



ACTIVITY TITLE: SCIP Nampula Project
Annual Report

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ACTIVITY SUMMARY

Implementing Partner: **PATHFINDER INTERNATIONAL**

Activity Name: **STRENGTHENING COMMUNITY THROUGH INTEGRATED PROGRAMMING – SCIP Nampula**

Life of Activity (start and end dates): **August 1st, 2009 – July 31, 2014**

Total Estimated Contract/Agreement Amount: **\$47,600,000**

Obligations to date: **\$15,874,093**

Accrued Expenditures in Year 2: **\$1,000,000**

Activity Cumulative Accrued Expenditures to Date: **\$12,761,409**

Report Submitted by: **Luc Vander Veken, Chief of Party**

Submission Date: **October 31, 2011**

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ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
APEs	Community Health Workers
ART	Anti-Retroviral Therapy
AYSRH	Adolescent and Youth Sexual and Reproductive Health
BC	Behavior Change
BCC	Behavior Change Communication
CBOs	Community-Based Organization
CCT	Community Counseling and Testing
CHA	Community Health Activist/Agent
C-HIS	Community Health Information System
CLCs	Community Leadership Councils or Village Health Committees
CLL	Local Leaders' council – <i>Conselho Local da Localidade</i>
COP	Chief of Party
CPR	Contraceptive Prevalence Rate
CT	Counseling and Testing
CYP	Couple Year Protection
DOT	Direct Observation of the Treatment
DPS	Direcção Provincial de Saude (Provincial Directorate of Health)
DPMAS	Direcção Provincial da Mulher e Acção Social (Provincial Directorate of Social Welfare)
DPOPH	Direcção Provincial das Obras Publicas e Habitação (Provincial Directorate of Public Works and Housing)
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EMoC	Emergency Obstetric Care
FP	Family Planning
GAAC	Community HIV Assistance and Adherence Group- <i>Grupo de Apoio e Adesao Comunitario</i>
GOM	Government of Mozambique
HC	Health Center
HF	Health Facility
HP	Health Post
ICAP	International Center for AIDS Care and Treatment Programs- Columbia University
IEC	Information, Education, Communication
IUD	Intrauterine Device
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MM	Maternal Mortality
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organization
NPCS	Provincial AIDS committee - <i>Núcleo Provincial de Combate ao Sida</i>
OIs	Opportunistic Infections
OJT	On-The-Job-Training
PE	Peer Educators
PLWHA	People Living with HIV/AIDS

PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post Natal Consultations
PSI	Population Service International
RH	Reproductive Health
SCIP	Strengthening Communities through Integrated Programming
SD	District Department Directorate- <i>Serviços Distritais</i>
SDP	Service Delivery Point
SDSMAS	District Health Women and Social Affair Directorate – <i>Serviços Distritais de Saúde, Mulher e Acção Social</i>
SDPI	District Public Works Directorate – <i>Serviços Distritais de Planeamento e Infraestruturas</i>
STIs	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
USG	United States Government
VCT-C	Voluntary Counseling and Testing at Community level
WASH	Water and Sanitation Hygiene
YFS	Youth Friendly Services – SAAJ – <i>Serviço Amigos dos Adolescentes e Jovens</i>

Introduction

The Strengthening Communities through Integrated Programming (SCIP) project in Nampula province, Mozambique is a 5-year project funded by the United States Agency for International Development (USAID). It is designed to improve quality of life at the household and community level by improving health and nutrition status and increasing household economic viability. Combining health, water and sanitation and youth farmer's club development, PSI, World Relief, CARE and CLUSA, under the leadership of Pathfinder International, are currently working at the provincial, district, and community levels in 14 districts of Nampula in close collaboration with government and in a complementary manner with development partners.

SCIP project is supporting government efforts to achieve the following results:

1. Quality health goods and services access and availability improved;
2. Appropriate health practices and health care seeking behavior adopted;
3. Accountability of community and district health structures to the people they serve increased;
4. Community social infrastructure sustained through a range of allies and networks of support they can draw upon to solve health problems;
5. Availability and use of clean, multi-use water increased;
6. Sanitation facilities and hygiene practices in target communities improved.

The project's strategy is to create progressive, transformational change by applying targeted packages of interventions designed to respond to prevailing conditions and leverage other resources to have the greatest impact. The targeted packages are designed to horizontally and synergistically integrate project activities across geographic regions and technical sectors, providing coordinated, efficient implementation with stakeholder engagement. All interventions are designed to promote gender equity and inclusion, and prevent fragmenting local participation or intensifying social inequality. SCIP tailors its interventions to each district according to three packages:

The "complementary package" of interventions is being implemented in nine districts (Angoche, Erati, Meconta, Memba, Mogovolas, Moma, Nacala-Porto, and Nacala-Velha) where Title II ¹ programs (e.g. the SANA project) are ongoing. Among the nine districts, five of them (Erati, Memba, Monapo, Nacala Velha and Nacala Porto) are also benefiting from WASH interventions, including increased access to potable water and latrine use. Building on and working in close collaboration with Title II, SCIP trains the SANA community volunteers to provide family planning counseling and referrals linked to health facilities. In addition, SCIP trains local *animadoras* in the areas of PMTCT, OVC, and chronically ill patients in the framework of the continuum of care.

The "specialized package" is being implemented in four districts (Ribaue, Nampula Rapale, Mecuburi and Malema) and two areas of Nampula city (Namutequelina and Mutauanha) that do not have Title II activities. These districts are benefiting from a more intensive package of interventions covering the whole four districts and two areas of Nampula city.

In all 14 districts, SCIP is implementing a "foundation package" designed to strengthen health systems by:

1. Improving the quality of health care offered at peripheral health facilities (HF);
2. Strengthening the linkages between SDSMAS and peripheral HF;

¹ Title II is the US government-funded Food for Peace Multi-Year Assistance Program (MYAP).

3. Strengthening the linkages between the health units and the communities, through the accompaniment of the peripheral HF committees;
4. Working with a variety of community health workers to disseminate health education and change hygiene behavior;
5. Implementing an HIV prevention program involving community counseling and testing;
6. Building a program dedicated to OVCs

Despite the many challenges faced by a large and complex program working in a health deprived area where there is a lack of commodities, a shortage of HIV tests, competing demands from health workers, and a weak capacity of intervention, SCIP nonetheless maintained its momentum and continues to strive to improve the quality of health services; demand for and access to health services; and the integration of health topics with water and sanitation, agriculture and social networks to mitigate the household's vulnerability. This resulted in significant achievements in terms of number of people reached with information on health and other sectorial components and along with strengthening community led responses to improving their overall welfare.

Strengthening Coordination

In February, SCIP attended a workshop which focused on sharing experiences between SCIP Zambezia and SCIP Nampula in Gurue. Following this, SCIP and SANA organized two regional meetings between SCIP district coordinators and SANA District Nutrition Officers and District Agriculture Technicians. It was agreed that monthly district meetings will be held to ensure an effective integration of SCIP and SANA activities in Nampula province.

In March, coordination meetings took place between ICAP and EGPAF district supervision teams and SCIP provincial and district technical assistants. The purpose of this meeting was to integrate SCIP activities with those being implemented by ICAP and EGPAF. All participants reviewed the opportunities and challenges for strengthening of the continuum of care between the health units and communities.

In April, a meeting was held between USG representatives, Nampula provincial government representatives, other USG-funded NGOs and local NGOs to discuss a joint planning cycle and how to integrate activities in order to scale up results for USG program interventions. More specifically, all participants agreed with the provincial government to implement regular review and planning at the district level; and to strengthen coordination at local level through regular meetings involving local NGOs and government partners.

In June, SCIP actively participated in the 2012 integrated planning exercise led by DPS for the provincial health sector.

In September, SCIP Nampula and SCIP Zambezia organized a BC workshop with provincial and district staff to share strategies and activities.

SCIP regularly attends the quarterly thematic meetings at the different provincial directorates (DPS, DPMAS, DPOPH, and DPA). These meetings are a venue for stakeholders to share activities being implemented throughout Nampula province.

Promoting Health in the Districts and Communities

Health promotion is a major focus for SCIP. Several activities took place to support this in Year 2.

In February, to introduce innovative tools to advance the Project's behavior change objective, SCIP brought a Pathfinder International behavior change expert to train project staff using the "Pathways to Change" game, which is based upon comprehensive debates and interactive role playing. This tool will help staff members better understand how to integrate data from informal community research into program design.

In April, the SCIP community health and behavior change team participated in an exchange visit with Pathfinder Ethiopia programs to learn more about the concept and design of the “leadership network model” approach. SCIP introduced the concept to community supervisors from *localidades* as well as to the *animadoras* during the fourth quarter. The “leadership network model” is a tool used to encourage community health workers to comply with defined criteria so that their households can be certified by CLC. Examples of the defined criteria are: correct use of latrine at home; children receiving and completing the required vaccination; pregnant women completing preventive measures such as IPT, PMTCT, institutional deliveries etc.

Throughout Year 2, several efforts have been made to reach communities with health promotion messages. Coverage of the households visited by volunteer home based visits in the specialized districts increased from 50% to 90% of the households. Furthermore, this year, theater groups reached all 14 districts with their messages compared to only 50% reach in Year 1. Partnerships with the community radios of Ribae, Mogovolas, Memba, Erati, and Nacala Porto (WATANA) have been established to complement mass health promotion efforts. SCIP supported three Maternal and Child Health campaigns which included vitamin A distribution, DTP3 vaccinations, primary school de-worming and FP interventions.

Continuum of Care

SCIP continues to strive in its activities related to the continuum of care. Much of the work done in this area is carried out by community volunteers who are trained to identify chronically ill people and OVCs and refer them to the health units and other social services. The volunteers also provide clients with family health kits which contain goods and information about nutrition and disease prevention.

In September, in order to improve the quality of HBC visits for chronically ill people, SCIP Nampula conducted training on the MOH HBC curriculum for 100 *animadoras*. Additionally, in order to strengthen the linkages between communities and health facilities, SCIP funded health facility HIV and psychosocial support focal points and District Head doctors to be trained in the GAAC (Grupo de Apoio e Adesao Comunitario) strategy. This training took place in the first week of October.

Mitigation of HIV epidemic

Much effort was put into interventions to increase the number of OVC being reached by SCIP. Throughout the year, SCIP conducted trainings for *animadoras* and promoters on the six essential OVC services. OVC services in the specialized districts, reached 60% of OVC in those districts. Particular focus was given to identification and referrals of OVC to the different services offered by the Government and locally, specific attention was given to refer the OVC to YFCs. After a request from USAID, SCIP initiated OVC services in the complementary districts; targeting one locality per district.

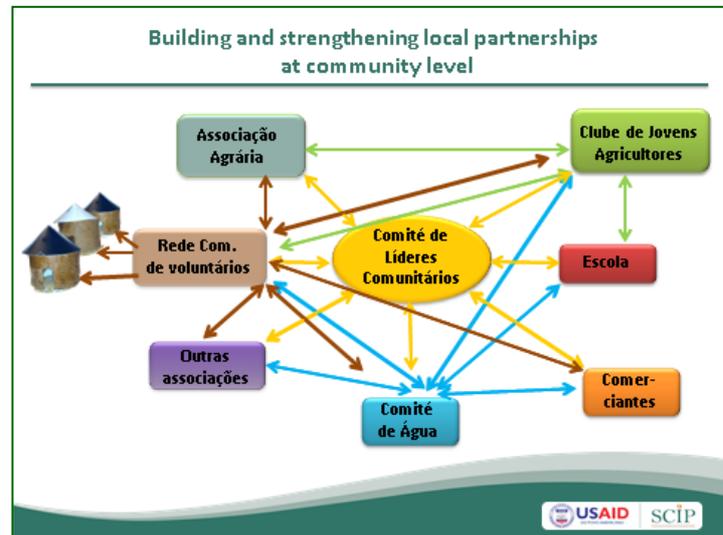
Strengthening National Health System’s Capacity to Offer High Quality Services

SCIP is making efforts to strengthen the national health system in each of the fourteen districts. This is being done through activities such as the rehabilitation of health facilities and/or expansion to include maternity wards as well as the construction of waiting huts for expecting mothers at several health facilities. SCIP is working with the peripheral health units in the districts to plan and implement outreach activities down to the most remote village of their catchment area. The Project is also supporting DPS and the SDSMAS to increase data quality collection and analysis as well as to implement MOH quality standards at peripheral health facilities.

SCIP continues to offer support to SDSMAS and DPS on request and as frequently as possible.

Increasing Sustainability of Community Interventions and Accountability of Community Structures

In order to implement awareness mobilization efforts at the community level, it is important to involve social and traditional leadership from the onset. To facilitate the adoption of behavior change, it is important to make communities and their leaders reflect on the causes of their problems and solutions for them; to design an action plan for their community, they must involve all resources in the community, (i.e. Farmers' association, YFC, Water committees, local businessmen, schools etc) and promote and define linkages between the groups. For example, local businesses generally do not carry health commodities in their stock. By integrating into the CLC network, they will be more involved and engaged to make such commodities available for the community. The linkages established should be monitored and discussed publicly by the CLC in order to recognize the importance of the partnership. As more partnerships are built, there will be greater sustainability of interventions at the community level.



To make CLC more accountable to the community, their plans should be monitored and recognized by CLL and the health facility committees and fit into their own plans. Outside of CLL meetings, the administrative authority of the *localidade* should also participate in the HF committee meetings so that linkages can be made between the health facility committees and the main resources of the *localidade*. Furthermore, the head of the *localidade*, after participating in the HF committee meeting, will be aware of any weaknesses in the operations of the HF and will be able to report them at the regular district government meetings. These meetings involve the directors of the SD.

Highlights of Year Two

Health Facility Upgrades

- 3 health facilities renovated
- 3 health facilities with construction ongoing by the end of FY2
- 4 health facility rehabilitations assessed and approved to start in quarter one of FY3.
- 4 health facility extensions with construction plan prepared but awaiting approval

Training Opportunities

- 31,855 community and health facility based health workers completed a training program on HIV
- 53,699 community and health facility staff participated in trainings covering the areas of malaria, FP and hygiene and water

Service provision

53,216 CYP registered
99,132 deliveries registered in health facilities
646,982 ANC visits (new and follow-up)
82,779 FP new visits
60,389 people tested for HIV at the community level
115,853 children under 12 months of age received DPT3 and **327,677** received Vitamin A

Community Care

31,426 OVC benefiting of at least one OVC service
3,215 eligible clients receiving food and or other nutrition services
1,390 people benefiting from home visit services

Community social infrastructure

197 CLCs established (cumulative)
7,924 community-based distribution systems in place

Youth Farmer clubs

521 YFC established
16,688 people trained in conservation farming
7,359 people trained in safe food handling and use

Water and Sanitation

871 people trained in safe water
52 water sources repaired
10 new water sources constructed
10,573 latrines built
42,292 Tip-Taps installed

The next section of this report discusses SCIP's activities and achievements in terms of the Project's six results and selected indicators. Each result segment elaborates the result's strategy, followed by a more detailed discussion of the Project's progress on indicators and the main activities planned for Year 3. The third section of this report provides a management overview for Year 2. The report concludes with a selected success story.

Activities and Achievements by Results and Indicators

Result 1: Access and availability to quality health goods and services improved

SCIP improves the access to and quality of health goods and services by working in close collaboration with Provincial Health Directorates (DPS), District Health Women and Social Affairs Directorate (SDSMAS), CBOs, NGOs, and CLCs. One of SCIP's main objectives is to strengthen the National Health System (NHS) by transforming some health posts into health centers with maternity services. District SCIP teams, together with the SDSMAS, have thus identified health facilities to be rehabilitated and/or expanded with a maternity ward; selection criteria included population, remoteness, and potential coverage of service provision.

SCIP also provides training to a diverse cadre of health providers and community members, which may occur through formal classroom work, on-the-job trainings/practical applications or both (Indicator 1.4). Focus areas include: Family Planning, Reproductive Health, Child Health, Maternal/Newborn Health, M&E, Surveillance, Quality of Care Standards, Hygiene and Water, Malaria Prevention, and Community Involvement in Health Issues. These trainings not only increase the capability of providers and caregivers to deliver services, but also foster a community environment conducive to behavior changes. Additionally, one of SCIP's priorities is to increase the capability of providers and caregivers through in-service training related to HIV/AIDS (Indicator 1.2). The Project targets not only caregivers but also *animadoras* in the community who can train other volunteers and CLCs members. In turn, training these individuals also enables SCIP and SDSMAS to better evaluate their capacity to mitigate the HIV/AIDS epidemic each year.

SCIP directly improves family planning services through the delivery of CYP activities and the distribution of contraceptive pills (Indicators 1.5 and 1.6). Crucially, changes in the number of USG-assisted service delivery points experiencing stock-outs influence these goals (Indicator 1.3), and SCIP works to coordinate supply levels with health authorities at the district, provincial and national levels.

In Year 2, SCIP implemented activities in all fourteen districts to strengthen the national health system. Activities initiated with the strengthening of the collaboration with DPS and involvement with SCIP supported activities at the district level. All targeted districts were visited in quarter one by the manager of the SCIP health component and a representative of the Provincial Directorate in order to evaluate Year 1 achievements and discuss the Year 2 work plan as well as the mechanism of local collaboration strengthening.

SCIP brought on a building expert to the team to conduct assessments for the rehabilitation/expansion of 16 health facilities. Shortly after this assessment, bids were submitted and rehabilitation of certain health facilities began. Some of the planned rehabilitations were completed but due to the administrative complexities involved in this process, the rehabilitation of health centers will take longer than originally expected.

Year 2 also produced improvement in the communication and coordination between SDSMAS and DPS. Additionally, joint NGO and SDSMAS district forums were created or strengthened and met quarterly to discuss collaboration and integration of activities. SCIP has participated in the district and provincial planning exercise for 2012 and is reporting quarterly to each district government.

To build capacity at the community level, SCIP focused on two main target groups: CHWs and CLs. The CHWs because they are responsible for transmitting key messages at the household level through IEC home based visits; and the CLs because they are the key to building a fostering

environment for behavior change. The trainings of CLs not only focus on content, but also participatory methodologies (i.e. Pathways for Change).

To build capacity at the HF level, SCIP supported 558 health provider training opportunities at district level on diverse topics such as MCH, EPI, quality of care, and FP/RH. In addition to trainings, SCIP has expanded its mentoring activities to health facility provider teams, specifically the peripheral health facilities in which SCIP has supported community mobilization and involvement. The mentoring activities focus on family planning, integration of FP within PNC and general curative consultations, at risk child consultations, EmOC and the humanization of the services provided. Some basic equipment and furniture were supplied to accompany the service quality improvement needs including special attention to biosafety.

In order to increase access to health services for the most remote households, SCIP supported mobile outreach brigades going out from the peripheral health units. Joint planning and logistic needs for the brigades are done in coordination with the health facility committees.

SCIP provided technical assistance to the head of each peripheral health facility to improve his/her management and leadership abilities in relation to the health facility committee. When the health facility committee is functioning properly, it is an effective tool for increasing quality and access of services.

Indicator 1.1: Number of rehabilitated health facilities R

1.1 # of rehabilitated health facilities						
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
1	0	1	1	3	6	2

This indicator counts the number of health facility rehabilitations or extensions. Only completed rehabilitations are counted.

One of SCIP's objectives is to strengthen the National Health System (NHS) by transforming some health posts into health centers with maternity services. District SCIP teams, together with the SDSMAS, have thus identified health facilities to be rehabilitated and or expanded with a maternity; selection criteria included population, remoteness, and potential coverage of service provision. Please see table below for description of ongoing and planned activities and respective status.

In quarter one, the Teterrene maternity ward rehabilitation was completed; in quarter two, the AYRH services of Rapale HC was completed; and in quarter four, the water distribution system of Rural Hospital of Ribaue, including reparation of the water source, was completed. SCIP did not reach the Year 2 target; nevertheless two health facility extensions (Murralelo and Riane) are ongoing as well as one rehabilitation (Murrupelane). Furthermore, four more request for proposals for health facility extensions were released and are being reviewed and/or submitted for approval; four HF rehabilitation works have been approved to be initiated in quarter one of Y3.

Description of works' progress district by district

Districts	HFs for Rehabilitation	Status	HFs for Extension	Status
Angoche			Parta Health Post	Planned for FY3
Erati			Nantoge Health Post	Proposal elaborated and under review by Pathfinder HQ and further on to USAID for approval
			Samora Machel Maternity	Planned for FY3
Meconta	Teterrene Maternity	Completed FY2		
	Meconta HC (porch and 2 consultation spaces)	Request for proposal sent out; Planned for FY3		
Mogovolas				
Monapo				
Moma	Lardes HC	Planned for FY3	Uala Health Post	Proposal elaborated and under review by Pathfinder HQ and further on to USAID for approval
			Nambilane Health Post	Planned for FY3
Memba			Nivale HP	Planned for FY3
Nacala – Porto	Murrupelane HC	ongoing		
	Naherengue HP	Request for proposal sent out; Planned for FY3		
	Quissimanjulo HC	Request for proposal sent out; Planned for FY3		
Nacala – Velha	Nacala Velha sede (porch and 2 consultation spaces)	Planned for FY3		
Malema			Murralelo Health Post	Contract signed and construction ongoing
Mecuburi			Popué Health Post	Proposal elaborated and under review by Pathfinder HQ and further on to USAID for approval
			Milhana HP	Planned for FY3
Nampula District	Caramaja HC	Completed FY1	Mucova H.P.	Proposal elaborated and under review by Pathfinder HQ and further on to USAID for approval
			Saua-Saua HP	TBD
Ribaue	Namiconha	Request for proposal sent out; Planned for FY3	Riane Health Post	Contract signed and construction ongoing
	HP of Escola Basica Agraria	Completed FY 1		
	Rural Hospital of Ribaue (water distribution system)	Completed in FY1		

Furthermore, based on SDSMAS priorities and the level of the community involvement and mobilization, a list of maternities in need of construction and/or rehabilitation of maternity waiting houses was established. Simultaneously, SCIP continues to work closely with the communities to create demand by increasing awareness of the utility of these waiting houses for pregnant women, taking into account culture and customs related to childbearing. Please see table below for information on the completed, ongoing and planned waiting houses.

Districts	Health Facilities Prioritized to get a Waiting House for Pregnant Mothers	Status
Angoche	Namitoria and Namaponda	Planned for FY3
Erati	Kutua and Samora Machel	Planned for FY3
Meconta	Teterrene	Completed in FY2
	Corrane	Ongoing
Mogovolas	Iulute	Ongoing
	Muatua	Planned for FY3
Monapo	Muatuca	Ongoing
	Mecuco	Planned for FY3
Moma	Metil	Ongoing
	Pilivili	Ongoing
Memba	Caleia, Namahaca and Mazua	Ongoing
	Lurio and Pavala	Planned for FY3
Nacala – Porto		
Nacala – Velha	Ger Ger, Barragem and Namalala	Ongoing
Malema	Nacata and Mutuali	Completed in FY2
	Nataleia	Planned for FY3
Mecuburi	Nahipa, Muite	Ongoing
Nampula District	Namaita	Planned for FY3
Ribaue	Chica, Iapala sede and Riane	Planned for FY3

As one of the SCIP's guiding principles is to work in close collaboration with government partners, SCIP has opted to establish its district office spaces in existing government premises; as much as possible at the SDSMAS Office of Statistics (NED) level. Therefore, SCIP has also rehabilitated the NED offices in Angoche, Rapale, Memba and Meconta; and completed the extension of the NED offices of Ribaue and Malema.

Indicator 1.2: # of health care workers who successfully completed an in-service training program within the reporting period (relevant to HIV) R

1.2 # of health care workers who successfully completed an in-service training program within the reporting period relevant to HIV						
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
12,612	6,738	1,149	11,356	31,855	12,000	9,861

This indicator counts the number of health care workers and caregivers who are available to support the mitigation of the HIV/AIDS epidemic each year. SCIP improves the skills of MCH and other Health Unit personnel through updates followed by training with Community Leaders of their respective health areas in the following topics: RH/FP/MCH including Newborn Health and STI/HIV/AIDS. The aim of these CL training sessions is to create a fostering environment for behavior change at the community level.

During FY2, 31,855 CHAs – Community Health Activist - completed an in-service training program. The trainings cover the six essential services for OVC, how to care for chronically ill people and how to identify, refer and follow up on both OVCs and chronically ill people as well as HIV prevention, FP integration, diarrhea and malaria prevention, early detection and treatment. This number counts volunteers and *animadoras* as well as YFC peer educators and community leaders.

SCIP surpassed its target for trained CHAs for Year 2. Next year, major reparations of the roads and railway line in Nampula will occur. SCIP felt it was important to train more CHAs than targeted in order to be prepared for all the outreach activities the Project will conduct with the workers coming in. Because the Project reached such high numbers earlier than projected, we do not expect to meet the Year 3 target for this indicator.

Indicator 1.3: # of USG assisted SDP experiencing stock-outs of specific tracer drugs R

1.3 # of USG assisted SDP experiencing stock-outs of specific tracer drugs						
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
44%	93%	49%	94%	N/A	50%	N/A

This indicator measures product availability (or lack thereof), and serves as a proxy indicator of the ability of a program to meet clients’ needs with a full range of products and services. SCIP has a rolling monitoring system and cannot capture all 143 units every quarter. The essential drugs to be tracked under SCIP are the same as the national list for Mozambique, and are divided into three sections:

- Section 1: Child Survival and EOC tracer drugs, including Sal Ferroso 90mg + Acido Folico 1 mg; Mebendazol; Paracetamol Oral; Cotrimoxazol, Suspensão; Amoxicilina, Suspensão; Cloranfenicol, Injectavel; Gentamicina, Injectavel; Sais de Rehidratação oral; Salbutamol, and Solução oral.
- Section 2: Oral Contraceptive Pills.
- Section 3: First-line Anti-Malaria Drugs.

Nampula Province experienced severe shortages of several essential drugs. Nevertheless, the stock out situation improved slightly from quarter three to quarter four but providers are still struggling to meet the needs of the community.

Related to the Section one drugs, during quarter four, 44% (24/55) experienced stock outs of at least one of the essential drugs from the list;

Related to the Section two drugs (oral contraceptives), during quarter four, 10% (5/55) experienced stock outs of at least one of the essential drugs from the list; meanwhile at least one time during the year, all peripheral health units reported stock-outs of “Mycrogynon” oral contraceptives, hindering the SCIP intervention to reach the expected results through the planned community based distribution (CBD) strategy to be progressively implemented by “*animadoras*” in the “complementary” districts (where there is one community worker for each community, an average of 500 families).

Related to the Section three drugs (first line antimalarial drugs), during quarter four, 18% (10/55) experienced stock outs.

Additionally, although not captured by this indicator, during this year, health units reported regular stock-outs of HIV and malaria rapid diagnosis tests, as well as Vitamin A. Such stocks-out occurred nationwide and are not unique to Nampula Province. SCIP made several contacts at both provincial and national level in an attempt to get a better sense of the source and scope of the problem. During quarter four, SCIP funded condom transportation from Beira to Nampula as the Nampula stock was nearly finished. On a fortnightly basis, SCIP vehicles coordinate with the Nampula deposit to support the regular district logistics.

Indicator 1.4: Number of people trained with USG funds, by type R

1.4 # of people trained with USG funds, by type							
Type	Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
Total	39,021	37,142	1,222	2,690	80,075	73,625	8,383
1) FP/RH	12,641	12,800	353	662	26,456		2,034
2) Child health	2,814	628		328	3,770		205
3) Maternal/newborn health	2,560	568		449	3,577		240
4) M & E, surveillance, &/or HMISR CMIS	96	14	45	544	699		208
5) Quality of care standards and guidelines	60				60		0
6) Hygiene/ water	10,068	11,326		276	21,670		1,394
7) Malaria	10,302	11,452	38	242	22,034		219
8) Community involvement in health and sanitation issues	480	354	786	189	1,809		4,083

This indicator counts the number of health providers and community members trained in the following areas: FP/RH; Child Health; Maternal/Newborn health; HIV/STI; Hygiene/Water/Malaria; Management & Supervision; M&E, Surveillance, and/or HMIS; Quality of care standards and guidelines; and Integrated Services. The indicator counts health providers as well as *animadoras* and volunteers in the community who can train others and council.

A total of **80,075** health providers, community health workers and CL benefited from various trainings to improve quality of services and to foster a community environment conducive to behavior changes. This number represents 109% of the Year 2 target for this indicator. SCIP was able to surpass this target due to the fact that the Project trained more volunteers than originally projected.

• **Family planning:** **39,021** nurses, midwives, *animadoras*, volunteers and community leaders were trained.

SCIP’s recent baseline survey revealed the dimensions of the family planning problems in Nampula. Only 7.9% of respondents indicated that they used modern contraceptive methods, even though around 95% of them were aware of these methods. This figure was reinforced by feedback during SCIP’s own training sessions on this issue, where many women revealed it is impractical for them to pay frequent visits to the health unit (often times due to distance and other demands to maintain the family). As such, SCIP cannot emphasize enough the importance of strengthening the community based distribution of contraceptives in these areas.

Training was given to nurses about how to have debates about “hot topics”. After these debates with the communities, women were interested in having IUD and their husbands agreed to let them get them. Six wanted IUDs while six more requested sterilization. These women went to the HFs, with their husbands, to request either the IUD or sterilization. Only one was able to have an IUD

inserted while others were requested to return another day. For those who wanted sterilization, they would have to go to another district where the HF has a surgeon.

•**Maternal and Newborn Health: 3,577** (F) Traditional Birth Attendants, animadoras, volunteers and community leaders were trained on Newborn topics and dangers signs of the pregnancy, delivery and post-partum care. The importance of the linkages and referrals between TBAs and health units was highlighted. Through these trainings with TBAs, it became clear that the woman’s mother and/or sisters are the first choice to assist with delivery. TBAs are only called in the case of difficulties.

•**M&E: 699** providers were trained in EPI, HIS, Community Information Systems, and the MOH Health Monitoring Information System (HMIS).

• **Malaria: 22,034** community volunteers and animadoras received training in the districts of Erati, Mecuburi, Rapale, Malema, Nampula Rapale and Nampula City; and a small number of community leaders were trained in the districts of Erati and Monapo.

•**Child Health: 3,770** SANA animadoras and Community Leaders were trained during Year 2. Specific focus was given to continuum of care services for chronically ill people and OVCs. The training curriculum introduced the following topics: What is the meaning of the continuum of care for an OVC child? What is the role of the community and CHW in the strengthening of the continuum of care? What is the “at risk child health consultation”, why is this consultation so important for vulnerable children? What are the community services that the CHW can offer at an OVC household and how should they be offered (Psychosocial support, Nutrition counseling, health unit referrals, YFC referrals)? What are the referrals and what is the follow up that the community can carry out for increasing the number of OVC enrolling in schools and getting their birth certificates?

•**Hygiene and Water: 21,670** volunteers, animadoras and Community leaders were trained in diarrhea prevention, water treatment and conservation and the importance of the use of latrines as well as the importance of hand washing.

•**Community involvement: 1,809** community leaders were trained in community involvement and mobilization issues such as how to identify the challenges and problems of a community and the local strategies that they can apply to overcome those problems and their causes.

Healthy changes to Initiation Rites: There was a meeting with all community members involved in initiation rites in Memba district, including community leaders. This was a 3 day debate about how to safely conduct initiation rites. After the debates, they understood the risk related to HIV transmission (ie using one blade for 10 boys) so they agreed to change this practice; the circumcision method that was being used; and what the difference between having circumcision in the hospital versus the traditional method. They agreed that a nurse could be brought into to do the circumcision or consult after or bring the child to the hospital to have it done. They used examples of actual cases to strengthen their point. Participants from education and health sectors were present for best integration.

Indicator 1.5: Number of contraceptive pills distributed through community-based distribution (CBD)

1.5 # of contraceptive pills distributed through community based distribution (CBD)						
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
626	656	324	1,032	2,638	10,000	2,264

This indicator counts the number of contraceptive pill packets distributed to CHWs for CBD. However, SCIP recognizes that some of the pills distributed to the CHWs may not reach end users.

There has been a continuous shortage of contraceptives at the provincial level from last year until August of this year. During this shortage, the relatively low quantities of pills received at the provincial level have only covered the minimal needs of Nampula’s health units, and not addressed the needs of the community health networks. There was some increase in the fourth quarter, particularly in the month of September, but overall the distribution of pills at the community level was low this year: 626 cycles were distributed in the districts of Mogovolas, Nacala Velha, Memba, Ribaua, Meconta, Moma, Malema and Angoche. Meanwhile, the animadoras of the complementary districts have started to be an active player in condom distribution at the village level. In order to be sustainable, SCIP supports the implementation of condom supplies for animadoras through the health units; nevertheless, SCIP recognizes that more support should be offered to improve the pharmaceutical warehouse management, as well as the coordination between the health unit team and CHW network.

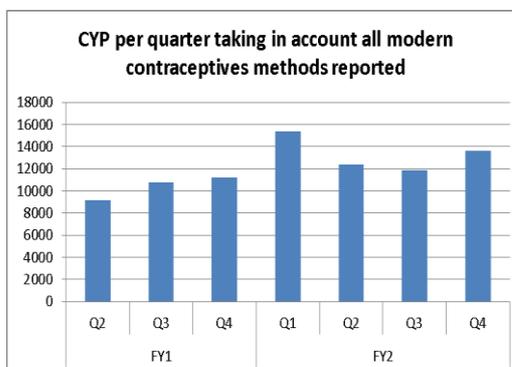
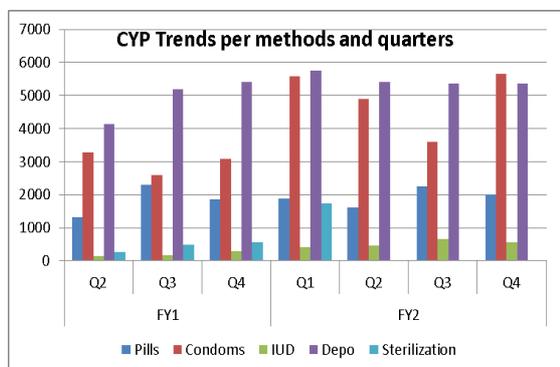
Indicator 1.6: CYP provided through USG-supported programs R

1.6: Couple Years Protection (CYP) provided through USG-supported programs

Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
13,581	11,865	12,402	15,368	53,216	42,000	30,869

This indicator estimates the level of protection provided by family planning services based upon the volume of all contraceptives distributed to clients during that period. This indicator is calculated by adding the number of contraceptive commodities supplied (condoms, pill cycles) and services performed (IUD, Injection, VSC) by both facilities and CBD over the year. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYPs for each method are then summed over all methods to obtain a total CYP figure. Numbers for IUD, pills and injections are collected directly from DPS, while SCIP Community Coordinators collect condom distribution information from the health districts’ warehouse.

During Year 2, the Project reached **133 %** of its target in CYP. Overall, **116,348** pill packs and **2,367,823** condoms were distributed, **601** IUDs were inserted and **87,553** Depoprovera injections were given.



Planned activities for Year 3

- SCIP has planned to bring water to six health units: Murralelo, Nantoge, Caleia, Nanhupo Rio, Calipo, and Iulute
- Continue the process of HFs renovation and extension
- Mentor service providers in the provision of FP services including insertion of IUDs, CACUM and AMTSL
- Continue cascade training in RH/FP/STI/HIV/AIDS for community leaders in all districts.
- Follow up on CLCS plans related to comprehensive reproductive health, including HIV/AIDS, gender and male involvement.
- Continue support to maternal and neonatal mortality committees.
- Continue to support the purchase and management bicycle ambulances through an MOU and provide training on bicycle management.
- Continue strengthening the implementation of the linkage mechanisms with AIDS treatment services.
- Continue to provide management assistance on the stock out of condoms, oral contraceptives and other medicines.
- Continue working sessions with DPS and districts to adequately manage and forecast contraceptives including condoms, and other essential drugs
- Conduct refresher training for SCIP community supervisors and counselors on adherence, confidentiality and the mechanism of coordination between health facilities/ health post support units and the community network
- Continue to train SANA “animadoras” and community leaders in continuum of care for chronically ill patients and OVCs
- Train community supervisors, “animadoras” and promoters in AYSRH in order to develop regular activities for YFCs
- Provide TOT for community supervisors, promoters and community leaders in CLTS followed by a training of CLC members
- Continue to support monthly data analysis at district level

Result 2: Appropriate health practices and health care seeking behavior adopted

SCIP recognizes that although improved access to health goods and services is necessary, improving the quality of life in Nampula also involves adopting the appropriate health practices and health care seeking behavior. To this end, SCIP promotes behavior change in HIV prevention, safe water use, latrine and hygiene promotion and other health CS/RH behaviors (including Certeza use).

SCIP monitors behavior change activities by reaching out to individuals through community health activities (Indicator 2.14 and 2.16) and the distribution of IEC materials (Indicator 2.2). SCIP also reaches out to the target population by providing food and/or nutrition services (Indicator 2.1), reaching individuals or small groups through HIV prevention interventions (Indicator 2.15), providing HIV testing and counseling (Indicator 2.18), providing pregnant women with a complete package of ANC services (Indicator 2.12) and vitamin A within six weeks post-partum (Indicator 2.9), providing children age 12-23 months of age with immunization (Indicator 2.20), and serving OVCs (Indicator 2.23).

If successful, SCIP should witness a number of improvements in the behaviors of the target populations. These improvements are captured through changes in the number of households that own and use ITNs (Indicators 2.3 and 2.4); in the percentage of women who regularly use modern contraceptive methods (Indicators 2.7 and 2.8), who exclusively breastfeed children 0-5 months (Indicator 2.22), who deliver with skilled birth attendants (Indicator 2.11) and/or in health facilities (Indicator 2.10), and who visit health facilities for ANC (Indicator 2.5); and in the number of facility visits to health facilities more generally (Indicator 2.14). As mentioned above, data for Indicators 2.3-2.9, 2.11 and 2.22 were collected as part of the recent baseline survey and will not be discussed below.

During Year 2, SCIP met or exceeded 12 out of the 13 (92%) indicators for this result. The main programmatic achievements are highlighted below:

Continuum of Care and Positive Prevention:

In order to strengthen collaboration with activities being implemented by clinical partners, in January, SCIP presented the Project's proposed strategy to strengthen the continuum of care between communities and health facilities at the annual provincial CLINIQUAL meeting attended by members of the DPS, ICAP, EGPAF and other health partners. Partners and DPS strongly supported the proposed strategy. Additionally, SCIP has started the training of 400 animadoras in the HBC MOH curriculum in order to a) increase the quality of services offered to those identified by the community health network and b) strengthen the linkages between health facility HIV, psychosocial support focal points and the communities. Finally, in October of Year 3, SCIP will support the training of health facility providers in the GAAC strategy.

In order to strengthen collaboration being implemented by OVC partners, in February, SCIP presented the Project's proposed strategy based on national PACOV standards at the annual OVC Nucleo Provincial Multisectorial meeting joining with 21 SDSMAS and DPMAS officials and other partners. The 2010 SCIP experience and results achieved in the specialized districts were presented and the Project's strategy to launch a pilot program that will mitigate the suffering of OVCs by linking them to government service delivery programs and to the youth farmer clubs in the complementary districts was discussed and approved.

VCT-C counselors were trained in supporting positive prevention activities. For example, in order to alleviate the burden on new mothers who are seropositive and are concerned about disclosing their status to their partners, VCT-counselors are working together with MCH nurses to conduct couple counseling and testing at home.

Strengthening the integrated BC and BCC approaches

Based on the experience of SCIP’s Year 1 interventions, the Project’s BC strategy was refined aiming at increasing the quality of the front line workers’ interventions at the community level enabling SCIP interventions to progressively integrate a “bottom-top” BC approach highlighting specific barriers and enablers identified by the beneficiaries. To implement the revised BC strategy, in the second quarter, SCIP introduced a new tool to health providers and CLC members: the “Pathways to Change” game to maximize opportunities to effectively address individual and/or small group level behavior change. Additionally, in the third quarter, SCIP introduced the “model family” package. From this intervention, the first target for “leadership network model” is the animadoras and volunteers of community networks. A “leadership network model” should comply with defined criteria and should be certified by CLC. Examples of the defined criteria are: correct use of latrine at home; children receiving and completing the required vaccination; pregnant women completing preventive measures such as IPT, PMTCT, institutional deliveries etc. Based on the concepts above, SCIP has multiplied participatory training sessions for community leaders, community debates using Pathways for Change and identifying barriers and facilitators which were used by the 14 theater groups to produce new plays and were shared through community radio programs by integrating interviews of community members participating in those activities.

To increase the quality of theater groups, SCIP has brought a Theater Group Coordinator to the team. To strengthen the partnership with the community radios, SCIP has signed MOUs with Ribaua, Mogovolas, Memba, Erati, and Nacala Porto (WATANA) through the Project supports the radio stations with equipment and field reporting opportunities. In return, the radio stations air radio spots, theater plays, debates and the findings from their field reporting.

Indicator 2.1: Number of eligible clients who received food and/or other nutrition services

2.1: # of eligible clients who received food and/or other nutrition services						
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
3,215	2,139	890	441	3,215	1,500	388

This indicator only counts the total number of OVCs who received services to improve food security, including household or community gardens, but not pregnant women. For the purpose of this indicator, OVCs who receive nutrition counseling or are participating in the demonstration plot activities will be counted.

Under the youth farmer’s club intervention, there was a total of 3,215 OVCs who benefitted from services offered in the YFCs during Year 2. OVCs are already members of YFCs and are receiving nutrition counseling, as well as seeds for vegetable gardens and other supplies through demonstration plots.

Indicator 2.2: Number of IEC materials produced and distributed

2.2: # of IEC materials produced and distributed						
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
9,663	25,506	38,000	3,100	76,269	85,000	68,335

This indicator measures efforts to distribute program-relevant materials to the target audiences. It counts quantities of IEC materials produced and distributed to communities and facilities. Printed copies of IEC materials that include posters, leaflets, brochures, banners, job aides, etc. will be aggregated irrespective of language. Topics include diarrhea, malaria, condoms, family planning and immunization. Because of the difficulty associated with tracking precise distributions, SCIP assumes that all materials it produces will be distributed and reports as such.

In Year 2, SCIP produced and distributed **76,269** IEC materials, 90% of the target for Year 2. Some examples of the IEC materials produced and distributed were:

- 18,100 flyers were produced and distributed on HIV prevention methods, including “The Seven Reasons to use a Condom” and the risks of having multiple partners;
- Radio spots on national, provincial and community radio stations, airing in both Portuguese and Emakwa, dealing with topics such as WASH and family planning
- 10,000 flyers about the contraceptive methods used in Mozambique;
- 5,000 “Pathways to Change” game boards for use in community group debates; and
- 26,000 posters with information on the importance of using iodized salt; family planning methods; malaria treatment and prevention; and the dangers of uncontrolled burning.
- 1,500 A3 *Albuns Seriados* for horticulture;
- 15,000 laminated flip books on TB, to increase adherence to treatment and prevention

Indicator 2.10: Number of deliveries performed in a USG-supported health facility R

2.10: Number of deliveries performed in a USG-supported health facility						
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
24,872	25,320	25,662	23,278	99,132	85,692	76,371

This indicator counts the total number of deliveries performed in a USG-supported health facility for Year 2. This information is collected directly from the health facilities and from the district health offices.

In Year two, **99,132** deliveries were registered in USG supported health facilities.

SCIP continues to explore ways to reduce maternal and neonatal mortality rates. SCIP will continue its efforts for health provider and TBA trainings as well as other outputs. Waiting houses for pregnant women have been constructed in some HFs while others are under construction. Ambulance bicycles are being used to ease the transport of pregnant women to the HF and continued involvement and mobilization of community leaders is being carried out. We expect that these efforts will progressively contribute to future reductions in maternal and neonatal mortality rates.

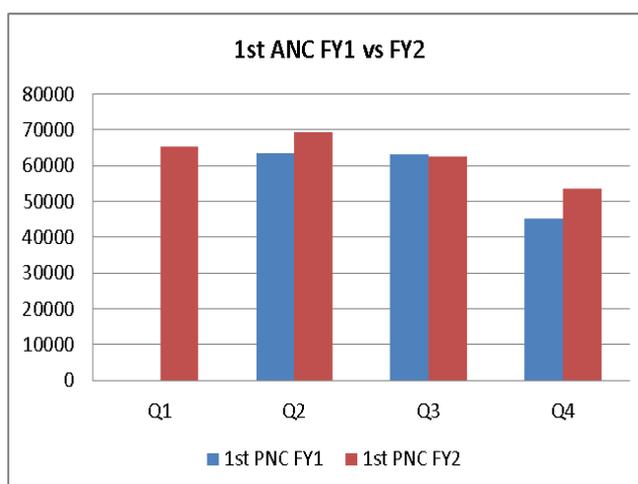
Indicator 2.12: Number of ANC visits with skilled providers in a USG-supported health facility R

2.12: # of ANC visits with skilled providers in a USG-supported health facility

Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
144,135	170,939	174,271	157,637	646,982	591,874	440,133

This indicator counts the total number of antenatal care (ANC) visits with skilled providers in a USG-supported health facility. Skilled providers include: medically trained doctors, nurses, or midwives. It does not include traditional birth attendants (TBA). This indicator is based on evidence that ANC visits are required to provide preventive and curative care to promote healthy birth outcomes.

In Year two, **646,982** ANC visits were registered in the health facilities of the 14 districts, which is greater than the target projected for Year 2. Of these **250,614** were new visits and **393,368** were follow-up visits. This corresponds to a ratio of 1.58 follow-up visits for every new visit which is below the ratio recommended by WHO. The graphs below show positive trends from Year 1 to Year 2.



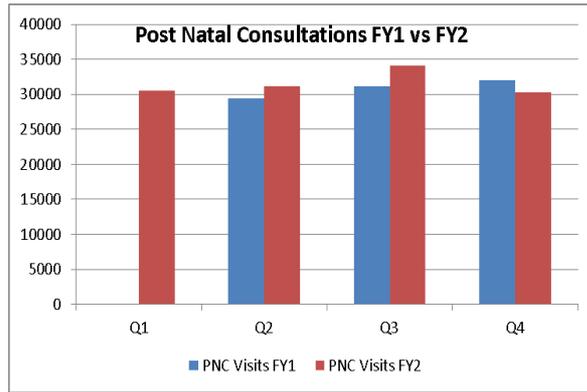
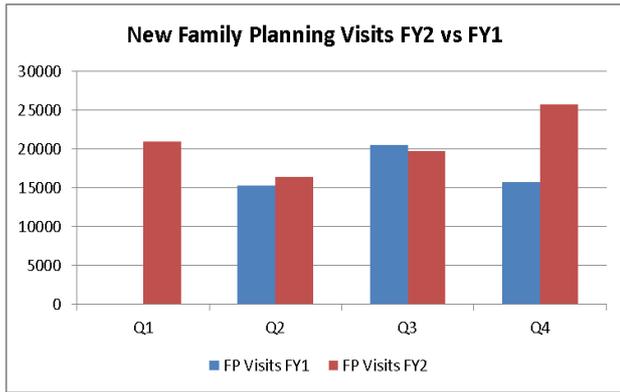
Indicator 2.13: Number of facility visits in a health facility, by type (FP, PNC) R

2.13 # of facility visits in a health facility, by type

Type	Q4	Q3	Q2	Q1	Y2 total	Y2 Target	Y1 Total
Total	55,999	53,894	48,062	51,509	209,464	200,000	144,144
1) FP New Visit	25,705	19,743	16,403	20,928	82,779	80,000	51,555
2) PNC	30,294	34,151	31,659	30,581	126,685	120,000	92,589

This indicator counts the total number of new and return visits to health facility by type. SCIP only tracks FP and PNC services because of the capacity of the HMIS. ANC services are also tracked but in a separate indicator.

A total of **208,464** visits were registered this year. Though SCIP was able to reach its targets for Year 2, the relative shortage of contraceptive methods at the provincial level represented a threat.



Indicator 2.14: Number of individuals reached through USG-funded community health activities (HIV/AIDS, Malaria, FP/RH) R

2.14: # of individuals reached through USG-funded community health activities (HIV/AIDS, Malaria, FP/RH)

Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
253,241	318,776	207,787	92,082	871,886	380,000	242,654

This indicator counts the total number of individuals reached through CHWs regarding community health activities (HIV/AIDS, Malaria, FP/RH). Because the SCIP program aims to strengthen integration, each household visit will include services addressing multiple health issues.

During year two, **871,886** people were sensitized at community level about HIV prevention, malaria and FP. This included home visits by the volunteers, HIV and FP counseling by the community counselors, contacts of *animadoras* for resupply of contraceptives. This great increase was made possible through home based visits by volunteers and *animadoras*. **145,972** visits were made targeting malaria prevention; **421,686** targeting HIV/AIDS prevention; and **178,564** targeting FP/RH.

Indicator 2.15: Number 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

2.15: # 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

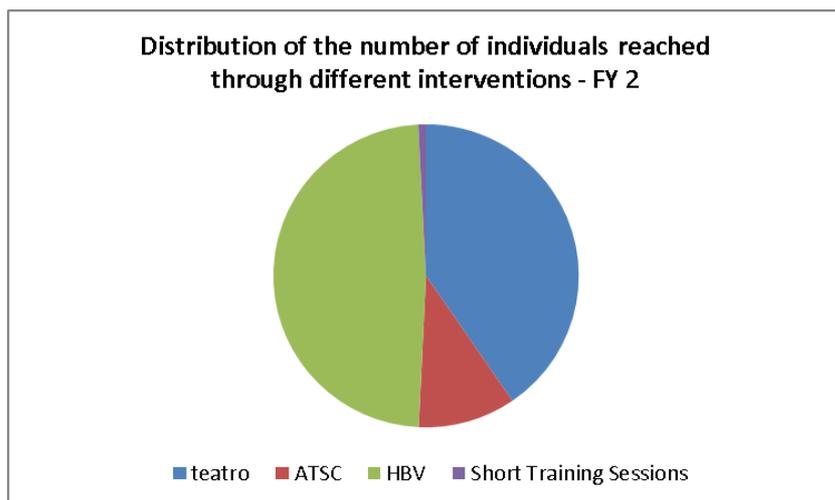
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
287,016	90,665	87,426	119,925	585,032	200,000	199,479

This indicator counts the total number of the target population reached with individual and /or small group level HIV prevention activities that are based on evidence and/or meet the minimum standards required. For SCIP, the relevant activities include home based visits (at which HIV prevention is the focus), and community promotion activities through theater and other events.

In Year two, **585,032** people within the targeted population were reached with HIV prevention interventions facilitated by peer educators, VCT-C counselors, community volunteers, health providers, theater groups and *animadoras* through short training sessions, interactive theater interventions, small group discussions and HIV/FP one-to-one counseling sessions targeting

household members, YFC members, and community leaders. SCIP recognizes that communication for behavior change is a continuous process which should complete a cycle; therefore these interventions are being implemented in a complementary manner at the village level. Specific short training sessions were carried out for community leaders progressively involving the leaders acting at the village social structure platform (CLCs, water committees, YFCs, farmer association etc.).

The graph below shows the weight of the different types of interventions to reach this indicator. In addition, SCIP is supporting mass media interventions through community radio programs and health fairs.



Indicator 2.16: Number of contacts by CHWs with individuals for health (HIV/AIDS, Malaria, FP/RH)

2.16: # of contacts by CHWs with individuals for health (HIV/AIDS, Malaria, FP/RH)						
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
242,869	318,776	260,625	92,082	914,352	380,000	90,209

This indicator counts the total number of contacts by a community health worker, regardless of the focus of the visit. **914,352** represents the number of contacts made by a counselor from CCT and community volunteers from specialized districts, as well as *animadoras* from complimentary districts.

SCIP comfortably exceeded the yearly target as the volunteer network in specialized districts reached nearly 90% of household coverage sooner than expected (January 2011). This allowed us to tackle HIV in quarter four and family planning in quarter one.

Indicator 2.17: Number of service outlets providing counseling and testing according to the national and international standards

Each district has one team of at least two, sometimes three, “mobile” counselors, making a total of 33 counselors in the 14 teams.

Indicator 2.18: Number of people HIV tested and counseled and received test results R

2.18: # of people HIV tested and counseled and received test results

Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
13,258	18,284	17,567	11,280	60,389	45,000	23,805

This indicator counts the total number of people receiving counseling and testing through VCT-C who also receive their result. The only mechanism for HIV counseling and testing SCIP provides is VCT-C. In Mozambique, VCT-C counseling is tracked through HMIS using the ATS-C form. These are used to determine the number of people who received counseling and testing and who received their result.

31,283 men and **29,106** women were tested by the community counselors in Year 2. **5,938** of the persons tested were children <15 years old and **54,451** were >15 years old.

During FY2, VCT-C counselors have increased their involvement in order to strengthen the implementation of the strategies of continuum of care and positive prevention; after these were presented and discussed with government and non-government partners. Additionally, counselors are making an effort to increase the number of couples receiving VCT-C. In total, during the second semester, **31,542** people received VCT and their test results. If we are taking in account couple's and family counseling sessions about 15% of the counseled persons are involving couples. For the whole year, this rate is 10%.

In year two, 52% of all people counseled were men; 87% of males were counseled through individual counseling sessions; this excellent result was achieved through the very specific SCIP community approach in which the members of the "Conselho Local das Localidades" as well as the members of the "Conselho de lideres comunitarios" at village level were sensitized on the importance of VCT-C and offered the opportunity to test as the majority (about 70%) of the member of these structures are men.

The FY2 target was exceeded because VCT-C counselors were strongly involved in a mass VCT-C campaign due to receiving a large amount of tests which were to expire in the last quarter. SCIP supported all 14 SDSMAS in organizing mini health fairs.

Indicator 2.19: Number of children less than 12 months of age who received DPT3 from USG-supported programs

And

Indicator 2.21: Number of children less than 12 months of age who received vitamin A from a USG-supported program R

2.19: # of children less than 12 months of age who received DPT3 from USG-supported programs

Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
34,413	22,874	18,286	40,280	115,853	100,000	76,369

2.21: # of children less than 12 months of age who received vitamin A from a USG supported program

Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
10,392	138,531	19,913	158,841	327,677	115,000	109,258

Indicator 2.19 counts the number of children less than 12 months old who received three doses of the DPT vaccine. It measures the ability of the health system to deliver a series of vaccinations and indicates continuity of use of immunization services by caretakers.

Indicator 2.21 counts the number of children aged 6-11 months of age who received vitamin A in the last three months. The number of doses of vitamin A provided aged 6-11 months will be tabulated from HMIS data.

Though there were some barriers, such as shortages of Vitamin A and DPT3, the Project surpassed both the targets for DPT3 vaccination and Vitamin A supplementation. Through fixed and mobile vaccination activities, **115,853** children received DPT3 before 12 months of age while vitamin A was distributed to **327,677** children. This data includes, respectively **145,430** and **113,876** children 6-11 months old who received Vitamin A during National Children’s Weeks (October 2010 and June 2011). All SCIP district teams were strongly involved in the campaign. Outside of the National campaigns, much of the outreach for both of these indicators was done through decentralized vaccination brigades from peripheral health units which were directly supported by the communities and peripheral health units with the help of SCIP. This is a clear result of the community involvement strategy at the health facility committee level

Indicator 2.23: Number of OVC served by OVC programs R

2.23: # of OVC served by OVC programs

Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
31,426	23,711	11,543	11,076	31,426	15,000	10,005

This indicator counts the number of individual OVC provided with services by OVC programs. Orphans are defined as children under 18 who have lost either a mother or father. Vulnerable children are those that reside in households affected by HIV/AIDS, for example a household in which a parent or principle caretaker is HIV infected.

The different activities of OVC services that SCIP provided or facilitated can be described as follow:

Food and Nutrition: **31,426** OVCs were visited by the *animadoras* and volunteers in coordination with community authorities. All of these OVC’s families have received home visits: the volunteers trained families on three health topics, Diarrhea control, HIV prevention and FP, as well as on hygiene and nutrition counseling and, have also distributed family health kits.

In the complementary districts, **3,215** additional OVC received nutrition counseling through the YFC.

Health: **2,079** OVCs with specific health needs were referred to various health centers in the four specialized districts and one complementary district. Follow up visits by *animadoras* and Volunteers were made to ensure their health improvement.

Education: **561** OVCs of the specialized districts were integrated into schools through a joint effort of the *animadoras*, the respective CLC, SDSMAS and SDEJTC. **191** OVC received school materials through INAS services after the request was submitted to SPSMAS and INAs. Another **350** OVCs

where directly integrated into schools by their respective families after the CG *animadoras* and volunteers visited them and mobilized them through sharing of information on the importance of school education for their children; this last data was not reported in the ARP data system as no evidence were recorded once there was no need to pass through the SDEJTC; nevertheless, this data represents a very positive step in the empowerment of the communities to solve their identified problems through a range of allies and networks of support at community level. Furthermore, at the end of FY2, **3,215** OVCs are benefiting of vocational training through the existing YFC networks throughout the all 14 districts. Youth who participate in YFCs gain skills in conservation farming, food handling and storage techniques. In addition, they receive seeds for vegetable gardens and others supplies for demonstration plots.

Legal Services: The birth registration for **602** OVCs was finalized in close cooperation with the SDSMAS and the *serviço de identificação civil* in the specialized districts.

OVC	OVC served Food and Nutrition (specialized districts)						OVC served (enrolled at school)		OVC served (Vocational Training through YFC)				OVC served (legal protection)		OVC served Economic strengthening	
	OVC reached through health family kit distribution and nutrition counseling		OVC reached through YFC						OVC reached through YFC							
			10 - 14 years		15 - 17 years				10 - 14 years		15 - 17 years					
	M Specialized districts	F Specialized districts	M Complementary districts	F Complementary districts	M Complementary districts	F Complementary districts			M Complementary districts	F Complementary districts	M Complementary districts	F Complementary districts				
Cidade De Nampula	5,076	5,537							63	83	59	82			10	15
Angoche	-	-	164	99	85	20			164	99	85	20				
Erati	-	-	83	64	37	17			83	64	37	17				
Malema	1944	1,873							16	7	0	2	99	70		
Meconta	-	-	122	132	89	95			122	132	89	95				
Mecuburi	1411	1,580					150	156	78	115	50	28	103	101		
Memba	-	-	64	65	27	18			64	65	27	18				
Mogovolas	-	-	90	58	30	26			90	58	30	26				
Moma	-	-	124	90	101	48			124	90	101	48				
Monapo	-	-	127	74	75	34			127	74	75	34				
Cidade De Nacala-Porto	-	-	73	75	18	9			73	75	18	9				
Nacala Velha	-	-	17	8	12	7			17	8	12	7				
Nampula-Rapale	2,862	2,645					41	26	47	30	73	47				
Ribaue	3,224	2,997					104	84	52	66	33	7	111	118		
SUB - TOTAL	14517	14632	864	665	474	274	295	266	1120	966	689	440	313	289	10	15
TOTAL	31426						561		3215				602		25	

Indicator 2.24: Number of clients receiving HBC- home-based care services R

2.24: # of clients receiving HBC						
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
1,390	898	589	0	1,390	2,155	0

This indicator counts the number of clients provided with Home Based Care (HBC) services by HBC programs. The number of clients receiving HBC services is a unique number where each client is counted only once. Only support services should be included for this indicator.

Support Services – Include a broad range of home-based care services for all persons living with HIV/AIDS (PLWHA). All home-based activities for HIV-infected adults and children are aimed at optimizing quality of life for HIV-infected (diagnosed or presumed) clients throughout the continuum of care, by means of:

- 1.Symptom diagnosis and relief;
- 2.Psychological and spiritual support;
- 3.Clinical monitoring, related laboratory services;
- 4.Management (and/or referral) of opportunistic infections including TB, malaria, and other HIV/AIDS-related complications (including pharmaceuticals);
- 5.Culturally-appropriate end-of-life care;
- 6.Social and material support such as nutrition support, legal aid, and housing; and
- 7.Training and support for caregivers.

In the area of HBC, in the specialized districts, all *animadoras* offered at least one of the HBC services defined in the PEPFAR guideline. They were able to reach **1,390** chronically ill people with their services. The most frequent services offered are: Psychological and spiritual support; referrals of opportunistic infections including TB, malaria, and other HIV/AIDS-related complications (including pharmaceuticals); Nutrition counseling; Training and support for caregivers.

In order to increase the quality of services provided to chronically ill people, SCIP trained 100 animadoras of the specialized districts in HBC MOH curriculum. The training lasted for 12 days and was facilitated by MOH accredited facilitators. SCIP plans to train more animadoras in Year 3.

SCIP was not able to meet the target for HBC year 2, but as HBC was so important to the USG funded clinical partners and the provincial directorates, we first developed a community care strategy in the first quarter of Year 2 and presented the strategy to be approved (during provincial CLINIQUAL annual work shop review) at the beginning of quarter 2. After this, we started to implement HBC activities. Additionally, since this is a new form that is being used by individuals with a low literacy level, it is understood that what is reported may be missing information. We believe that the actual number reached was higher.

SCIP is actually working in close collaboration with communities and HF in order to operationalize strategies to ensure effective dual referrals from community to clinics and vice-versa, and follow-up of defaulters; the following describes the main actions:

- The system that we have in place for dual referrals starts with monthly home visits from *animadoras*/ volunteers. They assess the needs of the client and if it is a chronically ill person they refer that person to a health facility

- In order to ensure dual referrals, the volunteer must visit the home every 15 days to see if the client followed the recommendation. If the client did not, the volunteer/*animadora* will encourage the family again to seek out care from the clinic
- The community supervisors participate in the ART committees at the health units. They receive the list of those who are LTFU and they try to locate this person through their family name with the help of the *animadoras* and the volunteer networks. At the following ART committee meetings, they will report on their efforts to locate those LTFU. If they have located them, they encourage the family to return to the clinic and they explain the importance of adherence to ARVs. They also offer to accompany them to the clinic.
- SCIP works with the CLCs in brainstorming how they will respond to the transportation needs for those who have difficulties access the health facilities and for those in an emergency situation.

Planned activities for Year 3

- Trained *animadoras* will continue to conduct HBC visits in households with chronically ill people and OVC to provide appropriate care, reinforce adherence to treatment and promote positive prevention. The remaining 300 *animadoras* of the specialized districts will be trained in MOH HBC curriculum.
- Strengthen the linkages between the *animadoras*, the VCT-C and the HF providing ARV and PMTCT services.
- SCIP will multiply the opportunities to facilitate community debates using the Pathways to Change game in regards to reproductive health issues according to different demographic groups, such as newly-weds, adolescents, the elderly, etc., in order to better understand the influence of group-level pressures and to share these findings across groups.
- In the 9 complementary districts, SCIP will expand its work to a second and third localidade with SDSMAS and SANA promoters and *animadoras* to identify OVC and facilitate access to public services (school enrollment, birth registration, referral to health facilities, etc). SCIP will also complement efforts to reach defaulters and those LTFU through HBC visits.
- In the specialized districts, SCIP will continue to facilitate linkages with companies, such as Coca Cola, and OVCs for potential economics strengthening activities and *animadoras* will continue to distribute “family health kits” and provide nutrition and health education to households with OVCs, as well as referrals to health facilities for OVCs with specific needs.
- SCIP will expand its work with an additional four community radio stations to air programs on topics such as family planning, LLIN use, HIV prevention and treatment adherence and proper hygiene practices.
- SCIP will reach approximately 50,000 individuals through counseling and testing and FP sensitization activities.
- Training activities will be carried out in order to improve couple counseling and increase counseling and testing quality and to follow up on HIV positive cases within the context of continuum of care.
- SCIP will work with DPS/SDSMAS and civil society organizations/networks to improve male involvement in FP/SRH, promote women’s sexual and reproductive rights and increase access to education for girls.
- SCIP will continue to partner with local NGOs, such as Ophavela, to qualify their work in HIV prevention and treatment adherence, increasing the demand of FP. SCIP will increase its

efforts to bring awareness to communities on HIV prevention in order to reach workers from the upcoming public works' projects (road and railroad construction) and surrounding communities

- SCIP will pilot the "health caravan" in 2-3 districts, with the intention of spreading to other districts in Year 4. The objective of the health caravan is to have a mobile mechanism to bring the theater groups, an audio visual mobile unit to project films, VCT-C counselors and to conduct community debates.
- SCIP will continue to produce IEC materials taking in account the different target groups' needs through population segmentation
- SCIP will adapt the theater groups' productions of plays in order to accommodate the segmented target audiences and therefore the Project will work with specific target groups rather than the general public.

Result 3: Accountability of community and district health structures to the people they serve increased

SCIP focuses a substantial amount of effort on strengthening community-based programming, particularly in the area of health by increasing the number of community based distribution systems (Indicator 3.1). Crucially, SCIP community-based interventions are based on close collaboration with community leaders (civil, traditional, religious), especially through CLCs. The CLCs serve as SCIP's entry point into the community and create a favorable environment for increasing the availability of community and facility-based services. As such, SCIP organizes meetings with CLCs to discuss community involvement in the 14 districts, and the percent of these CLCs that review data and support CHWs on at least a quarterly basis (Indicator 3.2) is an approximation of their accountability to the people they serve.

The Project focuses on key Child Survival (CS) and RH areas including: Integrated Management of Childhood Illness (IMCI), CDD, Expanded Program of Immunization (EPI), Maternal and Newborn Health (MNH), Prevention of Maternal-to-Child Transmission (PMTCT), Malaria, FP/RH, ASRH, and STI/HIV/AIDS. The "specialized package" provides additional support through Care Groups (CG), CLCs, and C-HIS, while the "complementary package" includes linkages with Title II community activities.

SCIP community interventions are heavily based on close collaboration with community leaders (civil, traditional, religious), especially through CLL, CLCs, HF committees, and Water and Sanitation Committees.

During Year two, SCIP focused a substantial amount of effort on strengthening community-based structures, particularly in the area of health. Therefore, SCIP trained **1,720** community leaders of CLL and CLC through a two-day workshop related to community mobilization and involvement. During these sessions, participants have conducted mapping of their communities and available resources, identification of the main health, water and sanitation, and agriculture-related problems and their respective root causes, articulation of micro-strategies that could be implemented by communities with little external support, as well as the definition of first steps to be implemented in their own "localidade" action plans. Facilitators included SCIP district personnel as well as district government representatives. These workshops have been instrumental in highlighting the importance of an integrated and multisectoral approach to solving community problems. **1,720** community leaders were trained through 55 workshops. 40% of participants were women.

Additionally, **3,781** (M=2,127; F=1,654) community leaders of CLCs were trained on health related topics for which the coverage indicators are low. Such topics include FP/RH, newborn health and institutional delivery, and HIV/AIDS/STI. 43% of participants were women. Participatory methods, such as "Pathways for Change" were used to identify the barriers and facilitators to behavior change within the group. At the end of this training, next step activities were planned and designed by community leaders at village level. These activities will be led and monitored by the community. Data collected by the community health network is reported to community leaders of the CLC on a monthly basis in order to give feedback in relation to the effect of the activities planned. At the end of Year two, **197** CLCs were involved in such exercises.

One representative of CLC from each village is part of the CLL. The activities of each CLC will be shared with the CLL and then discussed.

One representative of CLC from each village was invited to attend the health facility committees' sessions. During the sessions, the following topics are focused on: 1) quality of care from the point of view of the user; 2) presentation and discussion of primary health care coverage indicators by the

head of the health facility. Trends of these indicators are discussed and joint strategies are developed between CLC’s representative and health facility providers; and 3) planning of health facility outreach activities in the remote villages of catchment area.

Indicator3.1: Number of community-based distribution systems R

3.1: # of community-based distribution systems						
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
1,832	1908	1,792	1,723	1,832	1,600	1,602

This indicator counts the number of localities covered by SCIP that have the minimum components of a CBD system in place. In doing so, program staff examine if there are community health workers distributing commodities to households. If so, they also determine whether or not the CHWs have access to commodities and if a monitoring system exists (e.g. are there tools available?; a system of data collection?; regular supervision?). For “complementary” districts, this translates to one trained *animadora* per community. For “specialized” districts, the number of CBD systems equals the number of CLCs established.

Indicator3.2: % of health facilities meeting with CLC representatives at least quarterly to evaluate health issues

3.2: % of HF meeting with CLC representatives at least quarterly to evaluated health issues						
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
38%(54)	20%(28)	31%(44)	29%(42)	38%(54)	30% (43)	28% (41)

Note: The denominator is 143 Health Units

This indicator takes the total number of peripheral HF which organizes meetings with Community Leaders coming from the served areas by the same HF at least once per quarter which is divided by the total number of peripheral HF in the SCIP targeted districts (143 HF). This requires that SCIP staff members visit the HF on a quarterly basis, where they examine the meeting minutes and attendance sheets of the peripheral health committees.

38% of all health facilities supported by the project, or 54 HF, organized meetings with community leaders at least during Year 2. In a few districts there was more than one meeting during the year as a total of 242 meetings were reported. The meetings gave the opportunity to the representatives of the communities to discuss issues related to preventive health services coverage and quality of care in the health facilities. They usually lead to a better understanding of the need to involve more the communities in the planning and monitoring of the outreach activities.

Planned activities Year 3

- Continue to support the linkages between the *animadoras* and their respective health units
- Continue to support the HF committees and encourage other HF to form committees.
- Strengthen community engagement and accountability in addressing health issues by sharing CLCs best practices through exchange visits between communities and districts
- Support the trained CLL to meet biannually for monitoring of CLL plan.

Result 4: Community social infrastructure sustained through a range of allies and networks of support they can draw upon to solve health problems

Activities under this result are designed to contribute to the establishment of a community platform that brings together different actors working for overall health improvements and development. For SCIP, strengthening community social infrastructure involves working with CLCs, Youth Farmer Clubs and water committees (Indicator 4.1). The groups come together through a series of meetings and workshops during which they share experiences about challenges and priorities for improving health in their communities. Through these meetings, members gain specific skills to participate actively in tackling health and development issues. At the same time, participants also gain community trust and improve their confidence in their ability to solve community health problems.

One particularly effective approach to strengthening community social infrastructure is through the creation of community networks, which vary according to the “specialized” and “complementary” packages:

In the “complementary”² districts, the intervention was built on the farmers’ associations and already-existing health and nutrition community workers, called “*animadoras*”; these areas, supported also by the USAID-funded MYAP/SANA intervention, have *only one community worker for each community, or an average of 200 families*. This approach is intended to complement the ongoing training efforts already being implemented through the MYAP/SANA intervention. In the “complementary” districts, the training of the “*animadoras*” has focused mainly, up to end of Quarter 2, on family planning and HIV prevention. During the 3rd and 4th quarters of year 2, SCIP also implemented the training with the “OVCs and chronically ill patients” into this component in one *localidade* in each “complementary” district.

In the “specialized”³ districts, SCIP is supporting communities in building their own extensive community health worker networks which consists of *one volunteer for every 10 houses*. In Year 1, the communities conducted a census of their main target groups (WRA, pregnant women, children 0 to 4 years of age, OVC, the chronically ill) and selected their volunteers and future training supervisors, also called “*animadoras*”. In Year 2, in the “specialized” districts, SCIP supported communities to increase the coverage of the community network from roughly 50% to 90% of the concerned families. By the end of quarter one of FY2, SCIP finalized the training of trainers for the *animadoras*. These trainings span three months and were comprehensive, covering reproductive health and family planning, child survival, HIV/AIDS, tuberculosis, OVC basic packages, water and sanitation, conservation farming topics, and a home visiting package for the chronically ill, including adherence support. After they were trained, the *animadoras* trained the community health worker volunteers through fortnightly sessions using the “care group” methodology; the full curriculum for the volunteers will be completed by the end of 2012.

Usually the *animadoras* are responsible for a catchment area of around 4,000 residents. In order to reach the people in this areas, every 15 days, the *animadora* trains and supervises a group of 80 volunteers who are responsible for visiting ten houses each and are encouraged to make multiple references according to the needs of the household (schools, religious associations, YFCs, health facilities, *SIC*, etc). Chronically ill people and OVCs are a special focus of these visits. Each *animadora* oversees about 800 houses. Usually the catchment area has a CLC to which the *animadora* must report to on a monthly basis through a monthly meeting organized by the CLC. During this meeting the most important players in community development at the village level are invited (APEs, TBAs,

² Mogovolas, Angoche, Moma, Meconta, Nacala Porto, Nacala Velha, Memba, Monapo, Erati

³ Malema, Ribaue, Mecuburi, Nampula Rapale, Nampula Cidade

animadoras, heads of volunteer networks, water committee representative, *mahumus*, farmers' association representative, religious leaders and other community stakeholders). During this meeting, the *animadora* presents data collected at the household level. For example, she may report the number of houses without latrines; the number of children without required vaccinations; and/or if there were any deaths at the village level. Other community stakeholders report what issues they have identified during the month (water committee, YFC, farmers association etc). With this information, the meeting participants discuss possible interventions that can be made to reduce the identified gaps, building off the strengths of each group and creating linkages among them.

SCIP dedicates considerable effort to building Youth Farmer Clubs (YFCs). YFCs provide the opportunity to integrate priority OVC into an existing support network and to invest in the future generation of farmers who understand and are motivated to use improved farming techniques. SCIP facilitates the development of YFC protocols and the hiring and training of YFC assistants to be placed in each of the districts. SCIP then provides training to YFC members on improved conservation farming techniques (Indicator 4.2) and food handling, food use, and storage (Indicator 4.3)

Indicator 4.1: Number of community groups developed and supported R

4.1: # of community groups developed and supported						
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
772	666	460	423	772	500	359

This indicator counts the number of CLCs, YFCs, and water and sanitation committees provided with support from SCIP to begin or strengthen activities. Support for community groups is tracked through project reports, and activities include establishing new committees; facilitating the expansion in the size, reach or scope of a community group; providing training to group members; or increasing collaboration across groups.

During Year 2, SCIP established 357 new YFCs bringing the total number of YFCs supported by SCIP to 521. Additionally, SCIP supported 109 Water Committees in the 5 water districts and 197 CLCs.

During Year 2, the establishment of new YFCs was a success. In fact the concept of the YFC was so appreciated by the communities that the demand for new YFCs exceeded SCIP expectations. The aim for YFC development for Year 2 was to diminish the vulnerability of OVCs at the village level by integrating them into a group of their normal peers. Ideally, a YFC would not have more than 30-40% of OVC as members to avoid creating the impression that YFCs are only for OVCs. 3,207 OVC were referred and integrated into YFCs in Year 2. This represents 27% of total members, an increase from Year 1 which was 10%. This excellent result was achieved through the involvement of communities. OVCs are referred to YFCs from different community sources ranging from community leaders, *animadoras*, YFC monitors, schools and other community associations.

As the number of YFCs has considerably increased in Year 2, SCIP introduced an intermediate structure between the Assistant and YFC: the monitor. Monitors were selected from existing YFC members; one mentor for a maximum of 10 YFC per "*localidade*". Monitors were trained on all topics, attend three workshops per year (1 week/workshop) and work under the supervision of the district YFC Assistants. Topics covered in the training of mentors include technical aspects related to conservation farming, horticulture, integrated pest and disease management, harvest, peanut dryers, commercialization, children's rights, nutrition and entertainment activities. Training also covers YFC dynamics, leadership, monitoring and evaluation, and animation.

The following table shows the newly established YFCs (in Q4), and currently supported YFCs, members per sex, per district and OVC membership:

Specific attention is given to integrate OVC girls into YFCs. In Year 2, girls represented 44% of OVC members.

Indicator 4.2: Number of people (by type) trained in using conservation farming techniques as a result of USG assistance

4.2: # of people (by type) trained in using conservation farming techniques as a result of USG assistance						
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
6,519	5731	2182	2526	16,958	6300	3,677

This indicator refers to the total number of youth farmers and facilitators trained in conservation farming techniques. The topics include 1) association development and management; 2) conservation farming based on demonstration plots; 3) seed germination tests; 4) farming season planning; 5) integrated pest management and 6) credit management. Trainee refers to any type of participant in a training event, regardless of its duration. It should be noted that the unit of measurement is not uniform, in that one trainee may have attended a course for one day, whereas another may have participated in a course for several days within the three month period.

The five conservation farming messages selected for mass divulgation are “Start Farming Activities on Time”, “Do Not Burn”, “Always Maintain Soil Coverage”, “Practice Superficial Tillage - Do Not Remove Deeper Soil” and “Apply Crop Rotation”.

223 demonstration plots for rainy season crops (maize, peanuts, sesame etc) and **253** demonstration plots for horticulture were established.

Districts	Demonstration Plots Rainy season crops	Demonstration Plots Horticulture
Angoche	16	15
Erati	16	21
Malema	16	15
Meconta	18	10
Mecuburi	19	29
Memba	17	18
Mogovolas	15	12
Moma	18	31
Monapo	18	14
Nacala Porto	12	18
Nacala Velha	15	14
Nampula	7	18
Rapale	15	15
Ribaue	21	23
Total	223	253

In order to strengthen the capacity of monitors and YFC assistants to facilitate the lessons given at YFCs, SCIP developed *Albuns Seriados*- an interactive A3 flipchart with photos and the messages to be discussed with participants. In Year 1 these *albuns* covered rainy season agriculture; in Year 2, horticulture. Additionally, SCIP developed a poster which shows how “uncontrolled bush burning” can harm the household livelihoods by weakening crop production, depleting soil, reducing the retention of rain water in the soil and consequently affecting the geological water reserves. This poster is designed to raise awareness with communities through community leaders and YFC members.

Indicator 4.3: Number of people (by type) trained in safe food handling, use and storage techniques

4.3: # of people (by type) trained in safe food handling, use and storage techniques						
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target	Y1 Total
3,888	3,471	0	0	7,359	2,000	1,142

This indicator refers to the total number of youth farmers and facilitators trained in safe food handling and storage techniques. Trainee refers to any type of participant in a training event, regardless of its duration. As in the case of Indicator 4.2, the unit of measurement is not uniform, in that one trainee may have attended a course for one day, whereas another may have participated in a course for three months.

In Year 2, training in food handling and storage was held for both rainy season crops and horticulture products. Examples of topics covered during the trainings were product nutrition, the drying process and recipes for use.

Planned activities for Year 3

- Continue support of CLCs, YFC and water committees
- Provide short training sessions to the CLCs to strengthen their skills in community health management, support for FP, institutional delivery and use of HF services.
- Continue mobilization and establishment of YFCs, including OVC membership, in communities where other SCIP and/or SANA services are provided to take advantage of synergies among SCIP and/or SANA service clients/beneficiaries.
- Train YFC members on conservation farming, nutrition and food handling, animal husbandry, business planning, contract management, sexual and reproductive health rights, water and sanitation and community health.
- Establish and supervise demonstration plots - land preparation for dry season and rainy season.
- Link and engage YFC members in future emerging farmers initiatives
- Use communication channels (theater groups, radio, IEC materials) to disseminate message about CF practices and food handling and storage techniques.
- Engaging YFC member families and community authorities in dialogues about CF practices and food handling, use and storage techniques.
- Linking the YFCs with CLCs to ensure accountability and community ownership; strengthening the role of “padrinhos” in supporting the YFC dynamics.

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

The SCIP water component was implemented in five of the fourteen districts of Nampula province, namely Erati, Memba, Nacala Porto, Nacala Velha and Monapo (aka WASH districts). SCIP activities began with the revival/creation of water committees according to each community's own criteria, and then involved the training of committee members in safe water practices (Indicator 5.3). Including women in these committees was essential, partly because women are more involved in water issues in daily life, and therefore must be able to report on, operate, and repair the water sources, and also because increasing women's participation in community matters is regarded as an end in itself. Where ever possible, SCIP also sought to integrate water committees with health committees (Indicator 5.4). SCIP frequently facilitated the rehabilitation and or construction of water sources (Indicator 5.1). The goal of these efforts was to increase the number of people who had access to an improved drinking water supply in these targeted areas (Indicator 5.2 – reported in the baseline).

Data from Provincial Department of Water indicates that 48.4% of Nampula province has access to a water source (3,400 sources). Of these, 574 are not functioning, being 89 in the SCIP WASH districts. There are several causes for non-functioning water sources in the communities from lack of involvement by community members to lack of knowledge on operation and maintenance of the source. In order to resolve this, SCIP got both the Water Committees and community members more involved. Trainings were given on the operation and maintenance of water sources so many are being repaired.

This year focused on acceleration of construction of new water sources whose process has initiated in year 1. The full process takes a long time due to compliance with environmental issues and certification of the selected bidder. By the end of year 2 a total of 10 new water sources were concluded and 57 were repaired and/or rehabilitated as shown in the below table and indicator describing the total number of water sources repaired/constructed using SCIP funds, both in total and by type. Types include shallow wells, Afridev, and others.

Indicator 5.1: Number of water sources repaired/constructed, total and by type

5.1 # of water sources repaired/constructed, total and by type						
Type	Q4	Q3	Q2	Q1	Y2 Total	Y2 Target
Total	27	16	0	24	67	50
Type: Boreholes	24	16	0	17	57	
Type: Shallow wells	3	0	0	7	10	
Repaired:	24	16	0	17	57	
Constructed	3	0	0	7	10	

During the last quarter, 24 repairs of water sources were carried out: These water sources, built before SCIP intervention initiated, were no longer operational due to poor or non-functional water committees. Respective water committee maintenance groups were trained in the practical repair of their water source. Water from each water source was collected and sent to the provincial laboratory of Hygiene and Food. All analysis confirmed the water potability and the results were annexed in each water committee book – *caderno de gestão e manutenção da fonte*. Additionally SCIP supported communities to construct three new water sources in Monapo district.

The district which benefited most was Monapo with 22 water source repaired including three new ones followed by Memba and Erati with 15 and 14 respectively and Nacala Velha (9) and Nacala

Porto (7). Compared with the target of 50 water sources, SCIP reached 67 which represent a 34% achievement over the target. Cumulative, the total number of water sources new, repaired or rehabilitated reached 107 in the five WASH districts for the two year period. These water sources are borehole-type wells with hand pump wellheads, benefiting an estimated 68,000 people across the five districts and 107 communities. During the rehabilitation process it was noted that salty water continues to be a significant problem, particularly in the districts of Memba, Nacala Velha and Monapo. Lack of knowledge in operations and maintenance by the water committees were cited as the most common reasons for non-functioning water sources. The two water systems under development in were Nacalolo and Netia in Monapo district, which had initiated in year 1, are in the final phase of completion.

The project has worked very closely with provincial and district government for the procurement process including discussion of selected areas of intervention, approval of new sources, joint supervision and participation in coordination meetings, including the provincial level ‘Grupo Temático de Água e Saneamento’, an important platform for coordination of water players in Nampula province. It is important to highlight that the water and sanitation component received additional funds through WADA, which are directly canalized to Care International to build and complement USAID and SCIP funds.

Indicator 5.3: Number of people trained in safe water

5.3: # of people trained in safe water					
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target
268	238	244	121	871	377

This indicator counts the total number of people who receive training in the repair and maintenance of water sources, management of water fees, or hygiene and sanitation. Trainee refers to any type of participant in a training event, regardless of its duration.

One of the objectives of the SCIP WASH component is to contribute to the sustainability of the water sources, strengthening the abilities of the water committee members in maintenance and repairs, and management of water fees of these communities. A number of communities used their water sources to learn how to conduct equipment installation and repair as well the maintenance of water sources. In year two, **871** water committee members were trained – **449** men and **442** women. Along with the over achievement for the water sources, the number of water committees established or revitalized as expected also exceeded the target. Year two concluded with a cumulative number of **109** water committees which is two more than the number of water sources concluded.

During the second year SCIP also focused on consolidating the use of the “Caderno de Operação e Manutenção das Fontes”. This tool enhances trust among community members as well as ensures the transparency of the fees collected by water communities. It is reported that many communities have sufficient amounts for spare parts which in turn impacts positively the functioning of water sources.

Access to spare part kits is fundamental for consistent and continuous operation of water sources. Spare parts were purchased by the project and the kits – along with complete inventories, itemized pricing lists, and information regarding spare part vendors - were delivered to all water committees. Additionally, SCIP trained 35 artisans in the business of spare parts and had facilitated the establishment of three sites which sell spare parts: two in Monapo and one in Nacala Porto.

Indicator 5.4: Number of localities with integrated water and health committees

5.4: # of localities with integrated water and health committees					
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target
0	6	2	2	10	10

This indicator reports on the number of localities in which one of the following is true: i) CLCs members are trained in safe water; ii) Water and Sanitation Committee members have joined the CLCs; iii) Water and Sanitation Committee activities are expanded to include health. SCIP staff then document the integration of activities in monitoring reports.

The water and health committees are integrated on issues such as community health, hygiene and sanitation promotion and operation and maintenance of water sources. These committees are responsible for reporting diarrhea outbreaks to health facilities. They also serve as a role model to the community which means they are expected to have proper water and sanitation infrastructures. Members of the water committees are also members of the health facility committees and support talks on health days and actively participate on mobile brigades.

Planned activities for Year 3

For next year SCIP support will be provided for the consolidation of the water committees established focusing on their role and responsibilities for the maintenance of water source continuously in operation, along with the following:

- Support communities to revitalize water committees by analyzing water sources selected for repair and strengthening water committees through training.
- Continue to get community involvement in the construction of water sources
- Train water committees in operation and maintenance, conflict resolution, accountability, importance of safe storage and water treatment for new water sources.
- Coordinate with CLL and local vendors to sell spare parts for water sources and train vendors in use of spare parts.
- Use IEC materials, community radio spots and theater groups to disseminate potable water and WASH messages.
- Continuation with the training of the water committee members in the identified villages chosen for the repair and construction of water sources.
- Finalizing the Construction of the multipoint water systems (PSAA – Pequeno Sistema de Abastecimento de Agua) in Netia and Nacololo (Monapo district).

Result 6: Sanitation facilities and hygiene practices in target communities improved

SCIP strives to achieve this result through its “Community-Led Total Sanitation (CLTS) methodology” in the five WASH districts. The training content and approach encourage communities to improve their sanitation facilities using locally available materials, with a focus on the construction and consistent use of latrines, and hand-washing using the “Tip-Tap” method. The training emphasizes the need for participation and commitment of the entire community in order to achieve complete elimination of open defecation, and the importance of hand washing after defecation and before eating. Participants also learn that each latrine type has a specific cost to the participating household. Careful consideration of the latrine type is a key factor in subsequent use and maintenance. The CLTS approach is both participatory, as the community itself leads the process; and efficient, as communities initiate plans for latrine construction (6.1). These activities should encourage behavior changes in terms of increases to the percentage of the population using improved sanitation facilities (6.2, discussed in the baseline survey) and to the percentage of caregivers who demonstrate proper personal hygiene and food hygiene behaviors (6.3 and 6.4, discussed in the baseline survey).

Indicator 6.1: Number of households with latrines

6.1: # of households with latrines					
Q4	Q3	Q2	Q1	Y2 Total	Y2 Target
4452	2809	5	3307	10573	6000
17,808	11,236	20	13,228	42,292	24,000

Although this indicator counts the total number of households with latrines in a target area, it also reports the total number of latrines and Tip-Taps that were built over the quarter to approximate the effectiveness of the CLTS approach.

The construction of family latrines is the focus of the project, while communities are being mobilized to change their behavior and adopt good practices of hygiene and sanitation: “Participatory Hygiene and Sanitation Transformation – PHAST” methodology and “Community Lead Total Sanitation – CLTS” are the two approaches being used by the project to mobilize and promote community involvement, participation and behavior change.

The last phase of the CLTS methodology is very conducive once the community leaders are directly planning with their population, regarding the different phases of the latrines’ construction with concrete deadlines and responsibilities. In Year 2, a total of **10,573** traditional latrines were built benefiting **42,292** people.

Sixteen communities were certified as Free of Open Defecation (Livre do Fecalismo a Ceu Aberto – LIFECA). The process of certification includes members from DPS and DOPH where they visit the communities to count the number of latrines and houses.

In the districts of Erati and Monapo the project supported the building of two blocs with eight latrines for each school. The schools are in charge of maintenance and cleaning of the latrines.

The component also trained in each of the WASH districts 10 members of the YFCs in the content of hygiene and sanitation and for a few cases operation of manual bombs for water sources. It was interesting to see their enthusiasm and curiosity for basic hygiene education and the session was eyes open for change many of their practices regarding transport of water, hand washing and food handling.

The community also appreciates the education on water and sanitation through the theater groups. On these occasions, children, youth, mothers, fathers and grandmothers are together and actively participate in the interactive sessions of the theater groups where using concrete examples of life situation the actors promote hygiene behaviors in an accessible way for the community to receive the messages.

Planned activities for Year 3

High priority will be given to match community benefiting from water sources and communities implementing ODF for improved health outcomes and to reflect the integrated strategy of SCIP. In addition the following will be implemented.

- Finalize the certification process for “Open Defecation Free” (ODF) communities which benefited from the implementation of the CLTS approach initiated in Year 2 in the districts of Erati, Monapo, Nacala Velha, Nacala Porto and Memba.
- Introduce the Tip-Tap hand washing system along with the building of latrines in all communities benefiting from the ODF initiative
- Continue to mobilize communities for behavior change and adoption of good practice of hygiene and sanitation
- Continue to involve the YFCs in WASH activities

Overall Management

In Year 2, SCIP continued to improve various strategies adopted to maximize the community driven and integrated approach for improved health outcomes in the 14 districts of Nampula province. SCIP management continued to invest on the institutionalization of a culture of horizontal integration of activities implementation through joint planning among all components, technical discussions, integrated supervision visits to the districts and a cross fertilization exchange among Nampula and districts team. At the programmatic level the development of the BCC strategy further enhanced the integration efforts and the understanding of behavior change as instrumental in SCIP activities and transversal to all components.

Despite challenges of staff hiring in the area of Monitoring and Evaluation, SCIP continuous to focus on the need to improve and simplify its monitoring system. Efforts were made to improve collaboration with DPS, SDSMAS and other partners. The project also received several visits, both from USAID monitoring visits and Pathfinder Headquarters for technical assistance.

In November, Luc Vander Veken took the position of SCIP Chief of Party and Mamadou Diallo joined the team as Director of Integrated Services.

Meeting with Partners and Collaborators

SCIP started off Year 2 with a workshop for the annual work plan. All partners, district coordinators, M&E officers, technical officers and manager for the different components presented their achievements, challenges, what has worked to be continued and what has not worked that needs to be revised followed by development of district and components work plans.

SCIP participated in the quarterly meetings called by DPS to analyze service delivery situation and problems. At the district level the coordinators participated in the monthly meeting with the SDSMAS with the other health development partners (Save the Children, Cruz Vermelha, EGPAF, etc) and assisted in planning and monitoring the mobile clinics and national health weeks/days.

A meeting was held in December with ICAP and EGPAF at provincial level to discuss strategies to improve linkages for adherence to ARV treatment. Additionally, meetings were held in December 2011 between SCIP and SANA to agree on the content and the coordination mechanisms for the continuation of the SANA project.

From February 14 to 16, SCIP attended the “Strengthening the Coordination of USG Partners” in Gurue with its sister program in Zambezia and with the complementary MYAP programs also in the Nampula and Zambezia provinces. The purpose of the meeting was to share implementation strategies at the provincial and regional levels. The meeting further strengthened SCIP / MYAP coordination and interprovincial mechanisms. Two additional sub-regional SCIP/MYAP meetings took place in Nampula province in March: one on March 4th for the districts of Moma, Angoche, Mogovolas and Meconta, and another on March 8th for the districts of Nacala Porto, Nacala Velha, Erati, Monapo and Memba. In each of these meetings, around fifty participants gathered to discuss the 2011 operational strategies and refine the further coordination opportunities and steps.

The SCIP Zambezia team also visited SCIP Nampula at the end of February for an exchange visit focused on the water component and the in September the two projects organized a BCC workshop to share strategies and approaches.

Monitoring and Evaluation

After the complete baseline household survey was conducted in the 14 districts, the M&E Senior program officer visited all districts to review with the district M&E officers and coordinators the progress made in using the data bank and to assess further training or coaching needs. In early February, SCIP embarked on the preparation for the Data Quality Assessment. JSI, an independent evaluator, conducted a data quality assessment (DQA) of selected indicators from SCIP's Performance Management Plan from March 7th to 16th. The M&E USAID team participated in the DQA visit in Meconta and Rapale districts. Overall findings were positive and SCIP incorporated these findings in the review of the M&E procedures that followed through.

In June, SCIP hired a consultant to conduct an in depth review of M&E system, redesign of data collection and collation forms, refinement of indicator definitions and disaggregation's and processes for collection and collation. Each component reviewed the processes and concurred with updated processes. A training document for use in training staff on updated M&E collection and collation processes for pilot of updated system was finalized and translated into Portuguese. Pilot of the system for database development should begin early in Year 3. Following this pilot all forms and processes will be reviewed and final changes made to instruments and processes. Database development will commence and once done installed and relevant staff will be trained on its use.

Quality Improvement and Quality Assurance

Attention was also devoted to the need to improve systems and tools for quality assurance and improvement. To this end, Pathfinder gathered the ESD and the SCIP team to participate in the *Quality Improvement and Quality Assurance Workshop*, conducted by Cathy Solter, a *Senior Fellow*, and Pathfinder International Specialist on Quality Assurance and Quality Improvement (QA/QI). The workshop brought up a consistent and consensual definition of Quality Assurance and Quality Improvement according to the parameters of the SCIP interventions and the priorities of the country. This important exercise also built the basis - through the use of quality instruments - for the next steps needed on quality before the scale-up of activities. Furthermore it raised the opportunity to consolidate and systematize important tools also pointing out the necessity of including new instruments to be used by the project.

This workshop also addressed compliance issues in Family Planning focused on Tiaht policies. FP legislative and policy requirements were presented discussed to the group. The RH/FP senior staff had completed the e-learning course and scanned copies of certificates kept in their files.

Exchange Visit with Pathfinder Ethiopia

In June, the SCIP community health and behavior change team participated in an exchange visit with Pathfinder Program in Ethiopia to learn more about the concept and design of the family model approach. The objective of the visit was to expose the SCIP team to the concept and implementation process of the Model Family package to explore the feasibility to adapt to the community work currently on going on in the specialized districts. Participants found that SCIP has the infrastructure/management structure to operationalize a similar intervention. However, instead of working with the concept of Family model, SCIP would work with the concept of community network model where the supervisors, *animadoras* and later on the volunteers would be the focus of the model process, being certified by a list of indicators agreed upon in light of SCIP areas of intervention.



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Finally, a Water Source Within Reach

Namitil is a rural community in the district of Monapo in Nampula province in Mozambique. It is located 15 kilometers from the district center. There was no water source in Namitil. In order for members of the community to get water for their daily needs they had two choices: either go to the river, which was infested with crocodiles or go to the water source in the village of Napala, which would be a full day event due to the fact that Napala is seven kilometers away from Namitil and the village already has 4,000 inhabitants using the one water source. Many people in the community suffered from diarrheal diseases as a result of consumption of unclean water and lack of proper sanitation methods.

Then the USAID-funded Strengthening Communities through Integrated Programming (SCIP) project visited Namitil. Project team members met with community leaders who explained the challenge that members of the community faced everyday due to the lack of a water source. SCIP conducted a training where community members were elected to form a Water and Sanitation Committee. After the training, the community came together and made a contribution towards the construction of a water source. They brought in a geophysicist who searched for the best location for the water source. Shortly after, a team came in with equipment to build the water source. The members of the community of Namitil are very proud to have a safe and reliable water source.



Training of Namitil Community Leaders



Construction of Namitil water source