Mozambique Program Assessment

Community Care for Vulnerable Children in an Integrated Vulnerable Children and Home-based Care Program

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Abbreviations and Acronyms

ANEMO	National Association of Nurses of Mozambique *(Associação Nacional dos Enfermeiros de Moçambique)*
ART	Antiretroviral therapy
CBO	Community-based organization
FGD	Focus group discussion
HBC	Home-based care
HH	Household
INAS	National Institute of Social Action
MISAU	Mozambique Ministry of Health
MMAS	Mozambique Ministry for Women and Social Action
OVC	Orphans and vulnerable children
PCC	Community Care Project (*Projeto de Cuidados Comunitários*)
PLHIV	People living with HIV/AIDS
PEPFAR	United States President's Emergency Plan for AIDS Relief
SAT	Southern African AIDS Trust
SDSMAS	District Representation of Ministry of Health and Ministry of Women and Social Action *(Serviço Distrital de Saúde Mulher e Acção Social)*
RDMAS	Representation from the Ministry of Women and Social Action – within the SDSMAS *(Repartição Distrital de Mulher e Acção Social)*
TB	Tuberculosis
USAID	United States Agency for International Development

Executive Summary

The USAID/Mozambique-funded Community Care Program (*Programa de Cuidados Comunitários,* or "PCC" in Portuguese) is a five-year project (2010-2015) that seeks to strengthen the response to HIV and AIDS, specifically support to orphans and vulnerable children (OVC) and home-based care (HBC) service provision for people living with HIV and AIDS (PLHIV), in seven focus provinces through a network of community-based organizations (CBOs). Prior to PCC, OVC support and HBC had usually been provided by different *activistas* (community workers) and/or different CBOs, even when the same household had both HBC clients and OVC. PCC integrated OVC support with HBC service provision: a single *activista* would provide integrated support to all people living with HIV (PLHIV), OVC, and pre/post-partum women living in the household through HBC, as well as supporting households that may have only one beneficiary type (e.g., households with vulnerable children and no HBC client). Integration of services and service providers involved devising a schedule of visits based on those needing more frequent care and those needing less frequent care ("intensive" versus "maintenance" stages of care).

Stakeholders expected that this integrated approach would offer a more efficient model of service provision. USAID/Mozambique asked MEASURE Evaluation to assess the integrated model to better understand what integration of HBC and OVC services means for OVC beneficiaries. The three primary study objectives were to:

1. Understand *activista* perspectives about their work within an integrated project.
2. Understand the benefits/challenges of integration and its utility to beneficiary groups and stakeholders.
3. Understand how services for vulnerable children vary by presence of HBC clients in the household and phase of HBC client.

Methods

The study used a descriptive cross-sectional study design that included both qualitative and quantitative data collection methods. Data were collected at the central level and in Sofala and Manica provinces, priority provinces for PCC and USAID/Mozambique. We collected information from different types of stakeholders at the central, provincial, and local levels through in-depth interviews with government, program, and CBO informants; focus group discussions and self-administered questionnaires with *activistas*; and structured interviews with beneficiary households. We randomly selected two districts/CBOs from each province and randomly sampled 10 *activistas* from each selected CBO. Using household registers previously collected by the *activistas* and filed at the CBO, we constructed a household sampling frame of all households and HBC clients registered between October 1, 2012 and September 30, 2013. We attempted to conduct a random quota sample of 10 households per *activista*, and interviewed households that reported having at least one child under 18 years of age and receiving an *activista* visit in the 60 days prior to the interview. Household respondents were asked about the care and support they received from the *activista* in the last 12 months and at the last visit. In addition, data

collectors asked questions about specific child-level services for one randomly selected child in the household.

The team conducted thematic analysis for qualitative data. For quantitative data, we examined descriptive statistics and conducted analysis of frequencies. For household survey results, we also presented cross-tabs with chi square test results, and conducted logistic regression analysis to examine factors that influence the probability that a child would receive a service at last visit. Data generated from qualitative analysis were triangulated with findings from the *activista* survey and other data sources.

Findings

Twenty-four in-depth key informant interviews were completed: nine at the national level, six at the provincial level, and nine at the district level. Forty-seven *activistas* responded to the self-administered survey and thirty-seven *activistas* participated in four different focus group discussions. A total of 350 households were visited, with 311 interviews completed after initial screening questions.

Activista Perspectives

Activistas were on average 36 years old and experienced in working as an *activista*, with 79 percent working as an activista for three or more years. Sixty percent had received training in the last year and 72 percent reported being trained in both OVC and HBC. *Activistas* reported being more prepared to provide care and support to HBC clients (93 percent) than OVC (71 percent).

Activistas reported having a mixed caseload of beneficiary houses that included households with only HBC clients, only OVC clients, and households with both types of clients; though they acknowledged it is rare to provide care to households with only OVC. This finding was confirmed in the household survey results: just 10 percent of households registered in the last year were receiving only OVC care.

Two-thirds of *activistas* reported spending more time with HBC clients than OVC clients. Seventy-three percent of *activistas* reported that clients in need of *busca activa* (or *busca consentida*) – clients who have defaulted from their antiretroviral medications – take most of their time. When visiting homes with both beneficiary types, *activistas* report balancing the needs of clients, with HBC clients often needing more immediate care such as assistance with bathing and medication support.

Benefits and Challenges of Integration

Stakeholders reported several benefits of integration, noting that integration:

- Expanded program reach to include OVC – particularly in districts/CBOs where there was only HBC work before integration.
- Provides a more efficient model for addressing the needs of HBC and OVC clients and allows for addressing the holistic needs of the household, including provision of social- and health-related (i.e., clinical) support and services. *Activistas* are able to solve issues of all household beneficiaries, rather than having to contact another *activista* to provide care to a household member they are not trained to support. As such, integration is reported to provide clearer, more cohesive communication between the CBO and family.

- Has led to stronger coordination and communication between the Ministry of Health and the Ministry of Women and Social Action, particularly at the central level.

While there were many benefits of integration, informants noted challenges to the design and/or implementation of having one activista assisting both sets of clients:

- While Ministry of Health (MISAU) and the Ministry of Women and Social Action (MMAS) participated in a technical working group on the integration approach, and MISAU has approved the integrated curriculum, the PCC integrated model has not been formally adopted or operationalized at the national level.
- Some informants noted a tendency to focus on HBC clients in the integrated model.
- Integration results in an increased workload for *activistas*, with more beneficiaries to look after, more forms to complete, and no corresponding increase in pay.
- However, *activistas* noted that they are better equipped, through training, to serve the beneficiaries in their communities, and that they are willing to take on additional work to meet the needs of beneficiaries.
- *Activistas* reported needing more training, particularly for OVC and how to provide psychosocial support to them.
- The current model of integration may not have an overall integrated approach that incorporates planning, guidance, monitoring and evaluation, decision making, and supervision.

Household Perspectives

Sampling Findings: While constructing the sampling frame for this study, we learned that the PCC M&E system remains vertical – services are reported separately for HBC client services and OVC clients. Further, it was not possible to track service delivery at the household level. In addition, many of the forms were inaccurate, incomplete, and outdated, as evidenced by the high number of families that were unknown to *activistas*, had moved, or where a client had passed away. The high number of deceased clients was particularly alarming and requires an examination of the assumption that HBC clients are no longer bedridden or in need of end-of-life care due to the expansion of ART services.

Of households that received a visit in the last 60 days and had at least one child,[1] 20 percent reported they had received one-on-one services[2] only to HBC beneficiaries, 10 percent that they had received one-on-one services only to OVC, and 70 percent had received one-on-one services to both HBC and OVC in the last year. Twenty-two percent of households receiving HBC services reported that no child in the household had received a one-on-one OVC service in the last 12 months, despite the fact that every interviewed household had at least one child residing in the home.

[1] A child is defined as being less than 18 years of age.

[2] One-on-one services included direct attention provided via HBC to ill or incapacitated adults, services to a pregnant woman and support services to a child or youth under the age of 18.

Overall, nearly half of the interviewed households reported that the *activista* had visited in the last week. At the last visit, 80 percent of households reported receiving at least one household service (services that benefit the whole household, such as nutritional support, health kit, and support for a community garden).

A total of 1,074 children under 18 years old were reported living in the interviewed households. The number of children per household was similar across the CBOs, with between 3 to 3.8 children living in each household. Overall, an equal proportion of male and female children were residing in the households, and there was an equal distribution of children falling in the 0-4, 5-9, and 10-14 age ranges. The sex and age distribution of children living in the households was similar across the CBOs. We found no significant differences by age or sex among children who were seen at the last visit.

To better understand the effect of HBC-OVC integration of OVC services, we used logistic regression analysis to examine factors that influenced the probability that any child in the household would be visited at the last visit. We found:

- Children in larger families (more children under age 18) were less likely to receive one-on-one attention than children in smaller families.
- Children in active HBC households (defined as those HBC clients who reported receiving a visit in the last week) were more likely to receive one-on-one attention than children in households where HBC clients were seen less frequently.
- Children in households where HBC clients had graduated (defined as those HBC clients who were not seen at the last visit) were less likely to receive one-on-one attention than children in households where an HBC client was seen at the last visit (more than one week ago).
- Girls and boys were equally likely to receive one-on-one attention at the last visit
- Children of primary school age (5-14) were more likely to receive one-on-one attention than younger or older children.

Index Child Analysis: Half of the children who received one-on-one support were reported as having received health support[3] at the last visit, half received psychosocial support[4], fewer than one-third received food support[5], and 40 percent received school support[6]. Service provision to index children varied by CBO.

Conclusion

We found consensus regarding the value of having one activista provide services to all clients in one household for the efficiencies it offers, including offering holistic support to households, the potential for cost savings, and the integrated *activista's* ability to reach OVC that may not have been previously reached.

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[3] Referral to health facility, counseling on specific health-related questions

[4] Set aside some time to talk to the child about his/her feelings, referral to a spiritual leader, referral to a kid's club.

[5] Referral for food support (MMAS, WFP, others).

[6] Referral to assist in acquiring school materials (uniform, books, pencil and/or notebooks), referral for school fees, gave money for school fees, supported reintegration to school (support to help child register in school), help with homework.

At the household level, there appears to be a consistent association between HBC clients within the home and the likelihood that a child will or will not receive one-on-one attention at the last visit. However, when the HBC client is not present, there does not appear to be a difference in services provided to children in the home. These results, coupled with the results from our qualitative analysis, demonstrate that home-based care appears to be the driver of OVC service provision.

We found differences between provinces, and often between CBOs, suggesting that integration may be implemented differently across sites. While an integrated training curriculum has been developed and rolled out, other guidance and organizational supports that facilitate the integration process are not yet clearly established.

Recommendations

Given study findings and interpretation with key stakeholders, the study team offers the following recommendations for the PCC program to maximize the potential of integrating HBC and OVC care to serve both beneficiary groups. These recommendations are offered in no particular order of importance:

- Create a monitoring system with the family as the main unit of record-keeping. This would require exploring how *activistas* can provide integrated services during every household visit and developing a form to capture this.

- Organize files by beneficiary family to facilitate household case management. All forms, including the registration form, should be kept in the *activista* binder, by family, as long as any services are needed.

- Update family registration forms to include beneficiaries entering and exiting the program and what phase of the program each client is in.

- Develop other programmatic guidance and supports to operationalize integration among CBOs delivering the integrated model, establishing clear definitions of what an integrated care approach means in terms of service delivery to households and OVC in the household – for example, looking at how to differentiate between “phases” of service provision.

- Develop clear programmatic guidelines and accompanying tools for community workers for defining and targeting OVC based on accepted community norms, specifically looking at whether children in households receiving HBC are automatically considered vulnerable.

- Consider conducting a community trace and verify activity to ascertain how up-to-date and accurate program records are.

- Conduct a detailed skills assessment of *activistas* for OVC care and support. Develop a training plan based on these findings and consider enhancing training modules related to psychosocial support and other areas expressed.

At the central level, we recommend convening key stakeholders to discuss the utility of adopting an integrated approach for Mozambique. If stakeholders decide to continue with this approach, develop a comprehensive strategy and organizational supports to ensure established standard operating procedures for organizations offering the integrated model.

Background

Since the diagnosis of its first case of HIV in 1986, Mozambique has been combating the HIV/AIDS epidemic through national programs and policies and ongoing international support. Today, while the epidemic appears to be stabilizing nationally, on average there are 500 new infections per day, of which 90 are children born to HIV-infected mothers (UNICEF). Furthermore, HIV continues to affect a significant percentage of the working-age and reproductive-age population – 11.5 percent of men and women aged 15-49 are currently infected (INSIDA, 2010). Twenty-one percent of all households in the country house a person living with HIV/AIDS (PLHIV), while seven percent of households currently have an adopted or fostered child living in the home (INSIDA, 2009). Moreover, 20 percent of the 1.6 million orphaned children in Mozambique have lost one or both parents due to HIV/AIDS (UNICEF).

The strain of HIV/AIDS on family structures and community safety nets has been significant and has given rise to a network of community-based organizations (CBOs) throughout the country that use semi-skilled community workers (often referred to in Portuguese as *activistas)* to support families and health facilities. Such *activistas* conduct home visits to provide support/care to PLHIV through home-based care (HBC), and orphans and vulnerable children (OVC) affected by or infected with HIV (OVC). In this capacity, *activistas* serve as a crucial link to health and other social services.

As is the case in much of the world, community care programs in Mozambique have separate minimum standard care packages for HBC clients and OVC. The Ministry of Health (*Ministério de Saúde* – MISAU) is responsible for activities related to PLHIV and developed the standard care package for HBC, while the Ministry of Women and Social Action (*Ministério de Mulher e Acção Social* – MMAS) developed the minimum standard of care for OVC. Mozambique traditionally has had two sets of *activistas* – one providing support for HBC clients, the other for OVC. Those providing HBC support received a stipend or subsidy whereas those providing OVC support did not.

Home-based Care

The target group for HBC services in Mozambique is PLHIV in phase three or four of the illness (WHO, 2007), PLHIV on antiretroviral therapy (ART), and other chronically ill individuals who need assistance – with special attention to those who are particularly vulnerable, as well as their family members (MISAU 2003). Since 2006, all *activistas* in CBOs providing HBC must be trained by an accredited trainer at the National Nurses Association of Mozambique (*Associação Nacional dos Enfermeiros de Moçambique* – ANEMO) (MISAU DNAM 2014). Key HBC activities include health assessments, management of frequent symptoms, referral to health care and social service systems, and prevention of HIV at the household level.

Care for Orphans and Children Affected by or Infected with HIV/AIDS

For OVC, an orphan is defined as a child who has lost one or both of their parents. A vulnerable child is defined as a child: a) affected by or infected with HIV/AIDS; b) in a child-headed, female-headed or

elderly-headed household; c) in households where an adult is chronically ill;[7] d) who lives on the street or in an institution (orphanages, prisons, mental health institutions); e) in conflict with the law; f) who is disabled; a victim of violence, physical and/or sexual abuse; trafficking; or the worst forms of work; g) who is married prior to the legal age; and h) who is displaced or is a refugee (MMAS 2006).

OVC programming in Mozambique, particularly programs funded by the United States President's Emergency Plan for AIDS Relief (PEPFAR), specifically focuses on orphans and children affected by or infected with HIV/AIDS, though children who live in child-headed, women-headed, or elderly-headed households, or who live in a household where an adult is chronically ill can also be targeted for support. OVC *activistas* are responsible for assessing the status of the child, providing referrals, and counseling children within the households they serve. The services OVC *activistas* offer include food and nutrition, education, legal support, health, psychosocial support, economic strengthening, and shelter. The PCC basic services form includes the following:[8]

Food and Nutrition
- Referral for *cesta básica*[9]
- Community/family garden
- Nutrition counseling
- Enriched porridge

Education
- Vocational training referral
- Cotrimoxazole prophylaxis
- Reintegration into school
- School uniform referral
- School materials referral

Legal Support
- Birth registration/national ID support
- Poverty certificate support
- Education on children's rights

Health
- Referral for HBC
- Referral to health post[10]
- Mosquito net referral
- Water purifier (*certeza*)

Psychosocial Support
- Home visits
- Recreational activity
- Kid's clubs

Economic Strengthening
- Income generation

Shelter
- Construction referral
- Rehabilitation support

HBC and OVC Integration Programming

The Community Care Program (*Programa de Cuidados Comunitários* or "PCC" in Portuguese) is a $44 million United States Agency for International Development (USAID)/Mozambique bilateral project led by FHI 360 in partnership with Africare and Project HOPE and implemented by a network of CBOs throughout the country. PCC seeks to strengthen the community-based response to HIV and AIDS in seven focus provinces, and to improve the health and quality of life of PLHIV, vulnerable children, and

[7] For the first three categories, to be considered vulnerable, the children must live in a household that is below the poverty line.
[8] Taken from "*ficha de COVs - serviços basicos YR3*" FHI360 PCC form.
[9] Basic basket of food.
[10] Family planning, counseling, and testing.

HIV-positive pregnant and post-partum women. It is a five-year project which started in mid-2010 and will end in mid-2015.

PCC advocated for and created an integrated approach to OVC and HBC service provision, whereby a single *activista* would support all PLHIV, vulnerable and orphaned children, and pre/post-partum women living in the household. PCC selected this model for a few reasons:

- USAID/Mozambique began pursuing a family-centered approach[11] to community care (Hanise Sumbana & Dioniso Matos, personal communication June 10, 2013);
- A new national law came into effect – the *Lei do Voluntariado 7/2011 de 11 de Janeiro*[12] – which stipulated that programs operating in Mozambique must provide a subsidy to all volunteers that amounts to 60 percent of the minimum wage. This law, in particular, meant that any project working with two separate cadres of *activistas* (one for HBC and one for OVC) would need to provide financial support to both; and
- PCC staff considered the number of *activistas* and health workers coming through a home and determined that an integrated approach would reduce the number of visits by an *activista* and provide a single point of contact for families (personal communication with Linda Lovick, November 30, 2012 and Xavier Cândido, January 28, 2013).

Implementing Integration of HBC and OVC Services within PCC

Integration-related activities began in 2011 with the creation of a technical working group with FHI 360, MISAU, MMAS, and other partners including the Foundation for Community Development (*Fundação para o Desenvolvimento da Comunidade)*, Pain without Borders (*Dor sem Fronteiras)*, Mozambican Association of Palliative Care (*Associação Moçambicana de Cuidados Paliativa)*, National Counsel on Combating HIV/AIDS in Mozambique (*Conselho Nacional de Combate ao HIV/SIDA Moçambique)*, World Vision, and Food and Nutrition Technical Assistance III in Mozambique (FANTA III). Subsequently, the working group, with leadership from FHI 360, developed and piloted tested a draft joint HBC/OVC curriculum and materials in coordination with ANEMO. This curriculum was approved by MISAU in early 2014.

Following the pilot, a new cadre of integrated *activistas* was created within PCC in 49 of the 52 districts[13] where PCC operates. The community leader nominated candidates using similar criteria as prior to PCC, with two additional criteria: integrated *activistas* would need basic literacy (reading and writing) in Portuguese and would be willing to support both vulnerable children *and* HBC clients.

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[11] "A comprehensive coordinated care approach that addresses the needs of both adults and children in a family and attempts to meet their health and social care needs, either directly or indirectly, through strategic partnerships and/or linkages and referrals with other service providers." (Wakhweya, A. et al. 2008).

[12] Decree 72/2011, published in the *Boletim da República* on December 30, 2011, provides regulations to implement and enforce Law 7/2011.

[13] Integration did not occur in districts of Inhambane, where there are strong networks of church-based CSOs and they wanted to maintain a spirit of volunteerism and not decrease the number of volunteers.

"Intensive" versus "Maintenance" Phase

Prior to PCC, HBC *activistas* would visit families on a weekly basis for a roughly four- to six-month period before "graduating" from the program, based on when the client's status sufficiently improved. [14] OVC *activistas* provided household visits and care to OVC from the time they entered the program until they reached 18 years of age. Given the different timeframes for each client type, PCC needed to determine how an *activista* could organize visits using the new integrated approach. Program implementers decided to create two stages for households: "intensive" and "maintenance."

In households with both HBC and OVC clients, *activistas* visit newly enrolled HBC clients on a weekly basis during a four- to six-month period, called the "intensive phase." In this phase they also provide services to vulnerable children during the same visit. When the HBC client's status improves sufficiently[15] and he/she "graduates" from HBC, the *activista* shifts to a less frequent schedule of household visits, called the "maintenance phase." In this phase, their focus is more on the children in the household. The frequency of visits varies depending on the child's need, but is usually at least monthly. The project had similar guidelines for frequency of visits for households with only OVC clients, as well as for households with pregnant women. In both phases, the types of services provided to children are mostly based on an assessment of the individual needs of each child.

Study Purpose

Several studies have been conducted on integration of clinic-based services such as the integration of HIV/AIDS and family planning (Lush, 2002; Reynolds, Liku, & Maggwa, 2003; Banda, Bradley, & Hardee, 2004; Adamchak et al., 2007; ACQUIRE, 2008) or HIV/AIDS and sexual and reproductive health care (Askew & Berer, 2003; Fleischman, 2006; Bharat & Mahendra, 2007; Kennedy et al., 2010; AIDS Alliance, 2011; and Church et al., 2012). Limited research has been carried out in Mozambique or other sub-Saharan Africa countries that demonstrate the utility of an integrated strategy for community-based care programs and their effect on services delivered to vulnerable children.

To better understand what integration of HBC and OVC services means for OVC beneficiaries, USAID/Mozambique asked MEASURE Evaluation to conduct this assessment.

The three primary study objectives are to:

1. Understand *activista* perspectives about their work within an integrated project.

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[14] This includes several criteria defined by PCC including but not limited to the following: client is on ART with 100% adherence, asymptomatic and free of opportunistic infections, emotionally stable, economically secure as much as others in the same community, keeping clinic appointments, using condoms, using family planning methods or abstaining from sexual activity, aware of the need to go for PMTCT if pregnant, able to eat nutritious meals regularly, mobile and assuming regular tasks.

[15] This includes several criteria defined by PCC including but not limited to the following: client is on ART with 100% adherence, asymptomatic and free of opportunistic infections, emotionally stable, economically secure as much as others in the same community, keeping their clinic appointments, using condoms, family planning or abstaining from sexual activity, aware of the need to go for PMTCT if pregnant, able to eat nutritious meals regularly, HBC client on treatment and adherent, mobile and assuming regular tasks.

2. Understand the benefits/challenges of integration and its utility to beneficiary groups and stakeholders.
3. Understand how services to vulnerable children vary by phase of HBC client, presence of HBC clients in the household, and type of *activista*.

Methodology

Study Design

This study is a descriptive cross-sectional study that includes primary data collection at multiple project levels. We used a mixed method data collection approach using qualitative and quantitative methods. Quantitative data were triangulated with qualitative data to create a comprehensive understanding of factors that influence integrated community care (Greene, Caracelli, & Graham, 1989).

Study Location

In consultation with USAID/Mozambique and PCC, we purposively selected two of the central region provinces (Sofala and Manica) where PCC is operating and which PCC and USAID/Mozambique consider a priority due to their location in the Central Corridor where HIV risk factors are high (Foreit et al., 2001). Sofala and Manica provinces, both in the Central Corridor, have HIV prevalence rates of approximately 15 percent (INSIDA, 2009). We then selected two community-based organizations in each province based on the following criteria: previous participation in a non-integrated model, similar local language within a province (Sena and Chitewe), and one rural and one urban district per province.

Sampling

We collected information from different types of stakeholders at the national, sub-national, CBO, *activista*, and household beneficiary levels either through in-depth interviews, focus group discussions (FGD), self-administered surveys, or a structured questionnaire.

At the national level, we selected representatives from organizations and agencies involved with HBC and OVC programming, as well as those who had knowledge of the integrated approach. Individuals were selected based on their senior level responsibilities and ability to discuss the issue of community care integration.

At the sub-national level, we selected senior level government and PCC representatives who could speak to the issue of community care integration. In each province, district representatives of MISAU and MMAS based in the capital cities were interviewed, as well as senior PCC representatives. At the district level, district representatives of MISAU and MMAS were interviewed, as well as representatives of the CBO.

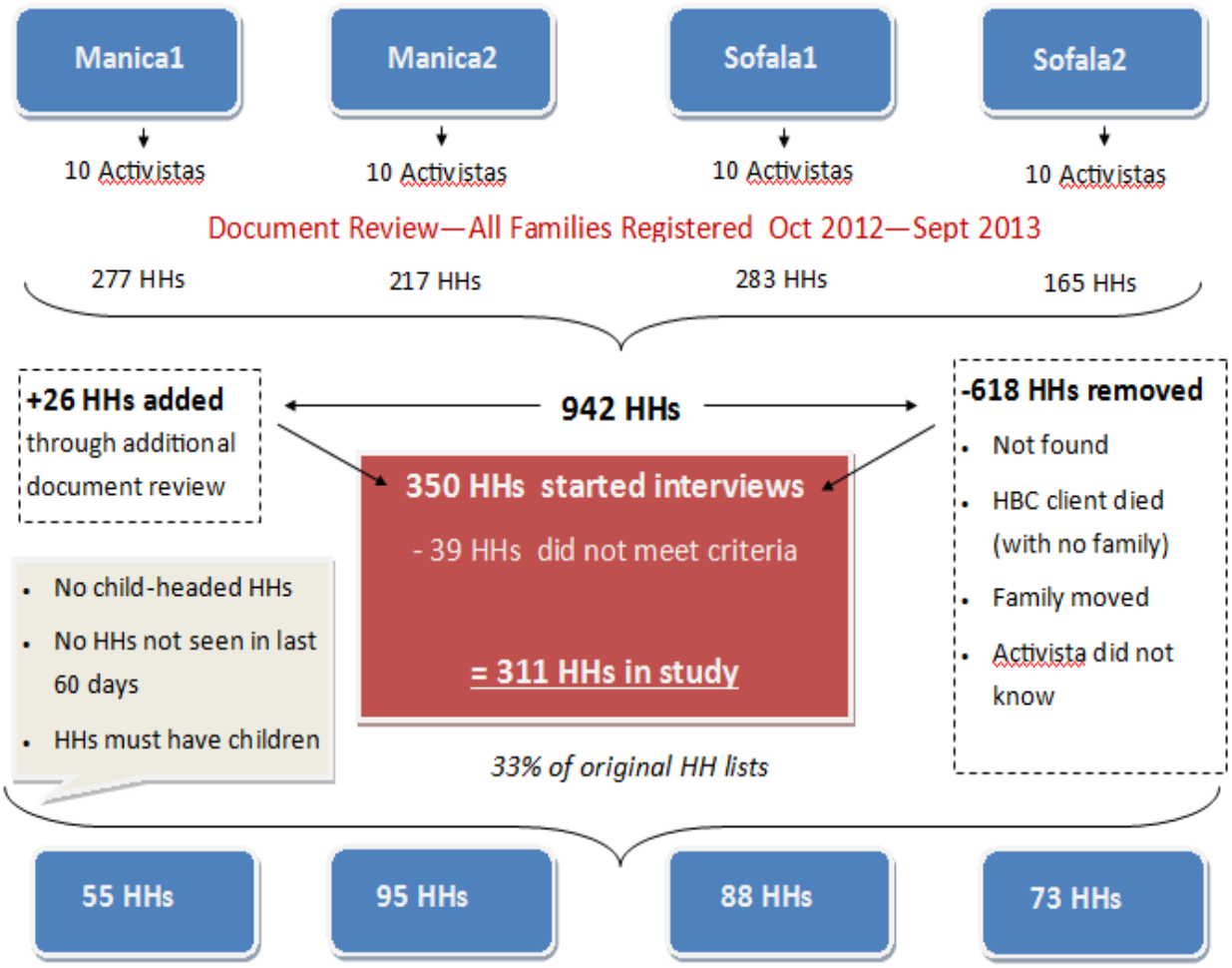
At each CBO, the study team invited a group of between 7 to 10 *activistas* to participate in a focus group discussion lasting between 1.5 to 2 hours. *Activistas* who participated in the FGD were to be different from those whose households were selected for a household visit. Also, a self-administered survey was administered to all available PCC *activistas* in each of the four selected districts on the day of the visit.

For each CBO, the study team randomly selected 10 *activistas* from between 11 to 30 *activistas* per CBO (Figure 1). For each selected *activista*, we constructed a sampling frame of all households listed in the household registration forms and HBC registration forms from October 1, 2012 to September 30, 2013. Using the Excel random number generator, we randomized the lists of households. When the data collection team arrived at the CBO, they met with each *activista* to review the full list of households. Households that the *activista* did not know were eliminated from the list. Households where the *activista* said that: 1) the sole beneficiary (in most cases an HBC client) had died, or 2) the family had moved away, were verified by having the data collector travel to the home to ensure no other beneficiaries could be interviewed. In other cases, the data collection team may never have reached the home either because they were unable to locate it or could not access it.

Due to the high number of individuals/families that had died and/or moved away, or households that the *activista* did not know, in three out of the four locations, the data collection team had to do an additional document review from the most recent family registration forms for each *activista* (October 1, 2013 to December 31, 2013). The same document review procedure was followed for these additional families and household lists were re-scrambled. Another 26 families were identified through this document review process.

There were 942 households listed for the 40 randomly selected *activistas,* and 618 were removed from the sampling frame, either because they were not found (12 percent), the family moved (17 percent), the *activista* did not know the family (18 percent), or an HBC client died and there was no other PCC client available in the home (10 percent). Once the household lists were finalized, data collectors visited each household on the list in order until they had completed 10 interviews (or as many as could be completed) at households for each *activista*.

Figure 1. Household Sampling Frame



Data Collection Instruments

Table 1 lists the data collection instruments and type of data collected from the study sample. We conducted semi-structured interviews with government, program, and CBO staff, fielded self-administered surveys to and held FGDs with *activistas* in the four selected CBOs, and administered structured questionnaires to caregivers in select households. Instruments were translated into Portuguese, and household questionnaires were translated into Sena and Chitewe. All instruments can be found in Appendix A.

The Mozambique Ministry of Health's Institutional Review Board (the Ministry of Health's *Comité Nacional de Bioética para a Saúde*) and the Health Media Lab Institutional Review Board in Washington, DC both reviewed and approved the study protocol and consent process. Written (or fingerprinted) informed consent for all instruments, which describes the rights and risks of those participating in the study, was obtained by all study participants.

Table 1. Data Collection Instruments by Participant Type

Sample Type	Data collection instrument	Type of data collected
Government, program and CBO staff	Semi-structured interviews	Perspectives of community care programs in an integrated program, participation in development and implementation of integration.
Activistas	Self-administered written survey	Experience as *activista*, households served and frequency of visits, workload, and training.
	FGD	What integration means, how integration works, OVC care and support provided in different types of households, training and preparation for work as an *activista*.
Caregivers	Structured Interview	Services received by household and OVC

Data Collection Procedures

A team of trained, local data collectors collected all data, with supervisors conducting FGDs and interviews at both the national and sub-national levels. National-level interviews were conducted in either English or Portuguese, and all other interviews and focus group discussions were conducted in Portuguese. Supervisors supervised the self-administered surveys, which were in Portuguese, and were on hand to explain the survey, answer any questions, and review responses as submitted to check for accuracy.

Caregiver interviews at the household level were administered in either Sena or Chitewe. Data collectors also had versions of the questionnaire in Portuguese to help with interpretation. When data collectors reached a household, they asked to speak with the primary caregiver of the children in the household. If the primary caregiver was a child (less than 18 years old) or if the primary caregiver was a seriously ill adult and no other adult could respond, the interview was not conducted. Initial screening questions were asked to determine eligibility. Households that had not received a visit from *activistas* in the last three months (18 families total), had no children under age 18 residing in the home, or had not received a visit from an *activista* in the last 60 days were excluded. Toward the end of the survey there was a set of questions regarding OVC services received for a specific child who was randomly selected using the Kish grid (Kish, 1949) from all children seen at the last visit. This child is referred to as the "index child."

Data Analysis Methods

Qualitative data (key stakeholder interviews and FGDs) were recorded and transcribed. Transcripts were reviewed and coded for *a priori* themes and sub-themes in Microsoft Word. Matrices were developed to look at patterns of themes among respondent types (i.e., program, government, *activista*) and levels (central, district, community). Information generated from qualitative analysis was triangulated with findings from the *activista* survey and other data sources.

Paper questionnaire responses were double-entered into CSPro. Data were exported to SAS files and transferred via secure Dropbox. Prior to conducting the analyses, we prepared the datasets by selecting only those households that met selection criteria (having received a visit in the last 60 days, at least one child under the age of 18), cleaning data and merging data files.

To answer each of the research questions, using SAS software, Version 9.0 (SAS Institute Inc.) we: a) examined descriptive statistics, b) conducted analysis of frequencies, and c) presented cross-tabs and chi square test results. New variables were created for the analysis – see Appendix B for more details regarding the variables. In addition, we conducted logistic regression analysis to examine factors that influence the probability for a child in the households (HHs) that received both OVC and HBC services in the last 12 months to be seen at the last visit. For these analyses we considered household characteristics: total number of children under age 18 residing in the household; HBC status – transitioning vs. active and active vs. graduated; and child characteristics – sex and age (5-14 years old vs. other ages). Two sets of analyses were conducted, one for the entire sample of children and the other for each of the two provinces. We included a fifth predictor variable for location – province in the first analysis and CBO in the second – to account for the provincial and CBO differences.

Table 2 presents some of the key variables and the household survey questions to which they correspond.

Table 2. Key Variables and Survey Questions

Variable	Question from Survey
Households receiving a visit in the last 12 months	In the last 12 months, did someone in your home receive a visit from a community *activista*?
Household where an adult received HBC in the last 12 months	In the last 12 months, did an adult (a person older than 18 years) in your home receive home-based care, even if they died or moved away since then?
Household where a child received support from an *activista* in the last 12 months	In the last 12 months, did a child or a young person under 18 years in this house receive support from an *activista*, even if they died or moved away since then?
Status of household – taken from when the last visit occurred • Active • Maintenance • Graduated	When was the last time an *activista* visted your house? • In the last week • In the last 7 and 30 days • In the last 30 to 60 days
Family services – those provided to benefit the whole family, received at the last visit	1. Nutritional education 2. Support for a community garden 3. Cooking demonstration 4. Referral for an income generation group 5. Left a health kit 6. Provided a bed net

Variable	Question from Survey
	7. Rehabilitated your home 8. Helped in obtaining a poverty certificate
HBC services received at last visit	During the last visit, did the *activista* provide home-based care services to any sick or incapacitated adult?
OVC support received at last visit	During the last visit, did the *activista* provide support services to any child or youth under 18 years?
Pregnant woman received support at last visit	During the last visit, did the *activista* provide services to any pregnant woman?
Child services – for the index child, which of the following services were received at the last visit	1. Referral to food support (MMAS, WFP etc.) 2. Referral for school support (uniforms, books, pencils and/or notebooks) 3. Referral for school fees 4. Gave money for school fees 5. Helped to return a child to school – support registration of [name of child] in school 6. Homework help 7. Referral to a health facility 8. Counseling on questions specifically around health 9. Spent time with [name of child] so that he/she could speak about his/her feelings 10. Referral for [name of child] to go to a spiritual leader 11. Referral for [name of child] to a kid's club

Results

Response Rates

Forty-seven *activistas* participated in the self-administered survey (Table 3) and thirty-seven participated in focus group discussions. The *activistas* in CBOs 1, 3, and 4 who participated in the FGD and self-administered survey were different from those whose clients were selected for the household caregiver survey. In CBO 2, the same *activistas* participated in all aspects of the data collection, as there were far fewer participating (11 *activistas* for the entire CBO).

A total of 350 households were visited, with 311 interviews completed after initial screening questions. Twenty-four in-depth key informant interviews were completed. Nine interviews were completed at the national level, six at the provincial level, and nine at the district level. Representatives at the national level included representatives from USAID/Mozambique (n=2), MMAS (n=2), MISAU (n=1), ANEMO (n=1), and PCC (n=3). Interviews at the provincial level included the Provincial Directorate of the Ministry of Health (n=2), the Provincial Director of Ministry of Women and Social Action (n=2), and PCC representatives (n=2). At the district level, there were interviews with representatives of Division of Women and Social Action within SDSMAS (district level) (n=2), District Representative of Health and

Women and Social Action Ministries (n=3) (RDMAS - representation within the SDSMAS), and CBO representatives (n=4).

Table 3. Number of Responses by Province and Community-based Organization

Province	CBO	*Activista* survey	Focus Group Discussion Participants	Household Surveys (n=350)	Qualitative Interviews
Manica	CBO 1	7	7	67	3
	CBO 2	20	10	104	5
Sofala	CBO 3	10	10	103	6
	CBO 4	10	10	76	3
National		-	-	-	9
	Total	47	37	350	26

Activista Perspectives about Their Work within an Integrated Project

This section presents findings related to the *activistas*, including their characteristics, impressions of what an OVC is, and their descriptions and impressions of integration overall, as well as their workload and preparedness to conduct OVC/HBC activities.

Activista *Characteristics*

Activistas participating in the self-administered questionnaire were on average 36 years old (n=46, SD=9.4, range 21 to 61). Thirty-two percent reported working for another CBO prior to the current CBO, twenty-eight percent had worked for their current CBO prior to PCC, and thirty-nine percent reported being brand new to PCC, meaning they had never worked with either HBC or OVC and never worked for another CBO (Table 4).

Table 4. *Activistas'* Previous Experience

Previous experience (n=47)	Frequency	Percent*
Worked for another CBO prior to current CBO	15	32
Worked for current CBO prior to PCC	5	13
New to PCC (reported never having worked before with HBC or OVC prior to PCC)	18	39

*Categories come from different questions and percents are not meant to total 100%.

Those participating in the survey are experienced, with 79 percent working for their CBO for over three years, 13 percent for between one and three years, and 9 percent for less than one year (Table 5).

Table 5. *Activista* Tenure with Current CBO

Tenure (n=46)	Frequency	Percent
Less than 1 year	4	9
Between 1 and 3 years	5	13
Over 3 years	37	79

Activista *Understandings of the Term "OVC"*

Activistas discussed what "OVC" means, and explained how they determine which vulnerable children to target for support. *Activistas* talked about OVC in different ways but often referred to them as children who are orphaned, have a sick caregiver, or are the poorest/most vulnerable within the community (given that so many of the children are poor). *Activistas* described the type of children they consider most vulnerable:

> *A vulnerable child is one that does not have minimal means for survival, for example, children who have lost their parents and have no shelter or food.*
>
> *It is not all of them. Only OVC who live in households with adults that are ill who cannot look after them. Some children are vulnerable, others are not. When parents are bedridden and have no means to support their children. We look at households and determine which OVC are in greatest need of assistance.*

Activistas reported that OVC are identified by community leaders, CBO leadership, or *activistas* themselves. Activistas identify OVC in homes of HBC clients, or when they may become aware of a critical situation such as an orphaned child, a family without financial means to care for such children, or children with limited or no food, clothing, difficulty accessing health services and/or not in school. FGD participants described how OVC selection occurs in the community, when not in the household of an HBC client:

> *Community leaders notify associations on the existence of OVC that live by themselves after their parents´ death or because of having been abandoned. We receive those children and provide them with care.*
>
> *In our communities all children are poor, we cannot take care of all of them; because of this, we normally focus on the poorest children, especially orphaned children.*

However, in FGDs *activistas* reported that it is rare to provide care to OVC-only households given the work they are also doing with HBC clients, and that children in households of sick adults are typically given priority, as evidenced by these participants' comments,

It [caring for OVC-only households] does not happen often. In these households OVC are identified by community leaders. They inform us that OVC are there and that their parents are ill, but they do not work and do not have basic needs to provide support to these children.

Only sometimes, the priority is OVC living in households with people who are ill.

There are OVC living in households with adults that have never received HBC services, but this is not very common.

Activista *Case and Workload*

All *activistas* reported working for PCC three days per week; 100 percent reported currently working with OVC, and 45 out of 47 reported currently working with HBC clients. Caseloads were mixed (Table 6): 96 percent of *activistas* have households that include HBC and OVC, 77 percent reported having OVC-only households, 85 percent had households where an HBC client formerly received services and now only the children are visited, and 38 percent had households with only HBC. The frequency with which they reported visiting the different types of households was similar, with most indicating they visit weekly. However, *activistas* reported visiting households with HBC clients only and with both HBC and OVC more frequently (twice or more per week).

Table 6. Activista Reports of Household Types Visited

Type of households* (n=47)	In current caseload		Visited 2x/week or more	Visited once a week	Visited every two weeks
	Frequency	Percent	Frequency	Frequency	Frequency
HBC only	18	38	12	1	4
Graduated	40	85	19	16	0
OVC only	36	77	14	17	1
HBC and OVC	45	96	31	6	3

*categories are not mutually exclusive

Two-thirds of *activistas* (n=45) reported spending more time with HBC beneficiaries and the other one-third reporting spending more time with OVC. FGD participants confirmed this, noting that HBC clients require more of their assistance with tasks such as bathing, preparing meals, and overseeing the time and dosage of medication. For OVC, however, their primary role is to provide counseling and referrals for other services, which takes less time than the care required for active HBC clients. One *activista* described the time allocation with clients:

We spend less time with OVC as we only offer counseling and referrals, but we also have to help adults bathe and eat.

When visiting a household with both types of clients, *activistas* reported that they provide services first to the sick person in the household before attending to OVC also in the household, as described by one FGD participant:

> *We first provide support to bedridden patients in stages four and three. Then we provide support to OVCs. Even though they are vulnerable, their needs are not as urgent as those of bedridden patients.*

When an HBC client has graduated, *activistas* reported mixed responses for what happens. Some reported visiting their OVC clients more frequently as they now spend less time with HBC clients; others reported visiting the children with the same frequency; and others reported a decline in the frequency of visits:

> *Once the HBC patients graduate, we have more time and space for OVC; we can give more attention to them as most of our time is dedicated to HBC patients.*

> *The frequency of visits changes when an HBC patient graduates as we no longer visit them as often. We use that time instead to visit other clients that are in greater need of assistance.*

Activistas were also asked to indicate the type of client that requires most of their time (Table 7). Eighty-nine percent of *activistas* reported that adults with HIV and AIDS require most of their time, with much smaller proportions reporting that OVC or pregnant women require more of their time.

Table 7. *Activista* Reports of the Type of Client that Requires Most of their Time

Client requiring most of their time, n=45	Frequency	Percent
Busca activa clients	33	73
HBC beneficiaries	7	16
OVC beneficiaries	4	9
Pregnant Women	1	2

Activista *Training and Self-assessed Preparedness*

Ninety-eight percent of *activistas* reported they had received OVC and/or HBC training (n=47). Forty-one percent of *activistas* indicated it had been more than one year since their last training (Table 8). The majority (72 percent, n=33) reported receiving an integrated training.

Table 8. Last Training Received by *Activistas*

	Frequency	Percent
Timing of last training (n=46)		
Less than 1 year	27	59
Between 1-3 years	13	28
Over 3 years	6	13
Areas covered in last training (n=46)		
OVC	8	17
HBC	5	11
Both	33	72

Three quarters or more of *activistas* reported receiving training on the following topics at their last training: counseling, cooking demonstrations, sensitization on the rights of youth, nutritional education, ART, Tuberculosis (TB) or other adherence support, and nutritional support (Table 9).

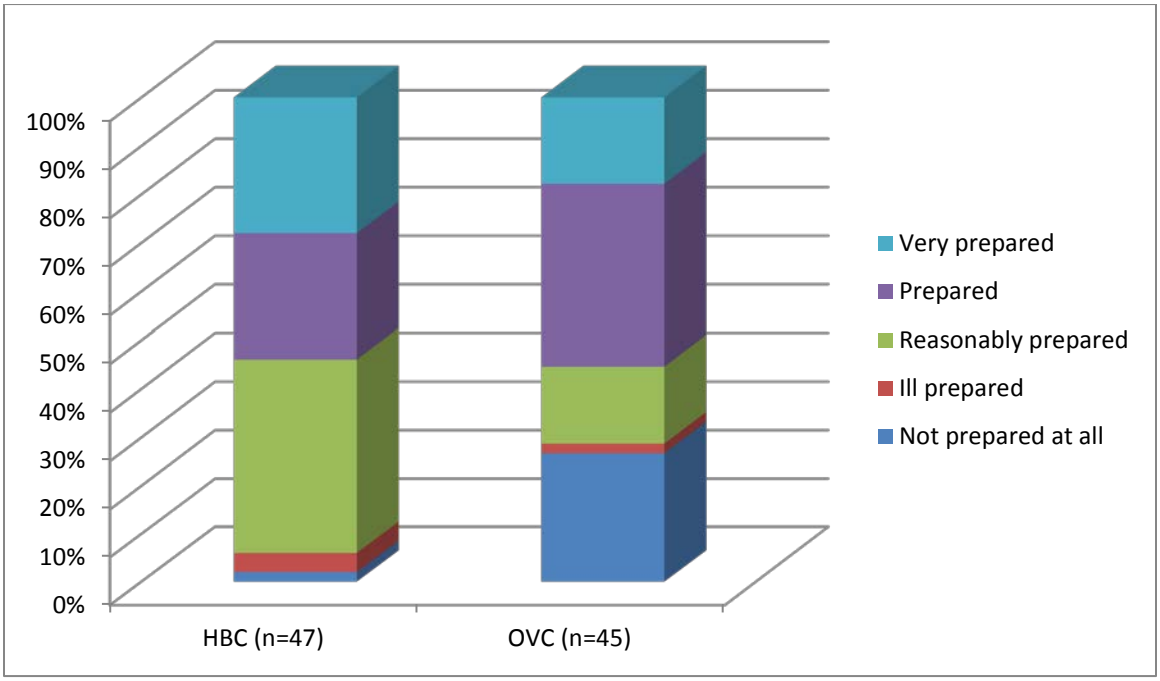
Table 9. Topics Covered in Last Training

Topics covered in last training (n=46)	Frequency	Percent
Basic psychosocial counseling	42	89
Cooking demonstrations	40	85
Awareness-raising on child rights	40	85
Nutritional education	38	81
ART, TB, or opportunistic infections adherence support	37	79
Nutritional support	37	79
Demonstrations on how to care for vegetable gardens	36	77
Homework help	33	70
Malaria prevention	28	60
Basic nursing care	27	57
Reintegration to school	27	57
Skills transfer for caring for HBC client	19	40

On a scale of 1 to 20, *activistas* rated their level of preparedness to provide care and support to HBC and OVC. The median rating for HBC and OVC was similar at 14; the mean was slightly higher for HBC than OVC (14.2 [SD=3.6] vs. 11.3 [SD=6.6]).

Ninety-three percent of *activistas* (n=44) reported feeling very prepared, prepared or reasonably prepared to provide care to HBC clients, as compared to just seventy-one percent (n=32) when asked the same about providing care to OVC clients. Twenty-nine percent of *activistas* indicated they were either not at all prepared or ill prepared to provide services to OVC, compared to six percent who indicated this for HBC (Figure 2).

Figure 2. *Activista* Reported Preparedness to Provide Care and Support to OVC and HBC on a Scale 0-20



Activistas in focus group discussions reported they needed additional training in OVC, particularly around psychosocial support, how to assist a traumatized child, and at one CBO more training on the minimum OVC package and children's rights. Statements from some *activista* participants capture their sentiments:

> *We do not know how to deal with children who are traumatized.*
>
> *For our level, we think we have minimal capacity [to provide care to OVC], but we do need to improve them [our skills]...*
>
> *…it is always necessary to participate in refresher courses; some techniques learnt are no longer applicable.*

Understanding the Benefits/challenges of Integration

Integration Benefits

FGD and interview participants described the benefits of the integrated approach. Stakeholders, particularly at the district level where there was only HBC work before integration, said that they are now able to reach OVC – a group that they wanted or felt the need to reach.

Stakeholders at all levels expressed that having OVC together with HBC presents a more efficient model for addressing the needs of HBC and OVC clients. Instead of *activistas* needing to call other *activistas* to provide care to a household member they are not trained to support, they can now provide the care themselves while at the household.

At the central level, multiple stakeholders discussed how integration has brought stronger coordination and communication between MISAU and MMAS. Many saw this as important given that while each group has separate beneficiaries, there is a great deal of overlap in terms of service provision, and thus it makes sense for the two ministries to work closely.

Expands Reach to Include OVC

For the community-based organizations more traditionally focused on HBC, they had not previously had a mechanism for directly reaching and providing support to OVC other than sick children. This left them uncertain as to who would care for such vulnerable children. A district and CBO representative described the consequence of this type of program:

> *There were problems when we looked at the patient only and we did not worry about children in the household and their needs (school, housing, food);* activistas *only looked after patients and that did not help them [children] improve.*

> *There were problems when households were visited and we did not look into the situation of orphans or children, as sometimes the parents had passed away and children did not have anyone to look after them.*

Provides a More Efficient Model

Participants from many levels reported that the integration of HBC and OVC services reinforces a family approach, allowing one *activista* to address the needs not just of HBC clients and OVC, but of the entire household. Interview respondents shared their perspectives on why an integrated approach is beneficial:

> *I think that in general terms OVCs are found in households with adults that are ill. This is why it did not make sense to have two different* activistas*.*

> *Because it helps maximize the use of resources;* activistas *involved that could do several things at the same time. It makes it possible for one person to look after the different dimensions of an individual. Synchronize services. I think that the integrated approach is better that having different people provide services at different times, in different circumstances and with different levels of sensibility to the same individual.*

> *Experience accumulated over the years in the area of OVC care and HBC services demonstrates that it is more practical to work with families as a whole. It generates benefits for all beneficiaries and for* activistas*. I think that it is because of this and other reasons that the integrated approach was adopted.*

Another benefit of integration described is that simultaneously it allows for provision of social and health-related (i.e., clinical) support and services. Such an approach is critical, as cited by one government official:

> *We understand that when talking about health, we are not only referring to physical issues alone, we also refer to mental issues and social well-being. It covers all of these issues, clinical and social issues. We cannot consider an individual to be healthy without considering their social dimension.*

The integrated approach is also perceived to offer clearer, more cohesive communication between the CBO and family. With one *activista* providing information to the family and serving as the main point of contact for services, referrals, and other communication, there is less opportunity for mixed messages. This helps avoid miscommunication, as described by one participant at the central level:

> *It was created because there were too many* activistas *providing assistance to the same family. This sometimes created problems as different groups gave contradictory recommendations; this is why it became necessary to group all the tasks around one* activista*.*

In the past, if an *activista* was visiting an adult client in the household and came across a child needing services, he/she would have had to return to the CBO to report the issue, which would be handled by another *activista*. This situation could cause a delay in responding to the child's need and leaving a caregiver uncertain about whether support would be provided. A central-level participant shared the type of situation that might have happened in the past:

> *So, [for] people who were ill and received support and lived with an OVC – the* activista *was not equipped to provide assistance to that minor. In the same way, if the person who was ill was accompanied by a pregnant woman, the* activista *was also not prepared to provide assistance [to her].*

Finally, *activistas* reported that households prefer dealing with one *activista* to address their household concerns to better protect their privacy; previously, multiple *activistas* would discuss a family's case to try to solve a problem that they were not trained to handle.

> *If more than one* activista *works with the household, information related to family health issues and the problems faced by household members would be all over the place.*

At the national level, the perception is that integration leads to a more cost effective model – and this holds true for both MMAS and MISAU, as indicated by program representatives:

> *Having less* activistas *facilitates the integration of activities. I think that implementation costs were reduced by the mere fact of there being a sole* activista*.*

> *With this approach [integration] we would maximize human and also financial resources, because instead of having to train and pay incentives to several* activistas *we can train one to assume the different types of care.*

Improves Collaboration and Communication among Government Partners

Central-level stakeholders also indicated that coordination has improved between MISAU and MMAS as a result of integration, given that they are now working together to achieve their objectives. Such

coordination is reinforced through their work on developing the training manual as well as through technical working groups, as described by two central-level participants:

> *It improved in terms of coordination. Before, our relationship was looser. But we improved coordination with integration. We created and strengthened technical groups that we all participate in. This is at central level. We decide on training contents and programs together*

> *I think that it helps Ministries achieve their objectives.* Activistas *are trained on various issues including health care and child protection. It is possible to achieve better results in each of the areas of work.*

At the district level, some participants reported that integration has helped to sensitize the health community to aspects of social welfare and strengthen linkages between the health and the social action systems (including through the common referral form introduced by PCC and approved by MISAU), as evidenced by the testimonials of the following participants:

> *It strengthens the relationship as OVC are linked more with social action and HBC with health so they end up being interlinked and coordination between the two institutions is better as they are both serving the same vulnerable groups.*

> *[There are] [q]uicker linkages with health facilities, children are seen faster [than before – at the health facilities], health facilities receive you now and they pay for the medication, but with INAS [National Institute of Social Action* - Instituto Nacional de Acção Social*] there is a link with the* activistas *that work with us.*

Challenges of Integration and its Roll-out

While participants cited several benefits of integration, they also noted challenges to how the integrated model has rolled out and perceived challenges of integration implementation. Some of the challenges raised and that will be discussed in this section include: integration has not been formally adopted or operationalized at the national level; there is a tendency to focus on HBC clients; integration results in an increased workload for *activistas*; *activistas* need more training in addressing OVC needs; and the flow of information is not always clear in the integrated program.

Integration Has Not Been Formally Adopted

Some central-level stakeholders noted that while integration has rolled out in the PCC program, it has not been formally adopted at the country level, nor is there a national guidance document. As one stakeholder explained:

> *In my view, integration would be possible first of all, by having a document guiding integration along with revised tools and training programs and by MISAU and MMAS technicians engaging in more joint work enabling them to assess which are the essential components of this new model.*

PCC has taken primary responsibility for rolling out the integration of its program. It was suggested that prospectively, the government be more involved in oversight of integrated programs, in an integrated model as evidenced by one participant:

When I referred to the two institutions, I meant that as national-level institutions we do not have any tools or protocol facilitating or approving that integration…at the institutional level there is nothing… That is the greatest challenge. I am concerned about this issue because we need to have a document that regulates this.

That said, the separation between the two ministries was not seen by stakeholders as being as prominent at the district level, given that the two ministries have joint representation and are focused on addressing the needs of household beneficiaries. A district-level official explained:

Some technical officers even say: OVC is not our thing. Another one says: the issue of ART and treatment is not my business, that is someone else´s business. But when we go to the field this is not an issue.

Further, the impression at the provincial level was that the new model of integration follows a trend that was already underway at the district level where some CBOs addressed the needs of both beneficiary types. For example, some CBOs had both types of *activistas,* or some *activistas* provided some care to OVC clients in addition to HBC – though this may have done more on an ad-hoc basis – as described by a district level participant:

There was always some collaboration. There was always some link between these two programs. Sometimes people think that all activities are not being implemented. I think however that when it was decided that HBC was needed, it was also known that these people had children who were also suffering. The same person providing HBC faced the issue of there being children that need care. Integration did not just happen all of a sudden. I think that to some degree integration has been there since the beginning.

Integration May Focus on HBC Clients

Some officials at the provincial and district level were concerned that the integrated approach is skewed to HBC:

On this issue of coordination, in reality it is evident that stakeholders place more attention on HBC.

We would like them to give more attention to the OVCs.

They place more emphasis on HBC than on OVC, but I think this is a mistake; both issues should be dealt with equally.

Integration Increases Workload of *Activistas*

At nearly all levels, the extent to which integration may increase the workload for *activistas* was expressed as an important concern. This was a concern even at the start of the program, as described by a program representative: "In the field we did find some resistance due to the workload."

An increase in *activista* workload was indeed perceived at the CBO and district levels. Participants noted this perception is associated with the small stipend they receive and completing forms in addition to their service delivery work. The following sentiments expressed by community level participants illustrate the workload concerns:

> *There was an increase in the amount of information that we needed to collect. What becomes challenging is having to deal with so many forms, there are too many of them. It is not that I do not agree on the need to collect information, but we have to collect too much information and we have to use far too many forms.*

> *Challenges are many, from sustaining the interest of* activistas *– at the slightest opportunity they prefer to drop out, as the incentives they receive are too low. On top of this we also face the challenge of having to reach more children that are still not benefiting from our services.*

While *activistas* indicated that integration has led to an increased workload, they noted that they are better equipped, through training, to serve the beneficiaries in their communities. They also acknowledged that this work is important and they will do what they have to, despite the challenges, to assist the vulnerable people in their communities.

> *Yes, workloads have increased and it is hard on us. But we have been trained so we will continue doing our duty.*

Some *activistas* indicated that integration makes their work easier, however:

> *We think that our work is easier now, firstly because now we deal with some issues at a family level, which was not possible before.*

> *We have more time because* activistas *do not have to make too much of an effort and split their time looking for OVC in one place and provid[ing] HBC in others.*

Integration May Not Have an Integrated Strategy

Some participants noted that integration of care and support to OVC/HBC in the same household may not be supported by an overall strategy. Integrated planning, decision making, and supervision are important to reinforcing integration at the household level. Yet, program staff within PCC are aligned with either OVC or HBC, rather than looking holistically at the needs of each beneficiary group. A district-level participant also noted the lack of balance of power within the project between the HBC and OVC sides of the program:

> *In some instances, decision makers make decisions independently, separately and in a non-integrated fashion. Joint planning needs to be strengthened along with the development of common views. In my view, the main challenge is balancing strengthened stakeholder roles. Another challenge is that mentors such as FHI work as a vertical and non-integrated program given that it starts off with the different packages: First HBC then OVC. It is only later that these packages are integrated. Integration requires the use of holistic approach to analysis and intervention development, encompassing elements jointly, in an integrated manner.*

Difficulty Meeting all Needs of PLHIV and OVC

Activistas expressed significant challenges in being able to provide food support to children and HBC clients requiring it, and noted that for anyone on ART, food support is critical to be able to take their medications.

… We feel awful. Many of the ill people we support need food. We do not have any food to offer them and at times neither the Hospital or Social Action do so either.

We just want to reduce mortality through food support. We, activistas*, want to see our patients improve without witnessing any deaths.*

Understanding How Services Received by Vulnerable Children Vary by Phase of HBC Client, Presence of HBC Clients in the Household, and Previous Experience of A*ctivistas*

Results described in this section come from data from the household survey in each of the four CBOs. We limited our sample to households that: had at least one child under 18 years of age resident in the household; reported having received at least one one-on-one service for HBC or at least one one-on-one child service in the last 12 months; and reported having received an *activista* visit in the 60 days prior to the interview.

This section presents findings related to the types of households visited by *activistas* in the last 12 months, timing of the last visit from an *activista*, household services received at the last visit, one-on-one services received at the last visit, descriptive information about all children in the households, and children seen one-on-one at the last visit, including the services they received. We found differences not only between provinces but in many cases also between community-based organizations. As such, where relevant, the findings are reported by CBO.

Household Visits in the Last 12 Months

We asked who in the household had received services in the last 12 months. Twenty percent of interviewed households reported they had received one-on-one services[16] only to HBC beneficiaries, ten percent reported services to OVC only, and seventy percent reported both HBC beneficiaries and OVC receiving one-on-one services (Table 10).Twenty-two percent of households that reported receiving HBC services (n=279) reported that no child in the household had received a one-on-one OVC service in the last 12 months – despite the fact that there were children residing in the home. In addition, 43 households had a pregnant woman resident in the household at the time of interview.

Three of the four CBOs showed similar profiles, with one out of four registered households receiving only one-on-one HBC services. The exception was CBO 2, where 90 percent of their households reported having received both HBC and OVC one-on-one services in the last year.

[16] One-on-one services included direct attention provided via HBC to ill or incapacitated adults, services to a pregnant woman, and support services to a child or youth under the age of 18.

Table 10. One-on-one Services Received in the Last 12 Months by Province/CBO

Province	CBO	One-on-one services received in last 12 months		
		Only HBC*	Only OVC**	Both HBC and OVC***
Manica	CBO 1 (n=55)	25%	20%	55%
	CBO 2 (n=96)	4%	6%	90%
Sofala	CBO 3 (n=86)	28%	10%	62%
	CBO 4 (n=72)	28%	6%	67%
Total (n=309)		20%	10%	70%

*Statistically significant between provinces and CBOs (p<.01)

*Only HBC – means that the household had only HBC clients receive one-on-one services in the last year.
**Only OVC – means that the household had only OVC clients receive one-on-one services in the last year.
***Both HBC and OVC – means that the household had both HBC and OVC clients receive one-on-one services in the last year.

Timing of the Last Visit

Next, we asked households when the last visit by an *activista* occurred. Overall, nearly half of the interviewed households reported that the *activista* had visited in the last week. Again, we found differences among the CBOs. In three of the four CBOs, one-third of interviewed households (35-36 percent) reported that an *activista* had visited within the past week, while more than three-quarters of the households served by CBO 2 reported receiving a visit in the last week (Table 11).

Table 11. Timing of Last Visit by Province and CBO

Province	CBO	Time of last visit		
		Last week	7-30 days	31-60 days
Manica	CBO 1 (n=55)	36%	29%	35%
	CBO 2 (n=96)	79%	18%	3%
Sofala	CBO 3 (n=88)	35%	42%	23%
	CBO 4 (n=72)	35%	38%	28%
Total (n=311)		49%	31%	20%

*Statistically significant between provinces and CBOs (p<.01)

Household Services Received at the Last Visit

The remainder of the questionnaire covered services received at the last visit. It included questions about specific services provided to the household, for example nutritional education or referral to an income-generation program (household services) and which – if any – household members received one-on-one services at the same time.

Overall, 80 percent of households reported having received at least one household service during the last visit. Over half of all households reported receiving nutritional support and a health kit; slightly less than half received support for a community garden. Slightly more than a third of interviewed households reported receiving a cooking demonstration and/or a referral to an income generation activity (Table 12). Only a small proportion of households reported receiving mosquito nets (9%), assistance in obtaining poverty certificates (7%), and/or rehabilitation of homes (2%). Services varied by CBO, with CBO 2 households reporting a higher percentage of services received than other households. Differences among CBOs for nutrition education, support for a community garden, referrals to income generation activities, and mosquito nets were significant. Differences among provinces were significant only for referrals to income generation activities and mosquito nets.

Table 12. Types of Services Received at the Last Visit by Province/CBO

Province	CBO	Percentage reporting household services at the last visit					
		Any service	Nut*	Health kit	Veg*	Cooking**	IG*^
Manica	CBO 1 (n=55)	78%	44%	55%	24%	27%	29%
	CBO 2 (n=96)	79%	67%	60%	55%	50%	55%
Sofala	CBO 3 (n=88)	86%	55%	49%	31%	34%	27%
	CBO 4 (n=72)	78%	69%	53%	59%	32%	25%
Total (n=311)		80%	60%	54%	44%	37%	36%

*,^indicates differences among CBOs/provinces are statistically significant (p<.01)

**indicates differences among CBOs are statistically significant (p<.05)

Note: percentages add up to more than 100% because households could receive more than one service at the same visit

Key: Nutritional Education, Health kit, Support for Community Vegetable Garden, Cooking Demonstration, Referral to Income Generation Activity.

One-on-one Services at the Last Visit

Half of the households with a pregnant woman (n=43, 51%) reported that the last visit did *not* include a one-on-one visit with the pregnant woman. We did not analyze these households separately by CBO due to the small sample of pregnant women.

Table 13 examines delivery of one-on-one HBC and/or OVC services received at the last visit. Nearly two-thirds of households reported receiving one-on-one HBC services, either with or without OVC services. Slightly more than half of households reported receiving one-on-one OVC services, either with or without HBC services. Notably, nearly one in five households reported receiving neither one-on-one HBC nor OVC services at the last visit. Variability in service mix can be seen across CBOs.

Table 13. Households Reporting Having Received One-on-one Services at the Last Visit by Province/CBO

Province	CBO	Percent of households reporting one-on-one services at the last visit			
		Only HBC	Only OVC	Both HBC and OVC	None
Manica	CBO 1 (n=54)	30%	19%	31%	20%
	CBO 2 (n=96)	11%	18%	55%	16%
Sofala	CBO 3 (n=88)	34%	17%	34%	15%
	CBO 4 (n=70)	37%	19%	23%	21%
Total (n=308)		27%	18%	38%	17%

Statistically significant between provinces and CBOs (p<.01)

Among households reporting one-on-one HBC services (n=199), 80 percent reported that one adult received HBC, 19 percent reported two adults received HBC, and 1 percent said that three HBC clients received care. Among households reporting receiving one-on-one OVC services (n=171), 13 percent reported that one child was seen, 17 percent that two children were seen, 23 percent that three children were seen, and 46 percent that four or more children were seen.

Relationship between Delivery of Household and One-on-one Services at the Last Visit

We examined the relationship between delivery of household and one-on-one services at the last *activista* visit. Eighty percent of households reported having received at least one household service at the last visit (Table 12) and eighty-three percent reported having received at least one type of one-on-one service (Table 13). Half of households that reported no one-on-one services at the last visit also did not report having received any of the family services listed in the questionnaire (Table 14).

In both provinces, those households that reported not having received any one-on-one services were also less likely to report having received any household service at the last visit.

In Manica, households receiving one-on-one services for both HBC and OVC were more likely to report receiving any family service than households reporting receiving only HBC or only OVC one-on-one services. In Sofala, households reporting one-on-one OVC services were more likely to report receiving any family services, regardless of whether they received HBC.

Table 14. Households Receiving at Least One Household Service at the Last Visit, by those Receiving One-on-one Services

Province	Percent receiving at least one household service at last visit, by one-on-one services received at same visit, by province			
	HBC only	OVC only	Both HBC and OVC	None
Manica (n=150)*	74% (n=27)	70% (n=27)	94% (n=70)	50% (n=26)
Sofala (n=158)*	84% (n=56)	93% (n=28)	91% (n=46)	50% (n=28)
Total (n=308)*	81% (n=83)	82% (n=55)	93% (n=116)	50% (n=54)

*Statistically significant at p<.05. CBO responses are not provided because of inadequate sample size.

Children in the Households

A total of 1,074 children were reported living in this sample of households. The number of children per household was similar across the CBOs, with between 3 to 3.8 children (under 18 years) living in each household (Table 15).

Table 15. Mean Number of Children by Province/CBO

Province	Mean number of children <18 resident in households (n=1,074)					
	CBO	# of HH	Mean	Std Dev	Min	Max
Manica	CBO 1	55	3.8	1.9	1	8
	CBO 2	96	3.6	1.8	1	9
Sofala	CBO 3	88	3.0	1.8	1	10
	CBO 4	72	3.3	1.9	1	10

Overall, an equal proportion of male and female children were residing in the households (Table 16). The sex distribution of children living in the households was similar at the CBO level, except for CBO 1, which had a higher proportion of female children than male (60 percent vs. 40 percent).

Table 16. Proportion of Male/female Children by Province/CBO

Province	Children <18 resident in all households (n=1,073)		
	CBO	Male	Female
Manica	CBO 1 (n=208)	40%	60%
	CBO 2 (n=349)	50%	50%
Sofala	CBO 3 (n=278)	53%	47%
	CBO 4 (n=238)	53%	47%
Total (n=1,073)		49%	51%

Overall, the age distribution tends to skew older than the child population at large,[17] with about one-fourth of children falling in the 0-4, 5-9, and 10-14 age ranges (Table 17).

Table 17. Age Distribution of Children by Province/CBO

Province	Children <18 resident in all households (n=1,071)				
	CBO	0-4	5-9	10-14	15-17
Manica	CBO 1 (n=208)	28%	28%	29%	15%
	CBO 2 (n=349)	26%	29%	33%	12%
Sofala	CBO 3 (n=277)	25%	29%	32%	15%
	CBO 4 (n=236)	25%	28%	27%	19%
Total (n=1,071)		26%	28%	31%	15%

Approximately 17 percent of all children in the sample (n=1,060) lived in households that had not received any one-on-one OVC services in the last 12 months (i.e., HBC-only HH); 10 percent lived in households that had received only OVC services in the last 12 months; and 73 percent lived in households that had received both OVC and HBC services in the last 12 months.

[17] As compared to the age pyramid found in the 2011 DHS.

Children Seen One-on-one at the Last Visit

We examined the characteristics of all children in the households with those children who were seen at the last visit and found no significant differences by age or sex.

Slightly more than half of the interviewed households reported receiving one-on-one OVC services at the last visit (Table 13). Fewer children were reported to have been seen one-on-one in Sofala than in Manica (32 percent vs. 51 percent, p<.01). The difference between provinces is due to a greater proportion children living in households with only HBC clients that received services in the last 12 months in Sofala, as compared with Manica (22 percent vs. 13 percent, p<.01). Further, a very low proportion of children are living in HBC-only households observed in CBO 2 (4 percent vs. 22-26 percent in the other three CBOs) (Table 18).

Table 18. Proportion of Children Living in Households with Only HBC Clients that Received Services in the Last 12 Months

Province	Proportion of children living in households with only HBC clients that received services in the last 12 months (n=1,053)	
	# of children	Percent
Manica	553	13%
CBO 1	208	26%
CBO 2	345	4%
Sofala	500	22%
CBO 3	261	22%
CBO 4	239	22%

Half (51 percent) of the 873 children living in households that had received one-on-one OVC attention in the last 12 months were reported as having received a one-on-one at the last visit. Fourteen percent of these children (who had received a service at last visit) lived in households that had received only OVC services in the last 12 months, and eighty-six percent lived in households that had received both HBC and OVC services.

Children living in households that had received only OVC attention in the last 12 months were equally likely to have been seen one-on-one at the last visit as children living in households that had received both HBC and OVC attention. There were no significant differences by province or by CBO.

To better understand the impact of HBC-OVC integration on OVC services, we examined factors that influence the probability that any child in the household would be visited at the last visit. We examined household characteristics including the total number of children under age 18 resident in the household, and HBC status – transitioning vs. active, and active vs. graduated.[18] We also examined child characteristics: sex and age (5-14 years old vs. other ages); and the extent that location might have influenced a child receiving services. This sample included 762 children residing in 217 households.

Table 19 presents the findings of the regression analyses. Overall, children in Manica were more likely to receive one-on-one attention than children in Sofala. In Manica province, children served by CBO 1 were as likely to receive one-on-one attention as children served by CBO 2. In Sofala province, children served by CBO 4 were less likely to receive one-on-one attention than children served by CBO 3.

In both Sofala and Manica provinces, children in larger families (more children <18 years old) were less likely to receive one-on-one attention than children in smaller families. Overall, children in active HBC households were more likely to receive one-on-one attention than children in households where HBC clients were transitioning.

Overall, children in households where HBC clients had graduated were less likely to receive one-on-one attention than children in households where an HBC client was transitioning. While this pattern was similar in Manica, it was the opposite in Sofala where children in a household with a graduated HBC client were more likely to receive one-on-one attention than children in households where the HBC client was transitioning.

Girls and boys were equally likely to receive one-on-one attention at the last visit; this was also the case in Sofala and Manica. Overall, children of primary school age (5-14) were more likely to receive one-on-one attention than younger or older children. This was also true in Manica. In Sofala, there was no difference between children of prime school age and other children.

Table 19. Logistic Regression Results for Characteristics that Influence OVC Attention

Province	**Odds Ratios for household and child characteristics**					
	Province or CBO	# of children	Active vs transitioning	Graduated vs. Transitioning	Sex	Age
Manica (n=423)	NS	.6**	2.0*	.1**	NS	2.1**
Sofala (n=339)	.5**	.8**	2.7**	1.8*	NS	NS

[18] Graduated HBC: did not get HBC on last visit (only OVC or no HBC, no OVC), Transitioning HBC: last visit > last week ago and got HBC on the last visit, Active HBC: last visit in last week and got HBC on the last visit (only HBC or both HBC and OVC)

Province	Odds Ratios for household and child characteristics					
	Province or CBO	# of children	Active vs transitioning	Graduated vs. Transitioning	Sex	Age
Total (n=762)	1.5*	.7**	3.3**	.6**	NS	1.9**

NS=not statistically significant, *statistically significant at .05; **statistically significant at .01

In summary, while we found differences between provinces, and in Sofala differences between CBOs, there appears to be a consistent effect of HBC clients within the home on the likelihood that a child will or will not receive one-on-one attention at the last visit: children living in HH with active HBC client(s) were the most likely to receive one-on-one attention during the *activista's* last visit. This means that when an HBC client is being seen regularly, it is more likely that an OVC client will also be seen regularly.

Index Child Analysis – One-on-one Child Services Received at the Last Visit

We also examined the age and sex breakdown for the 178 index children selected from the Kish grid for whom we asked questions about individual child-level services. There were no statistically significant differences in the age and sex of those children.

We created four main categories of one-on-one child support received at last visit based on the list of services provided in the questionnaire. These groups included school support, food support, psycho-social support, and health support.[19]

Overall, health support was reported most frequently, with well over half of all children receiving one-on-one attention receiving this service at last visit (Table 20). Half of the children seen were reported to have received some kind of psychosocial support, but the frequencies varied widely by CBO, from a low of 28 percent to a high of 69 percent. Households in Manica were more likely to report that children received psychosocial support compared to households in Sofala. Less than a third of children receiving one-on-one attention at the last visit were reported to have received food support; again, the proportions varied widely by CBO.

Finally, 40 percent of children ages five and older received some kind of school assistance at the last visit, and the proportions varied widely by CBO. Older children (10 and over) were more likely to receive school-related services than younger children. Children under five were the most likely to receive food support, and there were no age differences in the proportion receiving health or psychosocial support. No sex differences were found for any of the child services.

[19] **School support:** Referral to assist in acquiring school materials (uniform, books, pencil and/or notebooks), referral for school fees, gave money for school fees, supported reintegration to school (support to help child register in school), help with homework; **Food support**: Referral for food support (MMAS, WFP, others); **Psychosocial support:** Set aside some time to talk to the child about his/her feelings, referral to a spiritual leader, referral to a kid's club; **Health support:** Referral to health facility, counseling on specific health-related questions.

Table 20. Percent of Index Children Receiving One-on-one Services at the Last Visit

Province	CBO	Children receiving a one-on-one service at last visit			
		School** (n=121)	Food support** (n=175)	Health (n=173)	Psycho-social* (n=173)
Manica	CBO 1	45%	10%	62%	52%
	CBO 2	40%	30%	70%	69%
Sofala	CBO 3	53%	30%	59%	38%
	CBO 4	10%	50%	57%	28%
Total		40%	30%	64%	51%

* statistically-reliable differences among CBOs at <.01 ** statistically reliable differences among CBOs at <.05
Note: percentages add up to more than 100% because households could receive more than one service at the same visit

Discussion

At the household level, there appears to be a consistent association between HBC clients within the home and the likelihood that a child will or will not receive one-on-one attention at the last visit. However, when the HBC client is not present, there does not appear to be a difference in services provided to children in the home. These results, coupled with the results from our qualitative analysis, demonstrate that home-based care appears to be the driver of service provision.

The effect of HBC on the likelihood of an OVC receiving support might be explained in part by the history of community care in Mozambique – and that OVC was added on to existing HBC services. In this scenario, the priorities of CBOs and *activistas* may have historically been on HBC, and changing the mindset may be challenging, particularly if HBC needs remain high. It may also be explained by the difference in client needs, as expressed by *activistas*: HBC care involves care that may take more time, such as assisting with medication and bathing the client; whereas OVC support such as providing a referral or counseling is less time-consuming. However, some OVC care may require more time with children than is currently provided, such as taking children to activities, helping them with homework, and providing enhanced counseling.

The fact that not all children in households with HBC were seen in the last 12 months with specific services may be due to the fact that those children were perceived as not requiring support. However, this goes against program guidelines that advocate for each child in the home of an HBC client to receive psychosocial support.

We found differences between provinces, and often between CBOs, suggesting that integration may be implemented differently across sites. While an integrated training curriculum has been developed and rolled out, 80 percent of the training days focus on HBC.

Further, guidance and organizational supports that facilitate the integration process are not yet clearly established. Documents that define integration, thresholds, and frequency of services to be provided to OVC, what to do at a household visit, which clients to prioritize, and checklists for household visits were not widely available and did not appear to be actively used where they existed.

Further, within PCC there were inconsistent reports on how OVC are selected and targeted, which could have a large impact on which children receive services. Targeting of OVC is an area that many OVC programs are addressing and trying to improve upon in the region such as in Nigeria, Uganda, Kenya, Tanzania, and Zambia. For PEPFAR-funded programs, OVC include those infected with/affected by HIV/AIDS and are not selected solely on the basis of HIV-positive caregivers or other adults in the household (PEPFAR, 2012). In Mozambique, the definition of vulnerable children is quite broad and could mean that there is *de facto* targeting occurring at the local level to identify those children who are the most vulnerable of the children eligible for OVC services.

These types of supports have been identified by others as important when transitioning to an HBC/OVC integrated model (Southern African AIDS Trust (SAT), 2004). In a report compiled from a regional workshop, SAT identified the value of having a clear communication process for a newly integrated program, realigning management of the program, as well as adequately building capacity of the volunteers and staff on how to implement an integrated program.

Another type of organizational support is monitoring and evaluation systems, which are designed to facilitate the use of information to support service delivery improvements. Programs often use information in community care programs to determine coverage, assess progress, and facilitate service delivery. While constructing the sampling frame for this study, we learned that the M&E system is vertical and information is not organized by household. For example, there are separate HBC and OVC forms, and those forms are stored in different binders. This means that *activistas* or CBOs cannot easily find comprehensive information about a household. The results of this study enabled us to examine how services are received within a family context – something that had not previously done within the program. Without a specific measure of integrated services, the program has been unable to monitor the progress of integration.

In addition, we found many inaccurate, incomplete, and outdated forms. This was confirmed when data collectors traveled to the field and were unable to visit households, either because *activistas* did not know a family from their household list (though *activistas* themselves complete the forms), families had moved, or there were households where a client had passed away. Such inaccuracies mean that many programmatic decisions, such as coverage, may be made based on inaccurate information.

The number of reported HBC clients that had died was particularly alarming and belies the commonly held assumption that HBC clients are no longer bed-ridden or in need of end-of-life care due to the expansion of ART services (Phaladze et al., 2005).

Activistas in every program site reported that one of their main challenges is accessing food support for households, given that programs are decreasing the amount of food support provided. For example, in one of the dissemination meetings for this study, it was noted that the World Food Program has ceased providing food support. While PCC is conducting gardening and income generation activities, food security appears to remain an important concern of households they serve. Anecdotally, *activistas* and others on the ground cite the lack of food as a primary reason why patients default on their medication, and hence may contribute to the deaths of HBC clients within and outside the program.

Many study participants expressed the value of an integrated model for the efficiencies it offers, including offering holistic support to households, the potential for cost savings, and the *activista's* ability to reach OVC that may not have been previously reached.[20] Despite not all children receiving one-on-one attention from the *activista*, many children benefitted from family strengthening interventions such as support for a community vegetable garden and referral to income generation activities. Such interventions are those that reach all household members and point to the efficiency that many participants described as a benefit of integration. This was also identified as a perceived benefit to integration in the SAT regional workshop.

Another benefit of integration is the potential of linking OVC to clinics and other health services. Integrated programs have the benefit of having *activistas* with established contacts with clinics through their work with HBC. For example, a comprehensive HIV/AIDS program in Kenya has meant that children are referred and followed up on counseling and testing, and this can be tracked through the OVC data management system. These and other types of efficiencies have been well documented in other studies (Askew & Berer, 2003; Fleischman, 2006; AIDS Alliance, 2011; Church et al., 2012).

We did find evidence of some challenges to integration roll out, such as increased workload for *activistas*, the challenges of understanding maintenance and intensive phases, and the need for additional training and skill building around OVC, particularly for psychosocial support. Studies on integration of other health programs have documented similar challenges (Banda, Bradley, & Hardee, 2004; Bharat & Mahendra, 2007; Harries et al., 2007). Despite the reports of increased workload, *activistas* and CBOs still find the integrated approach useful.

Further, it is evident that *busca activa* requires a significant amount of the *activistas*' time, often outside of the three days they dedicate to providing care and support to households. We were not able to assess the extent to which *busca activa* is received at the household level, as this is an activity done to follow up on those who have defaulted on ART and would not be in the caseload for household visits.

Recommendations

Given study findings and interpretation with key stakeholders, the study team offers the following recommendations for the PCC program to maximize the potential to serve all beneficiary groups. These recommendations are offered in no particular order of importance:

[20] Note – this study did not assess whether integration was more effective.

- Create a monitoring system with the family as the main unit of record-keeping. This would require exploring how *activistas* can provide integrated services during every household visit and developing a form to capture this.

- Organize files by beneficiary family to facilitate household case management. All forms, including the registration form, should be kept in the *activista* binder, by family, as long as any services are needed.

- Update family registration forms to include beneficiaries entering and exiting the program and what phase of the program each client is in.

- Develop other programmatic guidance and supports to operationalize integration among CBOs delivering the integrated model, establishing clear definitions of what an integrated care approach means in terms of service delivery to households and OVC in the household – for example, looking at how to differentiate between "phases" of service provision.

- Develop clear programmatic guidelines and accompanying tools for community workers for defining and targeting OVC based on accepted community norms, specifically looking at whether children in households receiving HBC are automatically considered vulnerable.

- Consider conducting a community trace and verify activity to ascertain how up-to-date and accurate program records are.

- Conduct a detailed skills assessment of *activistas* for OVC care and support. Develop a training plan based on these findings and consider enhancing training modules related to psychosocial support and other areas expressed.

At the central level, we recommend convening key stakeholders to discuss the utility of adopting an integrated approach for Mozambique. If stakeholders decide to continue with this approach, develop a comprehensive strategy and organizational supports to ensure established standard operating procedures for organizations offering the integrated model.

Conclusion

We found consensus regarding the value of having one activista provide services to all clients in one household for the efficiencies it offers, including offering holistic support to households, the potential for cost savings, and the integrated *activista's* ability to reach OVC that may not have been previously reached.

At the household level, there appears to be a consistent association between HBC clients within the home and the likelihood that a child will or will not receive one-on-one attention at the last visit. However, when the HBC client is not present, there does not appear to be a difference in services provided to children in the home. These results, coupled with the results from our qualitative analysis, demonstrate that home-based care appears to be the driver of OVC service provision.

We found differences between provinces, and often between CBOs, suggesting that integration may be implemented differently across sites. While an integrated training curriculum has been developed and rolled out, other guidance and organizational supports that facilitate the integration process are not yet clearly established.

Study Limitations

As mentioned earlier in the report, incomplete HBC and family registration forms hindered the ability of the study team to develop a household sampling frame. The only way to link HBC registration forms to household registers was to compare the names of clients, a process that was prone to error (improper spelling of names, first names and not last names used or vice versa, etc.). Also, we found children listed on HBC registration forms that were not listed in the household registration forms, meaning there could have been children who receive support that were not included in the sample. There was no way of assessing this given the inaccuracy of the forms.

Data collection was initially scheduled for November 2013, but was postponed to February 2014 – the rainy season – due to political instability around provincial elections. Some households were not available to be visited as family members had relocated to be close to their farm plots (*machambas*), and some roads had been washed out and rivers were at a higher level than usual, often making crossing them impossible.

Activista surveys were self-administered in Portuguese. It is possible that some *activistas* may not have understood all of the questions, though the study team did have a proctor available to respond to questions and review surveys as they were submitted. As for interviews and focus group discussions, we relied on self-reported data, which could have introduced bias. We tried to address this by collecting data from multiple stakeholder types at different levels and triangulating findings.

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Appendix A. Data Collection Instruments

Stakeholder Interviews: Key Donor Stakeholders, PCC Program Staff

Opening/Rapport-building Questions

1. What are your current responsibilities for OVC programs? And for HBC?

Integration Questions

2. Why was integration – that is, having the same community activista deliver both HBC and OVC services – proposed for the PCC program? Probe:
   - Where/with whom did the idea originate?
   - Were there problems before integration?
   - Was quality of care a factor?
   - Was funding a factor?
   - Other reasons?

3. Were you directly involved in the decision to integrate? If so, what was your role? What was (your place of work's) role?

4. Outside of (your place of work), from your perspective was there strong consensus to integrate? What were the arguments for and against integration from outside (your place of work)?

5. At the time that the decision was made to integrate, what was your own, personal opinion of integration? Probe: were you supportive/against/no opinion?

6. Now that integration is underway, has your opinion changed? If yes – how? Which system do you prefer (integrated or non-integrated)? Why?

7. Which of the two models provides the best care/support to OVC (integrated/not integrated)? Which is best for HBC clients (integrated/not integrated)?

8. What has been your role (if any) in implementing integration?

9. How has integration influenced the work you are doing? Please describe how it has changed the work you are currently doing (if at all)? Probe: coordination with other stakeholders on information sharing, reporting, service delivery, number of *activistas* you work with

10. How do you think integration has affected the working relationship between MMAS and MISAU? National/district level coordination of OVC/HBC service provision?

11. How prepared do you think the CBOs are to manage integration? How prepared are the *activistas* to provide both HBC and OVC services? What are some of the training or skills gaps? How are those being addressed?

12. What have been the benefits of an integrated approach? Are they what you/others expected they would be? Why/why not? Probe: what are the benefits for
    - Beneficiaries and their families
    - Program staff at all levels
    - *Activistas*
    - Government ministries, donors

13. What have been the challenges to integration? Are they what you/others expected they would be? Why/why not? Probe: what are the challenges for
    - Beneficiaries and their families
    - Program staff at all levels
    - *Activistas*
    - Government ministries, donors

14. Do you think OVC and HBC beneficiaries have been affected equally? Meaning, do you think OVC and HBC receive equal attention under the integration model? Why? Why not?

15. If you could change anything about the current integrated activista model or the process of integration as a whole, what would it be?

16. Would you like to see/recommend that HBC/OVC integration be scaled up throughout Mozambique? Why or why not?

17. Would you recommend integration to other large, national projects? Why? Why not?

18. Anything else you would like to share?

Thank you for your time and willingness to participate in this study. As I mentioned at the beginning, please do not hesitate to contact me if you have any questions or comments [include contact information.

Stakeholder Interviews: MMAS, MISAU (National level)

Opening/Rapport-building Questions

1. What are your current responsibilities for OVC programs? And for HBC?

Integration Questions

2. Why was integration – that is, having the same community activista deliver both HBC and OVC services – proposed for the PCC program? Probe:
   - Where/with whom did the idea originate?
   - Were there problems before integration?
   - Was quality of care a factor?
   - Was funding a factor?
   - Other reasons?

3. Were you directly involved in the decision to integrate? If so, what was your role? What was (your place of work's) role?

4. What was the role of your place of work?

5. Outside of (your place of work), from your perspective was there strong consensus to integrate?

6. Outside of (your place of work)/ in general what were the arguments for and against integration of these services?

7. What have been the benefits of an integrated approach? Are they what you/others expected they would be? Why/why not? Probe: what are the benefits for
   - Beneficiaries and their families
   - Program staff at all levels
   - *Activistas*
   - Government ministries

8. What have been the challenges to integration? Are they what you/others expected they would be? Why/why not? Probe: what are the challenges for
   - Beneficiaries and their families
   - Program staff at all levels
   - *Activistas*
   - Government ministries

9. Do you think OVC and HBC beneficiaries have been affected equally? Meaning, do you think OVC and HBC receive equal attention under the integration model? Why? Why not?

10. How did integration affect the working relationship between MMAS and MISAU? How did it affect coordination of HBC and OVC program work at the provincial and district level?

11. If you could change anything about the current integrated activista model or the process of integration as a whole, what would it be?

12. Would you recommend integration to other large, national projects? Why? Why not?

13. Anything else you would like to share?

Thank you for your time and willingness to participate in this study. As I mentioned at the beginning, please do not hesitate to contact me if you have any questions or comments [include contact information].

Stakeholder Interviews: Provincial Level (DPMAS, DPS, PCC)

Opening/Rapport-building Questions

1. What are your current responsibilities for OVC programs? And for HBC?

Integration Questions

2. Do you know why integration – that is, having the same community activista deliver both HBC and OVC services – was proposed for the PCC program? Probe:
   - Were there problems before integration?
   - Was quality of care a factor?
   - Was funding a factor?
   - Other reasons?

3. How were you informed of the decision to integrate?

4. At the time that the decision was made to integrate, what was your own, personal opinion of integration? Probe: were you supportive/against/no opinion? Why did you feel that way about integration?

5. Now that integration is underway, has your opinion changed? If yes – how?

6. Which system do you prefer (integrated or non-integrated)? Why?
   a. Which system provides the best care/support to OVC?
   b. Which system is better for HBC clients?

7. What has been your role (if any) in implementing integration?

8. Please describe how integration has changed the work you are currently doing (if at all)? Probe: coordination with other stakeholders on information sharing, reporting, service delivery, number of *activistas* you work with

9. To the best of your knowledge, how do you think integration has affected the working relationship between DPMAS and DPS?

10. How did you communicate integration to key stakeholders in the province? (For example: To provincial staff? District staff? CBOs?) Probe: was it done by email, a formal launch, did PCC announce it?
    a. Was there a formal training on how integration would roll out? If so, who received that training?

11. Describe the process of rolling out integration at the provincial, district, and community level. Was it difficult/easy? Why? What were some of the challenges when rolling it out? How did you address those challenges?

12. How prepared do you think the CBOs are to manage integration? How prepared are the *activistas* to provide both HBC and OVC services [probe well on this]? What are some of the training or skills gaps? How are those being addressed?

13. What have been the benefits of an integrated approach? Are they what you/others expected they would be? Why/why not? Probe: what are the benefits for:
    - Beneficiaries and their families
    - Program staff at all levels
    - *Activistas*
    - Collaboration between DPMAS and DPS

14. What have been the challenges to integration? Are they what you/others expected they would be? Why/why not? Probe: what are the benefits for:
    - Beneficiaries and their families
    - Program staff at all levels
    - *Activistas*
    - Collaboration between DPMAS and DPS

15. Do you think OVC and HBC beneficiaries have been affected equally? Meaning, do you think OVC and HBC receive equal attention under the integration model? Why? Why not?

16. If you could change anything about the current integrated activista model or the process of integration as a whole, what would it be?

17. Would you like to see/recommend that HBC/OVC integration be scaled up throughout Mozambique? Why or why not?

18. Would you recommend integration to other large, national projects? Why? Why not?

19. Anything else you would like to share?

Thank you for your time and willingness to participate in this study. Again you can contact me at [include contact information] if you have any questions or comments at a later date.

Stakeholder Interviews: CBO Leadership, CBO Supervisors

Opening/Rapport-building Questions

1. Please tell us a little bit about your organization and your role within it. Probe: What are your current responsibilities within your organization? And within PCC program? [if respondent does not discuss working with OVC/HBC specifically prompt on the organization's work related to this]

Integration Questions

2. We understand that your organization experienced a transition from providing separate services to either HBC clients or OVC clients to now providing an integrated set of services through one activista per household. Based on your experience and knowledge of your organization's history, what services was your organization providing before the organization moved to providing integrated HBC/OVC services? Probe: did you only provide services to OVC? only to HBC? Other services?

3. How does your organization identify children to receive services under PCC?

4. How do you identify clients to receive home based care?

5. The PCC program has an intensive and maintenance period for households. Can you explain the difference between these two periods? What is the difference in services offered to OVC during these 2 periods?

What differences exist between what services are provided to OVC under these two periods?

	Intensive	Maintenance
OOVC		
HHBC		

How often do *activistas* visit households that receive OVC support in the intensive phase and in the maintenance phase?

	Intensive	Maintenance
OOVC		
HHBC		

6. Do you know why integration – that is, having the same community activista deliver both HBC and OVC services – was proposed for the PCC program? Probe:

- Where/with whom did the idea originate?
- Were there problems before integration?
- Was quality of care a factor?
- Was funding a factor?
- Other reasons?

7. How has the management of your CBO changed as a result of integration? [probe: do you have more/less *activistas*, more reporting requirements, more trainings to conduct etc.)] [collect documentation if possible]

8. How prepared are the *activistas* to provide both HBC and OVC services?
   - What are some of the training or skills gaps?
   - How are those being addressed?

9. Do you think your *activistas* are better able/less able to provide services for key beneficiaries after integration?
   - If better able, what are some of the reasons that they are better able? Which services are they better able to provide `
   - If less able, what are some of the reasons they are less able? Which services do they less capacity to provide?

10. Do you think integration has given *activistas* more work than they had before/the same amount of work than they had before/less work than they had before? Please explain your response (more time to do their work, more training to do their work etc.)?

11. What have been the benefits of an integrated approach? Are they what you/others expected they would be? Why/why not? Probe: what are the benefits for
    - Beneficiaries and their families
    - Program staff, including *activistas*

12. What have been the challenges to integration? Are they what you/others expected they would be? Why/why not? Probe: what are the challenges for
    - Beneficiaries and their families
    - Program staff, including *activistas*

13. Do you think OVC and HBC beneficiaries have been affected equally? Meaning, do you think OVC and HBC receive equal attention under the integration model? Why? Why not?

14. How do you think integration has affected your working relationship with SDSMAS? The health system? Other partners?

15. If you could change anything about the current integrated activista model, what would it be?

16. What can other CBOs learn about integration in their work? Would you recommend they replicate the integration process that was done under PCC? Are there certain things that you would suggest they do differently?
17. Anything else you would like to share?

Thank you for your time and willingness to participate in this study. Again you can contact me at [include contact information] if you have any questions or comments at a later date.

Focus Group Discussion Guide: *Activistas*

Date of FGD:	**Start Time:**	**End Time:**
FGD Moderator: **FGD Note taker:**		
Community Based Organization: **District:**		
Total Number of *Activistas*: ____ **[Note to facilitator: ask *activistas* to raise their hand if they fall into the following category, then record the number of *activistas* per category]** **a. # of *activistas* previously [before integration] OVC *activistas*: ____** **b. # of *activistas* previously [before integration] HBC *activistas*: ____** **c. # of new *activistas* (have only been an activista since integration): _____**		

OVC Care and Support in Different Types of Households

1. Can you describe how you identify OVC in a household? [Probe: does the CBO give you a list of households and/or a list of OVC in those households? If so, how is that list created? Is every child in a household with an HBC client included as an OVC needing care and support or just some? How do you decide which children to provide care for?]

2. Please describe who an HBC client is. [Probe: are HBC clients only those who are HIV+? Are there other categories of illness for HBC clients? When does an HBC client "graduate"? How do you determine this?]

3. When you are working with a household where you provide HBC to one or more clients, how frequently do you visit that home? When visiting a home with both HBC and OVC clients, how long do you usually stay? How do you prioritize whom to see first? How much time do you spend with the HBC client(s) and the OVC clients?

4. What happens when an HBC client "graduates"? Does the frequency of visits change? Does the amount of time you spend with the OVC in that household change? How about the amount or type of services provided? How does this change? Describe the extent to which you can meet the needs of the OVC once the HBC client graduates.

5. Do you ever visit OVC living in households where they are no HBC clients who have ever been served? How common is this? How are OVC in those households identified? Describe the services provided to these OVC, compared to OVC in HBC active and HBC graduated households.

6. Do you think you are reaching all of the OVC in the community where you work? [probe: are you reaching all of the OVC? Just some? If not all, why not all? What are some of the challenges you experience in reaching the OVC?]

Training and Preparation

7. Describe how prepared you are to provide care and support to OVC. [Probe: are you able to identify their needs? Are you able to respond to their needs appropriately? Why? Why not? Was the training you received adequate? Why? Why not? Why additional skills do you need to support OVC?]

8. Describe what type of supervision and/or technical support you receive for your work with OVC. [Probe: Is this type of support/supervision adequate? Why? Why not? What additional types of support or technical assistance would be helpful?]

9. Describe how prepared you are to provide care and support to HBC clients. [Probe: are you able to identify their needs? Are you able to respond to their needs appropriately? Why? Why not? What additional skills do you need to support HBC clients?]

10. Describe what type of supervision and/or technical assistance you receive for HBC clients. [Probe: Is this type of support/supervision adequate? Why? Why not? What additional types of technical assistance would be helpful?]

Impressions of Integration

11. [Direct question to those who were OVC volunteers before integration] For those of you who have been *activistas* for more than three years, describe the difference in how you are able to provide services to OVC now compared to before. Would you say you can do more for them, about the same, or less for the children than before? Why? How do you feel about adding HBC clients to your caseload? Has it made your worker harder, about the same, or easier than before? How has your workload changed? What would help you do your job better?

12. [Direct question to those who were HBC volunteers before integration] For those of you who have been *activistas* for more than three years, describe the difference in how you are able to provide services to HBC now compared to before. Would you say you can do more for them, about the same, or less for the HBC clients than before? Why? How do you feel about adding vulnerable children to your caseload? Has it made your worker harder, about the same, or easier than before? How has your workload changed? What would help you do your job better?

Activista Self-Administered Survey

Survey Questionnaire for Activists: Evaluation of Community Care Services Offered to Orphans and Vulnerable Children in the context of the Integrated Home-Based Care (HBC) and Support to Orphans and Vulnerable Children (OVC)

To be completed by *Activistas*:

Age (How old are you?): _____

Neighborhood(s) that you work in: _____

Part A.

Please answer the following questions by circling the response that best reflects your experience and opinion.

A1. How many years have you worked as an activista with this organization (CBO)?

1. Less than a year
2. Between one and three years
3. More than three years

A2. Did you work as an activista at another organization before this one?

1. Yes. For how many years? _____
2. No

A3. Do you currently provide support services for vulnerable children (OVC) as an activista?

1. Yes
2. No

A4. Do you currently provide services for adults in need of home-based care (HBC) as an activista?

1. Yes
2. No

A5. Have ever worked as an activista supporting ONLY orphans and vulnerable children (OVC)?

1. Yes
2. No

A6. Have you ever worked as an activista supporting ONLY adults in need of home-based care (HBC)?

1. Yes
2. No

A7. Type of Assistance Provided to Households Served and Frequency of Visits

Please take a moment to think about the type of assistance and households you provided services for in the last 12 months as well as on the frequency of visits. Please use the appropriate coding. *Please note that*

question A8, option 4 "not applicable" should only be selected if you have not worked with this type of household in the last month.

Target Group	**A7. Did you work with this household type in the last month?** **1.Yes** **2.No**	**A8. In the last month, on average how often did you visit this type of household?** **1. Twice a week or more** **2. Once a week** **3. Every two weeks** **4. Not applicable**
a) Households with only adults receiving home-based care services (HBC) (no children are receiving support from you in the household)		
b) Households with orphans and vulnerable children (OVC) receiving support services in a household where an adult once received home-based care (HBC) services, but no longer does		
c) Households where you currently only provide services to orphans and vulnerable children (OVC) living with adults that never received home-based care (HBC) services from you		
d) Households where both vulnerable children (OVC) and adults (HBC) are receiving care services		

Part B.

Second Part: Workload

B1. In a household where you have both OVC and HBC beneficiaries, which client type usually takes up most of your time during a household visit? Select only one response.

1. OVC beneficiaries
2. HBC beneficiaries

B2. In a full workweek, which client type usually takes up most of your time? Select only one response.

1. OVC beneficiaries
2. HBC beneficiaries
3. Mothers
4. *Busca activa* clients

B3. In a full workweek, which client type usually takes up least of your time? Select only one response.

1. OVC beneficiaries
2. HBC beneficiaries
3. Mothers
4. *Busca activa* clients

B4. How many days a week do you currently spend working as an activista for your current CBO? Select only one response.

1. Two days or less
2. Three days
3. Between four or five days
4. More than five days

B5A.	**B5B. Do you think you have sufficient time in the week to complete all of your planned activities […] as an activista?** **1- Yes; 2- No**
1. Working with OVC beneficiaries	
2. Working with HBC beneficiaries	
3. Working with pre/post partum mothers	
4. Working with *busca activa* clients	

B6. If you do not have sufficient time each week to complete all your planned activities, what activities do you wish you had more time for in relation to the four groups listed in question B5A?

_____

_____

_____

Capacity

B7. As an activista, how well prepared do you feel to provide care and support to adults in need of home-based care on a scale of 0 to 20? _____

0-5 Not prepared at all
6-9 Ill prepared

10-13 Reasonably / Sufficiently prepared
14-16 Prepared
17-20 Very prepared

B8. As an activista, how well prepared do you feel to provide care and support to children on a scale of 0 to 20? _____

0-5 Not prepared at all
6-9 Ill prepared
10-13 Reasonably / Sufficiently prepared
14-16 Prepared
17-20 Very prepared

B9. Have you ever attended any training on the provision of HBC and/or care and support to OVC for your work as an activista?

1. Yes
2. No

B10. When did you last attend training on HBC and/or OVC support to strengthen your capacity to work as an activista?

1. Less than one year ago
2. Between one and three years ago
3. More than three years ago
4. Don't remember
5. I have never attended this type of training

To answer questions 11 – 16, please describe the last training you attended on OVC support and/or HBC, regardless of it was held during a regular workday or away from your workplace. If you did not attend training, please circle option four in question B11 indicating "did not attend training"; the interview will come to an end at this point.

B11. Received training on (circle the correct option):

1. Support to Orphans and Vulnerable Children
2. Home-Based Care
3. Did not attend training – **If none, you may end the interview**

B12. How long did the training last?

1. Less than one day
2. One day
3. Two or more days
4. Did not attend this type of training

B13. In that training, how much time was given to OVC support?

1. Less than one day
2. One day

3. Two or more days
4. OVC support was not included in the training
5. Did not attend this type of training

B14. In that training, how much time was given to HBC?

1. Less than one day
2. One day
3. Two or more days
4. HBC was not included in the training
5. Did not attend this type of training

B15. Who led the training? Please indicate everyone who presented topics or facilitated discussions during the training. Do not include people who only opened or closed the training sessions.

a. Fellow activista(s)
b. Supervisor or leader of my CBO
c. Government official(s)
d. Other program official(s) outside of my CBO
e. Someone else (please explain) _____
f. Don't know
g. Did not attend training

B16. Please circle all topics that were covered during the training:

a) Basic nursing care
b) Skill transfer
c) ART, TB or OI adherence support
d) Malaria prevention
e) Nutritional support
f) Nutritional education
g) Cooking demonstrations
h) Basic psychosocial counseling
i) Homework support
j) Reintegration at school
k) Demonstrations on how to care for vegetable gardens
l) Awareness-raising on child rights
m) Don't remember
n) Did not attend training

Thank you for your time! If you have any questions or doubts about this questionnaire please contact the Research Coordinator.

Household Questionnaire

Instructions

This cover letter serves two purposes:

1. The first table in this questionnaire should be filled out prior to visiting each household. Your supervisor will complete it with essential information on the household to help you locate it.

2. The second table will be filled in by the survey administrator. It indicates the number of times the surveyor visits households to interview intended respondents. It is of utmost importance that the information in the table is correct. Your supervisor will verify if you visited each household at least three times before looking for a substitute household. Make sure that you do not leave any blank spaces / questions unanswered.

The survey questionnaire can only be filled in when interviewing a qualified respondent. When you reach the household, ask to speak with the main guardian. If the main guardian is a child (an individual under 18) and no other adult in the household can be interviewed, please do not proceed with the interview; rather take note of the situation in the table(s) below. In the event that the main childcarer is seriously ill / unable to participate in the interview, ask to speak with another adult in the household capable of answering the questions in this questionnaire.

In general, the survey requires that you only interview one individual per household. However, it is possible that you find the need to speak to other household members to obtain certain pieces of information.

1. Identification

To be filled in by the supervisor prior to visiting each household

<u>Supervisor:</u> Part of the information will be obtained at the CBO (neighborhood, activista code) and others from AGEMA (code, name of the CBO, household code, name of the activista).

A001	Survey code	
A002	Province 1-Sofala 2 - Manica	
A003	District	
A004	Neighborhood	
A005	Name of the Community Based Organization (OCB)	
A006	Household code	
A007	Name of the activista providing support to this household	
A008	Code allocated to the activista providing support to this household	

2. Number of Times the Surveyor Visits the Household to Conduct the Interview

To be filled in by the surveyor after each household visit

	VISIT 1	VISIT 2	VISIT 3
Date (day/month/year)			
Surveyor code and comments			

Codes for surveyor use: Interview completed = 1; Interview scheduled for later in the day = 2; Meeting scheduled for another day = 3; Did not accept to participate, did not set up a meeting = 4; Had to interview another adult in the household = 5; Needed to schedule an interview with another adult in the household for later as he/she was not present = 6 (and use Table 3 below); The main childcarer is aged 18 or under = 7; Other (explain) = 8.

3. Attempts to Interview a Second Person in the Household

To be filled in by the surveyor only if the response to question 006 is "yes" and the new respondent is not at home.

	VISIT 1	VISIT 2	VISIT 3
Date (day/month/year)			
Surveyor code and comments			

Codes for surveyor use: Interview completed = 1; Interview scheduled for later in the day = 2; Meeting scheduled for another day = 3; Did not accept to participate, did not set up a meeting = 4; Other (explain) = 5.

A009	Surveyor	A) Code	B) Name
A010	Date in which the interview was carried out (day/month/year)		
Comments			

Interview starting time [_____|_____:_____|_____]

Supervisor: **Signature_____ Date _____**

Comments

Thank you very much for agreeing to talk to me today.

No.	Questions and Filters	Responses / Coding	Skip to
B001	To start with, please tell me how many people currently live in this house with you?	___ ___ People	
B002	Do any children or youth under 18 live in this house?	Yes...1 No...2	 End of the interview
B003	Does a pregnant woman live in this house?	Yes...1 No...2 Do not know....3	
B004	In the last 12 months has anyone in this household ever been visited by a community activista?	Yes...1 No...2 Do not know....3	→ B006 End of the interview → B005
B005	Is there another adult in the household that could provide information on the visits received from community *activistas*?	Yes...1 *Ask to talk with the person now, continue the interview with that person. Obtain informed consent from the new interviewee in this household.* *If the person is not currently at home, agree on a suitable time for you to return to interview him/her (and obtain informed consent). Make sure to register the number of attempts in the cover sheet.* No...2 *If there is not another person who can be interviewed, thank the person that you are talking to and do not continue with the interview.* Do not know...3	 End of the interview → Return at another suitable time to try to speak to another adult

No.	Questions and Filters	Responses / Coding	Skip to
B006	**In the last 12 months**, have any adults (members aged 18 or over) in this household received home-based care services, even if he or she is now deceased or has since moved away?	Yes...1 No...2 Do not know....3	
B007	**In the last 12 months**, have any children or youth under 18 in this household been visited by an activista, even if he or she is now deceased or has since moved away?	Yes...1 No...2 Do not know ...3	
B008	When was **the last time** a community activista visited this household?	In the last week...1 In the last 30 days...2 Between 30 – 60 ago...3 --- It has been more than 60 days....4 I can´t remember...5 Do not know...6	--- End of the interview
B009	Where you in the house during that the last visit received from the activista?	Yes...1 No...2 I can´t remember/don´t know....3	→B011
B010	Is there another adult in the household who could better inform on the last visit received from the community activista?	Yes...1 *Ask to talk to the person now and thus continue with the interview with him/her. Obtain informed consent from the new person that you will interview in this household.* *If the person is not currently at home, agree on a suitable time for you to return to interview him/her (and obtain informed consent). Make sure to register the number of attempts in the cover sheet.* --- No...2 *If there is not another person who can*	--- End of the interview

No.	Questions and Filters	Responses / Coding	Skip to
		be interviewed, thank the person that you are talking to and do not continue with the interview.	
B011	What is the name of the activista that last visited you? What CBO organization does he work with?	Activista name: _____ CBO: _____ ☐ Does not know the activista´s name ☐ Does not know the name of the CBO	
B012	**<u>In the last visit</u>** received from the activista, which of the following services did he/she actually provide? *[Please read the list and indicate yes, no or do not know for each type of service]*	1. Nutrition education Y N DNK 2. Support for community vegetable garden Y N DNK 3. Cooking demonstration Y N DNK 4. Referral to income generation activities Y N DNK 5. Provision of a family health kit Y N DNK 6. Gave you a mosquito net Y N DNK 7. Rehabilitated your home Y N DNK 8. Helped you get your poverty certificate Y N DNK 9. Others (*please describe*): _____ _____ _____	
B013	**<u>In the last visit</u>** received from the activista, did he/she provide home-based care services to an adult who was chronically ill?	Yes...1 No...2 Do not know …3	 →B015 →B015
B014	How many adults received home-based care services from the activista in his/her **<u>last visit</u>** to this household?	___ adult(s)	
B015	Do you think that the activista had enough time to provide home-based care services to all	Yes...1 No...2 Do not know …3	

No.	Questions and Filters	Responses / Coding	Skip to
	of the adults that required it in his/her **last visit** to the household?	No adults in the household require home-based care services	→B018
B016	How often does the activista visit this household to provide home-based care services to all of the adults requiring it?	Daily……1 Weekly……2 Every two weeks……..3 Once a month……4 Other _____…….5	
B017	How often do you think the activista should visit adults who are chronically ill?	Daily……1 Weekly……2 Every two weeks……..3 Once a month……4 Other _____…….5	
B018	**In the last visit** received from the activista, did he/she provide services to a pregnant woman?	Yes...1 No...2 Do not know …3	

B019	Could you please give us the names of the children and youth under 18 that live in this house, starting with the eldest?		[Name] Girl or boy? *1: Boy* *2: Girl*	How old is he/she [Name]? *Fill in the age on the left, and the unit (years or months) on the right.* *Age*	*Unit* *1-Years* *2-Months*
	1				
	2				
	3				
	4				
	5				
	6				
	7				
	8				
	9				

B020	How often does the activista visit children under 18 in this household?	Daily……1 Weekly……2 Every two weeks……..3 Once a month……4 Other _____…….5	B022

No.	Questions and Filters	Responses / Coding	Skip to
B021	How often do you think the activista should visit children under 18 in this household?	Daily……1 Weekly……2 Every two weeks……..3 Once a month……4 Other _____…….5	
B022	**In the last visit** received from the activista, did he/she provide services to a child or youth under 18?	Yes...1 No...2 Do not know /can´t remember …3	→ B024 → B030
B023	Could you explain why the activista did not provide support to any children in this household in his/her last visit? Circle all applicable responses	Children were not at home during the visit…….1 Children did not need services at the time of the visit….2 The activista did not have time….3 I don't know……..4 Other……5 (specify): _____ _____	All of the above → B030

No.	Questions and Filters	Responses / Coding	Skip to
B024	What are the names of the children and youth that received support services from the activista in his/her **last visit** to this household [*For each name, note the corresponding line from question 19*]		

NOME DE CADA CRIANCA *(anote cada nome abaixo)*	ULTIMA NUMERO DO CODIGO DO QUESTIONARIO									
		1	2	3	4	5	6	7	8	9	0
	1	1	1	1	1	1	1	1	1	1	1
	2	1	1	2	2	1	1	2	2	1	1
	3	3	2	1	3	2	1	3	2	1	3
	4	2	3	4	1	2	3	4	1	2	3
	5	5	4	3	2	1	5	4	3	2	1
	6	1	2	3	4	5	6	1	2	3	4
	7	7	6	5	4	3	2	1	7	6	5
	8+	1	2	3	4	5	6	7	8	1	2

B025	Using the Kish Grid attached, select one of the children that received support during the last visit from the activista _____ _____ Child´s name *(Foremane(s))* Line number *(question B019)* Now, I would like to ask you a few questions only about [*name*]:	

No.	Questions and Filters	Responses / Coding	Skip to
B026	Which of the following services did the activista actually provide to [*child´s name*] in his/her last visit? *[Please read the list and indicate yes, no or do not know for each type of service]*	1. Referred for food (MMAS, WFP etc.) Y N DNK 2. Referred for or directly supplied school supplies, such as uniform, books, pencils or notebooks Y N DNK 3. Referred for school fees Y N DNK 4. Provided school fees Y N DNK 5. Supported returning to school– helping sign [*Child's Name*] up for school Y N DNK 6. Provided homework help Y N DNK 7. Referral to nearest health care center Y N DNK 8. Provided health advice/expertise Y N DNK 9. Spent time talking to [*Child's Name*] about his/her feelings Y N DNK 10. Referred [*Child's Name*] to spiritual leader Y N DNK 11. Referred [*Child's Name*] to Kid's Club Y N DNK 12. Other (describe): _____ _____	
B027	How often does the activista visit [*Child's Name*]?	Daily……1 Weekly……2 Every two weeks……..3 Once a month……4 Other _____…….5	B029
B028	How often do you think the activista should visit [*Child's Name*]?	Daily……1 Weekly……2 Every two weeks……..3 Once a month……4 Other _____…….5	
B029	In reference to all members of this household, do you think the activista had enough time to provide support to all the children in the household requiring it in his/her **last visit**?	Yes...1 No...2	→ B031
B030	What else did the child(ren) / youth require in that **last visit** received from the activista?	_____ _____	
B031	In the last two months (60 days) and in addition to the	Yes...1 No...2	→The end

No.	Questions and Filters	Responses / Coding	Skip to
	visit from the activista that we have already talked about who works with [*nome da OCB*], did the household receive other visits from *activistas* from other community organizations or the government?	Do not know …3	→The end
B032	What is the name of the organization that the activista is affiliated to?	_____ ☐ Does not know the name	

Is there anything else you would like us to know today about your activista or the services you receive?

_____
_____
_____
_____

Thank you very much. Those are all the questions I have for you today.

Time at the end of the interview [_____|_____:_____|_____]

Kish Grid

NAME OF EACH CHILD *(write the name of each child below)*

LAST DIGIT OF THE SURVEY CODE

	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**0**
1	1	1	1	1	1	1	1	1	1	1
2	1	1	2	2	1	1	2	2	1	1
3	3	2	1	3	2	1	3	2	1	3
4	2	3	4	1	2	3	4	1	2	3
5	5	4	3	2	1	5	4	3	2	1
6	1	2	3	4	5	6	1	2	3	4
7	7	6	5	4	3	2	1	7	6	5
8+	1	2	3	4	5	6	7	8	1	2

Appendix B – Household Data Analysis Methods

To prepare the Integration dataset for the analysis, we conducted the following steps:

- filtered out the HH that do not meet the selection criteria to begin the interview: b002=no and/or b004=no;
- selected only the HH with a visit in the last 60 days (b008<4);
- excluded one duplicate record (deleted ID 241457, A006=8204 and kept ID 231457, A006=8034)
- excluded records where a respondent was not present in the house during that the last visit received from the activista (b009=2) and there was no another adult in the household who could better inform on the last visit received from the community activista (b010=2 or missing).

As a result, our sample reduced from 350 to 311 observations. We cleaned the dataset by re-coding values for some of the variables:

- We examined cross-tab b006 x b013. If b013=1, b006 should also = 1. We recoded b006 where necessary.
- We examined cross-tab b007 x b022. If b022=1, b007 should also = 1. We recoded b007 where necessary.
- We examined cross-tab b003 x b018. If b018=1, b003 should also = 1. We recoded b003 where necessary.
- We found one record (ID 951340. A006=823) had b013=2 but b014=1. We re-coded b013 to "1" for this record.

We merged the HH integration data with data on sex and age of the index child.

Preparing a child file for the analysis

We prepared a child file by merging data on children visited last time and children's age and sex with the HH integration data. For child age, we used data on age units to create the age variable in years. There were 71 records with age specified in months, range equal to 0-20. We assigned the age of "1 year" to all children who were younger than 20 months. We created five categories for age - 0-4, 5-9, 10-14, and 15-17. There were 10 children who were 18 years old in the dataset. We excluded them from the analysis.

While working on the child file, we cleaned it the following way:

- We noticed that record ID 372226 was repeated twice in the b19 file on age. We deleted this duplicate from the child file.
- We deleted record 211340 as not having any children since B022=2, b07=1 for this HH but no children were listed in b19 file.

- One child (ID 12218, line#2 in b19) had name missing in b0251 (=99), order in b0252=2 and all questions in b26-29 missing. We treated questions b0251 and b0252 as missing for this child.
- The index child in ID 361340 was indicated as order #1 in b24 and as order #6 in the b19 file. We listed this child as order #6 in b24.
- The index child in ID 581340 was indicated as order #1 in b24 but as order #2 in b19. We listed this child as order #2 in b24.
- The child in ID 681462 had order #1 in b24 and order #5 in b19. We listed this child as order 5 in b24.
- The child in ID 751340 was listed as order #1 in b24 but order #2 in b19. We listed this child as order #2 in b24.
- One child in ID 811340 was listed as order #2 in B24 but as order#1 in B0252. We listed this child as order #2 in b24.

List of variables

The following is the list of variables used for the household questionnaire data analysis.

Age_new	Age in years (continuous variable created based on variables “age” and “unit”)
Age_cat_n	Child age categories 1=0-4 years old 2=5-9 years old 3=10-14 years old 4=15-17 years old
Age_school	5-14 years old vs. other ages 0=”age<5 or age>14” 1=”age 5-14”
b008nn	Last time a community activista visited HH 1= In the last week 2= In the last 30 days 3= In the last 30-60 days
b02613_y	Counseling services provided to the index child at last visit 1=Yes 0=No
B19COUNT	number of children <18 in HH
b24count	Number of children in the HH served at the last visit
B24visit	Child attended on last visit 1=Yes 0=No

Index_yn	Index child or not 1=Yes 0=No

HH services at last visit:

b0121_y	Nut (Nutrition Education) 1=Yes 0=No
b0122_y	Veg (Support for community vegetable garden) 1=Yes 0=No
b0123_y	Cooking (Cooking demonstration) 1=Yes 0=No
b0124_y	IG (Referral to income generation activities) 1=Yes 0=No
b0125_y	Health kit (Provision of a family health kit) 1=Yes 0=No
b0126_y	Mosquito net (Gave you a mosquito net) 1=Yes 0=No
b0127_y	Rehabilitated home (Rehabilitated your home) 1=Yes 0=No
b0128_y	Poverty certificate (Helped you get your poverty certificate) 1=Yes 0=No
famserv	Any service (Any HH services at last visit created based on the variables b0121_y, b0122_y, b0123_y, b0124_y, b0125_y, b0126_y, b0127_y, b0128_y) 1=Yes (at least one of the HH services variables equals “Yes”) 0=No (all HH services variables equal “No”)
Index_yn	Index child or not 1=Yes 0=No

Services received by index child at last visit:

b0261_yn	Food support (created based on the variable b0261) 1=Yes 0=No
sch26_yn	School services (created based on the variables b0262, b0263, b0264, b0265, b0266) 1=Yes (at least one of the school services variables equals “Yes”) 0=No (all school services variables equal “No”)
health26_yn	Health services (created based on the variables b0267, b0268) 1=Yes (at least one of the health services variables equals “Yes”) 0=No (both health services variables equal “No”)
psyc26_yn	Psychosocial services (created based on the variables b0269, b02610, b02611, b02613_y) 1=Yes (at least one of the psychosocial services variables equals “Yes”) 0=No (all psychosocial services variables equal “No”)
Target06	Services were received in the last 12 months 1=Only HBC (b006=1 and b007=2) 2=Only OVC (b006=2 and b007=1) 3=Both HBC and OVC (b006=1 and b007=1) 4=No HBC and No OVC (b006=2 and b007=2)
Target13	Services provided at last visit 1=Only HBC (b013=1 and b022=2 or 3) 2=Only OVC (b013=2 and b022=1) 3=Both HBC and OVC (b013=1 and b022=1) 4=No HBC and No OVC (b013=2 and b022=2)
HBC status	1= Graduated HBC: did not get HBC on last visit (only OVC OR no HBC no OVC; Target13=2 or 4) 2= Transitioning HBC: last visit > last week ago (b008=2 or 3) AND got HBC on the last visit (b013=1) 3= Active HBC: last visit in last week (b008=1) AND got HBC on the last visit (only HBC or both HBC and OVC; Target13=1 or 3)
Grad	Graduated HBC: did not get HBC on last visit (only OVC OR no HBC no OVC; Target13=2 or 4) 1=Yes 0=No
Trans	Transitioning HBC: last visit > last week ago (b008=2 or 3) AND got HBC on the last visit (b013=1) 1=Yes 0=No

ActiveHBC	Active HBC: last visit in last week (b008=1) AND got HBC on the last visit (only HBC or both HBC and OVC; Target13=1 or 3) 1=Yes 0=No

This is the list of the existing dataset variables used for the analysis:

A002	Prov (Province) 1=Sofala 2=Manica

MEASURE Evaluation

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http://www.cpc.unc.edu/measure/