



FY 2015 Mozambique Country Operational Plan (COP)

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Mozambique.

- 1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the “COP 15 Targets by Subnational Unit” sheets that follow for final approved targets.

- 2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

- 3) *Sustainability Index and Dashboard*

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the “FY 2015 Country Operational Plan Budget and Target Report.”

MOZAMBIQUE

2015

Country Operational Plan

Strategic Direction Summary

Definition of Acronyms

ACT	Accelerating Children's Treatment Initiative
ART	Antiretroviral Therapy
ARV	Antiretroviral drugs
CCM	Country Coordinating Mechanism
COP	Country Operational Plan
CSW	Commercial Sex Workers
DREAMS	Determined, Resilient, AIDS-free, Mentored, and Safe (DREAMS) Initiative
EA	Expenditure Analysis
FADM	Ministry of Defense
FSW	Female Sex Workers
GBV	Gender-based violence
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GRM	Government of the Republic of Mozambique
GII	Gender Inequality Index
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
LTFU	Loss to follow up
M&E	Monitoring and Evaluation
MGCS	Ministry of Gender, Children, and Social Action
MISAU	Mozambican Ministry of Health
MOF	Ministry of Finance
MSM	Men who have Sex with Men
NASA	National AIDS Spending Assessment
OGAC	Office of the U.S. Global AIDS Coordinator
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider Initiated Testing and Counseling
PMTCT	Prevention of Mother to Child Transmission of HIV
PPP	Public-Private Partnerships
PWID	People Who Inject Drugs
S/APR	Semi-annual or annual performance results
SI	Strategic Information
SIMS	Site Improvement through Monitoring System
SNU	Sub-National Unit (Province, in Mozambique)
TB	Tuberculosis
VMMC	Voluntary Medical Male Circumcision
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

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GOAL STATEMENT

The goal of the U.S. Government's Emergency Plan for AIDS Relief (PEPFAR) country operation plan for 2015 (COP15) is to support the Government of Mozambique (GRM) in setting and maintaining a trajectory to achieve national HIV epidemic control by 2020. In Mozambique, five United States Government (USG) agencies with PEPFAR funding support the GRM's efforts to control the HIV/AIDS epidemic.¹ PEPFAR collaborates with the Mozambican Ministry of Health (MISAU), National AIDS Council (CNCS), Ministry of Gender, Children and Social Action (MGCS), Ministry of Defense (FADM), multilateral organizations, and civil society. Meeting the COP15 goal will require advocacy with the GRM to change antiretroviral treatment (ART) policies; review of USG priority sites and services support; a coordinated plan for the transition of low burden sites to the GRM; renewed focus on children, adolescent girls, and young women through the Accelerating Children's Treatment (ACT) and the Determined, Resilient, AIDS-free, Mentored, and Safe (DREAMS) initiatives; more effective services for key populations; and targeted strengthening of the GRM's health systems necessary to achieve an AIDS Free Generation.

In COP14, 65 high burden districts were identified for intensified action. Located in ten of the eleven provinces of the country, HIV prevalence in these districts is greater than 8% and each has more than 4000 people living with HIV (PLHIV). These 65 districts account for 76% of the national total estimated number of people living with HIV (PLHIV). The programmatic focus of COP14 concentrated on reaching and starting treatment for all eligible HIV-infected persons. Eligible populations include all HIV infected persons with a CD4 level of 350 cells/mm³ or less or a clinical WHO stage of 3 or 4, as well as the following "test-and-treat" groups: children less than 5 years old; those co-infected with tuberculosis (TB); pregnant women; male partners of sero-negative pregnant women; and members of key population (KP) groups (Commercial Sex Workers (CSWs) and Men who have Sex with Men (MSM)).

COP15 strategically places intensified efforts on areas of the country with higher epidemic burden and higher unmet treatment needs as we work towards epidemic control. Districts identified as having the heaviest disease burden, greatest unmet need, and the possibility of achieving high ART coverage (defined as 73% of PLHIV on treatment) are at the focus of this plan. We propose to reach ART coverage of 73% of PLHIV within 77 scale up districts (1 district in FY15, 39 by the end of FY17 and 37 by the end of FY18) while simultaneously sustaining the response to safeguard the quality of care and treatment in the remaining 71 districts of Mozambique. HIV Testing and Counseling (HTC) targets and demand creation activities are aligned with treatment targets and focus on the 77 high burden districts in locations with maximum yield.

To achieve these ambitious treatment goals which will bring Mozambique closer to epidemic control, PEPFAR will continue to collaborate closely with the GRM to support a change of the CD4 threshold criteria for starting treatment to be 500cells/mm³ or less (from the current CD4<350) to align with 2013

¹ The five US Government agencies participating in PEPFAR are the Department of State, Department of Defense, Peace Corps, United States Agency for International Development (USAID), and the Centers for Disease Control (CDC)

WHO guidelines, as well as expanding the test-and-treat population to include children up to the age of 15 years (currently all children below the age of 5 are eligible for immediate treatment, but not those between 5 and 15 years of age).

COP15 also includes a focused prevention approach. As key populations are heavily impacted by HIV and are also important drivers of the epidemic, increased efforts to reach more commercial sex workers, their clients, and MSM are incorporated into this strategy. In addition, the condom portfolio will promote condom use with sero-discordant couples. These prevention programs will be complemented by activities addressing adolescent girls and young women and their male partners, funded through DREAMS and focused in 8 of the PEPFAR scale-up districts.

Voluntary medical male circumcision (VMMC) programs are also aligned with the scale-up districts, with a target in COP15 of 271,563 procedures for 58 sites in 47 scale-up districts. Since the launch of the GRM's first demand creation campaign, the VMMC program has been gaining momentum. COP15 continues to focus on young men for greater efficiency and impact on HIV prevention. VMMC activities will continue in military bases with large numbers of young, uncircumcised men, particularly bases with large numbers of new recruits.

The OVC program will focus on the 77 scale-up districts as well as catchment areas surrounding high volume clinical sites. Transition plans for areas outside of the scale-up districts will be developed with the MGCS at the central level and with government counterparts at the district level. An emphasis on family-centered programs, socio-economic support, and more clearly defined core and near-core interventions will be accompanied by improved targeting as well as community testing. OVC programs will maximize impact and efficiency by maintaining strong linkages with both the ACT and the DREAMS initiatives.

Mozambique has a fragile and under-staffed health system, which needs strengthening to achieve and sustain HIV epidemic control. COP15 includes key national interventions addressing supply chain, health information systems, human resources for health, and health financing that will continue to strengthen the government's ability to develop a national health system capable of fully meeting the needs of the population and turning the tide of the HIV epidemic.

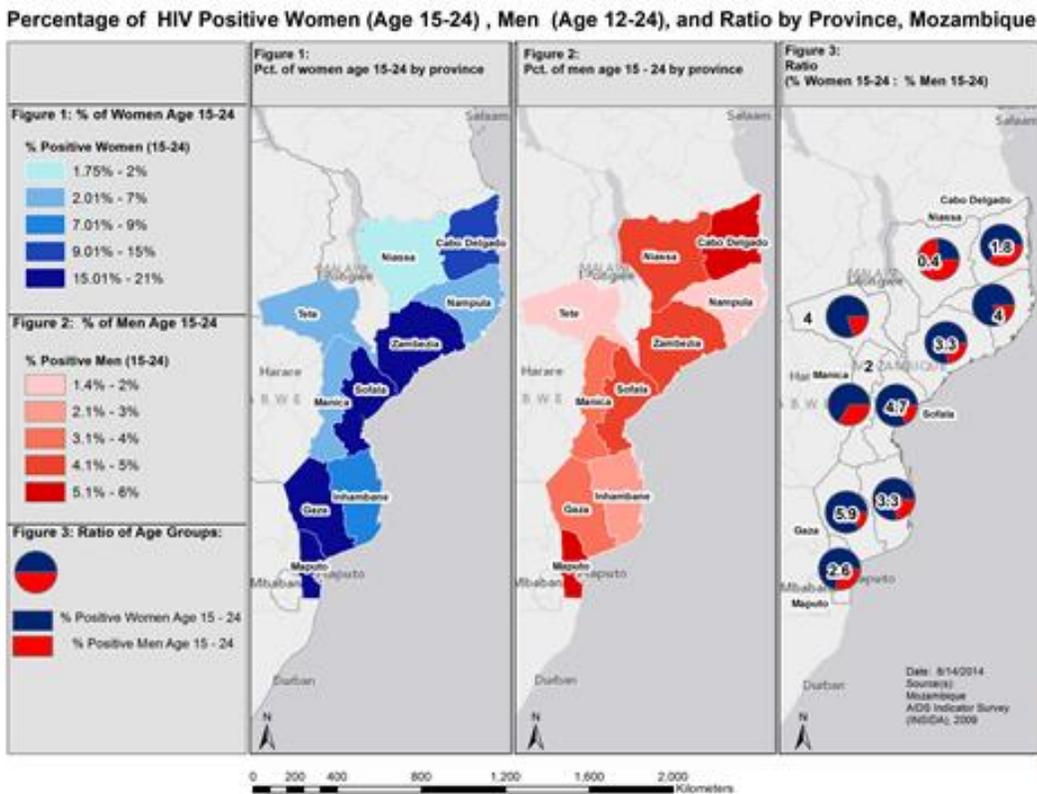
1.0 EPIDEMIC, RESPONSE, AND PROGRAM CONTEXT

1.1 Summary Statistics, Disease Burden and Country Profile

Mozambique is a predominantly rural country of approximately 26 million people challenged by a severe generalized HIV epidemic. National HIV prevalence is 11.5% with substantial variation in regional

prevalence rates ranging from 25.1% in Southern provinces to 3.7% in Northern provinces. In 2014, there were an estimated 1,623,822² people living with HIV, with a higher prevalence among women (13.1% vs 9.2% in men) and especially among young women (aged 15-24 years), particularly in Sofala and Gaza provinces, where they are disproportionately affected at rates five and six times higher in comparison to men (Fig 1.1.1). Prevalence among adolescent girls is estimated at 11.1%.³ Of the estimated number of PLHIV, approximately 54% are in care and 40% are currently on ART. The HIV epidemic has contributed to a low life expectancy of 51 years, and there are approximately 848,000 orphaned children.

Figure 1.1.1:



Key drivers of Mozambique’s HIV epidemic are low coverage of ART, risky sexual behaviors, low rates of male circumcision, low and inconsistent condom use, mobility and migration, and sex work. Qualitative studies highlight social and cultural factors that shape attitudes and behaviors towards risk, sexual relations, prevention, care seeking and use of services.

The 2009 AIDS Indicator survey (INSIDA) is the most current source of population level data about the epidemic.⁴ The 2009 data show a total of 433,000 HIV-serodiscordant couples, representing 10% of all

² EPP SPECTRUM Version 5.03.2014; 2015 estimate

³ AIDS Indicator Survey INSIDA 2009

⁴ A new survey is currently underway as of June 2015.

cohabiting heterosexual couples. At least 58% of PLHIV did not know their status. Condom use is limited but more common in urban populations. Among women age 15-49 that had sexual intercourse in the last 12 months, 8% reported the use of a condom during their last intercourse (19% urban, 3% rural). The proportion increases to 16% among men age 15-49 reporting the use of a condom during their last intercourse (33% urban, 7% rural). Male circumcision (MC) is common in the northern provinces of the country, where it is performed for traditional and religious reasons. National MC prevalence is reported at 51%, with geographic variations ranging from 2% (Central region) to 95% (Northern region).

A Modes of Transmission (MoT) model conducted in 2013 shows a very conservative 28.7% of new infections were among sex workers, their clients and MSM, and 25.6% of new infections occur among people in stable sexual relationships, due in large part to high rates of sero-discordance and low rates of condom use among couples. People in multiple partnerships contributed to 22.6% of new adult infections. Mobile and migrant workers such as miners, agricultural workers, prison populations, the military, and truck drivers also constitute priority populations.⁵

Despite encouraging economic growth, estimated at over 7% over the last 3 years, the Human Development Index ranks Mozambique 178 out of 187 countries.⁶ Sixty percent of Mozambicans live on less than \$1.25/day; gross national income (GNI) is \$640 per capita.⁷ Key health indicators indicate gradual improvement in health status; however, challenges remain. Although antenatal coverage, defined as at least 1 visit, is 91%, maternal mortality ratio remains high at 408/100,000 live births. Under-five child mortality is 97/1,000 live births, declining from 103/1,000 live births in 2010.⁸ Malaria, diarrhea, acute respiratory infections, and vaccine-preventable diseases are the main causes of child death, with malaria contributing to one third of child mortality. 43% of children under the age of 5 years are stunted.

The Gender Inequality Index (GII) reflects gender-based inequalities in three dimensions – reproductive health, empowerment, and economic activity - on which Mozambique ranks 144 of 149 countries. Mozambique has high rates of early marriage: 60% of women aged 25-49 were married before age 20. About 40% of Mozambican women become pregnant before the age of 20. The adolescent pregnancy rate is 137.8 births per 1000 live births, with the risk of death among pregnant teenagers four times higher than for women above the age of 20. One and a half percent of adult women have reached at least a secondary level of education compared to 6% of their male counterparts.⁹

⁵ Military – Seroprevalence and Behavioral Epidemiology Risk Survey in the Armed Forces of Mozambique 2010

⁶ Human Development Report 2014, UNDP

⁷ World Bank 2014

⁸ Mozambique DHS 2011

⁹ Human Development Report 2014, UNDP

The health sector struggles with limited funding and infrastructure and a critical shortage of human resources for health. The \$37 per capita health expenditure is well below the \$60 recommended by WHO.¹⁰ More than half of all Mozambicans walk over one hour to reach the nearest health facility. Overall the ratio of population per hospital bed is 1 bed per 1,038 persons, with great variation across the country.¹¹ Health facilities face a general dearth of basic amenities: 55% lack electricity and 41% lack running water. Human resources for health (HRH) are severely constrained with only 5.6 doctors, 41 MCH nurses and a total of 89 health care workers per 100,000 population, and 429 social workers in the country. Together with uneven geographic distribution, there are an inadequate number of trained and competent health care workers in all cadres and they often receive limited supervision. Of the total of 1,452 medical doctors in the country, 289 are foreigners, contracted by the GRM to fill the gap of specialized doctors. The distribution of medical doctors is inequitable with a very high concentration in a few urban areas.¹²

The GRM's ability to oversee policies and regulations and coordinate health actors is challenged. Information systems and monitoring and evaluation (M&E) efforts are heavily supported by external funding and technical assistance and are not yet able to provide timely and accurate health data. Development and capacity building of the National Health Information System is a priority for COP15.

Despite these challenges and the heavy burden of the HIV/AIDS epidemic, there has been remarkable progress. In 2013, the Government of Mozambique launched its National Accelerated Response to HIV/AIDS (the Acceleration Plan) to increase to 80% the percentage of HIV infected eligible adults (with 350 CD4 guidelines) and children who receive antiretroviral therapy; increase the percentage of HIV-positive pregnant women who receive ARVs to 90%; and increase the percentage of adult males circumcised in target provinces to 39% by 2015.¹³ The Acceleration Plan, developed in collaboration with PEPFAR, prioritizes high-impact interventions and geographic areas, and focuses on a continuum of response by addressing key and vulnerable populations. The country's next 5 year plan to guide the HIV response, the *Plan Estratégico Nacional (PEN IV)*, has now been finalized and will outline the priority response areas for the period 2015-2019.

Since 2011, the number of people on ART has increased threefold, with an exponential increase since the launch of the Acceleration Plan (see Fig 4.1.2 p38). With rapid expansion of MISAU supported health facilities offering ART from 255 in 2011 to 783 facilities, and 163,918 (126% of target) adults initiated on ART in 2014, by the end of 2014 there were 676,340 adults and children reported currently on ART. These figures represent an overall coverage of ART eligible of 68% (based upon national eligibility

¹⁰ National Health Account 2012

¹¹ MISAU – DRH. Relatório Anual dos Recursos Humanos. Maputo, Abril 2014

¹² For example, 372 doctors work in Maputo Central Hospital for a population of roughly 1.5 million, while the Province of Zambezia, with a population of over 4 million has only 72 doctors.

¹³ MISAU National Acceleration Plan

criteria consistent with 2011 WHO guidelines and SPECTRUM 2012 estimates) and a national saturation based on the SPECTRUM 2012 estimated number of PLHIV of approximately 40%.

There has also been remarkable progress in test and treat (B+ option) for pregnant women during ANC, which increased from 13% of all PMTCT in FY12 to 39% in FY13, to 78% in FY14.¹⁴ More HIV infected children are also being identified and started on treatment, with 13,566 initiated in 2014 and a total of 41,400 children at the end of 2014 on treatment, representing 41% of those eligible.¹⁵

Based upon the MISAU Acceleration Plan, ART enrollment of PLHIV as a result of intensified case finding targets an estimated 885,164 adults and children to be on ART by the end of 2016, and 996,593 by the end of 2017. The latter represents 90% of ART eligible persons based on UNAIDS SPECTRUM model (version 5.03 2014), and aligns with the 2013 WHO guidelines that prioritize test and treat for high risk populations,¹⁶ but maintains the 2011 recommended CD4<350 threshold. These targets form the basis of ARV drug forecasts by MISAU funded through PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

With COP15, PEPFAR will increase momentum to reach 73% saturation of PLHIV on treatment in 77 PEPFAR supported scale up districts in the next 2-3 years. Based on these criteria, MISAU targets would exceed the Acceleration Plan targets and be strongly focused on PEPFAR-supported sites in PEPFAR scale-up districts. The USG is in active discussion with MISAU and the GFATM to review the eligibility guidelines and the impact of the increased number of PLHIVs starting on ART to 915,606 by FY16 and 1,113,668 by the end of FY17. This will exceed the planned ARVs and other essential HIV commodities for these years.

In comparison to many other African countries, Mozambique's national retention rates of 67% at 12 months, and even lower in pregnant women (57%), are poor. There are, however, major challenges in determining accurate retention data. Specifically, with no unique identifier for patients started on ART and the rapid expansion of health facilities offering ART services, it is possible some patients have relocated to new sites and not actually defaulted off treatment, but we are unable to track them. Innovative efforts are being planned and implemented at both facility and community levels to retain and track people on treatment. The role of revitalized cadres of community health workers and community activists is being expanded in concert with care delivery models such as Community Adherence groups (in Portuguese, *Grupos de Adherencia e Apoio Comunitario* (GAAC)). Options for 3 monthly ARV distributions are being explored.

Health and HIV Financing: The total budget allocated to health in 2014, including domestic and external support, was US \$635 million, representing 7.9% of the total national budget. PEPFAR funds are not included in this total. Despite the positive trend of increased GRM investment in total dollar terms, the

¹⁴ Mozambique APR 2015 PEPFAR

¹⁵ Mozambique APR 2014 PEPFAR

¹⁶ (HIV/TB co-infected people, sero-positive pregnant women, children <5 years, key populations and sero-positive partners of sero-negative pregnant women)

proportion of the total domestic budget allocated to health continues to fall well below the 15% stated in the Abuja Declaration. Of the US \$635 million, 48% is dedicated to the central MISAU, 15.7% to the provincial directorates (DPS), 16.5% to the district health, gender, children and social action (SDSMAS), 11.6% to central hospitals, 1% to the Central Medical Stores (CMAM), and 1% to the National AIDS Council (CNCS).¹⁷

The share of internal resources to external resources has increased from 45/55% in 2009, to 78/22% in 2014. HIV expenditure in Mozambique reached US \$353 million in 2014, representing a 65% increase from US \$213.5 million reported in 2010 [13, 14]. External budget support to the health sector from general budget support (GBS) and health sector support (Prosaude) has decreased, falling from 52% of the overall health budget in 2008 to only 22% in 2014, due to the increase in internal resources.¹⁸

Routine budget and expenditure data on investment of public resources in initiatives linked to specific diseases like HIV is difficult to measure. However, efforts are underway to begin program-based budgeting at the MISAU. In 2014, a National AIDS Spending Assessment (NASA) was done for 2010 and 2011, showing US \$213 million in CY 2010 (68% PEPFAR financing) and US \$260 million in CY 2011 (72% PEPFAR financing). UNAIDS GARPR reports indicate CY 2012 US \$256 million (75% PEPFAR financing), CY 2013 US \$350 million (72% PEPFAR financing), and CY 2014 US \$353 million (72% PEPFAR financing).¹⁹

With significant increased state revenues from extractive industry gains expected within the next 7-10 years, the GRM must increase its investments in and ownership of the health sector, including the fight against HIV/AIDS. It is important for the GRM, GFATM, and PEPFAR to work closely to create a clear and sustainable financing plan for ARV drugs and other commodities, and execute timely disbursements to ensure the scale-up of treatment and improve systems to support almost a million people on treatment by the end 2017. MISAU, with PEPFAR support, is developing a Health Financing Strategy and discussions are underway between the MISAU and Ministry of Finance (MOF) regarding new financing schemes such as a Sovereign Health Fund and other innovative financing mechanisms.

¹⁷ UNAIDS GARPR 2014

¹⁸ UNAIDS GARPR 2014

¹⁹ UNAIDS GARPR 2014

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		<15				15+				Source, Year
	N	%	Female		Male		Female		Male		
			N	%	N	%	N	%	N	%	
Total Population	26,423,623		5,925,222	50	5,891,635	50	7,738,077	53	6,868,689	47	Census Projection 2016
Prevalence (%)		11.5*						13.1*		9.2*	INSIDA 2009
AIDS Deaths (per year)	59,548		2,651		2,718		28,167		26,011		Spectrum projections, 2016 est.
PLHIV	1,623,823		86,939		89,004		880,642		598,580		Spectrum projections, 2016 est.
Incidence Rate		South, 1.26, Center 0.31, North 0.80									Spectrum projections, 2016 est.
New Infections	100,816										Spectrum projections, 2016 est.
Annual births	1,302,180										UNICEF 2013 Statistics (5.2% of population)
% >= 1 ANC visit	90.6										DHS 2011
Pregnant women needing ARVs	94,319										Spectrum projections
Orphans (maternal, paternal, double)	876,317 2,000,000										Spectrum projections, 2016 est. UNICEF Statistics 2013
TB cases (Yr)	56,223										WHO Global Tuberculosis Report 2014

TB/HIV Co-infection	28,585											WHO Global Tuberculosis Report 2014
Males Circumcised	162,670				84,749					77,921		DNAM-MISAU (2014)
Key Populations												
Total Men Who have sex with Men (MSM)*	Maputo City – 10,121 Beira – 2,624 Nampula/Nacala – 3,069											MSM IBBS 2011
MSM HIV Prevalence	Maputo City – 8.2% Beira – 9.1% Nampula/Nacala – 3.7%											MSM IBBS 2011
Total Female Sex Workers (FSW)	Maputo City – 13,554 Beira – 6,802 Nampula – 6,929											FSW IBBS 2011-12
FSW HIV Prevalence	Maputo City – 31.2% Beira – 23.6% Nampula – 17.8%											FSW IBBS 2011-12
Total People who Inject Drugs (PWID)	Maputo City – 1,684** Nampula – 520**											PWID IBBS 2013
PWID HIV Prevalence	Maputo City – 50.3%** Nampula – 36.8%**											PWID IBBS 2013
Priority Populations												
Total Prisoners	NA											

Prisoner's HIV Prevalence	National – 24.0% Cabo Delgado – 11.7% Nampula – 18.2% Tete – 22.7% Manica – 27.7% Sofala – 31.9% Gaza – 35.1% Maputo Province – 29.2%										INS & UNDOC Report 2013
Truckers	NA										
Truckers HIV Prevalence	Inchope (Manica) – 15.4%										Truckers IBBS 2012
Miners	NA										
Miners HIV Prevalence	Maputo Province – 27.4% Gaza – 26.1% Inhambane – 14.7% All 3 Regions – 22.3%										Miners IBBS 2012
Adolescent girls***	2,687,975										Census 2016
Adolescent girls HIV prevalence***	11.1%										INSIDA 2009

*15-49 Year-Olds

** Preliminary Data Not Yet Officially Released

*** 15-24 Year-Olds

**** Prevalence number for the military cannot be shared with the general public due to military concerns regarding HIV prevalence as it relates to national security. However, prevalence data and other military data were shared with the country team to inform COP15 decisions and inclusion of the military as a priority population.

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)

				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	26,423,623	11.5	1,655,167*	928,642	676,340	67%	NA	5,726,580	486,125	222,701
Population less than 15 years	11,816,857	NA	183,631	68,832	53,234	65%	NA	Not available yet		17,480
Pregnant Women	1,302,180	15.2	98,206	NA	43,696	54%	NA	953,487	61,096	44,933
MSM	Maputo City - 10,121 Beira - 2,624 Nampula/Nacala - 3,069	Maputo City - 8.2% Beira - 9.1% Nampula/Nacala - 3.7%	Maputo City - 830 Beira - 239 Nampula/Nacala - 114	Data not available				20,402	5,100	1,836
FSW	Maputo City - 13,554 Beira - 6,802 Nampula - 6,929	Maputo City - 31.2% Beira - 23.6% Nampula - 17.8%	Maputo City - 4,229 Beira - 1,605 Nampula - 1,232	Data not available				10,774	2,693	969
PWID	Maputo City - 1,684** Nampula - 520**	Maputo City - 50.3%** Nampula - 36.8%**	Maputo City - 847 Nampula - 191	Data not available						
Priority Pop (specify)										
Prisoners	NA	Maputo Province - 27.4%** Gaza - 26.1%**		Data not available				12,119	3,023	1,088

		Inhambane – 14.7% ^{**} All 3 Regions – 22.3% ^{**}								
Truckers	NA	Inchope (Manica) – 15.4% ^{**}								
Miners	NA	Maputo Province – 27.4% Gaza – 26.1% Inhambane – 14.7% All 3 Regions – 22.3%		Data not available						
Military ^{***}	25,000		Not available yet							
Adolescent girls ^{****}	2,687,975	11.1%/ 3.7 for adolescent boys								

*0-49 Year-Olds, SPECTRUM 5.03 YR 2014

** Preliminary Data Not Yet Officially Released

*** Prevalence number for the military cannot be shared with the general public due to military concerns regarding HIV prevalence as it relates to national security. However, prevalence data and other military data were shared with the country team to inform COP15 decisions and inclusion of the military as a priority population.

**** 15-24 Year-Olds

Figure 1.1.2 HIV prevalence by Province, Mozambique, 2009

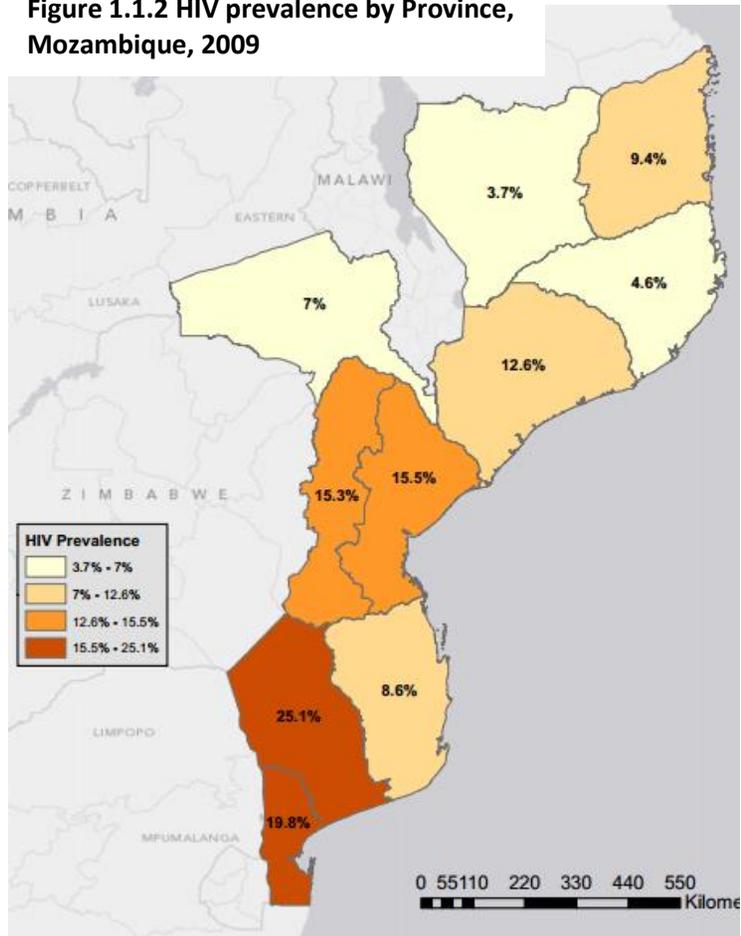


Figure 1.1.3 People living with HIV (PLHIV) by district, Mozambique 2015

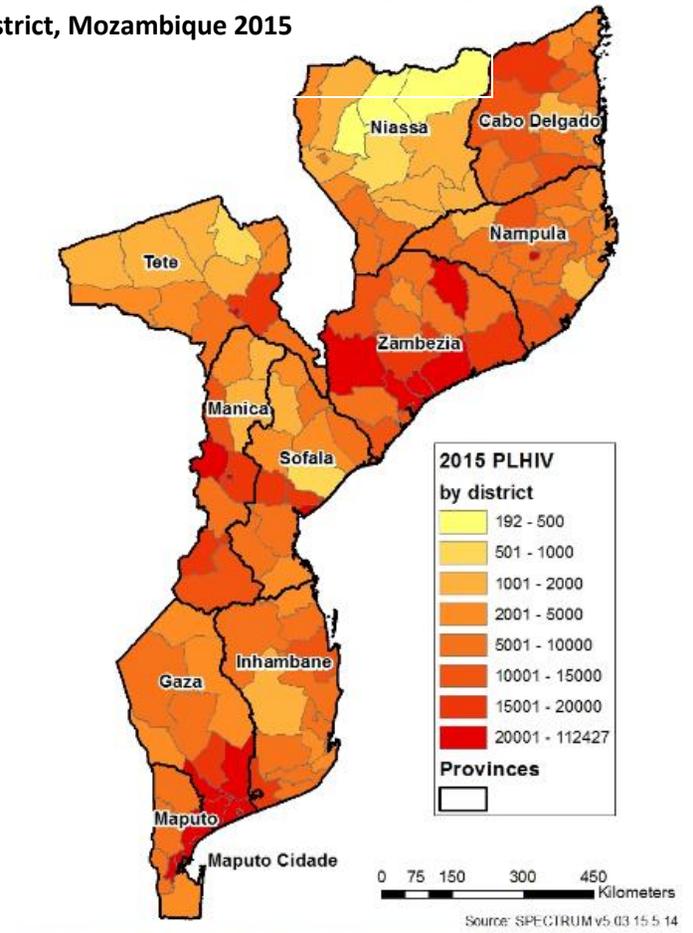


Figure 1.1.4 Pregnant women on ARV, by district, Mozambique, SAPR 2015

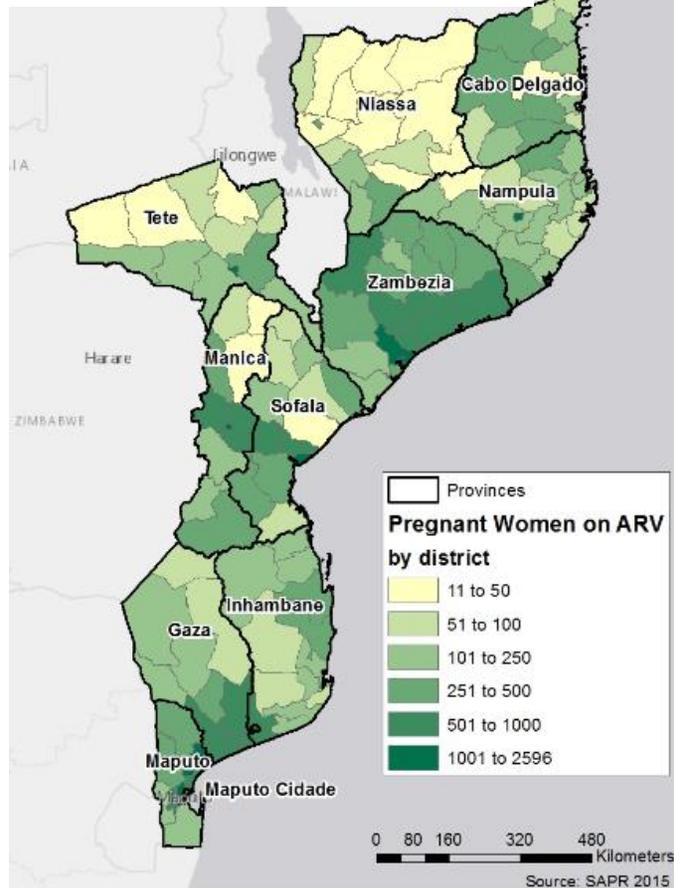
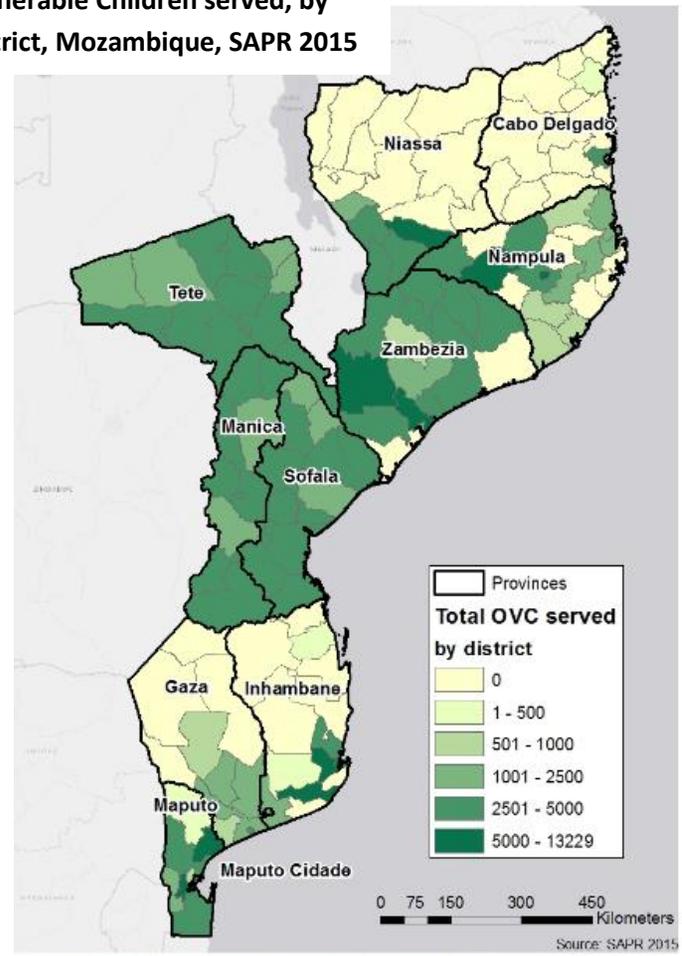


Figure 1.1.5 Orphans & Vulnerable Children served, by district, Mozambique, SAPR 2015



1.2 Investment Profile

Overall expenditures for health and allocation to HIV programs have increased in the last decade. The 2014 National AIDS Spending Assessment (NASA) for 2010 and 2011 reported US \$213 million in CY10 (68% PEPFAR) and US \$260 million in CY11 (72% PEPFAR) for HIV expenditures. The UNAIDS GARPR report (2015) indicate CY 2012 US \$256 million (75% PEPFAR financing), CY 2013 US \$350 million (72% PEPFAR financing), and CY 2014 US \$353 million (72% PEPFAR financing).

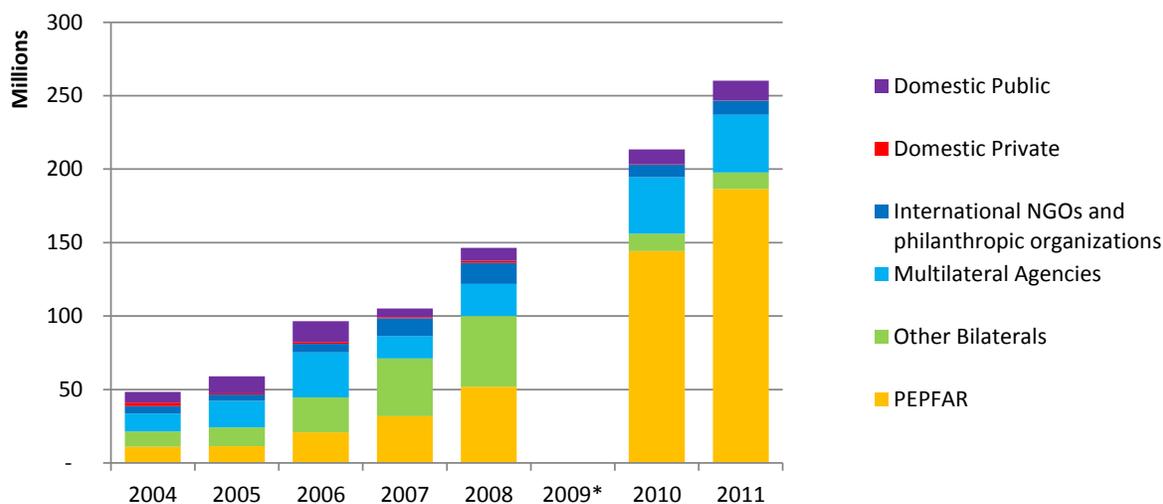
Currently, 96% of the resources available to the HIV response are received through development assistance. This international contribution has begun to level off, despite continuing increases in the numbers of patients requiring care and treatment.²⁰ If this trend continues, it will be challenging to meet the financial requirements for procuring drugs and providing essential services to people with living with HIV.

The GRM budget represents the third largest individual source of funding with US \$21 million allocated to HIV and TB in 2013, primarily used to cover 95% of salaries. Available data suggests 15% of MISAU salaries can be attributed to providing HIV-related services. Despite having doubled from 2004 to 2014, domestic public HIV expenditure represented only 3% of overall HIV expenditures in 2014.²² It is estimated that 11% of MISAU recurrent expenses are allocated to HIV and TB.²¹ Other domestic spending from MISAU covers lab reagents and material and specific services (3% each in 2011). In addition to these allocations to MISAU, the State Budget for HIV is also allocated to the National AIDS Council (CNCS) for the coordination of the national response, and civil society organizations for community activities. Such activities totaled US \$2.6 million in 2011.

²⁰ OECD CRS database on ODA (last visited 28 August 2014)

²¹ UNAIDS Estimates on the basis of official and available information, 2014

Figure 1.2.1 HIV expenditure by financing source (2004-2011)



*no data was collected for 2009; Source: CNCS, MEGAS 2010 & 2011 (2014)

HIV Expenditure by Programmatic Area. There is limited information on HIV expenditures by programmatic area. The most recent UNAIDS GARPR Report for CY 2014 (2015) showed 20% of HIV expenditures were used for prevention programs, while treatment and care accounted for 46%.

Expenditure towards Health System Strengthening. In 2013, US \$292 million was invested in health systems (52% domestic public resources, 23% PROSAUDE and 24% from other external partners).^{22,23} According to NASA, in 2011, US \$26.3 million was spent in HIV specific funding, including expenditure for construction and rehabilitation of facility infrastructure and laboratories (US \$13.6 million), information systems (US \$7 million), drug systems (US \$2.9 million), and others not specified (US \$2.8 million). An additional US \$32 million was spent in 2011 to train health care workers and community members on HIV related topics.

Expenditure by Cost Category. Most commodities for HIV are financed by international partners. In 2014, all ARVs were procured through international mechanisms such as VPP and SCMS, and financed by international donors, including PEPFAR USG (52%), GFATM (45%), and UNITAID/CHAI (3%). The same applied for the acquisition of rapid test kits, financed by the GFATM (57%), PEPFAR (39%), and CHAI (4%), as well as reagents and other commodities for CD4 tests. Condoms also depend on international assistance.

The Government of Mozambique pays salaries of health care workers (estimated at US \$12 million in 2011²⁴) and costs related to implementation. According to the 2014 NASA, 40% of labor costs for HIV

²² MISAU, Relatório de Execução Orçamental (2014)

²³ CNCS, MEGAS 2010-2011 (2014)

²⁴ MISAU, Plano Estratégico para TB

treatment in 2011 were supported by the State Budget, with an additional 8% from PROSAUDE. The remaining 52% was made off-budget, with USG funding including personnel costs for Implementing Partners delivering programs for HIV treatment in 2011 (US \$14.3 million) and MSF (US \$2.3 million). Service delivery is integrated into the national health system but salaries paid to doctors by some NGOs are at levels above the national scale to cover the gaps in health workforce. US \$2.4 million was spent by the USG in 2011 for labor related expenses of national NGOs for home-based care.

Planned Government Contributions. If commitments are maintained and service delivery expands, domestic public expenditure for HIV, TB and malaria will increase to reach US \$53 million in 2017, (totaling US \$127 million between July 2015 and December 2017). The Ministry of Health committed to increase its contribution by US \$28.4 million in 2015, which will raise the contribution of the Government to the three diseases in 2015-2017 to 20% of its health sector contribution. It will be essential to ensure that these funds are strategically allocated to cover key gaps and that funding is executed by MISAU within the calendar year. The Ministry of Defense (FADM) remains committed to development of its military medical system.

Data Availability and Estimations. Overall health sector expenditures are estimated from the annual execution budget reports of the Ministry of Health (*Relatorios de Execucao Orçamental*), complemented by estimations made by WHO and UNICEF. MISAU does not track or report spending by disease category. Reporting of HIV specific funding is based on the National AIDS Spending Assessment (NASA), elaborated by CNCS, which details HIV expenditure by financing source, programmatic area, beneficiary population or geographical location. Data available covers the years 2004 to 2011. HIV funding for 2012 and 2013 was estimated using the latest PEPFAR Expenditure Analysis, ODAMOZ and the Organization for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC) online data bases and donor reports.

Despite positive projections, the Government of Mozambique will not be able to fully cover the costs of its response to HIV (and TB and Malaria). The estimated gap from June 2015 to December 2017 reaches US \$365 million, representing 36% of the Government's Health Sector Budget for the same period.²⁵

²⁵ UNAIDS Estimates on the basis of official and available information, 2014

Table 1.2.1 Investment Profile by Program Area

Program Area	Total Expenditure	% PEPFAR	% GF	% GRP	% Other
Clinical care, treatment and support	131	60%	30%	4.0%	6.0%
Community-based care	13.2	99%	NA	0.5%	0.5%
PMTCT	25.6	97%	1%	NA	2%
HTC	21.1	67%	26%	5%	2%
VMMC	20.8	98%	NA	NA	2%
Priority population prevention	21.8	62%	2%	3%	33%
Key population prevention	5.5	92%	1%	NA	7%
OVC	11.6	100%			
Laboratory	15.5	100%	NA	NA	NA
SI, Surveys and Surveillance	15.5	84%	6%	2%	8%
HSS	58.9	99%	NA	NA	1%
Total	340.5				

Table 1.2.2 Procurement Profile for Key Commodities; Total expenditures SCMS FY 14

ARV	\$57,096,063
RTK	\$4,826,535
Other drugs	\$792,105
LAB reagents & Consumables: \$6,580,939	\$7,603,813
LAB equipment : \$1,022,873	
Condoms	\$0
VMMC kits	\$289,206
Other Commodities	\$293,489
Grand Total	\$70,901,211

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	\$13,818,000	\$12,918,000	8		The objectives of these activities include: Strengthened quality and safety of priority medicines; Improved pharmaco-vigilance and rational use of drugs; Increased capacity of Mozambican CBOs, FBOs, and NGOs to develop and manage programs that improve the quality and coverage of HIV/AIDS prevention, treatment, and care services; Partnerships with CSOs and youth to improve access to quality SRH/FP/STI and HIV/AIDS services; Commodities purchased including condoms, essential medicines, and diagnostics; Increased access to and use of voluntary FP contraceptive methods; Improved maternal and child survival.
USAID TB	\$4,500,000	\$700,000	4		The objectives of these activities include: Strengthened quality and safety of priority medicines; Improved pharmaco-vigilance and rational use of drugs; Increased capacity of Mozambican CBOs, FBOs, and NGOs to develop and manage programs that improve the quality and coverage of HIV/AIDS prevention, treatment, and care services.
USAID Malaria	\$28,000,000	\$16,253,300	5		The objectives of these activities include: Strengthened governance, supply chain, and public financial management systems; Improved maternal and child survival; Improved health behaviors; Improved GRM data quality for enhanced program management and data for decision-making.
USAID Family Planning	\$11,710,000	\$8,610,000	9		The objectives of these activities include: Strengthened quality and safety of priority medicines; Improved pharmaco-vigilance and rational use of drugs; Improved health behaviors; Increased capacity of Mozambican CBOs, FBOs, and NGOs to develop and manage programs improve the quality and

					coverage of HIV/AIDS prevention, treatment, and care services; Commodities purchased including condoms, essential medicines, and diagnostics; Increased access to and use of voluntary FP contraceptive methods; Improved maternal and child survival.
USAID Nutrition	\$5,696,000	\$3,100,000	3		The objectives of these activities include, but are not limited to: Increased capacity of MISAU to develop and implement nutrition-oriented policies and programs; Improved maternal and child survival.
Private Sector PPP	a) \$1,500,000	\$1,500,000	8		a) Expand coverage of early childhood development component of OVC platform in Maputo Province. The project goal is to improve child development outcomes for children of 0 -3 years of age through an integrated health, nutrition, sensitive care and stimulation approach; Integrate and expand the promotion of ECD into maternal and child health and nutrition (MCHN) and prevention of mother to child transmission (PMTCT) services at the health facility and community level in Maputo and additional provinces.
a) Hilton ECD PPP	b) \$1,149,000	\$1,149,000	1		b) Project VIDAS Scale-up For Extractive Industry: PPP agreement formed between CDC and Anadarko, implemented by Pathfinder International addressing key populations friendly health clinics and outreach activities.
b) Anadarko	c) \$225,000	\$ 225,000	1		c) The program works within Maputo Central Hospital in collaboration with Eduardo Mondlane School of Medicine. Maputo Central Hospital Maputo UCLA to improve the quality of care for pediatric [patients and increases technical capacity
c) Maputo Central Hospital Maputo UCLA Training Program with UEM					

PEPFAR Central Initiative: ACT	\$13,340,109	\$13,340,109	8		Objectives of these activities include: policy development, community engagement, HIV case identification, linkages, treatment, and monitoring, adherence and retention, SI for pediatric HIV, domestic resource commitment, to increase number of children receiving ART.
PEPFAR Central Initiative: DREAMS (pending approval)	\$14,273,257	\$14,273,257			Objectives of these activities include: empowerment for girls and young women, through condom promotion, HTC, PrEP, post-violence care, contraceptive education, social asset building, school-based HIV and violence prevention, community mobilization, social protection, parenting/caregiver programs to strengthen families, and activities to decrease risk in sex partners.

1.3 National Sustainability Profile (See Sustainability Index and Dashboard)

In Mozambique, we identified the following elements as unsustainable: financial/expenditure data, commodity security and supply chain, quality management, resource commitments and technical efficiencies. Key to the rapid expansion of care and treatment in the Mozambican context are commodity security and supply chain, quality management, human resources and strategic information. Moving towards a sustainable response requires improving the government's allocative efficiency and oversight and stewardship, including eligibility criteria for ART initiation. There are weaknesses in the generation of quality epidemiological and health program data, linkage and retention data; as well as systemic issues in access to healthcare services, availability of healthcare human resources, resource allocation and allocative efficiency. Some areas that scored green do not match the perception of country team members, perhaps because the instrument fails to capture enough granularity and the quality of the indicators requested.

With such fundamental systemic weaknesses in the health sector, PEPFAR has prioritized supply and laboratory chains, health information systems, human resources for health, and health care financing, and will continue to encourage the GRM to increase their share in these areas. Prioritized activities to target these weaknesses are described in Section 6.0.

1.4 Alignment of PEPFAR investments geographically to disease burden

Based on the geographic prioritization exercise revised in Windhoek June 2015, PEPFAR investments will concentrate on 77 high-burden scale up districts. Figures 3A and 3B (p35) summarize the FY16 and FY17 targets which will lead to 73% coverage+ of PLHIV in these scale up districts by 2017 (39 districts) and 2018 (37 districts). The new 77 scale up districts account for 86% of all PLHIV in Mozambique and have been prioritized to attain maximum impact of the treatment and prevention of HIV.

Figure 1.4.1 shows the percentage of PLHIV by sub-national unit (SNU, or province for Mozambique) and the total expenditure per PLHIV in FY 2014 (excluding ARV), indicating a national average of \$119.75 (range \$76 - \$170). Expenditures for ARVs in FY 2014 were \$57M.

Fig 1.4.2 shows care and treatment expenditures (excluding ARVs) by province which demonstrates increasing investments in care and treatment. These figures represent historic expenditures since 2012. Expenditure analysis (EA) data for 2015 will reflect increased investment in geographic areas designated as priority scale-up areas, as we 'pivot' our attention to strategic geographic focus for more rapid epidemic control.

Figure 1.4.3 and Fig 1.4.4 reflect provincial level expenditures excluding ARVs in FY14 prior to the geographic pivot.

Fig 1.4.1 2014 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by province (excluding ARVs)

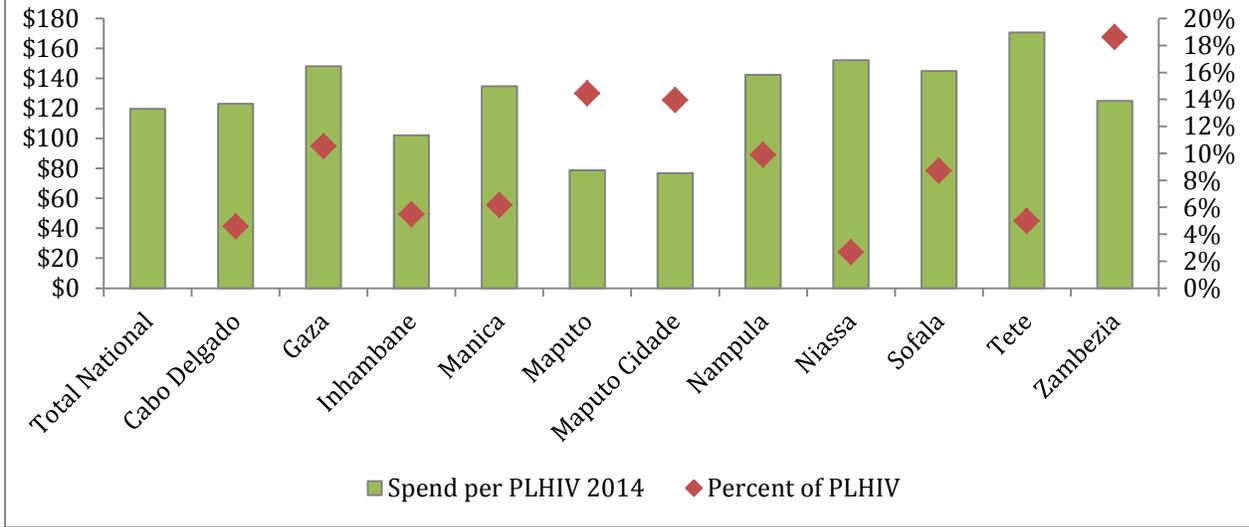


Fig 1.4.2 Care and Treatment Expenditure and Prevalence by Fiscal Year and province (excluding ARVs)

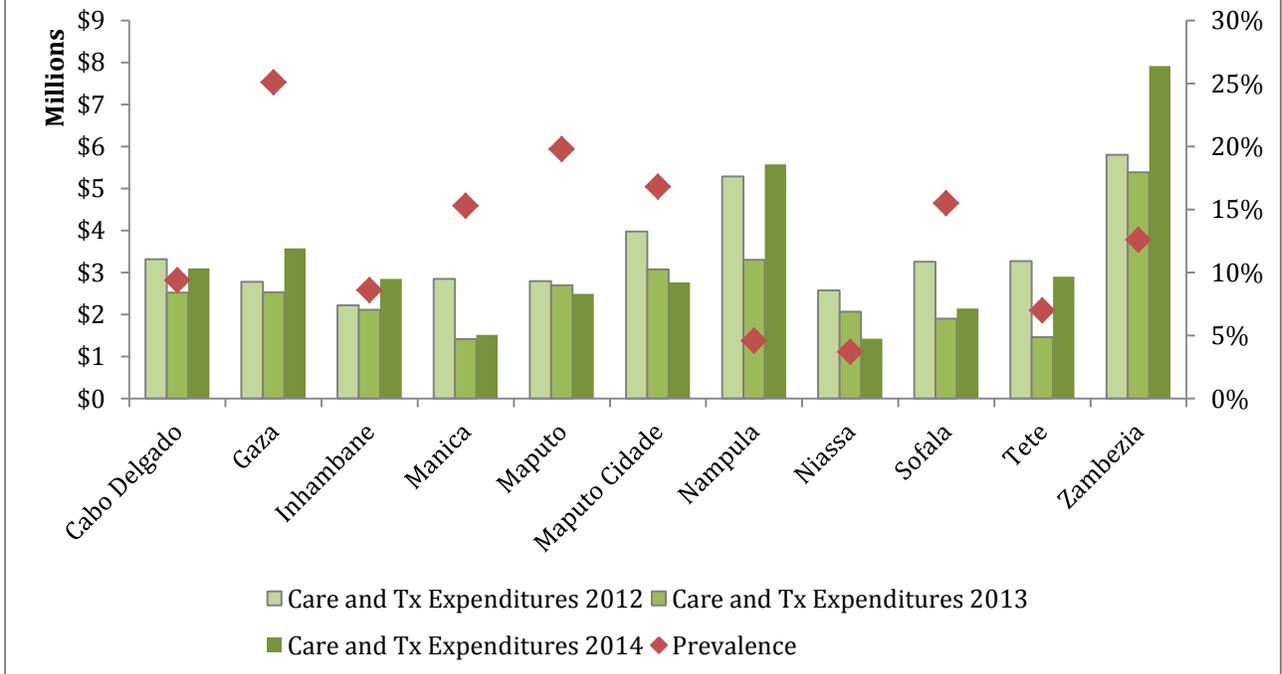


Fig. 1.4.3 2014 PEPFAR Care and Treatment Expenditure (excluding ARVs), Total PLHIV, and Number on ART by province

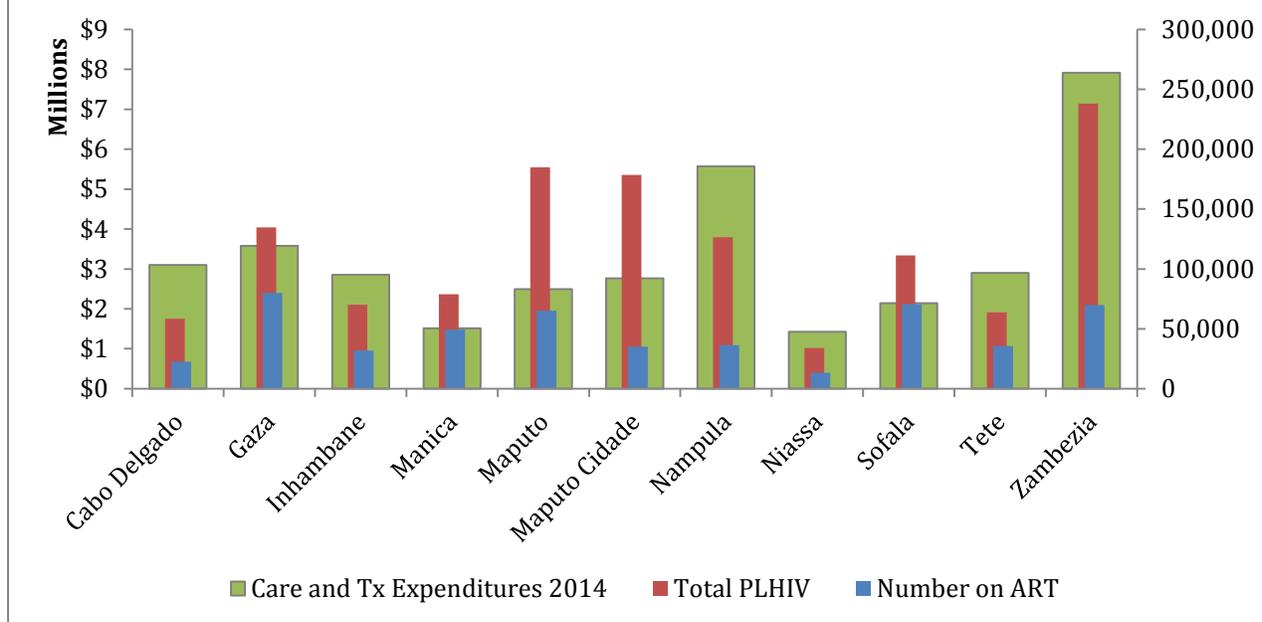
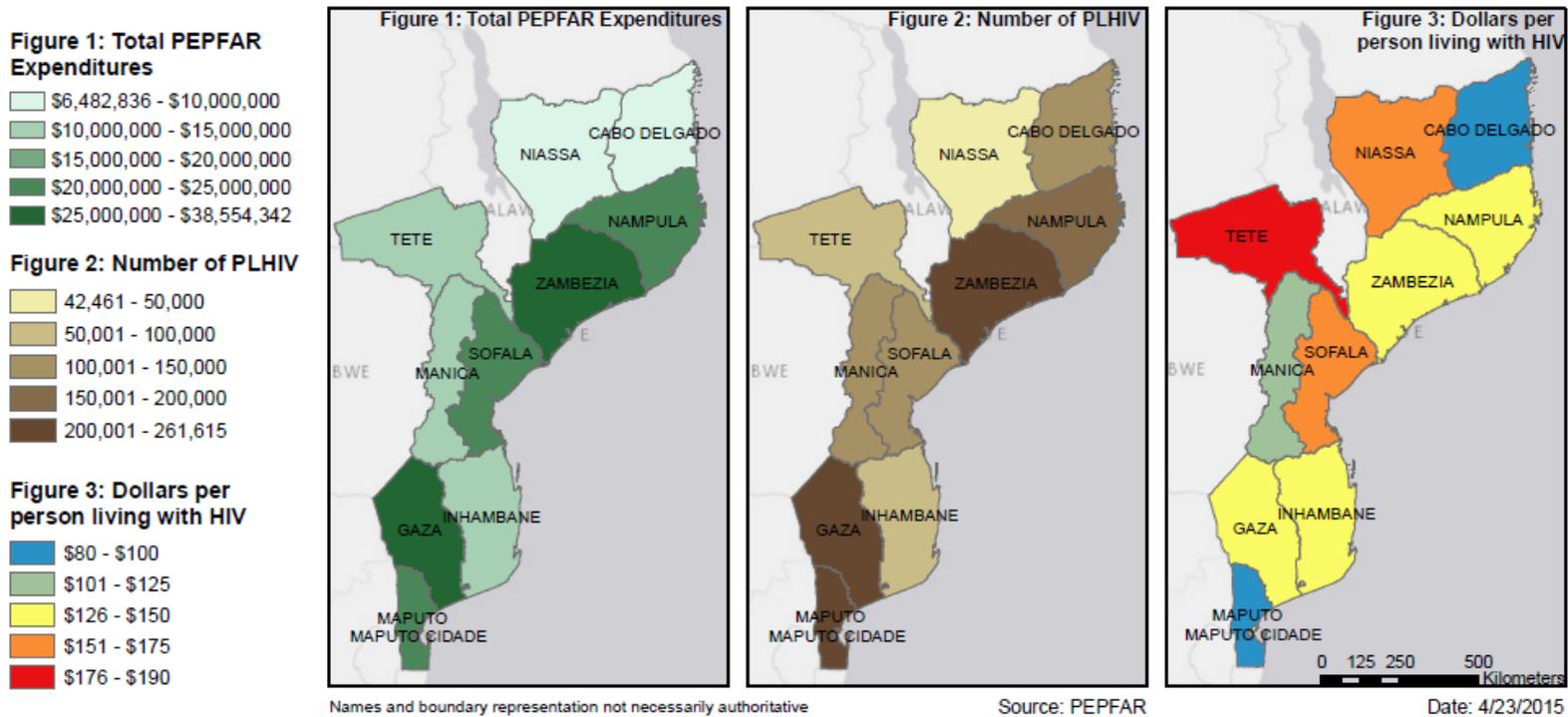


Figure 1.4.4 Total expenditure, PLHIV, and Expenditure per PLHIV by District*



* Note: This map only reflects PEPFAR spend and does not include MSF and Dream investments in ART, which may affect, for example, the investments in Maputo and Sofala.

1.5 Stakeholder Engagement

Government of Mozambique. The Government of Mozambique is the primary partner in everything that the PEPFAR program does in country. The USG holds regular meetings with senior officials in the Ministry of Health and other key ministries to ensure that PEPFAR programs align with MOH strategies and priorities while also maintaining an alignment with global PEPFAR goals. Agency leadership met with senior GRM officials between December 2014 and February 2015 to explain the geographic pivot to scale-up in particular districts and the proposed site-specific testing, care and treatment support packages. Similar meetings occurred in all provinces with Provincial Health Directors. The US Ambassador met with the Minister of Health on April 22, 2015 to discuss leveraging PEPFAR funds with increased GRM allocations to address the HIV epidemic as well as moving towards WHO 2013 treatment eligibility guidelines using a CD4 threshold of 500 cells/mm³. An interagency working group is working closely to develop analyses requested by the MOH to facilitate this decision. The PEPFAR team continues to work with MISAU to assure increased quality services.

Global Fund and other external donors. USG is a key representative of the donor community at the Country Coordinating Mechanism CCM. The CDC Country Director is the lead of the strategic supervision working group, and the USAID Integrated Health Office (IHO) Director is USG Alternate representative with the Global Fund. The USAID IHO Director represents the USG on the Health Partners Group, where other USG staff co-chair or are participants in technical subgroups.

The Mozambique PEPFAR team includes a dedicated staff member for liaising and coordinating with the Global Fund, and this staff member and other members of the team regularly meets with the Global Fund Portfolio Manager to ensure complementarity of response between PEPFAR funded components and those funded through the GFATM.

USG provided technical assistance to the CCM to apply for the New Funding Mechanism (NFM) of the Global Fund. The USG will closely collaborate with partners funded through the GFATM for new activities planned to be implemented through the NFM, especially addressing female sex workers and their partners and MSM. GFATM, MISAU and the PEPFAR supply chain team collaborate to forecast essential HIV commodities.

Civil Society.²⁶ There has been ongoing dialogue with civil society through meetings with the National AIDS Council (CNCS) and within national technical working groups. In March 2015, PEPFAR senior management met with more than 45 members of Mozambican civil society at the CNCS to review PEPFAR 3.0. In April 2015, PEPFAR Mozambique hosted a retreat with civil society to focus on COP15, particularly “right places” and “right things”, as well as to plan for meaningful engagement with civil society going forward. Participants included prime partners and sub-contractors, international NGOs,

²⁶ See PEPFAR Mozambique COP15 Supplemental Documentation of Civil Society Engagement Process for more details

local NGOs, and CBOs. Other civil society platforms and representatives were invited, as well as members funded through the Country Coordinating Mechanism. The PEPFAR team plans to have regular and robust engagement with civil society in the implementation of COP15, and particularly to be transparent, share results in a timely way, and actively seek civil society feedback and input into planning.

Private Sector. COP15 has three Public-Private Partnership (PPP) activities, two of which were approved in COP14 through the Office of the Global AIDS Coordinator (OGAC) Incentive Fund. The private health sector in Mozambique is small but growing. A number of private clinics cater to the upper middle class in cities, while private pharmacies reach sectors of the population that are less affluent. Extraction industry companies are opening clinics for their workforce and the provincial leadership of Tete Province has secured MISAU approval to pilot provision of ARVs for employees within private clinics. MISAU is tracking the progress of the private sector, and is concerned about “brain drain” to the NGO/donor sector. The human resources observatory has begun to collect data on the private sector, but these data are not yet available.

Table 1.5.1 Private Sector Funds Overview

Partner	Funds Programmed in COP				Private Sector Funds Pledged			
	COP FY 2014	COP FY 2015	COP FY 2016	COP FY 2017	Private Sector Funds 2014	Private Sector Funds 2015	Private Sector Funds 2016	Private Sector Funds 2017
Gorongosa National Park	200,000				358,800			
ICRH Project	235,204				264,269			
Youth: Work Mozambique	350,000				-			
Maputo Central Hospital Maputo UCLA Training Program with UEM	225,000				200,000			
Project VIDAS Scale-up for Extractive Industry	69,800	164,000	163,000	111,950	526,900	390,000	390,000	236,850
Integrating Early Child Development	500,000				1,500,000			
LabCorp/Mozambique Healthcare Consortium	450,000	607,444	467,444		80,000	183,433	141,433	
Labs4Life	592,980	1,425,000	1,425,000	1,425,000	159,000	250,000	300,000	
TOTAL	2,622,984	2,196,444	2,055,444	1,536,950	3,088,969	823,433	831,433	236,850

Human Rights.²⁷ The Mozambican Constitution recognizes the right to health care, ensuring all citizens enjoy the same rights regardless of color, race, sex, ethnicity, place of birth, religion, educational level, social position, or gender. The Charter on Patients’ Rights and Obligations (*Carta dos Direitos e Deveres dos Utentes*), adopted by the Ministry of Health in 2006, reaffirms and elaborates on the centrality of human rights in health services, highlighting human dignity, equality, ethics, and solidarity as fundamental values. It specifically addresses issues around non-discrimination, confidentiality, privacy,

²⁷ See PEPFAR Mozambique COP15 Supplemental Documentation Human Rights Referral System Assessment for more details

and the right to voice suggestions and grievances and to receive timely feedback. The Law on Protection of the Individual, the Worker, and the Candidate for Employment Living with HIV and AIDS (*Lei da Protecção da Pessoa, do Trabalhador e do Candidato a Emprego Vivendo com HIV e SIDA*), first adopted in 2002, revised in 2009 and again in 2014, guarantees protection of the rights of people living with HIV. This law states that persons living with HIV and AIDS have a right to free treatment at the National Health Service, that victims of sexual crime should have access to Post-Exposure Prophylaxis (PEP), legal and psycho-social support, and that the State guarantees allocation of necessary means to do so. In October 2010 Mozambique ratified the *International Convention on the Rights of Persons with Disabilities*.

Although there are a number of laws in place which address the right to equal and non-discriminatory access to services, the impact of these laws and policies continues to be undermined by insufficient dissemination and enforcement, high rates of illiteracy, and power dynamics that prevent those whose rights have been violated from pursuing redress.

In COP15, efforts to provide equal access to services and quality of services are included in all program areas. Equal access programs include interventions to train health providers to provide more humanized care and treatment for the specific needs of female sex workers (FSW) and men who have sex with men (MSM); focus on care and services for victims of Gender-Based Violence (GBV) is also a part. Elements of citizens' empowerment and awareness of their rights are also included. All interventions across prevention, care and treatment address stigma and discrimination to reduce barriers to access and continuous use of health services.

Country Health Partnership. The following processes and structures enable joint decision-making on PEPFAR resource allocation, increased transparency in the sharing data and results, and promote mutually accountable measures of progress and advocacy.

- a) USG has regular coordination meetings with MISAU, chaired by senior leadership of the Ministry of Health, with the National Directors. These provide a forum for joint decision-making and monitoring of progress, and a venue for USG to brief MISAU and MMAS on SAPR/APR results and key issues. MISAU has indicated a desire to be more engaged in COP16 planning to ensure alignment with GRM.
- b) USG briefs MISAU on performance (S/APR) and expenditure (EA) data process and results at a high level as well as SIMS, and provides regular, consolidated feedback on key issues identified through the Site Improvement through Monitoring System (SIMS) to MISAU and provincial DPS. MISAU has expressed interest in participating in SIMS site visits.²⁸

²⁸ The National Acceleration Plan (NAP) incorporated the model developed in SMS which they now use in their site visits.

- c) During COP15 the PEPFAR team will work with the GRM to identify benchmarks and milestones such as increased proportion of GRM resources dedicated to HIV/AIDS, and budget for HIV commodities and human resources for health (HRH) dedicated to scale-up districts.
- d) The USG is supporting MISAU to develop the first Health Financing Strategy, expected to be finalized during COP 15 implementation. USG will work with MISAU to develop an operational plan and financing strategy, to include options to increase domestic financing for HIV/AIDS and other key diseases such as malaria and TB.

2.0 CORE, NEAR-CORE AND NON-CORE ACTIVITIES FOR OPERATING CYCLE

PEPFAR Mozambique considered the activities required to achieve sustained epidemic control, the current country investment portfolio, and gaps/bottlenecks preventing program scale up (as illustrated by the sustainability index results and SIMS data) in defining core, near-core, and non-core activities for program implementation through COP15. Because PEPFAR is the primary funder for key activities in the national response, combination prevention activities and aspects of community-based care, OVC and priority population prevention are considered core, as well as technical assistance (TA) for commodity procurement and supply chain and information systems. PEPFAR is the prime source of TA to support care and treatment, which remains primarily a core activity. Combination prevention and care and treatment activities, palliative care, and Water, Sanitation and Hygiene (WASH) are classified as non-core and will end in 2016. (See Appendix A for full list of core, near-core, and non-core activities and transition plans.)

3.0 GEOGRAPHIC AND POPULATION PRIORITIZATION

During the COP15 review process it was determined that although the process of COP14 prioritization had been robust (based primarily on prevalence and then PLHIV), its core focus may not have been optimal for epidemic control, as well as the ability to reach “saturation” (80% care and treatment coverage for PLHIV) by 2017. Therefore, in COP15 the criteria for districts to be prioritized as scale-up changed. A care and treatment coverage target of 73% of all PLHIV at the district level for scale-up districts was set as the goal for the next 2-3 years (a reduction from the original 80% target, as it was determined that 80% coverage was not feasible, explained below). And finally, the time frame in which scale-up districts would reach saturation/coverage was extended to include not only 2017 but also 2018.

In COP15, the selection criteria for rapid ART scale-up districts was based primarily on the burden of disease (defined as number of PLHIV), secondarily on prevalence, and then on the district’s present coverage level (unmet need) and its feasibility to achieve rapid scale-up (delta to saturation, previous year’s growth rate, and retention-in-care rates) and contiguousness with other districts with HIV services (especially in urban areas).

The main reason that 80% saturation of PLHIV was deemed unattainable, and targets were instead set based on a coverage of PLHIV of 73%, is that given the present eligibility criteria for test and treat populations and assuming a change in the CD4 threshold level for treatment eligibility for others from 350 to 500 cells/mm³, only approximately 80% of PLHIV would be eligible for ART according to the Mozambican national guidelines. Of those eligible, we assumed the HIV program would only be able to locate, test, and link to care 90% of these HIV-infected individuals, which means that we can only reach a maximum of 73% coverage of PLHIV in the next 2 to 3 years.

Another methodological change in target setting for COP15 was the extension of the timeframe in which a district could reach the 73% coverage goal to either the end of 2017 or end of 2018, dependent upon its present coverage and retention-in-care rate. The general guide used to make this differentiation was districts that had above 40% coverage and above 70% retention were districts that could reach 73% coverage by the end of 2017. Other districts were given the extended time frame of 2018. The testing, care, and treatment facility and community packages remain the same for all rapid scale-up districts.

Based on the above criteria, 2 tiers of scale-up districts (n=77) were developed;

- 1 district is presently at saturation, with 28,893 PLHIV and ART coverage of 86%. PEPFAR support in this district will focus on retention and virologic suppression.
- 76 districts are considered aggressive scale-up, and include 1,367,012 PLHIV. These districts will receive the scale-up package (DSD support), to aid in the goal of 73% ART coverage. 39 of these districts are expected to reach 73% coverage by FY17, and the remaining 37 districts will reach 73% coverage by FY18.

These 77 districts account for approximately 513 ART sites and 1,395,904 PLHIV. In scale-up districts, almost all ART, PMTCT B+, and HTC sites reported in SAPR15 will be considered scale-up sites and will implement an aggressive scale-up package. The only sites that will no longer receive PEPFAR attributable support are those sites that have less than five people who tested positive for HIV in the last six months in the last 6 months in their Voluntary Counseling and Testing (VCT), Provider Initiated Counseling and Testing (PICT) or Prevention of Mother to Child Transmission (PMTCT) testing modalities. These sites are considered too low burden to maintain PEPFAR support. A transition plan will be developed with the MOH for these very low yield sites, and will be considered centrally supported sites.

In the 71 districts that were not selected for rapid scale-up (“sustained response” districts), which account for 267 sites and 227,919 PLHIV, it is expected that MISAU will continue to work in these sites and that the sites will continue at their current treatment growth rates. The treatment growth assumed for these areas for the purpose of targeting ranged from 10% to 12% depending on the site, its previous growth rates, and other factors.

In sustained response districts, PEPFAR will no longer support demand creation at the site or community level, OVC services, or community-based testing services. Other PEPFAR support in these sustained response districts (n=71), varies by site. Specific sites will receive either a sustained response package or a quality assurance package. (See Care and Treatment 4.2.1 and Figure 4.2.1 for details on sustained response and quality assurance packages).

- Sites with more than 500 ART/PMTCT B+ patients within the sustained response districts will receive a sustained response package that includes continued technical assistance (TA) support from PEPFAR implementing partners.
- Sustained response ART sites that range from 30 to 500 ART patients will receive a quality assurance package that includes a visit 2 times a year by PEPFAR funded clinical partners to assure quality services using a quality improvement lite approach, but otherwise will no longer receive PEPFAR attributable support.
- Centrally supported ART sites with less than 30 patients will be completely transitioned to the GRM by the end of 2017 (a two-year transition plan). A plan and timeline for these small ART and PMTCT sites identified for transition will be developed with MISAU and with provincial leadership to ensure that support for these sites is built into the GRM's annual planning budget and/or secured from other partners such as PROSAUDE.

PMTCT and HTC sites were similarly aligned with ART and PMTCT sites for scale up, sustained or central support. HTC-only sites with less than five identified HIV-positive patients in the last six months were not allocated targets for COP15 and will be transitioned to MISAU, regardless of being located in scale up or sustained response districts.

Targets: Understanding the rationale behind achieving 73% coverage within rapid scale up districts, COP15 sets ambitious treatment targets that aim to cover 90% of PLHIVs eligible for ART at CD4<500 and test-and-treat populations by FY17 or FY18. These targets can only be realized with the support of MISAU to change current national guidelines for the treatment threshold for ART initiation. Results from APR14 indicate 41% of newly initiated ART patients fall within the Test and Treat categories.²⁹ Based on these assumptions, 86% of estimated PLHIVs fall within the rapid scale-up districts. By reaching 90% of those eligible by FY17 or FY18, national treatment coverage in these districts by the end of FY17 will be approximately 72% of all PLHIV. New Mozambican national targets and PEPFAR attributable targets for FY16 and FY17 are presented in Figures 3A and 3B below.

Programs addressing female sex workers will focus in 28 scale-up districts and 8 sustained response districts which are either along transport corridors and/or hotspots. The USG has been the sole funder for MSM health advocacy to date and the Mozambique program is strongly aligned with the PEPFAR 3.0 Human Rights Agenda. The NFM application includes new programs with commercial sex workers and MSM, but it is anticipated that it will take some time for the GFATM programs to be established. All FSW and MSM sites and communities will continue to be fully supported by PEPFAR.

²⁹ Including HIV/TB co-infection, pregnant women starting B+, children <5 years. National data is not available or quantifiable for key populations and sero-positive male partners of sero-negative pregnant women.

Due to the migratory nature of the military and the high prevalence of HIV within this population, COP15 sets treatment targets that cover 90% of active-duty military PLHIV eligible for ART at CD4<500 by FY17, similarly to the general population. Scale-up of ART for active-duty military men and women will be achieved through addition of mobile ART units and improved capacity and linkage of military personnel to the current ART sites.

Figure 3A. New Mozambican National Targets

NATIONAL	CD4=500 v 5.03	PLHIV (2015)	Need (2017)	MOZ FY16 Targets	MOZ FY17 Targets	%Coverage of Eligible in FY17	%Coverage of PLHIV in FY17	TX_NEW FY16	TX_NEW FY17
	Scale Up	1,395,904	1,159,158	815,632	1,004,508	87%	72%	383,339	389,778
	Sustained Response	227,919	182,948	99,974	109,160	60%	48%	34,529	31,018
	Total	1,623,823	1,342,106	915,606	1,113,668	83%	69%	417,868	420,796

* MISAU targets for commodities were 885,164 for FY16 and 996,593 for FY17. Proposed COP15 targets are now (3.5%) and (12%) over the MISAU commodities calculations.

Figure 3B. PEPFAR Attributable Targets	CD4=500 v 5.03	PLHIV (2015)	Need (2017)	PEPFAR FY16 Targets	PEPFAR FY17 Targets	%Coverage of Need in FY17	%Coverage of PLHIV in FY17	TX_NEW FY16	TX_NEW FY17
	Scale Up	1,395,904	1,159,158	753,219	900,486	78%	65%	327,021	327,364
	Sustained Response	227,919	182,948	61,603	67,007	37%	29%	20,385	31,018
	Total	1,623,823	1,342,106	814,822	967,493	72%	60%	347,406	358,382

4.0 PROGRAM ACTIVITIES FOR EPIDEMIC CONTROL IN PRIORITY LOCATIONS AND POPULATIONS

4.1 Targets for Priority Locations and Populations

The PEPFAR care and treatment technical working group (TWG) defined three types of site support dependent on location and size within two categories of districts. The components of the testing, care, and treatment packages for site support in scale-up districts, and sustained response districts are further explained in Section 4.2. Efficiencies have been gained by focusing where support is needed, primarily in the scale-up sites in rapid scale-up districts.

As noted, the GRM has adopted a test and treat approach for HIV/TB co-infected patients, pregnant women (B+), children <5 years, key populations (CSWs and MSM) and sero-positive male partners of sero-negative pregnant women. PEPFAR's aim in COP15 is to support MISAU to adapt their treatment guidelines from eligibility criteria from a CD4 threshold of 350 to 500 cells/mm³. This change would allow for all 513 sites in rapid scale up districts to move towards treatment of 90% of all eligible (approximately 73% of all PLHIV in scale-up districts).

All ART and PMTCT B+ sites in scale up districts are considered scale up, given the low saturation rates in many districts and the large number of new ART sites established within the last 12 months. With concerted efforts to increase retention in care and treatment, retention will be at 80% by FY17. As targets were cascaded to site level, an operational feasibility cap of 500% growth for patients on treatment from SAPR15 to FY17 and FY18 was included.

For PEPFAR sustained response districts, a passive growth rate of 12-15% was assumed for districts included in the MISAU Acceleration Plan and a 10% passive growth rate was assumed if districts were neither a PEPFAR nor MISAU focus district.³⁰

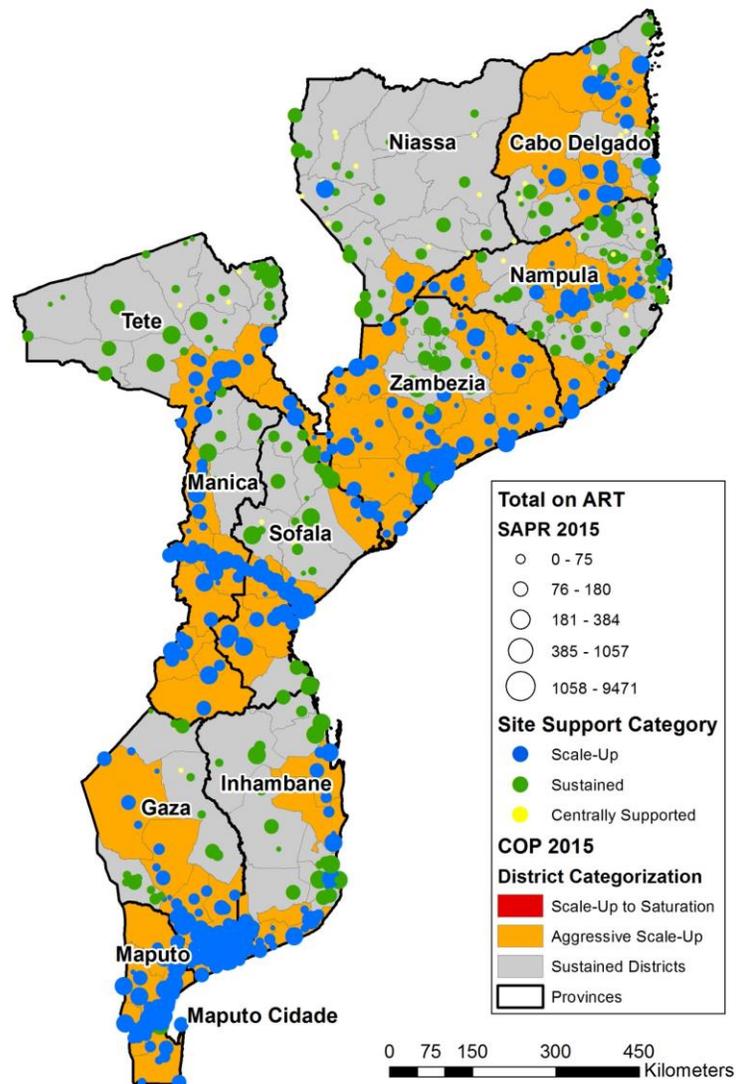
Based on these assumptions, it is estimated in total that 1,113,668 patients will be on ART in Mozambique by the end of 2017, of which 1,004,508 will be in scale up districts (Fig 3A). In these 77 districts, PEPFAR Mozambique is expected to reach 753,219 and 900,486 at 512 supported sites for FY16 and FY17, respectively. In the remaining 71 sustained response districts, PEPFAR Mozambique's attributable targets are 61,603 and 67,007 in FY16 and FY17. To ensure these national targets, Mozambique needs to newly enroll 383,339 in 2016 and 389,778 in 2017. Potential threats to achieving these targets include the need for the GRM to adjust the current treatment guidelines and reaching the targeted retention rate.

³⁰ These growth rates were based on historical data from PEPFAR and MISAU on the rate of increase of enrolling people on treatment.

The other patients will be seen at the 222 Ministry of Health sites. These sites will receive 2 visits per year from PEPFAR implementing partners to assure quality, but are longer PEPFAR attributable.

Of these 222 smaller ART and PMTCT B+ sites, there are 38 sites that are less than 30 patients. PEPFAR is working with MISAU to fully transition these sites to the Ministry by the end of 2017. As of SAPR15, these 38 sites include less than 1000 ART and PMTCT patients in total.

Figure 4.1.1

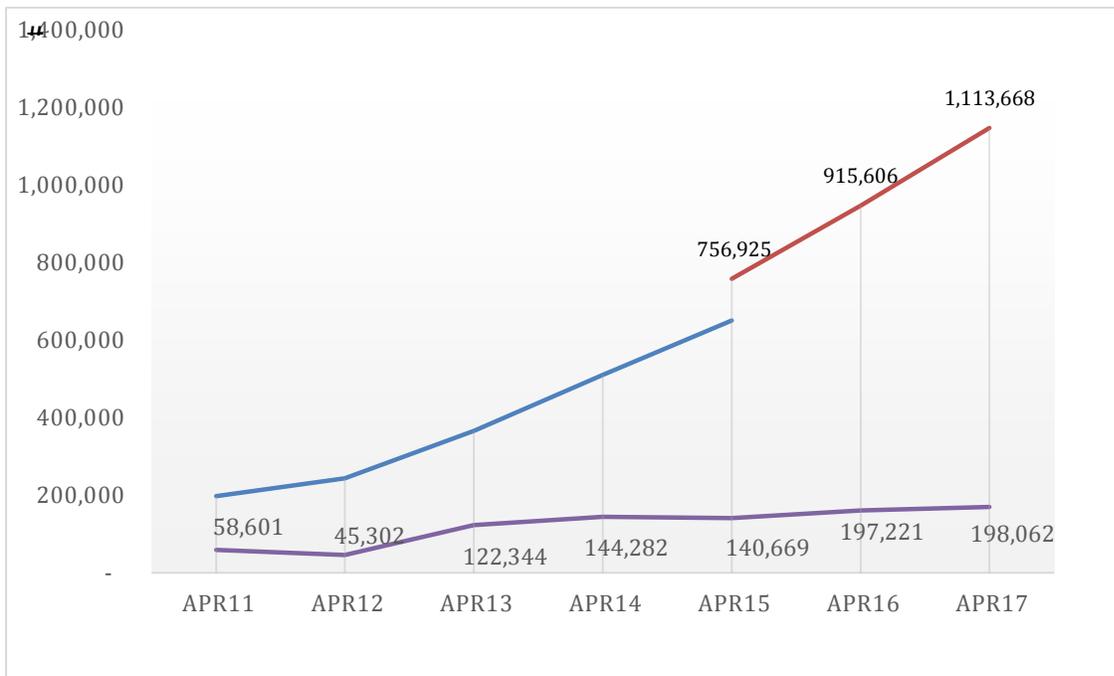


Understanding the need to strive for high ART coverage of PLHIVs on treatment by FY17, there are significant implications for commodity security and other health systems. The ambitious treatment targets of COP15 are greater than the present MISAU targets used to define commodity quantifications.

ARVs quantification is exceeded by 3.5% in FY16 and 12% in FY17. Consideration must also be made for increased requirements of lab reagents (CD4, viral load etc.). Without significant additional resources in the pipeline for commodity procurements to allow additional stock to arrive in country by FY17, exceeding the MISAU treatment targets by 12% would likely result in stock out of commodities in country.

The PEPFAR team has been working closely with GFATM to negotiate the earlier disbursement of future funding. ARV financing gaps are covered in FY15 and FY16 by GFATM Y4, GFATM Y5, new GFATM savings, GFATM GAC and PEPFAR resources. With rapid scale up, it will be essential that GFATM disbursements and procurements are on time as the country will be dependent on GFATM-funded HIV commodities. The financial gap for the procurement of ARVs for FY17 of is anticipated by July 2016, the size of which is dependent on the funding level for ARVs from the Global Fund. There are also critical commodities systems capacity limitations requiring time and funding to develop which include adequate warehousing, sufficient human resources, transport and logistics.

Figure 4.1.2: ART growth from 2011 to 2017.



HIV testing and counseling (HTC) targets were determined using an established methodology that incorporates program results to estimate the number of new PLHIV specifically by HTC modalities (Provider-Initiated Testing and Counseling (PITC), Voluntary Testing and Counseling (VCT) and Community Counseling and Testing (CCT)) to align with care and treatment targets. Offsets for case finding from other sources (e.g. PMTCT, TB, care pipeline) are incorporated, as well as adjustments for HIV prevalence, ART eligibility, and rates of successful linkages to care and treatment.

The ratio of HTC to ART targets varies geographically according to differences in these adjustment factors. Significant assumptions for efficiency gains (e.g. increased rate of linkage) were assumed to generate targets that matched ART program needs within the available budget envelope. The mix of HTC modalities was updated for efficiency purposes, with redirection of all community testing towards a national program for index-testing and key populations.

Further efficiencies in identifying PLHIVs include heavier reliance on index case testing/family tree approaches. The index testing approach can happen in facility (if partner/contact comes to facility) or community (if lay counselor/health educator etc. performs outreach). Overall, the majority of facility-based HTC targets are from ART/ PMTCT scale up sites. Community and index testing approaches are exclusively planned at scale-up sites. Final targets were reviewed to ensure HTC targets did not violate logic checks, such as finding more PLHIV cases than the estimated number of PLHIV in a given geographic area.

VMMC services will be focused on 47 scale-up districts where male circumcision rates are low. VMMC targets were set according to the stepwise process provided in the COP15 guidance, determining the current prevalence of VMMC in each priority geographic location, and how many additional male circumcisions are required to reach the level of VMMC saturation by 2017, which are operationally feasible and within the available funding envelope. Although demand creation will focus on men aged 15-29 years old, children younger than this will not be turned away should they request VMMC. The military VMMC program will primarily target active-duty military men, but will continue to reach both military and civilians. All PEPFAR VMMC support is classified as direct service delivery (DSD).

The OVC program will be aligned to the scale-up districts. OVC targets were defined based on the estimated OVC population in each district. Thirty percent of these OVC estimates were used as the PEPFAR OVC target, after which a few district-specific adjustments were made to account for specific contextual factors (such as HIV prevalence, level of poverty, and knowledge of the needs of OVC), with support from other donors.

The renewed focus on interventions for KP and other priority populations was aligned with district-level PLHIV population size estimations, as national data to inform these estimations remain sparse and only concentrated in several large urban areas, where behavioral and biological surveys have been conducted. COP15 will concentrate on mapping and size estimations of several key populations in Mozambique.

Table 4.1.1 ART Targets in Scale-up Districts					
SNU*	Total PLHIV	Expected current on ART (2015)	Additional patients required for 80% ART coverage	TX_CURR (FY16)	TX_NEW (FY16)
Alto Molocue	22,901	4,285	14,036	7,713	6,246
Ancuabe	7,711	2,410	3,758	3,242	1,893
Angoche	10,425	1,955	6,384	3,514	2,818
Barue	13,043	5,006	5,428	6,103	2,643
Bilene	29,917	12,934	10,999	16,076	7,012
Boane	25,218	9,430	10,744	12,815	5,893
Buzi	8,712	4,271	2,699	4,934	1,541
Changara	8,338	4,608	2,063	4,982	1,751
Chibabava	6,852	3,804	1,678	4,103	1,024
Chibuto	33,832	13,941	13,124	17,837	8,199
Chicualacuala	6,454	2,649	2,514	3,398	1,568
Chinde	11,305	2,237	6,807	3,888	3,070
Chiure	12,849	3,819	6,460	5,270	3,181
Chokwe	34,276	21,632	5,789	21,826	5,354
Cidade Da Beira	61,498	37,594	11,604	38,550	7,721
Cidade Da Matola	112,427	35,516	54,426	53,870	28,989
Cidade De Chimoio	31,761	19,006	6,403	19,705	5,714
Cidade De Lichinga	9,688	4,521	3,229	5,372	2,185
Cidade De Nampula	34,957	15,809	12,156	19,133	10,097
Cidade De Pemba	20,214	7,258	8,913	10,122	6,222
Cidade De Quelimane	28,893	20,699	2,416	22,148	8,857
Cidade De Tete	20,242	14,552	1,641	14,664	3,806
Cidade De Xai-Xai	25,844	16,480	4,195	16,541	3,970

Cuamba	7,130	3,419	2,285	3,791	1,288
Dondo	16,780	7,984	5,441	9,382	3,071
Gile	7,937	2,050	4,299	3,050	2,102
Gondola	19,685	7,546	8,202	9,205	3,990
Guija	16,277	6,107	6,914	7,523	3,192
Inharrime	9,389	2,584	4,927	3,713	2,185
Inhassunge	10,585	3,626	4,842	5,213	3,485
Kamavota	37,054	19,703	9,941	21,753	7,642
Kamaxakeni	33,565	17,012	9,841	19,287	7,244
Kampfumu	14,544	32,185	-20,550	30,392	7,455
Kamubukwana	31,977	12,298	13,283	16,420	8,401
Kanyaka	475	426	-46	468	161
Mabalane	5,352	1,873	2,409	2,384	1,075
Machaze	11,388	5,062	4,049	5,789	2,184
Macomia	8,234	1,724	4,864	2,895	2,134
Maganja Da Costa	24,385	6,092	13,416	9,232	6,482
Magude	8,156	4,012	2,512	4,626	1,505
Malema	8,258	2,118	4,489	3,163	2,167
Mandlakaze	19,301	8,320	7,121	9,639	3,579
Manhiça	39,497	18,068	13,530	21,721	7,855
Manica	24,769	11,316	8,499	13,614	5,804
Marracuene	20,853	7,245	9,438	9,252	3,769
Marromeu	7,067	4,346	1,307	4,443	876
Massinga	8,587	4,436	2,433	4,778	1,663
Matutuine	4,992	2,342	1,652	2,774	969
Maxixe	8,501	4,298	2,503	4,668	1,662
Mecuburi	12,252	2,596	7,205	4,329	3,277

Milange	12,186	6,119	3,630	6,974	3,365
Moamba	8,648	4,391	2,527	4,973	1,539
Moatize	18,525	9,736	5,084	10,818	4,078
Mocimboa Da Praia	7,303	1,972	3,871	2,863	1,834
Mocuba	19,401	9,841	5,679	11,152	5,325
Moma	11,736	2,805	6,583	4,359	3,103
Monapo	9,412	2,349	5,181	3,562	2,477
Montepuez	11,847	3,370	6,108	4,759	2,953
Mopeia	9,787	2,060	5,770	3,448	2,644
Morrumbala	21,160	4,680	12,249	7,607	5,692
Mossurize	15,185	7,215	4,933	8,030	2,828
Mucate	7,622	1,547	4,550	2,648	2,047
Mueda	16,129	4,577	8,326	6,472	4,021
Muidumbe	12,525	2,763	7,257	4,498	3,227
Mutarara	7,590	2,724	3,348	3,426	1,643
Nacala	9,971	3,957	4,020	4,752	2,455
Namaacha	7,064	2,902	2,750	3,720	1,542
Namacurra	27,725	7,147	15,033	10,644	7,346
Nampula	8,931	2,044	5,101	3,257	2,372
Nhamatanda	15,957	7,601	5,165	8,926	2,917
Nicoadala	27,011	15,005	6,604	16,179	6,979
Nlhamankulu	18,554	24,840	-9,997	23,919	6,014
Pebane	17,986	5,594	8,795	7,543	4,660
Sussundenga	7,172	3,642	2,095	4,125	1,540
Vilankulo	10,079	5,077	2,986	5,776	2,335
Xai-Xai	54,896	16,784	27,133	26,024	15,599
Zavala	7,157	2,912	2,814	3,459	1,513

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Scale-Up Districts (FY 16)

Entry Streams for ART Enrollment	Tested for HIV	Identified Positive	Enrolled on ART
	(in FY16)	(in FY16)	(in FY16)
PLHIV currently in care who will transition to treatment (due to CD4 change to 500 in FY16).	-	-	37,154
TB patients	27,979	8,078	8,093
PMTCT Patients	853,228	47,327	66,658*
Children in EID (age 1-5)	63,363	5,532	18,246**
VMMC	253,670	3,299	990
Facility-based testing (PITC and VTC combined)*	2,064,334	341,422	126,604
HIV testing through DREAMs, focused on adolescents	62,105	5,589	2,124
Testing occurring outside of health facilities (including index case testing, KP, and PP HTC)*	464,969	160,024	67,145
Total	3,789,648	571,271	327,014

* New enrollees on ART reflect recipients of Option B+

**New enrollees on ART reflect children <5 years old

4.2 Program Area Summaries

4.2.1 Care and Treatment (C&T)

The goal of the care and treatment portfolio is to implement evidence-based interventions to increase early access to ART, provide high quality services, ensure robust retention strategies and achieve epidemic control. A site level scale up package has been defined (See Figure 4.2.1) which will increase demand for ART, result in earlier ART initiation, improve the quality of service delivery, strengthen community/clinical linkages, and focus on specific populations to improve retention rates. Additionally, the care and treatment portfolio is committed to ensuring adequate support and coordination with the laboratory, health systems, and the supply chain sectors in order to ensure that tests and commodities are available everywhere they are required. The importance of strengthened coordination around data represents a fundamental priority of the care and treatment program.

All patients in care will benefit from a comprehensive set of interventions including post-test counseling, clinical staging, early and regular CD4 count testing, screening of opportunistic infections (OIs), sexually transmitted infections (STIs), TB, and cervical cancer, provision of cotrimoxazole prophylaxis (CTX), isoniazid preventive therapy (IPT), nutrition assessment and counseling (NAC), psychosocial and adherence support, condom promotion and distribution, partner/family testing, ART adherence counseling, reduction in alcohol use, family planning, and STI management, and viral load literacy (see appendix A for details).

In addition to the routine package of services that is offered to all ART patients, COP15 includes: case-management for patients during the first 6-months on ART, case management for all pregnant and lactating women until breastfeeding cessation, the option for eligible patients to participate in a CASG in all ART sites, and access to gender-based violence support in routine care and treatment services. Importantly, routine viral load will be rolled out for pregnant and lactating women and children ages 2-5, and targeted viral load for suspicion of treatment failure.

Additional efforts will be made to bring more men into treatment, with a target of 35% by FY16 (from 29% reported in APR14). In conjunction with efforts funded through ACT, the number of children <15 years old being treated will reach 83,196 in FY16, an increase of 62% over FY15. Of the 1,068,100 women who will receive testing in the antenatal setting, 79,107 (7.4%) will be started on lifelong ART.

The majority of care and treatment interventions are considered core activities with the exception of the following near-core activities: diagnosis and treatment of STIs, cervical cancer, and Kaposi's sarcoma; some laboratory monitoring (e.g. liver function tests); expansion of TB diagnosis (training, GeneExpert scale up); some sample referral systems; expansion of radiological diagnostic capacity (x-ray machines); therapeutic foods for acute severe malnutrition; development of nutritional messages; and supplies for nutritional screening (See Appendix A). WASH interventions and the provision of micronutrient powder supplements are non-core.

Figure 4.2.1: Care and Treatment Packages

	Scale-Up	Sustained Response	Quality Assurance
Visit Frequency*	≥8/year	• ≥6/year	• 2/year
Site support approach	<ul style="list-style-type: none"> Clinical mentoring (preART, ART, PMTCT, TB/HIV) QI 	<ul style="list-style-type: none"> Clinical mentoring (preART, ART, PMTCT, TB/HIV) QI 	<ul style="list-style-type: none"> 'QI-lite' with 5-15 indicators from key areas
Demand creation	Community Mobilization, Treatment Literacy, Promotion of ANC Care/Institutional Deliveries, Key Messaging (VL, ART)		
Innovative Strategies (for evaluation)	Sample-based LTFU, GAACs, APES, M2M groups		
HTC	Support of PICT, VCT, and community-based testing including index case with linkages	HTC for symptomatic patients (TB/HIV, children), ANC testing where prevalence > 13%	Through QI-lite
Pre-ART	Clinical mentorship, cervical CA screening, OI diagnosis and treatment, FP/HIV	Clinical mentorship, cervical CA screening, OI diagnosis and treatment, FP/HIV	Through QI-lite
ART	Clinical mentorship	Clinical mentorship	Through QI-lite
PMTCT	Clinical mentorship	Clinical mentorship	Through QI-lite
Retention	GAAC, M2M, treatment literacy, facility flow improvements, tiered defaulter tracing	GAAC, M2M, treatment literacy, facility flow improvements, tiered defaulter tracing	GAAC, M2M
TB/HIV	<ul style="list-style-type: none"> Clinical mentorship incl. MDR Infection control (assessment, plan, implementation) 	<ul style="list-style-type: none"> Clinical mentorship incl. MDR Infection control (assessment, plan, implementation) 	Infection control (assessment and plans only)
Nutrition*	NAC, therapeutic and supplementary feeding, linkages	NAC, therapeutic and supplementary feeding, linkages	Through QI-lite
OVC	Full OVC package with linkages to health facility		

*Implementation of NAC is part of the core clinical package and is embedded in the unit cost for treatment as part of the scale-up and sustained packages. Therapeutic feeding for those severely malnourished is covered by another donor. Provision of supplemental food is not currently supported by any other donors and is budgeted for HIV-infected patients with moderate malnutrition in most sites in scale-up districts (excluding low volume sites) and all sustained response sites in sustained districts which are, by definition, high volume.

4.2.2 Community Involvement in Scale-Up Districts

Linking and retaining patients in treatment and care is a major challenge. The community interventions framework will continue to implement client-oriented practices and enhance interaction between community and health systems to accelerate progress across the continuum of care. In scale-up districts the community package of interventions are built on the treatment cascade and are focused on improving retention in care and treatment through scale up of evidence based interventions. These interventions include: community adherence support groups (GAAC), involvement of community health agents, Mother to Mothers groups (M2M), Community Health Workers (APES), Savings Groups, treatment literacy programs, community screening and treatment for gender-based violence, and male engagement using different community platforms.

4.2.3 Preventing Mother-To-Child Transmission (PMTCT)

In the context of the rollout of B+, PMTCT activities have been considered to be part of treatment but with a different locus for the initiation of ART in newly diagnosed pregnant women. The GRM endorses the global initiative for elimination of vertical transmission with the objective of reducing new HIV infections in children by 90% by 2015. Long-standing challenges at MCH facilities include low rates of facility-based deliveries, limited infrastructure, and limited human resources. Male involvement remains challenging. The prevailing culture is not receptive to exclusive breast feeding. Mozambique has a high fertility rate (5.9) and low levels of modern contraceptive use³¹. Finally, data overall is a challenge, as the national PMTCT M&E system is paper-based. PEPFAR supports MISAU to revise and improve PMTCT/MCH registers to allow longitudinal follow up of pregnant, lactating women and linking mother/infant pairs.

The PMTCT cascade starts favorably in Mozambique, as there is a relatively high rate of women attending at least one antenatal care (ANC) visit. The antenatal clinic is an important venue for identifying HIV+ women. Ninety-six percent of pregnant women who attend ANC visits know their status, and 93% of HIV+ women received ARVs. Sixty-nine percent of all women initiate ART at the ANC. ANC uptake drops off to about 55% by ANC visit four. Male partner testing reached 34% in SAPR15.

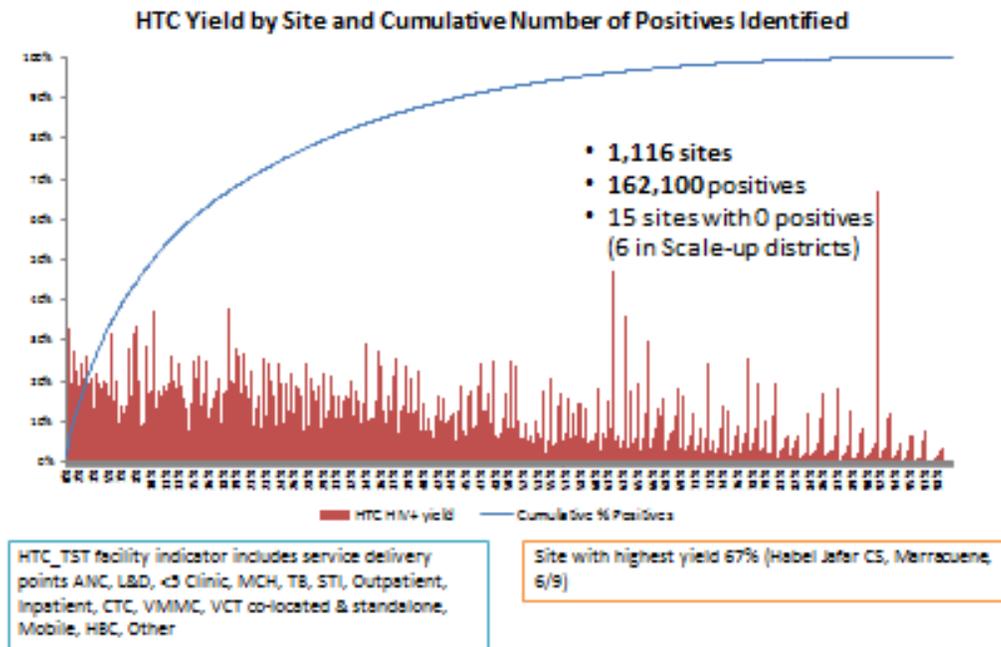
³¹ Mozambique DHS 2011

Sixty percent of women seek facility-based delivery, and Early Infant Diagnosis (EID) among HEI is about 60%.

Retention and linkages are critical issues for the PMTCT portfolio. Interventions include intensified peer educator support at a level necessary for case management and individual attention to prevent loss to follow-up in the immediate diagnosis and ART initiation phase. Community adherence support group strategies established in adult ART will be piloted in PMTCT settings. Community-based interventions will be implemented to improve follow up for mother-baby pairs, to increase male involvement, and to address the prevention and reduction of GBV including PEP, legal, and psycho-social support. (See Appendix D for more details of the PMTCT program.)

4.2.4 Site Yield Analysis

Fifteen of the health facilities currently supported by PEPFAR Mozambique were identified as zero yield HTC sites, of which six are in scale-up districts. These sites do not include any targets for COP15 and will no longer receive PEPFAR support.



4.2.5 Tuberculosis/HIV (TB/HIV)

The twin epidemics of TB/HIV have consistently resulted in high TB/HIV co-infection rates (56%) and high HIV associated mortality in TB/HIV co-infected patients (148/100,000 compared to 69/100,000 for HIV negative TB patients, WHO). In PEPFAR supported sites, Provider initiated testing and counseling

(PITC) for TB patients and ART initiation has been steadily improving over the recent years of program support. At a national level in SAPR 15, 98% of all TB patients had documented HIV status in the TB register (up from 95% in APR13) and 88% of all HIV-infected TB patients were started on ART (up from 68% in APR13).

Mozambique struggles to effectively manage a coordinated TB/HIV response. Limited access to health care services, a shortage of human resources, limited diagnostic capacity (including laboratory and radiologic services), and weak supply chain management all hinder a more robust TB/HIV response. Limited capacity to diagnose and manage pediatric and Drug-Resistant Tuberculosis (DR-TB) also pose a technical challenge. However, structures have recently been established to facilitate communication and programmatic linkages. As such, there has been real progress made in HIV Testing and Counseling (HTC) of TB patients nationally, with testing of approximately 96% of TB patients for HIV, 97% provision of Cotrimoxazole (CTX) to TB/HIV co-infected patients and coverage of 72% ART in TB/HIV co-infected patients.

Increasing implementation of key interventions decreases morbidity and mortality in the co-infected population. One key intervention is improved case detection. The USG will support MISAU within scale up districts to improve case detection through expansion of TB screening and case finding in PMTCT, antenatal clinics, HTC settings, ART settings, and for in-patients, including pediatric patients. Another intervention is the revitalization of the active contact tracing program by provision of motorcycles to district TB supervisors who will conduct contact tracing, supporting the newly established cadre of cough officers who will conduct routine screening for patients interacting with the health system. In all scale-up sites, IPT, infection control measures, and cotrimoxazole will be provided. Further expansion for TB diagnosis in HIV clinics and expansion of the laboratory network to increase smear microscopy in high volume sites, additional GeneXpert scale up, training of lab personnel to build management capacity for setting up referral system, and transportation of patients for x-ray referral are all considered near core activities since non-PEPFAR support is available for these important activities. A national TB survey funded by GFATM to be conducted late 2015 will provide a better understanding of TB rates in the country.

Increased ART coverage to 100% for co-infected military members will be reached through mobile treatment units and reduced lost-to-follow up through delivery of GeneXpert MTB/RIF diagnostic capabilities at military medical sites. TB prevalence amongst military PLHIV will be determined through an upcoming seroprevalence study.

4.2.6 Voluntary Medical Male Circumcision (VMMC)

The Mozambique national VMMC Strategy aims to achieve 80% coverage by 2017, by performing two million procedures within seven key provinces that have high HIV prevalence and low MC prevalence. PEPFAR is the only donor engaged at national level in VMMC activities. Since its beginning, 389,221 procedures have been performed with PEPFAR support, 160,660 of which were in FY14. In November 2014, the Mozambican government launched its first demand creation campaign.

VMMC is provided as part of a comprehensive package that includes provision of HTC, screening of STIs, condom provision and promotion of correct and consistent use, promotion of safer sex practices and provision of risk reduction counseling, sexual and reproductive messages for clients and accompanying family members, as well as information on and VMMC surgery.

There will be a strategic shift to focus on men aged 15-29, which has been determined to have the greatest magnitude on reduction on new HIV infections. In COP15, active demand creation will be implemented to attract 15-29 year olds. Working in close coordination with national counterparts, the VMMC program will focus on improving efficiencies based on the WHO published Considerations for Implementing Models for Optimizing the Volume and Efficiency of Male Circumcision Services (MOVE). Continuous Quality Improvement (CQI) activities remain a priority.

Table 4.2.1 VMMC Coverage and Targets by Age Bracket

Target Populations	Population Size Estimate - males 15-29	Current Coverage	VMMC_CIRC (total targets -- 50-70% of these are 15-29; rest are 10-14 and 30+)	Expected Coverage
	(Scale Up Districts)	(Dec 2014)	(in FY16)	(in FY16)
Zambezia	463,713	47%	73,500	71%
Tete	106,698	5%	22,969	39%
Manica	151,687	15%	18,374	48%
Sofala	196,956	30%	38,281	65%
Gaza	158,681	34%	39,813	69%
Maputo Província	228,734	54%	31,391	73%
Maputo Cidade	190,454	70%	26,359	81%
Military			20,849	

4.2.7 HIV Testing and Counseling (HTC)

COP15 HTC targets emphasize clinical testing, with focus on PITC, VCT, and index case testing approaches. Community-based testing (HTC-C) will focus on high risk populations and outreach beyond the clinical facility for the index case testing in high burden areas. Targets will be set against care and treatment goals, to ensure coordination between ART scale-up and HTC activities. Strategies to

strengthen linkages to ensure newly diagnosed PLHIV are enrolled in care include: intensified coverage of health educators to carry out active referral, accompanied linkages, case management with reminders and real-time defaulter tracing; opening of patient file at the site of testing; use of patient reminders (e.g., SMS texting, phone calls, home visits) and multiple-part referral slips that confirm linkage to HIV care of persons who tested HIV-positive at their site.

The objective of the HTC portfolio will be to identify PLHIV at an earlier stage of infection and link them to appropriate follow-up services, using active referral methodologies such as peer educators, peer navigators, escorting counselors, and case managers. HTC-C target populations include KP, active duty military personnel, adolescent girls, and young women. Linkages will be made within DREAMS districts to ensure any adolescent girls or young women who are identified as HIV-positive will receive appropriate services. To further encourage these HTC activities, PEPFAR has opened discussions with MISAU to revise the policy on anonymous testing in FY15, to non-anonymous, confidential testing.

To support quality rapid HIV testing, COP15 will: a) define HIV rapid testing minimum standards; b) provide health staff refresher training and ensure certification to perform HIV testing; c) meet HIV testing minimum standards; and d) ensure that all facilities that receive the PAINEL respond accordingly in collaboration with the National Institute of Health (INS), DPS, and implementing partners. Activities to assure quality of testing will continue, including use of dried tube specimens for external quality assessment (EQA), logbooks at service delivery sites, and provision of basic resources to maintain high quality testing. Supportive supervision will continue in collaboration with central and provincial health authorities.

Through ACT, strategies will be pursued to increase pediatric testing and case identification by systematically performing targeted case-finding in children and adolescents in high-yield sectors of the health system in high HIV prevalence geographic settings. COP15 will intensify youth counseling and testing at adolescent friendly health units (training, supervision, working aid distribution, etc.).

The National HTC guidelines are under revision and should be finalized and disseminated during COP15. They include new strategies to target HTC to increase case finding, improve HIV testing quality and strengthen linkages from HIV testing into care services.

During COP 15, PEPFAR will be involved in the national discussion of potential new platforms for the next generation of HTC in the country, including considerations for revision of the national testing assay algorithm and a pilot for HIV-Syphilis dual platform tests (in KP service settings). Finally, the HTC portfolio will help bring Mozambique into alignment with WHO normative guidance related to verification of PLHIV status prior to initiating ART. This guidance is increasingly important in Mozambique as CD4 eligibility criteria are gradually rolled back. Issues of misclassification of results, including false positives, are under active discussion with MISAU.

COP15 represents a significant programmatic pivot for HTC, moving towards focus on the first component of 90-90-90 goals. Increasing reliance on index case testing approaches and improving

observed HIV positivity across the portfolio will be critical, with increased attention on linkages and retention in order to protect gains made in case finding.

4.2.8 Key Populations (KP) and Other Priority Populations (PP)³²

Key Populations. COP15 will focus mainly on strengthening current investments in activities targeting commercial sex workers (CSW) and their clients/sexual partners as well as men who have sex with men (MSM) and their partners. Activities will occur at community and facility levels, ensuring linkages across the continuum of care, and with emphasis on reach-test-treat cascade approach. Interventions will cover 30 districts, 28 of which are among the 77 scale up districts³³. Proposed districts are fully aligned with MISAU KP prioritization where 22 health facilities were approved to offer test and treat for KPs.

Incarcerated (prison) populations. With surveys indicating HIV prevalence of 25%, prisoners have been identified as a priority population. The package of interventions includes training of peer educators, demand creation for HTC, VMMC, TB and STI screening and linkages to HIV care and treatment services. Prisons targeted for these interventions fall within scale-up districts.

Military is another priority population for PEPFAR Mozambique, with significantly higher HIV prevalence than the general population. Military are also highly mobile and geographically distributed across the country. Core prevention interventions will include VMMC, HTC, and GBV, in addition to aggressive scale-up of ART through mobile and fixed sites.

Mobile populations including long distance truck drivers and miners are also an important group. Prevalence among truck drivers (15.4%) and miners (22.3%) is higher than the general population. No specific activities, targets or budget were set. This population group is expected to be reached as clients of CSW through prevention activities targeting CSWs at the community level.

People who inject drugs (PWID). Preliminary data indicates that HIV prevalence among PWID ranges between 50.3%-73.1%.³⁴ Population size estimates show a very limited group: 1684 PWID in Maputo and 520 in Nampula Province. Information is still too incipient to inform implementation at a broader scale in the country. PEPFAR will continue to monitor trends and dynamics to assess the need for a more comprehensive approach for this group.

³² For more details in package of services that will be offered to key and priority populations please refer to Appendix E on KP

³³ as justified in the "Guidance for COP15 FY 2016 Target Changes" submitted

³⁴ IBBS Resultados Preliminares, Inquérito em Pessoas que Injectam Drogas, Moçambique 2014

Target Populations	Population Size Estimate	Coverage Goal (in FY16)	FY16 Target
	(scale-up districts)		
CSW	63,758	40%	25,503
MSM	33,670	40%	13,468
Prisoners	12,011	210%*	15,149
Military	Classified	40%	Classified
Total		54,120	

**Denominator reflects incarcerated individuals at a given time (cross-sectional snapshot); while PEPFAR program results reflect number of individuals reached over the reporting period. The latter number is significantly higher than the denominator due to prisoner turnover, attributable to relatively short sentencing*

4.2.9 Orphans and Vulnerable Children (OVC)

COP15 encompasses programmatic shifts with emphasis on aligning the OVC portfolio with the care and treatment scale-up districts and improved targeting to reach directly affected and infected OVC. Key interventions include: a) rotation of OVC home visitors to identify OVCs of PLHIV at the nearest ART sites b) index case testing of OVC and family members to identify PLHIV, and c) case management for positive pregnant and lactating women on B+ and exposed babies to enroll OVC. Emphasis will continue to be on a family-centered socio-economic care and support model and improved coordination/collaboration with ART and PMTCT sites through establishment of MOUs to strengthen community facility linkages and referrals. Core interventions include socio-economic activities critical to mitigating the impact of HIV/AIDS on children and ensuring their most basic needs are met. Near core activities which cannot as yet be undertaken by other partners or government include activities that provide for a sustainable social infrastructure.

Using a strength-based case management approach, the health needs of OVCs are addressed through building health and nutrition knowledge and skills among caregivers, facilitating access to HTC, and linkages to ART. Through ACT, CBOs/FBOs proactively identify children for testing and treatment and refer those identified in ART sites to community based social services. ECD platforms address developmental delays experienced by children infected, exposed to, and affected by AIDS by linking with and targeting mothers in PMTCT programs. Stable environments will be nurtured through economic strengthening emphasizing the expansion of savings groups plus parenting, access to social protection to reduce economic instability, protecting adolescents from GBV, and ensuring victims receive proper counseling and care. A special emphasis in conjunction with DREAMs will be focused on keeping adolescent girls HIV-free, using evidence-based interventions through education, psychosocial support, savings groups, and parenting skills. Subgroups of girls at high risk for HIV infection will be pro-actively identified. Cross referral mechanisms for these girls will be strengthened with relevant sites.

Activities in sustained response districts will end by September 2015. Implementers are currently focused on strengthening of Community Committees and Community Children's clubs and expanding Savings Groups, including OVC home visits and training of committee members to transition to community based response.

"Above site" activities include support to MGCS to provide decentralized Social Action Technician and Infant Educator courses in partnership with MISAU training Institutes, data collection tools and systems designs for both GRM and CSOs, FBO/CBOs capacity building including community based structures working with OVC, and advocating for social policy for child and social welfare. Resources will be set aside to evaluate OVC interventions through outcome and impact studies.

Table 4.2.3 Targets for OVC and Pediatric HIV Testing, Care and Treatment

	Estimated # of Children PLHIV (<15)	Target # of active OVC (FY16 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16) OVC_ACC	Target # of children on ART
Ancuabe	889	1184	379	313
Chiure	1,498	1,901	608	541
Cidade De Pemba	2,514	3,894	1,062	1,178
Macomia	961	1,221	387	211
Montepuez	1,392	1,683	539	466
Mueda	1,877	934	762	686
Muidumbe	1,431	1,930	618	284
Kamavota	4,698	2,533	810	1,930
Kamaxakeni	4,123	2,190	701	1,190
Kamubukwana	4,102	2,851	912	1,878
Nlhamankulu	2,283	901	295	1,057
Bilene	2,966	3,681	1,178	1,435
Chibuto	3,351	6,320	2,528	1,492
Chokwe	3,399	6,448	2,029	2,716
Cidade De Xai-Xai	2,540	4,368	1,398	2,293
Guija	1,654	3,128	1,001	664
Mabalane	540	1,052	337	229
Mandlakaze	1,906	3,860	1,235	1,071
Xai-Xai	5,533	10,576	3,384	1,554
Inharrime	941	3,434	1,099	228
Massinga	828	1,981	634	468
Maxixe	833	2,571	823	584
Vilankulo	992	3,335	1,067	469
Zavala	697	2,690	861	526
Barue	1,424	3,715	1,189	500
Cidade De Chimoio	3,286	12,195	3,902	1,824
Gondola	2,032	8,368	2,678	1,023
Machaze	1,176	5,210	1,563	478
Manica	2,553	6,754	2,026	1,191
Mossurize	1,597	6,198	1,983	350
Sussundenga	734	2,031	650	801
Boane	3,069	3,918	1,253	1,537

Cidade Da Matola	13,456	15,169	6,068	4,771
Manhiça	5,081	6,187	1,980	3,157
Marracuene	2,596	3,246	1,039	2,070
Angoche	1,252	3,242	1,037	185
Muecate	920	3,735	1,195	106
Malema	991	2,653	849	138
Cidade De Nampula	4,294	15,576	4,361	2,199
Moma	1,406	3,722	1,191	374
Mecuburi	1,470	4,013	1,284	175
Monapo	1,143	3,027	969	225
Nacala	1,190	3,024	968	483
Nampula	1,113	2,840	1,079	211
Cidade De Lichinga	1,158	1,306	418	394
Cuamba	825	2,332	746	203
Buzi	936	2,405	770	326
Chibabava	747	2,932	938	497
Cidade Da Beira	6,363	20,909	6,691	3,904
Dondo	1,808	6,345	2,030	732
Marromeu	785	1,413	452	247
Nhamatanda	1,759	6,630	2,055	701
Changara	855	3,914	1,252	379
Cidade De Tete	2,110	8,041	2,573	1,272
Moatize	2,003	5570	1,782	707
Mutarara	782	2,330	746	246
Cidade De Quelimane	2,941	9,999	3,000	2,915
Inhassunge	1,057	4,140	1,325	500
Gile	800	2,152	689	237
Maganja Da Costa	2,444	9,646	3,087	703
Alto Molocue	2,436	6,044	1,934	342
Mocuba	1,994	6,238	1,996	1,461
Milange	1,257	3,194	1,022	978
Chinde	1,137	4,435	1,419	234
Mopeia	1,024	3,950	1,264	220
Morrumbala	2,180	8,511	2,553	454
Namacurra	3,114	7,183	2,299	912
Nicoadala	2,697	7,044	2,254	1,515
Pebane	1,827	7,029	2,249	822

4.3 Complementarity of COP 2015 with Central Initiatives

Determined, Resilient, AIDS-free, Mentored, and Safe (DREAMS)

While the DREAMS proposal aligns within the GRM response, a key difference is the geographic and population focus. DREAMS will work in 5 epi-burden districts in 3 provinces (Gaza, Zambezia, and Sofala), with the highest HIV burden among young women aged 15-24 (11.1%), particularly in comparison with young men in the same age group (3.7%).

The DREAMS proposal includes evidence based interventions with the potential to reduce HIV incidence. Interventions focus on HIV negative adolescent girls and young women who are in-school (15-19); out-of-school girls (15-24) who are HIV negative pregnant/lactating, and out-of-school (15-24) socially vulnerable girls. The DREAMS proposal builds upon lessons learned from past and current national efforts to plan practical interventions that have demonstrated feasibility and acceptability, such as establishing reproductive health and prevention platforms in school settings. The core package of interventions include HTC, social asset building and socio economic approaches, prevention of gender-based violence and interventions for post-violence care, condom promotion and availability of family planning, and parenting and caregiver training - all underpinned with community mobilization. Programmatically DREAMS will link with ACT and PMTCT platforms. Activities build on the clinical GBVI platform and link to COP15 activities for post-violence care. Linkages with the COP15 OVC platform are around savings groups, school-block grants, and care-givers' programming. COP15 covers interventions for male partners, including partner characterization and survey activities. With the expansion of a reproductive health platform that will reach more girls, we will also reach male sexual partners and strengthen linkages to VMMC and referrals to Care and Treatment. Combination Prevention participants receive comprehensive HTC and HIV epidemic control interventions.

Accelerating Children's HIV/AIDS Treatment (ACT)

Given Mozambique's pediatric burden of disease, low access to pediatric treatment, and treatment disparity in treatment coverage for children compared to adults living with HIV, Mozambique was chosen as a priority country to implement the ACT Initiative. The ACT Initiative focuses on addressing policy barriers, intensified case finding, increased community engagement, improved communication, national advocacy and social mobilization for HIV services for children, expanded pediatric HIV service provision, expanded quality HIV services for adolescents, and improved care of HIV infected children and adolescents.

Over the past three years, the pace of Mozambique's HIV response has been remarkable due to the development and implementation of the Acceleration Plan. The Acceleration Plan goal for pediatric ART coverage is 80% of all eligible children receive ART by the end of 2015. Pediatric treatment coverage has increased from 22% in 2012 to 41% by September 2014 and the pace of acceleration continues. MISAU highlighted pediatric ART scale-up as one of the primary objectives of the National Health Strategy for 2014-2018, and as of March 2015, 53,234 children were reported on ART.

The ACT goal in Mozambique is to double the total number of HIV-infected children receiving life-saving ART from about 41,400 children (<15 years old) receiving ART in Mozambique in 2014, to reach 82,800 children on ART by the end of 2016.

Mozambique recently approved a key policy revision to change the CD4 count threshold for ART eligibility for all children aged 5-15 from 350 cells/m³ to 500 cells/m³. This policy change along with active case-finding strategies, increased linkage to care and treatment, and improved retention will all help Mozambique continue to expand access to treatment for children through the ACT Initiative.

5.0 PROGRAM ACTIVITIES TO SUSTAIN SUPPORT FOR OTHER LOCATIONS AND POPULATIONS

5.1 Package of Services in Other Locations and Populations

As part of the increased focus for the Mozambique PEPFAR program, 43 health facilities were identified as sustained response sites which fall outside of the 77 scale-up districts. Sustained response sites that receive the sustained response package of services are large, high-volume sites with greater than 500 patients on ART. Of the 43 sustained response sites, several have more than 1,500 ART patients, and therefore merit a robust package and interventions focused on ART retention and quality services. The package offered is outlined in Figure 4.2.1.

The main difference between the scale-up package and sustained response package is based on passive enrollment into treatment (ranging from 10-20% depending on the site assumptions), with no demand creation activities at facility or community sites and less frequent visits from PEPFAR implementing partners. By FY17, 109,160 people will be on ART in these sites of an estimated 227,919 PLHIV, with coverage of 60% of those eligible for treatment and 48% of those estimated PLHIVs in those districts.

Table 5.1.1 Number of Sites in Sustained Response Districts

Packages at ART sites	Districts		Total
	Scale Up	Sustained Response	
Scale-up	513		513
Sustained Response		43	43
Quality Assurance		222	222
Total	513	265	778

Table 5.1.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Response Districts

Maintenance Volume by Group	Indicator Code	Expected result APR 15	Expected result APR 16*	Percent increase (decrease)
HIV testing in PMTCT sites	<i>PMTCT_STAT</i>	476,091	348,350	(26%)
HTC (only maintenance ART sites in FY 16)	<i>HTC_TST</i>	490,326	413,968	(16%)
Current on care (not yet initiated on ART)	<i>CARE_CURR-TX_CURR</i>	40,267	42,846	6%
Current on ART	<i>TX_CURR</i>	116,540	142,820	22%
OVC	<i>OVC_SERV</i>	940	0	(100%)

5.2 Transition Plans for Redirecting PEPFAR Support to Priority Locations and Populations

PEPFAR Mozambique has identified 222 health facilities as centrally supported sites, of which 38 sites reported less than 30 patients. These sites are planned to be fully transitioned to MISAU by the end of calendar year 2017. During 2015, the PEPFAR team, in conjunction with MISAU and Provincial Directorates (DPS), will identify benchmarks that will need to be met in order for these facilities to be transitioned to support and supervision by the DPS. In COP15, these sites will receive 2 visits per year by implementing partners which will focus on IP-led quality improvement with clinical mentoring that focuses on quality of services rather than patient level encounters. Data on approximately 5-15 indicators extracted from the MISAU’s Quality Improvement strategy will be collected from these sites using MISAU aggregate information systems.

6.0 PROGRAM SUPPORT NECESSARY TO ACHIEVE SUSTAINED EPIDEMIC CONTROL

6.1 Laboratory Strengthening

USG funded partners will continue to support improved access to quality and timely diagnostic testing. To support rapid treatment scale up, USG funding will support 182 laboratories in scale up sites and 113 laboratories in maintenance sites. To guarantee access to quality laboratory services and capacity for testing, laboratory strengthening efforts will focus on providing essential lab equipment and commodities to facilitate roll out of EID, viral load, point of care systems for CD4 and Gene Xpert technology; specimen referral systems for transport samples; strengthening lab information systems; ensuring availability of competent laboratory work force; continuous lab quality improvement and developing drug resistance testing capacity.

Table 6.1: Laboratory Strengthening activities for COP 2015

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
1. HIV Diagnostics and Treatment monitoring tests											
Provide equipment, reagents and consumables for CD4, EID, VL, GeneXpert, viral load, POC CD4, POC EID, hematology, creatinine, CRAG, urine strips syphilis tests	54 Cd4 labs, 5 EID and Viral load labs. 145 Point of care CD4, 18 Gen 71 labs hematology, 2 TB culture, 18 Xpert labs and 100 smear microscopy labs supported to conducted testing	Uninterrupted testing provided in supported laboratories	HTXS HBHC PMTCT HVOP HVTB \$12,989,487	HTXS HBHC PMTCT HVOP HVTB 14 million	SCMS	5-7	X	X	X		X

Support equipment maintenance contracts and development on first line equipment maintenance capacity at facility level	MISAU equipment maintenance contracts negotiated ; facility based lab and maintenance staff trained in first line maintenance	MISAU equipment maintenance contracts negotiated ; facility based lab and maintenance staff trained in first line maintenance	APHL/MISAU 750,000	APHL/MISAU 750,000	HLAB	5.4	X	X	X		X
Support integration of specimen referral systems VL, EID, Gene Xpert and TB culture	Specimen referral system harmonized and turnaround times for delivery of results reduced	Established turnaround times for VL, EID, Gene Xpert and TB culture achieved	ASM/INS 275,000	ASM/INS 315,000	HTXS	5.7	X	X	X		X
Develop laboratory capacity for drug resistance testing at the National Reference Laboratory	Needs assessment of drug resistance capacity conducted, drug resistance capacity established	Ongoing drug resistance testing for drug resistance surveillance	INS 375,000	INS 375,000	HLAB	8.1	X	X	X		X
2. Laboratory workforce development											
Support in-service training & certification of laboratory staff in HIV testing, VL, EID, CD4, CRAG, HIV/DR, & biosafety, TB culture, TB smear microscopy, Gene Xpert	Certified and competent laboratory and non- laboratory personnel conducting testing and producing accurate results	Trained and certified staff in HIV testing, VL, EID, CD4, TB smear microscopy, Gene Xpert, CRAG, HIV/DR, & biosafety	INS, FIND, ASM, ASCP FIND, ASM 1,130,000	INS, FIND, ASM, ASCP FIND, ASM 1,130,000	HLAB HVTB	8.5	X	X	X		X
Support lab pre-service training	1) A competence-based curriculum implemented at the national level, and (2) Lab faculty capacitated in competence-based teaching methodologies	(1) A sustainable competence-based curriculum implemented (2) Skilled laboratory technicians adequately prepared for deployment into the national lab network	I-TECH ASCP 350,000	I-TECH ASCP 350,000	I-TECH ASCP	8.5	X	X	X		X

3. Laboratory Quality Improvement and Accreditation											
Implement rapid test quality improvement initiative	Training and certification program developed; HIV rapid test log book piloted and approved; MISAU policy for Point of care testing and HIV rapid testing developed; proficiency testing program for HIV rapid tests expanded	Continued expansion of HIV rapid test proficiency testing program. Ongoing monitoring of quality of testing and refresher training where required	FIND 350,000	FIND 350,000	HLAB	5.4	X	X	X		X
Support implementation of national laboratory quality improvement program at labs in priority sites	Quality managers and laboratory staff trained in QMS - 90, base-line assessments conducted in 30 labs	Annual assessments conducted in 30 laboratories. Two laboratories accredited (international). 10 laboratories with WHO-SLIPTA accreditation	ASCP INS APHL 1,150,000	ASCP INS APHL 1,150,000	HLAB	5.4	X	X	X		X
Support expansion and accreditation of National EQA Program for HIV serology and related tests	National EQA data base developed, participating HIV rapid testing sites increased by 15%, EQA staff trained in ISO 17043; Accreditation assessment conducted, plan to address non-conformities developed	Participating HIV rapid testing sites increased by additional 15%; National EQA program accredited by international standards	INS ASM 450,000	INS ASM 450,000	HLAB	5.4	X	X	X		X
4. Laboratory Information Systems											
Electronic lab information system at viral load/EID, CD4 laboratories; blood banks	Pilot eLIS systems at 2 labs; Lab assessment of utility of BLISS LIS	eLIS added to all high priority labs doing VL & 2-4 additional high priority labs	APHL 750,000	APHL 750,000	HLAB	8.1	X	X	X		X
Support central level web-based databases for viral load and Gene Xpert remote monitoring	Central database warehouse for remote monitoring for VL, GeneXpert test results developed and implemented	Timely availability of accurate Viral Load data for ongoing monitoring and programmatic decisions	APHL 220,000	APHL 220,000	HLAB	8.1	X	X	X		X

Implement paper-based registers	Lab personnel trained in use of registers; lab registers distributed and implemented.	Timely lab data analysis and reporting	APHL 180,000	APHL 180,000	HLAB	8.1	X	X	X		X
5. Laboratory Supply Chain											
Strengthen MISAU capacity for laboratory supply chain management	MISAU laboratory supply chain strengthened and staff trained in laboratory logistics including tools for data collection and commodities quantification (Forlab) and pipeline analysis (Pipeline)	Timely availability of quality data to inform decision making and management of the laboratory supply chain	APHL 350,000	APHL 350,000	HLAB	5.7	X		X		
Improve warehousing conditions for laboratory commodities	DCL staff mentored in warehousing of laboratory commodities	Laboratory warehouses well organized, clutter free and tidy	APHL 125,000	APHL 125,000	HLAB	5.7	X		X		
6. Policy											
Support inclusion of MISAU policy for Point of care testing and HIV rapid testing developed in national lab policy	Discussion on policy for Point of care and rapid HIV testing initiated	MISAU policy for Point of care testing and HIV rapid testing developed	FIND o	FIND o	HLAB	14	X				
Advocate for Approval of National laboratory Policy	National Laboratory Policy approval process initiated	National Laboratory policy approved	APHL o	APHL o	HLAB	14	X				

6.2 Strategic information (SI)

There are three foci of COP15 SI activities: a data improvement strategy is being developing both together with MISAU to include development and improvement of health information systems, paper-based systems, M&E staff capacity and data cleaning, triangulation and use. Data quality has been a struggle for strategic information systems for Mozambique with heavy reliance on clinical partners to support parallel systems. With the pivot of support, clinical partners will no longer be able to support the data cleaning of the national sites and data systems, so these must be strengthened to fully understand the National HIV epidemic.

Secondly, the SI portfolio will concentrate surveillance activities to better understand the HIV epidemic and key drivers of prevalence and incidence. There will be investments to the National Institute of Health to build capacity to better implement national surveys, maintain data and develop policy briefs to inform the programs. The most recent AIDS impact survey was conducted in 2009. New information on the HIV general epidemic is vital, as is a better understanding of the size and mapping of key populations. Presently, the district, provincial and central levels have difficulty processing the amounts of data are submitted by sites to improve programming at all levels in the health care systems, therefore, this COP will concentrate on data use and programming.

Table 6.2: SI activities for COP 2015

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)			6. Implementing	7. Relevant Sustainability Element and Score	Impact on epidemic control					
						Mechanism(s)							
	2. 2015	3. 2016	4. 2015	5. 2016	BC	ID	2. 2015	3. 2016	4. 2015	5. 2016	BC	12. Viral suppression	

Surveillance data in the general and key populations													
1	Surveillance: ANC/PMTCT surveillance	completion testing and comparison analysis; preparation for routine data use for surveillance purposes	no longer needed, sentinel surveillance will move to routine ANC/PMTCT data	\$250,000	\$ -	MTCT	INS						X
2	AIDS indicator survey and DHS secondary testing and dissemination	final analysis and dissemination of AIS survey 2015	AIS completed, preparation for DHS plus to start	\$250,000	\$ 750,000	HVSI	INS/INE						
3	Mapping and size estimations for key populations & For priority populations	Geographical map and size estimation of key populations in Mozambique for improved	Completed	\$500,000	\$ -	HVSI	USCF					X	
4	Surveillance IBBS MSM commodities, survey will be paid for through GF	implementation of a National survey for MSM, prevalence, incidence, risk factors and size estimations	implementation of a National survey for key and priority population	\$450,000	\$450,000	HVSI	SCMS					X	
5	Violence against children surveillance, response plan for violence against	implementation of the HIV component	completed	\$ 500,000	\$ -	HKID	TBD			X			

	children during the survey	for the VACS survey, including HIV testing											
6	HDSS and surveillance support activities will result in the improvement of essential data to monitor the HIV epidemic in Mozambique. This encompasses, behavioral surveys, national prevalence and incidence surveys, mortality estimation, hot spot identification and mapping and other necessary epidemiologic training, data analyses and reporting, these are all needed to track the HIV epidemic in Mozambique.	Annual HIV implemented surveillance activities, mortality reports, implemented surveillance in key populations	Annual HIV implemented surveillance activities, mortality reports, implemented surveillance in key populations	\$ 850,000	\$750,000	HVSI	JEMBI & MOASIS / INS						
7	EPI: Demographic Surveillance (CISM); CISM - Manhica Research Center	HIV services surveillance activities	complete	\$240,000	\$ -	HVSI	CISM						
8	Surveillance technical assistance. , These survey and surveillance activities are core to understanding where the HIV epidemic is geographically located in Mozambique and ensure services and ensuring is possible in accordance with the epidemic; without this data we do not know where to focus our HIV testing, linkage and ART program	Annual HIV, HIV/TB surveillance activities implemented , completed, analyzed disseminated	Annual HIV, HIV/TB surveillance activities implemented , completed, analyzed disseminated	\$ 600,000	\$600,000	HVSI	UCSF		X	X	X		

	and all aspects of the HIV response.												
9	Surveillance: Viral load and drug resistance surveillance, ANC and PMTCT routine data surveillance	implementation of a National survey for quality of viral load testing and acquired drug resistance in adults, pediatric and PMTCT	implementation of a National survey for quality of viral load testing and pre ART and transmitted drug resistance in adults, pediatric and PMTCT	\$850,000	\$500,000	HVSI/HTXS	INS/SCMS						X
10	PMTCT/ ANC data report system; This system aims to replace the ANC sentinel surveillance is presently used as the core elements of EPP SPECTRUM	developed, piloted	National and maintenance rolled out	\$ 500,000	\$ 400,000	MTCT	UCSF/MI SAU		X	X	X		
Data quality improvement routine M&E													
11	Data quality improvement strategy INS and National AIDS program to improve patient tracking and reporting through a site master facility list and health unique identifiers and clinical LTFU system pilot system piloted	working group with Ministry formed for Unique identifier, MFL coordinated and updated, needs assessment for LTFU information systems,	needs assessment for unique identifier developed and conducted	\$375,000	\$750,000	HSVI/MTCT/HTXS	Jembi/moasis/EGPAF			X	X		X

		developed program incorporated into Open MRS point of care												
12	Data quality improvement strategy - SISMA and LIS rolled out (aggregate level data system replacing Modula Basico); this is the DHIS II data reporting systems used for PEPFAR and MISAU reporting & OPEN HIE will ensure interoperability between aggregate data systems and patient level systems to improve efficiencies in data collection	National DHIS II aggregate data systems rolled out to all districts	National DHIS II maintained and upgraded and expanded, PEPFAR begins transition to National systems	\$950,000	\$ 850,000	HVSI/HLAB	JEMBI & MOASIS / UCSF							
13	Data quality improvement strategy: Improve paper based systems, National ART, ANC, HTC and TB registries developed for MISAU and rolled out	Criteria for registries developed, National ART registries developed and piloted in several sites	Roll out of National ART registries to all sites	\$ 500,000	\$ 400,000	HTXS	ICAP		X	X	X			X
14	Data quality improvement strategy: technical support to the MISAU information systems for the coordination and roll out of systems, improved data use and dissemination	hiring of new staff at MISAU DPC and INS, development of SOP for automated	automated reporting from aggregate and patient level data systems	\$ 250,000	\$ 250,000	HVSI	INS							

		reporting											
15	Data quality improvement strategy: Data quality assessments and improvement plans (DQA internal and external)	Finalization of SOPS for internal and external DQA for HIV; More than 25 sites visited for DQA; District Data quality improvement plan developed	More than 25 sites visited for DQA by central level and MISAU; District Data quality improvements implemented	\$1,000,000	\$1,000,000	HKID /HTXS /MTC T	UCSF/MS IP		X	X	X		
16	Data quality improvement strategy: Requirements and development for OpenMRS modules; TB, MCH, pharmacy and Require Pilot OpenMRS POC systems	development and pilot of ART, TB and MCH modules	National roll out of registries and development of pharmacy and laboratory modules	\$600,000	\$750,000	HTXS / MTCT	UCSF/ EGPAF		X	X	X		X
17	OVC monitoring, performance evaluations of Mozambique-based OVC IPs.	implemented evaluation for all OVC implementing partners	analysis and completion of OVC report	\$300,000	\$50,000	HKID	MEASURE		X	X			
18	PEPFAR investments for Transition Monitoring; determining impact of pivoting and determine the ability of MISAU to fully take on smaller health facilities in no priority	Transition SOP and protocol developed to determine the strengthen if the ministry	Implement transition SOP and protocol and develop a reports on sites moving to MISAU	\$410,000	\$500,000	HTXS	ICF Macro						

	districts	at provincial, district and sites level to ensure quality services	support only – monitor patient outcomes and sites ability for at least 12 months										
19	DEV results	Devresults developed for site level targeting and achievements with DSD/TA/NA for	Devresults transition to DATIM	\$76,000	\$76,000	HVSI	Devresults						
20	Combination prevention platform, an existing project in Chókwe District (Gaza Province) is designed to simultaneously scale up prevention interventions and measure incidence. Directly related to epidemic control in it demonstrates “proof of concept” for successfully achieving community-level saturation with resulting decline in HIV incidence.	Implementation of combination prevention platform and protocol at CHOKWE; midterm report of the evaluation and program	Further Implementation of combination prevention platform and protocol at CHOKWE; annual report of evaluation and program	\$250,000	\$250,000	HVSI	INS		X	X		X	
21	Mozambique's Monitoring and Evaluation Mechanism and Services (MEMS) platform providing logistic support, data cleaning and analytics for SIMS and SAPR/APR/Quarterly reporting, and SI related	Logistic support provided for 140 annual SIMS site visits. Four annual PEPFAR	Logistic support provided for 140 annual SIMS site visits. Four annual PEPFAR	\$850,000		HVSI	TBD						

	capacity building/training to ensure the availability of quality routine data. USAID Mozambique will be able to respond to epidemiologic trends as well as service delivery challenges, and will have a more comprehensive understanding of quality issues related to both clinical and community-based treatment and prevention services that are crucial in supporting optimal patient outcomes.	routine data cleaning and reviews (Quarterly/S APR/APR)	routine data cleaning and reviews (Quarterly/S APR/APR)										
PEPFAR and MISAU (province and ministry-level) Data use, modeling, data storage													
22	Modeling and forecasting, costing, incidence, key pops, SPECTRUM/ GOALS/AIMS / MOT, Commodities and HRH	Geographical Model and report developed for Mozambique specifically to understand the geographic pivot on incidence and prevalence and mortality based on COP15 prioritization	Geographical Model and report developed for Mozambique specifically to understand the geographic pivot on incidence and prevalence and mortality based on COP15 prioritization	\$400,000	\$2 50,000	HVSI	Futures/ UCSF						
23	Monitoring and evaluation staff for MISAU: ART ,	Hiring of international M&E staff at	Continued hiring of international	\$600,000	\$800,000	HVSI	FHI/ EGPAF						

	PMTCT, TB, HTC/linkages	MISAU programs, ART, PMTCT, TB, linkages	M&E staff at MISAU programs, ART, PMTCT, TB, linkages										
24	M&E and other systems staff at DPS and DPC/DIS	Hiring of M&E staff at DPC/DIS	Continued hiring of M&E staff at DPC/DIS	\$400,000	\$400,000	HVSI	JEMBI & MOASIS/DPS/DPC						
25	Staff at INS, data manager, IT support, surveillance, Data management unit support & GIS	continued hiring of data manager staff at INS	continued hiring of data manager staff at INS	\$500,000	\$500,000	HVSI	UCSF/INS						

6.3 Health System Strengthening (HSS)

The focus of COP15 HSS activities is on ensuring allocation of appropriately trained staff; supporting HR policy implementation; and standardized and coordinated in-service training, mentoring and quality improvement activities to ensure quality of care that directly supports the scale up of patients in care and treatment. It also includes continuation of pre-service training for courses already underway that are preparing HRH in the priority areas during the scale up timeline.

The second area of focus is capacity development and support to the Provincial Directorates of Health (DPSs), responsible for planning, implementing, supervising and monitoring all HIV service activities in the priority areas. DPS strengthening is an essential component of the implementation of a transition plan to the GRM.

The third area of focus is on health financing systems, and support to improve the MOH's public financial management systems via the finalization of tools to allow the MOH to routinely track expenditures on HIV and TB. The COP 15 includes support to help the MOH to finalize a health financing strategy, which is an important component of increasing domestic resources available for the HIV/AIDS response. This COP also includes targeted capacity building for local civil society organizations, including the national network of PLHIV.

The focus of COP15 Supply Chain activities is to make the national HIV and Lab commodity supply more secure, safe and stable, and to strengthen the country's fragile supply chain system to allow it to better support the rapid HIV program scale up by providing operational support and technical assistance in core functional areas (quality assurance and control, governance, procurement, supply planning and quantification, warehousing, distribution, and logistics management information systems). These are outlined in Table 6.3 below.

Table 6.3: HSS activities prioritized for COP 2015

Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism (s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression

Support for HRH planning and allocation to high volume sites and HR policy and guidance, including nursing practice to improve allocation efficiency.	Finalize interoperability framework. Provincial HRH allocation plans. HRIS Data QI. GIS platform for monitoring efficiency of scale up. HRH planning including workloads, staffing patterns, models of allocation, and monitoring.	Continue support of data quality improvement, GIS platform, and allocation of key HRH at high volume sites.	OHSS, HTXS, HVCT, MTCT USD 2,650,000 2 mi Jhpiego 400k Forsass 100k ARC 132k ICAP GN	OHSS, HTXS, HVCT, MTCT USD 2,650,000	Jhpiego + FORSASS TBD + ARC + ICAP GN	3. Performance Data 11.0. 4. Access and Demand 11.2. 5. Human Resources for Health 7.5. 7. Quality Management 5.4. 10. Allocative Efficiency 7.0. 11. Technical Efficiency 6.0.	X	X	X	X	X
In-service training system support, data integration and utilization Central level	Support to in-service training system and information to address worker performance and quality of education to be able to provide quality HIV services at high volume sites. Distance learning and distance mentoring activities.	Expansion of the national system to all priority Districts and support at Provincial level to manage and utilize system	OHSS, HTXS, HVCT, MTCT USD 950,000	OHSS, HTXS, HVCT, MTCT USD 950,000	Jhpiego	4. Access and Demand. 11.2 5. Human Resources for Health 7.5 7. Quality Management 5.4	X	X	X	X	X
Support practicum training sites development for Adult and Pediatric HIV services	Continue support to Catholic University School of Medicine to develop team oriented practicum site for TARV, and Maputo Central Hospital to increase capacity to care for critically ill children in Pediatric HIV services	Clinical practicum for HCW	OHSS, HTXS USD 600,000	OHSS, HTXS USD 725,000	UCM ICAP / UCLA	4. Access and Demand 11.2 7. Quality Management 5.4 11. Technical Efficiency 6.0	X	X	X	X	X

Pre-service training curriculum development support selected cadres	Revised curricula for Hospital Management and Administration course and faculty development	Continue faculty development and provision of teaching materials	OHSS USD 200,000		ICAP	5. Human Resources for Health	X	X	X	X	X
Promotion course (In-service) for Mid level to superior Level courses (Nurses) and basic to mid for TdMs and nurses.	Train 30 mid-level to university level nurses (Zambezia Province) and 120 TdMs and nurses from basic to mid.	Train additional 150 TdMs and nurses	OHSS, HTXS, HVCT, MTCT USD 400,000	OHSS, HTXS, HVCT, MTCT USD 450,000	ISCISA CCS, EGPAF, ICAP	5. Human Resources for Health 7.5 7. Quality Management 5.4	X	X	X	X	X
Pre-service training for technicians in pharmacy, Lab, medicine, statistics, and MCH nursing technicians for areas of high need	90 new lab, 90 new pharmacy, 404 continuing graduated by Jun 2017		OHSS, HKID, HTXS, HVCT, MTCT HLAB USD 820,000	OHSS, HKID, HTXS, HVCT, MTCT HLAB USD 0	CCS (Maputo to be distributed to areas of need)	4. Access and Demand 11.2 5. Human Resources for Health 7.5 7. Quality Management 5.4	X	X	X	X	X
DPS capacity building to plan, execute, and monitor HIV services in priority sites.	Organizational assessment, plan of action and implementation of a performance improvement plan in system areas at the provincial level necessary for scaling up and for creating sustainability in our highest	Continuation of support, milestones defined at the conclusion of the organizational assessment. Each year new areas of capacity focus	OHSS USD 890,000	OHSS USD 900,000	NASTAD	3. Performance Data 11.0 4. Access and Demand 11.2 5. Human Resources	X	X			X

	priority Provinces of Zambezia and Gaza, continuation of Cabo Delgado support					for Health 7.5 6. Commodity Security and Supply Chain 5.7 7. Quality Management 5.4 8. DRM: Resource Generation 7.0 10. Allocative Efficiency 7.0 11. Technical Efficiency 6.0					
DPS Cooperative agreements (local MISAU) to implement Provincial level activities necessary for scale up	Each CoAg defines a set of objectives and activities in the areas of QI, supervision, planning, staffing, transportation, lab and supply chain management	Continuation with new areas of focus	HKID, HTXS, HVCT, MTCT HLAB USD 1,996,503	HKID, HTXS, HVCT, MTCT HLAB USD ?	6 DPSs Maputo Gaza Inhambane Zambezia Nampula Cabo Delgado	1. Epidemiological and Health Data 9.9 2. Financial/Expenditure Data 1.3 3. Performance Data 11.0 4. Access and Demand 11.2 5. Human Resources for Health 7.5 6. Commodity Security and Supply Chain 5.7 7. Quality Management 5.4 13. Oversight and	X	X			X

						Stewardship 13.0					
						15. Planning and Coordination 14.0					
Support implementation of the QI lite package for maintenance sites and provincial support of in-service training and HRH performance improvement	Implementation of national HIV service QI plan “lite”, at Provincial and District levels. Two components, full support and plan for maintenance sites. Distance Learning hubs to reach professionals in high volume sites and priority districts. Support DPS capacity to manage complicated HIV related clinical cases through distance learning, clinical mentoring and phone hot line.	Continue support in these areas to build Provincial capacity to undertake these tasks	PDTX HTXS, HVCT, MTCT USD 2,300,000	PDTX, HTXS, HVCT, MTCT USD 2,000,000	ITECH	3. Performance Data 11.0 5. Human Resources for Health 7.5 7. Quality Management 5.4	X	X	X	X	X
Strengthening the Social Welfare System in Mozambique through Competency-based Course Development to better respond to the needs of OVCs	Support Ministry of Gender, Child, and Social Action (MGCAS) to further decentralize the Social Assistant trainings to the Provinces in partnership with MISAU training Institutes for 150 Social workers Conduct assessments and develop action plans for Social Welfare provincial directorates to build their capacity and to feed into their annual Social and Economic Plans	Continue to decentralize the trainings to other Provinces to promote local capacity and develop MGCAS human capital to improve the health conditions of OVC and PLHIV for 180 Social workers Support MGCAS strategies to advocate for increased investment in the social welfare workforce to make a lasting impact to	HKID 1,200,000	HKID 1,400,000	HSS TBD		X	X	X		

		beneficiaries.									
Support CHW (APEs) training on HIV/TB adherence and introduction of Family Planning methods at community level	Finalize the training of 1,625 APES (25 in the 65 districts) Update and improve register books and reporting forms for better accountability and traceability	Train and additional 1867 APES	HBHC, PMTCT \$560,000	HBHC, PMTCT 1,000,000	UNICEF						
Design and Development of Logistics Management Information System (LMIS): Initial and ongoing development of software	Completed assessment of SIMAM product monitoring and ordering system capabilities versus other possible options (eLMIS, other systems, etc.). Revised Quantimed to make the system more user-friendly. LMIS design and development activities; provide Central Tool training.	Logistics Management Information Unit (LMU) created within Central Medical Stores (CMAM). augment Central Tool-related staff. Mapping software installed and staff trained on its use. LMIS advisors fielded at pilot for intermediary warehouses.	OHSS 938,500	OHSS 938,500	SCMS	6. Commodity Security and Supply Chain: 5.7	X	X	X	X	
LMIS Infrastructure Support: hardware procurement, installation & maintenance; connectivity & consumables; software installation, maintenance, licensing	Installed SIMAM for 14 district clients. Supported hardware and software installation to improve SIMAM performance. Developed manuals, SOPs, and IT trainings related to SIMAM use. Completed trainings on SIMAM system maintenance. Provided Mozgate support for CMAM.	SIMAM installed in additional districts and high-volume ART sites. Version 2.1 released incorporating new functionalities identified by users. Support provided for provincial-level data analysis. Feedback reports regularly disseminated and discussed at quarterly supply chain meetings to improve	OHSS 136,365	OHSS 136,365	SCMS	6. Commodity Security and Supply Chain: 5.7	X	X	X	X	

		system implementation. SIMAM implementation systematically included in supervision checklists. CMAM IT staff capable of maintaining CMAM network/systems.									
Implementation and Use of LMIS: ensure data quality and accurate data on inventory management, ordering, reporting, and distribution and monitoring for the correct provision of data.	Improved distribution for HIV commodities for the health facilities. Completed SIMAM trainings at all levels. Provided stock problem resolution, stock monitoring and on-the-job mentorship for SIMAM users at the site level. Support use of SIMAM in provinces and hospitals. Provide overall central support to collect data from the provincial level to improve data quality and consolidate the use of SIMAM. Mentored CMAM in use of data for quantification and distribution decision-making.	Determined quantification of national need and distribution for HIV commodities to avoid stock outs at facility level, all Logistics Management Unit staff will be fully conversant with and regularly using CT, SIP, SSI and PipeLine.	OHSS 1,292,017	OHSS 1,292,017	SCMS	6. Commodity Security and Supply Chain: 5.7	X	X	X	X	
Manage the lab commodities supply chain down to site level, including viral load	Management oversight for lab commodity distribution and machine maintenance contract for 71 PEPFAR-supported labs; consumption data collected and analyzed for resupply and restock of machines and reagents for CD4, hematology & biochemistry, etc. Quantification completed. Assisted with viral load	Data collection network functioning properly and monitored regularly. Provinces are performing routine network analysis and disseminating results. Completed quantification and procurement for lab commodities. Provided lab system management, training on use of lab	HTXS, PTXD 513,679	HTXS, PTXD 513,679	SCMS						X

	logistics.	equipment and lab management, and developing and using a lab LMIS system.										
Optimizing efficiency of lab supply chain system – strategy for integration of parallel lab supply chain into CMAM supply chain system; requires STTA	Led stakeholder workshop to disseminate PEPFAR lab network requirements. Developed national lab strategic plan. Redesigned logistics system for lab network. Harmonized and optimized new lab network with MISAU lab network.	All procurement and equipment deployment aligned with Harmonization strategy - improved, more efficient coverage.	OHSS 119,645	OHSS 119,645	SCMS							X
Work with GTM sub-group to complete lab reagent procurement	Completed quantification and procurement activities with GTM sub-group to gain needed lab reagents	Completed quantification and procurement activities with MISAU to gain needed lab reagents	OHSS 21,785	OHSS 21,785	SCMS							X
Assure adequate oversight and handling of PEPFAR and Global Fund procured commodities at central warehouses	Improved adherence to Warehouse SOPs, proper use of MACs and good warehouse organization; monitoring warehousing at lower levels; 3D warehouse management, and data analysis and distribution planning.	Additional warehouse operations management and MACS training provided. Feasibility of outsourcing certain central warehouse functions revisited.	OHSS 935,483	OHSS 935,483	SCMS		X	X	X	X		
Strengthen capacity in distribution process	Organized national commodity sub-group meetings to discuss distribution planning for the year, and develop a national distribution annual plan. Held central-level stakeholder workshop to review and improve distribution system.	Organized national commodity sub-group meetings to discuss distribution planning for the year, and develop a national distribution annual plan.	OHSS 178,910	OHSS 178,910	SCMS	6. Commodity Security and Supply Chain: 5.7	X	X	X	X		

<p>Intermediary warehousing and inventory management from Provincial level to Health Facility (last mile)</p>	<p>Completed assessments for intermediary warehouses on transportation software design, outsourcing feasibility and distribution systems; Designed intermediary warehouse prototype; Piloted warehouse readiness; Completed workshop to discuss intermediary warehouse system design, trainings on warehouse reform; Coordinated with Global Fund and other donors to collaborate and report on warehouse reform implementation.</p>	<p>Assessment conducted to evaluate the implementation of the intermediate warehouse pilot and its impact on product availability and order satisfaction. Intermediate warehouse implementation rolled out to additional sites (including embedded SIMAM support). Outsourced transportation piloted for intermediate warehouse to health facilities level. Intermediate warehouse-level data analysis and calculation/packing of resupply for ART sites implemented in pilot intermediate warehouses. Evaluation of PELF implementation to date conducted and results disseminated.</p>	<p>OHSS 1,690,665</p>	<p>OHSS 1,690,665</p>	<p>SCMS</p>		<p>X</p>	<p>X</p>	<p>X</p>	<p>X</p>	
<p>Assure adequate warehouse space and proper operations</p>	<p>Rented warehouse space in Maputo, Nampula, and Beira for CMAM. Continued infrastructure support for warehouses, such as assuring good shelving unit and material handling equipment (MHE) are in place. Provided in-service systems training / mentoring. Implemented Radio Frequency (RF) warehouses in Beira and</p>	<p>Rented warehouse space in Maputo, Nampula, and Beira for CMAM. Continued infrastructure support for warehouses, such as assuring good shelving units are in place. Implemented RF warehouses in Nampula build, and trained warehouse staff on RF.</p>	<p>OHSS 1,359,906</p>	<p>OHSS 1,359,906</p>	<p>SCMS</p>	<p>6. Commodity Security and Supply Chain: 5.7</p>	<p>X</p>	<p>X</p>	<p>X</p>	<p>X</p>	

	Nampula rental, and trained warehouse staff on RF.	Provided in-service training/mentoring for warehouse staff regarding MACS and organization systems.									
Build capacity at provincial, district and health facilities (through on the job mentorship, in service training, and quarterly meetings) to ensure that the responsible staff adhere to the drug management SOPs, and assure link between care & treatment data and supply chain data for better quantification, forecasting and distribution. Critical to improve data visibility, quality and use.	Provincial (and below) health staff (warehouse managers, stock managers, supervisors, IP advisors, etc.) trained and mentored in the logistics cycle, good warehouse management practices and distribution processes to provide quality-site level data and analysis at the provincial level. MMIA reporting/ordering improved. Completed training, monitoring and other support relate to: movement of products through the different levels down to the site; transportation and distribution of products; warehouse and storage conditions; physical inventory stocks; stock cards; compliance with SOPs and Procedures Manuals for all aspects of the logistics and drug management cycle. This will improve overall practices and generate better data for quantification, forecasting, and distribution for the resupply of product, availability and ensuring proper treatment is available to patients at the site level.	Provincial (and below) health staff (warehouse managers, stock managers, supervisors, IP advisors) are trained and mentored in the logistics cycle, good inventory management practices, and distribution processes to provide quality-site level data and analysis at the provincial level. Overall, this will improve product availability and ensuring proper treatment is available to patients at the site level. Overall, this will improve overall practices and generate better data to be used for analysis for the resupply of product, availability and ensuring proper treatment is available to patients at the site level.	HTXS, PTXD 2,835,416	HTXS, PTXD 2,835,416	SCMS		X	X	X	X	

National Product Supply Planning: Support MISAU and CMAM to coordinate government supply chain stakeholders, donors, and implementing partners via GTM subgroups	Provided support for the continuation of Commodities Technical Working Group (GTM) sub-groups (Quantification, forecasting, procurement planning and supply monitoring, donor coordination for commodity support, emergency stock responses, & support to GTM sub-groups). Work collectively to establish objectives and plans to increase supply chain sustainability.	Provided support for the continuation of GTM sub-groups (Quantification, forecasting, procurement planning and supply monitoring, donor coordination for commodity support, emergency stock responses, & support to GTM sub-groups). Work collectively to establish objectives and plans to increase supply chain sustainability.	OHSS 98,680	OHSS 98,680	SCMS		X	X	X	X	X
Continue to develop local capacity in quantification, forecasting, supply planning, and supply chain evaluation	Completed training for GTM sub-group in quantification, forecasting, and supply planning; and provide follow-up mentorships. Completed in-service training for new CMAM and provincial-level staff regarding "Logistics 101." Continued trainings for CMAM's Monitoring and Evaluation (M&E) division regarding various supply chain M&E concepts.	LMU established to optimize analysis of data provided through SIMAM, MACS, SIP via Central Tool and other means. GTM sub-groups all conversant in and regularly using PipeLine software to regularly monitor commodity supply status.	OHSS 82,233	OHSS 82,233	SCMS	6. Commodity Security and Supply Chain: 5.7	X	X	X	X	X
Produce annual quantification and forecasting	Completed consumption, ordering and stock level data analysis with CMAM to complete annual quantification and forecasting	Completed data analysis with CMAM to complete annual quantification and forecasting activities for HIV	HTXD, HTXS, PTXD 217,015	HTXD, HTXS, PTXD 217,015	SCMS	6. Commodity Security and Supply Chain: 5.7	X	X	X	X	X

	activities for HIV commodities so country supply needs are met. Provided results to donor agencies so they can allocate funding for supplies.	commodities so country supply needs are met. Provided results to donor agencies so they can allocate funding for supplies.										
Tracking donor funding contributions, disbursements of funding and shipments for commodity security	Financial analysis reports produced to assist donor and MISAU planning/budgeting. Supply plans produced and shared. Global Fund New Funding Model (NFM) grant Procurement and Supply Management (PSM) plans coordinated and monitored.	Financial analysis reports produced to assist donor and MISAU planning/budgeting. Supply plans produced and shared. Global Fund NFM grant PSM plans coordinated and monitored.	OHSS \$65,786	OHSS \$65,786	SCMS	6. Commodity Security and Supply Chain: 5.7	X	X	X	X	X	
Conduct field office based procurement for CMAM	Assure adherence to SOPs and use of procurement databases. Support procurement work. Provided Field Office Managed Procurement (FOMP) training for all new procurement staff. Installed SIP system, and trained staff on its use.	CMAM procurement staff regularly entering all relevant data into SIP and (Importation System) SSI databases and maintaining them up-to-date. Procurement team exchanging data regularly with LMU and ensuring procurement module of CT is current and accurate.	OHSS 840,077	OHSS 840,077	SCMS	6. Commodity Security and Supply Chain: 5.7	X	X	X	X	X	
Strengthen the technical capacity at National Laboratory of Drug Quality Control (NLDQC) to quality tests on drugs in the supply chain	Collaborated with NLDQC to establish a national reference lab. Completed mentoring to establish capacity within NLDQC. Provided technical guidance to help NLDQC gain international certification. Worked with NLDQC to take random samples of tracer	Collaborated with NLDQC to establish a national reference lab. Completed mentoring to establish capacity within NLDQC. Provided technical guidance to help NLDQC gain international	OHSS 300,000	OHSS 300,000	PQM		X	X	X	X	X	

	drugs located at various levels throughout the supply chain, and test for quality	certification. Worked with NLDQC to take random samples of tracer drugs located at various levels throughout the supply chain, and test for quality									
Improve national medicines policy, legislation, regulation, norms, and standards	Continued work to adapt medicine policies and guidelines to be in-line with WHO and SADC standards. Worked with PD to implement new National Essential Medicines List (NEML), via training national and central staff on NEML, and developing systems to monitor NEML.	Continued work to adapt medicine policies and guidelines to be in-line with WHO and SADC standards. Worked with PD to implement new National Essential Medicines List (NEML), via training national and central staff on NEML, and developing systems to monitor NEML.	OHSS 303,000	OHSS 303,000	SIAPS	6. Commodity Security and Supply Chain: 5.7	X	X	X	X	X
Capacity development for pharmacists at central, provincial, and district levels	Completed trainings and on-the-job mentoring regarding electronic medicines registration system (PharmaDex) for PD Registration division (central level); national essential medicine list for pharmacists and prescribers at central, provincial, and district levels; and quality management systems for pharmaceuticals for the central-level National Laboratory of Pharmaceuticals Quality Control (LNCQM) quality assurance staff. Complete a Training-of-Trainers (TOT) at the national	Completed trainings and on-the-job mentoring regarding electronic medicines registration system (PharmaDex) for PD Registration division (central level); national essential medicine list for pharmacists and prescribers at central, provincial, and district levels; and quality management systems for pharmaceuticals for the central-level National Laboratory of Pharmaceuticals Quality	OHSS 307,000	OHSS 307,000	SIAPS		X	X	X	X	X

	level on essential medicine guidelines, to allow continued training at all-levels by PD.	Control (LNCQM) quality assurance staff. Complete a Training-of-Trainers (TOT) at the national level on essential medicine guidelines, to allow continued training at all-levels by PD.									
Strengthen the capacity of pharmacy staff to monitor and assure rational-use of essential medicines	Worked with PD and MISAU to use tracer list to keep track of essential medicine availability at facilities in high-burden areas. Completed workshop with officials in pharmacovigilance, and guidelines for reporting adverse drug reactions. Provided support to National Medical Assistance Directorate to monitor HIV treatment outcomes, and evaluate prescriber compliance with ART guidelines.	Worked with PD and MISAU to use tracer list to keep track of essential medicine availability at facilities in high-burden areas. Completed workshop with officials in pharmacovigilance, and guidelines for reporting adverse drug reactions. Provided support to National Medical Assistance Directorate to monitor HIV treatment outcomes, and evaluate prescriber compliance with ART guidelines.	OHSS 390,000	OHSS 390,000	SIAPS		X	X	X	X	X
HRH MOU developed with GRM – high level with USG; workplan level and capacity building plan with SCMS	Formalize a systematic approach to develop shared ownership and responsibility to build local staff capacity and foster the creation of skilled supply chain professionals.	creating cadre of supply chain and warehouse management professionals in national HR plan	OHSS \$34,090	OHSS \$34,090	SCMS		X	X	X	X	X

Improve administrative authority of CMAM	Started process of Merging CMAM and Centro de Abastecimento. CMAM single authority (Comando Unico) began at provincial level with help from SCMS Provincial Advisors.	Finalized merging of CMAM and Centro de Abastecimento for medical material and consumables. CMAM SOPs, Staff Structure and Job Descriptions approved by MISAU	OHSS 126,900	OHSS 126,900	SCMS		X	X	X	X	X
Support improvement of CMAM financial management capacity	Increased financial autonomy of CMAM via establishing SOPs and tools to manage GRM, external funds, and CMAM revenues; improving transparency in accounting for and reporting on funding streams; and gaining certification from MISAU, CMAM is an acquisition unit.	Increased financial autonomy of CMAM via establishing SOPs and tools to manage GRM, external funds, and CMAM revenues; improving transparency in accounting for and reporting on funding streams; and gaining certification from MISAU, CMAM is an acquisition unit.	OHSS 50,000	OHSS 200,000	SCMS		X	X	X	X	X
Identify potential cost savings and increase GRM HIV commodity contributions	Completed gap and procurement analyses and presented results to MISAU. Moved forward with increased HIV commodity procurements, with GRM contributing towards increase in HIV commodities.	Monitored and kept advocating for increased GRM funded HIV commodity procurements.	OHSS 100,000	OHSS 400,000	SCMS		X	X	X	X	X
Operationalize performance management via CMAM M&E system	Implemented internal M&E systems to evaluate staff performance, advise on performance improvement initiatives, and denote trainings completed and training staff need to	Implemented internal M&E systems to monitor supply chain performance and encourage use of data for decision making and note staff performance, provide performance	OHSS 25,000	OHSS 100,000	SCMS		X	X	X	X	X

	complete.	improvement initiatives, and denote trainings completed and training staff need to complete.									
Planning medium term transition of certain functions to government/3 rd party	Developed plan to implement strategic transition of near-core to MISAU or other party over a 5-10 year period.	Developed plan to implement strategic transition of near-core to MISAU or other party over a 5-10 year period.	OHSS 45,079	OHSS 45,079	SCMS		X	X	X	X	X
Support finalization and implementation of the 1st Health Financing Strategy (HFS)	HFS completed with clear policy options for (domestic) resource mobilization, polling and allocation, and provider payment mechanisms	Implementation of adopted policy options	OHSS USD60,000	OHSS USD 300,000	HSS TBD	8. resource generation 9. Resource commitments, 10, 11. Allocative and technical efficiency	X	X	X	X	X
Support establishment and/or institutionalization of expenditure tracking systems	Resource tracking systems in place to track HIV expenditures	Continue to develop and implement tracking systems	OHSS USD20,000	OHSS USD450,000	HSS TBD	2. Financial / Expenditure data, Resource commitments	X	X	X	X	X
Enhance MISAU's Program Budgeting Systems to better link PES (annual plan) and OE (state budget)	Tools and systems clearly demonstrate GRM commitment to HIV program and also increase transparency and accountability to stakeholders	Continue to improve and institutionalize program budgeting systems	OHSS 0	OHSS 300,000	HSS TBD		X	X	X	X	X
Improved PFM systems at all levels of health sector, and improve transparency and efficiency in funds administration	Better execution of planned and budgeted activities at provincial level to ensure smooth implementation of HIV program activities in PES and OE; increased access to	Better execution of planned and budgeted activities at district level to ensure smooth implementation of HIV program activities in PES and OE; increased		OHSS 400,000	HSS TBD		X	X	X	X	X

	HIV expenditure data	access to HIV expenditure data									
Improved procurement and governance capacity of UGEA	Improved procurement system activities will improve MISAU's ability to better procure HIV related commodities	Continue improvement in procurement systems	OHSS 0	OHSS 200,000	HSS TBD		X	X	X	X	X
Support advocacy efforts of People Living with HIV&AIDs, by increasing advocacy capacity and expertise of the Network of People Living with HIV and AIDS (RENSIDA)	Developed advocacy capacity, skills, tools, M&E, developed Advocacy Strategy w/ concrete deliverable; Train Member Associations; implement advocacy interventions at several technical and decision making levels.	Developed capacity, skills, tools, Implemented Advocacy Strategy w/ deliverables	OHSS 300,000	OHSS 300,000	DG IM	Enabling Environment, Civil Society engagement 4	X	X	X	X	X
Provide intensive institutional and programmatic capacity to local organizations to building their systems and skills	Conducted assessments, diagnosis of needs and gaps of local organizations receiving USG funds; develop tailored CB plan; provided training, TA, coaching and mentoring, day-to-day mentoring	Organizational needs and weaknesses identified addressed in a sustainable manner.	OHSS 400,000	OHSS 400,000	HODI/Eurosis	Enabling Environment, Civil Society engagement 4	X	X	X	X	X

7.0 USG MANAGEMENT, OPERATIONS AND STAFFING PLAN TO ACHIEVE STATED GOALS

In line with core/near-core/non-core decisions and geographic focus of COP15 in various districts in Mozambique, the PEPFAR interagency team reviewed its staffing profile to focus on strategic investments toward epidemic control within a limited M&O budget envelope. Agencies adjusted their cost of doing business (CODB) to reflect for expected increases in ICASS costs as well as projected increases in travel budgets to implement SIMS.

The Chief of Mission has asked all agencies to develop a long-term plan of staffing for results, carefully considering new and repurposed positions. Agencies identified specific skills needed to implement the scale up of COP15. All agencies recognized the imperative to improve data collection and analysis and the increased burden on human resources to implement ambitious targets in COP15 and have proposed adjustments to staffing accordingly.

CDC has conducted several assessments of staffing levels to 1) document gaps and barriers to achieving accelerated epidemic control in Mozambique 2) ensure CDC is able to provide consistent delivery of high quality interventions and TA, and 3) ensure CDC has robust business and operational systems in place to meet USG requirements. Based on these results, CDC is repurposing several vacancies to align with the new strategic direction as well as requesting four new staff in COP15. Of the four new requested staff, one will be a USDH while others will be FSN positions.

The overall number of full-time equivalent (FTE) PEPFAR-funded staff proposed by USAID in this year's COP is stable compared to COP 14. Within that FTE level, USAID is re-purposing vacancies to support core areas, including a vacant Community Advisor position which will be re-purposed to a Clinical-Community Advisor and an Organizational Capacity Development Advisor position which will be re-purposed to support supply chain strengthening. USAID has also included in this year's COP request one Fellow (one-year term) to support expenditure analysis, including analysis of trends in results, accuracy in reporting, and increased utilization of expenditure data in decision-making. USAID is also proposing re-purposing an existing USDH position to the health office to support PEPFAR implementation. USAID is proposing a TBD implementing mechanism (MMEMS) that will support data analytics and reporting for USAID's APR, SAPR, and quarterly reporting requirements.

The PEPFAR Coordination Office is repurposing one vacant position to increase support for data collection and analysis. Other agencies are not proposing any new positions.

APPENDICES

APPENDIX A CORE, NEAR-CORE, NON-CORE MATRIX

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	<p>HTC Care and Treatment (Tx), post-violence care TB- screening, diagnosis and Tx Retention – M2M, GAACS, health educators HRH- in service training, distance learning, accreditation SC LMIS, Lab: lab diagnostics & reagent resupply; equipment maintenance, integrated specimen referral, VL & drug resistance testing; in-service training & certification. EQA for rapid testing; laboratory information & results reporting systems OVC – case mgmt. approach Key & Priority Pops, Military, Adolescent girls, young women VMMC Condoms PrEP, PEP, GBV Blood banks – QA SI: SISMA, LTFU tracking, EPTS, data quality inputs, open MRS development HIV/TB/MCH</p>	<p>Couples testing, Pre-ART – some lab tests, cervical cancer screening and Tx, STIs, Kaposi, therapeutic feeding FP/HIV integration Infection control TB/HIV – MDR ward renovations OVC – village savings, vocational training, Household economic strengthening Stigma & discrimination community level activities Lab: Laboratory quality improvement implementation</p>	<p>General community HTC Palliative care WASH PMTCT - Option A sites Birth registration</p>
Sub-national level	<p>Supply Chain logistics, and operational support Provincial support for in-service training, mgmt., supervision Improved HW deployment LMIS, lab supply chain Lab: Specimen referral system, in-service training & certification of lab staff in HIV and HIV-related testing, Laboratory information & results reporting systems</p>	<p>Warehouse rentals LMIS inventory mgmt. Laboratory network support; lab pre-service training social worker/para social worker training</p>	<p>Birth registration</p>
National level	<p>Supply Chain: – LMIS, WH operations and quality management, Quantification & Supply planning, Lab SC,</p>	<p>Care and Tx National guidelines Commodity security, HIV commodity important LMIS; Provide training & mentorship to MISAU staff</p>	<p>Micronutrient powders National Health Accounts</p>

	<p>management; National product supply management.</p> <p>LMIS, lab supply chain, equipment & commodities, specimen referral, drug resistance testing, Laboratory information & results reporting systems</p> <p>SI: SISMA, LTFU tracking, EPTS, data quality inputs, open MRS development HIV/TB/MCH</p> <p>Surveillance: ANC, VL and DR, AIS/DHS</p>	<p>in lab logistics & tools for commodities quantification (ForLab), pipeline analysis (Pipeline), & warehouse management (MACS);</p> <p>SC: PELF implementation</p> <p>Pre-service training</p> <p>TA for HRH policy</p> <p>Drug quality control</p> <p>Warehouse rental</p> <p>Lab: EQA</p> <p>LMIS for lab supply chain management; Lab quality improvement program</p> <p>CSO – PLHIV network capacity building</p> <p>Social protection advocacy/ policies</p> <p>Blood safety – natl. guidelines</p> <p>SI: IBBS, HIV mortality survey, VACS, combination prevention evaluation; improve systems at MISAU</p> <p>HCF and Financial management: Strategy development & implementation</p>	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
HTC	<ul style="list-style-type: none"> • Focused HTC activities (PICT, VCT and index case testing) in epi burden districts • RTKS (Rapid Testing Kits): procurement , supply, distribution • Quality improvement – HW training, EQA • Reinforce linkages into care and Treatment 	<ul style="list-style-type: none"> • Couples testing, Quality improvement for HTC including GBV prevention • Reproduction/dissemination of materials 	<ul style="list-style-type: none"> • General community HTC
Care and Treatment	<ul style="list-style-type: none"> • Demand creation for testing, care, and treatment in scale-up districts • HCT – PICT, Index Case Testing, VCT (PICT, VCT, Realigned Community CT, EQA, HTC in SAAJ, GBV Screening, RTKs, Index-case testing, Case-finding in children (case management for children w/abuse) • Linkage of PLHIV into Care (Health Educators, Referral forms, Post-test counseling, PHDP) • Pre-ART Package, Counseling, PHDP, WHO staging, CD4, CTX, screening for OIs, FP Integration, NACS • TB/HIV: screening, Tx, HIV testing, Contact tracing, IPT, Cough officers, IC, Health Educators, MDR-TB, specific programs addressing miners and prisoners • ART: Clinical Mentoring, Tx monitoring (CD4, VL) Warm line, Job Aids, In-service training, POC diagnostics, Pre-ART counseling for same-day initiation (lay counselor), Pharmacovigilance Expand OSM; Test and treat KPs. • Treatment support & retention: Support Groups, GAACS, M2M, community ART distribution, Adherence counseling, Tx literacy, referrals, condoms, MCP, disclosure, Teen Club/SAAJs, Adolescent transition to Adult Care • Sex disaggregated data 	<ul style="list-style-type: none"> • Demand creation: -Training of HCW, replication of PHDP materials • HTC - Produce/distribute HTC materials • Pre-ART STIs, Hb, Cr, LFTs, Cervical CA, Kaposi Sarcoma; Therapeutic food, , TA for PRN, Messaging • Nutrition: nutrition education, therapeutic feeding, provincial/district supervision, QI, development. Of community service directories • Integration of FP and HIV - materials, training HWs and service provision • TB/HIV: Renovations to MDR-TB wards, expansion of TB diagnosis (lab); lab technician training, referral systems expansion of x-ray diagnosis, support electronic TB register • PMTCT partner testing, disclosure • Treatment support & retention VSLG, Stigma reduction, Nutritional Support 	<ul style="list-style-type: none"> • HTC - Blanket Testing and Counseling, Linkages/HTC national dissemination and discussion • Pre-ART - WASH, Micro-nutrient powder • Palliative/Home based care • PMTCT – Option A (by SAPR15)
Prevention	<ul style="list-style-type: none"> • Key Populations (CSW, MSM – combination prevention in KP friendly environments) Military, 	<ul style="list-style-type: none"> • Stigma & discrimination – HW training, community education (including KPs) & 	

	<p>Adolescent girls & young women; peer support groups, training HWs</p> <ul style="list-style-type: none"> • VMMC: focus on epi-burden districts with <80% VMMC saturation - 15-29 yrs with increased demand creation; military, • Condom procurement, promotion and distribution • PReP (Pre-Exposure Prophylactics):advocate for policies for KPs • PeP (Post-Exposure Prophylactics): Support pre- and in-service training re: PEP provision for health care workers and GBV, including post-rape care for minors (children). • Blood safety: HIV quality assurance in blood banks • Sex disaggregated data 	<p>increased male involvement in health councils, mass media toolkit;</p> <ul style="list-style-type: none"> • STIs: -update national guidelines and SOPs, adolescent SRH, Training of HWs • Infection control in HFs through training in SOPs and supply of protective materials • Blood safety: Revision of national guidelines and rational use of blood components • Household economic strengthening 	
OVC	<ul style="list-style-type: none"> • Case Management: Assessing child & family socio-economic status at Household level (across all areas: healthy, safe, stable, schooled) • Implementing special studies to identify gaps in programming impact • Healthy: Promotion of EID and confirmatory HIV testing • strengthen adherence assessment, counseling and support into routine OVC Home visitors work • referral of suspected malnutrition, nutritional education at HH and community level • Facilitating uptake of and monitoring completion of referrals for Health, Food and Nutrition, TB/HIV, treatment and care services for all children and family members of index cases, SRH and FH services for ALHIV, including AYFS • Safe: Facilitating birth registration and succession planning • Positive Parenting focusing on adult/child communication and protective and provider roles, HIV disclosure and child health • Support psychosocial health among children and their caregivers, teachers, through individual, home, group-based and relationship based 	<ul style="list-style-type: none"> • Case Management: Mapping services within targeted communities and developing service directories • Supporting the development of national MIS • Training in strength's based case management for Community OVC Volunteers within PEPFAR catchment areas • Strengthening referral mechanisms and other systems for linking clinical, social and protection services • Safe: Strengthening government-managed case management systems to prevent and respond to child abuse and Support family placement and temporary permanency support for children • Strengthening community-based structures for mediation of child abuse and violence cases • Professional Development for social and para-social workers • M&E systems for National child protection/ social welfare efforts • Stable: Carry out market assessments to identify potential Income generating Activities (IGAs) with links to existing businesses / agricultural projects and markets/value chain development • Targeted food security for destitute families 	<ul style="list-style-type: none"> • Large campaigns or standalone programs to disseminate of Child protection laws • USG Direct food support • Home visits related to clinical linkages only • Direct provision of houses • Support for non-market driven vocational trainings and IGAs • Direct provision of micro-credit

	<ul style="list-style-type: none"> activities Support Community and national level child protection/ GBV prevention and response activities, including emergency food and shelter for abuse survivors Stable: Facilitating the establishment of savings groups plus (including financial literacy) Supporting access to and uptake of social protection for all eligible according to GRM PSSB, PASD and PASP criteria Schooled: Facilitating access to primary and secondary education through temporary and targeted support through support with uniforms, school fees, exam fees Providing temporary school block grants to promote enrollment and progression Supporting early childhood development for children under five with strong linkages with PMTCT and Pediatrics Provision of long-term or open-ended school block grants or support for ECD centers, Positive parenting, Economic strengthening Sex disaggregated data 	<ul style="list-style-type: none"> Facilitating access to primary (and secondary education for girls) through long-term or open-ended subsidies Zero tolerance interventions to make classroom environments gender and HIV sensitive, as well as safe places for vulnerable children Supporting community school councils 	
Gender and gender based violence	<ul style="list-style-type: none"> Ensure availability of MISAU post-GBV services package at site level PEP for post GBV care Engage men in developing positive health seeking behaviors, communication strategies Gender disaggregated data 	<ul style="list-style-type: none"> Social protection –advocacy for polices, harmful traditional practices, 	
Program/system support	<ul style="list-style-type: none"> Laboratory: Lab diagnostics & reagent resupply, equipment & maintenance, specimen referral, VL & drug resistance testing; in-service training. EQA program; lab supply chain coordination; laboratory information & results reporting systems; HIV Rapid Testing Quality Improvement Initiative CSO_ capacity building for Network for PLHIV Supply Chain: – LMIS , WH operations and quality management, Quantification & Supply 	<ul style="list-style-type: none"> Commodities: ARVs, RTKs, OI drugs, Lab reagents- VL, CD4 Laboratory: Lab quality improvement program; Laboratory supply chain logistics & management strengthening of MISAU, Pre-service training for lab technicians; promote approval of national lab policy Supply Chain –hardware inputs for LMIS; PELF implementation strategic management and design, commodity security, commodity 	<ul style="list-style-type: none"> National Health Accounts; Costing tools

	<p>planning, Lab SC, management</p> <ul style="list-style-type: none"> • SI: SISMA, LTFU tracking, EPTS, data quality inputs, open MRS development HIV/TB/MCH • Surveillance: ANC, VL and DR, AIS/DHS • HRH: In-service training 	<p>importation</p> <ul style="list-style-type: none"> • Support a phased transition of commodity management from SCMS to MISAU • Warehouse management CMAM internal governance systems, drug quality • SI: IBBS, HIV mortality survey, VACS, combination prevention evaluation; improve systems at MISAU • HCF and Financial management: Strategy development & implementation • HRH: HRIS, pre-service training. 	
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APPENDIX B BUDGET PROFILE AND RESOURCE PROJECTIONS

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
\$6,552,407	\$330,523,502	\$337,075,909
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	18,370,157
HVAB	Abstinence/Be Faithful Prevention	56,385
HVOP	Other Sexual Prevention	4,338,801
IDUP	Injecting and Non-Injecting Drug Use	0
HMBL	Blood Safety	741,907
HMIN	Injection Safety	0
CIRC	Male Circumcision	27,209,357
HVCT	Counseling and Testing	15,257,212
HBHC	Adult Care and Support	34,957,165
PDCS	Pediatric Care and Support	4,312,950
HKID	Orphans and Vulnerable Children	22,481,352
HTXS	Adult Treatment	108,411,606
HTXD	ARV Drugs	31,557,096
PDTX	Pediatric Treatment	13,241,185
HVTB	TB/HIV Care	6,479,483
HLAB	Lab	7,599,169
HVSI	Strategic Information	7,295,571
OHSS	Health Systems Strengthening	14,521,531
HVMS	Management and Operations	13,692,575
TOTAL		330,523,502

B.2 Resource Projections

MTCT-The unit cost for HTC portion of MTCT is based on the 2014 EA. The other activities were costed out based on planned activities that would cost the same regardless of location or target volume. These non-HTC costed activities include GBV in MCH setting – mainstreaming with clinical partners, strengthening and expanding male involvement strategies, implemented at priority districts, job aids and data collection tools, ensuring the quality of HIV testing in PMTCT, and funding for small improvements in infrastructure to allow implementation of B+ and renovations at high volume faculties.

MTCT		Targets	UC- HTC	Target Costs	Activity Based Budget	Above Site Activities	Subtotal	M&O Allocation (FACTS)	Final Budget
Scale-Up Sites									
MTCT	Sum of # of Pregnant women tested and received results	541,851	2.63	\$1,425,068					
MTCT	Sum of PMTCT_EID	57,645	43.67	\$2,517,357					
MTCT	Re-Testing	223,399	2.63	\$587,539					
MTCT	Partner Testing	256,000	8.88	\$2,273,280					
MTCT	HEI rapid Test	35,040	2.63	\$92,155					
				\$6,895,400					
Sustained Sites									
MTCT	Sum of # of Pregnant women tested and Received Results	526,249	1.45	\$763,061					
MTCT	Sum of PMTCT_EID	17,068	24.02	\$409,973					
MTCT	Re-Testing	216,966	1.45	\$314,601					
MTCT	Partner Testing	248,629	4.88	\$1,213,310					
MTCT	HEI rapid Test	26,022	1.45	\$37,732					
				\$2,738,677					
TOTAL MTCT				\$9,634,077	\$5,606,200	\$3,031,387	\$18,271,663	\$98,494	\$18,370,157

CIRC – The unit cost in the 2013 Expenditure Analysis was \$92, and in 2014, the unit cost was \$135. 2014 targets were not met and it was determined the \$135 was driven by low volume outliers and high program start-up costs. Excluding outliers for the EA 2014 came to \$110; however this also seemed high considering substantial change in activities planned for COP 15 compared to previous COPs. Considering personnel efficiencies and moving beyond

the initial program roll-out phase, and further discussion at the Namibia review, it was determined that unit cost for VMCM should be set at \$99.

	Targets	Unit Cost	Target Costs	Additional Activities	Total Budget	M&O Allocation (FACTS)	Final Budget
CIRC	271,536	\$99	\$26,882,064		\$26,882,064	\$327,293	\$27,209,357

HKID- For OVC, initial run through of targets and UE by province estimated the budget to be \$21,329,662. Removing the outliers (Maputo Cidade, \$409 and Gaza, \$121), the average UE is \$48.67, which is close to the national UE of \$47.89 for a base package of providing OVC services. When considering additional above site activities, the unit cost was estimated to be \$65. Such activities will be captured in the UE based on partner reporting, but many of these above site activities are for specific projects. The base budget for OVC using the \$65 unit cost was \$21,650,265, which is similar to the initial estimate. This is also consistent with EA data trends from 2012 (\$69) and 2013 (\$62). Additional activities added on top of the target costs, include \$472,000 in Small Grants, which is separate from the unit cost as they have activity based budgets. An additional \$146,303 was added for new activities separate from the UC to meet the earmark.

	Targets	Unit Cost	Target Costs	Additional Activities (Activity Based Budgets and Earmark)	Total Budget	M&O Allocation (FACTS)	Final Budget
HKID	333,081	\$65	\$21,650,265	\$618,303	\$22,268,568	\$149,784	\$22,418,352

HVAB- These funds will all be awarded to Small Grants programs. Activity based budget, not target-based.

	Targets	UE	Target Costs	Additional Activities	Total Budget	M&O Allocation (FACTS)	Final Budget
HVAB			\$ -	\$50,000	\$50,000	\$6,385	\$56,385

HVCT- The unit expenditure for HCT was based on average unit expenditure data from 2012, 2013, and 2014.

HVCT	Targets	UE	Target Costs	Funding to Community Testing	Additional Activities	Total Budget	M&O Allocation (FACTS)	Final Budget
ATIP (PITC)	1,588,879	\$4.05	\$6,434,960					
UATS (Client Initiated)	718,266	\$4.05	\$2,908,977					
ATS Index Case	469,819	\$12.88	\$ 6,051,269					
TOTAL			\$15,395,206	\$(614,955)	\$32,505	\$14,812,756	\$444,456	\$15,257,212

HVOP- Average UE from EA 2014 for partners for KP is \$40.91. This is consistent with prior year COP planning. An HTC component, \$6.50, was added. Add additional funding for scale up and community outreach, \$11, makes a total unit cost \$58.

**Portion of the cost of UC was assigned to Care and Treatment Budget Codes – this amount is not part of HVCT but falls under HTXS.*

	Targets	UE	Target Costs	HVOP	Care and Treatment	Condoms	Additional Activities	Total Budget	M&O Allocation (FACTS)	Final Budget
CSW	25,503	\$58.00	\$1,479,174	\$1,109,381	\$369,794					
MSM	13,468	\$58.00	\$781,144	\$703,030	\$78,114					
Prisoners	15,149	\$58.00	\$741,839	\$560,126	\$181,713					
Total			\$3,002,157	\$2,372,537	\$629,621	\$949,950	\$713,657	\$4,036,143	\$302,658	\$4,338,801

HLAB, HVSI, OHSS, HMBL – The activities under these budget codes were costed out according to the program activities. Because there are no unit expenditures for these above site program areas, partner work plans, prior years EA data and COP guidance recommendations, were used help guide these budget codes. 30% of the EA expenditures for EA 2014 were reported in the program areas of HSS, SI, Lab, and Surveillance. These activities are described in the SDS.

	Activities	Construction RPSO NPHRL Completion	Sub-Total	M&O Allocation (FACTS)	Final Budget
HLAB	\$ 5,750,000	\$ 1,600,000	\$ 7,350,000	\$ 249,169	\$ 7,599,169

	Activities	M&O Allocation (FACTS)	Final Budget
HVSI	\$ 6,326,896	\$ 968,675	\$ 7,295,571
	Activities	M&O Allocation (FACTS)	Final Budget
OHSS	\$ 14,301,101	\$ 220,430	\$ 14,521,531
	Activities	M&O Allocation (FACTS)	Final Budget
HMBL	\$ 690,000	\$ 51,907	\$ 741,907

APPENDIX C: EXPENDITURE FOR CARE AND TREATMENT PACKAGES

PEPFAR Mozambique believes one of the main drivers of the cost of delivery of technical assistance is likely the number of site visits made by PEPFAR implementing partners. This is difficult to capture through EA data. Therefore, the approach taken has been to seek efficiencies in the delivery of the care and treatment TA gained through a higher number of visits to scale up sites with fewer visits to priority sites outside these districts. Although an average of about eight visits per site has been taken, it is also acknowledged and implementing partners are well aware that some sites might require more visits. Smaller sites and those that are functioning well within the priority districts will receive a minimum of four visits/year.

In order to calculate the cost of the care and treatment program a set of business rules was agreed upon. This defines a basic unit package cost at \$104 (minus ARVs) derived from the costing of specific indicators that drive the service delivery package and EA data. This was slightly higher than the EA 2014 weighted average of \$97, but because EA data was based on COP 13, and COP 14 had a slightly higher estimated unit cost, we went with the higher unit cost because the package of activities were slightly more compared to COP 13. Also in doing a cross walk between Unit Expenditure financial indicators and our own activity costing, we were able to allocate estimated costs to financial EA indicators in order to better link unit cost to unit expenditure. To capture the increased efforts required to increase demand, meet treatment targets and increase retention in care and treatment, and collect required indicator data, an additional \$33 was estimated. Of the \$33, \$26 will support increasing demand through community advocacy and mobilization, improving the efficiency of HCT including index case testing and better linkages from testing into care and treatment, increased efforts to retain people in care and on treatment (e.g. mHealth strategy, community distribution of cotrimoxazole and ARVs, POC diagnostics, treatment literacy, peer support groups, GAACs with efforts to increase male involvement, three monthly drug pickups) and increases in site visit frequencies. The remaining \$7 will cover partner costs attributable to supply chain, SI, and HSS activities. The health facility teams are engaged in quality improvement cycles including clinical mentoring to improve quality of care and other activities as well as improving patient flow. The most recent costing study for ART was in 2009, which placed the estimated unit cost for providing ART at \$120.

Acknowledging that there are provincial differences including varied geographical terrain and ease or difficulty in reaching health facilities which drive unit costs, a provincial weighting was also added, defined into three tiers – high, medium and low, based on EA trends. In order to also ensure essential data management, supply chain, laboratory support and other systems requirements are also included 4% of the site costs were also allocated to these areas. With a number of sites exceeding 5,000 patients, and with the rapid scale up of treatment, the Care and Treatment TWG also tried to identify factors that will define if a site is saturated. They also acknowledge during COP15, it will be important to consider different models of service delivery, building on ongoing innovative ways to decongest large facilities: for example, three-month drug distribution or decentralization to other ART sites.

Unit Cost Table	
Base Unit cost	\$104
Demand Creation, HTC, Linkages, Retention Interventions	\$26
SI	\$3
HSS	\$1
Supply Chain	\$3
Full package Unit Cost	\$137
Package Cost Category	
Maintenance	75% of Base Unit Cost (\$104) \$26
Transition	25% of Base Unit Cost (\$104)
Provincial Cost Categories	
Expensive Province	125%
Average Province	100%
Less Expensive Province	75%

Assumptions - Care and Treatment COP 2015							
Cabo Delgado	\$ 104.00	Nampula	\$ 104.00	Base Unit cost	\$ 104		
Package A	132% \$ 137.00	Package A	132% \$ 137.00	Full package Unit Cost	\$ 137		
Package B	75% \$ 78.00	Package B	75% \$ 78.00	Percentage increase	132%		
Package C	25% \$ 26.00	Package C	25% \$ 26.00				
Cidade de Maputo	\$ 104.00	Niassa	\$ 104.00				
Package A	132% \$ 137.00	Package A	132% \$ 137.00				
Package B	75% \$ 78.00	Package B	75% \$ 78.00				
Package C	25% \$ 26.00	Package C	25% \$ 26.00				
Gaza	\$ 104.00	Sofala	\$ 104.00				
Package A	132% \$ 137.00	Package A	132% \$ 137.00				
Package B	75% \$ 78.00	Package B	75% \$ 78.00				
Package C	25% \$ 26.00	Package C	25% \$ 26.00				
Inhambane	\$ 104.00	Tete	\$ 104.00				
Package A	132% \$ 137.00	Package A	132% \$ 137.00				
Package B	75% \$ 78.00	Package B	75% \$ 78.00				
Package C	25% \$ 26.00	Package C	25% \$ 26.00				
Manica	\$ 104.00	Zambezia	\$ 104.00				
Package A	132% \$ 137.00	Package A	132% \$ 137.00				
Package B	75% \$ 78.00	Package B	75% \$ 78.00				
Package C	25% \$ 26.00	Package C	25% \$ 26.00				
Maputo	\$ 104.00	Expensive Province	125%				
Package A	132% \$ 137.00	Average Province	100%				
Package B	75% \$ 78.00	Less Expensive Province	75%				
Package C	25% \$ 26.00						

ART Targets			
Province	A- Priority sites in priority	B- Priority sites in non priority	C- Non priority sites
Cabo Delgado	29,331	561	3143
Cidade De Maputo	91,439	948	0
Gaza	92,615	1,285	1876
Inhambane	17,247	12,939	2475
Manica	52,651	165	1327
Maputo	78,953	1,147	0
Nampula	36,337	5,270	7357
Niassa	7,561	2,710	4179
Sofala	57,083	8,908	2964
Tete	28,408	9,917	2962
Zambezia	68,611	21,977	2868
Grand Total	560,237	65,827	29152

PMTCT Targets			
Province	A- Priority sites in priority	B- Priority sites in non priority	C- Non priority sites
Cabo Delgado	4,222	93	980
Cidade De Maputo	5,099	148	46
Gaza	8,546	129	259
Inhambane	1,547	1,005	523
Manica	7,440	176	323
Maputo	7,493	-	22
Nampula	4,970	785	2,353
Niassa	606	224	576
Sofala	8,670	622	736
Tete	3,515	456	964
Zambezia	11,483	3,368	939
Grand Total	63,591	7,005	7,721

ART Budget					
A- Priority sites in priority districts	B- Priority sites in non priority districts	C- Non priority sites	All	Adjusting by Level of Effort	Category
\$ 4,018,359	\$ 43,789	\$ 81,726	\$ 4,143,873	\$ 5,179,842	high
\$ 12,527,188	\$ 73,915	\$ -	\$ 12,601,103	\$ 15,751,379	high
\$ 12,688,308	\$ 100,255	\$ 48,786	\$ 12,837,350	\$ 9,628,012	low
\$ 2,362,792	\$ 1,009,275	\$ 64,360	\$ 3,436,426	\$ 3,436,426	mid
\$ 7,213,241	\$ 12,897	\$ 34,506	\$ 7,260,645	\$ 5,445,483	low
\$ 10,816,586	\$ 89,481	\$ -	\$ 10,906,067	\$ 8,179,550	low
\$ 4,978,225	\$ 411,073	\$ 191,291	\$ 5,580,589	\$ 6,975,736	high
\$ 1,035,844	\$ 211,352	\$ 108,662	\$ 1,355,858	\$ 1,355,858	mid
\$ 7,820,335	\$ 694,802	\$ 77,057	\$ 8,592,193	\$ 6,444,145	low
\$ 3,891,907	\$ 773,501	\$ 77,011	\$ 4,742,419	\$ 4,742,419	mid
\$ 9,399,743	\$ 1,714,169	\$ 74,557	\$ 11,188,469	\$ 13,985,586	high
\$ 76,752,529	\$ 5,134,508	\$ 757,954	\$ 82,644,992	\$ 81,124,437	

PMTCT Budget					
A- Priority sites in priority districts	B- Priority sites in non priority districts	C- Non priority sites	All	Adjusting by Level of Effort	Category
\$ 578,375	\$ 7,244	\$ 25,484	\$ 611,103	\$ 458,327	low
\$ 698,612	\$ 11,517	\$ 1,196	\$ 711,325	\$ 889,156	high
\$ 1,170,808	\$ 10,060	\$ 6,724	\$ 1,187,593	\$ 1,187,593	mid
\$ 211,875	\$ 78,390	\$ 13,590	\$ 303,854	\$ 303,854	mid
\$ 1,019,281	\$ 13,744	\$ 8,408	\$ 1,041,434	\$ 781,076	low
\$ 1,026,576	\$ -	\$ 562	\$ 1,027,137	\$ 1,027,137	mid
\$ 680,880	\$ 61,238	\$ 61,171	\$ 803,289	\$ 803,289	mid
\$ 83,086	\$ 17,472	\$ 14,983	\$ 115,540	\$ 144,425	high
\$ 1,187,786	\$ 48,535	\$ 19,149	\$ 1,255,469	\$ 941,602	low
\$ 481,554	\$ 35,547	\$ 25,067	\$ 542,169	\$ 542,169	mid
\$ 1,573,173	\$ 262,675	\$ 24,424	\$ 1,860,272	\$ 2,325,340	high
\$ 8,712,005	\$ 546,421	\$ 200,757	\$ 9,459,184	\$ 9,403,966	

	Target Based Budget Allocations	Activity Based Budget Allocations and Program Allocations <i>(includes above site and attributable to other program areas and activities falling in C&T guidelines)**</i>	Program Budget Subtotal	M&O Allocation (FACTS)	Final Budget
HTXS	\$ 78,041,354	\$ 27,725,738	\$ 105,767,092	\$ 2,644,514	\$ 108,411,606
HBHC	\$ 23,163,727	\$ 10,838,540	\$ 34,002,267	\$ 954,898	\$ 34,957,165
PDTX	\$ 9,672,637	\$ 3,480,083	\$ 13,152,720	\$ 88,465	\$ 13,241,185
PDCS	\$ 4,135,675	\$ -	\$ 4,135,675	\$ 177,275	\$ 4,312,950
HVTB	\$ 3,922,228	\$ 2,332,515	\$ 6,254,743	\$ 224,740	\$ 6,479,483
HTXD*			\$ 31,500,000	\$ 57,096	\$ 31,557,096
Total	\$ 118,935,621	\$ 44,376,876	\$ 194,812,497	\$ 4,146,988	\$ 198,959,485

*No unit cost for commodities. Commodities were estimated based on country need/projections and Global Fund availability.

**This section captures above site activities and other program areas that are allocated to care and treatment budget codes because of their activities.

APPENDIX D: PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT) ADDITIONAL INFORMATION

A. Community and Clinical Activities to Improve Retention in Option B+

Currently a number of strategies and activities supported by PEPFAR to improve retention in care have been in place, however better coordination and strengthening are needed:

- 1) Task shifting – With PEPFAR support in 2012 MISAU approved MCH nurse cadre to prescribe ART and this strategy was rolled out since 2013 along with introduction of Option B+ and the one stop model of PMTCT service delivery. As the number of pregnant women in option B+ has increased drastically, other strategies are required both at the facilities and communities, to improve quality of care during pregnancy, labor and post-partum and to prevent HIV infection as well as maternal and child death.
- 2) Communication Strategy – PEPFAR has been supporting the MISAU and the National AIDS Council to develop a communication strategy to reinforce messages for women and their families to adhere and continue in the continuum of care. This strategy is also designed to target male partners to adhere to HIV counseling and testing, VMMC and care and treatment.
- 3) Lay counselors, “activistas” and peer educators – One of the identified reasons of loss to follow-up in option B+ is the high workload of MCH nurses in PMTCT settings. To address this issue PEPFAR implementing partners in coordination with MISAU have been supporting the HF to hire different modalities of lay health workers (lay counselors/activists/peer educators) to work closely with MCH nurses. The lay health workers help carrying out the following activities: counseling, testing and continuous counseling after ART initiation, navigation within the HF, organizing files to facilitate identification and tracking defaulting and LTFU patients. These lay workers provide a linkage between the facility and community continuum of care as they conduct consented case finding through home visits to track defaulting and LTFU pregnant, lactating women and HIV exposed children. HFs provide cellphones and air time for SMS reminders, phone calls to locate and bring back patients, with emphasis for those women who are in the first six months of treatment. These community cadres also support the HF in consent case findings.

Although the HF have the systems in place to identify and track defaulting and LTFU patients this is often non-functional and the finding/return rate is very low. As a result, for COP15 the PEPFAR team continues to work with MISAU to harmonize the activities being implemented by this cadre, to allow uniform approach and designation. We expect that lay health workers will split their efforts between clinical and community activities to follow-up patients and facilitate linkages between HF and community. We expect to assign 25 pregnant and lactating women for each lay health worker. They will implement individual case management following the HIV+ women from pregnancy through delivery, post-partum and lactating period (mother/infant pair)

to ensure they receive all PMTCT interventions, delivery at a maternity and are retained in services until they fill the requisites for discharge.

- 4) Mother-to-Mother- Groups (M2M) – This strategy has been approved and implemented across the country, however with different levels of efficiency. MISAU is currently in the process of revising the mother-to-mother strategy and align it with the lay health educators so that in COP15 PEPFAR team will strengthen this strategy within the HF, through training of community health workers, mentoring of MCH nurses to form or revitalize M2MG, and using the OVC platforms will extend to the community level.
- 5) Traditional Birth Attendants (TBA), community health workers (APE), and community involvement – Institutional delivery in Mozambique is still an important problem (60% among HIV+ women) (APR14), mainly due to structural factors such as limited coverage of the health system, long distances and lack of transportation to reach the maternities; cultural factors also play a role in preventing pregnant women to deliver at maternities; the final result is that women have their labor assisted either by family members or TBAs. The PEPFAR team will support the MISAU training TBA and other community members involved in birth attendance in HIV care and reference; there will also be a strengthened coordination and sensitization of these role players on the relevance of institutional delivery and prevention of delays that will ultimately prevent Maternal and Child death. The PEPFAR teams will also strengthen community mobilization through local radios, meetings with communities to discuss and encourage male and family participation in the timely decisions regarding women and child health.

B. Strategies and Activities for Male Partner Involvement

As of SAPR15 the current partners testing is 32%, being higher in northern than central and southern provinces, probably due to the differences in culture as well as migration. The target for partner testing in COP15 is 51%. Partner involvement is important in care and support for women and children, so the PEPFAR team is considering partners testing as a CORE activity and a point of entry for male involvement in MCH/HIV services. Following are some strategies to improve male involvement in MCH/HIV:

- 1) Partner notification – During ANC all pregnant women are offered a notification to invite their partners to visit the HF for HTC. PEPFAR team will also strengthen linkages among ANC and VMMC and care and treatment. Treatment of HIV+ male partners of HIV negative pregnant women regardless of their CD4 count is part of MISAU ART guidelines but it is facing challenges at implementation level. Therefore PEPFAR will continue to support the MISAU in strengthening activities for the treatment of sero-discordant couples.
- 2) Radio spots – PEPFAR has been supporting the MISAU in radio spots to reinforce messages for male engagement and involvement and timely decisions regarding women and child health. This will be also a target group in the communication strategy.

- 3) Community engagement - Through encounters for sensitization of Community Leaders, strengthen health committees, radio sport, role plays, etc.
- 4) Male groups at the HF and community – PEPFAR will support the HF to form or strengthen male groups, using male champions and community leaders. This platform will also be used to increase awareness in HIV as well as in linking male partners and sero-discordant couples to treatment.
- 5) Extended care – Where conditions exist, health facilities will be encouraged to find alternate schedules to care for male partners as they often have work related challenges for attending health services. Thus HF may extend the working hours, have staff available in night shifts at ‘bancos de socorros’, open for some hours during the week ends, etc.
- 6) Workspace activities - PEPFAR team in coordination with GRM and private partners also support workspace activities to target male partners, which includes sensitization, HIV counseling and testing and ensuring effective linkages to VMMC, care and treatment.

C. Strategic Information

- 1) Reproductive, Maternal and Child registers and monitoring tools – With PEPFAR support, Mozambique has finalized revision of MCH registers and their adaptation to a longitudinal model that will facilitate disaggregation, follow-up of mother and child pair as well as improving fast track of defaulters and LTFU. The MISAU is currently in the process of training MCH workers to roll-out the new RMCH registers and monitoring tools. Regional training of trainers has already been conducted and a cascade of training service providers will follow soon. The registers are expected to be roll out and start operating by the end of December 2015. PEPFAR will continue supporting this activity.
- 2) Evaluation of option B+ implementation – Programmatic evaluation of the implementation of option B+.
- 3) Evaluation of HIV vertical transmission rates in Mozambique - Currently the actual HIV transmission rate in Mozambique within the population is unknown, so PEPFAR in coordination with MISAU will conduct a study to serve as a baseline and to address that lack of knowledge. The primary objective of the evaluation is to measure the final MTCT rate of HIV after cessation of breastfeeding. It will be a retrospective, cross-sectional household survey which will identify HIV-exposed children 5 years or younger and test them to determine their HIV status. Age-specific estimates of MTCT rate will be generated based on child HIV test results. In addition, mothers on antiretroviral treatment will be tested to assess for viral resistance.

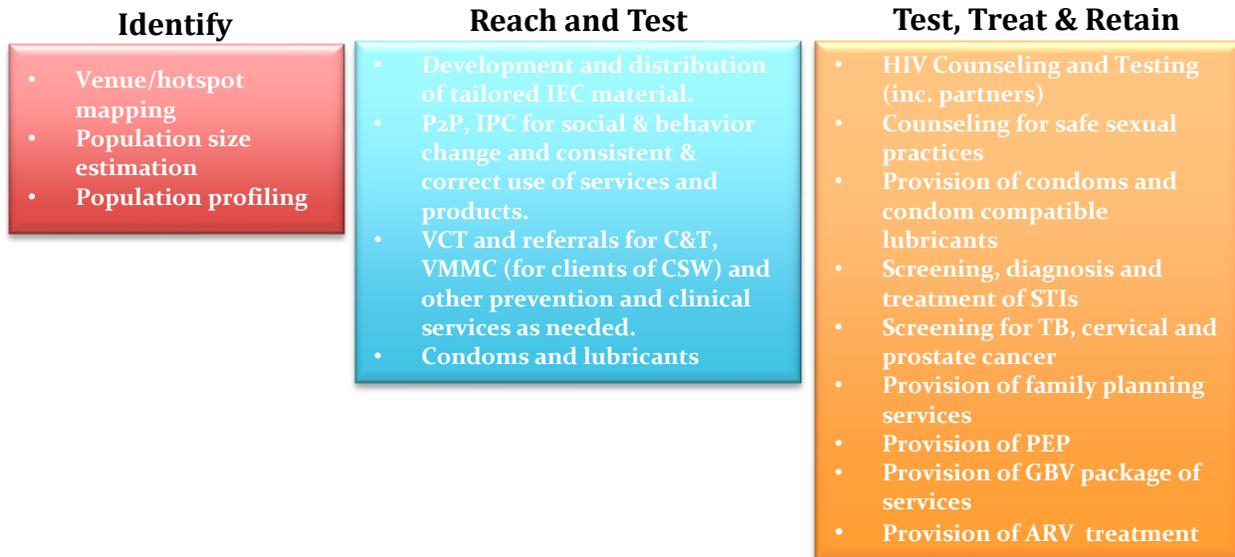
D. FP/HIV Integration

Access to voluntary family planning (FP) is a critical component of a comprehensive PMTCT strategy. The modern contraceptive prevalence rate (MCP) declined from 16.8% in 1997 to 11.9% in 2003 and has remained unchanged at 11.3% in 2011. Fertility has increased from 5.5 to 5.9 children per woman, according to the DHS 2011. Unmet need for family planning remains high with 29% of all women wanting to space or limit pregnancy, but without access to modern contraceptive methods (DHS 2011). Target populations, such as HIV-positive women and youth, have even higher levels of unmet need to delay, space, or limit childbearing.

FP/HIV integration activities to target HIV-positive women will be implemented in collaboration with other stakeholders. MCH settings, particularly FP clinics, as part of routine package of services, have been offering HIV counseling and testing and reference to care and treatment for HIV positive patients and their partners. In ART sites despite being part of the care package for HIV-positive patients, rarely they are counseled, offered or referred to get contraceptive methods, so PEPFAR will focus on increasing access to and uptake of contraceptives amongst HIV+ women at both the facility and community levels. PEPFAR will support the MISAU to strengthen the operationalization of the FP/HIV integration, which includes training, mentoring in counseling and provision of methods, logistic and supply chain of FP commodities.

APPENDIX E: KEY AND OTHER PRIORITY POPULATIONS PACKAGE OF SERVICES

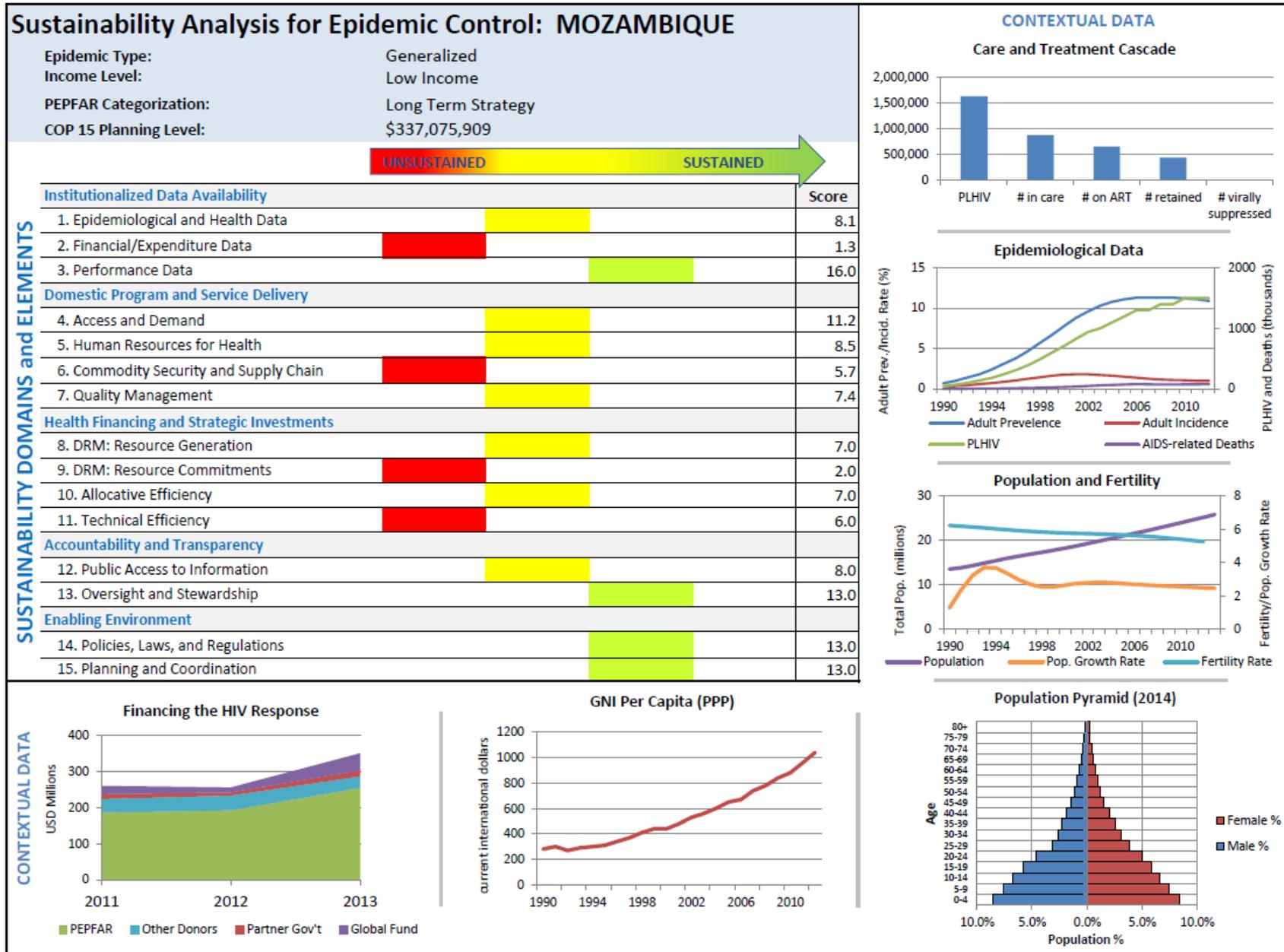
The comprehensive package of services that will be offered to KPs will include:



The program will provide technical support at all levels of the cascade to ensure that high quality services are offered to the key populations. At community and health facility levels technical support will essentially be training of peer educators, lay counselors and health providers, supervision of local sub-partners and prime partners and M&E.

COP15 will also implement activities aimed at creating an enabling environment for key populations to access HIV services by addressing stigma and discrimination, including in the health facilities; community empowerment; and addressing violence against people from key populations.

APPENDIX F: SUSTAINABILITY INDEX AND DASHBOARD



Mozambique FY15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Adm	-
Alto Molocue	9,706
Ancuabe	-
Angoche	-
Angonia	-
Balama	-
Barue	2,152
Bilene	3,953
Boane	1,822
Buzi	5,776
Cahora Bassa	1,141
Caia	-
Changara	4,874
Chemba	-
Cheringoma	-
Chibabava	7,478
Chibuto	5,908
Chicualacuala	2,730
Chifunde	-
Chigubo	-
Chinde	6,494
Chiure	-
Chiuta	-
Chokwe	4,115
Cidade Da Beira	9,905
Cidade Da Matola	8,378
Cidade De Chimoio	3,312
Cidade De Inhambane	-
Cidade De Lichinga	-
Cidade De Nampula	-
Cidade De Pemba	-
Cidade De Quelimane	4,700
Cidade De Tete	7,101
Cidade De Xai-Xai	2,083
Cuamba	-
Dondo	5,727
Erati	-
Funhalouro	-

Mozambique FY15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Gile	-
Gondola	4,326
Gorongosa	-
Govuro	-
Guija	3,247
Guro	-
Gurue	2,013
Homoine	-
Ibo	-
Ile	1,971
Ilha De Moçambique	-
Inharrime	-
Inhassoro	-
Inhassunge	5,476
Jangamo	-
Kamavota	7,054
Kamaxakeni	8,870
Kampfumu	-
Kamubukwana	10,435
Kanyaka	-
Katembe	-
Lago	-
Lalaua	-
Lichinga	-
Lugela	6,580
Mabalane	2,714
Mabote	-
Macanga	-
Machanga	-
Machaze	1,853
Macomia	-
Macossa	-
Maganja Da Costa	2,791
Magoe	-
Magude	2,668
Majune	-
Malema	-
Mandimba	-

Mozambique FY15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Mandlakaze	5,092
Manhiça	5,166
Manica	4,602
Maravia	-
Maringue	-
Marracuene	2,792
Marromeu	2,379
Marrupa	-
Massangena	-
Massinga	-
Massingir	2,571
Matutuine	3,174
Maua	-
Mavago	-
Maxixe	-
Mecanhelas	-
Meconta	-
Mecuburi	-
Mecufi	-
Mecula	-
Meluco	-
Memba	-
Metarica	-
Milange	3,774
Moamba	2,734
Moatize	9,853
Mocimboa Da Praia	-
Mocuba	9,630
Mogincual	-
Mogovolas	-
Moma	-
Monapo	-
Montepuez	-
Mopeia	7,628
Morrumbala	4,658
Morrumbene	-
Mossuril	-
Mossurize	2,128

Mozambique FY15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Muanza	-
Muecate	-
Mueda	-
Muembe	-
Muidumbe	-
Murupula	-
Mutarara	-
Nacala	-
Nacala-A-Velha	-
Nacaroa	-
Namaacha	4,656
Namacurra	2,965
Namarroi	-
Nampula	-
Namuno	-
Nangade	-
Ngauma	-
Nhamatanda	7,016
Nicoadala	3,138
Nipepe	-
Nihamankulu	-
Palma	-
Panda	-
Pebane	1,978
Pemba	-
Quissanga	-
Ribaue	-
Sanga	-
Sussundenga	-
Tambara	-
Tsangano	-
Vilankulo	-
Xai-Xai	7,401
Zavala	-
Zumbu	-
Total	250,688



HIV/AIDS Sustainability Index and Dashboard

To assist PEPFAR and government partners in better understanding each country's sustainability landscape and making informed investment decisions, PEPFAR teams and stakeholders completed the inaugural **Sustainability Index and Dashboard (SID)** during COP 2015. This new tool assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements, scores for which are displayed on a color-coded dashboard. As the SID is completed over time, it will allow stakeholders to track progress across these components of sustainability. On the pages that follow, you will find the 2015 country dashboard as well as the questionnaire responses that determined the scores. The legend for the colors depicted on the dashboard is below.

Dark Green Score (17-20 pts) (sustainable and requires no additional investment at this time)
Light Green Score (13-16.9 pts) (approaching sustainability and requires little or no investment)
Yellow Score (7-12.9 pts) (emerging sustainability and needs some investment)
Red Score (0-6.9 pts) (unsustainable and requires significant investment)

Sustainability Analysis for Epidemic Control: MOZAMBIQUE

Epidemic Type: Generalized
Income Level: Low Income
PEPFAR Categorization: Long Term Strategy
COP 15 Planning Level: \$337,075,909

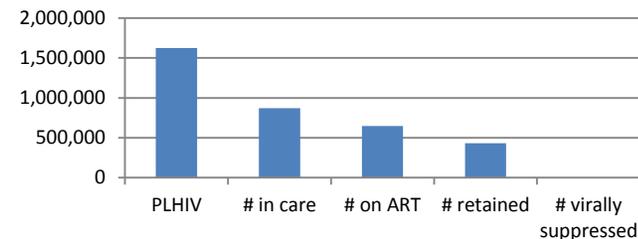


SUSTAINABILITY DOMAINS AND ELEMENTS

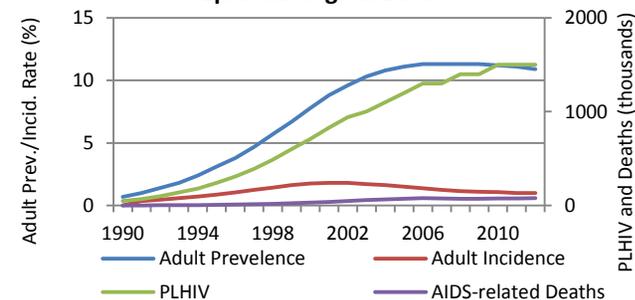
Category	Element	Score
Institutionalized Data Availability	1. Epidemiological and Health Data	8.1
	2. Financial/Expenditure Data	1.3
	3. Performance Data	16.0
Domestic Program and Service Delivery	4. Access and Demand	11.2
	5. Human Resources for Health	8.5
	6. Commodity Security and Supply Chain	5.7
	7. Quality Management	5.4
Health Financing and Strategic Investments	8. DRM: Resource Generation	7.0
	9. DRM: Resource Commitments	2.0
	10. Allocative Efficiency	7.0
Accountability and Transparency	11. Technical Efficiency	6.0
	12. Public Access to Information	8.0
	13. Oversight and Stewardship	13.0
Enabling Environment	14. Policies, Laws, and Regulations	13.0
	15. Planning and Coordination	13.0

CONTEXTUAL DATA

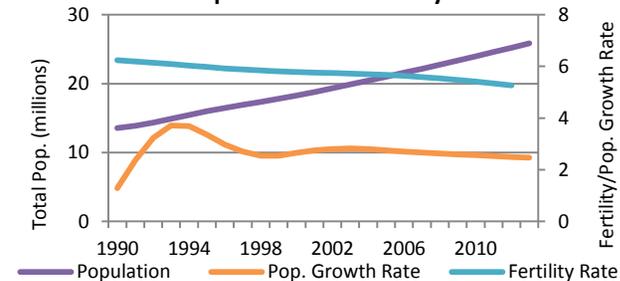
Care and Treatment Cascade



Epidemiological Data

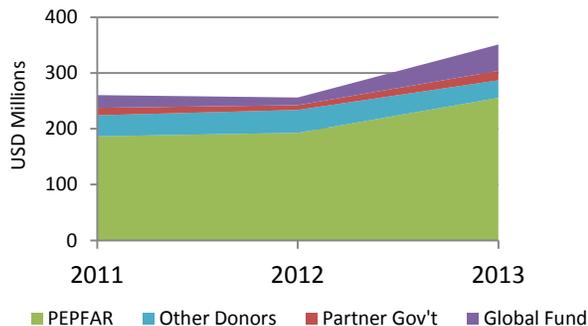


Population and Fertility

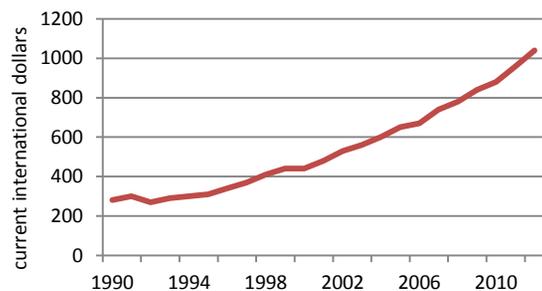


CONTEXTUAL DATA

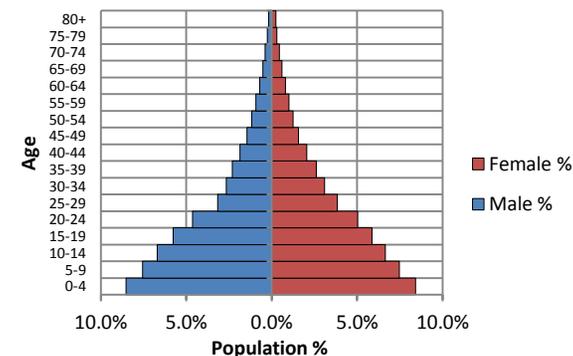
Financing the HIV Response



GNI Per Capita (PPP)



Population Pyramid (2014)



Domain A: Institutionalized Data Availability

What Success Looks Like: Using local and national systems, the Host Country Government collects and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

		Source of data	Notes/Comments
<p>1. Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV and OVC, HIV incidence, HIV prevalence, viral load, AIDS-related mortality rates, and co-infection rates.</p>			
<p>Q1. Who leads: Who leads/manages the planning and implementation of HIV/AIDS epidemiological surveys and/ or surveillance (convenes all parties and makes key decisions)?</p>	<p><input type="radio"/> A. Host Country Government/other domestic institution</p> <p><input checked="" type="radio"/> B. External agency with host country government</p> <p><input type="radio"/> C. External agency, organization or institution</p> <p><input type="radio"/> D. Not conducted</p>	3	<p>In country documented source, such as minutes of planning meeting, report, or memo: Not available</p> <p>While GOM (primarily the NIH/INS) has the mandate for coordinating, planning and implementing national surveys, USG has played a significant role in providing financial and technical resources to support the GOM in this role.</p>
<p>Q2. Who finances: Within the last three years, what proportion of the latest HIV/AIDS epidemiological data survey did the host country government fund?</p>	<p><input type="radio"/> A. 80-100% of the total cost of latest survey was financed by Host Country Government</p> <p><input type="radio"/> B. 60-79% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> C. 40-59% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> D. 20-39% of the total cost of latest survey financed by Host Country Government</p> <p><input checked="" type="radio"/> E. 10-19% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> F. 0-9% of the total cost of latest survey financed by Host Country Government</p>	1	<p>Census 2007 and 2017, AIS 2009 and 2015, DHS 2003,2007, 2011, next DHS date unknown</p> <p>Calculated this to be about 11% for IMASIDA based on 700K of the survey funded directly by MISAU</p>
<p>Q3. Comprehensiveness of Prevalence and Incidence Data: Does Host Country Government collect HIV prevalence and or incidence data?</p>	<p><input type="radio"/> No, the government does not collect HIV prevalence or incidence data</p> <p><input checked="" type="radio"/> Yes, the government collects (check all that apply):</p> <p><input checked="" type="checkbox"/> A. HIV prevalence</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Collected by age <input checked="" type="checkbox"/> Collected for children <input checked="" type="checkbox"/> Collected by sex <input checked="" type="checkbox"/> Collected by key population <input checked="" type="checkbox"/> Sub-national data <input checked="" type="checkbox"/> Collected every 3 years <input checked="" type="checkbox"/> Data analyzed for trends <input checked="" type="checkbox"/> Data made publicly available <p><input type="checkbox"/> B. HIV incidence</p> <ul style="list-style-type: none"> <input type="checkbox"/> Collected by age <input type="checkbox"/> Collected for children <input type="checkbox"/> Collected by sex <input type="checkbox"/> Collected by key population <input type="checkbox"/> Sub-national data <input type="checkbox"/> Collected every 3 years <input type="checkbox"/> Data analyzed for trends 	2.5	<p>Most recent country prevalence and incidence reports (provide citation): AIS (INSIDA and IMASIDA) 2009 and 2015, regular reports, Multiple IBBSs 2011-2015, ANC Surveillance every two years.</p> <p>Question is unclear as to whether this is routine or survey data and how frequently.</p>

	<input type="checkbox"/> Data made publicly available			
Q4. Comprehensiveness of Viral Load Data: Does Host Country Government collect viral load data?	<input checked="" type="radio"/> No, the government does not collect viral load data <input type="radio"/> Yes, the government collects viral load data (check all that apply): <input type="checkbox"/> Collected by age <input type="checkbox"/> Collected for children <input type="checkbox"/> Collected by sex <input type="checkbox"/> Collected by key population <input type="checkbox"/> Sub-national data <input type="checkbox"/> Collected every 3 years <input type="checkbox"/> Data analyzed to understand trends	0	In country source such as government report: Not available	Country is working on a National Viral Load Strategic Plan but not yet finalized. Rollout of VLM will begin in 2015 in 4 sites.
Q5. Key Populations: Does the Host Country Government conduct size estimation studies for key populations?	<input type="radio"/> No, the host country government does not conduct size estimation studies for key populations <input checked="" type="radio"/> Yes, the government conducts key population size estimates (check all that apply): <input checked="" type="checkbox"/> Men who have sex with men (MSM) <input checked="" type="checkbox"/> Female sex workers <input type="checkbox"/> Transgender <input checked="" type="checkbox"/> People who inject drugs (PWID) <input type="checkbox"/> Government finances at least 50% of the size estimation studies <input checked="" type="checkbox"/> Government leads and manages the size estimation studies	1.6	Multiple IBBS Report from 2011-2015.	No national data on key population size but there are some estimates of specific key populations in the 3 largest urban areas. There is significant USG financial and technical assistance.

Epidemiological and Health Data Score:

8.1

2. Financial/Expenditure data: Government collects, tracks and analyzes financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS from all financing sources, costing, and economic evaluation for cost-effectiveness.		Source of data	Notes/Comments
Q1. Expenditure Tracking: Does the host country government have a nationally agreed upon expenditure tracking system to collect HIV/AIDS expenditure data?	<input checked="" type="radio"/> No, it does not have a national HIV/AIDS expenditure tracking system <input type="radio"/> Yes, the government has a system to collect HIV/AIDS expenditure data (check all that applies): <input type="checkbox"/> A. Collected by source of financing, i.e. domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others <input type="checkbox"/> B. Collected by expenditures per program area, such as prevention, care, treatment, and health systems strengthening <input type="checkbox"/> C. Collected sub-nationally <input type="checkbox"/> D. Collected annually <input type="checkbox"/> E. Data is made publicly available	0	In country source, such as government HIV/AIDS expenditure tracking policy, strategy or SOP: Not available For discussion: National HIV/AIDS expenditure tracking system does not exist. The Government does ask that donors report on-budgetor on the execution of the budgets. CNCS (national AIDS Council) is working on developing specific HIV expenditure tracking system. USG is supporting the development of a tool to track HIV expenditures to start this year for MOH.

<p>Q2. Quality of Expenditure Tracking: Is the Host Country Government tracking expenditures based on international standards? What type of expenditure data are available in the country, i.e. NHA, NASA, others:</p>	<p><input checked="" type="radio"/> No, they are not using any international standards for tracking expenditures</p> <p><input type="radio"/> Yes, the national government is using international standards such as WHO National Health Accounts (NHA), National AIDS Spending Assessment (NASA), and/or methodology comparable to PEPFAR Expenditure Analysis or the Global Fund new funding tracking model.</p>	0	<p>in country citations for latest NHA, NASA, government expenditure tracking report, global fund new funding model for country</p>	<p>We have NASA, EA, NHA 2012 recently completed. The government has this data but it is completed by other stakeholders...</p>
<p>Q3. Transparency of Expenditure Data: Does the host country government make HIV/AIDS expenditure data (or at a minimum a summary of the data) available to the public?</p>	<p><input checked="" type="radio"/> No, they do not make expenditure data available to the public</p> <p>Yes, check the one that applies:</p> <p><input type="radio"/> A. Annually</p> <p><input type="radio"/> B. Bi-annually</p> <p><input type="radio"/> C. Every three or more years</p>	0	<p>In country source of latest expenditure data made available to the public: Not available</p>	<p>There are some incipient efforts to do this tracking but they have involved primarily donors</p>
<p>Q4. Economic Studies: Does the Host Country Government conduct special health economic studies or analyses for HIV/AIDS, i.e. costing, cost-effectiveness, efficiency?</p>	<p><input type="radio"/> No, they are not conducting special health economic studies for HIV/AIDS</p> <p><input checked="" type="radio"/> Yes, check all that apply:</p> <p><input checked="" type="checkbox"/> A. Costing studies or analyses</p> <p><input type="checkbox"/> B. Cost-effectiveness studies or analyses</p> <p><input type="checkbox"/> C. Efficiency studies or analyses</p> <p><input type="checkbox"/> D. Cost-benefit studies or analyses</p>	1.25	<p>Costing study is yet to be published, but the 2013-2015 acceleration plan was released, after it was signed by Minister of Health in July 2013. Updates to the targets in this plan also exist.</p>	<p>USG funded costing of the GRM Acceleration Plan</p>
Financial/Expenditure Data Score:		1		

<p>3. Performance data: Government collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data is analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including adherence and retention.</p>		Source of data	Notes/Comments
<p>Q1. Collection of service delivery data: Does the host country government have a system to routinely collect/report HIV/AIDS service delivery data?</p>	<p><input type="radio"/> No, the government does not have an HIV/AIDS service delivery data collection system</p> <p><input checked="" type="radio"/> Yes, service delivery data are collected/reported for (check all that apply):</p> <p><input checked="" type="checkbox"/> A. For HIV Testing</p> <p><input checked="" type="checkbox"/> B. For PMTCT</p> <p><input checked="" type="checkbox"/> C. For Adult Care and Support</p> <p><input checked="" type="checkbox"/> D. For Adult Treatment</p> <p><input checked="" type="checkbox"/> E. For Pediatric Care and Support</p> <p><input checked="" type="checkbox"/> F. For Pediatric Treatment</p> <p><input type="checkbox"/> G. For AIDS-related mortality</p>	6	<p>HIV/AIDS service delivery HMIS policy/SOP and latest report citation: Balanco do PES 2014 and Annual das Atividades do HIV/SIDA, 4/15/2015. Relatorio TARV (monthly)</p>
<p>Q2. Analysis of service delivery data: Does the Host Country Government routinely analyze service delivery data to measure Program performance? i.e. continuum of care cascade, coverage, retention, AIDS-related mortality rates?</p>	<p><input type="radio"/> No, the government does not routinely analyze service delivery data to measure performance</p> <p><input checked="" type="radio"/> Yes, service delivery data are being analyzed to measure (check all that apply):</p> <p><input checked="" type="checkbox"/> A. Continuum of care cascade, including testing, care, treatment, retention and adherence</p> <p><input checked="" type="checkbox"/> B. Results against targets</p> <p><input checked="" type="checkbox"/> C. Coverage</p>	3	<p>For each check, in-country source of latest data: Balanco do PES 2014 and Annual das Atividades do HIV/SIDA, 4/15/2015.</p> <p>what do we count as the cascade? Data points are collected for some (not all) but are not necessarily analyzed as such</p>

	<input type="checkbox"/> D. Site specific yield for HIV testing (HTC and or PMTCT) <input type="checkbox"/> E. AIDS-related death rates			
Q3. Comprehensiveness of service delivery data: Does the host country government collect HIV/AIDS service delivery data in a manner that is timely, accurate and comprehensive?	<input type="radio"/> No <input checked="" type="radio"/> Yes, service delivery data are being: (check all that apply): <input checked="" type="checkbox"/> A. Collected at least quarterly <input checked="" type="checkbox"/> B. Collected by age <input checked="" type="checkbox"/> C. Collected by sex <input checked="" type="checkbox"/> D. Collected from all clinical sites <input type="checkbox"/> E. Collected from all community sites <input checked="" type="checkbox"/> F. Data quality checks are conducted at least once a year	5	In country source, such as the latest HMIS report or presentation on HIV/AIDS services Estratégia de Melhoria de Qualidade dos Cuidados e Tratamento para HIV e SIDA. Resultados do piloto em 51 unidades sanitárias. 2015. Strategy of QI for care and treatment of HIV/AIDS. Result of the pilot in 51 health facilities. 2015. Relatório TARV (monthly)	Data quality checks are done in a few sites in each province. However, this is fully funded by USG. GoM is involved with this work.
Q4. Transparency of service delivery data: Does the host country government make HIV/AIDS program performance and service delivery data (or at a minimum a summary of the results) available to the public routinely?	<input type="radio"/> No, they do not make program performance data available to the public Yes, check the one that applies: <input checked="" type="radio"/> A. At least annually <input type="radio"/> B. Bi-annually <input type="radio"/> C. Every three or more years	2	Balanco do PES 2014 and Annual das Actividades do HIV/SIDA, 4/15/2015.	Balanco do PES
Performance Data Score:		16		

THIS CONCLUDES THE SET OF QUESTIONS ON THE INSTITUTIONALIZING DATA AVAILABILITY DOMAIN

Domain B. Domestic Program and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving HIV/AIDS prevention, care and treatment services and interventions. There is a high demand for HIV/AIDS services, which accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and or are affected by the HIV/AIDS epidemic.

4. Access and Demand: There is a high uptake of HIV/AIDS prevention, care and treatment services and programs among key populations and individuals infected and affected by HIV/AIDS, especially among those in the lowest socio-economic quintiles.		Source of data	Notes/Comments
<p>Q1. Access to ART: What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing ART.</p> <p><input checked="" type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing ART.</p>	<p>Q1 Score: 3</p>	<p>In country source, i. MOH ART Report Dec 2014 and Master Facility List</p> <p>Due to limited HRH, Mozambique often uses a hub and spoke model for ART care to reach the most people possible with quality services recognizing the HRH limitations. Often very small sites have testing, but are referred a larger facility in close proximity for ART treatment.</p>
<p>Q2. Access to PMTCT: What percent of facilities in high prevalence/burden locations are providing PMTCT (Option B+)?</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input checked="" type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing Option B+.</p>	<p>Q2 Score: 2</p>	<p>In country source, i.e., readiness assessments:</p> <p>Due to limited HRH, Mozambique often uses a hub and spoke model for PMTCT care to reach the most people possible with quality services recognizing the HRH limitations. Often very small sites have testing, but are referred a larger facility in close proximity for ART treatment.</p>
<p>Q3. Who is delivering HIV/AIDS services: What percent of Care and Treatment clients are treated at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. 80% or more of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> B. 50-79% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p>	<p>Q3 Score: 3</p>	<p>MoH annual report</p> <p>More than 80% of services are delivered through government services.</p>
<p>Q4. Access to HRH: What percent of facilities in high prevalence/burden locations are providing HRH services?</p>	<p><input checked="" type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p>	<p>Q4 Score: 0</p>	<p>Not available</p> <p>The vast majority of Mozambican populations access health services in government</p>

<p>Q4. Services to key populations: What percent of key population HIV/AIDS prevention program clients receive services at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p>	<p><input type="radio"/> A. 80% or more of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> B. 50-79% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p>			<p>facilities. There is no way of tracking what proportion is key populations</p>
<p>Q5. Uptake of services: What percent of PLHIV are currently receiving ART? _____%</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. 80% or more of PLHIV are currently receiving ART</p> <p><input type="radio"/> B. 50-79% of PLHIV are currently receiving ART</p> <p><input checked="" type="radio"/> C. 20-49% of PLHIV are currently receiving ART</p> <p><input type="radio"/> D. Less than 20% of PLHIV are currently receiving ART</p>	<p>Q5 Score 2</p>	<p>In country source, i.e. government annual HIV/AIDS report: ***Relatorio Semestral 2014 of HIV/AIDS Response Plan, Spectrum</p>	
<p>Q6. Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> No, the government does not recognize a right to nondiscriminatory access to HIV services for all populations.</p> <p><input checked="" type="radio"/> Yes, there are efforts by the government (check all that apply):</p> <p><input type="checkbox"/> educates PLHIV about their legal rights in terms of access to HIV services</p> <p><input type="checkbox"/> educates key populations about their legal rights in terms of access to</p> <p><input checked="" type="checkbox"/> National policy exists for de-stigmatization in the context of HIV/AIDS</p> <p><input checked="" type="checkbox"/> national law exists regarding health care privacy and confidentiality protections</p> <p><input type="checkbox"/> government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found</p>	<p>Q6 Score 1.2</p>	<p>In country source, i.e., government strategy/plan/SOP, HIV/AIDS Human Rights assessment report: See attached documents</p>	<p>There is a patient's rights charter, but nothing specific to HIV</p>

Access and Demand Score

11.2

5. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.

Source of data

Notes/Comments

Check the one answer that best describes the current situation:

This information is not available

Q1 Score: 0

DRH annual report 2014 ; HRIS data; in country training assessments; SIMS Above site

The DHR produces annual reports on HRH using the HRIS funded and supported by

<p>Q1. HRH Sufficiency: Does the country have sufficient numbers of health workers trained in HIV/AIDS to meet the HIV service delivery needs?</p>	<p><input checked="" type="radio"/> A. No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand</p> <p><input type="radio"/> B. Yes, HIV service sites do have adequate numbers of staff to meet the HIV patient demand (check all that apply)</p> <p><input type="checkbox"/> HIV facility-based service sites have adequate numbers of staff to meet the HIV patient demand</p> <p><input type="checkbox"/> HIV community-based service sites have adequate numbers of staff to meet the HIV patient demand, and CHWs have appropriate linkages to high HIV burden/ volume community and facility sites</p>		<p>SF tool "HRH Staffing CEE"</p>	<p>PEPFAR. It shows ratios of various HRH cadres to population. Overall this is well below WHO recommendations everywhere but in Maputo.</p>
<p>Q2. HRH Transition: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. There is no inventory or plan for transition of donor-supported health workers</p> <p><input checked="" type="radio"/> B. There is an inventory and plan for transition of donor-supported workers but it has not been implemented to date</p> <p><input type="radio"/> C. There is an inventory and plan for transition of donor-supported workers, but it has been only partially implemented to date.</p> <p><input type="radio"/> D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan</p> <p><input type="radio"/> E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated</p>	<p>Q2 Score: 1</p>	<p>"Análise e Processo de Regularização do Pessoal Contratado no MISAU Maio 2014 (Analysis and Integration of Contracted personnel in MOH May 2014)</p>	<p>There is an HRH absorption plan, but no funding to support. Plan is in the PES. There is an inventory, but substantially lacks details on transition implementation. Key cadres (lay counselors and data entry clerks, eg.) that do not exist in the civil service system, and unclear how to incorporate those. There is a presentation where MOH HR department shares the plan to absorb all the PEPFAR and donor health care workers salaries but there is no written document/plan.</p>
<p>Q3. HRH Financial reform: Has financial reform been undertaken in the last 5 years to address government financing of health workers?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. No financial reform has been undertaken in the last 5 years to address government financing of health workers</p> <p><input type="radio"/> B. Financial reforms have been undertaken in the last 5 years to address government financing of health workers (check all that apply):</p> <p><input type="checkbox"/> Wage reform to increase salaries and or benefits of health workers</p> <p><input type="checkbox"/> Increase in budget allocation for salaries for health workers</p>	<p>Q3 Score: 0</p>	<p>In country source, i.e. report on HRH reform or civil service reform: PESS</p>	<p>Physicians and clinicians, who comprise 1/16 of HCWs, received an increase in benefits catalyzed by strong civil society, but we do not think that this can be categorized as financial REFORM</p>
<p>Q4. Pre-Service: Does current pre-service education curricula for health workers providing</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. HIV/AIDS content used by pre-service institutions is out of date (has not been updated within the last 3 years) - For example, an average national score of RED in SIMS AS-SF "Pre-Service Education" CEE</p> <p><input checked="" type="radio"/> B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):</p> <p><input type="checkbox"/> content updated for all HIV/AIDS services</p>	<p>Q4 Score: 1</p>	<p>SIMS Above Site-SF Tool, "Pre-Service Education" CEE or if other country team knowledge ***Pre-service curriculum and manuals REPÚBLICA DE MOÇAMBIQUE MINISTÉRIO DA SAÚDE.DIRECÇÃO DE RECURSOS HUMANOS 2012 and 2013</p>	<p>Curriculum revisions have been done for physicians, nurses, MCH nurses and Clinical officers to include HIV. The laband the [pharmacy curricula are also being updated. Physican and clinical officer curricula have not been updated within the last 3 years.</p>

<p>HIV/AIDS services include HIV content that has been updated in last three years?</p>	<p><input type="checkbox"/> updated content reflects national standards of practice for cadres offering HIV/AIDS-related services</p> <p><input type="checkbox"/> updated curriculum is problem based/competency based</p> <p><input type="checkbox"/> updated curriculum includes practicums at high volume clinical/ social services sites</p> <p><input type="checkbox"/> institutions that track students after graduation</p>			
<p>Q5. In-Service: To what extent is the country institutionalizing PEPFAR/other donor supported HIV/AIDS in-service training (IST) into local training systems?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. National IST curricula institutionalizes PEPFAR/other donor-supported HIV/AIDS training.</p> <p><input type="radio"/> B. There is a strategy for institutionalizing PEPFAR/other donor-supported IST training and it is being implemented.</p> <p><input checked="" type="radio"/> C. There is a strategy in place for institutionalizing PEPFAR supported IST training but it is not being fully implemented to date.</p> <p><input type="radio"/> D. There is not a strategy in place for institutionalizing PEPFAR/other donor supported IST training.</p>	<p>Q5 Score: 1</p>	<p>Continuous Education Strategy 2011</p>	<p>There is a National Continuing education strategy and ART in-service training modules have been incorporated MOH leads all training development. PEPFAR supports MOH's training through technical assistance and implementation of the training plan. Once the training is developed it is owned and implemented by MOH.</p>
<p>Q6. HRIS: Does the government have a functional Human Resource Information System (HRIS) for the health sector?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. No, there is no HRIS</p> <p><input checked="" type="radio"/> B. Yes, the government does have a HRIS (check all that apply)</p> <p><input type="checkbox"/> The HRIS is primarily funded by host country institutions</p> <p><input checked="" type="checkbox"/> There is a national interoperability strategy for the HRIS</p> <p><input checked="" type="checkbox"/> The government produces HR data from the HRIS at least annually</p> <p><input checked="" type="checkbox"/> The government uses data from the HRIS for HR planning and management</p>	<p>Q6 Score: 1.5</p>	<p>national HRIS document or other country team knowledge HRIS data available on website: http://41.76.149.99:8080/esipsaude/</p>	<p>Platform is with MoF but implementation is financed by IP. Health sector HIS system was built on the basis of Civil Service payroll system with design input from PEPFAR. and continued TA, PEPFAR built on major system that helps with accounting of staff and deployment and training .The GRM finances the civil service information system in its entirety. USG supported the development of a specific health worker information system which is primarily supported by USG.</p>
<p>Q7. Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are funded with domestic resources?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p> <p><input type="radio"/> A. Less than 20%</p> <p><input type="radio"/> B. 20-49%</p> <p><input type="radio"/> C. 50-79%</p> <p><input checked="" type="radio"/> D. 80% or more</p>	<p>Q7 Score: 4</p>	<p>In country source, i.e. HRH report, HRIS data: PESOE HRIS data available on website: http://41.76.149.99:8080/esipsaude/</p>	<p>According to the HR Report 2013 there are 5257 contracted of a total 40,405 health workers.</p>
<p>Human Resources for Health Score</p>			<p>8.5</p>	

6. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, care and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.		Source of data	Notes/Comments
Q1. ARV domestic financing: What is the estimated obligated funding for ARV procurement from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: <input type="radio"/> This information is not known <input checked="" type="radio"/> A. 0-9% obligated from domestic public sources <input type="radio"/> B. 10-29% obligated from domestic public sources <input type="radio"/> C. 30-79% obligated from domestic public sources <input type="radio"/> D. 80% or more obligated from domestic public sources	Q1 Score: 0	NASA 2010-11 published in 2014 or GARPR 2015
Q2. Test Kit domestic financing: What is the estimated obligated funding for Rapid Test Kits from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: <input type="radio"/> This information is not known <input checked="" type="radio"/> A. 0-9% obligated from domestic public sources <input type="radio"/> B. 10-29% obligated from domestic public sources <input type="radio"/> C. 30-79% obligated from domestic public sources <input type="radio"/> D. 80% or more obligated from domestic public sources	Q2 Score: 0	NASA 2010-11 published in 2014 or GARPR 2015
Q3. Condom domestic financing: What is the estimated obligated funding for condoms from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: <input type="radio"/> This information is not known <input checked="" type="radio"/> A. 0-9% obligated from domestic public sources <input type="radio"/> B. 10-29% obligated from domestic public sources <input type="radio"/> C. 30-79% obligated from domestic public sources <input type="radio"/> D. 80% or more obligated from domestic public sources	Q3 Score: 0	Not available PEPFAR, UNFPA, GF
Q4. Supply Chain Plan: Does the country have an agreed-upon national supply chain plan with an implementation plan or a thorough annually-reviewed supply chain SOP?	<input type="radio"/> A. No, there is no plan or thoroughly annually reviewed supply chain SOP <input checked="" type="radio"/> B. Yes, there is a Plan/SOP. It includes these components: (check all that apply) <input checked="" type="checkbox"/> Human resources <input checked="" type="checkbox"/> Training <input checked="" type="checkbox"/> Warehousing <input checked="" type="checkbox"/> Distribution <input type="checkbox"/> Reverse Logistics <input checked="" type="checkbox"/> Waste management <input checked="" type="checkbox"/> Information system <input checked="" type="checkbox"/> Procurement <input checked="" type="checkbox"/> Forecasting <input checked="" type="checkbox"/> Supply planning and supervision	Q4 Score: 3.7	National supply chain plan/SOP: Plano de Implementacao 2014-2024 (PELF) Aug 2014 Central level procurement and forecasting through CMAM, but USG funds TA directly to CMAM. This question does not address laboratory commodities supply chain
	<input type="radio"/> A. No, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) less than 90% of the time	Q5 Score: 1	Supply chain assessment report (draft Jan 2015) , National LMIS data (monthlv) Only public sector, do not have control of private sector.

<p>Q5. Stock: Do Public and Private Sector Storage facilities (Central and intermediate level) report having HIV and AIDS commodities stocked according to plan (above the minimum and below the maximum stock level) 90% of the time?</p>	<p><input checked="" type="radio"/> B. Yes, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) 90% or more of the time</p> <p><input type="checkbox"/> Both public and (if they exist in the country) private storage facilities at central level</p> <p><input type="checkbox"/> Both public and (if they exist in the country) private storage facilities at intermediate level</p>			
<p>Q6. Assessment: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment?</p> <p>(If a different credible assessment of the national supply chain has been conducted, you may use this as the basis for response. Note the details and date of the assessment in the "source of data" column.)</p>	<p><input type="radio"/> A. No assessment has been conducted nor do they have a system to oversee the supply chain</p> <p><input type="radio"/> B. Yes, an assessment was conducted but they received below 80%</p> <p><input checked="" type="radio"/> C. No assessment was conducted, but they have a system to oversee the supply chain that reviews:</p> <p><input type="checkbox"/> Commodity requirements</p> <p><input type="checkbox"/> Commodity consumption</p> <p><input type="checkbox"/> Coordinates procurements</p> <p><input type="checkbox"/> Delivery schedules</p> <p><input type="radio"/> D. Yes, an assessment was conducted and they received a score that was 80% or higher</p>	<p>Q6 Score: 1</p>	<p>In country Assessment Report: Supply chain assessment report (draft Jan 2015)</p>	

Commodity Security and Supply Chain Score

5.7

<p>7. Quality Management: Host country ensures that HIV/AIDS services are managed and provided in accordance with established national/global standards and are effective in achieving positive health outcomes (reduced AIDS-related deaths, reduced incidence, and improved viral load/adherence). Host country has institutionalized quality management approaches in its HIV/AIDS Program that ensure continued quality during and following donor to government transitions.</p>	<p>Source of data</p>	<p>Notes/Comments</p>
<p>Q1. Existence of System: Does the government have a functional Quality Management/Quality Improvement (QM/QI) infrastructure?</p> <p><input checked="" type="radio"/> A. No, there is no QM/QI infrastructure within national HIV/AIDS program or MOH</p> <p><input type="radio"/> Yes, there is a QM/QI infrastructure within national HIV/AIDS program or MOH. The infrastructure (check all that apply):</p> <p><input type="checkbox"/> Routinely reviews national HIV/AIDS performance and clinical outcome data</p> <p><input type="checkbox"/> Routinely reviews district/regional HIV/AIDS performance and clinical outcome data</p> <p><input type="checkbox"/> Prioritizes areas for improvement</p>	<p>Q1 Score: 0</p>	<p>In country sources, i.e., QM/QI strategic plan/SOP, QM/QI Assessment Report: Estratégia de Melhoria de Qualidade dos Cuidados e Tratamento para HIV e SIDA. Resultados do piloto em 51 unidades sanitárias. 2015. Strategy of QI for care and treatment of HIV/AIDS. Result of the pilot in 51 health facilities. 2015.</p>
<p><input type="radio"/> No, there is no HIV/AIDS-related QM/Q strategy</p>	<p>Q2 Score: 0</p>	<p>QM/QI Strategy document:***MOH National HIV The MoH Pilot was been conducted the HIV national QI strategy and analysis has been done. GPM just (2014/2015)</p>

<p>Q2. Strategy: Is there a current (updated within the last 2 years) national QM/QI strategy that is either HIV/AIDS program-specific or includes HIV/AIDS program-specific elements?</p>	<p><input type="radio"/> B. Yes, there is a QM/QI strategy that includes HIV/AIDS but it is not current (updated within the last 2 years)</p> <p><input type="radio"/> C. Yes, there is a current QM/QI strategy that includes HIV/AIDS program specific elements</p> <p><input type="radio"/> D. Yes, there is a current HIV/AIDS program specific QM/QI strategy</p>		<p>Strategy for Quality Improvement</p>	<p>was been done. GRM just (2014/2015) completed a pilot in strategic locations. QM/QI strategy was developed in 2012 by MOH with inputs from key partners such as USG. GRM is developing a national QM/QI strategy roll-out plan.</p>
<p>Q3. Guidelines: Does national HIV/AIDS technical practice follow current WHO guidelines for PMTCT and ART?</p>	<p><input type="radio"/> A. No, the national practice does not follow current WHO guidelines for PMTCT or ART</p> <p><input checked="" type="radio"/> B. Yes, the national practice does follow current WHO guidelines for:</p> <p><input checked="" type="checkbox"/> PMTCT (option B+)</p> <p><input type="checkbox"/> Adult ART</p> <p><input checked="" type="checkbox"/> Pediatric ART</p> <p><input type="checkbox"/> Adolescent ART</p> <p><input checked="" type="checkbox"/> Test and treat for specific populations</p>	<p>Q3 Score: 2.4</p>	<p>Current government SOP/technical guidelines for PMTCT 2013 : MOH Guidelines for HIV/ART 2014</p>	<p>GRM tests and treats for serodiscordant couples and TB/HIV and pregnant and lactating women; GRM does not follow 2013 WHO Guidelines for Adult and Adolescent ART (CD4 and Viral Load Testing), but they do follow 2011 WHO Guidelines</p>
<p>Q4. QI Data use: Does the host country government monitor and use data for HIV/AIDS quality improvement?</p>	<p><input type="radio"/> A. No, there is no monitoring for HIV/AIDS quality improvement</p> <p><input checked="" type="radio"/> B. Yes, there is monitoring for HIV/AIDS quality improvement. Monitoring includes:</p> <p><input type="checkbox"/> All sites</p> <p><input type="checkbox"/> Use of data to determine quality of program or services</p> <p><input checked="" type="checkbox"/> Making recommendations and action plan for mid-course corrections</p>	<p>Q4 Score: 3</p>	<p>In country sources, i.e., report, presentation, or annual plan indicating use of data for quality improvement:</p>	<p>Not in all sites as we are in rolling out phase. GRM just (2014/2015) completed a pilot in strategic locations of the national QM/QI strategy that was developed in 2012 by MOH with inputs from key partners such as USG. GRM is developing a national QM/QI strategy roll-out plan. In some sites, GRM makes recommendations and action plans for mid-course corrections.</p>
<p>Q5. Post-transition: Does the host country government monitor whether the quality of HIV/AIDS service outcome is maintained at sites where PEPFAR/other donors have transitioned from a direct implementation role?</p>	<p><input checked="" type="radio"/> A. No, there is no quality monitoring at sites post-transition</p> <p><input type="radio"/> B. Yes, there is quality monitoring at transition sites. Monitoring includes:</p> <p><input type="checkbox"/> All transition sites</p> <p><input type="checkbox"/> Review of service outcomes</p> <p><input type="checkbox"/> Client feedback on changes in quality</p> <p><input type="checkbox"/> Quality improvement action plan</p> <p><input type="radio"/> C. PEPFAR/other donors have never supported direct service delivery in the country</p>	<p>Q5 Score: 0</p>	<p>In country sources, i.e., post-transition report or documentation:</p>	
<p>Quality Management Score</p>			<p>5.4</p>	

THIS CONCLUDES THE SET OF QUESTIONS ON THE DOMESTIC PROGRAM AND SERVICE DELIVERY DOMAIN

Domain C. Health Financing and Strategic Investment

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

8. Domestic Resource Mobilization: Resource Generation: The host-country government costs its national HIV/AIDS response, solicits and generates revenue (including but not limited to tax revenues, public sector user fees, insurance, loans, private sector and other strategic partnerships, and/or other innovative sources of financing) and allocates resources to meet the national budget for HIV/AIDS.		Source of data	Notes/Comments
Q1. Domestic budget: Is there a budget line item for HIV/AIDS in the national budget?	<input checked="" type="radio"/> A. No, there is no budget line item for HIV/AIDS in the national budget <input type="radio"/> B. Yes, there is an HIV/AIDS budget line item under the Health budget <input type="radio"/> C. Yes, there is an HIV/AIDS program-based budget across ministries <input type="radio"/> D. Yes, there is an HIV/AIDS program-based budget across ministries and the budget contains HIV/AIDS program indicators	Q1 Score: 0	In country source, i.e. national budget, budget summary or report for 2014: tREO (Relatório de Execução Orçamental) and/or PES e OE 2014 CFMP (MTEF) 2015-17
Q2. Budgetary Framework: Does the country's budgeting process utilize a Medium-Term Expenditure Framework (MTEF) or Medium-Term Fiscal Framework (MTFF)?	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, but it does not include a separate costing of the national HIV/AIDS strategy or program <input type="radio"/> C. Yes, and it includes a separate costing of the national HIV/AIDS strategy or program	Q2 Score: 3	In country source, i.e. national budget, budget summary or report for 2014: MTEF
Q3. Fiscal Policy: Does the country pass the MCC scorecard indicator for fiscal policy? (Countries without an MCC scorecard: Is general government net lending/borrowing as a percent of GDP averaged across 2011-2013 greater than (i.e. more positive than) -3.1 percent?)	<input type="radio"/> Yes <input checked="" type="radio"/> No	Q3 Score: 0	OGAC-provided data sheet (follows tab E) derived from: http://www.mcc.gov/pages/election/scorecards
Q4. Domestic public revenue: What was annual domestic government revenue as a percent of	Check the appropriate box for your country's income category: <u>FOR LOW INCOME</u> <input checked="" type="radio"/> A. More than 16.4% (i.e. surpasses category mean) <input type="radio"/> B. 14.8%-16.4%, (i.e. 90-100% of category mean) <input type="radio"/> C. Less than 14.8%, (less than 90% of category mean) <u>FOR LOW MIDDLE INCOME</u>	Q4 Score: 4	OGAC-provided data sheet (follows tab E) Original Source: IMF Government Finance Statistics

<p>GDP in the most recent year available? (domestic revenue excludes external grants)</p>	<p><input type="radio"/> D. More than 22.3% (i.e. surpasses category mean)</p> <p><input type="radio"/> E. 20.1-22.3% (i.e. 90-100% of category mean)</p> <p><input type="radio"/> F. Less than 20.1% (less than 90% of category mean)</p> <p>FOR UPPER MIDDLE INCOME</p> <p><input type="radio"/> G. More than 27.8% (i.e. surpasses category mean)</p> <p><input type="radio"/> H. 25.0%-27.8% (i.e. 90-100% of category mean)</p> <p><input type="radio"/> I. Less than 25.0% (less than 90% of category mean)</p>			
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Score for Domestic Resource Mobilization: Resource Generation: 7



<p>9. Domestic Resource Mobilization: Resource Commitments: Host country government makes adequate multiyear resource commitments to achieve national HIV/AIDS goals for epidemic control and in line with the available fiscal space. These commitments for the national HIV/AIDS program ensure a well-trained and appropriately deployed workforce, functioning health systems, sufficient commodities and drugs, and local institutions at all levels able to perform activities and carry out responsibilities.</p>		<p>Source of data</p>	<p>Notes/Comments</p>	
<p>Q1. Benchmarks for health spending:</p> <p>African countries: Is the government meeting the Abuja commitment for government health expenditure (at least 15% of General Government Expenditure)?</p> <p>Non-African countries: Is government health expenditure at least 3 percent of GDP?</p>	<p><input type="radio"/> A. Yes</p> <p><input checked="" type="radio"/> B. No</p>	<p>Q1 Score: 0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>NASA 2010-11 published in 2014 or GARPR 2015</p>	<p>8.80%</p>
<p>Q2. Domestic spending: What proportion of the annual national HIV response are domestic HIV expenditures financing (excluding out-of-pocket)? _____%</p>	<p><input type="radio"/> A. Less than 10%</p> <p><input checked="" type="radio"/> B. 10-24%</p> <p><input type="radio"/> C. 25-49%</p> <p><input type="radio"/> D. 50-74%</p> <p><input type="radio"/> E. 75% or Greater</p>	<p>Q2 Score: 2</p>	<p>NASA or NHA data: NASA Report 2012</p>	
	<p><input checked="" type="radio"/> A. None or information is not available</p> <p><input type="radio"/> B. 1-9%</p>	<p>Q3 Score: 0</p>	<p>In country source, i.e., NASA data, national expenditure analysis report: Not available</p>	

<p>Q3. Key population spending: What percent of key population-specific interventions are financed with domestic public and domestic private sector funding (excluding out of pocket expenditure)?</p>	<p><input type="radio"/> 10-24%</p> <p><input type="radio"/> 25-49%</p> <p><input type="radio"/> 50-74%</p> <p><input type="radio"/> 75% or Greater</p>			
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Score for Domestic Resource Mobilization: Resource Commitments:	2
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<p>10. Allocative Efficiency: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time).</p>	Source of data	Notes/Comments		
<p>Q1. Data-driven allocation: Does the host country government routinely use existing data to drive annual HIV/AIDS program investment decisions?</p>	<p><input type="radio"/> A. No, data are not used annually</p> <p><input checked="" type="radio"/> B. Yes, data are used annually. Check all that apply:</p> <p><input checked="" type="checkbox"/> Epidemiological data are used</p> <p><input checked="" type="checkbox"/> Health/service delivery data are used</p> <p><input type="checkbox"/> Financial data are used</p> <p><input type="checkbox"/> There is integrated analysis across data streams</p> <p><input type="checkbox"/> Multiple data streams are used to model scenarios</p>	<p>Q1 Score: 4</p>	<p>In country documentation of strategic plan or annual planning: HIV Acceleration Plan 2012-2015 (2012), Health Sector Strategic Plan 2014-2019 (PESS) Detailed MISAU PES e OE 2014</p>	
<p>Q2. Geographic allocation: Does the host country government use data to determine the appropriate number and location of HIV/AIDS service sites (proportional to yield or burden data)?</p>	<p><input type="radio"/> A. The government does not consider yield or burden when deciding on the number and location of HIV/AIDS service sites</p> <p><input type="radio"/> B. Less than 20% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p> <p><input checked="" type="radio"/> C. 20-49% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p> <p><input type="radio"/> D. 50-79% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p>	<p>Q2 Score: 3</p>	<p>In country government source, i.e., presentation, GIS data, planning document: **HIV Acceleration Plan 2012-2015, SI Calculation of Geographic Prioritization for COP 14</p>	<p>Confusing question. Government has used burden (prevalence) in the design and roll out of their Acceleration Plan, but it does not use yield to determine allocation.</p>

	<input type="radio"/> E. 80% or more of HIV/AIDS service delivery sites yield 80% or more of new positive HIV test results or ART clients		
Q3.Data driven reprogramming: Do host country government policies/systems allow for reprogramming investments based on new or updated program data during the government funding cycle?	<input checked="" type="radio"/> A. No, there is no system for funding cycle reprogramming <input type="radio"/> B. Yes, there is a policy/system that allows for funding cycle reprogramming but it is seldom used <input type="radio"/> C. Yes, there is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data <input type="radio"/> D. Yes, there is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data	Q3 Score: 0	In country source: policy/SOP:
Allocative Efficiency Score:		7	

11. Technical Efficiency: Through enhanced processes, economies of scale, elimination of waste, prevention of new infections, expenditure analysis, strategic targeting, and other technical improvements, the host country is able to achieve improved HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). Thus, maximizing investments to attain epidemic control.		Source of data	Notes/Comments
Q1. Unit costs: Does the Host Country Government use expenditure data or cost analysis to estimate unit costs of HIV/AIDS services? (note: full score of five points can be achieved without checking all disaggregate boxes).	<input checked="" type="radio"/> A. No <input type="radio"/> B. Yes (check all that apply): <input type="checkbox"/> Annually <input type="checkbox"/> For HIV Testing <input type="checkbox"/> For Care and Support <input type="checkbox"/> For ART <input type="checkbox"/> For PMTCT <input type="checkbox"/> For VMMC <input type="checkbox"/> For OVC Service Package <input type="checkbox"/> For Key population Interventions	Q1 Score: 0	In country source, i.e., government document, report or presentation:

<p>Q2. Improving efficiency: Which of the following actions is the Host Country Government taking to improve technical efficiencies?</p>	<p>Check all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Using findings from cost-effectiveness or efficiency studies to modify operations or interventions <input type="checkbox"/> Streamlining management to reduce overhead costs <input checked="" type="checkbox"/> Reducing fragmentation to lower unit costs, i.e. pooled procurement, resource pooling <input checked="" type="checkbox"/> Improving procurement competition <input type="checkbox"/> Integration of HIV/AIDS into national or subnational insurance schemes (private or public) <input checked="" type="checkbox"/> Scaling up evidence-based, high impact interventions and reducing interventions without evidence of impact <input checked="" type="checkbox"/> Geographic targeting in high burden/high yield sites to increase impact <input type="checkbox"/> Analysis of expenditure data to establish appropriate range of unit costs 	<p>Q2 Score: 2</p>	<p>In country sources for each checked: MOH Acceleration Plan 2012-2015, MOH/CMAM Procurement Plan</p>	<p>Prosaude, Acceleration Plan</p>
<p>Q3. Loss ratio: Does host country government have a system to measure the proportion of domestic public HIV/AIDS spending that supports direct service delivery (not administrative/overhead costs)?</p>	<p><input checked="" type="radio"/> A. No <input type="radio"/> B. Yes</p>	<p>Q3 Score: 0</p>	<p>In country source, i.e., national HIV/AIDS expenditure report:</p>	
<p>Q4. Benchmark prices: Are prices paid by the government for first-line ARVs and Test Kits within 5% variance of international benchmark prices (UNAIDS Investment Case)?</p>	<p>Check boxes that apply:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> They are not paying for any ARVs <input type="checkbox"/> They are not paying for any test kits <input type="checkbox"/> They are paying no more than 5% above the international benchmark price for first line ARVs <input type="checkbox"/> They are paying no more than 5% above the international benchmark price for test kits 	<p>Q4 Score: 0</p>	<p>http://apps.who.int/hiv/amds/price/hdd/Default.aspx</p>	
<p>Q5. ART unit costs: Have average unit costs for providing ART in the country reduced within the last two years? Unit cost 2 years ago: \$ _____</p>	<p><input type="radio"/> A. No <input checked="" type="radio"/> B. Yes</p>	<p>4</p>	<p>WHO, Global Price Reporting Mechanism - http://apps.who.int/hiv/amds/price/hdd/</p>	<p>Unit cost 2 years ago: \$ 100.07 Current unit cost: \$ 98.67</p>

Current unit cost: \$ _____				
Technical Efficiency Score:				6

THIS CONCLUDES THE SET OF QUESTIONS ON THE HEALTH FINANCING AND STRATEGIC INVESTMENT DOMAIN

Domain D. Accountability and Transparency

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders (donors) for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, and provides mechanisms for eliciting feedback.

12. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically.	Source of data	Notes/Comments
<p>Q1. OBI: What is the country's "Open Budget Index" score? (Alternative for countries lacking an OBI score: What was the country's score on the most recent Public Expenditure and Financial Accountability Assessment (PEFA) for PI-10: "Public Access to Fiscal Information"?)</p>	<p> <input type="radio"/> A. Extensive Information (OBI Score 81-100; or PEFA score of A- or better on element PI-10) <input type="radio"/> B. Significant Information (OBI Scores 61-80; or PEFA score of B or B+ on element PI-10) <input checked="" type="radio"/> C. Some Information (OBI Score 41-60; or PEFA score of B-, C or C+ on element PI-10) <input type="radio"/> D. Minimal Information (OBI Score 21-40; or PEFA score of C- or D+ on element PI-10) <input type="radio"/> E. Scant or No Information (OBI Score 0-20; or PEFA score of D or below on element PI-10) <input type="radio"/> F. There is neither Open Budget Index score nor a PEFA assessment to assess the transparency of government budget </p>	<p>Q1 Score: 6.0</p> <p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Open Budget Index (http://survey.internationalbudget.org/) and PEFA data (www.pefa.org)</p>
<p>Q2. National program report transparency: Does the host country government make an annual national HIV/AIDS program progress report and or results publically available?</p>	<p> <input type="radio"/> A. No, the national HIV/AIDS program progress report or presentation of results is not made public <input checked="" type="radio"/> B. Yes, the national HIV/AIDS program progress report and/or results are made publically available (Check all that apply): <input type="checkbox"/> On Website <input type="checkbox"/> Through any type of media <input checked="" type="checkbox"/> Disseminate print report or presentation of results </p>	<p>Q2 Score: 2.0</p> <p>In country source, i.e., last annual national HIV/AIDS progress report or presentation: They share with stakeholders via other social media more up to date reports sent out, last report 2012 on line</p>
<p></p>	<p> <input checked="" type="radio"/> A. No audit is conducted of the National HIV/AIDS program, or the audit report is not made available publically </p>	<p>Q3 Score: 0.0</p> <p>In country source, i.e., last HIV/AIDS audit report: no audit specific to HIV. Do audit but for common fund,</p>

<p>Q3. Audit transparency: Does the host country government make an annual national HIV/AIDS program audit report publically available?</p>	<p><input type="radio"/> B. Yes, the national HIV/AIDS program audit report is made public. Check all that apply:</p> <p><input type="checkbox"/> On website</p> <p><input type="checkbox"/> Through any type of media</p> <p><input type="checkbox"/> Disseminate print report</p>			<p>prosaude.</p>
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Public Access to Information Score: 8

13. Oversight and Stewardship: Government institutions are held accountable for the use of HIV/AIDS funds and for the results of their actions by the electorate and by the legislature and judiciary. Public employees are required to account for administrative decisions, use of resources, and results obtained. There is timely and accurate accounting and fiscal reporting, including timely audit of public accounts and effective arrangements for follow-up. There are mechanisms for citizens and key stakeholders to review and provide feedback regarding public programs, services and fiscal management.				
			Source of data	Notes/Comments
<p>Q1. Availability of Information on Resources Received by Service Delivery Units. PEFA score on PI-23 was C or higher in most recent assessment.</p>	<p><input type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input checked="" type="radio"/> B. PEFA was conducted and score was below C</p> <p><input type="radio"/> C. PEFA was conducted and score was C</p> <p><input type="radio"/> D. PEFA was conducted and score was B</p> <p><input type="radio"/> E. PEFA was conducted and score was A</p>	<p>Q1 Score: 0.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</p>	<p>PEFA score D</p>
<p>Q2. Quality and timeliness of annual financial statements. PEFA score for element PI-25 was C or higher in most recent assessment.</p> <p>Actual scores are C, A, C</p>	<p>Check A or B; if B checked, select appropriate disaggregates:</p> <p><input type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input checked="" type="radio"/> B. PEFA was conducted and score was C or higher for:</p> <p><input checked="" type="checkbox"/> (i) Completeness of the financial statements</p> <p><input checked="" type="checkbox"/> (ii) Timeliness of submission of the financial statements</p> <p><input checked="" type="checkbox"/> (iii) Accounting standards used</p>	<p>Q2 Score: 5.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</p>	<p>PEFA scores on Pi-25: C, A, C</p>
	<p>Check A, B, or C; if C checked, select appropriate disaggregates:</p>		<p>In country source, i.e., reports indicating CSO</p>	<p>***NAIMA and MONASO are</p>

<p>Q3. Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels and opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services?</p>	<p> <input type="radio"/> A. No, there are no formal channels or opportunities <input type="radio"/> B. No, there are no formal channels or opportunities but civil society is called upon in an ad hoc manner to provide inputs and feedback <input checked="" type="radio"/> C. Yes, there are formal channels and opportunities for civil society engagement and feedback. Check all that apply: </p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> During strategic and annual planning <input checked="" type="checkbox"/> In joint annual program reviews <input checked="" type="checkbox"/> For policy development <input checked="" type="checkbox"/> As members of technical working groups <input checked="" type="checkbox"/> Involvement on evaluation teams <input checked="" type="checkbox"/> Giving feedback through social media <input type="checkbox"/> Involvement in surveys/studies <input type="checkbox"/> Collecting and reporting on client feedback 	<p>Q3 Score: 5.0</p>	<p>engagement, policies or SOPs: (Reference: 2012 Global AIDS Response Progress Report - GARPR 2012) *CMAM - Stop Stockouts Now - Mobile App, NAIMA documents, MONASO documents, Annual Joint Review documentation</p>	<p>organizations designed to give CSOs a joint voice to government in annual and strategic planning, policy development, and reviews, CSOs are included in the Annual Joint Review Teams and as part of SWAp technical working groups</p>
<p>Q4. Civil society Enabling Environment: What score did your country receive on the 2013 Civicus Enabling Environment Index (EEI), which measure the socio-cultural, socio-economic and governance environments for civil society?</p> <p>If your country is not included in the EEI, are there any laws or policies that prevent a full range of civil society organizations from providing oversight into the government's HIV/AIDS response?</p>	<p> <input type="radio"/> A. EEI score of 0-0.38; or if no EEI score, there are laws or policies that restrict civil society playing an oversight role <input checked="" type="radio"/> B. EEI score of 0.39-0.50; or there are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it is not accepted by government <input type="radio"/> C. EEI score of 0.51 - 0.76; or there are no laws or policies that prevent civil society from playing a role in providing oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight </p>	<p>Q4 Score: 3.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Civicus Enabling Environment Index (civicus.org/eei/)</p>	
<p>Oversight and Stewardship Score:</p>		<p>13</p>		

THIS CONCLUDES THE SET OF QUESTIONS ON THE ACCOUNTABILITY AND TRANSPARENCY DOMAIN

Domain E. Enabling Environment

What Success Looks Like: Relevant government entities demonstrate transparent resolve and take actions to create an enabling policy and legal environment, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

14. Policies, Laws, and Regulations: Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.

	Source of data	Notes/Comments
<p>Q1. Structural obstacles: Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support?</p> <p> <input type="radio"/> A. No, there are no such laws or policies <input checked="" type="radio"/> B. Yes, there are such laws, regulations or policies. Check all that apply (each check box reduces score): <ul style="list-style-type: none"> <input type="checkbox"/> Criminalization of HIV transmission <input checked="" type="checkbox"/> HIV testing disclosure policies or age requirements <input type="checkbox"/> Non-disclosure of HIV status laws <input type="checkbox"/> Anti-homosexuality laws <input type="checkbox"/> Anti-prostitution legislation <input checked="" type="checkbox"/> Laws that criminalize drug use, methadone use or needle exchange </p>	<p>Q1 Score: 4.0</p>	<p>In country source, i.e., name of law or policy: HIV Testing and Treatment Laws and Policies in Mozambique: rights and duties in the era of scale-up . Verani, 2012</p>
<p>Q2. Access protection: Is there a National HIV/AIDS Policy or set of policies and laws that ensures non-discriminatory and safe access to HIV/AIDS services, providing social and legal protection where those rights are violated?</p> <p>(note: full score of six points possible without checking all boxes)</p> <p> <input type="radio"/> A. No, there are no such policies or laws <input checked="" type="radio"/> B. Yes, there are such policies and laws. Check all that apply: <ul style="list-style-type: none"> <input checked="" type="checkbox"/> For people living with HIV <input type="checkbox"/> For men who have sex with men <input type="checkbox"/> For transgendered persons <input checked="" type="checkbox"/> For sex workers <input type="checkbox"/> For people who inject drugs </p>	<p>Q2 Score: 5.0</p>	<p>In country source, i.e., the name of laws and policies: HIV Testing and Treatment Laws and Policies in Mozambique: rights and duties in the era of scale-up Verani 2012</p> <p>Disagreement here : Do we include MSM, CSW, and Young girls? This template says yes, other says NO. NEED LAWS</p>

	<input checked="" type="checkbox"/> For children orphaned or affected by HIV/AIDS <input checked="" type="checkbox"/> For young girls and women vulnerable to HIV <input checked="" type="checkbox"/> For survivors of gender-based violence			
Q3. Civil society sustainability: Does the legislative and regulatory framework make special provisions for the needs of Civil Society Organizations (CSOs) or give not-for-profit organizations special advantages?	<input type="radio"/> A. No, there are no special provisions or advantages for CSOs <input checked="" type="radio"/> B. Yes, there are special provisions and advantages for CSOs. Check all that apply: <input type="checkbox"/> Significant tax deductions for business or individual contributions to not-for-profit CSOs <input type="checkbox"/> Significant tax exemptions for not-for-profit CSOs <input checked="" type="checkbox"/> Open competition among CSOs to provide government-funded services <input type="checkbox"/> Freedom for CSOs to advocate for policy, legal and programmatic change	Q3 Score: 1.0	In country source, name of legislation: (Reference: Law 8/91 – Associativism Law; the Law 34/2007 – Law on taxes over collective people revenue – this is a word by work translation)	
Q4. Enabling legislation: Are there policies or legislation that govern HIV/AIDS service delivery?	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, there are. Check all below that are included: <input type="checkbox"/> A national public health services act that includes the control of HIV <input checked="" type="checkbox"/> A task-shifting policy that allows mid-level providers to provide key HIV/AIDS services	Q4 Score: 3.0	In country source, name of legislation or policy: MOH Ministerial decree 2014; HIV Testing and Treatment Laws and Policies in Mozambique: rights and duties in the era of scale-up Verani 2012	
Policies, Laws, and Regulations Score:			13	
15. Planning and Coordination: Senior policy makers prioritize health and the HIV/AIDS response. Host country develops, implements, and oversees a multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated.			Source of data	Notes/Comments
	<input type="radio"/> A. No, there is no national strategy for HIV/AIDS	Q1 Score: 4.0	In country source, name of current strategy:	

<p>Q1. National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?</p>	<p><input checked="" type="radio"/> B. Yes, there is a national strategy. Check all that apply:</p> <p><input checked="" type="checkbox"/> It is multiyear</p> <p><input checked="" type="checkbox"/> It is costed</p> <p><input checked="" type="checkbox"/> Its development was led by the host country government</p> <p><input checked="" type="checkbox"/> Civil society actively participated in the development of the strategy</p>		<p>... , PEN, HIV Acceleration Plan 2012-2015</p>	
<p>Q2. Data driven prioritization: Did the host country government develop the strategy using a data-driven prioritization approach, which coordinates the investment of multiple sources of funding, i.e. Investment Case?</p>	<p><input type="radio"/> A. No data-driven prioritization approach was used</p> <p><input checked="" type="radio"/> B. Yes, a data-driven prioritization approach was used but it did not coordinate the investment of multiple funding sources</p> <p><input type="radio"/> C. Yes, a data-driven prioritization approach was used that coordinated the investments of multiple funding sources</p>	<p>Q2 Score: 2</p>	<p>In country source, i.e., data analysis government used:</p>	
<p>Q3. CCM criteria: Has the country met the minimum criteria that all CCMs must meet in order to be eligible for funding by the Global Fund?</p>	<p><input type="radio"/> A. No or there is no CCM</p> <p><input type="radio"/> B. Yes, with conditions</p> <p><input checked="" type="radio"/> C. Yes</p>	<p>Q3 Score: 2</p>	<p>Global Fund Eligibility List 2014</p>	
<p>Q4. Coordination of national response: Does the host country government coordinate (track and map) all HIV/AIDS activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners, to avoid duplication and gaps?</p>	<p><input type="radio"/> A. No, it does not track or map all HIV/AIDS activities</p> <p><input checked="" type="radio"/> B. the host country government coordinates all HIV/AIDS activities. Check all that apply:</p> <p><input checked="" type="checkbox"/> Of Civil Society Organizations</p> <p><input type="checkbox"/> Of private sector</p> <p><input checked="" type="checkbox"/> Of donor implementing partners</p> <p><input type="checkbox"/> Activities are tracked or mapped</p> <p><input type="checkbox"/> Duplications and gaps are addressed</p>	<p>Q4 Score: 2.0</p>	<p>In country source, i.e., Coordination data or reports: ***Provincial PES, Implementing Partner Reports to Government - Confusion, PEN IV, acceleration plan</p>	<p>Disagreement here between NO, and yes for CS and IPS. ***Reporting, tracking happening at provincial level depending on the DPS, but not well-coordinated at a national level , The coordination capacity is the issue, this may be weak but they are trying to do this.</p>

	<input type="checkbox"/> Joint operational plans are developed that include key activities of all implementing agencies			
Q5. Civil society engagement: Is there active engagement of diverse non-governmental organizations in HIV/AIDS advocacy, decision-making and service delivery in the national HIV/AIDS response?	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, civil society (such as community-based organizations, non-governmental organizations and faith-based organizations, local leaders, and/or networks representing affected populations) are actively engaged. Check all that apply: <input checked="" type="checkbox"/> In advocacy <input checked="" type="checkbox"/> In programmatic decision-making <input type="checkbox"/> In technical decision-making <input checked="" type="checkbox"/> In service delivery	Q5 Score: 3.0	In country source for each checked: ***Partner reports to government, NAIMA documents, MONASA documents, HPG Reports, PEPFAR staff knowledge	
Planning and Coordination Score:		13		

THIS CONCLUDES THE SET OF QUESTIONS ON THE ENABLING ENVIRONMENT DOMAIN