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FY2015 5th Year of the Project

1st Quarter Report: October to December 2014



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ACRONYM LIST

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

PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PICT	Provider Initiated Counseling and Testing
PIMA	Point of Care technology for CD4
PLHIV	People living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
QIP	Quality improvement project
SAAJ	Serviço Amigável do Adolescente e Jovem (Youth and Adolescent Friendly Service)
SAPR	Semi-annual Performance Review
SDSMAS	District Health, Women and Social Action Services
SI	Strategic Information
TA	Technical assistance
TB	Tuberculosis
TDA	Tratamento da Desnutrição em Ambulatório (Outpatient Treatment of Malnutrition)
TDI	Tratamento da Desnutrição no Internamento (Inpatient Treatment of Malnutrition)
TSV	Technical Support Visit
UATS	Unidade de Aconselhamentos e Testagem para a Saúde (Health Counseling and Testing Unit)
USAID	United States Agency for International Development
WFP	World Food Program

LIFE OF PROJECT SUMMARY

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

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

Total Amount Obligated (to date): \$ 30,170,388

Actual Expenditures Through this Quarter: \$ 27,607,848

Current Pipeline Amount: \$ 2,562,540

Projected expenditure January to March 2015: \$ 1,853,567

Geographic Focus: Niassa Province, Mozambique

I . EXECUTIVE SUMMARY

Summary of Progress this Quarter

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

Key achievements for this quarter included:

- Implementation of a new technical assistance strategy that is consistent with the acceleration plan and prioritizes TA to high volume and high prevalence sites
- Initiation of CSB+ distribution to malnourished patients
- A DHIS-2 project data base was implemented with data reported using the new system
- Completion of retrospective data entry into the electronic patient tracking system at Cuamba Rural Hospital (4 pilot sites now have retrospective data entered)

Key Indicators

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

HCT

- The majority of people who are counseled and tested do so through PICT: 51% this quarter compared to 42% last quarter
- The percentage of HIV+ clients referred from community-HCT who received care and treatment services remained high at 92%

PMTCT

- 96% of HIV+ pregnant women in antenatal clinics and 90% of women in labor and delivery received ARV prophylaxis
- 89% of ARVs provided as PMTCT were Option B+, a substantial increase compared to 54% last quarter
- 94% of the HIV+ women (n=439) were provided with cotrimoxazole prophylaxis in ANC; a substantial increase from 62% last quarter
- 80% of HIV-exposed children (n=368) were provided with ARV prophylaxis in maternity wards
- Partner HIV testing and counseling as part of PMTCT also registered a significant increase: the partners of 45% of pregnant women in ANC services were counseled and tested for HIV

ART

- 1,212 patients, including 127 children, were newly initiated on ART; a 38% achievement relative to the annual target
- The number new patients enrolled increased by 6% despite a decline in the number of people testing positive
- 33% of newly enrolled patients were women receiving Option B+

TB/HIV

- 460 new TB patients registered
- 99% (445) of registered TB patients knew their HIV status
- 59% of registered TB patients were HIV positive; all of them received CTZ prophylaxis

Laboratory

- 5,959 CD4 counts were performed this quarter, a 12% increase compared to the previous quarter

GBV

-
- 42 patients were identified as victims of sexual violence (5 males, 37 females)
- 100% of the victims of sexual violence were tested for HIV

II. PROJECT OVERVIEW

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

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

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

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

III. PROGRESS REPORT

The majority of activities scheduled for this reporting period were completed or underway by the end of the quarter. A focus in this quarter was on the implementation of a new technical assistance (TA) strategy. Under the new strategy, health facilities (HFs) are classified into three tiers according to patient volume and HIV prevalence, with higher volume and higher prevalence sites prioritized for monthly technical support visit (TSV) whereas low volume, low prevalence sites will receive only quarterly visits. The roll out of this plan began in October 2014. It was presented to and approved by provincial leaders. During the quarter implementation of the Nutrition Rehabilitation Volume 2 (for adults) began as did the implementation of psychosocial support in the province. Regarding Monitoring and Evaluation (M&E), a project database was introduced and data validation efforts were documented. In addition, the program continued to strengthen its partnership and consultations by participating in the U.S. Government, MoH, and other relevant stakeholders' convened events.

Objective 1

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

HIV Counseling and Testing (HCT) Service Expansion

HIV counseling and testing is implemented in a total of 65 HF, in several health services, grouped in three testing settings: Provider-initiated counseling and testing (PICT), health counseling and testing units (UATS) and community HIV counseling and testing (C-HCT). PICT is done in various service points including triage, in-patient services, laboratories, Youth and Adolescent Friendly Service (SAAJ) units, family planning services, and emergency rooms. PICT is implemented in all 65 HFs while UATS is implemented in 11 HFs and C-HCT in 5 of the 16 districts: Cuamba, Mecanhelas, Lichinga City, Lago and Mandimba.

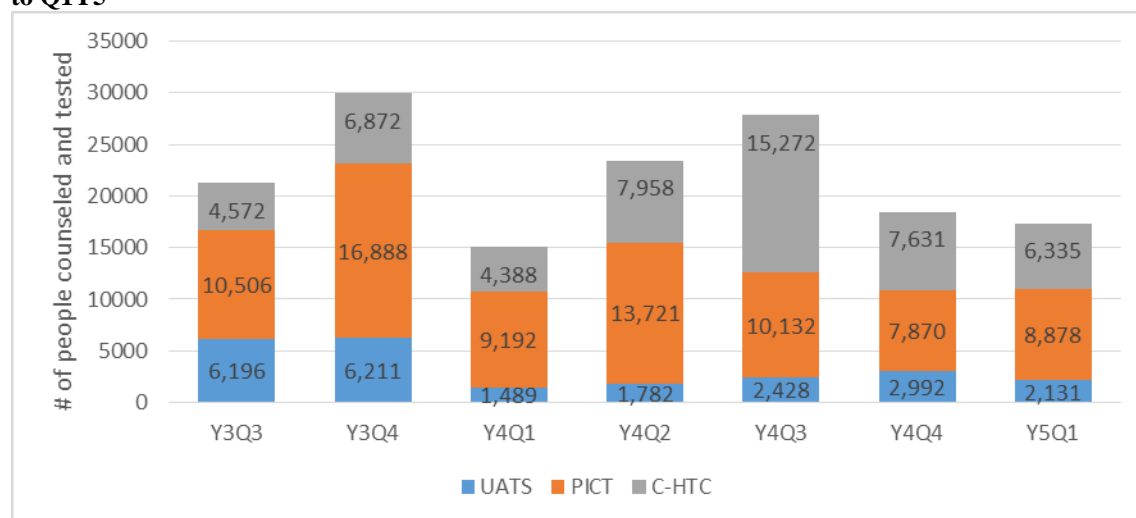
During quarter one a total of 17,344 people were tested in different points of care (UATS, PICT and C-HCT). Of those 2,131 (12%) people were tested in UATS at the 11 facilities providing these services¹, 199 of them (9%) were children under age 15 years. A further 6,335 (37%) were counseled and tested in C-HCT, 984 (16%) of whom were children. Finally, 8,878 (51%) were tested through PICT in various service points, 1,914 (22%) of whom were children. On average,

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

51% of those tested were women, although the percentage was slightly lower in UATS (49%) than in the other sites where it was just above 50%.

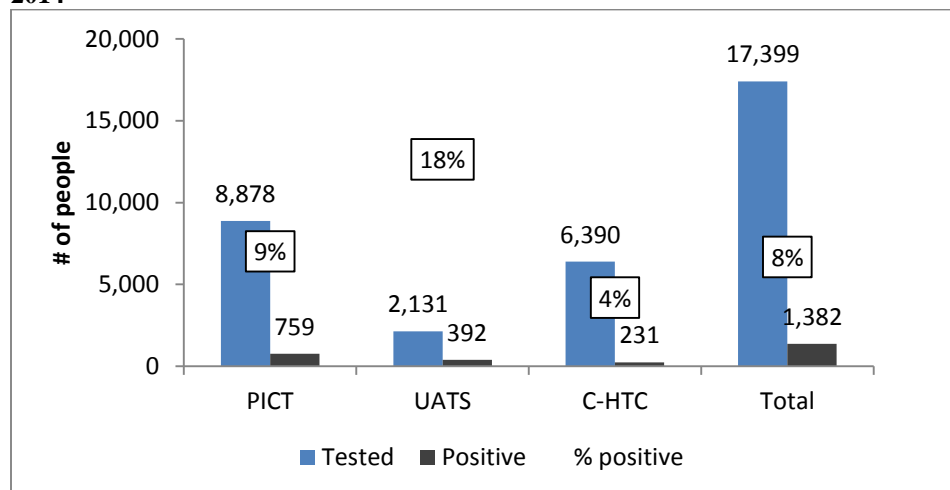
The number of individuals tested in UATS was lower than in the past two quarters (Figure 1) due to the shortage of tests and prioritization of available tests to testing in maternal and child health (MCH) and maternity services. In PICT, the number of people tested increased by 13% relative to the last quarter (from 7,870 to 8,878) but remained low relative to past performance, although the project is on track to achieve its annual target, having reached 24% of the annual target this quarter. The increase relative to last quarter was the result of efforts to ensure that record books were available in all entry points and to increase provider attention to offering tests to patients. The number of people tested via C-HCT continued to decrease this quarter as expected due to shifting HCT priorities.

Figure 1: Number of people receiving HIV counseling and testing in Niassa province, by type of testing, Q3Y3 to Q1Y5



Overall, the percentage of patients testing positive was 8%, about the same percentage as last quarter, but it ranged from 4% at C-HCT to 18% at UATS (Figure 2). As in the past two quarters, the majority of HIV positive patients were identified through PICT because of the large number of patients tested there. The percent positive among children ranged from 3% in HCT settings to 11% in PICT. In all settings, the percentage testing positive was slightly higher among females. This difference was greatest in PICT, where 7% of males tested positive versus 11% of females, and smallest in C-HCT where 3% of males and 4% of females tested positive.

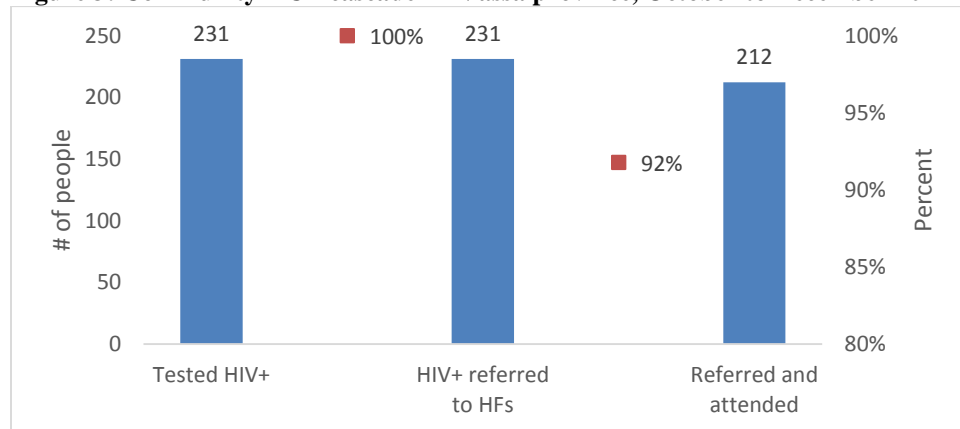
Figure 2: Total number of tests and percent positive by type of testing, Niassa province, October–December 2014



Relative to project targets, CHASS Niassa is on track to meet the PICT targets for fiscal year 5, having achieved 24% of the target this quarter. However, testing in UATS is just 10% of the target while CHASS Niassa has already achieved the target for C-HCT. The over-performance in C-HCT was in part due to an anticipated stock out of UniGold tests; as the expiration date on these tests approached, DPS pushed the remaining tests to partners doing C-HCT in order to ensure that the tests did not go to waste. Although CHASS Niassa is clearly underperforming with regard to UATS and over-performing with regard to C-HCT, over time the relative proportion of tests per setting is shifting in the direction recommended by MoH and USAID. Next quarter, CHASS Niassa will further focus its C-HCT on people identified through the case-index approach.

For community testing, ensuring that patients who test positive successfully reach care and treatment services is critical to ensuring access to care. This quarter, all patients who tested positive in C-HCT were referred to a health facility, with 92% of them (212; 79 males, 133 females) successfully reaching a health facility to receive HIV care or treatment (Figure 3). Compared to last quarter, the percentage of HIV+ referred patients who reached a HF decreased from 95% to 92%, but this is an insignificant difference ($p=0.12$).

Figure 3: Community HCT cascade in Niassa province, October to December 2014



Next quarter CHASS Niassa will continue to support the MoH strategies for HCT. As part of this effort, CHASS Niassa will sensitize District Medical Chiefs to the importance of ensuring that tests are available in PMTCT services and will provide support to monitoring the stock of tests and ensuring that supplies are moved to locations where they are needed when stocks are low. In the past, although districts stocks have been adequate, the tests have not always reached the peripheral health facilities where women seek services. Furthermore, CHASS Niassa will encourage the invitation of partners for their participation in MCH services and testing.

Prevention of Mother to Child Transmission Support Activities

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

- Support rollout of the national PMTCT program using national guidelines and training curricula;
- Increase enrollment of women and families in care and treatment programs by strengthening linkages between PMTCT and care and treatment;
- Increase access to quality PMTCT services, by linking women, children and their families in care and treatment;
- Increase uptake of antiretroviral (ARV) prophylaxis in HIV-positive pregnant women and HIV-exposed infants;
- Scale up Option B+ to peripheral HFs.

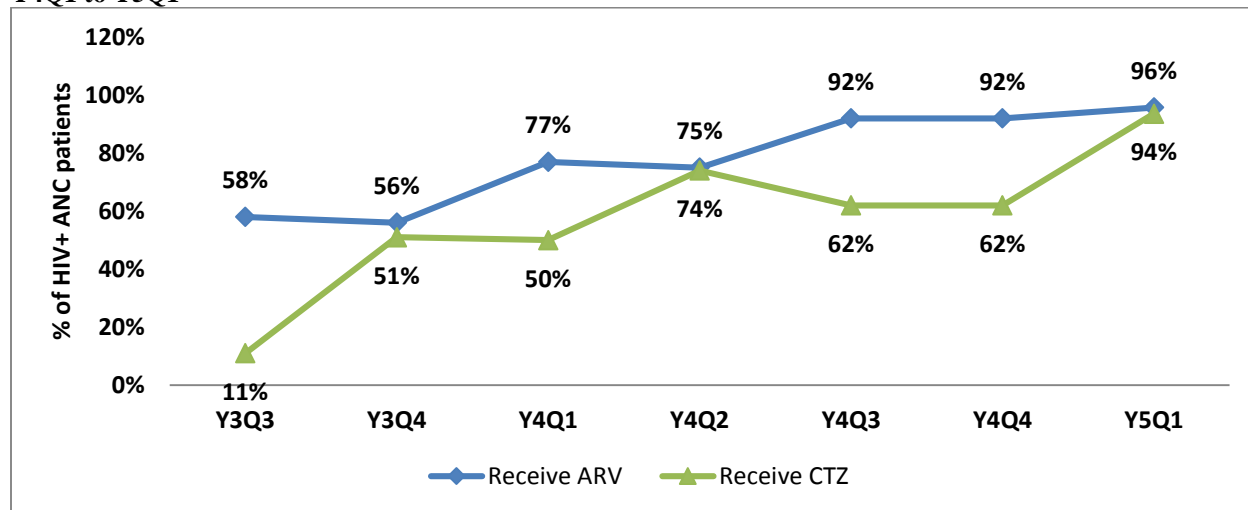
In the first quarter of year five a total of 15,613 women were newly registered in ANC, 14,089 (90%) of whom knew their HIV status, and 13,932 (89%) of them were tested for the first time in ANC services. The total number of pregnant women whose HIV status was known represents 34% achievement against the project target. The percentage of women with known HIV status (90%) remained below the target of 95%. Achieving the target is prevented by the stock outs of tests for short periods in some facilities.

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

The percentage of ANC clients who were HIV-positive was 3% (469) which is lower than the percentage seen over the past year (past data show 4-7% of women testing positive). Coverage of ARVs among HIV+ pregnant women was 96% (449), which contributed to achieving 75% of the annual target, and cotrimoxazole (CTZ) prophylaxis coverage was 94% (439) (Figure 4). Analysis

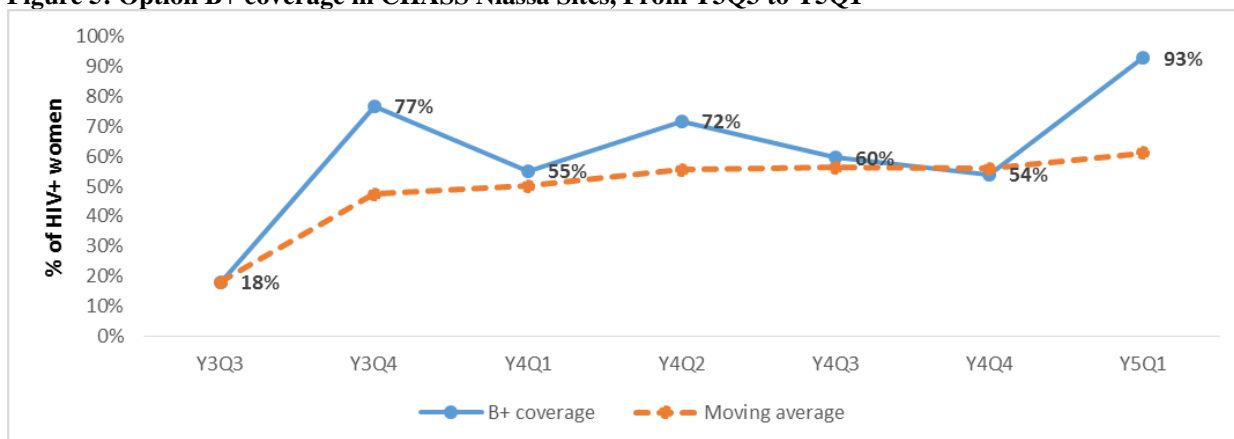
over the past five quarters shows that the coverage of ARV prophylaxis has maintained the strong performance seen last quarter, even improving slightly. Prophylaxis with CTZ increased dramatically after two quarters at 62% to 94%. These performance increases are likely related to the increased availability of ARVs and CTZ combined with increased awareness during TSV. In coordination with DPS and District Health, Women and Social Action Services (SDSMAS), CHASS Niassa is performing joint TSV and is ensuring the existence of ARV and CTZ stocks in HF. Routine data cross-checks of women diagnosed in MCH consultation and the level of ARVs and CTZ are also helping to ensure quality care for women and ARV coverage.

Figure 4: Changes in ART and CTZ coverage among ANC and maternity clients in CHASS Niassa sites, Y4Q1 to Y5Q1



Among the women provided with ARV prophylaxis, 400 (89%) were on Option B+, an increase of 35 percentage points compared to last quarter (Figure 5). To overcome the previous decline in coverage of HIV-positive women on antiretroviral therapy (ART) through Option B+, CHASS Niassa staff, in coordination with DPS and DDSMAS, reviewed the MoH guidelines regarding offering Option A for women who reject ART. During TSV in the previous quarter it was found that the providers were offering two options for pregnant women which made most women choose option A. During this quarter, providers were given clear explanations that the two options are not equivalent and told that Option A should only be offered when a woman refuses Option B+.

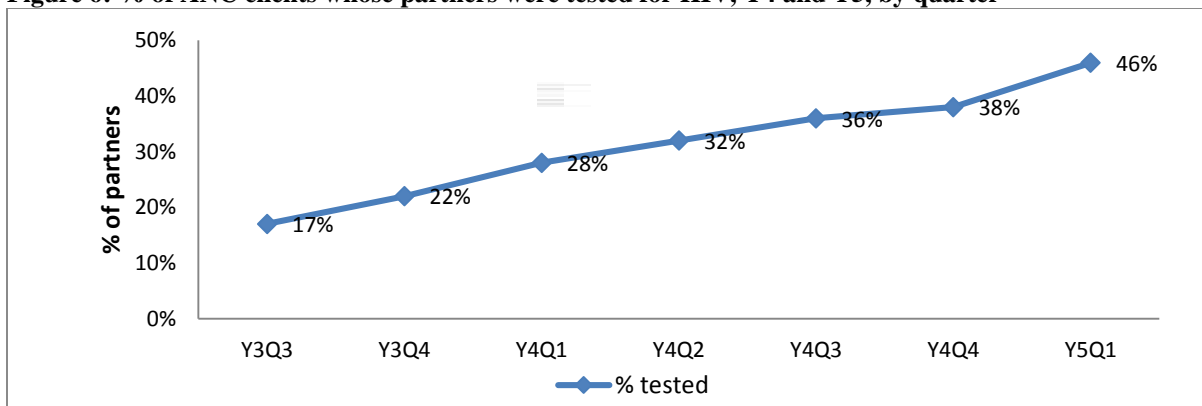
Figure 5: Option B+ coverage in CHASS Niassa Sites, From Y3Q3 to Y5Q1



Male involvement was another area of improvement during this quarter, 6,405 women brought their partners to ANC services and they were tested for HIV, corresponding to 46% of all women tested (6,405/13,932). This increase from 38% last quarter to 46% (Figure 6) this quarter continues an increasing trend over time and may be related to the consolidation of the use of invitations of the partners in the ANC, involvement of community leaders, implementation of the community case managers (CCMs) strategy, involvement of mother-to-mother and men-to-men (H2H) groups, and the community sensitization program.

The CHASS Niassa team (MCH and gender-based violence (GBV)) will continue to involve men in MCH health activities by mobilizing and training more H2H groups about the importance of joint testing of couples and to disseminate these messages in their communities.

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



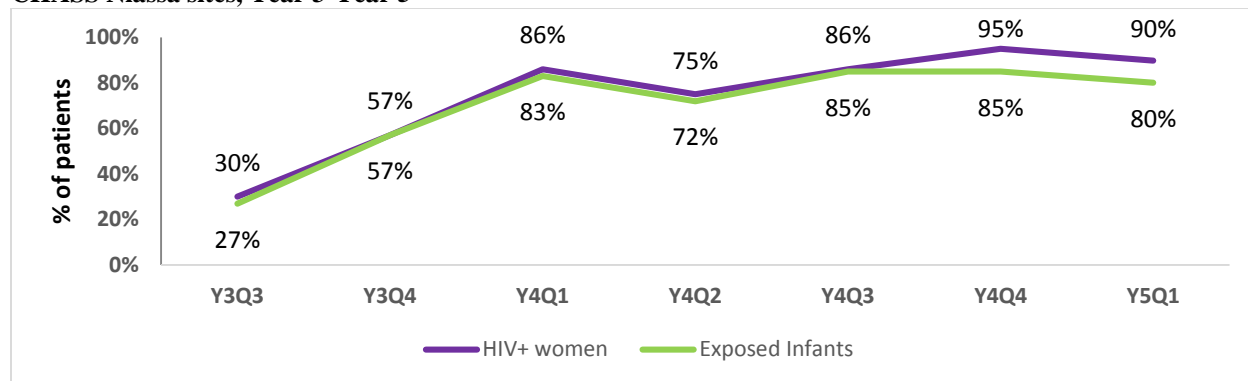
This quarter 12,297 pregnant women were registered in maternity wards, 3,244 of them had unknown status, and 2,827 (87% of those with unknown status) received HIV testing and their results. The increase from 78% last quarter to 87% may be associated with the prioritization of test kits in the maternity sector and increased awareness of the need to test all women meeting the criteria for testing in the maternity ward.

In total, 453 women who delivered in maternities were HIV positive and 407 (90%) of them were provided with ARVs. This was an increase relative to the 72% coverage last quarter although coverage is still below the 95% target. It is expected that over the next quarter more attention will be paid to the MCH nurses who take turns in maternity wards to ensure the registration of all women who have received ARVs at this service.

Regarding exposed infants, a total of 363 (80%) were provided with ARV prophylaxis, a percentage lower than in the past two quarters (Figure 7). This low prophylaxis coverage for exposed infants is the result of frequent stock outs of the pediatric ARVs suspension and, partly, because some health care providers do not systematically record in the registers when they dispense ARVs. CHASS Niassa and DPS are advocating to the Center of Medicines and Medical Supplies (CMAM) to increase the quantities of drugs supplied to the province.

Overall ARV prophylaxis for both pregnant women and exposed infants is increasing over time but the stock outs of pediatric suspensions and of ARVs for adults observed during the quarter, although they were of short duration, ultimately influence the coverage of all children and pregnant women who need ARVs.

Figure 7: % of HIV positive pregnant women in maternities and exposed infants receiving ARV prophylaxis, CHASS Niassa sites, Year 3-Year 5



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

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

- Ensure that providers understand the MoH guidelines for the provision of Option A for women who refuse Option B+ in order to decrease the number of women who do not take prophylaxis to prevent vertical transmission

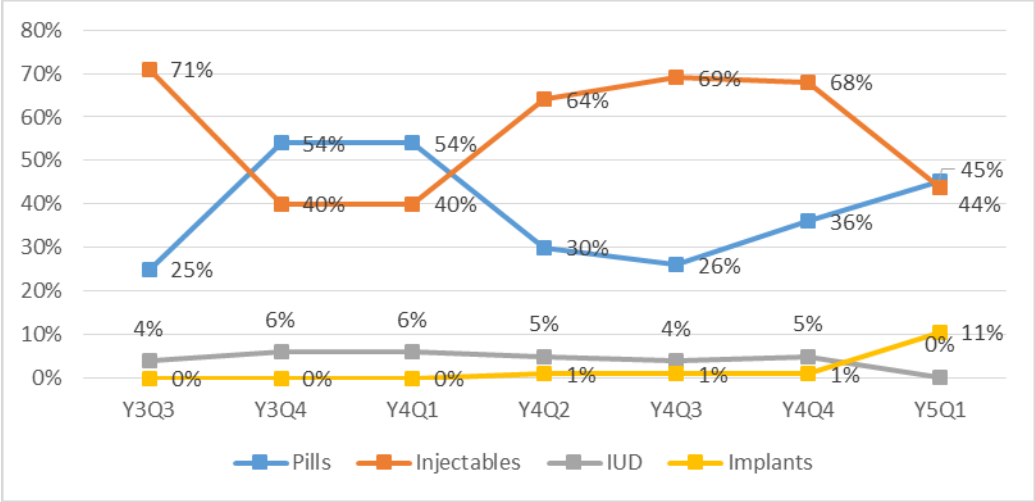
- Train medical staff to offer integrated family planning (FP) services during ART consultations
- Ensure follow up of in ART services of women discharged from MCH consultation
- Monitoring the reception of polymerase chain reaction (PCR) results through the electronic database of the National Health Institute

Family Planning

A total of 27,113 women had their first FP consultations this quarter. Their HIV status was unknown for 12,880 (48%) women, 8,214 (64%) of whom were tested for HIV, with 96 (4%) testing positive. Of these 96 HIV positive women, 8 were eligible for ART and started it in FP services, the remainder were referred to ART services where they initiated ART. The number of women who received FP services was 130% greater this quarter than last (11,775 to 27,113). This increase was due to training, in collaboration with Dharmindra Kummar Tyagi (DKT) a non-governmental organization, of *Tecnicos de Medicina Geral* in the integration of FP in HIV care, greater availability of FP methods, and registration in the ART services. The integration of FP in ART services is being implemented in 12 HFs. Next quarter CHASS will work with DPS to assess the results of these activities using existing monitoring data, and depending on the results, expand to more HFs.

In total 344 HIV+ women (including women with known HIV+ status at entry and those newly testing positive) were followed at FP consultations and 340 (99%) received a FP method: 149 (43%) injectables, 154 (45%) pills, 36 (11%) implants, and 1 (<1%) an intrauterine device (IUD). This rate of uptake is similar to that in most past quarters, with the exception of last quarter when uptake dropped to 76%. The method mix has, however, changed over time with a shift from pills to injectables over the course of the past year (Figure 8). This continued shift back to pills from injectable resulted from the continuing stock out of injectable contraceptives in HFs.

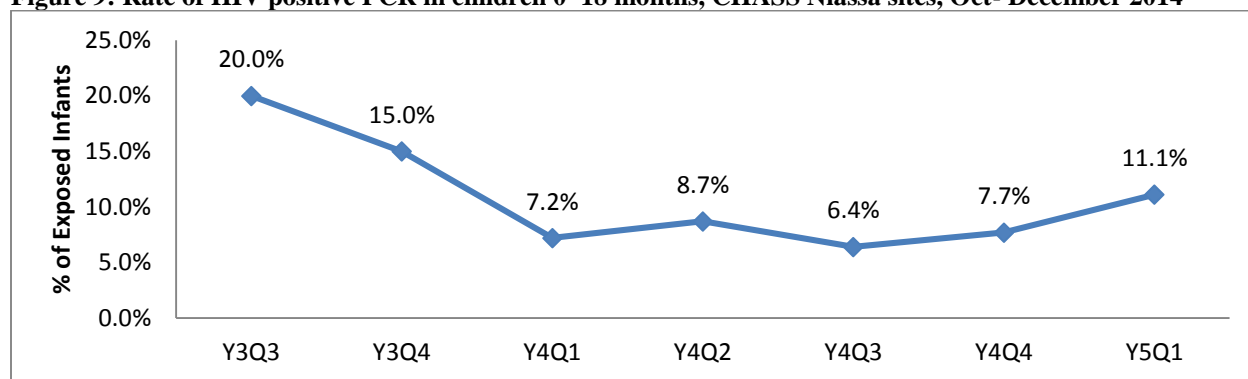
Figure 8: Method mix among HIV+ women using FP, at CHASS sites, from Y4Q1 to Y5Q1



Early Infant Diagnosis Technical Support

During the quarter, 503 children exposed to HIV were registered in high-risk consultation for children (CCR), this is about 70% of the expected number of exposed children. The percentage of children not reaching CCR is unacceptably high and CHASS Niassa is working with facilities to improve the flow of patients from maternity to CCR as well as to expand the number or sites where PCR can be collected to ensure better coverage of exposed infants. Among children seen at CCR, 397 (79%) initiated CTZ prophylaxis before 2 months of age. A total of 455 PCR samples were collected and sent to the Nampula lab, and in the same period the province received results of 459 samples², with 51 (11%) testing positive for HIV (Figure 9). All of the children who tested positive were enrolled in ART according to the MoH norms.

Figure 9: Rate of HIV positive PCR in children 0–18 months, CHASS Niassa sites, Oct- December 2014



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 from 405 last quarter to 455 this quarter and, consequently, improved early initiation of ART for infants below 18 months of age.

Pre-ART Care and Treatment Technical Support

During the quarter a total of 2,443 patients tested positive in all testing points: with 866 in maternal and child health (36 maternity, 469 pregnant women in ANC, 171 partners, 43 postpartum consultation, 96 FP, and 51 children in CCR), 195 in the Tuberculosis (TB) sector, 759 in PICT, 231 in C-HCT and 392 in UATS. Of those testing positive, 1,910 (78%) patients were enrolled in pre-ART services. Compared to the previous quarter the proportion of people testing positive who

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

were included in pre-ART services increased significantly (from 41% to 78%) (Figure 10). This increase was due to continued support to providers to encourage them to open the medical records at the moment of HIV diagnosis, allowing for a reduction in lost opportunities for enrolling patients in care. In the past, providers have hesitated to open a medical record until a client returned because they did not want to risk counting the patient as lost-to-followup. We are working to help them to understand the importance of opening a clinical record for all patients who are diagnosed as HIV positive. This was complemented by community awareness after testing to encourage those who tested positive to seek services quickly.

To ensure that all patients testing positive enter care or treatment, CHASS Niassa will continue to encourage the opening of medical records at the time of diagnosis by tracking the percentage of charts opened and will increase monitoring and follow-up of patients referred from communities to the HF.

Of the 1,910 people who tested positive, 1,212 (63%) started ART (Figure 10). The proportion of new patients enrolled in ART declined relative to last quarter (82% to 63%) while the percentage enrolled in pre-ART increased (41% to 78%) (Figure 11); this shift is likely due to earlier diagnosis. Our semi-annual cohort data will be used to assess this in further detail.

Figure 10: Pre-ART cascade, CHASS Niassa sites, October to December 2014

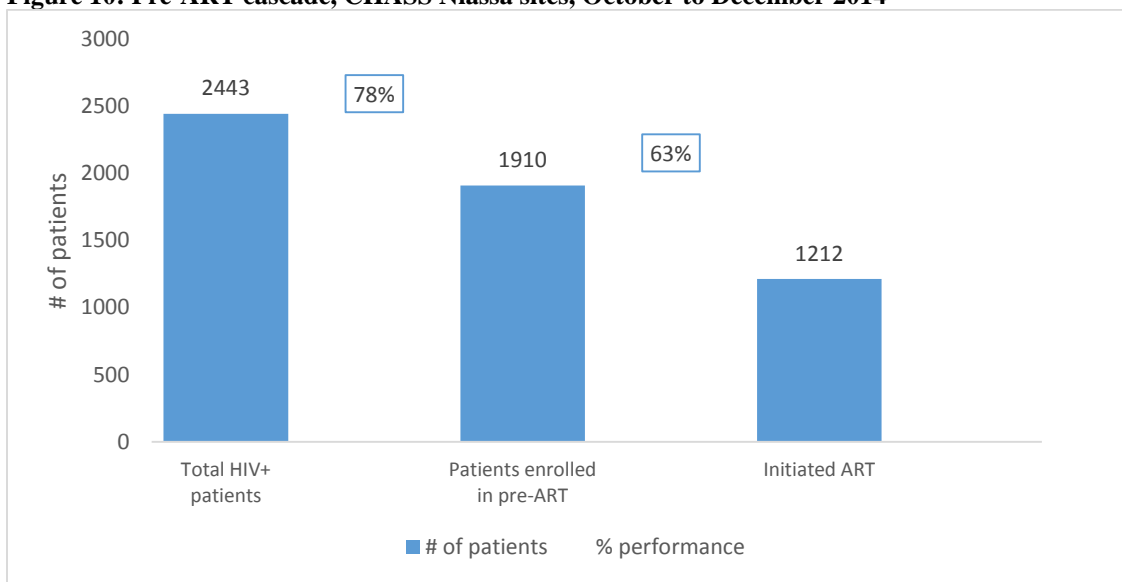
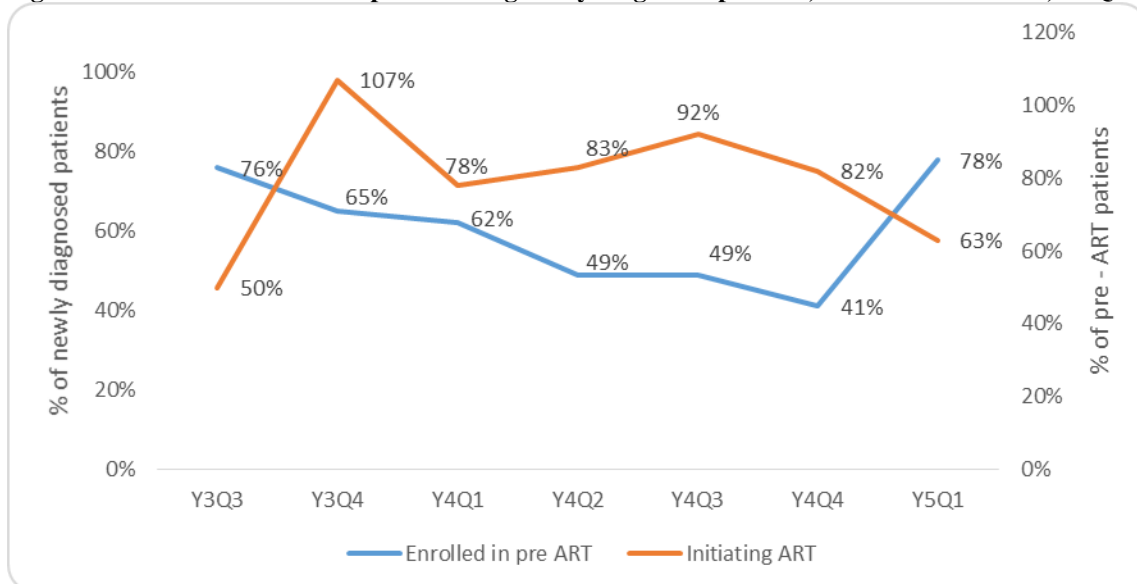


Figure 11: Pre-ART and ART uptake among newly diagnosed patients, CHASS Niassa sites, Y4Q1 to Y5Q1



Adult Care and Treatment Technical Support

During this quarter, 1,212 new patients initiated ART in all HF that are providing these services. This is a slight increase of 6.5% (1,138 to 1,212) compared to last quarter (**Error! Reference source not found.** 12) and is 37% achievement of the annual target (Figure 13). This small increase occurred in spite of a decline in the number of patients testing positive (from 3,366 to 2,443). Maintaining the number of new patients despite the decline in the number testing positive was due to strengthened technical review of clinical charts of patients on pre-ART in order to identify those meeting the criteria to start ART. Moreover, CHASS Niassa is helping to ensure regular follow up of pregnant women to ensure that they are accurately registered in the ART registers as well as in the PMTCT registers. As in each quarter last year, new enrollment is substantially higher than the target and we anticipate exceeding the target again this year given that we are already at 37% in the first quarter of the year.

Figure 12: Number of newly enrolled patients on ART in CHASS sites, by quarter, FY4 and FY5

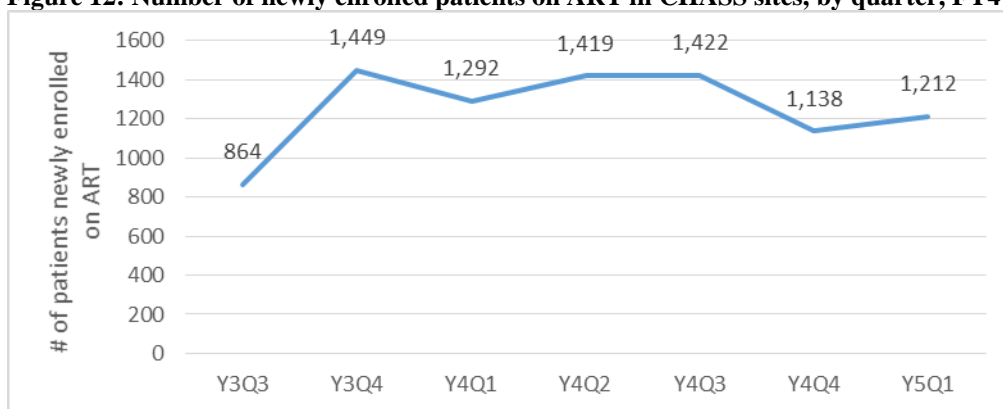
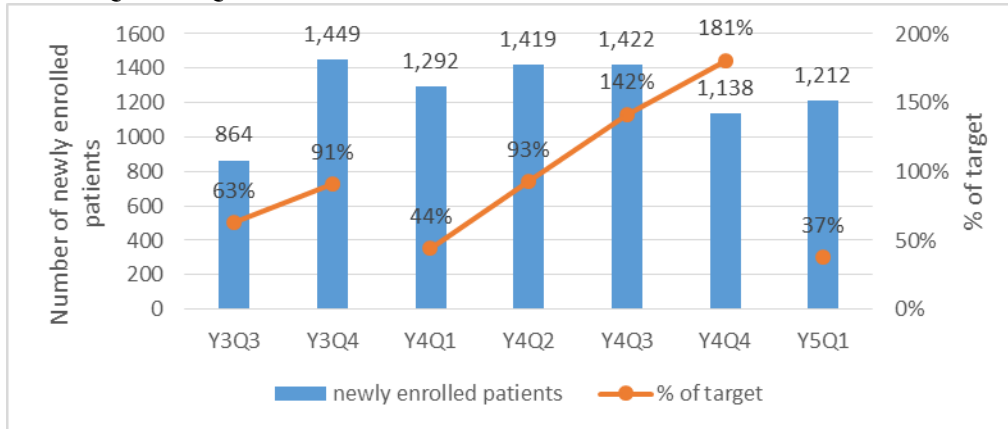


Figure 13: Percent achievement of annual target in number of newly initiating ART in CHASS Niassa sites, from Y1Q4 to Y5Q1



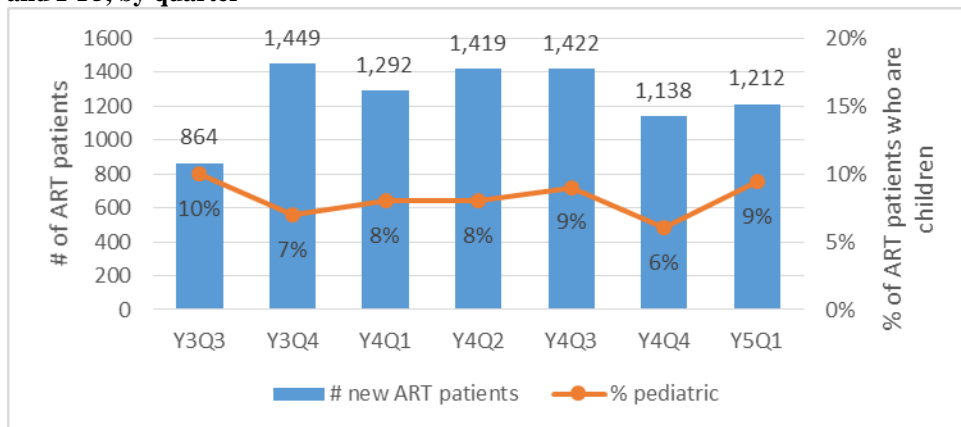
Of the patients enrolled in ART, at least 400 (33%) are pregnant women who have benefited from Option B+, the same percentage as last quarter. CHASS Niassa will continue to encourage evaluation of the clinical charts of pre-ART patients to ensure the selection and inclusion of those who have met the criteria for ART.

The number of patients currently in ART in December was 13,604, which is 115% of the annual target, and the number of patients ever enrolled on ART was 19,374.

Pediatric Care and Treatment Technical Support

During the quarter, 124 (70 males, 54 females) children were newly enrolled in ART, corresponding to 9% of all patients enrolled. Relative to last quarter, the percentage of pediatric patients increased from 6% to 9%. Although there was an increase relative to last quarter, performance this quarter is consistent with levels seen over the past year (**Error! Reference source not found.** 14). The CHASS Niassa project will continue to encourage testing for HIV among children, including in triage, in-patient services, CCR, immunization, and wellbeing consultations.

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



TB/HIV Co-infection Support Services

CHASS Niassa supports the implementation of TB/HIV services through the one-stop-shop model in a total of 17 HFs, specifically in HFs of the 16 district headquarters and Lichinga district with two HFs. Ten of the supported HFs are implementing the partial one-stop-shop model (it is partial because cluster of differential 4 (CD4) samples are not collected in the TB sector; they are collected on specific days and then sent to a reference laboratory for analysis of CD4), with health staff trained in prescription of ARVs.

This quarter, because of high turnover rates (>50%) among district TB supervisors, CHASS Niassa focused on providing on-the-job training to these new staff on the implementation of the one-stop-shop model. However, even with appropriate training, implementation remains a challenge because while almost all components of the model have been implemented in TB services, the collection of samples in the TB room has not been implemented. This is part of current discussions between DPS and CHASS Niassa. In addition, the discussion and sharing of information between TB and HIV sectors is limited. Moreover, the retention of HIV patients who have completed TB treatment remains a challenge.

This quarter, 460 patients were registered in the TB sector, about the same number of patients as last quarter (455). This quarter, 38 (8%) of the TB patients were children. Among these patients, 455 (99%) knew their HIV status but 75% (339) of them did not know it on admission and were tested for HIV (Figure 15). In total, 273 (59%) of new TB patients were HIV positive (those with known status on entry plus those who tested positive). Among all co-infected patients, 92% were provided with CTZ prophylaxis in the TB sector and the rest were provided with CTZ outside of the TB sector. Among the co-infected, 94% (257) were enrolled on ART (**Error! Reference source not found.**6).

Figure 15: TB/HIV cascade in CHASS Niassa sites, from October to December 2014

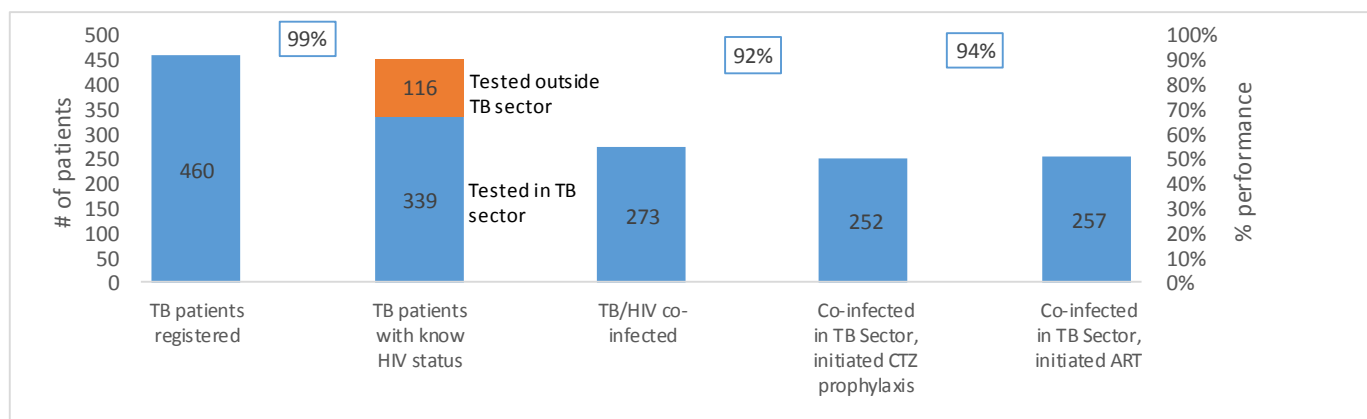
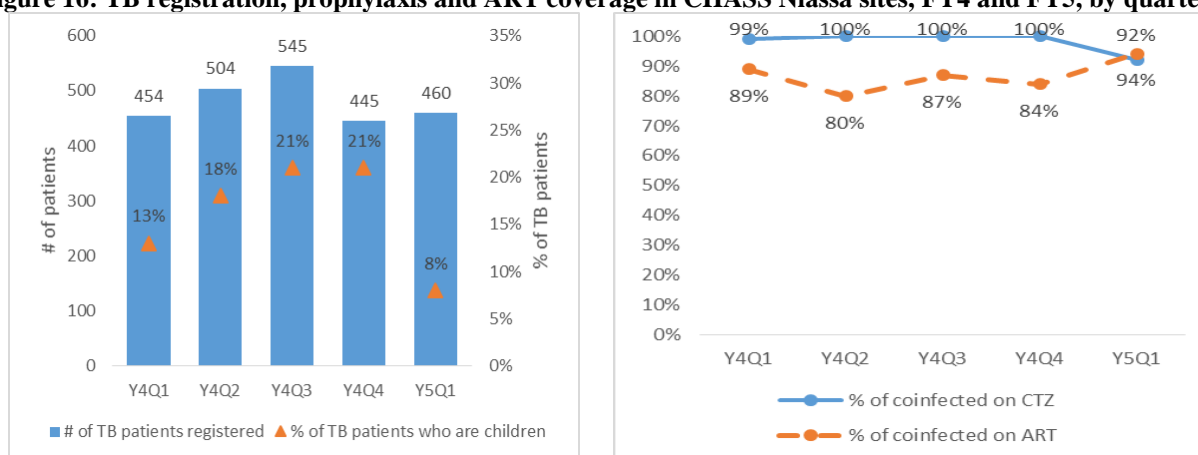


Figure 16: TB registration, prophylaxis and ART coverage in CHASS Niassa sites, FY4 and FY5, by quarter



This quarter, almost all co-infected patients received ARVs as part of universal access, with coverage reaching 94%. This increase was likely the outcome of TA provided by CHASS Niassa, in particular, a review of the TB register books with the TB supervisors to identify co-infected patients who had not yet started ART so that they could be encouraged to start ART at their next visit.

In the next quarter, CHASS Niassa in coordination with DPS Niassa will continue providing TSV to the TB sector and will work to improve linkages to the HIV sector. This will include encouraging TB supervisors to share with the ART services, on a weekly basis, information on the number of TB patients who have completed treatment and need to be transferred to ART services.

Adherence to Treatment and Retention in Care Technical Support

This quarter, CHASS Niassa continued to implement the strategies that are believed to have contributed to the improvement in ART retention seen in the Annual Performance Review (APR)

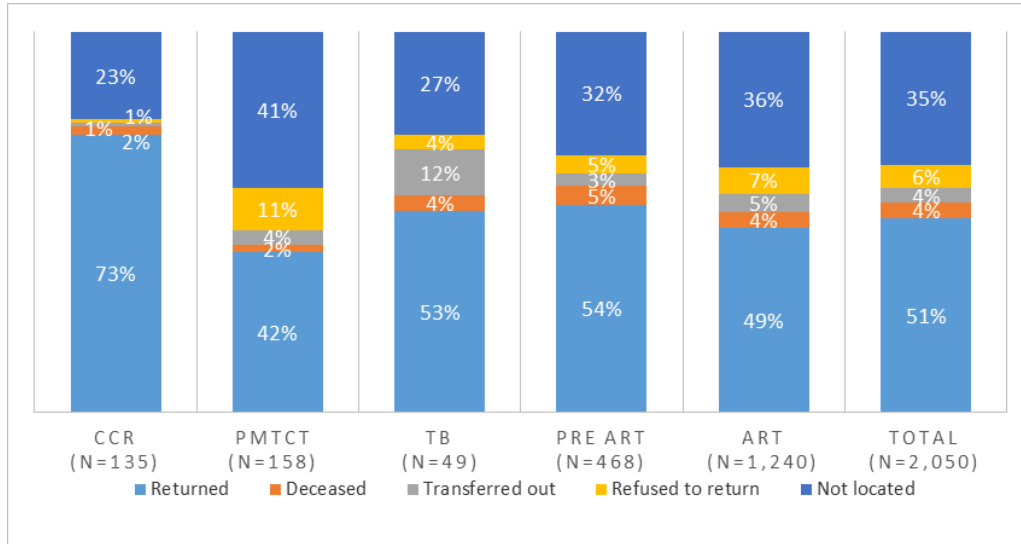
14. This included: 1) implementation of the acceleration plan which will allow HIV services to be provided nearer to patients, and 2) the implementation of the psychosocial support strategy (APSS). The outcome of these continued activities on retention will be reported in Semi-Annual Performance Review (SAPR) 15. However, *busca activa* continues as a means to encourage retention and is reported here.

This quarter, a list of 468 *defaulted* patients in pre-ART (178 males, 290 females) were delivered to the CCMs and C-HCT lay-counselors for tracing. Eighty-seven (19%) of these defaulted patients were children. In all, 54% (253; 105 males, 148 females) of these patients returned to treatment, 5% (25; 12 males, 13 females) had died, 3% (15; 4 males, 11 females) had transferred to other health facilities of the province or country, and 5% (24; 7 males, 17 females) refused to return to treatment even after sensitization and counseling sessions for adherence (Figure 17). The remaining 32% (152; 50 males, 101 females) could not be found at the addresses provided during pre-ART counseling sessions. The planned study on *busca activa* is scheduled to begin in Quarter 2 and will provide insight into the reasons that many patients in all areas cannot be found.

In ART, a total of 1,240 (436 males, 804 females) patients who *defaulted* treatment were delivered to CCMs for tracing; 12% of these defaulted patients were children. In all, 49% of these patients (602; 195 males, 407 females) returned to treatment (Figure 1), whilst the remaining patients had either died (4%, 44; 23 males, 21 females), transferred out (5%; 59; 23 males, 36 females), refused to return to treatment after sensitization (7%, 84; 27 males, 57 females), or could not be located at the provided addresses (36%, 451; 168 males, 283 females).

The percentage of defaulted patients who returned to care varied in other services. In CCR 73% (99) returned, 42% (67) in PMTCT and 53% (26) in TB. The percentage of defaulted patients that could not be located was 23% (31) in CCR, 41% (64) in PMTCT and 27% (13) in TB but all of these groups have small numbers of patients so a small difference has a large impact on the percentages.

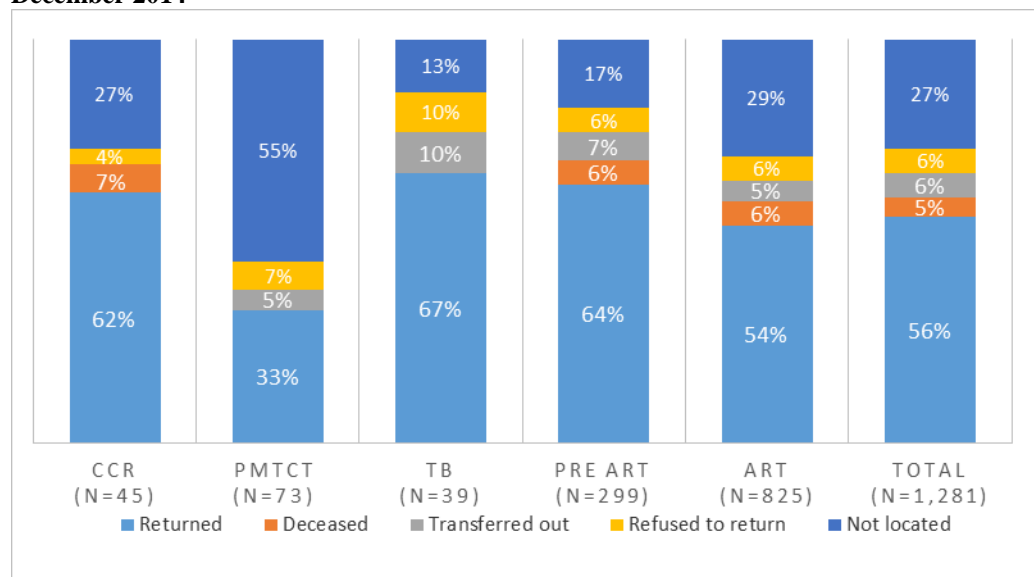
Figure 17: Outcome of patients who defaulted in CHASS Niassa sites, by type of care from, October to December 2014



With regard to efforts to ensure return of patients that *abandoned* pre-ART care, a list of 247 patients (112 males, 135 females) was delivered to the CCMs for tracing, 18% (44) of these abandoned patients were children. In all, 47% (115 patients; 50 males, 65 females) returned to treatment (Figure 17). An additional 6% were deceased (16; 8 males, 8 females), 11% had transferred out (27; 15 males, 12 females), 4% (11; 3 males, 8 females) had refused to return to treatment, and 32% (78; 36 males, 42 females) could not be located.

In ART, 842 patients who had *abandoned* treatment (343 males, 499 females) were listed and delivered to CCMs for active finding, 7% of these abandoned patients were children. Overall, 45% (378; 163 males, 215 females) returned to treatment (Figure 18), with 7% (55; 17 males, 38 females) having died, 11% (90; 38 males, 52 females) transferred out, 7% (57; 17 males, 40 females) refused to return, and 31% (262; 108 males, 154 females) could not be located.

Figure 18: Outcome of patients who abandoned care in CHASS Niassa sites, by type of care from October to December 2014



The percentage of abandoned patients returning was 51% (35) in CCR, 26% (47) PMTCT, and 78% (9) TB. Among the abandoned patients, 43% (15) in CCR, 72% (34) in PMTCT, and 0% in TB were not found.

Compared to last quarter, the percentage of patients who returned to care was lower for both those who had abandoned care and those who had defaulted from pre-ART, ART and PMTCT (results not shown). The consistency of these differences across service areas suggests that this decline may be due to the time of year (preparation of fields and other seasonal agricultural work). Challenges to active case finding include: the high proportion of patients who cannot be located, and patients who refuse to return to treatment after being located, especially in PMTCT and ART. The reasons some patients refuse to return to treatment are not clear, in early 2015 CHASS Niassa will conduct an assessment in order to identify the reasons.

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

Laboratory

This quarter CHASS Niassa continued supporting 18 micro and functional laboratories in the 16 districts of Niassa province; 61% (11 out of 18) of these laboratories have the capacity to perform CD4 counts. During the quarter a total of 5,959 CD4 counts were performed, a 12% increase compared to the previous quarter (5,245). Again this quarter, 36% of the CD4 counts undertaken were done using the Point of Care technology for CD4 (PIMA) machines (Table 1), however the number of tests done using PIMAs increased, keeping pace with the number of patients tested. This increase in the number of samples processed using PIMA occurred despite the breakdown of the PIMA in Entre Lagos during December and lack of a qualified operator in Mavago during October and November. These challenges were addressed through redirection of samples to HFs capable of CD4 testing and, in the longer term, through replacement of the broken machine with a backup machine. Samples from Entre Lagos were sent to Mecanhelas, where the number of samples processed increased dramatically compared to last quarter (Table 1) while those from Mavago were sent to Lichinga Provincial Hospital. Awareness about underuse of the PIMAs was raised during the Provincial Meeting of HIV and MCH, where the Provincial Lab Supervisor presented data on the performance of each PIMA in comparison to the number of samples requested by clinicians. Monthly feedback was also provided from the Provincial Laboratory to the district medical heads, to keep them informed about the productivity of PIMAs, showing commitment to improving performance.

Next quarter CHASS will continue to work with the clinicians raising their awareness about the need to request CD4 tests and to follow up to ensure that they receive the results from the lab. In addition, the lab team will implement the quality improvement project with the objective of guaranteeing that all samples requested are processed and the results are available in the patient's clinical charts.

Table 1: Number of CD4 counts using PIMA, by facility, October to December 2014

Health facility	Oct	Nov	Dec	Q4Y14	Q1Y15
Cobue	17	40	30	124	87
Metangula	108	127	123	406	358
Mavago	0	0	15	39	15
Mecula	35	27	29	97	91
Marrupa	32	106	75	148	213
Maua	41	95	36	182	172
Mecanhelas	131	318	203	381	652
Entre Lagos	21	76	1	139	98
Mandimba	125	182	125	424	476
Total	510	971	637	1940	2,162

During the quarter, 459 PCR samples (404 first collections and 55 repeated collections) were received from the Nampula reference laboratory, a 12% increase compared to the previous quarter (from 410 to 459). This increase was due to an expansion in the number of places conducting PCR and improved sample collection routes. Of the PCR samples sent, 100% of the results were received. As far as the test results are concerned, of the 459 samples, 51 (11%) were positive.

CHASS Niassa will work with DPS next quarter to explore why this many transmissions occurred even though all of the mothers were reportedly taking Option B+.

During the reporting period, a total of 2,787 smear slides for diagnosis of TB were processed with 270 (10%) diagnosed positive, a slight increase from 8% last quarter. The number of slides processed increased by 37% relative to the last quarter, when 2,036 slides were processed.

A total of 88 samples were processed using the Gene Xpert machine in Cuamba and Mycobacterium TB was detected in a total of 26 samples (30%) with five identified as resistant to rifampicin (Table 2). There was a 42 % decrease in the number of samples processed using the Gene Xpert machines (from 151 to 88). Although the number of samples processed declined, the number of samples positive for DNA M. tuberculosis increased which may be due to improved accuracy in identifying potentially resistant cases. Next quarter CHASS will continue to emphasize quality identification.

Table 2: Gene Xpert results in CHASS Niassa sites, FY4 by quarter, and FY5 1st quarter

	# of samples processed	Presence of DNA of M.Tuberculosis detected	Presence of DNA of M.Tuberculosis not detected	Invalid	Resistance to Rifampicine identified
Year 4					
Q1	260	42	207	2	6
Q2	80	19	61	0	1
Q3	144	26	104	1	5
Q4	161	23	120	0	1
Year 5					
Q1	88	26	56	0	5

Injection Safety/Infection Prevention & Control/Biosafety Technical Support

During the quarter, Infection Control Program (ICP) internal measurements were done in seven health facilities (Table 3). The average score remained constant relative to last quarter at 62%, but individual facilities faced challenges. For example, Chimbonila and Mandimba were missing supplies needed for both personal protection and sterilization. In general, the most frequent issues affecting infection control practices remain the limited availability and poor use of personal protective equipment, non-compliance with the rules of segregation of hospital waste, and difficulties in access to running water. Although CHASS Niassa cannot address all of these issues, it will purchase biosafety material in 2015.

Table 3: Overall infection control assessment score by HF, by quarter, Q3Y4 to Q1Y5

Health Facility	Y4Q3	Y4Q4	Y5Q1
Marrupa	53.0	44.5	--
Cuamba	54.4	67.7	--
Mecanhelas	--	69.8	--
Metarica	62.0	51.2	70.8
Majune	--	48.0	58.0
Nipepe	64.7	78.9	80.3
Muembe	53.1	69.7	69.6
Chimbonila	44.3	67.6	50.4
7 de Setembro	NF	NF	63.0
Mandimba	--	51.0	41.0

Post Expose Prophylaxis (PEP)

With regard to the PEP, this quarter there were 10 cases of occupational exposure to HIV reported with 3 males and 7 females. All of them received PEP (Table 4).

Table 4: Occupational exposures to HIV and PEP, by type and sex, October to December 2014

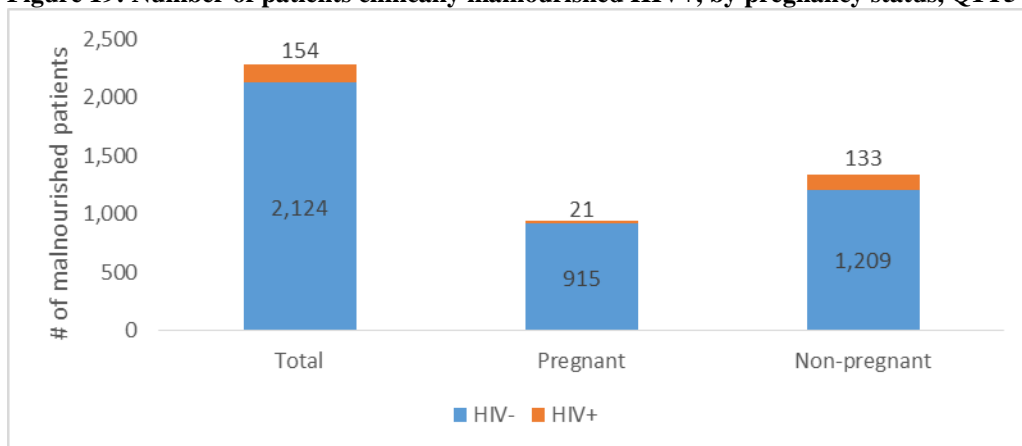
Health Facility	Type of Exposure						Total		PEP	
	Massive		Intermediate		Minimum		M	F	M	F
	M	F	M	F	M	F				
Mandimba	0	2	0	0	0	0	0	2	0	2
Chimbonila	0	1	0	0	0	0	0	1	0	1
Lichinga Provincial Hospital	0	0	3	4	0	0	3	4	3	4
Subtotal	0	0	3	0	0	0	3	7	3	7

Nutrition, Access to Food and Utilization Technical Support

The CHASS Niassa nutrition program aims to strengthen nutrition counseling and care for PLHIV in clinical- and community-based services in Niassa Province. The program supports the implementation of the Nutrition Rehabilitation Program (NRP) volume 1 and 2, which has been implemented in Niassa Province since July 2012, covering children under 14 years old in volume 1 and over 15 in volume 2 a total of 18 HFs. The NRP and ART, TB, PMTCT, and CCR services are entry points to reach HIV+ patients receiving supplementary or therapeutic food and the HIV+ patients clinically malnourished (non-pregnant). The community interventions under CHASS Niassa also contribute to improvements in nutritional status through the lectures and education on good practices demonstration.

In this quarter a total of 2,278 malnourished patients were referred to NRP from various consultations³, of these 154 (7%) were HIV+. Compared to last quarter, the number referred increased by 310% (from 555 to 2,278 patients) while the proportion of malnourished patients who were HIV+ remained unchanged (the 2 percentage point difference is not statistically significant). The number of patients increased as a result of the availability of Corn Soy Blend plus (CSB+) starting in the middle of the quarter as well as expansion from NRP vol 1 to NRP vol2 (allowing for services for adults). Pregnant women comprised 42% of the malnourished patients (n=936) and 21 (2%) of these pregnant women were found to be are HIV+; among the 1,342 non-pregnant patients, 133 (10%) tested HIV+ (Figure 19).

Figure 19: Number of patients clinically malnourished HIV+, by pregnancy status, Q1Y5



Data source: M&E CHASS N

Among the malnourished patients, 118 (5%) met the criteria for inpatient treatment while the remaining 2,160 were treated as outpatients.

Nutrition among HIV positive patients

This quarter is the first time that quarterly data have been collected on the PEPFAR nutrition indicators. These data were first reported by CHASS Niassa in APR14 but only 6 months of data were included at that time. Please note that data on the number of patients assessed are only

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

reported semi-annually because this information is entered into the patient chart but not the register books.

This quarter a total of 155 HIV+ patients were reported to be clinically malnourished, 21 of whom were ANC clients (19 pregnant and 2 postpartum). This is just 5% of the annual target for 2015. We believe these data are under-reported because the nurses and clinicians do not consistently fill in the registers when they provide services. In total, 57% of the clinically malnourished patients were female, 64% were severely malnourished and 37% were 0-4 years old whereas 49% were over age 15 and the remainder were 5-14 years old.

The majority of HIV+ patients who were malnourished were reported to have received supplemental or therapeutic food. All of the HIV+ pregnant women identified in ANC were reported to have received this as did 76% of the non-pregnant HIV+ patients. The total number of HIV+, non-pregnant patients who were reported to have received food was 123, 8% of the annual target. A higher percentage of moderately malnourished patients received food (94%) than did severely malnourished patients (66%). Patients who were HIV+, not pregnant and over age 15 were more likely to receive food (98%) compared to similar 0-4 year olds (62%) and 5-14 year olds (33%), though only 18 patients were 5-14 years old. We believe that the number of patients who received treatment is under reported because clinicians fail to complete the registers.

Table X. Nutrition status and receipt of supplemental or therapeutic food, by group, Niassa, Oct-Dec 2014

Sex		Age			Malnutrition Status		Pregnancy status	
Male	Female	0-4	5-14	15+	Mild/Moderate	Severe	Pregnant	Postpartum
HIV+ patients clinically malnourished (non-pregnant)								
58	76	50	18	66	48	86	NA	NA
# HIV+ pregnant women who are clinically malnourished								
					16	3		
# HIV+ patients receiving supplementary or therapeutic food								
43	80	31	13	79	48	75	19	2

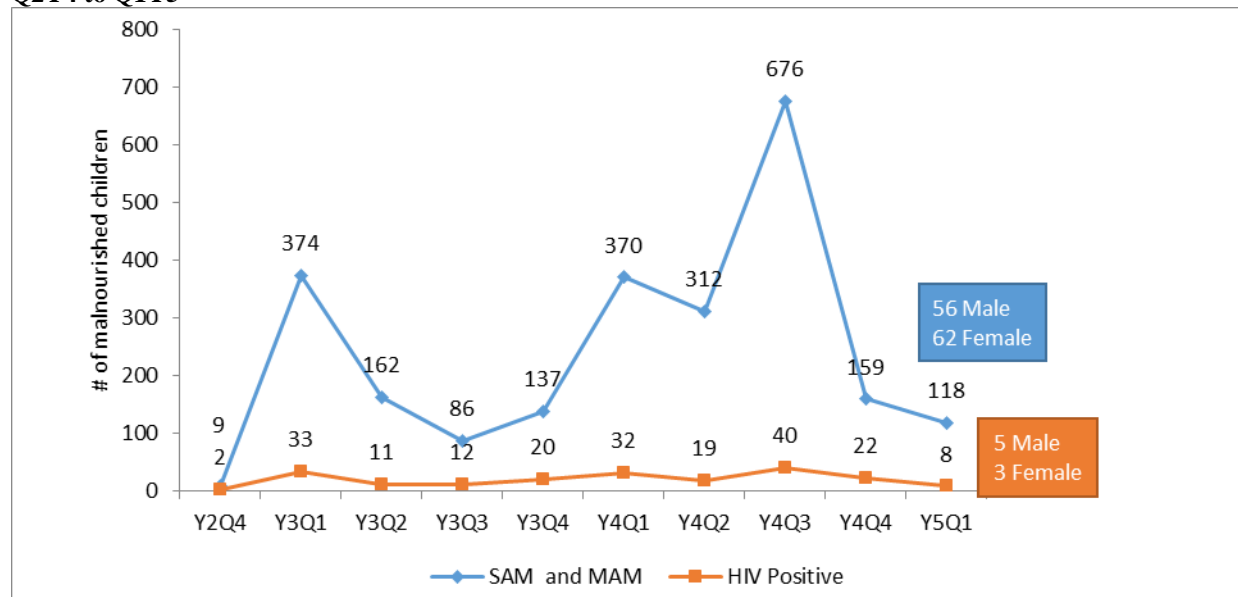
Nutrition Rehabilitation Program Technical Support – Clinical Component

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

During this quarter, a total of 118 children attended inpatient nutrition services. All of them were tested for HIV and 7% (8/118) tested positive (Figure 20). The number of children who arrived with severe malnutrition and who met the criteria for admission decreased by 26% (159 to 118) compared to last quarter, which may in part be related to community-level activities including lectures about good nutrition practices but may also be due to the season, with fewer patients

seeking services because of the heavy agricultural workload. During the joint TSV the team strengthened assessment of children and community education on good culinary practices, in order to reduce the number of children with severe malnutrition arriving at inpatient services. Furthermore, the importance of accurately recording patients in the registration books was reinforced and the parallel data collection by the M&E teams of DPS and CHASS Niassa continued to collect data required for President’s Emergency Plan for AIDS Relief (PEPFAR) reporting.

Figure 20: Number of patient treated for malnutrition in inpatient settings in select CHASS Niassa sites, Q2Y4 to Q1Y5

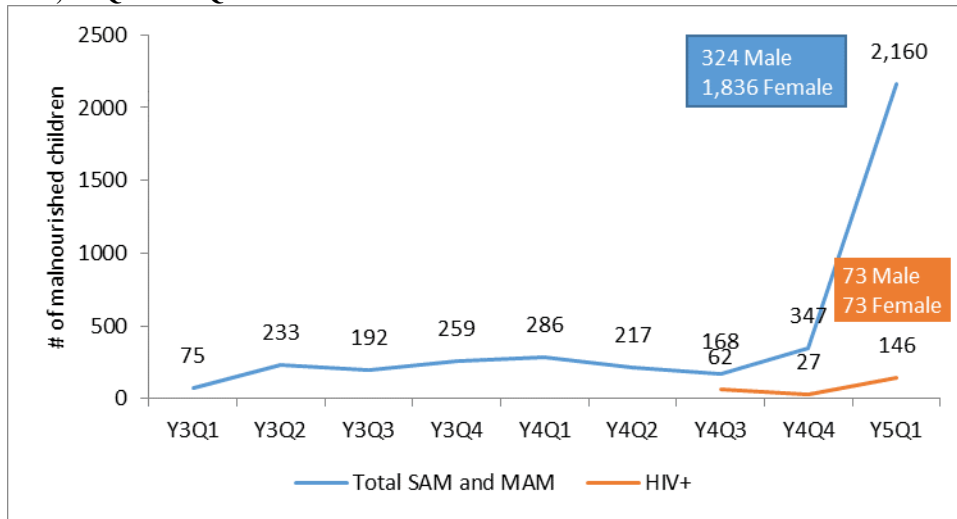


Data source: DPS, for FY14. CHASS Niassa M&E for Q3Y4 to Q1Y5

Nutrition Rehabilitation Program Outpatient treatment of malnutrition (TDA)

A total of 2,160 (324 male, 1,836 female) malnourished patients were seen in ambulatory care and all of them were tested for HIV with 7% (146/2,160) testing positive (Figure 21). Among the 1,836 female patients, 73 (4%) tested positive, and 21 (29%) were pregnant or lactating women. The number of malnourished patients increased dramatically by 522% (347 to 2,160) compared to the last quarter as a result of the implementation of CSB+ as well as improvements in nutrition screening, and recording and data collection.

Figure 21: Number of patients treated for malnutrition and number HIV+ in select CHASS Niassa outpatient sites, Y3Q1 to Y5Q1



Data sources: DPS for FY14. CHASS Niassa M&E for Quarter 1 of Y5

Challenges in Implementing the Clinical Component

The challenges in implementing the clinical component remain the same as last quarter. Consistent and correct nutrition screening in HIV/AIDS services is still a challenge to NRP implementation in the province. This is due in part to 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 DPS nutritionists during regular joint TSV to improve the screening of malnutrition cases, classification, and treatment according to the NRP protocol as well as to more accurately register patients.

The MoH policy does not include the integration of nutrition assessments in Pre-ART, ART, PMTCT, TB and other chronic diseases which limits the likelihood that these patients will be screened. The regular absence of professionals in the HFs to attend trainings and meetings at district and provincial levels also negatively influences the implementation of NRP. CHASS Niassa will continue to provide on-the-job training and mentoring of new technicians allocated to HFs as well as refresher training for implementation of CSB+. In addition, we will continue to verify the consistency of the data, particularly in CSB+ implementation. Moreover the stock management of the nutrition supplements will be required.

Nutrition Rehabilitation Program Technical Support – Community Component

Community Nutrition Intervention – Referrals and Counter-referrals

At the community level a total of 141 children were identified as malnourished and were referred to HFs by the CCMs; 113 of them were followed at a HF (Figure 22). The difference of 28 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 referred decreased by 2% and the number followed decreased by 12% compared to last quarter (Figure 23) due to 12 CCMs (6 in Lago, 2 in Mandimba, 2 in Mecanhelas and 2 in Maua) dropping out of the project. Fifty-five percent of those referred were under 15 years of age and 67% of them were male (Table 5).

Figure 22: Number of patients with malnutrition referred to HFs and followed in HFs in Niassa Province, Q1Y4 to Q1Y5, by quarter

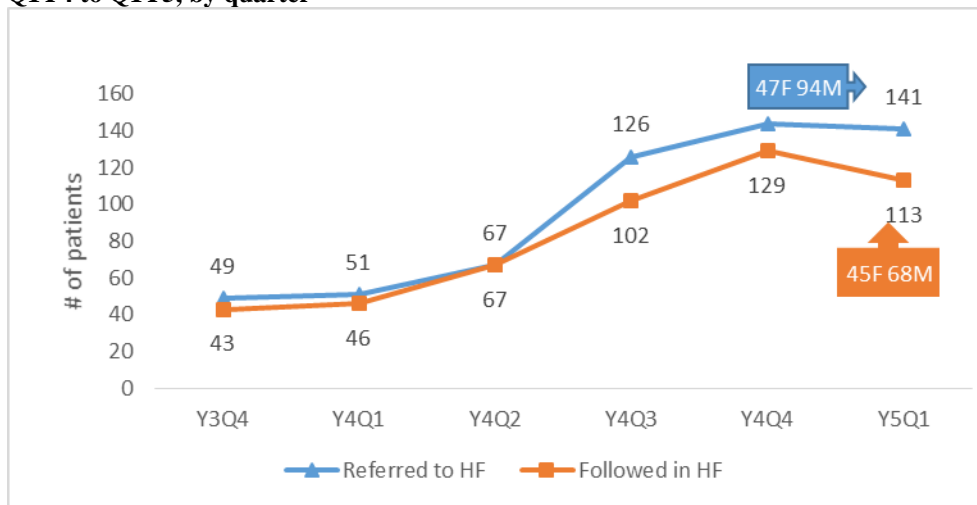


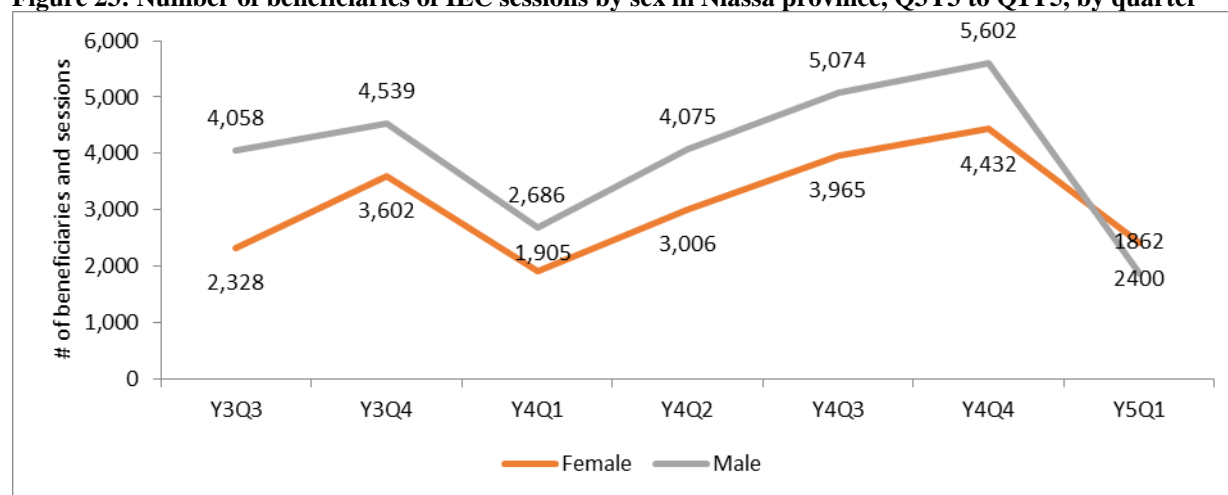
Table 5: Number of malnourished patients referred from the community and followed at HF level in Niassa, by age and sex, in Q1Y5

Health Centers	Patients Referred					Patients Followed				
	0-14		15+		Total	0-14		15+		Total
	M	F	M	F		M	F	M	F	
CS Maúa	1	0	1	0	2	1	0	1	0	2
PS Chizimbir	3	0	4	0	7	3	0	4	0	7
PS Nanlichá (Nipepe)	2	0	3	0	5	2	0	3	0	5
CS Cuamba	0	0	0	0	0	0	1	0	0	1
PS Mitande	3	0	1	0	4	2	1	0	0	3
CS Cheia-cheia	1	0	0	0	1	1	0	0	0	1
CS Massangulo	1	1	3	2	7	1	1	3	2	7
PS Namicunde	0	0	0	0	0	0	0	0	3	3
CS Mandimba	0	0	1	0	1	0	0	1	0	1
PS Meripo	1	0	0	0	1	1	0	0	0	1
CS Metarica	0	0	0	0	0	3	0	2	0	5
CS Etatara	2	0	4	0	6	2	0	4	0	6
CS Lichinga	4	8	1	2	15	4	7	0	2	13
CS Namacula	6	7	2	5	20	6	4	2	5	17
CS Lulimile	36	0	1	2	39	9	0	1	2	12
CS Chiuaula	1	0	12	20	33	1	0	11	17	29
Total	61	16	33	31	141	36	14	32	31	113

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

The number of beneficiaries of IEC sessions decreased by 58% (10,034 to 4,262) compared to last quarter and the number of home visits decreased by 46% (3,236 to 1,735) due to the issues noted above (Figure 23).

Figure 23: Number of beneficiaries of IEC sessions by sex in Niassa province, Q3Y3 to Q1Y5, by quarter



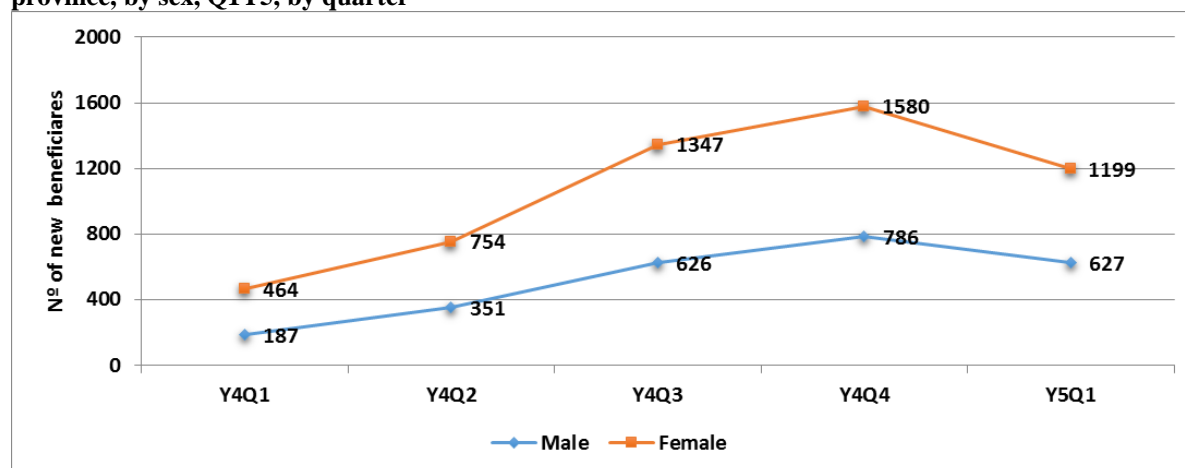
Community nutritional counseling and education, and demonstration gardens done in partnership with PCC

During this quarter the number of new participants who received nutritional counseling, education and demonstration of vegetable gardens decreased by 23% (2,366 to 1,826) compared to the

previous quarter (Figure 24), likely because the CCM were focused on their own gardens during this crucial period of the agricultural season. During the next quarter CHASS Niassa, with DPS, will reinforce this issue during TSVs.

Note: On review of the data, fourth quarter data from year 4 were corrected from 5,130 to 1,580 for female

Figure 24: Number of beneficiaries reached by nutrition activities of CCMs in select districts⁴ of Niassa province, by sex, Q1Y5, by quarter



Data source: From PCC M&E.

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

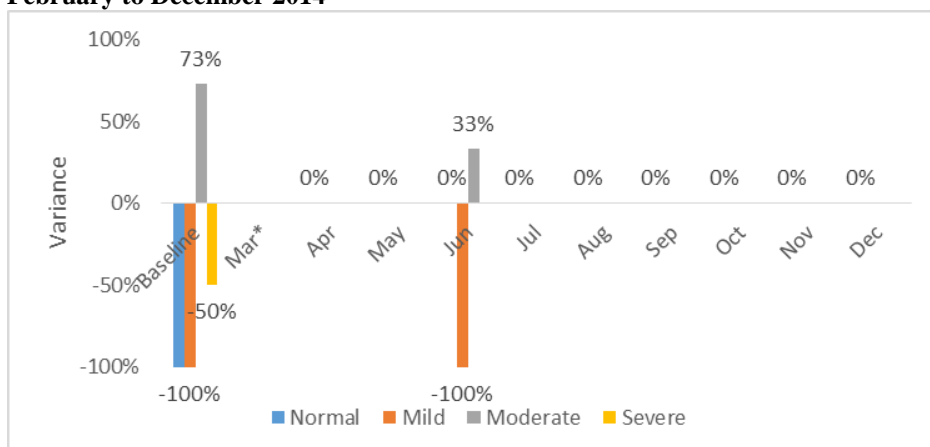
The overall goal of QIP is to improve the approach to managing malnutrition in children less than 15 years old in CCR and consultations for chronic diseases (TB/HIV, pre-ART and ART) in health centers of Lichinga, Cuamba and Muembe, including at Cuamba Rural Hospital between February 2014 and January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

Since the beginning of the implementation of the QIP of the NRP, HF's in Muembe and Lichinga City have shown significant improvement in the recording of anthropometric, nutritional

⁴ Distritcs of Ngauma, Mandimba, Cuamba, Metarica e Mecanhelas; of the OCB: Irmaos Unidos, Hankoni, Wupuwuela e Thandizanani.

assessment, classification and treatment data for malnourished patients. Figure 25 shows data from Muembe, which is typical of all sites.

Figure 25: QIP of the NRP, Classification of nutritional status of children using Weight / Height (P/E) and / PB=MUAC – variance obtained through the values reported / recorded and verified in Muembe HF, February to December 2014



Next quarter the Clinical and the MCH Nurses of CHASS Niassa and DPS will continue to follow-up the QIP 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.

Gender Equity and Gender Based Violence supported activities

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

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

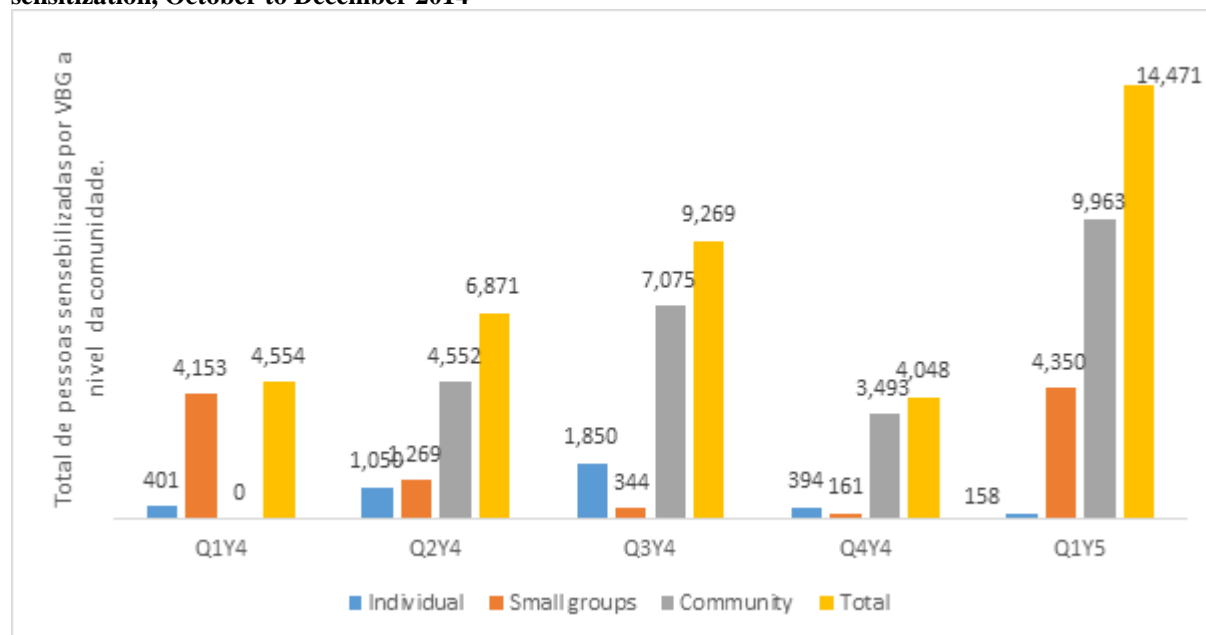
During this quarter a total of 14,471 individuals (6,227 males and 8,244 females) were reached through interventions addressing GBV. A total of 158 individuals (72 males and 86 females) were sensitized, 4,350 people were sensitized in small groups (1,960 males and 2,390 females), and 9,963 people (4,195 males and 5,768 females) were sensitized through community.

More people were reached with GBV interventions this period (14,471) than at any time during the last 5 quarters (Figure 26). Large increases were seen in both the number of people reached

through small groups and through community activities. These increases occurred in large part because CCM started carrying out community-based GBV activities this quarter. Following on-the-job training for CCM in the transmission of GBV messages and distribution of new Information, Education and Communication (IEC) material (posters with illustrations of GBV) for use in communities, they were empowered to sensitize community members through both small group and community-level activities. Furthermore, regular meetings with focal points, at which data was discussed, helped to strengthen the registration and notification systems. Finally, the district GBV committees likely contributed to raising awareness among communities for the referral of GBV cases as well as on the reporting of sexual violence cases.

Next quarter CHASS Niassa, in collaboration with MULEIDE and DPS, will continue to provide TSV to GBV committees on the management of GBV cases, particularly in districts with large numbers of GBV cases. In addition, two new committees will be formed, one each in Cuamba and Mandimba, and 32 community leaders will be trained, two from each district.

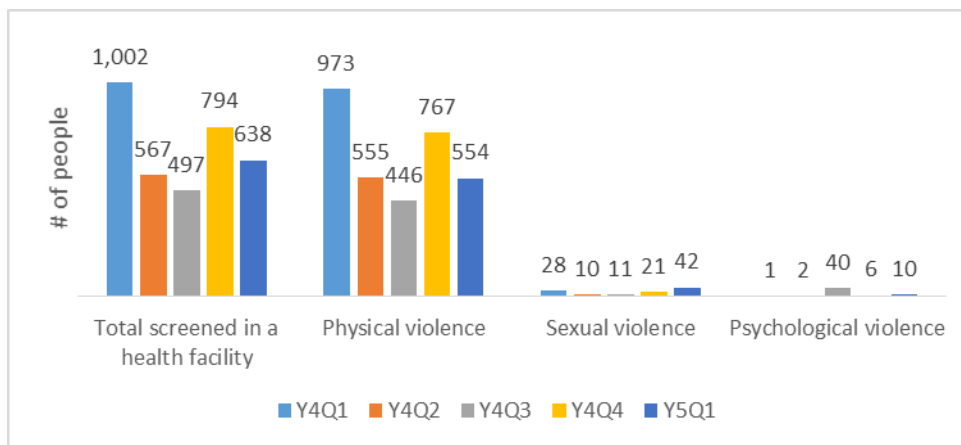
Figure 26: Number of people sensitized to GBV at HF's and in communities in Niassa Province, by type of sensitization, October to December 2014



GBV Screening at the HF

During this quarter a total of 638 people (283 males, 355 females) were referred to the gender units and were screened for violence (Figure 27). Of these, 554 (269 males, 285 females) were cases of physical violence, 42 were cases of sexual violence (5 males, 37 females), 10 were cases of psychological violence (all females), and 32 of moral violence (9 males, 23 females).

Figure 27: GBV screening at CHASS Niassa sites, by type of violence, Years 4 and Q1 Y5 by quarter



The 638 people screened in the gender units represents a decrease of 20% compared to last quarter when a total of 794 people were screened for violence in these units. This decrease may be due to the transfer of the gender focal points in the districts of Mandimba, Lago, Mecanhelas, Muembe, and Ngauma. The and newly assigned gender focal points for these districts were not yet trained in the Integrated Assistance to Victims of Violence. They will be trained next quarter together with the “*Técnicos de Psiquiatria*” and SAAJ Technicians. One technician in each district will also be trained to allow substitutes during the absence or transfer of gender focal points.

The number of cases of sexual violence doubled relative to last quarter and is higher than in any other quarter in the past five. This is likely the result of the intensification of awareness activities in the communities. Next quarter CHASS Niassa will continue supporting GBV committees, meeting with them monthly to encourage them to continue mobilizing their communities.

People Who Received Services Following Violence

In all, 98 people were found to have been victims of GBV: 42 sexual violence, 37 of whom were women; 10 of psychological violence; 32 moral violence and 14 physical violence. This is almost five times more cases than in the last quarter. A total of 56 cases (42 sexual violence and 14 physical violence) were tested for HIV and 18 females were eligible cases and received emergency contraception. The younger girls were not eligible for emergency contraception because they had not yet menstruated (1 girl was 4 years old and another one 9 years old).

A total of 18 people (40% of all victims of sexual violence) received PEP. This low percentage was due to the fact that most of the victims of violence came to the HF more than 72 hours after suffering violence. CHASS Niassa will prioritize encouraging providers to convey clear messages on the need to go to a HF within 72 hours after suffering violence in order to benefit from prophylaxis.

All of the 98 victims of GBV identified received psychosocial support, compared to just 48% in the prior quarter. This increase resulted from the training of psychiatric technicians to implement the integrated victims of violence treatment protocols, supplementing the gender focal points who had previously been the only source of psychosocial support. As a result of the training and

increased involvement of psychiatric technicians, 126 additional patients received psychosocial support even though they had experience violence that was not GBV.

Table 6: Number of clients who received services after violence in CHASS Niassa sites, October to December 2014

Type of service encounters		# of individuals		
		Males	Females	Total
GBV Screening	Physical Violence	269	285	554
	Moral Violence	9	23	32
	Psychological and Patrimonial Violence	0	10	10
	Sexual Violence	5	37	42
	Total Screened	283	355	638
Post GBV services	Screened GBV positive	17	81	98
	Tested for HIV	8	48	46
	Emergency contraception	NA	18	18
	Post-Exposure Prophylaxis	5	13	18
	Psychosocial support	17	81	98
	Police Referral	17	81	98

Trainings in GBV

Through on-the-job training, 12 clinicians (6 males, 6 females) were trained this quarter in adapting the GBV registration books in emergency and maternity wards using the "Protocol for Integrated Assistance to Victims of Violence". In coordination with PACTO (*Prevenção Activa e Comunicação para Todos*) a training on "*Conversa de Homens*" was held for 16 people, including 11 heads of H2H groups and 5 gender focal points (3 women, 2 men). It is expected that the participants in the training will use the materials from the training to share key messages about violence and HIV.

Next quarter psychiatric technicians recently assigned to SAAJ offices and new GBV focal points in the districts of Mandimba, Lago, Mecanhelas, Sanga and Chimbonila will be trained to provide integrated care to victims of GBV.

Men to Men Groups

CHASS Niassa continues to increase its support for H2H groups that are working on community awareness and changing men's behavior under the framework of the prevention of GBV. There are 5 H2H groups in Niassa, namely in Mandimba with 25 members, Lago with 25 members, Chimbonila with 5 members, Metarica with 25, and Mecanhelas with 25 members of which 5 were new additions this quarter. The aim of these groups is to discuss issues such as use of condoms, reducing multiple partners, the importance of the couple's joint testing, and harmful cultural barriers to gender and HIV, and in turn to sensitize other men in the community and in their families on these matters to encourage behavior change. This quarter 15 H2H group meetings were conducted and a total of 115 men participated. It is expected that in the next quarter they will start raising awareness in the community.

Next quarter more community-level interventions by groups in Muíta (Mandimba) and Namicunde (Metarica) are planned, as well as an experience exchanges between Mother to Mother and Men to Men groups in the province.

Objective 2

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

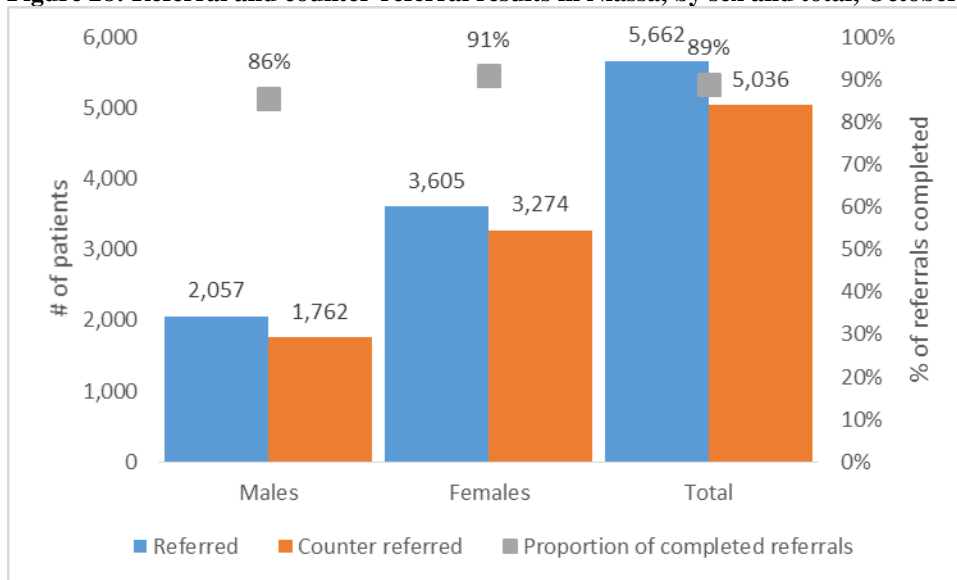
Strengthening the District Referral and Counter-referral Networks

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

During this quarter, a total of 5,662 individuals (2,057 males and 3,605 females) were referred for various services (Figure 28), including 1,400 (232 males⁵ and 1,168 females) for MCH services (ANC, CPP, FP, CCR, maternity), 11% of whom were men in couples; 369 for TB services (162 males and 207 females); 2,240 for HIV services (779 males and 1,461 females); and 1,653 (884 males and 769 females) to other services (Nutrition, GBV, and Malaria). Of the people referred, 89% (4,919 individuals; 1,645 males and 3,274 females) completed the referral cycle with males somewhat less likely to complete the referral.

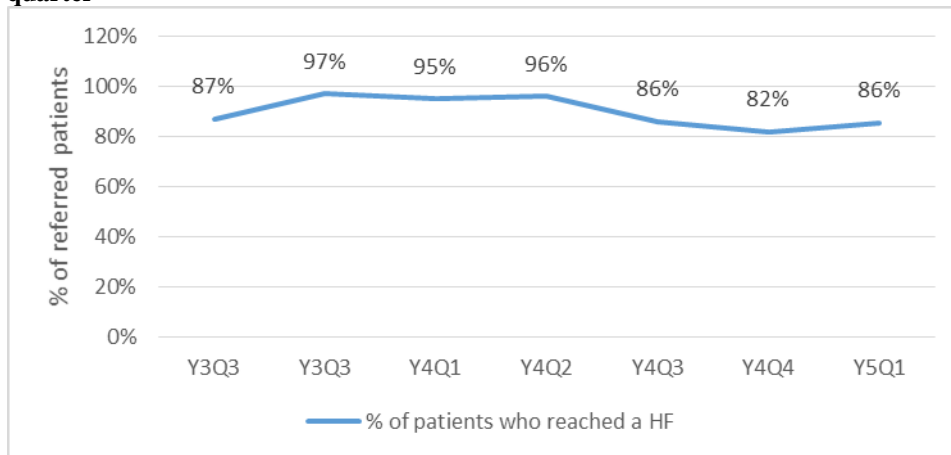
⁵ Males are included because male children are referred for CCR.

Figure 28: Referral and counter-referral results in Niassa, by sex and total, October to December 2014



Compared with the previous quarter there was a 16% increase in the number of people referred to HFs from 4,866 individuals to 5,662. The number of people who came to HFs also increased, from 82% to 86% (Figure 29); the percentage increase was almost identical for men and women. This increase was likely the outcome of the intensification of the provision of TA, on-the-job training in the referral and counter-referral system, improvement in the quality of the messages transmitted about the importance of seeking services when referred, and routine monitoring of field activities, and reinforcing of referral targets for *activistas* by the implementing agencies.

Figure 29: Percent of referred patients who reached a HF in CHASS Niassa sites, Q1FY4 to Q1FY5, by quarter



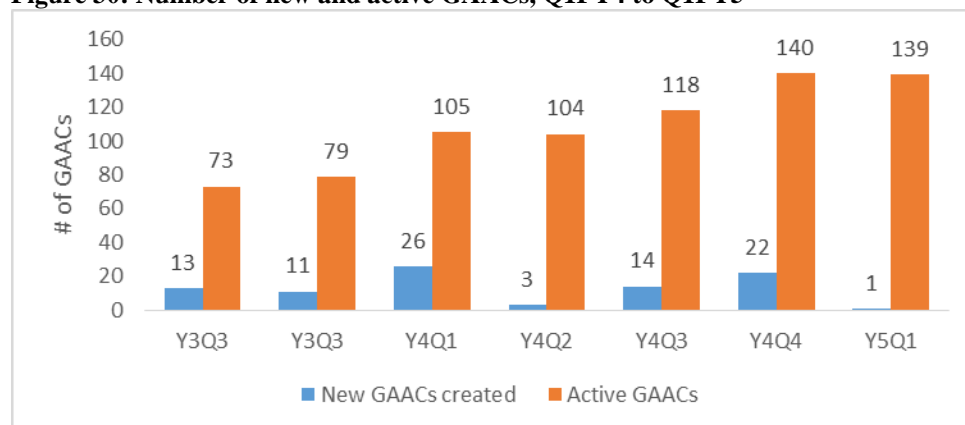
Community Adherence Support Group (GAAC)

From October to December 2014, one new GAAC was created and 2 were dissolved in Niassa; thus the total number of groups is currently 139 and 442 patients benefit (150 males, 292 females) (Figure 30). The number of patients per GAAC remains on the low end, with an average of 3 per group. CHASS Niassa will aim to ensure that all new groups have more than 3 members in alignment with the GAAC strategy.

The lack of expansion of GACCs this quarter was due to the fact that the *chá positivo* and the clinical services management committee meetings have not been held in Cuamba Rural Hospital for about three months and these meetings represented a great opportunity to raise awareness of patients. Furthermore, GAACs are being implemented only in the Rural Hospital of Cuamba and not in Cuamba HF where there is a greater number of patients. In Mecanhelas Health Center, although six groups were formed, the groups were not properly registered and have not, therefore, been included in the total number of GAACs. CHASS Niassa has already corrected this problem and these GAACs will be reported next quarter.

Next quarter CHASS Niassa will provide TA for revitalizing the *cha positivos* and the meetings of the management committees for clinical services, registration in GAAC books, home visits to the existing group members and expansion to three more HF: Cuamba, Metangula, and Maua. Technical assistance visits will also address Psychosocial Support and Positive Prevention to further strengthen this component.

Figure 30: Number of new and active GAACs, Q1FY4 to Q1FY5



Objective 3

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

This quarter CHASS Niassa has contributed to improving the health system in Niassa across the World Health Organization health system building blocks.⁶ In order to develop health system capabilities necessary to effectively plan, manage, and evaluate integrated HIV services in quarter 1 the project has supported the DPS/SDSMAS with the following interventions:

Strengthening of Service Delivery

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

From last quarter to this quarter four of year the number of TSV declined by 37% (604 to 383), in large part because of the new, more targeted technical assistance strategy. Of the 397 planned visits, 383 (96%) were performed. Out of these, 288 (75%) were made by CHASS Niassa Technical staff and 95 (25%) were joint technical visits with DPS, a percentage consistent with past quarters.

Next quarter CHASS Niassa will conduct an evaluation of the results of the implementation of the new TA strategy. The assessment will look at the effect of the strategy on the performance and quality of services at the HFs in each support tier.

Strengthening of Human Resource Management

Pre-Service Training Support

CHASS-Niassa continues to finance the in-service training of 31 mid-level ANC nurses at the Lichinga Health Training Center, which began in July 2013. The course is expected to finish in July 2015.

Post-Graduation Scholarship Support

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

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

the time of study. Currently the project supports three scholarship students who began their studies in August 2013 and continue to study for their master's degree in Public Health and HIV Health Services Management at the Catholic University in Beira City. The course is expected to finish in August 2015.

In-Service Training

During the period under review, the project trained 29 *Unidade Gestora das Aquisições do Estado* focal points and district directors as part of the second phase of training on procurement and financial management (the first phase was completed in March 2014). As a result of this training, all participants are now able to conduct needs assessments, develop procurement plans, launch tenders and monitor their implementation, and draft and manage contracts in accordance with MoH rules and regulations. TSV following phase I included assessments using the TA tool and the results showed improvements in some institutions. During the first five visits, the average score increased from 34% to 62% (Table 7), and most sites had gradually increasing scores over time, although only two facilities has reached the 80% target for good performance. CHASS Niassa will continue TSV for the priority districts selected during the TA strategy revision done in October to further improve performance.

Table 7: TSV assessment scores by visit

District	1st visit	2nd visit	3rd visit	4th visit	5th visit
DPS	69.23%	76.92%			
CS Cuamba	7.69%	30.77%			
Chimbonila	33.33%	53.85%	84.62%		
Cuamba	33.33%	30.77%	38.46%	30.77%	61.54%
HR Cuamba	100.00%	15.38%	38.46%	61.54%	84.62%
Lago	23.08%	30.77%			
Majune	27.27%	30.77%	38.46%	46.15%	46.15%
Mandimba	18.18%	53.85%	61.54%	61.54%	69.23%
Marrupa	27.27%	30.77%	38.46%	46.15%	46.15%
Sanga	15.38%	30.77%	30.77%	30.77%	
Cidade de Lichinga	15.38%	23.08%	38.46%		
Average	33.65%	37.06%	46.15%	46.15%	61.54%

Humanization of Health Services Activities

CHASS Niassa provided technical and financial support for the DPS Niassa to participate in the National Quality and Humanization Conference in December. During the conference Niassa's provincial hospital was awarded 1st place in the laboratory category for their adoption of the *Fortalecimento da Gestão Laboratorial para Acreditação* (FOGELA) quality improvement initiative. Likewise, Lichinga Provincial Hospital also won third place for their implementation of the Manchester protocol to reduce patient waiting times, and third place again for their evaluation of hospital mortality. Both of these initiatives were received technical and financial support from CHASS Niassa.

According to the Provincial Health Director in Niassa, HIV is a serious problem within the ranks of healthcare personnel working in Niassa Province, with an increasing number of clinicians dying from AIDS. In response, the Project funded a joint MoH / CHASS Niassa technical assistance visit to Lichinga, Cuamba and Chimbonila districts to strengthen district health services for healthcare workers with a focus on HIV prevention, care and treatment services. Key objectives included reviewing healthcare worker health services against MoH standards, with an emphasis on the quality and frequency of health promotion messages and counseling, PEP, data and patient flow, as well as the identification of a fixed location for service provision and a permanent focal point to provide services. By the end of the quarter, roughly 85 health workers had received consultations, 22 of whom were tested for HIV, 5 were HIV+ (23%), and 3 have already enrolled in ART. In addition, the TA team also visited 7 HFs in Chimbonila District to evaluate needs and establish a plan for the expansion of the MoH's healthcare work health services program to these sites.

Strengthening of Financial Management

Sub-agreement Management with DPS

Since the beginning of the implementation of the activities, CHASS Niassa has secured the participation of the Government of Mozambique in the project through sub-agreements with DPS and SDMAS where roles and responsibilities were defined and served as part of instruments of capacity building for the organizations supported. As in previous years, all activities described in the DPS work plan are to be executed through the DPS sub agreement. During year 5, the total costs for the implementation are estimated at \$1,085,685 USD.

In the first quarter of year five, DPS spent \$74,162.13 USD, 7% of the budget allocated to ensure minimal implementation of planned activities. Spending was low because of the delay in the approval of the Y5 work plan for CHASS Niassa.

This quarter CHASS Niassa continued to evaluate each district and the DPS using the 12 pre-selected clinical indicators that are being used to support the improvement of HIV Services (Table 8). The results for quarter 1 of Year 5 are not yet available. Overall, the results from quarter four did not show improvement relative to quarter 3 but the pattern varied widely by district. This quarter nine districts showed improvements relative to last quarter, and some of these improvements were quite large (for example, Cidade de Lichinga improved from 20% to 42% and Marrupa from 10% to 42%). However, a number of districts saw small declines and two (Mecanhelas and HPL) had large decreases. CHASS Niassa will continue to work with the districts to strengthen their capacity in this area.

Table 8: Level of absorption of performance based grants, by site

Table Districts/HF	% in Quarters				% in 12 months
	Q1	Q2	Q3	Q4	
Lago	0.0	0.0	10.0	8.0	4.5
Ngauma	0.0	0.0	10.0	8.0	4.5
Lichinga distrito	18.2	9.1	10.0	8.0	11.3
Majune	0.0	18.2	20.0	25.0	15.8
Mandimba	27.3	18.2	10.0	8.0	15.9
Muembe	18.2	18.2	20.0	25.0	20.3
Nipepe	27.3	9.1	20.0	17.0	18.3
Mavago	9.1	18.2	40.0	21.0	22.1
Sanga	27.3	27.3	20.0	17.0	22.9
Lichinga Cidade	36.4	27.3	20.0	42.0	31.4
Marrupa	54.6	36.4	10.0	42.0	35.7
Maua	45.5	36.4	20.0	25.0	31.7
Metarica	36.4	54.6	20.0	33.0	36.0
Cuamba	45.5	36.4	30.0	42.0	38.5
Mecanhelas	36.4	36.4	50.0	25.0	36.9
Rural Hospital, Cuamba	50.0	66.7	20.0	25.0	40.4
Provincial Hospital, Lichinga	66.7	33.3	40.0	13.0	38.3
Mecula	63.6	45.5	50.0	52.0	52.8
Total	32.4	28.0	23.5	24.0	27.9

Logistics & Supply Chain Management

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

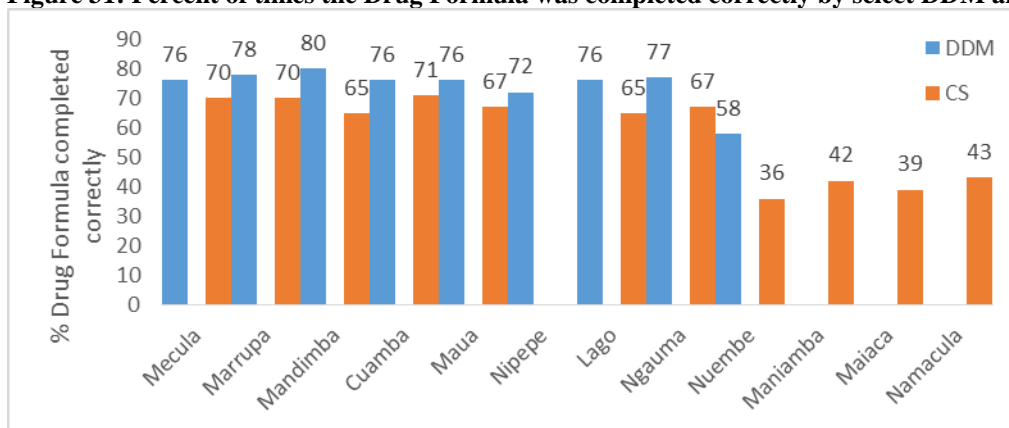
CHASS Niassa supports the DPS in assuring the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes. Currently CHASS Niassa is supporting 16 district warehouses, 1 provincial warehouse, and 3 warehouses at provincial/rural hospitals,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

During the quarter TSV were provided to the districts medical warehouses in order to perform technical support in Medicine Management Procedures. In addition, use of the Medicine Management tools was assessed for the Depósitos Distritais de Medicamentos (DDMs, or district drug depots) of Mecula, Marrupa, Mandimba, Cuamba, Lago, Muembe, Ngauma, Maua, and Nipepe and HF of Mecula, Marrupa, Mandimba, Mitande, Cuamba, Metangula, Muembe, Massangulo, Maua, Maiaca, and Namacula.

Figure 31 shows the result of assessments undertaken at the DDMs, HFs and Peripheral HFs during TSV. The DDMs scored from 58-80% on Medicine Management compliance while HFs and peripheral HFs scored from 39-70%.

Common problems with performance in HFs were delays in updating the stock control books, drug outflows without documentary support, and delays in updating *Folha Individual de levantamento de ARVs* (FILAs) and out *Registo Diário de Antiretrovirais*. On-the-job training was provided to address these challenges; it covered the use of management tools, quantification formulas, and the processes for updating FILAs and registering patients who have defaulted or dropped out. Special attention is being paid to the DDMs and HFs, with low performance, through on-the-job training planned for next quarter.

Figure 31: Percent of times the Drug Formula was completed correctly by select DDM and HF, Q1FY5



Availability of Pharmaceuticals

Regarding the availability of ARV drugs, Niassa did not have stock outs except for the pediatric version of the combined Lamivudine + Stavudine + Nevirapine treatment, the supply of which decreased during the quarter due to a halt in production by manufacturers and expiration of the stock in the Provincial deposit. In response, the MoH recommended that the Provincial Deposit provide alternative drugs including a Lamivudine + Stavudine + Zidovudine composition, Lamivudine + Stavudine composition, and Abacavir 60 mg. These were distributed by the Provincial Deposit to the HFs that provide ART.

Throughout this quarter Syphilis Tests were out of stock for 33 days due to unavailability in warehouses, and UniGold was out of stock for 21 days due to expiration of stores; this led to a cessation of testing in some Provincial HFs.

In general, during this quarter there was a decrease in drug availability (Table 9). Twelve pharmaceutical products had recorded stock outs, compared to nine during the fourth quarter although fewer stock outs occurred relative to the 21 in the third quarter of last year. The increase stock outs this quarter was the result of stock outs at the central level (CMAM).

Table 9: Number of days of drugs in stock-out in Niassa province, by quarter, Years 4 and 5

Medicine	Year 4				Year 5
	Q1	Q2	Q3	Q4	Q5
Teste Sifilis	60	0	25	30	33
Teste Uni Gold	0	0	0	0	21
Cotrimoxazol 480 mg comp	0	0	0	0	19
Multivitamina comp	0	0	0	0	12
Salferroso+ Ácido Fólico Comp. Composto	66	40	20	45	0
Paracetamol 500mg Comp.	42	40	0	0	0
Amoxicilina 500mg Comp.	32	13	8	0	0
Amoxicilina 250mg /5ml Susp.	90	18	30	0	0
Ampicilina 500mg Inj.	80	18	8	0	0
Ceftriaxona Inj. 1g/4ml	27	0	0	0	46
Cefixima 200 mg Comp.	52	60	60	30	90
Penicilina Benzatinica Inj. 2.4MUI	90	90	8	25	0
Azitromicina 500 mg Comp.	26	60	30	10	35
Alcool Liquido Volátil	60	90	0	0	0
Metronidazol 250mg Comp.	37	30	0	0	13
Cotrimoxazol Susp. 240mg/5ml	60	0	0	0	0
Eritromicina 500mg Comp.	13	10	39	0	13
Fenoximetilpenicilina 500mg Comp.	0	30	18	0	90
Kanamicina Inj. 2g/10ml	0	90	90	90	42
Nevirapina 200mg Comp.	0	90	15	0	0
Nevirapina Susp. 50mg/5ml	0	30	21	0	0
Ciprofloxacina 500mg Comp.	0	90	23	0	15
Quinina 300mg Comp.	90	90	90	40	90
Quinina Injectável 600mg/2ml	70	60	0	0	0
Coartem 6x3 blister	60	60	90	90	0
Coartem 6x4 blister	48	90	4	30	0
Diclofenac 50mg Comp.	0	30	0	0	14
Ibuprofeno 200mg Comp.	90	60	8	0	22
Isoniazida 100mg Comp.	31	0	24	0	0
Isoniazida 300mg Comp.	36	30	22	0	0
Acido Naldixico 500mg Comp.	0	60	0	20	19
Prometazina Injectável 50mg/2ml	90	0	20	0	0
Clorafenicol Injectável 1g/10ml	13	30	0	0	0
Test Kit Determine	0	0	10	0	0

Health Information System

Electronic Patient Tracking System (EPTS)

CHASS Niassa is working with DPS to pilot the EPTS, eSaude, in select health facilities in Niassa. 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, data entry was completed at the four initial facilities and review and cleaning of data already entered began as well as planning for assessment of the pilot.

During retrospective data entry, data quality reviews are ongoing to assess the accuracy of the information entered into the system. This is being done in two steps: 1) daily review of 3-5 randomly selected patient charts against the data entered and 2) regular review of OpenMRS data

quality reports. Results of the daily review showed about 71% agreement between the two sources and highlighted staff who were low and high performing. Staff who were performing poorly were given regular feedback on their performance and on the problems identified. Clear improvement was seen over time, the average precision in the first 5 days was 66% while in days 7-11 it was 92%.⁷ Based on these results, this same process will be used for future retrospective data entry and the tools will be adapted for use by health facilities to ensure data quality over time.

Staffing for ongoing data entry at the health facilities remains a challenge. HP Lichinga and HR Cuamba each have one staff member entering data. The Health Centers in Cuamba and Lichinga still do not have staff in place to enter data. We continue to work with DPS and facility management to identify appropriate staff and to define where these staff fall within the DPS structure. As we conduct data validation exercises, any data not entered up to that point will be entered prior to validation. However, if the staffing problem remains, maintaining the completeness of data at these sites will be a problem.

The planned data validation to be done with DPS staff was delayed due to competing priorities. This has been rescheduled for January-February 2015, although it may be further delayed due to the floods and lack of power in mid-January.

Routine Support Activities

Routine activities were undertaken at all levels, with focus on ensuring consistency of data and validity of data at the various data aggregation levels. Using data verification tools, both M&E and clinical staff from CHASS Niassa and DPS, conducted verification of the monthly summaries at 21 HFs, and corrected the existing problems through on-the-job support to 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 Review Meeting

No formal data review meeting was held this quarter because of other activities and the holiday season. However, informal meetings were held by technical area to review progress and plan accordingly. A formal data review meeting is planned for mid-February 2015.

⁷ Only those data entry operators who were assessed during the first 5 days were included in this analysis.

Data Quality

In Q4 of FY2014, the CHASS M&E staff, along with their counterparts from DPS, recoded information on the validity of data at a total of 37 facilities (57% of all facilities). The teams used a new data validation tool that is based on FHI 360's Data Validation and Improvement tool and focused on review of maternal and child health data. Priority was given to high volume sites and sites identified as having data quality issues. Not all sectors were assessed in all facilities because not all facilities offer all services and, again, because sectors with data quality issues were prioritized. The 38 facilities is only part of the total number of facilities that had a data validation; in sites with no data discrepancies, data were not recorded. In the future the team will document all sites visited.

Overall, approximately 68% of sites assessed had one data validation in the quarter, 27% had 2 validations, and 5% had 3 validations. The team used a standardized tool to compare the data reported in the monthly summary to a recount of the data in the registers. The average variance for the facilities assessed ranged from 7.45% for CCR (n=28) to 19.04% for FP (n=28). These averages should be interpreted with caution as they are driven by large variances for some indicators that are based on very small numbers of observations (often as few as one). That said, this preliminary assessment suggests that on the whole, the maternal and child health data are of reasonable quality. However, certain facilities stood out for both high levels of consistency between reported data and original sources while others lagged behind. In particular, Maniamba, Nungo, Marrupa, and Mandimba had almost no discrepancies in any of their data. On the other hand, CS Lichinga had problems in all areas except for postpartum care and Lione had many small errors in all sectors assessed. Sites with data quality issues will continue to be prioritized next quarter.

Looking across areas, substantial discrepancies were most common in antenatal care and family planning data while errors were not common in the children at risk data. This information will be used to target the technical areas requiring greater focus for data recording and summarization in the upcoming quarters.

Notably, in sites that had multiple visits, if the data were problematic in the first visit, the sites showed marked improvement at a followup visit. Table 10 shows one example of this improvement; the number of indicators with discrepancies decreased as did the degree of variance.

Table 10: An example of data quality results from one facility assessed multiple times in the quarter

Indicadores (PF incluir desagrações como sexo e idade)	JULHO				AGOSTO			
	Modulo Basico	Valor verificado	Resumo Mensal	Variância (%)	Modulo Basico	Valor verificado	Resumo Mensal	Variância (%)
1as Consultas	147	147	147	0.0	99	99	99	0.0
Consultas Seguintes	157	157	151	-3.8	156	156	141	-9.6
Gravidas Que Vieram a 4a CPN	11	11	14	27.3	13	13	14	7.7
HIV Desconheco a Entrada	130	130	147	13.1	99	99	99	0.0
HIV+ a Entrada na CPN	0	0	0	0.0	1	1	1	0.0
HIV+ em TARV a Entrada	0	0	4	400.0	0	0	0	0.0
Fizeram 1o Teste	45	45	147	226.7	37	37	23	-37.8
HIV Positivas	1	1	0	-100.0	1	1	1	0.0
Fizeram Testes Seguintes	1	1	0	-100.0	0	0	0	0.0
HIV Positivas	0	0	0	0.0	0	0	0	0.0
Iniciaram CTZ	3	3	0	-300.0	1	1	1	0.0
Iniciaram TARV	0	0	0	0.0	0	0	0	0.0
Biprofilaxia com AZT	3	3	4	33.3	3	3	0	-300.0
Biprofilaxia com NVP	0	0	0	0.0	0	0	0	0.0
Monoprofilaxia (NVP)	0	0	0	0.0	0	0	0	0.0
Iniciaram Outro Regime	0	0	0	0.0	0	0	0	0.0
Parceiros Testados	19	19	141	642.1	27	27	23	-14.8
Parceiros HIV+	0	0	0	0.0	0	0		0.0

This process was repeated this quarter in at least 21 facilities. As noted earlier, facilities without any discrepancies were not fully documented. In all, 43% had one validation, an additional 43% had 2 validations, and 14% had three validations. For this quarter we assessed the average percentage of indicators per area with variance greater than 5%, a different approach to that described above. This revised approach is not affected by the small number of patients for some indicators at some sites as is the average. Data in TARV, FP and postpartum care had the highest average percentages of indicators with variance above 5%; for TARV, an average of 14% of the indicators assessed had variances greater than 5% as did 13% of FP indicators and 10% of postpartum care indicators. On the other hand, large variances were least common in CCR (5%) and maternity (7%). Again, the results suggest that the data are, in general, of reasonable quality. Over 50% of facilities with validations reported in at least one area had no variances greater than 5% and in some cases when the variance was above 5%, it was just above 5% (e.g., 5.1%). Furthermore, one third of the sites had one or no indicators with variances above 5% across all areas assessed. These are underestimates of data quality overall given that most sites without any discrepancies between reported and validated data were not included.

In the next quarter, CHASS Niassa will improve and standardize its approach to summarizing these data while continuing to implement data validation at selected sites.

Project Database

This quarter CHASS Niassa completed the Beta version of its DHIS-2 project database. This database allows monthly entry of summary data for all technical areas and includes both data validation checks and reporting features. CHASS Niassa M&E staff will enter data from HF monthly summaries and use these data to verify data in *Modulo Basico*. Next quarter we will train implementing partners to enter the community-level data. This quarterly report used data from this new database.

Management Arrangements

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

The Project Management Team is ultimately responsible for assuring that the project remains on course to deliver the desired outcome of the project as defined in the Cooperative Agreement. The Implementing Mechanism – FHI360 performs the oversight function as well as monitoring and evaluation of the CHASS Niassa project in Niassa. Different stages of project implementation such as project amendments, annual workplan, travel requests, no cost extension request, are cleared by and submitted to USAID through the AOR.

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

Project Management Team

The Project Management Team has three major functions:

Project Management: This is composed of the Project Director/Chief of Party, the SI Director, the Technical Director, the Senior Program Officer, the Financial Manager, the Provincial Coordinator, the Provincial Chief Medical Officer and the USAID AOR. The COP is fully responsible for the overall coordination of the project activities. The Technical Director, and the

Provincial Coordinator work in close collaboration with the national and provincial counterparts and other stakeholders to implement the project.

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

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

Partners

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

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

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

Food for the Hungry: FH provide technical assistance that addresses nutritional needs (Nutrition assessment, counseling and support) and the implementation of the MoH's NRP in the province. The project is collaborating with WFP in the acquisition and distribution of the fortified supplement CSB in selected health facilities to improve the nutritional intake of the affected population. The nutrition technical officer is also collaborating with MoH in the development of mechanism to integrate nutrition data with other already existing MoH data collected through the *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 H2H groups to increase retention and male access in care.

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

Major Challenges Facing CHASS Niassa

As CHASS Niassa implements its new TA strategy, which prioritizes HFs with high patient volume and areas with higher HIV prevalence, ensuring performance across all sites will be a challenge. Sites with fewer patients will receive fewer TA visits under this new strategy and that may negatively affect performance. CHASS Niassa will compare results next quarter to assess the effects of this strategy.

In PMTCT, universal uptake of Option B+ remains a challenge with 89% of women accepting Option B+ this quarter. As noted above, CHASS Niassa will work with providers to ensure correct knowledge of Option B+ to improve uptake.

Pediatric enrollment also continues to be a challenge; 9% of new patients are children compared to a goal of 15%. Once children test positive, facilities are effective in enrolling them in treatment but not all children are being tested with PCR. A continued focus on patient flow and expansion of PCR to additional settings (e.g., postpartum consultations, wellbeing visits, immunization visits, and inpatient wards) will be used to address this.

Implementation of eSaude is a continuing challenge. Ensuring commitment of staff by DPS has been one challenge, a challenge that is being addressed in coordination with DPS. In addition, ensuring the quality of the retrospective data has been more time consuming than originally planned but this will be completed next quarter.

Upcoming Priority Activities

- Prioritize TA to the HFs implementing the PRN Vol.2 in the management, and registration of CSB+ stocks to avoid stock-outs during the quarter and maintain coordination of the distribution of CSB+ with the DPS and of WFP
- Implement QI projects in the following services:

- MCH, where the aim is to increase the quality of tracking of children at risk and reduce lost opportunities for beginning ART in the HF of Cuamba, Namacula and Marrupa
 - Lab, where the aims is to increase the use of CD4 testing equipment (PIMA) in the HF of Mandimba and Maua
 - Community, where the objective is to improve the process of consensual search of patients who have defaulted or abandoned HIV and AIDS care and treatment in and reduce the percentage of patients not found during active search especially in Lichinga city and Cuamba
- Complete the assessment of the EPTS pilot and plan for the rollout to additional facilities

ANNEXES

ANNEX 1 – Progress toward the Targets in CHASS Niassa from October to December 2014

Indicator	Annual Target	Q1 Results	% Achieved - end Q1
PMTCT ANC			
Number of health facilities providing MCH services that provide HIV testing and ARVs for PMTCT on site, ANC/ L&D settings	83	65	78%
Number of unique pregnant women registered in ANC	42,030	15,613	37%
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).	41,992	14,089	34%
# women receiving an HIV tests (with results received) in a PMTCT setting - Repeat Test	18,775	2,304	12%
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).	825	469	57%
Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission, total, by regimen, by setting (ANC)	788	449	57%
Number of HIV-positive pregnant women in ANC who have initiated CTZ	-	439	-
Number of partners of women who are HIV tested in ANC setting	18,913	6,405	34%
PMTCT L&D			
Total number of unique pregnant women registered in L&D		12,297	
# women receiving an HIV tests & results in a PMTCT L&D setting	5,954	2,827	47%
Number of pregnant women with known HIV positive status LD (includes women who were tested for HIV and received their results)		453	
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT/ L&D setting.		407	
Number of HIV-exposed infants who received ARVs to reduce risk of MTCT in L&D setting, (total/ by regimen)	678	363	54%
Number of infants born to HIV-positive women who received an HIV test within 12 months of birth	1,288	536	42%
PCR < 9 months	638	324	51%
Rapid test 9 - 11 months	650	212	33%
Children (<18months) born to HIV+ pregnant women who are started on CTZ prophylaxis within two months of birth	-	324	
FAMILY PLANNING			
Number of unique women registered in Family Planning	-	27,113	
Number of women with known HIV positive status in FP	-	307	-
Number of HIV positive women provided with at least one FP method-IUD	-	1	-
Number of HIV positive women provided with at least one FP method-Injectable	-	131	-
Number of HIV positive women provided with at least one FP method-Pills	-	139	-
Number of HIV positive women provided with at least one FP method-Other Methods	-	32	-
COUNSELING & TESTING			
Number of service outlets providing counseling and testing according to national and international standards (CT Setting: Clinical)	67	65	97%
Number of individuals who received counseling and testing for HIV and received their test results(CT setting: Clinical)	37,749	8,878	24%
Number of individuals who received counseling and testing for HIV and whose results were HIV+ (CT Setting: Clinical)		759	
Number of service outlets providing counseling and testing according to national and international standards (CT Setting: UATS)	11	11	-
Number of individuals who received counseling and testing for HIV and received their test results(CT setting: UATS)	20,940	2,131	10%
Number of individuals who received counseling and testing for HIV and whose results were HIV+ (CT Setting: UATS)		392	-
Number of individuals who received counseling and testing for HIV and received their test results(CT setting: ATSC)	3,822	4,026	105%
Number of individuals who received counseling and testing for HIV and whose results were HIV+ (CT Setting: ATSC)		74	

Indicator	Annual Target	Q1 Results	% Achieved - end Q1
HIV care and treatment			
Number of health facilities that offer ARV treatment clinical services	46	46	-
Number of HIV-positive adults and children receiving a minimum of one clinical service	19,664	19,946	101%
Number of adults and children with advanced HIV infection newly enrolled on ART	3,252	1,202	37%
Number of adults and children with advanced HIV infection currently receiving ART, by sex, pregnant women	11,846	13,604	115%
Number of adults and children with advanced HIV infection who ever started ART, by sex, pregnant women	-	19,374	-
# individuals w/advanced HIV infection currently receiving ART (Enrolled in GAAC)	2,572		0%
TB/HIV SERVICES			
Number of service outlets providing prophylaxis and or treatment for TB to HIV infected individuals (diagnosed or presumed.)	16	16	100%
Number of TB patients registered during the reporting period	1,640	460	28%
Number of HIV infected individuals attending HIV/AIDS care/treatment services also treated for TB disease	2,265	78	3%
Number of TB patients who had an HIV test result recorded in the TB register	1,607	339	21%
# HIV Positive TB (co-infected) patients with test result recorded in TB register	217	195	-
Number of HIV-infected TB patients in the TB sector who have initiated cotrimoxazole (CTZ) prophylaxis	935	252	27%
Number of HIV-positive TB patients who have started ART	819	257	31%
GBV			
Number of health facilities with Gender-Based Violence and Coercion (GBV) services available	16	16	100%
Number of people screened for GBV at a clinical health facility		638	
Number of people receiving post-GBV care : Post-rape		42	-
Number of people receiving post-GBV care : Other post-GBV care		56	
NUTRITION			
Number of HIV+ patients who are clinically malnourished (non-pregnant)	2,950	119	4%
Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	1,475	87	6%
Number of eligible clients who received food and/or nutrition services		2,017	
HIV+ patients screened/assessed for malnutrition		6,448	

ANNEX 2 – DPS Sub Agreement Financial Execution

PLANNING BUDGET PIPELINE PROJECTIONS (Column G)

Subawardee: DPS Niassa
 ID No. 0525,0008
 FCO No. 600856
 Subaward title: Strengthen the Capacity of health sector in Niassa
 Mod 6

	ent Fiscal Year/Project				Accrued Expenses	Balance	%
	01/10/2014-30/04/2015	Oct	Nov	Dec			
I. TOTAL COSTS INCURRED BY SUBAWARDEE						-	
TOTAL COSTS INCURRED BY THE SUBAWARDEE	2,550,000					2,550,000.00	0%
Subtotal Equipment	1,280,000					1,280,000.00	0%
Subtotal Travel	3,358,650	27,230	52,085	78,053	157,368	3,201,282	5%
III. OFFICE EXPENSES (Items less than 500 USD)							
Subtotal Office Expenses	318,800	33,213.96	33,213.96	33,213.96	99,641.88	219,158.12	31%
IV. OTHER DIRECT COSTS							
In-Service Training for Health Workers							
Subtotal In Service Training	5,887,215			349,682.50	349,682.50	5,537,532.50	6%
Subtotal Institutional Support	6,647,680	334,985.00	140,895.00	93,498.32	569,378.32	6,078,301.68	9%
Infrastructure/Rehab					-	-	
Subtotal Infrastructure /Renovation	2,622,601				-	2,622,601.00	0%
Total:Public Health and meetings support	479,400	0	0	82,307	82,307.20	397,092.80	17%
Subtotal Printing	3,718,990			164,614.40	164,614.40	3,554,375.60	4%
Subtotal Scholarship	1,296,000						0%
Subtotal Support districts	5,370,000	480,229.00	263,851.95	222,405.00	966,485.95	4,403,514.05	18%
Subtotal ODCs	25,542,486					25,542,486.00	
Total Costs incurred on behalf of Subwardee	30,499,936				2,389,478.25	28,110,457.75	8%
TOTAL COSTS INCURRED BY THE SUBAWARDEE	2,550,000					2,550,000.00	
TOTAL PROJECT COSTS	33,049,936				2,389,478.25	30,660,457.75	7%

ANNEX 3 – CHASS Niassa Financial Expenditures Up to December 2014

Item	Total Estimated Amount (LOP)	Total Obligated Amount	Total actual Expenditures from August 1, 2010 - 31th December 2014	Projected Expenditures for January 2015	Total Actual Expenditures Plus Projected Expenditures	Remaining Obligation Balance
Personnel & Consult	6,895,770		6,048,199	125,000	6,173,199	
Fringe Benefits	2,226,927		1,558,947	50,000	1,608,947	
Travel and Transportation	2,981,857		2,778,367	55,000	2,833,367	
Equipment	757,837		841,441	0	841,441	
Subrecipient & Grants	6,541,809		5,285,793	0	5,285,793	
Other Direct Costs	6,570,714		5,495,737	60,000	5,555,737	
Subtotal Direct Costs	25,974,914		22,008,484	290,000	22,298,484	
Indirect Costs	6,776,234		5,596,202	84,100	5,680,302	
Total Award costs	32,751,058	30,170,388	27,604,686	374,100	27,978,786	
Cost Share	3,232,265					
Grand Total US\$	35,983,323	30,170,388	27,604,686	374,100	27,978,786	2,191,602

LOP Estimated amount	35,983,323
Obligated amount to date	30,170,388
Actual expenditure to 31th October 2014	27,978,786
Balance of obligation at 1st Jan 2015	2,191,602
Mean monthly spend last 12 months	533,024
# of Months as of January 1st 2015	4.11

TOTAL cumulative IA obligation	5,479,239
TOTAL Cumulative IA disbursement	5,189,258
Balance of IA Obligation	289,980