
| *** Recognition of ARI Danger Signs |
| **Control of Diarrheal Diseases** 10 **%** |
| ** IMCI Integration |
| ** CHW Training |

| |
|---|
| ** HF Training |
| *** Water/Sanitation |
| *** Hand Washing |
| *** ORS/Home Fluids |
| *** Feeding/Breastfeeding |
| *** Care Seeking |
| *** Case Mngmnt./Counseling |
| **Malaria** 15 **%** |
| ** IMCI Integration |
| ** CHW Training |
| ** HF Training |
| *** Training in Malaria CM |
| *** Adequate Supply of Malarial Drug |
| *** Access to providers and drugs |
| *** Antenatal Prevention/Treatment |
| *** ITN (Bednets) |
| *** Care Seeking, Recognition, Compliance |
| **Maternal & Newborn Care** 30 **%** |
| ** IMCI Integration |
| ** CHW Training |
| ** HF Training |
| *** Emergency Obstetrical Care |
| *** Neonatal Tetanus |
| *** Recognition of Danger signs |
| *** Newborn Care |
| *** Postpartum Care |
| *** Delay 1st preg./Child Spacing |
| *** Integration with Iron/Folate |
| *** Normal Delivery Care |
| *** Birth Plans |
| *** STI Treatment w/Antenat. Visit |
| **Child Spacing** 15 **%** |
| ** CHW Training |
| ** HF Training |
| *** Child Spacing Promotion |
| *** Pre/Post Natal Services Integration |

*Target Beneficiaries:*

| Type | Number |
|---|---|
| **infants (0-11 months):** | 7,170 |
| **12-23 month old children:** | 10,038 |
| **24-59 month old children:** | 30,116 |
| **0-59 month old children:** | 47,324 |

| | |
|---|---|
| **Women 15-49:** | 65,394 |
| **Estimated Number of Births:** | 21,511 |

*Beneficiary Residence:*

| Urban/Peri-Urban % | Rural % |
|---|---|
| 25% | 75% |

# APPENDIX 1B

**Table 1.8 Training Plan**

| Trainees | Number of Trainees; Type(s) of training | # days | Trainer |
|---|---|---|---|
| Traditional Healers | 60 -- 20-NaVelha; 40-Memba<br>All TH trainings in groups of 20 people, carried out by district: | | |
| | • Diarrhea and ARI management/referral; diarrhea prevention; EPI. | 3 | SC/DHO |
| | • EPI Mobilization and IEC techniques. | 1 | SC/DHO |
| | • Pregnancy-related danger signs; referral of women with obstructed labor to HF; early/ exclusive BF promotion. | | |
| CHTs | 49 -- 14-NaVelha; 35-Memba<br>Each CHT has approximately 10 members; 3 members from each CHT attend trainings.<br>Seven CHTs (21 people) per training | | |
| | • Community HIS; diarrhea prevention; BCC; diarrhea/ARI/malaria recognition and case management (HAF, care-seeking behavior, especially for danger signs); promotion of early BF; discouragement of useless activities such as “malaria control through brush abatement”, use of talks, theater and songs. | 5 | SC/DHO |
| | • ANC mobilization; appropriate behavior for birth/postpartum; promotion of individual birth plans and community alarm and transport plans. Theater on danger signs. | 5 | SC/DHO |
| | • Exclusive BF promotion; reinforce HIS. | 1 | SC/DHO |
| | • Community mobilization; developing care-seeking and transport plans for pregnant women (more detail than first A&T). | 1 | SC/DHO |
| | • Community mobilization/IEC/counseling for child spacing (drama, song). | 1 | SC/DHO |
| | • Environmental health BCC (drama). | 1 | SC/DHO |
| APEs/ *Socorristas* | 28 -- 14-NaVelha; 14-Memba | | |
| | • IEC. | 2 | SC/DHO |
| | • Pneumonia and malaria DX/referral. Diarrhea case management (ORT/HAF, referral), prevention; counseling techniques based on GATHER; how to use simplified | 8 | IMCI trainers |

| Trainees | Number of Trainees; Type(s) of training | # days | Trainer |
|---|---|---|---|
| | IMCI flowcharts | | |
| TBAs | 77 new – 36-NaVelha; 37-Memba<br>To receive refresher training as well (see below)<br>MOH curriculum (21 days) +<br>• Recognition of diarrhea, dehydration and dysentery; use of ORT/HAF; recognition of danger signs; promotion of early/exclusive BF; promotion of birth plans and birth kits. | 25 | TBA trainers (SC/DHO) |
| | 75 current – 35-NaVelha; 40-Memba<br>These plus the 88 new to be refresher trained, as explained below.<br>MOH curriculum (10 days) +<br>• Promotion of birth plans/ birth kits; FP counseling techniques.<br>• Community mobilization/IEC for EPI/Mobile Brigades.<br>• Malaria case management (recognition and referral).<br>• IEC/counseling skills for malaria/diarrhea prevention; malaria/diarrhea/pneumonia case management. | 12<br><br>1<br>1<br>1 | TBA trainers (SC/DHO)<br><br>TBA trainers (SC/DHO)<br>TBA trainers (SC/DHO)<br>TBA trainers (SC/DHO) |
| SC Lead Trainer | Curriculum development (in-service) | 15 | Gaza consultant |
| SC staff | 10, including candidates for SC openings<br>• TOT-community modules, how to prepare dramas, songs. | 10 | Lead Trainer; Gaza consultant |
| PMT | PMT composed of 1 PHO representative, 4 DHO directors, 2 hospital directors (Nacala Porto and Monapo), SC program manager and SC project coordinator. Meets quarterly for several days.<br>• Use of HIS and data collection for planning.<br>• Logistics related to how to improve supply of drug kits to APEs. | 1 | Program manager Project coordinator, PHO |
| DHO Supervisors | 20 -- 10 Nacala-a-Velha, 10 Memba<br>• Monitoring and support-a-vision (repeated | 1 | Project |

| Trainees | Number of Trainees; Type(s) of training | # days | Trainer |
|---|---|---|---|
| | several times). | | coordinator, PHO |
| DHO Mobile brigade Members | 20- Nacala-a-Velha 10; Memba 10 | | |
| | • Strengthen logistical and resource management; cold chain; infection control; prenatal/postpartum care; IEC training . | 3 | Lead Trainer, PHO |
| | • Environmental health; how to do theater. | 3 | District trainers |
| DHO Maternity ward staff | 10 MCH nurses or elementary midwives; all four districts. | | |
| | • BCC for TT coverage, supervision of TBAs linked to US; pre / post natal counseling and care; promotion of early and exclusive BF (inc colostrums). | 3 | Lead Trainer, PHO |
| | • FP – enhance knowledge and counseling skills. | 3 | Lead Trainer, PHO |
| | • Swift appropriate care-seeking behavior especially for MNC danger signs; supervision and support of quality obstetric care, inc. life saving skills. | 3 | Lead Trainer, PHO |
| DHO Administration | 10 facility leaders/administration/pharmacists | | |
| | • Strengthen logistical and resource management; supplies and equipment maintenance; emphasis on contraceptives and vaccines. | 3 | Lead Trainer, PHO |
| DHO TBA Trainers | 12 – 3 from each district | | |
| | TOT | 25 | Lead Trainer, PHO |
| IMCI Trainers | 6 – Nacala-a-Velha 3; Memba 3<br>• IMCI basic training; TOT | 22 | Assistant coordinator, PHO |
| DHO staff | 40 – Nacala-a-Velha 20; Memba 20<br>• IMCI protocol | 11 | IMCI trainers |

# APPENDIX 1C

**Technical Assistance Plan**

**Table 2.3 Technical Assistance Plan**

| Type of Technical Assistance | Consultant | When |
|---|---|---|
| KPC 2000 Survey | Jorge Bardalez, Sylvi Hill | December 2000 - February 2001 |
| Health Facility Assessment | Sylvi Hill | February – March 2001 |
| Rapid Rural Appraisal | Sylvi Hill | January - February 2001 |
| Detailed Implementation Plan | Eric Swedberg; Joseph de Graft-Johnson | February-March 2001 |
| Development of IMCI training manuals | JSI | As soon as prepared -- November 2001 |
| Development of IMCI supervisory checklist | JSI | As soon as prepared -- November 2001 |
| Development of IMCI BCC materials | JSI | As soon as prepared -- November 2001 |
| Curricula Development | Intern, SC/Gaza staff | March, June-July 2001 |
| Production of Clean Birth Kits | Joseph de Graft-Johnson | October-November 2001 |
| Marketing of Birth Kits | Suzanne Smith, SC | December 2001 |
| Lot Quality Assurance Sampling | Joseph de Graft-Johnson | April 2002 |
| Midterm Evaluation | Eric Swedberg | April 2002 |
| Final Evaluation | Eric Swedberg; Joseph de Graft-Johnson | August 2003 |

# APPENDIX 1D

**Table 2.1 Human Resources for Project Activities**

| Worker type | Agency | P/V | Duties | Time in CS (FTE) |
|---|---|---|---|---|
| Field Office Director | SC | P | Overall guidance, strategic review, USAID and donor relations | .15 |
| Deputy Field Office Director | SC | P | Oversight of administrative management | .10 |
| Finance Manager | SC | P | Fiscal oversight and financial reporting | .05 |
| Program Manager | SC | P | Oversees program implementation and management, technical content of training; supervises project coordinator, Lead Trainer and data officer; links with other sectors; relates with partners on the provincial level; and prepares documents. | .25 |
| Project Coordinator (to be hired) | SC | P | Oversees day-to-day program implementation and management, develops and assures implementation of HIS, supervises Lead Trainer and data officer; relates with partners. | 1.0 |
| Lead Trainer | SC | P | Prepares plan for all trainings; uses existing curricula or writes new curricula; prepares supervision schema for each group of trainees; supervises training teams with the DHO with emphasis on the technical quality of training; and liaises with DHO to develop supervisory capacity regarding training. | 1.0 |
| District trainers (2) | SC | P | TOT/ supervision of DHO staff to train TBAs/TH/ CHT. | 2.00 |
| Monitoring and Evaluation specialist | SC | P | Responsible for HIS data collection, data entry, analysis and documentation; training community members to use data collection system | 1.0 |
| Driver (2) | SC | P | Drive DHO and SC staff to field | 2.0 |

| Worker type | Agency | P/V | Duties | Time in CS (FTE) |
|---|---|---|---|---|
| | | | for Mobile Brigades, supervision and other field activities | |
| MCH nurses (10) | DHO (6 paid by SC) | P | Prepares and implements TBA/TH/ CHT training using prepared curriculum; supervises TBAs/TH/ CHTs using prepared form. Antenatal/ postpartum care in Mobile Brigades. | 10.0 |
| DHO supervisors (20) | DHO | P | Provide “support-a-vision to staff”; to be trained by project | 10.0 |
| DHO Directors (4) | DHO | P | Provide leadership and supervision | 2.0 |

# APPENDIX 2

**Table 1: CS-16 Progress Towards Achieving End-of-Program Objectives**

| # | End-of-Program Objectives/Indicators | Baseline | Mid-term |
|---|---|---|---|
| 1 | 55% of children 12-23 months will be fully immunized by age 12 months baseline. | N-32% M-34% | N-11% M-13% T-12% |
| 2 | 80% of mothers with children < 24 months with fever in previous 2 weeks sought care within 48 hours | N-57% M-66% | N-30% M-34% T-32% |
| 3 | 85% of mothers with children < 24 months with cough and difficult/rapid breathing in previous 2 weeks sought care within 48 hours | N-64% M-73% | N-54% M-67% T-61% |
| 4 | 80% of mothers with children < 24 months with diarrhea in previous two weeks who managed the diarrhea with ORT (ORS or community-based oral rehydration fluids such as watery porridge) | N-66% M-67% | N-67% M-62% T-64% |
| 5 | Percent of women with children < 24 months who reported knowing at least two ways of preventing diarrhea | N/A | N-56% M-50% T-53% |
| 6 | Percent of women with children < 24 months who reported knowing 2 IMCI danger signs | N/A | N-86% M-73% T-79% |
| 7 | 50% of births attended by trained personnel | N-34% M-38% | N-51% M-28% T-39% |
| 8 | 85% of women have at least two antenatal visits with trained health personnel during their last pregancy | N-77% M-74% | N-74% M-55% T-64% |
| 9 | 80% of women with children < 24 months will have received at least 2 doses of tetanus toxoid during their last pregnancy | N-30% M-62% | N-74% M-42% T-57% |
| 10 | 80% of women with children < 24 months wiill know at least 3 pregnancy-related danger signs | N-18% M-44% | N-95% M-57% T-75% |
| 11 | 10% of women will have had a birthplan (3 of 5 components) during their last pregnancy. | N-0% M-0% | N-2% M-5% T-3% |
| 12 | 25% of women with children <24 months who do not wish to have another child in the next two years will be using a modern method of contraception | N-18% M-15% | N-18% M-12% T-15% |
| 13 | 50% of women with children <24 months will know at least two modern methods for childspacing | N-24% M-37% | N-28% M-23% T-25% |
| 14 | Percent of women with children < 24 months who reported giving colostrum to their children | N/A | N-79% M-70% T-74% |
| 15 | Percent of women with children < 24 months who reported initiating breastfeeding for their last child within 8 hours of birth | N/A | N-86% M-75% T-80% |
| 16 | Percent of women with children <= 6 months who reported giving their children only breastmilk | N/A | N-30% M-43% T-37% |

| | | | | | APPENDIX 3 | |
|---|---|---|---|---|---|---|
| **Mobile Brigade Sites of Operation for January-June 2002** | | | | | | |
| ***Nacala Velha*** | | | | | | |
| **Regulado/community** | **1st visit** | **2nd visit** | | | | |
| Jangane | 20-Mar | | | | | |
| Micolene | 21-Mar | | | | | |
| Motia | 25-Mar | | | | | |
| Muepane | 26-Mar | | | | | |
| Mutepane | 27-Mar | | | | | |
| ? | 14-May | | | | | |
| Mangani | 28-May | | | | | |
| Muetarzi | 29-May | | | | | |
| Napala | 30-May | | | | | |
| Nahipa | 4-Jun | | | | | |
| GerGer | 6-Jun | | | | | |
| Nacololo | 11-Jun | | | | | |
| Mepuhula | 12-Jun | | | | | |
| Marremano | 13-Jun | | | | | |
| Nantar | 18-Jun | | | | | |
| Jamarupe | 19-Jun | | | | | |
| Merunguze | 20-Jun | | | | | |
| Rassine | 26-Jun | | | | | |
| Namalala | 27-Jun | | | | | |
| | | | | | | |
| ***Memba*** | | | | | | |
| Mazua | 13-Mar | | | | | |
| Tropene | 3-Apr | | | | | |
| Ecopo | 16-Apr | | | | | |
| Simuria | 18-Apr | | | | | |
| Mazua-Sede | 23-Apr | | | | | |
| Cava | 25-Apr | 10-Jun | | | | |
| Muipia | 29-Apr | 13-Jun | | | | |
| Napila | 30-Apr | 18-Jun | | | | |
| Metupa | 4-Jun | | | | | |
| Nhaje | 6-Jun | | | | | |
| Caleia | 11-Jun | | | | | |
| Miroge | 20-Jun | | | | | |
| Baixo Pinda | 26-Jun | | | | | |
| Mangane | 27-Jun | | | | | |

# APPENDIX 4

## SC STAFF TRAINING

| Name/post | Background training | Short-term and on-the-job training |
|---|---|---|
| Adelia<br>Lead trainer | -3 years of SMI training<br>-10 years of experience as SMI responsible in Xai-Xai<br>-Advanced course in TOT 1997<br>-TOT for *activistas* | -Computing<br>-Programming<br>-Curricula elaboration<br>-Community auscultation of social problems |
| Adelina<br>Trainer<br>(recent hire) | -2 years of training as an Elementary nurse<br>-6 months of First Aid training | -TOT for CLCS training<br>-Clean delivery |
| Maria<br>M&E specialist | -3 months of Accounting training<br>-TOT for *activistas* | -Computing<br>-Clean delivery<br>-Curricula elaboration<br>-Nutrition and Vit A supply<br>-Community auscultation of social problems |
| Cristina<br>Trainer | -3 years of SMI training | -Computing<br>-Curricula elaboration<br>-TOT for CLCS training<br>-Reproductive Health |
| Florinda<br>Trainer | -3 years of SMI training<br>-1 year experience in NGO<br>-TOT for TBAs<br>-TOT for *activistas* | -Community auscultation of social problems<br>-Computing (incomplete)<br>-Curricula elaboration<br>-TOT for CLCS training<br>-Essential Obstetric Care<br>-Motorbike drivers ed<br>-TOT for Theater Training |

# APPENDIX 5

PROJECTO FORÇA
PROJECTO CONJUNTO DO
SAVE THE CHILDREN COM OS DISTRITOS DE
MEMBA E NACALA VELHA

AVALIAÇAO DE MEIO-TERMO DO PROJECTO

## METODOLOGIA DA AVALIACAO

A. Caracteristicas que norteiam o projecto
   1. **Trabalho de grupo**
   2. **Interactivo e participativo**
   3. **Formativo (reforcar a capacitacao, sustentatibilidade)**

B. Composicao da Equipa de Avaliacao

Externos:
1. Ana Paula MD, MPH;
2. Eric Swedberg MPH;
3. Joseph de Graft-Johnson MD, DrPH

Internos: Tecnicos de Saude:
1. Amilton L Alberto -DDS Memba,
2. Alexandre Agostinho -DDS Nacala Velha ;
3. Maria Adelia
4. Cristina Cardoso
5. Florinda Francisco
6. Maria Manicuela
7. Adelina Xavier

Apoio:
1. Ana Paula Cortez –tradutora
2. Izidine Omar -tradutor
3. 2 Motoristas
4. M. Lucia Alexandre- secretaria;
5. Jolly Muxahua- Logistica;
6. Fatima e Saraiva -servicos

C. Objectivos da Avaliacao
   1. **Avaliar a meia-vida do projecto**
   2. **Verificar os indicacoes e metas do projecto e resultados esperados nesta altura – LQAS (quantitativo)**
   3. **Avaliar a utilizacao das estrategias definidas e as mudancas esperadas no comportamento-questionairo qualitativo**
   4. **Redireccionar o projecto se necessario**
   5. **Elaborar e apresentar plano de accao preliminar - Este devera ser completado o mais rapido possivel**

D. Metodo de trabalho

1. Analise conjunta do LQAS e relatorios dos distritos
2. Elaboracao de questionarios appopriados: CLCSs, Maes, PT, Curandeiros, Activistas, Trabalhadores de Saude
3. Seleccao de amostra: 6 regulados em um total de 46, 1 regulado/PA: Olaika, Morrola, Mebile, Epuite em Memba e Mezope e Rojola em Nacala Velha
4. 2 equipas: 5 elementos para NV e 6 elementos para Memba.
   Lider do grupo – entrevista aos directors e DDS juntando-se mais tarde ao trabalho de grupo
5. 1 dia de trabalho na comunidade em cada regulado – Notas escritas de todos os questionarios

E. **Analise dos dados**

1. **Trabalho grupo e plenaria - analise dos dados dos inqueritos aos regulados, identificando os aspectos positivos e desafios**
2. **Sessao plenaria para identificacao conjunta das solucoes apropriadas aos recursos existentes**
3. **Sessao plenaria para elaboracao de plano de accao preliminar dirigido a ultrapassar os desafios encontrados**
4. **Apresentacao publica dos resultados**

## APPENDIX 7

## Qualitative Questionnaire

### QUESTIONÁRIOS PARA O CLCs

1. As CLCs  tem tido encontros regulares?
2. Quantas vezes as CLCs se reuniu durante o último ano?
3. O que trataram neste(s) encontro(s)?
4. Qual o Plano de trabalho que vocês tem? Que é que já fizeram?
5. Que problemas encontraram?
6. Como fazem o registo de informação de Saúde Comunidade?
7. Qual o propósito de fazer o registo?
8. Qual é a relação existente entre as DDS e as CLCs?
9. Contar as mulheres do CLCS (perguntar se falta algum membro). Contar todas as pessoas presentes do CLCS
10. Qual é o papel / responsabilidade de cada membro?
11. Qual e o conselho que o CLCS dá para as mulheres gravidas?
12. O que que CLCS faz (ou pode fazer) para aumentar os partos assistidos por pessoal treinado?
13. O que é que os CLCs recomendam a uma mulher grávida no sentido de preparar o seu Plano de parto?
14. Por acaso tem um sistema de ALARME e TRANSPORTE para as gravidas? Perguntar se ainda existe as Bicicletas? Como é que se comunicam entre o doente e o responsável de transporte? Como é que os CLCs fazem para sustentar o seu transporte e continuar a utilizar?
15. O que é que os CLCs fazem para que as mamas conheçam os metódos do P.F?
16. Que fazem para aumentar as crianças vacinadas?
17. Quando foi a última  vez que tiveram brigada móvel -  BM?

18. Como tem sido a participação dos membros da CLCS?

## QUESTIONÁRIO PARA AS MÃES

### PARTO E PRE-NATAL

1. Perguntar as mães sobre o que preparam para o seu parto?
2. Porque não chamam a PT para assistir o parto?
3. O que podem fazer para aumentar a utilização das PT?
4. Já ouviu a falar-se dum sistema de alarme e transporte?
5. Tem benefíciado do sistema de alarme e transporte da sua comunidade?
6. Como são atendidas nas consultas Pré-Natais?
7. Já ouviram falar de PF? Que metódos ouviram falar? Porque não usam?
8. Quem e que vos falou dos metódos?
9. O que é que a comunidade pensa acerca do PF?
10. Qual é o intervalo apropriado entre os nascimentos?
11. O que pode ser feito para o aumentar o uso de PF?

### DIARREIA:

1.1 .O que você faz em casa quando a sua criança apanha diarreia? Onde apanha o SRO?

1.2 . Como e que se pode prevenir a diarreia?

1.3 . Quando é que leva a sua criança imediatamente para P.S. / Centro de Saúde? (Quais são os sinais graves da diarreia?)

1.4 . O que não se deve dar quando a criança está com diarreia?

**IRA/PN**

2.1. Como reconhecem os sinais de IRA?

2.2. O que se faz quando a sua criança tem doença respiratórias?

2.3. Quando é que leva imediatamente ao P.S. / Centro de Saúde?

2.4. Como trata as doenças respiratórias em casa? O que não deve dar a criança doente de IRA?

2.5. Onde apanha o tratamento?

2.6. Quais são os sinais graves da penumonia (IRA)?

**FEBRE:**

3.1 O que faz quando a sua criança tem febre?

3.2 Quais os sinais e Sintomas da Malária na criança?

3.3 Como se transmite a Malária?

3.4 Como se pode prevenir a malaria?

3.5 O que fazer quando a criança tem febres altas? ( corpo muito quente )?

**VACINAÇÃO:**

4.1 Para que serve a vacina?

4.2 Quantas vezes levou a sua criança a Vacinação?

4.3 O que acontece quando a criança não apanha vacina?

**MUDANÇA DE COMPORTAMENTO**

5.1 Nós ouvimos que há mães que levam as suas crianças doentes com febre ao hospital mas outras não. Porque as outras mães não levam ao os filhos com febre ao hospital?

5.2 Nós ouvimos que outras mães não levam a sua criança a vacinação, Porque?

5.3 Muitas mães quando a criança de febre porque não levam logo ao hospital? Porque?

5.4 Muitas mães quando a criança tem doença respiratória porque não levam imediatamente ao Hospital?

5.5 Ouvimos dizer que quando as crianças tem diarreia, muitas mães não dão água, comida, mama etc.? Porque?

5.6 Quando foi ultima vez que mãe ouviu falar sobre Saúde?

5.7 Que assunto se falou?

5.8 Quem e que falou e que forma (método) e que usou

**QUESTIONARIO PARA CURANDEIROS**

1. Quais as doenças em mulheres e crianças que acha que tem de transferir para as unidades sanitárias? Que sinais?
2. Qual o material que utiliza para vacinar os doentes?
3. Por exemplo: uma lâmina que serve para vacinar quantas pessoas?
4. Como limpa o material de vacinar ? e que mais ?
5. Como faz quando recebe criança com diarreia?
6. E se for criança com dificuldade de respirar?

**QUESTIONARIO PARA PARTEIRAS TRADICIONAIS**

1. Quantos partos assistiu no mes passado?
2. Destes quantos partos foram complicados?
3. O que fez nesses casos?

4. Que dificuldados encontra no trabalho do dia a dia?

5. Qual e a sua relacao de trabalho  com a Parteira Elementar?

6. Como laqueiam o cordao?

7. Onde arranjam material para o corte do cordao?

8. Quando decide levar uma mulher gravida ao hospital?

9. Quando decide levar uma mulher em parto para o hospital?

10. Quando decide levar uma mulher pos-parto para o hospital?

11. Como ajuda a mulher que temproblema de parto a chegar ate ao hospital?

12. Tem ficha para registar:  nascimentos, mortes, etc…

13. O que fazem com os dados desse registo.

14. O que acontece na comunidade quando morre uma mulher de gravidez ou parto?

**QUESTIONARIOS PARA ACTIVISTAS**

1. Comprende o conceito de mudanca de comportamento?

2. Diga as menssagens chave da

    a. Malaria (fever);
    b. IRA
    c. Diarrhea

3. Que material utiliza para a educacao dos seus pacientes?

4. Recebeu treino sobre tecnicas de mobilizacao da comunidade?

5. Que maneira faz para aumentar a participacao dos participantes da palestras?

6. Qual e o seu calendario de trabalho em cada semana?

7. Em que dias faz as palestra visitas domiciliarias?

8. O que voce faz depois de receber treinamento da DDS e/ou SC?

9. Que informacao (dados) e' que voce regista? Onde regista? O que faz com esses dados?

10. Acha que o seu trabalho e' effectivo?

**QUESTIONARIO PARA OS TÉCNICO DE SAÚDE: SMI/CONSULTA DE CRIANÇAS**

1. Recebeu treino sobre AIDI

2. Quando recebeu a ultima supervisao sobre AIDI?

3. O treinamento ajudou a melhorar o seu trabalho? Como?

4. No mes passado quantos contactos teve com APE, PT, CLCS?

5. Porque muitas as mulheres que vao a consulta prenatal nao recebem VAT?

6. Porque que as vacinacoes estao tao baixas?

7. Porque as mulheres nao usam o PF

8. Que maneiras pode fazer para aumentar a numero de mulheres que usam PF?

9. Tem cloroquina? Para quanto tempo? Ultima rotura?

10. Tem antibioticos? Para quanto tempo? Ultima rotura

11. Tem soros IV? Para quanto tempo? Ultima rotura?

12. Quais sao os materiais que usa para a educacao e aconselhamento de pacientes para febre, IRA, diarrea, PF,e sinais de perigo da gravidez? Pode mostrar?

**QUESTIONARIOS PARA TRABALHADORES COMUNITÁRIOS DE SAÚDE:**
APE/SOCORRISTAS

1. Sabe sobre o sistema de Alarme e Transporte da comunidade?
2. Como e que envia doentes do PS para o Centro ou Hospital?
3. Como trata um caso de febre?
4. Que aprendeu durante o treinamento?
5. Que conselhos e que voce da a mae da crianca doente?
6. Que e que faz em caso de crianca com respiracao rapida?

**Questionario para EGP, DDS e SC Nacala Office sobre Capacitacao Institucional (distrito) e da Comunidade e Sustentabilidade do Projecto Forca**

**EGP**

1. Tem plano annual de trabalho com actividades, responsabilidades, recursos, calendario e avaliacao?
2. Os recursos sao usados apropriadamente? Observar o plano
3. Tem plano mensal de trabalho?
4. Podemos ver os relatorios das ultimas reunioes do EGD
5. Algum destes relatorios teve um impacto a nivel da provincia ou do distrito? Mudar a politica de saude ou certas actividades?
6. Os relatorios mostram o uso do HIS ou decisoes tomadas tomadas com base nesses dados?
7. Pedir dados estatisticos referentes aos indicadores do Projecto para comparacao
8. Plano de supervisao aos CLCS: visitas realizadas/visitas programadas
9. Fazem uso dos dados dos CLCS?
10. Apresentacoes por escrito ou oral das actividades a DPS (partilhar as licoes aprendidas)
11. O que fazer para manter o trabalho dos CLCS por muito tempo

**DDS e PAV**

1. Treinamentos executados
    - Numero
    - Participantes
    - Resultados dos testes
    - Curricula (topicos, objectivos, sessoes, metodologia, material didatico e outro, testes) fonte e ano da ultima revisao.
    - Os treinos incluem o SIS?
    - Participacao do SC, relatorios de actividades conjuntas

2. Uso do SI comunitario durante as visitas? O que fizeram? Como fizeram
3. Ver o plano annual sobre a parte da supervisao e avaliacao (se foi programada, se tem recurso alocados, se foi realizada, problemas encontrados)
4. Ver o plano sobre a parte das brigades moveis (o mesmo)
5. Informacao sobre vacinas e cadeia de frio
6. Mostrar os dados recolhidos na Estatistica e os dados do LQAS e obter feedback e explicacoes
7. Medidas tomadas para resolver os problemas

**SC Nacala**

1. Staff senior tem plano annual e mensal de trabalho. Baseado em que? pode mostrar documentos? Compreendem as actividades que tem que desenvolver?
2. Participou de encontros distritais e provinciais para explicar o trabalho realizado, as licoes aprendidas e as dificuldades?
3. Estes encontros tiveram algum impacto nas actividades da DDS ou DPS?
4. Podemos ver os relatorios destes encontros?
5. Plano de treinamento (completo – ver acima)
    a. Que modulos utilizam? Ultima revisao?
6. Acompanhamento das actividades de treinamento? Porque que nao?
7. Quantas reunioes como ontem fizeram com os distritos?
8. Que formacao receberam para cumprir com as vossas responsabilidades?
9. Qual e a situacao dos computadores? E do material para as maternidades? E das bicicletas?
10. Plano de M&E do projecto?
11. Quais sao as actividades de monitorizacao da Capacitacao institucional do DDS ? E da comunidade?
12. Porque que tem pouco conhecimento da situacao em Memba?
13. Quais sao as estrategias que deram mais resultado (capacitacao, sustentabilidade, mudanca do comportamento e comunicacao)? Como? Porque?

**Parceiros**

1. Quais sao as suas necessidades de reforco e capacitacao?
2. Que ajuda recebeu do SC nesse sentido
3. O trablho da su aorganizacao modificou-se devido a capacitacao dada ou contato com SC?

**Project Manager (over the phone)**

**1) What would you consider to be the main accomplishments of the program so far?**

**2) Regarding program objectives**:
Roughly LQAS results showed that for the 13 indicators of the 6 program intervention areas in relation to the baseline data:

- 3 (vacinacao, cuidados a febre em 48 h, 2 VAT na ultima gravidez) showed great reduction
- 2 (cuidados a respiracao rapida em 48h, conhecer metodos de PF) showed slight reduction
- 1 (2 visitas de ANC) showed slight increase
- 3 (manejamento da diarreia, parto assistido por agent treiando, usar metodo de PF) showed no impact
- 2 (2 metodos prevencao da diarreia, 2 sinais de perigo da AIDI) had no baseline data and were 53% (reasonable) and 79% (high) respectively
- 2 (sinais de perigo na gravidez e plano de parto) showed a sizable increase

**What are the reasons for such results? Please elaborate**

**3) What would you say are the main constraints/problems of the project? Please explain how those problems hindered the development of the program.**

5) Regarding the cross cutting approaches:

- community mobilization
CLCS are organized in most areas selected to the evaluation (we still have 2 more to visit), and they seem to function in a monthly schedule and keeping a varied representation of the community leaders. However, they still cannot use

data to make decisions. They seem to have a good relationship with SC staff, but a difficult one with some MOH staff from the health unit of reference. They do not have a relationship with the district or vice-versa. **What has been your experience with CLCS and could you add some insight to the above?**

- behavior change communication
Activistas are still very active in offering palestras and education. So have become some TBAs and healers. However their answer to why some people have been resistant to change their behavior, focused on insisting on palestras (this year they said there are more change than last year and last year there was more than the year before). When probed further they came up with some enforcement from the CLCS. **What are the guidelines for the training of CLCS members on this issue?**

-capacity building (DDS, EGPs, partners, other MOH staff, SC staff)
The staff at SC could not enumerate the objectives of the program and could not translate to me and list the “cross cutting approaches”. DDS Memba had some project documents (old) archived, a sign that they were not being used. He did not understand the core of the project beyond participating in the meetings. Nacala Velha director has been hard to reach. **What were some of the problems in this area?**

The work plan is heavy on training and addresses little supervision. Adelia has done supervision of 3 trainings this year. Memba director did not know what CLCS were, neither that he (with or without SC) should be doing supervision and improving their relationship. This does not also exist for NVelha. We know that training without follow-up might not yield the desired results. **Why its has been hard to plan for follow-up?**

**Adelia is not as knowledgeable about Memba as she is about Nacala Velha. Why?**

-program sustainability
Activities within the community might go on, in result of the CLCS training and work. However activities within DDS seem to be linked still to having a vehicle from SC to go on. This is very much needed and appreciated especially because it covers a wide range of activities that otherwise they could not cover. Are there any alternatives that you have tried to address the sustainability of the actions of this project, regarding transport or other. **With your knowledge of the field, what would be necessary steps to achieve sustainability?**

Regarding program management:

- I could not find a supervision plan and an M&E plan. The team says they have not started supervision yet as that would be the focus of this part of the project. **Could you elaborate on this please?** In the trimester work plan (Aug-Sep) there are two activities named supervision to PTAs but they really mean training. **What were/are the challenges of supervision?**

- Maria says she has received no training to prepare a monitoring plan and the graphs she prepares have many faults; they are filled with bars, are difficult to understand, are not well labeled etc and are not identified in terms of period the data refers to. **What are the reasons for such?**

- The minutes of the EGP (PMT) include Bridges and Strength projects, as you were managing both. The Strength activities got a bit masked that way. The identification of the problems is very general in most, so are the recommendations. Data is not used in a fashion that could lead to decision making. **Could you tell us about the challenges of these meetings?**

- The computers to both districts arrived about 2 months ago. As a matter of fact Memba computer is still locked up as nobody was trained to use it and the plan is to train the typist so he could type the letters of DDS. **Could you tell why the computers were so late? What was agreed in terms of training DDS people (who, when, for what?)**

**- Equipment (including two-way radios and other) and materials for maternities and Reference Hospitals of Nacala-Porto and Monapo should have been purchased by Q 5-6 and have not been purchased yet. What are the reasons for the delay?**

**- Bicycle-Ambulances for Memba district have not been purchase yet also. Why?**

- **What are the sources of the different training modules? When were they revised last? For the interventions? For CLCS? For BCC methodologies?**

**-What was the field office strategy in terms of budget management and involvement of local staff, Adelia for example?**

**-What is the status of birth kits?**

8) Please list your recommendations:
- for the program

-for the new director

# APPENDIX 8

## List of all individuals contacted and/or interviewed

### Mothers

Safina Morola, Gracinda João, Maria Ussene, Juliana Mocassi, Madelena Adriano, Aurora Nazário, Celestina Eugénio,Filomena Adriano, Laura Mussa,Laura Jaime,
Margarida Sical, Cristina Alupai, Fátima Buana, Aquina Massira, Marieta António, Atija Máquina, Fátima Martinho, Marília Fernandes Pedro, Rosa Niqueri, Angelina Hamede, Cristina Omar,Celestina Manuel, Esménia Pedro, Julieta Victor, Madelena Basílio, Gracinda Amisse, Elisa Nimorele, Carlota Mussagi, Aída Victorino.

### Regulos e Apiamwenes

Rojola Amade, Régulo Rojola;Helena Amade, Apiamwene Rojola; Nússura Waruma, Régulo Epuite; Paulo Tomás, Régulo Olaika; Juliana Tomás, Apiamwene Olaika; Mebile Cebola, Régulo Mebile

### THs

Augusto Molde, Curandeiro Rojola; António Sancula, Curandeiro Rojola; Agostinho Mariano; António Culete; Rosário Ismael; Caetano Maputa; Kanaxerehe Ibraimo.

### TBAs

Madelena Carreiro, Rojola; Fátima Abacar, Rojola; Margarida Rachide, Rojola; Maria Waquice, Rojola; Maria Nalelane, Epuite; Joana Tiquireria, Olaika; Menina Artur, Salina ( NaV ); Laurentina Ruhela, Filomena Gomes,Filomena Kavetho, Palmira Janela-(PT) Rosa Anánias-(PT),Aurora Joaquim-(PT), Julieta Lourenço-(PT), Ermelinda Rachide-(PT),Filomena Nacaia-(PT), Maria Amade-(PT), Maria Augusta Amade-(PT), Teresinha -(PT); Albertina Jacinto; Natália Armando; Florinda Saquina; Marieta Amade; Maria Lídia Sacança; Valentina Feliciano; Maria Olinda Zaíra; Rosa Cebola, Mezope.

### Activistas

Domingos Mutaiva, Chefe dos activistas, Epuite; Mariamo Sebastião, Chefe dos Activistas, Epuite; Candido Rajabo, Chefe dos activistas, Rojola; Pedro Sitanle; Pedro Baniane, Candido Rajabo, Rojola; Constantino Murarivo, Rojola; Vernísio Pinto Saquate, Mezope; Raimundo Rachide, Mezope; Augusto Muchanqueque, Mezope; Domingos Mutava, Epuite.

### DDS staff

Helena Alexandre, Parteira Elementar, CS Mueria; Saírose, Enf.Elementar, CS Mueria, Sr. Araujo, Tec Medio de Saude, CS Geba; Maria Sauia, PE, Formadora de PT, DDS Memba; Eusebio Jaimessone, resp PAV, Memba; Manuel Miguel Osorio, Tec Medicina Geral, Director, DDS Memba; Agira Faquira, enf SMI, Foramadora de PT de NaV; Sr Justino Ngomane Tec Medicina Geral, Director, DDS NaV; Pessoal do CS de Chipene e PS de Mazua em Memba e do PS de Covo em NaV.

### SC staff

All listed in the MTE team

## NGOs
Kathleen Stiebritz, MS, Memba; Jose Ngomane, ADPP, Monapo.

## Bridges to Health Project
Dra. Catarina Regina, program coordinator.

## Nampula SC Office
Richard Dixon, director of Food Security Program, Nampula; Steve McSween, Coordinator of Food Security Program, Nampula; Erica Weltzer, Nutrition Advisor Program, Nampula; Sr Cristovao, Logistics, Nampula.

## Maputo SC Office
Peter Nkhonjere, Deputy Director, Maputo; John , FOD Maputo

## USAID
Christian Barratt - Health, Population, and Nutrition Officer; Dr. Okey C. Nwanyanwu - Chief, Office of Health, Population & Nutrition; Ilka Esquivel - Health Sector Support Results Leader

# APPENDIX 11
# List of *Regulados* in Both Districts

**Lista nominal dos regulados de Memba**

1.-Metarrumo
2.-Mazeze
3.-Olaika
4.-Tiquereria
5.-Mapruma
6.-Melópia
7.-Mualia
8.-Kitaculo
9.-Morola
10-Mauala
11-Suka
12-Nampuitha
13-Mebile
14-Mazulia
15-Mazua
16-Nivale
17-Caleia
18-Namicolo
19-Kapulo
20-Mavia
21-Matico
22-Mutiquinheni
23-M'phatha
24-Napuco
25-Mepava
26-Motia
27-Tulua
28-Matilene
29-Muxaraua
30-Pazaquele
31-Capilelene
32-Epuite
33-Metupa

**Lista de regulados de NaV**

1.- Vantitia
2.- Meua
3.- Namanca
4.- Nacala
5.- Rojola
6.- Motia
7.- Mezope
8.- Nantar
9.- Morrimone
10-Mepira
11-Cathava
12-Kanira
13-Murrotho

# APPENDIX 12

## Health Facilities in Memba and Nacala-Velha
(Information supplied by the Strength Project staff in Oct 2002)

**Centros de Saúde de Memba**
Centro de Saúde de Memba Sede
-Namahaca
-Chipene
-Geba
-Caleia
-Baixo pinta ( por abrir )

**Postos de Saúde Memba**
-Napila
-Cavá
-Mazua
-Lúrio
-Nivale
-Simuco

**Centros de Saúde de Nacala-à-Velha**
1.-Nacala - Sede
2.-Muéria
3.-Namalala ( por abrir )

**Postos de Saúde de Nacala-à-Velha**
Barragem
Salinas

**Postos de Socorros de Nacala-à-Velha**
Micolene
Covó
Ger-Ger
Motia
Muentaze
Napala
Vida Nova

**Appendix 13: Results Presented at the Evaluation Debriefing as Positive and Challenging Findings**

## RESULTADOS: CLCS

| NACALA VELHA e MEMBA | |
|---|---|
| **POSITIVOS** | **DESAFIOS** |
| • CLCS de NV encontra-se regularmente, 8 a 12x/ano | • CLCS de Memba so reuniu 3 vezes |
| • Tratam sobre higiene, diarreia, avaliacao das actividades anteriores, mobilizacao da comunidade e fazer mais uso das PT | • Alguns CLCS nao entendem bem o PF |
| • Apresentam os dados comunitarios (PT, apiamwene, activistas) | • CLCS de Memba nem todos utilizam as informacoes da comunidade. |
| • Mantem registo de dados (activista aponta os dados no grafico) | • Os registos de dados sao incompletos |
| • Registo de dados para nao esquecer, apresentar a visitantes, tomar decisoes. CLCS tem bom registo dos nascimentos | |
| • CLCS manda os dados para o CS e depois para o distrito | |
| • Tem plano oral de actividades, principalmente palestras | |
| • Tomam decisoes sobre os assuntos de saude | |
| • As relacoes entre CLCS e DDS sao mistas | • Falta de comunicacao entre o distrito e as CLCS |
| | • Apenas um CS em Memba tem boas relacoes com o CLCS |
| | • Desconfianca entre CLCS e equipa de saude na epoca da colera (ultrapassado) |

**Appendix 13: Results Presented at the Evaluation Debriefing as Positive and Challenging Findings**

| | |
|---|---|
| • 6-8 membros em cada CLCS com balanco entre no. de mulheres e no. de homens<br>• Alguns membros tem papeis bem definidos<br>• Boa participacao dos elementos nos encontros<br>• Os membros participam nas BM | • Outros membros nao tem papel bem definido (se nao foi definido durante a formacao, como responsavel do transporte)<br>• CLCS de Memba – alguns faltou apiamwene |
| • CLCS recomendam o parto limpo | |
| • Usam o metodo de palestras e visitas domiciliares | • Insistencia em palestras como unico meio de provocar mudanca no comportamento |
| • CLCS tem sistema de ALARME (mulher em risco—chama PT—informa o regulo—regulo chama o grupo de apoio) | • Sistema de transporte nao funciona.<br>• Bicicletas nao sao de facil manejo com a carga e longas distancias<br>• Bicicletas avariadas em todos os regulados<br>• Problemas na manutencao das bicicletas (contribuicao so funcionou uma vez, depois falhou por entendimento que CLCS recebiam $ do SC / roubo da bicicleta |
| • A BM visitou recentemente apenas em alguns regulados | • Falta de visita da BM a certas comunidades ha mais de 1 ano |

**Appendix 13: Results Presented at the Evaluation Debriefing as Positive and Challenging Findings**

## RESULTADOS: MAES

| NACALA VELHA E MEMBA | |
|---|---|
| **POSITIVOS** | **DESAFIOS** |
| • Conhecem e preparam o plano do parto<br>• Conhecem sistema de Alarme e Transporte<br>• Utilizaram o sistema de transporte quando estava em funcionamento | • Utilizacao de palestras como unico meio de educar as maes sobre o parto assitido por pessoa formada |
| • Sabem que devem ter parto assistido por pessoa formada<br>• Usam os servicos da PT que vive perto<br>• Recebem estas informacoes e tambem sobre PF atraves da CLCS | • Se vivem longe da parteira, nao utilizam os servicos dela<br>• Falta de parteiras na comunidade |
| • Existe boa relacao entre as maes e enf SMI nas US e nas brigades movies na maior parte | • Mau relacionamento entre a mae e parteira elementar em algumas US |
| • Conhecem metodos de PF e seus beneficios<br>• Conhecem a recomendacao de espacamento da gravidez de pelo menos dois anos<br>• Algumas praticam abstinencia sexual | • Os metodos de PF nao estao disponiveis na comunidade, so nas US a grande distancia |
| • Sabem como preparar soros caseiros e dar muitos liquidos a crianca com diarreia | • Certos alimentos nao sao dados a crianca doente |

**Appendix 13: Results Presented at the Evaluation Debriefing as Positive and Challenging Findings**

| | |
|---|---|
| • Levam os filhos a US quando reconhecem que eles estao doentes<br><br>• Conhecem os sinais de perigo da diarreia<br>• Sabem como prevenir a diarreia<br>• Conhecem os sinais de IRA<br>• Levam os filhos com sinais de IRA a US imediatamente. Nao tratam em casa<br>• Em caso de febre fazem primeiro arrefecimento em casa<br>• Sabem os sintomas e sinais da malaria e o agente causador (o mosquito)<br>• Sabem como prevenir a malaria e como encaminhar ?<br><br>• Conhecem a importancia da vacina e que sao necessarias 5 visitas para completar a vacinacao da crianca<br><br>• Recebem a informacao atraves de palestras do CLCS e nas US | • Algumas maes vao ao curandeiro primeiro quando o filho esta doente<br><br>• Se a crianca brinca nao precisa de levar a US, porque nao e grave<br><br>• As maes que nao levam os filhos doentes a US citam as seguintes razoes:<br>Falta $, falta de medicamentos nas US, confiam mais no curandeiro, medo do chupa-sangue, medo que os filhos morram na US<br><br>• Algumas nao conhecem o causador da malaria<br><br>• Entao porque que os dados da vacinacao sao baixos?<br><br>• As maes nao se lembram quando foi a ultima palestra |

**Appendix 13: Results Presented at the Evaluation Debriefing as Positive and Challenging Findings**

## RESULTADOS: CURANDEIROS

| NACALA VELHA E MEMBA | |
|---|---|
| **POSITIVO** | **DESAFIOS** |
| • **USAM UMA LAMINA POR PESSOA**<br>• **FERVEM OKA E INSTRUMENTOS CORTANTES**<br>• **ALGUMAS VEZES CRIANCA COM DIARREIA E IMEDIATAMENTE MANDADA A US**<br>• **SABEM AS MEDIDAS A TRATAR EM CASO DE DIARREIA, MALARIA, IRA, MENINGITE, SARRAMPO E TETANO** | • **NEM SEMPRE ENVIAM A CRIANCA IMEDIATAMENTE**<br>• **AS VEZES TRATAM POR 2 DIAS COM TRATAMENTO TRADICIONAL ANTES DE MANDAR** |

**Appendix 13: Results Presented at the Evaluation Debriefing as Positive and Challenging Findings**

## RESULTADOS: PARTEIRAS TRADICIONAIS

| NACALA VELHA E MEMBA | |
|---|---|
| **POSITIVO** | **DESAFIOS** |
| • CONHECEM OS SINAIS DE PERIGO<br>• E QUANDO ENCAMINHAR A MULHER<br>• TEM BOA RELACAO COM A PARTERIA ELEMENTAR?<br>• TEM BOA RELACAO COM AS MAES<br>• FAZEM RECOLHA DE DADOS DE ACORDO COM A FICHA DELAS<br>• RECEBERAM EQUIPAMENTO DO SAVE<br>• RECEBEM ABASTECIMENTO DE MATERIAL DAS US<br>• ALGUMAS MAES TRAZEM A LAMINA<br>• SABEM FAZER O CORTE DO CORDAO DE ACORDO COM A NORMA ESTABLECIDA | • GRANDE VOLUME DE TRABALHO, POUCAS PARTEIRAS PARA MUITAS MAES<br>• AS MAES NAO ESTIMULAM AS PARTEIRAS PORQUE PENSAM QUE ELAS SAO PAGAS<br>• SISTEMA DE TRANSPORTE NAO EXISTENTE PARA OS CASOS URGENTES<br>• DISTANCIAS LONGAS PARA OS CS<br>• A QUALIDADE DO REGISTO PODE MELHORAR<br>• HA FALTA DE SAVLON, ALGODAO E NASTRO |

**Appendix 13: Results Presented at the Evaluation Debriefing as Positive and Challenging Findings**

## RESULTADOS: ACTIVISTAS

| NACALA VELHA E MEMBA | |
|---|---|
| **POSITIVO** | **DESAFIOS** |
| • SAO ACTIVOS NAS COMUNIDADES<br>• SAO MEMBROS DO CLCS<br>• RECOLHEM DADOS DA COMUNIDADE PARA APRESENTAR NO CLCS<br>• FAZEM PALESTRAS<br>• DESENVOLVEM MOBILIZACAO DAS COMUNIDADES<br>• CONHECEM AS BASES DA COMUNICACAO PARA A MUDANCA DO COMPORTAMENTO<br>• ALGUNS USAM PANFLETOS E ALBUNS SERIADOS E DESENHOS | • EM MEMBA NAO HA MUITOS ACTIVISTAS FORMADOS<br>• AS MENSAGENS SAO MUITO GERAIS E AS MENSAGENS CHAVES NAO SAO BEM DESCRITAS<br>• HA POUCO GRUPOS DE TEATRO, SO A NIVEL DISTRITAL<br>• PENSAM QUE A INSISTENCIA E OBRIGACAO SAO AS MANEIRAS DE EDUCAR A COMUNIDADE<br>• NAO TEM SUFICIENTE MATERIAL EDUCATIVO<br>• ALGUM MATERIAL NAO E PLASTIFICADO E ESTRAGA-SE |

**Appendix 13: Results Presented at the Evaluation Debriefing as Positive and Challenging Findings**

| | |
|---|---|
| • **CONHECEM AS VARIAS DOENCAS DA CRIANCA**<br><br>• **SAO ORGULHOSOS DA SUA ACTIVIDADE** | • **A COMUNIDADE PODE NAO RECONHECER O ACTIVISTA PORQUE NAO TEM DISTINTIVOS APROPRIADOS (CHAPEUS, T-SHIRTS, CRACHA)** |

**Appendix 13: Results Presented at the Evaluation Debriefing as Positive and Challenging Findings**

## RESULTADOS: TRABALHADORES DE SAUDE

| NACALA VELHA E MEMBA | |
|---|---|
| **POSITIVO** | **DESAFIOS** |
| **ENF DE MEDICINA E SMI:**<br><br>• **A MAIOR PARTE DAS US VISITADAS TEM ABASTECIMENTO DE MEDICAMENTOS NUMA BASE REGULAR**<br><br>• **TEM QUE IR BUSCAR AS VACINAS AO DISTRITO MENSALMENTE**<br><br>• **ALGUMAS PARTEIRAS ELEMENTARES UTILIZAM CARTAZES, ALBUM SERIADO E PANFLETOS**<br><br>• **ALGUMAS PARTEIRAS FAZEM PALESTRAS** | • **TEM ROTURA DE VAT E OUTRAS VACINAS**<br><br>• **TIVERAM FALTA DE CLOROQUINA POR UMA SEMANA – ROTURA DE STOCK**<br><br>• **NAO HA DISTRIBUICAO DOS KIT DE MEDICAMENTOS. AS UNIDADES E QUE VAO BUSCAR POR MEIOS PROPRIOS**<br><br>• **UM CS DISSE QUE SO VACINA UMA VEZ POR SEMANA**<br><br>• **HA FALTA DE MATERIAL DE IEC EM ALGUMAS US**<br>• **SALAS DE TRIAGEM NAO POSSUEM AMOSTRAS DE METODOS DE PF, E CARTAZES PARA MOSTRAR AS MAES**<br>• **EM ALGUNS CS NAO FAZEM EDUCACAO DE PF SE O MARIDO NAO ESTA PRESENTE**<br>• **NUNCA FIZERAM CONVOCATORIA DOS MARIDOS**<br>• **NUNCA PEDIRAM AJUDA DA CLCS PARA** |

**Appendix 13: Results Presented at the Evaluation Debriefing as Positive and Challenging Findings**

| | |
|---|---|
| • **MUITOS ENFERMEIROS RECEBERAM FORMACAO EM AIDI**<br>• **A FORMACAO EM AIDI AJUDOU A MELHORAR O DIAGNOSTICO E O TRATAMENTO PORQUE HA UM PROTOCOLO**<br>• **NAS CONSULTAS OS CARTOES DA CRIANCA SAO VERIFICADOS E VACINADOS AQUELES QUE ESTAO EM TEMPO**<br>• **SITUACAO ESPECIAL DE UM ENFERMEIRO:**<br>• **ANALISA OS DADOS DA CONSULTA**<br>• **IDENTIFICA COMUNIDADES DE RISCO**<br>• **INFORMA CLCS**<br>• **USA MATERIAL DO AIDI**<br>• **FAZ DIAGNOSTICOS MAIS ACURADOS DEPOIS DA FORMACAO AIDI**<br>• **TEM CONTACTOS COM ACTIVISTA QUE TRAZEM MAES PARA A US**<br>• **AJUDA O TRABALHO E A FORMACAO DA COLEGA PARTEIRA** | **CONVOCAR OS MARIDOS**<br>• **ALGUNS TRABALHADORES DE SAUDE NAO CONHECEM OS ELEMENTOS COM QUEM DEVEM TRABALHAR (PT, APE, ACTIVISTA, SOCORRISTA)** |

**Appendix 13: Results Presented at the Evaluation Debriefing as Positive and Challenging Findings**

| | |
|---|---|
| **APEs:**<br><br>• **APEs CONHECEM O SISTEMA DE ALARME E TRANSPORTE DO REGULADO**<br><br>• **ADMNISTRAM PRIMEIROS SOCORROS E TRATAMENTO COMPLETO PARA MALARIA E DIARREIA**<br><br>• **TRANSFEREM OS OUTROS CASOS PARA O HOSPITAL, POR EX: IRA**<br><br>• **EDUCAM AS MAES PARA LEVAR AS CRIANCAS A US MAIS PROXIMA** | • **NAO ESPECIFICARAM URGENCIA DE TRANSFERIR PARA O HOSPITAL**<br>• **NAO CONSEGUIRAM DESCREVER OS SINAIS DE PERIGO DAS DOENCAS QE REQUEREM TRANSFERENCIA**<br>• **ALGUNS NAO TEM MATERIAIS PARA EDUCACAO** |

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

## PLANO DE ACCAO: CAPACITACAO

| MEMBA e NACALA VELHA | | | | |
|---|---|---|---|---|
| **DESAFIOS** | **SOLUCOES** | **ACTIVIDADES** | **RESPONSAVEL** | **PERIODO** |
| **CLCS**<br><br>• CLCS de Memba so reuniu 3 vezes<br>• Alguns CLCS nao entendem bem o PF<br>• Os registos de dados sao incompletos<br>• Falta de comunicacao entre o distrito e as CLCS<br>• Desconfianca entre CLCS e equipa de saude na epoca da colera (ultrapassado)<br>• Alguns membros nao tem papel bem definido | Fazer o acompanhamento das CLCS formadas atraves de supervisao | - Treino rapido de habilidades de supervisao para DDS, SC, pessoal do CS e PS<br><br>- Elaboracao de guiao de supervisao apropriado as actividades das CLCS e de acordo com a sua formacao, durante o treino<br><br>- Elaboracao de um plano conjunto de visitas de supervisao as CLCS<br>- Aprovacao do plano pelo SC e Directores distritais<br><br>- Inicio visitas de supervisao | DDS<br>SC<br><br>Grupo treinado<br><br>Grupo treinado | 3a. semana Outubro<br><br>4a. semana Outubro<br><br>Novembro ate ao fim do projecto |

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

| | | | | |
|---|---|---|---|---|
| • **Sistema de transporte de emergencia nao funciona.**<br>• **Falta de bicicletas-ambulancia em Memba**<br>• **Bicicletas avariadas em todos os regulados -NV**<br>• **Problemas na manutencao das bicicletas (comunidade pensa que CLCS recebiam $ do SC, roubo** | **Reactivar o sistema de transporte de NV e iniciar o sistema de transporte de Memba** | **REFERIDO NO PLANO DE ACCAO DA MULHER** | **DDS, SC US** | |
| **<u>DDS</u>**<br><br>• **Falta de visita da BM a certas comunidades ha mais de 1 ano**<br><br>• **EGP (Equipa de Gestao do Projecto – conjunta)** | **Preparar um BOM plano de Brigadas Moveis (BM)**<br><br>**Fortalecer as reunioes dos EGP ao nivel do distrito** | **REFERIDO NO PLANO DE ACCAO DA VACINACAO**<br><br>- **Marcar encontros de trabalho (analise e planificacao) no proprio distrito**<br>- **Envolver toda a equipa da DDS na planificacao**<br>- **Decidir calendario de encontros**<br>- **Melhorar a analise dos dados estatisticos do distrito**<br>- **Tomar decisoes correspondentes aos** | **SC, DDS** | **MENSAL** |

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

| | | | | |
|---|---|---|---|---|
| | | **problemas encontrados e as localidades identificadas na analise dos dados** | | |
| • **Falta de supervisao generalizada** | **Elaborar um plano de supervisao sustentavel** | - **Aplicar o guiao de supervisao do MISAU** | **DPS DDS SC** | **Nov 02** |
| • **Plano de Accao da Avalaicao de Meio-Termo nao esta completo**<br>• **Nao houve a participacao dos directores e do resto da equipa distrital** | **Completar o plano de accao** | **-Envolver os directores e equipa distrital**<br>**-Continuar discussao dos desafios/solucoes da avaliacao de meio termo** | **Grupo da avalaicao +director das DDS + director do projecto** | **Plano de Accao pronto dentro de 3 semanas** |

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

## PLANO DE ACCAO : MUDANCA do COMPORTAMENTO

| MEMBA e NACALA VELHA | | | | |
|---|---|---|---|---|
| **DESAFIOS** | **SOLUCOES** | **ACTIVIDADES** | **RESPONSAVEL** | **PERIODO** |
| • Insistencia em palestras como unico meio de provocar mudanca no comportamento | Introduzir as variantes do teatro e drama | - Grupo teatro de NV deve comecar a formar membros na comunidade<br>- Recomendar os grupos de NV e Memba para fazer plano de actividades na comunidade<br>- Assistir alguns teatros para avaliar a qualidade e a reaccao da comunidade | Formado e CLCS<br><br>Formadoras<br><br>DDS, SC | 1a semana Outubro<br><br>2a semana Outubro |
| • As maes nao se lembram quando foi a ultima palestra<br>• As maes nao aceitam os conselhos dados nas palestras | Descobrir as razoes porque as pessoas nao aceitam os conselhos dados e decidir novas estrategias de educacao | Fazer visitas domicilares | CLCS, Activistas, Formadoras/ supervisoras | A partir de agora |

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

| | | | | |
|---|---|---|---|---|
| • **Os metodos de PF nao estao disponiveis na comunidade, so nas US a grande distancia** | **Discutir alternativas de disponibilizar metodos nas comunidades** | **Reunioes com DPS, com DDS, rever o Plano de implementacao do projecto** | **DDS, SC, Regulo** | |
| • **Mensagens-chave confusas** | **Revisar e melhorar as MENSAGENS CHAVE dos modulos e das palestras** | **REFERIDO NO PLANO DE ACCAO DA SAUDE DA CRIANCA** | | |
| • **A comunidade nao remunera as parterias** | **Esclarecer as maes sobre nao remuneracao das PT** | **Introduzir o assunto nas palestras e contactos com CLCS** | | **A partir de agora** |
| • **Activistas nao sao reconhecidos na comunidade** | **Criar distintivos para os membros dos CLCS** | - **decidir a sigla e o desenho**<br>- **procura e aquisicao de t-shirts, bones, crachas** | **SC, DDS, CLCS** | **Nov-Dez 2002** |

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

## PLANO DE ACCAO: SUSTENTABILIDADE

| MEMBA e NACALA VELHA | | | | |
|---|---|---|---|---|
| **DESAFIOS** | **SOLUCOES** | **ACTIVIDADES** | **RESPONSAVEL** | **PERIODO** |
| **DDS:**<br>• **Poucos contacto com CLCS** | **Aumentar e manter os contactos com CLCS** | **O distrito deve estar presente e liderar as visitas de supervisao** | **DDS, SC** | **Apartir de Nov 02** |
| • **Poucos encontros de planificacao** | **Manter os encontros de planificacao regularmente (todo o mes)** | **REFERIDO NO PLANO DE ACCAO DA CAPACITACAO** | | |
| • **Supervisao as US raramente** | **Utilizar o guiao e calendario de supervisao do MISAU** | **REFERIDO NO PLANO DE ACCAO DA CAPACITACAO** | | |
| | **Assegurar os recursos necessarios para o supervisao (transporte, combustivel)** | **REFERIDO NO PLANO DE ACCAO DA CAPACITACAO** | | |

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

| | | | | |
|---|---|---|---|---|
| **US:**<br>• **Alguns trabalhadores de saude nao foram envolvidos para manter contacto com CLCS**<br><br>• **Algumas enf. nao foram recicladas em cuidados obstetricos e DMS e Saude Reprodutiva** | **Integrar os enf. nas actividades do CLCS e PT**<br><br>**Integrar os enf. nas supervisoes aos CLCS**<br><br>**Assegurar que as restantes enf. completam as reciclagens** | **REFERIDO NO PLANO DE ACCAO DA CAPACITACAO**<br><br>**REFERIDO NO PLANO DE ACCAO DA CAPACITACAO** | | |
| **CLCS:**<br>• **Todos os regulados nao tem sistema de manutencao**<br><br>• **CLCS precisa aprender a usar os dados para tomar decisoes** | **Esclarecer as CLCS no sentido de se responsabilizarem pela manutencao das bicicletas-ambulancia**<br><br>**Manter a supervisao e apoio dos CLCS** | **Encontros com os CLCS**<br><br>**Discutir alternativas**<br><br>**Contar as licoes de NV e de XaiXai**<br><br>**Fazer acordos com com CLCS**<br><br>**Analisar em conjunto os dados dos graficos e decisoes com CLCS** | **DDS, Formadoras**<br><br>**DDS, Formadoras** | |

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

# VACINAÇAO DA CRIANCA- INDICADORES/OBJECTIVOS

| Indicadores/Objectivos do Fim do Programa | Linha de Base 1999/2000 | Médio –Termo 2002 |
|---|---|---|
| 55% de Crianças de 12 – 23 meses serão completamente vacinadas pela idade dos 12 meses linha de base. | N-32% M-34% | N-11% M-13% T-12% |
| 80% de mulheres com crianças < 24 meses terão recebido pelo 2 doses de vacina ante tétano durante a última gravidez | N-30% M-62% | N-74% M-42% T-57% |

## PLANO DE ACCAO: VACINACAO

| MEMBA e NACALA VELHA | | | | |
|---|---|---|---|---|
| **DESAFIOS** | **SOLUCOES** | **ACTIVIDADES** | **RESPONSAVEL** | **PERIODO** |
| • Os dados da vacinacao continuam baixos<br>• Numero limitado de postos fixos<br>• Postos que so vacinam uma vez por semana<br>• Planificacao inaqueada das BM | Aumentar o numero de Postos Fixos<br><br>Analisar a situacao do Lurio<br><br>Assegurar o cumprimento das normas do MISAU | - Por a fucionar o Posto Fixo de Baixo Pinda e outros imediatamente<br><br>- Buscar formas de abastecer a zona para fazer face ao isolamento causado pelas chuvas | DDS<br><br>DDS, EGP, regulos<br><br>DDS, SC | |

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

| | | | | |
|---|---|---|---|---|
| | **Preparar um Bom plano da BM com priorizacao das localidades a vacinar** | - **Dar prioridade aos lugares com 1 ou 2 visitas anteriores para permitir completar a vacinacao das criancas**<br>- **Cumprir com o horario para apanhar toda a gente na concentracao**<br>- **Preparar a BM no dia anterior para sair bem cedo e evitar atrasos**<br>- **Manter um bom registo das saidas do transporte das BM**<br>- **Aumentar o no de dias de apoio do carro da SC para as brigadas moveis em Memba**<br>- **Articulacao com o MS em Memba** | | **1a - 2a semana Outubro**<br><br>**permanente** |

## Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

# SAUDE DA CRIANCA- INDICADORES/OBJECTIVOS

| Indicadores/Objectivos do Fim do Programa | Linha de Base 1999/2000 | Meio-Termo 2002 |
|---|---|---|
| 80% de mães com crianças < 24 meses com febre nas 2 anteriores semanas procuraram cuidado dentro de 48 horas | N-57% M-66% | N-30% M- 34% T-32% |
| 85% de mães com crianças < 24 meses com tosse e respiração rápida/dificultada nas 2 anteriores semanas procuraram cuidado dentro de 48 horas | N-64% M73% | N-54% M-67% T-61% |
| 80% de mães com crianças < 24 meses com diarreia nas 2 anteriores semanas que manejaram a diarreia com TRO (SRO ou líquidos comunitários de reidratação oral tais como papas aguadas) | N-66% M-67% | N-67% M-62% T-64% |
| Percentagem de mulheres com crianças < 24 meses que reportaram conhecer pelo menos duas vias de prevenir diarreia | N/A | N-56% M-50% T-53% |
| Percentagem de mulheres com crianças < 24 meses que reportaram conhecer 2 sinais de perigo de AIDI | N/A | N-86% M-73% T-79% |

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

## PLANO DE ACCAO: SAUDE DA CRIANCA

| MEMBA e NACALA VELHA | | | | |
|---|---|---|---|---|
| **DESAFIOS** | **SOLUCOES** | **ACTIVIDADES** | **RESPONSAVEL** | **PERIODO** |
| • **Falta de clareza das mensagens chave:**<br><br>**-A mae nao da certos alimentos a crianca doente**<br>**-Algumas maes vao ao curandeiro primeiro quando o filho esta doente**<br>**-Se a crianca brinca nao precisa de levar a US, porque nao e grave**<br>**- Os curandeiros nem sempre enviam a crianca ao hospital imediatamente; tratam por 2 dias com tratamento tradicional antes de mandar** | **Revisar e melhorar as mensagens chave** | **-Assistencia tecnica de IEC e mudanca do comportamento de Xai-xai**<br><br>**- Revisao de todos os modulos de formacao, especialmente os relacionados com os resultados encontrados**<br><br>**- Supervisao continua dos CLCS**<br><br>**- Reciclagem dos CLCS e dos curandeiros** | **SC**<br><br>**SC Formadoras** | **Dez 02**<br><br>**Fev-Mar 2003**<br><br>**Nov 02**<br><br>**Nov 02** |

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

| | | | | |
|---|---|---|---|---|
| • As maes que nao levam os filhos doentes a US citam as seguintes razoes:<br>-Falta $,<br>-falta medicamentos nas US,<br>-confiam mais no curandeiro,<br>-medo do chupa-sangue,<br>-medo que os filhos morram na US | Melhorar o sistema de abastecimento de medicamentos as US<br><br>Esclarecer as maes sobre os seus medos | -Discutir durante os encontros de EGP solucoes para este problema<br><br>Palestras dirigidas as preocupacoes das maes | EGP, DDS Resp Farmacia DPS | |
| • Os APEs nao especificaram a urgencia de transferir as criancas para o hospital<br>• Os APEs nao conseguiram descrever os sinais de perigo das doencas que devem transferir | Melhorar as habilidades dos APEs | Supervisao e formacao em trabalho durante as visitas aos PS | Sr Amilton Formadoras DDS | |

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

# SAUDE DA MULHER- INDICADORES/OBJECTIVOS

| Indicadores/Objectivos do Fim do Programa | Linha de Base 1999/2000 | Meio-Termo 2002 |
|---|---|---|
| 50% de parto assistidos por uma pessoa formada | N-34% M-38% | N-51% M-28% T-39% |
| 85% de mulheres têm pelo menos duas visitas pré-natais com uma pessoa de saúde formada durante a última gravidez | N-77% M-74% | N-74% M-55% T-64% |
| 80% de mulheres com crianças < 24 meses terão recebido pelo 2 doses de vacina ante tétano durante a última gravidez | N-30% M-62% | N-74% M-42% T-57% |
| 80% de mulheres com crianças < 24 meses saberão pelo menos 3 sinais de perigo relacionados a gravidez | N-18% M-44% | N-95% M-57% T-75% |
| 10% de mulheres irão ter tido um plano de parto (3 de 5 componentes) durante a sua última gravidez | N-0% M-0% | N2% M-5% T-3% |
| 25% de mulheres com crianças < 24 meses que não desejam ter outra criança nos próximos dois anos estarão usando um método moderno de contracepção | N-18% M-15% | N-18% M-12% T-15% |
| 50% de mulheres com criancas < 24 meses conhecem pelo menos 2 metodos de contracepcao modernos | N-24% M-37% | N-28% M-23% T-25% |

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

## PLANO DE ACCAO: SAUDE DA MULHER

| MEMBA e NACALA VELHA | | | | |
|---|---|---|---|---|
| **DESAFIOS** | **SOLUCOES** | **ACTIVIDADES** | **RESPONSAVEL** | **PERIODO** |
| • Utilizacao de palestras como unico meio de educar as maes sobre o parto assitido por pessoa formada<br>• Se vivem longe da parteira, nao utilizam os servicos dela<br>• Falta de parteiras na comunidade<br>• Mau relacionamento entre a mae e parteira elementar em algumas US | MAIOR MOBILIZACAO ATRAVES DOS REGULOS, APIAMUENES E ACTIVISTAS<br><br>LEVANTAR OS PROLEMAS NO PRIMEIRO CONTACTO COM O REGULADO | REALIZACAO DE TEATROS<br><br>CANCOES<br><br>DANCAS<br><br>UTILIZAR OS PANFLETOS E ALBUMS SERIADOS E BROCHURAS NAS PALESTRAS | SC,<br>DDS<br>CLCS | NOV 02 |
| • Os metodos de PF nao estao disponiveis na comunidade, so nas US a grande distancia | REVISITAR A QUESTAO DA DISTRIBUICAO DE METODOS PELOS PT, APEs, SOCORRISTAS ETC | | | |

**Appendix 14: Preliminary Action Plan Prepared by Evaluation Team and Presented at the Evaluation Debriefing**

| | | | | |
|---|---|---|---|---|
| • **As maes nao estimulam as parteiras porque pensam que elas sao pagas**<br><br>• **Sistema de transporte nao existente para os casos urgentes** | **ESLCARECIMENTO SOBRE O ASSUNTO DO PAGAMENTO DAS PARTEIRAS**<br><br>**Compra e distribuicao aos CLCS de Memba**<br><br>**Sensibilizacao aos CLCS de Nacala Velha** | - **Contactar Dra Catarina e Sr Teodoro**<br>- **Preparar a lista**<br>- **Apresentar a Logistica para compra e entrega**<br>- **Sensibilizar CLCS para a entrega e manutencao**<br>- **Contar a licao aprendida de Nacala Velha**<br>- **Distribuir**<br><br>- **Encontros com os CLCS de NV para sensibilizar, recordar o acordo de entrega e negociar a reparacao e manutencao das bicicletas avariadas** | **SC, DDS**<br><br>**SC, DDS**<br><br>**DDS, SC** | **Assim que receber**<br><br>**Durante visitas supervisao** |

# APPENDIX 15

## Both Districts Combined: LQAS Analysis of Key Indicators

| Supervisory area | LQAS sample (n) | q (with condition) | p=q/n | N (P.A. pop) | Wt=Ni/sum(N) | Wt*p |
|---|---|---|---|---|---|---|
| **Early BF** | | | | **186407.00** | | |
| GerGer | 19.00 | 15.00 | 0.79 | 29075.00 | 0.16 | 0.12 |
| Sede | 19.00 | 17.00 | 0.89 | 58056.00 | 0.31 | 0.28 |
| Lurio | 19.00 | 14.00 | 0.74 | 13414.00 | 0.07 | 0.05 |
| Chipene | 19.00 | 15.00 | 0.79 | 17500.00 | 0.09 | 0.07 |
| Mazua | 19.00 | 14.00 | 0.74 | 29776.00 | 0.16 | 0.12 |
| Memba | 19.00 | 14.00 | 0.74 | 38586.00 | 0.21 | 0.15 |
| | | | | | | **0.80** |
| **Colostrum** | | | | | | |
| Gerger | 19.00 | 15.00 | 0.79 | 29075.00 | 0.16 | 0.12 |
| Sede | 19.00 | 15.00 | 0.79 | 58056.00 | 0.31 | 0.25 |
| Lurio | 19.00 | 13.00 | 0.68 | 13414.00 | 0.07 | 0.05 |
| Chipene | 19.00 | 15.00 | 0.79 | 17500.00 | 0.09 | 0.07 |
| Mazua | 19.00 | 13.00 | 0.68 | 29776.00 | 0.16 | 0.11 |
| Memba | 19.00 | 13.00 | 0.68 | 38586.00 | 0.21 | 0.14 |
| | | | | | | **0.74** |
| **Exclusive BF** | | | | | | |
| GerGer | 19.00 | 5.00 | 0.26 | 29075.00 | 0.16 | 0.04 |
| Sede | 19.00 | 6.00 | 0.32 | 58056.00 | 0.31 | 0.10 |
| Lurio | 19 | 9.00 | 0.47 | 13414.00 | 0.07 | 0.03 |
| Chipene | 19 | 6.00 | 0.32 | 17500.00 | 0.09 | 0.03 |
| Mazua | 19 | 9.00 | 0.47 | 29776.00 | 0.16 | 0.08 |
| Memba | 19 | 8.00 | 0.42 | 38586.00 | 0.21 | 0.09 |
| | | | | | | **0.37** |
| **Diarrhea** | | | | | | |
| **Treated with ORS** | | | | | | |
| Gerger | 19 | 14 | 0.74 | 29075.00 | 0.16 | 0.11 |
| Sede | 19 | 12 | 0.63 | 58056.00 | 0.31 | 0.20 |
| Lurio | 19 | 14.00 | 0.74 | 13414.00 | 0.07 | 0.05 |
| Chipene | 19 | 10.00 | 0.53 | 17500.00 | 0.09 | 0.05 |
| Mazua | 19 | 14.00 | 0.74 | 29776.00 | 0.16 | 0.12 |
| Memba | 19 | 10.00 | 0.53 | 38586.00 | 0.21 | 0.11 |
| | | | | | | **0.64** |

# APPENDIX 15



| | | | | | | |
|---|---|---|---|---|---|---|
| **Know 2 prevention methods** | | | | | | |
| Gerger | 19.00 | 14.00 | 0.74 | 29075.00 | 0.16 | 0.11 |
| Sede | 19.00 | 9.00 | 0.47 | 58056.00 | 0.31 | 0.15 |
| Lurio | 19.00 | 7.00 | 0.37 | 13414.00 | 0.07 | 0.03 |
| Chipene | 19.00 | 11.00 | 0.58 | 17500.00 | 0.09 | 0.05 |
| Mazua | 19.00 | 8.00 | 0.42 | 29776.00 | 0.16 | 0.07 |
| Memba | 19.00 | 11.00 | 0.58 | 38586.00 | 0.21 | 0.12 |
| | | | | | | **0.53** |
| **ARI treated within 48hrs** | | | | | | |
| GerGer | 19.00 | 13.00 | 0.68 | 29075.00 | 0.16 | 0.11 |
| Sede | 19.00 | 9.00 | 0.47 | 58056.00 | 0.31 | 0.15 |
| Lurio | 19 | 13.00 | 0.68 | 13414.00 | 0.07 | 0.05 |
| Chipene | 18 | 11.00 | 0.61 | 17500.00 | 0.09 | 0.06 |
| Mazua | 19 | 9.00 | 0.47 | 29776.00 | 0.16 | 0.08 |
| Memba | 19 | 16.00 | 0.84 | 38586.00 | 0.21 | 0.17 |
| | | | | | | **0.61** |
| **Fever sought care within 48hrs** | | | | | | |
| Gerger | 19 | 3.00 | 0.16 | 29075.00 | 0.16 | 0.02 |
| Sede | 19 | 7.00 | 0.37 | 58056.00 | 0.31 | 0.11 |
| Lurio | 19 | 7.00 | 0.37 | 13414.00 | 0.07 | 0.03 |
| Chipene | 19 | 7.00 | 0.37 | 17500.00 | 0.09 | 0.03 |
| Mazua | 19 | 4.00 | 0.21 | 29776.00 | 0.16 | 0.03 |
| Memba | 19 | 8.00 | 0.42 | 38586.00 | 0.21 | 0.09 |
| | | | | | | **0.32** |
| **IMCI (knowledge of 2 danger signs)** | | | | | | |
| Gerger | 19.00 | 17.00 | 0.89 | 29075.00 | 0.16 | 0.14 |
| Sede | 19.00 | 14.00 | 0.74 | 58056.00 | 0.31 | 0.23 |
| Lurio | 19.00 | 16.00 | 0.84 | 13414.00 | 0.07 | 0.06 |
| Chipene | 19.00 | 15.00 | 0.79 | 17500.00 | 0.09 | 0.07 |
| Mazua | 19.00 | 16.00 | 0.84 | 29776.00 | 0.16 | 0.13 |
| Memba | 19.00 | 14.00 | 0.74 | 38586.00 | 0.21 | 0.15 |
| | | | | | | **0.79** |

# APPENDIX 15

| | | | | | | |
|---|---|---|---|---|---|---|
| **Antenatal care** | | | | | | |
| **Trained health professional at ANC** | | | | | | |
| GerGer | 19.00 | 15.00 | 0.79 | 29075.00 | 0.16 | 0.12 |
| Sede | 19.00 | 17.00 | 0.89 | 58056.00 | 0.31 | 0.28 |
| Lurio | 19 | 12.00 | 0.63 | 13414.00 | 0.07 | 0.05 |
| Chipene | 19 | 16.00 | 0.84 | 17500.00 | 0.09 | 0.08 |
| Mazua | 19 | 12.00 | 0.63 | 29776.00 | 0.16 | 0.10 |
| Memba | 19 | 15.00 | 0.79 | 38586.00 | 0.21 | 0.16 |
| | | | | | | **0.79** |
| **ANC visit >=2 times** | | | | | | |
| Gerger | 19 | 14 | 0.74 | 29075.00 | 0.16 | 0.11 |
| Sede | 19 | 14 | 0.74 | 58056.00 | 0.31 | 0.23 |
| Lurio | 19 | 7.00 | 0.37 | 13414.00 | 0.07 | 0.03 |
| Chipene | 19 | 14.00 | 0.74 | 17500.00 | 0.09 | 0.07 |
| Mazua | 19 | 9.00 | 0.47 | 29776.00 | 0.16 | 0.08 |
| Memba | 19 | 11.00 | 0.58 | 38586.00 | 0.21 | 0.12 |
| | | | | | | **0.64** |
| **2+ TT immunization** | | | | | | |
| Gerger | 19.00 | 12.00 | 0.63 | 29075.00 | 0.16 | 0.10 |
| Sede | 19.00 | 15.00 | 0.79 | 58056.00 | 0.31 | 0.25 |
| Lurio | 19.00 | 3.00 | 0.16 | 13414.00 | 0.07 | 0.01 |
| Chipene | 19.00 | 12.00 | 0.63 | 17500.00 | 0.09 | 0.06 |
| Mazua | 19.00 | 8.00 | 0.42 | 29776.00 | 0.16 | 0.07 |
| Memba | 19.00 | 8.00 | 0.42 | 38586.00 | 0.21 | 0.09 |
| | | | | | | **0.57** |
| **3+ Pregnancy-related danger signs** | | | | | | |
| GerGer | 19.00 | 18.00 | 0.95 | 29075.00 | 0.16 | 0.15 |
| Sede | 19.00 | 18.00 | 0.95 | 58056.00 | 0.31 | 0.30 |
| Lurio | 19 | 14.00 | 0.74 | 13414.00 | 0.07 | 0.05 |
| Chipene | 18 | 12.00 | 0.67 | 17500.00 | 0.09 | 0.06 |
| Mazua | 19 | 11.00 | 0.58 | 29776.00 | 0.16 | 0.09 |
| Memba | 19 | 9.00 | 0.47 | 38586.00 | 0.21 | 0.10 |
| | | | | | | **0.75** |

# APPENDIX 15



| | | | | | | |
|---|---|---|---|---|---|---|
| **Delivery** | | | | | | |
| **Trained attendant** | | | | | | |
| Gerger | 19 | 13.00 | 0.68 | 29075.00 | 0.16 | 0.11 |
| Sede | 19 | 8.00 | 0.42 | 58056.00 | 0.31 | 0.13 |
| Lurio | 19 | 1.00 | 0.05 | 13414.00 | 0.07 | 0.00 |
| Chipene | 19 | 5.00 | 0.26 | 17500.00 | 0.09 | 0.02 |
| Mazua | 19 | 5.00 | 0.26 | 29776.00 | 0.16 | 0.04 |
| Memba | 19 | 7.00 | 0.37 | 38586.00 | 0.21 | 0.08 |
| | | | | | | **0.38** |
| **3+ birth plan items** | | | | | | |
| Gerger | 19.00 | 1.00 | 0.05 | 29075.00 | 0.16 | 0.01 |
| Sede | 19.00 | 0.00 | 0.00 | 58056.00 | 0.31 | 0.00 |
| Lurio | 19.00 | 1.00 | 0.05 | 13414.00 | 0.07 | 0.00 |
| Chipene | 19.00 | 2.00 | 0.11 | 17500.00 | 0.09 | 0.01 |
| Mazua | 19.00 | 0.00 | 0.00 | 29776.00 | 0.16 | 0.00 |
| Memba | 19.00 | 1.00 | 0.05 | 38586.00 | 0.21 | 0.01 |
| | | | | | | **0.03** |
| **Child spacing** | | | | | | |
| **Know 2+ FP methods** | | | | | | |
| GerGer | 19.00 | 4.00 | 0.21 | 29075.00 | 0.16 | 0.03 |
| Sede | 19.00 | 6.00 | 0.32 | 58056.00 | 0.31 | 0.10 |
| Lurio | 19 | 3.00 | 0.16 | 13414.00 | 0.07 | 0.01 |
| Chipene | 19 | 3.00 | 0.16 | 17500.00 | 0.09 | 0.01 |
| Mazua | 19 | 5.00 | 0.26 | 29776.00 | 0.16 | 0.04 |
| Memba | 19 | 5.00 | 0.26 | 38586.00 | 0.21 | 0.05 |
| | | | | | | **0.25** |
| **Using modern FP** | | | | | | |
| Gerger | 19 | 4 | 0.21 | 29075.00 | 0.16 | 0.03 |
| Sede | 19 | 3 | 0.16 | 58056.00 | 0.31 | 0.05 |
| Lurio | 19 | 5.00 | 0.26 | 13414.00 | 0.07 | 0.02 |
| Chipene | 19 | 1.00 | 0.05 | 17500.00 | 0.09 | 0.00 |
| Mazua | 19 | 1.00 | 0.05 | 29776.00 | 0.16 | 0.01 |
| Memba | 19 | 3.00 | 0.16 | 38586.00 | 0.21 | 0.03 |
| | | | | | | **0.15** |

# APPENDIX 15

| | | | | | | |
|---|---|---|---|---|---|---|
| **Immunization** | | | | | | |
| Gerger | 18.00 | 0.00 | 0.00 | 29075.00 | 0.16 | 0.00 |
| Sede | 19.00 | 3.00 | 0.16 | 58056.00 | 0.31 | 0.05 |
| Lurio | 19.00 | 1.00 | 0.05 | 13414.00 | 0.07 | 0.00 |
| Chipene | 19.00 | 5.00 | 0.26 | 17500.00 | 0.09 | 0.02 |
| Mazua | 19.00 | 2.00 | 0.11 | 29776.00 | 0.16 | 0.02 |
| Memba | 19.00 | 2.00 | 0.11 | 38586.00 | 0.21 | 0.02 |
| | | | | | | **0.12** |

## Appendix 16 MTE Team Members and Titles

External:

1. Ana Paula deMorais Oppenheimer, MD, MPH – team leader
2. Eric Swedberg MPH – SC Child Survival Specialist
3. Joseph de Graft-Johnson MBchB, MPH, DrPH, SC Africa Regional Advisor

Internal:

1. Amilton L Alberto - Tecnico de Saude, DDS Memba,
2. Alexandre Agostinho - Tecnico de Saude, Administrator DDS NaV
3. Maria Adelia - SMI nurse, Lead Trainer, SC Nacala
4. Cristina Cardoso – SMI nurse, Memba Trainer, SC Nacala
5. Florinda Francisco – SMI nurse, NaV Trainer, SC Nacala
6. Maria Manicuela – Accountant, M&E officer, SC Nacala
7. Adelina Xavier – Elementary nurse, Trainer, SC Nacala

Support:

1. Ana Paula Cortez –translator
2. Izidine Omar –translator
3. Filo, Salvado and Ismael - SC drivers
4. M. Lucia Alexandre- secretary
5. Jolly Muxahua- Logistics officer
6. Fatima and Saraiva –services