Service Delivery and Support for Orphans and Vulnerable Children

REVISED
ANNUAL
WORKPLAN
FOR FY20

October 1, 2019 – September 30, 2020

SUBMITTED
September 13, 2019

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<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADPP</td>
<td><em>Ajuda de Desenvolvimento de Povo para Povo</em></td>
</tr>
<tr>
<td>AGYW</td>
<td>Adolescent Girls and Young Women</td>
</tr>
<tr>
<td>AOR</td>
<td>Agreement Officer Representative</td>
</tr>
<tr>
<td>APR</td>
<td>Annual Performance Report</td>
</tr>
<tr>
<td>APS</td>
<td>Annual Program Statement</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-Based Organization</td>
</tr>
<tr>
<td>CCR</td>
<td>Child-at-risk Consultation</td>
</tr>
<tr>
<td>CCS</td>
<td><em>Centro de Colaboração em Saúde</em> (Center for Collaboration in Health)</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CHAI</td>
<td>Clinton Health Access Initiative</td>
</tr>
<tr>
<td>CHASS</td>
<td>Clinical and Community HIV/AIDS Services Strengthening</td>
</tr>
<tr>
<td>CLHIV</td>
<td>Children living with HIV</td>
</tr>
<tr>
<td>CSI</td>
<td>Child Status Index</td>
</tr>
<tr>
<td>DATIM</td>
<td>Data for Accountability, Transparency, and Impact</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>DPGCAS</td>
<td>Provincial Department of Gender, Children, and Social Action</td>
</tr>
<tr>
<td>DQA</td>
<td>Data Quality Assessment</td>
</tr>
<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
</tr>
<tr>
<td>eCSI</td>
<td>Electronic Child Status Index</td>
</tr>
<tr>
<td>EGPAF</td>
<td>Elizabeth Glaser Pediatric AIDS Foundation</td>
</tr>
<tr>
<td>FDC</td>
<td><em>Fundação para o Desenvolvimento da Comunidade</em></td>
</tr>
<tr>
<td>FGH</td>
<td>Friends in Global Health</td>
</tr>
<tr>
<td>FY</td>
<td>Fiscal Year</td>
</tr>
<tr>
<td>GTCOV</td>
<td><em>Grupo Técnico de COV</em> (OVC Technical Working Group)</td>
</tr>
<tr>
<td>HF</td>
<td>Health Facility</td>
</tr>
<tr>
<td>HF5</td>
<td>Health Facilities</td>
</tr>
<tr>
<td>HES</td>
<td>Household Economic Strengthening</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>IEC</td>
<td>Information, Education, and Communication</td>
</tr>
<tr>
<td>INAS</td>
<td><em>Instituto Nacional de Acção Social</em></td>
</tr>
<tr>
<td>INGO</td>
<td>International Non-Governmental Organization</td>
</tr>
<tr>
<td>IP</td>
<td>Implementing Partners</td>
</tr>
<tr>
<td>IR</td>
<td>Intermediate Result</td>
</tr>
<tr>
<td>M2M</td>
<td>Mothers 2 Mothers</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MELP</td>
<td>Monitoring, Evaluation and Learning Plan</td>
</tr>
<tr>
<td>MER</td>
<td>Monitoring, Evaluating, and Reporting</td>
</tr>
<tr>
<td>MGCAS</td>
<td>Ministry of Gender, Children, and Social Action</td>
</tr>
<tr>
<td>MISAU</td>
<td><em>Ministério de Saúde</em></td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>NPCS</td>
<td><strong>Núcleo Provincial de Combate ao Sida</strong> (Provincial HIV and AIDS Directorate)</td>
</tr>
<tr>
<td>MUAC</td>
<td>Mid-Upper Arm Circumference</td>
</tr>
<tr>
<td>NFI</td>
<td>No-Food Item</td>
</tr>
<tr>
<td>NUMCOV</td>
<td><strong>Núcleo Multisectoral para Crianças Órfãs e Vulneráveis</strong> (Multi-sectoral Steering Committee for Orphans and Vulnerable Children)</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PASSOS</td>
<td>Integrated HIV Prevention and Health Services for Key and Priority Populations <strong>Promoção Integrada de Direitos e Saúde</strong></td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PTO</td>
<td>Provincial Technical Officers</td>
</tr>
<tr>
<td>Q</td>
<td>Quarter</td>
</tr>
<tr>
<td>SAAJ</td>
<td><strong>Serviços Amigos dos Adolescentes e Jovens</strong> (Adolescent and Youth-Friendly Services)</td>
</tr>
<tr>
<td>SAVIX</td>
<td>Savings Groups Information Exchange</td>
</tr>
<tr>
<td>SDAE</td>
<td>Serviços Distritais de Actividades Económicas (District Directorate of Economic Activities)</td>
</tr>
<tr>
<td>SDS-OVC</td>
<td>Service Delivery and Support to Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>SDSMAS</td>
<td><strong>Serviços Distritais de Saúde, Mulher e Acção Social</strong> (District Services for Health, Gender, Children and Social Action)</td>
</tr>
<tr>
<td>SG</td>
<td>Savings Group</td>
</tr>
<tr>
<td>SNV</td>
<td>Netherlands Development Organization</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard Operating Procedures</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>TA</td>
<td>Technical Assistance</td>
</tr>
<tr>
<td>TOT</td>
<td>Training of Trainers</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>USG</td>
<td>United States Government</td>
</tr>
<tr>
<td>VSL</td>
<td>Village Saving and Loan</td>
</tr>
<tr>
<td>WV</td>
<td>World Vision</td>
</tr>
</tbody>
</table>
1. OVERVIEW

1.1 Project Summary

Project name
COVida – Juntos Pelas Crianças (formerly Service Delivery and Support to Orphans and Vulnerable Children (SDS-OVC))

Project duration
Five years

Starting date
June 23, 2016

Life of project funding
$84,380,486 USD

Geographic focus
At the beginning of FY20, COVida will implement activities in 60 districts in all provinces. Following USAID’s orientations for FY20, COVida will close-out implementation in districts that will no longer be priority in FY20 and transfer other districts to a local partner; at the end of Q4, COVida will be implementing in 30 districts.

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 President’s Emergency Plan for AIDS Relief (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 strengthen capacity of district government and communities to provide support to OVC and their families.

Consortium partners
The COVida consortium comprises of three partners with either geographic or technical responsibilities, or both. In FY20, PATH will no longer received funds through COVida, due to budget limitations and changing technical priorities. The responsibilities are assigned as follows:

<table>
<thead>
<tr>
<th>PARTNER</th>
<th>RESPONSIBILITY</th>
<th>AREA/TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>FHI 360</td>
<td>Project Lead</td>
<td>Maputo, Sofala, Manica, Tete, Niassa, Nampula, Cabo Delgado, Gaza, Zambezia*</td>
</tr>
<tr>
<td></td>
<td>Geographic partner</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Technical lead</td>
<td>Case Management, HIV, Organizational Development</td>
</tr>
</tbody>
</table>
1.2 Overview of Workplan

This fourth annual workplan covers the period October 1, 2019 – September 30, 2020, aligned with the USAID standard fiscal year, FY20. This narrative is in the format agreed upon with USAID at the start of our agreement; it accompanies the FY20 Costed Workplan Template (Annex 1), which provides details on location and costs. The overall OVC_SERV target provided by USAID is 267,846. In addition, USAID has instructed COVida to reach a target of 45,375 in Zambezia by Q3, which will count towards a local partner’s target. Annex 2 includes the targets provided by Data for Accountability, Transparency, and Impact (DATIM). The budget ceiling provided by USAID for this workplan is $10,782,384. This narrative document provides additional background and explanations that are not possible to include in the matrix. Section 2 covers Project Implementation, comprising the comprehensive array of COVida technical inputs across the three Intermediate Results (IRs). Section 3, Monitoring and Evaluation, describes the Strategic Information (SI) activities planned to monitor progress toward targets and provide information that allows for course adjustments and report on progress. Sections 4 covers Project Management, which addresses the changes to sites and site coverage, other practical factors and provides an update on Cost Share. Sections 5 and 6 provide updates on Key Collaborations and Exit Strategy.

2. PROJECT IMPLEMENTATION

2.1 FY20 Targets

Targets provided by USAID for FY20 are included in Annex 2. There are still pending questions that COVida has raised to USAID about its targets:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVC_SERV</td>
<td>267,846</td>
</tr>
<tr>
<td>OVC_HIVSTAT</td>
<td>236,242</td>
</tr>
<tr>
<td>PP_PREV</td>
<td>21,816*</td>
</tr>
</tbody>
</table>

They target for OVC_SERV includes 233,297 children under the age of 18, including 109,931 adolescents ages 10-14 (63% female).

COVida will do its best to achieve all targets. However, there are some that are inconsistent or illogical that will be extremely difficult or impossible to achieve: There are pending questions that COVida has raised to USAID about its targets:
- The PP_PREV target (see table below) in Matutuine is much higher than the population of adolescent girls and young women (AGYW) in the district, according to the latest census data (females between 10-24 years old).
- In some districts, the OVC_HIVSTAT target is higher than the <18 OVC_SERV target.
- *The PP_PREV target includes males in a Dreams program, which is designed for females.

<table>
<thead>
<tr>
<th>Indicator</th>
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</tr>
<tr>
<td>PP_PREV</td>
<td>21,816*</td>
</tr>
</tbody>
</table>

As mentioned above, USAID has also instructed COVida to reach a target of 45,375 in Zambezia by Q3, which will count toward a local partner’s targets and not FHI 360 targets.

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

#### 2.2.1 Identifying, reaching and retaining children and adolescents living with HIV

COVida will continue to hone its targeting strategy to identify children and adolescents living with HIV and reach children and adolescents at high risk of HIV infection. To increase the number of Children Living with HIV (CLHIV) enrolled in COVida and ensure an appropriate balance of subpopulations, COVida will provide its partner CBOs with targets by subpopulation (subsets of OVC_SERV target) based on available site-specific data such as the number of currently enrolled sub-populations, pediatric retention and the Key Populations (KP) project coverage. CBOs will also provide activistas with detailed targets by subpopulation, including monthly, weekly and even daily targets for enrollments and other key indicators. This approach will facilitate tracking progress towards the achievement of targets, as well as increase accountability for meeting targets among CBOs and activistas. The figure below illustrates the different sub-groups the project will reach in FY 20 and the proportion each group represents of the overall target for children/adolescents.
Identification and enrollment of priority sub-groups will require:

1. Improved collaboration with health facilities and clinical partners to receive referrals of eligible beneficiaries, coordinate support to treatment retention of CLHIV, and support index-case testing.
2. Focused efforts in the community to identify CLHIV or children with a high risk of HIV infection who are not linked to the health system.

In FY19, COVida continued to improve collaboration with health facilities (HFs) and clinical partners in all provinces. In Q3, 10,593 new families 58% of the 76,994 new families were referred by HFs, with notable increases in Zambezia, Nampula and Maputo provinces, where the proportion of beneficiaries identified through HFs in Q1 was below 20%. Zambezia identified 31 families through HF/CP in Q1, and 1,436 in Q3. Nampula identified 14 in Q1 and 2,926 in Q3; finally Maputo province identified 178 in Q1 and 1,197 in Q3. Key factors in this improvement include: placing a linkage facilitator in each high priority health facility, excellent collaboration with FGH in Zambezia where they support face-to-face referrals as opposed to lists. In addition, COVida has improved coordination between partners in Maputo City and Maputo Province, so that families who go to the hospital in the city, but live in the province, are still supported at home. COVida will continue to ensure that at least one fixed clinic-community Linkage Facilitator (LF) is allocated to each HF covered by COVida to help health staff identify and refer potential COVida beneficiaries. To achieve the subpopulation targets of CLHIV and children of HIV-positive caregivers, COVida will:

- Revise the job description and subsidies of LF to engage higher capacity individuals and enable CBOs to increase the time spent by LF in HFs, ensuring their availability during the busiest patient visit hours.
- Adjust the distribution of activistas, activistas chefs, and LF to be concentrated in the areas with the highest number of CLHIV based on analysis of pediatric treatment data provided by the mission and HFs.
- Support CBO staff (project officers, supervisors and LFs) to strengthen synergies and linkages with HFs and clinical partners, ensuring that both HIV+ children and HIV+ caregivers with children are referred to COVida. Solutions will vary for each facility and may include: advocating for consistent TARV committee meetings, orienting new health
facility staff to COVida, inviting health facility staff for a joint household visit, and organizing monthly meeting with clinical partners representatives to discuss results of bi-directional referrals.

- Implement “surge” campaign in strategic HFs in COVida’s area of intervention to maximize enrollment of eligible CLHIV in Q1. During this surge, COVida will use data to orient resources to those areas where we can have the greatest impact in a short period of time and provide intensive, on-site, high level Technical Assistance (TA) until the site-level team has adopted the new strategy. The laser focus that a surge campaign brings will mobilize clinical and community stakeholders and channel resources to the number one priority. Although enrollment will be possible throughout the year, Q1 will have a bigger focus so that CBOs can support these beneficiaries for a longer period.

- Place COVida poster in all HF entry points, i.e. Child-at-risk Consultation (CCR), HIV Testing and Counseling (HTC), Prevention of Mother-to-Child Transmission (PMTCT), Antiretroviral Therapy (ART) services, Tuberculosis (TB) and post-rape care services.

- Request monthly meetings with clinical partners at provincial level to jointly analyze pediatric data, including the number of children on ART in HFs and the proportion of these children enrolled by COVida, track retention of CLHIV supported by COVida and jointly problem-solve to address any barriers identified.

To improve new HIV case finding and identify new persons living with HIV (PLHIV) not already in the health system, COVida will:

- Refine the HIV risk screening tool (as described below under HIV_STAT) to ensure that we are identifying children with risk of HIV infection.
- Screen children for HIV risk (e.g. index case) and facilitate testing.
- Collaborate with HFs to review charts of adult and pediatric HIV+ patients to identify biological children and siblings that have not been tested.
- Review our community beneficiary identification and selection criteria/ SOP/ tools to ensure they are helping CBOs identify and enroll those at highest risk of/ most likely to be HIV+.
- Improve tracking and completion of HIV testing and treatment referrals.
- Improve disclosure of HIV status after testing.
- Improve activist skills in counseling to promote HIV testing and addressing stigma and discrimination.

The entry points to identify CLHIV and children of HIV-positive parents in HFs will include CCR, HTC, PMTCT, ART services, TB and post-rape care services. In addition, to help find potential beneficiaries who are not already in treatment and link them to care, COVida will continue to identify beneficiaries in the community through community testing partners, other community sources who also refer HIV+ beneficiaries to COVida, as well as other priority sub-groups.

Based on preliminary info from the “surge” activity COVida conducted at the end of FY 19 Q3, we are finding an HIV positive rate of 3-4%. Many of these were screened using the improved screening tool. We will analyze data from different sites to identify patterns that may help us improve case finding. We are finding variations in positive rate that are worth exploring, once we verify the data.

Vulnerable adolescents 9-14 for prevention groups and 10-17 for case management will be identified in Serviços Amigos dos Adolescentes e Jovens (SAAJ) and other entry points in HFs. In the community, adolescents can help find high risk peers, and SDMSMAS will continue to refer.
Additional entry points will be community leaders, teachers, youth organizations/groups and families, who know which adolescents are in the following vulnerable situations:

- Out of school;
- Missing school frequently;
- 2 years behind in school or not doing well in school;
- Those who risk not transitioning to secondary school due to insufficient grades, lack of resources, or other barriers;
- Living with neither parent/without a caregiver;
- Sexually active;
- Pregnant, married or have children; and
- Victims of violence;

Many adolescents 9-14 will be supported through the group prevention activities described below. All will be screened and referred to case management services described below if they require additional support (e.g. victims of violence, pregnant, young mothers, HIV positive).

To reach children of Female Sex Workers (FSW), COVida and Promoção Integrada de Direitos e Saúde (PASSOS) piloted a new approach in Mocuba (Q2 FY19), whereby PASSOS and COVida activistas went together to visit sex worker households. This approach proved more successful than the original strategy of referring FSWs in hot spots to COVida, since sex workers do not work in the same communities where they live and would not follow-up with referrals. With the new approach, the CBO in Mocuba managed to enroll 309 children of FSW in just a few weeks, which is three times more children of FSW enrolled in all FY18. COVida will scale-up this approach in all districts where we overlap with key populations (KP) projects and ensure that partner CBOs follow the Standard Operating Procedures (SOPs) developed with PASSOS.

2.2.1.1 Ensuring 95% of OVC have known HIV Status

In FY18 and FY19, COVida made significant progress in OVC_HIV_STAT, increasing the proportion of children with known status from 42% in FY17 to 72% in FY18, although this plateaued in FY19. The improvement was made possible due to better data collection, improved counseling and the introduction of the HIV risk assessment tool for Mozambique. However, with the current screening tool, we are referring about 90% of children for testing. As clinical partners are focusing more on treatment retention and now only test index cases, many of our referred beneficiaries are not being tested. This has created frustration at many levels and confusion about who is “at-risk”. It also jeopardizes the credibility of COVida in the community. Finally, it has had a negative impact on the rate of completed referrals for HIV testing and our OVC_HIV_STAT performance has remained the same since October 2018.

To improve new HIV case finding, in FY19 Q3, COVida refined improved the screening tool, aligning the assessment criteria with clinical risk criteria. COVida expects to achieve 95% known status in FY20. By more closely aligning the risk assessment criteria with those used by the health system, we expect to only refer cases where there is a risk of HIV infection and see an increase in the identification of new HIV+ cases. This will also improve the consistency of messaging around who is “at-risk”. In addition to helping children in the program know their HIV status (whether positive or negative), COVida will also aim to improve performance in finding new HIV cases in the community through the improved screening tool and ensuring that all children with unknown status who have an HIV+ biological parent or sibling are tested. We will repeat the risk assessment among youth not found at risk of HIV through the risk assessment or who test negative, but later become sexually active or engage in other high behaviors.
For all children with unknown status who are newly identified through the community, we will apply the HIV risk assessment tool during the well-being and needs assessment process. Caregivers of eligible children for testing will be mobilized and accompanied to HFs. Based on the volume of beneficiaries eligible for testing, COVida will coordinate with community testing partners to organize community testing. For index cases (children of HIV positive caregiver), COVida will coordinate with clinical partners to test them in their households; per our experience, most beneficiaries prefer to be tested at home. COVida will coordinate with the Clinton Health Access Initiative (CHAI), which supports Early Infant Diagnosis (EID) services.

For beneficiaries identified through the HF because they have an HIV-positive family member, COVida will promote disclosure support and apply the HIV risk assessment for all biological siblings or biological children of an HIV+ individual. To ensure that all children at risk are tested and the HIV-positive are linked to ART, COVida will include follow-up steps in the screening tool and continue to provide _activistas_ with daily lists of beneficiaries with unknown status.

For 9-14 year-old adolescents participating in HIV and violence prevention activities, HIV status will be collected privately, after group sessions, as they will not receive family-centered case management. During adolescent identification and enrollment, the facilitators will collect information on HIV status. The collection of personal information at enrollment will be individual and confidential. At the end of the session about HIV prevention, adolescents with unknown status will be screened, using the individual HIV risk assessment tool to identify adolescents who are at risk of HIV infection, mobilize and refer them to HIV testing at SAAJ within the HFs. In the following sessions, the debate facilitators will meet individually with each adolescent referred for HIV testing to collect and follow on the result of the test and HIV status. Adolescents who do not present any HIV risk factor will be reported as Test Not Recommended. For adolescents under age 11 with a risk factor, COVida will seek their parents’ consent to be tested, per Ministry of Health (MOH) guidelines. Those who present a risk factor will be considered for case management; any adolescents that test HIV positive, will immediately be enrolled in the case management program.

COVida provided additional training to field cadres on conducting the risk assessment, supporting families to get tested, and is working with implementing partners (IPs) to understand barriers to testing. In addition to improving the risk assessment tool, COVida will regularly analyze the HIV_STAT and screening cascade to pinpoint problem areas in different sites and intervene as appropriate. For example, we anticipate that some sites will need additional practice on encouraging families to get tested, others on disclosure support, others will require work with the HF to reduce stigma and discrimination or improve confidentiality.

### 2.2.1.2 95% of CLHIV on Treatment and 95% of those with Suppressed Viral Load

During FY19, COVida supported pediatric and adolescent retention and priority sites identified by the USAID/Mozambique mission. Initial results show a positive impact. As of Q3, COVida received 6,394 names through lists and/ or referrals from HF and CP. Of these 5, 125 lived in COVida coverage sites. Of these, 4,140 were locate and accepted to participate in COVida. 100% of those visited are still in treatment at the first and second support visits. Of particular interest are the retention barriers identified by COVida: lack of transport, lack of disclosure within the family (e.g. fear of the father or mother-in-law finding out), children who don’t know their status, lack of food, and poor treatment and long waits in the health facility. COVida will continue to request monthly meetings with clinical partners at provincial level to jointly analyze pediatric retention data, the number of beneficiaries referred to and enrolled by COVida, track retention of CLHIV supported by COVida and
jointly problem-solve to address any barriers identified. COVida will also adapt site coverage to ensure we are present in areas with high concentrations of PLHIV.

Currently, viral load reports are available only in a limited number of health facilities. As viral load becomes available in different health facilities, we will ask CBOs to request this information from the sites for HIV positive children. We will also request from clinical partners. We will provide MISAU consistent guidance to supervisors and activista chefs on how to support beneficiaries and their caregivers if the viral load is low, medium or high.

Pediatric retention in Mozambique continues to be low. For a child, pediatric retention goes beyond prescribing a pill; someone in the family needs to make sure the child gets the pills and takes them on schedule, monitors side effects and makes sure the child is eating properly. In Mozambique, stigma is an enormous barrier; for example, if the mother is afraid to tell other family members, the child may not have support when she is not around, or the husband or mother-in-law may ask why she is taking the child to the doctor all the time, which may impede her from going to the clinic. We also have cases where grandparents care for children and cannot walk the long distance to the clinic. All of these are real and present barriers to treatment, but beyond the scope of the clinic that is already understaffed. Clinicians do not have time to visit people in their homes. OVC programs do visit people in their homes, at least once a month if not more. OVC activistas are from the communities in which people live; they know the dynamics that can impede treatment and can help problem solve to overcome them. Activistas help people understand the medication and remind them about medication and visits; they accompany children and caregivers on visits, provide transport, help beneficiaries access nutritional support. Critically, activistas also help people disclose their status to family members. FHI 360 describes elsewhere in this workplan the additional complementary services that help families affected by HIV survive and thrive and prevent people who are negative from becoming HIV positive: savings groups, help staying in school, birth registration so they can access other services and have inheritance rights, nutrition support and access to services.

For adolescents, the issue is even more complex as the relationship with the caregiver may or may not be positive. The complexities of adolescent development complicate matters further. In many cases, adolescents living with HIV don’t know they are HIV positive and the parents don’t know how to tell them; COVida helps with disclosure within the family, and deciding if, to whom, and how to disclose (e.g. friends, teachers, sexual partners and more). While activistas will always promote a positive dialogue with the caregiver, in cases where that is not possible, the activista can remind adolescents about appointments and medication, encourage them to share concerns with the health care provider, and counsel them about how to have healthy relationships without transmitting the virus.

COVida proposes to test a model for adolescent retention groups in health facilities that do not already have this intervention. COVida will use MOH guidelines and curriculum for HIV positive adolescent adherence clubs. We will also review existing models such as those set up by Kenya 0+0=0, REPSII or Ariel and draw on experience in youth development and adolescent group interventions such as FHI 360’s Positive Connections. As starting point, COVida will prioritize health facilities with SAAJ-adolescent and youth friendly services and sites with Peace Corp Volunteers implementing group interventions for adolescents. COVida would identify 2-3 health facilities to test an approach, developed in collaboration with the health facilities and clinical partners, o bring together interested HIV positive adolescents in a support group format. We anticipate that the Linkage Facilitators or Peace Corps Volunteers would initiate the activity at the health facility, and
eventually groups would be lead by young HIV positive mentors. We would also monitor retention and viral load, where available, for these groups.

2.2.1.3 Service Delivery for Children and Families consistent with Monitoring, Evaluation, and Reporting (MER) requirements

**Service Delivery Approaches**

COVida’s current case management approach is family-centered for all subpopulations, based on individual needs assessments and monthly household visits to provide services or referrals. In FY20, COVida will implement a differentiated approach for each targeted sub-group.

![Figure 2: Service Delivery Approaches](image)

**Intensive:** HIV-positive children and children in crisis.

**Comprehensive:** Selectively targeted to children with multiple elevated risk factors.

**Prevention:** For 9-14 year old at-risk adolescents in high prevalence and impoverished areas to promote healthy relationships and behaviors. Time-limited group interventions. Per PEPFAR guidance, these adolescents will not require case management, unless they are found to have more critical needs (e.g. HIV-positive, survivor of violence, etc.).

**Intensive case management** will be provided to families with children and adolescents living with HIV and who have experienced violence, or who are otherwise in crisis. For these children, COVida will use a family-centered approach at the household level and group interventions in HFs. ART adherence and retention support and psychosocial support will be provided based on the specific barriers the family is facing. This will include the full family-centered, integrated case management, including needs assessment, family care plan, household visits, services, referrals and accompaniment to referrals. However, this may be more intensive with families visited as frequently as necessary to address the crisis; we anticipate twice a month as an average. COVida will continue to monitor and provide TA to the CBOs to ensure that the social emergency fund (provided in each CBO budget) is used for critical cases to overcome treatment barriers, such as lack of food and transport to HFs.

**For CLHIV under 5 years old, COVida will collaborate with mentor mothers and clinical partners** to organize educational and recreational activities in HFs, including lunch and nutritional counseling to motivate caregivers and children to follow their medical appointments. For under-five CLHIV who are not being followed by mentor mothers, COVida’s intensive support will include supporting the mother’s retention on ART, breastfeeding support, access to healthy nutrition as the child ages and ensuring the child is tested at the recommended intervals. LF’s and **activistas** will reinforce messages on pediatric retention during group interventions in HFs and household visits, including mobilizing beneficiaries to better understand the information on new granules and powder forms of pediatric ART. **Activistas** will monitor developmental milestones and reinforce Early Childhood Development (ECD) and nutritional interventions. For children suffering from acute malnutrition, COVida will immediately accompany them to nutrition services at the HF. COVida will also liaise with the Clinton...
Health Access Initiative (CHAI), which supplies nutritional supplements (Plumpy’nut/F75/F100) to the health sector for treatment of child malnutrition.

For CLHIV 6-17 years old, COVida will provide intensive support (e.g. via their caregivers) to promote disclosure and help them continue in treatment and comply with medical appointments. COVida will also support these children to be enrolled in school and attend regularly, supporting school fees and providing school uniforms and materials where necessary.

COVida will provide HFs in its area of intervention with toys and high-quality books for children who are waiting for medical appointments. COVida’s data show that one of the main barriers to pediatric retention is the long wait at the HF; toys and books will help motivate children and caregivers to attend their appointments. COVida will train its activistas and linkage facilitators in using books to stimulate children.

Families receiving intensive support will also receive household economic strengthening support (e.g. integration in a savings group).

Comprehensive support will be provided for children of HIV-positive caregivers, child-headed households, children of FSW and orphans. This will include: HIV risk assessment and referrals for HIV testing for children eligible for testing, promoting ECD activities for children under 5 years, HIV prevention activities for adolescents, education and legal (e.g. birth certificates) support depending on needs, and household economic strengthening. The process will be based on family-centered, integrated case management, including needs assessment, family care plan, household visits, services, referrals and accompaniment to referrals. The visits will be on average once a month at the start and taper off to quarterly visits as critical needs are addressed. COVida will continue to support its CBOs to strengthen referral relationships with key health and social service providers to ensure children and their families have access to a broader range of health and social services.

To reduce activistas’ workloads and at the same time ensure that families receive critical services, COVida will support CBOs to organize one-stop service fairs in communities, with the participation of health, social action, education, registry and notary, and economic activity services.

Support for at-risk adolescents is described below in the section on evidence-based approaches for adolescents 9-14.

**Case Management Consistent with MER requirements**

COVida’s current case management approach is an on-going process with all steps (identification, enrollment, assessment, case plan, service provision, monitoring progress and graduation) happening at the same time, depending where a family is in the cycle. The project design was that an activista would reach 90 beneficiaries per year, with a caseload of 60 beneficiaries at any given time. Field experience indicates that activistas are struggling to manage and document case management activities for families in various stages of the cycle. The new definitions of the OVC_SERV indicator in MER 2.3 require services in two consecutive quarters, updated and monitored care plans, and more difficult graduation criteria. We were doing most of these prior to the new guidance, but they were not systematically documented, and activistas were expected to complete the same steps for all

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1 FHI 360 anticipates that the books and toys included in the standard grants to CBOs working with OVC would include items such as those covered in Chapters 49 and 95 of the USAID Commodities Eligibility Listing.
beneficiaries. While the new requirements are intended to channel resources to those who need it the most and to reduce the burden of care for less intensive cases, it will take time and extensive support for activistas to understand and operationalize these changes.

Based on targets, it is anticipated that about 40 percent of beneficiaries will require the prevention program, and 60 percent will require comprehensive case management. To help activistas and CBOs properly follow case management procedures and improve services for those that require it, COVida will implement a phased case management approach, which, which focuses technical assistance support and activities on those phases of case management relevant for the majority of beneficiaries at key points during the year. For example, during Q1, there will be many transitions due to geographic realignment, and many beneficiaries have passed the one year mark. For those CBOs in these situations, we will focus on ensuring they apply the guidance for graduation and transfers properly (Module 3 below). For those needing to expand, or starting in new areas, we will focus on Phase I, identification, enrollment, assessment, care plan and emergency services (Module 1). This approach will help activistas focus their interventions and project staff to provide focused and timely mentoring supervision. With this approach, COVida will provide modular trainings to CBOs and activistas, rather than one full training at the beginning of year. Each activista will establish a caseload of 70 children in Q1 and manage the same beneficiaries throughout the year. New cases of beneficiaries, especially CLHIV, will still be referred to COVida throughout the year, but the bulk of beneficiaries will be enrolled in Q1. Case management activities will be implemented as presented in the table below. This approach will ensure consistent service provision.

Table 1: COVida Phased Case Management activities

<table>
<thead>
<tr>
<th>Case Management Step</th>
<th>Actions</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification</td>
<td>• Training on Module 1 – Case Management, priority subpopulations, identification, enrollment, assessment and care plan, emergency services (screening, link to ART, school enrollment, nutrition and WASH).</td>
<td>Oct</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Collaborate with HF and clinical partners with the aim for all eligible children, especially CLHIV, to be referred to COVida to ensure complementary support for CLHIV.</td>
<td>Oct-Nov</td>
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<tr>
<td></td>
<td>• Link all HIV-positive beneficiaries not on ART to ART.</td>
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<td></td>
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<tr>
<td></td>
<td>• Provide retention support to all PLHIV.</td>
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<td></td>
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<tr>
<td></td>
<td>• Activistas chefs and supervisors meet with community leaders and schools to identify eligible OVC in the community.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Activistas chefs and supervisors allocate cases to activistas considering balance of families requiring intensive or comprehensive support.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrollment, Assessment and Case plan</td>
<td>• Activistas visit their cases to enroll new households, conduct assessment, HIV risk assessment and testing referrals, and provide the first service.</td>
<td>Nov</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• Immediately refer any HIV positive not in treatment to treatment.
• Immediately link critical cases to services (e.g. victim of Gender-based Violence, acute malnutrition).
• Develop case plans.

<table>
<thead>
<tr>
<th>Services and Referrals</th>
<th>• Mobilize and support caregivers to enroll all school age children</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Screen for acute malnutrition (children 6-59 months)</td>
<td></td>
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<tr>
<td></td>
<td>• Provide nutritional counselling, WASH (in preparation for rainy season), especially for CLHIV and children under five</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Continue to address urgent needs</td>
<td></td>
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<tr>
<td></td>
<td>• Training on Module 2: Provision of eligible services and monitor care plan progress.</td>
<td>Jan</td>
</tr>
<tr>
<td></td>
<td>• Managing more complex cases.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Mobilize and refer caregivers to participate in Savings Groups (SG), especially families with PLHIV.</td>
<td>Jan</td>
</tr>
<tr>
<td></td>
<td>• Monitor and support ART retention.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide additional services based on care plan.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitor progress and graduation</th>
<th>• Monitor care plan.</th>
<th>Mar Jun Sep</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Training Module 3: Benchmarks and Graduation.</td>
<td>Jun</td>
</tr>
<tr>
<td></td>
<td>• Conduct graduation readiness assessment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Graduate eligible families.</td>
<td>Sep</td>
</tr>
</tbody>
</table>

For beneficiaries from the previous year that continue to require services, they will require an updated assessment and care plan. Most of this approach continues to be applicable. Supervisors will support *activistas* and *activistas chefes* to ensure appropriate interventions are being provided.

**Graduation and Phase Out Districts**

Recent research by Measure Evaluation found that OVC programs need more than 12 months to support families to reach the PEPFAR graduation benchmarks, especially in the “stable” domain. This is also borne out by COVida data. In FY 18, we had a few cases where we had to re-enroll graduated families because the correct processes were not followed; we find that activists get confused about the graduation readiness assessments are also a time-consuming process, that can distract field teams from providing needed services. COVida will assess readiness for graduation only after families have been in the program for 12 months. While graduation assessments may occur throughout the year, intensive support to the CBOs on the graduation process will take place when the majority of graduations are expected.

For districts that are not priority in FY20, COVida will phase out activities by December 31, 2019, providing critical services to beneficiaries, with an emphasis on those related to HIV and contributing
to graduation benchmarks. CBOs in phase-out districts will graduate all families that meet the graduation benchmarks; for families who do not meet the benchmarks, COVida will support partner CBOs to implement phase-out guidance and transfer the beneficiaries to other PEPFAR or non-PEPFAR supported programs (if they exist) and government health and social action services.

2.2.2 Prevention of HIV and sexual violence for adolescents 9-14 years old

2.2.2.1 Evidence-based and developmentally-appropriate interventions for adolescents

COVida will carry out evidence based and developmentally appropriate HIV and violence prevention interventions for 9-14 year-old adolescents (see vulnerability factors in section 2.1.1.1), both boys and girls. This target group will be reached through group interventions in the community and schools. Trained adolescent facilitators/mentors will implement educational sessions using evidence-based curriculums for HIV and violence prevention. COVida will review OGAC-approved curriculums covering both HIV and violence prevention, to determine which curriculum is most appropriate for Mozambique. Preference will be for curricula that have already implemented in Mozambique (e.g. Family Matters) or implemented in similar settings, since translation and cultural adaptation can delay implementation of activities and impact annual targets. If the curriculum does not already include the topics of healthy relationships, healthy decisions about sex, and sexual consent, COVida will include these three evidence-informed modules in the curriculum.

In addition to being between ages 9 and 14, the criteria for enrollment in the prevention program are:

1. Out-of-School Adolescents
2. Adolescents missing school frequently
3. Adolescents 2 years behind in school or not doing well in school
4. 13-14 year-olds ready for transition to secondary school (7th grade)
5. Sexually active and still HIV negative (so they stay negative)

Community leaders, youth associations, teachers and caregivers are the main entry points for identification of 9-14 year-old adolescents, as they interact with adolescents daily. To facilitate the identification process, facilitators, supervisors and adolescent program officers will meet with schools, community leaders, local associations, and religious institutions in their coverage area to present the objectives of the COVida prevention approach and the eligibility criteria, discuss collaboration and agree on roles and responsibilities. To ensure schools collaboration, COVida successfully obtained a credential from the Ministry of Education to implement prevention activities in primary and secondary schools.

As mentioned above, for adolescents participating in prevention activities, their HIV status will be collected at the individual level at the end of the session about HIV prevention. Adolescents will be screened for HIV risk, and those eligible will be mobilized and referred to HIV testing at SAAJ and/or HFs (caregiver consent will be sought for those under age 11, per MOH guidelines). HIV-positive adolescents identified through prevention activities, and adolescents caring for other children (child-headed households) will be immediately integrated in case management activities, as they require intensive and specialized support.

2.2.3 Co-planning and coordination with DREAMS activities

COVida will continue to implement the Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) program in two districts of Maputo Province, Matutuine and Namaacha, reaching AGYW with a package of HIV interventions at individual, familial and community levels. In
FY19 COVida managed to reach all AGYW enrolled with primary interventions, including social asset building in Girl clubs/safe spaces, in which mentors used the approved curriculum (covering self-esteem, relationships, Sexual and Reproductive Health (SRH) and HIV prevention, and violence), and referrals to SRH services. We also provided some secondary interventions with saving groups for AGYW and education subsidies to cover school fees, materials and uniforms.

With collaboration from current DREAMS partners and resource providers, COVida will focus FY20 activities on increasing secondary individual interventions (i.e. education subsidies, saving groups for AGYW, referrals for Contraceptive Mix) and introducing the following contextual interventions:

- Skills-building program for parents and caregivers of adolescents on how to have a positive relationship and decrease exposure to risks;
- Socio-economic strengthening for caregivers;
- Community mobilization and norms change;
- Reducing risk of sex partners (link to HTS, voluntary medical male circumcision, ART).

As Namaacha and Matutuine are in the list of phase-out districts for intensive case management, COVida will transition all 10-17 adolescent girls in general case management activities to DREAMS interventions if they are not yet benefiting from DREAMS.

2.2.3.1 Supervision of adolescent and DREAMS activities

COVida adolescents supervisors and DREAMS technical officers will be responsible for providing technical guidance, training, supervision and mentoring for partner CBOs to ensure the implementation of adolescent prevention activities with fidelity.

At the CBO level, DREAMS staff and adolescent prevention supervisors will be responsible for replicating the training provided by COVida, monitoring prevention activities to ensure that the debate facilitators and mentors follow the standard operating procedures and provide quality services to 9-14 year-old adolescents and AGYW. Supervisors will organize weekly meetings with their facilitators to plan topics to be introduced during the week, provide on-the-job training, clean completed forms and monitor facilitators’ performance.

2.2.4 Supervision of case management activities consistent with MER requirements

COVida provides multiple levels of supervision of case management activities at the IP level to support partners to operationalize the guidance and document correctly. In addition, FHI 360 provides TA to address weaknesses identified through data analysis and field visits.

In Q2, FY19 COVida provided a training on supervision of case management activities, systematizing the weekly meetings between activistas chefes and their activistas with specific SOPs and tools aligned with MER 2.3, for caseload management, service provision and tracking of beneficiaries.

As mentoring and supervision play an important role in the successful implementation of case management activities, COVida will continue to use activistas chefes and supervisors to provide supportive supervision to activistas. To enable CBOs to engage more qualified activistas chefes, we will revise their job descriptions and working hours (to work every working day). Activistas chefes will be primarily responsible for ensuring the quality of the activistas’ work and the CBO field supervisor and project officer will participate in managing critical cases, especially with underperforming activistas.

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The *activistas chefes* will perform the following tasks:

- Monitor *activistas*’ performance, provide support in case management activities and ensure that all beneficiaries receive quality services and that care plans are being monitored and updated.
- Participate in the case management process, particularly in identifying eligible beneficiaries, follow-up of difficult cases and follow-up of referrals.
- Ensure quality in the completion of forms, needs assessment and care plan development.
- Act as a link between *activistas* and the field supervisor (e.g. rolling out guidance).
- Manage case closure.

As supportive supervision is also meant to provide on-the-job training to increase *activistas*’ knowledge, decision-making skills and help *activistas* deal with stress, COVida will implement the following approaches:

**Joint household visits:** Visits will take place between the *activistas chefes* and/or field supervisors and their *activista* to review each case, observe the activities carried out by the *activista* and make joint decisions to support beneficiaries. It will also help *activistas* cope with work stressors and identify training needs, using the Mentoring and Supervision Tool.

**Group Weekly Meetings:** Visits will take place between the field supervisor, *activistas chefes* and their *activistas* for joint case review, exchange of experiences, mutual support between *activistas*, in-service training and sharing of project information by field supervisors. In these meetings, *activistas chefes* and supervisors will also manage the caseload of *activistas*, follow-up on references made and track retention of CLHIV.

For CBOs struggling to implement project guidance, COVida technical officers will be present to support them and provide hands-on supervision.

**2.2.4.1 Technical Assistance (TA)**

Senior technical/program staff and provincial technical officers (PTOs) will organize weekly situation meetings with strategic CBOs and monthly with others, to track performance against targets and implement an early warning system, which will focus on sites that risk not meeting targets or that have other performance issues, such as high exits without graduation. The staff will provide TA as necessary to address identified weaknesses, in addition to the routine visits described above. Service provision forms and reporting templates will be adjusted for high frequency reporting, with some key data (e.g. number of CLHIV enrolled, number of beneficiaries served) being provided on a weekly basis. In cases of underperformance, CBOs will be requested to submit daily data.

In addition, COVida will continue to implement routine TA visits for CBOs, with PTOs focusing on monthly TA to help implementing partners monitor performance of *activistas* and comply with MER and project guidelines. Senior technical/program staff will visit each province a minimum of 3-4 times a year. In addition to providing needed TA, these visits also serve as an early warning system based on more qualitative observations. Senior technical staff will identify weaknesses and best practices during these TA visits and provide guidance to improve performance.
2.3  IR 2: Reduced Economic Vulnerability of OVC Households

2.3.1  Critical material and cash support to improve retention and prevention
COVida will continue to provide CBOs with a “emergency fund” that can be used to improve ART retention, HIV prevention, contribute to children’s well-being, move a family along the economic strengthening pathway, and in emergencies. The emergency fund will respond to critical barriers affecting:

- ART retention (e.g. transportation costs to take a child to the health facility, temporary food support) support for households with HIV+ children who are experiencing extreme hardship and where HIV+ children are at risk of defaulting or have defaulted on ART.
- HIV prevention among adolescents (e.g. school materials, fees, uniforms).
- Food and nutrition (e.g. inputs for family gardens).
- Shelter (e.g. household items in critical cases).

COVida will also collaborate with the Ministry of Gender, Children, and Social Action (MGCAS) to disseminate information about cash transfers and other social support programs. We will also continue to advocate with National Social Action Institute (INAS) and Direct School Fund (ADE) and mobilize additional support from community resources, such as churches and the private sector.

2.3.2  Scale-up and support savings groups
In FY20, COVida will form 700 new savings groups (SG), in line with its reduced geographic focus. The FY19 strategy included one HES supervisor and four HES facilitators per CBO, each managing an average of five SGs each. After the close-out of their cycle, existing SG are evaluated using a “Change of Phase” checklist to see if they can become independent or still need support from an HES facilitator. If it is determined that SGs need additional support in the second or third cycles, the SGs will pay the HES facilitator a symbolic amount (called the “education fund” because the group is learning to become self-sustainable) through a pooled fund they contribute to. The SGs won’t need to buy supplies for new cycles, as their existing lock boxes and passbooks (cadernetas) last for four cycles.

HES supervisors and facilitators will receive refresher training from CARE in FY20 to address persistent weaknesses identified in TA visits.

To improve activista understanding of SGs so that they can more effectively promote them, the benefits of SGs will be part of the TOT and refresher training for aktivistas, including strategies to mobilize beneficiaries to participate, and IR2 progress will be discussed in aktivista meetings. Additionally, aktivistas will continue to be encouraged to integrate into a SG so they can be more successful at integrating COVida beneficiaries into SGs as they will understand the services offered through the SG and the methodology used.

HES facilitators and supervisors will build awareness during SG meetings about the importance of spending household income in favor of OVC; this will be reinforced by aktivistas during household visits. CARE will also include basic financial management in the training of facilitators and supervisors.

In addition, in Buzi, a district heavily affected by cyclone Idai, we will reimburse SG who lost SG kits due to the cyclone.
2.3.3 Technical assistance and supervision
The CARE HES technical team will provide both training and TA on the following:

1. Training and capacity building on the SG methodology.
2. In-service training and capacity building on the Savings Groups Information Exchange (SAVIX) for HES supervisors and M&E officers, including use of data for quality improvement.
3. TA visits to ongoing SG activities to monitor the application of good practices and develop suitable recommendations for continuing or improving performance.

The CARE HES technical team will also focus on the COVida districts that are closing in December 2019. During Q1 FY20, the IR2 technical team will focus on providing TA to the districts that are closing-out, in addition to implementing Village Saving and Loan Association (VSLA) methodology refresher trainings. This way we can ensure that the SGs are supported adequately prior to closeout. Furthermore, the technical team will ensure the adoption of the “education fund” to provide ongoing support to SGs if needed despite the end of COVida, ensuring sustainability of the groups. In Q4 FY19, CARE will design a closeout strategy for these districts. Moreover, a general closeout strategy will also be designed for IR2 COVida activities considering we are entering the second to last year of the project.

SAVIX has proven critical to ensure funds of OVC households are safeguarded. For example, data have flagged problems where SG were losing money and even one case where money was being stolen. With a growing number of groups, this software is critical to monitoring groups’ essential data and orient limited TA to be focused on the groups that are struggling the most. The CARE team will work closely with COVida PTOs to ensure that guidance reaches all CBOs, visiting provinces on a quarterly basis throughout the year.

2.4 IR 3: Capacity of district government and communities to provide essential preventative and protective services to vulnerable families and children

2.4.1 Strengthen capacity of district government and communities to coordinate and respond to OVC needs
COVida will continue to include Serviços Distritais de Saude, Mulher e Acção Social (SDSMAS) representatives in all trainings and as trainers whenever possible. COVida will also facilitate multi-sectoral coordination meetings at provincial and district levels. Joint supervision visits will continue in FY20, which is a means to both mobilize services for OVC and strengthen government coordination and capacity.

As explained in IR1 above, COVida will organize one stop service fairs, where beneficiaries will come together and be able to access various government services, such as notary, health, education and social action. This has proved effective in FY19, especially for services where government capacity to

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2 The “education fund” is funds collected from SG members to cover the cost of an advisor (current savings group facilitator) to continue educating the savings group to use the model properly. This may be for regular visits, or only during pay out, depending on what the SG feels it needs. These groups continue without project support.
respond to community needs is limited by lack of transport and time, such as for birth certificates and school registration. One-stop fairs also serve to promote collaboration amongst government services.

2.4.2 Develop technical and organizational capacity of CBOs
COVida will continue to provide training and TA on USAID rules and regulations. COVida will provide follow-on support for CBOs to comply with and better understand Site Improvement through Monitoring Systems (SIMS) requirements, including child safeguarding policy, anti-discrimination policy for PLHIV, GBV, confidentiality and case file management, and beneficiary engagement.

FHI 360 will continue to use its troubleshooting model for CBOs that have poor performance despite TA provided; often the challenges are rooted in organizational or structural problems. This model engages the board, fiscal council and executives to identify root causes and develop and implement meaningful solutions. COVida expects to serve 5-10 CBOs using this model in FY20.

3. MONITORING AND EVALUATION

SI priorities in FY20 are based on the assumption that indicator definitions will not have significant changes compared to FY19. Any major changes in the indicator definitions or forms will involve significant changes in eCSI, mainly in the data entry component, as well as the reporting formats. In addition, we will put significant effort in ensuring data collection from both main implementation modalities: (1) case management, focusing mainly on HIV+ children, and (2) group interventions for HIV prevention with adolescents.

3.1 Monitoring and Evaluation (M&E) Systems

3.1.1 Making the M&E System more agile
The COVida M&E team will focus on making key data more accessible more quickly. While the data have been reliable and of high quality, the M&E system has time-consuming processes given the volume and complexity of individual data we collect. In addition, we are seeking ways to streamline the process of adapting to changes, as change is inevitable with PEPFAR.

3.1.1.1 Review of the M&E Systems
We will make any necessary adjustments to data collection tools and roll these out in Q1, FY20. This will require a phased roll-out to ensure field-level implementers have a clear understanding of the tools and use them correctly. The steps include adjusting paper forms and piloting the changes; adjusting the data-entry modules of the database, piloting and rolling-out in phases; and adjusting the management and reporting modules, piloting and rolling out in phases. Depending on the changes, it may also be necessary to adjust the data aggregation systems, as we did this year.

In addition, we are also re-assessing various possibilities to make eCSI faster and provide real-time data for decision-making. Since the initial decision was made on the database, the priorities and needs of the project have changed and there have been significant changes in the options of available platforms. We will consider the cost benefit of changing in the context of current priorities, available resources and the need for agility given the frequent and significant changes in the indicators.
In addition, we are also analyzing the feasibility of integrating mobile data collection to permit easier access to data, timely data entry and more complete data, which has been a challenge thus far. One possible tool under consideration is DHIS2 Tracker, which is easier to establish interoperability with existing systems, and mitigates the limitations of access to internet in some areas. We are also weighing the cost benefit of the shifts at this stage of the project.

3.1.1.2 Increase data frequency and availability – early warning system

In FY19, we piloted an early warning system for case management to help ensure we meet targets with intended quality. We are developing a system to collect key data more frequently (weekly or daily in cases of weak performance) on key indicators (e.g. newly enrolled, served, key stages of the HIV_STAT cascade) that will allow us to identify problems early and channel resources (technical or financial) to analyze and address the issues. This system will be rolled-out first in those sites where focused attention can have the biggest impact.

We have learned from other OVC projects in the region that most of the options for this type of system involve the use of mobile systems for data collection and review. As mentioned above, we are considering ways to use mobile data collection, including how to overcome challenges of internet access and infrastructure. We are considering the level at which the mobile data collection will be used, but initial analysis indicates the level of activistas chefe will be the most effective.

3.1.1.3 Improve Data Analysis at all levels through use of Dashboards

We are currently designing a dashboard for the project, using DHIS2 as the platform. This will be accessible online and the aim is to be able to analyze progress on higher level results at the national and subnational levels. At the same time, we will continue to adjust the offline dashboard at the CBO level, which is incorporated into eCSI, and provides quick insight into the project progress and gaps and serves as the basis to course correct when needed.

Improved data analysis will enable us to use evidence to make better decisions on what practices to scale-up, which approaches are not producing the intended results and therefore need to be adjusted, and how to allocate resources to focus on areas that need more support.

3.1.2 Supportive Supervision and TA for M&E

3.1.2.1 Training of M&E Teams

Trainings will be provided to the team at the consortium level, as well as at the CBO level. At the consortium level, we intend to organize one workshop with the whole team to agree on best practices, share tools, and exchange field experiences.

For the CBO M&E teams we will organize a training covering new data collection tools, changes in indicators, and innovative data management tools.

3.1.2.2 Routine M&E- Supervision and Monitoring

We will continue to supervise CBOs in M&E. The provincial M&E officers will conduct at least quarterly supervision visits to the CBOs to ensure CBOs are implementing the M&E system as designed, both for case management and for the adolescent component. Senior M&E officers will continue to provide supervision visits, visiting each province once per semester.
3.1.3 Data quality
Data quality will continue to be at the center of the M&E activities. We will continue to reinforce the consistency checks in eCSI, to impede entering of invalid data into the system, and at the same time alert CBOs of data that need correction. We will also reinforce the mechanisms for protecting data integrity by locking data from previous periods, thus having better control over the process of entering late data.

On a monthly basis we will continue to check for completeness of data. In FY19 this has been a challenge since we relied mostly on CBOs to finish entering data, and many CBOs had delays in entering all the data. In many cases, this is due to the increased volume of data (additional documentation required with change in indicator definition); in others poor performance of CBO M&E officers. As discussed in the FY19 Q3 report, we have reduced the data necessary to enter into the database versus data to be kept on file (e.g. the CSI is now kept on file and not entered). We will analyze possibilities of creating a system that will objectively track this data quality dimension. At the same time, we plan to revise the M&E structure at the CBO level, to improve the levels of accountability for data entry. For example, we are piloting in two CBOs the use of data entry clerks who are directly managed by FHI 360. Many CBOs face difficulties ensuring the accountability of the M&E officers for their work, with managers not taking disciplinary actions when the M&E officer perform poorly. The pilot using data clerks will inform our decision on adjusting the CBO M&E structure.

Thirdly, we want to reinforce our auditing of graduated beneficiaries. We will ensure a sample of graduated beneficiaries is verified during supervision visits (with a greater focus in Q4), to assess how the CBO is following graduation benchmarks, allowing us to address problems in a timely manner. Finally, we will conduct a Data Quality Assessment (DQA) on a sample of CBOs in FY20. These will cover three provinces and 6 CBOs (two per province) to assess the quality of the data, and quality of the entire reporting system. The priority of the DQA will be on the key MER indicators.

3.2 Access Pediatric Data to Improve Retention
Pediatric retention for CLHIV is at the center of our interventions. In FY19, USAID shared data on pediatric treatment and retention and this information was used to guide the allocation of resources to districts, CBOs and health facilities. Assuming that we will have access to this data early in Q4 in FY19 to allow us to plan, this effort will continue in FY20, and we will continue to monitor and report back the progress on serving these beneficiaries with the health facilities. As mentioned above, COVida will request meetings with the pediatric partners to analyze pediatric retention data and collaborate to address weaknesses.

COVida also developed a tool for monitoring our retention work with CLHIV. We will assess the data and see if the form requires improvement, to act as a tool for an improved dialogue and collaboration with the health facilities.

3.3 Studies and Research
At the beginning of the project we planned to conduct data collection for MER outcome indicators through surveys. A baseline was done in year 1. A follow-up survey was scheduled to be carried out by Palladium in late FY20 (and continue into FY21). However, we understand that implementation of the MER survey has been suspended until further guidance is provided. If guidance is released on a schedule that will allow us to complete the survey, and available funds are sufficient, we will conduct this survey. It is difficult to budget for this without knowing the requirements and scope.
4. PROJECT MANAGEMENT

4.1.1 Changes in Priority Subnational Units (Districts)
For districts that are not a priority in FY20, COVida will close-out activities in December 2019, having given six months’ notice to CBOs (ensuring the CBO stopped registering new beneficiaries and focused on service provision and graduation). Where families do not meet the graduation benchmarks, they will be transferred to other services; for example, PLHIV will be transferred to clinical partners; those needed social protection will be transferred to SDSMAS, etc. COVida will dialogue with government authorities at all levels to ensure a smooth transition. These changes are noted in Annex 3.

In Zambezia, USAID has instructed COVida to transfer 9 districts to local partner N’weti in Q3-Q4. Discussions have already started between USAID, COVida, N’weti and World Education (WEI) to facilitate the Zambezia transition. In Q3-Q4, WEI will transition four districts in Gaza province to COVida, as directed by USAID.

In continuing districts, COVida will modify subawards to adjust targets (including subpopulation targets), include adolescent activities, extend periods of performance, and revise budgets.

In new districts, such as Chiuta (Tete province), COVida will assess whether any current partner in the province can take on the district, to ensure a faster roll-out. If this is not possible, COVida will launch a selection process to find a new CBO.

4.1.2 Subrecipients
COVida has two international subrecipients (CARE and Palladium) and numerous district level community-based organization subrecipients. All agreements and workplans will be adjusted in line with this workplan.

CARE is responsible for implementation and target achievement in Inhambane province and is the technical lead for IR2 activities as described above. Palladium is responsible for research and studies, as described in the M&E section of the workplan.

In each district, one or more CBOs are responsible for implementation of the activities outlined in this workplan. All CBOs implement case management, pediatric retention, HIV prevention with adolescents, SG activities and collaborate with district level government and other implementers. In some districts, CBOs are responsible for only implementing DREAMS or DREAMS and case management. Annex 3 lists the districts, CBOs, targets and references activities.

CBOs working in those districts that will no longer be supported by PEPFAR are scheduled to stop activities in December 2019.

4.1.3 CBO Management

4.1.3.1 CBO close-out
COVida will close-out 17 CBOs at the end of Q1 due to their districts not being priority in FY20 (some CBOs cover more than one district). Between Q3 and Q4, COVida will transfer 9 districts to a local implementing partner in Zambezia.
4.1.3.2 CBO modifications
COVida will issue close to 60 CBO modifications to increase incremental funding, incorporate changes to targets, revise budgets, revise periods of performance, and update technical scopes of work. Slight changes in geographic scope may also be part of some modifications.

4.1.3.4 CBO performance management
COVida will continue to closely monitor CBO performance with monthly CBO reviews, and a new early warning system that will allow us to catch problems earlier. COVida will also implement a performance-based management system, whereby *activistas* and adolescent facilitators will be paid an additional amount (maximum of 200 meticais per month) if they meet or exceed their targets and will be paid only if they hand in their forms on time. In cases of non-performance after repeated TA, COVida will continue to take several actions, based on the situation: troubleshoot model involving the CBO’s board; performance implementation plans; requiring changes to key personnel or imposing data clerks for M&E functions; and withholding payments until there is improvement.

COVida is also putting into place a system to implement directly (ability to hire and manage district-level staff, pay *activistas*, do procurements directly, etc.), which will be used where a strong CBO cannot be brought on board quickly enough, or to fill gaps between one CBO ending and another beginning.

4.1.4 Activista Stipends
COVida will raise the stipend of *activistas chefes* (from the current 2,300 MZN/month to 4,500 MZN/month), as we have found that the capacity of current *activistas chefes* is too low, which is a function of the amount they are paid. We will adjust the terms of reference (TOR) and requirements for this position to ensure that *activistas* receive adequate supervision. *Activistas chefes* will also be able to supervise 10 *activistas* rather than the current 8 if paid a higher amount, as they will be able to work every day. *Activistas* will receive an increase of 200 meticais per month based on performance, as explained above.

4.1.5 Staffing Changes
COVida will close offices in Niassa, Cabo Delgado, Tete and Sofala at the end of Q1, and will have to let go of provincial staff based in these offices. The remaining COVida districts in Cabo Delgado, Tete, and Sofala will be managed by neighboring provincial offices (Nampula or Manica). In Zambezia, Nampula, and Manica, there will be some shifts in staffing to accommodate changes in targets and the adolescent prevention activity. The DCOP position will be removed to accommodate the budget cuts. The LOE of the capacity building advisor position has been reduced. If other projects are not able to pick up the remaining time, we may need to shift to a consultancy for this position.

4.1.6 Clarifications of MER Guidance
COVida does not expect major changes in MER in FY20, since MER 2.3 in FY19 represented significant changes. Any adjustments will need to be incorporated in the M&E system in Q1 (assuming MER guidance is made available by October 1).

4.1.7 Cost Share
COVida signed a contract with Books for Africa to formalize the cost-share contribution of 300,000 children’s books. Distribution will start at the end of FY 19 and be completed in FY 20. The books will be distributed to beneficiaries, health facilities, and schools that partner with COVida, along with training on how to use the books for ECD and education enforcement. In FY20, *activistas* and linkage
facilitators will continue to ensure the books are used properly. The estimated value of the cost share is $6 million dollars.

COVida also signed a Memorandum of Understanding (MOU) with the Clinton Health Access Initiative to support pediatric retention and address malnutrition.

In FY20, COVida will support linkages between emergency recovery activities efforts and COVida beneficiaries through CARE’s projects funded by various donors. This will include the distribution of NFI (non-food items) kits and shelter vouchers in Buzi district in Sofala and the distribution of NFI kits, seeds and support from income generating activities to savings groups in Macomia district in Cabo Delgado.

Furthermore, COVida has three practicum students from Columbia University supporting M&E and case management activities in Inhambane and Zambezia provinces through Q1 FY20. The students’ time will be monetized and included as match in addition to other expenses related to their practicum that is covered by themselves or through the university.

4.1.8 Project Deliverables
COVida will submit the following reports according to the agreement:

- Quarterly reports
- Annual report
- Semi-Annual performance Report (SAPR) and Annual Performance Report (APR)
- Expenditure report

4.1.9 Procurement
In Q1, COVida will procure:

- Forms, adolescent manuals, training and IEC materials.
- Smartphones for tablets for *activistas chefes* and adolescent supervisors to do high-frequency reporting.

We will also receive a car, 6 motorcycles, and 42 tablets from TB Challenge.

4.1.10 Transitioning to and from other implementing partners
We understand that the following transitions are expected in FY20:

- Transition Zambezia province to implementation by N’weti under the new community project
- Transition Sofala and Manica provinces to a local partner yet to be selected.
- Receive beneficiaries from WEI’s DREAMS activities in Gaza and continue to support them.

FHI will collaborate fully to minimize impact on beneficiary services. USAID has already convened partners for the Zambezia transition, and FHI 360 respectfully requests that USAID convene the parties involved in the other provincial transitions and provide clear guidance with at least six months lead time to work out the details for a smooth transition.

Based on information received from USAID to date, FHI 360 has budgeted using the following assumptions:
• In Gaza, FHI 360 expects to assume responsibility for activities in one district on April 1, another district on May 1, a third on June 1 and the remaining districts on July 1. This will allow FHI 360 to provide the close and intensive support necessary to ensure a smooth transition. Lessons learned from transitioning the first district will be applied to improve processes in subsequent transfers. Similarly, we have planned for one of the two additional positions planned for Gaza to start on April 1, and the second at the end of June.

• In Zambezia, we expect to do the reverse as we hand over districts to N’weti. Transfer one each on April 1, May 1, and June 1 and the remainder on July 1. We will also reducing staffing during the quarter, eliminating about half of the positions around May 15 and the remainder July 1.

• Sofala and Manica will follow follow a similar process in Q4, handing over to a local organization selected by USAID. The first district would be July 1, the second August 1, the third September 1, and the remainder on October 1, 2020.

• In Gaza, COVida will assess the CBOs currently receiving grants from World Education. If they receive satisfactory assessments FHI 360 pre-award analysis, COVida will proceed with sub-awards without competition.

5. COLLABORATION WITH GOVERNMENT, OTHER DONORS AND STAKEHOLDERS

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. COVida will continue to collaborate with Government of the Republic of Mozambique (GRM) entities to review materials and tools.

COVida will continue to dialogue regularly with MGCAS, through the OVC Technical Working Group (GTCOV), on tools and updates on case management (the intake forms, CSI and care plan). We will also update MGCAS on the progress of the eCSI.

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, 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 period and bring to attention inconsistencies that arise at the field level that require attention at either provincial or national levels. Similarly, we will support CBOs to organize collaboration meetings at the district level that include government representatives and other stakeholders.

COVida will continue 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, where possible training them as trainers.

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 is also working on developing an automatic report in eCSI that will allow CBOs to print out the data in the format district authorities need.
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. COVida will continue to participate in the Pediatric HIV/PMTCT Technical Working Group at MISAU.

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

COVida will implement a small pilot of the case management tools developed by the 4Children project and Picture Impact. Depending on the results of the pilot, costs, and feedback from the Mission, COVida will roll-out to other sites in FY20.

COVida has identified a partnership with Population Services International (PSI) to collaborate on a film that PSI is producing aimed at adolescents. The collaboration would allow COVida adolescent beneficiaries to watch the film and discuss with their facilitators the messages on SRH, HIV prevention, peer pressure and healthy relationships. PSI and COVida will also coordinate events in some sites to promote the film and link adolescents to needed services.

COVida will continue to deepen the linkages with Peace Corps Volunteers in FY20. COVida presented to the new incoming group of PCVs in July 2019 during their pre-service training and will ensure that PCVs who are assigned to COVida CBOs, or are based in a COVida district, are integrated into their CBOs and effectively supporting the project. COVida has had most success working with PCVs to support clinical linkages, the work of the activistas and the adolescent prevention activities. COVida will ensure that this collaboration continues in FY20.

6. EXIT STRATEGY

Several elements were incorporated into the design of COVida to promote the sustainability of activities after the end of the award. While many of those were put aside in the drive to reach targets, COVida still maintains several key elements, such as training community members to serve beneficiaries in their own communities, use of MCGAS tools whenever possible, training of MCGAS staff as trainers, and requiring SGs to pay for their own facilitators after the first cycle. These strategies were described in more detail in prior workplans.

With a greater focus on CLHIV for case management, OVC programs in Mozambique are moving away from MGCAS tools, which creates consternation at the ministry. However, COVida continues to invest in local activistas and build the capacity of local organizations to the extent possible. The transition to a local partner in N’weti is part of USAID’s vision to sustainably support OVC in Mozambique.

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1 COVida seeks to verify this info with pediatric data