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Case Study on Strengthening Referral Systems for Children Orphaned or Made Vulnerable by HIV (OVC)

USING A SYSTEMS APPROACH AT THE COMMUNITY-LEVEL IN A HUMAN RESOURCE CONSTRAINED CONTEXT

The YouthPower Action Project in Mozambique

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List of Acronyms

ART	Antiretroviral therapy
CAI	Integrated Support Centre for Victims of Violence (*Centro Integrado às Vítimas de Violência)*
CBO	Community-based organization
CCP	Community care project
CCPC	Community child protection committee
CPC	Child protection committee
CSI	Child status index
DPMAS	Provincial Directorate of Women and Social Affairs
ES	Economic strengthening
FGD	Focus group discussion
GoM	Government of Mozambique
GT-COV	Technical working group on OVC (*Grupo tecnico – crianças órfãs e vulneráveis*)
FHI 360	Family Health International 360
IP	Implementing partner
INAS	National Institute for Social Action (*Instituto Nacional da Acção Social*)
INSIDA	National Survey on AIDS (*Inquérito Nactional de Prevalência, Riscos Compartamentais e Informação sobre o HIV e SIDA em Moçambique)*
KII	Key informant interview
OVC	Orphans and vulnerable children
MISAU	Ministry of Health
MGCAS	Ministry of Gender, Children and Social Action (formerly known as MMAS)
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
SAAJ	Youth-friendly services (*Serviços Amigos Adolescentes e Jovens)*
SDSMAS	District Service of Health and Social Affairs (*Serviço Distrital de Saude, Mulher e Acção Social)*
VSLG	Village saving and loan group
YP	YouthPower Action (program)

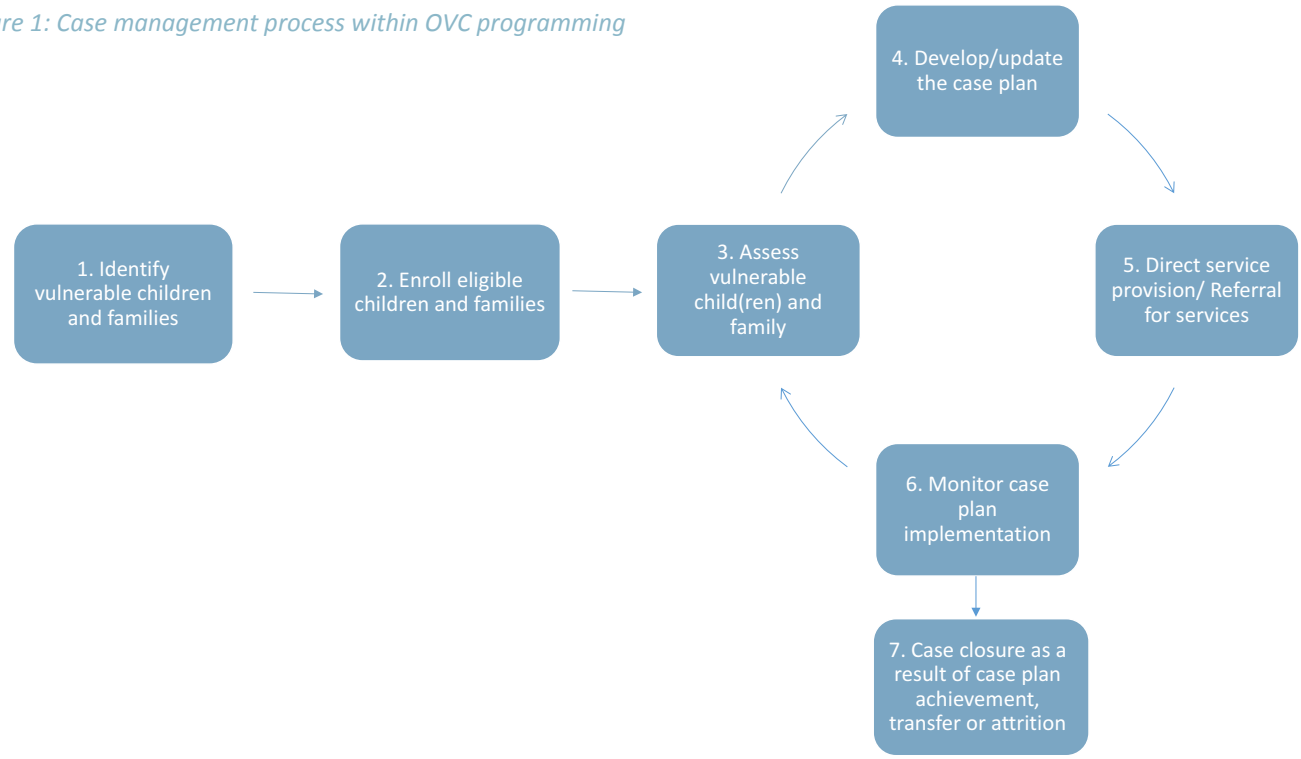
Objectives of the case study

In the context of Orphans and Vulnerable Children (OVC) programming, a referral is the process of directing a client to a service that the client requires, but is not offered by the referring service provider. Referrals include self-referral (e.g., the client calls a helpline to request services on his or her own behalf) or a referral from a service provider (e.g., a social worker refers a caregiver to a health clinic for HIV testing). Within OVC programming, direct service referrals from one service provider to another are most common. These referrals can occur within the same sector (e.g., from a health center to another larger or more specialized health facility) and between sectors (e.g., from a social service provider to a health provider). Referrals between the health sector and social service system are especially relevant given that children and families affected by HIV and other adversities tend to have multiple vulnerabilities that require services provided by both sectors. A health facility may refer a child affected by HIV to a program for OVC to address a range of psycho-social needs, and an OVC program may refer a child affected by HIV to a health facility for HIV services, such as testing and counseling. Referrals are supported by a referral system. This can be understood as the identified steps or processes that enable a referral to progress from initiation to completion. When a referral mechanism works well it can result in reduced duplication of services, improved cost-effectiveness, higher quality services offered by service providers with expertise and/or experience in specific technical areas (e.g., household economic strengthening), and, ultimately, a more holistic approach to improving the well-being and protection of all members of a household and higher client satisfaction.

To date, some government systems and civil society organizations have developed tools and approaches that support effective referrals mechanisms.[1] Models that have been utilized in OVC programming include but are not limited to the "hub and spoke" model, the network model and utilization of referral liaisons and the case-conferencing model. With more focus on leveraging OVC program platforms to improve pediatric HIV case identification, testing and treatment, highlighting promising practices, including relevant tools for functional, bi-directional referrals, is critical to strengthening the continuum of care among OVC.

The overall objectives of the case study are to highlight and help promote good practice related to referral mechanisms within orphans and vulnerable children (OVC) programming. The case study delineates what is involved in the process of developing and implementing one type of referral mechanism, the positive results of effective referrals and some of the challenges faced when developing and implementing such a mechanism within an OVC program. The information presented should be understood as just one example of a referral mechanism in practice. This case study presents a program in Mozambique that could be identified as a hub and spoke model of referral mechanism. The *activista* (a type of case worker) acts as a first point of entry for the target population of vulnerable adolescents into the social service system. The activista is responsible for assessing and determining the services that are required, either delivering

Figure 1: Case management process within OVC programming



1 MEASURE Evaluation (2013). Referral Systems Assessment and Monitoring Toolkit; Roelen, Long and Edstrom (2012). Pathways to protection-referral mechanisms and case management for vulnerable children in Eastern and Southern Africa. Lessons learned and ways forward.

them on behalf of the program she serves or referring to other service providers. Interestingly, there are also aspects of a network referral mechanism within the program as it involves many different organizations and service providers who are all providing services to the same target population based on commonly agreed-upon criteria.

Any case management system and referral mechanism should be adapted to best reflect the context in which they are utilized, the target population served and the programmatic needs of the implementer[s]. The case study is one in a series of case studies highlighting different aspects of a case management system and referral mechanisms utilized by OVC programs. The case studies aim to provide useful information that can inform the work of policymakers and practitioners engaged in programs serving vulnerable children and families. In particular, the case studies on referral mechanisms are targeted to government, especially Ministries of Health and Social Welfare, and OVC implementing partners to highlight ways of improving referrals among and between sectors, especially between the health and social service sectors.

The case study has been developed based on the review and analysis of 17 documents, including tools, programming documentation and peer-reviewed literature, as well as the Mozambican legal and policy framework on child protection and social welfare. In addition, 22 key informant interviews (KIIs) and focus group discussions (FGDs) were conducted with FHI 360's YouthPower Action program from 17–22 January 2016 in two provinces of Mozambique (Maputo and Sofala) with a total of 219 people. The focus of both the KIIs and FGDs was to identify promising practices and lessons learned regarding how the program contributes to the broader government-led referral systems for vulnerable children and youth at the community and district levels. The visits focused on collecting information from primary sources, including the YouthPower Action senior management team, implementing partners (IPs), district- and provincial-level government, community actors (including community child protection committees) and beneficiaries. These were also opportunities to review referral system tools used at the community level and tools used by IPs to collect and analyze data. Furthermore, training materials and some related group work outputs were reviewed. (Please see Annex for a list of documents reviewed).

The situation of vulnerable children and youth in Mozambique

POVERTY AND VULNERABILITY IN MOZAMBIQUE

Mozambique has a strong legal and policy framework aimed at addressing poverty and its impact on children. Mozambique has ranked among the top ten fastest growing economies in the world. However, with a Gross National Income per capita of USD 600,[2] it remains one of the world's poorest and least developed countries. As a response, the national framework targets the 55 percent of the population who live below the poverty line, and focuses on improving the coverage of and access to basic health and other essential services by vulnerable populations. Children constitute more than half (52 percent) of the population.[3]

The impacts of poverty are compounded by the impact of HIV and AIDS. Mozambique has the eighth highest prevalence in the world, with 11.5 percent of the population (15-49 years) living with HIV. The first, and most recent, national household survey on HIV and AIDS (INSIDA) found that more women were infected than men (13.1 percent and 9.2 percent respectively) within this age group.[4] There has been a decrease in new infections, but the absolute number of people living with HIV has been rising. This trend is likely to continue as higher treatment coverage reduces mortality. Of the estimated number of PLHIV, approximately 54 percent are in care, and 40 percent are currently on antiretroviral therapy (ART).[5] The number of people on ART has increased threefold since 2011 as a result of the rapid expansion of MISAU-supported health facilities offering ART. Despite progress in access to ARVs and preventing mother-to-child transmission services, the coverage rate for children remains extremely low, at only 36 percent.[6] The low coverage rate for children is reflected in the lower prevalence rate of 1.0 percent found among 5-to-9-year-olds. INSIDA found a prevalence of 1.4 percent in children ages newborn to 11, with rates varying between different age groups. Among children under a year old who were perinatally infected, a prevalence of 2.3 percent was found;[7] an estimated 110,000 children ages newborn to 14 live with HIV.[8]

The proportion of children orphaned due to HIV and AIDS has risen. Between 2003 and 2011, the proportion of children who are orphans of one or both parents due to AIDS rose by almost a third, from 10 percent to 13 percent. Double orphans, who have lost both their parents, constitute a small subset of these children, but their numbers have also risen during the same time period (from 1.3 percent to 1.7 percent). There are an estimated 590,000 orphans as a result of AIDS ages newborn to 17 years,[9] comprising approximately one third of Mozambique's total number of OVC, of whom there are approximately 2.1 million.[10] There remains a significant gap between the existence of a child rights-based legal and policy framework and the actual realization of Mozambican children's rights as evidence by the selected indicators related to child protection:

- 48 percent of children under age five have a birth certificate;
- Over 20 percent of children ages 5 to 14 are engaged in child labor;

2 Data retrieved from World Bank. Data by country: Mozambique.
3 UNICEF (2014). Situation analysis of children in Mozambique 2014.
4 Ministry of Health (2009). *National Survey on AIDS* (known by its Portuguese abbreviation, INSIDA).
5 U.S. President's Emergency Plan for AIDS Relief Country Operational Plan 2015.
6 CNCS (2014). Global AIDS Response Progress Report, *Conselho Nacional de Combate ao HIV e SIDA*, Maputo.
7 INSIDA (2009).
8 UNAIDS. HIV and AIDS estimates for Mozambique 2015. http://www.unaids.org/en/regionscountries/countries/mozambique
9 UNAIDS.
10 UNICEF (2014).

- One of every two girls is married before she reaches 18, and one out of ten girls is married before the age of 15;
- 13 percent of children have lost one or both parents, but 18 percent of children do not live with either biological parent, even when one of the parents is living. Among 15-to-17-year-olds, 40 percent do not live with either parent, even though both parents are alive for 23 percent of these children;
- There is no national quantitative data regarding violence against children, except for data on domestic violence cases reported to the police. Only 36 percent of women who are survivors of physical or sexual violence seek any form of help, and it can be inferred that reporting of cases of violence against children is even lower;
- Disability affects one out of 15 people, and 26 percent of households include at least one member with a functional limitation.[11]

THE SOCIAL WELFARE WORKFORCE

While the last periodic report of the Government of Mozambique in 2008 was commended by the Committee on the Rights of the Child for the strengthening of the national legal framework for children, the Committee emphasized the need for an accompanying increase in state budget allocations for child and social protection programs, with particular emphasis on the need to bolster the Ministry of Women and Social Action (now the Ministry of Gender, Children and Social Action) in terms of financial, technical and human resources.[12] In subsequent years, the percentage of GDP allocated to social action programs run by MGCAS and its implementing arm, the National Institute for Social Action (INAS) has increased from 0.23 percent to 0.74 percent.[13] Coupled with an increase in budget is the heightened awareness of the role that social workers play in a well-functioning child protection system, and in particular, their roles at the community and district levels to support the poorest and most vulnerable children and households.

Despite the important strides made both financially and in understanding the need to boost the quality and quantity of social welfare actors and services at the decentralized levels, the capacity of the social welfare workforce remains significantly weak. For example, more than half of MGCAS district-level technical posts remain vacant.[14]

Under the ambit of systems strengthening, MGCAS (then the Ministry of Women and Social Action), with the technical and financial support of various non-government actors, spearheaded the development of community child protection committees (CCPCs) to build a community-based multisectoral response as a first point of contact to comprehensively address the needs of vulnerable children and families.[15] Developing these structures has been an important step to coordinating action for vulnerable children between and among services, including in relation to promoting referrals between sectors, as well as between administrative levels.

THE YOUTHPOWER ACTION PROGRAM

YouthPower Action (YP) is a short-term (September 2015-June 2016) USAID/PEPFAR-funded project implemented by Family Health International 360 (FHI 360) aimed at strengthening the capacity of families to care for and protect older OVC, and to strengthen the capacity of youth heads-of-households to care for their younger OVC siblings. In partnership with the Government of Mozambique Ministry of Health (MISAU) and Ministry of Gender, Children and Social Affairs (MGCAS) and civil society partners, YP Action builds on the work of the five-year USAID-funded Community Care Program (CCP).[16] The majority of the CCP's beneficiaries who fall in the 10-to-18-year age range are now part of the target population of the YouthPower Action program,[17] and they are envisaged to be part of the new program as well. For youth specifically, the program seeks to empower vulnerable adolescents and youth to build skills, assets and competencies to lead healthy lives and foster healthy relationships. Likewise, the YouthPower Action program supports actors at the community level to facilitate referrals to community-based structures and service providers, with the aim of strengthening families' and communities' capacities to care for and protect orphans and vulnerable children (OVC), adolescents and youth (10-to-18-year-olds), as well as youth-headed households (up to 29 years old) in Mozambique.

The YouthPower Action program differs from the CCP in that it brings a "youth lens" to family- and community-strengthening efforts: it aims to create greater awareness regarding the needs of adolescent girls and boys, and provides information, through supporting access to trainings and awareness raising, on how parents, caregivers and community members and youth can positively view this period.

The project has four envisaged results:

1. Increased knowledge and understanding of adolescent development, in particular how they relate to the seven basic services offered by MGCAS (psychosocial support, nutrition, child and legal protection, education, health, shelter and financial support) as enshrined in the National Minimum Standards of Care and Support (hereafter the Minimum Standards).[18] Gender and gender-based violence, alcohol and drugs,

11 UNICEF (2014) discusses the various types of methodologies used to reach these figures.
12 Committee on the Rights of the Child (2009). *Concluding observations: Mozambique*.
13 ILO/UNICEF (2014). *Budget Brief on Social Protection* [Draft].
14 República de Moçambique. *Estratégia Nacional de Segurança Social Básica* (ENSSB) II (2015-2024). *5 esboço. Maputo, Setembro* 2015, page 72. The ENSSB II, in section 7.3, further notes the need to undertake a needs assessment in terms of human resources at the provincial and district levels, and to accordingly develop a human resource plan.
15 Save the Children/*Ministério de Mulheres e Acção Social* (2010). Reference guide for the establishment and management of the Community Committees for Child Protection.
16 For more information on the Community Care Program, see L. Lovick, A.P. Ndapassoa, M. Abilio, G.G. João, S. Mahumana. Best Practice: Highly Integrated Community Care and Support in Mozambique. USAID, Mozambique; USAID. Community Care Program: Final Report, September 26, 2015. USAID, Mozambique; USAID (2015). Community Care Program: An evaluation of selected effects of the Community Care Program on OVC beneficiaries.
17 Youth Program also enrolls children from 0-9 years, but not at the same level that CCP did.
18 These standards were contextualized based on the Southern African Development Community's Minimum Package of care and support for orphans and vulnerable children and youth. The standards cover seven domains: health, food and nutrition, education, protection and legal support, shelter, psychosocial support and economic strengthening.

stigma and discrimination and economic strengthening (ES) also comprise key aspects of YP Action training on adolescent development.

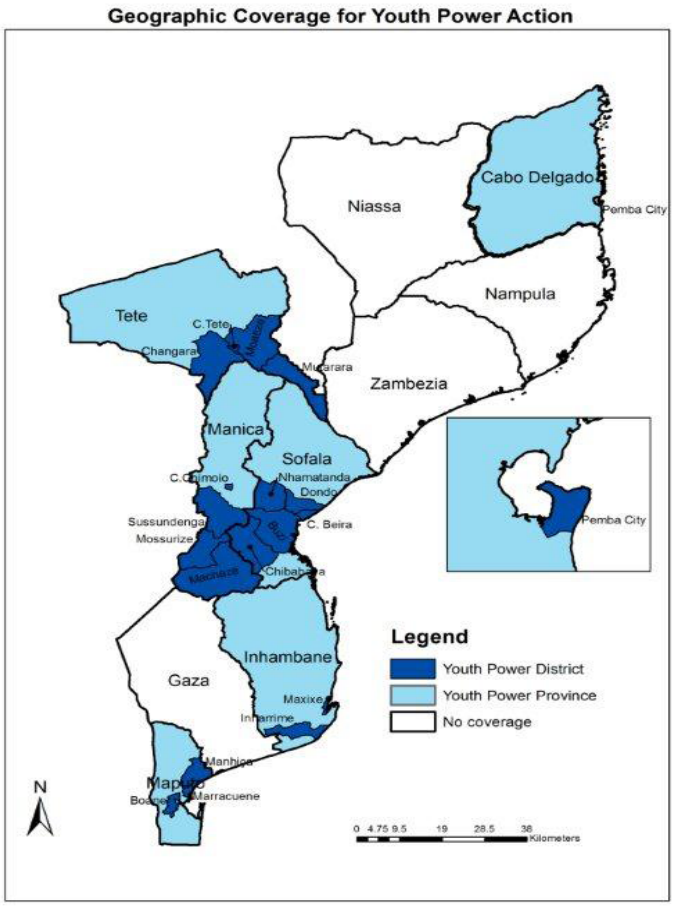
2. Increased opportunities for youth to voice their perspectives to inform decisions related to youth services, and in particular increasing youth's access to information via their access to youth services and their participation in community child protection committees (CCPCs).

3. Increased number of older OVC and youth-headed households that care for OVC to have access to savings and loans and financial literacy. This ES component is an innovative approach to directly include youth in mitigating the effects of HIV, as well as provide opportunities for youth to be engaged in community dialogue on HIV and broader health issues.

4. Increased access for older OVC and youth-headed households to community-based services that improve outcomes and quality of life and are implemented by the coordinated efforts of MGCAS and CBOs. Specifically, activistas are to provide beneficiaries with the national seven minimum services during home visits and small group discussions. In addition, YP Action is working with the District Service of Health and Social Affairs (SDSMAS) to create an enabling environment for youth by strengthening linkages for youth services through the Youth Friendly Services (SAAJ).[19]

The YouthPower Action program is implemented via 16 civil society organizations in 19 PEPFAR priority districts located within seven out of Mozambique's 10 provinces (see Figure 2: YouthPower Action coverage, below). FHI 360 is managing the implementation of YP Action together with local consortium partner N'weti.

Figure 2: YouthPower Action coverage in Mozambique



Key components of YouthPower Action efforts to strengthen the referral system at the community and district levels

AN OVERVIEW OF HOW THE REFERRAL SYSTEM WORKS AT THE COMMUNITY AND DISTRICT LEVELS

Community volunteers, or activistas, underpin the effective and efficient functioning of the referral system at the community and district levels. Even if they are not officially recognized as part of the social welfare workforce or continuum of care, activistas fill a fundamental gap in a context where the Government of Mozambique (GoM) is challenged in meeting the commitments under the Minimum Standards. In fact, GoM and CPCs, including CCPCs, consider it the job of activistas to play a central role in the referral system, including in the delivery of social services at the household level, even though they do not have government-issued job descriptions and are not remunerated by the state.

However, while the state budget cannot absorb the activistas as para-social workers, MGCAS and MISAU acknowledge the role that they play in the referral process, as highlighted in the MISAU and MGCAS approved referral form (Annex 1).[20] NGOs and CBOs, including the YouthPower Action implementing partners, support the government's recognition of the important role that activistas play, and ensure that activistas have a contract and a scope of work, which are based on the IP's program description and its related program targets.[21] The activistas commissioned by YouthPower Action receive a stipend calculated by MISAU's recommendation of approximately USD 25 per month.

The referral process at the community and district levels can be broken down into the following steps, which highlights the indispensability of the activista:

- *Identification of vulnerable children and youth*. The activista, often working with CCPCs and community leaders, identifies vulnerable individuals based on the MGCAS' matrix to identify vulnerable children or matrix to identify vulnerable adolescents.

- *Direct provision of social services.* If the activista has been trained by the CSO to which she/he is linked,

19 USAID (2016). YouthPower Action: Mozambique: 1st quarter report for Mozambique – September 27 to December 31, 2015.

20 That said, it is recognized by MISAU and MGCAS that various actors at the community level, through CBOs, are involved in the referral process, to include activistas, health workers, peer educators, and community volunteers. To streamline roles and responsibilities and to ensure an effective and efficient referral process, MISAU is developing scopes of work for "health educators," which would replace all current structures, and be officially recognized by MISAU with an established monthly stipend.

21 Information provided by FHI 360.

then she/he will provide services directly to the beneficiary. Psychosocial care and support are the services that are most often provided by the activista to the beneficiary within the household, followed by nutrition services (which include nutrition education, cooking demonstrations and referrals to health facilities for cases of suspected malnutrition) and education referrals (which include referral to support for school supplies, school enrollment or support with homework/study groups).

- F*acilitation of the Poverty Certificate.* If the beneficiary is poor and therefore unable to ensure access to any of the MGCAS' seven minimum care and support services, the activista will approach the community leader to ask him/her to develop a testimony that the beneficiary is living in poverty, according to village standards, and does not have the financial means to access the needed service(s). The activista will deliver this testimony to SDSMAS, which in turn, produces a Poverty Certificate that takes no more than two or three days to issue. SDSMAS sometimes verifies the community leader's testimony by conducting a household visit to the household in question, but it is not always able to do so, due to a heavy workload.[22] Once presented to a service provider by the beneficiary, the Poverty Certificate requires service providers to waive their fees and related costs pertaining to education and clinical health services.

- *Facilitation to the GoM basic food package.* Activistas can support vulnerable households, including youth-headed households to access the GoM basic food package, or *"cesta basica."* The activista conducts household visits with a SDSMAS representative to evaluate the family's living conditions and financial status. After the family is deemed eligible for the *cesta basica*, they will receive the food package approximately one month after their inscription, depending on the demand for the *cesta basica*. Poor families can be referred to activistas or to SDMAS via health centers and other services, such as schools.

- *Facilitation of access to other critical services.* When the activista is not able to directly provide the service, she/he will make a referral. The activista will accompany the beneficiary to the service provider if the activista is unable to offer the needed service directly within the home. At times, the activista uses his or her own funds to transport the beneficiary to a service, usually in cases where the beneficiary is unable to walk, however this is not as common as it used to be. At the service provider, the activista will present the Poverty Certificate, if relevant, and the MISAU-endorsed referral form, which the service provider will fill in based on the specific services offered to the beneficiary. The service provider will store a signed copy within their files. In the majority of cases, when an activista is not able to provide the service, the first point of entry for the referral is a health service provider. This is largely because the referral form is specific to health, including HIV, as it is a formally issued document of the MISAU. It is envisaged that it is also the first point of contact in recognition that health services are usually more readily available than social services, including child protection services, at the district levels; this has been confirmed by community mapping exercises undertaken by CBOs. The health provider will refer the beneficiary to other services based upon the individual needs of the case, however this is dependent on the healthcare provider's capacity in understanding the referral system and the use of the referral tool, as well as whether there are formal agreements between networked service providers that encourage intersectoral referrals.[23] There is space on the referral form to note the additional referral, although there is little room for the second service provider to detail the type of services offered and to suggest whether there should be an additional referral. The individual's care plan, however, does provide space to adequately identify and monitor the services that the beneficiary should receive, as assessed by the activista with use of the CSI; the YouthPower Action program has developed a care plan template with the additional aim to facilitate referrals.

- *Referral tracking, data collation and sharing.* There is no protocol or standardized guidance for activistas to conduct follow-up visits; they are in accordance with the needs of the child/ youth and documented in the care plan, which was developed based on the initial assessment using the CSI. On a monthly basis, the activista submits the referral forms to the CBO, who then collates the data on the number of children, adolescents and youth referred, and the types of services received. The CBO sends a copy of the report to FHI 360, as well as to SDSMAS. In addition, the service provider tallies the numbers of services offered, and sends the data to their respective line ministry. The data received from health and social service providers by SDSMAS is consequently shared with their respective ministries at the provincial level. In theory, the line ministries should analyze the data, in addition to the statutory child protection committees, to inform joint planning and decision-making processes, and reinforce collaborative efforts on child protection. However, the country visit showed that these multisectoral bodies often do not partake in these discussions, due to lack of funds to call joint meetings. However, one key informant noted that it does not cost much to host joint meetings, as most actors work in close proximity to each other anyway; motivation was cited as the key factor for whether CPCs and CCPCs convene.[24] Please see Figure 3 on the following page depicting the referral process.

22 Key informant interview, SAAJ focal point SDSMAS Beira; January 20, 2016.

23 Formal agreements, such as Memorandums of Understanding, do exist between networked service providers, but they are not standard practice; they are often donor requirements to strengthen comprehensive service delivery. Referrals can and do take place if there are informal partnerships between services, mostly established as a result of personal networks.

24 Key informant interview, Provincial Director, DPMAS, Beira; January 22, 2016.

THE IDENTIFICATION OF SPECIFIC REFERRAL FOCAL POINTS — ACTIVISTAS

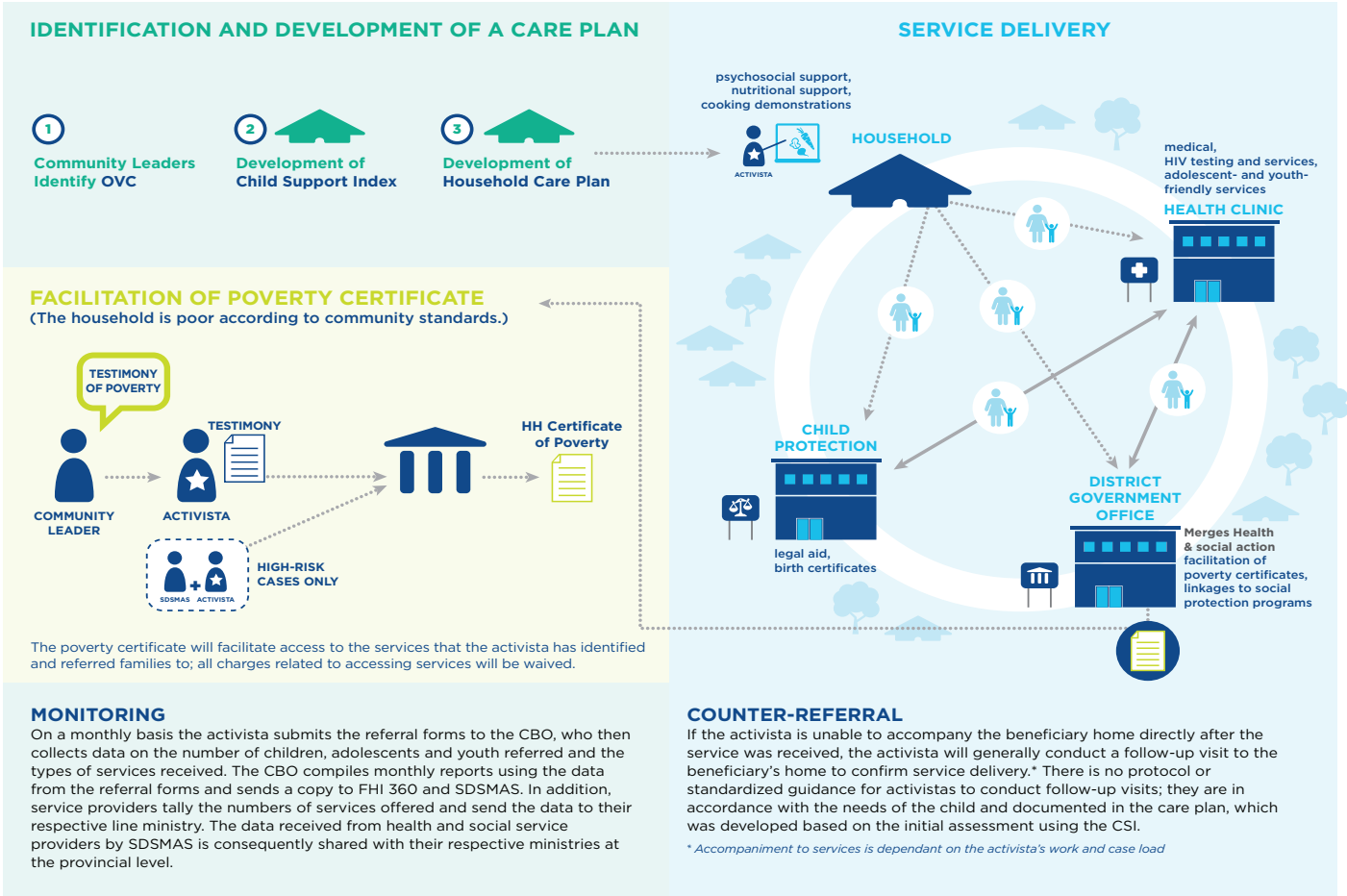
In a context in which the government's social welfare workforce is severely constrained, activistas are heavily relied upon by the Government of Mozambique to refer vulnerable children and youth to services, as well as be involved in the broader community case management process, as the above attests. Activistas are often the first point of contact by children, youth and their families to the social welfare and child protection system. Through door-to-door visits, activistas offer four types of support: (1) they offer services directly, if they are able; (2) refer and often accompany the beneficiary to the necessary service provider; (3) raise awareness about the availability, purpose and importance of accessing the services as prescribed in the Minimum Standards; (4) generate demand for accessible and appropriate services among households and adolescents. Activistas also participate in community-level discussion platforms and relevant campaigns to increase awareness among community members on child protection issues.

THE TRAINING OF COMMUNITY WORKERS

Activistas are trained by CBOs and the local SDSMAS focal point through a cascade training in which YP Action trained the CSO supervisors and the SDSMAS in a training of trainers. The overarching aim of the training is for activistas to support CBOs' implementation of their programs through the use of government-approved training tools. Currently, there is no standardized or government-approved training curriculum for activistas, because they are not recognized as a formal component of the social welfare workforce. This implies that activistas do not formally meet with recognized workforce members, such as health community workers, to review the number of referrals made versus the number of services accessed, for example. The YouthPower Action program, and the IP-supported CSOs, however, have incorporated government-approved standards and tools into their trainings of activistas to ensure that all work around strengthening referral pathways links to existing and standardized mechanisms.

The YouthPower Action program focuses on strengthening the capacities of activistas to ensure a functioning and effective referral system at the community and district levels. Activistas are trained by YP Action's implementing partners to use MGCAS tools to identify vulnerable children and youth, and use MISAU referral forms to refer, and often accompany, children and youth from their homes, schools or broader community to the necessary services. In addition, under the Community Care Program, 1,200 activistas were trained to provide services directly to beneficiaries, ensuring the delivery of community-based services while simultaneously building the capacity of activistas to do so.[25] To ensure

Figure 3: The referral process in Mozambique



MONITORING

On a monthly basis the activista submits the referral forms to the CBO, who then collects data on the number of children, adolescents and youth referred and the types of services received. The CBO compiles monthly reports using the data from the referral forms and sends a copy to FHI 360 and SDSMAS. In addition, service providers tally the numbers of services offered and send the data to their respective line ministry. The data received from health and social service providers by SDSMAS is consequently shared with their respective ministries at the provincial level.

COUNTER-REFERRAL

If the activista is unable to accompany the beneficiary home directly after the service was received, the activista will generally conduct a follow-up visit to the beneficiary's home to confirm service delivery.* There is no protocol or standardized guidance for activistas to conduct follow-up visits; they are in accordance with the needs of the child and documented in the care plan, which was developed based on the initial assessment using the CSI.

** Accompaniment to services is dependant on the activista's work and case load*

Note: The referral process represented in this graphic is based on information collected during a country visit and it may not adequately reflect the referral processes undertaken in all districts in Mozambique.

25 USAID. Community Care Program: Final Report.

linkages between the previous and current programs, the YouthPower Action program also requires activistas to provide services at the household level, where they are able. During the first quarter of the program's implementation, 5,032 beneficiaries were reached with psychosocial support services by activistas. Nutrition services (3,263) and education referrals (3,253) were also services commonly provided by activistas to beneficiaries at the household level. Of the approximate 9,000 active beneficiaries served by the YouthPower Action program in the first quarter, approximately two-thirds were female in recognition of the increased HIV risks and vulnerabilities girls face.[26] The majority of beneficiaries were between the ages of 10 and 14 years (2,143 beneficiaries), followed by 15-to-19-year-olds (1,365 beneficiaries).[27] A focus group discussion with community leaders in a rural community highlighted how activistas directly impact on children's well-being, as a result of their involvement in the referral and counter-referral process: "there is a clear decrease in children under five dying. We think this is a result of activistas convincing mothers to access health clinics, and not traditional healers."[28]

The YP Action program initiated a Trainer of Trainers to introduce adolescence and youth topics as they relate to the seven basic services encompassed in the Minimum Standards.[29] The *Expanded Life Skills* training was replicated by the CSOs in collaboration with SDSMAS in all the YP Action implementing districts; 353 activistas were trained in the first quarter.[30] Specific topics in the training include adolescent development, youth mapping exercise (see section 3.7 for more information on mapping), psychosocial support, child protection, gender and gender-based violence, education, health (including sexual reproductive health), alcohol and drugs, stigma and discrimination, nutrition and water and sanitation, shelter, and economic strengthening.

Activistas are also key to ensuring caregivers and broader community members understand the purpose and importance of accessing services in children's well-being. They are activists within their communities, and are often actively raising awareness about the whereabouts and roles of services at the community and district levels. They raise awareness through door-to-door visits, which coincide with visits to identify vulnerable children and youth, as well as play leading roles in relevant outreach campaigns organized by the government, international organizations and/or CBOs. In addition, they lead small group discussions with community leaders, parents and caregivers, and youth and adolescents, using the *Expanded Life Skills* curriculum to guide the discussions. Of the activistas who participated in the focus group discussions, they had "worked" as activistas for CBOs funded by FHI 360 for an average of five years.

THE DEVELOPMENT OF STANDARDIZED TOOLS AND RESOURCES

The tools to identify vulnerable children are influenced by the Child Status Index (CSI), a set of intake assessment and monitoring tools that are contextualized by the Minimum Standards.[31] The Community Care Program initiated the use of the CSI to identify the needs of children living with an HIV-positive adult. The YouthPower Action program is applying the tool to develop a care plan for all vulnerable children, and not just those living in HIV-affected households. This includes child-headed households, children living with disabilities, children living in informal care arrangements and children affected by extreme poverty.[32] While the CSI is considered effective in identifying the needs of vulnerable children, it was recognized that adolescents face different risks and vulnerabilities. Accordingly, during the first quarter of the program, YouthPower Action together with MGCAS and UNICEF developed a CSI for adolescents, which is currently being piloted. Key indicators included in the CSI for adolescents include awareness of and recent access to the SAAJ and sexual and reproductive health services. The activistas engaged during the country visit were well versed in how to apply both the CSI for children and adolescents, noting that identifying risks or violations of protection are best observed, rather than explicitly asked or discussed, especially if caregivers are present.

Under the Community Care Program, FHI 360 supported MISAU to streamline the tools used during the referral process. "It was recognized that beneficiaries have multiple needs, and that it was unpractical and inefficient to have a high volume of paper work. The more paper work, the bigger the burden for activistas and CSOs to fill in, store and process these documents. Out of this awareness, FHI 360 collaborated with MISAU to improve and streamline the referral tool to one single form to make reference to the multisectoral nature, and not just health focus, of children's needs."[33] Commonly referred to as the *Guia de Referéncia,* or Referral Guide, it was formally approved by MISAU in 2015 for countrywide use. The Referral Guide is seen as distinct from the MISAU-issued Health Card, which monitors individuals' access to health services only as part of the health case management system.

The referral forms in the Referral Guide officially aim to "promote the access and adherence to primary health care and social services."[34] The paper form allows for detailed, but clear, options for the health provider to check the boxes of the services offered and tests undertaken, including in relation to HIV. In this respect, the referral form is a user-friendly and multisectoral tool for documenting the referral from the community by the activista to the necessary service(s). "We welcome this referral tool, as before, each organization had their own guidelines and processes to

26 The program does not exclude boys, however.
27 USAID. YouthPower Action: Mozambique: 1st quarter report for Mozambique.
28 Focus group discussion, community leaders, ACIDECO, Manhiça; January 19, 2016.
29 Ministério de Mulher e Acção Social (2014). *Padrões Mínimos de Atendimento à Criança*.
30 USAID. YouthPower Action: Mozambique: 1st quarter report for Mozambique.
31 The CSI includes a matrix and a pictorial for each of the various standards, ranging from "absent" to "fully meets the standard."
32 Key informant interview, Youth Power Technical Officer, Beira; January 20, 2016.
33 Key informant interview, YouthPower technical officer, Maputo; January 18, 2016.
34 Republic of Mozambique Ministry of Health. *Guia de Referência do Agente Comunitário de Saúde (Promoção de acesso e adesão aos cuidados de saúde primário e serviços sociais)*.

document the needs and referral of beneficiaries, which created confusion between the government and CBOs, and ultimately it did not benefit the beneficiaries."[35] Furthermore, FHI 360, together with UNICEF and *Fundação para o Desenvolvimento da Comunidade,* are considered to be at the forefront of conducting user-friendly trainings on the use and implementation of the tool.[36]

THE DEVELOPMENT OF A SYSTEM FOR TRACKING REFERRALS AND ENSURING REFERRAL COMPLETION

The MISAU-approved referral tool is considered to embody a new understanding of referrals: "it is not simply advising someone to go for health services, but rather tracking that referral all the way through to that person receiving the services for which they were referred."[37] The health service is usually the entry point into the documented referral system. This is largely because the referral form heavily leans toward health and HIV-based services, and likely also because health and HIV-based services are more readily available at the district level compared to other services, particularly child protection services. For example, in the first quarter, 1,855 beneficiaries were referred for HIV services, such as ART, prevention of mother-to-child transmission (PMTCT), ATS and ART lost-to-follow-up. During the reporting period, 954 beneficiaries were referred for HIV counseling and testing services, 614 to the SAAJ, and 155 were referred to PMTCT services.[38] However, because activistas are not formal members of the workforce, there are no official standard practices or official linkages between activistas and health community workers to facilitate and track referrals between OVC services and health and HIV facilities. For example, if the health community worker does not refer the beneficiary to an OVC service, despite it being needed, she/he will not be held accountable; there are no policies, guidelines or frameworks that require or encourage health workers, including health and HIV facilities to refer to social service providers or community-based structures.

The referral tool is bi-directional and aims to track the counter-referral in addition to the referral. The form is carbonized and has three layers to allow for referrals to be tracked by the referring activistas, verified by the clinics, and processed by the CBOs. That said, it is unclear which service provider keeps the form if a second service referral is made. In principle, the activistas keep a copy of the forms in order to keep beneficiaries' histories in their files to make the process of follow-up more effective. Also, it allows for the activista to track the access to services by each beneficiary over time, in order to be able to extrapolate data and identify and monitor any particular risks or child protection violations. "Activistas and community health workers play very important roles in motivating individuals to access the necessary services, particularly in chronic cases such as HIV. The Ministry of Health does not conduct home-based care or accompanied visits, and our staff at the health centers find it difficult to generate incentives for individuals to access services. That is why activistas and community health workers play a key role in counter-referrals and overall follow-up."[39]

Every month, the activistas deliver the third copy of the carbonated paper-based referral form to the CBO for which they volunteer. The CBOs collate the data and send a monthly report tallying the number and types of cases, using a standardized format developed by FHI 360. The reports are sent to FHI 360,[40] with a copy to SDSMAS. At the district level, the SDMSAS receives these reports from CBOs, as well as the health providers. In theory, the district-level technical working group on OVC (GT-COV), a coordination body mandated by MGCAS, is tasked to discuss and analyze the data coming from these reports, as well as use the evidence to inform planning and decision-making processes within their respective line ministries. However, during the country visit, no mention was made of the GT-COVs convening in the four visited districts.[41]

Without a digitalized database monitoring access to basic services, however, the process to analyze data is time consuming, impacting on efforts to standardize the referral system between sectors. Another key challenge is not having a baseline, which makes it difficult to assess how much progress has been made in ensuring that individuals access services, follow up on services, and are better protected as a result of accessing the necessary services.

THE DEVELOPMENT OF PROCESSES TO SUPPORT ONGOING COLLABORATION

In one of the districts visited, it was noted that SDSMAS convenes quarterly meetings that offer a platform for CBOs to discuss their activities, and related progress and challenges. This was considered a welcome and effective way of exchanging information and generating learning on who is doing what, and how. This type of information exchange platform organized and coordinated by SDSMAS is an opportune venue for the CBO to share information about the YouthPower Action program, in addition to facilitating information exchange between the SDSMAS and the YouthPower Action technical team at the provincial levels. While these joint meetings highlight how the linkages between the YouthPower Action program and the government are reinforced, they also present an opportunity to jointly identify and address key bottlenecks in addressing the needs of OVC and their households, in addition to developing and implementing quality assurance action plans.

This is another example of the how the linkages between the YouthPower Action program and the government are reinforced, together with conducting joint supervision visits with SDSMAS at the district level. Joint supervision visits have been conducted at the national, provincial and district levels to build and maintain both formal and informal

35 Focus group discussion with DPMAS Matola; January 18, 2016.
36 *Ibid.*
37 USAID. Community Care Program Final Report.
38 USAID. Youth Power Action: Mozambique: 1st quarter report for Mozambique.
39 Focus group discussion with DPS Matola; January 18, 2016.
40 FHI 360 uses this information for its reporting purposes to USAID, and also shares relevant aspects of the report and related data with MGCAS. No interviews were conducted with representatives from the national-level MGCAS; hence, it is not possible to specify what MGCAS does with the data forthcoming from the YouthPower Action program.
41 FHI 360 actively participates in the national technical working group on OVC (GT-COV) meetings, where more high-level decisions are made.

channels for information sharing, communication and partnership building.

SERVICE MAPPING

Youth are an intrinsic part of the YouthPower Action project — not just as beneficiaries, but also as active participants in strengthening the referral system at the community and district levels. Youth involved in the program are part of 12 pragmatic skills-building sessions, based on the *Expanded Life Skills* training, with the end goal being strengthened resiliency, informed decision-making and protection against violence and HIV. A key, and innovative, part of the session is a youth-led mapping exercise, which aims to reflect the reality of the community from youths' perspectives. The mapping also calls for youth to identify and locate available services and resources (human and financial) in their communities that can address their needs, and decrease their degree of vulnerability. Specifically, the exercise goes beyond health, and also looks at education, sports and recreation.

While the mapping is set to take place in the second quarter of the YP Action program, some of the visited youth groups had already undertaken the exercise "as we were anxious to find out what is available to help us navigate the challenges we face as adolescents."[42] The mapping proved to be a powerful opportunity for youth to increase their awareness of what exists around them to support them in a situation where many youth are pessimistic about their future. In relation to discovering the existence and purpose of SAAJ through the mapping, an adolescent girl noted: "It allows us to be free to ask any questions about ourselves, without being embarrassed in front of our friends or family."[43] Tying this community-based activity, and identifying links, with youth-friendly service providers "seems to be encouraging the youth to stay on the right path."[44] Involving youth in the exercise itself is proving to have positive impacts on their confidence levels and their willingness to be active participants in their community around youth development: "We consider ourselves as young leaders in our community, as we know what our rights and responsibilities are. We share this information with our families and friends, and help them to understand that everyone has a choice and that there are people to help and support them make choices."[45]

While the overall youth-led mapping exercise designed by YouthPower Action is innovative, there is one community-level resource that the mapping identified that significantly stands out in being able to directly boost youths' resilience and empowerment to make decisions affecting themselves: their participation in village savings and loan groups (VSLGs).

VILLAGE SAVINGS AND LOAN GROUPS INCREASE RATES OF SELF-REFERRAL TO PREVENTIVE SERVICES AMONG YOUTH

Increasing the awareness and capacity of youth to be active players within the referral mechanism promises to be a highly effective means of decreasing activistas' workloads, allowing activistas to focus on providing services and referring the most vulnerable individuals that require care and support, such as young children and the elderly. At the same time, empowering youth to be their own care agents can boost demand for quality and accessible services for youth at the community level. VSLGs directly and indirectly offer a powerful opportunity for youth to build the necessary awareness and skills in order for them to self-refer to the appropriate service(s).

The YP Action program has encouraged the participation of youth in VSLGs that were initiated and supported under the CCP. The VSLGs have encouraged youth to be more aware and conscientious of their lifestyle: empowered youth will more readily self-refer themselves to both preventive and response services. As an adolescent girl noted: "Because we know where to go for information, and because we see that there are opportunities for us, we change our behavior. Me, for example, I know that I can delay sex, and that it is my choice about when I engage in sex." Vulnerable youth participating in VSLGs have the potential to self-refer themselves, decreasing the workload of activistas as a result of the youth accessing information, skills and tools via the participation in VSLGs.

THE ROLE OF STATUTORY CHILD PROTECTION MECHANISMS IN THE REFERRAL SYSTEM

Spurred by the development of the National Plan of Action for Children and the Plan of Action for Orphans and Vulnerable Children (the latter now defunct), in addition to three key child protection laws,[46] MGCAS initiated a process to systematize the formation of community child protection committees in recognition that the policy and legal framework enhanced the role of families and communities as primary providers of care and protection of children. The process resulted in the development of the Reference Guide for the Establishment and Management of the Community Committees for Child Protection[47] (hereafter Reference Guide). A profile of members is included in the Reference Guide, which refers to the social characteristics of potential members, rather than educational background. The Reference Guide highlights that children should comprise "a minimum of 30 per cent of the committee."[48] Key CCPC activities include:

- Identification of basic and urgent needs of children, and the mobilization of assistance within and outside of the community;
- Coordination with various community structures, such as School Boards and Councils of Community Leaders, to improve access for vulnerable children to various services;

42 Focus group discussion with youth, KugBeira; January 20, 2016.
43 *Ibid.*
44 KII with CBO coordinator, Beira; January 20, 2016.
45 FGD with youth, Beira; January 20, 2016
46 Namely Law 6/2008 of July 9 – Law on Trafficking in Persons, Especially Women and Children; Law 7/2008 of July 9 – Law on Promotion and Protection of the Rights of the Child; Law 8/2008 of July 15 – Law of Organization of Guardianship of Minors.
47 Save the Children/Ministério de Mulheres e Acção Social (2010).
48 *Ibid.*

- Coordination with SDSMAS to ensure that children have access to social services, such as through the direct support provided by INAS;
- Coordination with the Office for Assistance to Women and Children Victims of Domestic Violence, for reporting and referring cases of violence and child abuse.[49]

Key expected outcomes of these formalized community child protection structures include established linkages between the CCPC with local leaders, local government, advisory councils and the private sector, in addition to strengthened mechanisms for complaint, referral and monitoring of violence and sexual abuse of children.

While the national guidelines establishing the CCPCs do not set out a clear mandate, but rather offer a proposed set of actions that the child protection committees are encouraged to follow, it is clear that they are responsible for being involved in identifying and referring vulnerable children to both basic and urgent services, as in the case of sexual abuse. The focus group discussions undertaken with members of the CCPCs during the country visit highlighted that members were aware of their role in the referral process.[50]

On paper, the CCPCs play a fundamental role in facilitating the referral process in a context in which there is a dearth of social workers. In practice, as the country visit attested, the CCPCs have limited capacities — both technically and financially — to meet the expectations as highlighted in the Reference Guide. Even though the CCPCs are statutory bodies, there are no earmarked or generally available government funds to support these structures in terms of capacity building or ensuring a small quantity of cash to ensure the most urgent cases access the necessary services and support. While the CCPCs are tasked to mobilize community and outside resources, this requires a capacity to fundraise, which members don't necessarily have. Similarly, to be able to identify and refer vulnerable children and families "they need to know how to refer to services to the district level, but they don't know how to do that. For the committees that have some funds, they prefer to support activistas, for them to refer the child. When there are no activistas, the committees refer the child to a school, which sometimes has several services available (such as health and nutrition, in addition to education), and for the school to refer the child to any other services if needed."[51]

The YP Action program, through the training of activistas, refers to the flowchart (*fluxogram)*, developed as part of the Multisectoral Mechanism for Integrated Assistance to Women Victims of Violence,[52] which lays out the steps through which victims can access an integrated set of services, and notes that that survivors of sexual violence should receive psychosocial care and support, post-exposure prophylaxis and emergency contraception within 72 hours. However, weak technical capacity to understand urgent cases as such, and consequently effectively act on them, has negative and potentially harmful repercussions for the survivor. In sexual violence cases, members of a particular CCPC "come together to discuss the best course of action," and want to "try and handle the case ourselves as community members and protectors of our children."[53] The fact that members of community child protection structures tend to resort to informal solutions and structures rather than refer cases through the statutory channels has been validated by three other focus group discussions with activistas.[54] These discussions noted that the survivor often drops the case (whether encouraged to do so or on accord of their own decision) as the experience of waiting for the CCPC to "make their decision about the best course of action" is too drawn out. Not being able to immediately access the necessary services — in particular psychosocial care and support, health and legal and protection services — places the survivor at increased risk of further abuse, exploitation and potentially neglect. It has been recognized that the disconnect between the training's lessons and putting what is learned into practice may be due to YP Action being in its initial phase of rolling out; time is needed to generate change in knowledge, attitudes and practices.

In its aim to support the government-led referral system at the community and district levels, the YP Action program has recognized the need to strengthen the capacities of CCPCs to fulfill their obligations established by MGCAS and incorporated into the Reference Guide: "This learning has been taken into consideration and guides the current YouthPower Action project, and will influence future projects around child protection as well."[55] Due to lack of support, some communities have made the conscious decision to *not* have a CCPC: "We stopped acting as members of the CCPC because the government did not support us. Now we are supported by YouthPower, and we have come together again as a committee."[56] Specifically, the YP Action program, through activistas, is encouraging CCPCs to engage youth in community planning around child protection and youth services, as stipulated in the Reference Guide. In the first quarter of the project, 206 youth between the ages of 14 and 18 have been integrated into 80 CCPCs.[57] The activistas further involve the CCPCs in awareness raising on youth development and on the availability and purpose of related youth services, to encourage the referral of all cases with the government standardized tools to district level services.

In addition, the lack of data on the existence of functioning CCPCs has been recognized as a gap in efforts to strengthen the child protection system at the community and district levels by the YP Action program. Accordingly, the YP Action program is working with SDSMAS in Sofala Province to update

49 *Ibid*.
50 Focus group discussion, CCPC Marracuene. January, 18 2016; focus group discussion, CCPC Nhamatanda. January 21, 2016.
51 Focus group discussion, DPMAS Matola; January 18, 2016.
52 Ministerio da Mulher e da Acção Social (Maio 2013). *Mecanismo Multisectorial de Atendimento Integrado à Mulher Vitima de Violência*.
53 Focus group discussion, CCPC Marracuene; January 18, 2016.
54 Focus group discussion with CONFHIC activistas, January 18, 2016; focus group discussion with Kuphedzana activistas, January 21, 2016; focus group discussions with ACIDECO activistas, January 18, 2016.
55 Key informant interview with USAID, Maputo; January 22, 2016.
56 Focus group discussion with CCPC Nhamatanda; January 21, 2016.
57 USAID. YouthPower Action: Mozambique: 1st quarter report for Mozambique.

the list of active, functional and no longer existing CCPCs to address the gap in evidence regarding how many CCPCs are active or effective throughout Mozambique.[58]

Conclusion

The YouthPower Action program provides an interesting example of how the government can be supported at the community and district levels in strengthening the bi-directional referral system in resource-constrained settings. To ensure sustainability of efforts initiated under the Community Care Program, the YouthPower Action program has collaborated with the national-level Ministry of Gender, Children and Social Affairs, and other actors, to streamline and standardize referral tools that identify and track the access of vulnerable children and adolescents to the basic services established under the Minimum Standards. In addition, the YouthPower Action program has been noted by one of the provincial-level MGCAS structures as a key player in strengthening the capacities of the community volunteers to assess the needs of children and youth at household level, identify when they can provide services or when referrals must be made to other services providers at the community and district levels, and follow up on cases using the government-approved tools, in a context in which the social welfare workforce is lacking. Finally, linking youth to village savings and loan groups can be considered a pragmatic and innovative way to ease the burden of the community volunteer workload, as youth are empowered to self-refer to preventive and response services, building long-term self-reliance and agency.

58 *Ibid.*

Annex 1: Standardized referral guide endorsed by the Ministry of Health

REPÚBLICA DE MOÇAMBIQUE
Ministério da Saúde

Guia de Referência e Contra Referência

(Promoção de acesso e adesão aos cuidados de saúde primários e serviços sociais)

Mod. SIS-H-24

Nome do Utente: _____ Idade: ____ Sexo: ____ NID*:_____ NIT*: _____

Distrito: _____ Localidade: _____ Bairro: _____ Unidade Comunal: _____ **Nº do Guia**_____

Quarteirão: _____ A casa fica perto de: _____

Organização: _____ Projecto: _____ Programa: _____

A ser preenchido pelo ACTIVISTA **Motivos de referêrncia:**

SERVIÇOS SMI:	***SERVIÇOS HIV:***	***SERVIÇOS TB/Malária:***	***SERVIÇOS SOCIAIS:***
☐ Maternidade p/ parto:	☐ ATS	☐ Suspeito de TB	☐ OCB / Apoio Comunitário
☐ CPN	☐ ITS	☐ Contacto de TB	☐ Educação
☐ CP Familiar	☐ Pré-TARV / IO	☐ Controlo de BK	☐ Acção social
☐ Consulta Pós-Parto	☐ Testado HIV+	☐ Abandono de TTB	☐ GAVV
☐ CCR	☐ Abandono TARV	☐ Reacções do TTB	☐ Apoio Psico-social
☐ PTV	☐ PPE	☐ Suspeito de Malária	☐ Posto Policial
	☐ Circuncisão Masculina		

Suspeito de Malnutrição: ☐ Banco de socorro/Consulta de triagem: ☐ Controlo da Dor: ☐

Outros motivos/ Especificar o cuidado/ serviço prestado ou a ser prestado: _____

Nome da pessoa que referiu: _____ Data: ____ /____ /____

A ser preenchido pela UNIDADE SANITÁRIA *(marcar todos os serviços em que o utente passar)*

ATENDIDO NA CONSULTA DE/ SERVIÇOS PRESTADOS:

☐ Maternidade p/ parto:	☐ CCR	☐ TARV	☐ Controlo de BK: ____ º mês
☐ CPN	☐ ATS	☐ Sem TB	☐ Reacções do TTB
☐ CP Familiar	☐ ITS	☐ Profilaxia por contacto TB	☐ PPE
☐ Consulta Pós-Parto	☐ Testado HIV+	☐ Tratamento de TB	☐ Terapia nutricional
☐ PTV	☐ Pré TARV/IO	☐ Doenças crónicas	☐ CCS
	☐ CD	☐ Controlo da Dor	

Outros atendimentos/ Especifique: _____

Referido para (US, Acção Social, Educação, OCBs, apoio psicosocial, CRN): _____ Motivo de referência: _____

Observações: _____

Nome do trabalhador de saúde: _____ Nome da US: _____ Data: ____ /____ /____

A ser preenchido pela ACÇÃO SOCIAL

☐ Subsídio de alimentos	☐ Educação	☐ OCB	☐ GAVV
☐ Habitação	☐ Atestado de pobreza	☐ Acção social produtiva	☐ Apoio monetário
			☐ INAS

Outras Redes/ grupos/ instituição de apoio. Especifique: _____

*Especificar o cuidado / serviço prestado ou a ser prestado: _____

Nome do trabalhador que referiu: _____ Data: ____ /____ /____

CPN- *Consulta Pré Natal;* **ITS**- *Infecções de transmissão sexual;* **OCB**- *Organização Comunitária de Base;* **CCR**- *Consulta de Criança em Risco,* **PPE**- *Profilaxia Pós-Exposição;* **GAVV**- *Gabinete de Atendimento a Vítimas de Violência;* **CPP**- *Consulta Pós Parto;* **ATS**- *Aconselhamento e Testagem em Saúde;* **NID**- *Número de Identificação do Doente;* **CPF**- *Consulta de Planeamneto Familiar;* **TARV**- *Tratamento anti-retroviral;* **NIT**- *Número de Identificação de Tuberculose;* **PNCT**- *Programa Nacional de Controlo da Tuberculose;* **IO**- *Infecções Oportunísticas;* **CD**-*Cuidados Domiciliários;* **CCS**-*Consulta de Criança Sadia;* **PTV**- *Prevenção de Transmissão Vertical;* **BK**-*Bacilo de Koch.*

Annex 2: List of documents reviewed

Republic of Mozambique (2015; 5th draft). *Estratégia Nacional de Segurança Basica II (2015-2024)*.

Republic of Mozambique (2013). *Plano Nacional de Acção para a Criança 2013-2019*.

Republic of Mozambique Ministry of Gender, Children and Social Action. Matrix to identify vulnerable children.

Republic of Mozambique Ministry of Gender, Children and Social Action. Matrix to identify vulnerable adolescents (draft).

Republic of Mozambique Ministry of Health – *Ficha de notificação de casos de violência.*

Republic of Mozambique Ministry of Health. *Guia de Referência do Agente Comunitário de Saúde (Promoção de acesso e adesão aos cuidados de saúde primário e serviços sociais).*

Republic of Mozambique Ministry of Health and FHI 360. *Ficha de Registo dos Grupos de Pais e Actividades dos Jovens e Adolescentes.*

Republic of Mozambique Ministry of Health and FHI 360. *Ficha de Registo das Actividades de Clubes Infantils e Grupos de Estudo.*

Republic of Mozambique Ministry of Health and FHI 360. *Ficha de Beneficiários e Serviços.*

Republic of Mozambique Ministry of Health. *Ficha de Atendimento Integrado para Mulheres Atingidas por Violência.*

L. Lovick, A.P. Ndapassoa, M. Abilio, G.G. João, S. Mahumana. Best Practice: Highly Integrated Community Care and Support in Mozambique; USAID, Mozambique.

Republic of Mozambique and USAID. Summary of YouthPower Action PowerPoint presentation.

USAID. Fact sheet: *YouthPower: Empodermanto dos Jovens*.

USAID. Community Care Program Final Report, September 26, 2015; USAID, Mozambique.

USAID (2015). Community Care Program: An evaluation of selected effects of the Community Care Program on OVC beneficiaries.

USAID. YouthPower Action: Mozambique first quarter report: September 27 to December 31, 2015. USAID, Mozambique.

Coordinating Comprehensive Care for Children (4Children) is a five-year (2014-2019), USAID-funded project to improve health and well-being outcomes for Orphans and Vulnerable Children (OVC) affected by HIV and AIDS and other adversities. The project aims to assist OVC by building technical and organizational capacity, strengthening essential components of the social service system, and improving linkages with health and other sectors. The project is implemented through a consortium led by Catholic Relief Services (CRS) with partners IntraHealth International, Pact, Plan International USA, Maestral International, and Westat.