Global AIDS Response Progress Report
GARPR

COUNTRY PROGRESS REPORT

Mozambique

Submission date: 31 March 2014

Acknowledgements

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Preface

The Government of Mozambique has signed the 2001 UN Declaration of Commitment on HIV and AIDS, thus assuming the commitment to report the progress of the national response every two years since 2004 and every year since 2013.

Since then, the Government of Mozambique has produced regular report for the period 2001-2003, 2004-2005, 2006-2007, 2008-2009, 2010-2011 e 2012.

Mozambique has been registering remarkable economic progress with a fast economic growth at global level, linked to the recent discovery of vast mineral resources raising optimistic perspectives for the country.

Mozambique has signed the 2011 UN Political Declaration on HIV and AIDS, thus joining the international community committed to create an HIV-free world.

Mozambique is now proud of its improved performance. It is important to prepare the different response actors for this fight that can be secured through correctly linked and coordinated efforts at all levels. For the first time, the country is now producing information with high scientific value in quantity and quality. While imposing challenges, this information also contributes for better informing decision making.

HIV impact reduction requires the involvement of every institution, public and private, national and international partners and the general population, based on the principles of joint responsibility and integrated programs.

Without the selfless support of cooperation and implementation partners, the country could not have reached the present situation. It is important to keep on strengthening the articulation and coordination systems at all levels, so as to be able to face all the challenges that the country is confronted with.

Dr. Alexandre L. Jaime Manguele
Minister of Health and CNCS Vice-President

Acronyms

ACA	Joint Annual Evaluation
AIDS	Acquired Human Immunodeficiency Syndrome
ANC	Ante-Natal Care/Clinic
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
ATS	*Aconselhamento e Testagem em Saúde* Health Counselling and Testing
APE	Community health worker
APSS & PP	*Apoio Psicossocial e Prevenção Positiva* Psychosocial Support and Positive Prevention
BSS	Behaviour Surveillance Survey
CBO's	Community Based Organizations
CCR	Consultation of Child at Risk
CDC	Centre for Disease Control
CNDH	National Commission of Human Rights
CS	Civil Society
CSO	Civil Society Organisations
CSW	Commercial Sex Workers
CCM	Country Coordinating Mechanism (Global Fund)
CT	Counselling and Testing
CTA	Confederation of Business Associations
DDS	District Health Service
DFID	Department for International Development
DIS	Department for Information System
DHS	Demographic and Health Survey
DOTS	Direct Observation Treatment Strategy
DPC	Department of Planning and Coordination
DPS	*Direcção Provincial de Saúde* Provincial Health Directorate
ECOSIDA	*Empresários Contra o SIDA* Businesses Against AIDS
EMTCT	Elimination of Mother to Child Transmission
GAAC	*Grupos de Apoio à Adesão Comunitária* Community Adherence Support Groups
GARPR	Global AIDS Response Progress Report
GBV	Gender Based Violence
GCPCD	*Gabinete Central de Prevenção e Combate à Droga* Central Office for Drug Prevention and Control
GFATM	Global Fund to Fight AIDS, TB and Malaria
GTM	*Grupo Técnico Multi-sectorial* Multi-sectoral Technical Group
HAP	HIV Response Acceleration Plan
HBC	Home Based Care
HF	Health Facility
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
INE	*Instituto Nacional de Estatística* National Statistics Institute\
INGO	International Non- Government Organisation
INS	*Instituto Nacional de Saúde* National Health Institute

INSIDA	*Inquérito Nacional de Vigilância, Comportamento e Informação* National Survey on Surveillance, Behaviour and Information
LAMBDA	Association for Sexual Minority Rights in Mozambique
LDH	*Liga dos Direitos Humanos* Human Rights League
MAP	Multi-Country HIV/AIDS Program
M&E	Monitoring and Evaluation
MC	Male Circumcision
MFP	Ministry of Public Administration
MCH	Maternal and Child Health
MoH	Ministry of Health
MMAS	Ministry of Women and Social Action
MONASO	Mozambican Network of AIDS Services Organizations
MOT	Modes of Transmission
MSM	Men who have Sex with Men
NAC	National AIDS Council
NAP	National Acceleration Plan
NASA	National AIDS Spending Assessment
NCPI	National Commitment and Policy Instrument
NGOs	Non- Governmental Organizations
NHS	National Health Service
NPCS	Provincial AIDS Council
NSP	National Strategic Plan
OI	Opportunistic Infections
OTM	Mozambique Workers' Organization
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEPFAR	Presidents Emergency Fund for AIDS Relief
PES	Annual Sector Plan
PESS	*Plano Estratégico do Sector Saúde* Health Sector National Strategic
PID	People who Inject Drugs
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPE	Post Exposure Prophylaxis
RENSIDA	National Network of Associations of People Living with HIV and AIDS
SADC	Southern African Development Community
SAAJ	*Serviços Amigos do Adolescente e Jovem* Adolescents and Youth-Friendly Services
SESP	*Sistema Electrónico de Seguimento do Paciente* Patient Tracking Electronic System
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organisation
WPP	HIV Workplace Programmes

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I. Status at a glance

a. The inclusiveness of stakeholders in the report writing process

The National AIDS Council (NAC) has set up a Global AIDS Response Progress Report (GARPR) working group involving members from the NAC, Ministry of Health (MoH), Joint United Nations Programme on HIV and AIDS (UNAIDS) and the President's Emergency Fund for AIDS Relief (PEPFAR). This group orientated the GARPR data gathering and validation process.

Civil society organizations were actively involved in the process. Nearly 40 Non-government organizations, networks of people living with HIV, faith-based organizations, young people, trade unions and community-based organizations have provided quantitative and qualitative information for this report. The private sector was also involved in the reporting process.

A workshop was organised to openly present and discuss the data before being submitted. Key stakeholders, including line Ministries, civil society and private sector organizations were invited to participate at the workshop for validation of this report.

b. Status of the epidemic

Mozambique keeps ranking among the ten most HIV affected countries in the world. The epidemics threatens the social and economic future of the country. In some places, more than one-quarter of adults are infected by HIV.

It is estimated that nearly 1.5 million Mozambicans are living with HIV. Around 800 thousand are women and some 200 thousand are children.

Around 120 thousand new infections occur yearly. These arise mainly among sero-discordant couples, followed by commercial sex workers and their partners and clients as well as multiple partnerships.

c. Policy and programmatic response

- **Multisectoral HIV and AIDS Response - NSP III**

The multisectoral response is orientated by the National Strategic Plan III (2010 - 2014) (NSP III) which has four key thematic pillars: Reduction of Risk and Vulnerability, Prevention, Care and Treatment and Mitigation. These pillars are underpinned by the support areas of Coordination, M&E, Operational Research, Communication, Resource Mobilisation and Systems Strengthening. The NSP III emphasizes a mainstreaming approach of HIV and AIDS interventions in programmes and plans and a Communication Operational Plan was developed in 2011. The NSP III is not costed and there is no national budget for HIV.

Key Ministries at central and provincial level developed operational plans for 2011 and 2012 and some Ministries receive minimal state funding for the implementation of activities. Most efforts have been made by key Ministries such as Education, Women and Social Welfare, Agriculture, Youth and Sport and Internal Affairs. At the district

level, multisectoral planning has increased and in 2012 the role of the district HIV focal point was formalized and this position is now financed by the state budget.

Civil Society (CS) developed an operational strategy for the NSP III but the level of implementation is low due to lack of funds. Also it is not clear who has the mandate and overall support to coordinate the strategy. The coordination of the Private sector response is under the mandate of the Entrepreneurs against AIDS which supports companies to develop and implement HIV Workplace programmes (WPP). An operational plan and monitoring and evaluation (M&E) system were developed for the NSP III however ECOSIDA faces challenges in coordination due to a reduction in funding for this type of activity and there is no central data base

HIV is integrated into other country development plans and all partners have aligned to the strategic areas identified in NSP III. The main challenges in the HIV response are the same as stated in the GARPR 2012 -implementation of activities and resource mobilization. There is scarce funding available but the individual Ministries and actors also need to show more ownership and responsibility for the HIV response and prioritize specific actions and make best use of resources. Other key challenges are M&E lack of availability of baseline data which are used to define and plan targets and lack of data on spending. This affects the extent to which the country can develop and implement concrete operational plans.

- **United Nation Declaration on HIV and AIDS 2011**

In 2011, Mozambique was one of the United Nations Member States signatory of the General Assembly Declaration of Commitment on HIV and AIDS, whereby the international community pledged to reach the following objectives until 2015: (i) 80% coverage of ART for adults and children; (ii) reduce the number of new HIV infections by 50%; and (iii) reduce vertical transmission rate to below 5%. Mozambique nationalized this declaration and subsequently in 2012 developed an operational communication plan for Prevention of Mother to Child Transmission (PMTCT) and combined prevention.

- **Strategy to Combat HIV and AIDS in the Public Sector**

The Ministry of Public Administration (MFP) coordinates the implementation of the Strategy to Combat HIV and AIDS in the Public Sector (2009 -2013) which focuses on WPP for public sector employees. Key interventions have been implemented since 2011 across all sectors such as sensitization sessions for employees, distribution of IEC, voluntary counselling and testing, establishing referral systems, dissemination of the law 12/2009, advocacy to develop mechanisms which oblige the sectors to implement WPP for example the integration of the focal point in planning and Board meetings and the integration of HIV in the annual sector plan. The MFP has also supported the training of focal points, developed a manual for the facilitation of sensitization sessions and has held trimestral monitoring meetings with the participation of the majority of the sectors at central level. Some of the key challenges that MFP faces in the implementation of the Strategy are in the lack of commitment from leaders to implement WPP, supply of condoms and interpretation of the legislation 12/2009 which attributes 30% salary subsidy to support People living with HIV (PLHIV).

- **Health Sector HIV and AIDS Response**

The ITSs-HIV and AIDS Control Programme is the unit accountable for the management of HIV-related health services within the Mozambique National Health System. Its mission is the ruling, coordination, and supervision of prevention and care and treatment services delivery for PLHIV.

It covers the following components: Adult and paediatric Antiretroviral Therapy; Tuberculosis/HIV; Home-based Care; Psychosocial Support and Positive Prevention; Infections Transmitted Sexually; Counselling and Testing; Monitoring and Evaluation; Quality improvement.

The ITSs-HIV and AIDS Program is aligned with the Economic and Social Plan (*Plano Económico e Social* – PES), the Government Annual Plan defining activities to be developed so as to reach the targets defined for the MoH Programmes on the basis of the Health Sector Strategic Plan.

The Ministry of Health has produced a new plan defining the ways to comply with this commitment and reach respective targets: the *Plano de Aceleração da Resposta ao HIV e SIDA* (HIV and AIDS Response Acceleration Plan) was officialised on the second semester of 2013.

This highly ambitious plan´s priorities can be summarised as follows:

- ART massive scaling up
- Progressive Tenofovir (single daily dosage) introduction
- Widespread quality improvement actions
- Three-monthly drugs dispensing
- Option B+ implementation
- "One-stop" models setting up within Maternal Child Health (MCH) and TB Programmes
- Task-shifting – MCH nurses, general nurses and *agentes de medicina* as ART providers

The *Acceleration Plan* is based on the concept that treatment will also have a potent preventive effect (*Treatment as Prevention*), contributing not only for a reduction of the AIDS-related mortality but also for a reduction of the HIV incidence.

If the target of 80% ART coverage is reached until 2015 in Mozambique, it is estimated that both mortality and incidence will be reduced by more than 50% until 2025.

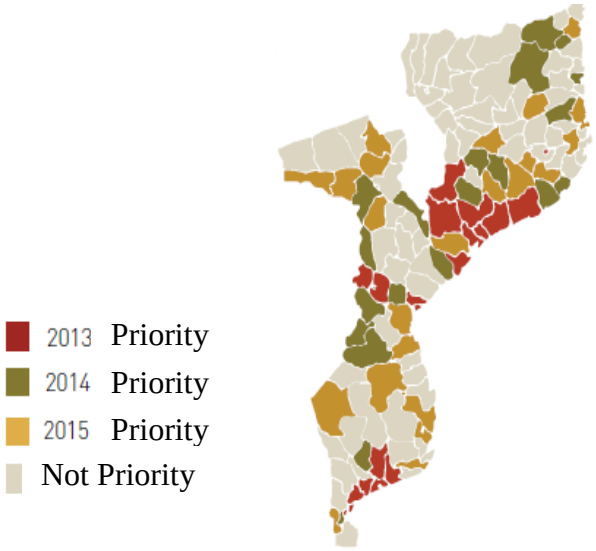
Additional results expected were:

- AIDS-related mortality reduction of 30%;
- Increase ART access of pregnant women up to 80%;
- Increase retention rate to care and treatment services at 36 months up to 70%;
- Reduction of the number of deaths due to TB in TB/HIV co-infected patients of 50%;
- Establishment of a culture free of HIV or TB-linked stigma and discrimination;
- Virtual elimination of unwanted pregnancies in HIV-infected women;
- Optimization of the national system of logistics and supply management;

- Strengthening of national human resources for a higher capacity on health;
- Optimization of the national laboratory networks for disease diagnosis and surveillance;
- Development of a rational and sustainable M&E system to enhance decision-making.

The *Acceleration Plan* is aligned with the NSP III, 2010 – 2014 and the Health Sector Strategic Plan, 2014-19 as well as the National Plan for the Eradication of Vertical Transmission and the 2015 Millennium Development Goals 4, 5 and 6.

The *Acceleration Plan* has identified and prioritised 70 districts in the country, corresponding to geographic areas with high HIV prevalence rates and low ART coverage (Figure 1). For a period of three years until 2015, these districts will get a more comprehensive specific support package. In the meantime, the basic equity principle guiding resources allocation is kept in the 128 districts in the country.



Source: Acceleration Plan, 2013

Figure 1 – Priority districts for care and treatment interventions

Indicator data in an overview table

Target 1. Reduce sexual transmission of HIV by 50% by 2015						
General population						
Indicator	**Gender**	**2004-05**	**2006-07**	**2008-09**	**2010-11**	**2012-13**
1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	All	22.3		34.8		34.9
	Female	20.0		35.7		30.2
	Male	33.0		33.7		51.8
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	All	27.6		25.1	24.9	
	Female	28.0		25.3	25.0	24.5
	Male	26.0		24.9	24.8	16.8
1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	All	11.1		10.8	15.3	
	Female	4.9		2.9	2.8	2.8
	Male	30.2		19.6	29.5	29.5
1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	All	17.0		23.6	18.5	
	Female	14.4		24.7	30.6	30.6
	Male	19.0		22,4	25.5	25.5
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	All	-	2.5	12.1	13.6	
	Female	-	2.0	14.5	17.0	25.9
	Male	-	3.0	8.9	8.9	14.2
1.6 Percentage of young people aged 15-24 who are living with HIV*	Female	N/A	14.4 (2007)	14.1	N/A	13.2 (2011)

Target 1. Reduce sexual transmission of HIV by 50% by 2015				
Sex workers				
Indicator	**City** (2011/2012)	**Age** **All ages**	**< 25**	**≥ 25**
1.7 Percentage of sex workers reached with HIV prevention programmes	Maputo Beira Nampula			
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	Maputo Beira Nampula	85.8 73.4 62.8		
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	Maputo Beira Nampula	33.5 30.0 28.8		
1.10 Percentage of sex workers who are living with HIV	Maputo Beira Nampula	31.2 23.6 17.8	14.5 17.4 8.8	60.3 47.9 48.0
Men who have sex with men				
Indicator	**City** (2011)	**Age** **All ages**	**< 25**	**≥ 25**
1.11 Percentage of men who have sex with men reached with HIV prevention programmes	Maputo Beira Nampula/Nacala			
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Maputo Beira Nampula/Nacala	76.0 80.3 61.9		
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	Maputo Beira	31.9 41.7		

	Nampula/Nacala	32.3		
1.14 Percentage of men who have sex with men who are living with HIV	Maputo	8.2	2.4	33.8
	Beira	9.1	2.8	32.1
	Nampula/Nacala	3.7	2.7	10.3

Targets 1 and 2. Size estimations for key populations

Key population	Size estimation performed?	Latest estimation performed	What was the size estimation (%)
Men who have sex with men	Yes	2011	Maputo 1.5 Beira 1.8 Nampula/Nacala 1.3
People who inject drugs	No		
Sex Workers	Yes	2011/2012	Maputo 2.0 Beira 5.0 Nampula 4.5
Comments: The size estimations studies were conducted in three cities in the country: Maputo (South Region), Beira (Central Region) and Nampula (North Region) and must not be generalized to the Country.			

Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015

Indicator	
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	N/A

2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	N/A
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	N/A
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	N/A
2.5 Percentage of people who inject drugs who are living with HIV	N/A

Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths**

Indicator	2004-05	2006-07	2008-09	2010-11	2012-13
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	6.7	29.8	45.8	66	83.7
3.1a Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding					-
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth			30.9	40.9	35.3
3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	24.6		29	20.2	10.5

Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

Indicator	2004-05	2006-07	2008-09	2010-11	2012-13
4.1 Percentage of adults and children currently receiving antiretroviral therapy*					31.7
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	-	-	-	74.0	71.0

Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015					
Indicator	**2004-05**	**2006-07**	**2008-09**	**2010-11**	**2012-13**
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV		3.9	9.8	9.8	24.6

Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22–24 billion in low- and middle-income countries					
Indicator	**2004-05**	**2006-07**	**2008**	**2010-11**	**2012-13**
6.1 Domestic and international AIDS spending by categories and financing sources (million USD)	107	202	146	474	

Target 7. Eliminating gender inequalities					
Indicator	**2004-05**	**2006-07**	**2008-09**	**2010-11**	**2012-13**
7.1 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months					27.5

Target 8. Eliminating stigma and discrimination					
Indicator	**2004-05**	**2006-07**	**2008-09**	**2010-11**	**2012-13**
8.1 Discriminatory attitudes towards people living with HIV					Male: 26.4% Female: 28.7% (2011)

Target 9. Eliminate travel restrictions						
Indicator		**2004-05**	**2006-07**	**2008-09**	**2010-11**	**2012-13**
N/A						

Target 10. Strengthening HIV integration						
Indicator		**2004-05**	**2006-07**	**2008-09**	**2010-11**	**2012-13**
10.1 Current school attendance among orphans and non-orphans aged 10–14*	orphans		62.6	77.3	66	73.9
	non-orphans			86.5	79.3	81.2
10.2 Proportion of the poorest households who received external economic support in the last 3 months		22	22	22	-	

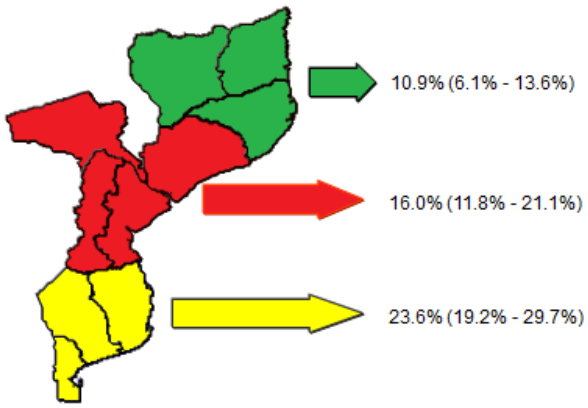
II. Overview of the AIDS epidemic

HIV Prevalence

- **Sentinel surveillance on pregnant women attending ANC facilities, 2011**

A sentinel surveillance on pregnant women attending ANC facilities was held in 2011 in Mozambique. This was the fifth round of a routine surveillance being implemented every 2-3 years since 2002.

Figure 2 shows the estimates for the median HIV prevalence, by region. At national level this has reached 15.8%.

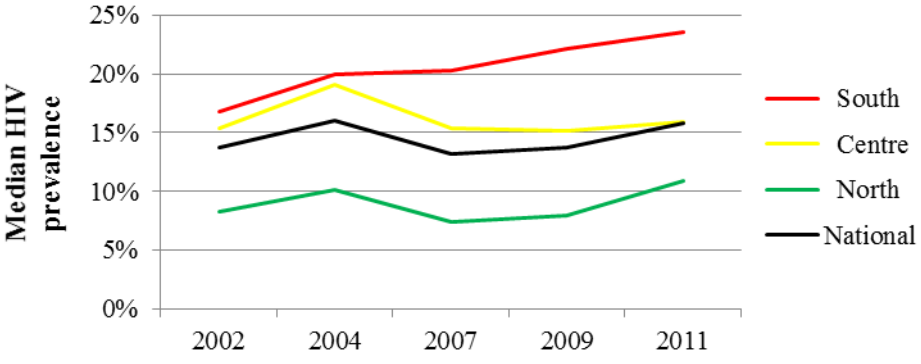


Source: RVE, 2011

Figure 2 – HIV prevalence among pregnant women attending ANC in Mozambique, by region, 2011

The epidemics regional behaviour captured in 2011 keeps being similar to the pattern of the last decade: the south region had the highest prevalence (23.6%), followed by the central region (16%) and the northern region (10.9%).

Figure 3 shows the trend of the median HIV prevalence by region for the period 2002-11.



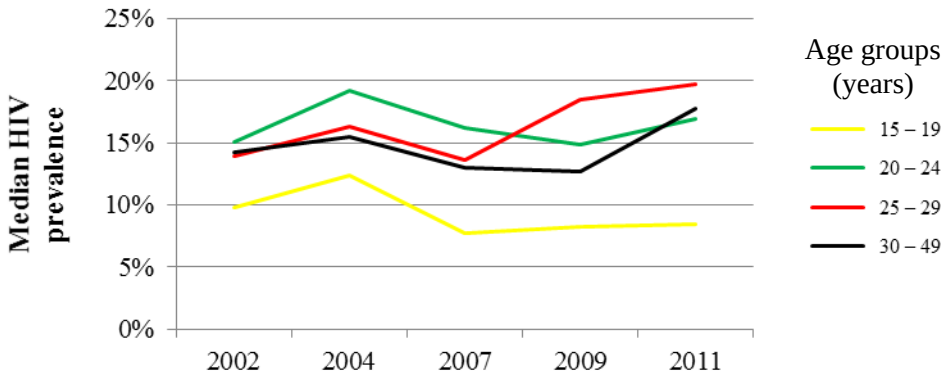
Source: RVE, 2011

Figure 3 - Trend of the median HIV prevalence among pregnant women attending ANC, by region (2002-11)

An unexpected generalised increase of the HIV prevalence when compared to the last surveillance could be worrying. However, it should be noted that HIV prevalence trend among pregnant women for the period 2002-11 has shown a limited oscillation between 13% and 16%.

Given the gradual increase on the number of people on ART, it is possible that reduction of AIDS-related mortality has contributed to the HIV prevalence increase.

Concerning age, HIV prevalence has been higher among older age groups (25-49). Figure 4 shows the trend of the median HIV prevalence by age group for the period 2002-11.



Source: RVE, 2011

Figure 4 - Trend of the median HIV prevalence among pregnant women attending ANC, by age group (2002-11)

Table 1 shows details of the sentinel surveillance on pregnant women attending ANC facilities (age group, region, area and number of pregnancies).

Table 1 –HIV median prevalence among pregnant women aged 15-49 attending ANC, by age group, region, area and number of pregnancies, Mozambique (2002-2011)

	2002	2004	2007	2009	2011
Age group					
15 – 19	9,8%	12,4%	7,7%	8,2%	**8,4%**
20 – 24	15,1%	19,2%	16,2%	14,9%	**16,9%**
25 – 29	13,9%	16,3%	13,6%	18,5%	**19,7%**
30 – 49	14,2%	15,5%	13,0%	12,7%	**17,8%**
Region					
South	16,8%	20,0%	20,3%	22,2%	**23,6%**
Centre	15,4%	19,1%	15,4%	15,1%	**16,0%**
North	8,3%	10,1%	7,4%	7,9%	**10,9%**

Area					
Urban	18,0%	19,0%	18,7%	22,1%	**19,9%**
Rural	12,0%	12,7%	9,4%	9,5%	**12,2%**
Pregnancy					
1st pregnancy	9,4%	13,0%	10,0%	10,5%	**9,1%**
2 or more pregnancies	14,0%	17,9%	14,6%	16,6%	**17,4%**
National	**13,7%**	**16,0%**	**13,2%**	**13,7%**	**15,8%**

Note: Between 2002 and 2004, two urban sites were replaced by two rural sites. For this, when undertaking trend analyses, consistent sites can only be considered after 2004.

Source: RVE, 2011

According to this 2011 sentinel surveillance the percentage of young women aged 15–24, who are living with HIV (GARPR Indicator 1.4) is estimated at 13.2 (Table 2).

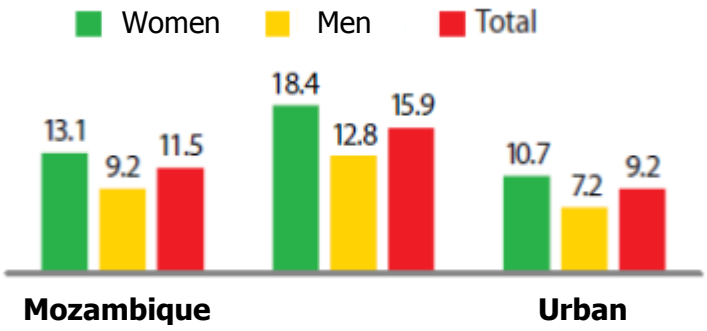
Table 2 - Indicator 1.6 - *Percentage of young women aged 15–24 who are living with HIV*, 2011

Age group	
15-19	8.4
20-24	16.9
15-24	13.2

Source: MoH, 2014

- **General population survey, 2009**

A general population survey, held in 2009 (INSIDA, 2009) found a total prevalence of 11.5% at national level (Figure 5). This was higher among women (13.1%) when compared with men (9.2%).



Source: INSIDA, 2009

Figure 5 – HIV prevalence (%) among adults aged 15-49, by area of residence, by gender, 2009

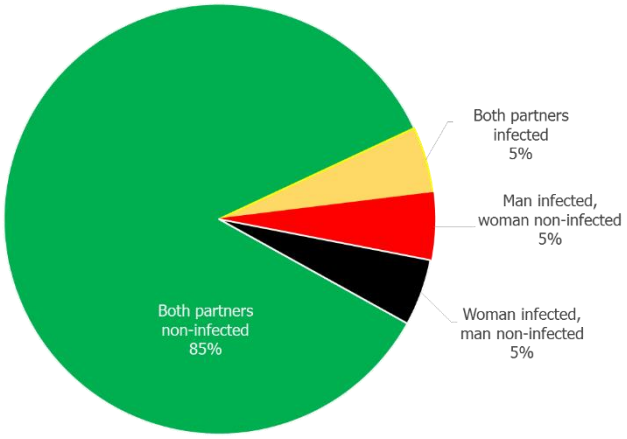
Urban areas were more affected than rural areas (15.9% and 9.2%, respectively).

Wide geographical variation was found within the country: among women, ranging between 3.3% in the northern Niassa province and 29.9% in Gaza province in the south; among men, ranging between 3.3% in the northern Nampula province and 19.5% in Maputo province in the south.
Women get infected earlier than men. Both for women and men, HIV prevalence grows as age advances, reaching a peak at 25-29 years old for women (16.8%) and at 35-39 years old for men (14.2%).

HIV prevalence among young women aged 15-24 is three-fold higher (11.1%) than among their male counterparts (3.7%).

HIV prevalence grows as the school level raises both among women and men. The highest HIV prevalence in the country is found among women with secondary or upper school level.

INSIDA 2009 found the rate of sero-discordance in the country: in 15% of the couples, one or both partners are infected with HIV (Figure 6). The proportion of couples when both are infected is approximately the same as the one when only the man is infected or when only the woman is infected (5%).



Source: INSIDA, 2009

Figure 6 – HIV prevalence among couples (women and men aged 15-49)

III. National response to the AIDS epidemic

Part 1. National commitments and action

Domestic and international expenditure on HIV and AIDS

The Funding Matrix of indicator 6.1 was reported using the results of a National AIDS Spending Assessment (NASA), which was conducted for the years 2010 and 2011. This represents the latest data available for HIV expenditure in the country. The expenditure

for the years 2012 and 2013 will only be capture in the next spending assessment. The spending Matrix is included in Annex 2 of this report.

Expenditure for HIV and AIDS in Mozambique reached a record high of US$ 260.3 million in 2011, representing over five-fold increase from 2004 to 2011, and a 22% increase from the US$ 213.5 million reported in 2010 (Figure 7).

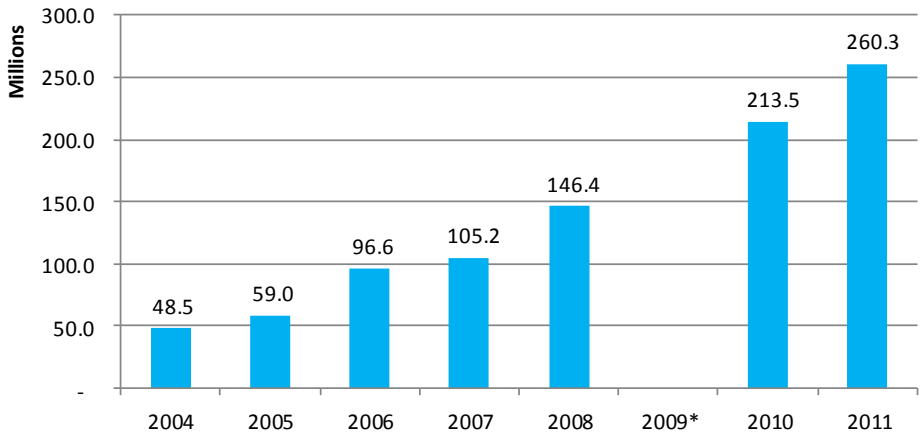


Figure 7 - Overall expenditures for the AIDS response in Mozambique, 2004-2011 (US$ millions)

The response to HIV/AIDS in Mozambique remains essentially sustained by external assistance. In 2011, international resources represented about 95% of overall expenditure for HIV in the country. Domestic public resources accounted for 5.1% of the response (US$ 13.4 million) and domestic private less than 0.1% with US$ 230 thousands. The biggest contribution was made by the Government of the United States of America which contribution totalled US$ 187 million dollars and accounted for 72% of the AIDS response in Mozambique. Other funders included the Global Fund for HIV, TB e Malaria (US$23 million), other bilateral funders (US$ 11 million), UN agencies (US$ 11 million), International NGOs and philanthropic (US$ 10 million), and other multilateral organisations (US$ 5 million).

Programmatic priorities vary among the different financing sources. Almost all resources from the GFATM (88%) were allocated for care and treatment (88%), with counselling and testing (6%) and PMTCT (4%). On the other hand, the United States Government and remaining international sources distributed they resources across most of the eight programmatic categories. Together they allocated their resources to care and treatment (35%) followed by prevention (29%), systems strengthening & programme coordination (19%), incentives for human resources (8%), Orphans and Vulnerable Children (OVCs) (5%) and enabling environment (3%). UN Agencies was the financial source that allocated the highest proportion of its resources to developing an enabling environment (10%).

The analysis of expenditure by AIDS Spending Categories (Table 3) shows that overall spending priorities in 2011 have been on care and treatment (US$ 105.2 million), followed by prevention (US$ 72.2 million), systems strengthening & national programme coordination (US$ 45.1 million), support to Orphans and vulnerable children (US$ 11.6 million) and others (US$ 26.2 million). Compared to previous years, the allocation of expenditure on prevention programmes gradually declined from 48%

of total expenditures in 2004 to 27% in 2008 and 22% in 2011; while expenditure on treatment and care increased from 21% of total spending in 2004 to 29% in 2008 and 40% in 2011.

Total spending on OVCs remained low at 7%, 9% and 4% of total spending respectively between 2004, 2008 and 2011. Likewise, resource allocation for an enabling environment remained low from 2007 (2%) through 2011 (3%).

Table 3 - HIV expenditure per programmatic area and financing sources, 2011 (US$ million)

(US$ millions)	Domestic Publico	Domestic Private	PEPFAR	Global Fund	Other external funds*	Total	%
01. Prevention	3.99	0.10	54.54	2.67	10.93	**72.24**	28%
02. Care and treatment	6.81	0.11	64.12	20.11	14.02	**105.17**	40%
03. Orphans and vulnerable children (OVC)'	-	-	9.42	-	2.15	**11.57**	4%
04. Systems Strengthening & Programme Coordination	2.58	<0.01	35.13	0.01	7.36	**45.09**	17%
05. Incentives for Human resources	-	-	<0.01	-	18.79	**18.80**	7%
06. Social protection and social services	0.01	0.02	-	-	0.37	**0.40**	0%
07. Enabling environment	-	-	5.30	-	1.65	**6.95**	3%
08. HIV and AIDS-related research	-	-	-	-	0.06	**0.06**	0%
Total	**13.4**	**0.2**	**168.5**	**22.8**	**55.3**	**260.3**	100%
%	5%	0%	65%	9%	21%	100%	

* Other external funds include UN Agencies, international NGOs, Philanthropies, and other multilateral organisations.

Considering the dependency on international aid for HIV prevention programme (94%) and the reduced share of resources allocated to prevention programmes over the study period, prioritized activities within HIV prevention programmes require greater attention. The results show that in 2011, a majority of funding (62%) was allocated to biomedical interventions. Communication and mobilization towards general population accounted for 24%, and a prevention for specific accessible or vulnerable populations an additional 10%. Only 3% of prevention expenditure was targeting key populations. More specifically, the five most funded HIV prevention activities were: PMTCT (US$ 21.4 million), counselling and testing (US$ 15.7 million), communication for social and behavioural change (US$ 8.2 million), community mobilization (US$ 4.4 million), and voluntary medical male circumcision (US$ 3.5 million).

The overall increase of expenditure in care and treatment reflects the increase of number of people accessing ART. In 2011 about 68% of total funding on care and treatment was spent on ART and 11% on Opportunistic infections' (OI) treatment. ART expenditure includes Pre-ART packages, and first and second line of treatment for Adults and Children. In 2011, Home Based Care (HBC) expenditure reached, US$ 7.5 million, much higher than the US$ 1.1 million reported for 2004, but more than US$ 2 million short from the US$ 9.7 million reported for 2006.

Resources for the national response to HIV and AIDS have contributed to the construction and improvement of infrastructure, upgrading of laboratory facilities (US$ 5.8 million), information technology and system ($12.8 million[1]), drug supply systems (US$ 0.9 million), and other health system strengthening not specified (US$ 2.4 million). The rest was spent for the management and coordination of the national

[1] Including 4.03 Monitoring and evaluation, 4.05 Serological-surveillance, 4.06 HIV drug-resistance surveillance, 4.08 Information technology, 4.09 Patient tracking

response (US$ 13.7 million), followed by program management costs at national level reported by PEPFAR (US$ 9.3 million).

Other important expenses were made for training of health care workers (US$ 17.2 million) and for AIDS specific institutional development activities towards civil society (US$ 6.1 million). They respectively represented 91% of the expenses for *5 .Incentive for Human Resources* and 88% of expenses for *7. Enabling Environment*. According to the National AIDS Spending Assessment, less than US$ 250 thousands were reported for activities related to Human Rights programs in the context of HIV, programmes to reduce Gender Based Violence and other AIDS-specific programmes focused on women. However, it is possible that certain expenses related to the above activities (e.g. Stigma reduction) are aggregated into other prevention activities.

National Commitments and Policy Instruments

Civil Society Involvement in the HIV and AIDS Response

There is an opportunity for dialogue between Civil Society (CS) and Government in the multisectoral HIV response as the NAC has a mechanism to promote information sharing through the Partners Forum at central level and Provincial Forums and meetings. At District level, there are more regular meetings which include community members and District services which permit information exchanges and discussion. In 2009, during the development process of the NSP III, CS formed a platform in order to increase involvement and participation in the process.

In the health sector, there is lack of opportunity for involvement of CS. This can be demonstrated by the fact that the processes for the formulations of key strategies in 2013 - National Acceleration Plan (NAP) and the Heath Sector Strategic Plan (PESS) - were closed for the majority of CS national organisations. These processes had high involvement from INGOs, UN and PEFAR agencies and only some national organisations were consulted.

In 2012 and 2013 the extent to which CS was involved in policy and strategy design, planning and budgeting processes for HIV and AIDS was limited,. In part due to the fact that there were no major developments in terms of multisectoral strategy or planning but also due to the fact that the roles between the NAC and MoH with regards to inclusion of CS activities in planning is not clear. The NAP and PESS do not include CS activities. Overall t there is a need to create more opportunities in order to guarantee more active involvement and participation, especially for PLHIV and key populations.

Overall CS participation is representative and generally inclusive and at Central level the national CS platform (formed in 2009) has participation from all networks and diverse organization but some key population groups (sex workers, migrants, minority groups) are underrepresented. CS also faces key challenges which impact on CS HIV response. In general CS is fragmented and organisations have a weak capacity to advocate for key issues in the HIV response (for example in the Board meetings of the NAC). Geographical coverage of CS programmes in not national and CS interventions are not consolidated or prioritized towards common priority interventions. There is a lack of coordination and flow of information on CS activities and funding interventions. There needs to be more communication between CS organisations and use of CS activity data for advocacy and prioritization.

CS provides over 75% of HIV programmes/services for PLHIVs, Men who have sex with Men (MSM), People who Inject Drugs (PID), Commercial Sex Workers (CSW), transgender people, palliative care, rights, reduction of stigma and discrimination, home based services and OVC support but lacks access to adequate financial and technical support to implement activities. In comparison to previous year reports there has been a decrease in access to support. There has been a reduction in funding for smaller CSO but funds are available (eg from PEPFAR, Global Fund) on a larger scale for more established national CSOs. The channels for accessing technical support are not clear and often the expertise is only available at central level. It is not easy for CS to access long term support mechanisms throughout life cycle of a project and also technical support is generally linked to funding.

The UN agencies and other INGO's have a variety of different interventions to support the involvement of Civil Society. The national association of miners (AMIMO) receives support from the International Organization for Migration (IOM) to build institutional and technical support. CSO's working in health and PMTCT receive capacity building support from the United Nations Children's Fund (UNICEF) and other organisations focusing on sexual and reproductive rights such as the *Associação Moçambicana para o Desenvolvimento da Família* (AMODEFA), *Coalizão, Forum Mulher*, LAMBDA and the and the United Nations Fund for Population (UNFPA). In 2012 and 2013, the United Nations Entity for Gender Equality and the Empowerment of Women (UNWomen) built the capacity of positive women's associations to influence policy makers which resulted in the development of a charter.

Political Leadership and Support for the HIV and AIDS Response

The Government continues to demonstrate leadership in the HIV response at all levels. The multisectoral HIV response is coordinated by the National AIDS Council and the Board is chaired by his Excellency the Prime Minister and co-chaired by the Minister of Health. The NAC coordinates the monthly Partners Forum which is an opportunity to share information on the HIV and AIDS response and prepare material for decision making. The Provincial Forums are led by the Provincial Governors and the District Forums by the District Administrators. A high level of leadership is shown also from the Permanent Secretaries at Provincial and District level. There are also different technical multisectoral working groups and another mechanism for interaction are the joint planning and evaluation processes which occur at Central, Province and District level.

A key event which demonstrates political commitment to the HIV response was the formulation of the Declaration of Maputo on the Elimination of Vertical Transmission. This was signed in 2012 by the First Ladies of the Southern African Development Community (SADC) and was hosted by the Mozambican First Lady.

Examples of leadership in other public sector Ministries include: On the 1st December 2012 the Minister, Vice Minister and other leaders from the Ministry of Internal Affairs all attended events to show support for HIV response, including visiting PLHIV in their homes. In 2012 the Ministry of Defence hosted an international Military conference on HIV and AIDS which was opened by the Minister of the Internal Affairs. In December 2013, the Minister, Vice Minister and Permanent Secretary of Agriculture all spoke of the importance of the HIV response during their speeches at a national meeting.

In 2012 the NAC recognized the substantial funding gap for CSO's and allocated resources of 1.6MZN to finance CSO's. This was positively received by CS however the criteria and mechanisms used for allocation of funds are not clear. The NAC also provides CSOs support in the implementation of HIV related activities through capacity-building, coordination with implementing partners and technical guidance.

Human Rights

Mozambique has specific non-discrimination laws or regulations which specify protections for PLHIV, migrants/mobile populations (including mine workers), OVCs, people with disabilities, women and girls and older people. Both the Government and CS agree that there are no specific protections for MSMs, PIDs and transgender people and this situation has not changed since the GARPR 2012.

The law 5/2002 protects the rights of PLHIV in workplace and the law 12/2009 defends the rights of PLHIV and fights against stigma and discrimination for PLHIV. The weaknesses of these laws were recognized and in 2013 the laws were revised and submitted to the National Assembly for approval in 2013. This process was coordinated by the HIV Office in the Parliament and included the NAC, the Mozambican Network of AIDS Services Organizations (MONASO), the United Nations Development Programme (UNDP), Mozambique Workers' Organization (OTM), Confederation of Business Associations (CTA) and ECOSIDA. Both Government and Civil Society state that there is a weak/ arbitrary implementation of these laws. Whilst there are efforts on both to disseminate these laws via trainings, seminars and debates, it is not possible to measure the degree in which the laws are implemented as no reporting mechanisms exist.

Civil Society identified laws, regulations and policies that present obstacles to effective HIV services for MSM, migrants/mobile populations, PID, prison inmates, CSW, transgender people, women and girls and young women/men. In particular the Penal code criminalizes "Non –natural acts". This is arbitrary and can be interpreted by some to criminalize homosexuality. The Government agreed that the interpretation of MSM as a crime, increases discrimination of this group and as such is a human rights issue and a political issue. There is slow progress in the recognition of MSM and although LAMBDA is not officially recognized there is a certain degree of openness around the topic of MSM. Another barrier to prevention which was identified for prison inmates was the lack of availability of condoms in prisons. Here the Government recognized that the informal policy on non- distribution of condoms in prisons, presents a barrier to prevention of HIV.

Migrant mine workers infected with TB also face barriers to effective treatment as the treatment regimens on TB are not harmonized between South Africa and Mozambique so patients are in practice unable to continue their treatment once they migrate or return. Another barrier which was identified is the lack of/or weak implementation of WPP which means that PLHIV are often denied access to HIV services during working hours. Overall the lack of recognition and protection for key populations and other vulnerable subpopulations poses a major barrier in access to services for these key groups, although there is no evidence of prosecution of these crimes for MSMs, CSWs and PIDs.

"Respect for Universal Human Rights" is the first a key principle in the NSP III which makes specific reference to the following groups: PLHIV, marginal populations, populations at high risk, women, people with disabilities and older people. The Pillar on Reduction of Risk and Vulnerability defines results in the area of human rights, for example implementation of protective laws. Although there is no specific policy which states that key populations and vulnerable populations must have equal access. The current HIV strategies and plans stipulate equal access for to all populations and some plans (such as NAP and NSP III communication plan) detail specific interventions for key populations. The creation of the National Commission on Human Rights in 2012 is seen as a positive step in monitoring Human Rights in Mozambique.

The world of work response

ECOSIDA keeps being the leading NGO coordinating and supervising HIV programmes within the private sector, and especially among Small and Medium Enterprises (SMEs) and larger companies. *ECOSIDA* is now present in nine out of the eleven country provinces (except Niassa and Zambézia). In each of these Provinces, ECOSIDA has placed a programme manager for supporting coordination meetings and sharing information with provincial response coordinating bodies (NAC and MoH).

The private sector operational plan is aligned with the NSP III where its objectives are defined and interventions suggested (prevention, advocacy among employers, stigma and discrimination reduction, and access to counselling and testing and care and treatment).

The coordination group of the response to HIV in the workplace led by NAC and involving main related stakeholders - ECOSIDA, the International Labour Organisation (ILO), the International Organisation for Migration (IOM) workers' associations, unions and organisations, including informal sector - has had some activity in 2012 but its performance was weak in 2013.

ECOSIDA coordinating role of the HIV response within the workplace was reduced during the reporting period (2012-13) when compared to 2010-11, due to reduced funding. As a result, ECOSIDA current role is more positioned to providing technical support to SMEs and companies for the elaboration of workplace policies and implementation of programs, usually in partnership with other related stakeholders. In 2012-13, 93 companies have adopted and are implementing HIV workplace policies.

M&E is guided by a specific M&E plan for the HIV workplace response, a subsystem of the NSP III. In 2012-13, this had to be adapted to the ECOSIDA two main projects implemented with support from the GFATM and USAID.

Partnerships were strengthened with UNAIDS, ILO and the IOM concerning HIV in the workplace, notably in the area of M&E. ILO has provided technical assistance to ECOSIDA.

Training aimed at improving workplaces programs was intense.

Main ECOSIDA actions:

- In 2012, 130 members of Parliament were trained on HIV-related legislation and 130 Ministry of Labour's inspectors across the country were exposed to refresher training on HIV-related legislation and use of monitoring tools.

- Forty workplace focal points were trained on the use of monitoring tools for an adequate data collection on the workplace programs, and 30 workplace focal points were trained on the development of an HIV workplace policy.

- A strong partnership between ECOSIDA, ILO, UNAIDS and health authorities launched a campaign at national level implemented by workers and employees' organisations that reached high levels of sensitization and mobilization, including counselling and testing (more than three thousand workers).

- Road transport associations mainstreamed HIV into their agenda and implemented awareness raising actions in Beira corridor, whereby around 5000 people including sex workers and truck drivers were exposed.

- At community level, impact mitigation activities were developed, including training on income generating activities and savings and micro-credit schemes, in order to reduce vulnerability of PLHIV or affected by HIV. 227 people were capacitated on the management of income generating activities.

- HIV workplace stakeholders have participated in the revision of HIV-related legislations for submission to Parliament.

Table 4 shows a quantitative summary of ECOSIDA and partners' activities for the reporting period.

Table 4 – ECOSIDA and partners' activities summary, 2012-13

	2012	**2013**
New ECOSIDA members	2	0
HIV policies produced	47	46
New companies implementing the roadmap	118	213
Workers counselled and tested (thousands)	35.4	30.3
HIV policy design facilitators training	131	48
Peer Educators training of trainers	157	64
Peer Educators training	555	85
Awareness raising actions in companies	74	48
Workers exposed to these actions (thousands)	17	18
Sensitization sessions held	2 341	4 312
IEC material distributed (thousands)	91	800
Male condoms made available (millions)	2.1	2.2

Source: ECOSIDA, 2014

Challenges

- Resources mobilisation;
- SMEs and companies awareness raising on the true meaning of the elaboration of workplace policies;
- Poor long-term investments in employees' health by enterprises (many employees on temporary contracts);
- Improving activities monitoring: systematic and regular approach for SMEs and companies data flow.

Part 2. National Programs

Prevention

The country has identified specific needs for HIV prevention and these are included in the main strategies which orientate the country's Prevention programmes. Key prevention messages are promoted in all these strategies and they cover all population groups and also have specific interventions for the key populations of MSM, CSW, customers of sex worker and prison inmates. (There is no specific focus on PID – they are included as general population but MoH is elaborating a drug substitution therapy policy)

The strategies and plans prioritize the following: Human and Social rights; Testing and Counselling; Condom use; PMTCT; Social and Behaviour Change; Strengthening of Rights for PLHIV; Positive Prevention; Treatment as Prevention; Male Circumcision (MC); Use of Health Services and Adherence to Treatment for STI/ART/TB; Support for OVCs and other affected Families; Capacity building and Coordination; Involvement of men in sexual and reproductive health and post-exposure prophylaxis (PEP) - for gender based violence and occupational exposure. The Education Strategy (2012/2015) includes programmes to promote life-skills based HIV education for youths and HIV is part of the School and teacher training curriculum.

Challenges exist in the level of implementation of prevention programmes and plans, in 2012 and 2013 there has been a reduction in funding for the area of prevention, (with a shift to care and treatment). There is a need for increased coordination on prevention activities, especially due to the often conflicting strategies in the area and lack of data on the impact of prevention programmes.

The two areas which present the highest challenge to effective prevention (1) behaviour change and (2) high levels of stigma and discrimination. Other challenges highlighted by the National Commitment and Policy Instrument (NCPI) are; increasing the prevention focus on out of school children and young people, design of socio-cultural interventions to address behaviour change, quality of services (including counselling, interventions, messages), access to services for MSM and CSW, investment in community mobilization and more targeted interventions.

Condom use

In 2009, the INSIDA survey found that in Mozambique, only 8% of women and 16% of men aged 15-49 have used a male condom during their last intercourse. Female condom use is much lower: 2% for both men and women.

The Demographic and Health Survey 2011 (DHS 2011) found that 58% of women and 70% of men have agreed that children aged 12-14 should be taught about condom use to prevent HIV. These proportions increase with the education level of the respondents.

Many youths of both sexes that never married practice pre-marital sex: during the 12 months before the DHS 2011, these amounted to 44% and 67% for single women and single men, respectively. Pre-marital sex is commoner in urban areas and among those with higher educational levels.

Nearly half (46%) of these sexual active youths, both women and men, said they had used a condom in the last sexual relation. Condom use is much higher in urban areas (60% of women and 64% of men) than in rural areas (23% of women and 27% of men) and increases significantly as the education level increases.

Some of the main findings of the DHS 2011 concerning the use of condom in the context of paid sex were as follows:

- One in four men aged 15-49 has ever had paid sexual relations;
- Only one-third of men that have had paid sexual relations in the last 12 months have used a condom in the last paid sexual relations.
- Condom use during paid sexual relations is higher in urban areas (55%) than in rural areas (23%).

- Multiple partners and condom use

Multiple partnerships' characteristics are discussed later in this report. We now discuss only the use of condom within these relationships.

In 2011, women who had more than one sexual partner in the past 12 months were slightly more prone to use a condom during their last intercourse (30.6%) than men (25.5%) (Table 5). This was particularly accentuated in the older age groups (25-49).

Table 5 - Indicator 1.4: *Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse* (2009 and 2011)

	Female		Male	
	2009	**2011**	**2009**	**2011**
Age group				
15-19	32	42,5	40,8	43,5
20-24	32,6	34,1	35,3	38,9
25-49	14,2	25	12,8	16,5
15-49	23,6	30,6	22	25,5

Source: INSIDA 2009, DHS 2011

When comparing the IDS 2011 and the INSIDA 2009 data (Table 4) - DHS 2003 does not include corresponding data – only a slight increase on the use of a condom in these circumstances is noted, especially among women. Older age groups (25-49) register the highest increases in both sexes.

Male circumcision

In Mozambique, around 48% of men aged 15-49 are circumcised. There are wide geographic variations (Figure 4).

In 2009, MoH started a male circumcision (MC) pilot programme with support from the Centers for Disease Control and Prevention (CDC) to test the feasibility of a wider programme with real impact on HIV incidence. This reached five health facilities only, in five provinces of Mozambique.

In 2012, MoH produced the National Strategy for the Male Circumcision scaling up, 2013-17, with the main target to reach two million men aged 10-49 years until 2017. A Male Circumcision National Programme was formally setup in 2013.

The number of fixed units offering MC has grown from 16 in 2012 to 27 in 2031. Six additional temporary units increase the total amount to 33, in six different provinces. These are provided with a total of 92 operating tables specific for MC.

This has been gradually scaled up through the renovation and improving of existing surgical infra-structures within health units or the addition of new special pre-fabricated MC surgical units. These are equipped appropriately and provided with trained staff.

Further to the operative procedure, emphasis is also given to HIV counselling and testing, ITSs screening and management as well as condom promotion and distribution.

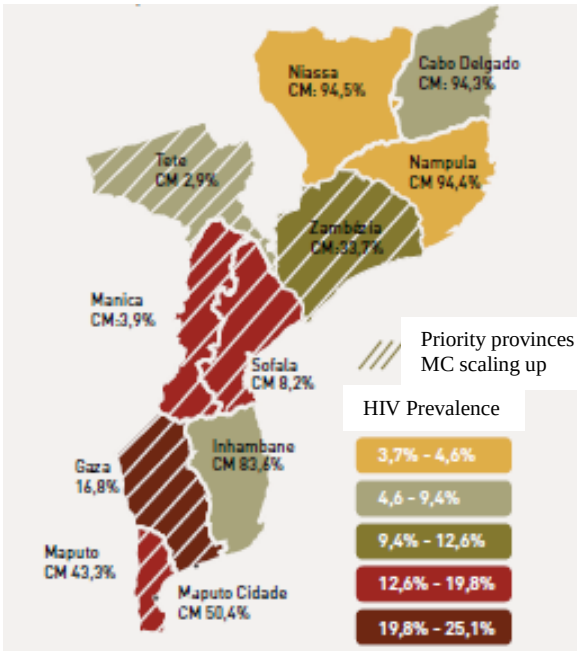
Demand promotion and generation activities are developed within communities, including two mobile units visiting remote health facilities.

Up to the end of 2013, nearly 283 thousand men were circumcised. These were mainly in 2012 (90 thousand) and 2013 (146 thousand).

The percentage of men aged 15-49 years that are circumcised is estimated at 47.4 (36.2% among those aged 15-19 years and 44% among those aged 20-24 years.

The Programme is financed by Implementation Partners only. Further to CDC, Population Services International (PSI) has supported military health facilities and ICAP is extending activities to Zambezia province.

Figure 8 shows the relationship between HIV prevalence at provincial level and respective rates of Male Circumcision. Seven priority provinces for MC scaling up according with the *Acceleration Plan* are also shown (lines).



Source: Acceleration Plan, 2013

Figure 8 - Relationship between HIV prevalence at provincial level and respective rates of Male Circumcision, and priority provinces

Prevention of Mother to Child Transmission

Mozambique accounts for 8% of all new paediatric infections in the world. In 2011, the country accepted the challenge of achieving a reduction of MTCT to less than 5%, reduce maternal deaths related to HIV by 50% and offer most effective ARV prophylaxis to 90% of all HIV infected pregnant women by 2015.

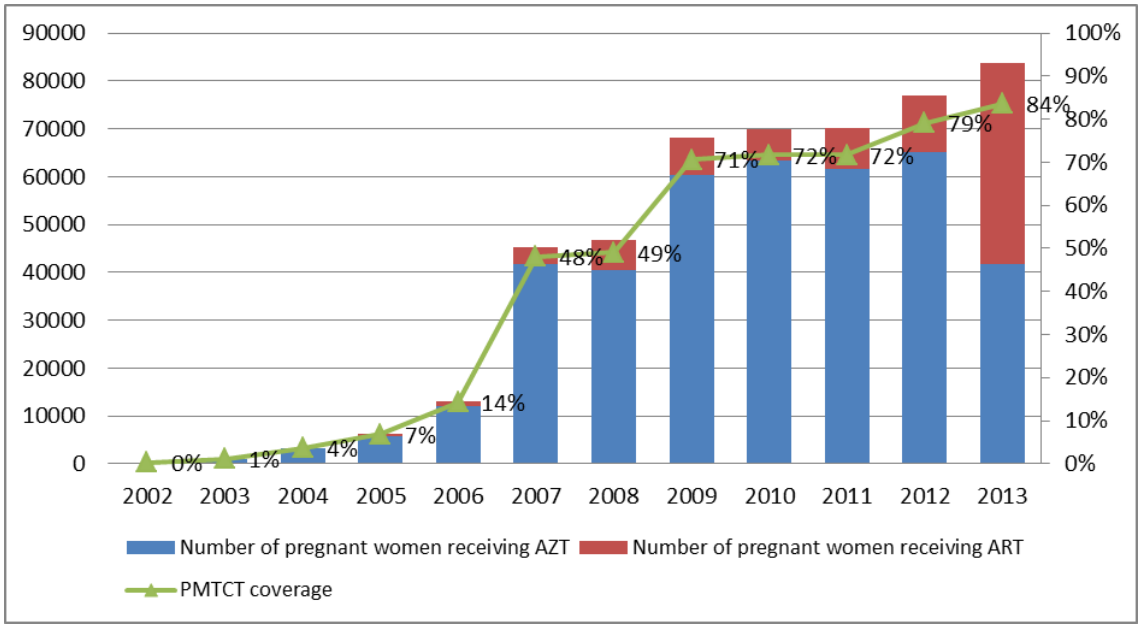
For this, in 2012 the country started the process of discussion, approval and material development for Option B+ implementation and the implementation started in June 2013.

In order to implement the Option B+ in the country considering the shortage of human resources, there was a need to promote and implement the task-shifting for MCH nurses and the "one-stop-model" within MCH services, with the provision of ART by the MCH nurses at the MCH services.

By December 2013, 1084 MCH nurses had been trained; Option B+ and the "one-stop-model" strategy were implemented in 534 health facilities in the country, representing 95% of all ART sites.

During the last two years there was an expansion of Prevention of Mother-to-Child Prevention (PMTCT) sites in the country, with 1170 health facilities providing PMTCT in 2012, and 1213 in 2013.

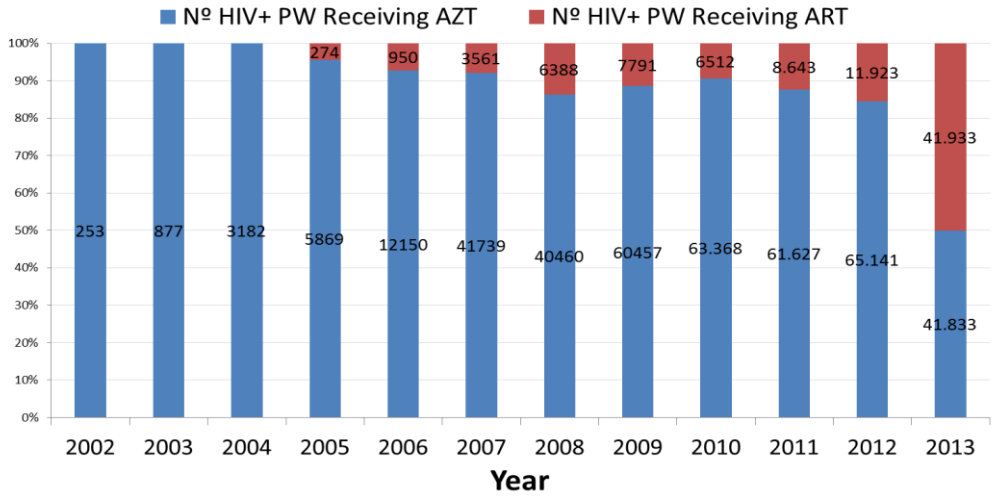
The number of seropositive pregnant women receiving ARV for PMTCT has increased in the last two years (2012-13) after a relatively stationary period of three years, achieving a population coverage of 83.7% in 2013[2], as shown in Figure 9.



Source: MoH, 2014

Figure 9 – Number of HIV infected pregnant women receiving ARV for PMTCT and PMTCT coverage (2002-2013)

Further to the evolution of the ARVs coverage for PMTCT in the country, Figure 10 also shows the effect of Option B+ implementation, with an enormous increase on the use of ART for PMTCT in 2013 (50% of pregnant women receiving ARVs for PMTCT being on ART).



Source: MoH, 2013

[2] Because epidemiologic projections (Spectrum) were recently updated, these figures are slightly different from those reported earlier.

Figure 10 - Number of HIV infected pregnant women receiving ARVs for PMTCT: AZT only and ART (2002-2013)

Early Infant diagnosis

Early Infant diagnosis is another priority and this was translated into an important scaling up of the number of health facilities in a position to offer sampling for PCR (DNA HIV): from 597 in 2012 up to 752 in 2013.

These have performed around 51 thousand samplings in 2012 and 60 thousand in 2013 (seropositivity 13.1% in 2012 and 10.2% in 2013). Currently, there are four referral laboratories processing PCR DNA HIV samples in the country (Maputo, Beira, Nampula and Quelimane).

The provision and expansion of mobile printing technology for PCR DNA HIV results to 500 health units in the country has decreased the turn-around time for PCR DNA HIV results at national level.

PCR Challenges

- Late PCR DNA HIV collection among infants (only 40% were taken in children under two months old)
- Sampling
    - quality
    - flow across health system
- Need staff training: early infant diagnosis platform and mobile printing technology

PMTCT Challenges

- Option B+ scaling up and strengthening;
- Adherence and retention (pregnant and lactating women, infants and children)
    - Psycho-Social support (national strategy, materials, training);
    - MCH "One-stop" (mother and child joint follow up).
- Male partners involvement;
- Programme M&E: data quality;
- Human resources and task shifting; regular mentoring;
- Improving quality
- Two PMTCT strategies implemented concomitantly

HIV Counselling and Testing

- HIV Counselling and Testing sites

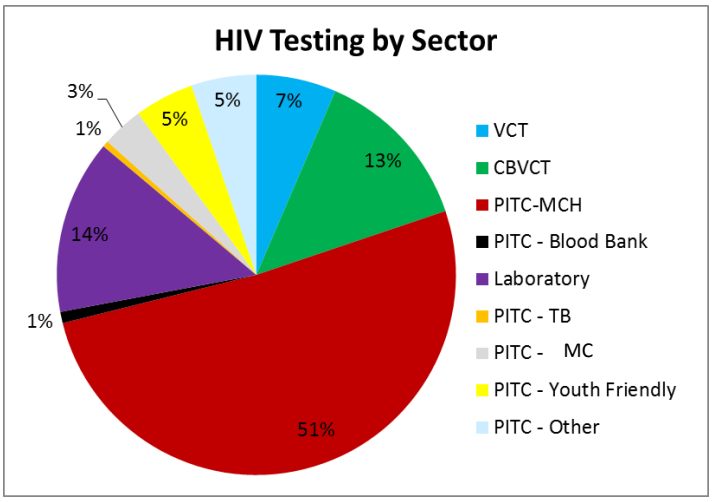
The 2011 DHS held in Mozambique has shown that 79% of women and 82% of men aged 15-49 are aware of the sites where they can get an HIV test.

This is higher for those living in urban areas (90% of women and men) when compared to those in rural areas (73% of women and 78% of men).

- People counselled and tested

Nearly 8.5 million tests for HIV were performed during the last two years (3.78 million in 2012 and 4.67 million in 2013).

In 2013, 51% of these occurred at MCH services and especially ANC. Other important testing sites were: Laboratory (14%), Community (13%) and user-initiated (7%) (Figure 11).



Source: MoH, 2014

VCT - Voluntary Counselling and Testing
CBVCT - Community Based Counselling and Testing
PICT – Provider Initiated Testing and Counselling

Figure 11 – HIV testing by sector and respective use proportions, 2013

The *Acceleration Plan* recommends testing 10 million more people until 2015. For this, Provider Initiated Counselling and Testing is being scaled up at key entry points within health facilities, the index case approach will be implemented in every health facility providing ART, and Community Health Counselling and Testing will be focused in high HIV prevalence areas with low testing coverage.

At the same time, effective links between HIV Counselling and Testing services and other Prevention, Care and Treatment services are being strengthened, including registry on ART services of newly diagnosed HIV-positive people and referral of HIV-negative males to Male Circumcision services. Peer educators/specialized patients will be used for this purpose.

<u>Population survey</u>

According to the DHS 2011, nearly half the women (45%) and 23% of men aged 15-49 had already been tested and knew their results. Urban areas were the main contributors for these results (57% of women and 36% of men) when compared to rural areas (only 38% of women and 15% of men).

The proportion of women and men aged 15-49 that had already been tested and knew their results increases with the wealth quintile: 65% of women and 44% of men of the highest quintile were tested, against only 29% of women and 7% of men of the lowest quintile.

Concerning specifically those that were tested in the 12 months before the survey and know their results, they total 25.9% of women and 14.2% of men, as shown in Table 5.

This illustrates the *Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results*, representing Indicator 1.5 for GARPR, by Gender and Age group in 2003, 2009 and 2011, when the last population surveys were held in Mozambique.

Table 6 - Indicator 1.5*: Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results*, by Gender and Age group (2003, 2009 and 2011)

	Female			Male		
	2003	**2009**	**2011**	**2003**	**2009**	**2011**
Age group						
15-19	3.5	15.1	17.8	1.8	5.6	7.7
20-24	3.1	24.2	35.7	4.8	11.6	16.4
25-49	1.8	13.4	26.1	2.5	8.7	16.4
15-49	2.4	17	25.9	2.7	8.9	14.2

Source: DHS, 2003, 2011. INSIDA 2009

As a result of the widespread availability of accessible counselling and testing opportunities, the results for this indicator have increased exponentially in the period 2003-11. Among female respondents this increase has been 10-fold or more among all age groups, except the 15-19 years old. The increase among male respondents has been more modest with smaller increases.

This remarkable female dominance is the result of easy access to HIV testing on the part of pregnant women attending ANC services where this is offered within the scope of PMTCT.

Albeit these substantial increases, it is important to note that in 2011, more than 75% of Mozambican males aged 15-49 were still not aware of their HIV status. This percentage was around 55% among female Mozambicans of the same age.

- Pregnant women Counselling and Testing

According to the DHS, in 2011 a total of 42% of women attending ANC services were counselled and tested. These varied widely according with their educational level: 68% of the women with secondary level or above, 42% with primary level and 33% with no schooling.

Concerning geographical and wealth characteristics, this indicator follows similar trends to the ones above described.

In 2013, more than 85% of pregnant women attending ANC (more than 1.2 million) in Mozambique were tested for HIV.

Sexually Transmitted Infections

To deal with STIs the National Health Service (NHS) keeps using the *syndromic approach* in Mozambique public health facilities. Treatment resistant or complicated cases are cared for at referral hospitals under an etiologic approach.

STIs are managed at every health facility and integrated into ANC services and Youth Friendly Services as well as General Medicine.

More than 1.5 million STIs cases were diagnosed and managed in the last two years (694 239 in 2012 and 882 020 in 2013). This keeps representing a consistent increase over time (410 699 in 2010 and 489 244 in 2011). This is hopefully the result of enhanced access to STI services on the part of the population as well as increased diagnosis capacity.

The Acceleration Plan recommends management of 2 million more STIs cases until 2015.

In 2013, vaginal discharge represented 51% of the total cases while genital ulcer and urethral discharge correspond to 30% and 19%, respectively.

Syphilis screening at ANC services had a coverage roughly between 40% and 60% from 2009 to 2011. This means more than half a million pregnant women tested for syphilis annually (from around 547 thousand in 2009 up to 684 thousand in 2011). Sero-positivity ranged between 5% and 7% during this period.

In 2012 and 2013, this has declined abruptly, with only around 330 thousand and 150 thousand pregnant women tested for syphilis at ANC services, respectively. This represents coverage rates of 37% and 14% only, for 2012 and 2013, respectively.

Syphilis prevalence among pregnant women aged 15-49 attending ANC is particularly high in the northern region (8.2%). Much higher than in the central and southern regions (1.7% and 1.2%, respectively). The median national prevalence is 2.2%. (RVE 2011)

Improving timely diagnosis and management of STIs continues to be part of the priority agenda of the MoH, so as to reduce HIV incidence. For this, training is being provided to health professionals on the syndromic approach and inter-personal communication. On the other hand, partners' notification is being strengthened.

STIs challenges

- Screening, diagnosis and reporting of contacts;
- Regular availability of medicines and consumables;
- Regular availability of monitoring tools to record adequately STIs;
- Improving M&E system.

Blood safety

The MoH's Blood Transfusion National (*Programa Nacional de Transfusão de Sangue – PNTS)* coordinates and supervises each activity related to blood transfusions in the country. These include 153 different sites scattered throughout Mozambique, providing blood transfusions within health facilities at all health attention levels.

The number of annual blood donations that was around 105-107 thousand in 2010 and 2011, increased to 121 thousand in 2012, to decrease again slightly (2%) in 2013 (119 thousand). This represents only around half of the estimated needs (200 thousand).

The rate of volunteer donations *vs.* family donations keeps balanced towards the later (51% and 56% in 2012 and 2013, respectively). This is far from the World Health organization (WHO) recommendations, decreasing blood safety.

For this, the major problem faced by the PNTS keeps being the detection of transfusion-transmissible infections. Table 7 provides a general view of the sero-prevalence of these infections in blood donations.

Table 7 – Percentage of infectious markers in blood donations (2010-13)

	2010	2011	2012	2013
HIV	7	5.8	6	6
Syphillis	4	1.4	9	2
Hepatitis B	6	4.5	4.6	3.6
Hepatitis C	0.8	0.9	0.7	0.5

Notwithstanding PNTS initiatives on strengthening staff training on the donors' selection under well-defined criteria, there is no evidence of significant change in the sero-prevalence of these infections.

The HIV infection risk in Mozambique is estimated at 1/1 000 transfusions (in the USA, it is 0.001/1 000).

At central and provincial levels, HIV and Hepatitis B and C is tested by enzyme-linked immunosorbent assay (ELISA). All the other sites use rapid tests.

PNTS is implementing a project for laboratory management strengthening at the Beira and Nampula central hospitals' blood banks. The national programme on external quality assessment reaches 25 blood banks.

Blood National Reference Centre

One of the WHO recommendations for blood safety is the setting up of a Blood National Service. In that sense, the PNTS has created the Blood National Reference Centre (*Centro de Referência Nacional de Sangue*) in 2013.

This Reference Centre is now leading the process of planning and implementing mobile teams for recruitment and maintenance of blood donors, aiming at the independent processing and distribution of blood donations.

Adequately equipped and provided with vehicles for mobile teams, the reference centre has the capacity to process 200 units daily. Adopting an aggressive marketing approach, the centre plans involving the community so as to provide it with ownership.

A youth-friendly approach is envisaged, turning the centre into an attractive site where youths can feel comfortable (*Cool Service*) and not stigmatized. This takes into consideration the fact that most volunteer donors are secondary school youths. Personal attention and modern information technologies are some of the characteristics of this service.

The fact that the reference centre is sited out of health facilities, removes the respective stigma usually associated with hospitals.

The reference centre will pioneer the implementation of the blood banks' quality systems, aiming at ensuring blood safety in adequate quantity and quality.

Currently, it is in the process of setting up and developing activities such as blood donors' mobilization and recruitment; pre- and post-donation counselling; donors triage; blood collection; blood products production; blood testing; quality control; storage of quarantine and tested blood.

Initiatives

A Donors' Recruitment and Mobilisation Manual was developed, in partnership with several donors' associations.

A blood donation campaign was initiated, with related information and educational materials available at blood banks.

Challenges

- Blood National Service setting up legislation;
- Blood National Reference Centre full operationalization;
- Number of unpaid volunteers increasing through strengthening of mobile teams;
- Donors' Recruitment and Mobilisation Manual wide dissemination, including in secondary schools;
- Mobilisation strategies development.
- Blood centres setting up in other important cities

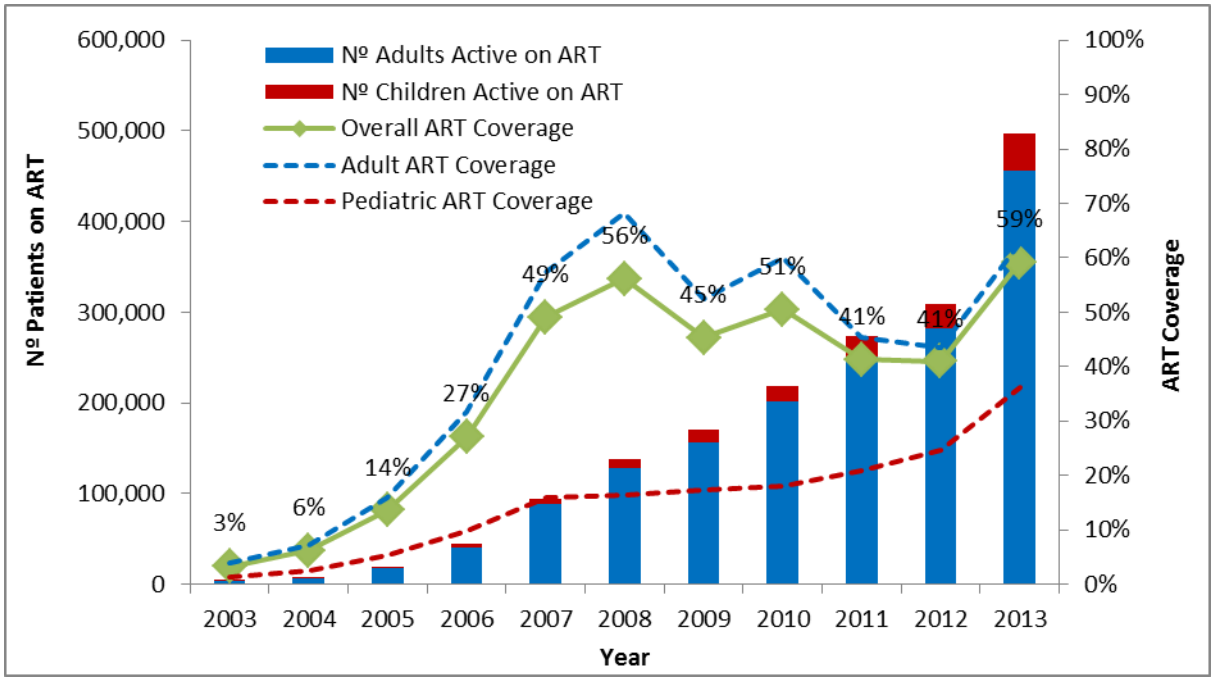
Care, treatment and support

Antiretroviral Treatment

The country has identified the essential elements of a comprehensive package of HIV treatment, care and support services and these are outlined in the MoH NAP. There are goals and targets for expanding ART services and increasing the number of people tested and new patients on ARVs.

For the last two years (2012-13), ARV therapy (ART) in Mozambique has increased exponentially, and especially in 2013, with a remarkable increase of nearly 200 000 more people getting ARVs when compared to 2012.

In fact, in 2012 the number of adults and children getting ARVs was just above 300 000 (308 578), while in 2013 this has reached nearly half a million (497 455) (Figure 12). This is nearly double the number registered in 2011 (273 561).



Source: MoH, 2014

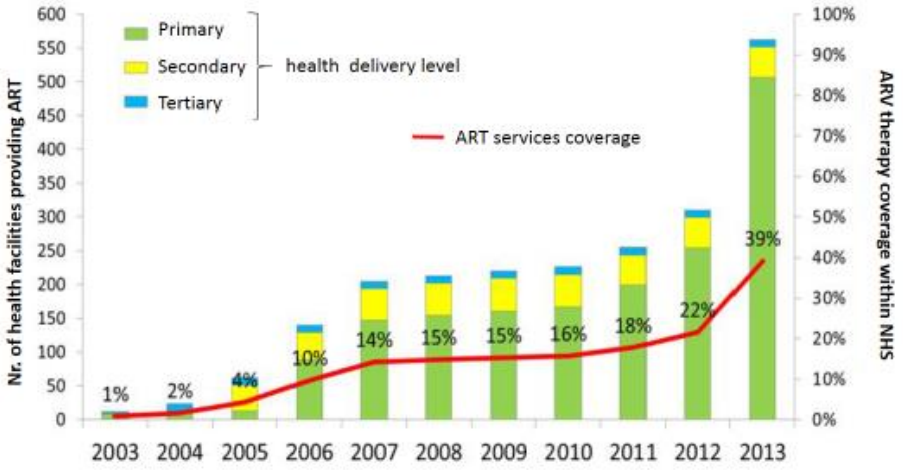
Figure 12- Number of adults and children on ARV therapy and respective coverage rates, Mozambique, 2003-2013

In terms of ART coverage, an increase from 41% in 2012 to 59% in 2013 was registered. This was mainly at the expenses of adults (62.8%). Children coverage still represents only 36% of the need[3]. Anyway, this represents a substantial growth from 43% and 26%, respectively, registered in 2012.

In 2013, children on ART represented only 8.3% (41 400) of the total number of people on ART. Although this percentage is below the 15% recommended by WHO for paediatric ART, it represents an important increase (40%) from the previous 25 891 children on ART recorded in 2012.

These unprecedented important increments were possible thanks to a unique scaling up of health facilities providing ART in the country. Actually, such facilities amounted to 316 in 2012 while in 2013 they represent 563, an increase of more than 200 in one year (Figure 13). The *Acceleration Plan* recommends increasing the number of health facilities providing ART in the country to 707 in 2015.

[3] Because epidemiologic projections (Spectrum) were recently updated, these figures are slightly different from those reported earlier.



Source: MoH, 2014

Figure 13 – Number of health facilities providing ART in Mozambique and respective ART services coverage within the NHS, 2003-2013

It should be noted however, that most of these new ART providers are still on an initial phase, with small number of beneficiaries. At present, 82% of ART provided at national level is still based at 140 health facilities only.

Coverage of ART services within the NHS jumped from 22% in 2012 to 39% in 2013. This 17% increase in one year is significantly higher than the small annual increases (1-4%) registered in previous years (Figure 8).

The Mozambique NHS includes a total of nearly 1 500 public health facilities. This means there is still a long way to go before a full national coverage of ART services is reached.

The augmentation of the number of health facilities providing ART is the result of the setting up of new services within existing health facilities – essentially of primary level - but also to the new definition of previously named "satellite" ART facilities.

This has been the result of the strategic decision for accelerating ART scaling up as defined in the *Acceleration Plan*. Guidance provided by this plan, including annual district prioritization and the definition of simplified criteria for starting ART sites has been instrumental for this matter. Training and task shifting and systems strengthening were additional ingredients of this success.

On the other hand, the introduction of Option B+ within the PMTCT Programme has contributed to the remarkable increase of new cases starting ART, indicated by the fact that the greatest increase occurred in the second semester of 2013, when the Option B+ was rolled out. Although many people still lack access to HIV services, the achievements are seen by the Government as proportional to the capacity of the health system.

Paediatric ART

Paediatric ART is one of the highest priorities of the MoH's HIV Programme. The estimated number of HIV seropositive children in Mozambique was around 180 thousand in 2013.

In 2013, MoH declared universal access to ART to all HIV seropositive children under 5 years old.

To be able to accomplish this, extensive training on paediatric ART has been provided to different health professionals, supported by respective training materials. The *Acceleration Plan* includes definitions and targets for paediatric ART.

In 2013, paediatric ART coverage was 36.3% up from 22% in 2011 and 26% in 2012.

This coverage is still modest, but prospects are good for its strengthening, given the evident acceleration registered in 2013: the number of new paediatric cases starting ART has been consistently above 1 000/month during the second semester, a mark that had been reached only twice in the past.

The 80% coverage committed to 2015 however, will be difficult to reach. On the other hand, targets concerning Paediatric ART were not met yet, as defined in the *Acceleration Plan*. Clinical follow up is still considered weak.

The ART retention rate keeps being a setback of the Programme. This is illustrated in Figure 14, showing low retention rates in 2013, particularly among children, after initiation of ART.

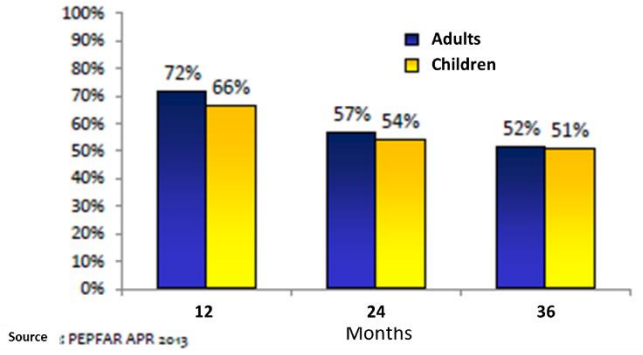


Figure 14 – Percentage of adults and children with HIV known to be on treatment after initiation of ART, 2013

Other ART issues

Several strategies, guidelines and other orientation documents were recently produced by the MoH, guiding the response at its level. The main ones are listed below as well as the MoH's HIV Department key initiatives aimed at developing the ART program:

- Pre-ART adult and paediatric package review;

- Acceleration Plan for Prevention, Diagnosis and Treatment of HIV and AIDS;
- New adult and paediatric ART guidelines;
- New comprehensive ART manual;
- Guideline on viral load;
- Trainings and supervisions;
- Collaborative activities with:
    - TB Program
    - PMTCT Program
    - National Institute of Health
    - Adolescent and Youth Program
    - Other Programs

ART Challenges

Weak financing, human resources and institutional capacity are envisaged as the main concerns hindering to meet the following challenges:

- To keep increasing adult and children ART coverage by scaling up the number of health facilities providing ART in the country;
    - Care and treatment services decentralisation;
- Community referral, care and support systems;
- Improving links between PMTCT and paediatric ART;
- Improving quality;
- Improving M&E;
- Introducing viral load measurement in the country.

Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

Indicator 4.1 - *Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV**

Total	Males	Females	<15	15+
31.7	25.9	36.0	22.1	33.0

** National criteria for ART eligibility varies by country. To make this indicator comparable across countries global reports will present the ART coverage for adults and children as a percent of all people living with HIV.*

Source: MISAU, 2014 (Spectrum)

Indicator 4.2 - *Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy* – **71 (**Source: MISAU, 2014 (Spectrum)

Co-Management of Tuberculosis and HIV Treatment

Tuberculosis incidence in 2012 was 552/100 000 people. The notification rate of all TB forms was 214/ 100 000 people and 219/100 000 in 2012 and 2013, respectively.

MoH's HIV Program and TB Program share responsibilities for the fulfilment of their collaborative activities.

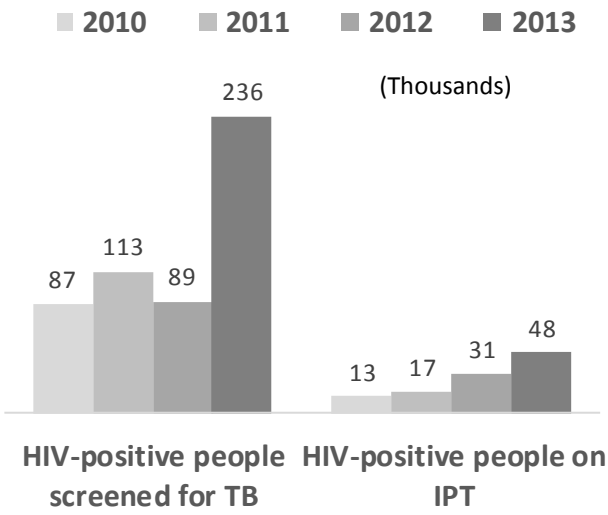
TB services delivered by the HIV Department

Eighty five percent of the total HIV-positive people diagnosed in 2013 (236 thousand) were screened for TB (Figure 15).

This represents a huge increase when compared with previous years. In fact, this is more than double the number of HIV-positive people screened for TB in 2011, the year when the best ever mark had been reached (113 thousand).

In 2012, only 67% of the total HIV-positive people diagnosed were screened for TB.

The number of HIV-positive people on Isoniazid Preventive Treatment (IPT) keeps its ascending curve, reaching nearly 50 thousand in 2013.

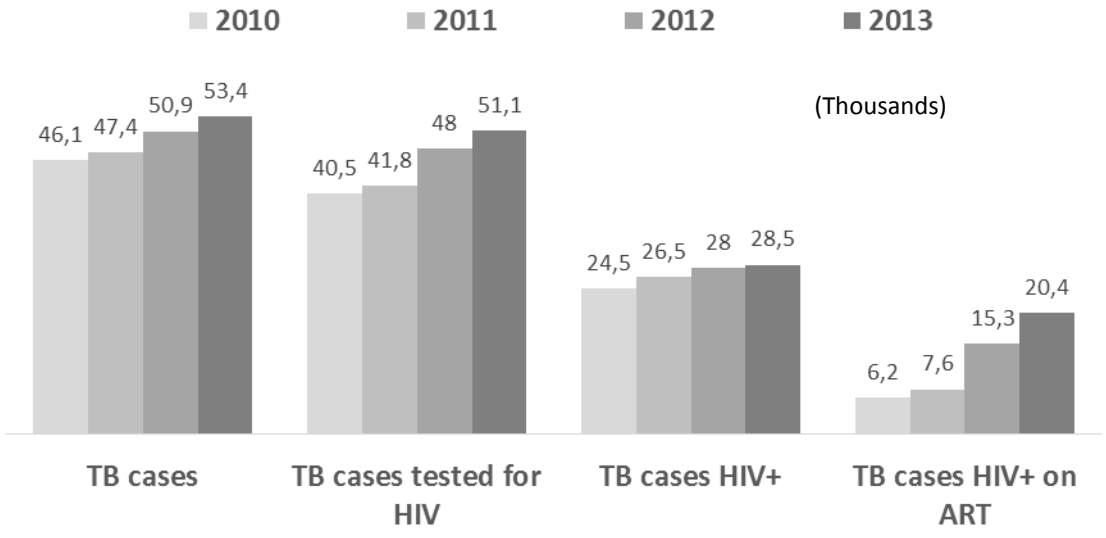


Source: MoH, 2014

Figure 15 – Number of HIV-positive people screened for TB and on IPT, Mozambique, 2010-13

HIV services delivered by the TB Department

Mozambique's TB services routinely test their patients for HIV. Figure 16 shows the annual evolution of the number of TB cases detected, tested for HIV, co-infected and those on ART, for the four year period 2010-13.



Source: MoH, 2014

Figure 16 – Number of TB cases detected, tested for HIV, co-infected and those on ART, Mozambique, 2010-13

It is evident a generalized and consistent scaling up of all these parameters over time. Around 95% of TB cases were tested for HIV in the period 2012-13 (88% in 2010-11). The *Acceleration Plan* recommends increasing this percentage to 99% until 2015.

Seroposivity for HIV in TB cases was around 57% in the same period (around 60% in 2010-11). Of these, 55% were started on ART in 2012, and 72% in 2013 (around 25% in 2010 and 29% in 2011).

This remarkable increment of co-infected cases starting ART in 2012-13, followed the above mentioned general increment of ART provision in the country.

Even so, there is still a long way to go before reaching all those co-infected in need of ART. In fact, it is estimated that these amount to around 82 thousand, while only around 25% (20.4 thousand) are currently benefitting.

Multidrug-resistant TB
The number of multidrug-resistant TB cases reported was 215 in 2012 and 304 in 2013.

HIV/TB Challenges

- Enhancing TB diagnosis in HIV-positive people;
- Balancing the numbers of health facilities providing ART services (523) and those providing TB services (1350);
- Implementing "one-stop" model;
- Anti-TB drugs regular availability;
- Implementing GeneXpert.

Home-based care

Given the ART scale-up, the number of HIV infected people that is bedridden is considerably reduced, thus creating the need to reorient the home-based care (HBC) unit. This is now more concentrated on patient tracking so as to support ART adherence and retention.

For this, in discussion with partners, a new HBC approach guide was produced, including implementation details and the links between the different levels of the health system and partner NGOs.

Ten provincial HBC Focal Points were trained on the Integrated HBC update so as to increase their capacity to support Community based Organizations (CBOs) on the implementation of their activities.

In general, CBOs have weak administrative and financial capacities, thus hindering the process and threatening their sustainability. Another setback is limited funding allocated to home-based care.

The *Cesta Básica* (Basic Basket) introduced some years ago by the MoH, aimed at providing a basic quantity of food to malnourished patients on ART, was shifted to the responsibility of the Ministry of Women and Social Affairs (MMAS) in 2012. The MoH has only kept its task of coordinating the patients' selection process within health facilities on the basis of biomedical criteria, and then referring those selected to the MMAS.

The MoH keeps providing the beneficiaries with counselling, nutritional education and clinical follow up. In collaboration with the MMAS, the MoH leads the M&E of the process.

In 2013, nearly 30 thousand people were newly enrolled in the HBC unit. During the same period, the program reported a total of approximately 2 500 deaths and 1 000 clients lost to follow-up.

Several documents and guidelines were elaborated:

- Palliative Care Reference Manual, Policy and Curriculum
- Integrated HBC provider curriculum
- Integrated HBC Training Program (MoH/MMAS)
- HBC Operational Manual
- Volunteers Trainer Manual, update

Challenges

- Weak M&E and supervision;
- Weak Direcção Provincial de Saúde (DPSs) involvement on partners' negotiations for HBC scaling up;
- High rotation of district HBC Focal Points

Knowledge and behaviour change

The 2011 DHS found that knowledge of individual aspects that compound extensive knowledge on AIDS is relatively high among women and men aged 15-49 (slightly higher among men than among women).

For example, 67% of women and 87% of men know that a health-looking person can have HIV, or 77% of women and 76% of men know that HIV cannot be transmitted by mosquito bites. Also, 81% of women and 90% of men reject the conception that HIV can be transmitted through supernatural means; and 82% of women and 87% of men believe that no one can get HIV by sharing food with someone who is infected.

However, these figures are considerably lower when wider knowledge is surveyed: only 48% of women and 63% of men aged 15-49 know that a health-looking person can have HIV and at the same time reject the two most common misconceptions about HIV transmission (HIV transmission by mosquito bites or through supernatural means).

Young people: Knowledge about HIV prevention

Table 8 shows specific data concerning young people only: this includes the *Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission,*

representing Indicator 1.1 for GARPR, by Gender and Age group in 2003, 2009 and 2011, when the last population surveys were held in Mozambique.

Table 8 - Indicator 1.1: *Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*, by Gender and Age group (2003, 2009 and 2011)

	Female			Male		
	2003	**2009**	**2011**	**2003**	**2009**	**2011**
Age group						
15-24	20	36.7	30,2	32,8	35.1	51,8
15-19	20,9	37.2	27,4	30,1	31.5	48,5
20-24	19,2	36.4	33,7	37,1	39.8	56,5

Source: DHS, 2003, 2011. INSIDA 2009

During an eight years period (2003-11) this indicator registered an important increase that is more visible among male respondents. The older age group (20-24) fared better than its counterpart among both sexes. This could be the result of a longer exposure to IEC messages. However, paradoxically, among young women and especially those aged 15-19, an evident decrease occurred between 2009 and 2011.

Higher risk populations

The NSP III identifies the key populations and other vulnerable populations. Specific interventions for key populations and other vulnerable populations, such as men who have sex with men (MSM), commercial sex workers (CSW), miners, truck drivers, and others, are defined in the Communication operational plans and the NAP.

Several plans and instruments detailing specific interventions for these key populations were produced:

- Action Plan for High Risk Groups (2010-14);
- User friendly services for MSM and sex workers;
- National Guide for HIV and STIs integrated health prevention, treatment and care services for high risk groups;
- Counselling and testing guidelines;
- NSP III Communication Plan.

These population groups keep being more and more under the focus of Mozambique's AIDS authorities. A new openness is apparent, these populations are more visible, stigma and discrimination is reducing, thus allowing better strategic thinking.

As a result, the publication in 2013, of the Integrated Biological and Behavioural Survey (IBBS) among Female Sex Workers (FSW), Mozambique 2011–12, and the IBBS among Men Who Have Sex with Men (MSM), Mozambique, 2011, as well as the implementation of similar surveys among truck drivers, mineworkers, and inmates, in 2012, provide the opportunity for the inclusion of new and effective approaches to these higher risk populations.

The FSW and MSM surveys, implemented in the three main cities in the country, sited in each of the three country geographic regions – Maputo (south), Beira (centre), and Nampula (north) covered more than 1 200 FSWs and 1 400 MSM.

Female Sex Workers

According to the National Strategic Plan for HIV and AIDS *(Plano Estratégico Nacional de Resposta ao HIV e SIDA de Moçambique* - NSP III), FSWs are considered a priority group for interventions to prevent HIV because of their increased vulnerability to HIV infection.

The survey among urban FSW estimated the HIV prevalence to be 31.2%, 23.6%, and 17.8% among FSWs in Maputo, Beira and Nampula, respectively.

These levels of HIV infection are comparable to those found among FSW in other sub-Saharan African countries and confirms that FSW are disproportionately affected by HIV in the three main urban areas of Mozambique. The prevalence of HIV among FSWs in Mozambique increases with age.

Some of the main conclusions of the FSWs survey are as follows:
There was a high proportion of undiagnosed HIV infection among FSW in all three cities. In Maputo, Beira and Nampula 48.1%, 79.8% and 89.6% of HIV-positive female sex workers were unaware of their HIV-positive status. In addition, a high proportion of FSW had never had an HIV test (26.3% in Maputo, 37.0% in Beira, and 40.9% in Nampula).

Of those participants in the survey who knew their HIV-positive status (49 in Maputo, 31 in Beira, and 11 in Nampula) only 49.0%, 54.8% and 27.3% of these were receiving antiretroviral therapy.

A notable percentage of FSWs did not use a condom the last time they had sex with a client or with a stable partner. Additionally, a large proportion of the FSWs had no contact with HIV/AIDS activists in the six months preceding the survey.

The survey estimated that there were 13,554 FSWs in Maputo, corresponding to 2.0% of women in the general population ages 15 and up; 6,802 FSWs in Beira, and 6,929 FSWs in Nampula, which corresponds to 5.0% and 4.5% of women ages 15 and up in the general population, respectively.

In summary, the survey suggests there are 4,229 FSWs infected with HIV in Maputo, 1,605 in Beira, and 1,233 in Nampula. This estimate suggests that a considerable number of FSWs are in need of HIV care and treatment. Moreover, this group of women may serve as a reservoir of HIV that may contribute to the ongoing transmission of HIV in Mozambique.

The study recommends the development of a comprehensive package of programs and interventions with the strengthening and expansion of actions to prevent HIV and STIs among FSWs. Prevention programs addressing the diverse local drivers of infection such as low education, sexual partnership patterns and infection with STIs are urgently required. These actions should be guided by the notion of "combination prevention",

including knowledge provision, male and female condoms, peer education and activists, Counselling and testing, Screening for STIs, Behaviour change as well as structural interventions.

Men Who Have Sex with Men

The survey among MSM estimated the HIV prevalence to be 8.2%, 9.1%, and 3.7% among MSM in Maputo, Beira and Nampula/Nacala, respectively. These data are relatively consistent with the rate of infection in the general male population in Mozambique.

HIV prevalence is significantly higher among MSM 25 years of age or older than among younger MSM (18–24 years old).

The survey concludes that:

This low HIV prevalence among MSM in Mozambique indicates that the country has a very important opportunity to intervene now with evidence-based HIV prevention interventions.

At a minimum, these should include a three-pronged strategy of ensuring access to condoms and water-based lubricants; ensuring access to non-stigmatizing HIV counselling and testing; and working with local non-government organizations familiar with the MSM population to develop innovative and effective social marketing campaigns designed to increase utilization of both.

Although homosexuality remains stigmatized in Mozambique, organizations that promote health and HIV prevention in the MSM population have been able to reach a sizeable number of MSM in each of Mozambique's three major urban areas. Additional resources could be brought to bear to expand their reach and improve MSM's access to basic HIV prevention materials and services to keep the HIV epidemic among MSM in check.

In the 12 months prior to the survey, 24.0% of MSM in Maputo, 19.7% of MSM in Beira, and 38.1% in Nampula/Nacala did not use a condom at last anal sex with another man. Knowledge, access and use of water-based lubricants were low.

About 6 in every 10 MSM in Maputo (61.9%), Beira (67.8%) and Nampula/Nacala (60.0%) had never used a lubricant during sex. Among MSM that used lubricants during the 12 months prior to the survey, only 7.0% in Maputo, 10.2% in Beira, and 28.2% in Nampula/Nacala had ever heard of water-based lubricants.

A notable proportion of MSM in the three urban areas had an HIV test prior to the survey: 52.1% of MSM in Maputo, 61.9% in Beira, and 45.5% in Nampula/Nacala. However, approximately 9 of every 10 HIV-positive MSM were unaware of their HIV-positive status.

The exchange of sex for money, goods or services, including paid sex, was relatively common among the MSM population: 47.7% of MSM in Maputo, 26.5% in Beira, and 39.2% in Nampula/Nacala received money, goods or services in exchange for sex with a man in the 12 months prior to the survey. In the same time period, 18.9% of MSM in

Maputo, 9.2% in Beira and 23.9% in Nampula/Nacala offered money, goods or services for sex with a woman.

Some of the recommendation of the study are the establishment of prevention programs aimed at improving comprehensive knowledge about HIV transmission, increasing HIV testing among MSM so as to increase access to early HIV diagnosis, increased access to condoms promoted in conjunction with access to water-based lubricants compatible with condoms, and peer educator-based interventions.

Treatment, positive-prevention and increasing awareness of HIV status programs are recommended specifically to older MSM (above 25 years), given their significantly higher prevalence when compared with younger groups.

The MSM community in Mozambique has expressed their concerns in regards the problems that is faced with when accessing HIV prevention services, as follows:

- Lack of prevention materials within the health system;
- Health professionals adopt negative attitudes against MSM on the basis of the physical look;
- So called friendly services are hostile for MSM for lack of health professionals appropriate training;
- MSM organisations are not legally recognised;
- Counselling and testing sites lack information on anal sex practices, and ITSs anal manifestations;

People who inject drugs

In the NSP III, injecting drug users are considered higher risk populations. However, prevention activities for these populations were not designed. The magnitude of this population and the degree of its contribution to the epidemic is not yet known. However, an IBBS was implemented among a sample of this population. Its results were not released yet.

Migrant mineworkers

A migratory flow of workers from Mozambique (mainly the three southern provinces) to work in South Africa mines is established since a long time. Given their social conditions – mineworkers migrate individually, leaving behind their families - and working settings, favouring the development of pulmonary diseases, they are considered a high risk population in the National Strategic Plan NSP III, and a target for HIV prevention and treatment programmes.

For this, a study on the health situation of these mine workers was implemented in 2012 in Ressano Garcia a border post Mozambique/South Africa, around 100 Kms. west of Maputo, where most Mozambican migrant mineworkers cross the border to South Africa.

Participants in the study were 432 active Mozambican mineworkers that had at least one year of previous working in South African mines.

Some of the preliminary results of this study are as follows:

- Around 1 in 20 mineworkers have ever had Tuberculosis in their lives;

- Around 1 in 10 mineworkers have had a sign of ITS, or had been told he had an ITS in the last 12 months;
- Around 1 in 5 mineworkers has HIV (22.3%);
- Around 9 in 10 mineworkers had ever received an HIV test
- Around 3 in 4 mineworkers that is HIV-positive are not aware of that;
- Miners aged 31-40 have a HIV infection risk nearly double of that of miners aged 30 years or less (26.7% vs. 13.6%);
- Around 1 in 5 mineworkers have had sex with three or more different women in the 12 months before the study;
- Around 1 in 5 mineworkers has used a condom the last time he had sex with his spouse/stable partner;
- Around 3 in 5 mineworkers have used a condom the last time they had sex with an occasional partner or whom to they have paid for sex.

The study recommends a special attention on this population group given its high HIV prevalence, namely through the promotion of condom use.

Truck drivers

The National Strategic Plan NSP III includes long distance truck drivers as a high risk population deserving priority for HIV prevention interventions, given their greater vulnerability to the infection.

An Integrated Biological and Behavioural Survey (IBBS) among truck drivers was conducted in 2012 in Inchope, a busy crossroads in the central region of the country, around 100 Kms. west of Beira, where hundreds of truck drivers travel daily

Participants in the study were 322 truck drivers older than 18 years that had travelled on duty at least once, driving a truck between provinces or internationally through Mozambican roads in the 12 months before the survey

Half the participants were Mozambican, while the remaining were essentially from Zimbabwe and Malawi.

Average age was 36 years old, and 45% of them were aged 31-40.

Some of the preliminary results of this study are as follows:

- 7 in 10 participants had received an HIV test;
- 5 in 10 participants had received an HIV test and knew the result in the 12 months before the survey;
- 9 in 10 participants have not attended talks discussing HIV in Mozambique in the 12 months before the survey;
- 7 in 10 participants had not receive condoms, lubricants or leaflets in the 12 months before the survey;

HIV prevalence of the participants was 15.4%. Disaggregation by age group is as follows: 18–30 years old - 15.8%; 31–40 years old - 11.7%; 41 years old and above - 21.8%

HIV prevalence was higher among those residing in Mozambique (21.9%) than among those residing out of Mozambique (8.9%).

8 in 10 HIV-positive participants were not aware of that

In the 12 months before the survey:

- 2 in 10 participants had had two main sexual partners (girlfriends or spouses)
- 1 in 10 participants had had three or more occasional partners,
- 3 in 10 participants had had at least one partner whom to they had paid for sex
- 3 in 10 participants did not use a condom every time they had sex with an occasional partner or transactional

The study recommends (i) the use of specific preventive messages for this population group as well as their partners; (ii) promotion of counselling and testing among truck drivers; (iii) workplace preventive interventions; and (iv) night clinics in strategic places.

Prison inmates

In 2012, a study was implemented among prison inmates so as to assess the situation of HIV, STI's and TB and health needs in prisons in Mozambique. The study concentrated on 2428 inmates (of which 176 were female) of 32 prisons in seven provinces of the country (two southern, three central and two northern). Sixty five percent of the inmates were 30 years old or below. Prison staff was also involved: 201 of which 41 were female. The majority (121) were prison guards.

Violence is common in Mozambican prisons. Inmates reported having heard or witnessed several forms of violence: psychological violence (67%), physical violence (61%) and sexual violence (34%) were the most commonly reported violent events.

Prison staff report that paid sex and consensual sex among inmates are the commoner forms of sexual contact in prisons (21.9% and 20.4%, respectively). Forced sex is not rare (13.4%).

The study assessed HIV, Syphilis and Tuberculosis prevalence (%) among inmates and prison staff. Table 9 shows respective results.

Table 9 – HIV, Syphilis and Tuberculosis prevalence (%) among inmates and prison staff, 2012

	HIV	Syphilis	Tuberculosis
Inmates	24	16	1.5
Prison staff	18.5	9.7	0

This assessment came to the following main conclusions:

- Inmates' level of knowledge about HIV transmission is still limited and misconceptions about transmission are common.
- Staff's knowledge about HIV transmission is good, but there is still some misconceptions.
- Knowledge about transmission, prevention and treatment of tuberculosis is limited;

- Both inmates as well as prison staff have positive attitudes towards people living with HIV.
- Some/many inmates are involved in drug use, but injectable drug use is not practiced in prisons.
- Symptoms of STIs are common in both inmates and prison staff.
- Inmates access to information about communicable diseases is limited;
- Access to health services for inmates and prison staff is limited;
- A significant proportion of inmates who were incarcerated while they were getting treatment for TB and HIV, this was discontinued.

On the basis of these findings, the assessment recommends:

- Inmates' access to information and health services should improve through continued implementation of strategies underway in the general population. Increasing access to HIV and Syphilis treatment is vital.
- Information, education and communication strategies to eliminate wrong conceptions on HIV and TB Transmission should be developed, peer education being part of it.
- Health units should be set up within prisons to meet the needs of inmates and prison staff, as well as strengthening contact mechanisms with health services.
- Ensuring that all inmates adhere to the treatment they were receiving before imprisonment.
- Monitoring mechanisms of the three diseases should be established in prisons.

Summary of HIV prevalence among higher risk populations

Table 10 shows the summary of HIV prevalence among higher risk populations

Table 10 – HIV prevalence among higher risk populations

Populations		**Site**		
		Maputo	**Beira**	**Nampula**
CSW (2011)	**All**	31.2	23.6	17.8
	15-24	14.5	17.4	8.8
	25+	60.3	47.9	48
HSH (2011)	**All**	8.1	9.1	3.7
	18-24	2.4	2.8	2.7
	25+	33.8	32.1	10.3
		Maputo	**Gaza**	**Inhambane**
Mineworkers (2012)		27.4	26.1	14.7
		Inchope (Manica)		
Truck drivers (2012)		15.4		
		National		
Prison inmates (2013)		24		

Acceleration Plan and high risk populations

The Acceleration Plan recommends scaling up ART universal access for FSWs and MSMs, reaching 60% of those HIV-positive until 2015. This includes prescribing ART to HIV-positive FSWs and MSMs, independently of their CD4 count (*Treatment as Prevention*), in priority districts.

One of the objectives of the *Acceleration Plan* is to ensure that high risk populations be reached by HIV services, including Counselling and Testing, Male Circumcision as well as Care and ART registry. For this, high risk populations specifically addressed sensitization interventions will be implemented.

On the other hand, Community Counselling and Testing, ATS-C is being strengthened so as to reach these high risk populations in areas where they are numerous, such as the transport corridors. Peer educators/counsellors will be used, and effective links to ART and Treatment as Prevention will be set up.

The Acceleration Plan proposes the setting up of a specific surveillance system for high risk populations (FSW, MSM, PID, miners and truck drivers).

Sexual Behaviour

- Sex before the age of 15

DHS 2011 found that 24.5% of women aged 15-24 in Mozambique have had intercourse before the age of 15 and 80% before the age of 18. Among men, these percentages are 16.8% e 71%, respectively.

The percentage of young women who have had intercourse before the age of 15 tends to be higher in rural areas when compared with urban areas: 27% and 21%, respectively. Concerning men, the reverse happens: 14.1% in rural areas and 20.6% in urban areas.

Only 14.3% of young women with secondary school level and above have had intercourse before the age of 15. Their counterparts without schooling represented 30.9%. Conversely, among men, this percentage increases slightly with the school level.

Table 11 compares the *Percentage of young women and men aged 15-24 years who have had sexual intercourse before the age of 15*, representing Indicator 1.2 for GARPR, by Gender and Age group in 2003, 2009 and 2011, when the last DHSs were held in Mozambique.

Table 11 - Indicator 1.2: *Percentage of young women and men aged 15-24 years who have had sexual intercourse before the age of 15*, by Gender and Age group (2003, 2009 and 2011)

	Female			Male		
	2003	**2009**	**2011**	**2003**	**2009**	**2011**
Age group						
15-24	28	25	24,5	26,4	24.8	16,8
15-17	28,1		21,8	33,5		16,8

15-19	27,7	23.1	21,8	31,3	27.3	16,8
20-24	28,3	26.5	27,9	18,4	21.4	16,9

Source: DHS, 2003, 2011. INSIDA, 2009

A general reduction of the percentage of this indicator in the 2003-11 period, notably among male respondents, is evident. Age group 15-19 (and especially its sub-age group 15-17) is the major contributor for this reduction that nearly halved among males. Hopefully, this reflects the emergence of younger generations gradually more conscious concerning their sexuality.

However, when including also the year 1997 for comparison (Table 12), it is noted that among females, this reduction has been consistent since then while among males, a surprising important increase was registered between 1997 and 2003.

Table 12 - Indicator 1.2: Percentage of young women and men aged 15-24 years who have had sexual intercourse before the age of 15, by Gender and Age group (1977, 2003, 2009 and 2011)

	Female				Male			
	1997	**2003**	**2009**	**2011**	**1997**	**2003**	**2009**	**2011**
Age group								
15-24	30,3	28	25	24,5	18,6	26,4	25	16,8
15-17		28,1		21,8		33,5		16,8
15-19	28,6	27,7	23.1	21,8	23,5	31,3	23.1	16,8
20-24	32	28,3	26.5	27,9	12,8	18,4	26.5	16,9

Source: DHS, 1997, 2003, 2011. INSIDA, 2009

- Multiple sexual partners

Concerning multiple sexual partners, women are overwhelming exceeded by men (Table 13): in 2011, the percentage of men who have had sexual intercourse with more than one partner in the last 12 months was more than 10-fold higher than women, for all age groups (except for the group 15-19, with the lowest percentage).

Table 13 - Indicator 1.3: Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months, by Gender and Age group (2009 and 2011)

	Female		Male	
	2009	**2011**	**2009**	**2011**
Age group				
15-19	4,1	2,7	10,2	17,9
20-24	4,1	3,3	24,2	35,6
25-49	1,9	2,7	20,7	32,8

15-49	3	2,8	19,6	29,5

Source: INSIDA 2009, DHS 2011

When comparing the DHS 2011 and the INSIDA 2009 data (Table 5) - for lack of corresponding data on the DHS 2003 – a slight decrease on multiple partnership is noted among women, but an important increase among men, in the period 2009-13. This is more evident in older age groups (25-49). This finding is worrying and frustrates expectations, raising doubts about the efficacy among men of messages aimed at discouraging multiple partnerships.

DHS 2011 found that the proportion of people who have had sexual intercourse with more than one partner in the past 12 months is higher in urban areas (5% for women and 32% for men) than in rural areas (2% for women and 28% for men). Women aged 15-49 report an average of 2.7 sexual partners for all their lives, while the corresponding average for men is 8.1.

In 2012-13, the NAC and PACTO (*Prevenção Activa e Comunicação para todos*) project launched a behaviour change campaign - *Andar Fora ("Stepping Out")* - that used mass media, social media, community mobilization and interpersonal communication to deliver messages relevant to multiple sexual partners while also addressing other HIV prevention behaviours such as HIV testing and condom use.

An impact evaluation of the *Andar Fora* campaign identified a positive impact of the campaign on three prevention behaviours (multiple sexual partners reduction, condom use at last sex, and HIV testing). In addition, the analysis also identified various significant relationships including a direct effect of: multiple sexual partners on condom use at last sex; condom use at first sex on condom ideation and use; condom use at first sex on attitudes that discourage MSP; and HIV disclosure on condom use at last sex.

Impact alleviation

Psychosocial Support and Positive Prevention

Psychosocial Support and Positive Prevention (*Apoio Psicossocial e Prevenção Positiva* – APSS & PP) is still relatively new at the MoH, being in the process of integration, organisation and harmonisation. So far, multiple approaches and tools have been used, given the lack of coordination.

However, renewed interest is promoted by the *Acceleration Plan* that includes as one of its objectives to ensuring that every PLHIV seeking health care has access to a basic package of APSS & PP, providing care autonomy, positive life and reducing new HIV infections.

The aim is to implement the APSS & PP basic package within 80% of the health facilities providing ART in the country, by 2015. It is expected that adherence and retention on pre-ART and ART will be greatly enhanced as a result of this basic package delivery.

Intensive health professionals and laypersons training on APSS & PP is planned.

MoH is still in the process of elaborating the following tools for APSS & PP:

- national strategy;
- activities guide
- training manual
- M&E tools

Orphans and other vulnerable children

Since 2011 there has been a high level of political support for this area and the number of interventions has increased. The National Child Action Plan (2013 -2019) was approved in 2012 addresses the need of OVC's.

Key achievements can be considered as the design and approval of instrument of minimum standards of care for OVC (2013); development of a community case management ToT manual to enable the implementation of a social welfare case management system at community level, enabling OVC and families to have access to quality services; Training manual for integrated services for OVCs (health and social action) volunteers (2013); Reference guide for clinical and social services for OVC's (2013). In addition, efforts were made to continue expansion and strengthening of district and community services including the strengthening of community committees which act as a referral system for OVCs; training of technicians; strengthening of children's clubs supported by Provincial Social services (2011 to 2013); monitoring of OVC indicator in country development plan and initiatives for OVC promoted and implemented by the Ministry of Agriculture.

At community level, in the sphere of HIV impact alleviation, around 220 thousand orphans and vulnerable children (nearly 50% were girls) received support in terms of food, school materials, clothing, mosquito nets and others.

In partnership with NGOs and civil society, in 2013, more than 280 thousand orphans and vulnerable children (45% were girls) were provided with support.

Challenges are intersectoral coordination, improving referral systems and feedback, lack of qualified human resources, limited financing to sustain implementation, implementation of existing instruments, monitoring and evidence based advocacy.

Target 10. Strengthening HIV integration

Current school attendance among orphans and non-orphans aged 10–14

School attendance among female orphans aged 10–14 has increased considerably between 2009 (53.1%) and 2011 (71.4%) (Table 14). However, among male orphans a slight decrease was registered (from 79.6% in 2009 down to 76.2% in 2011).

School attendance among non-orphans aged 10–14 has also increased in the same period but only by a small value (from 79.3% in 2009 up to 81.2% in 2011 in both sexes).

Table 14 - Indicator 10.1: *Current school attendance among orphans and non-orphans aged 10–14* (2009 and 2011)

	Female		Male		Both sexes	
	2009	2011	2009	2011	2009	2011
Among Orphans	53.1	71.4	79.6	76.2	66	73.9
Among Non-orphans	78.7	80.5	79.7	81.9	79.3	81.2

Source: INSIDA 2009, DHS 2011

The relative disadvantage in school attendance among orphans versus non-orphans was slightly reduced between 2009 and 2011, if both sexes are considered. This has been mainly at the expenses of the substantial decrease of the relative disadvantage registered among females in the same period. On the contrary, the relative disadvantage has increased among males.

IV. Major challenges and remedial actions

The most important progress made in 2012-13 was the extraordinary scaling up of health units providing ART as well as the respective number of beneficiaries. Counselling and Testing has also known exponential growth. The inclusion of Option B+ for seropositive pregnant women and the PMTCT services increased coverage were other important assets. Male circumcision registered important progress as well.

Main challenges faced throughout the reporting period (2012–13) that hindered the national response, were similar to the ones previously reported and can be summarised as: external support dependency, human resources deficit, insufficient infrastructures, problematic supply management, and weak M&A systems.

Progress towards achieving targets, in particular, is delayed by events such as inefficient drugs and HIV tests logistics, low ART adherence and retention as well as weak male partners' participation.

Concrete remedial health sector actions that are planned to ensure achievement of agreed targets include services delivery scaling up as well as logistics improvement (drugs, HIV tests, condoms, and IEC materials). Task shifting is another example of these remedial actions: ART for pregnant women provided by MCH nurses and for adults and children provided by general nurses and *agentes de medicina.* Patient Tracking Electronic Systems linked to SMS mobile technology, as described in the M&E section below, will also help to reach the targets.

Civil Society delivers more than 75% of non- clinical services in the national response but yet lacks opportunities and capacity to effectively scale up these services and deliver quality systems that can complement and support the scale up of clinical services delivered by the NHS. Remedial actions are:

- Heighten the recognition of the role of community systems in the national response, most specifically the role of the community "*activistas*" workers and health workers (APEs);
- Increase investments in community systems and define transparent funding mechanisms which enable Civil Society to access adequate support and resources to strengthen community interventions such as "*busca activa*" /search

for defaulting patients, positive prevention, psychosocial support, social protection and social-cultural activities;
- Increase involvement of National Civil Society Organisations in health sector planning, implementation and monitoring;
- Scale up of innovative community interventions Adherence and Community Support Groups (*Grupos de Apoio à Adesão Comunitária* - GAAC).

Within sectors, there is a need for increased ownership of the HIV response at their level, and its mainstreaming into sector plans and programs. Respective leaders need to be more involved and intersectoral coordination on strategy development and implementation must increase.

In the area of Human Rights, the existing laws 2/2005 and 12/2009 are designed to protect the rights of PLHIV however the major challenge is in the implementation and enforcement of these laws. In addition there are existing policies, laws and regulations which present barriers to accessing HIV services for certain populations. Remedial actions are:

- Approval of regulations for the laws 2/2005 and 12/2009 and strengthen mechanisms for implementation;
- Review existing laws, policies and regulations to determine how these affect access for different population groups;
- Include orientations for psychosocial support and social integration for PLHIV within the national policy for social protection (MMAS 2012);
- Increase protection for key populations.

Although there have been specific studies for high risk groups (MSM, truck drivers and prisoners) the definition of high risk groups in the national response is not uniformly used amongst different actors. Remedial actions are:

- Further define and disaggregate high risk groups
- Continue research and collection of evidence for high risk groups (MSM, Prisoners, Truck Drivers, PID, CSW, People with disabilities, Military, Para Military)

The private sector also faces major challenges. Although in 2012 and 2013 there was increased interest from companies in the development of WPP, the majority of companies do not invest in WPP and existing WPP are weakly implemented. There is a need for more action here, to encourage and advocate for more WPP in order to protect the rights of PLHIV in the workplace and to increase prevention efforts amongst the workforce.

The area of monitoring and evaluation needs to be strengthened in order to determine the impact of interventions across all sectors. Remedial actions are:

- Disseminate M&E mechanisms in order to improve data collection
- Strengthen research and production of evidence in order to orientate and further the "*Mozambicanização*" of the response

V. Support from the country's development partners

AIDS Response in Mozambique has been funded mainly by the *U.S. President's Emergency Plan for AIDS Relief* (PEPFAR), the *Global Fund to Combat AIDS, TB and Malaria* (GFATM).

PEPFAR financial contribution represents around three-quarters of the total expenses for the HIV response in Mozambique. Its budget has been around 260 million USD annually in 2012 and 2013. This support is essentially aimed at technical assistance and consumables. In 2013, 74 million USD were used for consumables, while the remaining was distributed to implementing partners.

GFATM has recently (Round 8) approved 17.4 million USD subsidy to support strengthening supply management mechanisms, as well M&E, human resources and laboratory services. Under Round 9, Phase 2, 233 million USD were approved for the period 2013-16, essentially to meet the needs for consumables.

DANIDA, CIDA-Canada, GIZ and UNDP were the main funding contributors to the NAC in 2012-13.

Partners' support will be essential for reaching the targets set by the 2011 UN Commitment Declaration. Care and treatment services within the health national system framework is still very dependent on partners' support. M&E systems strengthening is another important area where partners' support is instrumental.

VI. Monitoring and evaluation environment

The current HIV monitoring and evaluation system in Mozambique is guided by the NAC's M&E System for the National Response to Combat HIV and AIDS (2012 - 2014), aligned with the NSP III.

The NAC faces a major challenge in obtaining information from the public and private sector and from civil society thus the implementation of this system is weak and there are major deficiencies in data in the central HIV data base. The NAC M&E faces severe staff shortages, the existing M&E staff need more professional development at all levels, in 2012 a training manual was under development but not finished. Key progress has been made at District level, where the role of the District focal point has been officially recognised by the Government and the focal point is integrated into the payroll of the state budget. Trainings were held at District level for HIV focal points and District commissions and the NAC hopes that this will facilitate access to information at the District level.

The M&E plan stipulates that information/reports should be sent every trimester but the different actors working in the HIV and AIDS response do not send regular information either to the Provincial delegations (NPCS) or to the NAC. As a result there is limited data available on HIV and AIDS activities from all sectors. For CS and the key line Ministries in part this can be attributed to the reduction of funding for CSOs, when the NAC was financing CS activities, reporting and communication were more frequent. In terms of WPP in the public sector, the central Ministries send regular trimestral reports to MFP and MFP has trimestral monitoring meetings. However the data base system in the MFP is not functional and it was not possible to gain data on numbers from 2012 and 2013. The private sector also has an M&E plan for the NSP III but ECOSIDA faces challenges in in monitoring interventions. The reception of information is not systematic or regular and no data base exists

Many actors were not clear on M&E mechanisms and thus reports are sent only on request and on an ad –hoc basis. Information requests from the NAC are more common at Provincial and District level but are not consistent or regular. One issue here is the lack of obligation that the sectors have to send reports. The NAC developed an instrument to oblige actors to send reports but this has not been approved. Other challenges include the need to improve the dissemination of information from NAC and NAC Provincial Delegations (NPCS) to partners and to strengthen feedback mechanisms. Overall there is a need to further operationalize M&E and this requires an increased budget for resources.

For its specific M&E tasks, MoH's HIV Program has adopted a National Monitoring and Evaluation Plan for HIV and AIDS (2013 -2017), concentrated on the HIV response health issues.

All key partners (PEPFAR, GFATM recipients and international NGOs) were consulted in the elaboration of the plan. They have aligned and harmonized to this plan at the central level. However, at provincial level, alignment is not as clear.

The new plan will hopefully create a completely revamped M&E environment dominated by innovative approaches: scaling up of Patient Tracking Electronic Systems (*Sistemas Electrónicos de Seguimento do Paciente - SESP)* is initiating, linked to SMS mobile technology.

Data collection tools will be simplified and the number of routine data reported will be reduced, thus contributing for better data quality, and at the same time reducing health staff burden on M&E tasks.

According to the Acceleration Plan, an annual round of data quality assessment will be held, so as to measure the accuracy and integrity of priority indicators for Care and treatment, counselling and testing, PMTCT and TB/HIV programs.

Recent policy and strategy plans were designed on the basis of evidence provided by the M&E system. This the case of the Acceleration Plan, the GACC, and the Operational for Communication for PMTCT.

<u>Challenges</u>

- Volume of reporting on indicators required by external partners and the level of disaggregation required is demanding and places a high burden on the M&E units;
- Quality of data;
- Technical capacity of human resources;
- Need for M&E technical assistance;
- Capacity-building.
- Setting up a new surveillance system specific for higher risk populations

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV and AIDS

ANNEX 2: AIDS spending

ANNEX 3: National Commitments and Policy Instrument (NCPI)

ANNEX 4: Main documents studied

ANNEX 5: List of Participants in the GARPR report validation workshop

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV and AIDS

1) What institutions / entities were responsible for the filling out of the indicators forms?

a) NAC or equivalent	Yes
b) Others: MISAU, MMAS	Yes

2) With contributions of the Ministries:

Health	Yes
Education	Yes
Labour	Yes
Justice	Yes
Public Administration	Yes
Defense	Yes
Interior	Yes
Work	Yes
Agriculture	Yes
Woman and Social Affairs	Yes
Youth and Sports	Yes
Civil Society Organizations	Yes
People Living with HIV	Yes
Private sector	Yes
Organizations of the United Nations	Yes
Bilateral	Yes
International NGOs	Yes
Universities	No

3) Was the report discussed in extended forum?	Yes
4) Were its results filed at central level?	Yes
5) Are the data available for public consultation?	Yes

6) Who is the person in charge for the submission of the report and his continuation, if issues to explain in the Country Progress Report?

Name / title: Diogo Milagre, Deputy Executive Secretary, National Council of Combat to HIV and AIDS

Date: 31st of March of 2014

Signature: _____

Address: Rua António Bocarro, 106/114 – Maputo

ANNEX 2: AIDS spending

Target 6.

Close the global AIDS resource gap by 2015 and reach annual global investment of

US$ 22–24 billion in low- and middle-income countries

Indicator 6.1

Domestic and international AIDS spending by categories and financing sources

Cover Sheet Indicator 6.1: National Funding Matrix — 2011, 2012, 2013

Country	MOZAMBIQUE	
Date of Data Entry	24-Mar-14	day/month/year example: 20/02/2013

1) Which institutions/entities were responsible for filling out the indicator forms?

	NAC or equivalent	(NAC or equivalent, NAP or Others)
If Others, please specify:		

2) Who is the person responsible for submission of the report and for follow-up if there are questions regarding Indicator No. 1?

Name / title:	
Address:	
Email:	
Telephone:	

3) Name of Local Currency:	Meticais (MZN)	
4) Amounts reported in:	2011 US Dollars	(Local Currency or US Dollars)
	2012	(Local Currency or US Dollars)
	2013	(Local Currency or US Dollars)
5) Amounts expresed in:	2011 Units (x 1)	(Units (x 1), Thousands (x 1,000) or Millions (x 1,000,000))
	2012	(Units (x 1), Thousands (x 1,000) or Millions (x 1,000,000))
	2013	(Units (x 1), Thousands (x 1,000) or Millions (x 1,000,000))

6) Average exchange rate with US dollars during the reporting cycle:

	2011	Local Currency per 1 US Dollar
	2012	Local Currency per 1 US Dollar
	2013	Local Currency per 1 US Dollar
7) Reporting cycle:	2011 Calendar Year	(Calendar Year or Fiscal Year)
	2012	(Calendar Year or Fiscal Year)
	2013	(Calendar Year or Fiscal Year)

8) Please indicate month and year (M/YYYY) of reporting cycle:

	Month	Year
2011 From:	1	2011
2011 To:	12	2011
2012 From:		
2012 To:		
2013 From:		
2013 To:		

9) Methodology used:	2011 National AIDS Spending Assessment (NASA)	(National AIDS Spending Assessment (NASA), National Health Accounts/AIDS Sub-account, UNAIDS/UNFPA/NIDI Resource Flow Surveys or Other)
	2012	(National AIDS Spending Assessment (NASA), National Health Accounts/AIDS Sub-account, UNAIDS/UNFPA/NIDI Resource Flow Surveys or Other)
	2013	(National AIDS Spending Assessment (NASA), National Health Accounts/AIDS Sub-account, UNAIDS/UNFPA/NIDI Resource Flow Surveys or Other)

10) Unaccounted Expenditures:

Out-of-pocket expenditure was not considered in the study Traditional medicine and informal care and treatment services were not captured due to absence of data. Expenditure for M&E from the Misnistry of Health financed from central government revenu were not captured. However, most of these costs are covered from international assitance. Expenditure for the construction or reinforcement of infrastructure and Human resources could be undersestimated, especially for those that could be	(Please specify if there were expenditures for activities in any of the AIDS Spending Categories or sub-categories that are not included in the National Funding Matrix and explain why these expenditures were not included.)

11) Budget Support: Is general budget support from an international source reported under Public Sources of financing (e.g. a bilateral donor to Ministry of Finance)?

	2011 No	(Yes or No)
	2012	(Yes or No)
	2013	(Yes or No)

Country:		MOZAMBIQUE	
Reporting cycle:		Calendar Year	
Data Measurement Tool		National AIDS Spending Assessment (NASA)	
Amounts reported in:		US Dollars	
Please indicate month and year (M/YYYY)	From:	Month: 1	Year: 2011
	To:	12	2011
Name of Local Currency		Meticais (MZN)	
Currency expressed in:		Units (x 1)	
Average Exchange Rate for the year (local currency to USD)		29,100	

Financing Sources

2011 AIDS Spending Categories	TOTAL US Dollars	Public Sources						International Sources					
									Bilaterals		Multilaterals		
		Public Sub-Total	Central / National	Sub- National	Dev. Banks Reimbursable (e.g. Loans)	Social Security	All Other Public	International Sub Total	PEPFAR	Other Bilaterals	UN Agencies	Global Fund	Dev. Reir (e.g
TOTAL US Dollars	260 279 345	13 393 157	13 271 709	0	0	0	121 448	246 656 413	186 523 980	11 271 675	10 920 103	22 798 870	
1. Prevention (sub-total)	72 243 298	3 993 560	3 896 966	0	0	0	96 594	68 151 517	54 544 681	3 470 955	3 898 107	2 673 705	
1.01 Communication for social and behavioural change (BCC)	8 157 014	0						8 157 014	6 130 118	218 429	414 376		
1.02 Community/social mobilization	4 350 056	0						4 350 056	3 713 046	106 890			
1.03 Voluntary counselling and testing (VCT)	15 654 101	1 529 255	1 529 255					14 124 846	12 185 922		72 951	1 269 087	
1.04 Risk-reduction and prevention activites for vulnerable and accessible populations	2 780 988	0						2 685 471	1 492 563	358 440	522 131		
1.05. Prevention - Youth in school	2 835 703	5 224	5 224					2 830 479		981 113	1 649 090		
1.06 Prevention - Youth out-of-school	935 593	0						935 593		634 989	267 400		
1.07 Prevention of HIV transmission aimed at people living with HIV	444 002	0						444 002	437 435	0			
1.08 Prevention programmes for sex workers and their clients	1 399 821	0						1 399 821	1 353 834	45 987			
1.09 Programmes for men who have sex with men	95 090	0						95 090	7 798	0	87 292		
1.10 Harm-reduction programmes for injecting drug users	317 278	0						317 278	317 278	0			
1.11 Prevention programmes in the workplace	368 288	119 232	22 638				96 594	246 552		98 707	24 063	11 940	
1.12 Condom social marketing	0	0						0					
1.13 Public and commercial sector male condom provision	0	0						0					
1.14 Public and commercial sector female condom provision	0	0						0					
1.15 Microbicides	0	0						0					
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	862 443	302 806	302 806					559 637	98 057	0		411 837	
1.17 Prevention of mother-to-child transmission	21 444 945	1 887 627	1 887 627					19 557 318	16 990 072	853 656	583 893	885 983	
1.18 Male Circumsicion	3 531 622	37 748	37 748					3 493 874	3 464 683	0		23 964	
1.19 Blood safety	984 315	111 668	111 668					872 647	786 289	0		70 894	
1.20 Safe medical injections	0	0						0					
1.21 Universal precautions	1 546 340	0						1 546 340	1 546 340	0			
1.22 Post-exposure prophylaxis	1 425 234	0						1 425 234	1 425 234	0			
1.23 Pre-exposure prophylaxis *(new category for GARPR 2014)*	0	0						0		0			
1.98 Prevention activities not disaggregated by intervention	5 110 465	0						5 110 465	4 596 012	172 742	276 911		
1.99 Prevention activities not elsewhere classified	0	0						0					
2. Care and Treatment (sub-total)	105 166 538	6 805 882	6 794 894	0	0	0	10 988	98 251 371	64 115 679	1 606 225	1 942 816	20 111 040	
2.01 Outpatient care	103 013 198	6 805 882	6 794 894	0	0	0	10 988	96 098 031	63 031 730	1 606 225	1 942 816	20 111 040	
2.01.01 Provider- initiated testing and counselling	3 426 810	1 454 818	1 454 818					1 971 992	1 273 633			573 308	
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	11 968 052	0						11 968 052	11 936 754				
2.01.03 Antiretroviral therapy	71 185 922	5 306 118	5 306 118					65 879 804	36 900 197	609 859	1 446 262	18 694 316	
2.01.04 Nutritional support associated to ARV therapy	1 354 689	39 993	29 005				10 988	1 314 696	203 218	796 900	276 432		
2.01.05 Specific HIV-related laboratory monitoring	6 195 381	4 953	4 953					6 190 428	4 924 162			843 416	
2.01.06 Dental programmes for PLHIV	0	0						0					
2.01.07 Psychological treatment and support services	166 060	0						166 060					
2.01.08 Outpatient palliative care	0	0						0					
2.01.09 Home-based care	7 548 386	0						7 439 101	6 625 848	199 466	220 122		
2.01.10 Traditional medicine and informal care and treatment services	0	0						0					
2.01.98 Outpatient care services not disaggregated by intervention	1 167 898	0						1 167 898	1 167 898				
2.01.99 Outpatient Care services not elsewhere classified	0	0						0					
2.02 In-patient care	0	0	0	0	0	0	0	0	0	0	0	0	
2.02.01 Inpatient treatment of opportunistic infections (OI)	0	0						0					
2.02.02 Inpatient palliative care	0	0						0					
2.02.98 Inpatient care services not disaggregated by intervention	0	0						0					
2.02.99 In-patient services not elsewhere classified	0	0						0					
2.03 Patient transport and emergency rescue	0	0						0					
2.98 Care and treatment services not disaggregated by intervention	2 153 340	0						2 153 340	1 083 969				
2.99 Care and treatment services not-elsewhere classified	0	0						0					
3. Orphans and Vulnerable Children (sub-total)	11 569 515	0	0	0	0	0	0	11 569 515	9 417 054	885 905	1 017 047	0	
3.01 OVC Education	11 282	0						11 282					
3.02 OVC Basic health care	15 077	0						15 077					
3.03 OVC Family/home support	72 930	0						72 930					
3.04 OVC Community support	859 133	0						859 133	132 766	522 479	181 326		
3.05 OVC Social services and Administrative costs	0	0						0					
3.06 OVC Institutional Care	178 307	0						178 307	21 331	127 844	29 132		
3.98 OVC services not disaggregated by intervention	10 217 465	0						10 217 465	9 262 957	212 902	713 533		
3.99 OVC services not-elsewhere classified	215 321	0						215 321		22 680	93 056		
4. Systems Strengthening & Programme Coordination (sub-total) *[renamed from "Program Management"]*	45 088 979	2 582 418	2 579 849	0	0	0	2 569	42 502 333	35 126 536	4 423 273	2 383 881	14 125	
4.01 National planning, coordination and programme management	13 723 642	2 582 418	2 579 849				2 569	11 141 224	5 000 994	4 073 255	1 984 167		
4.02 Administration and transaction costs associated with managing and disbursing funds	235 586	0						235 586	20 213	187 759		13 904	
4.03 Monitoring and evaluation	7 326 361	0						7 326 361	6 844 001	112 049	369 714	221	
4.04 Operations research	0	0						0					
4.05 Serological-surveillance (Serosurveillance)	1 101 931	0						1 101 931	1 101 931	0			
4.06 HIV drug-resistance surveillance	51 997	0						51 997					
4.07 Drug supply systems	884 839	0						880 611	880 611	0			
4.08 Information technology	4 211 707	0						4 211 707	4 172 051	39 656			
4.09 Patient tracking	112 798	0						112 798					
4.10 Upgrading and construction of infrastructure	5 759 192	0						5 759 192	5 425 808	10 554	30 000		
4.11 Mandatory HIV testing (not VCT)	0	0						0					
4.98 Program Management and Administration Strengthening not disaggregated by type	9 280 220	0						9 280 220	9 280 220	0			
4.99 Program Management and Administration Strengthening not-elsewhere classified	2 400 707	0						2 400 707	2 400 707	0			
5. Incentives for Human resources (sub-total)	18 800 141	0	0	0	0	0	0	18 800 141	18 009 558	155 392	531 946	0	
5.01 Monetary incentives for human resources	25 414	0						25 414					
5.02 Formative education to build-up an HIV workforce	0	0						0					
5.03 Training	17 198 672	0						17 198 672	16 439 378	149 517	531 946		
5.98 Incentives for Human Resources not specified by kind	1 576 055	0						1 576 055	1 570 180	5 875			
5.99 Incentives for Human Resources not elsewhere classified	0	0						0					
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	397 646	11 297	0	0	0	0	11 297	368 308	6 976	299 100	0	0	
6.01 Social protection through monetary benefits	0	0						0					
6.02 Social protection through in-kind benefits	46 855	11 297					11 297	17 517					
6.03 Social protection through provision of social services	29 715	0						29 715					
6.04 HIV-specific income generation projects	321 076	0						321 076	6 976	299 100			
6.98 Social protection services and social services not disaggregated by type	0	0						0					
6.99 Social protection services and social services not elsewhere classified	0	0						0					
7. Enabling Environment (sub-total)	6 953 473	0	0	0	0	0	0	6 953 473	5 303 496	378 423	1 138 954	0	
7.01 Advocacy	274 620	0						274 620		24 971	149 649		
7.02 Human rights programmes	172 253	0						172 253			139 653		
7.03 AIDS-specific institutional development	6 092 468	0						6 092 468	5 303 496	153 247	635 725		
7.04 AIDS-specific programmes focused on women	63 284	0						63 284		23 800	39 484		
7.05 Programmes to reduce Gender Based Violence	6 443	0						6 443			6 443		
7.98 Enabling Environment and Community Development not disaggregated by type	344 405	0						344 405		176 405	168 000		
7.99 Enabling Environment and Community Development not elsewhere classified	0	0						0					
8. Research (sub-total)	59 754	0	0	0	0	0	0	59 754	0	52 402	7 352	0	
8.01 Biomedical research	52 402	0						52 402		52 402			
8.02 Clinical research	0	0						0					
8.03 Epidemiological research	0	0						0					
8.04 Social science research	7 352	0						7 352			7 352		
8.05 Vaccine-related research	0	0						0					
8.98 Research not disaggregated by type	0	0						0					
8.99 Research not elsewhere classified	0	0						0					

ANNEX 3: National Commitments and Policy Instrument (NCPI)

COUNTRY:

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

Postal address:

Tel:

Fax:

E-mail:

Date of submission:

Data Gathering and Validation Process

Describe the process used for NCPI data gathering and validation:

The National AIDS Council (NAC) set up a GARPR working group with members from the NAC, Ministry of Health, UNAIDS and PEPFAR. This group orientated the GARPR data gathering and validation process and two consultants were hired to gather data for the core indicators and the NCPI. The GARPR process was officially launched by the NAC on the 13th of February, key stakeholders and respondents for Part A and Part B participated.

A desk review was carried out of key documents. NCPI data was collected from key respondentz for Part A and B through individual interviews and two focus groups:(1) with the Coordinators of the Provincial NAC and (2) with members of the Civil Society Platform Focus group participants (AINSO, LAMDA, ADEMUC, MONARELA+, Coalizao, MSF, Forum Mulher, RENSIDA, Muleide, RENSIDA and Handicap International/FAMOD). Some organisations also preferred to send responses by email. Different sections of the questionnaire were targeted to different respondents.

After the first round of data collection, the results showed a lack of agreement among respondents in Part A and among respondents in Part B. It was deemed important to try and reach an agreement on the responses thus two meetings were held for all respondents of Part A and Part B in order to reach an agreement on the final data. Few participants attended these meetings, Part A had 3 personnel from the NAC and Part B had 10 participants (AMIMO, ECOSIDA, EGPAF, MONASO, PEPFAR, UNAIDS and USAID).

Analysis of data was carried out and any significant agreements and discrepancies between Part A and Part B were highlighted. Trend analysis was not always possible or relevant as the questions which required the respondents to indicate a rating (scale 0-5 or 0-10), were acknowledged to be very subjective. Thus any difference is rating from previous years cannot be seen as significant or representative of the current situation.

A GARPR validation meeting was held with all key stakeholders and respondents and comments were integrated into the final report.

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:

The process used for resolving disagreements was during the consensus meetings as stated above. However due to lack of participation from key respondents it is not possible to say if disagreements were resolved.

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):

- It is worth noting that the definition of civil society has different interpretations in the HIV response in Mozambique and in part this can be attributed to the way the response is structured. Many international HIV and AIDS service NGO's implement programmes and the majority work in partnership to support either Government authorities and/or "civil society organisations". Thus in general only Mozambican organisations, associations and representatives are referred to as "civil society" and international NGO's are not included in this definition. There are distinct differences in civil society involvement when referring to national civil society or international civil society, where this has an influence on respondent's questions is highlighted.
- In Mozambique different stakeholders the terms key populations, high risk groups, most at risk groups and vulnerable populations are used interchangeably.
- The tables in the prevention and treatment sections are very subjective and and in some cases based on knowledge as supposed to facts. The way the question was phrased in terms of "do the majority of people have access to" was difficult to answer as access was often confused with quality. The opinions varied substantially on this among the respondent in Part A and Part B.
- In the section V there was a repetition of a question on rating efforts for implementation for treatment, care and support (Part A, Q5 & 7 and Part B, Q1.2 & 3. As the second question followed the OVC section, the second question was changed to rating efforts in OVC care and support.

Part A

[to be administered to government officials]

NCPI Respondents

Organization	Name and Position	Respondents to part A					
		A.I	A.II	A.III	A.IV	A.V	A.VI
CNCS-SE	Dr. Diogo Milagre, Executive Deputy of National AIDS Council	x	x	x	x	x	
CNCS-SE	Dra. Ema Chuva, Planning and M&E Coordinator				x	X	
CNCS-SE	Benedito Ngomane, Communication Officer				x		
CNCS-SE	Cecilia Martine, Public Sector Officer and Prevention Officer				x		
CNCS-SE	Lourena Manembe, M&E Officer				X	x	x
CNCS-SE	Silvo Macamo, M&E Officer				x	x	
CNCS-SE	Izidio Nhamtumbo Information Manager						X
NPCS	Delso Damas, Coordinator Maputo Province	x	x	x	x	x	x
NPCS	Rita Isabel, Coordinator Sofala Province	x	x	x	x	x	x
NPCS	Teles Jemuce, Coordinator Cabo Delgado province	x	x	x	x	x	x
Ministry of Health	Dra Aleny Couto, Head of HIV Department	x	x	x	x	X	
Ministry of Health	Joseph Lara, ME Advisor						X
Ministry of Education	Aires Baptista, Coordinator of PCB and Life Skills	X	x		x		
Ministry of Education	Arlindo António Folige, Head of School Health, HIV and AIDS Department	x	x		X		
Ministry of Youth and Sport	Cacilda Machiana, HIV focal point	X	x		x	X	
Ministry of Agriculture	Filomena Nhantumbo, HIV focal point	x	x		x	X	
Ministry of Women and Social Affairs	Miguel Aurelio Mausse, National Director of Social Action	X	x		x	x	
Ministry of Justice	Albachir Macassar, Human Rights Focal point			X			
Ministry of Labour	Antonio Balate, HIV Focal point	x	x		x	X	
Ministry of Interior	Badrudino Rugnate, HIV Focal point	x	x		x		
Ministry of Defence	Tenant –Cornel Jossefa Saveca, HIV Focal Point	x	x		X		
Ministry of Public Administration	Mario Mausse, Technical Officer	x	x		x		x

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?
(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

YES NO

If YES what is the period covered?

National Strategic Plan for the HIV and AIDS Response (NSP III) 2010 – 2014. In general the Ministries do not have separate HIV and AIDS strategies, rather HIV and AIDS are integrated into their individual Sector Strategies.

The Ministry of Health (MoH) developed a HIV Accelerated Response Plan (HAP) but this is not multisectoral.

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one.
IF NO or NOT APPLICABLE, briefly explain why.

The NSP III is more specific and focused than the NSP II. It has 4 key thematic pillars: Reduction of Risk and Vulnerability, Prevention, Care and Treatment, Mitigation, which are underpinned by the following areas of support: Coordination, M&E, Operational Research, Communication, Resource Mobilization, systems strengthening. The NSP III also prioritizes key sectors and emphasizes a mainstreaming approach.

IF YES, complete questions 1.1 through 1.10; ***IF NO***, go to question 2.

1.1 Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to IV?

The NSP III is multisectoral so acts as a guide for all Ministries but most specifically it has the following as a priority: Health, Education, Youth and Sport, Ministry of Women and Social Action, Interior, Defense, Labour, Public Administration, Agriculture and Justice. In 2011 two additional Ministries were also included as priority – State Administration and Finance. At Provincial level 4 sectors are considered priority (Health, Education, Youth and Sport and Women and Social Action), the other additional sectors are Agriculture, Justice, Police and Finance.

1.2. Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

SECTORS	Included in Strategy		Earmarked Budget	
Education	Yes	No	Yes	No
Health	Yes	No	Yes	No
Labour	Yes	No	Yes	No
Military / Police	Yes	No	Yes	No
Social Welfare	Yes	No	Yes	No
Transport	Yes	No	Yes	No
Women	Yes	No	Yes	No
Young People	Yes	No	Yes	No
Justice	Yes	No	Yes	No
Agriculture	Yes	No	Yes	No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

The NSP III is not costed and there is no national budget for HIV, thus there are no earmarked funds or specific resource allocations. The NAC orientates the public sector to mainstream HIV activities into their annual plans and some sectors obtain state funding and/or use external funds used to implement HIV specific activities. The NAC states that one of the challenges is that there is no budget line for HIV funding in the Government Budget, so interventions in the area of HIV cannot be included in the budget for line Ministries.

Sector Funding

- Health has earmarked funds for the HIV programme from state budget and external donors (proSAUDE and Global Fund).
- Education receives funding from the state budget and the Donors Common Fund for Education (FASE),
- Women and Social Welfare budget is 90% funded by the State budget and the remaining funds from donors DFID, Netherlands, WFP and US agencies
- Defense receives no State Budget so relies on donor support
- Justice receives limited funding from state budget
- Youth receives limited funding from the state budget
- Internal Affairs receives funding from state budget and also receives funding from UNPFA, UNDP and PSI.
- Labour receives limited funding from state budget and support from ILO
- Agriculture receives funding from the state budget
- Public Administration receives funds from GfA , other sectors for WPP are from state budget
- At Provincial level, the 4 priority sectors receive state funding

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Discordant couples	Yes	No
Elderly persons	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children[3]	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations[4]	Yes	No
SETTINGS		
Prison	Yes	No
School	Yes	No
Workplace	Yes	No
CROSS CUTTING		
Addressing stigma and discrimination	Yes	No
Gender empowerment and/or gender equality	Yes	No
HIV and poverty	Yes	No
Human rights protection	Yes	No
Involvement of people living with HIV	Yes	No

IF NO, explain how key populations were identified?

There is not a big emphasis on the following key populations: Men who have sex with men, People with disabilities, People who inject drugs.

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country?

People Living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children[3]	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations[4] Military and para military, traditional medical practioners, community leaders, religious leader, government employees and agents, private sector employees, miners, truck drivers	Yes	No

1.5. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Ministry of Defense and Ministry of Internal Affairs have action plans YES

NO

1.6. Does the multisectoral strategy include an operational plan?

YES NO

1.7. Does the multisectoral strategy or operational plan include:

a) Formal programme goals?	Yes	No	N/A
b) Clear targets or milestones?	Yes	No	N/A
c) Detailed costs for each programmatic area?	Yes	No	N/A
d) An indication of funding sources to support programme implementation	Yes	No	N/A
e) A monitoring and evaluation framework?	Yes	No	N/A

Notes: The goals are very general and are not defined for all objectives. The NSP II was costed but the end result was not disseminated as the costing information was not complete. Some indication of funding sources exist but this is not very detailed.

1.8. Has the country ensured "full involvement and participation" of civil society[5] in the Development of the multisectoral strategy?

Active	Moderate	No

IF ACTIVE INVOLVEMENT, briefly explain how this was organised:
In 2009, during the development process of the NSP III, Civil Society (CS) formed a platform in order to increase involvement and participation in the process. As a result, CS representatives had an active role in the PEN III Steering Committee and CS developed a concept note which was received by steering committee and integrated into strategy.

During 2011 at the Provincial level, CS was involved in the development of operational plans, now it is harder to involve CS due to reduction of funding from the NAC to CS.

IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case:

1.9. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes	No	N/A

1.10. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners	Yes, some partners	No	N/A

IF SOME or NO, briefly explain why this was the case:
The NSPIII is very broad in terms of strategic areas and it covers all HIV related themes, thus all partners who work in HIV and AIDS are aligned to the strategic areas identified in NSP III. However the main challenge is to measure the progress and reach the goals.

2.1. Has the country integrated HIV in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS			
Common Country Assessment/UN Development Assistance Framework	Yes	No	N/A
National Development Plan	Yes	No	N/A
Poverty Reduction Strategy	Yes	No	N/A
National Social Protection Strategic Plan	Yes	No	N/A
Sector-wide approach	Yes	No	N/A
Other (write in) Agenda 20/25, 5 year development plan	Yes	No	N/A

2.2. IF YES, are the following specific HIV-related areas included in one or more of the development plans?

HIV-RELATED AREA INCLUDED IN PLAN(S)			
Elimination of punitive laws	Yes	No	N/A
HIV impact alleviation (including palliative care for adults and children)	Yes	No	N/A
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	No	N/A
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	No	N/A
Reduction of stigma and discrimination	Yes	No	N/A
Treatment, care, and support (including social protection or other schemes	Yes	No	N/A
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No	N/A
Other (write in)	Yes	No	N/A

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Not recently but macroeconomic study in Agriculture sector 10 years ago and in Education sector 6 years ago. Not at provincial level

Yes	No	N/A

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?

LOW					HIGH
0	1	2	3	4	5

4. Does the country have a plan to strengthen health systems? Yes

IF YES, Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications.

Health systems strengthening measures are outlined in the PESS, the Plan for Accelerated Institutional Reform in the Health Sector (PARI) and plans for human resource training and the action plan for CMAM (Centre for Medication and Pharmaceutical supplies). These plans are financed through a combination of Government funds, ProSAUDE funds and the Global Fund.

Since 2011 progress has been made in the construction or rehabilitation of health infrastructures for rural health centres and major hospitals, in 2013, 41 new type II health centres were completed. In 2012 the MoH also adopted a new system (SIMAM) for medical stock control however there are still significant challenges in this area including medical supply stock outs and the lack of accurate data for planning. In the area of human resources, the focus was on task shifting.

5. Are health facilities providing HIV services integrated with other health services?

AREA	Many	Few	None
a) HIV counselling & testing with sexual & reproductive health	x		
b) HIV counselling & testing and tuberculosis	x		
c) HIV counselling & testing and general outpatient care	x		
d) HIV counselling & testing and chronic non-communicable diseases	x		
e) ART and tuberculosis		x	
f) ART and general outpatient care	x		
g) ART and chronic non-communicable diseases	x		
h) PMTCT with antenatal care/ maternal & child health	x		
i) Other comments on HIV integration: The MoH has made an effort to integrated HIV into health services since 2008, operational challenges remain. HIV routine testing is offered in all consultations. HIV counselling & testing and tuberculosis is being rolled out and is offered in over 800HF			

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
The NSP III provides an overall guide to HIV and AIDS interventions and since 2011 all key sectors developed operation plans. The priority public sectors at central level were supported to develop operational plans which spanned 2011 and 2012, and at Provincial level the 4 priority public sectors made operational plans. Civil society and the private sector also developed operational plans. At the District level there has been an increase in multisectoral planning supported by WHO and GIZ. Many districts now have an HIV district focal point who supports to planning at the community level.
A Communication operational plan for the NSP III was developed in 2011 and included participation of all key Communication partners.
Following the UN 2011 Declaration on HIV and AIDS, Mozambique nationalized this declaration and subsequently in 2012 developed an operational communication plan for PMTCT and Combined prevention.
The Ministry of Health developed the PESS and the HIV Acceleration Response Plan (HAP) (2013 – 2015) which was disseminated in March 2014.

In general the planning efforts since 2011 have led to better prioritization of interventions. In the health sector this has resulted in substantial scale up in the number of health facilities providing HIV prevention and treatment service and the number of people on treatment.

What challenges will remain in this area:
Some of the key challenges in multisectoral strategic planning are the lack of availability of baseline data which are used to define and plan targets, lack of data on spending (NASA) and reduction of financial resource allocations. This affects the extent to which the country can develop concrete operational plans. For the HIV and AIDS health programme implementation key challenges are human resource capacity constraints and limited institutional capacity for scale up and integration of services. An example of this is stock outs of medication.
Another challenge is the perception of HIV and AIDS in the country, where HIV and AIDS are seen as an illnesses as supposed to a health issues, thus there needs to be more of a holistic approach to respond to HIV and AIDS. There are also limitations in the interpretation of the HIV and AIDS response, planning and management of the strategies.
Key challenges also exist in coordination and implementation of the NSP III (NAC) and the Strategy to Combat HIV in the Public Sector (Ministry of Public Administration).

II. POLITICAL SUPPORT AND LEADERSHIP

Strong political support includes: government and political leaders who regularly speak out about HIV and AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

A. Government ministers	Yes	No
B. Other high officials at sub-national level	Yes	No

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV? (For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue i a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)

Yes	No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:

The Government continues to demonstrate leadership in the HIV response as the Prime Minister chairs the Board of the NAC. In addition, local consultations on development, health, HIV are held during the annual open Presidencies (Presidencias Abertas) at Provincial and District level.

In 2012 the Declaration of Maputo on the Elimination of Vertical Transmission was signed by SADC First Ladies. This event was hosted by the Mozambican First Lady.

At Provincial level the political leaders are actively involved in the HIV response. The Governors orientate the Provincial Forums and the District Administrators orientate the District Forums. A high level of leadership is shown also from the Permanent Secretaries at Provincial and District level.

Examples of leadership in other public sector Ministries include: On the 1st December 2012 the Minister, Vice Minister and other leaders from the Ministry of Internal Affairs all attended events to show support for HIV response, including visiting PLHIV in their homes. In 2012 the Ministry of Defense hosted an international Military conference on HIV and AIDS which was opened by the Minister of the Internal Affairs.
In December 2013, the Minister, Vice Minister and Permanent Secretary of Agriculture all spoke of the importance of the HIV response during their speeches at a national meeting.

2. Does the country have an officially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?

Yes	No

IF NO, briefly explain why not and how HIV programmes are being managed:

IF YES, does the national multisectoral HIV coordination body:		
Have terms of reference?	Yes	No
Have active government leadership and participation?	Yes	No
Have an official chair person?	Yes	No
***IF YES**, what is his/her name and position title? Alberto Antonio Vaquina, Prime Minister*		
Have a defined membership?	Yes	No
***IF YES**, how many members? 16*		
Include civil society representatives?	Yes	No
***IF YES**, how many?7*		
Include the private sector?	Yes	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	No

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/ programmes?

Yes	No	N/A

IF YES, briefly describe achievements
The coordination mechanism is the NAC Partners Forum which meets monthly. This forum is an opportunity to share information on the HIV and AIDS response and prepares material for decision making. There are also different technical multisectoral working groups.

Other mechanisms for interaction are the joint planning and evaluation processes which occur at Central, Province and District level.

What challenges remain in this area
The main challenges are the quality and the content discussed in Partners Forum. The Forum has too much focus on information sharing and the participants are not always authorized to make decisions on behalf of their organizations. The Forum needs to be more technical with a stronger focus on decision making. This requires more commitment from Partners to increase the level of participation and include programme representatives/heads of agencies.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

n/a %

5. What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Capacity-building	Yes	No
Coordination with other implementing partners	Yes	No
Information on priority needs	Yes	No
Procurement and distribution of medications or other supplies	Yes	No
Technical guidance	Yes	No
Other [write in below]: Financial support and support to officialise registration of organizations	Yes	No

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?

Yes	No

6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?

Yes	No

IF YES, name and describe how the policies / laws were amended
Laws 5/2002 and 12/2009 were reviewed and submitted for approval to the National Assembly in September 2013

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

The Penal Code infers MSM as a crime. This has a direct impact on MSM and increases discrimination against this key population. This is recognized by the NAC as a human rights issue.

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2013?

Very Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
There was a high level of political support in 2011, when Mozambique operationalized the UN 2011 Political Declaration on HIV and AIDS.

In 2012 and 2013 there was a high level of participation and leadership from Provincial Governor's and also District level Administrators, especially in their support of the District HIV focal point.

What challenges remain in this area:
There is a need for more political support for the response and an increased understanding from the leaders of the challenges which exist. Leaders need to be more involved and lead by example through activities such as promoting HIV testing and supporting high risk groups.

III. HUMAN RIGHTS

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children[3]	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations[4] Miners	Yes	No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on nondiscrimination?

Yes	No

IF YES to Question 1.1. or 1.2., briefly describe the content of the laws:
There is no specific law on non- discrimination but the Constitution protects persons against harm from Society. This law is very general and covers the general population including IDU's and sex workers although these are high risk groups, MSM and transgender people are not specifically mentioned referred to in any law.

Mozambique has specific laws on non –discrimination. Law 2/2005 protects the rights of PLHIV in the Workplace. This is a general law and has a key restriction that it does not directly state that discrimination of PLHIV is prohibited. Thus the Law 12/2009 was approved which defends rights and fights against stigma and discrimination of PLHIV and AIDS. This law also has restrictions, especially in relation to the criminalization of intentional transmission of HIV which is hard to prove and as such difficult to implement.

Mozambique also has specific laws on non- discrimination for older people and people with disabilities.

Briefly explain what mechanisms are in place to ensure these laws are implemented:
A formal mechanism to guarantee the implementation of the specific HIV laws does not exist. In 2012 a proposal for legal regulation was developed but this was not approved. The reason for this was that in 2013, the NAC with other key actors led a process to revise these laws and the revisions were submitted for approval in September 2013.

The judicial support system has a key role in the implementation of these laws especially via the police and the police station unit to support women.

The dissemination of the laws is improving and they are disseminated by the Ministry of Justice, the NAC, ECOSIDA and Civil Society via trainings, seminars, debates, theatre, and community radio. Annually in November and December there are 15 days of activism were the laws are disseminated to Government and Civil Society. In addition the Ministry of Justice works with the Youth Organisation, Coalition and UNFPA to disseminate human rights. In 2012, 4 regional workshops were held.

Briefly comment on the degree to which they are currently implemented:
There is a weak and arbitrary implementation of these laws. Whilst dissemination of the laws is increasing, it is difficult to measure the degree in which the laws are implemented.

2. Does the country have laws, regulations or policies that present obstacles[6] to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

Yes	No

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
People living with HIV	Yes	No
Elderly persons	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children[3]	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations[4]	Yes	No

Briefly describe the content of these laws, regulations or policies:
There are no specific laws, regulations or policies which present obstacles to treatment however the interpretation of laws varies. The most specific example of this is the Penal Code which criminalizes “non natural acts”, this can be interpreted by some to criminalize homosexuality.

Another example is the availability of condoms in prisons; whilst there is no formal or written policy which prevents distribution, many prisons do not allow.

Briefly comment on how they pose barriers:
The interpretation of MSM as a crime, increases discrimination of this group and as such is a human rights issue and a higher political issue. There is slow progress in the recognition of MSM and although LAMBDA is not officially recognized there is a certain degree of openness around the topic of MSM.

The informal policy on non- distribution of condoms in prisons, presents a barrier to prevention of HIV.

IV. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

Yes	No

***IF YES*, what key messages are explicitly promoted?**		
Delay sexual debut	Yes	No
Engage in safe(r) sex	Yes	No
Fight against violence against women	Yes	No
Greater acceptance and involvement of people living with HIV	Yes	No
Greater involvement of men in reproductive health programmes	Yes	No
Know your HIV status	Yes	No
Males to get circumcised under medical supervision	Yes	No
Prevent mother-to-child transmission of HIV	Yes	No
Promote greater equality between men and women	Yes	No
Reduce the number of sexual partners	Yes	No
Use clean needles and syringes	Yes	No
Use condoms consistently	Yes	No
Other [write in below]: Bio security with traditional healers	Yes	No

Key messages on violence against women and gender equality are included in the NSP III but not specifically in the communication plan

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	No

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people? Included in Education Strategy 2012-2015 and NSP III

Yes	No

Is HIV education part of the curriculum in?		
Primary School	Yes	No
Secondary School	Yes	No
Teacher Training	Yes	No

2.2. Does the strategy include

a) age-appropriate sexual and reproductive health elements?

Yes	No

b) gender-sensitive sexual and reproductive health elements?

Yes	No

2.3. Does the country have an HIV education strategy for out-of-school young people?

Yes	No

From 2010 to 2012 the Ministry of Youth and Sport implemented the Geracao Biz Programme (PGB) Plan. This programme no longer exists and the PGB is included in the Ministry strategic plan (2014 to 2017) but the programme is not costed.

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub populations?

Yes	No

Briefly describe the policy or strategy:
The strategies and plans which include IEC on HIV and AIDS, cover all population groups and also have specific interventions for key populations.

- The NAC Prevention Acceleration strategy (2009) which has 8 priority action areas, underpinned by communication interventions for Behavior change.
- NSP III Communication Operational Plan (2012) identifies strategic priorities in the following areas; Human and Social rights; Testing and Counseling in Health; Condom use; PMTCT; Social and Behavior Change; Strengthening of Rights for PLHIV and Positive Prevention; Use of Health Services and Adherence to Treatment for STI/ART/TB; Support for OVCs and other affected Families; Capacity building and Coordination.
- Operational Plan for Communication for PMTCT and Combination Prevention (October 2012). This was developed to respond to specific targets of the UN 2011 Declaration on HIV and AIDS. The plan emphasizes actions in PMTCT and families and increased involvement of men in sexual and reproductive health.

Check which specific populations and elements are included in the policy/strategy

	IDU	MSM	Sex workers	Customers of sex workers	Prison inmates	Other
Condom promotion		x	x	x	x	
Drug substitution therapy						
HIV testing and counseling		x	x	x	x	
Needle & syringe exchange						
Reproductive health, including sexually transmitted infections prevention and treatment		x	x	x	x	
Stigma and discrimination reduction		x	x	x	x	
Targeted information on risk reduction and HIV education		x	x	x	x	
Vulnerability reduction (e.g. income generation)		x	x	x	x	

Notes: There is no specific focus on IDU – they are included as general population. MoH is elaborating a drug substitution therapy policy.

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

- Elaboration of above plans and strategies
- Elaboration of HIV Response Acceleration Plan by MoH (approved 2013)
- In 2013, the National Plan for the Eradication of Vertical Transmission was approved.
- Mozambican version of 2011 UN Declaration on HIV and AIDS developed in 2011
- Elaboration of Male Circumcision Plan by MoH (approved 2013)
- Development of Action Plan for High Risk Groups (2010 to 2014)
- Elaboration of Good Communication Manual for HIV and AIDS (2013)
- Roll out of Strategy to Combat HIV in the Public Sector by the Ministry of Public Administration including training of HIV focal points and advocacy for inclusion of WPP activities in the sector annual plans
- Interventions in communication were well received, most specifically TV Debates (Chova Chova) and spots in 2013 (andar fora e maningue riscado, Joao e Maria, uso de preservativos), Alo Vida (free phone line). The success of these interventions can also be attributed to the use to local language in the messages (Mozambicanization of the response)
- The Ministry of Education, throughout 2011 and 2012, trained teachers in HIV and AIDS material in the Teacher training institutes and through the support of the programme Geracao Biz trained staff at Provincial and District level to mainstream HIV into their plans and activities. In addition Social Assistants strengthened the WPP through working with Committees at provincial and district level, the approach to WPP for HIV was also broadened to include all chronic diseases.
- The Ministry of Youth and Sport works with 4000 activists and peer educators through the programme “Generation Biz” and since 2011 has trained 474 activists in Prevention and HIV in 5 Provinces. In 2013 the Ministry also produced a diary for girls and a pocket guide for boys which include key sexual and reproductive health messages. In addition, in 2013, 115 SAAJ personnel were trained.
- The Ministry of Agriculture since 2011 has continued to mainstream messages and information on HIV and AIDS with rural extension workers and agricultural producers

What challenges remain in this area:

- The high level of stigma and discrimination is the major prevention constraint
- Behaviour change is a huge challenge
- There needs to be more responsibility amongst all sectors to implement policies and strategies, including M&E and reporting.
- Intersectorial coordination
- Commitment from leaders to implement WPP and inclusion of WPP activities in PES with budget.
- Decrease in funding for prevention IEC
- Develop and adapt intervention to make them more locally appropriate
- Expansion of interventions to periphery areas
- Increased adhesion to PMTCT programmes
- Implementation of Option B+ regime (test and treat)
- Implement more testing campaigns
- Condom availability is limited in some key line Ministries for WPP
- Availability of female condoms
- Different definitions of Key Population exist. For the NAC these are Miners, sex workers, MSM and IDUs)

4. Has the country identified specific needs for HIV prevention programmes?

Yes	No

IF YES, how were these specific needs determined?
The specific needs were determined from various studies and data reviews. The NAC Prevention Acceleration strategy (2009) has 8 priority action areas which were included in the NSP III (2010 to 2014). The MoH HAP (2013) is aligned to the NSP III.

IF YES, what are these specific needs?
These specific areas are:
Prevention Acceleration Strategy 2009 (NAC): Counseling and Testing in Health, Condoms, High Risk Groups, Early Detection and Treatment of STI's, Male Circumcision, PMTCT Transmission, Access to Treatment and Biosafety
National Strategic Plan (NSP III): Counseling and Testing in Health, Condoms, High Risk Groups, Early Detection and Treatment of STI's, Male Circumcision, PMTCT, Biosafety, Prevention of HIV in the work place, Communication.

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Economic support e.g. cash transfers	1	2	3	4	N/A
Harm reduction for people who inject drugs	1	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A
HIV testing and counseling	1	2	3	4	N/A
IEC[11] on risk reduction	1	2	3	4	N/A
IEC on stigma and discrimination reduction	1	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A
Prevention for people living with HIV[12]	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	N/A
Risk reduction for intimate	1	2	3	4	N/A

partners of key populations					
Risk reduction for men who have sex with men	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
Reduction of Gender based violence	1	2	3	4	N/A
School-based HIV education for young people	1	2	3	4	N/A
Treatment as prevention	1	2	3	4	N/A
Universal precautions in health care settings	1	2	3	4	N/A
Other*[write in]*:	1	2	3	4	N/A

Note: Risk reduction for intimate partners of key populations is difficult to measure

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2013?

Very Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

In general Government respondents stated that the NSP III is well designed but the key challenges are in implementation. Financial resources are needed in order to increase implementation. The level of implementation also depends on the extent to which the individual sector assumes responsibility for a response to HIV and AIDS, for example the Private Sector has a low level of implementation of WPP in comparison to some key sectors such as Ministry of Internal Affairs and Ministry of Education.

TREAMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes	No

If YES, Briefly identify the elements and what has been prioritized:
The key priorities are defined in the MoH HAP

- Expansion of ART services with an increase in targets for sites offering ART
- Simplification of process for opening new ART sites
- Universal access for pregnant women
- Implementation of simplified treatment regime (B+)

Briefly identify how HIV treatment, care and support services are being scaled-up?

- Identification of priority sites
- Increased number of health facilities offering ART at all levels
- Training of health staff/task shifting (MCH nurse can administer ART to pregnant women and general nurse and *agentes de medicina* can administer to adults and children)
- Improvement of logistics and stock control

1.1 To what extent have the following HIV treatment, care and support services been implemented?

The majority of people in need have access to…	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**N/A**
Antiretroviral therapy	1	2	3	4	N/A
ART for TB patients	1	2	3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	N/A
Early infant diagnosis	1	2	3	4	N/A
Economic support	1	2	3	4	N/A
Family based care and support	1	2	3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	4	N/A
HIV testing and counselling for people with TB	1	2	3	4	N/A
HIV treatment services in the workplace	1	2	3	4	N/A

or treatment referral systems through the workplace					
Nutritional care	1	2	3	4	N/A
Paediatric AIDS treatment	1	2	3	4	N/A
Palliative care for children and adults	1	2	3	4	N/A
Post-delivery ART provision to women	1	2	3	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)) (depends if crime is reported)	1	2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	N/A
Psychosocial support for people living with HIV and their families	1	2	3	4	N/A
Sexually transmitted infection management	1	2	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4	N/A
TB preventive therapy for people living with HIV (access NB here)	1	2	3	4	N/A
TB screening for people living with HIV	1	2	3	4	N/A
Treatment of common HIV-related infections	1	2	3	4	N/A
Other*[write in]*:	1	2	3	4	N/A

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?

Yes	No

Please clarify what kind of support is provided?
No specific policy or strategy exists but there is a general strategy for social protection (2010 – 2014). No nutritional support is offered for PLHIV on a national scale but some public sector employees receive a basic package (cesta basica) and other PLHIV receive support through Civil Society programmes.

3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?

There is an ART factory in Matola, Maputo Province but this has had initial start up problems.

Yes	No

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?

Yes	No	N/A

If yes, for which commodities?

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2013?

Very Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
There have been significant achievements in this area and although the many people still lack access to HIV services, the achievements are proportional to the capacity of the health system. The following are highlighted as key achievements:

- Increased availability of services through the expansion of number of health facilities with ART services
- Increased numbers of new patients on treatment
- Implementation of simplified regime (B+)
- Progress made in task shifting and training of health personnel
- Development of new plans and setting of higher targets

What challenges remain in this area:

- Continued expansion of ART services
- Retention of patients on treatment
- Implementation of B+ regime
- Integration of HIV and TB services
- Increase efforts to expand pediatric treatment and adhesion/retention
- Resistance/treatment failure
- Stock management
- Monitoring and Evaluation, especially data collection and analysis.
- Manual data entry systems and processes for patients
- Lack of qualified staff
- Integration of the strategies between the NAC on NSP III and MFP on the Strategy to Combat HIV in the Public Sector, presents a challenge for some Ministries in terms of implementation
- Scale up of nutritional support
- Coordination of programmes and involvement of partners (sectors and NPCS in implementation and planning)

6. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?

National Child Action Plan (2013 -2019)

Yes	No	N/A

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

6.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?

Very Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

Since 2011 there has been a high level of Government support for this area and the number of interventions has increased.

- National Action Plan for Children approved in 2012
- Design and approval of instrument stating minimal standards for attending children in 2013
- Promotion of 6 basic services for children – health, education, protection, food, water and shelter.
- Increased number of childrens centres constructed and high level of involvement of CS in childrens centres and increased number of children attending centres
- Strengthened participation of children in forums for example Parlimentos Infantil
- Programme on education of children with deficiencies
- Expansion and strengthening of district and community services including the strengthening of community committees since 2011
- Monitoring of OVC indicator in country development plan
- Initiatives for OVC promoted and implemented by the Ministry of Agriculture

What challenges remain in this area:

- Coordination challenges between sectors and within the Social Welfare sector
- Continued scale up of support services for OVCs
- Increase the number of OVCs integrated in families (fostering
- Lack of financial resources and limited financing to sustain implementation
- Lack of qualified human resources

VI. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?

Yes	No	In Progress

Briefly describe any challenges in development or implementation:
In 2011 the NAC developed a Monitoring and Evaluation System for the National Response to Combat HIV and AIDS (2012 -2014). This is a multi -sector plan which covers the National Response and includes key indicators which were developed from the results and outputs defined in the NSP III. Key partners were involved in the development of the plan. The implementation of this plan is weak as the NAC faces a major challenge in obtaining information from the public and private sector and from civil society. The M&E plan stipulates that information/reports should be sent every trimester but the different actors working in the HIV and AIDS response do not send regular information either to the Provincial delegations (NPCS) or to the NAC. One key advancement that has been made since 2012 is the institutionalization of a District HIV focal point who is based in the District Administrators office. The NAC hopes that this will facilitate access to information at the District level.

The MoH has a national M&E plan for HIV (2013 -2017) which has indicators for the Health Sector. The MoH faces challenges in development of the plan as this needed to be harmonized with the overall sector-wide M&E plan (created by DPC) and in costing the M&E plan (especially due to the lack of long-term financial commitments from donors). In terms of implementation it is difficulty to address the human resource shortages given the current MoH staff categories. The MoH also experiences inconsistent messages from donors around the acceptability of the M&E plan in responding to conditions precedent (most specifically the Global Fund).

1.1. IF YES, years covered** [write in]**:

NAC: Monitoring and Evaluation System for the National Response to Combat HIV and AIDS (2012 -2014)

1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, some partners	No	N/A

Briefly describe what the issues are:
The indicators from the monitoring and evaluation System for the National Response were disseminated by the NAC but it is not fully possible to see to what extent partners have aligned and harmonized their requirements as limited data is available. According to the NPCS, at the provincial level, programmes arrive which are pre –designed and which respond to international organizational and donor priorities, thus there is a limited opportunity for NPCS to influence the design of these programmes and to ensure harmonization with national requirements.

For the MoH M&E plan at the central level all key partners (PEPAR/Global Fund recipients and INGOs) have aligned and harmonized to this plan and these partners were consulted in the elaboration of the plan. At provincial and district level there is limited information available to judge to what extent partners have aligned and harmonized there plans.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy	Yes	No
IF YES, does it include:		
Behavioural surveys	Yes	No
Evaluation / research studies	Yes	No
HIV Drug resistance surveillance	Yes	No
HIV surveillance	Yes	No
Routine programme monitoring	Yes	No
A data analysis strategy	Yes	No
A data dissemination and use strategy	Yes	No
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate)	Yes	No
Guidelines on tools for data collection	Yes	No

MoH Plan includes:

- Information sources, reporting frequency and roles and responsibilities
- Bi annual evaluations of the HIV programme and studies such as INSIDA and Spectram which are planned to be conducted
- Routine monitoring is conducted by trimestral joint supervisions (Department for health information (DIS), and DPC and routine data
- New instruments are developed as necessary and piloted before implementation
- Work sessions are conducted between different departments to analyse data
- Guidelines for tools on data collection are not included in the strategy as the focus was on the development of a concise document, these guidelines are included in the individual tools

3. Is there a budget for implementation of the M&E plan?

Yes	In progress	No

For the Monitoring and Evaluation System for the National Response to Combat HIV and AIDS there is no budget. Activities are budgeted annually in PES

For MoH Plan some activities are costed and included in the annual Health plan and the Round 9, phase 2 Global Fund proposal and the National HIV Acceleration plan.

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

In NAC PES <10%

4. Is there a functional national M&E Unit?

Yes	In progress	No

Briefly describe any obstacles:
The NAC M&E Unit has human resource constraints. It is understaffed and lacks qualified personnel. There have been long term vacancies in the M&E unit these positions have not been filled as the recruitment process is very slow. The M&E unit lack a demographer, statistician and data base personnel. The M&E unit also lacks financial and material resources. At the Provincial level the M&E personnel have a high workload as they often perform other tasks not related to M&E.

The MoH HIV programme M&E unit also faces obstacles related to Human Resources as qualified and specialist M&E persons not readily available at a national level, the specialists prefer to work with INGOs and partner organisations. Also within the MoH there is no efficient system for information sharing among staff and the M&E units as there is no shared drive, network or server to store M&E information. In addition the Health Information System (HIS) is outdated, not possible to network, and has many limitations which affect efficiency. The quality of data stored and used is also affected and it is not possible to analyse data electronically which limits the production of statistics.

4.1. Where is the national M&E Unit based?

Ministry of Health?	Yes	No
National HIV Commission (or equivalent)?	Yes	No
Elsewhere? (Write in)	Yes	No

MoH also has a M&E Unit for the HIV/AIDS programme

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION (permanent staff)	**Fulltime**	**Part time**	**Since when?**
Lourena Manembe, M&E Officer	x		2009
Izidio Nhamtumbo, Information Manager	x		2001
Silvo Macamo, M&E Officer	x		2009
Cecelia Uamusse, M&E Officer	x		2009 - 2012
2 x ME officers in the MoH and 1 ME advisor (funded by external partner since 2011)	x		>10 years

POSITION (temporary staff)	**Fulltime**	**Part time**	**Since when?**

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes	No

Briefly describe the data-sharing mechanisms:
The time period for submission of data is defined by the NAC. Key partners should submit there ME data/reports every trimester. In addition the NAC website includes reports, studies and HIV related info and the Partners Forum acts as an information sharing mechanism.

For the MoH, data and reports are consolidated monthly from all health facilities at District level, then compiled at Provincial level and sent to Central DIS. Key partners send monthly reports regularly to MoH and some directly to M&E unit in HIV programme.

What are the major challenges in this area:
The NAC faces a major challenge in the M&E area as the majority of key partners do not regularly send reports/data. Any information that is sent is only partial, for example it is only programmatic and not financial. The NAC recognize this challenge and hold the opinion that partners do not send reports/data because they are not officially obliged to send information. In 2010, the NAC developed an instrument including an operational mechanism for key partners to submit data. This instrument was not operationalized.

For MoH

- Stock shortages of key instruments at the health facility level, for example registration forms
- Compilation of statistics at health facility level which makes it difficult to consolidate all data, for example this is seen as a key challenge in the area of Counseling and Testing which has a low reporting rate, compared to the area of ARTs
- Control, quality and feasibility of statistics
- Follow up of reports not sent from health facilities
- In the area of reporting on ART, 82% of patients on ART's are from 110 HF and these HF still use paper reporting
- There is a need to operationalize the SESP (Sistema Electronico de Seguimento do Patiente)

5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

Yes	No

GTAM = M& E Multisectoral Work Group which includes participants from (NAC, MISAU, INE, INS, CDC, ONUSIDA, OMS, USAID) . Objective of this group is to work on HIV modeling and the group meets depending on the specific demand/need, for example the consolidation of data or HIV surveillance rounds

6. Is there a central national database with HIV- related data?

Yes	No

If yes, briefly describe the national database and who manages it
The NAC does not have a national data base with HIV related data.
The National Statistics Institute collects macro level data every 1-2 years.

In the MoH there is a database managed by DIS which receives consolidated Provincial reports from all Health Facilties. The HIV ME programme unit manually collects data from the DIS.

6. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes, all the above	Yes, some of the above	No, none of the above

IF YES, but only some of the above, which aspects does it include?
The MoH DIS data base includes information on geographical coverage from Provinces and Districts but not information on key populations or implementing organisations.

6.2. Is there a functional Health Information System[14]?

National Level	Yes	No
Sub-National Level	Yes	No
IF YES, at what level(s) *District and Province HF level*	Yes	No

7.1. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs	Estimates of current needs only	No

7.2. Is HIV programme coverage being monitored?

HIV national health services programmes are being monitored by MoH

Yes	No

(a) IF YES, is coverage monitored by sex (male, female)?

Yes	No

(b) IF YES, is coverage monitored by population groups?

Yes	No

IF YES, for which population groups?
The MoH HIV services are monitored by sex and for the age groups 0-14 and 15 and upwards

Briefly explain how this information is used:
MoH: Donor reports, Quantification of needs, Setting and adjusting of targets, To orientate and prioritise interventions (eg. NAP)

(c) Is coverage monitored by geographical area?

Yes	No

IF YES, at which geographical levels (provincial, district, other)? The MoH monitors by geographical level by Province and District

Briefly explain how this information is used: To orientate and prioritize interventions in the HIV and AIDS response such as the prioritization of Provinces or Districts with higher prevalence. Information is also used to guide strategy and policy and programme development and to determine needs estimates.

8. Does the country publish an M&E report on HIV, including HIV surveillance data at least once a year?

Bi annual reports are produced, last report (2011) not published	Yes	No

9. How are M&E data used?

For programme improvement?	Yes	No
In developing / revising the national HIV response?	Yes	No
For resource allocation?	Yes	No
Other *[write in]*: Orientate strategies and policies, accountability	Yes	No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any: M& E data is used to guide policy and strategy development and to design plans and programmes, recent examples of this include the NAP, GACC and the Operational Plan for Communication for PMTCT and Combined Prevention. To provide evidence, determine needs estimates and to set and adjust targets To orientate and prioritize interventions in the HIV and AIDS response for example the prioritization of Provinces or Districts with higher prevalence. To measure progress on targets, to justify funding, to produce reports and data analysis.

10. In the last year, was training in M&E conducted

At National level?	Yes	No
IF YES, what was the number trained: In 2013, 30 persons (2 from each Province and NAC staff), 3 day training, (no training in MoH)		
At subnational level?	Yes	No
IF YES, what was the number trained: With the NAC in 2013 there was 1 training with 15 staff (Southern Region in 2013: Inhambane, Gaza, Maputo City, Maputo Province) and 1 training 20 staff from Gaza. In MoH 110 personnel were trained (HIV officers, HIV programme managers, PMTCT staff, laboratory and pharmacy staff)		
At service delivery level including civil society?	Yes	No
IF YES, what was the number trained:		

10.1. Were other M&E capacity-building activities conducted other than training?

Yes	No

IF YES, describe what types of activities
- (2013) Supervision of activities at provincial level by NAC M&E staff (all provinces)
- Supervision and on the job training (all levels) MoH
- Participation in National and international conferences

11. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2013?

Low										**High**
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
Since 2011, the NAC have coordinated various studies such as NASA, GARPR 2012, ACA 2011 and 2012 and the Demographic Impact Study (2011). In 2012 the NAC developed the NSP III monitoring and evaluation system and disseminated this to the Provinces.
In addition since 2011, the multisectoral M&E group has been revitalized and strengthened. In 2013 there were efforts to increase capacity through trainings and joint supervision visits to all Provinces.
Key progress has also been made at District level, where the role of the District focal point has been officially recognized by the Government and the focal point is integrated into the payroll of the state budget. Trainings were held at District level for HIV focal points and District commissions.
A key achievement for the Ministry of Health in 2013 was the development of the national HIV M&E plan and development of new instruments for monitoring ART. In addition progress has been made in the synchronization of information, the reporting flow, the consolidation of data at the HIS level and development of feedback systems (from Central to Province).

What challenges remain in this area:
The key challenge is in the data collection mechanism for the NSP III indicators. The M&E department lacks financial and human resources and the staff need more professional development at all levels, in 2012 a training manual was under development but not finished. At the District level there is a need to further operationalize M&E, this requires an increased budget for resources. Other challenges include the need to improve the dissemination of information from the NAC and NPCS to partners and to strengthen feedback mechanisms.
For the MoH the volume of reporting on indicators required by external partners (eg PEPFAR, GF, GARPR) and the level of disaggregation required is demanding and places a high burden on the M&E units. Other challenges are related to the quality of data, the outdated HIS, technical capacity of human resources and the accreditation of an electronic patient data system (SESP) which is currently under evaluation but urgently needed especially for the larger HF with high number of patients on treatment.

NCPI - PART B

[to be administered to civil society organizations, bilateral agencies, and UN organizations]

Organization	Name and Position	Respondents to part B				
		B.I	B.II	B.III	B.IV	B.V
AINSO	Gertudes Arrone	x	x	x	x	x
ADEMUC	Sergio Jorge Sitoe	x	x	x	x	x
AMIMO	Gisela Macaipe			x		x
CDC	Nely Honwana, Paula Simbine, Inancio Malimane				x	x
Clinton Foundatin	Lise Ellyin				x	x
Coalizao	Farouk Simango	x	x	x	x	x
ECOSIDA	Jose Matingane	x			x	x
EGPAF	Etelvina Mbalane	x	x		x	x
FAMOD	Rui Maquene	x	x	x	x	x
FDC	Leucipo Goncalves	x	x	x	x	x
FHI	Haley Bryant	x	x		x	x
Forum Mulher	Maira Solange	x	x	x	x	x
GIZ	Claudia Herlt	x		x	x	x
ICAP	Eliana Ferreira				x	x
ILO	Paulo Ramao				x	x
IOM	Katy Barwise & Jason Theede	x	x	x	x	x
LAMBDA	Fauzia Mangone	x	x	x	x	x
Liga de Direitos Humanos	Helena Machatine Fulane			x		
MSF	Carlota Silva	x	x	x	x	x
MONASO	Manuel Antonio Chipeja	x	x	x	x	x
MONARELA+/Rede Crista	Jeremias Langa	x	x	x	x	x
Muleide	Fatima Issa	x	x	x	x	x
NAIMA	Sally Griffin	x	x		x	x
Pathfinder	Arminda Zandamela	x	x	x	x	
PEPFAR	April Kelley	x	x		x	x
Pfuka U Hanya	Sr. Tauzene			x		
PSI	Mary Cassidy				x	
UNAIDS	Jose Enrique Zelaya, Benjamin Gobet, Erika Fazito, Marta Bazima	x	x	x	x	x
UNDP	Salmira Merique			x	x	x
UNICEF	Dezi Mahotas, Massimiliano Sani, Ana Machaieie	x			x	x
UNFPA	Sebastiao Emidio	x		x	x	x
UN Women	Ondina de Barca Vieira	x		x	x	x
USAID	Seeren Thaddeus, Shadit Muragy, Dionisio Matos	x			x	x
WFP	Filippo Dibari					x
WHO	Abdul Moha				x	x

I. CIVIL SOCIETY INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

Low					High
0	1	2	3	4	5

Comments and examples:
In general there is an opportunity for dialogue between Civil Society (CS) and Government in the multisectoral response as the National AIDS Council (NAC) has a mechanism to promote information sharing through the Partners Forum at central level and Provincial Forums. However there is lack of opportunity from MoH for involvement of CS.

- CS were actively involved in the elaboration of the NSP III in 2010.
- In 2012 there was a CS meeting with MoH to advocate for increased access to treatment, here CS lobbied for improvement in medical stock, financing and strengthening of community systems mechanisms
- The process for the elaboration for the HIV Acceleration Plan (HAP) by the MoH in 2013 had high involvement of INGOs and PEPFAR agencies. Some national organisations were also consulted such as LAMDA, MONARELA+, AMIMO, but the process was closed for the majority of CS national organisations.
- The development of the National Strategic Plan for Health (2014 – 2019), PESS, had limited CS involvement
- The elaboration of the Plan for Elimination of Mother to Child Prevention only involved CS partners with more technical expertise in this area.
- Process for revision of clinical norms on ART in April 2012 was with clinical CS partners

lobbying role in medicines, financing and strengthening of community systems mechanisms

- CS organisations which represent migrants have limited institutional and technical capacity on how to approach leaders and there is no forum for dialogue on key issues which affect this population group.
- At the District level, the communication mechanisms for interaction between CS and Government are clearer than at provincial and central level. There are more regular meetings which include community members and District services which permit information exchanges and discussion which lead to resolutions of issues affecting the community. Thus there is an opportunity for these resolutions to influence policies and strategies using the channels of political coordination and governance.

2. To what extent on a scale of (0 to 5) have civil society representatives been involved in the planning and budgeting process for the NSP on HIV or for the most current activity plan (eg attending planning meetings and reviewing drafts)?

Low					High
0	1	2	3	4	5

Comments and Examples:
The extent to which CS is involved in planning and budgeting processes for HIV plans and strategies is weak and much work is needed in order to guarantee more active involvement and participation.

- CS was involved in planning (2010) but was not involved in costing review and in 2012 and 2013 there have been no opportunities for CS to be involved in planning or budgeting processes as the implementation of NSP III is weak
- The NAC provided an opportunity for CS involvement in the response by allocating resources to a CS fund in 2012 (1.6 million MZN), however the distribution criteria for this financing is not clear
- National CS were involved to a limited extent in planning for the MoH HIV Response Acceleration Plan (HAP) and the PESS but not involved in any budgeting processes as these plans are not costed and do not include any CS activities
- For the Global Fund, the sub recipients of the Round 8 HIV proposal were consulted on the new funding models

3. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?

Low					High
0	1	2	3	4	5

b. The national HIV budget?

Low					High
0	1	2	3	4	5

c. The national HIV reports?

Low					High
0	1	2	3	4	5

Comments and examples:
(a) NSP III includes strategic directions but not specific activities, CS services are included but the level of implementation is low due to the financial and technical challenges faced by CS to implement. At the district level there are meetings with multidisciplinary teams which include CS, here some activities from the NSP III are designated as the responsibility of CS.
(b) There is no national budget and the NSP III is not costed. The only national funds for CS are from the NAC (1.6 million MZN) which represents about a quarter of total NAC resources. CS stated that it is not clear how these funds are being allocated and distributed and for which priority areas/pillars of NSP III as no clear criteria exists.
(c) M&E for the HIV and AIDS response is a national challenge and key organizations do not send data to the NAC, limited data is available on CS activities in national reports, only ad-hoc data, including in GARPR and UNGASS. For the private sector there is not national reporting system.

4. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?

Low					High
0	1	2	3	4	5

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?

Low					High
0	1	2	3	4	5

c. Participate in using data for decision-making?

Low					High
0	1	2	3	4	5

Comments and examples:
In general, the participation and involvement of CS in M&E of the response is very weak. In part this is due to lack of opportunity but it is also due to the weak capacity of CS to engage in M&E meetings and planning processes. Often CS is invited to participate but the level of involvement is minimal.
(a) The National System for M&E for the NSP III was developed by the NAC. Responses on this question were mixed as the development of the plan involved more INGOs than National CSOs.
(b) CS is provided the space and opportunity to participate in the joint annual evaluations but the respondents has doubts about the functionality of the NAC national M&E group. It seems this group is called at ad hoc intervals. The MoH in general (including for joint evaluations) only provides a small opportunity for CS participation.
(c) In 2012 and 2013 there were few discussions involving using data for decision making

5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society representation in HIV efforts inclusive of diverse organizations (e.g. organizations and networks of people living with HIV, of sex workers, community-based organizations , and faith-based organizations)?

Low					High
0	1	2	3	4	5

Comments and examples:
Here opinions were divided.
There are many more organizations participating in HIV efforts than previously and many respondents felt that CS representation is generally inclusive, especially as the national CS platform has participation from all networks and diverse organisations. But others thought that key population groups (sex workers, migrants, minority groups) are underrepresented.
One of the issues is that the majority of consultations with CS are with the networks which prevents representation of key populations such as sex workers, MSM, IDUs and Miners. However there are very few organizations of key populations and not very visible due to the impact of stigma and discrimination which prevents active involvement in different forums. The majority of these organizations are also very weak, so they participate to the extent of their abilities, but are not necessarily effective.

6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access:

a. Adequate financial support to implement its HIV activities?

Low					High
0	1	2	3	4	5

b. Adequate technical support to implement its HIV activities?

Low					High
0	1	2	3	4	5

Comments and examples:
(a) There has been a reduction in funding for CS. There are funds available (eg from PEPFAR, Global Fund) but these are on a larger scale for more established national CSOs. Thus smaller CSO organisations have more difficulty in accessing funds. There is also a lack of clarity on CS funding from the NAC and whether there are possibilities for scale up of the existing fund. Short term funding can also fluctuate which can harm, instead of help local organizations. Funds should be available over a long time scale without dramatic changes in priorities or guidelines.
In December 2013 PEPFAR, UNAIDS and the CCM held a consultation with CSOs with a view to improve their ability to access to funding.
(b) There is a lack of adequate technical support available for CS to implement activities. The channels for accessing technical support are not clear and often the expertise is only available at central level. It is not easy for CS to access long term support mechanisms throughout life cycle of a project and also technical support is generally linked to funding. However there are some opportunities available for example FHI 360 through its project CAP trains CS in project cycle management and organizational development, which is fundamental for sustainability.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for Key Populations				
People living with HIV	<25%	25-50%	51–75%	>75%
Men who have sex with men	<25%	25-50%	51–75%	>75%
People who inject drugs	<25%	25-50%	51–75%	>75%
Sex workers	<25%	25-50%	51–75%	>75%
Transgender people	<25%	25-50%	51–75%	>75%
Palliative care	<25%	25-50%	51–75%	>75%
Testing and Counselling	<25%	25-50%	51–75%	>75%
Know your Rights/ Legal services	<25%	25-50%	51–75%	>75%
Reduction of Stigma and Discrimination	<25%	25-50%	51–75%	>75%
Clinical services (ART/OI)*	<25%	25-50%	51–75%	>75%
Home-based care	<25%	25-50%	51–75%	>75%
Programmes for OVC**	<25%	25-50%	51–75%	>75%

Notes: Respondents did not have information on IDU programmes but suggested that the majority of interventions are provided by CS. Most testing and counseling is provided by the MoH and INGOs.

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2013?

Low										**High**
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
Clarification from GARPR team was sought on this question "this question is asking to assess efforts by national authorities to increase civil society participation in the national response".

- Central, Provincial and District forums and committees provide an opportunity for CS participation
- In 2012 the NAC recognized the funding gap for CS and made an effort to increase the participation of CS through resource allocation of government funds to CS
- Resources from the Global Fund are allocated for specific CS activities
- The Plan for the Elimination of Mother to Child transmission has community activities

What challenges remain in this area:
Government efforts: The NAC provides an opportunity for CS to participate at Central, Provincial and District level forums and meetings. To a certain extent, community activities have been de -prioritised as the MoH strategy and plans do not include community activities. The roles and responsibilities of government to advocate for CS participation are not clear between the NAC and MoH.
Financing: Access to funds for CS interventions is limited and there is no clear criteria on the use of funds provided by the NAC.
CS Coordination: There is a lack of coordination and flow of information on CS activities and funding interventions. There needs to be more communication between CS organisations and effective use of CS activity data for advocacy and prioritization of activities.
CS Capacity: CS is fragmented and organisations have a weak capacity to advocate for key issues in the HIV response and often CS doesn't adequately use the space provided (eg the NAC Board meetings). Geographical coverage of CS programmes is not national and CS interventions are not consolidated or prioritized towards common priority interventions and many CSO's lack knowledge on how to economize resources to obtain specific results.
Representation: There are challenges in representation of CS in forums at all levels. CS networks attend meetings and forums but while networks are a convenient mechanism for donors and the government to interact with, not all networks are appropriately representative of their membership. There needs to be more of an effort to engage other organizations, to visit organisations in their own environment and not just invite organisations to government or donor meetings. At the Provincial level, participation is often limited to those in the capital and those organisations who are available to attend on short notice. Regular (e.g. quarterly) regional meetings should be held in every province and should be well facilitated with decision-makers present.

II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?

Yes	No

IF YES, describe some examples of when and how this has happened:
Political support (Little). In 2012 and 2013 CS was involved to some extent on the design of new plans but there was no specific opportunity for PLHIV and key populations to be involved in Government HIV policy design and programme implementation. The HAP and PESS do not include community activities. There is no political support for key populations, this can be demonstrated by the fact that the Government does not recognize LAMDA as a legitimate organisation.
Financial support (Yes). The NAC created a fund for CS.

III. HUMAN RIGHTS

1.1 Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS AND OTHER VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children[3]	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations[4] Mine workers and Older people	Yes	No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on nondiscrimination?

Yes	No

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:

- Non discrimination laws for PLHIV 5/2002 (rights of PLHIV in workplace) and 12/2009 (Rights and fight against stigma and discrimination)
- In the Constitution one article refers to the non discrimination
- The Labour law stipulates the right to equal pay and salary
- Law on Protection and Promotion of Older Peoples Rights (approved 2013)
- Law on Promotion and Protection of the Rights of People with Disabilities
- Law on Promotion and Protection of the Rights of a Child (7/2008)
- Mozambique explicitly has non-discrimination laws that protect nationals and foreign nationals including mobile populations, mine workers, migrants, and migration-affected communities

Briefly explain what mechanisms are in place to ensure that these laws are implemented:
The judicial system of the country is responsible for implementing these laws.
There is no formal mechanism for the implementation of the laws 5/2002 and 12/2009 as the Regulation has not been approved.

Briefly comment to the degree which they are being implemented:

- Laws 5/2002 and 12/2009 are not being implemented.
- Lack of dissemination and knowledge on laws at all levels
- Laws consist of technical language and are not easy for the general population to understand
- For example for migrant workers, workplace policies and programmes are the main mechanisms to enforce protection for PLHIV however, many workers are unaware of the protections and rights afforded to them under the HIV legislation, particularly foreign workers who are unfamiliar with the Mozambican labour laws.

2. Does the country have laws, regulations or policies that present obstacles[16] to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes	No

2.1. IF YES, for which sub-populations?

KEY POPULATIONS AND OTHER VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children[3]	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations[4] mine workers	Yes	No

Briefly describe the content of these laws, regulations or policies:

- In particular the Penal code criminalizes “Acts against nature”. This is arbitrary and can be interpreted as homosexuality. It also criminalizes injecting drugs, sex work and abortions.
- Transgender people are not recognized in Mozambique
- Policy in prisons prevents distributions of condoms as it is believed that the distribution of condoms promotes homosexuality
- Treatment regime on TB not harmonized between SA and Mozambique so Mozambican patients in South Africa are in practice unable to continue their treatment in Mozambique, or vice versa. Added to this, there are many barriers for Mozambican mine workers to access disability and occupational health compensation benefits when they are in Mozambique.
- School Policy on Pregnancy – young girls who are pregnant at school are not allowed to attend day classes and have to attend evening classes

Briefly comment on how they pose barriers:

- Key populations are not recognized or protected so this poses a major barrier in access to services for these key groups, although there is no evidence of prosecution of these crimes (MSM, CSW, IDU).
- Lack of prevention mechanisms in prisons
- Mozambican mine workers often continue to work in the mines in south Africa, even while they are on TB treatment, and highly infectious. Many return to work before completion of TB regimen in order to earn an income, thus increasing drug resistance, and putting others at risk.
- The lack of portable benefits for mine workers (i.e. they cannot access any occupational health, compensation, or pension benefits if they return to Mozambique) is a huge obstacle in addressing HIV and TB in the cross-border mining sector, and ensuring social protection for migrant mine workers. The situation for irregular (undocumented) Mozambicans migrants in South Africa is more perilous than for mine workers, as they are unable to access any services, for fear of exposure and deportation. They are often working informally in the sectors most vulnerable to HIV, including commercial agriculture and informal cross border trading.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

Yes	No

Briefly describe the content of the policy, law or regulation and the populations included.

- Law Against Domestic Violence 26/2009 which protects women against all types of domestic violence
- A manual for attending victims of violence was published in 2012

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:
" Respect for Universal Human Rights" is the first a key principle in the NSP III with specific reference to the following groups: PLHIV, Marginal populations, populations at high risk, women, people with disabilities and older people.
The Pillar on Reduction of Risk and Vulnerability defines results in the area of human rights, for example implementation of protective laws.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?

Yes	No

IF YES, briefly describe this mechanism:
There is no Government mechanism but some CS organisations work in this area such as the Human Rights League.

6. Does the country have a policy or strategy of free services for the following? Indicate if these
services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).

	Provided free-ofcharge to all people in the country		Provided free-of-charge to some people in thecountry		Provided, but only at a cost	
Antiretroviral treatment	Yes	No	Yes	No	Yes	No
HIV prevention services	Yes	No	Yes	No	Yes	No
HIV-related care and support interventions	Yes	No	Yes	No	Yes	No

According to MoH policy, STI medication is free of charge but this has been reported to be not the case in some HF. In some cases, patients have to pay for STI medication at private pharmacies if there is no stock available in the hospital.

If applicable, which populations have been identified as priority, and for which services?

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes	No

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes	No

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?

Yes	No

IF YES, Briefly describe the content of this policy/strategy and the populations included:
There is no specific policy which states that key populations and vulnerable populations must have equal access. The current HIV strategies and plans stipulate equal access for to all populations
However there are some plans and instruments which detail specific interventions for key populations:

- Plan for High Risk Groups (2010 -2014)
- NAP – promotes user friendly services for MSM and sex workers
- NSP III Communication Plan
- National Guide for integrated health prevention, treatment and care services for in HIV and ITS for high risk groups (supported by Pathfinder)
- Counselling and testing guidelines

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?

Yes	No

IF YES, briefly explain the different types of approaches to ensure equal access for different populations: The approaches for peer education, counseling and advocacy are derived according to the degree and level of exposure to HIV in key populations.

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes	No

IF YES, briefly describe the content of the policy or law:

- Law 5/2002, which protects employees or candidates living with HIV and AIDS

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. Existence of indeNSPdent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes	No

Human Rights League (LDH) and National Commission of Human Rights (CNDH).

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	No

IF YES on any of the above questions, describe some examples:

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)[19]?

Yes	No

b. Programmes for members of the judiciary and law enforcement[20] on HIV and human rights issues that may come up in the context of their work?

Yes	No

- In 2013 the LDH trained 54,000 secondary school pupils, women, young people (female and male), teachers, community leaders in rights regarding HIV and AIDS, sexual health, domestic violence, sexual harassment in in 8 Provinces (Maputo Province, Gaza, Sofala, Tete, Nampula, Cabo Delgado, Niassa, Quelimane). Replicas of this training are carried out by volunteers working with the LDH in these Provinces.
- LDH regularly works with member of judiciary on issues pertaining HIV and Human rights.
- UNDP works with CSO of key populations and in 2013 Government officials and the CNDH were trained on HIV and human rights materials.

12. Are the following legal support services available in the country?

a. Legal aid systems for HIV casework

Yes	No

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes	No

13. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes	No

IF YES, what types of programmes?		
Programmes for health care workers	Yes	No
Programmes for the media	Yes	No
Programmes in the work place	Yes	No
Other (write in) Community leaders, faithbased organisations	Yes	No

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?

Low										High
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

- In 2013 the laws (5/2002 and 12/2009) were revised and submitted to the National Assembly for approval in 2013. This process was coordinated by the HIV Office in the Parliament and included the NAC, MONASO, UNDP, OTM, CTA and ECOSIDA.
- Creation of National Commission on Human Rights in 2012

What challenges remain in this area:

- Slow process for approval of revised laws and regulation
- Laws are not specific about key or vulnerable populations (CSW, IDU, MSM). There needs to be a legislation protecting key populations, especially MSMs and sex workers
- Organisations which represent key populations are denied the right to register (LAMDA)
- Development of more WPP which enable persons to access HIV services in work time
- Stronger enforcement for the creation of WPP

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2013?

Low										High
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:
The effort by the Government to revise the laws in 2013 was positive. Other achievements are related to the work of CS such as:

- 130 members of Parliament trained in 2012 on HIV and AIDS legislation (by ILO)
- Refresher training in HIV and AIDS legislation and M&E of 130 Work Inspectors from the Ministry of Labour (with ECoSIDA) in 2012
- LDH- held many debates and communicates on human rights, disseminated
- RENSIDA conducted a study on Stigma and Discrimination
- UN Women: In 2012, in partnership with the Food and Agriculture Organization (FAO) and the Canadian International Development Agency (CIDA), designed and started to implement a capacity building activity which benefited 32 representatives of the associations from all provinces. This first workshop had a strong focus on legal empowerment included an overview of the government policy making processes and institutional mechanisms, was designed and implemented to help the associations and women to know their rights as well as how and where to effectively stand for them.

What challenges remain in this area:

- The existing laws on HIV are not implemented or fiscalized
- Protection for key populations
- Increased protection for women and girls
- Transgender people not recognized in Mozambique
- Need more specific programmes on HIV and Human rights
- Promotion and dissemination of human rights and laws to increase awareness of rights and mechanism which people can use to denounce breaches of human rights
- Monitoring and evaluation of implementation and mechanisms which report discrimination
- Stronger institutional action on stigma and discrimination
- Translation of laws to local languages and explained and written in a way that is possible for the community to understand
- Stronger implementation of WPP, while many workplaces and institutions have policies that protect PLHIV, there are few mechanisms in place to operationalize those policies

IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes	No

IF YES, how were these specific needs determined?
The needs were determined through INSIDA, Modes of Transmission study, surveillance rounds, population and epidemiological data, international guidance, priority gaps, programmatic results, geographic priorities
The specific needs are mainly bio medical, there is a need to define better the non- biomedical prevention needs especially for key populations.

IF YES, what are these specific needs?
Prevention Acceleration Strategy 2009 (NAC): Counseling and Testing in Health, Condoms, High Risk Groups, Early Detection and Treatment of STI's, Male Circumcision, PMTCT, Access to Treatment and Biosafety
National Strategic Plan (NSP III 2010 -2014, NAC): Counseling and Testing in Health, Condoms, High Risk Groups, Early Detection and Treatment of STI's, Male Circumcision, PMTCT, Biosafety, Prevention of HIV in the work place, Communication
PESS (2007 -2012, extended through 2013): Integrated HIV prevention and treatment services, Behaviour Change through IEC, Condom Use,Testing and Counselling, PMTCT, STI and OI.

National Acceleration Plan (2013, MoH): Counseling and Testing, Male Circumcision, Correct and Consistent Condom Use, PMTCT, Positive Prevention, Treatment as Prevention, STIs, PEP (for gender based violenece and occupational exposure). In addition there is a focus on high- risk groups (MSM and CSW)
EMTCT Plan: Sets targets in line with Global Plan

1.1 To what extent has HIV prevention been implemented?

The majority of people in need have access to…	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Harm reduction for people who inject drugs	1	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A
HIV testing and counseling	1	2	3	4	N/A
IEC[11] on risk reduction	1	2	3	4	N/A
IEC on stigma and discrimination reduction	1	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A
Prevention for people living with HIV[12]	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	N/A
Risk reduction for intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex with men	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
School-based HIV education for young people	1	2	3	4	N/A
Universal precautions in health care settings	1	2	3	4	N/A
Other*[write in]*: Male Circumcision	1	2	3	4	N/A

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?

Low										High
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

- Development of MoH NAP
- Resources mobilized for implementation of plans (NAP, EMTCT),
- PMTCT expansion of service and increased coverage and implementation of B+ regime
- Increased coverage of counseling and testing and development of guidelines
- Expansion of treatment as prevention
- Development of male circumcision strategy and scale up of voluntary Male Circumcision (426,000 males circumcised since 2011)
- Multisectoral working group on high -risk groups with participation from the NAC and the MoH
- Increased engagement of religious leaders in prevention activities
- Increased focus on Young people and adolescents, (2.3 million people reached through community based activities, 1.7 million children reached through life skills programme in schools, 3 million adolescents reached by Generation Biz Programme.
- More openness from sectors to discuss WPP.

What challenges remain in this area:

- Behavioral challenges need a non- biological focus and socio-cultural interventions
- Stigma and discrimination as a major barrier to prevention (need to strengthen actions)
- Coverage and access to prevention interventions including WPP, (need more planning to determine geographical priorities)
- Prevention seen as only sexual transmission, need more of a holistic approach with tailored and prioritized interventions for specific groups
- Quality of services including counseling, interventions, messages
- Quality and access for key populations, especially MSM and CSW
- Out of school children and young people (increase programmes and focus on this group)
- Coordination and participation of CS and community mobilization (,ore investment needs to be made in community interventions)
- Lack of coordination, communication and strategic orientations on prevention activities, conflicting strategies and competing priorities for key populations
- Lack of data available on prevention programmes so not possible to measure impacts and use data for decision making
- Condom use, condom distribution and access (need to increase)
- Reduction in funding for Prevention activities (2012 and 2013), funding has shifted to care and treatment
- Different definitions exist for key and vulnerable populations

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes	No

IF YES, Briefly identify the elements and what has been prioritized:

- Decentralization of HIV services
- Adoption of new WHO guidelines and regimens to improve quality of care such as universal treatment for pregnant women(Option B+ regime)
- Increase in targets for adult and pediatric treatment
- Treatment of co – infection of HIV and TB
- Positive Prevention
- Psychosocial support
- Treatment of OI
- Nutritional evaluation
- Adoption of guidelines for counseling and testing
- Design of basic care package which is approved but not yet implemented
- ARV support and community adherence groups (GAAC strategy)

Briefly identify how HIV treatment, care and support services are being scaled-up?
There has been significant support from in country partners – both funding and technical assistance to scale up the programs since 2005. The current scale up is defined in the NAP.

- Decentralization of services from general hospitals to periphery HF in Districts
- Increased number of sites, targets for HF, setting of target number of patients (in some Provinces there are targets for HF personnel, (eg Zambezia DPS)
- Task shifting for ARV provision (national norm since 2013) (SMI nurses, medical agents, medium levels nurses)
- Geographical priorities
- Increased external funding
- Expansion of care to COV through civil society
- Adoption of new treatment regimes

1.1. To what extent have the following HIV treatment, care and support services been implemented?

The majority of people in need have access to…	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Antiretroviral therapy	1	2	3	4	N/A
ART for TB patients	1	2	3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	N/A
Early infant diagnosis	1	2	3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	4	N/A
HIV testing and counselling for people with TB	1	2	3	4	N/A
HIV treatment services in the workplace	1	2	3	4	N/A

or treatment referral systems through the workplace					
Nutritional care	1	2	3	4	N/A
Paediatric AIDS treatment	1	2	3	4	N/A
Palliative care for children and adults	1	2	3	4	N/A
Post-delivery ART provision to women	1	2	3	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	N/A
Psychosocial support for people living with HIV and their families	1	2	3	4	N/A
Sexually transmitted infection management	1	2	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4	N/A
TB preventive therapy for people living with HIV	1	2	3	4	N/A
TB screening for people living with HIV	1	2	3	4	N/A
Treatment of common HIV-related infections	1	2	3	4	N/A
Other*[write in]*: Access to laboratory results for CD4 counts	1	2	3	4	N/A

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?

Very Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

- Increased scale up of MoH programmes, through decentralization of services and expansion of number of site.
- Increased number of adults accessing services
- Revised targets for accelerated ART, now increased to 80% of people who need have access for 2015
- Roll out of APE strategy (approved in 2013)
- Agreement on new WHO guidelines for treatment
- Pilot GAAC study which was approved as a national policy
- One stop model TB and MCH (2012),
- Universal ARV B+ (2013 rolled out nationally)
- Prioritization of services for Pregnant Women and Pediatrics in PESS.
- Implementation of TDF (one dose in new line regime) in 2013

What challenges remain in this area:

- Retention of PLHIV on treatment, there is a 40% drop off rate after the first 12 months on treatment
- Community systems do not work in parallel with the scale up of clinical services
- Weak community care and support systems for general population and OVCs
- Supply chain management - uncontrolled scale up has resulted in national stock outs of drugs (there needs to be improved planning for changing of regimes)
- Access to pediatric ART and lack of PCR
- Financial resources to scale up services and finance long term treatment as programmes
- Co- infection of TB and HIV and follow up of co-infected patients
- Quality of treatment
- Capacity of central MoH and DPS to supervise facilities, especially peripheral sites
- HR constraints (lack of staff and lack of qualified staff)
- Analysis of CD4 (logistical constraints)
- Implementation of APE strategy
- Quality of data
- Increase coverage to obtain maximum number of pregnant women, children and people in need
- Key challenges in HIV and nutrition are supply chain capacities and cost, technical capacity at all levels (MoH, DPS's, DDS's), MoH integration of the nutritional treatment activities and integrated reporting on nutrition in the HIS

2. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?

Yes	No

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV OVC, care and support programmes in 2013?

Very Poor										**Excellent**
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area:

- National Action Plan of Action for Children (2013 -2019), approved in December 2012. This is a general plan which also includes Orphans and Vulnerable Children, in the protection section;
- Minimum standards of care for OVC were developed and approved in 2013, in the scope of quality improvement process, and in line with the SADC minimum standard package,. The process, led by MMAS, was facilitated by URC and the national OVC technical working group.
- A community case management ToT manual was developed, to enable the implementation of a social welfare case management system at community level, enabling OVC and families to have access to quality services;
- Strengthening of CSO's and Community committees which act as a referral system for OVCs
- Increased coordination
- Other instruments developed in 2013 include: Training manual for integrated services for OVCs (health and social action) volunteers, Reference guide for clinical and social services for OVC's
- Strengthening of children's clubs supported by DMAS (2011 to 2013);
- Mid-level training of social action technicians by ISCISA
- MMAS increased linkages to community and facilities

What challenges remain in this area:

- Human resource technical capacity and training
- Increased coordination, more regular meetings at all levels and improving referral systems and feedback
- Inadequate funding
- Monitoring and documentation and evidence based advocacy
- Mechanisms and instruments exist for social protection but are weakly implemented

ANNEX 4: Main documents studied

CNCS. (2010). *Plano Estratégico Nacional de Resposta ao HIV e SIDA, 2010-2014*. Maputo

INS, CDC, UCSF, Pathfinder & I-TECH (2013). *Final Report: The Integrated Biological and Behavioral Survey among Female Sex Workers, Mozambique 2011–2012*. San Francisco: UCSF.

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MISAU. (2013). *Plano de Aceleração da Resposta ao HIV e SIDA, 2013-15*. Maputo

ANNEX 5: List of Participants in the GARPR report validation workshop