NFL—An Initiative of Episcopal Relief and Development (ERD)
Mucaba/Uige PMI Grant First Year Annual Report
October 1, 2007-September 30, 2008 (Year One, Life of Project)

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Project Summary and Context

Episcopal Relief and Development (ERD) and its NetsforLife (NFL) initiative received a five-year $1.5 million President's Malaria Initiative (PMI) grant to implement an integrated community malaria project (ICMP) in Mucaba municipality, Uige Province, Angola. This report provides an overview of first year of the life of the project (LOP) (Oct. 1, 2007-Sept. 30, 2008).

Mucaba and its population's access to health services had suffered greatly during the war. When ERD initiated this ICMP project, there was only one functioning health center, which were in a deplorable state, providing health services for the 92,000 individuals in the municipality. None of the Angolan Ministry of Health (MINSA) health posts was functional. Since MINSA defines access to health services as living within 10 km of a health facility, the vast majority of Mucaba's population had no access to health services. The lack of health services in combination with the geographic remoteness, poverty, and high illiteracy rates in the region and the fact that malaria is highly endemic in Mucaba had resulted in maternal and child health outcomes substantially lower than the national average. In collaboration with the Anglican Church of Angola, ERD's key local partner and the largest religious denomination in the municipality, ERD identified the municipality as one in great need of the type of integrated, community-based programming in which NFL specializes. At the end of the project's first year, the anecdotal evidence and data demonstrate that the project has had a significant positive impact on the health outcomes, knowledge of and attitude about malaria prevention and treatment, and use of nets in the Mucaba community.

One of ERD's hallmarks is that it accomplishes its health and development goals at the community level working with local partners. The program design for the NFL-Mucaba project is similar to other NFL projects emphasizing community mobilization and education for home-based symptoms recognition, appropriate treatment, and bed net usage. Working in cooperation with the National Malaria Control Program (NMCP) and with a strong network of church affiliates, women's groups, and community volunteers, NetsforLife partners distribute long lasting insecticide treated nets (LLITNs) to under-5 children and pregnant women in extremely rural areas. Distribution of nets takes place only after a baseline study of household behaviors (which is then used to assess progress at regular intervals) and community messaging and sensitization. Community IMCI is the framework for providing support to households and communities, linking them to health facilities and local providers. Even in remote villages and communities where health facilities do not exist or are limited, ERD's community IMCI approach is still effective since it trains selected community members to serve as community health agents and provide a basic level of information and healthcare that otherwise would not be available. In some cases, ERD has piloted programs to administer medicines at the community level. In Mucaba, for example, MINSA agreed to allow ERD to pilot a community-based IPT program (see p. 5) and MINSA is currently considering a community-based ACT pilot (see p. 5). As a result of this innovative approach, ERD's NFL has garnered international recognition for its work in malaria prevention, including at the December 2006 White House Summit on Malaria.

To ensure coordination and avoid duplication of effort, ERD collaborated closely with a number of domestic and international agencies, including MINSA, the NMCP, USAID/PMI, UNICEF, and WHO. Among other areas of assistance, these entities supplied nets and provided technical assistance in M&E and training, staff for the local health center, and information-sharing. In addition, relationships with a group of local and international NGOS working in Uige, including the ADJC (a church youth NGO), World Vision, the Mother's Union, and Youth Clubs, complemented the key local partnership with the Anglican Church of Angola, particularly in the area of community sensitization efforts.

A. Main Accomplishments

ERD accomplished the vast majority of its objectives for the project's first year. The NFL-Mucaba ICMP completed nearly all of the activities outlined its workplan, resulting in solid progress toward all of the project objectives (see table on p. 11), including:

- preventing malaria infection and illness through use LLITNs;
- increasing percentage of children U5 and pregnant women sleeping under a LLITN;
- contributing to effective treatment of malaria illness at household and facility level; and
- protecting pregnant women from malaria through the use of IPTp

Improved Health Services

Beyond the data and what it means for Mucaba's population in terms of improved health outcomes, ERD is also particularly proud of its partnership with MINSA in improving the ability of the local health center to deliver health services. In the project's first year, ERD used its own funding to refurbish the health center and equip it with necessary equipment and supplies (such as a delivery bed and fully equipped TBA kits), and arranged for delivery of medicines that had been sitting in a storehouse, but for which MINSA did not have the resources to deliver. Along with the refurbishment, the health center is now better managed and open 24 hours. As a way of increasing service provision, ERD also refurbished two other health facilities that had been closed during the war and provided training to nurses and TBAs, some of whom were placed as staff in the two smaller centers. In terms of long-term sustainability, ERD asked and MINSA agreed to pay the salaries of the newly-trained staff on an ongoing basis. This ERD investment leveraged PMI's funding since it is unlikely that ERD would have been able to justify use of its own funding without knowing that PMI was already covering the complementary program elements (i.e. community sensitization and LLITN distribution).

The other important accomplishment to highlight in "improved health services" is ERD's identification and training of unemployed individuals that had previous healthcare training. Many nurses and midwives in Mucaba were war returnees, but were not practicing as a result of the lack of health facilities and/or opportunities. ERD identified and provided refresher training to these individuals thereby taking unused capacity, strengthening it, and integrating it into the community. This effort not only helped the community-at-large, but also brought hope to those being trained. One midwife, who had trained in the Democratic Republic of Congo (DRC) during the war, had been

unemployed for seven years. Two months after her training, she visited the NFL-Mucaba staff to tell them how, even though she was not being paid for her services, she felt very gratified helping her community and that she had not realized what a significant difference her efforts could make.

In June 2008, the then Vice Minister of Health, who has since been promoted to Minister of Health, and the National Public Health Director visited Mucaba because it is endemic with so many diseases, including malaria, and they wanted to see the programs in place to address endemic diseases. As part of this trip, they visited the refurbished health center in Mucaba. The Vice Minister of Health asked "where are all of the people?" On a previous visit before ERD initiated its project, the Vice Minister had seen three rooms full of people waiting for malaria treatment. Later during the same visit, the Vice Minister went on a radio program and complimented the ERD project for its improvements in the provision in health services and for the noticeable decrease in patients with malaria.

Community-Oriented Monitoring and Evaluation

As noted above, ERD accomplishes its health and development goals at the community level working with local partners and members of the community. In the NFL-Mucaba project, ERD employed a fully participatory approach to program design, monitoring, and evaluation and feels that this is a key difference and comparative advantage over other malaria prevention and control projects that work in areas with limited health services. This stems from ERD's belief that long-term sustainability is predicated on grassroots community awareness, education, and participation and that ERD's role is one of technical assistance to partners to support their program implementation. To this end, members of the Mucaba community were involved in the data collection, helped identify objectives, indicators, and targets, and participated in focus groups at the baseline and at the 6-month evaluation. Members of the community will continue to be involved in the M&E process throughout the project's subsequent four years.

Influences on Policy

ERD also believes that its efforts to influence MINSA and UNICEF policies have the potential to benefit the other organizations working on malaria prevention and control in Angola. The three policy changes influenced by ERD are:

- **Net Delivery at Household Level**: UNICEF previously only permitted net distribution at health facilities. Because ERD's program is community-based and the intent is for its malaria volunteers to carry out net distribution within their immediate neighborhood, ERD convinced UNICEF that nets could be distributed at the household level in addition to the health center level. In a municipality like Mucaba, this change will ensure coverage since ERD's target population includes not only the population that visits to the health center, but also that population that does not have access to a health facility.
- **Community-Based IPT Pilot**: The national guidelines do not currently permit a community-based IPT program. With persuasion from ERD and advocacy from PMI Luanda, MINSA has agreed to permit NFL-Mucaba to pilot a community-

based IPT program as a first step toward policy change. To help integrate the pilot into the NFL-Mucaba project, ERD will include Fansidar in the kits provided to the TBAs. As part of their training, TBAs are asked to monitor all pregnant women in their villages. Based on the fundus' height of each woman, the TBAs will know whether a woman has completed her 20th week of pregnancy and, if the village's location precludes a woman from going to a health center, the TBA will administer the Fansidar and register it on a woman's pregnancy card. The government's Maternal Child Program Coordinator will supervise this program.

- **Community-Based ACT Treatment**: At the beginning of ERD's NFL-Mucaba project, the baseline study showed that few community members had used or were aware of ACT treatment of malaria. While the health facilities typically do have supplies of Coartem to be used in ACT, ERD provided training to health facility workers on the new Coartem treatment regimen. In addition, in order to reduce malaria related mortality resulting from delays in going to a health facility, ERD also is working with MINSA to allow the NFL-Mucaba program to pilot a community-based ACT program in the project's second and subsequent years. If MINSA approves the pilot, community health agents, who have been trained in home-based management of fevers algorithm under community IMCI, could proceed with treatment of uncomplicated malaria. This will be an important development particularly for communities in remote areas.

In recent years, MINSA has been focusing on strengthening health facilities, but not necessarily other resources for service delivery in the community. While MINSA's agreement to move forward with community-based IPT pilot and consider an ACT pilot represents a departure from their existing policy, health officials are beginning to see how these pilots, as well as the training of the community health agents and TBAs, provide a necessary complement to strengthened health facilities. Also, the NFL-Mucaba project director feels confident that MINSA will see the importance of bringing malaria therapy out into the community and will approve the ACT pilot beginning in the 2008/09 project year (Year 2). ERD believes that if these pilots are successful in demonstrating the efficacy of community-based delivery, they have the potential to serve as the basis for similar policy changes at the national level.

Establishment of Office and Creation of Policies/Procedures

In addition to the programmatic accomplishments, ERD NFL-Mucaba is proud of the policies and procedures the project director created in collaboration with ERD's New York office to help ensure transparency and accountability throughout the five years of the USAID/PMI-funded project. As a new USAID partner, ERD is using this grant as an opportunity to improve its in-house capabilities to administer projects using US-government funds and is making every effort to serve as a good steward of the PMI funding. The following are the relevant policies and procedures established at the project's inception:

- *Financial Management*: Financial procedures for reimbursement and payment authorization, cash and petty cash management, check authorizations, bank reconciliation, monthly financial reporting, and financial transfer requests.
- *Office Management*: Policies to ensure a well-functioning office, including procedures related to:
  - Human Resources--position descriptions for all staff and an employee log to help manage staff time toward achievement of project goals
  - Fixed Asset Management--protocol for managing hard asset inventory (computers, printers, laptops, generator, vehicles, motorbikes, and office furniture) to prevent theft and help maintain assets in good working order. This protocol includes ensuring that assets are branded with the USAID logo.
  - Other—vehicle and fuel control logs, and a guard reporting log,

To address issues that arose on a weekly basis, the Project Director convened program operation meetings with the office staff in Uige each Monday. These meetings provided the staff an opportunity to report achievements to, share lessons learned with, and discuss constraints and brainstorm possible solutions with their team members.

This report also provides the curricula vitae (see Appendix 3) of two new NFL staff members who will bring significant knowledge and support to the NFL-Mucaba program. Samuel Asiedu Agyei is the newly-hired NFL M&E director based in Accra, Ghana. The M&E director mentioned in the original proposal left his post for personal reasons after a short tenure. The other CV is that of Shaun Walsh, the first-ever NetsforLife Executive Director, whom ERD hired because NFL has grown significantly in the last several years and needed its own management structure. Both bring extensive programmatic expertise to the NFL-Mucaba project and also can provide comparative information and lessons from other NFL projects since they work on NFL projects throughout Africa.

Activities and Results

The NFL-Mucaba ICMP program completed nearly all of its planned activities and met the majority of its targeted results. The following summary highlights key activities by quarter as outlined in the Year One Workplan. The tables and graphs beginning on p. 9 provide summaries of the individuals trained, the number of community members sensitized, and the number of nets distributed. In addition, this report provides information on the changes in knowledge of and attitudes about malaria prevention and control, as well as how NFL-Mucaba's results match up with key indicators. For those activities for which PMI funding did not cover the full cost, ERD contributed a match, specifically ERD refurbished the three health facilities, paid for deworming and Vitamin A supplementation beginning in the 4th quarter, and covered 50 percent of the community mobilization and 60 percent of the training of the malaria agents.

First Quarter (Oct. 1, 2007-December 31, 2008)

Office Establishment and Recruitment

- Opened and outfitted its office, and recruited, hired and trained the 13 necessary staff.

- Held stakeholder meetings with USAID/PMI, MINSA/NMCP, and provincial and local administration to brief them on plans and obtain their input.
- Trained 13 members of staff in community development.
- Trained first set of 16 community health workers on program management and malaria prevention and control.
- Trained 20 additional malaria activists in malaria prevention and control

Second Quarter (Jan. 1, 2008-March 31, 2008)

Baseline Studies

- Trained 13 staff and 25 field officers on research and survey methodology.
- Conducted baseline data collection and analysis in five sample zone and debriefed 50 chiefs and elders from the five zones on baseline finding.
- Disseminated the baseline results to key stakeholders, including USAID/PMI, MINSA/NMCP, and NGOs.

Health Facility Staff Trainings

- Trained 29 nurses, midwives, and paramedical staff from throughout municipality on IMCI with a focus on malaria prevention, including IPT administration, ACT supply and administration, facility-based management of uncomplicated and complicated cases of malaria, diarrhea, ARI, and other common illnesses, and safe delivery and newborn care.

Community Sensitization/Education on Malaria Prevention and Control

- Performed house-to-house education and conducted community durbars/gatherings on malaria control and prevention reaching 20,125 members of the community with various malaria education messages and providing an opportunity for Q&A.
- Trained 16 community health agents (CHA) so that they could be prepared to train the malaria community volunteers as *activistas*. The training covered community health, malaria prevention, community education and mobilization, and reporting and information systems.
- Trained 30 women leaders on issues of women's empowerment and participation in community development and health to provide malaria education and awareness to participating mothers and grandmothers.
- Trained 30 Mother's Union and women leaders in IMCI, specifically how to prevent the most common childhood ailments (malaria, diarrhea, pneumonia, scabies, and malnutrition). The training focuses first on basic interventions (i.e. hand-washing, hydration for diarrhea, etc.) and also highlights when it is necessary to seek care at a health facility.
- Ordered 12,000 LLITNs from UNICEF.

Third Quarter (April 1, 2008-June 30, 2008)

Community Sensitization/Education on Malaria Prevention and Control

- The 16 CHAs trained 240 malaria agents as *activistas* or community volunteers responsible for following 20 households in their immediate neighborhood on a regular basis. ERD procured bicycles and megaphones for each CHA, who performed community sensitization activities two times a week in the 78 targeted villages at 7 am before people went to the fields. Also, the *activistas* educated

community members, register beneficiaries and help distribute and monitor use of nets.

- In collaboration with MINSA's Maternal and Child Department, trained 30 trained birth attendants (TBAs) in safe delivery, signs of danger during birth, health center transfer requirements, neonatal care techniques, IPT, immunization, and malaria prevention. ERD provided a fully-equipped TBA kit (which includes key supplies, folic acid, and essential medicines) to each. ERD's program was unable to train the 100 TBAs as planned because of MINSA's requirement that TBAs be literate. See p.13, in "impeded progress" section of this report for more detail on how ERD is trying to work with MINSA regarding this requirement.
- The 30 women leaders trained on IMCI (prevention and basic interventions for the most common childhood diseases) in the 2nd quarter provided a similar training to 90 additional women leaders.
- Performed community sensitization and education with various malaria education messages reaching an additional 30,000 community members.
- Received 6,900 LLITNs (see "impeded progress section" for difference in ordered versus received nets) and distributed them to various zonal points.

Health Facility Improvements and Staff Trainings

- Trained 10 midwives on safe motherhood initiatives and neonatal care practices.
- Refurbished three health facilities—the existing health center and two others that had been closed during and never reopened after the war--to conduct safer deliveries and provide better maternal and child health services. ERD also placed trained staff in the two reopened facilities as a way of extending service provision.
- Distributed 6,900 nets benefiting 20,000 vulnerable people. Unable to distribute three nets per household as planned because of problem with timing and volume of net delivery. However, ERD found that multiple children per household could share one net increasing the number of beneficiaries to 20,000. See p. 12 in the "impeded progress" section.
- Performed 6-month survey to evaluate project through first two project quarters.

Fourth Quarter (July 1, 2008-Sept. 30, 2008)

Health Facility Staff Trainings

- Provided training to 15 additional nurses, midwives, and nurse assistants on C-IMCI, IPT, ACTs, ANC, and safe delivery and neonatal care.

Community Sensitization/Education on Malaria Prevention and Control

- Sensitized over 10,000 community members with messages on LLITNs, IPT, ACT, environmental sanitation/personal hygiene, newborn care including breastfeeding and nutrition education, and the benefits of de-worming and vitamin A supplementation.
- Malaria agents performed weekly follow-up and monitored net usage at the community level.

The following charts and graphs (pp. 9-11) illustrate information on the changes in knowledge of and attitudes about malaria prevention and control, as well as how NFL-Mucaba's results match up with key indicators.

Comment: Does support for these integrated education messages come entirely from MCP funding? Or does MCP funding complement other sources of ERD NFL integrated efforts and approach? If additional funds support project activities beyond malaria it would be helpful to reference here and elsewhere as appropriate.

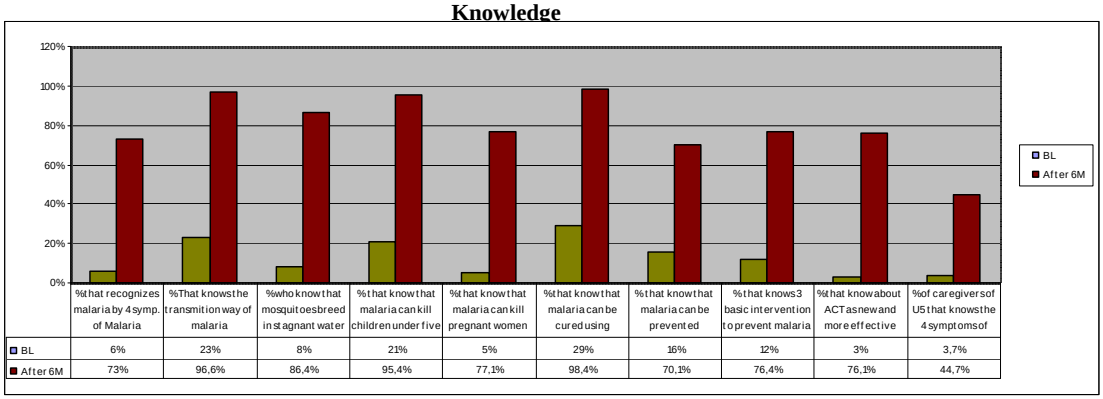
Summary of Individuals Trained

Malaria Community Health Agents Trained		Malaria Volunteers Trained		Women Leaders Trained on Malaria and IMCI		TBAs Trained		Priests and Churchworkers Trained	
Target	Ach.	Target	Ach.	Target	Ach.	Target	Ach.	Target	Ach.
16	16	240	240	200	120	100	30	62	30
	100%		100%				30%		48%

Individuals Sensitized and Nets Distributed

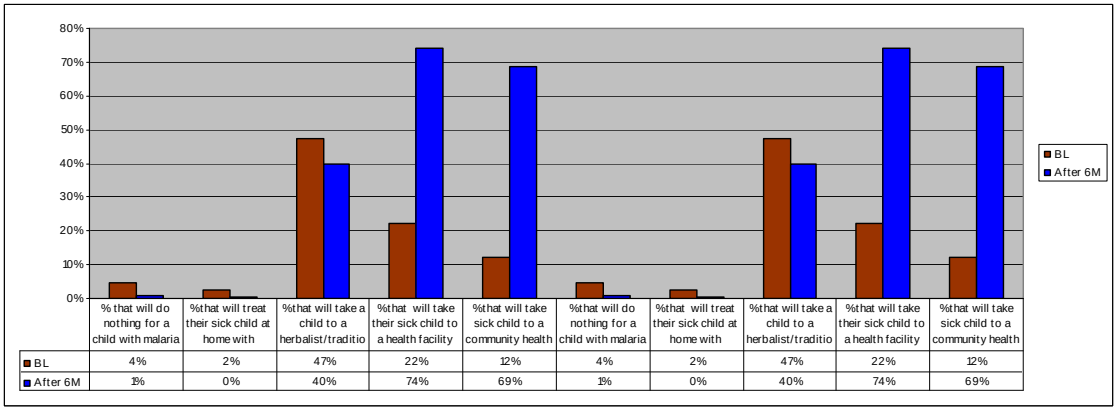
Total Population	Community Mobilization		Breakdown of Population Mobilized			Nets Distributed	
92,000 Inhabitants	Target	Ach.	Male	Female	Young	Target	Achieved
	40,000	37,223	5,907	14,584	16,732	15,000	6,900
		93%					46%

Knowledge



	%that recognizes malaria by 4 symp. of Malaria	%That knows the transmition way of malaria	%who know that mosquitoes breed in stagnant water	%that know that malaria can kill children under five	%that know that malaria can kill pregnant women	%that know that malaria can be cured using	%that know that malaria can be prevented	%that knows 3 basic intervention to prevent malaria	%that know about ACT as new and more effective	%of caregivers of U5 that knows the 4 symptoms of
BL	6%	23%	8%	21%	5%	29%	16%	12%	3%	3,7%
After 6M	73%	96,6%	86,4%	95,4%	77,1%	98,4%	70,1%	76,4%	76,1%	44,7%

Attitude



	% that will do nothing for a child with malaria	%that will treat their sick child at home with	%that will take a child to a herbalist/traditio	%that will take their sick child to a health facility	%that will take sick child to a community health	%that will do nothing for a child with malaria	%that will treat their sick child at home with	%that will take a child to a herbalist/traditio	%that will take their sick child to a health facility	%that will take sick child to a community health
BL	4%	2%	47%	22%	12%	4%	2%	47%	22%	12%
After 6M	1%	0%	40%	74%	69%	1%	0%	40%	74%	69%

Objective/Strategy/Activity	Status of Activities (including Outputs)	Indicators and Actual Results
Project Objective: Prevent malaria infection and illness through the use of LLITNs		
Strategy 1: Increase percentage of households with at least one LLITN		
Activity 1:Conduct baseline survey on household net possession	Baseline survey conducted in sampled communities in the municipality	PMI Target: More than 90% of households with a pregnant woman and/or children under five will own at least one LLITN Baseline: 8% 6-Month Actual: 86% Note: The baseline and 6-month actual reflect "% of houses (families) with at least one LLITN"
Activity 2: Training on household LLITN monitoring for activists	1 main training and two refresher trainings for 240 malaria activists	
Activity 3: Distribution of LLITNs to families without nets with members in priority groups	LLITNs distributed based on baseline coverage and 1 follow-up assessment	
Activity 4: Follow-up monitoring and reporting on net possession	1 follow-up assessment	
Strategy 2: Increase the percentage of children under five years of age and pregnant women sleeping under a LLITN the night before		
Activity 1: Conduct baseline survey on net usage before interventions	Baseline survey on net usage conducted in sampled communities in the Municipality	PMI Target: 85% of pregnant women and children under five will have slept under a LLITN the previous night Pregnant Women Baseline: 26% 6-Month Actual: 80% Children U5 Baseline: 42% 6-Month Actual: 72%
Activity 2: Train activists and malaria agents on community mobilization and behavior change communication	1 main training and 2 refresher trainings completed for 240 malaria activists on community entry/mobilization and household education/sensitization	
Activity 3: Conduct household visits, education/sensitization and follow-ups	At least one household visit conducted per month by 240 malaria activists (20 households per activist)	
Activity 4: Quality control through supervision	Bi-monthly supervision visits after activists are trained (6 visits)	
Activity 5: Monitoring data collected and analyzed	Malaria activists send report to field supervisor monthly	
Project objective: Contribute to effective treatment of malaria illness at household and facility levels		
Strategy: Increase percentage of children under five and pregnant women who receive effective antimalarial treatment within 24 hours of onset of symptoms of malaria		
Activity 1: Household education by trained activists on how to recognize symptoms of malaria and treat effectively at the home and community levels	20 household education/sensitization sessions conducted by each activist per month, beginning in 2nd quarter	% of population who will take their sick child to a health facility Baseline: 22.3% 6-month Actual: 74% % of population who know about ACT as new and more effective treatment for malaria Baseline: 3% 6-month Actual: 76.1%
Activity 2: community mobilization thorough activists to promote ANC attendance at health centers	Weekly community meetings conducted starting in May. At least 4 community meetings effectively completed per month	
Activity3: Outreach to health posts for ANC and CIMCI, including ACT administration	2 outreach sessions conducted per month beginning in 3rd quarter (12 sessions)	

Activity 4: Partner with NMCP and MINSA to train health staff on effective treatment of malaria and improving antimalarial drug supply chain.	One training conducted in each health facility for all heath care workers/prescribers on effective malaria treatment	
Program objective: Protect pregnant women from malaria through the use of Intermittent Presumptive Therapy (IPTp)		
Strategy: Increase the percentage of pregnant women who receive IPTp through attendance for at least 3 focused ANC visits that include IPTp and provision of LLITN		
Activity 1: Training of health staff on focused ANC and IPT and provision of outreach services from Health Centre to Health Posts and remote communities with ANC services	2 outreach sessions conducted per month starting in June, after MINSA health workers are trained in focused ANC delivery and IPT	PMI Target: 85% of pregnant women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy Baseline: 4% 6-Month Actual: 41% Baseline and 6-month actual reflect "%of pregnant women who receive appropriate IPT"
Activity 2: community mobilization to support ANC attendance	Weekly community meetings conducted starting in May. At least 4 community meetings effectively completed per month	

B. Factors That Impeded Progress

Late Net Delivery: UNICEF was late in its net delivery and delivered fewer nets than had been requested. ERD had requested 15,000 nets from UNICEF, which informed ERD that it would only be able to provide 12,000. ERD made its request in February 2008 for the nets to be delivered in March, but did not receive the nets until June and only received 6,000 instead of the 12,000 ordered. Because ERD already had done some of the community sensitization work on malaria prevention and net use, ERD had to continue with the sensitization for several more additional months than planned or risk losing the community's confidence and interest. The late delivery proved particularly frustrating because ERD learned that UNICEF had a supply of nets stockpiled in another province (other than Uige) in Angola and knew that UNICEF had not yet identified an organization that would be able to deliver the nets in the other province.

- *Action/Recommended Solution*: As a work-around for the delayed net delivery to ERD's NFL-Mucaba program, ERD suggested that UNICEF provide the 12,000 nets from the supply in the other province and then replenish the supply with the nets that ERD ordered. UNICEF was not able to fulfill this request and ERD recognizes that it might not have made the request/recommendation at the right level within UNICEF. Going forward, if this type of problem occurs, ERD plans to engage the USAID/PMI team to lobby UNICEF to consider a more creative approach to resolving supply problems.

Coordination with Ministry of Health: MINSA is a key training partner for the NFL-Mucaba project, but is overburdened with many competing demands. MINSA had

committed to providing technical support as their contribution to ERD's training, M&E, and data storage. ERD scheduled its malaria volunteer trainings without realizing that the dates coincided with some national programs like Polio immunization campaigns, which took key MINSA staff away from ERD target areas.

- *Action/Recommended Solution*: ERD tackled this challenge by conducting the training later than originally planned, but still in time to proceed with the other program activities dependent on training. Going forward, ERD will coordinate better with MINSA staff and avoid scheduling the training sessions when MINSA staff might be working on other important health programs.

TBA Training: As a community-based organization, ERD has experience in and believes that there are effective ways to provide training to community members whether literate or not. Training on safe delivery, signs of danger during birth, health center transfer requirements, IPT, immunization of newborns, and malaria prevention to trained birth attendants (TBAs), who deliver 80% of the children in Mucaba, represents an important component of ERD's IMCI program. ERD strongly believes that TBAs as an institution at the community level need to be strengthened and that they need MINSA's full support. However, MINSA's maternal and child department has a policy to train only literate women, which precludes many capable women from the training particularly since the female literacy levels are estimated at less than 47% in Angola's Northern region. Also, since 2005, MINSA had been encouraging women to go to hospitals for birthing despite the fact that the war had destroyed 85% of the health infrastructure and the existing system covers only 30-40% of the population.

- *Action/Recommended Solution*: As of October 2008, MINSA has provided a positive verbal response on training illiterate TBAs. ERD is collaborating with USAID Luanda to obtain formal approval of MINSA's verbal commitment to allow ERD to train illiterate and semi-literate TBAs. Both ERD and USAID agree that TBAs provide a critically important service in the community, particularly where there is no health facility. In order for the ICMP to be as effective as possible, all TBAs need to be eligible for the NFL-Mucaba training. Currently, at ERD's request, MINSA allows illiterate TBAs to participate in the training if they have a literate daughter accompany them to the training. The government has agreed to admit participating daughters to nursing school once they complete a prescribed level of education.

  Beyond the policy change, ERD also is working with MINSA to improve the TBA kits to incorporate full pre-natal consultation the community level. These changes will allow a TBA to follow the pregnancy in terms of weight change, growth, and illness and provide advice and some treatment. Finally, ERD is working with MINSA staff in Uige to revise the antenatal cards (ANC), which will be used beginning in 2009 and will reflect new information (such as the community-based IPT pilot).

High Levels of Malnutrition: While exact poverty levels in Mucaba are not known, it is estimated that they are higher than the national level of 62%. Before beginning the

project, ERD anticipated high levels of poverty and malnutrition. However, the child malnutrition rates were much higher than anticipated and it became clear that ERD's IMCI plan needed to include additional elements to address the malnutrition problem. At one of the community sensitization meetings, a grandmother who was sitting with her extremely malnourished grandson said "I like your nets, but how will a net help the fact that my grandson doesn't have enough food."

- *Action/Recommended Solution*: Beginning the 4th quarter of the project's first year (July-Sept. 2008) and going forward for the duration of the project, ERD is providing the funds to incorporate school deworming and Vitamin A supplementation as a small step in remediating the pervasive malnutrition. Also, officials from the Ministry of Agriculture (MOA) visited Mucaba to look at productivity in the region and met with the NFL-Mucaba project director. The MOA is amenable to receiving a proposal to provide funding to NFL-Mucaba for training of women on food security using some of the project's existing networks like TBAs, women leaders, and the church. ERD hopes to engage the PMI staff in Luanda in highlighting the importance of integrated programming to relevant actors in the national government in Angola.

Health Facility Challenges: The Anglican health center, which is staffed by MINSA, served as the only functioning health center in Mucaba municipality at the beginning of ERD's project. It did not have sufficient capacity or supplies to provide adequate health services to the population in Mucaba. As mentioned earlier in this report, although MINSA had a supply of some necessary drugs (ANC drugs, anti-diarrhea tablets, deworming, and Vitamin A supplements) available for Mucaba at a storehouse in Uige, MINSA did not have the staff or resources to deliver these drugs the final 68 km to Mucaba. The availability of other needed supplies and drugs, such as RDTs and drugs those necessary for integration of IPT and ACT, continues to be irregular. Finally, with the project's intensive community sensitization efforts and more of the community becoming aware of the increased level of health services, ERD is concerned that the three functioning health facilities will not be able to accommodate the potential influx of people.

- *Action/Recommended Solution*: ERD's NFL-Mucaba project has addressed some of the challenges associated with the health facilities. To address the inadequate health facilities, ERD renovated the existing health center and refurbished two smaller health facilities that had been closed, but never reopened after the war. In regard to the medicines, ERD picked up the available drugs in Uige and delivered them to Mucaba. However, the integration of IPT and ACT into the project and the ability of health workers to use RDT to confirm a malaria diagnosis will continue to be a problem unless the necessary drugs and supplies are available with more regularity.

Coartem Training: USAID/PMI asked that ERD participate in the MINSA program to train health workers on the use of Coartem. While ERD is not opposed to including information on the Coartem regime of treatment in its training for health facilities' staff,

it is frustrating since there is limited availability of Coartem in Mucaba and ERD does not have the budget to purchase it.

- *Action/Recommended Solution*: ERD, MINSA, and USAID/PMI need to collaborate to secure a supply of Coartem so that health center staff is able to use it as a treatment.

Levels of HIV/AIDS: There is a large burden of HIV/AIDS in Mucaba and ARVs are virtually non-existent. The challenge is that, with the improvements in ANC and the health delivery system as a result of ERD's project, MINSA has been pressuring NFL-Mucaba to institute HIV sentinel surveys at the ANC centers even though the staff is not trained in this function and, if women learned of survey, they might be less willing to come to the center.

- *Action/Recommended Solution*: NFL is resisting MINSA's pressure since it does not want introduction of an HIV sentinel survey to backfire and possibly reduce the number of women coming for antenatal care. In addition, if ERD decides to incorporate HIV-prevention messaging in future community education efforts, it will require special training for the staff considering the sensitivity and taboos around HIV in the region.

Translation of Manuals: Because a significant portion of the population speaks Kikongo, the local language, ERD knew that translation of NFL training manuals from Portuguese to Kikongo would be important. In the project's first year, ERD was able to translate the 16 community health agent manuals into Kikongo. For the 240 malaria volunteers, ERD was able to provide an oral training in Kikongo, but did not have the necessary funds to translate the malaria volunteer manuals into Kikongo.

- *Action/Recommended Solution*: In year two, ERD will try to secure the funds to translate the malaria volunteer manuals into Kikongo.

Transportation in the Rainy Season: The roads into and within Mucaba are very inadequate and become more difficult to navigate during the rainy reason. This presents two problems for ERD's project team. First, the project office is located in Uige (68 km from Mucaba) to allow for better coordination with government agencies and other NGOs. However, it makes travel and therefore supervision difficult during the rainy season. Second, the primary vehicle for the 16 community health agents is bicycle. When the roads are muddy, the CHAs are not able to travel to their villages very easily.

C: Technical Assistance

During the project's first year, the NFL-Mucaba team received the following technical assistance:

1. The NMCP provided technical assistance on national malaria control strategies in two separate training sessions for the project team and the community volunteers.
2. Since WHO's M&E staff, in collaboration with MINSA and UNICEF, were very active in designing the Malaria indicator surveys (MIS) in Angola, they

offered to review ERD's M&E indicators to avoid duplication and ensure that ERD only captured the kind of data that had not yet been captured in the MIS.

3. ERD's NFL finance manager traveled to Angola to train and assist the country team on proper finance/accounting processes and procedures
4. The Swiss Tropical Institute (STI), a member of the NFL Advisory Board, was instrumental in developing M&E framework for NFL, in particular as it relates to M&E on community relationships. For the NFL-Mucaba program, STI is providing assistance in evaluating the M&E.
5. USAID/PMI provided technical support in training and data collection.

D. Workplan Issues

The issues raised by USAID and PMI in the workplan consultation included the M&E plan and the training on the use of Coartem.

1) When Mr. Trent from PMI Washington visited ERD's Uige Program Office on December 17, 2007, he expressed concern about the interval between data collection (baseline-6 month-12 month), which he considered too short. He also expressed concern about the cost implications of such frequent surveys, but did recognize their importance in fostering communal spirit and project ownership. While the MICS and MIS had been completed before the start of ERD's project, Mr. Trent recommended that the project consider involvement in the nationwide surveys going forward because ERD's contribution would be useful. As a result of this conversation, ERD has been asked and agreed to participate in future surveys. He also suggested that ERD obtain technical support from the USAID team in Luanda in any study or data collection in Mucaba (see point 5 under "technical assistance" above).
2) In addition, USAID expressed concern regarding the differences in Angola's NMCP M&E plan and ERD's M&E plan. The NMCP indicators tend to be more health center focused whereas ERD's indicators are more community focused making it difficult to easily feed the ERD indicators into the NMCP framework. USAID wanted ERD to ensure that its indicators reflected all of the necessary information required in the NMCP M&E guidelines. As a result of this and further discussions, ERD succeeded in convincing the NMCP that there M&E data are incomplete without community data, which ERD will provide to them from now on.
3) USAID/PMI wanted ERD's NFL-Mucaba project to participate in MINSA program to train health work on the use of Coartem. While ERD had not included this training in the original budget, it agreed to provide Coartem training to health facility workers. The challenge is that there is no reliable supply of Coartem available so that, even with the training, the health workers cannot follow the Coartem treatment regime.

E. PMI Team Collaboration in country

ERD views USAID/PMI as a partner that has been integrally involved in NFL-Mucaba project since its inception.

- In early October 2007, Drs. Francisco Saute, USAID/PMI Sr. Malaria Advisor, and Jules Mihigo, CDC PMI Malaria Advisor, worked closely with Dr. Matondo

Alexandre, ERD's Project Coordinator, and Dr. Stephen Dzisi, ERD's Technical Director for Africa, to review and comment on ERD's workplan and as described in the previous section, ERD was able to incorporate the feedback and suggestions into its programming.

- On October 29, 2007, Dr. Saute made a presentation at the opening of the ERD project office in Uige. The following day, Dr. Saute also participated in the initial meetings that the project team and Anglican Bishop Andre Soares held with local administrators in Mucaba regarding the project and the importance of malaria control and prevention to the community.
- On December 17, 2007, Mr. Trent from the PMI office in DC visited Angola and met with Dr. Alexandre, ERD's project director. The content of the meeting is outlined in the previous section.

Since December, Dr. Alexandre has had frequent (typically) weekly conversations with Dr. Saute and/or other USAID/PMI staff. As mentioned in earlier sections of this report, the USAID PMI team has been central to the discussions with MINSA advocating for various policy changes, including persuading health officials to allow a community-based IPT pilot and to consider a community-based ACT pilot, and reinforcing the important role of TBAs—literate or not--in the health delivery system. The NFL-Mucaba project director also has started to engage the PMI staff in conversations about other programs, such as training in food security and nutrition for the women's networks developed by NFL, that ERD is exploring bringing to Mucaba. The Ministry of Agriculture has indicated that ERD can submit a proposal on food security and ERD hopes that the PMI team will advocate about the importance of an integrated program in combating malaria, as well as other endemic diseases.

ERD's NFL-Mucaba staff also coordinated closely with other partners, including UNICEF, WHO, and MINSA. Much of this collaboration is already highlighted previously in this report. For example, UNICEF is the key partner on net procurement and delivery, WHO provides technical assistance on M&E, and MINSA has been a key partner in training and staffing the health centers refurbished by ERD. In addition, the WHO Coordinator in Uige, NMCP Coordinator in Uige, and the UTCHA (Angola's national agency for humanitarian coordination) Coordinator all provided support to Dr. Alexandre, ERD's project coordinator, in identifying and interviewing the right program staff. In mid-November, the interview team developed an interview questionnaire to standardize the process and interviewed 32 candidates from which eight professional staff were selected on community health projects, reporting and management of a community project, and integrated approach in the community. Also, ERD received support from a number of partners, including UNICEF, WHO, the NMCP, the District Health Department in Uige, Save the Children-UK, World Vision, the Expanded Immunization Program (EIP), CUAMM (an Italian health NGO in Uige), and the ADJC (a church youth NGO) on verification of field activities during the 6-month evaluation.

F. Workplan Matrix

See Appendix 1 for 2008-2009 Workplan Matrix.

G. Annex 1: PMI Annual Report Call for Information

(See Appendix 2 for PMI Annual Report Call for Information)

H. Other Relevant Aspects

As much as possible, ERD wants to use an integrated approach in its programs. For example, the inclusion of messaging and education in IMCP around food security and nutrition as a way to combat endemic problems like malnutrition might be an effective way to make vulnerable populations less susceptible to health problems. ERD would like to explore ways to galvanize the same volunteer networks in malaria work to do more integrated programming, and appreciates USAID's willingness to explore how to best incorporate integrated methodologies to produce sectoral results in HIV/AIDS, Malaria, Child Survival, Food Security, etc. and how to advocate within USAID and with other possible partners for financial support for integrated programming.

I. Published Papers and Major Presentations

- November 6, 2007: Dr. Matondo Alexandre, Project Coordinator, ERD's NFL-Mucaba, and Anglican Diocesan Bishop Andre Soares, **presented the project to local Governor and the Vice Minister for Social Affairs in Uige**. They also presented and clarified the project and explained how the project would be implemented **to the Director for Coordination of Humanitarian Interventions in Uige Province**.
- November 17, 2007, **National Malaria Meeting** in Benguela Province, Dr. Filomeno, the National Malaria Control Director for Angola, invited Dr. Matondo Alexandre, Project Coordinator for ERD's NFL-Mucaba program, to make a presentation. Dr. Filomeno already had expressed his high level of satisfaction with the NFL-Mucaba integrated approach and proposed that Mucaba serve as a pilot Malaria Community Project and that results/experiences be well-documented to help develop new policies for the country's malaria community programs.
- February 8, 2008, **NetsforLife Annual Advisory Board** meeting which convenes NFL's technical advisors and donors to provide a program update; presenter Dr. Stephen Dzisi, Technical Director, Ghana Office, Episcopal Relief and Development
- May 28, 2008, "On the Ground: Community Partnerships for Malaria Prevention and Control" at **Global Health Council**'s 35th Annual Meeting in Washington, DC; presenter Dr. Stephen Dzisi, Technical Director, Ghana Office, Episcopal Relief and Development
- October 2008, "Instilling Net Culture in Communities" Presentation at annual **Roll-Back Malaria Conference** in Geneva; presenter Susan Lassen, Business Development Manager, NetsforLife—Note: When Roll-Back Malaria began looking in collaboration with the International Federation of the Red Cross at the number of nets distributed in malaria endemic communities versus the number of nets actually used, there was a large discrepancy. RBM identified the NFL program as one that effectively promotes net use and saw that there are significant changes in malaria awareness, net use and other malaria prevention and control behavior where NFL works.

ANGLICAN CHURCH
DIOCESE OF ANGOLA
DEPARTMENT OF PROJECTS FOR COMMUNITY DEVELOPMENT

NETSFORLIFE SM
A partnership for Malaria prevention in Africa

Integrated Malaria Community Program
IMCP-Mucaba

Objective	Purpose	Major Activities	O	N	D	J	F	M	A	M	J	J	A	S	Responsible	Partners	Indicators
I. Strengthen Office Management																	
1. Maintain administrative support of the Office	1. Guarantee good administrative and technical management	1. Payment of the salaries	X	x	x	x	x	x	x	x	x	x	x	x	Finance Offic (FO)	-	Salaries paid on 25th of each month
		2. Maintain supply of administrative materials and goods	x		x		x		x		x		x		Admin. Offic.	-	Nº of Supplies
		3. Purchase fuel and oil, and maintain vehicles and motorbikes	x		x		x		x		x		x		Admin. Offic.	-	Nº of Supplies
		4. Print leaflets (project news)				x			x			x		x	Admin. Offic.	-	Nº of bulletins made
		5. Solve insurance issues with the companies in Luanda		x											FO	-	Vehicle insured
	2. Refresh the staff on the project's working policies	6. Train staff on community project support, fund management, and integrated activities	X												Project Director (PD)	-	Nº of staff attending the training
	3. Support technical and administrative areas of the project	7. Purchase of technical supporting equipments (Bicycles, t-shorts, Megaphones,		x		x									Admin. Offic.		Presence of necessary materials

II. Monitoring and Evaluation																		
1. Maintain regular tracking of data and information	1. Refresher training on Data Collection Activities	8. Refresher training of the field staff on data collection and activity monitoring. Maps, Graphics and Cards.		x												M&E Assistant	MoH, NMCP	Nº of staff attending training
	2. Activities Supervision	9. Regular supervision of field activities	x		x		x		x		x		x			M&E Assistant & Proj. Staff		Nº of supervision reports made
		10. Creation of Project Database		x	x											M&E Assistant		Existence of Database
		11. Participate in M&E National meeting with partners														M&E Assistant & Proj. Direct.	MoH, NMCP, PMI, WHO	Nº Participation reports
		12. Record field reports on the Progress	x	x	x	x	x	x	x	x	x	x	x	x		M&E Assistant		Nº of the Reports
		13 Elaborate monthly M&E Reports	x	x	x	x	x	x	x	x	x	x	x	x		M&E Assistant		No reports Submitted
		14. Nets use Monitoring	x	x	x	x	x	x	x	x	x	x	x	x		CHAs/activists		Nº of houses followed
	3. Outcome Evaluation	15. 2nd Evaluation Exercise after 12 month									x					M&E Assistant		Evaluation Report
III. Supplies and Logistics																		
1. Increase household coverage on LLITNs	1. Supply Mucaba communities with LLITNs	16. Receive 6,900 nets remaining from 2008 request	x													Project Director	UNICEF	# of nets supplied
		17. Make 2009 net request to UNICEF		x												Project Director	UNICEF	# of nets supplied
		18. Shipment of nets from Luanda - Uige to Mucaba			x											UNICEF	UNICEF	# of nets supplied
		19. Community distribution of 15,000 nets				x	x	x	x	x	x	x	x	x		BCC-Coord.	Community	# of nets Distributed
2. Prevent infections during delivery	1. Supply health facilities with Autoclave and other items for sterilization	20. Procure autoclave	x													Project Staff	MINSA	Autoclaves procured
IV. Training and Capacity Building																		
1. Strengthen the technical knowledge of	1. Training of CHAs on malaria control and	21. Train CHAs on malaria control progress and new strategies of Integrated message		x												BCC-Coord	Community	# of trainers trained

CHAs on Malaria and Community Health.	integrated activities	(Diarrhea, Anemia, Deworming, Immunization and Vit. A supplementation)																
	2. Women Leaders Training	22. Continue trainings on malaria, Community-IMCI, Community-IPT for women in the communities				X										Heath Coord.	MoH	# of women trained
	3.TBA Training	23. Train TBAs on malaria and gestation and safe delivery				X										Heath Coord	Community Leaders	# of TBAs trained
	4. Health Workers Training	24. Train health staff in Mucaba on Coartem use and handling of simple and complicated malaria					X									Heath Coord/ Project Director	MoH, WHO	# of the staff trained
		25. Train health workers on net distribution through PNC and EIP services						X								Heath Coord/ Project Director	MoH, WHO	
	5. Community Groups training	26. Support the Mother's Union Training group for training of women groups				x	x	x	x	x	x	x	x	X		Mother's Union	Community Leaders	# of trainers trained
		27. Organize training for youth groups and support the malaria activities of the youth groups.				x	x	x	x	x	x	x	x	x		BCC-Coord		
	6. Church Groups training	28. Organize a training for the priests and church workers from the Anglican, Catholic, Baptist and Toquist Churches in Mucaba					x									BCC-Coord	Anglican and Catholic Church	# of women participating
V. Community Mobilization																		
1. Sensitize the community for malaria prevention activities	1. Motivate community to participate actively in malaria prevention activities	29. Support Community Mobilization workshops	x	x	x	x	x	x	x	x	x	x	x	x		BCC-Coord/CHAs& Activists	Community.	# of people mobilized
		30. Group workshops in the communities (Mothers, Fathers, young ladies, young man)				x	x	x	x	x	x	x	x	x		BCC-Coord	Community	# of people mobilized in respective categories
		31. Start Community Mobilization on HIV, and Other endemic diseases				X	x	x	x	x	x	x	x	x		BCC-Coord		# of people mobilized
VI. Integrated Activities																		
1. Support the heath	1. Guarantee supply of	32. Support the transportation of medicines				x	x	x	x	x	x	x	x	x		Project	MoH, WHO,	# supplies

Center in Mucaba to assist Malaria Patients	ACT and SP in Mucaba	stocked in Uige.													Administrator	NMCP	transported
		33. Make connections with partners for other special supports for the H.C in Mucaba , in diagnostic and treatment equipments (RDTs, Microscope)				x		x		x		x		x		x	Project Director	MoH, WHO, NMCP	Nº of RDTs and Microscopes supplied
		34. Support the health posts with RDTs for rapid testing of malaria				x		x		x		x		x		x	Project Director and Health Coord.	MoH, WHO, NMCP	Nº of RDTs and Microscopes supplied
VII. External Consultancy																	
1. Elevate quality of project implementation	1. Provide technical support to team in field	35. External Technical consultancy to M&E					x								Project Direc.	MoH, WHO, NMCP	Existence of activity Reports
		36. Technical consultancy on Community-IMCI			x										Project Direc.	MoH, WHO, NMCP	Existence of activity Reports
		37. Technical consultancy on Community IMCI and IPT					x								Project Direc.	MoH, WHO, NMCP	Existence of Guidelines
VIII. Diocesan Supervision and Audit																	
1. Verification of the management quality		38. Second year audit from the Diocese											x		Finance Assist.	DIOCESE	Audit Report
		39. Second year independent audit												x	Finance Assist.	DIOCESE	Audit Report
IX. Advocacy																	
1. Advocate for policy changes to benefit community IMCI	1. Work to secure policy changes	40. Meet with MINSA to get agreement on community ACT distribution	x	x	x	x	x	x	x	x	x	x	x	x	Project Director	MINSA, USAID/PMI	MINSA allows ACT distribution at community level
		41. Meet with MINSA to get agreement on training of illiterate TBAs	x	x	x	x	x	x	x	x	x	x	x	x	Project Director	MINSA, USAID/PMI	MINSA allows ERD to include illiterate TBAs in trainings
X. Fundraising																	
1. Perform additional integrated activities around food security	1. Secure additional funding to support activities not covered by	42. Follow-up with Ministry of Agriculture and submit a proposal for food security activities in Mucaba	x	x	x										Project Director	Ministry of Agriculture	MOA provides funding for complementary

and nutrition	PMI funding														food security activities
XI. Reporting															
1. Activities Report		43. Quarterly reporting to ERD			x			x			x			x	Project Director	Technical Assistants	# of reports submitted
		44. Informal quarterly reporting to USAID			x			x			x			x	Project Director/ERD NY	PMI Luanda and USAID/DC	# of reports submitted
		45. Annual Project review/Annual Report												x	Project Director		Report completed and submitted

Detailed Budget	**SECOND YEAR BUDGET**					
Item Description	**Unit**	**Nº of Unit**	**Costs US$**	**Total USAID**	**Total NGO**	**Budget 2009**
Field Costs						
1. Personnel						
1.1 Management (Luanda)						
Country Programme Director (30%)	Month	12	2.083	7.500	17.500	25.000
Finance Officer (Accountant) (40%)	Month	12	500	2.400	3.600	6.000
Secretary/Cashier (40%) (Administrative Assistant)	Month	12	400	1.920	2.880	4.800
Subtotal 1.1			**2.983**	**11.820**	**23.980**	**35.800**
1.2 Support Staff (Uige)						
Project Director (50%)	Month	12	5.000	30.000	30.000	60.000
BCC/Trainer Coordinator	Month	12	900	10.800	0	10.800
1 District Health Coordinator 100%	Month	12	350	4.200	0	4.200
1 District Health Coordinator 50%	Month	12	350	2.100	2.100	4.200
Logistic/Accountant (Administrative)	Month	12	450	5.400	0	5.400
M&E Coordinator	Month	12	900	10.800	0	10.800

3 Security Guards @$250 each	Month	12	750	9.000	0	9.000
2 Drivers @200 each	Month	12	400	4.800	0	4.800
1 Cleaner	Month	12	175	2.100	0	2.100
Subtotal 1.2			**9.275**	**79.200**	**32.100**	**111.300**
1.3 Technical & Consultancies Services						
Travel for Monitoring	Month	12	150	1.800		1.800
Travel for Evaluation	Quarterly	4	150	600		1.500
Travel for Government Networks	Month	12	150	1.800		1.800
Education/Training network and oversight	Days	105	40	4.200		1.200
Training for M&E Capacity Building	Year	2	1.250	2.500		4.600
Subtotal 1.3			**1.740**	**10.900**	**0**	**10.900**
2. Staff Local/Regional Travel						
(Transport+other Visit Expenses						
Country Program Director	Visit	4	750	2.000		2.000
Finance Director	Visit	4	750	2.000		2.000
Subtotal 2			**1.500**	**4.000**		**4.000**
3. Office Equipment/Furniture and						
Suppliers + Consumable						
Motorbikes	Unit	2	850	0	3.400	3.400
Megaphones	Unit	16	200	0	3.200	3.200
Subtotal 3			**1.050**	**0**	**6.600**	**6.600**
2. Office Running Costs +						
Consumables						
Printing and Photocopy paper	Various	1	970	970		1.000
Toner for printers	Unit	12	200	2.400		2.400
Toner for photocopier	Unit	12	200	2.400		2.400
Cleaning and Maintenance	Month	12	100	1.200		1.200
Office Utilities	Various	12	750	9.000		4.000
Vehicles Fuel, Oil & Maintenance	Year	1	5.760	5.760		5.760

Motorbikes Fuel, Oil & Maintenance	Year	1	2.050	2.050		2.050
Equipment Maintenance	Year	1	1.200	1.200		3.200
Insur/License - Vehicle	Year	1	3.520	3.520		3.520
Printing of Leaflets News	Semi-annual	2	1.200	2.400		2.400
Subtotal 3.1			**15.950**	**30.900**		**27.930**
3.Training Equipment +						
Consumable						
Flipchart Paper	Pad	60	25	1.500		1.500
Marker Pens	Pens	100	5	500		500
Subtotal 3.2		160	**30**	**2.000**		**2.000**
4. Communication Expenses						
Telephone System	Unit	2	350	2.000		2.000
Fax	Unit	1	595	2.000		2.000
Postage	Various		400	400		400
Mobile phones	Unit	4	125	500		500
Internet Connection			2.920	3.000		3.000
Subtotal 4			**4.390**	**7.900**		**7.900**
5. Community Activists Training						
(Workshops Training)						
Accom. Meals for 3days for 180 Participants (60 P/Training)	Workshop	6	7.200	21.600	21.600	43.200
Transport for 180 Participants (60 people p/training)	Workshop	6	2.400	7.200	7.200	14.400
Materials Translation		1	3200		3200	3.200
Subtotal 5			**12.800**	**28.800**	**32.000**	**60.800**
6. Community Mobilization						
Nets distribution					2.000	2.000
Support to Youth clubs	Year	6			10.000	10.000

Support to Mothers Clubs	Year	10	50	10.000	10.000	10.000
Incentives for Community Agents	Year	16	100		19.200	19.200
Subtotal 6			**150**	**10.000**	**41.200**	**41.200**
7. Monitoring and Evaluation						
Training (Refreshment Training)		1			5.000	5.000
Supervision visits	year	6			2.000	2.000
Second Evaluation Exercise					3.000	3.000
Subtotal 7					**10.000**	**10.000**
8. Bank, Legal & Accounting Fees						
Bank Charges Fees						
Annual Audit Fees	Year	1	5.000	5.000		5.000
Subtotal 7			**5.000**	**5.000**		**5.000**
Total Field Costs				**195.520**	**135.880**	**331.400**

Annex 1 – PMI Annual Report Call for Information from MCP Grantees

The following "Call for Information" report covers the first year activities (Oct. 1, 2007-Sept. 30, 2008) for Episcopal Relief and Development and its NetsforLife (NFL) integrated community malaria project (ICMP) in Mucaba municipality, Uige Province, Angola.

1. Insecticide-Treated Bednets	Number (MCP contribution only except where noted)	Comments	Data Source
Total number of ITNs procured	6,900	To meet its Year One Project goal, Episcopal Relief and Development (ERD) had requested that UNICEF provide 15,000 nets. UNICEF responded that they could only supply 12,000. Ultimately, they delivered only 6,900.	Project Records
Total number of ITNs distributed	6,900	As a result of the supply chain problem, ERD received only one half of its requested nets. The targeted population for net distribution was vulnerable people-- children under five and pregnant women. Although fewer nets were distributed than anticipated, the number of beneficiaries of the nets was approximately 20,000 since 2-3 children under five can sleep under one net in the same household.	Project Records
Please indicate the number of ITNs distributed through:		The ITNs in Angola are distributed for free. Of the 1,000 distributed at clinics, the breakdown is 300 at prenatal clinics, 400 during immunization drives, and 300 at health posts. The other 5,900 nets were distributed in the community.	Project Records
(a) campaigns	(a)		
(b) antenatal clinics or child health clinics	(b) 1,000		
(c) private/commercial sector	(c)		
(d) other distribution channels (specify)	(d) 5,900		

Number of nets retreated with insecticide	N/A	ERD has decided not to retreat existing bednets because the quality control is inconsistent and could have an adverse impact on program outcomes and the quality of the M&E data. In addition, ERD aims to "instill a bednet culture" in the communities where it works. This means engaging the population in project so that they will feel project buy-in and save money to purchase a new bednet every 3-5 years.	

If IEC activities have been carried for ITNs, please provide more information below. Describe any community sensitization/ mobilization meetings held, radio/TV spots aired, brochures/pamphlets/posters created, drama/theatre shows held.

Local drama and song in Kikongo (predominant language) was developed through the project community groups who trained peer community groups in these methodologies. Adapted NMCP and PMI materials were translated. The development of the messaging was guided by a Behavior Change and Communication Coordinator.

Radio Messages: Radios are available in most of the rural areas in Uige Province, though not every family has one. Generally, people gather around to listen to one radio. One hindering factor is that radios are largely controlled by the men, so programming had to be of interest to them as well. NetsforLife currently sponsors malaria messages about using nets. NfL – Mucaba provided additional malaria behavior promotions, LLITNs usage by the biologically vulnerable, on care-seeking for ACTs, and ANC attendance for nets and IPTp in both Portuguese and Kikongo

Through Mothers' Unions: ERD trained 30 women leaders through the existing 30 Mothers' Unions in Mucaba and adapted the updated NfL malaria curriculum for the education and background of the mothers and grandmother member of the unions. Grandmothers are enthusiastic members of the unions and are very influential in household child care behaviors. Mothers' Unions also were trained to address gender issues such as gender related delays like whether consent from a male member of household must be sought before seeking treatment for children or pregnant women. These 30 women leaders in turn trained 90 additional women leaders.

Activistas: ERD's NFL-Mucaba project team trained 16 community health agents (CHAs), who in turn trained 240 activistas as community volunteers who were selected to be trained in malaria interventions. They are responsible for following 20 households on a regular basis. Since these households are the activistas' neighbors, it is not a significant time burden and large numbers of the volunteers have proven to be manageable and still maintain program quality. (An approach similar to the effective "Care Group" model.) Activistas were trained using a NetsforLife curriculum that was updated to include information revealed by the baseline study on community specific knowledge, attitudes and perceptions, and local health services. Activistas reported regularly on the situation in their households using a census-based community monitoring and morbidity report. District Health Coordinators provided supervision. These are particularly dynamic individuals with experience in public mobilization. They have regular check lists of information on program indicators, plus household knowledge and practices and processes conducted in the activistas' work. There are follow-up check lists that are filled in at specified intervals after the LLITNs are distributed. This were extended to follow-up with pregnant women and their families to see if they have attended ANC (though they have a right to refuse to go), whether they have received IPTp and LLITNs as part of the ANC visits and if they are sleeping under the nets.

Private health providers, especially TBAs (parteras) were included in the program. Several of them have become activistas in NfL areas, and some are already involved in Mucaba. Emphasis was placed to encourage pregnant women to go for ANC and receive the pregnancy related malaria services there

Linkages through the Anglican Church and other Churches
Priest/Pastor training: Under the current Uige NetsforLife program, priests and pastors were trained in IMCI with an emphasis on malaria using the NfL training curriculum. This was continued and expanded to include seeking IPTp and ACT services through health centers. Pastors and priests also were involved as stakeholders in planning community mobilization activities and their ideas for approaches for overcoming obstacles to the desired behavior changes will be solicited.

2. Malaria in Pregnancy	Number (MCP contribution only except where noted)	Comments	Data Source
Number of health workers trained in IPTp	74	44 nurses, midwives and paramedical staff and 30 trained birth attendants (TBAs)	Project Records
Number of SP tablets procured	N/A	The health facilities with which ERD collaborates do distribute SP tablets, when a supply is available, but SP procurement and distribution is not a direct activity of ERD's project. Therefore, ERD does not track this information.	
Number of SP tablets distributed to health facilities	N/A		
If any IEC activities have been carried out for IPTp, please provide more information below. Describe any community sensitization/ mobilization meetings held, radio/TV spots aired, brochures/pamphlets/posters created, drama/theatre shows held. Because ERD program is an integrated community malaria program, the community sensitization/mobilization incorporated all aspects of malaria prevention and treatment. Therefore, please refer to Section 1 for information on promotion of IPTp.			

3. Case Management	Number (MCP contribution only except where noted)	Comments	Data Source
Number of health workers trained in ACT use	40	40 nurses, midwives and paramedical staff	Project Records
Number of ACT treatments procured	N/A	The health facilities with which ERD collaborates in Mucaba do procure (when available) and distribute ACTs, but ERD is not responsible for procurement and distribution and does not track this information.	
Number of ACT treatments distributed	N/A		
Please indicate the number of ACT treatments distributed through:			
(a) health facilities	(a)		
(b) community health workers (HBMF, CCM)	(b)		
(c) private/commercial sector	(c)		

Number of health workers trained in malaria diagnostic techniques (RDTs or microscopy)	N/A	Formal RDT training for health workers will be incorporated into ERD's project in Year 2. The Angolan Ministry of Health (MINSA), which is ERD's primary partner in training, is only now beginning its RDT training for health workers in Mucaba.	
Number of RDTs procured	N/A	MINSA had committed to supply RDTs for the three health facilities in Mucaba, but MINSA never delivered the supplies.	
Number of RDTs distributed to health facilities	N/A		

If any IEC activities have been carried out for ACTs/RDTs, please provide more information below. Describe any community sensitization/ mobilization meetings held, radio/TV spots aired, brochures/pamphlets/posters created, drama/theatre shows held.
Because ERD program is an integrated community malaria program, the community sensitization/mobilization incorporated all aspects of malaria prevention and treatment. Therefore, please refer to Section 1 for information on sensitization around ACTs.

Has your MCP-funded project played a role in logistics, supply chain management, and/or pharmaceutical management related to ACTs? Please describe. Include any effects that the your project has had on the logistics etc of ACTs procured by other donors as well.

USAID/PMI asked that ERD participate in the MINSA program to train health workers on the use of Coartem. While ERD now includes information on the Coartem regime of treatment in its training for health facilities' staff, it is frustrating since there is no reliable supply of Coartem in Mucaba and ERD does not have the budget to purchase it.

4. Additional information

(a) For any of the above focus areas, has your project helped *facilitate* the implementation of malaria activities by other major partners such as the MoH, Global Fund, UNICEF, WHO, etc ? Please list instances where MCP-funded activities resulted in synergies with other partners. Highlight examples that show how your project has complemented the work of other partners, resulting in greater impact, less duplication, more collaboration, etc

Episcopal Relief and Development collaborated with the Angola Ministry of Health (MINSA), the NMCP, UNICEF, USAID/PMI and WHO. The following highlights key areas of collaboration:

- **Angolan Ministry of Health (MINSA)**: MINSA provides staff to the primary health center and two smaller health facilities refurbished by ERD as part of the project. ERD coordinates extensively with MINSA on the training of health facility staff.
- **NMCP**: 1) The NMCP provided technical assistance on national malaria control strategies in two separate training sessions for the project team and the community volunteers. 2) The NMCP indicators tend to be more health center focused whereas ERD's indicators are more community focused making it difficult to easily feed the ERD indicators into the NMCP framework. USAID wanted ERD to ensure that its indicators reflected all of the necessary information required in the NMCP M&E guidelines. As a result of this and further discussions, ERD succeeded in convincing the NMCP that there M&E data are incomplete without community data, which ERD will provide to them from now on.
- **USAID/PMI**: ERD's NFL-Mucaba Project Director views USAID PMI as a key partner in its project. The PMI team has been central to the discussions with MINSA advocating for various policy changes, including persuading health officials to allow a community-based IPT pilot and to consider a community-based ACT pilot, and reinforcing the important role of TBAs—literate or not--in the health delivery system. The NFL-Mucaba project director also has started to engage the PMI staff in conversations about other programs, such as training in food security and nutrition for the women's networks developed by NFL, that ERD is exploring bringing to Mucaba. The Ministry of Agriculture has indicated that ERD can submit a proposal on food security and ERD hopes that the PMI team will advocate about the importance of an integrated program in combating malaria, as well as other endemic diseases. USAID/PMI provided technical support in training and data collection.
- **UNICEF**: Procured and delivered nets to ERD's project in Mucaba. Unfortunately, as noted in Section 1, the nets arrived late and in fewer numbers than had been ordered. UNICEF also participated in the Field Verification Exercise as part of ERD's M&E.
- **WHO**: WHO's M&E staff, in collaboration with MINSA and UNICEF, were very active in designing the Malaria indicator surveys (MIS) in Angola, they offered to review ERD's M&E indicators to avoid duplication and ensure that we only captured the kind of data that had not yet been captured in the MIS.

In addition, the WHO Coordinator, the NMCP Coordinator, and the UTCHA (Angolan national agency for humanitarian coordination) Coordinator in Uige province, where the project takes place, all provided support to ERD's project coordinator in identifying and interviewing prospective program staff. Also, ERD received support from a number of partners, including UNICEF, WHO, the NMCP, the District Health Department in Uige, Save the Children-UK, CUAMM (an Italian health NGO in Uige), and the ADJC (a church youth NGO) on verification of field activities during the 6-month evaluation.

(c) Have any new policies related to malaria been initiated since your project began in your target location? Please list these below. (Examples of any new policies or changes to policies include (but are not limited to): distribution of free nets, distribution of free drugs, adoption of ACTs/IPTp, support and adoption of community treatment (HBMF), new drug treatment policies and guidelines, new RDT policies and guidelines, new IVM policy or strategy, new NMCP strategy, adoption of IRS and/or agreement to spray households indoors, lifting of any taxes/fees imposed on malaria commodities, changes in government allocations or human resources)

- **Community-Based IPT Pilot**: The national guidelines do not currently permit a community-based IPT program. With persuasion from ERD and advocacy from PMI Luanda, MINSA has agreed to permit NFL-Mucaba to pilot a community-based IPT program as a first step toward policy change. To help integrate the pilot into the NFL-Mucaba project, ERD will include Fansidar in the kits provided to the TBAs. As part of their training, TBAs are asked to monitor all pregnant women in their villages. Based on the fundus' height of each woman, the TBAs will know whether a woman has completed her 20th week of pregnancy and, if the village's location precludes a woman from going to a health center, the TBA will administer the Fansidar and register it on a woman's pregnancy card. The government's Maternal Child Program Coordinator will supervise this program.
- **Community-Based ACT Treatment**: At the beginning of ERD's NFL-Mucaba project, the baseline study showed that few community members had used or were aware of ACT treatment of malaria. While the health facilities typically do have supplies of Coartem to be used in ACT, ERD provided training to health facility workers on the new Coartem treatment regimen. In addition, in order to reduce malaria related mortality resulting from delays in going to a health facility, ERD also is working with MINSA to allow the NFL-Mucaba program to pilot a community-based ACT program in the project's second and subsequent years. If MINSA approves the pilot, community health agents, who have been trained in home-based management of fevers algorithm under community IMCI, could proceed with treatment of uncomplicated malaria. This will be an important development particularly for communities in remote areas.

In recent years, MINSA has been focusing on strengthening health facilities, but not necessarily other resources for service delivery in the community. While MINSA's agreement to move forward with community-based IPT pilot and consider an ACT pilot represents a departure from their existing policy, health officials are beginning to see how these pilots, as well as the training of the community health agents and TBAs, provide a necessary complement to strengthened health facilities. Also, the NFL-Mucaba project director feels confident that MINSA will see the importance of brining malaria therapy out into the community and will approve the ACT pilot beginning in the 2008/09 project year (Year 2). ERD believes that if these pilots are successful in demonstrating the efficacy of community-based delivery, they have the potential to serve as the basis for similar policy changes at the national level.

- **Net Delivery at Household Level**: UNICEF previously only permitted net distribution at health facilities. Because ERD's program is community-based and the intent is for its malaria volunteers to carry out net distribution within their immediate neighborhood, ERD convinced UNICEF that nets could be distributed at the household level in addition to the health center level. In a municipality like Mucaba, this change will ensure coverage since ERD's target population includes not only the population that visits to the health center, but also that population that does not have access to a health facility.
- **Incorporation of Community Data into M&E:** See highlight number 2 under NMCP in above section. ERD succeeded in convincing the NMCP that there M&E data are incomplete without community data, which ERD will provide to them from now on.

6. Photos, Stories, and Quotes: Please include at least 2 success stories that illustrate PMI activities in your country. For photos, please include a photo credit and a brief caption. High-resolution photos are preferred. Please also send any quotes about PMI that are specific to your country. These can be quotes from MOH officials, other partners, community health workers, health facility workers, beneficiaries, etc.

Success Story 1: A Mother's Story: In one of the household interviews performed by the NFL-Mucaba staff, a mother recounted how she had lost five children to malaria in the previous three years. She told the NFL staff that, since using the LLITN provided by them, her household had not experienced a single case of malaria. While the tracking of data is important, this mother's story is the reason that ERD engages in this work and PMI funds it. It illustrates that a simple intervention—use of an LLITN--can be effective in preventing malaria and can have an incredibly positive impact on the lives women and children.

Success Story 2: Improved Health Services: As part of its project first year, ERD is partnered with MINSA in improving the ability of the local health center to deliver health services. ERD used its own funding to refurbish the health center and equip it with necessary equipment and supplies (such as a delivery bed and fully equipped TBA kits), and arranged for delivery of medicines that had been sitting in a storehouse, but for which MINSA did not have the resources to deliver. Along with the refurbishment, the health center is now better managed and open 24 hours. As a way of increasing service provision, ERD also refurbished two other health facilities that had been closed during the war and provided training to nurses and TBAs, some of whom were placed in the two smaller centers. In terms of long-term sustainability, ERD asked and MINSA agreed to cover the salaries of the newly-trained staff on an ongoing basis. This ERD investment leveraged PMI's funding since it is unlikely that ERD would have been able to justify use of its own funding without knowing that the complementary program elements (i.e. community sensitization and LLITN distribution) were already covered by PMI.

The other important accomplishment to highlight in "improved health services" is ERD's identification and training of unemployed individuals that had previous healthcare training. Many nurses and midwives in Mucaba were war returnees, but were not practicing as a result of the lack of health facilities and/or opportunities. ERD identified and provided refresher training to these individuals thereby taking unused capacity, strengthening it, and integrating it into the community. This effort not only helped the community-at-large, but also improved the hopefulness of those being trained. One midwife, who had trained in the Democratic Republic of Congo (DRC) during the war, had been unemployed for seven years. Two months after her training with ERD, she visited the NFL-Mucaba staff to tell them how, even though she was not being paid for her services, she felt very gratified helping her community and that she had not realized what a significant difference her efforts could make.

In June 2008, the then Vice Minister of Health, who has since been promoted to Minister of Health, and the National Public Health Director visited Mucaba because it is endemic with so many diseases, including malaria, and he wanted to see the programs in place to address endemic diseases. As part of this trip, they visited the refurbished health center in Mucaba. The Vice Minister of Health asked "where are all of the people?" On previous visit before ERD initiated its project, the Vice Minister had seen three rooms full of people waiting for malaria treatment. Later during the same visit, the Vice Minister complimented the ERD project for its improvements in the provision in health services and for the noticeable decrease in patients with malaria.

Success Story 3: Integrated Programming for Improved Nutrition: While exact poverty levels in Mucaba where ERD is performing its project are not known, it is estimated that they are higher than the national level of 62%. So, in designing its Integrated Malaria Control Program, ERD anticipated high levels of poverty and malnutrition. However, the child malnutrition rates were much higher than anticipated and it became clear that ERD's ICMI plan needed to include additional elements to address the malnutrition problem. At one of the community sensitization meetings, a grandmother who was sitting with her extremely malnourished grandson said "I like your nets, but how will they help the fact that my grandson is starving." Beginning the 4th quarter of the project's first year (July-Sept. 2008) and going forward for the duration of the project, ERD is providing the funds to incorporate school deworming and Vitamin A supplementation as a small step in remediating the pervasive malnutrition. Also, officials from the Ministry of Agriculture (MOA) visited Mucaba to look at productivity in the region and met with the NFL-Mucaba project director. The MOA is amenable to receiving a proposal to provide funding to NFL-Mucaba for training of women on food security using some of the project's existing networks like TBAs, women leaders, and the church. ERD hopes to engage the PMI staff in Luanda in highlighting the importance of integrated programming to relevant actors in the national government in Angola.

Success Story 4: Changing Misconceptions About Malaria: Prior to community sensitization and education, it was not uncommon in Mucaba for individuals to believe that malaria and its associated delirium were the result of witchcraft or of a demonic manifestation. Where these beliefs exist, the actual victim or mother of a victim frequently is accused of being involved in witchcraft causing familial and community conflicts after a malarial death. The community education efforts provide community members with an understanding of malaria's causes and symptoms. As a result, a Mucaba-based priest Manuel Junior Songa noticed a significant decline in family conflict over malarial death.

Success Story 5: Training Illiterate, but Competent Women and Their Daughters: As a community-based organization, ERD has experience in and believes that there are effective ways to provide training to community members whether literate or not. Training on safe delivery, signs of danger during birth, health center transfer requirements, IPT, immunization of newborns, and malaria prevention to trained birth attendants (TBAs), who deliver 80% of the children in Mucaba, represents an important component of ERD's IMCI program. ERD strongly believes that TBAs as an institution at the community level need to be strengthened and that they need MINSA's full support. However, MINSA's maternal and child department has a policy to train only literate women, which precludes many capable women from the training particularly since the female literacy levels are estimated at less than 47% in Angola's Northern region. Also, since 2005, MINSA had been encouraging women to go to hospitals for birth despite the fact that the war had destroyed 85% of the health infrastructure and the existing system covers only 30-40% of the population.

As of October 2008, MINSA has provided a positive verbal response on training illiterate TBAs on community IMCI. ERD is collaborating with USAID Luanda to obtain formal approval of MINSA's verbal commitment to allow ERD to train illiterate and semi-literate TBAs. Both ERD and USAID agree that TBAs provide a critically important service in the community, particularly where there is no health facility. In order for the ICMP to be as effective as possible, all TBAs need to be eligible for the NFL-Mucaba training. Currently, at ERD's request, MINSA allows illiterate TBAs to participate in the training if they have a literate daughter accompany them to the training. The government has agreed to admit participating daughters to nursing school once they complete a prescribed level of education.

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CAREER OBJECTIVE

To provide strategic technical support in project development & management as well as research, monitoring and evaluation, impart leadership skills and build capacity in public health and poverty reduction related issues by working closely with project teams, interface with target community as well as use appropriate strategies to contribute towards improving the quality of life of a defined target audience.

SUMMARY OF EXPERIENCE

Sam is a Public Health Specialist with social marketing, management and economics background. He has flair in research as well as monitoring and evaluation with much experience in operational research. Sam has a varied work experience in the field of public health and poverty reduction and food security.

Sam has worked on international project on Food Security in Sub-West African countries as a research assistant. His rich experience in organizing and conducting field research was useful as he was responsible for data management for the research project team.

In public health, Sam has worked in management positions in areas such as HIV/AIDS, **Malaria**, adolescent reproductive health, maternal reproductive health, tuberculosis, sanitation, contraceptive social marketing etc. with excellent skills in health education and promotion as well as social marketing.

Sam's skills include management of national projects. His monitoring skills come to bear in monitoring of GSMF workplace as well informal sector HIV/AIDS programs. He participated in the organization's operational research phase of GSMF Hawkers Empowerment Program (HEP) as a lead researcher – a program that sort to reduce the vulnerability of hawkers through business management training, HIV/AIDS education and women empowerment. Sam is also the M&E manager for GSMF/FHI collaborative project in reducing the burden of malaria with support from Pfizer global philanthropy.

EDUCATION

Sept. 2006 – Sept 2007	MPH (Masters in Public Health) School of Public Health College of Health Sciences University of Ghana, Legon
Sept. 2000 – June 2002	M.A (Administration) University of Ghana Legon Accra/Ghana
Sept. 1995 – June 1998	BSc. Agric. Economics University of Ghana Legon Accra/Ghana

SHORT COURSES

June 2007	Monitoring & Evaluation Workshop USAID/AWARE RH Elmina, Ghana
September 2005	Professional Project Management L'AINE Services Ltd. Accra, Ghana
May 2005	Research Skills Building Workshop Ghana Institute of Management & Public Administration (GIMPA) Accra, Ghana
March 2005	Skills Building Workshop for Strengthening Country Coordinating Mechanism (CCM) as Public & Private Partnership for Monitoring The Global Fund Projects. Lusaka, Zambia
July 2003	'A Practical Approach to Fundraising' GSMF International Accra

November 2003	Monitoring & Evaluation Ghana Institute of Management & Public Administration (GIMPA) Accra, Ghana
July 2002	Application of Logical Framework to Project Cycle Management The World Bank Institute, Global Development Learning Network (GDLN), Ghana Institute of Management & Public Administration (GIMPA), Accra, Ghana
Summer 2001	Missouri-Ghana Business Internship Exchange Webster University, International Business Internship Exchange State of Missouri, USA
June 2001	Research Methodology and Report Writing Institute of Social & Economic Research (ISSER) University of Ghana, Legon
May - June 2001	Attacking Poverty in Africa: Policy and Institutional Reform for sustainable Rural Development, The World Bank Institute, Global Development Learning Network (GDLN), Ghana Institute of Management & Public Administration (GIMPA), Accra
Nov. Dec. 2000	Rural Poverty Reduction through Food Security & Agricultural Growth The World Bank Institute, Global Development Learning Network (GDLN), Ghana Institute of Management & Public Administration (GIMPA), Accra

WORK EXPERIENCE & PROFESSIONAL SKILLS

October 2008 – to Date **Monitoring & Evaluation Consultant/Officer**
Episcopal Relief & Development, Ghana Office

Responsibilities

- Resource person in conducting training for each of the 16 implementing countries in malaria control M&E
- Designing M&E Tools
- Standardizing M&E indicators for measuring program impact across countries
- Evaluating program impact
- Interpreting and translating field data into marketable information for various audiences

July 2008 – September 2008 **Senior Technical Manager (Research, M&E/Support Services)**
GSMF International, Accra, Ghana

Achievements/Responsibilities

- Developing Research briefs
- Designing and implementing of appropriate research activities of GSMF programs
- Processing and analyzing data
- Designing monitoring and evaluation of GSMF Int. programs
- Ensuring that research findings feed into program planning and implementation
- Collating and reporting information in a simple manner
- Coordinating with Research Subcontractors to ensure timely delivery of activities undertaken
- Generally responsible for all activities relating to biding and proposal development
- Coordinating all activities relating to the organization's Consultancy and Small Business Unit
- Generally responsible for documenting GSMF's activities and website

April 2006 – June 2008 **Technical Manager (Consultancy Services)**
GSMF International, Accra, Ghana

Responsibilities

- Coordination of all activities relating to the Foundation's Consultancy and Small Business Unit

- Prospect for business opportunities, develop proposal and curriculum for identified training programs
- Provide support in the implementation of consultancy assignments, programs etc
- Responsible for providing support for Research, Monitoring & Evaluation activities
- Design and implement appropriate research and M&E activities and ensure that research findings feed into program planning and implementation
- Assist in the management of Foundation's website
- Assist in the development of innovative IE&C materials for GSMF programs
- Assist in the documentation and preparation of reports on the Foundation activities

Dec. 2004 - March 2006 **Technical Coordinator (Research, Monitoring & Evaluation)**
GSMF International, Accra, Ghana

Responsibilities

- ✓ Designing and implementation of research activities
- ✓ Coordinating and processing of GSMF International Programs data
- ✓ Provision of research information (marketing, public health, etc) for program managers
- ✓ Collating and reporting information in a simple manner to Technical team
- ✓ Developing of Research briefs
- ✓ Coordinating with research subcontractors to ensure timely delivery of activities undertaken

October 2003 – Nov. 2004 **Technical Coordinator**
(Informal Sector HIV/AIDS Programs – Drive Protected, Toolguard, HEP, & ILO Project)
GSMF International, Accra, Ghana

Achievements/Responsibilities

- ✓ Successfully determined the strategic direction of GSMF International's Informal sector HIV/AIDS programs
- ✓ Monitored and supervised the entire informal sector program
- ✓ Liaised with Professional Associations of the various informal groups for collaboration and support for the programs
- ✓ Successfully coordinated research activities for a smooth implementation of informal programs
- ✓ Liaised with ad agencies for the design and production of Behavior Change Communication/IEC materials

- ✓ Liaised with the marketing department to ensure condoms sales through the informal sector programs
- ✓ Production of quarterly reports for activities undertaken under the informal sector programs
- ✓ Worked in collaboration with the research department for the design and implementation of all GSMF International's research activities

March 2002 - Sept. 2003 **Technical Officer (Research, M&E)**
GSMF International

Achievements/Responsibilities
- ✓ Same as under Technical Coordinator (Research, Monitoring & Evaluation)

Summer 2001 **Data Analyst (Cooperate Finance)**
MONSANTO (Missouri, USA)

Achievements/Responsibilities
- ✓ Collection of Warehouse inventory data in two states and reconciling with SAP system
- ✓ Auditing of warehouse inventory
- ✓ Special assistant to Manufacturing Analysis Manager

July 1998 – Dec. 2001 **Research Assistant**
RESEAU GHANEEN OF SADAOC FOUNDATION
(NETWORK OF SUSTAINABLE FOOD SECURITY IN CENTRAL WEST AFRICA)
Institute of Statistics Social & Economic Research (ISSER)
UNIVERSITY OF GHANA
LEGON

Achievements/Responsibilities
- ✓ Successfully assisted researchers in writing proposals and research papers
- ✓ Collection of both secondary and primary data and conducted analysis for senior researchers
- ✓ Organizing workshops and dissemination of research information, newsletters and reports
- ✓ Writing of workshops reports
- ✓ Successfully managed Reasue Ghaneen Documentation Center and office computers
- ✓ Successfully trained enumerators for field data collection
- ✓ Managed the secretariat in the absence of the Program Manager
- ✓ Secretary to the Management Board Committee

October 1993 – June 1994 **Physics Tutor**

KOFORIDUA SECONDARY TECHNICAL SCHOOL
(National Service Posting)

Achievements/Responsibilities

- ✓ Successfully taught Physics in Senior High Level 1&2

Computer Skills

- ✓ Advance knowledge of Microsoft Office suite – Microsoft Word, Excel, Access, PowerPoint, Publisher, and Microsoft Project.
- ✓ Advance knowledge in SPSS (data analysis software)
- ✓ Working knowledge in Epi-info,
- ✓ Web search and browsing

RESEARCH PAPERS

- ✓ Economic Analysis of Pig Feed Formulation (BSc. Dissertation)
- ✓ Composition, Volume and Flow Patterns of Cross-Board Food Trade
- ✓ Effect of Trade Liberalization and Exchange Rate Policies on Food Supply and Prices
- ✓ Trade Infrastructure, Availability, Use and Cost
- ✓ Marketing Margins and Equity in Food Trade
- ✓ The Regulatory Framework Governing the Operation of Rural Financial Institution in Ghana (Graduate Studies)
- ✓ Unplanned Pregnancy and Factors Influencing Reproductive Decisions in Ho Municipality (Graduate Studies)

EXTRA CURRICULA LEADERSHIP EXPERIENCE

- ✓ Hall Representative (1997/98) – Campus Christian Fellowship, University of Ghana, Legon
- ✓ Chapel Prefect (1992/93) – Koforidua Secondary Technical School
- ✓ Scripture Union President (1992/93) - Koforidua Secondary Technical School
- ✓ SRC Secretary (1990/91) - Koforidua Secondary Technical School

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My passion is to assist an organization in reaching its vision and strategic objectives, centred on the well-being of disadvantaged people utilizing 26 years of extensive experience in both relief and development. My strengths include strategic thinking and planning, multi-cultural alliance building, donor relations, financial accountability, program development, able to work in and with ambiguity, flexible management style, a mentor and leader and have consistently achieved program implementation goals and objectives on time and within budget.

WORK EXPERIENCE

EXECUTIVE LEVEL STRATEGIC PLANNING

- Experience in developing a global and or regional plan of action that can be then implemented throughout the organization.
- Have led many workshops developing one, three and five year strategic and operational plans. Able to communicate those plans in such a way that all management levels throughout the organization can understand them and draw up their actions steps to accomplish those plans.
- As part of various executive teams assisted in the development of corporate vision, mission, purpose, values and organizational style statements.

PROJECT DESIGN AND PLANNING

- Familiar with rural development, social and economic infrastructure, appropriate technology both at the concept and detailed level stage. Project research, feasibility studies and report writing skills.
- Able to very quickly assess a situation, consult and get input from all stakeholders to design a program and draw up plans to implement the program and keep altering it based on a continually changing environment.

PROGRAMS

- Extensive experience in program implementation, monitoring and evaluation of activities in: education, agriculture, food security, setting up of agribusinesses, resettlement, health including Infectious Diseases, Health of Women and Children both at the community and national level, construction, child sponsorship, gifts in kind, rehabilitation, disaster mitigation, complex emergencies and natural and man-made disaster response.
- Have consistently met and exceeded program goals, objectives and expectations.
- Successfully designed and developed a HIV/AIDS/TB program in Malawi that went from Provincial to National in the first year.
- With minimal resources have led organizations in entering and becoming established in South Africa, Angola, Mozambique, Rwanda, DRC, Uganda, Somalia and Kenya.
- Developed a Gift in Kind program in Southern Africa from nothing to $10 million in one year by developing partnerships with other groups whom could utilize and track the GIK and others organizations whom could fund the shipments.

FINANCIAL MANAGEMENT

- Acquiring and ensuring grant compliance for various government, foundation and private funds including USAID, EU, DfID, various UN offices, etc.
- Drawing up and adhering to multi-year, multi-donor and multi-currency budgets.
- Success in leveraging private funding against larger governmental grants to maximize resources.

NETWORKING/CONSORTIUM BUILDING

- Have been a leader in a 45 member not for profit consortium to cultivate partnership and collaboration amongst members.
- Have led in the forming of consortiums and networks for many emergency and development responses in Honduras, Nicaragua, India, Afghanistan, Turkey, Iraq and many countries in Africa.
- Have been instrumental in developing a China Network for many organizations in and outside of China wanting to be better prepared for and have responded to emergencies together.
- Experience in forging partnerships between international and indigenous entities based around mutually acceptable partnership agreements.
- Have formed alliances with organizations from Africa, Europe and North America to implement jointly funded programs to address HIV/AIDS issues at the central/national level down to the community/family level.

TRAINING

- Have developed curriculum and trained people in different cultures, levels of expertise, languages and educational backgrounds in all areas of the relief and development continuum including workshops in China, Philippines, Kenya, Ethiopia, Japan, etc.
- Able to train one-to-one, experiential and in a classroom environment.
- Have developed material and led many workshops in the North America, Japan, Korea, UK and the Philippines regarding disaster preparedness and response planning and implementing and disaster mitigation initiatives.

PERSONNEL AND ADMINISTRATION

- Forged many cross-cultural teams to rally behind organizational and/or project goals and objectives in a multitude of challenging environments.
- Supervised and held accountable personnel worldwide overseeing regional and country programs.
- Put in place strict security policies and procedures for staff working in conflict areas. Led in the developing of comprehensive personnel policies with an emphasis on member/staff care.

LOGISTICS

- Negotiated contracts with Government, Aid and Development organizations.
- Procured equipment and materials for projects.
- Knowledge of logistics systems for imports and exports.
- Formulated commodity-tracking systems to ensure accountability to various donors such as EU and WFP.
- Overseen major logistical planning for aid distribution in many large-scale emergencies including war zones and complex emergencies such as in Angola, Mozambique, Sudan, Zaire/DRC, Kosovo, India, China, North Korea and Afghanistan.

FUNDRAISING

- Extensive experience in project presentation for funding and material donations.
- Successfully obtained funds from government institutions corporate companies, foundations and non-government organizations for various projects worldwide.
- Began new programs initiatives with no resources and built multi-million dollar, multi-sectoral, multi-country programs in Southern and Eastern Africa, Europe and Central Asia.

EMPLOYMENT SUMMARY

2004 – September 2007 Project HOPE – UK/USA
Africa Regional Director

1998 – 2004 Food for the Hungry International – South Africa/UK
Vice President for Relief

1996 – 1998 Food for the Hungry International – South Africa
International Relief Director

1995 - 1996 Food for the Hungry International – South Africa
Africa Regional Relief Coordinator

1989 - 1995 Food for the Hungry International - Mozambique
Country Director

1987 - 1989 Christian Mission Aid and Development Agency - Kenya
East Africa Representative

1985 - 1987 World Council of Churches - Ethiopia

Institutional Strengthening Consultant - seconded to the
Ethiopian Orthodox Church.

1981 - 1984 International Christian Aid – Somalia/Uganda

- Camp Coordinator based in Luge, Somalia
- Stores and Food Programs Coordinator based in Namalu, Uganda
- Resettlement Manager based in Namalu, Uganda
- Project Manager based in Namalu, Uganda
- Uganda Country Director based in Namalu, Uganda

TRAINING AND EDUCATION

- Disaster Response Workshop.
- Cranfield University Counter-Disaster Planning and Management Course.
- Field Management workshop.
- University of Oxford Training of Trainers in Disaster and Development Management.
- Community Development Training of Trainers Workshop.
- Royal Institute of Public Health and Hygiene Diploma

ACHIEVEMENTS AND EXPERIENCE OUTSIDE EMPLOYMENT

Second in UK National New Food Products competition

Organized and completed an England Coast to Coast sponsored walk for Ethiopian famine relief.

Chaired international conferences on various R & D topics especially strategic planning

Wrote and presented papers to international NGO gatherings on topics ranging from collaboration between international and local NGO’s to personnel security in war zones.

Appendix 4

ERD NFL-Mucaba, Uige, Angola

- Note: ERD is including a CD of the high resolution photos when it sends the hard copy report.

Photo Captions

(All photos should be credited: ERD NFL-Mucaba Staff)

- Photo 1: Trainer of Trained Birth Attendants (TBAs) discusses the importance of using sterile gloves during check-ups and delivery.
- Photo 2: TBAs try out sterile gloves during a training session.
- Photo 3: Mucaba women wait with their children outside of one of the health facilities refurbished by ERD.
- Photo 4: Malaria education and sensitization activities in a village in Mucaba.
- Photo 5: Distribution of "cartoon" leaflets on malaria prevention and control.
- Photo 6: Young woman in Mucaba receives her LLITN.
- Photo 7: Woman with child receives her LLITN.
- Photo 8: Young child holds a new LLITN.
- Photo 9: Child holds a new LLITN and a baby sibling.
- Photo 10: ERD's NFL-Mucaba truck is stuck in the mud, illustrating the difficulty of navigating the roads in Mucaba during rainy season.
- Photo 11: Training session on malaria education and sensitization for community volunteers in Mucaba.
- Photo 12: Training for women leaders.
- Photo 13: Women leaders gather for a photo following a training session.
- Photo 14: Children in Mucaba celebrate the arrival of their bednets.

NetsforLife®-Mucaba

Episcopal Relief & Development
Healing a hurting world

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