



Republic of Mozambique
National AIDS Council

UNGASS

United Nations General Assembly Special Session on HIV and AIDS

Progress Report, 2008 - 2009

MOZAMBIQUE



March
2010

Acknowledgments

The Progress Report of the Declaration of Commitment of the United National General Assembly Special Session (UNGASS) in Mozambique has been developed by the National AIDS Control Council (CNCS) with overall support from the United Nations Joint Program on HIV and AIDS (UNAIDS).

Government ministries, bilateral and multilateral partners, NGOs, faith-based organizations, PLHIV groups are thanked for their participation in preparatory meetings as well as the national validation workshop. CNCS would like to acknowledge the following organizations and individuals for having played an important individual and collective role in the provision of data and information to feed UNGASS indicator, as well as in the preparation and reviewing of the UNGASS Report:

Government: **Ministry of Health:** Rosa Marlene, Ema Chuva, Ilésh Jani, Francisco Mbofana, Mahomed Mussagy, Celso Inguane, Stelio Mazivila, Lídia Chongo, Daniel Lee, Nazir Amade, Laurence Ahoua, Dina Ibraimo, Célia Gonçalves, Abdul Mussa, Egídio Langa, Caroline Soi. **Ministry of Women and Social Action:** Sansão Buque, Ângela Ussivane. **Ministry of Youth and Sports:** Celmira da Silva, Cacilda Machiana. **Ministry of Justice:** Alcindo Gimo. **Ministry of Education:** Teodora Cassamo, Joana Meyer. **INE:** Pedro Duce. **Membros do Grupo Técnico Multisectorial (GTM),** which provided technical oversight throughout the report generation process.

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Foreword

In 2001, the Government of Mozambique signed the Declaration of Commitment of the United Nations General Assembly Special Session on HIV and AIDS (UNGASS), thus being linked to the international community as an effort to stop the spread of HIV epidemic.

In this quality, Mozambique is committed to elaborate a biennial report to the United Nations General Assembly, reporting the progress achieved on the national response to the HIV epidemic. This was already performed in 2001-2003, 2004-2005 and 2006-2007, and the present report corresponds to the period 2008-2009.

Since the last report, Mozambique has shown positive progress as a result of Government commitment and the support of its cooperation partners in collaboration with different sectors of society.

In fact, the country developed an intense activity on the various response components, during this period: thus, concerning to planning, important strategic documents were designed that will be the orientation basis for the HIV response in the nearest future.

Concerning prevention, several studies have been implemented with the aim of identifying the epidemic drivers, thus improving its knowledge as well as the capacity to plan, direct and provide services to the mostly in need populations. A new, coherent and evidence-based prevention strategy was also formulated.

As a response to the Government commitment to reach the universal access for HIV and AIDS, progress was achieved on the health area, with the antiretroviral treatment decentralization and integration into the health system, prevention of mother to child transmission, and counseling and testing in health, which includes HIV. This has resulted on significant coverage increase both for adults and children in a relatively short period of time. People living with HIV who initiate antiretroviral treatment, and have nutritional needs, now have access to food support (*food basket*).

New progress occurred relatively to human rights of people living with HIV: nowadays their rights are more protected through the law nr 12/2009 of 12th March, approved by the Parliament, representing a milestone for the strengthening of the political context for HIV prevention in Mozambique. In the same year, the law against domestic violence was promulgated, protecting women against any form of violence practiced by sexual partners or relatives.

The Government and political leaders have been providing a remarkable political support through their active and regular involvement. In parallel, civil society organizations participation has grown considerably, namely on the formulation of HIV related policies, strategies and laws. In spite of the

reported successes and the apparent stabilization of the epidemic, the Government is aware of the great investment that still needs to be done for the response against HIV, facing the growing impact of the HIV epidemic in the Mozambican society.

Prof. Dr. Paulo Ivo Garrido
Minister of Health and CNCS Vice-President

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral Drugs
ASC	AIDS Spending Categories
BMI	Body Mass Index
BSS	Behavioural Surveillance Survey
BTNP	Blood Transfusion National Program
CBO	Community Based Organization
CCR	<i>Consulta da Criança de Risco</i> HIV exposed child outpatients
CDC	Centers for Disease Control and Prevention
CNCS	<i>Conselho Nacional de Combate ao SIDA</i> National AIDS Council
CSO	Civil Society Organisations
CT	Counseling and Testing
CTH	Counseling and Testing on Health
CTHU	Counseling and Testing on Health Unit
CCTH	Community Counselling and Testing on Health
DHS	Demographic and Health Survey
DOTS	Direct Observation Treatment Strategy
DPS	<i>Direcção Provincial de Saúde</i> Provincial Health Directorate
EcoSIDA	<i>Empresários Contra o SIDA</i> Businessess Against AIDS
EPP	Estimates and Projections Packet
GAMET	Global AIDS Monitoring and Evaluation Team
GER	Gross Enrolment Ratio
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HIS	Health Information System
IDU	Injecting Drug Users
IEC	Information, Education and Communication

IMCI	Integrated Management of Childhood Illnesses
INAS	<i>Instituto Nacional de Acção Social</i> National Institute of Social Action
INE	<i>Instituto Nacional de Estatísticas</i> National Institute of Statistics
INJAD	National Survey on Reproductive Health and Sexual Behaviour among Young People and Adolescents
INS	<i>Instituto Nacional de Saúde</i> National Health Institute
INSIDA	<i>Inquérito Nacional de prevalência, riscos comportamentais e informação sobre HIV e SIDA</i> Population-Based Sero-Behavioural Survey
IPT	Isoniazid Preventive Therapy
I-RARE	International Rapid Assessment Response and Evaluation
M&E	Monitoring and Evaluation
MAP	Multi-Country AIDS Programme
MARPs	Most-At-Risk-Populations
MCH	Mother and Child Health
MDGs	Millennium Development Goals
MDR-TB	Multi-Drug Resistant TB
MICS	Multiple Indicator Cluster Survey
MINED	Ministry of Education
MISAU	<i>Ministério da Saúde</i> Ministry of Health
MMAS	Ministry of Women and Coordination of Social Action
MoH	Ministry of Health
MONASO	Mozambique Network of AIDS Services Organisations
MSM	Men who have sex with Men
MTG	Multi-sectoral Technical Group
NAC	National AIDS Council
NASA	National AIDS Spending Assessment
NCPI	National Composite Policy Index
NER	Net Enrolment Ratio
NGO	Non-governmental Organization
NPCS	<i>Núcleo Provincial de Combate ao SIDA</i> Provincial AIDS Council Nucleus
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children

PARPA	<i>Plano de Acção para a Redução da Pobreza Absoluta</i> Action Plan for the Reduction of Absolute Poverty
PCR	Polymerase Chain Reaction
PEN	<i>Plano Estratégico Nacional de Combate ao HIV e SIDA</i> National HIV and AIDS Strategic Plan
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
RENSIDA	Mozambique Network of PLHIV associations
RUTF	Ready-to-Use Therapeutic Food
SETSAN	<i>Secretariado Técnico para a Segurança Alimentar e Nutricional</i> Technical Secretariat for Food and Nutrition Security
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TARV	<i>Tratamento Anti-RetroViral</i> Anti-Retroviral Treatment
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session Declaration of Commitment on HIV and AIDS
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
US\$	United States Dollar
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization
YFHS	Youth Friendly Health Services

I. Contents

I. CONTENTS	6
II. STATUS AT A GLANCE	9
III. OVERVIEW OF THE AIDS EPIDEMIC	12
<i>HIV Prevalence reduction</i>	12
<i>Regional trends</i>	13
<i>National Trend</i>	14
<i>HIV prevalence among most-at-risk populations</i>	17
IV. NATIONAL RESPONSE TO THE AIDS EPIDEMIC	19
PART I. NATIONAL COMMITMENT AND ACTION	19
<i>Domestic and International AIDS Spending</i>	19
<i>National Level HIV and AIDS Policies and Strategies</i>	25
<i>Private, Informal and Cooperative Sector's response to HIV</i>	32
PART II: NATIONAL PROGRAMMES	34
PREVENTION PROGRAMMES	34
<i>Blood Safety</i>	34
<i>Prevention of Mother to Child Transmission</i>	38
<i>HIV Counselling and Testing</i>	47
<i>Knowledge about HIV Prevention and Prevention Programmes (Young people)</i>	52
<i>Knowledge about HIV Prevention and Prevention Programmes among Most at risk populations (MARPS)</i>	56
<i>Life Skills-based HIV Education in Schools</i>	62
<i>Sexual Behaviour</i>	64
<i>Condom Use</i>	67
<i>Drug Use</i>	71
TREATMENT PROGRAMMES	73
<i>Antiretroviral Therapy</i>	73
<i>Nutrition and HIV</i>	83
<i>Co-management of Tuberculosis and HIV Treatment</i>	88
CARE AND SUPPORT PROGRAMMES	92
<i>Support for Children Affected by HIV</i>	92
<i>School attendance among Orphans and Non-Orphans</i>	97
<i>Home-Based Care</i>	102
<i>Older People</i>	105
V. BEST PRACTICES	107
VI. MAJOR CHALLENGES AND REMEDIAL ACTIONS	110
VII. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS	123
VIII. MONITORING AND EVALUATION ENVIRONMENT	125
ANNEXES	135

List of Tables

<i>Table 1: HIV prevalence rate estimate among pregnant women (15-49 years old) attending ante-natal car, by region and national, 2002-2009.....</i>	12
<i>Table 2: Percentage of young women aged 15–24 who are HIV infected.....</i>	0
<i>Table 3: Median HIV prevalence rates among 15-24 year old pregnant women.....</i>	16
<i>Table 4: Total spending by area and by year (US\$).....</i>	20
<i>Table 5: Funding sources (US\$ thousands).....</i>	21
<i>Table 6: Spending by type of funding source and by year (US\$ thousands).....</i>	22
<i>Table 7: Disaggregation of external funding (3 main ones) (US\$ thousands).....</i>	23
<i>Table 8: Variation of the different types of external funding, 2007/2008.....</i>	23
<i>Table 9: Spending Categories by type of funding source and year (US\$ thousands).....</i>	0
<i>Table 10: HIV related activities implemented in enterprises, Mozambique 2008-09.....</i>	33
<i>Table 11: Percentage of donated blood units screened for HIV in a quality assured manner,</i>	1
<i>Table 12: Percentage of HIV-positive pregnant women who received antiretrovirals.....</i>	1
<i>Table 13: Percentage of HIV-positive infants born to HIV-infected mothers, 2008/09....</i>	1
<i>Table 14: People (15 years or older), attended in diverse CTH units de ATS of the National Health Service</i>	47
<i>Table 15: Table of CTH activities in Health Units, 2009 (adults and children)</i>	49
<i>Table 16: Community CTH: Table of activities implemented, 2009.....</i>	50
<i>Table 17: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.....</i>	1
<i>Table 18: Percentage of people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and are able to reject major misconceptions about HIV prevention, by sex and age group.</i>	1
<i>Table 19: Percentage of young women and men aged 15-24 who had sexual intercourse before the age of 15.....</i>	1
<i>Table 20: Percentage of women and men aged 15-49 who have had sexual intercourse</i>	1
<i>Table 21: Condom supply.....</i>	68
<i>Table 22: Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during sexual intercourse 2003,.....</i>	1
<i>Table 23: Percentage of adults and children with advanced HIV infection receiving ART</i>	1
<i>Table 24: Revised paediatric HIV Targets 2009, Ministry of Health, Mozambique.....</i>	80
<i>Table 25: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV.....</i>	1
<i>Table 26: Current school attendance among orphans and non-orphans aged 10-14, by sex</i>	1
<i>Table 27: Number of Health Facilities providing HBC services.....</i>	103

List of Figures

<i>Figure 1: HIV regional prevalence, 1988-2009</i>	0
<i>Figure 2: HIV national prevalence, 1988-2009</i>	14
<i>Figure 3: HIV Regional Prevalence, 2004-2009.</i>	15
<i>Figure 4: Annual growth rate</i>	0
<i>Figure 5: Annual spending on HIV and AIDS</i>	0
<i>Figure 6: Proportion of spending categories, total, 2007 and 2008</i>	0
<i>Figure 7: Spending by funding sources, (2007 and 2008)</i>	0
<i>Figure 8: NCPI Trend analysis, 2003-2009, Part A (Government assessment)</i>	30
<i>Figure 9: NCPI Trend analysis, 2003-2009, Part B (Non-government assessment)</i>	31
<i>Figure 10: Number of blood units collected in blood banks, 2003 - 2009</i>	35
<i>Figure 11: Percentage of pregnant women aged 15-49 years that were counselled and tested in antenatal clinics in 2003 and 2008, Mozambique</i>	39
<i>Figure 12: Coverage of health facilities with antenatal care services and PMTCT, Mozambique, 2009</i>	41
<i>Figure 13: Number of pregnant women that received ARV prophylaxis</i>	41
<i>Figure 14: Antenatal and postnatal cascade for PMTCT, 2009</i>	42
<i>Figure 15: Total number of ART Health Facilities and Beneficiaries in Treatment: 2003 – 2009</i>	75
<i>Figure 16: Trend in adult ART coverage, 2003-2009</i>	77
<i>Figure 17: ART Coverage by Region for Adult and Paediatric patients in 2009</i>	78
<i>Figure 18: Trend in Paediatric ART coverage, 2003-2009</i>	79
<i>Figure 19: Percentages of TB patients tested for HIV, co-infected, receiving cotrimoxazole prophylaxis, and on ART, 2006-2009 (TB-HIV collaborative activities – TB program)</i>	1
<i>Figure 20: Numbers of HIV patients screened for TB, co-infected, and on IPT, 2007-2009</i>	1
<i>Figure 21: Orphans and vulnerable children by province</i>	1
<i>Figure 22: Children orphaned and made vulnerable by AIDS whose house</i>	94
<i>Figure 23: Primary school attendance, ratio between double orphan and non-orphans,</i>	99

II. Status at a Glance

Indicator	Comments on changes in the indicator	2004/2005	2006/2007	2008/2009
National Commitment and Action				
1. Domestic and international AIDS spending (\$US)	Definition changed	107,496.637 (2004-05)	96,624.000 (2006)	146,425.000 (2008)
2. National Composite Index	Questions added	82% (2005)	70%	75%
National Programmes				
3. Percentage of donated blood units screened for HIV in a quality assured manner	Definition changed	100% (2005)	35.5%	69.5% (2009)
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Added children	7.4% (2005)	28.0% (2007) 13.7% (2006)	30.0% (2008) 38% (2009)
5. Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Definition changed	6.7% (2005)	29.8% (2007) 8.3% (2006)	32.1% (2008) 45.8% (2009)
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	New Indicator	Not reported in 2005	3.9% (2006)	9.8% (2009)
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results. (DHS: 2003)	New Indicator	Not reported in 2005	2.5% (2003) Masc.: 3% Femin.: 2%	12.1% Masc.: 8.9% Femin.: 14.5%
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	No changes	No data available	No data available	No data available
9. Percentage of most-at-risk populations reached with HIV prevention programmes	Definition changed	No data available	No data available	No data available
10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	No changes	22%	22%	22%
11. Percentage of schools that provided life skills-based HIV education in the last academic year	Definition changed	No data available	No data available	No data available

Indicator	Comments on changes in the indicator	2004/2005	2006/2007	2008/2009
Knowledge and Behaviour				
12. Current school attendance among orphans and among non-orphans aged 10–14. (DHS:2003; MICS: 2008)	Ratio calculation no longer required	Orphans: 62.6% (2003) Masc.: 72.6% Femin.: 54%	Orphans: 62.6% (2003) Masc.: 72.6% Femin.: 54%	Orphans: 77.3% Non-orphans: 86.5% (2008)
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. (DHS: 2003*, INSIDA: 2009)	No changes	22.3%* (2003) Masc.: 33%* Femin.: 20%*	22.3%* (2003) Masc.: 33%* Femin.: 20%*	34.8% Masc.: 33.7% Femin.: 35.7%
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	No changes	No data available	No data available	No data available
15. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15. (DHS: 2003, INSIDA: 2009)	Age range expanded	27.6% (2003) Masc.: 26% Femin.:28%	27.6% (2003) Masc.: 26% Femin.:28%	25.1% Masc.: 24.9% Femin.: 25.3%
16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months. (DHS: 2003). (DHS: 2003, INSIDA: 2009)	Age range expanded and definition changed	11.1% Masc.: 30.2% Femin.: 4.9%	11.1% Masc.: 30.2% Femin.: 4.9%	10.0% Masc.: 19.6% Femin.: 2.9%
17. Percentage of women and men aged 15–49 who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse. (DHS: 2003, INSIDA: 2009)	Age range expanded and definition changed	17% Masc.: 19% Femin.:14.4%	17% Masc.: 19% Femin.:14.4%	22.2% Masc.: 22.0% Femin.: 23.3%
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	No changes	No data available	No data available	No data available
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No changes	No data available	No data available	No data available
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse		No data available	No data available	No data available
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected		No data available	No data available	No data available

Indicator	Comments on changes in the indicator	2004/2005	2006/2007	2008/2009
Impact				
22. Percentage of young women and men aged 15-24 who are HIV infected.	No changes	-	14.4% (2007)	Female = 14.1%
23. Percentage of most-at-risk populations who are HIV infected.	No changes	No data available	No data available	No data available
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	Definition changed	No data available	No data available	No data available
25. Percentage of infants born to HIV infected mothers who are infected with HIV.	No changes	24.6% (2005)	-	31% (2008) 29% (2009)

*Data is different from UNGASS progress report for 2005 due to refinement in the method of calculation

III. Overview of the AIDS epidemic

HIV Prevalence reduction

HIV prevalence among adults in Mozambique is estimated on the basis of the HIV epidemiologic surveillance in sentinel posts, held among pregnant women attending ante-natal care. A quarter of the 144 administrative districts and cities of Mozambique has sentinel posts (Centre-15 posts; North -11 posts; South-10 posts).

National estimated is calculated using the prevalence rate measured among ante-natal care attendees, weighed for the population of each region where the sentinel post is sited. A população adulta é calculada utilizando as projecções do censo disponíveis actualmente, que foram feitos com base no censo populacional de 1997. As such, prevalence rates are calculated for each region and for the whole country. Prevalence rates are not disaggregated between rural and urban areas. Prevalence rates results for the last four surveillance rounds are shown on Table 1.

Table 1: HIV prevalence rate estimate among pregnant women (15-49 years old) attending ante-natal car, by region and national, 2002-2009

Region	2002	2004	2007	2009
South	16% (12%-18%)	19% (14%-21%)	21% (16%-23%)	21% (17%-25%)
Centre	18% (17%-20%)	19% (17%-21%)	18% (17%-12%)	18% (14%-21%)
North	8% (6%-9%)	9% (7%-19%)	9% (7%-10%)	9% (7%-11%)
National	15% (13%-15%)	16% (14%-16%)	16% (14%-17%)	15% (14%-17%)

[Source: MISAU/INS, 2009]

(Based on the EPP model, without calibration).¹

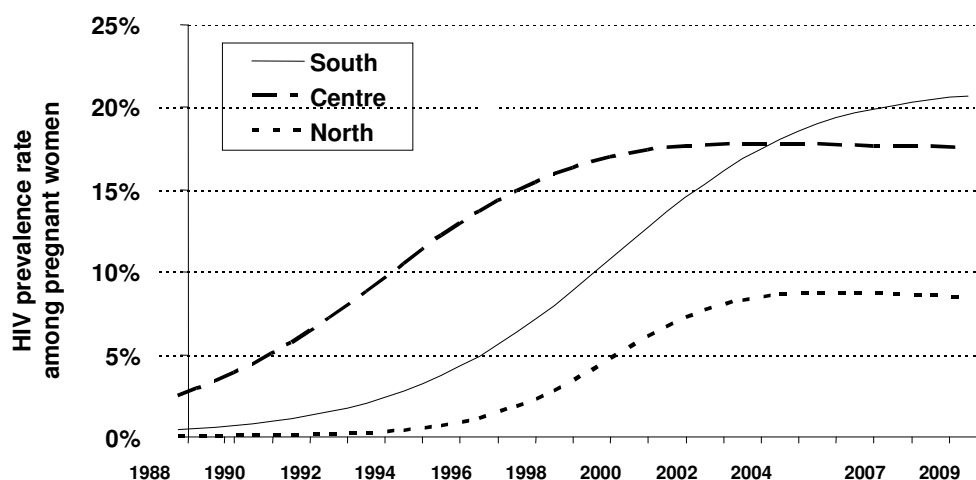
In 2009, epidemiologic surveillance was held in the same 36 sentinel posts as in 2004 e 2007. 13 373 women have agreed to be tested (approximately 300 women per sentinel post). The refusal rate was - 0.3%. Laboratory testing at central level has used ELISA to determine the HIV status.

¹ Data from the model Estimates and Projections Packet (EPP) is not calibrated. Data for 2009 was calculated with the new EPP version, although data from previous rounds is presented as in the 2008 UNGASS Report. Limits presented show the plausible values interval that each estimate can have, and this was done using the *uncertainty analysis* of the Spectrum program.

The analysis was done using the UNAIDS Estimates and Projections Packet (EPP) model that adjusts the Epi-curve to the surveillance data – projecting the epidemics past and future path. Studies implemented in countries where both sentinel ante-natal surveillance and general population based surveys, show that the prevalence rate obtained by ante-natal surveillance tends to over-estimate the general population prevalence rate. In Mozambique, the data from epidemiologic surveillance among ante-natal care attendees have never been validated against general population based prevalence rates. It was only in 2009 that a national population based sero-behavioural survey was implemented (INSIDA), whose results are expected in 2010. Although data presented in Table 1 can over-estimate the HIV prevalence absolute levels among the general population, they are still valid indicators of the trends over time.

Regional trends

Figure 1 shows the HIV prevalence rates historic trends among the adult population, at regional level, from 1988 up to 2009. Similarly to what was noted in previous rounds, the three regions in the country show marked differences: the southern region has the highest prevalence levels, followed by the central region and the northern one.



[Source: MISAU/INS, 2009]

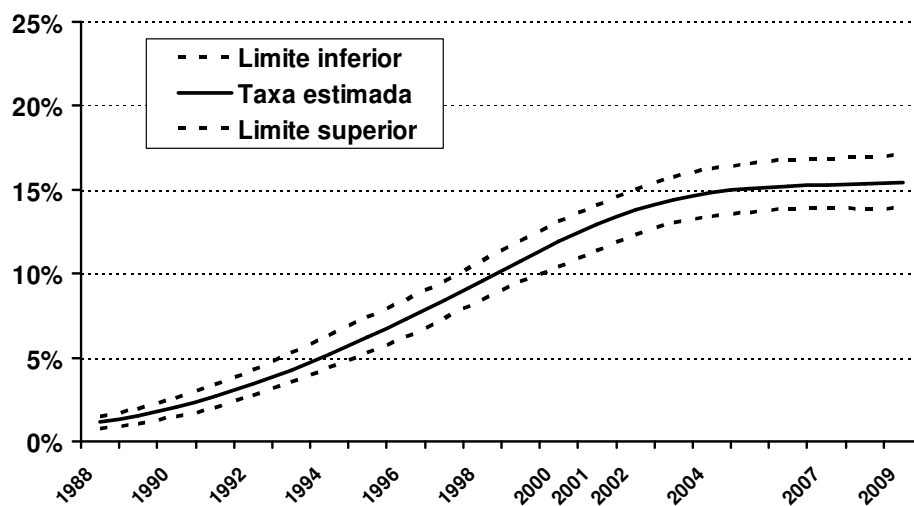
Figure 1: HIV regional prevalence, 1988-2009

More recent trend analysis on the median HIV prevalence among pregnant women at regional level, from 2001 up to 2009 (Figure 1), shows that the levels are stabilized in the northern region. In the central region, a slight decline of the median prevalence is registered since 2004. In the south, prevalence levels have grown between 2001 and 2007, having a growth disacceleration and possible stabilization between 2007 and 2009.

According to the EPP methodology, the estimated prevalence rate for the adult population in the southern region is 21 %. In the central and northern region, this rate is 18% and 9%, respectively.

National Trend

The analysis of the HIV prevalence rates historic trends among the adult population, at national level, from 1988 up to 2009 shows stabilization of the national prevalence (Figure 2).



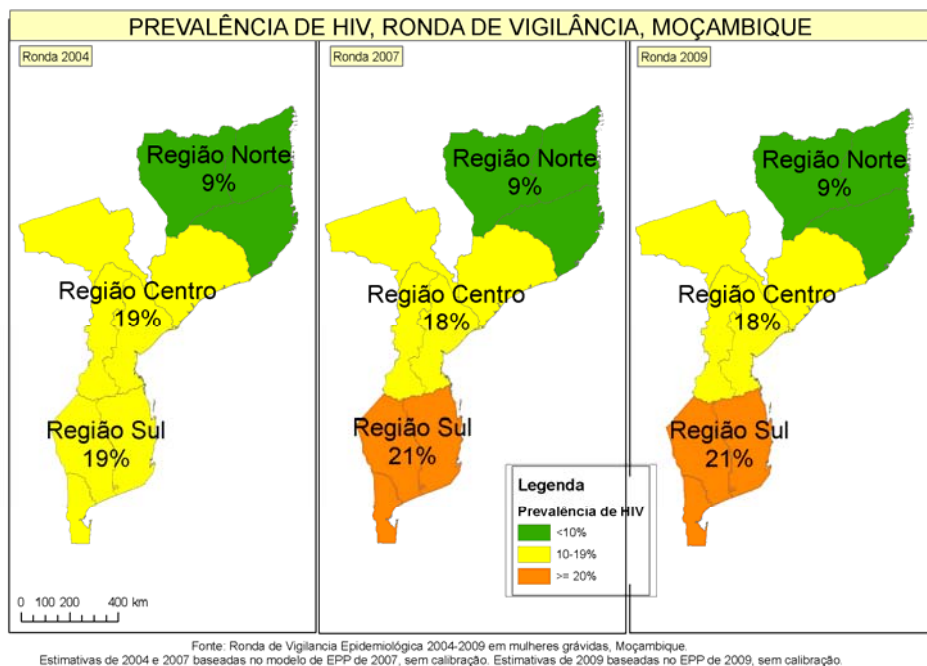
[Source: MISAU/INS, 2009]

Figure 2: HIV national prevalence, 1988-2009

The non-calibrated estimated national prevalence among the adult population calculated by EPP for 2009 is 15%. Having in mind the possible variation of this estimate, this rate should be between 14% and 17%.

This data shows that the HIV epidemic in Mozambique has a different degree of regional maturation, with three distinct epidemics. With the help of the survey INSIDA, it will be possible, for the first time, to get direct estimates of the HIV prevalence in women, men and children, by province and by age group. These estimates will be more accurate because they are the result of data collected directly from a sample representative of households in each province.

As it can be seen on Figure 3, a slight alteration is remarkable on the national prevalence: the central and northern regions show a tendency for stability, while the southern region has an ascending trend.



[Fonte: MISAU/INS, 2009]

Figure 3: HIV Regional Prevalence, 2004-2009.

UNGASS Indicator #22: Percentage of young women and men aged 15–24 who are HIV infected

Table 2: Percentage of young women aged 15–24 who are HIV infected

	All 15-24	Disaggregated Values	
		15-19	20-24
Numerator: Number of ANC clinic attendees (aged 15 -24) tested whose HIV test results are positive	843	255	588
Denominator: Number of ANC clinic attendees (aged 15-24) tested for their HIV infection status	5 999	2 738	3 261
Indicator Value Percent*	14,1%	9,3%	18,0%

Pooled prevalence percentage calculated as the numerator / denominator × 100
 Median of the site level prevalence percentages
 (Source: MISAU/INS, 2009)

It should be noted that figures mentioned in the Table above correspond to females only.

According to the UNGASS method of measurement HIV prevalence among young women (15-24 years) attending antenatal clinics in 2009 is 14.1%. The HIV prevalence rate is higher among age group of 20-24 (18.0%) when compared to the age group of 15-19 years (9.3%).

The median prevalence rates among 15-24 year old women who attended antenatal clinics during the sentinel surveillance rounds are presented in Table 3.

Table 3: Median HIV prevalence rates among 15-24 year old pregnant women attending antenatal clinics, 2001-2009[†]

Year	2001	2002	2004	2007	2009
National prevalence	12.5%	13.1%	15.6%	11.3%	12.0%

[Source: MISAU/INS, 2009]

[†] Median of the site level prevalence percentages

According to Table 3, the HIV prevalence rate among young women (15-24 years) attending antenatal clinics reached a peak value in 2004 (15.6%) and showed a significant decrease in 2007 (11.3%), that was not confirmed in 2009 (12.0%).

A linear regression analysis shows that, in the period 2002-2009 among female youth aged 15-24 years, at national level, there was not a significant reduction in the prevalence of HIV. At regional level, the northern region keeps on showing the lowest prevalence rate in the country in this age group. The central region shows a descending trend. Posts sited in urban areas present higher prevalences when compared to sites in rural areas, in the same age group, in 2009.

HIV prevalence among most-at-risk populations

In Mozambique, data on the HIV sero-prevalence among most-at-risk populations is not yet available. One of the difficulties to obtain this data was related to the lack of definition of the most-at-risk populations in the country. This was however overtaken when, through an extensive consultation process, government approved the National Strategy for the Acceleration of Prevention whereby the following most-at-risk sub-populations were considered prioritary: Women, Children and Adolescents, Police and Military, Health workers, Teachers, Prisoners, High competition Athletes, Miners, Sailors and Sex workers. Considering that these groups are relatively extensive, government decided to focus its interventions in the following more restricted sub-groups: Women and Adolescents, Prisoners, Miners, and Sex workers. However, there are no limitations to occasional government partners' interventions addressed to other most-at-risk groups.

The implementation of the National Strategy for the Acceleration of Prevention is very recent and it has not yet generated enough information to allow estimating the HIV sero-prevalence among most-at-risk populations. There is however, data derived from small scale and localized projects, implemented by the government and its partners. The Centre for Diseases Control and Prevention (CDC), in coordination with the Ministry of Health, implemented a qualitative research "International Rapid Assessment, Response and Evaluation – I-RARE" in three port cities of the country, namely Nacala-Porto, Beira e Maputo, on the risk behaviours for HIV among injecting and non-injecting drug users, sex workers and their clients, whereby it was possible to test for HIV a small proportion of the sample. Acceptability for testing was very low among these groups (24%). Among those tested the positive results for HIV were as follows: sex workers: 48% (30/63); drug users, 43% (13/30); sex workers clients, 42% (5/26)².

In 2009, Projecto 100% Vida, implemented by DPS/UNFPA/PSI/Pathfinder in Nacala-Porto, Cidade de Nampula, Inchope, Maputo e Matola reported that 28% (78/278) of the sex workers that attended counselling and testing services tested positive, representing approximately double the figure for the general population. Although these samples are very small, these results show clearly that HIV is a much bigger problem among most at risk groups when compared to the general population.

Using estimates of the HIV modes of transmission models, in 2008 it was estimated that about 2% of all new infections have occurred among sex workers and about 7% among their clients. It was also estimated that sex workers, their clients, and their partners are responsible for about 19% of the new infections. On the other hand, and in spite of the scarcity of data, the model has also allowed estimating that 5% of the new cases have occurred among men who have sex with men, and about 3% have occurred among injectable drug users³.

MISAU's epidemiologic surveillance data show that the highest prevalence rates occur along the transport corridors, suggesting that mobile populations are at high risk. On the other hand, other most-at-risk groups, such as sex workers and drug users tend to concentrate in these areas, thus increasing their risk to acquire and transmit the virus.

² I-RARE (2009): Risco de HIV em Trabalhadoras de de Sexo e em Usuários de Drogas nas Cidades de Maputo, Beira e Nacala, Moçambique. *Em: Livro de Resumos, XIII Jornadas de Saúde, Setembro de 2009, Maputo, Moçambique*

³ CNCS, UNAIDS, GAMET. Moçambique: Modos de Transmissão do HIV e Estudo de Prevenção do HIV; 2009.

In order to better understand the burden of the HIV epidemic among the most-at-risk populations, CDC will support the government in 2010 to implement research to determine the size of the populations of drug users and men who have sex with men, further to the establishment of an HIV surveillance system among sex workers.

Behaviour Surveillance Survey (BSS) in Mozambique: The first Behaviour Surveillance Survey in Mozambique is underway. After having started in 2008, its second phase will be finished in 2010 and the final results are expected by the end of 2011. The BSS's aim is to monitor and evaluate the baseline information on HIV-related knowledge, attitudes and behaviours among the main most-at-risk groups in Mozambique. The survey will include a biomarker so as to estimate HIV ser prevalence among these groups (BSS+).

Indicator #23: Percentage of most-at-risk populations who are HIV infected

Currently no data exists for this indicator.

IV. National Response to the AIDS Epidemic

PART I. National Commitment and Action

Domestic and International AIDS Spending

Mozambique has produced the first AIDS spending measurement for the years 2004-2006, in 2008, using the NASA methodology – National AIDS Spending, which allows tracking expenses financed by public, private and international sources with some profundity. During the above mentioned process, national level expenses were tracked on the basis of data collected on domestic, external and private expenses and provided by the main stakeholders in the national response.

Estimates have shown that Mozambique has spent on HIV and AIDS a total of US\$ 204 million in 2004-2006, presenting an exponential growth; expenses in 2006 were double the ones registered in 2005, and annual growth has oscillated from 22% between 2004 and 2005, up to 64% between 2005 and 2006.

In the same period, external financial sources have represented 82% of the expenses on HIV and AIDS, while 16% were public funds and only 2% from private sources.

National AIDS spending measurement for the years 2007-2008 as followed the same methodology as described above. Hence, expenses data was obtained through the registry kept by primary information sources. In some cases, data had to be adapted to the country's fiscal calendar, which corresponds to the civil calendar, that is different of the one adopted by some countries and international organizations. In other cases, there was the need to estimate HIV and AIDS expenses, using costing techniques, on the basis of the best available information and adequate assumptions.

This process has some limitations given that some organisations involved on the national response are not based in the country, and it was not possible to collect relevant information. In general, programs tend not to disclose expenses related to HIV and AIDS program management and administration. Another limitation derives from the fact that it is very difficult to estimate expenses incurred by families for services and drugs used in the sphere of HIV and AIDS control, in the absence of population based surveys.

It is important to mention that the total analysis of data will only be completed after the deadline for presentation of the UNGASS Report. For this, priority was given to the data analysis of expenses funding so as to allow calculating indicator 1. All the considerations related to beneficiaries, providers and agents as well as the detail on services provided will be part of the NASA Report to be formulated.

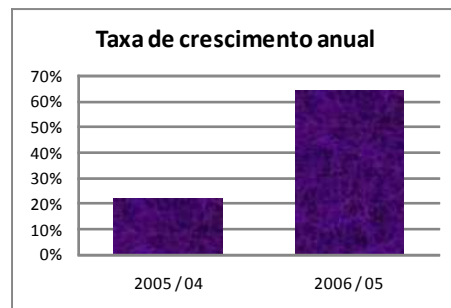


Figure 4: Annual growth rate

Main data

NASA estimates show that expenses on HIV and AIDS amount to a total of US\$ 251 million in 2007-2008. Estimated expenses in this period are 23% higher than during the three previous years (2004-2006).

Although the expenses growth between 2006 and 2007 has been modest, only 9%, it has accelerated to 39% between 2007 and 2008, thus confirming the tendency of high growth rhythms, as noted between 2004 and 2006.

Expenses on HIV and AIDS have tripled between 2004 and 2008.

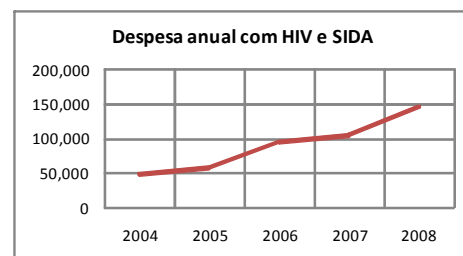


Figure 5: Annual spending on HIV and AIDS

Spending Categories	2007	2008	2007-2008	Var. 2007/2008 %
ASC.01 Prevention	26,073,100	39,329,935	65,403,035	51%
ASC.02 Treatment and Care	28,775,198	41,983,105	70,758,303	46%
ASC.03 Orphans and vulnerable children	9,037,798	13,030,921	22,068,719	44%
ASC.04 Program management and administration	32,646,848	36,075,023	68,721,871	11%
ASC.05 Human Resources	5,121,964	8,454,417	13,576,381	65%
ASC.06 Social protection and social services (excluding OVC)	1,062,073	2,139,460	3,201,533	101%
ASC.07 Favourable environment	1,781,923	2,520,410	4,302,333	41%
ASC.08 HIV and AIDS related research (excluding operational research)	736,684	2,891,690	3,628,374	293%
Total	105,235,588	146,424,961	251,660,549	39%

Table 4: Total spending by area and by year (US\$)

In 2007 and 2008, growth was noted in all eight main AIDS spending categories (ASC). Major growths were registered on HIV and AIDS related research (293%), Social protection and social services (101%) and Human Resources (65%). Program activities benefiting specific populations have increased between 44% and 51%, while Program management and administration expenses increased 11% only.

As shown in Figure 6, three spending categories – Prevention; Treatment and Care; and Program management and administration represent 81% of the total expenses. Treatment and Care is the category that has absorbed more resources (28%).

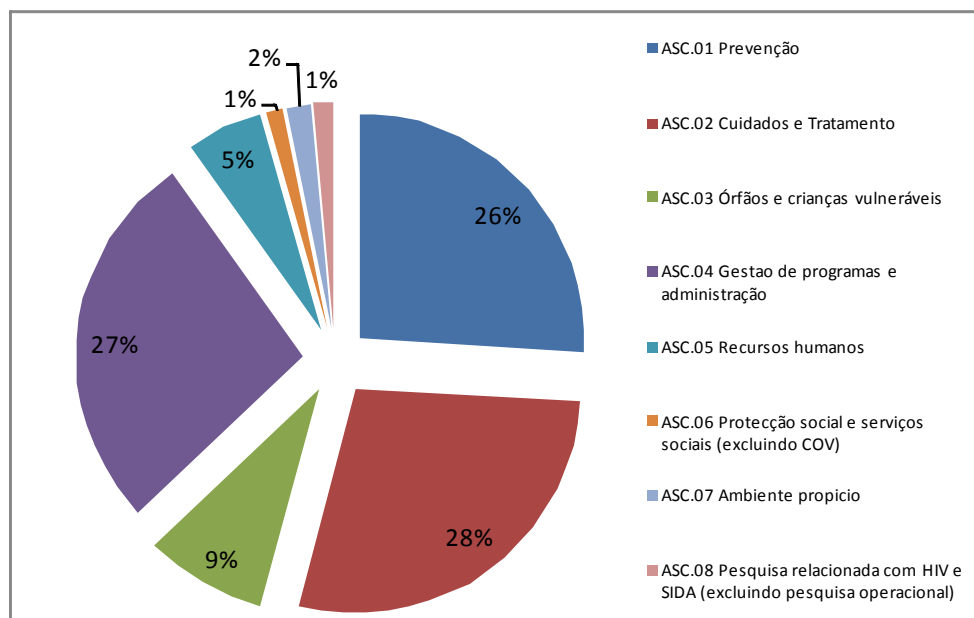


Figure 6: Proportion of spending categories, total, 2007 and 2008

Human Resources spending amounted to only 5% of the total spending, during these two years.

Funding for HIV and AIDS programs in Mozambique comes from three sources: Public, Private and External (International). As shown on Table 5 as well as on the associated Figures, the relative weight of direct external funding for HIV and AIDS has increased from 94% in 2007 up to 96% in 2008. Concerning public funding, there was a decrease from 6% down to 3%. Private funding was kept at the level of around 1%.

Table 5: Funding sources (US\$ thousands)

Funding sources	2007	%	2008	%
Public	5,967	6%	5,033	3%
Private	694	1%	1,479	1%
International	98,575	94%	139,912	96%
Total	105,236	100%	146,425	100%

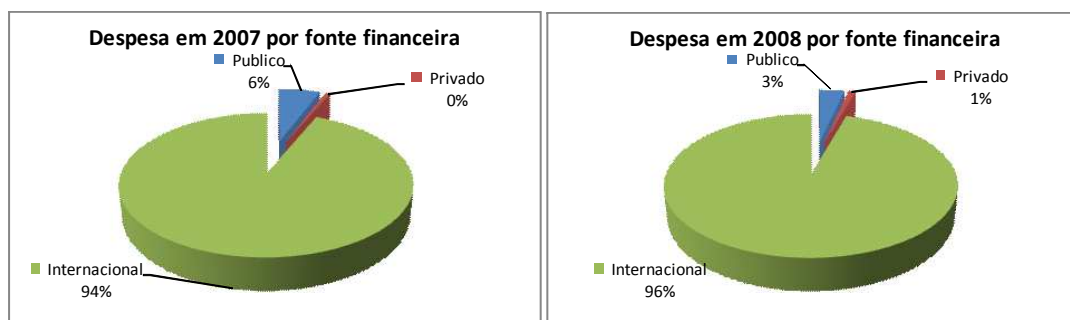


Figure 7: Spending by funding sources, (2007 and 2008)

Table below shows the distribution of different funding sources by spending categories:

Table 6: Spending by type of funding source and by year (US\$ thousands)

Spending Categories	Public		Private		International	
	2007	2008	2007	2008	2007	2008
ASC.01 Prevention	1,959	1,123	294	787	23,819	37,420
ASC.02 Treatment and Care	1,648	1,358	85	133	27,042	40,492
ASC.03 Orphans and vulnerable children	0	0	55	9	8,983	13,022
ASC.04 Program management and administration	2,252	2,252	60	258	30,335	33,565
ASC.05 Human Resources	4	140	168	220	4,950	8,095
ASC.06 Social protection and social services (excluding OVC)	30	0	30	67	1,003	2,072
ASC.07 Favourable environment	24	161	2	3	1,756	2,357
ASC.08 HIV and AIDS related research (excluding operational research)	49	0	0	2	688	2,889
Total	5,967	5,033	694	1,479	98,575	139,912

Public funding is concentrated on three spending categories: Prevention; Treatment and Care; and Program management and administration: Remaining spending categories have a minimal weight.

Private funding more than doubled in 2007 and 2008, although they keep on representing only 1% of the total spending in the two years. Thus, the national response to HIV is essentially funded by external sources.

Disaggregating external funding (international) shows that Bilaterals funding represent 72% and 73% in 2007 and 2008, respectively, Multilaterals 15% and 17% and NGOs and international Foundations 12% e 10%, respectively.

Table 7: Disaggregation of external funding (3 main ones) (US\$ thousands)

Spending Categories	BILATERALS		MULTI-LATERALS		NGOs and Foundations	
	2007	2008	2007	2008	2007	2008
ASC.01 Prevention	17,047	23,282	4,902	11,692	1,843	2,273
ASC.02 Treatment and Care	20,638	33,275	4,648	2,416	1,756	4,801
ASC.03 Orphans and vulnerable children	8,181	11,041	738	1,931	64	50
ASC.04 Program management and administration	19,200	21,891	3,430	5,250	7,706	6,424
ASC.05 Human Resources	3,230	6,192	1,172	1,611	548	291
ASC.06 Social protection and social services (excluding OVC)	852	1,015	134	1,032	17	25
ASC.07 Favourable environment	1,427	2,080	115	208	214	70
ASC.08 HIV and AIDS related research (excluding operational research)	560	2,679	8	61	120	149
Total	71,133	101,455	15,147	24,201	12,267	14,083

Bilaterals funding have increased by 43% between 2007 and 2008, and Multilaterals and NGOs and Foundations by 60% and 15%, respectively, in the same period. It is interesting to note that the growth of the Multilaterals funding has been negative concerning Treatment and Care, while Bilaterals contributions have grown in all spending categories. NGOs and Foundations' resources were preferably addressed to Treatment and Care, Prevention, Social Services and Research, as shown in Table 8.

Table 8: Variation of the different types of external funding, 2007/2008

Spending Categories	Var. 2007/2008 %		
	BILATERALS	MULTILATERALS	NGOs and international Foundations
ASC.01 Prevention	37%	139%	23%
ASC.02 Treatment and Care	61%	-48%	173%
ASC.03 Orphans and vulnerable children	35%	162%	-22%
ASC.04 Program management and administration	14%	53%	-17%
ASC.05 Human Resources	92%	37%	-47%
ASC.06 Social protection and social services (excluding OVC)	19%	670%	54%
ASC.07 Favourable environment	46%	81%	-67%
ASC.08 HIV and AIDS related research (excluding operational research)	379%	625%	24%
Total	43%	60%	15%

Some conclusions

Data shown above clearly reveals that a high volume of resources has been dedicated annually to the national response to HIV in Mozambique. Although growth between 2006 and 2007 has been relatively

low – only 9% - growth registered between 2007 and 2008 has been very high (39%) overtaking any other public health programs in the country.

The lack of a costed strategic plan for the national response does not allow to estimate the degree to which spending corresponds to the defined priorities in financial terms.

The degree of dependency on external funding to finance HIV and AIDS expenses kept on increasing during the years being analysed. For this, reservations about the sustainability of HIV and AIDS programs need to be taken into account. Spending financed by public funding has decreased between 2007 and 2008, confirming the tendency registered between 2004 and 2006

The difficulty to estimate expenses incurred by families keeps on being a strong limitation of these estimates, given that the weight that HIV and AIDS effectively represent to the population is not conveniently illustrated.

Indicator # 1: Domestic and International AIDS spending, by category and funding sources is summarised in the Table below:

Table 9: Spending Categories by type of funding source and year (US\$ thousands)

Spending Categories	Public		Private		International		Total	
	2007	2008	2007	2008	2007	2008	2007	2008
ASC.01 Prevention	1,959	1,123	294	787	23,819	37,420	26,073	39,330
ASC.02 Treatment and Care	1,648	1,358	85	133	27,042	40,492	28,775	41,983
ASC.03 Orphans and vulnerable children	0	0	55	9	8,983	13,022	9,038	13,031
ASC.04 Program management and administration	2,252	2,252	60	258	30,335	33,565	32,647	36,075
ASC.05 Human Resources	4	140	168	220	4,950	8,095	5,122	8,454
ASC.06 Social protection and social services (excluding OVC)	30	0	30	67	1,003	2,072	1,062	2,139
ASC.07 Favourable environment	24	161	2	3	1,756	2,357	1,782	2,520
ASC.08 HIV and AIDS related research (excluding operational research)	49	0	0	2	688	2,889	737	2,892
Total	5,967	5,033	694	1,479	98,575	139,912	105,236	146,425

National Level HIV and AIDS Policies and Strategies

Strategic Plan

Since 2000, Mozambique keeps responding to the HIV epidemic along the lines of an agreed national multi-sectoral strategy that has been regularly updated.

During the 2008-09 reporting period, there was intense strategic planning activity: in 2008, the Response to HIV and AIDS Strategy within the Civil Service (*Estratégia de Resposta ao HIV & SIDA na Função Pública*), 2009-2013, was designed.

In the same year, before the end of the period of the mandate of the last National Strategic Plan (PEN II), 2005-2009, on the face of an explosive AIDS situation, drastically undermining the perspectives of economic growth and human development, the CNCS decided to formulate a new strategy for the national response so as to urgently control the situation.

Thus, a Strategy for the Acceleration of Prevention of HIV Infection (*Estratégia de Aceleração da Prevenção da Infecção pelo HIV*) was produced for the period 2009-2010, under the auspices of the CNCS and with involvement of the governmental sector, nongovernmental organizations and other civil society entities. A costed operational plan for this strategy was developed.

The Strategy for the Acceleration of Prevention has two pillars: i) eight priority areas of action – Counselling and testing, Condoms, Most-at-risk sub-populations, Sexually Transmitted Infections, Male circumcision, PMTCT, Treatment, and Biosafety - and ii) technical and institutional capacity building – Coordination of the response, Communication for behaviour change and Monitoring and Evaluation. The goal of this strategy is to identify the most critical interventions that can contribute for a significant reduction of the HIV incidence in the country.

In 2009, the third National Strategic Plan (PEN III), 2010-2014 was formulated, again with wide involvement of all stakeholders and based on evidence provided by specific studies such as the Modes of HIV Transmission and HIV Prevention Study and the Data Triangulation Study conducted in 2008-09. The PEN III is planned to be validated in early 2010.

Political Support

In Mozambique, Government and political leaders keep providing strong political support to the HIV response. The national multisectoral HIV and AIDS coordination body (*Conselho Nacional de Combate ao SIDA - CNCS*), running since 2000, is chaired by the Prime Minister and co-chaired by the Minister of Health and includes several other Ministers, which translates into active Government leadership and participation.

The CNCS is well structured, with an inclusive membership, represented at the level of all provinces, and has a functional Secretariat. CNCS coordinates the HIV response, promotes policy decisions and provides opportunities for civil society to influence decision-making.

There was an effective use of government and civil society organizations and processes to support effective AIDS programmes. Also, national budgets are allocated to support the AIDS programmes.

However, although adequate funding has been available for HIV activities, CNCS efforts have not been sufficiently coordinated, resulting in the non-efficient use of financial resources. Funds were mobilized and committed but were not used. This has led to the shift of the World Bank's funding management for the UNDP (*Fundo de Resultados Rápidos*), which was managed by the CNCS in the past.

The first civil society organisations (CSO) conference on HIV and AIDS held in 2008, organized by civil society organisations in collaboration with the CNCS is a good example of this collaboration.

Prevention

Efforts in the implementation of HIV prevention programs for the 2008-09 reporting period deserved a very high rating from most stakeholders.

This is justified by a set of initiatives and approaches led by the CNCS:

- Data Triangulation study, aimed at identifying the drivers of the epidemic and to understand how prevention efforts have responded to them;
- Modes of Transmission study, aimed at contributing to better understand the epidemic and response in Mozambique so as to plan, target and deliver programmes that focus on the populations that most need the services;
- The National AIDS Indicator Survey (*Inquérito nacional de prevalência, riscos comportamentais e informação sobre HIV/SIDA*, INSIDA) is underway, as well as a behavioural surveillance survey (BSS+) among risk populations;
- Formulation of the Prevention Acceleration Strategy (*Estratégia de Aceleração da Prevenção*) a coherent, evidence-based national HIV prevention strategy;
- Qualitative studies in the area of multiple and concurrent partnerships.

Other achievements in the area of prevention in the country are:

- Promotion of Community Counselling and Testing;
- Consolidation of PMTCT and Youth programmes;
- Integration of Family Planning into HIV services;
- Application for the Global Fund for AIDS, Tuberculosis and Malaria funding;

However, sustainability of prevention programmes is a matter of concern raising the need to invest more domestic financial resources on them.

Also, it is felt that prevention programmes addressed at most-at-risk and high mobility populations still need to be strengthened.

The lack of a comprehensive plan for rapid scale-up of male circumcision activities represents another major challenge.

Treatment, Care and Support

There is agreement in considering that the efforts in the implementation of HIV treatment, care and support programs were very good during the 2008-09 reporting period. In fact, ARV treatment delivery has been decentralised and integrated into the health network system. This was translated into an exponential coverage increase for adults and children in a relatively short period of time. Furthermore, ARV treatment quality control program keeps being expanded to an increasing number of health units.

During this period, the Ministry of Health has assumed the provision of a food voucher scheme to PLHIV in need (*cesta básica*) during the first six months after initiating ARV therapy.

Integration of HIV issues into the health training institutions' curricula is another important achievement with important impact in the long term.

However, these efforts still need to be reinforced, namely in terms of human resources, so as to increase coverage, which is currently around 30%. Improving the M&E system, clinical quality and adherence (psycho-social support), and Home-based care management, are only a few of the challenges to be confronted.

By the end of 2009, 357,905 of 1,328,208 (27%) OVC were reached with at least three basic services through a combination of initiatives by government (280,613) and Civil Society Organisations (77,292). 22 per cent of households with OVC receive external support.

A Multi-Sectoral Technical Working Group on OVC, with representation at provincial level and at around half the districts, involving civil society and development partners, regularly reviews progress on the OVC Action Plan's implementation.

Community involvement in activities addressed to OVC has been recently enhanced by the production of the Management Guide for the Community Committees for the Protection of the OVC. Also, a database on OVC was set up.

Increasing capacity in terms of staff numbers and qualifications as well as budget allocations so as to increase coverage is still the main challenge in this area.

Monitoring and Evaluation (M&E)

In 2009, the CNCS has developed an integrated and costed M&E plan (*Plano Nacional de Trabalho Integrado e Orçamentado de M&A para Moçambique, 2009 - 2010*) aimed at operationalising the M&E system.

Now, the CNCS, as the body in charge of the coordination and M&E of the national response to HIV, has at its disposal a practical reference to guide its actions, as well as those of government partners and all partners involved (funders, implementers and civil society and private sector institutions).

This plan was endorsed by key partners and will be used to mobilize partners and resources into a coordinated effort to harmonize and implement the national M&E system.

M&E activities are coordinated by an M&E Committee or Working Group (*Grupo Técnico de Trabalho de M&A*) that include representatives from civil society, including people living with HIV that participate in the decision-making on issues related to their respective area of work.

The CNCS's M&E Unit implements data sharing mechanisms such as data dissemination through the CNCS website, reports sent quarterly to Provincial Nucleus and from these to the partners, as well as meetings of the M&E Technical Group

However, the system is still weak and needs extensive strengthening. Data is still not consistently used for daily management in the decision making process by all stakeholders. There is still need of a better compliance with the Integrated Plan on the part of all stakeholders, namely on the continuous feeding of the CNCS's information system.

Also, funding for M&E activities is not fully secured yet. There is a need to mobilise resources so as to ensure the missing 25% of the M&E budget.

Human Rights

The adoption of the 2009 Law on Defending Human Rights and the Fight against the Stigmatisation and Discrimination of People living with HIV and AIDS (*Lei da Defesa dos Direitos Humanos e da Luta contra a Estigmatização e Discriminação de Pessoas vivendo com HIV e SIDA*) - (law nr. 12/2009) - represents an important step for reinforcing the policy context for HIV prevention in Mozambique.

This law reflects the commitment of the national government and civil society organizations to anti-discrimination measures, privacy rights, and access to free treatment provided by the state, obligations to provide HIV education including via school curricula, and protection of women's property rights.

The weakest aspect of the law is that it criminalizes HIV transmission. This can be viewed as potentially presenting obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations. Some other problematic provisions in this law are compulsory HIV testing ordered by police in cases of sexual crimes, HIV testing without informed written consent, and routine HIV counselling and testing in ante-natal care.

The law on Domestic violence against Women, 2009 (*Lei sobre a Violência Doméstica praticada contra a Mulher*) states that domestic violence constitutes a public crime. It aims at protecting the physical, moral, psychological, patrimonial and sexual integrity of women, against any form of violence practiced by sexual partners or relatives. Similarly, it criminalizes HIV transmission.

Also, the Penal Code criminalises "vices against nature" which could be interpreted as homosexuality and sex work. However, there are no known reports of the application of this provision.

Support Units (*Gabinetes de Atendimento*) to Women and Children victims of violence integrated into police stations are the main mechanisms to ensure these laws are implemented. Workplace HIV policies can also act as such within the workplace.

However, there is a general perception that most of the population is still not aware of these laws given their recent inception. It is felt that it is still very low the degree to which they are currently implemented. There is the challenge to take them to the communities.

Previous experience in Mozambique has shown that the enforcement of laws, such as the law on non-discrimination of PLHIV in the workplace, has been weak, due to the lack of a corresponding regulation (*Regulamento*). For this, it is recommended that a *Regulamento* be created for law nr. 12/2009.

Although there is not a formal mechanism to record, document and address cases of discrimination experienced by people living with HIV, there are several civil society organizations, including groups of PLHIV, that assume this role (*Liga dos Direitos Humanos, Muleide, Kuyakana, Rensida, Monaso*, etc.), as well as the above mentioned *Gabinetes de Atendimento*. In the sphere of the workplace the Work Inspection (*Inspecção do Trabalho*) develops a similar responsibility.

Civil Society

Government recognition of the need for stronger partnerships with civil society is markedly being translated into practice in the reporting period 2008-09. In fact, meaningful participation of civil society organizations has increased visibly in recent times.

In particular, the involvement of PLHIV in the design of policies, strategies and laws has markedly increased and has been particularly extensive in the formulation of the Strategy for the Acceleration of Prevention of HIV Infection and the PEN III as well as the Law of the Defence of the Rights and Fight against Discrimination and Stigmatisation of PLHIV (law nr. 12/2009).

A hallmark of the civil society participation was the successful national meeting held in 2008, prepared by civil society organisations involved on HIV, under the umbrella of MONASO with collaboration from the CNCS.

On the other hand, it is recognised that civil society is providing HIV programmes/services on a large scale and especially in the areas of home-based care, reduction of stigma and discrimination as well as programmes for OVCs.

CNCS maintains a permanent interaction with nongovernmental organizations and other civil society entities, including organizations of people living with HIV, as well as the private sector and faith-based organizations for implementing HIV and AIDS strategies/programmes.

However, civil society representatives consider that their involvement in the budgeting processes for the strategic planning documents has been reduced, and recommend its strengthening. Mechanisms and management of financial support need to be clear and well known by civil society organizations so as to enhance their ability to access funding for their activities.

Civil society involvement in the planning, monitoring and oversight of the HIV response needs to be continuously intensified.

It is recognized that involvement of most-at-risk populations has been poor and needs to be strengthened.

In spite of the above mentioned significant civil society involvement, there is still the need to support the scaling up of its interventions and increase its organizational capacities for areas such as programming quality, financial management and the monitoring and evaluation of interventions.

NCPI Trend analysis, 2003-2009

Figures below show the trend on the key NCPI data since 2003.

Figure 8 shows that, under the point of view of the CNCS and government representatives (Part A), in 2008 and 2009, issues related to Strategic Plan and Political Support, have been kept at the same good level as in the previous reporting period (2006 and 2007), while Prevention and Treatment, Care and Support issues have improved slightly to an almost maximum rating. Issues related to Monitoring and Evaluation were rated lower than in the previous period. The reason for this seems to reside simply on subjective points of view.

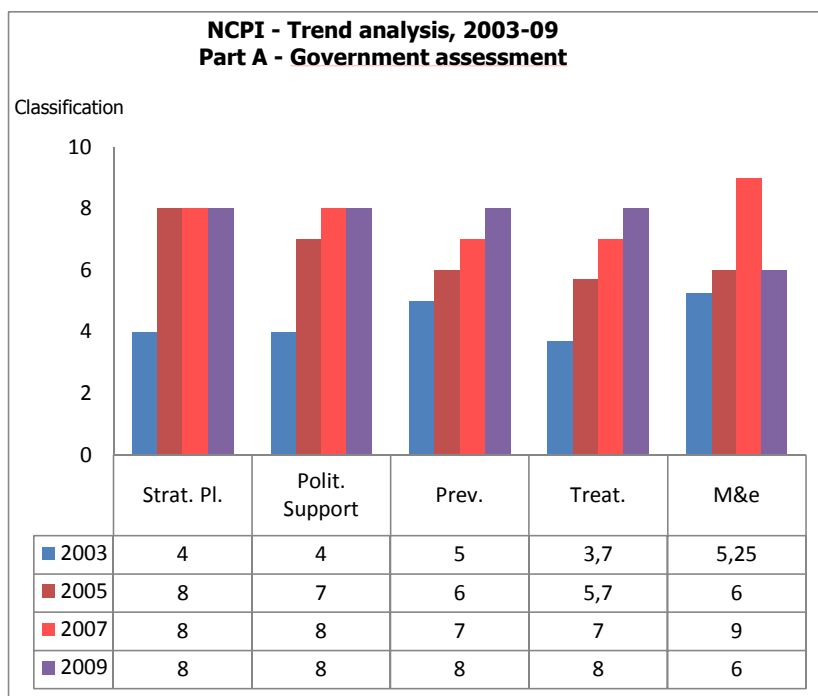


Figure 8: NCPI Trend analysis, 2003-2009, Part A (Government assessment)

Figure 9 shows that Human Rights and Civil Society Participation issues have deserved an improved rating in the period 2008-2009 from the part of non-government representatives (Part B) when compared with the previous reporting period, as well as the Prevention issues. Treatment, care and support, on the other hand, received a slightly lower rating.

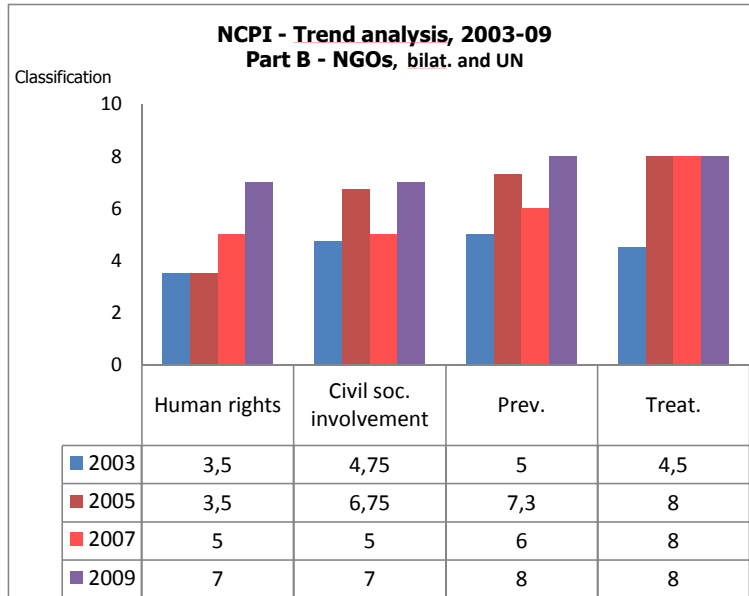


Figure 9: NCPI Trend analysis, 2003-2009, Part B (Non-government assessment)

Relevant discrepancies between the two Parts were not noted.

Private, Informal and Cooperative Sector's response to HIV

Introduction

In 2008 and 2009, the response within the workplace has increased significantly, with a higher number of enterprises of the various economic sectors, starting HIV prevention and AIDS mitigation programs, many of which in partnership with civil society organizations, PLHIV organizations and service providers. The number of enterprises affiliated to EcoSIDA (Association of Enterprisers against AIDS) has increased from 23 up to 62. Trade unions and the informal and cooperative sector have also been actively involved in the implementation of activities on the HIV area.

An initiative of national coordination of the response to HIV within the private, informal and cooperative sector was held in 2009, congregating different actors directly or indirectly linked to HIV prevention in the workplace, including the CNCS, United Nations agencies, institutions linked to the world of work and trade unions.

Private sector's response to HIV within the area of prevention represents 22% of the prevention activities catalogued all over the country. A special attention has been provided to workers in situations of higher vulnerability, such as migrant workers, especially those linked to the mining industry, public works constructions and seasonal workers. Within the mining industry, it is worth mentioning the existence of partnerships programs between national enterprises for mining workforce recruitment and mining enterprises in South Africa.

The response within the informal and cooperative sector, representing around 85% of the active population in the country, has also been intensified. The International Labour Organisation, in partnership with trade unions, has been leading the provision of services for these segments of economic activity.

Activities implemented

The various components of the response to HIV within the workplace are in line with the National Strategic plan, and include:

- Development of AIDS policies within enterprises;
- Prevention, including male and female condoms availability and IEC materials;
- Counselling and testing;
- Peer education;
- Treatment and Care for PLHIV;
- Coordination of the response.

In 2008-2009, the number of enterprises that have received support for the implementation of their activities within the HIV area has grown from 335 up to 557. In the same period, the number of AIDS policies within enterprises has grown from 38 up to 87.

Table 10 summarises the reach of some of the activities implemented in enterprises in the country.

Table 10: HIV related activities implemented in enterprises, Mozambique 2008-09

	2008		2009	
	Men	Women	Men	Women
Workers reached by IEC activities	24 552	4 156	19 623	4 463
Workers reached by testing	10 099	4 326	15 792	4 689
Trained peer educators	264	36	494	45

PART II: NATIONAL PROGRAMMES

Prevention Programmes

Blood Safety

Background

The Blood Transfusion National Program (BTNP) partially coordinates around 141 public blood banks all over the country. There is no private blood banks in the country. Every blood bank is integrated into hospitals and health centres; the majority run within clinic laboratories of the hospitals where they are integrated, with the exception of the blood banks at the central, general, and provincial hospitals.

The blood cycle activities, namely donor selection, blood collection, and blood testing are processed in all blood banks. Although blood transfusion services continue being based within hospitals, blood safety in general has registered evident improvements. In the next paragraphs, the progress made are described relatively to the four strategic objectives essential to guarantee access to safe blood for all Mozambicans.

Coordination and Management of Blood Transfusion National Service

To improve access to blood, WHO recommends the formulation of a policy and legislation that supports the creation of an institution which will in fact coordinate all blood transfusion activities in a country. Currently, blood services are partially coordinated by the BTNP. This body aims at recommending actions (technical and administrative) for the improvement of the National Blood Service. Nevertheless, this body is fragile because it does not actually have executive functions. In a general sense, the blood banks are firstly subordinated to hospitals in which they are integrated and also to the Medical Assistance National Directorate. Therefore, it is recommended the creation of blood services specifically and exclusively coordinated by the BTNP to accelerate the decision making process, improvement of resources coordination (financial and human), improvement of supervision and management, and maximization of existing resources.

Blood collection and blood donors

In Mozambique, blood donation can be made by individuals between 16 to 65 years of age. However, these individuals are subject to a screening so that lower risk donors are selected. Blood is collected in blood banks, and also in mobile brigades. From 2003 to 2009, the number of blood units changed from 66,932 to 91,818 per year, representing a growth of about 5.3% per year. In spite of the increased blood donations in recent years, this is still insufficient to meet the demand in the country.

In 2009, 91,818 units were collected, and according to WHO estimates, this number of blood units represents 43.1% of the country's needs (~ 200,000 units/year) (Figure 10).

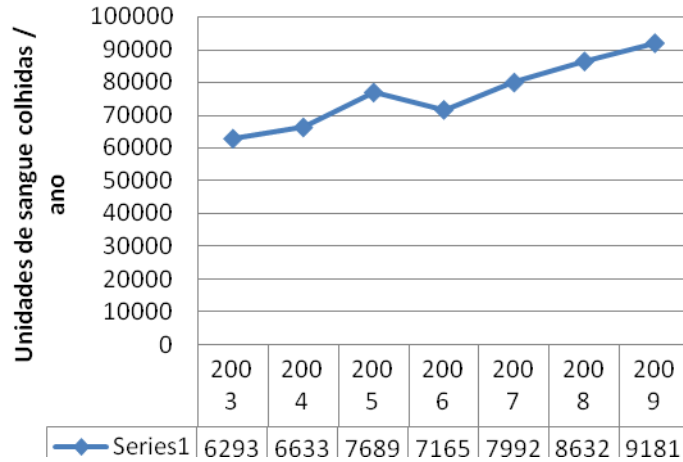


Figure 10: Number of blood units collected in blood banks, 2003 - 2009

The strengthening of low risk blood donors' mobilization and recruitment is still a priority for the BTNP, considering that blood safety begins with low risk blood donors' selection. From 2003 to 2009, the percentage of blood collected among volunteer donors has been increasing and has overtaken the corresponding percentage among relatives/restorers. 2009 data shows that about 64.2% of blood donations were made by unpaid volunteers while 35.8% were made by relatives/restorers.

Therefore, from 2003 to 2009, the number of voluntary donations increased from 35,548 to 58,964 units per year, representing a growth of about 66%. The BTNP is aware of the fact that although there is an increase in the number of unpaid volunteer donors, more efforts must be put in place to minimize the risk of transmission of infectious agents through blood transfusion.

Blood Testing and Prevalence of Transmissible Infectious through Transfusion in Blood Donors

The percentage of reactive blood units decreased from 8.3% (2003) to 5.6% (2009). This was lower than the estimated adults' national HIV prevalence.

The percentage of blood units reactive to syphilis and to hepatitis B decreased in the last years and it has been lower than the national HIV prevalence in blood donors: Exceptionally, last year the hepatitis B prevalence was higher than the HIV one.

Sucess Story

This year, the Blood Transfusion National Program started to test all the blood units for hepatitis C. Thus, the blood national service achieved the World Health Organization recommended goals for poor countries or with scarce resources. Therefore, this year all the blood units will be tested for HIV, syphilis, hepatitis B and hepatitis C, qualitatively increasing blood safety in the country.

Since 2009, all blood banks from central, provincial and general hospitals test for HIV with ELISA system. The use of ELISA Geenscreen system (ag-ab) reduces the HIV window period (from 22 days with rapid tests, to 16 days with Elisa). Approximately 70% of blood units are tested in central, provincial and general hospitals; for this, it can be considered that blood safety has significantly improved relatively to HIV.

Estimated Number of Blood Transfusion contaminated by HIV

The ELISA blood testing may have increase blood safety significantly in the country given that, further to increasing the window period, it has a sensitivity of nearly 100%. The majority of blood banks are still using rapid tests. However, these blood banks are responsible for the collection and transfusion of small quantities of blood.

Percentage of Blood Units Tested with Quality Assurance

Every blood bank and health unit performing activities of blood banks have a Standard Operation's Manual for HIV testing; however, an external quality control system is still inexistent. The Immunology Department has been performing quality control in national laboratories and blood banks. In 2009, this was performed in 34 of the existing 141 blood banks. In total, these 34 units collected 63,818 blood units, which represents 69.5% of all blood units donated in 2009 (91,818) (Table 11).

Indicator#3: Percentage of donated blood units screened for HIV in a quality assured manner

Table 11: Percentage of donated blood units screened for HIV in a quality assured manner, January to December 2009

Method of Measurement	Value
Numerator: Number of donated blood units screened for HIV in blood centres/blood screening laboratories that have both: (1) followed documented standard operating procedures and (2) participated in an external quality assurance scheme	63 818
Denominator: Total number of blood units donated	91 818
Indicator Value: Percent	69,5%

[Source: National Blood Transfusion Program – DNAM/MoH/Mozambique, 2009]

Currently, the Blood Transfusion National Program tests 100% of blood for the transmitted infections by transfusion. However, 29.5% of blood units are still not tested in adequate conditions in order to assure quality.

The percentage of tested blood with quality increased from 35.5% in 2007 to 69.5% in 2009.

Main Actions to assure access to safe blood

- Blood safety does not only depend on the blood units testing before they are transfused, given the inexistence of a diagnosis method which can reduce the HIV window period to zero. Therefore, safety begins with the recruitment of low risk donors. The BTNP is aware of the fact that it should strengthen blood donor's mobilization area so that 100% of blood donations are made by unpaid volunteer donors.
- § Despite the efforts made to increase blood donation, the country still collect less than half of blood quantities in need. Efforts must be reinforced so that 1-3% population donates blood on an annual basis. Mobilization and recruitment campaigns should be performed so that at least 200 000 people donate blood, every year.
- § The approval of a national blood transfusion policy which prioritizes, among other issues, the creation of a national semi-autonomous service is a pre-requisite for blood safety. The fact that blood banks are still integrated in the hospitals and under double subordination, has been making difficult actions envisaging the improvement of blood services in the country.
- § Establish a quality control system to assure that blood transfusion is made in conditions of quality control.
- § Improve the selection process and screening of blood donors to reduce the number of blood units reactive to HIV.

Prevention of Mother to Child Transmission

Background

Prevention of Mother-To-Child Transmission is one of the priorities of the Prevention Acceleration Strategy. This is an area which scaled up rapidly during the implementation of the HIV and AIDS National Strategic Plan 2005-2009 (PEN II).

In Mozambique, the estimated number of HIV positive pregnant women is around 150,000 per year, during the period 2008-2010, according to the 2007 epidemiologic surveillance round. Around half of all HIV positive women live in the central region of the country.

According to the results of the 2008 Multiple Indicator Cluster Survey (MICS), access to counselling and testing in antenatal services has increased when compared to the 2003 DHS. On the other hand, women's knowledge in relation to the possibility that HIV can be transmitted from the mother to the child has increased.

The level of knowledge on the transmission of Mother to Child among the Mozambican population has increased over the last five years. The 2003 DHS reported that only 44% of the women and 43% of the men aged 15-49 years knew that HIV can be transmitted from the mother to the child during pregnancy, delivery and breastfeeding. MICS 2008 data revealed that this knowledge has increased by 70% among women. This data has also shown that 70% of the women interviewed know that the virus can be transmitted by breastfeeding, when compared to 50% in 2003. Although the trend is positive, women that know all the three modes of transmission are still only slightly more than half (55%).

Nearly one in each two women (47%) were counselled and tested for HIV in antenatal clinics, a very significant increase when compared with 3% registered in 2003 (DHS, 2003). This increase can be attributed, among other factors, to the rapid scale up of the Prevention of Mother to Child Transmission (PMTCT) services, integrated into antenatal clinics, as well as the adoption, in 2007, of the Provider-Initiated counselling and testing approach into antenatal clinics. This policy includes routine HIV testing of all pregnant women, unless they ask not to be tested ("opt out").

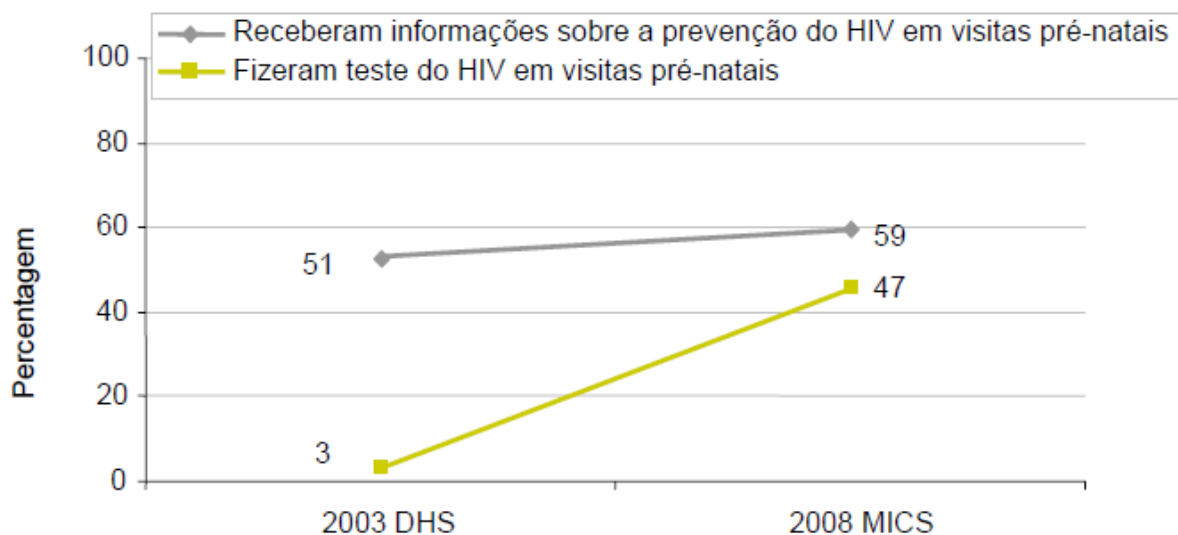


Figure 11: Percentage of pregnant women aged 15-49 years that were counselled and tested in antenatal clinics in 2003 and 2008, Mozambique

It is noteworthy that an increasingly higher proportion of counselled pregnant women also were tested (82%, in 2008).

Program scaling up and policies

At the inception of the PMTCT programme, in 2002, the majority of services were concentrated in health facilities of provincial capitals. Nowadays, PMTCT interventions are integrated into antenatal care services in all districts, including peripheral health facilities.

Following the update of global guidance to PMTCT in 2006, the Ministry of Health issued national guidelines introducing several key policies: Provider-initiated (“opt out”) testing to be offered in both antenatal care and maternity settings; blood samples for CD4 counts to be drawn in the antenatal care facility, thereby avoiding the need for women to visit a different service point for this procedure; DNA PCR testing for HIV exposed children under 18 months of age, using the collection method “*Dried Blood Spot*” (DBS).

In 2009, the PMTCT targets were reviewed for the period 2010-2014. The current guidelines, issued by the end of 2006, recommend administration of ARV combined prophylaxis with AZT (Zidovudina) at 28 weeks of pregnancy until delivery, plus a single dose Niverapine (NVP) during delivery plus AZT/3TC for seven days pos-partum.

In 2009, the threshold for eligibility to ART for pregnant women was increased from CD4 of $<250/\text{mm}^3$ to CD4 $<350/\text{mm}^3$, in line with WHO global guidelines. Pregnant women are referred to integrated services to start ART when eligible.

The MoH has adapted the guidelines on infant feeding in the context of HIV and PMTCT to the international guidance. Thus, national guidelines recommend that HIV positive mother breastfeed exclusively up to six months, followed by weaning, should the maternal milk's substitute be acceptable, viable, affordable, sustainable and safe. However, it is still a challenge that health technicians, counsellors and activists ensure that women are well counselled, so that they are able to make an informed decision, and be supported to implement the feeding option they have selected.

Every health facility providing PMTCT (antenatal services and maternities) ensure that HIV positive pregnant women and their babies get ARV prophylaxis and make a decision regarding the feeding option for their babies. Pos-test counselling also includes counselling on infant feeding options. In practice, many women in Mozambique opt for exclusive breastfeeding.

Exposed children are regularly followed up at the *Consulta da Criança de Risco* (CCR), where opportunistic infections prophylaxis with cotrimoxazole is offered, as well as regular checking of growth and psychomotor development, counselling on feeding and HIV early diagnosis in children with the viral test.

The establishment of “mother-to-mother support groups” by health facilities as a strategy towards promoting pregnant and lactating HIV positive women to adhere to Prevention of Mother-To-Child Transmission is a MoH worry. A study has documented in detail the various intervention models of groups of psychosocial support for PMTCT attendees, collected training and pedagogic materials existing in Mozambique and other African countries, and issued recommendations for filling gaps. In 2008, guidelines were developed following a nationwide mapping of this intervention.

The implementation of these new policies and the integration of services has enhanced the process of scaling up of PMTCT services as well as the change of treatment regimens – the move from monotherapy to more efficacious combined regimens – and will contribute for the reduction of the HIV transmission rate from mother to child.

Implementation results

The PMTCT program was started in 2002. Since then, the number of health facilities that provide PMTCT services was rapidly scaled up from eight in 2002 up to 386 in 2007, 744 in 2008, and 832 in 2009, representing coverage of 76.3% of the 1,090 health facilities with antenatal care services.

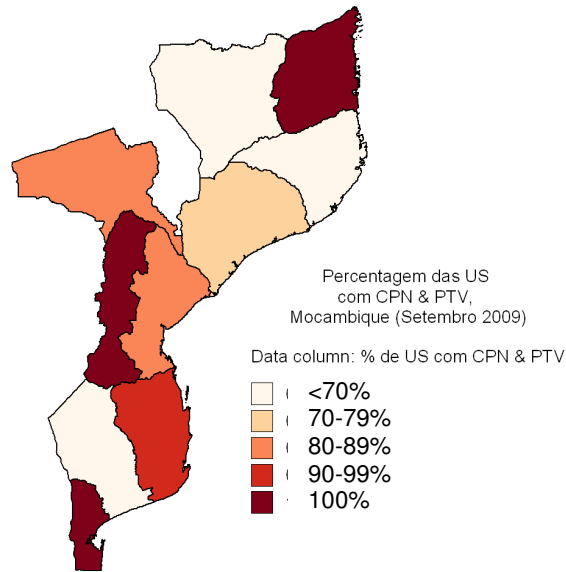


Figure 12: Coverage of health facilities with antenatal care services and PMTCT, Mozambique, 2009

In 2009, 888,861 pregnant women attended antenatal services for the first time (712,768 attended in 2008). On the other hand, the number of pregnant women that were counselled and tested also increased in the last three years: 371,736 (50.5% of women attending antenatal services for the first time) in 2007, 511,972 (71.8%) in 2008 and 649,820 (73.1%) in 2009.

Until December 2009, 68,248 pregnant women received ARV for PMTCT, corresponding to 45.8% of the total of HIV positive pregnant women estimated in the country. In 2008, 46,848 pregnant women received ARV (32.1% of the total) - Figure 13.

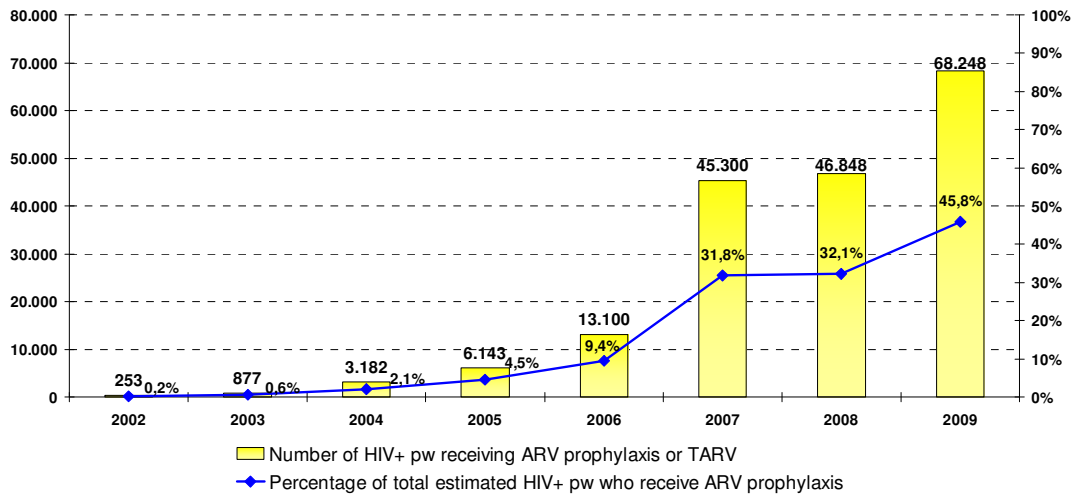


Figure 13: Number of pregnant women that received ARV prophylaxis and percentage of HIV positive pregnant women estimated in the country (2002-2009)

Access to ART for pregnant women is still difficult in Mozambique. However, a growing number of pregnant women have received ART in the last years: from around 950 (7% of all pregnant women that received ARV for PMTCT) in 2006, it has increased to 3,561 (8%) in 2007, 6,388 (14%) in 2008, and 7,791 (11%) in 2009.

Considering that 30% of HIV positive pregnant women were eligible for ART ($CD4 < 350/mm^3$), corresponding to a total of 44,700 HIV positive pregnant women, we learn that we are still far from the desired result.

PMTCT

PMTCT is an important entry point for care and ARV treatment for HIV positive women and their children. According to the 2008 MICS study, ANC coverage is high, around 92.4%, where women are counselled and tested, and finally get ARV for PMTCT.

However, there is still loss for follow up of HIV positive pregnant women within antenatal care services. Similarly, the low coverage of institutional deliveries – 58% according to the MICS 2008 – is limiting to the PMTCT interventions in the pos-partum period as well as in follow up for children born to HIV positive mothers in the CCR, until they get tested.

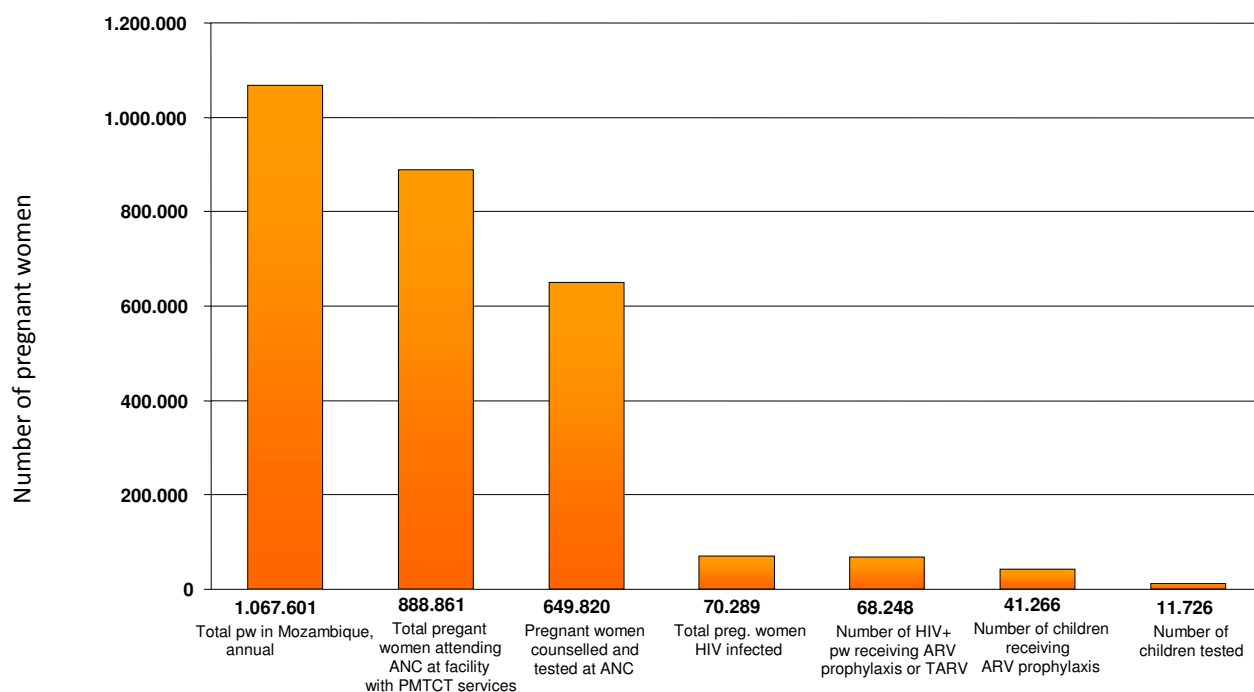


Figure 14: Antenatal and postnatal cascade for PMTCT, 2009

Finally, the number of children that received ARV prophylaxis is still limited – in 2008 and 2009, they were 38,822 (66.7% of the women that tested HIV positive in the same period) and 41,266 (58.7%), respectively. Access of exposed children to testing is still difficult as a result of the weak follow up. In

2009, of a total of 76,190 HIV positive women, only 11,726 children were tested with a rapid test when aged 18 months.

In 2009, a total of 25,466 children under 18 months old were tested with PCR. Of these, 2,882 had a HIV+ result, representing a prevalence of 11.3% among those that were tested. Using the Spectrum model to extrapolate the prevalence among the total population of children born to HIV positive mothers, 29% of the exposed children were infected by HIV in 2009, with variations of 25% in the southern region up to 32% in the northern region. This high percentage is due to the combination of long exposure to HIV during breastfeeding (22 months on average) and the low percentage of exposed children that are on exclusive breastfeeding during the first six months of life.

In 2009, more than 235 health facilities are collecting samples with the Dried Blood Spot technology that are sent to two laboratories in the country (Maputo and Nampula) to be tested with PCR. In 2010, the PCR scaling up plan foresees two more reference laboratories (Sofala and Zambézia provinces).

Partners' coordination

The MoH collaborates with several partners and funding organisations for the PMTCT program implementation. To ensure a good coordination among the partners, the MoH has set up a technical PMTCT Task Force. The group meets regularly under the leadership of the MoH and discusses programmatic issues and normative policies, as well as the progress in the implementation, challenges and lessons learnt. In the last two years, the group did the review of PMTCT integrated training materials for trainers at provincial level, and formulated the PMTCT component for the HIV Strategy for Acceleration of Prevention and provided inputs for the PEN III.

Child Health Card

The updated version of the Child Health Card was launched on the 1st of June 2009 – International Child Day. This update, led by the MoH with support from partners includes several new components on newborn health, nutrition and immunizations, as well as a component containing HIV related essential information. In 2008, approximately 32% of an estimated number of 145,000 HIV positive pregnant women have received prophylaxis with ARV and only 14% of the babies exposed to HIV were tested when aged 18 months. These results show the need to improving follow up of these children, so that they can be identified and referred for treatment and care, as early as possible.

The updated Child Health Card includes HIV related information, namely on the exposure state to HIV, ARV prophylaxis to the mother and the newborn, cotrimoxazole prophylaxis, HIV tests, and infected children on ART. A transversal study aimed at evaluating the acceptability of the inclusion of this information on the Child Health Card was implemented amongst health workers, mothers and key informants at community level. Health workers were of the opinion that the inclusion of this information was important and the vast majority of mothers, as well as community informants thought this inclusion was acceptable. More importantly, was that the people's feeling that this information would improve the follow up of children exposed to HIV. The updated Child Health Card is currently being used in every health facility in the country.

Challenges

The main challenges are related with:

- Insufficient access to ART on the part of eligible pregnant women at antenatal services;
- Low coverage of institutional deliveries, with insufficient use of maternities;
- Low coverage of PMTCT services;
- Low coverage of ARVs for children and weak follow up of exposed children in the CCR;
- Inconsistent adoption of safe child breastfeeding;
- Weak family inclusion, as well as from male partners and other people who make decisions within the family;
- Insufficient data quality control within the monitoring area, and deficient indicators standardization;
- Deficient implementation practice in operational research and program evaluation.

Priorities

- The strategic focus in this area is to ensure an adequate and comprehensive provision of quality PMTCT services to every women in reproductive age and their children, as well as the follow up at family and community levels, so as to strengthening adherence to the program.
- Integration of PMTCT/ART/AIDI into pre-service training curricula for MCH basic nurses, so as to increase quality access.
- Community involvement: strengthening the linkages of the National Health Service with families and communities, learning and dialoguing about social and cultural practices;
- Initiating ART in eligible HIV positive pregnant women;
- Strengthening PMTCT integration into SRH components, such as family planning and postpartum services;
- Strengthening counselling for safer infant feeding, especially in the postpartum period;
- Defining modalities of involvement for men, mothers-in-law, notable female elderly, traditional birth attendants, and traditional medicine practitioners, as well as improving coordination between the different sectors within the health facility, so as to increase access of women to PMTCT, and the follow up of the exposed children in the CCR. Food and nutritional support to women on PMTCT and their children needs special attention as it is a contributor to strengthening the adherence to the program;
- Strengthening early diagnosis for exposed children and increasing access to ART for HIV positive children.

UNGASS Indicator # 5: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission

Table 12: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission (2008/09)

Method of Measurement	Indicator Value	
	2008	2009
Numerator: Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission	46 848	68 248
Denominator: Estimated number of HIV-infected pregnant women in the last 12 months	145 760	148 996
Indicator Value: Percent	32,1%	45,8%

[Source: MISAU, 2009] *Antenatal care data only, so as to minimise double counting.

An important growth on the percentage of HIV-positive pregnant women who received ARV to reduce the risk of mother-to-child transmission is evident. In fact, this was 8.3% and 29.8% in 2006 and 2007, respectively, having grown up to 32.1% and 45.8%, in 2008 and 2009, respectively.

UNGASS Indicator # 25: Percentage of infants born to HIV-infected mothers who are infected

Table 13: Percentage of HIV-positive infants born to HIV-infected mothers, 2008/09

Method of Measurement	Indicator Value	
	2008	2009
Numerator: Estimated number of infants infected by HIV born to HIV-positive pregnant women	34 664	33 343
Denominator: Estimated number of pregnant women eligible for PMTCT in the last 12 months	110 871	113 281
Indicator Value*: Percent	31%	29%

The percentage of HIV-positive infants born to HIV-infected mothers has decreased slightly between 2008 and 2009, from 31% down to 29%, respectively.

HIV Counselling and Testing

Introduction

Counselling and Testing (CT) is a fundamental component for HIV and AIDS prevention given that this is an entry port for care, treatment and psychosocial support as well as for behaviour change. In December 2008, with the approval of the National Strategy to accelerate Prevention by the Ministers Council, CT was highlighted as number 1 priority among the prevention strategies to achieve universal access for testing.

According to the Ministry of Health (MoH), the number of people 15 years old or older, attended in at the various Counselling and Testing on Health (CTH) units of the National Health Service (Provider Initiated Counselling and Testing and User Initiated Counselling and Testing) increased from around 378,000 in 2006 to about 530,000 in 2009.

Table 14: People (15 years or older), attended in diverse CTH units de ATS of the National Health Service

Nº Total (15 anos ou mais) Aconselhado e Testado para HIV nas US				
	2006	2007	2008	2009
TOTAL	377.925	472.819	515.817	529.922
15 a 19 anos	71.343	81.529	83.380	92.973
20 a 24 anos	96.876	117.328	121.282	130.645
25 a 29 anos	73.664	96.510	117.610	126.468
30 a 49 anos	115.466	149.175	160.119	141.229
> 50 anos	20.576	28.277	33.426	38.607
% Feminino	63%	63%	60%	59%
% Masculino	37%	37%	40%	41%

Further to these routine CTH activities within the health facilities, these services are also offered in the community. The total number of units which offer CTH remains at 359, given that the MoH strategy for CTH recommends its integration into all National Health Service facilities, envisaging its popularisation.

In the centre region 59% of those units are found, while in the south and north regions they represent 28% and 13%, respectively. Given the limited access in the north region, the MoH is considering the possibility of supporting the opening of more sites that offer these services in this region.

Counselling and Testing Strategy

In 2009, the Ministry of Health approved and disseminated two important documents which reinforce the strategy of counselling and testing in the whole country: *The Counselling and Testing initiated by the Provider Guide in Clinical Context* and *Counselling and Testing on Health in the Community*. These documents clearly emphasize the guidelines for these services and strengthen the roles that should be performed by the central, provincial and district level partners on these actions.

The bigger MoH bet in this area is still the scaling up of CTH services within the National Health Service. This package of health promotion suggests the continuation and expansion of HIV counselling and testing for and strengthening the detection of diseases that are associated with HIV, and referral when necessary, such as Tuberculosis (TB) and Sexually Transmitted Infections (STIs). In addition, the package includes the detection of hypertension and counselling on health for the prevention of malaria, diabetes, environmental health education, orientation about sexual and reproductive health – especially in relation to early diagnosis for pregnancy and promotion of institutional deliveries.

Aiming at popularization of these services with quality, MoH defined priority activities:

- Training of all health staff and counsellors on the new approach on CTH;
- Training for all health professionals in rapid HIV tests;
- Use of *mass media* to disseminate publicity about CTH;
- Distribution of political-strategic guidelines on CTH and guidelines for CTH implementation in the community;
- Creation of educational material.

The scarcity of human resources is one of the major constraints for the achievement of planned results in the CT area in Mozambique. This, associated with the shortage of counsellors integrated into the National Health Service, is being a barrier against the improvement of CT service provision in Mozambique.

QUALITY OF TESTING FOR HIV DIAGNOSIS

In 2009, the Immunology Laboratory from the National Institute of Health translated “The Training Package for HIV Rapid Tests Material” and adapted it to the Mozambican context. This was originally formulated by CDC/WHO to train laboratories’ service providers. Considering that more than 70% of testing conducted in Mozambique occur out of laboratories, the material was strengthened to attend to testing issues in the testing units from CTH, in communities and clinical context.

Aiming at improving the quality of testing procedures in all sectors, the Immunology Laboratory from the National Institute of Health started the Trainers’ Nucleus for HIV Rapid Tests. This nucleus is comprised by professionals from the Provincial Health Directorates, Provincial Laboratories, Counselors from CTHU/Community, Nurses from the PMTCT Program and CT implementing partners. Composed by 72 Trainers from all over the country, the Trainers’ Nucleus for HIV Rapid Tests has the mission of training all the health service providers which perform testing, be it in the CTHU, in the clinical context or in the community.

Rapid tests for HIV diagnosis out of stock all over the country and in all contexts is still a great obstacle to be surpassed. The need of an efficient logistic system for the achievement of CT targets with safety is urgent in Mozambique.

Table 15: Table of CTH activities in Health Units, 2009 (adults and children)

Province	Users Attended		Users Tested		
	Nº Counsellled	% Regional Distribution	Nº Tested	HIV +	% HIV+
Niassa	40.411	6,7%	39.489	6.869	17,4%
Cabo Delgado	6.768	1,1%	6.713	2.489	37,1%
Nampula	33.565	5,6%	33.138	10.707	32,3%
Tete	54.306	9,0%	53.692	12.561	23,4%
Zambezia	73.738	12,2%	70.585	22.857	32,4%
Sofala	116.150	19,3%	114.179	29.640	26,0%
Manica	110.319	18,3%	109.248	21.706	19,9%
Inhambane	24.926	4,1%	24.281	5.042	20,8%
Gaza	36.144	6,0%	35.263	9.915	28,1%
Maputo Provincia	64.525	10,7%	61.257	16.741	27,3%
Maputo Cidade	41.319	6,9%	40.868	12.151	29,7%
Total	602.171	100%	588.713	150.678	25,6%

Donors and implementing partners continue to support the MoH for the expansion of counselling and testing initiated by the provider in the clinical context. It is expected that until the end of 2010, every Health Unit providing ART services have integrated into de Medicine outpatients units, triage and wards, the counselling and testing initiated by the provider activities, further to the testing services already in place and performing in outpatients' clinics, TB and PMTCT. It is expected the offer increase of CT among hospitalized people, as well as their relatives who accompany them.

Community CTH

Counselling and Testing in the Community is a strategy that aims at contributing to increase the access to Health Services in the communities through innovative modalities. MoH introduced this activity to promote preventive actions in the community, including related activities with HIV in such a way that will increase the effectiveness and acceptability of testing, and also will reduce the stigma that might be generated with isolated actions.

The preventive actions essentially consist of the provision of health basic educational actions in the areas of Malaria, TB, HIV, Reproductive Health, Hypertension, Skin Diseases, Nutrition; Personal and environmental Hygiene/sanitation, promotion of early diagnosis of pregnancy and institutional deliveries in a integrated manner. These actions are the responsibility of community staff trained by implementing partners with use of MoH approved material. It is important to highlight the performance of National Civil Society Organizations (CSOs) members in the expansion of activities of Community Counselling and Testing on Health (CCTH). Further to being strengthened to achieve institutional sustainability, the CSOs have been providing a greater capillarity in the CCTH actions in order to reach a far greater number of people. However, ensuring that patients referred to the health facilities near their communities do reach the services and receive the adequate treatment, remains a CCTH challenge.

Table 16: Community CTH: Table of activities implemented, 2009

Description	Male	Female	Total
Counselled	132,288	130,466	262,754
Tested			232,143
Positives			17,934
Negatives			213,369
Indeterminate			840

Referred

Hypertension	2,492
Tuberculosis	2,275
STI	3,405
HIV	10,141
MCH	5,783
Paediatric	440
CCR	207
Others	13,675

Tracked

Hypert.	81882
TB	101848
STI	97085

Challenges

- Human resources in a desired quantity and quality;
- Assure the quality of counselling and testing;
- Assure the efficient referral of patients;
- Strengthening the Health Information System;
- Need to disaggregate Community CTH data, by sex and age.

COUNSELING AND TESTING FOR HEARING DISABLED

In Mozambique there is little evidence on the reality of hearing disabled. It is known that this population has a greater vulnerability in face of HIV as a result of diverse factors such as limited access to prevention material; limited access to information on sexual and reproductive health, as well as care and health services qualified to attend these cases, treat and direct in situation of illness; besides stigma and discrimination in the family, community and institutions. Aiming at improving Access to the hearing disabled people, a partnership between the Ministry of Women and Social Action, Ministry of Health, Pathfinder International, JHPIEGO and PSI promoted the first course in CT for hearing disabled people. The pilot initiative integrates new counselors in the activities of CT in the community to promote access and follow up of these service users as well as for other health situations. Moreover, the pilot action in Maputo City and Maputo Province, foresees the training of health providers in the signal language. Thus, it is expected that the National Health Service provide a package of integrated care which benefits hearing disabled people.

Indicator#7: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results

Table 17: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results

Method of Measurement	Disaggregated Values					
	All 15-49	Sex		Age		
		Males	Females	15-19	20-24	25-49
Numerator: Number of respondents aged 15–49 who have been tested for HIV during the last 12 months and who know their results	1 193	373	820	177	301	716
Denominator: Number of all respondents aged 15–49	9 841	4 166	5 675	1 850	1 826	6 164
Indicator Value (Percent)	12,1%	8,9%	14,5%	9,5%	16,5%	11,6%

[Source: INSIDA, 2009]

Simultaneous disaggregation by sex and age is illustrated in the Table below:

Age	Sex	
	Male	Female
15-19	13,3%	5,6%
20-24	19,4%	11,6%
25-49	13,2%	9,4%

Important progress is noted relatively to this indicator which was situated in 2.5% in 2003, having increased to 12.1% in 2009.

Contrary to what was common in 2003, currently the predominance of females is significant: in fact, 14.5% of enquired women were tested in the last 12 months and know the results, and only 8.9% of men were tested. This is probably the result of the introduction of Counselling and Testing initiated by the Provider approach in antenatal care (ANC) units and maternities, as a result of expansion of PMTCT. This circumstance also justifies the predominance of age groups from 20 to 24 years of age (16.5%), the biggest users of ANC and maternities.

Indicator #8: Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results

Currently no data exists for this indicator.

Knowledge about HIV Prevention and Prevention Programmes (Young people)

Background

Adolescents and youth in the country continue to face enormous vulnerability to HIV and AIDS. Given that Mozambique's population is very young with adolescents and youth making up roughly a third of the country's population, any change in the behaviour and lifestyle of this age group would have a significant impact on the course of the epidemic. Accordingly, between 2008 and 2009, a number of prevention efforts in the country focussed on adolescent and youth prevention. An assessment on ongoing prevention activities in the country⁵, found that 11% of interventions were focussed on adolescents and youth, 9% of which were focussed on out-of school adolescents and young people. Infection rates continue high: it is estimated that approximately 95,000 young people aged 15-19 are currently HIV infected and HIV infection rates in the country are highest amongst the 20-24 age groups (at 18.3% in 2008)⁶.

The epidemic continues to have a largely female face and young women in particular carry a larger burden. The HIV prevalence rate amongst young women in the age group 15-24 is 2.6 per cent higher than amongst young men. Many factors influence increased risk and vulnerability amongst young people and particularly young women. These include socio-cultural aspects perpetuating unequal gender relations and gender based violence⁷, inter-generational sex involving young women and older men, multiple and concurrent partnerships, with low and inconsistent condom use.

Furthermore, recent qualitative studies on the practise of sex work in the country, have found that a large number of adolescent and young women are involved in sex work. A situational analysis⁸ conducted in late 2008 found that there are reports of children as young as 10 involved in sex work. The majority of sex workers interviewed in the study were aged between 20 and 35 and in the town of Massinga, the majority of sex workers interviewed were between 18 and 25 years old. This situation should be given significant consideration since the Modes of Transmission study (2009)¹ found that sex work contributes to 19% of new infections.

Knowledge about HIV transmission has increased significantly over the years: most young people in Mozambique have heard about HIV and AIDS (over 90 % of young women aged between 15 and 19, and over 92% aged between 20 and 24 had heard about HIV and AIDS, in 2008). The proportion of young women that know that the use of condoms can prevent HIV transmission appears to be on the increase; the 2008 MICS found that 66.7% of young women between 15 and 19 and 67.9 % of young women between 20 and 24 knew this. In comparison, in 2003 only 25% of young women in the age group 15-24 knew that the use of condoms can prevent HIV transmission.⁹ However, a serious gap exists between knowledge about HIV and taking action to prevent its transmission. While the use of condoms among young people has greatly improved, it remains unsatisfactory. In 2008, an average of 44.7% of young women aged 15-24 years reported that they had used a condom the last time they

⁵ CNCS, UNAIDS, GAMET. Analysis of HIV Prevention Response and Modes of HIV Transmission. 2009.

⁶ 2008 HIV Epidemiological Surveillance Round

⁷ Government of Mozambique. National Multi-sectoral Action Plan on Gender and HIV and AIDS; 2010-015. 2009

⁸ UNFPA. Vulnerability to HIV and AIDS; Sex Workers in Ressano Garcia and Namaacha Border Posts, and the Southern Transport Corridor in Inhambane Province. 2009. Sylvester, K, ANSA.

⁹ National Institute of Statistics. Multiple Indicator Cluster Survey. 2008

had sex with a non-marital, non-cohabitating partner¹⁰, compared to 24% in 2003 (DHS: 2003). Reports have shown that condom use is more frequent in non-regular relations and during the initial stages of a relationship (first few months of the relationship whether regular or non-regular), but after a few months couples feel that “trust” has been established, and condom use becomes less of a priority¹¹. There has also been a gradual increase in the proportion of young people who have been tested for HIV and who learned about their results.

Policy and Institutional Context

The Government of Mozambique approved the Strategy for the Acceleration of Prevention in 2008. The high level Prevention Reference Group created in 2007 and led by the Minister of Health, elaborated the strategy as a national response to the need to urgently control the explosive AIDS situation in the country. The strategy establishes mechanisms to progressively and sustainably reduce HIV incidence in the country and indicates priority actions for this purpose. The strategy recognises the increased vulnerability faced by Adolescents and Youth in the context of the epidemic. Adolescents and youth are therefore targeted for specific priority action under High Risk Groups.

The Government of Mozambique is committed to adolescent and youth issues. The National Youth Policy aims at empowering youth to have a voice in decisions that affect them, and promotes programmes that ensure their access to information and to sexual and reproductive health (SRH) services. One of the major components of the Ministry of Youth and Sports policy is the promotion of youth associations, aiming at increasing the involvement of youth and their leadership in prevention strategies for adolescents and youth¹².

The Ministries of Youth and Sports, Education (MINED) and the Ministry of Health (MoH), have been managing a multi-sectoral programme to address the prevention of HIV amongst in- and out-of-school adolescents and youth aged 10-24 years in the country, with linkages to Youth Friendly Health Services (YFHS). It is however felt that a lot more needs to be done to address the needs of out-of-school adolescents, who are the majority of adolescents in the country. Effectively targeting out-of-school adolescents and youth with HIV and AIDS prevention strategies has continued to be a challenge.

Since 1999, the MoH has managed a network of 244 YFHS, in 166 districts in the country, where young people aged 10-24 years have free access to information and a comprehensive package of SRH services including counselling and testing, access to condoms and SRH care and treatment. There was a remarkable increase in youth attending YFHS in 2008, with over 3,6 million adolescents and youth recorded in 2008, compared to 1, 3 million in 2007¹³. The YFHS however continue to be mostly attended by young people from urban areas.

The MINED has established HIV information and “counselling corners” in schools across the country where school going adolescents and youth can obtain information and counselling from peer educators on HIV prevention, access to condoms and referrals to YFHS, amongst other services. Some secondary

¹⁰ National Institute of Statistics. Multiple Indicator Cluster Survey. 2008

¹¹ Nweti. Parceiros Múltiplos e Concorrentes, Relatório de Pesquisa de Audiência. 2009

¹² Government of Mozambique. Strategy for Integral Youth Development. 2006

¹³ Programa Geração Biz. Standard Progress Report.2008

and technical schools have testing and referral services for treatment, if necessary. In 2008, the MINED approved an Incentive Package for school based peer educators. The Incentive package exempts young school based peer educators from paying secondary school fees, as a way by which to motivate young people to continue the work being done amongst their peers on HIV prevention.

Key Achievements

- National level consultation on prevention priorities and approval of a focussed and informed National Prevention Acceleration Strategy and Operational Plan, under which specific strategies are envisioned for young people;
- Active involvement of civil society organisations - including a youth association - in the elaboration of the third National AIDS Strategic Plan (PEN-III);
- Implementation of focussed campaigns addressing key drivers of the epidemic (Multiple and Concurrent Partners and condom use), targeting the adult population as well as young people;
- Best practices in prevention began to be documented;
- Adolescent and Youth associations are represented in different working groups of the Provincial AIDS Council Nuclei (NPCS), ensuring the inclusion of youth issues in prevention and mitigation strategies.

Key Challenges

- Civil society organizations need to be better coordinated, more critical and intervene more in the response;
- Few prevention programmes focussed on the particular needs of specific adolescent and youth groups, such as those involved in sex work and disabled;
- Distribution of prevention commodities, including condoms and prevention information remains a challenge, especially in reaching the most remote locations.

Key Actions needed to Scale up Universal Access to HIV Prevention

- Strengthen responses to the feminization of HIV and AIDS and efforts to reduce gender based violence amongst adolescent and youth, and improve the engagement of men.
- Continue efforts to strengthen capacity of key stakeholders to translate evidence into improved national prevention strategies, plans and budgets.
- Continue efforts to strengthen distribution networks for prevention commodities.
- Improve the involvement of young people in prevention programmes.

UNGASS Indicator#13: Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Table 18: Percentage of people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and are able to reject major misconceptions about HIV prevention, by sex and age group.

Method of Measurement	All 15-24	Disaggregated Values			
		Sex		Age	
		Males	Females	15-19	20-24
Numerator: Number of respondents aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	1 281	534	746	626	656
Denominator: Number of all respondents aged 15–24	3 677	1 586	2 091	1850	1826
Indicator Value (Percent)	34,8%	33,7%	35,7%	33,8%	35,9%

[Source: INSIDA, 2009]

This indicator has had an evident growth when compare to 2003 (22.3%), as expected. The great disproportion that was registered at that time, in terms of gender (20% of women and 33% of men), seems now to tend to a better balance (35.7% of women and 33.7% of men).

Knowledge about HIV Prevention and Prevention Programmes among Most at risk populations (MARPS)

The behaviors that expose people to major risk of infection by HIV include: high rates of unprotected sex with multiple partners, unprotected anal sex, and injection of drugs with shared equipment¹⁴. Thus, populations at higher risk of infection by HIV include sex workers and their customers and partners, injecting and non-injecting drug users, and their partners, partners of people living with HIV (PLHIV) and men who have sex with men (MSM).

Policy and Institutional Response

Within the National Reference Group for Prevention, a working subgroup was established to address, in a structured manner, the response to HIV within most-at-risk populations. The group comprises members of government institutions and international and local partners involved in the designing of policies, strategies and/or in implementation of interventions targeted to different groups of most-at-risk populations.

In 2009, the Ministry of Justice, in coordination with the United Nations Office on Drugs and Crime (UNODC) and implementing partners, organized a National Workshop under the theme “Prison Health is Good Public Health” with the purpose of contributing for greater understanding and dialogue among government and non-government institutions, with view to improving the effectiveness and coordination among prison services and other public health services in the promotion of health, prevention and control of diseases in prison settings¹⁵.

Most-at-risk populations covered by HIV prevention programs

To date, there have been few prevention programs targeted to most-at-risk populations. Prevention activities are primarily focused on sex workers, while neglecting addressing the major part of the most-at-risk populations with appropriate prevention strategies. The effectiveness of the small number of prevention activities related to most-at-risk populations is not yet visible, since many programs addressing these populations are run by small NGOs and CBOs, which, apart from their limited geographic scope, have little capacity to monitor the uptake and coverage of services and to assess the effectiveness of the prevention interventions. Therefore, there is an urgent need for scaling up and expanding the implementation of specific prevention activities related to most-at-risk populations.

Actions targeted to sex workers have been essentially: a) education in HIV prevention issues, with special focus on capacity building for negotiating the use of condom, behavior change, income generation alternatives; and b) delivery of STI and HIV counseling, testing and care services and reproductive health and family planning services, through provision of night health services and/or

¹⁴ UNAIDS, 2007. Practical Guidelines for Accelerated Prevention of HIV. Towards the Universal Access

¹⁵ Ministry of Justice, 2009. Workshops on Prison Health: Good Prison Health is Good Public Health. Final Report, April 2009

referral to these services. Sex workers demonstrate knowledge of HIV prevention measures, but some of them use condoms in an inconsistent manner, particularly when the client is “regular” (trust) or when he is willing to pay more to have sex without condom¹⁶.

A group of people with higher risk of HIV infection that has been excluded from the interventions of control of this infection is that of sex workers’ customers. For better understanding the risk behaviors in this population group, during the I-RARE study 47 customers of sex workers were interviewed, who attended identified “hot spots” of occurrence of sex work. The majority of the interviewees demonstrated awareness of STI and HIV and their prevention. They also stated that they had easy access to condoms which could be purchased in the pharmacies, kiosks or even in the rented rooms where sex is practiced, made available by the guards or non-government organizations/projects. While, in general, there is a good perception of the risk of HIV and STI among sex workers’ customers, and many claim consistent use of condoms with sex workers, some customers refer to issues such the “the looks” of the sex worker or “being his girl” (trust), as the motives for not using condoms. Others prefer to pay more money to have sex without condom because they prefer it that way. The alcohol considered as a tranquilizer for the contact with sex workers and stimulant for sexual activity, was also pointed as an important factor in inconsistent use of condom because under its effect, they easily forget to use it.

Interventions targeted to drug users are very limited, as this population group has been marginalized and regarded as of low importance, especially due to the tendency to underestimate the actual use of drugs in the country, as well as its weigh in the maintenance of HIV epidemic. In this area the few interventions have been in the sense of sensitizing youth and adolescents to stay away from drugs. On the other side, for youth already evolved in drug consumption, there are organizations such as *Rede Nacional de Luta Contra a Droga (National Network for Fight Against Drugs)*, with representation in all provincial capitals in the country, which dedicate to promoting prevention of HIV and other STI within this group. In spite of its nationwide expansion, this Network requires a strong capacity building support in order to gain skills for implementation of sustainable projects in locations identified as being of high consumption of drugs. In 2009, the National Network, with support of funds and technical assistance provided by *Academia de Educação e Desenvolvimento (AED)* (Academy for Education and Development), conducted a baseline survey on drugs and HIV¹⁷.

Prisoners constitute one of the Government priority groups for actions of prevention and control of HIV. One of the most striking features of the Mozambican prison population, which is currently around 15 thousand prisoners, is that the system comprises a majority of youth. This fact is particularly notable in the age group of 16 to 19 year, representing in Maputo facilities 42.5% of the population in 2002¹⁸. In a study conducted in 2002 in two prison facilities of Maputo and where HIV counseling and testing was provided, was found that 32,1% (35/109) were HIV+, being 37,2% (16/43) women and 28,7% (19/66) men¹⁹.

¹⁶ I-RARE (2009) Risk of Infection by HIV among Sex Workers: Findings from a Qualitative Study in Three Port Cities of Mozambique. *Em: Livro de Resumos, XIII Jornadas de Saúde, Setembro de 2009, Maputo, Moçambique*

¹⁷ UNIDOS (2009) Let’s Change our Behavior. Research Report

¹⁸ PNUD (2002). “Os Condenados de Maputo”

¹⁹ Ministry of Science and Technology: “Annotated Bibliography” – Studies, Researches and Documents Related to HIV/AIDS in Mozambique 1986-2007. July 2007; 34:41-42

The only data of national representativeness relating the prison facilities are derived from the study “HIV and AIDS in the Sector of Justice – A Research on the Level of Awareness of HIV and AIDS-related Issues”, conducted by the Ministry of Justice in 2008. This study, with a sample of 715 prisoners and prison staff of the three regions of the country, found the following information:

- Significant knowledge of the forms of transmission and prevention of STI and HIV, failure to adopt safe behavior, since more than half of the respondents stating not have used condom in all sexual intercourses in the last 12 months;
- Great proportion of prisoners with STI history but few sought health care;
- Existence of practices of sexual activity in the facilities, some between convicts and guards;
- Use of drugs among fellow convicts, convicts and police officers and, between convicts and visitors and, use of drugs including injectable drugs, sometimes sharing syringes and needles²⁰.

STI and HIV prevention and control interventions are very limited in most prison facilities of Mozambique and are conducted in close coordination with the Ministry of Health. In this sense, as it is common to the rest of the National Health System, there is lack of qualified staff and appropriate physical structures for delivery of quality health services to the prison population.

Peer education, distribution of educational material, counseling and testing for STI and HIV, are some of the activities ongoing in some prison facilities of the country, covering about 30% of the prison population²¹. In 2009, was conducted a training needs analysis at facility level and is anticipated for 2010 a study on HIV and TB prevention in prisons.

Mobile populations groups such as miners and Defense and Security Forces are among those of highest risk of STI and HIV due to behaviors they adopt, e.g. unprotected occasional sex, as well as excessive consumption of alcohol which sets an enabling environment for adoption of risk behaviors. Interventions targeted to these groups include peer education, distribution of educational/information material and condoms, counseling and testing for HIV by mobile units and conducting researches for better understanding the HIV problem among these most-at-risk groups.

²⁰ Ministry of Justice (2007) Project in support of citizens' access to justice. Final Report. September 2007

²¹ Ministry of Justice/UNFPA/Pathfinder, *Projecto Inclusão*

Study on vulnerability and risk of infection by HIV among men who have sex with other men, in Maputo city – Lambda, PSI/Mozambique, Pathfinder, UNFPA

The shortage of information on the composition of the social group of men who have sex with other men (MSM), their sexual practices, their perception of risk of infection and their conditions of access to health services underlie the conduction of this research with view to contributing to the designing of prevention strategies and actions aiming specifically to reduce the vulnerability of MSM in the face of HIV. The study was conducted in Maputo city, and qualitative methodologies were used for data collection and analysis.

From the analysis of data produced in interviews with 45 MSM are highlighted the findings summarized as follows:

- Heterogeneous profile of the group, in terms of age, level of education, occupation, religion, place of residence, sociability, nature of affective and sexual relations practiced and role performed in these relations;
- Shortage of information on prevention and fight against HIV specifically formulated for MSM;
- Difficult access to public health services; discrimination and hostility from the side of health providers.
- General knowledge of the risk and measures of STI and HIV prevention; therefore, there was found a major inconsistency in the practice of this measures, and the following were pointed out to be the reasons: the alleged trust in the partner, the belief that oral sex and anal sex practices are safe and the belief that it is possible to see the signs of infection by HIV with naked eye and, consequently, decide to use or not the condom;
- General unawareness of the importance of water-based lubricant;
- Some sexual practices that increase the vulnerability of MSM to infection by STI and HIV: transactional sex; sex in group; and sex under the effect of alcohol and other drugs.
- Some MSM also have sex with women, which broadens the sexual intercourse network and, ultimately, the possible circulation of HIV for the general population.

The general conclusion of the study is that MSM in Maputo city live in a context of multiple vulnerabilities that expose them to the risk of infection by HIV. The inefficiency of the current prevention and care programs to meet the specific needs of MSM and the social discrimination to which they are subject, cause them to remain hidden and therefore, deprived from demanding their right to information and health services that include their specificities.

Main Challenges

- Limited resources for interventions targeted to most-at-risk populations;
- The majority of the studies show a high level of knowledge of male condom, but its use is still inconsistent within most-at-risk populations, especially among partners of people involved in high risk behaviors;
- Need for addressing varied and concomitant behaviors of sexual and drug risks, including unprotected anal and vaginal sex, and sex with multiple partners. For instance, sex workers use alcohol and drugs (especially cannabis) to face their jobs and some drug users sell sex in order to get drugs;
- Inadequate provision of water-based lubricant gel for MSM and sex workers; need for increasing knowledge of the gel and correct forms of use;

- Increase provision of health services, especially for diagnosis and treatment of STI. It is necessary to develop health services that are responsive to health specifications of the most-at-risk populations (e.g. attention to anal STI), and that offer care to these groups, free of discrimination and prejudice;
- Human Rights – violence and discrimination are effective barriers among most-at-risk populations, to access prevention and health care services. In this context, it's necessary to promote linkages between prevention programs targeted to these groups and the initiatives of defense and guarantee of human rights, so that the processes of collaboration will increase their effectiveness;
- Complexity in the implementation of ongoing and consistent interventions, both of prevention and care, targeted to mobile population groups like miners and truckers, among others.

UNODC implements in Mozambique a HIV project in prisons, which aims to build capacity of the government and other stakeholders to plan, implement and monitor projects/programs about HIV prevention, Treatment, Care and Support in prisons, in order to: i) reduce the transmission of HIV in prisons and; ii) Reduce HIV/AIDS-related mortality in prisons.

UNFPA, in partnership with Pathfinder and Ministry of Justice, develops *Projecto Inclusão*, which aims to scale up HIV and STI prevention practices among prisoners and prison system employees, through peer education methodology, as well as increasing the technical capacity of the government to design, implement and monitor HIV prevention projects in prison settings.

To date, 100 peer educators have been trained in four prison facilities in the country, which offer health education services, promotion of rights, and referrals for health care for about 30% of the prison population in the country. Through collective activities such as talks, presentations of role plays and games and sports, accurate information about prevention of HIV, STI, TB and malaria are disseminated with support from the provision of educational material. Are also being developed health libraries in the prisons that participate of the project. The group of peer educators acts in close partnership with the health services available in prisons to increase the demand for counseling and testing in health, as well as diagnosis and treatment of STI and other diseases.

Main Actions required for rolling out Universal Access to HIV Preventions to most-at-risk populations

- Greater inclusion of most-at-risk populations in health policy and programs: the issue of TB among prisoners and the issue of family planning for sex workers in the reproductive health policy are some of the aspects to be considered;
- Greater access to HIV control services: should be scaled up, through sensitization of staff about the needs of these particular populations and promoting and expanding the use of the services among most-at-risk populations, like for instance, night clinics already implemented in Maputo city, Nacala-Porto and Nampula, as well as in Inchope.
- Produce methodologies of adherence to treatment, health care which include the specifications of most-at-risk populations.
- Increase access to condoms and to other means of prevention. There are places where condoms are not accessible, such as prison settings, where their provision is prohibited. For many MSM and drug users, condoms are not easily accessible, either due to unavailability of specific prevention services for these groups, or by virtue of logistic problems experienced for provision of condoms

throughout the country. It is not also possible to provide syringes and injection equipment to drug users, which constitutes another barrier to prevention practices.

Indicator #8

Percentage of most-at-risk populations that have taken a HIV test in the last 12 months and who know the results

Currently there is no data for this indicator.

Indicator # 9: Percentage of most-at-risk populations reached by HIV prevention programs

Currently there is no data for this indicator.

Indicator #14

Percentage of most-at-risk populations who can correctly identify the forms of prevention and sexual transmission of HIV and reject the major misconceptions about HIV transmission

Currently there is no data for this indicator.

Indicator #18: Percentage of sex workers of both sexes who reported to have used condom with their most recent customer

Currently there is no data for this indicator.

Indicator #19: Percentage of men who reported to have use condom in the last time they had anal sex with a male partner

Indicator #21: Percentage of injecting-drug users who reported to have used condom the last time they had sex

Currently there is no data for this indicator.

Indicator #23: Percentage of most-at-risk populations that are HIV infected

Presentemente, não estão disponíveis dados para este indicador.

Life Skills-based HIV Education in Schools

Policy and Institutional Response

The Strategic Plan for Education and Culture for the years 2006-2010/11 reflects the government commitment to working towards meeting the Millennium Development Goals (MDGs) and focuses on supporting key objectives of government's overall development strategy for the country including combating HIV and mitigating the impact of AIDS.

The strategy recognizes the threat posed by HIV to achieving universal primary education in the country as well as the key role that the education system can play in the fight against HIV in the country. The education system employs a large number of the country's workforce and has the potential to cover a large number of children and youth in the school system.

The education system is also well placed to cover the "window of hope"- children aged 10-14 years - whose attitudes and behaviours are still being formed, and who are mostly not yet sexually active. Adolescent girls and young women can also be positively affected by the education system in the context of their extreme vulnerability to the epidemic.

The sector's strategic plan points out that the education system in the country should provide life skills to all children and should enable them to participate in a responsible manner in society. This includes equipping school going children and young people with the necessary life skills to enable them to protect themselves from the threat posed by HIV, during their formative years and as future adults.

The Ministry of Education developed education curricula covering sexual and reproductive health and HIV and promoted extra-curricular life-skills based education activities supported by peer education. The Ministry is also implementing a policy to improve institutional capacity to manage and plan effective strategies in relation to life skills based education. The Ministry further developed a communication strategy for HIV and AIDS, covering Life Skills Based Education. In this context comprehensive programmes were developed to provide Life Skills based education in basic, secondary and technical education, such as:

The *Geração Biz* is a multi-sectoral programme implemented in all provinces of the country by the Ministry of Education, Ministry of Youth and Sports and Ministry of Health. Peer educators are supported under this programme to provide education on sexual and reproductive health to their peers in higher, primary, secondary and technical schools. 661 schools covered by the programme have 107 counselling corners where pupils are provided with access to information, debates are held, condoms are available and pupils are referred to YFHS. In 2009 up to 26,000 pupils visited a counselling corner and over 300,000 were reached by peer educators in schools.

The Basic Package Programme (*Pacote Básico*) is implemented in 7,560 primary schools at national level. The programme facilitates the development of activities to provide children with necessary life skills. More than 3 million pupils were covered by the programme in 2009. Through this programme, pupils have access to books and other education materials (school kits) on HIV and AIDS.

The Radio Programme “*Mundo Sem Segredos*” disseminates information on HIV prevention in all provinces, whereby debates are held between pupils and doubts on prevention are clarified.

Key Achievements

- Life skills based education was implemented in 13,000 primary and secondary schools in 2009, covering children and youth aged 10-18 years
- Over four million pupils in secondary schools were reached with life-skills based education and three million in primary schools.
- 90,000 teachers were trained in HIV prevention in 2008.
- Partnerships were built with actors at national, regional and international level for learning and knowledge sharing on HIV prevention in the education system. Approval and implementation of incentive package for school based life skills peer educators
- School directors were trained in life skills based education, improving their management, coordination and support of school initiatives.

Key Challenges

- Unavailability of reliable, nationally representative data on HIV activities in the school system.
- Weak monitoring and data collection systems with regard to life skills based education in schools.
- Insufficient state budget allocation for life skills based education.
- Deficient coordination between different actors involved in life skills based education.

Key Actions needed to scale up Universal Access to life skills based education in schools

- Include HIV and AIDS in the curriculum at teachers’ training institutes.
- Integration and coordination of different sectors and actors involved in life skills programming.
- Sustaining an enabling environment to implement life skills based education (policy, institutional capacity).
- Data collection systems need to be strengthened.

UNGASS Indicator #11. Percentage of schools that provided life skills based education within the last academic year

Currently no data exists for this indicator

Sexual Behaviour

Sexual transmission of HIV is responsible for most new infections amongst the adult population in Mozambique, as well as amongst adolescents and youth. Several reports (DHS 2003) INJAD (2001) Nweti (2009) have shown that sexual activity begins at a very early age in Mozambique. By the age of fourteen approximately a third of Mozambican adolescents are sexually active. However, initiation of sexual activity differs by region and also between urban and rural areas. Adolescents in urban areas initiate sexual activity (16.6 years) slightly later than adolescents in rural areas (15.8 years)²². Women and men in the northern region of the country initiate sexual activity earlier than those in other regions of the country. However, the northern region has the lowest prevalence rates in the country. This implies that the age of sexual debut may not be a significant risk factor for the contraction of HIV²³.

Inter-generational sex continues to be common in the country: the 2008 MICS found that 13.5 % of young women aged 15-19 years and 17% aged 20-24 years reported having had sexual relations with men 10 years or older, up to 12 months before the study. There is indication that condom use may be on the rise, particularly amongst adolescents and youth: the MICS 2008 found that 42.9% and 46.5% of adolescents and youth aged 15-19 and 20-24 respectively, reported the use of a condom in their last sexual relation with a non married or non cohabiting partner, compared to data from the 2003 DHS when 26% of females aged 15-24 reported the use of a condom in their last sexual relation with a non-regular partner. However, condom use amongst the adult population in the country is far from satisfactory and remains inconsistent.

Gender based violence and forced sex remains frequent. In the 2001 INJAD²⁴ a significant number of adolescent girls reported that their first sexual occurrence had been forced. Programme monitoring reports from the multi-sectoral programme on adolescent sexual and reproductive health consistently report accounts of forced sex amongst adolescent girls. A significant challenge therefore remains in obtaining positive sexual behaviour amongst adolescents and youth in the country.

²² CNCS, UNAIDS, GAMET. Analysis of HIV Prevention Response and Modes of HIV Transmission. 2009

²³ CNCS, UNAIDS, GAMET. Analysis of HIV Prevention Response and Modes of HIV Transmission. 2009

²⁴ National Institute of Statistics. Survey of Adolescent and Youth Reproductive Health in Mozambique. 2001

Indicator # 15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15
Table 19: Percentage of young women and men aged 15-24 who had sexual intercourse before the age of 15

Method of Measurement	All 15-24	Disaggregated Values			
		Sex		Age	
		Males	Females	15-19	20-24
Numerator: Number of respondents aged 15–24 who report the age at which they first had sexual intercourse as under 15 years	924	395	529	466	458
Denominator: Number of all respondents aged 15–24	3676	1586	2090	1850	1826
Indicator Value (Percent)	25,1%	24,9%	25,3%	25,2%	25,1%

[Source: INSIDA, 2009]

A slight decrease on the percentage of youth who had sexual intercourse before age of 15, from 27.6% in 2006, up to 25.1% at present was registered. Concerning the distribution by sex, females keep predominating, although not so much as in 2003 (women, 28%, vs. men, 26%).

Indicator #16: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
Table 20: Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months

Method of Measurement	All 15-49	Disaggregated Values				
		Sex		Age		
		Males	Females	15-19	20-24	25-49
Numerator: Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	983	816	167	131	212	641
Denominator: Number of all respondents aged 15–49	9 841	4 166	5 675	1 850	1 826	6 164
Indicator Value (Percent)	10,0%	19,6%	2,9%	7,1%	11,6%	10,4%

[Source: INSIDA, 2009]

A slight decrease was registered in this indicator, (11.1% in 2003). The disproportion between sexes that was evident at that time (30.2% among men and 4.9% among women), is now even more accentuated. The

great predominance of the age group 15-19 years that was registered in 2003 (60%) is not confirmed at present. There is a relative parity among all age groups.

Condom Use

Introduction

A Multi-Sectorial Condom Working Group constituted by the CNCS, several Ministries and UNFPA, PSI – Mozambique, CDC, USAID, Deliver Project, John Hopkins University and MONASO is running regularly. This group aims at reaching consensus on the implementation of initiatives that can anticipate success mainly in the areas of forecasting, acquisition, storage, distribution, promotion and condom use as one of the interventions to successfully prevent and reduce the frequency of STIs/HIV and AIDS, as well as unwanted pregnancies.

Community mobilization and demand generation

Two main channels of male condom distribution are used: public Health sector network (where condoms are free of charge) and the commercial sector (distributed by PSI using a subsidised price system). There are currently several actors supporting the MoH and NAC on the promotion of the male condom use. An opposite situation is found in relation to female condoms, with only a few institutions/organizations actively promoting female condoms.

Main institutions/organizations working on condom promotion are: UNFPA, CARE, LEPR, MSF, HOPE, FDC, Pathfinder, ISCOS, LWF, World Vision, FHI and Medicos del Mundo. They all distribute male condoms but only three distribute female condoms (UNFPA, Pathfinder and PSI).

Capacity strengthening

This area faces great challenges in terms of logistics and distribution. Human resources training and logistics and distribution capacity building will have a positive impact on the condom management and distribution at central, provincial and district levels, thus improving programs' management and service provision.

It is important to allocate staff to dedicate full-time to the condoms program, at the level of institutions such as NAC, Ministry of Women and Social Action, Ministry of Internal Affairs, Ministry of Defence, CDC, USAID and MONASO.

Resource Mobilization

Government needs to mobilize more financial resources for procuring and purchasing condoms. This is now ensured USAID and UNFPA, in a situation when in 2008 USAID informed that their funds had been reduced by more than 50%. For this specific situation, the MoH requested UNFPA to cover the resource gap in order to ensure the total quantities requested.

Condom supply

Table 21: Condom supply

Condom supply	
Foresight for 2009	
Male Condom	Female Condoms
Public Sector 70.1 million	1.3 million
Commercial Subsidiary Sector 25 million	

Male and Female Condom Distribution

For distribution, the “pulling” system is used: the distribution is according to the requests made by the provinces and other actors at this level. However, there is an urgent need to train program management and logistics staff on forecasting their needs and consequently the quantities to be requested, and how and when to request.

Distribution problems at all levels of the system have been reported and seen on site during supervision visits. In some sites, it is noted that, due to lack of knowledge of personnel on how to calculate the needs and make requests, instead of the “pulling” system the distribution is done through the “pushing” system.

Due to lack of capacity related to the supply chain management on the supply side, and inadequately understood requisition procedures on the demand side, the quantity of condoms that is actually made available to end-users is limited.

MISAU and CNCS, with strong support from UNFPA, UNICEF, USAID and others, are currently working to improve the public sector’s capacity for condom and contraceptive distribution. Based on market research and consumer surveys however, it is estimated that the end-user market share of public sector condoms in 2008 was around 32-35% only, despite a relatively large amount of imported condoms. If these estimates are correct, only about 25% of condoms imported by USAID and UNFPA reached the end-users in 2008, but this number could be even lower. Most condoms remain in central warehouses in Maputo and Beira. In June 2009, 85% of the 50 million public sector condoms available in Mozambique were in central warehousing.

Some provinces such as Maputo Province and Maputo City were without condoms altogether, while others had limited amounts stored in provincial warehouses. Nampula Province, with more than 4 million population, had 14,000 condoms in stock or 0.0003% of the nation’s condom supply.

In the past, condoms were included in the essential drugs kit and distributed through the “*via Clássica*” to the districts. However, given that the needs of kits and other medicines to be distributed

have increased, and the room for inclusion of condoms in the distribution vehicles is not enough. As a result, the condoms have been accumulated in the national warehouses.

Constraints/Challenges

Main challenges are related with the:

- § Capacity to perform a continuous analysis of the distribution chain of condoms allowing to make timely decisions;
- § Capacity to transport media for condom distribution (or resources to make a contract with transporters);
- § Provision of continuous technical support at all levels in order to improve capacities to forecast the needs, do requests and distribute;
- § Strengthen the coordination between several actors in the process (public and private sectors and youth associations);
- § Demand creation for the correct and consistent use of male and female condoms.

Opportunities

- Created a multisectorial working group at provincial level (similarly to the CPWG at central level) that created and consolidated a fluid dialogue between government, partners and civil societies;
- Initial Training of Training of trainers in female condom has already taken place in 2009 and a guidebook has been developed, with basic information to support the female condom promoters in advocacy and promotion work.

Main actions for the future

- Improve the process of management and logistic at the warehouse depots of condoms at central, provincial and district levels;
- Training of female condom promoters;
- To set up an institution responsible for condom distribution, whether it's within or outside the health system;
- To develop and approve an interim plan for distribution with partners support;
- Creation of technical capacity on programming and logistics to respond to the growing demand of female condom;
- Development of tools and mechanisms for better control and monitor condoms' distribution, especially for those organizations that operate outside health facilities;
- Better communication and transmission of messages about condoms, ensuring the adequacy of these messages to the local cultural realities, as well to ensure the attention that has to be made to the different types of age groups during the dissemination of messages;
- Production and dissemination of appropriate communication materials related with male and female condoms.

Indicator #17: Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse

Table 22: Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during sexual intercourse 2003, by gender and age group

Method of Measurement	All 15-49	Disaggregated Values	
		Sex	
		Males	Females
Numerator: Number of respondents/population (aged 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex	219	180	39
Denominator: Number of all respondents aged 15–49 who reported having had more than one sexual partner in the last 12 months	983	816	167
Indicator Value (Percent)	22,2%	22,0%	23,3%

[Source: INSIDA, 2009]

This indicator has increased from 17% in 2003 up to 22.3% in 2009. This happens in both sexes, but in a higher proportion among women (from 14.4% up to 23.3%). This increase is still not enough to influence HIV incidence reduction at national level.

Drug Use

The Department of Mental Health of the Ministry of Health recorded in 2009 an increase in 19% of cases attended in Psychiatry Services due to mental and behavioral disturbance related to consumption of psycho-active substances as compared to the year 2008 (MISAU, 2009). The majority (70%) of the cases attended was males, in which alcohol and *cannabis sativa* were reported as mostly consumed, as also referred by drug users interviewed under the I-RARE study²⁵.

In Mozambique there is an increase in the number of organizations fighting drugs. Part of these organizations is affiliated with the Mozambican Network of Organizations for Fighting against Drugs. In addition to the fight against drugs, these organizations implement activities of prevention and mitigation of HIV among drug users.

Assessment and Rapid Response Study (I-RARE):

Below is described the component of the study which focuses the analysis of the association between consumption of illegal drugs and practices of risk of infection by HIV in the three cities. This analysis aimed at understanding the relationship between the practices of consumption of illegal drugs and the risk resulting thereof for the infection by HIV, in users of those same drugs, in the three port cities. Collection and analysis of data was done using qualitative methods.

Main findings: peer pressure was reported as the main motivation to initiate and continue to use drugs, although there were also reports of use of drugs as a means to deal with social problems and unemployment. The respondents associate the type of drugs consumed to the socioeconomic living conditions and to the linkages to certain social networks. Cannabis was often referenced as an initiation drug in the three cities. Other drugs mentioned include cocaine, heroin, *mandrax* and *ecstasy*. Out of 132 drug users interviewed, 11 stated to use injecting drugs including cocaine and heroin. Users of injecting-drugs, while showing knowledge of the risks of infection by HIV, reported practices of risk associated to sharing of injection equipment. The main reasons stated for this were unavailability in the market and high cost, especially for syringes. In general, the respondents showed understanding of the benefits of using condoms but some engage occasional sexual practices without condom; reasons for not using the condom include the demonstration of trust in the partner; not enjoy condoms and the fact of being under the effect of drugs. Therefore, most of the drugs users argue the lack of interest for sexuality and/or claim fidelity to their partners, who in some cases are also drug consumers. The participants are aware of the counseling and testing services as well as their location, some argued to have already taken the test; some of those who never took the test argued fear for positive results, related stigma and, death as a reason for not taking the test. Most respondents knew of the existence of public/private care/support services for drug users.

These results clearly indicate the existence of behaviors' of risk of infection by HIV among users of illegal drugs and, therefore, they can help in designing appropriate strategies for their minimization/elimination.

²⁵ I-RARE (2009) Association between the consumption of illegal drugs and practices of risk of infection by HIV in three port cities of Mozambique: Maputo, Beira and Nacala. In: *Livro de Resumos, XIII Jornadas de Saúde, Setembro de 2009, Maputo, Moçambique*

Indicator #20 of UNGASS: Percentage of injecting-drug users who reported to have used sterilized injection equipment the last time they injected themselves

Currently, there is no data for this indicator.

Treatment Programmes

This section of the report will assess the success of the treatment response in Mozambique in the following areas: HIV treatment and Co-management of TB and HIV treatment.

Antiretroviral Therapy

Mozambique began providing AIDS care and treatment services in 2003 in alignment with the 2004-2008 National Strategic Plan for STIs, HIV and AIDS (*Plano Estratégico Nacional - PEN Health*). Treatment was cited as one of the seven priority areas in the PEN II (2005-2009). The approach in the PEN Health was to ensure that issues such as long-term sustainability would begin to be addressed together with the broader needs of the health sector, using the focus on antiretroviral treatment (ART) as the impetus to ensure a balanced approach to HIV and in the health sector. The result was a comprehensive and balanced strategy that covered the whole spectrum from prevention through diagnosis to care, treatment, and impact mitigation. It also undertook to ensure that issues of capacity at all levels are addressed as prerequisites to treatment and other complex service expansion.

Since the initiation of the national strategy in 2003, remarkable progress has been made in the area of care and treatment. In 2003 there were only 3,314 people actively on ART in Mozambique. By the end of 2009, there were a total of 170,198 (156,688 adults; 13,510 children) people actively in ARV treatment (2009 general target – 158,000). Approximately 8% of the totals are children less than 15 years old and 63% are females.

While paediatric HIV care and treatment was not specifically described or planned for in the original PEN Health, significant progress has been made in this area. Paediatric treatment was incorporated into the MoH's HIV and AIDS program in 2005 and guidelines, protocols and technical working groups specifically focused on paediatric HIV and AIDS have been created. However, Mozambique still has a long way to go with respect to paediatric care and treatment but has steadily improved performance in the critical area.

Geographic coverage of HIV services has also expanded significantly. In 2003, ART was offered in only 12 urban sites, in Maputo city and Maputo province. Until December 2009 every district in the country had at least one health facility offering ARV treatment, bringing the total number of ART sites to 220. Even with this significant expansion of access to ART services, treatment coverage in Mozambique remains low. By the end of 2009, with an estimated 373,020 adults and 72,652 children in the advanced stages of AIDS, approximately 42% of adults and 19% of children of those in need of ART were receiving treatment.

In terms of the percentage of adults and children with advanced HIV infection receiving antiretroviral therapy, Table 1 shows the latest results for 2008 and 2009. Overall, 30% in 2008 and 38% in 2009 of adults and children in need of treatment were receiving ART.

Indicator # 4: Percentage of adults and children with advanced HIV infection receiving ART

Table 23: Percentage of adults and children with advanced HIV infection receiving ART

Method of Measurement	Indicator Value	
	December 2008	December 2009
Numerator: Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period	128,330	170,198
Denominator: Estimated number of adults and children with advanced HIV infection	429,736	445,672
Indicator Value: Percent	30%	38%

[Source: MISAU, 2009]

The third national strategy for HIV and AIDS (PEN III)²⁶ was developed in 2009 and again prioritizes AIDS care and treatment as one of the four key components of the national response. The treatment of adult and paediatric AIDS is also prioritized in other government documents elaborated by the MoH. For example, AIDS treatment indicators are included as components of the second Mozambique Poverty Reduction Strategy 2006-2009 (PARPA II) with specific targets, and make up two of the 54 key monitoring indicators which are reviewed twice a year as a part of the Performance Assessment Framework monitored by the Government and the Program Aid Partners (the G19 donors providing direct budget support to Government). This performance assessment framework is intended to jointly evaluate progress made in the implementation of PARPA II. As such, these areas are considered crucial for monitoring the progress of the HIV and AIDS response.

Policy and Institutional Response

Since the initiation of the PEN Health a number of key policy changes have been implemented to reflect changing international guidelines to respond to the specific needs of the Mozambican health sector. In 2006, a mid-level cadre of health worker, *Técnico de Medicina*, was trained to initiate standard first line adult ART regimens and to follow-up stable patients on treatment. This mid-level cadre's responsibilities were further expanded in 2007 to include initiation of alternative first line treatments and ART in pregnant women and TB patients. Task-shifting of responsibilities from doctors to *Técnicos de Medicina* was done in an effort to respond to the growing number of people initiating ART and to facilitate the overall expansion and decentralization of the national health care system. As a result of this and other initiatives, ART care and treatment expanded significantly between 2007 – 2009, with an increase of 81,987 adult and paediatric patients alive and on ART since the end of 2007. In absolute terms, the number of patients alive and on treatment increased from 88,211 in 2007 to 170,198 in 2009, representing a 193% increase over two years.

²⁶ Plano Estratégico Nacional de Resposta ao HIV e SIDA 2010 – 2014.

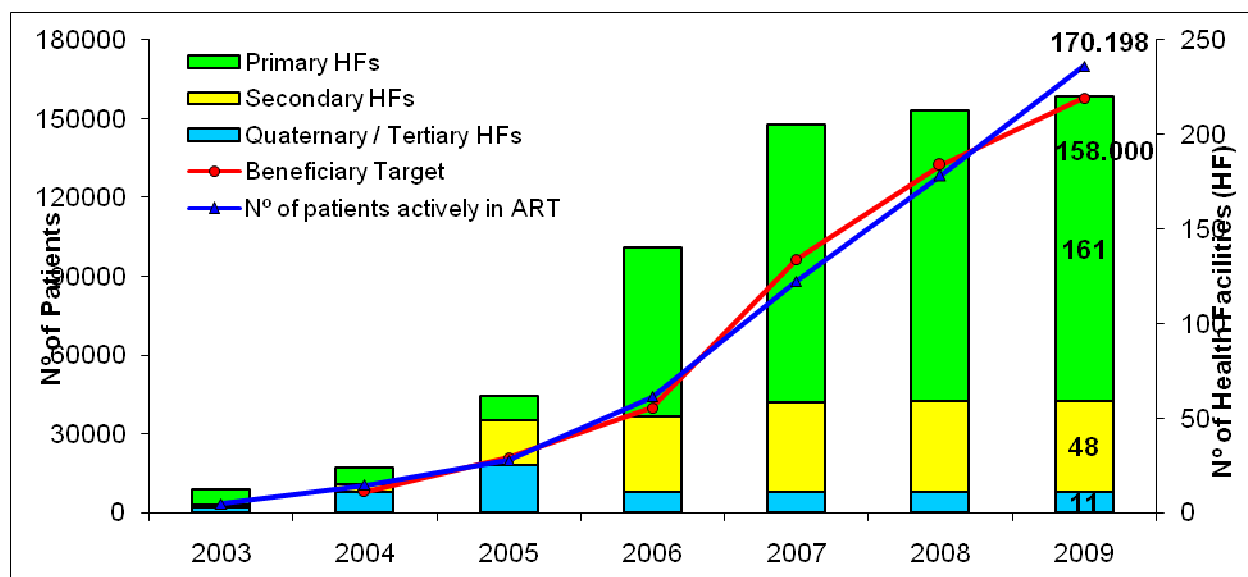


Figure 15: Total number of ART Health Facilities and Beneficiaries in Treatment: 2003 – 2009

In 2008, the Ministry of Health made the decision to decentralize adult and paediatric ART services from the former “day hospitals” of larger health facilities at the quaternary and tertiary level to peripheral health facilities at the secondary and primary level. The decentralization process began in early 2009 with the decentralization of adult patients from the Maputo Central Hospital.

By the end of 2009, 9,474 ART patients had been transferred from the 4 quaternary central hospitals and 7 tertiary provincial hospitals to the 209 health facilities at the secondary and primary level. The decentralization process for adult ART patients at these larger health facilities is underway in most of the 11 provinces; however, a slower and more phased approach has been adopted in relation to paediatric services given the additional complexities regarding clinical management and paucity of trained personnel.

While decentralization of services is necessary to ensure equity of access to services, strengthen referral systems and leverage existing resources to improve the overall health system, it also carries the risk of diminishing the quality of care provided if ongoing services quality improvement. To address this concern, the *Strategy for the Acceleration of HIV Prevention* (as developed by the multisectoral Prevention Reference Group in 2008/2009) calls for a shift in focus on geographic expansion to improvements in the quality of services provided. In particular, this approach involves the scale up of HIV quality improvement activities, clinical mentoring, integrated supervision of health facilities, and the updating of guidelines (to reflect WHO developments, etc.) and operational manuals to further facilitate the integration of ART services into primary health care. The Acceleration of Prevention Strategy also recommends improved collaboration between the Ministry of Health and Civil Society organizations working in communities in order to improve adherence to treatment, establish early warning systems for the detection of illness in HIV-infected patients not yet eligible for

ART, and implement simple screening programs to detect people at high risk for malnutrition, TB, and other common illnesses.

In 2009, the 2010-2012 national paediatric and adult ART targets were revised to reflect changes in the indicator definitions and relevant policy changes. For the first time, targets were defined for 2013-2014. The key policy changes that drove this revision process of the targets were the adult and paediatric treatment guidelines, changes to the immunologic eligibility criteria (CD4 cells) from <200cells/m³ to <250cells/m³, together with planned changes in the quantity and quality of available human resources due to various applications of task-shifting, prolonged working hours and overall the implementation of the Human Resource Development Plan 2010-2014.

The Ministry of Health has also approved national guidelines for nutritional support for HIV-infected patients, in particular the provision of a basic food basket (*cesta básica*) to patients on antiretroviral treatment with low body mass index.

A National Strategic Plan for TB (2008-2012) is now in place and focuses on further expanding TB and HIV collaborative activities as well as implementing a quality monitoring and evaluation system allowing impact measurement of program activities. However, routine implementation of the 3 I's (Intensive Case Finding, Isoniazid Preventive Therapy, and Infection Control) is not yet in place in the majority of health facilities, which is particularly worrisome considering that in 2008 more than 60% of TB patients tested for HIV were HIV-positive. As a part of the effort to strengthen TB-HIV collaborative activities, in 2009 the MoH began the process of updating the HIV care and treatment patient monitoring and reporting tools. These tools' development is being based on the WHO guidelines to simplify the Health Information System, so as to improve quality of reported data, as well as include critical indicators such as ART outcomes, early warning resistance indicators, TB-HIV collaborative activities, and treatment of opportunistic infections.

Key Achievements

Access

As demonstrated by Figure 16, significant progress has been made in expansion of ARV treatment since ART services became available in 2003. All targets set by the MoH for years 2004-2009 were either achieved or overtaken more than 90% of the goal. Furthermore, the percentage of all patients that were female and children less than 15 years old on TARV were 63% and 8% respectively in 2009. All 220 treatment sites provide data disaggregated by sex and age (adults 25 years or older, adolescents 15-24, and children less than 15 years old) in relation to the number of patients entering treatment as new, transferring in, or reinitiating patients. In addition, data is collected on the number of patients that discontinue treatment due to death, lost to follow, suspension, and transferred out. Of the 242,854 registered patients that entered ART as new (230,181) or reinitiating (12,673) patients since the beginning of treatment services at the end of 2003, until the end of 2009, 3% were suspended (6,269), 17% were lost to follow up (39,098), and 8% died (18,794).

The Health Information System (HIS) that allows for the collection, aggregation, analysis, and dissemination of care and treatment related data was centralized at the Ministry of Health until the

end of 2007. This made its good use increasingly difficult, given the rapid expansion of treatment sites and beneficiaries between 2006 and 2007. Given these increasing demands on the Ministry of Health’s HIS at the central level, the HIS was decentralized from the central level to the provincial and district levels in 2008 through the training of relevant staff from all provinces for data entry and monitoring and evaluation standard operating procedures.

Adult ART

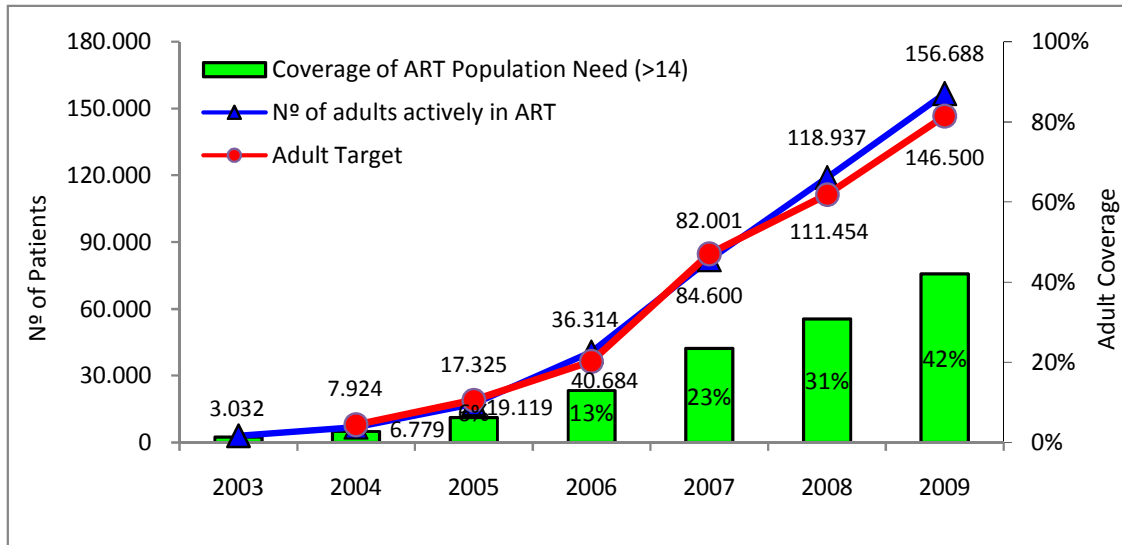


Figure 16: Trend in adult ART coverage, 2003-2009

In terms of ART for adults, Figure above highlights the expansion of services and coverage between 2003-2009. By the end of 2009, the MoH target of 144,500 adult patients on ART was surpassed by roughly 12,000 patients, with 156,688 adult patients actively in ART. Based on treatment needs estimates calculated using the Spectrum projections package, an estimated 42% of adults in need of treatment were on ART. While this is an impressive achievement for a national program that has been providing care and treatment services for only six years, the equity in the distribution of ART coverage across the different regions of Mozambique is an area of concern. As illustrated in Figure 17, the northern and central provinces have less than half the ART coverage as compared to the southern region where the national capitol resides.

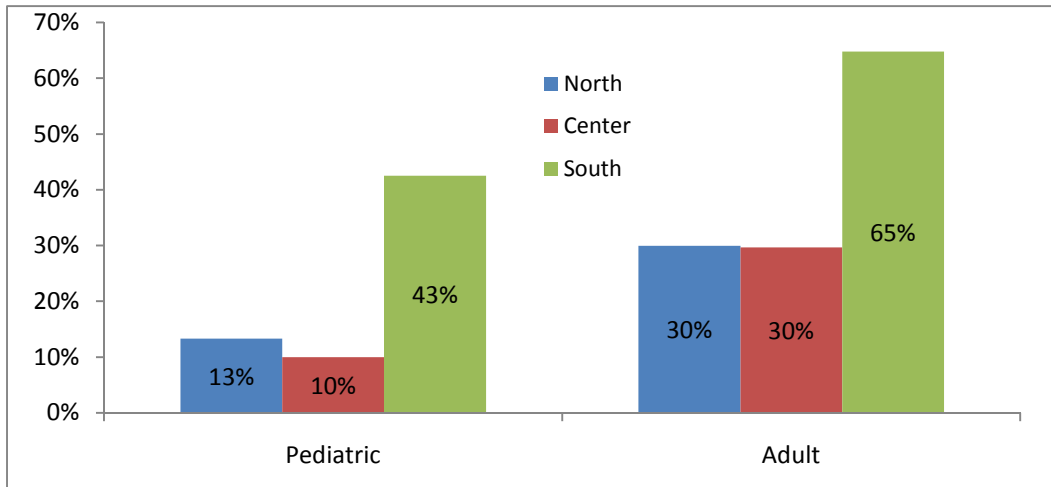


Figure 17: ART Coverage by Region for Adult and Paediatric patients in 2009

Paediatric ART

Mozambique has come a long way in scaling up paediatric ART services since the program’s inception in 2003. In this short period, the number of children under 15 years of age on treatment in the country increased from less than 300 in 2003 to 13,510 by the end of 2009. This represents coverage of 19% of children considered eligible for ART, which are based on projections calculated using Spectrum.²⁷

The official MoH projections were updated for the UNGASS report in light of the MoH changes in ART eligibility criteria in 2009 for both adults and children. In particular, these latest estimates show a reduction in coverage for children between 2008 (21%) and 2009 (19%) as a result of the new MoH paediatric treatment guidelines; however, the absolute number in treatment rose from 9,393 in 2008 to 13,510 in 2009. While representing a significant improvement from the 0.3% coverage recorded in 2003, the proportion of the number of children in need receiving ART is still far from satisfactory.

²⁷ Spectrum version 3.46 Beta 16

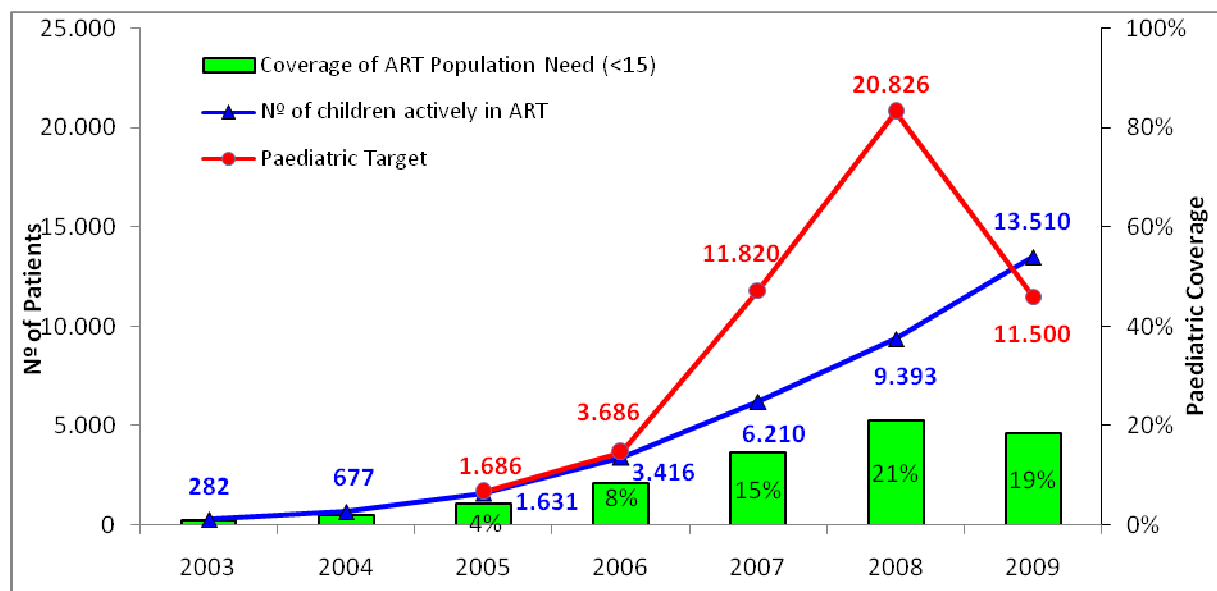


Figure 18: Trend in Paediatric ART coverage, 2003-2009

There has also been a rapid increase in the number of health facilities providing antiretroviral therapy: by December 2009 there were 220 health facilities with antiretroviral therapy services and 217 of these facilities (98%) were treating HIV-positive children,²⁸ compared with 188 out of 213 (88%) in 2008 and 148 of 205 sites (72%) in 2007.

Antiretroviral treatment for children is progressively being brought closer to the people and is expanding across the country: in 2006, 68% of all children receiving treatment were living in the four southern provinces of the country, and 55% were living in Maputo City. In 2008, the southern provinces accounted for 56% of all children receiving ARVs and Maputo City accounted for 33%. Similarly, in 2009 the southern provinces represented 57% of all children in TARV, with Maputo representing 30%. In spite of the expansion to other provinces, the geographic distribution of children accessing treatment is still highly inequitable as illustrated in Figure 17: in the southern region of the country, approximately half the children in need of Antiretroviral Treatment are able to access it, while the percentage of unmet needs is much higher in the central and northern regions.

An adjustment was made to the paediatric treatment targets between 2008 and 2009. In the PARPA II, an initial target of 50% coverage by 2009 was agreed upon, accompanied by an increase in the number of paediatric treatment sites from 34 in 2005 to 150 sites in 2009, with a particular focus on expanding services in the central and Northern provinces of the country.

However, in 2008 the MoH decided to reduce paediatric targets in response to the widening gap between expected results and achievements made in 2007 and 2008. Following a review of the progress made and an analysis of the number of new children starting ART in the previous year, the MoH reduced the 2009 target from the previously established PARPA II target of 50% coverage to 15% or 11,500.

²⁸ 217 sites had at least one paediatric patient in ART by the end of 2009, however, when looking at sites with 5 or more children on ARV treatment, the number drops to 186 (84%).

In 2009, following adoption by Mozambique of the guidelines for the scaling up of TARV (Early Infant Diagnosis) through the installation of two PCR machines in the northern and central regions of the country, the MoH, in collaboration implementing partners, decided to increase ART targets for 2010 – 2014 (Table below).

Table 24: Revised paediatric HIV Targets 2009, Ministry of Health, Mozambique

	2010	2011	2012	2013	2014
Children on ARV treatment	18,817	23,818	29,058	34,258	39,743
Children as a proportion of total on ART	9.9%	10.7%	11.4%	11.9%	12.3%

While representing an improvement, these revised targets remain far below the original PARPA II targets (50% in 2009) and even further from the universal access commitment.

While in the past some of the provincial day hospitals had a dedicated space for paediatric patients and others offer specific consultations for children at certain times, since 2008 the MoH policy is for treatment of HIV-positive children to be integrated within the general ART services.

Currently paediatric ART is initiated by physicians in the majority of health facilities. *Técnicos de Medicina*, were trained in 2006 to initiate standard first line adult protocols and to follow-up straightforward patients on treatment, and in 2007 they were allowed to initiate alternative first line treatments of pregnant women and TB patients. The process to train *Técnicos de Medicina* in paediatric ART as well is underway. Training modules for paediatric ART have been developed, and a Training of Trainers was planned for the first quarter of 2010.

Paediatric ART in Mozambique was initially based on the use of individual syrups. Mozambique changed this in 2009 and opted for paediatric fixed-dose combinations, which are cheaper, easier to administer, more durable and of equivalent efficacy.

Identification, referral and retention of HIV-infected children in HIV care and treatment services are still weak. Linkages between the various entry points for HIV+ children are still weak and inconsistent within most health units, and the referral systems between the existing paediatric care services require significant strengthening.

In terms of integration of services, the “Integrated Management of Neonatal and Childhood Illnesses” protocols were updated to include HIV and AIDS, and dissemination took place in 2008.

Overall Key Challenges

- Access to treatment estimates show that approximately 62% of those (adults and children) in need of treatment have access in the southern region, 26% in the centre, and only 27% in the north.

- With the decentralization of services in recent years many primary level health facilities have begun to saturate their capacity to absorb additional patients, weakening their ability to monitor and follow up patients both in care and treatment. This has ongoing implications for quality and supervision of the treatment program. To address this constraint, in the beginning of 2010, the MoH authorized the expansion of ART services to an additional 82 health facilities.
- The 2006 WHO guidelines for both adults and children, adopted by Mozambique in 2009, have had implications in relation to training of the various cadres of staff, transfer of responsibilities (task shifting), forecasting and procurement of drugs, and demand on facilities with already limited resources.
- Weaknesses continue in monitoring nutritional status (in particular anthropometric parameters) in PLHIV. However, monitoring of the nutritional status has been incorporated into the new HIS tools to be piloted and implemented in 2010
- Collaboration between the MoH and Community Based Organizations/NGOs in the area of home-based care (HBC) continues to be pivotal to an appropriate treatment program given the role HBC plays in monitoring adherence and nutritional status, and in providing essential psychosocial and other support to both patients and families. With the increasing number of patients in treatment, and the growing incidence of complicated cases (treatment failure, progression to more complex second line regimens, poor adherence, etc) the expanded provision of adjunctive HBC services will be imperative.
- Effective management of TB-HIV co-infection remains a critical priority for Mozambique but practical and logistical challenges remain in relation to the linkages between HIV and AIDS treatment services and those of the TB program. Collaboration between the two programs has improved, but referral systems remain weak and implementation of the 3 I's has not yet been taken to scale.

Overall Key Actions Needed

- Continued task-shifting of some treatment and counselling related activities from higher cadres to other appropriate cadres, e.g. nurses working in maternal and child health, non-medical counsellors, *agents de medicina*, etc. will be necessary to assume some of the growing burden of care and to free up more senior staff for other activities, complicated cases, etc.
- Capacity-building and training of health professionals in nutritional assessment and referral, and the establishment of community-based distribution and monitoring systems of the "cesta básica" (basic food basket) are still needed. Counselling and advice, nutritional/food support and monitoring of impact by community-based organizations needs to be strengthened.
- Coordination and collaboration between the MoH and CSOs/NGOs in the area of HBC and in particular nutrition, must be enhanced to reflect the growing need for closer supervision, monitoring and linkages between communities and formal health services as treatment continues to scale-up and more complex cases arise.
- Implementation of the 3 I's needs to be taken to scale to continue to address the ongoing problems with TB-HIV co-infection and development of MDR and XDR TB cases.
- Reductions in the time from HIV diagnosis to the initiation of ART and strengthening the linkages between services to reduce the dropouts and missed opportunities.
- Reductions in the rates of lost to follow up in the ART/OI treatment services.

Key Actions to Scale-up Universal Access to Paediatric Treatment

- Intensifying the process of task shifting on the TARV management for technical staff of a lower academic degree (e.g. MCH nurses), without sacrificing the quality of treatment and care, as a means for scaling up beyond the district capital;
- Integration of TARV management into pre-professional training, training on-the-job for every target technical staff;
- Strengthening TARV management in the context of the integrated attention of infant diseases;
- Enlarge the counseling package for non-medical polyvalent agents (lay people) beyond the CTH, aiming at including counseling for the start and continuity of pre-TARV and TARV measures, so as to ensure the existence of specific staff dedicated to this activity;
- To keep on ensuring the implementation of comprehensive pediatric package that includes psychosocial support to the child, support to parents and support staff, and above all, to sensitise for the adherence to TARV and care. When that is not possible, to follow the minimal pediatric package model, as a basis for scaling up in health centres;
- Identification of the HIV positive child needs to be extended beyond the mother herself and including other caretakers, such as older people.
- Increasing awareness on paediatric AIDS in families and increasing the demand for services for infected children, including early infant diagnosis.
- Introducing provider initiated testing for children in all clinical settings
- Improving the logistics for PCR tests to speed up the process
- Overcoming the reluctance and lack of confidence among health workers to enrol children on ART: better mentoring and regular supportive supervision needed
- Timely provision of quality data on paediatric ART and related information, e.g. numbers of children tested and HIV positive, number of children receiving cotrimoxazole, etc, especially at peripheral level.

Indicator #24: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Currently, there is no data for this indicator.

However, a recent study²⁹ reported that the percentage of adults with HIV known to be on treatment for 12 months and were alive (retention) was 79%, slightly higher than the levels found in other sites in Africa (75% among adult patients).

²⁹ DNAM/INS/CDC, 2009. National Adult Antiretroviral Therapy Program Evaluation – Mozambique, 2004-2007

Nutrition and HIV

Introduction

There are important links between HIV and AIDS and nutrition. Adequate nutrition is needed to maintain the immune system, to manage opportunistic infections, to maintain healthy levels of physical activity and to support an optimum quality of life for People Living with HIV (PLHIV). Nutrition related interventions can also help optimise the benefits of Antiretroviral Treatment (ART), and increase adherence to the treatment and/or to PMTCT protocols³⁰.

The World Health Organisation (WHO) recommends that evidence-based interventions should be part of all HIV care and treatment programmes³¹. Information on food consumption and surveys on the nutritional status of PLHIV (weight and changes in weight, height, Body Mass Index (BMI) or Mid Upper Arm Circumference, symptoms and food consumption) should be obtained as a matter of routine. Individual and household food security also need to be assessed.

The Government of Mozambique is highly committed to nutrition for PLHIV. Government institutions, in coordination with their partners, are implementing various activities in the area of nutrition and HIV, including nutrition and dietary assessments, nutritional counselling, distribution of food or food supplements (for example, through the Basic Food Basket (Cesta Básica) Programme for malnourished people on ART), and the treatment of moderate and severe acute malnutrition. Particularly in the areas of food distribution and income generation, several are initiatives implemented by community-based organisations, complementing Government interventions.

Nutritional situation of PLHIV

Not much information is available about the nutritional status of PLHIV. The weight of patients is not systematically measured in all health units, and height is measured on very few occasions. The individual patient files for adults do not have a space to record height, nor to register the BMI. The new version of these files will have space for these indicators. It is essential to calculate the BMI of the patients, since this is used as a selection criterion for the nutritional rehabilitation programme with the nutritional supplement or with the Basic Food Basket.

Public Health Consultants, with support from the World Food Programme (WFP), undertook a survey of 922 patients in 33 districts who received antiretroviral treatment. About 25% of the patients surveyed were malnourished (BMI equal to or lower than 18.5 kg/m²). About two thirds of the interviewees were vulnerable and food insecure, and only 20% of the interviewees mentioned receiving food support, whether from the Government, community committees, NGOs, the WFP or associations.

³⁰ Banco Internacional para Reconstrução e Desenvolvimento, HIV e SIDA, Nutrição e Segurança Alimentar: O que podemos fazer, Uma síntese de princípios de orientação internacionais. 2008

³¹ WHO, Priority interventions: HIV/AIDS prevention, treatment and care in the health sector, 2009

Of the 60 children aged between 6 and 60 months on ART in the DREAM programme in the Health Centres at Machava (Maputo Province) and Manga Chingussura (Sofala) in 2009, 1.7% were suffering from severe acute malnutrition and 65.5% from chronic malnutrition. Of the 458 children aged between 6 and 60 months born to mothers living with HIV (“children exposed to HIV”) in Manga Chingussura, 0.4% was suffering from severe acute malnutrition and 38.3% from chronic malnutrition³².

The data from the 2003 Vulnerability Analysis undertaken by the Technical Secretariat for Food and Nutrition Security (SETSAN), based on 29 districts with high rates of food insecurity and HIV prevalence, showed that 56% of maternal orphans suffered from chronic malnutrition (low height for their age) but only 38% of the children who were not orphans. The prevalence of severe chronic malnutrition was 36% among the orphans and 15% among the non-orphans (there was no difference in levels of chronic malnutrition between the paternal orphans and non-orphans)³³.

The prevalence of severe nutritional deprivation among orphans was 28.0% in 2003 and 23.8% in 2008 (n=391 in 2008). For children who were not orphans (n=10.284 in 2008), this prevalence was 27.0% in 2003 and 19.7% in 2008³⁴.

Strategies, protocols, training manuals and working groups at the national level

The main Government institutions responsible for nutrition and HIV matters are the Ministry of Health (MISAU) and the Food and Nutritional Technical Secretariat (SETSAN). The Ministry of Women’s Affairs and Social Action (MMAS) is the institution responsible for orphaned and vulnerable children (OVC). MISAU has set up a working group on nutrition, food and HIV. In 2008, MISAU in collaboration with the partners began to draw up a comprehensive Nutritional Intervention Strategy for PLHIV.

The Ministry of Health has developed the Guideline for Nutritional Orientation for People Living with HIV (a brochure aimed at health workers) and is finalising materials for nutritional counselling for PLHIV aimed at health workers, at activities linked to home based care, and at local NGOs.

In March 2007, the Council of Ministers approved a Nutrition Strategy for PLHIV, which focuses on a Basic Food Basket for PLHIV who receive ART who are moderately malnourished (BMI < 18.5 kg/m²). The objectives include improving the nutritional status of the PLHIV and improving adherence to treatment.

The Basic Food Basket programme began in 2009. In an initial phase, the Basic Food Basket programme is covering about 3,500 people in the 11 provincial capitals. In 2010, it is intended to make an assessment of the first phase of the programme, so that it may then be expanded to the remaining districts in the country so as to cover all eligible patients on ART. The Basic Food Basket consists of ten different foodstuffs, with a total weight of 28 kg of food a month, for a period of six

³² DREAM Program, Mozambique, Nutritional Surveillance & Monitoring Program, 2009

³³ SETSAN, UNICEF, Martel P, Additional Analysis of the Third Multisectoral Vulnerability Assessment, 2003

³⁴ Martel P, Análise detalhado dos dados do MICS 2008, (unpublished).

months. The eligible PLHIV receive a card at the health unit, which they need to show at a local shop in order to receive the food.

SETSAN developed a Manual of Procedures, Food and Nutritional Insecurity and HIV/AIDS in 2006, with the objective of providing guidelines for interventions in this area³⁵. This manual is being used by SETSAN to train NGOs and other stakeholders.

The treatment for HIV-positive and negative children with severe acute malnutrition is similar. The out-patient treatment for severe acute malnutrition with the use of Ready-to-Use Therapeutic Food (RUTF), provided by UNICEF and the Clinton Foundation) has already been introduced throughout the country for children without complications. Of the 216 health units that offer Antiretroviral Treatment (ART) for children, 146 provide out-patient treatment for severe acute malnutrition with RUTF. Community involvement is being developed and expanded. Under the nutritional rehabilitation programme, HIV-positive children with moderate acute malnutrition receive RUTF to ensure rapid rehabilitation.

In 2007, MISAU approved the use of RUTF for adults with HIV and/or tuberculosis with acute malnutrition. In the new (2009/2010) adaptation of the nutrition rehabilitation manual, treatment protocols for HIV-positive adolescents and adults or patients with AIDS who suffer from acute malnutrition are being included.

Interventions for PLHIV

A study published in 2008 found that, although 40% of the interventions supported by the National AIDS Council are classified as “related to nutrition”, these interventions focus mainly on food distribution and production and on income generation . The study also documented that the country’s capacity for the area of nutrition (for example, for counselling) is low.

In a survey undertaken to obtain data on the situation of nutrition and HIV for inclusion in this UNGASS report, many stakeholders in the area of nutrition and HIV said that, in their experience, the level of knowledge about nutrition among PLHIV is low, and there are still various taboos and beliefs about nutrition. The opinion of those surveyed is that, although food is available, people do not know how to prepare it or how to make adequate combinations.

In many health units that offer services for PLHIV, health staff provides counselling and/or information about nutrition and nutrition is included in various mutual support groups. Apart from the materials produced by MISAU, there are several manuals to facilitate nutrition counselling for PLHIV drawn up by the technical support partners. However, the coverage of counselling interventions is not universal and little information is available about their quality. The time available for counselling is limited. In the above-mentioned survey, several participants mentioned that the knowledge of the health staff about nutrition is not sufficient, and it seems that the nutrition area has a low priority within the services.

³⁵ SETSAN, Manual de procedimentos, Insegurança Alimentar e Nutricional e HIV e SIDA, 2000

³⁶ World Bank, Mozambique Relatório da Situação de HIV e SIDA e Nutrição, 2008

The WFP supports the distribution of food supplements (Corn Soy Blend) for several target groups in seven provinces: moderately malnourished pregnant and lactating women (including HIV positive women), HIV-positive adults and/or with tuberculosis (TB) who are moderately malnourished, and exposed children (children at risk) with moderate malnutrition and/or faltering growth. Apart from this nutritional supplement, the patients receive food aid, consisting of cereals and pulses, for their household.

The supplements are intended to improve the nutritional status of the clients and improve adherence to treatment or to the PMTCT protocol. Distribution is undertaken in collaboration with MISAU and with various partners (including several NGOs and the National Social Action Institute (INAS)). Throughout 2009, a monthly average of about 3,200 women and 3,900 children within the Mother and Child Health (MCH) programme, almost 10,000 patients on ART, and 3,600 with OI/TB received food aid (Corn Soy Blend plus the food basket for the household).

There is no information available about the links between counselling interventions, food distribution and income generation interventions (which are important to ensure sustainability).

Households affected by HIV and AIDS, and OVC may be eligible, as direct or indirect beneficiaries, for the Food Subsidy Programme of the Direct Social Support Programme, both of which are managed by MMAS and INAS. WFP also provides food support to the OVC and their households. In 2009, WFP provided food support (cereals and lentils/beans) to an average of 40,000 OVC a month. The WFP also provides nutritional and food support for people with chronic illnesses who are receiving home care. In 2009, the WFP provided this support to a monthly average of 14,500 people.

Conclusions and recommendations

There is strong political will to improve the nutrition of the PLHIV, and a variety of interventions in this area are being implemented. However, there are several constraints: there is still no comprehensive strategy on nutrition and HIV, the systems for measuring the nutritional status of PLHIV are weak, many interventions are being undertaken on a small scale, and there are insufficient linkages between the interventions.

To accelerate and increase coverage, and to guarantee the quality of nutrition interventions for PLHIV, the following are recommended:

1. Build consensus and support for the development of comprehensive national guidelines, protocols and operational plans for nutrition and HIV and AIDS among key stakeholders, including all ministries and departments of the Government involved in care and treatment of PLHIV and households and families affected by HIV, NGO representatives, and bilateral and multilateral agencies;
2. Develop a comprehensive nutrition and HIV strategy for children and adults;
3. Build consensus and promote the creation of a forum to coordinate the actions of all stakeholders to leverage resources to ensure the availability of necessary materials and supplies for nutrition and food interventions for PLHIV;

4. Strengthen the capacity of the workers in health centres and in the community about nutrition and HIV, particularly about the selection of patients based on anthropometric measurements, monitoring, follow-up and assessment;
5. Strengthen counselling on nutrition for PLHIV, including through the development and distribution of job aids;
6. Strengthen the linkages between the community and the health centres to 1) improve the identification of malnourished children and adults and improve access to nutritional services as well as services for HIV and 2) improve the follow-up of malnourished children and adults undergoing out-patient treatment.
7. Increase the linkages between food aid programmes and income generation programmes, food security and other programmes, to support the livelihoods of PLHIV when they graduate from the food aid programme.
8. Monitor the food distribution interventions and document the achievement of their objectives and their cost-effectiveness, and use this information to take decisions about these interventions; and
9. Increase the role of the Ministry of Women and Social Action in the nutrition interventions aimed at PLHIV.

Co-management of Tuberculosis and HIV Treatment

Policy and institutional response

The National Tuberculosis Programme's mission is to improve the quality of services and interventions in the primary health care system through early case detection and adequate treatment of patients. The Mozambique's National Tuberculosis Strategic Plan, 2008-2012 aims at reducing the country's burden of Tuberculosis (TB) by reducing TB prevalence from 636/100,000 in 2006 to 390/100,000 by 2012, reducing the TB lethality rate from 12% in 2006 to 7% by 2012, increasing the case detection rate of smear sputum positive from 50% in 2006 to 75% by 2012 and increasing the treatment success rate through Direct Observation Treatment Strategy (DOTS) from 80% in 2006 to 85% by 2012.

Mozambique ranks 19th among the 22 high burden countries in the world, with an estimated incidence rate of 431/100,000 population (all forms) in 2007 and an estimated prevalence of 504 cases/100,000 population in 2007.

DOTS Expansion

To improve access to services of people living in underserved areas, the National Tuberculosis Programme has expanded DOTS to the community as well as the number of peripheral health facilities offering DOTS services. While in 2006, 49% (666/1333) of health facilities offered TB treatment services, in 2009 this figure reached 100% (1368/1368).

Community DOTS was introduced in order to cover all geographical parts of the country and community volunteers actively participate in the detection of TB cases. In 2008, 32,797 suspects have been detected by volunteers and traditional healers involved in the community DOTS. The number of microscopic units has been increased from 252 in 2007 to 433 in 2009.

Collaboration between the national TB and HIV programs

TB-HIV co-infections in Mozambique are increasing: in 2007, 47% of TB patients were HIV-positive while in 2009 they represented 66%. The estimated TB incidence rate among PLHIV was 204/100,000, in 2007. Mozambique has the third highest estimated mortality rate among TB-HIV patients among 22 TB high burden countries (82/100,000 2007). The mortality related to TB-HIV co-infection is halting meeting the MDG target for treatment success rate.

The number of PLHIV screened for TB has increased (24,330) which contributed to the increase of the number of TB cases identified by HIV services.

As can be seen on Figure 19, TB treatment sites national data for 2009 show that, a total of 45,529 patients were diagnosed for TB, of which 38,087 (84%) were tested for HIV. Of these, a total of 25,056 (66%) were TB-HIV co-infected and 5,622 (22%) are on ART. In relation to opportunistic infections prevention, 22,183 (89%) were reported on cotrimoxazole prophylaxis.

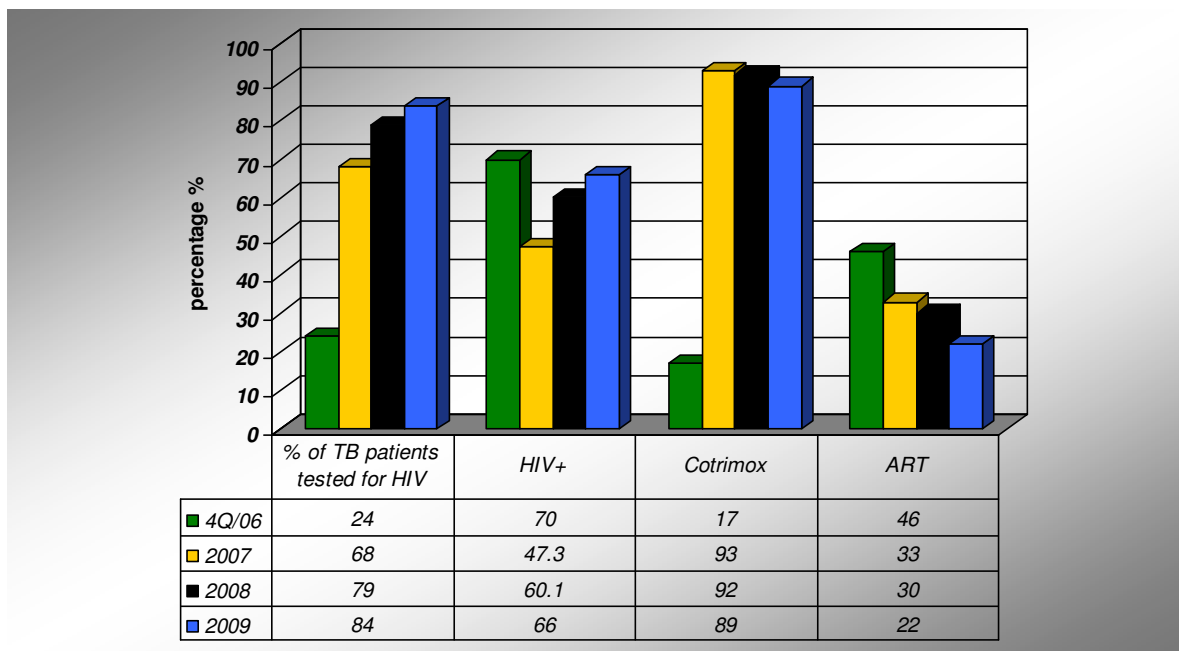


Figure 19: Percentages of TB patients tested for HIV, co-infected, receiving cotrimoxazole prophylaxis, and on ART, 2006-2009 (TB-HIV collaborative activities – TB program)

Beginning in 2008, greater emphasis was placed on promoting the “Three I’s”: Intensified TB case finding (ICF), Isoniazid preventive therapy (IPT) and Infection control (IC). An ICF tool was adapted and rolled out nationally in 2007 but use of the screening form at facility-level is inconsistent. As can be seen on Figure 20, national data shows that in 2009, of 24,330 HIV positive patients who were screened for TB in HIV care sites, 2,429 were started on IPT.

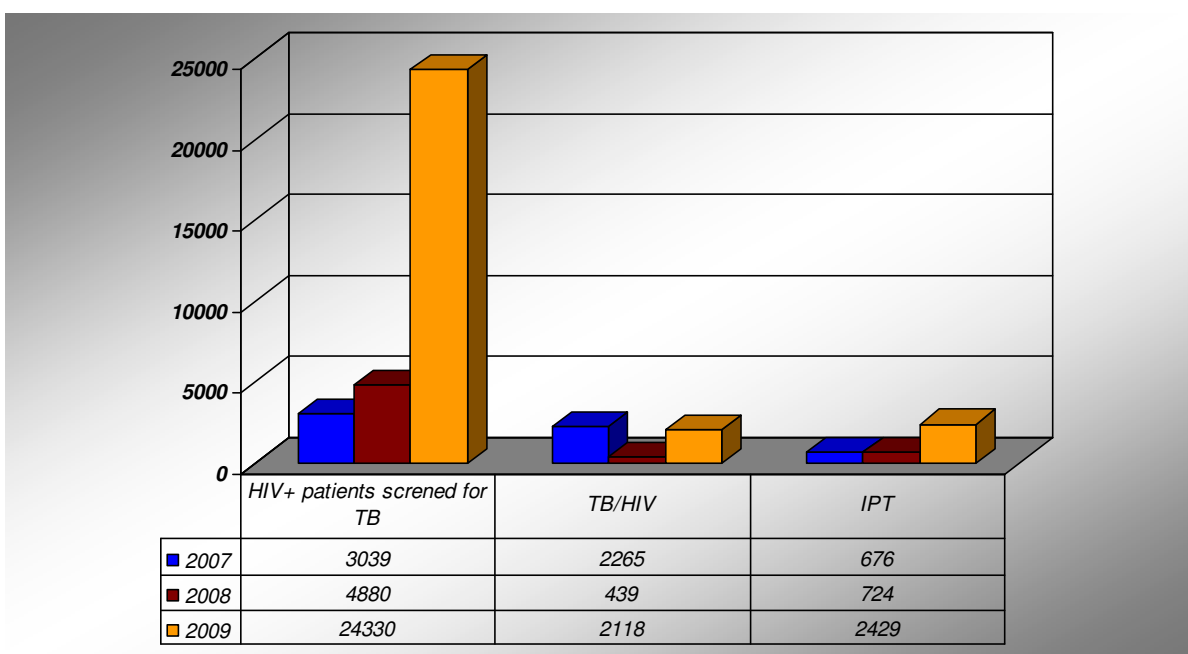


Figure 20: Numbers of HIV patients screened for TB, co-infected, and on IPT, 2007-2009 (TB/HIV collaborative activities – HIV program)

Multi-Drug Resistant TB

Mozambique has one of highest documented rates of multi-drug resistance (TB-MDR) in Africa (WHO/IUTLD drug resistance surveillance). The most recent drug resistance study finalized in 2008 found a 3.5% prevalence of multi-drug resistance among new cases. As a result, the number of cases diagnosed in the past 2-3 years has almost doubled. From 2006 up to September 2009, 295 patients were diagnosed and started treatment.

These improvements are also the result of several training courses, supportive supervision performed to health workers at all levels and increased availability of second line drugs.

The Rapid assessment of second-line drug resistance was already approved.

Prevention with positives

In 2006, in partnership with the University of California, San Francisco, a project on Prevention with Positives Partnership was setup initially in Maputo province and subsequently expanded to two more sites in Zambézia and Sofala provinces. Plans are to expand the services in additional provinces with assistance from implementing partners to put into practice HIV prevention with positives in TB settings. This is targeting men and women and will include risk reduction counselling, correct and consistent use of condoms, disclosure of serostatus to sexual partners, partner and child testing, reduction of the number of sex partners, reduction of alcohol use, adherence to HIV medications, management of STIs and family planning.

Challenges

1. Collaboration between TB and HIV services at all levels (joint planning, joint M&E) needs to be strengthened.
2. In general, the proportion of TB patients in whom HIV infection was diagnosed and started on ART is below the global target. In 2007 and 2008 (33% and 30%) the proportion of the HIV-positive receiving ART declined in comparison with 2006 (46%). This is the result of the change of criteria for ART in TB-HIV patients. In 2009, the percentage of TB-HIV patients receiving ART was even less in comparison with previous years.
3. Strengthening the implementation of the “Three I’s” by the HIV programme.
4. In some places, PLHIV are actually screened for TB, but are not reported. It is expected that the actual number of screened people is higher than reported.
5. Uniformisation of TB screening tools being used in the field.
6. Follow-up of IPT treatment in PLHIV needs to be strengthened.
7. Limited number of X-ray services, culture facilities, problems with patients’ referral to TB services.

Way Forward

- To strengthen the collaboration between HIV and TB services;
- To improve the implementation of the “Three I’s”;
- To improve the diagnosis of TB among PLHIV;

- To increase access of HIV-positive TB patients to ART.

Indicator # 6: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

Table 25: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

Method of Measurement	Indicator Value
	2009
Numerator: Number of adults with advanced HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines), within the reporting year	5 622
Denominator: Estimated number of incident TB cases in people living with HIV	57 000
Indicator Value: Percent	9,8%

[Source: MoH and WHO, 2009]

Care and Support Programmes

This section of the report will assess progress in providing care and support to households that are caring for orphaned and vulnerable children; and progress towards preventing relative disadvantage in school attendance among orphans versus non-orphans.

Support for Children Affected by HIV

Background

The Government of Mozambique defines orphans as children having lost one or both parents. In addition, there are twelve categories of children identified as vulnerable and in need of protection and support³⁷. 12 per cent of children surveyed in the 2008 Multiple Indicator Cluster Survey³⁸ were orphaned, of whom 11 per cent were single orphans and 1 per cent were double orphans. Another 6 per cent were considered 'vulnerable'³⁹.

The number of orphans is highest in areas with high HIV prevalence, particularly in the southern provinces, compared with the central and northern regions of the country (Figure 21). In addition, more orphans and vulnerable children live in urban areas as compared with rural areas (20 and 16 per cent, respectively).

In 2007, it was estimated that approximately 1.7 million children younger than 18 years of age were orphaned in Mozambique. Of these children, 400,000 (or about 28 per cent) are estimated to have lost their parents due to AIDS. This number is estimated to reach 630,000 by 2010.

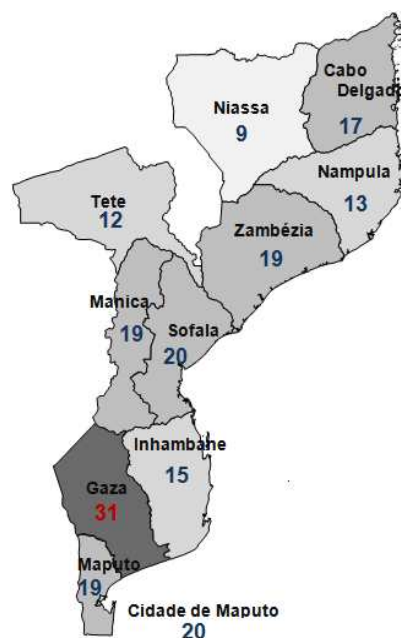


Figure 21: Orphans and vulnerable children by province

The probability of a child being orphaned or vulnerable is higher in older age groups: eight per cent for children between the ages of 0 and 4 years, as compared to 31 per cent for children between the ages of 15 and 17 years. Combined with earlier analysis of the 2003 Demographic and Health Survey, which found that female orphans aged 15 to 17 are more likely than non-orphans to have experienced sexual debut and that female maternal orphans are more likely than non-orphans to have been married⁴¹, the implication is that adolescents, and particularly girls, are especially vulnerable. Not surprisingly, one study in Mozambique found that orphans were more likely to be

³⁸ National Statistics Institute, 2009. Multiple Indicator Cluster Survey, 2008.

⁴⁰ UNICEF. *State of the World's Children*. November 2009.

⁴¹ Tia Palermo and Amber Peterman. *Are Female Orphans at Risk for Early Marriage, Early Sexual Debut, and Teen Pregnancy? Evidence from Sub-Saharan Africa*. *Studies in Family Planning*. 2009; 40[2]: 101–112)

bullied and depressed, and were less likely to have a trusted adult or friends. Caregivers of orphans also reported similar depression and isolation⁴².

Orphaned and vulnerable children (OVC) are more likely to live in poor households headed by women, elderly people and/or by an uneducated person. Some households are even headed by a child, or the children have to act as the main provider due to the illness or disability of the adult family members. They have very limited means of generating income and thus often have to resort to risky coping strategies, such as early marriage, transactional sex and hazardous child labour. They also have limited access to basic services such as health, education, food, legal, financial and psychosocial services. In addition to these challenges, children orphaned as a result of AIDS are often living with social stigma and discrimination, and potentially face exclusion from their communities. OVC are also prone to discrimination in the allocation of resources because they are not direct biological descendants of the household head. Inheritance claims by relatives often lead to dispossession of property in child headed households.

Policy and Institutional context

Mozambique has shown a steady commitment towards fulfilling the rights of children. In May 1994, the Government of Mozambique ratified the Convention on the Rights of the Child. The national Constitution adopted in 2004 places particular emphasis on child rights, setting a new legal and policy framework for children.

Mozambique has also supported comprehensive legal reforms to update national legislation in line with the Convention and other regional and international human rights treaties, such as the African Charter on the Rights and Welfare of the Child. This has resulted in important changes, such as the adoption of a Family Law in 2004, which articulates new legal standards on guardianship, adoptions, parental responsibilities, inheritance rights, and raises the age of marriage from 16 to 18 years. Another notable change is the adoption of the Children's Act in 2008. This new law effectively translates the Convention's articles into national child rights legislation and outlines the responsibilities of all stakeholders to realize these rights.

Mozambique's second poverty reduction strategy for 2005-2009 (PARPA II) includes targets concerning OVC, such as developing and consolidating social safety nets for the most disadvantaged citizens (including orphaned children) and ensuring that the ratio of school attendance and ratio of malnutrition among orphaned children is the same as non-orphaned children. PARPA II includes a target to provide 30% of households with OVC a minimum of three of the six identified basic services (health, nutrition, education, psycho-social support, legal support and financial support).

Mozambique has already taken some steps towards addressing the needs of the most vulnerable children in the country. The National Action Plan for Children (PNAC, 2006–2010) aims to ensure the protection of civil and human rights and security of children through the development and co-ordination of activities by key stakeholders. The Multisectoral Plan for Orphaned and Vulnerable

⁴² As reported in Cluver and Gardner. *The mental health of children orphaned by AIDS: a review of international and southern African research*. *Journal of Child and Adolescent Mental Health* 2007, 19(1): 1–17

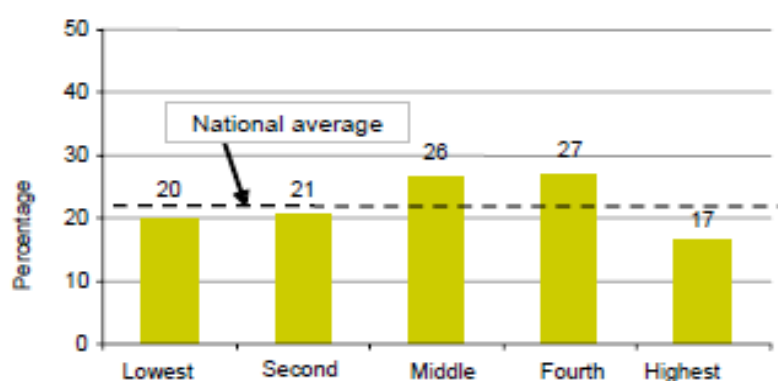
Children (PACOV, 2006-2010) addresses the specific needs of this growing population. Government defines the provision of at least three of these services as the minimum standard for the care of OVC. Both Plans also commit the government to scale-up birth registration to ensure greater coverage for OVC, essential for reducing vulnerability. The Social Protection Act, passed in 2007, calls for the provision of basic social security for poor people and children in difficult situations.

The Ministry of Women and Social Action (MMAS), together with its implementing arm, the National Institute of Social Action (INAS), is the main government entity responsible for programmes related to the care and support of vulnerable children, including designing Basic Social Protection policies and implementing them. However, MMAS (including INAS) receives one of the smallest allocations from the Government budget. In 2008, the budget allocation was just over 770 million Meticaís, corresponding to 0.86 per cent of the total state budget⁴³. While in absolute terms this is a doubling of the budget, in terms of the percentage of the state budget, this has remained static. The high execution rates of the budget (98 per cent in 2007 and 89 per cent in 2008) are a further indication that the budgets allocated to the Ministry are insufficient to meet the demands of vulnerable groups in Mozambique.

Indicator # 10: Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child

Currently no data exists for this indicator.

Only 22 per cent of households with orphans and vulnerable children receive any external support; most of this goes towards Education, with 2 per cent receiving material or financial support, and less than 1 per cent receiving medical support. Another worrying statistic is that only 20 per cent of children from the poorest quintile receive free external support, as compared to 27 per cent in the fourth poorest quintile⁴⁴ - Figure 22.



Source: MICS, 2008.

Figure 22: Children orphaned and made vulnerable by AIDS whose house received free formal support to care for the child, by wealth quintile, 2008

⁴³ FDC. *Budget brief*. Informe nr 6. November 2008

⁴⁴ INE, 2009. Moçambique –Multiple Indicators Survey, 2008.

Another issue to consider within the context of targeting programmes to reach OVC is that, as discussed earlier, many children live with elderly carers. However, one study in Mozambique in 2006 found that caring for an orphaned or vulnerable child cost an average of US\$ 21 a month and caring for someone living with HIV cost US\$ 30, while older people had an average monthly income of just US\$ 12.1. Obviously, for older people to meet these costs is a challenging burden.

Key Achievements

- 22 per cent of households with orphans and vulnerable children receive any external support;
- By the end of 2009, 357,905 of 1,328,208 (27%) OVC were reached with at least three basic services through a combination of initiatives by government (280,613) and Civil Society Organisations (77,292)⁴⁶;
- A Multi-Sectoral Technical Working Group on OVC, comprising of civil society and development partners, regularly reviews progress in implementing the PACOV. In addition, all 11 provinces and 54 districts have established similar working groups;
- Families affected by HIV and OVC might classify for the National Institute of Social Action's Food Subsidy Programme or the Direct Social Support Programme. The Programa de Subsídio de Alimentos (the national unconditional cash transfer programme for the elderly, disabled and children who are heads of households) programme now reaches 162,971 direct beneficiaries and 145,592 indirect beneficiaries, an estimated 60 per cent of whom are children;
- World Food Programme (WFP) also provides food support to OVC and their families. In 2009, WFP provided food support (cereals and lentils/beans) to a monthly average of 40,000 OVC. WFP also provides nutritional and food support to chronically ill people under Home Based Care. In 2009, WFP provided support to a monthly average of 14,500 people. This was complemented by support from UNICEF in terms of basic kits to 30,000 most vulnerable households;
- In partnership with USAID, MMAS is developing minimum standards of care and support for OVC;
- In partnership with Save the Children, MMAS developed a guide to the establishment and functioning of community committees for the protection of children;
- 531 community committees to support OVC currently exist;
- The creation of the National Council for Children has been approved and is in the process of being established;
- A database on OVC is being developed at MMAS;
- 204 police victim support centres established across the country.

Key challenges

- Defining and improving the quality standards of the six basic services provided to the most vulnerable children;

⁴⁵ HelpAge International. *Mind the gap: HIV and AIDS and older people in Africa*. 2008.

⁴⁶ This figure does not include all the civil society organisations; programs funded by the USG only have reached 161,934 OVCs in 2009.

- Improve capacity of MMAS at national, provincial and district levels and limits in terms of staff numbers, staff qualifications and budget allocations;
- Establishment of a comprehensive monitoring for reporting the number of children reached both through government and civil society.

Key Actions needed to scale-up Universal Access to care for OVC:

- Build the capacity of families and communities to respond to the needs of OVC and to provide access to basic services. The government policy promotes community-based, rather than institutional care for OVC;
- Strengthen psycho-social support, improve early childhood development programmes, and enhance gender-sensitivity in programming efforts;
- Enhance the capacity (both in terms of human and financial resources) of MMAS to scale up and deepen the range of social protection services, prepare a revised and harmonised National Action Plan for Children in conjunction with other line ministries and development partners, and monitor progress in terms of children reached;
- Ensure that an effective monitoring tool is in place to effectively and regularly measure the numbers of orphaned and vulnerable children reached;
- Ensure that the Food Subsidy Programme becomes an effective mechanism for social assistance reaching the most vulnerable children;
- Implement child grants for households supporting OVC as a measure to mitigate the impact of HIV as part of the Basic Social Protection strategy.

School attendance among Orphans and Non-Orphans

Background

In public schools, the enrolment ratios have continuously increased since the end of the civil war, both at primary and secondary education levels. At the primary level, in the period 1999 to 2008, the Gross Enrolment Ratio (GER) in EP1 increased from 85 per cent to 147 per cent, while in EP2 it increased from 22 per cent to 70 per cent. Over the same period, the Net Enrolment Ratio (NER) in EP1 and EP2 also increased substantially, from 50 per cent to 100 per cent in EP1 and from 2.5 per cent to nearly 16 per cent in EP2 (MINED, 2008). Access to secondary education exhibits a similar pattern, with the absolute number of students enrolled in ESG1 and ESG2 increasing almost six-fold between 1999 and 2008.

The massive increase in enrolment in primary education has been accompanied by a narrowing of the gender gap. The absolute gender gap in enrolment in EP1 decreased from a 25 percentage point difference in GER in 1999 to a 14 percentage point difference in 2008 (154 per cent enrolment among boys versus 140 per cent among girls). In terms of NER the gender gap is even smaller, with a Gender Parity Index of 0.96. However, overall GER and NER also vary by province. The NER in EP1, for example, ranges from 85 per cent in Inhambane Province to universal enrolment in Tete, Zambézia and Maputo Provinces.

Enrolment data only indicate whether a child is registered at school at the beginning of the school year, rather than whether a child is actually attending school. Though the gap between enrolment and completion rates gives an indication of whether or not children are attending throughout the school year, an analysis of attendance rates, as obtained from household survey data, provides a more informative picture of the situation, with trends in school attendance over time complementing trends in school enrolment. In sum, a significant number of children are enrolled in schools, but do not attend.

According to data from the 2008 Multiple Indicator Cluster Survey, primary school attendance among girls from the poorest quintile was only 70 percent while that of boys from households in the richest quintile was 95 percent. Girls are more likely to experience severe education deprivation than boys (13 and 10 per cent respectively). Attendance ratio is lower in girls in rural areas and children from households in the poorest wealth quintile.

Policy and Institutional context

The general policy environment in Mozambique is favourable to realisation of children's right to education. Education is guaranteed by the Constitution of Mozambique, which states that "education constitutes both a right and a responsibility of all citizens". The Constitution, along with additional legislation in force in the Republic of Mozambique, has further mandated that the State promote equality of access for all citizens. The United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child, to which Mozambique is a signatory, also establish education as one of the basic rights of all children.

The legal basis for Mozambique's National Education System, which defines the principles, roles and objectives of each sub-system of education, including primary education, was established by law in 1992 (Lei nº6/92). The primary education law does not state that education, including primary education, should be both compulsory and free, a requirement of the Convention on the Rights of the Child. School fees for primary education were abolished in 2004, but they remain in other levels of education.

The PARPA II discusses the relationship between education, poverty reduction and economic growth, with an emphasis on the role of girls' education in particular. The document also affirms education as a right. The strategies to shift primary education expenditure from parents to the State, including the abolition of school fees, provision of direct financing grants to schools and free text books, are clear demonstrations that the Government is committed to delivering progressively on fulfilling children's right to education.

The 2006-2011 Education and Culture Strategic Plan aims to strike a balance between extending access to universal primary education, increasing the expansion of the post-primary sector, and maintaining quality at all levels, as well as ensuring equity in terms of gender, wealth and amongst provinces and regions. The three key objectives of the 2006-2011 Education and Culture Strategic Plan are: (i) the expansion of access to basic education throughout all regions of Mozambique; (ii) the improvement of the quality of education services; and (iii) the strengthening of the institutions and the administrative framework for effective and sustainable delivery of education. In addition, there is an important emphasis on HIV prevention and mitigation through the school system.

Global public sector education financing increased at an annual average rate of 23 per cent between 2005 and 2009, resulting in total available resources of about US\$ 586 million in 2009, equivalent to a 6 per cent share of the Gross Domestic Product. Expressed as a share of the total Government budget, education spending stood at 18.5 per cent in 2009, illustrating the priority given to education expenditures by Government. The education sector increased its expenditures by about 68 per cent between 2004 and 2008. In terms of expenditure share, the sector's actual spending exceeded the amounts proposed in PARPA II. For instance, the share proposed in PARPA II for 2008 was 19 per cent, while the sector actually spent 24 per cent. In general, the execution rate of the education sector has been good (90 per cent) compared to other sectors.

UNGASS Indicator #12: Current school attendance among orphans and among non- orphans aged 10–14

Despite the rapid increase in the enrolment rate in recent years, there are still nearly 600,000 children out-of-school in Mozambique and these often comprise the most marginalised and vulnerable children. These children are the victims of severe education deprivation. The education deprivation indicator is defined as the proportion of children between 7 and 18 years of age who have never been to school and are not currently attending school. Twenty per cent of children living in households in which the head-of-household had received no education experience severe education deprivation in Mozambique. This compares to only two per cent of children living in households in which the head-

⁴⁷ various sources including Sal & Ximungo, MINED 2009, etc

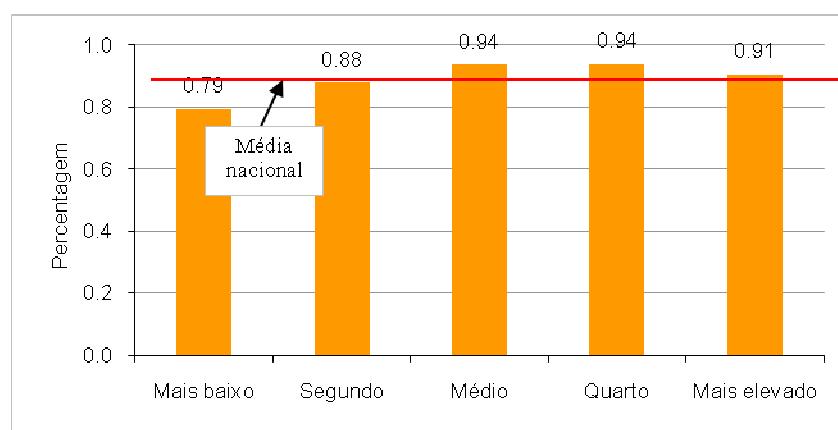
⁴⁸ Kelly B, 'Trends in Child Poverty in Mozambique. A deprivations-based approach', Ministry of Planning and Development, Maputo, 2009.

of-household attended secondary level education or higher. Children living in rural areas are three times more likely to experience severe education deprivation (15 per cent) than urban children (5 per cent). Severe education deprivation is strongly correlated with household wealth. Children from the poorest households are almost ten times more likely to experience severe education deprivation than children in the wealthiest households. Severe education deprivation is highest in Tete province (22 per cent) where children have the lowest primary school completion rate, at 5 per cent.

There is no evidence of overall severe education deprivation between Orphans and Vulnerable Children and non-orphans, with a school attendance ratio of 0.96 for boys and parity for girls . However, there is a difference between the school attendance rates of double orphans compared to non-orphans. Male double orphans and female double orphans have a school attendance ratio to their non-orphaned peers of 0.90 and 0.92 respectively. This is in keeping with the 2008 Multiple Indicator Cluster Survey finding that 90 per cent of the support received by households with OVC related to free basic educational support.

The DHS in 2003 found that only 62% of 10-14 year-old maternal orphans were attending primary school, compared with 76% of paternal orphans and 78% of non-orphans. The level of education of a child’s parents is also an important factor.

The attendance ratio among children aged between 10 and 14 whose father and mother have both died is 77 per cent, and this is lower than that of children of the same age group whose parents are alive and who are living with at least one parent (87 per cent). The difference between orphan and non-orphan school attendance is greater in urban areas (82 per cent against 92 per cent, respectively) than in rural areas (77 per cent against 84 per cent, respectively). Maputo City is the province with the greatest difference in attendance ratios between orphans (79 per cent) and non-orphans (98 per cent).



Source: MICS, 2008

Figure 23: Primary school attendance, ratio between double orphan and non-orphans, by wealth quintile

Key Achievements

- Through partnerships between multilateral and bi-lateral donors with civil society organisations, 800,000 school-aged OVC were integrated into school, and 350,000 children were provided with school materials to facilitate their retention in school;
- Through the Child-friendly Schools programme implemented by the Ministry of Education and Culture with support from UNICEF over 8,000 OVC were integrated into primary school and approximately 75,000 provided with a package of school materials and clothing;
- Over three million children have received birth certificates over the period 2008-2009. Children in Mozambique are required to produce a birth certificate to enter school, though this rule is only enforced at the time of admission to grade five examinations;
- Coordination between the Ministry of Education (MINED), Registration entities and the Ministry of Women and Social Action (MMAS) has been strengthened through the Technical Working Group for Orphaned and Vulnerable Children and other *fora*.

Key Challenges

- Significant inequalities persist in terms of access to education, based for example on gender, the level of poverty and parental education and where the child lives.
- Double orphans have lower enrolment rates than other groups; more data is needed on the attendance of school of OVC compared to non-OVC
- Stigma and discrimination around HIV and AIDS still persist in community level. This can result in the most vulnerable children being excluded from school on the pretence that there are no vacancies or due to discrimination at school.

Key Actions needed to scale-up Universal Access of orphans and vulnerable children to Education

- Families caring for Orphaned and Vulnerable Children need to be aware of the right of every child to a free primary education;
- Ensure MINED has enough resources to accommodate every child in school in all provinces, perhaps through the reinstatement of the OVC Education Grants; to improve school infrastructure; and to have enough qualified teachers;
- Continue to emphasise the implementation of activities by MINED and MMAS related to stigma and discrimination around HIV;
- Further strengthen the coordination between MINED and MMAS at local levels to ensure OVC school attendance rates are at parity to non-OVC;
- Facilitate OVC access to secondary schools through enhanced access to poverty certificates.

Indicator #12: Current school attendance among orphans and non-orphans aged 10–14

Table 26: Current school attendance among orphans and non-orphans aged 10-14, by sex

Method of Measurement	All 10-14	Disaggregated Values	
		Sex	
		Males	Females
ORPHANS			
Numerator: Number of children who have lost both parents and who attend school	218	113	104
Denominator: Number of children who have lost both parents	276	144	133
Indicator Value (Percent)	77,3%	78,7%	78,3%
NON-ORPHANS			
Numerator: Number of both of whose parents are alive, who are living with at least one parent and who attend school	5 079	2 573	2 500
Denominator: Number of children both of whose parents are alive who are living with at least one parent	5 872	2 941	2 931
Indicator Value (Percent)	86,5%	87,5%	85,3%

An increase in the school attendance among orphans from 62.6% in 2003, up to 77.3% in 2008 was registered.

Home-Based Care

Background

Home-Based Care (HBC) Programs aim to improve the quality of life and increase the lifespan of people living with HIV (PLHIV) and other chronic illnesses through community HBC initiatives, in coordination with the National Health System.

In 2002, there were fewer than 5 HBC programs in the country. At this time, most programs focused on visiting patients to provide emotional and spiritual support and lacked linkages to health facilities for testing, prophylaxis and treatment of opportunistic infections (OIs), ART and tuberculosis (TB). Subsequently, the Ministry of Health (MISAU) created a HBC component within its HIV and AIDS Program to play a regulatory role while programs are implemented by NGOs. In 2004, HBC was included as one of the six key areas of intervention in the Health Sector Strategic plan for STI/HIV/AIDS and as an important adjunct to the Treatment Area of the National Multisectoral Strategic Plan for HIV and AIDS (PEN II). Planned expansion together with ART, OI treatment and other HIV services strengthens the continuum of care and allows for the provision of more comprehensive services to PLHIV.

HBC in Mozambique emphasizes clinically related services such as adherence support, basic home nursing care, treatment/prophylaxis or referral for key symptoms, and management of medication side effects. Some programs serve as a link to nutritional and food support and medication adherence. Volunteers refer individuals and vulnerable family members (including orphans and vulnerable children) to existing formal or informal services related to socioeconomic needs such as food support or cash grants through Ministry of Women and Social Welfare (MMAS), legal support for issues related to protection against violence and succession planning, educational access, prevention and psychological support (disclosure and bereavement support). Volunteers are also trained promote respect for human rights and to address community stigma.

The target groups for HBC services are HIV-infected individuals in the World Health Organization (WHO) clinical Stages 3 and 4 of HIV, and individuals with other chronic illnesses. These include patients with problems related to, or at risk for, medication non-adherence. These activities are carried out by community programs most of which have volunteers receiving an incentive, an amount set by the MISAU at between 60% and 100% of the national minimum salary. However implementing partner incentives do not generally align with the pay scale defined by MISAU, which may impact quality of services delivered across programs.

Achievements

The HBC program in Mozambique has created a national policy that defines what constitutes HBC, monitoring and supervision tools, and a management and coordination structure consisting of provincial and district level Focal Points. All provinces currently have HBC services in place. Because of the need for rapid expansion of HBC and the high demand for training, the MISAU has delegated

⁵⁰ National Strategic Plan for STI/HIV/AIDS – health sector, 2004-2008

responsibility for the training of trainers of HBC volunteers to ANEMO (National Mozambican Nurses Association) in 2006. Future plans include forming the Mozambique Palliative Care Association, a Mozambican branch of APCA (African Palliative Care Association).

In 2009 the Ministry of Health launched a Food Basket program, targeting PLHIV who have been clinical assessed as malnourished. The program was launched in all provincial capitals, reaching approximately 3,000 beneficiaries. The MoH expects to expand this program to district level health facilities in 2010.

The MoH is also in the process of revising all training curriculum related to nutrition, in an effort to improve assessment and treatment at community level and at health facilities.

In addition, government is developing a multisectoral response to combat chronic malnutrition, which will also strengthen nutrition interventions under the Home-based care component.

Table 27: Number of Health Facilities providing HBC services and number of clients served from 2006 to 2009 (Jan-March)

HBC	Health Centres linked with HBC				Patients Served			
	2006	2007	2008	2009 (Jan-Mar)	2006	2007	2008	2009 (Jan-Mar)
PEN Targets	200	200	250	250	67,371	107,238	143,776	95,000
Total achieved	156	180	200	200	48,000	88,303	99,122	108,626

[Source: MISAU, 2009]

MISAU and MMAS collaboration: Integrated Care and Support

In 2008 and 2009, training activities were held in 70 districts, in four provinces, but many staff members were shifted to other areas. For this, there is a need for more nurses to be trained to support HBC management at the district level.

Challenges to scale-up of Universal Access to Care and Support

Scaling up community care and social support services while maintaining minimum quality standards, in coordination with ART and OI treatment expansion, requires functional coordination and monitoring systems which is challenging in Mozambique's Human Resource constrained environment. Challenges include the following:

- Continued scale-up of HBC given rapid expansion of ART.
- Functional two-way referral systems between health centres and community services
- Inconsistent application of cost-effective interventions such as cotrimoxazole prophylaxis, integrated TB-HIV services
- Lack of transportation;
- Defining/standardizing psychosocial support at point of service delivery;

- Poor integration of nutrition interventions in HBC (education and counselling).
- Absence of strategic document to guide priorities for the next five years
- Caring for caregiver strategies to address the emotional, physical and material demands of caring for the chronically ill.
- Functional supervision, management, and coordination structures at all levels.
- Absence of comprehensive mapping of HBC services to identify gaps
- Lack of clear guidance with on the alignment of HBC and palliative care
- Lack of a standardized and functional M&E system for community care linked to the National Health Information System.

Older People

Policy and institutional context

The Law on defense of the rights of PLHIV and combat of stigma and discrimination recognizes, on its preamble, that the epidemic affects all groups regardless the age, race, and sex. Articles 7 and 10 highlight older people's vulnerability to HIV and AIDS and their rights to receive support from family and to be cared for, apart from other rights foreseen in the Constitution and other laws.

Additionally, the National Policy, its strategy for implementation and the National Plan for Older People have the following priorities: a) carrying out of studies for the evaluation of the effects of HIV and AIDS on older people; b) Active involvement of older people in HIV and AIDS prevention and combat programmes; c) Provision of counseling and psychosocial support to older people who have lost their children.

With regard to PEN III, which has recently been drafted with participation of civil society organizations, the inclusion of older people as one of the vulnerable risk groups for HIV and AIDS was an important step in seeking universal access to treatment and HIV prevention and care. Like other age groups, older people should benefit from HIV and AIDS services and information on primary and secondary prevention, and access to treatment.

Monitoring of Indicators related to older people

While several national laws and policies do include older people as a risk group, there is no data available on the incidence of HIV and AIDS for this group. In the analysis of the national epidemiological profile of the PENII, no mention was made to the age group from 50 years and above. All data focuses on the age group from 15 to 49 years old. This makes it difficult to capture the real picture of how the epidemic affects the entire population and older people in particular; how many older people are infected; how many are receiving ART and how many went for testing. With a view to a more holistic response, PENIII draft proposes to include data from the age of 15 years and above, without having an upper age limit.

Challenges

The main challenges related to HIV and AIDS and older people are as follows:

- Lack of real data on the impact of HIV on older people as a result of no data collection for the over 50s;
- Counseling and testing services are in general geared towards service provision for younger people and not prepared to receive older people and provide them with the necessary information, and above all, to make them feel confident to speak openly;
- Sensitization and prevention education programmes are mostly destined to younger age groups;
- Shortage of the number of organizations working for the promotion and defense of older people's rights.

Recommendations

- There is an urgent need to have disaggregated data on the incidence of HIV and AIDS broken down by age groups: Youth (15-24 years); adults (25 a 49 years); older people (50 years and above);
- Counseling and testing units should be prepared to receive people of all age groups. This can be achieved through the carrying out of training of young counselors for the youth and older counselors for older people;
- In order to guarantee the inclusion of messages destined to older people, there is a need to consult and sound out organizations dealing with older people's rights during carrying out of studies for the evaluation of the effects of HIV and AIDS on older people; b) Active involvement of older people in HIV and AIDS prevention and combat programmes; c) Provision of counseling and psychosocial support to older people who have lost their children.

V. Best practices

Behaviour Surveillance Survey (BSS) in Mozambique

The first Behaviour Surveillance Survey in Mozambique is underway. After having started in 2008, its second phase will be finished in 2010 and the final results are expected by the end of 2011. The BSS's aim is to monitor and evaluate the baseline information on HIV-related knowledge, attitudes and behaviours among the main most-at-risk groups in Mozambique. The survey will include a biomarker so as to estimate HIV ser prevalence among these groups (BSS+).

Blood safety

This year, the Blood Transfusion National Program started to test all the blood units for hepatitis C. Thus, the blood national service achieved the World Health Organization recommended goals for poor countries or with scarce resources. Therefore, this year all the blood units will be tested for HIV, syphilis, hepatitis B and hepatitis C qualitatively increasing blood safety in the country.

Since 2009, all blood banks from central, provincial and general hospitals test for HIV with ELISA system. The use of ELISA Geenscreen system reduces the HIV window period (from 22 days with rapid tests, to 16 days with Elisa). Having been tested approximately 70% of blood units in the central, provincial and general hospitals; it can be considered that blood safety has significantly improved relatively to HIV.

Child Health Card

The updated version of the Child Health Card was launched on the 1st of June 2009 – International Child Day. This update, led by the MoH with support from partners includes several new components on newborn health, nutrition and immunizations, as well as a component containing HIV related essential information. In 2008, approximately 32% of an estimated number of 145,000 HIV positive pregnant women have received prophylaxis with ARV and only 14% of the babies exposed to HIV were tested when aged 18 months. These results show the need to improving follow up of these children, so that they can be identified and referred for treatment and care, as early as possible.

The updated Child Health Card includes HIV related information, namely on the exposure state to HIV, ARV prophylaxis to the mother and the newborn, cotrimoxazole prophylaxis, HIV tests, and infected children on ART. A transversal study aimed at evaluating the acceptability of the inclusion of this information on the Child Health Card was implemented amongst health workers, mothers and key informants at community level. Health workers were of the opinion that the inclusion of this information was important and the vast majority of mothers, as well as community informants thought this inclusion was acceptable. More importantly, was the general feeling that this information would improve the follow up of children exposed to HIV. The updated Child Health Card is currently being used in every health facility in the country.

Study on vulnerability and risk of infection by HIV among men who have sex with other men, in Maputo city – Lambda, PSI/Mozambique, Pathfinder, UNFPA

The shortage of information on the composition of the social group of men who have sex with other men (MSM), their sexual practices, their perception of risk of infection and their conditions of access to health services underlie the conduction of this research with view to contributing to the designing of prevention strategies and actions aiming specifically to reduce the vulnerability of MSM in the face of HIV. The study was conducted in Maputo city, and qualitative methodologies were used for data collection and analysis.

From the analysis of data produced in interviews with 45 MSM are highlighted the findings summarized as follows:

- Heterogeneous profile of the group, in terms of age, level of education, occupation, religion, place of residence, sociability, nature of affective and sexual relations practiced and role performed in these relations;
- Shortage of information on prevention and fight against HIV specifically formulated for MSM;
- Difficult access to public health services; discrimination and hostility from the side of health providers.
- General knowledge of the risk and measures of STI and HIV prevention; therefore, there was found a major inconsistency in the practice of this measures, and the following were pointed out to be the reasons: the alleged trust in the partner, the belief that oral sex and anal sex practices are safe and the belief that it is possible to see the signs of infection by HIV with naked eye and, consequently, decide to use or not the condom;
- General unawareness of the importance of water-based lubricant;
- Some sexual practices that increase the vulnerability of MSM to infection by STI and HIV: transactional sex; sex in group; and sex under the effect of alcohol and other drugs.
- Some MSM also have sex with women, which broadens the sexual intercourse network and, ultimately, the possible circulation of HIV for the general population.

The general conclusion of the study is that MSM in Maputo city live in a context of multiple vulnerabilities that expose them to the risk of infection by HIV. The inefficiency of the current prevention and care programs to meet the specific needs of MSM and the social discrimination to which they are subject, cause them to remain hidden and therefore, deprived from demanding their right to information and health services that include their specificities.

HIV project within prisons

UNODC implements in Mozambique a HIV project in prisons, which aims to build capacity of the government and other stakeholders to plan, implement and monitor projects/programs about HIV prevention, Treatment, Care and Support in prisons, in order to: i) reduce the transmission of HIV in prisons and; ii) Reduce HIV and AIDS-related mortality in prisons.

UNFPA, in partnership with Pathfinder and Ministry of Justice, develops *Projecto Inclusão*, which aims at scaling up HIV and STI prevention practices among prisoners and prison system employees, through peer education methodology, as well as increasing the technical capacity of the government to design, implement and monitor HIV prevention projects in prison settings.

To date, 100 peer educators have been trained in four prison facilities in the country, which offer health education services, promotion of rights, and referrals for health care for about 30% of the prison population in the country. Through collective activities such as talks, presentations of role plays and games and sports, accurate information about prevention of HIV, STI, TB and malaria are disseminated with support from the provision of educational material. Are also being developed health libraries in the prisons that participate of the project. The group of peer educators acts in close partnership with the health services available in prisons to increase the demand for counseling and testing in health, as well as diagnosis and treatment of STI and other diseases.

VI. Major challenges and remedial actions

MAJOR CHALLENGES REPORTED IN 2007	PROGRESS MADE UP TO DATE
POLITICAL AND FINANCIAL SUPPORT	
<p>The heavy reliance on external funding raises questions of sustainability of HIV and AIDS programmes in Mozambique.</p>	<p>Advocacy at political and international level has been implemented to reduce the resource dependency on external aid. However, NASA continues to show that the HIV national response still relies heavily on external aid (around 95%).</p>
<p>NASA institutionalisation</p>	<p>The second NASA for the years 2007 and 2008 was conducted in 2009 and beginning of 2010, with an active leadership and participation of CNCS. Aiming at establishing the basis for the NASA institutionalization, students from the Faculty of Economy, and staff from CNCS participated in this exercise. Although informants were sensitized by different channels, there is still a weak response to provide expenditure data timely. This phenomenon brings about delays to complete the whole process, taking more than five months for data collection. Thus, institutionalization of NASA needs to be seen in a two ways perspective, and not only from the Government side.</p>
<p>Continued investment in information, education and communication, have been uncoordinated, fragmented and with too much emphasis on material production. This has led to the lack of performance on communication.</p>	<p>In 2009, the CNCS implemented the process of realigning its functions as the national structure for coordination of the response to HIV. It was defined that CNCS must concentrate its action on coordination, communication and M&E activities, abandoning its function of financing structure.</p>

MAJOR CHALLENGES REPORTED IN 2007	PROGRESS MADE UP TO DATE
HUMAN RIGHTS	
<p>The 5/2002 law approved in 2002 protects PLHIV in the workplace but does not make discrimination a punishable offence hence the enforcement of this law remains weak.</p>	<p>The Bill on “Defending Human Rights and the Fight against the Stigmatisation and Discrimination of People living with HIV and AIDS” is a major step towards the strengthening of the policy context for HIV prevention in the country. The Bill reflects the commitment of the national government and civil society organizations to address HIV and AIDS-</p>

<p>A comprehensive law against stigma and discrimination has been developed and is still waiting for approval by parliament.</p>	<p>related issues in Mozambique, and provides a comprehensive and rights-based framework. The Bill, voted by the Parliament in 2008, largely conforms to the International Guidelines on HIV and AIDS and Human Rights of 2006.</p>
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<p>MAJOR CHALLENGES REPORTED IN 2007</p>	<p>PROGRESS MADE UP TO DATE</p>
<p>CIVIL SOCIETY</p>	
<p>Fragmented civil society voice</p>	<p>CSOs and CBOs have shown more active participation in policy, coordination and M&E mechanisms, Global Fund, PEN III development, Prevention Strategy and UNGASS. Some partners (Bilateral and Multilaterals) have conducted training to NGOs on capacity development. In addition, the different networks of NGOs have extended country wide.</p>
<p>Low levels of meaningful involvement in national coordination mechanisms</p>	<p>Civil society is represented in different structures of national coordination, such as the Reference Group for Prevention, Country Coordination Mechanism for the Global Fund, Partners Forum. Furthermore, the dialogue with different government sectors involved on the response has improved.</p>
<p>Need to scale up interventions across the national response, (4) limited organizational capacities;</p>	<p>It is recognised that civil society is providing HIV programmes/services on a large scale and especially in the areas of home-based care, reduction of stigma and discrimination as well as programmes for OVCs.</p>

<p>MAJOR CHALLENGES REPORTED IN 2007</p>	<p>PROGRESS MADE UP TO DATE</p>
<p>BLOOD SAFETY</p>	
<p>Coverage is limited to the same extent as access to health facility-based services in Mozambique in general is limited to an estimated 40-50%, with many remote and rural areas having limited or no access to facility-based health services.</p>	<p>The MoH is making efforts to increase the coverage of the blood bank's services, increasing from 111 in 2004 up to 135 in 2007 and 141 in 2009. Also, the number of units of blood collected has increased from 79,925 in 2007 up to 91,818 in 2009. In the same way, quality assurance increased from 35.5% up to 69.5%, respectively.</p>
<p>Many emergency blood transfusions occur outside blood transfusion centres.</p>	
<p>Health facilities without blood banks are sometimes still obliged to carry out a blood transfusion without having the possibility of testing.</p>	

MAJOR CHALLENGES REPORTED IN 2007	PROGRESS MADE UP TO DATE
PREVENTION OF MOTHER TO CHILD TRANSMISSION	
<p>Reduce the loss to follow-up of women and children due to (fear of) stigma and discrimination, insufficient human resources to pursue clients who dropped out and insufficient family and community support.</p>	<p>The number of health facilities that provide PMTCT services was rapidly scaled up from eight in 2002 up to 386 in 2007, 744 in 2008, and 832 in 2009, representing coverage of 76.3% of the 1,090 health facilities with antenatal care services.</p>
<p>Increase the number of pregnant women receiving ART for their own health.</p>	<p>A growing number of pregnant women have received ART in the last years: from around 950 (7% of all pregnant women that received ARV for PMTCT) in 2006, it has increased to 3,561 (8%) in 2007, 6,388 (14%) in 2008, and 7,791 (11%) in 2009.</p>
<p>Ensure sufficient qualified human resources.</p>	<p>At the inception of the PMTCT programme, in 2002, the majority of services were concentrated in health facilities of provincial capitals. Nowadays, PMTCT interventions are integrated into antenatal care services in all districts, including peripheral health facilities.</p>
<p>Strengthen the coordination between PMTCT and other HIV prevention and treatment programmes.</p>	<p>Following the update of global guidance to PMTCT in 2006, the Ministry of Health issued national guidelines introducing several key policies: Provider-initiated (“opt out”) testing to be offered in both antenatal care and maternity settings; blood samples for CD4 counts to be drawn in the antenatal care facility, thereby avoiding the need for women to visit a different service point for this procedure; DNA PCR testing for HIV exposed children under 18 months of age, using the collection method “<i>Dried Blood Spot</i>” (DBS).</p>
<p>Need for alignment and consistency in protocols and guidelines as well as planning.</p>	<p>A revised version of the Child Health Card was launched in 2009. This will improve follow up of HIV exposed infants so that HIV positive children can be identify and enrolled into care and treatment as early as possible.</p>
<p>Ensuring and strengthening the quality of maternal and child health services in general, which affects quality of PMTCT services ;</p>	<p>The establishment of “mother-to-mother support groups” by health facilities as a strategy towards promoting pregnant and lactating HIV positive women to adhere to</p>
<p>Ensure support from family members, in particular men and mothers-in-law;</p>	<p>The establishment of “mother-to-mother support groups” by health facilities as a strategy towards promoting pregnant and lactating HIV positive women to adhere to</p>

<p>Avoid missed opportunities for PMTCT by ensuring delivery of quality PMTCT services at identified sites;</p>	<p>Prevention of Mother-To-Child Transmission is a MoH worry. A study has documented in detail the various intervention models of groups of psychosocial support for PMTCT attendees, collected training and pedagogic materials existing in Mozambique and other African countries, and issued recommendations for filling gaps. In 2008, guidelines were developed following a nationwide mapping of this intervention.</p>
<p>Increase institutional deliveries for HIV+ women and ensure post natal prophylaxis for women and newborns in non institutional delivery settings.</p>	<p>low coverage of institutional deliveries – 58% according to the MICS 2008 – number of children that received ARV prophylaxis is still limited – in 2008 and 2009, they were 38,822 (66.7% of the women that tested HIV positive in the same period) and 41,266 (58.7%), respectively.</p>
<p>Ensure optimal infant feeding practices for HIV exposed children, both before the age of 6 months and after that.</p>	<p>The MoH has adapted the guidelines on infant feeding in the context of HIV and PMTCT to the international guidance. Thus, national guidelines recommend that HIV positive mother breastfeed exclusively up to six months, followed by weaning, should the maternal milk's substitute be acceptable, viable, affordable, sustainable and safe.</p>
<p>Strengthen monitoring and evaluation including the availability of M&E tools that incorporate all aspects of the PMTCT programme and capacity at all levels to use these tools for service delivery improvement.</p>	<p>The MoH collaborates with several partners and funding organisations for the PMTCT program implementation. To ensure a good coordination among the partners, the MoH has set up a technical PMTCT Task Force. The group meets regularly under the leadership of the MoH and discusses programmatic issues and normative policies, as well as the progress in the implementation, challenges and lessons learnt.</p>

<p>MAJOR CHALLENGES REPORTED IN 2007</p>	<p>PROGRESS MADE UP TO DATE</p>
<p>COUNSELLING AND TESTING</p>	
<p>Increase CT access for couples and families, with particular attention on support to discordant couples.</p>	<p>The number of people 15 years old or older, attended in diverse units for Counseling and Testing on Health (CTH) increased from around 378,000 in 2006 to about 530,000 in 2009.</p>
<p>Expand access of early HIV diagnosis through door-to-door counselling and testing specially in high prevalence areas.</p>	<p>In 2009, nearly a quarter of a million people was tested for HIV through Community AT</p>

<p>Improve policies for increasing access to counselling and testing among Most At Risk Populations.</p>	<p>The MoH bet in this area is still the expansion of CTH services in the National Health. Aiming at popularization of these services with quality, MoH defined priority activities:</p> <ul style="list-style-type: none"> - Training of all health staff and counselors in the new approach on CTH; - Training for all health professionals in rapid HIV tests; - Use of <i>mass media</i> to disseminate publicity about CTH; - Distribution of strategic, political guidelines and also CTH implementation guidelines in the community; - Creation of educational material. <p>Counseling and Testing in the Community is a strategy that aims at contributing to increase the access of Health Services in the communities through innovative modalities. MoH introduced this activity to promote preventive actions in the community, including related activities with HIV in such a way that will increase the effectiveness and acceptability of testing, and also will reduce the stigma that might be generated with isolated actions.</p>
<p>Increase the number of counsellors at CT sites as well as in clinical settings deploying trained multi-task counselors.</p>	
<p>Expand Provider Initiated Counseling and Testing in clinical setting paying special attention to TB, STI and paediatric clinics.</p>	

MAJOR CHALLENGES REPORTED IN 2007	PROGRESS MADE UP TO DATE
	PREVENTION
<p>Strengthen evidence on drivers of the epidemic and current response</p>	<p>The Modes of HIV Transmission Study and HIV Prevention study was finalised in 2009, providing evidence on the main drivers of the epidemic in the country, and providing a basis for the situation analysis for the PEN III.</p>
<p>Strengthen capacity of key stakeholders to translate evidence into improved national prevention strategies, plans and budgets</p>	<p>A training of the national networks of SCOs, including of PLHIV was held, related to the evidence that document the epidemiologic situation and the main drivers of the epidemic in the country. This training was part of a support package for CSOs for participation in the formulation of the PEN III.</p>
<p>Strengthen the national HIV-prevention strategy and scale-up a holistic approach to socio-culturally sensitive communication, with clearly defined budgets for communication beyond IEC materials, based on existing communication strategy.</p>	<p>The Council of Ministers of Health endorsed a National Prevention Strategy in December 2008; and operationalized and included in the Plan of Action at provincial level in 2009. Prevention was not adequately addressed in the National AIDS framework and there was an increasing need to develop a strategy in order to focus response and implementation efforts. The HIV Prevention Reference Group's main task is to plan and coordinate a scaled-up evidence based, locally appropriate and comprehensive prevention response.</p>

Scale-up effective prevention measures.	In the context of the Strategy for Acceleration of Prevention, a series of interventions have been implemented for the last two years, such as the national campaign for sensitisation on multiple and concurrent partnerships, IEC for youth and adolescents in schools and out-of-school, and wider scaling up of condoms.
Training of school directors in the life skills methodology and importance of life skills for students.	<p>School directors were trained in life skills based education, improving their management, coordination and support of school initiatives.</p> <p>Life skills based education was implemented in 13,000 primary and secondary schools in 2009, covering children and youth aged 10-18 years</p> <p>Over four million pupils in secondary schools were reached with life-skills based education and three million in primary schools.</p>
Increased quality training of teachers on HIV and AIDS and life-skills approach.	90,000 teachers were trained in HIV prevention in 2008.

MAJOR CHALLENGES REPORTED IN 2007	PROGRESS MADE UP TO DATE
UNIVERSAL ACCESS TO CONDOMS	
Female condoms are generally not available in either the public or the private sector, and few NGOs distribute them.	Female Condoms: - Foresight 2009: 1.3 Millions
The coordination between condom distribution and prevention must be ensured because condoms without messages on behaviour change or messages without condoms with both have limited effects. (World Bank Supervisory Mission MAP, Aide Memoire, March 2007).	Implementation of focussed campaigns addressing key drivers of the epidemic (Multiple and Concurrent Partners and condom use), targeting the adult population as well as young people.

MAJOR CHALLENGES REPORTED IN 2007	PROGRESS MADE UP TO DATE
PREVENTION PROGRAMS FOR MARPS	

<p>Partners alongside MoH and other Mozambique agencies need to prioritize MARPS groups within the context of Mozambique.</p> <p>HIV prevention activities need to focus both on general prevention but also needs to include targeted MARPS prevention strategies.</p>	<p>Within the National Reference Group for Prevention, a working subgroup was established to address, in a structured manner, the response to HIV within most-at-risk populations. The group comprises members of government institutions and international and local partners involved in the designing of policies, strategies and/or in implementation of interventions targeted to different groups of most-at-risk populations.</p>
<p>Conduct sub-national data collection and estimations disaggregated by age and sex regarding HIV prevalence amongst MARPS groups.</p>	<p>Not done yet. It is foreseen to start the process in 2010 and conclude in 2011.</p>
<p>Addressing most-at-risk populations is difficult therefore a clear understanding of both the epidemiological situation and behavioural context of MARPS needs to be understood by all agencies working with MARPS</p>	<p>Studies implemented for better knowledge about most-at-risk populations:</p> <ul style="list-style-type: none"> • I-RARE, 2009. -RARE (2009): Risk of HIV in Sex Workers and in Drug Users in the Cities of Maputo, Beira, Nacala, Mozambique. • Study on vulnerability and risk of infection by HIV among men who have sex with other men, in Maputo city – Lambda, PSI/Mozambique, Pathfinder, UNFPA
<p>Behaviour Change Communication efforts need to include specific interventions and materials targeting MARPS.</p>	<p>Peer education, distribution of educational material, counseling and testing for STI and HIV, are some of the activities ongoing in some prison facilities of the country, covering about 30% of the prison population</p>

MAJOR CHALLENGES REPORTED IN 2007

PROGRESS MADE UP TO DATE

ART FOR ADULTAS

<p>Integration of HIV and AIDS treatment services with other essential services, especially TB and reproductive health continues to be a practical and logistical challenge. Referral systems remain weak.</p>	<p>As a part of the effort to strengthen TB-HIV collaborative activities, in 2009 the MoH began the process of updating the HIV care and treatment patient monitoring and reporting tools. In particular, these new tools will facilitate the monitoring of the 3 I's.</p> <p>Practical and logistical challenges remain in relation to the linkages between HIV and AIDS treatment services and those of the TB program. Collaboration between the two programs has improved, but referral systems remain weak and implementation of the 3 I's has not yet been taken to scale.</p>
<p>Educational programs on ART aimed at ensuring adherence are still weak.</p>	<p>The Prevention Strategy recommends improved collaboration between the Ministry of Health and Civil Society organizations working in communities in order to improve adherence to treatment.</p>
<p>Human resource constraints across the sector continue to be a major challenge to scaling-up services at central and provincial levels, both in terms of numbers and capacity, at management and implementation levels.</p>	<p>Task-shifting of responsibilities from doctors to <i>Técnicos de Medicina</i> was done in an effort to respond to the growing number of people initiating ART and to facilitate the overall expansion and decentralization of the national health care system.</p>
<p>Ensuring an adequate balance between the urgency to scale-up and the need to guarantee safety and quality of interventions, particularly as numbers on treatment increase significantly in the lower level facilities, initiated and followed by other cadres of health staff, and numbers of those on treatment for some time move onto more complex regimens.</p>	<p>While decentralization of services is necessary to ensure equity of access to services, strengthen referral systems and leverage existing resources to improve the overall health system, it also carries the risk of diminishing the quality of care provided if carried out without adequate training, supervision or ongoing quality improvement. To address this concern, the <i>Strategy for the Acceleration of HIV Prevention</i> calls for a shift in focus on geographic expansion to improvements in the quality of services provided. In particular, this approach involves the scale up of HIV quality improvement activities (HIVQUAL), clinical mentoring, integrated site supervision, and the updating of guidelines, and operational manuals to further facilitate the integration of ART services into primary health care.</p>

<p>Providing timely and quality data continues to be a barrier to improved planning and budgeting, and is essential to be able to demonstrate results and keep all partners engaged in the Ministry of Health-led systems-strengthening approach to HIV and AIDS.</p>	<p>The health information system (HIS) that allows for the collection, aggregation, analysis, and dissemination of relevant care and treatment data was centralized at the Ministry of Health until the end of 2007, a task which became increasingly difficult given the rapid expansion of treatment sites and beneficiaries between 2006 and 2007. Given these increasing demands on the Ministry of Health's HIS at the central level, the HIS was decentralized from the central level to the provincial and district levels in 2008 with training of relevant staff from all provinces on data entry and monitoring and evaluation standard operating procedures.</p>
<p>Logistics will continue to be a challenge as scale-up continues beyond the current level in terms of laboratory capacity, drug supply and management, and monitoring and evaluation.</p>	<p>The decentralization of services in recent years many primary level health facilities put major challenges for the logistics for guarantee quality of care.</p>

MAJOR CHALLENGES REPORTED IN 2007	PROGRESS MADE UP TO DATE
<p>Increasing awareness on paediatric AIDS in families and increasing the demand for services for infected children, including early infant diagnosis.</p>	<p>PEDIATRIC ART</p> <p>The number of children under 15 years of age on treatment in the country increased from less than 300 in 2003 to 13,510 by the end of 2009. This represents coverage of 19% of children considered eligible for ART by the Ministry of Health, which are based on projections calculated using Spectrum.</p> <p>Antiretroviral treatment for children is progressively being brought closer to the people and is expanding across the country: in 2006, 68% of all children receiving treatment were living in the four southern provinces of the country, and 55% were living in Maputo City. In 2008, the southern provinces accounted for 56% of all children receiving ARVs and Maputo City accounted for 33%. Similarly, in 2009 the southern provinces represented 57% of all children in TARV, with Maputo representing 30%.</p>
<p>Improving the logistics for PCR tests to speed up the process.</p>	<p>In 2009, following adoption by Mozambique of the new Pediatric ART guidelines and the</p>

Reducing the time from HIV diagnosis to the initiation of ART and strengthening the linkages between services to reduce the dropouts and missed opportunities.	expansion of Early Infant Diagnosis through the installation of two PCR machines in the northern and central regions of the country.
Building capacity of health staff to use IMCI algorithm to identify children with suspected infection.	The integrated management of neonatal and childhood illness (IMNCI) protocols were updated to include HIV and AIDS, and dissemination took place in 2008.
Enrolling children in peripheral health facilities with few trained staff: once the <i>técnicos</i> (and possibly nurses) are able to prescribe paediatric ART, training needs to be enhanced and include hands on experience and close mentoring. <i>Técnicos</i> will need to be guided by clearly established algorithms to ensure quality of care and timely referral to a physician or higher level facility if needed. Peripheral facilities are also constrained in terms of the availability of psychosocial support.	Plans are now in place to train <i>Técnicos de Medicina</i> in paediatric ART.
Overcoming the reluctance and lack of confidence among health workers to enrol children on ART: better mentoring and regular supportive supervision needed.	
Timely provision of quality data on paediatric ART and related information, e.g. numbers of children tested and HIV+, number of children receiving cotrimoxazole, etc, especially at peripheral level.	Pediatric ART coverage increased to 13,510 children under 15 years of age, by the end of 2009, from 9,393 in 2008. This represents coverage of 19% of children considered eligible for ART by the Ministry of Health

MAJOR CHALLENGES REPORTED IN 2007	PROGRESS MADE UP TO DATE
TUBERCULOSIS AND AIDS TREATMENT	
The screening for tuberculosis at ART sites and other HIV care settings need to be strengthened.	The number of PLHIV screened for TB has increased (24,330) which contributed to the increase of the number of TB cases identified by HIV services.
Scale up implementation of Isoniazid Preventive Therapy (IPT) at the ART sites.	In 2009, of 24,330 HIV positive patients who were screened for TB in HIV care sites, 2,429 were started on IPT.

Diagnosis and treatment of X/MDR-TB patients.	The most recent drug resistance study finalized in 2008 found a 3.5% prevalence of multi-drug resistance among new cases. As a result, the number of cases diagnosed in the past 2-3 years has almost doubled. From 2006 up to September 2009, 295 patients were diagnosed and started treatment.
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MAJOR CHALLENGES REPORTED IN 2007	PROGRESS MADE UP TO DATE
	SUPPORT TO OVC's
Ensure that the Food Subsidy Programme becomes an effective mechanism for social assistance reaching the most vulnerable children.	22 per cent of households with orphans and vulnerable children receive any external support By the end of 2009, 357,905 of 1,328,208 (27%) OVC were reached with at least three basic services through a combination of initiatives by government (280,613) and Civil Society Organisations (77,292);
Expand unconditional cash transfers as an effective measure to mitigate the impact of HIV and AIDS on the most vulnerable population.	The Programa de Subsídio de Alimentos - (the national unconditional cash transfer programme for the elderly, disabled and children who are heads of households) programme now reaches 162,971 direct beneficiaries and 145,592 indirect beneficiaries, an estimated 60 per cent of whom are children;
Build the capacity of the MMAS at provincial and district levels in order to ensure effective coordination and implementation of social protection measures.	A Multi-Sectoral Technical Working Group on OVC, comprising of civil society and development partners, regularly reviews progress in implementing the PACOV. In addition, all 11 provinces and 54 districts have established similar working groups;
Build capacity of families and communities to respond to the needs of OVC and to provide access to basic services. The government policy promotes community-based, rather than institutional care for OVC.	World Food Programme (WFP) also provides food support to OVC and their families. In 2009, WFP provided food support (cereals and lentils/beans) to a monthly average of 40,000 OVC. WFP also provides nutritional and food support to chronically ill people under Home Based Care. In 2009, WFP provided support to a monthly average of 14,500 people. This was complemented by support from UNICEF in terms of basic kits to 30,000 most vulnerable households; 531 community committees to support OVC currently exist;
Ensure that an effective monitoring tool is in place to effectively measure the PARPA target specific to Orphaned and Vulnerable Children.	A database on OVC is being developed at MMAS;

Effective coordination mechanism up to the decentralised level between MINED and MMAS is required.	Coordination between the Ministry of Education (MINED), Registration entities and the Ministry of Women and Social Action (MMAS) has been strengthened through the Technical Working Group for Orphaned and Vulnerable Children and other <i>fora</i> .
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MAJOR CHALLENGES REPORTED IN 2007		PROGRESS MADE UP TO DATE
HOME BASED CARE		
Short and medium term food and nutritional support strategies.	Nutritional assessments and counselling under way but quality not always ensured. Counselling documents developed but distribution and use not universal. "Cesta Básica" (basic food basket) initiated end 2009 in all provincial capitals, targeting moderately malnourished people receiving ART. Protocols in place for the treatment of children with moderate and severe acute malnutrition.	

MAJOR CHALLENGES REPORTED IN 2007		PROGRESS MADE UP TO DATE
MONITORING AND EVALUATION		
There is a need to keep monitoring and develop studies focused on vulnerable groups, adoption of new methods and effective strategies to curb the increased rate of HIV infection.	In 2008 and 2009 new studies have been conducted like DT, MoT, INSIDA, RVE 2009, qualitative studies on MCP, Sex Workers, Mobile Populations, etc., to document the epidemic. All these studies were the evidence used to develop the PNE III.	
Develop a comprehensive M&E operational plan.	In 1 st quarter of 2009 the Costed and Integrated M&E Plan was finalized which include the 12 components of the M&E National System. It also includes the contribution of different partners.	
Revitalisation of the multi sectoral working group on M&E.	The multi sectoral working group on M&E has met periodically. Most often ad hoc meeting according to the subject to be handled. The most regular and specific meetings has been with the GTAM, in which the subjects are more related to estimates and surveillance. In 2009, RVE 2009 was conducted and new HIV and AIDS estimates for 2008 were produced.	
Strengthen the flow of information between district and provincial structures and national routine information systems.	In mid 2009, the new database for programme and project M&E at CNCS and NPCS was launched and installed, including harmonized and standardized indicators. A form to collect the data at district level also was produced. However, there is still lack of reporting from implementer partners at district and provincial levels.	

<p>Harmonization and standardization of M&E indicators, tools and mechanisms for monitoring;</p>	
<p>Strengthen research and evaluation by developing an evaluation agenda; and putting in place an effective strategy for dissemination and application of research findings.</p>	<p>A research and evaluation agenda was produced in 2008 in coordination of the Ministry of Science and Technology. In 2009, PEN III also defined a general agenda for the next 5 years.</p>

VII. Support from the Country's development partners

Mozambique continues to receive strong support from its development partners in its response to the HIV and AIDS epidemic. Since 2005, considerable amounts of financial resources have been made available to Mozambique in support of its national HIV and AIDS response. Funds from the President's Emergency Plan for AIDS Relief (PEPFAR) of the United States' Government, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank's Multi-Country AIDS Programme (MAP) and the United Nations Agencies, Programmes and Funds, in addition to bilateral resources from Canada, Denmark, Ireland, Sweden and the United Kingdom, among others, have contributed to achieving the significant results depicted in this report. The completed National AIDS Spending Assessment (NASA) indicates that Mozambique has spent over 48.5 million US\$ in 2004, 58.9 million US\$ in 2005 and 96.6 million US\$ in 2006. Mozambique is currently undertaking a NASA for the period of 2007-8 showing an increase of 105.2 million in 2007 and 146.4 million in 2008.

It is important to note that despite the significant economic progress made by Mozambique in recent years, it remains one of the poorest countries in the world and one of the most affected by the epidemic. Development partners should continue to increase its funding of the AIDS epidemic in Mozambique so that it has a chance to attain Universal Access targets for prevention, treatment and care. Predictable and sustainable financial support from its development partners will remain a necessity for Mozambique for many years to come in all areas key to development. A functioning Medium Term Expenditure Framework clearly depicting funding available for HIV and AIDS response would provide a secure environment for HIV and AIDS funding, and would allow the linking of available resources to plans. In this context, Development Partners would also like to see the GoM increase the amount of state funds allocated to support the high level multi-sectoral coordinating body in Mozambique (CNCS) in the fight against HIV and AIDS.

Since the establishment of the high level multi-sectoral coordinating body in Mozambique (CNCS), the epidemic has placed increased demands on CNCS to coordinate the response to deliver on Universal Access and scaling up processes. In this context, the importance of partnerships for HIV and AIDS related action is ever increasing. Development Partners continue to support CNCS' challenge to coordinate the response across government and work with multiple stakeholders (public sector, private sector, and civil society). It is recognised that mainstreaming HIV in sector strategies has been slow and uneven. More needs to be done to promote response to HIV across the public sector and sectoral budgets supporting HIV and AIDS activities need to be seen as a priority. CNCS should be supported as the national authority to set policy, coordinate and monitor multi-stakeholder performance and broker relations amongst stakeholders. Development Partners should support the work of the Executive Secretariat and of its Board, presided by the Prime Minister, to provide guidance on the implementation of the PEN III and public resource allocation for HIV and AIDS.

The significant focus on HIV and AIDS as a development issue in Mozambique has provided the Ministry of Health and its Partners with the impetus and opportunity to strengthen the health system across the board. Development Partners should continue to support the Ministry of Health in its ongoing efforts to integrate HIV and AIDS care and treatment with other relevant programmes and to

ensure that HIV and AIDS financing is fully included as a central part of the overall Government budget and is not treated as separate vertical programmes.

One of the key challenges remains Mozambique's weak data systems. Development partners need to support the strengthening of a sound and coordinated systems to collect data so as to ensure CNCS' effective decision making power as lead guidance on HIV and AIDS programming.

After the great achievements of the increased access to treatment in Mozambique, development partners should continue to advocate for a comprehensive and balanced approach to the national response which priorities prevention within a continuum of prevention, care, and treatment. The establishment by the Board of CNCS of a National Prevention Reference Group, a high level forum led by the Minister of Health (see Chapter IV of this report), reaffirmed the necessity to put emphasis on prevention measures in Mozambique. Another challenge for implementing the national response is the fact that only portions of the national HIV strategy and frameworks are costed.

The coordinated efforts of development partners and Government have led to the establishment of a Common Fund for CNCS as well as the signing in April 2006 of a Code of Conduct that guide the relationship of CNCS and its partners. Nonetheless, efforts from development partners to harmonize their requirements and to align with Government's priorities and cycle will need to be maintained, strengthened and closely monitored to result in a more effective and sustainable national HIV response.

Results from the INSIDA denote that much has been achieved in Mozambique in the past years. However, HIV and AIDS remains of the greatest threats to Mozambique's development. The results of the 2007 and 2009 sentinel surveys results demonstrate a stable epidemic nationally but one that shows great variation by province. Current efforts seem not to be sufficient, especially in the South of the country where the prevalence is very high. Mozambique's development partners need to continue to play a significant role in supporting the Government to address the specific challenges outlined in this report in order to halt and reverse the HIV epidemic.

VIII. Monitoring and Evaluation Environment

This section of UNGASS report reviews the current HIV M&E system in Mozambique based on the twelve components that are important for the successful functioning of a national M&E system.

Component 1: Organizational structures with HIV M&E functions

For the national HIV M&E system to function effectively, several organizations with adequate and qualified M&E human resources need to work together at national, sub-national and service delivery levels.

The assessment for the M&E structures established in the country was done, as well as, the needs addressing the strengthening that is needed for their operationalization. It is also in course the review, development and implementation of the private sector for M&E sub-system in its pilot phase. The schedule of the pilot phase is about 4 months and will be implemented in 5 provinces of the country.

The Ministry of Health is responsible for a number of key indicators from the national M&E framework as well as many outputs, coverage and quality indicators that are needed to paint a complete picture of the national HIV response.

The Ministry of Women and Coordination of Social Action (MMAS) HIV programs include primarily support for OVCs and income-generating activities for women affected by HIV. Both of these require relatively complex M&E systems. The MMAS HIV team has a full-time M&E officer.

UNFPA has also supported the implementation of a database for health and HIV and AIDS prevention activities at the Ministry of Youth and Sport. The database started in 2009.

In 2008-09, the CNCS M&E assessment established that most of the larger NGO partners and all of the NGO facilitating agents have staff capable of managing and using M&E data. Some of these have staff at the provincial level as well. However, smaller NGO partners lack such staff and expertise. On the contrary that was identified in the last UNGASS report (2006 -2007), a significant number of institutions of private sector have at least one M&E officer. Larger companies have systems in place for monitoring HIV issues.

CNCS ran a workshop for the private sector on the M&E system at central level. In each province CNCS ran several workshops on the M&E system with the participation of the private and public sector.

Challenges:

⁵¹ World Bank/UNAIDS, 2007: Organizing Framework for a Functional National M&E System

⁵² CNCS, 2006: Public and NGO M&E Capacity Needs Assessment

- The major challenge is to integrate the HIV and AIDS M&E subsystem in the different sectors to achieve the principle of one national M&E system for HIV and AIDS .

Remedial actions planned to overcome the challenges:

- Effectively manage and coordinate the human and technical expertise available for M&E at the national level, especially those within the CNCS, public and private sector, large and small (at provincial and district levels) implementing partners.
- CNCS needs to increase its leadership for M&E coordination between partners.
- Finalize and consolidate the private sector for M&E sub-system.

Component 2: Human Capacity for M&E

The costed multi-sectoral HIV M&E work-plan developed in 2008 and 2009 included in its component 2 the Human Capacity for M&E activities, focusing on: defining the HR needs, development a HR Plan, training on M&E and provision of technical assistance. Out of 7 activities of 13 were implemented in 2009 namely, HR and equipment need assessment, recruitment of new M&E officers, national training on M&E for NPCCS and implementers partners, participation in international trainings and conferences.

At national level, staff dedicated to the CNCS M&E unit within the department of Planning and M&E include seven M&E staff, one M&E Manager and two data officers and four M&E officers. The CNCS receives M&E technical support from several partners including UNAIDS, World Bank/GAMET, GTZ, DANIDA, CDC and USAID/MEASURE Evaluation among others. The CNCS currently has two dedicated information technology experts for programming, database design and maintenance, and computer-based communications.

At the decentralized level, each CNCS Provincial Nucleus has a database officer whose primary responsibility is to enter data from the Programme Activity Reporting System and to supervise reporting from implementers; they have the support of data entry staff that works in part-time. In 2009, the CNCS recruited Provincial M&E officers who provide M&E technical assistance for some Provincial Nuclei and it is underway the recruitment of 67 M&E Assistants at District level.

Challenges:

- Development of a national M&E Curricula for training.
- Implementation of supervision mission from central to provincial and district level.
- Better coordination of technical assistance.
- The recruitment of 67 M&E assistants has not been completed.

Remedial actions planned to overcome the challenges:

- Complete the recruitment of the 67 M&E assistants for district level.
- CNCS is working with USAID and Brazil cooperation on the development of a curriculum for M&E courses. The curriculum will be developed at central level (CNCS) and the courses should

be run in the regions. UNAIDS and MEASURE Evaluation are technically supporting the curriculum development.

- Continue with the planned workshops on training and supervision programme to strengthen provincial and district levels M&E officers and implementer partners.

Component 3: Partnerships to plan, coordinate and manage the HIV M&E System

Mozambique has a strong community of development partners committed to the national response and coordination for M&E.

The Multisectoral Technical Group (MTG), formed in 1999 and includes as members the CNCS and other key national and donor stakeholders, meets monthly at CNCS headquarters. It includes Ministry of Health (MISAU); National Institute of Health (INS); National Institute of Statistics (INE); National AIDS Council (CNCS); the Centre for Population Studies (CEP-UEM); and the Faculty of Medicine at Eduardo Mondlane University; and the Ministries of Planning and Development, Education, Justice, Interior and Agriculture; and other government sectors. In addition, international organizations like USG, CDC, PHI, PSI, UNADIS, UNICEF, UNFPA, Measure, DANIDA, GTZ and others, participate providing technical assistance to the MTG. Due to the large size of the group, a number of sub-committees have been formed to deal with such issues as special studies and surveys, and surveillance, including the Multisectoral Technical Group (MTG).

The MTG assists the government with designing and interpreting the results of sentinel surveillance, and projecting the health and demographic impact of the HIV epidemic. It also assists public and private sector partners and international donors in using the statistics for advocacy, program planning, and implementation.

In 2009, the MTG analyzed the 2009 sentinel surveillance round and prepared new ANC prevalence estimates which were presented on World AIDS Day by the President of the Republic. In 2010, the MTG will update the HIV impact projections by incorporating findings from the 2009 sentinel surveillance, the 2009 national HIV surveillance survey and the 2007 national census.

The implementation of the activities established at the M&E Integrated and budgeted Plan are underway, as well as the monitoring of these activities within the 12 components: i) with regards to reactivation and consolidation of the M&E Multi-sectorial technical group (GTM&E) at central and provincial levels. ii) Concerning the monitoring of the Accelerated Prevention Strategy, it was coordinated the implementation and operationalization at provincial level and included in the Plan of Action for 2010. In 2009, the M&E technical group for the private sector was reactivated and will work under the umbrella of GTM&E at both central and provincial levels.

Challenges:

- Full members' participation in the GTM&E.
- Better coordination between partners for M&E at central, provincial and district level.
- Lack of reporting from implementer partners at provincial and district level.

Remedial actions planned to overcome the challenges:

- Reactivate and building capacity of the provincial GTM&E.
- Continue to support the M&E technical working group in the provinces to coordinate the efforts to achieve a harmonized national M&E system.
- Include in the MoU with partners a clause to compel implementer partners to report to the M&E National System at district and provincial level.

Component 4: National Multisectoral HIV M&E Framework

The National Multi-Sector M&E working group used a participatory process to develop a National Multi-Sector Monitoring and Evaluation Framework in order to guide the M&E of the progress made in the implementation of the National Strategic Plan. The framework identifies a core set of 27 indicators that include the indicators agreed for the M&E of the UNGASS declaration. It also defines the sources of data for the indicators and other relevant information; the systems that need to be put in place to ensure the correct flow, storage, analysis, dissemination and use of data ; and the role of each stakeholder. Based in these indicators the M&E plan for the National Prevention Strategy was developed in 2009. However, with the development of the new PEN III, there is the need to review and update the National Multisectoral HIV M&E Framework.

Of the 27 national indicators in the framework, ten are available only through the DHS but this year will be available from the population-based surveys conducted in 2009 (INSIDA), one through antenatal care HIV surveillance, also available and updated, and seven through other special surveys (one each from a school survey, workplace survey, national composite index, health facility assessment, implementer survey of management training needs, national AIDS spending assessment, and a survey of condom acquisition/distribution). From these last indicators, data is updated for NASA (2007 and 2008) and National Composite Index (2009).

Nine of the 27 indicators are collected through existing more routine information systems, including the MoH HIS: PMTCT (2 indicators), percent who are on ARV and ARV survival (these indicators updated for 2009 data), facility information about ARV treatment in health facilities and HIV-test stock outs in transfusion centres, attendance at youth-friendly centres, fund flows from the CNCS and the completeness of CNCS M&E.

Data for those indicators that can be collected are available at national and provincial levels, but few are available at the district level. DHS data are routinely available every five years, and other surveys were conducted in 2008 like MICS and 2009 INSIDA.

Challenges:

- Conduct national surveys like DHS and other in a systematic way to document every 5 years HIV knowledge, behavior and national sero-prevalence.
- Coordination between research institutions.

Remedial actions planned to overcome the challenges:

- Review and update the national M&E framework according to the new PEN III 2010-2014.
- Improve the coordination between research institutions.
- Quarterly monitoring of progress of the National Response

Component 5: Annual, costed, national HIV M&E work-plan

In May 2008 the CNCS, with the technical support of World Bank and UNAIDS, and the participation of international and national partners, started the development of the costed multi-sectoral HIV M&E work-plan. This plan provided the opportunity for national institutions and partners to identify priority actions and allocate resources to make the M&E system work. A timeframe was set, budget and source of funds were identified, and a lead agency for its execution was designated.

The costed multi-sectoral HIV M&E work-plan is an implementation of the “Three Ones” principle, whereby all the M&E activities are implemented in a coordinated manner. This plan include also activities to be carried out by the Government at central and provincial level, and also activities to be implemented by partners, umbrella organizations and NGOs working on HIV.

In summary, the costed plan is an operationalization tool for the implementation of the M&E National System of the HIV National Response incorporating the 12 components of the HIV and AIDS M&E National System in Mozambique. From the 82 activities planned for 2009, 56 were implemented reaching a 68% of achievement.

The costed M&E plan was also shared at provincial level and incorporated into the provincial plan of action for 2010. Each province identified the priority actions to be implemented for M&E at provincial and district level.

Challenges:

- Monitor the implementation of the Costed Plan in a quarterly basis.
- Obtain funding update from partners.
- Improve partners’ participation during quarterly review of the costed plan.

Remedial actions planned to overcome the challenges:

- The costed plan needs to be reviewed and updated after the approval of the PEN III 2010 – 2014.
- Strengthen the coordination mechanism to improve the implementation of the costed plan in all its 12 components.
- Guarantee and follow up the implementation plan at provincial level.

Component 6: Advocacy, communication and culture for HIV M&E

In 2008, it was intensified the dissemination and publication of reports, studies, surveys on the epidemic drivers, strategies, epidemiologic situation, at all levels, thus contributing for the strengthening of decision making and priority definition on the response to HIV.

CNCS produced quarterly reports, data triangulation, three “informative bulletin”, and other documents in 2009 that were distributed among the Provincial Nuclei and partners.

Remedial actions planned to overcome the challenges:

- Update the CNCS website as one of major ways to disseminate information

Component 7: Routine HIV Programme monitoring

After the realignment of NAC, the M&E Unit is now responsible for the consolidation, analysis and dissemination of data to document the national response (*Routine medical and non-medical information*). However, each sector is responsible for too report to the M&E of the NAC.

Routine non-medical information

One of the functions of the M&E Unit is to gathering, analyzing and reporting on non-medical HIV and AIDS programmes which require significant time and resources.

Public sector

Key ministers involved in the HIV national response (Health, Education, Women and Social Action, Youth, Planning, Finance) report directly through the NAC.

In 2009, the board of Ministers approved the HIV Strategically Public Function is mandate is to coordinate implement and monitor HIV Aids Intervention on the Public Sector

Private sector

The private sector is currently piloting the M&E sub-system.

Remedial actions planned to overcome the challenges:

- Strengthen the M&E of different sectors (public, private, civil society) to guarantee that data from implementers be reported accurately, comprehensively and timely;
- Promote advocacy or identify mechanism to ensure that all stakeholders report to the M&E National System;
- Develop a training plan and respective materials for a training of trainers on the reporting system, and simplified written reporting guidelines for implementers.

Component 8: Surveys and Surveillance

In addition, starting in 2009 the surveillance activity includes analysis of recent HIV infections as an alternate method of estimating HIV incidence.

- Studies on the availability of condoms;

- Mortality surveillance – National survey on the causes of mortality (INCAM);
- Demographic surveillance (DSS)- protocol developed;
- Behaviour survey (BSS) and integration of most-at-risk groups – protocol developed;
- MEGAS – final phase of report;
- UNGASS;
- INSIDA – analysis completion phase for later report writing;
- MICS;
- Modes of transmission study – translation into Portuguese;
- Data triangulation – first phase disseminated, second phase initiated.

Remedial actions planned to overcome the challenges:

- Completion of planned studies and surveys;
- Dissemination of studies and surveys.

Component 9: National and sub-national HIV databases

Five databases are identified as essential for the M&E. These include:

1. National indicators database
2. Database of projects and initiatives
3. Database of activity outputs by all projects and initiatives
4. Research database
5. Financial resource database

The important aspect of these databases is that information is held in a standardized format that is routinely updated and accessible to all partners.

NAC Indicators database

A NAC database including the indicators of the national response to HIV is in place and installed at the NAC National and provincial levels. It reports on a quarterly basis.

M&E provincial staff (1 database assistant and 2 data entry clerks, per province) was trained and is now able to collect data from the implementers and other partners to enter it on the database at its level, such as provincial, district and administrative post levels. At present, there is a pilot installation in three districts that its success will bring a chance to decentralize the process of data collection, giving this responsibility to those big organizations working in districts (one organization per district) where the NAC personnel have difficulties to reach. Those organizations will mainly have the responsibility to collect data from the small organizations working in that district and send it to the provincial level in a quarterly basis. This decentralization will help on the data collection process at the lower levels. M&E provincial teams with a database assistant and two enterers were trained on the process of data collection and data entering at all levels (province, district and administrative post).

The process of data collection is done through a previously elaborated questionnaire that is identified for each network. However, there are still difficulties for the acceptance of this important tool on the part of all stakeholders.

It is important to refer that there is an obligation to guarantee a continuous technical assistance to the NAC personnel at all levels and also a continuous database updating, when necessary.

Indicator database

The ESDEM database that houses all indicators is still running at the National Institute of Statistics. The NAC Information System database that houses HIV indicators exports data to ESDEM and the last update will be done this quarter

Challenges:

- Provide NPCCS with equipment and information technologies.

Remedial actions planned to overcome the challenges:

- Review and update of database formularies, so as to adequate the new list of indicators.

Component 10: Supportive supervision and data auditing

Necessary elements of any data system are supportive supervision and routine data auditing. Data is now gathered at all levels, but little quality control is in place. Provincial and district structures often lack sufficient human resources and means of transportation to routinely travel to far-flung districts to supervise HIV activities, quality and data collection.

Remedial actions planned to overcome the challenges:

- As part of the training materials for the provincial M&E officers, design written guidelines and forms for supportive supervision and data auditing of implementers.
- Run workshops to provincial M&E officers in on-site supportive supervision and data auditing.
- Delegate for some organizations a supportive supervision after a capacity building

Component 11: HIV Evaluation and Research

The Ministry of Science and Technology received the Government mandate of coordinating all poverty related research, including HIV related research.

A list of national priorities for HIV research in Mozambique and the first National HIV Research Program were approved in 2008. The Program has two main pillars: support to production of quality research, and support to dissemination of research results and capacity building for research.

Research, which was one of the domains in the third National AIDS Strategy 2004-2009, is now integrated into all components of the new National AIDS Strategy 2010-2015. The main objective of research is to strengthen evidence-based decision making, planning, implementation, and evaluation.

The Ministry of Health is a major implementer of HIV research through its National Health Institute and is the home of the National Bio-ethics Committee. Other actors involved in HIV research include other ministries, universities and NGOs.

Main progress on HIV research in 2008-2009 can be summarized as follows:

Completion of several major research and evaluation studies with national significance, including NASA (National AIDS Spending Assessment), 2008/2010; MICS (Multiple Indicator Cluster Survey), 2008; Demographic Impact of HIV and AIDS Study, 2008; two rounds of epidemiological surveillance studies, 2007 and 2009; Evaluation of Five Years of Global Fund Support, 2008, Triangulation of Data from Different Sources 2008-2009; Analysis of Modes of Transmission Study and Prevention 2009. A National AIDS Indicator Survey (Inquérito nacional de prevalência, riscos comportamentais e informação sobre HIV/SIDA, INSIDA) is being finalized. The verbal necropsy has been formalized, 2009.

- Launch of two calls for submission of research proposals in the 21 national priority areas, of which nine among 27 were approved for funding and 40 new ones from all over the country are being reviewed. Guidelines and mentoring were made available nationwide for applicants.
- Development and testing of evidence based local planning models, which integrate national and local data.
- Finalization of a five year Strategy for the National Health Institute.

The main progress in dissemination of and capacity building for HIV research in 2008-2009 can be summarized as follows:

- Opening of a Knowledge Centre in Beira with the primary function of disseminating research results in appropriate ways to researchers and implementers;
- Establishment of an open data base of HIV related research produced from 1987 to 2007 in Mozambique;
- Conduction/Facilitation at the Knowledge Centre of various knowledge dissemination and training activities focused on research appreciation and use for school teachers, university teachers, staff of multi-media centres, Provincial AIDS Coordinators, Government and NGO Program Coordinators, Ministerial HIV Focal Points among others.
- Setting up of new research networks and conduction of several national knowledge sharing conferences, such as the “Jornadas de Saúde”.
- Conduction of the first Master level multisectorial HIV course and sponsorship of an increasing number of fellowships for HIV and AIDS related Masters and PhD studies abroad.

Challenges:

- Despite the efforts, more evidence-based knowledge is still needed in the areas of national prevalence, incidence in specific population groups, drivers of the epidemic, most vulnerable populations, effectiveness of programs;

- Insufficient coordination and dissemination of research;
- Insufficient capacity to use research results in planning and adjustment.

Remedial Actions:

- Developing a five year multisectorial National HIV and AIDS Research Strategy as basis for national coordination and capacity building;
- Reviewing, updating, and implementing the National HIV and AIDS Research Program in a participatory manner and in line with the new National AIDS Strategy priorities;
- Disseminating the National HIV and AIDS Research Strategy and Program to all sectors and advocating for increased financing and use of research in program development in all sectors;
- Increasing technical and financial support to implementation of priority research and research dissemination through the National HIV and AIDS Research Program and the National Research Fund;
- Strengthening institutional capacity for production and use of research at all levels, including facilitating knowledge sharing between researchers.

Component 12: Data dissemination & use

Data have been put available in the national and provincial level. With the dissemination of the information we expect to have more participation with all partners, government and civil society.

It is the overall responsibility of the CNCS to provide the data in a form that is easy to understand, visually pleasing and directed at the appropriate audiences. Information products (reports) and data use and planning formats should be organized to support the PEN III.

Remedial actions planned to overcome the challenges:

- Standardized reporting systems and formats need to continue be disseminated.
- Develop workshops to capacity building the province and district level
- Capacity building on data analysis should be done at the district level Continue to produce summary reports on a regular basis and shared with the districts and provinces.
- Advocate for the continually use of data in decision making.

Annexes

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

- 1) Which institutions/entities were responsible for filling out the indicator forms?
 - a) NAC or equivalent Yes
 - b) Other: MoH, MMAS, UN agencies Yes

- 2) With inputs from Ministries:

Education	Yes
Health	Yes
Labour	No
Foreign Affairs	No
Women and Social Action	Yes
Youth and Development	Yes

Civil society organizations	Yes
People living with HIV	Yes
Private sector	Yes
United Nations organizations	Yes
Bilaterals	Yes
International NGOs	Yes
Universities	No

- 3) Was the report discussed in a large forum? Yes

- 4) Are the survey results stored centrally? Yes

- 5) Are data available for public consultation? Yes

- 6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

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Date: 31 March 2010

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ANNEX 3: National Composite Policy Index

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ANNEX 3: National Funding Matrix — 2009

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Reporting Cycle: 2007 and 2008 calendar year

Local Currency: Meticais

Average exchange rate with US dollars during the reporting cycle: 2007: 25,29
2008: 24,43

Methodology: National AIDS Spending Assessments supplied the data for the National Funding Matrix.

Unaccounted Expenditures: Some expenditure for activities in some of the AIDS Spending Categories was not included in the National Funding Matrix because information was not available.

Budget Support: Budget support from bi- and multi-laterals donor that is part of the public funding, is the one that includes exclusively support to the central budget. Direct support, even if budgetary, to the sectors – MoH and CNCS – was attributed to the respective funding sources in the way of its effective contribution in the year (pro-rate).

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ANNEX 4: List of participants to the UNGASS validation workshop

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