SALVATION ARMY WORLD SERVICE OFFICE

ABAQULUSI CHILD SURVIVAL PROGRAM, ABAQULUSI MUNICIPALITY, ZULULAND DISTRICT, KWA-ZULU NATAL PROVINCE, SOUTH AFRICA

ANNUAL REPORT, OCTOBER 2003 – SEPTEMBER 2004 (YEAR 2)

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Acronyms Used in this Document

ACSP	Abaqulusi Child Survival Program
ARI	Acute Respiratory Infection
AIDS	Acquired Immunodeficiency Syndrome
BCC	Behavior Change Communication
CBIS	Community Based Information System
CBO	Community Based Organization
CHC	Community Health Committee
CHF	Community Health Facilitator
CHW	Community Health Worker
DIP	Detailed Implementation Plan
DOE	Department of Education
DOH	Department of Health
DOSD	Department of Social Development
DOTS	Directly Observed Therapy System
FOCHA	Faith Based Organization Committee for HIV/AIDS
HBC	Home Based Care
HBCV	Home Based Care Volunteers
HH IMCI	Household Integrated Management of Childhood Illness
HIV	Human Immune Virus
HIV/AIDS	Human Immune Virus Acquired Immunodeficiency Syndrome
HR	Human Resources
IMCI	Integrated Management of Childhood Illness
JHU	John Hopkins University
LOP	Life of Project
LQAS	Lot Quality Assessment Sampling
MOU	Memorandum of Understanding
NGO	Non-governmental Organization
OVC	Orphans and Vulnerable Children
PARECO	Provincial AIDS Religious Committee
PHC	Primary Health Care
PLA	Participatory Learning and Action
PMTCT	Prevention of Mother to Child Transmission
SAWSO	Salvation Army World Service Office
STI	Sexually Transmitted Infection
TDCSP	Thukela District Child Survival Program
TSA	The Salvation Army
TSA/SA	The Salvation Army/Southern Africa
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

I. Accomplishments to date and contributing factors

Background:
The Abaqulusi Child Survival Program (ACSP) is located in the northern Kwa-Zulu Natal municipality of Abaqulusi. The ACSP goal is to reduce the morbidity and mortality of 27,242 children under five years and 37,816 women aged 15 – 49 years, help prevent the spread of HIV and other STIs, and provide assistance to orphans and vulnerable children, especially those who have been impacted by the HIV pandemic. ACSP's main partners include The Salvation Army/South Africa, The Salvation Army World Service Office (SAWSO), The Department of Health (DOH), and the Department of Education (DOE). The ACSP partnership, focuses on the following areas:

- Main areas of focus
    - Control of Diarrheal Disease (20%)
    - Acute Respiratory Infection Case Management (20%)
    - Immunization (10%)
    - Promotion of Exclusive Breastfeeding from birth to 6 months (10%)
    - HIV/AIDS – (Mitigation of effects on OVCs and prevention) (40%)

This year has been quite exciting with a great deal of emphasis and planning put on implementation. Despite delays with start-up and staff hiring as reported previously, the ACSP team has worked well to accomplish the program's planned activities including intensive training, setting up monitoring systems in order to assess these and other project related activities, building/strengthening partner relationships and relationships with the program's primary stakeholder – the community.

ACSP's exceptional and motivated field team made the accomplishments this year possible. Major accomplishments this year include:

- Well established links with the Partners in particular the DOE and the DOH, and more recently the Department of Home Affairs and Department of Social Development.
- Development of training modules based on DOH HH IMCI materials
- Training of 14 community Health Facilitators
- Training of all Community Health Workers using the training modules
- Accompanied supervisory visits to assess CHW training and performance
- Successful Measles and Polio Campaign
- Initial steps to refine BCC strategy.
- HIV/AIDS peer learner program established and completed in 13 schools
- The volunteer Master trainer program as set up by the DOH has been augmented and fast tracked in the sub district through the training of three groups of religious leaders
- Design and use of an orphans registry tool
- Development of a community based information system

- In-depth assessment of DOH information systems
- Development of ACSP monitoring system for tracking inputs and outputs
- Discussions around water and sanitation with relevant statutory body

Household and Community IMCI:

- Adaptation of DOH HH IMCI materials

  ACSP developed training modules for CHWs based on DOH materials that were developed in conjunction with TDCSP (World Vision) and Valley Trust. ACSP decided to adapt the materials in order to include critical new information such as PMTCT, to focus more on key family practices targeted by the program, and to include key methodologies such as community counseling, the importance of counseling during home visits, supervision, and community-based information systems. The modules incorporate more adult education approaches. Each of the four modules includes a 3-5 day curriculum. CHWs receive training in the complete HH IMCI package including pneumonia and nutrition, key family practices that are not specific parts of the program.

- Training of Community Health Facilitators

  The DOH has a cadre of CHFs who are responsible for training and supervising the CHWs. There are two CHFs in the project area which as indicated later in this report is insufficient. Nonetheless, to ensure sustainability and good integration with the DOH system it was important to begin training efforts with the CHFs. ACSP made the training opportunity available to other CHFs from beyond the project area, and invited two League of Mercy members from each of the four TSA churches in the project area, as well as the PHC nurse that conducts mobile services from the TSA/SA hospital to the training. Training these individuals enables TSA to extend its outreach and take advantage of the frequent home visits made by League of Mercy members to educate people on child health and HIV awareness. This will help with program sustainability after LOP. The training was conducted from 13-17 October 2004, ahead of schedule. The BCC Coordinator facilitated the training with assistance from an external Consultant Ms Chris Gibson and Dora Ward the Project Advisor. Twenty two CHFs and eight League of Mercy members participated in the training.

  The five day workshop covered the following topics:
  - Community counseling.
  - Exclusive breastfeeding.
  - Promotion of psychosocial and physical development of a child including growth monitoring.

- HIV/AIDS prevention, and the care and feeding of HIV infected children
- Seeking outside treatment
- Immunization: schedule, benefits, barriers
- Danger signs: dehydration, chest in-drawing, fever lethargy, etc

The workshop utilized many adult education methodologies that stimulated active participant involvement. Comments from the trainees indicated their appreciation for the IMCI workshop.

The second CHF training took place 1-5 March 2004. A total of 16 CHFs were trained, including CHFs from beyond the project area. Unfortunately none of the volunteers from the Salvation Army League of Mercy were able to attend the training. The BCC Coordinator conducted the training with the assistance of the HIV/AIDS Coordinator, the Program Manager and a clinical nurse.

The objectives of the five day workshop were:

- To improve communication skills
- To revise the previous IMCI work
- To gain knowledge about HIV/AIDS and related issues i.e. PMTCT , VCT , stigma and discrimination
- To facilitate OVC care and HBC
- To improve supervisory skills
- To learn how to use the community-based health management information system and how to feedback information to communities
- To develop team work

In the second workshop adult education methods used included role plays, small group discussion, problem solving, videos and value clarification. The BCC Coordinator indicated that the group participated actively and wanted to learn new skills especially those pertaining to HIV/AIDS.

Training of Community Health Workers

To make the CHW training as interactive as possible, the 104 Community Health Workers in the municipality were divided into four groups of approximately 25 based roughly on geographic area. The course content was streamlined and the workshops were reduced to three days each in order not to overwhelm the CHWs. Following the training, CHWs received follow up support visits to assess how well they had assimilated the information from the training. ACSP training staff used this information to adjust and refine the approach for the upcoming training modules. A total of eight CHW workshops were conducted that covered the first two modules.

The first training session in Module 1 was held in Mondlo, the most densely populated township close to Vryheid. The three-day training (27-29 October

2003) was attended by 27 CHWs. The BCC Coordinator and two DOH CHFs jointly facilitated the training. The content of the training session was very similar to the CHF training with emphasis on the following topics:

- Community counseling
- Exclusive breastfeeding
- Promotion of psycho-social and physical development of a child
- Complementary feeding and micronutrients
- Danger signs and seeking treatment outside home
- Immunization/ RTHC weighing and plotting
- Weighing demonstration and the issuing of scales

The second training of 22 CHWs commenced at Vryheid Hospital on the 30 and 31 October 2003 and was concluded on the 11 November 2003. The venue was slightly cramped as hospital authorities had made a last minute change to the venue. Despite this setback, this group of CHWs was younger, eager to learn and, very happy to gain new knowledge.

On 12-14 November, the third group of 17 CHWs received training in the first module at the Ntbambomvu Tribal hall. Although the majority of the group were older and had not attained matriculation, their participation was amazing. The training was slightly interrupted on the final day due to an urgent meeting called by the Chief (iNkosi). Thus the danger signs were not covered in this training and were held over until the next module.

The final group of CHWs was trained in the first module in January 2004. This group included CHWs that work in the municipality but are supervised by CHFs from neighboring subdistricts due to the shortage of CHFs. Since this group is also scattered across a large geographic area, they had to be accommodated in Vryheid. This was a very mixed group consisting both of young CHWs that have matriculated as well as CHWs with very low levels of education.

Training for the CHWS in the second module was conducted in a similar manner. Second module training began in May and finished in June 2004.

Although growth monitoring is not a key intervention area, the program purchased a TALC scale for each CHW in the project area. The rationale is that child growth monitoring in the home provides an excellent opportunity for CHWs to dialogue with caregivers in order to jointly assess, analyze and take action on their child's health. Weighing children and assessing their growth on the RTH card provides a tangible basis for dialogue to begin. This opportunity allows for discussion around why a child has lost weight and relating that back to, for example, why it is necessary for the child to have increased feeds at the time of illness. Good growth can also be an opportunity for the CHW to encourage the mother to continue good behavior, such as in situations where exclusive breastfeeding is the mode of feeding.

Feedback from community members demonstrates that people value the work done by the CHWs especially the in-house growth monitoring and home visits. Some say that the growth of their children is very important to them and they are thankful that now it can be done right in their homes rather than having to walk long distances and wait in queues at the clinics just to have their children weighed. Most people appreciate the visits and the work done by the CHWs and some are keen to know more about the health status of their children. Comments include "We are very happy because we can now see our children growing".

An additional accomplishment of the CHF and CHW training is the sense of satisfaction and appreciation that the CHWs and CHFs convey. They now feel valued and acknowledged and "really appreciate the work done by the Salvation Army Child Survival Program." Whether this is attributable to the training, the approach that the training takes or whether it is just the fact they are being "looked after" is unknown and could be interesting to research.

Supervision of CHWs

An important part of supervision is to accompany CHWs as they make home visits. The BCC Coordinator, and sometimes with the DOH CHFs and/or the Program Manager accompany CHWs on home visits. The purpose of the supervision is to assess how well CHWs have put what they have learned during the workshops into action and make necessary adjustments to the training methodology, to clarify issues as they arise, to see how program implementation is working at the household level, as well as to support and encourage the CHWs. The supervision has been done in all geographical areas of the municipality including Louwsburg, Ngwelu, Khambi, Mondlo, Dlomo Dlomo, uMvunyane and Vryheid.

General findings on visits have been that CHWs still grapple with the need to be conduits of health information rather than counselors that can tailor their advice and counsel to each individual home situation. This is a key challenge to the program and will be discussed further under item II. There is also an indication that the CHWs are happy to be accompanied and supervised.

Measles Campaign

During July and August, 2004 the Department of Health held a Measles and Polio Campaign nationwide. The DOH surveillance systems indicate that measles cases are on the increase in Gauteng, the economic hub of this country. Gauteng province receives many economic migrants and visitors, heightening the importance of making the Measles campaign successful. The recent Polio cases in Nigeria, as well as a documented case in South Africa have highlighted the need to ensure adequate coverage for this preventable disease as well.

The ACSP was extensively involved in providing support to this campaign. Such support included attending the provincial planning meetings, clarifying the project's role at municipal level which included community mobilization, administrative assistance, and the provision of staff and vehicles to assist in both weeks of the campaign. The program saw this as a major accomplishment since it provided the opportunity for the project and the DOH to work side by side in trying to address a common issue.

The importance of trust, relationship building, and understanding people's belief systems could not have been more exemplified than in this activity. In some communities people only came forward to immunize their children 3-4 weeks after the initial round of the campaign. Apparently they were conducting their own "evidence based studies". Community members indicated that they first watched to see whether other people's children who had been immunized survived or not. They wondered whether the immunization was actually a lethal dose being given to the children and therefore wished to ascertain whether it was safe before they actually brought their own children for the immunization.

Behavior Change Strategy

During the year we made strides to refine our behavior change strategy. Although it was clear that CHWs and the community counseling process would be instrumental in this strategy, we needed to clearly define the benefits and barriers to our targeted behavior. The program took innovative and cost effective approaches to arrive at the definitions. First, the program wrote a scope of work for a consultant, possibly a graduate student, who could a) assess in greater depth the determinants to targeted behaviors and b) develop appropriate materials/activities. Second, ACSP team members conducted focus group discussions with various groups of caregivers from representative geographical areas. Third, the program discussion groups at schools that gave important insights into the reasons for certain behaviors. The most recent activity was training on the BEHAVE framework by SAWSO's Health Program Officer and the Program Advisor in July. The ACSP team then began using the Doer-Non Doer analysis of the benefits and barriers to exclusive breastfeeding. The BEHAVE framework has given us an opportunity to assess whether our targeted behaviors and the accompanying activities are in fact addressing the root cause of a non behavior. The final retro-fit of the framework has not been finalized although it is envisaged that this approach will facilitate our behavior change in the project area. Findings from our focus group discussions indicate knowledge is fairly high but this does not translate into targeted behavior.

The additional approach of Community Counseling will also assist in defining and enabling behavior modification. ACSP held Community Counseling training from the 6-10 September 2004 in a section of Mondlo Township. With years of expertise using this process, The Salvation Army's Africa Regional HIV/AIDS Team facilitated this highly participative approach to community development.

Nearly all TSA churches sent representatives to this training with the exception of one. Building the capacity of local Salvation Army churches in community counseling will greatly enhance their involvement in the ACSP, as well as strengthen their effectiveness as a local branch of TSA in other development efforts.

CHC Development

As indicated in the DIP the ACSP has attempted to design its interventions by building upon or strengthening existing structures. Community Health Committee (CHC) enhancement/development is documented as one of the vehicles that will enhance the Community Counseling approach. In trying to identify the extent of existence of CHCs, a consultant from the TDCSP with CHC establishment experience was engaged. The aim of the consultancy was to provide a situational analysis that would evaluate the status of CHCs in Abaqulusi and prepare communities and stakeholders for an ongoing process of forming and strengthening CHCs. The consultant conducted participatory meetings with the clinic committee for each clinic in the project area to assess the needs, interests, activities and strengths of each clinic committee and its corresponding CHCs. He also conducted participatory meetings with stakeholders throughout each ward in the district with representatives from each "esigodi" (village/ward) present to assess the needs, interests, activities and strengths of the communities with regard to CHCs. He then summarized the findings of the above activities in a Situational Analysis, which included recommendations for follow-up actions detailing next steps in all areas of the sub-district. In his findings the consultant indicated that although clinic committees functioned in all but three of the clinics, there were very few CHCs in the project area. Also political leadership was not aware of the project yet welcomed the need to build relationships with the project. Encouragingly, all clinic committee members were keen to have CHCs established on order to enhance representation and communication at the village level. The consultant further recommended that CHC development be seen as a priority of the project in order not only to enhance communication but also to ensure integration at community level. To date 15 CHCs have been established in Umvunyane with clear roles and responsibilities established for the office holders. These CHCs as well as school governing boards will participate in the Community Counseling process.

HIV/AIDS

The ACSP has committed to four strategies to reduce the scourge of HIV/AIDS that include life skills training, training for spiritual leaders, home based care, and OVC support.

- Life Skills Training
  The program adapted DOE's life skills curriculum, creating a five day course for peer leaders (rising 7th graders) and completed the training

as scheduled by the end of November 2003. The program invited two representatives and an educator from each of the 15 schools selected in Umvunyane. A total of 26 peer leaders/educators and 13 educators from 13 schools received the training. Facilitators from the DOE and other organizations assisted in the facilitation of this course.

The HIV/AIDS Coordinator has shown great enthusiasm and initiative and has conducted an evaluation of the training in conjunction with the educators and the DOE. (The team is still in the process of analyzing the data from that evaluation.)

Eighteen volunteers who requested to work with the life skills project have been recruited as "mentors." The process envisaged is that they would provide follow up for the peer leaders. The peer leaders, overseen by the HIV/AIDS Coordinator and the mentors, would spend three months conducting discussion groups and activities; spend three months developing dramas, songs and poems written by children with help from the mentors/teachers, and then three months preparing drama performances at the schools and in other community settings.

The mentors received training in HIV/AIDS, playwriting and directing, song writing and the use of other media to enhance communication of HIV/AIDS messages. During the June vacation the peer leaders and their respective educators also received this training in order to be able to develop effective HIV/AIDS messages. As a result of this training, most schools have held performances in conjunction with their September calendar celebration of HIV/AIDS month. An additional bonus is that these schools also invited their communities to the performances in order to create greater community awareness of HIV/AIDS and raised the awareness of the parents who came to see their children perform. This has really been an exciting and wonderful experience. The children have really outshone themselves.

One of the major accomplishments of these in-house activities is that local people recognize the importance of local community ownership and participation.

Traditional awareness events are typically large, inviting all the local schools to one specific community. They are expensive since public address systems must be acquired, locations rented, and food prepared, and only the host community benefits from it. Since ACSP encouraged each school to conduct their own performances with each inviting their respective community, many more people benefited from seeing the performances. When each community develops their own plays, songs, and poems about HIV/AIDS, the HIV/AIDS messages are more specific to the community's needs and specific factors

contributing to the spread of HIV/AIDS in that community. For example in one community the key factor portrayed was seeking employment outside the community and the influence of peer pressure. Another school focused on the role of the media on morality and another school focused on the need for after school activities for youngsters, seeing the link between a lack of recreational activities and sexual experimentation.

- Spiritual Leaders Training (stigma reduction, transmission prevention and OVC support).

  This activity started in the first year of the project and progress has been dramatic. The initial training was conducted in Vryheid, from the 22-26 September 2003.

  The DOH had trained Master Trainers who were volunteers selected from their local congregations. The DOH viewed their role as trainers who could raise awareness of the HIV/AIDS pandemic in the churches. With only four Master Trainers in the project area they cover a large number of churches which has in itself left some gaps in coverage. The ACSP has really helped to augment what these volunteer were meant to do.

  There had been very little program coordination and in fact the local religious leaders did not accept the program. This was exemplified when the project set up an initial meeting to get all the Vryheid religious leaders together in order to introduce the Master Trainers and to plan the way forward for the setting up the training. The district chairperson of the DOH-driven Provincial AIDS Religious Committee (PARECO) also attended to explain their role and provide input. There was major dissent amongst the religious leaders about the Master Trainers. They did not know these "young ladies" or who selected them. They viewed young ladies teaching the "amafundisi" (pastors who are seen traditionally as leaders and therefore should not be taught by young people) as inappropriate. The ACSP HIV/AIDS Coordinator managed the discussion well and helped the group to reach a consensus at the meeting. They agreed to establish a local sub-district faith-based religious leaders committee called the Faith Based Organization Committee for HIV/AIDS (FOCHA), whose main task would be to map out the training and to "provide" guidance for the Master Trainers. After the initial training, the committee met to evaluate the training using the Strengths, Weaknesses, Opportunities, and Threats analysis. Based on their input, the curriculum was refined for the second training held in Mondlo from 17-21 November 2003, attended by pastors in the most heavily populated area of the project (Mondlo and Umvunyane). Facilitated by the HIV/AIDS Coordinator,

TSA/SA Mission Coordinator and the Master trainers, the training was well attended and received "thumbs up" from the participants. The purpose of this intervention is to equip religious leaders with basic information on HIV/AIDS (HIV/AIDS-the basics, stigma, OVC, HBC) but an additional benefit is the general social mobilization achieved at these events. It has become clear that follow up is needed to encourage pastors to hold discussions at their churches and to implement their action plans. The Master Trainers have provided this follow up. In some instances the pastors either are not comfortable yet about discussing HIV/AIDS or require specific assistance with further workshops for their congregations. Four congregations have received this support so far. Another major project accomplishment has been getting the religious leaders to determine what their communities' needs are around HIV/AIDS. Most have indicated a need for home-based care.

- Home Based Care Volunteers

  The first step was to assess existing HBC support training materials and supervision systems. We found that DOH had curricula; there is a need to standardize our HBCV curriculum and ensure that the training is recognized by DOH. We also found that HBCV supervision has not been emphasized. DOH has a 59 day and a 10 day curriculum. The ACSP organized a curriculum drafting committee consisting of representatives from DOH, DOE, Lethimpilo Youth Organization and other "co-coordinating bodies" of HBCV to draft a 10 day curriculum to train HBCV. We developed two training modules of five days each. The first training was held in June and 17 HBCV selected by the churches in the North Western area of the project participated in the training. The second five day module was held four weeks later. Participants did a practicum in between the two modules. HBCV have been used extensively in the project area to assist in the Orphans registry.

  The project is currently focusing on developing criteria for levels of competence and a refresher training curriculum in order to meet the demand for refresher training as outlined in the Detailed Implementation Plan. The involvement of the Community Health Committees as well as TSA League of Mercy in this process is seen as critical to enhance HBCV initiatives since they can play a tremendous role in coordinating, and strengthening local HBC efforts.

- OVC support

  OVC support activities are on schedule. The initial plan was to develop an orphan's registry tool and to conduct the initial registry data collection including community mapping which would create a visual view of the

extent of this increasing problem. The project developed a tool called the safety net register that documents all double orphans and child headed households. The term safety net register was coined so as not to add to possible or perceived "stigmatization" of this vulnerable group. Data fields include name, address, and date of birth, current government grants, documents, school attendance, and general comments. As indicated above existing home based care volunteers were used for this activity and where there were gaps CHWs augmented the process. Safety net registry training involves CHWs in discussing why there is need to capture this information, defining "orphan" and "child headed households" and covers how to fill out the form. The safety net register is one of the tools of the CBIS that is seen to be owned by the community and will therefore ensure sustainability. The program will continue to work on systems that will enable the CHCs (through Community Counseling) and the communities to utilize these registers for the ongoing solutions to this growing challenge.

All registers have been entered into a computerized system using EPI INFO. There are approximately 2,000 orphans in the project area. Although many of these have the necessary documentation, they have been unable to access government grants. This confirms a previous finding that KwaZulu-Natal has a very low uptake of grants administered by the Department of Social Development. This challenge and how the program will overcome this will be discussed in the next section. Two test cases that have helped us to understand the challenges faced by this vulnerable group are covered in section II.

HMIS

The HMIS Coordinator has conducted an in-depth assessment of DOH information systems as planned in the DIP. The assessment included visits to all the clinics, and staff interviews using a standard assessment tool, including an interview with the sub district information officer. The District information officer responded with a written interview. Some of the clinics have computers that can be used for enhancement of the HMIS, however many of the clinic staff do not have the skills to appropriately use this technology. The project has offered to assist the DOH in this regard. We will offer guidance in terms of information use in decision making, and will help each clinic to monitor an indicator and a few related outputs. Since DOH indicated that monitoring immunization consistently presents challenges, and based on the preliminary results from the measles campaign that were compiled at sub-district level, we have decided to focus on immunization.

This year we began exploration on the development of community-based information system. At the community level, there exist the basic concepts of the child health card (Road to Health Card – RTHC) and the family card. CHWs use

the family card to record names of family members and CHW activities. In an effort to improve information collection and more especially INFORMATION USAGE the ACSP has re-designed the family cards and developed a Summary form for the CHW and for the CHF. Again this has been in an effort to streamline information collection, use and dissemination. There has been much debate as to whether to only include information for under fives as this is where the thrust of the ACSP intervention. This is also where the CHWs should concentrate their efforts in order to provide an effective preventive health service. However with the evolving health services in the province many hold the view that CHWs are conduits or the extension of an array of programs. CHW functions range from being DOTs supporters, rendering First Aid, providing home based care and chronic illness care. However although this is not optimum the ACSP wishes to at all times to ensure sustainability and integration into existing systems. The format has therefore tried to incorporate/accommodate elements that are seen to be important by the DOH. The household card has formed the basis of the community census to which we committed in the previous annual report.

There has also been work done on setting up a system using databases in Microsoft Access to track project inputs and outputs The HMIS Coordinator generates monthly reports for discussion at team meetings.

Partnership Strengthening

The ACSP has worked extensively on building relationships with all partners and utilizing participatory methodologies. The DOH partnerships have been particularly strengthened at clinic, at CHF and at primary health care level as well as district level, provincially and nationally. The DOH has employed a CHW Program Coordinator and an HIV/AIDS Coordinator for the sub-district. An excellent partnership has been established with her.

The DOE has a section that has as one of its foci HIV/AIDS. Again excellent relationships and partnerships have been strengthened with them and they have given their full support to the ASCSP. The DOE has also been very responsive and partnerships have been forged at ward level. Local DOE officials have indicated a willingness to embrace what the project is doing. One indicated that they "can never say no to anyone wanting to do HIV/AIDS work in the schools since our young people and future generation is going to be stamped out unless we make every attempt to ensure that they are informed." He has therefore been very accommodating by integrating the life skills program into the daily schools activities.

Quarterly meetings held with the TSA/SA THQ strengthen linkages and collaboration with the local Salvation Army partners. The ACSP is now included in TSA's quarterly Mission Task Force. The ownership and involvement dedicated by local Salvation Army leadership has been of immense value to the

project and certainly in terms of sustainability. The new Salvation Army Divisional leader has indicated the desire for the TSA to be community oriented. TSA church leaders and project staff meet monthly to ensure full involvement in the implementation of the project. This has helped to clearly articulate the work and role of the churches. In the Mentorship program there are eight mentors who each represent one of TSA's churches in the municipality.

Water and Sanitation

Activities planned for this year included the assessment of water/sanitation situation and adaptation of community water sanitation materials. Steps in achieving this have been hampered by the indecision amongst government departments as to who is responsible for water and sanitation in the project area. However an accomplishment has been the development of a Scope of Work for a consultant should there be a need to do any geological assessment and system design and then to oversee actual construction and work with community health committees on maintenance. It has been determined that areas to the North West of the Municipality may be the targeted areas for this activity. However the scourge of the drought was felt throughout the municipality. It was very recently determined that the responsible authority is the locally governed municipality. We have been invited to enter into a partnership with the municipality since their funding is limited at this time. Discussions are on going in this regard.

Microenterprise

The assessment of the micro enterprise situation was conducted. The Program Advisor in conjunction with an ILO consultant conducted various exploratory visits and meetings. The program assessed Pact's literacy-based savings materials developed by Pact for their Worth program. Because of the high rate of HIV/AIDS in the area and high levels of adult literacy, it was determined that the Worth tools would need to be adapted these to local conditions with greater emphasis placed on specific activities that could assist women's groups to deal with the results or impact of HIV/AIDS on their families and communities.

Schedule of activities as per Work Plan

Activity	Begun (Yes/No)	Completed (Yes/No)	Comments
HH IMCI/Staff Training			
Adaptation of DOH HH IMCI materials	Yes	Yes	Despite the existence of a manual from the DOH the ACSP has determined a need to make the information more participatory.
Training of Community Health Facilitators	Yes	Yes	Training is on schedule but curriculum has been modularized, therefore additional trainings are planned for the third year. Training should however be geared more to updates and in-service All training for this period was conducted. However due to the modularization and gaps noted training has been taken into year 3
Training of Community Health Workers	Yes	Yes	
HH IMCI/Health Promotion			
Materials development	Yes	No	Scope of work drafted. Held over till behavior change strategy finalized
HIV/AIDS Peer Education Groups			
Adaptation of DOE's curriculum to 5 day course for peer leaders (rising 7th graders)	Yes	Yes	Finalized by Program Advisor
Peer leader course	Yes	Yes	26 Peer Leaders trained at the end of November 2004. Program implemented and completed in 13 schools. Evaluation requires analysis.
HIV/AIDS training for spiritual leaders	Yes	Yes	Training conducted in all four quadrants. Follow-up in progress
OVC Support			
Finalization of orphans registry tool	Yes	Yes	Tool termed safety net register finalized 27/10/2003

Initial registry data collection (incl. community mapping) Monitoring of registry HBC training materials adaptation	Yes Yes Yes	Yes Yes Yes	Baseline information has been collected and analyzed. Highly participatory feedback sessions have also been conducted. Ongoing activity Highly participatory curriculum co-designed with DOH, DOE, & Lethimpilo- Training conducted by Lethimpilo for 17 HBCV.
HMIS			
In-depth assessment of DOH information systems Development of community-based information system Development of system w/I project for tracking inputs and outputs Development/adaptation of necessary training for DOH	Yes Yes Yes Yes	Yes Yes Yes Yes	Completed in November. Formats finalized and training carried out on initial household card. Data sets established and data entered. Curriculum is finalized but training dates not yet scheduled.
Water and Sanitation			
Assessment of wat/san situation Adaptation of wat/san community materials	Yes Yes	No Yes	Municipality has indicated that they will conduct a needs analysis Preliminary work conducted. Past methodology to be used

Micro enterprise			Due to the need for intensive training this year, microenterprise activities were postponed until year three.
Assessment of micro enterprise situation, pilot site identification	Yes	Yes	Completed but not finalized.
Adaptation of WORTH tools	Yes	No	
Other			
Compilation/Adaptation/Development of appropriate supervisory training material	Yes	Yes	Supervisory system set up. Transport and manpower proved challenging but should improve with the acquisition of three CHFs and 2 vehicles.
Enhancement/finalization of financial and administrative procedures	Yes	Yes	Bookkeeper has facilitated this
Negotiation w/ DOHre terms of employment for community health staff	Yes	Yes/No	Three CHFs employed by the ACSP

2. Challenges and Solutions

We have implemented the majority of the activities planned for this year. Some aspects of collaboration with some partners remain challenging. This is the case with the DOH and the DOSD. While the program has won the wholehearted support of the DOH officially, often the daily burdens of clinical duties and scheduling by higher DOH authorities present difficulties in scheduling events. Despite having set up a Task Force comprising all decision makers in partner organizations, there are still often insufficient opportunities for dialogue and consensus building and agreement on the next steps in particular at the sub-district level. The fact that the sub-district boundaries are not co-terminus with those of the municipality and therefore the project area may contribute to this challenge. The sub-district Coordinator oversees two municipalities and it is this latter one that presents far more health management problems, thus perhaps utilizing more of the management capacity. One solution would be to include this area in the event of program scale up after this cooperative agreement.

An additional challenge is that while the Primary Health Care Coordinators are very cooperative, they are sometimes over-stretched, especially when they must fill in for clinic staff that has died leaving clinics temporarily unstaffed. Otherwise the clinics would have to be closed.

In so far as the DOSD is concerned their compatibility with boundaries are totally deviant from the project area and one is shunted to and fro to areas beyond the project area. Their inability to fill key positions has also contributed to our inability to establish mechanisms for strengthening systems for OVCs.

Two TSA churches are being used as test cases to assess where the gaps and challenges are in supporting OVCs. The first church runs a feeding scheme for identified orphans in the Mondlo area. The families and in some instances child headed households are issued a monthly food parcel. The findings for this test case indicate that many of these children have their documentation, and in some cases have filled in the required forms for grant applications but are still waiting for longer than two years to receive government grants. This could be due to insufficient government staff. Mondlo is the most densely populated area of the municipality where more than 60 % of the population lives, and yet there is only one social worker servicing the area. In the other church the OVCs are solely supported by church members. There is no link to outside support. The project is particularly keen to build on this initiative. The program is the result of the community counseling process in which the community identified this concern and developed their own solution to the problem.

A second challenge is the length of time it is taking to train the CHWs. Some CHWs still are not filling out the safety net register correctly. This is a challenge since it was thought that the safety net register was much simpler than the CBIS information. The CBIS section has therefore been protracted with one form

being introduced at a time in order to ensure thorough understanding. This has delayed finalization of the household census.

Another challenge has been the delay in hiring the CHFs. Since these CHFs will augment the current DOH CHFs, they are attending the DOH modularized CHF training program. This requires one month away from the project site for training per quarter with another two month-long practicum. These CHFs are doing this training in addition to keeping up with their normal responsibilities. There may be a tendency for them to feel overworked. Fortunately they are all community development graduates with a good understanding of community work. This gives them an advantage since the training is geared toward enrolled nurses who usually come from a clinical setting and so therefore need intensive community orientation.

The water/sanitation component presents a challenge because of the difficulty in connecting with the party responsible for water and sanitation. Fortunately one of the CHFs has extensive experience in this field and has already been of useful assistance in this regard. The need to liaise with the responsible party is critical firstly for sustainability and secondly to ensure the ACSPs goals are in line with the plans of that party. We do not want to duplicate existing or planned activities which will ultimately result in wasted resources.

III Technical Assistance Required

Three major technical areas were identified: monitoring and evaluation, institutional sustainability and impact evaluation of HIV/AIDS programs.

In the arena of monitoring and evaluation, strengthening the DOH information system is a major aspect of the ACSP's work, especially the use of data in decision making at the local level. The ACSP also wishes to monitor project activities. To this end, the ACSP plans to engage in Lot Quality Assessment Sampling (LQAS) and to train the local DOH staff in this sampling method which has been used successfully by other child survival projects in the area. As the program staff does not currently include an expert on LQAS, further training in the methodology will be necessary. SAWSO has identified a consultant to provide LQAS training before the midterm evaluation in February. The LQAS approach will be used for the midterm evaluation.

The second major area in which the program will benefit from technical advice is institutional sustainability. The ACSP has been designed expressly to allow most of its activities to continue after the end of the program, relying on minimal external input for ongoing expenses such as CHW salaries or costs associated with supervision. However, thoroughly integrating the program's current activities into the existing structures of the DOH and DOE is a challenge. The ACSP hopes to identify a source of technical support to provide further insight into how

best to integrate these activities into existing government structures and procedures while still ensuring high quality programming.

Another area in which the program will seek expertise is the evaluation of the impact of HIV/AIDS programming. It is very difficult to measure program impact on the reduction of prevalence of high risk sexual behavior and mitigation of negative impact that the AIDS pandemic has on children. The program has struggled to do so, attempting to select indicators recognized as reasonably valid by the rest of the international health community. While the program has selected "percent of 14 to 16 year old school children who are virgins" and "percent of households who have received outside assistance for an OVC" as indicators. The former is complicated by interference from other possible causative factors and the latter is ultimately a measure of process only. The ACSP will seek out opportunities to further improve the validity of its measurement of HIV/AIDS programming.

IV. Substantial changes from the program description and DIP

There are no substantive changes to the program description.

V. Specific information requested for response during the DIP consultation

All requested information has been dealt with.

VII. Management System

The ACSP program design included an expatriate Program Advisor in county for the first two years who functioned as the overall program coordinator. This has been a year of transition since the Program Manager assumed responsibility for overall program management in March 2004.

- **Financial Management System**

  Enhancing the program's financial and administrative procedures has been a key issue this year. Despite difficulties finding and hiring a bookkeeper, the program has managed to ensure that all financial aspects of the program have complied with USAID regulations as well as TSA financial management systems. The appointment of a suitably qualified, bookkeeper has seen the enhancement of the financial systems of the program. Specific issues addressed include competitive bidding, adherence to TSA procedures, the set up of specific control mechanisms including a petty cash log book, reconciliation, and a reduction of petty cash in hand.

  The funding mechanism begins when project management submits a quarterly budget forecast to SAWSO. SAWSO reviews this budget and

transfers funds to TSA/SA Headquarters. A portion of the funds is retained for salary costs and benefits, motor vehicle insurance costs, bank charges and cell phone expenses for the Program Advisor. The balance of funds is transferred to the ACSP bank account located in Vryheid. Grant and match funds are then dispensed by the ACSP and expenses are tracked by a computerized expense report developed by SAWSO that requires properly authorized original source documents for all expenditures. The computerized spreadsheet has undergone some revision in order to retro-fit the original budget categories. This is working well. The bookkeeper prepares monthly expense reports which are reviewed by the Program Manager together with the team in order enhance transparency. These are checked against the original budget line items. The expense reports are sent to SAWSO for review by SAWSO finance staff and the Program Officer. Financial reporting to local TSA/SA has also been strengthened with copies of expense reports as well as expenditure to date, sent to TSA/SA. Concerns with financial oversight at project level have been mitigated by the greater involvement of the Divisional Commander in day to day management of the program, (He is currently co-signatory on the bank account and will also participate in budget vs. actual expenditure review). The bookkeeper has also re-categorized previous expenditure and at the field level and this has enhanced overall budget management.

While a low burn rate was described in the previous annual report, this year has seen both under and over expenditure. Under expenditure have largely been the result of delays in staff hiring and the early resignation of the Program Advisor. The over-expenditure has been due to the accelerated training schedule planned for year two, as well as the weakening of the US dollar. The rand is now worth slightly more than half of the original exchange rate at the time of the original budget preparation. Another confounder has been the steady increase in the inflation rate. The over-expenditure has been kept within the 10% guideline set down by USAID.

- **Human Resources**

The ACSP has tried to ensure that all human resource matters are conducted in line with TSA/SA policy and regulations. The project has and continues to liaise extensively with the Human Resource Coordinator at TSA/SA in order to ensure compliance with TSA/SA, the MOU and USAID regulations. For instance, we have reviewed recruitment procedures, and maintenance of HR records. All ACSP team members have received TSA/SA's employee handbook that details employment policies such as leave, disciplinary procedures and working conditions. Each team member has a job description and has developed an individual

work plan. Individual reports are written on a monthly basis to document progress on their work plans.

Filling staff positions continued to present challenges. We advertised and interviewed candidates for the bookkeeper position three times before we were able to place Ms. Yaka in that position. This was despite the fact that many candidates interviewed were B Com graduates.

Negotiations with the DOH regarding terms of employment for community health staff has posed a challenge. In the original proposal budget included both CHWs and CHFs with the idea that they would be integrated into the DOH system that would cover the costs of their salaries. The finalization of district boundaries has determined that there are just over 100 CHWs functioning within the project area who are supervised by two CHFs. DOH policy indicates that there should be one CHW for every 100-150 households and one CHF for every 25 CHWs. With approximately 26,000 households in the project are there are definitely insufficient CHWs for the population in the area. The program has however decided to focus on the hiring of three additional CHFs rather than focusing on hiring additional CHWs. The rationale for this has been that firstly the current CHWs are not receiving the desired supervisory guidance and support since the CHF: CHW ratio is inadequate and the project does not wish to create an untenable situation where the DOH cannot sustain the continued hire of CHWs particularly since their recruitment process is very community driven and owned, despite the DOH being responsible for their salaries.

Despite initial discussions at proposal stage indicating that the DOH would absorb community field staff, the DOH has indicated that they do not have sufficient positions for CHFs owing to their re-structuring and staff turnover(the Director position at Provincial level has been vacant for more than six months). Based on this and budgetary considerations, the ACSP has recruited and filled positions for three CHFs, who are undergoing the required DOH training to qualify as CHFs. The DOH is in the process of restructuring and wishes to re-outsource the management and administration of the Community health Worker Program to NGOs and CBOs that function at district level. They envisage that this process will be finalized shortly and it is hoped that the TSA/SA and/or SAWSO will be able to contribute to this process since it has implications for the program.

In terms if supervision the ACSP approach to supervision and work ethos is largely focused on support and creating an enabling environment for the team. All team members continue to be accompanied on field visits and during training sessions.

Team members are bound contractually to performance based annual salary adjustments. Written Performance reviews will be discussed annually before a salary adjustment is made. Quarterly performance reviews will however feed in to this process.

- **Communication System and Team Development**

The project team holds brief weekly staff meetings, and longer staff meetings monthly to share information, plans, progress and lessons learned. A team approach is central to the ACSP both internally and externally, and the role of the Program Advisor and Program Manager is conceived as one of support and guidance to the rest of the staff. The commitment to team oriented management and planning is facilitated by an open door policy, consensus-based decision making on most issues and the use of participatory techniques with the team.

The Program Advisor reports jointly to TSA/SA and the Health Technical Advisor at SAWSO. The Program Manager has reported to the Program Advisor, and will report jointly to TSA/SA and SAWSO now that the term of the Program Advisor's tenure has ended. Since the team is small, there is a fairly flat organizational structure. All team members have reported directly to the Program Advisor and Program Manager who have functioned as the project management team. With the departure of the Program Advisor, the majority of the team report to the Program Manager with the exception of the CHFs who report jointly to the BCC Coordinator. This allows for the integration of project and DOH CHFs in the planning and operationalizing of this aspect of the program, since the supervision of the DOH community heath workers is seen as an integral part of the program.

The Program Advisor and Program Manager have communicated directly with relevant TSA/SA and SAWSO staff, and major issues are discussed with SAWSO and TSA/SA on a quarterly basis at a formal meeting. The ACSP staff present a narrative report of progress in the previous quarter and plans at the quarterly meeting.

Team development is seen as key to ensuring the success of this program. All team members are encouraged to identify their own training needs, since this approach facilitates self-empowerment and allows them to reach their goals and potential. However, the management has also identified and encouraged specific performance enhancement courses as well. Specific team development activities outside the project area (not in-service training) are as follows:

- Exchange Visits: the BCC Coordinator and the Program Manager attended a five-day Community Counseling Workshop in Malawi. The

workshop was facilitated by the Regional team, with the ACSP staff helping at times, based on our experiences. Lessons learned included an appreciation of the level of involvement and perception of local Salvation Army pastors on development.

- The project team with the exception of the Program Advisor and the HIV/AIDS Coordinator participated in the final evaluation of the Uthukela Child Survival Program. This lasted for one-and a half weeks and all reported that they had benefited extensively.
- The project team with the exception of the HIV/AIDS Coordinator visited the Ndwedwe Child Survival Program run by Medical Care and Development International
- The HIV/AIDS Coordinator attended the DIP review and JHU mini university
- The HIV/AIDS Coordinator together with the Program Manager attended the South African AIDS Conference
- The HIMS Coordinator, the Project Assistant and the Program Adviser attended an OVC operational research workshop
- The Program Assistant and the BCC Coordinator took a v=basic computer course.
- The Program Manager attended a Project Management course.
- The Bookkeeper has undergone an advanced computer training course.
- The HIMS Coordinator and the Program Manager are currently doing a distance learning database course
- The program Manager attended the second South African Public Health Conference
- The Bookkeeper obtained her drivers license.
- All team members enrolled in the first module of a distance learning HIV/AIDS Care and Counseling course, since HIV affects us all!
- The HIV/AIDS Coordinator attended the Provincial DOH Youth Conference on HIV/AIDS
- The HIV/AIDS Coordinator attended a course on HIV Counseling.

Development and performance enhancement has not been limited to the team members only. In an effort to enhance partner capacity and local ownership, the following inclusions were made:

- The DOH Sub-district Coordinator for HIV/AIDS enrolled in the distance learning HIV/AIDS Care and Counseling Course, as well as the volunteer HIV/AIDS Master Trainers.
- The DOH HIMS Coordinator and mobile clinic supervisor are taking driving lessons.
- The DOH Sub-district Coordinator for HIV/AIDS enrolled in a basic computer skills course.

In addition numerous in-service training courses have been run by the Program Advisor, TSA as well as the SAWSO Program Officer. Various

partners have been invited to attend these training sessions which included:

- HH IMCI Training
- Community Counseling
- Adult Education
- The BEHAVE Framework
- Focus groups
- PLA methodology

- **Local partner relationships**

The previous annual report mentioned that an MOU has been written to govern the cooperation between TSA/SA and SAWSO. This was finalized and signed by all concerned and now governs the relationship between SAWSO and TSA/SA. As mentioned in item (II) administrative integration with DOH has proven somewhat more challenging. To date, the program has employed three additional CHFs but no additional CHWs as discussed above. The original intention was for the DOH to assume responsibility for any CHFs or CHWs and the ACSP hoped to integrate these positions into the DOH HR system from the beginning. However the DOH has agreed to the number and placement of positions needed as well as to train them in CHF modularized training program. The DOH indicated that the administrative processes would take too long and suggested that the program continue to hire and once DOH's restructuring is finalized our CHFs would be considered along with any other applicants. Generally however the local partners have seen the ACSP as an important supportive entity within the sub-district.

- **PVO coordination/collaboration in country**

The ACSP has continued to draw significantly on the experience of the other two child survival programs in the province, one run by World Vision and the other run by Medical Care and Development International. The World Vision project has now come to an end but they have allowed us to be part of their evaluation team. Even though their project has finished, their Program Manager has still made she available to assist us by phone or email. The Medical Care and Development International project has provided insight into programming that targets OVCs. The ACSP staff communicates regularly with the staff of these two projects and various members of the staff have made exchange visits to these programs.

The program maintains regular contact with the Health Technical Advisor for the USAID mission in South Africa through meetings and by copying her on regular reporting. When the SAWSO technical team is in country, meetings are also arranged with her.