



iCCM in Mozambique  
InSCALE inception Meeting Report

16<sup>th</sup> April, 2010  
Kaya Kwanga,  
Maputo, Mozambique



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## List of abbreviations

**APE** – Agente Polivalente Elementar

**APEs** – Agentes Polivalentes Elementares

**CIDA** – Canadian International Development Agency

**iCCM** – Integrated Community Case Management

**iNSCALE** – Innovations at scale for community access and lasting effects

**MDG** – Millennium Development Goals

**MISAU** – Ministério da Saúde

**MoH** – Ministry of Health

**NGOs** – Non Governmental Organizations

**PNCM** – Programa Nacional de Controlo da Malária

**USSR** – Union of Soviet Socialist Republics

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## Background

During the last decade child mortality has reduced significantly in a number of African countries. Scale up of appropriate management of diarrhea, pneumonia and malaria was partly the reason behind the success. As a way of increasing access to treatment for sick children where health services are geographically and financially inaccessible, several African countries are currently investing in community based agents (CBAs) to deliver treatment. In Mozambique the strategy of community involvement dates back to the year 1977 when it was decided to increase the coverage of health services through an approach of primary health care using Agentes Polivalentes Elementares (APEs) to deliver treatment. As part of this strategy, APEs do not only provide health promotion / health education and treatment for malaria, but also treatment of diarrhea and pneumonia – so called “integrated community case management” (iCCM). The process of revitalization of the APEs is in course through the Ministry of Health in collaboration with its partners but the previous experience has shown that there are weaknesses to the program, such as the supervision and motivation of the APEs. Also the correct collection of data, flow and use of the same by the APEs together with the health system are other challenges that affect not only the implementation of the program but also the planning of the needs and activities.

Recently, Malaria Consortium was awarded a grant from the Canadian International Development Agency (CIDA) to support implementation of the APE strategy in one province of Mozambique. In addition, another grant from Bill & Melinda Gates Foundation was awarded to better understand work motivation, attrition and better use of data, and to find feasible and acceptable solutions to APE retention and performance which are vital for successful implementation of iCCM at scale.

## Meeting overview

To achieve the project goal of increasing coverage of integrated community case management (iCCM) in the two countries with APEs who perform their tasks optimally and who remain functional over longer periods of time, there is need to address the following questions:

- ❖ What are the main challenges that currently limit coverage of iCCM in terms of its geographical distribution and quality and how they can be overcome?
- ❖ How to improve supervision of APEs to ensure regular and effective feedback which result in high performance of APEs?
- ❖ How to increase motivation of APEs to ensure high satisfaction and retention of APEs?

### **iNSCALE programme goal:**

The overall goal of the iNSCALE is to demonstrate that government-led iCCM programmes in 2 African countries (Uganda and Mozambique) can be scaled up to 33% of the districts and reach 50% of the children in these districts, primarily resulting in greater access to standard case management for children with diarrhea, pneumonia and malaria.

### Objectives of the meeting:

- To discuss the role of various stakeholders in iCCM implementation in Mozambique
- To share views on the requirements for successful scale up of iCCM in Mozambique
- To consult with stakeholders on the ways which supervision and motivation of APEs can be improved as well as the information flow and use of data collected by APEs.

### The expected outcomes:

- Stakeholder awareness of the Malaria Consortium iNSCALE programme and its objectives
- Stakeholder agreement on how the Malaria Consortium iNSCALE programme can address the country's needs through testing and documentation of the effect of new and improved strategies
- Stakeholder recommendations and advice on essential interventions that can facilitate scale up of iCCM.

- ❖ How to improve the information flow and make better use of the data collected by APEs?

It is anticipated that governmental and non-governmental organisations will play a major role throughout the life of the project. In particular, we foresee a fruitful collaboration whereby partners will provide input into intervention design, participate in dissemination activities, be involved in development of guidelines for introduction of iCCM at district level, support districts to mobilise resources for iCCM and to have regular supply of medicines for iCCM, and sustain the program at national scale. The continuous MoH support of health facilities to provide referral care and equip VHTs with medicines, tools, supervision and training is also a necessity for the success of the project.

The meeting was divided into two parts: oral presentations and group discussions. This report presents a synthesis of the presentation highlights and group discussions, and the questions which arose from the debates.

## Introductory speech

**Kate Brownlow – Country Director, Malaria Consortium Mozambique**

In the opening speech all the participants were welcomed. She started by focusing on the APEs program recently approved by the MoH. One of the reasons that motivated Malaria Consortium to promote the meeting was to better explore successful practices and experiences and discuss the difficulties of the above mentioned program. It was also mentioned that analysis of past and future experiences can be included in the revitalization of the APEs in order to come up with better ways to implement the strategy.

After that, the moderator highlighted the objectives of the meeting, the expected outcomes and referred to the agenda of the day.

## **The Role of the APEs in the Promotion of the Community Health**

### **Dr. João Schwabach**

The main aspect of this presentation was the background history of the program, and his experiences as the first director of the APEs.

After that he covered some historical aspects:

- ❖ The years following the independence showed weakness in the system of health care, especially in the rural areas, therefore, there was a need to define strategies that could alter the situation, decentralizing the system and taking it to the periphery;
- ❖ The first national health seminar, in October 1975, launched the idea of health promotion in the community, by the community;
- ❖ Experiences from the national liberation struggle, different medical experiences of China, USSR, Tanzania, among others, were inspiring sources for the training of the APEs;
- ❖ The concept of promotive medicine by the communities.

It was emphasized that the APEs were not servants of the national health system because they were not employees and nor were they exclusively occupied with health care tasks. They helped to promote health in their communities, constituting the link between them and the national health system.

## Questions and discussions

Questions about the relationship between the APEs training program and the present movement of the public sector reform: what should be done to guarantee that APEs could be integrated in the actual reforms? The Ministry is taking responsibility of the process and that violates the concept of community involvement.

Answering the above question: the Mozambican act concerning the matter rules that the primary health care should be under the supervision of the local authorities . In his personal opinion he disagrees suggesting it might be premature for two reasons: local authorities don't have resources or experience and there is the ideological and philosophical danger of breaking the primary health care. The system should be redesigned in order to avoid ruptures. The APEs should be updated in terms of technical knowledge.

It is important to address the question of lack of salary and involve them to continue performing the task. An example: the population of the Magude district decided to give a contribution to the APEs. Another experience, considered positive, was the linking between the traditional healers and the APEs, making the union stronger.

Another contribution on the issue of compensation to the APEs, stress that this was a serious matter, requiring the MoH to discuss the program's sustainability. The investment in APEs has high returns. Looking at the actual circumstances in the country, how would the training be conducted today? Who would pay the salaries? The MoH? What would be the role of the MoH?

Two questions were raised: the program sustainability and the APEs sustainability *who cannot live only on oxygen*. The MoH should provide tools for their work, such as transport and a stretcher. He doesn't agree with APEs becoming servants of the MoH because they would be considered their employees. In that case they would have to account to the Ministry. They should instead account to the community, especially when they are sustained by it.

## Results of Stakeholder Analysis and Mapping

### Celso Inguane – Consultant, Malaria Consortium

The presentation constituted an approach to the preliminary results of the consultancy on stakeholders involved in the iCCM of the main childhood diseases through APEs strategy in Mozambique, conducted for Malaria Consortium.

Two contexts:

- ❖ The renewed international interest on the use of the rural health agents in order to guarantee better access to primary health care and attain the Millennium Development Goals (MDG) numbers four and five;

- ❖ The renewed interest in Mozambique, in the APEs revitalization program, with potential to improve and guarantee the access to primary health care and expand the health care.

The use of rural health agents like the APEs had been successful but faced difficulties, such as sustainability, performance, supervision, retention and motivation and use of information.

Three objectives were highlighted:

- ❖ Identify the main actors involved in the iCCM of the main childhood diseases, through the strategy of APEs;
- ❖ Recognize opportunities and challenges to the program;
- ❖ Identify actual, planned and alternative solutions with potential for an improved performance of the APEs, their retention and motivation, and effective use of the information produced by the APEs.

He presented the sample, the places visited, the methods of collection of data and analysis of the same. Two constraints were appointed: access to information and documentation (ongoing) and the availability of potential interviewees.

Opportunities and challenges to the program were listed. As challenges, the financial sustainability, planning and coordination, the institutional capacity, the transparency on the selection of APEs and the impact of subsidies to the APEs, were detailed.

Some solutions, with potential to improve the program, were given, such as:

- ❖ The improvement of the performance of the APEs, through a clear, decentralized and regular supervision;
- ❖ Continuous training;
- ❖ Retention and motivation of the APEs through monetary, material and non-material incentives;
- ❖ The use of information produced and provided by the APEs, by collecting data and producing reports for example.

Some relevant aspects covered in the presentation were underlined, for example the implications of subsidies on the performance of the APEs. It was also stressed that even without clear answers, the program should not stop and there should be no fear. People were reminded that in 1977 there were no answers to all the critical questions but even so, it continued.

After the above presentation few questions were raised for further discussion:

- ❖ How to improve the APEs on their performance and assure quality of their task?
- ❖ How to assure that APEs continue motivated throughout time?
- ❖ How to use the information collected by the APEs, at the community level, and how to ensure flow of the same to others?

# Community Case Management of Childhood Diseases in Rural Mozambique: Province of Nampula, Nacarôa District

Luigi d`Aquino, Save the Children

The presenter began by saying that it was a project designed in partnership with the MoH, giving basic information, such as, the duration, intervention area and area population. He then presented a diagram containing the goal (to reduce the mortality in children under five), objective (to increase the use of services and key behaviors), results (increase of access and availability of services and supplies, increase of quality of the provided services, improve the knowledge and acceptance of services) and the strategy of the project.

The initial phase of the project was the design of a national package of iCCM, which was possible by adapting the existing material from other countries to Mozambique, revising the existing APEs curriculum, as well as protocols and tools of work, and then elaborating a draft manual in partnership with the MoH.

In the implementation phase they did the rural mobilization, the training of supervisors and APEs, rehabilitation of health centers and the purchase of medicines for the APEs. The training of supervisors, who were health center staff, aimed to guarantee the link to the APEs. However, according to the MoH, for their training, they should work with the existing APEs and could not train new ones.

He shared a diagram on the outcome of access and quality of services. Some observations arose from the exercise of supervision of the APEs. They had registration cards from which the supervisors evaluated and reported on the role of the APEs, concluding that there was much work to be done. Apart from refresher training there should be continuous training to improve the quality of work of the APEs.

Constraints and lessons:

- ❖ Coverage and access – initially the major problem was its expansion in areas without coverage but the new plan covers it
- ❖ Services demand – not only increase the demand for APEs in the community but also involve other key actors
- ❖ Supervision - from the beginning, the involvement of health center staff constituted a big challenge because they are very few and their role is not easy; the ways of access in the country affect the frequency of supervisions even when there are funds
- ❖ Motivation – the project began with no monetary incentive and it might be said that the performance of the APEs was good; from 2010 there is a plan to introduce some incentive to be given at the district level and not by the Non Governmental Organizations (NGO`s); there should be an alignment of all the actions to the national plan
- ❖ Continuous link with the health centers
- ❖ Monitoring and evaluation – design of various types of registration cards that contribute for the work having structured information; what is the importance of the person collecting them; it is not easy for the APEs to collect lots of information; during the training the capacity of the APEs should be taken in to consideration
- ❖ Logistics – the supply of Kit C was not regular during the time of the implementation of the project, which affected the performance of the APEs.

## Questions and discussions

An observation emphasized the importance of the documentation of these projects in which the *Save the Children* is involved. The documentation of good practices and histories of success should be disseminated to the Ministries and other organizations.

About the APEs profile it is typically said that it has a curative, preventive and promotive role, but it should be noted that there is the rehabilitative part. One of the biggest problems is the capacity of rehabilitation of the communities and therefore the APEs should be trained to do so. It is also necessary to create a supervision structure inside the APEs, where they can become APEs supervisors with their own experience.

About the referral documentation he noted that MoH is using them in their discussions. The role of rehabilitation and APEs career has already started and furthermore the experience will show whether it is possible and makes sense to construct a scheme of supervision. It should start according to what was defined and later, the community may help the APEs to develop even more.

Another observation focused on the importance of facing the challenges with transparency and to be concerned about the levels of management. He mentioned a research conducted in Malawi. A question was placed: whether they have an understanding of the source of difficulty with the APEs, if it was not delivery methodology. Another question: was the training appropriate and the supervision not? What actions the organization is taking to correct the deficiencies?

In answer it was said that there is a geographical difference between Mozambique and Malawi, which creates difficulty of access and affects the supervision. Also the regular follow up was not optimal and it didn't help to improve the quality. They see only two solutions: explain that not all the APEs have the same level and not all can train others; and insist on the refresher training and increased supervision.

Another question raised on the expectations of the *Save the Children*: how they see the small jump that the APEs had from one period to another, was it worth it? What should be done to increase the numbers of people received prompt treatment for malaria, diarrhea and pneumonia?

About data collection, production and use of information by the APEs and authorities, many systems were created to collect the maximum information but without effective use.

Answering, it was not worth describing the monitoring system, they have been working on that issue and everyone agrees on having the necessary information to guarantee an absolute simplification of the system.

The supervisor is not familiarized with the registration cards and that the collection of data should take place monthly. The APEs are continuing to work and the same data should be compared next year. There are two components: the role of the supervisor and of the supervised, where it is necessary to reinforce not only the APEs but also the supervisor.

It was clear that the MoH group discussions are in course, where the questions raised will be resolved. It also welcomed contributions to be integrated in the handbook of the APEs, which is being produced. On the scope of revitalization of the program, the *Save the Children* was questioned on what is the role of the NGOs after this intense work.

Answering they said there should be a clear demarcation among the donors. Apart from technical assistance they should also be connected to the implementation phase, guarantee supervision, continuous support in the collection and analysis of data and in the field training.

Another comment was on the data presented, where it was said that everyone would like to have better percentages in terms of APEs' performance. The training on malaria (diagnosis and treatment) at the national level started last year and has trained about 1500 APEs. It is important to guarantee quality of training at the APEs level; check the information that goes from the central level to the APEs. Not always the training of trainers have the results that are expected, at the community level. It is believed that in 2010 the data will improve.

## **Integrated Community Case Management Program - CIDA**

### **Helen Counihan – Malaria Consortium**

Started by naming the countries where the program is in course, namely Uganda, Mozambique, Zambia and Southern Sudan. In Mozambique, the project was launched in the Inhambane province, focusing on the rural areas. The program goal is to reduce child mortality. The approach presented is what the standard is across the four countries, but every country has its own strategies and policies into which the program is integrated.

The training in iCCM should follow the MoH guidelines, starting at the district level to the APEs. The district and health staff should also be trained as supervisors.

Some important discussions: the need of ongoing support supervision to the APEs by the health staff; the guarantee that resources are given to the supervisors on a regular basis; and opportunity for refresher training. To make the process of supervision effective its policy should be supervised.

The current situation of the program:

- ❖ Mapping of APEs completed in Inhambane
- ❖ Working with the Provincial Directorate of Health
- ❖ Supporting the MoH to develop the new APEs revitalization program
- ❖ Additional funding secured for initial weeks of APEs training
- ❖ Baseline study protocol submitted for ethical approval.

The presenter ended by stating that nothing will work if people don't change their behavior. In the process of research the first important thing is to find out how people perceive the program.

## Questions and discussions

Although the project has a lot of potential there are lots of challenges. The target of reducing child mortality (up to 35%) should be discussed. There are risks of confusion when comparing to districts where there is no intervention, because of the many implementation partners in Mozambique. The three contemplated districts will have a better performance because they will have a stronger support. There are lots of challenges if this kind of evaluation is to be considered.

The country is attracting many other partners. It was made clear that the control districts will be selected where there are no community-based interventions taking place but of course the work of other implementation partners in Mozambique is beyond the control of this program. About the 35% it was agreed that this is an ambitious target and in fact the aim is to reach to as close to this figure as possible.

## iNSCALE Programme

Dr. Karin Källander – Malaria Consortium

The iNSCALE program is a new Malaria Consortium program, which stands for “innovations at scale of community access and lasting effects” and is present in two countries.

There has been a large scale implementation of ICCM in seventeen African countries but that was often constrained because of lack of drugs, APes drop-out, poor performance and poor use of data. The iNSCALE programme is building on the CIDA project implementation in Uganda and Mozambique.

The project goal is to demonstrate that government iCCM programs in two African countries can be rapidly driven to scale with quality, leading to a sustained increase in the proportion of sick children receiving appropriate treatment.

The Bill & Melinda Gates Foundation require the organizations to propose and evaluate solutions for improvement in three areas, which will increase the scaling up of the program in the countries. One of the objectives of the iNSCALE program is to identify best practices and innovations with potential to increase quality and coverage of iCCM. Some innovations are in use and their acceptability should be evaluated.

A timeline was also presented to show the framework of the project. The first objective is the formative research, which is an ongoing activity. For the theoretical background, motivation and satisfaction are key. Satisfaction leads to retention and motivation is linked to performance. A person can be highly motivated if there is structure, resources and a good working environment, and therefore give good assistance. But when not motivated they might also give good service but look for other ways of surviving.

The data can be used to improve the motivation of the APEs, giving feedback and helping them to have an improved performance. The relationship with their clients and community is important for them to feel that they have an important role and are doing an important task.

What is expected with the program is that, at a national scale, the APEs are keen to stay in their job, engaged, happy and enthusiastic to carry out their duties, and provide care at high standards over time.

## **Questions and discussions**

The first observation remarked that the biggest challenge in the health sector in Mozambique are the human resources, and the presentation gave a clear image of the brain drain of qualified staff. The iCCM will be led by the government; the APEs will be MoH servants and therefore it is thought that they would receive a salary.

The aspect of retention: the health staff may not be happy because they might feel the retention is not good. Even if an NGO gives its support, there is the performance question. The aspect of retention is related to other bigger challenges and constitutes a greater problem.

Answer: it is interesting to compare Uganda to Mozambique: in Uganda the process was made with volunteers and without subsidies. The financial aspect is not the sole incentive to maintain people working.

Another issue emphasized was that the 5-year program goal is to have 33% of the districts in Mozambique covered with iCCM. However, we should think beyond the 5 years and ask ourselves how to sustain APEs even after five years?

The presenter answered that they are facilitating the iCCM implementation for the MOH and the strategy beyond the 5 year plan will be decided by the government.

Another remark was that operational research is very interesting, but questioned how they are going to maintain 1500 APEs that have been working.

The presenter answered that in the first year only formative research will be conducted, where some questions will be analyzed. They will see what motivates people in this context and then look at previous experiences.

About the indicators, was the list presented complete or just a part of it? Perhaps we should look at the indicators that measure the promotive and preventive side, and not invent new ones. They will try to measure the use and demand on the same. The program is to see if the APEs have quality and coverage.

Regarding the indicators, the MoH is designing something, but they don't know if Malaria Consortium is prepared to receive it. There is work that should be done with all the MoH partners in order to standardize the indicators.

The answer from the presenter: Malaria Consortium is involved in the working groups at the MoH and everything is shared with them. The approach to projects is common and the indicators are specific to the evaluation. It will focus on the work with partners. A key moment could be when the MoH presents its annual planning, where there is need of discussion at different levels and with different working groups.

One question was about the Health Coordinating Council, is there is any mechanism that will be used to influence it? What mechanisms should be discussed?

On supervision, how to make it more effective? About the role and objective of supervision, should the APEs be evaluated or is it for their continuous training? Or both of them?

About the flow and use of information that the APEs give to the central level, which instruments exist? Who does the data analysis? At which level? What kind of feedback the APEs have in terms of the data they provide?

The quality of services provided: which factors influence quality? Is it the training of APEs? Does it have the desirable quality?

What makes the APEs remain in their functions? What is the motivation? What are the working conditions? What instruments and means do they have at their disposal to do their task?

## **Introduction to group discussions**

### **Fernando Bambo – Malaria Consortium**

The objective of the group discussions was to identify new ideas and good practices to improve the performance of the APEs.

For debate: the proposal was made that existing, experienced APEs can act as mentors to the newly trained APEs; to motivate the APEs it emphasized the availability of materials that could make a difference; people were also reminded about the problem of the volume of information that the APEs have to manage.

For the first group, on motivation, they should list the elements that contributed to the quality of service and to the retention of APEs. Also cover the challenges to guarantee quality.

The second group, on supervision, should discuss issues related to the existing formal structure, created by the MoH that regulates supervision. Make a comparison with the experience of work in the field: what kind of innovation can be brought in for the existing context.

The last group, about data flow and use of data, should analyze what is necessary as data; what to do with the data; why the need for that data; the barriers and solutions.

## Presentation from the groups

### Group 1 – data flow and use of data

The group changed the subject to *system of information of the APEs* and decided to work with the cycle of information.

They have identified two needs:

- ❖ Evaluate the management of the APEs, using the following indicators: use of a system of stock management, data on training and supervisions, consumption data.
- ❖ Evaluation of the services provided to the APEs: number of disease cases treated by the APEs, demographical data, use and quality of services.

One barrier identified was the distance to the APEs. They emphasized the existence of multiple systems of information where each partner has its own, which constitutes a difficulty. As a possible solution they suggested linking the system of information to performance and incentives. May also be a technological solution, such as the use of mobile phones for example.

On the issue of data flow the barriers identified were: the existence of multiple and heterogeneous tools, the system of the MoH linked to pharmacy and the existence of vertical flows. The solution would be the harmonization of data and tools which can be through the partners working groups.

On the evaluation of the individual performance it should be guaranteed that the primary data reach the supervisors, at the district level.

The barrier to guaranteeing quality was that the collected data was not reliable, incomplete and sometimes non-existing. The solutions: reinforce the role in the health committees, guarantee the data verification and evaluate the quality of data.

Other barriers were the indefinite denominators and the low or no local use of the data provided by the APEs. The solutions: make an estimate of the population covered by the APEs, define targets to the APEs, train the leaders and others on data use, and inquire of the APEs what use to be made of the data.

### Discussion – Use of data

The first observation asked for more information on the use of data of the APEs by the community and the MoH: see how the information could be integrated into the health system. The actual system of information doesn't reflect the activities at the community level. It is important to know how much is done at the different levels.

It has been made clear that there is information that will flow from the community to the MoH and out (issue of mortality for example), but there are data that the Ministry doesn't need to know, for example the number of latrines in the community. The MoH will not make use of all data because not all are of interest to it.

The experience in Maputo province is that the APEs have a registry book and that information is collected every month. The information comes from the APEs to the district, then to the province and from there to the MoH. At some stage the data of the communities should flow to other levels. For example notifying the cases of cholera. If this kind of information is communicated further situations might be prevented.

One of the important issues in the collection of data, apart from knowing the activities of the APEs, is the planning for medicines and materials needed for their work, in order to avoid stock rupture. The data should reach the MoH and be shared with the planning department and the medicines center. The country is vast and the provinces have got different number of population, APEs and needs.

The flow of data seen at two levels: flow of information from the base, passing to the health center of the APEs, to the district, to the province and from there to the central level. Comparing to the first structure of flow, the second reflected the flow in the other direction. The information has to flow in both directions. It is the structure of retro-information, that in a closed cycle would at least create motivation and satisfaction.

The question of retro-information should be considered with caution, it is hard for the APEs to receive information from the central level. This should come from someone close to the activities of the APEs, for example the community leaders. This information should be written to allow further use, for example for their career development.

The data is not really from the central level to the APEs. For example Maputo (central) receives the data on the number of tests that the APEs use and they give a feedback, questioning some issues. This feedback allows the APEs to understand their possible mistakes.

The supervision is done monthly in each health center. The District Directorate of Health is responsible for the supervision. The data comes for each health center and then at the pharmacy department they do the analysis. This exercise allows seeing the situation of malaria in the different areas and taking actions.

A question was on how the medicines and tests are sent to the health centers and to the APEs? Does it influence further sending of goods?

They get on the basis of what the district asks for and they calculate according to previous data.

## **Group 2 – supervision**

One positive aspect was that the supervisors are recognized as important at the community level but not at all levels. At the health center sometimes the APEs are not recognized nor getting the support they should have (in the campaigns for example).

It is important to define the number of APEs that a supervisor could have and that could be limited for geographical factors, such as the conditions and distance. The number of supervisors should be defined per district and they should have subsidies and transport.

The regular turnover of health staff causes difficulties to the program implementation because it means have to start from the beginning again.

There is a demand for supervisors. The APEs want support through supervision. Another issue is that many health centers are small and have no staff and the amount of work is very heavy. On top of that to get energy, time and conditions for supervision might be a greater challenge.

The group focused on the following suggestions as possible solutions: possibility of integrating the APEs supervision into mobile brigades; include the component of support to the APEs; possibility of exchanging of experience in which APEs with high capacities are promoted to help the ones with less capacity.

Quality of supervision is important if there is the aim of behavior change. The involvement of the community in the supervision, eg through the community health committee is also very important. One question with no answer is if there is the concept of a supervisor being a mentor. The supervision of the supervisors should also be done. The question of accountability of supervisors and APEs also need to be clearly defined.

Formative research is being conducted. The outcome of the research will help to identify what kind of support and supervision the APEs expect.

### **Discussion - supervision**

The supervision should be pedagogical and not controlling, but somehow it has to evaluate, because otherwise the opportunity of correcting things is lost. The supervision should have the clear objective of identifying possible mistakes to be corrected. To achieve this goal it should have a guideline.

Supervising the supervisor is an interesting and necessary issue. The supervision of the MoH has not been well done. One of the key elements should be the self-supervised APE, who could fill in information about what he learned and how the supervision was done.

There are no statutes of the APEs, they are untouchable from the legal point of view. Since they are not servants of the National Health Service nor the community's, they are then immune. An effort should be made to create a legal frame under which the APEs would fit.

It has been emphasized that it would be a great contribution if we could have doctors and experts as APEs mentors. In Malawi it was proposed that each APE have a mentor from the health center. The clinical quality of care of the staff from the health center is worse than the APEs level: which makes it necessary to think about what would be the desired role of the mentor: the clinical issue or the professional development.

Another issue raised was of whom the APE is accountable to. For example they receive the Kit C and then to whom do they account? They account to the community since they are “servants” of the same. After receiving the Kit C they account to the Provincial Directorate of Health. They should also produce a report to guarantee that in the next month they receive another one. They have double accountability: to the community where they are based and working; and to the health center that supervises them.

It was then remarked that a central issue was raised, the question of accountability. For instance who could dismiss an APE? Because that would be the person or entity to which it should be accountable.

Who could dismiss an APE? No answer was given because there is work ongoing at the MoH. But if the APEs are selected by the community, for its confidence, what if the latter says they no longer want that APE? It’s a question for reflection. Someone asked if it wouldn’t be the council of community leaders who has that competence, since it is the main structure of power in the community? One experience was referred to: the Kit C is opened in the presence of the community leaders. The APEs account to them and the leaders are aware of all the APEs activities.

### **Group 3 – motivation**

The group reporter started by referring to the quality of service where they have identified some aspects that incentivize the APEs: permanent supervision on the technical aspects to the APEs; the place of work should be equipped; the material for work should be adequate; the selection and identification of the APEs should be done by the community; and continuous and regular training.

As ways of retention: the selection should be done by the community and that would make them confident; the APEs that have been in place for a certain time could have promotions, applying for a basic course for example; medical assistance for the APEs and their families; the community encourages mechanisms of sustainability of the APEs, based on communication with the APEs where they say what they need.

Instead of salary they could have incentives such as uniform, badges, transport and means of communication, which would motivate them to work. Supervision not only improves the quality of service but also motivates it.

The presentation also appointed challenges and solutions.

- ❖ One challenge for the APEs was to have a base organization to fit them.
- ❖ Another issue raised was the fact that since it is the community that selects the APEs they could possibly select friends. They proposed the selection of a few and then the evaluation at the district level
- ❖ The trainers should be dedicated to the training.
- ❖ The APEs who outstand should be rewarded, making the others improve as well.

Another important point is that each community should not have only one APE. It is hard to train many at the first stage but in a second it should also contemplate the same community, in case of disease, holidays or departure of the existing APE. This will also make the APEs competitive.

Finishing, the issue of knowing what is motivating the APEs that are already working, was stressed, stating that there is no information about that. Are they being supervised by the communities?

## **Discussion - Motivation**

The first observation mentioned that there are a lot of challenges for the implementation of the APEs program, the challenge of the NGOs in the provinces have to do with capabilities. Another contributor mentioned the experience of working with the health activities in Cabo Delgado and Nampula, where the work of APEs and other health activities were not specific to organizations. What was defined by the Provincial Directorate of Health is that they didn't want different organizations but a single structure of work in the community.

In the above mentioned provinces there was the leadership of the Provincial Directorate of Health in order to do the harmonization of the approaches, but in other provinces there are activities that receive various incentives and there is an area of action which is confusing. How can it be studied and analyzed to assure that harmonization might not be prejudiced because of the "mess" of actors at the districts and communities? The mapping of organizations working there is huge.

The partners solve an instant problem in communities where there were no health centers. The MoH should not dismiss itself from the program of the APEs because it has been part of their thinking since 1977.

## **Summary, conclusions and recommendations**

### **Baltazar Chilundo – Malaria Consortium**

- ❖ The meeting objectives were all realized.
- ❖ During the discussions it was clear that the management will only succeed if there is active involvement of all the actors and interested parties.
- ❖ There was also a clear message about the important role for the success of different projects and programs around the issue. Positive efforts should continue and strengthen the existing ones.
- ❖ There should be a more intense interaction between different implementing partners with more sharing of experiences and communication.
- ❖ The MoH should be consulted on any procedures.
- ❖ Invitation for the participation in the working groups at the MoH, if we want to see our contributions reflected.
- ❖ Malaria Consortium should finalize the report of analysis of the inputs of stakeholders and disseminate it.

## Evaluation of the workshop

Positive aspects: Malaria Consortium congratulated for the workshop; a good meeting and the level of discussion brought positive aspects that will contribute for the working groups at the MoH; allowed the interaction of the involved parties.

To be improved: less time for the discussions.

## Closing

### **Kate Brownlow – Malaria Consortium**

With not much to add she said that the meeting was very interesting and the contributions rich. What was extremely important was the approach was based on the history and the wealth of experiences of the country, for the development and implementation of the APEs program.

The approach at the central level has much to do with the actors inside the health sector. The APE does not happen in isolation - it is under a Ministry, under a context where there are many partners, ideas and experiences to enrich and inform the way ahead. There is need to have dynamic people at the MoH to lead this process.

She finished by saying that she is proud to be part of the process and will continue to support in the process.

## Attachment I - Kate Brownlow speech

Good morning everyone,

It was recently approved by the MoH program of revitalization of APEs. This approval revalidates the recognition that the APEs are a key part in efforts to improve the health status of communities, especially those with limited access to health care offered by Health System.

However, we the MoH partners have experience of working with this group. We believe that this revitalization process, practices and successful experiences should be capitalized, and better use; continually up against the difficulties at work and support APEs should be discussed and identify possible solutions.

This is one of the reasons that prompted the Malaria Consortium to organize this meeting. For, in response to the strategy of revitalizing APEs intends to implement a project to ensure that the APEs motivated and continue to improve the quality of work that has been developed. But for that, it is important to look at the different actors in this area the best way to do this considering the existing experiments.

I hope that the time available for this meeting is sufficient for this discussion and so we can leave here with clear ideas about what can be done to help the APEs to offer more and better healthcare to rural communities.

I wish us all an excellent day's work.

Thank you.

## Attachment II – Agenda

8h00 – Participants reception

8h15 – Opening speach - Kate Brownlow

8h45 - CHW revitalization program - Decisions and Challenges - Dr. João Schwalbach

20 min Questions and discussions

9h15 - Results of stakeholder analysis and mapping – Celso Inguane

10 min Questions and discussions

9h45 – Coffee break Presentation

10h15 – Save the Children - Luigi d`Aquino

11h00 - Presentation Malaria Consortium iCCM/CIDA – Helen Counihan

10 min Questions and discussions

11h30 - Presentation Malaria Consortium iNSCALE project – Karin Källander

12h45 – Lunch

13h45 - Introduction to group discussions - Fernando Bambu

- Group discussions
  - Group a) supervision of APEs
  - Group b) motivation of APEs
  - Group c) data flow and use of data
- Presentation from group a) supervision
- Discussion supervision All
- Presentation from group b) motivation
- Discussion motivation All
- Presentation from group c) data flow and use of data
- Discussion use of data All
- Discussion

16h30 - Summary, conclusions and recommendations

17h00 - Cocktail

## Attachment III - list of participants

1. Abraão Jalane – Associação Moçambicana de Saúde Pública
2. Albino Machava – MISAU
3. Ana Cristina – MALARIA CONSORTIUM Mozambique
4. Ana Paula Gabriel – MALARIA CONSORTIUM Mozambique
5. Anne Griggs – MALARIA CONSORTIUM Mozambique
6. Antoine Bureau – OMS
7. Arsénio Machava – MALARIA CONSORTIUM Mozambique
8. Baltazar Chilundo – MALARIA CONSORTIUM Mozambique
9. Catarina Regina – Cooperação Suíça
10. Celso Inguane – Consultor
11. Cláudia Manjate – MALARIA CONSORTIUM Mozambique
12. Daniel Bomba – FHI Maputo
13. Daniel Strachan – Institute of Child Health – University College of London
14. David Magaia – N´weti
15. Eder Ismael – MALARIA CONSORTIUM Mozambique
16. Fernando Bambo – MALARIA CONSORTIUM Mozambique
17. Frederico Brito – UNICEF
18. Guus Tenasbroek – London School of Hygiene & Tropical Medicine (LSHTM)
19. Hafeeza Hassan Makda – NOTE TAKER
20. Helen Counihan – MALARIA CONSORTIUM Mozambique
21. Humberto Cossa – Banco Mundial
22. Humberto Muquingue – JHPIEGO
23. Inácio Ezequiel – World Relief
24. James Tibenderana – MALARIA CONSORTIUM Uganda
25. Jonas Chambule – Embaixada da Irlanda
26. Judite Pinto – MALARIA CONSORTIUM Mozambique
27. Karin Källander – MALARIA CONSORTIUM Uganda
28. Kate Brownlow - MALARIA CONSORTIUM Mozambique
29. Lesong Conteh – London School of Hygiene & Tropical Medicine (LSHTM)
30. Luigi d`Aquino – Save the Children
31. Manuel Tamarit – MALARIA CONSORTIUM Mozambique
32. Maria Augusta Ferrão – MALARIA CONSORTIUM Mozambique
33. Nick Ahlers –IRD
34. Rui Reis – Agência Catalana Cooperação
35. Samuel Mabunda – PNCM/MISAU
36. Saul Morris – Bill & Melinda Gates Foundation
37. Teresa Mapasse – Coordenadora Nacional do Programa dos APEs/MISAU
38. Yasmin Cassam – LSDI Maputo
39. Yasmin Kalumia – MALARIA CONSORTIUM Mozambique
40. Zelee Hill – Institute of Child Health – University College of London
41. Zulmira da Silva – MALARIA CONSORTIUM Mozambique