



## USAID Community Care Program (Programa de Cuidados Comunitários)

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## List of Acronyms

AED	Academy for Educational Development
ANEMO	National Association of Mozambican Nurses
APE	Agente Polivalente Elementar (CHW with prevention focus)
APR	Annual Progress Report (PEPFAR)
AWP	Annual Work Plan
BOM	Banco Oportunidade de Moçambique
CCC	Community Care Committee
CLC	Community Leaders Council
CNCS	National Council to Combat AIDS
CSO	Civil Society Organization (community based organization)
DPMAS	Provincial Directorate of Women and Social Action
DPS	Provincial Directorate of Health
ES	Economic Strengthening
FHI & FHI 360	Family Health International
GAAC	Community Antiretroviral Group
GOM	Government of Moçambique
GSC	Global Surveys Corporation
GUC	Grant Under Contract
HBC	Home Based Care (for PLHIV)
IGA	Income Generating Activity
INGO	International Non-Government Organization
LRO	Local Research Organization
M&E	Monitoring and Evaluation
MOH / MISAU	Ministry of Health
MONASO	Mozambican Network of AIDS Organizations
MOU	Memorandum of Understanding
MMAS	Ministry of Women and Social Action
NGO	Non Government Organization
NPCS	Provincial Núcleo to Combat AIDS

OVC	Orphans and Vulnerable Children
PH	Project HOPE
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PPP	Public Private Partnership
PSS	Psycho Social Support
REPSSI	Regional Psycho Social Support Initiative
Q -	Quarters of the project
QA / QI	Quality Assessment / Quality Improvement
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
USG	United States Government
VS & L	Village Savings and Loan Groups
Yr1	Year 1 (of project)
Yr2	Year 2 (of project)

## EXECUTIVE SUMMARY

Early in this reporting period, the USAID Community Care Program Year 2 Annual Workplan and budget were approved, setting the stage for activating and reporting on all the project's components. Key Year 2 Q1 accomplishments highlighted here are developed more fully in their respective sections:

- CSOs implementing in 33 of the 52 districts intended for Year 2
- Baseline survey data collection completed in the 13 survey districts
- HBC provided to 6,210 adults and children
- OVC care and support services provided to 5,481 children
- CCC and CLC inventory initiated
- Tete Province office and team substantially equipped and staffed
- Referral and Counter-Referral form pilot testing underway
- USAID site visits to Manica and Inhambane province partners
- Integrated HBC and OVC *activista* training plan finalized and supervisors trained in Tete province
- Psychosocial Support Training pilot carried out by REPSSI in two districts
- HS 20/20 site visits to Niassa and Maputo province partners for costing activity
- Children's Clubs starting up
- 27 VS&L groups founded in Maputo Province
- Start-up of pre-post partum women's referral services
- CSOs Start-up workshops in Tete and Sofala provinces
- Continued collaboration with PSI for provision of family health kits to project families
- Year 2 All Partners Workshop introduced new activities and staff
- Community Care Program staff participated in the FHI 360 QA/QI initiative

In addition to performance against key PEPFAR indicators in this reporting period, the Project also contributed to overall GOM HIV goals by linking with clinical partners to return ART defaulters to active treatment. 57% of those PLHIV names forwarded to CSO *activistas* were located and supported. As well, while adherence support – for ART, TB treatment, pre-ART prophylaxis – is an ongoing activity, the 88% of HBC clients on ART remained so, and 83% of HBC clients go to their health unit for regular follow ups. Reporting on referral to PMTCT services is incomplete this quarter, but 91% of those pre-partum women completed the referral process, meaning they received the services for which they were referred.

Project implementation offers different challenges than start up, and the Project team across the current six provinces are analyzing and responding to any issues or gaps with robust technical assistance and mentoring site visits.

## **OVERVIEW**

USAID/Mozambique's Community Care Program 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/post partum women. 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/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, 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.

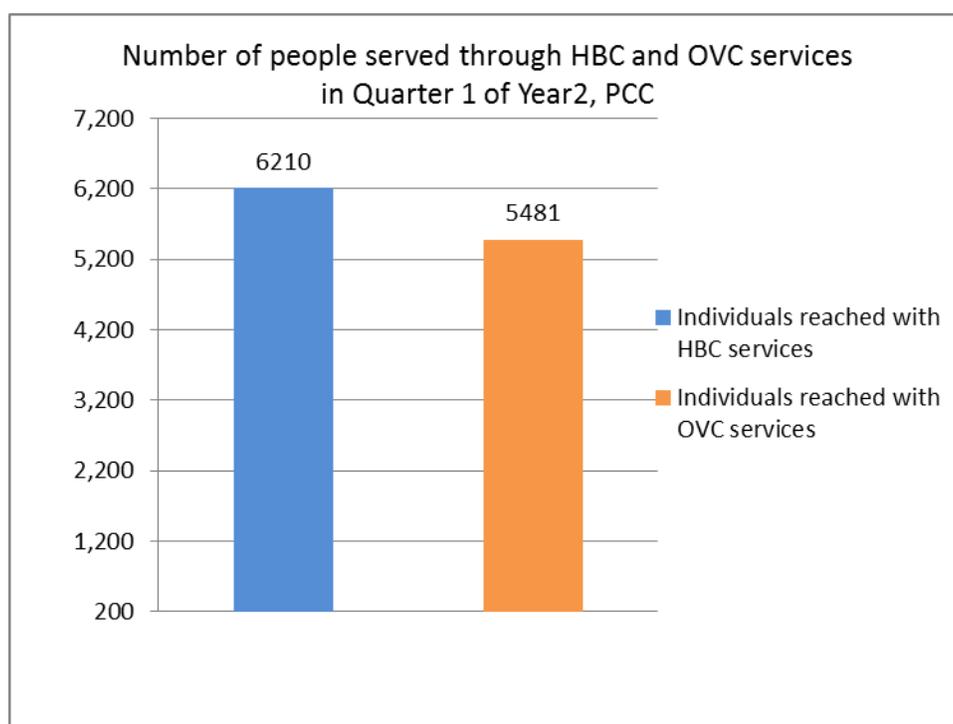
## 1.1 ACHIEVEMENT BY OBJECTIVES

### Coverage

CSO's are implementing in 33 of the 52 intended districts for Year 2. New Year 2 CSOs in Tete (for 13 districts), Niassa (for 2), and Cabo Delgado (for 1) will be implementing next quarter, with their Grants under Contract (GUC) currently in final phases of execution.

Through the end of this quarter, 6,210 adults and children received HBC services and 5,481 children received OVC services.

Graph 1



**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

The capacity building assessment conducted by MONASO revealed a need for substantial capacity building in the majority of CSOs. Plans to build the capacity of the CSOs will be individualized and where possible, common needs will be planned for joint interventions for efficiency without diminishing impact. The project is exploring alternative options to the MONASO approach to capacity building, particularly with the tools and activities of former AED's CAP project, now under FHI 360. MONASO is in a downsizing phase and will be unable to provide either the geographic or programmatic

breadth of consistent capacity building coverage necessary for the project. An added benefit of exploring the CAP project would be harmonizing approaches across the two projects for better capacity outcomes ultimately. Discussions continue, to identify the possibilities with CAP in collaboration with the projects' AOR and COR. During this quarter all provincial project teams were provided capacity building in the areas of M & E, yearly work planning, budgets and accounting as well as other implementation issues.

New CSOS were oriented on the project and assisted to bring their project proposals in line with the Project model and budget through the Scope of Work (SOW) workshop mechanism. During these workshops at district level for implementing CSOs, plans, activities and budgets were reviewed and the new indicators for Year 2 explained.

This report cites specific provinces as examples of what is being implemented across the project. In many districts, especially in Manica Province, extensive field visits early in this implementation phase ensured that new partners are provided start-up support to best achieve compliance and quality implementation of activities. This has been effective in building capacity in financial management systems and thus minimizing risk with GUCs.

### **Technical Working Groups**

Participation in technical working groups continues to be a major conduit to influence and build capacity within and between the government structures and other stakeholders. At national, provincial and some district levels the working groups focus on key elements of the Project – OVC, HBC, Gender, QI, Integration of HBC and OVC among others.

One key outcome that the Project has influenced is the national level GTCOV (TWG on OVC of the Ministry of Women and Social Action (MMAS), supporting a broadly inclusive model of communities supporting “their” children. One activity under discussion in the GTCOV is creating a Manual to support the Child Protection Committees that are already active in communities, while another activity is MMAS asking the GOM to authorize the establishment of a TWG specifically on Psychosocial Support. MMAS in January will begin elaborating the PNAC II, the National Plan of Action for Children, which will include a section for OVC, with effect beginning 2012.

### **Training**

#### Integrated HBC/OVC Training

A key achievement this reporting period was the approval by the project partner ministries – MMAS and MISAU – on piloting the integrated HBC/OVC training. This initiative recognizes and supports the reality that a majority of HBC *activistas* are already caring for OVC but with little or no training. Additionally, this initiative supports the idea of a family centered approach which needs to be reinforced. The integrated training plan developed by the technical working group was used in the first integrated supervisors trainings in December in Tete Province. This supervisors' training specifically targets DPMAS, DPS, and SDSMAS técnicos and focal points, as well as

the CSO supervisors. Integrated *activistas* training will be rolled out next quarter. A consolidated curriculum will be designed following the feedback and analysis of the pilot trainings. In this model, each training uses two Master Trainers, one each from ANEMO for HBC and MMAS for OVC., and all integrated training certificates are being signed off by both MMAS and ANEMO. In Tete, the first supervisors training included 4 Técnicos from SDSMASs and 23 CSOs supervisors.

#### Psychosocial Support (PSS) Training

Across the board, in addition to community caregivers lacking skills in OVC care and support, the unique life experiences of OVC require additional specialized attention, provided through PSS. This “felt need” is underpinned by a technical analysis of the PSS segment of the existing OVC training curriculum, which showed that component to be somewhat weaker than needed.

The Project is addressing this by contracting REPSSI to pilot two-level PSS training for 1) DPMAS and SDSMAS Técnicos, and CSOs Supervisors, and 2) HBC *activistas*, in two diverse provinces, using appropriate materials targeted to each group level this quarter. REPSSI already had various levels of training materials in Portuguese from which to select, as well as Master Trainers on board. The training was provided as follows:

Pilot Training Model for Niassa and Maputo, including Inhambane in Maputo:

- 1) Técnicos and Supervisors from all the active project districts for five (5) days “Introduction to PSS” training including units on supervision.  
Project districts: 4 in Niassa, 5 in Maputo, 5 in Inhambane (mostly Year 1 districts)
- 2) HBC *activistas* of one (1) CSO on “Weaving PSS into HBC”. The six day training included four days of PSS, 1-1/2 days OVC Minimum packet, ½ day M&E.  
Mandimba district / ESTAMOS in Niassa;  
Manhiça district / ACIDECO in Maputo

The 1-1/2 days OVC Minimum packet references all the topic areas of the MMAS Minimum Standards for OVC care, attached, serving as Annex 4. The ½ day M&E session trains on the OVC monitoring tools used by the project.

Next steps: MMAS officials are collecting feedback from their provincial and district teams in order to advise on further roll out of the PSS trainings. Concurrently, the Project is analyzing the budget for ability to accommodate this essential but costly activity, since the best technical capacity for this service does include the personnel described, within both the GOM institutions and the local CSOs.

**Table 1: Training Summary**

<u>Province</u>	<u>Nutrition</u>	<u>HBC</u>	<u>PSS</u>	<u>VS&amp;L</u>	<u>Family Kits (PSI)</u>
Manica					
Sofala					216 <i>activistas</i>
Niassa	16 Técnicos 4 CSO supervisors		16 Técnicos 30 <i>Activistas</i>		
Maputo	28 youth		14 Técnicos 35 <i>Activistas</i>	10 Trainers 27 CSO facilitators	
Inhambane			12 Técnicos		137 <i>activistas</i>
Tete		Supervisors training: 4 SDSMAS Técnicos 23 CSO supervisors			

Notes on the Training Summary Table above: The refresher trainings in the HBC column reflect the standard HBC refresher trainings provided by ANEMO, for *activistas* and Master Trainers according to their levels. Such refresher trainings keep skills and practices up to date and serve as a platform for any new changes in national policy or standards of care. The nutrition component was examined and strengthened during the period of integrating the *activistas'* training curriculum, by collaboration with FANTA. The PMTCT/Nutrition Technical Officer will join the project in the next Quarter. Important tasks will be to organize specific nutrition refreshers as needed, in collaboration with GOM community nutrition activities, as well as to support the CSOs to best design their nutrition demonstration activities. Psychosocial Support is being taken up in much greater scope than as refresher, see page 9.

**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

### Mapping

With the addition of Tete Province, Pemba (Cabo Delgado), Ngaúma and Metarica (Niassa Province) Districts in Year 2, the mapping exercise completed last quarter is being converted into a Service Directory for each district for use among the local stakeholder groups.

### Integrated Referral Networks

There are existing forums within the Districts which the Project uses as opportunities to coordinate with multi-sectoral partners. For example, in Inhambane Project staff participated in the *Rede das Organizacoes de Sociedade Civil* (ROSC) meeting for the creation of a district forum to work with children.

Referrals and counter-referrals occur but in many instances not adequately reported or tracked. This should be rectified with the use of the new referral form that includes a paper based feedback loop. The referral/counter-referral system pilot will be completed by next quarter and presented to MOH and to MMAS for their final buy-in. This referral form was expanded from an existing MOH referral form to include referrals to social services as well as the clinical services, but also improved by designing the forms 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. This project plans to provide a “block” of referral forms to: a) each of district level social services partners, including district level INASs, SDSMASs, and Offices on Domestic Violence, for counter referrals to the implementing CSOs, as well as b) each of the partner clinics. This important tool will be launched across all USG supported sites within FHI 360 and its partners, to best reinforce the linkages system.

### **Collaboration with Other donor projects and associations**

PSI continued to provide the family health kits as well as provide training on these kits. Project staff in Sofala, Manica, and Tete Provinces work in coordination with clinical partners CHASS SMT, and CHASS Niassa in that province. In Sofala Province, the Project coordinates with ROADS who is developing an HIV prevention resource center near the port of Beira. TB Care will also be part of the referral system in several project districts and with many HBC clients on TB treatment this is a very important link for the health and well-being of HBC/TB patients.

World Relief district CSOs meet with ICAP supported clinic partners, listed in the table below, to establish and strengthen that set of referral linkages in Inhambane Province. ICAP has peer educators at all health posts where Community Care Program partners are working. A follow up meeting is planned to discuss the GAAC initiative and conduct a joint visit to Homoine.

District / OCB	ICAP supported clinic	“meeting” outcome
Maxixe - Liwoningo	Hospital Rural de Chicuque Centro de Saude da Maxixe	CSO rep. and health staff discussed challenges and proposed solutions on TARV, UATS, PTV and peer education.
Inhambane - UTOMI	Centro de Saude de Inhambane	CSO rep., health staff and ICAP staff discussed challenges and improvements of HBC, UATS and peer education.
Inharrime – Rede Pastoral de Inharrime	Unidade Sanitaria de Inharrime	CSO rep., health staff and ICAP staff discussed challenges and improvements of HBC, UATS and peer education.
Homoine – Rede Pastoral de Homoine	Centro de Saude Homoine	CSO rep., health staff and ICAP staff discussed challenges and improvements of HBC, UATS and peer education.
Morrumbene – Rede Pastoral de Morrumbene	Centro de Saude Morrumbene	CSO rep., health staff and ICAP staff discussed challenges and improvements of HBC, UATS and peer education.

Notes on the table: TARV is the Portuguese acronym for Anti-Retroviral Treatment; UATS is the Portuguese acronym for Counseling and Testing Unit; PTV is the Portuguese acronym for Prevention of Mother to Children Transmission.

Project staff has also made visits to the Forum Provincial das Organizações da Sociedade Civil de Inhambane (FOPROI) and was encouraged to join the forum by the FOPROI Provincial Coordinator. This is a forum where planning, information sharing and coordination can take place with other organizations in the province. Project implementing partners in other provinces also participate in similar NGO forums.

### **Coordination with Public Sector**

This project is also contributing to the Moçambique national pilot of the GAACs, community based treatments groups for PLHIV. *Activistas* refer their clients to their clinic partners wherever a health unit is supporting a GAAC pilot site. Group membership has been set by GAAC for PLHIV with CD4 above 200, and in future the *activistas* and community mobilizers will be provided the GAAC participation criteria to share in the communities.

Project staff attended a DPMAS meeting about disability where the national plan on disabilities 2012-2018 was presented. That meeting recommended that all organizations should consider the needs of the disabled during their activities in order to better serve this vulnerable group. Such recommendations reinforce the principles and practice the Project supports.

Government officials, including Provincial Governors, have welcomed the Project in all the operational provinces to date.

### **Public Private Partnership**

Project HOPE leads the private sector partnership with Bank Oportunidade de Mozambique (BOM), a partnership to ensure quality financial literacy modules for VS&Ls and link “graduating” groups to financial institutions. (See Objective 4). A revised version of the financial literacy manual will be tested next quarter in Maputo, Inhambane, Sofala, Manica, Tete and Niassa VS&L groups.

The mHealth initiative with Mcel is back in design stage, to best balance community perceived needs and CSO staffing capacities to take on and manage this activity. With the MOU with Mcel in place, it was then more clear that the personnel needs might overwhelm the CSOs ability to manage an mHealth activity, and saw the need to dial down the scope of the initial activity. In addition, an assessment of perceived community needs was seen as useful and Project HOPE will lead a community dialogue with the Manhiça district CSO partner in Maputo during the next quarter. The project feels that the mHealth activity has such potential to do good, that we really want to take all the necessary time to best define the needs and possible applications within the structure of this community based services project to get it right.

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

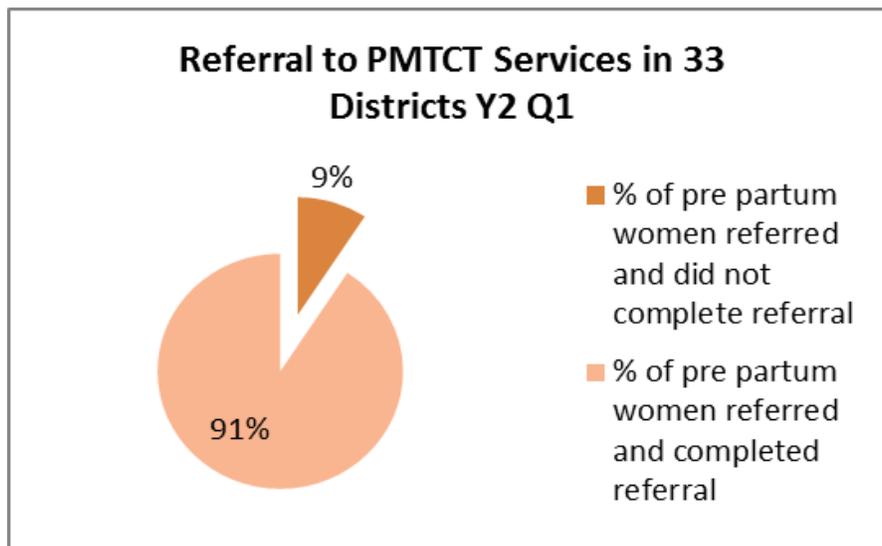
**Services Provided including Referrals**

This quarter implementation was significantly expanded.

**PMTCT Services**

A key achievement this quarter was the inclusion of pre- and post-partum women (a Year 2 activity). This was taken up in all but the new Year 2 areas (Tete Province, 2 Districts in Niassa and 1 in Cabo Delgado) who are just coming on board. 100% of pregnant women in active sites were referred to PMTCT clinical services during the quarter. A total of 304 pre-partum women were referred to PMTCT services at their community health centers; out of this number 276 used the services. This means the *activista* fills in the referral form in duplicate, signs and gives it to the pre partum woman to take and present to the health worker at the health unit or health post. After she presents this form, if she is attended to, that health worker will then fill in the form and give her a copy that she will give back to the *activista* to reflect the health services provided. This is a system that contributes to positive achievement for the Project and for PMTCT services.

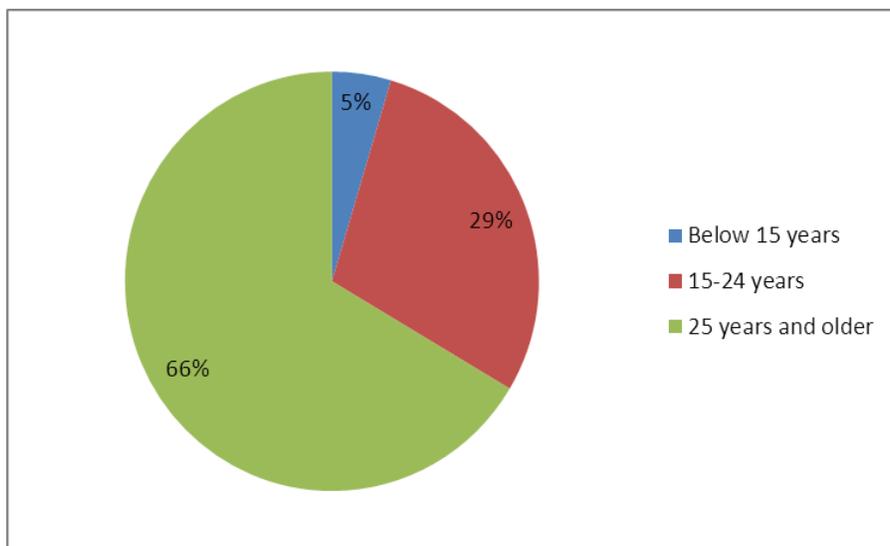
Graph 2



These women are continually followed up by the *activistas* to encourage them to have institutional birth and benefit from PMTCT services available to them at their community level.

It is important to note that of these women, 14 are below 15 years old; 88 are between 15 to 24 years old and the remaining 202 are 25 years and above.

Graph 3



### HBC and OVC services

Overall, the HBC service provision far outstrips services to OVC in this early quarter for implementation – this is an indication that more training on working with OVC is needed as well as a better understanding of the family approach. Each HBC patient's family members should be part of the family assessment and considered as vulnerable; this aspect will be emphasized in all future Integrated Caregiver trainings, as well as all OVC initial or refresher trainings. On average, this will mean a substantial increase in the number of OVC enrolled and receiving services in the program, as well as increases in OVC being enrolled by means of community referrals of OVC households to the program, such as by community leaders or social services. As pre- and post-partum women are enrolled, the family approach means that children in their families would also be enrolled. It remains to be seen what size case load each *activista* can maintain while providing high quality care, and we will learn this very well over the implementation period.

### Clients reached with HBC

Table 2 and the graph below show that a total number of 6,210 clients (2,407 males and 3,803 females) received HBC provided by community *activistas*. 2,545 entered HBC in this reporting period, the remaining 3,665 were in care at the end of FY11 and continued in care. 224 deaths were registered, about 4%, 92 of whom were males and 132 were females. 80 clients, slightly over 2%, have left the program in this reporting period due to moving away, for example. While the project cannot control where people live, it does hope to do its part in reducing mortality through fortifying the continuum of care by strengthening both the community based services and the system of referrals to clinical services. 704 clients graduated from the program based on the MOH criteria. 5,202 clients will continue to receive HBC in FY Q2, out of which 648 are children under 15 years old. These under 15 HBC clients benefit very well from the family approach; each family member is assessed at enrollment for needs as can be fulfilled by the

project either through direct or linked/referred services, thus this age group can link automatically to the OVC component. A general trend noted across all provinces showed that there are more females in HBC than males; this data has shown that services provided to HBC beneficiaries by sex is congruent with the national prevalence rate at 9.2% for men and 13.1% for women<sup>1</sup>.

More than 10% of HBC clients were graduated from HBC according to criteria provided by the Ministry of Health. This is an indication of successful outcomes for the beneficiaries. See *Annex II for the MOH HBC Graduation criteria*. That said, the project will be able to learn from the regular monitoring data the extent to which there are “graduated” HBC clients coming back into HBC, over time.

In the relatively short implementation period to date, a number of challenges are found repeatedly related to HBC implementation, among them:

- waiting lists of those wanting to enroll into HBC
- lack of transport of patients to health facilities when needed
- food insufficiency
- too few GAACs
- influence is still strong by churches, traditional practitioners, Chinese herbalists, on using alternatives to TARV, potentially leading to treatment resistance when PLHIV go off and back on TARV.

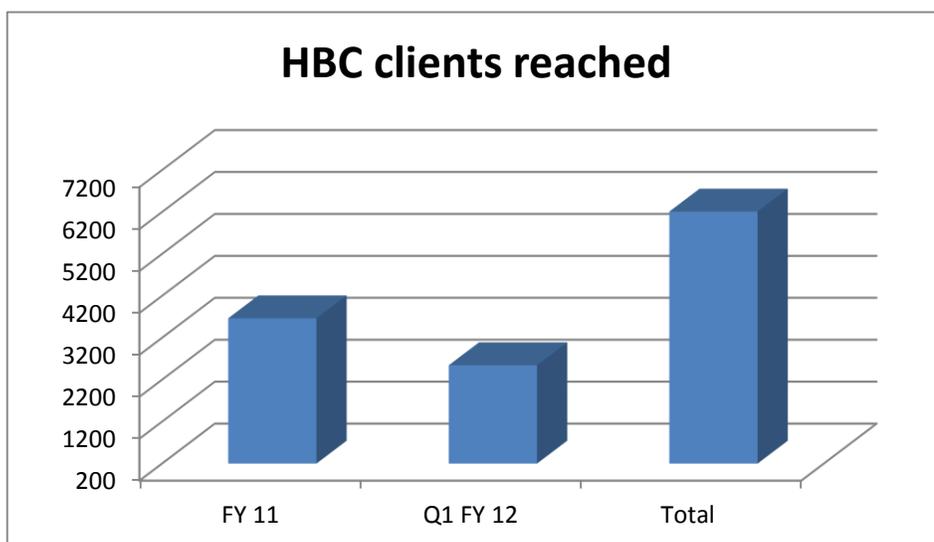
Obviously not all these challenges can be solved within HBC, as some challenges have more to do with endemic poverty, broader health services systems, and deeply embedded cultural realities.

Table 2: Total # of Clients Reached in Q1-Y2 with HBC by Outcome in 33 Districts

Description	Aged 0-14		15 and older		Total M/F		Total
	M	F	M	F	M	F	
<b># of Clients receiving HBC services</b>	<b>364</b>	<b>397</b>	<b>2,043</b>	<b>3,406</b>	<b>2,407</b>	<b>3,803</b>	<b>6,210</b>
# of clients who received HBC who are dead	7	10	85	122	92	132	224
# of clients who received HBC who are lost to follow up	8	7	26	39	34	46	80
# of clients who received HBC who are discharged	27	54	160	463	187	517	704
<b># Clients receiving HBC and are alive and in HBC</b>	<b>322</b>	<b>326</b>	<b>1,772</b>	<b>2,782</b>	<b>2,094</b>	<b>3,108</b>	<b>5,202</b>

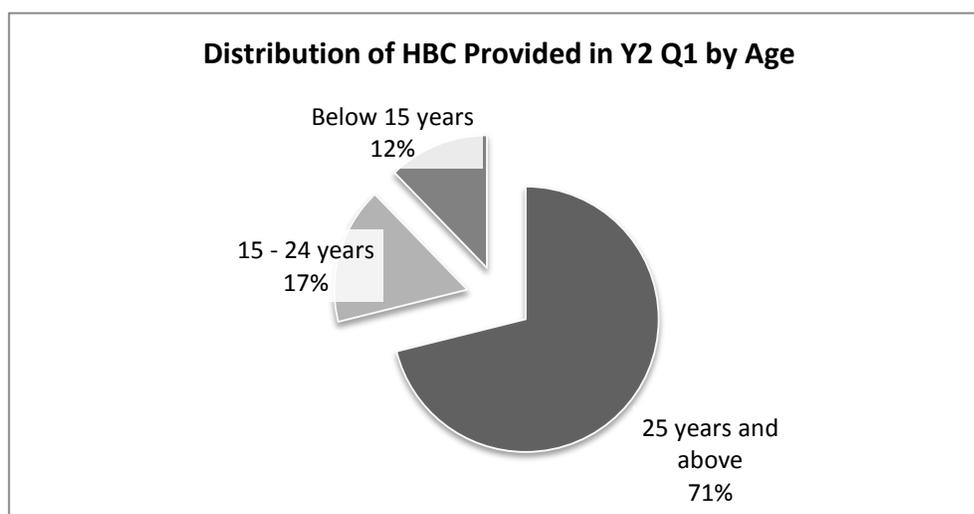
<sup>1</sup> Inquérito Nacional de Prevalência, Riscos Comportamentais e Informação Sobre HIV e SIDA em Moçambique. INSIDA 2009

Graph 4



In terms of age distribution of HBC clients, it is apparent that the age group of 25 years and above represents the highest number of beneficiaries out of the total number of HBC clients at 71%, followed by 15 - 24 years at 17%, and lastly below 15 years at 12%. This service delivery data correlates with the national prevalence rate by age group, where we see the prevalence rate of infection of 0-14 year at 1.6%, 15-24 years at 7.9% and 25 and above at 11.2%<sup>2</sup>.

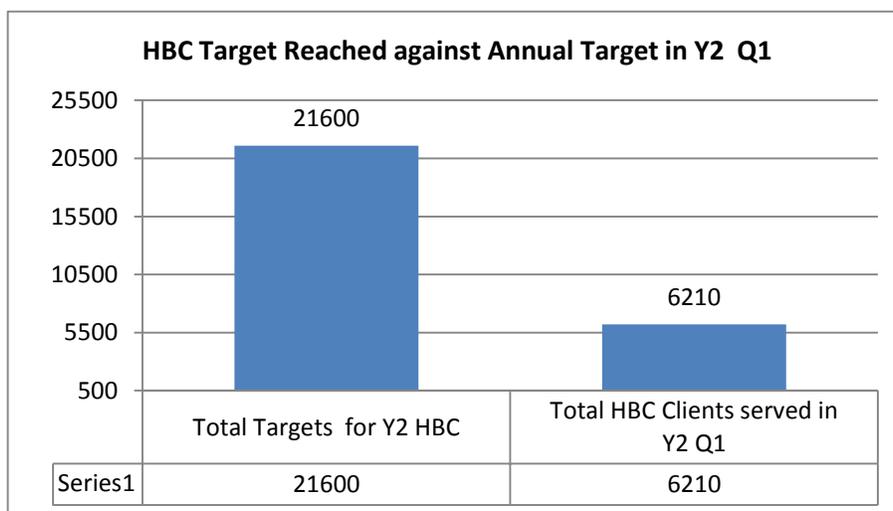
Graph 5



<sup>2</sup> Inquérito Nacional de Prevalência, Riscos Comportamentaia e Informação Sobre HIV e SIDA em Moçambique. INSIDA 2009

In Q1 Year 2, 33 of the total 52 project districts are implementing and reporting service delivery. Starting with Q2, the Year 2 districts should be fully operational and thereby reporting on all indicators.

Graph 6



### Adherence Support

Table 3 and the graph below gives a summary of adherence support provided to HBC clients by community *activistas* on ART, TB and prophylaxis treatment, as well as encouraging these clients to go their health centers for regular follow-up and treatment of opportunistic infections. 4,587 or 88% of HBC clients are currently on ART, 990 clients are receiving adherence support for TB treatment, 5,147 clients go for regular follow up at health units within their communities. Adherence support is a continuous process of counseling PLHIV by *activistas* to maintain their treatment and ensure that they take their medications correctly. The number of clients on ART is close to the number of total HBC clients (5,202). This is a positive trend that seems to indicate, HBC adherence support is having a positive influence.

More women than men are accessing services and that is roughly proportionate to the population and HIV prevalence in the country. However, it may also indicate that more needs to be done to encourage men to avail themselves of health services.

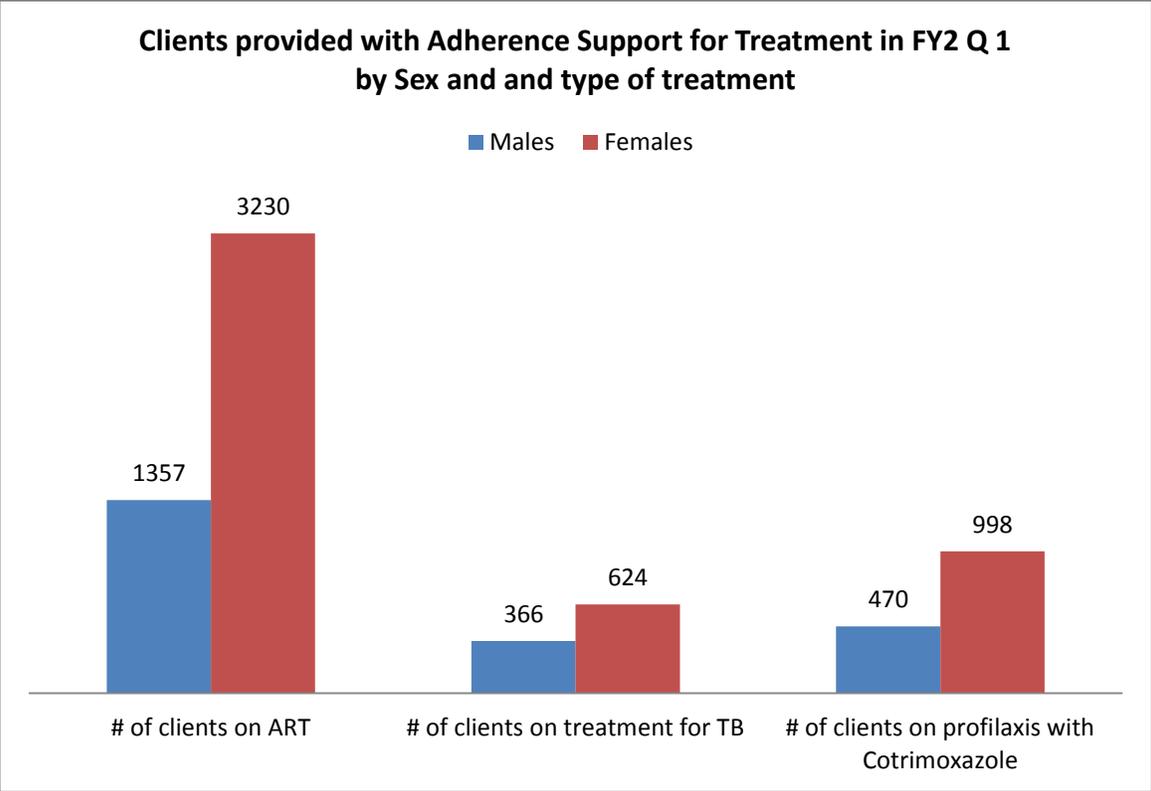
Table 3: Adherence support

Description	Below 15 years		15-24 years		25 years and above		Total M/F		Total
	M	F	M	F	M	F	M	F	
# of clients on ART	195	198	151	371	1,011	2,661	1,357	3,230	4,587

# of clients on treatment for TB	32	30	40	103	294	491	366	624	990
# of clients on prophylaxis with cotrimoxazole	107	112	61	169	302	717	470	998	1,468
# of clients that go for regular follow up	255	278	224	557	1,180	2,653	1,659	3,488	5,147

Note to table above: There is a difference between the total number of HBC clients and the number who report going for regular clinic follow ups, which may simply be due to not all HBC clients going for regular clinic follow ups, some HBC clients not reporting correctly if they do go for regular follow ups, or that some HBC clients may consider their clinic follow ups as ad hoc and not regular.

Graph 7



**Busca Activa**

This activity is the focused on returning ART defaulters to their treatment regimens. These are people who may be enrolled or are not enrolled in the Project but are on a list of defaulters provided by the health units for assistance by the *activistas* to follow-up. Table 3 below shows that out of 721 ART defaulters on the list provided by the Health Units (HU) to Project CSOs, 411 of them were successfully found and returned

to HUs to re-initiate ART treatment in supported districts. The remaining 310 were not found, this may be due to various reasons: moving from one location or community to another; death; or even providing wrong names and addresses.

Table 4: Busca Activa

<b>Description</b>	<b>Below 15 years</b>		<b>15-24 years</b>		<b>25 years and above</b>		<b>Total M/F</b>		<b>Total</b>
	M	F	M	F	M	F	M	F	
List of PLHIV given to CSOs by HU for <i>busca activa</i>	79	29	25	44	183	361	287	434	<b>721</b>
List of PLHIV recovered, referred back to HU and have reinitiated ART treatment	55	17	16	33	90	200	161	250	<b>411</b>

### **Orphans and Vulnerable Children**

The results table below shows performance on care and support services provided to OVC during Year 2 Q1. At the end of Year 1, 2,158 OVC (males 930 and 1,228 females) benefited from care and support services provided by community *activistas*, most of these OVC continue to receive care and support services in Year 2. By the end of this reporting period, a total of 5,481 OVC (2,506 males and 2,975 females) received care and support whether directly or through the services referral system established by the project at community levels in collaboration from SDSMAS and existing district organizations.

#### Description of services for OVC:

OVC standards of care include: Nutrition, Education, Legal Aid, Health, Psychosocial support, financial support and habitation support. Of these standards of care listed above for OVC, project *activistas* either provide these services directly or refer the OVC to Social, community or Health services available in their area. The following is a breakdown of direct services provision and indirect services provision through the referrals system.

**Direct services:** a) *Nutrition support* may include nutritional education, counseling and culinary demonstration for the OVC or their guardian, demonstration of household garden ; b) *Education* may include reintegrating the OVC back to school, assisting with homework, follow up on school progress, c) *Health* support is linking OVC to health services available in their community, including Home Based Care; d) *Psychosocial Support* is the community level service that is provided by the *activistas*, who when fully trained can provide age appropriate support through counseling, prayer, emotional support, encouragement, and, recognize when a child needs higher level psychological

care.

**Indirect services:** OVC can be referred to Social, community, and Health services by project *activistas*. This includes: **a)** Nutrition support; in the form of food aid or supplements from INAS, referral to a Nutrition Rehabilitation Unit of a Health Center when malnutrition is suspected. **b)** Education support; in the form of school admission support, assistance with school uniform, books, school bag through INAS. **c)** Financial support, from INAS when available and as the project matures, more links will be found to vocational training or income generating activities. **d)** Protection and Legal support, in the form of working with community leaders to obtain the necessary declarations required to obtain a birth registration and/or poverty certificate. The latter enables registering for school, and access to health services at no cost, in addition to other benefits. Protection against abuse or exploitation again relies on community involvement in the form of linking with the Child Protection Committee and/or the Office on Women and Children Victims of Violence. **e)** Health support in the form of referral to health units for general health needs as identified by the *activistas* during the family intake and care plan design. **f)** Psychosocial support, again could take the form of referral to professional psychologists where they exist, when certain cases require more support than the community level provides.

This project is breaking new ground in the area and practice of referrals to services, and further, on the concept of follow up to assure those services are obtained with appropriate results. The project intention is to assure a complete referral and follow up as needed. Over time we believe repeated trainings, supportive supervision, and capacity building will help achieve this goal. One methodology we can use is to identify where “complete” referrals are taking place, learn from those *activistas* who are doing so, and replicate that across the project target areas.

Table 5: OVC Disaggregated by Province and Service Areas- Revised

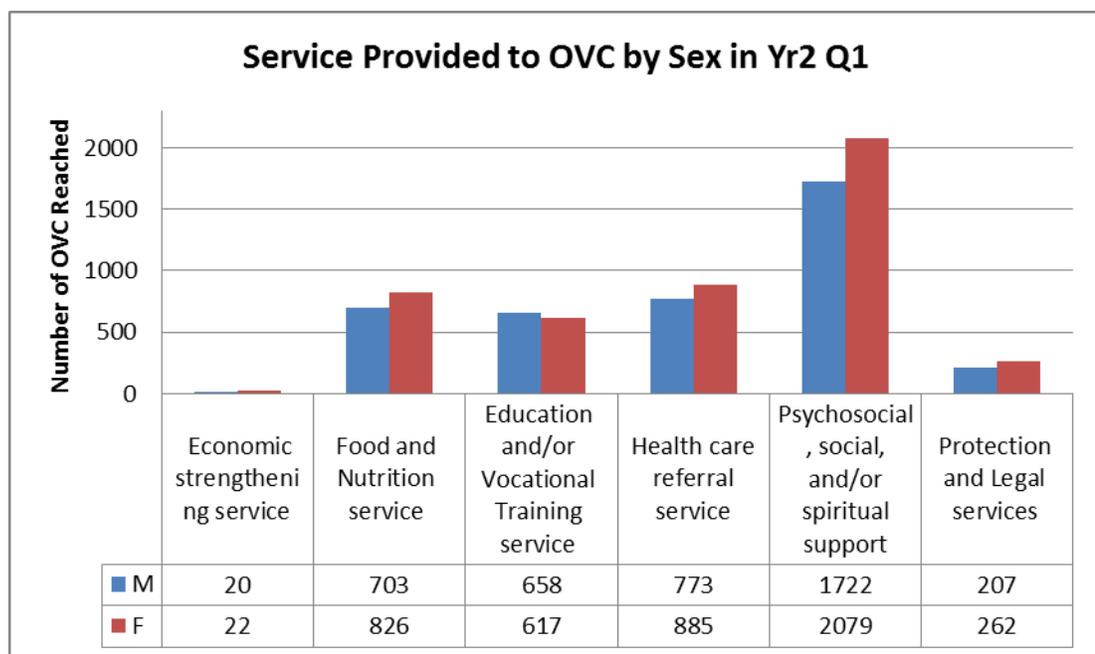
Province	Number of OVC from end FYI (old)			Number of OVC Enrolled in Yr 2 Q1 (New)			# of OVC Currently Receiving Care			Economic strengthening service		Food and Nutrition service		Education and/or Vocational Training service		Health care referral service		Psychosocial, social, and/or spiritual support		Protection and Legal services	
	M	F	Total	M	F	Total	M	F	Total	M	F	M	F	M	F	M	F	M	F	M	F
Maputo	175	246	421	648	601	1249	823	847	1670	9	10	180	260	57	60	138	163	305	325	114	129
Inhambane	527	636	1163	130	201	331	657	837	1494	0	0	130	201	0	0	7	7	137	167	4	9
Manica	0	0	0	446	577	1023	446	577	1023	11	7	38	41	349	313	363	448	746	884	22	28
Sofala			0	334	357	691	334	357	691	0	5	152	123	98	106	78	98	60	59	67	96
Niassa	228	346	574	18	11	29	246	357	603	0	0	203	201	154	138	187	169	474	644	0	0
<b>Total</b>	<b>930</b>	<b>1228</b>	<b>2158</b>	<b>1576</b>	<b>1747</b>	<b>3323</b>	<b>2506</b>	<b>2975</b>	<b>5481</b>	<b>20</b>	<b>22</b>	<b>703</b>	<b>826</b>	<b>658</b>	<b>617</b>	<b>773</b>	<b>885</b>	<b>1722</b>	<b>2079</b>	<b>207</b>	<b>262</b>

NB: All designated Year 2 districts (13 in Tete, 1 in Cabo Delgado, and 2 in Niassa) are not included since their GUCs will be finalized and their activities will commence in Q2. Since the date of report drafting, Sofala Province has been able to clarify their service delivery for this quarter and it is shown in the new Table 5 above.

The revised current quarter numbers for Newly Enrolled OVC and Currently Receiving Care OVC have been verified.

Further, since the time of report writing, the overcounting in the PSS activity in Niassa and Manica Provinces, and undercounting in the services delivered breakdown in Maputo and Inhambane Provinces remaining in the revised table above, have both been examined and corrected for the SAPR submission. We suspect there is some double counting in the PSS activity provision, and the project team is taking action to remedy that by re-training on the M&E tools and undertaking DQAs first in the reporting challenged areas, then following sequentially across the project provinces.

Graph 8

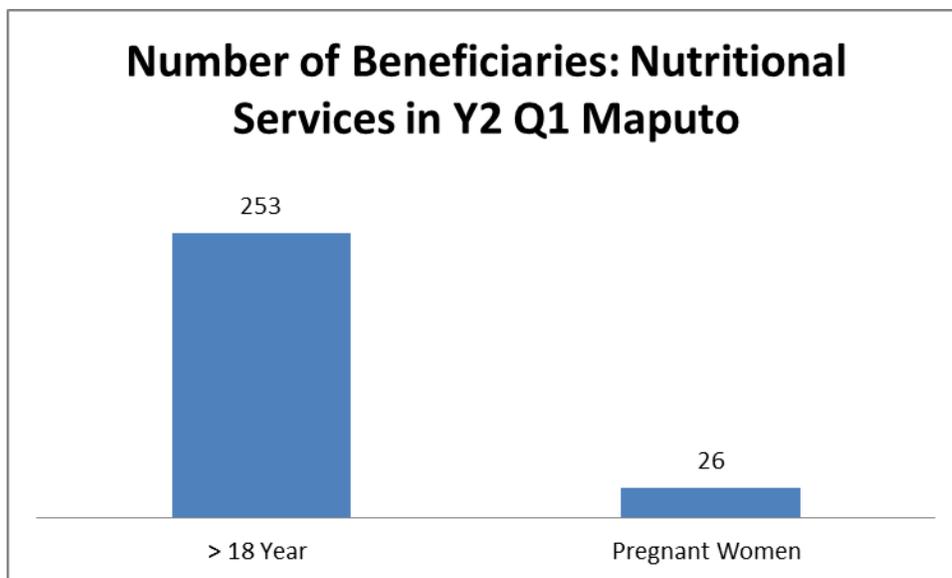


While there are national graduation criteria for HBC patients according to MISAU, there are no similar criteria for OVC. It is imperative that debate continues for determining the best strategy to achieve child wellbeing at the community level both within the project as regards the integrated HBC/OVC approach, and within policy making bodies such as MMAS and MISAU as regards Mozambique broadly. Challenges and discussion points include any possible service delivery completion standards, broader community involvement in ongoing support and strengthening capacity for that, balancing the evolving roles of the *activistas*, APEs, CSOs, and other community resources. Integrating the HBC and OVC services provision into a single *activista* has been driven by two major factors: households wishing to have reduced number of volunteers and *activistas* coming to them, and SDSMASs being overwhelmed with too many volunteers and *activistas* to control or supervise well to result in family well being. Finding the right balance can avoid the risk of poor quality services, and/or needs of the most vulnerable children and families in the community going unmet.

### Nutritional Services:

From the Graph below it is clear that nutritional support<sup>3</sup> is underreported, due to misunderstanding of what constitutes the service delivery, given that **only Maputo Province** provided data for this indicator. The Project has hired a PMTCT and Nutrition officer to take her post next quarter (January 2012), who can provide technical assistance and follow-up to the nutritional component of the Integrated Caregiver training. The Graph below also reflects an implementation challenge as regards reporting on nutrition services provided, disaggregated by age. Reporting according to the age groups 0-14 years old and 14-17 years old will need to be further developed. Older OVC of 12-14 years old, for example, can be targeted for actual nutrition education or cooking demonstration, if they are in responsible roles in their respective households more like the 14-17 year olds may be. The majority of children in the 0-14 age category, however, would be considered secondary beneficiaries of mothers or guardians who have received nutrition education, with some proportion of the total being referred to Nutritional Rehabilitation services in local clinical sites, where operational. We expect fuller reporting in Q2.

Graph 9



### Community Care Committees (CCCs and CLCs)

The assessment of CCCs, CLCs, and other community entities across the project districts commenced this quarter, but much verification work remains to determine status, real activities, and capacity. This assessment/inventory is expected to be completed next quarter. Preliminary assessment results show for example in Maputo project districts, the committees exist but they need revitalization. This is a very challenging area but critical to the sustainability of community support. It will be a major

<sup>3</sup> Activists provided nutritional support to beneficiaries through a) nutrition counseling and education; b) culinary demonstration and c) household gardens demonstration

role of the Project technical officers and coordinators to work closely with the community leaders and stakeholders to build the capacity of the committees based on MMAS and MoH established guidelines and procedures.

One key activity of the CCCs and CLCs is the determination of the most vulnerable families in their communities. This varies from one environment to another and also is influenced by cultural and economic aspects of the society. It is also these committees' role to develop approaches to address the most common problems facing their families, including economic constraints and limited vocational opportunities. The economic strengthening work of Project HOPE will align closely with the CCCs and CLCs to develop viable projects tailored to the community profile.

**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 (VS&L)**

Training for village savings and loan (VS&L) groups was conducted in Maputo Province districts (Matutuine, Manhiça and Marracuene) where Project HOPE is directly implementing project activities. This has proven to be an activity that is in demand and has been taken up by 544 members within 27 VS&L groups. The variety of group membership is encouraging as it encompasses the project's target groups (PLHIV, *activistas*, OVC caregivers, CCC members) including members of Mothers to Mothers groups. Other community members have also joined and this is also very positive because it broadens the impact within the community and de-stigmatizes the intervention. A strong village savings and loan entity can strengthen the village – not just one person. 10 trainers and 27 CSO facilitators are now equipped with skills to facilitate the early phase of VS&L - savings, loans and social capital. This initiative will be expanded as Project HOPE finalizes its subcontracts with one CSO each for economic strengthening activities in Manica, Inhambane and Sofala provinces, early next quarter.

Though the CSOs have some experience with VS&L, it is the first time that they are working within a public health initiative. As part of this linkage with government, the 27 groups are linked to the District Economic Activities Extension Services (SDAE). In Manhiça District in Maputo, a partnership with SDAE is being consolidated and the District Administrator and others in Boane District are helping to promote the initiative. Project HOPE is also working with the SDAEs of local district governments to create district economic strengthening working groups. The purpose of such working groups is to become established in the near term, to later provide an advocacy platform on market and other finance issues when needed, as members of VS&L groups, or groups themselves, mature to the point of initiating Income Generating Activities (IGAs).

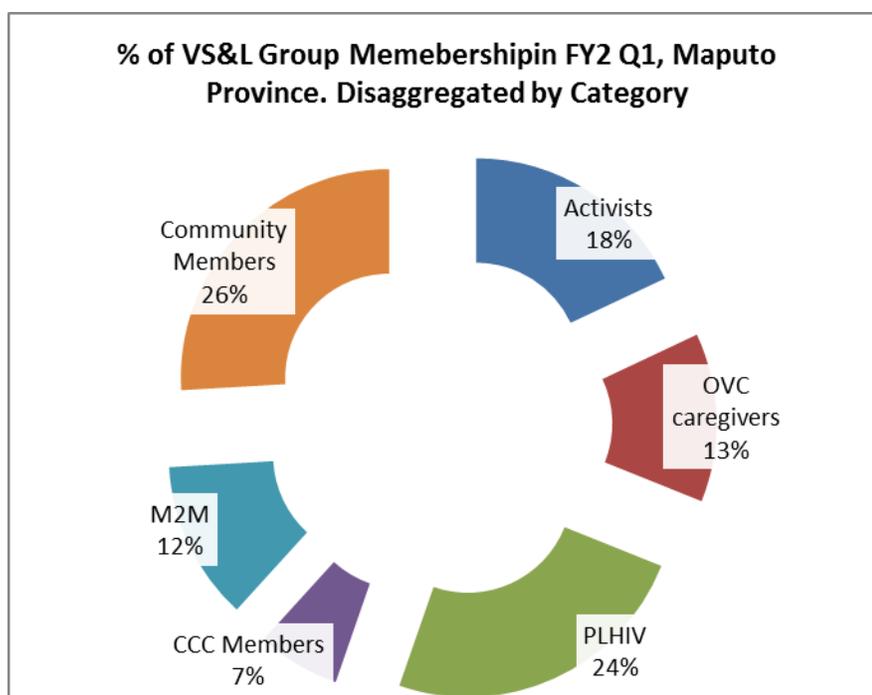
Table 6 and graph 10 below describe VS&L membership by category in Maputo province. Creating VS&L group membership broader than just the families enrolled in care and support provides a much stronger community network. The groups

themselves are comprised of people who choose to commit to this activity. One strength of the VS&L methodology is that trust is key to success of each group; trust is actually the only social asset on which loans are based. CSOs wisely opted for more open groups, to avoid any possible stigma as “sick people’s groups”, to enhance community learning, understanding, and most of all, economic strengthening.

Table 6: Number of VS&L Groups in Maputo Province by District and Membership District and categories

District	Nr. Groups	Types of Members						Total
		Activistas	OVC caregivers	PLHIV	CCC Members	M2M	Community Members	
Moamba	05	22	12	21	09	17	15	96
Matutuine	05	16	13	42	06	12	19	108
Manhica	06	26	12	21	05	10	49	123
Marracuene	04	18	12	37	05	08	00	80
Boane	07	16	22	11	10	20	58	137
<b>Total</b>	<b>27</b>	<b>98</b>	<b>71</b>	<b>132</b>	<b>35</b>	<b>67</b>	<b>141</b>	<b>544<sup>4</sup></b>

Graph 10



<sup>4</sup> All figures need to be updated every month as membership always changes with new people joining the groups and some other people leaving. At this time we are not able to report data disaggregated by gender due to how the data was reported, this will be addressed in Q2.

## **Health Education**

In all project sites many opportunities have been created to give information to the public, to mobilize the community around health issues, particularly HIV, and create awareness of the needs of PLHIV and OVC. In December, World AIDS Day provided a forum for a focus on HIV and also enabled the project to play an active role alongside other donor and government entities (e.g. PSI, Irish AID, CCM, NPCS, FOPROI). Presentations at churches, health fair exhibitions, dramas, dance, and discussion forums are used to encourage the use of services, raise awareness of risky behaviors and mobilize community members around health issues.

## **Support Groups**

Children's Clubs and Mother to Mother (M2M) support groups are two types of groups that are encouraged within the Project. There are nine M2M groups, which were created and supported by the MCH clinics, within one district in Maputo. This is a positive indication of the potential of these types of groups to bring mothers together, encourage use of PMTCT and other pre- and post-partum services and as reported earlier, participate in economic strengthening activities such as the VS&L groups.

Children's Clubs are at a nascent stage in most districts. It is hoped that as CCCs are strengthened their ability to bring community resources together to provide recreational and experiential activities for the children will be an expected outcome.

## **Skills Transfer**

In one District in Maputo, 195 individuals received skills transfer in order to care for their family member needing care. This is an activity that is under-reported as it is a primary function of *activistas* to transfer skills and responsibility for care to family members wherever possible. This assures bringing care closer and more reliably to the HBC client, is a critical element of the family centered approach of the Project and is emphasized during supervisory visits and training.

## **Family Kits from PSI**

The USAID funded PSI Family kits are a means of providing practical support for good health and hygiene in the home, and serve as an excellent wrap around service for this project. The training that is provided alongside the kit content brings information about the importance of clean water, symptoms and prevention of malaria and other important basics of health care in the home. During this quarter 12,797 family kits were distributed to both HBC and OVC households. The process is that PSI ships the kits either to a provincial hub or in some cases to the districts themselves. PSI conducts trainings for the CSOs staffs and *activistas* on the uses and meanings of the kit contents. The *activistas* then distribute the Family kits to the enrolled households, and teach the recipient families how to use each component of the kit, or reinforce the utilization, depending on whether it is a first kit or a later refill kit. PSI bases the frequency of refills (quarterly) on the usage rate of the water purification product Certeza, and reports on uptake and utilization to USAID directly.

## **1.2 Challenges and Ways to Overcome Challenges**

### **Economic Strengthening CSO model**

Project HOPE primarily uses a model of one economic strengthening CSO per province, but with the Community Care Program implementing in only one district in Cabo Delgado there is no logic to following the same model. The proposed solution is for Project HOPE to provide the economic strengthening services directly to the CSO selected for provision of other Project services and its implementation area.

### **OVC Services Provision**

As mentioned above, the GOM has no such OVC graduation criteria similar to that in the HBC structure. At the time of report writing, broader approaches are being debated to assure continuous support for community children over time. One strong idea would be derived from the “community case management” principle, where from the beginning of the Integrated Caregiving to the entire family, support roles for community entities such as the CCCs would be identified and utilized. This reflects a step beyond referrals, and suggests co-management of family needs by various community entities. The project will complete its CCCs inventory, and Community Mobilization project team members will look to ways to strengthen this level of community resource as well. One possibility would be to include a member of a CCC or other active community group in psychosocial support training when possible, to broaden the social safety net. Another strong idea which can fit nicely is a phased approach wherein over time, the *activistas* would give more frequent visits during an intensive phase of the family care plan, and reduce visit frequency over time as needs are met. Both ideas could be woven together for a stronger and more long-term model of a community responding to its own families’ needs.

### **Reporting on Nutritional Services**

The indicator age breakdown of 0-14 years old creates a reporting challenge. The project team, however, continues to work with the implementation and reporting elements to best capture the services delivery in this important programming area. FHI 360 Mozambique is launching systematic DQAs across its projects over the next months, which includes this project.

## **1.3 Program and Operational Management**

### **Baseline Survey**

The baseline survey field work – quantitative and qualitative data collection has been completed. A draft report will be available early in Qtr 2 Year 2, and plans will be made to present to USAID for review and discussion when available.

### **Year 2 Planning Seminar**

The Year 2 planning workshop was held in early December and provided an opportunity for all implementing partners to discuss plans, budgets and program approaches to assure project-wide consistency. It was also a forum to discuss issues and clarify expectations. In all districts project workplans are to be harmonized with DPS and DPMAS workplans for 2012.

### **Sub-Contracts**

- Signed amendment #1 for the Year 1 CSOs, allocating funds for Year 2.
- GUC signed with CSO implementing in Marromeu district.
- For economic strengthening (Project HOPE), two new CSOs – one in Niassa and one in Tete provinces were identified and technical and financial pre-award assessments completed.
- Start-up workshops were held in Tete and Sofala provinces October 31- November 4<sup>th</sup>.

### **Psychosocial Support Training**

While this REPSSI training was very well received the current budget for this activity within the Project is not sufficient to expand this pilot to all sites. Therefore, a way forward is being considered with the following possibilities:

- 1) Build a coalition of donors to share the activity costs (other OVC projects e.g.)
- 2) Revise the model to that of TOT format, to build local pool of trainers (2 per district) and significantly reduce the cost burden of the REPSSI Master Trainers rate
- 3) Obtain permission to reproduce the training materials (photocopy).  
Consider 1 manual per every 3-5 *activistas* instead of 1 for each.
- 4) Assure continued practice of the training venue being no-cost, or donated.  
Publish a tender for a bidder to provide the revised model.

This is a top priority project activity and the Project will have a finalized way forward in the next quarter, after consultations with MMAS and the project COTR.

### **Organizational Structure and Personnel**

- The Provincial Coordinator for Inhambane (World Relief) resigned. A vacancy announcement was made and CVs received and shortlisted. In the interim, the Country Director and M&E Officer are more engaged, following a strong program structure established by the previous Provincial Coordinator.
- The PMTCT/Nutrition Technical Officer was hired and will start in January.
- TOs to help with Economic Strengthening in Sofala, Tete, and Maputo are in various stages of hiring.
- The Maputo/Pemba TO, based in Maputo, was hired and started in December. This TO resembles the TOs in the provincial offices, with oversight of designated CSOs. The management burden of 6 districts (5 in Maputo and 1 in Pemba) poses a feasible balance of day trip distances in Maputo province and domestic flight to Pemba for all technical assistance and support. This remains a better use of resources than opening and staffing a Cabo Delgado province office to support only one CSO. At times, it has been best to bring the Pemba CSO

leaders to Beira, for the SOW and Start Up Workshops, for example. In this way, the Pemba CSO had the opportunity to interact with other CSOs for cross learning and solidarity. While all the project TOs have designated caseloads, either for specific CSOs or technical areas, support and follow up are always a balance of regular mentoring and capacity building, against responsiveness to specific needs or gaps that arise and need more focus and support.

- The TORs for the Gender Strategy Consultant were drawn up for January solicitation.
- The hiring process for the Project Technical Director was put into final stages for the selected candidate's February start. (latest update at time of report writing: this candidate declined and an internal candidate has been put forward to USAID and now approved, for immediate commencing of the post.)

### QA/QI

The Project has selected the referral system as a quality improvement project under the internal FHI 360 Technical Capacity Building strategy. The pilot phase will be completed within the second Quarter of Year 2, resulting in a report and recommendations on integrating the QA/QI strategy across all the project districts and local implementers.

### Project Coordination

A Management Committee Meeting was held October 31<sup>st</sup>, where the reality checking of the mCel initiative was the major focus. The way forward was determined to be a community needs assessment or community inputs activity, to understand better what utilizations of mHealth possibilities would best accommodate felt needs and capacities. Scheduling constraints and the holidays pushed this forward to early next quarter.

### Procurement

The following table summarizes the distribution and procurement of motorbikes/helmets and bicycles during the quarter

Table 7: Procurement during Y2 Q1

Province	Bicycles	Motorbikes and helmets
Maputo	113*	5 and 10
Manica	201	10 and 20
Inhambane	80	5 and 10
Sofala	40	8 and 16
*includes 12 bicycles for VS & L facilitators through Project HOPE		

## 1.4 Financial Summary

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

Total expenditure to date: \$1,725,441

CSO budgets were revised upward for Year 2, to levels that can be sustained over the LOP. As described above, expected start-up funding this quarter for the CSOs covering 16 new Year 2 districts was delayed until next quarter, due to unanticipated repeated rounds of searching for viable CSOs in Tete Province. While normal Holiday closures were well anticipated, and Leaves at all levels were well managed, additional unforeseen complications further contributed to start up delays. Also, the anticipated Year 2 sub contract with MONASO has not been implemented, due to poor performance during Year 1, which consisted of late or incomplete report submissions, not revising the main deliverable to include local level inputs upon presentation of the Capacity Building Assessments, not providing the database as per agreement. Other strategies for the Capacity Building component are under development, as written above. We anticipate that taking the necessary time to craft a strong and substantive CSOs Capacity Building strategy with the CAP project hopefully, and others, will compensate for the delay in starting up the capacity building activities.

**Pipeline** report is included in Annexes.

## 1.5 Plans for Next Quarter

**January 2012** (most staff out for Leave much of January)

- 9-13 Tete SOW Workshop with three CSOs covering five Districts
- 17-20 FHI 360 Finance Training for provincial finance staff
- 17-17 Feb Regional Technical Assistance TDY: Carla Horne
- 18 Manhiça District FHI 360 QA/QI data collection
- 23-24 USAID Retreat re PMTCT, and Care and Treatment
- 23-27 Financial Site Reviews of CSOs in Niassa Province
- 23-4 Feb First Integrated *Activista* Training in two Districts in Tete Province
- 24 mHealth community needs assessment with ACIDECO in Manhiça District
- 27 USAID site visit to ACIDECO, Manhiça District
- 30-3 Feb Tete Province Capacity Assessments of new CSOs
- 31 Baseline Survey report due

## February 2012

- 1 USAID OVC meeting
- 1 Technical Committee Meeting, on Review Year2 Q1 M&E
- 1 Meeting with MMAS on OVC services timeframe
- 6-10 OVC pre-training of Tete CSO without OVC experience
- 6-10 Tete CSOs Start Up workshop and M&E Training
- 7 Internal Baseline report presentation
- 13-25 Second Integrated *Activista* Training in 2 Districts: 1 each in Tete and Sofala
- 16 MISAU APEs meeting
- 20 USAID Baseline report presentation
- 29 Next USAID meeting on PMTCT, and Care and Treatment
- TBD Meeting of Project and CAP with respective C/AOTRs on Capacity Building  
Central project 1-day team "retreat" to restructure with new Technical Director  
Distribution of Services Directories of new Year2 districts  
Introductions to GOM structure of new CSO in Pemba District  
Procurement and dissemination of motorbikes to new Year2 CSOs  
Project HOPE CSOs select local facilitators, start up 112 more VS&L groups  
Roll out new project name  
Complete pilot of Referral/Counter-Referral form  
Determine with MMAS next steps on Psychosocial Support Training  
Verifying inventory of CCCs, CLSs, etc for planning community networks  
Project HOPE facilitator recruitment and VS&L groups formation

## March 2012

- 5-17 Third Integrated *Activista* Training in 2 Districts: 1 each in Tete and Niassa
- 6-8 MISAU National Nutrition Meeting in Sofala on Integrated Programming ( present case study)
- 7 Technical Committee
- 8 QA/QI workshop with ACIDECO in Manhiça District (FHI360 activity)
- TBD Province and District level Baseline presentations  
SAPR preparation  
Project HOPE facilitator recruitment and VS&L groups formation

## **1.6 Areas Requiring USAID Assistance**

### **Branding and marking**

With recent directives from USAID on changing the project name, more guidance will be needed on presentation details. Once concluded, FHI 360 will move forward with providing all CSOs a branded banner to display in their trainings and other public events.

### **CSO Determination**

Inconsistencies were found concerning the vetting and approving of one CSO in Sofala province. It has been determined that a grant under contract will not be provided to the CSO due to an ongoing investigation, unless any other mitigating information comes to light.

### **Annexes:**

## Annex 1: Project Pipeline

Organization Name	Family Health International												
Cooperative Agreement No.													
ComCHASS/USAID Community Care Program													
Date of submission:	06-02-2012												
Item	Year 1 (Sept 2010 to Sept 2011)			Year 2 (Oct 2011 to Sept 2012)					Cumulative YTD (Aug 2010 to Dec 2011)			LOP (Aug 2010 to July 2015)	
	Estimated amount (realigned) US\$	Obligated amount US\$	Actual expenditure US\$	Estimated amount US\$	Obligated Amount (mod3 and 4) US\$	Actual Expenditures Oct and Dec 2011 US\$	Projected January 2012 US\$	TOTAL Projected to Jan 2012 US\$	Estimated amount (US\$)	Obligated amount US\$	Actual expenditure US\$	Estimated Amount US\$	Remaining balance (LOP) US\$
Personnel	1,079,092	1,079,092	752,537	1,613,633	1,613,633	174,672	60,000	234,672	2,692,725	2,692,725	987,210	7,146,631	6,159,421
Fringe Benefits	417,196	417,196	285,440	583,030	583,030	34,869	15,000	49,869	1,000,226	1,000,226	335,309	2,268,004	1,932,696
Travel and Transport	331,002	331,002	326,558	630,967	630,967	76,381	20,000	96,381	961,969	961,969	422,939	1,443,637	1,020,698
Equipment	664,900	664,900	846,052	168,500	168,500	38,209	10,000	48,209	833,400	833,400	894,261	886,549	-7,712
Supplies	146,000	146,000	92,402	169,700	169,700	83,571	10,000	93,571	315,700	315,700	185,973	539,132	353,159
Subrecipient & Grants	3,077,301	3,077,301	1,970,919	4,642,384	4,642,384	687,369	500,000	1,187,369	7,719,685	7,719,685	3,158,288	20,949,020	17,790,732
Other Direct Costs	832,877	832,877	663,225	979,334	979,334	370,243	100,000	470,243	1,812,211	1,812,211	1,133,467	4,049,029	2,915,561
		0			0								
Subtotal Direct Costs	6,548,368	6,548,368	4,937,132	8,787,548	8,787,548	1,465,314	715,000	2,180,314	15,335,917	15,335,917	7,117,447	37,282,002	30,164,556
		0			0								
Indirect Costs	1,080,428	1,080,428	700,949	1,303,141	1,303,141	260,127	143,000	403,127	2,383,569	2,383,569	1,104,076	5,155,824	4,051,748
Fees	381,440	381,440	240,676	504,534	504,534	27,252	0	27,252	885,974	885,974	267,927	2,121,891	1,853,964
Total US\$	8,010,236	8,010,236	5,878,757	10,595,223	10,595,223	1,752,693	858,000	2,610,693	18,605,460	18,605,460	8,489,450	44,559,717	36,070,267
Cost Share													
Grand Total US\$	8,010,236	8,010,236	5,878,757	10,595,223	10,595,223	1,752,693	858,000	2,610,693	18,605,460	18,605,460	8,489,450	44,559,717	36,070,267

## **Annex 2: Ministry of Health HBC “Graduation Criteria”**

Whether the person for a period of 6 months has been:

On ART with 100% adherence

Asymptomatic and free of opportunistic infections

Emotionally stable

Economically secure as much as others in the same community

Keeping their clinic appointments

Using condoms, family planning or abstaining from sexual activity

Aware of the need to go for PMTCT if pregnant

Able to eat nutritious meals regularly

Within the Family Context

Has family members who are also either on ART or HIV negative

Has disclosed to family members and is open about being HIV+

Has a supportive relationship

Has had all children tested for HIV and on treatment if necessary and adherence is not a problem

Has been able to disclose to HIV + children as appropriate to their age

In the Community Context

Is not afraid of being stigmatized by the community (or self-stigmatizing)

Is able to be a participating member of the community as much as they would like to be involved (e.g. attends church freely, attends community functions)

Is able to explain HIV to others so that they understand how to avoid infections  
able to participate in a support group or other group that assists them

### Annex 3: Success Stories

The following success stories are samples of the improvement in people's lives that community care has been able to achieve.

#### Maputo

In Bairro de Mumemo-1, Maracuene District, about 30 kms from the capital city of Maputo, there was an HIV positive elderly woman living alone, in very poor conditions. Seeing her deteriorating situation, her community leader, aware of the services of HBC provided by CONFIC (Congregacao das Irmãs Franciscanas Hospitaleiros da Imaculada Conceicao) in his community, contacted the *activista* for the area so that this client could benefit from their services. She was successfully enrolled and the community leader, together with her *activista* mobilized community members to rehabilitate her house. While the rehabilitation was on going, CONFIC coordinated with Sisters of the Immaculate Conception in Hulene to provide the client with a temporary living arrangement for 2 months. During this time *activistas* took her medications to where she was staying in Hulene. Thereafter she returned to her repaired house in her community, her situation is much improved and she continues to receive support through the *activistas*. Even though she was graduated (discharged) from HBC, she still receives one or two adherence support visits per month. She has joined a women's IGA group that makes clothes.

#### Niassa

A 27 year old woman who was three months pregnant went for her first prenatal consultation and was counseled to go for an HIV test. She did and was found to be HIV positive. She began to think that she should have an abortion because she thought her child would be infected also and die. She was aware of the HBC services in the community and went to see an *activista* nearby. She received more counseling from the *activista* and due to the new information she received, came to realize that it was possible for her to prevent passing on HIV to her child through PMTCT. She subsequently delivered a healthy child who is now 5 months of age. The baby is HIV negative and the mother is very grateful for the counseling she received.