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CHASS Niassa

Agreement No. 656-A-00-10-00-113

FY2014 4th Year of the Project

3rd Quarter Report: April to June 2014



July 2014 (Revised Sept 2014)

This publication was produced for review by the United States Agency for International Development. It was prepared by Paultre Pierre Desrosiers and Staff through the Clinical HIV/AIDS Services Strengthening Project (CHASS Niassa) FHI360.

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ACRONYM LIST

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AOR	Agreement Officer's Representative
ARV	Antiretroviral
ART	Antiretroviral Therapy
CCR	Consulta da Criança de Risco (high-risk consultation for children)
CD4	Cluster of Differentiation 4
CHASS	Clinical HIV/AIDS Services Strengthening Project
CHASS N	Clinical HIV/AIDS Services Strengthening Project, Niassa
C-HCT	Community Counseling and Testing
CCM	Community Case Manager
CMAM	Central de Medicamentos e Artigos Médicos (Center of Medicines and Medical Supplies)
CS	Centre de Saude (health center)
CSB+	Corn Soy Blend Plus
CTZ	Cotrimoxazole
DBS	Dried blood spot testing
DPMAS	Direcção Provincial da Mulher e da Acção Social (Provincial Department of Women and Social Action)
DPS	Direcção Provincial da Saúde (Provincial Health Directorate)
EID	Early infant diagnosis
EPTS	Electronic Patient Tracking System
FANTAIII	Food and Nutrition Technical Assistance (FANTAIII) project
FAST	Finding, Actively, Separating Safely, and Treating Effectively strategy
FILAs	Folha Individual de levantamento de ARVs
FOGELA	Fortalecimento da Gestão Laboratorial para Acreditação
FP	Family planning
GAAC	Grupo de Apoio para Adesão das Comunidades (Community adherence support groups)
GBV	Gender based violence
HCT	HIV Counseling and Testing
HF	Health Facility
HIV	Human Immunodeficiency Virus
HP	Hospital Provincial (provincial hospital)
HPL	Hospital Provincial de Lichinga (Provincial hospital of Lichinga)
HR	Human Resources
ICP	Infection Control Program
IP	Implementing partner
IUD	Intrauterine device
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MOH	Ministry of Health
MTCT	Mother-To-Child Transmission

NRP	Nutrition Rehabilitation Program (Programa de Reabilitação Nutricional)
PCC	USAID Community Care Program
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PICT	Provider Initiated Counseling and Testing
PIMA	Point of Care technology for CD4
PLHIV	People living with HIV
PMTCT	Prevention of Mother-To-Child Transmission (of HIV)
QIP	Quality improvement project
SAAJ	Serviço Amigável do Adolescente e Jovem (Youth and Adolescent Friendly Service)
SDSMAS	District Health, Women and Social Action Services
SIFo	Sistema de Informação Para Formações
SIMAM	Sistema Infomatizado de Gestao de Medicamentos
SMT	Sofala, Manica and Tete
TB	Tuberculosis
TDA	Tratamento da Desnutrição em Ambulatório (Outpatient Treatment of Malnutrition)
TDF	Tenofovir
TDI	Tratamento da Desnutrição no Internamento (Treatment of Malnutrition in Internment)
TSV	Technical Support Visit
UATS	Unidade de Aconselhamentos e Testagem para a Saúde (Health Counseling and Testing Unit)
USAID	United States Agency for International Development
WFP	World Food Program
WHO	World Health Organization

LIFE OF PROJECT SUMMARY

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

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

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

Actual Expenditures Through this Quarter: \$24,504,308

Current Pipeline Amount: \$2,666,080

Projected expenditure April 2014 to June 2014: \$1,710.548

Geographic Focus: Niassa Province, Mozambique

I . EXECUTIVE SUMMARY

Summary of Progress this Quarter

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

Key achievements for this quarter included:

- Expansion of community counseling and testing to one additional district, Cuamba
- Introduction of a new data collection system for nutrition screening which resulted in an increase in reporting and substantial increases in the number of HIV+ children provided with nutrition services
- Creation of two new district committees for gender based violence and two new men to men groups, in Lago and Metarica
- Improvement in the availability of drugs, in part due to early identification of stockouts by CHASS Niassa and immediate efforts to resolve these stockouts
- Completion of retrospective data entry into the electronic patient tracking at the Provincial Hospital in Lichinga and entry of data at the Lichinga Health Center

Key Indicators

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

HTC

- 32% increase in testing done at the health counseling and testing units (UATS)
- 90% of HIV+ clients referred from community HCT received care and treatment services

PMTCT

- 92% of HIV+ pregnant women provided with ARV prophylaxis

- The percentage of ANC clients initiating ART who initiated Option B+ increased from 24% in quarter 2 to 60% in quarter 3
- 62% of the HIV+ women were provided with CTZ prophylaxis in ANC
- 85% of HIV-exposed children provided with ARV prophylaxis in maternity wards
- 100% of HIV-exposed children registered in the CCR started cotrimoxazole prophylaxis

ART

- 1,422 new patients (125 children) initiated ART which is the same number as in the previous quarter, achieving 138% of the set target

TB/HIV

- 545 new TB patients registered, achieving 101% of the annual target
- 96% (522) of registered TB patients knew their HIV status
- 37% of registered TB patients were HIV positive; all of them received a CTZ prophylaxis
- 87% of the HIV positive newly registered TB patients initiated ART

GBV

- 497 (247 males and 250 females) individuals were screened for GBV
- Eleven (females between the ages of 0 and 24 years) were identified as victims of sexual violence and one female was identified as a victim of severe physical (non-sexual) violence
- 100% of the victims of sexual violence were tested for HIV; they all tested negative and 100% received PEP
- The two females over age 10 who were victims of violence received emergency contraceptives

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 Directorate for Health (DPS) in efforts to prevent, care for, and treat people living with (PLHIV) in Niassa and is implementing critical programmatic, and advocacy initiatives aimed at eliminating HIV infections and supporting HIV-positive children, mothers, and families. In collaboration with our international and local implementing partners (IPs) and the DPS, the project works directly with individual districts to implement a broad range of HIV/AIDS services that focus on:

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

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

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

III. PROGRESS REPORT

The majority of activities scheduled for this reporting period were completed or underway by the end of the quarter. CHASS Niassa's work activities included: finalization of modifications for all sub-awardees; supporting the implementation of HIV acceleration plan and MTCT elimination plan at provincial and district level; provision of extensive technical assistance to 65 HFs, 16 districts and DPS staff and local IPs; convening a Program Management Meeting and Quarterly Review Meeting with CHASS Niassa staff and partners; expansion of universal access for patients co-infected with TB/HIV and under five children infected by HIV; expansion of the program to increase the uptake of ARV, PMTCT/Option B+, HCT, the one-shop-model and creating linkages to increase access to treatment, care and support for people living with HIV/AIDS (PLWHA). Regarding M&E, the quarter brought a new focus on data use now that data quality efforts are moving forward and progress was made in the roll out of eSaude, the electronic patient tracking system (EPTS). In addition, the program continued to strengthen its partnership and consultations by participating in the U.S. Government (USG), MISAU 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.

HCT Service Expansion

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

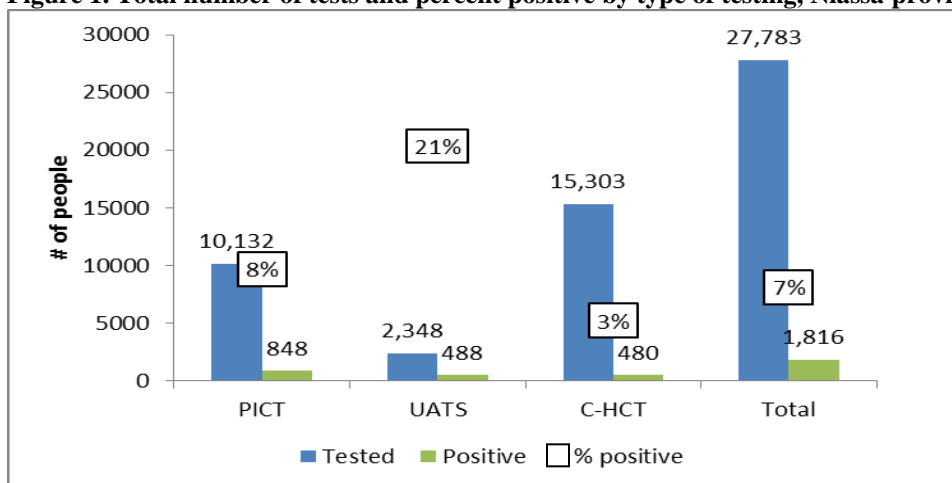
As of the end of June 2014 CHASS Niassa had facilitated the expansion of C-HCT to five districts, with Cuamba added in the last quarter. In addition, CHASS Niassa has supported expansion of UATS, from the initial four to eleven currently providing these services (HP Lichinga, CSC Lichinga, CS Namacula, CS Chiuaula, CS Marrupa, CS Metangula, CS Massangulo, CS Mandimba, CS Cuamba, HR Cuamba, and CS Mecnhelas). No new UATS facilities were added this quarter. The expansion process involved:

1. HCT Units (UATS):
 - Identification of offices within the HFs to provide services
 - Capacity building of new lay-counselors and refresher training to the health staff

- Distribution of registers and support in monthly data reporting
2. Community HCT:
- Selection of districts, based on population and HIV prevalence
 - Selection of IPs, based on previous experience with C-HCT
 - Training of new lay-counselors to provide the service
 - Strengthening linkages between IPs and the district health offices to ensure timely availability of HIV tests
 - Continuous technical support visits (TSVs) to the IPs

During quarter three a total of 2,348 people were tested in UATS at the 11 facilities providing these services¹, 202 of them (8%) were children under age 15 years. A further 15,303 were counseled and tested in C-HCT, 3,127 (20%) of whom were children. Finally, 10,132 people were tested through PICT in various service points, 1,733 (20%) of whom were children. The percentage of patients who were positive was 7% but ranged from 3% at C-HCT to 21% at UATS (Figure 1), the same pattern seen in the last quarter when the percent positive was highest among those tested in UATS and the majority of HIV positive patients were identified through PICT. The percent positive among children ranged from 3% in HCT settings to 11% in PICT.

Figure 1. Total number of tests and percent positive by type of testing, Niassa province, April to June 2014

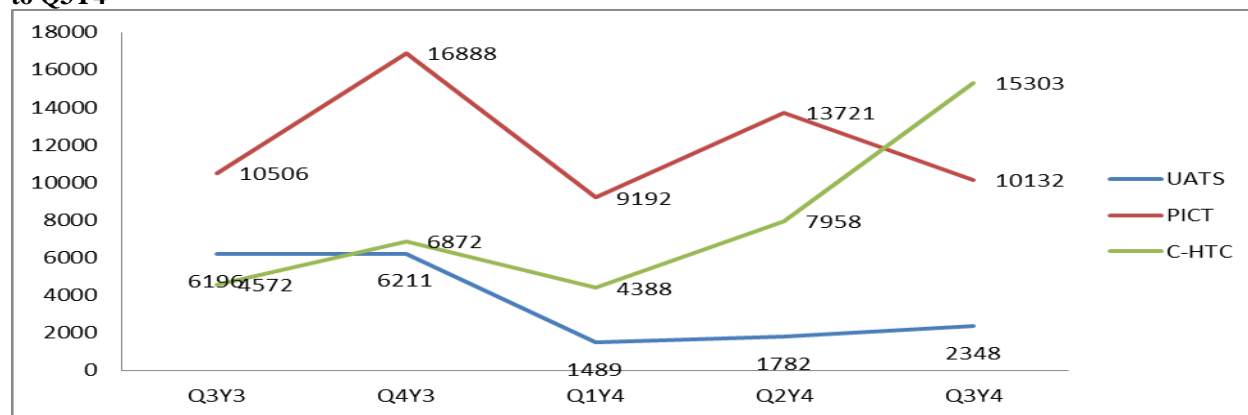


Since the beginning of year four, the number of individuals tested in UATS has increased slightly, after a decrease in the third quarter of year 3 (Figure 2). This earlier decrease resulted from the separation of testing in the Youth and Adolescent Service (SAAJ) from UATS; SAAJ was included in PICT in order to comply with the President’s Emergency Plan for AIDS Relief (PEPFAR) definition of PICT. With regard to PICT, the number of people tested has fluctuated regularly due to semi-annual data cleaning exercises. However, C-HCT has increased

¹ Note: The number of facilities providing UATS was misreported in the last quarter as 12 facilities.

consistently over time, with the most significant increase being observed in the last quarter (the number tested almost doubled the previous quarter's results) as a result of both the expansion in sites noted above as well as special campaigns organized during the quarter to respond to the challenges imposed by the short validity of the test kits available in the province. The increases in both UATS and C-HCT contributed to reaching 64% of the annual target in UATS, and surpassing the annual target in C-HCT. With regard to PICT, the total number of people tested is only 32% of the annual target.

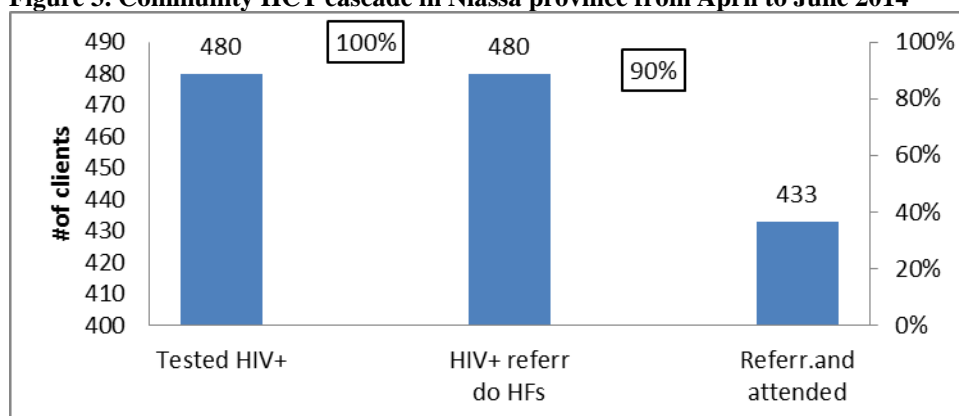
Figure 2. Number of people receiving HIV counseling and testing in Niassa province, by type of testing, Q3Y3 to Q3Y4



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

A total of 15,634 people were counseled about HIV testing and 15,303 (98%) were tested in C-HCT settings (7,129 males, 8,174 females). Among people tested in these settings, 3% (480; 201 males and 279 females) tested positive. Ninety-eight percent of those who tested positive in C-HCT were successfully referred to a health facility (Figure 3), with 90% of them (433; 172 males and 261 females), reaching a health facility in the province. CHASS Niassa is exploring the reason that 10% of patients who are referred from C-HCT did not reach a health facility and will develop mechanisms to address the situation of the patients who did not reach the HF. Active case finding is undertaken to follow up these patients.

Figure 3. Community HCT cascade in Niassa province from April to June 2014



Prevention of Mother to Child Transmission (PMTCT) Support Activities

During this quarter, the project continued to promote access to PMTCT services and strengthen linkages for pregnant women and their HIV-exposed infants to care and treatment at 65 HF's 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 HF's.

In Niassa, because the introduction of Option B+ is gradual, ARV prophylaxis in PMTCT is still partially provided under both Option A, although universal use of Option B+ is the goal. Implementation of Option B+ began in July 2013, followed by introduction and expansion of Tenofovir (TDF)-based Option B+ in all 46 HF's with antiretroviral therapy (ART) services.

Achievements in quarter three indicate a total of 15,334 women newly registered in antenatal care (ANC), 13,354 (88%) of whom knew their HIV status. The percentage of HIV-positive women among those with known positive status or tested HIV+ was 4.9% (661). Coverage of ARVs among HIV+ pregnant women was 92% (607), whilst coverage of cotrimoxazole (CTZ) prophylaxis was 62% (413) among this group (Figure 4). Among the women provided with ARV prophylaxis, 362 (60%) were on Option B+, a substantial increase from 24% last quarter.

Implementing Option B+

The DPS, under recommendations from the MOH PMTCT program, expanded their ART public health program to test-and-treat for pregnant and breastfeeding women, who are now all eligible for lifelong treatment, whatever their CD4 count or clinical stage. After a positive HIV test, women receive efavirenz/tenofovir/3TC – a regimen that will soon become the standard adult first line regimen in Mozambique.

Option B+ implementation began in July 2013 and required the decentralization of ART into all ANC facilities, resulting in rapid expansion from 5 to 46 sites in Niassa. It also required training of all health care workers who provide PMTCT services; CHASS Niassa supported the training 57 of these providers and DPS has trained the rest. Prior to implementation of Option B+ many pregnant women still received only single dose nevirapine prophylaxis at most ANC sites.

Routine ANC and ART data are collected during quarterly TSV, which include validation of reports from primary patient records.

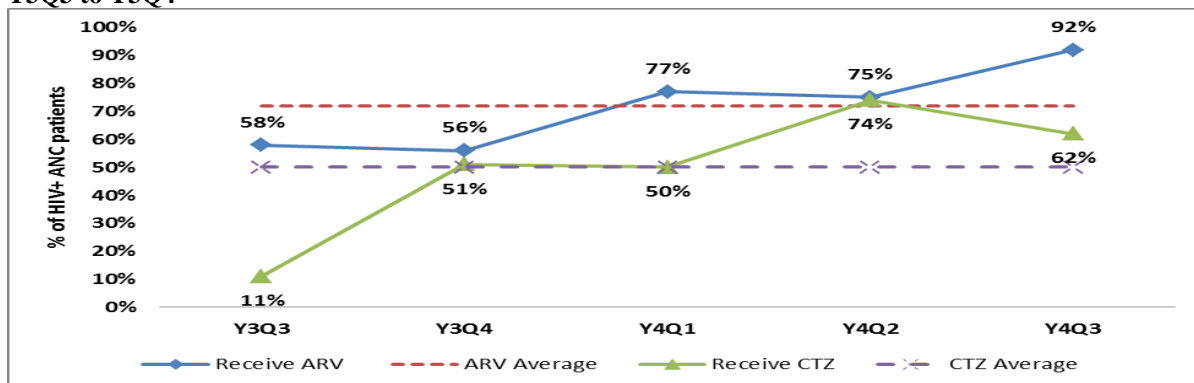
The number of new patients starting treatment increased rapidly from 13% in the first few months of the program to 60% in the third quarter of 2014. The total number of women receiving any antiretrovirals during pregnancy increased to 92% from 69% in the last quarter of 2013. This was a 33% increase in antiretroviral coverage of known HIV-positive pregnant women.

Several key recommendations to support the project PMTCT interventions:

- Reduce the number of women who do not start ART during pregnancy.
- Continue to monitor and support PMTCT coverage and retention on ART, including reasons for lack of uptake and loss to follow up.
- Examine family and community influence on the sustained high ART initiation during the breast feeding period
- Document maternal and infant outcomes.
- Document the public health impact of Option B+.

Analysis over the past five quarters (from third quarter of year 3) shows that the coverage of ARV prophylaxis continued to increase, reaching 92% coverage in this quarter (Figure 4), and contributing to further surpassing the annual target. This level of coverage (92%) is just below the PEPFAR target of 93%. This continued increase could be related to the improvements in the availability of ARV drugs, strengthening of the one-stop-shop model in ANC, together with improvements in data quality.

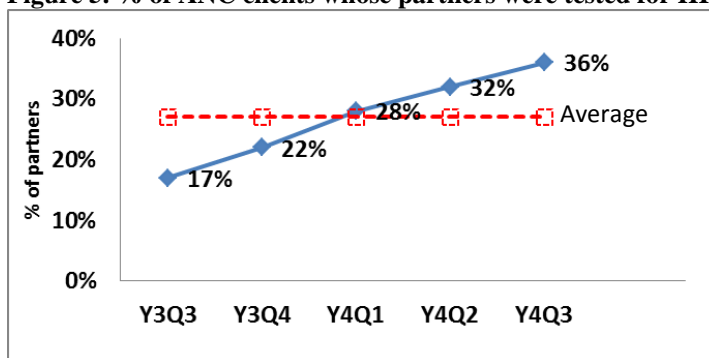
Figure 4. Changes in ART and CTZ coverage among ANC and maternity clients in CHASS Niassa sites, Y3Q3 to Y4Q3



Performance over the past five quarters shows that as with ARV prophylaxis, CTZ prophylaxis has increased over time (Figure 4), although there was a decrease this quarter, possibly due to the irregular availability of CTZ in HFs. Between May and June, the quantity of CTZ distributed was below the needs in the province; CHASS Niassa is working with DPS to strengthen the capacity of facilities to predict demand and to improve the and distribution of CTZ.

Male involvement was another area of improvement during this quarter. Of the 15,334 women registered in ANC, 5,569 brought their partners, who were tested for HIV, corresponding to 36% of all women registered. Among them, 125 (2.4%) tested positive for HIV. This is the highest percentage covered in the past 5 quarters, which is consistent with the rising trend over the period (Figure 5). Innovative interventions that are likely contributing to this increasing trend include the strengthening of the mother-to-mother groups together with the involvement of community leaders in the sensitization activities. One approach that CHASS Niassa believes has contributed to this increase is the introduction of invitations for partners. When women come for their first ANC visit they are enrolled in a mother to mother group and at that time, they are provided with an invitation for their partner to come to their next ANC visit. Furthermore, in Niassa it is customary for men to accompany their partners to the facility, although they do not usually come for the one on one consultation. CHASS Niassa has worked with SMI nurses to hold daily meetings in the waiting area. During these meetings, partners are encouraged to attend the ANC consultation. Finally, CCMs and community leaders have been sensitized to the need for male involvement and actively encourage men to accompany their partners to ANC consultations. In the next quarter, the new men-to-men groups may also contribute to partner testing.

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

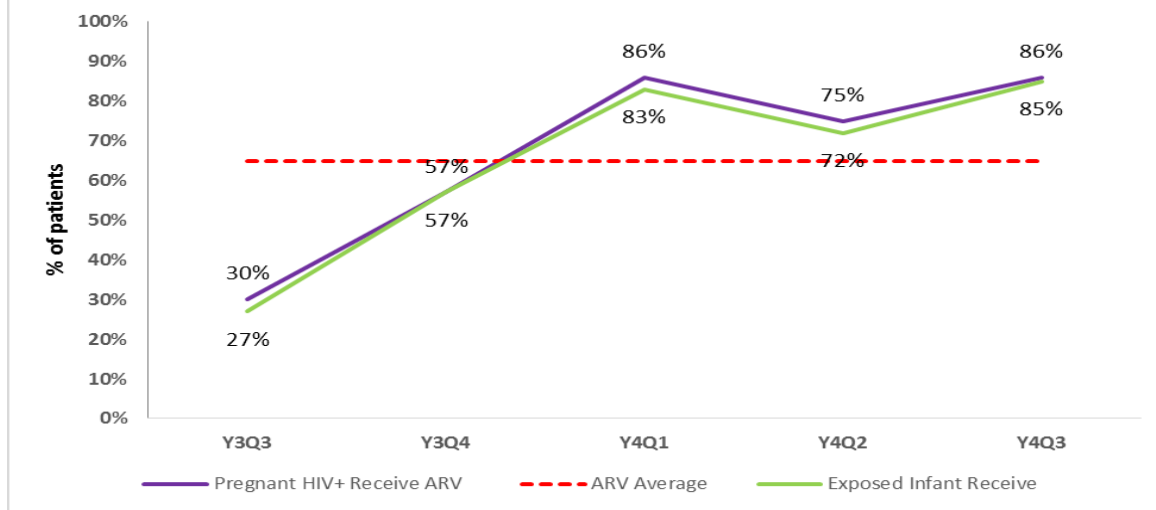


This quarter, 10,467 pregnant women were registered at the maternity ward, 3,302 women with unknown status, and of these 2,561 (78%) received HIV testing and their results. Women with unknown status who were not tested either refused to be tested or were not willing to disclose a prior result in the maternity. CHASS Niassa is supporting staff at HFs to provide improved and repeated counseling for women in maternities in an attempt to address this.

In total 373 (14%) of all women who were tested were found to be HIV+ and 322 (86%) of them were provided with a complete ARV course (Figure 6); 22 of these women initiated Option B+. Regarding ARV prophylaxis for exposed-infants, a total of 317 (85%) exposed infants were covered.

The overall trends for both ARV prophylaxis for pregnant and exposed infants show increases over time (Figure 6). This has contributed to reaching the annual targets for both groups. Routine reviews of documentation by CHASS Niassa and DPS technical staff could have contributed to this good performance.

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



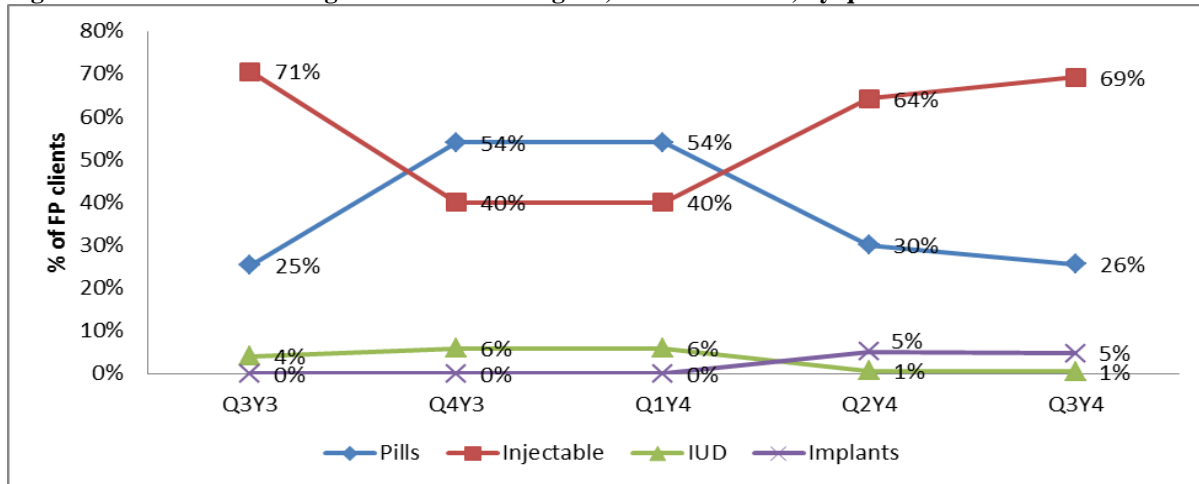
Implementation of Option B+ remains a major challenge for PMTCT in the province. The HF's in the province lack the capacity to perform biochemistry analysis, there is still a noticeable proportion of pregnant women refusing to adhere to the program, and some HF staff have misinterpreted the new ministry of health (MOH) guideline regarding Option B+ and are presenting the options as long- and short-term options without fully discussing efficacy, assuming Option A and Option B+ are equivalent choices. To address this, CHASS Niassa is working, in collaboration with DPS, to intensify on-the-job training for maternal and child health (MCH) nurses and increase involvement of the community case managers (CCMs) and community leaders in the sensitization of communities about the importance of Option B+.

Family Planning (FP)

With regard to family planning activities, a total of 20,154 women had their first consultation, 12,551 (62%) with unknown HIV status, of which 7,477 (60% of the women with unknown HIV status) were tested for HIV, and 104 (1%) tested positive. Of this number, and as an extension of the reach of Option B+, 15 HIV+ women (14% of those who tested HIV+ at FP consultation) initiated ART in FP, while the others were referred to HIV services to be enrolled in HIV care.

In total 419 HIV+ women (including 315 women with known HIV+ status at entry) were followed at FP consultations and 399 (95%) received a FP method (276 injectables, 102 pills, 19 implants, and 2 an intrauterine device (IUD)). This rate of uptake is similar to that in most past quarters. The method mix has, however, changed over time with a shift from pills to injectables over the course of the past year (Figure 7). The shift is likely the result of a change in the MOH guidelines which allows for provision of injectables to young women, something that had not been allowed in the past.

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



Challenges in FP include the integration of FP into HIV care and treatment services as well as low levels of HIV testing for women in FP, in part because testing in MCH has been prioritized and in part because FP workers have heavy workloads which creates a challenge for introducing a new service like HIV testing. CHASS Niassa and DPS are piloting this integration in two HFs (CS Lichinga and CS Mandimba) as a preparation for rollout of the strategy to other HFs in the next fiscal year. At this time, the FP approach does not include a community component but this is being considered for the future.

To improve performance in family planning, CHASS Niassa and DPS will train general medicine technical staff in every sector to provide FP methods, ensuring FP commodities are available in ART sites, and ensuring that ART sites have FP registers.

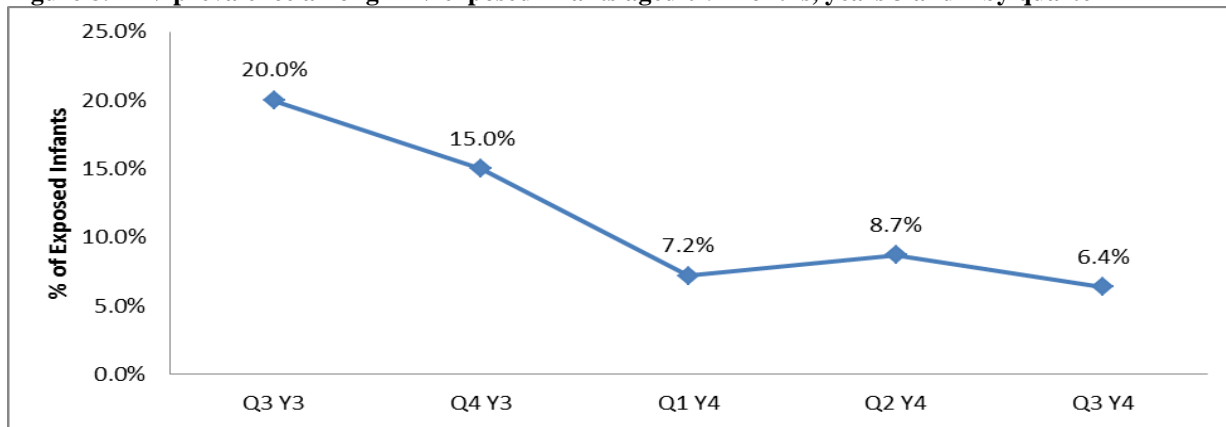
Early Infant Diagnosis Technical Support

The successful use of dried blood spot testing (DBS), and the effective transportation routine initiated by the CHASS Niassa project, increased the numbers of infants receiving early diagnosis and consequently improved early initiation of antiretroviral therapy (ART) for infants below 18 months of age.

During this quarter, 421 children exposed to HIV were registered in high-risk consultation (CCR). All of the HIV-exposed children initiated CTZ prophylaxis, 223 of whom were less than 2 months old. A total of 421 DBS samples (100% of children registered in CCR) were collected and sent to the Nampula lab for Polymerase Chain Reaction (PCR) testing, and in the same period, the province received 392 results back, with 25 (6.4%) testing positive for HIV. All of the children who tested positive were enrolled in ART.

As a result of the implementation of PMTCT in the province, the percentage of PCR results that are positive has decreased over time. Although the current level of 6.4% at the end of quarter 3 (Figure 8) is not representative of the general pediatric population in Niassa, the percent positive is encouragingly close to the mother to child transmission elimination target of less than 5%. This decrease is likely the result of improved PMTCT with decreased dropout along the PMTCT cascade, the introduction of Option B+ in the fourth quarter of Year 3 and improvements in the quality of collection and transportation of PCR samples.

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



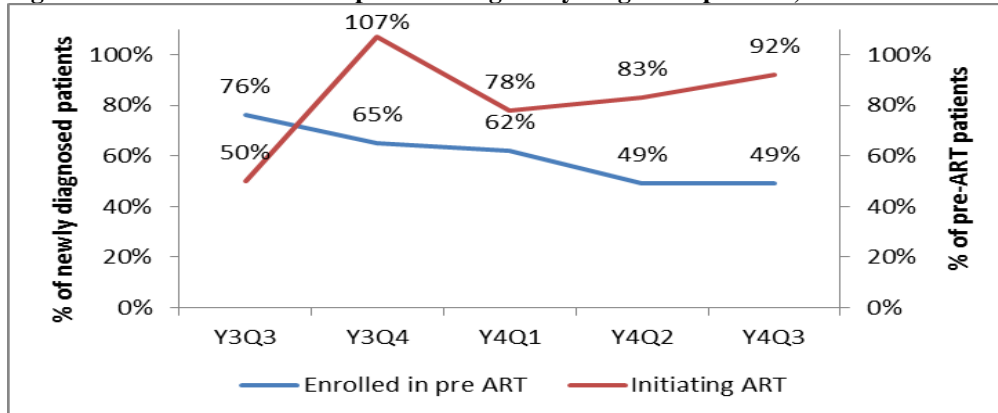
The major challenge in early infant diagnosis (EID) is ensuring that every exposed child returns to the HF within 4 weeks of birth to receive continued prophylaxis and to collect PCR samples. CHASS Niassa and DPS will use CCMs based at maternities to provide post-partum counseling and sensitization and to ensure that women know where to return for CCR and post-partum care. CHASS Niassa will also use the existing PCR web-based database to check and send results to the HFs. Another important challenge is making PCR results available on a timely basis. In addition to a recent assessment by Clinton Foundation, CHASS Niassa is developing a plan to collect data on the time it takes to receive PCR results.

Pre-ART Care and Treatment Technical Support

During the quarter a total of 3,168 patients tested positive in all testing points (848 in PICT, 480 in C-HCT, 488 in UATS, 1,156 in PMTCT services, and 196 in tuberculosis (TB) sector). Of those testing positive, 1,541 (49%) patients were enrolled in pre-ART services, 1,422 (92%) of them were newly enrolled in ART while 119 (8%) of those who started pre-ART did not start

ART. Fifty one percent of positive patients did not receive care or treatment (see below for discussion). Over the past five quarters, the proportion of pre-ART patients initiating ART has increased, despite a decrease observed in the first quarter of year 4 (Figure 9). This positive trend is contributing to meeting the targets for the year and is the result of the expansion of universal access to ART.

Figure 9. Pre-ART and ART uptake among newly diagnosed patients, CHASS Niassa sites, Y3Q3 to Y4Q3



The challenge continues to be in the proportion of HIV positive patients who enroll in pre-ART, with only about half of all patients enrolled. Over the past five quarters, this has decreased continually although there was no change in the most recent quarter (Figure 9). In the province, testing in blood banks and laboratories has intensified but they are open at night and during weekends and holidays, times when ART services are closed. This could result in challenges to enrolling these patients in care because they cannot be immediately referred to services. CHASS Niassa is working to ensure rapid post-diagnosis provision of prophylaxis and opening of clinical charts by the clinicians working in emergency rooms. To complement this, CHASS and DPS will build capacity of HF staff working in laboratories and blood banks to strengthen referral of these patients to the emergency care and treatment services as soon as they are diagnosed.

Adult Care and Treatment Technical Support

During this quarter, 1,422 new patients initiated ART (Figure 10), a number similar to that in each of the past four quarters. This contributed to exceeding the annual target of 2,919 (Figure 11). During the same period, the number of patients currently in ART was 12,268, which was above the target for the year, and the number of patients ever enrolled on ART was 16,103.

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

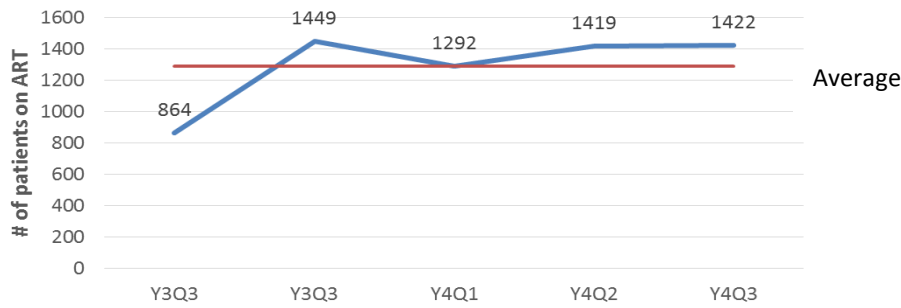
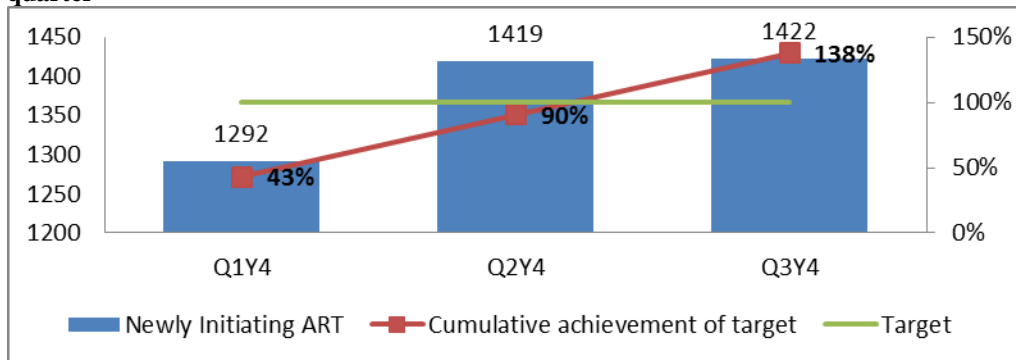


Figure 11. Achievement in number newly initiating ART against targets in CHASS Niassa sites, Y4 by quarter



Activities contributing to the positive results include the expansion of the number of HFs providing universal access to ART over time, as part of the MOH acceleration plan. Despite these results, the province continues to face challenges with the retention of patients in care, as the last estimates were below the previous results and below the PEPFAR targets for the retention rate (75%). CHASS Niassa and DPS are implementing home-visits, improving the process for creating lists of defaulted patients for active case finding, and are piloting ARV distribution in peripheral HFs without ART, all as strategies to improve retention. CHASS Niassa had planned to promote awareness among ART patients about the clinical meaning and danger of failure during this quarter, but that was postponed to coincide with a new initiative to implement psychosocial support as a means to ensure adherence and positive prevention. The new approach will integrate psychosocial support and positive prevention; all providers who provide care and treatment will be trained in the new MOH guidelines.

Ensuring compliance by all 46 HFs with the new guidelines from MOH that dictate a change in the treatment line to TDF was a priority action for this quarter. During the quarter, this activity was fully implemented for patients who had initiated in the last 6 months. In the next quarter,

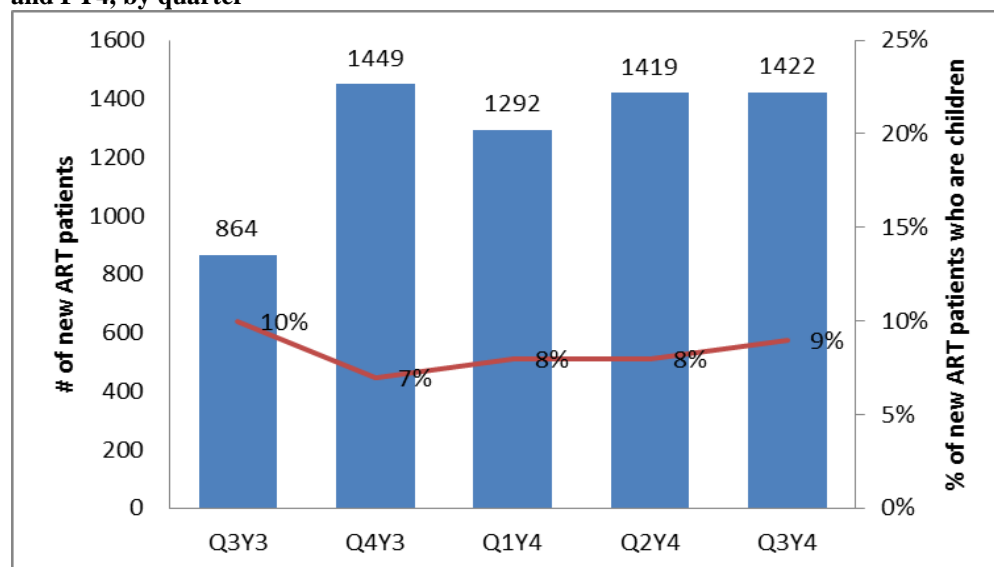
CHASS Niassa will work with DPS to implement the recent change in the guidelines, which dictates a change to TDF for all patients enrolled since January 2012.

Pediatric Care and Treatment Technical Support

During the quarter, 125 (64 males and 61 females) children were newly enrolled in ART, totaling 341 children enrolled over the first three quarters of year 4, which is 77% (341/445) of the set target for the year. If the province continues at this rate, it is likely to meet the annual target by the end of the fiscal year.

The main challenge facing pediatric care and treatment is the low proportion of children enrolled in ART compared to the total number of patients newly enrolled in ART. Over the past four quarters this proportion has been stable at around 8% (Figure 12), below the recommended 15%. This could be related to the low HIV prevalence among children in the province. Nevertheless, CHASS Niassa will intensify testing for HIV among children, including in triage, in-patient services, CCR, immunization, and wellbeing consultations.

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

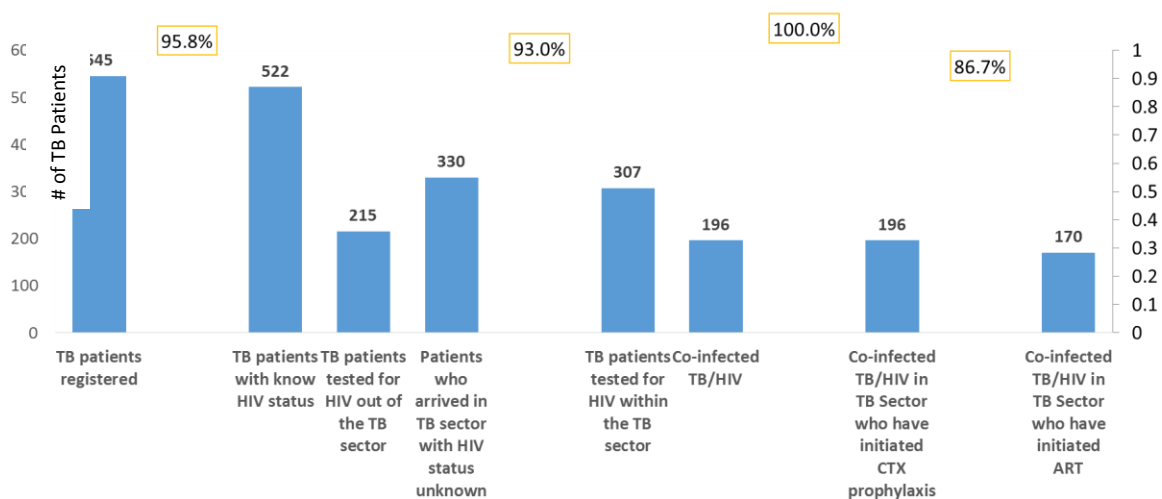


TB/HIV Co-infection Support Services

CHASS Niassa supports the implementation of TB/HIV services in a total of 17 HFs, specifically in HFs of the district headquarters (with 2 facilities in Lichinga). All the supported HFs are implementing the partial one-stop-shop model, with health staff trained in prescription of ARVs. In ART services, the full one-stop-model is being implemented. However, while almost all components of the model have been implemented in in TB services, the collection of samples in the TB room has not; this is part of current discussions between DPS and CHASS Niassa.

This quarter, 545 patients were registered in the TB sector, 115 (21%) of whom were children. Among these patients, 522 (96%) had known HIV status and 196 (37%) were HIV positive. All the co-infected patients were provided with CTZ prophylaxis, with 87% (170) on ART (Figure 13), exceeding the PEPFAR targets for both ART and CTZ coverage of co-infected patients. In terms of numbers, the province has thus far achieved 68% of the annual targets for CTZ prophylaxis of co-infected patients and 66% of the target for ART treatment of coinfecting patients. The province remains below target because the number of HIV+ coinfecting patients is lower than expected. For example, in each of the last two quarters just 37% of TB patients were HIV+ compared to the expected 60%.

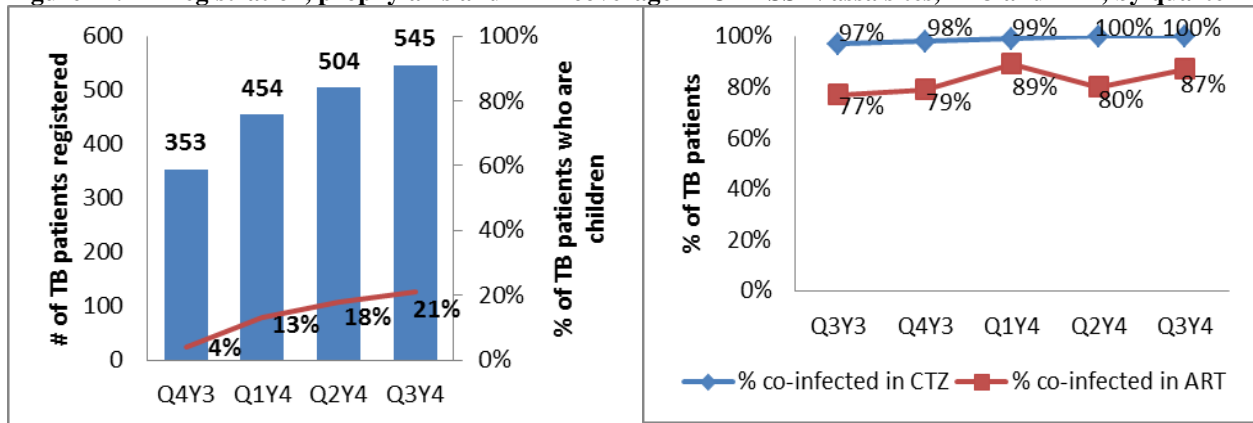
Figure 13. TB/HIV cascade in CHASS Niassa sites, from April to June 2014



The number of patients registered in the TB sector has increased continuously over the past four quarters (Figure 14) as has the proportion of patients registered in the TB sector who are children, which reached 21% at the end of this quarter. Coverage of CTZ has remained stable at between 97% and 100% over the past five quarters, while coverage of ARVs in co-infected patients has increased, despite a slight decrease last quarter (Figure 14).

The increase in the total number of TB patients registered is likely associated with refresher trainings of the TB focal persons provided by CHASS Niassa and DPS during TSVs. The involvement of traditional healers in the referral of TB suspect to HFs could also be contributing to these results. Moreover, the implementation of the pilot of the FAST (Finding, Actively, Separating Safely, and Treating Effectively) strategy could be another important factor driving the results.

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



Increasing the level of TB screening among HIV care and treatment patients continues to be a challenge in the province. Overcoming this challenge will involve training clinical staff, including the MCH nurses providing ART under Option B+, to screen and refer suspects of TB to the TB sector for diagnosis, followup and treatment (if appropriate).

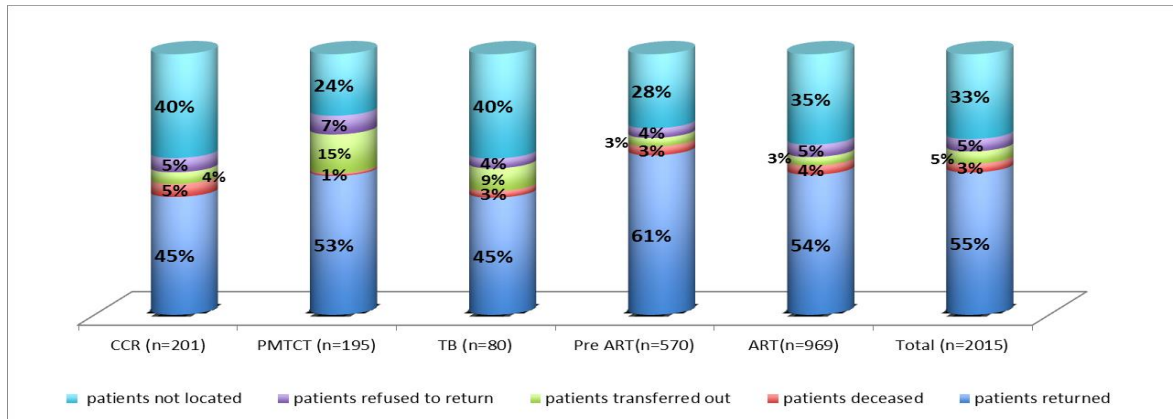
Adherence to Treatment and Retention in Care Technical Support

During the quarter, a list of 570 (258 males and 312 females) *defaulted* patients in pre-ART were delivered to the CCMs and C-HCT lay-counselors for tracing (132 or 23% of these defaulted patients were children), and 61% (349 patients, 161 males and 188 females) of these patients returned to treatment, 3% (19 patients, 10 males and 9 females) had died, 3% (19 patients, 5 males and 14 females) had transferred to other parts of the country, and 4% (21 patients, 9 males and 12 females) refused to return to treatment even after sensitization and counseling sessions for adherence (Figure 15). The remaining 28% (162 patients, 73 males and 89 females) could not be found at the addresses provided during pre-ART counseling sessions.

In ART, a total of 969 (356 males and 613 females) patients who *defaulted* treatment were delivered to CCMs for tracing, and 54% of these patients (521, 200 males and 321 females) returned to treatment (Figure 15), whilst the remaining patients had either died (4%, 34 patients, 19 males and 15 females), transferred out (3%, 32 patients, 12 males and 20 females), refused to return to treatment after sensitization (5%, 46 patients, 17 males and 29 females), or could not be located at the provided addresses (35%, 336 patients, 108 males and 228 females).

The percentage of defaulted patients who returned to care varied in other services. In CCR 45% (n=90) returned versus 53% in PMTCT (n=103) and 45% in TB (n=36). The percentage of defaulted patients that could not be located was 40% in CCR (n=80), 24% in PMTCT (n=47) and 40% in TB (32) but all of these groups have small numbers of patients so a small difference has a large impact on the percentage.

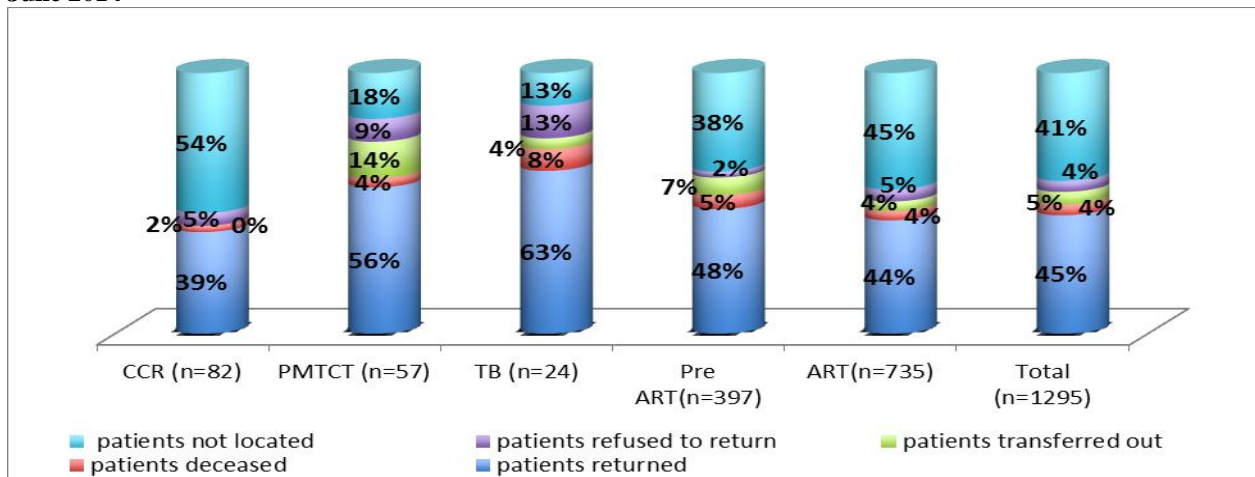
Figure 15. Outcome of patients who defaulted in CHASS Niassa sites, by type of care from, April to June 2014



With regard to efforts to ensure return of patients that *abandoned* pre-ART care, a list of 397 patients (173 males and 224 females) was delivered to the CCMs for tracing, and 48% (190 patients, 85 males and 105 females) returned to treatment (Figure 16). Among the remaining patients 5% were deceased (21 patients, 13 males and 8 females), 7% had transferred out (27 patients, 16 males and 11 females), 2% (9 patients, 4 males and 5 females) had refused to return to treatment, and 38% (150 patients, 55 males and 95 females) could not be located.

In ART, 735 patients who had *abandoned* treatment (310 males and 425 females) were listed and delivered to CCMs for active finding, of which 44% (320 patients, 132 males and 188 females) returned to treatment (Figure 16), with 4% (26 patients, 5 males and 21 females) having died, 4% (27 patients, 12 males and 15 females) transferred out, 5% (34 patients, 8 males and 26 females) refused to return, and 45% (328 patients, 153 males and 175 females) who could not be located.

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

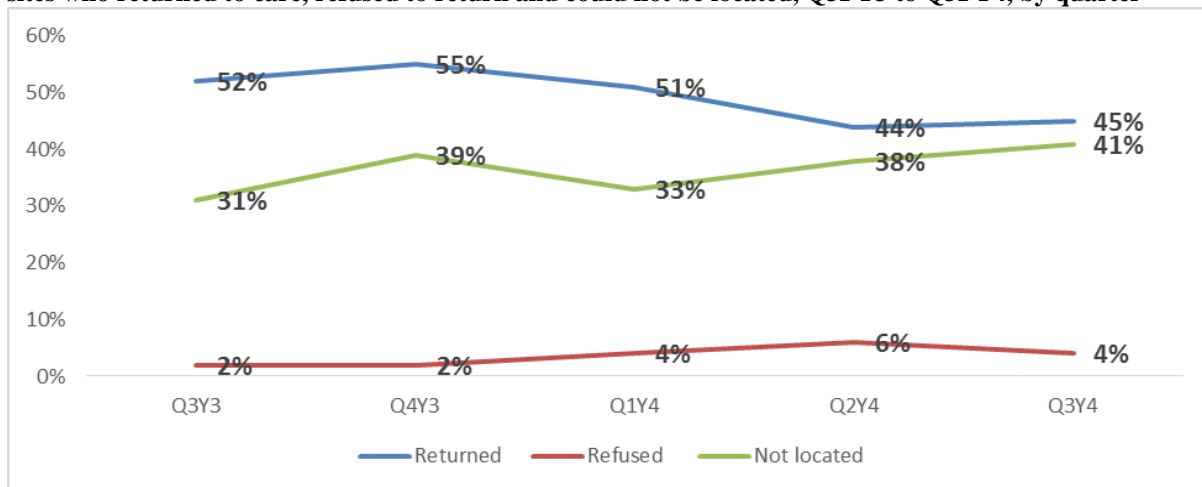


The percentage of abandoned patients returning was 39% in CCR, 56% PMTCT, and 63% TB. Among the abandoned patients, 54% in CCR, 18% in PMTCT, and 13% in TB could not be found.

Challenges in active case finding include the high proportion of patients who cannot be located, especially in CCR and ART. Information on the reasons for these high proportions remains anecdotal (e.g., inaccurate addresses and phone numbers). CHASS Niassa is preparing a protocol for an assessment that will document the accuracy of the lists and timeliness of listing as well as reasons patients are not found and reasons patients default. The protocol will be submitted to institutional review boards in Mozambique and the United States in August. In the meantime, CHASS Niassa and DPS are implementing home-visits just after diagnosis and improving the process for creating lists of defaulted patients for active case finding.

Over the past five quarters, among all defaulted and abandoned patients combined, the proportion of patients not located has increased, leading to a decrease in the proportion returned to care (Figure 17). Although the proportion not located has increased over the last three quarters, it has actually remained fairly constant over the past year. However, the lack of improvement was a key impetus for the assessment of Busca Activa that will be conducted next year. Among ART patients, the percentage that has not returned has declined steadily over the course of the year while the percentage of pre-ART patients that has not returned has been more variable although it has never returned to the high of 58% seen in the last quarter of year 4 (results not shown). The failure to increase the percentage of patients that return to care is a major issue.

Figure 17. Percentage of defaulted and abandoned patients included in active case finding in CHASS Niassa sites who returned to care, refused to return and could not be located, Q3FY3 to Q3FY4, by quarter



To improve performance on active case finding, CHASS Niassa is providing on-the-job training to CCMs to check the completeness of clinical charts of patients newly enrolled, specifically the demographic data (name, age, sex, place of residence, mobile number, and other relevant

information). In addition, CCMs will make an initial home-visit to new patients as a means of establishing a relationship with the patient, providing psychological support to the patient and the family, as well as confirming the information that will be used in cases of loss to follow up. With the clinical staff, CHASS Niassa is sensitizing the clinicians to cross-check the addresses provided by patients (that includes the neighborhood, name of their community leaders, and CBOs providing support in their place of residence) with the existing list of community leaders and CBOs in each community, which has been provided by CHASS Niassa and the Community Care Program (PCC). With regard to CCR, a new initiative to link the mother's record to the infant's may help in finding infants who are challenging to locate.

Laboratory

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 Cluster of Differentiation 4 (CD4) counts. During the quarter a total of 7,020 CD4 counts were performed, a 15% increase compared to the previous quarter (from 6,088 to 7,020). This increase was complemented by the full operation of the lab equipment in the province, together with the use of Point of Care technology for CD4 (PIMA) equipment in 9 HFs, which led to more timely return of results to clinicians. As an illustration of the effect of the POCT-CD4 PIMA Machines, 32.5% of the CD4 counts undertaken during this quarter were done using these machines (Table 1).

Table 1. Number of CD4 count in Niassa using POCT-CD4 PIMA, April to June 2014

Health facility	April	May	June	Total 3rd quarter	Total 2nd quarter
Cs Cobue	35	79	46	160	148
Cs Metangula	123	123	104	350	144
Cs Mavago	38	33	18	89	32
Cs Mecula	50	45	33	128	79
Cs Marrupa	53	76	53	182	100
Cs Maua	55	125	95	275	169
Cs Mecanhelas	173	235	200	608	765
Cs Entre Lagos	65	46	39	150	114
Cs Mandimba	100	113	129	342	281

During the quarter, 421 PCR samples (385 first collections and 36 repeated collections) were collected and sent to the Nampula reference laboratory, a 3% decrease compared to the previous quarter (from 435 to 421).

Of the PCR samples sent, 392 results were received. This was due to improvements in the processing of the samples, lab response time, laboratory equipment and management of the process of sending results from the HFs to HC Nampula and back. As far as the test results are concerned, of the 392 samples, 25 (6.4%) were positive, which was the same proportion as in the prior quarter. These sero-positivity rates of children under 18 months, assessed via PCR, are just

higher than the national average of 5% reported in the Annual Report of Conselho Nacional de Combate ao SIDA (CNCS—the National Council to Combat AIDS) 2013.

During the reporting period, a total of 5,080 smear slides for lab diagnosis of TB were processed with 424 (8%) diagnosed positive, an increase from 6.9% last quarter. This increase of 23% in the number of smear slides was due to the training of personnel at the district level to improve the collection and fixing of smear slides which resulted in more samples.

A total of 144 samples were processed using the Gene Xpert machine in Cuamba and M DNA was detected in a total of 26 samples, 5 were identified as resistant to rifampicin (Table 2). There was a 55.5% increase in the number of samples processed using the Gene Xpert machines (from 80 to 144) due to the full operation of the machine and printers recently bought by DPS. Although all clinicians have been trained in the referral criteria, this is a new service and further follow up is needed to encourage clinicians to make referrals.

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

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

With the existence of the PIMAS, CHASS Niassa will continue to advocate for the introduction of inter-district routes using motorcycles already available at DPS as a way to increase the number of CD4 tests done. Because the biochemistry equipment is obsolete and the hematology is discontinued, CHASS Niassa will advocate to rent auto-analyzers for biochemistry and hematology for use in the districts with conditions to operate the machines with the standards required by MOH. This will allow them to conduct the complete exams required for ART patients and will improve the quality of care provided.

Accreditation of the laboratories (FOGELA)

The Clinical Laboratory of Lichinga Provincial Hospital is participating in the Building Programme Management of Laboratory Accreditation. In an audit done after the beginning of the implementation of FOGELA, Lichinga provincial hospital was awarded one star on a scale of 0-5. To improve the quality of the lab, laboratory facilities need to be improved (humidity controlled and painting done); privacy is needed in the collection rooms; furniture is needed for the infant collection room; better operation of equipment (e.g., biochemical) must be ensured; and freezers must be available to ensure continuous testing and uninterrupted response to users. Unfortunately, the existing infrastructure cannot be adequately improved to address these issues, new laboratories need to be built. CHASS Niassa will, however, support additional required

changes like improved control of documents and better delegation of tasks by the in-charge of the laboratory through TSV.

Injection Safety/Infection Prevention & Control/Biosafety Technical Support

The core functions of infection prevention and control (IPC) that the project supports in Niassa are strategies to protect clients/patients, staff and others from exposure to infection.

During the quarter 8 health workers (2 males and 6 females) had occupational exposures at HP Lichinga (4), District Hospital, Marrupa (3) and CS Malanga (1). Three of these exposures were massive, two intermediate, and three minimum. Thus, five of the exposed professionals had criteria for post-exposure prophylaxis (PEP), and 4 of the 5 received PEP.

This quarter an IPC baseline assessment was conducted in five additional HFs not covered in previous assessments: CS Chimbunila, CS Massangulo, CS Nipepe, CS Muembe, and CS Mavago. The new IPC guidelines from MOH were used as planned. Scores for each facility are presented below (Table 3); all of them scored below the acceptable level of 80. These facilities had an average score of 51.3 on a scale of 0 to 100 which is low compared to the current provincial average of 59% for all 17 facilities CHASS Niassa has assessed. Common weaknesses were failure to separate different types of waste, providers and staff not using protective equipment, and lack of piped water. These assessments resulted in expansion of IPC to all the district headquarters.

Table 3. IPC assessment scores for HFs in Niassa assessed in Q3 FY4

Health facility	Assessment score
CS Chimbunila	44.3
CS Muembe	53.1
CS Nipepe	64.7
CS Mavago	55.0
CS Massangulo	39.6

Behaviors and attitudes among health professionals remain a challenge, as they do not consistently use the individual protective materials available and when they do, most do not use them correctly. The availability of protective materials is another challenge that was identified in an assessment done by DPS. Gloves, masks, aprons, boots and eye protection are all materials that were lacking. CHASS Niassa and DPS are in the process of promoting sensitizations and on-the-job trainings among health professionals to ensure improved self-protection, at the same time they are in the process of procuring IPC materials to ensure timely availability in the HFs.

Nutrition, Access to Food and Utilization Technical Support

The CHASS Niassa nutrition program aims to strengthen nutrition counseling and care for PLHIV in clinical- and community-based services in Niassa Province. The program supports the implementation of the Nutrition Rehabilitation Program (NRP) volume 1, which has been

implemented in Niassa Province since July 2012, covering children under 14 years old in a total of 18 HFs. The NRP interventions are grouped into three components: Outpatient Treatment of Malnutrition (TDA), Treatment of Malnutrition in Internment (TDI) and Community NRP.

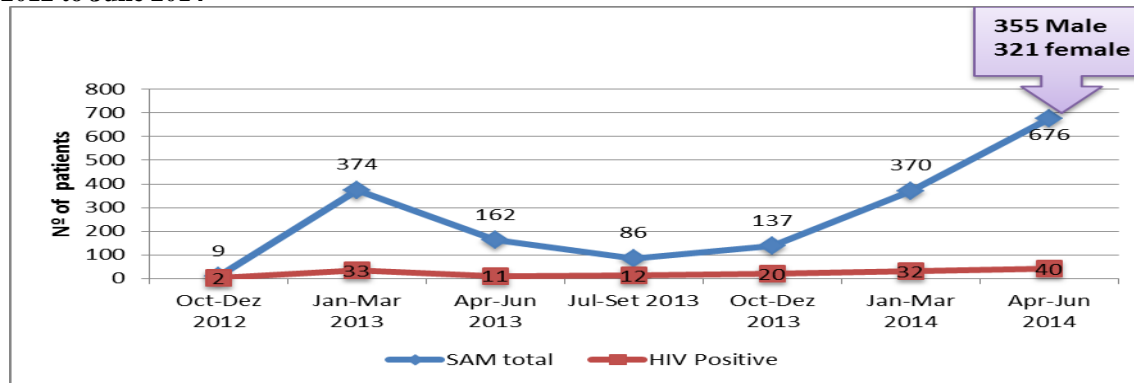
Nutrition Rehabilitation Program Technical Support – Clinical Component

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

A total of 676 children attended the in-patient nutrition services. All of them were tested for HIV and 6% (40/676) tested positive. The number of children receiving services increased by 83% (370 to 676) compared to the last quarter, due the improvement of assessment of children, better recording in the registration books, joint TSVs and the introduction of parallel data collection for nutrition data by the monitoring and evaluation (M&E) teams of DPS and CHASS Niassa in order to collect data required for PEPFAR reporting. As a result of this additional data collection, it is also possible to report sex disaggregated data for the first time.

Since the beginning of the implementation of the NRP in 2012, due to poor data recording and irregular transmission of data from the districts to the DPS the number of cases of severe malnutrition in the TDI has been low but it has been increasing steadily for the past three quarters (Figure 18).

Figure 18. Number of children treated for malnutrition in inpatient settings in select CHASS Niassa sites, Oct 2012 to June 2014



Data source: DPS: From 2012 to Quarter 2 of FY 14. CHASS Niassa M&E for Q3 of FY14

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

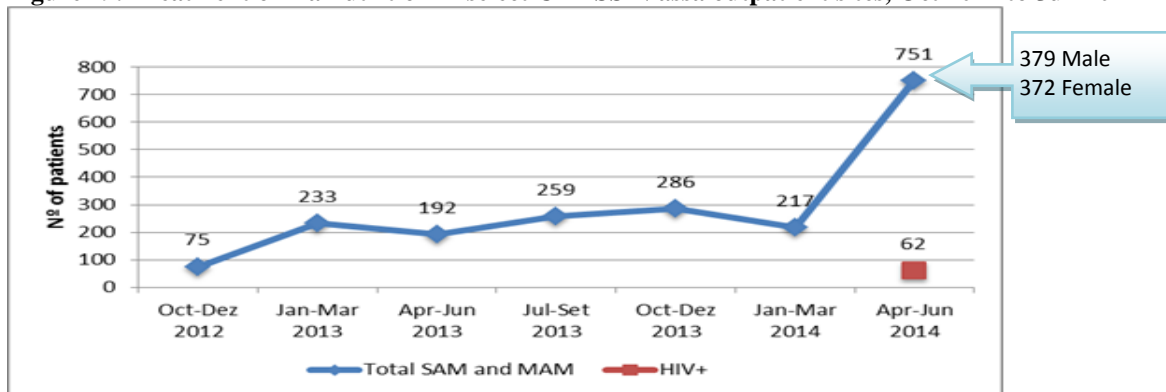
A total of 751 children were seen in ambulatory care and all of them were tested for HIV with 8% (62/751) testing positive (Figure 19); there were almost equal numbers of males and females seen. The number of children increased by 246% (217 to 751) compared to the last quarter as a result of the parallel data collection discussed above.

Since the beginning of the implementation of the NRP data collection has been difficult due to

gaps in the MOH instruments vis a vis PEPFAR indicators. Furthermore, lack of regular submission of data from the Districts to DPS has affected the total number of reported cases.

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

Figure 19. Treatment of malnutrition in select CHASS Niassa outpatient sites, Oct 2012 to Jun 2014



Data sources: DPS from 2012 to Quarter 2 of FY 14. CHASS Niassa M&E for Quarter 3 of FY14.

Challenges in Implementing the Clinical Component

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

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

Nutrition Rehabilitation Program Technical Support – Community Component

Community Nutrition Intervention – Referrals and Counter-referrals

At the community level a total of 126 children were identified as malnourished and were referred to HFs by the CCMs; 102 of them were followed at a HF (Figure 20). The difference of 24 children is because some children who were referred may have been referred late in the quarter and will seek services in the following quarter. The number of beneficiaries has increased since year 4 (Figure 20) due improvements in data recording as result of regular TSV. Seventy seven percent of those referred were under 15 years of age and 60% of them were female (Table 4).

Figure 20. Number of patients with malnutrition referred to HFs and followed in HFs in Niassa Province, Q3Y3 to Q3Y4, by quarter

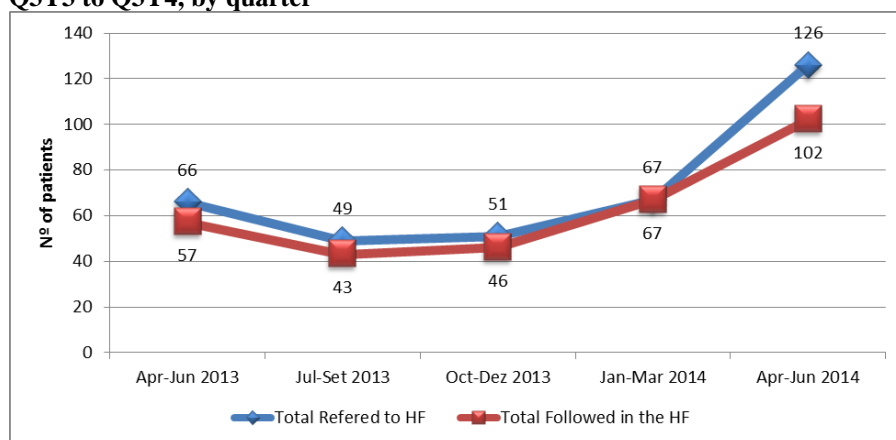


Table 4. Number of malnourished patients referred from the community and followed at HF level in Niassa, by age and sex, April to June 2014

Age	Patients Referred				Total	Patients Followed				Total
	0-14		15+			0-14		15+		
Sex	M	F	M	F		M	F	M	F	
Cidade	6	8	1	4	19	6	8	1	4	19
Namacula	1	5	0	1	7	0	3	0	1	4
Lulimile	2	3	0	1	6	1	2	0	1	4
Chiuaua	4	4	1	3	12	2	2	0	2	6
Messumba	3	2	1	2	8	3	1	0	2	6
7 de setembro	0	1	0	0	1	0	1	0	0	1
Nassinhenge	0	2	1	0	3	0	2	1	0	3
Meponda	0	1	0	0	1	0	0	0	0	0
Lione	0	2	1	0	3	0	2	1	0	3
Chimbunila	3	2	0	0	5	2	2	0	0	4
Muembe	3	0	0	1	4	2	0	0	1	3
Chiuanjota	2	2	0	0	4	2	2	0	0	4
Nzizi	3	1	1	0	5	2	1	1	0	4
Msauise	0			1	1				1	1
Malanga	2	2	1	0	5	2	2	1	0	5
Marrupa	0	2	0	0	2	0	1	0	0	1

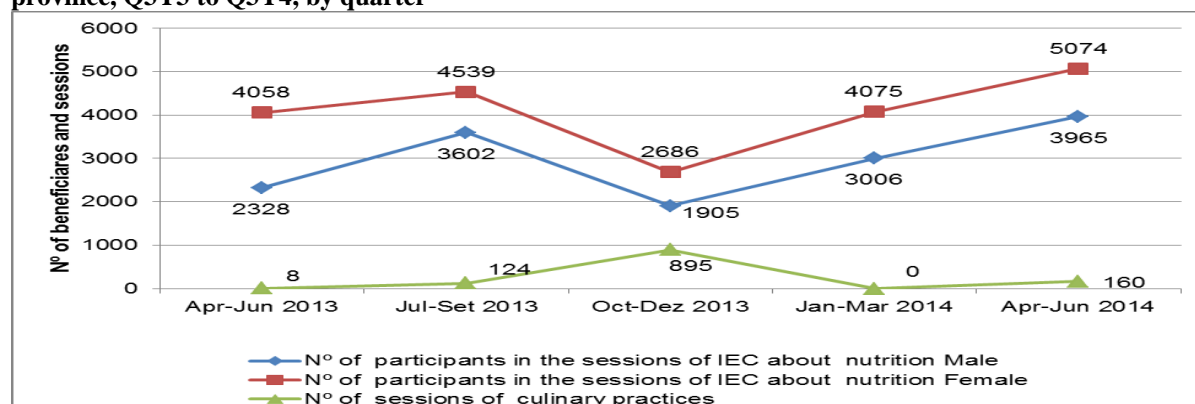
Nungo	0	0	2	1	3	0	0	0	1	1
Mecula	1	1	0	0	2	1	1	0	0	2
Mussoma	0	2	0	0	2	0	1	0	0	1
Mitende	0	2			2					0
Nipepe	4	6	0	0	10	4	6			10
Metarica	1	4	0	0	5	1	4	0	0	5
Massangulo	3	3	1	5	12	3	2	1	5	11
Lúrio	2	1	0	0	3	2	1	0	0	3
Mecanhelas	0	1	0	0	1	0	1	0	0	1
Total	40	57	10	19	126	33	45	6	18	102

Data source: CHASS Niassa M&E

Nutrition Community Intervention – Information Education and Communication (IEC)

The number of beneficiaries in IEC sessions increased by 28% (7,081 to 9,039) compared to the last quarter, due to improvements in data recording as result of regular TSV. Over the last five quarters, the number of beneficiaries has increased (Figure 21), except in the first quarter of FY2014 when the work plans for the ARV and CCM had not yet been approved.

Figure 21. Number of beneficiaries of IEC sessions by sex and number of culinary practice sessions in Niassa province, Q3Y3 to Q3Y4, by quarter

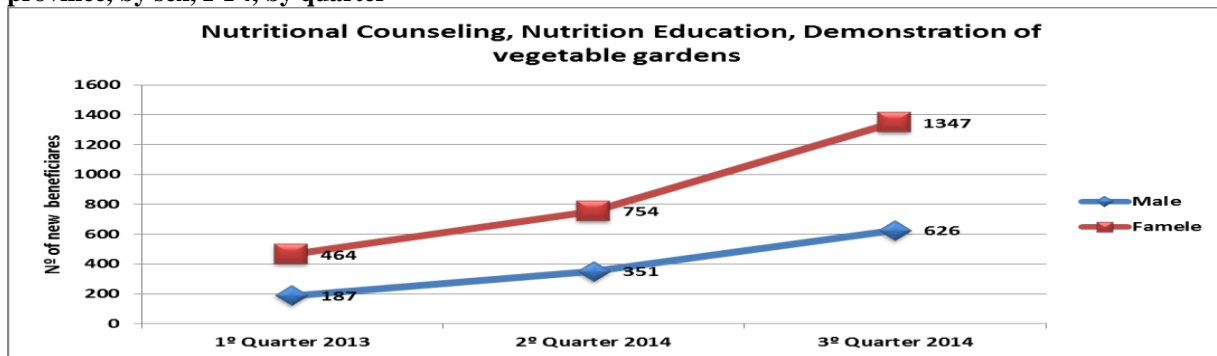


Community nutritional counseling and education, and demonstration gardens done in partnership with PCC

During this quarter the number of new participants who received nutritional counseling and education and demonstration of vegetable gardens² increased by 83% (1,105 to 1,973) compared to the previous quarter (Figure 22), due to the improvements in the identification of cases and recording of data. This quarter, approximately two thirds of the beneficiaries were female. The improvements resulted from TSVs in the Ngauma, Mandimba, Cuamba, Metarica and Mecanhelas HFs.

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

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



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

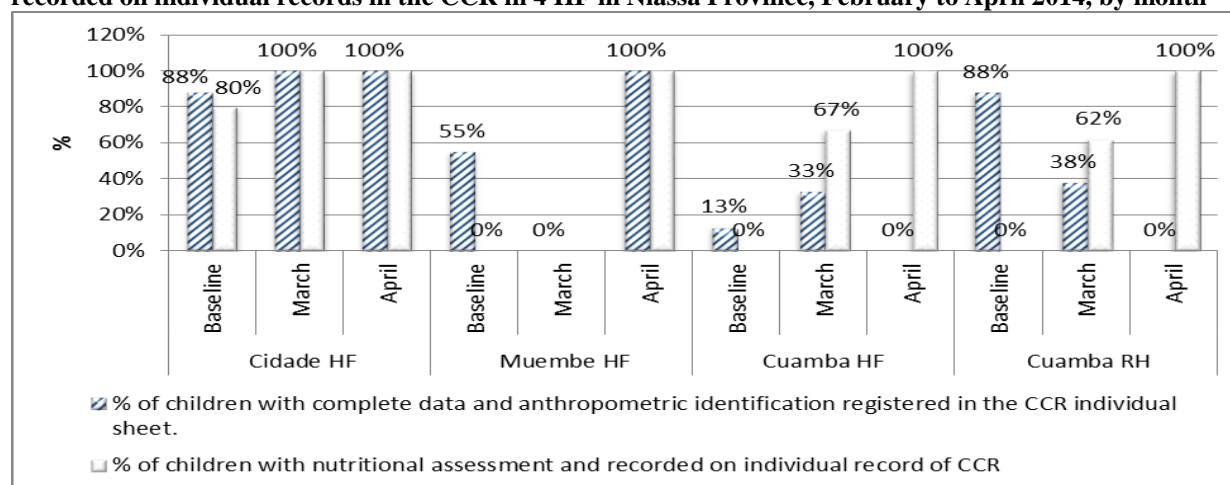
Implementation of QIP within the Scope of Nutrition Rehabilitation Program in collaboration with FANTA III and DPS Niassa

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

In the four HFs included in the baseline, only Lichinga had good performance in the nutritional assessment in CCR with about 80% of children with information such as age, sex, weight and height recorded in the CCR record having been evaluated. Other health facilities did not have registration identification data and individual anthropometric records in the CCR. The situation in ART consultations was similar to that in CCR.

Since the beginning of the implementation of the QIP of the NRP, HFs in Muembe and Lichinga City have shown significant improvement in the recording of anthropometric and nutritional assessment data (Figure 23). This has resulted in part from on-the-job training during joint TSVs with DPS. Unfortunately, registration in both facilities in Cuamba has not improved, likely because of staff turnover. Furthermore, throughout the implementation of QIP, data from the CS and rural hospital in Cuamba have not been sent to DPS in time. In the next quarter the Clinical and the MCH Nurses of CHASS Niassa and DPS will continue to make follow-up visits during the joint TSVs, and also sensitize the technicians at HFs on the importance of implementing the NRP, registration, collection of data for analysis and monitoring of the gaps found. Particular attention will be paid to the HFs in Cuamba.

Figure 23. % of children with complete data, anthropometric identification and with nutritional assessment recorded on individual records in the CCR in 4 HF in Niassa Province, February to April 2014, by month



Note: Muembe HF did not have any patients in March.

Gender Equity and Gender Based Violence (GBV) supported activities

Gender equity has been a component of CHASS Niassa since implementation began. In 2012 GBV was also incorporated as part of the intervention, starting with 9 HFs. During quarter four of FY13 the interventions were expanded to 20 HFs, with a focus in the district headquarters. Since then, the focus has been on implementation in these sites. In each district, a focal point for GBV has been indicated by DPS and trained by CHASS Niassa in the overall GBV package. Interventions take place in both HFs (including sensitizations and clinical services such as screening and post-GBV services) and at the community level (mainly sensitizations).

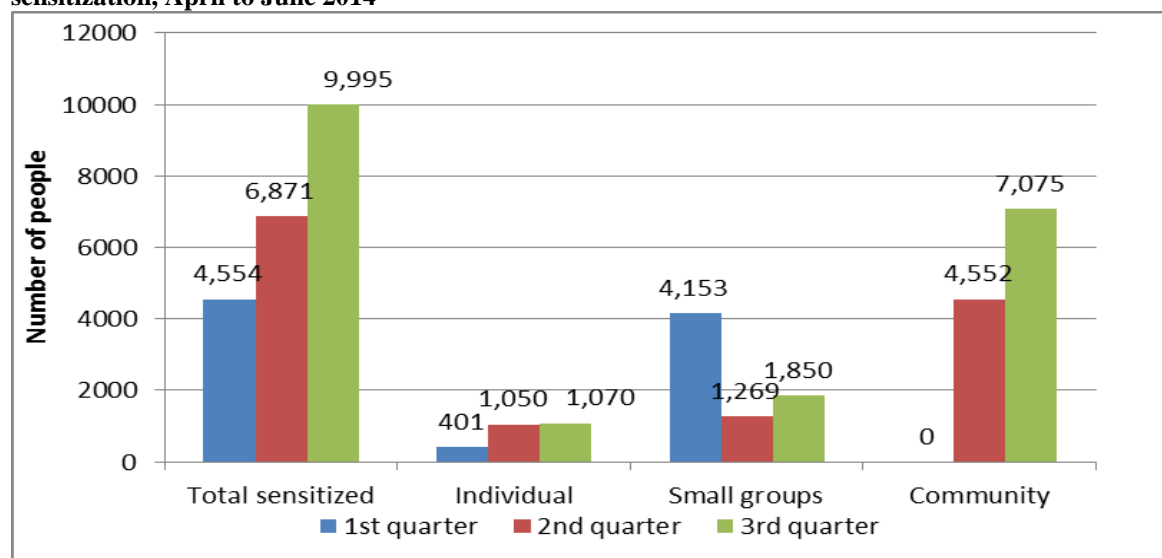
A provincial level GBV meeting that was planned for June was moved to September because the original dates coincided with National Health Week.

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

During the past quarter, a total of 9,995 individuals (5,004 males and 4,991 females) were reached through interventions addressing GBV (Figure 24). These individuals were reached as individuals or in small groups. A total of 1,070 individuals (430 males and 640 females) were sensitized, 1,850 people were sensitized in small groups (976 males and 874 females) and 7,075 people (3,598 males and 3,477 females) were sensitized through community interventions.

Over the course of year 4, the number of people reached has steadily increased although the proportion reached by each mechanism over time, in part because of a change in the strategy from classroom (small group) to school level communication (community).

Figure 24. Number of people sensitized to GBV at HFs and in communities in Niassa Province, by type of sensitization, April to June 2014



During the last quarter, CHASS Niassa created district GBV committees in Sanga and Lago districts. The groups are composed of Provincial Department of Women and Social Action (DPMAS), community leaders, religious leaders, traditional birth attendants, and *Gabinete de Atendimento a Mulher e Criança Vitimas de Violência*. IEC materials with GBV illustrations were distributed in all 16 districts CHASS is supporting and on-the-job training was provided for 15 CCMs in Mecanhelas, Cuamba and Mandimba Districts. The training in GBV for community leaders was not held this quarter due to other priorities such as the training of pre-service trainers.

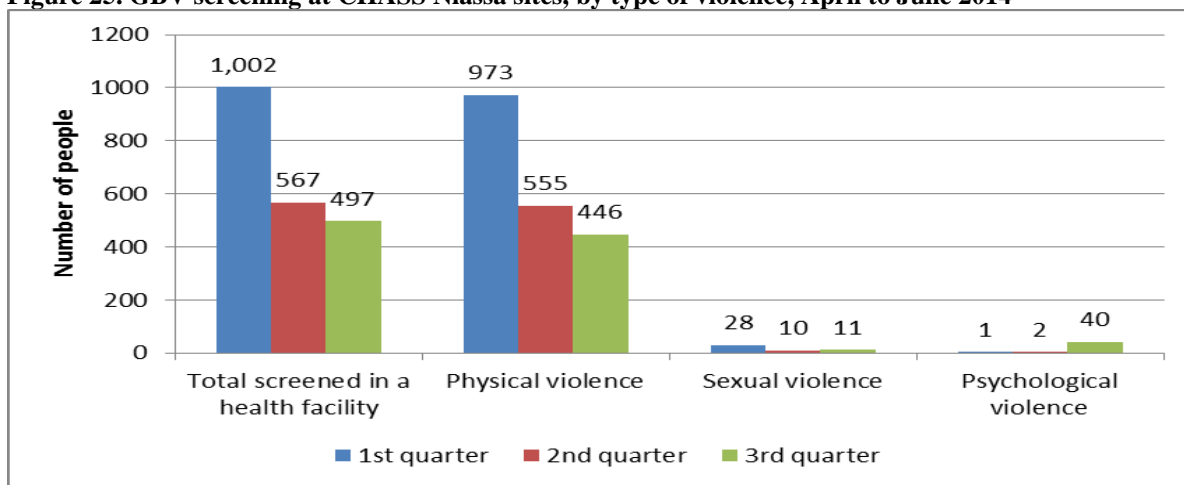
In the next quarter the priority will be training of community leaders in Mandimba and Cuamba in order to reach more cases of violence, particularly sexual violence, and sensitization of the leaders as well as the support of local organizations in the family centered approach to GBV.

GBV Screening at the HF

During this quarter a total of 497 people (247 males and 250 females) were screened for violence (Table 5). Of these, 446 (244 males and 202 females) were cases of physical violence, 11 were cases of sexual violence in females, and 40 were cases of psychological violence (14 male and 26 female) (Figure 25). Regarding the 11 women who suffered from sexual violence, five were between 0-4 years old, 4 were between 5-10 years old, and 2 cases were between 18-24 years old. The fact that almost all cases of sexual violence reported occurred among youth under age 10 is likely because of a confluence of factors: 1) beliefs about the ability of sex with a child to cure AIDS and that sex with a child will make you rich have led to a situation in which children are raped, 2) CHASS Niassa has raised awareness about the issue of child rape and this has led to improved reporting, 3) it is likely more acceptable to report sexual violence against children than against adults, 4) when adults do experience sexual violence they prefer to use traditional forums

to solve these problems, and 5) wives are unlikely to report their husbands because of shame and their reliance on their husbands for support. CHASS N, with the CCMs, is increasing awareness of both the issue of sexual violence, even among adults, and the need for HCT and PEP following incidents of sexual violence. In addition, in Sanga district CHASS is piloting a one-stop-shop with police posted to the GBV unit to minimize barriers for people who experience sexual violence however, because rates of reported violence are low in Sanga, CHASS is discussing with DPS expanding this approach to other districts with more reported cases of violence.

Figure 25. GBV screening at CHASS Niassa sites, by type of violence, April to June 2014



Physical violence is the main type of violence suffered by those screened (over 90% in all three quarters of year 4), although the percentage of cases attributable to physical violence decreased from over 97% in the prior quarters to 90% this quarter. This is the result of a dramatic increase in the number of cases of psychological violence, from 2 or less in the prior quarters to 40 this quarter because of increased awareness of psychological violence and resulting better case detection.

To improve screening of patients, CHASS Niassa distributed 100 flowcharts showing the approach for screening adults to HFs in all 16 districts. Next quarter, CHASS Niassa will distribute flowcharts for screening of children for GBV.

People Who Received Services Following Violence

All 11 cases of sexual violence were tested for HIV and the two cases over age 18 years received emergency contraception. The younger girls were not eligible for emergency contraception because they had not yet menstruated. Although all women and girls who were victims of sexual violence received services, CHASS Niassa is well below the target of 150 people receiving post GBV care, likely because violence continues to be underreported.

A total of 12 people received PEP of which 11 were cases of sexual violence and one a case of severe physical violence who was exposed to HIV. Of all victims of violence screened, 240 (130 males and 119 females) received psychosocial support (Table 5) and 211 people were referred to the police (122 were male and 89 female). This represents a significant decrease in the percentage of cases who receive psychosocial support and referrals to the police. This is likely because of more accurate reporting with revised forms and recent training about data collection. However, this shows a gap in service provision as all people who are identified as victims of violence should receive psychosocial counseling. In reality some people do not receive it because the staff who are trained in this are not available during their visit and others refuse this service. Because of a change in the indicator from number of services received to number of individuals receiving services, it is not possible to compare the totals over time.

Table 5. Number of clients who received services after violence in CHASS Niassa sites, April to June 2014

Type of service encounters		# of individuals		
		Males	Females	Total
GBV Screening	Physical Violence	246	202	446
	Psychological and Patrimonial Violence	14	26	40
	Sexual Violence	0	11	11
	Subtotal – screening			497
Post GBV services	Tested for HIV	0	12	12
	Family Planning	0	0	0
	Ante-Natal Care	0	0	0
	Partners Tested	0	0	0
	Emergência contracepção	0	2	2
	Post-Exposure Prophylaxis	0	12	12
	Psychosocial Counseling	130	110	240
	Police Referral	122	89	211
Total number of individuals receiving post GBV services		NA	NA	463

Once victims of violence are identified at facilities, they are then followed by community partners. Household visits are made by the CCM to sensitize the family to the issues of violence, to try to prevent discrimination against the victim within the family, and to reinforce the importance of follow up visits. Additional counseling and psychosocial support is also provided to the victim at this time. Community sensitizations are another mechanism used by CHASS Niassa to mitigate the effects of violence and to try to prevent future violence against the same people. When a victim of violence is identified at a health facility, the CCM, the gender focal point, and CHASS Niassa staff talk with the community leaders in the victim's community and encourage them to hold sensitization meetings. Such sensitizations raise awareness about violence in general but also address the problem of discrimination against victims of violence and the importance of not contributing to such discrimination.

During this quarter CHASS Niassa supported DPS by distributing GBV kits to the HFs in the district headquarters of all 16 districts.

Trainings in GBV

During this quarter 16 clinicians (10 male general nurses who are gender focal points and 6 female MCH nurses) were trained in adapting the books for registration of GBV in emergency and maternity wards using the "Protocol for Integrated Assistance to Victims of Violence". Their training has been recorded in the technical assistance register at the facilities where they work. The district gender focal point at DPS is responsible for tracking providers who have been trained.

Twenty-two trainers from Cuamba training health center (13 men and 9 women) were trained in Gender/GBV so that they can address gender issues during their trainings and the students in turn can address these issues during consultations and can screen for GBV and implement the protocol for integrated assistance to victims of gender violence in care and treatment.

In the next quarter, CHASS Niassa will work with MULEIDE to train community leaders about harmful traditional practices that contribute to GBV and HIV.

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

During this quarter 12 females received PEP, of which 11 were victims of sexual violence and 1 of severe physical violence that exposed her to HIV. To improve PEP coverage, post exposure prophylaxis kits were distributed to the emergency and maternity wards in all HFs implementing GBV. The gender focal points still need to be trained but this will be done after the new PEP book being piloted by MOH has been introduced.

CHASS Niassa is continuing to explore ways to track people who receive PEP over time to understand their testing behaviors. CHASS Niassa proposed this to the e-Saude working group and will continue to follow up regarding the addition of a module for GBV in that system.

Men to Men Groups

Men to Men groups are an approach CHASS Niassa is using to increase understanding of gender and health issues on the part of men and to increase male involvement in health. Two new groups were formed in Metarica and Mecanhelas for a total of five men to men groups. Furthermore, in this quarter new forms were developed for these groups to better capture who is participating, what themes are discussed, and suggestions from the groups. They were introduced in all groups and we anticipate reporting these data in the next quarter.

The groups provide a great place to connect, and provide the ideal environment to help men realize that they are not unique or alone and see first-hand that other men experience similar problems and issues. In addition, these groups can provide support, encouragement, and

accountability when men are challenging themselves, learning new ways of thinking and acting, and breaking life-long habits.

Objective 2

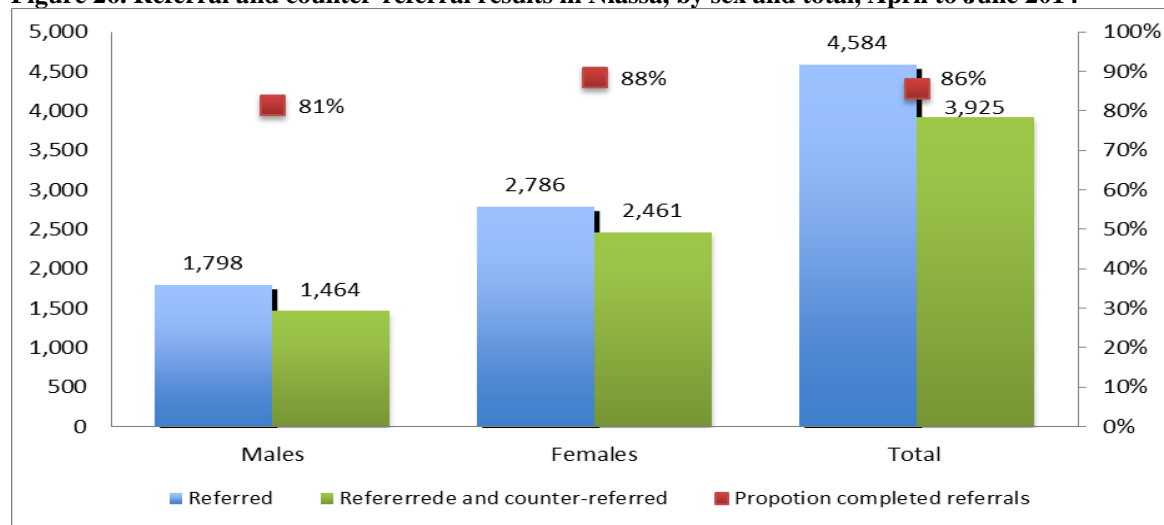
Create an integrated system of HIV/AIDS and primary health care with strong linkages to community services.

Strengthening the District Referral and Counter-referral Networks

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

During this quarter, a total of 4,584 individuals (1,798 males and 2,786 females) were referred for various services (Figure 26), including 910 (114 males³ and 796 females) for MCH services (ANC, CPP, FP, CCR, L&D), 4% (30) of whom were couples; 364 for TB services (173 males and 191 females); 1,609 to HIV services (688 males and 921 females); and 1,701 (823 males and 878 females) to other services (Nutrition, GBV, and Malaria). Of the people referred, 86% (3,925 individuals, 1,464 males and 2,461 females) completed the referral cycle with males somewhat less likely to complete the referral.

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

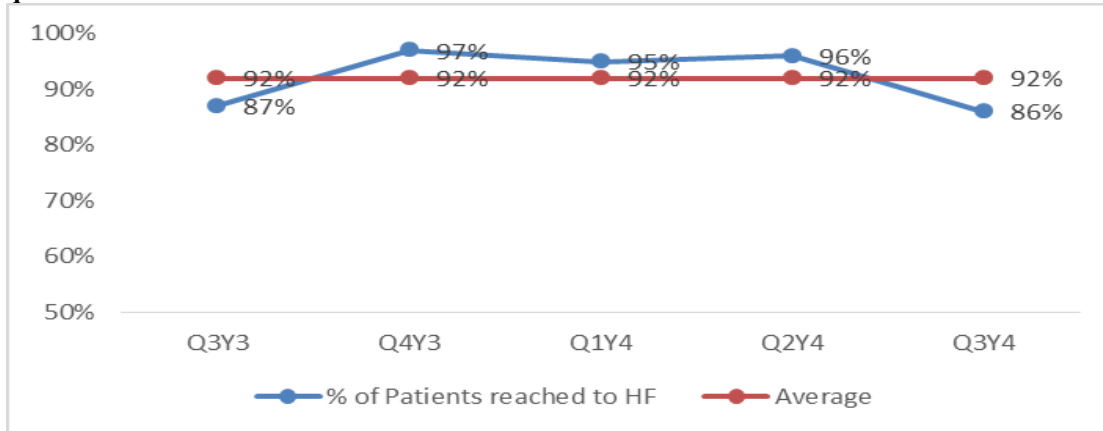


Over the past five quarters, the percentage of patients who successfully completed the referrals cycle has been stable (Figure 27), despite a decrease observed this quarter, which was a

³ Males are included because male children are referred for CCR.

documentation issue related to a stockout of referrals guide in the northern part of the province, especially in Lichinga.

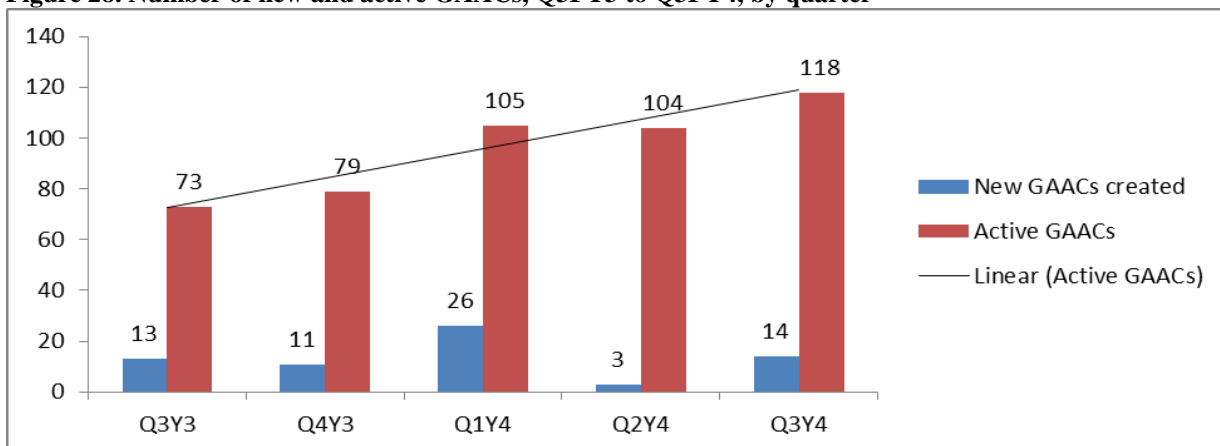
Figure 27. Percent of referred patients who reached a HF in CHASS Niassa sites, Q3FY4 to Q3FY4, by quarter



Community Adherence Support Group (GAAC)

From April to June 2014, 14 new “*Grupos de Apoio para Adesão dazs Comunitarios*” (GAACs) were created in the province for a total of 118 groups; no GAACs discontinued this quarter. The currently active GAACs benefit 385 patients (123 males and 262 females). Over the last five quarters, there has been an overall increase in the number of active GAACs, despite a slight decrease in the previous quarter when the number of GAACs that disbanded was higher than the number of GAACs created. Regarding the new GAACs created this quarter, the number was higher than in the previous quarter (Figure 28), likely because CHASS Niassa conducted TSVs aimed specifically at the creation of new GAACs.

Figure 28. Number of new and active GAACs, Q3FY3 to Q3FY4, by quarter



Objective 3

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

This quarter CHASS Niassa has contributed to improving the health system in Niassa across the World Health Organization health system building blocks.⁴ In order to develop health system capabilities necessary to effectively plan, manage, and evaluate integrated HIV services in quarter 3 the project has supported the DPS/SDSMAS with the following interventions:

Strengthening of Service Delivery

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

This quarter CHASS Niassa planned to conduct 680 TSVs (both CHASS N-specific and joint TSV); 624 (91%) of the planned visits were conducted. Not all planned visits were conducted because of overlapping tasks during the period, including the need to participate in seminars and meetings with DPS as well as the need to facilitate trainings not planned in the previous quarter. During joint site visits, CHASS Niassa is mentoring DPS staff to develop their supervisory skills.

Within the framework of technical assistance to the DPS in the implementation of the national strategy to make health services more user-friendly (*Estrategia Nacional de Humanização*), TSVs were conducted in HFs in Cuamba, Muembe, Mavago, Lago, Mecula, Ngauma, Marrupa and Sanga districts, the objectives of which were to:

- Verify/measure client waiting times and client satisfaction at health facilities;
- Verify compliance with hygiene norms and procedures at health facilities;
- Provide technical assistance to health professionals staffing the client liaison units at health facilities;
- Verify the punctuality of health workers; and
- Verify vehicle log books and registers.

The main findings were:

Average waiting time per health facility (following adult triage and child triage) was measured, via a received a ticket registering time of arrival at HF and time at the end of their consultation, for a random sample of 12 people in each facility. Average waiting time was 90 minutes though it ranged from 56 minutes at Cuamba HC to 131 minutes ta Marrupa HC (Table 6). This was

⁴ Service delivery; governance; human resources for health; finance; medical products, vaccines and technologies; and information systems

somewhat better than in a prior assessment conducted in a different set of facilities in September 2013. In those facilities, average waiting time was 102 minutes (range: 78-152 minutes).

Table 6. Average waiting time in adult and child triage sections at health facilities assessed in Niassa province from April to June 2014

Health facility	Average waiting time (minutes)
Mavago HC	70
Muembe	81
Mecula	111
Marrupa HC	131
Cuamba HC	56
All facilities assessed	90

The 14 client liaison units created last year are all functioning and all have registers for recording suggestions, complaints and other information. Eight community forums were held at selected health facilities during which the team solicited feedback on community perceptions of health services. In general, communities provided positive feedback and expressed their satisfaction with services provided. However, communities requested that more information on medical procedures be systematically provided, and complained about the quality of food provided. Additional results can be found in the full report from the TSV.

CLINIQUAL Meetings

The sixth round of CLINIQUAL had been planned for June 2014, however it was postponed per an MOH recommendation in response to changes in the MOH guidelines, database and indicators which are not yet complete.

Strengthening of HR Management

Pre-Service Training Support

CHASS-N supports pre-service training of health workers. This quarter CHASS Niassa continued to monitor the MCH nurse class that started in February 2014. All 30 candidates are still attending and are expected to graduate in December 2015. In collaboration with MULEIDE we are training pre-service training trainers in order to include GBV issues during the training. Twenty-two trainers were already trained (9 women and 13 men) in Cuamba training health center and this quarter the same training will be provided at the Lichinga health training center.

Post-Graduation Scholarship Support

In order to improve the quality of management skills for the DPS senior staff, the project continues to support post-graduate scholarships for master degree in public health, management and HIV. The beneficiaries of the scholarships are drawn from provincial and district managers and are expected to return and work in the province/districts for a minimum period equivalent at least to the time of study. One DPS staff has completed the theoretical part of the course and is

currently writing a master's thesis, and three continue to attend class at Catholic University at Beira campus in part time enrollment.

In-Service Training

During the quarter, in-service trainings were conducted in the areas of Pharmacy management and procedures, training of CCM in Psychosocial support and Positive Prevention, and participation of the provincial Lab staff in the FOGELA regional meeting held in Nampula (See Annex 2).

CHASS Niassa is working with DPS to strengthen the training information and management system (SIFo). According to the DPS, management of in-service training has improved, particularly following the SIFo training held in March 2014.

Strengthening of Financial Management

Sub-agreement Management with DPS

This quarter the cumulative financial implementation of CHASS Niassa awards to the DPS was 63% (US\$ 660,043.73) of the total budget **for the fiscal year** (Annex 3). Of these expenditures, US\$ 499,584.51 (76%) were at the provincial level and US\$ 160,459 (24%) at the district level. Technical support visits were made to all 19 sites including DPS. During the last quarter we faced turnover of the sub-agreement technical managers at district level which had an impact on performance. All new personnel are provided with on-the-job training by CHASS Niassa and SDSMAS. This quarter the program and finance teams focused the TSV in order to support the district teams in the implementation of activities as well as to improve financial expenditures. CHASS Niassa has started the process of monitoring and evaluating the 12 goals using pre-selected indicators of health service delivery coverage. The evaluations to date show that districts are eligible to receive 20% of the funds by results; it also shows the need for ownership of the process at the district level.

Logistics & Supply Chain Management

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

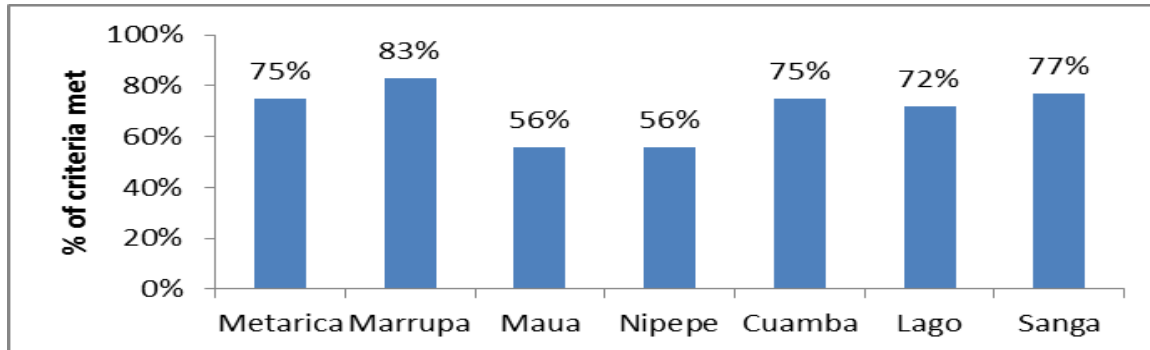
CHASS Niassa supports the DPS in assuring the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes. Currently CHASS Niassa is supporting 16 district warehouses, 1 provincial warehouse and 3 warehouses of provincial/rural hospitals, totaling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

Technical supervision visits were provided to CS Maniamba, DDM (District medical warehouse) Sanga, CS Macaloge, DDM Muembe, CS Muembe, DDM Majune, DDM Mavago, DDM Metarica, CS Nacumua, DDM Maua, DDM Nipepe, DDM Marrupa, CS Marrupa and DDM Chimbonila in order to assess the level of compliance and medicines supplies management. Areas where the DDMs showed improvement on the management procedures of particular drugs, included:

- Conducting inventory;
- Documentation of inventory received and distributed;
- Achievement of timely information to the Deposit Provider; and
- Management of expired and accumulated medicines.

However, DDMs still need to improve their skills in preparing the Balance Sheet-Requisition/MMIA. Furthermore, some DDM have difficulty in using the Drug Formula Quantification, thereby providing poor availability of medications or drugs despite accumulated deposits. Only one of the seven DDMs assessed this quarter correctly filled the Drug Formula more than 80% of the time and did it correctly only just more than half the time (Figure 29). On-the-job training was provided to address these issues and stressed the importance of correctly using the register books and other tools to monitor the availability of medicines and supplies.

Figure 29. Percent of times the Drug Formula was completed correctly by select DDMs, Q3FY4



Availability of Pharmaceuticals

During this past quarter medicine availability was better and medicine stock outs less common compared to the previous quarters this year. Stockouts of iron sulfate and folic acid were identified during a TSV. This stockout was solved within 3-4 days using the CHASS Niassa transport system for CD4 tests. While this type of approach does not build the capacity of the health system, it is required to ensure smooth delivery of services. In the longer term, the capacity of DPS to address these problems needs to be strengthened, at least in part through replacing the pharmacy advisor within DPS.

Table 7 presents the list of essential drugs which had stockouts, by quarter. As soon as a stockout in HIV test kits was identified by CHASS Niassa, the project worked with FHI 360 to arrange air shipments from Central Medical Store (CMAM) to DPS, thereby ensuring a rapid end to the stock out, which lasted just 10 days.

In general, during this quarter there was an improvement in drug availability. Twenty-one pharmaceutical products had recorded stockouts, compared to 33 during the first quarter and 25 in the previous quarter. For some drugs that did have stock outs in this quarter, the number of stockout days was fewer, specifically for Iron sulfate, Amoxicillin Capsules, and Azithromycin. This improvement was due to more complete (i.e., a larger proportion of the drugs requested were supplied and more drugs were supplied the quantities requested) fulfillment of requests by CMAM.

However, during this quarter, the stock of kits of the “Programa de Medicamentos Essenciais” at the central level improved which resulted in better availability at the provincial level.

Table 7. List of drugs in stock-outs in Niassa province, FY4, by quarter

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

Health Information System

Electronic Patient Tracking System (EPTS)

CHASS Niassa is working with DPS to pilot the EPTS, eSaude, in select health facilities in Niassa. CHASS Niassa is managing the retrospective data entry required to get the system up and running and is training staff at DPS to manage the system. During this quarter, retrospective data entry at Lichinga Provincial Hospital (HPL) was completed and the same began at Lichinga Health Center. In trying to assess the quality of the data entered compared to Modulo Basico, the team encountered some problems with eSaude and worked with Eurico of Friend's in Global Health to correct the monthly reports generated by the system. Information on data quality will be provided next quarter.

Training on eSaude for the identified staff at HPL began during the last week of June. Unfortunately, the two staff who had been selected are no longer available. One had been in charge of the database at HPL in the past but he is currently in charge of the transport department and ism, therefore, not available to do the data entry. A training manual for this purpose was drafted and shared with select OpenMRS working group members as agreed at the last meeting.

In early quarter 4, the team entering retrospective data will move to Cuamba to enter data at Cuamba Rural Hospital and Cuamba Health Center. Data entry is expected to take approximately 2 months given the number of patients at these facilities. CHASS Niassa anticipates that retrospective data entry will be completed in one additional HF by the end of year 4 as planned.

The server for DPS was installed during this quarter and the internet connection is functional with a public internet provider set up so that openMRS is accessible by internet. However, linking the facility level databases requires additional work that will be carried out during Quarter four. Web access at DPS will be tested using the HPL database in Quarter four.

Per discussion with the (Agreement Officer's Representative) AOR during his site visit, CHASS Niassa and DPS are considering expanding eSaude to additional facilities in Year 5. These would include CS Metangula, CS Chiuaula, CS Namacula, and HD/CS Marrupa. This expansion would ensure that 80% of patients in the province are covered by eSaude and would facilitate the finer disaggregations required for the MER indicators.

Data Use Workshop

Targeting CHASS Niassa staff, a workshop on data use was held from June 10-11th, 2014 at the Girasol Hotel in Lichinga. The workshop introduced key topics including basics of health data, a review of indicators and targets, and data consistency, as a means to improve understanding of technical staff of key performance indicators and data quality analysis aiming. This workshop and subsequent support for data use are designed to strengthen the capacity of CHASS Niassa

technical staff which will, in turn, support data quality. Staff worked in small groups to implement the skills discussed and analyze their own data. New data quality verification tools were created for use by technical staff during site visits and will be implemented in the next quarter. These easy-to-use tools allow technical staff to enter key data and obtain immediate feedback on data consistency; this is one step toward strengthening data quality as they can immediately followup on inconsistencies and discuss any concerns with facility staff in order to resolve these issues or document logical reasons for such differences. The tools also allow for rapid assessment of performance on key performance indicators

Revisions to Cohort Methodology

Following submission of the SAPR, the M&E team worked with the technical team to review the protocol and tools for the collection of the cohort data, which captures data on retention in care as well as key indicators of quality of care, to incorporate learning from the prior data collection and to incorporate new indicators that were not previously captured (e.g., # HIV+ patients screened/assessed for malnutrition). The team also developed protocols for data quality review at all stages of data collection. Finally, a cohort data analysis plan was formalized to ensure a clear and consistent understanding of how each indicator is calculated from the cohort data collection. In Quarter four, CHASS Niassa will use mobile data collection for this process for the first time.

Per the suggestion of USAID, CHASS Niassa arranged a meeting with CHASS Sofala, Manica and Tete (SMT), with participation of USAID strategic information team members, to understand the changes made to their methodology leading to improvements in their results. One of the key lessons learned from CHASS SMT, which was already under discussion, was the importance of using the ARV pick-up register in pharmacies to assess outcomes among ART patients, as FILAs (ARV Pickup Individual Forms) are not consistently updated.

Planning for Next Fiscal Year

The CHASS Niassa M&E team held a meeting with DPS M&E team to discuss priorities for next fiscal year, as a preparation for the annual planning exercise. Priorities for CHASS Niassa support to DPS discussed included the need for capacity building to the districts (to strengthen knowledge and skills in consistency analysis); expansion of EPTS together with all the necessary logistics; as well strengthening data quality assurance activities.

Routine Support Activities

Regarding the technical assistance to the districts, HFs, and DPS in monitoring and evaluation, CHASS Niassa finally recruited the M&E Advisor for DPS, seconded by CHASS Niassa. He has considerable experience with M&E of clinical data and is expected to focus on improving data quality and promoting data use at DPS. In addition, routine activities were undertaken at all levels, with focus on ensuring consistency of data and validity of at the various data aggregation levels. Using data verification tools, both M&E and clinical staff from CHASS Niassa and DPS,

conducted verification of the monthly summaries at the HFs, and corrected the existing problems through on-the-job support to the HF clinical staff. At the district level, the support provided by the M&E team included crosschecking the data entered to correct transcription errors, as was done at the DPS level. In most cases, the problems encountered included aggregation errors, as well as errors in counting data registered in the books. Transcription errors also existed, in most cases with huge impact on performance, and thanks to this exercise, the quality of information is considerably better for most services. Work is ongoing to document the results of these efforts.

Data Quality

During the USAID visit by the AOR and the MCH advisor in June, some concerns were raised with regard to data quality and the need for forums at the facility level for discussion of data to strengthen data quality. These suggestions are very much in line with steps that CHASS Niassa has already taken including increasing the role of the CHASS Niassa and DPS technical teams in supporting data collection at the facility level through data review and feedback to facility staff, support for district data review meetings of SMI data (including PMTCT data) in select districts where DPS is piloting this approach, and implementing data review meetings with DPS. In fact, CHASS Niassa has been working with DPS for some time to finalize the agenda for district data review meetings which was finalized this quarter. It includes a validation of data and a discussion of performance, using a standard set of tools for both assessing and analyzing the data. The final agenda was disseminated to the districts during the Health Information System meeting held from 15 to 18 July 2014, together with the data verification tools designed to support the process. CHASS Niassa and DPS have formed a team that will travel to each district to support these meetings, beginning in the districts with the highest patient volume.

Linkages and Partnerships

In this quarter, CHASS Niassa worked with PCC to transfer all responsibility for active case finding and referrals of patients for adherence to ART, TB, and PMTCT to PCC activistas. Furthermore, PCC activistas posted in HFs were linked to CCMs of CHASS Niassa to ensure coordination of both referrals and active case finding. In addition, the projects worked together to revise the process for developing lists of patients who were lost-to-follow-up, with these lists given to PCC activistas for follow up by the CHASS Niassa CCM. A mechanism was also established for referrals for C-HCT by PCC activistas in the districts where CHASS Niassa is implementing C-HCT services. Finally, joint TSVs of activistas and CCMs were conducted by CHASS Niassa and PCC staff.

CHASS collaborates with the TB CARE project on TB/HIV interventions including capacity building for health professionals, referrals of TB suspects from the community to the HF

(community DOTs), rehabilitation and provision of equipment to HF laboratories, as well as technical support activities to the HFs. This quarter, CHASS Niassa and TB CARE conducted joint TSVs to supervise community DOTs and began implementing the FAST strategy.

CHASS Niassa partners with the FANTA III project in the implementation of the QIP for the NRP. FANTA III provides technical assistance to CHASS Niassa and the province as a whole in the implementation of the NRP. In nutrition, CHASS Niassa also partners with the World Food Program for provision and distribution of CSB+ for HIV+ patients. Specific areas of collaboration with both FANTA III and WFP this quarter are described in the nutrition section of this report.

Finally, this quarter CHASS Niassa held coordination meetings with the Maternal and Child Health Integrated Program (MCHIP) and conducted joint TSVs to select facilities that looked at PMTCT, model-maternity and screening and treatment of cervical cancer.

Management Arrangements

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

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

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

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

Project Management Team

The Project Management Team has three major functions:

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

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

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

Partners

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

Provincial Health Directorate, Ministry of Health, Government of Mozambique

This Project aims at enhancing the DPS/Ministry of Health 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 HTC, STI diagnosis and treatment, Anti Retro Viral Treatment and monitoring, as well as procurement and supply management capacity building. The project is directly implemented by the DPS in the province of Niassa.

Abt Associates

Abt provide comprehensive technical assistance that addresses some aspects of the provincial's health system, including health financing, human resources for health, and governance which are related to the third objective of the project which is to strengthen DPS/MOH capacity to effectively manage high-quality, integrated HIV services.

Food for the Hungry

FH provide technical assistance that addresses nutritional needs (Nutrition assessment, counseling and support (NACS) and the implementation of the MISAU's Nutrition Rehabilitation Program (PRN) in the province. The project is collaborating with WFP in the acquisition and

distribution of the fortified supplement Corn Soy Blend (CSB) in selected health facilities to improve the nutritional intake of the affected population. The nutrition technical officer is also collaborating with MISAU in the development of mechanism to integrate nutrition data with other already existing MISAU data collected through the National Health System data base (Módulo Básico) as well as improving the already existing data information system.

MULEIDE

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

Implementing Partners (ARV, CCM, CISLAMO)

These local NGOs/CBOs are responsible for the implementation of the key interventions under the following Service Delivery Areas (SDAs): (1) Behavior Change Communications (BCC) – 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

- In the area of MCH, the turnaround time for processing DBS in the PCR laboratory is too long. CHASS Niassa needs to work with DPS and the Nampula lab to reduce the time between testing and receipt of PCR results. A recent assessment by the Clinton Foundation showed that the average turnaround time in Niassa was 22 days compared to a national average of 7 days.
- The number of people who enroll in ART is low relative to the number of people who test positive. CHASS Niassa needs to analyze the completed referral rates for different entry points (e.g., Laboratory, Blood Bank) and train providers in these sectors in counseling and testing and psychosocial support so that they can provide counseling to all those who test positive to encourage them to initiate ART.
- Pediatric ART enrollment remains a challenge as CHASS Niassa has not yet achieved its targets. CHASS Niassa will intensify work at all entry points, particularly healthy child consultations, to improve rates of counseling and testing among youth.

- Access to biochemistry tests is limited. CHASS Niassa needs to ensure that patients enrolled in ART who are taking TDF have a biochemistry analysis within 30 days from initiation; currently the biochemistry is not consistently collected at the same time as samples for CD4 and biochemistry analyzers are only available in Cuamba and Lichinga. CHASS will create a referral system to sites where the equipment is available using the same routes currently used for CD4 and PCR samples. CHASS Niassa will also advocate for the acquisition of biochemistry and hematology equipment that will meet the requirements of MOH in order to ensure that the minimum required package for ART is provided in the conventional laboratories.

Upcoming Priority Activities

- Assess the tracing of HIV+ pregnant women and their children (post-partum) to ensure that their consultations are done on the same day, and that the clinical charts of mother and child are kept together.
- Reinforce screening for malnutrition among HIV+ patients in all the sectors (PMTCT, TB, and ART) as well as documentation of that screening.
- Implement psychological support activities to improve retention of patients in HIV care and treatment services.
- Improve enrollment in pediatric HIV care and treatment through intensification of HIV testing in all entry points (CCR, triage, TB, in-patient service, and clinical consultations).
- Assess the pilot phase of the TB FAST strategy.
- Implement the cohort study for the Annual Progress Report (APR14) using mobile data collection.
- Finalize and assess the pilot phase of EPTS implementation at select sites.
- Assess district performance and distribution of incentives under performance-based financing.

ANNEXES

ANNEX 1 – Progress Toward the Targets in CHASS Niassa from April to June 2014

Indicator	Annual Target	Q1 Results	% Achieved - end Q1	Q2 Results	% Achieved - end Q2	Q3 Results	% Achieved - end Q3
PMTCT ANC							
Number of health facilities providing MCH services that provide HIV testing and ARVs for PMTCT on site, ANC/ L&D settings	65	65	100%	65	100%	65	100%
Number of unique pregnant women registered in ANC	41,043	14,208	35%	14,238	69%	15,334	107%
Number of pregnant women with known HIV status (before CPN+ who received HIV counseling and testing for PMTCT and received their test results in CPN).	39,131	13,313	28%	12,861	67%	13,354	101%
Number of pregnant women with known HIV positive status (before CPN+ who received HIV counseling and testing for PMTCT and received their test results in CPN).	824	903	105%	458	165%	661	245%
Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission, total, by regimen, by setting (ANC)	765	697	105%	342	136%	607	215%
Number of HIV-positive pregnant women in ANC who have initiated CTZ	-	450	-	337	-	413	
Number of partners of women who are HIV tested in ANC setting	15,392	4,011	26%	4,517	55%	5,569	92%
PMTCT L&D							
Total number of unique pregnant women registered in L&D		12,192		12,080		10,467	
# women receiving an HIV tests & results in a PMTCT L&D setting	8,323	5,151	62%	4,335	114%	2,561	145%
Number of pregnant women with known HIV positive status LD (includes women who were tested for HIV and received their results)		439		536		373	
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT/ L&D setting.	734	376	51%	404	106%	322	150%
Number of HIV-exposed infants who received ARVs to reduce risk of MTCT in L&D setting, (total/ by regimen)	1,223	366	30%	387	62%	317	87%
Number of infants born to HIV-positive women who received an HIV test within 12 months of birth	900	405	45%	746	128%	613	196%
PCR < 9 months						420	
Rapid test 9 - 11 months						193	

Indicator	Annual Target	Q1 Results	% Achieved - end Q1	Q2 Results	% Achieved - end Q2	Q3 Results	% Achieved - end Q3
Children (<18months) born to HIV+ pregnant women who are started on CTZ prophylaxis within two months of birth	-	358		246		223	
FAMILY PLANNING							
Number of unique women registered in Family Planning	-	17,470				25,154	-
Number of women with known HIV positive status in FP	-	542	-	626	-	419	-
Number of HIV positive women provided with at least one FP method-IUD	-	32	-	4	-	2	-
Number of HIV positive women provided with at least one FP method-Injectable	-	217	-	381	-	276	-
Number of HIV positive women provided with at least one FP method-Pills	-	293	-	178	-	102	-
Number of HIV positive women provided with at least one FP method-Other Methods	-	-	-	30	-	19	-
COUNSELING & TESTING							
Number of service outlets providing counseling and testing according to national and international standards (CT Setting: Clinical)	65	65	100%	65	100%	65	100%
Number of individuals who received counseling and testing for HIV and received their test results(CT setting: Clinical)	103,736	9,195	9%	13,721	22%	10,132	30%
Number of individuals who received counseling and testing for HIV and whose results were HIV+ (CT Setting: Clinical)		1,062		1,086		848	-
Number of service outlets providing counseling and testing according to national and international standards (CT Setting: UATS)		11	-	11	-	11	-
Number of individuals who received counseling and testing for HIV and received their test results(CT setting: UATS)	8,791	1,489	17%	1,782	37%	2,348	65%
Number of individuals who received counseling and testing for HIV and whose results were HIV+ (CT Setting: UATS)		289	-	385		488	
Number of individuals who received counseling and testing for HIV and received their test results(CT setting: ATSC)	2,747	4,649	169%	7,958	459%	15,303	1015%
Number of individuals who received counseling and testing for HIV and whose results were HIV+ (CT Setting: ATSC)		253		651		480	
HIV care and treatment							
Number of health facilities that offer ARV treatment clinical services	42	46	110%	46	110%	46	110%

Indicator	Annual Target	Q1 Results	% Achieved - end Q1	Q2 Results	% Achieved - end Q2	Q3 Results	% Achieved - end Q3
Number of HIV-positive adults and children receiving a minimum of one clinical service	18,280	22,373	131%	22,422	123%	17,766	97%
Number of adults and children with advanced HIV infection newly enrolled on ART	2,919	1,292	44%	1,419	93%	1,422	142%
Number of adults and children with advanced HIV infection currently receiving ART, by sex, pregnant women	11,012	11,749	138%	11,200	102%	12,268	111%
Number of adults and children with advanced HIV infection who ever started ART, by sex, pregnant women	-	12,911	-	14,330	-	16,103	-
TB/HIV SERVICES							
Number of service outlets providing prophylaxis and or treatment for TB to HIV infected individuals (diagnosed or presumed.)	16	16	100%	16	100%	16	100%
Number of TB patients registered during the reporting period	1,490	454	30%	504	64%	545	101%
Number of HIV infected individuals attending HIV/AIDS care/treatment services also treated for TB disease	2,194	178	10%	190	17%	140	23%
Number of TB patients who had an HIV test result recorded in the TB register	1,431	448	45%	495	66%	522	87%
# HIV Positive TB (co-infected) patients with test result recorded in TB register	-	178	-	190	-	196	-
Number of HIV-infected TB patients in the TB sector who have initiated cotrimoxazole (CTZ) prophylaxis	833	178	28%	190	44%	196	68%
Number of HIV-positive TB patients who have started ART	760	159	30%	152	41%	170	63%
GBV							
Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion (GBV)	50,000	4,554	9%	2,465		9,995	25%
Number of GBV service-encounters at a health facility	18,000	1,351	8%	-	-	-	-
Number of health facilities with Gender-Based Violence and Coercion (GBV) services available	16	20	125%	20	125%	20	125%
Number of people receiving post-GBV screening		-	-	1,745		1,002	
NUTRITION							
Number of HIV+ patients who are clinically malnourished (non-pregnant)	2,742	20	1%	32	2%	102	6%
Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	1,371	20	1%	32	4%	102	11%
Number of eligible clients who received food and/or nutrition services		5,242		8,186		11,012	
HIV+ patients screened/assessed for malnutrition						-	

ANNEX 2 – In-service Training in Niassa from April to June 2014

Technical Area	Nr. Facilitators	Target	Nr. of Participants	Dates	Place of training	Observations
Pharmacy						
Supply Chain Management	6	Pharmacy Technicians	38	14 to 17 April	Cuamba	
Community						
Community Case Managers in CT, APSS & PP	4	Case Managers at HFs	16	26 to 30 May	Cuamba	
Total						
	10		54			

ANNEX 3 – DPS Sub Agreement Financial Execution

Subaward title:	Strengthen the Capacity of health sector in Niassa				
	Current Fiscal/Project Year	Accrued Expenses	Balance	%	
	01/10/2013-30/09/2014	01/10/2013 - 30/06/2014			
I. TOTAL COSTS INCURRED BY SUBAWARDEE					
TOTAL COSTS INCURRED BY THE SUBAWARDEE	3.675.600	126.745	2145600	1.530.000	58%
II. FHI Purchases on Behalf of Subawardee					
Subtotal Equipment	1.044.795	36.027	1044795,83	0	100%
Subtotal Office Expenses	634.426	21.877	253582,17	380.843	40%
SubTotal In-Service Training for Health Workers	1.167.884	40.272	1090536	77.348	93%
SubTotal Institutional Support	5.490.245	189.319	3635493,65	1.854.751	66%
SubTotal Infrastructure/Rehab	4.337.359	149.564	884971,83	3.452.387	20%
SubTotal Public Health and meetings support	171.873	5.927	147248,4	24.625	86%
Sub total M&A: printing of forms	1.200.000	41.379	1194366,65	5.633	100%
SubTotal Supervision Visits	2.084.246	71.871	1924942,2	159.304	92%
SubTotal Master degree scholarship	1.200.000	41.379	797100	402.900	66%
Sub Total DPS	21.006.428	597.615	13.118.637,09	7.887.791,35	62%
SubTotal Direct activities support in the districts	11.250.777	387.958	4653317,18	6.597.459,83	41%
Supervision/Techncial Assistance (Y4	783.505		661095,8	122.409,19	84%
Printing MCH registers (Y3)	708.218		708218	-	100%
SubTotal Y3	1.491.723	577.786	1.369.313,80	122.409,19	92%
Total Project Costs	33.748.928	1.088.675	21.286.868,07	12.462.060,37	63%

ANNEX 4 – CHASS Niassa Financial Expenditures Up to June 2014

See Attachment

ANNEX 5 – Success Story

CHASS Niassa introduces innovative services to combat GBV

Globally, gender based violence (GBV) affects men, women and children from all walks of life. In Mozambique, an estimated 50% of women have experienced violence, 30% at the hands of their partner. However, traditionally, GBV has been a private issue and few women have sought care. This is changing with a 2009 law on domestic violence and with support from the Gender-based Violence Initiative (GBVI) in Mozambique, a part of the United States President’s Plan for AIDS Relief (PEPFAR). The GBVI aims to expand and improve coordination and effectiveness of GBV prevention efforts; improve the policy implementation in response to GBV and improve the availability and quality of GBV services in Mozambique. In Niassa province in Northern Mozambique, the CHASS Niassa project is collaborating with the Provincial Department of Health in establishing comprehensive for GBV at health facilities. With funding from USAID, CHASS Niassa has supported the establishment of GBV units in 20 health facilities throughout the 16 districts of Niassa, including one at the Lichinga Provincial Hospital.

In the past, victims of violence who came to the Hospital were seen in a public space where victims were unable to tell their stories and where there were few staff to provide services. Today, following the introduction of the unit for victims GBV, the scenario has changed.

Located inside the hospital, the GBV unit is a clean, cozy space with a waiting area that provides services 24 hours a day. Now when victims come to the hospital, they are met by a team of trained staff who provide coordinated care so that women do not need to seek out needed services. Alzira Alfredo, a 24-year old resident of Chiuaula neighborhood in Lichnga is one client. After receiving care she said:

“I came in and was immediately answered. This was the first time I had the courage to talk about my problems, thank you for the help I received. I will return whenever I need it.”

The team consists of a team leader, a general practitioner, a psychologist, a social worker, an obstetrician/gynecologist and a medical examiner. All of them have been trained on GBV service provision. The services provided by the team are integrated with other services victims may need, including laboratory, radiography, and psychiatric services.

CHASS Niassa links these comprehensive services to community activities, in order to build awareness of the availability of these services and increase their use by the people who need them.

Data from January to March, 2014 show that 567 people received services at GBV units in Niassa. Of the 332 women and 235 men, 10 were victims of GBV. All of them received post-

exposure prophylaxis to prevent HIV infection and all of the adult women victims received emergency contraceptive services.

These GBV units are still in their early days. As one member of the team suggested:

"Our team is cohesive, flexible and provides a fast service..., however we feel that we need to work more with the community and encourage them to report and refer more cases for our services," said Laurindo Tawanja, one of the members of the team.