



USAID
FROM THE AMERICAN PEOPLE

**USAID Community Care Program
(USAID Programa de Cuidados Comunitários)
Task Order No. GHH-I-05-07-00043-00
Quarterly Report: Q1-Yr 5, October-December 2014 (Q17)**



USAID
FROM THE AMERICAN PEOPLE

**COMMUNITY CARE
PROGRAM**

Date of Submission: January 2015

TABLE OF CONTENTS

List of Acronyms	3
1. Project Duration, 2. Starting Date, 3. Life of Project Funding, 4. Geographic Focus, 5. Program Results/Objectives	5
6. Summary of the Reporting Period	6
7. Project Performance Indicators Matrix	7
Project Performance Narrative begins	9
Result 1	9
Result 2	28
Result 3	34
8. Program Management	42
9. Major Implementation Issues	44
10. Collaboration with Other Donor Projects	44
11. Upcoming Plans	46
12. Evaluation/Assessment Update	47
13. Financial Information – Annex	
List of Tables & Graphs	
1: Trainings and Refresher Trainings	9
2: Capacity Building	13
3: Technical Assistance	14
4: Completed Referrals	16
5: New HBC Clients	19
6: HBC disaggregated	20
7: New OVC enrolled	21
8: OVC Service Delivery	22
Graph 1: OVC Service Delivery	22
9: <i>Busca Activa/Consentida</i>	23
10: Community Entities Created	24
11: Nutrition services	26
12: Kits	26
13: Children’s Clubs	28
14: Parenting Skills	30
15: VS&L Groups	34
16: VS&L Groups Composition	36
17: VS&L Groups – OVC Beneficiaries	37
18: VS&L Groups Savings	38
19: Exemplary New Accounts	40
Annexes to Q1 - Yr 5 Report (Q17)	
1: Financial Information	
2: Detailed Data Annexes on Referrals, HBC, OVC, Nutrition, Org. Capacity Building	
3: Organizational Capacity “Diagnostic” Instruments	
4: VS&L Groups by District	
5: Pemba District “ <i>Busca Card</i> ”	
6: Success Stories	

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
FANTA	Food and Nutrition Technical Assistance
FHI 360	Family Health International
GAAC*	Community Adherence Support Group
GAVV*	Office of Victims of Violence
GRM	Government of the Republic of Mozambique
HIV	Human Immunodeficiency Virus
HBC	Home Based Care
HU	Health Unit
INAS*	National Institute of Social Action
M2M	Mother to Mother (groups)
M&E	Monitoring and Evaluation
MISAU*	Ministry of Health
MMAS*	Ministry of Women and Social Action
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
PSI	Population Services International
PSS	Psychosocial Support
RMAS*	Department for Women and Social Action
ROADS	Regional Outreach Addressing AIDS through Development Strategies
SDSMAS*	District Services of Health, and Women and Social Action
TA	Technical Assistance

TB CARE	TB Project Care
ToT	Training of Trainers
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VS&L	Village Savings and Loan (groups)
WR	World Relief International

1. **Project Duration: (5)** Five years
2. **Starting Date:** September 2010
3. **Life of project funding:** September 2010 – September 2015
4. **Geographic Focus at Q17 (Q1 – Yr 5):** Maputo (5 districts), Inhambane (5 districts), Sofala (10 districts), Manica (9 districts), Tete (8 districts), Cabo Delgado (1 district) and Niassa (4 districts), **42 districts** per the map.



5. Program/Project Results (Objectives)

USAID/Mozambique’s Community Care Program (CCP), also known as Programa de Cuidados Comunitários (PCC) in Portuguese, is 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 Women and Social Action (MMAS in Portuguese), and the private sector, CCP will also strengthen the government’s capacity to coordinate, manage, and oversee an integrated continuum of care and support and will build the CSOs’ capacity to provide comprehensive, community-based care and support services. Within five years, CCP will 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.

The CCP Results (objectives) are:

- 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 the Ministry of Women and Social Action (MMAS), the Ministry of Health (MISAU), and civil society organizations (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 applies 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.

6. Summary of the reporting period, Q1 – Yr 5

CCP continued its normal implementation highlighted by a few remarkable successes, while awaiting substantive guidance on expected changes in mission approach, leading up to all prescribed Close Out year project activities. This reporting period was fraught with some uncertainty due to the delayed way forward for Yr 5, regarding the change from PEPFAR 2 to PEPFAR 3 and the ensuing cascade of delays - the annual workplan and budget approvals, and funding modifications being chief among them. Nonetheless, the most notable success was the final highest level Ministry of Health (MISAU) approval of the CCP-led referral tool known as the *Guia de Referência*, for national use in the clinical health structure. This tool serves as the mechanism for linkages between community and clinical and/or social services, underpinning the referrals network. A public launch is planned for the next reporting period.

Following a strong Yr 4 performance, CCP achieved well during this quarter. Yr 5 needs to be regarded differently than past project years, in that there are only three (3) implementation quarters so our quarterly achievement target hovers around 33% (rather than 25% in a four quarter-year.) CCP exceeded its targets for four indicators, specifically new HBC clients which has broadened to include a much greater focus on adherence support, Nutrition Services, Children's Clubs participation, and referrals to TB/Malaria/CCR services. The CCP 60% target for *busca activa* is really the target for each quarter, and CCP performs very strongly when defaulters on the list are actually found – 85% of those found were returned to treatment. VS&L groups continue to be an especially energized and successful CCP component. All implementation areas are discussed in detail in their respective Result section of the report.

CCP is currently on track towards its Yr 5 targets for the most part; however, late in this reporting period, the long anticipated funding guidance came, reducing the CCP budget by 39%, without its targets being cut commensurately. This understandably represents an enormous challenge for the project, especially

considering CCP aims to conduct its project Close Out leaving the best possible community relationships in place. CCP expects its revised annual workplan and budget to be approved in Q2 – Yr5, in time for the first tier of CSOs to conclude their implementation under the FHI 360 sub-contractors on the project, who need time for their level of project close out as well.

Extreme weather had effect on this report's content, since Niassa province was one of the hardest hit with heavy rains and flooding at the time of report compiling/writing in January. CCP's four implementing districts in Niassa are in the southern part of the province, supported by the Cuamba office. Cuamba itself was entirely cut off, all roads into and out of Cuamba were flooded and left the town virtually an island without electricity, internet, other vital services and of course at risk for food and medications shortages. Niassa province data and information will be found inconsistently throughout this report. Attempts continue to retrieve and verify data.

7. Project Performance Indicators for Q1 – Yr 5 (9 month performance period)

Indicator	Annual Target #	Q1 Results	% Achieved end Q1	Q2 Results	% Achieved end Q2	Q3 Results	% Achieved end Q3	Q4 Results	% Achieved in Q4
# of new HBC clients	10,783	3,867	36%						
# of cumulated HBC clients receiving care		21,001*							
# of New OVC served	79,127	15,583	20%						
# of cumulated OVC served		138,338*							
# pre/post-partum women referred to PMTCT	4,811	242	5%						
# receiving nutrition services	20,423	12,133	59%						
# participating in Kids' Clubs	5,446	2,111	39%						
# referrals to MCH (general) HIV (CT), Social Services, including GAVV	15,113	4,451	29%						
# referrals to MCH(general)		207							
# referrals to HIV(CT)		2,428							
Referrals to Social services		1,816							
# referrals to TB/Malaria and CCR	2,986	1,858	62%						
# referrals to TB		411							
# referrals to Malaria		1,130							
# referrals to CCR		317							
# of OVC 15-17 y.o. referred to family planning	681	167	25%						
% HIV defaulters on list returned to ART/clinic	60%		48% 85%**						
# of pregnant women	N/A	1,130						7	

referred with suspect of malnutrition									
# of children referred with suspect of malnutrition	N/A	411							
# of new VS&L groups established	N/A	101							
# of VS&L members by gender	70% of all members are female			71%					

*Signifies calculations per APR methodology: cumulative achievement against “New” targets. See Tables 5 and 7, respectively, for details.

CCP reports both the original indicator - % defaulters from clinic LTFU lists returned to ART and % defaulters from clinic LTFU lists **found and returned to ART, 48% and 85% respectively, demonstrating high achievement by the *activistas* when defaulters are actually found.

Regarding the Performance Indicators table above, New HBC clients are notable this quarter as CCP is implementing with a broader PLHIV focus. The CSOs are enrolling not only the treatment defaulters found by the *activistas* through *busca activa/consentida*, but many PLHIV who are not bedbound and who can benefit from regular adherence support home visits, ultimately contributing to retention rates. The HBC section in Result 1 carries more detail.

While New OVC were lower than the quarter target, the fact remains that a stunning 138,338 total OVC (cumulatively) are receiving care and support services through CCP local implementing partners. The Intensive and Maintenance phases of OVC care and support have been described in previous reports, and the OVC section in Result 1 carries more detail. The 2,111 new children in Children’s Clubs (also called Kids Clubs) exceeded the quarter target, across 78 new clubs established this quarter. See Table 13 later in this report.

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

During this reporting period, trainings focused on refreshers and one type of initial training, directly in relation to Close Out Year goals. A primary aim is that all *activistas* and other key stakeholders all receive a final input of updated technical refresher trainings across all of their implementation areas during this Close Out year. The underlying thinking is twofold; for these cadres to be best prepared for sustaining their activities to whatever extent their particular community has designated, and to have them well positioned for whatever implementation opportunities may arise.

Table 1: Q1 – Yr 5 Selected Trainings and Refresher Trainings by area, sex

Province	ToT Child Protection and Gender		Parenting Skills		Refresher on Referral tool (<i>Guia</i>)		CCPC initial training		M & E – refresher	
	M	F	M	F	M	F	M	F	M	F
Tete									3	5
Maputo					36	112	39	35		
Manica	18	8	7	14						
Inhambane					5	5				
Total Q1 – Yr 5	26		21		158		74		8	

Trainings look different each quarter, depending on needs and other strategic factors. This quarter, the **refresher training on using the referral tool** in Maputo Province included the coordinators, nurse/supervisors, *activistas*, and M&E staff from the CSOs, clinical staff including MCH and HIV focal point, Help Age¹ *activistas*, community leaders, SDSMAS, ROADS², Education Department and legal services representatives. Participants continue to see the advantage to community members of the linkages and stronger coordination across the continuum of care providers.

In Inhambane province, this refresher training was conducted specifically for the health professionals in Chicucue rural HU, and Maxixe and Inharrime Health Centers, rightly addressing the very frequent rotation of new staff into the facilities. These trainings were facilitated by the respective CSOs supervisors, demonstrating a solid transfer of training skills from the project team to the local implementers.

¹ Help Age is a separate implementing partner of ACIDECO, in Manhiça district only. There is good collaboration.

² ROADS is implementing in Moamba district only, as regards co-location in Maputo province.

Initial training of Community Child Protection (CCPC) members was held with four (4) CCPCs, two each in Moamba and Matutuine districts in Maputo province. CCP and SDSMAS district technical staff co-facilitated this training, a logical pairing since CCP is a key CCPC supporting partner of these GRM designed community platforms.

The training participants included not only the CCPC members, but also CSO supervisors and two (2) DPMAS representatives, reflecting both provincial level interest and partnership. During the trainings, 74 copies of the recently approved (by MMAS in 2014) “*Manual de Formação de Formadores de Membros dos CCPC*”³ were distributed to the trainees. The aim is to strengthen the CCPCs for taking a greater role on child protection in the communities they serve, each supervised by their local Social Action Technical Officer (in SDSMAS). MMAS appreciates the CCP assistance with this strengthening role in the project’s implementing areas. The district level people trained will then replicate the training with other existing CCPCs. This ToT and cascade training model is the CCP norm, for building local capacity and “ownership”. DPMAS Maputo expressed interest in carrying out joint follow up visits on CCPC activities in future.

The **ToT on Child Protection and Gender** in Manica province, was facilitated by CCP technical Officers. The ToT participants rightly drew from a broad spectrum, including relevant staff from DPMAS and DPS (provincial level); staff from Justice, Public Protector, and GAVV offices; SDSMAS (district level) technical staff, CSO supervisors and Africare Technical staff.

One DPMAS recommendation was that ToT participants should share ideas and experiences with each other which contribute to health and harmonious child development, especially on socio-economic development which so impacts any child’s life. Another was to use all available resources to respond to abuse against children and women, and to integrate gender aspects in community activities.

A special highlight of the ToT was two (2) members of the Manica province Child Parliament, voicing children related concerns:

- a) Lack of CCPCs in some districts
- b) Only a few institutions support the Child Parliament (which engages 9-14 y.o’s.)
- c) Some Churches have negative practices that are prejudicial to children

The DPMAS Provincial Director recommended the importance of both the district level Social Action Officers and the CSOs to work with the provincial Department of Religious Affairs.

In Manica province, the **Parenting Skills** roll out and trainings were delayed and limited due to the shipping vendor having lost that province’s shipment some months ago. CCP in Tete province loaned enough copies to CCP Manica in order to get the ball rolling, but the full provincial scale roll out will come to fruition in the next reporting period when a sufficient re-procurement will finally be completed. Trainings this quarter took place in Machaze and Mussorize districts, using the CCP-developed *Album Seriado*, include a “practicum” component, when those *activistas* trained are then observed delivering the Parenting Skills. As per CCP norms, SDSMAS technical staff are also trained, to support their leadership and mentoring of same.

Further in Manica, the relationship with SDSMAS has taken another, innovative direction. CCP *activistas* are now being trained to provide Counseling and Testing themselves. Selected *activistas* from the CCP Barue and Tambara CSO partners

³ Training Manual for CCPC members

received training in October, and from the Macossa CSO partner in November, totaling 28. The CCP family approach is an ideal platform for OVC HIV testing, greatly enhanced when combining with the established *activistas* themselves, who already have relationships with the enrolled families.

In Tete Province, an **M&E** refresher training was conducted for the CSO supervisors and program officers, as this is an area needing continuous reiteration. In this example, one theme was correctly filling in the nutrition data collection tool, and another was for those responsible for compiling reports to better harmonize the data regarding PPPW. While perhaps very small details, it is important to understand the reality of community level data reporting capacity in the context of the complexity of CCP implementation.

The following trainings were not provided by CCP Technical Officers but are of benefit to the project and its beneficiaries regardless.

The CCP partner Kaeria in Cabo Delgado province enjoys a particularly robust and prominent place in Pemba City, and at times has opportunities for trainings that no other CCP partner has. In this reporting period, two (2) *activistas* and one (1) supervisor attended a training on **sexual reproductive health**, facilitated by AMULEIDE⁴. The following example topics were discussed: exclusive breast feeding; girls' right to sexuality; myths regarding sexuality, and domestic violence.

Two (2) Kaeria staff also attended a DPMAS training on **stigma and discrimination**, especially as regards children and HIV. Attendees of both trainings will cascade what they learned to their other members.

In Niassa province a training on the **Essential Package** was conducted by MMAS to 28 (6 male and 22 female) participants, which included CCP technical officers, CSO supervisors, SDSMAS technical staff, justice providers, and GAVV from all the CCP districts of Mecanheles, Cuamba, Mandimba, and Metarica, and Lichinga City being the provincial capital. The Ministry of the Interior, CCP, and Save the Children staff also served as training co-facilitators. The training objective was to facilitate piloting the Essential Package for children 0 - 8 years old, and their caregivers. The relevance to CCP is the more detailed attention to Early Childhood Development, and also an emphasis on infancy. CSO supervisors, CCP field officers and *activistas* together will select the families for piloting the Essential Package for the trial period. The pilot results would be shared out at a national level meeting in the future.

Organizational Capacity Building

CCP Organizational Capacity Building activities carried out in this reporting period continued to be facilitated by ADEM, implementing in Inhambane, Cabo Delgado, Niassa and Tete Provinces. CAP implemented the activities in Maputo, Sofala and Manica provinces. In this quarter, 70 people (42 male and 28 female) benefitted from Capacity Building activities, provided by ADEM and CAP.

This quarter the results of CSO assessment in Yr 4 became available, and reflected 10 months of sequenced capacity building conducted, and inputs, by ADEM:

⁴ AMULEIDE is a Mozambican organization roughly translating to Women, the Law and Development, which devotes itself to improving women's knowledge especially.

1. Development of training manuals

Training manuals on Association Leadership, Governance, Internal Control Systems, Project Management and Fund Raising were developed and adapted for CSO usage.

2. Technical staff workshop

Eight (8) technical staff, (ADEM 5, and FHI360 3) held a workshop on scope of work, harmonization of work methodology, diagnostic and administrative procedures.

3. Diagnostic process (assessment)

The diagnostic was conducted in each CSO, with the board of directors. At least 10 people participated in this diagnostic. Four specific CSO abilities were discussed:

- 1) The ability to be – identity and values
- 2) The ability to manage – regarding capacity, competence, internal control, leaning and flexibility
- 3) The ability to do – regarding performance, efficiency, efficacy and innovation
- 4) The ability to establish relationship – regarding linkages and cooperation within and outside the CSO.

4. CSOs training and coaching

Training and coaching were conducted with CSOs' Boards of Directors and management, aiming to better implement defined strategies effectively to achieve the association objectives, focusing on governance and association management.

5. Post training evaluation

The CSO evaluation was conducted during coaching visits through telephone contacts, e-mails and also coordination meetings between FHI360 and the CSOs. It was notable that CSOs were "owning" the teaching given, and also in achieving their Action Plans in regard to the Statutes, Internal Regulations, Administrative and Financial Procedures Manual, and Strategic and Annual Plans. One way that CSO growth was assessed was by the way the CSO managers expressed and explained the concepts and the actions taken, and also through the documents developed and shared. This kind of evaluation exceeds the limits of simply ticking off boxes; the content of the replies exhibited good comprehension and applying of the lessons on these important structural matters.

6. Analysis of CSOs Evaluation

In general, the norms and procedures the CSOs have established do a good job of laying the foundation for longer term organizational capacity and health. Currently the CSOs have updated statutes and internal regulations. They also have the process for legal recognition at the national level (which exceeds the district or provincial level legal status that many hold), improved communication and accountability through reports and meetings of various management boards. These results indicate that the interventions carried out were productive and are producing good outcomes.

The "diagnostic" or assessment instruments of ADEM can be viewed in the report Annexes.

Table 2: Q1 – Yr 5 Organizational Capacity Building Trainings by ADEM and CAP

Nr of Trainings	Participants	Module	Province	Organization	Participants		
					M	F	Total
1	Coordinator (01), Secretary (01), FC Secretary (01)	Fiscal Council	Sofala	KUGARISSICA	2	1	3
1	Fiscal Council President (1)	Fiscal Council	Sofala	KUGARISSICA	1	0	1
1	Coordinator (03), Secretary (01),	Fiscal Council	Manica	Centro Aberto Barué, Shingirirai e Rubatano	4	0	4
1	Administrative (02),	Internal Control System	Maputo	CONFHIC	1	1	2
1	Coordinator (10) Supervisors (9), Fiscal Council President (7), Board of Directors President (8), Administrative (8) Members (15)	Final CSOs evaluation	Inhambane, Niassa, Cabo Delegado e Tete	All CSOs	32	25	57
1	Coordinator (01), Administrative (01) Supervisor (01)	HR Policies and Procedures	Maputo	CONFHIC	2	1	3
		TOTAL			42	28	70

Further visits to CSOs were carried out to cross check the ADEM results. One methodology used was to meet with members of their Boards of Directors, to verify their Action Plans. Most of those CSOs receiving cross check visits showed they were following the recommendations, that the normative processes are under way. One in Inhambane was not quite on the mark and needs more follow up.

CAP remains an important partner project, in both training and TA provision among CCP CSOs. Examples follow below for this reporting period:

- Reinforcement on basic management procedures on internal accounts, support on development of accountability modules, budget execution control, pay slips and inventory, with ACIDECO and CONFHIC in Maputo province.
- Follow-up on the implementations of Health Check, PAOP recommendations, including revision of the personnel files, and the Policies, Administrative and Financial procedures manual, with CONFHIC and Centro Aberto de Barué in Maputo and Manica provinces respectively.
- Conducted internal control system, inventory, procurement, internal accounts management, budget execution control and follow up on previous recommendations regarding personnel filing, with Rubatano and Shinguiriri in Manica province.
- Support for ACIDECO's general assembly, also supporting Centro Aberto de Barué planning for their general assembly in January 2015.

Support and Technical Assistance visits to CSOs

Technical Assistance (TA) including the M&E area remains a hallmark value added by CCP through both FHI 360 and subcontractor technical staff. Past reports have detailed the locations, recipients, focus areas, collaborating partners, and many details of TA and data verification provided. For this reporting period, **illustrative** rather than exhaustive examples are provided. Not all TA and/or data verification, and not all locations, will be given. Subcontractors ANEMO and ADEM figure in this activity, per their particular TORs and portfolios with CCP. Trip reports and Visit reports are on file.

Table 3: Q1 – Yr 5 Selected Technical Assistance (TA) and Joint Visits

Province	Team members	Conducted activities	Findings or Next Steps
Maputo	1.FHI360/CCP 2.ANEMO SDSMAS	1.Moamba: medication and stock control tools procedures reviewed. ARIEL focal point introduced to CSO supervisor; the rotating activista posted to HU TORs were reviewed. Manhiça: cross sector site visit to verify administrative/financial compliance re <i>activistas</i> and implementation. Data verification, coaching on data files, activista performance evaluation finalized 2.Supportive supervision visits all districts	Update CSO files related to <i>activistas</i> – contract, training history, HBC kits, etc. This compliance review process to be replicated across CCP CSOs/districts
Inhamitane	FHI360/CCP ADEM WR	Capacity building to WR team on quarterly report production. Early coaching on final report content. OCB follow ups on previous recommendations.	
Manica	FHI360/CCP SDSMAS Africare	Mossurize: reinforcing Parenting Skills training, with OVC TWG. Barue: M&E, data analysis and capture for reporting. Gondola, Manica: data and files verification Overall: reinforced data verification and close out planning	
Tete	FHI360/CCP	<i>Activistas'</i> files verification Database verification Financial procedures review and coaching	
Cabo Delgado	FHI360/CCP PSI	Supporting uptake of <i>Super Bebê</i> in malnutrition cases	
Sofala	1.FHI360/CCP 2.USAID 3.ANEMO SDSMAS DPS 4.Beneficiaries SDSMAS	1.Assets inventory updated. Chibabava: financial procedures verification. 2.Dondo, Nhamatanda: IMS data verification 3.Dondo, Nhamatanda, Machanga, Chibabava: supportive supervision visits. 4.Pulse-taking on satisfaction with CSOs	On-site mentoring on procedures. Generally happy with <i>activistas'</i> work, acknowledge CCP contribution. They can improve on CT communication, learn causes of CCR defaulters
Niassa	1.FHI360/CCP 2.ANEMO SDSMAS	1.Metarica: Yr5 planning 2.Supportive supervision visits all districts	

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 includes both referrals to clinical and social services, and directly provided services by the CSOs through trained and supervised *activistas*. While early in the LOP of CCP, a project focusing largely on referrals was challenging for stakeholders to understand and accept. Over these four (4) years of the project to date, understanding the value of the established or reinforced referral networks has replaced lack of knowledge about, and access to, clinical and social services.

The CCP **referral process** constitutes a key activity along the continuum of care in the project communities for those infected with and affected by HIV. This quarter, there were a total of **9,210** completed referrals to different health and social services. HIV services were the most frequent referrals at about (3,320). Combined referrals to other services were about (2,577), Maternal Child Health (MCH) referrals were about (1,497) and combined referrals to social services were about (1,816).

It is clear that the total completed referrals for this reporting period are down from last quarter. There were 13,481 in Q4 – Yr 4 and the 9,210 in Q1- Yr 5 is about 4,271 less. CCP understands this decrease to be the result of the following:

- a) The constant mobilizing and sensitizing efforts by the *activistas* to make use of available health and social services in their implementation areas are paying off in people going to the services they need on their own.
- b) A portion of the referrals made (892, see Table 4) were incomplete (did not have a counter-referral back to the CCP community services for follow up), due to constantly changing HU staff, yielding new people unfamiliar with using the referral tool. This reality underscores the need for frequent refresher trainings for HU staff on using the *Guia*.
- c) The early close out of five (5) CSOs/districts in this reporting period, logically results in lower referrals totals. More information on CSO closures is given in the Management Section later in this report.
- d) This reporting period included holiday Leaves by CSO staff and *activistas*; caseloads were attended to though, to prevent beneficiary needs going unmet.
- e) The nation-wide Presidential campaign and election also diverted attention away from normal activities, at many levels.

On the plus side:

- f) The strategy of allocating an *activista* to each referral HU is bearing measurable fruit. Referrals from the HU to the community based services reached 6,177 in this reporting period. This growing practice underscores the complementarity of community provided services to the clinical settings.
- g) As in past quarters since the introduction of the *Guia de Referência*, there are other institutions making referrals in the communities using this tool.

Table 4: Q1 – Yr 5 Total Completed Referrals by province, service referral area

Province	Referral received from HU (ALL)	Uncompleted Referral	MCH Services (1,497)						HIV Services (3,320)						Social Services (1,816)						Other Services (2,577)				
			Maternity for birth	MCH	Family planning consultation	Post birth consultation	Consultation for children at Risk	PMTCT	CT	STI	Pre TARV/IO	HIV+ Test	LTFU TARV	PPE	Community/CSO	Education	Social Action	GAVV/Police post	Psychology/Psychiatrist	IPAJ	Children, suspected malnutrition	Pregnant women , suspected malnutrition	Emergency	Suspected TB	Suspected Malaria
Cabo Delgado	193	193	46	37	53	46	87	47	32	34	28	0	2	0	23	29	31	3	9	1	18	10	28	26	54
Inhambane	991	149	23	41	96	13	16	33	405	34	32	40	79	0	6	7	12	6	5	0	12	0	80	43	215
Manica	1,040	86	50	52	23	95	25	36	285	42	58	47	75	4	12	105	25	3	90	9	24	0	141	117	261
Maputo	361	0	4	9	70	3	5	80	93	12	8	12	12	0	13	2	29	1	3	2	0	0	27	6	48
Niassa	550	270	7	8	44	12	30	20	118	15	6	9	25	1	255	1	189	4	4	0	14	0	25	51	87
Sofala	1,173	0	19	37	12	22	8	11	667	13	23	29	70	1	29	3	96	4	4	0	5	3	62	61	106
Tete	1,869	194	41	23	13	39	146	15	828	32	40	58	47	4	41	299	94	18	341	8	271	13	303	107	359
All totals	6,177	892	190	207	311	230	317	242	2,428	182	195	195	310	10	379	446	476	39	456	20	344	26	666	411	1,130

Of the 3,320 beneficiaries referred for HIV services, 2,428 were to Counseling and Testing. While it is unusual for CCP implementers to be privy to HIV test results, this quarter the project can say it is aware of 195 of those testing positive, made possible by the completed *Guías de Referência* coming back to the *activistas*. And, completely separate from *busca activa/consentida*, 310 LTFU patients were “found” during *activistas*’ normal activities and referred back to their clinic for ART reintegration. This demonstrates another way that CCP contributes to adherence/retention efforts. During this quarter, 344 children and 26 pregnant women suspected of malnutrition were referred for clinical diagnosis, and rehabilitation if clinically indicated. These referrals are a result of either the initial family intake assessment, or *activistas* noticing children in Kids Clubs, and all of these referrals are based on using the MUAC tape. In this particular service area, tracking results from quarter to quarter isn’t very helpful. Larger or smaller numbers do not reflect success or lack thereof, rather the needed work getting done. Identifying needs and getting people to the needed services **is** the success.

In Social Services, Tete province hugely stands out for referring 341 individuals for psychological/psychiatric services. This province is lucky to have qualified technical staff to provide more in-depth support when needed, over and above the psychosocial support provided directly by the *activistas*. Most provincial health systems do not have this type of staff or service. Of the children referred to access education, linking with UNICEF in one district yielded school materials for a few children. Notably, some of these children are getting back into school after having dropped out for family reasons. In Manica province this quarter, their notable result includes children past the normal school entry age and will now be able to “catch up” and attend school for the first time.

Within MCH services, CCR referrals merit some discussion, given the importance of this activity. Tete implementers were notable this quarter, for their CCR referrals. To achieve this, the CSOs/*activistas* worked with the MCH nurses and M2M groups, emphasizing educational messages on the advantages and importance of CCR. Cabo Delgado also performed very well in referring to CCR, made more possible than normal while *Kaeria activistas* were distributing *Super Bebe*⁵ to CCP households with appropriate aged infants. In Niassa province their 30 CCR referrals came through another strategy. These were identified through collaborating HUs providing lists of mothers on PMTCT consultation who did not return. This process is another example of the benefit of CCP’s strategy of posting an *activista* to the HU, to emphasize the linkage to the community services, and facilitate such sharing of information for *activista* follow up.

Continued efforts to strengthen the linkage relationship with the ARIEL supported clinics in Maputo and Cabo Delgado CCP implementation areas has borne fruit this quarter on Family Planning referrals. ARIEL carries out some community mobilization

⁵ A nutritional product piloted by PSI and in process now with MISAU for national utilization and distribution through the health facilities.

activities, then CCP *activistas* are continuously there for follow up and making the referrals to the actual service.

Referral Network

Underpinning the referrals of CCP PLHIV, OVC, and PPPW to needed clinical and social services, is the CCP-developed referral tool called the *Guia de Referência*. After long months of collegial development and revising and with MISAU, MMAS, other FHI 360 projects, and other sector stakeholders, as well as preliminary utilization across CCP implementing districts, the *Guia* finally received the highest level formal approval necessary from MISAU, during this quarter.

[At time of reporting, CCP had undertaken a procurement of the final approved version of the *Guia* for its community partners' use, as well as has CHASS SMT to provide to its clinical partners. Enough fresh copies of the *Guia* were provided to MISAU for their distribution to all their DPSs in all the provinces, with a guidance letter on its approval and usage. While at first a public launch of the *Guia* was not supported, it later became desirable and CCP expects to lead the Launch event in the next quarter, with the partner ministries, USAID, and relevant sector partners and other FHI projects.]

CCP also distributed remaining stock of *Guias* to all CSOs (*activistas*, nurse/supervisors) during this reporting period through its provincial lead partners, as well as to their referral partners such as GAVV, HUs, INAS, etc. It also bears noting that all *Guia* users receive training on its use, especially noting the service provided and signing off on it, indicating a complete referral; as well as for social or clinical services to initiate referrals to the community based services providers (CCP in this case). Refresher trainings are not heavy time sinks and thus it is not too problematic to provide repeat refreshers especially among clinical staff who are rotated onward so frequently.



Dr Bocuane in MISAU (Department of HIV) with approved *Guia* for distribution to DPSs throughout Mozambique.

In addition to PATH procuring and using the *Guia* where it implements, another manifestation of the uptake of the *Guia* was the CCP Technical Officer serving as guest trainer with another NGO called REENCONTRO, implementing in Gaza province. CCP was invited to provide trainings on the *Guia* during this reporting period, (and on the Parenting Skills educational materials, see Section 5.2).



CCP Technical Officer training on the *Guia de Referência*, Gaza province.

Home Based Case

Since HBC – a CCP **direct service** – has benefited from broadening its PLHIV target group, more and more HBC recipients are patients on ARVs even when not bedridden, particularly those that have negative treatment behavior. Regular defaulters, those not collecting their medications, those with alcoholism, bad nutritional habits or multiple partners, fall into this group. The *activistas* identify and enroll these patients, and even re-enroll those who have been discharged from CCP earlier who *activistas* continue providing follow up for. Those PLHIV found during *busca activa* are also enrolled in CCP and counted in HBC, in the table below. CCP is on track for the Close Out year, at 36% of Yr 5 HBC target this quarter.

Table 5: Q1 – Yr 5 New and Cumulative HBC clients by province and sex

Province	HBC Annual Target Yr 5	Newly Enrolled in Q1 - Yr 5	Cumulative HBC Q1 - Yr 5 Disaggregated by sex			Alive & In Care
			Male	Female	Total	
Cabo Delgado	76	101	322	532	854	795
Inhambane	1,445	711	1,126	2,552	3,678	3,288
Manica	2,890	438	474	919	1,393	912
Maputo	806	390	976	2,339	3,315	3,115
Niassa	1,232	503	931	2,132	3,063	2,654
Sofala	2,601	974	906	2,037	2,943	1,983
Tete	1,734	750	2,005	3,750	5,755	5,122

TOTAL	10,783	3,867	6,740	14,261	21,001	17,869
--------------	---------------	--------------	--------------	---------------	---------------	---------------

During this reporting period 3,867 new HBC patients entered the program, as already mentioned including both bedridden and not bedridden PLHIV. Sofala province results this quarter reflect many people returning to their normal locality after political-military conflicts ceased, especially Chibabava, Maringue and Gorongosa districts. Tete and Inhambane implementers have also been strongly mobilizing and integrating PLHIV emphasizing ARV adherence, the Inhambane implementers' partnership with CCS-supported clinics is going well.

Regarding the cumulative Alive and In Care data, it is useful to remember the number of districts reflected in each province for better understanding of proportions. That is: 1, 5, 9, 5, 4, 10, and 8 respectively per the table above.

Table 6: Q1 – Yr 5 HBC disaggregated by sex and age

PROVINCE	Sex		Age		Patient Status (CCC)			
	Male	Female	0-14	15+	Alive & In Care	Lost to Follow-Up	Dead	Discharged
Cabo Delgado	32	69	11	90	101	3	2	54
Inhambane	217	494	61	650	711	7	23	360
Manica	142	296	24	414	438	21	35	425
Maputo	120	270	16	374	390	10	33	157
Niassa	146	357	45	458	503	2	27	380
Sofala	293	681	112	862	974	12	38	910
Tete	269	481	54	696	750	22	34	577
TOTAL	1,219	2,648	323	3,544	3,867	77	192	2,863

Table 6 above addresses New HBC clients in this reporting period, Alive and In Care corresponding to New HBC in Table 5. Of these, 323 are under 14 years of age and on pediatric ARVs. Sadly 192 patients died during this quarter, often due to delayed identification and consequently late treatment uptake, or frequent defaulters who may have run out of treatment regimen options. Living positively and being on treatment in one's own community can still be tricky for some people. In still other situations, some deaths in three districts in Sofala province were due to a diarrhea outbreak.

Orphans and Vulnerable Children

While New OVC enrollment this quarter did not meet the target level⁶ (20% instead of 33%), *activistas* continue to identify and enroll new OVC often in collaboration with various community leaders, while continuing to provide care and support to those already enrolled. Table 7 shows both new OVC and the cumulative OVC in care. As a

⁶ While Year 5 targets were assigned to CCP with the shortened Close Out year timeframe of 9 months in mind, the further reduction of CSOs/districts due to administrative closures was not accounted for but does contribute to lower new enrollment.

result of the *activistas'* dedication and community stakeholder involvement, a massive cumulative 138,338 OVC received various services across the project.

Table 7: Q1 – Yr 5 New and Cumulative OVC by province and sex

Province	OVC Target for Yr 5	Newly Enrolled OVC in Q1 Yr 5	Newly Enrolled OVC in Q1 Y5, by sex			Cumulative OVC in care, Disaggregated by sex		
			M	F	Total	Male	Female	Total
Cabo Delgado	558	521	231	290	521	1,287	1,497	2,784
Inhambane	10,602	2,307	1,053	1,254	2,307	7,590	8,636	16,226
Manica	21,205	2,154	1,059	1,095	2,154	11,949	12,022	23,971
Maputo	5,915	1,382	699	683	1,382	6,386	6,695	13,081
Niassa	9,040	2,352	1,179	1,173	2,352	7,589	7,820	15,409
Sofala	19,084	3,309	1,720	1,589	3,309	16,784	16,831	33,615
Tete	12,723	3,558	1,818	1,740	3,558	16,513	16,739	33,252
TOTAL	79,127	15,583	7,759	7,824	15,583	68,098	70,240	138,338

CCP is a dynamic, living activity, wherein effective strategies get enhanced and other strategies get formulated to replace approaches that do not work so well. More and more, involvement of community leaders, local NGOs, DPMAS, civil society organizations and community members, all contribute to OVC enrollment in CCP. This seems to show that community safety nets and structures continue to grow in responsibility toward vulnerable members of their communities. That said, during this quarter, community leader involvement was weaker than usual since the majority of them, and other sectors, were involved in time and attention consuming campaign activities.

The per province performance in each service area in Table 8 below also needs to be considered as a dynamic process. Various situations and strengths combine in each reporting period to yield CCP results. A total of 8,414 children received food services, meaning referral to clinical rehabilitation if MUAC suggests referral, nutrition education, cooking and gardening demonstrations. A total of 7,504 children received education services, which included getting children into school or aligned for the next school year from February to November, or receiving school materials, or those supported in final exams preparation. 7,287 children were referred for various health services.

The highlight of the quarter is reporting that at least 20,576 OVC received economic services, the vast majority of these children (19,768) benefitting from a parent or caregiver/guardian actively participating in a CCP sponsored VS&L group (Table 17). However, by including this reality, the normal logic of Table 8 appears to break down, since the number of OVC benefitting from CCP economic service delivery exceeds the number of New OVC for this reporting period. Admittedly, this table mixes New quarterly data with a Cumulative outcome; CCP will work with USAID to find a sensible reporting solution. More details can be found in the Result 3 section later in this report.

CCP was invited to present at the OVC Task Force Meeting in Washington, DC, during this quarter. The COP was on a plenary session panel, addressing OVC Programming

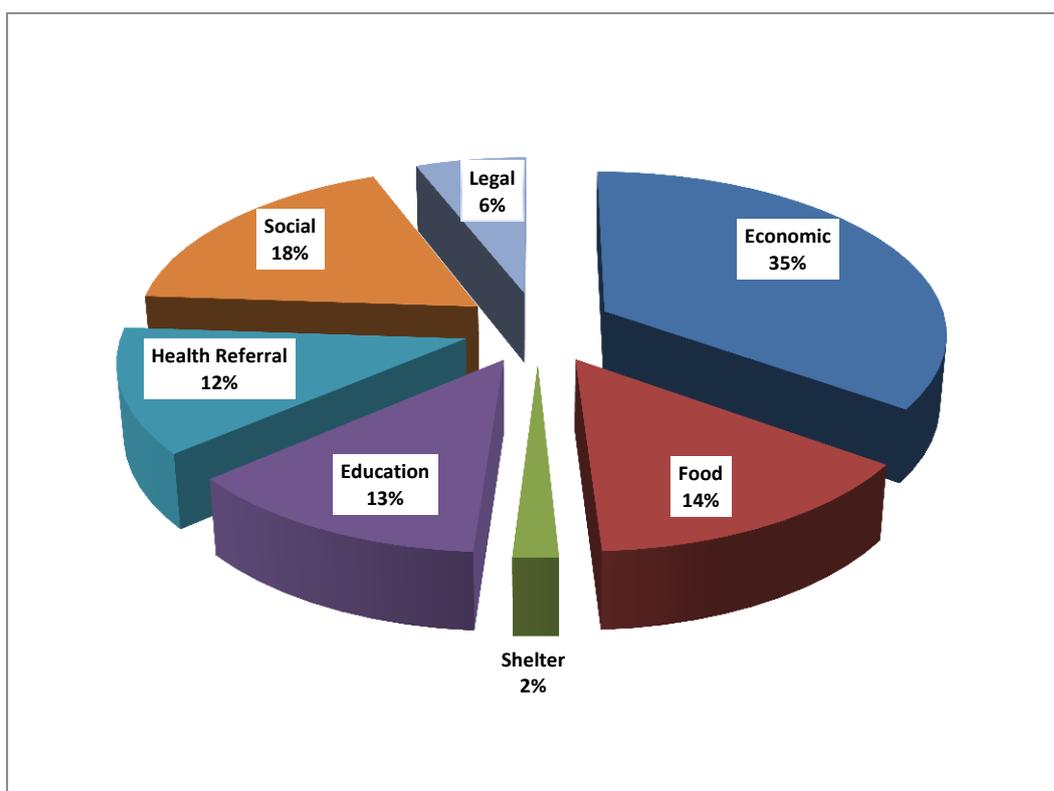
Field Realities. While components of CCP by themselves are somewhat normal OVC approaches, the strength of CCP's integrated program model, especially including the HES component, was a standout feature. As well, the referral tool – *Guia de Referência* – drew lots of attention.

Table 8: Q1 – Yr 5 Services provided to OVC disaggregated by Service and sex

Province	Yr 5 target	Male	Female	Economic	Food	Shelter	Education	Health Referral	Social	Legal
Cabo Delgado	558	231	290	350	277	98	339	404	373	115
Inhambane	10,602	1,053	1,254	1,844	2,307	101	1,087	748	2,042	124
Manica	21,205	1,059	1,095	3,900	839	110	1,245	772	1,491	356
Maputo	5,915	699	683	2,724	921	276	771	699	827	493
Niassa	9,040	1,179	1,173	1,065	1,153	171	1,175	910	1,420	273
Sofala	19,084	1,720	1,589	10,589	1,099	168	1,137	1,326	1,839	442
Tete	12,723	1,818	1,740	104	1,818	173	1,750	2,428	2,597	1,712
TOTAL	79,127	7,759	7,824	20,576*	8,414	1,097	7,504	7,287	10,589	3,515

- 19,768 resulting from OVC benefitting from caregivers being members of VS&Ls. The other 808 reflect other community or social services sources of economic support.

Graph 1: Services provided to OVC by proportion (Oct - December 2014)



Adherence Support

Busca activa or *consentida*, continues to be a key activity to contribute to adherence support and retention. There are still challenges regarding false names and addresses of patients, false defaulters and unreported deaths. However, across the program

1,106 patients were found and referred back to HUs to be reintegrated on ARV. This represents 85% of patients who were found by *activistas* that were fully returned to clinical treatment programs.

Table 9: Q1 – Yr 5 Busca Activa/Consentida by province and sex

Province	List to CBO			Recovered			Recovered and Reintegrated in HU			% of Recovered and reintegrated to HU against lists	% of Recovered and reintegrated to HU against recovered
	M	F	TOTAL	M	F	TOTAL	M	F	TOTAL		
Cabo Delgado	39	50	89	15	14	29	15	14	29	33%	100%
Inhambane	82	167	249	51	106	157	51	95	146	59%	93%
Manica	264	376	640	119	197	316	95	169	264	41%	84%
Maputo	63	105	168	32	42	74	18	33	51	30%	69%
Niassa	79	172	251	52	112	164	42	85	127	51%	77%
Sofala	231	393	624	115	221	336	113	200	313	50%	93%
Tete	106	185	291	76	144	220	69	107	176	60%	80%
TOTAL	864	1,448	2,312	460	836	1,296	403	703	1,106	48%	85%

According to Table 9 above, the CCP Cabo Delgado implementing partner performed very well with the re-integration of all defaulters found - 29 (100%), back onto treatment regimens. Coordination meetings between the CSO and clinical partners in Cabo Delgado resulted in a new *Busca Card* in Cabo Delgado. A *Busca Card* has more details that can facilitate the location of patients and was produced by the MoH. While this innovation seems to have great potential, it is only a local pilot. A copy of this Card is in the Annexes for details. Hopefully it will be taken up and scaled up, if warranted.

Inhambane and Sofala provinces also had good results (93%) having reintegrated 146 (51 male and 95 female) and 313 (113 male and 200 female) of the treatment defaulters they found, respectively. In Tete province, with its reintegrated against found defaulters was 80%, five (5) CSOs/districts, like Cabo Delgado, reintegrated 100% of found defaulters back into treatment. Adherence and voluntary testing mobilization activities seem to be resulting in reduced cases of defaulters, but only the clinics can verify that type of data. As well, the clinic task of developing the defaulters lists remains a significant challenge.

Pre- and Post-partum Women

CCP achieved 29% of its quarterly target of referrals of pre- and post-partum women (PPPW) to MCH services (broadly) which includes referrals to HIV Counseling and Testing. A total 4,451 women, characterized by not knowing their HIV status were referred to MCH, which houses PMTCT services. When such a woman knows she is HIV+, she can be referred directly to PMTCT, as were 242 during this quarter.

During *activista* home visits to HIV+ PPPW, the PPPW receive adherence support, counseling and referral to support groups, particularly to the M2M and VS&L groups,

and nutrition services, including the promotion of exclusive breast feeding. Sensitizing males to accompany their partners and children to health services continues to be an encouraging practice across the project. When men do accompany them, their access to HIV testing is right there, which could also facilitate disclosure between the partners. When fathers get accustomed to accompanying their children to health services, this could help to balance those responsibilities in a family so that it is not the mother who carries the majority of that activity. The more the male of the family is involved, either for the *activista* home visits or accessing health services, the greater the contribution to adherence overall.

Support groups

As in previous quarters, Tete province continues to perform well in creating support groups, perhaps a combination of need and available support. A total of 15 M2M groups were created this quarter, The strategy used in Tete and Cabo Delgado provinces is a result from the strong collaboration with the HUs. As soon as PPPW are identified in the clinic, they are sensitized to join M2M groups close to where they live. In addition, the presence of *activistas* posted in the HUs who work with the MCH nurses there and in M2M group meetings, facilitates the process of forming and operating the groups. The M2M groups provide a platform for sharing experiences on positive living, receiving information on treatment adherence; discussing issues related to child protection, gender equality, family planning, correct use of condoms, exclusive breast feeding and water purification, and receive cooking demonstrations. CCP *activistas* play a major partnership role in the M2M groups, providing talks, leading meetings, doing the cooking demonstrations - providing significant support to the MCH nurses who would otherwise bear the entire responsibility themselves.

Inhambane, Manica and Sofala provinces implementing partners gave their efforts this reporting period to consolidating the M2M groups previously formed.

CCP *activistas* also play a strong role in supporting PLHIV groups who meet monthly in the community, some of whom are also members of GAAC groups (small groups of PLHIV whose members take turns making the trips for medications refills). During the PLHIV group meetings, topics related to ARV adherence are reinforced, also consistent and correct use of condoms, family planning, and savings groups opportunities. They also share experience on positive living and provide support in finding treatment defaulters.

Table 10: Q1 – Yr 5 Committees and Groups Created, disaggregated by type, sex

Province	Total active groups												New (additional) groups in Q1 – Yr 5								
	CLC			CCPC			M2M			PLHIV			CCPC			M2M		PLHIV			
	Nº	M	F	Nº	M	F	Nº	M	F	Nº	M	F	Nº	M	F	Nº	F	Nº	M	F	
Maputo				4	24	8	11		160							2	31				
Sofala	17	42	50	29	255	258	41		471	39	173	457	1	7	11	1	7	7	24	43	
Manica	6	40	19																		
Tete	7	71	76	25	193	220	62		686	75	228	240	2	28	23	10	134	18	50	58	
Cabo Delegado				1	6	4	5		9							2	43				
Niassa													*								
Total	30	153	145	59	478	490	119	0	1,326	114	401	697	3	35	34	15	215	25	74	101	

*3 additional CCPCs were created in Niassa this quarter, in Cuamba, but member sex disaggregation not available due to flooding preventing communication

Legend Table 10: CLC=Community Leaders Committee (or Council)
 CCPC=Community Child Protection Committee
 M2M=Mother to Mother Group
 PLHIV=People Living with HIV or AIDS Group

Notable in Table 10, three (3) new CCPCs were formed, 2 more in Tete and 1 more in Sofala. The CCPCs are formed in coordination with the SDSMAS with the aim of supporting the community children as needed; they identify children in need, refer them to various services using the *Guia de Referência*, and also sensitize the communities against child abuse. A community follows several steps in creating a CCPC. Community leaders first broadly sensitize on children’s rights and the role of the CCPC. A meeting would then take place to propose creating the CCPC and select potential members to represent the community diversity. These could include respected leaders, any traditional chiefs, pastors, ward leaders, traditional healers, women, older children, elderly people, school leaders or school committee members, any local vendors, people with disabilities. At such time, the CCPC TORs are disseminated. When members are elected, then working groups are formed and the CCPC develops an Action Plan. CCP assists then with capacity building the CCPC on organizational aspects, deepening information on children’s rights and protection, and how to carry out the TORs.

The Parenting Skills messages were delivered in all the above new groups created this quarter, as well as those already established, represented in the “Others” category in Table 14 later in the report.

Nutrition

The nutrition component in CCP is a cross cutting service area that benefits all target groups, with greater focus on 0-5 year old children, pregnant women, PLHIV and bedridden patients. This quarter’s achievement is nearly 4,000 more than last quarter, and continues to include nutrition education, cooking and/or gardening demonstrations, and MUAC assessment for referral to clinical malnutrition interventions if indicated. 17,997 beneficiaries received these services.

As mentioned above, PPPW receive nutrition services both in their houses and in M2M groups, and OVC receive nutrition services in their houses (with assessment and clinical referral if needed, and age appropriate nutrition education), or in the Kids Clubs, which includes the same services. The CSOs avoid double counting by comparing the lists of PPPW receiving nutrition services in their houses, with lists of those receiving in the M2M groups and only report a name once. To clarify, the *activistas*, in their ongoing interactions with the Kids Clubs, do carry out MUAC assessments there if any children need such attention. Meals prepared during the cooking demonstration sessions are shared with the children. PHFS activities can be found in Section 5.2 of this report.

Table 11: Q1 – Yr 5 Nutrition services disaggregated by age (OVC) and PPPW

Province	Age			TOTAL OVC	PPPW
	0-14	15-17	18+		
Cabo Delgado	99	114	280	493	131
Inhambane	1,972	338	711	3,021	213

Manica	1,239	493	800	2,532	1,816
Maputo	574	234	517	1,325	265
Niassa	614	277	398	1,289	1,055
Sofala	1,123	329	879	2,331	2,054
Tete	176	155	811	1,142	330
TOTAL	5,797	1,940	4,396	12,133	5,864

Inhambane, Manica, and Sofala provinces, in that order, provided the most nutrition services to OVC this quarter, noting that children benefit indirectly through their parent or caregiver/guardian practicing what they learn on their children. Sofala, Manica, and Niassa provinces, in that order, provided the most nutrition services to PPPW this quarter. Messages on using local produce to diversify household diets across three meals each day formed a consistent theme.

Kits in CCP: HBC kits, Family Kits, PSI Family Health Kits

As can be seen in the table below, quantities of HBC replenishment kits have decreased from previous quantities, except in Sofala. Three factors are at work in procuring the HBC kits; refills have been undertaken consistently on a 6 month basis, not all provinces are on the same 6 month cycle, and in most areas the need for their contents is decreasing corresponding to decreased numbers of bedbound PLHIV. Earlier in the life of CCP, each activist was provided her or his own kit, whose contents were to be used to fulfill the care plans drawn up for each PLHIV, and with nurse/supervisor concurrence. Each nurse/supervisor was provided with a higher level kit to better fit a nurse's qualifications and treatment paradigms. Now, the nurse/supervisor retains the nurse kit contents, as well as the activists refill kit contents, and dispenses things as needed per the fewer patient needs. Why Sofala is still showing higher numbers of HBC kits, as mentioned earlier, people were returning to their home communities after the quieting down of the violence that was in their areas. More need is still being exhibited there. However, CCP expects Sofala to "normalize" with the rest of the CCP provinces in the near future.

The 60 Family kits are very different from the HBC kits, and include such things as a plastic bucket and cups, mats, and sometimes other basic needs. The CSOs distribute them to the very most needy enrolled families. Amongst the kits beneficiaries were 4 OVC heads of household; 3 elderly and 10 blind people.

Table 12: Q1 – Yr 5 Distribution of Various Kits (Family Kits, HBC kits)

Province	Family Kit	HBC Kit	
		Activista	Supervisor
Tete	60	50	4
Maputo	-	67	4
Sofala	-	161	7
Cabo Delgado	-	10	1
Total		288	16

Inhambane province CCP implementers identified HBC kits replacement needs in coordination with their SDSMASs. Sharing this task is part of the World Relief sustainability strategy re the continuing community clinical partnership.

In this reporting period, no PSI family health kits were distributed, neither the physical kits which PSI distributed to the CSOs who then distributed to CCP beneficiary households through the *activistas*, nor, through the voucher system that was piloted in Maputo province last quarter. With that valuable input no longer available, households will either opt to spend money on the products they became accustomed to using – the *Certeza* water purifier, soap - or fall back on other methodologies being shared out. Such as cleaning hands with ash, boiling one's drinking water, and obtaining condoms from local clinics. Hygiene and safe water remain high impact family inputs, especially going into the rainy season.

From the CCP perspective, the voucher system seems to solve a number of logistical and cost issues – transport, warehousing, and distribution are good examples. Other challenges arose with the voucher system though, which PSI could overcome with time and improvement to this country's infrastructure. In any district there are a number of players in the voucher system: PSI, the CCP CSO, the shops who serve as the voucher system (called *Troca Aki*) agents, the mobile money networks M-kesh and M-Pesa, CCP team, stockists, and others. For Troca Aki to totally replace the physical distribution of the physical kits/contents themselves, all the players would need to combine to form an equivalent system. As it was, many CCP beneficiaries live too far from where the shops are located to be able to cash in the vouchers they received on their cell phones, some shops carry too little stock to make stock deliveries viable, the mobile money systems were sometimes behind, and inconsistent communications between CCP, PSI, and the CSOs all contributed to the challenges. But much was learned for future attempts.⁷

⁷ Thanks to PSI for sharing their September 2014 report.

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 Women and Social Action (MMAS), the Ministry of Health (MISAU), and civil society organizations (CSOs).

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

While all CCP OVC care and support activities reflect MMAS minimum standards, the Kids Clubs (Children's Clubs more formally) activity across CCP implementing districts really stands out. CCP support is two-fold: CCP CSOs in all the active districts help support SDSMASs with either the creation of new Kids Clubs or the rejuvenation of ones who had gone dormant, with *activistas* leading activities for OVC ages 6-15 years old. The children participate in age appropriate recreation activities such as soccer, singing and dancing, poetry and hand making toys with local materials. Children 15 and older participate in human development, where different topics are discussed, such as: children's rights, child sexual violence and abuse, sanitation, oral hygiene, prevention of diarrhea, malaria, etc. The disease prevention topics were highly discussed leading up to and during this rainy season, in order to help children adopt healthy behaviors.

Some Kids Clubs have developed their singing and dancing to a level where they perform in cultural events, invited by district authorities, due to their relevance in the community.

Table 13 below indicates Kids Clubs created this quarter, where the above described activities that take place in all Kids Clubs, commence upon start up.

Table 13: Q1 – Yr 5 Kids Clubs created, per province disaggregated by sex

Province	# of New Clubs Established in Q1 – Yr 5	Children disaggregated by sex		Total children participating in Kids Clubs in Q1 – Yr 5
		M	F	
Cabo Delgado	1	10	18	28
Manica	3	23	31	54
Inhambane	3	40	70	110
Maputo	27	380	459	839
Niassa	4	65	57	122
Sofala	12	108	96	204
Tete	32	397	479	876
Total	82	1,023	1,210	2,233

This quarter a total of 2,233 children (1,023 male and 1,210 female) are participating in 82 new Kids Clubs created during this reporting period. The average size is around 27-28 children per club. Maputo province with its five (5) implementing districts really shined this quarter, with 27 new clubs. This surge was likely due to recent TA by the

OVC Officer who a) intensified the messages to integrate all the children in Kids Clubs; b) raised awareness of the *activistas* on the importance of identifying and using locally available resources for the Kids Clubs activities as well as for their development/learning; and c) also emphasizing sustainability of the clubs.

Tete province created 32 new Kids Clubs, where 874 (395 male and 479 female) children participate. One contributing factor for this is that some CSOs have their own space/place to carry out the activities, and other CSOs have started to install playground equipment such as swings, slides etc. made from local materials.

Manica province created only 3 Kids Clubs this quarter, with 54 (23 male and 31 female) children participating, compared to having created 47 clubs last quarter. Seasonal and locational variations usually provide understanding; in this case children were preparing for exams, others were visiting their families in other communities, and still others went with their families to their farms.

Parenting Skills

While the Parenting Skills “trainings” are delivered to the adults in OVC’s lives, certainly over time the OVC themselves will be receiving the benefits of the parent or caregiver/guardian becoming better equipped to care for and raise the OVC in their care. As originally conceived, the *activistas* would be trained on using the *Album Seriado* (flipchart type educational material), then capitalize on the massive number of VS&L groups as a very logical platform for such training, given that adults/parents comprise the vast majority of VS&L group members. The Parenting Skills training opportunities have expanded to also include Kids’ Clubs, family households, and *Co-Gestão* Committee meetings, noting that child protection is a strong theme being presented. Some implementers are experimenting with other community gathering points. In Sofala province, *activistas* are also availing of community water sources, grinding mills, churches and market places. According to participants and SDSMAS, this Parenting Skills methodology is very welcome; the topics create opportunity for exchanging experiences and facilitate capturing information through using illustrative images and day-to-day examples. Plus the messages can be delivered in brief (and frequent) amounts of time and do not interfere with daily activities.

While CCP has not done so with this quarter’s Parenting Skills results data, we propose to find a way to integrate the total participants somehow into the OVC Social services area. The challenge will center on the delivery methodology which is by theme, so over a reporting period, one participant could receive multiple themes/sessions. As mentioned earlier, the other challenge will be how to report the New OVC services recipients with a Cumulative service recipient base, as with the Economic services reporting. Regardless of receiving multiple sessions, it is clear that females outnumber males.

Table 14: Q1 – Yr 5 Parenting Skills sessions delivered, by type of recipient and theme

Theme	Kids Clubs				VS&L groups				Households				Co-gestão Committees				Others				Total Overall			
	Nr of sessions	Participants			Nr of sessions	Participants			Nr of sessions	Participants			Nr of sessions	Participants			Nr of sessions	Participants			Nr of sessions	M	F	Total
		M	F	Total		M	F	Total		M	F	Total		M	F	Total		M	F	Total				
Let's talk about childrens rights	306	1,400	1,611	3,011	285	845	1131	1,976	365	771	1186	1,957	70	231	292	523	156	440	597	1037	1182	3,687	4,817	8,504
How to help children with problems	119	341	485	826	123	352	647	999	150	329	458	787	71	96	153	249	111	187	336	523	574	1,305	2,079	3,384
Let's protect our children	152	292	512	804	118	304	634	938	208	457	608	1,065	104	100	182	282	82	280	514	794	664	1,433	2,450	3,883
Take care of yourself to manage emotions	95	279	362	641	86	156	296	452	171	357	502	859	54	39	97	136	92	88	107	195	498	919	1,364	2,283
Let's eat food that helps us grow	177	587	758	1,345	115	278	510	788	222	521	741	1,262	62	96	105	201	103	273	301	574	679	1,755	2,415	4,170
Good hygien habits	172	687	974	1,661	67	221	503	724	168	495	838	1,333	61	80	125	205	278	265	587	852	746	1,748	3,027	4,775
Our attitude towards HIV and TB	133	546	589	1,135	121	280	516	796	211	309	686	995	48	124	142	266	33	156	268	424	546	1,415	2,201	3,616
Let's solve our problems at work	93	182	223	405	91	148	211	359	171	173	536	709	35	42	8	50	71	109	128	237	461	654	1,106	1,760
Total	1,247	4,314	5,514	9,828	1,006	2,584	4,448	7,032	1,666	3,412	5,555	8,967	505	808	1,104	1,912	926	1,798	2,838	4,636	5,350	12,916	19,459	32,375

Where analysis can be applied is comparing results across reporting periods. To correct the imbalance of giving less attention to some themes than others, CCP Technical Officers and CSO supervisors sensitized the *activistas* and VS&L Community Facilitators (who do also present Parenting Skills but only in the VS&Ls) to look at the themes with the same level of importance. So for example, the theme “*Take care of yourself to manage your emotions*” was given 311 sessions this quarter, compared to only 77 sessions last quarter.



A Parenting Skills session in a VS&L group in Tete province, using the *Album Seriado* (Parenting Skills flipchart); with CCP Tete staff and Africare representatives, there on an exchange visit.

Another useful comparison is number of sessions held per type of platform; VS&L group sessions, over which CCP has considerable influence, more than doubled this quarter compared to last, from 365 to 759 sessions. However, sessions given in *Co-Gestão* Committee meetings (137 sessions) were fewer this quarter. CCP is grateful for any and all opportunities given in that milieu, since these meetings are only held monthly or semi-monthly, with a HU predetermined agenda.

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

Forming partnerships and linkages throughout the life of CCP has been essential in accomplishing project goals and objectives. **HIV Counseling and Testing** is hugely important for OVC, and the CCP family approach to OVC care and support provides a logical platform to achieve that. In this reporting period, CCP continues to make progress.

In Tete province, 1,045 children aged 0-17 years of age were voluntarily tested, 62% of them in the HUs, and 38% of them tested in their households, thanks to CHASS SMT community mobile testing brigades. Only slightly more children tested were girls than boys.

The CHASS SMT VMMC intervention is picking up steam as it gets going. In Tete City, 182 children in CCP family households were referred and circumcised in the context of this partnership.

DPMAS Tete convened meeting with all partners working on OVC in Tete province, with a focus on coordinating all the actions that can lead to observation of children's rights.

In Cabo Delgado, 61 (16 male and 45 female) children aged 0-2 years and 116 children between 3-17 years (32 male and 84 female) were identified and HIV tested through partnering with the *Nucleo Provincia de Combate ao Sida* (NPCS)⁸. Additionally, 87 children were referred to CCR. Using the MUAC, 18 OVC were referred to HU with suspected malnutrition.

Partnership with ARIEL, who supports clinical partners in Cabo Delgado province, is strengthening. A meeting this quarter resulted in two agreements:

- Every 15 days the ARIEL staff will hold meetings with *activistas*, to provide psychosocial support and discuss other clinical topics, such as the new ARV therapy. The CSO supervisor will also be provided psychosocial support. (This is a welcome step, since the supervisor and *activistas* also deserve "care for the caregivers")
- The CSO will be responsible for handing in the HBC Lost-to-Follow Up list report to ARIEL, which is additional to collaborating with them on *busca activa*.

In Manica province, the partnership with SDSMAS continues bi-directionally, the focal points receiving trainings and engaging in joint supervision, and now has taken a new direction, detailed in Result 1. CCP *activistas* are now being trained to provide Counseling and Testing themselves.

In Inhambane province, the partnership with CCS (who supports the clinical partners there) resulted in identification and integration of 23 (9 male and 14 female) children into pediatric ARV, through the *activistas* and CCS volunteers working together.

World AIDS Day (December 1st) was aligned with OVC this year with the theme "*Protecting the girl from HIV is a National Imperative and a Responsibility of Mozambican Citizens*". CCP implementing partners helped mobilize for and participated in various commemorative activities across the project. Some examples follow:

- Niassa province: walks in the districts to disseminate messages on HIV prevention; radio debates to reflect on HIV impact, the need to eradicate stigma and discrimination against PLHIV as well as OVC.
- Tete province: drama presentations; speeches or talks about HIV symptoms and treatment, premature marriage, and counseling for ARV adherence and retention, in coordination with SDSMAS and NPCS. In addition, a solidarity Christmas snack was provided for Kids Clubs in Chiuta district, followed by singing and dancing.
- Sofala province: walks; Health Fairs including HIV Counseling and Testing, blood pressure checks, cooking demonstrations, advice on using the bicycle ambulances where they exist, speeches, some drama. The Chiringoma CSO also organized walks for the Kids Clubs. Kids Clubs soccer teams in Buzi and Gorongosa districts played games with other community teams.

⁸ These 177 children are additional to the CT results for Cabo Delgado in Table 4, Completed Referrals

- Maputo province:

Moamba district: walks, soccer matches for Kids Clubs teams; sensitization session on using of health services. In addition, discussions were held using the Parenting Skills flipchart.

In Manhiça district, a Health Fair was held to commemorate December 1st activities combining with the annual 16 Days of Activism, and 356 (154 male and 203 female) attended. Mobilization for voluntary testing was a key activity, and 166 community members (80 male and 86 female) did HIV tests. Among them, 38 tested positive. 36 community women underwent a breast and Utero cancer testing and screening. Challenges related to the distance place where the fair was held, resulted in limiting the opportunity for blood donors, malaria consultation and pharmacy services.

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

During this reporting period, the HES component of CCP remained vibrant and continually builds on itself. Even though Q16 was to be the last quarter for starting new groups, there were still CCP beneficiaries not yet integrated into VS&L groups. Sixty-six (66) new VS&L groups were established to accommodate this *activista*-driven “demand” bringing the cumulative number of VS&Ls now to **1,193**. The resulting 1,386 new VS&L group members includes many enrolled in CCP through Lost-to-Follow-Up activities meaning enrolling those found through *busca activa/consentida*, referred (and enrolled) OVC caregivers, as well as some non-target group individuals (meaning HIV status not known), following the same group formation principles as from inception. The total number of members increased from 22,978 the previous quarter to 24,325 (male 6,531 and female 17,794) this reporting period, with female members still comprising the majority.

Table 15: Q1 – Yr 5 VS&L groups disaggregated by province and sex

Prov- ince	Overall targets			Cumulative VS&L groups to date			New VS&L groups Q1 – Y5					
	Nr of groups	Number of beneficiaries			Nr of groups	Number of beneficiaries			Nr of groups	Number of beneficiaries		
		M	F	T		M	F	T		M	F	T
Maputo	95	480	720	1,200	101	462	1,569	2,031	0	0	0	0
Inham-bane	140	560	840	1,400	176	632	4,468	5,100	28	159	487	646
Sofala	319	1,096	1,644	2,740	360	2,096	4,899	6,995	17	162	198	360
Manica	257	936	1,404	2,340	171	1,377	2,733	4,110	10	89	131	220
Tete	289	936	1,404	2,340	271	1,362	2,698	4,060	11	10	150	160
Niassa	95	200	300	500	96	523	1,098	1,621	0	0	0	0

Cabo Delgado	22	96	144	240	18	79	329	408	0	0	0	0
Total	1,217	4,304	6,456	10,760	1,193	6,531	17,794	24,325	66	420	966	1,386

VS&L groups further disaggregated by district can be found in this report’s Annexes.

As noted above, the orientation for this quarter across CCP was on strengthening the already established groups and not creating new ones. Thus the three CCP provinces showing zero new VS&Ls this quarter is not a concern; TA was provided on consolidating existing groups, with special effort given to the newly formed groups last quarter. Inhambane province had an unusual situation, that being the recruitment of four new VS&L Community Facilitators in Maxixe and Homoine districts, and Inhambane City, contributing to the ramp up of VS&Ls there. The Community Facilitators will be especially oriented to help the 66 new groups reach maturity by June 2015.

In Tete province, although the number of VS&L Community Facilitators overall was reduced due to low performance, 11 new groups were established. Other innovative and positive developments in Tete, are that some of the VS&L groups are evolving into coalitions an solidarity groups and are further attracting more people to join them. The coalition aspect is more about positioning for sustainability after CCP project funding support ends. District leaders in both Moatize and Changara districts have a vision that VS&L groups banding together may have better chances to access technical or material support as a “coalition” of groups, than a single VS&L group might. The “solidarity” aspect really just means that members are increasingly joining their efforts together for helping a group member, say to replace a bad roof, or to give extra assistance to an elderly person. One could call these types of activities an intensification of the Social Fund concept, but these are more group actions than group financial assistance.

In Sofala province, where political-military violence had caused serious uncertainty and insecurity in past periods, many situations improved with the end of those hostilities. With the revived ability to live and work peaceably, *activistas* and Community Facilitators collaborated for forming 17 new groups.

One opportunity that reflects the important linkages between the VS&Ls and agricultural extension efforts was Trade Fairs held by SDAEs where VS&L members could use their savings to purchase the agricultural inputs they need at the proper time of the year at good prices. Some SDAEs also hold fairs at the harvest time of year, where growers can also sell their outputs.

The nature of the VS&Ls and their increasing presence across the CCP implementing districts and provinces are having the positive effect of attracting a lot of local attention. This HES component has such power to improve the quality of life for PLHIV, OVC, and PPPW. As other community members observe that improvement and seek to form further groups as time goes by, VS&Ls can have even broader impact as communities become better off generally, with

families taking care of their own members, withstanding the effects of chronic illness, becoming more healthy and less needy.

Table 16: Q1 – Yr 5 Cumulative Composition of VS&L Groups by province, type of member, disaggregated by sex

Province	Nr of Groups	Activistas		Caregivers		PLHIV		GAAC Members		CCC members		M2M	Community members		Totals	
		F	M	F	M	F	M	F	M	F	M		F	M		
Maputo	101	100	46	146	74	434	277	37	1	4	2	260	526	354	1.507	754
Inham-bane	176	145	42	96	121	422	542	62	87	110	192	890	1966	213	3.691	1.197
Sofala	360	285	401	382	520	581	1.152	171	146	80	46	930	599	1.378	3.028	3.643
Manica	171	82	213	207	324	218	524	3	4	4	7	99	1.064	1.471	1.677	2.543
Tete	271	125	48	232	149	177	69	50	22	54	46	206	1.488	1.069	2.332	1.403
Niassa	96	80	41	164	74	63	95	26	8	32	25	26	587	445	978	688
Cabo Delgado	18	7	6	15	5	115	32	0	0	32	26	96	370	180	635	249
Total	1,193	824	797	1,242	1,267	2,010	2,691	349	268	316	344	2,507	6,600	5,110	13,848	10,477
Grand Totals		1,621		2,509		4,701		617		660		2,507	11,710		24,325	

In terms of group constitution, as well documented from project inception, the VS&L groups can be said to reflect community diversity, meaning not everyone is HIV+. Having never wanted to stigmatize themselves as “sick groups”, the self-formed VS&Ls included members who were not overtly CCP target groups, such as PPPW, PLHIV, or OVC. CCP has called this type of member “Community Member”. CCP has worked hard on both assuring that all project beneficiaries take advantage of the HES project component, and keeping the focus on the project target groups. That said, not all CCP beneficiaries choose to join a VS&L. Currently, the ratio of CCP target groups to community members in VS&Ls is 52% PLHIV target groups, 48% community members.

Table 17: Q1 – Yr 5 Number of OVC per family household for each Member Type

Province	Activistas	Caregivers	PLHIV	GAAC Members	CCC Members	M2M	Community members	Total
Inhambane	447	553	50	48	484	229	702	2,513
Sofala	872	2,814	5,006	115	417	1,224	1,533	11,866
Manica	368	1,578	1,600	32	24	218	5,442	9,230
Tete								
Niassa	535	169	176	-	11	44	211	1,146
Cabo Delgado		283		-				283
Maputo	137	991	838	-	-	505	626	3,097
Total	2,359	6,388	7,670	195	936	2,220	8,514	28,282

Although CCP still is working out the challenges to accurately measuring the impact of VS&L group participation for OVC, progress is being made. In this reporting period, CCP can now show at least 19,768 OVC related to project target groups are benefitting from their parent or caregiver actively engaging in the HES component of the project, or 70% of OVC benefitting. This data point excludes the children in Community member households who are not overtly project target groups. However, there is high likelihood that the majority of children in those member households at minimum meet GRM vulnerable criteria, and could be counted but CCP prefers to not assume such. CCP believes this is still an underreported number of OVC and is continuing to strengthen the data collection, showing as needed still since the numbers of OVC benefitting are not proportional to the number of districts implementing in each province.

Table 18: Q1 – Yr 5 VS&L Groups Savings in Meticaís and US\$ by province

VS&L Data Type	Maputo	Inhambane	Sofala	Maníca	Tete	Niassa	Cabo Delgado	TOTAL
Total savings	1,673,292	4,159,782	30,655,719	3,152,238	5,514,079	928,466	874,820	46,958,396
	\$ 5,315	\$13,513	\$1,013,412	\$104,206	\$18,284	\$ 30,693	\$ 28,920	\$ 1,552,344
Total fine	585	279,608	54,482	2,929	22,637	4,358	645	365,244
	\$ 19	\$ 9,243	\$ 1,801	\$ 97	\$ 748	\$ 144	\$ 21	\$ 12,074
Total social fund	148,670	738,743	533,372	64,787	257,328	45,956	199,020	1,987,876
	\$ 4,915	\$ 24,421	\$ 17,632	\$ 2,142	\$ 8,507	\$ 1,519	\$ 6,579	\$ 65,715
Total interest from loans	2,168,350	1,015,601	4,815,280	169,736	1,054,817	74,787	48,460	9,347,031
	\$ 71,681	\$ 33,574	\$ 159,183	\$ 5,611	\$ 34,870	\$ 2,472	\$ 1,602	\$ 308,993
Total income (1+2+4)	1,950,567	5,454,991	30,111,255	3,717,965	5,938,959	1,400,112	1,122,945	49,696,794
	\$ 64,482	\$180,330	\$ 995,413	\$122,908	\$196,329	\$ 46,285	\$ 37,122	\$ 1,642,869
Total disbursed loans	1,199,500	17,367,282	25,499,536	955,074	6,562,311	432,825	240,000	52,256,528
	\$ 39,653	\$574,125	\$ 842,960	\$ 31,573	\$216,936	\$ 14,308	\$ 7,934	\$ 1,727,489
Total reimbursed loans	671,310	4,011,084	11,089,343	385,552	3,852,358	273,942	-	20,283,589
	\$ 22,192	\$132,598	\$ 366,590	\$ 12,746	\$127,351	\$ 9,056	\$ -	\$ 670,532
Total outstanding loans	476,685	17,367,282	1,347,345	517,769	6,097,222	602,570	240,000	26,648,873
	\$ 15,758	\$574,125	\$ 44,540	\$ 17,116	\$201,561	\$ 19,920	\$ 7,934	\$880,954,48
TOTAL – value in cash box (at the end of savings, reimbursements and disbursements)	1,029,650	4,353,845	10,025,945	5,402,128	2,084,161	2,769,815	158,520	25,824,064
	\$ 34,038	\$ 143,929	\$ 331,436	\$ 178,583	\$ 68,898	\$ 91,564	\$ 5,240	\$ 853,688

The cumulative amount of savings has increased to 46,958,396 MT, or an amazing \$1.5 million. This suggests that across beneficiary members, there is also an increase of their income generating capacity, which enables them to make some profit as well as to improve their culture of saving over time. While not honoring the details of real “age” of each group, number of

members of each group, or monthly savings amount of each group, a **very** broad brush analysis could say that the average group savings is \$1,300, or even that the average savings per group member is around \$64. While to some eyes this may seem a small amount, to a grandmother looking after her deceased adult child's children, this makes the difference between indigence and a measure of autonomy, benefitting the OVC in her care.

Other positive HES factors merit highlighting. Linkages to markets facilitate selling produce. Loans increased during this period, suggesting both planning for Festive Season needs, as well as maturing in money management since members know they must repay the loans they take out. The number of members seeking linkages to Financial Institutions increases each quarter, giving an opportunity either as a group or as individual members with sufficient business to have access to real bank loans. Members also advance to the formal banking sector to keep their money more safe as they open individual bank accounts. VS&L group members compliance with paying interest on the loans they take out helps prepare them for the formal banking sector as well.

TA this quarter in the HES component of CCP took various and relevant forms, as needed. The VS&L Community Facilitators take the approach of meeting the current needs of the group members, within the context of the Project HOPE methodology that comprises the foundation of all the groups. The Financial Literacy curriculum provides the substance, on an ongoing basis, for training on needed skills to manage household finances. At each VS&L group meeting, members update their notebooks on their personal transactions in the group, which can include their own savings amount, loans taken, interest paid on repaid loans, any fines, etc. Meanwhile the elected leaders are also continuously updating and documenting the transactions of the group overall. The VS&L groups are actually a strong model of transparency and mutual accountability. TA is also provided on identifying opportunities for income generating activities as appropriate.

An added benefit, as noted in earlier sections, is VS&L members receiving Parenting Skills messages from the *activistas* and/or Community Facilitators. Linking a culture of saving and building household economic strength to good adult/parenting practices serves as building a foundation for meeting OVC needs, reducing household vulnerability in the face of chronic illness such as HIV, and strengthening one's community overall for the long term.

Other CCP HES activities are very long term and don't necessarily have concrete results. Lobbying with local and national government institutions to certify the VS&L Community Facilitators as providers of financial services in the communities continues. This initiative leads to the sustainability of structured support for the VS&Ls after CCP external funding support ceases. Also, linkages with private initiatives may facilitate business opportunities that can add value to group members, and, help solve VS&Ls safe/cash box vulnerability.

An example of both maturing VS&Ls and needed next steps in their maturing process follows, based in Sofala province. BOM there continues with presenting bank "products" and services to VS&L members in Dondo, Nhamatanda and Beira districts. A number of members are in the

process of opening bank accounts. Since this is a first time experience for many, some members do not have all the documentation required by the bank to open their accounts. The HES Community Facilitators and CSO staff work together to support CCP beneficiaries in the VS&L groups to collect and organize such needed documentation.

Another example in Inhambane province follows, springing from the partnership with BOM, and resulting in 15 groups establishing linkages with the following financial institutions: BCI, FNB, BIM and MKesh, as the table below shows. Such links arise with whichever banking institution is present in any given area, since no one Mozambican bank has branches covering the entire country. This array will vary from province to province in CCP.

Table 19: Q1 – Yr 5 Inhambane example VS&Ls new accounts with institutions by sex

Local name of VS&L Group	Bank or mechanism of account opened	M	F
Tsinela	BCI Maxixe	1	24
Timissela	BCI Maxixe	4	21
Bem vindo	BCI Maxixe	0	25
Unido	BCI Maxixe	0	25
Tsembeka	BCI Maxixe	5	18
Gracas a deus	BCI Maxixe	2	23
Kindlimuka	FNB	3	22
Kuzuanana	Mkesh	0	23
Bem unido	Mkesh	0	25
Kurula	BIM	2	23
Zamane Va Makuero	BCI	5	20
Ringuetela	BCI	3	22
Nova Visao	BCI	5	20
Kutiwonela	BCI	2	23
Kuwonekela	BCI	4	21

Total members opening accounts or mechanisms		36	335
---	--	-----------	------------

It is notable that among the 371 group members that opened bank accounts the majority are female 335, and 36 are male. While CCP has never excluded men from the VS&L groups, an emphasis has been on women since they more often bear the family responsibilities.

In Tete Province, partnership with BOM, resulted in two VS&L groups being granted a loan BOM, while two groups (SANGO 16 women, and ACN 16 men and 6 women) benefitted from the District Development Fund (DDF) in Changara district. As noted in previous reports, this local HES opportunity seems like a logical resource to link to on a massive scale. However, these funds remain uncertain and poorly monitored, managed, and regulated. Rarely there is a district administrator who is visionary and really understands the HES potential of the DDF. These loans have a very poor repayment record and those who take the loans do not necessarily learn accountability from the process. The VS&Ls actually offer a better learning and life changing model.

Finally, VS&L groups are also identifying specific OVC needs in their communities and electing amongst themselves as a group to give assistance. Sometimes this takes the form of school materials support or basic food support. Considering there are nearly 1,200 VS&L groups, it is not possible to summarize the many contributions made, as each group determines its own ability to assist against the needs they identify.

8. Program Management

Q1 of Yr 5 was a very mixed reality quarter. The implications of new direction and focus under PEPFAR 3.0 affected CCP in the following ways. The Yr 5 Workplan and Budget approval was delayed the entire quarter, due to cascade effects of new direction and focus from PEPFAR 3.0 coming on line. CCP did finally receive both funding and geographic information mid-December with which to re-plan, for revising the CCP Yr 5 Workplan and Budget. [approval still pending as at report submission] While the PEPFAR 3.0 new direction and focus are logical and well founded, the donor agency constraints carrying over onto CCP, who is trying to carry out a quality and forward thinking Close Out year, do take a toll. Receiving incremental funds only in early November increased the challenges of issuing timely funding modifications to subcontractor and subgrant partners. At the same time, CCP submitted its APR as well as several quarterly provincial government reports.

CCP keeps reaching higher levels of achievement in quality of implementation, despite the ordinary challenges arising continually to test the obtaining of results. Two clouds of uncertainty loomed over the CCP horizon, however; the first having to do with the timing of Yr 5 USAID funding. The reality of re-doing the Yr 5 package of Annual Workplan and Budget can be regarded as somewhat demotivating, whether CCP is unique to that situation or not. Additional managerial burdens result from uncertainty, such as attending to super budget scrutiny and foregoing certain activities to stretch funds, developing the internal FHI 360 mechanisms for emergency funding coverage (initiated in September) when project funds will come late, and the likelihood of inconvenient timing and challenges to a quality Close Out. The second was the upcoming general election, given the politically motivated violence already experienced during preceding months. Managing the latter: FHI 360 complied with its security policies and procedures to lay plans for assuring the safety of staff during the election period. Managing the former: until incremental funds arrived in November, the CCP COP was doing everything possible to avoid shutting down prematurely for lack of funds, thus also avoiding the unwelcome, inefficient, and potentially unsuccessful re-start-up of the project to run just until close of project date.

The last quarterly report covering the end of Yr 4 gave a full recounting of the CSOs process under GUCs. This quarter, proceedings that began last quarter to finalize closure of Igreja Anglicana in Tete province were completed. This CSO implemented CCP in Angonia, Chifunde and Tsangano districts. Only Chifunde district remains operational of the three, with approval by USAID to transfer its operations to Kuthandizana Kuchira. The CSO Kuwangisanna implementing in Caia and Chemba districts in Sofala province did close this quarter, with no viable replacement CSOs. CCP has proposed closing two more (so-called) non-priority districts due to the sharply reduced (by 39%) planning budget for Yr 5, which we received in mid-December and which still awaits approval. The current 42 implementing CCP districts will reduce to 40 when that action is approved with the Yr 5 Workplan and Budget.

During this reporting period, evaluation of *activistas* and CSO performance (both technically and financially) concluded, as described last quarter. Some intended uses of this evaluation are to identify *activistas* who are strong in specific parts of their tasks who can then be designated to mentor those whose performance is not as strong, to identify strong *activistas* for special recognition during closure events to take place either in March or June depending on which CSOs/districts, and for the CSOs themselves to know who they can best rely on in the future.

This reporting period included revising the Yr 5 Workplan and Budget, as mentioned above given a 39% funding cut to plan with, submitted after the holidays. Close Out year becomes less and less resilient to externalities the longer CCP goes without its Workplan and Budget approvals. Regardless, Close Out activities and documentation strategies were key topics of the FHI 360 Projects Coordination retreat in November, where all the FHI project leaders as well as its Provincial Coordinators and Country and Regional Directors gathered to review rules, best practices, plans, staffing realities, and other key issues in this major projects closure year for FHI 360 Mozambique.

Staffing

No key issues in FHI.

“Strategic or Consortium” Partners

CCP holds regular Partners Meetings, the last one held during last quarter on September 16. Holiday Leaves precluded this quarter’s Meeting but the COP held individual follow up meetings with the country directors of Project HOPE, World Relief, and Africare in lieu of a group meeting.

World Relief: Mr Jamene Sangalakula has fully assumed the Mozambique leadership of World Relief after the departure of Ms Nia Olupona last quarter.

Africare: This INGO has been going through a total re-organization since July 2014, and cascading from that the Africare Mozambique Finance Officer left his position during this reporting period. This leaves a big gap for their office here, evidenced by late monthly financial reports. Normal follow up measures were taken to no effect locally, as their expected new hire would join in January 2015 (the next quarter). Africare had to engage its HQ for reporting support but wasn’t getting what it needed. Eventually, the COP intervened with Africare HQ.

[Update at this report submission time: Sept and Oct reports were received 12 Jan 2015, Nov and Dec reports were received 12 Feb 2015]

Project HOPE: Their Sr Technical Advisor, John Bronson, was approved for travel to Mozambique to support the HES programming vital to CCP. His inputs were also invaluable in looking ahead to the CCP End of Project Evaluation.

USAID activities

CCP had the honor of kicking off Yr 5 with hosting the Deputy Assistant Secretary of State for Africa, Ms Shannon Smith, on a visit to our Pemba district CSO partner, Kaeria in October 2014. The visit was very focused and this CSO did a very good job of representing the entire CCP project to the visitors, which included US Embassy DCM Mark Cassayre and senior staff, and USAID officials. The DAS Smith was able to learn first-hand what the *activistas*’ activities were on behalf of OVC, PLHIV, and PPPW; participate in a VS&L group meeting; and chat one-on-one with Ms Chila Carioca, Coordinator of Kaeria. Ms Carioca was the 2013 Mozambique nominee for the “PEPFAR Heroes: Giving Hope, Saving Lives Award”. Kaeria is itself an association of PLHIV and supporters.

Subawards:

Primarily discussed above in Program Management.

FHI's regular and standardized Financial Site Visits help to uncover any irregularities. At times, gaps arise when there is turnover of CSO staff, which are usually easier to resolve than management issues. This quarter, FHI initiated a cross-sector (internally, within FHI departments) detailed administrative compliance exercise with two CCP CSOs. Those observations will be addressed, and the compliance exercise will be further carried out across all the implementing CSOs.

9. Major Implementation Issues

See Program Management and Strategic Partners sections above.

10. Collaboration and partnership, and with other donor projects

While collaboration and partnership are ongoing and normal and noted throughout the report, this section will only serve to summarize for a concise listing. It is truly impressive the length and breadth of the implementation network created by all the linkages involved in CCP, there may even be some not listed which were less active this quarter.

- Collaboration with CAP in selected districts for Organizational Capacity Building of CSOs
- ADEM Organizational Capacity Building report on their second phase
- Continuous partnership and collaboration with SDSMASs in all CCP districts
- Continuing partnership with ANEMO for joint supervision of integrated services
- Collaboration with INASs where possible, meeting specific food basket needs or rallying community resources
- Collaboration with PATH on ECD activities in limited areas
- Collaboration and partnership with clinical facilities across CCP implementing districts, for health services referrals, HIV services including PMTCT within the Maternal Child Units, joint efforts on *busca activa/consentida*, supporting M2M and GAAC groups, nutritional rehabilitation units
- Partnership within *co-gestã* committees at clinics, to guide *busca* efforts and strengthen referral networks
- Partnership with CHASS SMT, CHASS Niassa, and ROADS for community HIV testing
- Collaboration with GRM entities re child protection and addressing sexual violence – GAVV, police, courts
- Partnership with URC and FANTA for implementing PFHS in Sofala Province
- Collaboration with SMI nurses in providing education to M2M groups' members
- Partnership with MMAS (continuous), on disseminating and supporting minimum standards of care for children
- Collaboration with ARIEL on clinical referral partnership
- The highly productive intra-project partnership with Project HOPE on HES activities – the VS&L groups which also serve as primary platform for CCP Parenting Skills
- Partnership between Project HOPE and banks, developing bank accounts with VS&L groups

- Intra-project partnership with Africare and World Relief who ably implement CCP in Manica and Inhambane Provinces respectively.

Specific key partnerships and linkages merit their own write-ups this quarter, which follow.

Partnership HIV Free Survivor (PHFS) in Dondo district

CCP remains the designated community partner in Dondo district, Sofala province, for the PHFS activity, the acronym for Partnership for HIV Free Survival. The implementing partners include CHASS SMT and the local health facility, URC and FANTA, with local implementation by CCP CSO partner Kuphedzana. Following the finalized MoU between URC and CCP last quarter, this quarter these partners conducted joint site visits to the CSO. The Health District Head was also on these visits, who was assessing the impact of the key HIV and nutrition messages that PHFS disseminates. PHFS on-the-job training this quarter benefitted 38 participants (10 male and 28 female) including *activistas*, CHASS SMT lay counselors and case managers, VS&L Community Facilitators, POs, and supervisors. Cooking demonstrations benefitted an additional 26 participants (7 children, 8 male, and 11 female). The usual CCP PMTCT and Nutrition activities carried out during the reporting period do benefit from the additional programming focus from being a PHFS partner. Additional PHFS activities included:

- Public service radio spots were aired four times a day with educational messages on PMTCT and nutrition in Portuguese, Ndau and Sena, through Dondo Community Radio.
- Five TA visits were carried out to the CSO Kuphedzana, one joint TA visit with URC to follow up the activities of the partnership.
- Activity coordination meetings, between HU *Medico Chefe* and community partners (CCP and URC), to evaluate the impact of Radio messages and the need for a second evaluation of the clinical indicators, for further dissemination and discussion with community partners.
- Coordination meeting with Project FANTA.

In this reporting period, reproductive-aged women and children were HIV tested at home in coordination with CHASS SMT, and subsequent referrals were made to all MCH and nutrition services as indicated. That service delivery data is included in Sofala province reporting.

PATH

While PATH carries out its Early Childhood Development programming with only minimal overlap with CCP, in Boane district in Maputo province, the complementarity between their work and the CCP Parenting Skills educational messages is quite strong. The PATH methodology is to use the HU waiting room as the platform to explain child development norms to mothers who have come for growth monitoring consults. A technician uses a similar basic approach that CCP uses, she hangs visuals on the wall and explains the meaning of those images. This reflects the Parenting Skills approach, wherein the *activistas* present visuals from the flipchart and explain the messages the images represent. This complementarity should be considered when any scale up of the PATH project is possible, or in future OVC programming.

REENCONTRO

During this reporting period CCP was honored to extend the reach of its effectiveness to some areas in Gaza province. REENCONTRO invited CCP to conduct ToT on Parenting Skills and its

Album Seriado (and on the referral system with the *Guia de Referência* discussed earlier in the report) for their staff and partners in Xai Xai and Chibuto districts. The CCP OVC Technical Officer (and Community Mobilization Officer) very capably conducted the ToTs. The 105 people trained (19 male and 86 female), included *activistas*, coordinators, supervisors, M&E and program officers, community leaders, notary services, and referral partners (DPMAS, SDMAS, INAS, GAVV, HUs). For the Parenting Skills, as in the CCP methodology, there is first a class room type training, then a practicum segment where the *activistas* present to some households overseen by the trainer, then they assume their community role of presenting the Parenting Skills messages to the VS&L groups and other designated target audiences.



REENCONTRO *activistas* in Parenting Skills training group work before presenting at households, Gaza province.

10. **Upcoming Plans for Q2 – Y5 (Q18)** (notable events over and above usual ongoing activities)

PCC will continue to implement per usual until the revised Yr 5 Workplan and Budget are approved. Q18 anticipated plans and events include the following, while the next Advisory Council Meeting is TBD.

January 2015:

- Q17 quarterly report development and submission by 30 Jan
- Annual national and provincial GRM reports developed and submitted by 30 Jan
- 20th – Abstract submission to South Africa AIDS Conference
- Anticipate revised Yr 5 Workplan and Budget approval, accommodating the 35% budget cut
- Collaborate with USAID-contracted JSI on DQA
- Continue EOP Evaluation protocol development
- Accommodate 15th Jan additional national holiday to observe new president's inauguration

February 2015:

- Final Refresher *activista* trainings in Manica and Inhambane province districts (15); toward sustainability strategy
- 13th – EOP Evaluation protocol submission to GRM Ethical Review Board
- First 2 weeks: participate in FHI 360 2-week internal audit
- Second 2 weeks: support JSI 2-weeks field work as needed
- Third week: Regional Director and Finance Director visit

- Week of 16th: tentative public launch of *Guia de Referencia* with USAID, MISAU, MMAS
- Week of 16th: host PHFS site visit with CHASS SMT in Dondo district
- 10th – participate in CAP CSOs graduation

March 2015:

- District level Close Out events held in each Manica and Inhambane province district (15)
- COP out of office first 2 weeks of the month

12. Evaluation/Assessment Update -

Underway during the reporting period:	
End of Project Evaluation: Protocol drafted, progressed through initial reviews; external and final reviews planned for January. Time plan also includes local and FHI IRBs submissions in mid-February, to support May data collection.	