

Mozambique Report NCPI

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is indicator/topic relevant?: Yes

is data available?: Yes

Data measurement tool / source: NCPI

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Additional information related to entered data. e.g. reference to primary data source, methodological concerns::

Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source::

Data measurement tool / source: GARPR

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Describe the process used for NCPI data gathering and validation: The NAC set up a GARPR working group with members from the NAC, MoH, 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 respondents 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. 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 in 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 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.

NCPI - PART A [to be administered to government officials]

Organization	Names/Positions	Respondents to Part A
NAC	Dr. Diogo Milagre, Executive Deputy of National AIDS Council	A1,A2,A3,A4,A5
NAC	Dra. Ema Chuva, Planning and M&E Coordinator	A4,A5
NAC	Benedito Ngomane, Communication Officer	A4
NAC	Cecilia Martine, Public Sector Officer and Prevention Officer	A4
NAC	Lourena Manembe, M&E Officer	A4,A5,A6
NAC	Silvo Macamo, M&E Officer	A4,A5
NAC	Izidio Nhamtumbo Information Manager	A6
NPCS	Delso Damas, Coordinator Maputo Province	A1,A2,A3,A4,A5,A6
NPCS	Rita Isabel, Coordinator Sofala Province	A1,A2,A3,A4,A5,A6
NPCS	Teles Jemuca, Coordinator Cabo Delgado province	A1,A2,A3,A4,A5,A6
Ministry of Health	Dra Aleny Couto, Head of HIV Department	A1,A2,A3,A4,A5
Ministry of Health	Joseph Lara, ME Advisor	A6
Ministry of Education	Aires Baptista, Coordinator of PCB and Life Skills	A1,A2,A4
Ministry of Education	Arlindo António Folige, Head of School Health, HIV and AIDS Department	A1,A2,A4
Ministry of Youth and Sport	Cacilda Machiana, HIV focal point	A1,A2,A4,A5
Ministry of Agriculture	Filomena Nhamtumbo, HIV focal point	A1,A2,A4,A5
Ministry of Women and Social Affairs	Miguel Aurelio Mause, National Director of Social Action	A1,A2,A4,A5
Ministry of Justice	Albachir Macassar, Human Rights Focal point	A3
Ministry of Labour	Antonio Balate, HIV Focal point	A1,A2,A4,A5
Ministry of Interior	Badrudino Rugnate, HIV Focal point	A1,A2,A4
Ministry of Defence	Tenant -Cornel Josefa Saveca, HIV Focal Point	A1,A2,A4
Ministry of Public Administration	Mario Mause, technical officer	A1,A2,A4,A6

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

Organization	Names/Positions	Respondents to Part B
AINSO	Gertudes Arrone	B1,B2,B3,B4,B5
ADEMUC	Sergio Jorge Siteo	B1,B2,B3,B4,B5
AMIMO	Gisela Macaipe	B3,B5
CDC	Nely Honwana, Paula Simbine, Inancio Malimane	B4,B5
Clinton Foundation	Lise Ellyin	B4,B5
Coalizão	Farouk Simango	B1,B2,B3,B4,B5
ECOSIDA	Jose Matingane	B1,B4,B5
EGPAF	Etelvina Mbalane	B1,B2,B4,B5
FAMOD	Rui Maquene	B1,B2,B3,B4,B5
FDC	Leucipo Goncalves	B1,B2,B3,B4,B5
FHI	Haley Bryant	B1,B2,B4,B5
Forum Mulher	Maira Solange	B1,B2,B3,B4,B5
GIZ	Claudia Herlt	B1,B3,B4,B5
ICAP	Eliana Ferreira	B4,B5
ILO	Paulo Ramao	B4,B5
IOM	Katy Barwise & Jason Theede	B1,B2,B3,B4,B5
LAMBDA	Fauzia Mangone	B1,B2,B3,B4,B5
Liga de Direitos Humanos	Helena Machatine Fulane	B3
MSF	Carlota Silva	B1,B2,B3,B4,B5
MONASO	Manuel Antonio Chipeja	B1,B2,B3,B4,B5
MONARELA+/Rede Crista	Jeremias Langa	B1,B2,B3,B4,B5
Muleide	Fatima Issa	B1,B2,B3,B4,B5
NAIMA	Sally Griffin	B1,B2,B4,B5
Pathfinder	Arminda Zandamela	B1,B2,B3,B4
PEPFAR	April Kelley	B1,B2,B4,B5
Pfuka U Hanya	Sr. Tauzene	B3
PSI	Mary Cassidy	B4
UNAIDS	Jose Enrique Zelaya, Benjamin Gobet, Erika Fazito, Marta Bazima	B1,B2,B3,B4,B5
UNDP	Salmira Merique	B3,B4,B5
UNICEF	Dezi Mahotas, Massimiliano Sani, Ana Machaieie	B1,B4,B5
UNFPA	Sebastiao Emidio	B1,B3,B4,B5
UN Women	Ondina de Barca Vieira	B1,B3,B4,B5
USAID	Seeren Thaddeus, Shadit Muragy, Dionisio Matos	B1,B4,B5
WFP	Filippo Dibari	B5
WHO	Abdul Moha	B4,B5

A.I Strategic plan

1. Has the country developed a national multisectoral strategy to respond to HIV?: Yes

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 HIV?: 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?

Education:

Included in Strategy: Yes

Earmarked Budget: No

Health:

Included in Strategy: Yes

Earmarked Budget: Yes

Labour:

Included in Strategy: Yes

Earmarked Budget: No

Military/Police:

Included in Strategy: Yes

Earmarked Budget: No

Social Welfare:

Included in Strategy: Yes

Earmarked Budget: No

Transportation:

Included in Strategy: Yes

Earmarked Budget: No

Women:

Included in Strategy: Yes

Earmarked Budget: No

Young People:

Included in Strategy: Yes

Earmarked Budget: No

Other: Justice and Agriculture

Included in Strategy: Yes

Earmarked Budget: 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

Elderly persons: Yes

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: Yes

Sex workers: Yes

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations: No

SETTINGS:

Prisons: Yes

Schools: Yes

Workplace: Yes

CROSS-CUTTING ISSUES:

Addressing stigma and discrimination: Yes

Gender empowerment and/or gender equality: Yes

HIV and poverty: Yes

Human rights protection: Yes

Involvement of people living with HIV: Yes

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

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: Yes

Prison inmates: Yes

Sex workers: Yes

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific key populations/vulnerable subpopulations [write in]: Military and para military, traditional medical practitioners, community leaders, religious leader, government employees and agents, private sector employees, miners, truck drivers

: Yes

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)?: Yes

1.6. Does the multisectoral strategy include an operational plan?: Yes

1.7. Does the multisectoral strategy or operational plan include:

a) Formal programme goals?:

b) Clear targets or milestones?: Yes

c) Detailed costs for each programmatic area?: Yes

d) An indication of funding sources to support programme implementation?: No

e) A monitoring and evaluation framework?: Yes

1.8. Has the country ensured “full involvement and participation” of civil society in the development of the multisectoral strategy?: Active involvement

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

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

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why: The NSP III 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

National Development Plan: Yes

Poverty Reduction Strategy: Yes

National Social Protection Strategic Plan: Yes

Sector-wide approach: Yes

Other [write in]: Agenda 20/25, 5 year development plan

: Yes

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: No

HIV impact alleviation (including palliative care for adults and children): Yes

Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support: Yes

Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support: N/A

Reduction of stigma and discrimination: No

Treatment, care, and support (including social protection or other schemes): No

Women's economic empowerment (e.g. access to credit, access to land, training): Yes

Other [write in]:

:

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?: No

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?:

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

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications and children: 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?

a) HIV Counselling & Testing with Sexual & Reproductive Health: Many

b) HIV Counselling & Testing and Tuberculosis: Many

c) HIV Counselling & Testing and general outpatient care: Many

d) HIV Counselling & Testing and chronic Non-Communicable Diseases: Many

e) ART and Tuberculosis: Few

f) ART and general outpatient care: Many

g) ART and chronic Non-Communicable Diseases: Many

h) PMTCT with Antenatal Care/Maternal & Child Health: Many

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?: 7

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 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).

A.II Political support and leadership

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

B. Other high officials at sub-national level: Yes

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?: Yes

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

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

2.1. IF YES, does the national multisectoral HIV coordination body:

Have terms of reference?: Yes

Have active government leadership and participation?: Yes

Have an official chair person?: Yes

IF YES, what is his/her name and position title?: Alberto Antonio Vaquina, Prime Minister

Have a defined membership?: Yes

IF YES, how many members?: 16

Include civil society representatives?: Yes

IF YES, how many?: 7

Include people living with HIV?: No

IF YES, how many?:

Include the private sector?: Yes

Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?: No

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

IF YES, briefly describe the main 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?:

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

Coordination with other implementing partners: Yes

Information on priority needs: Yes

Procurement and distribution of medications or other supplies: No

Technical guidance: Yes

Other [write in]: Financial support and support to officialise registration of organizations

: Yes

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

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

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?: 7

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.

A.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? Select yes if the policy specifies any of the following key populations and vulnerable groups:

People living with HIV: Yes

Men who have sex with men: No

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: No

Prison inmates: Yes

Sex workers: Yes

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]: Miners

: Yes

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:
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 where 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 to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?: No

IF YES, for which key populations and vulnerable groups?:

People living with HIV: No

Elderly persons: No

Men who have sex with men: No

Migrants/mobile populations: No

Orphans and other vulnerable children: No

People with disabilities: No

People who inject drugs: No

Prison inmates: No

Sex workers: No

Transgender people: No

Women and girls: No

Young women/young men: No

Other specific vulnerable populations [write in]:

: 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.

A.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

IF YES, what key messages are explicitly promoted?:

Delay sexual debut: Yes

Engage in safe(r) sex: Yes

Fight against violence against women: No

Greater acceptance and involvement of people living with HIV: Yes

Greater involvement of men in reproductive health programmes: Yes

Know your HIV status: Yes

Males to get circumcised under medical supervision: Yes

Prevent mother-to-child transmission of HIV: Yes

Promote greater equality between men and women: No

Reduce the number of sexual partners: Yes

Use clean needles and syringes: Yes

Use condoms consistently: Yes

Other [write in]: Bio security with traditional healers

: Yes

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

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?: Yes

2.1. Is HIV education part of the curriculum in:

Primary schools?: Yes

Secondary schools?: Yes

Teacher training?: Yes

2.2. Does the strategy include

a) age-appropriate sexual and reproductive health elements?: Yes

b) gender-sensitive sexual and reproductive health elements?: Yes

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

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

Briefly describe the content of this 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.

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

People who inject drugs:

Men who have sex with men: Condom promotion, HIV testing and counseling, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education, Vulnerability reduction (e.g. income generation)

Sex workers: Condom promotion, HIV testing and counseling, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education, Vulnerability reduction (e.g. income generation)

Customers of sex workers: Condom promotion, HIV testing and counseling, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education, Vulnerability reduction (e.g. income generation)

Prison inmates: Condom promotion, HIV testing and counseling, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education, Vulnerability reduction (e.g. income generation)

Other populations [write in]:

:

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?: 7

Since 2011, what have been key achievements in this area?: • Elaboration of HIV Response Acceleration Plan by MoH • Approval of the National Plan for the Eradication of Vertical Transmission • Mozambican version of 2011 UN Declaration on HIV and AIDS developed in 2011 • Elaboration of MC Plan by MoH • Development of Action Plan for High Risk Groups • Elaboration of Good Communication Manual for HIV and AIDS • Roll out of Strategy to Combat HIV in the Public Sector by the Ministry of Public Administration • Interventions in communication were well received, most specifically TV Debates (Chova Chova) and spots in 2013, Alo Vida. The success of these interventions can also be attributed to the use to local language in the messages. • 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 challenge • There needs to be more engagement of sectors to 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 • 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

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...:

Blood safety: Agree

Condom promotion: Agree

Economic support e.g. cash transfers: Disagree

Harm reduction for people who inject drugs: Disagree

HIV prevention for out-of-school young people: Disagree

HIV prevention in the workplace: Agree

HIV testing and counseling: Strongly agree

IEC on risk reduction: Agree

IEC on stigma and discrimination reduction: Agree

Prevention of mother-to-child transmission of HIV: Strongly agree

Prevention for people living with HIV: Agree

Reproductive health services including sexually transmitted infections prevention and treatment: Agree

Risk reduction for intimate partners of key populations: N/A

Risk reduction for men who have sex with men: Disagree

Risk reduction for sex workers: Agree

Reduction of gender based violence: Disagree

School-based HIV education for young people: Strongly agree

Treatment as prevention: Agree

Universal precautions in health care settings: Agree

Other [write in]::

:

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?: 7

A.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

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...:

Antiretroviral therapy: Agree

ART for TB patients: Disagree

Cotrimoxazole prophylaxis in people living with HIV: Strongly agree

Early infant diagnosis: Agree

Economic support: Strongly disagree

Family based care and support: Disagree

HIV care and support in the workplace (including alternative working arrangements): Disagree

HIV testing and counselling for people with TB: Agree

HIV treatment services in the workplace or treatment referral systems through the workplace: Agree

Nutritional care: Strongly disagree

Paediatric AIDS treatment: Disagree

Palliative care for children and adults Palliative care for children and adults: Agree

Post-delivery ART provision to women: Agree

Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault): Strongly disagree

Post-exposure prophylaxis for occupational exposures to HIV: Agree

Psychosocial support for people living with HIV and their families: Agree

Sexually transmitted infection management: Agree

TB infection control in HIV treatment and care facilities: Agree

TB preventive therapy for people living with HIV: Agree

TB screening for people living with HIV: Agree

Treatment of common HIV-related infections: Agree

Other [write in]:

:

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?: No

Please clarify which social and economic 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?: Yes

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

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?: 7

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 adherence/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?:
Yes

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

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

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?: 6

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

A.VI Monitoring and evaluation

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

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: 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, some partners

Briefly describe what the issues are: 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

IF YES, does it address:

Behavioural surveys: Yes

Evaluation / research studies: Yes

HIV Drug resistance surveillance: No

HIV surveillance: Yes

Routine programme monitoring: Yes

A data analysis strategy: Yes

A data dissemination and use strategy: Yes

A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate): Yes

Guidelines on tools for data collection: Yes

3. Is there a budget for implementation of the M&E plan?: No

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

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

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?

In the Ministry of Health?: No

In the National HIV Commission (or equivalent)?: Yes

Elsewhere?: No

If elsewhere, please specify:

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

POSITION [write in position titles]	Fulltime or Part-time?	Since when?
Lourena Manembe, M&E Officer	Full-time	2009
Izidio Nhamtumbo, Information Manager	Full-time	2001
Silvo Macamo, M&E Officer	Full-time	2009
Cecilia Uamusse, M&E Officer	Full-time	2009-2012
2 x ME officers in the MoH and 1 ME advisor (funded by external partner since 2011)	Temps plein	>10 years

POSITION [write in position titles]	Fulltime or 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

Briefly describe the data-sharing mechanisms: The time period for submission of data is defined by the NAC. Key partners should submit their 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 Seguimiento do Patiente)

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

6. Is there a central national database with HIV- related data?: 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 Facilities. The HIV ME programme unit manually collects data from the DIS.

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?: Yes, but only some 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?

At national level: Yes

At subnational level: Yes

IF YES, at what level(s): District and Province HF level

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

7.2. Is HIV programme coverage being monitored?: No

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

(b) IF YES, is coverage monitored by population groups?: 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?: 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?: No

9. How are M&E data used?

For programme improvement?: Yes

In developing / revising the national HIV response?: Yes

For resource allocation?: Yes

Other [write in]: Orientate strategies and policies, accountability

: Yes

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

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

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?: No

IF YES, how many?:

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

IF YES, describe what types of activities: 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?: 6

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.

B.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?: 2

Comments and examples: In general there is an opportunity for dialogue between CS and Government in the multisectoral response as the 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 of the HAP by the MoH in 2013 had high involvement of INGOs and PEPFAR agencies. Some national organisations were also consulted, but the process was closed for the majority of CS national organisations. • The development of the 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 where 0 is “Low” and 5 is “High”) have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?: 2

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?: 3

b. The national HIV budget?: 0

c. The national HIV reports?: 2

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?: 2

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?: 2

c. Participate in using data for decision-making?: 2

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. organisations and networks of people living with HIV, of sex workers, community based organisations , and faith-based organizations)?: 4

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?: 1

b. Adequate technical support to implement its HIV activities?: 1

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: >75%

Men who have sex with men: >75%

People who inject drugs: >75%

Sex workers: >75%

Transgender people: >75%

Palliative care : >75%

Testing and Counselling: 25-50%

Know your Rights/ Legal services: >75%

Reduction of Stigma and Discrimination: >75%

Clinical services (ART/OI): <25%

Home-based care: >75%

Programmes for OVC: >75%

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?: 3

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 CSOs 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.

B.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

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.

B.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 VULNERABLE SUBPOPULATIONS:

People living with HIV: Yes

Men who have sex with men: No

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: No

Prison inmates: No

Sex workers: No

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]: ine workers and Older people

: Yes

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

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 on the degree to which they are currently 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 to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?: No

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:

People living with HIV: No

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: No

People with disabilities: No

People who inject drugs: Yes

Prison inmates: Yes

Sex workers: Yes

Transgender people: Yes

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable populations [write in]: mine workers

: Yes

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: • 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

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

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

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?: 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).

Antiretroviral treatment:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

HIV prevention services:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

HIV-related care and support interventions:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

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

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

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?: No

IF YES, Briefly describe the content of this policy/strategy and the populations included::

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

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:: 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

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

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 independent 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

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

b. Programmes for members of the judiciary and law enforcement⁴⁶ on HIV and human rights issues that may come up in the context of their work?: Yes

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

a. Legal aid systems for HIV casework: No

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV: No

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

IF YES, what types of programmes?:

Programmes for health care workers: Yes

Programmes for the media: Yes

Programmes in the work place: Yes

Other [write in]: Community leaders, faithbased organisations

: Yes

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?: 6

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?: 2

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

B.IV Prevention

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

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 violence 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...:

Blood safety: Agree

Condom promotion: Agree

Harm reduction for people who inject drugs: Strongly disagree

HIV prevention for out-of-school young people: Disagree

HIV prevention in the workplace: Agree

HIV testing and counseling: Strongly agree

IEC on risk reduction: Agree

IEC on stigma and discrimination reduction: Disagree

Prevention of mother-to-child transmission of HIV: Strongly agree

Prevention for people living with HIV: Agree

Reproductive health services including sexually transmitted infections prevention and treatment: Agree

Risk reduction for intimate partners of key populations: Disagree

Risk reduction for men who have sex with men: Disagree

Risk reduction for sex workers: Disagree

School-based HIV education for young people: Agree

Universal precautions in health care settings: Agree

Other [write in]: Male Circumcision

: Disagree

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?: 5

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

B.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

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 Zambesia 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...:

Antiretroviral therapy: Agree

ART for TB patients: Agree

Cotrimoxazole prophylaxis in people living with HIV: Agree

Early infant diagnosis: Disagree

HIV care and support in the workplace (including alternative working arrangements): Disagree

HIV testing and counselling for people with TB: Strongly agree

HIV treatment services in the workplace or treatment referral systems through the workplace: Disagree

Nutritional care: Disagree

Paediatric AIDS treatment: Disagree

Post-delivery ART provision to women: Agree

Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault): Strongly disagree

Post-exposure prophylaxis for occupational exposures to HIV: Disagree

Psychosocial support for people living with HIV and their families: Disagree

Sexually transmitted infection management: Agree

TB infection control in HIV treatment and care facilities: Disagree

TB preventive therapy for people living with HIV: Disagree

TB screening for people living with HIV: Disagree

Treatment of common HIV-related infections: Disagree

Other [write in]: Access to laboratory results for CD4 counts

: Disagree

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?: 6

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

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

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?: 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 treatment, care and support programmes in 2013?: 7

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