Service Delivery and Support for Orphans and Vulnerable Children

Revised Annual Workplan
October 1, 2017- September 30, 2018

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ACRONYMS

ADE  Apoio Directo a Escola (Direct School Fund)
ADP  Area Development Program
ADPP Development Aid from People to People
AMME Associação Moçambicana Mulher e Educação (Mozambican Association of Women and Education)
AMODEFA Associação Mocambicana para o Desenvolvimento da Família (Mozambique Association for Family Development)
ANEMO Associação Nacional dos Enfermeiros de Mozambique (Mozambique National Association of Nurses)
AOR Agreement Officer Representative
APE Agente Polivalente Elementar (Community Health Worker)
APS Annual Program Statement
ART Antiretroviral Treatment
BCI Banco Comercial de Investimento
BCM Basic Case Management
BOM Banco Oportunidade Moçambique
CAP Capable Partners Program
CBO Community-Based Organization
CC Community Committees
CCPC Community Child Protection Committee
CCS Centro de Colaboração em Saúde (Center for Collaboration in Health)
CD Community Dialogue
CHASS Clinical HIV/AIDS Services Strengthening
CIHO Communications for Improved Health Outcomes
COP Chief of Party
COV Crianças Órfãs e Vulneráveis (Orphans and Vulnerable Children-OVC)
CP Consortium Partner
CSI Child Status Index
DCOP Deputy Chief of Party
DPCAS Direcção Provincial de Género, Criança, e Acção Social (Provincial Directorate of Gender, Child and Social Action)
DPS Direcção Provincial de Saúde (Provincial Health Directorate)
DQA Data Quality Analysis
DVIT Data Verification Tool
ECD Early Childhood Development
EGPAF Elizabeth Glaser Pediatric AIDS Foundation
EMMP Environmental Mitigation and Monitoring Plan
ENSSB Estrategia Nacional para Segurança Social Básico (National Strategy for Basic Social Security)
FDC Fundação para o Desenvolvimento da Comunidade (Community Development Foundation)
FFBS Farmer Field Business Schools
FGH Friends in Global Health
FRELIMO Frente de Libertação de Moçambique (Mozambique Liberation Front)
FY Fiscal Year
GAAC Grupo de Apoio e Adesão Comunitário (Community Adherence and Support Group)
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GBV</td>
<td>Gender-based Violence</td>
</tr>
<tr>
<td>GLM</td>
<td>Governance, Leadership and Management</td>
</tr>
<tr>
<td>GRM</td>
<td>Government of the Republic of Mozambique</td>
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<tr>
<td>GTCOV</td>
<td>Grupo Técnico de COV (OVC Technical Working Group)</td>
</tr>
<tr>
<td>HES</td>
<td>Household Economic Strengthening</td>
</tr>
<tr>
<td>HF(s)</td>
<td>Health Facility(ies)</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Testing and Counseling</td>
</tr>
<tr>
<td>ICAP</td>
<td>Columbia University Mailman School of Public Health</td>
</tr>
<tr>
<td>ICB</td>
<td>Integrated Capacity Building Plan</td>
</tr>
<tr>
<td>ICS</td>
<td>Internal Control Systems</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education, and Communication</td>
</tr>
<tr>
<td>IGA</td>
<td>Income-generating Activities</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
</tr>
<tr>
<td>INAS</td>
<td>Instituto Nacional de Acción Social (National Social Action Institute)</td>
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<tr>
<td>INGO</td>
<td>International Non-Governmental Organization</td>
</tr>
<tr>
<td>IR</td>
<td>Intermediate Result</td>
</tr>
<tr>
<td>LOA</td>
<td>Letters of Authorization</td>
</tr>
<tr>
<td>MANGO</td>
<td>Management Accounting for Non-governmental Organizations</td>
</tr>
<tr>
<td>MCSP</td>
<td>Maternal and Child Survival Program</td>
</tr>
<tr>
<td>MER</td>
<td>Monitoring, Evaluation, and Reporting</td>
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<tr>
<td>MESAT</td>
<td>Monitoring and Evaluation System Assessment Tool</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MGCAS</td>
<td>Ministério de Género, Criança, e Acção Social (Ministry of Gender, Children, and Social Action)</td>
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<tr>
<td>MINEDH</td>
<td>Ministério de Educação e Desenvolvimento Humano (Ministry of Education and Human Development)</td>
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<tr>
<td>MISAU</td>
<td>Ministério de Saúde (Ministry of Health)</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>MMEMS</td>
<td>Mozambique Monitoring and Evaluation Mechanism Services</td>
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<tr>
<td>MNEC</td>
<td>Ministério de Negócios Estrangeiros e Comércio (Ministry of Foreign Affairs)</td>
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<tr>
<td>M-SIP</td>
<td>Mozambique Strategic Information Project</td>
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<tr>
<td>mSTAR</td>
<td>Mobile Solutions, Technical Assistance and Research</td>
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<tr>
<td>MUAC</td>
<td>Mid-Upper Arm Circumference</td>
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<tr>
<td>NPCS</td>
<td>Núcleo Provincial de Combate ao Sida (Provincial Nucleus for Fighting AIDS)</td>
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<tr>
<td>NUMCOV</td>
<td>Núcleo Multisectoral para Crianças Órfãs e Vulneráveis (Multi-sectoral Steering Committee for Orphans and Vulnerable Children)</td>
</tr>
<tr>
<td>OFDA</td>
<td>Office of U.S. Foreign Disaster Assistance</td>
</tr>
<tr>
<td>PASSOS</td>
<td>Integrated HIV Prevention and Health Services for Key and Priority Populations Project</td>
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<tr>
<td>PATH</td>
<td>Program for Alternative Technologies in Health</td>
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<tr>
<td>PCC</td>
<td>Community Care Program</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PESOD</td>
<td>Plano Económico Social Distrital (District Social Economic Plan)</td>
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<tr>
<td>PESS</td>
<td>Plano Estratégico do Sector de Saúde (Health Sector Strategic Plan)</td>
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<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PMSD</td>
<td>Participatory Market Systems Development</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>PMP</td>
<td>Performance Monitoring Plan</td>
</tr>
</tbody>
</table>
1 OVERVIEW

1.1 Project Summary

Project duration: Five years
Start date: June 23, 2016
Life of project funding: USD $84,380,436

Geographic focus: COVida - Together for Children (formerly Service Delivery and Support for Orphans and Vulnerable Children or SDS – OVC), will implement activities in the President’s Emergency Plan for AIDS Relief (PEPFAR) priority districts indicated by the United States Agency for International Development (USAID) in Maputo City, Maputo Province, Inhambane, Gaza, Sofala, Manica, Tete, Zambezia, Nampula, Cabo Delgado, and Tete Provinces.

Project objectives: The overall objective of COVida is to improve the health, nutritional status and well-being of orphans and vulnerable children (OVC) living in the PEPFAR-defined priority districts for epidemic control.

The project’s specific objectives are:

1. To increase utilization of quality social, health and nutritional services.
2. To reduce economic vulnerability of OVC households.
3. To improve early childhood development (ECD) services.
4. To strengthen capacity of district government and communities to provide support to OVC and their families.

1.2 Overview of Workplan

This second annual workplan covers the period October 1, 2017 – September 30, 2018, thus aligned with the USAID standard fiscal year, FY 18. This overview describes the overall approach for FY 18 and includes key updates on Sub-award Management and Project Deliverables, in those respective sections. Section II covers Project Implementation, comprising the comprehensive array of COVida technical inputs across the four Intermediate Results (IRs) and the FY 18 Gantt Chart is annexed, complementing the narrative. Section III describes the monitoring and evaluation (M&E) efforts needed to adequately track and report on COVida targets. Sections IV, V, and VI provide updates on Exit Strategy and key collaborations, and Section VII covers Project Management, which addresses practical factors and provides an update on Cost Share.

COVida has made tremendous progress since the award was signed on June 24, 2016, having reached 260,651 of the 285,964 beneficiaries targeted as of September 2017, which is 91.2% of the FY 17 target. Despite enormous challenges linked to mounting a structure to identify and support 57 community-based organizations (CBOs) in 62 districts to recruit, train and monitor 4,454 activistas, 475 activista chefs, 120 supervisors, the COVida consortium team partners and the Ministry of Gender, Children, and Social Action (MGCAS) worked together diligently and effectively. The COVida consortium started working in the districts with highest targets first and prioritized those activities that would lead most directly to the targets and results provided. The structure is now in place, the core tools and systems have been developed, and 245,449 children and caregivers are enrolled and receiving services. We have responded to the priorities USAID Mozambique provided for this year.

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1 According to MER 1.0 definition, as explained in the Q4 report.
We have done our best to plan FY 18 while respecting the original scope of work (SOW), aiming to achieve the high targets provided by USAID Mozambique, and staying within budget. We note the targets for FY 18 (338,023 beneficiaries) are 18% higher than FY 17 (285,964 beneficiaries). The $12.8 million earmarked for FY 18 is 80% of what would be needed if we maintained the same cost per beneficiary as in FY 17. This amount is also only 62% of the $20,632,102 scheduled for FY 18 (as reflected in the approved budget for Modification 01).

We embraced the challenge presented by the reduction in funds in the development of this workplan, but find that even our powers of adaptation and “doing more with less” have limits. As stewards of the funds provided by USAID Mozambique, we are responsible to propose a strategy that will most effectively utilize those funds to achieve the agreed-upon outcomes. With OVC funds, we also have an ethical responsibility to ensure the project is making a real difference in the lives of OVC and their families.

Even with redesigning the model and prioritizing those activities deemed essential by PEPFAR, we are still stretched to reach all of the districts with the minimum services while improving quality. Below, we provide a detailed description of the changes we have made to the program for FY 18 based on the funds made available to COVida at this time.

The COVida consortium has given significant thought to the challenge. We have agreed to focus investment on those activities that will have the greatest impact on program outcomes for the volume of beneficiaries indicated. Some activities previously presented in the project proposal or workplan have been dropped or modified to ensure resources are concentrated on individual case management, which has been proven effective in making a significant impact for beneficiaries and addressing the 90-90-90 outcomes. The key strategy for reaching the targets and contributing to project outcomes in FY 18 will be to improve case management at the field level. To do this, we will provide additional training for the front-line activistas and the people who supervise them, and utilize technical assistance (TA) more strategically at all levels. COVida will provide training to help activistas integrate ECD into household visits and introduce ECD playgroups in selected areas (IR 3). We will scale up savings groups (IR 2), add debate sessions to reinforce messages covered in household visits, and discuss community norms such as stigma and discrimination. We will continue to engage local authorities and collaborate with district agents of SDMAS ([District Health and Women, Children and Social Action Services]) to monitor and support CBOs. While we will continue to support IRs 2, 3, and 4, strengthening case management (IR 1) will also contribute to these IRs.

COVida will support the implementing CBOs, activistas and staff at all levels to understand and effectively implement case management. We will prioritize Human Immunodeficiency Virus (HIV) related services (90-90-90), as well as those services that contribute to safety, health, stability and education.

To accommodate the reduced budget, we have made the adjustments outlined in Table 1 below. In many cases we are either finding ways to do “skinny” or minimal versions of the activities initially planned or postponing activities for Year Three. The third column illustrates what we would be doing if we had the full budget. We believe this strategy is the best approach to align with Mission priorities and contribute to project outcomes with available resources.
### Table 1: Impact of reduced budget for COVida activities

<table>
<thead>
<tr>
<th>Activity area</th>
<th>Actions taken to respond to reduced budget / Impact on project</th>
<th>What COVida would do with additional funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>M&amp;E Staff</td>
<td>Converted three long-term M&amp;E positions into six-month consultancies. We are not adding additional staff to help manage the additional targets and districts in FY 18; instead will focus TA on larger sites. Risk is that data quality at some sites will be weak.</td>
<td>Additional M&amp;E staff would allow project to conduct more frequent visits TA and monitoring visits to each site, which in turn would improve data quality, increase our capacity to respond to changes and ad hoc data requests, allow us to support CBOs to collect accurate data, and enable us to use data to monitor trends and take prompt action.</td>
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<tr>
<td>TA provision</td>
<td>Re-designed the TA system to a cascade model to reduce the number of technical experts and their travel to provide TA to CBOs. Technical experts will now visit each province two - three times a year (instead of visiting each CBO) and focus on supporting the COVida provincial technical staff who will conduct TA visits to the CBOs on a monthly or bi-monthly basis. Districts with higher targets will be prioritized for TA, meaning quality may suffer in smaller districts.</td>
<td>Additional technical staff (to support savings groups, ECD, community dialogue sessions and adolescents) would allow a technical expert to visit every CBO at least three times a year, which would increase quality and accelerate uptake of interventions.</td>
</tr>
<tr>
<td>Training for activistas and their supervisors</td>
<td>Reduced the number of days of training for 3,800 activistas and instead will invest in training for 475 activista chefs and supervisors who will then coach the activistas and handle more complex cases, with the goal of improving case management.</td>
<td>Additional days of training would allow us to address the following topics more comprehensively: challenging stigma and discrimination, adolescents and HIV, additional risk factors for HIV prevention, parenting education, ECD, and prioritizing children’s needs in management of household resources.</td>
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<tr>
<td>Adolescent support</td>
<td>Reduced planned adolescent-focused activities and instead will focus on leveraging existing resources for support. This includes providing a shorter (2 hour) training for activistas focusing on the following communication with youth and coaching parents to speak with their adolescents about HIV. COVida will provide referrals for adolescent-specific services, engage youth in the community mapping exercise for new CBOs, encourage adolescents to study together in groups. COVida will also disseminate existing tools developed under Youth Power, that</td>
<td>Develop an adolescent component that provides targeted support to adolescents and helps adults learn to better support and engage adolescents: includes specialized adolescent groups that address HIV prevention, sexual and reproductive health (SRH), treatment literacy and more; three-day training with activistas to improve communication with adolescents; adolescent-focused savings groups, parenting groups or parenting education; revised adolescent child status index (CSI), session in community dialogues on creating positive opportunities for adolescents.</td>
</tr>
<tr>
<td>IR 2 – Household Economic Strengthening</td>
<td>Savings group facilitators have been asked to increase their workload from supporting approximately 2-3 groups to 5-6 in order to expand coverage. Reduced TA providers mean they will not be able to visit every CBO to ensure quality. This may have an impact on the quality of support savings groups receive.</td>
<td>Increase TA for savings groups, initiate Farmer Field Business Schools, income-generating activities (IGAs) and linkages with formal financial institutions.</td>
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<td></td>
<td>Consumption support will be offered only to the neediest of families, and where funds are available in CBO budgets</td>
<td>Offer consumption support to 10% of families to address urgent needs that are not met by other services.</td>
</tr>
<tr>
<td>IR 3 - ECD</td>
<td>Initiated ECD play groups in 1 district.</td>
<td>Accelerate roll-out of ECD play groups. Additional TA and follow-up to improve pilot intervention.</td>
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<tr>
<td></td>
<td>Will provide only one day of training on ECD for activistas and their supervisors in lieu of a more complete, three-day training.</td>
<td>An additional two days of training would allow more practical application, which would reinforce learning and capacity to respond to unexpected situations in the field.</td>
</tr>
<tr>
<td></td>
<td>Instead of providing more complete nutrition counseling and training activistas to screen for chronic malnutrition, will prioritize identification of and referrals for acute malnutrition cases to health clinics.</td>
<td>Train and equip activistas to screen for chronic malnutrition and provide more complete support to families on diversifying their diet.</td>
</tr>
<tr>
<td>Peer group interventions</td>
<td>Delayed implementation all other group activities (community dialogues with formal and informal leaders, parent groups, kid’s groups) beyond savings groups. Activities that bring together peers (school age kids, adolescents, parents of infants and toddlers, parents of adolescents) provide critical supplementary support that, once initiated, is not dependent on the activistas. Group support builds social capital that contributes to family stability and reduces the possibility of regressing. Community dialogues engage community leaders, particularly adult men, in changing social norms that affect children.</td>
<td>Reinstate implementation of group activities for FY 18. A relatively low-cost intervention in the long run, these activities still require an initial investment(^2) to train and orient the activistas to start these groups and develop the systems to collect the data to report on them.</td>
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<tr>
<td>Support government at</td>
<td>Reduced the frequency of multi-sectoral meetings at national and provincial levels from semi-annual to annual. The project</td>
<td>Hold semi-annual meetings at national and provincial level. Increasing the frequency of meetings strengthens the</td>
</tr>
</tbody>
</table>

\(^2\) A three-day training of all 3,800 activistas and their supervisors costs approximately $700,000, plus monitoring and supervision visits.
<table>
<thead>
<tr>
<th><strong>multiple levels to monitor project activities</strong></th>
<th>will use existing platforms as much as possible, but will still need to support annual meetings at national and provincial levels to ensure productive working relationships, especially with MGCAS and DPGCAS.</th>
<th>relationships between stakeholders, thus strengthening the platform for supporting OVC. Also support Community Child Protection Committees (CCPCs).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support for CBOs</strong></td>
<td>Reduced investment in organizational sustainability of CBOs. Support is now focused on addressing critical issues related to subagreement special terms and conditions and troubleshooting structural issues that affect performance. CBOs with larger caseloads are struggling the most, so will be prioritized.</td>
<td>Increase investment in organizational capacity building (such as teaching board members how to execute their oversight role, helping CBO managers implement effective performance review systems so only the most effective staff continue, coaching on advocacy, etc.), which increases the CBOs’ capacity to address their own problems, and in turn promotes sustainability.</td>
</tr>
<tr>
<td><strong>Research</strong></td>
<td>Delayed additional studies, including a study of the relationship between caseload and quality of services. In lieu of this we will analyze existing routine data to generate some learning on this link.</td>
<td>Conduct a robust, independent study on caseload and quality including time tracking of activistas and focus groups.</td>
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<td><strong>CBO budgets</strong></td>
<td>Reduced the budget ceiling for CBOs with 70 activistas or more from 850 per beneficiary to 750 per beneficiary. This means CBO staffing reductions, no annual salary increases or benefits, no increases to activista stipends, less equipment, less participation in commemorative events, and reduced incentives for activistas such as hats, t-shirts, bags, etc.</td>
<td>Fund CBOs at an appropriate level, allowing them to follow their internal HR policies for annual salary increases and benefits and to purchase the equipment necessary to do their work, e.g. photocopier machines to reproduce forms, computers to conduct data entry and reporting and use the electronic CSI (eCSI), etc. Increasing the activista stipend (as discussed in the section on Project Management) would increase retention, which would ultimately improve quality and sustainability.</td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td>Postponed procurement of one vehicle to Year three. We will rent as necessary which over the longer-term has the potential to be costlier.</td>
<td>Purchase a vehicle as a one-time investment that reduces costs over time.</td>
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<tr>
<td></td>
<td>Postponed procurement of bicycles for activistas in new districts, which inhibits their ability to reach beneficiaries and in turn affects the quality of support and the rate at which households can be graduated.</td>
<td>Purchase bicycles for activistas to improve access and increase the frequency at which they can conduct visits.</td>
</tr>
</tbody>
</table>
We have proposed various strategies to mitigate the effects of these cuts to ensure we are still able to make a positive difference in families’ lives, but these adjustments will affect the quality and effectiveness of program interventions. It bears noting that in FY 17, due to the high targets, we had already tripled the number of activistas, cut in half their number of training days, eliminated additional training for activista chefes and supervisors, and increased the activista caseload from 30 to 45 OVC per activista. Expanding and improving the skills and knowledge of activistas, activista chefes and supervisors leads to higher quality services, and stretching the limited resources has already had an impact on what the project is able to deliver. As such, the FY 18 plan prioritizes additional training (though with activista chefes and supervisors) and TA (using the cascade model described above).

COVida is reconsidering its model of having a “maintenance phase” before graduating families. The maintenance phase – one year of quarterly visits to support and monitor the family’s stability – was developed to smooth the transition and reduce the number of families that re-enroll. The alternatives COVida is considering are discussed below in the section on IR 1.

The COVida consortium is committed to supporting OVC and their families effectively and the proposed approach reflects our best effort to balance cost effectiveness with the intent of the SOW and the mandate to achieve high numbers. We believe the model proposed can work, although the quality of case management, the speed at which field workers master this approach, and the accuracy of the data is affected by the quality and frequency of TA. While we will continue to ensure the quality of TA, the frequency of TA is directly tied to funding availability.

This FY 18 workplan is based on an analysis of FY 17 data available, as well as the designated funding levels.

**March 2018 update.**

*Early in March 2018, COVida leadership was instructed by USAID to only spend the $12,638,488 that was allocated to COVida in COP 17, a 13% reduction from the $14,490,846 in the approved workplan budget. To respond, the team made the following adjustments:*  
- Postponed signing agreements and starting in new districts until next fiscal year.  
- Scale down early in districts with lower targets next year.  
- Freeze hiring of any new staff and replace people who leave only when critical for service delivery at all levels, including activistas.  
- Reduce playgroup activity to demonstration activity in 1 district.  
- Freeze roll out of savings group debates. Only continue in those districts where facilitators have already been trained.  
- Freeze roll out of SAVIX system. Only continue in those districts where it is already working successfully.  
- Postpone importing Books for Africa cost share contribution until next fiscal year.  
- Reduce regional coordination and in-service training meetings for COVida staff.  
- Cancelled the annual workplan meeting.

Even with these adjustments, the budget reaches a little over $13 million. The reduction in number of districts served represents a corresponding reduction of 45,217 in targets. We will do our best to compensate for the reduction by supporting CBOs in other districts to overachieve. We will strive to reach the 338,023 beneficiaries in the target USAID provided before the start of the fiscal year. Based on first quarter data, we are on the path to achieving that target, but the OVC _SERV indicator disaggregations have changes, which will impact the number we can reach. Similarly, there is a reduction in the number of savings groups from 1302 to 1035. Without the new districts, there is neither the time nor resources to make up these targets in other districts. While our aim this year
was to improve the quality of services, our progress will be less than initially expected. Similarly, our progress in rolling out the case management aspects of the eCSI will be limited, as we are unable to mobilize the HR necessary for this.

1.3 Consortium Partner Roles

In FY 18 the geographic consortium partners will continue to manage implementation in their respective provinces: World Vision (WV) (Zambezia and Gaza), CARE (Inhambane), and FHI 360 (remaining seven provinces). FHI 360 continues as the technical lead for case management and HIV, covering most of IRs 1 and 4. N’weti continues as the technical consortium partner for community mapping and influencing social norms (reinforcing the information shared in household visits), contributing to IRs 1 and 4. As technical lead in IR 2, CARE will continue to improve the capacity of CBOs and geographical partners to support families to manage finances, generate income and address inequalities of access to household income among family members. PATH continues as the technical consortium partner responsible for leading IR 3, namely ECD. They will focus on strengthening activistas to integrate ECD interventions into household visits to improve parental and caregiver responsiveness for children under five.

1.4 CBO Management

USAID has provided a list of 74 districts in which COVida is expected to provide services in FY 18. This includes 12 new districts, five of which were designated as maintenance districts (including one new one, Mocimboa da Praia in Cabo Delgado), and three of which have very low targets: Lichinga (280), Kanyaka (244), and Kampfumu (511). To allow the project time to consolidate in the 57 districts that started in Year One and prepare for a proper start in new districts, COVida will sign agreements with the CBOs in the new districts this year so that they can start in October 2018. Annex 2 includes the list of districts and CBOs.

COVida has concluded subagreements with all 57 CBOs covering 62 districts indicated by USAID for Year One. In FY 18, we will extend those subagreements, modifying them to add the new activities once this workplan is approved. We will continue to monitor existing CBOs, as well as execute new subagreements with CBOs in five to ten new districts.

COVida will select CBOs to work in ten new districts through a competitive annual program statement (APS) launched in August 2017, following the process outlined in the Year One workplan.

For those CBOs in the districts designed as maintenance districts, COVida will work with the CBOs to develop a strategy to conclude services for existing beneficiaries and refer those still requiring support to other services whenever possible. We will also support CBOs in developing and implementing close-out plans.

1.5 Project Deliverables

In FY 18 COVida will submit the following deliverables in accordance with the schedule in the Cooperative Agreement:

Table 2: COVida deliverables for FY 18

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Due Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Annual Workplan</td>
<td>September 30, 2017</td>
</tr>
<tr>
<td>2 Quarterly Narrative Reports</td>
<td>January 31, 2018</td>
</tr>
</tbody>
</table>
2 PROJECT IMPLEMENTATION

As described in detail in the Overview above, the key strategy for reaching the targets and contributing to project outcomes in FY 18 is to improve case management at the field level. The diagram below summarizes the menu of services available to beneficiaries of different ages. Case management is cross-cutting and foundational for all services. With the emphasis on achieving 90-90-90, health and safety components are the most urgent priorities. Stability and education are longer-term investments that help families become more self-sufficient. Table 3 below illustrates the menu of services.

Table 3: COVida menu of services by age³

<table>
<thead>
<tr>
<th></th>
<th>0-5 years</th>
<th>6-12 years</th>
<th>13-17 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable</td>
<td>Savings groups for caregivers</td>
<td>Savings groups for caregivers encouraged to include adolescents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Poverty certificate, family consumption support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schooled</td>
<td>ECD integrated into household visits 3-5 year-old playgroups</td>
<td>School enrollment support (documents, registration, referrals to access school subsidy) Support to stay in school and progress Homework help</td>
<td></td>
</tr>
<tr>
<td>Safe</td>
<td>Birth registration</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Victim identification and post-violence care/follow-up including gender-based violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy</td>
<td>Referrals to HIV Testing and counseling and treatment, treatment adherence and retention, and disclosure counseling (if needed) for children and/or caregivers</td>
<td>Routine referrals for common illnesses Refer adolescents to sexual and reproductive health services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ECD in household visits Screen for acute malnutrition Monitor immunization Breastfeeding education</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

³ Adapted from CDC - Atlanta's diagram: Leveraging OVC programs to improve pediatric outcomes.
The narrative below provides an overview of the specific activities COVida proposes for FY 18. Annex 1 is a Gantt Chart that outlines the timeframe for activities.

### 2.1 IR 1: Increased Utilization of Quality Social, Health and Nutritional Services

Under IR 1 in FY 18, COVida will improve health outcomes and contribute to 90-90-90 targets by supporting existing CBO partners to facilitate mapping exercises in their communities and increasing the number of beneficiaries identified through the health system. During FY 18, COVida will: 1) provide additional training to activistas, activista chefs, and supervisors to improve case management quality, and 2) support CBO partners in managing their high caseloads by transitioning beneficiaries to the maintenance or graduation phase. COVida also will seek to improve collaboration with health units and other services for referrals, and support the environment for OVC support through debate sessions. Finally, COVida will explore other approaches such as “group case management” to reduce the case management burden for activistas and allow them to focus on the HIV-infected or affected patients.

#### 2.1.1 Mapping existing services

In its first year, COVida consortium partner, Nweti, developed a guide and trained CBOs to conduct a mapping process that identified key community stakeholders that provided services for OVC, including local decision-makers (e.g. CPCCs, community courts) and community members who influence children’s well-being. Through the mapping exercise, CBOs also identified barriers to accessing services and appropriate channels for advocacy. Some of the barriers include: a lack of responsiveness of civil registry and health services, which we are addressing through sensibilization of these services; lack of availability of services that provide food, ECD, or psychosocial support, two of which COVida is addressing; some people in the community have resources, but don’t wish to be recognized for this, and prefer to let NGOs support OVCs. Feedback from CBOs that have already conducted the exercise suggests the mapping has been useful for identifying existing services that could benefit OVC and has also increased awareness around support and protection mechanisms communities can establish, such as CCPCs, community courts, and safe play spaces for children. To follow-up on this exercise, COVida will encourage CBO partners to establish partnerships and advocate with the identified stakeholders and services to mobilize resources for OVC and their families.

CBOs that have already conducted the mapping process will continue to expand the exercise to more communities implementing the project. For actions with adolescents, COVida will integrate the identification of specific services available to adolescents in the community into the stakeholder and service mapping process. The results of this mapping will be summarized and shared with activistas so that they can make appropriate referrals for adolescents.
2.1.2 Identification of OVC

During start-up, COVida used three main channels to identify beneficiaries: 1) the community, with collaboration from community leaders and other social institutions (churches, CBOs, National Social Action Institute [INAS]); 2) health facilities; and 3) referrals from other PEPFAR partners. The cumulative results reported through September 2017 indicate that 90% of families originated in the community and 10% of total families were identified through health facilities and clinical partners. Although the initial expectation was that most beneficiaries would be identified from clinical HIV services, the process of establishing partnerships and defining collaborative strategies is not easy and comprises a series of steps from the central level to district and health facility level. In addition, demand from community leaders for services is very high. In FY 18, COVida will work to increase referrals from health facilities, key populations programs, and other PEPFAR partners to have a higher proportion of beneficiaries that are HIV positive or HIV-affected, and require complementary services. As current COVida beneficiaries transition to maintenance phase and graduate, COVida will increase the percentage of referrals from health facilities and/or PEPFAR partners in Year Two.

COVida will increase efforts to educate health facility staff about the project in collaboration with clinical partners. COVida receives referrals from prevention of mother-to-child transmission (PMTCT), antiretroviral therapy (ART), HIV counseling and testing (HTC) and other departments, but the results vary by province. We expect to receive more referrals from health units as they become more familiar with COVida and the support we provide to HIV+ and at-risk families, and as the health system provides orientations to refer to COVida. The clinical referrals to COVida are important for capturing those on ART who need retention support. COVida will fortify its existing strategy which involves:

1. COVida staff at central level build PEPFAR partners’ awareness of the COVida project, with support from USAID.
2. COVida geographic partners increase awareness at the provincial level with DPS (Direção Provincial de Saúde [Provincial Health Directorate]), and provincial offices of implementing partners.
3. CBO partners dialogue with district-level authorities to build awareness and operationalize the collaboration.
4. Monitor referrals and share data with collaborators on a monthly basis.

Current data shows that Manica, Tete, Cabo Delgado and Sofala have the highest percentages of beneficiaries originating from health facilities. In these provinces, COVida technical officers, together with clinical partner technicians, CBO representatives (coordinators, supervisors, activités chefes) and health facility teams have conducted meetings to clarify the objectives of each project and define bi-directional referral mechanisms for beneficiaries. The basic premise is that any health facility technician or COVida CBO representative assigned to the clinic will inform HIV+ patients and other eligible families about COVida project activities and ask whether they would like to be beneficiaries of the project. If the patient accepts, a COVida activista is appointed to visit the family to register and follow up on the case immediately. In FY 18, COVida will support its partners to implement this practice, adjusted to the realities of each site. N’wetti’s Hyalisa project, Communication for Improved Health Outcomes (CIHO), Serving Communities through Integrated Programming (SCIP), Integrated HIV and Health Services for Key and Priority Populations (PASSOS), Pathfinder, Ophavela and other interventions conducting community testing will also be referring families to COVida.

In addition, COVida will develop and disseminate a job aid to help field level staff understand who should be referred to COVida, how to refer, and what the client can expect in their first contact with COVida. A draft is included in Annex 3. This will be attractively laid-out and produced as a convenient handout and poster for health unit walls and partner offices.
As more beneficiaries are identified through the health system, there will be an increasing need to screen families for level of risk to prioritize the higher-risk families. COVida will refine a tool to help CBOs screen for level of risk.

COVida will continue to seek collaboration with clinical partners and health facilities directly to receive referrals from them. COVida also requests USAID Mozambique’s support in motivating clinical partners to refer HIV+ children and families with an HIV+ caregiver and at-risk children to COVida.

To support children of key populations (KP) and members of KP who are children, COVida is working with PASSOS where we serve in the same districts. We have agreed to follow the same approach that proved successful in strengthening collaboration with CHASS, i.e. bringing together all relevant parties together at the district level to define roles and responsibilities. In Maputo, Tete, Niassa, Zambezia and Gaza, PASSOS’s activistas will inform HIV+ KP about COVida project activities, and ask if they would like to participate in the project. If consent is provided, PASSOS and COVida activistas will visit the family together to introduce the COVida activista to provide follow-up support. FHI 360 has also initiated conversations with Pathfinder in Nampula to outline areas of overlap, define a strategy for collaboration, and coordinate support for children of KPs.

2.1.3 Capacity development for high-quality case-management services

Existing literature and FHI 360’s own experience indicates that activistas need time and supportive supervision to assimilate the concept of case management into their work. The success of the program hinges on the ability of activistas to effectively assess families, prioritize needs, and successfully support families to become more stable, safe, healthy and educated. Based on the high Year One targets and accelerated start-up to reach these targets, we anticipated that the usual difficulties of learning a new system would be multiplied.

Field TA and supervision visits indicate that many CBO activistas and supervisors continue to face challenges in applying the CSI tool, developing care plans, planning household visits, and understanding the concept of case management – especially CBOs with limited experience implementing the Ministry of Gender, Children, and Social Action (MGCAS) guidelines. While results reported through June 2017 indicate that activistas are providing an average of two types of services per beneficiary, MGCAS guidelines recommend that at least three services be provided. For OVC care to become more holistic and sustainable over time, activistas need to move beyond raising awareness among caregivers about children’s rights and needs, and support caregivers to carry out the actions required to access services.

Training and TA planned for CBO partners in FY 18 is outlined below:

**In-service training for activistas**: COVida will develop a three-day curriculum to strengthen the skills of trained activistas, consisting of:

- Two days to review the case management approach, and
- One day for strengthening skills in the HIV technical area (prevention, stigma and discrimination, care and treatment).

This second refresher training will be used only for CBOs that have been implementing the project for over six months in the field. The team will develop the training packages, then organize a five-day training of trainers for CBO trainers and SDSMAS staff. These trainers will then replicate this training for all continuing activistas.
Training to support *activista* supervision: COVida will develop and implement, as soon as possible, a training module for SDSMAS technicians, supervisors, and *activistas* *chefes* on *activista* mentoring and supervision. This module is designed for three days, with the first two dedicated to the general aspects of mentoring and the last day reserved for supervision and mentoring ECD activities. After this training, COVida will ensure supervisors and *activistas* *chefes* utilize the following tools:

- Activity mentoring and supervision tool for the *activista*, and
- The one-page “Basic Services Checklist” for *activistas* adapted from the Community Care Program (PCC), which summarizes the concrete activities an *activista* needs to provide during household visits. This checklist will be an essential resource for *activistas*, since effective implementation of each of the seven basic services requires a subjective assessment of the situation for each beneficiary, in addition to the execution of a series of complex actions – a considerable amount of information for *activistas* to memorize.

Structured TA at all levels: To help *activistas* become more proactive in helping families, COVida will implement a new TA strategy whereby COVida technical officers identify two to three critical OVC cases from each CBO and support supervisors and *activistas* to undertake concrete actions to meet the needs of these OVC. This strategy is based on the premise that by demonstrating how linkages to services – such as nutritional support and access to poverty certificates (required to waive standard service fees) – can be made, CBOs will learn how case management ought to be conducted. Experience shows that CBOs that have already succeeded in helping families overcome difficult situations are more likely to mobilize all their efforts and resources to meet their beneficiaries’ needs. COVida is also producing a short video with good case-management practices, based on real stories. Section 8 below describes the structure to provide TA to the CBOs.

2.1.4 Case management and service delivery

COVida *activistas* will continue to provide the most urgent services as indicated in the individual or family action plans that are prepared after the child assessment. In FY 18, there will be a greater emphasis on services that help families become stable and children safe, educated and healthy as described in the introduction to the project implementation section, Section 2. COVida is also articulating a framework to help *activistas* and collaborators understand how COVida supports different subpopulations: families with an HIV positive caregiver, HIV positive children, and other vulnerable families.
Table 4: COVida support for different subpopulations

<table>
<thead>
<tr>
<th>Services</th>
<th>Specific activities</th>
<th>HIV+ children</th>
<th>HIV+ caregiver</th>
<th>Other OVCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV testing HIV Treatment</td>
<td>• Screen for HIV risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>adherence and retention</td>
<td>• Referral to HIV testing if they are eligible (present at least one risk factor)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Problem-solving to overcome barriers to testing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosure</td>
<td>• Disclosure counseling for children and/or caregivers</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Referral to link caregivers with community adherence and support groups (GAACs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial support</td>
<td>• Assess stressors related to stigma and discrimination, isolation or family instability</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>• Help child and caregiver to identify a source of social and emotional support in the family or community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Childhood Development</td>
<td>• Screen for developmental delays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(0-5 years)</td>
<td>• Screen for acute malnutrition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Referral for nutritional rehabilitation programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social and Cognitive stimulation integrated in household visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Playgroups (3-5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Monitor immunization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Breastfeeding education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SRH services (Adolescents)</td>
<td>• Counseling and referrals for SRH services (Serviços Amigos dos Adolescentes e Jovens [SAAJ])</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

See Annex 5 for more detailed OVC interventions in HIV-positive families, by age.
<table>
<thead>
<tr>
<th>Stable</th>
<th>Household economic strengthening</th>
<th>Safe</th>
<th>Protection and Legal support</th>
<th>Safe</th>
<th>Schooled</th>
<th>Education and life skills</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Savings groups for caregivers, encouraged to include adolescents</td>
<td></td>
<td>• Birth registration</td>
<td></td>
<td></td>
<td>• School enrollment support (documents, registration, referrals to access school subsidy)</td>
</tr>
<tr>
<td></td>
<td>• Poverty certificate</td>
<td></td>
<td>• Victim identification and post-violence care/follow-up including gender-based violence</td>
<td></td>
<td></td>
<td>• Referrals for vocational training programs and job-training</td>
</tr>
<tr>
<td></td>
<td>• Family consumption support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Homework help</td>
</tr>
<tr>
<td></td>
<td>• Advocacy and referrals for food support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Support to stay in school and progress</td>
</tr>
</tbody>
</table>

**Debate sessions to provide risk reduction, health choices and positive prevention information and strategies**
2.1.5 Case load management

COVida will improve case management by providing additional training for *activistas* and their supervisors, applying new quality assurance tools that reinforce performance standards, and improving supportive supervision. COVida will also support CBOs and *activistas* to achieve a caseload of 45 beneficiaries per *activista*, prioritize the highest-risk families, and focus on the most critical needs for each family. A more balanced caseload and an understanding of how to appropriately prioritize will allow *activistas* more time to provide action-oriented support, rather than simply imparting advice to families. This focus will also concentrate time and resources to families with the most needs, and less to those that are more stable.

Current data indicates that COVida *activistas* manage an average active caseload of 65 beneficiaries (children and caregivers), when it should be 45 beneficiaries at a given time. *Activistas* are still learning to periodically review care plans, re-apply the CSI, and assess if beneficiaries are ready to transition to a less intensive phase of support. The fact that these elements of the case management system are not yet consistently applied contributes to the high case load, thus limiting *activistas’* ability to provide quality services for beneficiaries and to take on new beneficiaries. Improving skills through training and supportive supervision as described above will help.

We also observed that *activistas* are struggling with the large number of care plans they need to analyze before conducting household visits. In Nampula, for instance, where families can be composed of 10-12 children, *activistas* struggle to analyze all care plans and decide what to focus on during a household visit. Completed actions mentioned in the care plans are not updated regularly and it becomes difficult to assess the quality of services provided and readiness for transition to the maintenance phase. In addition, some individual needs are similar for all members of the family, (i.e. availability of latrines or participation in savings groups), yet they are repeated in each family member’s care plan as an action point, creating unnecessary duplications. To address this challenge, COVida developed a family-based care plan, incorporating the findings of all individual CSIs. We are piloting the new format in Nampula and, if it proves valuable, will standardize it across the project. We are sharing these experiences and our mitigating efforts with MGCAS’ OVC Technical Working Group (GTCOV).

Although we are still introducing retroactive data into the eCSI database, the new database has already proven to be a useful tool for case management. It allows a CBO to determine the actual case load for each *activista* and make an equitable distribution of beneficiaries to *activistas*. Supervisors and *activistas chefes* will lead this redistribution of cases to ensure continuity of services and minimize the effects of anxiety on families with the introduction of a new *activista*.

COVida will explore other approaches to easing the load for *activistas*, including innovative strategies such as “group case management”.

2.1.6 Transition assessment and graduation

As mentioned in the Overview section, COVida is reconsidering its graduation process. In the initial design, COVida’s case management model included an intermediate “maintenance” phase before graduating families. COVida would support *activistas* in transitioning beneficiaries who have had their most critical needs met to the maintenance phase, which reduced their visits from *activistas* from one or two times per month to once per quarter. This would allow *activistas* to begin working with new families, while still supporting individuals in the maintenance phase (individuals in the maintenance phase continue receiving support for a full year following transition). The transition phase is risky for families; one of the goals of the maintenance phase is to catch families that might be regressing and contribute to more sustainable family independence.
We are analyzing whether the quarterly visits during maintenance will be used to provide services or simply monitor progress (since most critical services should have been addressed early on). If the latter, there are two options: reduce the maintenance phase to three or six months or eliminate the maintenance phase altogether but provide ongoing monitoring for six to twelve months graduation. We feel the maintenance phase is valuable yet it represents time spent for activistas. We are dialoguing with USAID to determine how best to capture this data and these costs.

If the maintenance phase is eliminated, COVida would need to adapt the maintenance transition criteria to serve as the new graduation criteria. COVida recently revised the beneficiary transition criteria to make them more appropriate to the varied local contexts and cultures. Activistas and CBOs that have applied these new criteria are increasingly confident that these will help them maintain a case load of 45 beneficiaries at any given time. COVida is working with MGCAS to adapt the criteria to more clearly indicate HIV status as a factor and will then continue to support its partners to adhere to the current OVC case management dynamics and approaches. The draft criteria included in Annex 4 are based on prioritization of critical needs and delivery of essential services to improve health, education, protection and stability of OVC and their families.

COVida will continue to support CBOs to assess OVC care plans after three months and CSIs after six months to determine if beneficiaries are ready to be transitioned, applying the new criteria. Once all children in the family meet the criteria, the family will be transitioned.

Later in the year, COVida will start to build CBO M&E officers’ capacity to use the database to regularly extract lists of beneficiaries who need their action plans re-evaluated or require a re-application of the CSI to determine their transition to the maintenance phase or graduation from the program. These lists will be handed over on a monthly basis to activistas as a reminder of those beneficiaries who are ready for assessment. With the current data management system, this work has been massive and outstrips activistas’ and supervisors’ ability to implement consistently.

2.1.7 Referrals to HIV and basic health care and other social services

COVida will seek to improve collaboration with health units, clinical partners, other implementing partners and other services to refer HIV-infected and affected beneficiaries to other critical services. Commitments to collaborate have been made at the national level, but with varying levels of implementation at the provincial level, each province will require a different strategy to fully operationalize that commitment.

COVida continues to refer beneficiaries to HTC, ART, nutrition, and other health services. We will continue to promote referrals to health facilities, clinical partners and social services through regular meetings and the use of the Guía de Referencia (the bi-directional referral tool developed earlier under PCC and adopted by MISAU [Ministry of Health] for national utilization). The quarterly joint supervision visits conducted by CBOs with health, social action, education, registry and notary and economic activity services will continue in FY 18, as they have proven to be useful in orienting activistas and CBOs on existing resources for OVC in these sectors, as well as facilitating access to these services. In addition, each province may develop its own strategy, appropriate for the context at provincial and district level.

Based on preliminary data gathered in the project, of the beneficiaries 18 years and under identified as HIV+ but not receiving ART, only 42% were referred to ART. Analysis of the data illustrates that in some cases this is an error in data collection and reporting. For example, when activistas find these beneficiaries in a family, they give only one Guía de Referencia to the whole family, rather than providing to each individual referred to ensure that each individual is counted. Now, activistas are being oriented to provide a Guía de Referencia to each individual referred for ART or HTC. For other
cases, COVida will conduct a more thorough analysis of challenges and use the results to tailor the capacity-building of *activistas*.

Data analysis also demonstrated that of the 98,303 OVC that reported not knowing their HIV status, 24% were referred for testing. Of the beneficiaries referred, 48% were tested. Our data verification visits indicate there is also a referral count error due to some CBOs only reporting referrals when they are complete. On the other hand, MISAU and clinical partners’ guidelines do not allow all COVida beneficiaries to be eligible for testing, particularly in cases where a child has no HIV-infected parent (index case). In order to avoid *activistas* mobilizing beneficiaries who are then refused at the health facility, COVida is advocating for the MISAU ART pediatric technical working group to establish clear guidelines on testing OVC; these will then inform the screening process for COVida.

At the moment, the operational HTC guide allows orphans to be tested, but MISAU is in the process of revising this guide and has already begun to orient health facilities to avoid mass testing. The US Office of the Global AIDS Coordinator (OGAC) allows OVCs to be categorized as “testing not indicated” for those who don’t meet the criteria, but requires a screening tool to do so. COVida had intended to validate the PEPFAR HIV risk screening tool to identify children who need to be tested, but now that MISAU is working on a pediatric screening tool, it will be important to advocate that the criteria being used by COVida are consistent with MISAU guidance. Once these criteria are defined, COVida will disseminate them to COVida partners. Similarly, COVida and CIHO are piloting a community testing screening tool in Zambezia, with results anticipated early in Quarter 2. For the time being, we will continue to support CBO partners to refer beneficiaries to clinical and community partners and health facilities, depending on the criteria accepted at each location.

As described in the section on Identifying Beneficiaries, in order to improve the rate of completed referrals, COVida will continue to build awareness with health facilities, and other USG partners at all levels, and to monitor referral data. The table below outlines specific strategies undertaken in each province, and those where a strategy has not yet been defined.

*Table 5: Coordination and referral linkages with other partners, by province*

<table>
<thead>
<tr>
<th>Province</th>
<th>Clinical Partner</th>
<th>Next steps</th>
</tr>
</thead>
</table>
| Cabo Delgado | *Fundação Ariel Glaser Contra o SIDA Pediatrico* (Ariel)                          | - Continue to participate in ART committees in each health unit.  
- Place *activista chefe* in health facilities (new districts) to manage referrals. |
| Gaza         | Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)                               | - Continue meetings with EGPAF to set concrete steps to improve collaboration.                                                              |
| Inhambane    | Center for Collaboration in Health (CCS)                                         | - CCS Counselor in health facilities will link tuberculosis (TB) and HIV patients to the COVida *activista* in their community.  
- CBOs participate in periodic clinic-based co-management meetings.  
- Development Aid from People to People (ADPP) to start HTC with COVida beneficiaries at the household level. |
| Manica       | Clinical HIV/AIDS Services Strengthening (CHASS)                                | - Continue joint visits with CHASS and participate in ART community in health facilities.  
- Continue to participate in monthly meetings with United States Government (USG) partners and DPS. |
<table>
<thead>
<tr>
<th>Province</th>
<th>Organization</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Maputo City   | CCS          | - After presenting letter from DPS to CCS, the situation has improved.  
- COVida is continuing to advocate with CCS for greater collaboration.  
- Advocate to place *activistas* in health facilities to manage referrals to COVida. |
| Maputo Province | Ariel ADPP   | - Continue to place *activista chefs* in health facilities on a rotating basis.  
- Conclude Memorandum of Understanding with Ariel.  
- Visit families referred by ADPP. |
| Nampula       | ICAP         | - Follow-up on agreement with DPS that the PSS officer in health facilities will inform HIV+ patients about COVida support and link them to *activistas*.  
- COVida CBOs will allocate one filing folder in health facilities for HTC and ART referrals from COVida.  
- Evaluate effectiveness of this system. |
| Niassa         | CHASS        | - Place *activistas* in health facilities to work together with CHASS case managers. |
| Sofala         | CHASS        | - Continue with quarterly joint visits with DPS and CHASS.  
- Continue to participate in monthly meetings with USG partners and DPS. |
| Tete           | CHASS        | - Continue synergy strategy with CHASS and continue with *activista chefs* in health facilities.  
- Continue to organize monthly meetings with USG partners and DPS. |
| Zambezia      | Columbia University Mailman School of Public Health (ICAP) | - Place one *activista* in every health facility where COVida operates to serve as the clinical-community linkage focal point and manage referrals to and from the community.  
- ICAP and COVida technical teams agreed to share monthly and quarterly data. |
|               | CIHO         | - HIV testing for adolescents; mechanisms under discussion as CIHO is still starting. |
|               | Friends in Global Health (FGH) | - Conclude Memorandum of Understanding.  
- *Activistas* placed in health facilities will continue to participate in ART meetings. |
|               | CHASS        | - Place *activistas* or *activista chefs* in health facilities to facilitate bi-directional referrals. |

To respond to non-health needs that are not covered by COVida (e.g. HES, ECD described below), COVida CBOs will continue to strengthen linkages with other government services to establish and maintain referral networks. For example, the district offices of the Ministry of Education have access to funds to support families who cannot pay school fees; the district office of the Ministry of Agriculture can provide extension agents and inputs to help families prepare *machambas*, INAS agents can help families access basic food baskets, the Office for responding to victims of violence can support victims of gender-based violence (GBV).

COVida will also build relationships with the private sector and other NGOs as CBOs alone cannot meet the needs of OVC and no entity has the resources to provide all essential services. Experiences and good practices in some provinces in the mobilization of school materials, agricultural goods, and integration of adolescents into vocational training will be shared with CBOs in other provinces for their inspiration and guidance.
2.1.8 Support for adolescents

In addition to the mapping of services available for adolescents, boosting adolescent-specific referrals and supporting school retention, COVida recognizes the need for specialized support for adolescents who are HIV+ and at-risk. Limited resources prevent COVida from launching a specialized program that might include helping adolescents, caregivers and communities understand how to better support youth, such as specialized savings groups or specialized GAACs.

There are some basic principles and best practices that can be implemented by CSOs on their own. COVida would stimulate CSO action through a toolkit that builds on existing materials and activities that have been implemented in Mozambique and general guidance based on global best practices in youth development.

At a minimum, it will include activities and materials developed under YouthPower Action Phase 1, including the life skills curriculum for youth clubs, study groups, youth participation in CCPC, discussion guides from parents and community leader debate sessions, and training materials for youth score cards. Best practice tips will address youth engagement and ideas around creating a group of youth champions and training materials for community youth mapping.

COVida will refer adolescents to the various district-level adolescent and youth support services, e.g. Serviços Amigos dos Adolescentes e Jovens (SAAJ), Dom Dinis Sengulane/Massinga Foundation, Laura Vecuna/Inharrime Center, Pathfinder, Creative Associates International (CAI) / Vilankulo. COVida will also develop an expanded list of referrals. In developing this strategy, FHI 360 carried out meetings with a number of donor NGOs working with adolescents. These meetings identified several resources to support adolescents beyond those currently in the list of referral services. This list will be updated as COVida staff and partners are able to hold more meetings with other entities. Examples of additional support include:

1. CHASS and N’weti manage SAAJ clinics through which adolescents girls and young women and boys, in some cases, receive services such as SRH, HTC, condoms, GBV treatment and referrals and education on GBV prevention.
2. Ophavela. Although Ophavela doesn’t have an adolescent-centered approach, they test adolescents that are index cases and provide HIV-positive adolescents with treatment adherence support. Some adolescents are included in Ophavela’s savings groups, where they access information on SRH and treatment adherence.
3. SCIP in Zambezia. With World Vision, we are analyzing possibilities for referrals, although the geographic overlap is minimal.
4. SMS Biz. This SMS platform implemented by Coalizão currently reaches more than 80,000 youth (the target beneficiary group is ages 15-24 younger youth can access the platform). It provides basic information on SRH, HIV/AIDS, early marriage, GBV and other topics. With 24 trained young counselors, SMS Biz can provide answers to specific questions and can refer youth to local CBOs or other services. SMS Biz has specific campaigns and topics that it pushes out and can also implement surveys of youth. UNICEF has offered to provide training to activistas on SMS Biz so they can in turn provide this information to adolescents.
5. Rapariga Biz. The UN, in collaboration with Coalizão, is supporting a peer mentoring program in Nampula and Zambezia that will reach significant numbers of adolescents and youth, especially adolescent girls, to address a broad range of skills and knowledge.
6. Pathfinder and N’weti family planning project in Nampula for adolescents and youth. Pathfinder will raise awareness with COVida activistas and adolescents, receive referrals, and provide SRH services.
7. Communication materials. UNICEF, Ariel and others are producing new communication materials, including videos, films, debate session and radio that can provide opportunities for community debate and access to information. COVida can refer to these events when they occur and make relevant materials available to CBOs.

8. MoBiz. Mobile social marketing platform implemented by Populations Services International (PSI), which aims to increase demand for and access to SRH information, services and products.

By providing materials for how to carry out community youth mapping, CSOs can engage youth to map their community to identify community-based youth supports such as recreational activities (sports, arts, dance, music, faith-based groups, media, etc.), community service, advocacy or political participation opportunities, etc.). While such youth-oriented activities may be rare in rural areas, youth in urban areas may not be aware of recreational or learning opportunities in their communities. This will be implemented as CBOs renew their mapping process during the year.

COVida will include a module on communication with adolescents in the refresher training for activistas to prepare them to dialogue with youth on HIV and other topics and to help parents improve communication with youth.

COVida will consider what can be done by encouraging HIV+ youth to mentor other HIV+ youth to stay on treatment, reveal their status, and so forth, and will refer them to adherence and support partners such as SCIP, CHASS and Ophavela. COVida will also coordinate with the American International Health Association, which has developed materials to help caregivers disclose status to their HIV-positive adolescent children, to train COVida activistas in these skills.

Beyond the costs to develop the toolkit, COVida’s funding limitations will not allow additional TA or training or monitor the impact of CSO-driven supports for adolescents. COVida recognizes the risks of providing tools and materials without adequate training and expects that CBOs already working with youth will be better prepared to implement these without support.

2.1.9 Supportive environment for OVC and healthy life choices
N’weti, in collaboration with FHI 360 and PATH, is finalizing the development of a debate sessions manual to be delivered to savings groups, community leaders and SDSMASs. The manual is currently comprised of ten sessions:

1. Gender
2. HIV prevention
3. HIV/AIDS and treatment literacy
4. HIV-related stigma and discrimination
5. Food and nutrition
6. Protection and legal support – child rights
7. Gender-based violence
8. Early marriage and adolescent development
9. PSS – sensitive relationships with children
10. Education – girl retention and continuation into secondary education

Drawing from the COVida planning retreat, N’weti has added a session on stigma and discrimination. The manual content will be finalized in the first quarter of FY 18 and shared with USAID for review.

After approval of the manual by FHI 360, N’weti will print the manual and facilitate two provincial trainings (Cabo Delgado and Nampula) to debate session facilitators from CBOs, as well representatives from SDSMASs in the two provinces. These facilitators will then conduct debate sessions with COVida savings groups and community leaders following the new manual structure.
N’weti, with support of the COVida geographic partners, will provide TA and monitoring in the two provinces.

N’weti, together with local partners (Reencontro-Gaza, Mozambique National Association of Nurses [ANEMO] and Dimagi) will implement the Hlayisa project, to support USAID and the Government of Mozambique (GRM) to achieve epidemic control by reaching PLHIV through community-based interventions that support the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 goals. The goal of this project is to enhance and improve the HIV treatment, nutrition, general health outcomes, and livelihoods of PLHIV – children, women and families – in Maputo, Gaza, and Inhambane provinces.

Through the Hlayisa project, N’weti will conduct trainings for facilitators, who will carry out community dialogue sessions reaching to local communities, including members of the local leadership and community groups (which reaches some savings group members). Since the Hlayisa project is being implemented in same districts as COVida, N’weti will not carry out trainings on the debate sessions in these provinces to avoid overlapping. N’weti’s COVida team will hold regular meetings with the Hlayisa project team to coordinate on activities and give a follow-up on the project outputs. COVida geographic partners will encourage their activistas to work in collaboration with Hlayisa activistas in order to have COVida beneficiaries attending the sessions implemented by the Hlayisa project. Hlayisa will also identify OVCs within PLHIV families they support and refer them to COVida.

Throughout the year, GRM seeks to build awareness of child rights and children through commemorative events such as June 1 Children’s Day and June 16 Africa’s Children’s Day. COVida will continue to support the MGCAS in organizing these events at national, provincial and district levels through TA, material support for activities, and/or support for beneficiaries. At the district level, the CBOs will participate; at the provincial level, geographic partners; and at the national level, COVida will participate.

2.1.10 Provide structured TA at all levels to support operationalization of guidance and protocols

To maximize the impact of the reduced TA COVida will be able to provide, COVida will systematize a structured TA protocol for use in all visits. Limited resources mean that COVida will rely heavily on generalist provincial technical officers (PTOs) to provide comprehensive follow-up support in all areas (HIV/AIDS, case management, ECD, HES, completing and filing forms correctly, referrals, action plans, activista management, and more). These PTOs will visit each CBO every one to two months. Each visit the PTO will have a TA plan for each CBO that will be based on a review of the prior visit’s data and CBO progress, follow-up on prior feedback and guidance provided. Inputs from technical experts will also inform the structure of each visit. In addition, a checklist will ensure that routine monitoring of forms, compliance checks, etc. takes place.

Regional or national level technical specialists will visit each province two – three times during the year, visiting one or two CBOs in the process. The specialist will provide feedback to the CBO, but is focused on providing guidance to the PTO and developing a plan for TA for the next quarter. Figure 1 below illustrates the flow of TA.
2.2 IR 2: Reduced Economic Vulnerability of OVC Households

Beyond the immediate actions to address basic consumption needs, efforts will continue in FY 18 to improve the capacity of families to manage and save money and generate income, and to address inequalities of access to household income within the family. COVida will focus primarily on improving families’ capacity to manage money through savings groups. Support for basic consumption needs will be provided as budget constraints allow. Certain planned income-generating activities (Farmer Field Business Schools, capacity development on income generating activities, links with more formal institutions) will not be pursued this year due to budget constraints.

One of the main challenges for FY 18 is to address the low inclusion rate of COVida beneficiaries as participants in the savings groups established under the project. Extra focus will be given to increasing this participation in FY 18 and facilitating their inclusion while also supporting the groups’ capacity to serve the needs of all members.

2.2.1 Meeting basic consumption needs

In FY 18, CBO partners will continue to refer the most vulnerable families to INAS for registration in the GRM’s social protection program. However, as experience from Year One demonstrates, inclusion in the INAS program is not guaranteed, so CBOs will continue to provide the most destitute of families a low-cost package of basic supplies while mobilizing additional support from resources identified via the social network analysis and community committees.

During family assessments and using the CSI, activistas will determine the need for basic supplies. These may include plates, blankets, plastic tarp for the roof or a bucket to safely store water. Such packages are locally known as Family Kits. A supervisor will verify the activista’s assessment prior to processing the support. However, as budgets have been significantly reduced for FY 18, the capacity of CBOs to provide adequate consumption support through family packages will be extremely limited.
2.2.2 Improve capacity of families to manage money and generate income

In FY 18, the COVida consortium will focus on strengthening current savings groups’ performance. COVida will add 1,035 new savings groups in FY 18. Existing trained savings group facilitators (part-time volunteers receiving stipends) will manage four to six groups each depending on distance and schedule. Savings groups supervisors (full-time paid staff) will be expected to manage around five groups directly and provide supportive supervision to facilitators, as well as monitor data quality. The number of groups per facilitator will vary depending on distance to be covered, and flexibility of groups in choosing their meeting times to accommodate the facilitator’s schedule. Prior experience in multiple projects indicates that four to six groups per facilitators is reasonable, particularly as the methodology is still relatively new for facilitators.

For FY 18, COVida has developed strategies to address the weaknesses identified in the first year, including the following:

Savings group field supervisors: In Year One some provinces had no funds available for savings group supervisors and therefore relied on facilitators to become facilitator chefs. These more junior people struggled to form groups with the quality desired. In FY 18, resources will be allocated to fund one savings group field supervisor per CBO, who will supervise up to four facilitators.

Facilitators with savings group experience: Now that groups have been established in most districts, there should be a pool of savings group participants with the experience to be effective facilitators. In FY 18, all new facilitators selected will have been members of Year One groups. The current facilitators will be assessed to determine if they are ready to form and support new groups.

Essential materials for savings groups: In addition, new passbooks and lockboxes meeting the specifications for savings groups (three lock slots) will be procured. As budgets allow, CBOs will be trained to use the Savings Groups Information Exchange (SAVIX) database. SAVIX is an online data collection and management tool developed for use by organizations supporting the development and replication of savings groups so that the groups’ information can be stored, analyzed and shared as required. SAVIX provides “transparent and standardized data on savings groups and is the most comprehensive database in the sector.”⁵ SAVIX is used by a wide range of practitioners because it has already been developed to capture the information necessary to monitor and manage savings group initiatives and their quality. SAVIX provides information on savings group performance indicators such as retention, amounts saved, amounts loaned, etc. and so will enable COVida to monitor its overall performance as well as that of CBOs and facilitators be able to address issues accordingly. SAVIX also avoids the duplicative effort of creating a separate database for savings group information. Finally, all CBOs will be able to use SAVIX not only throughout the life of COVida but beyond, promoting sustainability and a longer-term investment. Despite its advantages, we are finding it difficult to implement. COVida will continue to support those that are already using SAVIX competently, but suspend further expansion. This allows the team to focus on increasing the number of groups and evaluate the appropriateness of SAVIX for COVida.

Inclusion of COVida beneficiaries in savings groups: In Year One it was a challenge to ensure participation of IR 1 beneficiaries in savings groups. With the start-up phase now complete and with teams well established in their roles, ensuring HES facilitators and activistas work together to increase participation of beneficiaries in savings groups towards the 30% inclusion target will

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be prioritized. The most vulnerable in communities often lack the confidence to participate in such groups and require additional support.

While these are significant challenges to overcome, COVida partners will seek to address them in FY 18 in the following ways:

- Invite COVida beneficiaries to witness savings cycle close-out ceremonies to see the benefits of participation.
- Link COVida beneficiaries to existing savings group participants to explain the benefits of and requirements for participation.
- Assist CBO savings group supervisors to review fund accumulation versus loan requests to ensure that the inclusion of the most vulnerable households does not introduce excessive risk to the group. If the review indicates excessive risk, the COVida technical team will review the case with the relevant HES officers to propose changes in limits on loan and savings values.
- Facilitate review and planning meetings between IR 1 and IR 2 supervisors within CBOs to review caseload and participation of beneficiaries within savings groups.
- Introduce content into the savings group facilitator training to help them learn to work with beneficiaries as the basis for starting a savings group, rather than trying to integrate beneficiaries into groups formed independently.
- Encourage activistas to participate in groups to learn and better share information on groups.
- Involve activistas in mobilizing beneficiaries to participate in groups.
- Facilitate “lessons learned” sessions/discussions between CBOs so that those who have a lower uptake can learn from those who have successfully included COVida beneficiaries.

2.2.3 Transform resources allocation in the household in favor of OVC

Increased household income is not necessarily spent in favor of OVC. Many savings group programs in Mozambique have a higher participation of women than men in the groups; however, men generally control financial decisions around family resources. Once their money is saved, women must first bring the money to their husbands who have the ultimate control over how the money is spent. In FY 18, COVida will attempt to influence this in the following manner:

- When possible, have activistas continue working with the husband and wife pair during home visits to develop joint priorities prior to joining the savings groups;
- Transform household allocation of resources in favor of OVC through the negotiations that activistas have with caregivers during the development of the care plans, and engagement with the family during bi-weekly visits; and
- Have group facilitators address household decision-making and spending during savings group meetings. This is included in the savings group methodology and will be reinforced through case management and TA.

2.2.4 Technical assistance and supervision

The HES technical team will be reinforced in FY 18 by including an additional full-time technical advisor for a total of two advisors (one national and one regional). An additional regional advisor was planned for FY 18 but is no longer possible given budgetary constraints.

The CARE technical team (with the support of a CARE technical specialist advisor) will provide three quality control functions during FY 18:

1. Training and capacity building on savings group methodology (for new districts and refresher courses, where required);
2. Support on the SAVIX app for already trained savings group supervisors and M&E officers; and
3. Technical visits to ongoing savings group activities to evaluate the application of good practice and develop suitable recommendations for continuing or improving performance.

The CARE team will work closely with COVida PTOs to ensure that all CBOs receive support and guidance linked to savings groups on a regular basis. CARE will aim to visit all CBOs in the year, with priority given to those with the largest beneficiary populations.

2.3 IR 3: Improved Capacity to Provide ECD Services for Vulnerable Children under Age Five

During FY 18, PATH will lead the COVida consortium in integrating basic ECD into household visits and demonstrating the model of community playgroups in one or two CBOs in Maputo.

2.3.1 Use of quality community child care and development interventions increased

In Year One, PATH developed a comprehensive ECD package of services to be integrated into activista household visits and will be rolled out in all COVida geographic areas and districts. COVida will train activistas, activista chefes, supervisors, SDSMAS technical officers, CBO project staff, and COVida staff to implement and provide supportive supervision on integrating ECD into household visits. The package aims to improve child-nurturing practices amongst OVC caregivers and improve referrals of children with developmental delays to health services. The training package includes the following topics:

- Developmental monitoring
- Responsive care
- Young child stimulation, including recognition of the importance of play and communication
- Nutritional practices
- Learning how to make toys/learning materials using locally-available or recycled materials

To make this approach possible, in Year One PATH worked with consortium partners and the government to integrate ECD content into COVida core project training and information, education, and communication (IEC) materials, including the case management initial training package, job aids used by CBO activistas during household visits and group sessions/community dialogue manuals. Also in Year One, PATH provided a training-of-trainers (TOT) on ECD in home visits for COVida geographic partners’ staff and key provincial government partners.

Building on the Year One activities, COVida will conduct short, one-day ECD training replicas for all activistas, activista chefes and supervisors and an additional one-day training for activista chefes, supervisors and key SDSMAS district officers in FY 18. These replicas will mostly be organized at the district level and facilitated by SDSMAS and BCM-accredited CBO trainers who have participated in ECD refresher trainings. PATH and the geographic partners’ technical officers will ensure quality by participating and providing TA during the first training, ensuring that different provincial training teams receive adequate support and acquire ECD skills. Planning will be done in coordination with COVida geographical partners.

2.3.2 Improve parental care and responsiveness for children under five

In FY 18, COVida will increase the use of high-quality community child care and development interventions by increasing CBO capacity to offer 4 informal playgroups for around 15 children per group, aged three to five years, in one districts to be determined in Maputo city/province. The playgroup intervention will be designed to both promote child development in a safe setting and free-up caregiver time for other tasks.
As the COVida ECD technical partner, PATH has reached an agreement with the MGCAS to lead the development of a national community preschool activity manual and implementation guide, which will then be used for implementing COVida-promoted playgroups. The drafts of the activity manual and implementation guide have been developed and presented to a group of national ECD stakeholders during two validation meetings in May and June 2017. The manual and the guide will be finalized and submitted for formal MGCAS approval in the first quarter of FY 18, with the aim of having them ready for printing in early 2018.

The playgroups will be demonstrated in FY 18 with the creation of 4 playgroups that will be established by the CBOs with PATH technical support. These initial playgroups will be created in Maputo province/city. A number of management and programmatic efficiencies also make it cost effective to support this province than others: a regional ECD specialist, who will provide technical leadership and support, is based in this province; the province has strong government and partner human resources who can provide post-training implementation support; there are complementary ECD activities managed by PATH; Maputo City/Province ECD interventions serve as learning/observation sites for all the other provinces during national ECD trainings and events, which facilitates dissemination of effective ECD practices across the country.

Playgroup demonstration districts will be selected based on the strength of the CBOs serving those districts and will be discussed and agreed with the geographic partner. The costs for each playgroup are extremely low.

In FY 18, PATH will develop and conduct a step-by-step six-day initial training module for playgroup facilitators and their CBO and geographic partner supervisors. MGCAS, DPGCAS, and SDSMAS staff will be invited to participate. The training will focus on three key areas: 1) how to start a playgroup, 2) how to implement learning and free-play activities with children, and 3) how to ensure playgroup quality on an ongoing basis.

Following this initial training in Maputo, a PATH regional technical advisor will work with geographic partners to provide monthly TA to the CBOs to create operational playgroups in identified target communities. Play group facilitators will work with interested mothers to start the groups, with the expectation that the model will prove effective and fill a niche in the community, thus providing an opportunity for income generation later. PATH will complete and distribute a small kit of materials for each playgroup.

2.4  WASH behavior

COVida will continue to promote healthy water sanitation practices through household visits. This includes encouraging each family to have a household latrine (not so practical in urban areas), to keep clean water covered and clean, washing hands, etc. In addition to the sensitization, consumption support is available to help families by providing covered receptacles for water and funds from participating in savings groups can be mobilized to improve sanitation.

2.4.1  Technical assistance and supervision

In FY 18, PATH will continue to provide TA for integrating ECD into household visits to geographic partners, provincial teams, and implementing CBOs through joint TA field visits as well as promote the integration of ECD topics into regular CBO meetings and refresher trainings. These TA visits will be conducted by the regional technical advisors in ECD based in the COVida regional offices.

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6 i.e. existing MGCAS and Provincial Directorate of Gender, Child and Social Action (DPGCAS) trainers in Maputo who have participated in the USAID-supported ECD teacher training course, and active provincial association of ECD teachers in Nampula led by the DPGCAS director
Regional technical advisors will work and plan their activities in close coordination with provincial geographic partner teams. They will primarily support geographic partners’ provincial technical teams, key provincial and district government partners and CBO supervisors. Geographic partners’ provincial teams will reinforce ECD integration into the household visits as part of their routine activities. When specifically needed or requested, in coordination with geographic partners, regional technical advisors will be able to provide specific support to CBOs that require it.

2.5 IR 4: Capacity of district government and communities to provide essential preventative and protective services to vulnerable families and children

In FY 18, COVida will engage government at all levels, and provide support to district level government, CCPCs and CBOs.

2.5.1 Facilitate multi-sectoral coordination meetings to promote collaboration and further the objectives of the project

To build upon the foundation laid in Year One, COVida will continue to collaborate with MGCAS to engage representatives from the Ministries of Health, Agriculture, Interior, Education and Human Development, Youth, Sports and Technology, and Constitutional Rights and Religious Matters. This collaboration will ultimately help the CBOs access services and reduce barriers to services for beneficiaries. COVida will also collaborate with clinical partners, other USG implementing partners, other service providers, and the private sector to mobilize and access as many resources as possible to help beneficiaries become more independent.

During FY 18, COVida will support MGCAS to play its coordination role at all levels and in the GTCOV and the Multi-Sectoral Steering Committee for Orphans and Vulnerable Children (NUMCOV). The following events are planned:

- One national coordinating meeting with all seven ministries involved with COVida;
- Provincial-level coordination meetings involving representatives of the respective ministries, implementing partners, and other stakeholders, leveraging available platforms; and
- District coordination meetings involving the relevant players (government, health service providers, CSOs and local leaders) that collaborate on solving the problems or assisting the OVC, leveraging available platforms.

All these events will be led by MGCAS, with COVida technical and financial assistance. Apart from the above-mentioned events, COVida will continue the best practice of joint field monitoring visits, a proven vehicle for increased MGCAS/DPGCAS/SDSMAS engagement. The frequency of all of these meetings and visits will be reduced due to budget constraints.

2.5.2 Strengthen capacity of district government and communities to coordinate and respond to OVC needs

COVida will continue to involve SDSMAS in selecting CBOs and in joint monitoring visits of CBO work on a quarterly basis. We will continue to include SDSMAS representatives in all trainings and as trainers whenever possible, including the debate sessions organized by N’weti. N’weti, in collaboration with COVida geographic partners, will provide the provincial and district representatives of MGCAS and the CCPCs with the results of the mapping exercises for their respective locations. We will include SDSMAS in trainings to use the eCSI database.

If additional funds become available, COVida will reconsider its plan to support CBO partners to provide coaching and concrete experience with case management for those CCPCs that have already
been trained by FDC with the support of Unicef. These CCPCs will learn to mobilize community resources and advocate with government institutions for quick resolution of cases that will be referred to them. With this approach, CCPCs will learn to apply their skills serving as a practicum, and leverage their positions as leaders in support of OVC. Over time, these skills and connections will allow them to become advocates for children beyond the life of the project.

2.5.3 Develop technical and organizational capacity of CBOs

To enhance the capacity of CBO partners to implement their projects successfully, COVida will continue to provide training on USAID rules and regulations through post-award conferences to all new subgrantees and TA for complying with special award conditions. This TA will be expanded to Gaza and Inhambane provinces where WV and CARE are the geographic leaders.

In FY 18, COVida will assist all CBOs to adopt and implement key policies and procedures including:

- Child Safeguard Policy and respective Code of Conduct based on templates that were prepared in FY 17,
- Policies and Code of Conduct to protect PLHIV that will be based on the Mozambican law for protection of PLHIV,
- Protocol for responding to cases of GBV,
- Policies and procedures for backing-up the database and other important project files, and
- Practices for securing beneficiary files so as to maintain confidentiality and facilitate case management.

In addition, FHI 360 will introduce the troubleshooting model for CBO support. There are CBOs that continue to have low performance despite the TA provided; often the challenges are rooted in organizational or structural problems. For example, a staff person is not performing well, but the organization does not want to let the person go, because s/he is related to a board member; an executive director is afraid to delegate, and thus impedes implementation because all processes need to be reviewed by him/her. The troubleshoot model engages the board, fiscal council and executives to identify root causes and develop meaningful solutions. COVida expects to serve 6-10 CBOs using this model in FY 18.

Finally, COVida staff have been invited by Akilizeto, a very strong organization in Nampula, to facilitate Management Accounting for Non-Governmental Organizations (MANGO’s) Basics of NGO Financial Management course in Nampula. COVida proposes to contribute ten days of organizational development TA time if Akilizeto allows COVida CBO partners to participate in the workshop. This will strengthen the capacity of CBOs at minimal cost to the project.

3 MONITORING AND EVALUATION

We knew the dramatic increase in Year One targets and accelerated pace of start-up, considering the resources allocated, would represent significant challenges for the M&E team. The sheer volume of data, the demands of PEPFAR, and the fact that the forms and system were new to 90% of the people using them were challenges enough. Then in Quarter 2, USAID directed COVida to adjust reporting timelines, which reduced the time for cleaning and aggregating data from five weeks to about one week. We quickly developed and rolled out standardized tools and training for activistas. We organized workshops for CBO M&E staff and consortium partner staff, and shifted tasks to engage PTOs in reviewing forms during their routine site visits. We conducted data verification exercises and adjusted tools, protocols and systems in response to issues identified.
At the end of Year One, we had the opportunity to analyze the results of our field visits, internal data quality analysis (DQA), and preliminary feedback from the Mozambique Strategic Information Project (M-SIP) DQA to identify what was working and where we need to improve. We observed that CBOs who received more frequent TA and data verification visits were stronger performers on data. We also identified that CBOs managing larger volumes of activistas, and therefore data, struggle more with data quality. The challenge is to ensure sufficient TA for all the districts and CBOs with COVida’s existing staffing levels. COVida will prioritize those districts with larger numbers of beneficiaries for TA, visiting them monthly, while smaller districts will be visited less frequently.

In FY 18 we intend to build upon the progress made in FY 17 by creating a functional M&E system, establishing a strong database, and developing tools, such as a dashboard, to assist decision-making. The priority in FY 18 will be to develop the capacity of the CBO staff to implement the M&E system correctly and analyze the data. We will provide regular assistance to the CBOs, conduct DQA and routine data verifications. We will use eCSI as a tool to respond to USAID/PEPFAR data requirements. We will also start to operationalize it for case management, but this will require more time.

3.1 Develop CBO and Provincial M&E staff Capacity

Training to support the implementation of the M&E system in FY 18 will include:

**Training for CBO M&E officers:** Twice during the year, there will be specific trainings for all CBO M&E Officers. These provincial or regional workshops will explain the new tools and build their capacity to use and analyze data. During the workshops, the M&E officers will also develop their skills in coaching the activistas, activista chefes, and supervisors. To provide proper training to the CBO M&E officers, we will seek to establish partnerships with relevant and existing players, such as the MMEMS project.

**COVida Consortium M&E team workshop:** We will invest in building the capacity of the geographic partner’s provincial M&E officers to better assist the CBOs. This will be integrated into the provincial and regional workshops that have been scheduled with the technical team to discuss relevant topics, exchange experiences, and clarify various issues. Participants will include all the M&E staff at the provincial and national levels.

3.2 Monitor Implementation of Activities and M&E System

In FY 18 we will continue to implement DQAs at various levels. The aim is to assess the extent to which the data generated at all levels within the M&E system is accurate, valid, timely and complete, identify challenges and constraints, and identify opportunities for system improvements. In addition to the routine data verification done in all the CBOs throughout the year, we will also conduct DQAs at selected sites. This will be done once during the year, using a combination of data verification (using FHI 360’s Data Verification Tool) and assessment of the M&E System (using FHI 360’s Monitoring and Evaluation System Assessment Tool [MESAT]).

Our M&E team will continue to undertake routine monitoring visits to CBOs partners. These serve as technical support visits for capacity building, identifying challenges and constraints facing the CBO and the activistas, and will inform the development of improvement packages to ensure activities are implemented as planned, and are producing the intended results. M&E officers at the provincial level will provide the most regular visits to the CBOs – at least once every month for each CBO. At the national level, senior M&E officers will visit each CBO twice a year to provide the necessary support to the field team, build their capacity to assist the CBOs, and identify areas of improvement in the M&E system.
3.3 Collect and Aggregate Data for Reporting

We will continue to invest in regular data collection, cleaning, aggregation and analysis. This will continue to be done monthly, as experience from Year One demonstrated that this practice improves performance. At the CBO level, *activistas* will continue to fill in the forms on a regular basis as services are provided to the beneficiaries. These will be cleaned by their *activista chefes* and supervisors and entered into the eCSI. At the provincial level, COVida consortium partner staff will conduct additional data verification and aggregation, before sharing with FHI 360 at the national level.

In addition, we are working with FHI360’s Mobile Solutions, Technical Assistance and Research project (mSTAR) to develop a project to revise the M&E system by decentralizing data entry from the CBO M&E officer to the *activistas*, using technology. Currently we are analyzing various options, such as having the *activistas* use cellphones to enter services, keeping in mind currently limitations in accessing mobile network services (network signal and/or internet). Given the reality in most of the districts, the most promising solution is to use Unstructured Supplementary Service Data (USSD) codes via SMS to enter services provided to the beneficiaries. We will discuss with SCIP regarding their community level data gathering mechanism and other resources in Mozambique as well. We understand that the funds intended to support MStar to work on this may not be available.

3.4 Data for Decision-making

3.4.1 Monthly provincial CBO reviews of data and performance

CBOs, the provincial teams, and the national teams will use data to analyze progress monthly, which will include a comparison of the achievements to the targets, performance gaps, and caseloads, with the view to improve project performance. At the CBO and provincial levels, program, technical, M&E and financial teams will come together to assess progress made and identify strategies for improvement.

3.4.2 Project level analysis

COVida analyzes data from the dashboard monthly. The data is shared with the government quarterly, with multi-sectoral meetings held twice a year.

3.4.3 Electronic Child Status Index

The database is up and running with all sites using eCSI to enter data for FY 17 starting October 1. In the first quarter of FY18, COVida will complete the data entry process for retroactive data from FY 17. We recognize that substantial time will be necessary to support CBOs in using this system and ensuring quality data from the beginning. However, we feel the investment will be well worth it as the tool will improve decision-making at every level and allow COVida to be more responsive to USAID requests.

During the year, we will continue to adapt the system both behind the scenes to do the analyses we need, and the user interface to make it more user-friendly and encourage its use for decision-making at all levels. We also anticipate the need to revise the eCSI once a year to adapt to indicator changes (new disaggregations, changes in indicator definitions, or even the introduction of new indicators). While behind the scenes adjustments to how data is reported may be possible more than once a year, we only plan one update to field level forms a year, as these changes require a massive roll-out and retraining. We are also discussing with mStar the possibility of developing a cell phone system to facilitate data collection by *activistas*.
3.5 Baseline Study

The project baseline and Monitoring, Evaluation, and Reporting (MER) essential survey indicator study has two parts: a household survey and focus groups with youth. Data collection for the household survey will wrap up at the end of FY 17. In FY 18, Palladium will do the following:

- Produce the MER essential survey indicators for USAID. FHI 360 will report these into DATIM directly (Quarter 1),
- Prepare a short brief on the MER essential survey indicators (Quarter 1),
- Conduct the focus groups with youth (Quarter 1),
- Analyze the household survey data in full (Quarter 1),
- Present on our experiences of collectsing the MER essential survey indicators at an international conference (the annual American Evaluation Association conference in Washington, D.C.) (Quarter 1),
- Produce a brief baseline survey report and a 2-page brief and PowerPoint on the findings (Quarter 2),
- Produce a situation analysis report, a brief and a PowerPoint on children aged 0-4 years (Quarter 2), and
- Produce a situation analysis report, a brief and a PowerPoint on children aged 12-17 years (Quarter 2).

As data become available we will use them to inform our workplan.

Palladium will also engage USAID in discussions around other critical areas of research, and if funding permits, pursue these ideas. Results of the evaluation will also be shared with relevant ministries and GTCOV.

Technical partners, including PATH and CARE, will collaborate with Palladium in analyzing the baseline results and making recommendations for project adjustments in light of the results.

3.6 Additional Studies

COVida had proposed an analysis of the effect of caseload on quality in FY 18, comparing the higher caseload of 45 per activista with the initial caseload of 30 per activista. COVida will do some basic analysis of existing data to identify trends. However, a more complete objective study that involves tracking time use of activistas, and focus groups, would require additional funds. Should additional funds be available during the year, the COVida consortium will prioritize this study as it will contribute valuable information to an important ongoing debate on how caseload affects quality.

4 EXIT STRATEGY

Several elements were incorporated into the design of COVida to transition activities to local organizations and community leadership before the end of the award. While many of those were put aside in Year One in the drive to reach targets, COVida still maintains the following elements:

1. COVida utilizes MGCAS tools and resources as much as possible, such as the CSI, the CPC guide, and the Essential Package. This ensures that activistas, committee members and CBOs learn about and can use government systems that will continue beyond the life of the project.

2. CBOs provide certain services directly during household visits, such as psycho-social support, Mid-Upper Arm Circumference (MUAC) testing, savings groups, and case management. Other services will be provided by other agencies and institutions through referrals. To strengthen these linkages, COVida supports CBOs to develop relationships, and in some cases, agreements
with the other service providers. Knowledge of services and access criteria will remain in the community beyond the life of the project.

3. Local CBOs who will directly implement activities are based in the communities and can continue to serve as resources. COVida strengthens their technical and management capacity so that they can continue activities beyond the life of the project. While some CBOs may continue beyond the life of the project based on good will and commitment, most will require external financial resources to ensure the continuation of activities that meet GRM/USAID expectations for quality.

4. Multiple elements of the design put information and skills in the hands of multiple community members, who can continue to use their knowledge to help others, even after the project ends. Activistas are selected from communities with vulnerable children in priority districts and community leaders are engaged at multiple levels.

5. As mentioned in IR 4, in FY 18, the project will collaborate with trained community committees, providing TA and field experience on case management. We hope that this develops awareness and know-how at the community level and encourages people to do what they can to support families in need instead of waiting for government services to do so.

6. COVida will continue to engage SDSMAS representatives as trainers and participants in trainings as much as possible. This will increase their understanding of case management, how to supervise case management, and improve their understanding of the issues families face, potential solutions, and their role in advocating for improvement. We also plan to engage them in using the eCSI.

5 COLLABORATION WITH MOZAMBICAN GOVERNMENT

COVida will continue to collaborate closely with MGCAS and MISAU at all levels. At the national level, we will ensure that activities align with national guidelines as much as possible, including the National Action Plan for Children II, the National Strategic Plan Against HIV/AIDS, and the National Strategy for Basic Social Security. COVida also will respond to the emphasis on the importance of community participation in improving access to health services described in the Health Sector Strategic Plan.

COVida will continue to collaborate with GRM entities to review materials and tools. For example, PATH has reached an agreement with MGCAS to lead the development of a national community preschool activity manual and implementation guide, which will then be used for implementing COVida-promoted playgroups. MGCAS has instructed the technical team from its Child Department to work with PATH technical staff, the COVida ECD focal point, and the United Nations Children’s Emergency Fund (UNICEF) education focal point to develop and pilot the community preschool manual. MGCAS has agreed that the manual can be piloted in the home-based playgroups under COVida, to generate some evidence for the Ministry about the playgroup model, as well as about the effectiveness of the manual in general. The manual and the guide will be edited, finalized, and submitted for formal MGCAS approval in the first quarter of FY 18.

COVida will continue to dialogue regularly with MGCAS, through GTCOV, on the tools for transition and graduation, as well as updates on case management tools (the intake forms, CSI and care plan). As COVida considers implementing a family action plan to synthesize its individual action plans, we will seek input from GTCOV. We will also update MGCAS on the progress of the eCSI. UNICEF has a plan in place to train SDSMAS staff on the eCSI, and COVida will collaborate with them on this initiative. COVida will collaborate with MISAU on developing a screening tool that will help activistas refer individuals that meet MISAU criteria for HIV testing, as above in IR 1.
We will continue working with MGCAS at national and provincial levels to organize annual multi-sectoral meetings with the Ministries of Health, Education and Human Development, the Interior, Technology, Agriculture, AIDS Constitutional Rights and Religious Issues, and Youth and Sports; and the National AIDS Council. The purpose of these meetings is to share results, seek input in planning for the subsequent time period and bring to attention inconsistencies that arise at the field level that require attention at either provincial or national level. Similarly, we will support CBOs to organize collaboration meetings at the district level that include government representatives and other stakeholders.

COVida will continue with joint field visits that involve representatives of social action, health, education and registration. Geographic partners will continue to include SDSMAS representatives in all technical trainings, often training them as trainers. CBOs will continue to refer beneficiaries to existing services, as described above in IR 1. They will also receive referrals from health units, schools, INAS and other government agencies.

COVida will continue to submit annual reports at the national level, quarterly reports to provincial authorities and encourage CBOs to submit reports to district authorities.

COVida will participate in routine meetings of the GTCOV and NUMCOV to share field-based experiences, update the case management tools, and stay informed of any new OVC strategies of mutual interest.

Geographic partners will encourage CBOs to collaborate with their respective district officials to advocate with the government to include COVida beneficiaries in social services targets such as INAS and ADE (Direct School Support). This activity would take place in quarter one supporting IR 1, during the 2018 General State Budget planning cycle.

COVida will dialogue with MGCAS staff who manage the ministry’s M&E database to see how the eCSI database might be programmed to produce reports responding to the requirements of the ministry’s database. Geographic partners will reinforce the importance of CBOs submitting regular reports at the district level.

6 COLLABORATION WITH OTHER DONORS AND STAKEHOLDERS

COVida will continue to collaborate with health units and the clinical partners that support them. This is further described under IR 1.

In Zambezia, WV will partner with CIHO in partnership with the John Hopkins Bloomberg School of Public Health, to ensure that CBO partners refer their beneficiaries for community HIV counseling and testing. In FY 18, CIHO will implement in five COVida overlap districts and they will focus on providing HIV testing for adolescents. COVida and CIHO have finalized a community HIV testing screening tool, which they will first pilot in Zambezia and then scale up nationwide. CIHO will establish partnerships with WV-identified CBOs such as NANA and Associação Moçambicana Mulher e Educação (AMME) to implement the project by recruiting counsellors and community mobilizers for HIV testing at the household level.

Geographic partners and, where logistically feasible, CBOs will participate in or reinvigorate provincial coordination mechanisms involving other non-government service providers. This may include the Forum of Health NGOs or Provincial Offices of the Committee to fight AIDS (NCPS) meetings; the mechanism will depend on which is most effective and appropriate in each province.
Other useful partnerships can arise, since other forum members include Pathfinder (implementing prevention and eradication of malaria), PSI working in reproductive health, etc.

COVida’s adolescent strategy in FY 18 will depend greatly on identifying and linking with local resources for adolescents. This may include: SMS Biz, PSI’s mobile family-planning project, local churches, and business people. COVida will support CBOs and collaborate with SDSMAS to reach out to and mobilize these resources, to be accomplished by sharing examples where this has already happened and providing TA to executive directors and project coordinators to identify and approach new sources. We will also support them to document these contributions for cost share.

In alignment with the nurturing care model proposed in the Lancet ECD series issued in 2016, in Year One PATH started conversations to promote collaboration with several key implementing partners including UNICEF, the Maternal and Child Survival Program (MCSP), COVida, and other PATH ECD projects. The objective is to design and implement a comprehensive nurturing care intervention for 0–5 year olds at clinical and community levels in Monapo district of Nampula Province during FY 18 and subsequently to implement. COVida will engage to the extent possible, recognizing that Monapo is a maintenance district and will not be supported after September 2019.

7 PROJECT MANAGEMENT

This section addresses both non-technical aspects of the project and external factors that affect the COVida consortium’s ability to achieve results.

7.1 Project Staffing

COVida’s new Deputy Chief of Party (DCOP), Shirley Eng, will start on October 2, 2017. Now that the various components have been designed, it is important that the implementation on the ground be well coordinated. To that end, FHI 360 is creating an associate director technical position that will ensure coordination amongst technical partners and technical interventions. With 11 new districts, but no additional funding, we are redistributing responsibilities for geographic areas amongst existing team members for M&E, grants and finance, technical and program to ensure balanced coverage.

CARE has proposed to convert its project coordinator position, which has been open for an extensive period, to a local expatriate position. PATH will be replacing a regional technical advisor on ECD, and adding a third. All other positions have been placed on a hiring freeze due to budget constraints.

7.2 Managing Agreements with Consortium Partners

Once the FY 18 workplan is approved, FHI 360 will review and approve annual workplans for consortium partners, and the accompanying budgets. FHI 360 will process additional obligations as funds become available. FHI 360 continues to monitor implementation and compliance, both on operationalizing the Standard Operating Procedures (SOPs) for implementation and in managing CBO subagreements.

If challenges or problems are identified, FHI 360 will act quickly to communicate with the consortium partners and develop a corrective course of action.

7.3 External Factors Affecting Performance

Several external factors may impact COVida’s ability to implement in the coming year.
The exchange rate has dropped from 70 Mozambique Metical (MT) to 60 MT to 1 US Dollar in the past year. Prices have adjusted throughout the year. The COVida budget has absorbed this shift for now, but any further shifts could have a dramatic negative impact on the projects ability to meet its targets.

The security situation resulting from ongoing clashes between the ruling and opposition political parties (respectively) Frente de Libertação de Moçambique (FRELIMO) and Resistência Nacional Moçambicana (RENAMO) has stabilized, allowing COVida to monitor activities in areas that were once isolated due to conflict. If this changes, we will revisit our strategy.

Obtaining work permits for expatriate employees continues to be a challenge. So far, all COVida expatriates have all up-to-date documentation. We hope there are no challenges in obtaining a work permit for the new DCOP.

7.4 Child Safeguarding

COVida will ensure that all partners have child protection policies and procedures and codes of conduct in place in the first quarter of FY 18. The topic was covered in the BCM training in Year One, so activists are trained, but we will follow-up to make sure the institutional supports are in place.

Child protection and child rights are paramount for COVida. We uphold the Convention on the Rights of the Child that states that all children, without any exception whatsoever, have equal rights to survival, health, education, protection and participation.

7.5 Recommendations from SIMS Visit

COVida looks forward to receiving the reports from the SIMS visits conducted by USAID. Based on our own observations during prior visits, we intend to address the following:

- Ensure all CBOs have institutional child safeguarding policies,
- Ensure all CBOs have policies that protect the rights of HIV+ people,
- Ensure that all CBOs have a protocol for responding to cases of GBV,
- Ensure that beneficiary files are properly stored to maintain confidentiality,
- Improve proper completion of the action plans and follow-up sheets with a focus on making sure the action plan is appropriate for the CSI and that fichas include services that are under-reported,
- Disaggregate education data by gender and age, and
- Ensure that CBOs are complying with the Environmental Mitigation and Monitoring Plan (EMMP).

7.6 Activista Stipends

COVida has heard that discussions are underway to increase the stipend being offered to Community Health Workers (APEs), or community-health outreach workers, to 2,500 MT/month. If this happens, it would provide an opportunity for COVida to increase the stipend offered to CBO partner activists, activista chefs and facilitators. In principle, COVida fully supports increasing the subsidy, particularly considering the increased caseloads and more complex processes of transition that they are being requested to undertake. Increasing the stipend would help us retain activists as stipends in other projects increase; this, in turn, saves on the costs of recruiting and training new activists. Also, experienced activists are more effective and recognized by the communities as such. Practically, however, such an increase would require an additional $760,000/ year for the 3,800 activists supporting COVida, and an additional $135,000/year for the 475 activista chefs and 200 facilitators that make up the community cadres. If the guidance indicates that this stipend is
appropriate for 20 hours/week, then we will need to recruit and train about 1200 additional activistas and hire additional staff to supervise them ($280,000 for training, $600,000/year for stipends, $90,000/year for 150 activista chefs and $120,000/year for supervision plus $265,000 for bicycles, $200,000 for motorcycles for supervisors). COVida will continue to monitor the situation, dialoguing with USAID, MGCAS and MISAU, where possible, to find a reasonable solution.

7.7 Cost Share

FHI 360 will conclude an agreement with Books for Africa who will provide 300,000 high-quality, full-color children’s books in Portuguese for COVida beneficiaries at a cost of approximately $1.36 per book. The value of these books on the local market is over $6 million. MGCAS is very pleased with the contribution and has included it in their budget to facilitate importation. We expect delivery of the books next fiscal year.

WV will provide cost share for COVida by contributing the costs for travel, shared staff, and subsidized office rental and equipment at provincial and national levels. WV will also ensure that the project beneficiaries in their provinces benefit from other WV projects, including other large-scale projects like Global Fund mosquito nets distribution.

CARE is implementing a cyclone-response project in the Massinga and Morrumbene districts in Inhambane Province, supporting the agriculture, social infrastructure rehabilitation, and GBV components. Most of the beneficiaries of the COVida project also benefit from the cyclone response activities. CARE will document these contributions, and calculate their cost share value to the project. N’weti and PATH will continue to identify cost share opportunities in FY 18 and COVida will continue to discuss opportunities with local donors and companies to leverage the investment made by USAID, with an emphasis on adolescent services. Finally, we will educate CBOs about documenting the cost share contributions they are obtaining from local resources.

7.8 Project Facebook Page

N’weti is leading the management of the project’s Facebook page, though all consortium partners and CBOs are asked to contribute. The page will seek to share information about the project, success stories, and partnerships. In addition, the page will bring to light challenging situations that COVida beneficiary families face that are beyond the capacity of the project to address; this will provide the opportunity to mobilize other support or advocacy for services to meet their needs.

7.9 Program Quality and Technical Assurance Visit (PTQA)

FHI 360 supports projects to implement a PTQA normally within the first 18 months of the project. Because of budget constraints, this was postponed and FHI 360 has identified other funds to cover 95% of the costs of the organization’s OVC expert, Tanya Medrano, Strategic Information Director, Mike Merrigan and Regional project manager, Liz Kariuki to conduct the PTQA in May 2018. The team will provide valuable feedback and guidance that will also inform the development of the FY 19 workplan.
## Activities

### Subactivities

<table>
<thead>
<tr>
<th>Activities</th>
<th>Deliverable</th>
<th>Target-mouth</th>
<th>Specific Sites (Provinces)</th>
<th>Fully loaded cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1 Select CBOs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.1 Selection of CBOs in new districts</td>
<td>CBOS selected</td>
<td>106</td>
<td>Niassa</td>
<td>35,769</td>
</tr>
<tr>
<td>1.1.2 Grant development workshop and conclude agreements with new CBOS</td>
<td>CBOS supported to develop SW and Budget</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.3 Start-up - post award conference, recruitment and hiring of staff and activistas, communication with local authorities</td>
<td>All new CBOS trained and ready to implement COVida</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.2 Capacity Development for Case Management</strong></td>
<td></td>
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<td></td>
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<tr>
<td>1.2.1 Train CBO staff, activistas, SDSMAS representatives in basic case management in 12 new districts.</td>
<td>All CBO staff, activistas, SDSMAS with adequate skills to do BCM</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2.2 Develop training materials for in-service training on case management, 90-90-90</td>
<td>BCM materials adjusted to project needs</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2.3 Refresher TOT for accredited trainers and new potential trainers</td>
<td>Accredited trainers to conduct BCM refresher trainings</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2.4 In-service training for existing activistas, CBO staff and SDSMAS representatives on BCM - three days (see comment for disaggregated total)</td>
<td>Activistas, CBO staff and SDSMAS with adequate skills to do BCM</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2.5 Training for supervisors and activista chefs on BCM, focus on transitioning, HIV, action oriented support and supportive supervision</td>
<td>Supervisors and activista chefs with improved skills to build capacity of activists in CM</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2.6 Produce an attractive handbook for health facilities to post to remind them of who should be referred to COVida for support. Also tools for activities (Guia de referencia, forms)</td>
<td>RF staff oriented to refer HIV infected and affected OVCs to receive COVida support</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.3 Conduct Basic Case Management</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1.3.1 Identify beneficiaries through health facilities, DSG partners and communities, conduct CTS, develop care plan.</td>
<td>Eligible families, identified through diverse channels, increasing percentage from health system</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3.2 Provide age appropriate services and referrals as outlined in workplan and MGCAS guidelines, assess for graduation.</td>
<td>OVCs and Caregivers supported to access critical services</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3.3 Referrals for HIV testing</td>
<td>Priority OVCs know their HIV status</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3.4 Referrals for ART</td>
<td>All OVCs and Caregivers known to be HIV+ are in ART</td>
<td>106</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Key Indicator/Activities

<table>
<thead>
<tr>
<th>Component</th>
<th>Deliverable</th>
<th>Target-mouth</th>
<th>Specific Sites (Provinces)</th>
<th>Fully loaded cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVC_Serv Number of active beneficiaries served by PEPFAR OVC programs for children and families affected</td>
<td>388,774</td>
<td>Niassa</td>
<td>93,744</td>
<td></td>
</tr>
<tr>
<td>OVC_HIVSTAT Percentage of orphans and vulnerable children (18 years old) with HIV status reported to be implementing partner/PEPFAR OVC programs for children and families affected by HIV</td>
<td>83,764</td>
<td>Niassa</td>
<td>4,081</td>
<td></td>
</tr>
<tr>
<td>Number of referrals made to health or social services</td>
<td>106</td>
<td>Niassa</td>
<td>3,287,088</td>
<td></td>
</tr>
</tbody>
</table>

### Collaborators

- GP
- FHI 360
- USAID

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**CBOs selected**: 106

**CBOS supported to develop SW and Budget**: 106

**Accredited trainers to conduct BCM refresher trainings**: 106

**Activistas, CBO staff and SDSMAS with adequate skills to do BCM**: 106

**Supervisors and activista chefs with improved skills to build capacity of activists in CM**: 106

**RF staff oriented to refer HIV infected and affected OVCs to receive COVida support**: 106

**Eligible families, identified through diverse channels, increasing percentage from health system**: see targets above for beneficiaries reached

**OVCs and Caregivers supported to access critical services**: see targets above for beneficiaries reached

Submitted 1 December 2017

COVida Revised Workplan for FY 18

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<table>
<thead>
<tr>
<th>Activities</th>
<th>Subactivities</th>
<th>Deliverable</th>
<th>Specific Sites (Provinces)</th>
<th>Fully loaded cost</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Partners and Collaborators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4.1 Training of point person at new CBOs and conducting mapping</td>
<td>-</td>
<td>New CBOs staff with adequate skills to conduct mapping</td>
<td>Niassa, Cabo Delgado, Nampula, Zambezia, Tete, Manica, Sofala, Inhambane, Gaza, Maputo Prov, Maputo City</td>
<td>$ -</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>N‘weti</td>
</tr>
<tr>
<td>1.4.2 Conduct mapping (new CBOs)</td>
<td>-</td>
<td>OVC services mapped, report shared with activists, OVCs informed</td>
<td>-</td>
<td>recurring</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>GP</td>
</tr>
<tr>
<td>1.5 Supportive environment: conduct community dialogues and savings groups debates to promote a healthy environment</td>
<td>1.5.1 Finalized debate session manual and curriculum</td>
<td>Debate session Manual ready for trainings</td>
<td>N/A</td>
<td>$ 61,508</td>
<td>investment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>1.5.2 Train debate session facilitators, CBO staff and SDSSMAS in CBOs in 8 provinces.</td>
<td>Facilitators, CBO staff and SDSSMAS, with adequate skills to facilitate debates</td>
<td>-</td>
<td>investment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>N‘weti</td>
</tr>
<tr>
<td></td>
<td>1.5.3 Conduct debates with savings groups and community leaders</td>
<td>OVC caregivers and community members reached with healthy environment messages</td>
<td>$ 104,803</td>
<td>recurring</td>
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<tr>
<td>1.6 Supportive environment: mobilize additional resources to support beneficiary families</td>
<td>1.6.1 Translation, printing, shipping and distribution of 300,000 childrens books contributed by Books for Africa.</td>
<td>High quality children’s books available for beneficiaries</td>
<td>$ 205,500</td>
<td>investment</td>
<td>-</td>
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<td></td>
<td>1.6.2 Training CBOs in mobilizing additional resources for families and documenting them for cost share.</td>
<td>Increased cost share contribution from communities</td>
<td>100,000 Unit</td>
<td>included with IR 4</td>
<td>investment</td>
<td>-</td>
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<td></td>
<td>1.7.1 Systematize a structured TA protocol for use in all visits</td>
<td>All CBOs receive basic TA</td>
<td>$ 1,889,374</td>
<td>recurring</td>
<td>-</td>
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<td></td>
<td>1.7.2 Supervisors hold weekly meetings and visits with activists and chiefs.</td>
<td>All activists receive oriented and supportive supervision on BCM and 90-90-90</td>
<td>-</td>
<td>recurring</td>
<td>-</td>
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<td></td>
<td>1.7.3 Provincial technical staff visit CBOs monthly to implement BCM and paperwork (10x/year)</td>
<td>All CBOs staff receive adequate TA to implement BCM and to use CM tools</td>
<td>$ 358,095</td>
<td>recurring</td>
<td>-</td>
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<td>1.7.4 National and Regional technical advisors visit provinces quarterly to support provincial technical staff (3x/year)</td>
<td>Provincial technical staff receive support and guidance</td>
<td>$ 36,211</td>
<td>recurring</td>
<td>-</td>
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<td>1.7.5 Joint supervision visits with government officials at distrital level</td>
<td>CBOs supported to create and maintain linkages with other services</td>
<td>$ 164,261</td>
<td>recurring</td>
<td>-</td>
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<td>FHI 360</td>
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<td>1.7.6 Periodic regional technical meeting</td>
<td>Technical team able to provide consistent and updated guidance to CBOs</td>
<td>-</td>
<td>recurring</td>
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**COViDa Revised Workplan for FY 18**
Submitted 1 December 2017
<table>
<thead>
<tr>
<th>Activities</th>
<th>Subactivities</th>
<th>Deliverable</th>
<th>Target- how many</th>
<th>Specific Sites (Provinces)</th>
<th>Fully loaded cost</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Partners and Collaborators</th>
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</thead>
<tbody>
<tr>
<td>1.7 CBO supervisors accompany activists</td>
<td>activistas improve application of case management, increase in transitions</td>
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<td>$ 986,273</td>
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