



USAID
DO POVO AMERICANO

**PROGRAMA DE CUIDADOS
COMUNITÁRIOS**

USAID Community Care Program (Programa de Cuidados Comunitários)

Quarterly Report Nº. 6 – January – March 2012

Task Order #: Task Order No. GHH-I-05-07-00043-00

Project Period of Performance: September 2010 – September 2015

Date Submitted: April 30, 2012

Resubmitted: June 26, 2012

Linda Lovick, Chief of Party, llovick@fhi360.org

Year 2 Q2 Table of Contents

List of Acronyms	3
Executive Summary	5
Project Overview	6
1.1 Achievements by Objective	
Objective 1	9
Objective 2	13
Objective 3	17
Objective 4	28
1.2 Challenges and Ways to Overcome Them	31
1.3 Program and Operational Management	32
1.4 Financial summary	34
1.5 Plans for Next Quarter	34
Annexes	
I. Project Pipeline (attached separately)	
II. Formulário de Perfil (Household Economic Profile Form)	36
III. OVC Matrix (attached separately)	
IV. Success Story	39

List of Acronyms

ACIDECO	
AED	Academy for Educational Development
ANEMO	National Association of Mozambican Nurses
ART	Antiretroviral Treatment
BOM	Banco Oportunidade de Moçambique
CCC	Community Care Committee
CCP	USAID Community Care Program (formerly ComCHASS)
CLC	Community Leaders Council
CSO	Civil Society Organization (community based organization)
CTARV	Care for ART
DPMAS	Provincial Directorate of Women and Social Action
DPS	Provincial Directorate of Health
FONGIM	Forum for International NGOs in Manica
GAAC	Community Antiretroviral Group
GAVV	Office for Attending to Victims of Violence
GTCOV	Technical Group for Orphans and Vulnerable Children
GUC	Grant Under Contract
HBC	Home Based Care (for PLHIV)
IEC	Information, Communication and Education
INGO	International Non-Government Organization
M&E	Monitoring and Evaluation
MMAS	Ministry of Women and Social Action
MOH / MISAU	Ministry of Health
MONASO	Mozambican Network of AIDS Organizations
MOPCA	Mozambique Association of Palliative Care
MOU	Memorandum of Understanding
M2M	Mother to Mother
NGO	Non Government Organization
NPCS	Provincial Núcleo to Combat AIDS

OVC	Orphans and Vulnerable Children
PES	Strategic Social Plan
PH	Project HOPE
PLHIV	People Living with HIV
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother to Child Transmission (of HIV)
POA	Plano Operacional Anual
PPM	Pre/Post Partum Women
PSI	Population Services International
PSS	Psychosocial Support
REPSSI	Regional Psychosocial Support Initiative
Q -	Quarters of the project
QA / QI	Quality Assessment / Quality Improvement
SESP	Sector de Educação para a Saúde no Distrito (Health Education)
SAPR	Semi Annual Progress Report
SDAE	District Services for Economic Activities
SDSMAS	District Services of Health, and Women and Social Action
SOW	Scope of Work
TO	Technical Officer
TOT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
VS & L	Village Savings and Loan Groups
Yr1	Year 1 (of project)
Yr2	Year 2 (of project)

EXECUTIVE SUMMARY

USAID's Community Care Program (CCP) witnessed significant growth and expansion across various levels of the project in this reporting period. At the community level, the range of services available to families reached continued to be broadened and strengthened. Two of the most recent services, PMTCT (a Yr 2 activity, referral to the clinical service) and nutrition, have expanded their reach, both within the already targeted geographic areas. Nutrition services underwent a different type of expansion, from simply a component of the HBC and OVC minimum packages of services to a reportable deliverable under a PEPFAR indicator. In this last quarter, 760 pre- or post-partum women were referred to PMTCT clinical services of which 188 pre-partum women are in HBC. Nutritional services increased positively with 8,141 individuals benefitting from this service, an increase of 7,098 over last quarter. Such increases primarily reflect the expected growth of project effectiveness in achieving results. The primary contributing factors have been Technical Assistance on implementing the PMTCT services referrals, and increased emphasis in the HBC and Integrated Caregiver trainings on nutritional services activities, especially nutrition education, as well as reporting properly on both. Keystone services such as home-based care and care and support for OVC continue to show positive trends. HBC enrollment increased to 7,245 clients (2,502 males and 4,743 females) of which 2,043 new clients enrolled in this past quarter. Care and support for OVC may be the most sensitive area of CCP programming, with the most change in approach, the most innovation, the steepest learning curve for quality implementation. By March 31st, 12,568 OVC were enrolled of which 7,690 were newly enrolled in this quarter.

As the program makes progress to meet targets, it also continues to grow and expand at a steady pace to ensure quality is built in the process. The project coverage increased to 48 of the 52 districts while aiming to complete full coverage by next quarter. Fifteen sites were added during this reporting period, and are in the midst of the various stages of start-up such as finalizing the SOW, training the *activistas*, or implementing. New local partners in Tete, Niassa and Sofala provinces completed Start Up workshops this quarter, which include review of monitoring and evaluation tools as well as reporting requirements to track program progress, and carried out the trainings which precede services delivery. Within each province, the role of the CSOs also continues to be strengthened by start up of economic strengthening activities. The Project HOPE subgranted CSOs in Sofala and Manica completed the Mobilization phase of the village savings and loan groups. The aim of these groups is to improve the livelihood of the families receiving community-based services by the *activistas*. To date, 28 groups are functional in Maputo province and 38 VS&L community facilitators are trained in Sofala and Manica, 22 and 16 respectively. Each CSO funded through a Provincial Lead will develop a partnership with Project HOPE to ensure families receiving services are prioritized for VS&L groups.

Grassroots community structures such as Community Care Committees and Community Leader Councils were inventoried this quarter. This assessment identified existing and functional committees and gaps within the leadership and operations. These committees are vital to long-term sustainability of community based responses to HIV.

National level trainings continue to be supported by CCP. This quarter, a total of 10 trainings took place to roll-out the Integrated Caregiver HBC/OVC curriculum in Tete, Niassa and Sofala for newly subgranted CSOs. Four additional training of trainers were completed by ANEMO to further grow the pool of qualified trainers in home-based care in Tete and Niassa province. Eleven trainings on the OVC minimum package were held in Tete, Inhambane, Manica to strengthen *activistas* and supervisors on the delivery of OVC services. A separate training piloted the Child Status Index to assess and monitor the well being of a child in six different domains. Together, the skills learned by *activistas* and supervisors in the various trainings will strengthen community services to be delivered in each of the provinces. And including GOM personnel from the provincial and district health and social action directorates in trainings and joint supervision activities continues to strengthen government service providers and deepen collaborative relationships.

Throughout the quarter, the consortium is meeting routinely to share successes and challenges as the project moves into full implementation across seven provinces. The Chief of Party convenes the consortium partners at least once each quarter, and these same partners also participate in the monthly Technical Committee meetings.

Each meeting is an opportunity to reflect, listen and identify areas of improvement and growth.

OVERVIEW

USAID/Mozambique's Community Care Program, also known as Programa de Cuidados Comunitários 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, and their families. Working in close partnership with civil society organizations (CSOs), the Ministry of Health (MoH), the Ministry of Women and Social Action (MMAS), and the private sector, the Program will strengthen the government's capacity to coordinate, manage, and oversee an integrated continuum of care and support and will build the capacity of CSOs to provide comprehensive, community-based care and support services. Within five years, the Program will achieve for PLHIV, pre- or post-partum women, OVC and their families, all expected results: increased provision of family-centered, community-based HIV and care and support services and increased access to economic strengthening activities and resources for HIV-affected households.

PROJECT DESCRIPTION

The Project team, composed of FHI 360, World Relief Corporation, Africare and Project HOPE, is working to accomplish the following four objectives: 1) strengthen the organizational, technical, and leadership capabilities of CSOs and the public sector to deliver health and wrap-around services for groups targeted by the project; 2) strengthen coordination, collaboration, linkages, and partnership within and across sectors and develop

efficient, innovative community-based service delivery; 3) increase the availability, accessibility, quality, and use of family-centered, age-appropriate, and gender-equitable care and support; 4) improve the capacity of vulnerable households to sustainably meet their own needs by strengthening livelihood, caregiving, and health-seeking skills. Six cross-cutting strategies are employed by the project 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.

1.1 ACHIEVEMENT BY OBJECTIVES

Project Coverage

The USAID Community Care Program (CCP) continued to expand its coverage in the seven provinces targeted. To complete full coverage in the seven provinces, Tete and Cabo Delgado completed the selection process in this reporting period by finalizing Grants Under Contract (GUC) with the qualified civil society organizations (CSOs) to be funded. Their first phase of implementation was carrying out the pre-service trainings needed to deliver home-based care services and provide care support to orphans and vulnerable children in their respective communities.

Overall, the project continues to increase the number of beneficiaries enrolled and receiving services as illustrated in Graph 1. In this quarter alone, a total of 12,568 OVC benefitted from care and support service, 7,245 PLHIV received home-based care, 8,141 individuals received nutritional support, and 760 pre- or post-partum women were referred to PMTCT services.

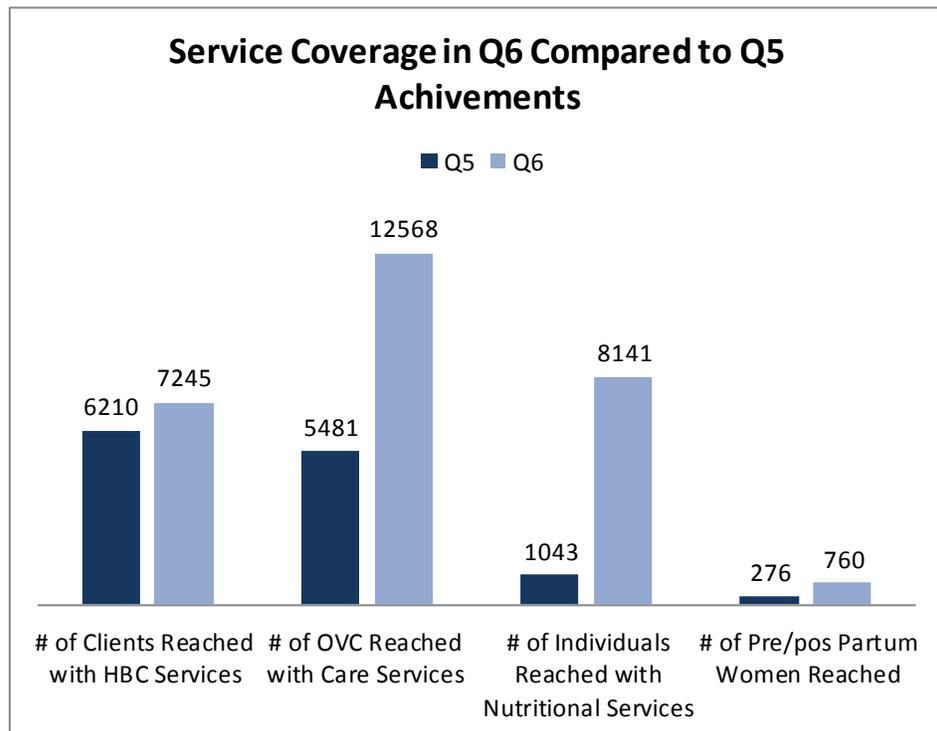
A significant emphasis was placed this quarter on OVC support and relevant documentation of that support. *Activistas* from eight new districts participated in the new Integrated Caregiver training in March. The training focused on the process to enroll eligible families and to identify their health and social services needs to be addressed by the project implementers. The Integrated Caregiver training includes both the HBC curriculum and OVC support curriculum and is delivered by ANEMO and MMAS-based master trainers.

The number of districts covered by a local organization increased to 48 of the 52 target districts. The remaining districts yet to be funded are at various stages in the GUC process. Two districts (Ngauma and Muanza) have been approved by USAID this quarter and the final refinement of scope of work and budget is in process. In Tete, Mutarara district faced difficulty in identifying a qualified local organization. After a few rounds of casting a wide net in the community, Caritas Diocesana was identified. Approval for this organization is pending from USAID. In Gorongosa district, a local organization originally identified has since been withdrawn due to inconsistencies. In the next quarter, CCP will launch a solicitation to identify a new local organization in this district.

Project HOPE is in process of finalizing their full start up of economic strengthening activities. The first three CSOs funded in the previous quarter have started work in this quarter in Sofala, Manica and Inhambane provinces to support the development of village savings and loan (VS&L) groups. The GUC process is nearly complete with two more local organizations in Tete and Niassa provinces.

Africare and World Relief continue to support the CSOs they have funded through GUCs and are implementing in Manica and Inhambane provinces, respectively.

Graph 1



Note on Graph 1:

Q6 is this reporting period, January through March 2012.

Q5 is the previous reporting period, November through December 2011.

This quarter's achievements towards Yr 2 targets include:

HBC	34%
OVC	20%
Nutrition services	41%
PMTCT referrals	127%

Objective1: Strengthen the organizational, technical and leadership capacity of civil society and the public sector to deliver project services to target populations.

Capacity Building of CSOs

During the quarter, CCP continued to support local CSOs in the planning and implementation of activities. Each CSO selected has a workplan and monitoring and evaluation (M&E) plan to ensure that a clear path for implementation has been developed. CSOs have been trained on the use of M&E tools which include family intake forms to identify health and social support needs of families and individuals reached. The tools also assist in the management of caseloads to track progress in achieving better health for

patients who are HIV positive and referrals to existing services in the community to support on-going clinical care for HIV patients and social support needs, especially of OVC.

On administrative issues, each CSO has been trained on monthly report formats to be submitted to track implementation progress which includes data collection forms and monthly narrative reports. Financial reports are also required to be submitted on a monthly basis with supporting documentation. The finance staff provides initial training during the start-up workshop with follow-up provided via telephone or on site, depending on the skills and abilities each CSO has in tracking and recording expenditures.

During the quarter, CCP held on-going meetings with the Capable Partners (CAP) project to further define organizational capacity building approaches and available technical services to strengthen CCP supported local organizations in this domain. As the MONASO contract reached an end after initial organizational capacity assessments were carried out on each CSO, the data gathered during the assessment was used to identify a tailored approach including specific areas of training and on-site mentoring to be provided to CSOs in Maputo and Sofala provinces. Trainings proposed include development of policy and procedures, financial management, human resources, governance, and board development. Finalization of the partnership between CCP and CAP should be complete next quarter pending final negotiations on the technical services to be provided by CAP and approval by USAID. FHI 360 remains responsible for providing capacity building in the technical implementation, M&E, and financial reporting areas.

In monitoring local organizations this quarter, systematic site visits took place by each Provincial Lead to review the integrity of implementation and quality of services to be delivered. Visits were conducted jointly with GRM officials from SDSMAS and DPS to ensure integrated and quality service provision.

Technical assistance visits were also organized with ANEMO and the Provincial Leads in Sofala, Niassa, Manica and Maputo province. (note: Provincial Leads are the consortium partner INGOs: FHI 360, Africare, or World Relief, depending on the province.) Since ANEMO is the lead technical organization who trains facilitators and *activistas* in home-based care, follow-up visits to local organizations were made to monitor and support caregiving activities. Further, the visits strengthened linkages between government partners, Provincial Leads and district level authorities.

Trainings

Integrated HBC/OVC

This quarter, the integrated HBC/OVC training continued to be rolled-out to the provincial sites. ANEMO and MMAS master trainers facilitated the training which used the pilot integrated curriculum for HBC and OVC caregivers. Both supervisors and *activistas* in Tete, Sofala and Niassa provinces participated. In Tete province a total of 200 *activistas* from 9 districts participated in the Integrated Caregiver training and 9 trainers (6 from Tete, 3 from Manica) were fully accredited. In Sofala and Maputo provinces, 53 newly recruited *activistas*

(45 from Sofala and 8 from Maputo) were trained using the integrated HBC/OVC curriculum.

In Sofala province Kugarissica, the CSO covering Beira district, has played a pivotal role in linking with the ROADS project implemented in the same district. Coordination with ROADS has resulted in increased coverage. Kugarissica has been receiving HBC referrals from the ROADS project team, as well as referring project enrollees to the ROADS community counseling and testing activity.

In Cabo-Delgado 21 *activistas* were provided with initial HBC/OVC training in the single project district Pemba and Niassa province trained 20 *activistas* and accredited three trainers.

OVC Minimum package

As part of the CCP commitment to provide quality community services and address gaps in OVC support services, in Tete Province a total of 60 *activistas* from three districts received trainings on the OVC minimum package. This training provided knowledge on the minimum standard services established by MMAS to support OVC. Dondo district in Sofala Province, in collaboration with SDSMAS, provided a pilot training on OVC assessment using the CSI Matrix to a total of 17 *activistas*.

Village Savings & Loan Groups

This quarter, Project HOPE rapidly facilitated partnerships between the Provincial Leads and the economic strengthening CSOs funded by Project HOPE GUCs. In each province, Project HOPE subgrants to one CSO to lead the implementation of village savings and loan (VS&L) groups as part of the CCP economic strengthening component. The three initial CSOs for Inhambane, Manica, and Sofala provinces successfully initiated the VS&L early mobilization phase which introduces the concept of the VS&L activity to community groups served by CCP. The introduction provides an overview of the methodology and operations of a VS&L group, and tips for continued commitment by the groups over the long-term. Further during this quarter, 38 new VS&L community facilitators were identified (22 in Sofala, 16 in Manica) and trained. The next step of implementation is the Intensive phase which includes self-selection of group members, voting for group leaders, and defining group functions and procedures for managing funds. It is in this phase that the group initiates savings. Going forward, the community facilitators play an important role on follow up and supporting the formation of groups.

In Maputo Province, where Project HOPE is responsible for direct implementation, the 27 VS&L groups formed during last quarter have entered the intensive phase (initiated savings), and one additional group was formed. The number of people participating in VS&L groups in Maputo province has increased from 544 to 603. This economic strengthening approach is not a quick fix for impoverished communities, but rather takes a long term developmental view to improvement of household well being. The VS&L groups and the later phases covering financial literacy and income generating activities (IGAs) require a substantive change in mindset that takes time for genuine uptake on the individual level.

Monitoring and Evaluation

To increase CSOs capacity in monitoring and evaluation (M&E), the Project conducted trainings for a total of 527 *activistas*, supervisors and coordinators amongst project sites in this reporting period. These trainings were focused on use of M&E tools, including data collection, data flow, data analysis and reporting.

A complete summary of all training activities from the quarter are detailed below in Table 1. Given the need to collect quality data, emphasis this quarter has been on training on the M&E tools in each of the provinces at various levels.

Table 1: Training Summary for Q2 Yr 2 (numbers of people trained)

Province	Integrated Curriculum for HBC/OVC	OVC Minimum package or assessment	HBC only	VS&L	M&E	MHealth initiative	Trainer Accreditations
	A	B	C	D	E	F	G
Maputo			8		1	30	
Manica			19	16			3
Tete	93	60	107		69		6
Cabo Delgado			21		21		
Niassa	44				111		3
Inhambane			30		136		
Sofala	40	17	22	22	189		
Total	177	77	207	38	527	30	12

Notes on the Training Summary Table 1 above:

Column A reflects piloting the Integrated HBC/OVC curriculum for supervisors and *activistas*, facilitated by ANEMO and MMAS master trainers for supervisors, or by accredited trainers for *activistas*.

Column B reflects OVC minimum package training to new Tete CSOs who had no previous OVC care and support experience, to provide *activistas* with knowledge on the MMAS minimum standard of services to support OVC, facilitated by FHI Technical Officer.

This column also reflects the pilot training on using the CSI Matrix in Sofala with DPS.

Column C reflects HBC only (non integrated curriculum)

Column D reflects trainings provided to community facilitators on forming and leading VS&L groups in Manica and Sofala provinces, by Project HOPE.

Column E reflects trainings for *activistas* on M&E tools in Niassa, Inhambane, Tete, Sofala and Cabo Delgado Provinces. In Niassa and Inhambane, the FHI M&E Senior officer additionally provided on the job M&E training to the Provincial Technical Officers.

Column F reflects training for pilot implementation of the MHealth initiative carried out in Manhiça district in Maputo province, by Project HOPE.

Column G reflects the number of HBC or Integrated Caregiver Trainers successfully passing the ANEMO or ANEMO/MMAS trainer accreditation process to be able to train *activistas* in their own provinces or districts.

Technical Working Groups

As part of the effort to improve national policies and standards of care for targeted groups, the project team continued participating in technical working groups (TWGs) at all levels: national, provincial and district. This provides a key opportunity to influence and build capacity within and between the government structures and other stakeholders. These TWGs focus on key elements of USAID Community Care Program, including OVC, HBC, Gender, QA/QI, Integration of HBC and OVC, PMTCT, Nutrition, and income generation activities for targeted groups.

Through the Technical Group for Orphans and Vulnerable Children (GTCOV) at the national level, the Project participated in drafting a Manual to Support Child Protection Committees. The manual is expected to be completed next quarter. As well, discussions on establishing a TWG on psychosocial support have advanced to later stages, with development of TORs which now await MMAS approval. In Manica province, CCP partner Africare participated in that province's GTCOV Annual Meeting, which evaluated 2011 activities and planned for 2012. Since CCP project activities intentionally align to GOM national OVC strategies and goals, our Africare partner example in Manica reflects the expected project activity of collaborating with GOM line ministries on developing Strategic Social Plans (PESs), Annual Operational Plans (POAs), and other annual planning mechanisms.

While the new MOH HBC national strategy is still in development in the HBC TWG, CCP staff advocated in this reporting period for inclusion of trainings, monitoring and supervision, ultimately for standardization across national implementation. CCP staff also advocate for the possible introduction and use of palliative care drugs (Opioids) in the national policy, still under discussion with MISAU and MOPCA, to better address the unmet pain relief needs of PLHIV of all ages. MOPCA carried out a pain assessment in 2011, and is now developing curricula to train nurses in both the clinical and community settings. Policy change documents to expand prescribing and dispensing authority more broadly to district level health system providers have been submitted to work their way through the MISAU structure.

In the PMTCT TWG, initial discussions have taken place to establish a minimum package for community PMTCT service provision. The project is participating in this dialogue and will be contributing to its development, ultimately beneficial to standardize community PMTCT activities across all implementing partners, within CCP and other projects active in Mozambique.

Objective 2: Strengthen coordination, collaboration, linkages and partnership within and across sectors to promote the development of more efficient and innovative community-based multi-sectoral responses in support of target groups

Integrated Referral Networks

This quarter, USAID Community Care Program made significant, progress in strengthening referral networks. With the introduction of the new comprehensive referral form developed by FHI 360 project technical teams that includes a paper based feedback loop, the referrals and counter-referrals system is now operational in many districts of the Project. This referral form was expanded from an existing MOH form to include referrals to both social and clinical services. The form was also improved with multiple carbon copies, all bound in a “block” to best facilitate the feedback and completion of referrals and counter-referrals by tracking the copies remaining in the caregivers’ keeping.

The CCP carried out trainings on the use of the referral and counter-referral form with the CSO *activistas* in the following provinces: Manica (2 districts), Sofala (2 districts) and Niassa (3 districts), but also included Health Unit *Técnicos*, SDSMAS Social Welfare Officers and representatives from GAVV (Gabinete de Atendimento de Vitima de Violencia - Office on Victims of Domestic Violence). This methodology logically promotes referrals from the institutional side **to** the project, as well as **from** the community based services to the clinical and institutional services providers. The selection of these districts was based on the fact that CHASS SMT and CHASS Niassa implement clinical-based care and services activities in the same provinces, and this referral form will facilitate linkages and collaboration between the different projects within FHI 360. When this form receives MISAU and MMAS official approval, universal use of the referral form across all project districts will facilitate linkages and collaboration between this project and all referral clinical sites, including those supported by CDC funded projects.

In addition, CCP and CHASS SMT leads in Sofala province inaugurated the practice of joint site visits to district level CSOs and their referral clinical sites. This practice will become standard as the provincial teams of each project take it up. This model provides an ideal opportunity for strengthening the referrals network through discussing concerns, establishing a shared understanding of a “complete” referral, strengthening the communication for supporting a continuum of care.

A key element in the referral system is to tap into existing community resources. CHASS SMT and CHASS Niassa are funding community case managers (CCMs) to support *busca activa* (finding ART defaulters) and linkages between clinical and community services. CCP is actively coordinating the linkage between *activistas* and CCMs to maximize reach within the community and to minimize overlap in services at the district level. In other project provinces, district health centers have Peer Educators who function as *busca activa* partners the same way as the CCMs do in the CHASS projects provinces. The methodology is the same for both type of collaborator, the CCM or Peer Educator brings the clinic list of ART defaulters to the *activistas* who assist with finding such persons based on their knowledge of the communities. Peer Educators based in EGPAF supported clinics also contribute positively to the referral and counter-referral system. For example, in Inhambane Province, meetings were held including project staff, SDSMAS and other local organizations to improve the referral and counter-referral services for the health center to better follow up on beneficiaries and improve quality of service provision to HIV/AIDS

patients. These also served to clarify areas of operation by sharing geographic coverage of each organization to eliminate duplication of patients and service provision.

USAID CCP teams at provincial and district levels continue to participate in existing forums to coordinate with multi-sectoral partners to strengthen the referrals networks. In Manica province for example, project staff participated in the Manica International NGO's Forum – (FONGIM) to strengthen coordination with GOM structures and amongst INGOs. Participating in all such forums contributes to greater clarification on NGOs intervention areas to best leverage each other's implementation and contributions to GOM strategies and plans, and to avoid duplication of services.

Collaboration with Other donor projects and associations

The CCP team capitalized on numerous opportunities over the past quarter to strengthen collaboration and coordination with other projects and institutions. In Manica, Africare was a key partner in actualizing the TB/HIV Task Force meeting, organized by DPS and CHASS SMT. One significant outcome of the first meeting was that *activistas* would now participate in the regular SESP¹ meetings on Education and Public Health at the Health Units, to improve community-clinical services linking. As a next step, DPS will be expanding the task force to better interact with organizations working on HIV and TB issues in all Manica province districts.

The World Relief team in Inhambane met with Project HOPE and Kukula, the economic strengthening CSO partner, to concretize the initial VS&L activities. They also met with CARE Mozambique who is carrying out a similar community savings and loan scheme in the same areas, to best coordinate coverage sites. The more VS&L groups that arise, communities will increase their access to savings which can be used to improve household well being. Meetings between CCP staff and all five Inhambane project district SDSMASs promoted the joint support/supervision visits and strengthened the partnership between the Provincial Lead and SDSMASs. The joint supervision visits also provided an opportunity to evaluate the quality of the data reports submitted by each CSO.

In Sofala and Manica provinces, project staff participated in the DPS meetings to review activities and provide input to the draft 2012 National Strategic Plans (PES, POA). Manica project staff also met with other PEPFAR supported programs to discuss coordination and mutual use of all relevant national guidelines (e.g. Agrifuturo, former AED's Capable Partners Project, World Bank and Global Fund, PMI).

Partnership and collaboration between USAID CCP and PSI in this reporting period consisted of revising the PSI Family Health Kit data collection form, and updating the training and kits refills plans. PSI will continue to provide the Family Health Kits as well as provide training on using the kits to the *activistas*, who cascade that knowledge to the families in their care.

¹ Sector de Educação para a Saúde no Distrito (Health Education)

Joint supervisory visits between ANEMO, SDSMAS, and CCP staff were carried out to evaluate the quality of services provision (by *activistas* and trainers). The visits have been useful in identifying common issues throughout the various provinces, such as insufficient social services to meet community needs, thus impeding referral processes. Families are often poor and registering for a poverty certificate can be problematic. The *activista* may initiate the process, involving the community leader who must provide a “declaration” of need, which is then taken to SDSMAS, or the Civil Registrar, or INAS. It was found that some officials charge a fee for the poverty certificate, which thus makes a barrier to obtaining this vital document. Without the poverty certificate families are not able to access services to support their livelihood which feeds back into the cycle of poverty. Further, the district level agency designated to provide subsidies for needy families frequently does not have sufficient funds to fulfill this service. In light of these system level challenges, CCP can perhaps carry these findings to MMAS colleagues at the central level. At community level, efforts can be stepped up to spread the knowledge that the poverty certificate is meant to be free of charge, so that families (as consumers of public services) can be better informed.

Coordination with Public Sector

USAID Community Care Program is also striving to ensure close coordination with the public sector. The CCP is contributing to the MISAU national pilot of the GAACs (community based treatment support groups for PLHIV). *Activistas* refer their clients to their clinic partners wherever a health unit is supporting a GAAC pilot site. The practice of first going through the GAAC participation criteria with their HBC clients before referring was initiated successfully in Manica province, with CCP and CHASS SMT working collaboratively. To address fewer men joining GAACs than women, *activistas* will continue to remind and follow up with all PLHIV, encouraging them to check with their local clinic for a referral to a GAAC that is geographically accessible. Since national statistics show HIV prevalence among women as disproportionately higher than in men (about 13% and 9% respectively), some imbalance within the GAACs might be expected.

Manica project staff are further working in coordination with CHASS SMT for distribution of ART adherence IEC materials. In Inhambane, CSO-promoted visits took place among four GAACs to exchange experiences in the strengthening of these groups. With the MISAU TORs to guide operationalization of the groups, there are many successes to highlight: communities speak more openly about HIV/AIDS and the GAAC sets a platform for fighting against stigma and discrimination, as well as other pressing issues affecting PLHIV.

In addition, coordination meetings with SDSMAS, CCP staff participated in four other monthly TARV committee meetings in Inhambane. These meetings are attended by health center HIV staff and HBC organizations, to coordinate services and harmonize activities, and to best divide treatment defaulter lists to avoid duplication of efforts for *busca activa*.

District Level Service Directories

Yr 1 CSOs are currently carrying out the annual updating of their own district’s Service Directory developed from the initial project Mapping exercise. These Service Directories

are a supportive component to both collaborations described above, with GOM and other organizations. During this reporting period, an inventory of community groups such as CLC, CSC, CCPC, M2M was completed, forming the foundation for broader social safety nets in the communities and basic capacity building plans to be developed going forward.

Public Private Partnership

Project HOPE leads the private sector partnership with Banco Oportunidade de Mozambique (BOM), a partnership to ensure quality financial literacy modules for VS&L groups and later to link “graduating” groups to financial institutions. During this reporting period, planning, and compilation of the Financial Literacy Manual were advanced, and technical discussions took place with Project HOPE HQ-based Director of Economic Strengthening Programs.

Objective 3: Increase availability, accessibility, and use of family-centered, age-appropriate, and gender equitable care and support services for target groups

Services Provided including Referrals

Integrated HBC and OVC services

Piloting the Integrated Caregiver curriculum for HBC and OVC care and support was completed at the end of this reporting period. Results were presented to the bi-annual CCP Advisory Council in March, consisting of partner Ministries of Health, and Women and Social Action, USAID, consortium partner country directors, as well as FHI 360 country director and project COP. Analysis of the results recognized that there is an advantage to having one *activista* providing integrated services to target groups **as families**, addressing individual family member needs. One *activista* following the various modes of care and referral means the household will receive consistent service. Another advantage is that the integrated trainings strengthen and assure linkages between the project main partners MMAS and MISAU, and other implementing partners. However, the Advisory Council did recommend the following: (i) review the selection criteria for TOT participants to better assure existing capacity to serve as a trainer and to improve the accreditation rate; (ii) revise the HBC/OVC curriculum contents to assure sufficient OVC care and support coverage; and (iii) upon completion of recommendations and subsequent revision, the curriculum must receive final approval from MMAS and MISAU.

While it is too early in the utilization of the Integrated Caregiver to draw conclusions about this model, an early challenge found in the field is actually applying the ‘family approach’. Our response is to step up CSO level accompaniment, technical assistance, and mentoring where we have found this early challenge. Long term OVC care and support is discussed in other sections.

Clients reached with HBC

Table 2 and Graph 2 below show that a total number of **7,245 clients** (2,502 males and 4,743 females) received HBC provided by community *activistas* in this reporting period. 2,043 new clients entered HBC; added on to 5,202 clients in care at the end of Q1 Yr 2 and carried over to Q2 Yr 2. 205 deaths occurred, slightly below 3%, of which 92 were males and 113 were females. There do not appear to be consistent death rates across the CCP

provinces and districts, likely due to status of illness when entering HBC, co-morbidities, and the many other variables at play. 87 clients or slightly above 1%, have left the program in this reporting period due to various reasons; anecdotally we know that limited ability to buy food, alcohol abuse and change of residence are some. A total of 832 clients graduated from the program based on the MOH criteria. A total of 6,121 clients will carry forward into the next quarter.

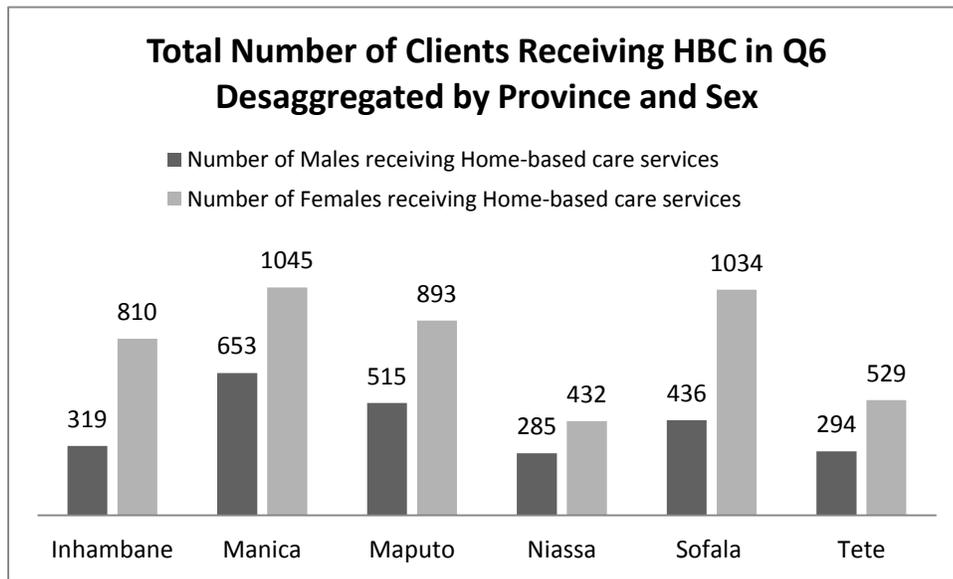
A total of 832 clients or slightly below 12% of HBC clients graduated from HBC according to MISAU criteria. This result shows an increase of 2% over the last quarter. Use of bicycles and motorbikes distributed to *activistas* and supervisors respectively, facilitated their regular visits to beneficiaries.

Table 2: Total number of Clients Reached in Q2 –Yr 2 with HBC by Outcome

Province # of districts providing HBC this period	# of Males receiv- ing HBC	# Females receiv- ing HBC	Total # of clients receiving HBC	# of clients aged 0 to 14 years old in HBC	# of clients 15 years and older in HBC	# of clients alive and in HBC	# of clients who received HBC Lost to Follow- up	# of clients who received HBC who are Dead	# of clients who received HBC who are Discharged
Inhamba ne 5 districts	319	810	1,129	105	1,024	1,025	17	24	63
Manica 10 districts	653	1,045	1,698	192	1,506	1,400	29	49	220
Maputo 5 districts	515	893	1,408	239	1,169	1,327	15	29	37
Niassa 3 districts	285	432	717	87	630	464	5	33	215
Sofala 12 districts	436	1,034	1,470	129	1,341	1,097	20	66	287
Tete 5 districts	294	529	823	39	784	808	1	4	10
Total	2,502	4,743	7,245	791	6,454	6,121	87	205	832

Table 2 above and Graph 2 below also describe performance of HBC service provision across all project provinces in Q2 Yr 2, except Cabo Delgado. Number of districts in a province and actual variations of timing of start up are factors reflected in the table.

Graph 2

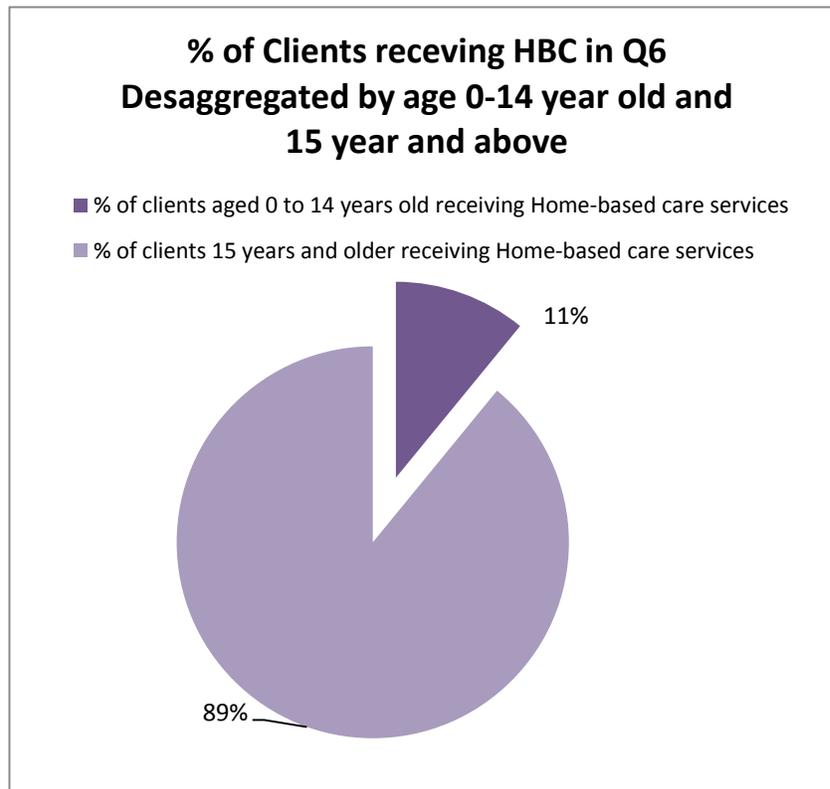


As per the above graph more females are reached with HBC services across all project provinces, at 53% of total HBC clients. This remains consistent with previous quarters' enrollment and service delivery.

From the 7,245 clients who received HBC services in this reporting period, 6,454 are 15 years and above and only 791 are between the ages of 0 to 14 years, around 11%.

|

Graph 3



Orphans and Vulnerable Children

Care and support for OVC may be the most sensitive area of CCP programming, with the most change in approach, the most innovation, the steepest learning curve for quality implementation. CCP continuously strives to improve implementation through training, supervision, reporting, and analysis. Seeking ways to assist the community *activistas* in OVC assessment, action planning, and follow up, in Q2 Yr 2 the project piloted the CSI Matrix for OVC Assessment and Follow up in three diverse provinces; Matutuine in Maputo province, Dondo in Sofala province, and Manica district in Manica province. The pilot concluded that the Matrix is an instrument which can be used easily by *activistas* because it is pictorial in nature, with demonstrative figures. This tool will be incorporated into the Integrated Caregiver curriculum for future such trainings, and will be disseminated to all current *activistas* through ongoing technical assistance.

Thanks to the CCP family approach, orphans and vulnerable children are the project's most reached target group. Table 3 below shows the number of OVC reached disaggregated by province and service areas.

Table 3 revised: Number of OVC Reached in Q2 Yr2 Disaggregated by Province and Type of Service

Province	Number of OVC from end Q1 Yr 2 (old)			Number of OVC Enrolled in Q2 Yr 2 (New)			Total number of OVC Currently Receiving Care end of Q2 Yr 2			A	B	C	D	E	F	G
	M	F	Total	M	F	Total	M	F	Total							
Inhambane 5 districts	657	837	1494	26	5	31	683	842	1525	4	533	0	343	393	743	238
Manica 10 districts	446	577	1023	1753	1904	3657	2199	2481	4680	0	995	0	2246	263	1582	243
Maputo 5 districts	823	847	1670	509	433	942	1332	1280	2612	3	1157	0	597	779	2015	388
Niassa ** 3 districts	0	0	0	8	11	19	8	11	19	0	0	0	0	16	19	0
Sofala 12 districts	334	357	691	1459	1564	3023	1793	1921	3714	24	1571	0	1297	1887	2179	1145
Tete *** 5 districts	0	0	0	9	9	18	9	9	18	0	9	0	3	5	4	6
Total	2260	2618	4878	3764	3926	7690	6024	6544	12568	31	4265	0	4486	3343	6542	2020

The revised table now matches the SAPR12. Discrepancies had occurred when one province submitted numbers of OVC registered but whose services delivery could not be verified during DQA. Those OVC numbers were thus deleted from the SAPR12.

*** Niassa Province is having very significant data collection, reporting, and analysis problems in this reporting period. Both the FHI 360 Strategic Information Director and CCP team are already investigating and rectifying.*

**** Tete Province implementers are just collecting data and reporting for the first time. The reporting structure serves to alert CCP managers to 'repeat counting' and other problems at the field implementation level, and the team takes such things very seriously to respond with robust follow up and technical assistance.*

In both cases where there are discrepancies, CCP is opting to report the number of enrolled OVC for this quarter to avoid inflating numbers when we are not certain about actual service deliver.

Column A: Economic Strengthening Services

Column B: Food and Nutrition Services

Column C: Shelter and Caregiving Services – while this is a PEPFAR service area, the MMS data collection system on OVC care and support does not include this area so we have no data to report. Additionally, our implementing partners report that it is culturally

mandated for grandparents or other family members to take in OVC as needed so that reporting on shelter finding is not relevant.

Column D: Education or Vocational Training Service

Column E: Health care referral services

Column F: Psychosocial, social and/or spiritual support

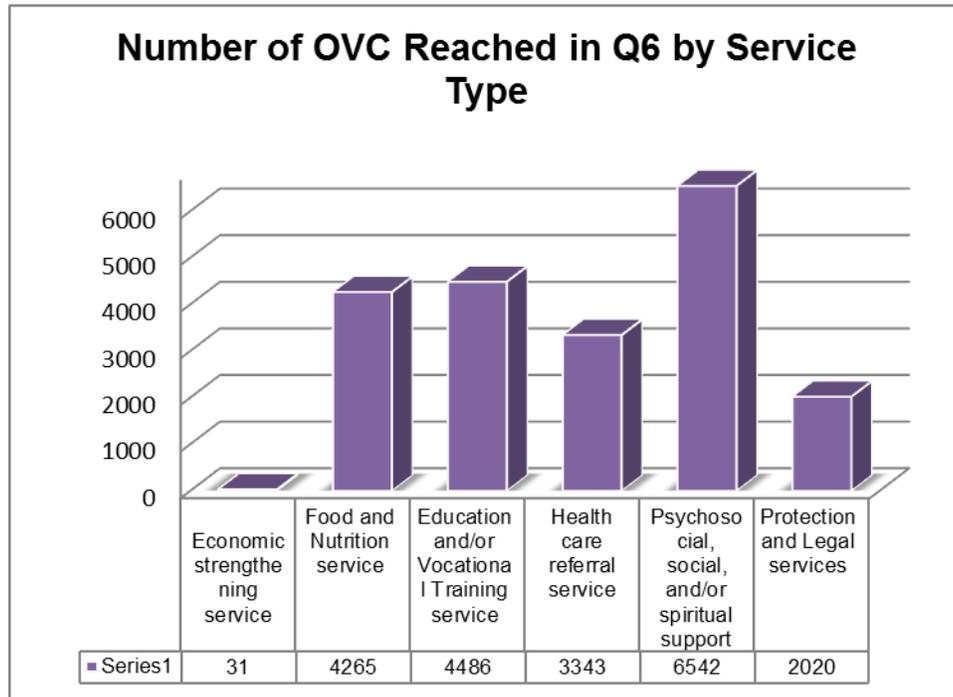
Column G: Protection and Legal Services

The table above shows performance on care and support services provided to OVC during Q2 Yr 2. A total of 12,568 OVC (6,544 females and 6,024 males) received care and support whether directly by the community *activistas* or through the services referral system established by the project at community level in collaboration with SDSMAS, existing community organizations, and clinical sites. CCP shows an increased enrollment of 30% over Q1 Yr 2 enrollment, and continual increases are anticipated over the rest of this project year. Trainings on Psychosocial Support, OVC minimum package and M&E contributed positively to the identification, service delivery and reporting, of OVC services.

Recognizing the tremendous gap at all levels in the area of Psychosocial Support (PSS), the project has been working diligently for several months to address this programming concern. Two quarters ago saw the REPSSI pilot of PSS training for supervisors, and *activistas* in selected areas. Last quarter the project issued a public tender for a provider to create a cadre of PSS trainers based in SDSMASs and project CSOs across all project districts. This ToT model will 1) build sustainable resources and capacity for supervision, mentoring, and refresher trainings **within the districts**, and 2) gain some efficiencies by avoiding having to fly trainers from Maputo or outside country to the implementation areas. Contract finalization will occur early in the next quarter. CCP also completed an inventory of all project districts and learned that each SDSMAS has on staff a focal point or “*tecnico*” covering OVC and/or Social Action. Once the Trainers are accredited, they will cascade the trainings to *activistas* in their districts. Targeting one SDSMAS staff and CSO supervisor also further deepens the partnership between the CSOs and their partner SDSMASs as they will jointly train the *activistas* and jointly provide supportive supervision.

|

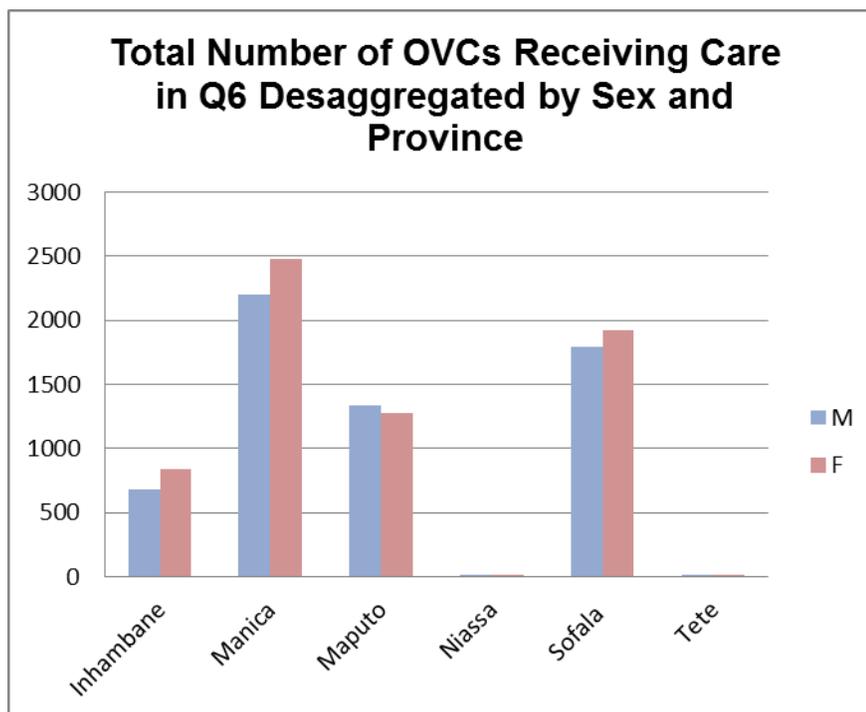
Graph 4



Graph 5 below shows number of OVC reached in this reporting period, disaggregated by province and sex. Tete just started implementing this quarter and new Yr 2 Niassa districts will start their implementation next quarter.

|

Graph 5



PMTCT Services

During this reporting period, 760 pre- or post-partum women were referred to PMTCT services by implementing CSO *activistas*, of which 188 pre-partum women are in HBC. This affirms that the project is reaching beyond the project enrollees to the broader communities for identifying and referring this target group to needed services.

The CCP implementing partners report their numbers as completed referrals of pre- or post-partum women to PMTCT services, confirmed by health unit visit cards, prescriptions, and where piloted, the FHI 360 referral / counter-referral form. From the high level USAID site visit to Beira district in Sofala province in March, however, we know there is a mixed or perhaps immature understanding of “completed referral”. CCP will continue to develop the understanding of this vital programming area, aware that the project is “raising the bar” on referrals to clinical care. In the past, as soon as anyone sent someone to the clinical site, that was a “referral” regardless of affirming the person went to the clinic, the person was attended to by clinical staff, the person went all the way through to receiving the treatment intended by the referral. This is another long term developmental issue, depending on a change of mindset. CCP is committed to promoting this change in mindset, over the life of the project.

Adherence Support

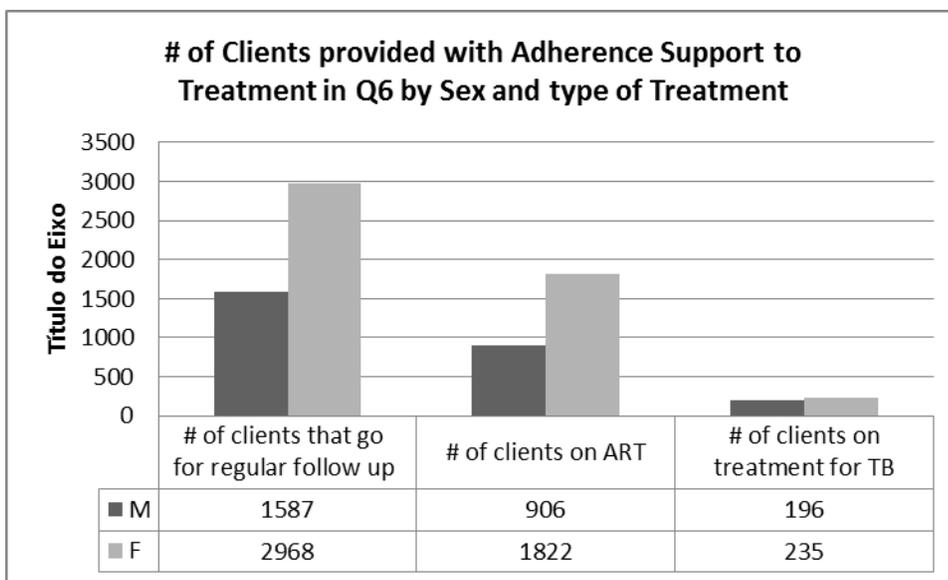
Table 4 below gives a summary of adherence support provided by community *activistas* to HBC clients on ART, or TB treatment. 2,728 of HBC clients are currently on ART, 431 clients are receiving adherence support for TB treatment. Adherence support is a continuous process of counseling PLHIV by *activistas* to maintain their treatment and ensure they take their medications correctly.

Table 4: Adherence Support

Description	# Of clients 0-14 years old (n=791)	%	# of Clients 15 years and above (n= 6454)	%	Total
# of clients on ART	362	46	2366	37	2,728
# of clients on treatment for TB	66	8	365	6	431

In the last quarter more women than men are accessing treatment, this trend continued in this quarter as demonstrated in the Graph 6 below, where 1,822 women are receiving ART compared to 906 men.

Graph 6



Busca Activa

This adherence support activity focuses on returning PLHIV who have defaulted on their ART to their treatment regimens. The referral Health Unit (HU) case manager shares their clinic list of ART defaulters with the CSO community *activistas*, to assist the clinic teams on searching for and returning such clients to their ART regimens. This collaboration between clinical and community based services providers is a better way to find such PLHIV, than using clinical staff alone. The *activistas* are based in the communities and have good potential for contributing to improved treatment outcomes overall. Table 5 shows that from the lists of 1,671 ART defaulters across the project districts,

849 or 51% were identified and referred to health units (HUs), of which

697 or 42% of the total actually returned to their HUs,

152 opted to not return.

Thus the remaining 822, or 49%, were not found in this quarter.

Table 5: Busca Activa

Province	List of PLHIV given to CSO for BA				Identified and referred back to their Hu				Number who did actually return to their HU			
	0-14 Years old		15 Years and older		0-14 Years old		15 Years and older		0-14 Years old		15 Years and older	
	M	F	M	F	M	F	M	F	M	F	M	F
Maputo	2	5	59	122	2	3	45	68	1	2	24	53
Inhambane	6	11	137	271	3	6	33	68	2	5	26	45
Manica	5	1	182	220	2	0	78	85	2	0	69	71
Sofala	19	33	148	213	13	22	98	130	12	19	81	105
Niassa	3	8	99	123	3	7	91	88	3	6	90	77
Tete	0	0	2	2	0	0	2	2	0	0	2	2
TOTAL	35	58	627	951	23	38	347	441	20	32	292	353

Nutritional Services:

A total of 8,141 individuals benefited from the nutritional support component, this shows an increase of 7,098 over last quarter. Inhambane Province reached 2,734 individuals out of which the the larger number of individuals (1,568) were in the age range 15 to 17 years old. The same scenario applies in Maputo province. Table 6 below details individuals reached with nutrition support services in accordance with PEPFAR guidelines (C-FOOD.01), which describe nutritional support as nutritional counseling or education, cooking demonstrations with nutritional foods, household nutrition garden demonstration, or referral to nutritional rehabilitation service all under one indicator. The age range of 0-14 years old is not well suited for this type of intervention; anecdotally we know that it is really older children in this age group, 12-14 year olds, who can best benefit from these direct interventions. We can consider the children aged 0-12 years old as perhaps secondary beneficiaries, when their parent or guardian is the one receiving the direct nutritional service interventions.

Table 6

Province	0 to 14 years old	15 to 17 years old	18 and over	Pre Partum Women	Total
Inhambane	401	1,568	695	70	2,734
Manica	121	170	0	243	534
Maputo	625	800	193	780	2,398
Niassa	147	100	188	64	499
Sofala	763	422	453	166	1,804
Tete	70	37	47	18	172
Total	2,127	3,097	1,576	1,341	8,141

As the FANTA III project, now under FHI 360, starts up its implementation, anticipated cross-collaboration will take place to leverage both projects to support community nutrition activities.

Community Care Committees (CCCs)

An assessment was conducted this quarter, to document community structures currently in place, leading up to a strategy to help build their capacity to better serve in the continuum of care. CCCs is a broad category of support groups based in the communities and who play a very important role in the identification of the program target groups, as well as mobilization/sensitization of families to enroll in the program. Table 7 below, gives a summary by province of the number of various Community Care Committees (CCCs) in place.

Community Leader Councils (CLCs) were established in many project districts 10-15 years ago and are also key in identifying families in need of services and helpful in facilitating certain acquisition of needed services. The CLCs were part of the assessment. Child Protection Committee (CCPCs) are still in strengthening/reinforcement phases in most project districts. Currently they are acquiring materials for their functioning such as types of balls and play equipment, and project teams are supporting their development by providing a framework for their operations. Findings from the assessment will identify specific capacity building services to be prioritized for these community level structures. Since Tete and Cabo Delgado are still in start up activities, those CSOs will assess the community committees next quarter.

Table 7: Number of Community Care Committees found by type per Province

Province	Types of CCC			
	CCC	CLC	CCPC	Other groups
Inhambane	24	23	24	0
Manica		04		
Maputo	36	09	14	15 Community Councils for PLHIV (CCPVHS)
Niassa	42	0	0	2 (management committee of MCH death and community management committee)
Sofala	9	58	10	2 (CTARV)
Total	111	94	48	19

One major challenge for the project team is to define a strategy for strengthening these groups without creating dependence on external resources as they deepen their understanding of their self-determined community responsibilities. To facilitate, the Project HOPE economic strengthening VS&L group creation activity will be offered to these community support groups as well. Maturing through the VS&L stages and later IGA development will enable them to establish viable projects tailored to their community profile, allowing them some level of financial viability with which to support continuing community based activities.

Objective 4: Improve capacity of vulnerable households to meet their own needs in sustainable ways by strengthening their livelihoods, care taking and health seeking skills

Village Savings and Loan Groups (VS&L)

This quarter yielded positive trends in establishing village savings and loan groups (VS&L). Maputo province is the most advanced where the VS&L concept has been widely accepted by each of the five project districts. By the end of this quarter, 27 groups have been developed with 603 individuals participating in VS&L groups. Acceptance of this model has been uniformly positive in each of the Maputo districts and it is anticipated community members will remain active as the groups enter into the intensive phase where the groups will elect group leadership, develop a constitution, define management structure and procedures for a social fund. In Table 8 below, the member composition for Maputo province is described showing about 25% are general members of the community “outside of target groups” for good integration. VS&L group membership by sex shows more women (466) are participating in groups than men (137), per Graph 8 also below.

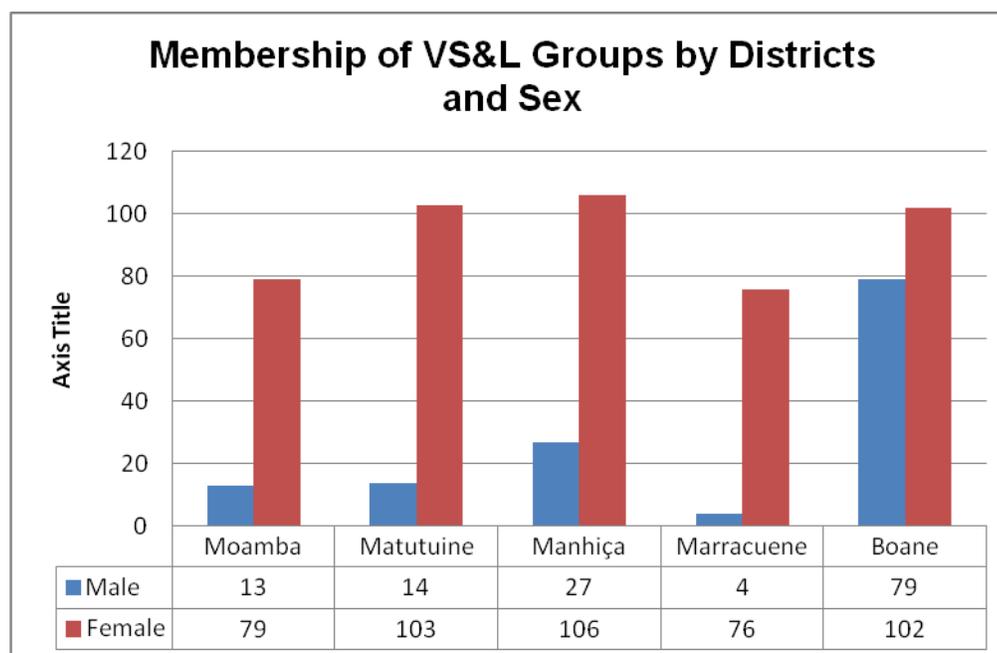
In Sofala and Manica provinces, Project HOPE through GUCs is supporting local organizations in the Mobilization phase to develop VS&L groups. By the end of this quarter, 22 facilitators in Sofala, and 16 facilitators in Manica Province were trained to mobilize communities to participate in the VS&L groups. In the next quarter the groups will be formalized and will move into the Intensive phase.

To monitor progress of the VS&L group members, a household member profile has been developed. Project HOPE will be training each of their subgranted provincial economic strengthening CSOs on its application. Where Project HOPE is a direct implementer (Maputo), the tool will be administered by Project HOPE staff. In Cabo Delgado, Project HOPE is working directly with Kaeria, the local organization funded through FHI 360 CCP. Kaeria will receive technical support on the implementation of the tool which first provides the baseline for household economic well being.

Table 8: Number of VS&L Groups in Maputo Province by District and Community Member Type

District/ Category of members	Number of Groups	HBC activ- istas	OVC care- givers	PLHIV	CCC mem- bers	M2M mem- bers	Com- muni- ty at large	Male	Female	TOTAL
Moamba	04	22	12	20	9	17	12	13	79	92
Matutuine	05	18	12	44	6	18	19	14	103	117
Manhiça	06	27	13	23	5	10	52	27	106	133
Marracuene	04	18	12	37	5	8	00	4	76	80
Boane	09	20	26	35	10	22	68	79	102	181
TOTAL	28	105	75	159	35	75	151	137	466	603

Graph 7



Skills Transfer

The role of the *activista* extends beyond providing HBC services to clients in need and care and support for OVC. During the home visits, *activistas* provide life skills to families so they can be more reliant on themselves and less on the *activistas* for caring for their family members. Emotional and spiritual support are provided to family members in need, as well as how to keep clothes clean and cook nutritious foods. Family members also receive household cleaning materials known as the Family Kit (bucket, broom and soap), and different than the PSI wrap around service of Family Health Kit discussed below. Maputo Province shows the highest rate of skills transfer having reached 522 people. Niassa reached 211 people and Sofala reached a total of 289 people. This assures continuum of care to HBC client.

Family Kits from PSI

The USAID funded PSI Family Health Kits are a means of providing practical support for good health and hygiene in the home, complementing the Family Kit described above, and serve as an excellent wrap around service for this project. During this reporting period new beneficiary numbers were sent to PSI for this year's provision of kits and refills.

MHealth Initiative

Partnership with MCell has taken a step ahead with startup of pilot implementation of the MHealth initiative in Manhiça district in Maputo Province. A total of 30 *activistas* from ACIDECO (CCP funded CSO) were trained to operate the MHealth system. CSO *activistas* are responsible for identifying beneficiaries and the message type they need as well as orienting beneficiaries on the MHealth initiative. Based on a menu of educational messages and reminders to be sent directly to CCP beneficiaries via their cell phones, the *activistas* fill in a form indicating the needed communication and submit to the CSO information manager who disseminates the messages using the MCell technology installed on their computer. This manager collaborates with the health facility and any other community associations involved. The objective of the messages is to enhance *activistas* activities on ART adherence, pre- or post-partum women clinical consultations as well as nutritional habits, while empowering program recipients.

As well, productive negotiations between FHI 360 CCP, its consortium partners, and USAID have taken place regarding a process evaluation of this activity. MHealth initiatives can be very useful in low resource environments where cell phone usage is high, and the project anticipates that there are important lessons to be learned from this project component.

1.2 Challenges and Ways to Overcome Challenges

Areas Requiring USAID Assistance

Realistic Year 2 Targets

The project experienced unanticipated delays in Year 2 start up districts which seriously compromise the annual services delivery targets in the approved Year 2 Workplan. A revised set of realistic targets was submitted to USAID, but the 2012 COP was already locked in. The project needs USAID support for the revised targets of 18,600 and 93,000 for HBC and OVC respectively, since the majority of the Yr 2 targets were based on all 13 Tete province districts being operational by the first quarter of Year 2. The delays are well documented and well known, and are mainly due to insufficient pool of registered or capable CSOs in that province from which to draw for CCP implementation.

CSOs Capacity Building

During this reporting period, USAID has already stepped in with approval for the Capable Partners project to support CCP in some areas of CSO Capacity Building. The CCP will need USAID to continue supporting this cross project collaboration to assure expected outcomes in this project component.

Community Services Provision

Challenges:

Ways to Overcome:

Lack of transport of HBC patients to clinics	Investigate community options, research possible bicycle ambulances
Lack of district level food providers	
Broadly higher need for services than communities and social services can meet, especially for OVC,	
Malnutrition is widespread; poor community level mechanisms for identifying	Pursue acquisition of and training on MUAC tapes
Limited household capacity to buy food	The VS&L strategy and subsequent activities that build on it should help with this in the long term
Some districts lack sufficient <i>activista</i> candidates due to below minimum education	
Lack of pain management for clients with Herpes	Liaise with linked health clinics to assure pain coverage
Inconsistent uptake of M&E tools utilization and reporting, impacting deliverables	Roll out intensified CSOs mentoring & monitoring activities. Institute a more rigorous site visit Action Planning process that assures meeting milestones deadlines
Long process to roll out referral counter-referral standard form	Push pilot results for Ministries' approval for full roll out and implementation
Standardize OVC well being monitoring	Roll out CSI now that pilot is concluded
Building the grassroots community committees for long term sustainability	Continuous involvement of community leaders
Community PMTCT activities not yet codified	
Some supervisors lack the correct license	Intensify follow up to assure all intended

for the motorbike intended for joint field supervision	motorbike users have proper license
--	-------------------------------------

1.3 Program and Operational Management

Baseline Survey

The baseline survey field work – quantitative and qualitative data collection – has been completed in previous quarters, and results will be disseminated at multiple levels during the next quarter. While adhering to the original agreed upon deliverables timeline through much of the contract, the baseline contractor in March encountered unanticipated mechanical and equipment failures, significantly impacting the closure of USAID and FHI 360 approvals and the contract. The project plans to disseminate the baseline findings in concert with launching the new project name USAID Programa de Cuidados Comunitários. This contractor has also encountered serious and debilitating health problems, further delaying our receipt of both the PPT presentation responding to USAID queries, and the Baseline report itself. Senior project staff maintain frequent contact with the contractor, when possible (when he is not in hospital for example), to solicit the contract deliverables.

Sub-Contracts and Consultancies

- MONASO subcontract is in Close out process.
- Additional GUCs signed with CSOs implementing in Niassa (1), Tete (7), Sofala (1) and Cabo-Delgado (1)
- Gender Consultancy with Ernest & Young: TORs are to develop a gender strategy and integration plan for the project to weave into its activities and components across all implementing CSOs.
- Project HOPE CSOs for economic strengthening activities in Tete and Niassa provinces are in final USAID approval process.
- Consultancy to provide 52 districts TOT coverage on Psychosocial Support is in finalization process, to yield a cadre SDSMAS and CSO trainers, one each per district. PSS ToT is hoped to take place during the next quarter, depending on final negotiations and approval processes.

Organizational Structure and Personnel

- The hiring process for the CCP Technical Director was completed and candidate, Ms. Ana Paula Ndapassoa, is on board
- The hiring process for the Provincial Coordinator for Inhambane (World Relief) was completed but the candidate very quickly resigned to take another post, yielding a new search. The WR Country Director and M&E Officer are combining to fill the gap while they continue to search for their replacement Provincial Coordinator.
- TOs for 1) Community Mobilization to fill that position vacated by the new Technical Director, and 2) to assist on Economic Strengthening, and 3) the Program Officer, all based in Maputo are in finalization
- TOs hiring to assist on Economic Strengthening in Sofala and Tete are complete

QA/QI

FHI 360 Mozambique has initiated several capacity building trainings for all staff over project years 2011 and 2012. CCP staff, like all other projects national staff, participated fully and benefitted. Under this internal FHI 360 Technical Capacity Building strategy, the FHI 360 QA/QI methodology was taught, requiring a real, hands-on activity upon which to practice the methodology, rather than simply giving a QA/QI exercise which would take time away from real project work. In this context, the CCP team has selected the referral counter-referral system as a quality improvement project. The pilot phase expected to be completed by the end of this quarter was instead expanded to end of April. During follow up on the training for using the referral and counter-referral forms, it was verified that some key social and clinical service providers were not using the form. In order to evaluate the QA/QI and obtain reasonable results, it is important to have all sectors implementing the tool at the same time, thus meriting the delay.

Project Coordination

The Quarterly Management Committee Meeting, comprised of the consortium partner directors and COP was held. Major issues such as technical assistance, project entry points and change of project's name were discussed.

The semi annual Project Advisory Council also met during this quarter, comprised of Ministry of Health and Ministry of Women and Social Action partners, consortium partner directors, FHI 360 Country Director, USAID, and project leadership, yielding recommendations for proceeding with the Integrated Caregiver curriculum, described in an earlier section.

A project team travelled to Niassa to carry out team building and re-define the project's functional structure, including roles and responsibilities of provincial team members. The same process will be carried out with the Tete province team, as they are a new provincial office.

1.4 Financial Summary

Year 2 approved budget: \$ 10,595,223 (included savings from Year 1)

Total expenditure to date: \$ 4,648,155 roughly 44% overall burn rate

1.5 Plans for Next Quarter

Routine Technical Assistance and capacity building site visits on OVC, PMTCT/Nutrition, M&E, HBC, Financial Reporting throughout the Quarter

April 2012

02 - 06 Inhambane CSOs select VS&L facilitators

04 Monthly project Technical Committee meeting, focus on USAID success stories

10 Revision of CSO capacity building with CAP

09 - 13 Joint supervisory visit to Sofala, FHI360 and ANEMO

11 - 13 USAID site visit to Pemba

- 16 - 20 Revision of gender strategy and action plan
- 18 Project semi annual Advisory Council meeting
- 20, 30 SAPR and Quarterly Report submissions
- 23 - 27 Complete and approve the FHI 360 MoUs with MISAU and MMAS
- 23 - 27 Distribution of motorbikes to Yr 2 CSO subgrantees

May 2012

- TBD Baseline Survey Dissemination and New Project Name Launch at national, provincial, and district levels across project provinces
- TBD Psychosocial Support TOT trainings
- 02 Monthly Technical Committees meeting, focus on SAPR and Q2 Yr2 results review
- 07 - 11 Tete project team building trip
- 07 - 11 Data collection and analysis on pilot referral and counter-referrals forms
- 07 - 11 Follow up and monitor on PSI trainings and kit distribution
- 09 - 10 DQA and QA/QI Manhiça district
- 14 - 18 Refresher integrated trainings on HBC/OVC
- 14 - 18 Revision of database for CSO capacity building
- 15 - 19 Pemba field visit
- 15 - 21 Joint supervisory field trip (FHI and ANEMO)
- 21 - 25 Submit revised Integrated HBC/OVC curriculum to MMAS and MISAU for approval
- 21 - 16 DQA Tete
- 25 - 28 Boane field visit
- 28 - 30 Conclusion of Gender strategy consultancy
- 28 - 02 Inhambane field visit
- 28 - 02 Presentation of referrals forms pilot results to MIMAS/MISAU for approval

June 2012

- Nutrition and PMTCT TA site visits
- VS&L monitoring and supervisory visits to all sites
- Project HOPE Intensify implementation of MHealth initiative in Manhiça, start up process assessment with FHI 360, Africare, World Relief and USAID
- 02 - 06 Select and train 4 VS&L community facilitators Manica Province
- 04 - 08 Sofala/Niassa field visit
- 05 - 06 Moamba field trip
- 06 Monthly Technical Committee meeting
- 11 - 15 Select/train VS&L community facilitators, establish VS&L groups Tete and Niassa
- 11 - 15 VS&L activities start up with CSO Kaeria in Cabo Delgado, 2 VS&L community facilitators and form 8 VS&L groups
- 12 - 13 Matutuine field visit
- 18 - 22 Sofala/Manica field visit
- 26 - 29 Tete, Inhambane and Cabo-Delgado field visits

Annexes:

Annex 1: Project Pipeline find attached separately

Annex 2: Current VS&L household member profile

Annex 3: OVC CSI Matrix

Annex 4: Success Story

|

Annex 2: Revised and currently in use VS&L household member profile

Formulário do Perfil – Projecto HOPE

Instruções – Use este formulário para todos os membros. *Questões sombreadas não devem ser feitas, mas repondidas basendo-se em observação (se possível). As restantes questões devem ser feitas exactamente como eescritas. Instruções para o entrevistador estão em itálico.*

Precisamos de perguntar qual é a posição na família e estado civil do entrevistado

10	Data da entrevista (DD-MMM-AAAA)	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
11	Nome do entrevistador (Nome, Meio, Apelido)		
12	Que colecta de dados é esta?	Inicial (primeira)..... Recolecta (segunda).....	
100	Inserir o número de identificação	<input type="text"/>	
100ª	Tem documento de identificação? (B.I./Passaporte)	Sim1 Não sabe....88 Não.....0 Sem resposta....99	
101ª	Qual é o seu primeiro nome?		
101b	Qual é seu último nome (entrevistado)?		
102	Qual é o seu sexo?	Feminino Masculino	
103	Em que ano nasceu?	Não sabe88	
104	Qual é o nome da sua vila ou comunidade?		
105	Qual é o nome do seu Distrito?		
106	Por favor escreva o Código/Nome do Grupo:		
107	Em que ciclo de poupança e empréstimo está?	Não sabe.....88	
108	Em que data entrou no programa? (mês e ano ou apenas o ano)	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Não sabe88	
	<i>Diga “Gostaria de lhe fazer perguntas sobre pessoas da sua habitação”. Para este inquérito, habitação é uma pessoa ou grupo de pessoas que partilham o mesmo tecto, seus recursos e comem da mesma <u>panela</u></i>		
110	Quantos adultos (maiores de 17 anos) vivem neste momento na habitação (incluindo você)?	Não sabe88	
111	Quantos adultos geram Rendimentos para a habitação (incluindo você)?	Não sabe88 <i>Inclua os que não vivem na habitação mas contibuem ou enviam seus Rendimentos para a habitação.</i>	
112	Algum adulto morreu depois de adoecer por mais de 3 meses no último ano?	Sim1 Não sabe....88 Não.....0 Sem resposta....99	
113	Quantas crianças vivem neste momento na habitação (entre 0 e 17 anos de idade)?	<i>Se for nenhuma, escreva 0.</i>	

114	Dentre as crianças que vivem nesta habitação, quantas são órfãs?	(Criança cuja mãe ou pai morreu é considerada órfã)	
200	Por favor leia isto: Nós gostamos de poupar e produzir na machamba. (Depois, o facilitador dita uma frase)	Membro sabe ler e escrever Membro sabe ler e escrever mas com dificuldades..... Membro não sabe ler nem escrever..... Membro sabe ler mas não sabe escrever.....4 Membro não responde.....	
Economia			
300	De que tipo são as paredes da casa principal ou palhota? <i>Fazer a pergunta, em seguida, marcar a resposta</i>	Caniço/Paus/Bambú/Palmeira Cartão/Papel/Saco/Casca Bloco de Argila ou matope Madeira/Zinco Cimento/Blocos/Tijolos Outros	
301	Que tipo de material de cobertura tem a casa principal ou palhotas? <i>Fazer a pergunta, em seguida, marcar a resposta</i>	Capim/colmo/palmeira..... Laje de Betão Chapas de Zinco/Lusalite Telha/Tijolos Outros	
310	Quantas refeições principais, você comeu nos últimos dois dias (o dia de hoje não conta)?		
311	Ontem foi um dia de comida normal (nao foi dia de festa, feriado ou dia especial)?	Sim Não	
312	Agora, referindo-se apenas ao dia de ontem, comeste alguma destas comidas?	<i>Mencionar cada opção, e digite 1, se tiveres consumido ontem, 0 se não consumir qualquer ontem</i>	
	a) Algum Grão/Cereal (ex: gergelim, milho, arroz, trigo, pão, massa/esparguete)?	g) Algum Legume (ex. feijão, lentilha, amendoim, amêndoa)?	
	b) Alguma Raiz/Tubérculo (ex: batata reno, batata-doce, inhame/madumbe, mandioca)?	h) Algum leite/ lactícínio (ex. leite, iogurte, queijo)?	
	c) Alguma carne/fonte de proteínas (ex: leite, ovos, bife, cabrito, peixe, galinha, peru, feijão, ervilhas)?	i) Ovos?	
	d) Algum Peixe/Marisco (ex: peixe fresco, peixe seco, marisco)?	j) Utilizou algum Açúcar ou Mel para preparar a comida?	
	e) Algum Vegetal (ex: abóbora, melancia, papaia laranja, beterraba, cebola, tomate, cenoura)?	k) Utilizou algum Óleo/banha/manteiga para preparar a comida?	
	f) Alguma Fruta (ex: abóbora, melão, manga, bananas, laranja)?		
320	Quantos sacos de grão têm no celeiro neste momento? <i>Se for nenhum, escreva 0. (tamanho do saco, ex: de 25 ou 50 kg)</i>		
321	Que tipo de coisas tem em casa? Quantas das seguintes coisas você tem em casa? <i>Leia as opções e assinale tudo o que tiver. Se for nenhum, escreva 0.</i>	a) Galinhas ou outro tipo de aves b) Cabritos, ovelhas, porcos c) Bois, búfalo d) Cavalos/burros e) Rádio	g) Televisor h) Geleira ou Congelador i) Bicicleta j) Motorizada k) Veículo ou carro

		f) Telefone ou celular	l) Tractor
322	Nos últimos 12 meses, em quantos meses os rendimentos NÃO foram suficientes para satisfazer as necessidades da família?	<i>Deve ser 12 ou menos. Se for nenhum, escreva 0.</i> Não sabe..... Sem resposta	
323	Por favor estime o valor total dos seus rendimentos no mês passado (MZM) <i>Se for nenhum escreve 0.</i>		
324	Que situação reflecte as necessidades e a compra de roupa na família?	Compra menos do que a família precisa Compra em media o que a família precisa Compra mais do que a família precisa	
325	A sua família consegue enviar dinheiro <u>ou</u> <u>ajudar</u> a outros familiares regularmente? (numa situação normal)	Sim Não Não sabe Sem resposta	
326	Algum membro deste agregado familiar tem conta bancária?	Sim Não Não sabe Sem resposta	
327	O que vai fazer com as poupanças: <i>Selecciona todas as opções aplicáveis e digite 1, 0 se não</i>	a) Construir ou reabilitar a sua casa	
		b) Comprar bens para a casa	
		c) Pagar contas de saúde/hospital	
		d) Pagar escola/educação	
		e) Sem planos, continuar a poupar	
		f) Iniciar negócio	
		g) Outros	

Annex 4: Success Story

#1: *“If João becomes sick or dies, don’t look for me”*

João² is a 10 ten year old boy in Maputo Province. He lives with his father and stepmother and 2 little brothers and is currently enrolled in 5th grade. The father is employed in South Africa while João and his brothers stay with their stepmother, who earns a living through subsistence agriculture. Her husband does provide routine financial support to the family from South Africa.

Maria, an *activista* in Maputo province met João last year. She noticed his sadness and solitude which are uncommon for a child his age. He rarely smiled and seemed very withdrawn. His stepmother and father were mentally and physically abusive towards him. He reached a point where he could not continue living with his parents and decided to run away from home to live with his maternal grandmother which was a safe place for him, leaving behind his studies.

It was in this new environment where he met Maria, the *activista*, who enrolled him into the Children’s Club in his new community. To better understand his behavior she met with his grandmother to learn more about his living conditions. The grandmother was open about this past history and shared the threats received from his father trying to force his return back home with him. Despite this, the father was also known to have proclaimed

“If João becomes sick or dies, don’t look for me”

actually displaying his abusive nature.

The grandmother felt that not many options were available to her and regrets that her grandchild didn’t stay with her from the time of his mother’s death. Under constant threats from the father she was forced to return João to his father.

Maria, not satisfied with the situation and with the permission of the grandmother, contacted the local community leaders and obtained João’s school transfer to the primary school in the community where the grandmother lives. João is now authorized to live with his grandmother in a safe place.

However, the grandmother had no financial and material resources. Maria referred her to INAS to receive a poverty certificate which facilitated other inputs such as nutritional support. It was this poverty certificate that also facilitated the process of transferring into a new school based on shifting residency to his grandmother’s.

² The child’s name and other identifiers have been changed to protect the child’s identity

As a result of the intervention of the project *ativista* in coordination with community leaders, João was in a safe place and his behavior changed. He had greater happiness which could be seen by the smile on his face and was now placed in a positive environment that will support his growth and development through adulthood.

“All I want is to obtain support for João” commented the *ativista*.

From a community perspective, this level of commitment and intervention by an *ativista* is expected, and often well fulfilled, as well as gaining recognition from community leaders and government.

Organization N Family Health International
 Task Order No. GHFI-105-07-00043-00
 USAID Community Care Program (formerly ComCHASS)
 Date of submission: 30 April, 2012

Item	Year 1 (Sept 2010 to Sept 2011)				Year 2 (Oct 2011 to Sept 2012)				2012			2015	
	Estimated amount (reallocated) US\$	Obligated amount US\$	Actual expenditure US\$	Estimated amount US\$	Obligated Amount (mod 4) US\$	Actual Expenditures Oct and Feb 2012 US\$	Expenditure March 2012 US\$	TOTAL Projected to March 2012 US\$	Estimated amount (US\$)	Obligated amount US\$	Final expenditure US\$	Estimated Amount US\$	Remaining balance (LOP) US\$
Personnel	1,079,092	1,079,092	752,537	1,613,633	1,613,633	306,424	64,564	370,978	2,692,725	2,692,725	1,315,515	7,146,631	6,023,116
Fringe Benefits	417,196	417,196	285,440	583,030	583,030	61,912	29,922	91,833	1,000,226	1,000,226	177,273	2,268,004	1,890,732
Travel and Transport	331,002	331,002	326,558	630,967	630,967	159,803	49,797	209,600	961,969	961,969	111,158	1,443,637	907,479
Equipment	664,900	664,900	846,052	168,500	168,500	39,057	453	39,510	833,400	833,400	111,562	886,549	987
Supplies	146,000	146,000	92,402	169,700	169,700	149,066	32,201	181,267	315,700	315,700	111,669	539,132	265,463
Subrecipient	3,077,301	3,077,301	1,970,919	4,642,384	4,642,384	1,612,774	566,678	2,179,452	7,719,685	7,719,685	4,1370	20,949,020	16,796,650
Other Direct Costs	832,877	832,877	663,225	979,334	979,334	715,668	165,260	880,928	1,812,211	1,812,211	111,153	4,049,029	2,504,876
Subtotal Direct Costs	6,548,368	6,548,368	4,937,132	8,787,548	8,787,548	3,044,704	908,865	3,953,568	15,335,917	15,335,917	8,111,700	37,282,002	28,391,302
Indirect Costs	1,080,428	1,080,428	700,949	1,303,141	1,303,141	492,564	102,873	595,457	2,383,569	2,383,569	113,406	5,155,824	3,859,418
Fees	381,440	381,440	240,676	504,534	504,534	72,624	26,506	99,130	885,974	885,974	113,300	2,121,891	1,808,591
Total US\$	8,010,236	8,010,236	5,878,757	10,595,223	10,595,223	3,609,912	1,038,244	4,648,156	18,605,460	18,605,460	10,111,407	44,559,717	34,059,310
Cost Share													
Grand Total	8,010,236	8,010,236	5,878,757	10,595,223	10,595,223	3,609,912	1,038,244	4,648,156	18,605,460	18,605,460	10,111,407	44,559,717	34,059,310

Matriz de Apoio Infantil

Nome completo da Criança: _____ Idade da Criança: _____ Código de Identificação: _____
 Nome do Encarregado de Educação: _____ Nome do Voluntário: _____
 Nome do Líder Comunitário: _____ Nome da DCB: _____ Distrito: _____
 A Criança é HIV+? 1. Sim [] 2. Não [] 3. Desconhecido [] - Se sim, (a receber TARV? Não [] Sim [])
 Data de avaliação: / / Primeira avaliação da criança? [] ou Avaliação de seguimento? [] Hora de avaliação: de _____ até as _____

EDUCAÇÃO	EDUCAÇÃO	EDUCAÇÃO	EDUCAÇÃO	SAÚDE	SAÚDE
A Criança está inscrita no ensino primário, secundário ou curso profissional 	Foi à escola todos os dias durante a semana anterior 	A criança tem uniforme e material escolar (se no ensino primário) 	A criança passou da classe anterior 	As últimas 3 vezes que a criança precisou de ir a uma unidade sanitária, ela foi 	Sem febre ou diarreia nas últimas 2 semanas 
Totalmente imunizada 	Teve educação acerca do HIV em 12 meses (> 6 anos de idade) 	Bebe água potável 	Dorme sob uma rede mosquiteira tratada 	Tem acesso a uma latrina limpa ou casa de banho e acesso a água para lavar as mãos 	Teve pelo menos 4 refeições nos últimos 2 dias 
Comeu alimentos dos 3 grupos alimentares nos últimos 2 dias 	A criança beneficia do apoio económico da família (ex: machamba ou AGR) 	O encarregado de educação é capaz de poupar algum dinheiro, ex: através do grupo de poupança 	Casa adequada, segura, seca e ventilada com paredes e telhado fortes 	Tem o próprio cobertor para dormir 	Tratada de forma igual pelo encarregado de educação 
A criança está segura contra abuso, negligência ou exploração 	A criança está feliz e satisfeita com uma disposição, em geral, positiva 	Obedece aos adultos de forma semelhante às outras crianças (não desafia nem se revolta) 	Participa de serviços religiosos caso deseje 	Tem um bom amigo ou fala com um adulto acerca dos problemas 	Participa regularmente em actividades de clube infantil (ex: Cantos, desportos e mais) 
O encarregado de educação tem uma atitude positiva e esperança acerca do futuro 	Principais preocupações, acontecimentos ou mudanças na vida da criança: _____				 = Bom (4)
					 = Razoável (3)
					 = Mau (2)
					 = Muito Mau (1)
					 = Não Aplicável

Desenvolvido 1. Sim [] 2. Não []; Plano de Acção para Cuidados Implementado 1. Sim [] 2. Não []; Se sim, como, usa a escala de 1-4: Bom, Razoável, Mau, Muito Mau