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USAID Community Care Program (USAID Programa de Cuidados Comunitários)

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**COMMUNITY CARE
PROGRAM**

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List of Acronyms *indicates the Portuguese acronym here rendered in English

AIDS	Acquired Immune Depressant Syndrome
ANEMO*	Mozambique National Nurses Association
ART	Anti-Retroviral therapy
ARV	Anti-Retroviral
BOM*	Banco Oportunidade de Mozambique
CAP	Capable Partners Project
CCP	Community Care Program
CDC	Centers for Disease Control and Prevention
CHASS-Niassa	Clinical HIV AIDS Systems Strengthening Project – Niassa
CHASS-SMT	Clinical HIV AIDS Systems Strengthening Project – Sofala, Manica, Tete
CSO	Civil Society Organization (same as CBO, Community Based Organization)
DNAM*	National Directorate of Medical Assistance
DPMAS*	Provincial Directorate of Women and Social Action
DPS*	Provincial Directorate of Health
DQA	Data Quality Assessment
FHI360	Family Health International
GAAC*	Community Adherence Support Group
GAVV*	Office of Victims of Violence
GRM	Government of the Republic of Mozambique
HBC	Home Based Care
HIV	Human Immunodeficiency VirusHU Health Unit
INAS*	National Institute of Social Action
M2M	Mother to Mother (groups)
M&E	Monitoring and Evaluation
MGCAS*	Ministry of Gender, Child and Social Action
MISAU*	Ministry of Health
MoU	Memorandum of Understanding
MUAC	Middle Upper Arm Circumference
NGO	Non-Governmental Organization
NPCS*	Provincial Nucleo to Fight AIDS
OVC	Orphans and Vulnerable Children
PH	Project HOPE
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PNAC*	National Action Plan for Children
PPP	Public Private Partnership
PPPW	Pre- and/or Post-Partum Women
PSS	Psychosocial Support
RMAS*	Department for Women and Social Action
SDSMAS*	District Services of Health, and Women and Social Action
TA	Technical Assistance
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
VS&L	Village Savings and Loan (groups)

Project Duration: Five (5) years

Starting Date: September 27, 2010

Life of project funding: September 27, 2010 – September 26, 2015

Final Report Background

USAID/Mozambique's Community Care Program (CCP), also known as *Programa de Cuidados Comunitários* (PCC) in Portuguese, was designed to strengthen the community-based response to HIV/AIDS in seven provinces and improve the health and quality of life of people living with HIV (PLHIV), orphans and vulnerable children (OVC), and pre- or post-partum women. Working in close partnership with civil society organizations (CSOs), the Ministry of Health (MoH, or MISAU in Portuguese), the Ministry of Gender, Children and Social Action (MGCAS in Portuguese), and the private sector, CCP aimed to also strengthen the government's capacity to coordinate, manage, and oversee an integrated continuum of care and support at community level, and build the CSOs' capacity to provide comprehensive, community-based care and support services. Within five years, CCP endeavored to achieve for PLHIV, pre- or post-partum women, OVC and their families: increased provision of family-centered, community-based HIV care and support services, and increased access to economic strengthening activities and resources for HIV-affected households.

This Final Report will report on the strides made toward those aims, and show the contributions made to systems and structures for continuing to provide community based services to PLHIV, OVC, and pre- and post-partum women. This report will also address challenges and share lessons learned across the implementation areas.

Integration was a central idea throughout the CCP project. Family level services were integrated within the community providers, the CSOs. Supported by the CSOs, *activistas* provided both home based care (HBC) and OVC care and support services. Supervision and trainers were combined to be represented by the CSOs and SDSMAS, and services were integrated with the clinical providers. One of the most important integrations in CCP was combining the community based HIV services with the household economic strengthening (HES) activities. These integrated services will be discussed throughout the report.

The Sofala province CCP close out event on June 19th, 2015, pictured below with representation from local government, CSO, FHI360, local office to assist victims of violence, and provincial nucleo contra SIDA, is exemplary of these levels of integration. The standardized CCP activities contributed to both MGCAS and MISAU national plans. The CSOs partnered closely with the district level offices of the two ministries, and the project reported to the provincial level directorates as well. Other local entities that contribute to the integrated nature of the project include Community Child Protection Committees and District Administrators, whose collaboration was essential to deliver the community based services comprehensively across the target groups of PLHIV, OVC, and pre- and post-partum women.



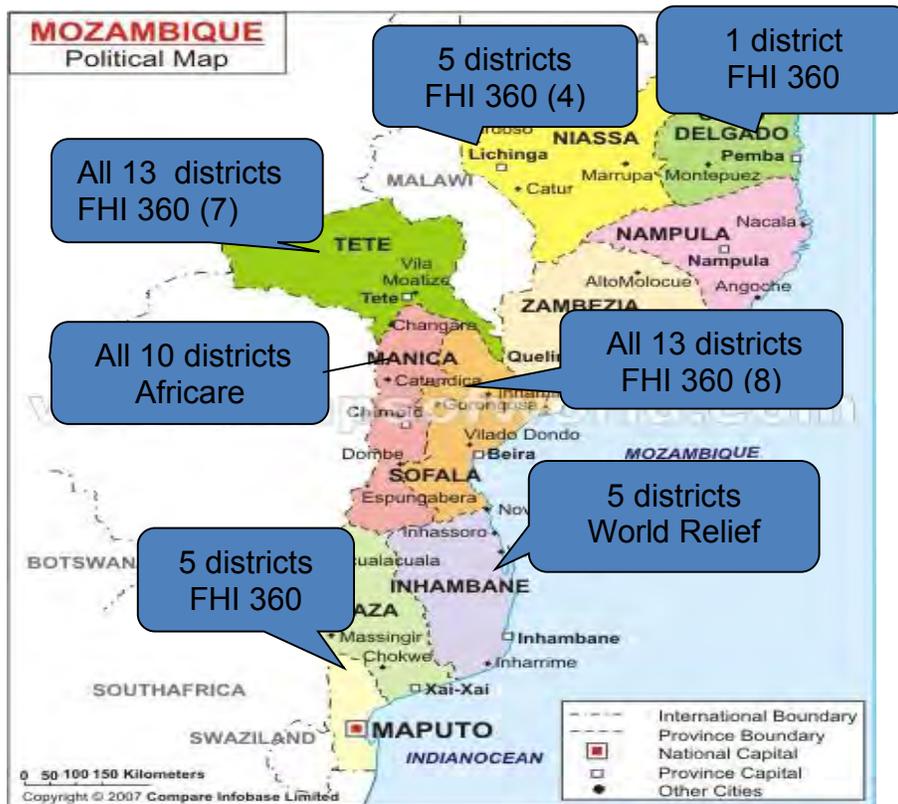
Front row includes: representatives of implementing CSO partners; DPS HBC focal point, DPMAS OVC focal point, other sector stakeholders. Standing row includes: additional CSO partners and sector stakeholders; provincial Permanent Secretary's representative, Office for Assisting Victims of Violence, provincial Nucleo Contra SIDA; FHI 360 CCP staff.

GRM stakeholders at the district level, the SDSMAS specifically, used the district level Close Out events to pledge their continuing support for CCP activities after the close of the project. Such commitments had been created and nurtured over the CCP LOP, but codified in the CCP Sustainability Plan through the following methodology. At the beginning of Yr 4, each CSO was tasked to develop their own final sustainability plan in their respective districts. At this time, each implementer assessed which activities they could continue, at what level, and with what SDSMAS level of participation or assistance. Examples of SDSMAS sustained inputs include: replenishing the CSO nurse HBC kits, and monitoring continuing care for those bedridden PLHIV. CCP's efforts included final refresher trainings near the end of LOP to insure latest technical input for *activistas* to go forward as volunteers, replacement of broken bicycles, again to facilitate continued service delivery to the extent possible at the implementer level. Community Child Protection Committees have taken on some commitments for continued response, as they are able. CCP also massively contributed to the sustainability of households and individuals with the deeply embedded Household Economic Strengthening component.

The final report will also touch upon data from the final end-line quasi-experimental evaluation of the CCP project which showed positive effects of this family-centered approach on ensuring that vulnerable children and their households receive the basic services they need to meet their health and social needs. The results of the evaluation suggested that OVC beneficiaries are likely to have better health and quality of life than OVC who were not direct beneficiaries of the project. From a project perspective, these results validate the project approach and the investments made to support these vulnerable children, youth and their families.

This level of detail is useful here, as understanding this approach helps to contextualize the entire Final Report in the following pages. All project inputs over the LOP combined to aim for strengthened community and household level HIV responses, and capacity to implement them, targeting those most vulnerable – OVC, PLHIV, pre- and post-partum women, and their families.

Geographic Focus from start to finish: The project began with a total of 52 implementation districts, and finished with 42. The map below indicates the number of initial and concluding number of districts (in parenthesis). Provincial Lead organizations were either FHI 360, Africare, or World Relief, as indicated.



Executive Summary

CCP met and/or exceeded expectations, while contributing to Mozambican systems and structures throughout the LOP. More than 185,000 OVC received services mandated by both PEPFAR and the MGCAS, through a phased approach that addressed both immediate and long term needs. More than 93,400 individual PLHIV received Home Based Care and/or adherence support, “graduating” from HBC according to MOH standards. At least 1,200 community based *activistas* were trained, continuously supported and supervised by CSOs and SDSMAS focal points, to provide the HBC and OVC services. At least 1,200 Village Savings & Loan groups were created, the majority of them completing at least two savings cycles. Some 1,030 Children’s Clubs were created or reinstated, with more than 24,900 children aged 5-18 participating at the end of the project. More than 421,400 beneficiaries received the various nutrition services. In partnership with USG supported health facilities, CCP *activistas* brought 88% of treatment defaulters who they found, back to ART treatment regimens. Moreover a total of 2,480 youth were referred to FP consultation. The project also created 3,206 M2M groups in coordination with HU, with participation of 31,631 women.

FHI 360 served as the CCP prime, with INGO subcontractees Africare, Project HOPE and World Relief, and major Mozambican subcontractees ANEMO and ADEM. Most of the 52 target districts were served by a local CSO, while a few CSOs implemented the project in more than one district, achieving a modicum of efficiency. A number of the CSO implementers grew significantly in capacity, over the LOP. The community based implementer model was designated to serve as the foundation for the 9-month Youth Power Bridge project.

CCP spearheaded the bi-directional referral tool – *Guía de Referência*, adopted by the MISAU for national utilization. CCP also produced the basic Parenting Skills educational flipchart with MGCAS which was implemented by all CSOs and printed for ongoing future use. CCP implementation also validated an integrated programming model, whereby community based HIV and social services were combined with the VS&L groups and other HES inputs, for very positive quality of life improvements and building long term self-reliance and resilience. An additional achievement is the enduring knowledge base amassed among the hundreds of community caregivers – the *activistas*, the family members themselves and community committee members, as well as the partnerships built between the community and clinical entities. CCP and FHI360 were gratified to have been given the opportunity to serve the needs of Mozambican PLHIV, OVC, and pre- and post-partum women during the life of the project.

Program/Project Results

The CCP Results were:

- 1) Increased provision of quality, comprehensive, community-based care and support services to people living with HIV and AIDS and their families.
- 2) Increased family-centered, community-based services that improve health outcomes and quality of life for PLHIV, OVC, and pre/post-partum women and that are implemented by the coordinated efforts of MMAS, MISAU, and CSOs.
- 3) Increased numbers of HIV/AIDS positive individuals and affected households have adequate assets to absorb the shocks brought on by chronic illness.

CCP also applied six cross-cutting strategies to ensure the sustainability of project results, including: 1) community-driven approaches; 2) services integration; 3) capacity building and systems strengthening; 4) partnership and coordination; 5) performance improvement; and 6) gender-sensitive and age-appropriate interventions.

Result 1: Increased provision of quality, comprehensive, community-based care and support services to people living with HIV and AIDS and their families.

Activity Area 1.1: Training and capacity building of CSOs and providers in community-based care and support

The Community Care Project (CCP) was mandated to both deliver community-based services through local CSOs which could include associations of PLHIV and faith based organizations, **and**, simultaneously build their capacity to do so. Technical support was provided in all the technical areas of implementation (HBC, support to OVC and pre and post-partum women (PPPW), gender and nutrition, economic strengthening and organization development) as well as in the management, financial, and organizational aspects of the CSO.

The CCP model engaged one CSO per target district, closely linked geographically to a USG supported clinical facility providing ARVs and PMTCT. Each CSO engaged, on average, 25 community level providers known as *activistas*. The main CCP activities of HBC for PLHIV, and care and support for OVC, were provided by separate individuals before CCP. The HBC *activistas* received a monthly stipend mandated by the MISAU, and those providing care and support to OVC served as volunteers. Under CCP, these activities became integrated under one *activista*.

Training

All *activistas*, the CSO supervisors, and the HBC and OVC focal points at the SDSMAS were trained on integrated HBC and OVC care and support. The CCP model included an initial training followed up by annual refresher trainings. The project used a “cascade” model for these trainings, meaning first holding a training of trainers (ToT) followed by those trained individuals further training the *activistas*.

CCP worked with local subcontractor ANEMO, the Mozambican National Association of Nurses, mandated by the MOH as the responsible entity for HBC training. ANEMO partnered with CCP to “accredit” HBC trainers who lacked their accreditation credential and to identify and accredit new trainers. HBC Trainers delivered the training under ANEMO observation. Additionally, as a result of the CCP training model to accredit both the CSO supervisor and SDSMAS focal point, a local/provincial cadre of accredited/certified trainers was established. This model provided both long term sustainability and cost efficiencies such as avoiding flights from the capital city to the provinces to carry out the trainings.

CCP also worked with ANEMO to develop supportive supervision for follow-up. During the last year of CCP, ANEMO provided this supervision in partnership with local SDSMAS focal points strengthen institutional-community linkages, in addition to monitoring *activistas*’ work in their communities and the administration of the HBC kits contents.

Over the LOP, both CCP and the Capable Partners Project (CAP) worked with ANEMO, providing funds and various capacity building inputs. ANEMO eventually qualified for direct USAID funding support, and credits both CCP and CAP for their increased capacity as an organization to be able to receive and program such funds.

While the HBC and OVC trainings comprised the bulk and foundation of *activista* work, other technical service delivery areas were added into the training. These areas included: psychosocial support for OVC through REPSSI, child protection, gender mainstreaming, M&E, using the *Guia de Referência* (referral tool discussed later), Parenting Skills, and strengthening community committees. Addressing gender mainstreaming specifically, the *activistas*’ training topics included **male** participation in: health seeking behaviors such as accompanying wives/partners to ante-natal and MCH clinic visits, family nutrition education and cooking demonstrations, and joining M2M groups (discussed later in this report). Topics also included **female** participation in: VS&L groups and IGA opportunities, and equal opportunity for accessing all clinical and social services needed. CSO teams were also trained on balancing numbers of capable men and women both on their Boards and their staffs. Mapping the existing services for victims of violence provided additional opportunities to engage male community leaders in sensitizing their communities for necessary awareness and proper conduct when supporting prevention and incidences of violence.

While nutrition training was already within the HBC and OVC curricula (later integrated into one curriculum), a CCP innovation was adding the use of the Middle Upper Arm Circumference (MUAC) as a nutrition screening tool by the *activistas*. During the initial Intake Assessment of CCP beneficiaries, children and pre- or post-partum women received special nutritional status

screening focus; anyone whose MUAC registered in the concern range was referred immediately to the local health facility for diagnosis and malnutrition rehabilitation care, if needed.

Over the LOP, over 1,200 *activistas* received initial full trainings, and annual refresher trainings on these technical service delivery areas. Given that some CCP years included budget cuts, the project learned to be flexible on the duration of the trainings to fit within budget ceilings. It is important to note that refresher trainings served to update *activistas'* knowledge and skills to maintain quality service delivery to project beneficiaries. While certainly not desirable technically to whittle down the time, therefore the content, of refresher trainings, CCP learned that the morale and dedication boosts derived from even shortened trainings are still worth the effort, and did derive positive outcomes.

From time to time, *activistas* in one CSO/district or another benefitted from additional technical trainings outside of CCP structures but still well fitted with CCP aims and their role in the communities. Examples include: PATH engaging CSO partners in two districts in Maputo province on Early Childhood Development where they work, and the Cabo Delgado CSO *activistas* being trained by the District Health Officials on cholera prevention to add to their community based service provision during the cholera season. The additional training resulted in: the trained and experienced *activistas* attracting confidence from other entities, as well as the recognition of the superb placement of these human resources – with the families, in the homes. It also resulted in *activistas* being overwhelmed, because of time to continue taking on more activities. The vast majority of *activistas* have families of their own, in general are poor and vulnerable themselves, and perhaps 50% of them are also HIV+.

Organizational Development (OD)

Organization Development (OD) was a significant CCP focus throughout the LOP. The OD component followed the idea that organizations with better systems and structures in place, in turn, contribute towards the goal of increased and better-quality service delivery by local partners. Without an organizational structure, supportive tasked for program implementation such as receiving and accounting for funds, data collection and reporting, management and supervision and standards-based service delivery is not possible. CCP worked with several nascent organizations in which organization development proved to be an essential component to in engaging community providers. Through experiences working with local organizations, CCP recommends OD be an ongoing part of integrated programming.

The OD component of CCP activity commenced within the initial subcontractor MONASO, a Mozambican nation-wide network engaged in HIV and community capacity, carrying out a baseline assessment of each CSO as they came on line with CCP. CCP then provided local capacity development through tailored technical assistance based on the needs assessment and through standard training topics and coaching. Unfortunately, the MONASO subcontract was not renewed due to unsatisfactory performance. To fill the gap, CCP developed a two pronged approach to OD. The Capable Partners (CAP) project was engaged as a partner to implement their thorough OD model in the districts where their project was authorized to implement. CCP then subcontracted with ADEM, a Mozambican capacity building NGO, to cover the non-CAP districts. This less than ideal situation did in fact yield desired results. Seventeen (17) CSOs

were assigned to ADEM's (5 in Niassa, 5 Inhambane, 6 Tete and 1 in Cabo Delgado) and 16 CSOs were assigned to CAP (4 Maputo, 4 Sofala , 8 Manica).

Improvements in the organization development of the CSOs supported by CCP was observed through improvements in the assessment results from baseline to the final assessment. As part of a phased process, CSOs are first assessed in 5 domains: (i) governance, leadership and management, (ii) policies and procedures (iii) internal control system (iv) project design and management (v) association. Assessment results are ranked in the following categories: 1- emerging, 2 - growing, 3- consolidated, 4 – sustainable. An action plan is developed based on the assessment results and implemented with the TA from CAP or ADEM. The accomplishment of the action plan determines if the CSO moves from phase 1 to 2 of the OD program. If a CSOs is able to reach the consolidated level, they are able to move into the second phase of support. Those in emerging or growing status remain in the first phase of support. At the end of phase 2 support, a seconded assessment is carried out to determine if there has been an improvement or not.

One of the threads of continuity supporting this key activity was that CCP central and provincial technical teams were all trained to provide the necessary “coaching” as regards the OD component. This meant that whenever CCP technical officers were carrying out technical assistance (TA) visits to the field, they could also pay attention to the latest OD activity of the CSO and help to support it. A good example would be checking on the progress of developing a Procedures Manual for their own CSO operations. The technical officers would have been briefed before the visit on the status of OD activities and could then contribute knowledgeably to the current OD process under development.

The 16 CSOs in Maputo, Manica and Sofala Provinces supported with CAP OD technical assistance demonstrated showed the following improvement:

- Six (6) CSOs (ACIDECO, CONFHIC, Kugarissica, Shinguirirai, Centro Aberto de Barue and Rubatano) moved to from phase 1 to phase 2 of assessment evaluation. By the end of the project, four (4) of the above 6 CSOs reached the top (level 4- sustainable) assessment ranking. These were: Kugarissica, Shinguirirai, Centro Aberto de Barua and Rubatano. The other 2 CSOs (ACIDECO and CONFHIC) achieved a level 3 assessment. These CSOs are still improving their internatal control policies and administrative procedures. The table below shows the scores:

Item	Name of CSO	First assessment	Second assessment	Final ranking
1	Kugarissica	2	3	4
2	Rubatano	2	3	4
3	Shinguirirai	2	3	4
4	ACIDECO	3	3	3
5	CONFHIC	3	3	3
6	Centro Aberto de Barue	2	3	4

- The remaining 10 CSOs continued receiving support to improve their institutional capacity in the various areas, including human resources, and segregation of duties.

The 17 CSOs in the Niassa, Tete, Inhambane and Cabo-Delgado provinces supported with **ADEM** OD technical assistance showed the following improvements:

- Six (6) CSO achieved ranking level 2 (growing) of improvement. These are: Rede Pastoral de Inharrime, Rede Pastoral de Morrumbene, Irmaos Unido, Caritas, Filhas de Caridade and Kaeria).
- Eight (8) CSOs showed ranking level 3 (consolidated) of improvement. These are: Rede Pastoral de Homoine. Liwoningo, Utomi, Wupuwela, Hankoni, Kupulumussana, Thandizani and Kuthandizana Kuchira. The remaining 3 had early shut down due to mismanagement. These CSO did not reach the top level as they are still developing their internal control procedures and project management systems.

While not all CSOs reached the highest level of improvements, they continue to develop their internal systems and structures. Many started as nascent, emerging organizations.

By the end of the project, many CSOs created instruments and tools (such as procedures manuals) to facilitate operational procedures and strengthening their internal control systems.

Having reached acceptable standards in terms of organizational structural, operational systems, and performance, some CSOs were able to move toward improving external resources which means establishing partnerships with other donors. FHI360 credits these improvements to the organization development trainings and “coaching” described above.

CCP Technical Assistance and Support

Technical Assistance (TA) was the biggest value added by the CCP consortium led by FHI360 as prime. While several technical officers were hired for their specific technical backgrounds required by the project, they and others with more general HIV backgrounds were all cross trained on the CCP technical components. TA was provided during site visits, during trainings, by phone and email, by central and provincial technical officers.

A supportive methodology that CCP used for TA entailed: before any TA visit was over, the technical officer(s) would sit with the CSO leadership and go over the visit and points of observation. An action plan would be drawn up for the CSO to follow, and it would go in a binder to be taken up with the subsequent visit as a starting point for observing progress against the previous visits’ action plan or recommendations.

TA visits provided by CCP teams were based on the CSOs’ needs, which are identified through monthly reports, direct observation, or direct request for technical support by the CSO. During TA visits, technical officers verified accomplishment of action plans, recommendations following trainings, and previous visit action points. The greatest benefit of TA visits was quality service delivery and meeting targets.

At times, TA visits were carried out jointly by CCP and collaborating partners. To emphasize linkages with and referrals to the health facilities, CCP and CHASS projects staff would make joint

site visits. Sometimes, it would be CCP and CAP, for emphasizing the OD activities. Additionally, CCP also conducted joint visits with other stakeholders such as DPMAS and DPS. The benefits of this type of joint visit strengthened relationships with government partners and increased their knowledge of the project's activities and support for GRM goals and aims.

Activity Area 1.2: Strengthen the provision of comprehensive services at community level for PLHIV, OVC and Pre- and Post-partum women and their families.

This Activity Area focuses on both referrals of beneficiaries to needed clinical and social services, as well as services directly provided by the CSOs' *activistas*. CCP was such a strongly referrals-based project, which was at first a challenge for government and civil society to understand. Now at the end of the project, one legacy is a changed mindset as to what a referral actually means, which will be clarified in this section.

Referral Network

A bi-directional referral tool (referral and counter-referral) – the *Guía de Referência* – was developed by enhancing a MISAU referral form. CCP took the lead within FHI360 to collaborate with other projects in this exercise, largely because this project had the most diverse entities to refer to. CCP noted the high volume of paperwork can overwhelm *activistas* and CSOs, therefore the project attempted to make the *Guía de Referência* multi-sectoral and not just health based, keeping to one single form. For example, under child protection activities, domestic or sexual violence may also come up as an area to address. This needs the attention of the Office of Assistance to Victims of Violence (GAVV) as well as the police and health facility. The *Guía de Referência* was adapted to include these other support options.

The *Guía de Referência* received MISAU approval in late 2014 for national scale up, after long, collaborative work. Due to the lengthy nature of the formal approval process, CCP had conditional approval to roll it out and use it where the project was active. Since the intent was bi-directional (referral and counter-referral), use by the health facilities was part of the planned usage. Clinics could also use the *Guía de Referência* to refer patients to the CCP community based services as appropriate. There has been visible progress on the use of the referral tool by health facilities, though much less frequent referrals than from the community to the clinics.

Community Care Project took the lead on training all implementing partner CSOs, as well as all the linked health facilities CCP engages with since its linkages mandate was so strong. This included CDC-supported clinical sites in three (3) CCP provinces. The innovation of the *Guía de Referência* was its efficiency of materials and the bi-directional nature of it. It is printed in blocks with carbonized pages so that a referral form has three layers, therefore referrals can be tracked by the referring *activistas*, verified in the clinics, and carried by the patient. During the project implementation a total of 1,200 blocks of *Guía de Referência* were printed. Of these 1,033 were distributed to the CSO, Health Units, *Gabinete de Atendimento a família e Criança Victima de Violência*, MISAU and USAID. The remaining 167 *Guías* are in FHI360 central office and will be distributed to the CSO, based on their needs.

The legacy outcome referred to above is a new interpretation of referral; that it is not simply advising someone to go for health services, but rather tracking that referral all the way through to that person receiving the services for which they were referred. Another outcome is that during the last year of the project, reported referrals started decreasing. When CCP investigated possible root causes, the project learned that people are internalizing the use of health services in a new way, taking themselves to the health unit without being referred by anyone. In the beginning, CCP was mandated to create demand for health services, and therefore the project can report some success in that area.

This *Guía de Referência* was very important in CCP implementation, since it facilitated obtaining needed services identified during the Initial Intake Assessment process of PLHIV, OVC, pre- and post-partum women and their families into CCP. The *activistas* would tick the necessary boxes on the *Guía de Referência* for the person to carry with them, referring them to clinical or social services including government social grants for the most needy, and assistance for reentering school. The referrals system has been strengthened during CCP, and will need the multi-sectoral district level stakeholder meetings to continue in order to maintain its proper usage and value added. Challenges remain, such as clinic staff turnover that requires continuous training input on using the *Guía de Referência*. Not all referrals get used, and not all referrals get signed off on by the provider in the clinic, e.g., even if they are used, not all referrals get properly filed for case management purposes. Forth coming community based services projects should be sure to continue supporting this initiative.

Home Based Care

Home Based Care for PLHIV was much more significantly needed and practiced in 2010 when CCP commenced under its original name ComCHASS. Over the LOP of CCP, the number of “classic” bedbound PLHIV has reduced significantly, thanks to the increased availability of ARVs and HIV related services. Also over the LOP of CCP, MoH HBC guidelines were redirected to focus on treatment adherence.

The original CCP model for providing HBC followed the MoH provider:patient ratio of 1:6. Annual targets were at first based on an approximate average four month active HBC period, with however many home visits were needed each week. Of course each HBC client was provided care as long as necessary but CCP made 20 HBC clients per year per *activista* the target. The active period would culminate in “graduation” from HBC when the MISAU criteria were all met, largely focusing on mobility, self-care capacity, adherence to medications regimens, e.g. When the *activistas*’ provider model was integrated to include OVC, a family multiplier was used for setting those annual targets.

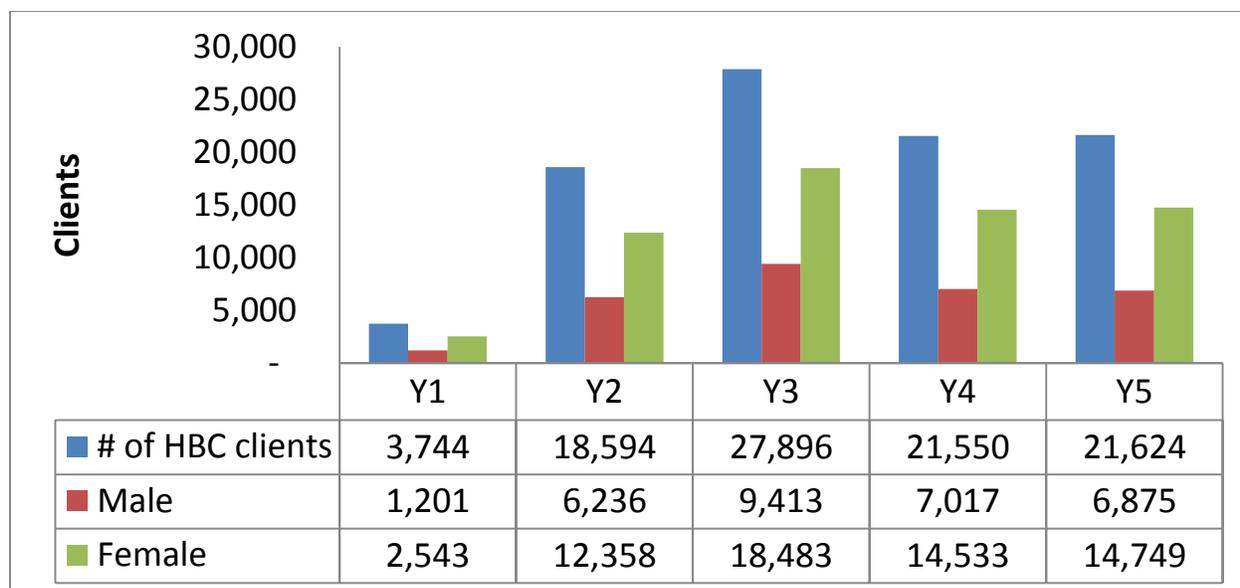
Home Based Care clients usually joined CCP through the following ways; Community leaders who knew their constituency well would refer people to the CSO for intake as beneficiaries. *Activistas* were often very diligent about identifying PLHIV and sick people with unknown HIV status, and enrolling them in CCP. Success Stories abound about the commitment and dedication of the *activistas* in getting people into care and treatment. And as mentioned above, sometimes the clinics made the initial referral of PLHIV to the CSOs for HBC. As the Treatment Defaulters case finding activity described below has grown in strength, this too is a source of referrals to HBC-adherence support by CCP.

Home Based Care comes from the neighbor assisting a neighbor concept. Many who are providing community based services say of themselves that they are helping now when they are able, and hopefully if in the future they need such help, that others will help them.

Table 1 below shows the LOP annual HBC service delivery, disaggregated by sex. The consistency over the five years of the female:male HBC client ratio is worth noting. Understandably, Yr 1 showed quite low HBC performance due to all the startup activities of the project such as the public competition for CSO selection. Future projects could note that this activity took around nine (9) months from public announcement through to funds being obligated to the selected CSOs. Steps included district level review of CSO applications by local government and stakeholders and ranking them on a standard scale, central level final review, pre-award financial and technical assessments, development of the SOW and CSO budget, approval by USAID, and start up workshops. Then *activistas*’ training, provision of the bicycle and HBC kit to each *activista*, to get started. CCP was allowed to fast track three (3) CSOs in target districts in Niassa province, who had been active with other FHI360 HIV projects and had previously undergone the competitive process.

Since HBC clients graduate out, the annual totals below represent non-cumulative data. The total CCP HBC service delivery over LOP therefore is 93,408.

Table 1: CCP LOP HBC annual service delivery by sex



Orphans and Vulnerable Children

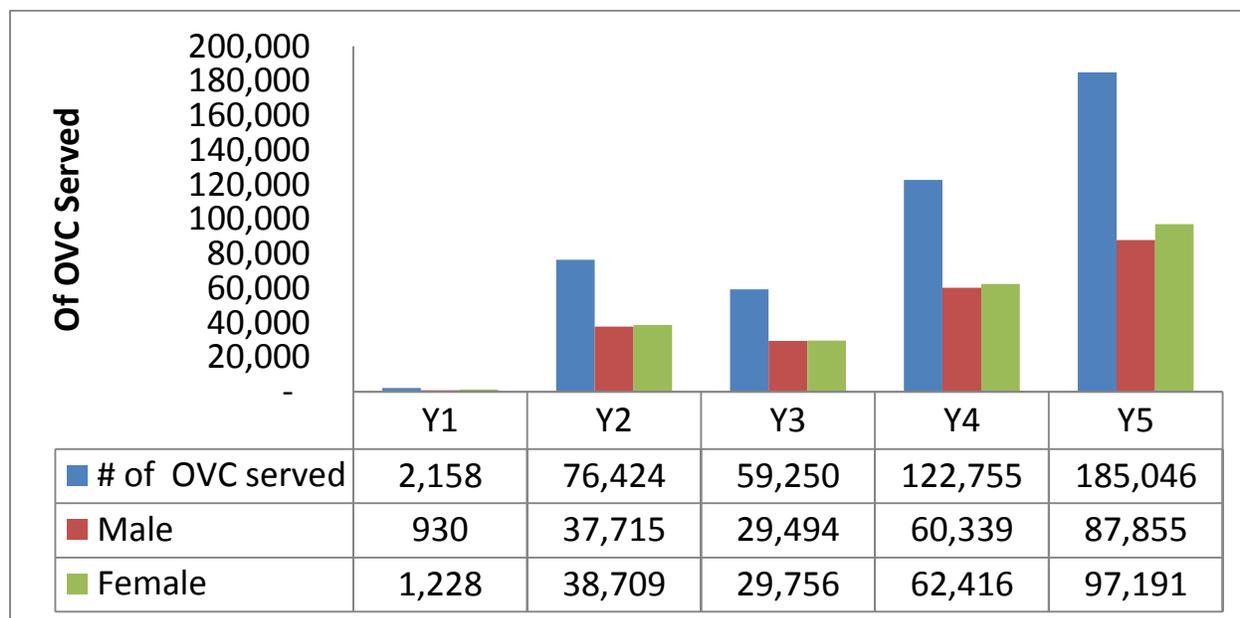
Orphans and Vulnerable Children care and support differs from HBC in that there is no graduation mechanism for beneficiaries, other than becoming overage at age 18. Orphans and Vulnerable Children care and support subscribe carefully to Mozambique national guidelines of the “minimum package” designated by the Ministry of Gender, Children, and Social Action (MGCAS), which actually closely aligns with PEPFAR OVC activity areas. To help the *activistas* manage a reasonable and feasible OVC case load, CCP conceived of the following model to accommodate both the expected and needed service delivery, and, OVC not graduating. Since children in the same household of an adult PLHIV HBC client are by definition vulnerable, an Intensive Phase for OVC was demarcated to correspond to the HBC period of service delivery. During the Intensive Phase, those enrolled OVC would undergo Initial Intake Assessment and the first use of the Child Status Index (CSI), obtain all the services by referrals indicated as needed, receive as many home visits with psychosocial support as needed. Following the HBC client graduation, if the OVC present in the household warranted it, they could move to the Maintenance phase, which was marked by much less frequent home visits, and joining a Children’s Club if one was locally available and of interest to the enrolled child(ren).

CCP includes OVC in both Intensive and Maintenance phases when reporting, since the *activistas* are in fact still seeing to the OVC.

Table 2 below again shows low Yr 1 performance due to start up activities taking the majority of the year. The decrease in reported OVC service delivery from Yr 2 to Yr 3, has to do with an extensive and systematic data verification process, which resulted in lower but more accurate service delivery totals. These findings included scattered evidence of: double counting, missing data, forms with incomplete data, miscounting, data mis-aggregation, blank forms, and also over/under reporting data. These led to invalidation of data by CCP M&E staff, and corrected

SAPR or APR submissions. To overcome this, the CSO M&E officers received further training on data management and M&E.

Table 2: CCP LOP OVC cumulative service delivery by sex



The standard OVC service areas include: health services, education, shelter, legal (all by referral), “food” actually means nutrition services, social meaning psychosocial both provided directly, and economic whose benefits accrue to children either through government social grants to their parents or guardians, or parents or guardians membership in VS&L groups.

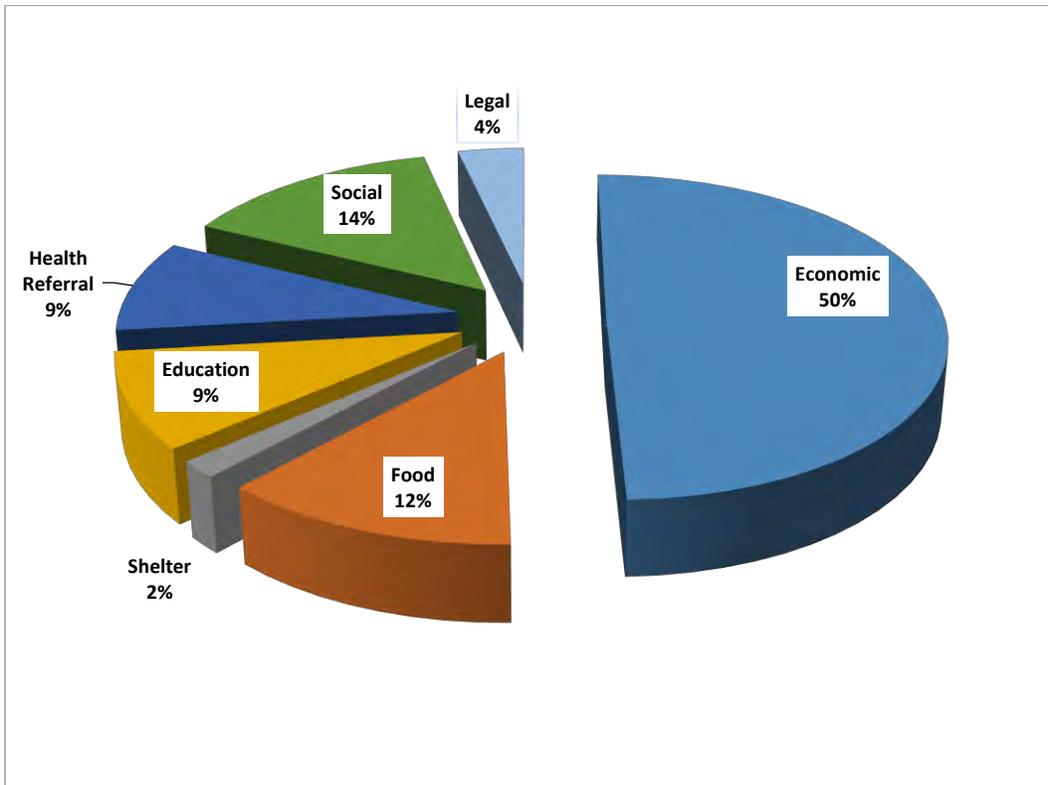
Graph 1 below shows the quarterly disaggregation of OVC services provided by area, actually at the project high water mark of reporting the accomplishment correctly. CCP struggled for a long time to properly show the VS&L group members OVC data and to be able to include it with the rest of the data contributing to the PEPFAR indicator; the VS&L data was in a separate data base, so was very challenging to integrate. Usually the graphed economic service proportion in any quarter would hover around 6%, based on needy OVC households accessing social grants from INAS, the Mozambique national social services agency. Being able to include the HES activity in the proportions graph shows the potential of the VS&L groups’ to meet OVC needs. The potential is present in the CCP VS&L groups’ members’ households, with or without the project ability to report it properly.

Nutrition services (food) included referrals to malnutrition rehabilitation clinical services if MUAC assessment suggested, nutrition education, cooking and home garden demonstrations. This indicator also includes those who have received direct food basket support from INAS, by referral, when a household is extremely needy.

The shelter service has always been a small proportion of the OVC service delivery. However, CCP is confident in and quite satisfied with the manner in which the shelter service is provided. Consistently, when OVC needed improvements to the place they lived, the activists and CSOs

mobilized community leaders and stakeholders, and activated linkages with government services through SDSMAS and/or INAS to collaboratively meet the shelter needs indicated. This reflects the community sustainability model that CCP built over the life of the project for community oversight and ownership of OVC care and support needs.

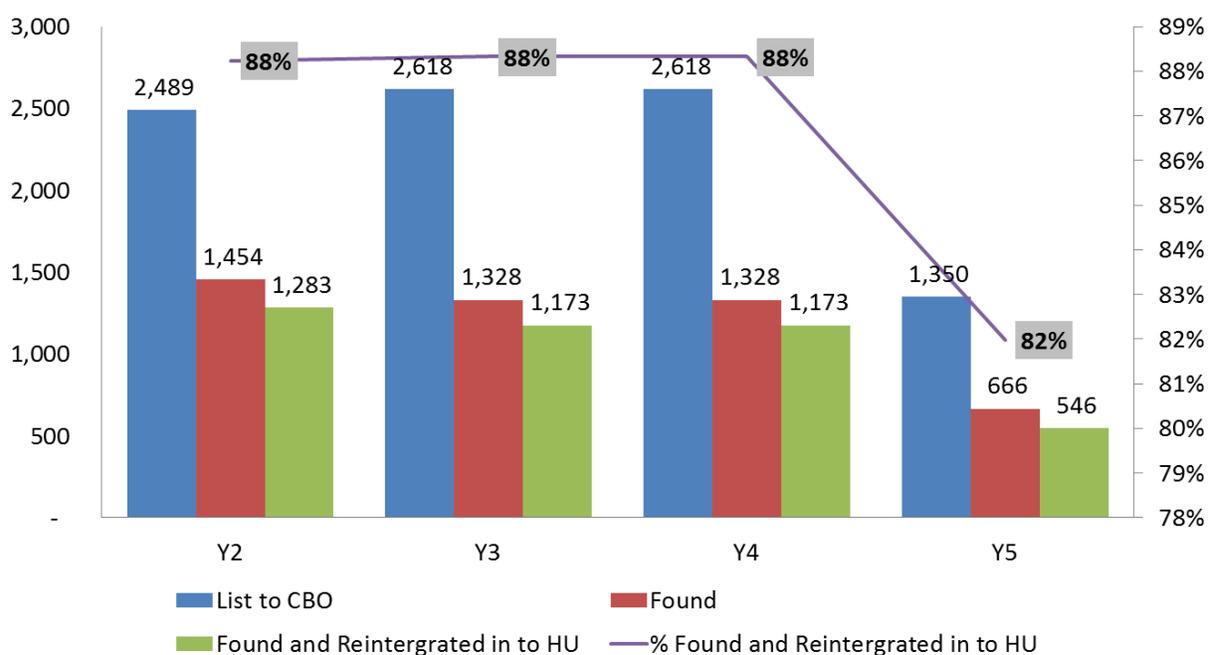
Graph 1: Exemplary Yr 5 Quarter: Services provided to OVC by proportion, including HES activity



Adherence Support

CCP was a key participant in *busca activa/consentida*, which is the active case finding activity as concerns ART patients who are lost to follow up primarily by defaulting on HIV treatment. This activity was implemented through mature linkages with the clinic partners in each CCP district: CHASS Niassa in Niassa province, CHASS SMT in Sofala, Manica, and Tete provinces, CDC-supported Ariel in Maputo and Cabo Delgado provinces, and CCS in Inhambane province. The methodology is that the clinics would compile a monthly list of treatment defaulters, share it with the CCP CSOs, and the *activistas* would use their community knowledge and their position of trust to locate as many defaulters on the list as possible. The results are somewhat mixed; CCP was consistent in that *activistas* were able to locate around 50% of those on the defaulters lists. But they were quite successful in counseling 88% of found defaulters back to treatment when they found the listed persons, consistently through most of the CCP LOP. Close Out Yr 5 understandably saw a big drop in numbers, since of the 42 Yr 5 implementing districts, 15 ceased implementation at the end of March, the remaining 27 ceased at the end of June, and there was 0 implementation for the last quarter.

Table 3: CCP LOP *Busca Activa* performance



The challenging part of the active case finding process is only finding patients. *Activistas* are only able to local approximately 50% of listed persons. This issue has been under national discussion since the activity started. Further, while the data reflect the effectiveness of the *activistas* in counseling defaulters back into treatment, clinic level retention data on those individuals were not shared with the CSOs as they are considered data managed by the HU.

Lasting and effective solutions have yet to be found. Some districts have improved on community collaboration like ART patients identifying a relevant community leader for their file, to be followed up with in case of defaulting. Some clinics have improved their patient files. There is enough evidence to suggest that the clinic based system needs revamping to perhaps do the process more frequently than monthly. As well, health facility files have been found through studies to be out of date, inaccurate, or both. The starting materials need to be improved to improve the “found” rate in the first place. All of that said, the continuing fact has remained that many people simply do not want to be identified correctly, or found if they default.

As mentioned above, treatment defaulters reintegrated to ARVs through *Busca Activa/Consentida* and their family members were enrolled into CCP, thereby accessing all the PLHIV care and support assessments, interventions, and referrals, as appropriate. Such referrals include the VS&L groups, the GAACs and other community support groups. Of course OVC in the household were also assessed, referred, and received direct care and support per the normal CCP program.

Pre- and Post-partum Women (PPPW)

The PPPW component of CCP involved identifying this target group, enrolling them and their family members into CCP, to access all the services referrals needed through the Intake Assessment process. Service provision to these women included counseling on always attending their MCH appointments, HIV Voluntary Counselling and Testing, nutrition education including cooking and home gardens demonstrations, orientation for breastfeeding, and referrals to Mother to Mother (M2M) groups in the communities, as well as VS&L groups. CCP *activistas* also played a very important role in mobilizing fathers to accompany their wives to MCH appointments whenever possible.

The main objective for targeting PPPW was to get them into PMTCT services. CCP reporting in this area has always fallen short, partly due to the wording of the indicator, “PPPW referred to PMTCT services”. To be referred to PMTCT services, one’s serostatus must be known. If a PPPW is not willing to disclose her status to anyone, such a referral will not be made. On the other hand, the PMTCT services are housed within the Maternal Child Health (MCH) department of health facilities, and PPPW are referred there in much greater numbers, though still below the assigned target for referral to PMTCT. The MCH clinic can help PPPW to get tested for HIV once in the facility, then if positive, set them up right away for PMTCT. A challenge to a community based project like CCP, is that confidential patient information from the health facilities was not shared with us, logically. Perhaps that can be overcome with a project that covers both the clinical and community side of HIV work, “collecting” their own project clinic data.

Support Groups

Various support groups are a critical aspect of community life. Part of CCP *activistas'* work was to link PLHIV and PPPW to appropriate support groups to fit their needs. The CSOs would assist clinical staff with the groups they initiated such as the M2M, GAAC1 and PLHIV groups, as well as assisting the SDSMAS OVC focal point with starting up or reviving Community Child Protection Committees (CCPCs). These various community groups serve different purposes, depending on the group. The *activistas'* role also varied per group type, but can consistently be said to be one of skills transfer such as nutrition education for breastfeeding mothers, PLHIV, or their children; providing training and/or messages such as Parenting Skills, children's rights, or on how to be a community committee.

Small steps in improving male involvement in family needs and health care have been noted toward the end of the CCP LOP. Some M2M groups are now also including men, while in one province (Niassa) men chose to start their own group of Fathers to Fathers. Activistas had worked very hard at men using the peer education model. Responsive men started to participate in M2M groups, accompany their wives to the pre-natal consultations, support their wives in domestic work. In Niassa province, CCP *activistas* and CHASS Niassa case managers jointly invited men to participate in M2M groups, and to form F2F groups.

While perhaps small steps and more work needs to be done to engage men, these are very important advances in improved gender roles, improved parenting, improved care for family members by those in charge, and another testament to the effectiveness of the CCP community based *activistas* in broadening support for children.

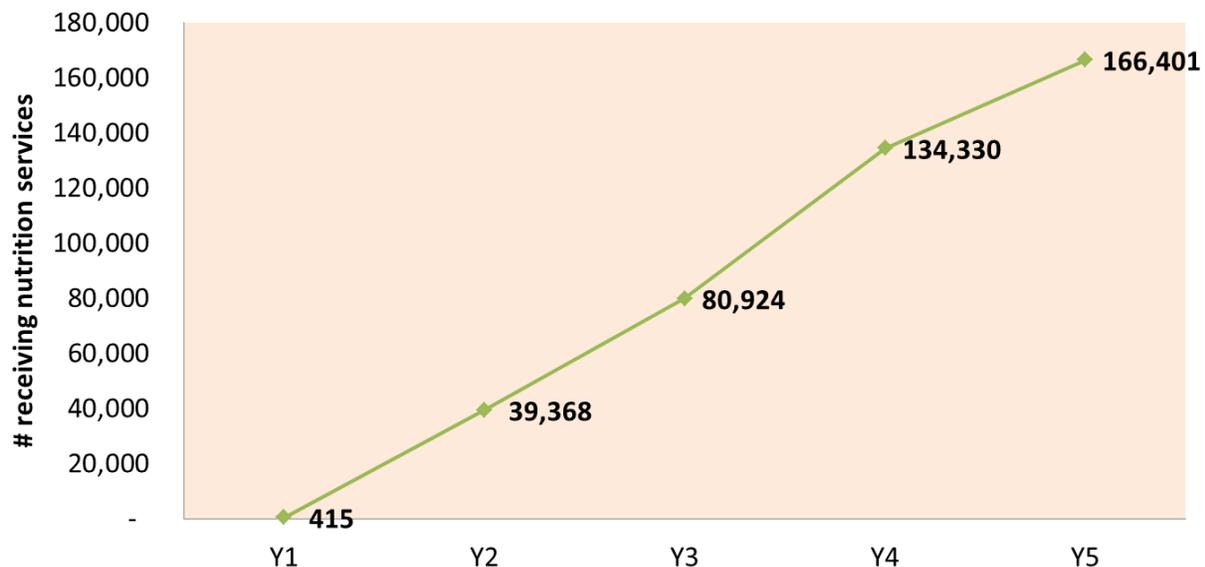
¹ Community Treatment Adherence groups, where one feature is that members take turns collecting ARVs resupplies for their whole group.

Nutrition

Nutrition is a cross cutting component in CCP that benefits all target groups, with extra focus on PLHIV, pregnant women, breastfeeding women and children from 0-5 years old, and has been consistently a strong performance area for the project. In CCP, nutrition services consist of three broad activities: nutrition education delivered appropriate to age, situation such as breastfeeding mother, PLHIV, etc., cooking and garden demonstrations, and Mid Upper Arm Circumference (MUAC) screening for referrals to malnutrition rehabilitation services as needed.

CCP reports to PEPFAR on nutrition services disaggregated by age. **Table 4** below shows nutrition services delivery by year, including all age groups and PPPW. The 0-14 age group includes children who benefit indirectly from nutrition services provided to their parents or guardians. Standard venues for the nutrition services provision were during the home visits, in M2M groups, VS&L groups, and even the Children's Clubs. The nutrition education component is drawn from the Integrated HBC/OVC Caregiver Training curriculum, is reinforced when also delivered during the Parenting Skills talks, and were especially effective when delivered in the VS&L groups, tying good family nutrition to HES efforts and results. Cooking demonstrations always utilized locally grown produce.

Table 4: CCP LOP Nutrition Services Annual performance



Over the LOP of CCP, two kinds of kits have played important very different roles: the HBC kit and the PSI Family Health Kit.

Home Based Care (HBC) kits

When CCP started, as mentioned above, the classic bedbound PLHIV HBC patient was more the norm. HBC providers underwent an initial two week training, which included using the items in their HBC kit correctly. While HBC has been delegated by the MISAU to the NGOs to implement, the care guidelines, HBC kit contents, and monthly stipend were all mandated by the MISAU. Initially and correctly, each *activista* was provided a HBC kit for use with their HBC clients; the

kits contents were replenished systematically. The supervisor, who was a nurse, was provided a kit with higher level medications for dispensing for patient use. Over time, CCP provided fewer kits to the CSOs, to the point of reduction where the nurse/supervisor had the nurse's kit and just a few activista level kits and judiciously dispensed as needed for the fewer HBC clients in that level of need.

PSI Family Health Kits

When CCP commenced in 2010, PSI was distributing their Family Health Kits through health facility partners, in the case of FHI360 Mozambique, through and FHI360 clinical HIV project in Niassa province. Building on the already established partner relationship with PSI, CCP encouraged the strategy of using the community based services platform to distribute the Family Health Kits to CCP enrolled families. This kit contained *Certeza*, a point of use water purifier product, soap, condoms, and a health education pamphlet. The *activistas* delivered the kits and used the pamphlet for family health education. This worked well for a few years, and certainly unburdened the clinic pharmacies. PSI later switched from the kit containing the actual products and cyclical replenishments, to a mobile phone based delivery system in some pilot districts. Beneficiaries were provided coded vouchers which they would take to their local store, the store owner transmitted the codes onward for accounting for dispensing the products to the voucher holders. To this day, it remains a good idea but PSI had problems with execution and some vendors haven't been fully paid yet for the products they stocked then released to voucher holders.

Result 2:

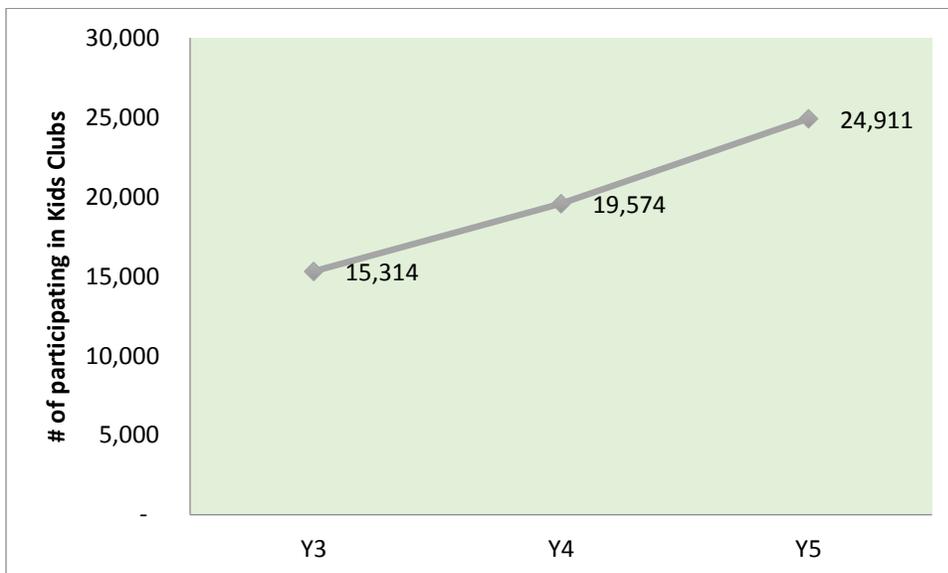
Increased family-centered, community-based services that improve health outcomes and quality of life for PLHIV, OVC, and pre/post-partum women and that are implemented by the coordinated efforts of the Ministry of Gender, Children and Social Action (MGCAS), the Ministry of Health (MISAU), and civil society organizations (CSOs).

Activity Area 2.1: Strengthen the CSOs to assure compliance with MGCAS minimum standards for OVC and support the National Action Plan for OVC

As noted above, all CCP OVC care and support activities reflect MGCAS (formerly MMAS) minimum service delivery standards. CCP support for the Children’s Clubs activity across CCP implementing districts is two-fold, both provided by the *activistas* who facilitate various recreation activities including soccer, singing and dancing, poetry, and hand-making toys using local materials. Playing and learning together are central to the activities and help the children learn various aspects regarding human values on day to day basis. These sites are also key opportunities for CCP *activistas* to engage the children depending on their age, on broad topic areas, such as: children’s rights, child sexual abuse, sanitation, oral hygiene, prevention of diseases such as diarrhea, malaria through use of mosquito nets, and water purification using *Certeza* or even boiling water before consumption.

Over the LOP of CCP, CSO implementing partners established 1,030 Children’s Clubs across the 52 districts, which is a significant factor for community sustainability of OVC care and support after the project concludes. In addition to the *activistas*’ support of the children’s activities, they also lead small group discussions on parents/caregivers support to their children, using the Parenting Skills IEC.

Table 5: CCP LOP Children’s Clubs participation



An example of the Children’s Clubs’ role in the communities is the following story.

International Day of the Child, June 1st

In 2015, CCP marked the International Day of the Child by partnering with MGCAS to hold a commemoration in Maputo province on Saturday June 6th. The CCP implementing partner in Marracuene district CONFHIC hosted the event, which convened 200 Children’s Clubs member children from all five (5) CCP districts in Maputo province. The day aimed to provide the opportunity to reflect and talk about their rights in their families and society, as well as an opportunity to express their opinions. The theme of the international day was “Marriage after the age of 18” and activities that day included: recreation, food, reciting poems, performing traditional dances and dramatic skits, playing games, and displaying items made from local products. The wonderful Mozambican musician Momad Ali Faque performed a few of his famous hits, as well as a few songs with the children. The MGCAS national head of Child Protection attended, and provincial and district level government representatives from DPMAS and SDSMAS, as well as international organizations such as PATH, Save the Children, and the CCP donor agency USAID. CCP provided t-shirts, snacks, balloons, balls, toys, and books for all the children attending.

USAID Mozambique Mission Director Alex Dickie dances with a youth (left), a group of children perform a dance routine they have practiced (right), another group of children display their t-shirts and toys from the day.





The June 1st commemoration also took place in all the Children’s Clubs at various scale of event, but at minimum, with dissemination of messages regarding child rights and protection, prevention of domestic violence with emphasis on sexual abuse, and preventing early marriage, featuring the international theme this year of “marrying after the age of 18 years old”. Community leaders participated in these activities in a way to assure continuation of such sensitization after the project closes.

Parenting Skills

The Parenting Skills referred to above, is an IEC material used to deliver basic parenting messages. The IEC itself is an often used delivery model, a flip chart with relevant pictures or graphics facing forward to the audience, with the corresponding messages facing the back for the presenter’s reference. Overall the project printed 1,300 materials. Of these, 937 were distributed and 352 were lost while transporting them to the provinces. This case is still on negotiation with the transporter *skynet*. CCP has targeted specific venues for these messages developed in conjunction with MGCAS, such as the VS&L groups, to help members make the leap of logic to use their savings’ profits to improve the lives of their children and families. However, *activistas* are also using the Children’s Clubs, family households, CCPCs, M2M groups and *co-gestão* committees which include community leaders and health unit’s Humanization Technical Officers², as expanded opportunities for disseminating the parenting skills messages, as well as carrying tem further less formal gatherings such as market places, churches, water sources, and grinding mills.

Activity Area 2.2: Partnerships and linkages are used to ensure OVC services are comprehensive and accessible.

² Humanization is a MISAU initiative to improve how clinic staff treat patients who come for health services

MGCAS is a key government partner of CCP. Over the LOP of CCP, the strength of the partnership has grown very well. CCP and this ministry accomplished a number of things together, CCP assisting by initiating with inputs, guidance, and ultimately approvals from MGCAS. Legacy CCP material contributions include the Child Visit Protocol and the Parenting Skills IEC, and adapting the CSI for local use. Less tangible CCP contributions include consistent and energetic participation in the NUMCOV (Nucleo Multisectorial de Crianças Orfas e Vulneráveis) and GTCOV, and CCP OVC Technical Officer assistance with delivering the MGCAS strategy in regional fora.

**Result 3:
Increased number of HIV/AIDS positive individuals and affected households have adequate assets to absorb the shocks brought on by chronic illness.**

Activity Area 3.1: Increase access to skills building and household economic strengthening opportunities to improve the wellbeing of all target groups

As mentioned above, the integration of community based services with HES is one of the most powerful integrations within the CCP design. The technical subcontractor Project HOPE had responsibility for this project component, rolling out a standardized systematic village savings and loan (VS&L) group strategy, ultimately producing 1,120 VS&L groups across the 52 CCP districts. Women have comprised around two-thirds of the VS&Ls groups.

Most impressively, by the end of implementation, the combined value of savings was \$1,341,582, with an additional Social Fund total of \$52,021, across the 1,120 groups.

Table 5: CCP LOP creation of VS&L groups

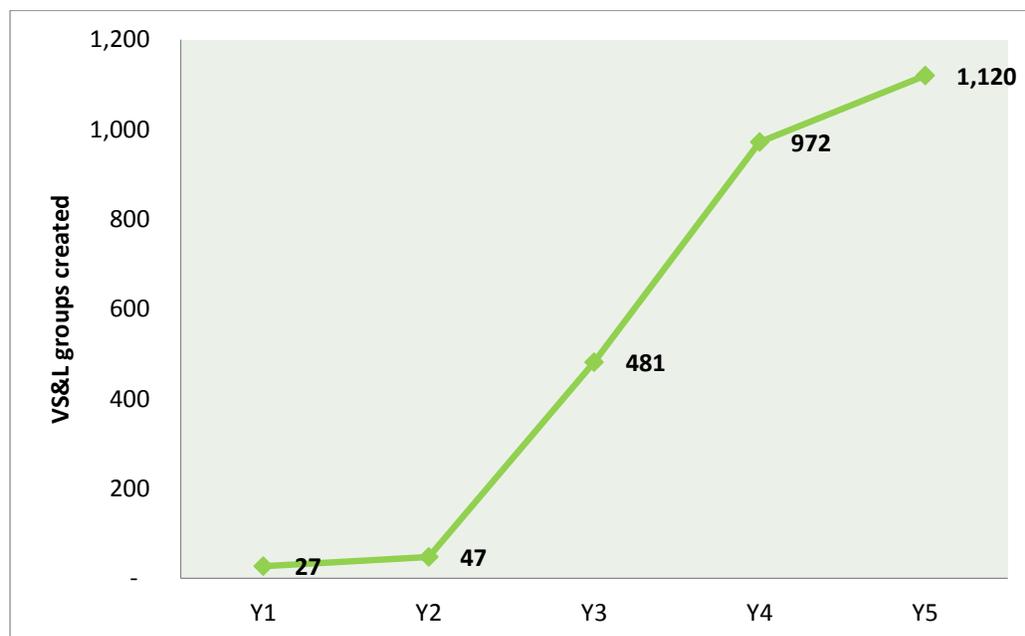


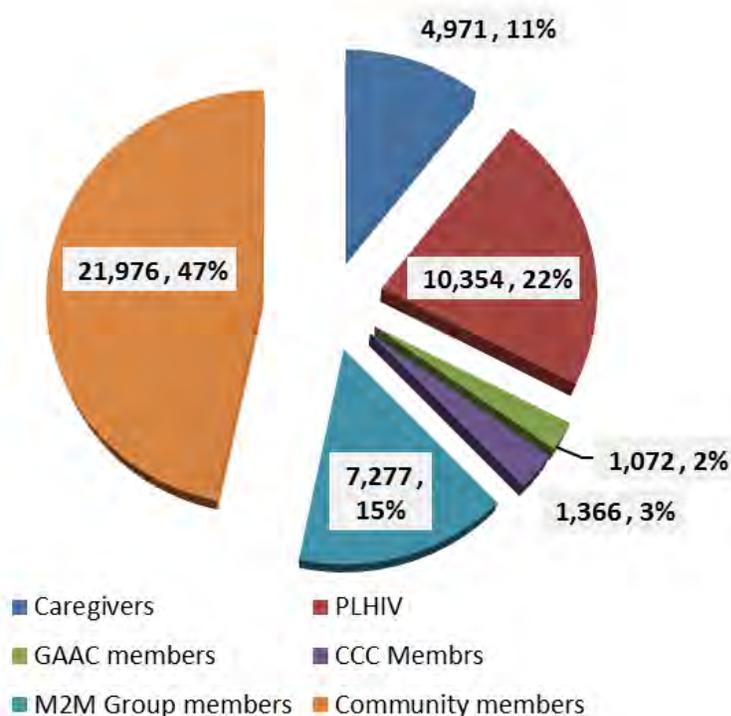
Table 5 above shows nearly exponential growth in the number of groups, largely due to USAID urging the project to ramp up the activity. Trained Community Facilitators support the creation of the groups, then shepherd them through at least one savings cycle of anywhere from 9 months, depending on the groups decision. The groups are also self-formed, selecting trusted known people to join as CCP beneficiaries are referred to the groups.

In the beginning of the project, the initial groups firmly concluded to be mixed, selecting trusted known people— PLHIV, with members from the larger community. They did not want to be known as “sick groups” and attract discrimination. This has been a successful strategy. The groups have become very popular and other groups have formed mimicking the CCP model independently. With money from their savings, VS&L members have accomplished many different activities. Some members replaced their thatched roofs with galvanized metal, improving the durability and hygiene of their house. Members improved their seed stock and agricultural outputs, improving both their household nutrition status and their income. Members upgraded the conditions of their existing small businesses, bringing in electricity for running a fridge in their food shop, e.g. Members commenced an IGA or small business, capturing the possibility for all specific improvements named herein. Members bought bicycles, improving access to their local health facility. Many prioritized their children’s material school needs such as uniforms, shoes, notebooks. The overarching principle transformative result of VS&L group participation is that of a productive, long term strategy to maintain household capacity and assets to withstand living with HIV as a chronic illness.

Establishing the VS&L groups was just the first step in the Project HOPE HES strategy. All groups were trained on Financial Literacy and developing IGAs. Furthermore, Project HOPE was a tireless liaising force with the formal banking sector, and in some CCP provinces and districts the formal banks came to the VS&L groups offering banking services.

Graph 2 below shows that the CCP target groups PLHIV and OVC caregivers combined comprise 53% of VS&L group members, while community members comprise 47% of members.

Graph 2: CCP VS&L Groups membership by target groups



Evaluation/Assessment

Over the CCP LOP, the project conducted a Baseline Survey and End of Project Evaluation. USAID contracted for external mid-term evaluation to be carried out, and that initiative evolved into two very focused evaluations on 1) the Integrated Caregiver Model, and 2) the CHASS SMT *busca activa* pilot using mobile phones which used CCP CSO *activistas*.

The CCP EOP Evaluation methodology was able to capture important differences between CCP-exposed individuals and non-exposed, regarding CCP services received in the past four years. Exemplary highlights follow. Caregivers living in CCP beneficiary households were significantly more likely to report receiving all of the project services. The biggest differences were seen in HIV services, with a 19 percentage point difference in PSS, an 18 percentage point difference in HIV prevention information, and a 17 percentage point difference in HIV testing. Children under 10 living in CCP beneficiary households were also more likely to have received CCP services. 18% of those received PSS, while only 2% in non-beneficiary households received, $p=0.00$. They were also more likely to have received services from a health care provider (37% vs 25%, $p=0.00$).

In terms of the two key outcomes assessed in the endline quasi experimental evaluation of the CCP project, beneficiaries performed significantly better than non-beneficiaries. Households that were beneficiaries of PCC were twice as likely to have received 2 or more services in the basic package of services, services intended to address the needs of vulnerable households and their members. Furthermore, youth who had benefitted from PCC had higher resilience scores, suggesting that PCC may have contributed to improving their resilience. The fact that

improvements were seen on both the relationship and contextual sub scales is consistent with the project approach which aimed to strengthen families and communities.

These differences were seen after controlling for the underlying vulnerability of these households. The initial comparison of beneficiaries and non-beneficiaries showed that the households that benefitted from PCC were, in fact, the more vulnerable households that the project set out to serve. They were more likely to be female headed, they had more family members, they were more likely to have double orphans in residence and the heads of household were more likely to be widowed, divorced or separated than were their non-beneficiary counterparts. In addition, youth in beneficiary households were more likely to report that they were their own caretaker than were youth in non-beneficiary households.

In interpreting these results, some key limitations which were known during the design phase need to be taken into account. First, an experimental design was not possible allowing for selection biases. Propensity score weighting was used to address this but is most effective if the key factors are measured accurately and there is minimal effect of unobserved or unobservable variables. We took every step to ensure that this was the case. Second, there is a reasonable likelihood of non-differential misclassification of exposure, with some people reporting that they are exposed who were not and others reporting that they were not exposed when they were. This may result because people do not remember whether or no they were exposed in the past, because they were exposed to another intervention that they misclassify as PCC intervention, or because they do not fully understand the questions on exposure. Every effort was made during the training of the interviewers to ensure that questions were clear and that that the interviewers could provide clear answers to participants who had questions about exposure but this threat could not be completely avoided. The full CCP EOP Evaluation Report is annexed to this Final Report.

Program Management

Staffing

The majority of CCP technical and program team members remained loyal to CCP throughout the LOP. This factor has been a great strength to the project, affording a measure of stability and reducing the need to retrain new people. This stability has also fostered deeper relationships with the CSOs, who also experienced the long term continuity of the project.

USAID activities

There were many USAID activities over the CCP LOP. Site visits have included high level USAID specialist leads, the US ambassador and other senior State Department figures, as well as USG staff from the US. Launches have included the mHealth activity formerly carried out in Maputo province, and the Parenting Skills IEC launch in Inhambane province. In the last year, CCP implementing CSOs have hosted USAID staff carrying out the SIMS exercise.

A significant USAID activity was putting forth the YouthPower Action (YP) activity in July, for start-up immediately after CCP closes. YP is an older OVC focused program, for 9 months in 19 PEPFAR 3 priority districts, with the same CSO partners as CCP worked with, to garner a rapid

start up in a short implementation period. They had all been previously competed, reviewed, vetted, and assessed fully under CCP.

Environmental Compliance

CCP complied with relevant environmental requirements throughout the LOP. As a project with very few sensitive materials, the activists did handle them by either treating them with chlorine bleach, or buried or burned them, as was delineated in the project Mitigation plan. These few materials consisted of soiled bed linen or used bandages.

Major Implementation Issues

Major implementation issues over the LOP included late and/or incremental USAID funding and budget cuts. CCP was nearly forced into early close-out on two occasions due to delayed funding. Inconsistent and late funding significantly challenges quality implementation due to inconsistent messages to slow down and then speed up of project activities. This can further compromise morale across the project with the prime organization, the INGO subcontractors, the Mozambican NGOs, the CSOs in the 52 districts and their staff and cohort of *activistas* as well as government partners at district, provincial level, who find it hard to understand. A stronger funding model would include timely Annual Work Plan approvals, timely funding Modifications, full yearly funding as opposed to partial Modifications.

Sub granting to local CSO partners is a logical and highly desirable methodology for implementing community based services and activities. There are inherent risks, however, alongside the advantages, which impact project results and achieving targets. Educational and skill levels vary widely across CSOs, districts, and provinces, yielding correspondingly varied ability levels. Often when individual staff capacity is improved, they may qualify for higher level formal sector employment which has certainly drawn good people away from CSOs. FHI 360 invests enormous effort to monitor CSO compliance, to manage the many possible risks regarding USG funds, in addition to the Organizational Development activities detailed earlier in this report. Through such monitoring, CCP found it necessary to close specific CSO implementers due to mismanagement issues, resulting in the 10 fewer districts at EOP compared to the start-up district target of 52. CCP practiced committed partnership principles throughout such early closure processes, providing assistance, time windows for corrections, proper documentation, and more assistance. In some cases, an alternate CSO was able to take over the CCP activities in that district, after going through the same vetting process as was carried out initially and gaining USAID approval. The periods of change did engender much uncertainty among CSO staffs and activists, requiring excellent communication and collaboration with local government entities. Such transfers from one implementer to another were potential minefields for acrimony, but were carried out successfully.

Fortunately throughout the LOP, CCP lost \$ 3,598 in uncollectable CSO disallowed costs. These costs were not charged to the donor and were covered through FHI360 G&A funds. It is important to note that as a result of regular technical assistance and site visits by FHI360 finance and

technical officers, FHI360 demonstrated being able to reduce risk and manage the CSO expenses.

Collaboration and partnership and with other donor projects

CCP was a project built on collaborations and partnerships. Most were formalized with MoUs, while some were less formal. Across the project, CCP developed a total of 10 MoUs both with government institutions and NGOs. These included: Ministry of Health (MISAU), Ministry of Social Action (MMAS), National Aids Council (CNCS), Banco de Oportunidade de Moçambique (BOM), Centro Colaborativo de Saude (CCS), ARIEL Foundation, Capable Partners Program (CAP), International Children Development Program (ICDP), Population Services International (PSI), Rede CAME. Already mentioned were the linkages with clinic facilities in every implementing district, and also with the government social services providers.

Primary donor project partnerships included CHASS SMT and Niassa, whose projects aimed to strengthen the clinical services providers that CCP linked with, and later SMT started up VMMC. When ROADS was active, they would refer clients to CCP HBC, in Beira City for example, where both ROADS and CCP were co-located. PSI was already mentioned as the provider of very useful Family Health Kits. PATH was the partner for ECD in only two districts in Maputo province, while Save the Children is a partner more broadly in the OVC sector. ANEMO had remained a collaborator till the end, over the LOP spanning HBC trainer accreditation and supportive supervision. N'weti was a partner with CCP in one district in Maputo province.

Technical coordination meetings

Over the LOP of CCP, technical team members at central and provincial levels energetically participated in various technical working groups, engaging on OVC, HBC, Nutrition, PMTCT, Community Mobilization and Gender, on a regular basis.

Best Practice

CCP developed a partner level Close Out model which we wish to strongly encourage for others to take up as a Best Practice. CCP held a Close Out ceremony with each implementing CSO partner, in all the districts where CCP was still implementing at the time to close. This model was standardized across all the provinces, regardless of Provincial Lead – FHI 360, Africare, or World Relief. The ceremony model included the CSO staff and activists, that district's VS&Ls Community Facilitators, and CCP representatives – either provincial lead and/or FHI CCP leaders. Key participants also included SDSMAS officials, representatives from district government, GAVV, INAS, CHASS Niassa or SMT, or CDC-funded clinic colleagues, clinic representatives, and various community leaders, depending on availability. The purpose of this Close Out ceremony was to honor the contribution of the CSO and *activistas*, acknowledge the many linkage partners who comprised the strengthened social safety-net, and express appreciation for all the hard work and results accomplished during the years of CCP. A secondary purpose of this approach was to leave in place motivation to follow their sustainability plans as best possible, and lay the ground work for future collaboration opportunities, should they arise.

The legacy package for each CCP CSO included: a summary of their LOP results and total funds managed, in Portuguese and English, to assist with any future proposals they may need past performance information for, a Certificate of Appreciation for the CSO, and their updated Services Directory to facilitate continued linkages and referrals to various services. Referral clinics also received a Certificate of Appreciation, as did the VS&Ls Community Facilitators (through Project HOPE), and also every individual *activista*.

CCP believed this approach to be a minimum in terms of respect and appreciation for all the collaboration and partnership. It was quite a shock to learn we had exceeded expectations when the following was spoken to us:

“This is the first time anyone has ever done this with us. Before we would only get a letter saying the project was closing...”

CCP also conducted provincial level Close Out meetings, engaging the DPMAS, DPS, and Governor’s office representatives. The legacy package at that level was a provincial summary of CCP results, and Services Directories of all the active CCP districts.



CSO/district level Close Out: the *activistas* of CONFHIC, in Marracuene district, Maputo province, with their certificates of appreciation

Through the life of CCP, many valuable lessons were learned, such as:

- 1- Continuous, dedicated introductions and trainings using the *Guia de Referencia* resulted in a new shared mindset on what a referral to services means. In the past someone would just tell someone to go to the clinic or to Social Services without ever knowing if the services were obtained. CCP instilled the concept of a complete referral across its target implementation districts, meaning those referred were tracked to assure they had received the service and were following through.

- 2- Partnership and linkages with other key projects and activities to achieve a continuum of care for PLHIV, OVC, and pre- and post-partum women takes relentless effort from both sides of the linkages for best effectiveness.
- 3- People were 'hungry' for the VS&L groups, the uptake was energetic and non-CCP groups even formed just from following project-supported example groups. The VS&Ls fulfill such an important set of needs in rural community life, from learning to save and better meet the needs of group members' families, to serving as an informal banking opportunity where the formal banking sector has not yet reached.
- 4- Much attention is needed in the M&E domain. Numeracy (and literacy) levels pose a huge challenge nationally, and PEPFAR data needs continue to increase, training inputs and DQA efforts need to be budgeted and attended to on a regular basis.
- 5- One fully integrated CCP database would have improved project reporting and data analysis.

Recommendations for future OVC programming

- 6- CCP recommends to continue the model of integrated community services with household economic strengthening activities in the CCP holistic family approach. The combined implementation of the activities supports families to build family resilience, prevent and mitigate the impact of HIV/AIDS, enables orphans and vulnerable children and their families to cope with the adverse effects and the financial hardships caused by caring for someone with HIV.
- 7- CCP recommends to continue working with the and building momentum for MOH in the support of the dissemination of the *Guia de Referencia*,
- 8- CCP recommends USAID provide full annual funding to support project implementation.
- 9- CCP recommends continuing the CCP Best Practice model of district and provincial level project close outs.
- 10- CCP recommends GRM give priority to developing a national cadre of professional Social Workers, to more correctly lead the social services sector in Mozambique and reduce the expectation on community volunteers to perform such services.
- 11- CCP recommends the VS&L groups methodology to be scaled up to national scale.
- 12- GRM to prioritize development of industry and job creation, with national campaigns on adult life skills.