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EVALUATION

USAID/MOZAMBIQUE STRENGTHENING COMMUNITIES THROUGH INTEGRATED PROGRAMMING PERFORMANCE EVALUATION

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Performance Evaluation of the USAID/Mozambique Strengthening Communities through Integrated Programming (SCIP)

Evaluation Report

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COVER PHOTO

Credit: Santos Nassivila. This is a photograph of a SCIP beneficiary using a “tippy-tap” to wash her hands after using a latrine.

DISCLAIMER

The author’s views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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Thank you to all,

The Evaluation Team

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	II
ACRONYMS.....	V
I. EXECUTIVE SUMMARY	9
II. PROJECT BACKGROUND	16
III. EVALUATION PURPOSE & EVALUATION QUESTIONS	19
EVALUATION PURPOSE.....	19
EVALUATION QUESTIONS.....	19
AUDIENCE.....	20
IV. EVALUATION METHODS & LIMITATIONS.....	21
EVALUATION TEAM STRUCTURE.....	21
EVALUATION DESIGN.....	21
SITE AND RESPONDENTS SELECTION	21
DATA ANALYSIS	23
EVALUATION RESULTS DISSEMINATION	24
LIMITATIONS AND CHALLENGES	24
V. FINDINGS BY EVALUATION DOMAIN	26
EVALUATION DOMAIN: EFFECTIVE INTEGRATION OF SCIP MODELS	26
EVALUATION DOMAIN: SELF-SUSTAINING COMMUNITY SYSTEMS.....	38
EVALUATION DOMAIN: DEMAND FOR SERVICES.....	43
VI. CONCLUSIONS & RECOMMENDATIONS.....	48
CONCLUSIONS.....	48
RECOMMENDATIONS.....	48
ANNEXES	50
ANNEX 1: EVALUATION STATEMENT OF WORK	51
ANNEX 2: DATA COLLECTION MATRIX.....	63
ANNEX 3: LIST OF DOCUMENTS REVIEWED.....	66
ANNEX 4: DATA COLLECTION TOOLS	68
ANNEX 5: SITE SELECTION CRITERIA.....	87
ANNEX 6: TECHNICAL EXPERT REVIEW PANEL REPORT	89
ANNEX 7: PMP DATA FROM OGUMANIHA AND SCIP NAMPULA OGUMANIHA PMP DATA	90

ANNEX 8: KIIS AND FGDS COMPLETED.....	100
ANNEX 9: SUSTAINABILITY INDEX.....	101
ANNEX 10: LIST OF KEY INFORMANTS	104
ANNEX 11: CASE STUDIES.....	110

ACRONYMS

ADRA	Adventist Development Relief Agency
AIDI	Agent of Integrated Management of Childhood Diseases [<i>Agente de Atenção Integrada as Doenças da Infância</i>]
AMASI	Association of Water Consumer Educators of Nampula [<i>Associação de Educadores dos consumidores de Água de Nampula</i>]
ANC	Antenatal Care
ANEMO	National Association for Nurses of Mozambique [<i>Associação Nacional de Enfermeiros Moçambicanos</i>]
AOR	Agreement Officer's Representative
APE	Community health worker [<i>Agente Polivalente Elementar</i>]
ARI	Acute respiratory Infection
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASCA	Accumulated Savings and Credit Associations
ATS-C	Community-based Rapid HIV Test
AYSRH	Adolescent and Youth Sexual and Reproductive Health
CBD	Community-based Distribution
CBO	Community-based Organization
CF	Conservation Farming
C-HIS	Community Health Information System
CIDA	Canadian International Development Agency
CL	Community Leader
CLC	Community Leaders Council [or Village Health Committee]
CLL	Local Leaders Council [<i>Conselho Local da Localidade</i>]
CLTS	Community-led total sanitation
CLUSA	Cooperative League of the USA
COP	Chief of Party
CSO	Community Service Organization
CT	Counseling and Testing
CVM	Mozambique Red Cross
CYP	Couple-years of Protection
DAS	Water and Sanitation Department [<i>Departamento de Água e Saneamento</i>]
DPA	Provincial Directorate of Agriculture [<i>Direcção Provincial de Agricultura</i>]
DPE	Provincial Directorate for Education
DPS	Provincial Directorate of Health [<i>Direcção Provincial de Saúde</i>]
DPMAS	Provincial Directorate of Women and Social Action [<i>Direcção Provincial da Mulher e Acção Social</i>]

DPOPH	Provincial Directorate of Public Works & Housing [<i>Direcção Provincial das Obras Publicas e Habitação</i>]
DPT	Diphtheria, Pertussis, and Tetanus
EGPAF	Elizabeth Glazer Pediatrics AIDS Foundation
EPI	Expanded Program on Immunization
FGD	Focus Group Discussion
FGH	Friends in Global Health
FP	Family Planning
GAAC	Community HIV Assistance and Adherence Group [<i>estratégia de Grupos de Apoio a Adesão Comunitária</i>]
GOM	Government of Mozambique
HBC	Home-Based Care
HBLSS	Home-Based Life-Saving Skills
HC	Health Committee (formerly referred to in project documents as community leadership council)
HMC	Health Management Committee
HTCC	HIV Testing and Counseling Counselor
HF	Health Facility
HV	Home Visitor
ICAP	International Center for AIDS Care and Treatment Programs/Columbia University
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
IRD	International Relief and Development
IRS	Indoor Residual Spraying
IUD	Intrauterine Device
JFC	Junior Farmer Clubs
JHU/CCP	Johns Hopkins University Center for Communication Programs
KII	Key Informant Interview
LLIN	Long Lasting Insecticidal Net
M&E	Monitoring and Evaluation
MARP	Most-at-risk Population
MCH	Maternal and Child Health
MCP	Multiple Concurrent Partner
MFG	Mothers' and Fathers' Group
MMAS	Ministry of Women and Social Action
MNCH	Maternal, newborn and child health
MOH	Ministry of Health
MOPH	Ministry of Public Works and Housing
MOU	Memorandum of Understanding
MYAP	Title II Multi-Year Assistance Program
NDCS	District-level AIDS Committee [<i>Núcleo Distrital de Combate ao SIDA</i>]

NGO	Nongovernmental Organization
NICRA	Negotiated Indirect Cost Rate
NNMM	Neonatal and Maternal Mortality
NPCS	Provincial AIDS Committee [<i>Núcleo Provincial de Combate ao SIDA</i>]
OCP	Oral Contraceptive Pill
OglS	Ogumaniha Information System
Ogumaniha	Strengthening Communities through Integrated Programming (SCIP) Zambézia
ORS/ORT	Oral Rehydration Solution/Therapy
OVC	Orphans and Vulnerable Children
PE	Peer Educator
PES	Socioeconomic Plan [<i>Plano Económico Social</i>]
PHAST	Participatory Hygiene and Sanitation Transformation
PLWHA	People Living with HIV/AIDS
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission [of HIV]
PNC	Postnatal Consultation
PSI	Population Services International
PVO	Private Voluntary Organization
PWS	Protected Water Source
RDQA	Routine Data Quality Assurance
RH	Reproductive Health
SANA	Food Security through Nutrition And Agriculture [<i>Segurança Alimentar Através De Nutrição E Agricultura</i>]
SCIP	Strengthening Communities through Integrated Programming
SD	District Department Directorate [<i>Serviços Distritais</i>]
SDAE	District Economic Activity Services [<i>Serviços Distritais de Actividade Económico</i>]
SDP	Service Delivery Point
SDPI	District Public Works Directorate [<i>Serviços Distritais de Planeamento e Infraestruturas</i>]
SDSMAS	District Directorate of Health, Women, and Social Action [<i>Serviços Distritais de Saúde, Mulhere Acção Social</i>]
SODIS	Solar Disinfection (of water)
SOW	Scope of Work
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
TTHV	Tchova Tchova – Story of Life
UCODIN	Coordination Unit for the Integrated Development of Nampula
UNICEF	United Nations Children’s Fund

USAID	United States Agency for International Development
VCT-C	Voluntary Counseling and Testing at the Community Level
VU	Vanderbilt University
WASH	Water, Sanitation, and Hygiene
WF	Women First
WFP	World Food Program
WV	World Vision
YFC	Youth Farmers Club
YFS	Youth-Friendly Services [SAA], <i>Serviço Amigos dos Adolescentes e Jovens</i>]

I. EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

United States Agency for International Development (USAID)/Mozambique currently funds two consortia to implement Strengthening Communities through Integrated Programming (SCIP) activities that focus on integrating health, HIV/AIDS, agriculture, nutrition, water and sanitation service delivery to communities in Zambézia and Nampula. The objectives of this mid-term evaluation were two-fold: 1. Assess the effectiveness of integration as a model for service delivery by SCIP; and 2. Assess processes and mid-term progress toward results in selected areas and determine whether interventions designed are contributing toward the desired result, with the objective of informing future programming decisions (e.g., scale-up, modification, and enhancement) during the second half of SCIP's implementation. The evaluation team was provided eight core questions, detailed below (table 1):

Table 1: Evaluation questions

<p><u>Integration of the SCIP activities</u></p> <ol style="list-style-type: none">1. To what extent is the SCIP activities integrated in practice?<ol style="list-style-type: none">a. How successfully have components (youth farmers club, water, sanitation and Hygiene (WASH), health) been integrated within SCIP?b. How successfully do SCIP interventions integrate with or build upon other United States Government (USG) interventions, including the Multi-year Assistance Program (MYAP)?2. What have been the management and implementation benefits of activity integration?3. What are the management and implementation challenges of activity integration?<ol style="list-style-type: none">a. Do certain activity areas get reduced attention because of the management needs of other activity areas? <p><u>Community-based organizations</u></p> <ol style="list-style-type: none">4. To what extent is the SCIP strategy strengthening the relationship between Community Leader Councils (CLCs) and other government structures?5. Of the organizations supported by SCIP, are community organizations more likely to continue their activity after completion of the SCIP activities? <p><u>Community Health Mobilization</u></p> <ol style="list-style-type: none">6. To what extent has SCIP succeeded in creating demand for health services?<ol style="list-style-type: none">a. Which interventions are the biggest drivers of increased demand for health services? <p><u>Youth Farmers Clubs</u></p> <ol style="list-style-type: none">7. To what extent do youth participants and their families perceive youth farmers clubs to be beneficial?<ol style="list-style-type: none">a. What aspects of the Youth Farmer Clubs (YFCs) are most beneficial and effective?8. To what extent do former participants in YFCs who “aged-out” of the program continue to employ lessons learned as part of YFC participation?
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PROJECT BACKGROUND

The overall purpose of SCIP is “to integrate health, HIV/AIDS, water/sanitation, and rural enterprise components with nutrition and agriculture to strengthen communities in Nampula and Zambézia.” SCIP utilizes this innovative approach to activity delivery at the provincial, district, and community levels. SCIP Zambézia (known locally as Ogumaniha) is led by World Vision International (WVI), supported by Johns Hopkins University Center for Communication Programs, Vanderbilt University – Friends in Global Health (VU/FGH), Adventist Development and Relief Agency (ADRA), and International Relief and Development (IRD). With funding of \$49,412,197 between July 1, 2009 to June 30, 2014, the partnership seeks to create an integrated, self-sustaining system to ensure targeted communities have equitable access to health, nutrition, HIV/AIDS and WASH interventions. The SCIP Zambézia works in 16 districts to reach a potential 3,800,800 beneficiaries. SCIP Nampula is led by Pathfinder International and

supported by Population Services International (PSI), World Relief (WR), CARE, and the Cooperative League of the USA (CLUSA). With funding of \$47,600,000 between August 1, 2009 to July 31, 2014, the partnership focuses on community system strengthening to bring about behavior change to improve health, HIV, and WASH outcomes. The SCIP Nampula works in 14 districts, with an estimated reach of 1,779,927 beneficiaries. Both SCIPs have the same overall objectives of increasing access, quality and use of community and facility-based health services; practices and use of clean water and sanitation facilities. SCIP Nampula had centralized approach for implementation with elements run by one organization whereas SCIP Zambézia had decentralized approach with each consortium member focusing on its areas of work and expertise.

EVALUATION DESIGN, METHODS AND LIMITATIONS

Evaluation Design and Methodology: This evaluation used a mixed approach with qualitative and quantitative methods, including: literature review (SCIP documents, limited peer review and grey literature); existing data from Performance Monitoring Plans (PMPs); key informant interviews (KII) and focus group discussions (FGDs).

Evaluators selected three districts in Zambézia (Gurué, Lugela, Morrumbala) and three districts in Nampula (Mogovales, Ribaué, Monapo) for data collection. Evaluators also purposely selected sites with a maximum variation in activity elements, target populations, and intervention packages. The selected sites included areas with large and small population sizes, presence of low and high number of community structures, and presence of low- and high-level of health infrastructure (number of health services/facilities). This report draws on interviews with a wide range of stakeholders in SCIP activities implementation including: SCIP staff; Government of Mozambique (GOM) officials; community organization officials; and health facility, community workers and members. In addition, evaluators developed a 24-question sustainability index (Likert scale 1-7) to assess sustainability of community structures focused on Community Leaders Councils (CLCs). The sustainability framework assessed factors, such as: buy-in; enabling policy environment; organizational structure functionality; financial viability; satisfactory infrastructure; service delivery needs; ability for advocacy, and public image.

The evaluation methodology had key limitations. First, the timeframe of the evaluation was limited considering the SCIP's size and complexity. Second, the purposive selection of evaluation sites and the lack of random selection of stakeholders limit generalizability of findings. Finally, a lack of comparison sites limited the team's ability to compare intervention and non-intervention areas.

Data Collection: Evaluators collected data from June to August, and additionally in November 2013. The Team conducted 50 focus group discussions (FGDs) and 94 key informant interviews (KIIs) total in the two provinces of Nampula and Zambézia (table 2).

Table 2: Number of FDG and KII conducted

Province	FDGs					KIIs			
	YFCs	CLCs, HMCs	SCIP Trainers	CLLs	CLC (Nov 2013)	SCIP staff	GOM provincial official	GOM district official	Health facility staff
Zambézia	5	9	9	1	3	16	5	12	8
Nampula	7	8	5	1	2	25	6	11	8

A majority (more than two thirds) of respondents in FDGs and KIIs were male. A Technical Expert Panel met in August 2013 to review the team's findings and provided technical input to further contextualize the findings and inform additional analyses. In November 2013, evaluators collected

additional data using the 24-question index to assess sustainability. This questionnaire was administered to 48 participants (32 male and 16 female) of the total five CLC focus groups.

Data Analysis and Results Dissemination: The team conducted secondary analysis of progress against four selected core health indicators (contraceptives access, antenatal care (ANC) care seeking, facility births, and immunizations) using an activity performance monitoring plan (PMP). In addition, evaluators also reviewed key water, sanitation, and hygiene (WASH) indicators. During qualitative data analysis, the team adapted a **matrix of integration** tool (based on literature on integration and health- WHO 2008, 2009; Gadja 2004; Heath et al, 2013) to assess the level of integration across SCIP activities. Integration was analyzed along continuum of multiple stages, starting with *networking*, where integration is at discussion level, to *cooperating*, where sharing occurs and ability to actively influence exists, to *partnering*, where strategies converge to provide holistic services, to *unifying*, the end goal of integration, where various entities act harmoniously to provide a one-stop shop of holistic services. The team evaluated each SCIP's progress towards integration by assessing the following factors: leadership and decision making; strategy, planning and project design; administrative and human resources; implementation of services; community ownership and accountability; monitoring and learning; and partnership and linkages.

The evaluation results were disseminated at stakeholders' meetings in Quelimane, Zambézia, and Nampula, Nampula, in November 2013.

FINDINGS AND CONCLUSIONS

EVALUATION DOMAIN: EFFECTIVE INTERGRATION OF SCIP MODELS

Integration of SCIP Partners, Government, and Other USG Activities

Overall, integration of services is occurring, and is strongest at the community level, with most progress attributable to work that both SCIP partners do with and through community mechanisms. However, in both provinces, SCIP activities experience government of Mozambique (GOM) and donor-related limitations to full integration. Integration matrix analysis indicates that for: **Leadership and decision making:** SCIP partners are in a cooperating stage¹ with the GOM and community stakeholders. Integration conceptual frameworks are shared, but decision making is not yet collective. In Nampula, the GOM leads multi-sectorial activity within the Ministries, non-government organizations (NGOs) and businesses, and SCIP works closely with the Coordination Unit for Integrated Development of Nampula (UCODIN). SCIP Zambézia does not have a similar governmental coordinating body and works separately with each ministry to obtain buy-in for plans; **Strategy, planning and project design:** SCIP Zambézia is at a cooperating stage, while SCIP Nampula is at a partnering stage² of integration. This difference is mainly due to the aforementioned differences in governance in the two provinces described above; **Administrative and human resources management:** SCIP Zambézia remains at the networking ³level, unable to integrate these systems within its consortium members. SCIP Nampula spent initial years developing a unified identity among its partners and harmonizes many administrative functions.

Implementation of service: SCIP Zambézia is at the cooperating stage, with multiple service provision by various partners and various volunteer types. In Nampula, SCIP consortium partners work together to create unified training material, and CLCs provide a multitude of services. However, the team was

¹ *Cooperating stage*, where sharing occurs and ability to actively influence exists

² *partnering stage*, where strategies converge to provide holistic services

³ *Networking stage*, where integration is at discussion level

unable to verify the quality of CLC service provision⁴. Referral systems had been established by both SCIP, but with gaps. Formal health sector referral/counter referral systems are not fully functional in either Nampula or Zambézia; **Community ownership and accountability:** Both SCIP consortia support community structures in identifying and prioritizing their own needs. Communities are not yet able to formally request GOM or other NGO support on their own and are working towards demanding better services directly; **Monitoring and learning:** Significant work remains for both SCIP to reach the goal of one monitoring system, where activity data is fully integrated with the Ministry system, and one quality control system. SCIP Zambézia still needs to improve its internal M&E processes and is at the networking stage of integration with monitoring and learning processes of the Ministry. SCIP Nampula is at the cooperating stage of integration for its health data and is partnering strongly with the Ministry; and For **Partnerships and linkages**, SCIP activities are at varying degrees of integration. In Zambézia, harmonization with GOM is limited, while in Nampula, due to participation with UCODIN, there are stronger GOM linkages through joint planning and support. Neither SCIP were part of a partnership framework with the GOM that defines the coalition.

SCIP activities at both provinces have good integration with the MYAP. Consortia members were previous implementers of MYAP and currently work with CLCs with MYAP experience. Both consortia work with other USG-funded partners, including President's Emergency Plan For AIDS Relief (PEPFAR) and President Malaria Initiative (PMI). Ogumaniha (the name for SCIP Zambézia) is working with health facilities in 9 districts supported by FGH to identify anti-retroviral treatment program drop-outs, conduct home visits, and encourage re-enrollment. SCIP Nampula works indirectly through the health committees, with Elizabeth Glazer Pediatric AIDS Foundation (EGPAF) and International Center for AIDS Treatment Program (ICAP) supported districts. SCIP Nampula also works with PSI and Malaria Consortium to ensure delivery and use of bed nets.

In conclusion, both consortia are actively integrating activities with multiple ministries and partnering with other USG-funded partners (MYAP, PEPFAR, PMI) to increase relevance and impact. Efforts to integrate nutrition, health and WASH activities are achieving the intended result of improving access and quality of services. SCIP is showing early signs of integrating services between CLCs with GOM health facilities, however, work remains to facilitate open dialogue and equality between the two.

EVALUATION DOMAIN: SELF-SUSTAINING COMMUNITY SYSTEMS

Both Consortia placed CLCs at the heart of their implementation strategy, linking them with GOM service providers (Health Centers, Mobile Brigades, Health Camps) and with departments (Social Action, Public Works, CLLs). Results from the sustainability index scoring revealed that the CLC sustainability is evolving (index score: 4.9). Results for factors with index scores are described below: **Buy-in:** CLC demonstrate good understanding and agreement with SCIP vision (4.46) and believe that SCIP activities are meeting recurrent needs of the community (6.62). Many CLC members also have personally benefited from SCIP, for example by building latrines while participating with SCIP; **Enabling policy environment:** CLC membership often includes local policy makers facilitating community needs expression. However, CLCs were unaware of additional support that make policy environment supportive of lay community members in SCIP activity implementation, and some expressed lack of interaction with health facilities staff. The Ministry of Health, compared to other ministries, is further along in supporting community involvement in health and has provided a legal framework through which health management committees can operate. (4.73); **Functional organization, infrastructure and financial viability:** Most CLCs agreed that roles and responsibilities within the CLCs were clear, and had developed systems for accountability (5.88). CLCs not yet well integrated within the government

⁴ Quality assessment of CLC activities either through direct observation or service provision documentation were not done

institutional strategy. SCIP funding has been used for training and purchase of materials (stationary supplies, stipends/some transport) (1.75). Few expressed dissatisfaction with lack of office space (most meetings occur under a tree). Most agreed that the communities themselves collaborate and fund latrines when needed. However, while all CLCs recognize the need for additional funds to promote integrated service delivery at their level, most CLCs admit that they do not have the capacity to manage their own funds should they receive any (2.27); **Service delivery:** CLC members believed their communities needed SCIP services, but some felt they had insufficient skills / capacity to provide services without external support (5.88); **Ability for advocacy:** CLC members expressed confidence in community engagement ability to address priority needs and provided examples where they had already done so (e.g., need for latrines). They feel they have sufficient access to local policy makers and government representatives (6.54). However, a majority of KII from SCIP reported that the ability for advocacy varies depending on quality of leadership, dynamics of the CLC, and information available to the members; **Public image:** The CLCs are positively engaged with integrated service delivery, though concerns were raised about the extent to which community members valued health advice received from CLCs. (4.14).

Respondents affirmed that YFCs are an effective initiative in providing children and young adults space to play safely, learn life skills and new farming skills, including conservation farming. The graduation age from YFCs in Nampula is 24, and in Zambézia 17 (<18). A majority of YFCs respondents reported that they are likely to apply lessons learned after graduating. Currently, there is no follow-up mechanisms to trace participants after graduation. The evaluation team could not interview any graduates of YFCs.

In conclusion, sustainability of integrated service delivery through CLCs is evolving. Other factors e.g. strong buy-in of SCIP's long term visions, meeting needs perceived as important / recurring, and ability to advocate within a community-worker-friendly policy environment enhances sustainability. On the other hand, minimal financial viability and weak operational infrastructure/public image/legitimacy impedes it. The community considers YFCs to be effective and beneficial.

EVALUATION DOMAIN: DEMAND FOR SERVICES

Overall, based on the PMP data and annual reports, Ogumaniha and SCIP Nampula are progressing towards their targets and, in many cases, the targets have already been met or surpassed (Table 3).

Table 3: Summary of PMP Target vs. Actual Performance at Year

PMP indicators	Zambézia			Nampula		
	Actual By Y4	Target By Y5	% achieved	Actual By Y4	Target By Y5	% achieved
ANC Visits	267,909	166,700	160%	2,060,380	2,490,321	83%
Facility Deliveries	68%	75%	68%	353,322	396,083	89%
Immunizations (DPT3)	180,348	174,000	103%	439,197	499,646	88%
Contraceptives Distributed	88,403	120,000	74%	50,823	64,585	79%

CLCs and traditional birth attendants (TBAs) corroborated the above findings. The biggest drivers of demand for health services were the interrelationship between various interventions: information shared with community; improved quality of health facility services; strengthened skills in the community and at facilities; GOM involvement to improve oversight of health facility practices; and improving outreach of communities services (mobile brigades, maternal waiting houses, health camps, campaigns, trained community volunteers and APEs). SCIP Nampula facilitated the signing of memoranda of understanding

(MOUs) between health facilities and the Chief of the Localidade to build Pregnant Mother Houses. To date, SCIP has supported 24 pregnant mother houses. Though this is a slow process and not all houses have been delivered yet, SCIP staff believe that such houses, where women can come early and stay up to one week before delivery, have increased ANC attendance and facility-based deliveries. SCIPs have increased access to safe WASH interventions and already exceeded the majority of their targets at both provinces. Table 4 presents summary accomplishments to date by province:

Table 4: Percentage (%) achieved of targets for SCIP WASH activities by province

Zambézia		Nampula	
Rehabilitations of protected water sources completed	77%	Rehabilitations of protected water sources completed	92%
People trained on water treatment	170%	People trained in safe water	100%
Community-based water committees established, equipped and maintained	101%	Localities with integrated water and health committees	160%
Household latrines constructed	90%	Households with latrines built	124%
Tippy taps installed at household	50%	Tippy taps installed at household	NA

In both provinces, respondents acknowledged the relevance of SCIP in building the management capacity of water committees and raising awareness about the correlation between sanitation, hygiene and health, especially for diarrheal diseases. Some interventions have challenges, for example, tippy-taps had limited acceptance in a few communities (50% of target achieved in Zambézia) and constructed latrines were reportedly not strong enough to withstand the rainy season in some locations.

In conclusion, success was seen in the improved ANC access, contraception distribution and WASH interventions. While additional research is needed to better document drivers of demand, various interventions — ranging from distribution of information through community volunteers to the involvement of GOM in oversight of health facility practices — seem to play a role.

RECOMMENDATIONS

To maintain the effectiveness of integration as a model for service delivery:

- USAID should encourage partners to determine the internal logic of integrated interventions so that the activities are based on community needs and resources are optimized;
- USAID and partners should provide more capacity building support to CLCs in assessing community needs, prioritizing activities and demanding needed services from authorities; activities should focus on developing skills of CLCs to do this analysis from cradle to grave;
- USAID and partners should advocate deeper commitment and support for integrated activities and cross-sectorial planning and follow-through at all GOM levels (particularly in Zambézia).

To establish self-sustainable community structures, SCIP partners should:

- Explore creative use of appropriate community media to elevate perceived CLC status in community;
- Devolve more decision making to the community level, following their lead with regards to ways to more efficiently provide integrated services
- Build CLC and YFCs capacity for financial management, networking, and consider promoting micro-businesses to sustain these community infrastructure;

- Promote opportunities for shared learning between community structure supported, and consider creating friendly competition between communities towards set outcome indicators;
- Develop YFCs graduation criteria based on skills levels achieved instead of age criteria.
- Develop tracking mechanisms for YFC graduates to understand long-term outcome of this activity.

To achieve sustained demand for integrated services, SCIP partners should:

- Strengthen the M&E system and data management to capture demand creation interventions; develop indicators that measures level of integration between community and service provider. For example, number of women that received services at the health facility following referral among those referred by the community worker. Modify WASH indicators to measure usage of intervention- for example: usage of tippy taps instead of number of tippy taps installed.
- Conduct a qualitative assessment of the value of selected activities (especially in regard to the number of community groups created or trained) vis-à-vis demand created; it is likely that some interventions are better at creating demand than other interventions;
- Focus on measuring and improving the quality of services delivered by CLCs after they receive capacity building support from SCIP;
- Increase adherence to formal referral agreements and referral systems, including referral tracking and counter-referral systems to ensure information-sharing between community and GOM systems.

II. PROJECT BACKGROUND

The United States Agency for International Development (USAID) has historically provided support to Mozambique communities in the sectors of health (including HIV/AIDS), nutrition, water and sanitation, agriculture, democracy, rights, governance, education and broader economic development. Each of these sectors typically has been implemented via one or more activities⁵, overseen at USAID by different individuals. Even projects that had seemed to have a natural fit, such as nutrition and health, were not supporting each other in the field. Furthermore, while a number of projects relied on community volunteers, even these projects were not holistically trying to provide community services in an integrated manner. Volunteers were asked to give up their time every few days, often to visit the same households but for different issues, resulting in duplication of their efforts and poor use of United States Government (USG) resources, including vehicles and staff. To be more effective, USAID needed to re-evaluate implementation frameworks to allow for the simultaneous leveraging of multiple elements. USAID's new planning led to harmonized design of new activities, with integrated funding streams and management, leading to the issuance of two request for proposals (RFPs) for what is now a set of integrated activities. Those activities, known as USAID/Mozambique's Strengthening Communities through Integrated Programming (SCIP), combine health, HIV/AIDS, Water, Sanitation and Hygiene (WASH), nutrition, agriculture and rural enterprise for communities living in Zambézia and Nampula provinces.

The SCIP in both provinces comprise multi-tiered activities at the provincial, district and community levels reaching a variety of beneficiaries. The purpose of both SCIP is: *“to integrate health, HIV/AIDS, water/sanitation, and rural enterprise components with nutrition and agriculture to strengthen communities in Nampula and Zambézia”*. The overall aim of SCIP in both provinces is to: increase access, quality and use of community and facility-based health services; increase hygienic practices, and increase the use of clean water and sanitation facilities.

SCIP Zambézia, known locally as Ogumaniha, is led by World Vision International (WV) and supported by the Johns Hopkins University Center for Communication Programs, Vanderbilt University – Friends in Global Health (FGH), the Adventist Development and Relief Agency (ADRA), and International Relief and Development (IRD). With an estimated budget of \$49,412,197 between July 1 2009 and June 30, 2014, the partnership has sought to create an integrated, self-sustaining system across mbézia in target communities to ensure equitable access to health, nutrition, HIV and WASH services with a target outreach to 3,800,800 beneficiaries⁶ in 16 districts⁷.

SCIP Nampula is led by Pathfinder International and supported by Population Services International (PSI), World Relief, CARE, and the Cooperative League of the USA (CLUUSA). With an estimated budget of \$47,600,000, this partnership has focused on community system-strengthening to bring about behavior change to improve health, HIV, and WASH outcomes for communities. SCIP Nampula operates in 14 districts and in Nampula.⁸, with a target reach of 1,779,927 beneficiaries⁹ The projects in

⁵A program is aligned with a Country Development Cooperation Strategies (CDCS) Development Objective (DO) and includes all projects and other activities that are associated with a particular DO. A project is a set of executed interventions, over an established timeline and budget intended to achieve a discrete development result (i.e. the project purpose) through resolving an associated problem. It is explicitly linked to the CDCS Results Framework. An activity is a sub-component of a project that contributes to a project purpose. It typically refers to an award (such as a contract or cooperative agreement), or a component of a project such as policy dialogue that may be undertaken directly by Mission staff. (ADS Chapters 200-203, USAID)

⁶This data was not disaggregated by sex.

⁷Namacurra, Alto Molocue, Morrumbala, Gurue, Gile, Pebane, Ile, Lugela, Milange, Mopeia, Chinde, Nicoadala, Quelimane, Mocuba, Maganja da Costa, and Namarroi.

⁸Angoche, Erati, Moma, Malema, Meconta, Mecuburi, Memba, Mogovolas, Monapo, Nacala-Porto, Nacala-Velha, Ribaue, Nampula City, Nampula Rapale, and Malema districts.

Zambézia and Nampula, Mozambique, have similar objectives* and expected results in common (Table 5):

Table 5: Objectives and expected results of SCIP activities

<p>Objective 1: Increase access, quality and use of community and facility-based health services</p> <p>Expected results:</p> <p>Result 1: Quality health goods and services access and availability improved.</p> <p>Result 2: Appropriate health, HIV/AIDS, and nutritional practices and health-seeking behaviors adopted.</p> <p>Result 3: Accountability of community and district and provincial health structures improved.</p> <p>Result 4: Community and social infrastructure sustained through a range of allies and networks of support they can draw on to solve health problems.</p>
<p>Objective 2: Increase hygiene practices and use of clean water and sanitation facilities</p> <p>Expected results:</p> <p>Result 5: Availability and use of clean, multi-use water increased.</p> <p>Result 6: Sanitation facilities and hygiene practices improved.</p>

*The program in Zambézia had an additional, third, objective: to enhance and protect livelihood capabilities; but this was dropped in 2011.

⁹This data was not disaggregated by sex.

III. EVALUATION PURPOSE & EVALUATION QUESTIONS

EVALUATION PURPOSE

Approximately midway through SCIP implementation, USAID/Mozambique contracted International Business & Technical Consultants, Inc. (IBTCI) to conduct a performance evaluation of the SCIP activities, with two objectives:

1. To assess the effectiveness of integration as a model for service delivery by SCIP to inform recommendations on whether to continue this approach or modify it for future programming; and;
2. To gauge processes and midterm progress toward results in selected areas and determine whether the interventions designed to achieve these results are contributing to the objectives to inform programming decisions (e.g., scale-up, modification, and enhancement) in these areas during the second half of the project.

The performance evaluation scope of work (SOW) is provided in Annex I.

EVALUATION QUESTIONS

USAID framed eight core questions to guide the independent the evaluation. The questions fell into the following three domains: the effectiveness of the integration of the SCIP activities; whether Community Systems were self-sustaining; and whether there was demand generated for the services being offered. The first two domains specifically relate to objective one (above), while the third domain relates to objective two.

Integration of the SCIP activities

1. To what extent are SCIP activities integrated in practice?

How successfully have components (youth farmers club, water, sanitation and Hygiene (WASH), health) been integrated within SCIP?

How successfully do SCIP interventions integrate with or build upon other United States Government (USG) interventions, including the Multi-year Assistance Program (MYAP)?

2. What have been the management and implementation benefits of activity integration?
3. What are the management and implementation challenges of activity integration?

Do certain activity areas get reduced attention because of the management needs of other activity areas?

Community-based organizations

4. To what extent is the SCIP strategy strengthening the relationship between Community Leader Councils (CLCs) and other GOM structures?
5. Do community organizations supported by SCIP exhibit characteristics that are linked to a greater likelihood of continued level of activity after the completion of the SCIP activities?

Community Health Mobilization

6. To what extent has SCIP succeeded in creating demand for health services?

Which interventions are the biggest drivers of increased demand for health services?

Youth Farmers Clubs

7. To what extent do youth participants and their families perceive youth farmers clubs to be beneficial?

What aspects of the Youth Farmer Clubs (YFCs) are most beneficial and effective?

8. To what extent do former participants in YFCs who “aged-out” of the program continue to employ lessons learned as part of YFC participation?

AUDIENCE

The audience of this performance evaluation included USAID/Mozambique, the Government of Mozambique (GOM) at both the national level and in Nampula and mbézia provinces, and other in-country stakeholders. The intent was to provide them with independent evidence about: how effective integration has been to date; what has been achieved; whether or not community structures that are being strengthened are sustainable; and then to offer recommendations for improving SCIP implementation in its final years and for planning future integrated programs.

IV. EVALUATION METHODS & LIMITATIONS

EVALUATION TEAM STRUCTURE

The Evaluation Team consisted of Team Leader Susan Amoaten; Deputy Team Leader Cristiano Matsinhe, executive director of Kula; two community health experts, Juliao Matsinhe and Santos Nassivila, Director of Kixiquila; and four research assistants who also helped with translation: Angelo Eduardo, Laldia Alide, Dulce Passades, and Lourindo Verde. The team undertook the assignment and initial data collection between June and August 2013. Juliao Matsinhe took responsibility for the overall analysis of the quantitative data of both SCIP Nampula and Ogumaniha. For the field work, the team was divided into two: Susan Amoaten and Santos Nassivila conducted field work in Nampula, supported by Angelo Eduardo and Laldia Alide, whilst Cristiano Matsinhe and Juliao Matsinhe, supported by Dulce Passades and Lourindo Verde, went to Zambézia. Sheila Zacarias (USAID) came as observer in the second week of field research in Nampula, and Hanise Sumbana (USAID) joined the Zambézia team, also in week two of field research. In late November 2013, Dr. Rachel Jean-Baptiste, Director of IBTCI, travelled to Mozambique along with Juliao Matsinhe for additional data collection to enhance the quality of the report.

EVALUATION DESIGN

The evaluation used mixed methodology with both qualitative and quantitative data collection methods.

Data Collection Methods

The data collection methods included: a **literature review** (primarily of activity documents), **existing monitoring data** (i.e., Performance Monitoring Plans-PMPs), **qualitative research** including key informant interviews – (KIs), and focus group discussions (FGDs), and **analysis of progress against four selected core health indicators** (contraceptives, antenatal care (ANC) visits, facility-based deliveries, and immunizations), as well as detailed analysis against WASH results. A data collection matrix was developed to determine which research techniques would be used to answer the core questions of the evaluation (Annex 2). Qualitative data collection tools were designed and field-tested in each province and adjusted as necessary. Annex 3 contains a list of background documents reviewed; Annex 4 contains all data collection instruments used for this evaluation; and Annex 8 contains list of KIs and FGDs completed.

SITE AND RESPONDENTS SELECTION

Primary data was collected in three districts in Zambézia (Gurué, Lugela, Morrumbala) and three districts in Nampula (Mogovales, Ribaue, Monapo). These districts were selected in order to sample populations that received a) intensive intervention, b) complementary intervention with the WASH component, and c) complementary intervention without the WASH component (as was the case in the former MYAP). The selection of sites in SCIP intervention areas was purposive to allow for maximum variation in activity elements, target populations, and intervention packages. The selected sites included areas with large and small population sizes, areas with the presence of low and high number of community structures, and areas with low and high levels of health infrastructure (number of health services/facilities). Additional details of the site selection criteria and sampling strategy at different levels of the implementation of SCIP (provincial, district, community) is included in the inception report (Annex 5). The following districts satisfy the site selection method described above (Table 6 and Table 7):

Table 6: Site selected in Nampula

District	Population size	Number of HMCs	Number of Rural hospital	Other health services (HCs with nurse, HCT centers/ ART centers)	Type of Package
Monapo	370,604	10	1	24	Complementary with WASH
Mogovolas	359,053	6	0	12	Complementary without WASH
Ribaue	236,961	8	1	13	Intensive

Table 7: Site selected in Zambézia

District	Population size	Number of Health committees	Other health services (HCs with a nurse, HCT centers, ART centers)
Gurué	301,033	86	24
Namarroi	147,345	53	16
Pebane	187,298	34	25

Table 8: Type of stakeholders consulted

Stakeholders consulted:
<ul style="list-style-type: none"> • SCIP staff (Chiefs of Party, M&E Managers, representatives from implementing partners, district trainers, and mentors); • GOM officials (Health, Social Action, Agriculture, Public Works) and community health workers (APEs¹⁰) at provincial and district levels; • Community structures (CLCs, CLLs, HMCs, and YFCs) at the community level; • Health facility staff (Chief Medical Officer, Health Facility Managers, Mobile Brigades, Nurses) at the district and community level.

The Team conducted 50 FGDs with trainers, staff of community care clinics called *Conselho Local da Localidade* (Community Leader Councils (CLCs) and Youth Farmers Clubs (YFCs) and 94 KIIs with staff from SCIP and from provincial, district and health facilities in the two provinces (Table 8). A majority (more than two thirds) of respondents in FDGs and KIIs were male. These discussions helped to generate an understanding of: local contextual factors that have shaped the course of implementation and level of effectiveness of the activities; and of the governance structures and incentives (financial, other) for achieving the main project outcomes.

A debrief of initial findings was presented to USAID in August. Feedback from USAID led to additional fieldwork in early November 2013. USAID re-oriented the team to focus the evaluation of the domain of ‘**self-sustaining community systems**’ to be specifically on CLCs, since they are the main community system working with both projects. Thus, in early November 2013, five additional FDGs were conducted with CLCs in the districts of Gurué, Lugela and Morumbala in Zambézia province, and Mogovolas and Monapo in Nampula province. Data was not collected in Ribaue due to security risks in

¹⁰ APEs are government-trained community health workers who promote and mobilize action for priorities such as vaccination campaigns, disease prevention and assessment of undernourished children.

that district at the time of data collection. Evaluators asked the focus groups of CLCs to talk about key themes for “sustainability”, and summarized the conversations to gain a deeper understanding of the 24 questions (organized under similar themes) found in the Sustainability Index (Annex 9). In addition to discussing these as themes in the focus groups, a 24-question index was developed and administered to 48 participants (32 male and 16 female) of the focus group on sustainability, with answers ranging from 1 to 7 on a Likert scale.

DATA ANALYSIS

The Evaluation Team reviewed published and un-published literature to develop conceptual frameworks for organizing the data and analysis of the domains of interest for this evaluation.

The Team adapted **matrix of integration** tools to assess integration across SCIP activities, based on literature on integration and health (WHO 2008, 2009; Gadjia 2004; Heath et al, 2013). The evaluation matrix lays out seven key areas for measuring integration. Those are::

- Leadership and decision making;
- Strategy, planning & project design;
- Administration and human resources;
- Implementation of services;
- Community ownership and accountability;
- Monitoring and learning, and
- Partnerships and linkages.

For each of these factors, Integration was analyzed along a continuum of multiple stages, starting with *networking*, where integration is at discussion level, to *cooperating*, where sharing occurs and ability to actively influence exists, to *partnering*, where strategies converge to provide holistic services, to *unifying*, the end goal of integration, where various entities act harmoniously to provide a one-stop shop of holistic services. Data was collected to identify where each activity fell for each factor, and results presented in a **Matrix of Integration**.

A Technical Expert Panel was organized in August 2013 to help the Evaluation Team analyze the qualitative and quantitative data collected. Evaluators invited nine national experts from state and non-state sectors with backgrounds in health and community system strengthening, livelihoods, and nutrition interventions to participate in the technical expert panel. An external organization, Optimoz, facilitated the discussions, and the data was analyzed thematically using constant comparison. Evaluators collected data, coded it vertically (by scanning across the data for specific terms) and then developed it into categories and themes that panel experts then discussed. Optimoz documented the Panel’s recommendations, and these have been used to inform analyses for integration using the Matrix of Integration described above (Annex 6).

Sustainability Analysis

While it is common to address sustainability largely from the point of view of financial viability, the team recognized the need to take a different approach for this project, i.e., one that considers factors for sustainability specifically related to community structures. Building on the work done previously by USAID on civil society organizations, as well as other relevant literature, the team approached the evaluation of sustainability as a spectrum of possible outcomes that depend on a number of factors, of which financial viability is one.

The Sustainability Index was analysed quantitatively. Age, sex, and length of time volunteering were calculated using percentages and averages. Questions were scored on a scale of 1 to 7, then were grouped. Averages were calculated for each grouping first, and then overall to obtain an understanding

of where each SCIP was with regards to sustainability. Scores were grouped in a hierarchy defined as follows: 1 to 3.9: sustainability impeded; 4 to 5.9: sustainability evolving; or 6 to 7.0: sustainability enhanced.

Specific aspects of sustainability assessed by the team were the following:

- **Buy-in**, which included the extent to which CLC members understood the long-term vision of SCIP, particularly the integrated delivery of community services, and that the community perceived the activities of SCIP and the CLCs to meet specific, recurrent and urgent needs;
- **Policy environment** that is supportive of SCIP activities done by CLCs, and governmental support and recognition of work done;
- How **organizationally functional** the CLCs are, with clear roles and responsibilities, accountable, resourceful, with clear ability to plan; well-integrated with GOM institutional strategy;
- **Financial viability** of SCIP activities post SCIP funding, and to assess whether or not these CLCs are supported by other donors/private sector to implement activities promoted;
- Operating **infrastructure is deemed satisfactory**, with sufficient staffing, appropriate office space and equipment, access to necessary technology and abilities for monitoring progress;
- **Ability for advocacy**, including ability to raise awareness of decision makers on key issues of priority to the community; and
- **Public image**, including positive media attention and involvement, interaction with other donors and the business community, perception of being a trusted community institution, and public awareness of activities.

The effect of SCIP on the **demand for services** was assessed by discussing with key informants (list of key informants can be found in Annex 10) and reviewing progress based on each project's PMP measures. As suggested by USAID, the team focused on discerning progress with regard to three key health measures: contraceptive use access/distribution, ANC seeking, and immunization (DPT3 among children <12 months). The team also used existing monitoring data to conduct an in-depth analysis of progress toward WASH indicators, and relied on KIIs and focus groups to provide context and deeper understanding of findings.

EVALUATION RESULTS DISSEMINATION

Evaluation results were disseminated at the Stakeholders meetings that included both projects in Quelimane, Zambézia and Nampula, Nampula in late November 2013.

LIMITATIONS AND CHALLENGES

The evaluation methodology and analytical frameworks were designed taking into account the limited timeframe for the research and the size and complexity of the SCIP activities. Other challenges which the methodology tried to address included:

- SCIP is a highly ambitious program being undertaken by two different implementation consortia under two different task orders from USAID. The evaluation did not aim to do a comparison of the performance of the two consortia, yet inevitably such a comparison entered the discussions. The Matrix of Integration attempts to create an objective tool with which to determine levels of integration in each activity, which leads to comparisons of performance.
- This is a descriptive performance evaluation and while we relied on a mixed-methods approach, we did not randomly select districts or stakeholders, and therefore cannot generalize findings of the entire catchment area of the projects.

- The project design did not include a comparison group, thus we cannot be certain that quantitative findings from the project are due solely to the projects' efforts.
- Interviewer and respondent biases are common drawbacks of qualitative studies, including this one. It is likely that during the course of an in-depth interview or focus group discussion, the interviewer may instill his/her own interpretation and biases when asking the question and especially when probing the respondent. Similarly, the stakeholders we interviewed had their own agendas and perceived advantages and disadvantages of answering questions in a particular way, and at times may have provided answers that he/she feels were social acceptable.
- It is likely that due to recall bias, respondents might not have completely remembered all of the facts, possibly mistakenly attributing interventions or results to SCIP, or alternatively forgotten important milestones which were attributable to SCIP's work.
- There was a substantial amount of data on SCIP activities and their integration and sustainability that was beyond the team's ability to go through in great detail given the timeframe of this evaluation. Every effort was made to focus on and incorporate sentinel documents.
- Because a large portion of the data we reviewed were secondary analyses of SCIP or GOM data and documents, assumptions were made as to the reliability and validity of the data, some of which might not be accurate.
- Each data collection method was undertaken simultaneously and therefore initial findings were available only as of week eight of the twelve-week study. This meant there were limited opportunities for each research domain to feed into the other, and in particular, existing quantitative data could not be explored in detail before moving on to the qualitative stage. The data analysis framework took this into account by using an evidence-based approach.

V. FINDINGS BY EVALUATION DOMAIN

EVALUATION DOMAIN: EFFECTIVE INTEGRATION OF SCIP MODELS

Assess the effectiveness of integration as a model for service delivery by SCIP to inform recommendations on whether to continue this approach or modify it for future programming

The Team's approach to analyzing integration was to evaluate the extent to which the two SCIP activities delivered all services in an integrated manner, considering local context and political/governing realities. This was a re-orientation by USAID from a previous analysis where the team evaluated integration within the consortium. These findings were further discussed with the SCIP Nampula and Ogumaniha, and further modified.

Soon after SCIP was awarded, in 2010, the Ministry of Health started to push for increased community involvement in health. A Health Committees policy was launched that established the organization and function of community health workers and provided a legal framework within which they would operate. In both provinces, SCIP used this framework to provide Community Leadership Councils with multi-sectorial training that enabled them to operate as health education volunteers and much more, providing service delivery packages that integrate health, HIV, water and sanitation, nutrition and agricultural messages.

This did not, however, lead to full integration. Historically, selection criteria for funding support for agriculture favours places where agriculture will be implemented, and these have been historically different from that of health. For agricultural activities, one must focus in areas where the soil is rich, while for health, in areas where there are no health facilities, and these are not necessarily the same areas. Secondly, because of limits in funding for WASH, this activity is only available in a limited number of districts in both provinces (six in Zambézia, five in Nampula), thus, full integration of all SCIP activities at the level of implementation would only be theoretically possible in those districts. Yet, even in those districts, full integration is only theoretically possible in certain communities, not all. In such places, data from KIIs revealed that multiple services were being provided, and in some instances, the one-stop-shop model was operational with CLCs having received training in all sectors. However, the Evaluation Team found that while systems for referral had been established by SCIP activities in both provinces, they had limited functionality. Referrals between sectors were barely existent and formal referral systems within the health sector were not functional, making holistic, integrative care unrealistic for SCIP communities at this time.

Overall, results indicate that some integration of services is happening and is strongest at the community/service delivery level. For example, SCIP Nampula is experiencing partnering relationships. At the provincial levels, SCIP activities in both provinces are more at the stage of cooperation. Much work remains before it can be said that all SCIP activities are being implemented in a fully-integrated manner at all levels.

Evaluation Question I.

To what extent is the SCIP activities integrated in practice?

The Matrix of Integration tool (table 9) was used to answer evaluation questions I and Ia. Table 9 summarizes integration on a continuum, from Networking to Unifying (color coded: blue = Zambézia; gray = Nampula; red = both projects).

a) Leadership and Decision-making

Integrated leadership leads to a reduction in duplication, complementary interventions, and better

collaboration between stakeholders. The Team found that in both SCIP Nampula and Zambézia, leaders internally develop integrated conceptual frameworks covering holistic service. They participate in Ministry strategic planning processes at various GOM ministries (Health and Social Action, to a lesser extent Agriculture and Local Works) to follow decision-making and ensure their contributions are made within an overall Ministry-led framework. However, the governing landscape is different in the two provinces. In Nampula, the provincial GOM has a body, UCODIN (Coordination Unit for the Integrated Development of Nampula) that provides leadership and coordinates all NGOs, GOM ministries, and some local businesses towards a vision of integrated development. UCODIN has been a strategic home for the SCIP Project.

The Government in Zambézia functions differently, with each ministry acting in its own silo. Zambézia does not yet have a defined, shared vision for integrated development. The SCIP Zambézia finds it necessary to develop relationships and obtain direction from each related government ministry¹¹, and the bulk of the work to integrate delivery of services at the community level is left up to the SCIP. This, coupled with a need for having a clear understanding of integration concept and more communications or sharing of plans between the SCIP and the provincial government, makes integration in Zambézia somewhat more challenging.

World Vision, the prime partner for SCIP Zambézia, has operated in the province since 1983, and other members of the consortium also have been operating in the province for a number of years. As such, World Vision has a history of working in the communities, though consortium members also have worked independently, and in some instances, competitively with each other. While multiple activities are being implemented in the same districts, consortium members struggle to have complete buy-in to the concept of integration and work remains to foster a universal understanding of integration and its potential. Staff from one among the four consortium members said, *“As soon as Ogumaniha is over, we will go back to our old way of working.”* Without a common understanding of and buy-in to the vision, members of the Consortium either work in parallel, or even independently. Thus while the provincial government exhibited clear gaps in multi-sectorial planning, the Team found that SCIP Zambézia, because of these fragmented views on integration concept, was not able to adequately advocate with the GOM in taking a leadership role in ensuring integration. Decisions are made within GOM frameworks, and the project leadership meets with and participates in meetings hosted by GOM officials.

In contrast, most of the members of the SCIP Nampula Consortium do not have a long history of working with communities in Nampula. The concept of integration was at the heart of the original proposal. From the onset, the leadership emphasized the importance of developing a shared conceptual framework within which to operate at the provincial, district, and community levels. *“This took time and effort as it involved a move away from vertical approaches and the development of a shared organizational culture,”* a KII Nampula SCIP staff members among 5 consortium members reported. The Evaluation Team found that this initial time investment not only helped with implementing activities in an integrative manner, but that all partners were able to work with the GOM with one voice, promoting integrated leadership at all levels. Government in Nampula considered SCIP as a strong collaborating partner providing necessary technical and financial support for the government to do its work.

b) Strategy, Planning, and Project Design

Inter-sector collaboration within various Ministries in Zambézia is lacking

In Zambézia, because intersector collaboration with various GOM ministries are lacking, individual consortium members of the SCIP/Ogumaniha set up separate meetings with the relevant GOM ministries (Health and Social Action, to a lesser extent Agriculture and Local Works) at district and provincial levels to discuss project plans. Different priorities, relationships and planning cycles among various ministries are

¹¹Government ministries (DPS, DDS, DPMAS)

major challenge to multi-sectoral collaboration and joint planning meetings.. Ogumaniha provides financial support to facilitate the quarterly provincial meetings (to enable greater input from districts), and to facilitate existing GOM's strategic planning processes. As a result of these efforts, some Ogumaniha interventions have been integrated into the Economic and Social Plans of 2010, 2011, 2012, and 2013. However, the Provincial Director of Health in Zambézia asserts that Ogumaniha's plans are pre-defined without the possibility of integrating Provincial Directorate of Health's [DPS- *Direcção Provincial de Saúde*] agenda. DPS argues that USAID regulations are inflexible in critical areas relevant to the DPS's agenda such as vehicle usage. According to a KII among 5 GOM staff interviewed in Zambézia, "the fulfilment of the Province's indicators cannot be considered as less important than the Donor's". Other GOM officials indicate persistent challenges in coordinating water and sanitation activities, and as one KII (1 out of 5) from the GOM suggested, factors in the obsolescence of water sources include a lack of effective coordination between the GOM and multiple partners operating in the WASH sector, weak community engagement, and a paucity of spare parts for repairs.

In Nampula, the GOM leads Multi-sectorial planning

Joint strategy development between USG-funded activities and the GOM has the potential to link service providers and service users into one system, ensuring that a variety of stakeholders shape the approaches and interventions, thereby increasing impact. In Nampula, Coordination Unit for Integrated Development of Nampula (UCODIN) calls together multi-sectorial meetings to develop strategies and plans. The SCIP Nampula project is an active participant in these meetings, and while plans cannot align fully due to donor priorities and funding realities, they are informed by these interactions. Furthermore, SCIP Nampula's strategy, much like Ogumaniha's, is to build the capacity of community mechanisms to ensure a broader range of services are accessible to communities, and improve linkages between communities and service providers. At district level, coordination and collaborations for training and mentoring is more evident. There is an emphasis on planning and activity development at the district level in collaboration with GOM, according to KIIs with SCIP district staff and GOM staff.

Top-down relationship with CLCs

A major strength of the Ogumaniha project is that it builds on an existing extensive network of CLCs established over a number of years through previous World Vision projects, bringing lessons learned and experiences from previous projects (e.g. Ocluvella), and alliances (e.g. Youth Power). An equally important element of Ogumaniha's strategy has been collaboration with and support to GOM. This support takes the form of training (malaria), finance (orphan and vulnerable children (OVC) assistance) and logistics (transportation for mobile health brigades). While Consortium members plan their activities at the district level, the relationship with the CLCs appeared to remain top-down, with Ogumaniha directing CLC activity, as opposed to CLCs being given the space to take initiative and prioritize the needs of their communities. When the Evaluation Team discussed this finding with the Ogumaniha team, they were reminded that activities are directed by the funding streams from USAID, and as such, did not leave much room for the project to promote CLC leadership and initiative at the strategic planning level, although World Vision has the capacity to facilitate this process. CLCs supported by SCIP Nampula were more involved in the process of planning and prioritizing, but were not yet leading that process.

Greater Need for Community Input on Use of Funding

As one member of the Ogumaniha consortium (1 out of 5) said, "SCIP does not allow room for communities to decide how to use the funding. USAID decides based on the targets they set... we must go to the communities and tell them what we need to get done." This may represent a missed opportunity for the project to 1) strengthen capacity of community leadership to identify and prioritize needs of their communities and plan and advocate for them; and 2) to provide integrated services that is in line with perceived needs and priorities of the community when doing this would strengthen the project's impact.

One example of the impact of this lack of involvement came up in the FGD with participants in the

Women First project. Ogumaniha provided input to this microcredit project to support women in building viable income-generating activities. However, the specific input provided caused conflict with existing business people in the same communities who had no external support and saw this approach as undermining their own work.

c) Administration and Human Resources

SCIP has struggled to harmonize administrative and human-resources procedures. In both Zambézia and Nampula, all Consortium members are international Civil Society Organizations with institutional procedures reflecting the expectations of their head offices. This has made the streamlining of internal systems time-consuming and problematic. An example of a challenge created by internal procedures with regards to integrating interventions is organizational vehicle insurance policies. Vehicles cannot be shared within the Consortium as insurance can only cover one organization at a time. Remuneration policies (salaries, terms, and conditions) also are not implemented in an integrated or harmonized fashion, resulting in different packages for staff doing similar work. Furthermore, decision-making is seen as highly centralized, with district staff being implementers rather than having any devolved responsibility for budgets or action plans. *“To be responsive to requests from the GOM, and fulfill our targets, we sometimes have to break the rules, as the system is very slow,”* a KII Nampula District staff member reported. Communication across the Consortium is affected by these procedural issues, particularly in Zambézia. For instance, while Johns Hopkins University (JHU) is responsible for developing communication materials, World Vision is responsible for printing, which leads to delays and misunderstandings.

For SCIP Zambézia, there was initial reluctance to have joint office structures. As one member of the consortium admitted, *“SCIP Zambézia brought everyone under one funding umbrella, but not a common office.”* However, after encouragement from USAID for an integrated structure, staff funded by SCIP began working in the same office in Zambézia instead of at their respective NGO offices. Nevertheless, some work remains to harmonize administrative and HR procedures. Consortium members each have their own regulation, timetable for use of resources and salary policies, and in the districts, each partner uses its own internal system. Though some challenges have been addressed, some are still outstanding, such as contractual conditions of service. Each of the implementers have maintained their internal procedures, and have been reluctant to change *“because one day the project will end”*, according to one SCIP Zambézia Consortium member (1 out of 5) speaking during a KII.

SCIP Nampula has tried to harmonize administrative and HR procedures where possible. The Consortium has worked in a shared office from the beginning, with the Chief of Party providing oversight and supervision to all staff being funded by SCIP, and the project’s initial few months were used to set up shared operational systems. One KII summarizes this well, stating that *“at the beginning, integration was difficult as each organization was only focusing on its own activities without looking at the broader picture. Now the activities work in a more coordinated manner with joint meetings to improve planning and participate in provincial forums to coordinate with other CSOs working in Nampula Province.”* Consortium members generally believed working together under a unified leadership works well because it consolidates the Consortium’s efforts and has resulted in economies of scale, but this process took about two years to establish.

d) Monitoring and Learning

Building GOM monitoring systems that reflect the spirit of integration is more likely to build sustainable M&E systems. However, the Evaluation Team found that neither of the SCIP activities in either of the provinces share the same M&E infrastructure with the GOM, though they share data reports. The monitoring systems of both Ogumaniha and SCIP Nampula were designed mainly to report on output indicators tied to health and WASH results.

Ogumaniha opted to develop its own monitoring system in order to report on progress against the intended results. Simple forms were developed that took into account the education levels of community volunteers. The project started with more than 250 indicators. In 2010, under the leadership of a new

M&E manager, the monitoring system was consolidated to report against 58 indicators. But the process led to many challenges, including a change in the units of measurement (from percentages to absolute numbers), making it difficult to monitor progress. In 2013, data quality audits undertaken by external agencies were performed in Nampula and Ogumaniha to investigate areas for improvements and the establishment of an electronic data collection system was initiated.

Ogumaniha’s monitoring system is not fully aligned with GOM indicators, and their reporting cycles are not in sync. *“We are not speaking the same language,” a KII GOM official said.* This leads to challenges in comparing Ogumaniha data with official data. For example, Ministry of Health indicators are facility based indicators while SCIP indicators are community based indicators. Additionally, GOM is challenged with lack of human and material resources to ensure quality of its monitoring system. Lack of clear understanding of indicators and data quality hinders planning process. However, there are signs of improvements of data sharing with GOM, and CLCs are now better equipped to share information with local administrative authorities.

SCIP Nampula took a different approach to monitoring. It conceptualized its role as an important improvement partner to the monitoring systems of GOM service providers. It did not develop parallel data collection systems, but relies solely on GOM-collected data for its health indicators. To support data quality, SCIP Nampula has placed an M&E officer in each district, and these officers liaise with relevant GOM departments, work with HMCs, and build the capacity of community volunteers and CLCs to report to the GOM system. The M&E officer also works with district offices to provide mentoring on data quality control with communities and conduct periodic data quality assessments on the data submitted to USAID. This strengthened monitoring system has the advantage of improving health data quality, and has led to a growing commitment within GOM to the use of data for planning and reporting purposes as it is more reliable. However, this approach also has the disadvantage of making it harder to assess SCIP activity contributions to the overall improvements in health-seeking behavior or WASH.

Evaluation Question 1a.

How successfully have components (Youth Farmers Clubs¹², or YFCs; WASH; and health) been integrated within the project?

e) Implementation of Integrated Services¹³

SCIP pulls together a wide variety of different activities focusing on health issues such as: WASH, HIV and broader health issues, nutrition and conservation farming. The success of this approach is closely linked to leadership, strategy and internal systems to enable components to be pulled together into a seamless package of holistic support for communities, including vulnerable groups such as orphans and vulnerable children (OVCs).

Both Ogumaniha and SCIP Nampula have successfully integrated a number of health, nutrition and WASH-related services from the perspectives of staff, GOM and CLCs in a number of communities. In this case, integration has resulted in both improving access and quality of combined services simultaneously as well as providing a mix of services from one outlet. Methodologically, mobile brigades and health camps (where health staff move from health facilities to hard-to-reach communities providing a range of health services over a period of days) have proven to be successful at getting services closer to communities, and have bridged gaps and misunderstandings between service providers (health facilities) and communities. *“People used to be frightened of health centres but now understand their role,”* a staff member with FGD Nampula CLC reported. Programmatically, the greatest success of integrated services

¹²YFCs are the focus of two questions within the evaluation and therefore will not be covered here.

¹³The PRP has no indicators to measure the relationship between services and outcomes. Responses to the evaluation question on progress of SCIP towards its intended results give statistical details against service delivery areas, but cannot link this to any specific intervention or strategy.

is in combining ANC with contraception, child health, hygiene and sanitation.

Based on data from PMP and SCIP annual reports over 4 years:

1. Institutional deliveries have increased (68% in Zambézia and 89% in Nampula) because of campaigns on ANC and construction of mother's shelters, which provide a safe place for women close to their homes.
2. TBAs have been trained to refer pregnant women to ANC clinics.
3. Linkages between community level (i.e., bicycle ambulances, mobile brigades, HMCs) and health posts have been established through community awareness.
4. Community education and mobilization have helped DPS achieve its outreach work in increasing immunization rates, maternal and child health service utilization (Ogumaniha).
5. HBC volunteers advise patients to go for testing and advocate for treatment adherence, creating a link with health facilities.
6. HMCs create a bridge between communities and health facilities facilitating use of facility services.
7. The combined effect of community radio, capacity building of CLCs and HMCs, and the use of health post staff in community outreach has helped change community attitudes and knowledge about health. Community volunteers identify malnourished children and refer them to health care workers; bicycle ambulances help access medical support; and YFCs produce moringa¹⁴ to improve nutrition. Nutrition education is provided through CLCs (healthy eating, food hygiene and storage, cooking techniques, and use of soy).
8. Community volunteers identify orphans and vulnerable children (OVC) and work with the Department of Social Action to get them registered, provide school materials and food aid, and link them to YFCs.

The Team noted challenges of seamless integration for some services. As noted earlier, in Zambézia, full integration is only possible in some communities in six districts, with WASH being the limited factor because WASH funding it is not available in every district where SCIP is implementing services. Hygiene, sanitation, HIV, and nutrition were done in all communities. Maternal and Child Health activities were done to a different degree, depending on the number of reproductive health agents working in that community. In some communities where MYAP was active, there are no maternal and child health activities supported by SCIP at the moment. In Nampula, the Evaluation Team found that, by late 2012, nearly 47 percent of the 902 CLCs were trained in health because the project is using a phased approach in training. Those who are trained do provide all services where possible (in Nampula, only certain communities in five districts have WASH), but admittedly to varying degrees of quality and consistency.

f) Partnerships and Linkages¹⁵

There was evidence of linkages at many levels in both Nampula and Zambézia, and between different stakeholders, particularly with GOM. One of the most successful linkages between SCIP and health care providers in the two provinces was through support to mobile health brigades and health camps. Mobile

¹⁴ A moringa is an edible plant rich in protein, vitamins and minerals.

¹⁵ For the purpose of this evaluation, a linkage denotes a relationship with other stakeholders working in the same geographic area on similar issues and tends to be less official than a partnership, which is a more concrete relationship, often working within a formal agreement.

brigades are a GOM initiative to bring priority health services to communities, but a district health department's ability to put this initiative into action is often limited by funding and transportation shortages. SCIP has played a pivotal role in this regard, not only by supporting the mobile brigades but also by undertaking community mobilization to raise awareness of the brigades' role. Another successful initiative evident in both provinces, was the distribution of bicycle ambulances (In year 3: 65 out of 80 in 7 districts of Nampula; 210 in Ogumaniha), which have bolstered ties between communities and health centers. The construction of maternal waiting houses (in year 3: 12 new construction and 5 planned in Nampula and 33 repaired or equipped in Ogumaniha), which give women a place to stay close to maternity wards in the final days of pregnancy, helps more pregnant women deliver their babies in a medical setting.

Linkages with other community-based activities were evident with church groups working with ADRA, additional formal CSO partnerships established beyond those between members of the Consortium itself were not observed.

Ogumaniha has developed a more formal system for tracking referrals from the community level to health centers, although CLCs have said that when they take referral forms to health centers they are often disregarded. There is also some evidence that these data are used for planning purposes in the district-level health sector and that districts are better able to report through to provincial counterparts. Linkages have been formed with GOM at the provincial level through quarterly meetings. According to annual reports, representatives of the GOM departments of Health and Social Action are regular attendees at these meetings, while representatives of the GOM departments of Agriculture and Public Works and Housing attend less frequently.

District-level linkages are also in evidence between Consortium members and GOM departments, mainly through monthly meetings with health center staff and Social Action and Health. However, these meetings mostly allow for information-sharing and not strategic planning. District health officers did acknowledge the important role ADRA has played in its support with mobile brigades and vaccination campaigns, and saw a useful symbiotic relationship. Linkages between Ogumaniha and other GOM departments are less apparent. *"Infrastructure and Agriculture do not do planning, so we are not involved with them. Linkages with Agriculture are through MYAP, but that is almost at an end,"* said a KII Ogumaniha district coordinator.

This District Coordinator believes more formal linkages would be important, such as a memorandum of understanding that clearly explained how Ogumaniha could collaborate better with GOM. At the district level, there was a degree of satisfaction in how the project is supporting the PES and providing funds for GOM to implement its District Strategic Plan. Some GOM officials said they worked hand in hand with Ogumaniha, going into communities and developing work plans based on GOM and community priorities.

At the community level, Ogumaniha has successfully created linkages between CLCs and TBAs, community volunteers and health centers, as well as between CLCs, CLLs and Health Management Committees (HMCs). These have become important linkages between communities and district health centers/hospitals. However, these linkages have yet to be transformed into more formal referral systems that can be tracked.

Distances limit the opportunity for meaningful linkages between health service providers and communities and between CLCs and CLLs, which is beyond the scope of SCIP to resolve. In some communities, linkages between the different committees has improved, either through membership of the CLC, or because the purpose of linkages has become more obvious through the project, such as those between a water committee and a hygiene committee. ADRA has collaborated with the church in some instances to encourage consistent messaging on key themes and overcome skepticism within communities, which is an obstacle to some elements of health-seeking behaviors: *"This family planning is meant to kill children?"* one Ogumaniha CLC FGD participant commented, illustrating that misunderstandings about family planning efforts exist.

In Nampula, linkages were most evident at community and district levels, and were often seen as formal partnerships, particularly with the Department of Health and Social Action. Working from the community level upward, establishing linkages has been a priority of the SCIP Nampula approach. Community volunteers are linked into CLCs, thereby creating the possibility of accountability for their actions. APEs, TBAs, and Community Health Volunteers (a cadre of people trained over five days in health-related issues) link to HMCs, CLCs, and Health Centers. Orphans and vulnerable children (OVC) are linked into systems through community volunteers (HBC community volunteers), CLCs and Social Action. HIV-positive people are linked through the same system. This system has created an informal structure linking from community volunteers, APEs and community members through to community mechanisms (CLCs, HMCs) through to local GOM and district departments (CLLs, DSD, DAS). This evaluation did not have the opportunity to look in detail at how effective or successful these linkages were (evaluation team did not review community registers to confirm referrals procedures).

Table 9 summarizes integration (questions I and Ia) on a continuum, from Networking to Unifying (color coded: blue = Zambézia; gray = Nampula; red = both projects).

Table 9: Matrix of Integration

	Networking	Cooperating	Partnering	Unifying
Leadership and decision making	<ul style="list-style-type: none"> Integration discussed at leadership level, , no conceptual framework. Decision making individual, not collective. 	<ul style="list-style-type: none"> Leadership develops conceptual framework, not shared universally. Decision making collective. 	<ul style="list-style-type: none"> Leadership develops conceptual framework by extensive discussions with key stakeholders covering holistic service provision from cradle to grave. Decision making follows framework. 	<ul style="list-style-type: none"> Conceptual framework outlines the parameters of integration: definition, strategies, admin and financial systems, interventions, government and community roles and monitoring and ownership.
Strategy, planning & project design	<ul style="list-style-type: none"> Individual plans developed and <u>shared with</u> partners aimed at reducing fragmentation. 	<ul style="list-style-type: none"> Stakeholders develop individual <u>plans in line with a shared</u> strategic document. 	<ul style="list-style-type: none"> Stakeholders develop plans and projects <u>collaboratively</u> within a single multi-sectorial strategy. 	<ul style="list-style-type: none"> CSO, community and GOM work together within a <u>single strategy undertaking joint planning</u> and project design, identifying gaps and overlaps in service provision.
Admin and human resources	<ul style="list-style-type: none"> Each organization works within its own administrative, financial and HR systems. 	<ul style="list-style-type: none"> Each organization works within its own administrative and HR systems, plus uses a shared financial reporting system. 	<ul style="list-style-type: none"> Organizations work together, sharing office space and <u>harmonizing some aspects</u> of their administrative and HR systems. 	<ul style="list-style-type: none"> The organization has developed its own identity and its administrative and HR systems are harmonized into <u>one management support system</u>.

	Networking	Cooperating	Partnering	Unifying
Implementation of services	<ul style="list-style-type: none"> Multiple services provided by <u>multiple stakeholders in different locations.</u> 	<ul style="list-style-type: none"> Multiple services provided by multiple stakeholders <u>Informal referral systems formed.</u> 	<ul style="list-style-type: none"> <u>One-stop shop provides holistic services</u> including public health education within communities. Informal referral systems formed. 	<ul style="list-style-type: none"> One-stop shop provides holistic services to communities <u>with formal referral systems and linkages between different sectors</u> relevant to health.
Community ownership and accountability	<ul style="list-style-type: none"> Communities <u>invited to participate</u> in project design through service mapping. Analysis is conducted elsewhere. 	<ul style="list-style-type: none"> <u>Community mechanisms established to participate</u> in identifying and prioritizing needs. 	<ul style="list-style-type: none"> Community mechanisms undertake <u>own needs assessments.</u> Analyze priorities and request support from state and non-state service providers but unable to demand better services. 	<ul style="list-style-type: none"> Communities <u>take responsibility</u> for improved health outcomes through behavior change in health seeking behavior, and <u>advocating its needs</u> with service providers & holds them accountable.
Monitoring and learning	<ul style="list-style-type: none"> Each organization implements its own monitoring system, sharing its data with other partners. Data used for donor reports. 	<ul style="list-style-type: none"> Individual monitoring indicators collected into one system, with data going back to each org. Limited use of data for planning. 	<ul style="list-style-type: none"> One monitoring system established. Standardization of data collection and subject to one quality control system. 	<ul style="list-style-type: none"> One monitoring system used to measure progress, develop reports and identify trends to be used in planning and strategy. High priority placed on quality and sharing of data.
Partnerships and linkages	<ul style="list-style-type: none"> Network established within limited group of partners primarily focussed on division of labour. Linkages with GOM are limited to sharing data. 	<ul style="list-style-type: none"> Collaboration among organisations with formal partnership agreements. Limited harmonization and linkages with GOM are informal. 	<ul style="list-style-type: none"> Partnership framework clearly defines the Coalition, GOM linkages through joint planning and support but no formal referral systems in place. 	<ul style="list-style-type: none"> Formal partnerships established between Consortium, GOM and communities. Clear referral system across sectors.

Evaluation Question 1b.

How successfully do SCIP interventions integrate with or build upon other USG interventions, including the Multi-Year Assistance Program (MYAP)?

Both projects have had strong integration with the Multi-Year Assistance Program (MYAP), since members of both consortiums were previous implementers of MYAP. Both projects currently work with community infrastructures (CLCs) that were previously used by MYAP, and continue to build activities and implementation on these historical relationships. In Zambézia, Ogumaniha has introduced them to new technical areas, in line with SCIP's mandate. It appears, however, SCIP activities add or build onto MYAP rather than integrated, in the sense that the baseline for SCIP did not appear to include analysis of MYAP strategies or conduct research into the degree to which CLCs supported by MYAP had succeeded in changing behaviors.

Ogumaniha and MYAP are integrated in 241 communities in 13 districts. For more than one year, SCIP activities are ongoing with health facilities in nine districts supported by FGH, SCIP consortium partner, to identify antiretroviral treatment program drop-outs, conduct an active search including home visits, and encourage their re-enrollment. Results to date are encouraging; among nearly 1,400 re-recruitment searches, slightly more than 50 percent of drop-out patients have been brought back to treatment. The relationship is not as strong with ICAP, another USG partner, funded by US Center for Disease Prevention and Control (CDC), to provide ART services. The SCIP Zambézia team pointed out that this is not due to lack of interest on their part, but possibly due in part to turnover at the leadership level.

In Nampula, SCIP covers nine of the 14 districts previously supported by MYAP (SANA). SCIP staff members said some of the CLCs they work with were previously supported by SANA, through Save the Children. However, many of the community volunteers selected were illiterate and, as a result, it took some time to build their capacity in the areas of health, nutrition, and WASH. Cooperative League of the USA (CLUSA), one of the members of the SCIP Nampula consortium, is still a member of MYAP, and SCIP signed a memorandum of understanding with SANA to take over its nutrition activities beginning in August 2013.

SCIP Nampula works with two clinical partners, EGPAF and ICAP (both funded by CDC), indirectly through the health committees. In all 14 districts where they overlap, SCIP's HIV Testing and Counseling Counsellor (HTCC) participates in the ART Committee supported by ICAP and receives a list of defaulters and patients lost to follow-up. The HTCC then circulates this list with focal points in each CLC, thus facilitating active search and eventual return to treatment of a number of people. SCIP Nampula also works to identify HIV-positive patients and link them to clinics where ART is being provided by these partners. For example, the Evaluation Team was told that SCIP Nampula is currently following approximately 2,800 HIV-positive individuals from the community, of whom 1,700 are on treatment, and the other 1,100 tested by HTCC at the community level (home-based testing and counseling) are being followed regularly. In addition, community testing at home of women found to be HIV-positive has led to the identification of approximately 700 husbands being tested, up to 77% of whom were found to be HIV-positive. SCIP Nampula has facilitated the entry of these beneficiaries into care and treatment programs in health facilities supported by these USG partners and is actively monitoring their health at the community level. SCIP Nampula has also integrated with USG malaria partners, particularly PSI and the Malaria Consortium, to ensure delivery and proper use of bed nets. Community health networks and CLCs were used to define how bed nets should be distributed, and net distribution verification was done by community health workers who also taught household members ways to prevent malaria. The evaluation team did not verify these reports through data collection.

Evaluation Question 2.

What have been the management and implementation benefits of project integration?

In general, the SCIP partners, communities and GOM officials all extolled the benefits of integration, claiming that this model promotes collaborative working relationships among multiple partners that have not traditionally worked together, and that this makes for clearer and more transparent management of USG funds. This was more apparent to the Evaluation Team in Nampula, than in Zambézia, where in several Klls, program staff expressed doubt about the positive benefits of integration, possibly due to challenges in leadership and strategic planning. In general, most people interviewed believed that integration reduced duplication and improved coordination, and that it was a more flexible strategy that lends itself well to building on existing governmental and traditional infrastructure and mechanisms, and could more easily meet community needs in a holistic manner. Below, we summarize key findings in this area:

- Klls from USAID acknowledged that integration works by providing holistic services to communities when implementers understand the concept well and there is sufficient planning time allocated. Flexibility is key, as priorities of communities, government, donors often change, and SCIP approach lends itself well to these changes.
- Support for integration as a strategy for activities was particularly strong in SCIP Nampula among staff and GOM officials. It was less evident in Zambézia among staff, and GOM staff often commented they did not believe Ogumaniha worked in a coordinated fashion.
- Staff in Ogumaniha were less positive about management benefits of project integration, although they did say that working in a Consortium meant they knew more about each other's activities in the districts. From the perspective of senior SCIP staff in Nampula, working together under unified leadership is clearer, and results in economies of scale and the consolidation of efforts. It has led to a reduction in duplications of effort, has enabled staff members to think through the complementary technical areas, and has led to better collaboration between implementing organizations and other USG organizations. Another benefit has been the opportunity to work in a more coordinated fashion, leveraging the strengths of different partners.
- At the implementation level, an integrated approach is seen as a way to provide holistic services to communities because it more closely mirrors the challenges faced by households and communities where problems of poverty are interrelated. *“Health problems are not linear, poor sanitation is a major problem and diarrhea is endemic during certain times of year but SCIP has looked at sanitation and health care together,”* one Kll district medical officer. GOM officials believe integration fosters flexibility, creating a more collaborative and cooperative framework within which to work. Majority saw the approach as better able to address the root of health problems as integrated activities seek to simultaneously address different levels of health care: demand for services (improvements in health-seeking behavior); better commitment to preventative health care; and supply of services (improving quality and access to health services). The evaluation team triangulated these with PMP data, annual reports and observed increasing trends in various services access and utilization.

Evaluation Question 3.

What have been the management and implementation challenges of project integration?

There were a number of fundamental challenges with management and implementation of project integration raised during the key informant interviews with USAID officials and SCIP implementation partners. Klls were conducted with SCIP staff; Government of Mozambique (GOM) officials; community organization officials; and health facility and community workers.

- A number of key informants recognized that integration is a less visible approach than direct service delivery, making the concept less tangible. “*SCIP is a ‘software’ program, building systems, strengthening coordination, improving linkages etc. Its results are harder to see than in a vertical program,*” a USAID representative said during a KII.
- When integration involves building the capacity of GOM, the project’s success is inextricably tied to the performance of another institution over which implementers have no control. This can present a huge management challenge, particularly when you are expected to demonstrate results over a very short timeframe.
- Integration by definition means working under one strategy, within one M&E system. This is a challenge for CSOs working with the government if the donor is not fully aligned with GOM policy. Planning cycles between SCIP and GOM are not harmonized, nor are their indicators.
- Integration can be used as an all-encompassing approach where different interventions are added without really thinking through how they relate to each other, or whether they overwhelm the capacity of the implementing organization and communities alike.
- The time required to ensure integration is out of sync with expectations of immediate tangible results. Both projects struggle with this, and have dealt with it in different ways. For example, SCIP Nampula takes a phased in approach to training and operationalizing CLCs as opposed to training all CLCs simultaneously. SCIP Zambézia rightly acknowledges that better results are obtained in communities where there are more, better-trained MNCH volunteers, yet this is difficult to balance with budgetary realities.

Evaluation Question 3a.

Do certain program areas get reduced attention because of the management needs of other program areas?

Based on the analysis of number of PMP indicators per program area as a proxy, the team concluded that the health program areas got more attention than agriculture and economic strengthening activities¹⁶. Both SCIP partners reported that much of their energy and efforts goes towards HIV treatment and prevention activities. In Zambézia, volunteers who provide HIV treatment and prevention services are paid for their work (per ministry-established payment schedule), the distribution of incentives was seen as an additional management work. In Nampula, project staff highlighted that turnover and changes within clinical partner organizations, as well as turnover at health facilities, played a significant role in increasing management workload associated with finding and following up with HIV-positive patients in the field. In some cases, CLC members were introduced to the community case-finding program accepted by one HF manager, but when the new manager came in, SCIP had to start over with orientation and buy-in of that person into SCIP’s long-term vision. This turnover also often results in disorganization of PLHIV clusters, making them less effective in supporting community outreach activities. However, SCIP staff also stated that different activities developed during the last three years, including training of CLC members by HF providers and operationalization of the HF co-management committees, have resulted in community leaders becoming focal points for specific activity areas within CLCs, including stigma prevention, male involvement, and CLTs. This continuum of care should help to alleviate the management burden.

SCIP Nampula further identified contraception and family planning as activity areas that require significant time and management to work on community education and behavior change in accepting interventions. This is largely due to a very low CYP coverage (four percent in 2009) within a context of high socio-cultural resistance to family planning in rural areas. More time and effort is needed to convince potential

¹⁶ SCIP budget or expenditures analysis was beyond evaluation scope of work.

user in adopting the intervention. When community mobilization and involvement has led to increased demand for contraception, weak supply chains and resulting shortages of contraceptives have threatened gains.

EVALUATION DOMAIN: SELF-SUSTAINING COMMUNITY SYSTEMS

Both Consortia placed CLCs at the heart of their implementation strategy, linking them with GOM service providers (Health Centers, Mobile Brigades, Health Camps) and with departments (Social Action, Public Works, CLLs). Community ownership is a cornerstone of sustainable systems, and in Mozambique, this represents a unique blend of traditional and governmental systems.

Evaluation Question 4.

To what extent is the SCIP strategy strengthening relationships between Community Leader Councils¹⁷ (CLCs) and other government structures?

The Community Leader Council (CLC) is a group of community leaders at the village level. In each community there are committees for water, education, health, etc. SCIP has looked to consolidate these groups within the CLC. Each CLC has a maximum of 30 members and is expected to solve its own problems. CLCs were in existence before SCIP, and form part of a traditional structure for governing and social rule. They are usually made up of neighborhood and locality chiefs, as well as other community elders who normally play a role in resolving conflicts and in developing rules and policy for communal living, and as such, hold the respect and regard of the communities in which they live.

SCIP activities, and others before, are attempting to develop the capacity of these bodies to accurately deliver an integrated message package that covers MNCH, HIV, nutrition, WASH, and agriculture in accordance with the needs of their communities. CLCs are formed at the village/bairros, but in order to influence policy, SCIP supports:

- The Conselho Local da Povoacao (CLPs), a ten-member group made up of one representative from 10 CLCs;
- Conselho Local da Localidade (CLLs), a 20-member group made up of representatives from the CLPs;
- Conselho Local do Posto Administrativo (CLPA), a 40-member group made up of representatives from CLLs; and
- Conselho Local do Distrito (CLD), a 50-member group made up of 40 representatives from CLPAs, and ten politically appointed members.

These Conselho Locals correspond geographically to: district (CLD), Posto Administrativo (CLPA), Localidade (CLL), Povoacoes (CLP) and Aldeias/Bairros (CLCs). They fall under the government/administrative jurisdiction of the district administrator, administrative post chief, locality chief, and Povoacao chief. Yet, despite efforts, community structures do not communicate effectively with these governmental structures, thus they have minimal influence on policy, and joint decision making is rare. However, FGDs with CLC members revealed that stronger, confident CLCs, particularly those proud of key achievements (such as introducing latrines to the communities), are in a stronger position to network with GOM officials, particularly in CLCs where community leaders such as Regulos or

¹⁷CLCs are groups of community leaders who come together to analyze, plan and monitor the resolution of their community and strengthen cooperation among various leaders

Secretarios do Bairro are part of the CLC. Both projects actively seek ways to leverage this. The Team found that CLCs were universally positive about the SCIP activities. Ogumaniha built on its existing network of CLCs, some of which have been in existence since 2000. It aimed to strengthen the capacity of CLCs in areas specifically related to SCIP, namely: health, WASH, and agriculture. In Nampula, SCIP is operated by partners who do not have a long history of working with CLCs. Yet, the overall picture is mixed. Despite more than 10 years of support by projects including SCIP in Zambézia, members of CLCs still have relatively low levels of technical knowledge. There was some evidence of CLCs which had become more autonomous developing plans to present to their CLL, but there was also evidence of CLCs which had a strong dependency on Ogumaniha. For instance, in one community, a number of boreholes were broken, but the CLC had not made the needed repairs, even though the borehole was only about 100 meters from the CLC. One of the major challenges was that, after many years of vertical support, numerous committees had been established at the community level and competition between committees was apparent, each focusing on its own activities with limited cooperation or organization. Thus part of the work to be done is to create a new culture of technical support and collaboration that overrides the previous culture of hand-outs or one-off technical support. This is a major challenge, particularly in poorer communities where a large proportion of residents make less than \$6.50 per month.

Of note, the evaluation team did not find formal evidence of linkages between CLCs and health facilities. However, members of CLCs were able to recount episodes of connecting community members to health facilities. One FDG member noted that she picks up contraceptives at health facilities to distribute to women in the community, while others noted their ability to recognize pregnancy complications. *“These days it is very rare for a woman to give birth at home,”* one FDG participant said. PMP reports show that by year 4.68% of institutional deliveries target is achieved (target by year 5 is 75%). Another FDG participant noted that *“we get along pretty well with the health care facility staff. Sometimes we go and build latrines for the health facility.”* FGD CLC members reported that referrals are done on a regular piece of paper and are signed by the community leader (the team did not verify these statements). The Team did not find any memoranda of understanding (MOUs) between CLCs and health facilities included in decentralization strategies, or related to using referral forms in either Ogumaniha or SCIP Nampula. In the absence of counter-referral documentation, the team was not able to demonstrate community-facility referral relationships. However, the referral system developed by Ogumaniha did create a possible tool to start forming a formal linkage between communities and health facilities.

In Nampula, CLC members say that SCIP has helped build their knowledge (about contraception and ANC, pit latrines, tippy-taps, and hygiene), and strengthened their ability to link with GOM service providers (health facilities, mobile brigades, health facilities, and Social Action). In one FDG, a CLC member in Nampula noted that *“before SCIP came, we used to have high mortality rate, but now SCIP has come, this rate has decreased a lot.”*

In the view of CLC members, the most important interventions promoted by SCIP have been: latrines, environmental sanitation, family planning and male involvement. However, some CLC members believed they needed more skills. While they have made some progress in building some institutional capacity (record-keeping, structure), it was not clear what mechanisms exist to include more marginalized groups from communities or if they would have the ability to hold GOM bodies accountable for improved service provision. Nevertheless, majority believed they would continue beyond SCIP. As one CLC member from Nampula said during a FGD: *“We will continue to work together even after the project has ended, because we have ‘seen the light’ of the benefit of working together and won’t go back to the past when we had a lot of instances of diarrhea and death during child labour.”*

Evaluation Question 5.

Do community organizations supported by SCIP exhibit characteristics that are linked to a greater likelihood of continued level of activity after the completion of the SCIP activities?

The 24-question sustainability questionnaire to calculate sustainability index (possible score 1 to 7 on a likert scale) developed by the evaluation team was administered to CLC respondents. The index provides a framework for understanding sustainability of community institutions focused exclusively on CLCs, since they form the cornerstone of community systems through which SCIP delivers services. Of the 48 CLC members (less than 0.05% of total CLCs supported) who completed this index, the average age was 42.4 years, members had been volunteering for an average of 8.2 years, and approximately one third of respondents were women. Overall, the Team found that sustainability was evolving for CLCs with index score 4.9 (scale of 1 (low) to 7 (high)), and could be further strengthened by working to improve financial viability, operational infrastructure, particularly ensuring that work done by CLCs is recognized within the governmental legal infrastructure, and enhancing the public image of CLCs among multiple levels of stakeholders as important community service providers. Table 10 below summarizes findings of overall assessment for both province together (blue = sustainability enhanced; gray = sustainability evolving; and red = sustainability impeded).

Table 10. Overall assessment of CLCs (both province) using Sustainability Framework

Factors	Score and explanation (scale of 1 (low) to 7 (high))
Buy-in by CLCs, or shared understanding and long-term vision of SCIP	For the most part, CLC members understand the long term vision of SCIP, though some admitted not having a full understanding of all aspects (4.46).
Buy-in by lay Community, or shared perception of need that SCIP fulfils (from perspective of CLC members)	According to CLC members, SCIP activities are perceived to be meeting specific, recurrent needs in the community (6.62).
Policy Environment is supportive of SCIP activities done by CLCs	Often CLC membership includes local policy makers, and as such, facilitates their awareness of needs. However, CLC members were unaware of additional activities that SCIP currently does to make the policy environment more supportive of lay community leadership in implementing multi-sector integrated activities, and expressed concern about their interaction with health facility staff in some health facilities. The Ministry of Health is further along, compared to other ministries, with its push for increased community involvement in health, and has provided a legal framework through which health management committees can operate. Much work remains to support the work of other community structures such as CLCs (4.73)
Functional Organization, with clear roles and responsibilities, accountable, resourceful, with clear ability to plan, well-integrated with government institutional strategy	Most CLCs agreed that roles and responsibilities within the CLCs were clear, and that they had come up with systems for keeping each other accountable. They appeared resourceful, and have found ways to implement some SCIP interventions in their communities without external funding. However, they are not well-integrated within the government institutional strategy. (5.88).
Financial Viability of SCIP activities post SCIP funding; Organizational support from other donors or businesses; ability to manage own funding	SCIP funding has been used for training and purchase of materials (pens, notebooks, stipends, and some transport). Most CLC members say that the communities themselves collaborate and fund latrines when they are needed. However, all recognize the need for additional financial support to better promote integrated service delivery at their levels, but most admit that they do not have the capacity to manage their own funds should they receive any (2.57).
Satisfactory Infrastructure, with sufficient staffing, physical (office and equipment), and in formational (technology, M&E)	While CLCs noted that each member has his or her own specialty, they also note that there are not enough qualified personnel; “we would like to do HIV testing in our communities”, a member said. All were very dissatisfied with ‘office space’, as they generally meet under a tree. They do not have any equipment and often do not have pens and paper for data collection. While it was difficult for the team to verify, they were able to verbalize a process for using data to identify topics for discussion, and a reasonable accountability mechanism (1.75).
Service delivery perceived to reflect recurrent needs and priorities of community; Capacity and training sufficient to ensure skills transfer	CLC members believed that SCIP services were much needed by the community, but some felt they did not have enough skills nor sufficient capacity to continue to provide services without external support (5.88).
Advocacy, including ability to raise awareness of decision makers on key issues of priority to the community	CLC members expressed confidence in their ability to engage the community in addressing priority needs, and provided examples where they had already done so (e.g., need for latrines). They also feel they have sufficient access to local policy makers and to some extent, government representatives. (6.54).
Public image, including positive media attention and involvement, interaction with other donors and the business community; perception of being a trusted community institution, and public awareness of activities	CLC members expressed that the community was positively engaged with integrated service delivery, though concerns were raised about the value community members gave to health advice received from CLCs. CLCs closest to health facilities reported having less credibility with community members, citing examples of community members who have been told to disregard advice from CLCs by health facility staff. Some work is needed to institutionalize CLCs as a credible source of health education for the community. (4.14)

Evaluation Question 6.

To what extent do youth participants and their families perceive Youth Farmers Clubs (YFCs) to be beneficial?

Youth Farmers Club (YFC) in Zambézia include children ages 10 to 17 years, while in Nampula, ages range from 10 to 24 years. Youth beyond the ages of 17 in Zambézia and 24 in Nampula are considered to have graduated from YFCs, and are encouraged to join farmer association. YFCs include both male and female members. About 698 YFCs (82% of the target) in Zambézia and 112 (72% of the target) in Nampula have been established by year 2012. Majority of members of YFCs who participated in FGDs affirmed that YFCs are beneficial. They provide younger children with space to play safely, learn new farming skills, and learn valuable life skills. In both Nampula and Ogumaniha, members of YFCs said they believed the clubs to be beneficial, particularly for learning conservation farming. However, few YFCs were able to demonstrate that they apply conservation farming methods learned into farming practice. When probed more deeply, challenges with the YFCs from the perspective of participants emerged. In Nampula, benefits from conservation agriculture were barely visible, as most YFC had not been able to produce enough surplus to take any home and any income raised from sales was too little as to be shared among the group. One YFC (in Ribaue) had been successful at selling its produce, but the Monitore had decided to buy chickens from the proceeds to develop an IGA without consulting the YFC. It was noted in both Zambézia and Nampula that parents' knowledge of or involvement in the YFC was very limited, although data from a recent evaluation in Nampula demonstrated that YFCs are passing on their knowledge to their parents. Approximately 84.5 percent of parents of YFC participants surveyed reported adopting three of five practices, including preparing land during dry season, superficial tiling to not mix anaerobic with aerobics, and crop rotation¹⁸. More detailed discussion on YFCs can be found in the Case Study in Annex 11.

Evaluation Question 6a.

What aspects of the YFCs are most beneficial and effective?

Focus group discussions were asked about the skills they learned and how they use them, when participating in YFCs. Below is a summary of findings:

- The opportunity for young people to come together in a club, learn about HIV, nutrition and ways to maintain their health, and work as a group towards shared goals. YFC participants enjoyed learning new skills in agriculture and hoped to be able to learn more in the future. However, younger children had little to say, and appeared to come to the clubs to play games and be with their friends and siblings.
- Monitores responsible for the YFCs' activities saw them as providing youth with an opportunity to improve livelihood security for young members. But this very much depended on the energy and skills of the monitores, and by no means all had the necessary skills to inspire young people. Furthermore, many were not clear about the goals of the SCIP.

In Zambézia, during FGDs with CLCs and YFCs, discussants said communities saw the value of the skills learned in YFCs and believe conservation agriculture is an important concept, and that children should be stimulated to learn about this type of agriculture. They also reported that the success of YFCs encouraged other children to join in these activities. However, one monitore (adult facilitator/leader) of a YFC said that attendance was often poor because *“they are at school which means they do not have much time to spend in the vegetable gardens.”* And the young people believed they needed larger demonstration plots, plus information on irrigation.

YFC members were not always able to implement conservation farming methods learned in these clubs,

¹⁸ INQUÉRITO SOBRE A SITUAÇÃO ACTUAL DOS CLUBES DE JOVENS AGRICULTORES EM NAMPULA - 2012

since they may not have access to their own land or equipment. However, CLUSA (Nampula) sees evidence that communities with both YFCs and Farmers Clubs are more likely to adopt conservation farming than those communities with Farmer’s clubs alone, in part due to graduated YFC members joining farmers associations.

Evaluation Question 7.

To what extent do former participants in YFCs who “aged out” of the program continue to employ lessons learned as part of YFC participation?

Graduation from YFCs in Nampula occurred at age 24, and in Zambézia, age 17 (before turning 18). For those who remain in the area, they are encouraged to join Farmers Associations and in Nampula, mentor other YFCs. Anecdotal evidence from CLUSA suggest that when this does happen, conservation farming practices are more likely to be adopted by these Farmer Associations, but the Team did not observe this in the field. During FGDs, however, the majority of members were reported to have left for opportunities away from the project areas, thus, there is no way of knowing if they continue to practice conservation farming or any of the other lessons learned.

EVALUATION DOMAIN: DEMAND FOR SERVICES

Evaluation Question 8.

To what extent has SCIP succeeded in creating demand for health services?

Overall, based on the PMP data and annual reports (Annex 7), Ogumaniha and SCIP Nampula are progressing towards their targets and, in many cases, the targets have already been met or surpassed. To answer this question, we do not summarize the entire PMP, but highlight only indicators dealing with ANC, contraceptive use, immunizations, and will go into greater detail analyzing WASH indicators (Table 11).

Table 11: Target and Actual Achievement for Key Indicators for SCIP

	Zambézia			Nampula		
	Actual By Y4	Target By Y5	% achieved	Actual By Y4	Target By Y5	% achieved
ANC visits	267,909	166,700	160%	2,060,380	2,490,321	83%
Facility Deliveries	68%	75%	68%	353,322	396,083	89%
Immunizations (DPT3)	180,348	174,000	103%	439,197	499,646	88%
Contraceptives Distribute	88,403	120,000	74%	50,823	64,585	79%

Data indicates increase in facility births, FGDs with CLCs and TBAs corroborated these findings, and as one Nampula CLC FDG participant noted, “these days, it is very rare for a woman to give birth at home.” However, FGD participants in Gurué and Lugela also reported that pregnant women did not always allow nurses to assist them during delivery, since many of them preferred TBAs in the community. Of note, TBAs inevitably lose their income with health facility deliveries, and this, in reality, may create competition between health facility staff and TBAs.

In Nampula, the Team learned that memoranda of understanding (MOUs) had been signed between health facilities and the Chief of the Localidade in a number of localities to build Pregnant Mother Houses. To date, the project has supported 24 pregnant mother houses, though this is a slow process and not all of these houses have been delivered yet. SCIP staff interviewed believes that Pregnant Mother Houses,

where women can come early and stay up to one week before giving birth, have increased ANC deliveries at facilities. There are three nurses providing supervision to the facilities, with their primary focus on the management of deliveries. Each nurse covers four districts. SCIP also supports the maternal audit committee and provides expertise in reviewing maternal and neonatal deaths. SCIP Nampula also uses existing GOM standards, the “*Iniciativa de Maternidade Modelo*”, to reduce high levels of maternal and neonatal mortality. It also advocates for providing family planning to patients at every opportunity.

“In the past, people were afraid of going to the health facility because there was a lot of misinformation that they wanted our money. Now we have information and have opened our eyes,” FGD participants in Nampula reported.

In Zambézia, it was noted that MNCH interventions were strongest in communities with more community health workers, but they too can see a clear link between community outreach and increases in ANC visits and facility-based deliveries. Similar trends for immunizations are noted, where five-year targets have already been surpassed in Zambézia and nearly reached in Nampula. For contraceptive use, progress seems to be relatively slower. KIIs with community volunteers in Lugela and Morrumbala districts suggested that women are unable or unwilling to complete the contraceptive cycle package due to traditional attitudes towards birth control and women’s weak position in negotiating family planning in relationships. A shortage of contraceptive drugs continues to be a widespread and persistent problem that has affected the project. The Case Studies in **Annex II** provide additional detail for some of these indicators.

Access to clean water increased; sanitation facilities and hygiene practices improved in Zambézia

In Zambézia, the full WASH program is implemented in six districts, but hygiene and sanitation is implemented in all 16 districts. Participants of KIIs and FGDs in all three districts from which data was collected acknowledged the relevance of the project in building the management capacity of water committees and raising awareness about the correlation between sanitation, hygiene and health prospects, particularly in regard to diarrheal diseases and cholera. Qualitative research also demonstrated challenges in the construction of latrines, as many were not strong enough to withstand the rainy season. The use of tippy-taps for hand-washing also have had limited acceptance (10,357 out of 20,140: 50% of target achieved). Below is a summary of SCIP’s accomplishments to date with WASH activities in Zambézia.

- 87% of target reached with regards to number of people reached with improved drinking water.
- 64% of targeted number of new protected water sources built.
- 77% of targeted rehab of protected water sources completed.
- 101% of targeted number of community-based water committees established, equipped and maintained.
- 170% of targeted number of people trained on water treatment.
- 94% of targeted number of people with access to sanitation facilities.
- 90% of targeted number of household latrines constructed.
- 50% of target number of households with tippy tap installed

Qualitative results in all districts highlighted the relevance of SCIP-provided assistance in promoting guidance to water committees on management of water sources, where available, and raising awareness about the correlations between sanitation, hygiene, and health prospects, with special attention to diarrhea and cholera. However, GOM documents indicate persistent challenges in coordinating water and sanitation activities in Zambézia. As a KII with a GOM representative suggested, factors in the obsolescence of water sources include a lack of effective coordination between the GOM and multiple

partners operating in the WASH sector, weak community engagement, and a paucity of spare parts for repairing water infrastructure. Reports indicate a doubling in non-functional water sources between 2011 and 2012, and according to a GOM official speaking during a KII, the “lack of an effective coordination mechanism between GOM and multiple partners operating in the WASH sector”, coupled with weak community engagement and lack of spare parts for repairing water infrastructure are inhibiting progress in this sector.

Access to Clean water increased; sanitation facilities and hygiene practices improved in Nampula

The full SCIP WASH program is implemented in five of the 14 districts of Nampula. In each district, WASH activities are integrated with other SCIP components. According to available data, progress in WASH areas have improved and increased year by year in most areas. By 2012, SCIP had worked hand-in-hand with *Serviços Distritais de Planeamento e Infraestruturas* (SDPI) to identify damaged pumps as well as the causes of damage.¹⁹ By year three, SCIP has contributed to the repair of 40 of them, either through water committees, local artisans or specialist contractors. Below is a summary of results to date of key WASH indicators in SCIP Nampula:

- 92% of targeted number of rehabilitations completed
- 100% of targeted number of people trained in safe water achieved
- 160% of targeted localities with integrated water and health committees
- 124% of targeted number of households with latrines achieved

CLC FGD members also noted the difference latrines is making in their communities, commenting on the perception of lower cholera and diarrheal disease. In one CLC focus group of nine participants, seven had latrines that were built through the SCIP activities.

Progress toward targets related to pit latrines has been particularly successful, with the number of households building pit latrines increasing yearly (124% of target achieved). The Team found that a multipronged, integrated approach has led to the success, and “*community involvement was higher than expected in the five WASH districts*”. Participants of FGDs with CLCs articulated the community perspective that behaviors in the area of hygiene (such as hand washing) and sanitation (burying rubbish) had reduced, diarrhea and reduced the numbers of flies and mosquitos, and that pit latrines had reduced diarrhea and other diseases. Through training, SCIP has emphasized: the need for participation and commitment of the entire community to achieve complete elimination of open defecation²⁰; and, the importance of hand washing after defecation and before eating. Seventy-five communities have been certified as open defecation-free during external evaluations in 2011 and 2012 that were carried out by a multidisciplinary team of officials from the Provincial Directorates of Public Works and Housing, Education, Culture, Health, Environment, and other District GOM officials, as well as project technicians.

Evaluation Question 8a.

Which interventions are the biggest drivers of increased demand for health services?

¹⁹ January 2012 DPOPH listed 89 damaged water sources in need of repair: 12 in Memba, 31 in Erati, 17 in Monapo, 14 in Nacala Velha and 15 in Nacala Porto. Not all can be repaired as they have dried out, could not be included due to high salinity or insufficient water pressure. None of these were constructed by SCIP.

²⁰ Areas of the community set aside for defecation.

The range of interventions aimed at increasing demand is extremely broad, as is evident from indicators included in the PMP and annual reports:

- **Health:** Increasing knowledge of sexual and reproductive health (SRH) and use of family planning (FP), increasing knowledge and use of ANC services and facility-based deliveries, increased acceptance of child immunization, increased knowledge and practice of exclusive breast feeding, improved behavior change related to HIV, improved knowledge of malaria prevention and treatment.
- **HIV:** increased acceptance of condoms, improved behavior change related to HIV.
- **Nutrition:** increasing knowledge and practice in nutrition.
- **Water:** improved knowledge of water source maintenance.
- **Sanitation:** increasing knowledge and practice in hygiene, increased uptake of latrines and tippy taps.

The biggest drivers of increased demand for health services were: information shared at the community level; improved quality of services at the health facility level; strengthened skills at the community and facility levels; GOM involvement to improve oversight of health facility practices; and improving outreach of services to communities (mobile brigades, maternal waiting houses, health camps, campaigns, trained community volunteers and APEs). APEs received training and retraining support from SCIP implementing partners. It is the inter-relationship between these interventions that creates increased demand, and the stronger the understanding of integrated programming is, the more successful the activities.

OBSERVATIONS ON THE M&E SYSTEMS OF SCIP NAMPULA AND OGUMANIHA

Ogumaniha M&E System

Ogumaniha collects data directly from community volunteers. Initially, each Consortium member took responsibility for collecting data relevant to its role, reporting into a shared monitoring system. As a result, the monitoring system was unwieldy with over 200 indicators. In 2010, FGH (responsible for the monitoring system) began the process of creating a more streamlined and functional system, reducing indicators from more than 200 to 58, and reviewing annual targets for indicators performing $\pm 20\%$ of targets. They also introduced innovations such as an online database — the Ogumaniha Information System (OgIS) — a smart phone mapping and RDQA system, and cross-learning activities between the two programs to inform the M&E process.

The system suffers from a number of known and acknowledged challenges related to the quality of data from community volunteers in semi-literate communities. This challenge goes beyond SCIP, but does underscore the need to develop excellent quality control measures. Capacity needs to be developed at each level and monitored regularly. However, there was evidence that community capacities were patchy, and regular monitoring was not universal. Respondent community volunteers from Morrumbala reported lack of basic materials to record data such as pens and notebooks. Furthermore, whilst Zambézia were subject to periodic quality audits, regular data quality control was limited as M&E offices in the districts are understaffed (KII Ogumaniha). In addition, USAID commissioned external data quality audits in 2012.

Nampula M&E System

SCIP Nampula collects most of its health data from health facility sources, and they conduct regular DQAs on such data.²¹ The benefit of this approach is that SCIP is helping build the quality of health data at facility

²¹ An analysis conducted by the SCIP Nampula M&E team indicates trends of demand increase during specific periods of implementation of Communication campaigns. *SCIP Nampula – 2013 – Análise da Contribuição do Projecto SCIP na Criação de Demanda e Utilização de Serviços de Saúde em 14 Distritos da Província de Nampula.*

through to district levels so that it can demonstrate community trends in health-seeking behaviour by individual health facility. However, it is difficult to wholly attribute such changes in trends to SCIP, given that there are likely other factors at play. When the Evaluation Team discussed this with SCIP Nampula staff, the general sense was that SCIP Nampula was the only partner to the Ministry for remote health facilities, and as such, could be fairly certain that improvements in indicators in these facilities would be due to interventions by SCIP Nampula, and not due to other partners. Nevertheless, SCIP's work to develop the capacity of health facility data means that changes each quarter may be due to improvements in reporting and recording of information rather than in SCIP interventions themselves.

Data for non-health indicators is collected from forms developed for use at the community level. The quality of this data is questioned by SCIP Nampula in their annual reports, which refer to the challenges of collecting data from communities with limited literacy skills. The M&E Coordinators at the district level are aware of these challenges and work directly with communities, but such an approach is time-consuming and expensive, particularly given that there are 10,000 volunteers working within the SCIP Nampula, all of whom are expected to report some data to the district level.

VI. CONCLUSIONS & RECOMMENDATIONS

CONCLUSIONS

Integration

Both consortia are actively integrating activities with multiple ministries, while also leveraging and partnering with other USG-funded partners, including partners with funding from MYAP, PEPFAR, and PMI, to increase relevance and impact. Integration across nutrition, water, sanitation and health achieved the intended result of improving access and quality to each, although integration of WASH activities into the overall SCIP project is limited by funding. This was seen in both consortia in both regions. Results were seen as linked to the bundling or package of services, complementarities and emphasis on building systems. SCIP is showing early signs of promise toward integrating services between community level mechanisms (CLCs) with GOM (health facilities), but much work remains to facilitate open dialogue and equality between these two structures. The integration was seen most strongly at the community level, and was less evident in the oversight and planning offices at the provincial level, particularly in Zambézia.

Sustainability

Sustainability of integrated service delivery through CLCs is evolving. CLCs are likely to continue providing integrated services to communities, since CLCs, as a community structure, pre-dates all projects. Their strong buy-in of the project's long term visions, their perception that they are meeting important and recurrent needs, and their ability to advocate within a policy environment that is currently friendly to community workers enhances sustainability, while minimal financial viability and weak operational infrastructure and public image/legitimacy impedes efforts towards sustainability. CLCs need support in building their confidence in representing their needs and demanding services. Youth participants and their families perceive YFCs as beneficial and effective. YFCs participants appreciated knowledge gained and likely to continue employ lessons learned as part of YFC participation.

Demand for Services

Demands of ANC, institutional delivery and contraceptive services have been created successfully through SCIP activities, resulting in increased service utilization. While additional research is needed to better document the drivers of demand, various interventions ranging from information shared at the community level through community volunteers, to the involvement of the GOM in oversight of health facility practices seem to play a role. Both projects are on track for or have already exceeded targets for WASH, have measurably increased access to safe water, and improved sanitation.

RECOMMENDATIONS

To maintain the effectiveness of integration as a model for service delivery:

- USAID should encourage partners to determine the internal logic of integrated interventions so that the activities are based on community needs and resources are optimized;
- USAID and partners should provide more capacity building support to CLCs in assessing community needs, prioritizing activities and demanding needed services from authorities; activities should focus on developing skills of CLCs to do this analysis from cradle to grave;
- USAID and partners should advocate deeper commitment and support for integrated activities and cross-sectorial planning and follow-through at all GOM levels (particularly in Zambézia).

To establish self-sustainable community structures, SCIP partners should:

- Explore creative use of appropriate community media to elevate perceived CLC status in community;
- Devolve more decision making to the community level, following their lead with regards to ways to more efficiently provide integrated services
- Build CLC and YFCs capacity for financial management, networking, and consider promoting micro-businesses to sustain these community infrastructure;
- Promote opportunities for shared learning between community structure supported, and consider creating friendly competition between communities towards set outcome indicators;
- Develop YFCs graduation criteria based on skills levels achieved instead of age criteria.
- Develop tracking mechanisms for YFC graduates to understand long-term outcome of this activity.

To achieve sustained demand for integrated services, SCIP partners should:

- Strengthen the M&E system and data management to capture demand creation interventions; develop indicators that measures level of integration between community and service provider. For example, number of women that received services at the health facility following referral among those referred by the community worker. Modify WASH indicators to measure usage of intervention- for example: usage of tippy taps instead of number of tippy taps installed.
- Conduct a qualitative assessment of the value of selected activities (especially in regard to the number of community groups created or trained) vis-à-vis demand created; it is likely that some interventions are better at creating demand than other interventions;
- Focus on measuring and improving the quality of services delivered by CLCs after they receive capacity building support from SCIP;
- Increase adherence to formal referral agreements and referral systems, including referral tracking and counter-referral systems to ensure information-sharing between community and GOM systems.

ANNEXES

ANNEX I: EVALUATION STATEMENT OF WORK

SECTION C – STATEMENT OF WORK

BACKGROUND

The Strengthening Communities through Integrated Programming (SCIP) project was developed to increase synergies across USAID/Mozambique’s various health, agriculture, and community programs in Zambézia and Nampula Provinces in order to amplify their collective impact at the provincial, district, and community levels.

OBJECTIVES

The title of the program to be implemented under this contract is the “*Strengthening Communities through Integrated Programming (SCIP) – Performance Evaluation*”.

This performance evaluation comes at the third year of a five year implementation schedule. SCIP activities initially were designed to respond to the USAID/Mozambique Mission Strategic

Objectives (SOs) from the Country Strategic Plan 2004-2010:

Rapid Rural Income Growth Sustained in Target Areas

Increased Use of Child Survival and Reproductive Health Services in Target Areas
Transmission of HIV Reduced and the Impact of the Epidemic Mitigated.

However, by the time SCIP began, the CSP was replaced by the Country Assistance Strategy (CAS) 2009-2014, in which SOs were changed to Assistance Objectives (AOs). SCIP activities therefore also respond to these redesigned mission goals:

Inclusive growth of target economic sector¹ Improve health of Mozambicans

SCIP also supports the achievement of goals outlined in the Partnership Framework by:

Strengthening capacity of both clinical and community-based health care workers; Strengthening linkages between services working towards comprehensive health care;
and
Decentralizing and strengthening of health system

SCOPE OF WORK

Implementation overview

The lead partner for SCIP Zambézia (known locally as Ogumaniha) is World Vision International, which is supported by Johns Hopkins University Center for Communication

¹The emphasis on this goal was reduced with the cancellation of the rural enterprise component.

Programs (JHU/CCP), Vanderbilt University – Friends in Global Health (FGH), ACIDI/VOCA (A/V)², Adventist Development and Relief Agency (ADRA), International Relief and Development (IRD), and the Mozambican Red Cross (CVM). These organizations have established a partnership to integrate community health, nutrition, and HIV and AIDS care program components with the objective to create an integrated self-sustaining support system for target populations.³

The lead partner for SCIP Nampula is Pathfinder International, which is supported by Population Services International (PSI), World Relief (WR), CARE and the Cooperative League of the USA (CLUSA) have established a partnership to integrate health, HIV, and water/sanitation components to contribute to an overall objective of strengthening communities.

SCIP is implemented at provincial, district, and community levels.

In Zambézia Province it is implemented in 16 districts: Namacurra, Alto Molocue, Morrumbala, Gurué, Gile, Pebane, Ile, Lugela, Milange, Mopeia, Chinde, Nicoadala, Quelimane, Mocuba, Maganja da Costa, and Namarroi. The number of beneficiaries is estimated at 3,800,807 people including 646,137 children under five.

In Nampula province it is being implemented in 14 districts: Angoche, Erati, Moma, Malema, Meconta, Mecuburi, Memba, Mogovolas, Monapo, Nacala-Porto, Nacala-Velha, Ribaué, Nampula City, Nampula Rapale and Malema. The number of beneficiaries is estimated at 1,779,927 people including 282,700 children under five.

Project goals and development hypothesis

The overall purpose of SCIP, as outlined in the Activity Approval Document (AAD), is to integrate health, HIV/AIDS, water/sanitation, and rural enterprise components with nutrition and agriculture to strengthen communities in Nampula and Zambézia. The development hypothesis outlines seven key results (see Figure 1) with expected outcomes under each.

In the Cooperative Agreements for each SCIP (submitted separately), the implementing partner identified a specific results framework based on the seven results outlined in the AAD results framework. However, USAID had determined that agriculture funds to support Result 7 (reduce constraints to the development and growth of value chains for focus commodities) would be competitively awarded to only one of the programs. Funds for this area were awarded to SCIP Zambézia; however, the component was dropped in September 2011 due to the desire to harmonize activities in this area under the broader Feed the Future strategy. In figure 1, the result area associated with this component is shaded gray to represent its cancellation.

ACIDI/VOCA has not been part of the consortium since May 2011.

SCIP Zambézia also had a rural enterprise component, but this component was discontinued during the second year.

In addition, both SCIP Zambézia and SCIP Nampula also later established slightly revised results frameworks as part of their Performance Management Plans (PMP), which will be provided to the evaluator upon selection. See Annexes 1 and 2 for a list of indicators that each SCIP reports as part of its PMP. See also Figure 1: SCIP Development Hypothesis.

Integration

The project uses an integrated, multi-sectoral approach to achieve its goals in community health (and rural enterprise in Zambézia, until the cancellation of the relevant component). The holistic approach encouraged in this project is also meant to improve communication among key partners, empower provincial and district-level GOM counterparts, and provide more cost-effective to achieving development results. There are two levels of integration: 1) integration within SCIP across various health and rural enterprise initiatives, and 2) integration with other USG programs in the target areas.

In particular, SCIP was designed to build on the platform of PL 480 Food for Peace Title II Multi-Year Assistance Program (MYAP) with complementary activities. MYAP has been in place in Zambézia and Nampula since 2008 with the overall goal to reduce food insecurity in selected communities. Primary agriculture activities are focused on the organization, structuring, legalization, and support of farmer associations, business training for these associations, and the establishment of demonstration plots to transfer best practices. A health and nutrition component includes activities such as growth monitoring, health council creation and support, and health and nutrition education for households. MYAP is operating in 13 districts in Zambézia and 14 districts in Nampula, in roughly half of the communities in each district. There is considerable but not complete overlap between MYAP and SCIP communities.⁴ The current MYAP program is slated to end in July 2013.

Program/Project Information

USAID/Mozambique’s SCIP portfolio currently consists of 2 different projects each striving to achieve specific goals and contribute to achieving IHO and ATB’s higher level goals, as listed below:

Project Title: Strengthening Communities through Integrated Programming (SCIP)

	<u>Zambézia</u>	<u>Nampula</u>
Start-End Dates:	July 1, 2009 – June 30, 2014	August 1, 2009 – July 31, 2014
Budget:	\$49,412,197	\$47,600,000
Implementing Organization	World Vision International	Pathfinder International

SCIP Nampula has two “packages” of activities: one in areas that overlap with Title II activities and one in areas where there is no overlap.

Target Areas and Groups

The coverage for World Vision International (Zambézia) and Pathfinder International (Nampula) is in two provinces.

Critical Assumptions

The critical assumptions as outlined in the SCIP PMP are: 1) that political and civil stability will generally prevail; and 2) that no major natural disasters will occur

Existing Data

Baseline survey: Both SCIPs undertook a baseline survey in late 2010 (this was not a “true” baseline in that implementation had already started in late 2009). Each SCIP developed its own survey tool, but in general both collected information on malaria prevention, treatment-seeking behavior for childhood illnesses, childhood immunization, contraceptive use, receipt of ante-natal care services, prevalence of deliveries in health facilities, breastfeeding practices, water and sanitation access/use, HIV knowledge, attitudes, and practices, and basic demographic information. The Nampula survey also includes information on child anthropometrics. Both SCIPs are planning to do an endline survey near program completion. SCIP Zambézia’s baseline survey report is found online at the following link: http://www.globalhealth.vanderbilt.edu/community-and-service/SCIP/scip_docs/report_20110531.pdf/view.

Monitoring data: Both SCIPs collect substantial regular monitoring data and report it quarterly to USAID. Performance Management Plans (with a list of the indicators tracked and annual targets) and the most recent annual reports (for the 12-month period October 2010-September 2011) will be provided to the evaluator to review.

Activity mapping: SCIP Zambézia has conducted a mapping of its activities and has a database that shows which activities and services are available in which communities. This mapping was completed in 2011, but another round is planned for mid-2012.

Health facility records: Health facilities maintain records and monthly summaries of services provided.

Evaluation Fundamentals

Audience

The primary audience of the evaluation report will be the USAID/Mozambique Mission, specifically the Integrated Health Office and Agriculture Trade and Business teams, the Mission Management team, the Program Office, and the Financial Office. The implementing partners will be another key audience. In addition, summary points and recommendations will be provided to other stakeholders including the Ministry of Health (MOH), the Ministry of Women and Social Action (MMAS), the Ministry of Public Works and Housing (MOPH), the Provincial Directorates of Health (DPS), the Provincial Directorate of Women and Social Action (DPMAS), and the Provincial Directorates of Public Works and Housing (DPOPH), and community members, as relevant.

Intended Uses

USAID/Mozambique will use the report to facilitate discussions internally and with the implementing partners about whether changes to the implementation plan are recommended for the duration of the program. The findings will also be used to inform future project design. It will also be used to enhance in-house organizational learning and will provide important information about integrated programs to stakeholders, including the GOM and implementing partners.

Evaluation Questions

The evaluation will seek to address the following questions in the areas outlined below:

Integration of the SCIP activities

To what extent is the SCIP activities integrated in practice?

How successfully have components (youth farmers club, water/sanitation, health) been integrated within SCIP?

How successfully do SCIP interventions integrate with or build upon other USG interventions, including MYAP?

What have been the management and implementation benefits of program integration?

What are the management and implementation challenges of program integration?

a) Do certain program areas get reduced attention because of the management needs of other program areas?

Community-based organizations⁵

To what extent is the SCIP strategy strengthening the relationship between Community Leader Councils (CLCs) and other government structures?

Do community organizations supported by SCIP exhibit characteristics that are linked to a greater likelihood of continued level of activity after the completion of the SCIP activities?

Community Health Mobilization

To what extent has SCIP succeeded in creating demand for health services?

Which interventions are the biggest drivers of increased demand for health services?

Youth Farmers Clubs

To what extent do youth participants and their families perceive youth farmers clubs to be beneficial?

What aspects of the YFCs are most beneficial and effective?

To what extent do former participants in YFCs who “aged-out” of the program continue to employ lessons learned as part of YFC participation?

Recommendations

Based on the above evaluation questions the Evaluation Report should provide targeted evidence as generated from the evaluation to make actionable recommendations for improving SCIP implementation in its final years and for planning future integrated programs.

Technical Requirements Evaluation Scope

This Evaluation will cover SCIP activities in Nampula and Zambézia provinces that are focus on Health activities. Since this program is a result of integration of Health and Economic growth, a review of relevant documents from the two teams since the approval of CAS until today will be required.

Evaluation Design

The evaluation will utilize a combination of quantitative and qualitative data collection and analysis, using primary and secondary data sources to answer the questions outlined above. Suggested methods will include (1) review of relevant program related documents, (2) in-depth interviews of key informants and/or focus groups, (3) analysis of performance monitoring data.

To establish a basis on which to build, the evaluation team should review all relevant documents/resources about the projects, including, but not limited to the online resources listed below. USAID will supply a complete set of additional project documents to the evaluation team at the beginning of the evaluation.

SCIP Zambézia:

SCIP Nampula:

<http://www.ogumanihascip.org/>
<http://adramozambique.org/en/ogumaniha.html>

http://www.pathfind.org/site/PageServer?pagename=Programs_Mozambique_Proje_cts SCIP

<http://www.globalhealth.vanderbilt.edu/community-and-service/SCIP>

<http://www.care.org/careswork/projects/MOZ071.asp>

Evaluation Methods

Data collection methods

Evaluation Design and Data Collection Methods

This section outlines some guidance for evaluation design for each of the three evaluation areas. The evaluator is expected to expand and improve upon (or revise) this guidance, as necessary. A detailed design and evaluation plan is required as the first deliverable of the evaluator. The final design will be documented and agreed to in writing.

Integration of the SCIP activities

USAID/Mozambique requests that the evaluator propose a framework and assessment tools to properly measure integration and assess its benefits. In particular, USAID is interested in the following aspects of integration but welcome additional proposals from the evaluator: 1) the extent to which there is

overlapping coverage, i.e., activities are implemented in the same areas, 2) the extent to which there is coordination in planning, implementation, and on-going assessment among the different activity areas, and 3) the extent to which the different activity areas leverage one other to maximize benefit,

There are two levels of integration: 1) within-SCIP integration of program elements, and 2) integration with external USAID programs. To assess internal integration of programs within SCIP, the approach to this question will likely entail at a minimum key informant interviews with SCIP management of USAID (in the Integrated Health Office and the Agriculture Trade and Business Office) and implementing partners. To assess external integration, SCIP's integration with MYAP, the team will likely also meet with the USAID management team and implementing partners of MYAP. For SCIP Zambézia, the evaluator should also analyze the activity mapping done by the implementing partner to address the questions around integration.

Quantitative monitoring data from the implementing partners should be used as necessary to support qualitative information on whether certain program areas get reduced attention.

The evaluator will also likely want to include relevant GOM structures (e.g. governor's office, provincial health departments (*Direcção Provincial de Saúde*, DPS), provincial departments of women and social action (*Direcção Provincial da Mulher e Acção Social*, DPMAS), provincial departments of public works and housing (*Direcção Provincial de Obras Públicas e Habitação*, DPOPH), and district services for health, women, and social action (*Serviços Distritais de Saúde, Mulheres e Acção Social*, SDSMAS).

Community-based organizations

For this evaluation area, the methodology may entail individual interviews with leaders of community organizations (i.e. CLCs, CHCs, ACSs), as well as key informant interviews with health facility staff, implementing partners, and relevant local GOM structures.

For question 6, *Do community-based organizations supported by SCIP exhibit characteristics that are linked to a greater likelihood of continuation after the completion of the SCIP activities?*, USAID requests that the evaluator establish (or utilize a pre-existing) framework that enumerates the key organizational characteristics that are associated with future sustainability based on the research literature in this area. The evaluator would then evaluate the community-based organizations against those characteristics.

Community Health Mobilization

For this evaluation area, the methodology may entail individual interviews with beneficiaries (community members), as well as key informant interviews with the community organizations

(i.e. CHCs, ACSs), activists actually undertaking mobilization activities, implementing partners, and relevant local government structures. Since this question also seeks to assess progress toward results, qualitative findings should be analyzed in conjunction with analysis of quantitative monitoring data from the implementing partner and/or from health facilities. In addition, the implementer should also take into account the information from a baseline survey conducted in late 2010.

The evaluator should select to focus this question on certain health services to be agreed upon with USAID, for example: use of ante-natal care services, use of assisted deliveries/institutional births, use of

immunization services, use of insecticide-treated nets, use of appropriate treatment for diarrhea, use of contraceptives, etc.

Youth Farmer Clubs

For this evaluation area, the methodology could include a survey, focus groups, and/or interviews with current and former participants of youth farmer clubs and family members of participants. Former participants should include, if possible, not just those who “aged out” but also those who may have dropped out for other reasons.

USAID will rely on the expertise of the evaluator to come up with the appropriate methodology and questions. However, to the extent possible, USAID would be interested in obtaining information that might indicate whether or not Youth Farmer Clubs are likely to continue after the completion of the SCIP and what aspects of the project are most beneficial, including which message areas are most useful/best understood. Since these questions also seek to assess progress toward results, qualitative findings should be analyzed in conjunction with an analysis of quantitative monitoring data from the implementing partner.

Review of secondary source data

In addition to collecting original data for the evaluation through interviews and focus groups, etc., there are a number of pre-existing data sources from which the evaluator can draw.

Baseline survey: Both SCIPs undertook a baseline survey in late 2010 (this was not a “true” baseline in that implementation had already started in late 2009). Each SCIP developed its own survey tool, but in general both collected information on malaria prevention, treatment-seeking behavior for childhood illnesses, childhood immunization, contraceptive use, receipt of ante-natal care services, prevalence of deliveries in health facilities, breastfeeding practices, water and sanitation access/use, HIV knowledge, attitudes, and practices, and basic demographic information. The Nampula survey also includes information on child anthropometrics. Both SCIPs are planning to do an endline survey near program completion. SCIP

Zambézia’s baseline survey report is found online at the following link:
http://www.globalhealth.vanderbilt.edu/community-and-service/SCIP/scip_docs/report_20110531.pdf/view.

Monitoring data: Both SCIPs collect substantial regular monitoring data and report it quarterly to USAID. Performance Management Plans (with a list of the indicators tracked and annual targets) and the most recent annual reports (for the 12-month period

October 2010-September 2011) will be provided to the evaluator to review.

Activity mapping: SCIP Zambézia has conducted a mapping of its activities and has a database that shows which activities and services are available in which communities. This mapping was completed in 2011, but another round is planned for mid-2012.

Health facility records: Health facilities maintain records and monthly summaries of services provided.

The table below provides an illustrative evaluation design matrix that links the evaluation questions with data sources, data collection methods, and analysis methods.

Sampling of sites

SCIP operates in 30 districts across two provinces, so it will be necessary to sample from among beneficiary communities to create a manageable task. A suggested approach would be to limit the districts in which the evaluation would take place to three to four per province and limit the communities selected within those districts to one to two. Ideally, it is important to capture a diversity of community characteristics (e.g. more urban, more rural, on a main road, off the main roads, etc.); however, time and cost should also be factored into the selection of the sites for the evaluation. USAID requests that the evaluator submit a process to determine a sampling plan as part of the first deliverable, the Evaluation Framework.

Analysis of gender, geographic and other differences

USAID expects the evaluator to consider whether answers to questions are different for different groups, particularly for the questions on community level organizations and various initiatives.

Community organizations

How do answers compare across different types of community-based organizations?

How do answers to the questions compare across the two provinces?

Within Nampula, how do the answers compare across the two different models/approaches?

Community health mobilization

To the extent that community organizations are increasing demand for health services, how does the change in demand compare among men and women, among youth and adults, and for guardians of children under age 5?

How do the results compare across provinces and models?

Perceptions of specific initiatives

Youth farmer clubs

Do male and female participants derive different utility?

Do male and female household heads derive different utility from their participation or from the participation of their dependent family members in

YFCs?

Do orphans and vulnerable children (OVC) impacted by HIV and AIDS derive different utility from non-OVC?

How do perceptions of utility differ across provinces?

Conservation agriculture

Do male and female beneficiaries derive different utility

How do perceptions differ across provinces?

Data disaggregation

We also expect that the evaluator will employ cross-sectional analysis to look at potential differences by gender, age, geography, etc. as they relate to changes in indicators values. These are broad, notional ideas of quantitative analysis to accompany the qualitative components.

Data Quality standards

Generally, the data collected should adhere to the rigorous requirements for data quality as stipulated in the new USAID Evaluation Policy as in ADS 578 and ADS 203. This Evaluation Policy and ADS 203 and 578 will be provided to the consultants prior to commencing the evaluation. The Inception Report should detail how the evaluation team will ensure the data collected will meet these requirements.

Data analysis

Qualitative data from interviews and focus groups will first be transcribed; transcription will be turned in to USAID as a key deliverable at the end of the project. Qualitative data should then be coded for pattern analysis. The coding process should look for emerging key words and phrases in the responses, as well as latent meaning behind responses. Where it is possible to quantify qualitative data (e.g. x% of respondents considered the intervention to be useful), this is encouraged. The evaluator is then asked to interpret the qualitative findings to extract meaning from the information gathered.

For the evaluation questions that will include triangulation of qualitative information with an analysis of pre-existing monitoring data and/or health facility records, a variety of data analysis techniques may be applicable. Because this evaluation is non-experimental, it is expected that data analysis will largely focus on descriptive statistics. It is expected that the evaluator will look at changes over time in indicators of interest, using before-and-after analysis or a limited time series analysis (where enough data points are available). We also expect that the evaluator will employ cross-sectional analysis to look at potential differences by gender, age, geography, etc. as they relate to changes in indicators values. These are broad, notional ideas of quantitative analysis to accompany the qualitative components.

It is expected that the evaluator will further elaborate a data analysis strategy, including the identification of the software packages to be used for qualitative and quantitative analyses, in the proposal. Upon selection, the evaluator will refine this proposal based on receipt of additional program data.

Constraints to data collection and analysis

A number of factors could constrain the ability to collect data or analyze data.

Geography and infrastructure: Zambézia and Nampula provinces cover nearly 185,000 square kilometers. Most roads within districts are not paved, which leads to longer travel times, particularly as the rainy season progresses (roughly November through April). To help control travel time, it will likely be

necessary to purposively sample the districts and communities in which the evaluation will take place (see section on sampling of sites below).

Language: There are a dozen or so local languages spoken in Zambézia and Nampula; many people do not speak Portuguese. This will likely require translation into one or more local languages. Verbal translation is readily available, but in many cases written translation will be very difficult to locate. The evaluator is requested to propose how it might conduct and record information from focus groups in these types of circumstances.

Limited sample: Question 8 asks about what happens to youth after they “age out” of the youth farmer club program. Since the program has only been underway for just over two years and many youth were younger pre-teen or adolescents when they started YFC participation, there may not be a large number of “graduates” from the program. The evaluator should discuss the limitations of a small sample as part of any findings.

Data quality: There are some known challenges to collecting high quality monitoring data for community-level programs (e.g. double counting of participants in community activities, counting people outside the “target audience,” problems with data collectors’ understanding of indicator definitions or data collection forms, etc.). Both SCIP activities have monitoring and evaluation teams in place whose staff makes concerted efforts to address and minimize these challenges; however, since it is a continuous process, it is likely that some problems still exist. The evaluator should discuss known limitations with the implementing partners’ monitoring and evaluation teams in order to better understand these challenges and caveat findings as appropriate.

LOE and budget

The final budget for this Evaluation is \$254,296.69. The duration is 14 weeks for all team members.

IMPLEMENTATION AND MANAGEMENT PLAN - EVALUATION TIMELINE

The contractor’s performance will be evaluated based on the completion of specific tasks as outlined in the Task Order, adherence to the work plan, and reports submitted to the Contracting Officer Representative (COR).

Personnel and Logistics

The contractor should provide the following key personnel for the performance of this task order. The following four positions are considered Key Personnel.

Name Position

Ms. Susan Amoaten – Team Leader

Dr. Cristiano Matsinhe – Deputy Team Leader

Mr. Juliao Matsinhe - Community Health Evaluation Specialist

Mr. Santos Alfredo -Community Health Evaluation Specialist

The individuals identified above are considered to be essential to the work being performed; they are considered to be “Key Personnel”. Unless otherwise agreed to in writing by the Contracting Officer, the contractor shall be responsible for providing such personnel as specified in the Task Order.

Failure to provide the key personnel designated above may be considered as being grounds for nonperformance by the contractor, unless such failure is beyond its control, and through no fault or negligence.

The contractor shall immediately notify the COR and Contracting Officer of any key personnel’s departure, and the reasons for the departure. The contractor shall take the necessary steps to immediately rectify this situation and shall propose a substitute candidate for each vacated position along with a budget impact statement, if requested, in sufficient detail to permit evaluation of the impact on the program.

However, the contractor shall not replace any of the individuals in this Section without the prior written approval of the Contracting Officer.

USAID reserves the right to adjust the level of key personnel during the performance of this task order.

Implementation and Management Plan

The Implementation and Management Plan is included in IBTCI’s proposal, which is attached.

[END OF SECTION C]

ANNEX 2: DATA COLLECTION MATRIX

Evaluation Question	Data Source	Data Collection Method	Data Analysis Method
#1 To what extent is the SCIP activities integrated in practice?	Activity mapping (Zambézia)	Pre-existing data	Levels of Integration Rubric (Woodland & Hutton, 2012) Collaborative Outcome Reporting Technique (CORT) Expert Panel
	Implementing Partner managers and staff USAID/SCIP managers USAID/MYAP managers	Key Informant Interviews Document review	
#1a How successfully have components (youth farmers club, water/sanitation, health) been integrated within SCIP?	Activity mapping (Zambézia)	Pre-existing data	
	Implementing Partner managers and staff USAID/SCIP managers	Key Informant Interviews Document review	
#1b How successfully do SCIP interventions integrate with or build upon other USG interventions including MYAP?	Activity mapping (Zambézia)	Pre-existing data	
	Implementing Partner managers and staff USAID/MYAP managers	Key Informant Interviews Document review	
#2 What have been the management and implementation benefits of program integration?	Implementing Partner managers and staff USAID/SCIP managers	Key Informant Interviews Document review	Levels of Integration Rubric (Woodland & Hutton, 2012) CORT Expert Panel
#3 What are the management and implementation challenges of program integration?	Implementing Partner managers and staff USAID/SCIP managers	Key Informant Interviews Focus Group Discussions (FGD) with Youth Farmer Club (YFC) participants, dependents and drop-outs	Levels of Integration Rubric (Woodland & Hutton, 2012)

Evaluation Question	Data Source	Data Collection Method	Data Analysis Method
		Document review	CORT Expert Panel
#3a Do certain program areas get reduced attention because of the management needs of other program areas?	Implementing Partner managers and staff USAID/SCIP managers	Key Informant Interviews FGD with YFC participants, dependents and drop-outs Document review	
#4 To what extent is the SCIP strategy strengthening the relationship between Community Leader Councils (CLCs) and other government structures?	Community Leader Councils (CLC) Implementing partner management and staff Local government structures	Key Informant Interviews	Attributes of Sustainable Health Programs Framework (Bongiovanni A, et.al, 2012 CORT Expert Panel
	Health facility staff (nurses, midwives, and doctors) Community Health Agents (ACS) Elementary Polyvalent (health) Agents (APE)	FGD *Selective Key Informant Interviews with health facility staff	
#5 Do community organizations supported by SCIP exhibit characteristics that are linked to a greater likelihood of continued level of activity after the completion of the SCIP activities?	CLCs Implementing partner management and staff Local government structures	Secondary data sources for health outcomes (i.e., health statistics, recent studies and surveys)	Attributes of Sustainable Health Programs Framework (Bongiovanni A, et.al, 2012 CORT Expert Panel
#6 To what extent has SCIP succeeded in creating demand for health services?	Community Health Councils (CHC) (Zambézia) CLCs Implementing partner management and staff	Key Informant Interviews	Thematic Analysis <i>NB: This analysis will contribute to the Attributes of Sustainable Health Programs Framework.</i>

Evaluation Question	Data Source	Data Collection Method	Data Analysis Method
	Local government structures Activists/Community Mobilizers		CORT Expert Panel
	ACs APEs Health facility staff	FGD	
	Beneficiaries (i.e., men and women of reproductive age (in separate groups); pregnant women (multi-parous with living infants and children under five years);	FGD	
#6a Which interventions are the biggest drivers of increased demand for health services?	YFC participants, families, dependents and drop-outs	FGD	
#7 To what extent do youth participants and their families perceive youth farmers clubs to be beneficial?	YFC participants, families, dependents and drop-outs	FGD	Thematic Analysis <i>NB: This analysis will contribute to the Attributes of Sustainable Health Programs Framework.</i>
	SCIP Performance Monitoring Plan (PMP) results	Pre-existing data source	
#7a What aspects of the YFCs are most beneficial and effective?	YFC participants, families, dependents and drop-outs	FGD	
#8 To what extent do former participants in YFCs who “aged-out” of the program continue to employ lessons learned as part of YFC participation?	YFC “graduates”	Key Informant Interviews Also FGD if access to large numbers of graduates	Attributes of Sustainable Health Programs Framework (Bongiovanni A, et.al, 2012)

ANNEX 3: LIST OF DOCUMENTS REVIEWED

Collaboration Evaluation and Improvement Framework. Woodland & Hutton.

Comparaç o mapeamento 2011 e 2012.

Comprehensive Knowledge of HIV among Women in Rural Mozambique: Development and Validation of the HIV Knowledge 27 Scale. Philip J. Ciampa, Shannon L. Skinner, Sergio R. Patricio, Russell L. Rothman, Sten H. Vermund, Carolyn M. Audet. October 31, 2012.

Conselho de Saude - 12-11-12 update.

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Evaluating the coverage of, communication by, and cost of community health worker programs in Nampula and Gaza provinces in Mozambique: Terms of Reference. Global Surveys Corporation, June, 2012.

Global HIV/AIDS Response : Epidemic update and health sector progress towards Universal Access. 2011 Progress Report. World Health Organization.

GSC Question and Answer for CHW. November 29, 2012.

Health Facility Data - 06-11-12 update (3).

Letter to Susan About Background Materials. Jessica Gajarsa.

Mozambique PEPFAR Interagency Partner Performance Review. August 31, 2010.

NHA Indicators. The World Health Organization.

NHA Indicators, The World Health Organization. Annette Bongiovanni, November 30, 2012.

Ogumaniha Final, Version 2.

Ogumaniha PMP Final. December 10, 2010.

Pathfinder International's Integrated Systems Strengthening Framework. Pathfinder International.

Performance Evaluation of the USAID/Mozambique Agriculture Portfolio. Mendez England & Associates

Performance Management Plan: USAID funded Ogumaniha SCIP Zamb zia Program. USAID, December 2011.

Presentation on Evaluating and Improving Organizational Collaboration. Woodland et. al.

Proposal for Research Study on Community Health Services Providers: Technical and Financial Proposal. Glocal Surveys Corporation Research and Pathfinder International. March 2012.

SCIP Nampula Activity Sheet Template. November 2010.

SCIP Nampula Annual Report: October 2009 – September 2010. USAID, October 30, 2010.

SCIP Nampula Annual Report: October 2010 – September 2011. USAID, October 31, 2010.

SCIP Nampula Annual Report: October 2011 – September 2012. USAID, October 31, 2012.

SCIP Nampula Baseline Survey. USAID, March 22, 2011.

SCIP Nampula Cooperative Agreement No. 656-A-00-09-00134-00. USAID, August 1, 2009.

SCIP Nampula Performance Management Plan. Pathfinder International, October 30, 2009.

SCIP Nampula Project Fiscal Year 4 Work Plan Narrative.

SCIP Nampula Project Work Plan: Year 3.
SCIP Nampula Project Work Plan: Year 4.
SCIP Nampula Quarter 1 Report: October – December 2009. USAID, February 15, 2010.
SCIP Nampula Quarter 1 Report: October – December 2011. USAID, January 31, 2012.
SCIP Nampula Quarter 1 Report: October – December 2012. USAID.
SCIP Nampula Quarter 2 Report: January – March 2010. USAID, May 24, 2010.
SCIP Nampula Quarter 2 Report: January – March 2011. USAID, April 31, 2011.
SCIP Nampula Quarter 2 Report: January – March 2012. USAID, April 30, 2012.
SCIP Nampula Quarter 3 Report: April – June 2010. USAID, July 30, 2010.
SCIP Nampula Quarter 3 Report: April – June 2011. USAID, August 1, 2011.
SCIP Nampula Work Plan: August 2009 – September 2010.
SCIP Ogumaniha Annual Report: July 2009 – September 2010. USAID, November 5, 2010.
SCIP Ogumaniha Annual Report: October 2010 – September 2011. USAID, October 31, 2011.
SCIP Ogumaniha Annual Report: October 2011 – September 2012. USAID, October 31, 2012.
SCIP/Zambézia Factsheet. October 11, 2012.
Unidade Sanitária - 31-10-11.
WASH-Nutrition Child Anthropometrics Baseline Summary. USAID.

ANNEX 4: DATA COLLECTION TOOLS

SCIP Midterm Evaluation FGD GUIDELINES

Beneficiary Entities

(CLCs/HCs, CLLs, YFCs, Women First - at district and community level)

Type of Beneficiaries:

of Participants

Location:

Date:

Other info:

	Interview Topics/Questions
Background	a. For how long have you been working/benefiting with/from SCIP initiatives? What are the exact activities you are involved in?
Integration of the SCIP activities <i>Domain: Effective Integration</i>	
1. To what extent is the SCIP activities integrated in practice?	<p>a. At what extent those activities/services are linked to other activities services supported by SCIP at community level? Provide examples of interlinked services or activities being implemented in this district, community (ex: WASH, Health, Agri-business, etc.).</p> <p>b. How do you assess the quality/benefit for those integrated services? What are the results so far? Provide specific examples?</p>
3. What are the management and implementation challenges of program integration?	a. What are the specific challenge faced at different levels (community level, district level, provincial level and national policy level) to ensure program (activities and services) integration, management and implementation? Provide specific examples.
	Community-based organizations <i>Domain: Self-sustained Support System</i>

	Interview Topics/Questions
4. To what extent is the SCIP strategy strengthening the relationship between Community Leader Councils (CLCs) and other	a. <i>What changes have been observed, positive and negative in the relationship between CLCs and other government structures (ex: health facilities)? Which changes can be attributed to work from the SCIP activities?</i>
5. Do community organizations supported by SCIP exhibit characteristics that are linked to a greater likelihood of	a. <i>What have been the main SCIP methods used to build capacity of CLCs, YFCs, and APEs? Training, mentoring, inputs (bicycles, equipment etc.), providing guidelines, peer support, exchange visits and how do you assess the results/outcome? Explain and provide specific examples</i>
	Community Health Mobilization Domain: <i>Demand for Services</i>
6. To what extent has SCIP succeeded in creating demand for health services?	<p>a. <i>Which interventions are the major drivers of increased demand for health services (including wash, agriculture)? Explain at what extent SCIP is contributing to that.</i></p> <p>b. <i>What is the level of involvement of males and females in accessing and use of available services? Provide examples</i></p> <p>c. <i>How do you assess the quality of services provided? Why?</i></p>
	Youth Farmers Clubs
7. To what extent do youth participants and their families perceive youth farmers clubs to be beneficial?	<p>a. <i>What are the main activities of YFCs, and which are most beneficial and effective?</i></p> <p>b. <i>Do male and female participants derive different utility?</i></p> <p>c. <i>Do male and female household heads derive different utility from their participation or from the participation of their dependent family members in YFCs?</i></p> <p>d. <i>Do orphans and vulnerable children (OVC) impacted by HIV and AIDS derive different utility from non-OVC?</i></p> <p>E <i>How many Youth Farmer Clubs have been “graduated” and are continuing to employ lessons learned as part of YFC participation? And what are the most valuable aspects/ components leading to continuation (farming techniques, technology, conservation farming, food handling and storage, linkages with market, etc.)? Explain.</i></p>

SCIP Midterm Evaluation – KII GUIDELINES

SCIP- SERVICE DELIVER LEVEL PROVINCIAL & DISTRICT LEVEL

(Chief Medical Officer, Health Facility Managers, Mobile Brigades, APEs, Nurses -at Provincial, District and Community levels)

Organization:	_____	Name of Person:	_____
Location:	_____	Date:	_____
Role/Function	_____	Other Info:	_____

	Interview Topics/Questions
Background	<p>a. <i>For how long have you been working with SCIP and what your role encompasses?</i></p> <p>b. <i>What is your understanding about the SCIP activities and the concept of integration behind SCIP?</i></p>
Integration of the SCIP activities	
Domain: Effective Integration	
1. To what extent is the SCIP activities integrated in practice?	<p>a. <i>How SCIP articulates the activities in terms of Planning, Harmonization and Coordination with different Consortium members, program areas (water/ sanitation, health) and other USG interventions (ex: MYAP)? Provide concrete examples?</i></p> <p>b. <i>At what extend have the components been integrated with government initiatives (annual plans, sectoral plans, district development plans, provincial strategic plans)? What are the contributing factors and challenges?</i></p>
2. What have been the management and implementation on benefits of program integration?	<p>a. <i>To what extent has SCIP contributed to improved integrated management practices at different levels/ sectors - e.g. governor's office, provincial health departments, provincial departments of women and social action, provincial departments of public works and housing and district services for health, women, and social action. Provide Specific examples.</i></p>
3. What are the management and implementation challenges of program integration?	<p>a. <i>What are the specific challenge faced at different levels (community level, district level, provincial level and national policy level) to ensure program integration, management and implementation? Provide specific examples.</i></p>
	<p>Community-based organizations <i>Support System</i></p> <p align="right">Domain: Self-sustained</p>

	Interview Topics/Questions
4. To what extent is the SCIP strategy strengthening the relationship between Community Leader Councils (CLCs) and other government structures?	<p>a. Which other government structures do CLCs work with? And How do CLCs work with other government structures (i.e. regular formal minuted meetings). In what ways do CLCs work with other govt structures (i.e. collaboration, coordination, planning, quality assurance)?</p> <p>b. What changes have been observed, positive and negative in the relationship between CLCs and other government structures? Which changes can be attributed to work from the SCIP activities?</p> <p>c. What is the relationship between CLCs and health facilities? Are meetings pre-organised or on a case-by-case basis, in what ways do HF's utilize CLCs ie. Adherence to govt health guidelines, health service quality assurance, improved health-seeking behavior?</p>
5. Do community organizations supported by SCIP exhibit characteristics that are linked to a greater likelihood of continued level of activity after the completion of the SCIP activities?	<p>a. What have been the main SCIP methods used to build capacity of CLCs, YFCs, and APEs? Training, mentoring, inputs (bicycles, equipment etc.), providing guidelines, peer support, exchange visits and how do you assess the outcome? Explain and provide specific examples</p> <p>b. How have community organizations been integrated into communities and government health and livelihood structures? At what extent are they linked with SDSMAS, or DPS?</p> <p>c. At what extent the community health promoters trained under SCIP activities exhibit characteristics that are linked to a greater likelihood of continued level of activity after the completion of the SCIP activities? What are the evidence or basis for your assessment?</p> <p>d. What are the mechanisms in place to absorb the Community Health Agents (ACS), and Elementary Polyvalent (health) Agents (APEs) by the National Health System?</p>
	Community Health Mobilization Demand for Services Domain:
6. To what extent has SCIP succeeded in creating demand for health services?	<p>a. Which interventions are the major drivers of increased demand for health services (multiple health services including wash)? Provide evidence data and explain at what extent SCIP is contributing to that.</p> <p>b. What is the level of involvement of males and females in accessing and use of available services? Provide evidence data sources and age groups desegregated information.</p> <p>c. How the users / beneficiaries assess the quality of services provided? And at what extend the beneficiaries perceive the linkages/ integration of services provided? What is you source of information, evidence?</p>
	Youth Farmers Clubs
7. To what extent do youth participants and their families perceive youth farmers clubs to be beneficial?	<p>a. What are the main activities of YFCs, and which are most beneficial and effective?</p> <p>b. Do male and female participants derive different utility?</p> <p>c. Do male and female household heads derive different utility from their participation or from the participation of their dependent family members in YFCs?</p> <p>d. Do orphans and vulnerable children (OVC) impacted by HIV and AIDS derive different utility from non-OVC?</p>

	Interview Topics/Questions
<p>1. 8. To what extent do former participants in YFCs who “aged-out” of the program continue to employ lessons</p>	<p><i>a. How many Youth Farmer Clubs have been “graduated” and are continuing to employ lessons learned as part of YFC participation? And what are the most valuable aspects/components leading to continuation (farming techniques, technology, conservation farming, food handling and storage, linkages with market, etc.)? Provide evidence data.</i></p> <p><i>b. For YFC members who “drop-out” what are the main reasons?</i></p>
<p>9. Lessons Learned</p>	<p><i>a. What are the lessons learned from SCIP so far?</i></p>

Interview Topics/Questions	
Background	<p>a. For how long have you been working with SCIP and what your role encompasses?</p> <p>-----</p> <p>b. How SCIP was conceived and what was the rationale?</p> <p>-----</p> <p>c. Which concept of integration SCIP works with or aim to achieve?</p> <p>-----</p> <p>d. How the implementation arrangements were defined and what are the differences between the two provinces (Nampula and Zambézia)?</p> <p>-----</p>
1. To what extent is the SCIP activities integrated in practice?	<p>a. How SCIP articulates the activities in terms of Planning, Harmonization and Coordination with different Consortium members, program areas (water/sanitation, health) and other USG interventions (ex: MYAP)? And what is the Role of USAID Maputo in leading those interactions? Provide concrete examples?</p> <p>-----</p> <p>b. How do you assess the level of integration of progress/success of SICIP towards its mains objectives?</p> <p>-----</p> <p>c. At what extend have the components been integrated with government initiatives (annual plans, sectoral plans, district development plans, provincial strategic plans)? What are the contributing factors and challenges?</p> <p>-----</p>
2. What have been the management and	<p>a. To what extent has integration improved resource usage: economies of scale of VIPs, increased geographical coverage and reduced overlap, reduced 'double counting' of services provided to beneficiaries, improved beneficiaries access to multiple services simultaneously. Any differences between the two provinces?</p> <p>-----</p>
3. What are the management and	<p>a. What are the specific challenge faced at different levels of SCIP Implementation (community level, district level, provincial level and national policy level) to ensure program integration, management and implementation? Provide specific examples.</p> <p>-----</p>
	<p>Community-based organizations Domain: Self-sustained Support System</p> <p style="text-align: right;">73</p>
y ted by	<p>a. What have been the main SCIP methods used to build capacity of CLCs, YFCs, and APEs? Training,</p>

SCIP Midterm Evaluation - KII GUIDELINES

USAID Personnel - Maputo

Name of Person:

Interview Date:

Role/Function

Other Info:

SCIP– Midterm Evaluation - KII Guidelines

SCIP Implementation Personnel

(Chief of Party, M&E Manager, representatives of all five organizations implementing SCIP)

Organization: _____ Name of Person: _____

Location: _____ Date: _____

Role/Function _____ Other Info: _____

	Interview Topics/Questions
Background	<p>a. For how long have you been working with SCIP and what your role encompasses?</p> <p>b. How SCIP was conceived and what was the rationale?</p> <p>c. Which concept of integration SCIP works with or aim to achieve?</p> <p>d. How the implementation arrangements were defined and what are the differences between the two provinces (Nampula and Zambézia)? (conceptual level)</p>
Integration of the SCIP activities Domain: Effective Integration	
1. To what extent is the SCIP activities integrated in practice?	<p>a. To what extent is coordination and harmonization in planning, implementation, and on-going assessment happening among the different Consortium members in different activity areas?</p> <p>How SCIP articulates the activities in terms of Planning, Harmonization and Coordination with different Consortium members, program areas (water/sanitation, health) and other USG interventions (ex: MYAP)? Provide concrete examples?</p> <p>How successfully have community systems been integrated under SCIP? (Youth farmers club, Women First, APes)</p> <p>How do you assess the level of integration of Communities structures/organizations under SCIP? Provide Specific examples/experiences.</p> <p>How successfully have program areas been integrated under SCIP? (Water/sanitation, health)</p> <p>How successfully do SCIP interventions integrate with or build upon other USG interventions, Including MYAP?</p> <p>b. At what extend have the components been integrated with government initiatives (annual plans, sectoral plans, district development plans, provincial strategic plans)? What are the contributing factors and challenges?</p>

	Interview Topics/Questions
2. What have been the management and implementation benefits of program integration?	<p><i>a. To what extent has integration improved resource usage: economies of scale of IPs, increased geographical coverage and reduced overlap, reduced 'double counting' of services provided to beneficiaries, improved beneficiaries access to multiple services simultaneously. Provide evidence/Examples.</i></p> <p><i>b. To what extent have the different activity areas been able to leverage impact 'the whole is greater than the sum of its parts' to maximize benefit for beneficiaries,</i></p> <p><i>To what extent has SCIP contributed to improved integrated management practices at different levels/ sectors - e.g. governor's office, provincial health departments, provincial departments of women and social action, provincial departments of public works and housing and district services for health, women, and social action. Provide Specific examples.</i></p>
3. What are the management and implementation challenges of program integration?	<p><i>a. Do certain program areas get reduced attention because of the management needs of other program areas? Are some programme results areas in need of more management attention than others? Which and why?</i></p> <p><i>What are the consequences of reduced management attention in some result areas?</i></p> <p><i>b. What are the contributing factors to successful integration of specific program areas or components? (NOTE: in the final evaluation framework we will articulate this). Provide specific examples?</i></p> <p><i>c. What are the specific challenge faced at different levels (community level, district level, provincial level and national policy level) to ensure program integration, management and implementation? Provide specific examples.</i></p>
	<p>Community-based organizations Domain: Self-sustained Support System</p>
4. To what extent is the SCIP strategy strengthening the relationship between Community Leader Councils (CLCs) and other government structures?	<p><i>a. Which other government structures do CLCs work with? And How do CLCs work with other government structures (i.e. regular formal minuted meetings). In what ways doe CLCs work with other govt structures (i.e. collaboration, coordination, planning, quality assurance)?</i></p> <p><i>b. What changes have been observed, positive and negative in the relationship between CLCs and other government structures? Which changes can be attributed to work from the SCIP activities?</i></p> <p><i>c. What is the relationship between CLCs and health facilities? Are meetings pre-organised or on a case-by-case basis, in what ways do HFs utilize CLCs ie. Adherence to govt health guidelines, health service quality assurance, improved health-seeking behavior?</i></p>

	Interview Topics/Questions
5. Do community organizations supported by SCIP exhibit characteristics that are linked to a greater likelihood of continued level of activity after the completion of the SCIP activities?	<p style="text-align: center;"><i>a. What have been the main SCIP methods used to build capacity of CLCs, YFCs, and APEs? Training, mentoring, inputs (bicycles, equipment etc.), providing guidelines, peer support, exchange visits and how do you assess the outcome? Explain and provide specific examples</i></p> <p>-----</p> <p>-----</p> <p style="text-align: center;"><i>b. How have community organizations been integrated into communities and government health and livelihood structures? At what extent are they linked with SDSMAS, or DPS?</i></p> <p style="text-align: center;"><i>c. How formalized are the community organizations (govt guidelines and standards, recognition within the community, representative of different stakeholders in the community)?</i></p> <p>-----</p> <p>-----</p> <p style="text-align: center;"><i>d. At what extent the community health promoters trained under SCIP activities exhibit characteristics that are linked to a greater likelihood of continued level of activity after the completion of the SCIP activities? What are the evidence or basis for your assessment?</i></p> <p style="text-align: center;"><i>e. What are the mechanisms in place to absorb the Community Health Agents (ACS), and Elementary Polyvalent (health) Agents (APEs) by the National Health System?</i></p> <p>-----</p> <p>-----</p>
	Community Health Mobilization <i>Domain: Demand for Services</i>
6. To what extent has SCIP succeeded in creating demand for health services?	<p style="text-align: center;"><i>a. Which interventions are the major drivers of increased demand for health services (multiple health services including wash)? Provide evidence data and explain at what extent SCIP is contributing to that.</i></p> <p>-----</p> <p>-----</p> <p style="text-align: center;"><i>b. What is the level of involvement of males and females in accessing and use of available services? Provide evidence data sources and age groups desegregated information.</i></p> <p>-----</p> <p>-----</p> <p style="text-align: center;"><i>c. How the users / beneficiaries assess the quality of services provided? And at what extent the beneficiaries perceive the linkages/integration of services provided? What is your source of information, evidence?</i></p> <p>-----</p> <p>-----</p>
	Youth Farmers Clubs

Interview Topics/Questions	
<p>7. To what extent do youth participants and their families perceive youth farmers clubs to be beneficial?</p>	<p><i>a. What are the main activities of YFCs, and which are most beneficial and effective?</i></p> <p>-----</p> <p>-----</p> <p><i>b. Do male and female participants derive different utility?</i></p> <p><i>c. Do male and female household heads derive different utility from their participation or from the participation of their dependent family members in YFCs?</i></p> <p><i>d. Do orphans and vulnerable children (OVC) impacted by HIV and AIDS derive different utility from non-OVC?</i></p> <p>-----</p> <p>-----</p>
<p>4. To what extent do former participants in YFCs who “aged-out” of the program continue to employ lessons learned as part of YFC participation?</p>	<p><i>c. How many Youth Farmer Clubs have been “graduated” and are continuing to employ lessons learned as part of YFC participation? And what are the most valuable aspects/components leading to continuation (farming techniques, technology, conservation farming, food handling and storage, linkages with market, etc.)? Provide evidence data.</i></p> <p>-----</p> <p>-----</p> <p><i>d. For YFC members who “drop-out” what are the main reasons?</i></p> <p>-----</p> <p>-----</p>

SCIP Midterm Evaluation – KII GUIDELINES

SCIP- PARTNERS PROVINCIAL & DISTRICT LEVEL

(Health, Social Action, Agriculture/Rural livelihoods - at Provincial and District levels)

Organization:	_____	Name of Person:	_____
Location:	_____	Date:	_____
Role/Function	_____	Other Info:	_____

Interview Topics/Questions	
Background	<p>Relationship with SCIP (Use this topic as ice-breaker for the good flow of the interview)</p> <p><i>a. For how long have you been working with SCIP and what your role encompasses?</i></p> <p>-----</p> <p>-----</p> <p><i>b. What is your understanding about the SCIP activities and the concept of integration behind SCIP?</i></p> <p>-----</p> <p>-----</p>
<p>Integration of the SCIP activities Domain: Effective Integration</p>	
1. To what extent is the SCIP activities integrated in practice?	<p><i>a. How SCIP articulates the activities in terms of Planning, Harmonization and Coordination with different Consortium members, program areas (water/sanitation, health) and other USG interventions (ex: MYAP)? Provide concrete examples?</i></p> <p>-----</p> <p>-----</p> <p><i>b. How do you assess the level of integration of Communities structures/organizations under SCIP? Provide Specific examples/experiences.</i></p> <p>-----</p> <p>-----</p> <p><i>c. At what extend have the components been integrated with government initiatives (annual plans, sectoral plans, district development plans, provincial strategic plans)? What are the contributing factors and challenges?</i></p> <p>-----</p> <p>-----</p>

Interview Topics/Questions	
2. What have been the management and implementation benefits of program integration?	<p><i>a. To what extent has integration improved resource usage: economies of scale of IPs, increased geographical coverage and reduced overlap, reduced 'double counting' of services provided to beneficiaries, improved beneficiaries access to multiple services simultaneously.</i></p> <p>-----</p> <p>-----</p> <p><i>b. To what extent has SCIP contributed to improved integrated management practices at different levels/ sectors - e.g. governor's office, provincial health departments, provincial departments of women and social action, provincial departments of public works and housing and district services for health, women, and social action. Provide Specific examples.</i></p> <p>-----</p> <p>-----</p>
3. What are the management and implementation challenges of program	<p><i>a. Do certain program areas get reduced attention because of the management needs of other program areas? Are some programme results areas in need of more management attention than others? Which and why?</i></p> <p>-----</p> <p>-----</p> <p><i>b. What are the specific challenge faced at different levels (community level, district level, provincial level and national policy level) to ensure program integration, management and implementation? Provide specific examples.</i></p> <p>-----</p> <p>-----</p>
Community-based organizations	Domain: Self-sustained Support System

Interview Topics/Questions	
4. To what extent is the SCIP strategy strengthening the relationship between Community Leader Councils (CLCs) and	<p>a. <i>Which other government structures do CLCs work with? And How do CLCs work with other government structures (i.e. regular formal minuted meetings). In what ways doe CLCs work with other govt structures (i.e. collaboration, coordination, planning, quality assurance)?</i></p> <p>-----</p> <p>-----</p> <p>b. <i>What changes have been observed, positive and negative in the relationship between CLCs and other government structures? Which changes can be attributed to work from the SCIP activities?</i></p> <p>-----</p> <p>-----</p> <p>c. <i>What is the relationship between CLCs and health facilities? Are meetings pre-organised or on a case-by-case basis, in what ways do HFs utilize CLCs ie. Adherence to govt health guidelines, health service quality assurance, improved health-seeking behavior?</i></p> <p>-----</p> <p>-----</p>
5. Do community organizations supported by SCIP exhibit characteristics that are linked to a greater likelihood of continued level of activity after the	<p>a. <i>What have been the main SCIP methods used to build capacity of CLCs, YFCs, and APEs? Training, mentoring, inputs (bicycles, equipment etc.), providing guidelines, peer support, exchange visits and how do you assess the outcome? Explain and provide specific examples</i></p> <p>-----</p> <p>-----</p> <p>b. <i>How have community organizations been integrated into communities and government health and livelihood structures? At what extent are they linked with SDSMAS, or DPS?</i></p> <p>c. <i>How formalized are the community organizations (govt guidelines and standards, recognition within the community, representative of different stakeholders in the community)?</i></p> <p>-----</p> <p>-----</p> <p>d. <i>At what extent the community health promoters trained under SCIP activities exhibit characteristics that are linked to a greater likelihood of continued level of activity after the completion of the SCIP activities? What are the evidence or basis for your assessment?</i></p> <p>e. <i>What are the mechanisms in place to absorb the Community Health Agents (ACS), and Elementary Polyvalent (health) Agents (APEs) by the National Health System?</i></p> <p>-----</p> <p>-----</p>
Community Health Mobilization	Domain: Demand for Services

Interview Topics/Questions	
6. To what extent has SCIP succeeded in creating demand for health services?	<p><i>a. Which interventions are the major drivers of increased demand for health services (multiple health services including wash)? Provide evidence data and explain at what extent SCIP is contributing to that.</i></p> <p>-----</p> <p>-----</p> <p><i>b. What is the level of involvement of males and females in accessing and use of available services? Provide evidence data sources and age groups desegregated information.</i></p> <p>-----</p> <p>-----</p> <p><i>c. How the users / beneficiaries assess the quality of services provided? And at what extend the beneficiaries perceive the linkages/integration of services provided? What is you source of information, evidence?</i></p> <p>-----</p> <p>-----</p>
Youth Farmers Clubs	
7. To what extent do youth participants and their families perceive youth	<p><i>a. What are the main activities of YFCs, and which are most beneficial and effective?</i></p> <p>-----</p> <p>-----</p> <p><i>b. Do male and female participants derive different utility?</i></p> <p><i>c. Do male and female household heads derive different utility from their participation or from the participation of their dependent family members in YFCs?</i></p> <p><i>d. Do orphans and vulnerable children (OVC) impacted by HIV and AIDS derive different utility from non-OVC?</i></p> <p>-----</p> <p>-----</p>
7. 8. To what extent do former participants in YFCs who	<p><i>e. How many Youth Farmer Clubs have been “graduated” and are continuing to employ lessons learned as part of YFC participation? And what are the most valuable aspects/components leading to continuation (farming techniques, technology, conservation farming, food handling and storage, linkages with market, etc.)? Provide evidence data.</i></p> <p>-----</p> <p>-----</p> <p><i>f. For YFC members who “drop-out” what are the main reasons?</i></p> <p>-----</p> <p>-----</p>

Interview Topics/Questions	
9. Lessons	<p>b. <i>What are the lessons learned from SCIP so far?</i></p> <p>-----</p> <p>-----</p>

SCIP Midterm Evaluation - KII GUIDELINES

GOVERNMENT OFFICIALS AND OTHER STAKEHOLDERS - CENTRAL LEVEL

Organization: _____ **Name of Person:** _____
Location: _____ **Date:** _____
Role/Function _____ **Other info:** _____

Interview Topics/Questions	
Background	<p><i>a. For how long have you been aware of SCIP activities and what do you know about SCIP?</i></p> <p>-----</p> <p>-----</p> <p><i>b. What is your understanding about the SCIP activities and the concept of integration behind SCIP?</i></p> <p>-----</p> <p>-----</p>
Integration of the SCIP activities Domain: Effective Integration	

	Interview Topics/Questions
1. To what extent is the SCIP activities integrated in practice?	<p><i>a. How SCIP articulates the activities in terms of Planning, Harmonization and Coordination with different Consortium members, program areas (water/sanitation, health) and other USG interventions (ex: MYAP)? Provide concrete examples?</i></p> <p>-----</p> <p>-----</p> <p><i>b. At what extend have the components been integrated with government initiatives (annual plans, sectoral plans, district development plans, provincial strategic plans)? What are the contributing factors and challenges? Provide Specific examples.</i></p> <p>-----</p> <p>-----</p>
2. What have been the management and implementation benefits of program integration?	<p><i>a. To what extent has integration improved resource usage: economies of scale of IPs, increased geographical coverage and reduced overlap, reduced ‘double counting’ of services provided to beneficiaries, improved beneficiaries access to multiple services simultaneously. Provide Specific examples?</i></p> <p>-----</p> <p>-----</p> <p><i>b. To what extent has SCIP contributed to improved integrated management practices at different levels/ sectors - e.g. governor’s office, provincial health departments, provincial departments of women and social action, provincial departments of public works and housing and district services for health, women, and social action. Provide Specific examples.</i></p> <p>-----</p> <p>-----</p>
3. What are the management and implementation challenges of program integration?	<p><i>a. What are the specific challenge faced at different levels (community level, district level, provincial level and national policy level) to ensure program integration, management and implementation? Provide specific examples.</i></p> <p>-----</p> <p>-----</p>

Interview Topics/Questions	
	Community-based organizations <i>Domain: Self-sustained Support System</i>
4. To what extent is the SCIP strategy strengthening the relationship between Community Leader Councils (CLCs) and other government structures?	<p>a . <i>What changes have been observed, positive and negative in the relationship between CLCs and other government structures? Which changes can be attributed to work from the SCIP activities? Provide examples and indicate differences between Nampula and Zambézia if any?</i></p> <p>-----</p> <p>-----</p>
5. Do community organizations supported by SCIP exhibit characteristics that are linked to a greater likelihood of continued level of activity after the completion of the SCIP activities?	<p>a . <i>How have community organizations been integrated into communities and government health and livelihood structures? At what extent are they linked with SDSMAS, or DPS?</i></p> <p>b . <i>How formalized are the community organizations (govt guidelines and standards, recognition within the community, representative of different stakeholders in the community)?</i></p> <p>-----</p> <p>-----</p> <p>c . <i>At what extent the community health promoters trained under SCIP activities exhibit characteristics that are linked to a greater likelihood of continued level of activity after the completion of the SCIP activities? What are the evidence or basis for your assessment?</i></p> <p>d . <i>What are the mechanisms in place to absorb the Community Health Agents (ACS), and Elementary Polyvalent (health) Agents (APEs) by the National Health System?</i></p> <p>-----</p> <p>-----</p>
	Community Health Mobilization <i>Domain: Demand for Services</i>

	Interview Topics/Questions
6. To what extent has SCIP succeeded in creating demand for health services?	<p><i>a. Which interventions are the major drivers of increased demand for health services (multiple health services including wash)? Provide evidence data and explain at what extent SCIP is contributing to that.</i></p> <p>-----</p> <p>-----</p> <p><i>b. How the users / beneficiaries assess the quality of services provided? And at what extent the beneficiaries perceive the linkages/integration of services provided? What is your source of information, evidence?</i></p> <p>-----</p> <p>-----</p>
	Youth Farmers Clubs
7. To what extent do youth participants and their families perceive youth	<p><i>a. What are the main activities of YFCs, and which are most beneficial and effective? Who are the main beneficiaries?</i></p> <p>-----</p> <p>-----</p>
10. 8. Lessons learned	<p><i>g. What are the lessons learned from SCIP so far?</i></p> <p>-----</p> <p>-----</p>

ANNEX 5: SITE SELECTION CRITERIA

CRITERIA FOR SELECTING DISTRICTS AND COMMUNITIES

SAMPLE SELECTION

The team has adopted a maximum variation sampling approach based mainly on the demand for and supply of health and complementary services. We will use the general population size of Zambézia and Nampula as proxy indicators of demand. For supply levels, we will use the number of available health services and social infrastructures to proxy. More specifically the criteria for selecting districts and communities are provided here.

Table 3: Criteria for Selecting Districts

Nampula		Zambézia	
A	Large general population size (high demand)	A	Large general population size (high demand)
B	Small general population size (low demand)	B	Small general population size (low demand)
C	Large number of community social infrastructures (co-management committees)	C	Large number of community social infrastructures (community committees)
D	Small number of community social infrastructures (co-management committees)	D	Small number of community social infrastructures (community committees)
E	Large number of health services (high supply level)	E	Large number of health services (high supply level)
F	Small number of health services and facilities (low supply level)	F	Small number of health services and facilities (low supply level)

District One: large population size, large number of community social infrastructures, and large number of health services and facilities to demonstrate both high demand and high capacity levels of supply.

District Two: high population size, small number of community social infrastructures, and a small number of health services and facilities to provide insights into the effectiveness and process of integration in the context of high demand for and low supply of health and complementary services.

District Three: a small population size, large number of community social infrastructures and a small number of health services and facilities.

The following districts satisfy the characteristics above:

Table 4: Nampula

District	Population	Health management committees	Rural hospital	Other health services (HCs with nurse, HCT centers/ ART centers)	Package
Monapo	370,604	10	1	24	Complementary with WASH

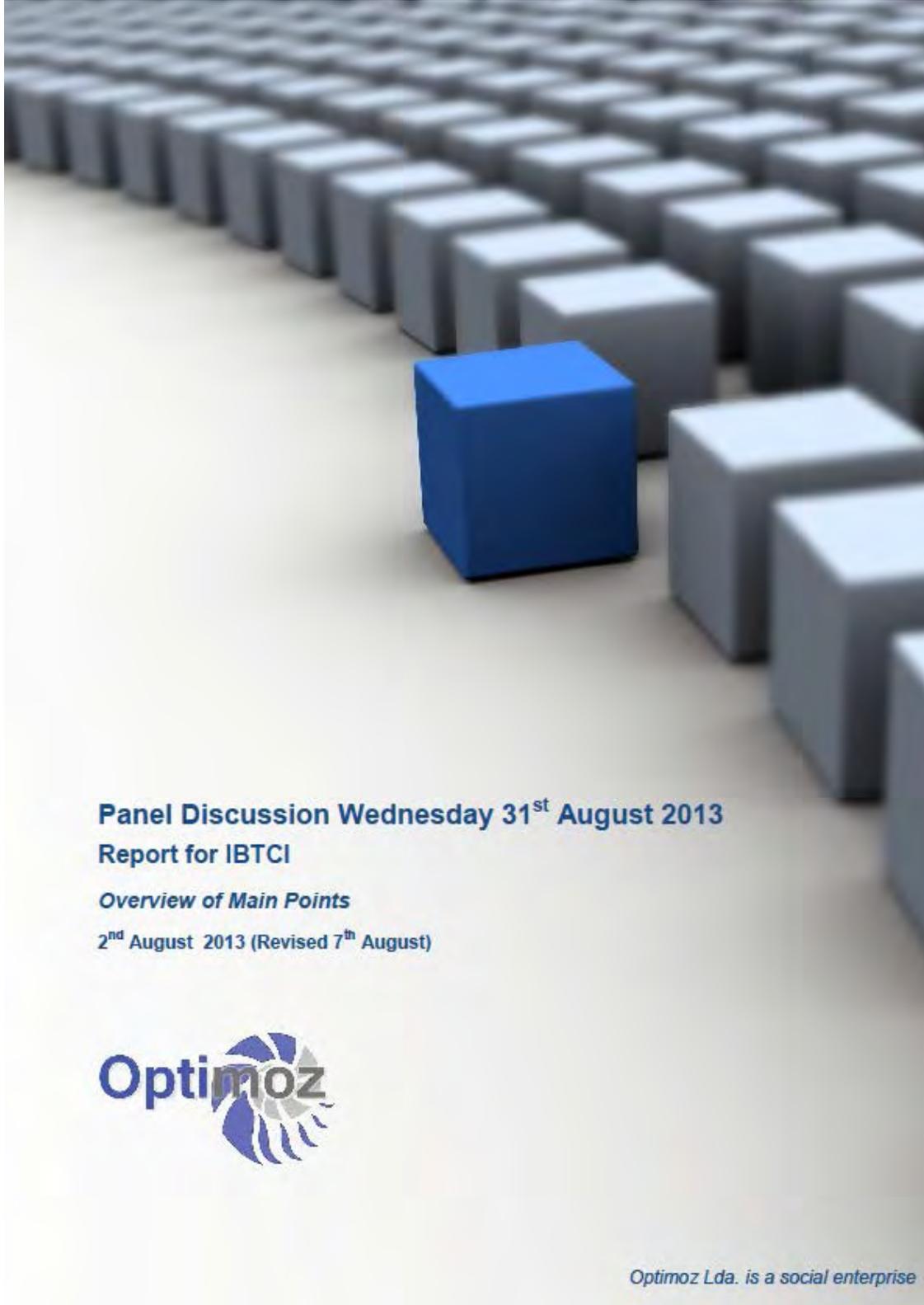
Mogovolas	359,053	6	0	12	Complementary without WASH
Ribaue	236,961	8	1	13	Intensive

Table 5: Zambézia

District	Population	Health committees	Other health services (HCs with a nurse, HCT centers, ART centers)
Gurué	301,033	86	24
Namarroi	147,345	53	16
Pebane	187,298	34	25

ANNEX 6: TECHNICAL EXPERT REVIEW PANEL REPORT

Available as a separate document



Panel Discussion Wednesday 31st August 2013
Report for IBTCI

Overview of Main Points

2nd August 2013 (Revised 7th August)



Optimoz Lda. is a social enterprise

ANNEX 7: PMP DATA FROM OGUMANIHA AND SCIP NAMPULA
OGUMANIHA PMP DATA ²²

#	Indicator	Targets 1-5 Year	Achieved Year 1	Achieved Year 2	Achieved Year 3	Quarter 1 - 3 Achieved	Overall Achieved	Overall Achieved %
R1.5	# of pregnant/postpartum women in community registered in Ogumaniha	133,400		25,538	32,917	22,654	81,109	61%
R1.6	# of ANC visits by skilled providers from USG-assisted facilities, by type of service	166,700	210,270	21,501	20,040	16,098	267,909	161%
R1.7	% of pregnant women who delivered at health facility	75%		63%	69%	71%	68%	90%
R1.8	% of deliveries with a traditional birth attendant (TBA) in USG-assisted programs	20%		32%	27%	27%	29%	143%
RI.11	# of contraceptive cycles distributed	120,000	27,905	14,536	17,598	28,364	88,403	74%
RI.15	# of children less than 12 months of age who received DPT3 from USG-supported programs	174,000	81,040	28,470	26,983	43,855	180,348	104%
RI.16	# of children less than 12 months of age receiving vitamin A from a USG supported program	270,000	82,250	69,139	42,558	102,545	296,492	110%

²²

Calculations done by Ogumaniha. The evaluation team could not entirely verify the accuracy of the calculations due to missing and inconsistent M&E data.

RI.17	# of children ages 6 - 59 months who received vitamin A from USG-supported programs	655,700	185,511	231,276	86,288	412,350	915,425	140%
RI.18	% of children under 6 months exclusively breastfed	77%		57%	64%	64%	62%	81%
RI.20	# Children 0-59 months with diarrheal disease treated with ORT and/or referred to health facility	52,380	Did not collect Y1	11,582	8,735	8,822	29,139	56%
RI.24	# of people HIV tested and counseled and received test results	114,276	2,693	19,436	38,766	34,810	95,705	84%
RI.25	# of condoms distributed	1,116,180	168,681	311,215	418,447	303,539	1,201,882	108%
RI.26	% of individuals (male or female) who report use of condom in the last sex encounter (intercourse)	71%		68%		41%	49%	
RI.27	# of providers/caregivers trained/retrained in caring for OVC	20,240	3,434	4,132	2,579	616	10,761	53%
RI.28	# of people trained/retrained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	67,600	2,667	6,838	204	0	9,709	14%
RI.29	# of people trained/retrained to promote HIV/AIDS prevention through behavior change other than abstinence and/or being faithful (disaggregated by sex)	66,840	5,247	8,515	417	52	14,231	21%
RI.30	# of people trained/retrained in child health through USG supported	8,760	Did not collect Y1	2,297	997	109	3403	39%

	programs							
RI.31	# of people trained/retrained in maternal/newborn health through USG-supported programs	9,900	2,173	2,287	724	98	5,282	53%
RI.32	# of people trained/retrained in FP/RH with USG funds	9,900	3,142	4,096	1,454	183	8,875	90%
RI.33	# of people trained with USG funds in malaria treatment or prevention		1,439	3,965			5,404	
RI.34	# of community-based staff trained in strategic information (M&E, surveillance, and/or HMIS) ^H	21,300	0	12,970	3,711	314	16,995	80%
RI.35	# of community groups developed and supported by Ogumaniha activities	675	787	585	645	644	644	95%
RI.37	# of Mobile Brigades & outreach campaigns carried out	11,904	1,547	1,827	1,275	1,063	5,712	48%
RI.38	# of insecticide treated nets purchased with USG funds		0	628			628	
RI.39	# of LLINS distributed by community volunteers		0	617			617	
RI.41	# of couple years protection (CYP) in USG-supported programs	12,428	1,707	3,563	4,660		9,930	80%
Result 2: Appropriate Health, HIV & AIDS and Nutrition Practices and Health Seeking Behaviors Adopted								
R2.1	# of children under five years of age appropriately referred by APEs/CHVs to health facilities for suspected malaria	58,100	7,479	11,316	12,893	11,354	43,042	74%

	treatment							
R2.2	# of pregnant women referred by TBAs/CHVs to health facilities for antenatal care	139,200	12,812	38,503	44,317	30,709	126,341	91%
R2.3	# of pregnant women referred by TBAs/CHVs to health facilities for delivery		6,986	33,105			40,091	
R2.4	# of OVC and PLWHA referred to HF for CT, PMTCT	6,900	1,871		3,314	2,655	7,840	114%
R2.5	# of demonstration sessions on breast feeding and other nutritional aspects for HIV children, carried out by MFGs	147,560	5,315	33,105	36,294	25,394	100,108	68%
R2.7	# of CLC's with community based emergency transportation system	675	188	110	210	368	876	130%
R2.9	# of OVC served by OVC programs	55,500	25,035	34,601	38,721	46,344	46,344	84%
R2.10	# of clients receiving home-based care services	6,400	5,143	7,257	10,011	5,576	5,576	87%
R2.11	# of mass media spots produced	22,467	No data Y1	4,982	10,646	8,656	24,284	108%
R2.12	# of the targeted population reached with individual and/or small group level; preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	131,751	50,439	25,255	3,947	10,410	90,051	68%
R2.13	# of individuals reached through community outreach that promotes HIV &	123,270	9,555	24,184	11,176	15,273	60,188	49%

	AIDS prevention through behavior change other than abstinence and/or being faithful							
R2.15	# of targeted condom service outlets	750	No data Y1	704	766	750	750	100%
R2.16	# of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards	69,524	4,605	16,305	22,986	16,456	60,352	87%

R 3: Accountability of Community, District and Provincial Health Structure

R3.1	# of monthly coordination meetings between HF staff, CLCs leaders and SCIP field staff	15,900	880	1,433	2,401	3,119	7,833	49%
R3.2	# of quarterly meetings between HFs and community members to ensure quality assurance of HF services (PDQ) at district level	320	81	48	33	34	196	61%
R3.3	% of maternal mortality cases that are investigated	75%		79%	81%	88%	80%	107%
R3.4	% of target communities that have formally constituted Community Leaders Councils with at least 20% women members	100%	42%	98%	0%	100%	99%	99%
R3.5	% of CLCs with plans based on prioritized solutions to health in these respective communities	100%	9%	76%	41%	53%	57%	57%
R3.6	# of PLA meetings between CLCs, community members	6,330	234	370	294	475	1,373	22%

	and other community organizations							
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Result 4: Community and Social Infrastructure Sustained Through a Range of Allies and Networks of Support they can draw upon to solve health problems

R4.1	# of OVC families benefiting from Ogumaniha-supported saving groups	256	0		79	415	494	193%
R4.2	% of target communities (CLCs) that ensure adequate service provision for OVCs through linkages with community and clinical support services	100%	0	38%	0%		38%	38%
R4.3	# of community savings groups supported by Ogumaniha	96		0	29	65	65	68%
R4.4	# of OVC households participating in economic strengthening activities	1,440	514	171	67	233	985	68%
R4.5	# of communities with a supply chain and social marketing network	30	0	15	30	30	30	100%
R4.6	# of OVCs receiving education/vocational training support in new farming techniques and health topics	10,160	330	2,109	2,678	2,466	2,466	24%
R4.7	# of young farmers groups established and trained in conservation farming	156	6	72	110	156	156	100%

Result 5: Availability and use of clean, multi-use water increased

R5.3	# of people in target areas with access to improved drinking water supply as a result of USG	112,100	15,339	48,524	33,960	0	97,823	87%
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	assistance							
R5.4	# of vegetable garden supported by water sources, by type of garden owner (water committee, other)		14				14	
R5.5	# of new protected water sources built, by type	96	24	37	0		61	64%
R5.6	# of rehabilitated protected water sources, by type	204	37	54	66	0	157	77%
R5.7	# of community-based water committees identified, organized, trained, equipped and maintained	288	88	80	66	59	293	102%
R5.8	# of people trained on water treatment, by type of person	1,549	783	439	902	513	2,637	170%
Result 6: Sanitation facilities and hygiene practices improved								
R6.2	# of people in target areas with access to sanitation facilities as a result of USG assistance	100,000	19,988	33,766	28,180	12,227	94,161	94%
R6.3	# of household latrines constructed	20,000	3,325	6,987	5,677	1,916	17,905	90%
R6.4	# of households with tippy-tap (stations) systems installed	20,140	980	4,987	4,111	279	10,357	51%

SCIP Nampula PMP DATA

Indicators	PROGRAM TARGETS	Y1 Achieved	Y2 Achieved	Y3 Achieved	Y4 Achieved	Y4 Achieved	Overall Achieved
Result 1: Quality health goods and services access and availability improved							
# of rehabilitated health facilities ^R	38	2	2	9	2	15	39%
# of health care workers who successfully completed an in-service training program (relevante para HIV) within the reporting period ^R	109,676	9,861	31,855	50889	21,725	114,330	104%
# of people (by type) trained with USG funds in:	337,294	8,383	53,699	177974	105,415	345,471	102%
1) FP/RH ^R	76,075	2,034	17,738	51562	30,889	102,223	134%
2) Child health	74,779	205	3,586	63714	26,444	93,949	126%
3) Maternal/newborn health ^R	51,562	240	3,398	32204	2,299	38,141	74%
4) M&E, surveillance, and/or HMIS ^R	5,102	208	699	1990	90	2,987	59%
5) Quality of care standards and guidelines ^R	280	0	60	182	38	280	100%
6) Hygiene/water	61,975	1,394	13,252	14493	21,977	51,116	82%
7) Malaria	62,969	219	13,157	12304	22,048	47,728	76%
8) Community Involvement for Health and Sanitation Issues	4,551	4,083	1,809	1525	1,213	8,630	190%
# of contraceptive pills distributed through community based distribution (CBD)	64,585	2,264	2,638	23087	22,834	50,823	79%
CYP provided through USG-supported programs ^R	219,351	30,869	53,216	71559	38,741	194,385	89%
Result 2: Appropriate health practices and health care seeking behavior adopted							
# of eligible clients who received food and/or other nutrition services ^R (Note: This indicator will include activities from Result 4)	12,570	388	7,796	20296	12,662	41,142	327%
# of IEC materials produced and distributed	360,159	68,335	66,606	114076	0	249,017	69%
#of deliveries performed in a	396,083	70,526	99,132	119596	64,068	353,322	89%

USG-supported health facility							
# of ANC visits with skilled providers in a USG-supported health facility ^R	2,490,321	440,133	646,982	637497	335,768	2,060,380	83%
# of facility visits in a health facility, by type	824,020	149,522	209,464	282467	129,470	770,923	94%
FP new visit	345,488	56,933	82,779	163921	63,494	367,127	106%
PNC	478,531	92,589	126,685	118546	65,976	403,796	84%
# of individuals reached through USG-funded community health activities (HIV/AIDS, Malaria, FP/RH)R	2,587,853	242,654	1,112,710	1130224	627,983	3,113,571	120%
# of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required ^R	1,387,555	199,479	585,032	653821	186,401	1,624,733	117%
# of contacts by CHWs with individuals for health (HIV/AIDS, Malaria, FP/RH)	2,279,353	90,209	914,352	889029	638,199	2,531,789	111%
# of service outlets providing counseling and testing according to national and international standards	50	30	56	56	28	170	340%
# of people HIV tested and counseled and received test ^R	191,888	37,151	60,389	62356	29,617	189,513	99%
# of children less than 12 months of age who received DPT3 from USG-supported programs ^R	499,646	76,936	115,853	172186	74,222	439,197	88%
# of children less than 12 months of age who received vitamin A from a USG supported program ^R	532,772	109,258	327,677	149490	162,660	749,085	141%
# of OVC served by OVC programs ^R Note: For SCIP, this indicator is the same as the indicator: Number of eligible adults and children provided with a minimum of one care service because no HIV/AIDS care will be provided to populations other than OVC.	96,640	10,005	55,807	136170	63,799	265,781	275%
# of clients receiving home-	7,560	0	2,808	5538	3,818	12,164	161%

based care services							
Result 3: Accountability of community and district health structures to the people they serve increased							
# of community based distribution systems ^R	5,730	1,602	7,266	7989	4,141	20,998	366%
% of health facilities meeting with CLC representatives at least quarterly to evaluate health issues	2	57	80	1.936993	1	141	8742%
Result 4: Community social infrastructure sustained through a range of allies and networks of support they can draw upon to solve health problems							
# of community groups developed and supported (CLC, YFC, water) ^R	4,149	701	3,402	4865	3,362	12,330	297%
# of people (by type) trained in using conservation farming techniques as a result of USG assistance	90,625	6,202	16,958	54977	35,825	113,962	126%
# of people (by type) trained in safe food handling, use and storage	56,180	629	7,359	40773	28,417	77,178	137%
Result 5: Availability and use of clean, multi-use water increased							
Shallow wells	15	0	10	0	0	10	67%
Rehabilitation	120	32	33	40	5	110	92%
Small urban system	5	0	0	1	1	2	40%
# of people trained in safe water	2,796	482	871	1117	319	2,789	100%
# of localities with integrated water and health committees	91	7	10	88	41	146	160%
Result 6: Sanitation facilities and hygiene practices in target communities improved							
# of household with latrines	24,648	3,291	10,573	11861	4,888	30,613	124%

ANNEX 8: KIIS AND FGDs COMPLETED

Zambézia KIIs & FGDs (targets in black, actual in red)								
	FGD YFCs	FGDs CLCs & HMCs	FGDs SCIP trainers	FGDs CLLs	KIIs SCIP staff	KIIS GOM Provincial Officials	KIIS GOM District Officials	KIIS Health Facility staff
Quelimane	-	-	-	-	5 (5)	3 (5)	-	1
Gurué	2 (2)	3 (3)	3 (3)	1	1 (6)	-	1 (3)	3(3)
Lugela	2 (2)	3 (3)	3 (3)	1(1)	1(2)	-	1(4)	3(3)
Morrumbala	2(1)	3 (3)	3 (3)	1	1(3)	-	1(5)	3(2)
Target	6	9	9	3	8	3	3	10
Actual	5	9	9	1	16	5	12	8
Nampula KIIs & FGDs (targets in black, actual in red)								
	FGDs YFCs	FGDs CLCs/ HMCs	FGDs Trainers SCIP	FGDs CLLs	FGDs & KIIs SCIP staff	KIIS GOM Provincial Officials	KIIS GOM District Officials	KIIS Health Facility staff
Nampula City	-	-	-	-	5 (11)	3 (6)	-	1 (1)
Mogovolas	2 (1)	3 (2)	3 (1)	1	1 (4)	-	1 (3)	3(1)
Ribaue	2 (3)	3 (4)	3 (1)	1(1)	1(4)	-	1(4)	3(3)
Monapo	2(3)	3 (2)	3 (1)	1	1(5)	-	1(4)	3(3)
Target	6	9	9	3	8	3	3	10
Actual	7	8	3²³	1²⁴	25	6	11	8

²³ Trainers are based at district level and therefore were met as a group

²⁴ FGDs were called, but hard to organize due to commitments of CLL members

ANNEX 9: SUSTAINABILITY INDEX

PERFORMANCE EVALUATION OF USAID SUPPORTED SCIP IN MOZAMBIQUE

GUIDE FOR DATA COLLECTION ON SUSTAINABILITY

QUESTIONNAIRE IDENTIFICATION NUMBER: |_____|_____| PROVINCE [] Zambézia
[] Nampula

DISTRICT ID NUMBER: _____ GROUP TYPE [] District
[] CLL
[] CLC

SEX OF RESPONDENT: |__M__|__F__|

AGE OF RESPONDENT: _____

My name is I am here on behalf of IBTCI a consulting firm based in Washington DC, USA who has been entrusted by the USAID Mozambique to conduct performance evaluation of two SCIP namely Ogumaniha in Zambézia and SCIP Nampula implemented by World Vision and Pathfinder respectively.

We are collecting information that will help us to understand the extent to which SCIP activities that you are helping to implement will be sustained. We are particularly interested in those dealing with pregnancy and child birth, child health and immunizations. We are collecting this information to inform USAID how they can better support efforts to improve these services and insure their sustainability in the provinces of Zambézia and Nampula.

The discussion will last for approximately 1.5 hours. I would like you to express your views freely and openly. All information that you give is strictly confidential. We also request permission to have your age.

Your participation is voluntary and there is no penalty for refusing to take part. You may refuse to answer any question in this questionnaire/interview or stop the interview at any time. You are free to ask questions at any time.

Would you be willing to participate? 1=Yes 2=No

Thank you.

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

INTERVIEWER: Code: [] [] Name (Initials):

DATE OF INTERVIEW: [] [] \ [] [] \ [] [] [] []
Day Month Year

SHORT QUESTIONNAIRE

On a scale of 1 (low) to 7 (high), please rate the extent to which:

1. You understand the long term vision of SCIP in your community []
2. You believe that SCIP activities are meeting specific, recurrent needs of the community []
3. SCIP has supported policy development or implementation that supports your abilities to implement SCIP activities []
4. Your ability to address roadblocks in implementing SCIP []
5. SCIP activities are part of your strategic planning process []
6. You have clearly identified needs in the community, and engaged community
In addressing priorities []
7. You have access to policy makers and government representatives []
8. Policy makers really understand priorities and needs of your communities addressed
By SCIP []
9. There is staffing (in your level) to implement SCIP activities []
10. You are sufficiently trained to implement SCIP activities []
11. You have the skills to provide SCIP Services []
12. You have access to necessary technology to implement SCIP activities []
13. Financial support for implementing key SCIP activities come from SCIP partner []
14. You will be able to continue to implement SCIP activities if SCIP funding were to stop []

15. You work in formal or informal partnership with other sectors (WASH, Nutrition, Health, as well as local business and others) to achieve SCIP goals
16. Your group is able to manage its own funds, should it be provided
17. You have the skills to carry out SCIP activities should SCIP stop
18. The Government at (community, district, or provincial level) recognize the value that you can add in the provision and monitoring of activities promoted by SCIP
19. Roles and responsibilities for implementing SCIP activities are clear to you
20. You are satisfied with your office space and equipment to do your work
21. You are satisfied with the use of data to promote decision making
22. Your group enjoy positive media coverage
23. The community's perception of SCIP activities
24. The business sector have a positive perception of SCIP activities

ANALYSIS:

PROJECT BUY-IN: PROFESSIONAL (1,)

COMMUNITY BUY-IN: (2)

POLICY ENABLING (3, 8, 18)

ORGANIZATION (4, 5, 19)

FINANIAL VIABILITY (13, 16) (with reverse coding of #13)

INFRASTRUCTURE (9, 12, 20, 21)

SERVICE DELIVERY (10, 14, 15)

ADVOCACY (6, 7)

PUBLIC IMAGE (22, 23, 24)

ANNEX 10: LIST OF KEY INFORMANTS

Annex —List of People Contacted — Zambézia		
Name	Institution	Function/Role
	Quelimane	
Fernando Alilo	DPOPH	Chefe do Departamento de Planificação e Estatística
Luís Tomo	DPA	Chefe dos Serviços Provinciais de Agricultura
Hou Sei Caelos	IRD	Gestor deo Programa WASH
Elise Ndatimana	FGH	Coordenador de Monitoria e Avaliação
Omo Olufona	SCIP-Zambézia	Chefe de Equipa
Cyprian Chavatama	SCIP	Gestor de Finanças
Caldina Voabil	SCIP	Coordenadora dos CD
Rolando Vela	SCIP	Cordenador de Saúde e HIV/SIDA
Octávio Pedro	SCIP	<i>Reporting Officer</i>
Estela Consula	SCIP	Coodenadora Provincial de Formação
Rudy Henriques	SCIP	Deputy COP
Angelica Soares	SCIP	Senior Adm. Coord
Juliana Zinhão	DPMAS	Directora
António Artur		Director Adjunto
Moíses Alberto		Chefe do Departamento
Dercio Filomão	DPS	Supervisao Provincial do Programa de ITS/HIV/SIDA
	Mocuba	
	Mocuba	Coordenador da ADRA
	Ile	
	Ile	Coordenador SCIP-Ile
Felizarda	Ile	Coordenadora da JHU
	Gurué	
António Magalhães	SCIP-Gurué	Coodenadora Regional
Arnete Alfredo	SCIP-Gurué	GDO
Reginaldo Muluco	SCIP-Gurué	Coordenador Reg. De Dados
Tembe Ruth	SCIP- Gurué	Coodenador Distrital
Justina Varinde	SCIP- Gurué	Conselheira

Annex — List of People Contacted — Zambézia

Josefina Estevão	SCIP-Gurué	Supervisora
António Caetano	SCIP-Gurué	Treinador
Manuel Almeida	SCIP-Gurué	Treinador Lioma
Rosa Voabil	SCIP-Gurué	Treinadora
Joaquim Pahare	Governo Distrital	Adminstrador
Carlitos	CLC Murimo	Presidente do Conselho e activista de cuidados domiciliarios;
Faustina	CLC Murimo	agente comunitário e membro do conselho de saúde;
Cidalia	CLC Murimo	Chefe do Grupo Mae e Pai e Activista de Saúde Reprodutiva
Victorina	CLC Murimo	Madrinha de Jovens Força e Visitante Domiciliário
Armando	CLC Murimo	Auxiliar de agricultura e trabalha com jovens força.
Cristina	CLC Murimo	Grupo Mae e Pai;
Rosa	CLC Murimo	Grupo Mae e Pai
Custodio	CLC Murimo	Vice Presidente d
Deolinda	CLC Murimo	Água e saneamento e higiene
Jovens Força	CLC Murimo	Jovens Força
Fátima	CLC Murimo	Grupo Mae e Pai
Lucinda	CLC Murimo	Grupo Mae e Pai
Leonardo Luis	Gurué-Sede/SDSMAS	Director
Domingos Sarama	Gurué-Sede/US	Medico Chefe
Carlos Quiari	CLC Murimo	CD/AIDI
Faustino Pedro	CLC Murimo	AIDI
Alberto Jaksoni	CLC Murimo	AIDI/AP
Golçalves Jackson	CLC Murimo	Chefe do Comité
Rafael Domingos	CLC Murimo	Joven Forca
Simões Macaule	CLC Murimo	Adjunto chefe do Conselho
Jaime Juma	CLC Murimo	Comite de Agua (Mecanico)
António da Costa	IRD-Gurué	Supervisor
Alvaro Batista	SCIP-Gurué	Cuidados Domiciliarios
Manuel Antones	CLC Incisa	SR

Annex — List of People Contacted — Zambézia

Cardoso Prato	CLC Incisa	SR/GMP
Maria Jose	CLC Incisa	PT
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ANNEX II: CASE STUDIES

CASE STUDY I: ANTENATAL CARE (ANC)

Under Result 2: Appropriate health, HIV & AIDS and nutrition practices and health seeking behaviors adopted in Nampula and Zambézia included indicators related to antenatal care (ANC).²⁵ ANC was regarded as an important area to improve health seeking behavior in both provinces. Mozambique has one of the highest maternal mortality rates in Africa, with Zambézia reporting 400 maternal deaths per 100,000 live births in 2010.²⁶ Distances to health facilities are long and only a limited number of facilities provide ANC. These factors, coupled with many women's poor understanding of the importance of modern antenatal care, has led to pregnant women placing their trust in community-based traditional birth attendants (TBAs), whose knowledge of the medical aspects of ANC is limited.

Both provinces took a similar approach to improving the use of ANC health facilities:

- Training health care professionals and TBAs;
- Ensuring adherence to minimum quality ANC standards for health facilities;
- Conducting campaigns and distributing information to encourage the spread of health-seeking behavior and encouraging the use of medical facilities;
- Strengthening linkages among health facility staff through mobile health teams and including health staff in community sensitization;
- Building maternity waiting houses, or “pregnant mother houses” closer to communities;
- Increasing the commitment to monitoring and analysis of maternal and neo-natal mortality through Community Leaders Councils (CLCs) and health facilities

In **Nampula**, SCIP applied the “Making Pregnancy Safer” (MPS) approach, which includes facility training in key areas in addition to focused community education and mobilization. The use of bicycle ambulances was used to increase access to health centers (though focus group discussions [FGDs] indicated confusion on whether these could be used for transporting pregnant women to health facilities). Theaters were used to demonstrate the benefits of ANC usage and male involvement in the process.

The use of ANC services appears to be improving at even the lowest health center level. In Nampula in Year 3 of the program, 12 new maternity waiting houses were constructed and handed over to their respective communities, 73% of the intended target.²⁷ There has been an increase in ANC visits: 475,046 (Y1), 646,982 (Y2), and 637,497 (Y3) ANC visits with skilled providers in a USG-supported health facility, the slight dip in Y3 being accounted for by different reporting methods at the health facility level. There were 76,371, 99,132, and 119,596 deliveries performed in USG-supported health facilities in FY1, 2, and 3 respectively.

Women are now eager to use ANC services, in part because they are no longer required to pay any extra or side fees for ANC-related services at health facilities apart from the institutionalized one medical, which is encouraging women to seek health services. Health education from CLCs has made a difference in battling cultural barriers; it is now quite common for men to take their pregnant wives to ANC visits at the health post. However, there were two reported obstacles to ANC service access:

²⁵ Nampula: Number of ANC visits with skilled providers in a USG-supported health facility. Zambézia: Number of pregnant women referred to a health facility for ANC at least once.

²⁶ SCIP Zambézia 2011, Baseline Survey Report, December 12, 2011.

²⁷ Statistics provided by SCIP Nampula 2012, Annual Report: October 2011 – September 2012.

distances to health services or maternal waiting houses and the still relatively low level of knowledge at the community level.

In **Zambézia**, achieving changes in ANC health-seeking behavior have mainly occurred as a result of work with TBAs. Ogumaniha worked with TBAs to sensitize them on the importance of taking pregnant women to health facilities, as well as training community health workers (APEs) and community volunteers. Maternity waiting houses seem to have contributed to an increase in health-seeking behavior. Quantitative data for indicators R1.7 show an increase in the percentage of pregnant women who delivered at a health facility, rising from 63% in Y2 to 71% in Y4. Indicator R1.8 shows a decrease in the percentage of deliveries occurring in communities with TBAs, which dropped from 32% in Y2 to 27% in Y4. The indicators evidence an increase in health-seeking behavior as a result of Ogumaniha interventions.

There are reports of some barriers to ANC service access: “People want to go to the house for waiting pregnant mothers, but when they get there there’s no food.” Another challenge common to Zambézia is the lack of transportation to take pregnant women to health centers. Long distances also make it a challenge to improve health seeking behavior when services are geographically inaccessible. Another barrier is conflicts between TBAs and health facility staff (TBAs are only able to charge for their services if they actually help deliver the baby).

With regards to results, there is some evidence that SCIP has been the root of successes in ANC:

“Institutionalized deliveries have increased since the program was started because of campaigns on ANC-related issues and the construction of mother’s shelters, which provide a safe place for women closer to their homes.” (Nampula Chief Medical Officer). This comment clearly indicates that perhaps the most significant positive result has been that SCIP has supported communities in building and/or equipping maternity waiting houses at the peripheral health unit level.

CASE STUDY 2: FAMILY PLANNING AND CONTRACEPTIVES

Under Result 1: Quality Health Goods and Service Access and Availability Improved, both the Nampula and Zambézia projects included indicators on contraception²⁸ and have placed a priority on increasing access to and use of contraceptives. In both provinces, knowledge of modern contraceptive methods was low, access to contraceptives through health centers was limited, and use of different contraceptives was inconsistent (baseline surveys 2011), resulting in low usage of contraceptives Nampula (Nampula Baseline Survey Report, 2011)²⁹ and Zambézia 12.8% (Ogumaniha Baseline Survey Report, 2010).

As a result, families had little control over family size or child spacing, which has affected the health of both mothers and children. The Population Reference Bureau reported that in 2010, the total fertility rate in Mozambique was 5.1. While about 33.6% to 49.2% of women in selected districts in Zambézia reported they would be unhappy if they got pregnant, only 17% of married women ages 15-49 used any contraceptive method; only 12% of the same used modern contraceptive methods in Mozambique overall. In Nampula contraceptive prevalence was reported at a meager 7.2%. Government views the improvement of reproductive health care as a priority in its health services to help reduce fertility rates.

Nampula SCIP took a varied approach to increasing access to and use of contraceptives:

²⁸ Nampula: Number of contraceptive pills distributed through community based distribution, number of CYP provided through USG-supported programs. Zambézia: Number of contraceptive cycles distributed, number of CYP provided through USG-supported programs.

²⁹ Nampula baseline survey 2011.

- It trained community volunteers on the benefits of contraception and how to hold participatory debates at the community level.
- Theatre groups were trained in conducting family planning plays.
- CLCs and HMCs were provided knowledge and understanding of the benefits of contraception as a way of families gaining control of child spacing to encourage acceptance of this health innovation.
- SCIP accompanied Health Mobile Brigades at the community level to introduce different contraceptive methods such as the pill, then Depo-Provera, and later IUDs, and brought APEs into its trainings.

Results have been promising to date, and it was one of the most-often mentioned successes of SCIP during FGDs and key informant interviews (KIIs.) “One success of the SCIP activities has been in the area of family planning as men now go with women to hospital when she gives birth and for appointments. They undertake an HIV test together so they can get treatment if they need to. They then can learn about FP together and like it because it ‘liberates’ them” (FGD Mogovales, Nampula). In particular, men believed that contraceptive use reduces misunderstanding and friction within the home and the main benefit of FP is to give the woman some “rest” or a breathing space by not having children every year. This was corroborated by health care professionals who have seen an increase in demand for injectables in particular. PMP data demonstrates a steady increase in couples-years of protection (CYP), which is likely to achieve the program's target by the end of 2013.

Indicators	PROGRAM TARGETS	Y1 Achieved	Y2 Achieved	Y3 Achieved	Y4 Achieved	Overall Achieved	Overall Achieved
CYP provided through USG-supported programs ^R	219,351	30,869	53,216	71,559	38,741	194,385	89%

The supply of contraceptive pills has been increased in Y3 of the program, up from previous years due to additional support from PSI in this area, particularly at the community level. However, practical challenges persist. Injectable contraception can only be administered by trained health professionals and distances to health posts are long. In addition, stock-outs persist and supply chains to more remote health posts are inconsistent.

In **Zambézia**, contraception is viewed as an area of more mixed attainment. To access contraception, the first consultation takes place at the health facility (with a male technician); in subsequent consultations the women can access contraceptives closer to the community. Indicator R1.II on the “Number of contraceptive cycles distributed” shows a decrease in the number of new contraceptive cycles distributed each year for the first three years of Ogumaniha. There were 27,905 distributed in Y1; 14,536 in Y2, and 17,598 in Y3. While community members believe it is possible to see an improvement in FP and contraception, as shown in R1.II, for the first three quarters of Y4 with 28,364 contraceptive cycles distributed, there has been some resistance to contraception within the community. It is reported that some husbands are unhappy with their wives using contraception and ask whether “It’s not like

killing [their] children?” Church congregations are also skeptical and echo the same confusion—that family planning is meant to kill children (FGDs Zambézia).

The multitiered, community-based integrated approach of improving demand for contraception by increasing knowledge and reducing concerns about contraception, building confidence in health care services within communities, and working in collaboration with health care professionals has been a success. If this were complemented by a stronger element of building capacity at the health center level to reduce stock-outs and bring services closer to the community level, the intervention would be even more successful.

CASE STUDY 3: YOUTH FARMERS CLUBS

Poor agricultural practices and methods as well as the low use of farming inputs have diminished agricultural yield potentials in Mozambique. This is particularly a problem among the most vulnerable households and orphans and vulnerable children (OVC). The problem extends beyond low yields to post-harvest losses that result from poor food handling and food storage practices. This has led to insufficient food production, leading to food shortages and food insecurity in both Nampula and Zambézia. The World Food Program (WFP) estimates that such losses may add up to 30% of total harvested products in northern Mozambique. With favorable agro-ecological conditions, Zambézia and Nampula provinces possess agricultural potential that should be exploited to tackle food shortages and food insecurity.

In Nampula, the SCIP developed the foundation package, complementary package, and specialized package, which served as the source the development of the concept of Youth Farmers Clubs (YFCs) to provide members with training on record-keeping skills and conservation farming as well as to protect OVC livelihoods. YFCs were reportedly the first community mechanism to be implemented in project communities. Members were identified and groups then formed; mentors taught farming skills, providing group members with practice on demonstration plots. Since then, YFCs have increased in size and scope to include health, nutrition, and WASH components as well as providing theatre for young members. SCIP visits YFCs to conduct special sessions on SRH, malaria, and HIV. With the age of members ranging from 10 to 24 years, YFC activities were successfully segregated so younger members could play, sing, and dance, while older members learn about agriculture, health issues, and nutrition. YFCs include both male and female members, a significant achievement in that gender restrictions imposed by society have not barred attendance in the program for girls. Results have been visible and the project believes that targets will be reached or exceeded by program end. The YFC component has reached 23,287 youth, close to 30% of whom are OVC—93% of its target of integrating 25,000 youth. The project has established 698 YFCs, 82% of the target of 850 YFCs established. All YFCs have received training on conservation farming techniques and safe food handling, use, and storage. Communities report that YFCs are an effective initiative and have given a space for children to play safely and learn valuable new farming and life skills.

In Zambézia the YFC component was developed with the same intention: to teach agricultural technology skills in conservation farming to adolescents, which they would pass on to their parents. The general steps for starting a group are the following: volunteers undertake home visits to identify OVC in the community, sensitize parents about what Ogumaniha can teach the children, form a group of about 30 children, train them on what they will be doing, and begin practical lessons. When a junior farmer exhibits desired skills, they graduate and work on their own. The SCIP YFC component has achieved 72% of the YFC target of 156 YFCs formed, with some 112 YFCs established to date. It had also reached 164% of OVC training target by the end of Year 3. Communities see the value of the skills learned in YFCs and believe conservation agriculture is a key area and children should learn about this type of agriculture. They also report that when children see others changing, they want to join vegetable

gardens and talks despite their young age. There have been some reports of poor attendance from participants because “they are at school which means they do not have much time to spend in the vegetable gardens.” There were also calls for more funds, as the demonstration plots are small. There was a suggestion to include education on irrigation processes.

What remains unclear about YFCs in Nampula and Zambézia is whether the learning taken back home by members has led to significant uptake among their families: Have members’ families started adopting conservation farming techniques? Are parents content with receiving knowledge from their adolescent children? While most communities appear to believe in the sustainability of YFCs, there is nevertheless an unanswered question of whether they are strong enough to last after SCIP’s end. There is also the question of whether communities have gained sufficient know-how in conservation farming to apply their knowledge to the marketing of agricultural produce. Can these techniques be incorporated into mainstream farming methods in Mozambique in line with the view of YFCs as a platform for investing in a future generation of trained farmers who use improved farming techniques?

A frequently voiced concern that goes well beyond YFCs and merits attention is whether all project goals are feasible within the context of a five-year life of the project. For example, while it is plausible that YFCs will lead to the “opportunity to invest in a future generation of well-trained farmers who also use improved farming techniques,” can this be measured within the five years that the program is active? And if not, how will the achievement of this objective be measured and consequently classified as successful or unsuccessful?

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