CHASS Niassa
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FY2015 5th Year of the Project

2nd Quarter Report: January to March 2015

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TABLE OF CONTENTS

TABLE OF CONTENTS 2
LIST OF FIGURES 3
LIST OF TABLES 4
ACRONYM LIST 5
LIFE OF PROJECT SUMMARY 7
I . EXECUTIVE SUMMARY 8
Summary of Progress this Quarter 8
Key Indicators 8
II. PROJECT OVERVIEW 10
III. PROGRESS REPORT 11
Objective 1 12
HIV Counseling and Testing (HCT) Service Expansion 12
Prevention of Mother to Child Transmission Support Activities 14
Family Planning 18
Early Infant Diagnosis Technical Support 19
Pre-ART Care and Treatment Technical Support 20
Adult Care and Treatment Technical Support 21
Pediatric Care and Treatment Technical Support 22
TB/HIV Co-infection Support Services 23
Adherence to Treatment and Retention in Care Technical Support 24
Laboratory 28
Injection Safety/Infection Prevention & Control/Biosafety Technical Support 30
Post Expose Prophylaxis (PEP) 31
Nutrition, Access to Food and Utilization Technical Support 31
Gender Based Violence (GBV) 34
Objective 2 37
Strengthening the District Referral and Counter-referral Networks 37
Community Adherence Support Group (GAAC) 38
Objective 3 40
Strengthening of Service Delivery 40
Strengthening of Financial Management 42
Logistics & Supply Chain Management 42
Health Information System 45
Management Arrangements 48
Project Management Team 48
Partners 49
Major Challenges Facing CHASS Niassa 50
Upcoming Priority Activities 50
ANNEXES 52
ANNEX 1 – Progress toward the Targets in CHASS Niassa from January to March 2015 52
ANNEX 3 – Details of Trainings Held by CHASS Niassa 55
ANNEX 2 – DPS Sub Agreement Financial Execution 56
ANNEX 3 – CHASS Niassa Financial Expenditures Up to March 2015 57

LIST OF FIGURES

Figure 1. Number of people receiving HIV counseling and testing in Niassa province, by type of testing, Q1Y4 to Q2Y5 13
Figure 2. Total number of tests and percent positive by type of testing, Niassa province, Jan–Mar 2015..... 13
Figure 3. Community HCT cascade in Niassa province, Jan to Mar 2015 14
Figure 4. Changes in ART and CTZ coverage among ANC and maternity clients in CHASS Niassa sites, Y4Q1 to Y5Q2..... 16
Figure 5. Option B+ coverage in CHASS Niassa Sites, From Y3Q3 to Y5Q2 16
Figure 6. % of ANC clients whose partners were tested for HIV, Y4 and Y5, by quarter 17
Figure 7. % of HIV positive pregnant women in maternities and exposed infants receiving ARV prophylaxis, CHASS Niassa sites, Y3 to Y5, by quarter 17
Figure 8. Method mix among HIV+ women using FP, at CHASS sites, from Y4Q1 to Y5Q2 19
Figure 9. Rate of HIV positive PCR in children 0–18 months, CHASS Niassa sites, Q3Y3-Q3Y5..... 20
Figure 10. Pre-ART cascade, CHASS Niassa sites, Jan to Mar 2015 20
Figure 11. Pre-ART and ART uptake among newly diagnosed patients, CHASS Niassa sites, Y4Q1 to Y5Q2..... 21
Figure 12. Number of newly enrolled patients on ART in CHASS sites, by quarter, Y3Q3 to Y5Q2.... 21
Figure 13. Percent achievement of annual target in number of newly initiating ART in CHASS Niassa sites, from Y3Q3 to Y5Q222
Figure 14. Number newly initiating ART and percent of those who are children in CHASS Niassa sites, FY4 and FY5, by quarter22
Figure 15. TB/HIV cascade in CHASS Niassa sites, from Jan to Mar 2015 23
Figure 16. TB registration, prophylaxis and ART coverage in CHASS Niassa sites, FY4 and FY5, by quarter 24
Figure 17. 12-month adult retention in ART in priority sites, SAPR15 25
Figure 18. Outcome of patients who defaulted in CHASS Niassa sites, by type of care from, Jan to Mar 2015.....26
Figure 19. Outcome of patients who abandoned in CHASS Niassa sites, by type of care from Jan to Mar 2014.....26
Figure 20. Percentage of defaulted 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 Q2Y5 27
Figure 21. Number of patients listed as defaulted for Busca Activa, by type and quarter, Y4Q3 to Y5Q2.....28
Figure 22. Number of patients clinically malnourished HIV+, by pregnancy status, Q2Y5 32
Figure 23. Classification of nutritional status of children using Weight / Height (P/E) and / PB=MUAC – variance in Muembe HF, from February 2014 to February 2015 34
Figure 24. Number of people sensitized to GBV at HFs and in communities in Niassa Province, by type of sensitization, Jan to Mar 2015 35
Figure 25. GBV screening at CHASS Niassa sites, by type of violence, Y4 and Y5, by quarter 36
Figure 26. Referral and counter-referral results in Niassa, by sex and total, Jan to Mar 2014..... 38
Figure 27. Percent of referred patients who reached a HF in CHASS Niassa sites, Q1FY4 to Q2FY5, by quarter 38
Figure 28. Number of new and active GAACs, Q1FY4 to Q2FY5 39
Figure 29. Percent of times the Drug Formula was completed correctly by select DDM and HF, Q2FY5.....43

LIST OF TABLES

Table 1. Number of CD4 counts using PIMA, by facility, Jan to Mar 2015 and Q3Y4 to Q2Y5 29
Table 2. Gene Xpert results in CHASS Niassa sites, FY5 by quarter 30
Table 3. Overall infection control assessment score by HF, by quarter, Q3Y4 to Q2Y5..... 30
Table 4. Occupational exposures to HIV and PEP, by type and sex, Jan to Mar 2015 31
Table 5. Nutrition status and receipt of supplemental or therapeutic food, by group, Niassa, Jan-Mar 2015.....32
Table 6. Number of clients who received post-GBV services in CHASS Niassa sites, Jan to Mar 2015, by type of care.....36
Table 7. Number of days of drugs in stock-out in Niassa province, by quarter, Years 4 and 5 ... 45

ACRONYM LIST

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AOR	Agreement Officer's Representative
APR	Annual Performance Review
ART	Antiretroviral Therapy
ARV	Antiretroviral
CCM	Community case manager
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 HIV Counseling and Testing
COP	Chief of Party
CSB+	Corn Soy Blend Plus
CTZ	Cotrimoxazole
DDM	Depósitos Distritais de Medicamentos (District drug depots)
DPS	Direcção Provincial da Saúde (Provincial Health Directorate)
EPTS	Electronic Patient Tracking System
FANTAIII	Food and Nutrition Technical Assistance project
FILAs	Folha Individual de levantamento de ARVs
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
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
QIP	Quality improvement project
SAAJ	Serviço Amigável do Adolescente e Jovem (Youth and Adolescent Friendly Service)

SAPR	Semi-annual Performance Review
SDSMAS	District Health, Women and Social Action Services
SI	Strategic Information
TA	Technical assistance
TB	Tuberculosis
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

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): $ 31,687,070

Actual Expenditures Through this Quarter: $ 29,246,989

Current Pipeline Amount: $ 1,582,231

Projected expenditure January to March 2015: $ 1,420,041

Geographic Focus: Niassa Province, Mozambique

I . EXECUTIVE SUMMARY

Summary of Progress this Quarter

This quarterly report presents an elaborated report of the multi-sectoral 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:

- Handover of EPTS to the Provincial Hospital of Lichinga
- Revision of polymerase chain reaction (PCR) result for exposed babies who did not yet have a defined HIV status
- Joint meetings were held with United States Agency for International Development USAID Community Care Program (PCC) regarding means to increase adherence and retention in ART as well as to improve the referral and counter referral between community and health facilities.
- HIV testing for health staff was implemented as a part of the biosafety strategy within the work environment.
- The cohort study was conducted to determine the retention rate for Pre-ART and ART patients and to track service quality indicators

Key Indicators

The following list presents key indicators at the aggregate level; more detailed and disaggregated information is provided in the body of the report.

HCT

- The majority of people who are counseled and tested did so through PICT: 56% this quarter compared to 51% last quarter
- Overall 2,347 clients tested positive for HIV and were referred for care and/or treatment; 1,498 (64%) were enrolled into care and 1,097 (73%) were enrolled into ART
- The percentage of HIV+ clients referred from community-HCT who received care and treatment services increased to 96%
- 88 family members were tested using the case index approach; 10% (9) of them were HIV+

PMTCT

- 128% of HIV+ pregnant women in antenatal clinics and 96% of women in labor and delivery received ARV prophylaxis. The overachievement in ANC is discussed in the body of the report.
- 80% of women who started PMTCT enrolled on Option B+

- 92% of the HIV+ women (n=478) were provided with cotrimoxazole prophylaxis in ANC; almost similar to the 94% observed last quarter
- 87% of HIV-exposed children (n=407) were provided with ARV prophylaxis in maternity wards
- Partner HIV testing and counseling as part of PMTCT remained roughly the same with the partners of 47% of pregnant women in ANC services counseled and tested for HIV

ART

- 1,097 patients, including 81 children, were newly initiated on ART; leading to 50% cumulative achievement relative to the annual target
- 38% of newly enrolled patients were women receiving Option B+, an increase from 33% last quarter

TB/HIV

- 391 new TB patients were registered
- 96% (445) of registered TB patients knew their HIV status
- 42% of registered TB patients were HIV positive; all of them received CTZ prophylaxis

Laboratory

- 5,827 CD4 counts were performed this quarter, only a 2% decrease compared to the previous quarter despite substantial disruptions due to electricity shortages and disruption of transport due to the floods

GBV

- 30 patients were identified as victims of sexual violence
- 100% of the victims of sexual violence were tested for HIV

II. PROJECT OVERVIEW

The 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 Health Directorate (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, and,
- Strengthening systems and building capacity.

Through extensive technical assistance (TA) 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:

- Implementation of the Quality Improvement Projects (QIPs) for laboratory, PMTCT, and community
- Implementation of the pilot of integration of family planning (FP) into ART services
- Initiation of the expansion of SIMAM in Pharmacy to the districts
- Completion of the verification of EPTS at the Provincial Hospital in Lichinga and handover to the HF management
- Training of the IPs in data review procedures and use of the DHIS2 database for data entry

EFFECTS OF THE FLOODS

To assess the effect of the floods on the work of CHASS Niassa, an online survey was sent to all members of the technical team in early March. Twenty-three people responded which is the majority of the team. Eight of them reported no activities delayed or suspended due to the floods. However, 17 staff reported that their work was disrupted because of the problems with electricity. On average, technical staff reported almost 2 activities cancelled (average 1.78; range: 0-6). As expected the effects were seen mainly in the south with 23 activities disrupted there vs 9 in the north. The sites most heavily affected in terms of number of activities cancelled were: Namacula, Chamba, Entre-Lago, and Mecanhelas.

When asked about other ways in which the floods and the resulting electrical shortages affected work, responses included:

- Interruption of transport routes for CD4 and other items
- Disruption of laboratory analysis for new and returning patients (CD4, biochemistry and blood count)
- Disruption of *Buscas consentidas* at CS de Lurio, Etatara, Meripo e Meticue
- Postponement of collection of additional data
- Weak distribution of drugs due to a standstill in use of SIMAM
- Disruption of printing of PCR results at HF

In addition, three staff participated in meetings related to floods.

III. PROGRESS REPORT

The majority of activities scheduled for this reporting period were completed or underway by the end of the quarter. A focus in this quarter was consolidation of the implementation of the new TA strategy focused on priority sites. During the quarter the process of distribution and reporting of Corn Soy Blend Plus (CSB+) was strengthened. Furthermore, the program continued to strengthen management of sub awards with DPS and local partners. 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.

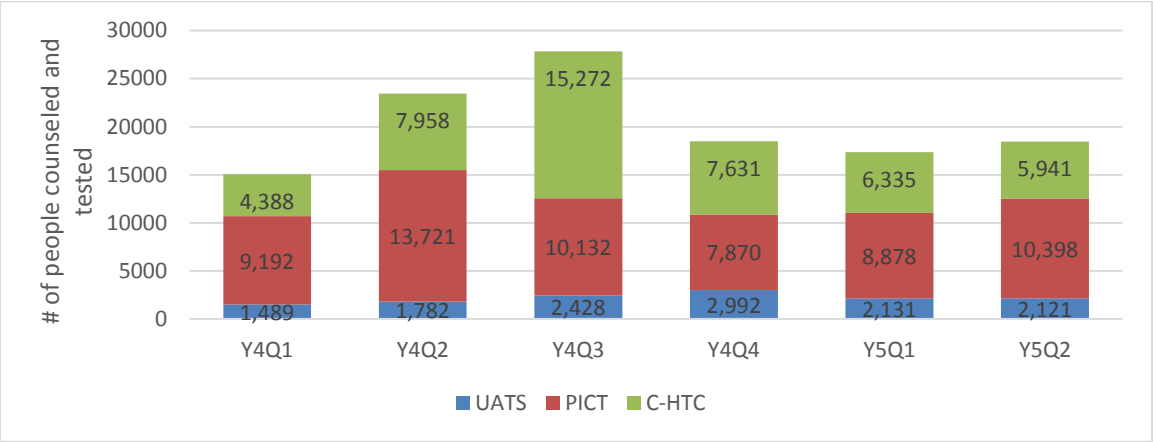
HIV Counseling and Testing (HCT) Service Expansion

HIV counseling and testing is implemented in a total of 65 health facilities (HF), in several health services, grouped in three testing settings: Provider-initiated counseling and testing (PICT), health counseling and testing units (UATS) and community HIV 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 HFs and C-HCT in 5 of the 16 districts: Cuamba, Mecanhelas, Lichinga City, Lago and Mandimba.

During this quarter a total of 18,460 people were tested in different points of services (UATS, PICT, and C-HCT). Of those 2,121 (12%) people were tested in UATS at the 11 facilities providing these services, 239 of them (4%) were children under 15 years. Another 5,941 (32%) were counseled and tested in C-HCT, 1,056 (18%) of which were children and 10,398 (56%) were tested through PICT in various service points, 2,022 (19%) of whom were children. Overall, 9,719 (54%) of those tested were women, and this percentage was similar in all HCT services.

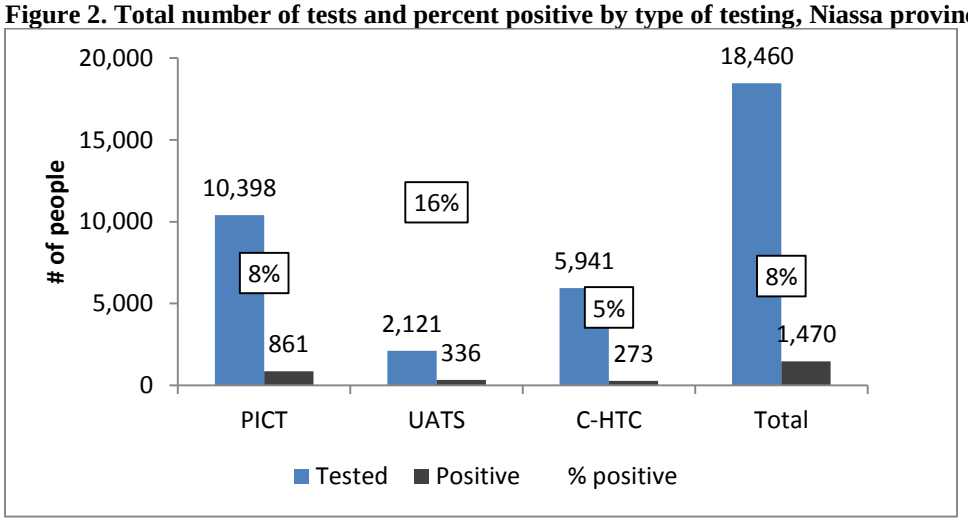
The number of individuals tested in UATS was similar to last quarter (Figure 1). In PICT, the number of people tested continued to increase and was 17% higher than last quarter (8,878 to 10,398). The increase over last quarter was the result of efforts to ensure that the record books were available at all entry points (to ensure more complete data), provision of on-the-job training on how to test e on how to register tests correctly. The number of people tested through C-HCT declined slightly (by 6%).

Figure 1. Number of people receiving HIV counseling and testing in Niassa province, by type of testing, Q1Y4 to Q2Y5



In general, the percentage of patients tested positive was 8%, about the same percentage as in the last two quarters, but it varied by type of testing: it was 5% in C-HCT, 8% in PITC, and 16% in UATS (Figure 2). As in the past quarters the majority of HIV positive patients were tested through PICT because of the large number of patients tested there. In all settings, the percentage testing positive was slightly higher among females as expected but the difference was small (1-2%).

Figure 2. Total number of tests and percent positive by type of testing, Niassa province, Jan–Mar 2015

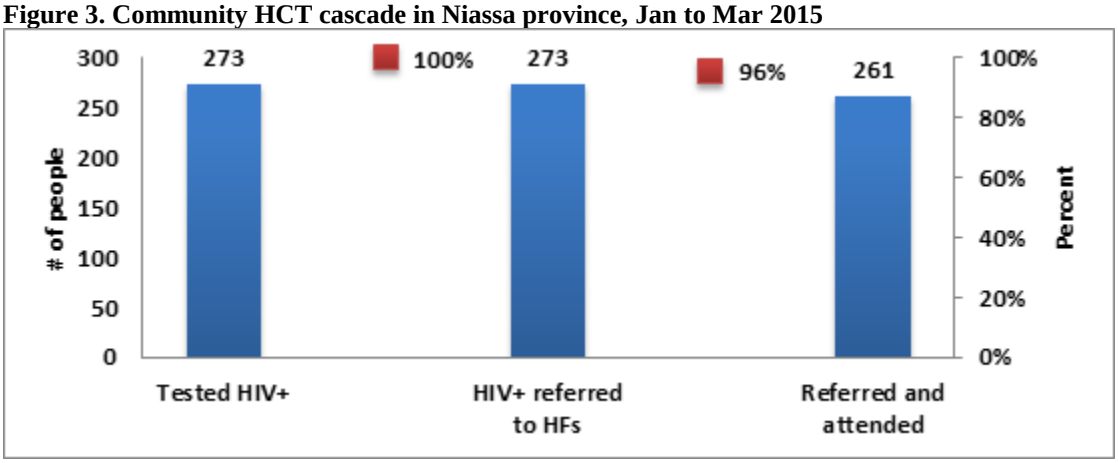


At the end of this quarter, CHASS Niassa was below 50% of the annual target for both PICT (28%) and UATS (11%). However, CHASS Niassa has already achieved the target for C-HCT (173%). The over-performance in C-HCT was in part due to an anticipated stock out of UniGold tests in quarter 1; as the expiration date on these tests approached, DPS pushed the remaining tests to partners doing C-HCT in order to ensure that the tests did not go to waste. However, CHASS Niassa will further focus its C-HCT on people identified through the case-index approach and consider expanding this approach to additional sites. This quarter CHASS Niassa, in coordination with the DPS and SDMAS, conducted technical service visits (TSV) to 11 HF to prioritize

capturing information on tests in different services and training staff in preparing the monthly report while also training new focal points.

For community testing, ensuring that patients who test positive successfully reach care and treatment services is critical to ensuring access to care. This quarter, all patients who tested positive in C-HCT were referred to a health facility, with 96% of them (261; 96 males, 165 females) successfully reaching a health facility to receive HIV care or treatment (Figure 3). Compared to last quarter, the percentage of HIV+ referred patients who reached a HF increased from 92% to 96%.

Figure 3. Community HCT cascade in Niassa province, Jan to Mar 2015



The index case strategy is being implemented in three HFs (Lago, Lichinga and Mecanhelas) but, due to lack of availability of testing kits at Lichinga Health Center and Lago, only 54 patients were tested via home visits (4 males; 50 females, 2 of whom were children under 14 years). For Mecanhelas district, 20 families were tested using the case index approach with 88 family members tested. Among those tested, 10% (9 people, 4 males; 3 female all over 15 years old and 2 male children between 0-14 years old) were HIV positive and were referred to care.

Prevention of Mother to Child Transmission 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 maternal and child health (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;

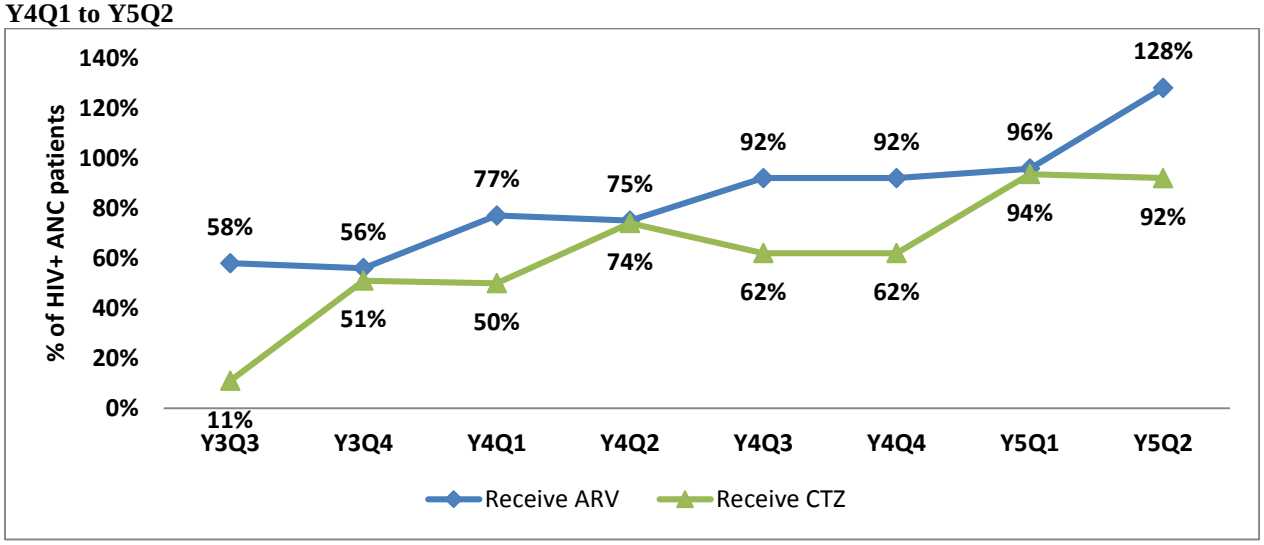
- Scale up Option B+ to peripheral HFs.

In the second quarter of year five a total of 14,601 women were newly registered in ANC, 13,862 (96%) of whom knew their HIV status, and 13,625 (93%) of them were tested for the first time in ANC services. The total number of pregnant women whose HIV status was known represents 65% achievement against the annual project target. The percentage of women with known HIV status was below the target of 100% of women in ANC. Achieving 100% is unlikely in a setting where stock outs of tests occur for short periods in some facilities.

CHASS Niassa, in coordination with DPS, is training the District Medical Chiefs in supervision techniques, including use of the TSV tool, and daily record reviews in order to facilitate monitoring and improving the quality of MCH service provision. CHASS Niassa is working to familiarize them in the use of the TA tools and standards, and the review of monthly data. They are doing the same for new providers. Part of their supervision is aimed at ensuring that providers are monitoring stock so that stock outs can be avoided, especially for testing in MCH services.

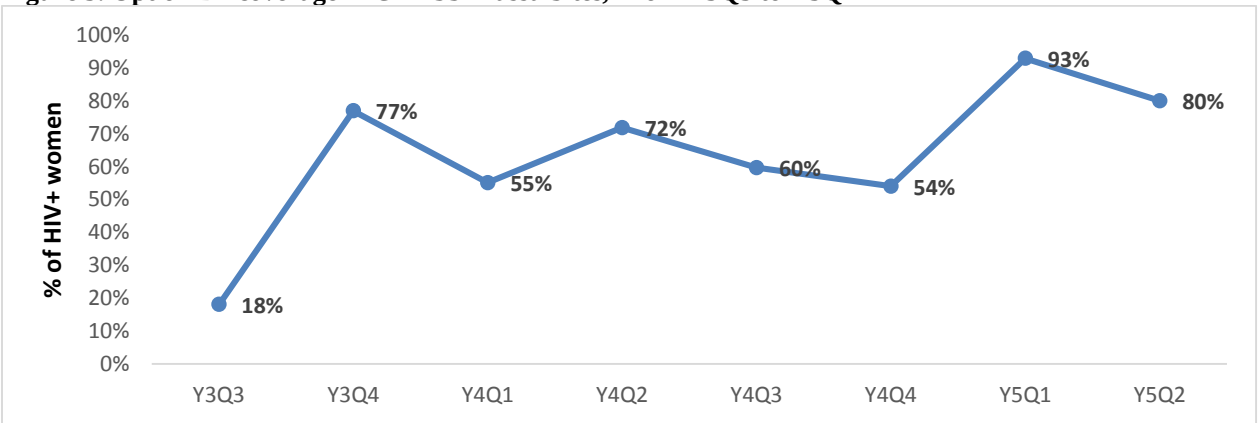
The percentage of ANC clients who were HIV-positive was 4% (518) which is consistent with trends over time. Reported coverage of ARVs among HIV+ pregnant women was 128% (665). This high level is likely in part due to two related causes: 1) an initiative to ensure that women were enrolled on Option B+ and 2) reporting errors. Because providers were encouraged to switch women to Option B+ from Option A, some women may have been double-counted, under both ARV regimens (a problem we have noted in the past and something we regularly address during TA visits). We think the data quality issue is only a small contributor to this problem but will assess the extent of this problem during future TA visits. In addition, some women may have enrolled later (at the time of a followup visit) since this initiative to enroll women also focused on women who had not enrolled previously. At this point, Niassa has achieved 88% of the annual target for Option B+ enrollees. Coverage with Cotrimoxazole (CTZ) prophylaxis was also high at 92% (478) (Figure 4). Analysis of trends over time shows that the coverage of ARV prophylaxis has maintained the strong performance seen last quarter, even improving slightly. Prophylaxis with CTZ also maintained the high level seen last quarter. The continued support from DPS and District Health, Women and Social Action Services (SDSMAS), and CHASS Niassa has allowed for this.

Figure 4. Changes in ART and CTZ coverage among ANC and maternity clients in CHASS Niassa sites, Y4Q1 to Y5Q2



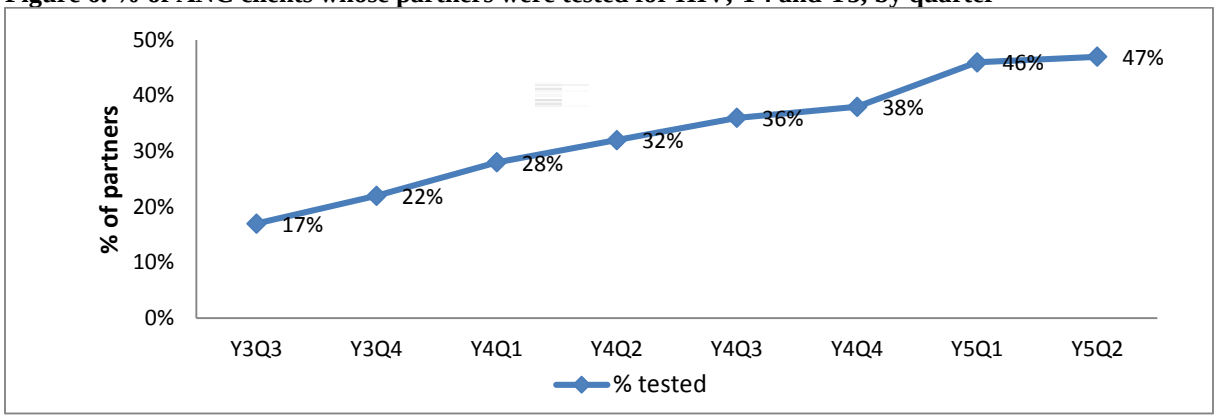
Among the women who tested positive for HIV, 413 (80%) started Option B+, a decrease in the percentage compared to last quarter but still a higher level than in the past (Figure 5). The percent on Option B+ decreased due to an increase in the proportion of women who had already initiated anti-retroviral therapy (ART) (from 23% to 30%). The proportion of women who were enrolled on Option A remained constant at 8%. Thus, this change reflects a difference in the population of women (with more ANC clients who are already on ART) rather than a decrease in performance with regard to Option B+. The high level of Option B+ coverage is the result of training providers to prioritize B+ during consultations with pregnant and post-partum women and use of support groups to spread messages about the advantages of Option B+.

Figure 5. Option B+ coverage in CHASS Niassa Sites, From Y3Q3 to Y5Q2



Male involvement was another area of improvement during this quarter, 6,870 women brought their partners to ANC services and they were tested for HIV, corresponding to 47% of all women tested (6,870 /14,601), about the same level as last quarter (Figure 6). Among the partners tested, 149 (2%) tested positive.

Figure 6. % of ANC clients whose partners were tested for HIV, Y4 and Y5, by quarter



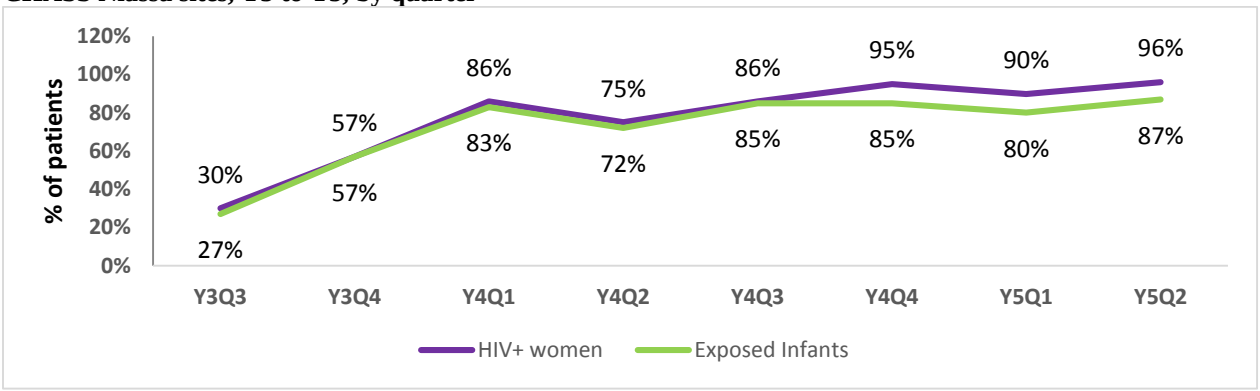
This quarter 11,340 pregnant women were registered in maternity wards, 2,818 of them had unknown status, and 2,540 (90% of those with unknown status) received HIV testing and their results. The small increase from 87% last quarter to 90% may be associated with the prioritization of test kits in the maternity sector and increased awareness of the need to test all women meeting the criteria for testing in the maternity ward.

In total, 467 women who delivered in maternities were HIV positive and 449 (96%) of them were provided with ARVs (Figure 7). This was a small increase relative to the 90% coverage last quarter and coverage has now surpassed the 95% target. This increase was in part due to the focus on ensuring that MCH nurses register all women who have received ARVs in the maternity.

Regarding exposed infants, a total of 407 (87%) were provided with ARV prophylaxis, a return to the levels seen in most of the last year (Figure 7). This resulted from increased focus on correct registration of patients during the TSV; this included review of the monthly summaries and feedback to providers on their performance in this regard.

In order to maintain the improvements seen in ARV prophylaxis for both pregnant women and exposed infants, stock outs of pediatric suspensions and of ARVs for adults must be overcome.

Figure 7. % of HIV positive pregnant women in maternities and exposed infants receiving ARV prophylaxis, CHASS Niassa sites, Y3 to Y5, by quarter



Despite improvements in PMTCT indicators, CHASS Niassa in coordination with DPS and SDSMAS are reviewing the record books to ensure the quality of reported data. This is a response to problems with data consistency and accuracy noted the MoH/USAID site visit in July 2014. One approach being implemented to address issues with accurate registration of pediatric ARV distribution is regular review of maternity ward registers during shift changes. CHASS Niassa, DPS, and SDSMAS are encouraging this review in order to hold the providers responsible before they leave the ward at the end of their shifts.

In order to achieve the PMTCT objectives, in the next quarter CHASS Niassa will continue to focus on the same interventions:

- Ensure that providers understand the MoH guidelines for the provision of Option A for women who refuse Option B+ in order to decrease the number of women who do not take prophylaxis to prevent vertical transmission
- Train medical staff to offer integrated FP services during ART consultations (counseling and select methods—pills, injectables and condoms—and referrals for other methods)
- Ensure follow up in ART services of women discharged from MCH consultation
- Monitoring the reception of PCR results through the electronic database of the National Health Institute and support for transport of samples

Family Planning

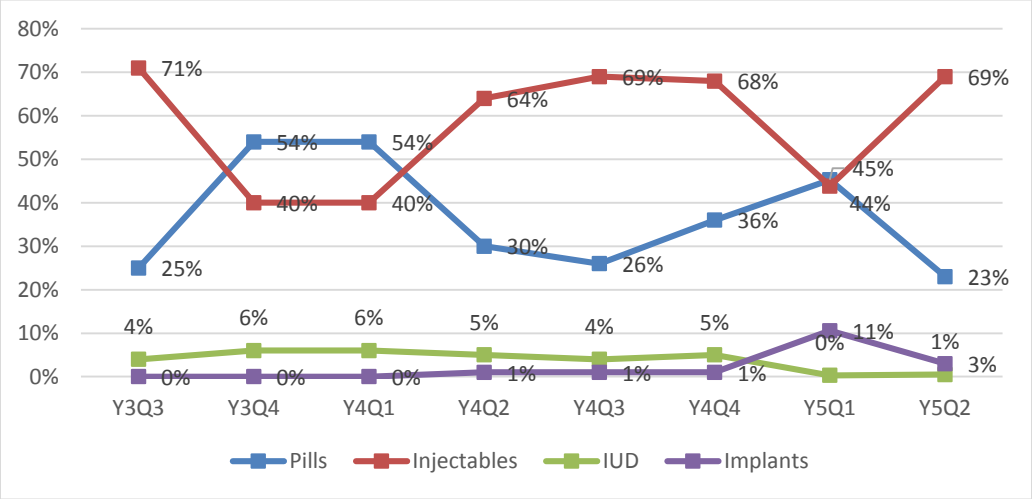
A total of 12,026 women had their first FP consultations this quarter. Their HIV status was unknown for 9,636 (80%) women, 7,760 (81%) of whom were tested for HIV, with 97 (1%) testing positive. Of these 97 HIV positive women, 13 were eligible for ART and started it in FP services, the remainder were referred to ART services where they initiated ART. The percentage women who received FP services is 56% less this quarter than last (27,113 to 12,026) and closer to the levels seen in earlier quarters. This decrease was possibly due to the rainy season when the majority of women are working in their farms but the number seen last quarter was exceedingly high.

The integration of FP in ART services is being implemented in 12 HFs. This quarter the Provincial Medical Chief sent a letter to all District Medical Chiefs informing them about this integration. Moreover, CHASS Niassa worked with DPS to assess the integration. Monitoring data were reviewed and discussed. The team decided that at this time too few providers[1] are trained in integration of FP to expand activities and further information is needed on the current efforts. Disaggregated data, collected by providers in ART services using FP registers, are now being collected in order to assess further.

[1] 23 providers have been trained but not all of them are providing services.

In total 360 HIV+ women (including women with known HIV+ status at entry and those newly testing positive) were followed at FP consultations and all of them received a FP method: 251 (69%) injectables, 84 (23%) pills, 12 (3%) implants, 2 (<1%) an intrauterine device (IUD), and 11 (3%) other methods. This rate of uptake is similar to that in most past quarters. The method mix has, however, has again shifted back toward high levels of injectables and lower levels of pills (Figure 8). This shift back to injectables resulted from the availability of injectable contraceptives, we believe the preferred method, in HFs this quarter.

Figure 8. Method mix among HIV+ women using FP, at CHASS sites, from Y4Q1 to Y5Q2



Early Infant Diagnosis Technical Support

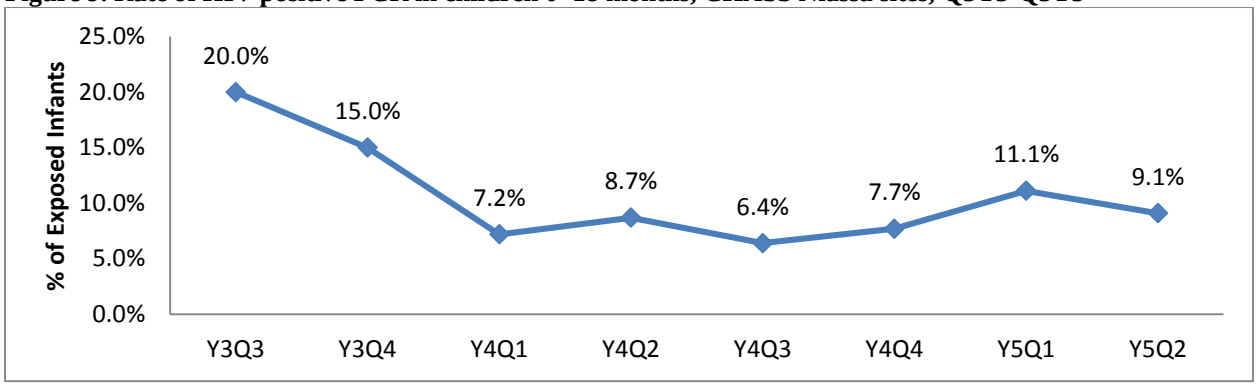
During the quarter, 431 children exposed to HIV were registered in high-risk consultation for children (CCR), this is about 92% of the expected number of exposed children (i.e., the total number of HIV+ women who gave birth) compared to 70% last quarter. This was the result of a major initiative by CHASS Niassa, DPS, and SDMAS to train providers in the registration of samples collected and of results received in order to decrease the discrepancy between the data at the facility level and that in the National Institute of Health database.

Among children seen at CCR, 322 (74%) initiated CTZ prophylaxis before 2 months of age. A total of 449 PCR samples were collected and sent to the Nampula lab, and in the same period the province received results of 198 samples[2], with 18 (9%) testing positive for HIV (Figure 9). All of the children who tested positive were enrolled in ART according to the MoH norms. The low

[2] More results were received than samples submitted because there is a time delay. Some of the results received this quarter are results from tests sent in the prior quarter.

percentage of PCR samples sent to the lab that were returned is discussed in the laboratory section of this report.

Figure 9. Rate of HIV positive PCR in children 0–18 months, CHASS Niassa sites, Q3Y3-Q3Y5



Pre-ART Care and Treatment Technical Support

During the quarter a total of 2,347 patients tested positive in all testing points: with 825 in MCH (38 maternity, 518 pregnant women in ANC, 149 partners, 5 postpartum consultation, 97 FP, and 18 children in CCR), 52 in the Tuberculosis (TB) sector, 861 in PICT, 273 in C-HCT, and 336 in UATS. Of those testing positive, 1,498 (64%) patients were enrolled in pre-ART services (Figure 10). Compared to the previous quarter the proportion of people testing positive who were included in pre-ART services decreased (64% this quarter, compared to 78% last quarter). The decrease is likely the result of seasonal migration for agriculture. It may also be related to issues with the referral systems in PICT, an issue we will explore next quarter.

Of the 1,498 people who enrolled in pre-ART, 1,097 (73%) started ART (Figure 10). The proportion of new patients who initiated ART increased relative to last quarter (63% to 73%). This positive shift is likely due to the increase in the percentage of new patients enrolled in Pre-ART that are women on Option B+ and because of intensified joint TSV by DPS /CHASS Niassa, which included review of cluster of differential (CD4) results to update the eligibility of patients whose CD4 counts had declined over time.

Figure 10. Pre-ART cascade, CHASS Niassa sites, Jan to Mar 2015

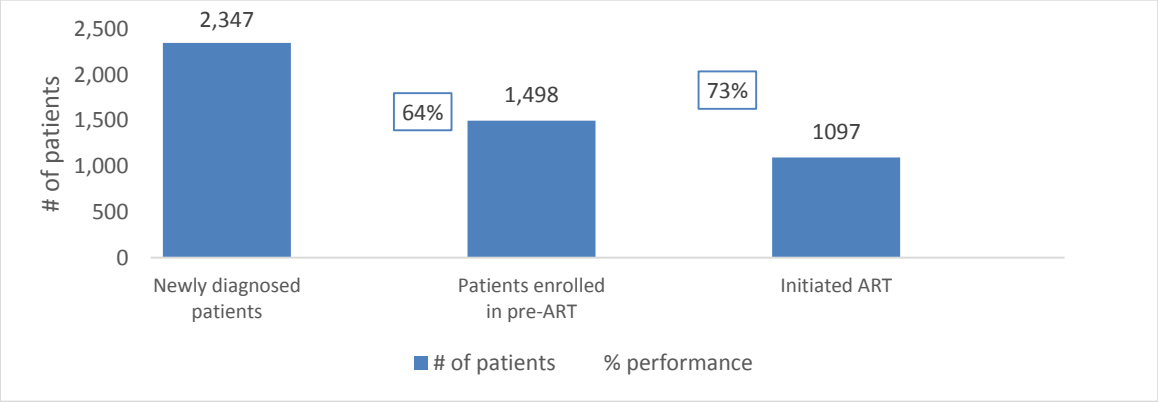
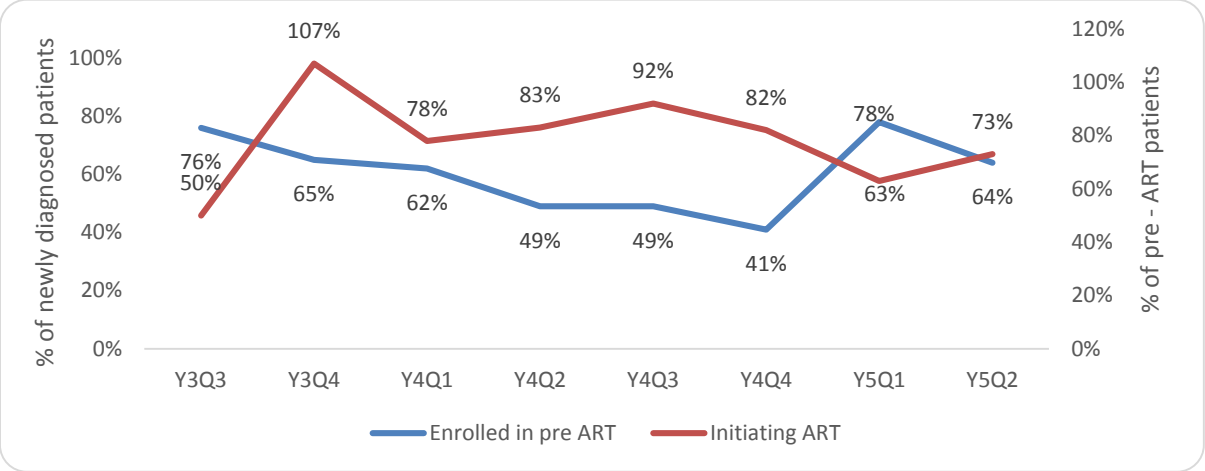


Figure 11. Pre-ART and ART uptake among newly diagnosed patients, CHASS Niassa sites, Y4Q1 to Y5Q2



Adult Care and Treatment Technical Support

During this quarter, 1,097 new patients initiated ART in all HF that are providing these services. This is a slight decrease of 10% (1,212 to 1,097) compared to last quarter (Figure 12) but contributed to cumulative achievement of 71% of the annual target by the end of the quarter (Figure 13). The decrease this quarter is in part associated with the reduced number of CD4 tests completed which limited the initiation of ART of patients. This was due to the limited electricity supply that affected the whole province in the early part of the quarter.

Figure 12. Number of newly enrolled patients on ART in CHASS sites, by quarter, Y3Q3 to Y5Q2

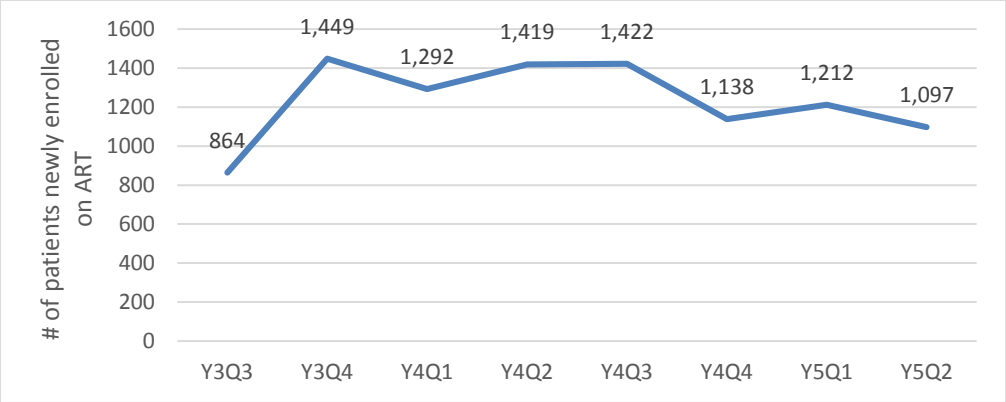
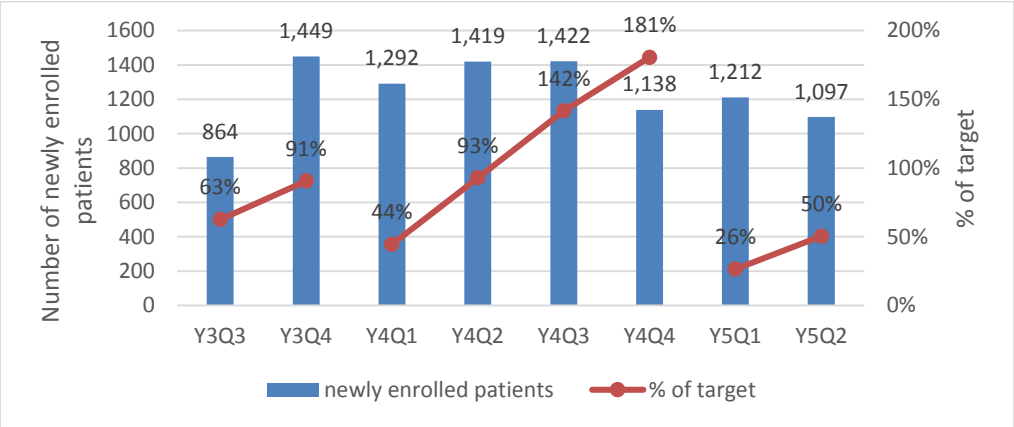


Figure 13. Percent achievement of annual target in number of newly initiating ART in CHASS Niassa sites, from Y3Q3 to Y5Q2



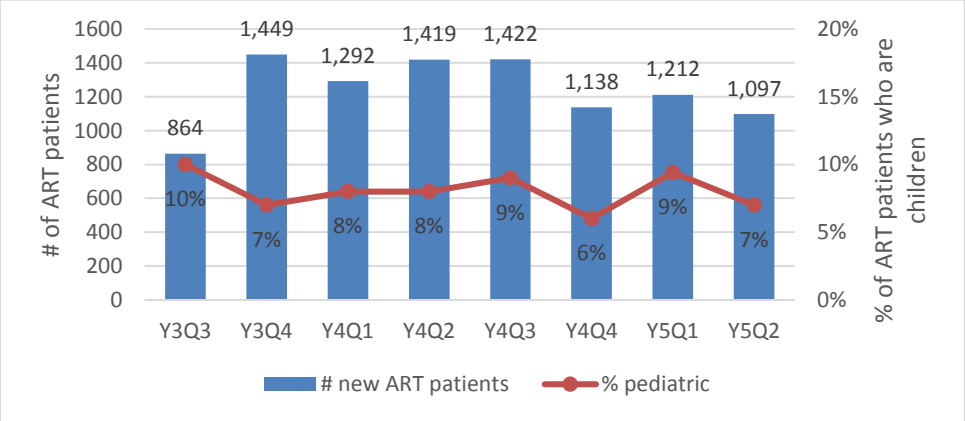
Of the patients enrolled in ART, at least 413 (38%) are pregnant women who have benefited from Option B+. While the number of women enrolled on Option B+ remained roughly constant, the total number of new enrollees decreased, leading to a small increase as compared to last quarter (33%).

The number of patients currently in ART in March was 13,801, which is 115% of the annual target, and the number of patients ever enrolled on ART was 20,920.

Pediatric Care and Treatment Technical Support

During the quarter, 81 (35 males, 46 females) children were newly enrolled in ART, corresponding to 7% of all patients enrolled. Relative to last quarter, the percentage of pediatric patients remained the same (p=0.08).

Figure 14. Number newly initiating ART and percent of those who are children in CHASS Niassa sites, FY4 and FY5, by quarter



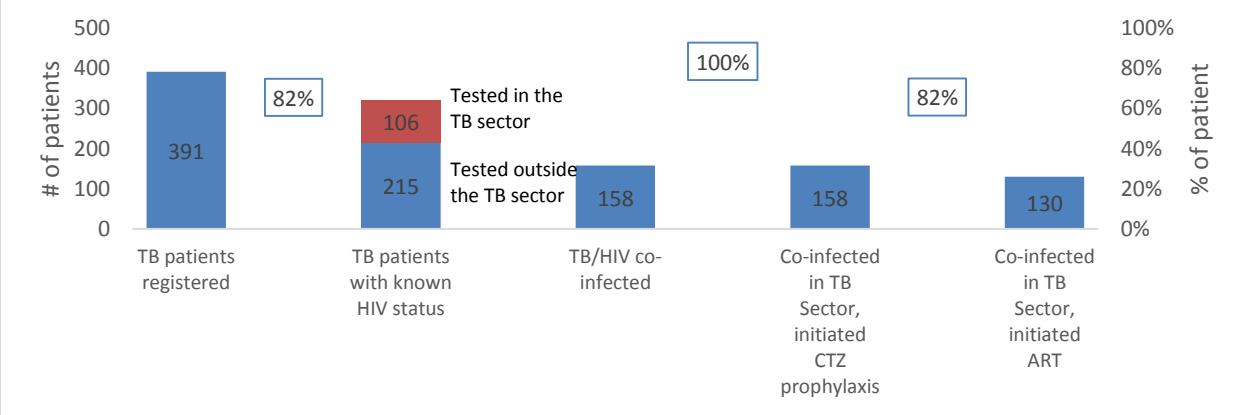
TB/HIV Co-infection Support Services

CHASS Niassa supports the implementation of TB/HIV services through the one-stop-shop model in 17 HFs, specifically in HFs of the 16 district headquarters and Lichinga district with two 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 ARV prescription.

However, the retention of HIV patients who have completed TB treatment remains a challenge, to ensure retention of patients who completed TB treatment in the TB sector, the list of names and additional medical information is shared with the HIV/AIDS care and treatment sector.

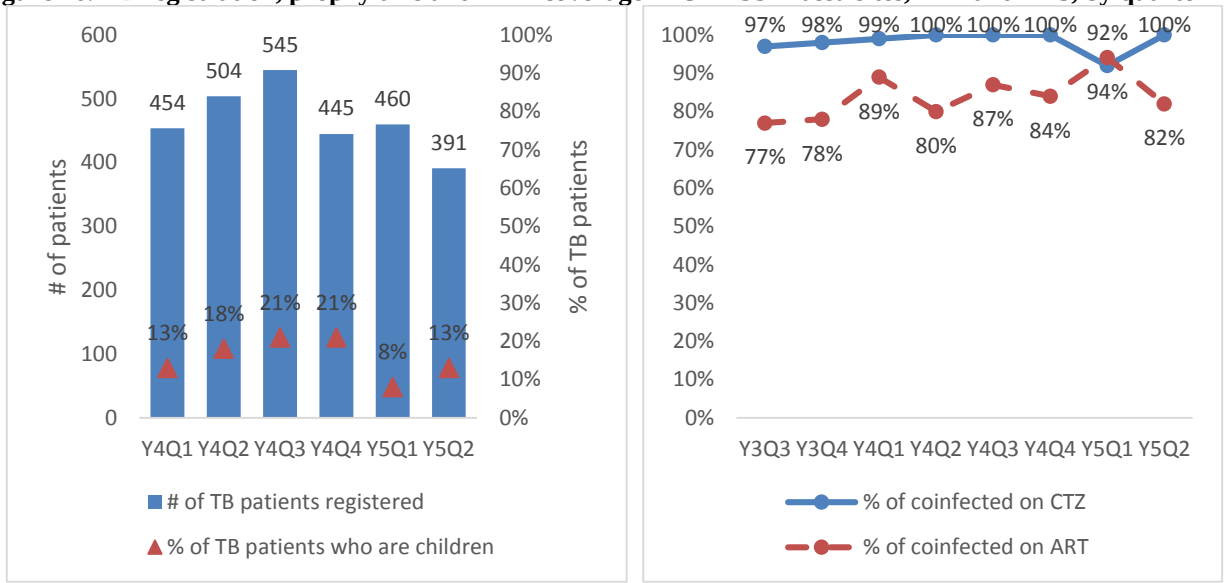
This quarter, 391 patients were registered in the TB sector, a decrease of 15% when compared to the 460 patients registered in the last quarter. This quarter, 54 (14%) of the TB patients were children. However, in spite of the decreased number of patients registered in TB sector, the proportion of children enrolled in TB increased due to emphasis on infant TB diagnosis during on-the-job training. Among the TB patients, 55% (215) did not know their HIV status on admission and were tested for HIV (Figure 15) resulting in 376 (96%) who knew their HIV status. In total, 158 (40%) of new TB patients were HIV positive (those with known status on entry plus those who tested positive). Among co-infected patients, 100% were provided with CTZ prophylaxis and 82% (130) were enrolled on ART (Figure 15).

Figure 15. TB/HIV cascade in CHASS Niassa sites, from Jan to Mar 2015



This quarter, 130 co-infected patients received ARVs as part of universal access, with coverage reaching 82%, substantially below the 94% last quarter (Figure 16). This decrease is likely the result of substitution of some trained TB supervisors with untrained supervisors which affected the identification of patients who were not in ART.

Figure 16. TB registration, prophylaxis and ART coverage in CHASS Niassa sites, FY4 and FY5, by quarter

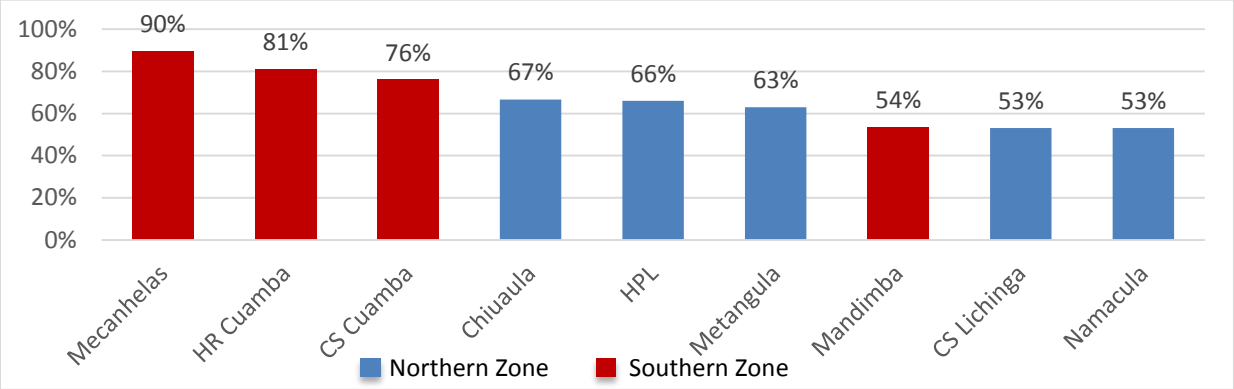


In coordination with DPS, next quarter CHASS Niassa will continue providing TSV to the TB sector and will work to improve linkages to the HIV sector to ensure inter-sectorial coordination on patient tracking after TB treatment is complete.

Adherence to Treatment and Retention in Care Technical Support

This quarter, CHASS Niassa continued to implement the strategies that are believed to have contributed to the improvement in ART retention seen in the Annual Performance Review (APR) 2014. This included: 1) implementation of the acceleration plan which will allow HIV services to be provided nearer to patients, and 2) implementation of the psychosocial support strategy. However, in semi-annual performance review (SAPR) for 2015 retention declined to 66%; while this is an improvement over the 56% reported in SAPR14, it is a significant reduction relative to the 71% in APR 2014. The reasons for this decline are not clear. It does not appear to be the effect of the floods in early 2015 as retention in the Southern area of the country is higher than retention in the Northern Zone. A comparison of the 9 priority sites (Figure 17) shows that the top three sites in terms of retention are in the south; retention is particularly low in Lichinga City. Understanding the reasons for this difference is important to improving retention both at these low performing sites and in the province as a whole since these sites are among the largest in terms of patient volume and is something CHASS Niassa will pursue next quarter. Retention at 6 months was substantially higher at 81% suggesting that a significant proportion of patients are dropping out both in the first 6 months and in the second half of the first year. Effective strategies for preventing early dropouts are being explored.

Figure 17. 12-month adult retention in ART in priority sites, SAPR15

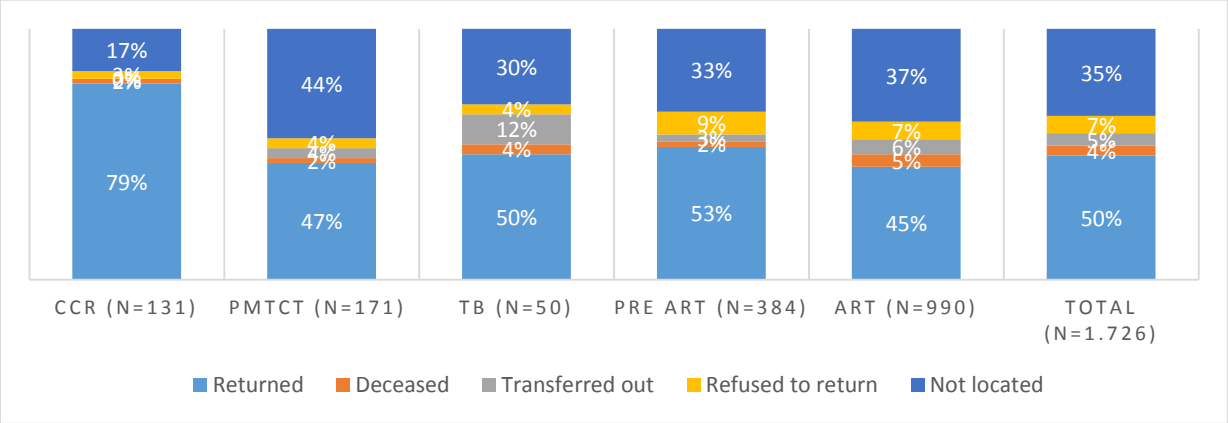


With regard to *busca activa*, one key strategy used to encourage retention, this quarter, a list of 384 *defaulted* patients in pre-ART (150 males, 234 females) was delivered to the Community-Case Managers (CCMs) and C-HCT lay-counselors for tracing; 99 (26%) of these defaulted patients were children. In all, 53% (203; 81 males, 122 females) of these patients returned to treatment, 2% (8; 2 males, 6 females) had died, 3% (12; 7 males, 5 females) had transferred to other health facilities of the province or country, and 9% (35; 12 males, 23 females) refused to return to treatment even after sensitization and counseling sessions for adherence (Figure 18). The remaining 33% (126; 48 males, 78 females) could not be found at the addresses provided during pre-ART counseling sessions.

In ART, names of a total of 990 patient (580 males, 410 females) patients who *defaulted* treatment were delivered to CCMs for tracing; 18% of these defaulted patients were children. In all, 45% of these patients (444; 268 males, 176 females) returned to treatment (Figure 18), whilst the remaining patients had either died 5% (47; 25 males, 22 females), transferred out (6%; 62; 33 males, 29 females), refused to return to treatment after sensitization (7%, 67; 37 males, 30 females), or could not be located at the provided addresses (37%, 370; 217 males, 153 females).

The percentage of defaulted patients who returned to care varied in other services. In CCR 79% (103) returned, 47% (80) in PMTCT, and 50% (25) in TB. The percentage of defaulted patients that could not be located was 17% (22) in CCR, 44% (75) in PMTCT, and 30% (15) in TB but all of these groups have small numbers of patients so a small difference has a large impact on the percentages.

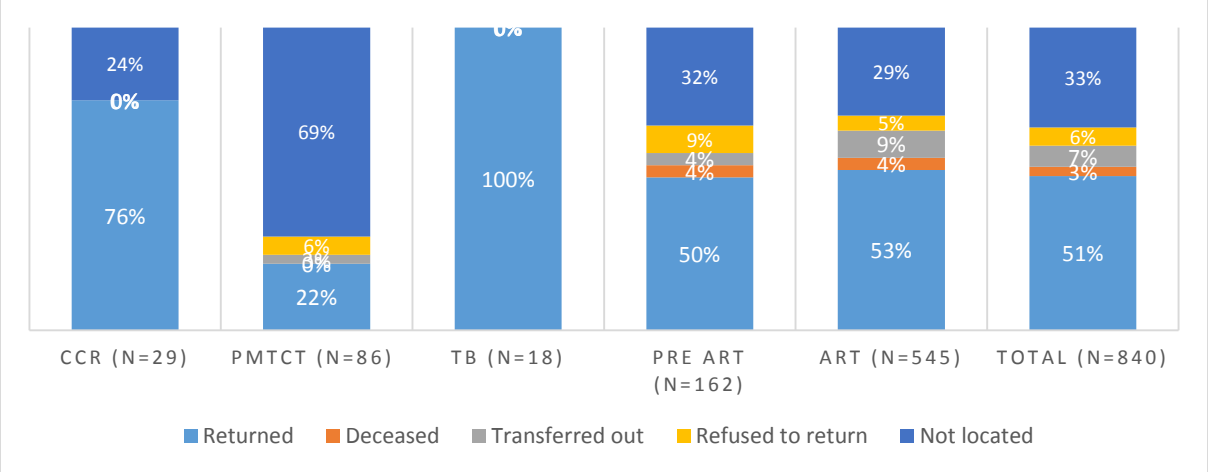
Figure 18. Outcome of patients who defaulted in CHASS Niassa sites, by type of care from, Jan to Mar 2015



With regard to efforts to ensure return of patients that *abandoned* pre-ART care, a list of 162 patients (73 males, 89 females) was delivered to the CCMs for tracing, 21% (34) of these abandoned patients were children. In all, 50% (81 patients; 33 males, 48 females) returned to treatment (Figure 19). An additional 4% were deceased (7; 5 males, 2 females), 4% had transferred out (7; 7 males, 0 females), 9% (15; 5 males, 10 females) had refused to return to treatment, and 32% (52; 23 males, 29 females) could not be located.

In ART, 545 patients who had *abandoned* treatment (310 males, 235 females) were listed and delivered to CCMs for active finding, 15% of these abandoned patients were children. Overall, 53% (290; 174 males, 116 females) returned to treatment (Figure 19), with 4% (22; 12 males, 10 females) having died, 9% (49; 22 males, 27 females) transferred out, 5% (28; 16 males, 12 females) refused to return, and 29% (156; 86 males, 70 females) could not be located.

Figure 19. Outcome of patients who abandoned in CHASS Niassa sites, by type of care from Jan to Mar 2014

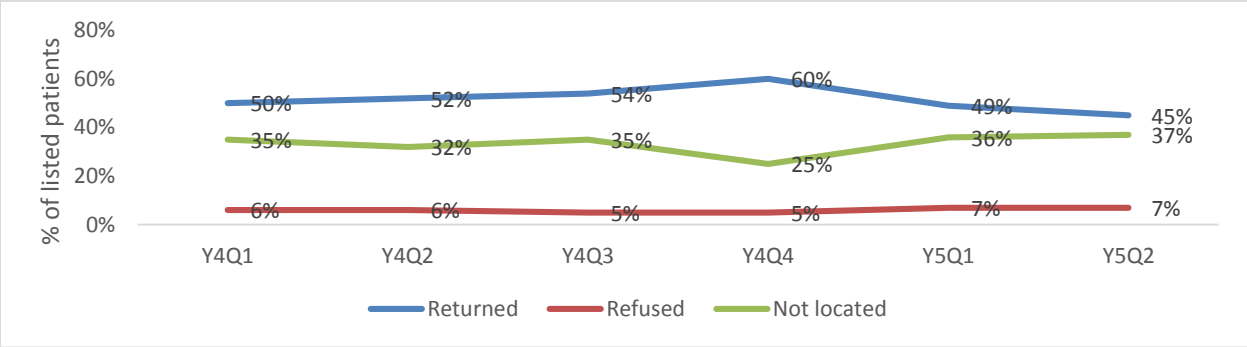


The percentage of abandoned patients returning was 70% (22) in CCR, 22% (19) PMTCT, and 100% (18) TB. Among the abandoned patients, 24% (7) in CCR and 69% (59) in PMTCT were not found.

Challenges to active case finding include: the high proportion of patients who cannot be located, and patients who refuse to return to treatment after being located, especially in PMTCT and ART. 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 reasons. However, after some delay due to hesitation on the part of DPS, CHASS Niassa is expanding community adherence support groups (GAACs), a strategy shown to reduce loss to followup. Ideally this will reduce the number of people referred for *busca activa* and thereby allow greater attention to those patients who are listed.

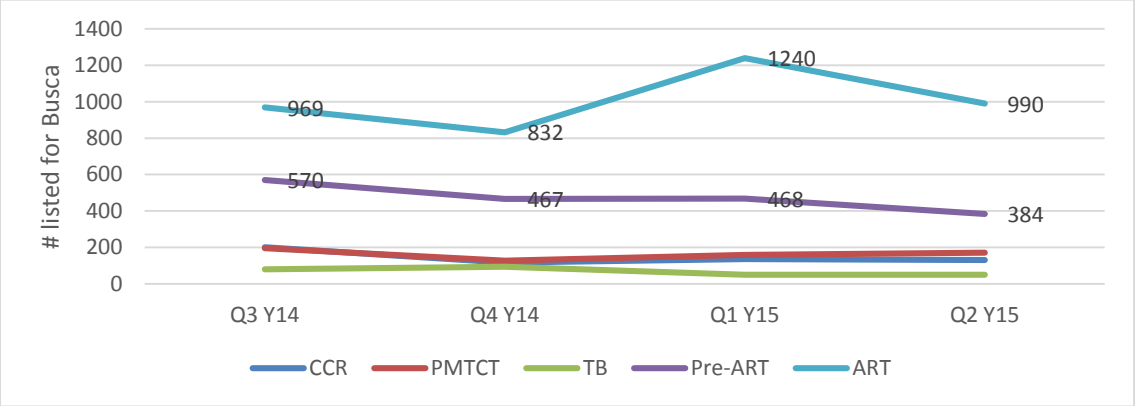
The results this quarter are disturbing compared to trends over time. After a marked improvement at the end of year 4, the percentage of defaulted ART patients returned to care has decreased to lower levels than at the same time last year (Figure 20) and the percentage of patients not located has increased. A different pattern is seem among Pre-ART patients, but there too, the percent of patients returning to care has declined during the past two quarters (results not shown). The special efforts to reach defaulted patients in the last quarter or 2014 appear to have been effective so attention will be given in the next quarter to determine how those strategies can be replicated on an ongoing basis. However, the low performance last quarter may be due to the fact that motivation was low among *activistas* who believed that the project was coming to an end.

Figure 20. Percentage of defaulted 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 Q2Y5



Although the percentage of patients returned to care is lower this quarter and the number of patients listed for *busca activa* has remained relatively constant in most services, in Pre-ART the number defaulted has steadily decreased over the last year (Figure 21) from 570 to 384 (30% reduction) as has the number who have abandoned pre-ART (results not shown). Reducing the number of patients who default and therefore require *busca activa* is likely a more effective and more cost-effective strategy. However, whether this decline reflects a decline in defaulters or a change in registration of defaulters needs further inquiry.

Figure 21. Number of patients listed as defaulted for Busca Activa, by type and quarter, Y4Q3 to Y5Q2



In addition to the *busca activa* carried out directly by CHASS Niassa IPs, *busca activa* was conducted by PCC IPs in 4 districts (Cuamba, Mandimba, Mecanhelas, and Metarica). A total of 239 people were provided to PCC *activistas*; 70% of them were located and 57% of them were returned to care. This is about 9% of all patients listed this quarter and 11% of all patients returned to care. PCC data are not disaggregated by type of care. In addition, PCC *activistas* referred 899 people who received services (PCC only tracks completed referrals); this included 179 MCH referrals, 210 HIV referrals, 312 Social services referrals and 198 referrals for other services.

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 5,827 CD4 counts were performed, similar to last quarter (5,959). Again this quarter, 1,886 (32%) of the CD4 counts undertaken were done using the Point of Care technology for CD4 (PIMA) machines. The decrease in the number of tests done could be related to the flooding that occurred which affected roads and blocked CD4 routes in some places for 30 days. In fact, all facilities in the southern part of the country saw a decrease of at least 20% relative to last quarter whereas some facilities in the north (Cobue, Mecula and Mavago) had substantial improvements in the number of CD4 tests done using PIMA this quarter (Table 1), recuperating from declines seen in recent periods. Both Marrupa and Metangula suffered declines although they were not affected by the floods; in these facilities management and staffing were barriers to testing. These issues have been described in TSV reports and discussed with the provincial coordinator; we will continue to follow up on these in the next quarter. Finally, levels of CD4 testing in many facilities was limited by the lack of electricity resulting from the floods; this affected facilities in both zones.

After the rainy season, roads have improved with the rapid intervention of the Government, and the CD4 route restarted functioning normally. In order to improve the productivity of the PIMAs in March CHASS Niassa started implementing a QIP in Maua and Mandimba with the objective of guaranteeing that all samples requested are processed and the results are available in the

patient's clinical charts. Registers are being used to document when samples are sent, when they are received, and the sample rejection rate in order to identify sectors or providers who need support to improve sample collection as well as to identify issues related to processing of samples. The results of this 4 month process will be disseminated in July 2015.

Table 1. Number of CD4 counts using PIMA, by facility, Jan to Mar 2015 and Q3Y4 to Q2Y5

Health facility	Jan	Feb	Mar	Q3Y14	Q4Y14	Q1Y15	Q2Y5
Cobue	42	52	70	160	124	87	164
Metangula	48	58	150	350	406	358	256
Mavago	25	28	15	89	39	15	68
Mecula	49	34	60	128	97	91	143
Marrupa	40	40	73	182	148	213	153
Maua	10	20	98	275	182	172	128
Mecanhelas	81	113	227	608	381	652	421
Entre Lagos	0	0	78	150	139	98	78
Mandimba	134	145	196	342	424	476	475
Total	429	490	967	2,284	1,940	2,162	1,886

During the quarter, 449 PCR samples (445 first and 4 repeated collections) were received from the Nampula reference laboratory, almost comparable to last quarter (467 versus 449). This slight decrease may be the effects of the floods, which interfered with the transport to Nampula. Of the PCR samples sent, 44% (198) results were received; 18 (9%) were positive. This quarter the Laboratory response time for PCR samples was longer (2 months) compared to last quarter (45 days). This delay in receiving results is linked to the operation of the Nampula Reference Laboratory although the energy shortages in Nampula may have exacerbated the existing problems. In order to overcome this issue, CHASS Niassa will advocate with the Nampula Lab in order to review the process of sending the results to Niassa.

In January the Entre Lagos Health Center lab did not process CD4 samples in PIMA, due to the breakdown of the equipment. To solve this issue, a backup machine was brought from Lichinga provincial laboratory and the equipment began work on 24 February. In the period in which the machine was broken, the samples were processed at the Laboratory of Mecanhelas Health Center with the support of CHASS Niassa.

With the objective of training and certifying the PIMA operators in Simplified Technologies PIMA for LT-CD4 Count, and according to the expansion plan, a 3-day training was held in Mandimba. The course covered theory and included practicums. Participants learned about the relationship between the CD4 + T cell ratio and HIV; significance and clinical utility of the test CD4; description of PIMA characteristics and its technical limitations; storing of reagents and consumables for reagents management inventory; biosafety and waste management; results of reports, records and documentation (including a practical exercise); how to send results using the internet; internal quality control; external quality assurance; most common mistakes and corrective actions; procedures for sampling, venous and capillary puncture; and standard operating procedures. In addition the operators practiced collecting blood samples by capillary and venous puncture in patients needing a CD4 test and processed them using the PIMA equipment. Eight

Technicians coming from 7 de Setembro, Chimbunila, Massangulo, and Mecula Health Centers and Marrupa District Hospital participated in this training.

During the reporting period, a total of 2,506 smear slides for diagnosis of TB were processed with 142 (7%) diagnosed positive, a slight decrease from 10% last quarter. The number of slides processed decreased by 11% relative to the last quarter, when 2,787 slides were processed.

A total of 96 samples were processed using the Gene Xpert machine in Cuamba and Mycobacterium TB was detected in a total of 16 samples (17%) with one identified as resistant to rifampicin (Table 2). There was a 9% increase in the number of samples processed using the Gene Xpert machines (from 88 to 96). This slight increase may have been because of improved laboratory response time, resulting from the intervention of the Cuamba Medical Chief in order to improve the management of the results between the lab staff and the clinicians by sending the clinical results via email or telephone when they are ready.

Table 2. Gene Xpert results in CHASS Niassa sites, FY5 by quarter

	# of samples processed	Presence of DNA of MTB detected	Presence of DNA of MTB not detected	Invalid	Resistance to Rifampicine identified
Year 5					
Q1	88	26	56	0	5
Q2	96	16	71	0	1

Injection Safety/Infection Prevention & Control/Biosafety Technical Support

During the quarter, Infection Control Program internal measurements were done in ten health facilities (Table 3). The average score has increased slightly each quarter in the past year resulting in an 8% overall increase, although individual scores show more variability. In general, the most frequent issues affecting infection control practices remain the limited availability and poor use of personal protective equipment, non-compliance with the rules of segregation of hospital waste, and difficulties in access to running water.

Table 3. Overall infection control assessment score by HF, by quarter, Q3Y4 to Q2Y5

Health Facility	Y4Q3	Y4Q4	Y5Q1	Y5Q2
Marrupa	53.0	44.5	--	61.1
Cuamba	54.4	67.7	--	73
Mecanhelas	--	69.8	--	53.8
Metarica	62.0	51.2	70.8	76
Majune	--	48.0	58.0	--
Nipepe	64.7	78.9	80.3	66.2
Muembe	53.1	69.7	69.6	--
Chimbonila	44.3	67.6	50.4	66.2
7 de Setembro	NF	NF	63.0	43.7
Mandimba	--	51.0	41.0	--
HPL	--	--	--	66.3
CSL	--	--	--	69
Ngaúma	--	--	--	61.1
Average	55.3	60.9	61.9	63.6

Post Expose Prophylaxis (PEP)

With regard to the PEP, this quarter there were 7 cases of occupational exposure to HIV reported with 5 males and 2 females. Five of them received PEP (Table 4). The two who did not had minimal exposure and did not, therefore, meet the criteria for PEP.

Table 4. Occupational exposures to HIV and PEP, by type and sex, Jan to Mar 2015

Health Facility	Type of Exposure						Total		PEP	
	Massive		Intermediate		Minimum					
	M	F	M	F	M	F	M	F	M	F
HPL	0	0	2	0	0	1	2	1	2	0
Cuamba	0	0	0	1	0	0	0	1	0	1
Máua	0	0	2	0	0	0	2	0	2	0
Metarica	0	0	0	0	1	0	1	0	0	0
Subtotal	0	0	4	1	1	1	5	2	4	1

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 and 2. The NRP and ART, TB, PMTCT, and CCR services are entry points to reach HIV+ patients who are clinically malnourished and provide them with supplementary or therapeutic food. The community interventions under CHASS Niassa contribute to improvements in nutritional status through lectures and education demonstrations on good practices. Thirty Technical Health staff (8 new Medical Chef, 19 Medicine Technical and 3 Nurses) were trained on NRP vol.1 and Vol.2 (CSB+) from 16 to 21 March 2015 at *Instituto de Formação em Administração Pública e Autárquica* –Lichinga.

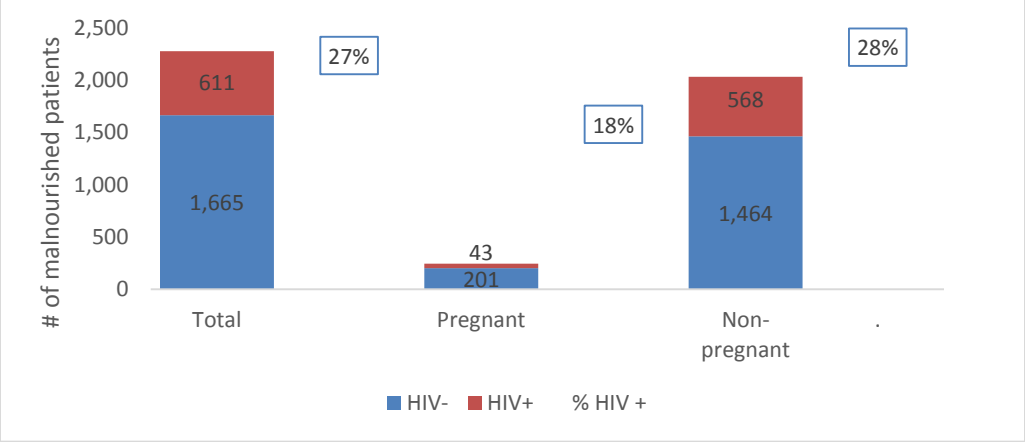
This quarter a total of 2,278 malnourished patients were referred to NRP from various consultations[3], of these 611 (27%) were HIV+. Compared to last quarter, the number referred remained the same (2,278 patients) while the number of malnourished patients who were HIV+ increased by 297% (from 154 to 611). In total, 64% (390/611) of the clinically malnourished HIV + patients were female. The increase in the number of malnourished patients who were HIV+ is likely related to multiple factors including the availability and distribution of CSB+ for HIV+ patients (malnutrition screening is required prior to distribution), reinforced TA on

[3] Note: The NRP Registers do not identify the entry point of patients who do not enter directly through the nutrition program. As noted, sources may include: ART, TB, PMTCT, CCR, CCS, and inpatient services.

nutrition screening for adult patients (pregnant women and HIV adult patients), and improved data recording and reporting.

All patients that were referred to the nutrition program received supplementary or therapeutic food. The number of patients remained high as a result of the availability of CSB+ as well as expansion from NRP vol. 1 to NRP vol. 2 (allowing for services for adults). Pregnant women composed 11% (244/2,264) of the malnourished patients and 18% (43/244) of these pregnant women were found to be HIV+. Among the 2,020 non-pregnant patients, 611 (27%) tested HIV+ (Figure 19).

Figure 22. Number of patients clinically malnourished HIV+, by pregnancy status, Q2Y5



Data source: M&E CHASS N

Nutrition supplementation among HIV positive patients

All the HIV+ patients (611) who were malnourished were reported to have received supplemental or therapeutic food. The total number of HIV+ patients who were reported to have received food was 31% (611/1998) of the annual target compared to just (8%) last quarter. We hope that with availability of CSB+ and implementation of PRN 2 we can achieve the annual target. A higher percentage of moderately malnourished patients received food (63%) than did severely malnourished patients (39%). The patterns of patients receiving food by age, sex and nutrition status are similar to those for patients found to be malnourished.

Table 5. Nutrition status and receipt of supplemental or therapeutic food, by group, Niassa, Jan-Mar 2015

Sex		Age			Malnutrition Status		Pregnancy status	
Male	**Female**	**0-4**	**5-14**	**15+**	**Mild/Moderate**	**Severe**	**Pregnant**	**Postpartum**
HIV+ patients clinically malnourished (non-pregnant)								
222	389	99	23	489	376	235	NA	NA
# HIV+ pregnant women who are clinically malnourished								
	43				43			
# HIV+ patients receiving supplementary or therapeutic food								
222	389	99	23	489	376	235	43	12

We believe that the consistent completion of the registers when services are provided remains a challenge. As a result, both the number of patients who were malnourished and the number who received treatment are likely underreported. The team from CHASS Niassa and DPS will continue providing on-the-job training to health facility staff during joint TSV to address this issue.

Nutrition Rehabilitation Program Technical Support

Key results under the NRP include:

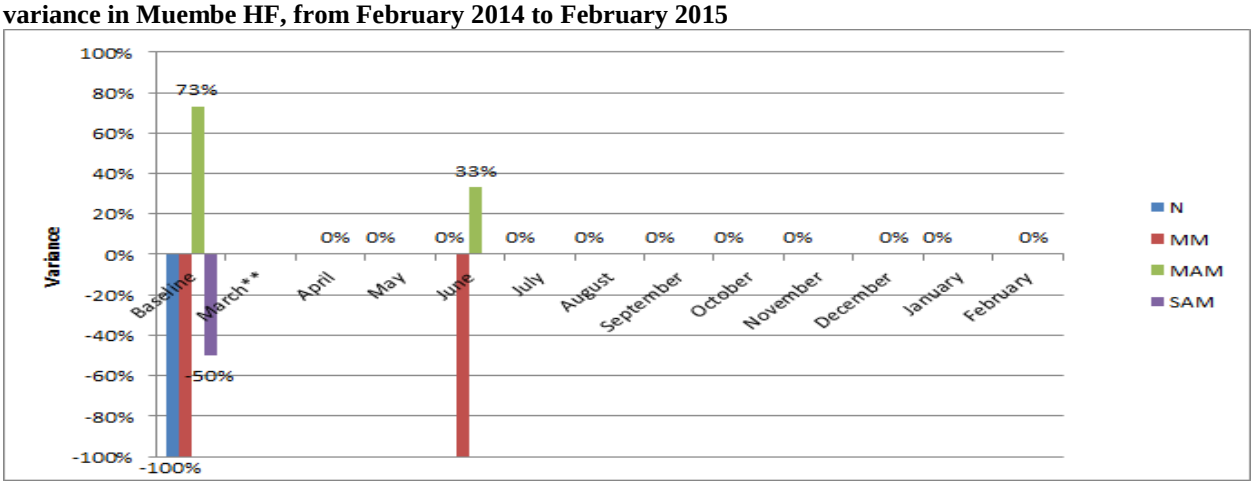
- 384 (17%) of the malnourished patients met the criteria for inpatient treatment while the remaining 1,894 were treated as outpatients
- All of the malnourished patients were tested for HIV; 20% (76/384) of inpatients and 28% (537/1,894) of those in ambulatory care tested positive
- At the community level 171 patients were identified as malnourished and referred to HFs by the CCMs
- 148 (87%) of those referred in the community reached a HF
- 9,964 people benefitted from nutrition information, education, and communication (IEC) sessions and the number of home visits increased by 36% (1,735 to 2,325) compared to last quarter
- 1,913 people participated in nutritional counseling, education and demonstration of vegetable gardens

Implementation of Quality Improvement Project within the Scope of NRP in collaboration with FANTA III and DPS Niassa

The QIP aims to improve the approach to managing malnutrition in children less than 15 years old in CCR and consultations for chronic diseases (TB/HIV, pre-ART and ART) in HFs of Lichinga, Cuamba and Muembe, including at Cuamba Rural Hospital between February 2014 and February 2015. A baseline study in February 2014 evaluated whether or not nutritional evaluations were done during consultations, and if so, if they were referred to receive treatment or supplementation in the NRP.

Since QIP implementation began, HFs in Muembe and Lichinga City have shown significant improvement in the recording of anthropometric, nutritional assessment, classification and treatment data for malnourished patients. Cuamba had more difficulty with implementation of the QIP due the frequent rotation of the health staff. Figure 23 shows data from Muembe, which is typical of all sites in Muembe and Lichinga City.

Figure 23. Classification of nutritional status of children using Weight / Height (P/E) and / PB=MUAC – variance in Muembe HF, from February 2014 to February 2015



The first meeting about the QIP evaluation was held on 25 March 2015 with staff of the 4 HFs, DPS and CHASS Niassa. The evaluation was complicated by the high levels of staff turnover and planned quarterly meetings were never held because this activity was not part of the DPS sub-agreement. The MCP concluded that there was weak ownership of nutrition activities (QIP) by health facility staff. The DPS recommended that the Nutrition Program staff re-evaluate the 4 HF and that the HFs then develop action plans, share them with DPS and monitor compliance with them through the minutes of the monthly meetings. Furthermore, the DPS Nutrition Program staff were asked to do a presentation of the new QIP at the 4 HFs for the Medical Chief and District Directors (in coordination with the DPPC) in order ensure ownership of the process.

Next quarter the Nutrition Program staff from DPS and the Nutrition adviser from CHASS Niassa will redesign the QIP database with the monitoring and evaluation (M&E) team and will conduct a new baseline. They will follow-up the QIP during joint TSVs and will sensitize the technicians at HFs on the importance of implementing the NRP, registration, collection of data for analysis, and monitoring of the gaps found.

Gender Based Violence (GBV)

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

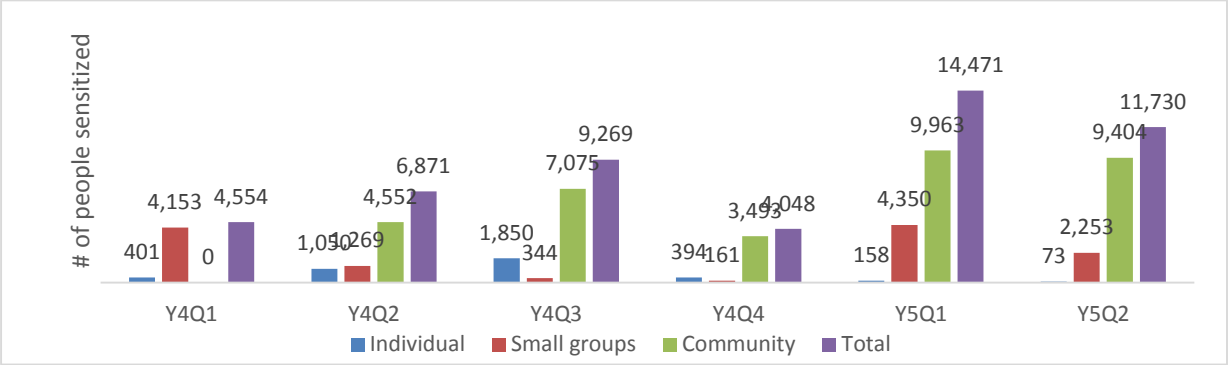
Reaching individuals through Individual, Small-group and Community Interventions related to GBV

During this quarter a total of 11,730 individuals (5,268 males; 6,462 females) were reached through interventions addressing GBV. 2,263 people were sensitized in small groups (1,067 males; 1,186 females), 9,404 people (4,178 males; 5,226 females) where sensitized through community, and 73 people (23 males; 50 females) through one-on-one interactions.

There was a 19% decrease in the number of people reached with GBV interventions this period (11,730) compared to last quarter (14,471) (Figure 24). The decrease was most pronounced for small groups (a 50%) decrease and was minimal for those reached through community interventions (5%). These decreases may be related to the rainy season when people usually move to the farms and to the floods, which prevented the CCM from reaching some communities.

During this period in collaboration with MULEIDE and DPS a GBV committee was formed in Mandimba district adding to the two already in existence in Sanga and Lago; new committees will be formed in Cuamba and Maua during the next quarter.

Figure 24. Number of people sensitized to GBV at HFs and in communities in Niassa Province, by type of sensitization, Jan to Mar 2015

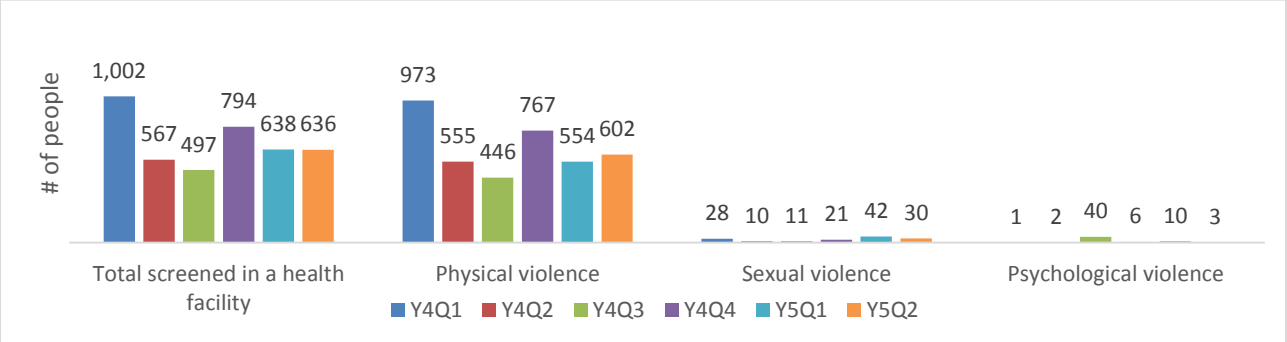


GBV Screening at the HF

During this quarter a total of 636 people (238 males, 348 females) were screened and found to be victims of violence (Figure 25)[4]. Of these, 602 were cases of physical violence, 30 were cases of sexual violence, 3 were cases of psychological violence, and 1 of moral violence. Note that as part of efforts to improve data quality, the monthly summaries have been reduced to only required information; sex disaggregation of cases is not included.

[4] At this time, Niassa does not have an effective mechanism for accurately recording the number of people screened. The numbers reported here do not include people who were screened and found to be negative for GBV.

Figure 25. GBV screening at CHASS Niassa sites, by type of violence, Y4 and Y5, by quarter



The number of cases of sexual violence decreased compared to last quarter from 42 to 30 (29% decline). This may be the result of fewer people reaching facilities due to the floods.

People Who Received Services Following Violence

A total of 24 (80%) victims of sexual violence were tested for HIV; 9 tested positive. It is possible that those who were not tested refused the test. In addition, 7 females were eligible and received emergency contraception (4 cases 10-14 years old, 3 cases 18-24 years old). Six younger girls were not eligible for emergency contraception because they had not yet menstruated (3 girls were 0-4 years old and another 3 were 5-9 years old). One 15-18 year old and 2 case 10-14 year olds did not have penetrative sex so emergency contraception was not provided. The reason that the 8 remaining cases did not receive emergency contraception is not known.

A total of 8 people (27% of victims of sexual violence) received PEP; 9 did not receive PEP because they tested positive for HIV and were referred to ARV services for treatment and follow up. The high percentage of cases that were not given PEP (almost 50%) resulted from victims of violence coming to the HF more than 72 hours after suffering violence. CHASS Niassa will continue to promote the need for victims of violence to go to a HF within 72 hours after suffering violence in order to benefit from prophylaxis, both through community sensitizations and in HF.

Just over 20% of the 636 victims of GBV received psychosocial support (Table 6). This is a 40% increase relative to last quarter and is likely the result of on-the-job training of psychiatric technicians to implement the integrated victims of violence treatment protocols. The majority of patients (69%) were referred to the police, the reason for the large increase in referrals to the police is not clear but may be because more staff were recently trained on the correct protocols.

Table 6. Number of clients who received post-GBV services in CHASS Niassa sites, Jan to Mar 2015, by type of care

Service	Post-rape	Other	Total
Tested for HIV	24	4	28
Emergency contraception	7	0	7
Post-Exposure Prophylaxis	8	1	9
Psychosocial support	23	112	135
Police Referral	27	413	440

Trainings in GBV

Through on-the-job training, 32 clinicians (26 males, 6 females) were trained this quarter in using the "Protocol for Integrated Assistance to Victims of Violence" for better Integrated care and treatment for the victims, referral between services within the HF, following cases in psycho-social support, and referral to other social services (e.g., social action, GBV units, and legal assistance). Next quarter we will continue providing on-the-job training for clinicians in the districts that have not yet received this training in order to intensify lectures at the HF and in the communities about prevention of violence.

Objective 2

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

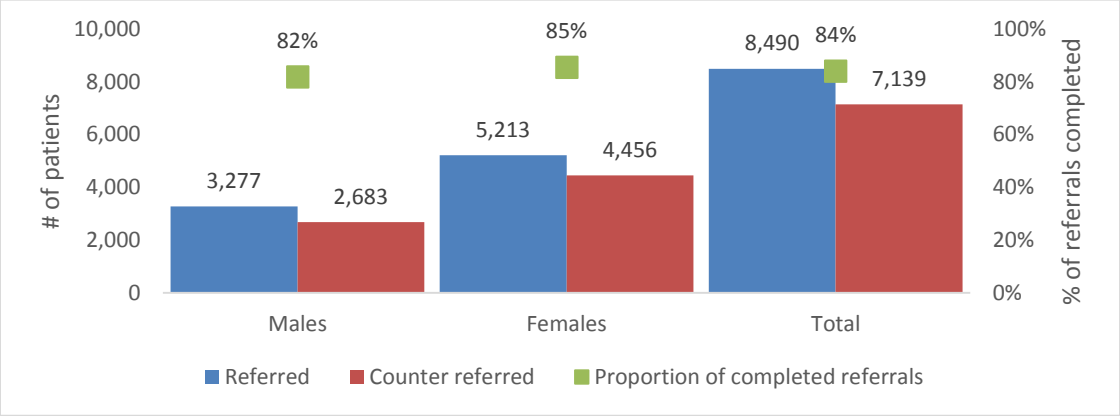
Strengthening the District Referral and Counter-referral Networks

CHASS Niassa supports establishment and strengthening of the referral network to link community interventions to health facilities in 46 HFs with ART services.

During this quarter, a total of 8,490 individuals (3,340 males; 5,5150 females) were referred for various services (Figure 26, including 1,195 (211 males[5]; 984 females) for MCH services (ANC, CPP, FP, CCR, maternity), 14% of whom were men in couples; 326 for TB services (164 males; 162 females); 5,524 for HIV services (2,239 males; 3,285 females); and 1,445 (726 males; 719 females) to other services (Nutrition, GBV, and Malaria). Of the people referred, 84% (7,155 individuals; 2,760 males; 4,395 females) completed the referral cycle with males somewhat less likely to complete the cycle although the percentage completing varies by type of referral. For example, 87% of females referred to TARV completed the referral cycle compared to 76% of males whereas 75% of males who were referred because they had abandoned TARV completed the referral cycle compared to 64% of females.

[5] Males include male children referred for CCR and partners referred for testing.

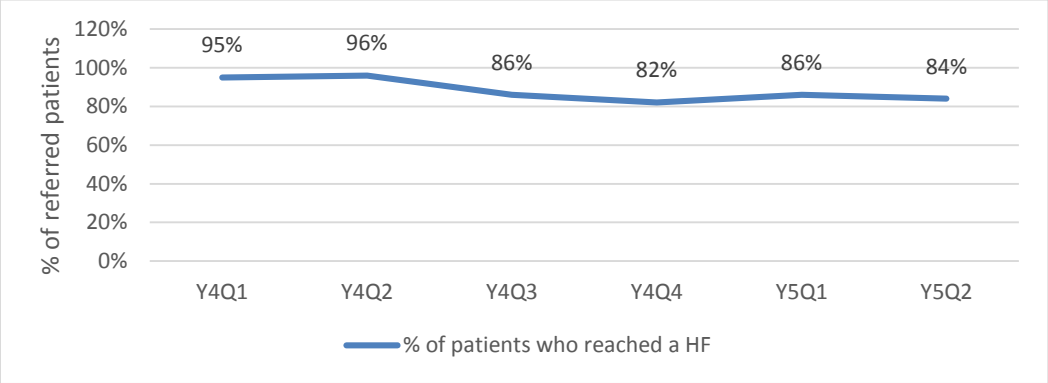
Figure 26. Referral and counter-referral results in Niassa, by sex and total, Jan to Mar 2014



Compared with the previous quarter there was a 50% increase in the number of people referred to HFs from 5,662 individuals to 8,490.

Overall, 84% of referred patients reached services, the same proportion seen in all of the last year (Figure 27). However, during this quarter, there was a stock out of log books and reference guides that may have affected data quality. CHASS Niassa is procuring this material and will provide them to the partners along with continued TA and on-the-job training in the use of books. CHASS Niassa IPs will also build awareness at the community level of the referral process for all illnesses.

Figure 27. Percent of referred patients who reached a HF in CHASS Niassa sites, Q1FY4 to Q2FY5, by quarter



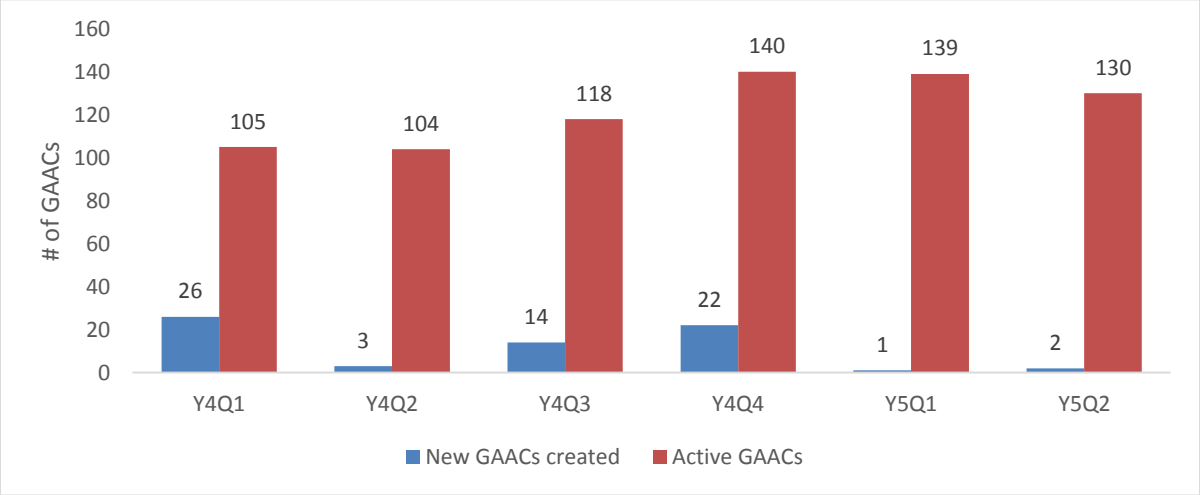
Community Adherence Support Group (GAAC)

From January to March 2015, 2 new GAACs were created and 11 were dissolved in Niassa; they were dissolved as part of a data cleaning exercise at CS Mecanhelas. Thus, the total number of groups at the present is 130 (Figure 28); they comprise 426 patients (145 men, 281 women). The number of patients per GAAC remained the same as last quarter at just above three. CHASS Niassa will aim to ensure the creation of new groups according to the strategy already published and updated by the MOH. To sustain existing groups, CHASS Niassa will work with the DPS

focal point to make regular visits to GAACs and revitalize groups, encouraging meetings at the HF that allow members to exchange experiences.

For the next quarter CHASS Niassa will provide TA to revitalize the *Cha Positiva* and meetings of clinical services management committees, to improve registration of members in the GAAC registers, and to encourage home visits to members of existing groups by the GAAC focal points and community leaders. This is in addition to ongoing work described in prior reports (e.g., *palestras*, IEC, improved information for clinicians, psychosocial support). Furthermore, CHASS Niassa will support the introduction of GAACs in three new HF: Cuamba, Metangula and Maua. Support includes identification and training of focal points, training for relevant staff (pharmacy, lab, MCH, etc), and TA for the development of plans for creation of groups and for monitoring them over time.

Figure 28. Number of new and active GAACs, Q1FY4 to Q2FY5



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.[6] In order to develop health system capabilities necessary to effectively plan, manage, and evaluate integrated HIV services in quarter 1 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

During quarter 2, CHASS Niassa planned a total of 376 TA visits (220 joint TSV and 156 by Project staff). There was no a significant change in the number of the visits planned for this period compared to quarter 1 and 70% of the total visits planned were performed, mainly by the project staff (57%). However, special attention was given to the new TA strategy based on the prioritization of HF with 59% of the visits were made to Level I sites, 19% to level II, and 22% to level III.

Technical Support to DPS Human Resources Department

CHASS Niassa has been providing TA to the HR Department of the DPS so as to improve the Personnel information System (SIP) and the Electronic System for Personnel Registration (eCAF) indicators with the goal of having 95% of staff registered in the system (the MoH national target). The technician in charge of SIP was replaced at the end of last year, and the new technician does not yet have the capacity to operate SIP. The data reported by Niassa DPS still includes some irregularities, for example employees without physical or financial allocation. The DPS is currently in the process of correcting this data and by March 31 the province had registered 93.5% of staff.

Pre-Service Training Support

The training of MCH nurses, which began in February 2014 in the Centro de *Formação de Saúde de Lichinga* with funding from CHASS, currently has 34 students, including three who transferred

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

from other institutions. Currently the students are carrying out their practicum and are expected to complete their studies in July 2015.

Post-Graduation Scholarship Support

The three people who began their training in August 2013 with financing from CHASS continue to attend their Masters in Public Health and HIV Health Services Management in part-time status at the *Universidade Católica de Moçambique- Delegação da Beira*. They are expected to complete their studies in August 2015.

Two of the three students already have post-graduate certificates and their dissertation projects have already been approved and are under way. One student is slightly behind the other two in terms of course completion due to having started the course later.

In-Service Training

Training on the New Financial Management Procedures for the provincial level

CHASS-Niassa trained 35 district and provincial level financial management staff from the Department of Administration and Finance (DAF). Topics covered in the training included principles of financial management; procedures for financial execution; procedures for payment of goods, services, and construction; procedures for financial execution, filing of accounting and document security, and elaboration of the management accounting processes. Expected results from the training include increased knowledge and implementation of basic principles of financial management, ability to prepare annual budgets and the PES according to accounting principles, and improved ability to execute expenses and properly account for them.

Humanization of Health Services Activities

CHASS Niassa carried out a TA visit to Mandimba District to support the expansion of clinical consultations for health workers to all peripheral sites; these are currently available only at the District Hospital. Given the high workload in these facilities, staff themselves often do not have time to care for their own health. During the TA visit, CHASS supported the opening of clinical files for each staff member to document annual health screenings, including nutritional screening and HIV testing. Two health workers were found to be HIV positive, both of whom were referred for CD4 counts, and started on ART and CTZ prophylaxis. It was observed that health workers do not routinely conduct quarterly HIV screening as stipulated by MoH norms. CHASS Niassa is expanding the availability of health units for health personnel so that they have increased access to HIV testing and other health screening. During TSV, health workers are also encouraged to use those services that are already available.

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. As in previous years, all activities described in the DPS work plan are to be executed through the DPS sub agreement. During year 5, the total costs for the implementation are estimated at $1,085,685 USD.

There was significant improvement on the implementation of DPS sub-agreements this quarter as expenditures were estimated at 24% of the total budget (219.534,147 USD). As mentioned in quarter 1, delays in approval of the work plan led to the postponement of planned activities. With the effective beginning of the activities in March and extension of the project through July, reasonable improvement in the sub-agreement is expected.

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 at 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.

During this quarter, in order to ensure compliance with the procedures of management and control, utility and rational use of medicines, TSV were provided to the districts medical warehouses and their respective health centers namely: (DDMs, or district drug depots) of Mandimba, Ngauma, Cuamba, Namacula, and Lichinga and rural Hospital of Cuamba, Centre de Saude de Cuamba, and Lichinga.

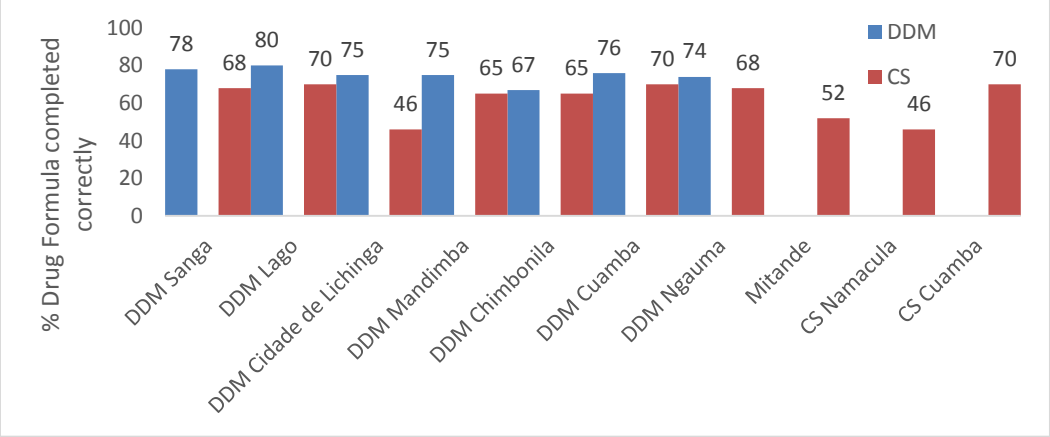
In the period of this report, in collaboration with districts managers, pharmacovigilance training was provided for the pharmacovigilance focal points for all districts of Niassa province. The same training was provided for 16 Technicians for General Medicine in Mandimba district and 5 Psychiatry Technicians in Lago district. Six technicians for Preventive Medicine were also trained in Lichinga district, in other to prepare for the installation of pharmacovigilance sentinel sites in Expanded Program on Immunization (EPI) offices in the Health centers of Lichinga city, Chiaula and Namacula. In the same period, 12 MCH Nurses received on-the-job training on pharmacovigilance in the districts of Lichinga, Chimbonila, Marrupa, Muembe, Maúa and Nipepe.

Finally, a meeting was held on 21st March with all district medical chiefs and the district in-charges for pharmacy to discuss the importance of the Therapeutic Pharmacy Committees and to review their role in controlling medicines at the district level and thereby ensuring the rational use of medicines in the health facilities.

Figure 29 shows the result of assessments of drug management undertaken at the DDMs, HFs and Peripheral HFs during TSV. The results ranged from 46 to 80% for district warehouses and HFs in relation to the standards of product management. Deficiencies were observed in updating daily ARV records for patients collecting medicines for more than one month, availability of testing record books, updating the records of patients who had abandoned care, and agreement between the completed forms and the stocks, and the a backlog of drugs in the deposits.

In order to overcome the constraints found during the TSV, the following activities were undertaken: correction of register books for the late and drop out patients in public pharmacies, correction of FILAS, MMIAs and monthly summaries in cases where discrepancies were found, correction of inventory in stock sheets with discrepancies, and updating of SIMAM. CHASS also advocated with technical staff at the health facilities to ensure compilation of a coordinated summary that includes consumption of isoniazid in both the HIV and TB sectors so that the reports submitted to the SIMAM will provide accurate assessments of the stock in order to better prevent stock outs. Finally, backlogs of drugs in the district deposits were returned to the Provincial Deposit.

Figure 29. Percent of times the Drug Formula was completed correctly by select DDM and HF, Q2FY5



Over time, performance on these evaluations has improved, particularly among the DDMs. Although the DDMs included in each quarter vary, the average score has increased from 64% in Q3 of Y4 to 75% or more this year. The pattern among the health facilities is less clear although performance in the first round was 56% compared to 58% or more in both quarters this year. Select facilities have particularly low performance. For example, in both of the last two quarters Namacula has scored just above 40% and although it improved slightly (form 43% to 46%), such

low performing sites will receive additional support in the next quarter and they will be included in the subsequent round of evaluations.

Availability of Pharmaceuticals

During the quarter we observed stock outs at the provincial level of metronidazole 250mg tablets, paracetamol 500mg tablets, and Fenoxmetil penicillin 500 mg tablets (

Table 7). These stock outs were stock outs in the “Classic route” but were covered, as last in part, by the key Essential Medicine Program which provided 344 Kits, thereby suppressing stock out. In some cases, substitution of drugs were also made to make up for the shortfall. The stock out of zidovudina suspension continued this quarter but it was replaced by nevirapine suspension which was available throughout the supply chain. Compared to the last quarter, the number of stock out days was higher (23 versus 17) as a result of the late arrival of drugs in the last shipment from Maputo to the Province, however 7 drugs has a decrease in the number of days with a stock out at the provincial level while 10 had an increase. Thus, the situation this quarter is not markedly different than last quarter. In response to stock outs, drugs were distributed to the districts using the security stock in order to minimize stock outs at the facility level; CHASS directly supported the transport of drugs. In general, the situation of drug stocks has shown some improvement relative to last year. The average number of days of stock out at this time last year was 38 days compared to 19 days this year and 16 drugs have been out of stock each quarter of this year compared to an average of 20 drugs per quarter last year.

Table 7. Number of days of drugs in stock-out in Niassa province, by quarter, Years 4 and 5

Medicine	Year 4				Year 5	
	Q1	Q2	Q3	Q4	Q1	Q2
Teste Sifilis	60	0	25	30	33	26
Teste Uni Gold	0	0	0	0	21	15
Cotrimoxazol 480 mg comp	0	0	0	0	19	0
Multivitamina comp	0	0	0	0	12	60
Salferroso+ Ácido Folico Comp. Composto	66	40	20	45	0	0
Paracetamol 500mg Comp.	42	40	0	0	0	19
Amoxicilina 500mg Comp.	32	13	8	0	0	0
Amoxicilina 250mg /5ml Susp.	90	18	30	0	0	0
Ampicilina 500mg Inj.	80	18	8	0	0	19
Ceftriaxona Inj. 1g/4ml	27	0	0	0	46	21
Cefixima 200 mg Comp.	52	60	60	30	90	60
Penicilina Benzatinica Inj. 2.4MUI	90	90	8	25	0	60
Azitromicina 500 mg Comp.	26	60	30	10	35	60
Alcool Liquido Volátil	60	90	0	0	0	0
Metronidazol 250mg Comp.	37	30	0	0	13	13
Cotrimoxazol Susp. 240mg/5ml	60	0	0	0	0	0
Eritromicina 500mg Comp.	13	10	39	0	13	
Fenoximetilpenicilina 500mg Comp.	0	30	18	0	90	90
Kanamicina Inj. 2g/10ml	0	90	90	90	42	
Nevirapina 200mg Comp.	0	90	15	0	0	0
Nevirapina Susp. 50mg/5ml	0	30	21	0	0	0
Ciprofloxacina 500mg Comp.	0	90	23	0	15	0
Quinina 300mg Comp.	90	90	90	40	90	0
Quinina Injectável 600mg/2ml	70	60	0	0	0	0
Coartem 6x3 blister	60	60	90	90	0	0
Coartem 6x4 blister	48	90	4	30	0	0
Diclofenac 50mg Comp.	0	30	0	0	14	45
Ibuprofeno 200mg Comp.	90	60	8	0	22	34
Isoniazida 100mg Comp.	31	0	24	0	0	0
Isoniazida 300mg Comp.	36	30	22	0	0	0
Acido Naldixico 500mg Comp.	0	60	0	20	19	45
Prometazina Injectável 50mg/2ml	90	0	20	0	0	69
Clorafenicol Injectável 1g/10ml	13	30	0	0	0	47
Test Kit Determine	0	0	10	0	0	0

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. During this quarter, data at HP Lichinga were validated and the pilot phase finalized. The validation process, which was required prior to the HF and DPS to accept the SESP, included the review of all charts entered in open MRS against the registers to identify missing process in both sources and to eliminate duplicated patients or NIDS so that the two sources are consistent. Parallel to that, all the status all patients in both sources was updated. Finally, the manual Monthly summary prepared using the HIV registers was compared with the summary produced by the system to identify any discrepancies. The EPTS POP developed by the OpenMRS working group was used to ensure; revisions continued until the discrepancy was less than 10%. Moreover, prior

to handover of the system to the HF the staff were trained to ensure they could manage and produce the monthly summary and the data previously collected through the cohort study. When these components were in place and the data flow clearly defined, a report was submitted to the in charge of the HF for signature. CHASS Niassa will continue to monitor implementation and to provide support to sites following handover. Data validation began in CS Cuamba in March 2015 and should be completed early next quarter.

The need for a system that can manage HIV patients and produce regular reports, including monthly summaries, is clear to both CHASS Niassa and DPS. DPS has identified key staff of DPS-NEP to work on the SESP implementation team and is asking more for the expansion of SESP to additional sites. The pilot will be complete by the end of June in the four initial sites and expansion will begin at that time.

Two CHASS Niassa staff and one DPS staff (with support from CHASS Niassa) attended the OpenMRS Conference in Maputo in from 27 January to 1 February. This provided an opportunity to exchange information with other users and learn from their experiences. It also served as a means to build support for OpenMRS rollout within DPS.

Data Review Meeting

A data review meeting was held 20-21 February 2015 in Lichinga at which time the technical team presented data to the entire CHASS Niassa team, results were discussed, and planning for the next period was done based on the data. Continued support is needed to strengthen the skills of the team in analyzing and presenting their data; support will be provided through feedback on presentations and training sessions incorporated into review meetings.

Routine Support Activities

Routine activities were undertaken at all levels, with focus on ensuring consistency of data and validity of data 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 25 HFs (see next section), and corrected the existing problems through on-the-job support to the HF clinical staff. At the district and provincial levels, the M&E team supported DPS to crosscheck the data entered to correct transcription errors. They, along with the technical team, also continue to give feedback and mentoring on problems in recording and aggregation of data by clinicians.

In addition, team members attended various meetings and trainings at the provincial and national level and participated in the development of POPs for OpenMRS data verification and GBV tool development.

Data Validation

In Q2 of FY2015, the CHASS M&E staff, along with their counterparts from DPS, validated data in a total of 25 facilities (37% of all facilities), focusing on MCH data. The number of facilities validated this quarter was lower than last quarter due to the intensive data collection efforts for

SAPR during the latter part of March and April. Priority was given to high volume sites and sites identified as having data quality issues in past quarters. Not all sectors were assessed in all facilities because not all facilities offer all services and, again, because sectors with data quality issues were prioritized.

Overall, approximately 28% of sites assessed had one data validation in the quarter, 20% had 2 validations, and 52% had 3 validations, an improvement from last quarter when 68% had only one validation. The team used a standardized tool to compare the data reported in the monthly summary to a recount of the data in the registers. The average number of indicators with variance above 5% ranged from 5.86% for post-partum care (n=21) to 20.65% for FP (n=22). In all but one of the areas assessed (pre-ART and ART), more than 40% of the facilities assessed had no differences between the source data and the monthly summary. Similarly, at the facility level, when looking across all areas assessed, 10 of the 25 facilities assessed averaged no more than 5% of indicators with variance above 5% while 5 of the 25 had more than 20% of indicators with variance of 20% or more.

On the whole, these results continue to support that the maternal and child health data are reasonably consistent between the original source documents and the monthly summaries. Again, certain facilities stood out for both high levels of consistency between reported data and original sources while others lagged behind. In particular, CS Lichinga, Namacula, Cobue, Marrupa and Mucaiacaia had high levels of errors. Sites with data quality issues will continue to be prioritized next quarter, with a particular focus on the priority sites.

Project Database

This quarter CHASS Niassa M&E staff held a day long training for the three implementing agencies to introduce them to the new DHIS2 database and to train them to enter their data. Tools for community data collection and aggregation were reviewed and the partners received hands-on training in using the database so that they could enter all of their data for the quarter into the database. CHASS Niassa continued to make improvements to the DHIS2 database, incorporating data consistency checks and revising some of the forms to facilitate data capture.

Cohort Data Collection

Training for Cohort Data collection for SAPR15 was held from March 11th to 13th in Lichinga. Members of the technical and M&E teams received refresher training on the process of data collection, the criteria for inclusion, the definitions of patient status, and use of tablets. This was followed by a 1-day practicum at Namacula health center to ensure that the software was functioning properly and to provide feedback to the team on their work. Improvements were made to the data collection program this round, including additional checks for data inconsistencies. Data collection began on 16th of March and continued into April. For this round, CHASS Niassa implemented a data review process to assess and strengthen data quality. A sample of entries were reviewed against the clinical files by team supervisors during the first

week of data collection to assess data quality and provide feedback to the data collectors, especially to those with high error rates. Overall, the error rate averaged 6%. The process for locating files was refined during this round and standard operating procedures are being developed to ensure a consistent approach across teams.

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 strategic information (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, three M&E officers and two 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, sexually transmitted infection diagnosis and treatment, ARV 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 TA 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 TA that addresses nutritional needs (Nutrition assessment, counseling and support) and the implementation of the MoH's NRP in the province. The project is collaborating with the World Food Program in the acquisition and distribution of the fortified supplement CSB in selected heath 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 *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. It 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 H2H groups to increase retention and male access in care.

Implementing Partners (ARV, CCM, CISLAMO): These local NGOs/Community-based organizations 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

As noted in the last report, CHASS Niassa is concerned about the effect of its new TA strategy on sites that receive less support. With SAPR and reporting requirements, it has not been possible to analyze results by level of support but we will do this in the following weeks and provide feedback to USAID.

In PMTCT, universal uptake of Option B+ remains a challenge with 80% of women accepting Option B+ this quarter. As noted above, CHASS Niassa will work with providers to ensure correct knowledge of Option B+ to improve uptake and will strengthen the skills of nurses to convince women to use Option B+ instead of Option A.

Now that EPTS has been handed over to HPL and will soon be handed over the HRC, the challenge is to ensure that the facilities continue to support the system with quality. CHASS Niassa, with DPS, will monitor progress at these sites and provide ongoing TA to both the facilities and DPS.

With regard to community activities, there are two key challenges. The first is to address the decline in the success of *Busca Activa* following the improvement at the end of 2014. CHASS Niassa will work with the IPs to implement a revised strategy in order to decrease the number of patients that cannot be located during the *Busca* process; special attention will be given to patients who are hard to reach. Second, CHASS Niassa will work with the IPs to ensure their understanding of the need to shift strategies in community HCT—from community-wide testing to targeted testing using the index case approach.

Upcoming Priority Activities

- Followup on the GAAC expansion plan following approval of the MoH and work with health facilities to implement GAACs
- Finalize the QIPs in laboratory, PMTCT and community and share the results of these activities
- Advocate with the reference laboratory in Nampula about the need to reduce the time taken to return test results

- Work with community IPs to strengthen their data collection and aggregation and validation processes
- Conduct EPTS validation at CS Cuamba and CS Lichinga in order to hand these sites over to HF management

ANNEXES

ANNEX 1 – Progress toward the Targets in CHASS Niassa from January to March 2015

Indicator	Annual Target	Q1 Results	% Achieved - end Q1	Q2 Results	% Achieved - end Q2
PMTCT ANC					
Number of health facilities providing MCH services that provide HIV testing and ARVs for PMTCT on site, ANC/ L&D settings	83	65	78%	65	78%
Number of unique pregnant women registered in ANC	42,848	15,613	36%	14,601	71%
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).	42,848	14,089	33%	13,862	65%
# women receiving an HIV tests (with results received) in a PMTCT setting - Repeat Test	18,343	2,304	13%	2,223	25%
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).	988	469	47%	518	100%
Number of HIV-positive pregnant women who received ARVs to reduce risk of mother-to-child-transmission, total, by regimen	970	449	46%	665	115%
Number of HIV-positive pregnant women in ANC who have initiated CTZ	-	439	-	478	-
Number of partners of women who are HIV tested in ANC setting	18,913	6,405	34%	6,870	70%
PMTCT L&D					
Total number of unique pregnant women registered in L&D	27,026	12,297	46%	11,340	87%
# women receiving an HIV tests & results in a PMTCT L&D setting	-	2,827	-	2,540	-
Number of pregnant women with known HIV positive status LD (includes women who were tested for HIV and received their results)	-	453	-	467	-
Number of pregnant women provided with antiretroviral prophylaxis in a PMTCT/ L&D setting.	-	407	-	449	-
Number of HIV-exposed infants who received ARVs to reduce risk of MTCT in L&D setting, (total/ by regimen)	764	363	48%	407	101%
Number of infants born to HIV-positive women who received an HIV test within 12 months of birth	1,601	536	33%		33%
PCR < 9 months	938	324	35%	449	82%
Rapid test 9 - 11 months	663	212	32%	235	67%
Children (<18months) born to HIV+ pregnant women who are started on CTZ prophylaxis within two months of birth	-	324		216	
FAMILY PLANNING					
Number of unique women registered in FP	-	27,113		12,026	
Number of women with known HIV positive status in FP	-	307	-	97	-

Indicator	Annual Target	Q1 Results	% Achieved - end Q1	Q2 Results	% Achieved - end Q2
Number of HIV positive women provided with at least one FP method-IUD	-	1	-	2	-
Number of HIV positive women provided with at least one FP method-Injectable	-	131	-	251	-
Number of HIV positive women provided with at least one FP method-Pills	-	139	-	84	-
Number of HIV positive women provided with at least one FP method-Other Methods	-	32	.-	23	-
COUNSELING & TESTING					
Number of service outlets providing counseling and testing according to national and international standards (CT Setting: Clinical)	67	65	97%	65	97%
Number of individuals who received counseling and testing for HIV and received their test results(CT setting: Clinical)	70,213	8,878	13%	10,398	27%
Number of individuals who received counseling and testing for HIV and whose results were HIV+ (CT Setting: Clinical)		759		861	
Number of service outlets providing counseling and testing according to national and international standards (CT Setting: UATS)	11	11	100%	11	100%
Number of individuals who received counseling and testing for HIV and received their test results(CT setting: UATS)	38,948	2,131	5%	2,121	11%
Number of individuals who received counseling and testing for HIV and whose results were HIV+ (CT Setting: UATS)		392	-	336	
Number of individuals who received counseling and testing for HIV and received their test results(CT setting: ATSC)	7,108	4,026	57%	5,941	140%
Number of individuals who received counseling and testing for HIV and whose results were HIV+ (CT Setting: ATSC)		74		273	
HIV care and treatment					
Number of health facilities that offer ARV treatment clinical services	46	46	100%	46	100%
Number of HIV-positive adults and children receiving a minimum of one clinical service	26,634	19,946	75%	19,963	75%
Number of adults and children with advanced HIV infection newly enrolled on ART	4,586	1,202	26%	1,097	50%
Number of adults and children with advanced HIV infection currently receiving ART, by sex, pregnant women	16,045	13,604	85%	13,801	86%
# individuals w/advanced HIV infection currently receiving ART (Enrolled in GAAC)	3,488	442	13%	423	12%
TB/HIV SERVICES					
Number of service outlets providing prophylaxis and or treatment for TB to HIV infected individuals (diagnosed or presumed.)	16	16	100%	17	106%
Number of TB patients registered during the reporting period	1,640	460	28%	391	52%

Indicator	Annual Target	Q1 Results	% Achieved - end Q1	Q2 Results	% Achieved - end Q2
Number of HIV infected individuals attending HIV/AIDS care/treatment services also treated for TB disease	-	78	-	283	-
Number of TB patients who had an HIV test result recorded in the TB register	1,607	339	21%	215	34%
# HIV Positive TB (co-infected) patients with test result recorded in TB register	964	195	20%	158	37%
Number of HIV-infected TB patients in the TB sector who have initiated CTZ prophylaxis	935	252	27%	158	44%
Number of HIV-positive TB patients who have started ART	820	257	31%	130	47%
GBV					
Number of health facilities with GBV services available	16	16	100%	16	100%
Number of people receiving post-GBV care: Post-rape	150	42	425%	30	849%
Number of people receiving post-GBV care: Other post-GBV care		596		606	
NUTRITION					
# of PLHIV that were nutritionally assessed and found to be clinically undernourished	3,995	154	4%	613	19%
Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	1,998	123	6%	613	37%

ANNEX 3 – Details of Trainings Held by CHASS Niassa

Technical Area	Nr. Facilitators	Target	Nr. of Participants	Dates	Place of training	Observations
Pharmacy						
Pharmacovigilance training and hospital committee	**3**	**Doctors and Pharmacy Technicians**	**35**	**18 March**	**Cuamba**	
HSS						
New procedure of financial Management - Provincial Level	**4**	**Administrators**	**36**	**23 to 27 March**	**Cuamba**	
GBV						
Integrated Service Protocol victim of Violence	**4**	**Doctors**	**32**	**23 to 27 March**	**Lago**	
LAB						
PIMAS	**4**	**Lab Technicians**	**8**	**16 to 18 March**	**Mandimba**	
NUTRITION						
PRN	**7**	**Doctors, General Technicians for Medicine, General Nurses and MCH Nurses**	**30**	**16 to 20 March**	**Lichinga**	
TOTAL	**22**		**141**			

ANNEX 2 – DPS Sub Agreement Financial Execution

Description	Total Budget Year 01/10/2014-31/09/2014)	Accrued Expenses Out/14-March/15	Balance	%
I. COSTS INCURRED BY THE SUBAWARDEE				
Subtotal : Pre service	2.550.000	765.000,00	1.785.000,00	30%
II. COSTS INCURRED ON BEHALF OF THE SUBAWARDEE				
Subtotal : Equipment	1.280.000,00	-	1.280.000,00	0%
Subtotal: Travel/TA and Integrated Visits	3.358.650,00	1.936.903,80	1.421.746,20	58%
Subtotal: Office expenses	318.800,00	159.855,84	158.944,16	50%
In-service Training for health workers	5.887.215,00	1.649.661,00	4.237.554,00	28%
Subtotal : Institutional support	6.647.680,00	852.407,42	5.795.272,58	13%
Subtotal: Infrastructure/Rehabilitation	2.622.601,00	354.180,72	2.268.420,28	14%
Subtotal :Public Health and meeting support	479.400,00	138.570,70	340.829,30	29%
Subtotal : Printing	2.760.190,00	190.600,00	2.569.590,00	7%
Subtotal: Master degree scholarship	1.296.000,00	936.000,00	360.000,00	72%
Subtotal : Direct Support to the districts	5.370.000,00	922.920,67	4.447.079,33	17%
GRAND TOTAL	**32.570.536**	**7.683.695,15**	**24.664.435,85**	**24%**

ANNEX 3 – CHASS Niassa Financial Expenditures Up to March 2015

Organization Name: Family Health International
Cooperative Agreement No.: 656-A-00-10-00113-00
CHASS- Niassa
Date of submission: 4/27/15

Item	Total Estimated Amount (LOP)	Total Obligated Amount	Total actual Expenditures from August 1, 2010 - 28th March 2015	Projected Expenditures for April 2015	Total Actual Expenditures Plus Projected Expenditures	Remaining Obligation Balance
Personnel & Consult	7,330,847		6,448,323	125,000	6,573,323	
Fringe Benefits	2,090,032		1,661,356	50,000	1,711,356	
Travel and Transportation	3,060,960		2,906,968	55,000	2,961,968	
Equipment	818,403		848,050	0	848,050	
Subrecipient & Grants	6,955,384		5,803,779	375,000	6,178,779	
Other Direct Costs	5,999,954		5,631,122	60,000	5,691,122	
Subtotal Direct Costs	26,255,579		23,299,596	665,000	23,964,596	
Indirect Costs	6,495,569		5,947,393	192,850	6,140,243	
Total Award costs	32,751,058	31,687,070	29,246,989	857,850	30,104,839	
Cost Share	3,232,265					
Grand Total US$	35,983,323	31,687,070	29,246,989	857,850	30,104,839	1,582,231

LOP Estimated amount	35,983,323
Obligated amount to date	31,687,070
Actual expenditure to 28th March 2015	30,104,839
Balance of obligation at 1th April 2015	1,582,231
Mean monthly spend last 12 months	538,157
# of Months as of April 1st 2015	2.94

TOTAL cumulative IA obligation	6,401,102
TOTAL Cumulative IA disbursement	5,893,510
Balance of IA Obligation	507,592