CAP Mozambique

Strengthening Leading Mozambican NGOs and Networks II

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CAPABLE PARTNERS PROGRAM
Mozambique

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Annex 1: Pre-Post Refresher

Reciclagem Final dos Activistas de COVs
Pré Teste ou Pós Teste

Pontuação (0-34 Mau, 35-50 Bom, 51-63 Muito Bom)

1. Assinale com X os 5 grupos de direitos da criança (5P)

- ☐ 1. Direito à identidade e à nacionalidade
- ☐ 2. Direito à consumir drogas
- ☐ 3. Direito à protecção e ao afecto
- ☐ 4. Direito à maltratar outas crianças
- ☐ 5. Direito educação e ao desenvolvimento pessoal
- ☐ 6. Direito à saúde e à alimentação
- ☐ 7. Direito à participação e liberdade de expressão

2. Escolha com X as 4 categorias de COVs que o MGCAS considera como grupos prioritários a atingir (4P)

- ☐ Crianças órfãs (de mãe, de pais ou de ambos)
- ☐ Crianças da e na rua
- ☐ Crianças infectadas e afectadas pelo HIV/SIDA
- ☐ Crianças casadas antes da idade legal
- ☐ Crianças refugiadas e deslocadas
- ☐ Crianças que vivem em agregados familiares chefiados por crianças, mulheres ou idosos
- ☐ Crianças que vivem em agregados familiares onde um adulto se encontra cronicamente doente

3. Ligue através da ceta, os sinais de sofrimento numa criança e a respectiva área (4P)

Sinal	Area
Perde o controlo de urinar e defecar	Sentimental
Querer ficar sozinha em silêncio	Física
Dores de cabeça e de coluna	Conhecimento
Fraca capacidade de concentração e atenção	Comportamento
Ser agressiva	Física

4. Assinale com X as formas de prevenção do HIV (4P)

- ☐ Ter relações sexuais sem preservativo (anal, oral e vaginal)
- ☐ Praticar o sexo seguro (uso do preservativo, fidelidade e abstinência sexual)
- ☐ Evitar a partilha de agulhas e seringas, bem como práticas tradicionais de risco (Kuchinga, Kupitakufa)
- ☐ Usar material cortante ou perfurante (lâminas, seringas e agulhas,) para mais de uma pessoa
- ☐ Usar apenas lâminas novas ou esterilizadas, para as vacinas tradicionais
- ☐ Transfusão de sangue (contaminado)
- ☐ Procurar o serviço de Prevenção de Transmissão Vertical (PTV), quando estiver grávida

5. Das afirmações abaixo sobre saúde, indique as que são Verdadeiras com V e as que são Falsa com F (6P)

- ☐ A identificação precoce da infecção pelo HIV (testagem) é muito importante, pois oferece às PVHS a chance de iniciar o tratamento cedo, ter um vida longa e mais saudáveis
- ☐ Durante a visita, só fazemos a mobilização para testagem de adultos doentes e acamadas
- ☐ As pessoas que seguem o tratamento conseguem recuperar e manter o estado de saúde e são menos propensas a adquirir infecções oportunistas, tais como Tuberculose
- ☐ Todas as crianças de até os 5 anos devem ser levadas regularmente a unidade sanitária para a vacinação e controlo do peso
- ☐ Não é necessário que as crianças ate os 5 anos sejam levadas a unidade sanitária porque os serviços de saúde já realizam campanhas de saúde da criança
- ☐ O consumo de água limpa e tratada, a boa higiene e o saneamento do meio contribuem para a prevenção de doenças como a diarreia, e malaria.

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6. Indique a que grupo de alimentos pertence cada alimento, colocando X na coluna correspondente (6)

Alimento	Alimentos de base	Alimentos de crescimento	Alimentos protectores	Alimentos de energia
Frango				
Feijão				
Laranja				
Açúcar				
Coco				X
Couve				
Arroz				

7. Que acções podem prevenir a diarreia. Marque com X as respostas correctas (3P)

- ☐ Lavar as mãos com água limpa e sabão ou cinza sabão antes de preparar os alimentos
- ☐ Lavar muito bem os vegetais com água tratada
- ☐ Deixar a comida for a da geleira 6 horas de tempo, depois de cozida
- ☐ Cozinhar muito bem os alimentos de origem animal

8. Assinale com X os principais sinais de malnutrição (6P)

- ☐ A perda de peso;
- ☐ Fraco crescimento (o peso e altura não é igual ao das crianças da sua idade);
- ☐ Ser magro
- ☐ Inchaço da barriga e pernas;
- ☐ Ossos e costelas visíveis
- ☐ Pele fina, seca e pálida;
- ☐ Adoecer
- ☐ Cabelo seco, sem brilho e cai facilmente.

9. Quem deve estar presente quando realizamos uma sessão sobre jornada da vida na família. Marque com X a resposta correcta, ou indica outra (1)

- ☐ Cuidadores
- ☐ Cuidadores e crianças
- ☐ Depende da sessão
- ☐ Outro (Qual): _____

10: Qual das tabelas possui os passos certos para aplicação da árvore da vida? Circule a letra correcta (1)

A

1. Desenhar a Arvore;
2. Explicar a actividades apresentando a sua árvore
3. Pedir para as crianças desenharem as suas árvores
4. Escrever cartas para pessoas importantes
5. Cada criança apresenta a sua árvore
6. Escrever habilidades nas árvores dos outros
7. Entrega de certificados

B

1. Explicar a actividades apresentando a sua árvore
2. Pedir para as crianças desenharem as suas árvores
3. Cada criança apresenta a sua árvore
4. Fazer a floresta da vida
5. Escrever habilidades nas árvores dos outros
6. Escrever cartas para pessoas importantes
7. Entrega de certificados

11. Diga de que tipo de abuso se trata, colocando X na coluna correspondente (4P)

Abuso	Tipo de Abuso			
	Sexual	Física	Emocional	Não é Abuso

Acariciar as partes sexuais				
Casamento prematuro				
Bater a criança por não fazer TPC				
Transmitir a ideia de que a criança é inútil ou bura				
Forçar a criança a ter relações sexuais	X			

12. O que faze rem casos de abuso sexual. Duas respostas são certas, marque-as com X (2P)

- ☐ Negociar com violador para pagar a família pelos danos causados
- ☐ Informar o caso à polícia, seja através denúncia presencial ou anónima
- ☐ Informar o caso às autoridades locais e deixar que elas cuidem do caso
- ☐ Acompanhar a vítima para atendimento na Unidade Sanitária

13. Qual é a principal actividade que os membros dos grupos de PCR realizam. Marque a com X (1P)

- ☐ Elaborar estatutos, elegem um comité de gestão e poupam
- ☐ Poupam, fazem empréstimo para investir em negócio, devolvem o empréstimo e poupam
- ☐ Poupam, fazem empréstimo para comprar bens, devolvem o empréstimo

14. Quem decide o valor mínimo valor de poupança e as percentagens de juros nos grupos de PCR (1P)

- ☐ Os membros dos grupos de poupança
- ☐ A metodologia de PCR já trás uma orientação sobre os valores, o grupo cumpre.
- ☐ Os membros do comité de gestão eleitos pelo grupo

15. Identifique 5 problemas na casa abaixo. Assinale com X nas respostas ao lado (5P)

- ☐ Falta janelas
- ☐ Falta de entrada
- ☐ Falta de porta
- ☐ Falta de cortinas
- ☐ Falta de tecto ou cobertura
- ☐ Cobertura com infiltração
- ☐ Falta de mosquiteira
- ☐ Falta de pessoas
- ☐ Falta de latrina

16. Escolha 2 acções que o activista pode realizar para apoiar a família a melhorar a sua habitação (2P)

- ☐ Sensibilizar a família para que tenham um espaço limpo, coberto e protegido para as crianças e os adultos dormirem
- ☐ Sensibilizar e educar a família para abrir as janelas nos dias que não há mosquitos
- ☐ Informar o supervisor para mobilizar a comunidade, lideranças e acção social, para apoiar a construção de casas para famílias chefiadas por crianças, por idosos ou doentes crónicos.

17. Se os pais brincam e conversam com suas crianças diariamente, as suas crianças. Marque com X (4P)

- ☐ Vão tornar-se mal comportadas
- ☐ Vão ter um bom proveito na escola, e terão um bom emprego
- ☐ Vão ter bons laços com seus pais, e irão querer cuidar deles na velhice
- ☐ Vão ter menos problemas com drogas e álcool, na adolescência
- ☐ Já não vão obedecer
- ☐ Vão ser menos violentes, quando crescer

18. Se o cuidador disser que não tem tempo para brincar e conversar com a criança, o que deve aconselhar-lhe? (1P)

- ☐ Fazer tudo possível para arranjar o tempo

- Brincar e conversar com criança quando está a fazer suas tarefas diárias (comer, banho, dormir)
- Dizer que não há problema, pelo menos você vai passar para brincar e conversar com a criança

19: Quais são as 3 razoes que contribuem para a criança desistir ou faltar regularmente a escola? (3P)

- A falta de apoio e motivação familiar (os cuidadores não falam sobre a importância da educação)
- Falta de lanche para levar a escola
- Ocupação das crianças (cuidar dos irmãos, quando o cuidador está a trabalhar ou doente)
- Experiência escolar negativa como o bullying, ou abuso pelo professor
- Falta de escolas na comunidade onde a criança vive

PROGRAMA DE PARCEIROS COMPETENTES MOÇAMBIQUE

GUIÃO DO ACTIVISTA DE ATENDIMENTO ÀS Crianças Órfãs e Vulneráveis

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CAPABLE PARTNERS PROGRAM Mozambique

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FICHA TÉCNICA

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PROGRAMA DE PARCEIROS COMPETENTES
MOÇAMBIQUE

GUIÃO DO ACTIVISTA DE ATENDIMENTO ÀS

Crianças Órfãs e Vulneráveis

A elaboração deste manual foi possível graças ao generoso apoio do povo americano através da Agência dos Estados Unidos da América para o Desenvolvimento Internacional (USAID). Os seus conteúdos são da responsabilidade da FHI 360 - Programa de Parceiros Competentes - Moçambique e não reflectem necessariamente as opiniões da USAID ou do Governo dos Estados Unidos.

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Introdução

O Presente Guião foi desenvolvido pelo Programa de Parceiros Competentes ou Capable Partners Program (CAP), financiado pela USAID/Moçambique, e implementado pela FHI 360.

Este Guião destina-se aos activistas, promotores ou animadores comunitários que trabalham no atendimento as crianças órfãs e vulneráveis e suas famílias, incluindo os supervisores, oficiais de campo e gestores de projectos das organizações vocacionadas e interessadas neste grupo alvo.

Pretende-se que ele seja uma ferramenta prática, para o reforço das habilidades dos activistas e orientá-los no apoio às famílias na satisfação das necessidades básicas das crianças, durante as visitas domiciliárias.

Para este efeito, o Guião aborda diferentes temas tratados nas diversas capacitações dos activistas dos parceiros do CAP Moçambique no período de 2011 a 2015, sobre o atendimento de crianças órfãs e vulneráveis, seguindo os padrões mínimos de atendimento a criança, definidos pelo Ministério de Género, Criança e Acção Social.

PARTE I

CRIANÇAS ÓRFÃS E VULNERÁVEIS (COVs)

CRIANÇA E OS SEUS DIREITOS

Segundo a Convenção dos Direitos da Criança, adoptada por Moçambique em 1990 e em funcionamento desde 1994, criança é todo o ser humano com idade igual ou inferior a 18 anos de idade.

A CRIANÇA É UMA PESSOA

Três áreas interligadas formam o que é uma PESSOA no todo: a física, a mental (espiritual) e a social.

Todas essas áreas funcionam ao mesmo tempo, e cada área reage influenciando as outras. Exemplo: quando uma criança tem fome e dão-lhe logo comida, o seu estômago fica cheio, sente-se com forças – **área física**; ela fica contente – **área mental**; ela brinca e sorri para os outros – **área social**.

DIREITOS DA CRIANÇA

Uma das coisas mais importantes que toda a criança deve conhecer e exercer são os seus direitos. Tal como temos um corpo, todos nós temos da mesma forma direitos e responsabilidades iguais.

Direitos são as coisas que cada criança deve ter ou ser capaz de fazer. Todas as crianças têm os mesmos direitos. Esses direitos estão listados na Convenção das Nações Unidas sobre os Direitos da Criança.

O nosso país, como a maioria dos países no mondo, comprometeu-se a garantir o cumprimento desses direitos. A seguir o resumo da Convenção em 5 categorias simples de direitos.

1 DIREITO À IDENTIDADE E À NACIONALIDADE
Ter um nome e apelidos dos nossos pais na Cédula de Nascimento e BI, onde consta a data e o local do país em que nascemos

2 DIREITO À PROTECÇÃO E AO AFECTO
Receber protecção familiar e também de dar e receber demonstrações de afecto (palavras correspondentes a amor, amizade, abraços e beijos quando nos sentimos à vontade para o fazer)

3 DIREITO EDUCAÇÃO E AO DESENVOLVIMENTO PESSOAL
Estudar numa escola onde podemos aprender muitas coisas. Brincar e crescer, tendo as mesmas oportunidades que os outros e melhorar cada vez mais as nossas habilidades.

4 DIREITO À SAÚDE E À ALIMENTAÇÃO
Cuidar do nosso corpo e consumir alimentos nutritivos. Crescer saudável, vivendo num local limpo, ir ao hospital quando estivermos doente e quando temos de receber vacinas.

5 DIREITO À PARTICIPAÇÃO E LIBERDADE DE EXPRESSÃO
Poder decidir sobre que pensamos e sentimos. Ser ouvidos na família, na escola e na comunidade, e ser valorizados como cidadãos moçambicanos.

CONVENÇÃO SOBRE OS DIREITOS DA CRIANÇA NUMA LINGUAGEM ADAPTADA PARA CRIANÇAS

Artigo 1
Todas as pessoas com menos de 18 anos têm estes direitos.

Artigo 2
Todas as crianças têm esses direitos, não importa quem elas são, onde vivem, o que seus pais fazem, a língua que fala, qual é a sua religião, se é menino ou menina, qual é a sua cultura, se elas têm uma deficiência, se é rica ou pobre.

Artigo 3
Todos os adultos devem fazer o que é melhor para a criança. Quando os adultos tomam decisões, eles devem pensar sobre como as suas decisões afetarão as crianças.

Artigo 4
O governo tem a responsabilidade de certificar-se de que os direitos da criança sejam protegidos. O governo deve ajudar a família a proteger os direitos da criança e a criar um ambiente onde ela possa crescer e atingir o seu potencial.

Artigo 5
A família tem a responsabilidade de ajudar a criança a aprender a exercer os seus direitos, e garantir que os direitos dela sejam protegidos.

Artigo 6
A criança tem o direito de estar viva.

Artigo 7º
A criança tem o direito a um nome, oficialmente reconhecido pelo governo. Tem ainda o direito a uma nacionalidade (de pertencer a um país).

Artigo 8
A criança tem o direito a uma identidade – um documento formal que diz quem ela é.

Artigo 9
A criança tem o direito de viver com o seu pai (s) e de viver numa família, a menos que seja prejudicial para ela.

Artigo 10
Se a criança vive num país diferente do país em que os seus pais vivem, ela tem o direito de viver com eles.

Artigo 11
A criança tem o direito de ser protegida de ser sequestrada.

Artigo 12
A criança tem o direito de dar a sua opinião, que deve ser ouvida e levada a serio pelos adultos.

Artigo 13
A criança tem o direito de descobrir coisas e compartilhar o que ela pensa com os outros, seja falando, desenhando, escrevendo ou de qualquer outra forma, a menos que prejudique ou ofenda outras pessoas.

Artigo 14
A criança tem o direito de escolher sua própria religião e crenças. Seus pais devem ajudá-la a decidir o que é certo e errado, e o que é melhor para si.

Artigo 15
A criança tem o direito de escolher seus próprios amigos e juntar-se ou criar grupos, desde que não seja para prejudicar os outros.

Artigo 16
A criança tem o direito à privacidade, ou seja, direito a reserva de informações pessoais e da sua própria vida.

Artigo 17
A criança tem o direito de obter a informação que é importante para o seu bem-estar, de rádio, jornais, livros, computadores e outras fontes. Os adultos devem certificar-se de que as informações que elas recebem não são prejudiciais.

Artigo 18
A criança tem o direito de ser criada pelos seus pais, sempre que possível.

Artigo 19
A criança tem o direito de ser protegida contra violência (ser ferida e maltratada).

Artigo 20
A criança tem o direito de receber cuidados especiais e ajuda, caso ela não possa viver com os seus pais.

Artigo 21
A criança tem o direito a cuidados e proteção, caso seja adoptada.

Artigo 22
A criança tem o direito à proteção especial e ajuda, caso seja refugiada (se tiver sido forçado a deixar sua casa e viver noutro país), bem como todos os direitos nesta Convenção.

Artigo 23
A criança tem o direito à educação especial, caso tenha uma deficiência, incluindo todos direitos nesta Convenção.

Artigo 24
A criança tem o direito aos melhores cuidados de saúde possíveis, água potável para beber, alimentos nutritivos, uma ambiente limpo e seguro, e as informações que possam ajudá-la a manter-se saudável.

Artigo 25
Se a criança vive em instituições como orfanato, ela tem o direito de ter essas condições de vida e a um acompanhamento regular para verificar se as condições são as mais adequadas.

Artigo 26
A criança tem o direito à ajuda do governo, caso ela viva em condições de pobreza e a sua família não consiga satisfazer muitas das suas necessidades básicas.

Artigo 27
A criança tem o direito à alimentação, roupas, um lugar seguro para viver e de ter suas necessidades básicas atendidas.

Artigo 28
A criança tem o direito a uma educação de boa qualidade e de ser incentivada a ir à escola até atingir o nível mais alto que puder.

Artigo 29
A educação da criança deve ajudá-la a usar e desenvolver os seus talentos e habilidades. Esta educação também deve ajudar a criança aprender a viver em paz, proteger o ambiente e respeitar as outras pessoas.

Artigo 30
A criança tem o direito de praticar a sua própria cultura, língua e religião.

Artigo 31
A criança tem o direito de brincar e descansar.

Artigo 32
A criança tem o direito à protecção do trabalho que pode prejudicar a sua saúde e educação. Se a criança, ela tem o direito de ser paga de forma justa.

Artigo 33
A criança tem o direito à protecção dos danos das drogas e de ser envolvida no tráfico de drogas.

Artigo 34
A criança tem o direito de ser protegida contra o abuso sexual.

Artigo 35
A criança tem o direito de ser protegida contra o rapto, venda ou tráfico de pessoas.

Artigo 36
A criança tem o direito de ser protegido contra qualquer tipo de exploração (ser aproveitada, escravizada ou usada).

Artigo 37
A criança tem o direito de ser protegida contra formas cruéis e prejudiciais de punição ou de tortura.

Artigo 38
A criança tem o direito de não participar na guerra. As crianças menores de 15 anos não podem ser forçadas a ir para a tropa ou ir combater numa guerra.

Artigo 39
A criança tem o direito de ser ajudada, caso seja ferida, negligenciado ou maltratado.

Artigo 40
A criança tem o direito de ajuda jurídica e um tratamento justo no sistema de justiça que respeite os seus direitos.

Artigo 41
Se as leis do país da criança proporcionarem uma melhor protecção dos seus direitos, do que os artigos desta Convenção, deve-se aplicar essas leis.

Artigo 42
A criança tem o direito de conhecer os seus direitos! Os adultos devem informar-se sobre esses direitos e ajudá-la a aprender sobre eles.

Artigos 43-54
Estes artigos explicam como os governos e as organizações internacionais, como a UNICEF irão trabalhar para garantir que as crianças sejam protegidas e gozem os seus direitos.

CRIANÇAS ÓRFÃS E VULNERÁVEIS

CRIANÇA ÓRFÃ

Órfã, refere-se a criança que perdeu um ou ambos os pais. Neste caso podemos ter:

- Criança órfã de pai – quando perdeu o pai;
- Criança órfã de mãe – quando perdeu a mãe; ou
- Criança órfã de ambos – quando perdeu o pai e a mãe.

CRIANÇA VULNERÁVEL

O MGCAS define Criança Vulnerável como aquela que se enquadra numa destas categorias:

- Crianças afectadas ou infectadas pelo HIV;
- Crianças em agregados chefiados por crianças, jovens, mulheres ou idosos;
- Crianças em agregados familiares nos quais um adulto se encontra cronicamente doente;
- Crianças da e na rua;
- Crianças em instituições (orfanatos, prisões, instituições de saúde mental);
- Crianças em conflito com a lei (crianças procuradas pela justiça por crimes menores);
- Crianças com deficiência;
- Crianças vítimas de violência: abuso, exploração sexual e tráfego de pessoas;
- Crianças vítimas das piores formas de trabalho;
- Crianças casadas antes da idade legal;
- Crianças refugiadas e deslocadas.

Havendo a necessidade de estabelecer áreas de intervenção prioritárias, o Ministério de Género Criança e Acção Social (MGCAS), considera como grupos prioritários a atingir, crianças que vivem em situações de extrema pobreza e sofrimento, numa das seguintes categorias:

- Crianças órfãs (de mãe, de pais ou de ambos);
- Crianças infectadas e afectadas pelo HIV/ SIDA;
- Crianças que vivem em agregados familiares chefiados por crianças, mulheres ou idosos;
- Crianças que vivem em agregados familiares onde um adulto se encontra cronicamente doente.

RECONHECER A CRIANÇA QUE SOFRE

Todos passamos por situações difíceis, que causam dor e sofrimento, como por exemplo: doenças, infelicidades, violência, separações, guerra, pobreza, calamidades, etc. No entanto, há pessoas que podem recuperar dessas situações, mais facilmente do que as outras.

Sofremos um trauma (choque), porque não estávamos preparados e nem esperávamos por estes acontecimentos dolorosos. Este choque pode trazer consequências nas várias áreas que formam a pessoa.

Assim como os adultos, as crianças sofrem quando passam por estas situações. Algumas das formas de mostrar como sofrem esses choques podem ser manifestadas através das seguintes mudanças:

FÍSICAS (DO CORPO)

- Falta de sono;
- Pesadelos;
- Queixar-se de estar sempre cansada;
- Dores de cabeça e de coluna;
- Tonturas;
- Vómitos;
- As pernas e os braços tremem;
- O coração bate muito depressa;
- Perde o controlo de urinar e defecar.

SENTIMENTAIS (EMOCIONAIS)

- Estar sempre irritada (zangada);
- Não estar triste, nem alegre;
- Querer ficar sozinha em silêncio;
- Ter medo (de ficar doente, estar só, de barulhos, não confiar em ninguém);
- Sentir-se culpada pela doença ou morte;
- Sentir-se sem vontade;
- Chorar sempre sem poder parar;
- Perder auto-confiança e auto-estima.

CONHECIMENTO

- Confusão (não reconhece lugares, pessoas, acontecimentos);
- Dificuldades em tomar decisões;
- Fraca capacidade de concentração e atenção;
- Esquecimento frequente;
- Não consegue resolver problemas.

COMPORTAMENTO

- Estar sempre agitada;
- Não conseguir ficar quieta;
- Estar sempre muito quieta;
- Ser agressiva (provocar, insultar e bater as outras crianças);
- Consumir álcool e drogas.

Adaptado de: DSF 2007

APOIAR AS CRIANÇAS A ULTRAPASSAR A DOR DA PERDA DOS PAIS

A morte dos pais afecta muito as crianças, independentemente da sua idade. Sendo que muitas das crianças com as quais trabalhamos perdeu os seus pais, é muito importante ajudar as crianças a reconhecer e enfrentar a situação difícil em que se encontram, de acordo com a sua maneira de ser, com as condições em que vivem e com as suas capacidades nas diferentes fases de desenvolvimento. A seguir partilhamos um quadro que pode ajudar o activista e o cuidador no apoio a criança.

FAIXA ETÁRIA	CARACTERÍSTICAS GERAIS DA CRIANÇA	COMO ATENDER A CRIANÇA
0 - 2 Anos	• São dependentes da mãe e do pai em relação ao amor, alimentação, protecção, contacto físico e segurança; • Comunicam os sentimentos de conforto e desconforto através do choro.	• A pessoa que cuida da criança deve ser alguém de que ela gosta; • A pessoa deve manter contacto físico com a criança (nenecar, pegar ao colo, dar a mão); • Manter o mesmo horário de actividades (comer, dormir, banho, passear, brincar); • Evitar separar a criança dos seus irmãos.
2 - 4 Anos	• São preocupadas com elas próprias e com as suas necessidades; • São capazes de aprender muita coisa sobre objectos e pessoas; • Tem dificuldades de compreender o que é a vida, a morte, a amizade.	• A pessoa que cuida da criança deve ser alguém de que ela gosta e deve manter o mesmo horário de actividades • O cuidador deve dedicar algum tempo a brincar e divertir-se com a criança; • Usar uma linguagem simples para falar com ela, repetir as coisas e responder as perguntas; • Contar histórias sobre a mãe/pai que faleceu; • Encoraje a criança a brincar com outras crianças.

FAIXA ETÁRIA	CARACTERÍSTICAS GERAIS DA CRIANÇA	COMO ATENDER A CRIANÇA
5 - 7 Anos	• São mais independentes dos pais; • Gostam de descobrir o mundo fora de casa; • Compreendem o que é pertencer a uma família; • Gostam de ouvir historia; • São criativas e exploradoras; • Desenvolvem um forte sentido do que é certo e errado.	• Manter o mesmo horário das actividades; • O ambiente da criança deve manter-se (evitar separação dos irmãos); • Conversar com ela sobre doença e morte, explicar como a doença pode causar sofrimento; • Compartilhar com a criança histórias positivas da família (vejam fotografias dos pais);
8 - 12 Anos	• Procuram explicações sobre o significado dos acontecimentos; • Tem interesse nas actividades académicas; • Aprendem habilidades práticas (agricultura, jardinagem, actividades culturais e desporto).	• Informar o professor sobre a situação da criança; • Encorajar a criança a participar nas cerimónias fúnebres, a visitar a campa; • Sensibilizar o cuidador para compreender os sentimentos de luto (tristeza, agressividade, medo, culpa, isolamento) sem castigar a criança; • Conversar com ela sobre seus medos, pensamentos; • Encorajar a participação em actividades recreativas.
13 - 18 Anos	• Querem saber mais sobre a sua origem e procuram a sua identidade; • Gostam e cuidam do corpo; • Pensam em si próprios e cuidam dos mais novos; • Ficam preocupados com o que lhes possa fazer mal, mas na maioria das vezes não evitam os comportamentos de risco (consumo álcool e drogas e não se sentem capazes de negociar o sexo seguro, em particular as raparigas).	• Encorajar a criança a falar sobre seus medos, pensamentos com alguém que não seja da família • Encorajar a realização de actividades desportivas; • Conversar sobre a protecção contra HIV/ SIDA e gravidez; • Realizar visitas domiciliárias de apoio na satisfação de necessidades básicas, dando especial atenção às que são chefes de famílias • Conversar com o adolescente/jovem sobre as consequências de atitudes e práticas negativas.

Adaptado de: DSF 2007

MATRIZ DE APOIO A CRIANÇA

Por orientação do Ministério do Género, Criança e Acção Social (MGCAS) a avaliação das necessidades da criança é feita usando um instrumento denominado Matriz de Apoio a Criança, vulgarmente conhecido por CSI (Child Status Index ou Índice do Estado da Criança). O instrumento avalia a situação de cada criança nos sete serviços básicos definidos pelos padrões mínimos de atendimento a criança, nomeadamente: Saúde, Educação, Alimentação e Nutrição, Protecção e Apoio Legal, Habitação, Apoio Psicossocial e Fortalecimento Económico.

A matriz é aplicada de 3 em 3 meses, porém devido a sua complexidade, algumas organizações aplicam de 6 em 6 meses.
Ele contém 29 perguntas, sendo que cada pergunta apresenta três opções de resposta (1, 2 e 3), representados por caricaturas, com o seguinte significado:

Não **1**

Às Vezes **2**

Sim **3**

Existe também o "Não aplicável " para algumas perguntas de acordo com a idade da criança. O "Não aplicável" é simbolizado por N/A e é usado nos seguintes serviços e perguntas:

- Saúde: Se a criança possui menos de 13 anos de idade, a resposta para a pergunta sobre o HIV/SIDA é N/A;
- Saúde: Se a criança tem mais de 5 anos de idade, a resposta para a pergunta sobre vacinação é N/A;
- Educação: Se a criança não tem idade escolar, ou seja menos de 6 anos de idade, a resposta para todas as perguntas é N/A;
- Apoio Psicossocial: Se a criança possui menos de 3 anos de idade, a resposta para todas as perguntas é N/A.

PROCESSO DE APLICAÇÃO DA MARIZ DE APOIO A CRIANÇA

- A matriz é aplicada para cada criança da família beneficiária, com duração máxima de 1 hora;
- Para crianças menores de 14 anos, a aplicação é feita aos cuidadores, envolvendo a criança para determinadas perguntas;
- Para crianças maiores de 14 anos, pode ser aplicado directamente à criança, com autorização dos cuidadores;
- Para as crianças da mesma família, algumas respostas podem ser as mesmas em certas perguntas como é o caso de habitação, água tratada, alimentação, etc. Mas ainda assim, é necessário que as perguntas sejam feitas para cada criança;
- Aprofundar as respostas dadas pelos cuidadores, através de perguntas (porquê? Como? Quando? Etc.).
- Registar as respostas dadas pelos cuidadores na folha de resumo que vem em anexo é matriz, por exemplo: *não tem camisa, tem notas baixas na matemática, falta muito na escola por causa de doença, etc.*;
- Depois de fazer todas as perguntas e obter as respostas devidamente assinaladas na matriz, calcula-se o índice do estado da criança, somando todas as respostas válidas (que não tem a resposta "N/A - não aplicável) e dividindo pelo número de perguntas consideradas válidas (com pontuação 1,2 ou 3). O valor que obter deste cálculo, corresponde ao índice total do estado da criança, que é registado na matriz, onde vem *pontuação total.*

PLANO DE ACÇÃO PARA A CRIANÇA

Da mesma forma que cada criança tem a sua matriz, cada criança deve ter o seu plano de acção. O plano de acção é também elaborado de 6 em 6 meses (dependendo da periodicidade da aplicação), logo a seguir a aplicação da matriz, seguindo os procedimentos abaixo indicados:

- Fazer o levantamento de todas as respostas onde a criança tem a pontuação 1 na matriz e de seguida as respostas com pontuação 2, para determinar os assuntos prioritários para os próximos seis meses de intervenção;
- Envolver a família na definição de acções que visam melhorar a vida da criança. No plano de acção há uma coluna denominada " acção da família" e deve ser preenchida em concordância com a família porque é ela que vai realizar tais acções em benefício da criança;
- Preencher período de implementação do plano de acção na parte superior da matriz do plano.
- Os seis (ou 3 meses) de implementação do plano começam no dia em que aplica a matriz para a criança, por isso, cada criança terá as suas datas de acordo com o dia em a matriz foi aplicada. Exemplo: *se o plano de acção da criança foi elaborado no dia 10 de Novembro de 2015 o período do plano tem que ser 10/11/2015 á 10/05/2016*;
- Assinar o plano de acção e colocar a data da sua elaboração na parte inferior da tabela do plano.

MODELO DO PLANO DE ACÃO

Nome da Criança ---------- Código ----------

Periodo de:...../...../..... a ...../...../.....

SERVIÇO	NECESSIDADES PRIORITÁRIAS (3 PRIMEIRAS NECESSIDADES)	ESTÁGIO INICIAL (1,2,3)	ACÇÃO DA FAMÍLIA	ACÇÃO DA ORGANIZAÇÃO		MUDANÇAS VERIFICADAS APÓS 6 MESES DE ACÇÃO	RESPONSÁVEL
				APOIO DIRECTO	REFERÊNCIA		

Elaborado Por: _____ Data_____/_____/_____

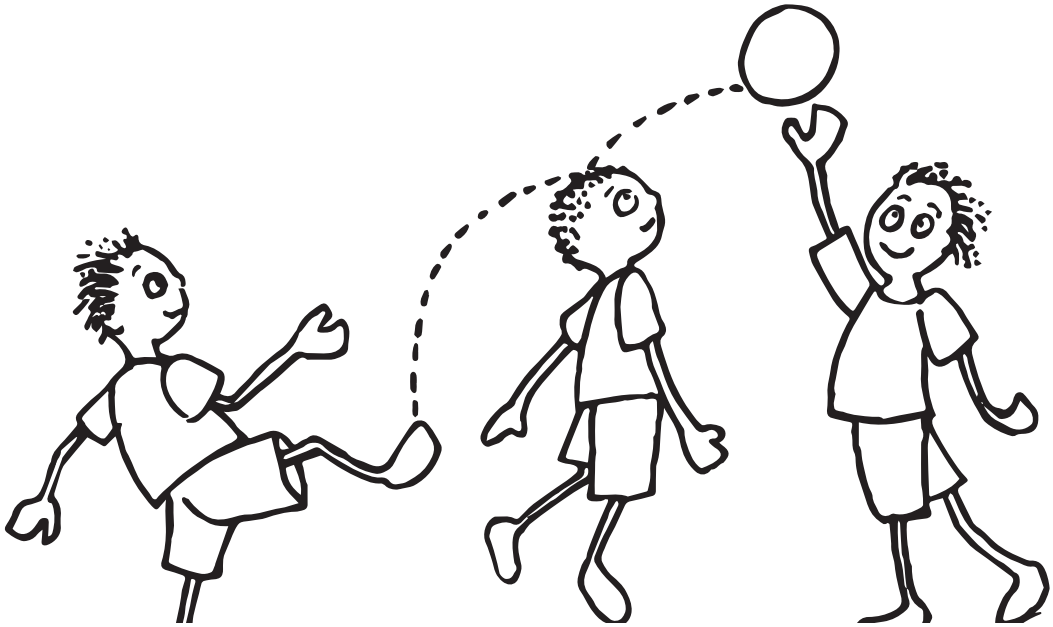
O plano de acção deve ser avaliado periodicamente de 3 em 3 meses, com objectivo de orientar o activista e a família sobre as acções que ainda precisam ser realizadas de modo que, no fim de 6 meses de implementação, todas as acções planificadas sejam cumpridos. Antes de uma nova aplicação da matriz de apoio a criança, é necessário fazer a avaliação do plano anterior, por forma a identificar as acções que não foram realizadas, e as que devem passar para o período seguinte.

Cada activista deve ter cópia do plano de acção de cada criança, anexado à ficha de seguimento da criança, para permitir a consulta das acções prioritárias e controlo do nível de implementação durante as visitas domiciliárias.

PARTE II

PRESTAÇÃO DE SERVIÇOS BÁSICOS PARA O APOIO AS COVs

1 Apoio Psicossocial – APS



Psicossocial

O termo Psicossocial provém de uma palavra composta que combina a **psique** (aspectos psicológicos individuais) e o **social** (comunidade onde o individuo vive e interage com outros).

Os efeitos psicológicos envolvem mudanças em várias funções cerebrais, como a cognição (percepção e memória), afecto (emoções) e comportamento. Os efeitos sociais envolvem mudanças no relacionamento com outras pessoas, incluindo as relações familiares e comunitárias.

Apoio Psicossocial

Apoio — Acto ou efeito de prestar atenção e cuidados a alguém ou a alguma situação.

Psique — deriva de psicologia e refere-se à mente, pensamentos, emoções, sentimentos e comportamentos de um indivíduo.

Social — refere-se as interações e relações do individuo com os outros, o ambiente, a cultura, as tradições e os papeis sociais atribuídos a cada grupo de indivíduos.

OBJECTIVO DAS ACTIVIDADES DE APS

Ao fornecer Apoio Psicossocial a uma criança, é importante que o activista saiba que o objectivo do seu trabalho é de desenvolver na criança a capacidade de reconhecer, enfrentar e ultrapassar as situações difíceis. Este objectivo é alcançado quando se observam os seguintes sinais:

- Criança que interage/convive com familiares, amigos e a comunidade;
- Criança que participa e coopera nas actividades do meio familiar e comunitário;
- Criança que se sente amada e cuidada pelos seus cuidadores;
- Criança que confia na ajuda e atenção de outros membros da comunidade;
- Criança que se sente valorizada pelos outros e sente confiança em si mesma (auto-estima);
- Criança com esperança e planos em relação ao futuro;
- Criança que percebe o efeito do seu comportamento, toma cuidado e aprende dele;
- Criança que está habilitada para ajudar outras crianças a partir da sua experiência;
- Criança capaz de adaptar-se à situação e fazer mudanças positivas na sua vida.

Actividades a Desenvolver

1 Realizar visitas domiciliárias para acompanhar e estimular o desenvolvimento psicossocial da criança e dos seus familiares;

2 Usar jornada da vida com os cuidadores (na família e na comunidade) por forma a prestarem atenção e cuidados para o bem - estar e desenvolvimento das crianças;

3 Usar a árvore da vida com grupos de crianças para apoiar e acelerar a recuperação das crianças órfãs e vulneráveis;

4 Estabelecer uma relação empática, colocando-se no lugar das crianças e dos adultos da família, de forma a auscultar o seu estado emocional e social, e prestar apoio necessário;

5 Desenvolver actividades lúdicas (desenho, jogos, música, dança) orientadas para o desenvolvimento psicomotor da criança (DPI), e que contribuem para a interação entre a criança e os seus familiares;

6 Referir e acompanhar as crianças e/ou adultos da família profundamente afectados para apoio especializado (psicólogo, técnico psiquiatria, supervisor).

MATERIAIS E METODOLOGIAS A USAR

MATERIAL	GRUPO ALVO	METODOLOGIA	OBSERVAÇÕES
Jornada da Vida	**Adultos** Todas as temáticas com cartazes da jornada de vida, excluindo a parte de workshops com crianças (1ª parte do manual)	• Sessão de debate com os adultos da família, durante a visita domiciliária. Os temas são escolhidos em função das necessidades identificadas na família. • Sessão de debate nos encontros com os adultos da comunidade	Pode ser usado individualmente ou em grupo. As crianças não devem participar para evitar que sejam mais traumatizadas, pois os adultos podem falar negativamente sobre o comportamento delas
	Crianças Workshops com crianças (2ª parte do manual)	• Seminários de 4 dias contínuos ou intercalado com o máximo de 10 crianças por grupo	Para não interromper as aulas escolares, pode-se aproveitar os fins-de-semana ou período de férias para realizar as actividades
Árvore da Vida	**Crianças** Que estão em fase de recuperação (a ultrapassar o trauma)	• Seminário de 1 dia inteiro com o máximo de 10 crianças por grupo	

2 Saúde

A Organização Mundial da Saúde (OMS) considera a saúde como um estado de completo bem-estar físico (corpo), mental e social e não somente a ausência de doenças.

A saúde é um direito fundamental das pessoas, que deve ser assegurado sem discriminação de raça, religião, ideologia política ou condição socioeconómica.

Todos merecemos ter boa saúde. Ela não é um bem individual, uma vez que nenhuma pessoa se sentirá bem quando, em seu redor, muitos estiverem a sofrer. Neste caso a saúde é um bem de todos, devendo cada um gozá-la individualmente, e ajudar os outros a gozar de boa saúde também.

A prevenção de doenças e promoção da saúde, é um aspecto muito importante para todos, especialmente para as COVs, porque a maioria delas tornaram-se vulneráveis principalmente por causa de questões relacionadas com a saúde, como o HIV.

O activista é um pessoa chave para mobilizar e incentivar as COVs e suas famílias a procurar os serviços de saúde, como a testagem de HIV e tratamento anti-retroviral (TARV). O activista deve também transmitir a importância da água potável, saneamento do meio, higiene e vacinação.

PREVENÇÃO E TRATAMENTO DO HIV

HIV — VÍRUS DE IMUNODEFICIÊNCIA HUMANA

O HIV é um vírus que entra nas células do sangue (CD4), multiplicando-se rapidamente. Ele destrói o sistema de defesa do organismo e leva ao desenvolvimento da SIDA, que é a fase de doença.

SIDA — SÍNDROME DE IMUNODEFICIÊNCIA ADQUIRIDA

É a doença causada pelo HIV, depois deste enfraquecer o sistema de defesa da pessoa. Uma pessoa infectada pelo HIV não tem necessariamente que ter a SIDA. Significa que a pessoa tem o vírus no seu corpo e provavelmente vai desenvolver a SIDA mais tarde.

FORMAS DE TRANSMISSÃO DO HIV:

- Relações sexuais sem preservativo (anal, oral e vaginal);
- Material cortante ou perfurante (lâminas, seringas e agulhas, instrumentos de tatuagem e escarificações);
- Transfusão de sangue (contaminado);
- Da mãe para o filho (durante o parto e através da amamentação).
- Não se transmite HIV nas seguintes situações: falar ou apertar a mão, beijar a cara de pessoas contaminadas; conversar e conviver com PVHS (Pessoas Vivendo com HIV e SIDA); tocar lágrima, suor, tosse ou saliva de pessoas infectadas.

FORMAS DE PREVENÇÃO DO HIV:

- Prática do sexo seguro (uso do preservativo, fidelidade e abstinência sexual);
- Evitar a partilha de agulhas e seringas, bem como práticas tradicionais de risco (cerimónias de purificação tais como: Kuchinga, Kupitakufa,etc);
- Usar apenas lâminas novas ou esterilizadas, para as vacinas tradicionais;
- Procurar o serviço de Prevenção de Transmissão Vertical (PTV), quando estiver grávida, para fazer o teste e se for positivo fazer o tratamento que previne a transmissão vertical (mãe para o bebe).

ACONSELHAMENTO E TESTAGEM EM SAÚDE – ATS

Aconselhamento é o acto de fornecer informação e conselhos a alguém. Em relação ao HIV e SIDA, o aconselhamento antes do teste ajuda as pessoas a decidirem se podem ou não fazer o teste do HIV. Depois do teste, o aconselhamento ajuda as pessoas com resultado negativo a aprenderem como prevenir-se da infecção do HIV e, para as pessoas com resultado positivo, ajuda a manter uma vida saudável, a evitar reinfecções e a transmissão do vírus para outras pessoas.

Ao realizar ATS na família, o activista deve informar aos cuidadores e às crianças (dependendo da idade), que a identificação precoce da infecção pelo HIV é muito importante, pois oferece às PVHS a chance de iniciar o tratamento cedo, ter um vida longa e mais saudáveis. Por isso, é importante que todos façamos o teste HIV.

Este teste pode ser feito na unidade sanitária ou na comunidade, durante as campanhas ou brigadas móveis de ATS. O teste é gratuito e não é obrigatório.

As crianças com idade inferior a 13 anos devem ter o consentimento de um dos pais ou cuidadores para realizar o teste de HIV.

TRATAMENTO ANTIRETROVIRAL - TARV

Os antiretrovirais (ARVs) são medicamentos usados para tratar a SIDA, mas não curam a doença, pois o HIV continua no organismo. Os antiretrovirais tentam parar os estragos que o HIV faz nas nossas células de defesa e diminuem o risco das pessoas infectadas apanharem infecções oportunistas como a tuberculose.

O tratamento com antiretrovirais deve continuar para toda a vida da pessoa. As PVHS têm o direito de ter acesso ao tratamento, cuidados e receber apoio dos seus familiares, activistas da comunidade, profissionais de saúde e acção social.

A Adesão ao tratamento é muito importante, porque as pessoas que seguem o tratamento conseguem recuperar e manter o estado de saúde e são menos propensas a adquirir infecções oportunistas, tais como Tuberculose.

Actividades a Desenvolver

Para que o activista tenha sucesso na mobilização para ATS e tratamento do HIV, é importante que inicialmente, estabeleça uma relação de confiança com os cuidadores e crianças antes de abordar a temática do HIV, pois trata-se de um tema sensível devido ao estigma e descriminação existente nas comunidades sobre a doença. Recomenda-se uma sessão para os adultos/cuidadores e outra para as COVs (adolescentes a partir dos 12 anos).

Para realizar esta sessão activista deverá realizar as actividades seguintes:

1 Cumprimentar a família e fazer o seguimento dos assuntos da visita anterior, incluindo as referências feitas;

2 Explicar os objectivos da visita e informar que a conversa de hoje é muito importante, especialmente para as meninas, porque eles são normalmente mais afectadas pelo HIV do que os rapazes;

3 Informar que haverá um dia para conversar com os adultos e outro para as crianças dos 12 anos em diante;

4 Usar o guião do activista no tema sobre HIV/SIDA, para explicar os fatos básicos sobre o HIV (como se transmite, como pode ser prevenido e sobre o tratamento);

5 Depois de cada sessão (adultos e crianças) informe aos participantes onde podem aceder aos serviços de testagem e pergunte se alguém estaria interessado em fazer o teste de HIV;

6 Passar a guia de referência para as pessoas mobilizadas (interessadas) ou informe que a sua organização irá deslocar um técnico para a testagem das pessoas naquela comunidade ou família;

7 Agradecer aos participantes da sessão e marque a data da próxima visita.

VACINAÇÃO OU IMUNIZAÇÃO

A imunização protege as crianças (e adultos) contra as infecções prejudiciais, pois usa o mecanismo de defesa natural do corpo para construir a resistência a determinadas infecções. A imunização é dada como uma injecção ou pode ser dada por via oral, na forma de gotas.

Desde o nascimento até os 5 anos de idade é imprescindível que as crianças estejam com as vacinas em dia, pois são elas que ajudam a protegê-las de doenças graves que podem colocar a vida em risco.

Actividades a Desenvolver

1 Verificar o seguimento das acções de saúde nas crianças menores de 5 anos (consultas, controlo da curva de peso, vacinações, toma de medicação e TARV);

2 Solicitar a ficha de vacinação da criança, caso ela tenha menos de 5 anos de idade para ver se ela tem todas as suas vacinas atualizadas e se costuma fazer o controlo de peso regularmente;

3 Elogiar o cuidador pelas boas práticas observadas no seguimento da saúde de crianças;

4 Referir as crianças e mulher grávida para consultas de controlo de peso e vacinação.

Atualmente, as vacinas são muito seguras e não apresentam reações às crianças, além de uma possível irritação e dor no local da picada ou uma eventual febre moderada, que são sintomas normais e observados como resposta positiva do organismo.

Existem nove doenças que podem ser prevenidas através da vacinação infantil de rotina, nomeadamente: Poliomielite (pólio), Tuberculose, Difteria, Tétano, Tosse convulsa, Hepatite B, Hemófilo influenza, Pneumonia e Sarampo.

Todas essas doenças podem causar complicações graves à saúde da criança e às vezes levar à morte. As crianças que não são vacinadas têm mais probabilidade de contrair estas doenças.

Todas as crianças de até os 5 anos devem ser levadas a unidade sanitária para a vacinação completa prescrita no cartão de criança, com as vacinas indicadas abaixo:

IDADE	VACINAS
Ao nascer	PÓLIO + TUBERCULOSE
2 – 4 Meses	PÓLIO + DPT (Difteria, tétano e tosse convulsa) + HEPATITE B + ROTAVÍRUS + HIB + PNEUMONIA
9 Meses	SARAMPO

SANEAMENTO DO MEIO, HIGIENE E ÁGUA POTÁVEL

O saneamento do meio, a prática de higiene e o consumo de água potável são aspectos importantes para a prevenção de doenças que podem comprometer o crescimento das crianças, incluíndo dos adultos.

O consumo de água limpa e tratada, a boa higiene e o saneamento do meio contribuem para:

- Reduzir a mortalidade por diarreia e outras doenças transmitidas através da água contaminada;
- Reduzir doenças como a malaria, que são causadas por agentes que se reproduzem no lixo amontoado, água estagnada e plantas verdes não cuidadas;
- Um ambiente mais limpo e bonito;
- Alimentos mais seguros e melhor nutrição nas crianças;
- Mais dignidade e privacidade para os membros da família, especialmente para as mulheres e meninas.

Actividades a Desenvolver

1 Durante a visita domiciliária, o activista deve se certificar de que as crianças têm acesso à água potável, saneamento e boa higiene;

2 Visitar a cozinha e procurar saber sobre a água que é consumida pela família em termos de: onde é tirada, como é conservada, como é tratada. Aqui é importante falar sobre o perigo do consumo de água não tratada para a saúde;

3 Solicitar para ver a rede mosquiteira e falar sobre a importância de se proteger dos mosquitos para não contrair a malária;

4 Solicitar para ver o local onde a família faz as necessidades maiores e observar as condições de higiene, (se as fezes estão tapadas e se o local tem água disponivel para lavar as mãos após fazer as necessidades);

5 Caso a família não tenha latrina, é necessário promover a sua construção e a correcta utilização;

6 Informar sobre os casos de diarreia nas crianças e na família e referir para a unidade sanitária.

DESENVOLVIMENTO DA PRIMEIRA INFÂNCIA - DPI

O Desenvolvimento da Primeira Infância refere-se à forma como uma criança cresce e aprende durante os primeiros anos da sua vida, ou seja, as mudanças que ocorrem à medida que a criança desenvolve a capacidade de ter um pensamento mais complexo, de comunicar, de autonomia de se movimentar, de relacionar com os outros e de controlar as suas emoções.

A Primeira Infância é a fase que inicia no período pré-natal até aos 3 anos de idade. Durante os primeiros anos (0 aos 3 anos de idade), as crianças são muito sensíveis e a forma como elas são estimuladas afecta o desenvolvimento ao longo da vida.

As crianças infectadas e afectadas pelo HIV e SIDA são especialmente vulneráveis, pois o HIV pode atrasar todas as áreas do seu desenvolvimento, devido aos efeitos físicos do próprio vírus e pela maior probabilidade de que as suas necessidades básicas não sejam satisfeitas.

ÁREAS DO DESENVOLVIMENTO NA PRIMEIRA INFÂNCIA

Físico
refere-se à forma como as crianças usam o seu corpo: rebolar, ficar sentado, gatinhar, andar, desenhar, pegar a colher, lançar e apanhar.

Linguagem
trata-se de como as crianças expressam as suas necessidades e partilham o que pensam, assim como entendem o que lhes é dito: dizer "mamã" enquanto apontam para alguma coisa para beber quando têm sede.

Pensamento Lógico
relaciona-se com a forma como as crianças aprendem algo novo e resolvem problemas: observar o ambiente para entenderem as coisas, deixar algum objecto cair para observar a queda.

Social e Emocional
tem a ver com a forma como as crianças interagem entre si e mostram emoções: sorrir quando alguém olha para elas, brincar com outras crianças, dar abraços e beijos, chorar quando alguém especial, como um dos pais, vai embora e imitar outras crianças.

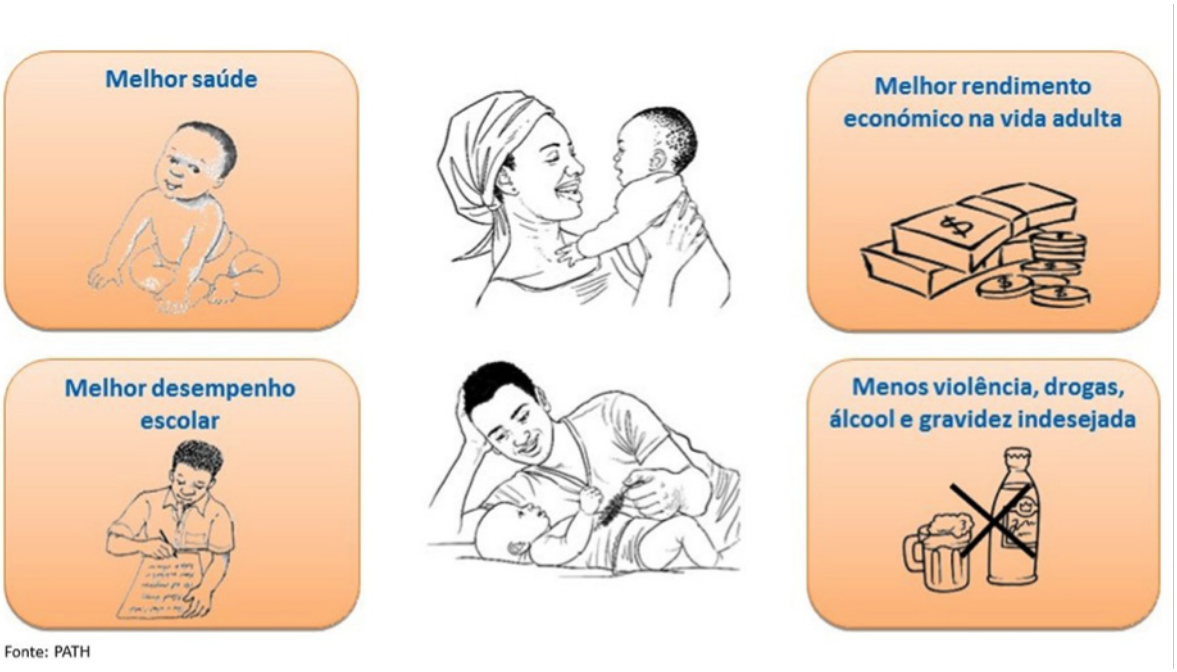
Adaptado de: PATH 2015 & Inter-Agency Taskforce on HIV and ECD 2012

BENEFÍCIOS DA ESTIMULAÇÃO

As crianças que vivem em um ambiente onde são protegidas e estimuladas pelos seus pais, crescem e aprendem mais rápido e têm maior probabilidade de sucessos na vida adulta.

Quando os pais brincam e conversam com suas crianças diariamente, as suas crianças terão:

- Melhor crescimento e saúde;
- Bom aproveitamento na escola, e terão um bom emprego;
- Bons laços com seus pais, e irão cuidar deles na velhice;
- Menos problemas com drogas e álcool na adolescência, e irão evitar a gravidez precoce;
- Bom comportamento, e serão menos violentos quando adultos.



Fonte: PATH

ACTIVIDADES ESTIMULANTES PARA CRIANÇAS DE DIFERENTES IDADES

Criança de 0 – 3 meses

- Olhe para o bebé e converse com ele cara a cara. Faça expressões faciais diferentes para criança.
- Varie o tom da voz, ao falar com bebé (voz alta, voz baixa, sussurrar).
- Imite os sons e gestos do bebé.
- Mexa os braços e as pernas do bebé, e faça massagens.
- Baloice o bebé, para treinar a coordenação dele.

Criança de 3-6 meses

- Olhe para o bebé e converse com ele. Imite os sons e gestos dele.
- Pendure ou passe coisas coloridas em frente do bebé, ou amarre no pulso dele, para treinar a visão.
- Coloque o bebé de barriga para baixo. Deixe alguns brinquedos interessantes no chão para ele tentar pegar.
- Deixe a sua criança ouvir sons diferentes e observe a reacção dela.
- Passe uma pena pelo corpo da criança, e observe a reacção dela.

Criança de 6 a 12 meses

- Cante e faça jogos simples de bater palmas com a criança.
- Diga nomes das coisas que atraem a criança.
- Esconda um brinquedo para a criança procurar.
- Cubra a sua cara com lenço para a criança lhe descobrir.
- Estimule a criança a gatinhar e a levantar-se, colocando um objecto atraente encima ou em frente da criança.
- Dê alguns objectos de casa para a criança pegar, deitar, meter dentro e retirar.

Criança de 1 a 2 anos

- Converse com a criança, por exemplo, pergunte: "O que é isso?", ou "Onde está (o seu nariz, a tia...)?".
- Mostre imagens nos plásticos, caixas, recipientes e revistas, diga nomes ou pergunte a criança o que é.
- Dê a criança caixas, latas, ou garrafas, e algumas coisas pequenas para meter dentro e retirar, abrir e fechar.
- Deixe a criança cheirar coisas diferentes (limão, alho, flor...), pergunte o que é, e de que cheiro gosta mais.
- Faça um brinquedo para criança empurrar para frente e estimule-a a andar.
- Produza uma bola para a sua criança e jogue com ela (atire, role, e chute a bola).

Criança de 2 a 3 anos

- Mostre imagens nos plásticos, caixas, recipientes e revistas, diga nomes ou pergunte a criança o que é.
- Conte histórias a criança.
- Quando leva a criança para um sítio, conversem sobre o que estão a ver pelo caminho, para onde vão, etc.
- Dê a criança objectos de várias formas, tamanhos e cores. Peça para que ela lhe entregue algo amarelo, algo azul, 2 coisas redondas, uma coisa pequena, etc.
- Dê coisas para criança amontoar (fazer torres) e derrubar, construir casas (ex., restos de pranchas de madeira, copos vazios de iogurte etc.)

Fonte: PATH

Actividades a Desenvolver

1 Conversar com o cuidador sobre a importância do DPI, usando o cartaz de aconselhamento para ajudar na explicação;

2 Ajudar e ensinar o cuidador a praticar uma actividade estimulante (preparar papinha, fazer jogo com criança, fazer limpeza do quintal), explicando a importância de práticas que está a promover;

3 Usar a comunicação não-verbal positiva (aproximar-se e tocar no cuidador, sorrir e brincar com a criança, sentar-se no mesmo nível);

4 Aconselhar o cuidador sobre a nutrição apropriada para a idade/fase de crescimento da criança, incluindo a prática do aleitamento materno exclusivo;

5 Verificar o desenvolvimento das crianças (se já conseguem realizar as actividades relacionadas com a sua fase de crescimento) e referir para o centro de saúde, caso identifique problemas ou atrasos na criança.

MATERIAIS E METODOLOGIAS A USAR

MATERIAL	METODOLOGIA	OBSERVAÇÕES
Cartaz de Aconselhamento sobre Estimulação	Conversa com os adultos/cuidadores da família, durante a visita domiciliária. Passos para aconselhamento: 1. Pergunte: Como é que você brinca /fala com sua criança? Peça para demonstrar, e elogie. 2. Demonstre e ajude o cuidador a praticar uma nova actividade estimulante com a criança. Elogie. 3. Explique o que a criança aprende, com essa actividade. 4. Pergunte: Será que pode continuar a brincar e conversar assim com a criança? Como? Elogie.	Tente sempre seguir os passos descritos na metodologia. Estes passos já constam na parte de baixo do Cartaz
Brinquedos (produzidos pelo activista e pela família)	Usar os brinquedos durante a conversa com o cuidador para ajudar na explicação prática sobre actividades estimulantes.	O activista não é impedido de brincar com a criança, porém não pode esquecer o seu papel é de capacitar a família para estimular o desenvolvimento da sua criança.

3 Educação

A *Educação* é o processo de transmissão de conhecimentos e habilidades com vista ao desenvolvimento de habilidades e personalidade da criança para a sua melhor integração social na comunidade.

Todas as crianças têm o direito e dever de frequentar a escola. No entanto, para além de uma educação formal, as crianças também precisam de habilidades para a vida, que ajudam a ter uma vida decente, a saber tomar decisões certas e a controlar suas próprias vidas.

ABSENTISMO ESCOLAR

O *Absentismo* escolar, ou seja, faltar várias vezes e durante muito tempo às aulas escolares é comum entre as COVs. Isto pode acontecer com o conhecimento do cuidador, especialmente em circunstâncias em que este, não podem arcar com as despesas do material escolar para a criança. Em algumas situações, os cuidadores podem não estar cientes de que a criança não está a frequentar a escola. Crianças que ficam longe da escola geralmente gastam o seu tempo brincando na rua.

Há várias razões que contribuem para a criança não frequentar a escola. Estas podem incluir a família, escola e factores pessoais:

- A falta de apoio e motivação familiar - os cuidadores não falam com a criança sobre a importância da educação;
- A pobreza familiar- alguns cuidadores não podem pagar uniformes, material escolar, taxas escolares ou transporte para a escola;
- Ocupação das crianças - as crianças, especialmente meninas são usadas para o trabalho de geração de renda ou para realizar tarefas domésticas (cuidar dos irmãos mais novos, quando o cuidador está a trabalhar ou doente);

- Experiência escolar negativa como o bullying, ou o insucesso escolar, devido a dificuldades de aprendizagem;
- Medo de punição por parte dos professores, caso a criança não tenha feito o TPC;
- Crenças tradicionais, como a de que as meninas não precisam de completar a escola, pois elas vão casar-se e cuidar do marido e da família;
- Ritos de iniciação – feitos para os adolescentes durante o período de aula;
- Gravidez na adolescência.

Actividades a Desenvolver

COM A CRIANÇA

Ao ajudar uma criança que desistiu ou falta frequentemente às aulas, é importante não julgar ou culpar a criança, porque existem motivos fora do controle da criança, que podem contribuir para que tal aconteça. Por isso, é necessário identificar os fatores que contribuem para a desistência ou faltas escolares, recorrendo a algumas perguntas:

Como foram as aulas na escola?

Você tem amigos na escola?

Gostas do tempo que passas na escola?

Como é a sua relação com seus professores?

O que você acha sobre suas notas/provas?

Os teus amigos, professores e encarregadas de educação, têm-te apoiado para teres boas notas?

O que queres fazer quando cresceres ou concluíres com os estudos?

COM OS CUIDADORES

Conversar com os cuidadores sobre a importância da educação e como os cuidadores podem contribuir para que a criança tenha bom desempenho e sucesso na escola;

Procurar saber sobre a situação escolar das crianças maiores de 5 anos (está matriculada, continuam a frequentar regularmente a escola, resultados das provas, material e uniforme suficiente);

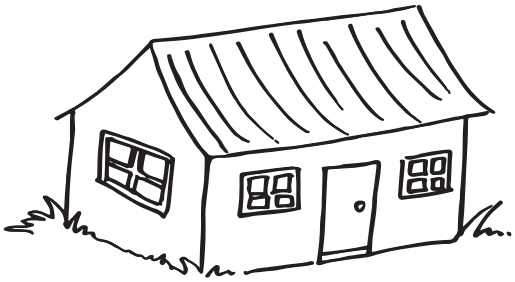
Ajudar os cuidadores no apoio as crianças na resolução do TPC e compreensão de outras matérias;

Sensibilizar ou referir sempre que possível, os adolescentes e jovens para a integração em actividades de habilidades para a vida (costura, carpintaria, seralharia, etc);

PASSOS PARA O RECONHECIMENTO DA SITUAÇÃO ESCOLAR E APOIO DURANTE A VISITA

RECONHECIMENTO DA SITUAÇÃO	MEDIDAS A TOMAR PARA AJUDAR A RESOLVER A SITUAÇÃO
Se visitar a família no início ou final do ano lectivo, é importante procurar saber se a criança está matriculada na escola?	Caso não esteja, procure saber das razões e faça o devido seguimento para a matrícula e integração da criança: fazer referência para a escola, em conjunto com os cuidadores fazer o seguimento junto da escola até que a criança fique matriculada e integrada
Pergunte se as crianças têm uniforme e material escolar. Uniforme: se está completo (camisa, calças/saia) e em condições (rasgado, encardido, cansado). Material escolar: se tem cadernos suficientes para a classe e se tem canetas, estojo de desenho, pasta.	Caso encontre crianças com necessidades, aconselhe á família para encontrar possíveis soluções ao nível familiar. Depois da visita procure saber do seu supervisor se é possível adquirir-se o material e uniforme escolar para as crianças com necessidade e faça o devido seguimento
Pergunte se as crianças (uma por uma) vão á escola todos os dias. Se não, porquê? Procure entender se as meninas vão á escola de igual forma como os meninos Verifique se na família há crianças com necessidades educativas especiais (devido a deficiência ou doenças crónicas)	Aconselhe aos cuidadores para ajudarem as crianças a não faltarem á escola: preparar as crianças há tempo, solicitar apoio dos vizinhos para alertarem as crianças na hora de irem á escola Aconselhe aos cuidadores para proverem os mesmos direitos aos meninos e meninas quanto a educação e outros direitos Caso encontre situações de crianças com necessidades educativas especiais, ajude a família a identificar instituições de apoio: Acção social para obter próteses (óculos, aparelhos de audição, muletas, cadeira de rodas) e Saúde para assistência psicológica, com vista a recuperação da auto - estima e para obter ajuda em técnicas de aprendizagem
Pergunte sobre o aproveitamento escolar da criança: notas das provas feitas, correções do professor nos cadernos, verifique as habilidades de escrita, leitura, matemática e peça para ver a caderneta escolar da criança. Verifique também se a criança tem feito o TPC e se alguém a tem ajudado no TPC.	Caso a criança esteja a ser bem acompanhada e com bom aproveitamento escolar, elogie a criança e aconselhe a manter o desempenho e elogie aos cuidadores pelo seu empenho na vida escolar da criança. Caso a criança apresente problemas, aconselhe a família a encontrar possíveis soluções, como por exemplo: dar-se tempo para ajudar a criança com o TPC ou solicitar apoio de amigos e vizinhos.

4 Habitação



Habitação, refere-se ao local onde vivemos (casa ou abrigo). Este deve ser um local adequado, seguro e confortável para viver com a família.

Muitas crianças órfãs e vulneráveis vivem em situações precárias de abrigo, sem condições para mantê-las aquecidas durante o período de frio ou chuvas, e sem estruturas e cuidados higiénicos para a prevenção de doenças, como a malária.

Por este motivo, as crianças tem estado frequentemente doentes, com gripe, malária, diarreia, tungíase (matequenha), devido às condições de habitação em que vivem. Estas doenças, assim como as outras, têm consequências negativas no desenvolvimento da criança e no seu desempenho escolar.

OBJECTIVOS DA PRESTAÇÃO DO SERVIÇO DE HABITAÇÃO

- Avaliar o estado de segurança da habitação da família (paredes, tecto, pilares e janelas);
- Apoiar a família na procura de formas alternativas de melhorar as condições de habitação;
- Coordenar com as lideranças comunitárias para a mobilização da comunidade para apoio na construção de casas dos beneficiários.

Actividades a Desenvolver

1 Verificar o estado e segurança da casa (as paredes sem rachas graves, o caniço está bem apertado para não permitir a entrada de frio e animais, o tecto é seguro, os barrotes estão em boas condições, as chapas de cobertura não apresentam aberturas e furos maiores que podem permitir a infiltração em caso de chuva, possui janelas ou espaços para a ventilação da habitação, e se possui porta para proteção);

2 Sensibilizar a família para que tenham um espaço limpo, coberto e protegido para as crianças e os adultos dormirem e sobre a necessidade de melhorar as estruturas e segurança da casa, caso necessário;

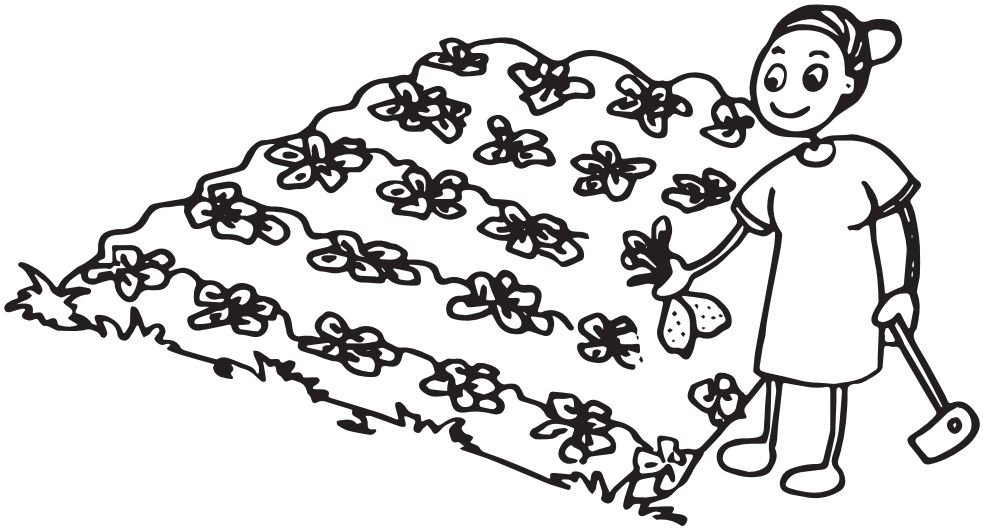
3 Sensibilizar e educar a família a abrir as janelas da casa durante o dia para ventilação e prevenção de doenças;

4 Conversar com os membros da família (adultos e crianças) sobre a importância e bons hábitos da utilização da latrina;

5 Informar o supervisor para mobilizar a comunidade, lideranças e acção social, para o apoio, nos casos de famílias com dificuldades para a reparação ou construção da casa, como nas famílias chefiadas por crianças, por idosos ou doentes crónicos debilitados.

5

Fortalecimento Económico



O fortalecimento económico é uma actividade que se enquadra no serviço básico de Apoio Financeiro.

Não importa o quão pobre uma pessoa possa parecer, ela deve ser mobilizada e encorajada a economizar a partir do pouco que ela tem.

Actualmente os programas têm-se centrado no fortalecimento da capacidade económica das famílias, visto que isso é mais efectivo e sustentável do que tentar fornecer apoio económico directamente a elas. O fortalecimento da capacidade económica pode ser feito de várias formas, porém a metodologia dos grupos de poupança e crédito rotativo tem sido a mais aplicada para os programas de COVs.

GRUPOS DE POUPANÇA E CRÉDITO ROTATIVO (PCR)

Os grupos de poupança e crédito rotativo são grupos criados por membros da comunidade que se conhecem e se sentem bem uns com os outros. A criação destes grupos tem duas grandes funções:

1. Serve para que os membros do grupo façam suas poupanças e empréstimos para diferentes fins, incluindo negócios e assim melhorem a situação económica e financeira. Neste momento o grupo assume um carácter económico;
2. Serve para que os membros do grupo se encontrem, conversem, troquem ideias, se socializem, se ajudem, etc. Neste momento assume um carácter social

OBJECTIVO DAS ACTIVIDADES DE FORTALECIMENTO ECONÓMICO

Ao conversar com a família sobre a actividade de fortalecimento económico, o activista tem o objectivo de:

- Conseguir que o membro da família, com possibilidades de poupar, se interesse pelo assunto;
- Apoiar a família a encontrar meios de melhorar as suas condições, junto de outros membros da comunidade que provavelmente estejam nas mesmas condições;
- Apoiar a família a criar laços de amizade mais fortes com outros membros da comunidade para que não se sintam muito só.

Actividades a Desenvolver

1 Realizar visitas domiciliárias para sensibilizar e estimular a família a participar num grupo de poupança e crédito rotativo;

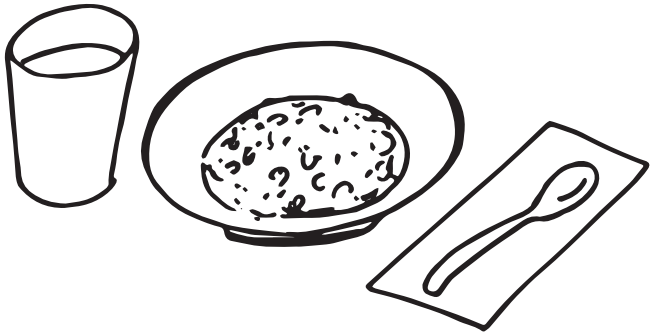
2 Durante as visitas falar sobre os benefícios que a família pode ter por fazer parte de um grupo de PCR. É importante observar as condições e necessidades da família para poder usar esta informação na sensibilização sobre as vantagens dos grupos de PCR;

3 Informar-se sobre a frequência/ participação dos membros da família inscritos nos grupos de PCR;

4 Incentivar e apoiar o cuidador participante no grupo de PCR a realizar alguma actividade de geração de rendimentos;

5 Conversar com os membros da família sobre a importância de utilizarem os resultados da poupança para a satisfação das necessidades da família, com atenção às necessidades das crianças.

6 Alimentação e Nutrição



Alimentação equilibrada ou boa alimentação significa uma alimentação certa em quantidade (mínimo de 3 refeições/dia) e em qualidade (pelo menos um alimento de cada grupo de alimentos em cada refeição principal), para dar ao organismo os nutrientes necessários para o seu funcionamento.

Malnutrição é o estado de doença resultante tanto da deficiente ingestão e/ou absorção de nutrientes pelo nosso corpo (*desnutrição*), como da ingestão e/ou absorção de nutrientes em excesso (*sobrenutrição*).

GRUPOS DE ALIMENTOS

1. ALIMENTOS DE BASE

São alimentos que dão força, e incluem cereais e tubérculos.

2. ALIMENTOS DE CRESCIMENTO

São alimentos que constroem e reparam o nosso corpo, e incluem alimentos de origem animal e seus derivados, bem como leguminosas.

3. ALIMENTOS PROTECTORES

São alimentos que nos protegem contra doenças, e incluem frutas e vegetais.

4. ALIMENTOS DE ENERGIA CONCENTRADA

são alimentos que melhoram o sabor e aumentam a força da refeição, e incluem óleos e gorduras, açúcares, coco e oleaginosas.

ALIMENTAÇÃO EQUILIBRADA

Uma alimentação equilibrada é composta pelos seguintes alimentos:

PERIODICIDADE	ALIMENTOS	GRUPOS DE ALIMENTOS DE QUE FAZEM PARTE
A cada refeição	Cereais (milho, arroz, mapira, mexoeira) e tubérculos (batata, batata doce, mandioca)	Alimentos de base
Todos os dias	Leguminosas (todo tipo de feijão, ervilha, lentilha, soja, amendoim)	Alimentos de crescimento
Todos os dias	Vegetais (abóbora, folhas de abóbora, alface, espinafre, repolho, tomate, feijão verde, abacate, couve, folhas de mandioca); Frutas (manga, laranja, tangerina, maçã, goiaba, banana, ananás, limão, maracujá, amora, frutas silvestres da época)	Alimentos protectores
Todos os dias, se possível	Carne de animais (peixe, aves, carne bovina, carne de porco, e insetos culturalmente aceitáveis, como gafanhotos), ovos, leite e outros derivados	Alimentos de crescimento
Poucas vezes-moderação	Gorduras e óleos (manteiga, margarina, óleo de cozinha), e açúcares (açúcar de mesa, mel, bolos e biscoitos)	Alimentos de energia concentrada
Sempre	Água limpa e potável (cada pessoa deve beber pelo menos 2 litros por dia)	

RECEITAS DE PAPAS ENRIQUECIDAS E REFEIÇÕES EQUILIBRADAS

Abaixo podem ser encontrados alguns exemplos de papas enriquecidas e refeições equilibradas para a família, mas são só exemplos. Pode-se fazer outros pratos com o que se gosta mais e com o que está disponível no mercado e em casa em determinada época.

REFEIÇÕES	INGREDIENTES	PREPARAÇÃO
Papa de farinha de milho com banana e amendoim 	2 colheres de sopa de amendoim pilado e torrado com açúcar 3 colheres grandes de farinha de milho 2 bananas esmagadas Água q.b.	Ponha água a ferver, e numa tigela à parte dilua a farinha com uma pequena quantidade de água. Junte a farinha à água em fervura e mexa bem até cozer. Desligue o lume e depois de arrefecer misture o amendoim pilado e a banana esmagada.
Papa de batata doce com amendoim 	3 batatas doces 1 chávena de amendoim torrado e pilado Água para lavar e ferver a batata doce	Lave as batatas e coza em pouca água, ou asse no carvão ou lenha. Depois de cozidas ou assadas, descasque e esmague as batatas. Junte o amendoim torrado e pilado, misturando bem.
Papa de folha de Moringa 	3 chávenas de água 4 colheres de sopa de milho moído ou farinha de milho 4 colheres de sopa de gergelim crú 2 colheres de sopa de feijão torrado e pilado 1 colher de sopa de amendoim torrado e pilado 1 mão cheia de folhas verdes de moringa	Ferva a água, adicione a farinha e deixe cozer. Junte o gergelim e o feijão. Quando tudo estiver cozido, junte as folhas verdes e o amendoim e deixe cozer por mais 2 minutos.

REFEIÇÕES	INGREDIENTES	PREPARAÇÃO
Xiguinha de batata-doce ou mandioca 	3 - 4 batatas-doces ou mandiocas frescas 2 chávenas de amendoim pilado peneirado 2 chávenas de folha de cacana cozida e escorrida Água q.b. Sal q.b.	Descasque a mandioca, lave e corte em pequenos cubinhos; ferva a mandioca até ficar meia cozida. Numa panela, ponha uma camada de mandioca, seguida de folhas de cacana previamente cozidas, água e por último o amendoim; deixe ferver durante 20 minutos, até que o amendoim esteja cozido; misture bem, para incorporar o amendoim e a cacana, adicione sal que baste. Sirva de preferência quente.
Caril de amendoim com folhas de abóbora 	1 chávena de amendoim pilado 4 molhos e folhas de abóbora 2 tomates 1 cebola Água q.b. Sal a gosto	Corte as folhas de abóbora e lave; numa panela misture o amendoim com água de modo que fique bem diluído e ponha a ferver; adicione a cebola picada e o tomate e deixe cozer; adicione as folhas de abóbora e deixe cerca de 15 minutos. Sirva com xima ou arroz.

HIGIENE DOS ALIMENTOS

A contaminação dos alimentos com micróbios é uma das principais causas de infecções que causam diarreia e vómitos. Os micróbios gostam da humidade e temperaturas mornas, mas não se dão muito bem em condições secas ou quando está muito frio ou muito quente. Por isso, alimentos secos têm menos probabilidade de serem contaminados por micróbios do que alimentos mais húmidos, e alimentos guardados na geleira ou aquecidos a altas temperaturas têm menos chance de serem contaminados por micróbios que alimentos guardados à temperatura ambiente.

MENSAGENS CHAVE SOBRE A HIGIENE DOS ALIMENTOS

- Antes de cozinhar os alimentos lave muito bem as mãos com água limpa e sabão ou cinza.
- Cozinhe muito bem os alimentos de origem animal, pois quando crus eles carregam muitos micróbios. Por isso, as carnes e aves devem ser cozinhadas até que os sucos estejam transparentes e não cor-de-rosa, e os ovos devem ser cozinhados até que a gema esteja dura.
- As carnes, aves, peixes, mariscos e ovos crus devem ser preparados numa área diferente e com utensílios diferentes daqueles que usa para preparar outros alimentos, especialmente se for a consumir esses outros alimentos crus.
- Lave muito bem os alimentos consumidos crus (vegetais ou frutas) com água tratada ou descasque-os antes de usar.
- Uma vez pronta, consuma a comida imediatamente. Não deixe a comida pronta à temperatura ambiente por mais de 2 horas.

- Se tiver de levar comida consigo para o trabalho, escolha alimentos secos e que não se estragam facilmente, tais como pão, castanha de cajú ou amendoim torrado, etc. Se trabalhar na machamba, aproveite para consumir as frutas e vegetais fresquinhos, depois de bem lavados com água tratada.
- Reserve a comida que restar num recipiente fechado, em ambiente refrigerado, por não mais que 2 dias. Se não tiver como refrigerar os alimentos, evite cozinhar quantidades maiores do que aquelas que vão ser consumidas.

PRIORIDADES NA ALIMENTAÇÃO DA FAMÍLIA

Na família, todos têm direito a uma alimentação adequada e saudável. No entanto, alguns membros da família têm necessidades alimentares maiores em relação a outros, por isso importa sensibilizar as comunidades sobre as prioridades na alimentação da família.

- Mulheres grávidas ou que estejam a amamentar – estas mulheres precisam de comer não só para manter o funcionamento do seu próprio corpo mas também para apoiar no crescimento e desenvolvimento dos seus filhos. Frutas, vegetais, ovos, fígado e outras miudezas são especialmente ricos em vitaminas e minerais muito essenciais para estas mulheres, mas muitas vezes elas são impedidas de os consumir devido a crenças culturais que passam de geração para geração, pondo em risco a saúde das mulheres e crianças da comunidade ao longo de várias gerações.
- Crianças e adolescentes – estes estão em constante crescimento e desenvolvimento, por isso a sua alimentação deve ter uma variedade de alimentos em quantidades adequadas para a sua idade. Muitas vezes as crenças culturais e as normas sociais também impedem que as crianças comam muitos alimentos essenciais para o seu crescimento e desenvolvimento saudável. As crianças devem ser as primeiras a ser servidas, pois o futuro delas depende de uma boa alimentação.
- Pessoas com infecções crónicas – Pessoas infectadas pelo HIV e/ou a tuberculose precisam de comer mais que pessoas não infectadas para poderem lutar contra essas infecções e outras doenças associadas, e manterem-se saudáveis.

Quando as pessoas não consomem alimentos suficientes em relação às suas necessidades alimentares, elas ficam desnutridas.

CONSEQUÊNCIAS DA DESNUTRIÇÃO

NAS CRIANÇAS	NAS MULHERES GRÁVIDAS E NAS QUE AMAMENTAM
• Perda de peso (porque o corpo utiliza as reservas de nutrientes); • Falta de energia para brincar, correr e saltar; • Maior frequência de doenças (o corpo não tem energia ou vitaminas/minerais essenciais para resistir às doenças); • A longo prazo: crescimento impedido, mau desempenho escolar, e baixa produtividade.	• Complicações na gravidez e parto: • Perda de peso ou ganho inadequado de peso; • Bebés com baixo peso à nascença e, a longo prazo, desnutridas; • Maior frequência de doenças da mãe e da criança;

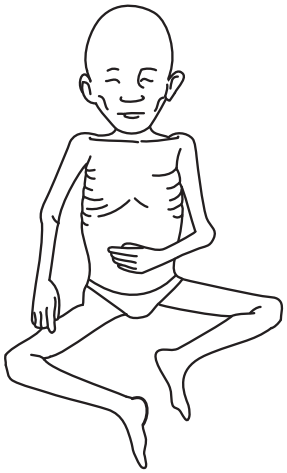
RASTREIO DE CASOS DE DESNUTRIÇÃO AGUDA

Nas comunidades, o rastreio dos casos de desnutrição aguda pode ser feito através de:

- Identificação de sinais clínicos de desnutrição aguda nas crianças da sua comunidade;
- Medição dos braços das crianças e das mulheres durante a gravidez ou nos 6 meses após o parto, o chamado "perímetro braquial". Sabe-se que uma criança ou mulher está desnutrida se a medição do seu perímetro braquial estiver abaixo de um limite determinado especificamente para a sua idade.

OS PRINCIPAIS SINAIS E SINTOMAS DA MALNUTRIÇÃO SÃO:

- A perda de peso;
- Fraco crescimento (o peso e altura não é igual ao das crianças da sua idade);
- Cansaço constante (fadiga);
- Sensação de frio;
- Demora na cura de feridas, até mesmo de pequenos cortes;
- Inchaço da barriga e pernas;
- Ossos e costelas visíveis
- Pele fina, seca e pálida;
- Olhos encovados;
- Cabelo seco, sem brilho e cai facilmente.

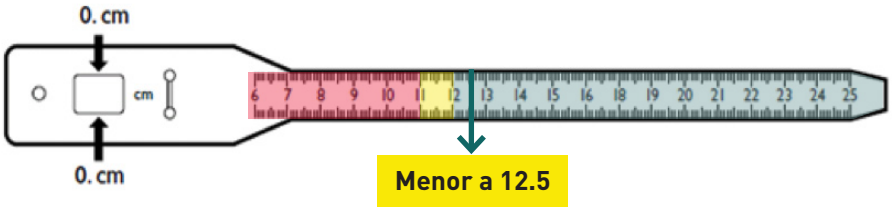


MEDIÇÃO DO PERÍMETRO BRAQUIAL

1. Peça ao pessoa para arregaçar a manga da blusa/camisa e dobrar o seu braço esquerdo fazendo um ângulo de 90 graus.
2. Localize o meio da parte superior do braço menos usado, entre o ombro e o cotovelo. Se possível, marque com um marcador a localização do ponto médio.
3. Com o braço do pessoa relaxado e descaído para o seu corpo, enrole a fita do PB à volta do braço no ponto intermédio. Não deve haver qualquer espaço entre a pele e a fita, mas também não aperte demasiado.
4. Faça a leitura em milímetros a partir do ponto intermédio exactamente onde a seta aponta para dentro. O PB é registado com uma precisão de 1mm (0.1cm).

CLASSIFICAÇÃO DO PERÍMETRO BRAQUIAL EM CRIANÇAS DOS 6 MESES AOS 5 ANOS

CRIANÇAS 6meses – 5 Anos: PB menor que 12,5 cm



MULHERES GRÁVIDAS e nos 6 meses após o parto: PB menor que 23,0 cm

PASSOS PARA APOIO EM CASOS DE DESNUTRIÇÃO

- Referir os casos de desnutrição aguda identificados na comunidade para tratamento na Unidade Sanitária;
- Fazer o acompanhamento do tratamento de cada caso da desnutrição a nível da família;
- Assegurar que retorna à Unidade Sanitária para as visitas de seguimento;
- Referir ao INAS os casos de crianças/ famílias que necessitem de apoio alimentar (cesta básica).

Actividades a Desenvolver

Caso a organização não forneça cesta básica, nem suplementos alimentares ou nutricionais, recomenda-se que o activista, ao identificar situações de pessoas com problemas alimentares e nutricionais, as encaminhe para a unidade sanitária ou aos SDSMAS. As actividades a desenvolver neste serviço, incluem:

1 Verificar o estado nutricional das crianças, mulheres grávidas, mulheres que amamentam, e pessoas doentes na família;

2 Conversar com a família, e principalmente o cuidador, sobre a desnutrição, explicando as suas consequências no crescimento e desenvolvimento saudável de uma criança;

3 Aconselhar sobre as práticas alimentares saudáveis (tipos de alimentos, número de refeições, higiene dos alimentos);

4 Referir para a unidade sanitária os casos de crianças e mulheres grávidas ou nos 6 meses após o parto com sinais de desnutrição, ou com a medição do perímetro braquial abaixo do limite;

5 Referir ao INAS os casos de crianças/famílias que necessitem de apoio alimentar (cesta básica).

7 Protecção e Apoio Legal

O *Apoio Legal* refere-se a toda e qualquer actividade que garante o acesso da criança a documentos legais (cédula, BI, atestado de pobreza) e a assistência jurídica (GAFM, IPAJ), por forma a assegurar a sua protecção e o acesso aos serviços básicos.

A *Proteção* da criança refere-se à prevenção e combate à violência, exploração e abuso contra crianças. Inclui a prevenção e combate à exploração sexual comercial, o tráfico de crianças, o trabalho infantil, o abuso no lar, escola e comunidade, e as práticas tradicionais nocivas e abusivas, como a mutilação genital feminina e casamentos de crianças (UNICEF, 2006).

ABUSO DE CRIANÇAS

O Abuso é uma exploração por parte de quem tem o poder em relação a uma pessoa indefesa. As principais categorias de abuso de menores/ crianças ou abuso infantil são:

- Abuso físico – causa danos corporais (bater, espancar, queimar, envenenar, sufocar);
- Abuso emocional – prejudica de forma contínua o desenvolvimento emocional (transmitir a ideia de que a criança é inútil, burra, não é amada, fazer chantagem, ameaçar);
- Negligência – não satisfazer as necessidades físicas e/ou psicológicas prejudicando a saúde ou o desenvolvimento da criança (falta de afecto, alimento, abrigo, cuidados de saúde, vestuário adequado, relacionamento com outras crianças, protecção dos perigos);
- Abuso sexual – forçar uma criança a participar em actividades sexuais com um adulto ou criança mais velha para obter ou satisfazer o prazer sexual destes;
- Exploração – usar ou forçar a criança para benefícios próprios (casamentos prematuros, exploração de mão de obra infantil).

ABUSO SEXUAL DE CRIANÇAS

O abuso sexual da criança está relacionado com o sexo e é praticado de várias formas, nomeadamente:

- Relação sexual penetrante com ou sem violência (introdução forçada do pénis do adulto, nas partes genitais, na boca ou no ânus);
- Sem penetração (esfregar o pénis entre as coxas ou partes genitais, na boca ou no ânus);
- Acariciar as partes sexuais (órgãos genitais, seios, nádegas);
- Masturbação entre o adulto e a criança;
- Exibir os órgãos sexuais à criança;
- Exploração sexual da criança (prostituição, pornografia ou outras práticas sexuais para o benefício do abusador).

RECONHECER A CRIANÇA ABUSADA

Todo o abuso da criança, seja violento ou não, tem consequências que podem ser físicas, emocionais e comportamentais. Estas mudanças podem servir de sinal de alerta para o reconhecimento da criança abusada.

FÍSICAS (CORPO)

- Arranhões, lacerações, cicatrizes profundas (feridas internas)
- Infecções urinárias e outras
- Sangramento, corrimento e ITS
- Lesões várias na vagina e no ânus
- Gravidez precoce

EMOCIONAIS

- Confusão de sentimentos (bons e maus),
- Tristeza profunda
- Isolamento, perda de interesse
- Medo de ficar sozinha com uma pessoa
- Nervosismo, mudanças de humor
- Baixa auto-estima (não gostar de si própria)
- Grande ansiedade
- Dificuldades de aprendizagem e falta de concentração
- Rejeição, desconfiança.
- Dificuldade em relacionar-se com os outros

COMPORTAMENTAIS

- Fugas (de casa, da escola, isto é do lugar onde possa estar o abusador ou que cause medo)
- Vadiagem
- Delinquência: consumo de drogas, bebidas alcoólicas
- Perturbações de sono e pesadelos

- Agressividade (contra si própria e os outros)
- Perturbações de alimentação (não ter vontade de comer/ ter vontade de comer muito)
- Comportamento sexual exagerado (para a idade): mostrar que conhece palavras com sentido sexual e actos sexuais; fazer jogos sexuais com crianças mais novas; frequentes desenhos de cenas sexuais
- Comportamento reservado (fazer segredo de tudo)
- Ausência frequente da escola, fraco aproveitamento escolar
- Exibição de prendas e de dinheiro.

PASSOS PARA APOIO E ENCAMINHAMENTO NOS CASOS DE ABUSO DE CRIANÇAS

1. Contenção, ou seja perceber o que a pessoa diz, escutar calmamente sem demostrar surpresa. Isso indica que respeitamos o direito à integridade física e mental da pessoa.
2. Em casos de abuso sexual e lesões corporais graves, acompanhar a criança e seu cuidador para a unidade sanitária onde a vítima irá receber um conjunto de serviços:
   - Teste de HIV;
   - Prevenção do HIV, através da profilaxia pós-exposição;
   - Prevenção das infeções de transmissão sexual (sífilis, Hepatite B e Gonorreia);
   - Prevenção da gravidez, através de contraceptivos de emergência;
   - Tratamento das lacerações, feridas, lesões;
   - Apoio psicológico para ajudar a superar o trauma (choque) que sofreu;
3. Denúncia: levar o caso às secções de atendimento junto à esquadra, comandos distritais, posto policial nas localidades ou na unidade sanitária.
4. Informar as crianças e seus cuidadores sobre a possibilidade de fazer denúncia anónima através da Linha Fala Criança 116, que é gratuita.

Adaptado de: DSF 2007, MMAS 2010, & PACTO

Actividades a Desenvolver

1 Conversar com a família sobre a temática da protecção, abuso de menores e direitos das crianças;

2 Aconselhar a família sobre a necessidade de respeitar e cumprir os direitos das crianças, usando a tabela de direitos acima;

3 Verificar se os direitos das crianças estão a ser cumpridos (não ter fome nem sede, não passar frio, ter lugar seguro para dormir, ter carinho, amor e cuidado dos pais, ter cuidados de saúde, estar matriculada numa escola, etc.);

4 Referir as crianças e apoiar os cuidadores para obtenção de documentos legais (atestado de pobreza, cédula, BI, etc.);

5 Verificar se as crianças apresentam algum sinal de abuso/violência (choro constante, medo, pesadelos, timidez, isolamento, consumo de álcool e drogas, corrimentos, feridas e inflamações, voltar a fazer xixi na cama, falar ou fazer gestos sobre relações sexuais, fraco aproveitamento escolar);

6 Informar o supervisor e referir as crianças com direitos negligenciados ou sinais de violência para o Gabinete de Atendimento a Mulher e Criança.

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Certificado

Certificamos que _____ realizou actividades como Activista de Desenvolvimento Comunitário no projecto desenvolvido com fundos da USAID/PEPFAR prestando serviços básicos às crianças orfãs e vulneráveis e suas famílias na Associação Batsirai Nyerera, de ____/20____ à ____/20____, tendo neste percurso passado pelas seguintes formações:

- *Voluntarismo comunitário*
- *Avaliação das necessidades da criança usando a matriz de avaliação Infantil (Child Status Index - CSI) e seu plano de acção*
- *Apoio Psicossocial*
- *Desenvolviemnto da 1ª Infância (DPI)*
- *Prestação dos sete serviços básicos aprovados pelo Ministério do Género, Criança e Acção Social*
- *Mobilização para aconselhamento e testagem em Saúde*
- *Uso de ferramentas de recolha de dados no campo*

Este certificado serve para reconhecer o empenho, dedicação e compromisso na aplicação dos conhecimentos adquiridos tendo contribuido de forma significativa na melhoria da qualidade de vida das famílias vulneráveis.

Chimoio, aos ___ de _____ de 20___

_____

(Assinante)

USAID DO POVO AMERICANO

PEPFAR

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Hope for African Children Initiative

ASSOCIAÇÃO BATSIRAI NHERERA (ABANHE) CRIANÇAS ORFÃS CHIMOIO - MANICA

Annex 4: ED Performance Evaluation Review Tool

CAPABLE PARTNERS PROGRAM
Mozambique

FORMULÁRIO DE AVALIACÃO DE DESEMPENHO DO DIRECTOR EXECUTIVO

USAID FROM THE AMERICAN PEOPLE

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ACORDO ANUAL DE DESEMPENHO

O propósito deste formulário é de ajudar na formulação dos principais objectivos (SMART) a serem considerados para a Avaliação Anual de Desempenho do colaborador, devendo ser preenchido, discutido e acordado entre o supervisor e seus colaboradores no princípio de cada ciclo de Gestão de Desempenho.

Nome do Colaborador		Categoria		Período		Área	
Nome do Supervisor		Cargo Ocupacional		Período		Área	

Exemplos: Principais objectivos retirados da descrição de tarefas do colaborador; objectivos que reflictam a Visão e Missão da organização.
Os trabalhadores encarregues de supervisionar os outros devem apresentar pelo menos um objectivo relacionado com a Prestação de Contas na Gestão do Pessoal.
Recomenda-se no máximo fixar 3 – 5 objectivos (SMART) Específicos, Mensuráveis, Alcançáveis, Relevantes, para cada ciclo de gestão (Período Determinado).

	Objectivos de Desempenho	Resultados Esperados	Período (quando deve acontecer)
1.			
2.			
3.			
4.			
5.			

Declaro para reconhecimento geral e para os devidos efeitos, que tive a oportunidade de discutir com o meu supervisor e acordar objectivos/metas que construem parte integrante do presente Acordo de Desempenho, e a minha assinatura abaixo atesta este facto.

Assinatura do Colaborador: _____ Data: _____/_____/201__

Assinatura do Supervisor:_____ Data: _____/_____/201__

Versão de 5 de Abril de 2016

AVALIAÇÃO ANUAL DO DESEMPENHO

Faça um comentário para cada objectivo acordado referindo-se ao grau do seu cumprimento no período em avaliação, baseado no Acordo de Desempenho assinado.

REVISÃO/MUDANÇA DE ACTIVIDADES					
Objectivos de desempenho/Metas acordadas		Grau de Alcance das metas e classificação (Excelente, Bom, Suficiente e Medíocre)			
		Auto- Avaliação do/a Director/a Executivo/a	Classificação do/a Director/a Executivo/a	Comentários da Presidente	Classificação da Presidente
1.					
2.					
3.					
4.					
5.					

2.1 PLANIFICAÇÃO

A planificação para o futuro é uma das responsabilidades crítica da liderança da associação. No trabalho consistente com o Conselho de Direcção (CD, o Director Executivo deve desenvolver uma visão partilhada do Futuro da associação, construindo um entendimento à volta da missão, e desenvolver metas apropriadas e estratégias para a prossecução da missão.

Por favor indicar se o DE alcançou as suas expectativas nas seguintes áreas:		Fracassou no alcance das expectativas	Alcançou as Expectativas	Excedeu as	Meios de verificação
2.1 a	Em colaboração com o CD tem articulado uma visão clara do futuro da Organização	1 ☐	2 ☐	3 ☐	# de encontros de divulgação da visão
2.1 b	Demostra um sólido domínio da Missão da Organização e tema usado para a tomada de decisão	1 ☐	2 ☐	3 ☐	Decisões tomadas respeitaram a missão organizacional
2.1 c	Envolve significativamente o CD no pensamento estratégico da organização	1 ☐	2 ☐	3 ☐	Evidências
2.1 d	Desenvolve metas apropriadas e objectivos para o alcance da missão	1 ☐	2 ☐	3 ☐	Planos de acção
2.1 e	Lidera de forma efectiva o pessoal na estratégia de implementação dos objectivos e metas anuais	1 ☐	2 ☐	3 ☐	

Por favor dê mais exemplos e acrescente os seus comentários aqui sobre competências centrais do DE

2.2 ADMINISTRAÇÃO

O DE tem a responsabilidade geral do dia-a-dia do funcionamento da organização. O DE trabalha com o pessoal para desenvolver, manter, e usar sistemas de gestão de Recursos que facilitam a operação efectiva da organização.

Por favor indicar se o DE alcançou as suas expectativas nas seguintes áreas		Fracassou no alcance das expectativas	Alcançou as Expectativas	Excedeu as Expectativas	Meios de verificação
2.2 a	Entendimento sólido da missão da organização	1 ☐	2 ☐	3 ☐	
2.2 b	Gestão efectiva dos recursos da organização baseado no dia-a-dia	1 ☐	2 ☐	3 ☐	
2.2 c	Recrutou, treinou o pessoal necessário para a implementação do Plano Anual de actividades	1 ☐	2 ☐	3 ☐	
2.2 d	Liderou de forma efectiva o pessoal na implementação do Plano Anual.	1 ☐	2 ☐	3 ☐	
2.2 e	Assegurou a conformidade com todo o quadro legal e estatutário (incluindo Politicas e procedimentos)	1 ☐	2 ☐	3 ☐	
2.2 f	Delegou o trabalho de forma efectiva	1 ☐	2 ☐	3 ☐	

2.4 GESTÃO FINANCEIRA

Assegurar que os recursos geridos Segundo as boas práticas que orientam as organizações sem fins lucrativos, como a nossa organização. O papel do DE é de avaliar se as metas e objectivos e o plano estratégico da organização servem de base para a uma boa e correcta gestão, bem como os sistemas de controlo interno e gestão de risco.

Por favor indique se o Director Executivo atingiu as expectativas nas seguintes áreas :		Fracassou no alcance das expectativas	Alcançou as Expectativas	Excedeu as Expectativas	Meios de verificação
2.4 a	Tomou decisões e recomendações baseadas na visão financeira geral e boas práticas da organização	1 ☐	2 ☐	3 ☐	
2.4 b	Alocou pessoal técnico financeiro com habilidades necessárias para se atingir as metas e objectivos da Organização	1 ☐	2 ☐	3 ☐	

2.4 c	Apresenta o orçamento anual dentro dos prazos e de forma precise para revisão e tomada de decisão pelo CDCD	1 ☐	2 ☐	3 ☐	
2.4 d	Implementa sistemas de controlo interno apropriados de forma a proteger a organização de fraude.	1 ☐	2 ☐	3 ☐	

Por favor dê exemplos e acrescente os seus comentários aqui nas competências chave.

SECÇÃO 3: QUALIDADES PESSOAIS DE LIDERANÇA

Para além das funções e responsabilidades chave da organização existe um número de habilidades interpessoais e de liderança que são importantes para o sucesso da missão da Organização

3.1 HABILIDADES DE LIDERANÇA

Indique por favor se o/a DE atingiu a sua expectativa nas seguintes áreas:		Não alcançou a expectativa	Alcançou a Expectativa	Excedeu Expectativas	Meios de Verificação
3.1 a	Claro cometimento do/a DE na prossecução da missão e Valores da organização	1 ☐	2 ☐	3 ☐	
3.1 b	Habilidade de motivação e engajamento de parceiros, beneficiários na prossecução da missão da organização.	1 ☐	2 ☐	3 ☐	
3.1 c	Habilidade de aprender das lições de sucessos e de fracassos do passado para melhor planificar o futuro.	1 ☐	2 ☐	3 ☐	
3.1 d	Tendência de tomada de consciência sobre ameaças externas que possam ter impacto na acção da organização	1 ☐	2 ☐	3 ☐	
3.1 e	Senso de criatividade e inovação	1 ☐	2 ☐	3 ☐	

Por favor dê exemplos e acrescente os seus comentários aqui sobre habilidades de liderança

3.2 HABILIDADES INTERPESSOAIS

Indique por favor se atingiu as expectativas nas seguintes áreas:		Não alcançou a expectative	Alcançou a Expectative	Excedeu Expectativas	Meios de Verificação
3.2 a	Habilidades de resolução de problemas de forma eficaz e efectivas (elevadas qualidades de resolução de conflitos)	1 ☐	2 ☐	3 ☐	
3.2 b	Realiza um bom julgamento na tomada de decisão	1 ☐	2 ☐	3 ☐	
3.2 c	Habilidade de manter uma Comunicação efectiva a todos os níveis (CD, CF, colegas, etc)	1 ☐	2 ☐	3 ☐	
3.2 d	Habilidade de construir relações de confiança	1 ☐	2 ☐	3 ☐	
3.2 e	Habilidade de balançar pontos de vista divergentes ou em oposição	1 ☐	2 ☐	3 ☐	
3.2 f	Habilidade de aceitar criticas construtivas	1 ☐	2 ☐	3 ☐	

Por favor dê exemplos e acrescente os seus comentários aqui sobre habilidades interpessoais

SECÇÃO 4: AVALIAÇÃO ANNUAL FINAL:

CUMPRIMENTO DE TAREFAS E DESAFIOS

A sessão anterior apresenta-nos uma imagem importante sobre **a** avaliação do desempenho realizada pelo CDCD à DE, nas áreas chave de responsabilidade. A presente secção da avaliação providencia uma oportunidade para incluir pensamentos e dicas acerca da organização, as quais não são captáveis na avaliação quantitativa. Por favor responda as seguintes questões:

AVALIANDO O PASSADO

As questões seguintes tomam em consideração as realizações bem sucedidas da nossa organização no ano passado e serve de fundamentação para a discussão entre o CDCD e a Direcção Executiva da organização.

4.1 Quais são as conquistas mais importantes/ significativas da nossa organização no ano findo?

4.2 No ano passado, quais foram as maiores dificuldades/desafios que a nossa organização enfrentou? E como o CDCD e o/a DE enfrentaram-nas?

PLANIFICAÇÃO PARA O FUTURO

Enquanto a maioria das questões apresentadas nesta avaliação enfoca sobre o desempenho passado, a questão final olha para o futuro. As perguntas seguintes irão apoiar o CDCD no estabelecimento de indicadores chave de desempenho e prioridades para o ano seguinte.

Pensando no presente ano

4.3 Quais são as duas prioridades mais importantes da sua organização?

4.4 Quais são as duas tarefas mais importantes do/a DE (o)?

4.5 Quais são as duas metas de desenvolvimento profissional para o/a DE

Versão de 5 de Abril de 2016

APRECIAÇÃO FINAL DO DESEMPENHO DO COLOBARADOR

Inclui as avaliações anuais dos objectivos, todos os semestres, o desempenho baseados nos objectivos extraídos da Descrição de Tarefas (DT), reconhecimentos e prémios, feedback múltiplo (avaliação feita por colegas, outras áreas em que o seu trabalho se relaciona), áreas de desenvolvimento e pontos fortes e fracos.

RESUMO DOS OBJECTIVOS, ANÁLISES SEMESTRAIS, BASEADOS NA DT, RECONHECIMENTOS E PRÉMIOS
ÁREAS PARA DESENVOLVIMENTO PROFISSIONAL
PONTOS FORTES
RESUMO DO FEEDBACK MÚLTIPLO (avaliação de terceiros)

RESULTADOS: SELECCIONAR A AVALIAÇÃO FINAL (Assinale com **X** a classificação final do desempenho)

Excelente ☐ **Bom** ☐ **Suficiente** ☐ **Mediocre** ☐

Annex 5: Financial Health Check Analysis

ASF					
Evaluation category	**2014 Score**	**2016 score**	**Change**	**TA provided**	**Analysis**
1. Planning and budget	32	37	15.63%	• Mango training. • Comments on draft of institutional budget. • TA thru comments and cash flow forecast and request of funds. • TA on Request of Funds and Annex W development.	• There is an institutional budget. • The budgeting process is participatory. • There is control of expenditure versus approved budget. • Cash flow forecasts are prepared regularly.
2. Accounting systems	50	51	2.04%	• Mango training. • TA on archives. • TA through comments on monthly reports. • TA for dealing with internal funds. • TA on internal control systems. • TA on correct procedures to registration of timesheet.	• Transactions are recorded daily in the cash/bank book. • Bank reconciliations performed consistently every month. • Physical cash count is performed regularly.
3. Financial reports	29	25	-13.79%	• Mango training. • TA for proper reporting to the General Assembly and regularly to the board and Fiscal council. • TA in correct procedures to registration of timesheet.	• There is culture of accountability to governing bodies. • Responsible for budgets receive expenditure reports monthly. • Cash/bank book are updated monthly. • Bank reconciliations are done consistently every month. • There is a safe. • Transactions are authorized prior to the payments.
4. Internal Controls	65	62	-4.62%	• Mango training. • TA on internal control systems. • TA for designing Admin/fin policies and procedures. • TA on assets inventory. • TA on correct procedures to registration of timesheet. • TA on Request of Funds and Annex W development.	• Bank reconciliations performed consistently every month. • There is a safe. • Transactions are authorized prior to the payments.
5. Grant management	32	34	6.25%	• Mango training. • Comments on financial monthly reports	• All partnerships are based on written and signed agreements. • There is no loaning from one project to another.
6. Personnel	32	37	15.63%	• Mango training. • TA on correct procedures to registration of timesheets.	• The different financial roles are defined, known and followed up. • The financial staff has the required competencies for their job. • There is a job description for each staff.
Score	**240**	**246**	**2.5%**		

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ANDA					
Evaluation Category	**2014 Score**	**2016 Score**	**Change**	**TA Provided**	**Analysis**
1. Planning and Budget	39	44	12.82%	• TA thru comments to the monthly cash flow forecast and requests of funds. • TA on reserve funds policy; • Grants Management Workshop II in Finance. • TA in Request of Funds and Procurement Procedures.	• Existence of budgeted Strategic Plan. • There is a practice of Global Financial Reporting illustrating the incomes and expenses of the association. • The budgeting process is participatory. • There is control of expenditure compared to the budget. • Cash flows are prepared regularly.
2. Accounting Systems	48	51	6.25%	• TA on internal control systems. • Grants Management Workshop II in Finance. • TA on shared salaries calculation. • TA on correct procedures to registration of timesheet. • AT on Request of Funds and Procurement Procedures.	• Production of global reports to all partners. • Daily register of bank/cashbooks. • Consistent monthly bank reconciliation. • Regular physical cash counting. • Still need to improve filing system and storage of documents.
3. Financial Reports	30	36	20%	• TA thru comments to the monthly financial reports. • TA for preparation of reports to the General Assembly. • Grants Management Workshop II in Finance. • TA on shared salaries calculation. • TA on correct procedures to registration of timesheet.	• There is culture of accountability to governing bodies. • The financial reports are used for decision making. • Responsible for the budget receive monthly budget execution reports. • Bank/Cashbooks and bank are updated monthly. • The audits are conducted by firms not registered in Mozambique.
4. Internal Controls	70	68	-2.86%	• TA on internal control systems. TA for proper inventory of assets. • TA thru FC follow up meetings. • Grants Management Workshop II in Finance. • TA on shared salaries calculation. • TA on correct procedures to registration of timesheet. • TA on Request of Funds and Procurement Procedures.	• Existence of an administrative policies and procedures manual. • Consistent carrying out of bank reconciliations. • Availability of a safe. • The transactions are authorized before making the payments. • Inventory not updated and assets not fully labeled. • External audit by a foreign based firm.
5. Grant Management	33	34	3.03%	• Resouce mobilization training; • Grants Management Workshop II in Finance.	• All partnerships are documented through agreements and memorandums. • There is no practice of loaning funds from one project to another.

6. Personnel	36	36	0%	• TA and provision of Excel format for shared salaries calculation; TA for "one staff-one contract-one salary. • TA on performance evaluation. • Grants Management Workshop II in Finance. • TA on shared salaries calculation. • TA on correct procedures to registration of timesheet.	• The different roles within the financial functions are properly defined, known and followed. • Financial staff have the skills (and qualifications) needed to carry out financial activities. • The personal files include job descriptions. • ANDA needs to carry out a proper performance evaluation process for all staff.
Total Score	**256**	**269**	**5.07%**		

HACI					
Evaluation category	**2014 Score**	**2016 score**	**Change**	**TA Provided**	**Analysis**
1. Planning and budget	28	32	14.29%	• TA thru comments on monthly requests of funds. • TA on Financial Close-out process. • TA on Tracking of Financial Information including sub partners.	• Currently HACI has approved its Strategic Plan. • The funds resulting from membership fees are recorded and controlled.
2. Accounting systems	45	45	0%	• TA on Financial Close-out process. • TA on Tracking of Financial Information including sub partners. • TA on correct procedures for registration of timesheet. • TA in Search in Anti-Terrorism List.	• The transactions are properly supported by evidences. • A bank reconciliation is carried out each month for each bank account specific to each project.
3. Financial reports	21	21	0%	• TA thru review of monthly financial reports. • TA for Financial Close-out process. • TA on Tracking of Financial Information including sub partners. • TA on correct procedures for registration of timesheet. • TA on Search in Anti-Terrorism List.	• Financial reports are submitted to the Board and the Fiscal Council (FC). • One FC member performs activity visits and checks financial reports regularly despite not issuing opinions. • Financial information is shared with the HACI sub partners in coordination meetings.
4. Internal Controls	72	72	0%	• TA on Internal control systems and archives. • TA thru Fiscal Council follow-up meetings. • TA on Tracking of Financial Information including sub partners.	• There is an administrative policies and procedures manual approved by the Board. • There is a purchase committee and clear segregation of duties. • Bank reconciliations are checked by someone other than who prepared, followed by a proper approval. • The organization has an updated inventory and goods are labeled.
5. Grant management	32	32	0%	• Resource Mobilization training.	• Donors receive financial reports timely and in the correct format.
6. Personnel	32	32	0%	• TA on correct procedures to registration of timesheet. • TA in Search in Anti-Terrorism List.	• Opportunities are given to staff for training. • There is a job description for each staff. • There are policies & guidelines for staff health policy and compensations, with the respective budgets.
Score	**230**	**234**	**1.74%**		

HOPEM					
Evaluation category	**2014 Score**	**2015 score**	**Change**	**TA provided**	**Analysis**
1. Planning and budget	22	30	36.36%	• Mango training. • TA for understanding HOPEM Agreement with the US Department of State.	• Has a budgeted strategic plan. • Core costs are budgeted and annually updated, although not fully funded. • There is improvement in the preparation of budgets, with details and notes with calculations.
2. Accounting systems	46	44	-4.35%	• Mango training. • TA on timesheets.	• The transactions are properly supported by evidences. • A bank reconciliation is carried out each month for each bank account specific to each project.
3. Financial reports	18	17	-5.56%	• Mango training. • TA on improved reporting to the US State Dept.	• External Audit is carried out regularly.
4. Internal Controls	66	72	9.09%	• Mango training. • TA on archives.	• There is an administrative policies and procedures manual, but not yet finalized; procurement and travel policies are still missing. • There is a purchasing commission and a clear segregation of duties. • Bank reconciliations are checked by someone other than who prepared, followed by a proper approval.
5. Grant management	33	35	6.06%	• Mango training.	• Donors receive the financial reports timely and in the correct format.
6. Personnel	32	38	18.75%	• Mango training. • TA on time allocation and delegation.	• There is a job description for each staff.
Score	**217**	**236**	**8.76%**		

Kubatsirana					
Evaluation category	**2014 Score**	**2016 score**	**Change**	**TA provided**	**Analysis**
1. Planning and budget	25	39	56.00%	• Mango training. • TA for designing TORs for strategic plan revision and comments on drafts of strategic plan. • Comments on draft of institutional budget. • TA thru comments and cash flow forecast and request of funds. • Two Grants Management Workshops in Finance. • TA on Request of Funds and Annex W development. • TA for development of Chart of Accounts.	• There is an approved Strategic Plan. • There is an Institutional Budget. • The budgeting process is participatory. • Cash flows are prepared monthly. • The budget includes explanatory notes and detail.
2. Accounting systems	40	51	27.50%	• Mango training. • TA on archives. • TA on monthly reports. • TA to deal with internal funds. • TA on internal control systems. • Two Grants Management Workshops in Finance. • TA on shared salaries calculation. • TA on correct procedures to registration of timesheet. • TA for Development of Chart of Accounts.	• Cashbooks are filed daily. • Consistency in the monthly bank reconciliation. • Physical cash count is carried out regularly. • Financial filing system is properly organized.
3. Financial reports	23	27	17.39%	• Mango training. • TA for proper reporting to the General Assembly and regularly to the board and Fiscal council. • Two Grants Management Workshops in Finance. • TA on shared salaries calculation. • TA in correct procedures to registration of timesheet.	• There is culture to make accountability to governing bodies. • Financial reports are used to assist in decision making. • Daily cash and bank are updated monthly.
4. Internal Controls	49	69	40.82%	• Mango training. • TA on internal control systems. • TA for designing Admin/fin policies and procedures. • TA for proper salary calculation procedures. • TA on assets inventory. • Two Grants Management Workshops in Finance. • TA on shared salaries calculation. • TA on correct procedures to registration of timesheet. • TA on Request of Funds and Annex W development.	• There is an administrative policies and procedures manual approved by the Board. • Consistent carry out of bank reconciliations. • There is a Safe. • The salary processing is global and not separated by project.

				• TA on development of Chart of Accounts.	
5. Grant management	21	33	57.14%	• Mango training. • Comments on financial monthly reports. • Resource mobilization training. • Two Grants Management Workshops in Finance.	• All partnerships are documented through agreements and memoranda. • There is no practice of loaning funds from one project to another.
6. Personnel	23	36	56.52%	• Mango training. • TA for designing HR policies and procedures. • Two Grants Management Workshops in Finance. • TA on shared salaries calculations • TA on correct procedures to registration of timesheets	• The different roles within the financial functions are defined, known and followed. • Financial staff have the skills (and qualifications) needed to carry out financial activities. • The personal files include the staff job description.
Score	**181**	**255**	**40.88%**		

Kukumbi					
Evaluation category	**2014 Score**	**2015 score**	**Change**	**TA Provided**	**Analysis**
1. Planning and budget	40	43	7.50%	• TA on chart of accounts. • TA thru comments on monthly cash flow forecast and requests of funds.	• Budgets include notes and clear calculations. • All program and operations staff are involved in the budgeting process. • All operating costs are adequately funded. • Budgets are approved by the Board. • The Kukumbi appointed an individual who is responsible for managing every budget.
2. Accounting systems	54	55	1.85%	• TA on chart of accounts.	• Each payment made is recorded and has a supporting document as evidence. • A bank reconciliation is performed for each account once a month. • There is a separate cash book for each account.
3. Financial reports	21	37	76.19%	• TA thru comments on monthly financial reports.	• The Board of Kukumbi reviews the quarterly financial reports. • The financial reports include details of cash and bank balances. • Senior managers discuss the financial reports at least once each quarter. • The financial reports are used to making decisions. • Audits are annual and prepared on time.
4. Internal Controls	74	74	0%	• TA on Internal control systems. • TA thru Board and Fiscal council follow-up meetings.	• Cash and checks are stored safely in a safe, at a custody of one person. • All checks are signed by at least two authorized people. • No blank checks are signed. • There is a written policy detailing the limits of authorization. • All transactions are properly authorized. • Tax deductions are processed and paid within the deadline.
5. Grant management	31	30	-3.23%	• Comments on financial monthly reports. • GNW I Refreshment. • Induction of new accountants to the CAP Financial Grants	• All partnerships are properly documented through signed agreements. • The financial and narrative reports are consistent and related to each other.

				procedures. • Revision of procurement processes and annex W.	• The Senior Managers check that the contractual terms are reasonable before signing the contract. • Donors receive the financial reports timely and in the correct format.
6. Personnel	40	39	-2.50%	• TA on staff performance evaluation.	• The Board has at least one member with the necessary skills to monitor all financial activities. • Financial staff have the required skills and qualifications to perform financial tasks. • The different roles within the financial functions are clearly defined, known and followed. • Financial staff are recruited fairly and non-discriminatory, based solely on merit.
Score	**260**	**278**	**6.92%**		

Niiwanane					
Evaluation category	**2014 Score**	**2015 Score**	**Change**	**TA provided**	**Analysis**
1. Planning and budget	28	33	17.86%	• TA on chart of accounts.	• The project budgets are based on costs of planned activities. • The budgets of the organization are approved by the General Assembly (GA). • Both the finance and the program teams are involved in budgeting. • The budget includes notes and clear calculations.
2. Accounting systems	45	46	2.22%	• Induction TA to the new accountant.	• All payments made have a supporting document as evidence. • All payments and receipts are recorded in the cash book. • There is a cash/bank book separated for each account. • A bank reconciliation is performed at least once a month.
3. Financial reports	16	31	93.75%	• TA thru comments on monthly financial reports. Note: After the 2015 evaluation a TA was done for creating a tracker for monitoring the budget execution.	• The governing bodies review the financial reports at least once a quarter. • Senior staff discussed the report at least once each quarter. • The financial reports are used for decision making.
4. Internal Controls	64	63	-1.56%	• TA on internal control systems. • TA on archives. • TA to the fiscal council through follow-up meetings. • Training of Fiscal council on spot check.	• Two signatures are required for checks. • Bank reconciliations are prepared and checked by different people. • Taxes are deducted and paid within the prescribed period. • All transactions are duly approved.
5. Grant management	33	33	0%	• Training on resource mobilization. • Refreshment training on GMW I.	• All funds received are supported by duly signed agreements. • The contractual conditions for procurement are known by the financial staff, responsible for the budget and logistics. • The financial and narrative reports to donors are consistent and related to each other.
6. Personnel	40	39	-2.50%	• TA on staff performance evaluation.	• The Board has at least one member with basic knowledge of Finance. • Financial staff have the required skills and qualifications to perform financial tasks. • The senior staff is exemplary in

					complying with the procedures. • Financial staff are recruited on merit.
Score	**226**	**240**	**6.19%**		

Annex 6: ANDA's Succession Plan for Its Executive Director

Associação Nacional para o Desenvolvimento Auto-sustentado (Anda)

CP.111, Estrada Nacional 6 (em frente das Alfândegas), Tel/Fax: 251-62164

Cidade de Manica, Provincia de Manica, Moçambique.

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PLANO DE SUCESSÃO DO DIRECTOR EXECUTIVO DA ANDA

I. Justificação

O **PS** é uma contingência para o caso de saída temporária longa ou permanente da Organização do **DE**.

O **PS** é um instrumento de gestão de RH que contém procedimentos que devem ser activados no caso da saída do **DE**, para diminuir o impacto negativo da sua saída e orientar a contratação do novo **DE**.

O **CD** é responsável para implementação deste **PS**.

II. Procedimentos para a substituição do DE da ANDA

Logo que o **CD** é informado da saída do **DE** deve fazer o seguinte:

1. Se possível, no prazo de três dias sentar com o **DE** cessante, para:
    a. Definir as prioridades do período até a saída do **DE**
    b. Entender as experiências do **DE**

c. Aperceber-se das fraquezas e do que deve ser melhorado
d. Obter subsídios para a descrição de tarefas do novo **DE**
e. Ouvir sugestões sobre possíveis substitutos internos

2- No prazo de cinco dias criar uma Comissão de Sucessão constituída por titulares dos **OS** e Gestores seniores para preparar a contratação do novo **DE** nomeadamente:

i. Propor Termos de referência
ii. Preparar anúncio de vaga
iii. Anunciar a vaga
iv. Preparar informe sobre a organização para os candidatos seleccionados
v. Fazer a selecção dos candidatos
vi. Organizar as entrevistas
vii. Verificar as contas
viii. Preparar os documentos da indução do novo **DE**

3- No final do período de pré-aviso (trinta dias) o **DE** cessante faz entrega das pastas à Comissão de Sucessão ou, se possível, ao novo **DE**.

4- Caso até uma semana antes da data do período do pré-aviso, não tenha sido contratado um novo **DE**, o **CD** deve indicar um Director Interino.

4.a) - Pode ser indicado como Director Interino **(DI)** um colaborador sénior que conheça bem a organização. Por exemplo:

- Gestor de programas,
- Gestor de administração e Finanças
- Outro colaborador sénior
- Titular do CD

4.b) - A função do DI é de dar continuidade ao funcionamento da organização nos mesmos níveis de desempenho e qualidade requeridos.

4.c) - O DI tem a responsabilidade total pela gestão do dia- a- dia, excepto o despedimento e contratação do pessoal.

5- A Comissão de Sucessão procede a indução do novo DE através de:

a) Disponibilização para leitura dos seguintes documentos na primeira semana de trabalho:

- Estatutos
- Regulamento de Órgãos Sociais e Membros
- Políticas e Procedimentos
- Plano Estratégico
- Documentos de projectos
- Outros.

b) Visita aos vários sectores dos escritórios da organização, até o final da segunda semana de trabalho.

c) Visita aos projectos até ao final da terceira semana de trabalho.

d) Encontros com parceiros – Doadores, Governo e outras partem interessadas a partir da terceira semana de trabalho.

6- O CD procede a substituição da assinatura do DE nas contas bancárias da Organização até ao final da primeira semana de trabalho.

7- ANDA considera o período de transição, o tempo que vai do dia da apresentação da carta de rescisão de contrato do DE até o fim do período probatório do novo DE.

8- Se após o período probatório o novo DE não reunir os requisitos exigidos, o processo de procura do novo DE continua.

Manica, Janeiro 2016

Annex 7: Notes from Quelimane Follow Up Board and CF Meeting

Notas das discussões do encontro de seguimento dos CD e CF da Zambézia sobre Cobranças de quotas

Quelimane, 16 de Março de 2016

Para quê quotas?

1. Para funcionamento da Asssociação (Agua, Energia, Renda);
2. Como base de angariação de recursos;
3. Pagar despesas da Assembleia Geral e de outros encontros;
4. Manter as portas abertas na falta de doadores.

Porquê o membro deve pagar quotas?

1. Motivação
   i. Ter acesso a formações da organização/oportunidade de aprender;
   ii. Contribuir para assegurar a organização;
   iii. Ter acesso a outros benefícios;
   iv. Ter direito de cobrar dos líderes da associação.

2. Obrigação
   i. Pré- condição para ser membro;
   ii. Ter direito a votar e ser votado;
   iii. Prova de existência da associação membro;
   iv. Cumprimento do dever de membro.

Porquê alguns membros não pagam quotas?

1. Sentem-se injustiçados em relação às oportunidades;
2. Desorganização interna dos membros colectivos;
3. Falta de interesse;
4. Interesses pessoais não satisfeitos;
5. Comunicação deficiente;
6. Fraca entrega da pessoa que deve cobrar;
7. Falta de transparência e deficiente prestação de contas sobre o uso do valor das quotas;
8. Baixo espírito de voluntarismo;
9. Uso de fundos para interesses pessoais;

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10. Não ter o valor para pagar.

O que acontece aos devedores?

1. Recebem carta de cobrança;
2. São cobrados nos encontros.

O que dizem os Estatutos?

1. Após seis meses de dívida perde o direito de ser membro (AMME);
2. Perde direitos e benefícios (Nafeza).

Propostas de solução

1. Fazer cumprir os Estatutos – tirar benefícios aos devedores;
2. Fazer cumprir as deliberações da Assembleia Geral;
3. Informar os devedores sobre a sua situação;
4. Auscultar os devedores sobre as razões do seu não pagamento;
5. Criar espaços de motivação para o pagamento de quotas pelos membros;
6. Publicar a situação de quotizações pelo menos uma vez em cada três meses

Recomendação :

Sempre que possível, deve-se evitar cobrança coersiva!

Annex 8: Partners' Meeting Agenda

Agenda do Encontro Semestral dos Parceiros do CAP
Data 17 – 19 de Fevereiro de 2016, Sala do CAP – Maputo

Dia 1 (17 de Fevereiro)		
Horas	**Temas/Sessões**	**Objectivos/ Actividades**
08:00 - 8:30	Chegada e Registo	Participantes fazem o registo da sua presença.
08:30 - 09:00	Sessão de Abertura e Apresentação dos participantes	• Boas vindas, • Dinâmica, • Apresentação dos participantes, • Apresentação da agenda e, • Apresentação os objectivos do Encontro Semestral.
09:00 - 10:00	Resultados Anuais	**Objectivo**: Partilhar e celebrar os sucessos do ano 2015
10:00 - 10:30	**Intervalo - Café**	
10:30 - 11:30	Resultados Anuais	Continuação
11:30 - 13:00	Feedback do inquérito sobre governação nas organizações	**Objectivos:** • Partilhar os resultados do inquérito sobre governação nas organizações capacitadas pelo CAP • Responder as questões colocadas pelos intervenientes durante o inquérito
13:00 - 14:00	**Intervalo - Almoço**	
14:00 - 15:00	Apresentação da ANDA sobre política de fundo reserva e Plano de Sucessão do DE	**Objectivo**: Partilhar a experiencia da Anda sobre o processo de elaboração da política de reservas
15:00 - 17:00	Avaliação do DE via Survey Monkey	**Objectivo:** Apresentar a ferramenta Survey Monkey aos Parceiros para avaliação do DE
17:00	**Fim do primeiro dia**	
Dia 2 (18 de Fevereiro)		
08:30 - 09:00	Revisão do Primeiro Dia	• Revisão do dia anterior • Dinâmica
09:00 - 10:00	MS BIZ – ponto a ponto-aconselhamento sobre prevenção de SRH, GBV e VIH	**Objectivos:** • Apresentar aos parceiros uma ferramenta que possa beneficiar seus beneficiários adolescentes • Plano sobre como introduzir a ferramenta

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10:00 - 10:30	**Intervalo - Café**	
10:30 - 11:30	Instrumento de mentoria e supervisão dos activistas	**Objectivos:** Partilha de experiências sobre o uso da ficha de mentoria e supervisão dos activistas durante as visitas domiciliárias
11:30 - 13:00	VBG e Avaliação Final	**Objectivos:** Partilhar os resultados de VBG e do estudo de avaliação final dos parceiros para que saibam o que foi que avaliação externa disse que alcançamos juntos
13:00 - 14:00	**Intervalo - Almoço**	
14:00 - 15:30	ECSI	**Objectivo:** Demonstrar a última versão do CSI realizado, e o dispositivo portátil.
15:30 - 16:15	Partilha dos Materiais de PACTO	**Objectivo**: informar aos participantes sobre os materiais produzidos pelo PACTO
16:15 - 17:00	O que aprendemos na conferência sobre SBBC na Etiópia	**Objectivo**: Partilhar a experiência da Conferência de SBCC e discutir como aplicar esse novo aprendizado no contexto do CAP e seus parceiros de trabalho
17:00	**Encerramento do Encontro Semestral**	
Evento de celebração do CAP e seus parceiros - 17:30 – 19:00 Local por anunciar		
3º dia (19 de Fevereiro)		
08:00 - 08:30	Revisão do Segundo Dia	• Revisão • Dinâmica
08:30 - 10:00	Grandes Conquistas	**Objectivo**: Visualizar o portfólio de conquistas que os parceiros obtiveram como resultado de capacitação e assistência técnica do CAP.
10:00 - 10:30	**Intervalo - Café**	
10:30 - 11:30	O que será a seguir?	**Objectivo***:* Partilhar os planos de continuidade das actividades dos parceiros – perspectivas de continuidade e manutenção.
11:30 - 12:00	Considerações Finais	**Objectivo***:* Fazer o fecho do último Encontro Semestral do CAP
12:00 - 13:00	Pequenos encontros: OPHAVELA, ANDA e KUBATSIRANA	**Objectivos:** • Aprender do PACTO sobre MHealth e prevenção com positivos - OPHAVELA • Apresentar os planos de visita somente para ANDA e Kubatsirana
13:00 - 14:00	**Fim do Encontro Semestral**	

Annex 9: Partners' Perspectives on Capacity Gains under CAP

Anexo

Conquitas dos parceiros e clientes de OD com apoio do CAP e continuidade após o CAP

Encontro Semestral dos parceiros do CAP, Maputo, 17 - 19 de Fevereiro de 2016

Nome da Organização	Conquistas
ANDA	Alcançadas as metas e resultados preconizados com os projectos (ANDA COVs e KP)
	Reforçados mecanismos de colaboração com instituições públicas e parceiros de implementação (referências – contra referências)
	Melhorada visibilidade da ANDA com a graduação pelo CAP
	Melhorada a capacidade técnica e de intervenção da DE, CD e membros da ANDA (PAOP, ROSME, Manual RH, Ad. e finanças)
Kubatsirana	Melhoramento da habitação (novas construções)
	Pagamento de propinas, uniformes escolares
	Compra de bens diversos e alimentação em tempos de crise
	Despesas de saúde, apoio e confiança mútua entre os membros
	Capacidade interna para realizar PAOP
	Conclusão e implementação das políticas e procedimentos de administrativas e de recursos humanos, e outros documentos afins (Política salarial, política de sucessão, política de mobilização de recursos e outras políticas)
	Investimento na machamba e negócios
OPHAVELA	Fortalecimento dos membros dos órgãos sociais; (clarificação dos papeis dos seus papeis e instrumentos) e Revisão da identidade da OPHAVELA (Visão, missão)
	Graduação pelo CAP
	Fortalecidos os sistemas de controlo Interno (administrativo e financeiro) - revistas/desenhadas as políticas de procedimentos
	Finalizado o processo de registo da Ophavela
	Instalado um website institucional para melhorar a sua visualização
	Reforçada a capacidade de mobilização de recursos
	Elevou a capacidade de intervenção na área do HIV e SIDA e Género
	Estabelecimento formal de parceiras
	Actualizado sistema de contabilidade primavera e capacitado para usá-lo
	Planificação e monitoria montada e usado regularmente
HACI	Das poucas organizacionais nacionais com capacidade de gestão de programas de subvenções
	Sistemas de gestão: manuais de políticas e procedimentos; manuais de gestão de subvenções, plano estratégico

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	Competências específicas de gestão de subvenções para programas comunitários de apoio e cuidados a COVs, Mobilização de recursos
Niiwanane	Viragem/mudança de abordagem de Prevenção para COVs, cuidados e tratamentos
	Metas de COVs atingidas
	Referência dos serviços prestados na cidade de Nampula
	Legalização da organização (registo definitivo e publicação no BR)
	Finalizados os Manuais de políticas e Procedimentos administrativos e financeiros, e de Recursos Humanos
CCMs	Referência a nível da Sede Nacional
	Manuais de Políticas e Procedimentos finalizados
	Metas atingidas
	Referência a nível das comunidades
Clientes de OD	
ASF	Sistema de monitoria e gestão da base de dados melhorada;
	Sistemas de Gestão financeira, administrativa, de recursos humanos da ASF elaborados e aprovados
	PAOPs e Assembleias Gerais realizados periodicamente
	Orientação no estabelecimento de parcerias com o sector privado no processo de inserção profissional dos jovens, bem-sucedido
	Resultados concretos da Iniciativa de Mentores nas áreas de comunicação interna da ASF, Mobilização de fundos
	Treinamento realizados nas áreas Fiscais, do CD (Gestão e Governação) resultando no melhoramento do funcionamento dos O.S. da organização
Kugarissica	Realização de PAOPs periódicos
	Treinamento em Associativismo, Governação Liderança e Gestão, Liderança e Mentoria
	ATs na organização do arquivo físico

Nome da Organização	Continuidade após o término do CAP
ANDA	Realização do PAOP – Semestralmente.
	Refrescamento dos membros dos órgãos sociais - Regularmente.
	Monitoria das actividades e auditorias interna – Regularmente.
	Adaptação e uso de instrumentos (CS, data base, ficha de seguimento, ficha de M&A e rastreio).
	Realização de pesquisas formativas e Inclusão de género e VGG nas novas propostas – regularmente
	Actualização da página facebook e website da ANDA para reforço da visibilidade da ANDA – até Junho de 2016.
Kubatsirana	Facilitadores comunitários remunerados pelos membros dos grupos continuam a formar novos grupos e apoiar os grupos de poupanças existentes;
	Os Coordenadores distritais locais que após o fim do projecto irão assegurar a continuidade das actividades dos projectos;
	Realização do PAOP
	Continuar o processo de angariação de fundos e parceiros;

	Fazer o uso dos manuais de Políticas e Procedimentos internos
OPHAVELA	Continuar o processo de angariação de fundos e parceiros;
	Fazer o uso dos manuais de Políticas e Procedimentos internos
	Continuar com as actividades de crédito e poupança rotativa
HACI	Alguns projectos de negociação ao nível dos PI e da HACI
	Fortalecer parcerias com outras organizações para mobilização conjunta de recursos
	Iniciativas de sustentabilidade: Parcerias com município de Boane (espaço para o funcionamento e outras iniciativas)
Niiwanane	Angariar fundos e parceiros
	Concluir o processo do registo
	Uso dos Manuais da Políticas e Procedimentos organizacionais
CCMs	Uso dos Manuais da Políticas e Procedimentos organizacionais
	Realização de casamentos
	Mobilização de Recursos
Clientes de OD	
ASF	Continuação da Formação e Inserção Profissional dos jovens formados nos ciclos anteriores do PPF;
	Legalização do "espaço do PPF" como Centro de Formação e Inserção Profissional a luz das políticas de Formação Profissional;
	Ministrar curso sobre gestão, governação, liderança e gestão financeira para Associações (modelo de assistência técnica do CAP);
	Ministrar cursos técnico profissionais como TICs, empreendedorismo, entre outros, para jovens, usando metodologia ABP/PBL
Kugarissica	Realização da Assembleia Geral eleitoral
	Mobilização de membros, fundos e parceiros

	Reponsavel	7-12 meses antes do fecho	6 meses antes do fecho	5 meses antes do fecho	4 meses antes do fecho	3 meses antes do fecho	2 meses antes do fecho	1 mês antes do fecho	FECHO	1 mês depois do fecho	2 meses depois do fecho
ACTIVIDADES CHAVE											
Preparação do plano de fecho											
Informar todo o pessoal sobre o plano de fecho											
Pré notificação do close out aos subparceiros											
Fazer plano de saída e retencao do pessoal											
Fazer um encontro individual com o staff para falar sobre o plano de saida											
Preparar um plano de aquisições para o tempo que falta (ex: pagamento de auditoria)											
Cálcular as indemnizações											
Fazer revisão/realinhamento do orçamento baseado nos custos reais, nao o 'burn rate'											
Fecho de todas as subvenções											
FINANÇAS											
Decidir como serão cobertos os custos partilhados pelo projecto que fecha											
Fazer plano para pagamento de serviços pós fecho											
Verificar os adiantamentos em aberto dos trabalhadores											
Verificar dívidas que provavelmente posssam existir com os provedores de serviços											
Fazer o relatório financeiro final											
Zerar a conta											
ADMINISTRAÇÃO											
Verificar termos de rescisão dos contratos com os provedores de serviços											
Pedir transferência de titulos de propriedade (viaturas, motas, etc)											
Avisar prévio para o senhorio											
Avisar prévio para serviços (internet, telefone, água, luz, etc)											
Verificar o inventário e preparar o plano de disposição dos bens											
PROGRAMAS											
Preparar o ano de elaboração dos relatórios finais											
Preparar os relatórios trimestrais programáticos e tabela de resultados											
Submeter drafts dos relatórios programáticos incluindo a tabela de resultados											
Finalizar relatório programático final											
RECURSOS HUMANOS											
Enviar cartas de rescisão dos contratos dos trabalhadores											
Verificar os documentos de RH que devem estar devidamente assinados pelos trabalhadores											
Informar as finanças, INSS, MITRAB, caso dispeçam mais de 10 pessoas											
OUTROS											
Informar os orgãos sociais sobre o fecho do projecto e o plano de fecho											
Informar ao CD sobre o plano de saida e retenção do pessoal											
As equipes de Programas, Administração e Finança devem organizar os documentos que serão guardados por 10 anos.											

Annex 11: Supervision Tool

Ficha de Supervisão e Mentoria do Activista durante a Visita Domiciliária

Data:	**Local:**	**Organização:**
Nome do Mentor/Supervisor:		**Nome do Activista:**

Avaliação do Desempenho do Activista:
1. O activista precisa de muito apoio nesta área (não fez)
2. O activista precisa de algum apoio nesta área (não fez de forma satisfatoria)
3. O activista demonstra habilidades nesta área (fez satisfatoriamente)
NA - Não Aplicável
NP - Não Planificado

Em todos os campos, verifique como o Activista realiza as acções descritas, colocando as pontuações correspondentes	Desempenho (1,2,3, NA ou NP)	Notas do mentor/supervisor
INTRODUÇÃO - Início da Visita		
Convidou todos os membros da família presentes a juntar-se a visita.		
Perguntou se a família tem alguma preocupação.		
Apresentou os objectivos da visita.		
Fez o seguimento da visita passada.		
Trousse consigo uma pasta com material de trabalho (fichas de seguimento, plano de acção, guia de referência, Jornada da Vida, cartaz DPI, ect.)		
SAÚDE		
Verificou o estado de saúde das crianças e dos adultos na família		
Verificou as práticas de higiene e prevenção de doenças (ex: lavar as mãos, uso de rede mosquiteira, limpeza do quintal, uso de latrina, conservação e puroficação da água, ect.).		
Verificou o seguimento das acções de saúde nas crianças menores de 5 anos (consultas, controlo da curva de peso, vacinações, toma de medicação e TARV).		
Verificou o seguimento das acções de saúde na mulher grávida (consultas pré-natal e pós-parto, vacinações, toma de medicação e TARV).		
Oreintou e apoiou a prática do aleitamento materno excusivo (crianças de 0-6 meses)		
Verificou o seguimento das acções de saúde nas pessoas doentes (consultas, toma de medicação e TARV).		
Referiu as crianças, mulher gravida e adultos aos serviços de saúde relevantes caso seja necessário, incluindo planeamento familiar e ATS		
ALIMENTAÇÃO E NUTRIÇÃO		

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Verificou o estado nutricional das crianças (uso do MUAC, edemas, cor do cabelo)		
Verificou o estado nutricional da mulher grávida		
Verificou o estado nutricional dos doentes na familia.		
Aconselhou sobre as práticas alimentares saúdaveis (tipos de alimentos, número de refeições, conservação dos alimentos).		
Fez a demostração culinária		
Ensinou e aconselhou a abertura de hortas caseiras		
Referiu as crianças/familia para apoio alimentar (ex: cesta básica)		
APOIO PSICOSSOCIAL		
Procurou informar-se sobre o estado emocional das criancas		
Procurou informar-se sobre o estado emocional dos adultos da familia.		
Usou a Jornada de Vida para apoiar os cuidadores nos cuidados psicossocias com as crianças		
Conversou e brincou com as crianças.		
Olhou directamente para a pessoa com quem esteve a falar.		
Escutou com muita atenção e demonstrou interesse.		
Conversou com os cuidadores para zelarem pela auto-estima das crianças e outros membros da família.		
Referiu crianças e/ou adultos da familia profundamente afectados para apoio especializado (psicólogo, técnico psiquiatria).		
EDUCAÇÃO		
Procurou informar-se sobre a situação escolar das crianças maiores de 5 anos (está matriculada, continuam a frequentar regularmente a escola, resultados das provas, meterial e uniforme suficiente).		
Aconselhou os cuidadores sobre a importancia da educação e do apoio nos trabalhos para casa (TPC).		
Ajudou os cuidadores no apoio as crianças na resolução do TPC e compreensão de outras matérias.		
Sensibilizou ou referiu sempre que possivel os adolescentes e jovem para a integração em actividades de habilidades para a vida (costura, carpintaria, seralharia, etc)		
PROTECÇÃO E APOIO LEGAL		
Aconselhou a família sobre a necessidade de respeitar e cumprir os direitos das crianças (caso verifique uma situação de violação dos direitos).		
Referiu as crianças ou apoiou os cuidadores para opteção de documentos legais (atestado de pobreza, cédula, BI, etc.).		
Verificou se os direitos das crianças não estão a ser negligenciados		
Verificou se as crianças apresentam algum sinal de violencia		
Referiu as crianças com direitos negligenciados ou sinais de violencia para o Gabinete de Atendimento a Mulher e Criança.		
FORTALECIMENTO ECONÓMICO		

Sensibilizou os cuidadores e outros adultos da familia sobre as vantagens de participar nos grupos de PCR.		
Procurou informar-se sobre a frequência/participação dos membros da familia inscritos nos grupos de poupança.		
Verificou se o cuidador particpante no grupo de PCR, pratica alguma actividade de geração de rendimentos.		
Aconselhou/conversou com os membros da familia sobre a importância de utilizarem os resultados da pounça para a satisfação das necessidaes da familia, com atenção as necessidades das crianças.		
HABITAÇÃO		
Verificou o estado e segurança das paredes, janelas, pilares e tecto da casa		
Sensibilizou a familia sobre a necessida de melhorar as estruturas e segurança da casa		
Sensibilizou a familia para que tenha um espaço limpo, coberto e protegido para as crianças e os adultos dormirem		
Sensibilizou e educou a familia a abrir as janelas da casa durante o dia		
Falou sobre a importancia e bons habitos da utilização da latrina		
DPI - Desenvolvimento da Primeira Infância (0-3 anos)		
Verificou o desenvolvimento das crianças (o que já conseguem fazer).		
Perguntou ao cuidador se brinca e/ou conversa com a(s) criança(s).		
Ajudou o cuidador a praticar uma actividade relevante e estimulante (preparar papinha, fazer jogo com criança, fazer limpeza do quintal).		
Utilizou a comunicação não-verbal positiva (ex: aproximar-se e tocar no cuidador, sorrir e brincar com a criança, sentar-se no mesmo nível).		
Usou desenhos ou objectos (ex: cartaz de aconselhamento em DPI) pelo menos uma vez, para ajudar nas explicações.		
Explicou a importância de práticas que está a promover.		
FECHO DA VISITA		
Elogiou e agradeceu o cuidador pelos pequenos avanços observados na visita.		
Agradeceu ao cuidador e combinou sobre a data da próxima visita.		
Registou os serviços prestados na ficha de seguimento de cada membro atingido (criança e adulto).		
Registou outras informações relevantes sobre a visita (no bloco de notas/caderno do campo).		

COMENTÁRIOS GERAIS (habilidades fortes do activista, áreas por melhorar, sugestões, recomendações, necessidades de formação, acções que o supervisor levará a cabo para ajudar a melhorar as habilidades do activista):

ANDA							
Evaluation Category	**Baseline Score**	**Midline Score**	**Endline Score**	**Change Mid-End line Score**	**Change Base-End line Score**	**TA Provided**	**Analysis/Results**
1. OVC project design							
1. OVC project design Maximum score: 18	3	15	18	20%	500%	TA on proposal Development and use of data	In November 2014, ANDA prepared a quality proposal and budget for the OVC award extension. The various documents submitted (proposal Gantt chat, budget and goals) aligned well. ANDA understand the importance of use research data for proposal development. Proposals submitted to various donors include the use of data, both for the drafting process as well as at the start of projects in order to have a baseline. ANDA has obtained funding from different sources by applying these skills and producing quality proposals.
2. OVC program standards							
2.1 Availability of competent staff to provide care to OVC Maximum score: 15	13	14	14	0%	7%	TA on HR recruitment processess	ANDA developed good terms of references for the recruitment of a Project Manager Assistant, facilitators and social workers. ANDA consistently follows recruitment processes described in their policies. CAP has always approved selected candidates. Through the consistent application of recruitment processes, ANDA identifies and selects qualified personnel which results in quality project implementation.

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2.2 Availability of appropriate processes for the support to and care of OVC and their families Maximum score: 24	14	20	24	20%	71%	TA and training of Village Savings and Loan (VSL) facilitators TA and training on Early Childhood Development (ECD) TA to define OVC transition criteria TA to establish and run the vococational training center	ANDA has consolidated its skills to support OVC and caregivers and requires little TA from CAP other than for the introduction of new project elements. ANDA completed the last two CSIs effectively and with quality. ANDA continues to successfully refer beneficiaries to different services, operationalizing MGCAS tools and guidelines. ANDA creates and maintains good relations with various stakeholders at the district level. As a result, ANDA transitioned 300 OVC to the maintenance phase. ANDA mobilized communities to participate in HIV prevention debate sessions and has reached its annual targets. ANDA's vocational training center is functioning well. ANDA is providing two courses and a cross cutting IT/Life skills course as per project proposal. Two training cycles have been completed and two students are employed by ANDA. For the cooling systems course, ANDA succeeded in establishing partnerships with companies involved with refrigerator and air-conditioning maintenance to secure internships for the students. In the context of household economic strengthening, ANDA trained community facilitators who have expanded the number of savings groups. ANDA was able to integrate OVC caregivers in VSL groups and change in the socio-economic well-being of OVC families is described in various success stories.
2.3 Processes used to determine client satisfaction Maximum score: 6	6	6	6	0%	0%	TA on the importance on assessing beneficiary satisfaction	Facilitators routinely accompany the *Assistentes Sociais* to supervise implementation. The HES and Prevention officials implement individual visits as required, the project manager and assistant conduct fortnightly visits. The manner in which AS are received by the beneficiaries demonstrates that they are valued and have good relations with the beneficiary.
2.4 Availability of adequate data management and report dissemination system for OVC services Maximum score: 9	6	8	9	12%	50%	TA on narrative and results reporting TA on analysis and use of data	ANDA collects and reports quality data, and uses quantitative and qualitative instruments efficiently. ANDA is coping well with the frequent changes in indicators and tools. ANDA frequently submits good success stories and photographs that demonstrate the activities and changes in beneficiaries' well-being.
TOTAL SCORE	**42**	**63**	**71**	**12%**	**69%**		

HACI							
Evaluation Category	**Baseline Score 2013**	**Midline score 2014**	**Endline Score 2015**	**Change mid-endline score**	**Change base-endline score**	**TA Provided**	**Analysis/Results**
1. OVC project design							
1.1 OVC Project Design Maximum score: 24	9	23	23	0%	156%	TA on proposal design and award extension.	HACI continues to use the skills it acquired to conduct situational analyses. Even though donors sometimes give a short response time, HACI strives to conduct a basic situational analysis by consulting key personnel and fieldworkers of local partners to inform the proposal or concept note. In addition, HACI includes situational assessments in implementation plans. This year HACI submitted several proposals and concept notes to AGIR, Embassy of France, OCISA, European Union, Embassy of Japan. None of the proposals were accepted at the time of this assessment.
2. OVC program standards							
2.1 Availability of skilled personnel to provide OVC care Maximum score: 15	6	14	15	7%	150%	TA on staff recruitment, TA to replicate this TA with HACI's sub-partners, TA on use of technical assessment results to develop capacity building plan for sub-partners, TA on conducting the 2nd technical assessments of sub-partners	HACI provides good TA to support sub-partners' staff recruitment. HACI is able to conducted technical assessments with sub-partners and determine capacity gaps accurately. With continued support from CAP, HACI increased capacity to provide quality TA to sub partners as evidenced by the improved results achieved. HACI has a tracking system to monitor TA but it is not used.
2.2 Availability of appropriate processes to support OVC care Maximum score: 21	6	21	21	0%	250%	Training Child Status Index (CSI) application and care plan development, Household Economic Strengthening, defaulters tracing, and other social services. Intensive TA on providing technical assistance to sub-partner on improving referral networks	HACI developed and conducted refresher trainings for each sub partner and provided technical assistance during the second CSI application process. HACI applied the 3rd CSI without CAP TA. Both HACI and sub-partners improved capacity to conduct CSI. HACI also improved the results of its economic strengthening activities, defaulters tracing and service referral completion, all of which points to HACI's increased capacity to provide TA to subs.

						and collecting information on completed referrals. TA on training module design.	
2.3 Processes used by UG/Network to determine client satisfaction Maximum score: 6	0	4	5	25%	500%	TA for utilization of CSI and to develop OVC care plan to monitor delivery of OVC services	HACI was able to build the capacity of its sub-partners to conduct CSIs and develop care plans. Sub-partners are able to apply the CSI and develop care plans with minimal errors.
2.4 Availability of adequate data management and reporting system for OVC services Maximum score: 12	2	11	12	9%	500%	Training/TA on data management and reporting	HACI believes that sub-partners are able to prepare narrative reporting. Due to the frequent changes in project indicators, however, HACI still has to frequently train and provide TA on reporting. HACI and sub-partners are now using CAP developed data collection instruments and reporting formats. To measure the client satisfaction level, HACI conducts semi-annual meetings with its sub-partners and field visits.
TOTAL SCORE	23	73	76	4%	230%		

Kubatsirana							
Evaluation Category	**Baseline Score Nov 2012**	**Midline Score April 2015**	**Endline Score Jan 2016**	**Change Mid-End line Score**	**Change Base-End line Score**	**TA Provided**	**Analyze/Results**
1. OVC project design							
1.1 OVC project design Maximum score: 18	11	17	17	0%	55%	TA to design original proposal.	Kubatsirana continues to submit good proposals to various donors using skills acquired through CAP and has gained access to new funding sources.
2. OVC program standards							
2.1 Availability of competent staff to provide care to OVC Maximum score: 15	5	12	14	17%	180%	TA on recruitment and HR management	Kubatsirana conducts transparent staff recruitment processes for all projects, not only the one financed by CAP.
2.2 Availability of appropriate processes for the support to and care of OVC and their families Maximum score: 27	15	21	27	29%	80%	TA and training of Village Savings and Loan (VSL) facilitators. TA and training on Early Childhood Development (ECD). TA and training on family visits and support, with na emphasis on improving uptake of HIV Testing and Counseling (HTC).	Kubatsirana showed considerable improvements in the ability to provide OVC care. Kubatsirana trained staff and led the CSI application process without technical assistance from CAP. Kubatsirana increased the number of beneficiaries it referred to services, particularly health services. Many beneficiaries went to health facilities for HIV testing. Kubatsirana continues to struggle with HIV care and treatment defaulter tracing, largely due to factors beyond their control. Kubatsirana expanded the number of village savings and loan groups. The results of this activity are encouraging. Participating OVC families' lives improve, as illustrated in success stories presented in narrative reports.

							Kubatsriana has successfully expanded its OVC service package to include ECD activities.
2.3 Processes used by Kubatsirana to determine client satisfaction Maximum score: 6	3	5	6	20%	100%	TA to define and use effective beneficiary satisfaction monitoring systems.	Kubatsirana continues to routinely supervise the family visits. The district coordinators accompany each promoter twice a month, using these visits to assess family satisfaction monthly. The project officer visits each district twice a month while the project manager conducts monthly visits.
2.4 Availability of adequate data management and report dissemination system for OVC services Maximum score: 9	3	5	7	40%	133%	Training and TA on data management and reporting.	Kubatsirana's files are better organized and easy to use. Kubatsirana has a better understanding of the importance of storing data appropriately. Currently, Kubatsirana's staff has the capacity to manage qualitative and quantitative data on OVC services. Kubatsirana also is capable of presenting success stories about project achievements.
TOTAL SCORE	**37**	**60**	**71**	**18%**	**92%**		

Kukumbi					
Evaluation Category	**Baseline Score August 2014**	**Endline Score September 2015**	**Change**	**TA Provided**	**Analyze/Results**
1. OVC project design					
1.1 OVC project design Maximum score: 18	4	6	50%	Capacity building and technical assistance in designing the original proposal.	During project design, the organization did not know the Ministry of Gender, Children and Social Action (MGCAS) minimum standards. Now they are able to design a proposal that responds to Government of Mozambique determined standards of OVC care and the needs of children and their families.
2. OVC program standards					
2.1. Availability of competent staff to provide care to OVC Maximum score: 15	6	10	66%	TA to design the terms of reference and the approval of the key project staff (OVC Officer, HES Officer). TA to design the profile and roles and responsibilities of *activistas*. Training and TA on CSI application and care plan dvelopment, psycho-social support, household economic strengthening, early childhood development and debate sessions.	Senior management did not sufficiently support the process to recruit key personnel for the OVC project. As a result, Kukumbi took a long time to recruit the HES and Prevention officers. The staff that was recruited was qualified for the job. Staff and *activistas* were re-trained to conduct the CSI, develop individual care plans, and implement the care plan either by providing or referring to services. *Activistas* were also trained to provide Early Childhood Development support to families. Field staff capacity to plan the training and application of the CSI, monitor the implementation of care plans as well as their knowledge in certain technical areas (ECD, PSS) increased between the two assessment period. Project HOPE trained and conducted site visits to support the HES officer mobilize communities to form VSL groups, support the groups in drafting statues and complete a full cycle. Staff The project closed before the VSL cycle concluded. Niiwanane provided TA during the critical share-out phase.

2.2. Availability of appropriate processes for the support to and care of OVC and their families Maximum score: 27	4	19	375%	Technical assistance in use the appropriate processes to support to and care of OVC and their families	Kukumbi is using MGCAS approved tools to assess and address OVC and care givers needs. These tools include the CSI and individuals care plans. In addition, Kukumbi learned to accurately record follow-up support provided to OVC and caregivers. Kukumbi also improved capacity to conduct debate sessions with communities and OVC families. Debate session addressed HIV related topics including HIV prevention, HTC, HIV treatment literacy, gender, GBV and masculinity norms. Following sessions on HTC, Kukumbi provided community based HTC services. Kukumbi also provided an opportunity to strengthen economic capacity of OVC families by promoting participation in VSL groups formed with Kukumbi's guidance and support.
2.3. Processes used to determine client satisfaction Maximum score: 6	0	3	300%	Technical assistance in defining and using effective beneficiary satisfaction monitoring systems	Each week the community assistant holds meetings with volunteers to evaluate the work done in the previous week and plan activities for the following week. Besides these meetings, the community assistant monitors visits to families. The community assistant holds conversations with caregivers to check their level of satisfaction with the volunteers' work. Follow-up fact sheets are used to check the number of visits that families and children receive during a month.
2.4. Availability of adequate data management and report dissemination system for OVC services Maximum score: 9	1	3	200%	Training/TA on data management and reporting	Kukumbi has an OVC data base. It has a minimally organized physical archive.
TOTAL SCORE	15	31	173%		

NIIWANANE							
Evaluation Category	**Baseline Score 2012**	**Midline Score 2014**	**Endline Score 2015**	**Change mid-endline score**	**Change base-endline score**	**TA Provided**	**Analysis**
1. OVC project design							
1.1 OVC Project Design Maximum score: 18	4	18	18	0%	350%	TA to introduce new project activities.	Niiwanane has consolidated its capacity to design and integrate new project activities rapidly. The organization is also able to independently review project results, identify challenges and formulate solutions.
2. OVC program standards							
2.1 Availability of skilled personnel to provide OVC care Maximum score: 15	2	15	15	0%	650%	TA developing Job descriptions, evaluating candidates, interview guide and documenting selection process.	Niiwanane continues to apply proper recruitment processes.
2.2 Availability of appropriate processes to support OVC care Maximum score: 27	3	24	24	0%	700%	TA on CSI application, prioritizing needs and developing care plan for each OVC. TA on establishing referral networks.	Niiwanane is consolidating the capacity apply the CSI, and formulate care plans. Niiwanane has learned to use the CSI results to analyse change in OVS's well-being and determine OVC that can be transitioned to a lower intensity support phase. Niiwanane continues to expand the number of institutions it works with to be able to better repond to the needs of OVC.
2.3 Processes used to determine client satisfaction Maximum score: 6	2	6	6	0%	200%	Training and TA on supervision using tools developed by CAP.	Niiwanane continues to strenghten the capacity to supervise field activities, identify stengths and weaknesses na gaps, and provide supportive and constructive feed-back to activistas and others. All staff members are conducting supervision visits,

							including the ED. Niiwanane continues to assess target group satisfaction. Supervisory staff regularly conducts visits to beneficiaries to assess the quality and usefullnes of the services provided by activistas.
2.4 Availability of adequate data management and reporting system for OVC services Maximum score: 9	3	7	9	29%	200%	Training / TA data management and reporting.	Niiwanane continues to share results with activista so that they understand the contribution they make to the success of the project, and thte challenges that still need to be addressed. Niiwanane is able to use the complex OVC data base.
TOTAL SCORE	14	70	72	3%	429%		

Annex 13: Transition Criteria

Transition criteria

CSI domain	# of questions	Total score	Minimum score for transition (75%)	Converted min score to domain index score	Transition criteria - Minimum Domain Index Score	Other minimum requirements
Education	8	24	18	2.25	2.25 or higher	Q2 must be three
Health	6	18	13.5	2.25	2.25 or higher	Score in question 15 not included in calculations for transition
Nutrition	2	6	4.5	2.25	1.5 or higher	Score for questions 16 must be three
HES	2	6	4.5	2.25	2 or higher	
Protection	3	9	6.75	2.25	2.7 or higher	Score for question 23 and 25 must be three
Psychosocial support	6	18	13.5	2.25	2.25 or higher	Score for question number 28 and 29 must be three
Shelter	1	3	2.25	2.25	2 or higher	-
General						No score '1' in any of the questions

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Annex 14: DOs and DON'Ts of CSI Data Analysis

CSI is first and foremost a case management tool. The tables below was developed to guide decision making on analysis and reporting of CSI data.

DO	Describe the characteristics of children covered by projects (e.g. age, sex)	
DO	Identify areas most in need of support **in a local area**. Example: If a project wants to know in which area a particular CSO can most help the children in a given district, they can aggregate the scores *in each service area* to identify which areas are better and which are worse. This could tell you, for example, that many children are able to go to primary school, but few have access to health care.	Programs may make use of local CSI data for program planning by aggregating CSI ratings by individual factor in their local service provision area.
WITH CAUTION	Document the number or percent of children who have seen change Option 1: Number of OVC who show at least X (to be defined) score improvement in at least three service areas, since last assessment Option 2: Number/percent of OVC who have seen an increase, no change or decrease in their score in area X (e.g., health, education)	This is likely (based on evidence) to create an incentive for the people administering the CSI (*activistas*) to bias their results to show change What constitutes a meaningful change is not yet defined and would require research. For example, if score for education domain increases from 1.5 to 1.8, is this meaningful change? Or should meaningful change be defined as an increase or decrease of 0.5?
DON'T	Aggregate scores across service areas (one score for well-being). Example: Assume the overall CSI score is 2.6 – higher than the minimum transition or graduation score. One would arrive at this score by adding the scores of each domain and dividing it by 7 (# of domains). Upon further investigation, the child has no proof of birth registration or legal documents. This child's over-all well-being look good but he/she misses a critical document and should not be transition or 'graduated' out of the system. The overall score hides this.	The CSI is used to identify children's needs and status *relative* to their local community. Local differences make it challenging to define universal standards for each service area to guide scoring. Thus you cannot compare results in one community to results in another. While Mozambique has made good progress on making the CSI less subjective, the way a child is scored will still be relative to their community. Each service area has a different number of factors that contribute to the overall score of the services area so it can hide what is really going on in the life of a child. In other words, even though the overall score may have increased, it does not mean the child's situation meets minimum acceptable standards. Two children could have the same score but very different status. For example, a child may be rated as "3" (good) in all 12 factors, equaling a total score of 36, which requires no immediate action. Another child may also have a total score of 36, but have a "1" (urgent) and "2" (bad) in two factors—requiring attention in these two areas—but 3's and 4's in the other areas.

Annex 15a: Savings and Loan Profile Analysis, Kindlimuka

Project HOPE Mozambique

Capable Partners Program VSL Participants Profile - Kindlimuka [1st - 2nd]

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Q#	Pergunta	Opções de resposta	Values	1st Contagem	Coleta inicial % / Value	2nd Contagem	Recoleta % / Value
10	Data da entrevista	Range - Min:			1-Mar-15		25-Feb-16
		Average			25-May-15		27-Feb-16
		Range - Max:			15-Aug-15		28-Feb-16
12	Que colecta de dados é esta?	Inicial (1°)	1	18	100%	0	0%
		Recolecta (2°)	2	0	0%	18	100%
Informações Gerais				**#VALUE!**		**#VALUE!**	
100	Tem documento de identificação? (B.I./Passporte)	*Contagem de resposta*		*18*		*0*	
		Sim	1	16	89%	0	#DIV/0!
		Não	0	2	11%	0	#DIV/0!
101	Qual é o seu sexo?	Femenino	1	16	89%	0	#DIV/0!
		Masculino	2	2	11%	0	#DIV/0!
		Não sabe	88	0	0%	0	#DIV/0!
103	Quantos anos você tem?	*Contagem de resposta / Média*		*#VALUE!*	44	*#VALUE!*	#DIV/0!
		< 20 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!
		20 - 29 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!
		30 - 39 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!
		40 - 49 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!
		50 - 59 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!
		>= 60 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!
107	Em que cíclo de empréstimo ou de poupança está?	1	1	18	#VALUE!	0	#VALUE!
		2	2	0	#VALUE!	18	#VALUE!
		3	3	0	#VALUE!	0	#VALUE!
		4	4	0	#VALUE!	0	#VALUE!
		5	5	0	#VALUE!	0	#VALUE!
		6	6	0	#VALUE!	0	#VALUE!
		7 ou mais	7	#VALUE!	#VALUE!	#VALUE!	#VALUE!
		Sem resposta		#VALUE!	#VALUE!	#VALUE!	#VALUE!
110	Quantos adultos (maiores de 17 anos) vivem neste momento na habitação (incluindo você)?	*Contagem de resposta / Média*		*18*	#VALUE!	*0*	#VALUE!
		0		#VALUE!	#VALUE!	#VALUE!	#VALUE!
		1		#VALUE!	#VALUE!	#VALUE!	#VALUE!
		2		#VALUE!	#VALUE!	#VALUE!	#VALUE!
		3		#VALUE!	#VALUE!	#VALUE!	#VALUE!
		4 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!
		Não sabe		#VALUE!	#VALUE!	#VALUE!	#VALUE!
111	Quantos adultos geram Rendimentos para a habitaçã (incluindo você)?	*Contagem de resposta / Média*		*18*	#VALUE!	*0*	#VALUE!
		0	0	0	0%	0	#DIV/0!
		1	1	9	50%	0	#DIV/0!
		2	2	5	28%	0	#DIV/0!
		3	3	1	6%	0	#DIV/0!
		4 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!
		Não sabe	88	0	0%	0	#DIV/0!
	Rácio de dependência	Média (HH tamanho / Rendimentos)		*18*	5.9	*18*	2.8
		Elevada Dependência (>4)	4	4	22%	2	11%
		Dependência Moderada (3-4)	4	7	39%	7	39%
		Dependência Baixa (2 ou menos)	2	7	39%	9	50%
112	Algum adulto morreu depois de adoencer por mais de 3 meses no ultimo ano?	*Contagem de resposta*		*18*		*0*	
		Sim	1	1	6%	0	#DIV/0!
		Não	0	15	94%	0	#DIV/0!
		Não sabe	88	0	0%	0	#DIV/0!
		Sem resposta	99	0	0%	0	#DIV/0!
113	Quantas crianças vivem neste momento na habitação (entre 0 e 17 anos de idade)?	*Contagem de resposta / Média*		*18*	#VALUE!	*18*	#VALUE!
		0	0	2	11%	0	0%
		1	1	3	17%	3	17%
		2	2	4	22%	6	33%
		3	3	5	28%	7	39%
		4	4	1	6%	0	0%
		5	5	2	11%	1	6%
		6 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!
		Não sabe	88	0	0%	0	0%

Project HOPE Mozambique

Capable Partners Program VSL Participants Profile - Kindlimuka [1st - 2nd]

Q#	Pergunta	Opções de resposta	Values	1st Contagem	1st % / Value	Coleta inicial 2nd Contagem	Coleta inicial 2nd % / Value	Recoleta	
114	Dentre as crianças que vivem nesta habitação, quantas são órfãs?	*Contagem de resposta / Média*		*18*	#VALUE!	*18*	#VALUE!		
		0	0	9	50%	7	39%		
		1	1	2	11%	3	17%		
		2	2	2	11%	5	28%		
		3	3	2	11%	2	11%		
		4 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!		
		Não sabe	88	0	0%	0	0%		
Educação									
200	Capacidade de ler e escrever (com base na leitura de uma declaração)	*Contagem de resposta*		*18*		*18*			
		Cuidador sabe ler e escrever	1	10	59%	5	28%		
		Cuidador sabe ler e escrever mas com dificuldades	2	6	35%	13	72%		
		Cuidador não sane ler nem escrever	3	1	6%	0	0%		
		Sem resposta	99	0	0%	0	0%		
Habitação									
300	De que tipo são as paredes da casa principal ou palhotas?	*Contagem de resposta*		*18*		*18*			
		Caniço/Paus/Bambú/Palmeira	1	1	6%	0	0%		
		Lata/Cartão/Papel/Saco/Casca	2	0	0%	0	0%		
		Bloco de Argila ou matope	3	1	6%	0	0%		
		Madeira/Zinco	4	0	0%	0	0%	11%	
		Cimento/Blocos/Tijolos	5	16	89%	18	100%		
		Outros	9	0	0%	0	0%		
301	Que tipo de material de cobertura tem a casa principal ou palhotas?	*Contagem de resposta*		*18*		*18*			
		Capim/colmo/palmeira	1	0	0%	0	0%		
		Laje de Betão	2	0	0%	0	0%		
		Chapas de Zinco/Lusalite	3	18	100%	18	100%	0%	
		Telha/Tijolos	4	0	0%	0	0%		
		Outros	9	0	0%	0	0%		
Alimentos									
310	Quantas refeições principais, você comeu nos últimos dois dias (o dia de hoje não conta)?	*Contagem de resposta / Média*		*18*	#VALUE!	*18*	#VALUE!	#####	
		2 ou menos refeições		#VALUE!	#VALUE!	#VALUE!	#VALUE!		
		3		#VALUE!	#VALUE!	#VALUE!	#VALUE!		
		4		#VALUE!	#VALUE!	#VALUE!	#VALUE!		
		5		#VALUE!	#VALUE!	#VALUE!	#VALUE!	#####	
		6 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!		
311	Ontem foi um dia de comida normal (nao foi dia de festa)?	Sim	1	4	22%	18	100%		
		Não	0	14	78%	0	0%		
312	Você comeu alguma destas comidas ontem?	*Contagem de resposta / Média*		*18*	3.9	*18*	10.4	6.5	
		Grão/Cereal (arroz, trigo, pão)	1	6	#VALUE!	18	#VALUE!		
		Raiz/Tubérculo (batata)	1	5	#VALUE!	17	#VALUE!		
		Carne/Fonte de proteínas	1	3	#VALUE!	17	#VALUE!		
		Fish/Marisco (fresco o seco)	1	6	#VALUE!	16	#VALUE!		
		Vegetal	1	8	#VALUE!	17	#VALUE!		
		Fruta	1	12	#VALUE!	17	#VALUE!		
		Legume (feijão, lentilha, amendoim, amêndoa)	1	11	#VALUE!	17	#VALUE!		
		Lacticínio (leite, iogurte, queijo)	1	2	#VALUE!	16	#VALUE!		
		Ovos	1	2	#VALUE!	17	#VALUE!		
		Açúcar ou Mel	1	13	#VALUE!	18	#VALUE!		
		Óleo/banha/manteiga	1	3	#VALUE!	18	#VALUE!		
	Número de grupos de comidas:	0 - 4 grupos		#VALUE!	#VALUE!	#VALUE!	#VALUE!		
		5 - 8 grupos		#VALUE!	#VALUE!	#VALUE!	#VALUE!		
		> 9 grupos		#VALUE!	#VALUE!	#VALUE!	#VALUE!	#####	
Bens Domésticos									
320	Quantos Kg. de grãos estão armazenados atualmente na casa?	*Contagem de resposta / Média*		*18*	#VALUE!	*18*	#VALUE!	#####	
		2 ou menos	3	18	100%	18	100%		
		4 ou menos	5	18	100%	18	100%		
		8 ou mais	7	0	0%	0	0%		
		11 ou mais	10	0	0%	0	0%		

Project HOPE Mozambique

Capable Partners Program VSL Participants Profile - Kindlimuka [1st - 2nd]

Q#	Pergunta	Opções de resposta	Values	1st Contagem	Coleta inicial % / Value	2nd Contagem	Recoleta % / Value	
321	Que tipos de animais que a sua própria casa?	*Contagem de resposta*		*18*	*% owning*	*18*	*% owning*	
		Nenhum	0	15	83%	17	94%	
		Número médio de Galinhas, Pássaros	50	0.2	#VALUE!	0.0	#VALUE!	
		Número médio de Cabritos, Ovelhas, Porcos	100	0.1	#VALUE!	0.0	#VALUE!	
		Número médio de Bois, Búfalo	600	0.0	#VALUE!	0.0	#VALUE!	
		Número médio de Cavalos/burros	600	0.1	#VALUE!	0.1	#VALUE!	
		Número médio de animais de propriedade			0.3		0.1	-0.2
		Valor médio total de animais			47		33	(14)
321	Quantos de cada um desses itens faz sua própria casa?	*Contagem de resposta*		*18*	*% owning*	*18*	*% owning*	
		Nenhum	0	1	6%	0	0%	
		Número médio de Rádio	50	0.4	#VALUE!	0.4	#VALUE!	
		Número médio de Telefone ou celular	100	0.9	#VALUE!	0.9	#VALUE!	
		Número médio de Televisão	400	0.7	#VALUE!	0.9	#VALUE!	
		Avg. number of Geleira ou Congelador	600	0.5	#VALUE!	0.9	#VALUE!	
		Número médio de Bicicleta	200	0.1	#VALUE!	0.0	#VALUE!	
		Número médio de Motorizada	600	0.0	#VALUE!	0.0	#VALUE!	
		Número médio de Veículo ou carro	5000	0.0	#VALUE!	0.0	#VALUE!	
		Número médio de Tractor	5000	0.0	#VALUE!	0.0	#VALUE!	
		Número médio de itens de propriedade			2.7		3.2	0.6
		Valor médio total de itens			717		1,028	311
Rendimentos								
322	Nos últimos 12 meses, em quantos meses os rendimentos NÃO foram suficientes para satisfazer as necessidades da família?	*Contagem de resposta / Média*		*18*	#VALUE!	*18*	#VALUE!	#####
		0	0	9	#VALUE!	0	#VALUE!	
		1	1	0	#VALUE!	0	#VALUE!	
		2	2	0	#VALUE!	0	#VALUE!	
		3	3	0	#VALUE!	0	#VALUE!	
		4	4	0	#VALUE!	0	#VALUE!	
		5 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!	
		Não sabe	88	7	#VALUE!	17	#VALUE!	
		Sem resposta	99	2	#VALUE!	1	#VALUE!	
323	Por favor estime o valor total dos seus rendimentos no mês passado:	*Contagem de resposta / Média*		*18*	63	*18*	0	(63)
		Zero	0	5	28%	18	100%	
		Menos que Mt.500	500	18	100%	18	100%	
		Menos que Mt. 1,000	1000	18	100%	18	100%	
		More than Mt. 1,000	1000	0	0%	0	0%	0%
		Mais do que Mt. 2,000	2000	0	0%	0	0%	
324	Que situação reflecte as necessidades e a compra de roupa na família?	*Contagem de resposta*		*18*		*18*		
		Compra menos do que a família precisa	1	10	67%	2	11%	
		Compra em media o que a família precisa	2	5	33%	16	89%	56%
		Compra mais do que a família precisa	3	0	0%	0	0%	
325	A sua família consegue enviar dinheiro ou ajudar a outros familiares regularmente?	*Contagem de resposta*		*18*		*18*		
		Sim	1	5	29%	18	100%	71%
		Não	0	12	71%	0	0%	
		Não sabe	88	0	0%	0	0%	
		Sem resposta	99	0	0%	0	0%	
Poupanças								
326	Algum membro deste agregado familiar tem conta bancária?	*Contagem de resposta*		*18*		*18*		
		Sim	1	8	44%	17	94%	50%
		Não	0	10	56%	1	6%	
		Não sabe	88	0	0%	0	0%	
		Sem resposta	99	0	0%	0	0%	
327	O que vai fazer com as poupanças:	*Contagem de resposta*				*18*		
		Construir o reabilitar a su casa	1	1	4%	1	2%	
		comprar itens para em casa	1	1	4%	6	13%	
		Gastar em custos de saúde	1	0	0%	0	0%	
		Gastar com os custos da educação	1	10	36%	18	39%	
		Segure a poupança / Não finalidade	1	2	7%	3	7%	
		Iniciar um negócio	1	14	50%	18	39%	
		Outros	1	0	0%	0	0%	
	Média de Indices de Econômicos Bem-Estar (300,301,310,320,321,324,325)				**#VALUE!**		**#VALUE!**	#####

Annex 15b: Savings and Loan Profile Analysis, ANDA

Project HOPE Mozambique

Capable Partners Program VSL Participants Profile - ANDA

Q#	Pergunta	Opções de resposta	Values	1st Contagem	Coleta inicial % / Value	2nd Contagem	Recoleta % / Value		3rd Contagem	Recoleta % / Value	
10	Data da entrevista	Range - Min:			27-Jun-14		28-Jan-15			18-Dec-15	
		Average			24-Jul-14		6-Mar-15	225		1-Feb-16	332
		Range - Max:			12-Aug-14		20-Jan-16			15-Mar-16	
12	Que colecta de dados é esta?	Inicial (1°)	1	36	100%	0	0%		0	#DIV/0!	
		Recolecta (2°)	2	0	0%	36	100%		0	#DIV/0!	
108	Tempo em Programa	Mes média			0.9		1.1			1.4	
Informações Gerais				**#VALUE!**		**#VALUE!**			**#VALUE!**		
100	Tem documento de identificação? (B.I./Passporte)	*Contagem de resposta*		*36*		*0*			*0*		
		Sim	1	3	10%	0	#DIV/0!		0	#DIV/0!	
		Não	0	27	90%	0	#DIV/0!		0	#DIV/0!	
101	Qual é o seu sexo?	Femenino	1	32	89%	0	#DIV/0!		0	#DIV/0!	
		Masculino	2	4	11%	0	#DIV/0!		0	#DIV/0!	
		Não sabe	88	0	0%	0	#DIV/0!		0	#DIV/0!	
103	Quantos anos você tem?	*Contagem de resposta / Média*		*#VALUE!*	51	*#VALUE!*	#DIV/0!		*#VALUE!*	6	
		< 20 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		20 - 29 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		30 - 39 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		40 - 49 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		50 - 59 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		>= 60 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
107	Em que cíclo de empréstimo ou de poupança está?	1	1	36	#VALUE!	6	#VALUE!		0	#VALUE!	
		2	2	0	#VALUE!	30	#VALUE!		21	#VALUE!	
		3	3	0	#VALUE!	0	#VALUE!		15	#VALUE!	
		4	4	0	#VALUE!	0	#VALUE!		0	#VALUE!	
		5	5	0	#VALUE!	0	#VALUE!		0	#VALUE!	
		6	6	0	#VALUE!	0	#VALUE!		0	#VALUE!	
		7 ou mais	7	#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		Sem resposta		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
110	Quantos adultos (maiores de 17 anos) vivem neste momento na habitação (incluindo você)?	*Contagem de resposta / Média*		*36*	#VALUE!	*2*	#VALUE!		*15*	#VALUE!	
		0		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		1		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		2		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		3		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		4 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		Não sabe		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
111	Quantos adultos geram Rendimentos para a habitaçã (incluindo você)?	*Contagem de resposta / Média*		*36*	#VALUE!	*2*	#VALUE!		*36*	#VALUE!	
		0	0	0	0%	0	0%		0	0%	
		1	1	27	75%	1	50%		10	28%	
		2	2	6	17%	1	50%		3	8%	
		3	3	2	6%	0	0%		2	6%	
		4 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		Não sabe	88	0	0%	0	0%		0	0%	
	Rácio de dependência	Média (HH tamanho / Rendimentos)		*36*	4.2	*36*	3.7		*36*	4.2	
		Elevada Dependência (>4)	4	14	39%	9	25%		12	33%	
		Dependência Moderada (3-4)	4	15	42%	19	53%		17	47%	
		Dependência Baixa (2 ou menos)	2	7	19%	8	22%		7	19%	
112	Algum adulto morreu depois de adoencer por mais de 3 meses no ultimo ano?	*Contagem de resposta*		*36*		*2*			*15*		
		Sim	1	0	0%	0	0%		0	0%	
		Não	0	36	100%	2	100%		15	100%	
		Não sabe	88	0	0%	0	0%		0	0%	
		Sem resposta	99	0	0%	0	0%		0	0%	
113	Quantas crianças vivem neste momento na habitação (entre 0 e 17 anos de idade)?	*Contagem de resposta / Média*		*36*	#VALUE!	*35*	#VALUE!		*36*	#VALUE!	
		0	0	0	0%	0	0%		0	0%	
		1	1	7	19%	5	14%		4	11%	
		2	2	4	11%	2	6%		6	17%	
		3	3	10	28%	12	34%		6	17%	
		4	4	5	14%	7	20%		9	25%	
		5	5	5	14%	4	11%		4	11%	
		6 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		Não sabe	88	0	0%	0	0%		0	0%	

Project HOPE Mozambique

Capable Partners Program VSL Participants Profile - ANDA

Q#	Pergunta	Opções de resposta	Values	1st Contagem	Coleta inicial % / Value	2nd Contagem	Recoleta % / Value		3rd Contagem	Recoleta % / Value	
114	Dentre as crianças que vivem nesta habitação, quantas são órfãs?	*Contagem de resposta / Média*		*36*	#VALUE!	*35*	#VALUE!		*36*	#VALUE!	
		0	0	1	3%	2	6%		0	0%	
		1	1	6	17%	4	11%		4	11%	
		2	2	9	25%	6	17%		9	25%	
		3	3	9	25%	13	37%		8	22%	
		4 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		Não sabe	88	0	0%	0	0%		0	0%	
Educação											
200	Capacidade de ler e escrever (com base na leitura de uma declaração)	*Contagem de resposta*		*36*		*35*			*36*		
		Cuidador sabe ler e escrever	1	8	22%	8	23%		7	19%	
		Cuidador sabe ler e escrever mas com dificuldades	2	10	28%	11	31%		7	19%	
		Cuidador não sane ler nem escrever	3	18	50%	16	46%		22	61%	
		Sem resposta	99	0	0%	0	0%		0	0%	
Habitação											
300	De que tipo são as paredes da casa principal ou palhotas?	*Contagem de resposta*		*36*		*35*			*36*		
		Caniço/Paus/Bambú/Palmeira	1	3	8%	3	9%		3	8%	
		Lata/Cartão/Papel/Saco/Casca	2	0	0%	0	0%		2	6%	
		Bloco de Argila ou matope	3	29	81%	26	74%		23	64%	
		Madeira/Zinco	4	0	0%	0	0%	6%	1	3%	5%
		Cimento/Blocos/Tijolos	5	4	11%	6	17%		7	19%	
		Outros	9	0	0%	0	0%		0	0%	
301	Que tipo de material de cobertura tem a casa principal ou palhotas?	*Contagem de resposta*		*36*		*35*			*36*		
		Capim/colmo/palmeira	1	14	39%	13	37%		10	30%	
		Laje de Betão	2	0	0%	0	0%		2	6%	
		Chapas de Zinco/Lusalite	3	22	61%	21	60%	2%	20	61%	1%
		Telha/Tijolos	4	0	0%	1	3%		1	3%	
		Outros	9	0	0%	0	0%		0	0%	
Alimentos											
310	Quantas refeições principais, você comeu nos últimos dois dias (o dia de hoje não conta)?	*Contagem de resposta / Média*		*36*	#VALUE!	*35*	#VALUE!	#####	*36*	#VALUE!	######
		2 ou menos refeições		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		3		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		4		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		5		#VALUE!	#VALUE!	#VALUE!	#VALUE!	#####	#VALUE!	#VALUE!	######
		6 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
311	Ontem foi um dia de comida normal (nao foi dia de festa)?	Sim	1	35	97%	35	100%		36	100%	
		Não	0	1	3%	0	0%		0	0%	
312	Você comeu alguma destas comidas ontem?	*Contagem de resposta / Média*		*36*	4.7	*35*	7.4	2.7	*36*	6.4	-1.0
		Grão/Cereal (arroz, trigo, pão)	1	36	#VALUE!	35	#VALUE!		36	#VALUE!	
		Raiz/Tubérculo (batata)	1	11	#VALUE!	35	#VALUE!		23	#VALUE!	
		Carne/Fonte de proteínas	1	6	#VALUE!	13	#VALUE!		13	#VALUE!	
		Fish/Marisco (fresco o seco)	1	9	#VALUE!	18	#VALUE!		18	#VALUE!	
		Vegetal	1	29	#VALUE!	33	#VALUE!		23	#VALUE!	
		Fruta	1	14	#VALUE!	30	#VALUE!		16	#VALUE!	
		Legume (feijão, lentilha, amendoim, amêndoa)	1	18	#VALUE!	20	#VALUE!		21	#VALUE!	
		Lacticínio (leite, iogurte, queijo)	1	0	#VALUE!	3	#VALUE!		7	#VALUE!	
		Ovos	1	1	#VALUE!	5	#VALUE!		10	#VALUE!	
		Açúcar ou Mel	1	19	#VALUE!	35	#VALUE!		31	#VALUE!	
		Óleo/banha/manteiga	1	26	#VALUE!	31	#VALUE!		31	#VALUE!	
	Número de grupos de comidas:	0 - 4 grupos		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		5 - 8 grupos		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		> 9 grupos		#VALUE!	#VALUE!	#VALUE!	#VALUE!	#####	#VALUE!	#VALUE!	######
Bens Domésticos											
320	Quantos Kg. de grãos estão armazenados atualmente na casa?	*Contagem de resposta / Média*		*36*	#VALUE!	*35*	#VALUE!	#####	*36*	#VALUE!	######
		2 ou menos	3	32	89%	32	91%		34	94%	
		4 ou menos	5	35	97%	34	97%		35	97%	
		8 ou mais	7	0	0%	0	0%		1	3%	
		11 ou mais	10	0	0%	0	0%		1	3%	

Capable Partners Program VSL Participants Profile - ANDA

Q#	Pergunta	Opções de resposta	Values	1st Contagem	Coleta inicial % / Value		2nd Contagem	Recoleta % / Value		3rd Contagem	Recoleta % / Value	
321	Que tipos de animais que a sua própria casa?	*Contagem de resposta*		*36*	*% owning*		*35*	*% owning*		*36*	*% owning*	
		Nenhum	0	20	56%		3	9%		4	11%	
		Número médio de Galinhas, Pássaros	50	0.8	#VALUE!		4.0	#VALUE!		4.7	#VALUE!	
		Número médio de Cabritos, Ovelhas, Porcos	100	0.4	#VALUE!		1.2	#VALUE!		1.2	#VALUE!	
		Número médio de Bois, Búfalo	600	0.0	#VALUE!		0.3	#VALUE!		0.1	#VALUE!	
		Número médio de Cavalos/burros	600	0.1	#VALUE!		0.0	#VALUE!		0.0	#VALUE!	
		Número médio de animais de propriedade			1.3			5.5	4.2		5.9	0.5
		Valor médio total de animais			146			507	361		388	(120)
321	Quantos de cada um desses itens faz sua própria casa?	*Contagem de resposta*		*36*	*% owning*		*35*	*% owning*		*36*	*% owning*	
		Nenhum	0	14	39%		1	3%		1	3%	
		Número médio de Rádio	50	0.4	#VALUE!		0.9	#VALUE!		0.8	#VALUE!	
		Número médio de Telefone ou celular	100	0.5	#VALUE!		1.0	#VALUE!		1.3	#VALUE!	
		Número médio de Televisão	400	0.1	#VALUE!		0.3	#VALUE!		0.4	#VALUE!	
		Avg. number of Geleira ou Congelador	600	0.0	#VALUE!		0.0	#VALUE!		0.1	#VALUE!	
		Número médio de Bicicleta	200	0.1	#VALUE!		0.1	#VALUE!		0.3	#VALUE!	
		Número médio de Motorizada	600	0.0	#VALUE!		0.0	#VALUE!		0.0	#VALUE!	
		Número médio de Veículo ou carro	5000	0.0	#VALUE!		0.0	#VALUE!		0.0	#VALUE!	
		Número médio de Tractor	5000	0.0	#VALUE!		0.0	#VALUE!		0.0	#VALUE!	
		Número médio de itens de propriedade			1.0			2.3	1.3		2.9	0.6
		Valor médio total de itens			132			316	184		442	126
Rendimentos												
322	Nos últimos 12 meses, em quantos meses os rendimentos NÃO foram suficientes para satisfazer as necessidades da família?	*Contagem de resposta / Média*		*36*	#VALUE!		*35*	#VALUE!	######	*36*	#VALUE!	######
		0	0	7	#VALUE!		15	#VALUE!		2	#VALUE!	
		1	1	1	#VALUE!		0	#VALUE!		1	#VALUE!	
		2	2	2	#VALUE!		3	#VALUE!		5	#VALUE!	
		3	3	0	#VALUE!		1	#VALUE!		15	#VALUE!	
		4	4	4	#VALUE!		4	#VALUE!		9	#VALUE!	
		5 ou mais		#VALUE!	#VALUE!		#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		Não sabe	88	7	#VALUE!		4	#VALUE!		2	#VALUE!	
		Sem resposta	99	0	#VALUE!		1	#VALUE!		0	#VALUE!	
323	Por favor estime o valor total dos seus rendimentos no mês passado:	*Contagem de resposta / Média*		*36*	719		*35*	1,091	372	*36*	1,333	242
		Zero	0	0	0%		0	0%		0	0%	
		Menos que Mt.500	500	9	25%		1	3%		0	0%	
		Menos que Mt. 1,000	1000	25	69%		17	49%		5	14%	
		More than Mt. 1,000	1000	7	19%		11	31%	18%	21	58%	30%
		Mais do que Mt. 2,000	2000	0	0%		2	6%		3	8%	
324	Que situação reflecte as necessidades e a compra de roupa na família?	*Contagem de resposta*		*36*			*35*			*36*		
		Compra menos do que a família precisa	1	35	97%		34	97%		30	83%	
		Compra em media o que a família precisa	2	1	3%		1	3%	0%	6	17%	14%
		Compra mais do que a família precisa	3	0	0%		0	0%		0	0%	
325	A sua família consegue enviar dinheiro ou ajudar a outros familiares regularmente?	*Contagem de resposta*		*36*			*35*			*36*		
		Sim	1	3	8%		2	6%	-3%	7	19%	14%
		Não	0	33	92%		33	94%		29	81%	
		Não sabe	88	0	0%		0	0%		0	0%	
		Sem resposta	99	0	0%		0	0%		0	0%	
Poupanças												
326	Algum membro deste agregado familiar tem conta bancária?	*Contagem de resposta*		*36*			*35*			*36*		
		Sim	1	7	19%		9	26%	6%	8	22%	-3%
		Não	0	29	81%		26	74%		28	78%	
		Não sabe	88	0	0%		0	0%		0	0%	
		Sem resposta	99	0	0%		0	0%		0	0%	
327	O que vai fazer com as poupanças:	*Contagem de resposta*					*35*			*36*		
		Construir o reabilitar a su casa	1	17	35%		23	20%		25	19%	
		comprar itens para em casa	1	7	15%		24	21%		23	17%	
		Gastar em custos de saúde	1	0	0%		5	4%		12	9%	
		Gastar com os custos da educação	1	2	4%		14	12%		14	11%	
		Segure a poupança / Não finalidade	1	1	2%		14	12%		22	17%	
		Iniciar um negócio	1	6	13%		20	18%		28	21%	
		Outros	1	15	31%		13	12%		9	7%	
	Média de Indices de Econômicos Bem-Estar (300,301,310,320,321,322,324,325)				#VALUE!			#VALUE!	#####		#VALUE!	######

Annex 15c: Savings and Loan Profile Analysis, Kubatsirana

Project HOPE Mozambique

Capable Partners Program VSL Participants Profile - Kubatsirana

Q#	Pergunta	Opções de resposta	Values	1st Contagem	Coleta inicial % / Value	2nd Contagem	Recoleta % / Value		3rd Contagem	Recoleta % / Value	
10	Data da entrevista	Range - Min:			10-Feb-14		15-Apr-14			9-Feb-16	
		Average			7-Dec-14		12-May-15	155		2-Apr-16	326
		Range - Max:			12-Dec-15		6-Jul-15			13-Apr-16	
12	Que colecta de dados é esta?	Inicial (1ª)	1	61	100%	0	0%		0	#DIV/0!	
		Recolecta (2ª)	2	0	0%	61	100%		0	#DIV/0!	
108	Tempo em Programa	Mes média			-174.5		#DIV/0!			#DIV/0!	
Informações Gerais				**#VALUE!**		**#VALUE!**			**#VALUE!**		
100	Tem documento de identificação? (B.I./Passporte)	*Contagem de resposta*		*60*		*0*			*0*		
		Sim	1	57	95%	0	#DIV/0!		0	#DIV/0!	
		Não	0	3	5%	0	#DIV/0!		0	#DIV/0!	
101	Qual é o seu sexo?	Femenino	1	58	95%	0	#DIV/0!		0	#DIV/0!	
		Masculino	2	3	5%	0	#DIV/0!		0	#DIV/0!	
		Não sabe	88	0	0%	0	#DIV/0!		0	#DIV/0!	
103	Quantos anos você tem?	*Contagem de resposta / Média*		*#VALUE!*	44	*#VALUE!*	#DIV/0!		*#VALUE!*	4	
		< 20 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		20 - 29 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		30 - 39 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		40 - 49 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		50 - 59 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		>= 60 anos de idade		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
107	Em que cíclo de empréstimo ou de poupança está?	1	1	61	#VALUE!	0	#VALUE!		0	#VALUE!	
		2	2	0	#VALUE!	61	#VALUE!		0	#VALUE!	
		3	3	0	#VALUE!	0	#VALUE!		61	#VALUE!	
		4	4	0	#VALUE!	0	#VALUE!		0	#VALUE!	
		5	5	0	#VALUE!	0	#VALUE!		0	#VALUE!	
		6	6	0	#VALUE!	0	#VALUE!		0	#VALUE!	
		7 ou mais	7	#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		Sem resposta		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
110	Quantos adultos (maiores de 17 anos) vivem neste momento na habitação (incluindo você)?	*Contagem de resposta / Média*		*61*	#VALUE!	*0*	#VALUE!		*0*	#VALUE!	
		0		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		1		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		2		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		3		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		4 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		Não sabe		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
111	Quantos adultos geram Rendimentos para a habitaçã (incluindo você)?	*Contagem de resposta / Média*		*61*	#VALUE!	*0*	#VALUE!		*61*	#VALUE!	
		0	0	0	0%	0	#DIV/0!		0	0%	
		1	1	32	52%	0	#DIV/0!		0	0%	
		2	2	14	23%	0	#DIV/0!		0	0%	
		3	3	11	18%	0	#DIV/0!		0	0%	
		4 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		Não sabe	88	0	0%	0	#DIV/0!		0	0%	
	Rácio de dependência	Média (HH tamanho / Rendimentos)		*61*	4.9	*61*	5.1		*60*	4.7	
		Elevada Dependência (>4)	4	29	48%	35	57%		27	45%	
		Dependência Moderada (3-4)	4	28	46%	21	34%		23	38%	
		Dependência Baixa (2 ou menos)	2	4	7%	5	8%		10	17%	
112	Algum adulto morreu depois de adoencer por mais de 3 meses no ultimo ano?	*Contagem de resposta*		*60*		*0*			*0*		
		Sim	1	11	18%	0	#DIV/0!		0	#DIV/0!	
		Não	0	49	82%	0	#DIV/0!		0	#DIV/0!	
		Não sabe	88	0	0%	0	#DIV/0!		0	#DIV/0!	
		Sem resposta	99	0	0%	0	#DIV/0!		0	#DIV/0!	
113	Quantas crianças vivem neste momento na habitação (entre 0 e 17 anos de idade)?	*Contagem de resposta / Média*		*61*	#VALUE!	*61*	#VALUE!		*61*	#VALUE!	
		0	0	0	0%	0	0%		1	2%	
		1	1	1	2%	1	2%		3	5%	
		2	2	5	8%	4	7%		6	10%	
		3	3	10	16%	9	15%		10	16%	
		4	4	16	26%	12	20%		14	23%	
		5	5	15	25%	14	23%		10	16%	
		6 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		Não sabe	88	0	0%	0	0%		0	0%	

Project HOPE Mozambique

Capable Partners Program VSL Participants Profile - Kubatsirana

Q#	Pergunta	Opções de resposta	Values	1st Contagem	Coleta inicial % / Value	2nd Contagem	Recoleta % / Value		3rd Contagem	Recoleta % / Value	
114	Dentre as crianças que vivem nesta habitação, quantas são órfãs?	*Contagem de resposta / Média*		*61*	#VALUE!	*60*	#VALUE!		*61*	#VALUE!	
		0	0	21	34%	18	30%		22	36%	
		1	1	8	13%	8	13%		8	13%	
		2	2	10	16%	9	15%		10	16%	
		3	3	7	11%	7	12%		7	11%	
		4 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		Não sabe	88	0	0%	0	0%		0	0%	
Educação											
200	Capacidade de ler e escrever (com base na leitura de uma declaração)	*Contagem de resposta*		*61*		*61*			*61*		
		Cuidador sabe ler e escrever	1	25	41%	31	51%		29	48%	
		Cuidador sabe ler e escrever mas com dificuldades	2	11	18%	13	21%		13	21%	
		Cuidador não sane ler nem escrever	3	25	41%	17	28%		19	31%	
		Sem resposta	99	0	0%	0	0%		0	0%	
Habitação											
300	De que tipo são as paredes da casa principal ou palhotas?	*Contagem de resposta*		*61*		*61*			*61*		
		Caniço/Paus/Bambú/Palmeira	1	0	0%	2	3%		1	2%	
		Lata/Cartão/Papel/Saco/Casca	2	0	0%	1	2%		1	2%	
		Bloco de Argila ou matope	3	35	57%	35	57%		29	48%	
		Madeira/Zinco	4	0	0%	1	2%	-5%	0	0%	11%
		Cimento/Blocos/Tijolos	5	26	43%	22	36%		30	49%	
		Outros	9	0	0%	0	0%		0	0%	
301	Que tipo de material de cobertura tem a casa principal ou palhotas?	*Contagem de resposta*		*61*		*61*			*61*		
		Capim/colmo/palmeira	1	27	44%	23	38%		17	29%	
		Laje de Betão	2	0	0%	2	3%		0	0%	
		Chapas de Zinco/Lusalite	3	34	56%	34	57%	3%	42	71%	13%
		Telha/Tijolos	4	0	0%	1	2%		0	0%	
		Outros	9	0	0%	0	0%		0	0%	
Alimentos											
310	Quantas refeições principais, você comeu nos últimos dois dias (o dia de hoje não conta)?	*Contagem de resposta / Média*		*61*	#VALUE!	*61*	#VALUE!	#VALUE!	*61*	#VALUE!	######
		2 ou menos refeições		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		3		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		4		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		5		#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	######
		6 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
311	Ontem foi um dia de comida normal (nao foi dia de festa)?	Sim	1	61	100%	61	100%		60	98%	
		Não	0	0	0%	0	0%		1	2%	
312	Você comeu alguma destas comidas ontem?	*Contagem de resposta / Média*		*61*	4.9	*61*	6.4	1.5	*61*	5.4	-1.0
		Grão/Cereal (arroz, trigo, pão)	1	60	#VALUE!	61	#VALUE!		57	#VALUE!	
		Raiz/Tubérculo (batata)	1	14	#VALUE!	30	#VALUE!		15	#VALUE!	
		Carne/Fonte de proteínas	1	11	#VALUE!	5	#VALUE!		13	#VALUE!	
		Fish/Marisco (fresco o seco)	1	19	#VALUE!	22	#VALUE!		28	#VALUE!	
		Vegetal	1	55	#VALUE!	61	#VALUE!		50	#VALUE!	
		Fruta	1	33	#VALUE!	56	#VALUE!		26	#VALUE!	
		Legume (feijão, lentilha, amendoim, amêndoa)	1	16	#VALUE!	37	#VALUE!		27	#VALUE!	
		Lacticínio (leite, iogurte, queijo)	1	4	#VALUE!	3	#VALUE!		3	#VALUE!	
		Ovos	1	2	#VALUE!	7	#VALUE!		7	#VALUE!	
		Açúcar ou Mel	1	29	#VALUE!	47	#VALUE!		42	#VALUE!	
		Óleo/banha/manteiga	1	57	#VALUE!	61	#VALUE!		59	#VALUE!	
	Número de grupos de comidas:	0 - 4 grupos		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		5 - 8 grupos		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		> 9 grupos		#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	######
Bens Domésticos											
320	Quantos Kg. de grãos estão armazenados atualmente na casa?	*Contagem de resposta / Média*		*60*	#VALUE!	*61*	#VALUE!	#VALUE!	*61*	#VALUE!	######
		2 ou menos	3	26	43%	22	36%		49	80%	
		4 ou menos	5	26	43%	22	36%		49	80%	
		8 ou mais	7	34	57%	39	64%		11	18%	
		11 ou mais	10	34	57%	39	64%		11	18%	

Project HOPE Mozambique

Capable Partners Program VSL Participants Profile - Kubatsirana

				1st	Coleta inicial	2nd	Recoleta		3rd	Recoleta	
Q#	**Pergunta**	**Opções de resposta**	**Values**	**Contagem**	**% / Value**	**Contagem**	**% / Value**		**Contagem**	**% / Value**	
321	Que tipos de animais que a sua própria casa?	*Contagem de resposta*		*61*	*% owning*	*61*	*% owning*		*61*	*% owning*	
		Nenhum	0	28	46%	23	38%		18	30%	
		Número médio de Galinhas, Pássaros	50	3.3	#VALUE!	3.2	#VALUE!		2.6	#VALUE!	
		Número médio de Cabritos, Ovelhas, Porcos	100	0.9	#VALUE!	1.1	#VALUE!		0.8	#VALUE!	
		Número médio de Bois, Búfalo	600	0.6	#VALUE!	0.8	#VALUE!		0.7	#VALUE!	
		Número médio de Cavalos/burros	600	0.0	#VALUE!	0.0	#VALUE!		0.0	#VALUE!	
		Número médio de animais de propriedade			4.8		5.1	0.3		4.1	-1.0
		Valor médio total de animais			598		716	118		605	(111)
321	Quantos de cada um desses itens faz sua própria casa?	*Contagem de resposta*		*61*	*% owning*	*61*	*% owning*		*61*	*% owning*	
		Nenhum	0	11	18%	8	13%		9	15%	
		Número médio de Rádio	50	0.5	#VALUE!	0.5	#VALUE!		0.4	#VALUE!	
		Número médio de Telefone ou celular	100	1.4	#VALUE!	1.9	#VALUE!		1.2	#VALUE!	
		Número médio de Televisão	400	0.3	#VALUE!	0.4	#VALUE!		0.3	#VALUE!	
		Avg. number of Geleira ou Congelador	600	0.1	#VALUE!	0.1	#VALUE!		0.2	#VALUE!	
		Número médio de Bicicleta	200	0.4	#VALUE!	0.4	#VALUE!		0.4	#VALUE!	
		Número médio de Motorizada	600	0.1	#VALUE!	0.1	#VALUE!		0.1	#VALUE!	
		Número médio de Veículo ou carro	5000	0.0	#VALUE!	0.0	#VALUE!		0.1	#VALUE!	
		Número médio de Tractor	5000	0.0	#VALUE!	0.0	#VALUE!		0.0	#VALUE!	
		Número médio de itens de propriedade			2.9		3.5	0.6		2.7	-0.8
		Valor médio total de itens			625		782	157		788	6
Rendimentos											
322	Nos últimos 12 meses, em quantos meses os rendimentos NÃO foram suficientes para satisfazer as necessidades da família?	*Contagem de resposta / Média*		*61*	#VALUE!	*61*	#VALUE!	#VALUE!	*61*	#VALUE!	######
		0	0	15	#VALUE!	29	#VALUE!		12	#VALUE!	
		1	1	10	#VALUE!	13	#VALUE!		9	#VALUE!	
		2	2	26	#VALUE!	13	#VALUE!		26	#VALUE!	
		3	3	4	#VALUE!	6	#VALUE!		6	#VALUE!	
		4	4	1	#VALUE!	0	#VALUE!		1	#VALUE!	
		5 ou mais		#VALUE!	#VALUE!	#VALUE!	#VALUE!		#VALUE!	#VALUE!	
		Não sabe	88	1	#VALUE!	0	#VALUE!		4	#VALUE!	
		Sem resposta	99	0	#VALUE!	0	#VALUE!		1	#VALUE!	
323	Por favor estime o valor total dos seus rendimentos no mês passado:	*Contagem de resposta / Média*		*61*	1,206	*61*	3,574	2,368	*61*	2,204	(1,369)
		Zero	0	2	3%	0	0%		1	2%	
		Menos que Mt.500	500	12	20%	1	2%		11	18%	
		Menos que Mt. 1,000	1000	31	51%	3	5%		17	28%	
		More than Mt. 1,000	1000	21	34%	57	93%	115%	33	54%	-85%
		Mais do que Mt. 2,000	2000	6	10%	40	66%		12	20%	
324	Que situação reflecte as necessidades e a compra de roupa na família?	*Contagem de resposta*		*61*		*61*			*61*		
		Compra menos do que a família precisa	1	29	48%	15	25%		16	26%	
		Compra em media o que a família precisa	2	31	51%	44	72%	23%	41	67%	-2%
		Compra mais do que a família precisa	3	1	2%	2	3%		4	7%	
325	A sua família consegue enviar dinheiro ou ajudar a outros familiares regularmente?	*Contagem de resposta*		*61*		*61*			*61*		
		Sim	1	14	23%	13	21%	-2%	18	30%	8%
		Não	0	47	77%	48	79%		43	70%	
		Não sabe	88	0	0%	0	0%		0	0%	
		Sem resposta	99	0	0%	0	0%		0	0%	
Poupanças											
326	Algum membro deste agregado familiar tem conta bancária?	*Contagem de resposta*		*61*		*61*			*61*		
		Sim	1	24	40%	24	39%	-1%	26	43%	3%
		Não	0	36	60%	37	61%		35	57%	
		Não sabe	88	1	2%	0	0%		0	0%	
		Sem resposta	99	0	0%	0	0%		0	0%	
327	O que vai fazer com as poupanças:	*Contagem de resposta*				*61*			*61*		
		Construir o reabilitar a su casa	1	28	23%	29	33%		33	34%	
		comprar itens para em casa	1	23	19%	17	19%		19	19%	
		Gastar em custos de saúde	1	5	4%	0	0%		9	9%	
		Gastar com os custos da educação	1	7	6%	7	8%		10	10%	
		Segure a poupança / Não finalidade	1	22	18%	9	10%		10	10%	
		Iniciar um negócio	1	27	22%	17	19%		11	11%	
		Outros	1	11	9%	9	10%		6	6%	
Média de Indices de Econômicos Bem-Estar (300,301,310,320,321,322,324,325					**#VALUE!**		**#VALUE!**	**#VALUE!**		**#VALUE!**	######

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THE SCIENCE OF IMPROVING LIVES

Ensuring Local Capacity to Adequately Address Gender and Gender-based Violence in HIV Programs

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1. INTRODUCTION

This case study documents the experience of FHI 360´s Capable Partners Program in Mozambique (CAP Mozambique) and 6 of the 22 Mozambican civil society organization (CSOs) it partnered with between 2009 and 2015 that successfully integrated gender and gender-based violence (GBV) prevention into their HIV prevention projects:

Associação da Mulher Moçambicana na Educação (AMME), Conselho Cristão de Moçambique (CCM)—Sofala, Kukumbi, Núcleo de Organizações Femininas de Zambézia (NAFEZA), N´weti and Ophavela.

The program used transformative approaches to address gender and GBV barriers that increase vulnerability to HIV transmission. The program documents notable changes in attitudes and norms and some behaviors linked to gender and GBV and HIV prevention. Equally important for continuity beyond the life of the project, the CSO partners demonstrated increased organizational and technical capacity and an organizational commitment.

When local CSOs indicated that their communities identified gender and GBV as risk factors in HIV prevention, CAP Mozambique took advantage of USAID's CSO support to integrate gender and GBV into HIV projects. This decision, rooted in a trust of local knowledge, and the ensuing interventions led to results that far exceeded expectations.

In a society where intransigent social norms perpetuate inequality and GBV, project staff were pleased to learn that program participants and community leaders alike indicated positive changes in behavior and gender norms in their communities. A cross-sectional household survey, conducted by external evaluators of 1,500+ households demonstrates positive impacts on communication between sexual partners and among community members regarding GBV, gender and HIV, increased HIV testing, condom use, faithfulness to one partner and changing perceptions of gender norms that influence behavior that together furthering the goals of gender equality, HIV prevention and health improvement programs. In a qualitative study, community leaders indicated change in gender norms in communities and in themselves; beneficiaries described a reduction in GBV in their communities.

These results and the fact that they were obtained with CSOs with "low capacity" led the CAP Mozambique team and USAID to request this case study to explore the factors that contributed to this success.

This case study reviewed existing literature, analyzed project data and documentation and obtained valuable information from CSO staff and other key informants interviewed to document the process of integration, describe the interventions, and identify the key factors for success.

Over half of the Mozambique population lives below the poverty line. It has one of the highest HIV prevalence levels in southern and eastern Africa. HIV/AIDS hits women earlier and harder than men. The CSO capacity in Mozambique is lower than in other countries in the region, with organizational, technical, and financial constraints. Paradoxically, a recent UNAIDS report estimates that CSOs are responsible for delivering over 75 percent of the HIV response in communities across the country. To address these important gaps, CAP Mozambique developed a robust and comprehensive capacity building program. Different from other projects in the country, CAP Mozambique is unique in that it provides holistic support to develop internal organizational capacities and promote the use of transformative gender approaches along with HIV prevention.

In line with existing literature, this case study confirms that successful integration of gender and GBV prevention requires responding to locally identified needs with effective yet context-specific responses, using participatory methods, working at multiple levels to enable behavior change and providing strong technical assistance throughout the project cycle. It highlights that the success of transformative gender approaches in HIV prevention programs and performance rest on strong management capacities for quality design, planning, coordination, implementation, monitoring, and evaluation with adequate resources throughout the entire life of the program and building such capacities when they did not exist. The case study shows how CAP Mozambique was successful in bringing all these elements together in a comprehensive capacity building program to enable CSOs to effect changes in gender and GBV in their communities and in their own organizations. As one of the representatives of these organizations stated during the field work for this case study: "We thought we implemented good HIV prevention and gender projects but it was only with CAP Mozambique that we realized what it meant to be effective."

2. BACKGROUND

2.1 Gender, GBV and HIV

International health organizations, academics and donors, including the World Health Organization (WHO) and UNAIDS, have long recognized the relationship between gender inequality, including gender-based violence (GBV), and HIV/AIDS. [I]Gender inequality and resulting GBV increases the risk of sexual transmission of HIV among adults and youth and limits the demand for and use of life-saving care and treatment services.

The United States President´s Emergency Plan for AIDS Relief (PEPFAR) has played a leading role responding to the HIV crisis across the globe. Over time, PEPFAR has expanded from promoting abstinence, being faithful, and using condoms (the ABC strategy)[II] to substantially improving HIV service delivery, building the capacity of local organizations to engage in the fight against HIV and AIDS[III] and heightening the link between HIV and gender disparities that disproportionately affect women.[IV] Beyond HIV-specific funding, USAID´s 2012 Gender Equality and Female Empowerment Policy further recognizes the effects of gender norms and GBV on a range of health outcomes and human and economic development.[V]

The three-year PEPFAR-funded Gender-based Violence Initiative (GBVI) launched in 2011 contributes to addressing gender and GBV in HIV prevention in three countries, one of which is Mozambique. Through targeted support, GBVI aims to prevent, respond to and mitigate the effects of GBV within the HIV context with the use of transformational strategies.[VI]

Existing guidance and recent reflections at international level suggest program principles and areas where integration of GBV and HIV programs are considered beneficial or have produced results.[VII]

However, gaps are visible in the literature on how to ensure quality management of integration, on how to effectively build capacity for integration and on the need for targeted resources for integration to be successful.

2.2 Gender Inequality and HIV in Mozambique

Women in Mozambique have multiple responsibilities. They produce food from the land, fetch water and fuel to meet daily needs, clean, cook and care for their children. Despite their central role in the family´s livelihood and wellbeing, women have limited decision-making power in the home and community, even on issues that have a direct impact on responsibilities attributed to them or on their rights.[VIII]

Women and girls do not have leverage to make decisions regarding their sexuality, including when to have sex or to negotiate condom use. Like in other sub-Saharan African countries, adolescent girls in Mozambique are far more likely to be HIV positive than boys their age, because directly or indirectly the contexts in which they live—poverty, desire for new consumer goods and pressure from parents and peers—encourage them to engage in behaviors that heighten their risk of HIV infection, specifically, to engage in unprotected multiple concurrent partnerships,

Source: INE, 2011.

transactionals ex and cross-generational sex.[IX] Girls face sexual harassment in schools. In rural areas[X] early marriages are common.[XI] Although robust statistical information is not available, GBV is reported to be widespread in Mozambique.[XII]

HIV prevalence by age group	Women	Men
15 - 19	**7.1 %**	**2.7 %**
20 - 24	**14.5 %**	**5.0 %**
25 - 29	**16.8 %**	**11.6 %**
30 - 34	**15.4 %**	**13.5 %**
35 - 39	**13.3 %**	**14.2 %**
40 - 44	**13.1 %**	**12.4 %**

Source: INE, 2011.

Some of the good news is that laws to protect women´s rights have been approved in Mozambique (Family Law N.10/2004 and Law Criminalizing Domestic Violence N. 29/2009). In addition, with the help of UNICEF, over 260 police stations countrywide have integrated Service Centers for Families and Children of which 20 are freestanding units either next to a police station or close to a health facility.[XIII] Further, in 2010, PEPFAR partner JHPIEGO began to support the Ministry of Health to scale up non-occupational post-exposure prophylaxis (PEP) and develop training manuals for maternal and child health nurses on integrated clinical care for victims of sexual violence. A Multisector Mechanism for the Integrated Care for Women Victims of Violence was approved in 2012 by the Council of Ministers and outlines the protocol for the Ministries of Gender, Children and Social Action, Health, Interior and Justice;[XIV] however, the implementation of laws and related mechanisms out are still limited.

In Mozambique, the main modes of sexual transmission of HIV are unprotected sex in couples and through casual heterosexual encounters.[XV] The latest official data available dates back to 2009, which shows women consistently display higher prevalence until the age of 34, when infection peaks for men.[XVI] Disparity in age for peak prevalence between men and women shows that sex between older men and younger women is widespread.

According to a UNAIDS report, civil society organizations (CSOs) deliver over 75 percent of community services in the country´s national response to HIV and AIDS, but lack the human capacity and financial resources to deliver quality services.[XVII] A study of CSOs found that capacity in Mozambique is substantially lower than in other countries in the southern Africa Region.[XVIII] Another recent study on CSO sustainability cites a weak sense of good governance and management, technical limitations and funding uncertainties as some of the key limitations for Mozambican civil society.[XIX] These factors together limit their ability to effectively implement programs and impede access to international funding with high accountability standards such as PEPFAR and USAID.

3. METHODOLOGY

The Capable Partners Program in Mozambique´s (CAP Mozambique) mid-line and end-line evaluations show very encouraging results related to gender and GBV prevention. Community Wisdom Partners (CWP) was tasked with examining the factors that explain this success through the development of a case study. CWP used a qualitative case study methodology that consisted of an intensive literature review and review of secondary documentation, including CSO project proposals, annual work plans and project reports, success stories, mid-term and end-line evaluation reports, relevant policy documents, training manuals, films produced with CAP Mozambique support, transcriptions of focus group discussions (FGDs) carried out as part of a qualitative inquiry

to complement the final evaluation of 2014 and donor guidelines. Background context was gained by interviewing USAID, as well as two FHI 360 specialists at headquarters and a former Health Policy Project (HPP) technical specialist. Semi-structured in-depth confidential interviews were held in Mozambique with 26 representatives from six CAP Mozambique partner CSOs, service providers, donors and representatives of other national organizations. Simple 1–5 rankings allowed CSO interviewees to quantify their views, enabled comparison and avoided interviewer subjectivity. Case study research took place between June and October 2015.

In total, 22 CSOs received the full package of support (described below) from the CAP Mozambique program to work on orphans and vulnerable children (OVC) and HIV prevention. Of these 22, 15 were selected through a competitive process for HIV prevention grants. Seven were selected to receive complementary technical assistance (TA) on integrating gender and GBV. This selection was based primarily on identifying GBV/gender through formative research and CSOs expressed interest in working on the issue on the one hand, and the organization´s capacity together with CAP staff analysis of CSO responsiveness to TA on the other. Responsiveness was based on qualitative data collected in the selection process and observation during the formative research phase. One OVC partner was also included to diversify the type of activities. However, this OVC partner did not follow through (despite having received TA), and therefore is not included in this case study.

The sample group was narrowed to six HIV-prevention CSOs that identified gender and GBV issues based on community feedback and proceeded to implement activities. The six organizations have very different backgrounds, reach and scope. One is a grassroots organization that works exclusively in education **(Associação da Mulher Moçambicana na Educação, AMME).** One specializes in savings and credit in a very circumscribed area **(Ophavela)**. One faith-based organization is present throughout the country **(Conselho Cristão de Moçambique, CCM in Sofala)**. One organization works on local development in a single province **(Kukumbi)**. Another organization works on communication for behavior change with wide reach **(N´weti)**. One provincial network of organizations works for women´s rights **(Núcleo de Associações Femininas da Zambézia, NAFEZA)**. These CSOs are based and operate in three different provinces: Nampula, Zambézia and Sofala.

3.1 Study Limitations

This is a qualitative case study based on external project evaluations, internal program data and documentation and interviews with those involved in shaping and implementing the program. Since Mozambique lacks robust data on GBV or gender norms, this study could not provide impact data on the degree to which gender norms have changed over time or GBV has been reduced in the target populations. Also, quantification or qualification of factors that influence gender norms and GBV such as male alcohol abuse, women's economic development or legal and justice systems were beyond the scope of this case study.

4. CAP MOZAMBIQUE

4.1 The Program at a Glance

As its name suggests, CAP Mozambique aims to first and foremost build the capacity of CSOs in Mozambique to reach their objectives in the fight against HIV/AIDS with high-quality standards. It provides partners intensive TA and grants to implement HIV projects in communities. The program is implemented by FHI 360 and funded by USAID under PEPFAR, and was implemented in two phases.

Phase I (2006–2009) set the foundation for organizational capacity building and implemented several HIV projects (primarily in prevention, along with one OVC project). The program supported CSOs to implement HIV prevention interventions in communities and schools. During the situation analysis leading up to the design phase, local CSOs complained that the materials and methodologies that were used seemed irrelevant to local realities and were often disregarded. CSOs implemented activities commonly used by other international agencies in the country such as community talks, song and dance, theater and radio, but lacked the experience and know-how to understand the deep theory and research behind the programs and how to adapt to the specific contexts where they worked.

During this phase, CAP Mozambique staff learned that most proposals were designed in an office or by a consultant with little or no interaction with target communities and that proposals had little to do with each organization's strengths. At that point CAP Mozambique's mandate prioritized institutional strengthening as opposed to technical capacity building, so the focus of TA was on basic project design—clear objectives, targets and budgets. The projects that were eventually implemented exceeded intended numbers—a priority for PEPFAR—but partners and CAP Mozambique staff alike realized that partner CSOs needed substantial support in using participatory approaches, a much deeper understanding of how to engage communities and skill in how to use data in project design. CAP Mozambique provided support in these areas. Communities identified several barriers to HIV prevention that were not addressed in existing materials, in particular issues of gender norms and GBV.

Phase II (2009–2014) with an extension to mid-2016 allowed the team to expand on improved understanding of local organizations´ capacity and interests. CAP made a few strategic decisions: (1) To fully embrace social and behavior change communications (SBCC) and support local organizations to do so. SBCC values local knowledge and strengths to effectively address the sensitive drivers of HIV in Mozambique. This change aligned well with new PEPFAR orientations concerning HIV prevention; (2) To implement a two-phased CSO selection process for significant investments in TA necessary for them to develop effective HIV interventions based on formative research. The process helped determine organizational commitment to learning and improvement for their work; (3) To invest in an intentional, more structured capacity development process to strengthen partners' organizational systems and technical project management.

Source: CAP Mozambique Monitoring and Evaluation System, November 2015.

Partner organizations received TA to conduct simple formative research and develop their SBCC strategies based on it. An assessment of successful international methodologies such as Stepping Stones[xx] conducted as part of program design helped CSOs understand and assess the relevance of successful participatory, multi-level, community-based HIV/AIDS and GBV prevention approaches. CSOs shifted from one-way communication that delivered information, to engaging men and women within their target groups through trained field workers (*Activistas*) chosen from the communities in which they worked. Engagement stimulated critical reflection, debate and the possibility for change. Multi-level interventions targeted individuals, their family members, friends, and influential leaders in the community. Partner interventions included at a minimum:

- A series of small group debates with males and females aged 12–49 in groups segregated by age and gender
- Short films to prompt thoughtful discussion on specific barriers to prevent sexual transmission of HIV
- Continuous, meaningful engagement of community and religious leaders
- Community-based HIV testing and counseling

The activities that took place were in line with recent literature on what works in GBV prevention.[XXI] The community debates, for example, enabled participants to access key, easy-to-grasp information about gender, GBV and HIV prevention and related services. Likewise, activities prompted participants to critically assess key barriers that affect HIV and health outcomes identified through formative research such as: attitudes about gender norms, peer pressure, the appeal of transactional sex, traditional practices, low perceptions of risk of HIV transmission and discomfort in talking about HIV. Further, these methodologies enabled community participants to consider alternative behaviors to address unequal gender norms, GBV and sexual practices that increase the odds of acquiring HIV, together with the benefits of using existing clinical and other services for survivors of GBV and people living with HIV and AIDS.

CAP Mozambique partner CSOs explicitly involved local leaders to raise their awareness of project goals, obtain project buy-in, coordinate community activities, choose participants for debate sessions and discuss progress and results. Each project was built on the particular strengths of the partner organization implementing it. For example, a partner religious organization worked through churches and religious leaders. One of two CSOs that work in schools engaged teachers and school principals since sexual harassment from teachers in exchange of good grades is common in Mozambique.

Although partners were responsible for interventions, CAP Mozambique was responsible for supporting CSOs to achieve quality standards. Experience had taught the team that robust design was not enough. Consequently, CAP Mozambique provided in-depth and ongoing TA to ensure quality; this included helping partners to provide structured supervision to their *Activistas* and to collect and analyze data. Based on a participatory organizational assessments, CAP Mozambique supported CSOs to strengthen organizational systems and thus their integrity. By August 2015, the six CSOs had together reached 76,303 people with interventions that address gender and GBV in the context of HIV.

4.2 Integration of Gender and GBV Prevention and Response

CAP Mozambique decided to invest in integrating Gender and GBV into the HIV Prevention interventions because communities and CSOs had expressed their concern and because the resources – technical and financial – were made available. USAID Mozambique recognized the importance of community-based GBV prevention to complement planned clinical responses and

broader government capacity building in GBV prevention. USAID was equally interested in investing in local organizations, expecting that improving CSOs´ understanding of gender and GBV and their organizational capacity would enable them to take the work beyond the limits of grant-funded projects. USAID Mozambique created the opportunity; each stakeholder also made an investment and challenged itself to change how they work.

- **Community members.** Communities trusted and believed in the CAP Mozambique partner CSOs that worked with them enough to identify sensitive gender and GBV issues that challenged prevailing social norms. As a result, they expressed their need and openness to engage in addressing these with the right assistance.

- **CSOs.** CSOs listened to men and women in communities and challenged themselves to develop skills and competencies to address community needs, and with acquired capacity, in time, to leverage their influence in other arenas.

- **CAP Mozambique.** Beyond following often restrictive donor agendas, CAP Mozambique listened to target CSOs and the communities they serve and was committed seizing opportunities to make things happen and integrate gender and GBV into HIV programs. This also meant walking down the more strenuous path of leaving aside blueprints and responding to specific and multiple partner CSOs' needs and recognizing that each setting is unique.

- **USAID.** USAID took the unusual step of supporting demand-driven integration of gender and GBV in a visionary strike to build a foundation for sustainability that encompassed communities. In Mozambique this was possible by understanding stakeholder relations, adopting a long-term view and being sensitive to spot a unique opportunity to support truly grassroots development.

- **HPP.** HPP made its expertise in gender and GBV available for improved health outcomes in response to a call from USAID. Over the course of three years it built CAP Mozambique, partner CSOs and, indirectly, community capacity to transform prevailing gender norms that had previously limited the effectiveness of HIV prevention investments. It addressed the technical gap among all relevant players.

CAP Mozambique´s capacity building and the local expertise in SBCC created in Phase II became fundamental pillars for integrating GBV prevention activities. Guided by the Gender Equality Continuum Tool the program used a transformative gender strategy to assist communities to assess prevailing gender norms to influence gender relations and achieve program and gender equality goals. The Gender Equality Continuum Tool is used to analyse, diagnose and plan gender integration in programming, categorizing the gender interventions into Aggravating, Accommodating and Transformative. As such, the tool illustrates how barriers to gender equality can be approached in projects. The tool is currently used by USAID and PEPFAR.

Transformative
· Fosters critical examination of gender norms and dynamics
· Strengthens or creates systems that support gender equality
· Strengthens or creates equitable gender norms and dynamics
· Changes inequitable gender norms and dynamics

Source: IGWG, 2004.

Between August 2011 and September 2014, HPP followed a five-step capacity development process: (1) analyzing capacity needs and gaps on which to base training curricula; (2) focused training on competencies on gender norms and GBV; (3) provision of TA to CSOs; (4) training CSO offices and *Activistas*; and (5) coaching and providing technical support during implementation to address challenges. CSOs identified common target competencies for improvement. HPP´s approach ensured that it catered to the diverging needs of each organization.[XXII]

KEY AREAS CSOs IDENTIFIED TO STRENGTHEN WITH HPP SUPPORT	
1	Impact of gender on HIV prevention
2	Evidence-based design of gender-sensitive approaches to engage men
3	Increased understanding of local laws related to GBV
4	How to improve programming for adolescents and vulnerable girls
5	Gender-sensitive monitoring and evaluation

Source: Harris-Sapp,T., Kiesel R., Rottach, E., Dent, J., Yinger, N., 2015.

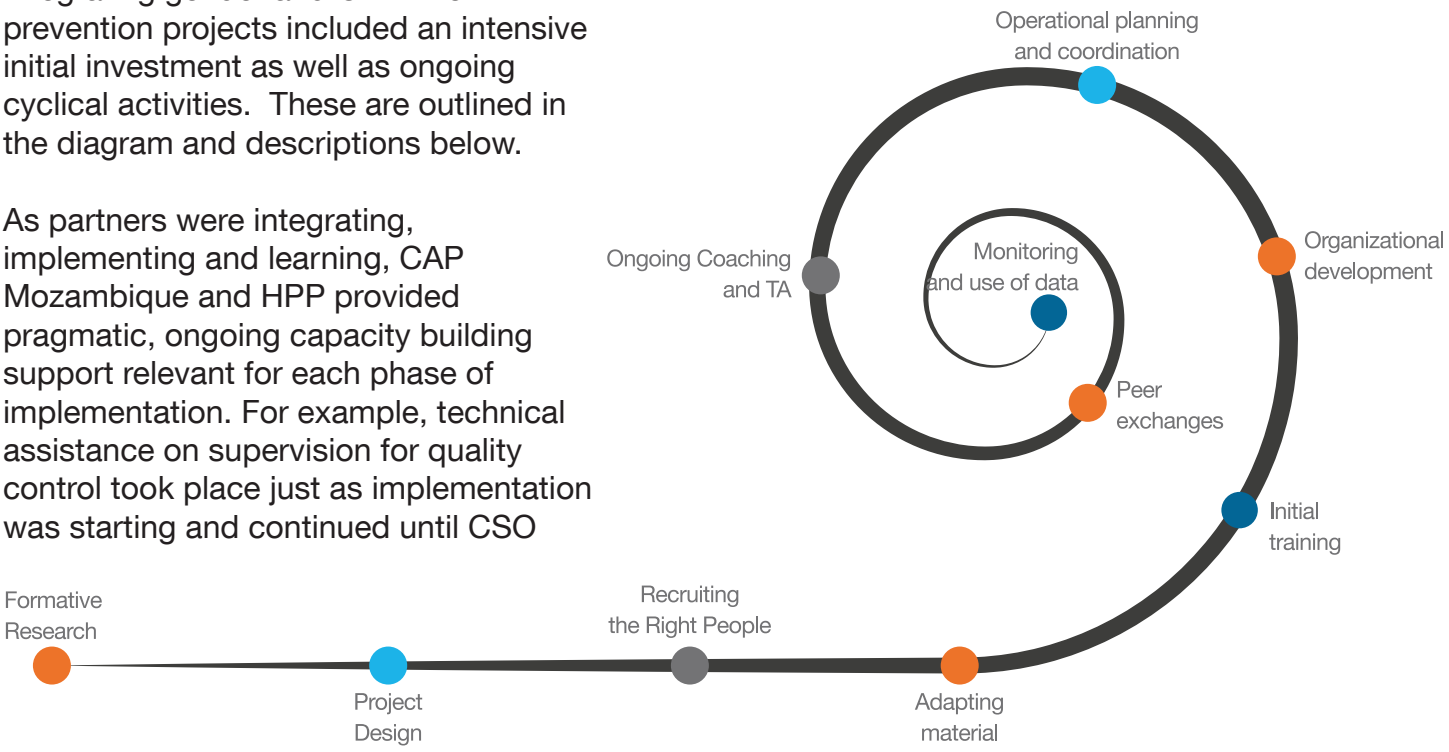
Each CSO identified target groups according to their objectives: pre-teens (10- to 13-year-olds), teens (14- to 17-year-olds), youth (unmarried adults) and adult men and women in communities or in schools where teachers were also targeted as key actors for change. All but one of the partners engaged men and women separately.

CAP Mozambique participation in the capacity building program enabled its staff to carry over what they learned about gender and GBV to their work with other non-GBVI CAP Mozambique partners. Those organizations integrated gender and GBV into their programming, though not with the same intensity as the GBVI-participating CSOs.

4.3 Program Stages

Integrating gender and GBV into HIV prevention projects included an intensive initial investment as well as ongoing cyclical activities. These are outlined in the diagram and descriptions below.

As partners were integrating, implementing and learning, CAP Mozambique and HPP provided pragmatic, ongoing capacity building support relevant for each phase of implementation. For example, technical assistance on supervision for quality control took place just as implementation was starting and continued until CSO



staff were strong. TA on transparent recruitment took place just as the project was starting. In each case, training and TA were based on capacity assessments and partner-determined priorities. Levels of experience and professionalism varied widely.

CAP Mozambique consistently supported partners to do the work themselves. The program maintains high standards, yet provides ample support for partners to reach those standards Sometimes "support" meant insisting on pre-approval of key staff or consultants or the curriculum to ensure quality. More often, capacity-builders questioned, posed alternatives, shared information, developed tools and taught CSOs to use these tools. They pushed for analyses and decisions, but did not do the work for the partner. CAP Mozambique staff noted that it was difficult to wait and watch partners make mistakes, especially with the PEPFAR pressure to deliver numeric results, yet failures are learning moments and painful lessons often penetrate more deeply.

Each stage described below includes what the partners were doing to integrate gender and GBV as well as the capacity building support they received for this purpose.

GENDER ISSUES ASSOCIATED WITH HIV-RISK BEHAVIOR IDENTIFIED BY CSOs

- Lack of dialogue in couples and between parents and children on issues related to sexuality and safe sex
- Transactional and cross-generational sex
- Early marriage
- Unsafe sex behavior, including low negotiation of condom use
- Gender-based violence
- Stigma and discrimination
- Excessive alcohol consumption

A. Formative research.

Formative research was a pre-requisite under the partnership with CAP Mozambique. This included a review of available epidemiological data and other tertiary information to inform problem analysis and identify the root causes of sexual transmission of HIV in target communities. In these discussions, gender and GBV often surfaced as key drivers. Focus group discussions and individual interviews ensured the target groups were consulted before outlining any plans. To properly conduct FGDs and interviews, CSOs needed support. The support included training to identify appropriate questions and methods for people to share their worries about these sensitive issues and providing support in the analysis of data gathered. CAP Mozambique also supported community consultations among each of the six CSOs to better understand how to apply masculinity concepts, as later required by PEPFAR (2012).

Each prevention partner conducted a significant number of FGDs and in depth interviews. Questions were included to better understand gender norms, barriers and opportunities related to HIV prevention in each geographic context. CAP Mozambique provided intensive support to analyze the data and articulate the findings.

During the field work for this case study, the six CSOs (100 percent) expressed that their staff valued highly the CAP Mozambique support for the formative research and community consultations. All the CSOs claimed they felt much more capable of conducting this type of research to high-quality standards, including the 50 percent that had used some form of pre-design consultation tool before partnering with CAP Mozambique.

B. Grounded project design. Formative research findings informed the communications

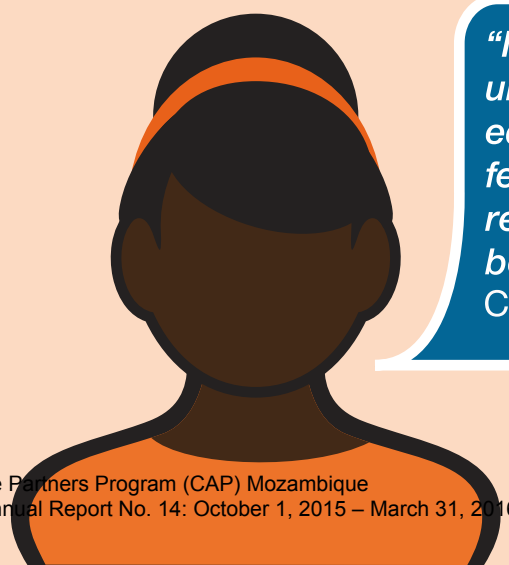
strategy that became the basis for CSO project design documents and detailed budgets. Each CSO communication strategy included customized communication channels for each target group, and realistic, reasonable design and budgets that were in line with best practices. All partners' final project designs had to meet a minimum score to be accepted for funding.

In accordance with PEPFAR prevention guidelines, all CSOs covered common core issues in their proposals, such as disseminating information on HIV transmission, promoting fidelity and condom use, promoting HIV testing, making testing available in target schools and communities, and disseminating laws protecting women´s rights, including the law criminalizing domestic violence. Some chose to add activities, such as promoting abstinence (four CSOs), active case-finding of patients who had missed clinical HIV appointments (four CSOs), discouraging early marriages (four CSOs), household follow-up of suspected GBV cases and referrals for survivors of GBV (two CSOs) and working with teachers as change agents to stop sexual harassment of girls in schools (one CSO). Those CSOs had not worked in gender and GBV previously and showed a greater improvement in their analysis of the problems and root causes of HIV; this may be because they are now considering – and better understand - a previously neglected, but significant, factor affecting the HIV epidemic.

To ensure high quality standards, CAP Mozambique, HPP and partners agreed on minimum standards for "counting" someone as having been reached regarding GBV. **These criteria were:** (1) definition of GBV, (2) where to go in case of a GBV situation, (3) GBV legislation, (4) types of GBV faced by adults and children and (5) linkage between GBV and HIV.

C. Recruiting the Right People. After project designs were approved, CSOs received support to prepare for project implementation.

CAP Mozambique supported CSOs to develop transparent recruitment processes for hiring office staff, *Activistas*, consultants and trainers, including *Activistas* profiles and job descriptions. **Care was taken to attain gender balance among *Activistas* to ensure they reached both men and women. Through formative research it became clear that men wanted to talk about these sensitive issues with other men and women with women.** Particular attention was paid to having local community leaders and school staff recommend potential *Activistas* based on a profile that included credibility—not only education level and comfort speaking in groups (criteria which favored men) but also credibility with girls and women, and compassion. Trainings of *Activistas* reinforced female facilitators who had less confidence, exposure and experience than their male counterparts.



"It was really important to understand why we should hire equal numbers of male and female Activistas. We had not realized it was so important before"
CSO representative

D. Adapting communication materials. Each CSO was supported to be able to analyze and select from existing SBCC methodologies the one most appropriate for their target population, capacity and objectives. Each CSO adapted its field manual for *Activistas* and other material developed in Phase I. For example, flipchart images that were used to prompt communities to start discussing HIV were transformed to integrate and address gender and GBV issues. Training manuals were revised to reflect changes in new gender-sensitive topics and adapt to changes in PEPFAR orientations on HIV prevention, care and treatment. All CSOs expressed the importance of receiving supporting communication materials needed for field operations (some of which were in local languages) and in sufficient numbers.

Four 15–20 minute films called *"Quebrando Barreiras"* portray relevant local situations that constitute barriers for adopting safe sexual practices. One film shows how a young couple perceives condom use. Topics of faithfulness, trust, macho-male behavior, and peer pressure are portrayed through the conversation of the couple that is about to have sex, to which separate conversations between the woman and her friends and the man and his friends have been added.

The films' themes were identified based on the issues and true life stories partner CSOs and target community members identified. By presenting issues provocatively and without a clear ending, the films trigger active discussion of issues such as inter-generational sex and multiple concurrent partnerships, two of the most important channels for HIV transmission in Mozambique, disproportionately affecting women aged 15–29.

CAP Mozambique checked all facts concerning HIV and integrating cross-cutting gender and GBV issues for the films. Using a local film producer and local actors and dubbing the film in three local languages gave credibility to the context. The films were well received by communities, reflected in their enthusiasm to participate in the debates after screenings. The debates lasted much longer on days when a film was shown than when it was not.

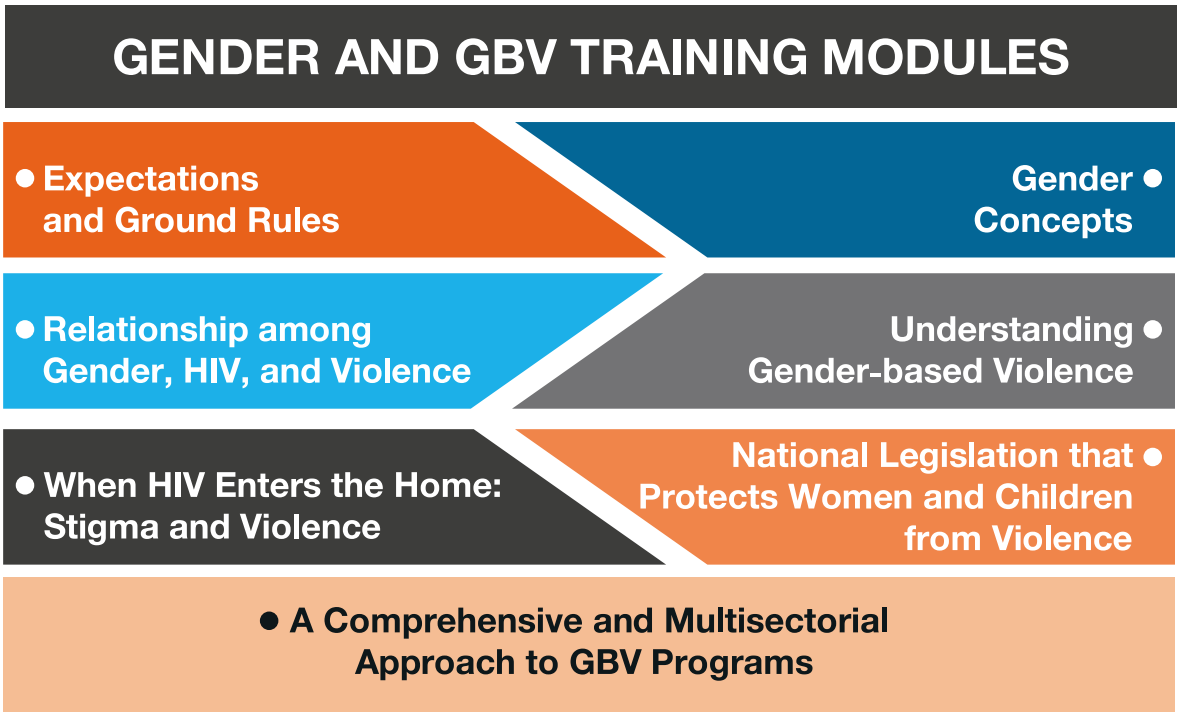
"Simulation of the upcoming session in the weekly meeting with Activistas was extremely useful for them to practice how to deal with gender and GBV issues."
CSO representative

E. Operational planning and coordination. CAP Mozambique and each CSO had regular planning sessions that involved finance and program staff. Partners discussed progress made against plans, budgets and indicators, and identified operational challenges and corresponding corrective measures. When prompted to review project performance data, one partner discovered that male participation in debate sessions was very low. Upon further exploration, they learned that the men who worked in the markets were reluctant to leave their stalls to attend debate sessions, so they moved the debates to locations in or near the markets. In

another instance, one of the CSOs realized that younger men preferred to play soccer than attend debates when they were scheduled at the same time, so the debate times were changed. Another partner realized that the methodology they had chosen was too sophisticated for their *Activistas.* The partners adapted their methodology and performance improved.

With guidance from CAP Mozambique and HPP, the *Activistas* met weekly with their CSO supervisors to assess progress in implementing weekly plans, and operational challenges and opportunities, including those related to gender and GBV prevention. Through these and annual planning meetings CAP and CSO staff were able to examine project monitoring data and draw patterns between plan implementation and the targets associated with gender and GBV. This information together with the results from the mid-line review and end-line evaluation prompted reflection and constituted the basis for fine tuning strategies and revising project targets annually.

F. Practical, relevant technical training for implementers. HPP provided initial and follow-up technical training to help CSO staff and outreach workers put words to and analyze their experiences with gender and GBV. The workshops provided factual information about gender and GBV, Mozambican legislation on domestic violence and additional resources. Clear training objectives and methodologies guided content and structure of all gender and GBV trainings provided to *Activistas*. The following gender and GBV modules were included in trainings:[XXIII]



Source: HPP, 2014.

CSO trainers were trained and refresher trainings were conducted as they were required. Additional in-depth training was provided to CSOs that requested it, including one that benefitted from training through an academic institution in neighboring South Africa.

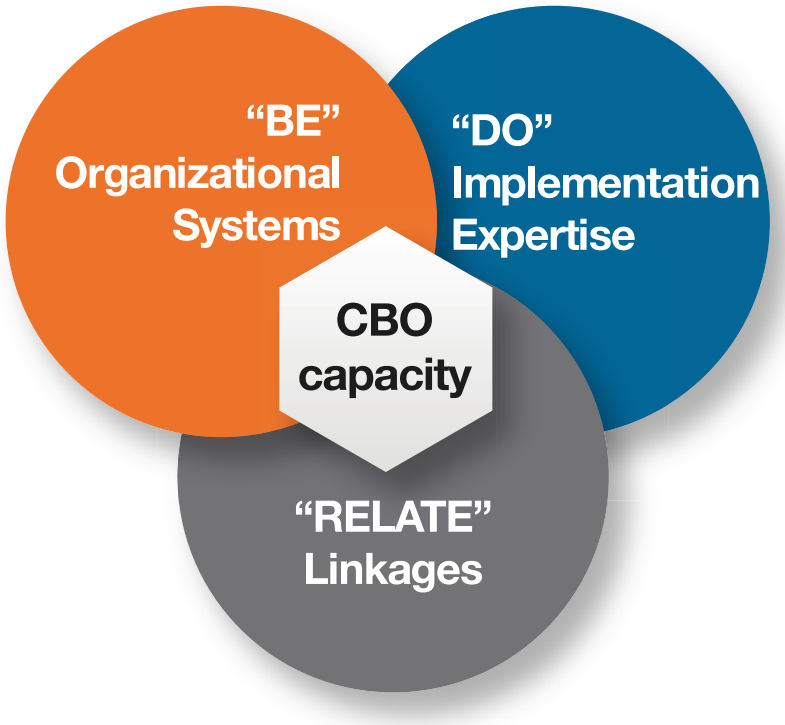
"CAP accepted to fund our training with Wits University on communication for behavior and social change, as well as a field visit to Brazil with PROMUNDO to learn about their experience in working with issues related to masculinity." – CSO representative

Coaching aimed to troubleshoot implementation challenges and addressed them by equipping CSOs to simulate upcoming sessions during weekly meetings. *Activistas* were able to practice delivering gender norm concepts, such as women not being obliged to obey men, that a man can maintain a strong male identity without having multiple partners and issues of GBV, including GBV typologies and correctly citing relevant laws. Especially important was for *Activistas* to receive support in correctly identifying the societal structures and systems that link GBV and HIV. All of the information was new to the *Activistas*. According to a district supervisor interviewed in the field work for this case study, ***"It was easy for Activistas to slip into concurring with statements such as ´women have to obey men´ or to mix up the information from different laws and such mistakes would have made us fail."*** In this manner, regular supervision meetings provided the opportunity to identify areas for continuous improvement.

CAP Mozambique TA visits took place at least monthly during the sensitive and intense start-up phase, then reduced to quarterly once partners demonstrated consistent performance and eventually less often, when partners mastered the use of quality control and reporting systems.

G. Holistic organizational development. With CAP Mozambique support CSO staff and governing board members developed the core organizational systems for sustaining the organization and its work.

CAP Mozambique supports each organization based on the results of a participatory organizational capacity assessment. CAP Mozambique uses three general pillars: "Be" (how the organization operates); "Do" (what the organization does); and "Relate" (how the organization interacts with beneficiaries, government and other relevant external stakeholders). Staff and board members received training and technical assistance under each pillar. The systematic approach to strengthening organizations and individuals ensures that all who have a role in a given system (such as finance) are able to understand and effectively execute their responsibilities.



KEY ISSUES COVERED IN GENDER AUDITS	
PROGRAMMING	**ORGANIZATIONAL**
• Program design and guidelines • Program implementation • Technical expertise • Monitoring and evaluation • Partner organizations	• Gender policies • Staffing • Human resources • Advocacy, marketing and communications • Financial resources • Organizational culture

Source: InterAction, 2010.

In the area of gender, HPP involved three people from each organization to conduct a gender audit for their organizations, exploring program and organizational issues relevant to gender integration.[XXIV] Each CSO then delineated a plan that both HPP and CAP Mozambique helped them realize over time.

Board members were trained on gender equality and GBV issues. Equally important was the inclusion of gender considerations into recruitment practices, codes of conduct, policies and procedures. Five CSOs produced or updated their human resource procedures and policies to avoid gender discrimination, with corresponding measures in their internal codes of ethics. Vacancy announcements now encourage female applications and CSOs practice zero tolerance for sexual harassment in the workplace. By mid-2015 the majority of CSOs had mainstreamed gender into their strategic plans. Others did as well but with the support of other agencies prior to those CSOs entering into Phase II of CAP Mozambique.

CAP Partners	Integration of gender and GBV as a result of CAP support		
	Strategic Plan	HR Policies & Procedures	Code of Ethics
CSO 1			
CSO 2		✓	✓
CSO 3	✓	✓	✓
CSO 4		✓	✓
CSO 5		✓	✓
CSO 6	✓	✓	✓

H. Accessing peer experience. Quarterly and later semi-annual partner meetings enabled additional learning moments on all capacity-building aspects of the program, including the integrating gender and GBV. Of the six CSOs interviewed for this case study:

Partners and CAP staff cite one partners' meeting as a pivotal moment in CSOs recognizing, owning and fully embracing the value of engaging community and religious leaders to mobilize communities and promote change. During this critical meeting, partners unsuccessful in maintaining participation in debate sessions asked, and heard, from those partners (often smaller, less sophisticated associations) who had the opposite problem of turning people away.

Organizations with less experience in GBV gained more from exchanges.

2 CSOs with experience with gender programming and women´s rights expressed that they found the meetings slightly less useful than all other steps.

2 CSOs with very little experience in these topics found the exercise very useful since it gave them the opportunity to learn from the experience of others.

I. Monitoring. CAP Mozambique helped CSOs develop simple tools and systems for gathering and aggregating data according to PEPFAR's specific and increasingly complex standards. Since there was no definition for GBV, the program worked with partners to develop one that would ensure minimum standards and consistency across partners. Partners learned to verify data and to ensure quality reporting.

In sum, gender considerations were integrated into the entire project cycle, guiding CSO operations: issue identification, design, planning, coordination, implementation and monitoring and evaluation. In this particular case this was done through an intensive capacity building approach, as CAP Mozambique´s core interest was to strengthen local CSOs to become effective agents for HIV programming.

5. PROGRAM RESULTS

The mid-line (2013) and end-line (2015) **evaluations[xxv] showed impressive results** both in terms of community attitudes toward gender norms and GBV and consequently, HIV risk behavior. *Community leaders interviewed during the mid-line review proudly pointed to changes in their own attitudes and behaviors toward the distribution of tasks and shared decision making in households.* Testimonies captured in the qualitative study conducted at end-line show that dialogue is replacing GBV, as indicated by an adult man: "Now with the advice received from the CSO, couples talk to overcome challenges."

One CSO representative interviewed shared a special and now widely known anecdote in the area where they work. A prominent church leader changed his own understanding of gender norms and equality as a result of participating in the debate sessions with one of the CSOs. Moreover, he actively and openly demonstrated new behaviors toward his wife in the distribution of household chores, or sharing information and making plans with his wife, to set an example for his congregation. Though he met with resistance and criticism he moved on to even promote gender equality at church, where he has inspired others. Likewise, the quantitative end-line survey showed impressive impacts on attitudes and behaviors concerning gender norms and HIV prevention. This cross-sectional household survey conducted in July

and August 2014 assessed HIV knowledge, attitudes and behaviors at the end of the project. "The survey was conducted in four provinces with 1,531 household members aged 15-59. Program impact was estimated using propensity score matching, comparing respondents who were exposed to CAP to those not exposed to any HIV programs in the past 6 months (n=963)." These results were further tested using a counterfactual model. The survey showed particularly compelling results on HIV testing, dialogue (considered a step toward behavior change) and participating attitudes toward gender norms and risky sexual practices.

	CAP	Not exposed to HIV interventions
· Condom use in last sexual encounter	20%	5%
· Use of HIV Counseling and Testing services	45%	20%
· Dialogue between partners around HIV	70%	30%
· Dialogue with co-workers, family & friends around HIV	69%	35%
· Being faithful to one partner	67%	38%
· OPINIONS: I agree!		
· Men who have sex with a lot of women are real men	12%	26%
· Men may make all family decisions without including the wife	21%	33%
· It is acceptable for teachers to request sex from their students	12%	22%

Source: Health Info. Matrix, 2015.

An additional set of 49 focus group discussions provided valuable testimonies associated with these changes.

References to changes in gender norms, manifested in men's assumption of household tasks not usually performed by men in rural Mozambique that resulted in lessening the burden on women´s workloads, and greater dialogue in couples and between members of family units, were very common among focus group participants.

- ***"In the past, there was neither communication nor dialogue between the couple; everything was solved based on violence. However couples are now talking to solve their problems."*** - Male community member 25–49 years old (FGDs end-line)

- ***"...We also witness differences within our families. Thanks to the various activities implemented by [CSO name] behavior, that is, relationships with us parents is starting to be very good."*** – Community member (FGDs end-line)

- ***"...For example, at times when my wife arrived tired from working in the fields or other work, when she laid down to rest a bit without having cooked I would yell at her, call her names (I would get very angry). But now I let her rest and I cook myself and then we have dinner together."*** – Male community member (FGDs, end-line)

- ***"When my girlfriend and I want to have sex, we must use condoms."*** – Male youth (FGDs, end-line)

A few cited examples of men opting to no longer engage in extra-marital relationships.

- ***"I am very conscious now. Before I was the kind of man that always had extra-marital***

relationships. I loved engaging with other women. But the advice provided by [CSO name] made me change my mind. I am very grateful to [CSO name].”
– Male community member (FGDs end-line)

- *“Instead of giving due value to the women we have lived with for a long time, we think—now (that I have an income) I am doing well. I have money now so I will get girlfriends. So what happens is that we end up spending our money with strangers. This is why I would like to invite my peers to stop acting this way.”* – Male community member (FGDs end-line)

Other men and women described explicit changes about GBV in their communities.

- *“In the past it was common. I for example was one of those people that constantly beat my wife when she annoyed me. With what we have learnt, I can see that most of us have changed, even if there are still some that continue with these practices.”*
– Male community member (FGDs end-line)

- *“Before, it was common to hear about cases of violence. It is not so common now.”*
– Female community member (FGDs end-line)

- *“In the past, we continuously faced aggression. Our husbands were violent. The situation has improved since [CSO name] came [to our community].”*
– Female community member (FGDs end-line)

Some of these testimonies further described the links between gender norms and / or different forms of GBV with HIV.

- *“There are changes. Before men would have sex without using condoms, even when women suggested it. They would refuse, but now they use condoms.”*
– Female community member (FGDs end-line)

In addition, participants in these FGDs cited the value of information presented on the types of support and legal mechanisms available to victims of violence and how to access these services.

- *“Also, on sexual violence, the message I got is that if someone is violated they have to be taken to hospital run some tests and get treatment. After the treatment the hospital will give you a note to take to the authorities and they will know how to punish these individuals.”* – Female community member 15–24 years old (FGDs end-line).

Success stories collected during the course of the program also provide rich anecdotal evidence of the impact these projects have on people’s lives. CAP Mozambique has documented two cases of girls finding the courage to report sexual harassment from teachers or other adults in the communities, and CSOs supporting them to bring the perpetrators to justice.

Another success story shows a young man's change in attitude about multiple partnerships.

SUCCESS STORY FROM A PARTNER CSO: THWARTED SEXUAL ABUSE ATTEMPT

Participating in debates about sexual behavior gave one young girl the courage to go to her father after she was accosted by a teacher who threatened to withhold her grades if she didn't spend "time alone" with him. Her father confronted the teacher, much to the latter's surprise, and stopped the inappropriate behavior. The

Source: CAP, 2012. Semi-Annual Report N.7, April 1st 2012 – Sept 30th, 2012.
See www.ngoconnect.net/mozambique.

Consistent with the results of the end-line evaluation and project documentation, CSO staff and community leaders interviewed indicated seeing the following results in target communities.

SUCCESS STORY:
From Playboy to Monogamous. One Young Man´s Change in Attitude about Multiple Partnerships

After Jossefa's father died, young Jossefa felt that he no longer had to be accountable to anyone for his behavior. He started violating his curfew, became less and less involved in his church, left school, and refused to listen to his mother. Dismayed, his mother tried to speak to him about his behavior, but he ignored her and went his own way. He began to cultivate friends who each had several girlfriends with whom they were having sex with—a mark of their masculinity. At 15, Jossefa met his first girlfriend and began having sex with her. Peer pressure, however, encouraged him to seek out more girlfriends with whom to have sex.

Then his pastor invited him to join a youth group that was engaging in debates about sexual behavior and the risks of HIV and AIDS. Though unconvinced at first, Jossefa eventually saw how risky his behavior was, and that concentration on girlfriends was preventing him from concentrating on school and his dream of becoming a doctor. He now has one girlfriend who also attends his church, and together they have decided to abstain from sex so they can concentrate on their studies and pursue their dreams of becoming a doctor and a nurse.

Involving men in debates about sexual behavior and violence, facilitated by a trusted local CSO like Jossefa's church, has been an important factor in changing community attitudes toward girls' and women's rights and roles and gender-based violence—important factors in the fight against HIV and AIDS.

Source: CAP, 2012. Semi-Annual Report N.7, April 1st 2012 – Sept 30th, 2012.
See www.ngoconnect.net/mozambique.

- Addressing gender-based communication barriers and stigma regarding HIV at household level has facilitated negotiation of condom use in couples.
- Demand for HIV testing, enrollment in clinical HIV care and treatment services and adherence to care and treatment has increased among targeted couples.
- Traditional and religious leaders and other people of influence in the community can become champions for gender equality and prevention of GBV and HIV.

CSO interviewees also suggested that greater fidelity among stable couples has likely reduced the risk of infection of HIV and other sexually transmitted infections (STIs) in stable unions. The reduction

of sexual harassment from teachers to students in schools together with HIV prevention sessions with pre-teens and teens has likely reduced exposure to STIs and HIV among these groups.

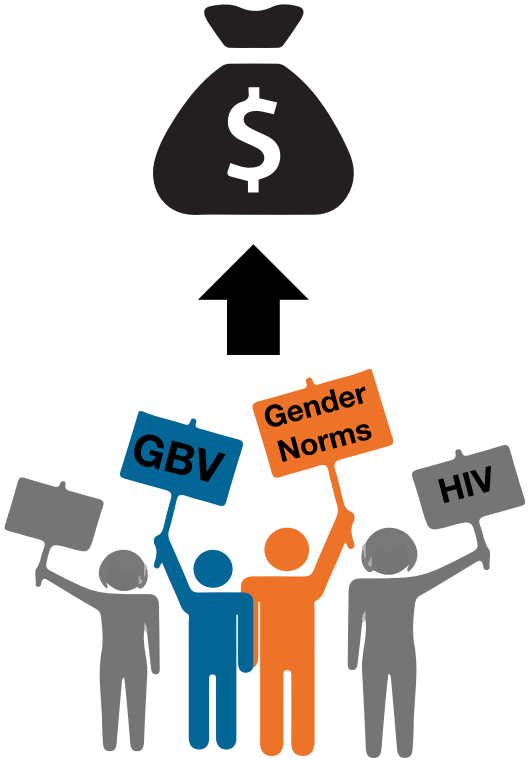
6. ORGANIZATIONAL RESULTS

Since sustainability is an aspect of success, the organizational change resulting from the investment in capacity building is significant. All of the GBV prevention partners registered improvement in two or more areas of organizational capacity measured. All six CSOs demonstrated improved technical capacity in SBCC, met CAP Mozambique's rigorous graduation criteria and were recommended to USAID for direct funding. The two GBV partners that completed the resource mobilization workshop series received positive responses to 10 of the 12 proposals they submitted, many of which included gender or GBV. These organizational gains are the result of the investment each organization has made in its own development, as well as the capacity building support. These improvements have strengthened implementation and allowed the organizations to continue to contribute to the fight against GBV beyond the life of the funding.

7. FACTORS FOR SUCCESSFUL INTEGRATION

CSO staff identified four important, interrelated factors for successful integration of gender and GBV in their HIV prevention projects. These success factors are (1) identification by communities, (2) use of sound, relevant methodologies, (3) intentional, multidimensional capacity building approaches and (4) strategic and sufficient investments of resources for long-term results.

7.1 Identification by Communities



Four CSOs partnered with CAP Mozambique in Phase I. Their target communities determined that gender norms was an issue that constrained their HIV projects, but that they did not understand how they could influence gender barriers to HIV prevention. This is unusual in Mozambique in that it was not CAP who approached the CSOs and requested that gender and GBV issues should be included.

One partner working with OVC was selected to receive gender and GBV integration even though their communities had not asked for it. Despite training and TA HPP provided, the partner never reached implementation and integration of gender and GBV into their OVC programs because it lacked community engagement.

7.2 Use of Sound Methodologies Suited to the Local Context

The Lancet Commentary of May 2004[XXVI] described education of communities, workplace and school-based prevention, training health care providers and cooperation between governments, NGOs and others to be key to eliminating gender inequalities. A series of articles also published by The Lancet in 2014 and other publications provide further insights into the building blocks for successful integration of gender and GBV in health programs, including HIV prevention. These documents highlight the need to transform gender norms that support male dominance and associate male identities with having multiple sexual partners as well as alcohol and drug abuse. This male dominance also encourages suppressing women and limiting their access to resources, participation in decision making and enjoyment of opportunities and benefits.[XXVII]

BUILDING BLOCKS FOR INTEGRATION OF GBV IN HIV AND BEHAVIOUR CHANGE PROJECTS

- Promote women´s empowerment
- Promote men´s and women´s engagement as actors for change
- Address key constraints to behavior change
- Ensure that men and women are reached
- Support critical examination and transformation of gender norms
- Promote consistent use of condoms with regular partners
- Work at multiple levels to address individual, interpersonal and community constraints

Source: Adapted by authors Lancet 2004; IGWG 2004 and Lancet Series Violence Against Women and Girls, 2014.

Facilitated debate sessions with target groups entailed discussions on topics including gender roles and identifying potential tasks that could be more equitably shared between men and women; ideal relationships between couples against analysis of real life situations; communication techniques; HIV / AIDS, care and treatment and sexuality, as well as HIV transmission and prevention.

Discussions were stimulated by combining the presentation of key information with questions aiming to encourage participants to constructively but critically analyse their own situations and identify desired improvements and corresponding actions.

WHAT TYPES OF QUESTIONS DID DEBATE SESSION PARTICIPANTS DISCUSS?

- Where do we learn about men´s and women's roles?
- What barriers do women face when they reveal their HIV status? And men?
- What challenges do women face if they want their partner to use a condom? And men?
- What happens to men who try to follow different gender norms? Why?

7.3 Intentional, Multi-dimensional Capacity Building Approach

CAP Mozambique´s tailored and robust capacity building approach built on existing but varied partner strengths by combining (1) intensive training and coaching, (2) on-going TA throughout all stages of the program catering to partner needs and (3) establishing relevant linkages with program partners, other stakeholders involved in the GBVI and relevant sector services. Organizations were selected because they had certain systems and experience, were already implementing projects in communities and indicated a desire to improve them. This ensured a foundation on which to build for more rapid progress. Even so, partner capacities varied greatly.

CSOs gained significant capacity on management issues such as financial **management**, human resource management, project management and project design. **Organizational support** was not restricted to covering common governance and accountability issues. CSOs gave managerial, technical, organizational support and the promotion of linkages between partners and between CSO partners and relevant institutions at all stages of the CAP Mozambique program consistent high rankings (on a scale 1 to 5). Four interviewees rated all stages at 5 and two interviewees at 4. **CSOs consistently stated that having robust managerial, organizational and technical capacities were necessary to produce successful results, not technical capacity alone.**

With integration, gender became another element of program management practice rather than an afterthought or add-on. In addition, all six met CAP Mozambique's rigorous standards for graduation or recommendation to USAID for direct funding.

7.4 Strategic and Sufficient Investment of Resources for Long-term Results

CAP Mozambique provided adequate funding over a sufficient period of time for all program components to ensure that CSOs could organize their administration and finances and have the management staff necessary to support effective implementation and promote sustainability.

The amounts invested by CAP Mozambique in technical capacity, including gender and GBV, organizational development and grants to CSOs, were roughly equal and helped CSOs to meet the strict requirements of international funding such as PEPFAR and USAID. As gender requirements have rolled out from donors to implementing partners, one of the challenges has been availability of high-quality gender technical support to be able to meet those requirements. Moreover, as CSOs became better at implementation, TA costs were lessened with their diminishing needs.[XXVIII]

Integration of gender equality in HIV projects generates results and enables the number of people reached to be substantially higher than gender and GBV projects alone allow. Integration should be considered both due to the intrinsic causal link between gender inequality, GBV and HIV transmission and cost-effectiveness reasons.[XXIX] Furthermore, by involving community leaders and *Activistas*, who are already part of the communities, it is expected that the debates and the results continue beyond the lifetime of the program. Sustainability is enhanced as CSOs integrate gender into other programs and projects and apply the SBCC principles in other programs. Integration of gender into HIV programming achieves HIV results, gender equality results and removes gender barriers which hinder the achievement of many development outcomes.

CAP Mozambique working in partnership with CSOs with limited capacity has produced impressive results. The project has created a practical, concrete model of how to effectively integrate gender and GBV in HIV programs and demonstrated the importance that capacity building plays in the success of that integration. The four factors that have contributed to the success of CAP Mozambique CSO partners are relevant to implementers and donors alike. As the four factors are interrelated the combination of the factors makes the key turn for change.

8. RECOMMENDATIONS

CAP Mozambique's experience highlights important considerations to help donors, program managers and project implementers to identify, design, budget, plan, implement and monitor high-impact HIV prevention interventions that effectively address harmful gender norms and GBV:

- In line with literature, this case study finds gender norms affect health risks, service-seeking behavior and uptake of services. Targeting gender norms and GBV helps people recognize and address barriers to healthy behavior. Left unaddressed, the barriers posed by harmful gender norms and GBV hinder HIV prevention efforts, uptake of existing HIV services and the achievement of gender equality.

- Provision of financial and technical resources, and adequate timelines to engage communities in project design and gender analysis, should be part of every project to allow communities to determine for themselves the issues of concern so they can address them in their strategies.

- The integration and effective implementation of gender approaches in HIV prevention programs require that:
    - Local implementers consider gender and GBV vital topics to work on.
    - Local implementers have adequate technical and managerial capacities to achieve quality, and support to develop these abilities where lacking.
    - Projects identify clear interventions and approaches tailored to the local context.
    - Sufficient resources are allocated.

- All of these issues should be incorporated in donor grants, programs and projects. Results should not be expected just by implementing training on gender and GBV, or because of having full capacity in any single domain (management, organizational or technical), being fully sensitive to the context or having sufficient funds. The combination of these factors creates synergies that lead to short-term results and set the stage for the longer term work that can achieve gender equality and eliminate GBV.

- Although GBV is reported to be widespread in Mozambique, no robust statistical information is available. Understanding the scale of GBV as well as key drivers of GBV and other contextual aspects such as poverty, education, and geographical and cultural differences in behaviors helps to set and monitor objectives.

- Documenting HIV prevention results associated to gender-sensitive community programs remains challenging. Monitoring and evaluation plans should consider measures from the outset to cross data from community prevention projects with clinical and epidemiological data to provide a robust platform for further evidence.

- CAP Mozambique´s experience demonstrates that with adequate support local CSOs can be effective players in the fight against HIV and GVB. In this context, increasing CSO involvement in HIV programs that integrate gender and GBV and meet international standards merit serious consideration.

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THE SCIENCE OF IMPROVING LIVES

Capable Partners Program (CAP) Mozambique
Semi-annual Report No. 14: October 1, 2015 – March 31, 2016

Integrating Gender and GBV into HIV Prevention Programming in Mozambique

WISDOM FROM THE FIELD

By: Marty Galindo-Schmith, Hayley Bryant (FHI 360)
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A TACKLING GENDER INEQUALITY & GBV WITH LIMITED CSO CAPACITY

To be born female in Mozambique can imply a lifetime of disadvantage relative to men. Despite the central role women play in the family's livelihood and well-being, they have limited decision-making power at the household and community level – even on issues that bear a direct impact on them or their rights[i]. Women and girls are afforded little room to make decisions related to their sexuality, including when to have sex or in negotiating condom use. Not surprisingly, Mozambican women are disproportionally affected by the HIV/AIDS epidemic (13.1% for women versus 9.2% for men).[ii]

Mozambican women and girls also face the very real threat of gender-based violence (GBV) during their lifetimes. Levels of GBV have been documented at one in three women having experienced physical violence, and 12% of women over 15 years old having experienced sexual violence .[iii] Strong evidence exists on the risks GBV poses for HIV, specifically for women,[iv] and numerous studies highlight the benefits of tackling GBV and HIV as twin epidemics. The success of HIV prevention largely depends on addressing the social and cultural norms that structure inequalities in the family, the community and in institutions.[v] In Mozambique, factors such as early marriage, unprotected and coerced sexual intercourse, male dominance in decision-making and physical, emotional and psychological violence disempower women and children, expose them to risks and limit their access to services.

A young girl is accompanied by her mother to the emergency ward after she is sexually assaulted.

In 2011, the United States Agency for International Development (USAID) launched the Gender-Based Violence Initiative (GBVI) to address gender and GBV in HIV prevention in three countries, including Mozambique. Funded through the President's Emergency Plan for AIDS Relief (PEPFAR), GBVI aims to prevent, respond to, and mitigate the effects of GBV within the HIV platform with the use of transformational strategies[vi].

At this time, a number of Mozambican civil society organizations (CSOs) were implementing HIV prevention activities throughout the country. Based on their legitimacy within the communities they served, these organizations were identified as the most effective channel for integrating gender and GBV into community HIV programming. At the same time, these CSOs and their peers comprised one of Southern Africa's most nascent civil societies – which meant that their governance and management structures were relatively underdeveloped, and their technical experience and capacity was limited. The challenge became two-fold – designing practical strategies that would directly and yet appropriately tackle sensitive cultural and social norms related to GBV, and strengthening the capacity of Mozambican CSOs to effectively implement these strategies.

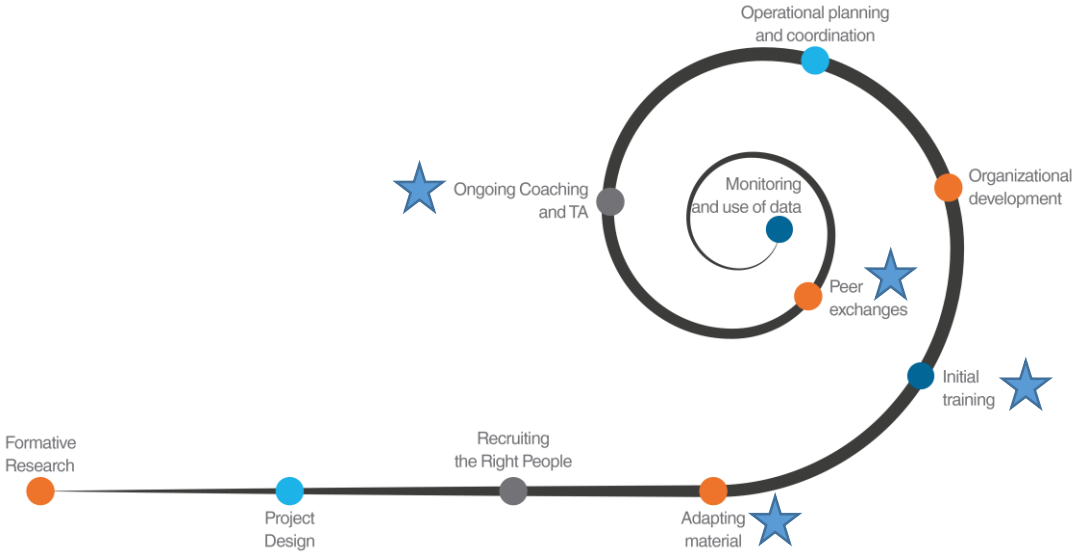
B A COMPLETE APPROACH TO INTEGRATING GENDER/GBV INTO HIV PROGRAMMING

USAID/PEPFAR engaged a willing partner in this challenge with the Capable Partners Program (CAP) Mozambique, an FHI 360 project funded through USAID/PEPFAR designed to strengthen the capacity of leading Mozambican organizations to contribute to the fight against HIV/AIDS and gender-based violence. CAP selected six of its existing CSO partners (Associação da Mulher Moçambicana na Educação, AMME); (Ophavela); (Conselho Cristão de Moçambique, CCM in Sofala); (Kukumbi); (N´weti); (Núcleo de Associações Femininas da Zambézia, NAFEZA) that had already identified the links between gender norms and GBV and HIV in their formative research and expressed a desire to engage in this new programmatic area.

Evidence based interventions that engage community at multiple-levels. These partners were already developing social behavior change communication (SBCC) prevention activities in their respective communities – strategies built upon a solid foundation of SBCC theory, formative research, and communication strategies tailored to each target community. GBV technical concepts were strategically layered onto existing SBCC activities to create robust and holistic HIV/GBV programs for the participating CSOs. Key elements included small group community debate sessions for men and women, community leader engagement throughout the process, community-based HIV testing and counseling, and providing information about available resources for addressing GBV.

CAP worked with CSOs to develop a multi-level approach targeting individuals, households and leaders. Structured debate sessions for small groups of up to 25 people (separated by gender and age, as relevant) prompted reflection on specific issues identified in the formative research such as: peer pressure, gender norms and power relationships, intergenerational sex, and more. Carefully selected and trained *activistas* facilitated a series of 8-12 community sessions which typically started with a short film or theatrical sketch to engage people in active discussion around the topic. CAP created and distributed four high quality, provocative short films to CSOs to complement existing curricula. The films portray relevant local situations that constitute barriers for the adoption of safe sexual practices, spurring discussion and learning.

Participants in a women's discussion group



Support at all stages of the project cycle. CAP provided support at each stage of the cycle illustrated in the above diagram, from project design to start-up, through multiple years of implementation and adaptation.

Examples included:

- Assisting CSOs in conducting formative research to consult with communities on project design.
- Developing effective SBCC strategies and projects based on that formative research.
- Revising recruitment process to transparently select credible community outreach workers (*activistas*).
- Adapting HIV Prevention curriculum to target audiences and to include gender and GBV.
- Training and TA for CSO project staff, *activistas*, and supervisors on SBCC, facilitation skills, gender, and GBV.
- Conducting regular monitoring visits and planning sessions to identify operational challenges and corresponding corrective measures.
- Supporting CSOs to develop structured supervision systems that emphasize quality and problem-solving.
- Developing simple tools and systems to gather, analyze, and verify project data.

ADAPTING PROJECT STRATEGIES

CAP helped CSOs understand and resolve obstacles to participation by:

- Changing activity times and locations so men would not need to leave their market stalls to attend, and young men would not miss soccer practice.
- Providing additional training to *activistas* after realizing that the approach/content was not being fully internalized.

HPP provided TA to both CAP and CSOs to ensure effective integration of gender and GBV at key stages, represented by the stars in the diagram.

Holistic organizational development support. Providing intensive organizational development support to CSOs created a solid foundation from which the SBCC and gender/GBV programming could thrive. CSOs (staff and governing board members) participated in an organizational self-assessment process, identified gaps, and developed capacity-building plans. CAP providing tailored training, coaching, and TA to develop and improve the core organizational systems necessary for the sustainability of each organization and its work. CAP and HPP engaged three representatives from each CSO to conduct a gender audit and highlight programmatic and organizational issues ripe for gender integration. CSO staff and board members were trained on gender quality and GBV. Gender considerations were incorporated into recruitment practices, codes of conduct, and organizational policies and procedures.

The successful integration of gender and GBV into HIV prevention programming at the community level is characterized by the following:

a) Linking programmatic decisions to evidence (raised through formative research, community consultations, gender audits, organizational assessments, etc.).

b) The integration of gender and GBV into each stage of the project cycle and organizationally.

c) Support for the development of solid organizational systems.

IMPACT OF CSO INTERVENTIONS

70,892
individuals reached with HIV/GBV messages

Increased dialogue between partners about HIV and gender/GBV

Increased **condom use**

Increased **HIV counseling & testing**

Changing attitudes about distribution of household work and violence as the means to resolve conflict between couples

Another critical element in this process was the internalization of gender and GBV amongst the implementing staff members: CAP ensured that CAP staff, CSO staff and *activistas* were competent in the topics before and during their outreach to communities. This guaranteed that implementing staff were able to conduct quality debate sessions with community members, and that staff members themselves took up equal gender perspectives in all the work they did, whether it was related to CAP or other projects they were involved in.

C CONCRETE CHANGES FOR WOMEN, GIRLS, MEN AND THEIR COMMUNITIES

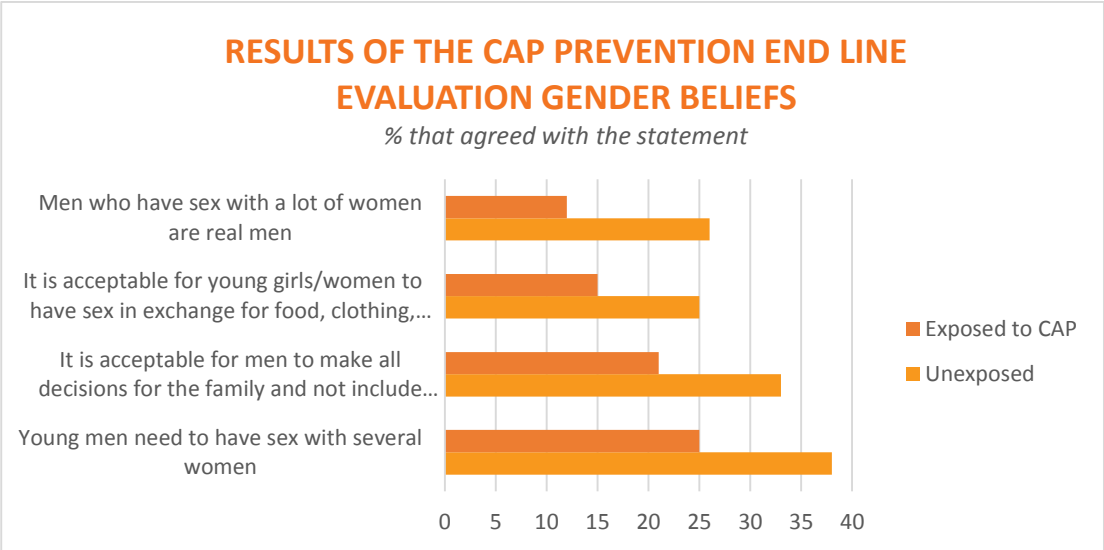
Between September 2012 and August 2015, the six CSO partners had reached 70,892 men and women with HIV prevention activities integrated with gender and GBV messages. As a

result, traditional attitudes about gender roles in these communities had begun to shift, both improving the status of women and decreasing their vulnerability to HIV transmission and gender-based violence.

CAP project impact has been measured through two studies: a mid-term evaluation conducted in 2013 to assess the the project's capacity development work with 21 partner CSOs, and an endline impact evaluation of HIV prevention activities completed in 2015[vii]. Both studies illustrated positive impacts on gender inequality,GBV, and HIV prevention, as a result of CAP's CSO interventions.

One of the key findings of the mid-term evaluation was that incorporating gender and GBV into the standard HIV/AIDS-prevention messaging illuminated the link between violence and HIV in some communities, and, according to the majority of community leaders interviewed, contributed to improvements in gender equality in those geographical areas.[viii]

The endline impact evaluation interviewed males and females aged 15 to 59 years (1,531 total respondents) in four provinces about their HIV-related knowledge, attitudes, practices and behavior, as well as exposure to the CAP program[ix]. The impact of the CAP programs was assessed by comparing individuals who were exposed to CAP programs in the prior 6 months and those who were not exposed to any HIV-program in that same period[x]. Overall, the project had a positive impact on some key behaviors and attitudes linked to



HIV orevention (see insert). Key results related to attitudes and beliefs about gender are highlighted below.

Focus groups conducted with CSO project participants reinforced the role of interventions in changing attitudes and behaviors related to gender and gender-based violence. The majority of respondents in these focus groups reported that gender-based violence had decreased as a result of the interventions. According to participants, the prevention sessions presented the types of support and legal mechanisms that protected human rights and how to access protection and legal services from community leaders, the police and other relevant bodies. However, participants in some groups noted they were most effective in getting women who were long-term victims of abuse to access services. In their own words:

- "In the past, there was neither communication nor dialogue between the couple; everything was solved based on violence. However, couples are now talking to solve their problems." - male community member[xi]
- "In the past it (GBV) was common. I for example was one of those people that constantly beat his wife when she annoyed me. With what we have learned, I can see that most of us have changed, even if there are still some that continue with these practices" – male community member[xii]
- "Also on sexual violence, the message i got was that if someone is violated, they have to be taken to hospital, run some tests and get treatment. After the treatment, the hospital will give you a note to take to the authorities and they will know how to punish those individuals" --female community member[xiii]

AMME Executive Director, discussing the organization's performance in the organizational assessment process

Besides the impact on communities, the CSOs themselves were affected. Women now assume leadership positions and the organizations have been provided with gender equality assessment tools. Of the six participating CSOs, five have since produced or updated their internal codes of ethics and human resource procedures and policies to avoid gender discrimination. CSOs specifically encouraged female applicants in vacancy announcements, for example, and established 'zero tolerance' policies to sexual harassment in the workplace. By mid-2015 the majority of CSOs had mainstreamed gender into their strategic plans.

D STRIKING A BALANCE BETWEEN EXTERNAL AND INTERNAL WISDOM & RESOURCES

Ranked 178 out of 187 countries in the Human Development Index, Mozambique needs to adopt innovative strategies to achieve developmental growth on multiple fronts. Gender inequality is recognized as a key obstacle to development, and Mozambique ranks among the five places with the sharpest gender inequality.[xiv] The lessons learned from CAP's integration of gender and GBV into HIV programming can inform future initiatives on a larger scale, ultimately narrowing this gender gap and improving the quality of life for all Mozambicans. External consultants interviewed all six CSOs for a case study and identified the following key factors in enabling the successful integration of HIV and gender/GBV, and resulting positive changes in attitudes and behaviors:

- **Identification of gender and GBV by communities //** CSOs and their target communities identified gender and GBV as constraints for HIV prevention themselves. This ownership meant they embraced the concepts more fully and provided the space to introduce sensitive topics into debate sessions. The CSOs have integrated gender and GBV into their organizations and other aspects of their programming.
- **Use of sound relevant methodologies //** CAP´s support for formative research and behavior-change communication enabled CSOs to further understand gender and GBV

barriers and identify context-specific measures to address them. SBCC methodologies and materials – such as the films- were adapted to local realities based on this research, so that questions spurring debate on these issues were provocative and yet appropriate to the context. Specific Information on locally available services made it easier for people to access support. The multi-level approach engaged community members that influence social norms, creating a conducive environment for change.

- **Support for managerial, technical, and organizational capacity //** CAP linked capacity building efforts in project management, SBCC/GBV technical capacity, and organizational development to create a holistic approach that lead to project success. This holistic approach also lends toward greater sustainability of the intervention within the organizations and their communities. The integration of gender throughout CSOs organizational systems and processes reinforced the commitment to quality project implementation.
- **Support at all stages of the project cycle //** CAP ensured dedicated support and staff for CSOs throughout the entire project cycle. Beyond simply training CSOs on technical concepts at project initiation, CAP provided the intensive follow-up required to help CSOs deal with the inevitable challenges of applying a new program strategy. All CSOs interviewed for the case study emphasized the value of consistent support at all stages.
- **Sufficient financial and technical resources //** USAID/PEPFAR and CAP mobilized resources to support this integration. In the beginning, the financial investment in capacity development outweighed the amount provided in grants, but this gradually shifted over time. The investment allowed CAP to tailor capacity building, to provide hands-on assistance throughout the life of each grant award, formative research and project design, and to fund organizational systems necessary for solid implementation. HPP's expertise in gender and GBV complemented CAPs experience in capacity building,
- **Promote ownership //** The CAP approach promoted CSO (and community) ownership over the process. While this requires more time and resources, the investment is ultimately worthwhile. CAP promoted CSO growth by questioning, posing alternatives, sharing information, creating space for peer exchanges, creating new tools, coaching CSOs to use tools and systems, and pushing for CSOs to make their own decisions. Most importantly, CSOs were forced to do the work themselves. It was difficult for CAP staff to watch and wait for CSOs to make their own mistakes – particularly in the face of PEPFAR pressure to deliver results – and yet failures are learning moments and painful lessons often penetrate more deeply.

In Mozambique, where HIV prevalence is high, gender inequalities and GBV are intertwined in social and cultural life. Through CAP and the GBVI, CSOs partners have leveraged community expertise to adapt international approaches and intervention models to local cultural standards. Respecting community wisdom and building upon it by strengthening CSO capacity sets valuable groundwork for more lasting attitudal and behavioral change. The results presented here demonstrate impressive gains for the short term, but the approach used is expected to enable more sustainable impact over time in the target communities and CSOs themselves.

[i] Inge, Tvedten, 2011. Mozambique Country Case Study: Gender, Equality and Development. World Development Report. Gender Equality and Development, Background Paper. World Bank.

[ii] INE and MISAU, 2009. INSIDA: National Survey on Prevalence, Behavioral Risks and Information about HIV and AIDS.

[iii] Moçambique Inquérito Ministerio da Saude (MISAU), Instituto Nacional de Estatística (INE), and ICF International (ICFI), Demográfico e de Saúde 2011 (Calverton, MD: MISAU, INE, and ICFI, 2012).

[iv] Campbell JC. 2000, Health consequences of intimate partner violence. The Lancet 359: 1331-6.; WHO 2004, Violence against women and HIV/AIDS: critical intersections, intimate partner violence and HIV/AIDS, WHO Information Bulletin Series The Global Coalition on Women and AIDS 1: 3; Dworkin SL & AA Ehrhardt, 2007, Going beyond 'ABC' to include 'GEM': critical reflections on progress in the HIV/AIDS epidemic. American Journal of Public Health 97: 13-18.

[v] Dunkle K.L. and Jewkes R. (2007), Effective HIV prevention requires gender-transformative work with men. *Sexually Transmitted Infections* 83: 173-74.

[vi] PEPFAR, March 2013. Addressing Gender and HIV/AIDS.

[vii] HIV Prevention End line Report, March 19, 2015. Health Info Matrix. Field work was conducted in 2014.

[viii] Blid N., D'Alessio O'Donnell C., Souto M., Parviainen R., 2013. External Evaluation for Capable Partners Program (CAP) – Mozambique Final Evaluation Report. Page 2.

[ix] To maximize the power of analysis the clearest groupings were used, and the study excluded individuals whose exposure status could not be determined. This resulted in a total of 963 individuals, 624 of whom were exposed to CAP interventions, and 299 of whom were not exposed to any HIV intervention.

[x] Program impact was assessed using Propensity Score Matching (PSM)[x]. PSM is a statistical technique used to create comparable comparison groups in studies like this, where randomization to the intervention is not possible.

[xi] CAP HIV Prevention End line Evaluation. Focus Group Discussion.

xii Ibid.

xiii Ibid

[xiv] UNDP Human Development Report, 2014, Mozambique.

DECEMBER 2015

Building Capacity to Address Gender-Based Violence in HIV Prevention in Mozambique

A case study identifies success factors

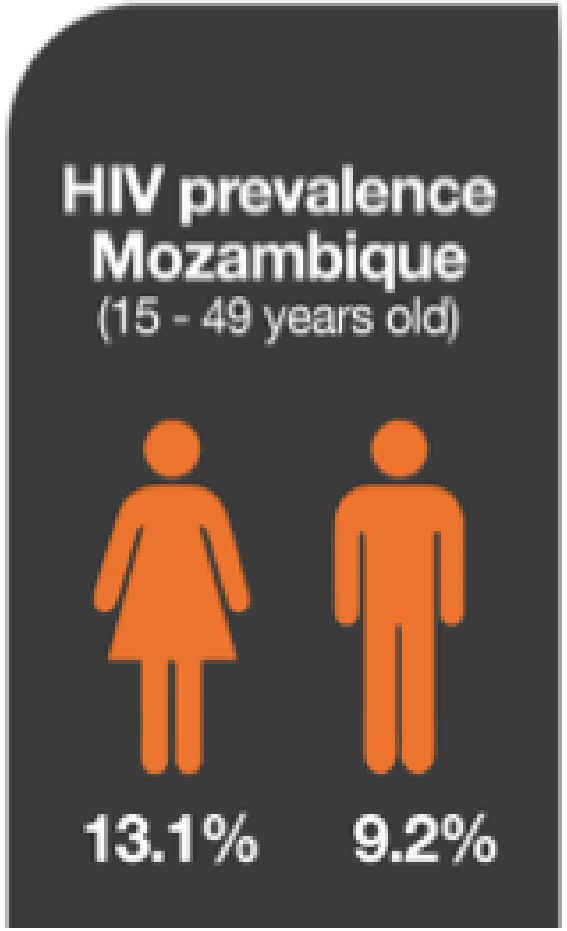
Presenter: HAYLEY BRYANT, Chief of Party, Capable Partners Program – Mozambique

Study conducted by Chiqui Arregui, Katinka Cranenburgh, Rosalia Miguel

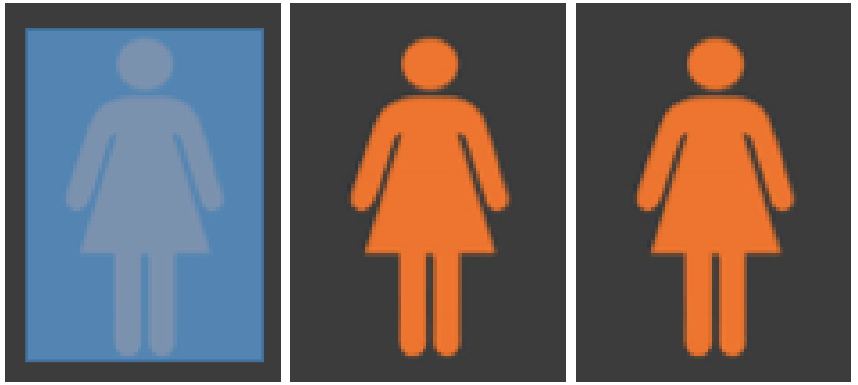
A story To Tell

- Of surprises

GBV, gender norms and HIV in Mozambique



1 in 3 Women experience physical violence

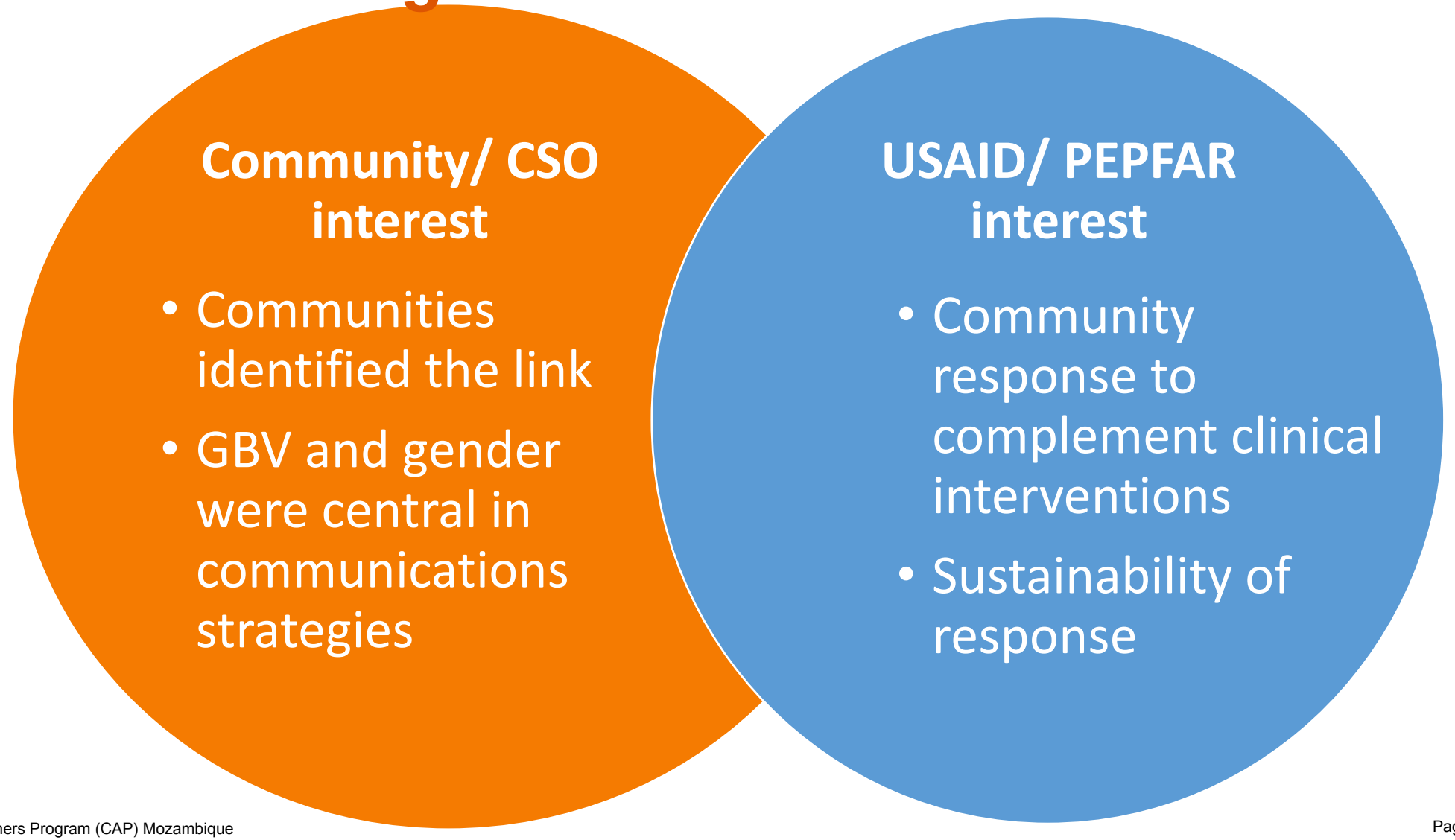


12% of women over 15 experienced sexual violence

Risk Factors

- early marriage
- unprotected and coerced sexual intercourse
- transactional sex
- male dominance in decision-making
- physical, emotional and psychological violence

Decision to integrate



2013 Mid Term Evaluation Shows Unexpected Results

- Almost all of the 67 community leaders interviewed cited changes in gender norms or GBV in their community as a result of the CBO's interventions.
- Led us to analyze this in the prevention endline

Religious Leader who changed how he treated his wife

Prevention End line Evaluation Shows Changes in Risk Behavior

	Unexposed to CAP	Exposed to CAP
Condom use in last sexual encounter	5%	20%
Use of HIV counseling and testing services	20%	45%
Dialogue between partners around HIV	30%	70%
Dialogue with coworkers, family and friends around HIV	35%	69%
Being faithful to one partner	38%	67%

- Cross-sectional household survey of 1531 households in July 2014
- Analysis conducted using propensity score matching

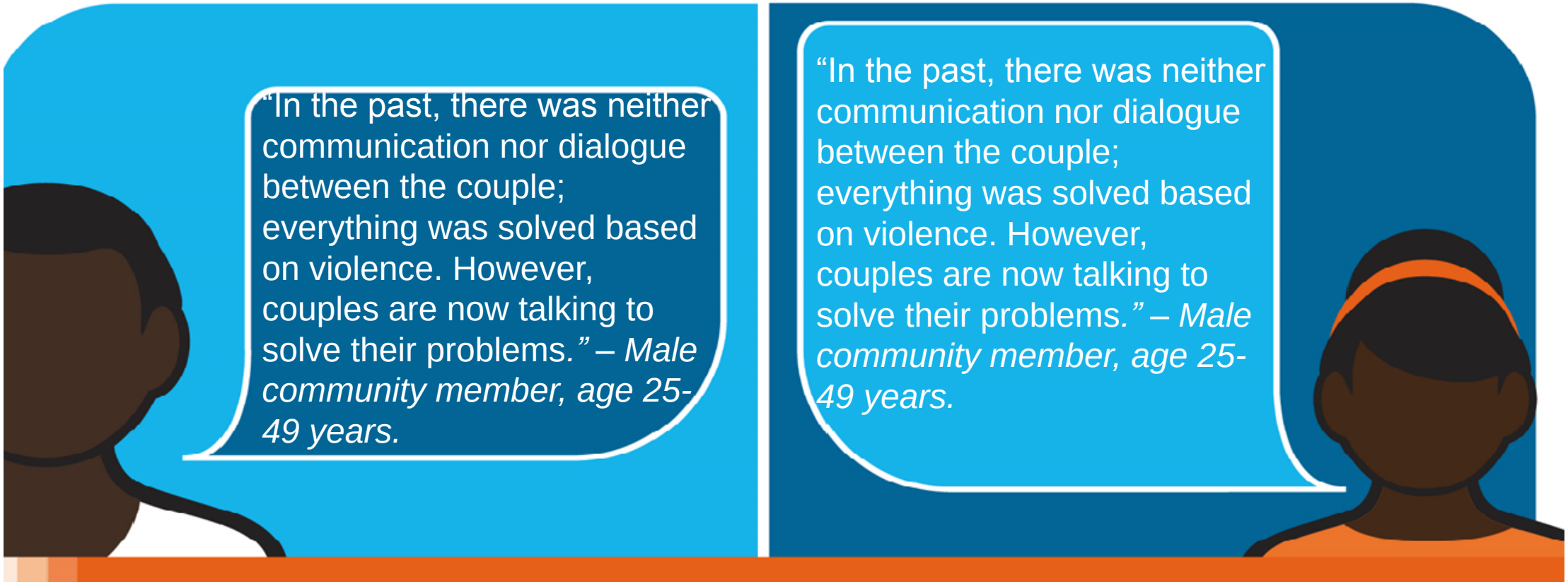
70,892 People Reached

Prevention End line Evaluation Shows Changes in Attitudes about Gender Norms, GBV

Variable	Unexposed to CAP	Exposed to CAP
Young men need to have sex with several women	38%	25%
Young women should not have sex with several males	66%	74%
It is acceptable for men to make all decisions for the family and not include the wife	33%	21%
It is acceptable for young girls/ women to have sex in exchange for food, clothes, etc	25%	15%
It is acceptable for teachers to request sex from their students	24%	12%
Men who have sex with a lot of women are real men	26%	12%

Forty-six percent (46%) of CAP participants encourage alternative forms of widow purification, compared with 29% of the unexposed population

Prevention End line Evaluation Shows Changes in Attitudes about Gender Norms, GBV



Additional quotes

"...For example, at times when my wife arrived tired from working in the fields or other work, when she laid down to rest a bit without having cooked I would yell at her, call her names (I would get very angry). But now I let her rest and I cook myself and then we have dinner together." – Male community member

"Instead of giving due value to the women we have lived with for a long time, we think—now (that I have an income) I am doing well. I have money now so I will get girlfriends. So what happens is that we end up spending our money with strangers. This is why I would like to invite my peers to stop acting this way." – Male community member

"There are changes. Before men would have sex without using condoms, even when women suggested it. He would refuse, but now they use condoms." – Female community member

Case Study Methodology

- Descriptive case study approach
  - Interviews with CSOs, and intervenors

- Review existing documentation
  - Midterm project evaluation
  - Endline Prevention evaluation

Limitations

- Lack of good data on GBV
- Triangulate info from staff

Key Success Factors

1. Communities identified gender norms and GBV as a barrier to HIV prevention. Ownership was promoted.

2. Sound methodologies relevant to local context

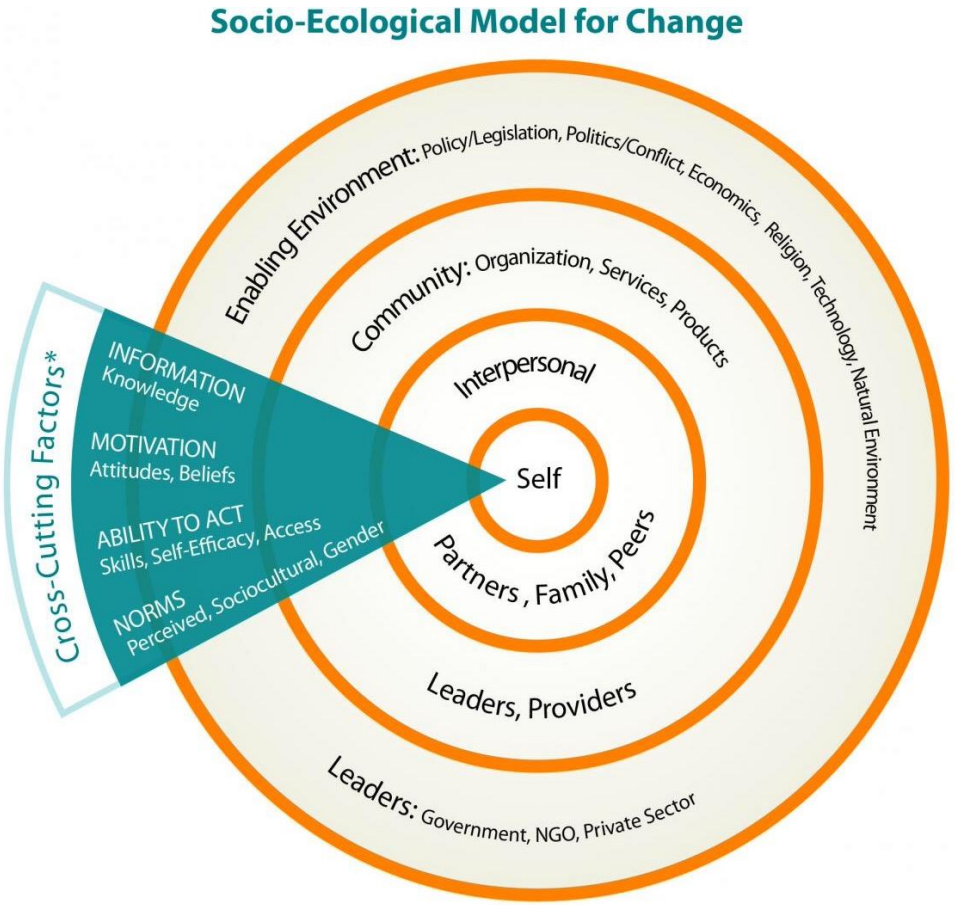
3. Depth and breadth of capacity building

4. Resources invested for long-term results

Communities and CBOs Identified Gender and GBV as Issues

Target communities identified the problem. It was not the donor, the implementing agency or even the CBO who imposed it.

Appropriate, Relevant Methodologies

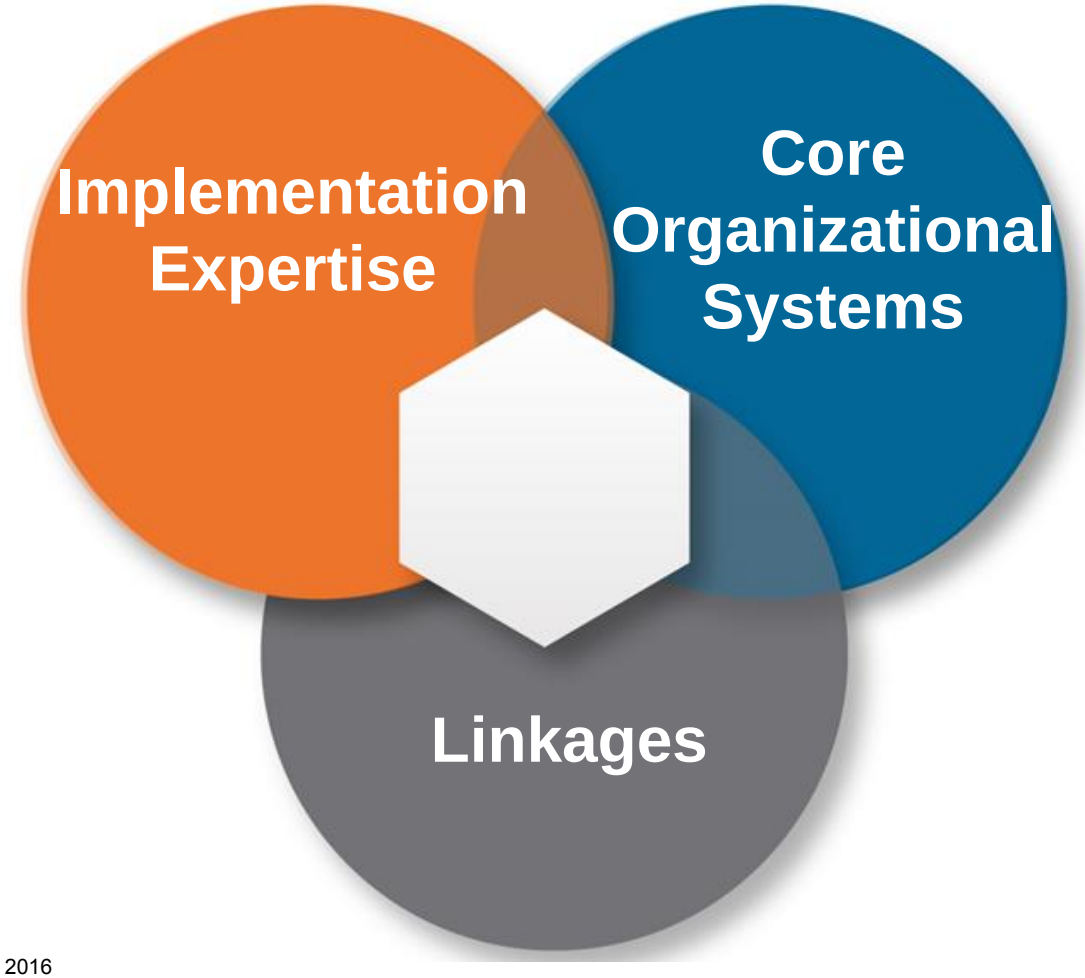


- Multi-level approach
- Included Men
- Proven methodologies – participatory and reflective
- Adapted to the nuances of each location
- Adapted to include gender norms and GBV
- New materials created -- Films

Community Level Interventions

- Small group debates with targeted groups (youth, couples, men or women) on barriers to preventing HIV, including gender norms and GBV
- Community leader engagement
- Community HIV Counseling and Testing
- Radio programs

Comprehensive Capacity Building

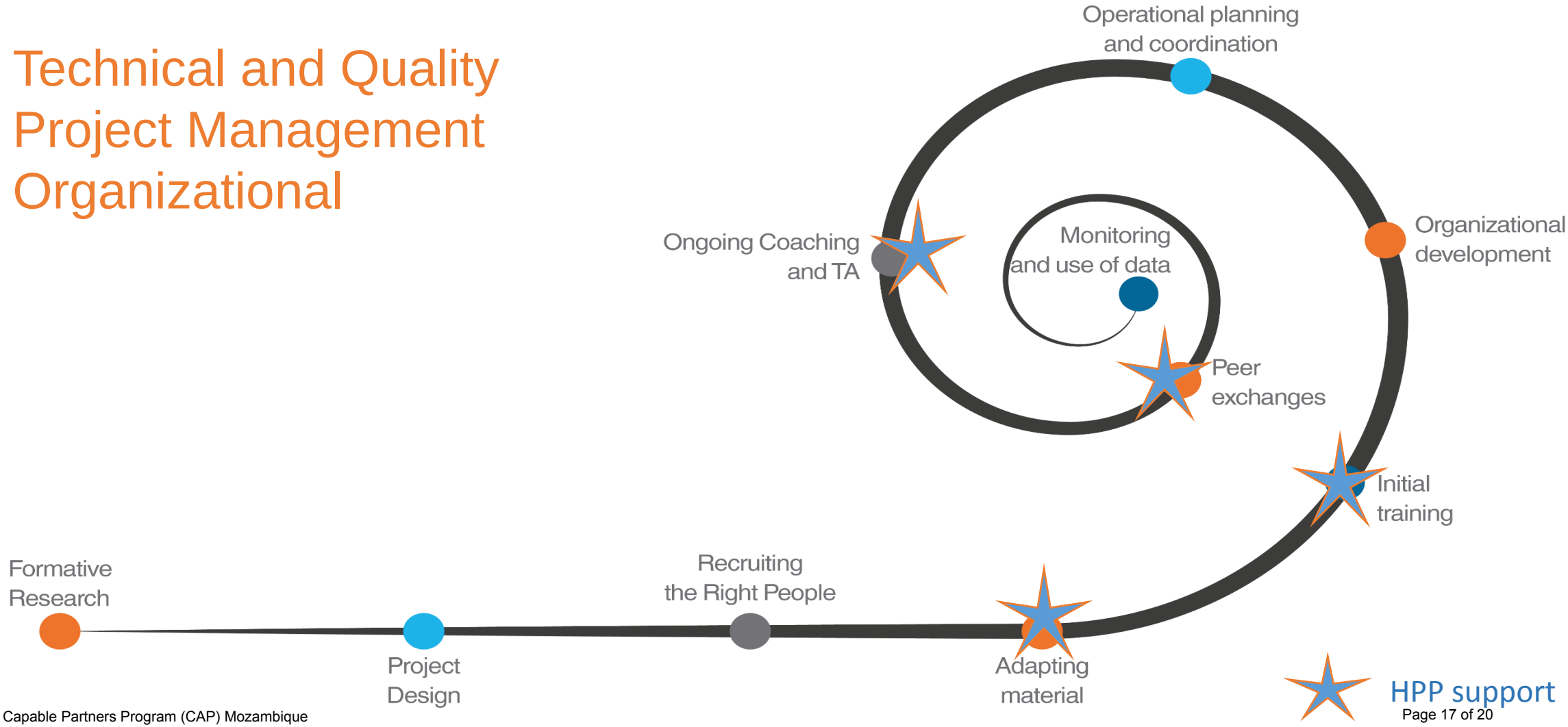


Results – Organizational

- All six demonstrated improvement in two or more areas of organizational capacity measured.
- All six improved technical capacity using C-Change assessment tool.
- All six “ graduated” and were recommended for direct USAID funding.
- 10 of 12 proposals funded for the two CSOs who received intensive resource mobilization support; many included gender or GBV
- Included in strategic plans

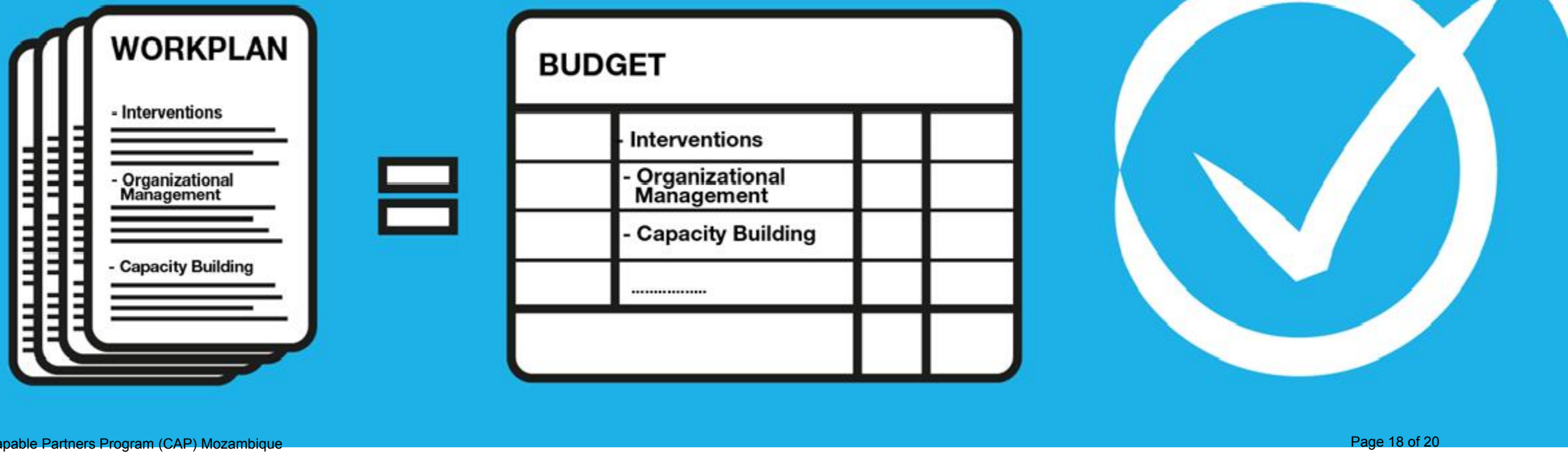
Support at All Stages

- Technical and Quality
- Project Management
- Organizational



Resources Invested With Long Term Vision

CAP ensured funding for CBOs to implement and effectively manage quality interventions, including those related to G&GBV. USAID invested in capacity development.



FHI 360 Mission

Our mission is to improve lives in lasting ways by advancing integrated, locally driven solutions for human development

Obrigada
Kanimambo

Annex 19c: Abstract - Promising Practice

SVRI 2015

Promising Practice: Integrating Gender and GBV into CBO capacity building, HIV prevention, Counseling and Testing Programs

Track E – Implementation Research, Economics, Systems and Synergies with other Health and Development Sectors

Integration of HIV services with other Programmes

Authors: **Hayley Bryant,** Project Director, CAP Mozambique, FHI 360, **Rosalia Miguel,** Coordinator, CAP Mozambique, FHI 360, **Chiqui Arregui**, Community Wisdom Partners, **Katinka Van Cranenburgh**, Community Wisdom Partners.

Background: In Mozambique, HIV prevalence is 13.1% for women, 9.2% for men, 1 in 3 women experience physical violence; 12% of women over 15 experience sexual violence. Risk factors include early marriage, transactional sex, and male dominance in decision making. Under the PEPFAR Gender-based Violence Initiative, USAID/Mozambique supported the Capable Partners Program (CAP) to scale up GBV prevention within their capacity building program. CAP and the Health Policy Project provided training and technical assistance to help six CBOs design and implement social and behavioural change communication activities that address gender norms/GBV and HIV together.

CBOs organized series of 8-12 small group debates addressing gender-based risk factors and barriers to HIV prevention and testing. CAP developed videos to spur meaningful debates. Interventions aimed at preventing sexual transmission of HIV and promoting HIV testing reached 70,892 women and men ages 15-49 in four provinces during 2012-2015.

A 2014 quantitative cross-sectional endline population survey interviewed 1531 men and women aged 15-49 about gender norms and testing. Propensity score matching compared people exposed to CAP to those not exposed.

Results: Among the exposed group, 21% agreed it is acceptable for men to make all decisions for the family without including the wife, versus 33% among the unexposed. The exposed were less likely to think it acceptable for teachers to request sex from their students (12% vs 24%) and to think that men can have sex with girls younger than 14 (16% vs 26%). Furthermore, 32% of the exposed indicated that they tested with their sexual partner compared to 5% of the unexposed ($p<0.01$). Qualitative results indicate a strong, but not yet pervasive, effect on awareness about the legal framework and GBV reporting.

Conclusions: Community-based interventions that integrate GBV with HIV prevention are positively associated with more balanced community gender norms and lead to increased preventive behaviors.

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A dose-response relationship between exposure to an HIV prevention intervention and preventive behaviors in Mozambique: Findings from the Capable Partners Program (CAP)

Authors: F. Gennari[1], E. Oliveras[2], E. Marinda[3], S. Baird[1], H. Bryant[2]

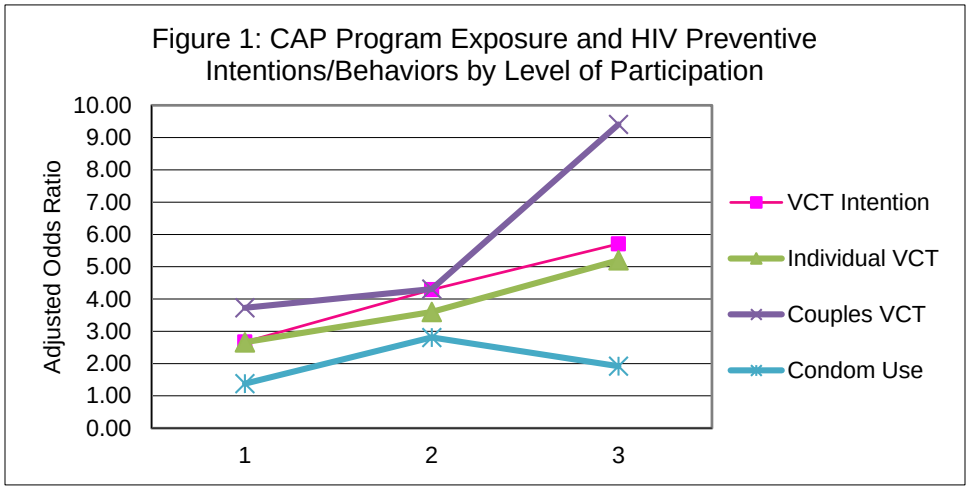
Institution(s): *[1]George Washington University, Washington, United States, [2]FHI 360, Maputo, Mozambique, [3]Health Info Matrix, Johannesburg, South Africa*

Background: Mozambique has seen improvements in condom use and in the uptake of voluntary HIV counseling and testing (VCT), yet the overall uptake of preventive behaviors (such as reduction of sexual partners) is limited. Continued investments have been made in HIV prevention programs, including community-based behavior change communications (BCC) efforts carried out by FHI360's Capable Partners Program (CAP). However, evidence from Mozambique is limited regarding the minimum dosage of intervention programming necessary to encourage behavior change.

Methods: In 2014, we conducted a multi-phased household cluster survey in 12 districts in 4 provinces of Mozambique where CAP was implemented. We interviewed 923 individuals aged 15-64 (399 men, 524 women), 624 of whom were exposed to CAP BCC, and 299 who were not exposed to any HIV intervention. Participation was divided into three levels according to respondent involvement in eight CAP activities in the past 6-12 months: low (1-3 instances of participation), medium (4-6 instances) and high (more than 7 instances). Activities included one-on-one talks with a peer educator, participation in discussion groups, and watching theater performances or films about HIV/AIDS. The participation variable was regressed on five outcomes: intention to seek VCT in the next 6 months, ever sought counseling and testing for HIV/AIDS (individual VCT), ever gone for an HIV test with any of their sex partners (couples VCT), condom use at last sex, and current multiple concurrent partners.

Results: Our results suggest a significant dose-response relationship between CAP participation and three outcomes: intention to test for HIV at low (AOR=2.67;95%CI:1.49-4.78), medium (AOR=4.29;95%CI:2.14-8.58), and high (AOR=5.71;95%CI:3.32-9.81) participation, individual VCT at low (AOR=2.66;95%CI:1.52-4.67), medium (AOR=3.60;95%CI:2.14-8.58) and high (AOR=5.71;95%CI:3.32-9.81) participation and couples VCT at low (AOR=3.73;95%CI:1.52-4.67), medium (AOR=4.31;95%CI:1.79-10.38) and high (AOR=9.41;95%CI:4.48-19.79) participation. For condom use, only a medium level of participation was positively associated with reporting condom use at last sex (AOR: 2.81;95%CI:1.49-4.78), while no association was found for current multiple concurrent partners.

Conclusion: Initial findings suggest higher levels of participation in CAP activities are significantly associated with increased intention to seek VCT, and reporting individual and couples VCT. Investing in greater dosages of intervention programming may be worthwhile for behavior change.



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Annex 19c: Abstract - Involving community leaders and CBOs

SVRI 2015

Involving community leaders and CBOs from design phase leads to strong results in addressing GBV and HIV Prevention.

Track E – Implementation Research, Economics, Systems and Synergies with other Health and Development Sectors

E22 Working with community led organizations, including key pops, faith based grups and traditional healer organizations and with community leaders.

Authors: **Hayley Bryant,** Project Director, CAP Mozambique, FHI 360, **Rosalia Miguel,** Coordinator, CAP Mozambique, FHI 360, **Chiqui Arregui**, Community Wisdom Partners, **Katinka Van Cranenburgh**, Community Wisdom Partners.

Background: In Mozambique, HIV prevalence is 13.1% for women, 9.2% for men, 1 in 3 women experience physical violence; 12% of women over 15 experience sexual violence. Risk factors include early marriage, transactional sex, and male dominance in decision making. Under the PEPFAR Gender-based Violence Initiative, USAID/Mozambique supported the Capable Partners Program (CAP) to scale up GBV prevention within their capacity building program. When six community-based organizations (including one faith-based organization) (CBOs) identified the influence that gender and GBV had on HIV vulnerability in their communities, CAP provided training and technical assistance to help these CBOs engage community leaders, design and implement social and behavioural change communication activities that address gender norms/GBV and HIV together.

In collaboration with community leaders, CBOs organized series of 8-12 small group debates addressing gender-based risk factors and barriers to HIV prevention and testing. CAP provided support in ensuring quality implementation and produced videos on gender and HIV to spur reflective discussion of these sensitive topics. Interventions aimed at preventing sexual transmission of HIV and promoting HIV testing reached 70,892 women and men ages 15-49 in four provinces during 2012-2015. A 2014 quantitative cross-sectional endline population survey interviewed 1531 men and women aged 15-49 about HIV prevention knowledge, attitudes and behaviors, comparing people exposed to CAP to those not exposed. This survey found a positive association between participation in interventions, and more balanced community gender norms and increased preventive behaviors

Lesson Learned. A team of consultants interviewed CBO representatives and outreach workers to document the process and identify key factors that lead to this success. This qualitative case study identified the following success factors:

1. communities identified gender norms as a factor in HIV transmission;
2. sound, relevant methodologies,
3. comprehensive capacity building,
4. resources invested for long-term results,
5. ownership of interventions by CBOs and community leaders.

Conclusions: When communities and leaders are engaged in identifying the issues and supported to shape interventions that are meaningful, change in seemingly intransigent norms can happen.

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Annex 20: Data Verification Report from Verification Visits

CAP Mozambique Data Verification Report
October 2015 – March 2016

From October 1, 2015 – March 31, 2016 CAP conducted six data verification visits of its grant recipients. CAP´s policy is to conduct a data verification exercise annually with each grantee, or more frequently if regularly scheduled monitoring visits indicate that extra attention to data collection and reporting is warranted. In this case, CAP decided to repeat the DQA exercise with ANDA KP, resulting in two data verifications conducted over a four-month period (one in November 2015 and the other in February 2016). The objective of the second DQA (February) was originally to verify follow-up on the recommendations provided to the organization in November, but given that the CAP project is at its final stage, it was decided to provide ANDA with the opportunity to participate in one final full DQA exercise.

The DQA process traces data collected at its origin (i.e., an *activista* recording participation in prevention sessions) through reporting to CAP Mozambique and USAID. In the case of our OVC partners, this includes the registry of data from origin sources into an OVC database prior to reporting as well. In order for the data verification process to be effective, the organization needs to have been implementing for at least a few months. This enables CAP Mozambique to compare data across a number of sessions, geographic locations, and implementers (*activistas*). This process is accompanied with information collected during regular monitoring visits, where CAP M&E and Program staff regularly communicate with beneficiaries, *activistas* and supervisors about project activities.

Any gaps in the system are discussed with the partner, and TA is provided to improve performance. If there are doubts about the data being presented to CAP, conversations with beneficiaries and other project staff are built into the data-verification process as well. In more than a few cases, this has helped CAP determine the real causes behind data quality issues.

CAP approaches data verification through a capacity-building lens. It is not altogether easy to determine whether data is being reported incorrectly due to human error, or it is being falsified. CAP engages the partner staff, supervisors/*activistas,* and beneficiaries to first gain a complete understanding of the situation before making a decision on how to handle data that does not meet our standards of integrity. In most cases, CAP´s partner recognizes and agrees with the final decisions made to accept or not accept the data being presented. The data verification process has in fact been cited by many partners as a very important learning process, which they attempt to replicate within their own organizations. Following the data verification exercise, the M&E Team then tracks the partner´s progress in meeting data quality standards.

Data verification visits were conducted with Kubatsirana, ANDA (OVC Team), ANDA (Key Populations Team), Niiwanane, and HACI's subpartner ABANHE. A brief summary of each of these exercises is included below, with references to annexes of the full reports from these visits. Due to the workload of the CAP M&E Team, when limited negative findings are found during a data verification visit, feedback is provided to the partner in person and followed-up by Email. Should more serious issues come out of a data verification visit, a formal report is sent to the partner. The reports in the annex to this document include

feedback provided via Email. This was the fourth DQA for ANDA (OVC Team), Niiwanane, Kubatsirana, and HACI (although the first for this subpartner). The two visits conducted during this period for ANDA (KP Team) constituted their second and third DQA visits. Details specific to each process are included below.

ANDA Key Populations (Manica Province) – November 2015 and February 2016

During ANDA's second DQA visit in November, a number of data collection sheets not previously reported were located, revealing serious deficiencies in the organization's archival system. Additional problems were discovered in the transfer of data from data collection sheets to reporting templates. Data collection sheets themselves, however, were in general complete and accurate. Full report in Annex 1.

In the third data verification visit with the KP Team (February 2016), comparison against data reported and located had improved, but deficiencies remained in archive use and management. CAP recommended that ANDA delegate someone within their team to manage the archival system and seal the archives of all data already reported to CAP. Full report in Annex 2.

Kubatsirana (Manica Province) – February, 2016

This is the fourth data verification with Kubatsirana. The quality of Kubatsirana's data has evolved since the first data verification. In this third data verification, Kubatsirana has acceptable levels of differences between data located and reported (up to 3%). In the data verification visit conducted in 2014, differences reached 10% for some indicators. This reduction in the discrepancies between data reported and data located demonstrates that Kubatsirana followed the recommendations provided by CAP during previous DQA visits. Kubatsirana also demonstrated dramatic improvement in its capacity to completely and accurately fill out data collection sheets. During its first DQA visit, approximately 60% of data collection sheets demonstrated gaps, in their third DQA this reduced to 8% error, and in this final DQA the organization presented data collection sheets with only 3% indicating gaps in information. Kubatsirana's archives still require attention, however, and CAP provided assistance to help the organization improve their archival system. Full report in Annex 3.

ANDA OVC (Manica Province) – February, 2016

This is the fourth data verification with ANDA OVC. ANDA OVC maintains the quality verified in the last data verification (May 2015), with an average of less than 5% of differences between the data reported and evidence presented. However, the issue of archive use and management remains a major challenge, which is resulting in data being reported, but evidence not located at the time of the DQA because it is not appropriately archived. CAP recommended that ANDA delegate this task to an archive manager to prevent the entire team from accessing (and potentially disturbing) the archives. CAP also recommended that ANDA seal all older archives to prevent this data from being relocated. Full report in Annex 4.

Niiwanane (Nampula Province) – February, 2016

This is the fourth data verification with Niiwanane. Niiwanane demonstrated great improvement in the quality of data reported, compared to the previous data verification held in March 2015. In the previous exercise, Niiwanane had over-reported on some indicators, and under-reported on others. In the current visit, only one indicator had three individuals over-reported (compared to 200 in the last DQA) for a single indicator. This improvement is due in part to having more people involved in the verification of data entry, per CAP's suggestion during the last DQA visit. However, Niiwanane's archival system could use some improvement, as it was challenging to locate documents for certain activities. This has been observed in

previous DQA visits, but the situation prevails. CAP provided Niiwanane with guidance on how best to organize their files. Full report in Annex 5.

HACI (Maputo Province) – February, 2016

HACI is an umbrella organization that provides services through sub-partners. This is the fourth data verification for HACI. For this exercise, the DQA was conducted with ABANHE, one of HACI's sub-partners. This was the first DQA from CAP for ABANHE. Through this DQA, it was observed that the quality of completion of data collection tools was good, while the management and archival of data is relatively poor. In many cases, particularly for referrals, ABANHE was accepting and reporting data by telephone (SMS) from community health workers, while the data collection sheets were kept by these workers (and not housed by ABANHE). CAP advised ABANHE to have all data evidence on hand in the office when it was reported, since that data needed to be based on data collection sheets archived by the organization. Full report in Annex 6.

Anexo 1: Relatório de Verificação de Dados
Organização: ANDA KP
Data: 12 de Novembro de 2015

Introdução
A 12 de Novembro de 2015, a especialista de Monitoria e Avaliação do CAP, realizou o exercício de verificação de dados com ANDA KP, esteve representada pelo oficial do projecto e dois supervisores de campo. Esta é a terceira verificação de dados que é realizada com ANDA KP.

Metodologia usada
A verificação de dados enfocou em dois períodos de reportagem (Março a Maio e Junho a Agosto de 2015). Foram analisados os seguintes indicadores:

- Número de indivíduos que receberam serviços Aconselhamento e Testagem (AT) e que receberam os seus resultados.
- Número de trabalhadores referidos aos Serviços de Saúde pelas organizações baseadas na comunidade.
- Número de pessoas abrangidas por uma intervenção ou serviço a nível individual, em pequenos grupos ou comunitário que explicitamente aborde a questão da violência e coerção baseadas no género (VBG 1).
- Numero de cada uma das populações prioritários atingido que completaram os padrões mínimos de prevenção de HIV, incluindo as componentes mínimas necessários durante o período de relatório (Camionistas);
- Número de população de alto risco beneficiada de intervenções de prevenção a nível individual e/ou a nível de pequenos grupos baseados na evidência e/ou no cumprimento dos requisitos mínimos (Trabalhadoras de sexo).

A escolha destes indicadores deveu se ao facto de nas verificações anteriores de dados, não terem sido tomados em consideração, visto que esta organização ainda não tinha actividades que respondessem a estes indicadores.

Foi ainda parte do processo de verificação de dados a verificação do arquivo físico dos dados.

Principais Constatações
Violência Baseada no Género (VBG 1)

A. Preenchimento de fichas
Foram verificadas todas as fichas dos períodos de Marco a Agosto de 2015 e, desta verificação foi constado o seguinte:

- De uma forma geral as fichas são bem preenchidas.
- Há alguns casos em número de dois que não completaram o número de sessões requeridas e no entanto tinham uma nota de que contam como atingidos.
- Algumas rasuras nas datas.
- Duas fichas sem datas de realização das actividades.
- Maior parte das fichas não tem a assinatura do oficial e do facilitador e constitui um requisito da ferramenta de recolha.

Testagem

As fichas de testagem estão devidamente preenchidas pelos conselheiros.

Referencias

As guias são devidamente preenchidas, no entanto algumas unidades sanitárias recomendaram o uso de uma outra ferramenta de referência, diferente do livro de referência.

B. Comparação dos dados reportados e os dados das fontes primárias (Relatório e Fichas de recolha de dados)

Tabela 1: Comparação entre os dados reportados e a indicação das fichas (VBG, Testagem e Referencias)

	Marco - Maio 2015			Junho - Agosto 2015		
	VBG1	**Testagem**	**Referências**	**VBG 1**	**Testagem**	**Referências**
Fichas	704	296	15	939	367	28
Relatório	730	265	29	543	322	34
Reportado a mais	26	0	14	0	0	6
Reportado a menos	0	31	0	396[1]	45	0

Como pode ser visto na tabela acima há diferenças em relação aos números reportados e o que as evidências mostram. Esta situação deve se a fraca organização do arquivo e ainda algumas lacunas no processo de transferência de dados, visto que há casos em que nem todos dados que constam das pastas de arquivo foram lançados na base de dados e ainda casos de dados lançados mais que uma vez dai que a tabela a cima mostra alguns casos de dados reportados a mais.

Tabela 2: Comparação entre os dados reportados e a indicação das fichas (Camionistas e trabalhadoras de sexo nas sessões de debate)

	Março - Maio 2015		Junho - Agosto 2015	
	Camionistas	**Trabalhadoras de sexo**	**Camionistas**	**Trabalhadoras de sexo**
Fichas	568	136	869	70
Relatório	617	115	563	70
Reportado a mais	0	0	0	0
Reportado a menos	49	21	305[2]	

À semelhança dos dados de violência baseada no género, há neste período muitos camionistas não reportados, mesmo com evidência de estes terem participado com sucesso nas sessões de debate. Esta

[1] 285 fichas foram colocadas num período já reportado o que fez com que não fizessem parte do lançamento e só foram descobertas depois de enviar o relatório de Junho – Agosto 2015

[2] 285 fichas foram colocadas num período já reportado o que fez com que não fizessem parte do lançamento e só foram descobertas depois de enviar o relatório de Junho – Agosto 2015

situação deve se a fraca organização do arquivo e ainda algumas lacunas no processo de transferência de dados das fichas para a base de dados.

C. Organização do arquivo

De uma forma geral o arquivo da ANDA KP não facilita o uso de dados (não está bem organizado), o que resultou nas diferenças entre os números reportados e os que realmente as evidências mostram

Ainda como resultado desta falta de organização do arquivo, no período de Junho – Agosto 305 camionistas não foram reportados.

D. Conclusões e Recomendações

A equípa da ANDA, já tem experiencia e habilidades suficientes para conduzirem por si (sem acompanhamento do CAP) o exercício de verificação de dados. Esta conclusão é sustentada pela forma activa com que a equipa da ANDA KP esteve envolvida neste processo.

No que diz respeito ao preenchimento de fichas de recolha de dados no terreno a qualidade é boa, no entanto a equipa de supervisão após a verificação da qualidade do preenchimento não assina, embora seja requisito da própria ferramenta, facto que pode ser interpretado como falta de verificação das fichas por esta equipa de supervisão.

Por forma assegurar melhoria na qualidade, recomenda - se a ANDA maior rigorosidade na revisão do preenchimento das fichas e assinatura das mesmas para validação da qualidade da informação.

Há algumas lacunas no processo de transferência de dados das fichas para a compilação e depois para a tabela de reportagem. Esta situação é visível em algumas diferenças entre os dados reportados e os evidenciados nas fichas de recolha de dados.

O sistema de arquivo é deficiente, facto que origina falhas no lançamento de dados para a reportagem.

No que refere ao arquivo recomenda - se que ANDA faça organização do arquivo de forma a facilitar a identificação e transferência de dados. Este processo deve ser feito num período de uma semana, a partir da data de realização do exercício de verificação de dados.

Dado facto de estes dados já terem sido reportados para USAID, associado facto de fazerem parte do anterior ano fiscal será complicado o seu ajustamento.

Anexo 2: Relatório de Verificação de Dados
Organização: ANDA KP
Data: 17 de Fevereiro de 2016

Introdução

A 17 de Fevereiro de 2016, a especialista de Monitoria e Avaliação do CAP, realizou o exercício de verificação de dados com ANDA KP e, esta esteve representada pela oficial do projecto e dois facilitadores de sessões com camionistas e trabalhadoras de sexo. Esta é a terceira verificação de dados que é realizada com ANDA KP. De referir que o exercício de verificação de dados é feita numa periodicidade anual. No entanto, para ANDA KP no mês de novembro de 2015, foi conduzida um exercício de verificação de dados mas pelos motivos a seguir apresentados, houve a necessidade de não só verificar o seguimento das constatações da anterior verificação, como também conduzir na totalidade um novo processo de verificação de dados, a seguir as motivações:

a. Na verificação de dados feita em Novembro 2015, havia grandes diferenças de números entre os dados reportados e as evidências, especialmente dos camionistas que participaram nas sessões de debate e nas sessões de violência baseada no género. A explicação dada pela ANDA na altura, foi de que no momento da reportagem Junho a Agosto 2015 algumas fichas tinham sido arquivadas em períodos já reportados. Perante esta situação, foi incumbida a ANDA efectuar a devida organização do arquivo. E, como forma de verificar se realmente houve seguimento desta questão, nesta verificação de 17 de Fevereiro, repetiu – se a verificação do trimestre Junho a Agosto 2015 que já tinha sido verificado em Novembro.

b. Considerando que esta é a última verificação de dados (dado o fim do projecto CAP) e face as grandes diferenças de números constatadas em Novembro, (especialmente para os camionistas que por sinal eram os mesmos dados para Violência Baseada no Género, houve a necessidade de verificar se houve ou não melhoria em termos de diferença entre os dados reportados e as evidencias, dai que foi realizada a verificação de todos dados do período de Setembro a Novembro de 2015.

Metodologia usada

A verificação de dados enfocou em dois períodos de reportagem (Junho a Agosto e Setembro a Novembro de 2015). De referir que o período de Junho a Agosto já tinha sido verificado em Novembro 2015, tendo sido incluindo em Fevereiro 2016 para efeitos de verificação do seguimento das recomendações deixadas em Novembro. Nesta verificação de dados foram analisados os seguintes indicadores:

- Numero de cada uma das populações prioritários atingido que completaram os padrões mínimos de prevenção de HIV, incluindo as componentes mínimas necessários durante o período de relatório (Camionistas);
- Número de população de alto risco beneficiada de intervenções de prevenção a nível individual e/ou a nível de pequenos grupos baseados na evidência e/ou no cumprimento dos requisitos mínimos (Trabalhadoras de sexo);
- Número de indivíduos que receberam serviços Aconselhamento e Testagem (AT) e que receberam os seus resultados;
- Número de trabalhadores referidos aos Serviços de Saúde pelas organizações baseadas na comunidade e;

- Número de pessoas abrangidas por uma intervenção ou serviço a nível individual, em pequenos grupos ou comunitário que explicitamente aborde a questão da violência e coerção baseadas no género (VBG 1).

Para o caso das sessões de debates, dado elevado número de fichas foi definida uma amostra de cerca de 63% do total das fichas e, para os restantes indicadores foram analisadas todas fichas dos períodos a cima referidos, e ainda foi feita a comparação dos resultados reportados para nestes períodos em causa com os dados da contagem feita das fontes primárias (fichas de recolha de dados).

Principais Constatações

A. Preenchimento das fichas de sessões de debate e guias de referências

Um total de 139 fichas de debates com camionistas foi verificado para Setembro a Novembro 2015 e 115 referentes ao período de Junho a Agosto. De uma forma geral, as fichas estão bem preenchidas, com excepção de cinco (5) participantes dos debates cujo seu registo não incluía a idade e três fichas que não continham a assinatura do facilitador. Foram ainda verificadas 42 fichas de debates com trabalhadoras de sexo e destas nove (9) participantes não tinham o registo de idade.

B. Comparação dos dados reportados e os dados das fontes primárias (Relatório e Fichas de recolha de dados)

Tabela 1: Dados referentes aos camionistas atingidos pelas sessões de debate (Indicador "Numero de cada uma das populações prioritários atingido que completaram os padrões mínimos de prevenção de HIV, incluindo as componentes mínimas necessários durante o período de relatório").

	Junho - Agosto 2015	Setembro - Novembro 2015	Observações
Fichas	594	620	5 Camionistas sem registo da idade
Relatórios	563	670	
Reportados a mais	0	50	
Reportados a menos	31	0	Os dados reportados a menos são do ano fiscal passado, por essa razão não poderão ser reportados neste ano fiscal

Na verificação de dados de Novembro, cerca de 396 camionistas não tinham sido reportados no período de Junho a Agosto, dado facto de as fichas terem sido colocados num arquivo com dados já reportado. Relativamente a esta análise de Fevereiro, pode se notar que os casos não reportados reduziram, tendo passado de cerca de 46% de não reportagem para cerca de 5%. Para o período de Setembro a Novembro, cerca de 8% dos camionistas reportados não foi encontrada a evidência da sua participação nas sessões de debates, enquanto para o período de Junho a Agosto não foi verificado nenhum caso de reportagem a mais.

Tabela 2: Dados referentes a trabalhadora de sexo atingidos pelas sessões de debate (Número de população de alto risco beneficiada de intervenções de prevenção a nível individual e/ou a nível de pequenos grupos baseados na evidência e/ou no cumprimento dos requisitos mínimos).

	Junho - Agosto 2015	Setembro - Novembro 2015	Observações
Fichas	70	65	Nove trabalhadoras de sexo não tinham o registo de idade
Relatórios	70	70	
Reportados a mais	0	5	
Reportados a menos	0	0	

Em relação a participação das trabalhadoras de sexo nas sessões de debate, para o período de Junho a agosto tanto na verificação de novembro bem com na de fevereiro, não houveram casos de reportagem a mais nem a menos. No entanto, no período de Setembro a Novembro há uma ligeira diferença entre os dados da fonte primária (fichas) e os dados reportados, 5 pessoas. Esta diferença deve se ao facto de cinco trabalhadoras de sexo reportadas pela ANDA não reunirem os requisitos estabelecidos pela ANDA para serem consideradas como atingidas, (ou seja não assistiram o número de sessões estabelecido pela ANDA para serem considerados como atingidos, no entanto ANDA quando fez a sua reportagem de setembro a novembro incluiu estas cinco trabalhadoras de sexo como atingidas).

Tabela 3: Dados referentes aos camionistas e trabalhadoras de sexo atingidos pelas sessões de Violência baseada no género (Número de pessoas abrangidas por uma intervenção ou serviço a nível individual, em pequenos grupos ou comunitário que explicitamente aborde a questão da violência e coerção baseadas no género (VBG 1).

	Junho - Agosto 2015		Setembro - Novembro 2015	
	M	F	M	F
Fichas	594	70	620	70
Relatórios	488	55	670	70
Reportados a mais	0	0	50	0
Reportados a menos	106	15	0	0

A semelhança dos dados de prevenção, para violência baseada no género na verificação de dados de novembro foi observado que cerca de 42% de camionistas com evidência da sua participação não foram reportados e, para esta verificação (fevereiro), foi encontrado cerca de 18% de camionistas com evidência de participação e que não foram reportados. Relativamente as trabalhadoras de sexo da verificação de Novembro, não havia casos de reportagem a mais ou a menos para o período de Junho a Agosto, no entanto, repetida a verificação em fevereiro para o mesmo período, não foi encontrada evidência de participação de 15 trabalhadoras de sexo. Relativamente ao período de setembro a novembro, cerca de 8% de camionistas reportados não foram encontradas evidências da sua participação nas sessões de VBG.

Tabela 4: Dados referentes a pessoas testadas (Número de indivíduos que receberam serviços Aconselhamento e Testagem (AT) e que receberam os seus resultado).

	Junho – Agosto 2015			Setembro – Novembro 2015		
	M	F	Casos positivos	M	F	Casos Positivos
Fichas	248	120	12	294	128	294
Relatórios	222	100	13	271	129	271
Reportados a mais	0	0	1	0	1	0
Reportados a menos	26	20	0	23	0	23

Em relação a testagem, foi observado na verificação de novembro que cerca de 12% de pessoas testadas não tenham sido reportadas para o período de Junho a agosto e, repetido o exercício de verificação para este período nota - se que a situação prevalece. Relativamente a setembro a novembro, nota se igualmente que cerca de 8% dos testados não foram reportados.

Tabela 5: Dados de Referencias de saúde (Número de trabalhadores referidos aos Serviços de Saúde pelas organizações baseadas na comunidade).

	Junho - Agosto 2015		Setembro - Novembro 2015		Observações
	M	F	M	F	
Fichas	17	16	15	10	ANDA KP não possui um sistema que lhe permite verificar as referencias completas de uma forma sistemática, por essa razão não foram analisadas
Relatórios	18	16	15	14	
Reportados a mais	1	0	0	4	
Reportados a menos	0	0	0	0	

Em relação as referências, na verificação de dados feita em Novembro para o período de Junho a Agosto, 6 referencia não tinham evidências ou seja não foram localizadas as guias de referência, repetido o exercício para o mesmo período em fevereiro, apenas uma guia de referência é que não foi localizada. Para o período de setembro a novembro, quatro guias de referência, não foram localizadas.

C. Arquivo de dados

De um modo geral ANDA KP ainda tem desafios em relação ao uso e gestão do arquivo. Esta situação deve se ao facto de qualquer membro da equipa quando precisa de alguma informação, recorre ao arquivo e ninguém assegura se as fichas ou ferramentas que foram retiradas foram devolvidas ao arquivo, por outro lado, fichas usadas para o lançamento de dados nem sempre é assegura que estejam devidamente arquivados nas pastas após o lançamento. Esta situação do deficiente arquivo, já tinha sido identificado na verificação de dados de Novembro e, no entanto continua critica.

Passos seguintes Perante o Constatado

Quanto aos dados de Junho a Agosto

Em relação aos dados de Junho – Agosto, tratando se do ano fiscal já findo, não será possível fazer o ajuste destes dados em função dos resultados da verificação de dados.

Quanto aos dados de Setembro a Novembro

Prevenção

No que diz respeito as sessões de debate: 50 camionistas e 5 trabalhadoras de sexo reportados a mais.

Acção da ANDA KP: Num prazo de 7 dias após a recepção do relatório de verificação de dados, deverá procurar identificar as fichas que contém estes participantes não identificados na altura da verificação e, enviar ao CAP.

Acção do CAP: Caso as fichas contendo os 50 camionistas e as 5 trabalhadoras de sexo não sejam identificadas nos próximos relatórios (Março a Maio) estes números serão ajustados.

Violência Baseada no Género (VBG)

Em relação a este indicador, 50 camionistas foram reportados a mais

Acção da ANDA KP: Num prazo de 7 dias após a recepção do relatório de verificação de dados, deverá procurar identificar as fichas que contém estes participantes não identificados na altura da verificação e, enviar ao CAP.

Acção do CAP: Caso as fichas contendo os 50 camionistas não sejam identificadas nos próximos relatórios (Março a Maio) estes números serão ajustados.

Em relação a testagem

Para este indicador, 23 pessoas do sexo masculino testados (de cordo com a ficha do conselheiro) não foram reportados. Ainda em relação a testagem, 7 pessoas testados positivos não foram igualmente reportados.

Acção da ANDA KP: Com recurso as fichas dos conselheiros e a tabela de testagem do período de Setembro a Novembro, identificar os testados não reportados e os positivos não reportados e incluir no relatório de Março a Maio de 2016 e colocar uma nota no relatório explicando que são casos não reportados no período de Setembro a Novembro.

ANDA KP envia para o CAP as fichas que comprovam estes dados antes de reportar no relatório de Março a Maio.

Acção do CAP: CAP verifica as fichas enviadas pela ANDA referente aos dados reportados a menos e autoriza a ANDA a reportar ou não estes dados no período de Março a Maio.

Referencia para saúde

Quatro referências de saúde cujas guias não foram encontradas durante a verificação de dados

Acção da ANDA KP identificar as guias de referência das quatro pessoas e scanar e enviar ao CAP.

Acção do CAP. Caso não sejam localizadas as fichas estas referências será feito o acerto nos dados de Março a Maio.

Arquivo.
ANDA KP: Assegurar que os arquivos sejam geridos por uma única pessoa e no caso de os outros membros da equipa solicitarem algumas ferramentas deve ser com autorização do gestor do arquivo e este deve assegurar que todas fichas retiradas possam ser devolvidas ao arquivo.
As fichas cujos dados já foram reportados, com recurso a fita-cola selarem as pastas de arquivo.

Acção do CAP: equipa de programa na sua visita de final de Março verificar o cumprimento desta orientação.

Conclusões
Comparativamente a anterior verificação de dados (Novembro de 2015) ANDA demonstrou uma ligeira melhoria no que diz respeito a relação entre os dados reportados e as evidencias, contudo há ainda aspectos a serem melhoradas, especialmente a questão do uso e gestão do arquivo que acaba afectando a qualidade dos dados reportados (reportagem a mais ou a menos).

Anexo 3: Relatório de Verificação de Dados
Organização: KUBATSIRANA
Data: 18 de Fevereiro de 2016

Introdução
A 18 de Fevereiro de 2016, a especialista de Monitoria e Avaliação do CAP, realizou o exercício de verificação de dados com KUBATSIRANA e, esta esteve representada pela oficial de projecto. Esta é a terceira verificação de dados que é realizada com KUBATSIRANA, sendo que a segunda foi realizada em Maio de 2015. De referir que o exercício de verificação de dados é feita numa periodicidade anual, no entanto dado ao facto de o projecto CAP estar no fim, está última verificação foi antecipada, portanto passados 10 meses e não 12 meses conforme o previsto.

Metodologia usada
A verificação de dados enfocou em dois períodos de reportagem (Junho a Agosto e Setembro a Novembro de 2015). Nesta verificação de dados foram analisados os seguintes indicadores:

- Número de trabalhadores referidos aos Serviços de Saúde pelas organizações baseadas na comunidade;
- Número de referências de organizações baseadas na comunidade designadas por completas;
- Número de pessoas activamente procurado através da busca consentida;
- Número de pessoas com resultado definido através da busca consentida;
- Número de pessoas referidas para o serviço de saúde (TARV) através da busca consentida;
- Número de pessoas que voltaram a fazer a medicação por causa da busca consentida e;
- Número de participantes nos grupos de poupança e crédito apoiados pelo PEPFAR.

Principais Constatações

A. Preenchimento das fichas de cartões de busca activa, guias de referências e fichas de seguimento
Fichas de busca: Foi analisado o preenchimento de todas fichas e, todas se apresentavam devidamente preenchidas.

Guias de referência: Verificadas todas guias de referência do período de Junho a Agosto (115) e para o período de Setembro a novembro foram verificadas 210 fichas de um total de 305 e, destas cinco não apresentavam o motivo de referência.

Fichas de seguimento: Verificadas 72 fichas de Machipanda e, destas apenas oito (8) é que apresentaram algumas lacunas de preenchimento, sendo que sete, sem data no detalhe dos serviços e uma com um serviço assinalado sem detalhe. Para Catandica foram analisadas 71 fichas e apenas duas é que não apresentavam data no detalhe do serviço.

B. Transferência de dados da ficha de seguimento para a base de dados
Foram verificadas para os dois períodos 40 fichas e, destas, 8 fichas apresentavam algumas lacunas de lançamento, sendo que seis fichas apresentavam um serviço não lançado na base de dados e uma tinha um serviço na base que não constava da ficha de seguimento.

C. Comparação dos dados reportados e os dados das fontes primárias (Relatório e Fichas de recolha de dados).

Tabela 1: Dados de Referencias de Saúde (Número de trabalhadores referidos aos Serviços de Saúde pelas organizações baseadas na comunidade).

	Junho - Agosto 2015		Setembro -Novembro 2015		Observações
	Cantandica	Machipanda	Cantandica	Machipanda	
Fichas	68	47	230	75	16 Referencias não reportadas em Junho a agosto e 11 referências em setembro reportadas a mais
Relatórios	66	33	235	81	
Reportados a mais	0	0	5	6	
Reportados a menos	2	14	0	0	

Em relação as referências, notam se algumas discrepâncias entre as evidencias e o reportado. Esta situação resulta de algumas falhas no processo de lançamento, aliado ao facto de a verificação ser feita pela mesma pessoa que efectua o lançamento.

Tabela 2: Dados de Referencias Completas (Número de trabalhadores referidos aos Serviços de Saúde pelas organizações baseadas na comunidade).

	Junho – Agosto 2015		Setembro – Novembro 2015		Observações
	Cantandica	Machipanda	Cantandica	Machipanda	
Fichas	97	65	253	76	11 Referências reportadas como completas sem evidência
Relatórios	99	66	255	82	
Reportados a mais	2	1	2	6	
Reportados a menos	0	0	0	0	

À semelhança das referências, as referencias completas também tem algumas possui 11 casos reportados como referencias completas, no entanto não foram encontradas evidencias e, na origem destas ligeiras diferenças está o facto de o lançamento e a verificação der feito pela mesma pessoa.

Tabela 3: Fortalecimento Economico (Número de participantes nos grupos de poupança e crédito apoiados pelo PEPFAR).

	Junho – Agosto 2015				Setembro – Novembro 2015			
	Cantandica		Machipanda		Cantandica		Machipanda	
	Cuidadores	Comunidade	Cuidadores	Comunidade	Cuidadores	Comunidade	Cuidadores	Comunidade
Fichas	2	177	2	3	49	281	5	84
Relatórios	2	172	1	3	24	385	25	150
Reportados a mais	0	0	0	0	0	104	20	66

Reportados a menos	0	5	1	0	25	0	0	0

Como pode ser visto a cima há diferenças significativas em relação ao reportado e o que as evidências mostram, principalmente para o período setembro a novembro. De acordo com a representante da Kubatsirana, o oficial de projectos, essa situação deve se ao facto de a pessoa responsável pelo fortalecimento económico ter um sistema seu de arquivo que não é dominado pela oficial de projectos, facto que dificultou a localização de fichas de alguns grupos de poupança activos.

Tabela 4: Busca activa (Número de pessoas activamente procurado através da busca consentida, Número de pessoas com resultado definido através da busca consentida, Número de pessoas referidas para o serviço de saúde (TARV) através da busca consentida e Número de pessoas que voltaram a fazer a medicação por causa da busca consentida).

	Junho - Agosto 2015								**Setembro - Novembro 2015**							
	Cantandica				**Machipanda**				**Cantandica**				**Machipanda**			
Indicadores	**1[3]**	**2[4]**	**3[5]**	**4[6]**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Fichas	26	26	20	18	44	44	11	11	28	28	15	15	23	23	10	10
Relatórios	28	28	20	14	42	42	11	10	34	34	20	20	18	18	10	10
Reportados a mais	2	2	0	0	0	0	0	0	6	6	5	5	0	0	0	0
Reportados a menos	0	0	0	4	2	2	0	1	0	0	0	0	5	5	0	0

Há ligeiras diferenças entre os dados reportados e os dados das evidências e, estas são devido a algumas falhas no processo de lançamento, aliado ao facto de os dados serem verificados pela mesma pessoa que efectua a entrada de dados.

D. Arquivo de dados

De um modo geral o sistema de arquivo da Kubatsirana é funcional, havendo alguns desafios no arquivo de fortalecimento económico, não permitindo com muita facilidade identificar os grupos em função do seu tempo de criação e início da poupança.

Passos seguintes Perante o Constatado

Kubatsirana: apresenta essencialmente dois grandes desafios:

a. Revisão dos dados feita pela mesma pessoa que faz o lançamento e;
b. Sistema de arquivo para fortalecimento económico.

[3] Número de pessoas activamente procurado através da busca consentida

[4] Número de pessoas com resultado definido através da busca consentida

[5] Número de pessoas referidas para o serviço de saúde (TARV) através da busca consentida

[6] Número de pessoas que voltaram a fazer a medicação por causa da busca consentida

Revisão dos dados feita pela mesma pessoa que faz o lançamento

Acção da Kubatsirana: Assegurar que os dados após o lançamento sejam revistos com por menor por uma outra pessoa diferente da que fez a entrada de dados.

Acção do CAP: Fazer seguimento do cumprimento desta orientação em finais de Março pela equipa de programa, especialmente para os dados de Março a Maio.

Sistema de arquivo para fortalecimento económico.

Acção da Kubatsirana: Num período de 7 dias após a recepção do relatório de verificação de dados, Kubatsirana deverá organizar o arquivo de fortalecimento económico de forma a torna - lo de fácil consulta.

Acção do CAP: Fazer seguimento seja via telefónica/e - mail em relação a esta questão.

Conclusões

A qualidade de dados de Kubatisrana, foi evoluído desde a primeira verificação de dados no que tange a qualidade, estando nesta terceira verificação de dados com níveis de diferenças aceitáveis (até de 3%), sendo que nas verificações anteriores, a de 2014 as diferenças se situavam em cerca de 10%. Esta redução das discrepâncias entre o reportado e as evidências demostra que as recomendações que foram sendo dadas nas anteriores verificações de dados estão sendo tidas em consideração. De referir que a recolha de dados (preenchimento da ficha de seguimento), teve uma melhoria bastante considerável, tendo na primeira verificação de dados rodando em cerca de 60% das fichas com lacunas de preenchimento, passado para cerca de 8% em 2015 e nesta verificação está Kubatisrana com menos de 3% de fichas com lacunas de preenchimento

No entanto a questão do arquivo de fortalecimento económico, já identificado nas anteriores verificações de dados ainda necessita de ser melhorada.

Anexo 4: Relatório de Verificação de Dados
Organização: ANDA OVC
Data: 16 de Fevereiro de 2016

Introdução
A 16 de Fevereiro de 2016, a especialista de Monitoria e Avaliação do CAP, realizou o exercício de verificação de dados com ANDA OVC e, esta esteve representada pela assessora do gestor de projecto, oficial de fortalecimento económico e o oficial de prevenção. Esta é a quarta verificação de dados que é realizada com ANDA OVC, sendo que a terceira foi realizada em Maio de 2015. De referir que o exercício de verificação de dados é feita numa periodicidade anual, no entanto dado ao facto de o projecto CAP estar no fim, está última verificação foi antecipada, portanto passados 10 meses e não 12 meses conforme o previsto.

Metodologia usada
A verificação de dados enfocou em dois períodos de reportagem (Junho a Agosto e Setembro a Novembro de 2015). Nesta verificação de dados foram analisados os seguintes indicadores:

- Número de indivíduos que receberam serviços Aconselhamento e Testagem (AT) e que receberam os seus resultados;
- Número de trabalhadores referidos aos Serviços de Saúde pelas organizações baseadas na comunidade;
- Número de referências de organizações baseadas na comunidade designadas por completas;
- Número de pessoas abrangidas por uma intervenção ou serviço a nível individual, em pequenos grupos ou comunitário que explicitamente aborde a questão da violência e coerção baseadas no género (VBG 1),
- Número de população alvo alcançado com intervenções a nível individual e/ou a nível de pequenos grupos baseados na evidência e/ou no cumprimento dos requisitos mínimos;
- Número de pessoas que concluíram uma intervenção referente a norma de género que atenda aos critérios mínimos e;
- Número de participantes nos grupos de poupança e crédito apoiados pelo PEPFAR.

Para os indicadores a cima listados, foram analisadas todas fichas para os dois períodos.

Principais Constatações

A. Preenchimento das fichas de sessões de debate, guias de referências e fichas de seguimento
Fichas de Sessões de debate: Foi analisado o preenchimento de todas fichas e, todas se apresentavam devidamente preenchidas.

Guias de referência: Verificadas cerca de 200 guias de referência e, destas apenas quatro é que não tinham a colocação do bairro nos dados de identificação dos referidos.

Fichas de seguimento: Verificadas 128 fichas, sendo 60 para Junho a Agosto e 68 para Setembro a Novembro e, destas apenas seis (6) é que apresentaram algumas lacunas de preenchimento, sendo que três tinham serviços assinados sem detalhe no verso, uma com detalhe sem data e duas com detalhe sem indicação do serviço prestado.

B. Transferência de dados da ficha de seguimento para a base de dados

Foram verificadas para os dois períodos 65 fichas e, destas 7 fichas apresentavam algumas lacunas de lançamento, sendo que quatro crianças que receberam serviços os nomes não constavam da base de dados, duas tinham recebido um serviço e que este não constava da base de dados e uma tinha um serviço registado na base de dados e que não faz parte da ficha de seguimento.

C. Comparação dos dados reportados e os dados das fontes primárias (Relatório e Fichas de recolha de dados).

Tabela 1: Dados referentes as sessões de debate - Prevenção (Indicador "Número de população alvo alcançado com intervenções a nível individual e/ou a nível de pequenos grupos baseados na evidência e/ou no cumprimento dos requisitos mínimos").

	Junho – Agosto 2015		Setembro – Novembro 2015		Observações
	M	F	M	F	
Fichas	91	109	19	34	Não encontradas evidencias de participação de 18 pessoas em Junho a Agosto e 19 pessoas de Setembro a Novembro
Relatórios	109	108	20	53	
Reportados a mais	18	0	0	19	
Reportados a menos	0	1	0	0	

Em relação as sessões de prevenção, como pode ser visto na tabela a cima, tanto no período de Junho a Agosto assim como de Setembro a Novembro, houveram casos de reportagem a mais. Questionada ANDA sobre esta situação, referiu que existiam sim fichas de sessões que comprovam a participação destas pessoas, no entanto, no momento da verificação não conseguiram localizar devido ao deficiente arquivo, podendo segundo ANDA ter algumas fichas em pastas de outros períodos.

Tabela 2: Dados referentes a violência baseada no género (Indicador "Número de pessoas abrangidas por uma intervenção ou serviço a nível individual e ou em pequenos grupos comunitários que explicitamente abordam a questão da violência e coerção baseadas no género -VBG 1).

	Junho – Agosto 2015		Setembro – Novembro 2015		Observações
	M	F	M	F	
Fichas	98	110	20	53	17 Pessoas reportadas não foram encontradas a evidência da sua participação
Relatórios	111	113	19	53	
Reportados a mais	14	3	0	0	
Reportados a menos	0	0	1	0	

À semelhança das sessões de prevenção, para o período de Junho a Agosto, houveram casos de participantes reportados, que não foi encontrada nenhuma evidência da sua participação e, para ANDA OVC o sistema de arquivo é que não permite localizar de imediato. No entanto, para setembro a Novembro, já se observa uma grande melhoria, como pode ser visto na tabela a cima com diferença de apenas uma pessoa entre os dados reportados e as evidencias encontradas nos arquivos.

Tabela 3: Dados referentes VBG 10 horas (Indicador "Número de pessoas que concluíram uma intervenção referente a norma de género que atenda aos critérios mínimos).

	Junho - Agosto 2015		Setembro - Novembro 2015		Observações
	M	F	M	F	
Fichas	91	109	19	34	Não encontradas evidencias de participação de 18 pessoas em Junho a Agosto e 19 pessoas de Setembro a Novembro
Relatórios	109	108	20	53	
Reportados a mais	18	0	0	19	
Reportados a menos	0	1	0	0	

Em relação a este indicador, como pode ser visto na tabela a cima, tanto no período de Junho a Agosto assim como de Setembro a Novembro, houveram casos de reportagem a mais. Questionada ANDA sobre esta situação, referiu que existiam sim fichas de sessões que comprovam a participação destas pessoas, no entanto no momento da verificação não conseguiram localizar.

Tabela 4: Testagem (Número de indivíduos que receberam serviço de aconselhamento e testagem (AT) e que receberam seu resultados).

	Junho - Agosto 2015		Setembro - Novembro 2015	
	M	F	M	F
Fichas	44	64	61	63
Relatórios	53	75	26	32
Reportados a mais	9	11	0	0
Reportados a menos	0	0	35	31

Para o caso dos dados não reportados, ANDA OVC referiu que esses dados foram recebidos após a elaboração do relatório, dai não ter sido possível efectuar o lançamento, enquanto que para os reportados a mais refere – se a alguma falha de lançamento.

Tabela 5: Dados de Referencias de Saúde (Número de trabalhadores referidos aos Serviços de Saúde pelas organizações baseadas na comunidade).

	Junho - Agosto 2015		Setembro - Novembro 2015		Observações
	M	F	M	F	
Fichas	40	83	50	95	Algumas guias de referência são entregues depois da reportagem
Relatórios	43	77	51	81	
Reportados a mais	3	0	1	0	
Reportados a menos	0	6	0	14	

Em relação as referências, notam se alguns casos de referencias não reportados e, de acordo com ANDA OVC esta não reportagem deve – se à entrega tardia das guias pelos assistentes comunitário, não tendo permitido que estes dados sejam lançados.

Tabela 6: Dados de Referencias Completas (Número de trabalhadores referidos aos Serviços de Saúde pelas organizações baseadas na comunidade).

	Junho - Agosto 2015		Setembro - Novembro 2015		Observações
	M	F	M	F	
Fichas	91	122	99	138	Não foram localizadas as contra referências de 37 casos reportados como completas.
Relatórios	96	124	117	150	
Reportados a mais	5	2	18	12	
Reportados a menos	0	0	0	0	

Em relação as referencias completas, ANDA mais uma vez referiu existirem sim estas referencias completas, no entanto, o mecanismo de arquivo, não está a facilitar a identificação, podendo estas referencias completas terem sido colocadas em outros arquivos.

Tabela 7: Fortalecimento Economico (Número de participantes nos grupos de poupança e crédito apoiados pelo PEPFAR).

	Junho – Agosto 2015		Setembro – Novembro 2015	
	Cuidadores	Comunidade	Cuidadores	Comunidade
Fichas	9	104	77	324
Relatórios	9	75	77	324
Reportados a mais	0	0	0	0
Reportados a menos	0	29	0	0

Observado na verificação de dados que 29 participantes dos grupos de poupança, não foram reportados e, esta situação deveu - se a algumas falhas no processo de transferência de dados das fichas para a base de fortalecimento económico.

D. Arquivo de dados

O arquivo da ANDA OVC tem desafios, não tem um gestor do arquivo, para cada serviço o responsável faz a gestão do seu arquivo, facto que em alguns casos dificulta a identificação e compreensão dos dados para quem é responsável pelos dados. Por outro lado, nota se nos arquivos da ANDA há retirada de fichas nos devidos arquivos e sem a devida reposição, facto que ao longo da verificação de dados influenciou na não identificação de algumas pessoas consideradas como atingidas mas no entanto sem nenhuma evidência.

Passos seguintes Perante o Constatado

ANDA OVC apresenta essencialmente dois grandes desafios:

c. A recepção tardia de alguns dados por parte dos assistentes sociais, principalmente quando há necessidade de rectificar algum aspecto na ficha e;
d. Uso e gestão do arquivo.

Recepção tardia das fichas/Daddos não reportados

Acção da ANDA OVC: assegurar que recebem todos dados antes de terminar o processo de compilação de dados, incluindo aquelas fichas que são devolvidas para alguma rectificação. Para os dados de Setembro a Novembro não reportados, ANDA pode incluir no relatório de Março a Maio, colocando uma nota referindo que se trata de dados de Setembro a Novembro.

Acção do CAP: No relatório de Março a Maio, certificar que realmente foram também reportados os dados em falta para o trimestre setembro a novembro.

Uso e gestão do arquivo

Acção da ANDA OVC: Sugere - se que ANDA identifique um um gestor dos arquivos e, deverá ser este o responsável pela gestão do arquivo, que inclui o controlo da retirada de fichas e a colocação em pastas a apropriadas todos dados. Para todas pastas cujos dados já foram reportados, selar as pastas para assegurar que nenhuma ficha seja retirada.

Conclusões

Comparativamente a anterior verificação de dados (Maio de 2015) ANDA OVC mantém a qualidade verificada na última verificação de dados, com uma média de menos de 5% de diferenças entre os dados reportados e as evidencias. No entanto, a questão do uso e gestão do arquivo continua sendo um grande desafio.

Anexo 5: Relatório de Verificação de Dados
Organização: Niiwanane
Data: 29 de Fevereiro de 2016

Introdução
A 29 de Fevereiro de 2016, a especialista de Monitoria e Avaliação do CAP, realizou o exercício de verificação de dados com Niiwanane e, esta esteve representada pelos activistas chefe, técnico de fortalecimento económico e os responsável pela busca activa. Esta é a quarta verificação de dados que é realizada com Niiwanane, sendo que a terceira foi realizada em Março de 2015.

Metodologia usada
A verificação de dados enfocou em dois períodos de reportagem (Junho a Agosto e Setembro a Novembro de 2015). Nesta verificação de dados foram analisados os seguintes indicadores:

- Número de trabalhadores referidos aos Serviços de Saúde pelas organizações baseadas na comunidade;
- Número de referências de organizações baseadas na comunidade designadas por completas;
- Número de participantes nos grupos de poupança e crédito apoiados pelo PEPFAR.
- Número de pessoas activamente procurado através da busca consentida;
- Número de pessoas com resultado definido através da busca consentida;
- Número de pessoas referidas para o serviço de saúde (TARV) através da busca consentida;
- Número de pessoas que voltaram a fazer a medicação por causa da busca consentida e;

Para a análise do preenchimento das fichas de seguimento, dado numero elevado, houve a necessidade de definição de uma amostra, tendo sido considerado 10% do total das fichas de seguimento para cada bairro, desta forma foram analisadas 157 fichas para Napipine e 162 fichas para Natiquire. Para os restantes indicadores a cima listados foram analisadas todas fichas.

Principais Constatações

A. Preenchimento das fichas de sessões de debate, guias de referências e fichas de seguimento

Guias de referência: Verificadas cerca de 250 fichas de referência, o preenchimento é bom, tendo sido observadas 5 fichas sem motivo de referência.

Fichas de seguimento: Verificadas no total319 fichas, tendo sido observado que há um bom preenchimento, apenas oito (8) fichas é que apresentaram algumas lacunas de preenchimento, sendo que quatro (4) não tinham a data no detalhe, duas sem assinatura da animadora e as restantes havia discordância entre as datas registadas para os serviços e as datas colocadas no detalhe.
Fichas de busca - activa: verificadas cerca de 30 cartões de busca e, foi observado que todos estavam devidamente preenchidos.

B. Transferência de dados da ficha de seguimento para a base de dados

Foram verificadas para os dois períodos 30 fichas e, destas quase todas a informação estava devidamente transferida, com excepção de duas fichas cujos nomes não foram localizados na base e uma que tinha um serviço que não estava registado na base de dados.

C. Comparação dos dados reportados e os dados das fontes primárias (Relatório e Fichas de recolha de dados).

Tabela 1: Dados de Referencias de Saúde (Número de trabalhadores referidos aos Serviços de Saúde pelas organizações baseadas na comunidade).

	Junho – Agosto 2015				Setembro - Novembro 2015			
	Napipine		Natiquire		Napipine		Natiquire	
	M	F	M	F	M	F	M	F
Fichas	41	77	37	44	10	27	18	17
Relatórios	47	64	36	42	10	25	18	17
Reportados a mais	6	0	0	0	0	0	0	0
Reportados a menos	0	13	1	2	0	2	0	0

Em relação as referências, notam se alguns casos de referências não reportados e, de acordo com Niiwanane, trata se de algumas guias de referência que os animadores/activistas chefes enviaram ao responsável de dados após a reportagem. Maior número de casos foi observado no período de Junho a Agosto, tendo melhorado significativamente em Maio, como resultado da sensibilização da equipa pela coordenação da Niiwanane para entrega atempada das guias.

Tabela 2: Dados de Referencias Completas (Número de trabalhadores referidos aos Serviços de Saúde pelas organizações baseadas na comunidade).

	Junho – Agosto 2015				Setembro - Novembro 2015			
	Napipine		Natiquire		Napipine		Natiquire	
	M	F	M	F	M	F	M	F
Fichas	91	110	77	90	11	24	24	21
Relatórios	80	85	75	90	11	26	24	21
Reportados a mais	0	0	0	0	0	2	0	0
Reportados a menos	11	25	2	0	0	0	0	0

Em relação as referencias completas, houveram ligeiras diferenças no período de Junho a Agosto e, á semelhança das referências, estas não foram reportadas devido a chegada tardia das guias para o lançamento.

Tabela 3: Fortalecimento Economico (Número de participantes nos grupos de poupança e crédito apoiados pelo PEPFAR).

	Junho – Agosto 2015		Setembro – Novembro 2015	
	Cuidadores	**Comunidade**	**Cuidadores**	**Comunidade**
Fichas	12	96	122	538
Relatórios	13	98	112	506
Reportados a mais	1	2	0	0
Reportados a menos	0	0	10	32

Observado na verificação de dados que 42 participantes dos grupos de poupança não foram reportados e, esta situação deveu - se a questão do arquivo que não se apresenta devidamente organizado, dificultando a identificação de alguns membros dos grupos de poupança, por cada período de inicio da poupança.

Tabela 4: Busca activa (Número de pessoas activamente procurado através da busca consentida, Número de pessoas com resultado definido através da busca consentida, Número de pessoas referidas para o serviço de saúde (TARV) através da busca consentida e Número de pessoas que voltaram a fazer a medicação por causa da busca consentida).

	Junho – Agosto 2015								Setembro – Novembro 2015							
	Napipine				Natiquire				Napipine				Natiquire			
Indicadores	**1**[7]	**2**[8]	**3**[9]	**4**[10]	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Fichas	19	2	0	0	9	2	0	0	9	2	0	0	0	0	0	0
Relatórios	16	2	0	0	9	2	0	0	9	2	0	0	0	0	0	0
Reportados a mais	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reportados a menos	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

D. Arquivo de dados

O sistema de arquivo da Niiwanane, ainda tem alguns desafios, principalmente para busca activa e fortalecimento económico, não facilitando uma identificação rápida dos documentos. Esta situação já tinha sido observada nas anteriores verificações de dados, no entanto ainda prevalecia. Face a esta situação a especialista de monitoria organizou um arquivo para mostrar a Niiwanane como deveria ser feito.

Passos seguintes Perante o Constatado

[7] Número de pessoas activamente procurado através da busca consentida

[8] Número de pessoas com resultado definido através da busca consentida

[9] Número de pessoas referidas para o serviço de saúde (TARV) através da busca consentida

[10] Número de pessoas que voltaram a fazer a medicação por causa da busca consentida

Niiwanane, apresenta dois pequenos desafios, sendo a recepção tardia de algumas guias de referência e a questão do arquivo.

Recepção tardia das fichas/Dados não reportados
Acção da Niiwanane: Já está a tomar alguma acção, sensibilizando a equipa, recomenda - se que continue com essa sensibilização da equipa de campo.

Acção do CAP: Dado fim do projecto, não mais terá possibilidade de verificar este seguimento.

Organização do arquivo
Acção da Niiwanane: Dar seguimento a organização dos arquivos, de acordo com o modelo deixado pelo.

Acção do CAP: Organizar uma pasta modelo para Niiwanane seguir (já feito pelo CAP a 1 de Março).

Conclusões
Niiwanane, continua demostrando grandes melhorias na qualidade de dados reportados. Comparativamente a anterior verificação de dados Março de 2015 (onde houveram casos de reportagem a mais em busca activa – 69 casos e Fortalecimento económico 209 casos não reportados), comparando com os actuais resultados, é evidente que houve uma grande melhoria, não sendo observado nenhum caso reportado a mais para busca activa e para fortalecimento económico apenas 3 casos comparativamente a mais de 200 casos observados na última verificação de dados. Esta melhoria deve se em parte ao envolvimento de mais pessoas na verificação do lançamento de dados, caso concreto dos activistas chefes.

Anexo 6: Relatório de Verificação de Dados
Organização: ABANHE - CHIMOIO
Data: 15 de Fevereiro de 2016

Introdução
A 15 de Fevereiro de 2016, a especialista de Monitoria e Avaliação do CAP, realizou o exercício de verificação de dados com ABANHE (Sub-parceiro da HACI) e, esta esteve representada pela oficial do programa e três supervisores de campo. Esta é a primeira verificação de dados realizada com ABANHE. De referir que o exercício de verificação de dados é feita numa periodicidade anual. No entanto, dado facto de a HACI estar a trabalhar com 7 sub-parceiros, não foi possível que durante a vigência do projecto, todos pudessem beneficiar de mais que uma verificação de dados directa do CAP, tendo sido dada a responsabilidade de verificação a HACI.

Metodologia usada
A verificação de dados enfocou em dois períodos de reportagem (Março a Maio e Setembro a Novembro de 2015). Nesta verificação de dados foram analisados os seguintes indicadores:

- Número de beneficiários servido por programas de PEPFAR para OVC e famílias afetadas pelo HIV/SIDA
- Número de trabalhadores referidos aos Serviços de Saúde pelas organizações baseadas na comunidade e;
- Número de referências de organizações baseadas na comunidade designadas por completas

Foram analisadas cerca de 648 fichas para os dois períodos.

Principais Constatações

A. Preenchimento das fichas de sessões de debate e guias de referências
Um total de 648 fichas de seguimento foram analisadas no que diz respeito ao preenchimento e, destas apenas 52 fichas é que não se apresentava devidamente preenchidas, sendo que algumas apresentavam alguns serviços assinalados e sem o detalhe no verso e outras sem a colocação de data no detalhe do verso.

B. Transferência de dados das fichas de seguimento para a base de dados
Em relação a transferência de informação da ficha para a base de dados para o período de Março a Maio 2015, foi analisado o lançamento na base de dados (transferência de dados da ficha de seguimento para a base de dados) de 40 fichas, tendo estas sido escolhidas das 648 referentes a amostra da alínea anterior e, destas foi constatado: 2 fichas com serviços assinalados mas que não constavam da base; 7 nomes que não constavam da base que no entanto receberam serviços.

Para Setembro a Novembro, foi analisada a transferência de dados de 32 fichas e, destas 5 nomes não constavam da base de dados e 5 com serviços assinalados na ficha e não lançados na base de dados.

C. Comparação dos dados reportados e a base de dados da ABANHE

Tabela 1: Dados referentes aos beneficiários servidos (Indicador Número de beneficiários servido por programas de PEPFAR para OVC e famílias afetadas pelo HIV/AIDS).

	Março - Maio 2015	Setembro - Novembro 2015	Observações
Base da Abanhe	5	575	Na base de dados da ABNHE as 14 crianças tinham recebido serviço mas não assinaladas como atingidas
Relatórios	5	589	
Reportados a mais	0	0	
Reportados a menos	0	14	

Como pode ser visto na tabela a cima, não há diferenças muito significativa entre os dados enviados pela ABANHE a HACI e os que a HACI reportou ao CAP e, estas diferenças devem se ao facto de ABANHE na sua base de dados ter o registo de alguns beneficiários que receberam serviços, no entanto não foram assinalados como atingidos.

Tabela 2: Dados de Referencias de saúde (Número de trabalhadores referidos aos Serviços de Saúde pelas organizações baseadas na comunidade).

	Março - Maio 2015	Setembro - Novembro 2015	Observações
Fichas	127	80	ABANHE tem um deficiente sistema de arquivo para as referencias, por outro lado há pouca rigorosidade no processo lançamento o que há alguns casos resulta em duplicação. Há algumas referências que estavam com os activistas para seguimento, tendo os activistas facultado os dados das referências via SMS para a reportagem.
Relatórios	189	65	
Reportados a mais	62	0	
Reportados a menos	0	25	

Em relação as referências de saúde nota se uma diferença entre os dados reportados e os que possuem evidência e, o facto deve se ao deficiente arquivo, sendo que existem algumas referências feitas pelos activistas e que ainda estão com os activistas, tendo passado os dados para ABANHE no período de reportagem via SMS. Segundo ABANHE estas guias permanecem com os activistas para efeitos de seguimento. Em relação a este procedimento de recepção de dados vis SMS, foi advertido a ABANHE que sempre que reportam dados precisam ter evidencia, portanto sempre que estão em período de reportagem todos os dados devem estar no escritório para o lançamento e, terminado o lançamento para casos que necessitam de seguimento os activistas já podem levar as guias mas assegurando que haja uma indicação das guias que foram retiradas do arquivo e assegurar que a quando da devolução, estejam devidamente arquivadas.

Percebendo o processo de lançamento da ABANHE, há algumas limitações (por exemplo interrompe o lançamento de dados na base e não há devida sinalização da última ficha lançada), facto que em alguns casos propícia a duplicação de referências, o que justifica em parte o elevado número de referências reportadas e que não foram encontradas as devidas guias. Estas diferenças são igualmente observadas

para referencias a outros serviços, caso da educação, onde temos referencias reportadas mas não foram encontradas algumas evidências destas referências.

Tabela 3: Dados de Referencias completas: (Número de referências de organizações baseadas na comunidade designadas por completas)

	Março – Maio 2015	Setembro – Novembro 2015	Observações
Fichas	214	156	Durante o processo de reportagem, alguns casos de referência ainda estavam com os activistas para verificar se elas já são completas ou não, tendo sido entregues a ABANHE depois do lançamento dos dados.
Relatórios	229	123	
Reportados a mais	15	0	
Reportados a menos	0	33	

Em relação as referências completas, foi observado que há algumas fichas que não foram identificadas e segundo ABANHE essas fichas estão com os activistas mas a informação foi passada via SMS no momento da reportagem, por outro existem outras que estão com os activistas e estes não passaram a informação para a coordenação da ABANHE durante o processo de reportagem dai a existência de dados reportados a menos.

D. Arquivo de dados

O arquivo das fichas de seguimento é bem feito, no entanto, para as referências ainda há necessidade de melhoria do arquivo.

Passos seguintes Perante o Constatado

Quanto aos beneficiários servido por programas de PEPFAR para OVC e famílias afetadas pelo HIV/SIDA

HACI: Caso ABANHE queira usar a mesma base de dados em próximos projectos de OVC, HACI poderá reforçar o uso da base de dados e reforçar também a necessidade de os dados após o lançamento serem revistos por mais que uma pessoa.

Referencia para saúde e referencias completas

HACI: Aconselhar a ABANHE para no caso de referências que necessitam de seguimento, a equipa da ABANHE tenha o devido registo e, à semelhança dos outros dados a contagem das referencias deve ser feita por mais que uma pessoa.

Arquivo

HACI: Organizar uma pasta de arquivo modelo para ABANHE, especialmente para as referencias.

Nota: Dado facto de o projecto estar no fim, CAP não terá acções de seguimento para ABANHE.

Conclusões

ABANHE está a fazer um bom trabalho de recolha de dados, há alguns desafios mas está a níveis aceitáveis (menos de 5%) de falhas na transferência. No entanto, no que diz respeito ao sistema de arquivo, especialmente para as referencias, ainda necessita de melhorar.

Rede Internacional de Acção pela Alimentação do Bebé (IBFAN)

Project Assessment

Capable Partners Program (CAP Mozambique) FHI 360

November 2015

CAPABLE PARTNERS PROGRAM Mozambique

I. Introduction

CAP Mozambique prepared this assessment to share with potential donors and partners its view as a donor of IBFAN's performance in implementing a project with CAP Mozambique funds (through USAID/PEPFAR). The assessment includes data on project performance, data from assessments conducted by CAP to evaluate IBFAN organizational capacities, and scores from a self-assessment. The project being evaluated was jointly managed – IBFAN as the technical lead and Associação Moçambicana para o Desenvolvimento da Família (AMODEFA) as the fiscal agent. AMODEFA is a member of the IBFAN network.

As a capacity-building organization that provides grants to sub-recipients, CAP monitors its projects very closely. CAP staff thoroughly reviewed IBFAN's proposals and budgets, annual planning documentation, and quarterly reports; conducted monthly and eventually quarterly field visits to activities; facilitated annual data verification visits; and reviewed all transactions in monthly financial reports. CAP helped NAFEZA identify gaps in technical capacity and provided technical assistance to expand the organization's capacity to meet beneficiary needs with quality programming. CAP staff challenged IBFAN to use its data for decision-making and provided technical assistance to help the organization develop the core systems necessary to improve implementation and enhance resiliency. This proximity allowed CAP a unique perspective on IBFAN's performance.

II. Organizational Background

Rede Internacional de Acção pela Alimentação do Bebé (IBFAN) is a network established in 1996. It comprises of voluntary organizations working to improve the health and nutrition of mothers and their children through protection, support and the promotion of good infant and young child feeding practices.

III. Project Description

From September 1, 2010 to March 31, 2015, IBFAN implemented the "Well-nourished Children Free of HIV" project through nine network members in Maputo City and Maputo province (see box). The project was funded by USAID/PEPFAR with a grant that was managed by FHI 360's Capable Partners Program (CAP) Mozambique. In addition to the implementation grant, CAP also provided organizational and technical assistance (TA) to help IBFAN expand its role in the fight against HIV/AIDS. The budget for this grant period was 19,479,219 MT (USD $533,677). AMODEFA, one of IBFAN´s members with a history of receiving donor funding and implementing HIV/AIDS projects, acted as the fiscal agent for this project.

Implementing Partners

Associação Nacional de Enfermeiros de Moçambique (ANEMO)

Associação Moçambicana para o Desenvolvimento da Família (AMODEFA)

Homens Contra Sida (HOCOSIDA)

Associação Mulher, Lei e Desenvolvimento (MULEIDE)

Associação Moçambicana Para Apoio e Desenvolvimento da Criança Órfã (Reencontro)

AAES (Associação dos Activistas de Educação para Saúde)

Associação Para Recreação Infantil (Ndyoko)

Associação de Nutrição e Segurança Alimentar (ANSA)

Comité da Mulher Trabalhadora (COMUTRA)

The goal of the project was to increase the number of mothers implementing good infant feeding practices in the context of HIV/AIDS and issues related to gender-based violence. Key project beneficiaries included pregnant and lactating women, their husbands, elderly women/mothers-in-law, community leaders, and

health workers. Through home visits and debates, IBFAN counselled women (and their husbands) on babies' health issues, vaccinations, hygiene, postpartum issues, family planning, exclusive breast feeding, and gender-based violence. Through cooking demonstrations IBFAN showed communities how to enrich staple food for infants and young children such as porridge to be more nutritious.

The objectives of the project were to:

- Increase the knowledge of individuals in the area of infant feeding, gender-based violence, and agricultural and nutritional components of infant feeding to increase their capacity to transmit correct messages to project beneficiaries.
- Create an environment conducive to pregnant and lactating mothers to adopt good infant feeding practices in the context of HIV/AIDS and issues related to gender-based violence in the districts of Katembe, Kamavota, Hlamanculo, Kamaxaquene, Kamubukwane, Marracuene and Machava in Maputo City and Province.

IBFAN activistas discuss infantile nutrition during a home visit.

- Increase knowledge and skills of members of IBFAN through capacity building activities during the project.

IV. Project Results

The table below illustrates the targets and final results for the entire IBFAN project for key indicators.

Indicator	Target	Result
Number of Supervisors and Activistas trained	394	612
Number of pregnant and lactating women reached through home visits and counseling	6740	7312
Number of elderly women reached through home visits and counseling	1372	2890
Number of husbands (of pregnant and lactating women) reached through home visits and counseling)	986	2402
Number of individuals referred to health services	630	1764
Number of individuals with completed health referrals	475	1608

V. Organizational Growth

Through CAP Mozambique, IBFAN (and appropriate AMODEFA staff as fiscal agents for the grant award) received training and technical assistance in these areas: Governance & Leadership, Strategic Planning, Monitoring & Evaluation, Project Management, Financial

Management, Facilitation Techniques, Formative Research, Project Design, Gender and Gender-based Violence, Network Role & Structure, Organizing a General Assembly, Internal Controls, Code of Conduct, Policies & Procedures, Human Resources (including staff recruitment), Fiscal Council, and others.

CAP Mozambique recognizes IBFAN's strong points and the progress they have made, as well as the areas where the organization demonstrates room for further improvement. IBFAN is a well-respected partner and appreciated for the following strengths:

- IBFAN serves a critical need in Mozambique as one of few Ministry of Health (MoH) partners providing nutritional support for children to complement the work of health units at the community level. IBFAN closely follows MoH policies, and its curriculum and trainers are pre-approved by the MoH. IBFAN has built a credible reputation within the MoH, and is frequently invited to participate in meetings regarding infant nutrition and consulted for input on strategic shifts in infant nutrition at the national level.

- Programmatically, IBFAN is well respected by MoH and the communities in which it works. During the life of the grant, the network improved supervision of activities and performance. The network consistently met its targets. The quality of facilitation – both of debate sessions and food preparation demonstrations – improved significantly over time. IBFAN struggled to maintain its database for accurate reporting, but improved over time. Late in the life of its grant award, IBFAN initiated the referral and counter-referral system with its implementing partners. This is one area that IBFAN could have acted upon earlier in the life of the project.

Feeding children with enriched foods following nutritional demonstrations.

- IBFAN presented good practices in formative research during a MoH meeting, and was invited to train MoH Nutrition Department staff in formative research techniques.

- IBFAN worked diligently in the last few years of its grant to achieve independence and prepare for direct funding from donors for nutritional activities. The network was tasked with developing and approving its policies and procedures, improving financial management systems, and hiring appropriate staff to assume administrative responsibilities. IBFAN successfully managed to complete the majority of these tasks. A final policies and procedures manuals were submitted to its Board of Directors, but has not yet been approved.

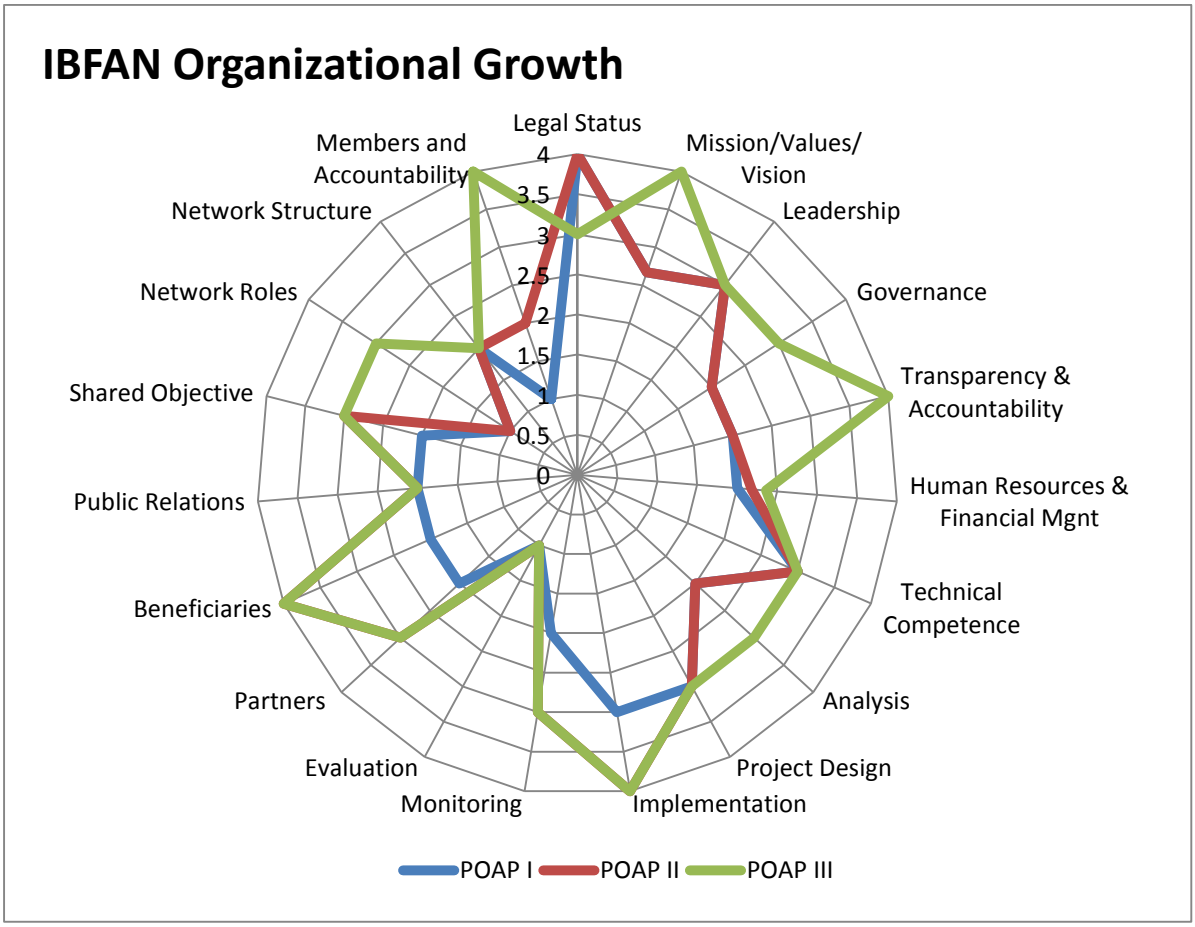
- The complexity of joint management over this grant award (IBFAN as technical lead, AMODEFA as the fiscal agent), made it challenging for IBFAN to resolve all of its issues with its donor (CAP Mozambique). IBFAN worked hard to solve any challenges

that arose during implementation, and acted with integrity throughout the life of the grant.

- In the final year of the grant, IBFAN's Board of Directors became much more active – meeting more regularly and engaging more in the life of the network. As a result, the President of the Board (also the Executive Director of an organization within the network) requested specific support from CAP Mozambique for his own organization.

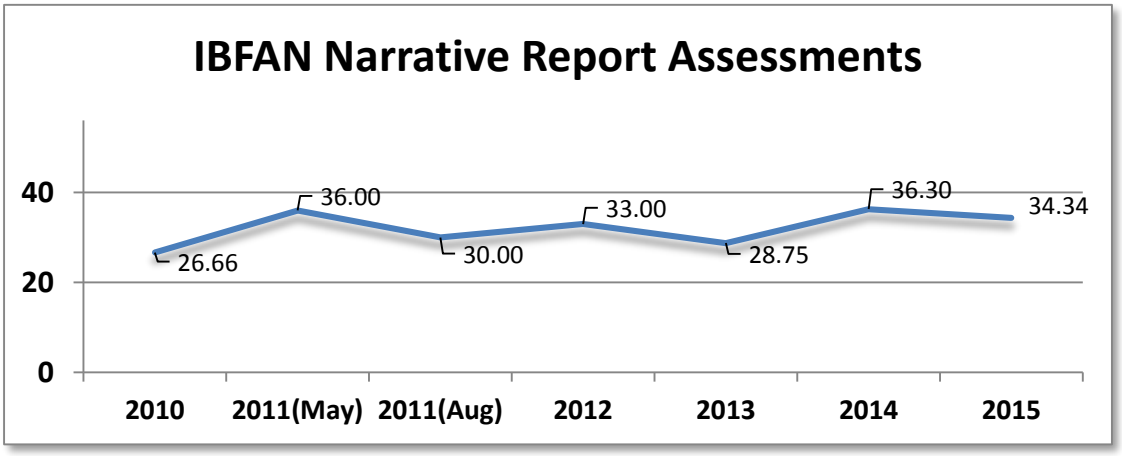
To measure growth, CAP Mozambique conducted two assessments at intervals during the life of IBFAN's project. An external report writing assessment was conducted by CAP staff to measure change in report writing capacity over time. A participatory self-assessment was facilitated with IBFAN to score its own institutional growth against various programmatic and organizational categories. During the life of the award, CAP Mozambique conducted seven reporting writing assessments and facilitated three self-assessments with IBFAN.

Participatory Organizational Assessment Process (POAP)
CAP facilitated three Participatory Organizational Assessment Processes with IBFAN, through which the network rated itself across multiple organizational development domains. The network's growth is illustrated through the spider graph presented below. IBFAN's first POAP as a network was conducted in 2012, the second in 2014, and the final in 2015. The POAP has four levels: 1 = Emerging, 2 = Growing, 3 = Consolidating, and 4 = Sustainable. As demonstrated below, IBFAN moved into the sustainable range in multiple categories, notably in its accountability to network members, relationship with beneficiaries, mission/vision/values, implementation, and transparency/accountability.



Report Writing

CAP Mozambique assessed IBFAN's capacity to produce quality narrative reports over time. The maximum score possible is 54. This table demonstrates how IBFAN scored on the reporting writing assessment. The reliability of IBFAN's data was confirmed through field visits by CAP staff (minimum quarterly), and an annual data quality verification exercise.



VI. Conclusion

IBFAN is well respected by the community, the government, and donors. The network remains faithful to its mission and its beneficiaries, and has credibility with stakeholders for the positive work it does. IBFAN surpassed the majority of its project targets, and greatly increased the quality of facilitation during debate sessions and presentations. IBFAN responded well to capacity building efforts, as the organization continued to improve in technical and organizational development areas over time.

Núcleo das Associações Femininas da Zambézia (NAFEZA)

Project Assessment

Capable Partners Program (CAP Mozambique) FHI 360

November 2015

CAPABLE PARTNERS PROGRAM Mozambique

I. Introduction

CAP Mozambique prepared this assessment to share with potential donors and partners its view of NAFEZA's performance in implementing a project with CAP Mozambique funds (through USAID/PEPFAR). The assessment includes data on project performance, data from assessments conducted by CAP to evaluate NAFEZA technical and organizational capacities, information from a CAP Mozambique impact study on HIV prevention activities, and scores from a self-assessment.

As a capacity-building organization that provides grants to sub-recipients, CAP monitors its projects very closely. CAP staff thoroughly reviewed NAFEZA's proposals and budgets, annual planning documentation, and quarterly reports; conducted monthly and eventually quarterly field visits to activities; facilitated annual data verification visits; and reviewed all transactions in monthly financial reports. CAP helped NAFEZA identify gaps in technical capacity and provided training and technical assistance to expand the organization's capacity to meet beneficiary needs with quality programming. CAP staff challenged NAFEZA to use its data for decision-making and provided technical assistance to help the organization develop the core systems necessary to improve project implementation and enhance organizational resilience. This proximity allowed CAP a unique perspective on NAFEZA's performance.

II. Organizational Background

NAFEZA (Núcleo das Associações Femininas da Zambézia), was founded in 1997 as an initiative from three women's associations (AMUDDEZA, ACTIVA, ADDOM). Its creation was guided by the vision to *"form a strong intervening network, representing civil society in Zambézia province that ensures women's empowerment through information and training interventions, using mechanisms that pressure the government to create policies and programs to benefit women."* NAFEZA is made up of 53 member associations located in the 17 districts of the Zambézia province, with the exception of three (Inhassunge, Chinde e Lugela).

NAFEZA Training Activistas in SBCC in 2012.

NAFEZA's mission is to *"coordinate member organizations´ interventions and implement activities to promote women, gender equity and women´ rights."* It´s objectives are to (i) contribute to minimizing the differences between men and women and increase women' position by coordinating and strengthening civil society interventions on behalf of women in the Province of Zambézia (especially in the areas of agriculture, education, health, women's rights, the fight against poverty, violence against women and HIV/AIDS); (ii) promote access to information, training and education of women; pressure the government to adapt and implement policies that creates gender equity and women empowerment, in politics and programs, and introduce positive changes to gender relations as well as contributing to building the capacity of its members.

III. Project Description

From May 1, 2012 to September 30, 2015, NAFEZA implemented the "Listen to the Message about HIV/AIDS" project in Zambezia province. The project was funded by USAID/PEPFAR with a grant that was managed by FHI 360's Capable Partners Program (CAP) Mozambique. In addition to the implementation grant, CAP also provided organizational and technical assistance (TA) to help NAFEZA expand its role in the fight against HIV/AIDS. The budget for this grant period was 16,233,660 MT (USD $586,053).

The goal of the project was to contribute to reducing the risk of HIV infection among adolescents, youth, and couples in identified communities in Nicoadala and Inhassunge districts, Zambezia province. The objectives of the project were to:

- Reduce the practice of unprotected sexual activity within couples and young people in selected communities.
- Strengthen the motivation of adolescents to delay the onset of sexual activity
- Strengthen the capacity of the NAFEZA structure and its member organizations to intervene in the community.
- Promote access of people in communities to health facilities.

HIV prevention debates held in the community.

Key project beneficiaries included pre-adolescents (10-14 years), adolescents (15-17 years), youth (18-25 years), and adults. Secondary target audiences includes parents, traditional educators, mothers, and community leaders. NAFEZA facilitated community dialogues, conducted peer education, provided counseling and testing services, provided health referrals, conducted ART defaulter-tracing, conducted home visits to screen for gender-based violence and supported victims to access services to meet the objectives of this project.

IV. Project Results

Table 1: NAFEZA targets and final results for key indicators of the life of the project

Indicator	Target	Result
Number of Supervisors and Activistas trained	149	138
Number of individuals reached with a cycle of HIV/AIDS prevention sessions	8,186	10,548
Number of individuals reached with messages related to gender-based violence (GBV) prevention and mitigation	3,134	9,705
Number of individuals tested for HIV	538	781
Number of referrals to health services	3,563	7,497
Number of completed referrals	111	1,254
Number of individuals screened for gender-based violence	110	208
Number of leaders trained	90	90

In 2014, a CAP End line Prevention Survey was conducted to evaluate the impact of the Social Behavior Change Communication (SBCC) HIV prevention activities implemented by CAP Partners, including NAFEZA. This cross-sectional household survey interviewed 1,531 people in four provinces, including Zambezia. Propensity Score Matching was used to assess program impact — comparing respondents who were exposed to CAP (n=624) to those not exposed (n=299) to any HIV programming the past 6-12 months. The results listed in the graphs below include contributions from NAFEZA to specific behavior changes and gender beliefs.

Figure 1: % of individuals that responded positively to changing HIV-related behaviors

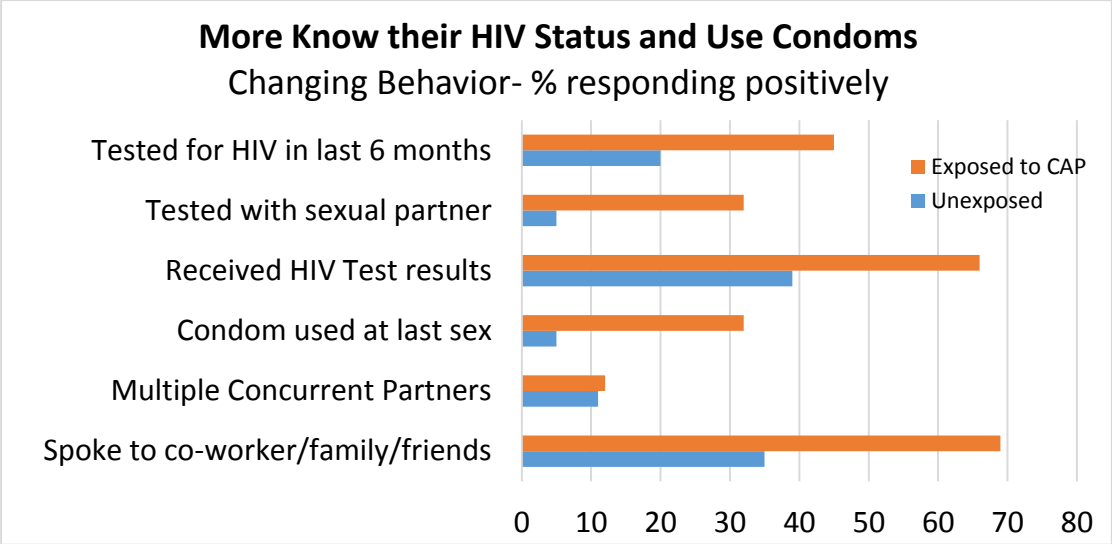
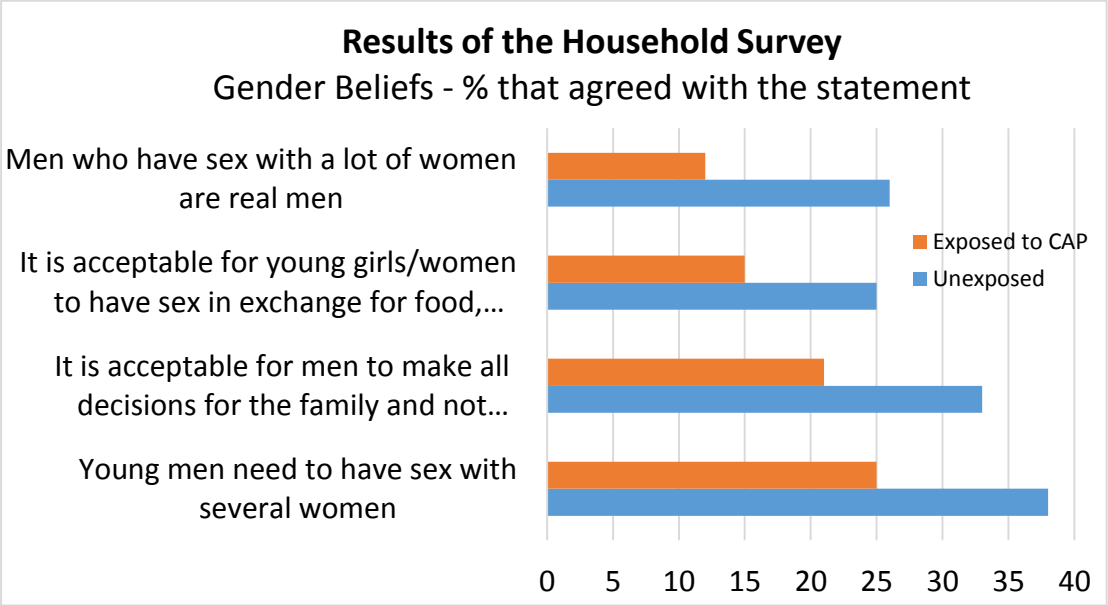


Figure 2: % of individuals that agreed with statements about gender beliefs



V. Organizational Growth

Through CAP Mozambique, NAFEZA received training and technical assistance in these areas: Governance & Leadership, Strategic Planning, Monitoring & Evaluation, Proposal Design and Development, Social Behavior Change Communication, Gender and Gender-Based Violence, Project Management, Financial Management, Facilitation Techniques, Network Role & Structure, Organizing a General Assembly, Internal Controls, Code of Conduct, Policies & Procedures, Human Resources, Resource Mobilization, Fiscal Council, and others.

CAP Mozambique recognizes NAFEZA's strong points and the progress they have made. They are a well-respected partner and appreciated for the following strengths:

- **Governance:** NAFEZA has a clear separation of roles between the Board of Directors (*conselho de direcção)* and staff. The Board has regular meetings documented with minutes. The Fiscal Council is becoming more active and organized. The most recent general assembly was organized according to statues and best practices. All members were invited with sufficient notice and information and documents were shared ahead of time, allowing time for review.

- **External Relations:** NAFEZA is well known within the provincial government and has excellent relationships with them. NAFEZA implements projects in collaboration with several governmental institutions, such as the police, health authorities, services to assist victims of violence, social action, etc. NAFEZA always consults with the community when designing new projects. Often, the Executive Director is directly involved in these consultations to ensure that NAFEZA is responding effectively to the community.

- **Programmatic Performance:** NAFEZA exceeded its planned targets for the project, following a slow start at the beginning of the project. NAFEZA negotiated with the target group to organize two sessions per week to allow them to recover from this slow start, allowing them to exceed their targets in the end. NAFEZA responded rapidly to the opportunity to refer beneficiaries to testing and counseling and mobilized CT services. Also, when asked about their interest in doing GBV screening, NAFEZA quickly gathered information on available services and mobilized to conduct this activity. The quality of supervision of field activities has increased significantly in the past two years. The Executive Director has a new appreciation for how monitoring and evaluation (M&E) is also a management tool and has requested assistance in designing an M&E system that captures all of the organization's activities. As demonstrated below, NAFEZA has demonstrated consistent growth in its SBCC capacity over time.

- **Financial and Administrative Management** – NAFEZA expanded its finance team based on CAP's recommendations following graduation to ensure segregation of duties. Performance has improved since this change was made. NAFEZA's administrative, financial, and human resources policies and procedures have been approved by its board. They have conducted performance reviews for all staff except the Executive Director. The policies and procedures manual outlines a segregation that discourages dishonest practices. NAFEZA has revised its chart of accounts to include those codes more applicable for their organization, and are using accounting software to professionalize their accounting systems. Financial reports are submitted on time.

To measure growth, CAP Mozambique conducts various assessments with grant recipients at intervals during the life of the project, including:

- **External Assessments** – These are used to complement and add objectivity to the self-assessment data gathered through the POAP, and include Financial Health, Social Behavior Change Communication, and Report Writing assessments.

- **Participatory Organizational Assessment Process (POAP)** – This is a participatory self-assessment used for grant recipients to score their own institutional growth against various programmatic and organizational categories.

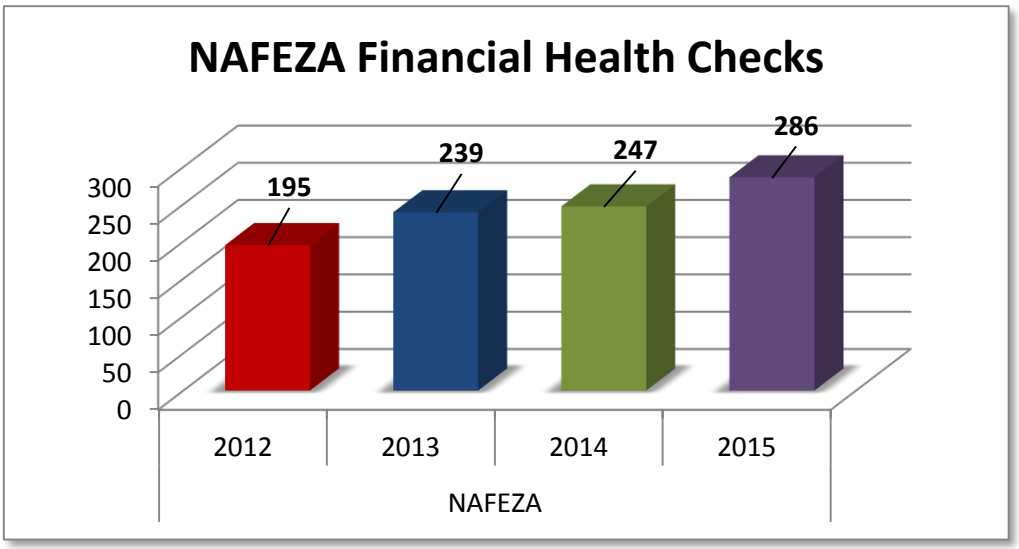
- **Graduation Assessment** – This is a rigorous desk review, site visit, and in-depth discussion to evaluate the organization's programmatic, financial, and organizational performance in order to recommend candidates to USAID for a direct grant award.

For NAFEZA, CAP conducted four Financial Health Checks, four SBCC Assessments, six Report Writing Assessments, and six POAPs. In addition, NAFEZA was assessed through CAP's graduation process, as discussed in Section VI.

Financial Health

The Financial Health Check[1] ranks organizations according to set criteria to gauge financial and administrative health of the organization. NAFEZA has improved with each subsequent financial health check, remaining in the Low Risk category for the last two assessments, as highlighted in Figure 3 below. NAFEZA has approved its strategic plan, improved its archives, conducts appropriate procurement processes, maintains assets on an inventory list, has begun using a chart of accounts and cost centers, and has greatly improved the quality of its financial reports to CAP. NAFEZA's Fiscal Council is increasingly active and conducts internal compliance reviews. The Board has full control of membership contributions and internal funds are kept in a separate account.

Figure 3: NAFEZA Financial Health Check Scores from 2012 - 2015

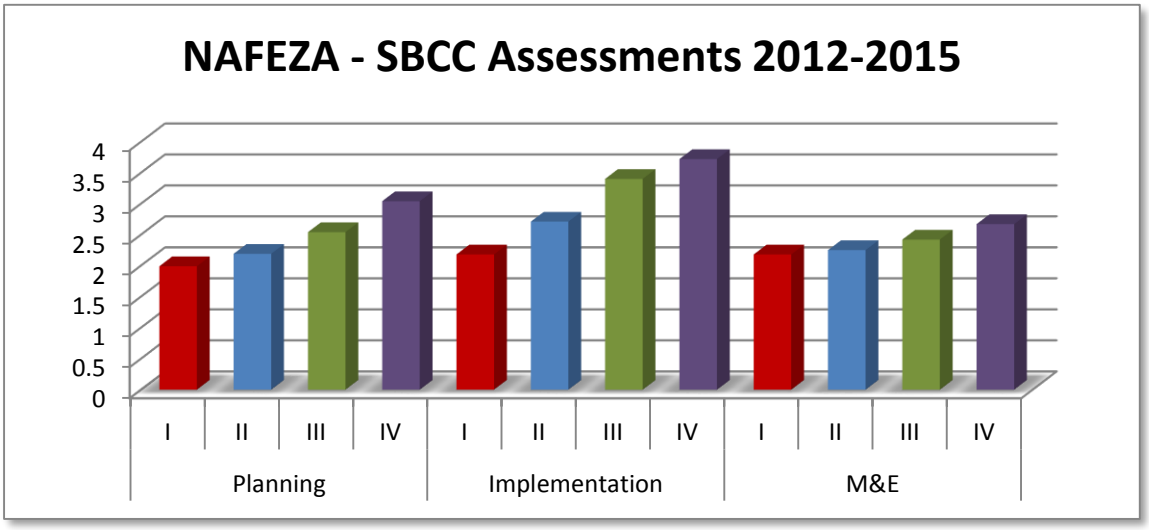


[1] Based on the Financial Health Check® developed by MANGO, a UK – based NGO.

Social Behavior Change Communication

NAFEZA has demonstrated consistent growth in SBCC since the first assessment conducted with the organization in 2012. Between 2012 and 2015, over four different SBCC assessments, the organization's global score has increased from 2.11 to 3.19, illustrating a 51.18% improvement. A maximum score of 4 in each category is possible. The graph below illustrates growth over the four assessments in the three main assessment categories: Planning & Design, Implementation, and M&E. As shown in Figure 4 below, NAFEZA has demonstrated consistent growth in all three areas over time, in particular in the implementation of SBCC activities.

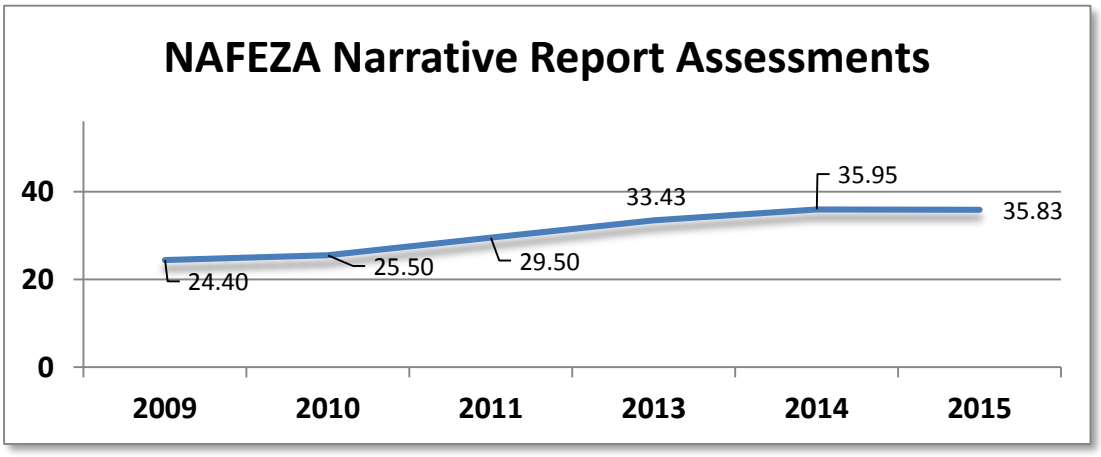
Figure 4: NAFEZA Social Behavior Change Assessment Scores from 2012 – 2015



Report Writing

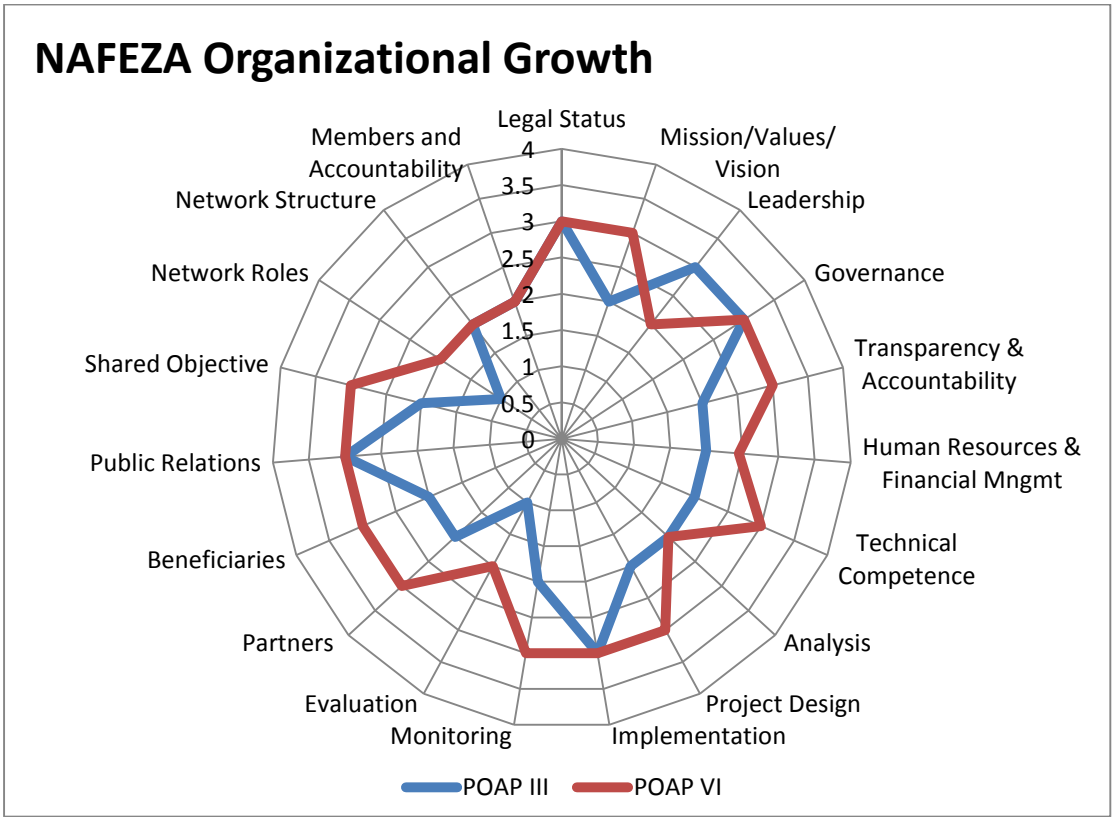
CAP Mozambique assessed NAFEZA's capacity to produce quality narrative reports over time. The maximum score possible is 54. This table demonstrates how NAFEZA scored on the reporting writing assessment over time. The reliability of NAFEZA's data was confirmed through field visits by CAP staff (minimum quarterly), and an annual data quality verification exercise.

Figure 5: NAFEZA's Narrative Report Assessment Scores from 2009 - 2015



Participatory Organizational Assessment Process (POAP)
NAFEZA participated in six POAPs, through which the network rated itself across multiple organizational development domains. NAFEZA's first POAP was conducted in 2008, and the most recent in 2015. The network's growth during the life of the grant award described in this assessment is illustrated through the spider graph presented below, with change between POAP III (2012) and POAP IV (2015). The POAP has four levels: 1 = Emerging, 2 = Growing, 3 = Consolidating, and 4 = Sustainable. As demonstrated on the following page, NAFEZA improved in multiple areas, particularly in programmatic capacity and in their role as a network.

Figure 6: NAFEZA Organizational Change Between POAP III (2012) and POAP IV (2015)



VI. Graduation Assessment

In February 2014, CAP Mozambique assessed NAFEZA through its graduation process, which evaluates candidates to be recommended to USAID for a direct grant award. In this process, CAP Mozambique determined that NAFEZA was not yet ready to graduate, and provided the organization with conditions (mainly linked to financial systems) that would need to be met in order to graduate. In July 2014, CAP Mozambique assessed NAFEZA's progress in complying with these requirements, and determined that the organization had in fact responded satisfactorily to CAP's recommendations. The organization was recommended for direct-USAID funding as a result. NAFEZA is one of only eight organizations to graduate according to CAP's rigorous standards.

VII. Conclusion

NAFEZA demonstrated incredible growth over the past four years. The organization expanded its team, and implementation is now strong and effective. It demonstrated its capacity to adapt its program to include new activities in gender-based violence awareness,

screening, and referral, HIV care and treatment defaulter tracing, and HIV testing and counseling. At the same time, NAFEZA's capacity to accurately report on project data improved over the years, and the organization became one of CAP's stronger performers in data collection and reporting. NAFEZA's financial and administrative systems have proven responsive to capacity development, resulting in the establishment and use of solid policies and procedures, internal controls, and consistent financial reporting. NAFEZA is a strong advocate for the communities it supports and engages them effectively in design and implementation. The network's internal governance processes have improved; board members are dedicated and want to contribute to the network. The network is well respected by the government, beneficiaries, and donors.

MAURO VOMBE | FHI 360

MOZAMBICAN CSOs RISE TO THE CHALLENGE: GOOD GOVERNANCE IN PRACTICE

Shifting Accountability from Donors Back to CSOs

Early in its ten-year institutional strengthening project, the Capable Partners Program (CAP) in Mozambique struggled with poor performance by a number of civil society organizations (CSOs) that had received grant funds to implement HIV/AIDS programs. Warnings to CSO leadership were sent, suspension letters were issued, and yet, in some cases, there was still no change. CAP met with the Boards of Directors of these program Partners and organizational development (OD) Clients[1] as a last effort and was surprised at what it discovered.

In many of these organizations, CSO Board members were also employees of those same organizations. Without a clear separation between the roles and responsibilities of staff and the Board and Fiscal Council, it was impossible for these organizations to be held accountable by anyone other than their donors. In fact, Mozambican CSOs widely believed that donors should be accountable for project activities, not their own organizations' Board and Fiscal Councils. When CAP first began working with its CSO

[1] CAP distinguished between Partners and OD Clients. CAP provided HIV/AIDS implementation grants to the former. OD clients received grants and support for program implementation and financial reporting from other sources. CAP provided both Partners and OD Clients with assistance on their core organizational systems (e.g., internal governance, policies and procedures, financial management).

Learning to Address a Sensitive but Critical Issue

A 2015 survey of 20 CAP Mozambique Partners regarding changes to their internal governance showed significant improvements in core systems. Furthermore, it showed that leadership had begun taking more care to ensure accountability for their grants and project activities. These important gains were hard-won. For CAP Mozambique, as an international donor-funded project, tackling internal governance issues with Mozambican CSOs was a challenging and sensitive process.

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Partners, only seven organizations (of 20 CAP Partners surveyed) were being guided by current strategic plans, and only seven had Board-approved policies and procedures (see figures on the following pages).

CAP encountered governing bodies that had little understanding of what was going on inside their organizations. In the case of one CSO (eventually terminated for poor performance and suspected financial mis-management), the Board of Directors was not even aware the organization had received funding from CAP. The lack of knowledge about the role and function of governing bodies was perpetuating a lack of accountability within Mozambican CSOs. Only ten CSOs (out of 20 surveyed) had ever conducted Board or Fiscal Council visits to field activities.

Like most donors, CAP expected its CSO Partners to have internal checks and balances in place to ensure effective project implementation and transparent use of funds. However, most local CSOs were unaware of these expectations, uninformed about their roles, and ignorant as to how to execute their responsibilities. Both donors and CSOs alike expressed frustration with the lack of accountability as project activities were not realized, funds were not accounted for, and grants were terminated. Donors were reluctant to offer funds to local CSOs for fear of seeing them misused again and had little confidence in the capacity of local CSOs to independently manage projects and funds. In the process, the Government of Mozambique's willingness to engage with and "hear" civil society was also negatively affected. This crisis of confidence jeopardized the sustainability of project activities as well as the effectiveness of organizations and civil society itself.

Rather than continuing to simply terminate grants with CSOs that lacked necessary systems, accountability, and transparency, CAP made the strategic decision to tackle the highly sensitive governance issue head on. CAP knew that in order for its investment in Mozambican civil society to evolve into lasting change—ensuring that grant funds were transformed into quality programs to improve lives and that organizational changes were sustained beyond the life of CAP—it would have to learn how to increase the capacity of CSO Boards and Fiscal Councils to recognize their duties as stewards of their organizations.

The Right Mix: Knowledge + Tools + Practice + Incentives for Change

For CAP, as an international donor-funded project, tackling internal governance issues with Mozambican CSOs was not a straightforward process. First, there was a learning curve to understand how Mozambican CSO Boards and Fiscal Councils are structured and intended to operate, the legal framework regulating Mozambican CSOs, and typical challenges and opportunities related to CSO governance. Next, CAP experimented with the best mix of interventions that would increase understanding about the importance of good governance, provide tools to operationalize this new understanding, and support internal processes associated with the practice of good governance.

CAP Mozambique

CAP Mozambique was funded by the U.S. Agency for International Development (USAID) and the President's Emergency Plan for AIDS Relief (PEPFAR) and implemented by FHI 360. It was designed to strengthen the capacity of leading Mozambican organizations to contribute to the fight against HIV/AIDS and gender-based violence. From 2006 to 2016, CAP Mozambique integrated intensive capacity development of its Partners with grants to provide the organizations with opportunities to apply what they learned and demonstrate their capacities to affect HIV/AIDS at the community level. CAP Mozambique not only enhanced technical capacity, but also addressed organizational structures and systems, including financial and administrative systems and internal governance.

Self-assessments and training create a foundation

CAP's Governance, Leadership, and Management (GLM) course became the foundation for all subsequent work on CSO governance. Malawian CSO expert Chiku Malunga traveled to Mozambique to design and conduct the initial trainings, which provided a framework for understanding the roles and responsibilities of CSO governing bodies and, by default, the staff of the organization as well. These trainings were eye-opening for CAP's Partners, who had not understood that the roles of staff and governing bodies should be separate—or what the consequences might be if they were not. CSOs began requesting support in organizing and conducting their General Assemblies. In these (typically) annual events, new members are elected to governing bodies; annual reports, workplans, and budgets are approved; and other strategic and administrative matters are resolved.

Obstacles to change surfaced. Some Board members did not want to give up control of project implementation. Others refused to relinquish their staff positions (and forfeit salaries or other incentives). Although the separation of Board and staff roles is a concept embedded in Mozambican CSO law, the drive to make concrete changes was coming from a donor. CAP knew it needed to tread carefully, and that real changes would only result if they came from the organizations themselves.

CAP used its Participatory Organizational Assessment Process (POAP), an institutional strengthening process that fosters transparency and accountability, to mobilize CSO staff and Board members to discuss internal governance issues and decide when and how to tackle them. Board members as well as staff from all CAP CSOs engaged in self-assessments and prepared capacity development plans. Governance was a hot topic. Skilled facilitation enabled each organization to discuss internal problems—and solutions—often for the very first time in an open and safe space. Links were made between poor programmatic performance and the lack of transparency and accountability. It became clear to the CSOs that tackling their internal governance issues was imperative to improving the quality of their work.

Governance Structure of CSOs in Mozambique

The Mozambican Law of Associations prescribes three governing bodies for Mozambican associations: the General Assembly of Members, the Board (Conselho de Direcção), and a Fiscal Council (Conselho Fiscal). The Board provides regular oversight, while the General Assembly meets at least once a year. The Fiscal Council ensures that the other bodies adhere to their own processes (including documented policies and procedures to guide the governing bodies).

Operationalizing good theory with practical tools

As CAP dove deeper into this process, it became clear that CSOs also lacked the tools they needed to build stronger internal governance. Tailored training with CSOs helped them sort out the roles and responsibilities within their organizations. This in turn led CSOs to revise their statutes (which describe the characteristics of the given organization, the governing bodies and the policies that regulate them, and procedures for revising the statutes and holding General Assemblies). Often, CSO statutes had been written by individuals outside the organizations without organizational input. Sometimes these statutes were not consistent with Mozambican law. Clarifying policies and procedures in these statutes was a key first step. Over time, CAP worked with Partners to develop several tools and to articulate clear processes to operationalize the very general statutes.

"Before, we elected people [Board members] based on our familiarity with them."
—CSO Partner
Auxilio Sem Fronteras

In 2015, CAP assembled these tools into a comprehensive one that provided a guide for developing association bylaws fully aligned with Mozambican law. Titled Regulations for Governing Bodies and Members (*Regulamento de Orgãos Sociais e Membros*—ROSME), it provides an easily accessible guide for Mozambican CSOs to improve internal governance. As Mozambican civil society is relatively nascent, this is a key step in professionalizing the sector in the country.

With all of these positive improvements in internal governance focused on transparency and accountability, a key issue had yet to be addressed. Many Board members were selected based on their relationships with individuals in the organization (familial or otherwise), and some had few qualifications for their roles. As CAP OD Client Auxilio sem Frontereiras (ASF) said, "Before we elected people based on our familiarity with them." CAP worked with CSOs to develop Board Profiles, which outlined the tasks and responsibilities for different governing members, and advised CSOs to present these Profiles for consideration at annual General Assembly meetings as tools for transparent recruitment.

CAP also helped organizations develop the tools necessary to hold CSO staff accountable. Training, technical assistance, and financial resources were provided to CSOs to create strategic plans and human resources policy and procedure manuals.

Grants create incentives for change

As with each step in this journey, the incentives for committing time and energy to make changes were not always clear to participating CSOs. Not all donors were concerned about their grant recipients' strategic goals, and many donors opted to impose their own policies and procedures on CSOs rather than accept each organization's policies or foster their creation.

CAP STAFF SHARES FINANCIAL ASSESSMENT RESULTS WITH PARTNER BOARD AND STAFF. (FHI 360)

CAP's approach was different. It supported organizational autonomy by putting resources into improving CSO capacity to create their own tools and apply them. It then held them accountable. The grant award was a key mechanism to motivate CSOs to change. For example, CSOs that wanted to include salary increases within their multi-year grant awards, or during grant modification processes, quickly learned that increases were not accepted unless accompanied by Board-approved salary scales, policies, and a performance evaluation process. Other incentives were created as well. For example, only organizations with Board-approved strategic plans were invited to participate in CAP Mozambique's resource mobilization program to identify potential new funding sources.

Fiscal Councils learn to ensure accountability

CSO capacity and interest in governance was growing, and yet one critical piece was still missing. The majority of organizations had limited understanding about the role of the Fiscal Council—the governing body responsible for ensuring that CSO statutes and internal policies and procedures are being followed. Even some of CAP's most sophisticated Partners assumed the Fiscal Council was a sub-committee under the Board of Directors, when in fact the Fiscal Council is the body with the highest level of accountability for the organization.

CAP Mozambique trained CSO staff, Board members, and Fiscal Council members on CSO financial management and internal controls using the course titled *Practical Financial Management for NGOs*, developed by Mango, a British NGO focused on strengthening the financial management and accountability of other NGOs. CSOs began to internalize that their own governing bodies—not their donors—are ultimately responsible for what their organizations do or do not do.

PARTNER STAFF EXPLAINS RESULTS TO THE TEAM. (MAURO VOMBE | FHI 360)

During the course and through follow-up technical assistance, CAP Mozambique walked Partners step by step through key processes to learn for themselves how to operationalize the guidance they were receiving. Fiscal Council members, for example, were tasked with choosing an organizational procedure, checking the files and interviewing staff to see if/how the procedure was being implemented, and following up if they were not. For most, it was the first time that they deeply examined the organization for which they were responsible. Over time, CAP Mozambique Partners realized the value of a Fiscal Council's contribution to improving financial systems, whereas before the Council was seen as a dispensable body whose presence neither helped nor hindered the organization from functioning effectively.

CAP CSOs Model Good Governance in Practice

CAP CSOs are more accountable than they were before, and they accept that accountability rests with them. Governing members are reviewing proposals before they are submitted to donors, visiting field activities, approving annual reports and workplans, conducting internal audits, reviewing and approving organizational policies and procedures, and much more. For most Mozambican CSOs, these changes have been revolutionary.

CAP measured changes in governance through three processes: a mid-term evaluation (21 organizations surveyed), the POAP (24 organizations assessed), and a governance survey conducted with 20 CSOs participating in CAP training/TA.

"There [has been] a major upgrade in Partner governance—in the division of responsibilities between Board and staff, and internal coordination applied to the entire organization. The impact of this is much better leadership and coordination at the district level, better ability to problem solve, and 'more union,' which allows for a more sustainable presence in the community."
—CAP Partner responding to mid-term evaluation survey

CAP's capacity development work with 21 Partner CSOs was assessed in 2013 through an external mid-term evaluation.[2] The evaluation found that:

Strong support to organizations´ governance structures and internal controls helps the Partners become more transparent, systematic, and stable, allowing them to improve services in the areas of HIV/AIDS prevention and OVC care. Project implementation is carried out in a more enabling environment, and there is an increased probability that the Partner will continue to support the communities after the CAP project is completed due to well-functioning organizational systems.

When examining one cohort of Partners, 13 organizations (of 24 assessed) improved their scores in the POAP with regard to internal governance. Ten organizations improved their scores in the area of transparency and accountability. These scores were determined by the organizations themselves through self-assessments; however, organizations were required to show concrete evidence—statues, registration, policies and procedures manuals, and so forth—to back up the scores.

To measure change from the CSOs' perspectives, CAP Mozambique surveyed 30 people from 20 CSO Partners to identify improvements in internal governance and the effects on their organizations. CSO Board members and executive staff (usually the executive director) were asked to describe various governance processes both before and after CAP interventions. Before CAP's support, only seven CSOs said they had a clear understanding of the roles and responsibilities of governing members and staff, whereas all 20 said they had a clear understanding following CAP support. Associação Rubatano, a CAP OD Client, described the positive effect on their project: "The quality of activities on the ground improved, because the community health workers were no longer Board members and could spend more time working in the community." Other Partners echoed this sentiment, claiming that Board members could now focus on resource mobilization and strategic direction, and also help promote the organization among donors.

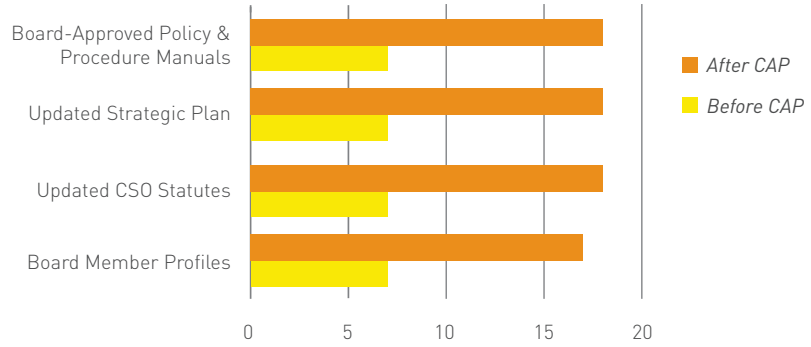
"[For us], management of project funds has become more transparent now that it is clear who does what."
—CAP Partner Ophavela

Figure 1 (see next page) describes several areas of improvement. Following CAP support, 18 CSOs had Board-approved strategic plans and 18 had Board-approved policy and procedure (P&P) manuals. This accomplishment took some CSOs more than two years to achieve. But as a result, CSOs also gained bargaining power with donors—they now have firm foundations from which to negotiate benefits, travel policies, and other policies as new grant awards are developed. The existence of written policies has increased transparency and reduced conflicts. As CAP OD Client Centro Aberto Barué e das Irmãs Reparadoras do Sagrado Coração de Jesus (CA Barue) explained: "All of our members [now] have the same rights."

Eighteen CSOs, compared to seven CSOs prior to CAP's support, now have updated statutes. These organizations are now complying with Mozambican law and have clear guidelines for governing member roles and responsibilities.

[2] Blid N., D'Alessio O'Donnell C., Souto M., Parviainen R. (2013) External Evaluation for Capable Partners Program (CAP)–Mozambique Final Evaluation Report.

FIGURE 1: NUMBER OF CSOs WITH TOOLS TO SUPPORT CSO PERFORMANCE BEFORE AND AFTER CAP SUPPORT (N=20)



"Our new finance manual has lots of instruments that we used before, but they were not written down as policies. [Our] manuals are based on the laws of Mozambique."

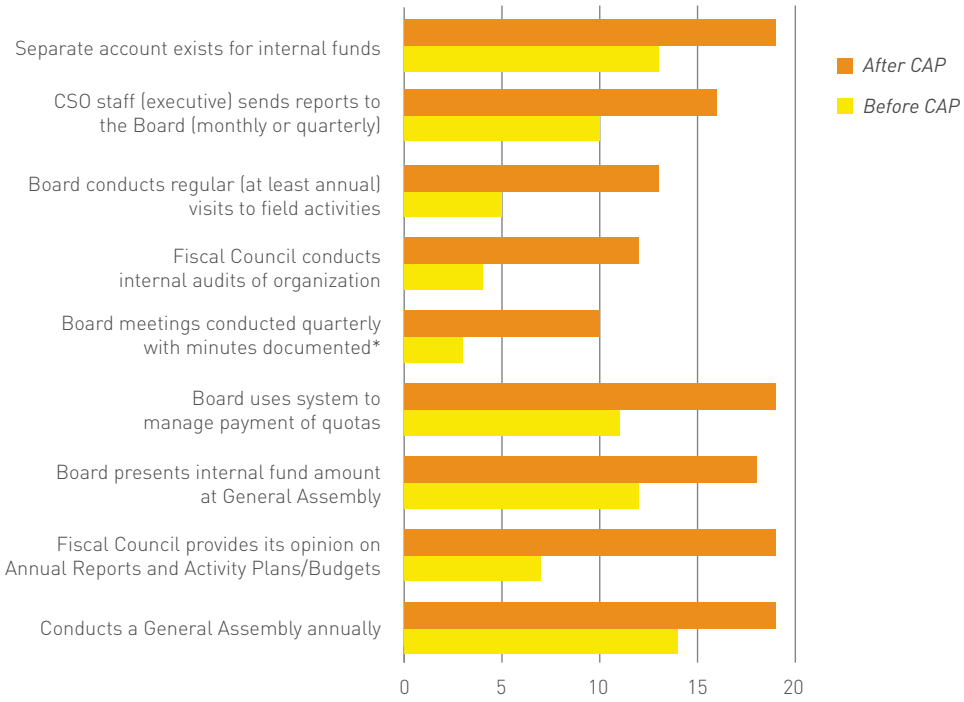
—CAP Partner AMME

Figure 2 provides information about changes in governance practices among CSOs relative to their participation in CAP Mozambique. Over time, all of the organizations made substantial gains in areas such as sharing of financial and programmatic reports with their Boards and visits by Board members to observe field activities on at least an annual basis. According to CA Barue and Associação Rubatano, Board members also contribute to implementation problem-solving during these visits. CAP OD Client Associação Shingirirai

"As our Board and Fiscal Council members began to monitor more closely, they began to act like the stewards of the organization and this helped a great deal with project performance."

—CAP Partner IBFAN

FIGURE 2: NUMBER OF CSOs FACILITATING GOOD GOVERNANCE PRACTICES BEFORE AND AFTER CAP SUPPORT



* These data represent only Board meetings held quarterly. Other organizations hold meetings monthly, semi-annually, or as needed.

mentioned that "Project staff concentrate on implementing their project plans because they know that Board members will be coming to check on activities."

The financial training and follow-up TA helped raise the number of CSO Fiscal Councils conducting internal audits from four to 12. For CAP Mozambique Partner Associação Nacional para o Desenvolvimento Auto-sustentado (ANDA), this has been an especially positive experience: "The mistakes are discovered and dealt with jointly. For example, the Fiscal Council found that many personnel files were incomplete. They told us about the problem and made the time to work with staff to complete the files." According to Associação Rubatano, the internal audits increased transparency and ultimately trust within the organization. "In the past, some of our members didn't believe that our food distribution program was really helping orphans and vulnerable children, but after they checked, their doubt disappeared."

Boards are better organized, meet more frequently, and conduct business professionally. Ten CSOs, compared to three before CAP support, hold and document Board meetings on a quarterly basis. "Now that our Board meetings are regular we don't have stalled processes. There is no accumulation of problems that impedes decision-making," reported CAP Mozambique Partner Conselho Cristão de Moçambique-Sofala (CCM-Sofala). Nineteen organizations now conduct annual General Assemblies, as required by Mozambican law. For most organizations, however, the real change has been in the quality of this event. "We always held them, but the difference now is that we actually discuss our projects and not just our own activities," said CAP Mozambique Partner Congregação da Irmãs Franciscanas Hospitaleiras da Imaculada Conceição (CONFHIC).

PRESIDENT OF FISCAL COUNCIL FOR ANDA EXPLAINS RESULTS WITH BOARD MEMBERS. (MAURO VOMBE | FHI 360)

A challenge faced by Mozambican CSOs is how to generate unrestricted reserve funds—emergency resources that can be used during times of crisis or to fund activities that donors are not willing to fund. Most CSOs establish quotas for members to pay toward such reserve funds, but few have systems in place to ensure these are paid. CAP Mozambique helped organizations create these systems. At the end of CAP's assistance, the number of CSOs with separate accounts for discretionary funds grew from 13 to 19; the number with systems to manage payment of quotas grew from 11 to 19; and the number of Boards presenting their internal fund amounts at General Assembly meetings grew from 12 to 18.

CSOs interviewed found the link between good governance and improved project implementation an obvious one. According to CAP Mozambique Partner International Baby Food Action Network–Mozambique (IBFAN):

As our Board and Fiscal Council members began to monitor more closely, they began to act like the stewards of the organization, and this helped a great deal with project performance. We had struggled for a long time with how to meet our targets for health referrals, but since the governing bodies got involved we began seeing positive results.

A Critical Investment: Strengthening CSO Governance Requires Patience, Commitment, and Intent

PARTNER STAFF AND BOARD MEMBERS LEARN ABOUT FINANCIAL MANAGEMENT TOGETHER. (FHI 360)

CAP's investment in improving CSO governance clearly paid off. Donors have demonstrated increased confidence in CSOs' capacity to manage money accountably and projects professionally. Even organizations that have struggled with poor performance linked to weak governance and organizational systems have experienced a turn-around. According to CAP CSO Partner Associação Ecuménica Cristã (Kubatsirana), "CAP helped revitalize Kubatsirana in a moment when few donors believed in the organization."

When confronted with poor grant performance, one of CAP's challenges was to know whether problems were due to a lack of capacity or intentional abuse. But as capacity was developed, performance improved across CAP's CSO Partners. When new issues arose, it was no longer possible to rationalize mistakes by blaming capacity—and organizations were forced to address performance and integrity issues. As a funder, in cases of abuse found through CAP's own audit processes, CAP was faced with decision points about whether to terminate grants or take lesser measures. CAP's duty was always to ensure that U.S. government funds were appropriately accounted for; but even the most challenging of circumstances were emphasized as valuable teachable moments for the CSO Partners.

Lessons for Future Investments

For future investments in civil society, it is important that program designers and policy makers consider the following:

- **Anticipate that Partners may not initially understand or appreciate the need for change—**The process of change for CAP Partners began with guided self-assessment and education about the reasons for adhering to certain established practices. CSOs

may not even understand the consequences of their current governance systems (or lack thereof) and the benefits they may gain through change. A true appreciation of the need for change only came after a year or more of capacity development efforts.

- **Engage willing Partners—**Some of the changes required were at first hard for Partners to swallow. Board members who were asked to relinquish their dual roles as staff had to give up salaries. Transparent recruitment of Board members meant that friends and family were not elected. If CSOs are not committed to making hard choices required along this journey, any changes they make in the short term will not be sustainable. The capacity development process should begin with clear expectations that change will be required, will be monitored, and may be challenging. A pre-requisite for CSO participation should be a commitment to engage in institutional strengthening activities and a willingness to be held accountable.

NIIWANANE'S EXECUTIVE DIRECTOR DISCUSSING RESULTS WITH BOARD MEMBERS. (MAURO VOMBE | FHI 360)

- **Provide tools to operationalize the theory—**Tools based on Mozambican laws were hard to find and yet essential to ensure that CSO governance structures and processes conform to these. CAP's ROSME and other tools helped CSOs operationalize the principles they learned about in training and TA and provided valuable references. It is critical to invest in practical, relevant, field-tested tools to support CSOs in applying new knowledge.

- **Develop incentives that make it in the CSO's self-interest to change—**For CAP, it was imperative to use the grant mechanism to hold CSOs accountable for improving governance. CSOs were required to submit evidence of improvements to engage in specialized training and TA; and decisions regarding salary increases and personnel benefits were made based on approved policies and procedures (that also met CAP's standards). Few incentives exist to motivate CSOs to improve internal governance, so the CAP grant mechanism was invaluable for this purpose.

- **Be patient with change—**Working on governance issues was extremely sensitive and politically charged. CSOs were often unaware of governance issues or accustomed to letting them slide and had to navigate new relationships and roles—while also implementing projects. Individuals who are complacent or prefer the status quo must be motivated to make changes that will benefit the organization as a whole. Even the most willing Partners will face setbacks in this process. Support CSOs during this journey by celebrating their successes and sticking around for those who demonstrate a sincere commitment to change.

Knowledge, skills, tools, and processes: these were the building blocks that helped Mozambican CSOs learn the importance of good governance and how to operationalize it. And yet, why did CSOs choose to engage? Building trust as a donor by providing adequate support and yet holding CSOs accountable, advocating for CSOs to own their organizational development through the POAP, engaging all levels of an organization through tailored training and TA, using the grant as a mechanism for accountability, and providing practical steps to operationalize new knowledge and tools—those were the success factors that led to concrete results for CAP's CSO Partners.

If Mozambican CSOs are to be leaders in their nation's development, they must be able to ensure their own organizational integrity and legitimacy. Such transformation takes time. CAP CSO Partners in Mozambique have made significant progress and are now models for other up-and-coming organizations.

Document written in 2016.

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MAURO VOMBE | FHI 360

HARNESSING POTENTIAL: CAP'S ORGANIZATIONAL DEVELOPMENT RESULTS

Introduction

The Capable Partners Program (CAP) in Mozambique was implemented by FHI 360 and funded by the U.S. Agency for International Development (USAID) and the President's Emergency Plan for AIDS Relief (PEPFAR). CAP Mozambique built the institutional capacity of Mozambican non-governmental organizations (NGOs), community-based organizations (CBOs), faith-based organizations (FBOs), associations, and their networks to improve the service delivery of HIV/AIDS treatment, care, and prevention programs. CAP Mozambique provided intensive training, technical assistance (TA), coaching, and mentorship to its Partners and organizational development (OD) clients over the life of the project. CAP Partners were Mozambican organizations that received both grants and tailored capacity-development support. OD clients received only organizational capacity-development support, typically tied to priorities raised through self-assessment.

This brief describes changes in the technical, financial, and organizational capacities of a selection of the civil society organizations (CSOs) that received assistance from CAP Mozambique from 2009 to 2016—including 13 Partners and eight OD clients (see table 1 on the following page).[1]

Tailoring Capacity Development to Organizational Needs

From 2009–2016, CAP Mozambique provided 50 integrated grants (grants combined with capacity development) to 37 Mozambican CSOs. An additional nine OD clients received capacity-development support, and other Mozambican CSOs and networks benefited as sub-partners under CAP Partners or through other CAP-sponsored initiatives. Capacity-development interventions were tailored for each organization based on the results of each organization's capacity assessment.

[1] CAP Mozambique's first phase took place from 2006–2009 and its second phase from 2009–2016. This document focuses on progress made during the second phase because a number of external assessments (conducted by CAP, external to the Partner) were conducted during that time period. Self-assessments were conducted regularly throughout both project periods.

TABLE 1: SELECT CAP MOZAMBIQUE PARTNERS AND OD CLIENTS RECEIVING ASSISTANCE, 2009–2016

CAP Partners:

- Associação para o Desenvolvimento Sócio Economico (Ophavela)
- Associação Ecuménica Cristã (Kubatsirana)
- Associação de Fomento para o Desenvolvimento Comunitário (ADC)
- Associação da Juventude de Luta contra SIDA e DROGA (AJULSID)
- Associação Moçambicana Mulher e Educação (AMME)
- Associação Nacional para o Desenvolvimento Auto-sustentado (ANDA)
- Associação Niiwanane Wamphula (Niiwanane)
- Conselho Cristão de Moçambique-Sofala (CCM-Sofala)
- Hope for African Children Initiative (HACI)
- Liga dos direitos da Crianca da Zambezia (LDC)
- Núcleo das Associações Femininas da Zambézia (NAFEZA)
- Organização de Desenvolvimento Rural (Kukumbi)
- Rede Contra o Abuso de Menores (Rede CAME)

OD Clients:

- Auxílio Sem Fronteiras (ASF)
- Associação Cristã Interdominical Nacional para o Desenvolvimento da Comunidade (ACIDECO)
- Associação Kugarissica
- Associação Rubatano
- Associação Shingirirai
- Centro Aberto Barué e das Irmãs Reparadoras do Sagrado Coração de Jesus (CA Barue)
- Congregação da Irmãs Franciscanas Hospitaleiras da Imaculada Conceição (CONFHIC)
- Rede de Homens pela Mudança (HOPEM)

Methodology

To establish a baseline and to track progress over time, CAP Mozambique facilitated its Participatory Organizational Assessment Process (POAP) and a number of other assessments using internationally accepted tools appropriate to the local context. The tools included:

- **Participatory Organizational Assessment Process (POAP)**[2]—CAP's POAP measured growth across multiple organizational categories.
- **Financial Health Check (FHC)**—The MANGO Financial Health Check[3] assessed financial reporting and management health, focusing on financial systems.

[2] See also the CAP Mozambique technical brief, "Motivating Change: Mozambican Organizations Transform Themselves through the Participatory Organizational Assessment Process."
[3] For further information see: https://www.mango.org.uk/guide/healthcheck.

- **OVC Care Assessment**—CAP's OVC Care Assessment measured the capacity of grant recipients to deliver quality care for orphans and vulnerable children (OVC).
- **SBCC Capacity Assessment**—FHI 360's C-Change Social and Behavior Change Communication (SBCC) Capacity Assessment Tool[4] measured the capacity of grant recipients to develop and deliver effective SBCC programming.
- **Report Writing Assessment—**CAP's Report Writing Assessment measured the capacity of CSOs to report accurately and comprehensively on their quarterly activities and results.

While the POAP was a self-assessment process facilitated with each organization by CAP Mozambique, all other assessments were conducted by CAP staff, with scoring dependent upon CAP's assessment of the organization at that moment in time. Assessments were typically conducted at 18–month intervals. The project assessed Partners in the areas that were relevant to their CAP-funded projects. For example, only those implementing OVC projects received the OVC Assessment.

Data are presented in this document for organizations that had at least a baseline and one follow-up assessment in a given area. Some of the earliest Partners' grants ended before it was possible to complete a baseline and follow-up in all areas.

Organizations participated in varying numbers of assessments over different amounts of time. Data are presented in this document for organizations that had at least a baseline and one follow-up assessment in a given area. Some of the earliest Partners' grants ended before it was possible to complete a baseline and follow-up in all areas.[5] On the other hand, some organizations had as many as three or four follow-up assessments in certain areas, depending on the life of their partnership with CAP. For this reason, it is difficult to compare quantitatively the progress made by the different organizations. Discussion of results therefore focuses on progress made by individual organizations from their own baseline measures to their last assessments (as of March 2016).

Partner data are included here for 13 organizations with baseline and follow-up data in the POAP, the FHC, the Report Writing Assessment, and at least one technical area (OVC and/or SBCC). Eight of the organizations were assessed for their SBCC capacity, seven were assessed in OVC care, and two were assessed in both areas.

Because OD clients received grants and support from other sources, CAP assistance focused on their core organizational systems (e.g., internal governance, policies and procedures, financial management). OD clients participated only in the POAP and FHC assessments and received support tailored to those results. The progress made by OD clients between their respective baselines and end lines in these areas is also discussed.

CAP PARTNER ANDA PROVIDES JOB SKILLS TRAINING FOR OVCS. (MAURO VOMBE | FHI 360)

[4] For further information see: https://www.c-changeprogram.org/sites/default/files/SBCC-CAT_Organizations.pdf.
[5] Some grants were terminated for non-performance; others were ended due to changing funding priorities and budget cuts.

Key Results for CAP Partners

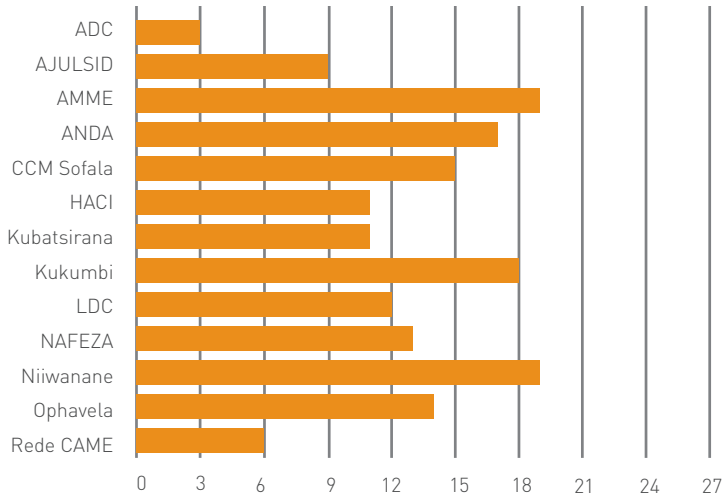
POAP for Partners

The POAP served as a cornerstone of the CAP project. It required each organization to score its own capacities in a range of areas based on careful reflection and the review of evidence produced by the organization itself—such as its statutes, policies and procedures, organizational charts, and project evaluations. After discussing its results, each organization then prioritized areas in which it wanted to improve and created a capacity development plan. CAP provided training, technical assistance, and/or coaching tailored to each of these plans.

The POAP assessed 27 organizational domains—ranging from governance, to human resources, to technical capacity, to external relations.[6] Umbrella grant organizations providing grants to other CSOs were assessed in three additional domains[7] (for a total of 30 domains). Organizational networks were assessed in four additional domains,[8] adding a review of the role and structure of the network (for a total of 31 domains).

Figure 1 shows the number of domains (out of the basic 27 in which all organizations were assessed) in which the 13 different Partners demonstrated progress from their own baselines to their most recent follow-up assessments. The figure only highlights areas of growth in which progress could be attributed to CAP training, TA, and/or coaching.

FIGURE 1: NUMBER OF DOMAINS (OUT OF 27) IN WHICH PARTNERS DEMONSTRATED IMPROVEMENT VIA THE POAP



[6] Legal Statutes, Mission, Vision, Values, Leadership, Governance, Transparency and Accountability (one area), Member Management, Human Resources, Archives, Staff Training, Performance Evaluations, Budget Planning, Internal Procedures, Reports, Audits, Assets, Information Technology, Technical Competence, Analysis, Project Planning & Design, Implementation, Monitoring, Evaluation, Partnerships, Beneficiaries, and Public Relations.
[7] Knowledge and Ability to Develop the Capacity of Sub-partner, Access Financial Resources to Strengthen Sub-partner, and Capacity to Monitor and Evaluate Progress of Sub-partner Projects.
[8] Shared Objectives, Roles in the Network and its Members, Network Structure, and Accountability (internal members to network and network to members).

It is not altogether surprising that a large number of organizations demonstrated improvement across these domains. Mozambican civil society is relatively nascent compared with other countries in the region, and CAP Mozambique was one of the first organizations to take the deep dive into institutional strengthening with its Partners—so there was considerable work to be done in all 27 areas covered in the POAP. It is actually more surprising to see that two organizations scored so far below the rest of the group. In these two cases (ADC and Rede CAME), dominant executive directors, coupled with weak or inactive Boards of Directors, blocked CAP Mozambique from providing the support these organizations desperately needed. One of these organizations has since disintegrated; the other has introduced some changes but struggles to find funding for activities.

The areas demonstrating the most (positive) change across organizations were Project Design (11 of 13 Partners), Implementation (10 of 13 Partners), Technical Competence (10 of 13 Partners), Internal Procedures (nine of 13 Partners), Reports (nine of 13 Partners), and Performance Evaluations (nine of 13 partners). Due to the amount of resources committed to improving Partner capacity to implement quality projects—in both SBCC and OVC—it is not surprising to see improvements in technical capacity. CAP Mozambique also concentrated on the development of policy and procedures manuals with many Partners early on in the project as a strategy for helping them articulate and use written policies to guide their organizations. One of CAP's signature trainings—Governance, Leadership, and Management—was combined with follow-up TA and facilitated with all CAP Partners. This intervention supported five OD domains (Mission, Vision, Values, Leadership, and Governance); Partners that fully embraced working on the five areas typically demonstrated positive change across all five of these domains.

One of CAP's signature trainings—Governance, Leadership, and Management—was combined with follow-up TA and facilitated with all CAP Partners. This intervention supported five OD domains.

CAP did not provide extensive support for member management or information technology, which may have contributed to the more limited gains in these areas. Although many organizations revised their legal statutes, the process for officially registering the revised statutes is long, and the scoring was tied specifically to achieving registration.

Figure 1 on the previous page shows the number of domains demonstrating improvement between each organization's baseline and end line scores, but not the roller coaster in between. The first POAP (and often the subsequent one, due to staff turnover) included a learning component for each OD domain used in the tool so that organizations were better equipped to rate themselves. That said, Partners often rated themselves higher than warranted in the first POAP application, due both to lack of experience with the process and possible score inflation connected with concern about the current (and potential future) donor's perception. As organizations became more knowledgeable about each domain—and as they were better able to comprehend what the evidence showed about their capacities—their scores sometimes dropped simply due to this improved understanding. Sometimes a score dropped because an organization faced a crisis that brought it face to face with a specific weakness. Regardless, the numbers alone did not tell the story.

Partners often rated themselves higher than warranted in the first POAP application, due both to lack of experience with the process and possible score inflation connected with concern about the current (and potential future) donor's perception.

Kubatsirana provides an interesting example of the rocky change process. Following its first POAP, the organization faced a leadership crisis that seriously affected performance.

In its second POAP, Kubatsirana improved in one area, remained the same in eight areas, and declined in 11 areas. Spurred by these poor results (and by rapidly declining donor confidence), Kubatsirana hired a new executive director, revamped its Board of Directors, and turned itself around in several respects. As figure 1 on page 4 shows, the organization demonstrated improvement in 11 domains by the time of its end line.

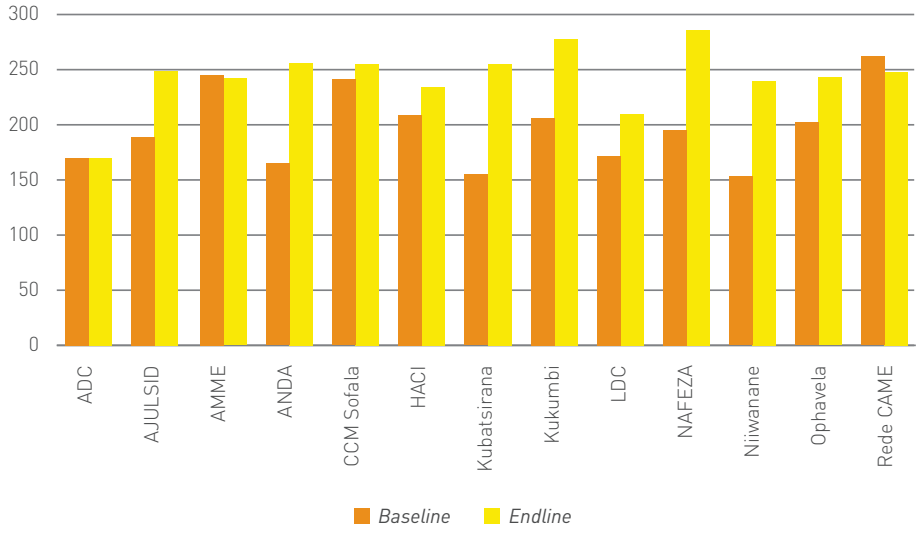
The quantitative data paint a picture of change between two points in time for each organization, but do not reveal why that change happened, whether the trajectory was smooth, or whether the change will be lasting. That said, the results demonstrate that even when an organization might not be completely open to growth (at least initially), change is still possible. When an organization is ready, willing, and engaged with a TA provider/donor that has the capacity to provide timely, practical, and quality support, then achievements can be significant.

The quantitative data paint a picture of change between two points in time for each organization, but do not reveal why that change happened, whether the trajectory was smooth, or whether the change will be lasting.

Financial Health Check (FHC)

The FHC analyzed six categories of organization financial and administrative health (Planning and Budget, Basic Financial Systems, Financial Reporting, Internal Controls, Grant Management, and Staffing). Scoring for the FHC was as follows: high risk (0–150 points), medium risk (151–240 points), and low risk (241–300 points). Figure 2 below shows progress made by all 13 CAP Partners discussed in this document that were assessed vis-à-vis financial health.

FIGURE 2: PARTNER BASELINE AND END LINE SCORES IN FINANCIAL HEALTH



When Partners started working with CAP Mozambique, three of the 13 organizations assessed were in the low risk category (AMME, CCM Sofala, and Rede CAME). At the end of the project, nine organizations were ranked as low risk (AMME, CCM Sofala, Rede CAME, AJULSID, ANDA, Kubatsirana, Kukumbi, NAFEZA, Ophavela). One additional Partner

was just one point from being considered low risk (Niiwanane). Sound financial and administrative management requires transparency and openness, and organizations that demonstrated fewer of these qualities also showed the least positive change. Financial management, in particular, is also heavily affected by staff turnover. When a key finance person exits the organization, it can take time for the team to re-build and systems to continue functioning well—or improve. As finance staff can often command higher salaries in other sectors, CAP Partners experienced frequent turnover in finance staff during the life of their grant awards.

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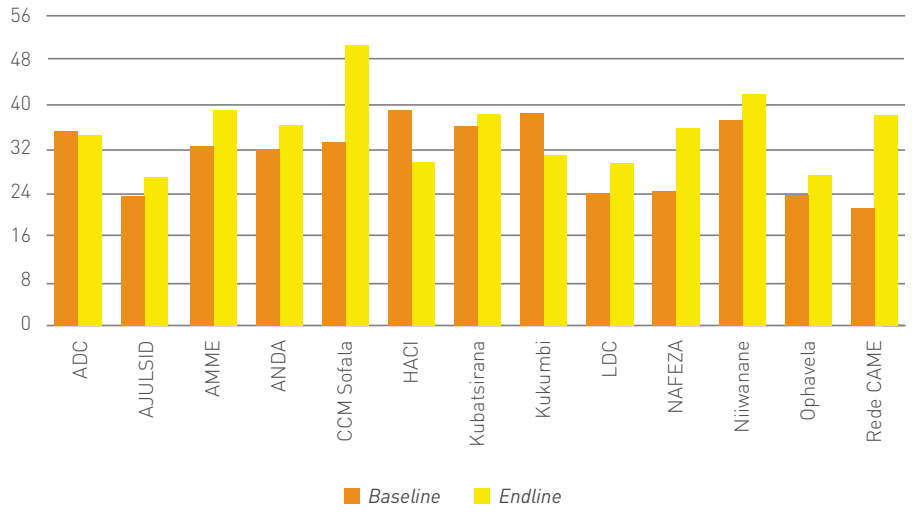
For the majority of Partners, the biggest improvement (out of the six areas assessed) was in Internal Controls. Improvement can be attributed to three complementary interventions: 1) diligent feedback from CAP on Partners' monthly financial reports covering application of internal control systems, 2) focused TA visits to address weaknesses identified in FHCs, and 3) the MANGO Financial Management Training. During this training, non-finance staff from Partner organizations learned about their roles in financial management. Members of the organization's leadership, Board, and Fiscal Council all learned how their responsibilities are integral to supporting internal controls and improving transparency and accountability. The follow-up TA and monitoring of financial reports complemented the content of the training.

Report Writing Assessment

CAP Partners submitted quarterly narrative and data reports as part of their required grant reporting. The Report Writing Assessment measured their capacity to describe project progress logically and comprehensively, with a maximum score of 56. Ten of the 13 Partners assessed more than once in report writing capacity demonstrated improvements in their overall scores.

FIGURE 3: PARTNER BASELINE AND END LINE SCORES IN REPORT WRITING



Capturing an accurate picture of change in Partner Report Writing capacity is challenging. In CAP's experience, a Partner might see improvement in one assessment only to lose ground again in the next. Since programmatic reports are often the responsibility of a single person within an organization, if that person is absent or leaves the organization, the quality of reporting may decline purely as a result of that. However, if an organization has instituted a review process that ensures consistency (with more than one individual accountable for the final product) the assessment may reflect more than just the abilities (or presence) of one person. Although CAP Mozambique alerted Partners to the necessity of quality control, project coordinators and executive directors often simply rubber-stamped reports for submission.

SBCC Capacity Assessment

CAP Partner HIV/AIDS prevention interventions utilized proven SBCC methodologies and a focus on participatory processes to spur genuine engagement of the target populations.[9] To complement activities aimed at individual behavior change linked to HIV prevention, organizations also conducted community-level advocacy and community mobilization to create a positive environment supporting pertinent changes in social conditions. Evidence-based methodologies for community small group discussions were adapted to tackle the barriers to behavior change highlighted by the formative research conducted with specific target groups. The primary intervention activities were group debates, typically prompted by a short film or theatrical sketch to engage people in active discussion around a topic. CAP Mozambique produced four films to address barriers identified by the local organizations and disseminated these films to Partners to use in their sessions. Community leaders were important in mobilizing local participation in project activities and influencing social norms.

To complement activities aimed at individual behavior change linked to HIV prevention, organizations also conducted community-level advocacy and community mobilization to create a positive environment supporting pertinent changes in social conditions.

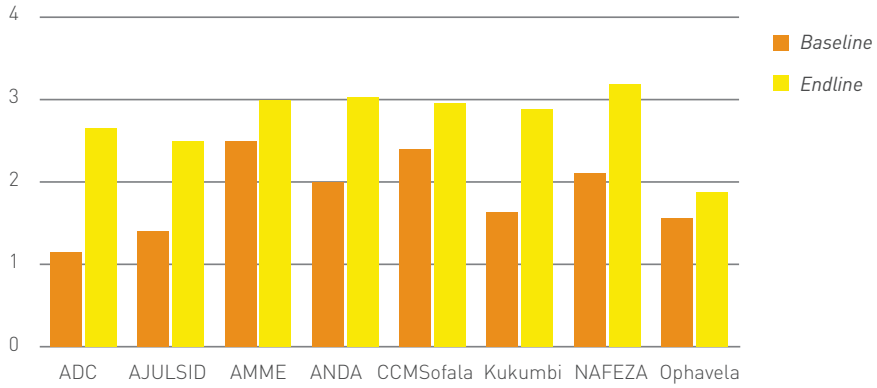
Organizations also provided access to HIV testing and counseling services, referred individuals to other services, distributed condoms, conducted defaulter tracing for treatment adherence, facilitated screening for gender-based violence, and created radio spots to reach mass audiences. Through these approaches, CAP Mozambique had a significant positive impact on attitudes, beliefs, HIV testing, and some preventative behaviors among members of targeted communities.[10]

The SBCC Capacity Assessment Tool measured capacity across three main areas: Project Design, Implementation, and Monitoring & Evaluation (M&E) of HIV/AIDS prevention interventions. The maximum score possible under each category was 4, with 4 points also possible as a "global" score.

Eight of the 13 CAP Partners included in this analysis took part in baseline and end line SBCC assessments. All eight improved their SBCC capacities during the time they received support from CAP. All but one organization achieved a score of at least 2.5 (out of 4) at end line. ADC and AJULSID demonstrated the greatest percentage increases in their global

[9] See also the CAP Mozambique technical brief, "Mozambican CSOs Embrace Social and Behavior Change Communication."
[10] See also the CAP Mozambique technical brief, "CAP Mozambique HIV Prevention End Line Evaluation."

FIGURE 4: PARTNER BASELINE AND END LINE SCORES FOR SBCC IN HIV/AIDS PREVENTION



scores (130 percent and 78 percent improvement, respectively), mainly because their baseline scores started lower than those of the rest of the group. These two organizations eventually hired staff who were capable of carrying out the interventions. Their end line scores remained slightly below those of the other Partners, with the exception of Ophavela. Ophavela had never implemented SBCC or HIV prevention interventions prior to working with CAP (reflected in its low baseline score of 1.56). Although Ophavela's capacity to integrate HIV/AIDS programming into its core work (village savings and loan groups) increased, the organization lost staff prior to the final assessment, so its initial improvements were not captured. Kukumbi, AMME, and ANDA had capable teams and quickly embraced the SBCC approach, which affirmed and provided a theoretical framework for what they knew from their own experiences to be effective.

Kukumbi, AMME, and ANDA had capable teams and quickly embraced the SBCC approach, which affirmed and provided a theoretical framework for what they knew from their own experiences to be effective.

The receptiveness of these organizations to engage in training/TA/coaching on SBCC over the lives of their grant awards paid off through increased capacity as assessed through this tool. Since technical capacity can have a noticeable effect on the quality of project implementation—and may also improve an organization's credibility in its communities and among stakeholders—CAP Mozambique expected to see gains in this area before gains in more "behind the scenes" organizational capacities.

OVC Care Assessment

CAP Mozambique's Partners provided family-centered care to OVCs and their families. Partners used a community consultation process to engage community leaders in identifying eligible families and assess family and OVC needs. As part of CAP support, Partners were trained to use the Child Status Index (CSI)[11] to assess the needs of each child in the family in seven areas (as stipulated in the Ministry of Gender, Children and Social Action minimum guidelines) and measure changes in needs over time. The seven areas were: education, health, nutrition, shelter, protection, food/nutrition, and economic strengthening. By applying the CSI, Partners identified OVC needs and developed individualized care plans. They provided those services they could and established referral networks to provide holistic care to OVC and their families.

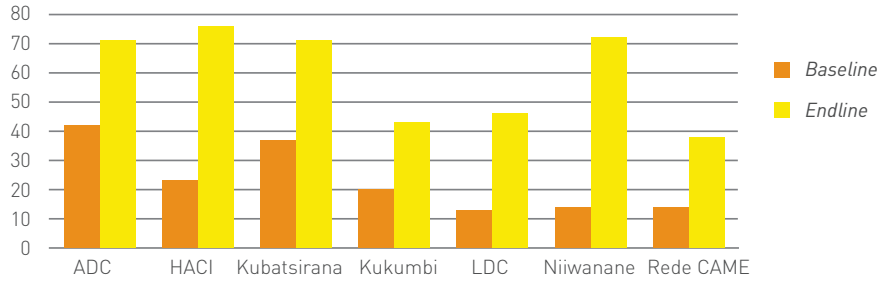
As part of CAP support, Partners were trained to use the Child Status Index (CSI) to assess the needs of each child in the family in seven areas (as stipulated in the Ministry of Gender, Children and Social Action minimum guidelines) and measure changes in needs over time.

[11] For more information see: http://www.cpc.unc.edu/measure/resources/tools/child-health/child-status-index.

The data seem to imply that the progress Partners made in this technical area (OVC Care) was greater than in the area of SBCC. However the assessment tools for these areas were fundamentally different.

The OVC Care Assessment measured capacity in five areas: OVC Project Design, Adherence to OVC Minimum Standards, Existence of Sufficient Strategies to Support OVC, Existence of Methods to Determine Client Satisfaction, and Adequate Data Management and Dissemination of Reports. Seven of the 13 CAP Partners included in this analysis took part in baseline and end line OVC Care Assessments. Figure 5 shows the baseline and end line scores using the OVC Assessment tool for these Partners.

FIGURE 5: PARTNER BASELINE AND END LINE SCORES IN OVC CARE



All of the organizations increased their scores dramatically, with Niiwanane increasing its score by more than 400 percent. The data seem to imply that the progress Partners made in this technical area was greater than in the area of SBCC. However, the assessment tools for these areas were fundamentally different. The SBCC tool focused on process—measuring how well the organizations complied with internationally recognized standards of SBCC practice. The OVC tool included process, but was more oriented to the presence of resources, tools, and approaches to implement OVC activities. As Partners worked with CAP Mozambique and gained access to new tools and approaches, their scores improved. This also explains why the Partners that worked longest with CAP in this area—ANDA, HACI, and Niiwanane—reached the highest scores in the OVC Care Assessment.

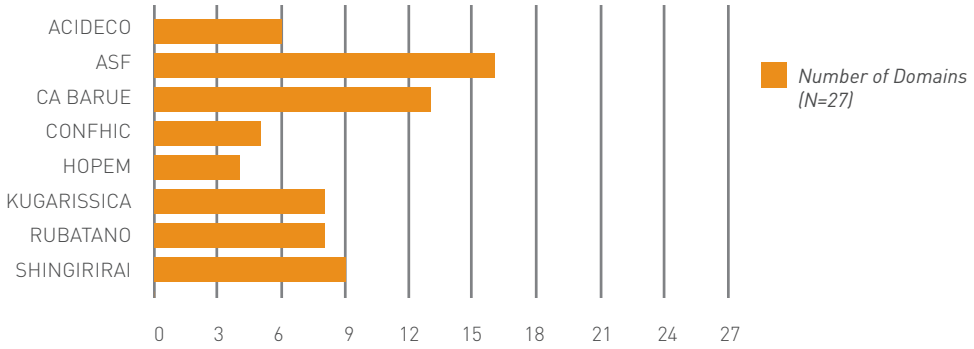
CAP PARTNER HACI DURING A POAP SESSION.
(MAURO VOMBE | FHI 360)

Key Results for OD Clients

POAP for OD Clients

Figure 6 shows the number of domains (out of the basic 27 in which all organizations were assessed) in which the eight OD clients demonstrated progress from their baselines to their final follow-up assessments. (The figure only highlights areas of growth in which progress could be attributed to CAP training, TA, and/or coaching.) The figure captures change within a one-year period. Of the eight OD clients assessed, six improved in six or more of the 27 categories covered by the POAP; three improved in nine or more categories.

FIGURE 6: NUMBER OF DOMAINS (OUT OF 27) IN WHICH OD CLIENTS DEMONSTRATED IMPROVEMENT VIA THE POAP



As with CAP Partners, the number of domains showing improvement was linked to the organization's willingness to engage in the capacity development process. Of the two organizations showing the least improvement, one did not make the necessary investments of time and energy to realize measurable change. The other, CONFHIC, was interested in improving governance systems, but was tied to an organization in Portugal, which complicated the change process. CONFHIC functions well as an organization but its lack of documentation (a factor included in the POAP) affected its score. ASF and CA Barue were open to change—and tackling issues identified by the POAP required them to make changes. ASF also benefited from receiving grant funds from another component of CAP, which meant that it had additional support in financial reporting, M&E, and technical areas.

Financial Health Check

CAP staff only conducted organizational assessments for OD clients in the area of financial health (not in report writing or HIV/AIDS technical areas). Figure 7 shows progress made over 12–18 months by OD clients from their respective baselines to their final follow-up assessments as measured via the FHC tool. Out of the eight organizations, only one (CONFHIC) did not make progress during the project; as mentioned above, while the organization functioned well, the lack of documentation affected its score. At end line, seven OD clients were in the medium risk category and one (ASF) was only one point short of reaching the low risk category.

HEALTHY ORGANIZATIONS ARE BETTER ABLE TO HAVE POSITIVE IMPACT ON THE COMMUNITIES THEY SERVE. (JESSICA SCRANTON | FHI 360)

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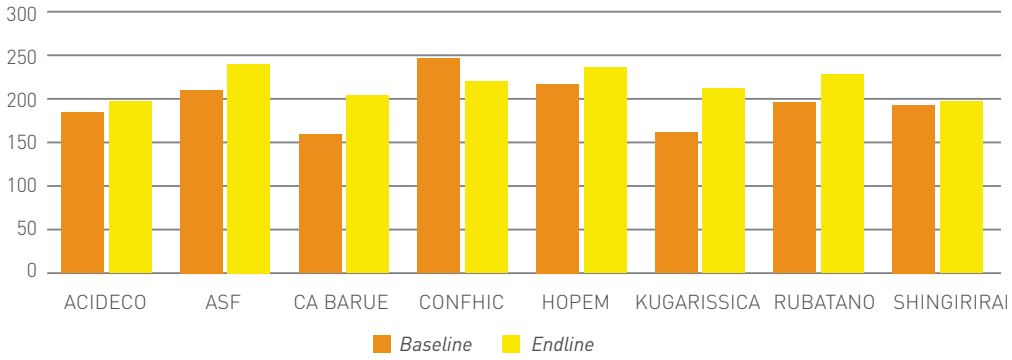
FIGURE 7: BASELINE AND END LINE SCORES FOR FINANCIAL HEALTH CHECK FOR OD CLIENTS



Conclusion

The purpose of this document was not to describe clear trends in organizational change across either Partners or OD clients. However, the assessment results demonstrate that change occurred and that there is also potential for change in the future. The data help highlight individual stories of organizational growth for a selection of CAP Partners and OD clients. These stories unfolded differently based on the willingness of each organization to engage in the capacity-development process, the quality of its relationship with the TA provider, and the inputs provided by CAP staff.

CAP Mozambique produced a substantial body of quantitative data about organizational change—ranging from improvements in governance, to internal procedures, to project M&E, to technical competence. But telling the story of change for each Partner and OD client would require a combination of methods, including those of a more qualitative nature—such as interviews, reports, observations, and so forth. Through such methods CAP Mozambique learned about changes in Partner relationships with community leaders, other service providers, and government agencies. CAP witnessed the transformation of a Board of Director's perception of its role as steward of an organization; the improved confidence an organization gains from having formative research data and knowing how to use it to back up decisions; improved understanding (on the part of staff and Board members) of how an organization should function; and the increased respect and credibility with target audiences and other stakeholders that an organization can gain through all of these processes.[12]

CAP Mozambique believes that the Partners described in the technical brief and all others touched by the project will remain on their trajectories of growth.

Document written in 2016.

[12] For more about the complexities of measuring organizational development, please see the CAP Mozambique technical brief, "Capacity Development Programming and Measurement: Lessons from a Decade of Experience in Mozambique."

PROMOTING QUALITY DATA SYSTEMS AND THE VALUE OF GOOD DATA

Making Data Real

The United States Agency for International Development (USAID) and its implementing partners are obliged to produce concrete evidence of the positive impact of U.S. dollars spent abroad. In the past, accountability for project funds meant fiscal responsibility and descriptive reporting. Now—and particularly under USAID's President's Emergency Plan for AIDS Relief (PEPFAR) funding—rigid and complex standardized data-reporting requirements force implementing partners to adapt to external systems and reach high standards of excellence in the collection, analysis, and reporting of large quantities of data.

In theory, this is a positive development. In order for project data to be meaningful, implementing partners must be able to stand behind project data just as solidly as financial management practices. We should feel confident that each individual counted as served in a PEPFAR-funded project, for example, can be traced from point of service through reporting channels to the highest levels. However, local organizations responsible for collecting and reporting these data in Mozambique initially had little, if any, experience with rigorous monitoring. Until recently, Mozambican civil society organizations (CSOs) had limited experience documenting results, being held accountable for tracing results to source, using data to inform programming, and developing adequate data-collection tools. Many lacked monitoring and evaluation

CSOs and the Data Challenge

Intermediary organizations like FHI 360 play a critical role in ensuring the quality of data submitted by their local subs, yet many struggle with the low capacity of partner civil society organizations (CSOs) to respond to the increasing volume and complexity of indicators and requirements for collection, reporting, and more. This technical brief describes how CAP Mozambique bridged the gap.

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PEPFAR
fhi360 THE SCIENCE OF IMPROVING LIVES
CAPABLE PARTNERS PROGRAM Mozambique

(M&E) systems altogether, lacked sufficient funding to conduct monitoring visits, and struggled to train individuals with low education levels to collect data correctly.

In Mozambique, few CSOs receive direct USAID funding; therefore, they report on project activities to an intermediary organization (IO)—such as FHI 360, which managed the Capable Partners Program (CAP) in Mozambique. This arrangement provided the space to coach Mozambican CSOs and provide them with the knowledge and skills required to meet USAID/PEPFAR's standards. CAP Mozambique also played a critical role helping CSOs interpret and adapt to changes in the PEPFAR environment that required systems adjustments—such as shifts in strategy, changes to indicators, introduction of new indicators, and additional reporting requirements.

Since CAP Mozambique depended on Mozambican CSOs for PEPFAR results, the program developed tools and processes to help these organizations meet CAP and USAID/PEPFAR data-quality standards. More than that, however, it was important for Mozambican CSOs to have quality data to analyze project progress, inform decisions, and build their reputations as accountable and credible implementing partners—one of the most significant lessons of all.

Strengthening CBOs—Helping Communities

The Capable Partners Program (CAP) in Mozambique strengthened the institutional capacity of Mozambican nongovernmental organizations (NGOs), community-based organizations (CBOs), faith-based organizations (FBOs), associations, and their networks to improve the service delivery of HIV/AIDS treatment, care, and prevention programs.

CAP integrated intensive capacity development of its Partners with grants to provide the organizations with opportunities to apply what they learned and demonstrate their capacities to affect HIV/AIDS at the community level. CAP Mozambique was managed by FHI 360 from 2006 to 2016 and was funded by the U.S. Agency for International Development (USAID) and the President's Emergency Plan for AIDS Relief (PEPFAR).

Make it Real, Make it Relevant

Over the past decade, a huge influx of resources has been pumped into Mozambique to support HIV/AIDS programming. Between 2004 and 2014, PEPFAR-planned funding for the country totaled $2,117,300,000 cumulatively.[1] This presented both an enormous opportunity and a challenge. Generous funding yielded substantial positive impacts vis-à-vis the epidemic. On the flip side, pressure to spend such resources and deliver large-scale results affected the capacity of CSOs and IOs to focus on the quality of services they provide and the ability to deliver training and technical assistance (TA) to improve implementation capacity. Just as important, it affected the ability of CSOs and IOs to conduct high-quality monitoring.

Mozambican civil society is young in comparison to some neighboring countries and relatively small. Even CSOs with the capacity to implement HIV/AIDS programming at scale struggle to keep up with the demand to deliver quality results (and data) as well as to serve high numbers of individuals with HIV/AIDS treatment and care. USAID/PEPFAR's demands for data excellence in such a low-capacity environment can at times feel unreachable, and yet the demands are the reality in this funding environment. Therefore, motivating Mozambican CSO Partners to produce quality data is a critical first step in this journey.

[1] Data reflect information available on the PEPFAR Dashboards, which represent planned new bilateral funding initially approved in the PEPFAR Country Operational Plans/Regional Operational Plans (COPs/ROPs) each fiscal year. As additional funding may be approved and made available after the initial COPs/ROPs submission, or to PEPFAR-supported countries that are not required to submit an annual COP/ROP, data on the Dashboards may not represent the final PEPFAR programmatic funding level in countries each fiscal year.

Over a 10-year period, CAP Mozambique awarded more than 60 grants to Mozambican CSOs providing HIV/AIDS services throughout the country. CAP relied on the following key principles to motivate CSO Partners to produce quality data:

- **Build on grantee knowledge and experience.** Since individuals and organizations are motivated when they feel ownership, taking the time to focus on this relationship between the organization and the work it will be doing is a valuable investment. CAP did this by placing project-developed indicators alongside PEPFAR indicators, building from existing CSO data tools, actively listening to CSO solutions to program and data challenges, and coaching CSO Partners to participate actively during monitoring visits and data quality assessments (DQAs). (The DQA is an assessment process that measures five aspects of data quality: validity, reliability, timeliness, precision, and integrity.)

- **Capitalize on CSO Partner incentives for producing quality data.** People and organizations are motivated by incentives. CAP explored with Partners how producing quality data would help their organizations—not only meet donor requirements. Would quality data result in a better reputation? More funding? Better relationships with stakeholders? Provide information for communications materials? Help the organization learn new skills? Respond to donor pressure? Once the drivers were identified, CAP's approach was tailored to target them.

- **Demonstrate that data help CSOs, not just donors.** It is possible to create processes that will result in quality data to meet USAID/PEPFAR reporting requirements and also make that data meaningful for the CSO Partners themselves. Striking this balance can be tricky when funding is limited, but is possible, and Partners are motivated to perform when they realize that their own data needs are valued as well.

- **Enforce policies about reporting accurate data.** CAP took the same zero-tolerance approach to data mismanagement that it took to financial mismanagement, by reiterating that data integrity was as important as financial integrity. CAP followed through on this commitment by conducting regular DQA visits, monitoring progress on action plans to improve data quality, and investigating the source and cause of data irregularities found during DQA exercises. Sometimes this led to delays in sending funding advances until incorrect data were cleaned. In one case a CSO Partner did not receive a grant extension as a direct result of regularly reporting incorrect data.

"Now we understand very well what we are going to do and how we are going to do it. Unlike our other project [not CAP funded], with this training we will be able to prove with our data collection sheets the work we are doing with children."

—CAP CSO Partner

CAP operationalized its approach through the following interventions:

1. **Practical training on M&E fundamentals.** Within the first two months of every grant award, CAP facilitated a three-day training with each Partner to help it understand basic M&E theory and develop an M&E plan, data-collection tools, and an internal system for data collection and reporting.

   During the workshop, CAP worked with Partners to "deconstruct" USAID/PEPFAR indicators to help Partners understand how to report accurately. Due to the complexity of the language of many indicators, CAP helped Partners specify exactly how information from their program activities should be described, collected, and consolidated for each PEPFAR indicator.

For example, the following PEPFAR indicator needed to be converted into language that made sense to one CSO's program and staff. Addressing this single PEPFAR indicator also required aggregating information derived from monitoring several activities.

PEPFAR Indicator:
Number of community health workers that successfully completed a pre-service training

Partner Indicators:
—Number of *activistas* facilitating student sessions trained in facilitation, communication, and use of the project sessions guides
—Number of project staff trained in facilitation, in communication about materials in project session guides, and in the supervision of *activistas* to ensure quality
—Number of peer educators trained to work with commercial sex workers and long-distance truck drivers

The reporting tables had the original PEPFAR indicator side by side with its parallel project indicators so that Partner staff became more familiar with the PEPFAR terminology.

2. **Frequent participatory monitoring trips.** Monitoring trips are learning opportunities, and Partner staff and community health workers were actively engaged. Members at all levels of the organization were encouraged to accompany CAP staff visits to the field. M&E-specific monitoring trips occurred quarterly during regular implementation but were more frequent during the grant start-up period or when there were substantial changes to project indicators. Technical staff also reviewed data-collection sheets and reports during their routine visits to the field and provided appropriate support; this additional feedback reinforced the guidance from the M&E team in a cost-effective manner. TA was provided on site to improve data systems and at times included the participation of executive directors and even Board members.

3. **Thorough review and feedback on performance reports.** CAP carefully reviewed results data to check for the consistency of data collected with the narrative description of each activity. Aggregate results were compared against data recorded on data collection forms for key indicators to ensure data quality. TA was provided each quarter to help CSO Partners transfer data correctly (from aggregate forms to the report template and/or from a database to the report template), aggregate results properly, and align results data with the narrative description. A minimum of one conversation was required with each Partner to obtain final results in each quarterly reporting period. In some cases more than ten conversations were required. In one case, CAP worked with the Partner in its office for more than two full days to finalize results for that quarter.

"[I gained] capacity to review quarterly reports and monitoring tools, which in the beginning was more like a "seven-headed beast" because CAP was always asking to explain the how, why, and when of everything [in the reports]."
—CAP CSO Partner

4. **Annual participatory DQA exercises.** CAP Partners, along with community health workers and their supervisors, were required to participate actively in the DQA process so that CSOs could become skilled enough to facilitate their own DQAs in the future. CAP helped Partners review and reflect on the data on site to troubleshoot problems and analyze how project performance, as well as project reporting, could be improved.

Every attempt was made to include all levels of the organization—including Board members—in the DQA process. For some organizations, the DQA was a critical learning moment that helped them realize how they could use data to feed into management decisions, not only to complete donor reports.

5. **Tailored capacity development in M&E.** Through either CSO Partner meetings or individual training/TA sessions, CAP helped CSO Partners learn how to develop M&E systems, use quantitative and qualitative data for decision making, and identify and write success stories. CAP worked with organizations to ensure adequate, structured supervisory systems[2] that ensured the continuous monitoring of data collected by Partner staff. When new or different indicators were introduced, CAP invested significant resources to help each Partner adapt data-collection and -reporting systems, retrain field workers and supervisors, and answer the many questions that arose.

Mozambican CSOs Rise to the Challenge

CAP's CSO Partners are now better positioned to respond to USAID/PEPFAR data requirements. They understand the value their data bring to their donor, their organizations, and their beneficiaries. They have developed the systems necessary to guide the implementation of quality programming, collect data to measure progress toward project objectives, and submit quality reports to their donors. Specifically, CAP Partners have demonstrated:

- **Increased ability to meet beneficiaries' needs.** CAP's capacity development work with 21 Partner CSOs was assessed in 2013 through an external mid-term evaluation.[3] A key finding from the evaluation was: "Increased capacity in M&E through adoption of more systematic approaches and reliable tools allows the Partners to track the programs better and make adjustments as needed to maximize impacts in their communities."

CSO STAFF WORKING WITH COMMUNITY MEMBERS. (MAURO VOMBE | FHI 360)

- **Increased quality of data collected.** Over time, the numbers of errors discovered during the quarterly review of reports and annual DQAs decreased as organizations became more diligent about training and supporting community health workers to fill out data-collection forms correctly and completely and increased the number of staff involved in the verification of data. Organizations reached out to CAP for guidance when they were unclear how to proceed with new requirements. The ability of Partners to respond logically to questions about data they reported also improved dramatically.

[2] For CAP Partners, the M&E process included delegation of supervisory roles to certain individuals, templates to help supervisors observe activities and oversee data-collection processes and data forms, a location for archiving information, and a mechanism to discuss issues as they arose.
[3] Blid N, D'Alessio O'Donnell C, Souto M, Parviainen R. (2013) External Evaluation for Capable Partners Program (CAP)—Mozambique Final Evaluation Report.

"[Following the DQA] we had to rethink our monitoring structure and increase monitoring visits. We involved community leaders and began monitoring not only the supervisors, but also the activistas *and the families served by the project. We realized we were not collecting the information we needed to support our beneficiaries."*

—CAP CSO Partner

CAP Partners learned why data integrity is important and how to reach high standards, and they now want to meet their own high expectations.

- **Increased quality of reporting.** CAP evaluated report-writing capacity through an assessment tool applied annually. Over the life of CAP, 19 of the 28 Partners whose report-writing capacity was assessed more than once achieved improvement in their overall scores.

- **Increased ability to monitor their own activities.** Ten out of 11 Partners using social and behavior change communication (SBCC) strategies to influence attitudes and behaviors related to HIV/AIDS (and who were assessed at least twice on the M&E component of CAP's SBCC assessment) improved their M&E scores. These Partners are now better equipped to ensure that project activities contribute toward SBCC goals. At least three CAP Partners incorporated regular DQAs into their own monitoring activities.

- **Ability of some Partners to recognize and resolve problems evidenced by data.** Some Partners progressed quickly and used the DQA exercise to investigate why beneficiaries were not participating at levels originally anticipated. In other cases, incorrect reporting on indicators (a challenge that surfaced during the DQA) led to troubleshooting on how to mobilize the priority target audience as well as properly train project staff.

"We have always faced challenges reporting on results because there is so much data and our database was difficult to manage. CAP helped us create a new database and now we are able to manage our data much better."

—CAP CSO Partner

CAP reached a high level of confidence in the integrity of its CSO Partner data with regular verification, project monitoring, review of quarterly data, and annual DQAs. USAID/Mozambique found project data to be accurate and verifiable, which indicates a level of preparedness by Mozambican CSOs to meet USAID/PEPFAR data requirements if they are funded directly by USAID in the future.

For the CSOs, project monitoring is no longer something they are afraid of or only commit to because it is required. Project monitoring has become clear and tangible—supported by practical tools and processes—and helps Partners see progress towards objectives, provide evidence for the work they are doing, and improve the quality of life in their communities.

Bridging the Gap: Role of IOs in Coaching CSOs to Meet USAID Data Standards

Notwithstanding the advances made by CAP CSOs, the capacity of Mozambican CSOs remains limited in some respects. CAP has learned lessons that IOs can use to support their Partners in meeting this challenge:

- **Allocate sufficient resources.** Allow for sufficient staffing, training, and transportation for monitoring activities. Be flexible with timelines and funding to enable grantees to respond to PEPFAR data requirement changes; allow for grant budget revisions to fund additional project staff training; and monitor the implementation of PEPFAR changes.

- **Initiate frequent discussions about data use.** Demonstrate how solid data will serve the CSOs' own purposes. Link the role of formative research to their reputations in

their communities. (Gathering data from beneficiaries demonstrates a commitment to respond to beneficiary needs.) Illustrate how data can feed into project design and increase the likelihood of receiving funding. Show how data can contribute to decision making, development of communication products, and other resource mobilization efforts. Talk about how quality data reporting increases their credibility with the government. Insist that they use their own data to prepare annual work plans. Use data in project review meetings and demonstrate how to analyze and use the data to improve performance.

- **Make data everybody's business.** Train program staff, management staff, and members of the Board in data quality, analysis, and use. When the connections between quality data and resource mobilization, organizational sustainability, and an organization's credibility have been demonstrated, staff and Board members at all levels can be motivated to engage. Once project monitoring is deconstructed into a process that is manageable and practical, individuals will no longer be afraid to get involved.

- **Model ethical behavior.** Demonstrate that the IO holds itself to the same high standards to which the implementing CSOs are held. Share project results with Partners, present results to wider stakeholder audiences to promote their successes, and help Partners create communications materials for fundraising. Translate key documents into the local language for dissemination (e.g., success stories, project evaluations, documents demonstrating project results). Verify data with CSOs prior to wider dissemination.

- **Pay attention.** The knowledge that the IO is carefully reviewing the data and asking questions about them is a powerful motivator for Partners to take data seriously.

Finally, IOs must advocate on behalf of CSOs with the donor. IOs understand the needs of both donor and project partners and must act as a bridge, bringing them closer together. Part of the IO's responsibility in ensuring solid data is to inform the donor about how changes to the system affect the quality of data and what the costs of implementing changes may be. Minor changes in M&E requirements can result in substantial (and expensive) changes to tools and processes for local CSOs reporting on activities. A change to one indicator typically leads to a cascade of activities: revision of data collection and aggregation tools, training for CSO staff, training for community health workers, and revision of reporting templates. The good news is that even low-capacity local organizations can reach high standards of data integrity when they have appropriate and timely support to do so.

Document written in 2016.

"[Because of CAP support], we are noticing improvements in the success stories we submit, the accuracy of the data collection forms, our database, and also in the capacity of our facilitators. We had to create (and implement) an action plan to improve the facilitators´ capacity to facilitate sessions, complete the data collection forms, and collect ideas for success stories."

—CAP CSO Partner now receiving direct USAID funding

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MAURO VOMBE | FHI 360

OPERATIONALIZING GOVERNMENT GUIDELINES FOR ORPHANS AND VULNERABLE CHILDREN

OVC Call to Action

HIV/AIDS has had an enormous impact on Mozambique; in 2014, UNAIDS estimated that 610,000[1] children in Mozambique were orphaned because of the disease. A 2014 situation analysis conducted by UNICEF cited several challenges faced by Mozambique's orphans and vulnerable children (OVC) that increase their vulnerability—namely poverty, lack of household assets, lack of social protection, frequent natural disasters, and loss of parents through disease.[2] These challenges are exacerbated by long-term climate change and food deprivation. Other key factors influencing the well-being of children include gaps in local knowledge and the pervasiveness of certain attitudes and practices rooted in cultural traditions, including unequal gender relations.[3]

Overall vulnerability also creates conditions that increase children's own exposure to HIV—especially for young girls and young women. Children who have been left behind by parents who died from HIV may also be HIV-positive themselves. According to UNICEF, in 2013 only 37 percent of HIV positive children in Mozambique were receiving treatment.[4] Those caring for these children need additional support so that these young people can live with HIV and grow into productive adults.

Empowering Communities to Care for OVC

In an attempt to improve the quality of care for OVC and to shift the approach from charity to empowerment, the Ministry of Children, Gender and Social Action articulated guidelines promoting minimum standards of care and a family-centered approach. However, implementation of these guidelines has been a challenge. CAP Mozambique worked with local CSOs to systematically apply the guidelines in a way that was relevant to and respectful of local communities.

[1] http://www.unaids.org/en/regionscountries/countries/mozambique/
[2] http://sitan.unicef.org.mz/english/files/UNICEF%20SitAn%20FULL%2014%20EN_WEB.pdf
[3] Ibid.
[4] http://www/unicef.org/about/annualreport/files/Mozambique COAR 2013.pdf

To help address the critical needs of these children, the Ministry of Gender, Children, and Social Action (MGCAS) integrated three objectives in the National Strategic HIV and AIDS Response Plan, 2010–2014, specifically geared towards assisting OVC:

- create a protective environment that reduces the impact of HIV/AIDS on OVC
- strengthen the capacity of the Ministry and its partners to support OVC
- strengthen family and community capacity to care for and protect OVC

The United States President's Emergency Plan for AIDS Relief (PEPFAR) supported the Ministry in this endeavor by obligating funds for this agenda,[5] The U.S. Agency for International Development (USAID)/Mozambique recognized the important role that local organizations—embedded in their communities and at times established by people living with HIV/AIDS (PLWHA)—could play in caring for OVC. With their knowledge of community dynamics, access to local resources, and, in some cases, their very personal connections to the impact of HIV on children and families, these civil society organizations (CSOs) have the potential to act as a powerful and sustainable force for change.

CAP Mozambique OVC Implementing Partners

Umbrella organization Partner:
- Hope for the African Child Initiative (HACI) managed nine local partners

Direct implementing Partners:
- Associação Niiwanane Wamphula (Niiwanane)
- Associação Ecuménica Cristã (Kubatsirana)
- Associação Nacional para o Desenvolvimento Auto-sustentado (ANDA)
- Organização de Desenvolvimento Rural (Kukumbi)
- Liga dos direitos da Crianca da Zambezia (LDC)*

*LDC ended in 2014 and did not complete the program.

The Capable Partners Program (CAP) in Mozambique was designed to strengthen the capacity of leading Mozambican organizations and their networks in the fight against HIV/AIDS. Funded by USAID through PEPFAR, the project was implemented by FHI 360. CAP combined implementation grants with intensive, tailored capacity development to support local community-based organizations (CBOs) to play a bigger role in fighting HIV and promoting health in their communities. In addition to providing technical assistance, CAP supported core organizational systems—financial, human resources, accountability, and internal governance systems—to improve the sustainability and resilience of the organizations. CAP Mozambique developed and tested strategies and tools to manage a capacity development and grants project that support organizations (not just individuals) to identify the most promising partners; foster ownership and self-determination; and anticipate, prevent, and respond to challenges.

In December 2011, CAP Mozambique launched a competitive process in Manica, Nampula, Zambezia, and Maputo through which it identified local organizations with experience and interest in supporting OVC and their caregivers. Since 2012, CAP provided intensive capacity development support and sub-grants to these local NGOs to design and implement interventions to support OVC and their families affected by HIV.

This technical brief describes the support provided to these organizations and the results of their efforts. It also highlights success factors identified through interviews conducted with Partners.

[5] http://www.bu.edu/cghd/files/2012/05/Mozambique-OVC-Evaluation-Project-FINAL.pdf

Operationalization of MGCAS Minimum Standards for OVC Care

MAURO VOMBE | FHI 360

Guidelines and tools

In July 2013, MGCAS, which is responsible for OVC support, approved guidelines on a minimum package of OVC care and a needs assessment tool—the Child Status Index (CSI). (Measure Evaluation, a USAID-funded project, developed the CSI in 2009 to support improved OVC case management.[6]) The guidelines outline seven areas of support: nutrition, health, psycho-social support, education, shelter, legal and social protection, and economic strengthening. For each area, MGCAS stipulated essential actions and activities. CSOs working with OVC were required to ensure that their beneficiaries had access to all seven services. MGCAS required service providers to conduct an individual needs assessment for each OVC using the CSI, develop a care plan following the approved MGCAS guidelines, and respond accordingly. OVC service providers were not expected to provide all seven services. They could provide quality services in one or two key area/s but were required to make sure other needs were addressed through referrals to other governmental and non-governmental services providers. In addition, MGCAS increasingly advocated for a family-centered approach. It supported the premise that children cannot be viewed in isolation from their caregivers; assisting children without addressing the needs of caregivers cannot generate the desired outcomes.

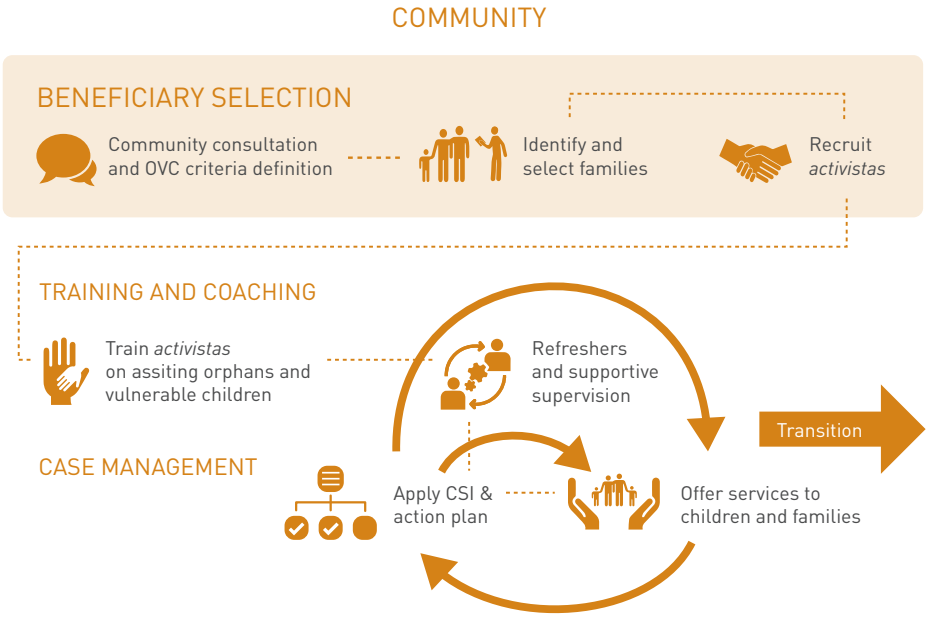
Putting the MGCAS minimum OVC care standards into practice and focusing on family-centered care represented a shift for CAP Mozambique's Partners, who mostly worked in one particular area of support and tended to be charity focused—providing short-term benefits. For example, CSOs might provide school uniforms and supplies for OVC, but did not identify and address barriers to doing homework or encourage parental involvement in the school life of the children.

The case management process

Case management is an iterative process of assessing and addressing needs and analyzing change (see Figure 1). The process starts with CBO Partners and local leaders identifying beneficiaries. Once beneficiaries are identified, community health workers are chosen (based on their proximity to beneficiaries, knowledge of a community's needs, language/s spoken, and capacity for interpersonal dialogue) and trained. Community health workers, under strict supervision, conduct the CSI and develop a care plan. With the care plan in place, community health workers conduct bi-weekly household visits to beneficiaries to provide services, or make referrals, accordingly. Six months after a CSI is conducted and a care plan developed, a re-assessment follows and the care plan is adjusted. Once the OVC and the family have progressed sufficiently, the OVC transitions, and the intensity of the support decreases.

[6] For more information see: http://www.cpc.unc.edu/measure/resources/tools/child-health/child-status-index.

FIGURE 1: CASE MANAGEMENT PROCESS



Implementation strategies that improved outcomes

CAP Mozambique identified the following key implementation strategies that led to improved outcomes:

Involving the community in beneficiary selection. Local organizations know the importance of involving communities. CAP strengthened Partners' abilities to involve communities more effectively for longer-term benefit. CAP developed and trained Partners in an approach to facilitate community involvement in the selection of beneficiaries. The previous process (of asking leaders to identify OVC without first establishing eligibility criteria) did not always lead to the neediest beneficiaries being supported. CAP helped OVC Partners work closely with community leaders to define community-specific eligibility criteria to complement standardized criteria suggested by MGCAS's definition of OVC. Communities tended to define OVC differently; it might be a child who only takes one meal per day, who has no shoes, or who is not attending school. Establishing clear criteria provided legitimacy, transparency, and community ownership to the entire process.

The process of defining community-specific eligibility criteria also provided Partners with an opportunity to explain the minimum guidelines for OVC care and raise awareness about OVC needs and mitigating actions. The community understood that eligibility criteria were partly defined by them and not solely imposed by the Ministry or the CBO. Each Partner worked with community leaders to form a selection committee of two to three people who then made house calls to children identified by leaders as OVC. The committee decided jointly if the OVC fit the eligibility criteria.

CAP Training and Coaching for Partners

Training

- Community consultation process
- Establishing and maintaining networks
- MGCAS guidelines
- Case management
- CSI application
- Household visit techniques
- Essential OVC services:
  - HIV care and treatment
  - household economic strengthening
  - psycho-social support
  - early childhood development

Coaching

- Bi-monthly monitoring site visits
- Data quality verification
- OVC database management

Engaging community leaders early on in the process meant that: 1) the project reached the OVC most in need of support; and 2) leaders became more aware of and sensitized to the plight of the OVC and felt ownership over the process and a greater responsibility for helping the children.

Conducting case management with a holistic, family-centered approach. Case management starts with a solid needs assessment. To guide OVC needs assessments, MGCAS adapted the Child Status Index (CSI) tool to the Mozambique context and approved its use in 2013. Individual care plans were developed based on CSI assessments. Community *activistas* negotiated with caregivers to set priorities and determine the various stakeholders' roles and responsibilities (including those of the caregivers themselves) to meet children's needs. Discussion of the CSI and subsequent negotiations of priorities also provided an opportunity to raise awareness about OVC needs and rights.

Activistas conducted bi-weekly visits to families and provided services directly or made referrals to other services. For example, an *activista* might provide psycho-social support to a child who has lost a parent, discuss personal hygiene and sanitation, talk about the importance of education, find resources to assist a child with homework, give basic nutritional advice, and share information on child rights. Referrals might also be made to other services if required, such as birth registration, HIV testing, care and treatment, and family planning. An *activista* might support a caregiver to negotiate a child's re-entry into school. Each *activista* kept careful records of progress made towards beneficiary care plan goals.

CAP Mozambique provided Partners an initial five-day training on MGCAS guidelines and the CSI, followed by annual refresher trainings prior to CSI re-application. CAP also provided frequent on-the-job technical assistance both during CSI application and household visits, particularly in the first two years of the project. In addition, CAP supported Partners to analyse their staffing structures. CSI application and care plan development and implementation are complex processes that need to be strictly guided and supervised. Over the years, as Partner staff and community health workers gained experience and confidence with case management, CAP's technical assistance shifted from case management to specific technical areas—such as mobilization for HIV testing, psycho-social support, household economic strengthening, and early childhood development. CAP provided training and on-the-job coaching in each of these areas.

"At first the activistas *thought that the CSI was a mandatory rapid survey. Once they applied the CSI for the second time, they realized it allowed them to assess the impact of their work and be more accurate about the support they provide."*

—OVC officer, Kubatsirana

Community health workers identified two key benefits of the structured needs assessment process. First, it helped them focus on long-term needs rather than only those that can be addressed immediately. The CSI allowed them to identify and respond to more complex underlying issues that require a long-term perspective. A second important benefit was the opportunity to re-apply the CSI over time and help them see the changes in children's lives as a result of their efforts.

Strengthening connections for additional resources. The needs of OVC are many and complex. CSOs do not have the resources to provide all the services that OVC require—and neither should they. The government provides basic social services such as healthcare, education, birth registration, and social grants. Communities are also willing to help, and CSOs within a community may have different areas of focus. OVC and their caregivers,

however, often face myriad obstacles to accessing government services as well as community-based support. CAP Mozambique assisted Partners to create access to existing services by identifying service providers, establishing relationships, and expanding referral networks. Partners mapped potential referral partners, and where possible, formalized relationships by signing memoranda of understanding. Through a combination of direct service delivery and referrals, they managed to provide a full package of OVC services.

With CAP Mozambique support, Partners improved their capacity to advocate for and negotiate access to services for OVC and caregivers and to mobilize community support. For example, Partners were able to successfully advocate with health facilities to provide HIV testing and counseling services within the community rather than only through health facilities. They negotiated with school management and school committees to eliminate registration and matriculation fees for OVC. They mobilized authorities to collectively register OVC who did not have identification papers. They mobilized local leaders to issue poverty statements through which OVC gained access to free health consultations and basic medication. And they organized community members to contribute materials and labor to improve housing for OVC families.

Capitalizing on opportunities for sustainability. CAP Mozambique tried to place knowledge and skills in the hands of both organizations and people so they in turn could channel good intentions into effective action and assume increased responsibility for the children under their care. Although financial resources are critical, improved knowledge, skills, and solid relationships have a chance of remaining in a community long after a project ends.

Example of psycho-social support from Kubatsirana

A child whose caregiver could not afford to contribute to building funds for the school bore the brunt of his teacher's anger when the teacher castigated him in front of his peers. The child was embarrassed, opted out of school, and started to live on the street. However, the *activista* worked with the child and his friends to return the child to school and re-socialize with other students.

CAP Mozambique pursued a dual approach of both training and follow-up coaching. CAP provided significant technical assistance in terms of initial training to staff and *activistas* on the MGCAS guidelines and case management. As the years progressed and *activistas* grew increasingly comfortable with case management and the family-centered approach, CAP helped Partners improve the quality and depth of their service offerings. Partners increased their knowledge and skills in household economic strengthening and introduced village savings and loan (VSL) groups; OVC participation in these groups led to tangible improvements in housing and nutrition. CAP invested considerable resources in strengthening the capacity of community health workers to provide much needed psycho-social support, using the respected methodologies of Regional Psycho-Socio Support Initiative's (REPSSI).[7] Community health workers learned to apply the methodologies and reported improved communication between children and elderly caregivers, retention of OVC (previously stigmatized) in school, and helping children cope with the death of caregivers and friends. CAP helped Partners to overcome community health workers' reluctance to talk about HIV testing and counseling—resulting in more OVC and caregivers getting tested and gaining access to care. Whenever community health workers noticed that fear of stigma and discrimination continued to prevent beneficiaries from seeking HIV services, *activistas* devised

[7] REPPSI is a non-profit organization that aims to lessen the social and emotional (psychosocial) impact of HIV and AIDS, poverty, and conflict on children and youth by building capacity to provide psychosocial care. The organization works with (I)NGOs and governments across East and Southern Africa.

alternative strategies to create access and support and advocate for retention in care. Finally, CAP introduced Partners to the importance of early childhood development, providing community health workers with the ability to engage their youngest beneficiaries in stimulating activities and teach caregivers to do the same.

CAP conducted frequent on-the-job coaching visits to support Partners and *activistas* in improving the quality of their work. Without such visits, CAP Mozambique and its Partners would not have achieved the same implementation quality.

"Before the training we provided care mainly to OVC of 5-18 years of age. We did not know what to do with younger children. Now we learned what to do and the activistas *are enthusiastic. Caregivers thank them for teaching them things that are so important for the development of their infants."*

— Project officer for Associaçao Kurera Wana Gondola (HACI sub-partner)

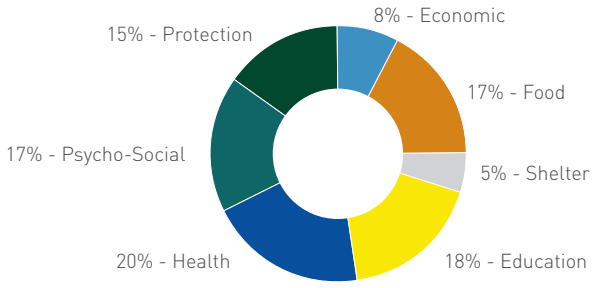
The Results—More and Better Services for OVC

In fiscal year 2015, OVC Partners reached 10,189 OVC and caregivers. More than half (55 percent) of beneficiaries were under 15 years of age; about one third (32 percent) were older than 18 years. Partners provided 36,244 discrete services to OVC that year (see figure 2), with an average of 3.6 services provided to each OVC. In addition, Partners initiated 4,786 referrals to other service providers (primarily associated with health care, birth registration, and education) and verified that the vast majority of these referrals (72 percent) were completed (i.e., OVC accessed the services).

OVC now have access to more services and opportunities to enrich their lives as a result of CAP Mozambique's efforts. Children have improved access to school, health facilities, and personalized attention. Their own community leaders are more aware of their needs and advocate on their behalves. Specialized support for the families, such as VSLA and nutrition training, also helps to ensure that children benefit over the longer term.

FIGURE 2: SERVICES PROVIDED TO OVC IN FISCAL YEAR 2015

Total = 36,244 services provided



Lessons Learned

CAP Mozambique Partners helped change the way communities think about and respond to OVC. They have seen many caregivers assume responsibility for their own lives and those of their children, and they have given them knowledge and means to sustain these changes. Asked what key factors they believe contributed to this success, the Partners identified the following:

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- **Early commitment by the village elders is critical**—The elders of Mozambican communities are highly trusted individuals. Gaining the confidence of these leaders is vital to the acceptance of any program that aims to support the community. The elders bring critical information about the families and their dynamics. They can facilitate access to services, influence barriers to services, and can point community health workers to the appropriate resources. If CBOs work with community elders early in their programs by including them in decision making, program implementation will ultimately be more acceptable, successful, and sustainable.

- **The CSI tool is very useful for case management but complex to master**—The CSI is an essential first step in the case management process. However, it is a complex tool to use, particularly in resource-poor settings, and requires extensive and continuous training and rigorous and supportive supervision and coaching. CAP Mozambique supported Partners during application of the CSI as well as in the development and implementation of action plans. Role plays and joint applications are effective ways to establish consensus on scoring.

- **CSI assessments and action planning should take place every six month**s—The CSI is designed to be applied every three months. Three months of data, however, are not sufficient to measure change in a child's well-being. A period of at least six months is needed to gain an accurate snapshot of the change that is occurring or to begin planning for the next cycle. Bi-weekly household visits ensure that critical situations do not go unattended. CSI applications and re-applications must be meticulously planned in order to avoid spending excessive time conducting the assessments at the expense of service delivery.

- **Empower caregivers**—Negotiations with caregivers during CSI application and conversations during household visits foster greater awareness about parental/caregiver responsibilities. These interactions help improve caregiver knowledge and ability to support a child, thereby reducing dependence on the Partner CBO.

- **CBOs cannot tackle OVC issues alone**—No single entity has the resources to provide all services needed by OVC. Building and maintaining support networks is therefore critical. CBOs can help families to access resources through the formal system and identify and mobilize informal resources in the community. These efforts also foster a sense of community in support of OVC. It is not possible for all support to be provided by a single entity. The community must come together in support of its OVC and their families.

- **Continuous training and coaching for *activistas* and project managers is key for quality services**—Case management is not learned overnight, but rather through continuous application and supportive supervision. As required services become more complex and varied, training and coaching for those providing services is essential.

CAP Mozambique was able to operationalize the MCGAS guidelines because the Government of Mozambique had the vision to create necessary guidance on OVC care. CAP Mozambique and its Partners were thus able to develop a framework on which to create comprehensive family-centered interventions to support OVC who are healthy and able to give back to their communities.

Document written in 2016.

YES CBOs CAN! Preventing HIV by Integrating Gender and GBV

Chiqui Arregui[1], Katinka C. van Cranenburgh[1], Rosália Miguel[2], Hayley Bryant[2]

GENDER, GBV and HIV CAP IN MOZAMBIQUE

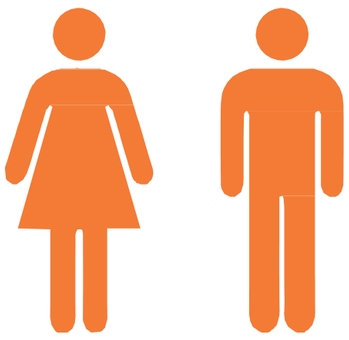
BACKGROUND

Violence and abusive behavior towards women and girls enhances their vulnerability to HIV infection.

International organizations and donors (WHO, UNAIDS, USAID, PEPFAR) recognize the relation between gender inequality and HIV. The need for addressing gender imbalances and considering cultural variations and perceptions of HIV risk in HIV prevention efforts has also been documented by academia (Dunkle & Jewkes, 2007).

In 2010, PEPFAR committed to USD30 million to the Gender-Based Violence (GBV) Initiative in three African countries, including Mozambique.

HIV prevalence Mozambique
(15 - 49 years old)



13.1% **9.2%**

In Mozambique, GBV, limited space to negotiate condom use, sexual harassment in schools, early marriage and multiple concurrent partnerships increase female vulnerability to HIV. In 2009, HIV prevalence was 13.1% for women and 9.2% for men aged 15-49.

The capacity of CBOs in Mozambique is known to be lower than in the rest of the Southern Africa region. The FHI360 Capable Partners Program (CAP) was implemented based on the hypothesis that Community-Based Organizations (CBOs) can design and implement effective social behavior change communication activities that address gender norms / GBV and HIV together.

CAP IN MOZAMBIQUE

RESULTS SHOW CHANGE IN ATTITUDES ABOUT GENDER NORMS

With funding from USAID under PEPFAR, CAP supports CBOs working in the fight against HIV. Of these, six CBOs implement HIV prevention activities at community level and independently identified prejudicial gender norms and GBV as problems in target communities, namely:

- *Associação da Mulher Moçambicana na Educação (AMME)*
- *Conselho Cristão de Moçambique - Sofala*
- *Kukumbi*
- *Núcleo de Associações Femininas da Zambézia (NAFEZA)*
- *N´weti*
- *Ophavela*

The end-evaluation (March 2015) based on a household survey amongst 1,588 individuals, showed impressive results related to HIV knowledge, condom use and use of healthcare services. Moreover, the integration of gender norms in CBO HIV prevention projects lead to a change of attitudes towards women and girls about prevailing gender norms.

COMMUNITIES INDICATED THAT GBV IS DECREASING

Most participants from focus groups conducted in a complementary qualitative study with 54 groups indicated that GBV had decreased as a result of CAP-supported interventions.

Participants described that the knowledge gained around human rights and existing laws protecting the rights of women, together with the fact of learning about the existence of legal mechanisms and support services for survivors of GBV were key drivers for change.

"In the past, there was neither communication nor dialogue between the couple; everything was solved based on violence. However, couples are now talking to solve their problems."
– Male community member, age 25 - 49 years.

		Not exposed to HIV interventions
· Condom use in last sexual encounter		
· Use of HIV Counseling and Testing services		
· Dialogue between partners around HIV		
· Dialogue with co-workers, family & friends around HIV		
· Being faithful to one partner		
· OPINIONS: I agree!		
· Men who have sex with a lot of women are real men		
· Men may make all family decisions without including the wife		
· It is acceptable for teachers to request sex from their students		

TABLE 1:
CAP RESULTS ON GENDER NORMS, GBV AND RISK BEHAVIOR SHOW POSITIVE RESULTS

WHAT MADE IT WORK?

THE CAP APPROACH – KEY TO SUCCESS

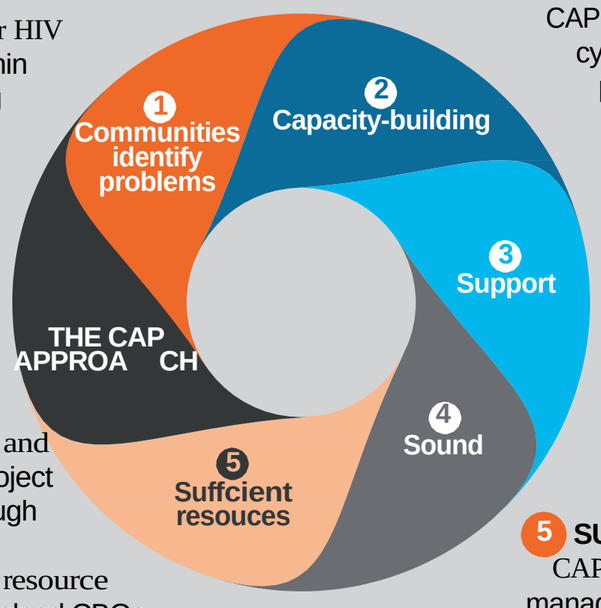
A case-study on the comprehensive CAP approach conducted mid-2015 by Community Wisdom Partners highlights that CBOs were able to successfully integrate gender and GBV and achieve impressive HIV prevention results due to:

1 IDENTIFICATION OF G&GBV BY COMMUNITIES

CBOs and their target communities identified gender and GBV as constraints for HIV prevention. CBOs continuously raised the need to integrate these issues within their HIV projects; full integration was possible as soon as USAID made funding available for it. CAP´s support to formative research and behavior-change communication enabled CBOs to further understand gender and GBV barriers and identify context specific measures to address them.

2 MANAGERIAL, TECHNICAL AND ORGANIZATIONAL CAPACITY

Each organization benefitted from comprehensive capacity building to strengthen its ability to deliver effective gender/ GBV/ HIV interventions. The Health Policy Project (HPP) provided training on gender and GBV for CBO staff and field workers in direct contact with communities. CAP provided practical project management technical assistance and supported quality improvement through structured monitoring and supervision. CAP also supported program and financial staff, the organization's governing bodies to develop sound human resource and accountability systems. The skills developed with CAP support has helped CBOs strengthen other projects.



3 SUPPORT AT ALL STAGES OF THE PROJECT CYCLE

CAP ensured dedicated support and staff for CBOs throughout the project cycle. This included the conduction of formative research, designing a project and materials appropriate for the local context, quality improvement, data gathering, and analysis, exchanges with other organizations, substantial training, along with structured monitoring and supervision.

4 USE OF SOUND METHODOLOGIES

CAP worked with CBOs to develop a multi-level approach targeting individuals, households and leaders. Structured debate sessions for small groups of up to 25 people (disaggregated by gender and age, as relevant) focusing on key issues around HIV prevention, gender norms, GBV and increased use of health care and other services.

5 SUFFICIENT FINANCIAL RESOURCES

CAP ensured sufficient funding for organizations to implement and effectively manage quality interventions, including those related to gender and GBV. USAID invested in capacity development.

CONCLUSIONS

The FHI360-led CAP program underlines the need for integrating gender norms and GBV in HIV prevention. It responds to the call for action by governments, donors and academics to ensure interventions are context specific and evidence-based.
The experience of CAP Mozambique shows that with appropriate support, CBOs are very effective change agents. When communities self-identify GBV as an issue, changing community norms in two years is possible.

MORE INFORMATION

For those interested, various in-depth documents are available outlining the program and its results.
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Acknowledgements

CAP Mozambique would like to acknowledge Mary Ellen Duke, Gender Advisor, USAID Mozambique, for being willing to listen to communities, invest in local organizations and capacity development. She also mobilized the right GBV and gender expertise through HPP.

Annex 28: CAP Mozambique January 1 – March 31, 2016 Financial Information

Quarterly Report - Financial Information
Implementing Partner: FHI360
Activity Name: CAP Mozambique
Implementation Period: October 2015 - March 2016

Line Item[1]	Total Life of the Project Budget (LOP)	Total Amount Obligated (to date)	Mortgage	Planned Expenditures for the quarter	Actual Expenditures Thru this Quarter			Deviation % (actual Vs Planned Expenditures)[2]	Pipeline	Projection (April - July 2016)
					Prior	This Quarter	Total			
	(A)	(B)	(C)=A-B	(D)	(E)	(F)	(G)=D+E	(H)=F/D-1	(H)=B-G	(H)
Personnel & Fringe	11,652,787.00			372,641.00	10,951,519.95	424,305.66	11,375,825.61	0.14		483,015.00
Benefits & Fringe	4,702,546.00			114,815.00	3,618,824.24	130,854.95	3,749,679.19	0.14		183,190.00
Travel	3,774,268.00			89,640.00	2,635,405.76	49,493.06	2,684,898.82	(0.45)		159,260.00
Equipment >$5K	190,059.00			-	170,059.06	-	170,059.06	-		55,007.00
Supplies				-	-	-	-	-		-
Training	565,268.00			10,000.00	348,617.15	6,407.16	355,024.31	(0.36)		-
Sub grants*	16,508,616.00			452,889.00	14,078,236.42	189,622.09	14,267,858.51	(0.58)		147,466.00
Consultancy	366,086.00			42,291.00	254,809.55	28,486.54	283,296.09	(0.33)		8,483.00
Other Direct Costs	7,031,806.00			304,391.00	5,593,215.56	127,665.46	5,720,881.02	(0.58)		518,873.00
Total Direct Costs	44,791,436.00			**1,386,667.00**	**37,650,687.69**	**956,834.92**	**38,607,522.61**	(0.31)		**1,555,294.00**
Indirect Costs	10,208,564.00			380,086.00	8,385,793.84	296,519.64	8,682,313.48	(0.22)		525,939.00
Grand Total	**55,000,000.00**	**49,606,788.00**	5,393,212.00	**1,766,753.00**	**46,036,481.53**	**1,253,354.57**	**47,289,836.10**	(0.29)	2,316,951.90	**2,081,233.00**

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CURRENT GRANTS							
Sub Partner Name: Local/Portuguese	Grant Number	PEFPAR Area	Start Date	End Date	Approved Budget MTN	Budget USD (1 USD=49.36 MTN)	**Longevity with CAP II**
Associação Niiwanane Wamphula (NIIWANANE)	3253-17-RFA10.04-11-NIIWANANE-01	OVC	12/1/2011	4/30/2016	13,765,469	$278,879	CAP II Partner since 5/2010
Associação Nacional para o Desenvolvimento Auto-sustentado (ANDA) MARP	3253-17-RFA10.05-11-ANDA-01	Prevention	4/2/2012	4/30/2016	13,747,075	$278,506	CAP II Partner since 4/2012
Associação Nacional para o Desenvolvimento Auto-sustentado (ANDA) OVC	3253-17-APS11.02-ANDA-02	OVC	6/1/2013	4/30/2016	18,745,149	$379,764	CAP II Partner since 4/2012
Associação para o Desenvolvimento Sócio Economico (OPHAVELA)	3253-17-SS-Ophavela-02	Prevention	11/2/2015	5/31/2016	4,948,309	$100,249	CAP II Partner since 9/2012
Kubatsirana - Associação Ecuménica Cristã	3253-17-APS11.02-12-KUBATSIRANA-01	OVC & HBC	11/1/2012	4/30/2016	11,205,299	$227,012	CAP II Partner since 11/2012
CLOSED GRANTS							
Sub Partner Name: Local/Portuguese	Grant Number	PEFPAR Area	Start Date	End Date	Final Budget MTN	Budget USD	Reason for End of Grant
Associação de Fomento para o Desenvolvimento Comunitário (ADC)	3253-17-CAPI-09-ADC-01	Prevention	8/3/2009	8/31/2011	4,372,402**	$143,635	Completed Award
Associação de Fomento para o Desenvolvimento Comunitário (ADC)	3253-17-RFA10.05-ADC-02	Prevention	9/1/2011	10/31/2013	10,270,111**	$355,533	Completed Award
Associação dos Deficientes de Moçambique (ADEMO)	3253-17-APS001-10-ADEMO-01	Prevention	5/17/2010	11/30/2011	1,193,894**	$37,109	Completed Award
Ajuda Desenvolvimento Povo para Povo (ADPP)	3253-17-RFA10.03-11-ADPP-01	Prevention	3/1/2012	4/30/2013	11,313,208**	$385,888	Ended early due to shift in PEPFAR priorities
Associação dos Jovens de Nacala (AJN)	3253-17-RFA10.04-11-AJN-01	OVC	7/16/2012	4/30/2013	1,644,107***	$55,193	Ended early due to shift in PEPFAR priorities
Associação da Juventude de Luta contra SIDA e DROGA (AJULSID)	3253-17-APS001-09-AJULSID-01	Prevention	10/1/2009	3/31/2011	1,994,810**	$59,707	Completed Award

Associação da Juventude de Luta contra SIDA e DROGA (AJULSID)	3253-17-RFA10.05-11-AJULSID-02	Prevention	8/1/2012	10/31/2013	4,990,907**	$167,455	Ended early due to shift in PEPFAR priorities
Associação Moçambicana Mulher e Educação (AMME)	3253-17-APS001-09-AMME-01	Prevention/OVC	11/1/2009	3/31/2012	2,551,955**	$83,117	Completed Award
Associação Moçambicana Mulher e Educação (AMME)	3253-17-RFA10.05-AMME-02	Prevention/OVC	3/1/2012	12/31/2013	9,168,119**	$312,308	Ended early due to shift in PEPFAR priorities
Associação de Mineiros Moçambicanos (AMIMO)	3253-17-APSOO I-09-AMIMO-0 1	Prevention	11/1/2009	8/14/2010	844,712**	$26,714	Terminated for financial misconduct or poor performance
Associação Moçambicana para a promoção da Rapariga (AMORA)	3253-17-APS001-10-AMORA-01	Prevention	5/17/2010	12/31/2011	1,174,582**	$37,106	Completed Award
Associação Nacional de Enfermeiros de Moçambique (ANEMO)	3253-17-RFA003-07-ANEMO-02	Care and Treatment + Treatment Adherence	1/1/2010	6/30/2011	9,237,247**	$281,122	Completed Award
Associação Nacional de Enfermeiros de Moçambique (ANEMO)	3253-17-SS-11-ANEMO-03	Care and Treatment + Treatment Adherence	1/2/2011	2/28/2013	8,813,234**	$310,305	Completed Award
Associação Nacional de Enfermeiros de Moçambique (ANEMO)	3253-17-SS-11-ANEMO-04	Care and Treatment + Treatment Adherence	3/1/2013	9/30/2013	2,615,260**	$87,459	Completed Award
Conselho Cristão de Moçambique-Sofala (CCM-Sofala)	3253-17-APS001-09-CCM-01	Prevention	10/1/2009	6/30/2011	2,713,026****	$119,895	Completed Award
Conselho Cristão de Moçambique-Sofala (CCM-Sofala)	3253-17-RFA10.05-11-CCMS-02	Prevention	7/1/2011	5/31/2015	31,303,881***	$963,196	Completed Award
Conselho Cristão de Moçambique-Zambezia (CCM-Zambezia)	3253-17-RFA10.01-11-CCMZ-01	OVC	10/3/2011	12/3/2013	7,439,249***	$256,912	Terminated for financial misconduct or poor performance
Comité Ecuménico para o Desenvolvimento Social (CEDES)	3253-17-RFA10.05-11-CEDES-01	Prevention	7/16/2012	12/31/2013	4,828,856**	$161,779	Ended early due to shift in PEPFAR priorities
Conselho Islâmico de Moçambique (CISLAMO)	3253-17-APS001-09-CISLAMO-01	Prevention	1/1/2010	12/16/2010	1,392,318**	$38,876	Terminated for financial misconduct or poor performance
Comunidade Moçambicana de Ajuda (CMA)	3253-17-APS11.02-12-CMA-01	Prevention (MARP)	1/2/2013	4/30/2013	458,999**	$15,218	Ended early due to shift in PEPFAR priorities

Associação dos Empresários contra o HIV e SIDA, Tuberculose e Malária (ECoSIDA)	3253-17-RFA11.01-ECOSIDA-01	Prevention	7/16/2012	12/31/2013	15,575,376**	$523,041	Completed Award
Fórum Nacional de Rádios Comunitárias de Moçambique (FORCOM)	3253-17-APS001-09-FORCOM-01	Prevention	10/1/2009	6/30/2011	2,502,655**	$86,346	Completed Award
Associação para a Promoção do Emprego (Get Jobs)	3253-17-RFA003-07-GetJobs-02	Prevention	1/1/2010	12/31/2010	1,880,356**	$57,159	Completed Award
Hope for African Children Initiative (HACI)	3253-17-RFA002-09-SAVE/HACI-01	OVC	10/1/2009	5/31/2011	N/A	$156,307**	Completed Award
Hope for African Children Initiative (HACI)	3253-17-RFA10.01-11-HACI-02	OVC	6/1/2011	3/31/2016	6,1937,324***	$1,543,032	Completed Award
International Breastfeeding Action Network (IBFAN)	3253-07-SS-10-AMODEFA-01	Systems Strengthening	9/1/2010	3/31/2015	19,479,219***	$599,361	Completed Award
Organização de Desenvolvimento Rural (KUKUMBI)	3253-17-RFA10.05-11-KUKUMBI-01	Prevention	5/1/2012	4/30/2015	12,934,127 ***	$397,973	Completed Award
Organização de Desenvolvimento Rural (KUKUMBI)	3253-17-SS-KUKUMBI-02	OVC	11/1/2014	10/31/2015	4,363,333***	$108,703	Completed Award
Organismo de Desenvolvimento Socioeconómico (KULIMA)	3253-17-RFA003-07-KULIMA-02	Prevention	4/1/2010	3/31/2011	1,725,629**	$51,138	Completed Award
Liga dos direitos da Crianca da Zambezia (LDC)	3253-17-APS11.02-12-LDC-01	OVC	11/1/2012	8/8/2014	6,008,769***	$198,061	Terminated for financial misconduct or poor performance
Movimento de Mães Intercessoras Contra HIV e SIDA (MMICHS)	3253-17-RFA003-07-MMICHS-02	Prevention	4/1/2010	3/31/2011	1,154,919**	$32,569	Completed Award
Núcleo das Associações Femininas da Zambézia (NAFEZA)	3253-17-RFA04-09-Nafeza-01	Prevention	9/7/2009	9/30/2011	3,383,891**	$105,469	Completed Award
Solidariedade da Zambézia -Delegação de Nampula (Solidariedade)	3253-17-APS001-10-Solidariedade-01	Prevention (& OVC)	9/13/2010	9/12/2011	1,167,539**	$29,477	Completed Award
Rede Moçambicana de Organizações contra o SIDA- delegação de Sofala (MONASO-Sofala)	3253-17-CAPI-09-SOFALA-01	Prevention	8/3/2009	7/31/2011	4,654,603***	$144,265	Completed Award
Rede Moçambicana de Organizações contra o SIDA- delegação de Sofala (MONASO-Sofala)	3253-17-RFA10.05-11-MONASO-S-02	Prevention	8/1/2011	12/15/2012	4,602,942**	$169,546	Terminated for financial misconduct or poor performance

Monaso Rede Moçambicana de Organizações contra a SIDA - Delegação de Nampula (MONASO-Nampula)	3253-17-RFA04-09-MONASO/Nampula-01	Prevention	9/7/2009	4/18/2010	88,533**	$2,729	Terminated for financial misconduct or poor performance
Monaso Rede Moçambicana de Organizações contra a SIDA - Delegação de Zambezia (MONASO-Zambezia)	3253-17-RFA04-09-MONASO/Zambezia-01	Prevention	9/7/2009	1/21/2010	165,657**	$5,104	Terminated for financial misconduct or poor performance
Núcleo das Associações Femininas da Zambézia (NAFEZA)	3253-17-RFA10.05-11-NAFEZA-02	Prevention	5/1/2012	9/30/2015	16,233,660***	$499,497	Completed Award
Associação para o Desenvolvimento da Criança e Educação da Rapariga (NAMUALI)	3253-17-APS001-09-NAMUALI-01	Prevention	11/1/2009	8/28/2010	468,137**	$14,647	Terminated for financial misconduct or poor performance
Associação Niiwanane Wamphula (NIIWANANE)	3253-17-RFA004-10-NIIWANANE-01	Prevention (& OVC)	5/17/2010	11/30/2011	1,267,384**	$41,065	Completed Award
N´weti Comunicação para Saúde (N´WETI)	3253-17-RFA10.03-11-NWETI-01	Prevention	8/1/2011	10/31/2013	35,196,365**	$1,230,736	Completed Award
Organização Nacional de Professores (ONP)	3253-17-APSOOI-09-ONP-01	Prevention	11/1/2009	7/5/2010	261,453**	$7,979	Terminated for financial misconduct or poor performance
Associação para o Desenvolvimento Sócio Economico (OPHAVELA)	3253-17-RFA10.05-11-OPHAVELA-01	Prevention	9/10/2012	4/30/2015	15,071,182***	$463,729	Completed Award
Rede Contra o Abuso de Menores (REDE CAME)	3253-17-RFA10.02-11-REDECAME-01	OVC	11/1/2011	4/30/2013	9,186,050**	$320,116	Ended early due to shift in PEPFAR priorities
Rede Nacional Contra Droga (UNIDOS)	3253-17-APS001-09-REDE-01	Prevention	10/1/2009	5/31/2011	2,908,915**	$91,995	Completed Award

Exchange Rate (March 22, 2016) 49.36

** Value at final close-out of award.

*** Estimated final value at close-out of award. Close-out still in progress.

****Close-out for this award still in process. This estimate is above real value at close of award.

Annex 30: Partner Profiles

CAP Mozambique Partner Profiles
September 1, 2015 – February 29, 2016

This chart presents award details and progress toward project goals for each CAP Mozambique grantee. The reporting period for CAP Mozambique sub-grants differs slightly from CAP Mozambique's reporting period. The six-month results are for the sub-grantee period from September 1, 2015 – February 29, 2016.

PEPFAR Focus & Status	Grantee & Award Details	Project Description & Geographic Targets	Project Implementation: Comments on Progress
CBCTS/ Prevention **Graduated**	**Associação Nacional para o Desenvolvimento Auto-Sustentado (ANDA) – Key Populations** **Award Ceiling:** 13,747,075 MTN ($278,506) **Period of Performance:** April 2, 2012 – April 30, 2016	**ANDA** contributes to reducing the risk of HIV infection among students and teachers, truckers, commercial sex workers, and practitioners of transactional sex in the Districts of Manica and Gondola, Manica Province. **Geographic Targets:** Districts of Manica end Gondola (Manica Province)	During this reporting period, ANDA: • in coordination with District Health, Gender and Social Action Services (SDSMAS), opened a night clinic at the Machipanda border on the premises of the Mozambican customs. ANDA mobilizes beneficiaries to through rapid debate sessions. An SDSMAS technician screens truck drivers, commercial sex workers and other community members for STI, including, HIV, and other common illnesses such as malaria. Treatment is available but no ART is administered. • Continued to conduct HIV Testing and Counseling (HTC) and distribute condoms in all hotspots where the project is operating, (Motocrosse, Garimpo, Machipanda, Vanduzi, IAC and Messica) • Continued to conduct film projection, music and animation sessions, accompanied by quick debates with truck drivers, specially the breaking barriers film package (*escondidos*, Buzi's sisters, a special gift and safe travel). • Conducted five advocacy campaigns in Manica, IAC and Messica. During these campaigns, ANDA supports leaders to talk about and exhibit posters containing information on laws prohibiting entry of minors into entertainment venues. Leaders were demanding bar owners and shop liquor shopkeepers to post signs prohibiting entry of minors into their establishments. • Continued to conduct radio debates facilitated by community leaders addressing topics related to prohibiting entry of minors into places selling alcoholic beverage and projecting pornographic films, and raising awareness about cultural practices that influence the spread of HIV/AIDS and gender-based violence. • Prepared and implemented a close-out plan using CAP developed close-out check list. CAP conducted an assessment of ANDA's technical capacity in the area of Social Behavioral Change Communication. ANDA's knowledge, technical capacity and ability to conduct prevention activities with a focus on individuals' behavior change had increased.

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PEPFAR Focus & Status	Grantee & Award Details	Project Description & Geographic Targets	Project Implementation: Comments on Progress
CBCTS/ Prevention **Graduated**	**Núcleo das Associações Femininas de Zambézia (NAFEZA)** **Award Ceiling:** 16,233,660 MTN ($328,883) **Period of Performance:** May 1, 2012 – September 30, 2015	**NAFEZA** aims to contribute to the reduction of the risk of HIV infection among adolescents, young people and couples in communities identified in the Districts of Nicoadala and Inhassunge. Target groups include pre-adolescents aged 10 to 14 years old, teens aged 15 to 17 years, youth aged 18 to 25 years, and married people over 18 years old. **Geographic Targets:** Zambézia Province, District of Inhassunge (Localities of Mucopia, Mussangane and Abreu),District of Nicoadala (Localities of Bilila, Nanthide and Mutchessane)	Note: This grant ended on September 30, 2015.
CBCTS/ Prevention **Graduated**	**Associação para o Desenvolvimento Socio-Económico (OPHAVELA)** **Award Ceiling:** 4,948,309 MTN ($100,249) **Period of Performance:** November 2, 2015 – May 31, 2016	**OPHAVELA:** contribute to reducing the barrier to adherence and retention in HIV care and treatment. **Geographic Targets:** Nampula provinice - Nampula, Muecate, Mecuburi e Malema	Ophavela began to implement the project in November, conducting the following activities: • Recruited key project staff to manage the project, including a project manager, counselors and finance staff. • Developed project Implementation Plan. • Developed project monitoring plan, including data collection tools. • Trained on financial management of this award. • Prepared and signed sub-grant documents for Niiwanane. Niiwanane has started the selection and training of *animadores* and *activistas*. • Contracted consultant (Nweti) to adjust debate session manuals and conduct *animadores* training. • Trained 65 *animadores* in the four districts. The *animadores* started to conduct debate sessions on HIV prevention, testing, care and treatment adherence, gender norms and GBV, and STI with Village Saving and Loan groups in the four districts. • Trained leaders in four districts. Ophavela will work with the leaders to create an environment supportive for HIV testing and counseling and HIV treatment adherence and retention. • Contracted consultant (ANEMO) to develop and training manual with an emphasis on HIV treatment adherence and conduct *activistas* training • Trained 28 *activistas* in the four districts implementing. • Offered HTC to savings and loan group members in one district with support from a health center counselor, referred individuals testing HIV-positive to health facility, supported these individuals to disclose their status at home, and offered HTC to family members/contacts. • Initiated defaulter tracing • Signed the memorandum of understanding with the DPS. Ophavela

PEPFAR Focus & Status	Grantee & Award Details	Project Description & Geographic Targets	Project Implementation: Comments on Progress
			submitted the MoU in January but DPS signed in March only, hampering earlier initiation of key project activities.
Orphans and Vulnerable Children (OVC) **Graduated**	**Associação Nacional para o Desenvolvimento Auto-Sustentado (ANDA) – OVC** **Award Ceiling:** 18,745,149 MTN ($379,764) **Period of Performance:** June 1, 2013 – April 30, 2016	**ANDA-OVC** contributes to reducing the high vulnerability of OVC and their families in the context of HIV in locations identified within Manica district. **Geographic Targets:** Districts of Manica (Manica Province)	During this reporting period, ANDA-OVC: • Realigned its budget the months remaining in the award, including activities relating to the exit strategy such as social workers' final refresher training, delivery of school materials and birth registration of new children selected to replace those who have transitioned. • Conducted 3rd and final CSI assessment for children, identifying 68 children whose well-being had progressed enough to be transitioned to a less intensive phase. • Continued to conduct household visits to assist OVC and their families. • Continued to conduct HIV prevention debate sessions on HIV and AIDS and its treatment, family planning, gender-based violence, masculine norms with communities, including beneficiaries, and offer HTC to participants. If HIV positive, ANDA supported access to ART. • Continued to screen for GBV among debate session participants. GBV victims were supported to access services. • Continue to refer OVC beneficiaries to various social services according to their needs. Nearly all referrals (99 percent) were completed, meaning that the OVC gained access to the service. • Continued to supported VSL groups, particularly those newly established and supported by community VSL facilitators. ANDA continued to provide on-the-job support to the facilitators. • Continued to facilitate access for OVC families to INAS provided *cestas basicas* and construction material for OVC home improvement. • Continued to facilitate integration of OVC in secondary school, exempting fees. • Continued to facilitate acquisition of birth certificates, identity cards and poverty certificates for OVC beneficiaries in partnership with District Youth and Technology Services, District Civil Identification Services, and Manica Municipality. In this period, school uniforms and materials were acquired to benefit OVC in the project. During this period, school materials were distributed to 426 OVC project beneficiaries. • Continued to conduct training and demonstrations on food production and preservation techniques for OVC families in collaboration with government agricultural extension workers. The Manica district hospital nutritionist and Chinhambuzi health center staff treated malnourished children identified by ANDA *activistas*. • Support families to generate income by selling produce at local markets. Income from selling produce will reinforce their participation in VSL

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			groups. • Continued vocational training activities for adolescent OVC beneficiaries, ANDA continues to be challenged by supporting students to access the job markets after the training. • Continued to trace HIV treatment defaulters and – if found – support reintegration into ART. • Prepared and implemented a close-out plan using CAP developed close-out check list. CAP conducted a technical assessment of ANDA's capacity to support OVC following MGCAS guidelines. The assessment showed that ANDA's capacity continued to grow
OVC	**Hope for the African Child Initiative (HACI)** **Award Ceiling:** 61,937,324 MTN ($1,254,808) **Period of Performance:** June 1, 2011 – March 31, 2016	**HACI** provides training, technical assistance, and grants to five NGOs (three in Maputo City/Province and two in Manica Province) and supports two CBOs in Maputo directly to provide services to orphans and vulnerable children. NGOs will be trained in community consultation, proposal and budget development, contractual compliance, M&E, and OVC care to enable them to implement projects in their communities. **Geographic Targets:** Maputo and Manica provinces	In this reporting period, HACI: • Supported seven sub-partner to close-out their grants. • Realigned its budget the months remaining in the award. HACI's budget ceiling could not accommodate activities relating to the exit strategy (final refresher training for *activistas*, delivery of school materials and acquisition of bicycles for *activistas*). CAP covered these expenses. • Conducted an exchange visit with ANDA Manica. Six sub-partners participated as well. • Facilitated CAP training and coaching of sub-partners on Early Childhood Development (ECD. • Conducted final refresher trainings for sub-partner *activistas* in the basic package of care and support for OVC and their families with support from CAP. A representative of the health facility co-facilitated health related topic, including HIV testing, prevention, care and treatment. Community leaders also participated in training to encourage their involvement in OVC support after the project closes out and to expose them to the skills of *activistas* for future projects. • Identified 1,049 children using the CSI results who have significantly improved their status and can be transitioned into a maintenance phase, i.e. they will start receiving less intensive assistance. • Continued to provide technical assistance visits to sub-partners. • Prepared and implemented a close-out plan for sub-partners and HACI using CAP developed close-out check list. • Continued to support sub-partner PACO to participate in piloting the CSI software. This work was assisted directly by CAP and VPHealth consultants who developed the tool.

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			CAP conducted a technical assessment of HACI's capacity to support OVC following MGCAS guidelines. The assessment showed that HACI continues to improve its technical capacity. Some areas of sub-grant management, however, remain weak, including the use of tracking systems to capture data on grant management and database verification.
OVC	**Kubatsirana** **Award Ceiling**: 11,205,299 MTN ($227,012) **Period of Performance**: November 1, 2012 – April 30, 2016	**Kubatsirana** HIV OVC and provides psycho-social support, strengthening parenting skills, improving the life skills of OVCs, improving economic resiliency, promoting advocacy and community mobilization, and creating/improving networks for service referrals. **Geographic Targets:** Manica, District of Gondola - Inchope, Manica - Machipanda and Barué – Catandica	During this reporting period, Kubatsirana: • Realigned its budget the months remaining in the award, including activities relating to the exit strategy such as social workers' final refresher training, delivery of school materials and birth registration of new children selected to replace those who have transitioned, and bicycles for *activistas*. • Conducted 3rd and final CSI assessment for children, identifying 109 children whose well-being had progressed enough to be transitioned to a less intensive phase. Kubatsirana demonstrated considerable technical growth in this subject matter. It conducted the CSI application process without CAP technical assistance. • Continued to conduct household visits to chronically ill people and those bedridden to provide care and support. • Engaged parents in registering/integrating children in school and distributed school materials and uniforms according to the needs identified in the CSI. • Conducted dialogues with OVC to provide psycho-social support using the REPSSI developed "Journey of Life" approach for adults and "Tree of Life" approach for children. • Continued to conduct economic strengthening activities and expanded the number of groups to 36. In this period, most groups finalized a savings and loan cycle and initiated a new cycle. The beneficiaries are satisfied with this activity because most of them are conducting small businesses and are improving their housing conditions and the quality of life of their families. • Continued to refer beneficiaries to the different basic services but with particular attention to HTC services. The number of individuals referred to HIV testing services has greatly increased due to a new mobilization strategy. • Continued to trace HIV treatment defaulters and – if found – support reintegration into ART. Kubatsirana continues to have great challenges in conducting this activity due to disorganized and incomplete patient files in

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			health facilities. In recognition of mobilization and counseling work that is done by Kubatsirana *activistas*, health services requested Kubatsirana to make two *activistas* available in Machipanda and Catandica to be the case managers. Since CHASS left in 2015, the health facilities have not been able to hire other people for this post. • Improved Early Childhood Development capacity with support from CAP, and continued to support families to stimulate growth of toddlers and young children. • Conducted refresher training in the OVC care and support package for social workers in Machipanda with support from CAP. Participants had the opportunity to revisit the topics covered in the past throughout the project and learn more about child protection and nutrition. It was also a moment to share experiences and knowledge about good practice. Unfortunately, due to political-military tension it has not yet been possible to conduct the refresher training for social workers in Catandica yet. CAP conducted a technical assessment of HACI's capacity to support OVC following MGCAS guidelines. The assessment showed that Kubatsirana continued to improve its capacity to support OVC. Kubatsirana has gained access to resources from other donors and is expanding their portfolio of projects.
OVC	**Associação Niiwanane Wamphula (Niiwanane)** **Award Ceiling:** 13,765,469 MTN ($278,879) **Period of Performance:** December 1, 2011 – April 30, 2016	**Niiwanane** will contribute to the improvement of school-based education and reduce the impact of trauma in orphans and vulnerable children aged 6-12 years in Nampula City. **Geographic Reach:** Napipine and Natiquir neighborhoods, Nampula City/Province	In this period the report, Niiwanane: • Conducted final refresher trainings for *activistas* in the basic package of care and support for OVC and their families with support from CAP. A representative of the health facility co-facilitated health related topic, including HIV testing, prevention, care and treatment. Community leaders also participated in training to encourage their involvement in OVC support after the project closes out and to expose them to the skills of *activistas* for future projects. • Conducted 3rd and final CSI assessment for children, identifying 125 children whose well-being had progressed enough to be transitioned to a less intensive phase. • Screened all OVC beneficiaries of 0-5 years for malnutrition using the Mid-Upper Arm Circumference tool, and supported caregivers to prepare balanced meals for the family. • Continued to conduct household visits to assist OVC and their families. • Continued to conduct HIV prevention debate sessions on HIV and AIDS and its treatment, family planning, gender-based violence, masculine norms with communities and encouraged participants, including

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			beneficiaries, to accept HTC. • Continued to refer OVC beneficiaries to various social services according to their needs. Nearly all referrals (99 percent) were completed, meaning that the OVC gained access to the service. • Continued to supported VSL groups, particularly those newly established and supported by community VSL facilitators. Niiwanane continued to provide on-the-job support to the facilitators. • Continued to screen for GBV among debate session participants. GBV victims were supported to access services. • Continued to participate in ART committee of health facilities 25 September and General Hospital Marrere which meets once a week and is responsible for examining the adhesion and retention activities in each health unit. Incomplete patient files remains an obstacle to more efficient HIV defaulters tracing. • Improved Early Childhood Development capacity with support from CAP, and continued to support families to stimulate growth of toddlers and young children.
OVC	**Organização de Desenvolvimento Rural (Kukumbi)** **Award Ceiling:** 4,363,333 MTN ($88,398) **Period of Performance:** November 1, 2014 – October 31, 2015	**Kukumbi** Contribute to increased access, retention and success of OVCs in formal education. **Geographic Targets:** Mobede Communities, Lugela District, Zambezia Province	Note: This grant ended on October 31, 2015.