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ACRONYM LIST

| | |
|---------|--------------------------------------------------------------------------------------|
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal Care |
| AOR | Agreement Officer's Representative |
| APSS | Psychosocial Support |
| APR | Annual Performance Review |
| ARV | Antiretroviral |
| ART | Antiretroviral Therapy |
| CBO | Community-based organizations |
| CCR | Consulta da Criança de Risco (high-risk consultation for children) |
| CD4 | Cluster of Differentiation 4 |
| CHASS | Clinical HIV/AIDS Services Strengthening Project |
| C-HCT | Community Counseling and Testing |
| CCM | Community Case Manager |
| CMAM | Central de Medicamentos e Artigos Médicos (Center of Medicines and Medical Supplies) |
| COP | Chief of Party |
| CS | Centre de Saude (health center) |
| CSB+ | Corn Soy Blend Plus |
| CTZ | Cotrimoxazole |
| DBS | Dried blood spot testing |
| DPS | Direcção Provincial da Saúde (Provincial Health Directorate) |
| EPTS | Electronic Patient Tracking System |
| FANTAIH | Food and Nutrition Technical Assistance (FANTAIH) project |
| FILAs | Folha Individual de levantamento de ARVs |
| FOGELA | Fortalecimento da Gestão Laboratorial para Acreditação |
| FP | Family planning |
| GAAC | Grupo de Apoio para Adesão das Comunidades (Community adherence support groups) |
| GBV | Gender based violence |
| H2H | Homen para Homen (Men to Men) |
| HCT | HIV Counseling and Testing |
| HF | Health Facility |
| HIV | Human Immunodeficiency Virus |
| ICP | Infection Control Program |
| IEC | Information, education, and communication |
| IP | Implementing partner |
| IUD | Intrauterine device |
| M&E | Monitoring and Evaluation |
| MCH | Maternal and Child Health |
| MoH | Ministry of Health |
| NRP | Nutrition Rehabilitation Program (Programa de Reabilitação Nutricional) |
| PCC | USAID Community Care Program |
| PCR | Polymerase Chain Reaction |
| PEP | Post-Exposure Prophylaxis |

| | |
|--------|-----------------------------------------------------------------------------------------|
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PICT | Provider Initiated Counseling and Testing |
| PIMA | Point of Care technology for CD4 |
| PLHIV | People living with HIV |
| PMTCT | Prevention of Mother-To-Child Transmission (of HIV) |
| QIP | Quality improvement project |
| SAPR | Semi-annual Performance Review |
| SDSMAS | District Health, Women and Social Action Services |
| SI | Strategic Information |
| STI | Sexually Transmitted Infections |
| TB | Tuberculosis |
| TDA | Tratamento da Desnutrição em Ambulatório (Outpatient Treatment of Malnutrition) |
| TDI | Tratamento da Desnutrição no Internamento (Treatment of Malnutrition in Internment) |
| TSV | Technical Support Visit |
| UATS | Unidade de Aconselhamentos e Testagem para a Saúde (Health Counseling and Testing Unit) |
| USAID | United States Agency for International Development |
| WFP | World Food Program |

LIFE OF PROJECT SUMMARY

Life of Activity (start and end dates): August 2010 – July 2015

Total Estimated Contract/Agreement Amount: \$35,983,413

Total Amount Obligated (to date): \$27,170,388

Actual Expenditures Through this Quarter: \$26,268,298

Current Pipeline Amount: \$902,090

Projected expenditure October 2014 to December 2014: \$1,852,190

Geographic Focus: Niassa Province, Mozambique

I . EXECUTIVE SUMMARY

Summary of Progress this Quarter

This quarterly report presents an elaborated report of the multisectoral response activities performed in Niassa at all levels. It reports both improved and unsatisfactory performance while elaborating on major challenges faced during this reporting period and planned actions for the immediate future.

Key achievements for this quarter included:

- Implementation of a revised approach for active case finding in all 46 sites that were providing ART
- Evaluation of the productivity of PIMAs in order to better target services
- Expansion of Men to Men groups to two additional districts
- Improved linkages and communication with non-health services for victims of GBV (i.e., police, SDSMAS)
- Completion of retrospective data entry into the electronic patient tracking at the Lichinga Health Center and Cuamba Health Center and start of data entry at Cuamba Rural Hospital

Key Indicators

This quarter brought substantial improvements in some key indicators, particularly in the area of retention in ART. However, challenges remain, especially with regard to pediatric ART coverage, cotrimoxazole coverage for ANC clients, and TB. The reasons for these challenges and responses to them are discussed later in the report. The following list presents key indicators at the aggregate level, more detailed and disaggregated information is provided in the body of the report.

HCT

- 23% increase in testing done at the health counseling and testing units (UATS) relative to last quarter (from 2,428 to 2,992) and a doubling of the number tested in the first quarter of this year
- 95% of HIV+ clients (n=321) referred from community HCT received care and treatment services, an increase from 90% last quarter

PMTCT

- 92% of HIV+ pregnant women (n=663) and 95% of women who delivered in a maternity (n=447) provided with ARV prophylaxis

- The percentage of ANC clients initiating ART who initiated Option B+ decreased slightly (60% to 54%) in quarter 4
- 62% of the HIV+ women (n=443) were provided with cotrimoxazole prophylaxis in ANC; this reflects no change
- 85% of HIV-exposed children (n=401) were provided with ARV prophylaxis in maternity wards
- 87% of HIV-exposed children registered in the CCR (n=392) started cotrimoxazole prophylaxis, a slight decrease from 100% in quarter 3

ART

- 1,138 new patients (125 children) initiated ART, the project achieved 180% of the annual target
- Retention into ART: overall, 74% of patients (77% of children and 74% of adults) enrolled in ART 12-15 months ago were alive and in care one year later

TB/HIV

- 445 new TB patients registered
- 92% (408) of registered TB patients knew their HIV status
- 38% of registered TB patients were HIV positive; all of them received a CTZ prophylaxis

GBV

- 794 individuals (283 males and 511 females) were screened for GBV
- 21 females were identified as victims of sexual violence
- 100% of the victims of sexual violence were tested for HIV

II. PROJECT OVERVIEW

The United States Agency for International Development (USAID)/Mozambique clinical HIV/AIDS Services Strengthening Project (CHASS) is a five-year project (August 2010 - July 2015) supporting the expansion of HIV/AIDS prevention, care and support activities and capacity building in Niassa, Mozambique. CHASS Niassa is supporting the Provincial Directorate for Health (DPS) in efforts to prevent, care for, and treat people living with HIV (PLHIV) in Niassa and is implementing critical programmatic, and advocacy initiatives aimed at eliminating HIV infections and supporting HIV-positive children, mothers, and families. In collaboration with our international and local implementing partners (IPs) and the DPS, the project works directly with individual districts to implement a broad range of HIV/AIDS services that focus on:

- Expanding the provision of comprehensive prevention of mother to child transmission (PMTCT) services;
- Improving access to HIV care and treatment;
- Reducing stigma and increasing awareness; and,
- Strengthening systems and building capacity.

Through extensive technical assistance and capacity building support to the DPS and its local partner organizations, CHASS Niassa has covered all 16 districts working in the HIV response with service delivery that significantly contributes to USAID/Mozambique's targets. In order to achieve the desired goals of the Ministry of Health (MoH) HIV/AIDS Response, major activities during the period included:

- Development of harmonized multi-sectoral joint plans and capacity building at all levels to increase participation and sense of ownership of the community regarding implementation of activities related to HIV/AIDS prevention, treatment, and care and support.
- Expansion of HIV prevention services.
- Awareness creation and mobilization activities that ensure participation of the community in order to stimulate and maintain demand for services.
- Mobilization and distribution of resources for program implementation through strengthened partnerships.
- Strengthen the multi-sectoral monitoring and evaluation system.

III. PROGRESS REPORT

The majority of activities scheduled for this reporting period were completed or underway by the end of the quarter. CHASS Niassa's work activities included: the provision of technical assistance visits with a focus on the promotion of primary health care and the integration of the consultation for children at risk (CCR) in maternal and child health (MCH) consultations, in order to increase the number of children at risk with access to PCR tests at 4-8 weeks. Moreover consensual search was intensified for children with criteria for inclusion on ART who have not yet enrolled. During the quarter implementation of the Nutrition Rehabilitation Volume 2 (for adults) began as did the implementation of psychosocial support in the province. Regarding Monitoring and Evaluation (M&E), work on data use continued and further progress was made on the roll out of eSaude, the electronic patient tracking system (EPTS). In addition, the program continued to strengthen its partnership and consultations by participating in the U.S. Government, MoH, and other relevant stakeholders' convened events.

Objective 1

Improve the accessibility of high-quality HIV services by strengthening clinical service delivery in six key areas and their utilization through increased retention and demand by clients.

HIV Counseling and Testing (HCT) Service Expansion

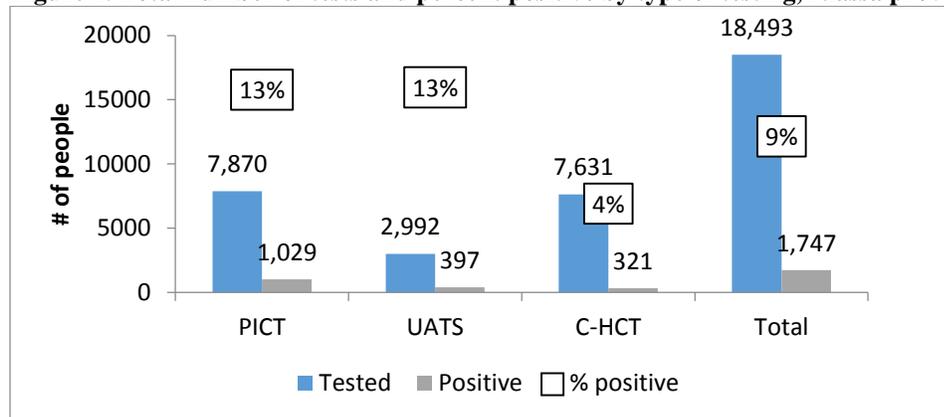
HIV counseling and testing is implemented in a total of 65 health facilities (HFs), in several health services, grouped in three testing settings: Provider-initiated counseling and testing (PICT), health counseling and testing units (UATS) and community counseling and testing (C-HCT). PICT is done in various service points including triage, in-patient services, laboratories, antenatal care (ANC) units, maternities, and emergency rooms. PICT is implemented in all 65 HFs while UATS is implemented in 11 sites and C-HCT in 5 districts: Cuamba, Mecanhelas, Lichinga City, Lago and Mandimba.

In the fourth quarter, overall 18,493 (7,754 males and 10,740 females) people were tested: a total of 2,993 people were tested in UATS at the 11 facilities providing these services 266 of them (9%) were children under age 15 years. A further 7,631 were counseled and tested in C-HCT, 1,302 (17%) of whom were children. Finally, 7,870 people were tested through PICT in various service points, 1,220 (16%) of whom were children.

Overall, 9% of patients tested were positive but this percentage ranged from 4% at C-HCT to 13% for both UATS and PICT (Figure 1). In the next quarter, in order to have more patients tested in PICT and UATS, the project will reinforce the importance of testing patients for HIV in clinical sites. The project, in coordination with District service for health, women and social action (SDSMAS), will provide on-job-training of clinical staff on counseling and testing and on recording in the register books and reporting the information using the monthly summary. The

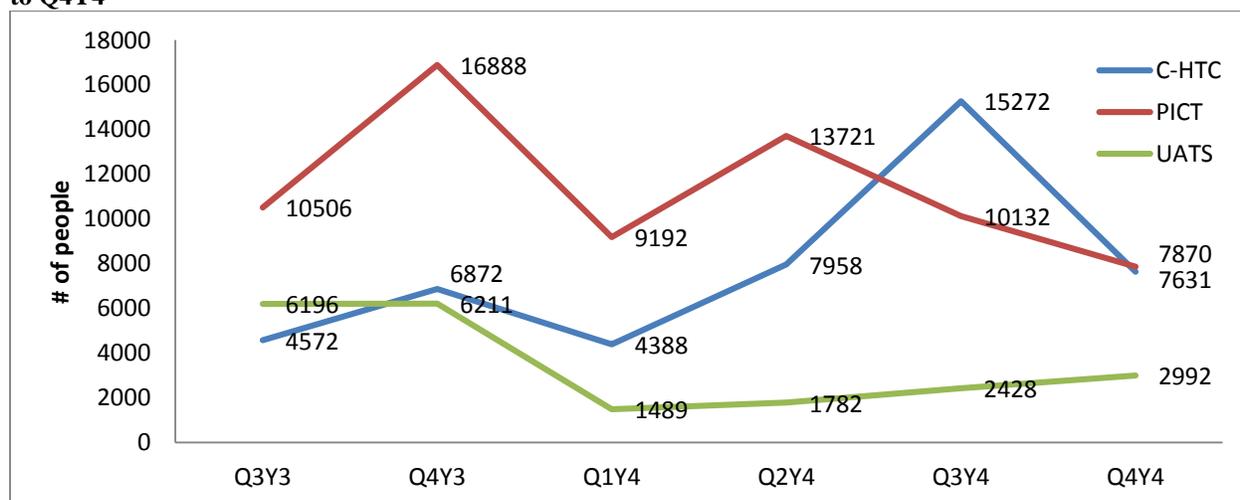
project will promote weekly reporting and discussion of HCT data and triangulation between HIV testing records and HIV test consumption during the clinical committee meetings held at each health facility. Finally, the project will implement the index HIV testing approach in C-HCT following the recommendations from the MoH.

Figure 1. Total number of tests and percent positive by type of testing, Niassa province, July–September 2014



The number of individuals tested in UATS has increased by over 100% since the beginning of year four (Figure 2). In PICT, the number of people tested has fluctuated regularly due to semi-annual data cleaning exercises and the availability of different HIV test points using PICT but was lower in quarter four than at any other point this year. C-HCT also decreased in this quarter after a steady increase over the first three quarters of the year. The main reason for this decrease was the realignment of our testing strategy to be consistent with the new recommendations from the MoH and USAID, which prioritize testing in maternal and child health (MCH) services and blood banks as well as UATS and PICT. The increases in UATS contributed to reaching 98% of the annual target whereas Niassa surpassed the annual target in C-HCT.

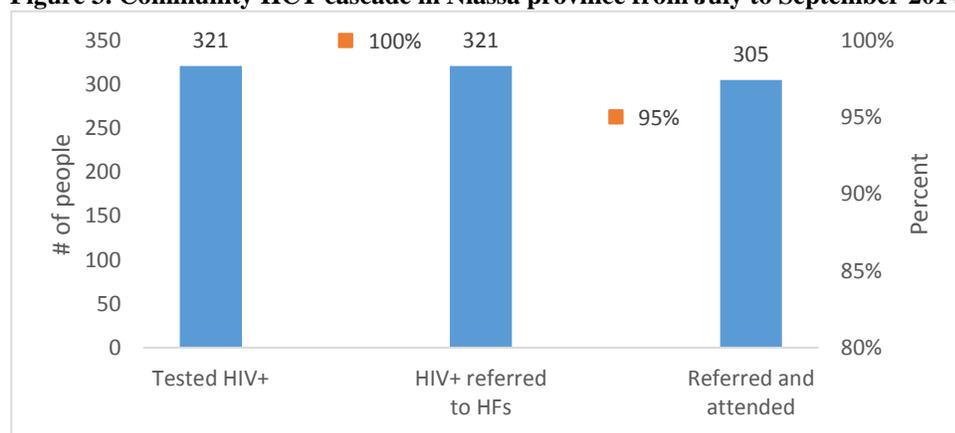
Figure 2. Number of people receiving HIV counseling and testing in Niassa province, by type of testing, Q3Y3 to Q4Y4



The lower than desired levels of HCT in PICT is likely because many patients who should be provided with PICT are in fact referred to the UATS unit for testing. While this is not ideal, in large facilities there is a high patient load in many units leading to heavy workloads and there is limited privacy for testing in the main consultation rooms. Another contributing factor could be the presence of C-HCT in the districts with the largest populations, which might be leading to clients reaching HFs with known HIV status and the target may have been over estimated.

A total of 8,046 people were counseled about HIV testing and 7,631 (95%) were tested in C-HCT settings (3,258 males, 4,373 females). Among people tested in these settings, 4% (321; 123 males and 198 females) tested positive. All patients who tested positive in C-HCT were successfully referred to a health facility (Figure 3), with 95% of them 305 (115 males and 190 females), reaching a health facility to receive HIV care. Compared to the last quarter, the number of HIV+ patients referred to a HF who reached a HF increased from 90% in the last quarter to 95% in this quarter. This improvement is related to the renewed emphasis on psycho-social support after testing positive for HIV, active case finding for those patients who were referred but had not yet reached the health facilities, and regular supervision and mentoring to Community case managers (CCMs).

Figure 3. Community HCT cascade in Niassa province from July to September 2014



Prevention of Mother to Child Transmission (PMTCT) Support Activities

During this quarter, the project continued to promote access to PMTCT services and strengthen linkages for pregnant women and their HIV-exposed infants to care and treatment at 65 HFs by integrating PMTCT services into routine MCH services. The interventions in PMTCT aim to:

- Support rollout of the national PMTCT program using national guidelines and training curricula;
- Increase enrollment of women and families in care and treatment programs by strengthening linkages between PMTCT and care and treatment;

- Increase access to quality PMTCT services, by linking women, children and their families in care and treatment;
- Increase uptake of antiretroviral (ARV) prophylaxis in HIV-positive pregnant women and HIV-exposed infants;
- Scale up Option B+ to peripheral HFs.

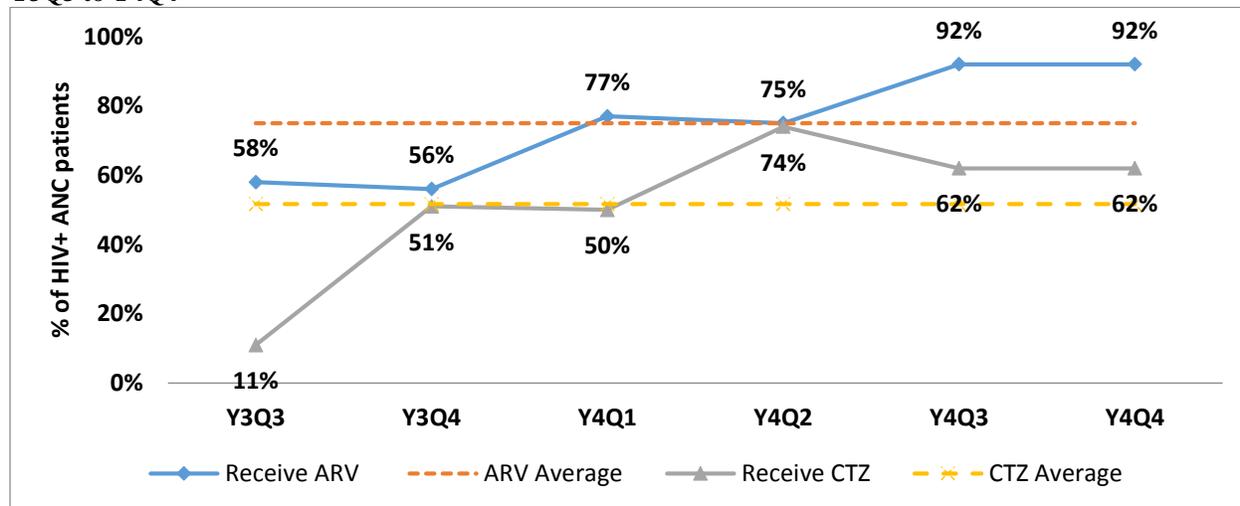
Last quarter, CHASS Niassa observed that two groups of HIV+ women were not interested in taking Option B+ for treatment: one group due to fear of disclosing their HIV status to their partners, which resulted in them discontinuing treatment after labor, and another group that thinks they are very healthy and see no reason to take lifelong treatment. This quarter the project sensitized service providers to offer them Option A treatment and to reinforce psychosocial support to these women.

The project assists in the delivery of small quantities of medicine for PMTCT to the outskirts of the districts when they routinely collect Cluster of Differentiation 4 (CD4) samples to bring to the central laboratory in Lichinga city. This quarter the CHASS Niassa project continued with this intervention which contributed to the reduction of stock out of PMTCT medicine at health facilities and also contributed to surpassing PMTCT targets.

In quarter four a total of 17,233 women newly registered in ANC, 15,179 (88%) of whom knew their HIV status. This contributed to further overachievement of the annual target, with 149% of the target achieved. The percentage of women who were HIV-positive among those with known status was 5% (717) which is consistent with last quarter, although the percent positive has varied over the year between 4% and 7%. Coverage of ARVs among HIV+ pregnant women was 92% (663), which contributed to achieving 297% of the annual target; cotrimoxazole (CTZ) prophylaxis coverage was 62% (443) among this group (Figure 4). Among the women provided with ARV prophylaxis, 359 (54%) were on Option B+, a decrease of six percentage points compared to last quarter. This could be related to misinterpretation by MCH nurses of the criteria on when to use Option A. Next quarter CHASS Niassa, during the technical assistance visits, will reinforce the criteria for use of Option A and will emphasize the advantages of Option B+.

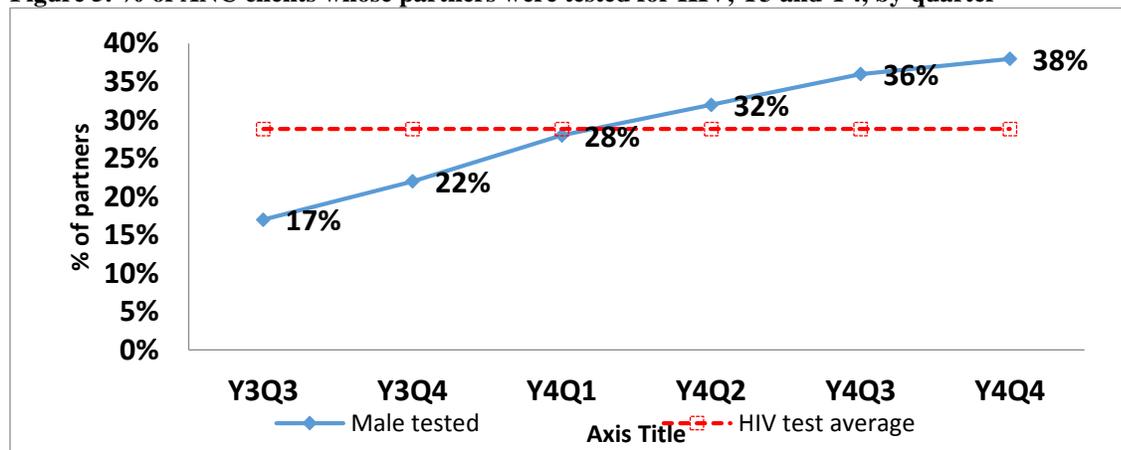
Analysis over the past six quarters shows that the coverage of ARV prophylaxis has maintained the strong performance seen last quarter, with 92% coverage (Figure 4). Prophylaxis with CTZ increased in the first half of year 4 and remained above the average level this quarter (Figure 4).

Figure 4. Changes in ART and CTZ coverage among ANC and maternity clients in CHASS Niassa sites, Y3Q3 to Y4Q4



Male involvement was another area of improvement during this quarter, 6,501 women brought their partners to ANC services and they were tested for HIV, corresponding to 38% of all women registered. Although achievement relative to the target was 134%, the proportion of partners tested (38%) is consistent with the proportion tested per the targets and is the highest level reached to date (Figure 5). Two percent (149 of the partners who were tested were found to be positive for HIV. This high percentage covered is related to: direct written invitations to partners, involvement of community leaders, implementation of the GCC strategy, involvement of mother-to-mother & man-to-man (H2H) groups, and the community sensitization program.

Figure 5. % of ANC clients whose partners were tested for HIV, Y3 and Y4, by quarter



This quarter, 11,007 pregnant women were registered at the maternity ward, of whom 4,412 had unknown status, and 3,450 (78% of those with unknown status) received HIV testing and their results.

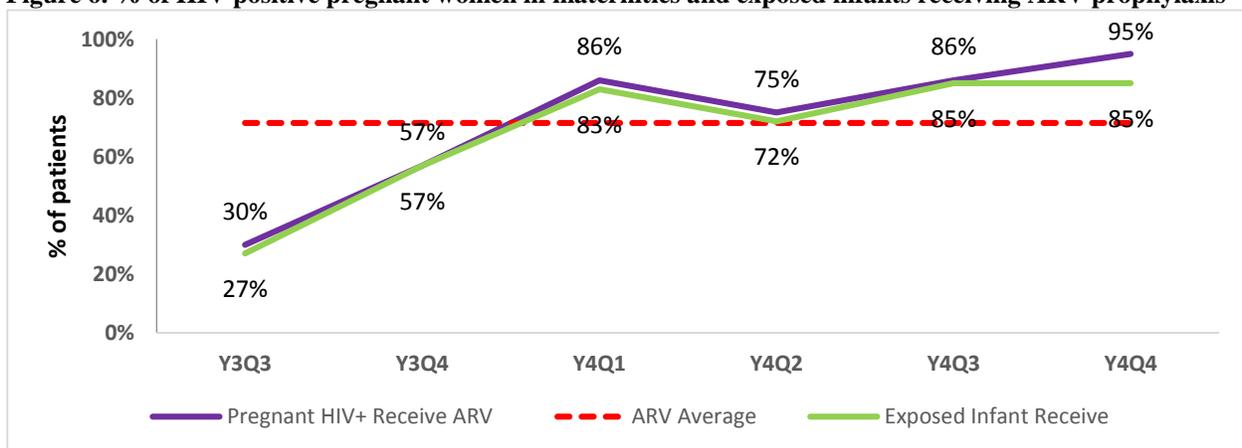
In maternity wards, testing of women with unknown status remains a challenge because some women refuse the offer for testing because of fear of disclosure of their status to their husbands

(which could result in divorce), and fear of stigma and discrimination. In the next quarter CHASS Niassa will continue supporting staff at HF's to reinforce HIV counseling for women in maternities and psycho-social support for tested pregnant women; the project will also introduce psycho-social support through community interventions.

In total, 470 women who delivered in maternity were HIV+, of them 447 (95%) were provided with a complete ARV course (Figure 6). Regarding ARV prophylaxis for exposed-infants, a total of 401 (85%) exposed infants were covered. This low coverage of prophylaxis for exposed infants is related to stock out of ARVs in August and September. CHASS Niassa and DPS will advocate to the Central Medicines and Medical Supplies (CMAM) to increase quantities of drug supplied to the province.

The overall trends for both ARV prophylaxis for pregnant women and exposed infants show increases over time (Figure 6). This has contributed to surpassing the annual targets for both groups. Routine reviews of documentation by CHASS Niassa and DPS technical staff could have contributed to this good performance. CHASS Niassa technical and M&E staff trained newly enrolled MCH nurses in recording and analyzing the information in the summary books and monthly summaries.

Figure 6. % of HIV positive pregnant women in maternities and exposed infants receiving ARV prophylaxis



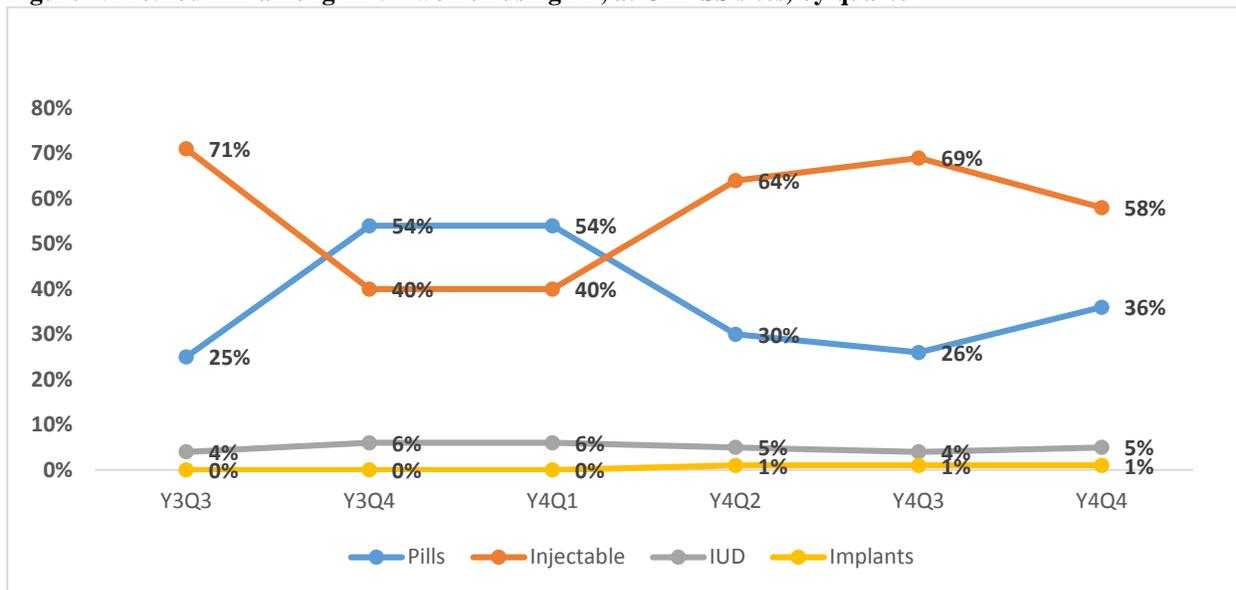
Family Planning (FP)

In the family planning sector a total of 11,775 women had their first consultation, 8,411 (71%) with unknown HIV status. Among those with unknown status, 6,962 (82%) were tested for HIV and 140 (2%) tested positive. Forty-two women (30%) who tested positive at FP consultation initiated antiretroviral therapy (ART) in FP. The remaining HIV+ women were not eligible to initiate ART in FP services and were referred to HIV services for follow up.

In total 358 HIV+ women (including women with known HIV+ status at entry) were followed up at FP consultations and 273 (76%) received a FP method (58% injectable, 36% pills, 5% implants,

and 1% an intrauterine device (IUD)). During this quarter the percentage of FP users who were using injectables decreased by 11 percentage points (Figure 7), this may be related to the stock out of this method at the provincial level in the last two months. This shortfall was made up for largely by an increase in use of pills.

Figure 7. Method mix among HIV+ women using FP, at CHASS sites, by quarter



Challenges in FP include the integration of FP into HIV care and treatment services due to the lack of training, unavailability of FP register books and high work load. In the next quarter CHASS Niassa and DPS will train general medicine technical staff in every sector to provide FP methods, ensure FP commodities are available in ART sites, and ensure that ART sites have FP registers.

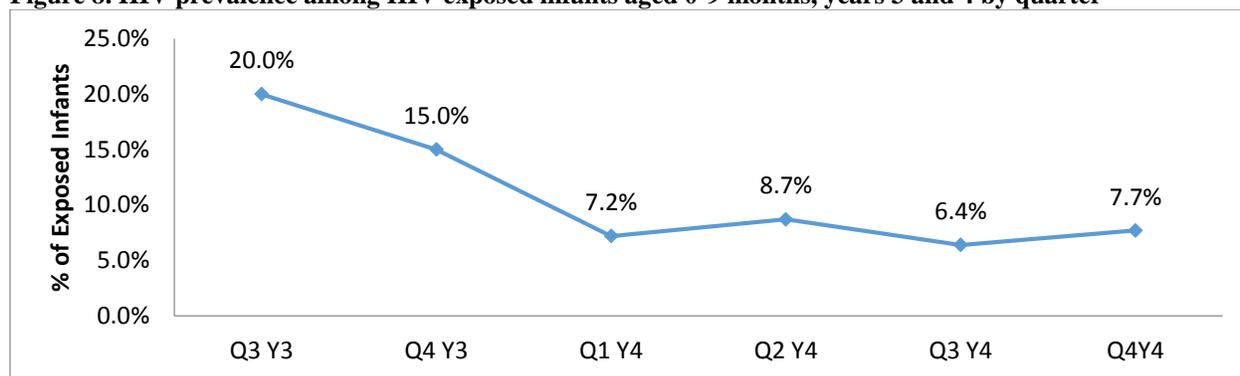
Early Infant Diagnosis Technical Support

During this quarter, 405 children exposed to HIV were registered in high-risk consultation (CCR). Of the HIV-exposed children, 392 (87%) initiated CTZ prophylaxis before they were 2 months old. All children exposed to HIV and registered in CCR had dried blood spot (DBS) samples collected and sent to the Nampula lab for Polymerase Chain Reaction (PCR) testing, and the province received 359 results back, with 28 (8%) testing positive for HIV. All of the children who tested positive were enrolled in ART.

The percentage of PCR results that are positive remained relatively stable over the last year, hovering around 7% (Figure 8), but this percentage is low relative to the national mean of 11.7%. Our target is to reduce the percentage of exposed babies who acquire HIV to less than 5% as recommended by MoH. This lack of progress in this area could be related to a stock out of ARV drugs for HIV prophylaxis to prevent the transmission from mother to baby in the first quarter of this year and poor quality of follow up of the babies in the CCR consultation. CHASS Niassa and DPS will advocate to CMAM to increase quantities of ARV drugs to the province, on other hand

CHASS Niassa will reinforce on-the-job training for MCH nurses and follow up of exposed babies during the technical support visits (TSVs).

Figure 8. HIV prevalence among HIV exposed infants aged 0-9 months, years 3 and 4 by quarter

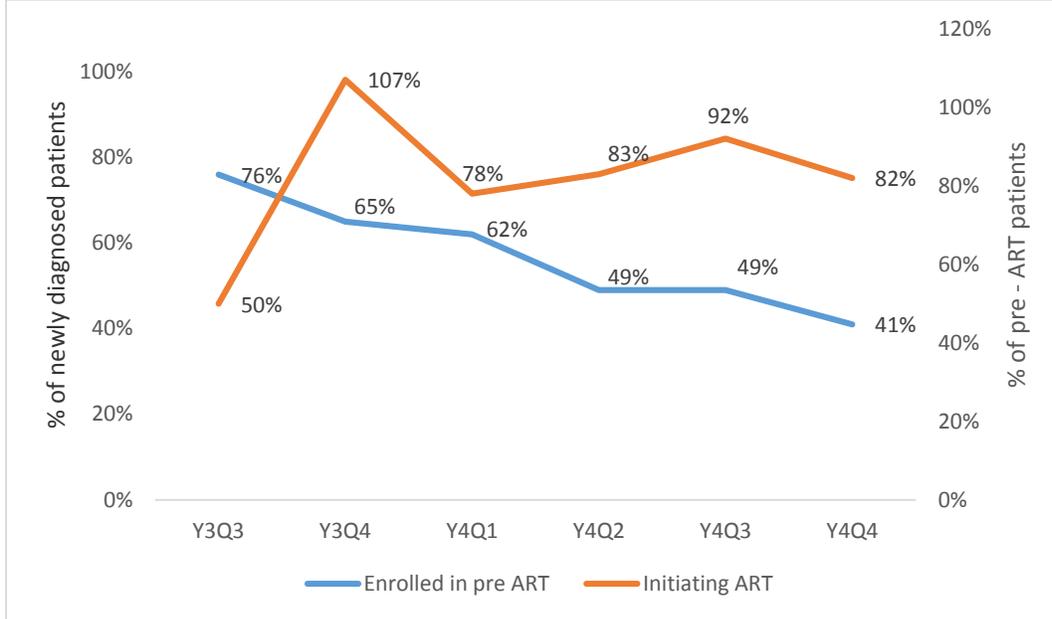


This quarter, in coordination with DPS, the project trained the District Medical Chefe and MCH nurses on the use of the MoH online platform for accessing PCR results. We believe this will improve the accessibility of the PCR results, which may contribute to early enrollment of PCR+ children in pediatric ART.

Pre-ART Care and Treatment Technical Support

During the quarter a total of 3,366 patients tested positive in all testing points: with 1,437 in maternal and child health (470 maternity, 717 pregnant women in ANC, 149 partners and 101 post-partum consultation), 35 children in CCR, 147 in the Tuberculosis (TB) sector, 1,029 in PICT, 321 in C-HCT and 397 in UATS. Of those tested positive, 1,388 (41%) patients were enrolled in pre-ART services, 1,138 (82%) of them were newly enrolled in ART. In both cases, this represents a decrease relative to last quarter and for ART, it represents a continuation of a downward trend seen over the past year and a half (Figure 9). This decrease in the percentage of HIV+ patients enrolled in pre-ART treatment is related to the rapid expansion of PICT in several points of testing of HIV with pre-ART services; in these services, the referral and counter-referral systems are not yet well solidified, with many lost opportunities for enrollment in pre-ART. To strengthen the referral and counter-referral systems between HIV testing points and pre-ART services, case managers will be engaged to guaranteeing that referred patients arrive at testing points. Clinicians will also have to be encouraged to open the clinical process on the day when a patient is diagnosed, however, approval from DPS is needed before this can be done; we are currently seeking that approval.

Figure 9. Pre-ART and ART uptake among newly diagnosed patients, CHASS Niassa sites, Y3Q3 to Y4Q4



Adult Care and Treatment Technical Support

During this quarter, 1,138 new patients initiated ART (Figure 10), which contributed to surpassing the annual target by 80% (Figure 11). However, as noted above, the percentage of newly positive patients who enrolled on ART is decreasing and is quite low, at just 41%. Of the new patients enrolled on ART, 376 (33%) were enrolled in Option B +.

In the same period, the number of patients currently in ART was 13,322, which was 121% of the annual target, and the number of patients ever enrolled on ART was 17,775.

Figure 10. Number of newly enrolled patients on ART in CHASS sites, by quarter, FY3 and FY4

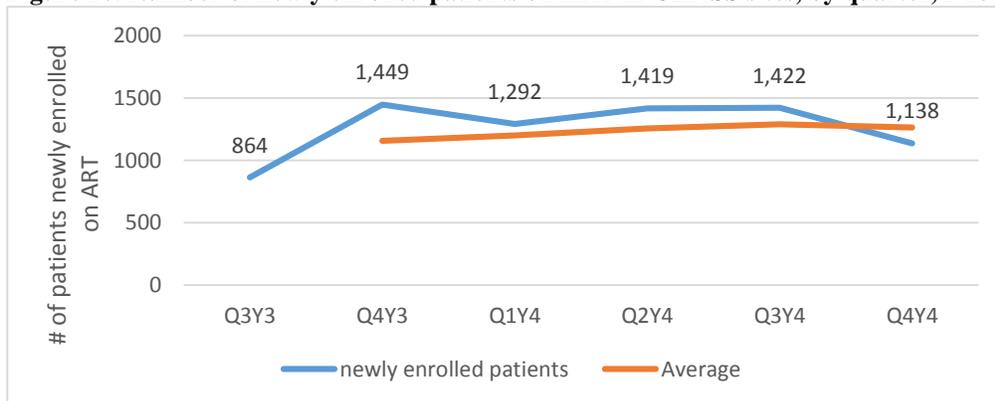
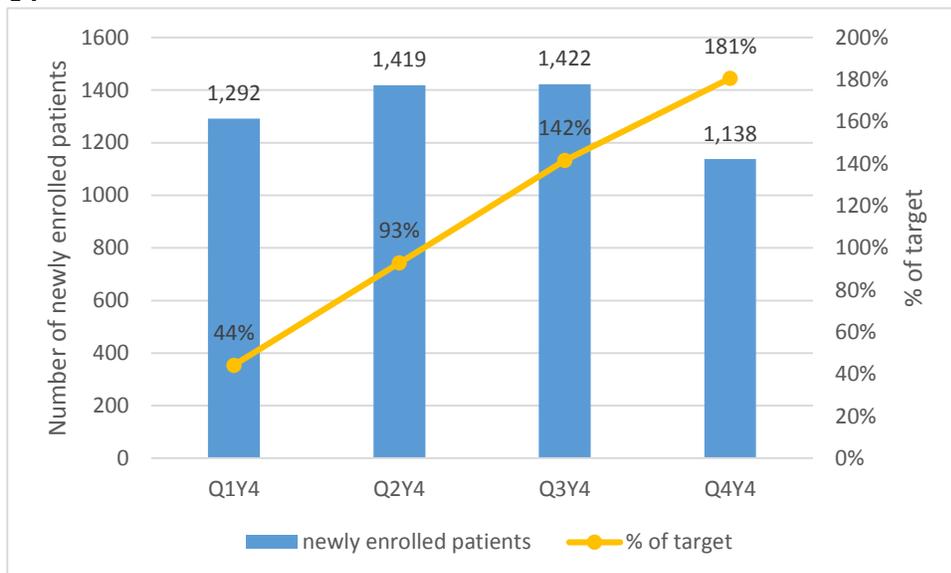


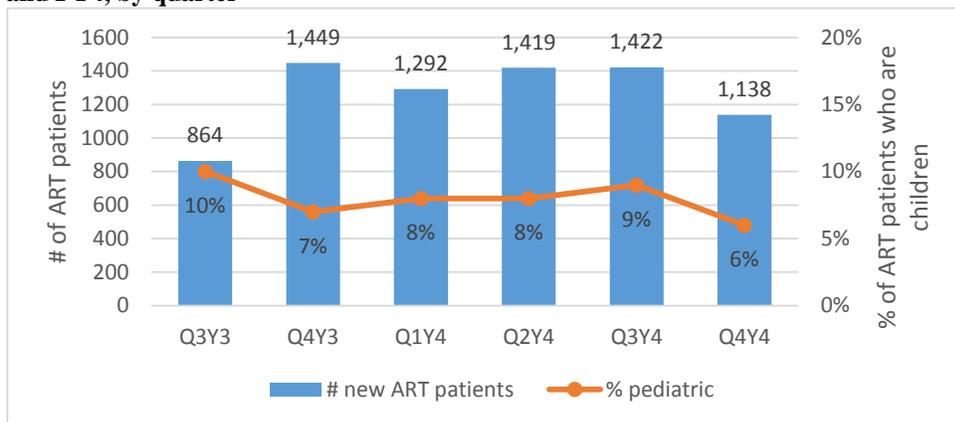
Figure 11. Achievement in number newly initiating ART by quarter against targets in CHASS Niassa sites, Y4



Pediatric Care and Treatment Technical Support

During the quarter, 65 (42 males and 23 females) children were newly enrolled in ART, totaling 379 children enrolled over year 4, which is 85% of the annual target. The main challenge facing pediatric care and treatment is the low proportion of children enrolled in ART compared to the total number of patients newly enrolled in ART. Unfortunately, although it had remained fairly constant at around 8% for over a year (Figure 12), this quarter it was lower, at just 6% which is less than half the recommended level of 15%. This could be related to the low HIV prevalence among children in the province; prevalence among children tested is just 5.5% overall compared to 13% among adults tested in clinical settings and is one quarter of the prevalence found among children of mothers with HIV in the 2009 INSIDA. Nevertheless, CHASS Niassa will intensify testing for HIV among children, including in triage, in-patient services, CCR, immunization, and wellbeing consultations. Ensuring that all children who test positive via PCR are enrolled on ART is a focus of recent efforts to improve active case finding, but delays in receiving results from the Nampula lab as well as incorrect contact information remain challenges.

Figure 12. Number newly initiating ART and percent of those who are children in CHASS Niassa sites, FY3 and FY4, by quarter



TB/HIV Co-infection Support Services

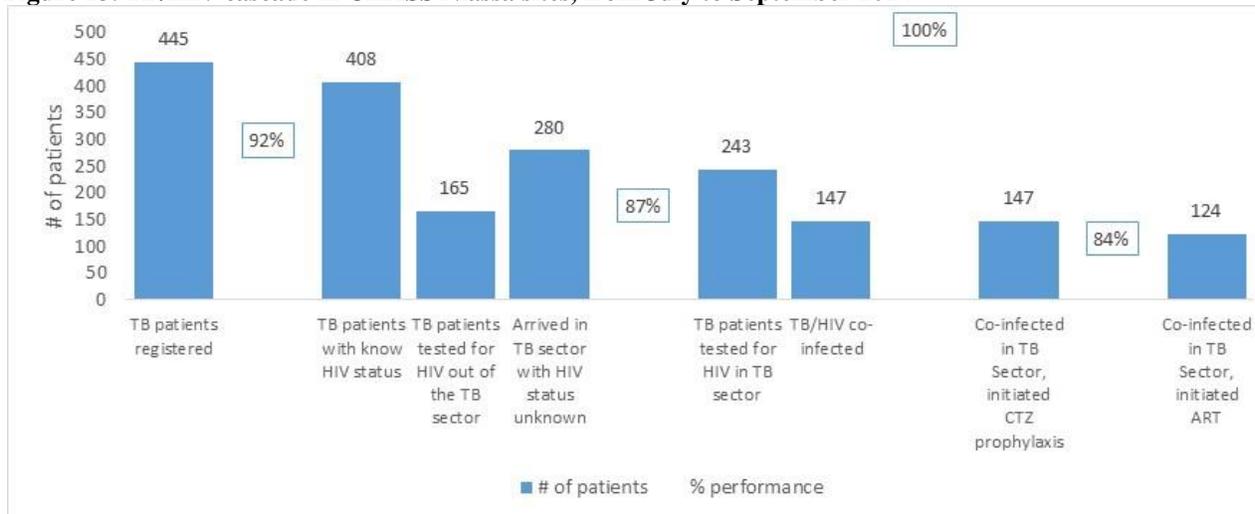
CHASS Niassa supports the implementation of TB/HIV services in a total of 17 HFs, specifically in HFs of the 16 district headquarters and Lichinga district with 2 HFs. Ten of the supported HFs are implementing the partial one-stop-shop model (it is partial because CD4 samples are not collected in the TB sector; they are collected on specific days and then sent to a reference laboratory for analysis of CD4), with health staff trained in prescription of ARVs.

The challenge is however, while almost all components of the model have been implemented in TB services, the collection of samples in the TB room has not; this is part of current discussions between DPS and CHASS Niassa. In addition, discussion and information sharing between sectors (TB and HIV) is limited and retention of HIV patients who have finished TB treatment remains a challenge.

In the next quarter, CHASS Niassa in coordination with DPS Niassa will continue with supportive supervision in the TB sector and will work to improve linkages to the HIV sector.

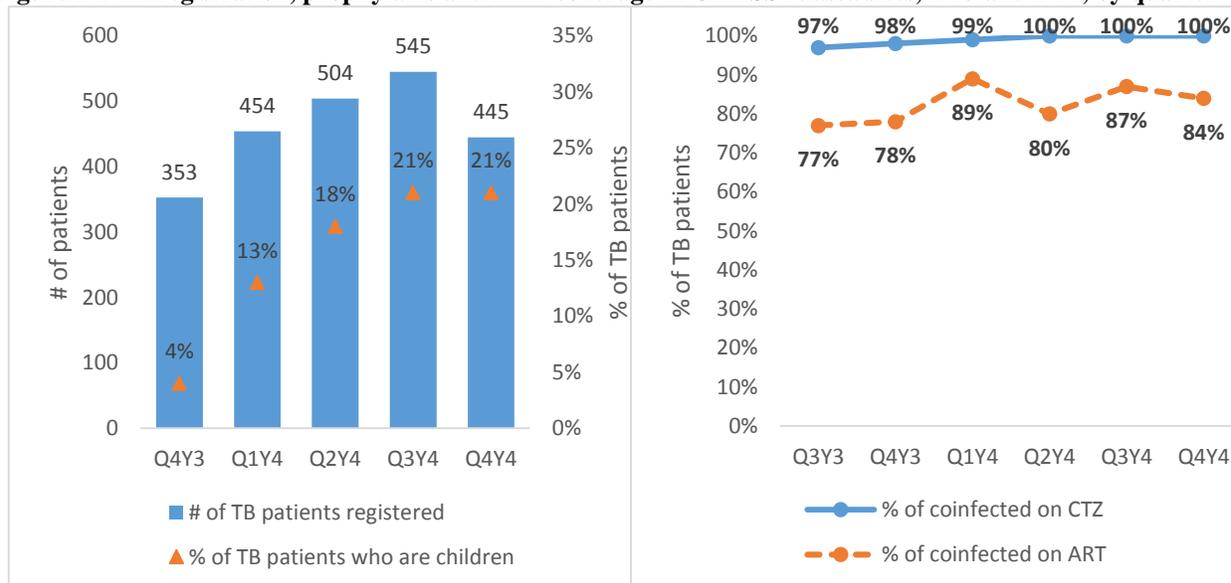
This quarter, 445 patients were registered in the TB sector, 115 (26%) of whom were children. Among these patients, 408 (92%) had known HIV status and 147 (33%) were HIV positive. All the co-infected patients were provided with CTZ prophylaxis and 84% (124) were enrolled on ART (Figure 13). In terms of numbers, the province has thus far achieved 78% of the annual targets for CTZ prophylaxis of co-infected patients and 80% of the target for ART treatment of co-infected patients. The province remains below target because the number of HIV+ co-infected patients is lower than expected. In the last two quarters only 33% of TB patients were HIV+ compared to the expected 60%.

Figure 13. TB/HIV cascade in CHASS Niassa sites, from July to September 2014



Throughout the quarter, with the support of TB CARE, doctors and district representatives of the National TB program or their deputies who had not yet been trained in Lago district, were trained on HIV and multi-drug resistant TB.

Figure 14. TB registration, prophylaxis and ART coverage in CHASS Niassa sites, FY3 and FY4, by quarter



Adherence to Treatment and Retention in Care Technical Support

Twelve month retention of patients in pre-ART and ART has been a challenge for the project over time: 12 month retention is now 71% (84% of the national target). Many factors have contributed to this, particularly long distances between HF and patients' residences, and limited psychosocial support delivered to HIV patients. Reductions in the SAPR14 were likely also influenced by

changes to the process of data collection in the cohort studies and changes in the definitions of the cohorts¹. This year a number of strategies have been implemented to improve retention including: 1) the introduction and implementation of the acceleration plan which will allow HIV services to be provided nearer to patients, and 2) the implementation of the new psychosocial support strategy (APSS) which helped in improving home visits, positive prevention and active case finding (*busca activa*). In terms of the data, in 2014 CHASS Niassa 1) instituted regular review of the status of the patients in the register books and clinical charts in order to improve data quality, 2) introduced mobile data collection for APR14 which reduced human error by introducing immediate checks on the data entered and allowed for ongoing review of data during data collection, 3) added additional data sources for assessment of status (namely the *Folha Individual de Levantamento de ARVs—FILA* and *Medicamento anti-retroviral—MARV*), and 4) clarified for data collectors who should be included and the importance of collecting data on all eligible patients, even if their records could not be located. In combination, these strategies contributed to the improvement of this indicator from 67% in APR 2013 to 71% in APR 2014.

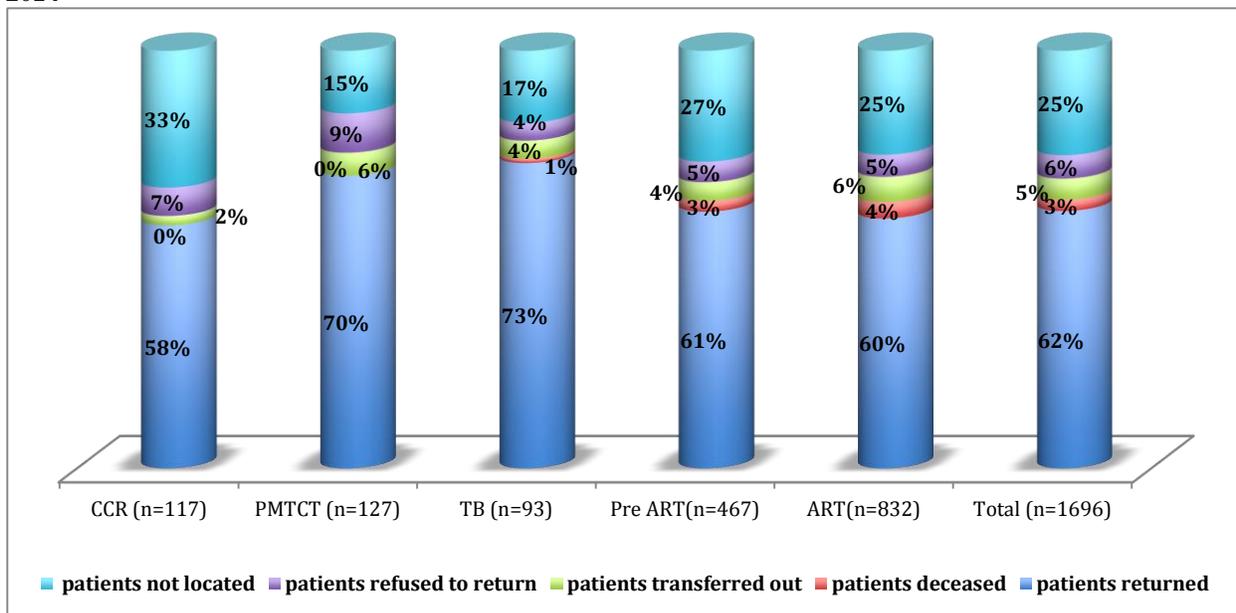
This quarter, a list of 467 *defaulted* patients in pre-ART (186 males and 281 females) were delivered to the CCMs and C-HCT lay-counselors for tracing. Ninety-one (19%) of these defaulted patients were children. Sixty-one percent (287 patients, 125 males and 162 females) of these patients returned to treatment, 3% (12 patients, 2 males and 10 females) had died, 4% (21 patients, 9 males and 12 females) had transferred to other health facilities of the province or country, and 5% (23 patients, 16 males and 7 females) refused to return to treatment even after sensitization and counseling sessions for adherence (Figure 15). A planned study on *Busca Activa*, which is currently under review by the Bioethics Committee, will explore reasons why some patients are refusing to return to treatment. The remaining 27% (124 patients, 32 males and 90 females) could not be found at the addresses provided during pre-ART counseling sessions.

In ART, a total of 832 (281 males and 551 females) patients who *defaulted* treatment were delivered to CCMs for tracing. One hundred nine (13%) of these defaulted patients were children. Sixty percent of these patients (498, 171 males and 327 females) returned to treatment (Figure 15), whilst the remaining patients had either died (4%, 33 patients, 13 males and 20 females), transferred out (6%, 50 patients, 14 males and 36 females), refused to return to treatment after sensitization (5%, 44 patients, 12 males and 32 females), or could not be located at the provided addresses (25%, 207 patients, 71 males and 136 females).

The percentage of defaulted patients who returned to care varied in other services. In CCR 58% (103) returned versus 70% (89) in PMTCT and 73% (68) in TB. The percentage of defaulted patients that could not be located was 33% (58) in CCR, 15% (19) in PMTCT and 17% in TB (16) but all of these groups have small numbers of patients so a small difference has a large impact on the percentage.

¹ Before SAPR14, patients without a clinical process were excluded from the retention analysis. Now all patients without a process are considered to be Lost to Follow up.

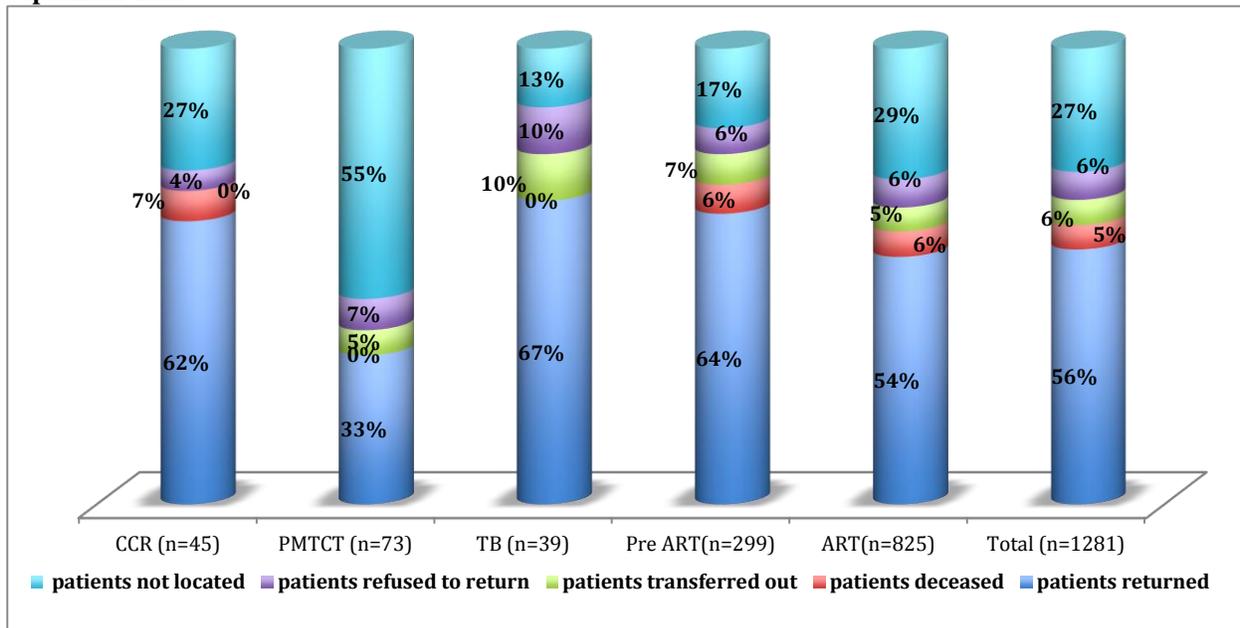
Figure 15. Outcome of patients who defaulted in CHASS Niassa sites, by type of care from, July to September 2014



With regard to efforts to ensure return of patients that *abandoned* pre-ART care, a list of 299 patients (137 males and 162 females) was delivered to the CCMs for tracing, 23 (8%) of these abandoned patients were children. Sixty four percent (191 patients, 87 males and 104 females) returned to treatment (Figure 16). An additional 6% were deceased (19 patients, 7 males and 12 females), 7% had transferred out (20 patients, 13 males and 7 females), 6% (17 patients, 10 males and 7 females) had refused to return to treatment, and 17% (52 patients, 20 males and 32 females) could not be located.

In ART, 825 patients who had *abandoned* treatment (333 males and 492 females) were listed and delivered to CCMs for active finding, 92 or 11% of these abandoned patients were children. Overall, 54% (449 patients, 185 males and 264 females) returned to treatment (Figure 16), with 6% (46 patients, 12 males and 34 females) having died, 5% (43 patients, 15 males and 28 females) transferred out, 6% (51 patients, 12 males and 39 females) refused to return, and 29% (236 patients, 109 males and 127 females) could not be located.

Figure 16. Outcome of patients who abandoned care in CHASS Niassa sites, by type of care from July to September 2014



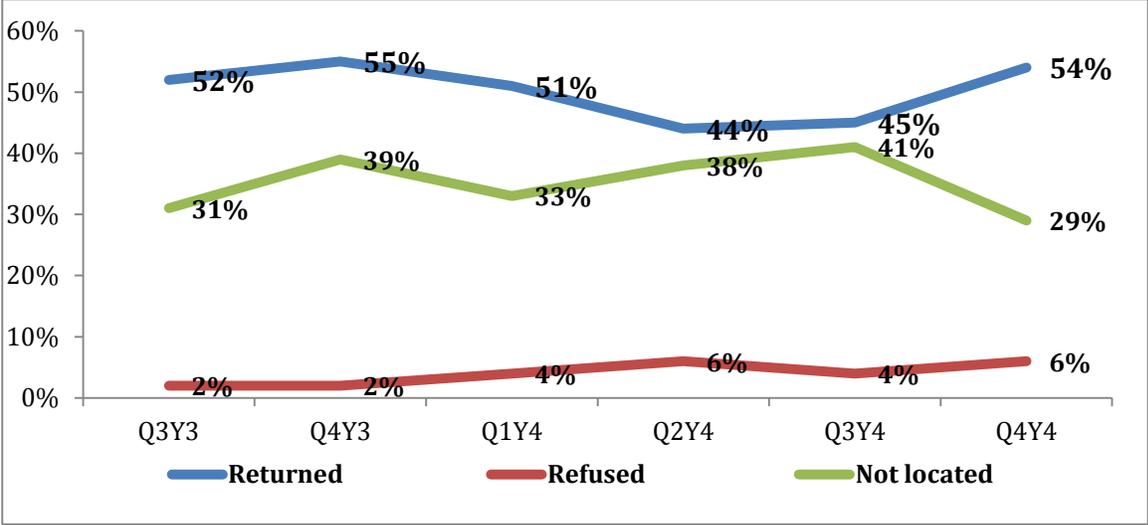
The percentage of abandoned patients returning was 62% (28) in CCR, 33% (24) PMTCT, and 67% (26) TB. Among the abandoned patients, 27% (12) in CCR, 55% (40) in PMTCT, and 13% (5) in TB were not found.

In active case finding challenges include; the high proportion of patients who cannot be located, especially in PMTCT and ART and patients who refuse to return to treatment after location. Patients are difficult to locate because they provide inaccurate names, addresses and phone numbers. The reasons some patients refuse to return to treatment are not clear, in early 2015 CHASS Niassa will conduct an assessment in order to identify the reason.

To improve the performance on active case finding, CHASS Niassa is providing on-the-job training to CCMs to check the completeness of clinical charts of patients newly enrolled, specifically the demographic data (name, age, sex, place of residence, mobile number, and other relevant information). In addition, CCMs are making an initial home-visit to new patients as a means of establishing a relationship with the patient, providing psychological support to the patient and the family, as well as confirming the information that will be used in cases of loss to follow up. With the clinical staff, CHASS Niassa is sensitizing clinicians to cross-check the addresses provided by patients (that includes the neighborhood, name of their community leaders, and community based organizations (CBOs) providing support in their place of residence) with the existing list of community leaders and CBOs in each community, which has been provided by CHASS Niassa and the Community Care Program (PCC). With regard to CCR, a new initiative to link the mother's record to the infant's is being implemented to help in finding infants who are lost to follow up.

In the most recent quarter, the proportion of defaulted and abandoned patients not located decreases to the lowest level in the past year and a half leading to an increase in the proportion returning to care (Figure 17). We believe this is the result of the various interventions that are being implemented. However, the percentage that refused to return to care has remained high relative to the historical levels, at 6%.

Figure 17. Percentage of abandoned ART patients included in active case finding in CHASS Niassa sites who returned to care, refused to return and could not be located, Q3FY3 to Q4Y4



Laboratory

This quarter CHASS Niassa continued supporting 18 micro and functional laboratories in the 16 districts of Niassa province; 61% (11 out of 18) of these laboratories have the capacity to perform CD4 counts. During the quarter a total of 5,245 CD4 counts were performed, a 26% decrease compared to the previous quarter (from 7,020 to 5,245). This decrease was due to the clinicians failing to request CD4+ counts per the MoH guidelines. The quality of data and data reporting is also a challenge. This quarter 37% of the CD4 counts undertaken were done using the Point of Care technology for CD4 (PIMA) machines (

Table 1).

Next quarter CHASS Niassa, in coordination with DPS Niassa, will continue with supportive supervision in the lab and HIV sectors to emphasize the importance of requesting CD4+ in the clinical process and of following up patients to ensure that the CD4 has been obtained.

Table 1. Number of CD4 counts in Niassa using PIMA, July to September 2014

| Health facility | July | August | September | Total 3rd quarter | Total 4th quarter |
|--------------------|------|--------|-----------|-------------------|-------------------|
| Cobue | 62 | 36 | 26 | 160 | 124 |
| Metangula | 155 | 136 | 115 | 350 | 406 |
| Mavago | 13 | 14 | 12 | 89 | 39 |
| Mecula | 26 | 28 | 43 | 128 | 97 |
| Marrupa | 54 | 57 | 37 | 182 | 148 |
| Maua | 86 | 61 | 35 | 275 | 182 |
| Mecanhelas | 153 | 99 | 129 | 608 | 381 |
| Entre Lagos | 45 | 53 | 41 | 150 | 139 |
| Mandimba | 178 | 121 | 125 | 342 | 424 |
| Total | 772 | 605 | 563 | 2284 | 1940 |

During the quarter, 421 PCR samples (385 first collections and 36 repeated collections) were collected and sent to the Nampula reference laboratory, a 3% decrease compared to the previous quarter (from 421 to 410).

Of the PCR samples sent, 100% of the results were received. This was due to improvements in the processing of the samples, lab response time, laboratory equipment and management of the process of sending results from the HFs to HC Nampula and back. As far as the test results are concerned, of the 410 samples, 28 (8%) were positive. These sero-positivity rates for children under 18 months, assessed via PCR, are lower than the national average of 11.75% reported in the online PCR results from the National Institute for Health.

During the reporting period, a total of 2,036 smear slides for lab diagnosis of TB were processed with 156 (7.6%) diagnosed positive, which is the same percentage positive as last quarter. The number of slides processed decreased by 59% relative to the last quarter, when 5,008 slides were processed.

A total of 151 samples were processed using the Gene Xpert machine in Cuamba and Mycobacterium TB was detected in a total of 23 samples with one identified as resistant to rifampicin (Table 2). There was a 5% increase in the number of samples processed using the Gene Xpert machines (from 144 to 151). This is slightly fewer samples than expected based on the criteria for use of Gene Xpert in Mozambique. All clinicians have been trained in the referral criteria, and this is likely contributing to the increase in the number of cases but further follow up is needed to encourage clinicians to make referrals.

Table 2. Gene Xpert results in CHASS Niassa sites, FY4, by quarter

| | # of samples processed | Presence of DNA of M.Tuberculosis detected | Presence of DNA of M.Tuberculosis not detected | Invalid | Resistance to Rifampicine identified |
|------------------|------------------------|--------------------------------------------|------------------------------------------------|---------|--------------------------------------|
| Quarter 1 | 260 | 42 | 207 | 2 | 6 |
| Quarter 2 | 80 | 19 | 61 | 0 | 1 |
| Quarter 3 | 144 | 26 | 104 | 1 | 5 |
| Quarter 4 | 161 | 23 | 120 | 0 | 1 |

Injection Safety/Infection Prevention & Control/Biosafety Technical Support

During the quarter, Infection Control Program (ICP) internal measurements were done in eight health facilities (Table 3), two of which were newly added in quarter 4. The average score increased from 55.3% in quarter 3 to 62.2% in quarter 4 but not all sites saw improvement. Both the district hospital in Marrupa and CS Metarica continued to demonstrate issues similar to those in the last quarter. Were found that the most frequent issues affecting infection control practices were the limited availability and poor use of personal protection equipment, not compliance with the rules of segregation of hospital waste, and difficulties in access to running water. Although CHASS Niassa cannot address all of these issues, it will purchase biosafety material in 2015.

Table 3. Results of internal measurements of infection control program*

| Health Facility | Q3 | Q4 |
|-----------------|------|------|
| Marrupa | 53.0 | 44.5 |
| Cuamba | 54.4 | 67.7 |
| Mecanhelas | -- | 69.8 |
| Metarica | 62.0 | 51.2 |
| Majune | -- | 48.0 |
| Nipepe | 64.7 | 78.9 |
| Muembe | 53.1 | 69.7 |
| Chimbunila | 44.3 | 67.6 |

*Only facilities assessed in Q4 are included in this table

Post Expose Prophylaxis (PEP)

With regard to the PEP, this quarter there were 5 cases of occupational exposure to HIV reported and three of them received PEP (Table 4). The 2 cases of minimum exposure did not receive PEP because this is not recommended per the MoH guidelines.

Table 4. Occupational exposures to HIV and PEP, by type and sex, July to September 2014

| Health Facility | Type of Exposure | | | | | | Total | | PEP | |
|------------------------------|------------------|----------|--------------|----------|----------|----------|----------|----------|----------|----------|
| | Massive | | Intermediate | | Minimum | | M | F | M | F |
| | M | F | M | F | M | F | | | | |
| Mandimba | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 2 | 1 | 0 |
| Muembe | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Lichinga Provincial Hospital | 0 | 0 | 2 | 0 | 0 | 0 | 2 | 0 | 2 | 0 |
| Subtotal | 0 | 0 | 3 | 0 | 0 | 2 | 3 | 2 | 0 | 0 |

Nutrition, Access to Food and Utilization Technical Support

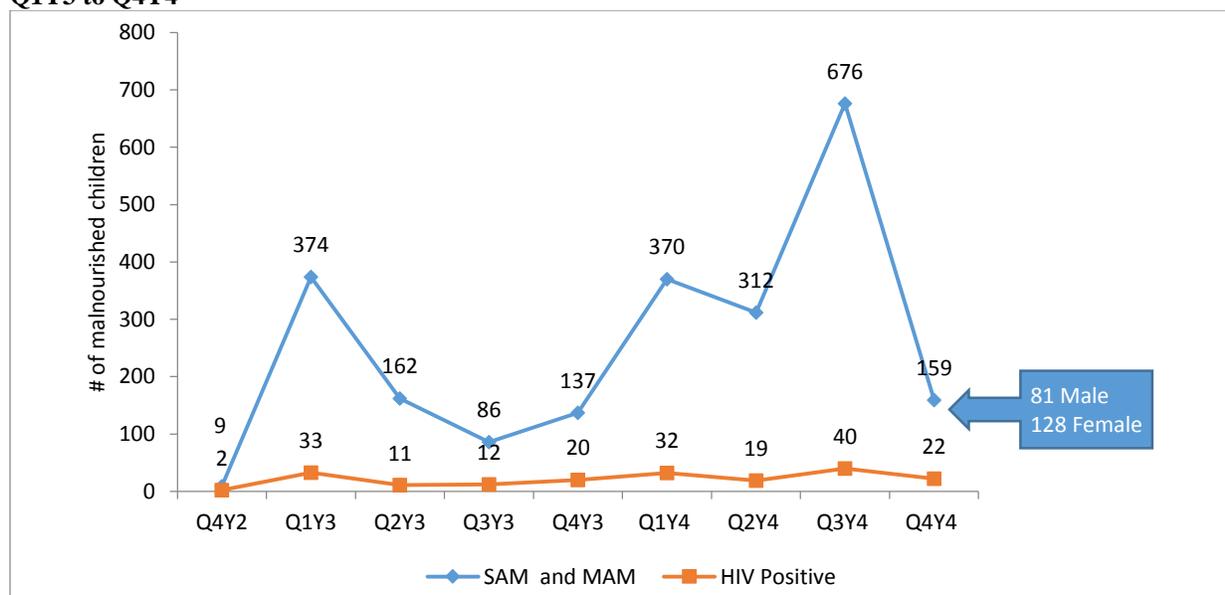
The CHASS Niassa nutrition program aims to strengthen nutrition counseling and care for PLHIV in clinical- and community-based services in Niassa Province. The program supports the implementation of the Nutrition Rehabilitation Program (NRP) volume 1, which has been implemented in Niassa Province since July 2012, covering children under 14 years old in a total of 18 HFs. The NRP interventions are grouped into three components: Outpatient Treatment of Malnutrition (TDA), Treatment of Malnutrition in Internment (TDI) and Community NRP.

Nutrition Rehabilitation Program Technical Support – Clinical Component

Nutrition Rehabilitation Program TDI (Treatment of Malnutrition in the Inpatient)

A total of 159 children attended the in-patient nutrition services. All of them were tested for HIV and 14% (22/159) tested positive (Figure 18). The number of children receiving services decreased by 76% (676 to 159) compared to the last quarter, due to improvements in community level activities including lectures about good practice in nutrition and continued challenges with data collection in some sites. During the joint TSVs the team will continue to strengthen assessment of children and better recording in the registration books. The parallel data collection for nutrition data by the M&E teams of DPS and CHASS Niassa will also continue in order to collect data required for PEPFAR reporting. The decision not to include nutrition indicators for HIV patients in the current data system was decided at the national level. Thus, CHASS Niassa has limited ability to incorporate this into the Nutrition Database. However the Project will continue to advocate with DPS/MoH to incorporate this data in the future.

Figure 18. Number of children treated for malnutrition in inpatient settings in select CHASS Niassa sites, Q1Y3 to Q4Y4



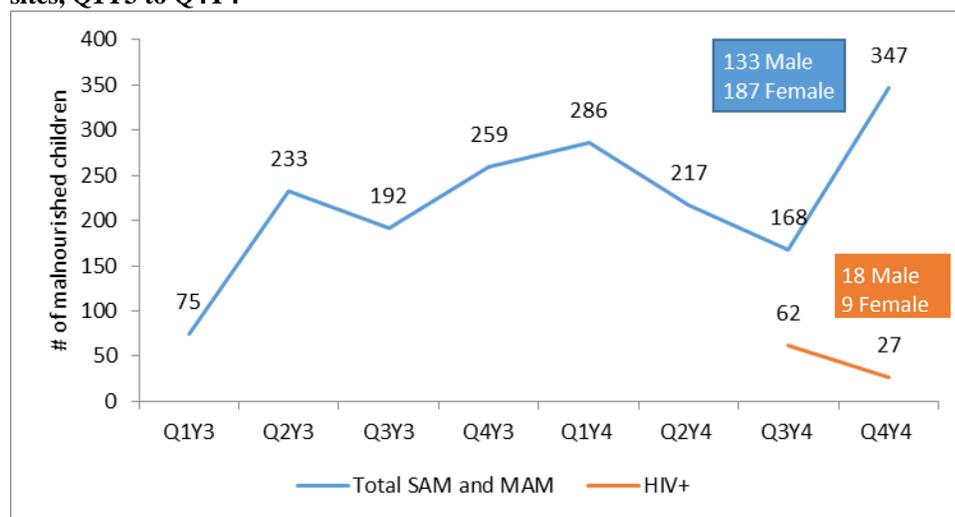
Data source: DPS: From Q1Y3 to Quarter 2 of FY 14. CHASS Niassa M&E for Q3 and Q4 of FY14

Nutrition Rehabilitation Program in TDA (Treatment of Malnutrition in the Outpatient services)

A total of 347 children were seen in ambulatory care and all of them were tested for HIV with 8% (27/347) testing positive (Figure 19); 53% of all children seen were female. The number of children decreased by 54% (751 to 347) compared to the last quarter as a result of the same that it was explained above.

A key next step is to collaborate with the World Food Program (WFP) to start distribution of Corn Soy Blend plus (CSB+) in 18 health facilities in Niassa. Distribution of CSB+ did not start this quarter because the CSB+ distributed by WFP for HFs was infested with insects despite being within its expiration date. After discussion with WFP, it was agreed that WFP will collect all of the infested food from the health facilities and will simultaneously provide a new batch. Although this was anticipated to take place in mid-September, it was delayed until early October (at the time of this writing, collection and redistribution have begun). Moreover, CHASS Niassa will continue working in collaboration with Food and Nutrition Technical Assistance (FANTAIII) project on the implementation of Quality Improvement Project (QIP).

Figure 19. Number of children treated for malnutrition and number HIV+ in select CHASS Niassa outpatient sites, Q1Y3 to Q4Y4



Data source: DPS from 2012 to Quarter 3 of FY 14. CHASS Niassa M&E for Quarter 4 of FY14.

Challenges in Implementing the Clinical Component

The challenges in implementing the clinical component remain the same as last quarter. Consistent and correct nutrition screening in HIV/AIDS services is the biggest challenge to NRP implementation in the province. This is due in part to the heavy workload as well as to the rapid turnover of staff without prior training of new staff. In the next quarter, CHASS Niassa expects to continue working with the nutritionists in DPS during regular joint TSVs to improve the screening of malnutrition cases, classification, and treatment according to the NRP protocol as well as to more accurately register patients.

The main gaps in the realization of universal access to nutrition care include weak support for integration of nutrition interventions in HIV/AIDS policies and programs in the national health care system; the problem of malnutrition screening, recording and reporting; work overload; and the constant absence of professionals in the HFs to attend trainings and meetings at district and provincial levels. CHASS Niassa will continue to provide on-the-job training and mentoring of new technicians allocated to health as well as refresher training for implementation of CSB+.

Nutrition Rehabilitation Program Technical Support – Community Component

Community Nutrition Intervention – Referrals and Counter-referrals

At the community level a total of 144 children were identified as malnourished and were referred to HF's by the CCMs; 129 of them were followed at a HF (Figure 20). The difference of 15 children is because some children who were referred may have been referred late in the quarter and will seek services in the following quarter. The number of beneficiaries has increased since year 4 (Figure 20) due to improvements in data recording as result of regular TSV. Fifty nine percent of those referred were under 15 years of age and 46% of them were female (Table 5).

Figure 20. Number of patients with malnutrition referred to HF's and followed in HF's in Niassa Province, Q3Y3 to Q4Y4, by quarter

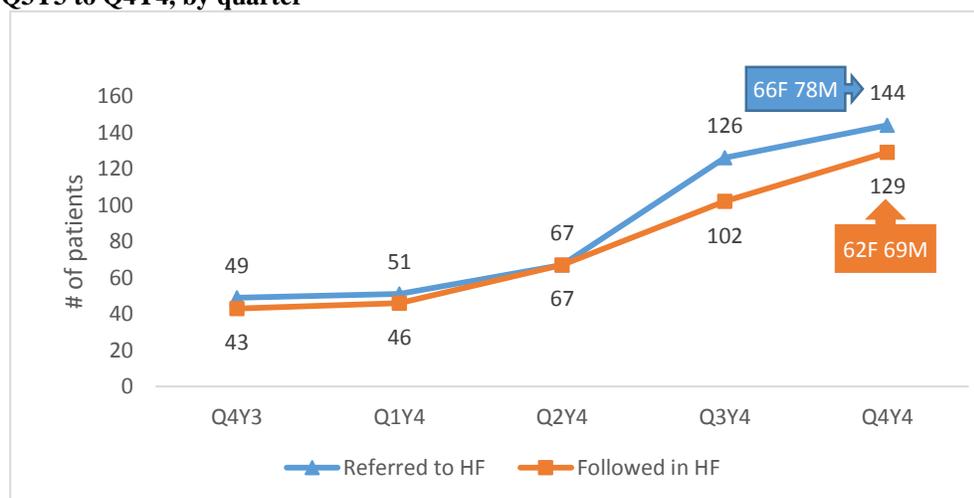


Table 5. Number of malnourished patients referred from the community and followed at HF level in Niassa, by age and sex, in Q4Y4

| | Patients Referred | | | | | Patients Followed | | | | |
|----------------------|-------------------|---|-----|----|-----------|-------------------|---|-----|----|-----------|
| | 0-14 | | 15+ | | Total | 0-14 | | 15+ | | Total |
| | M | F | M | F | | M | F | M | F | |
| Chiuaula | 1 | 1 | 1 | 1 | 4 | 1 | 1 | 1 | 1 | 4 |
| Nipepe | 5 | 2 | 0 | 0 | 7 | 5 | 2 | 0 | 0 | 7 |
| Namacula | 9 | 6 | 21 | 12 | 48 | 7 | 5 | 18 | 10 | 40 |
| Chissimbir | 4 | 6 | 0 | 0 | 10 | 4 | 6 | 0 | 0 | 10 |
| CS Chimbunila | 3 | 2 | 0 | 0 | 5 | 2 | 2 | 0 | 0 | 4 |
| Majune | 2 | 2 | 1 | 0 | 5 | 2 | 2 | 1 | 0 | 5 |
| Mitande | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 |
| CS Marrupa | 0 | 2 | 0 | 0 | 2 | 0 | 1 | 0 | 0 | 1 |
| Nungo | 0 | 0 | 2 | 1 | 3 | 0 | 2 | 0 | 1 | 3 |
| Mecula | 1 | 1 | 0 | 0 | 2 | 1 | 1 | 0 | 0 | 2 |
| Massangulo | 5 | 6 | 3 | 2 | 16 | 5 | 6 | 3 | 3 | 17 |
| Muembe | 3 | 0 | 0 | 1 | 4 | 2 | 0 | 0 | 1 | 3 |
| Msawize | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 1 |
| Etatara | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 1 |
| Lulumile | 3 | 1 | 2 | 0 | 6 | 3 | 1 | 0 | 0 | 4 |
| CS Lichinga | 0 | 3 | 0 | 0 | 3 | 0 | 3 | 0 | 0 | 3 |

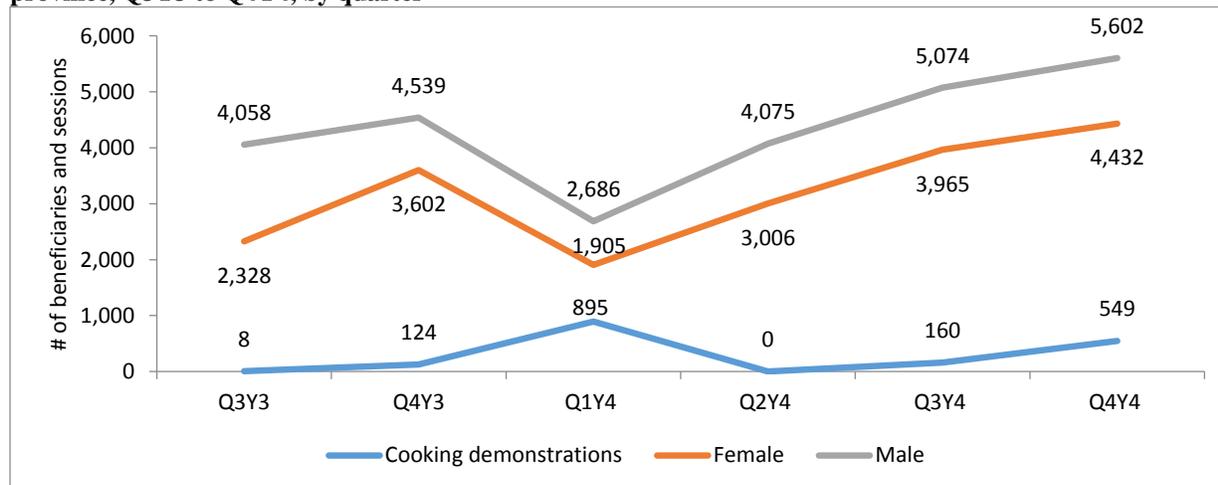
| | | | | | | | | | | |
|-------------------|-----------|-----------|-----------|-----------|------------|-----------|-----------|-----------|-----------|------------|
| Metangula | 1 | 1 | 6 | 4 | 12 | 1 | 1 | 5 | 3 | 10 |
| Nazinhenge | 1 | 1 | 0 | 0 | 2 | 1 | 1 | 0 | 0 | 2 |
| Sanga | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 1 |
| Mandimba | 0 | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 2 |
| Chiuanjota | 2 | 2 | 0 | 0 | 4 | 2 | 2 | 0 | 0 | 4 |
| Meponda | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Lugenda | 0 | 2 | 0 | 0 | 2 | 0 | 1 | 0 | 0 | 1 |
| Lione | 0 | 2 | 1 | 0 | 3 | 0 | 2 | 1 | 0 | 3 |
| Total | 41 | 44 | 37 | 22 | 144 | 38 | 42 | 29 | 20 | 129 |

Data source: CHASS Niassa M&E

Nutrition Community Intervention – Information, Education and Communication (IEC)

The number of beneficiaries of IEC sessions increased by 11% (9,039 to 10,034) compared to the last quarter, due to improvements in data recording as a result of regular TSV. Over the last five quarters, the number of beneficiaries has increased (Figure 21), except in the first quarter of FY2014 when the work plans for the ARV and CCM had not yet been approved.

Figure 21. Number of beneficiaries of IEC sessions by sex and number of culinary practice sessions in Niassa province, Q3Y3 to Q4Y4, by quarter

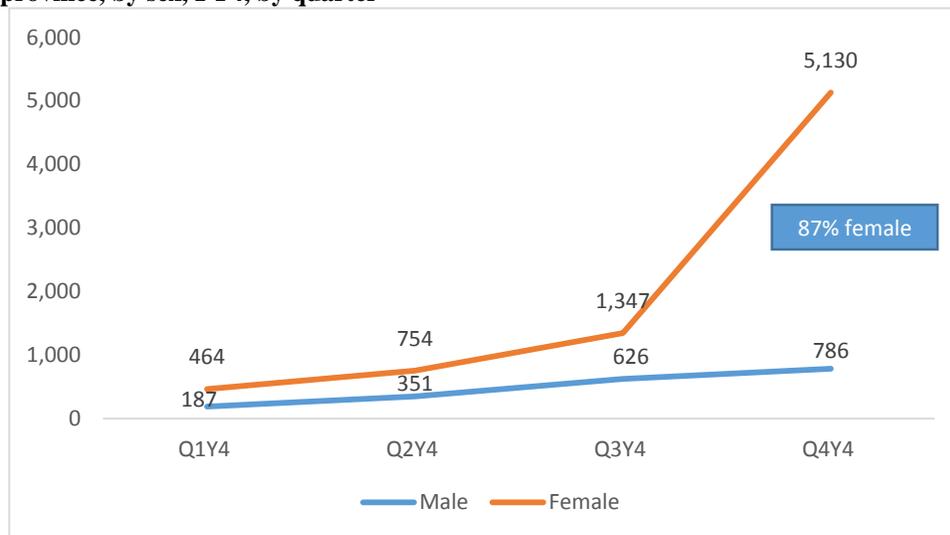


Community nutritional counseling and education, and demonstration gardens done in partnership with PCC

During this quarter the number of new participants who received nutritional counseling and education and demonstration of vegetable gardens² increased by 200% (1,973 to 5,916) compared to the previous quarter (Figure 22), due to the improvements in the identification of cases and recording of data. The improvements resulted from TSVs in the Ngauma, Mandimba, Cuamba, Metarica and Mecanhelas HFs.

² These activities were carried out in the following districts: Ngauma, Mandimba, Cuamba, Metarica, and Mecanhelas; by the following organizations: Trilho Juvenil, Irmaos Unidos, Hankoni, Wupuwuela e Thandizanani.

Figure 22. Number of beneficiaries reached by nutrition activities of CCMs in select districts of Niassa province, by sex, FY4, by quarter



Data source: PCC M&E

The main challenges in the community component were the lack of regular reports and timely information by CCM and ARV activists. During the next quarter, TSVs will be carried out with DPS staff to follow-up the activities of community NRP.

Implementation of QIP within the Scope of Nutrition Rehabilitation Program in collaboration with FANTA III and DPS Niassa

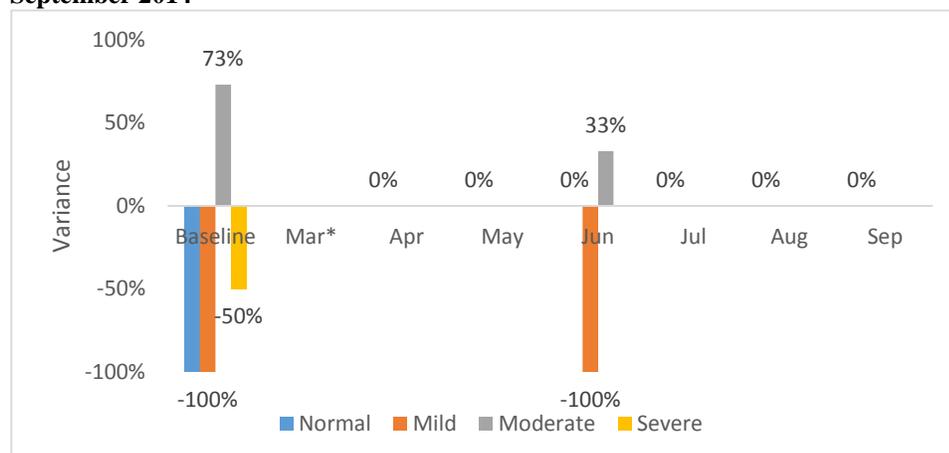
The overall goal of QIP is to improve the malnutrition approach in children less than 15 years old in CCR and consultation for chronic diseases (TB/HIV, pre-ART and ART) in health centers of Lichinga, Cuamba and Muembe, including at Cuamba Rural Hospital between February 2014 and January 2015. A baseline study was done in February 2014 in the CCR, pre-ART and ART that aimed to evaluate whether or not nutritional evaluations were collected during such consultations, and if so, if they were referred to receive treatment or supplementation in the NRP.

Since the beginning of the implementation of the QIP of the NRP, HFs in Muembe and Lichinga City have shown significant improvement in the recording of anthropometric, nutritional assessment, classification and treatment data for malnourished patients. Figures 23 and 24 show data from Muembe, which is typical of all sites. In general the HFs that are implementing the QIP have better performance than others, with the exception of the HFs in Cuamba.

This improved performance has resulted in part from on-the-job training during joint TSVs with DPS. Unfortunately, registration of the same parameters in both facilities in Cuamba (Cuamba HF and Rural Hospital) has not improved, likely because of staff turnover. In the next quarter the Clinical and the MCH Nurses of CHASS Niassa and DPS will continue to make follow-up visits during the joint TSVs, and also sensitize the technicians at HFs on the importance of implementing the NRP, registration, collection of data for analysis and monitoring of the gaps

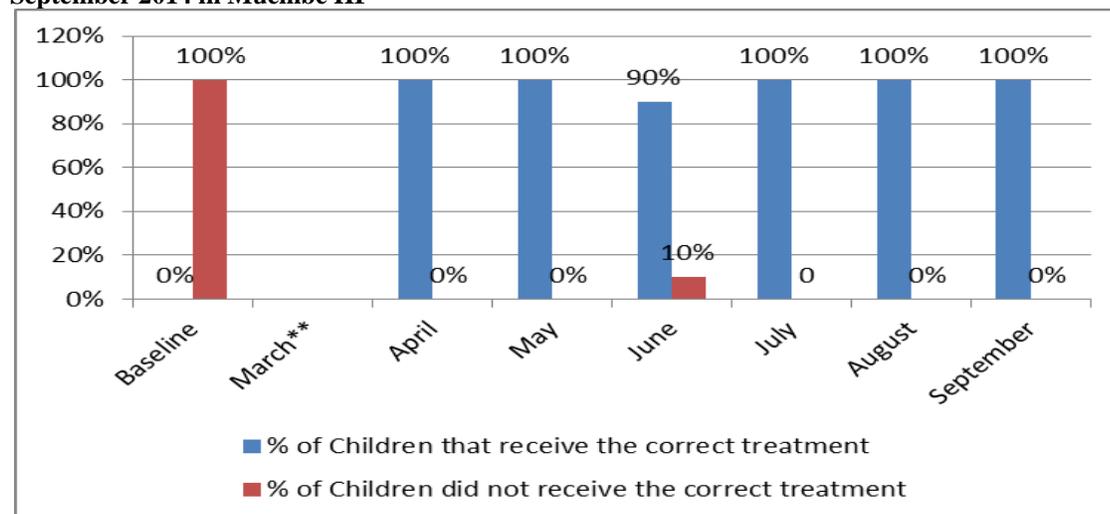
found. Particular attention will be paid to the HFs in Cuamba because they are new staff providers.

Figure 23. Classification of nutritional status of children using Weight / Height (P/E) and / PB=MUAC – variance obtained through the values reported / recorded and verified in Muembe HF, February to September 2014



Data source: Registration book of NRP at HF
 *Muembe HF did not have any patients in March

Figure 24. Treatment and supplementation: % of children who received proper treatment or not, February to September 2014 in Muembe HF



Data source: Registration book of NRP at HF

Gender Equity and Gender Based Violence (GBV) supported activities

Gender equity has been a component of CHASS Niassa since implementation began. In 2012 GBV was also incorporated as part of the intervention, starting with 9 HFs. During quarter four of FY13 the interventions were expanded to 20 HFs, with a focus in the district headquarters. Since then, the focus has been on implementation in these sites. In each district, a focal point for GBV has been indicated by DPS and trained by CHASS Niassa in the GBV package. Interventions take

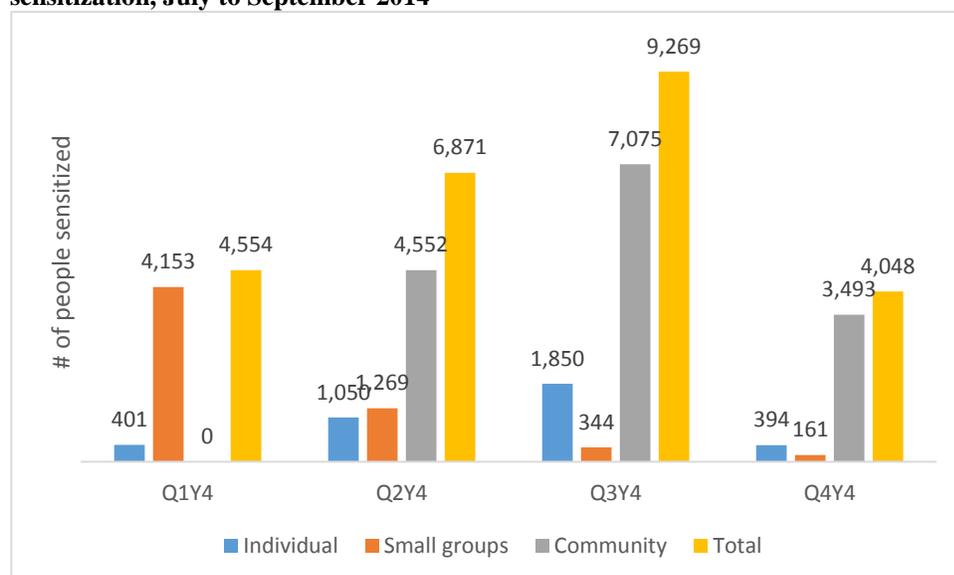
place in both HFs (including sensitizations and clinical services such as screening and post-GBV services) and at the community level (mainly sensitizations).

Reaching individuals through Individual, Small-group and Community Interventions related to GBV

During quarter four, a total of 4,048 individuals (1,745 males and 2,303 females) were reached through interventions addressing GBV (Figure 25). These individuals were reached as individuals or in small groups. A total of 394 individuals (193 males and 201 females) were sensitized, 161 people were sensitized in small groups (38 males and 123 females) and 3,493 people (1,514 males and 1,979 females) were sensitized through community interventions.

During this quarter, the activities at community level decreased over 50% as a result of multiple health campaigns (e.g., Trachoma, distribution of mosquito nets, measles vaccination) and the elections. The community leaders and CCMs who normally do GBV sensitizations were involved in the preparation for and implementation of these campaigns. During the 6-week campaign season CCMs, who are community leaders, were trained to take part in the polling on election day.

Figure 25. Number of people sensitized to GBV at HFs and in communities in Niassa Province, by type of sensitization, July to September 2014



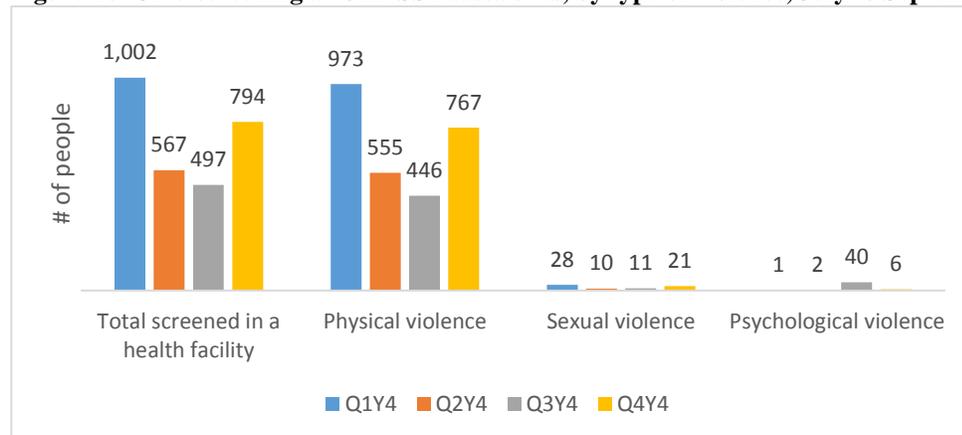
In two districts, Lago and Sanga, GBV committees were created in collaboration between the CCMs, community leaders, AMETRAMO and traditional birth attendants. In these districts, meetings were conducted in collaboration with MULEIDE and Associations working with the PCC project in Mandimba, Metarica, Mecanhelas and Cuamba districts in order to intensify the sensitization in the community in preventing GBV, so that all cases of violence are referred to HFs for care and treatment.

GBV Screening at the HF

During this quarter a total of 794 people (283 males and 511 females) were screened for violence (Figure 26)³. Of these, 767 (307 males and 460 females) were cases of physical violence, 21 were cases of sexual violence in females, and 6 were cases of psychological violence (4 male and 2 female). All 21 cases of sexual violence were female. Four of them were 0-9 years old, 2 cases were 10-14 years old, 9 cases were 15-18 years old, 3 cases were 18-24 years old and 3 cases were over 25 years of age.

In the prior quarter, a new committee approach was piloted at 7 de Setembro HF in Sanga. The committee aims to work in co-ordination with the Integrated Assistance to victims of violence, and includes the following sectors: social affairs, community leaders, justice, police and health. This quarter, one 10 year old girl who suffered sexual violence by a stranger was referred to the committee. According to the protocol of Integrated Assistance to Victims of Violence, the victim had the following services in the same location: HIV testing, post exposure prophylaxis, Counseling, and psychosocial support. The girl was not eligible for emergency contraception but was referred to the police. With the help of a community leader, the rapist was identified, led to justice authorities and was sentenced of 12 years in prison, which he is now serving. With this positive outcome, the pilot service was expanded to the districts of Mecanhelas and Mandimba and will be further expanded in the coming quarters.

Figure 26. GBV screening at CHASS Niassa sites, by type of violence, July to September 2014



³ In this quarter, only people who were screened and found to be victims of violence were reported. CHASS Niassa has, however, introduced new forms and provided on-the-job training to all staff who screen patients for violence so that future reports will include the total number of people screened, regardless of the result.

People Who Received Services Following Violence

All 21 cases of sexual violence were tested for HIV and 17 eligible cases received emergency contraception. The younger girls were not eligible for emergency contraception because they had not yet menstruated.

A total of 21 people, all victims of sexual violence, received PEP. This was an increase of 75% compared to the 12 cases reported in the previous quarter. Of all victims of violence screened, 27 (4 males and 23 females) received psychosocial support, while in the previous quarter 497 people were screened and 240 received psychosocial support (Table 6). In addition, 27 people were referred to the police (4 males and 23 females). This represents a significant decrease in the percentage of cases who received psychosocial support and referrals to the police. There is still a gap in service provision as all people who are identified as victims of violence should receive psychosocial counseling. In reality some people do not receive it because the staff who are trained in this are not available during their visit and others refuse this service. Furthermore, there was substantial turnover of GBV focal points this quarter with little transfer of skills; in the coming quarter CHASS Niassa plans to visit sites with new focal points to provide on-the-job training for the new focal points.

Table 6. Number of clients who received services after violence in CHASS Niassa sites, July to September 2014

| Type of service encounters | | # of individuals | | |
|----------------------------------------------------------------|----------------------------------------|------------------|---------|-------|
| | | Males | Females | Total |
| GBV Screening | Physical Violence | 307 | 460 | 767 |
| | Psychological and Patrimonial Violence | 5 | 1 | 6 |
| | Sexual Violence | 0 | 21 | 21 |
| | Subtotal – screening | | | 794 |
| Post GBV services | Tested for HIV | 0 | 21 | 21 |
| | Family Planning | 0 | 0 | 0 |
| | Ante-Natal Care | 0 | 0 | 0 |
| | Partners Tested | 0 | 0 | 0 |
| | Emergência contracepção | 0 | 17 | 17 |
| | Post-Exposure Prophylaxis | 0 | 21 | 21 |
| | Psychosocial Counseling | 5 | 22 | 27 |
| | Police Referral | 5 | 22 | 27 |
| Total number of individuals receiving post GBV services | | NA | NA | 27 |

Trainings in GBV

Through on-the-job training, this quarter 16 clinicians (10 male general nurses who are gender focal points and 6 female MCH nurses) were trained in adapting the books for registration of GBV in emergency and maternity wards using the "Protocol for Integrated Assistance to Victims of Violence", as well as in sensitization of men coming to HFs with their wives to adhere to the Men to Men (H2H, for *Homen ate Homen* in Portuguese) groups.

During this quarter, H2H group meetings were held in Mandimba, Lago and Chimbonila. At each of these meetings, key themes related to GBV and masculinity are discussed using materials from MoH, MULEIDE, Forum Mulher, and I-TECH. The topics covered in each session are captured on a data collection form developed for these groups and may include use of condoms, male circumcision, the relationship between GBV and HIV, fatherhood, maternity/labor, antenatal medical consultations, immunization, family planning, nutrition, and cultural habits and gender.

Persons Provided with PEP, by Exposure Type - Rape/Sexual Assault Victims

During this quarter 21 females who experienced sexual violence received post exposure prophylaxis. CHASS Niassa will continue to support the DPS to advocate for the allocation of prophylaxis kits and to provide on-the-job training for all technicians trained in the integrated protocol for victims of gender based violence. As planned in the previous quarter, prophylaxis kits were allocated in the emergency and maternity wards that have not yet been trained by district PEP focal points.

In the next quarter, CHASS Niassa will support the CCMs to intensify community sensitization about the availability of PEP and the importance of receiving PEP in HFs. They will also be supported to transmit messages regarding the importance of preventing GBV, identifying cases of violence and referring them to the HFs.

Men to Men Groups

Men to Men groups are an approach CHASS Niassa is using to increase understanding of gender and health issues on the part of men and to increase male involvement in health. The groups provide a great place to connect, and provide the ideal environment to help men realize that they are not unique or alone and to see first-hand that other men experience similar problems and issues.

During this quarter two more H2H groups were created in the districts of Metarica (25 members) and Mecanhelas (20 members). We have thus far created 5 groups with a total of 110 men who are reached with information that explicitly addresses masculinity norms related to HIV. Next quarter CHASS Niassa will continue working with these groups to encourage them to sensitize their families and to work in the community to reach more men with information about cultural norms related to HIV.

During quarter four, CHASS Niassa distributed t-shirts and caps to H2H group members. They will wear these when they are working in the community to sensitive other men about harmful cultural barriers related to gender and HIV.

Objective 2

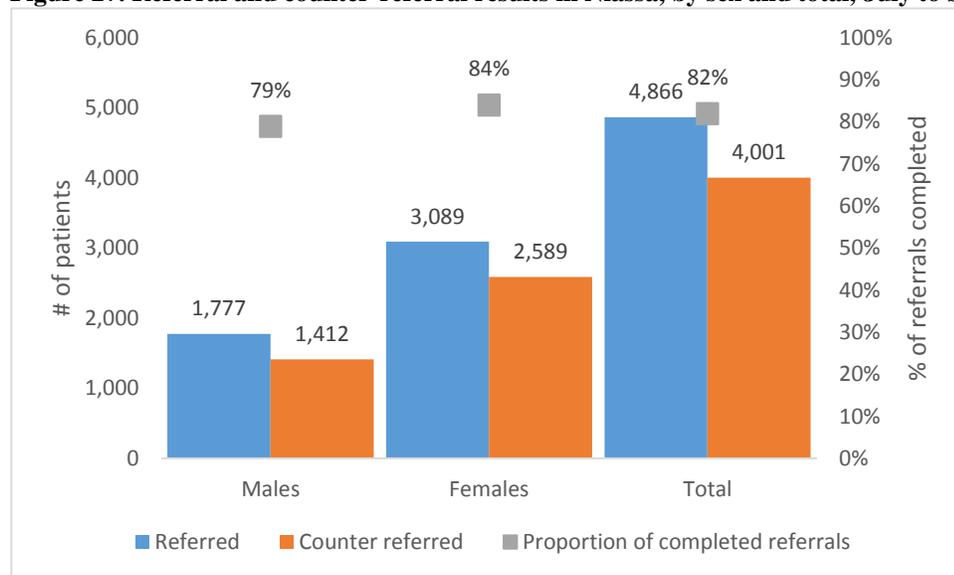
Create an integrated system of HIV/AIDS and primary health care with strong linkages to community services.

Strengthening the District Referral and Counter-referral Networks

CHASS Niassa supports establishment and strengthening of the referral network to link community interventions to health facilities. It has already been established in 46 HFs with ART services, following the expansion of the ART sites.

During this quarter, a total of 4,866 individuals (1,777 males and 3,089 females) were referred for various services (Figure 27), including 1,077 (101 males⁴ and 976 females) for MCH services (ANC, CPP, FP, CCR, maternity), 5% (50) of whom were couples; 398 for TB services (197 males and 201 females); 1,758 to HIV services (723 males and 1,035 females); and 1,633 (756 males and 877 females) to other services (Nutrition, GBV, and Malaria). Of the people referred, 82% (4,001 individuals, 1,412 males and 2,589 females) completed the referral cycle with males somewhat less likely to complete the referral.

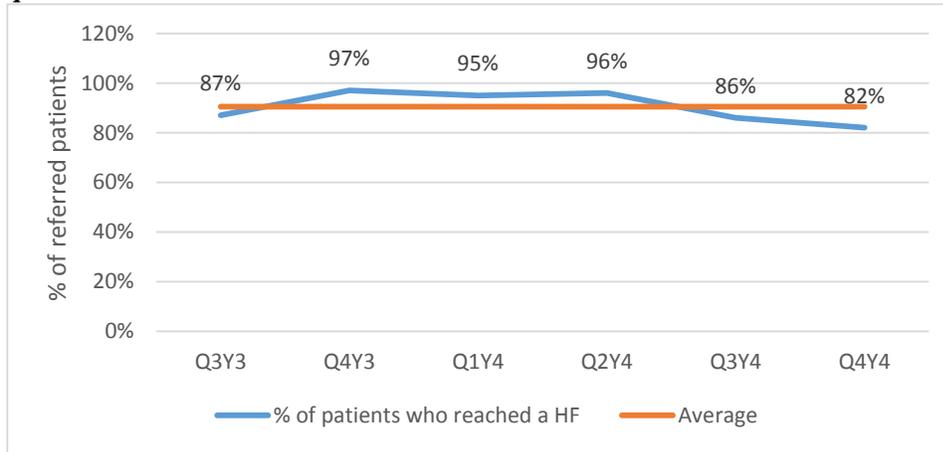
Figure 27. Referral and counter-referral results in Niassa, by sex and total, July to September 2014



In the past two quarters the percentage of patients who are reported to have successfully completed the referral cycle has declined after being stable for almost a year (Figure 28). We have increasingly noticed a reduction in the percentage of counter-referrals, which may be associated with reduced quality of awareness messages provided by CCM. In the next quarter the CHASS Niassa technical team will do on-the-job training for CCM in community mobilization and the referral and counter-referral package

⁴ Males are included because male children are referred for CCR.

Figure 28. Percent of referred patients who reached a HF in CHASS Niassa sites, Q3FY4 to Q3FY4, by quarter

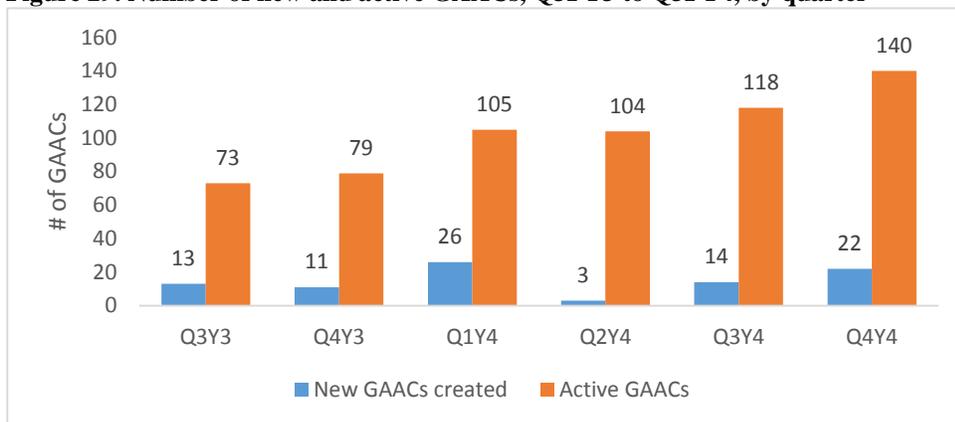


Community Adherence Support Group (GAAC)

From July to September 2014, 22 new “*Grupos de Apoio para Adesão dazs Comunitarios*” (GAACs) were created in the province for a total of 140 groups; no GAACs discontinued this quarter. The currently active GAACs benefit 442 patients (159 males and 291 Females). Over the last five quarters, there has been an overall increase in the number of active GAACs and GAAC members. No patients abandoned care and only one patient died. This quarter saw the creation of the second highest number of GAACs in a single quarter at any point in the past year and a half (

Figure 29), likely because CHASS Niassa conducted TSVs aimed specifically at the creation of new GAACs. The increase in the number of new GAAC is due to the technical assistance being conducted about enforcement of community sensitization activities and implementation of the strategy of APSS and positive prevention. GACCs are still implemented only in the pilot areas. A main challenge for GACCs in Niassa is the low number of the member in each group (mean of 3). This is due to continuing concerns over disclosure. In the next quarter CHASS Niassa and DPS will work to expand the GACC to other districts and will reinforce counseling on disclosure as well as disseminate information on psychosocial support and positive prevention.

Figure 29. Number of new and active GAACs, Q3FY3 to Q3FY4, by quarter



Objective 3

Strengthen Government of Mozambique/MoH capacity at the provincial and district levels to effectively manage high-quality, integrated HIV services by building management and financial capacity, reducing human resource constraints, and increasing the capacity to use data for program improvements.

This quarter CHASS Niassa has contributed to improving the health system in Niassa across the World Health Organization health system building blocks.⁵ In order to develop health system capabilities necessary to effectively plan, manage, and evaluate integrated HIV services in quarter 3 the project has supported the DPS/SDSMAS with the following interventions:

Strengthening of Service Delivery

Joint TSVs with DPS/SDSMASs to health facilities to strengthen the technical support system in Niassa

This quarter CHASS Niassa planned to conduct 646 TSVs (both CHASS Niassa-specific and joint TSV); 604 (93%) of the planned visits were conducted. Of the visits made, 178 (29%) were joint visits with DPS. Not all planned visits were conducted because of overlapping tasks during the period, including the need to participate in seminars and meetings with DPS as well as the need to facilitate trainings not planned in the previous quarter. During joint site visits, CHASS Niassa is mentoring DPS staff to develop their supervisory skills.

⁵ Service delivery; governance; human resources for health; finance; medical products, vaccines and technologies; and information systems

Strengthening of Human Resource Management

Pre-Service Training Support

CHASS-Niassa supports pre-service training of health workers. This quarter CHASS Niassa continued to monitor the MCH nurse class that started in February 2014. All 30 candidates are still attending and are expected to graduate in December 2015.

Post-Graduation Scholarship Support

In order to improve the quality of management skills for the DPS senior staff, the project continues to support post-graduate scholarships for master's degrees in public health, management and HIV. The beneficiaries of the scholarships are drawn from provincial and district managers and are expected to return and work in the province/districts for a minimum period equivalent at least to the time of study. Three beneficiaries continue to attend class at Catholic University at Beira campus in part time enrollment.

In-Service Training

No in-service trainings were held this quarter as no training was planned for this quarter.

Strengthening of Financial Management

Sub-agreement Management with DPS

Since the beginning of the implementation of the activities, CHASS Niassa has secured the participation of the Government of Mozambique in the project through sub-agreements with DPS and SDMAS where roles and responsibilities were defined and served as part of instruments of capacity building for the organizations supported.

In the last quarter of the fourth year, the cumulative financial implementation of the Sub agreement with DPS was 79% of the annual total funds obligated (US\$ 857,765).

During Fiscal Year 4, DPS spent (US\$ 590,992), 88% of the budget allocated, while in year 3 they spent 82% (US\$ 685,879). The 16 districts and 2 HF spent with sub agreements showed a higher capacity of absorption of funds in Year 4, spending 74% (US\$ 268,866) against 68 % in year 3 (US\$ 160,088).

Last quarter, CHASS Niassa started evaluating 12 pre-selected indicators which contribute to access to and delivery of medical, psychosocial and community services for people living with HIV. Funds are then provided based on the percent of indicators for which targets were met⁶. All 18 sites was evaluated each quarter of 2014 (the results for quarter four are not yet available). However, all indicators cannot be evaluated every quarter because some indicators are not available from monitoring data (e.g., 12 month retention is only collected every 6 months and is

⁶ Any funds that are not “earned” by the district/HF are returned to DPS.

not assessed in intervening quarters). The evaluation done over the first 3 quarters of the year shows that on average, the 18 sites were eligible to receive 28% of the available funds. However, there was substantial variation with some districts eligible to receive less than 5% and others eligible to receive over 50% (

Table 7). Performance also varied over time with many sites performing better in the first half of the year than in quarter 3; this is attributed largely to high turnover of DPS staff.

During this quarter, technical assistance was provided to districts on the administrative and financial procedures for the use of performance based grants.

Table 7. Level of absorption of performance based grants, by site

| Districts/HF | % in Quarters | | | % in 9 months |
|-------------------------------|---------------|--------------|--------------|---------------|
| | Q1 | Q2 | Q3 | |
| Lago | 0.0 | 0.0 | 10.00 | 3.33 |
| Ngauma | 0.0 | 0.0 | 10.00 | 3.33 |
| Lichinga distrito | 18.18 | 9.09 | 10.00 | 12.42 |
| Majune | - | 18.18 | 20.00 | 12.73 |
| Mandimba | 27.27 | 18.18 | 10.00 | 18.48 |
| Muembe | 18.18 | 18.18 | 20.00 | 18.79 |
| Nipepe | 27.27 | 9.09 | 20.00 | 18.79 |
| Mavago | 9.09 | 18.18 | 40.00 | 22.42 |
| Sanga | 27.27 | 27.27 | 20.00 | 24.85 |
| Lichinga cidade | 36.36 | 27.27 | 20.00 | 27.88 |
| Marrupa | 54.55 | 36.36 | 10.00 | 33.64 |
| Maua | 45.45 | 36.36 | 20.00 | 33.94 |
| Metarica | 36.36 | 54.55 | 20.00 | 36.97 |
| Cuamba | 45.45 | 36.36 | 30.00 | 37.27 |
| Mecanhelas | 36.36 | 36.36 | 50.00 | 40.91 |
| Rural Hospital, Cuamba | 50.00 | 66.67 | 20.00 | 45.56 |
| Provincial Hospital, Lichinga | 66.67 | 33.33 | 40.00 | 46.67 |
| Mecula | 63.64 | 45.45 | 50.00 | 53.03 |
| Total | 32.39 | 27.95 | 23.46 | 27.93 |

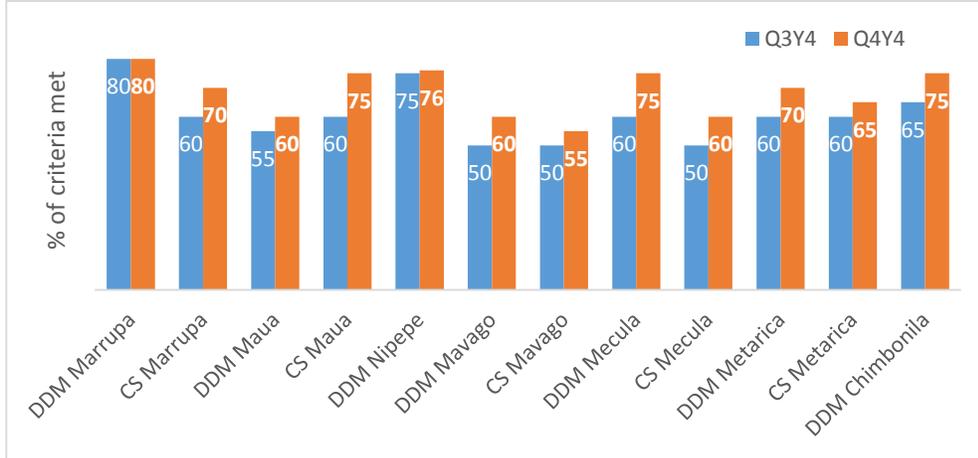
Logistics & Supply Chain Management

Capacity Building of Supply Chain Managers at Provincial, District, and Facility Levels

CHASS Niassa supports the DPS in assuring the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes. Currently CHASS Niassa is supporting 16 district warehouses, 1 provincial warehouse and 3 warehouses of provincial/rural hospitals, totaling 20 warehouses. The support consists of capacity building, improvement of working conditions, and training and installation of software (*Sistema Informatizado de Gestão de Medicamentos – SIMAM V2*) in 8 locations: the provincial warehouse, Lichinga Provincial Hospital warehouse, and warehouses in Mandimba, Lago, Marrupa, Cuamba, Sanga and Mecanhelas districts.

This quarter, technical supervision visits were provided to district medical warehouses (DDMs) of Marrupa, Metarica and Mavago and HFs of Nungo, Maua, Nipepe, Mecula, Lugenda, Chimbonila, Mavago and Metarica in order to assess the level of compliance and medicines supplies management. Areas of improvement were preparation of the Balance Sheet-Requisition and the use of Drug Formula Quantification (Figure 30). However, almost all DDMs need to improve their skills in preparing MMIA (*Mapa Mensal Informação de ARVs*—a monthly summary of ARVs), filing in the ARV daily register book and updating the register of defaulting patients and dropouts, mainly in Peripheral HFs. In order to overcome this constraint during the TSV support was provided on completing the MMIA and ARV register books as well as on the elaboration of the corresponding reports.

Figure 30. Percent of times the Drug Formula was completed correctly by select DDMs, Q3FY4



Availability of Pharmaceuticals

During this past quarter medicine availability was better and medicine stock outs less common compared to the previous quarters this year. Stockouts of Cotrimoxazole 480 mg tablet were identified during TSVs in Cuamba, Sanga and Mecanelhas. This stockout was solved within 15 days with the support of the Nampula Provincial warehouse using the DPS trucks and re-distributed to the warehouses that were showing eminent stock outs.

In general, during this quarter there was an improvement in drug availability (

Table 8). Nine pharmaceutical products had recorded stockouts, compared to 21 during the third quarter and 33 in the second quarter. This improvement was due to more complete fulfillment of requests by CMAM (i.e., a larger proportion of the drugs requested were supplied and more drugs were supplied the quantities requested).

Table 8. List of drugs in stock-out in Niassa province, FY4, by quarter

| Medicine | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter |
|------------------------------------------------|--------------------|--------------------|--------------------|--------------------|
| Salferroso+ Ácido Fólico Comp. Composto | 66 Dias | 40 Dias | 20 Dias | 45 Dias |
| Paracetamol 500mg Comp. | 42 Dias | 40 Dias | Sem Ruptura | Sem Ruptura |
| Amoxicilina 500mg Comp. | 32 Dias | 13 Dias | 8 Dias | Sem Ruptura |
| Amoxicilina 250mg /5ml Susp. | 90 Dias | 18 Dias | 30 Dias | Sem Ruptura |
| Ampicilina 500mg Inj. | 80 Dias | 18 Dias | 8 Dias | Sem Ruptura |
| Ceftriaxona Inj. 1g/4ml | 27 dias | Sem Ruptura | Sem Ruptura | Sem Ruptura |
| Cefixima 200 mg Comp. | 52 Dias | 60 dias | 60 Dias | 30 Dias |
| Penicilina Benzatinica Inj. 2.4MUI | 90 Dias | 90 dias | 8 Dias | 25 Dias |
| Azitromicina 500 mg Comp. | 26 dias | 60 Dias | 30 Dias | 10 dias |
| Alcool Liquido Volátil | 60 Dias | 90 dias Meses | Sem Ruptura | Sem Ruptura |
| Metronidazol 250mg Comp. | 37 Dias | 30 Dias | Sem Ruptura | Sem Ruptura |
| Cotrimoxazol Susp. 240mg/5ml | 60 Dias | Sem Ruptura | Sem Ruptura | Sem Ruptura |
| Eritromicina 500mg Comp. | 13 Dias | 10 Dias | 39 Dias | Sem Ruptura |
| Fenoximetilpenicilina 500mg Comp. | Sem Ruptura | 30 dias | 18 dias | Sem Ruptura |
| Kanamicina Inj. 2g/10ml | Sem Ruptura | 90 dias | 90 dias | 90 Dias |
| Nevirapina 200mg Comp. | Sem Ruptura | 90 dias | 15 dias | Sem Ruptura |
| Nevirapina Susp. 50mg/5ml | Sem Ruptura | 30 Dias | 21 dias | Sem Ruptura |
| Ciprofloxacina 500mg Comp. | Sem Ruptura | 90 dias | 23 Dias | Sem Ruptura |
| Quinina 300mg Comp. | 90 dias | 90 dias | 90 Dias | 40 Dias |
| Quinina Injectável 600mg/2ml | 70 Dias | 60 Dias | Sem Ruptura | Sem Ruptura |
| Coartem 6x3 blister | 60 dias | 60 dias | 90 Dias | 90 Dias |
| Coartem 6x4 blister | 48 dias | 90 dias | 4 Dias | 30 Dias |
| Diclofenac 50mg Comp. | Sem Ruptura | 30 dias | Sem Ruptura | Sem Ruptura |
| Ibuprofeno 200mg Comp. | 90 dias | 60 dias | 8 Dias | Sem Ruptura |
| Isoniazida 100mg Comp. | 31 Dias | Sem Ruptura | 24 Dias | Sem Ruptura |
| Isoniazida 300mg Comp. | 36 Dias | 30 dias | 22 dias | Sem Ruptura |
| Acido Naldixico 500mg Comp. | Sem Ruptura | 60 dias | Sem Ruptura | 20 Dias |
| Prometazina Injectável 50mg/2ml | 90 dias | Sem Ruptura | 20 Dias | Sem Ruptura |
| Clorafenicol Injectável 1g/10ml | 13 Dias | 30 Dias | Sem Ruptura | Sem Ruptura |
| Test Kit | Sem Ruptura | Sem Ruptura | 10 Dias | Sem Ruptura |

Health Information System

Electronic Patient Tracking System (EPTS)

CHASS Niassa is working with DPS to pilot the EPTS, eSaude, in select health facilities in Niassa. CHASS Niassa is managing the retrospective data entry required to get the system up and running and is training staff at DPS to manage the system. During this quarter, retrospective data entry was completed at Cuamba Health Center and began at Cuamba Rural Hospital. Although we had planned to complete retrospective data entry at one additional facility this quarter, that was not possible due to challenges described below.

During retrospective data entry, data quality reviews are ongoing to assess the accuracy of the information entered into the system. This is being done in two steps: 1) daily review of 3-5 randomly selected patient charts against the data entered and 2) regular review of OpenMRS data quality reports. In general, the level of agreement between the paper data and the data in the database is above 80%. Review of the data quality reports began once the IT/Data manager was in place and identified a number of inconsistencies in the data from HPL and CSL. A team of 4 was

sent back to these facilities to resolve these problems, working with clinicians to determine the correct information.

Although both the provincial hospital and the health center in Lichinga were supposed to take over implementation of EPTS this quarter, this only happened at the provincial hospital. At the health center, the staff who were assigned were not available and did not have the capacity to enter data. We are working with DPS to resolve this issue and, in the meantime, have had SWAT team members return to Lichinga to enter new patients and new visits.

This quarter we had multiple meetings with DPS about EPTS roll out. Key issues discussed included problems identified at CSL, validation of data in the EPTS, use of EPTS by HFs and reporting on the pilot. The Medico Chefe is committed to working with CHASS Niassa to resolve current issues around staffing at HFs. He has also committed DPS staff to an upcoming review process that will validate the EPTS data. Finally, we agreed that CHASS Niassa will present the results of the pilot early next quarter.

Data Review Meeting

A Data Review Meeting was held on August 26-27th, 2014 in Lichinga. At the meeting, each member of the CHASS Niassa technical team presented the July data from the sites they support. The results were discussed by the team as a whole and feedback provided on both the content and mode of presentation. The meeting provided an opportunity to identify common technical and data challenges, identify sites in need of support, and strengthen the skills of the team in presenting data. During the second day of the meeting, the September workplan was revised based on the review. Data review meetings will now be a regular occurrence and the technical team, with support from the M&E team, will also present the data at the district level. At the next meeting, staff will be provided with tips on presenting data and will be provided additional training on presentation skills.

Routine Support Activities

Regarding the technical assistance to the districts, HFs, and DPS in monitoring and evaluation, CHASS Niassa finally recruited the M&E Advisor for DPS, seconded by CHASS Niassa. He has considerable experience with M&E of clinical data and is expected to focus on improving data quality and promoting data use at DPS. In addition, routine activities were undertaken at all levels, with focus on ensuring consistency of data and validity of at the various data aggregation levels. Using data verification tools, both M&E and clinical staff from CHASS Niassa and DPS, conducted verification of the monthly summaries at the HFs, and corrected the existing problems through on-the-job support to the HF clinical staff. At the district level, the support provided by the M&E team included crosschecking the data entered to correct transcription errors, as was done at the DPS level. In most cases, the problems encountered included aggregation errors, as well as errors in counting data registered in the books. Transcription errors also existed, in most cases with huge impact on performance, and thanks to this exercise, the quality of information is considerably better for most services. Work is ongoing to document the results of these efforts.

Data Quality

To facilitate the review of data consistency in Modulo Basico data, using skills gained during a recent international training, CHASS Niassa developed a set of programs in STATA that enable automated importing and review of data from Modulo Basico (they currently cover ANC, HCT, ART and maternity). Any inconsistencies are automatically output by facility to facilitate feedback and review. CHASS Niassa presented this approach to the DPS and they agreed that they will use these in the coming months. This new approach, which was well received by DPS, addressed a number of challenges faced by the DPS. In particular, there is a short period of time between receipt of summaries from the districts and the date when the provincial data need to be sent to MoH. Unfortunately, despite continued support, a considerable number of districts fail to enter complete summaries into MB and this requires additional effort by DPS to recover the missing data. These new automated consistency checks, together with easy to use output, will facilitate identification of problems so that they can be quickly corrected with the facilities.

CHASS Niassa is supporting the development of analysis skills among DPS staff. CHASS Niassa supported the participation of one DPS staff in a STATA training in India in July 2014 and has included a STATA license for DPS in the FY15 budget. CHASS Niassa will continue to support DPS staff in the running these consistency checks but aims to transfer this capacity to DPS.

Revisions to Cohort Methodology

This quarter the technical team worked in facilities to list all patients eligible for the cohort study. This is a new approach to the cohort study, aimed at ensuring more complete data given that 13% of eligible clients had missing processes in the SAPR 14 cohort.

From September 10-12, 2014 a group of technical and M&E staff were trained in the revised cohort methodology (as described in the past report), the use of tablets for data collection, and a new approach to supervising the data collection. M&E staff were also trained in use of and support for the mobile data collection system. Data collection followed. Use of the tablets was well received by the data collection teams and resulted in improved data quality with 4% missing data on outcome compared to 23% in the SAPR. Furthermore, the field team submitted data on a daily basis and was provided with daily feedback on potential data errors, allowing for more rapid review and correction of problems.

In the next quarter, the CHASS Niassa team will work with FHI 360's Tech Lab, the group that developed the mobile application, to implement automated data visualizations of the cohort results. This will enable immediate feedback to facilities while the team is still at the facility. The teams will also collaborate on developing a mobile tool for quality assurance of the cohort data.

Linkages and Partnerships

In this quarter, CHASS Niassa continue working with PCC to reinforce the responsibility for active case finding and referrals of patients for adherence in the districts where these activities are supported by PPCC. Regular meetings are conducted, where issues regarding both referrals and active case finding are discussed. Many challenge were identified in Ngauma where PCC stopped working with the local partner. Chass Niassa is looking at the possibility of replacing the PCC partner with a CCM.

During this quarter, CHASS Niassa and PCC collaborated to develop a protocol for an assessment of Busca Activa that will be carried out in Year 5. The assessment aims to identify gaps in the Busca Activa process in use by FHI 360 projects in Niassa Province and identify changes that can be made to in order improve retention of patients in care. The protocol was approved by DPS and the FHI 360 Protection of Human Subjects Committee. It was submitted to the Comité Nacional de Bioética para a Saúde on Setpember 15th and was reviewed at the September meeting of the Committee; we are still awaiting their feedback.

CHASS Niassa's partnership with the FANTA III project continued with the implementation of the QIP for the NRP. FANTA III provides technical assistance to CHASS Niassa. In nutrition, CHASS Niassa also partners with the World Food Program. In this quarter CHASS Niassa and WFP planned for replacing the infested CSB+ in all health facilities.

Finally, this quarter CHASS Niassa continued working with MCHIP on the implementation of MCH activities at maternities to ensure the correct implementation of MoH guidelines. Joint TSVs were conducted to provide on-the-job training for the health staff on PMTCT, model-maternity and screening and treatment of cervical cancer.

Management Arrangements

CHASS Niassa project operates under the oversight of a Project Management Team which includes the Project Director/Chief of Party (COP), the Technical Director, FHI360 Strategic Information (SI) Director, the Provincial Coordinator, the Senior Program Officer, the Financial Manager, the Provincial Chief Medical Officer and the USAID Agreement Officer's Representative (AOR). The Project Management Team is responsible for the overall direction and management of the project and has responsibility and authority for the project within the remit of the project mandate. The Project Management Team approves all major plans and authorizes any major deviation from agreed plans. It is the authority that signs off the completion of each year of the project, as well as authorizes the start of the next year. It ensures that required resources are committed, and arbitrates on any conflicts within the project, negotiating solutions to any problems between the project and external bodies.

The Project Management Team is ultimately responsible for assuring that the project remains on course to deliver the desired outcome of the project as defined in the Cooperative Agreement.

The Implementing Mechanism – FHI360 performs the oversight function as well as monitoring and evaluation of the CHASS Niassa project in Niassa. Different stages of project implementation such as project amendments, annual workplan, travel requests, no cost extension request, are cleared by and submitted to USAID through the AOR.

The project COP provides oversight of the project implementation, conducts verification of the programmatic and financial reports and makes recommendations to USAID with regards to project progress and disbursement of funds.

Project Management Team

The Project Management Team has three major functions:

Project Management: This is composed of the Project Director/Chief of Party, the SI Director, the Technical Director, the Senior Program Officer, the Financial Manager, the Provincial Coordinator, the Provincial Chief Medical Officer and the USAID AOR. The COP is fully responsible for the overall coordination of the project activities. The Technical Director, and the Provincial Coordinator work in close collaboration with the national and provincial counterparts and other stakeholders to implement the project.

Finance Management: This team is made up of the FHI360 Finance Director, the project Finance Manager, one finance associate, and one administrative assistant. The finance team is responsible for budget management.

Monitoring and Evaluation: This team is composed of the SI Director, the Senior M&E Officer, Data Manager, M&E Coordinator, and five M&E assistants based at the provincial level. The team is responsible for monitoring of project activities, review and verification of data and preparation of progress reports to the donor.

Partners

CHASS Niassa works with six national and international partners and the DPS/MoH to execute the project. The partners are:

Provincial Health Directorate, MoH, Government of Mozambique: This Project aims at enhancing the DPS/MoH capacity at the provincial level to implement as well as monitor the health sector response to HIV and AIDS in Niassa. The key components of the project include provision of technical support at all levels of the health system, training and monitoring of service delivery HCT, STI diagnosis and treatment, Anti Retro Viral Treatment and monitoring, as well as procurement and supply management capacity building. The project is directly implemented by the DPS in the province of Niassa.

Abt Associates: Abt provide comprehensive technical assistance that addresses some aspects of the provincial's health system, including health financing, human resources for health, and

governance which are related to the third objective of the project which is to strengthen DPS/MoH capacity to effectively manage high-quality, integrated HIV services.

Food for the Hungry: FH provide technical assistance that addresses nutritional needs (Nutrition assessment, counseling and support) and the implementation of the MoH's Nutrition Rehabilitation Program in the province. The project is collaborating with WFP in the acquisition and distribution of the fortified supplement CSB in selected health facilities to improve the nutritional intake of the affected population. The nutrition technical officer is also collaborating with MoH in the development of mechanism to integrate nutrition data with other already existing MoH data collected through the National Health System data base (Módulo Básico) as well as improving the already existing data information system.

MULEIDE: MULEIDE assists the project in addressing gender-related issues that affect quality, access and sustainability of health services including HIV/AIDS. In addition, the organization supports the project in the integration of USAID GBV initiative at both the health facility and community levels through the creation of partners involvement in antenatal care and the creation of Men to Men groups to increase retention and male access in care.

Implementing Partners (ARV, CCM, CISLAMO): These local NGOs/CBOs are responsible for the implementation of the key interventions under the following Service Delivery Area: (1) Behavior Change Communication–Community Mobilization, (2) education and prevention, (3) Counseling and testing, and (4) psychosocial support at the community level. These NGOs/CSOs are key to the implementation of the Community Case Management initiative and facilitate linkages with the community and affected populations, promote involvement in referral networks and ART adherence support.

Major Challenges Facing CHASS Niassa

- Health sector campaigns (e.g., distributions of bed nets, Trachoma, Measles vaccination) and the election campaign interfered with the implementation of CHASS Niassa interventions this quarter.
- CHASS Niassa also faced a number of challenges with access to drugs and supplies. There was irregular provision of prophylactic antiretroviral for the babies (AZT and Niverapin), HIV kit tests and Isoniazid 300mg this quarter.
- Use of PIMA at health facilities was low with PIMAs performing two CD4+ tests per day on average instead of the 20 tests per day recommended by MoH. This is mainly due to clinicians failing to request CD4+ tests from the lab.

Upcoming Priority Activities

- Introduction of index case for HIV testing in the districts of Lichinga city, Mandimba, Lago, Mecanhelas and Cuamba.
- Reinforcement of active case finding, home visits and psychological support activities to continue the trend of improved retention of patients in HIV care and treatment services.
- Distribution of CSB+ with support of WFP and DPS for HIV+ patients who are malnourished as well as for other malnourished patients.
- Review of the Technical support strategy based on the priority districts identified. This priority districts are based on volume of activities and HIV prevalence rate.
- Identification of a minimum package of activities that the DPS can continue to implement after the end of the project.
- Finalize and assess the pilot phase of EPTS implementation at select sites.
- Assess district performance and distribution of incentives under performance-based financing.

ANNEXES

ANNEX 1 – Progress Toward the Targets in CHASS Niassa from July to September 2014

| Indicator | Annual Target | Q1 Results | % Achieved - end Q1 | Q2 Results | % Achieved - end Q2 | Q3 Results | % Achieved - end Q3 | Q4 Results | % Achieved - end Q4 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------|---------------------|------------|---------------------|------------|---------------------|------------|---------------------|
| PMTCT ANC | | | | | | | | | |
| Number of health facilities providing MCH services that provide HIV testing and ARVs for PMTCT on site, ANC/ L&D settings | 65 | 65 | 100% | 65 | 100% | 65 | 100% | 65 | 100% |
| Number of unique pregnant women registered in ANC | 41,043 | 13,742 | 35% | 14,238 | 69% | 15,403 | 106% | 17,233 | 148% |
| Number of pregnant women with known HIV status (before CPN+ who received HIV counseling and testing for PMTCT and received their test results in CPN). | 39,131 | 13,040 | 28% | 12,861 | 67% | 13,390 | 100% | 15,179 | 139% |
| Number of pregnant women with known HIV positive status (before CPN+ who received HIV counseling and testing for PMTCT and received their test results in CPN). | 824 | 915 | 105% | 458 | 165% | 674 | 248% | 717 | 335% |
| Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission, total, by regimen, by setting (ANC) | 765 | 697 | 105% | 342 | 136% | 559 | 209% | 661 | 295% |
| Number of HIV-positive pregnant women in ANC who have initiated CTZ | - | 450 | - | 337 | - | 412 | - | 442 | - |
| Number of partners of women who are HIV tested in ANC setting | 15,392 | 4,011 | 26% | 4,517 | 55% | 5,522 | 91% | 6,501 | 134% |
| PMTCT L&D | | | | | | | | | |
| Total number of unique pregnant women registered in L&D | | 8,883 | | 12,080 | | 9,699 | | 11,007 | |
| # women receiving an HIV tests & results in a PMTCT L&D setting | 8,323 | 4,387 | 62% | 4,335 | 114% | 2,591 | 136% | 3,450 | 177% |
| Number of pregnant women with known HIV positive status LD (includes women who were tested for HIV and received their results) | | 439 | | 536 | | 370 | | 470 | |
| Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT/ L&D setting. | 734 | 376 | 51% | 404 | 106% | 300 | 147% | 443 | 207% |
| Number of HIV-exposed infants who received ARVs to reduce risk of MTCT in L&D setting, (total/ by regimen) | 1,223 | 366 | 30% | 387 | 62% | 347 | 90% | 395 | 122% |
| Number of infants born to HIV-positive women who received an HIV test within 12 months of birth | 900 | 410 | 45% | 1,156 | 128% | 560 | 236% | 638 | 307% |
| PCR < 9 months | | | | 744 | | 367 | | 359 | |
| Rapid test 9 - 11 months | | | | 412 | | 193 | | 279 | |
| Children (<18months) born to HIV+ pregnant women who are | - | 326 | | 572 | | 223 | | 279 | |

| Indicator | Annual Target | Q1 Results | % Achieved - end Q1 | Q2 Results | % Achieved - end Q2 | Q3 Results | % Achieved - end Q3 | Q4 Results | % Achieved - end Q4 |
|-------------------------------------------------------------------------------------------------------------------------------------|---------------|------------|---------------------|------------|---------------------|------------|---------------------|------------|---------------------|
| started on CTZ prophylaxis within two months of birth | | | | | | | | | |
| FAMILY PLANNING | | | | | | | | | |
| Number of unique women registered in Family Planning | - | | | 17,470 | | 18,094 | - | 11,775 | - |
| Number of women with known HIV positive status in FP | - | 542 | - | 626 | - | 324 | - | 358 | - |
| Number of HIV positive women provided with at least one FP method-IUD | - | 32 | - | 4 | - | 1 | - | 2 | - |
| Number of HIV positive women provided with at least one FP method-Injectable | - | 217 | - | 381 | - | 206 | - | 159 | - |
| Number of HIV positive women provided with at least one FP method-Pills | - | 293 | - | 178 | - | 81 | - | 98 | - |
| Number of HIV positive women provided with at least one FP method-Other Methods | - | - | - | 30 | - | 15 | - | 14 | - |
| COUNSELING & TESTING | | | | | | | | | |
| Number of service outlets providing counseling and testing according to national and international standards (CT Setting: Clinical) | 65 | 65 | 100% | 65 | 100% | 65 | 100% | 65 | 100% |
| Number of individuals who received counseling and testing for HIV and received their test results(CT setting: Clinical) | 103,736 | 9,195 | 9% | 13,721 | 22% | 10,132 | 32% | 7,870 | 39% |
| Number of individuals who received counseling and testing for HIV and whose results were HIV+ (CT Setting: Clinical) | - | 1,090 | - | 1,058 | - | 848 | - | 1,029 | - |
| Number of service outlets providing counseling and testing according to national and international standards (CT Setting: UATS) | - | 11 | - | 11 | - | 11 | - | 11 | - |
| Number of individuals who received counseling and testing for HIV and received their test results(CT setting: UATS) | 8,791 | 1,555 | 18% | 1,716 | 37% | 2,348 | 64% | 2,992 | 98% |
| Number of individuals who received counseling and testing for HIV and whose results were HIV+ (CT Setting: UATS) | - | 367 | - | 371 | - | 484 | - | 397 | - |
| Number of individuals who received counseling and testing for HIV and received their test results(CT setting: ATSC) | 2,747 | 2,729 | 99% | 7,958 | 389% | 15,272 | 945% | 7,631 | 1223% |
| Number of individuals who received counseling and testing for HIV and whose results were HIV+ (CT Setting: ATSC) | - | 30 | - | 651 | - | 480 | - | 321 | - |
| HIV care and treatment | | | | | | | | | |
| Number of health facilities that offer ARV treatment clinical services | 42 | 46 | 110% | 46 | 110% | 46 | 110% | 46 | 110% |

| Indicator | Annual Target | Q1 Results | % Achieved - end Q1 | Q2 Results | % Achieved - end Q2 | Q3 Results | % Achieved - end Q3 | Q4 Results | % Achieved - end Q4 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------|---------------------|------------|---------------------|------------|---------------------|------------|---------------------|
| Number of HIV-positive adults and children receiving a minimum of one clinical service | 18,280 | | 131% | 19,839 | 123% | 17,766 | 97% | 25,346 | 344% |
| Number of adults and children with advanced HIV infection newly enrolled on ART | 2,919 | 1,292 | 44% | 1,419 | 93% | 1,412 | 141% | 1,138 | 180% |
| Number of adults and children with advanced HIV infection currently receiving ART, by sex, pregnant women | 11,012 | | 138% | 11,200 | 102% | 12,268 | 111% | 13,334 | 334% |
| Number of adults and children with advanced HIV infection who ever started ART, by sex, pregnant women | - | 12,917 | - | 14,336 | - | 16,103 | - | 20,500 | - |
| TB/HIV SERVICES | | | | | | | | | |
| Number of service outlets providing prophylaxis and or treatment for TB to HIV infected individuals (diagnosed or presumed.) | 16 | 16 | 100% | 16 | 100% | 16 | 100% | 16 | 1600% |
| Number of TB patients registered during the reporting period | 1,490 | 454 | 30% | 504 | 64% | 545 | 101% | 445 | 131% |
| Number of HIV infected individuals attending HIV/AIDS care/treatment services also treated for TB disease | 2,194 | 178 | 10% | 190 | 17% | 196 | 26% | 147 | 32% |
| Number of TB patients who had an HIV test result recorded in the TB register | 1,431 | 464 | 45% | 959 | 66% | 307 | 121% | 243 | 138% |
| # HIV Positive TB (co-infected) patients with test result recorded in TB register | - | 178 | - | 190 | - | 56 | - | 101 | - |
| Number of HIV-infected TB patients in the TB sector who have initiated cotrimoxazole (CTZ) prophylaxis | 833 | 159 | 28% | 152 | 44% | 195 | 61% | 145 | 78% |
| Number of HIV-positive TB patients who have started ART | 760 | 159 | 30% | 152 | 41% | 170 | 63% | 124 | 80% |
| GBV | | | | | | | | | |
| Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion (GBV) | 50,000 | | 9% | 2,465 | | 549 | 6% | 473 | 7% |
| Number of health facilities with Gender-Based Violence and Coercion (GBV) services available | 16 | 20 | 125% | 20 | 125% | 20 | 125% | 20 | 125% |
| Number of people receiving post-GBV screening | | - | - | 1,745 | | 563 | | 347 | |
| NUTRITION | | | | | | | | | |
| Number of HIV+ patients who are clinically malnourished (non-pregnant) | 2,742 | 20 | 1% | 32 | 2% | 102 | 6% | 60 | 8% |
| Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food | 1,371 | 20 | 1% | 32 | 4% | 102 | 11% | 71 | 16% |

| Indicator | Annual Target | Q1 Results | % Achieved - end Q1 | Q2 Results | % Achieved - end Q2 | Q3 Results | % Achieved - end Q3 | Q4 Results | % Achieved - end Q4 |
|------------------------------------------------------------------------|---------------|------------|---------------------|------------|---------------------|------------|---------------------|------------|---------------------|
| Number of eligible clients who received food and/or nutrition services | | 5,242 | | 8,186 | | 11,012 | | 955 | |
| HIV+ patients screened/assessed for malnutrition | | | | 8,186 | | 11,012 | | 8,596 | |

ANNEX 2 – DPS Sub Agreement Financial Execution

| Subaward title: | Strengthen the Capacity of health sector in Niassa | | | |
|------------------------------------------------------------|----------------------------------------------------|-------------------------|------------------|-------------|
| | Current Fiscal/Project Year | Accrued Expenses | Balance | % |
| | 01/10/2013-30/09/2014 | 01/10/2013 - 30/09/2014 | | |
| I. TOTAL COSTS INCURRED BY SUBAWARDEE | | | | |
| TOTAL COSTS INCURRED BY THE SUBAWARDEE | 3.675.600 | 2,910,600 | 765,000 | 79% |
| | | | | |
| Subtotal Equipment | 1,044,795 | 1,044,796 | 0 | 100% |
| Subtotal Office Expenses | 489,426 | 397,807 | 91,619 | 81% |
| SubTotal In-Service Training for Health Workers | 1,167,884 | 1,149,826 | 18,058 | 98% |
| SubTotal Institutional Support | 5,490,245 | 4,783,993 | 706,252 | 87% |
| SubTotal Infrastructure/Rehab | 4,337,359 | 884,972 | 3,452,387 | 20% |
| SubTotal Public Health and meetings support | 171,873 | 161,249 | 10,624 | 94% |
| Sub total M&E: printing of forms | 1,200,000 | 1,565,209 | -365,209 | 130% |
| SubTotal Supervision Visits | 2,084,246 | 2,080,036 | 4,210 | 100% |
| SubTotal Master degree scholarship | 1,200,000 | 1,013,100 | 186,900 | 84% |
| Sub Total DPS | 20,861,428 | 15,991,588 | 765,000 | 84% |
| SubTotal Direct activities support in the districts | 11,250,777 | 8,307,965 | 2,942,812 | 74% |
| | | | | |
| Supervision/Technical Assistance (Y4) | 783,505 | 1,561,833 | -778,328 | 199% |
| Printing MCH registers (Y4) | 708,218 | 708,218 | - | 100% |
| SubTotal Y4 | 1,491,723 | 2,270,051 | -778,328 | 152% |
| Total Project Costs | 33,603,928 | 26,569,604 | 7,034,324 | 79% |

