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**USAID Community Care Program  
(USAID Programa de Cuidados  
Comunitários)  
Task Order No. GHH-I-05-07-00043-00**

**FY2010 1<sup>st</sup> Year of the Project**

**# Quarter Report: Q4 of Yr 2, July – September 2012**

Project Logos

**Date of Submission: 31 October 2012**

1. **Project Duration:** 5 years
2. **Starting Date:** 27 September, 2010
3. **Life of project funding:** \$ 44,559,717
4. **Geographic Focus:** 52 total districts per below  
all districts in Sofala, Manica, Tete provinces (36)  
5 districts in Maputo, Niassa, Inhambane provinces (15)  
1 district in Cabo Delgado (Pemba)

**5. Program/Project Objectives**

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

The CCP objectives are:

- 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.

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

**6. Summary of the reporting period**

Please describe main activities and achievements of the reporting period grouped by objective/IR, as structured to in the monitoring plan or work plan. Explain any successes, failures, challenges, major changes in the operating environment, project staff management, etc.

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

### **Activity Area 1.1:**

#### **Technical Working Groups**

Summary information on TWG activity updates by CCP technical staff:

##### **OVC TWG**

- Contributed to developing the National Plan for Child Action II, under MMAS
- Contributed to revising the PSS ToT training manual
- Working on mapping of organizations providing PSS human and material resources
- Presented FHI 360 originated Behavior Protocol for working with children to MMAS
- Joined PSS TWG

##### **HIV/ HBC TWG**

- Contributed to development of national palliative care strategy led by MOPCA
- Contributed to updating HBC strategy under MISAU
- Contributed ongoingly to HBC/OVC integrating plan

##### **Health Promotion TWG**

- Participated in MISAU discussion of the approval process for all IEC materials through DePros (Department of Health Promotion)
- Facilitating technical group for harmonization of referral/counter referral tools used by community implementing partners

##### **SDSMAS Training**

CCP is contributing to building the capacity of SDSMAS staff in areas that support CCP target groups, for example OVC in this reporting period. The PSS training represents one of CCP's best practices, building capacity in both SDSMASs and the local CSOs. One social service officer and a CSO supervisor from each of the 52 districts were trained as PSS Trainers by REPSSI, the recognized regional leader in psychosocial support services. These new Trainers then trained the *activistas* in their own districts, building SDSMAS capacity to lead in this technical area. This model builds district level resources, knowledge, and skills, and also avoids the costs of bringing in trainers from the capital.

#### **Supportive Supervision**

Overall, CCP is simultaneously carrying out supportive supervision in various ways, and, developing a standardized supervision strategy for the HBC/OVC Integrated Care and Support providers with the partner Ministries. A multi-level approach brings supervision capacity building to the public sector (SDSMAS) and private sector (CSOs) both.

- The CCP joint supervision strategy is working well in 20 districts across six provinces, with joint visits to the CSOs by CCP technical staff and SDSMAS
- Project HOPE carries out joint supervision in Sofala province with their economic strengthening CSO ADEM; and with World Relief and the economic strengthening CSO Kukula in Inhambane province
- CCP, ANEMO, and SDSMAS staff undertook joint supportive supervision visits to follow up on accredited trainers' performance in Maputo and Sofala provinces in this reporting period

- Overall, CCP technical staff have maintained their technical assistance value added through supportive supervision visits covering all technical areas, in all project provinces.

## **Activity Area 1.2:**

### **Capacity Building of CSOs**

#### **Organizational Training**

In collaboration with Capable Partners Project (CAP) and utilizing their in-depth capacity building program, CCP facilitated the following trainings:

- *Associativismo* for boards of directors (18-*organs sociais*) of implementing CSOs: KUPONA, AMODEFA, ACIDECO & CONFHIC in Maputo province
- *Procedures and Policy* for boards of directors from CSOs: KUGARRISKA, ADS, KUPHEDZANA and AMICUMO of Sofala province (18), and CHINGIRIRAI, RUBATANO, CENTRO ABERTO and KUZVIPIRA of Manica province (20)
- Each CSO developed an Action Plan at the end of CAP trainings to address organizational weaknesses identified during training, triangulating with the MONASO Capacity Assessment carried out in Yr 1 of CCP. CSOs get grouped together according to their assessed capacity level; this serves as a strong platform for discussing and accepting or clarifying the capacity issues they face.
- CCP and CAP staff conducted joint follow up visits to Maputo province CSOs.

#### **Project Management**

- CCP provided feedback to CSOs on Q7 achievements against targets, and refreshed on Q8 targets
- Technical Assistance (TA) to the CSOs on effective workplan and service delivery implementation. CSOs' follow up of their community activities is improving after a Register (book) for tracking issues and recommendations was introduced
- World Relief (WR) conducted a workshop for their Inhambane province CSOs to review and discuss reporting mechanisms and follow up, targets achieving results
- SOW and Start-Up workshop for new the new CSO in Muanza district of Sofala province.

#### **Monitoring & Evaluation**

CCP trained provincial M&E officers on Data Quality Assessments (DQA) (using an FHI 360 simplified 2 page tool) to support the quality of CSOs' reported data. Over time, the CSOs can improve on their reporting by frequent data verification which can also support improved project management.

CCP also provided provincial M&E officers a 3-day theoretical and practical training on data cleaning and verification, for comparing reported data to primary sources on key indicators.

M&E TA continues in the cascade model, from prime to provincial M&E officers, to the CSOs, through mentoring and on the job training, building their M&E capacity.

CCP M&E teams reviewed data collection tools for CSO *activistas* to reduce the burden of filling many forms; now forms are separated into two groups: a) Technical which the CSO supervisors are now responsible for compiling and analyzing, and b) M&E used by *activistas*. Trainings have

been provided to provincial M&E officers on the use of the tool and will cascade to the districts/CSOs.

## Technical Trainings

### HBC/OVC, PSS, PPPW, and Nutrition

Community *activistas* under the implementing CSOs undergo trainings based on several factors: their start-up date drives both the initial training as well as the annual refreshers, which aim to continuously build their capacity to meet community level needs.

**Table 1: Activista Integrated trainings on HBC/OVC, and M&E (also Refreshers)**

| Province     | # of trainers accredited | # <i>activistas</i> : Integrated HBC/OVC* Training | # <i>activistas</i> : Integrated HBC/OVC* Refresher | # <i>activistas</i> : initial M&E | # <i>activistas</i> : Refresher M&E** |
|--------------|--------------------------|--|---|-----------------------------------|---------------------------------------|
| Niassa       | 2                        | 40   | 85  |                                   | 8                                     |
| Sofala       | 2                        | 20   | 40  |                                   |                                       |
| Tete         | 3                        | 53   | 0   | 25                                | 89                                    |
| Maputo       | 1                        | 30   | 145   |                                   | 6                                     |
| Inhambane    | 0                        | 0  | 130   |                                   | 110                                   |
| Manica       | 0                        | 0  | 203   |                                   | 26                                    |
| Cabo Delgado | 0                        | 0  | 0   |                                   | 1                                     |
| <b>Total</b> | <b>8</b>                 | <b>143</b>   | <b>603</b>  | <b>25</b>                         | <b>240</b>                            |

\*Integrated caregiver (*activista*) trainings use the combined MOH and MMAS curricula.

\*\*M&E refresher trainings are provided based on identified needs of the CSO. This covers specific data collection tools for HBC, OVC, PPPW, Nutrition; storage and filing of primary sources of data, DQA, data cleaning and verification, data analysis and compilation of reports.

**Table 2: Multi-level trainings on Psychosocial Support (PSS) and OVC Minimum Package**

| Province     | # ToT PSS Training | # <i>activistas</i> : PSS Training | # Supervisors on OVC Minimum Package |
|--------------|--------------------|------------------------------------|--------------------------------------|
| Niassa       | 13                 | 0                                  | 0                                    |
| Sofala       | 28                 | 357                                | 1                                    |
| Tete         | 28                 |                                    | 3                                    |
| Maputo       | 11                 | 144                                | 14                                   |
| Inhambane    | 12                 | 131                                | 2                                    |
| Manica       | 21                 | 0                                  | 0                                    |
| Cabo Delgado | 2                  | 21                                 | 0                                    |
| <b>Total</b> | <b>115</b>         | <b>653</b>                         | <b>20</b>                            |

As mentioned above, the PSS training represents one of CCP's best practices, building capacity at both the CSO and SDSMAS (district) levels. One social service officer and a CSO supervisor from each of the 52 districts were trained as PSS Trainers by REPSSI, the recognized regional

leader in psychosocial support services. These new Trainers then trained the *activistas* in their own districts, building CSOs' technical capacity to provide PSS as a direct CCP service, especially to OVC. This model builds district level resources, knowledge, and skills, and also avoids the costs of bringing in trainers from the capital.

Capacity building on the OVC Minimum Standards Package was a pilot, in partnership with MMAS, for coordinators, supervisors and program officers to improve their understanding of:

- OVC services and support including creating Children's Clubs and people working with children to practice the Behavior Protocol
- the integrated approach, including clarifying on the intensive and maintenance phases of OVC care and support under CCP.

## **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**

### **Activity Area 2.1:**

#### **Referral Networks**

- SDSMAS coordination meetings (district level) addressed important issues such as linkages across community and clinical services, health fairs, and the constitution of a single OVC body (NUMCOV).
- Coordination meetings with ARIEL Foundation took place in Maputo and Cabo Delgado provinces in this reporting period to improve referral of PPPW to PMTCT services, including identification, education and sensitization.
- While CCP referral rates of beneficiaries to needed services are improving over time, a lack of nutritional services providers still poses a large challenge.
- In preparation for universal usage of the Referral/Counter-Referral form starting Q1 Yr 3, *activistas*, supervisors, and staff of social welfare and clinics received training on the form.

#### **Service Directories**

Initial mapping of all district level social and health services, and the resultant Service Directories, remain a good programming concept. However, successful referrals to providers other than the GRM clinics and social services institutions have shown to be few. CCP will investigate this situation in Yr 3.

#### **Baseline Survey**

CCP successfully renegotiated the contract closing terms with the baseline contractor in this reporting period. The contractor's failure to provide the final baseline report has caused significant delays to the dissemination activity. However, CCP was able to present its baseline findings at the MOH *Jornadas de Saude* annual conference in September, thus accomplishing the highest level dissemination of the results. Final report completion has been taken on by FHI 360 internal experts, for finalization and dissemination to take place in Q1 of Yr 3.

### **Activity Area 2.2**

#### **Public Private Partnerships (PPPs)**

### **Financial Literacy**

Project HOPE continues fruitful collaboration with BOM on the development of Financial Literacy training materials. The curriculum has been finalized between the two, and they will share the reproduction costs in Q1 of Yr 3 to begin rolling out Financial Literacy trainings to the VS&L groups when they have reached maturity phase.

### **Capacity building for the Economic Strengthening CSOs**

Project HOPE was intensively engaged for the entirety of this reporting period on VS&L start up and support across the seven CCP provinces, and was not free to pursue this PPP activity with Standard Bank.

### **Mcel: mHealth Activity**

The planned Process Evaluation of the 6-month mHealth pilot in Manhica district of Maputo province continues to move forward. The protocol was approved by the FHI 360 bioethics committee (PHSC) and is currently undergoing translation into Portuguese for submission to the Mozambican national bioethics committee (CNBS). While Q3 Yr 2 saw a strong initial uptake of the mHealth messaging opportunity in the pilot district, there were only a few new people in this Q4 opting to receive the messages. *Activistas* were re-trained on their role in recruiting people for the mHealth message activity during this reporting period, and uptake is once again on the rise.

Initial discussions were also held with USAID national and regional M&E staff to establish an external evaluation of this key CCP activity. They have contracted with MEASURE; see also Section 11, Evaluation Updates for more details.

### **Millennium Bank and the USAID DCA**

Project HOPE identifies the activity in this PPP to best be activated after matured and graduated VS&L groups have already been linked to BOM and other financial institutions.

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

### **Activity Area 3.1:**

#### **Community committees**

On a monthly basis, CSOs *activistas* participate in community committee (CC) meetings (such as CLC, CCPC, CSC and other support groups) to identify problems and collaborate on possible solutions. Also at the CSO level, discussions to clarify the role of community committees are taking place. To best support this initiative, terms of reference (ToRs) regarding the establishment and functioning of CCs have been distributed to all Provincial Leads, to facilitate standardizing CC operations through the CSOs' support. This is a major CCP Yr 3 activity, aiming to strengthen community level sustainability of support activities.

In Inhambane province for example, CCP CSOs facilitated meetings with community committees to ensure their full involvement in project activities and strengthen their committees. For instance, Liwongo Association met with 15 existing community management committees.

The number of Children's Clubs increased this quarter, due to clarification on their purpose and functioning and collaboration with community leadership to identify space in the community for them. Establishing the importance of such structures provided the foundation for the increase.

The gender mainstreaming strategy developed by CCP in Q2-3 of Yr 2 will be fully rolled out in Yr 3, and data will be collected on the approved indicators.

## **Activity Area 3.2**

### **Educational Materials**

CCP reproduced for implementing partners the following materials to support quality service delivery: both FHI 360 and PEPFAR OVC care and support guides (translated to Portuguese), and the GRM Child Protection Committee manual. As well, all trainings for *activistas*, supervisors and GRM district focal points include training manuals for ongoing use as a technical resource.

CCP is also participating in an FHI 360-wide initiative to inventory all existing IEC materials and job aids to best inform next steps on production of needed materials without duplication.

### **PSI Family Health Kits**

In this reporting period, PSI distributed 2,500 family health kits in Inhambane province and 2,650 in Sofala province.

PSI distribution delays were due to ongoing negotiations regarding the inclusion of nutritional supplements in the kits. Our understanding is that the supplements will be intended for PPPW and children, according to need.

### **Basic continuing activities**

CSOs regularly report condom distribution to local Nucleos.

HBC kits for *activistas* and nurse/supervisors are procured regularly as per scheduled refilling needs to avoid any interruptions in care provision.

### **Comprehensive Service Delivery**

CCP implementation overall has matured throughout Yr 2 and has produced strong results towards annual targets by the end of this reporting period. While HBC and OVC implementation are integrated in most CCP districts, they will still be discussed separately as per PEPFAR indicators and CCP targets. Q4 Yr 2 saw a steady rise in integrated services delivery; see Section 7 below for discussion.

## **Activity Area 3.3**

### **Care of Caregivers**

The psychosocial support (PSS) trainings which provide the foundation for this activity were finally realized in this reporting period. Providing PSS to OVC is the CCP first tier priority; expanding PSS to the *activistas* themselves and other family members will commence with Yr 3 activities, delayed due to the extended preparation period for the comprehensive PSS trainings.

**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**

## Activity Area 4.1

### VS&L groups

During this reporting period a total of 47 **new** VS&L groups were established by the economic strengthening CSOs under Project HOPE in Inhambane (15), Maputo (2), Sofala (29) and Cabo Delgado (1) provinces, totaling 993 **new** community members, (868 women, 125 men).

**Table 3: New VS&L Groups and Membership in Q4 Yr 2**

| Province     | VS&L Groups | VS&L Membership in Q8 |            |            |
|--------------|-------------|-----------------------|------------|------------|
|              |             | M                     | F          | Total      |
| Cabo Delgado | 1           | 0                     | 11         | 11         |
| Inhambane    | 15          | 56                    | 336        | 392        |
| Maputo       | 2           | 25                    | 38         | 63         |
| Sofala       | 29          | 44                    | 483        | 527        |
| <b>Total</b> | <b>47</b>   | <b>125</b>            | <b>868</b> | <b>993</b> |

In Niassa province 10 new community facilitators were trained, (two per district) by ROADS (Rede das Organizações para Ambiente e Desenvolvimento Sustentável), totaling 102 trained community facilitators to date.

Project HOPE is implementing directly in Maputo province, where 4 VS&L groups reached the end of their first savings cycle and have “shared out”, meaning all members received back their own savings amount plus interest earned (114.645,00 Meticaís, around \$4,100 US). They have started a new VS&L cycle. In the VS&L strategy, community facilitators intensify their support visits to new groups and lower their visit frequency to groups going into repeat cycles, allowing attention and support to further new groups starting up.

Routine monitoring data from household member profiles of VS&L members at the time of start up will later contribute to learning about actual economic progress.

### Public Private Partnerships (PPPs)

Project HOPE conducted a session on developing PPPs to one of the monthly CCP Technical Committee meetings, to begin to build capacity of all CCP Provincial Leads in this area.

Initial communications have started with letters to other potential PPPs such as Mozal, Coca-Cola and HCB (Hidro Eléctrica de Cahora Bassa). Yr 3 will see significant efforts on developing such PPPs as opportunities either for vocational training, or support for community activities.

In two districts in Sofala province, four community facilitators have started a collaboration with the National Central Bank for adoption of national monetary social mobilization for the introduction of new coins and notes to replace the old ones. This has potential to extend the reach of knowledge to rural areas most often far from bank facilities on this upcoming national initiative, where getting stuck with unusable currency could be very detrimental to household economic status.

## Activity Area 4.2

Community sensitization activities are part and parcel of routine CSO implementation, obviously resulting in increased use of care and support services.

There were no health promotion days or campaigns reported during this period.

### Activity Area 4.3

Self care and self protection knowledge and skills are routine components within the family approach of CCP, to all target groups, including general home care of the sick, hygiene, nutrition education, and living positively. CCP also initiated linkages with PACTO, to investigate collaboration on their positive prevention project activities.

## 7. Project Performance Indicators

### Option 1: Basic Format

| Indicator         | Annual Target | Q1 Results | % Achieved - end Q1 | Q2 Results | % Achieved - end Q2 | Q3 Results | % Achieved - end Q3 | Q4 Results | % Achieved - end Q4 |
|-------------------|---------------|------------|---------------------|------------|---------------------|------------|---------------------|------------|---------------------|
| New OVC           | 64,800        | 3,890      | 6                   | 8,959      | 20                  | 6,053      | 60                  | 37,522     | 118%                |
| HBC               | 21,600        | 5,805      | 27                  | 2,380      | 38                  | 4,978      | 61                  | 5,306      | 86%                 |
| PPPW              | 813           |            |                     |            |                     |            |                     | 1,651      | 203%                |
| Nutrition Support | 22,413        | 1,043      | 5                   | 7,098      | 36                  | 19,342     | 123                 | 39,368     | 298%                |

### Comments:

CCP implementation has met or exceeded its annual targets for OVC, HBC, PPPW, and Nutritional Support, with steady quarterly increases in both services delivery, and importantly, improvement in reporting on activities at all levels. CCP technical staff at central and provincial levels have worked very hard to improve the monitoring and reporting components of the project, thus correcting earlier under reporting problems. In addition to taking up Data Verification Exercises, CCP initiated a very focused Year End Data Clean Up exercise throughout September. CCP is therefore very confident in its Q4 Yr 2 data.

### OVC

CCP worked very hard over Yr 2 to identify and provide services to OVC. Achieving 120% of the Yr 2 target demonstrates the efficacy of the *activista* trainings, clarifications on integrated caregiving, the family approach, supervision, mentoring, and improved monitoring and reporting. One additional key factor is the new *activista* capacity in this reporting period to deliver psychosocial support as a direct service, to meet this particular overarching need among OVC. Anecdotally, project team often heard from *activistas* how they wanted so much to provide more than referrals and education on various components.

### HBC

Q4 Yr 2 HBC delivery pushed the achievement for the year to 86%. While on the face of it, this performance seems lower than desired, CCP has fairly good understanding of the shortfall in HBC service delivery. A total of 14 Yr 2 districts experienced later than anticipated start up, thus missing the opportunity in Q1 Yr 2 to initiate HBC services to the target 1,650 for the 14 districts (13 in Tete, 1 in Cabo Delgado). This calculation is derived from the formula of 6 initial

HBC clients (and their families) per each *activista*. This volume of service delivery alone would have increased achievement for the year to 94%.

Another issue CCP found was lack of adherence to HBC graduation criteria, thus keeping some HBC clients in service longer than necessary and slowing the intake of new HBC clients to more closely attain the target. CCP worked to correct this practice during this quarter. It should also be noted that comparing the APR data to this quarterly results matrix, one finds a difference of about 100 HBC clients resulting from earlier quarters. This is an artifact of data collection and reporting problems in this project year, which have now been largely solved.

### PPPW

That CCP exceeded the pre- and post-partum woman (PPPW) target is a bit complex. As reported throughout Yr 2, achieving *completed* referrals of PPPW specifically to PMTCT services is an ongoing challenge. CCP is reporting for this quarter only on referrals to PMTCT within the Referral/Counter Referral form pilot districts as follows:

|        |             |                          |
|--------|-------------|--------------------------|
| Tete   | 4 districts | 328 referrals to PMTCT   |
| Sofala | 4 districts | 668 referrals to PMTCT   |
| Manica | 6 districts | 304 referrals to PMTCT   |
| Niassa | 5 districts | 332 referrals to PMTCT   |
| Maputo | 1 district  | <u>19</u>                |
|        |             | 1,651 referrals to PMTCT |

We expect these results to increase when the Referral/Counter Referral form is universally rolled out in Yr 3 to **all** CCP districts, to better report on PPPW referral specifically to PMTCT services. CCP performance in the PPPW area more broadly includes counseling, referral, and follow up for this project target group and reached 1,590% of annual target. Clearly the PPPW annual target was set low and the project has learned a lot from this implementation year.

### Nutritional Support

- In order to improve nutritional services referrals, CCP continued to intensify the use of Middle Upper Arm Circumference (MUAC) across the project areas in this reporting period.
- At district level contacts with the health units were established to ensure the smooth implementation of referral system.
- At central level in collaboration with FANTA, a nutrition module was completed and merged into the Integrated Caregiver curriculum (HBC/OVC).
- Nutrition services are found to be inconsistent across the CCP implementation provinces and districts. For example, WFP previously provided nutritional supplements in Matutuine district in Maputo province, but in Q4 Yr 2 shifted to Moamba district, where 350 OVC and 150 PLHIV were referred for nutritional supplements. Another 60 CCP clients were referred to WFP nutritional supplements in Inharrime district in Inhambane Province. Further in Inhambane, the CSO Rede Pastoral de Morrumbene in Morrumbene district referred 343 OVC to Acção Social for needed food.
- This target was significantly exceeded, by improved reporting.

### Adherence Support

CCP contributes to adherence support, not only for ARVs, but for TB treatment and for keeping routine clinic appointments.

**Table 4: Adherence Support provided to HBC clients in Q4 Yr2**

| Description of Adherence Support | # of clients aged 0 to 14 years old |            | # of clients 15 years and older |              |
|----------------------------------|-------------------------------------|------------|---------------------------------|--------------|
|                                  | M                                   | F          | M                               | F            |
| # of Clients for Control at HU   | 457                                 | 478        | 2,462                           | 5,301        |
| # of Clients on ARV Treatment    | 285                                 | 241        | 1,498                           | 3,158        |
| # of clients on TB Treatment     | 45                                  | 37         | 378                             | 626          |
| <b>Total</b>                     | <b>787</b>                          | <b>756</b> | <b>4,338</b>                    | <b>9,085</b> |

### Busca Activa

Another key initiative under CCP is *busca activa*, a highly collaborative activity between the community- and clinic-based services. The CSO *activistas* assist the HIV clinics with tracing and finding treatment “defaulters” in their communities, and returning these “patients” to their treatment regimens. The *activistas* have recovered and returned to the clinics 88% of those they were able to locate at the community from the clinic lists. Results have improved this quarter given better collaboration, intervention of case managers at the clinics and follow up of clients returned to the clinics. As well, the *activistas* are becoming known and their efforts recognized by community leaders and members. Community leaders are an especially important resource when any defaulters on the clinic lists may be known to be resistant to being found or returned to their treatment regimen, more often true of men than women. In general, in order to achieve the best outcome (the defaulter back on treatment) *activistas* collaborate amongst themselves to match the gender of the defaulter to that of the *activista* and to draw in any appropriate community leaders when that is deemed helpful, regardless of gender.

**Table 5: Summary Busca Activa Disaggregated by Province and Gender in Q4 Yr2**

|                           | # of PLHIV on Lists given to CSOs for <i>Busca Activa</i> |              | # of Defaulters Identified and Referred to their Health Unit |            | # of Defaulters fully returned to their Health Unit and ARVs regimen |            |
|---------------------------|---|--------------|--|------------|--|------------|
|                           | M   | F            | M  | F          | M  | F          |
| <b>Province</b>           |   |              |  |            |  |            |
| Inhambane                 | 80  | 147          | 47   | 80         | 44   | 73         |
| Manica                    | 326   | 323          | 195  | 234        | 175  | 226        |
| Maputo                    | 56  | 72           | 23   | 48         | 21   | 42         |
| Niassa                    | 105   | 159          | 68   | 98         | 53   | 67         |
| Sofala                    | 254   | 491          | 160  | 302        | 151  | 269        |
| Tete                      | 143   | 144          | 71   | 92         | 61   | 85         |
| Cabo Delgado              | 92  | 97           | 13   | 23         | 10   | 6          |
| <b>Total</b>              | <b>1,056</b>  | <b>1,433</b> | <b>577</b>   | <b>877</b> | <b>515</b>   | <b>768</b> |
| % Disaggregated by Gender |   |              | 40%  | 60%        | 40%  | 60%        |

|  |       |       |       |
|--|-------|-------|-------|
| Total M/F                                    | 2,489 | 1,454 | 1,283 |
| % Identified and Referred<br>(from lists)    | 58%   |       |       |
| % Return to HU and ARVs<br>(from found list) | 88%   |       |       |

## 8. Major Implementation Issues

List any issue related to budget, assumptions, staffing, procurement, planning that should be brought to attention of the COR/AOR/AM, particularly mentioning those that could potential jeopardize activity from achieving the expected results - in bullet points.

- Providing a photo ID name badge and constructing an *activista* database with names, identification numbers, and dates of joining and training is still underway.
- The late finalization of the Tete province economic strengthening CSO ADELTA - Agencia de Desenvolvimento Local de Tete, contributed to underachieving in the VS&L groups area.
- The newly mission-required Negotiation Memos for the GUC approval process created a huge administrative burden when the requirement became retro-active.
- Under performing by a few CSOs in some districts, and any GRM request for scaling up in others, suggest a comprehensive analysis of district level conditions and needs is necessary to rationalize project resources. This analysis will be carried out in Q1 Yr 3, and extend to the consortium partners as well.
- Some services for OVC are significantly limited to non-existent. CCP is committed to using Yr 3 to energetically pursue PPPs to augment GRM institutional resources.
- CSOs Capacity Building has gotten a late start, with much of Yr 2 lost to negotiating and searching for implementing partners. These activities did get under way in this reporting period and will continue at pace from now on.
- Referrals to clinical services, and from the clinic sites to community services remains a work in progress. Internally, the FHI 360 project Technical Directors now meet regularly to continue to seek ways to improve the referral systems.
- Timing of the Yr 3 Modification could become a major implementation issue if delayed to the point of interruption of services delivery. Approval of the Yr 3 Workplan and Budget was very timely this year, which is helpful.

## 9. Collaboration with other donor projects

Please describe the integration USAID funded program with other donor funded programs.

Collaborations with non-USAID funded clinical support projects are still inconsistent, despite continued efforts at district level. CCP continues to explore other levels for best linkages to result between the community and clinical services.

The PSI, FANTA, and CAP collaborations are noted above.

Collaboration with the CHASS SMT and Niassa projects are standard procedure in CCP.

**10. Upcoming Plans:** The IP will discuss expected upcoming activities to be implemented and plans to achieve results in the upcoming reporting period(s). This discussion may also be grouped by thematic “result” area, if relevant. No limits on space.

**October**

GUC annual Amendments  
 Hold semi-annual Advisory Council mtg with partner Ministries  
 Presentation of CCP poster at OVC conference in South Africa  
 Meet all end of year reporting obligations

**November**

CCP rationalization exercise  
 Submit mHealth process evaluation protocol to Mozambique IRB  
 CCP technical team receive training on CAP coaching and mentoring skills  
 Finalize consultancy contract for capacity building in non-CAP provinces  
 Start Up activities for the Gorongosa district CSO when approved by USAID  
 Hiring new M&E officers

**December**

Data collection on mHealth process evaluation  
 Quarterly Management mtg of consortium partner heads

**Rolling activity throughout the next quarter**

Roll out of gender mainstreaming component  
 Refresher trainings on CCP technical components – Integrated HBC/OVC, M&E, etc  
 Joint supervision  
 Providing of Technical Assistance  
 Periodic distribution of PSI family health kits  
 Project HOPE continuous establishment and support of new VS&L groups  
 Work with MEASURE team via phone and on site to develop evaluation protocols  
 Explore PPPs at national, provincial, or district levels, whenever opportunities arise

**11. Evaluation/Assessment Update**

If IPs have any evaluations, assessments, special studies, or audits planned, underway or completed, these should be briefly discussed here using the format below.

| Completed during the reporting period:  |  |
|---|--|
| Title or subject for study 1<br>FHI 360 Technical Quality Assessment (TQA)  | Date completed<br>August 2012              |
| Technical recommendations fit well with Yr 3 Workplan content. The strongest most useful recommendations were related to M&E, from which PCC already took up the Year End Data Clean Up activity and budgeted two additional provincial level M&E officers for Yr 3 and beyond. |  |
| Title or subject for study 2  | Date completed                             |
| Brief description of major findings and recommendations   |  |
| Underway during the reporting period:   |  |
| Title or subject for study 3<br>Process Evaluation of mHealth Pilot   | Estimated completion date<br>February 2013 |
| Brief description of process  |  |

Protocol for process evaluation of mHealth initiative has been approved by FHI 360 bioethics committee (PHSC) and is currently undergoing translation into Portuguese for submission to Mozambican bioethics committee (CNBS) for their November deliberations. Data collection is hoped for December, with data entry, analysis, and reporting during January and February.

| Planned:   |   |
|--|---|
| Title or subject for study 4<br>mHealth activity outcome evaluation  | Dates planned<br>Commencing April 2013, pending all necessary IRB approvals |
| USAID contracted with MEASURE to conduct this evaluation. Study design will be paired with scale up of activity to the remaining 5 or 6 CCP provinces (with information learned from the Process Eval above) Protocol development to take place in Q1 and 2 of Yr 3, via teleconferences and in-country eval team visit. |   |
| Title or subject for study 5<br>Outcome evaluation of integrated HBC and OVC service delivery  | Dates planned<br>TBD by eval contractor, during Yr 3                        |
| USAID contracted with MEASURE to conduct this evaluation. Study design under development.  |   |

**12. Success Stories and photos:** IPs should plan to submit at least one success story per year, but they are not required each quarter. Success stories should focus on specific activities that have already happened or are ongoing; they should not describe planned activities or expected results. USAID encourages the submission of accompanying photos where possible. If pictures or other information in the success story identify individuals, please ensure that proper (written) consent has been obtained before submitting to USAID. Consent forms do not need to be provided to USAID.

Annexed separately.

**13. Financial Information:** this section does not replace formal financial reporting using form SF 425. Please provide actual expenditures for the reporting period projected expenditures for the next reporting period.

Annexed separately.