



REPUBLIC OF MOZAMBIQUE  
NATIONAL AIDS COUNCIL

# Universal Declaration of Commitment on HIV and AIDS

Mozambique Progress Report for the United Nations General Assembly  
Special Session on HIV and AIDS

2006-2007

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## Acronyms

AABB	American Association of Blood Banks
ACA	Annual Joint Evaluation of Performance
AFASS	Affordable, Feasible, Acceptable, Safe and Sustainable
AIDS	Acquired Immunodeficiency Syndrome
ANCs	Antenatal Clinics
ANEMO	National Mozambican Nurses Association
APCA	African Palliative Care Association
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral Drugs
BB	Blood Banks
BdPES	Balance of Economic and Social Plan
BSS	Behavioural surveillance survey
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CMAM	Centre for Drugs and Medical Supplies
CNCS	National AIDS Council
CRIS	Country Response Information System
CSW	Commercial Sex Workers
CT	Counseling and Testing
CTX	Cotrimoxazole
DNA	Deoxyribonucleic Acid
DNAM	National Directorate of Medical Assistance
DOTS	Direct Observation Therapy-Short Course
Eco-SIDA	Businessmen Against AIDS
EGPAF	Elizabeth Glaser Paediatric AIDS Foundation
ELISA	Enzyme Linked Immunosorbent Assay
EPP	Estimates and Projection Package
ESDEM	National database that holds all indicator data
ETR	electronic TB register
FAO	Food and Agricultural Organization
FBO	Faith Based Organization
FDC	Fixed Dose Combination
FHI	Family Health International
FS	Financing Sources
GFATM	Global Fund to fight AIDS, Tuberculosis, and Malaria
GMA	Grant Management Agent
GOM	Government of Mozambique
HAI	Health Alliance International

HBC	Home Based Care
HBsAg	Hepatitis B Surface Antigens
HER	Health Expenditure Review
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HP	Provincial Hospital
HR	District Hospital
IAF	Household Survey on Living Conditions
IDS (DHS)	Demographic and Health Survey
IDT	Infectious Disease Testing
IDU	Injecting Drug Users
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
INE	National Institute of Statistics
INH	Isoniazid
INJAD	National Survey on Reproductive Health and Sexual Behaviour among Young People and Adolescents
INSIDA	Population-Based Sero-Behavioural Survey
IPT	Isoniazid Preventive Therapy
I-RARE	International Rapid Assessment Response and Evaluation
IUATLD	International Union Against TB and Lung Disease
JFFLS	The Junior Farmer Field and Life Schools
JSI	John Snow International
KAP	Knowledge Attitudes and Practices
M&E	Monitoring and Evaluation
MADER	Ministry of Agriculture and Rural development
MAP	Multi-Country AIDS Programme
MARPs	Most-At-Risk-Populations
MCT	Ministry of Science and Technology
MDGs	Millennium Development Goals
MDR-TB	Multi-Drug Resistant TB
MEC	Ministry of Education and Culture
MIJUS	Ministry of Justice
MITRAB	Ministry of Works
MJD	Ministry of Youth and Sports
MMAS	Ministry of Women and Coordination of Social Action
MOH/MISAU	Ministry of Health
MSM	Men who have sex with Men
MTC	Ministry of Transport and Communications
MTEF	Medium Term Expenditure Framework

NAC/CNCS	National AIDS Council
NACP	National AIDS Control Programme
NASA	National AIDS Spending Assessment
NBTP	National Blood Transfusion Programme
NBTS	National Blood Transfusion Service
NCPI	National Composite Index
NGO	Non-governmental Organization
NHA	National Health Accounts
NSF	National Strategic Framework
NSP	National HIV/AIDS Strategic Plan (PEN)
NTCP	National TB Control Programme
OI	Opportunistic Infection
OOP	Out-Of-Pocket
OVC	Orphans and Vulnerable Children
PAF	Performance Assessment Framework
PARPA	Action Plan for the Reduction of Absolute Poverty
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Plan for AIDS Relief
PES	Economic and Social Plan
PESS	Health Sector Strategic Plan
PICT	Provider Initiative for Counseling and Testing
PLWH	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
POA	Plan of Action
PSI	Population Services International
QA	Quality Assurance
RENSIDA	Network of PLWHIV
RPSO	Regional Procurement Support Office
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
SWAP	Sector Wide Approach
TAP	Treatment Acceleration Programme
TB	Tuberculosis
ToTs	Training of Trainers
TTIs	Transfusion Transmitted Infections
UAT	Unlinked Anonymous Testing
UCSF	University of California in Sao Francisco
UEM	University of Eduardo Mondlane
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme

UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session Declaration of Commitment on HIV and AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization
XDR-TB	Extensively Drug Resistant TB
YFHS	Youth Friendly Health Services

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## I. Status at a Glance

Indicator	Comments on changes in the indicator	Status 2004/2005	Status 2006/2007
<b>National Commitment and Action</b>			
1. Amount of national funds disbursed by the government	Definition changed	No data available	\$96,624,000
2. National Composite Index	Questions added	82% (2005)	70%
<b>National Programmes</b>			
3. Percentage of donated blood units screened for HIV in a quality assured manner	Definition changed	100% (2005)	35.5%
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Added children	7.4% (2005)	28.0% (2007) 13.7% (2006)
5. Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Definition changed	6.7% (2005)	29.8% (2007) 8.3% (2006)
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	New Indicator	Was not reported in 2005	No data available
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results. (DHS: 2003)	New Indicator	Was not reported in 2005	2% (2003) Men: 2% Women: 2%
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	No changes	No data available	No data available
9. Percentage of most-at-risk populations reached with HIV prevention programmes	Definition changed	No data available	No data available
10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	No changes	No data available	No data available
11. Percentage of schools that provided life skills-based HIV education in the last academic year	Definition changed	No data available	No data available
<b>Knowledge and Behaviour</b>			
12. Current school attendance among orphans and among non-orphans aged 10-14. (DHS: 2003)	Ratio calculation no longer required	Orphans: 62.6%	62.6%
		Males: 72.6% Female: 54%	Males: 72.6% Female: 54%
		Non-Orphans: 78.4% (2003)	78.4%
		Males: 81.5% Female: 75%	Males: 81.5% Female: 75%

Indicator	Comments on changes in the indicator	Status 2004/2005	Status 2006/2007
13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. (DHS: 2003)*	No changes	28% Men: 39%* Women: 25%*	28% Men: 39%* Women: 25%*
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	No changes	No data available	No data available
15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15. (DHS: 2003)	Age range expanded	27.6% Men: 26% Women: 28%	27.6% Men: 26% Women: 28%
16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months. (DHS: 2003)	Age range expanded and definition changed	29% Men: 52% Women: 24%	29% Men: 52% Women: 24%
17. Percentage of women and men aged 15-49 who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse. (DHS: 2003)	Age range expanded and definition changed	27% Men: 33% Women: 24%	27% Men: 33% Women: 24%
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	No changes	No data available	No data available
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No changes	No data available	No data available
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Composite indicator divided into component indicators (part1)	No data available	No data available
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Composite indicator divided into component indicators (part2)	No data available	No data available
<b>Impact</b>			
22. Percentage of young women and men aged 15-24 who are HIV infected.	No changes	TBD (2004) †	14.4% (2007)
23. Percentage of most-at-risk populations who are HIV infected.	No changes	No data available	No data available
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	Definition changed	No data available	No data available
25. Percentage of infants born to HIV infected mothers who are infected with HIV.	No changes	24.6% (2005)	to be modelled at UNAIDS HQ

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

† Recalculated using UNGASS method of indicator measurement

## II. Overview of the AIDS epidemic

### 1. HIV Prevalence in Mozambique

The goal of the national HIV response in Mozambique is to reduce HIV infection. As the highest rates of new infections occur in young adults, the country has committed to achieving major reductions in HIV prevalence among young people.

At older ages, changes in HIV prevalence are slow to reflect changes in the rate of new infections (HIV incidence) because the average duration of infection is long. Furthermore, declines in HIV prevalence can reflect saturation of infection among those individuals who are most vulnerable and rising mortality rather than behaviour change. At young ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behaviour. Thus, reductions in HIV incidence associated with genuine behaviour change should first become detectable in HIV prevalence figures for 15-19-year-olds (Source: UNGASS Guidelines, 2007)

HIV prevalence among adults in Mozambique is estimated based on the results of HIV sentinel surveillance carried out among pregnant women attending antenatal consultations. Surveillance began in 1988 at a sentinel site in Maputo City. During the 1990s, 5 additional sentinel sites were added, all in the central region of the country. In 2000, sentinel surveillance was broadened to a more representative number of 20 sentinel sites, one rural and one urban site in each province, and for the first time a national estimate was calculated. In 2001 an additional 16 sites were added, further increasing the representativeness of the surveillance carried out. A quarter of the 144 administrative districts in Mozambique possess sentinel sites (Centre - 16 sites; North - 11 sites; South - 10 sites).

**Table 1: Estimated HIV prevalence rates among pregnant women (15-49 years) ANCs by province, region and national for 2001-2007, based on the new EPP model.**

Province	2001	2002	2004	2007
<b>Southern Region</b>	<b>15% (10%-17%)</b>	<b>16% (12%-18%)</b>	<b>19% (14%-21%)</b>	<b>21% (16%-23%)</b>
Maputo City	17% (12%-20%)	18% (13%-23%)	21% (16%-26%)	23% (18%-29%)
Maputo Province	16% (10%-24%)	18% (12%-26%)	22% (15%-31%)	26% (18%-34%)
Gaza	19% (12%-26%)	21% (14%-29%)	25% (17%-33%)	27% (18%-35%)
Inhambane	8% (6%-14%)	9% (6%-15%)	10% (7%-16%)	12% (7%-16%)
<b>Central Region</b>	<b>18% (16%-20%)</b>	<b>18% (17%-20%)</b>	<b>19% (17%-21%)</b>	<b>18% (17%-12%)</b>
Sofala	25% (15%-31%)	24% (16%-32%)	24% (17%-33%)	23% (17%-33%)
Manica	18% (10%-23%)	17% (10%-25%)	18% (12%-28%)	16% (10%-23%)
Tete	16% (11%-21%)	15% (11%-21%)	14% (11%-21%)	13% (11%-21%)
Zambézia	16% (9%-23%)	17% (10%-25%)	18% (12%-28%)	19% (12%-29%)
<b>Northern Region</b>	<b>7% (6%-8%)</b>	<b>8% (6%-9%)</b>	<b>9% (7%-19%)</b>	<b>9% (7%-10%)</b>
Niassa	6% (3%-11%)	7% (4%-12%)	8% (4%-14%)	8% (4%-14%)
Nampula	8% (5%-10%)	9% (6%-11%)	9% (6%-12%)	8% (6%-12%)
Cabo Delgado	8% (4%-12%)	9% (5%-13%)	9% (6%-14%)	10% (6%-14%)
<b>National (UA fit)</b>	<b>14% (12%-14%)</b>	<b>15% (13%-15%)</b>	<b>16% (14%-16%)</b>	<b>16% (14%-17%)</b>

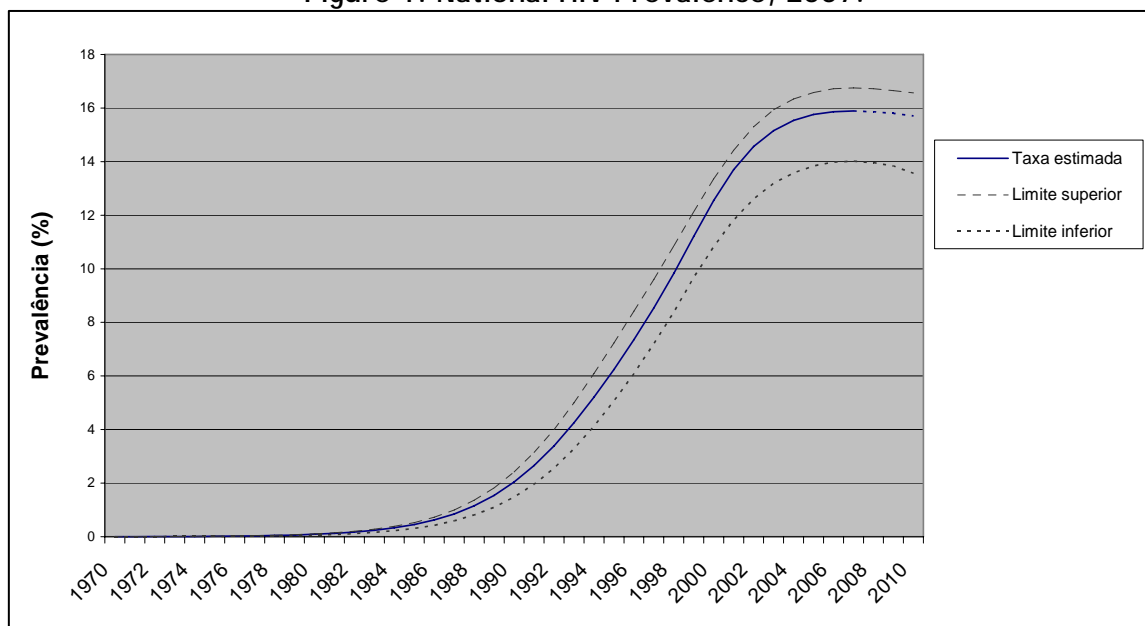
[Source: MISAU/INE, 2007]

The national estimate is calculated by applying the prevalence rate measured in antenatal clients to the adult population (15-49 years old) of the district in which the sentinel site is located. Districts that do not have a sentinel site are attributed the prevalence rate of a similar nearby district that does have a sentinel site. The adult population of each district is estimated by extrapolating the figures of the most recent census, which was carried out in 1997. Consequently, weighted prevalence rates are calculated for each province, each region and for the country as a whole. Prevalence rates are not disaggregated between rural and urban areas. The results of the weighted prevalence rates of the four surveillance rounds are presented in **Table 1** above.

Sentinel surveillance in 2007 was carried out at the same 36 sites as in 2001, 2002 and 2004. Prior to 2007 sentinel surveillance in Mozambique used Unlinked Anonymous Testing (UAT), where leftover blood for RPR syphilis testing was HIV tested anonymously and without the consent or knowledge of the woman. In 2007, women attending the sentinel surveillance sites during the period were asked to consent to using their leftover blood for HIV testing in a method known as Linked Anonymous Testing. This change in methodology has not affected acceptance rates, and more than 11,000 women agreed to be tested (~300 women per sentinel post). Due to the very low refusal rate -0.5%, the results from this round are similar to estimates produced in previous rounds using UAT. Laboratory testing followed WHO's new recommendations to use either an ELISA or two rapid tests rather than a single rapid test alone to determine HIV status. Also, and as a result, laboratory testing occurred centrally instead of at the provincial level.

Analysis was done using the new UNAIDS Estimates and Projections Package (EPP) model which fits the Epi-curve to the surveillance data - projects the past and future course of the epidemic, and confidence intervals (plausibility bounds). The new EPP Model was also used to adjust regional and national trends in HIV Prevalence for prior years. In Mozambique, the results of sentinel surveillance in antenatal clients have never been validated against population-based prevalence rates. A nationwide population-based sero-behavioural survey (INSIDA) will be carried out in 2008.

**Figure 1: National HIV Prevalence, 2007.**



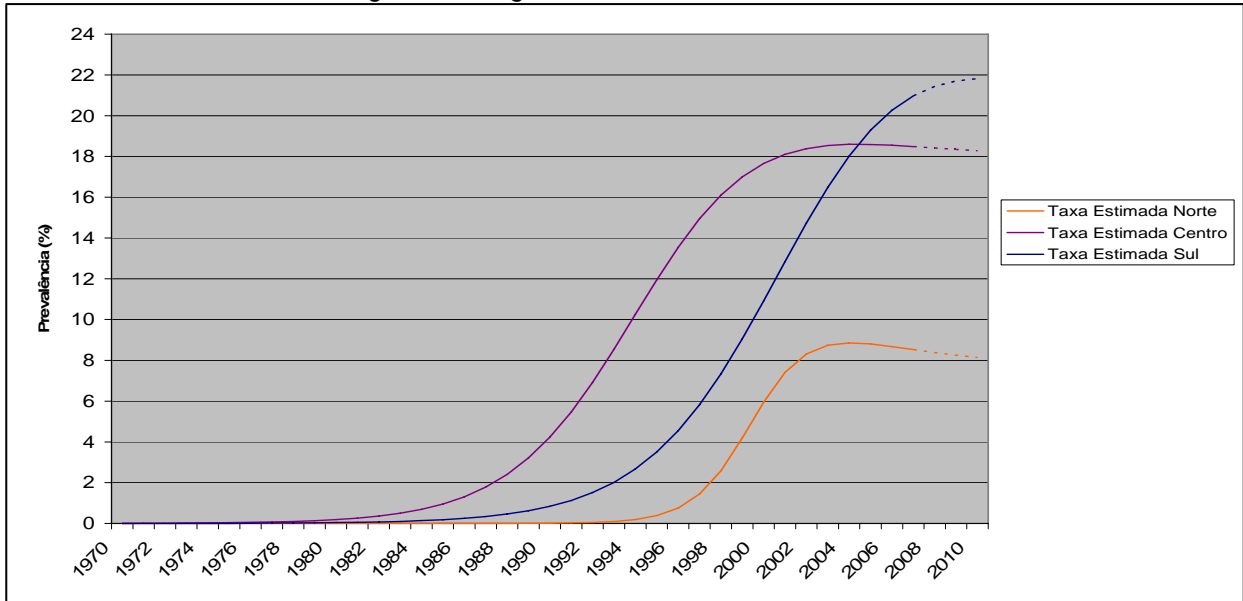
[Source: MISAU/INE, 2007]

National prevalence is calculated by weighting the provincial prevalence rates by respective adult populations. From **Figures 1 & 3** national HIV prevalence is 16% (14%-17%) among adults aged 15-49 in 01/02/2008

2007. National prevalence maintains a very similar prevalence curve to that observed in 2004 and has levelled off at unacceptably high rate of 16%.

Regional prevalence is calculated by weighting the provincial prevalence rate observed by the provincial adult population (15-49 years - most sexually active, substantive risk of infection). According to Figures 2 & 3, HIV prevalence in South Mozambique is showing a rising trend in the epidemic at 21% (16%-23%). In the Central and North regions, HIV prevalence is levelling with a slight percentage decrease at 18% (17%-21%) and 9% (7%-10%). The ranges around the HIV estimates define the boundaries within which the actual numbers lie.

Figure 2: Regional HIV Prevalence, 2007.

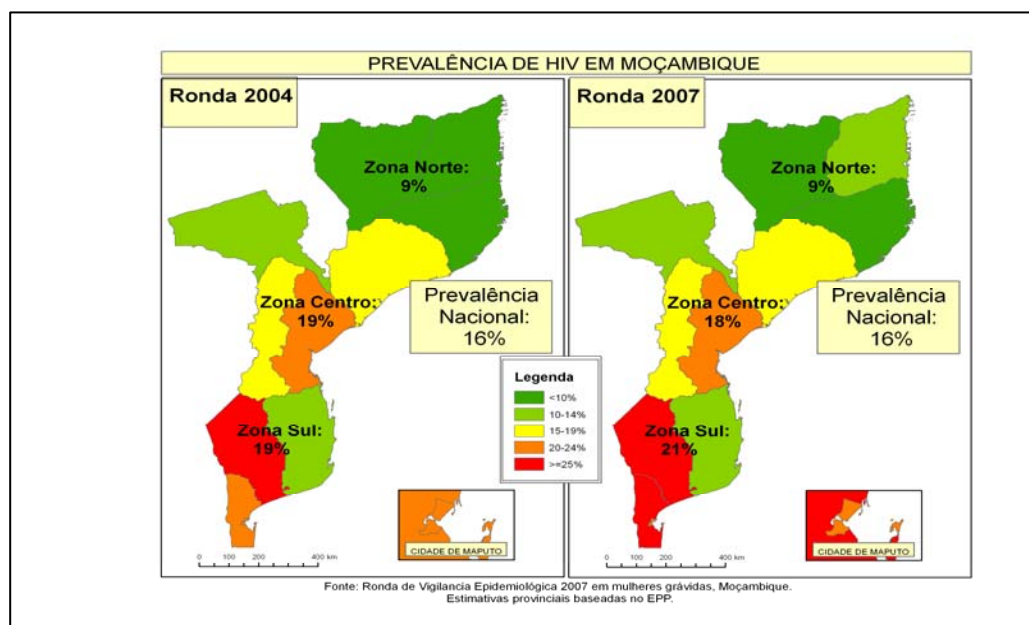


[Source: MISAU/INE, 2007]

Taking into account the surveillance of 2004, little alteration is noted in national prevalence. As may be observed, the centre and the northern regions show a trend towards stability, while the south shows a rising trend in the epidemic as a whole.

Provincial prevalence is calculated by weighting the prevalence rate observed by the adult population (15-49 years -most sexually active, substantive risk of infection). Table1 shows that there is great variation by province, with provinces in the south showing a dramatic increase in prevalence rate since the last surveillance done in 2004. The sharpest growth in HIV prevalence was noted in Gaza and Maputo province.

Figure 3: Regional HIV Prevalence, 2007



(Source: MISAU/INE, 2007)

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

Many of the people now HIV-positive were infected several years ago. Most new HIV infections occur at a young age. The prevalence rate in 15-24 years old is therefore more representative of recent infections and is an indication for the incidence rate. The percentage of young women aged 15-24 who are HIV infected according to UNGASS calculations is presented in Table 2.

Table 2: Percentage of young women aged 15-24 who are HIV infected (2007)

	All 15-24	Disaggregated Values	
		15-19	20-24
Numerator: Number of ANC clinic attendees (aged 15 -24) tested whose HIV test results are positive	895	264	631
Denominator: Number of ANC clinic attendees (aged 15-24) tested for their HIV infection status	6,229	2,773	3,456
Indicator Value Percent <sup>†</sup>	14.4%	9.5%	18.3%

Pooled prevalence percentage calculated as the numerator / denominator × 100  
 Median of the site level prevalence percentages  
 (Source: MISAU/INE, 2007)

**Interpretation of the indicator data:**

According to the UNGASS method of measurement HIV Prevalence among young women (15-24 years) attending antenatal clinics in 2007 is 14.4%. The HIV prevalence rate is higher among age group of 20-24 (18.3%) when compared to the age group of 15-19 years were it is 9.5%.

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

Table 3: Weighted HIV prevalence rates among 15-24 year old pregnant women attending antenatal clinics, 2000-2007<sup>†</sup>

Year	2000	2001	2002	2004	2007
National	12.2%	12.5%	13.1%	15.6%	16.2%

<sup>†</sup> Median of the site level prevalence percentages  
[Source: MISAU/INE, 2007]

**Interpretation of the indicator data:**

According to Table 3 the HIV Prevalence rates among young women (15-24 years) attending antenatal clinics continues to rise from an estimated 15.6% in 2004 to 16.2% in 2007, indicating that HIV incidence is probably still rising. These sentinel surveillance results will be validated against the results of the population-based prevalence rates (INSIDA) which will be carried out in 2008.

## 2. HIV Prevalence among Most-at-Risk-Populations (MARPS)

To date, there is no HIV prevalence data regarding MARPS in Mozambique. The data available regarding MARPS has focused on determining the number of MARPS as well as risk behaviours of most at risk populations. These data are derived from small scale, localized research projects conducted by NGOs/CBOs, such as the *Milking the Cow* study conducted by PSI, the Maputo corridor assessment conducted by USAID, and the World Vision corridor project. The data available estimates that 380,000 women in Mozambique may be involved in sex work (World Vision 2005). Also, there is a young age of sexual debut (15.4 years) in Mozambique and early entry into sex work (17.8 years) which increase the risk of HIV- infection among female sex workers (World Vision, 2005). In the study conducted by PSI many young women interviewed perceive their greatest risk engaging in sex work as loss of social and economic status not risk to their sexual health. Data regarding MARPS is limited and focuses on understanding the behaviours of MARPS with limited knowledge regarding the prevalence of HIV.

HIV prevalence in MARPS is not known, however, the higher prevalence observed along transport corridors suggest that mobile populations are at high risk. For example, amongst those interviewed in the USAID-supported study, HIV prevalence differed based on geographic location in which higher HIV prevalence corresponded roughly to transport corridors, border areas, and larger cities in Mozambique (USAID, 2001). Ministry of Health (MOH) HIV epidemiological surveillance data in 2004 found the highest HIV prevalence in the central region of the country at 20.4%, followed by 19.1% in the south and 9.3% in the north (Mozambique Ministry of Health, National Program to Control STI/HIV/AIDS, 2005). Many MARPS reside and/or work in these areas, thus increasing their risk of contracting and transmitting HIV (USAID, 2001). Therefore, there is a crucial need to determine prevalence of HIV among most at risk populations to gain a more comprehensive view of the epidemic amongst MARPS in Mozambique.

**Behavioural Surveillance Survey in Mozambique:** To date, Mozambique has not implemented a Behavioural Surveillance Survey. In 2008, however, the Centers for Disease Control and Prevention (CDC), in collaboration with the Government of Mozambique and key national stakeholders, will support the implementation of the first round of Behavioural Surveillance Survey in Mozambique. The BSS will monitor and assess baseline information in HIV-related knowledge, attitudes, and behaviours among key risk groups in Mozambique. The survey will also include a biomarker to estimate HIV prevalence for these groups (BSS+). The BSS+ in Mozambique is planned to be implemented in several phases.

- In Phase 1, at-risk populations to be included in the BSS will be identified through consultations with stakeholders. This input will be used to select and prioritize the most at risk populations (MARPs) to be included in Mozambique's BSS. Phase 1 is planned to be implemented January to March 2008.
- Phase 2 activities will focus on protocol development for BSS implementation. This will include eliciting information on strategies to recruit members of the risk populations into the sample, identifying sites for sampling and sampling frame, instrument development, and general protocol development. Phase 2 activities are planned for April to June 2008.
- Phase 3 will include collection of data on HIV- and AIDS-related knowledge, attitudes, and risk behaviours from identified risk groups; data management and analysis, and data dissemination and interpretation. Phase 3 activities are expected to begin in approximately July 2008, with preliminary results available by the end of 2008.

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

Currently no data exists for this indicator.

### III. National Response to the AIDS Epidemic

#### PART ONE. NATIONAL COMMITMENT AND ACTION

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##### 1.1 Domestic and International AIDS Spending

Funding for HIV and AIDS programmes in Mozambique come from three main sources: public, external (international) and private sources. Like many developing countries, Mozambique's national response to HIV and AIDS is to a large extent sustained by external assistance secured from international, multilateral and bilateral organisations alongside foundations and NGOs supporting the HIV and AIDS response.

These sources channel HIV and AIDS funding using three main funding mechanisms: through the state budget, through Sector-Wide Approach (SWAp) for health sector financing; and/or vertical project funding.

In 2006, the government committed itself to undertake a full National AIDS Spending Assessment (NASA) to exhaustively track actual HIV and AIDS spending from public, international and private sources (UNGASS, 2005). The assessment focused on tracking national level HIV expenditure for the period 2004, 2005 and 2006. Data collection covered domestic, external and private spending on HIV and AIDS, including funds channelled through the government. The assessment did not cover total household out-of-pocket expenditure on HIV and AIDS only out-of-pocket payment for services and drugs.

Most of the key sources of data (detailed expenditure records) were obtained from the majority of primary sources for the reporting period. Secondary sources were used only where primary sources were not available. In other cases costing techniques were used to estimate some of the expenditures on HIV and AIDS related activities using best available data and the most suitable assumptions. There were a number of limitations to this study. Key among them was the problem relating to missing HIV expenditure information especially in the sectoral ministries. It is therefore difficult to draw firm conclusions about HIV and AIDS financial flows to certain sectors. However, on the basis of information provided by funding sources and service providers, the study attempts to reconstruct some sectoral spending on HIV and AIDS programmes. It was also difficult to carry out a detailed comparison of expenditure by priority HIV and AIDS intervention areas due to the lack of a costed National Strategic Framework (NSF) and differences in NSF categories and the NASA categories.

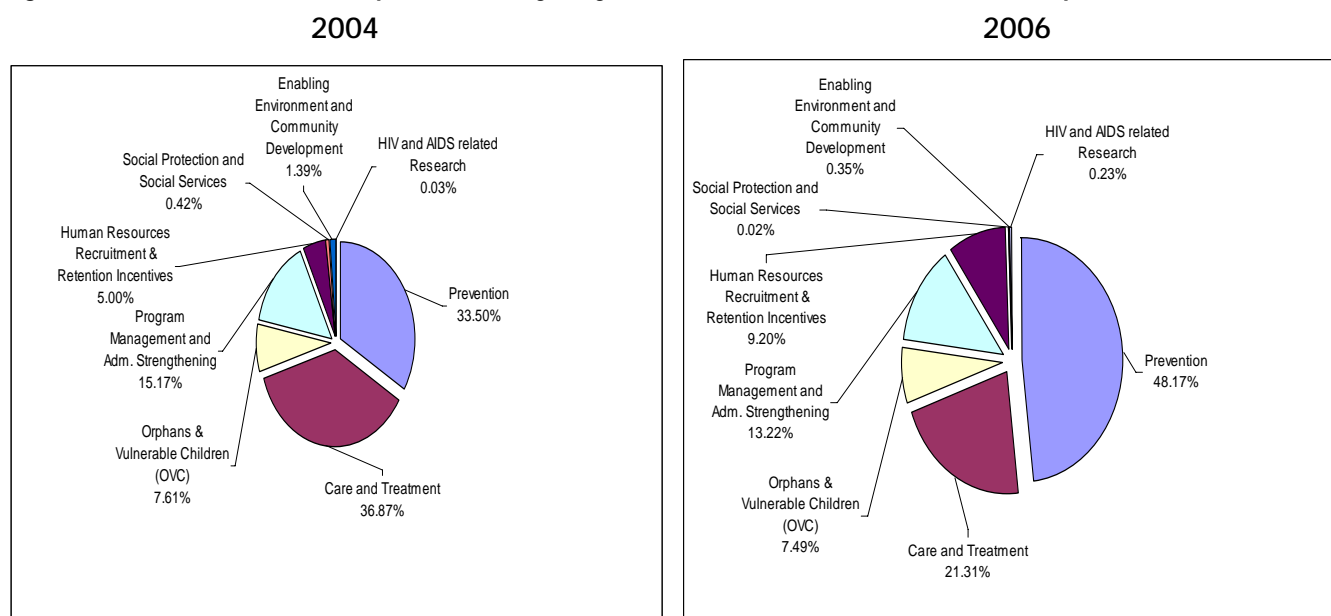
##### Main Findings

The NASA estimations show that overall; **Mozambique spent a total of US\$204,120,637 on HIV and AIDS between 2004 and 2006.** Although HIV expenditure increased by only 5% from 2004 to 2005, total expenditure increased by 18% between 2005 and 2006. HIV and AIDS spending in 2006 made up nearly half of total spending during the reporting period. External financing sources account for 82% of all HIV expenditure during 2004-2006. Public funds constituted 16% of the total HIV and AIDS expenditure, while private sources of funding accounted for only 2%.

The NASA estimations regarding HIV service providers show that public organizations provide the majority of these services in Mozambique. **An estimated US\$93,993,442 (46% of total expenditure) was spent by public service providers over the three year period.** Private sector HIV service providers mainly consist of for-profit and non-for profit organisations. The results from the NASA

confirm the general trend that the provision of HIV services has relied heavily on Private non-profit providers (NGOs). The public-private partnership with the MOH, which acts as a “contractor” of services, enable HIV services to be delivered to those in need, and also integrates NGO activities and staff into government run facilities. Between 2004 and 2006, NGOs spent US\$77,468,243 (38%) on HIV and AIDS. Some bilateral and multilaterals organizations are also involved in the provision of various HIV and AIDS services. Between 2004 and 2006, bilateral and multilaterals share of HIV service provider spending decreased from 13% of total HIV service provider spending in 2004 to 7% in 2006.

Figure 4: % HIV and AIDS Expenditure by Key Areas of Intervention, Mozambique NASA 2004-2006



[Source: 2008 NASA Report]

A further disaggregation of data by the NASA AIDS Spending Categories show that the key spending priorities between 2004 and 2006 have been on prevention (40%); care and treatment (30%); and programme management and administrative strengthening (15%). Total expenditure on prevention programmes declined from 48% of total funding in 2004 to 34% in 2006; while expenditure on treatment and care increased from 21% of total spending in 2004 to 37% in 2006. Another important key intervention area where spending has been decreasing over the years is human resources recruitment and retention incentives. Spending fell from 9% of total spending in 2004 to a low 5% in 2006. Total spending on Orphans and Vulnerable Children (OVC) and HIV and AIDS related research remains low at 7% and 8% of total spending respectively between 2004 and 2006.

The overall decline in expenditure on prevention programmes as a share of total expenditure over the study period should be monitored given the importance of intensifying prevention so as to turn the tide of the epidemic in Mozambique. The results show that between 2004-2006, 96% of HIV prevention expenditure was spent on the following ten activities: communication for social and behavioural change (13%), prevention, diagnosis and treatment of STI (10%), condom social marketing (10%), PMTCT (11%), counselling and testing (8%), prevention for youth out-of-school (9%), prevention for youth in school (8%), community mobilization (7%), programmatic interventions for vulnerable populations (3%) and other prevention activities (17%).

There was a reversal in trend in the case of care and treatment category. Total expenditure on care and treatment increased from US\$10,336,214 in 2004 to US\$13,020,739 in 2005 and to a high US\$35,626,000 in 2006, a 173% increase from 2005. In 2004 about 64% of the total spent on care and treatment was spent on ART and 17% on Opportunistic infections’ (OI) treatment. By 2006, this

configuration of spending had changed. Although ART remained the main treatment spending category the share of Home Based Care (HBC) expenditure increased nearly ten-fold from US\$ 1,068,880 in 2004 to US\$ 9,681,318 in 2006. Other spending categories such as Nutritional support associated to ARV therapy also constituted a major share of the total expenditure in 2006.

A summary of OVC spending from the study shows that total spending on OVC increased slightly from US\$3 million in 2004 to US\$4.1 million in 2005 and increased further to \$7.4 million in 2006. Generally there was more targeted spending on OVC in 2006 than in 2004 and 2005. In 2006, about 32% of the total spent on OVC was on OVC family/home support; 32% on OVC community support 2006; 13% on administrative costs; 11% on unspecified services; 9% on education and 3% on basic health care.

Resources for the national response to HIV and AIDS have contributed to the improvement of infrastructure, procurement and distribution, upgrading of laboratory facilities and blood banks, nutrition, and logistics management. Total spending on programme management and administrative strengthening activities increased from 2004 to 2006. **On average over 85% of total spending for this category was on administrative, planning and coordinating activities for all the years under study.**

An insufficient number of trained and retained public sector health personnel constitute a major constraint in scaling up HIV and AIDS care and treatment in Mozambique. **Spending on human resources and retention incentives has remained the same from 2004 to 2006.** In all three years, most of the spending went into training with the rest into monetary incentives for other staff on HIV and AIDS related activities. Human capacity constraints cannot be overlooked. Currently, there are a limited number of personnel to plan, manage and implement the many initiatives to the national response outlined in the PEN II.

The lack of a disaggregated data on HIV and AIDS spending by gender made it difficult to assess whether activities targeting women and girls and men and boys are well resourced. This also raises questions regarding the delivery of programmes to address gender related issues that lead to feminisation of the HIV epidemic in Mozambique.

Between 2004 and 2006, 98% of total HIV and AIDS spending during the reporting period benefited the following populations: people living with HIV (PLWH), OVC, children born or to be born to HIV mothers, people attending STI clinics, children and youth out of the school, youth at school, factory employees and children in school and other populations. In 2004, 22% of the total spending benefited People living with HIV (PLWH), about 9% on OVC and the rest spread evenly between the other groups. In 2005, 61% of total spending was spent on general population, 16% on PLWH and 6% on OVC. In 2006 spending on PLWH increased to 40% of the total spending as a result of the increase in spending on ART.

### **Conclusions and Recommendations**

Substantial amounts of resources have been invested in the national response to HIV and AIDS. The growth in funding for HIV and AIDS prevention and care has outpaced that for most other public health programmes. However, an insufficient number of trained and retained public sector health personnel constitute a major constraint in scaling up HIV and AIDS care and treatment in Mozambique. It is therefore difficult to judge whether the implementation of these HIV and AIDS related programmes will reach the desired groups in all the provinces across the country.

The heavy reliance on external funding raises questions of sustainability of HIV and AIDS programmes in Mozambique. The internal budget allocation to the CNCS has sharply decreased in the past three years and while the shortfall has been made up by external sources of funding. It is worth noting that the harmonization and alignment of donor support through the channelling of funds through a common fund reduces the duplication of programmes and ensures a more efficient allocation of resource.

One major limitation of the study was the inability to undertake a comprehensive assessment of out-of-pocket (OOP) payment on HIV and AIDS related activities. It is recommended that some questions related to HIV spending be incorporated into existing household surveys to enable the government to establish the proportion of households with catastrophic HIV and AIDS expenditure in Mozambique.

### UNGASS Indicator#1: Domestic and International AIDS Spending by categories and Financing Sources

Table 4: AIDS Spending Categories by Funding Sources and Year (USD '000)

Categories	Public			Private			External			Total		
	2004	2005	2006	2004	2005	2006	2004	2005	2006	2004	2005	2006
Prevention	3,596	4,930	7,647	72	127	816	19,698	21,306	23,908	23,366	26,363	32,371
Care and Treatment	516	3,848	5,103	921	82	138	8,899	9,092	30,386	10,336	13,021	35,626
Orphans & Vulnerable Children (OVC)	3	5	604	825	74	84	2,806	4,096	6,669	3,633	4,175	7,357
Program Management and Administration Strengthening	1,898	2,641	588	359	8	81	4,156	7,868	13,985	6,413	10,517	14,654
Human Resources Recruitment & Retention Incentives	1,314	101	45	97	102	-	3,051	3,694	4,782	4,462	3,898	4,828
Social Protection and Social Services	-	-	4	-	20	-	10	22	405	10	42	409
Enabling Environment and Community Development	-	8	299	26	336	-	145	129	1,048	172	473	1,346
HIV and AIDS related Research	-	-	13	-	-	-	112	505	21	112	505	34
<b>Total</b>	<b>7,326</b>	<b>11,533</b>	<b>14,302</b>	<b>2,301</b>	<b>747</b>	<b>1,118</b>	<b>38,876</b>	<b>46,712</b>	<b>81,204</b>	<b>48,504</b>	<b>58,993</b>	<b>96,624</b>

[Source: 2008 NASA Report]

The key recommendations from this study are centered on the need to have a costed National Strategic Plan to ensure a needs-based resource allocation mechanism. The advantages of such a process are two-fold. First it helps in resource mobilisation both internally and externally to ensure adequate provision of resources to areas where they are most needed. Secondly it provides the basis for an immediate assessment of funding gaps; which could justify the need for more adequate budgetary allocations to national response.

HIV and AIDS expenditure data on the flow of resources from funding agencies to implementers and target groups is vital for effective planning of HIV and AIDS programmes and efficient use of resources. There is the need to institutionalize the NASA process in Mozambique for the ease of data collection and reporting on HIV and AIDS spending.

## 1.2 National Level HIV and AIDS Policies and Strategies

Mozambique has in the past decade made great strides in curbing the spread of HIV and AIDS which threatens to undermine economic achievements gained over this period. Although Mozambique's epidemic is lagging behind those of most other countries in the Southern African region, sentinel surveillance data shows a worsening epidemic overall, with rising infections in all regions. Approximately 1.6 million Mozambicans are currently living with HIV, and in the age group 15-49 the prevalence of infection is estimated at 16%. Current projections suggest that by 2010 the number of people infected will rise to 1.9 million.

### **Strategic Plan**

The National response to HIV and AIDS epidemic in Mozambique started in 1988 with the establishment of a prevention and control programme in the Ministry of Health. In 2000, the Government approved a National Strategy (PEN); and established the National Council to Combat AIDS (CNCS). The first National Strategic Plan to Combat HIV/AIDS, 2000-2002 (National PEN) which sought to slow the spread of HIV infections and to mitigate the effects of the epidemic, through a multi-sectoral approach, focused mainly on prevention activities. Treatment and providing ARV therapy was not envisaged because of the high cost of ARV at that time, and the complexity of implementation.

The second generation National Strategic Plan (PEN II) for the period 2005-2009, developed in 2004, is the current guiding strategy for the implementation of the National response. It encompasses existing plans, including those of the line Ministries. The main objectives underlined in PEN II are the promotion of interventions to reduce the level of new infections and increase the care and treatment of people living with HIV and finally engage all stakeholders in mitigation process that will ensure that people living with HIV (PLWH) are treated humanely and their rights are protected. A comprehensive costing of the National Strategic Framework has not been undertaken.

The Plan was widely endorsed by all bi-lateral and multi-lateral partners and is currently being harmonised with the bilateral and multi-lateral partners' individual HIV programs. Since 2005, HIV and AIDS has been mainstreamed into many national policy framework documents as well as the current Action Plan for the Reduction of Absolute Poverty 2006-2009 (PARPA II), showing the government's commitment to adopt a comprehensive approach to the national response of the HIV and AIDS epidemic. Several Ministries have now elaborated HIV and AIDS plans. The current policy framework of the health sector emphasizes primary health care and the need to halt the negative impact of endemic diseases especially HIV. Specifically, the National Strategic Plan for STI/HIV/AIDS 2004-2008 (PEN-Saude) outlines the HIV prevention, care and treatment efforts of the health sector.

### **Political Support**

2006 was marked by renewed political commitment to address HIV and the drivers of the epidemic in Mozambique.

Key achievements during the UNGASS reporting period include: (1) The Presidential Initiative on HIV and AIDS led by President Guebuza during the first half of 2006 was a clear expression of political commitment at the highest level. The initiative brought together community leaders from all levels, senior central government, provincial and district government, and representatives from civil society, faith based organizations, youth and others, to discuss and renew their commitments to the national AIDS effort. These commitments are being followed through by CNCS and Government, and have given rise to other events such as the Youth Conference on HIV; (2) In general, there has been a shift and recognition by government of role of civil society organizations as valid partners in the response to HIV and AIDS. The 2008 CSO conference on HIV and AIDS which is being organized by CSO in collaboration with the Government is a concrete example of increased collaboration; and (3) Establishment of the

high level HIV Prevention Reference Group chaired by the Minister of Health to coordinate and intensify evidence-based prevention efforts

Despite this political commitment, much more needs to be done at all levels particularly provincial and district levels including the establishment of a frank dialogue about changing sexual norms.

### **Prevention**

Key achievements during the UNGASS reporting period include: (1) expansion of the Youth Friendly Health network with 46 new sites opened, bringing the total number YFHS in the country to 179 (2) integration of HIV prevention education in the basic education curriculum; (3) increase in the availability of male condoms, (4) integration of PMTCT with other health services and the introduction of opt out approach for testing in ANC and maternity wards contributed significantly to the increase in PMTCT sites and the increase in women receiving ARV prophylaxis; (5) Approval of the Communication Strategy for HIV and AIDS, launch of the Window of Hope campaign which is focusing on HIV prevention in the 10-14 year age group; (6) Establishment of a high level HIV Prevention Reference Group to coordinate and intensify evidence-based prevention efforts (see chapter IV for details).

The key factors impeding performance in the prevention area include: (1) the absence of a coherent national HIV prevention strategy based on evidence about the drivers of the epidemic is an obstacle to accelerating and scaling up prevention efforts; (2) the linkages between condom distribution and prevention is limited, leading to low utilisation of condoms; (3) Referral and linkages of services between for example ANC and PMTCT are not optimal, contributing to drop out of women and children from the PMTCT programme; (4) the lack of social communication in the community and psychosocial support for women identified as HIV positive, contributes to the relatively low uptake of PMTCT services and the high rates of women and children who drop out of the programme; (5) low access to health services impacts on access to PMTCT services; and (6) low coverage of HIV prevention programme in schools (less than 50% of primary and secondary schools covered).

Continued implementation of the strategy on information, education and communication on HIV and AIDS remains strong with a specific focus on youth and other vulnerable groups. Close collaboration with schools is being strengthened while also encouraging voluntary testing and counselling to the general public. However, continued investment in information, education and communication, have been uncoordinated, fragmented and with too much emphasis on material production. This has led to the lack of performance on communication. There is a need to keep monitoring and develop studies focused on vulnerable groups, adoption of new methods and effective strategies to curb the increased rate of HIV infection.

### **Treatment, Care and Support**

Mozambique has a national strategy to promote comprehensive HIV treatment, care and support. Government has embarked in an effort to broaden access to ARV and TB treatment to all the identified priority districts. There has been a tremendous expansion in the number of health units providing TARV from 39 in 2005 to over 200 health units offering HIV/AIDS treatment nationwide. This significantly increased number of sites offering treatment corresponds to coverage of 70% of all districts, and in practice means that the previous inequity in terms of geographical access to treatment - approximately 60% in previous years located in Maputo City and province - has begun to be addressed. However disparities in access still exist with 34% of those in need of treatment have access to it in the southern region, decreasing to 11% in the central region, and further to 6% in the northern region. While access to treatment has rapidly expanded, over 80% of the needs are still not met.

Key achievements include: (1) the integration of ART services with other health services has significantly facilitated increased access to treatment. The training of a broader cadre of health workers also contributed to expanding the number of people receiving ART; (2) Strengthening between

the ANC and treatment facilities and specifically the linkage between CD4 count testing and the ANC check-up has facilitated the increase in the number of pregnant women who receive ART (950 in 2006 in comparison to 554 in 2005).

The key factors impeding performance in the treatment area include: (1) Providing timely and quality data continues to be a barrier to improved planning and budgeting, and is essential to be able to demonstrate results and keep all partners, in particular the vertical funders, engaged in the Ministry of Health-led systems strengthening approach to HIV/AIDS; (2) Integration of HIV/AIDS services with other essential services, especially TB and reproductive health continues to be a practical and logistical challenge. Referral systems remain weak; (3) Adjunctive services pivotal to an appropriate treatment programme continue to be very weak, e.g. home-based care; (4) Education programmes on ARV treatment to ensure adherence are still weak; (5) Essential interventions such as paediatric treatment have yet to optimise links with PMTCT, and in fact potentially risk the overshadowing of PMTCT as an essential prevention intervention unless this is strengthened.

By the end of 2006, 23% of Orphans and vulnerable children (OVC) identified in the OVC Action Plan (or over 220,000) had gained access to at least 3 basic services. In addition, through support provided to Civil Society Organizations by various bi-laterals, multi-laterals and governmental and non-governmental institutions, more than 285,000 OVC were reached, corresponding to 18% of the OVC Action Plan target for 2006.

#### **Monitoring and Evaluation (M&E)**

The National M&E Framework (2005-2009) identifies a core set of 27 indicators that include the indicators agreed for the M&E of the UNGASS declaration. It also defines the sources of data for the indicators and other relevant information; the systems that need to be put in place to ensure the correct flow, storage, analysis, dissemination and use of data; and the role of each stakeholder. The CNCS has not yet developed an integrated and costed M&E work-plan to mobilize partners and resources into a coordinated effort to harmonize and implement the national M&E system. A national multisectoral M&E working group also exists, although it meets sporadically and primarily comprises representatives of the public sector and partner organizations. Sharing of M&E results between the CNCS and its partners is not yet optimized. Mozambique has a functional Health Information System but no Educational Information System. HIV biological surveillance reports and demographic impact reports are produced biennially.

Key achievements during the reporting period include: (1) Definition and collection of baseline information for a standardized set of national level outcome and impact indicators; (2) Strengthened M&E capacity at central level; (3) Mainstreaming of HIV targets and indicators in key development policies and plans including the Poverty Reduction Strategy (2006-2009); (4) Establishment of a system to track HIV and AIDS resource flows and expenditure (international, private, public flows); and (5) Mapping of existing HIV and AIDS research and evaluation in Mozambique

Key challenges include: (1) Development of a comprehensive M&E operational plan; (2) Revitalisation of the multi sectoral working group on M&E; (3) Strengthen the capacity of sectors at national and provincial level for regularly monitoring progress made in implementing the PEN II; (4) Strengthen the flow of information between district and provincial structures and national routine information systems needs to be strengthened; (5) Harmonization and standardization of M&E indicators, tools and mechanisms for monitoring; (6) Strengthen research and evaluation by developing an evaluation agenda; and putting in place an effective strategy for dissemination and application of research findings.

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<sup>7</sup> Basic services include: health, education, food/nutrition, legal support, psycho-social support and financial support.

## **Human Rights**

Human Rights monitoring in Mozambique is done mainly through CSO organizations such as “*Liga dos Direitos Humanos*” (Human Rights League).

Key achievements during the reporting period are: (1) Government, through broad based consultation has involved CSOs and PLWH in HIV program implementation; (2) Mozambique has a free services policy for HIV prevention, treatment and care through its national health services complimented by CSO efforts targeting all priority districts; and (3) Training of the judiciary on HIV and AIDS has been carried out.

Key challenges include: (1) The 5/2000 law approved in 2002 protects PLWHA in the workplace but does not make discrimination a punishable offence hence the enforcement of this law remains weak; (2) A comprehensive law against stigma and discrimination has been developed and is still waiting for approval by parliament; (3) Limited progress has been noted in the judicial system on addressing HIV and AIDS cases.

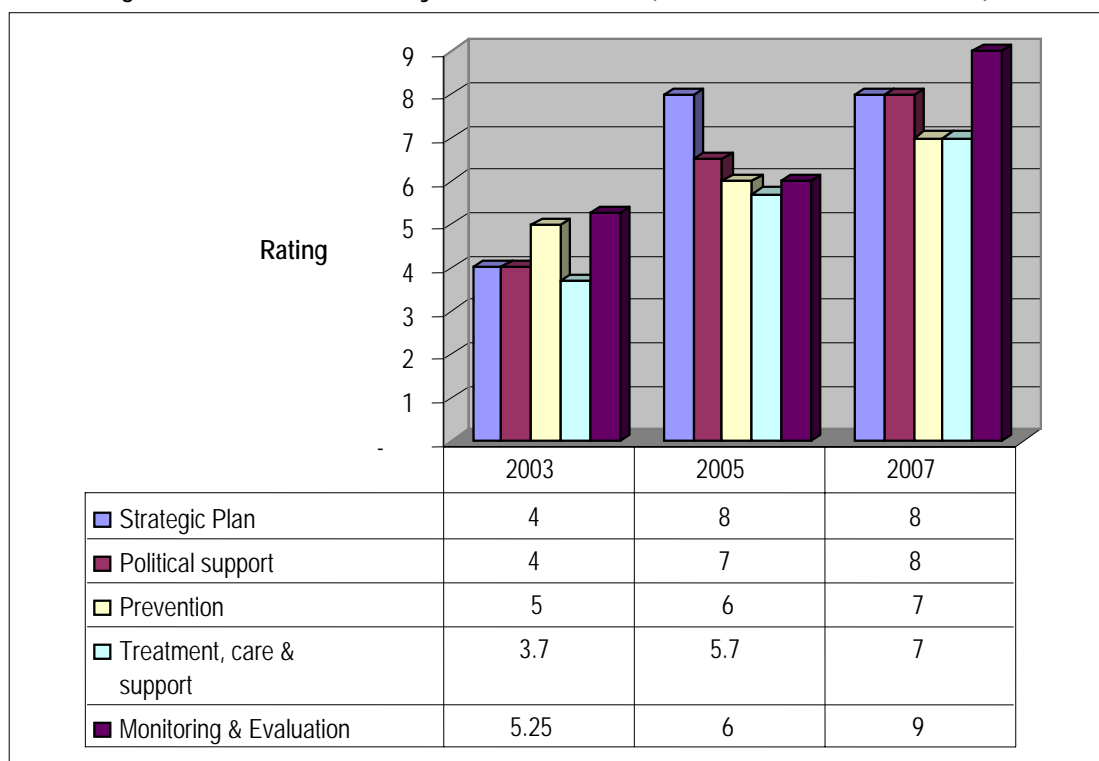
## **Civil Society**

Government acknowledges the critical role of civil society in the planning, review and implementation of HIV and AIDS activities and is increasingly open to the meaningful involvement of civil society as a partner in the national response. While more can be done, civil society often lacks the capacity and coordination ability to utilize existing opportunities to raise and advocate on issues. Capacity of civil society is an ongoing issue, increased and ongoing support is required to scale up civil society interventions and overcome obstacles such as access to funds, programming quality, financial management and the monitoring and evaluation of interventions.

Key achievements during the reporting period are: (1) Government recognition of the need for stronger partnerships with civil society, (2) in 2007, the Ministry of Health created a Unit for the management of community involvement; (3) Civil society is maturing and accessing funds on an increasing basis, (4) the increasing role of young people in coordination activities.

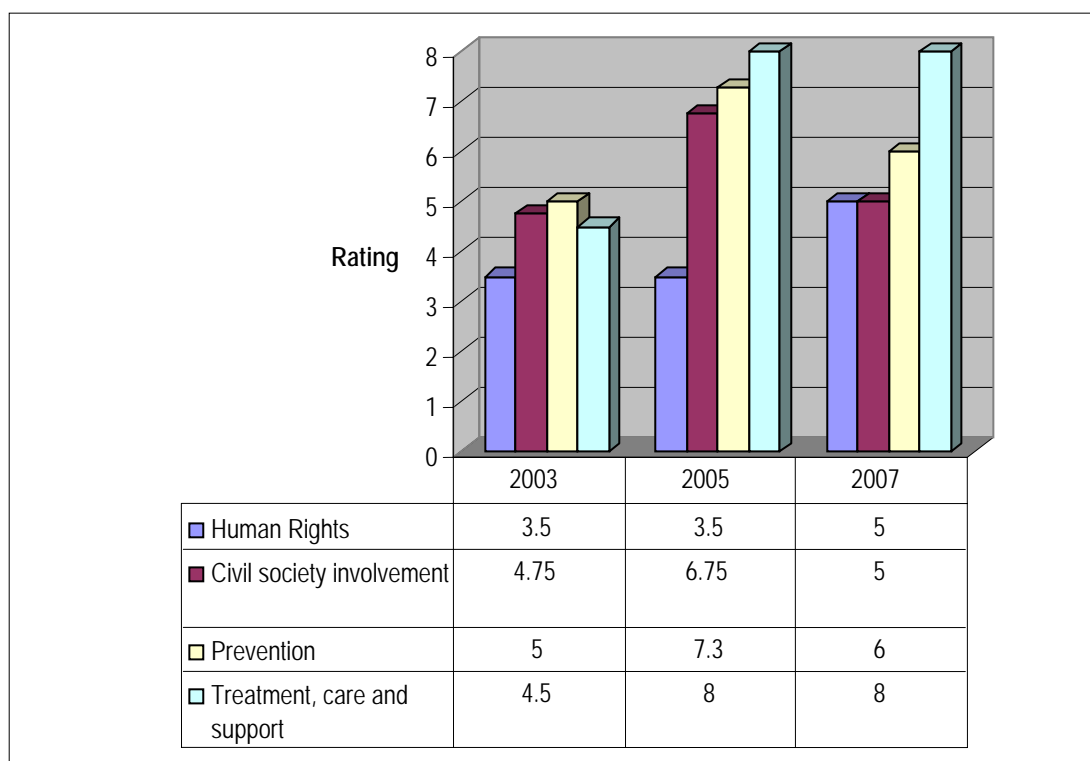
Key challenges include: (1) fragmented civil society voice, (2) low levels of meaningful involvement in national coordination mechanisms, (3) need to scale up interventions across the national response, (4) limited organizational capacities; and (5) role in monitoring the national response

Figure 5: NCPI Trend Analysis 2007 - Part A (Governmental Assessment)



(Scale 0-10)

Figure 6: NCPI Trend Analysis 2007 - Part B (Non-Governmental Assessment)



(Scale 0-10)

## **PART TWO: NATIONAL PROGRAMMES**

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### **Prevention Programmes**

This section of the report will assess the success of the prevention response in Mozambique in the following areas: Blood safety, prevention of mother-to-child transmission, HIV testing, Stigma and Discrimination, and prevention programmes.

#### **2.1 Blood Safety**

##### **Background:**

In 2003/4, there were 111 public stand-alone blood banks (BB) overseen by the National Blood Transfusion Service (NBTS) and operating under the umbrella of the Mozambique Ministry of Health (MoH) - no private blood banks existed. The country collected around 66,000 units a year, with a wide range of collections per center (from 8 to 16,000 units/year). Over 50% of these donations were from family replacement donors. Up to the end of 2004, blood donors were screened for HIV and Syphilis only (prevalence of 8.5% and 4.4%, respectively). HIV rapid tests were used to screen about 60% of the country's blood supply. No screening for HBsAg or HCV antibody was in place at the time. With the exception of the Maputo Central Hospital BB that processes platelets, all other BBs produce whole blood or red blood cells.

##### **Policy and Institutional context:**

Since 2005, the National Blood Transfusion Service (NBTS) has had a senior mobilization coordinator in place and has hired 10 donor recruiters for each provincial BB. These measures contributed to a 10% increase in the country's blood collection (from 66,041 in 2003 to 72,170 in 2006). HBsAg screening was introduced in early 2005 averting nearly 6,000 cases of HBV transmission by blood that year. Testing for HIV antibodies by ELISA has switched to antigen/antibody assays. Training on Infectious Disease Testing (IDT) has been conducted and in 2008 all provincial blood banks will be screening blood by ELISA, thus increasing the percentage of ELISA-tested blood from the current 40% to 63%. In addition to HIV, syphilis and Hepatitis B screening already in place, Hepatitis C screening assay will soon be introduced.

The American Association of Blood Banks (AABB), the NBTS's main technical assistance provider, has assisted the NBTP for the development of a National Blood Transfusion Policy as well as blood safety norms and standards, which serve as the foundation of a quality assurance (QA) system for blood transfusion services in Mozambique. AABB supports an ongoing revision of Standard Operation Procedures and has begun to incorporate QA into training activities.

The NBTS has proposed a re-organization of the services and a transition to a network model of service provision. In 2005, the MoH started the re-organization whereby 27 blood banks (2-3 per province) are upgraded to become reference units for 83 smaller blood banks. While reference blood banks will conduct a full range of procedures—blood collection, testing, production of blood components, storage, administration of blood units—they will also be responsible to supply smaller blood banks and health facilities with blood units. The 83 smaller blood banks will be divided into two groups: those performing collection, testing, and administration of blood units, and those storing blood units and administering blood transfusion only. To-date a total of 135 blood banks currently provide blood transfusion services at health facilities in Mozambique. Coverage is limited

01/02/2008

to the same extent as access to health facility-based services in Mozambique in general is limited to an estimated 40-50%, with many remote and rural areas having limited or no access to facility-based health services.

AABB technical experts have assisted the NBTP with the development of training materials for blood donor services, donor evaluation, and infectious disease testing (IDT). In August 2007, following several courses for BB staff, a first training of trainers (ToT) on donor evaluation was conducted in Maputo for six individuals. This first group of Mozambican trainers will now proceed to roll out on-the-job training to staff in other provincial blood banks. At least two further trainings will be conducted until March 2008.

Data collection for a Knowledge Attitudes and Practices (KAP) Study, to assess barriers and enhancers to blood donation in Mozambique is scheduled for the first quarter of the calendar year 2008. This study will inform further improvements in blood donor recruitment. Efforts to support improved mobilization of low-risk and repeat blood donors will continue.

New data collection forms for blood transfusion service monitoring are currently piloted at selected blood banks. Upon completion of the pilot, forms will be adjusted as needed and used to establish an improved manual data collection system for routine program monitoring. The second phase will establish a computerized blood bank data system. In planning for this activity, recently completed AABB-supported assessments of existing blood bank computer systems will be examined. Related activities will include recruitment and training of Mozambican IT staff to manage and maintain the data base and blood bank monitoring system.

Currently the Mozambique MoH, with technical support from AAB, and funding provided through the Regional Procurement Support Office (RPSO), has initiated planning, design and preparations for construction of a new facility which will bring the Blood Transfusion Services Directorate and the National Referral Blood Bank together under one unit. The establishment of this unit aims to: improve the coordination of services between these two bodies, establish an improved National blood safety training facility, and strengthen the coordination of the National Blood Transfusion Quality Assurance and M&E. An appropriate site located in a compound adjacent to Mavalane Hospital (one of three major hospitals in Maputo City) that is property of the MoH has already been identified.

#### **Success Story**

Our success story describes the development of the Mozambican Training Manuals for Donor Services & Evaluation, and Infectious Disease Testing (ITD).

Before the development of these manuals, trainings did not have standardized didactical material, so that consistency and quality of training were hard or impossible to monitor. In 2006/07, the MoH NBTS and AABB teams collaborated to develop a didactical instrument that corresponded to the technical standards for blood safety and met the needs of the blood transfusion services. A well structured curriculum, combining practical and theoretical lessons, will allow for Mozambican trainers to conduct high quality trainings on Donor Services & Evaluation as well as Infectious Disease Testing (ITD). The training material includes a trainer's and a participant's manual together with systematic lessons for all the necessary content. The trainer's manual provides the trainer with step by step instructions for guaranteeing the continuation of high quality teaching within the country. The participant's manual is designed for use as a reference manual for blood bank personnel in Mozambique.

### Challenges and Key Actions needed to Scale-up Universal Access to Blood Safety

- Coverage is limited to the same extent as access to health facility-based services in Mozambique. Overall, access is limited to an estimated 40-50%, with many remote and rural areas having limited or no access to facility-based health services.
- Many emergency blood transfusions occur outside blood transfusion centres.
- Health facilities without blood banks are sometimes still obliged to carry out a blood transfusion without having the possibility of testing. The number of these unofficial transfusions is unknown, because they are not captured by the existing monitoring systems.

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

**Table 5: Percentage of donated blood units screened for HIV in a quality assured manner, January to September 2007.**

Method of Measurement	Value
<b>Numerator:</b> Number of donated blood units screened for HIV in blood centres/blood screening laboratories that have both: (1) followed documented standard operating procedures and (2) participated in an external quality assurance scheme	15,253
<b>Denominator:</b> Total number of blood units donated	42,965
<b>Indicator Value:</b> Percent	35.5%

(Source: National Blood Transfusion Program - DNAM/MoH/Mozambique, 2007)

**Interpretation of the indicator data:** The National Blood Transfusion Programme presently screening 100% of blood for major transfusion transmitted Infections (TTIs). However, according to **Table 4** only 35.5% of blood units are screened in a quality assured manner.

## 2.2 Prevention of Mother-to-Child Transmission

### Background

In 2007, it was estimated that there were 150,995 HIV+ pregnant women in the country, which, in the absence of interventions, would result in an estimated 50,000 new paediatric infections.

The Ministry of Health initiated prevention of Mother-to-Child Transmission (PMTCT) activities in April 2002. By end 2002, eight PMTCT sites were established in the cities of Maputo, Beira, and Chimoio. In 2004, the Ministry of Health decided to raise the PMTCT component to a national programme, and it was included in the National Strategic Plan on HIV/AIDS for the Health Sector (*PENSAUDE 2004-2008*) as well as in the National Strategic Plan on HIV/AIDS (*PEN II 2005-2009*).

The percentage of women who has at least one antenatal visit is relatively high (83%<sup>2</sup>) in Mozambique, and 53% of women have more than four visits. The Ministry of Health considers that a complete package of antenatal care consists of five visits. Only 18% of women have the first antenatal visit in the first trimester of pregnancy. The percentage of institutional deliveries is just under 52%. Coverage of postnatal care is 66.9% within two days.

### Scaling up of services

At the start up of the PMTCT programme, the prophylactic protocol used was single dose Nevirapine for pregnant women, to be handed out at 36 weeks of pregnancy, and single dose Nevirapine for newborns. Rapid HIV tests were included in the intervention package from the start of the programme. PMTCT interventions were provided in the health centres' compounds, but in many facilities, some components (like counselling and testing) were provided in separate consultation rooms or in annex buildings.

Since early 2006, in line with the Ministry of Health's policy on integrated networks for service delivery, an increasing number of health facilities physically integrated PMTCT rooms or structures into the health facilities and PMTCT services became an integral part of the maternal and child health services. Functional integration has been occurring in other services. By end 2007, this integration of PMTCT has been achieved in practically all health centers providing PMTCT services.

In addition to the integrated networks, other policies were introduced to facilitate the expansion of PMTCT services and strengthen the quality of services. In November 2006<sup>3</sup>, the Ministry of Health issued a guidance note introducing several key policies. Provincial health authorities were given the authority to approve PMTCT protocols of implementing partners when they meet the requirements set by the Ministry of Health. Provider initiated ("opt out") testing was recommended in both antenatal care and maternity settings. The guidance note recommends that blood samples for CD4 count are drawn in the antenatal care facility, avoiding the need for women to visit a different service point for this purpose. DNA PCR testing was introduced for HIV exposed children under 18 months of age.

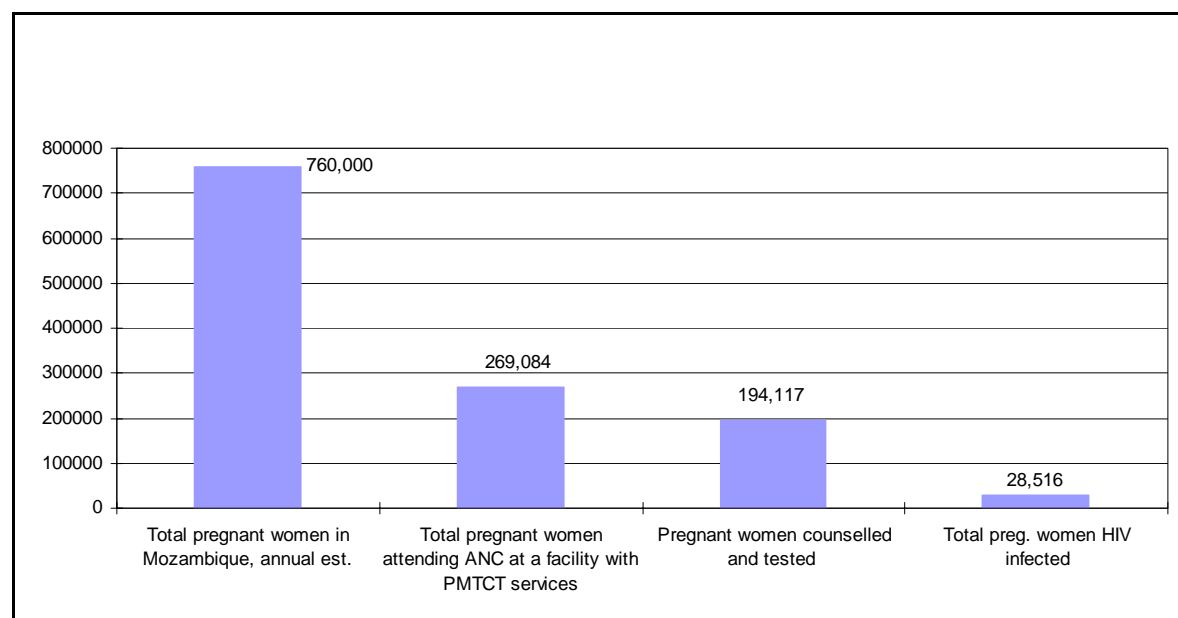
The establishment of mother support groups by health facilities is included in the guidance note, as well as the recommendation to revitalize the consultations for at-risk children. The use of combination therapy for prophylaxis (Single dose NVP during delivery plus AZT from 28 weeks) was introduced officially and the provision of NVP to pregnant women shifted from 36 to 28 weeks. It is felt that all these policies have facilitated the scale up of PMTCT services to a great extent.

<sup>2</sup> All data in this paragraph: DHS 2003 / Moçambique Inquérito Demográfico e de Saúde 2003

<sup>3</sup> Ministry of Health Circular No. 7820/GPS-3/DNS of November 2006

In April 2007<sup>4</sup>, the Ministry of Health developed targets for each province, for the number of women and children receiving PMTCT services (including ART for pregnant women). The provincial authorities were expected to develop and share district level targets. Achievements against these targets can be discussed during progress meetings and supervision visits. The prophylactic regime including 3TC during delivery and 7 days postpartum was also introduced in April 2007. In September 2007<sup>5</sup>, maternal and child health nurses and health technicians were authorized to prescribe ART for pregnant women.

Figure 7: PMTCT Antenatal cascade (2006 data).



[Source: MISAU/PMTCT Program, 2006]

### Achievements

The number of PMTCT sites has increased to 386 by December 2007, up from 222 by end 2006. The number of health centers with antenatal care facilities is almost 800, which means that almost half of the antenatal care sites are now offering PMTCT services.

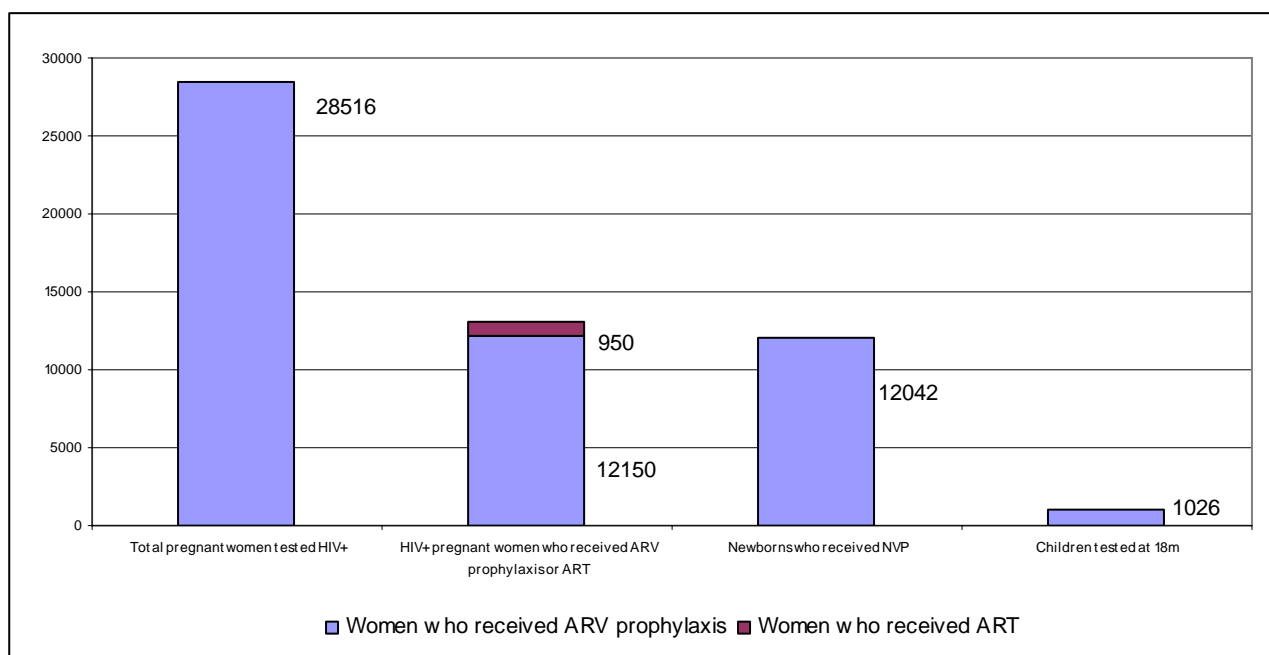
In 2006, the total estimated number of pregnancies in Mozambique was 760,000, and 35% of these women (269,084) received antenatal care at a health facility with PMTCT services. The number of pregnant women receiving counselling and testing in PMTCT services has increased from 4,641 in 2002 (82% of women attending antenatal clinics with PMTCT services) to 194,117 in 2006 (72%) and 366,281 (48.6%) in 2007.

The number of HIV+ pregnant women receiving ARV prophylaxis has increased from 253 in 2002 (27% of women who tested positive) to 12,150 in 2006 (43%) and 44,975 (100%) in 2007. Coverage of ARV prophylaxis for the estimated overall HIV+ pregnant woman population was 0.2% in 2002, increasing to 8.3% in 2006 and 29.7% in 2007. The number of HIV+ pregnant women who receive ART for their own health has increased from 53 in 2003 (6.2% out of 20% pregnant women who tested positive estimated to be eligible for HAART) HIV+ to 3,647 in 2007 (41.5%). The number of children tested increased from 14 in 2003 to 1,026 in 2006 and 1,976 in 2007.

<sup>4</sup> Ministry of Health Circular No. 7/PMS-1/GM of April 2007

<sup>5</sup> Ministry of Health Circular No. 3282/GPS-3/DNS of September 2007

Figure 8: PMTCT Antenatal and postnatal cascade (2006 data).



(Source: MISAU/PMTCT Program, 2006)

Antiretroviral treatment (ART) for pregnant women was introduced in 2003, when 53 pregnant women initiated ART. The number has gradually increased to 950 in 2006 and 3,647 in 2007.

The PMTCT protocol recommends that HIV+ pregnant women receive infant feeding counselling to make an informed choice for an infant feeding method. A balance of risks assessment<sup>6</sup> concluded that in virtually all circumstances, short duration (6 months) “safer” breastfeeding would result in fewest infections and deaths. With only 30% of children under six months being exclusively breastfed<sup>7</sup>, it is a challenge to ensure exclusive breastfeeding by women living with HIV.

It has been found that there is a significant difference between HIV+ mothers and mothers of unknown status, in the mean intended age of weaning reported by mothers. In a study in three provinces<sup>8</sup> this age was 10.6 + 7.0 months for HIV positive mothers and 21.7 + 5.4 months for mothers of unknown HIV status. It has been observed, however, that many HIV+ mothers continue breastfeeding well into the second year. The same study found that in two provinces, a diet that is adequate in most nutrients (low in iron) can be developed using locally available foods, but in one province an adequate replacement diet can not be developed with local foods. The nutrition policy is currently being revised to recommend an evaluation of the AFASS<sup>9</sup> criteria before deciding on breastfeeding cessation, thus placing greater emphasis on the mothers’ individual circumstances in making a feeding recommendation.

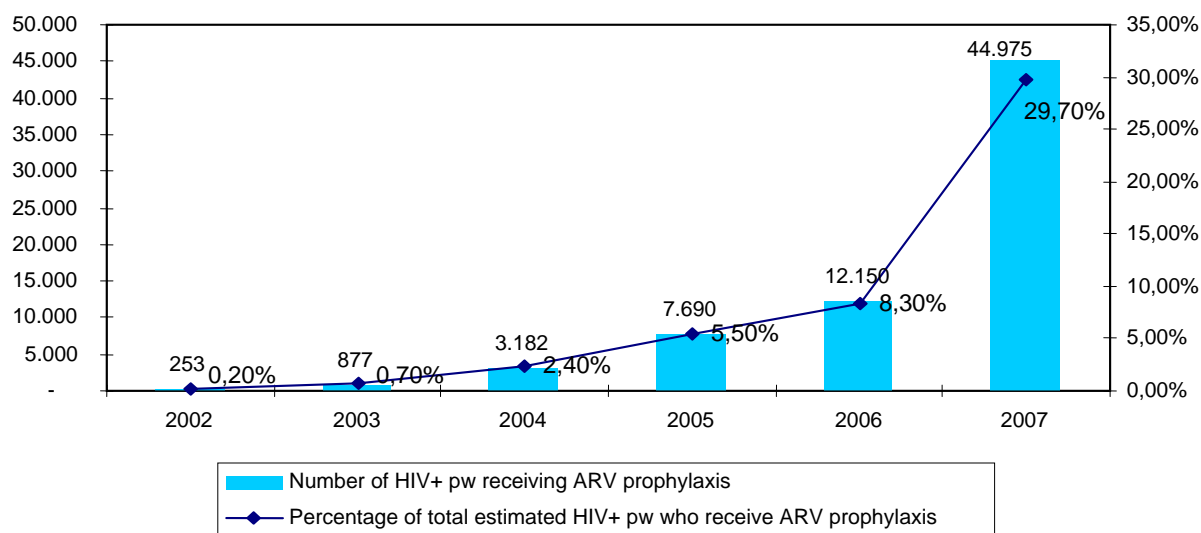
<sup>6</sup> Balancing the risks, L. Fidalgo, K. Selvester, nutrition, September 2005

<sup>7</sup> DHS 2003 / Moçambique Inquérito Demográfico e de Saúde 2003

<sup>8</sup> Source: “The challenge of providing adequate infant nutrition following early breastfeeding cessation by HIV-positive, food-insecure Mozambican mothers”, EGPAF/HAI/Ministry of Health, abstract presented at the Toronto IAS, July 2006

<sup>9</sup> Affordable, Feasible, Acceptable, Safe and Sustainable

Figure 9: Numbers of HIV+ pregnant women receiving ARV prophylaxis and percentage of the total number of estimated HIV+ pregnant women in the country receiving ARV prophylaxis from 2002 - 2007.



[Source: MISAU/PMTCT Program, 2007]

Knowledge of mother-to-child transmission and its prevention was quite low in 2003: Only 26% of women and 32% of men knew that HIV can be transmitted via breastfeeding and that the risk of transmission can be reduced if the mother takes medicines during pregnancy. Few specific communication activities are currently carried out. A communication strategy on PMTCT was developed in 2005 and it is being updated in 2007.

### Collaboration with partners

The Ministry of Health collaborates with various technical and implementing partners and donor organizations for the implementation of the PMTCT programme. To ensure coordination between the relevant Ministry of Health Departments and the partners, the Ministry of Health established a PMTCT Task Force in 2002. This task force meets around four times per year and has proven to be a key mechanism for discussions about programme progress, sharing of constraints and lessons learned and policy discussions.

#### Activistas provide psychosocial support

Since 2006, several NGOs, including Elizabeth Glaser Paediatric AIDS Foundation (EGPAF) and Health Alliance International (HAI), in collaboration with the Ministry of Health, are recruiting women living with HIV who participated in the PMTCT programme, or women from community based organizations, as peer supporters called "activistas". They perform a variety of tasks to support HIV+ pregnant women and their children, with some differences between organizations. The tasks can include: accompany women diagnosed as HIV+ in the health centre, facilitate, together with nurses, mother support groups and visit defaulting women and their children in their homes. It is expected that the involvement of these activistas will help reduce drop outs from the PMTCT programme.

### Key Actions needed to scale-up Universal Access to PMTCT

- Reduce the loss to follow-up of women and children due to (fear of) stigma and discrimination, insufficient human resources to pursue clients who dropped out and insufficient family and community support;

- Increase the number of pregnant women receiving ART for their own health;
- Ensure sufficient qualified human resources;
- Strengthen the coordination between PMTCT and other HIV prevention and treatment programmes: need for alignment and consistency in protocols and guidelines as well as planning;
- Ensuring and strengthening the quality of maternal and child health services in general, which affects quality of PMTCT services ;
- Ensure support from family members, in particular men and mothers-in-law;
- Avoid missed opportunities for PMTCT by ensuring delivery of quality PMTCT services at identified sites;
- Increase institutional deliveries for HIV+ women and ensure post natal prophylaxis for women and newborns in non institutional delivery settings;
- Ensure optimal infant feeding practices for HIV exposed children, both before the age of 6 months and after that;
- Strengthen monitoring and evaluation including the availability of M&E tools that incorporate all aspects of the PMTCT programme and capacity at all levels to use these tools for service delivery improvement.

#### Involvement of men

One health centre in Maputo introduced a system to enhance male involvement in PMTCT. While only 2.7% of partners were tested when the invitation was done verbally and only to the partners of HIV+ women, this percentage increased to 9% when the invitation was done in writing and to the partners of all pregnant women. The health centre noted many challenges, including persisting attitudes not favouring the participation of men in antenatal care facilities, both the health facilities' clients as well as the staff.

Source: Increasing Partner Involvement in Antenatal Care Settings - Comparing Two Approaches, ICAP/Ministry of Health, Abstract presented at the IAS in Toronto in July 2006.

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

Table 6: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission (January to December, 2006/07)

Method of Measurement	Indicator Value	
	2006	2007
<b>Numerator:</b> Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission	12,150	44,975*
<b>Denominator:</b> Estimated number of HIV-infected pregnant women in the last 12 months	146,245	150,995
<b>Indicator Value:</b> Percent	8.3%	29.8%*

[Source: MISAU, 2007]

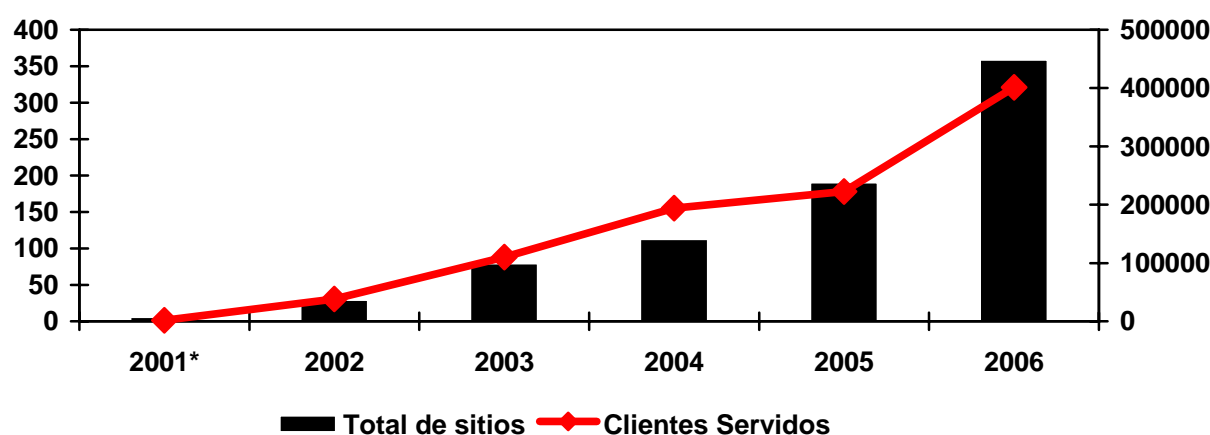
\*The figure may change because of availability of partial data for December 2007.

2.3 HIV Counselling and Testing

Background

Provision of HIV Counselling and Testing (CT) services began in Mozambique at four sites in 2000. According to Ministry of Health (MOH) data, 401.303 clients attended CT services at 359 CT sites in 2006, including 281 facility-based CT sites and 78 PMTCT sites providing CT services. These numbers represent an increase of 80% of clients served and 87% of CT sites compared to the calendar year 2005, an impressive achievement for Mozambique.

Figure 10: Number of CT Sites and Number of Clients Served, Mozambique 2001-2006



[Source: 2006 Report on Counselling and Testing for Health, NACP/MOH]

However service expansion has been primarily concentrated in the Central (53%) and Southern (36%) regions, and has been limited in the Northern region to 11% of sites.

The comparison of the population per province, estimated number of HIV infected people and number of CT service sites available in each geographical area shows the need to expand CT services throughout the country, but particularly in the so far underserved Northern Region.

Counselling and Testing Strategy

The national CT expansion strategy has undergone major changes since 2005, which aside from greater emphasis on expansion of Provider Initiated CT (PICT) in clinical settings, includes the "Counselling and Testing in Health" (CTH) approach being introduced to include health promotion and prevention activities aimed at increasing the number of people who access health services. This health promotion package proposes continuation and expansion of HIV counselling and testing as well as the inclusion of Tuberculosis (TB), Sexually Transmitted Infections (STIs) and hypertension screening and referrals where necessary, counselling on malaria prevention, environmental health education, and sexual reproductive health orientation - especially in relation to early pregnancy diagnosis and promotion of institutional delivery. With the support of partners, the MOH has released a National Guideline on CTH that was made available to Provincial Health Directorates and CTH services sites.

Table 7: Mozambique C&T services showing number and % of population served, including the number attendees tested and the equivalent HIV prevalence rates, 2006.

Province	Attendees served		Attendees tested		
	Number	%	Tested	HIV+ (#)	HIV+ (%)
Cabo Delgado	11,906	2.97	11,761	3,569	30.35%
Inhambane	14,884	3.71	14,454	4,177	28.90%
Gaza	42,073	10.48	40,693	15,935	39.16%
Manica	30,099	7.5	29,767	8,620	28.96%
Maputo-Cidade	65,914	16.42	65,442	19,904	30.41%
Maputo-Provincia	43,706	10.89	42,764	13,582	31.76%
Nampula	15,651	3.9	15,309	4,765	31.13%
Niassa	16,779	4.18	16,036	3,998	24.93%
Sofala	60,345	15.04	59,878	20,846	34.81%
Tete	32,235	8.03	31,983	8,797	27.51%
Zambézia	67,711	16.87	66,286	17,081	25.77%
<b>Total</b>	<b>401,303</b>	<b>100.00</b>	<b>394,373</b>	<b>121,274</b>	<b>30.75%</b>

[Source: MOH-2006 Annual Report on Counselling and Testing For Health]

Human resources continue to be a challenge in the health sector of Mozambique especially in relation to counselling and testing activities. Direct observation in the Maternal Child Health Services shows that replacement of lay counsellors by health providers is adding to the burden of work for nurses with the risk of lowering the quality of HIV testing as well as administration and adherence to Anti-Retroviral (ARV) prophylaxis or treatment where applicable. In an effort to create a cadre of multi-task counsellors who can provide counselling and testing for HIV in CT sites and clinical settings, appropriate referrals for HIV infected and negative clients and treatment education among many other duties, partners have been providing technical assistance to MOH helping in the definition of roles and outline responsibilities for counsellors who will be able to take on non-clinical tasks - to-date mostly taken on by nurses - and contribute to task-shifting efforts.

### Key achievements

Partners and stakeholders have advocated strongly for expansion of CT services as well improved linkages with TB and STI services. Assistance has been provided to the MOH to align their policy to the revised UNAIDS/WHO recommendations and guidance on PICT. CT service provision for patients with Sexually Transmitted Infections (STIs) remains a challenge in Mozambique, as STI services are embedded and provided as part of the general outpatient services. During 2006, all TB program supervisors from the MOH were trained as CT trainers. CT trainings are being rolled out to facilitate service provision through TB program staff in all 11 provinces. Efforts are being made with support from partners and donors for a better coverage and expansion of CT to hospital in-patients services where a high proportion of HIV-infected patients are expected and patients can be referred to ART services available at those hospitals.

Referrals constitute an important part of the CTH activities with the inclusion of TB, STIs and hypertension screenings at CT sites symptomatic patients (both HIV infected and HIV negative patients) are being referred to services as needed. This is one of the most important potential improvements resulting from the new CTH approach.

In addition to supporting PICT in clinical settings, partners have supported the MOH and National AIDS Council (NAC) in the establishment of the first community-based CT (CCT) services in Mozambique, during 2006/7. These services are being implemented in five provinces with strong support from international and national NGOs and Faith Based Organizations (FBOs) testing different models such as: CT services delivered at non-traditional locations (e.g. churches and mosques); satellite CT services at fixed locations (i.e. mobile CT teams providing services at health facilities

where CT services are not yet available on a daily basis); CT campaigns at markets and other non-traditional locations; and home-based (door-to-door) CT services. Of the 9,094 people that were reached (from January- September 2007) through different modalities, 98.7% accepted being tested. Of the 2,868 people counselled and tested through door-to-door activities, 27.4% were children less than 15 years of age and 13% were couples. A significant result of this initiative is women and children accessing CT and being referred for treatment and care through home-based CT. The expansion of CCT activities has recently been approved by the Minister ensuring direct MOH and NAC involvement, coordination, and quality assurance.

Increased capacity for CT data management is one of the key challenges for monitoring CT scale-up. In late 2005/early 2006, the patient-level data entry and management system collapsed because human resource losses at the central level and only aggregate CT data are available for 2006 and 2007. With the increase of services in multiple settings in Mozambique, routine CT data collection and compilation has become considerably more complex. These data are crucial to inform program planning and improvements, to correctly forecast of HIV Rapid Tests and ARV needs, and to produce accurate and timely reports for both internal MOH use and for various donor initiatives supporting CT services. With technical assistance provided by partners, the MOH is currently revising the national CT data system to accommodate new and changing program needs and to be compatible with existing M&E systems in other MOH program areas.

**Key Actions needed to scale-up Universal Access to Counselling and Testing:**

- Increase CT access for couples and families, with particular attention on support to discordant couples
- Expand access of early HIV diagnosis through door-to-door counselling and testing specially in high prevalence areas.
- Improve policies for increasing access to counselling and testing among Most At Risk Populations
- Increase the number of counsellors at CT sites as well as in clinical settings deploying trained multi-task counsellors
- Expand the PICT in clinical setting paying special attention to TB, STI and paediatric clinics

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

Table 8: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.

Method of Measurement	Disaggregated Values					
	All 15-49	Sex		Age		
		Males	Females	15-19	20-24	25-49
<b>Numerator:</b> Number of respondents aged 15-49 who have been tested for HIV during the last 12 months and who know their results	306	58	248	87	94	178
<b>Denominator:</b> Number of all respondents aged 15-49	15,318	2,900	12,418	3,127	2,860	8,921
<b>Indicator Value (Percent)</b>	2%	2%	2%	2.8%	3.3%	2%

[Source: DHS, 2003]

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

Currently no data exists for this indicator.

## 2.4 Prevention of Sexually Transmitted Infections (STI)

### Background:

Sexually transmitted infections (STIs) are a significant public health problem in both developed and developing countries. Untreated STIs may result in pelvic inflammatory disease, chronic abdominal pain, and infertility. Data from biological and epidemiological studies have demonstrated that both ulcerative and non-ulcerative STIs facilitate HIV transmission.

### STI Strategy:

The STI component is part of the National HIV/AIDS Control Program within the Ministry of Health. It establishes as main priorities: i) strengthening of HIV/AIDS and STI prevention, and ii) Improvement of diagnostic capacity and STI treatment. Although a specific strategic document for STIs is under development its activities are being guided by the PEN Saude and it established the following strategic objectives for 2007:

- a. Reduction on number of children with congenital syphilis and increase the number of women diagnosed and treated for syphilis;
- b. Increase on number of cases of genital ulcers diagnosed and treated correctly;
- c. Improvement of quality of diagnosis and treatment of STI patients;
- d. Improvement of patients' adherence to health facilities for STI treatment.

### Achievements:

All of the outpatient clinics in the country are already fully capacitated to diagnose and treat STIs according to the PEN-SAUDE. STI clinics are already integrated within the clinical outpatient services offered in all of the country's health facilities.

According to the STI Program for the first 3 quarters of 2007 (January to September), 508,685 STI cases were reported against 388,195 reported in the same period of 2006. Contacts of the STI patients represent 29% of the reported cases in 2007 and 26.2% in 2006. Females are the most affected group, comprising 59% of reported cases in 2007 and 57% in 2006. The most affected age group is 20 years and above representing 79% of the STI cases in 2006 and 2007.

The STI Program undertook syphilis screening on pregnant women using RPR tests, during the antenatal consultations. In 2007, out of 784,066 women who attended the first consultations, 510,164 were screened for syphilis, thus representing a coverage rate of 65%. Out of these, 43,913 tested positive, representing a prevalence rate of 8.6%. For the same period in 2006, 482,118 attended the first consultations, 64.9% were screened for syphilis and out of these 14.1% were positive. This significant reduction on STI prevalence is due to improvements introduced at the health facility, like better follow-up of mother at antenatal clinics and on treatment.

The STI programme distributed rapid test at national level to ensure syphilis screening at the antenatal consultations on health facilities without laboratory.

In 2007, the STI national program distributed 40,000,000 condoms against 21,000,000 distributed for the same period in 2006. Additionally, 25,000,000 millions of condoms were distributed with support of the MOH partners, against 21,000,000 in 2006. Thus showing a great improvement on condom distribution by the MOH and partners.

### **Major constraints for STI prevention and service delivery**

- Weaknesses on drug distribution chain;
- Lack of funds for training of service providers on the syndromic new approach;
- Lack of basic materials for physical examination of patients, which would improve the quality of diagnosis.

### **Collaboration with partners**

The STI unit within the HIV and AIDS Programme in the Ministry of Health is supported by four other MOH Units (Sexual and Reproductive Health Department, Youth Friendly Services Unit, Health Education Unit) and collaborates with four technical and implementing partners and donor organizations (WHO, CDC, FHI, UNFPA and JSI), for the implementation of the STI programme. To ensure coordination between the relevant Ministry of Health Departments and the partners, the Ministry of Health established a STI Task Force in 2006.

### **Key interventions required to ensure universal access to STI services**

1. Need for improved reporting of STI cases and routine program monitoring, through more timely submission of data and reports at district and provincial levels, improved capacity to compile and analyze data among STI program managers and supervisors
2. Coordination with CMAM to adjust STI drug procurements to approved revised STI algorithms and treatment protocols
3. Development and implementation of a strategy to improve partner notification. Currently < 30% of partners are notified. Examples of possible measures: STI medications free of charge for partners, closed invitations sent out to partners.
4. Revitalization of Maputo Central Hospital Reference Consultation as well as establishment of STI reference consultations at all provincial hospitals (currently in place only in Tete).
5. Increased and improved support to the STI reference laboratory at the Faculty of Medicine, so that it can support reference consultations, establish quality control for STI laboratory testing, conduct training and supervision
6. Strengthening of IEC and community-based activities for both prevention and early diagnosis and treatment of STIs
7. Improvement of condom distribution system.

## 2.5 Knowledge about HIV Prevention and Prevention Programmes (Young people)

### Background

Mozambique's young people<sup>10</sup> represent over a third of the country's total population and the nation's most important resource for the future. Yet the estimated six million young people aged 10-24 years face enormous threats to their health and wellbeing. These include increasing rates of HIV infection, high rates of maternal morbidity, mortality and unsafe abortion resulting from early and unprotected sexual activity, inadequate services, violence and exploitation. Sixty percent of new HIV infections occur in the 15-24 age group. Young girls face the burden of HIV infection, with HIV infection rates among girls aged 15-19 three times higher than their male counterparts (8.9% vs. 2.9% in 2005). (Ministry of Youth and Sports: Draft Policy Note HIV and AIDS, 2005)

Although most young people in Mozambique have heard about AIDS (over 95% in 2003) and knowledge about HIV and HIV prevention has greatly improved from 1997 to 2003, it still is extremely low. The proportion of young women in the age group 15 to 24 knowing that the use of condoms can prevent HIV transmission has risen from 13% in 1997 to 25% in 2003. Yet only 47% of young women and 63% of young men are able to identify two principle means of protection against HIV infection. The levels of knowledge vary greatly between provinces and depend on the level of education. Also the level of misconception about HIV transmission remains very high. For example, in 2003, over half of young people believed that HIV can be transmitted by mosquito bites. (UNICEF (2006): Childhood Poverty in Mozambique, A situation and trend analysis)

In addition, a serious gap exists between knowledge about HIV and taking action to prevent its transmission. While the use of condoms among young people has greatly improved, it is still very low. In 2003, 12% of young women and 27% of young men had used a condom the last time they had sex, compared to 2% and 11% respectively in 1997. There are massive differences related to education level, with only 1% of young women with no education using a condom the last time they had sex compared to 46% of young women with secondary or higher education. Also the level of testing for HIV among young people is very low, estimated at less than 5% in 2003 (UNICEF (2006): Childhood Poverty in Mozambique, A situation and trend analysis).

Reasons for differences in levels of knowledge and behaviour are many and complex. In many places services such as testing facilities and condoms are not easily available. Young people may lack the psychosocial life skills to apply the knowledge effectively. Girls especially may lack the assertiveness and negotiation skills to extricate themselves from situations in which they may be at risk of contracting HIV and boys may be unable to ignore peer pressure to start having sex at an early age and to have multiple partners and frequent sexual encounters (UNICEF (2006): Childhood Poverty in Mozambique, A situation and trend analysis).

### Policy and Institutional Context

The Government of Mozambique indicated its commitment to adolescent and youth issues by ratifying in 1996 the *National Youth Policy*, revised in 2006. The policy aims to empower youth to have a voice in decisions that affect them, and promotes and implements programmes that ensure their access to information and high quality sexual and reproductive health (SRH) services. One of the major components of the Ministry of Youth and Sports policy is the promotion of youth associations. (Estratégia de Desenvolvimento Integral da Juventude, GOM. August 8, 2006)

The Ministry of Youth and Sports (MJD) addresses the prevention of HIV and reduction of its impact on youth aged 10 to 24 through out of school activities. In 2000 MJD approved the Outreach Strategy

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<sup>10</sup> Young people/women/men in this text refer to the 15-24 age group, unless specified otherwise.  
01/02/2008

for Youth Outside the School System and the AIDS Operational Plan (Plano Operacional de Combate à SIDA - POSIDA). The strategy addresses HIV prevention through: 1) HIV and STI prevention activities for out of school youth; 2) Advocacy activities to reduce misconceptions about HIV, improve the rights of people living with HIV, and to increase financial resources for programmes; and 3) Capacity strengthening of the Ministry to coordinate, monitor and evaluate programme activities. The Ministry works to strengthen youth associations and give a voice to young people to ensure active leadership to raise the concerns of youth to a higher political forum. In 2007, the Ministry hosted a National Youth Conference on HIV and AIDS which debated questions around HIV infection, stigma and discrimination, the relationship between HIV and AIDS and poverty, and the role of youth leadership in HIV prevention (Plano Estratégico Nacional de Combate ao SIDA, Ministério de Juventude e Desportos).

The communication strategy of the NAC was finalized in 2006 and roll-out of the strategy continues to take place through the development of communication plans at provincial level and the creation of provincial communication groups. The Window of Hope campaign, developed in 2007, reaches to children and youth aged 5 to 24 with different interventions to address issues of SRH, body image and self esteem (Estratégia Nacional de Comunicação para o Combate ao HIV/SIDA, CNCS, Junho de 2006). The communication initiatives are supported by a working group (G-12) comprised of government, civil society, bi-lateral, and multi-lateral partners.

Since 1999, the Government has rapidly expanded a network of YFHS; where young people aged 10 to 24 have free access to information about HIV and AIDS. The YFHS are however mostly attended by young people from urban areas and less than 10% of attendees are within the "window of opportunity" age group (i.e. 10 to 14).

Other major HIV prevention initiatives include the establishment of the Prevention Reference Group and the Presidential Initiative (see Section on Best Practices).

### **Key Achievements**

- Approval of the National Communication Strategy and its operationalization at national and provincial level.
- Integration of HIV & AIDS in the basic education curriculum
- Expansion of youth friendly health services
- Appointment of a project officer responsible for youth in CNCS
- Establishment of the high level HIV Prevention Reference Group

### **Key Challenges**

- Lack of youth involvement in policy and decision making
- Little data on youth behaviour
- Lacking evidence of impact of existing prevention activities
- Limited capacity for design and implementation of prevention activities
- Limited human resources
- Conservative, fragmented, top-down models of communication
- Scale and intensity of appropriate interventions insufficient

### **Key Actions needed to Scale up Universal Access to HIV Prevention**

- Strengthen evidence on drivers of the epidemic and current response
- Identify global, regional and local best practices in prevention

- Strengthen M&E systems to accurately capture data
- Produce strategic reports to guide HIV-prevention strategy and activity implementation
- Strengthen capacity of key stakeholders to translate evidence into improved national prevention strategies, plans and budgets
- Scale-up a holistic approach to socio culturally sensitive communication, with clearly defined budgets for communication beyond IEC materials, based on existing communication strategy.
- Strengthen the national HIV-prevention strategy
- Scale-up effective prevention measures
- Improve coordination of prevention programmes

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

From 2003 to 2005 only one representative population-based survey, measuring HIV and AIDS-related knowledge, behaviour and attitudes throughout the country, was carried out: the Demographic and Health Survey (DHS) of 2003. In 2000-2001, the Ministry of Health conducted a first round of behaviour surveillance among young people living within the catchment area of the 36 HIV surveillance sentinel sites, but there has been no subsequent second round. The questions in the surveillance were also asked in a different way from that required for the calculation of the UNGASS indicators. At the same time as the Ministry of Health survey (2001) a National Survey on Reproductive Health and Sexual Behaviour among Young People and Adolescents (INJAD) was conducted, although it did not measure behaviour in the same way as the DHS. The Ministry of Health is planning a national population-based Sero-behavioural survey in 2008/09, which would measure HIV and AIDS-related knowledge, behaviour and attitudes.

In the DHS, respondents were asked if they had ever heard about HIV and AIDS. Those who had were asked if they thought a healthy-looking person could have HIV, and if they knew ways to prevent HIV. They were then specifically asked if they thought that (1) the risk could be reduced by having sex with only one faithful, uninfected partner; (2) the risk could be reduced by using condoms; (3) a person could contract HIV from mosquito bites; and (4) a person could contract HIV by sharing a meal with someone who is infected. The percentage of people that gave a correct answer to all the questions is presented in Table 8.

**Table 9: Percentage of people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and are able to reject major misconceptions about HIV prevention, by sex and age group.**

Method of Measurement	All 15-24	Disaggregated Values			
		Sex		Age	
		Males	Females	15-19	20-24
<b>Numerator:</b> Number of respondents aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	1,647	420	1228	880	767
<b>Denominator:</b> Number of all respondents aged 15-24	5,986	1,076	4,910	3,127	2,860
<b>Indicator Value (Percent)</b>	<b>28%</b>	<b>39%</b>	<b>25%</b>	<b>28%</b>	<b>27%</b>

[Source: DHS, 2003]

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

Behaviours that put people at greater risk of HIV infection include high rates of unprotected sexual partnerships, unprotected anal sex with multiple partners, and injecting drugs with shared equipment and drug preparations (UNAIDS, 2007). Thus, most-at-risk populations (MARPS) for HIV infection include sex workers, clients and partners of sex workers, injection and non-injection drug users, partners of drug users, partners of people living with HIV (PLWHIV) and men who have sex with men (MSM). Other populations that are at increased risk of infection may include men and women with multiple sexual partners, street children, and male prisoners. It is important to note further research and discussion is needed to determine the priority MARPS groups within Mozambique.

### Policy and Institutional response

So far, there has been limited attention placed on most at risk populations and limited policy and institutional response. Nonetheless, in 2007, a number of events were carried out in an attempt to raise awareness and start addressing HIV/AIDS in some groups of most at risk populations. Accordingly, the National AIDS Council (NAC) held a meeting in April 2007 to raise awareness and start a multilateral dialogue among different stakeholders about alcohol consumption and HIV transmission. During the meeting evidence from other African countries where HIV risk behaviour and prevalence was higher among alcohol abusing groups was presented. Recommendations of the meeting included to involve all society sectors in the development of suitable policies and strategies to address the concurrent epidemics of alcohol consumption and HIV, mainly among the young generations. Secondly as African countries have become more aware of the need to address needs of vulnerable groups besides the general population, Sub-Region conference of SADC countries on HIV/AIDS and Sex Work was conducted in Maputo from October 31<sup>st</sup> to November 2<sup>nd</sup>, 2007. The meeting was organized by the NAC with support from UNFPA, and attended by stakeholders' from 5 African countries who discussed the strategies to advocate and design interventions to reduce HIV risk among sex workers. In addition, as part of a response to address HIV in most at risk populations, a National Prevention Reference Working Group, as well as a MARPS Working Group, was established in October 2007. Both government representatives as well as international and national stakeholders are actively participating in these working groups and will serve as an important advocacy tool to help guide and increase support and services for MARPS.

In October 2007, the National AIDS Council hosted the 1<sup>st</sup> sub-regional conference on HIV and Sex Work. The conference brought together government, civil society, NGOs, multi-lateral partners and sex workers from six countries in the region (Botswana, Lesotho, Malawi, Mozambique, Swaziland, and Zimbabwe) around issues of access to services, economic vulnerability and opportunities, laws, policies, and protection of rights, and issues of mobility and migration. The conference culminated in the Maputo Call for Action which called upon conference delegates to work in achieving a number of commitments towards better access to health, legal, and support services, elimination of violence and stigma and discrimination, and capacity building of NGOs and sex workers in accessing services, opportunities, and strengthening cross border partnerships. The conference was seen as a success in bringing to light issues that affect sex workers, giving sex workers a space and a voice to express their concerns and needs, and achieving a high level of political commitment necessary to ensure the reduction of HIV transmission to sex workers and their clients.

## **MARPS reached with HIV prevention programmes**

There have been limited MARPS targeted prevention programs to date. Prevention activities are mainly targeted towards sex workers while most other most-at-risk populations are not targeted with appropriate prevention strategies. The effectiveness of the small number of MARPS related prevention activities are still unclear as many programs addressing these populations are conducted by small NGOs and CBOs that may have limited capacity to monitor uptake and coverage of services and evaluate efficacy of prevention interventions. There are numerous organizations focusing on HIV-related prevention activities in Mozambique but few if any conduct targeted prevention activities with most-at-risk populations. Therefore there is a crucial need to not only focus on general HIV prevention activities but implementing specific MARPS related prevention activities.

## **Knowledge about HIV prevention among MARPS**

Currently, there is no nationally representative data regarding knowledge about HIV and STIs prevention among MARPS. Some studies have shown knowledge of male condom use amongst interviewed MARPS is relatively high. According to World Vision study (2005) 82.5% of women having sex with a paying contact used a condom during their last sexual contact. Of the commercial sex workers interviewed during this study, all had heard of male condoms and over 95% knew where to obtain male condoms. Along the same lines, 95.3% of long distance truck drivers interviewed knew where to obtain condoms. Other prevention methods such as the female condom are less known. For example, only 69.4% of commercial sex workers had heard about female condoms of which 12.8% had ever used a female condom.

### **International Rapid Assessment Response and Evaluation (I-RARE):**

In November 2007, the CNCS, the MOH, the University of Eduardo Mondlane (UEM), CDC and other stakeholders have started I-RARE in Maputo, Beira, and Nacala Porto.

#### **The assessment targets:**

- Women and men who are engaged in venue-based sex work
- Women and men who are non-injection drug users (NIDUs) and injection drug users (IDUs),
- Male clients of female sex workers
- Providers who deliver health or social services to or intervene with these populations.
- Policy makers who are in a position to influence regulation and policy or otherwise create an environment that either impedes or facilitates services for these groups.

#### **the rapid assessment's objectives are to:**

- Describe the sexual and drug using HIV risk behaviours of sex workers, including drug use among female venue-based sex workers, sexual risk behaviour among NIDUs and IDUs, and the potential for overlapping risk behaviours, mixing among these populations, and bridging to the general population.
- Identify and describe the range of available services for sex workers and drug users, and understand, from the perspectives of drug users, sex workers, and service providers, the barriers to accessing these services.
- Assess the acceptability of rapid HIV and syphilis testing among the target population
- Assess the prevalence of HIV and syphilis among the target populations
- Provide evidence-based recommendations for necessary changes or adaptation to existing services in order to better serve sex workers and drug users.

**The data are collected through trained field teams and consist of:** Observation and Mapping; Key Informant and Focus group interviews; Demographic survey; and Rapid HIV and syphilis testing (Maputo only)

The Mozambique I-RARE will utilize collaboration between international, national, provincial and local government and civil society organizations to recruit participants collect and analyze the data. This project will provide much needed knowledge regarding HIV risk behaviours amongst sex workers and drug users and lead to the development of interventions and modifications in services to better meet the needs of these high-risk populations. The rapid assessment will also serve to build capacity by training and entrusting analysis to the UEM.

## **Key Challenges**

There are several key challenges when working with MARPS. Currently, there is no HIV surveillance data or population size estimates for this group which presents a great challenge in assessing the scope of the problem and the scale of the response that is needed. Without data regarding the specific HIV prevalence and behavioural risk factors it is difficult to develop and implement appropriate prevention activities. Most studies point out high knowledge of male condoms, but condom use is still inconsistent among MARPS especially among partners of persons engaged in high risk behaviours. This is a key point of intervention--increasing condom use among both regular, long-term partners, and other paying or non-paying partners (UNAIDS, 2007). Another key challenge is the lack of resources directed towards most-at-risk populations. Since MARPS are harder to reach, many resources are diverted to more accessible populations. Even though it is difficult to reach these hidden and often mobile populations it is crucial to reach them with services as they can serve as a bridge for the spread of HIV into low-risk individuals within the general population.

It is also a challenge to understand the complex transmission routes and behavioural risk factors that may increase MARPS vulnerability to HIV. Interventions for MARPS may need to address multiple and overlapping drug and sexual risk behaviours, including unprotected anal and vaginal sex, sex with multiple partners, men who have sex with men, injecting and non-injecting drug use and alcohol use. For example, sex workers may use drugs to cope with their work and drug users may trade or sell sex to obtain drugs. Sexual mixing among various MARPS also occurs, and interventions also need to address the sexual partners of MARPS, such as clients of sex workers and spouses.

When addressing HIV and AIDS issues amongst MARPS it is crucial to understand the contextual determinants of risk amongst these groups. For example, women are at higher risk for HIV infection especially if women have migrant husbands as these women may need to resort to commercial or transactional sex to provide for themselves and their families (UNAIDS 2007). Men who are mobile and spend time away from home, traditional social structures and their regular partners (for instance, truck drivers, the military or migrant workers) are at increased risk of extramarital and non-regular sexual activity. Due to the gender differentials in Mozambique it is also often the case that wealthier men use their power to influence young women (both CSW/non-CSW) to have unprotected sex. Also the widely held acceptance of multiple concurrent partners among men may increase the transmission of HIV from urban to rural areas (USAID, 2001). Another key issue that may increase the risk of HIV transmission is the migration of miners who leave spouses and families behind. Many times these men will engage in high risk behaviour such as having engaging with sex workers, using injection or non-injection drugs, or having sex with men. These miners than return home to their spouses and can in turn infect them and spread the epidemic. When addressing HIV/AIDS issues within MARPS it is crucial to account for the various routes of transmission, behavioural factors, and complex networks to fully develop and implement effective prevention activities.

## **Key Actions needed to scale-up Universal Access to HIV prevention for MARPS**

- Partners alongside MOH and other Mozambique agencies need to prioritize MARPS groups within the context of Mozambique.
- Conduct sub-national data collection and estimations disaggregated by age and sex regarding HIV prevalence amongst MARPS groups.
- HIV prevention activities need to focus both on general prevention but also needs to include targeted MARPS prevention strategies.

- Addressing most-at-risk populations is difficult therefore a clear understanding of both the epidemiological situation and behavioural context of MARPS needs to be understood by all agencies working with MARPS
- Behaviour Change Communication efforts need to include specific interventions and materials targeting MARPS. This requires careful monitoring and evaluation of how existing and new BSS for MARPS actually reaches these hard-to-reach populations and how effective they are or will be in promoting prevention, contributing to risk reduction and greater access of services.
- Little attention has been paid to increasing and facilitating access of MARPS to HIV/AIDS and STI services. Promising models with night-time or moonlight clinics have been started by partners in Maputo City and Beira and expansion of such services is needed.
- Improved access to existing HIV and STI services should be enhanced through sensitization of staff about the needs for these particular populations and promotion of service up-take among MARPS.

**UNGASS Indicator# 9: Percentage of most-at-risk populations reached with HIV prevention programmes**

Currently no data exists for this indicator.

**UNGASS Indicator# 14: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**

Currently no data exists for this indicator.

## 2.7 Life Skills-based HIV Education in Schools

### Policy and Institutional Response

In the Ministry of Education and Culture's Strategic Plan (2005-2009), HIV and AIDS was recognized as one of the key threats to reaching universal access to education due to the impact of HIV and AIDS on teaching staff and students. It is estimated that 17% of teachers will be lost between 2000 and 2010 and the impact of absenteeism due to teacher illness or the need to care for family members has a dramatic effect on student's learning.

For these reasons, the Ministry of Education and Culture (MEC) adopted a strategy that would diminish the impact of HIV and AIDS of staff through workplace policies and of students through the development of life skills programming in schools, AIDS and Sexual Reproductive Health (ASRH) integration into the school curriculum, and provision of kits of HIV and AIDS information material. (*Resposta ao HIV/SIDA ao nível da Política e Estratégia no MEC, Ministério da Educação e Cultura ; Direcção de Programas Especiais, Julho 2006*). MEC has also developed a HIV and AIDS Communication strategy in schools to standardise the messages that are transmitted at different levels.

In 2005, the school curriculum underwent a revision which made provisions for locally adapted material and the inclusion of material on sexual and reproductive health for grades 1-7 and includes topics such as HIV and AIDS and STIs starting from secondary education grades. Teacher training on the new curriculum and pedagogical methods for the HIV and AIDS sections are on-going.

#### School Awareness Programme

Through a partnership between the Ministry of Education and Culture and the National Network of Associations of People Living with HIV & AIDS (RENSIDA), the School Awareness Programme reached 725 primary schools and approximately 469,367 children (of which 55 per cent were girls) in 10 provinces and Maputo city in 2007. The programme focuses on children aged 10 to 14 and the main strategy of the programme is to support the development of psycho-social skills to prevent HIV infection through life-skills sessions led by activists living with HIV. These sessions are extra-curricular activities in HIV & AIDS school clubs and include activities such as debates and interactive theatre work that enable children to identify and prevent various risk situations. Activists are trained in this approach through a range of educational materials.

#### School Kits

The school kits for children 8-16 years old provide didactic material and intra and extracurricular activities for the training of teachers in new teaching methodologies in life skills. The programme covers 4000 schools in three provinces and plans to expand to all primary schools in three additional provinces and expansion to a seventh province by 2007 (*Resposta ao HIV/SIDA ao nível da Política e Estratégia no MEC, Ministério da Educação e Cultura; Direcção de Programa Especiais , Julho 2006*).

#### Mundo Sem Segredos (World without Secrets)

This Ministry of Education and Culture programme, which began in 2003, has the objective of encouraging an open dialogue between children and other members of the community on sexual and reproductive health and HIV/AIDS. The children supported by the programme receive training on radio communication methodologies in order to develop programmes for their peers aged 12 to 15 years. The programme reaches six provinces and has improved the knowledge, attitudes, and behaviour of children who are reached by the radio programmes (*Mundo Sem Segredos, MEC*).

**Key Achievements:**

- Increased government ownership and buy-in to life skills methodology, despite the need for improvements
- Expansion of School Awareness Programmes in 2007 reaching 11 provinces, covering 56 districts;
- Establishment of coordination mechanism between MEC and provincial associations of PLWHIV
- Integration of life skills education into school curriculum
- Increased scale-up of life skills programmes, for example expansion of “Geração Biz” sexual and reproductive health programme for youth to all 11 provinces
- 43% of schools covered by basic package (school kits) and Geração Biz (Presentation by MEC, *Resposta do sector do HIV/SIDA, 2006*)

**Key Challenges:**

- Low commitment from policy makers to implement life skills programmes
- Lack of budget allocation for life skills based HIV education activities
- Little time allocated to teachers to teach life skills

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

- Training of school directors in the life skills methodology and importance of life skills for students
- Increased quality training of teachers on HIV and AIDS and life-skills approach
- Integration and coordination of different sectors and actors involved in life skills programming
- Creation of an enabling environment by and to teachers, directors, community members, and policy makers for the life skills approach to be implemented
- Strengthen systems to collect disaggregated data to monitor and evaluate all aspects of life skills based HIV education programmes at different national and sub-national level.

**UNGASS Indicator#11: Percentage of schools that provided life skills-based HIV education in the last academic year**

Currently no data exists for this indicator. A school-based assessment, measuring the percentage of schools that have provided life-skills-based HIV education, is planned for 2008.

## 2.8 Sexual Behaviour

The data in the tables below show that sexual activity continues to start at a very early age in Mozambique. By the age of 16 years approximately half of all young Mozambicans are sexually active. This tendency has become more pronounced in recent years. Disaggregated data by age group shows that adolescents in Mozambique are becoming sexually active at an even younger age than young people above the age of 20 years did previously. The age at which the first sexual experience occurs shows clear geographical differences. Somewhat surprisingly, sexual activity tends to start earlier in those provinces with the lowest HIV prevalence rates (the Northern provinces and Inhambane).

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

During the 2003 DHS, young people aged 15-24 were asked if they had ever had sex, and if so at what age. The percentage that was sexually active before the age of 15 is presented in Table 10.

Table 10: Percentage of young women and men aged 15-24 who had sexual intercourse before age of 15.

Method of Measurement	All 15-24	Disaggregated Values			
		Sex		Age	
		Males	Females	15-19	20-24
Numerator: Number of respondents aged 15-24 who report the age at which they first had sexual intercourse as under 15 years	1,665	280	1375	896	760
Denominator: Number of all respondents aged 15-24	5,986	1,076	4,910	3,127	2,860
Indicator Value (Percent)	27.6%	26%	28%	28.6%	26.6%

[Source: DHS, 2003]

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

During the 2003 DHS, women and men aged 15-49 were asked if they had had sexual intercourse in the previous 12 months. Those who had were asked about the type of relationship that they had had with their last sexual partner. This question was repeated if they had a second or third sexual partner during the same period. Table 11 below shows the proportion of all young people reporting sexual activity in the past year who had had a sexual partner with whom they were neither married nor co-habiting.

**Table 11: Percentage of women and men aged 15-49 who have had sexual intercourse with a more than one partner in the last 12 months**

Method of Measurement	All 15-49	Disaggregated Values				
		Sex		Age		
		Males	Females	15-19	20-24	25-49
Numerator: Number of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	3,459	1,101	2,358	1,196	812	1,426
Denominator: Number of all respondents aged 15-49	11,941	2,117	9,824	2,007	2,424	7,509
Indicator Value (Percent)	29%	52%	24%	59.6%	33.5%	19%

[Source: DHS, 2003]

The Table 11 shows that a large majority of young, sexually active Mozambican men and almost a quarter of young, sexually active Mozambican women reported having had non-marital sexual intercourse. The proportions are even higher in adolescents aged 15-19, with almost all sexually active young men reporting having engaged in high-risk sex.

Before 2003 no national survey measured higher-risk sex among young people in the same way. It is therefore not possible to detect trends. In the 2000-2001 survey conducted by the Ministry of Health among young people aged 15-24 living in the catchment areas of HIV sentinel surveillance sites, 26% of sexually active young women and 68% of sexually active young men reported having had a casual partner in the previous 6 months. During the 2001 National Survey on Reproductive Health and Sexual Behaviour among Young People and Adolescent<sup>s</sup> (INJAD), 31% of sexually active young women and 73% of sexually active young men reported that they were not married or living with someone. Both these surveys therefore appear to indicate a similar level of higher-risk sex as that measured in 2003.

## 2.9 Condom Use

### Policy and Institutional response

The availability of and access to condoms is an essential element in the prevention of HIV transmission. Increasing the rates of condom use is one of the specific objectives of the National Strategic plan for HIV and AIDS (PEN II). To achieve this the national plan proposes strategies to strengthen the distribution of condoms and promote the availability and accessibility of the female condom; improve the levels of acceptance of condoms, by inducing change in attitudes and through information and education targeting primarily young people, women and vulnerable sectors of the population.

### Key Achievements

The Government is expanding condom distribution. The National AIDS Control Program of the Ministry of Health (MOH) has distributed about 43 million male condoms in 2006 (21 million by the MOH and 22 million by PSI) and over 50 million in 2007 (approx 33 million by the MOH and 25 million by PSI). It has also started a female condom program. There have been no nationally representative surveys measuring reported condom use since the 2003 DHS. However, two large surveys, one focusing on urban and peri-urban areas and another on school-aged youth (ref: PSI 2004 and Geração Biz/Pathfinder 2005) suggest that condom use has risen substantially since the DHS (2003).

Increases in male condom distribution since the DHS also suggest a continuing increase in condom use. Distribution by the MOH increased from 11 million in 2005 to more than 30 million in 2007, while sales of socially marketed male condoms increased from 15 million in 2003 to 25 million in 2007 (Condom Working Group and PSI). At least one large NGO (World Vision) increased its free male condom distribution during this period as well (from 465,000 in 2004 to 760,000 in 2006 - ref: Condom Supply Survey). Though there has been an increase in the range of commercial male condom brands available in major urban areas, MOH and socially marketed male condoms distributed by PSI are estimated to represent 90% of the total market.

#### Measuring Coverage and Quality of Coverage of PSI Condoms:

In November 2005, PSI/Mozambique conducted a "Measuring Access and Performance" (MAP) study on condom coverage and quality of coverage of Jeito condoms in high-risk areas and residential areas in Beira. The findings were used to augment the program monitoring system, which collects information about sales volumes and penetration in specific outlet types. High-risk areas ("hotspots") are entertainment venues where people are likely to meet sexual partners, and in some cases where female sex workers are present. They are often located around or near markets, truck stops or other commercial centres. The study found that the coverage of Jeito condoms was relatively high in both high-risk areas (~81%) and residential areas (~70%). In high-risk areas, coverage is as high as 90% for 'usual' condom availability. Overall quality of coverage of Jeito was much lower (51% and 25%) because of the small number of outlets displaying promotional items. Very few outlets were found to sell other condom brands, showing that PSI accounts for most of the condom coverage in the study area.

### Collaboration among partners /Coordination of interventions

A Condom Working Group consisting of the MOH, NAC, PSI, John Snow International and other civil society actors has been in existence since 2005 and seeks improve policies, coordination and communications with respect to condoms.

### **Challenges and Key Actions needed to scale-up Universal Access to Condoms:**

- The DHS and the more recent surveys further suggest that condom availability, at least in urban and peri-urban areas, does not pose a substantial barrier to condom use. Barriers to condom use in these areas appear to be more related to partner dynamics (“trusting” one’s partner and self-efficacy). However, the relatively low reach of the formal health system and the commercial sector in rural areas continue to pose challenges to ensuring easy condom access for the rural population.
- Female condoms are generally not available in either the public or the private sector, and few NGOs distribute them. A recent initiative involving the MOH, NAC, and civil society has resulted in some 50,000 female condoms being distributed for free by trained activists in the Maputo area.
- Even if the PEN II target of 80 million condoms by 2007 and 150 million by 2009 were reached, it would bring Mozambique only half way compared to high-performing countries. There is evidence from studies by PSI in Mozambique that low demand for condoms may play a more significant role in low condom use than limitations in supply.
- The coordination between condom distribution and prevention must be ensured because condoms without messages on behaviour change or messages without condoms with both have limited effects. (World Bank Supervisory Mission MAP, Aide Memoire, March 2007)
- A significant boost in funding for and an expansion of the number of actors involved in condom-related education and promotion - especially in rural areas - will be necessary to achieve the PEN targets.
- Continuous funding for condom supply (both free and subsidized) will also be necessary - again, with emphasis on expansion in rural areas.

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

During the 2003 DHS, people aged 15 to 49 years were asked if they had used a condom they had sex. **Table 12** present the number who reported the use of a condom during higher risk sex. When prompted, about 58% of women and 72% of men mentioned specific ways to avoid HIV and AIDS—condom use or limiting sexual partners. Among women, knowledge of condoms as a specific way to avoid HIV is especially low in two provinces, Cabo Delgado (26%) and Zambezia (30%); among men, this knowledge is more uniform, although only 27% of men in Cabo Delgado mentioned condom use as a specific way to avoid HIV. Only 6% of women and 12% of men used a condom during last sexual intercourse. Most condom use occurred in non-cohabiting sexual relationships: 24% among women and 33% among men. For both women and men, condom use is higher in urban areas, among those never married, and among more educated respondents. Condom use is also higher among younger women.

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

Method of Measurement	All 15-49	Disaggregated Values				
		Sex		Age		
		Males	Females	15-19	20-24	25-49
<b>Numerator:</b> Number of respondents/population (aged 15-49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex	918	364	554	360	248	298
<b>Denominator:</b> Number of all respondents aged 15-49 who reported having had more than one sexual partner in the last 12 months	3,412	1,103	2,309	1,200	814	1,399
<b>Indicator Value (Percent)</b>	<b>27%</b>	<b>33%</b>	<b>24%</b>	<b>30%</b>	<b>31%</b>	<b>21%</b>

[Source: DHS, 2003]

**UNGASS Indicator #18:** Percentage of female and male sex workers reporting the use of a condom with their most recent client

Currently no data exists for this indicator.

**UNGASS Indicator #19:** Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Currently no data exists for this indicator.

**UNGASS Indicator #21:** Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse

Currently no data exists for this indicator.

## 2.10 Drug Use

The use of drugs, whether injection or non-injection, has implications for the spread of HIV, both through the sharing of needles and high-risk sexual behaviour associated with drug use. Data on drug use in Mozambique are also limited, however there is evidence that heroin from Southwest Asia enters seaports in Mozambique and is transported overland along routes from Maputo to cities in South Africa (UNODC, 2002, 2005). Mozambique is also reported to be part of transshipment routes for cocaine and club drugs, and there are reports that use of these drugs is on the rise in the country (U.S. Department of State, 2006).

The Department of Mental Health in Maputo reported increases in hospital admissions for drug and alcohol use from 8% in 2004, to 13% in 2005, and there are anecdotal reports of drug activity in the Colombia and Serrano neighbourhoods of Maputo. The use of drugs and alcohol among young people in Mozambique, as a means of coping with unemployment and poverty, and as part of changing social norms, has been reported in qualitative studies (Hawkins 2005; Wilson 2001). In addition to reports of increased drug use among female sex workers between 2002 and 2004 (World Vision 2005), there are also reports of drug dealers frequenting sex workers and trading drugs for sex with female drug addicts (Wilson 2001). In Mozambique more organizations are becoming involved on fight against drugs. The Youth Organization Against Drug (OJCD) supported by the Primer Minister is part of a Mozambican Network of National Organizations Against Drugs created in 1997. Studies in South Africa among sex workers and injection and non-injection drug users documented considerable overlap in drug and sexual risk behaviours, and mixing of drug using and sex worker populations (I-RARE, 2005). Risk behaviours included needle sharing, unprotected sex with multiple partners, using drugs with clients to enhance or prolong sex, and the selling of sex to finance drug addiction. The planned I-RARE is an important step in a proactive response to meeting the HIV prevention needs of high risk populations in Mozambique.

**UNGASS Indicator #20: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected**

Currently no data exists for this indicator.

## Treatment Programmes

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

### 2.11 Antiretroviral Therapy among Adults

#### Policy and Institutional Response

In 2002, the health sector was providing care and treatment for HIV/AIDS to less than two thousand people, primarily through private clinics, and Government policy<sup>11</sup> at that time allowed for the provision of treatment for health care workers infected with HIV during the course of their duties and prophylaxis for prevention of vertical transmission. Prompted by the increasing international and national emphasis on the provision of antiretroviral (ARV) treatment in developing countries, and the favourable environment in terms of decreasing costs and availability of generic ARVs, the Ministry of Health subsequently developed a strategy<sup>12</sup> for HIV/AIDS care and treatment through a joint process of consultation with its national and international partners. The approach taken to this strategy development was to ensure that issues such as long-term sustainability would begin to be addressed together with the broader needs of the health sector, using the focus on antiretroviral treatment as the impetus to ensure a balanced approach to HIV/AIDS in the health sector. The result was a comprehensive and balanced strategy that covers the whole spectrum from prevention through diagnosis to treatment, care and impact mitigation. It also undertook to ensure that issues of capacity at all levels are addressed as prerequisites to treatment and other complex service expansion. Treatment was also included as one of the seven priority areas of intervention in the multisectoral strategic plan for HIV/AIDS<sup>13</sup>.

#### Scaling-up of HIV and AIDS Services

The initial approach to scaling-up treatment as outlined in the National Strategy was centred on the concept of an integrated health network (IHN) which had as its focus the HIV/AIDS 'Day Hospital'. This initial vertical focus was necessitated by the fact that at that time there was little expertise available in relation to HIV/AIDS treatment and a specific focus was deemed necessary to safeguard the quality of clinical care (ARV treatment at this time was only initiated and followed by Physicians) and to provide a focal point for referral from other services. Since then, this approach has been changed in line with the directive from the Ministry of Health to integrate and decentralise HIV/AIDS care and treatment. Separate 'day hospitals' no longer exist except at the tertiary level and HIV/AIDS services are increasingly being integrated into existing services.

This approach was necessitated by the increasing numbers on treatment and therefore the growing burden of care on existing staff and facilities. A subsequent amendment to the existing policy in 2006 allowed for the provision of treatment by another cadre of health worker *Técnicos de Medicina* (health technicians). Follow-up to this decision was rapid with development of the curriculum and subsequent trainings being carried out by mid 2006. *Técnicos de Medicina* were initially trained to initiate standard first line protocols and to follow-up straightforward patients on treatment. This has now been amended and alternative first line treatments may be initiated in pregnant women, children and TB patients. Current consideration is being given to training of nurses to follow patients on treatment.

<sup>11</sup> Diploma Ministerial n° 01/PLS/GM/2001, de 17 de Dezembro de 2001

<sup>12</sup> National Strategic Plan for STIs/HIV/AIDS - Health Sector, 2004-2008

<sup>13</sup> National Strategic Plan for HIV/AIDS, 2005-2009

Oversight of the treatment component of the treatment programme has been carried out at a number of levels since its initiation. A 'Therapeutic Committee' has oversight for clinical and technical decisions such as choice and change of regimens; substitution options; clinical, immunological and virological monitoring of response to treatment; resistance monitoring, etc. A 'Treatment Management Committee' has oversight for implementation and management of the roll-out of treatment services, e.g. supervision; planning and setting of targets; collection and interpretation of data, etc. Given the rapidly increasing expansion of treatment, it is intended that some of the Therapeutic Committee functions will be decentralised to the provincial level with the setting up of provincial level therapeutic committees.

In 2007, the Ministry of Health increased its focus on ensuring quality of interventions across the HIV/AIDS programme. Supervision visits by Ministry of Health staff (from across all areas of the programme, including medicines) to all provinces are now carried out, together with the provincial coordinator for AIDS, TB, and Malaria and implementing partners. These visits focus on: (amongst others) record keeping, level of integration with other services, clinical follow-up including of adherence monitoring, loss to follow-up, etc. In addition, the Ministry of Health has begun to implement an internationally recognised quality assessment tool in the form of the HIV Qual programme. HIV Qual is a capacity-building model designed to build capability for quality improvement in health facilities and provides a systematic approach to: ongoing quality management program in a health facility providing HIV services: collection and analysis of data specifically related to HIV care processes and outcomes; and the use of data to develop and implement focused quality improvement projects. Included in this approach to monitoring of quality are efforts being made around resistance monitoring, e.g. monitoring of some of the WHO 'Early Warning Indicators'; phenotypic resistance typing; and some data from the sentinel surveillance survey on resistance in a treatment naive population.

### Achievements

As mentioned above, in 2002 ARV treatment was being provided to less than 2000 people, mainly through private services. Since implementation of the strategy began in 2003, tremendous progress has been made in the provision of services. The number of people on ARVs by the end of December 2007 was around 91% of the target of the Ministry of Health for end 2007 (being 96,420), approximately 7% of those were children less than 15 years old, while 62% were women. The number of sites now offering antiretroviral treatment has increased to 211 from 150 in 2006 and 38 in 2005. By June 2007 119 out of the then 200 ARV sites were also providing paediatric treatment. Given the increasing focus on expanding rural access and decentralisation of services, previous geographical inequities are now being addressed and all districts in the country currently have at least one treatment site. However, much remains to be done with respect to expanding further access as estimates show that approximately 50% of those in need of treatment have access in the southern region, 15% in the centre, and only 5% in the north.

Table 13: Updated HIV and AIDS Treatment Data 2003 - 2007

Categories	2003	2004		2005		2006		2007	
		Actual	Target	Actual	Target	Actual	Target	Actual	Target
# of Health facilities providing ARVs	N/A	12	17	38	24	150	112	211	112
# of Patients on ARVs	<2000	10,494	7,924	19,779	20,805	44,100	40,000	88211	96,420

[Source: DAM/MISAU, 2007]

As a result of the Ministry-led comprehensive approach to HIV/AIDS, comprehensive sector wide planning has been bolstered as a result of the inclusion of all core HIV/AIDS activities into the annual operational plan of the MOH. The financial structures of the health SWAp have been further

strengthened and harmonised as a result of the channelling of some of the additional funds (brokered as a result of the increasing international focus on treatment) through the common funds. Additional benefits for the health sector include: the increased focus on human resource needs for the sector as a whole; support to the development of a solid, functioning pharmaceutical supply system (including both logistics and procurement in general and specifically for more complex items such as paediatric ARVs); and the development of a routine HIV information system which yields consistent useful reports with a growing impetus towards the improvement of the broader health information system. Other areas which have benefited as a result of increased funding and partner engagement at the health facility level are infrastructure development, laboratory capacity development, and waste management and sanitation.

### **Target Setting**

The methodology used by the Ministry of Health in setting targets is similar to that of other countries in the region and has been used since 2002. The UNAIDS Estimation Projection Package (EPP<sup>14</sup>) is used to estimate and project adult HIV prevalence from sentinel surveillance data. The national prevalence projections produced by EPP are then imported into the software package Spectrum (AIDS Impact Model) to calculate the number of people infected, AIDS cases, AIDS deaths, etc. and to estimate the number of people in need of treatment, children in need of Cotrimoxazole prophylaxis, etc. The recent 2007 sentinel surveillance data will facilitate the updating of previous prevalence data and therefore needs and targets for ARV treatment (including provincial level needs and targets) and other areas of the programme. This sentinel surveillance round will also provide the first incidence data for Mozambique.

To date, data collected on treatment has been collated at the central level, a task which has become increasingly difficult given the rapid expansion of treatment sites and numbers in the last two years. This data has been fed into the overall data system of the Ministry of Health (SIS) since 2004. Given the demands currently on the Ministry of Health at the central level to continue to collect, collate, analyse and disseminate the relevant data, it is planned to decentralise some of the data responsibilities to the provincial level. In January 2008 training will be held for relevant staff from all provinces on data entry and monitoring and evaluation requirements. It is intended that subsequently ARV treatment data will be collected and collated at the provincial level and then fed up to central level in a more complete format.

### **Key Challenges and Actions needed to scale-up Universal Access to ART**

- Human resource constraints across the sector continue to be a major challenge to scaling-up services at central and provincial levels, both in terms of numbers and capacity, at management and implementation levels.
- Ensuring an adequate balance between the urgency to scale-up and the need to guarantee safety and quality of interventions, particularly as numbers on treatment increase significantly in the lower level facilities, initiated and followed by other cadres of health staff, and numbers of those on treatment for some time move onto more complex regimens.
- Providing timely and quality data continues to be a barrier to improved planning and budgeting, and is essential to be able to demonstrate results and keep all partners engaged in the Ministry of Health-led systems-strengthening approach to HIV/AIDS.
- Integration of HIV/AIDS treatment services with other essential services, especially TB and reproductive health continues to be a practical and logistical challenge. Referral systems remain weak.

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<sup>14</sup> [http://www.unaids.org/en/HIV\\_data/Epidemiology/episoftware.asp](http://www.unaids.org/en/HIV_data/Epidemiology/episoftware.asp)  
01/02/2008

- Logistics will continue to be a challenge as scale-up continues beyond the current level in terms of laboratory capacity, drug supply and management, and monitoring and evaluation.
- Adjunctive services pivotal to an appropriate treatment programme need to be scaled up and strengthened, e.g. home-based care.
- The ARV treatment programme (including paediatric treatment) have yet to optimise links with PMTCT, and potentially risk the overshadowing of PMTCT as an essential prevention intervention unless this link is strengthened.

## 2.12 HIV - Paediatric Antiretroviral Therapy

### Policy and Institutional response

Paediatric treatment was mentioned but not concretely addressed in the 2004-2008 national strategic plan of the health sector (*PEV Saúde*), where it was described as “not urgent”, and no targets were defined. However, it became a part of the Ministry of Health’s HIV/AIDS Programme in 2005 and it was also included in the 2006-2009 Poverty Reduction Strategy (PARPA II). The MOH developed a detailed plan to scale up paediatric treatment in 2006. The 2005 MOH manual for the treatment of children with HIV/AIDS is currently being updated and specific training modules on paediatric ART for lower level staff (*técnicos de medicina* or medical technicians) are being developed. The number of adults and children receiving ART are among the PAF indicators reviewed twice a year by the Programme Aid Partners who review the progress in the implementation of the PARPA II.

**Paediatric targets:** The Government targets for paediatric ART reflected in the PARPA are as follows:

2005	2006	2007	2008	2009
1,686	3,686	11,820	20,826	30,000

[Source: PARPA, 2005]

However, the MOH targets for paediatric ART provided for the Round 6 Global Fund proposal are lower (set at 10% of the total target):

2005	2006	2007	2008	2009	2010
2,081	5,000	9,642	13,228	16,500	21,500

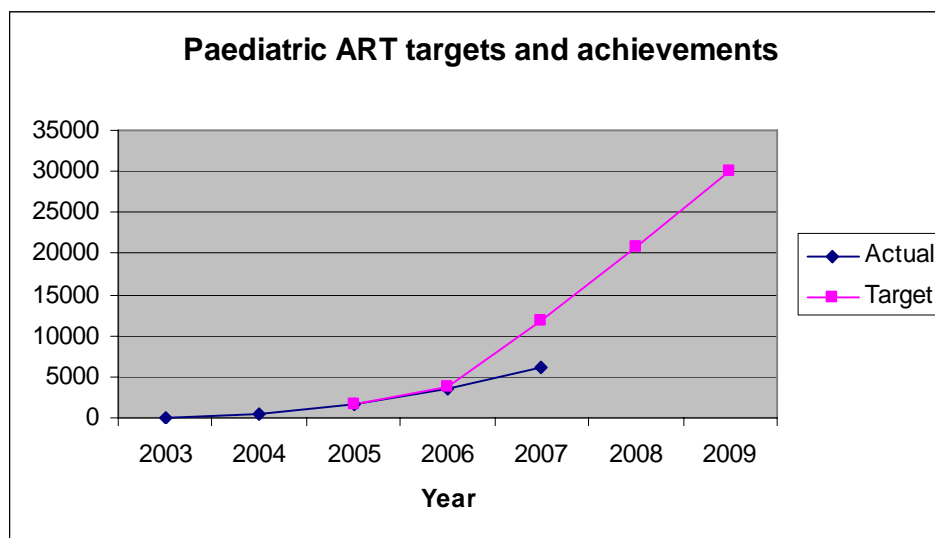
[Source: PARPA, 2005]

The MOH is currently discussing issues related to the current paediatric target and is likely to define a revised, lower target, although for the moment the PARPA targets still apply. The number of children who are eligible for ART had been estimated at 75% of all HIV+ children in Mozambique. For 2007, this would be around 78,000 children. The MOH is reviewing the calculation of children eligible for ART based on the 2007 epidemiological surveillance and applying the updated Spectrum software which has a module for estimating eligible children. It is assumed that the updated estimates, due to be finalized in early 2008, will be significantly lower, and thus the coverage of paediatric ART will be higher.

### Paediatric treatment coverage

**Scale:** Paediatric ART began in 2003. Since then the number of sites providing paediatric ART has grown from 22 sites in 2005 and 70 sites in 2006 to 148 sites by September 2007 (71% of total sites). There are currently three specialist paediatric day hospitals in the three central hospitals of Mozambique: one at Maputo Central Hospital, operating since 1994, the second in Beira, which opened in temporary installations in 2006, and the third in Nampula, which opened in 2007. These specialist centers serve as training, demonstration and referral centers and their staff provide supervisory support to other ART treatment sites in their respective regions. Overall, the Ministry of Health provides oversight and supervision for paediatric ART.

Figure 11: Paediatric achievements and targets.



[Source: MISAU/DAM]

NB: 2007 coverage data as of September. Targets are those of the PARPA II

Some of the provincial day hospitals have a dedicated space for paediatric patients and others offer specific consultations for children at certain times, while in general the treatment of children is integrated within the general ART service.

To date, paediatric ART is only initiated by physicians. *Técnicos de medicina*, who were initially trained in 2006 to initiate standard first line adult protocols and to follow-up straightforward patients on treatment, and then in 2007 allowed to initiate alternative first line treatments and treatment of pregnant women and TB patients, are now being considered for training on paediatric ART. Training modules on paediatric ART for *técnicos* are currently being prepared. One of the key constraints to more rapid expansion of paediatric ART is the limited availability and capacity of staff in some sites, and also a reluctance among some staff to enrol children on ART, as it is believed to be much more complicated and with risks of under or over dosing. Paediatric ART in Mozambique was initially based on syrups and as of mid-2007 first line fixed dose combination (FDC) therapy has been made available. Once widely introduced, this should greatly facilitate the more rapid expansion of paediatric ART in the country. Effective quality control mechanisms will be essential.

**Survival rates** reported from ART sites are around 95 per cent after one year. Specific data regarding the inclusion of younger children (below two years of age) is not available at national level, and analysis of specific sites would be needed. Improving enrolment of infants will be important to reduce mortality among vertically infected children.

**Referral linkages** between the various existing paediatric care structures in health centres, district hospitals and provincial hospitals still requires significant strengthening to enrol all eligible children and reduce missed opportunities and abandonment. In some paediatric wards all mothers and caretakers are counselled and offered testing for their children; most accept. The HIV+ children are then either enrolled in the ART service in the paediatric ward (i.e. an ART file is opened, CD-4 count tests are done, ART is explained, etc), or the children are accompanied by health workers or activists to the ART consultation. These close linkages help to facilitate better uptake of ART.

However, in some paediatric wards children suspected of being HIV+ are simply referred to the nearest testing site (ATS) and are lost to follow up. At the frontline of care, there is currently no system for identifying the HIV exposure or infection status of children coming for immunization or for curative outpatient services. The current child health card does not have a space to indicate the status, and while some health workers note it on the card, many do not. The updated card, to be disseminated in early 2008, includes sections on PMTCT and ART.

In terms of integration of services, in 2007 the integrated management of childhood illness (IMCI) protocols were updated to include HIV/AIDS, and dissemination will begin in early 2008. The protocol for the treatment of acute malnutrition also includes guidelines on HIV, and malnutrition treatment services in most of the larger hospitals are well integrated with HIV/AIDS services. These hospitals have found that around half of the malnourished children are living with AIDS. Similarly, ART centers have found that around half of the children being enrolled are malnourished. Starting in 2006, outpatient malnutrition treatment services are integrated in ART sites, with 110 sites offering the service to date.

In terms of the information system, ART was initially not disaggregated by age at national level, but since 2005 the national ART information system provides information on numbers of children under 15 receiving ART. The data on children is not disaggregated further by age.

In terms of evaluation studies on paediatric ART, a study to monitor HIV drug resistance emerging during paediatric treatment is currently ongoing. The paediatric day hospital in Maputo is also conducting studies on risk factors for horizontal transmission in children, sexual abuse of children and HIV, knowledge, attitudes and practices on paediatric AIDS among children and caretakers, Kaposi's sarcoma

### Key Actions to Scale-up Universal Access to Paediatric Treatment

- Increasing awareness on paediatric AIDS in families and increasing the demand for services for infected children, including early infant diagnosis.
- Introducing provider initiated testing for children in all clinical settings
- Improving the logistics for PCR tests to speed up the process
- Reducing the time from HIV diagnosis to the initiation of ART and strengthening the linkages between services to reduce the dropouts and missed opportunities
- Building capacity of health staff to use IMCI algorithm to identify children with suspected infection
- Reducing rates of abandonment of the ART/OI treatment services
- Enrolling children in peripheral health facilities with few trained staff: once the *técnicos* (and possibly nurses) are able to prescribe paediatric ART, training needs to be enhanced and include hands on experience and close mentoring. *Técnicos* will need to be guided by clearly established algorithms to ensure quality of care and timely referral to a physician or higher level facility if needed. Peripheral facilities are also constrained in terms of the availability of psychosocial support.
- Overcoming the reluctance and lack of confidence among health workers to enrol children on ART: better mentoring and regular supportive supervision needed
- Timely provision of quality data on paediatric ART and related information, e.g. numbers of children tested and HIV+, number of children receiving cotrimoxazole, etc, especially at peripheral level

**UNGASS Indicator #4: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy**

**Table 14: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy**

Method of Measurement	Indicator Value	
	October 2006	October 2007
<b>Numerator:</b> Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period	37,133	82,587
<b>Denominator:</b> Estimated number of adults and children with advanced HIV infection	270,317	294,986
<b>Indicator Value: Percent</b>	<b>13.7%</b>	<b>28.0%</b>

[Source: MISAU, 2007]

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

There is no data for this indicator.

## 2.13 Co-management of Tuberculosis and HIV Treatment

### **Policy and Institutional response**

The National TB Control Program (NTP) has taken a leadership role in strengthening the national response to TB/HIV. A national TB/HIV Task Force, chaired by the head of NTP, meets on a regular basis. The National Strategic Plan TB 2008-2012 focuses on increasing the detection rate, strengthening the laboratory network, improving case-management and patient support, tackling the emerging multi drug -resistant TB (MDR-TB) and extensively drug -resistant TB (XDR-TB) problem and further expanding TB and HIV collaborative activities as well as implementing a quality monitoring and evaluation system allowing impact measurement of program activities. An important component of the plan is aimed at extending and strengthening the DOTS strategy. In order to improve the case detection rate, the plan focuses on increasing the suspicion of TB among health workers working in the different components of the health care system. In addition, the NTP recently completed a successful application for Round 7 Global Fund funding and submitted a proposal to the Green Light Committee for funding to provide TB treatment for drug-resistant cases. Each of these proposals includes strategies for managing patients co-infected with TB and HIV.

### **Collaboration between the national TB and HIV programs**

Since Mozambique has a more recent (and still growing) HIV epidemic, it is estimated that the proportion of TB patients who are HIV-infected will continue to rise. The National TB Program (NTP) recognizes the importance of expanding TB/HIV services in Mozambique and progress in implementing these activities have been improving. The MoH endorses routine HIV testing to all TB patients using a provider-initiated model, provision of cotrimoxazole at TB clinics to all HIV-infected TB patients, including referrals for ART services and screening HIV+ patients for TB in all care settings: VCT, home-based care, and HIV day hospitals. Several partners with MOH endorsement are scaling up ART initiation in TB facilities. To date, TB/HIV policies, training materials, and new reporting formats have been developed and implemented in most of provinces.

National data for the first 6 months of 2007 show that at TB treatment sites, a total number of 15.732 patients were detected from which 13.076 (83.1%) were tested for HIV. A total of 5.544 (42.4%) were TB/HIV co-infected and 1.645 (29.7%) are on ART. In relation to opportunistic infections prevention, 4.970 (89.6%) were reported on CTX prophylaxis.

### **Detection and treatment of TB patients living with HIV and reduction of the TB burden in the community**

Mozambique adopted the DOTS Strategy through technical assistance from the International Union Against TB and Lung Disease (IUATLD) in the 1980s, and has had 100% DOTS coverage since 2000. However, health infrastructure is extremely limited in Mozambique and an estimated 40% of the population has access to DOTS services (defined as a health facility within 10 km of a patient's residence). The NTP is working with partners to expand Community DOTS to permit more TB patients access to DOT closer to their homes. Community DOTS will also benefit HIV-infected TB patients. In addition, home-based care programs for persons with HIV and other chronic diseases, incorporate TB screening and referrals into their training programs. Partners received TB and HIV funding (such as LEPRO and World Vision) are collaborating to provide TB and HIV messages at community level.

### **Prevention for positives**

In 2006 a Prevention with Positives Partnership pilot project was set up in Maputo province in partnership with University of California in Sao Francisco (UCSF). Plans are to expand to 2 more sites (Zambézia and Sofala provinces). Partners are providing training and technical assistance to

lay counsellors and health staff to improve community-based prevention services and prevention counselling to HIV-positive patients who visit the clinic. They are also working together implementing interventions that help people living with HIV become aware of prevention and gain skills in how to reduce their risk of transmitting the virus to others. These programs are being integrated into existing services.

### **Multi Drug Resistant TB (MDR)**

Mozambique has one of the highest documented rates of multidrug-resistant TB (MDR) in Africa (2<sup>nd</sup> WHO/IUATLD Drug Resistance Surveillance). A national survey in 1998-1999 found that 3.4% of new patients had MDR TB and that drug resistance (Isoniazid and streptomycin) was higher among HIV-infected TB patients. This is of great concern since HIV-infected patients with MDR have exceedingly high mortality rates, even in settings where they have access to HIV treatment (including ART). During the first quarter of 2007, 90 MDR-TB patients had been started on second-line treatment, corresponding to 15,4% of expected number of MDR cases.

In February 2007, the NTP initiated a new national drug resistance survey in collaboration with the supra-national reference laboratory in Milan and the World Health Organization, and it is expected to have the results in April 2008. The NTP is also planning a rapid assessment of second-line drug resistance in 2008. In September, the NTP submitted an application to the Green Light Committee to provide greater access to treatment for drug-resistant cases. Finally, several partners, including FHI and JHPIEGO, are assisting the NTP in developing and disseminating improved infection control activities. NTP is also working to improve the diagnosis of drug resistance through more rapid diagnosis of first-line drug resistance in Maputo as well as second-line drug resistance testing through a partnership with the National Health Laboratory System in South Africa.

### **Key Actions needed to scale up Universal Access to TB/HIV treatment:**

- The screening for tuberculosis at ART sites and other HIV care settings need to be strengthened.
- Improvement of the diagnosis of Pulmonary TB (smear positive and smear negative) and extrapulmonary TB by training and setting up a referral path for further evaluation.
- Scale up implementation of Isoniazid Preventive Therapy (IPT) at the ART sites.
- Intensified case finding and provision of INH for adults HIV+ patients and under 5 children with household contact after ruling out TB active disease.
- TB/HIV collaborative activities for high risk groups (prisons, refugees)
- Diagnosis and treatment of X/MDR-TB patients
- Expansion and strengthening of the implementation of infection control measures in health facilities by education of patients and health workers, training of personnel and provision of equipment and establishment of appropriate infrastructure guided by international standards.
- Expansion and strengthening of M & E including activities related to implementation of the electronic TB register (ETR) and MDR-TB surveillance.

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

Although the numerator is available for 2006 at national level, the denominator is calculated at global level (WHO HQ) and this is not yet available for 2006.

## Care and Support Programmes

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

### 2.14 Support to households that are caring for orphaned and vulnerable children

#### Background

Government of Mozambique defines orphans as children having lost one or both parents, and there are twelve categories of children identified as vulnerable and in need of protection and support<sup>15</sup>. In 2006, approximately 1.6 million children less than 18 years of age were orphaned (12% to 16% of the total population) (UNICEF, *Childhood Poverty in Mozambique. A Situation and Trends Analysis*, 2006). Of these children, projections estimate that 380,000 (more than 20% of the total of orphaned children) have lost their parents due to AIDS and this number is estimated to reach 630,000 by 2010 (Instituto Nacional de Estatística (INE), Ministério da Saúde (MISAU), Ministério do Plano e Finanças (MPF), Centro de Estudos de População da Universidade Eduardo Mondlane (CEP) - UEM, Conselho Nacional de Combate ao HIV/SIDA (CNCS), Faculdade de Medicina - UEM, 'Impacto Demográfico do HIV/SIDA em Moçambique - Actualização Ronda de Vigilância Epidemiológica 2002', Maputo, Maio de 2004.). The number of orphans is highest in areas with high HIV prevalence.

Orphaned and vulnerable children (OVC) are more likely to live in poor households headed by women, elderly people and/or by an uneducated person. Some households are even headed by a child, or the children have to act as the main provider due to the illness or disability of the adult family members. They have very limited means of generating income and thus often have to resort to risky coping strategies, such as early marriage, transactional sex and hazardous child labour. They also have limited access to basic services such as health, education, food, legal, financial and psychosocial services. In addition to these challenges, children orphaned as a result of AIDS are often living with social stigma and discrimination, and potentially face exclusion from their communities. OVC are also prone to discrimination in the allocation of resources because they are not direct biological descendants of the household head. Inheritance claims by relatives often lead to dispossession of property in child headed households (UNICEF, 2006).

#### Policy and Institutional context

Until recently Mozambican legislation has been marked by a lack of one coherent Children's Act that brings together all the rights of children in line with the Convention on the Rights of the Child. Nevertheless, all aspect related to children protection are being guided by the National Constitution

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<sup>15</sup> In Mozambique, vulnerable children are defined as: i) Children affected by HIV/AIDS, or infected by HIV/AIDS; ii) Children living in households headed by other children, youth, women or elderly persons; iii) Children living in households headed by a chronically ill adult; iv) Children living on the street; v) Children living in institutions (orphanages, prisons, mental health institutions); vi) Children in conflict with the law (children being prosecuted under law for minor crimes); vii) Children with disabilities; viii) Child victims of violence; ix) Children who are the victims of sexual exploitation; x) Child who are victims of trafficking; xi) Children married before the legal age; xii) Child refugees or children who have been internally displaced.

These definitions differ from those used in UNGASS reporting for orphans and vulnerable children. UNGASS indicators define an orphan as a child below the age of 18 that has lost both parents, and a child made vulnerable by HIV is defined as a child below the age of 18 and i.) has lost one or both parents; or ii.) has a chronically ill parent (regardless of whether the parent lives in the same household as the child); or iii.) lives in a household where, in the last 12 months, at least one adult died and was sick for three of the four months before he or she died; or iv.) lives in a household where at least one adult was seriously ill for at least three of the past 12 months.

and the Family Law. A draft Children's Act is currently with parliament for review in early 2008 and is expected to be approved and implemented thereafter.

There are a number of complementary policies and action plans that address the needs of orphaned and vulnerable children. Mozambique's second poverty reduction strategy for 2005-2009 (PARPA II) includes targets concerning OVC, such as developing and consolidating social safety nets for the most disadvantaged citizens (including orphaned children) and ensuring that the ratio of school attendance and ratio of malnutrition among orphaned children is the same as non-orphaned children. PARPA II includes a target to provide 30% of households with OVC a minimum of three of the six identified basic services.

A National Action Plan for Children (NACP, 2006-2010), developed by the Ministry of Women and Social Action (MMAS) and approved in 2006 by the Council of Ministers, is a compilation of priority actions for children identified in the sectoral plans of line ministries. Also a Plan of Action for Orphaned and Vulnerable Children (POA OVC) developed by the Ministry of Women and Social Action (MMAS) was approved in 2006 by the Council of Ministers. The costed interventions of POA OVC aim to strengthen national capacities as a pre-condition for expanding the response to OVC and to provide direct support to the most vulnerable children. The POA OVC defines a set of six basic services to be provided to OVC: health, education, nutritional and food support, legal and psycho-social support as well as financial support (defined as unconditional cash transfers for households caring for OVC). MMAS defines the provision of at least three of these services as the minimum standard for the care of OVC. A crucial achievement of the POA OVC was the adoption of a Mozambican definition of "vulnerable child", essential in informing policy development and creating the basis for the targeting of social protection interventions. Both NACP and POA OVC also commit the government to scale-up birth registration to ensure greater coverage for OVC, essential for reducing vulnerability.

#### **Key Achievements:**

- A costed multi-sectoral Action Plan (from 2005 to 2010) to address the situation of OVCs approved. In 2006, 1.2 million OVC were targeted by the Plan, costed at US\$ 71 million (HIV Joint Review 2007).
- By the end of 2006, 24% of OVC identified in the OVC Action Plan (or over 280,000) had gained access to at least 3 basic services, reaching about 120% of the 2006 PARPA annual target. Under the Social Action section of the BdPES (Balance of Economic and Social Plan), it is reported that 62,918 OVCs were reached with at least three basic services (or 5.2% of the target of 1.2 million set out in the OVC Action Plan for the year 2006). (HIV Joint Review 2007)
- In addition, through support provided to Civil Society Organisations by various bi-laterals, multi-laterals and governmental and non-governmental institutions, more than 220,000 OVC were reached. (HIV Joint Review 2007)
- One of the main social protection programmes run by the National Institute for Social Action (INAS), the implementing arm of MMAS, provides material support to highly vulnerable families caring for OVC. INAS is also considering targeting households caring for OVC through the Food Subsidy Programme.
- A Multi-Sectoral Technical Working Group on OVC, comprising of civil society and development partners, has been created to support MMAS to develop, coordinate, implement and monitor the PoA OVC. Six provinces and some districts have established and the rest are planning to establish similar Working Groups at provincial and district level

**Key challenges:**

- The reach of services aimed at preventing violence, abuse and exploitation of children remains limited, as does the capacity of judicial and police institutions to enforce protective measures.
- Access by the most vulnerable children to social assistance that would enable them to benefit from basic social services remains extremely limited.
- The most effective social protection modalities to reach OVC have not yet been defined by the Government.
- Inadequate capacity of MMAS at provincial and district levels limits their ability to adequately monitor and coordinate civil society interventions for OVC.
- Insufficient funding constrains adopting new policy and planning instruments.
- The absence of a comprehensive monitoring and evaluation system for reporting the number of children reached both through government and civil society is a major challenge to the effective monitoring of the PARPA indicator. A set of forms to effectively monitor this indicator exists in draft and will be tested in 2008.

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

- Ensure that the Food Subsidy Programme becomes an effective mechanism for social assistance reaching the most vulnerable children.
- Expand unconditional cash transfers as an effective measure to mitigate the impact of HIV and AIDS on the most vulnerable population.
- Build the capacity of the MMAS at provincial and district levels in order to ensure effective coordination and implementation of social protection measures.
- Build capacity of families and communities to respond to the needs of OVC and to provide access to basic services. The government policy promotes community-based, rather than institutional care for OVC.
- Ensure that an effective monitoring tool is in place to effectively measure the PARPA target specific to Orphaned and Vulnerable Children.

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

Currently no data exists for this indicator. The NAC and the Ministry of Women and Social Affairs are planning to collect data for this indicator through a National AIDS Indicator Survey in 2008

## 2.15 School attendance among Orphans and Non-Orphans

### Background

Abolishment of primary school fees and expansion of school network in Mozambique have resulted in a rapid increase of the net enrolment ratio<sup>16</sup> to 94.1% (97.3% for boys and 90.9% for girls) at primary level in 2007 (Figures for boys; calculation from Annual School Survey 2007, others: Balanço de PES 2007 1º Semestre). This has however not been matched by increased investment in the quality of education or by adaptive strategies for such massive increases in student numbers. Indicators on the quality of education, such as the proportion of teachers who are qualified and the ratio of learners to teachers, have worsened. In the lower level of primary education, there was on average one teacher for every 82 learners in 2007 (Annual School Survey 2007).

The number of children actually attending school is much smaller than the number enrolled at school. Surveys done in 2003-2005 give net primary school attendance rates between 60% and 71% (Instituto Nacional de Estatística (INE), 'Inquérito Demográfico e de Saúde 2003', Maputo, June 2005; Instituto Nacional de Estatística (INE), Household Survey on Living Conditions (IAF) 2002-2003; Instituto Nacional de Estatística (INE), 'Inquérito Integrado à Força de Trabalho (IFTRAB)', 2004/2005', 2006). The gender gap is approximately as big as in enrolment, but is greater in certain provinces, in rural areas and in poor households. There are striking differences between enrolment and attendance rates at provincial level and across different provinces. For example, in Niassa province, primary net attendance among girls was only 40% compared to 92% for girls in Maputo City (UNICEF, Childhood Poverty in Mozambique. A Situation and Trends Analysis, 2006).

While the lower primary school completion rate has improved, it remains very low. More than half of primary school age children leave school before having completed Grade 5, without adequate reading, writing and numeric skills. Although the PARPA II sets a target of increasing primary school completion rate to 59% (55% for girls), currently only around one third successfully complete their primary education, making the attainment of the Millennium Development Goal relating to education unlikely by 2015. (UNICEF, 2006).

### Policy and Institutional context

Education is guaranteed by the Constitution of Mozambique, which states that "education constitutes both a right and a responsibility of all citizens". But in contrast to the Convention on the Rights of the Child, the law does not establish that education, including primary education, should be compulsory and free. Strategies to shift primary education expenditure from parents to the State, including the abolition of primary school fees in 2004, direct financing grants to schools and free text books, demonstrate that the Government is progressively fulfilling children's right to education. Yet the proposed budget for 2008 in education has declined to 18.4% from 22% in 2007 (Analysis of OE 2008 proposal by SAL & CALDEIRA for Budget Analysis Group).

The general policy environment in Mozambique is favourable to realisation of children's right to education. Both the PARPA II (2005-2009) and the Education and Culture Strategic Plan (ECSP, 2006-2011) present strategies for delivery of universal primary education, based on expansion and improved efficiency and quality. Both also put an emphasis on HIV prevention and mitigation through the school system. Inclusion on the basis of gender, vulnerability and special needs is included in the objectives of PARPA II as is a commitment to increase the access and retention of

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<sup>16</sup> Net Enrolment ratio (NER) is calculated as the ratio of all children in a given education level who are of the right age for that level compared with all children in the age range formally corresponding to that education level.

OVC to ensure that the ratio of school attendance among orphaned children is the same as non-orphaned children.

### **Access of orphans and vulnerable children to education**

Orphans, especially maternal orphans are likely to suffer from education deprivation. The OVC are more likely to live in households where the head of household has no education, and in poorer than average households and such have often limited access to education. The DHS in 2003 found that only 62% of 10-14 year-old maternal orphans were attending primary school, compared with 76% of paternal orphans and 78% of non-orphans. The level of education of a child's parents is also an important factor. The DHS showed that 38% of children aged 7-17 living with an uneducated head of household had never been to school, compared to only 4% in households where the head had a secondary level education or higher. Gender is another major factor influencing access to education. Reasons for taking girls out of school include concerns that school would alienate them from local culture, fear of violence and sexual abuse which are prevalent at schools as well as early marriage and pregnancy (UNICEF, 2006).

Poor families have to weigh the benefits of education against the scarce resources and the loss of time to work while the child is at school (opportunity cost) as well as against direct costs of education (such as books and clothing). Negative perceptions of the quality or value of education can therefore result in the decision to remove a child, especially girls and orphaned children, from school. A study conducted in 2005 in Sofala province found that over half of the children living in child headed households did not attend school, mainly due to the opportunity costs. Another study established that in poor households, children with no direct biological relationship to the household head were discriminated against in terms of their access to education, in both rural and urban areas. Children, especially girls, living in households dependent on subsistence farming may drop out of school if there is lack of food because they become too malnourished to attend school, or in order to help the parents with farming, or even engaging in child prostitution in order to contribute to family income (UNICEF, 2006).

### **Key Achievements:**

- Increasing trend in numbers of children enrolling, attending and completing school.
- Through partnerships between multilateral and bi-lateral donors with civil society organisations, 20,000 school-aged OVC were integrated into school, and 38,000 children were provided with school materials to facilitate their retention in school
- Through the Child-friendly Schools programme implemented by the Ministry of Education and Culture with support from UNICEF 18,000 OVC were integrated into primary school and provided with a package of school materials and clothing

### **Key Challenges:**

- Significant inequalities persist in terms of access to education, based for example on gender, the level of poverty and parental education and where the child lives.
- Orphaned children, particularly maternal orphans, are systematically found to have lower school attendance than non-orphaned children.
- Indicators on the quality of education have worsened.
- Evidence suggests that birth registration levels in Mozambique are extremely low. Although children in Mozambique are not required to produce a birth certificate to enter school, it is required for admission to grade five examinations. Nevertheless efforts are being done to ensure child registration by extending the registration period from 30 day to 120 days after birth and conducting awareness and registration campaigns at national level.

- Stigma and discrimination around HIV and AIDS still persist in community level. This can result in the most vulnerable children being excluded from school on the pretence that there are no vacancies or due to discrimination at school.
- Coordination between MEC, MIJUS, Registration entities and MMAS is weak. The Technical Working Group for Orphaned and Vulnerable Children is a forum where MEC and MMAS engage in dialogue on Orphaned and Vulnerable Children. Although there is a good coordination at central level it needs to be strengthened considerably, both at provincial and district level.

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

- Families caring for Orphaned and Vulnerable Children need to be aware of the right of every child to a free primary education.
- Resources need to be made available for MEC to accommodate every child in school in all provinces and to have enough qualified teachers.
- Although the stigma and discrimination around HIV and AIDS is addressed in the strategy of MEC and MMAS its implementation needs to be strengthened.
- Effective coordination mechanism up to the decentralised level between MEC and MMAS is required.

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

During the DHS of 1997 and 2003, households were asked if the mother and father of the children in the household were alive and if the children were currently attending school. Table 15 below shows the current school attendance rate among orphans aged 10-14 who have lost both parents compared to the school attendance rate among children aged 10-14, both of whose parents are still alive.

**Table 15: Current school attendance among orphans and non-orphans aged 10-14, 2003, by sex.**

Method of Measurement	All 10-14	Disaggregated Values	
		Sex	
		Males	Females
<b>ORPHANS</b>			
Numerator: Number of children who have lost both parents and who attend school	129	69	61
Denominator: Number of children who have lost both parents	207	95	112
<b>Indicator Value (Percent)</b>	<b>62.6%</b>	<b>72.6%</b>	<b>54%</b>
<b>NON-ORPHANS</b>			
Numerator: Number of both of whose parents are alive, who are living with at least one parent and who attend school	4,324	2,356	1,968
Denominator: Number of children both of whose parents are alive who are living with at least one parent	5,515	2,891	2,624
<b>Indicator Value (Percent)</b>	<b>78.4%</b>	<b>81.5%</b>	<b>75%</b>

[Source: DHS, 2003]

## 2.16 Home-Base Care

### Background:

In 2007 approximately 8% of people with AIDS in Mozambique died, and according to Ministry of Health records, at least 15% of those on antiretroviral therapy (ART) had stopped treatment or died<sup>17</sup>. Home-Based Care (HBC) Programs aim to improve the quality of life and increase the lifespan of people living with HIV (PLWHIV) and other chronic illnesses through community HBC initiatives, in coordination with the National Health System.

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

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

The target groups for HBC services are HIV-infected individuals in the World Health Organization (WHO) clinical Stages 3 and 4 of HIV, and individuals with other severe chronic illnesses. These include patients with problems related to, or at risk for, medication non-adherence. These activities are carried out by community programs most of which have volunteers receiving an incentive, an amount set by the MISAU at between 60% and 100% of the national minimum salary.

### Achievements:

The HBC program in Mozambique has created a national policy that defines what constitutes HBC, monitoring and supervision tools, and a management and coordination structure consisting of provincial and district level Focal Points. All provinces and 55% of districts currently have HBC services in place. Because of the need for rapid expansion of HBC and the high demand for training, the MISAU has delegated responsibility for the training of trainers of HBC volunteers to ANEMO (National Mozambican Nurses Association) in 2006. Access to training improved resulting in a 3-fold increase in the number of trainers trained in 2006 over 2005. MISAU and ANEMO continue to collaborate in the development of continuing education materials and will offer a course in the management of OIs in 2008 to improve the quality of care and referral. Future plans include forming a Mozambican branch of APCA (African Palliative Care Association).

<sup>17</sup> According to projections from the Demographic Impact Report, 2002: 1,736,675 people were living with HIV and 135,929 died in 2007. According to statistics from the MISAU approximately 15% of those on ART were officially reported to have died or abandoned treatment and this is considered to be an underestimate.

<sup>18</sup> National Strategic Plan for STI/HIV/AIDS – health sector, 2004-2008

**MISAU and CNCS Collaboration at the Provincial Level:**

In 2006 MISAU and the National AIDS Council (CNCS) held a joint 2 day meeting to improve coordination in the selection of HBC proposals for financing by the Provincial level CNCS (NPCS). It was decided that DPS (Provincial Health Department) HBC Focal Points would participate in the Desk Review of proposals, together with their NPCS counterparts, to improve technical quality of the proposals and assure that sites selected were priority areas for the DPS. Progress is being monitored through the HBC Technical Working Group. *Obstacles to this resolution include the lack of availability of DPS Focal Points (who have other clinical and administrative duties), and frequent changes in personnel in both the NPCS and the DPS*

**Table16: Number of Health Facilities providing HBC services and number of clients served in 2004, 2005, 2006 and 2007.**

HBC	Health Centers linked with HBC				Patients Served			
	2004	2005	2006	2007 (Jan-Jun)	2004	2005	2006	2007 (Jan-Jun)
PEN Targets	60	120	200	225	11,355	27,582	67,371	53,619
Total achieved	79	100	156	180	17,790	29,640	48,000	49,666

[Source: MISAU, 2007]

**MISAU/MMAS collaboration: Integrated Care and Support**

In 2007, the MISAU and MMAS (Ministry of Women and Social Action) trained District level Focal Points in their joint management role (coordination, supervision and monitoring) of Community activities related to HBC and "Home Visitors" or community based "para-social workers" providing psychosocial support. These Focal Points will conduct integrated supervision to strengthen the coordination between community based social services and paramedical services, and their links with their formal counterparts. A standard community based "para-social worker" training is being developed by MMAS within the Central Level OVC (Orphans and Vulnerable Children) Technical Working Group.

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

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

- Expansion of HBC coverage in conjunction with ART and OI services while maintaining quality standards.
- Functional referral systems between health centers and communities.
- Short and medium term food and nutritional support strategies.
- Data collection and management systems integrated in the National Health Information System (SIS) for timely and quality data.
- Functional supervision, management and coordination structures at all levels.
- Emphasis on priority and cost-effective palliative care measures as: cotrimoxazole prophylaxis, TB case finding and referral, pain management, adherence support and hygiene measures to prevent OI transmission.
- Difficulties related to lack of transportation.
- Integration of HBC activities with psychosocial support activities at the community level.
- Collaboration between the MISAU and CNCS at central, provincial and district levels to select proposals and award grants more swiftly.
- Caring for caregiver strategies to address the emotional, physical and material demands of caring for the chronically ill.

## **IV Best practices**

The best practices listed in this section of the report were identified by government and non-governmental stakeholders who were interviewed during the UNGASS review process. Among the most effective programs that were identified were those aiming to increase community involvement, awareness raising through broad information dissemination and strengthening of civil society. Promotion of dialogue at community level both at leadership and domestic levels were effective in raising awareness, reduction of discrimination and encouraging voluntary counselling and testing.

### **Best Practice: Community Counselling and Testing**

At the end of 2006, the Minister of Health approved a pilot initiative for Community Counselling and Testing (CTH) in community settings, implemented in 5 sites in 3 Provinces with the support of JHPIEGO, CDC and implementing partners. The program was implemented by 41 trained community lay-counsellors, supervised by community educators and supervisors from implementing partner agencies. In the first nine months, 9,094 persons were reached and 98.7% accepted to be tested. Among these, 45,9% were reached through satellite CT, followed by the door-to-door approach (31,5%). More than a half of the clients counselled and tested through community CTH were women, compared to 68,4% of women tested at facility-based CT service sites in 2005. While most of the people reached by community CTH were above 15 years of age, the proportion of children tested is three fold higher than those tested within health facilities services in 2005 (11,6% versus 4%). Door-to-door CT services in particular showed high acceptability among family members, reaching more children and couples, including concurrent partners - than the other models. Of the 2,868 people counselled and tested through door-to-door activities, 27.4% were children under 15 years old while 13% were couples.

The Minister recently approved the expansion of Community CTH ensuring direct MOH and NAC involvement in monitoring and quality assurance. The results of this first initiative in Mozambique showed that more people in hard-to-reach areas received information about health prevention including HIV, as well as were referred to services when needed. Moreover, the experience allowed for entire families to access CT services together, contributed to couples' disclosure, and provided psychosocial support to children and their parents, raising awareness to one of the most challenging public health situations in the country contributing to decrease the stigma and discrimination in relation to HIV and AIDS.

### **Best Practice: The Junior Farmer Field and Life Schools (JFFLS)**

Government with support from FAO is implementing a junior farmers program called The Junior Farmer Field and Life Schools (JFFLS) in 28 schools in Manica and Sofala provinces. The programme will expand to reach 58 schools in 2008. Each JFFLS trains 30 orphans and vulnerable children, between the ages of 12-18 years and the youth attend the JFFLS three times a week, receiving an extra meal from WFP on training days. The approach of the curriculum is inspired by the Farmer Field School methodology which is rooted in a 'learning by doing' approach, and active stimulation of critical analysis and decision-making. The agricultural practical learning is linked with life issues such as nutrition, health care and hygiene, HIV & AIDS, protection of child rights and marketing. The methodology has been modified in order to stimulate children to learn and communicate in highly creative ways - the curriculum therefore also includes cultural activities (song, dance, theatre and sports). An income generation component for JFFLS graduates is presently being piloted to assist them to improve their livelihoods. This program gives the children life skills for their future, opening a "window of hope" for the next generation.

### **Best Practice: The Presidential Initiative**

President Guebuza launched his own advocacy initiative to raise the population's awareness about the destructive effects of HIV and AIDS in 2006. The advocacy activities focus on open, public debates on the causes and consequences of the pandemic and the President of the Republic has held open discussion meetings with various sectors of society, including traditional leaders, youth, religious leaders, women's groups, and business people across the country. The most affected provinces had representatives from remote districts.

The President's initiative was replicated through 20 ministries and then through the 11 provinces. The plans for 2008 are to take the programme to district level led by the district administrators in partnership with the traditional leaders. Training material and packages are being developed and will be distributed to local leaders. This has been an excellent initiative that has helped increase political commitment throughout the country, improve knowledge about the epidemic and encourage the population to take preventive and mitigating measures.

### **Best Practice: The Prevention Reference Group**

Based on the need to intensify and coordinate HIV prevention efforts in Mozambique, a high-level Prevention Reference Group (PRG) was established in October 2007. The PRG is composed of government representatives from the MISAU (Chair), CNCS, MEC, MJD, and MMAS, and stakeholder representatives from UNAIDS, WHO, UNICEF, UNFPA, CDC and civil society.

The PRG has identified five priority areas based on criteria such as relevance, feasibility, impact, new developments and need for prompt action, namely: Coordination, Monitoring and evaluation, Communication strategies, Counselling and testing and Interventions for most at risk populations. Other important areas identified include: Condom promotion, PMTCT, male circumcision, diagnosis/treatment of STIs and ART. Task Forces for each of these thematic areas have been established to liaise with the existing technical working groups in order to identify local, regional and international best practices. The aim is to create an evidence-informed, costed and prioritized list of key prevention activities, combining and taking advantage of synergies between different interventions.

Several activities are underway or planned to provide additional evidence on key drivers of the HIV epidemic and most-at-risk populations as well as on the current response. This information can be used to prioritize and direct resources to populations and areas where the need for prevention efforts is greatest, to develop an evidence-based and costed prevention plan, and to build capacity of national authorities and managers to use evidence to set priorities and develop action plans.

High level government commitment, MOH and NAC leadership, and participation of key Ministries enable rapid implementation of actions towards improved HIV prevention. Collaboration between government and stakeholders has improved coordination and immediate mobilization of support. The PRG has also acted as an advocacy tool and increased the visibility of HIV prevention in the media.

### **Best Practice: The Geração Biz programme**

The *Geração Biz* programme (GBP) is a National Government Programme. Based on multi-sectoral approach, it is being implemented by Ministries of Education and Culture, Health, and Youth and Sports with technical assistance from UNFPA and Pathfinder International and support from DANIDA, SIDA and the Embassy of Norway. The programme is also implemented in collaboration with local NGOs and youth associations.

The programme reaches more than 1.2 million youth through in-school and out-of-school activities through 425 schools, 306 youth associations and 192 Youth Friendly Health Services within health facilities in all provinces of Mozambique. The programme provides adolescents and youth with counselling on sexual and reproductive health, as well as information and preventive services to protect the youth against unwanted pregnancies, and STIs particularly HIV. The in-school life skills activities are based on work by students and teachers trained by the programme to be peer educators. Counselling corners serve as a venue where youth can seek counselling information from their peers. Face-to-face activities by peer educators and school events in the form of debates, video sessions, interactive exhibitions, cultural and sport events are also part of the programme. The programme has steadily increased the knowledge of young participants.

*Geração Biz* serves as important interlocutor in the processes of development of policies and reference tools for Mozambican youth. It is a bridge between youth associations and government structures as it encourages young people to participate in policy formulation, thus contributing to the structural reform processes towards the creation of an environment favourable to initiative targeting adolescents and young people. Furthermore, GBP is an important reference programme for prevention among adolescents and youth and is considered as a worldwide best practice (World Bank, 2004)

#### **Best Practice: Scaling up the HIV response in the humanitarian emergency response**

Mozambique is prone to recurrent natural disasters including chronic drought situation in southern provinces, floods in the Zambezi basin and cyclones in the coastal regions.

In early 2007, heavy rains in Northern and Central Mozambique and in several neighboring countries caused severe flooding in Tete, Sofala, Zambezia and Manica provinces. Inhambane and Sofala provinces were also hit by a cyclone in 2007. These two calamities led to the destruction of homes, hospitals, schools and crops. Four of the provinces which were affected were also provinces with high HIV prevalence (Tete-16.6%, Sofala -26.5%, Zambezia-18.4%, Manica-19.7%), causing a double emergency of HIV and floods.

In April 2007, the CNCS organized a meeting entitled "HIV/AIDS and disaster: a double emergency" both as a follow-up to the CNCS Board meeting about the HIV and AIDS situation in the central region in 2006 and as a result of the emergency situation created by the floods and the cyclone. The meeting which was chaired by the Prime Minister was attended by several Ministers (including Finances, Social Action, Education), vice-Ministers, provincial Governors and Municipalities representatives; and development partners.

The objectives of the meeting were twofold:

(1) To launch an emergency HIV and AIDS programme funded by the CNCS through the Common Fund (USD 2.4 million) to support HIV and AIDS projects in the flood and cyclone affected provinces (Tete, Manica, Sofala, Zambezia and Inhambane). During the meeting, several contracts with national and international NGOs were signed with the CNCS to support among other things prevention efforts and strategic research on the drivers of the epidemic.

(2) Renew the commitment of provincial Governors in the central region to respond to HIV and AIDS. During the meeting, all four Governors of the central provinces signed a joint document entitled "Despacho Conjunto para a Actuação Estratégica Nacional de Combate ao HIV/SIDA, nas Províncias de Sofala, Manica, Tete e Zambézia". The document highlighted 5 priority areas where actions will be given priority by the provincial authorities, namely:(1) coordination (including coordination with

partners through provincial partners forum); (2) home based care and treatment; (3) nutrition for PLWHIV; (4) child protection; and (5) prevention among children and young people.

## V. Major challenges and remedial actions

### Progress made on key challenges reported in the 2005 UNGASS Country Progress Report

MAJOR 2005 CHALLENGES	PROGRESS MADE UP TO DATE
<ul style="list-style-type: none"> <li>▪ Increase knowledge and awareness about HIV and AIDS in rural areas and pay particular attention to women.</li> <li>▪ “Scaling-up” of activities, particularly to more neglected communities.</li> <li>▪ Conduct a Data Triangulation exercise to establish the drivers of the epidemic.</li>   <li>▪ Complement the scaling up of HAART with intensification of prevention efforts.</li>   <li>▪ Prevention programmes to focus on informing the population about the availability of treatment- and care-specific services and encourage them to seek these services.</li> </ul>	<p style="text-align: center;"><b>PREVENTION</b></p> <ul style="list-style-type: none"> <li>▪ The Presidential Initiative led by President Guebuza during the first half of 2006 is being replicated at all levels.</li> <li>▪ In 2005, 40 districts were being covered, 85 are being covered in 2007 and 91 targeted for 2008.</li> <li>▪ A Stakeholders Triangulation Workshop was conducted by the University of California, San Francisco (UCSF) in November 2007 with analysts from the CNCS, MOH, and interested stakeholder organizations such as CDC, UNAIDS, MISAU and the Multisectoral Working Group. The Data Triangulation Workshop is planned to be held in February 2008.</li> <li>▪ The Modes of Transmission work will be undertaken during the first half of 2008. It will be led by a nationally appointed team and aims to: (1) identify the key drivers of the HIV epidemic and the populations at greatest risk for infection, (2) assess the appropriateness of current prevention efforts, and (3) make recommendations for prevention policy and programmatic action to ensure a more effective national prevention strategy</li> <li>▪ According to MOH data, 401.303 clients attended VCT services at 359 CT sites in 2006, including 281 facility-based VCT sites and 78 PMTCT sites providing VCT services. Compared to 2005, these numbers represent an increase of 80% of in the number of clients served and 87% in the number of VCT sites.</li> <li>▪ The MOH POA (Annual Operational Plan) 2007 and 2008 place specific emphasis on ensuring adherence to treatment and care.</li> </ul>

MAJOR 2005 CHALLENGES	PROGRESS MADE UP TO DATE
<b>PREVENTION</b>	
<ul style="list-style-type: none"> <li>▪ Closer cooperation between traditional healers and organizations working on prevention to ensure cultural appropriateness of interventions.</li> <li>▪ CNCS (NAC) to strengthen coordination of HIV prevention activities</li>   <li>▪ Increase substantially the availability of PMTCT services in health facilities around the country.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Concrete actions are being undertaken by the NAC and MOH to ensure collaboration with not only traditional healers, but also with traditional and local leaders.</li> <li>▪ Mozambique complies with the 'Three Ones' Principles (One Coordinating Body, One Plan and One M&amp;E System). The National Response is being led by the CNCS (National AIDS Council).</li> <li>▪ Establishment of a high level multisectoral HIV Prevention Reference Group to coordinate and intensify evidence-based prevention efforts</li> <li>▪ The number of HIV-positive pregnant women receiving ARV prophylaxis has increased from 253 in 2002 (27% of women who tested positive) to 12,150 in 2006 (43%) and 44,975 by the end of 2007. Coverage of ARV prophylaxis for the estimated population of HIV-positive pregnant women was 0.2% in 2002, increasing to 8.3% in 2006 and 29.7% in 2007.</li> </ul>
<b>ACCESSIBILITY TO HEALTH SERVICES</b>	
<ul style="list-style-type: none"> <li>▪ Need to increase access and availability of health services, particularly those specific to HIV and AIDS (e.g. VCT, PMTCT, treatment of OI, HAART).</li>   <li>▪ Make efforts to reduce geographical discrepancies.</li> <li>▪ Identify geographic and thematic priority areas.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Home Based Care: In 2004, 79 Health Facilities provided HBC serving 17,790 clients. These figures increased to 180 HF and 49,666 clients in June 2007.</li> <li>▪ HAART: In 2004, 12 health facilities provided HAART serving 10,494 patients. These figures increased to 209 health facilities and 96,420 patients in September 2007.</li> <li>▪ VCT: In 2004, 104 health facilities provided VCT serving 188,000 clients. These figures increased to 359 health facilities and 401,303 clients in 2006.</li> <li>▪ PEN II (2005-2009) and NAC and MOH POA (Annual Operational Plan) 2007 and 2008 emphasize strategies that ensure reduction of geographical discrepancies.</li> <li>▪ PEN II and POA (Annual Operational Plan) 2007 and 2008 identify 7 thematic priority areas and 91 priority districts.</li> </ul>

MAJOR 2005 CHALLENGES	PROGRESS MADE UP TO DATE
<b>HUMAN RESOURCES</b>	
<ul style="list-style-type: none"> <li>▪ Given the increasing workload that HIV and AIDS is placing on health professionals, there is a need to transfer certain responsibilities to lower-level but qualified medical staff (nurses and clinical officers for example) wherever possible.</li> <li>▪ Allow non-medical staff to carry out non-medical but essential HIV and AIDS -related activities (e.g. counselling and testing, prevention of mother-to-child transmission, HAART counselling for adherence).</li> </ul>	<ul style="list-style-type: none"> <li>▪ An amendment to the existing policy was introduced in 2006 to allow for the provision of ARV treatment by <i>Técnicos de Medicina</i> (health technicians). Soon after this decision, a curriculum was developed and training started in mid 2006. <i>Técnicos de Medicina</i> were initially trained to initiate standard first line protocols and to follow-up treatment of patients with no complications.</li> <li>▪ MOH and Ministry of Women and Social Action (MMAS) are training Focal Points at the district level in their joint management role (coordination, supervision, monitoring and evaluation) of Community activities related to HBC and "Home Visitors" or community based "para-social workers" providing psychosocial support. These Focal Points will conduct integrated supervision to strengthen the coordination between community based social services and paramedical services, and the links with the formal counterparts.</li> <li>▪ A standard training for community based "para-social workers" is being developed by MMAS within the Central Level OVC Technical Working Group, and is in its final stages of development.</li> </ul>
<b>WOMEN AND CHILDREN</b>	
<ul style="list-style-type: none"> <li>▪ Conduct more interventions that increase the level of knowledge and awareness about HIV and AIDS among women.</li> </ul>	<ul style="list-style-type: none"> <li>▪ In 2007, sentinel surveillance was carried out at 36 ANC sites. Pregnant women attending the sentinel surveillance sites who consented were counselled and tested for HIV.</li> <li>▪ A nationwide population-based sero-behavioural survey (INSIDA) will be carried out in 2008.</li> <li>▪ The Government revised the National Youth Policy that was ratified in 2006.</li> <li>▪ Sexual and Reproductive Health Policy is in the process of approval by the Ministry of Health.</li> <li>▪ The national multisectoral communication strategy was finalized in 2006 and roll-out of the strategy continues to take place.</li> <li>▪ In September 2007 a Prevention Reference Group was formed to develop a scaled-up, evidence-based, locally adapted and comprehensive prevention response.</li> </ul>

MAJOR 2005 CHALLENGES	PROGRESS MADE UP TO DATE
<b>WOMEN AND CHILDREN</b>	
<ul style="list-style-type: none"> <li>▪ Ensure involvement of men in HIV and AIDS interventions targeting women.</li> <li>▪ The government and MMAS in particular needs to provide leadership and coordinate the growing response from communities, NGOs, faith-based and local organizations in order to ensure quality, consistency and coverage in their interventions targeting women and children.</li> <li>▪ Scale up ARV treatment to ensure that more HIV-positive parents live longer lives and their children avoid being orphaned by AIDS.</li> <li>▪ Scale up PMTCT services rapidly.</li> <li>▪ Prioritize scaling up of HAART for children.</li> </ul>	<ul style="list-style-type: none"> <li>▪ In 2005, one health centre in Maputo introduced a system to enhance male involvement in PMTCT.</li> <li>▪ Initiatives to ensure civil society involvement are being undertaken by institutions like CNCS, MISAU and MMAS.</li> <li>▪ Twelve health facilities provided ARV treatment in 2004. These facilities serve 10,494 patients, this figure increased to 209 HF and 96,420 patients served by September 2007.</li> <li>▪ 385 HF are providing PMTCT services in August 2007, compared to from 93 sites in 2005.</li> <li>▪ The number of sites providing paediatric ART has grown from 22 sites in 2005 and 70 sites in 2006 to 148 sites by September 2007 (71% of all sites providing ART).</li> </ul>
<b>CIVIL SOCIETY AND COMMUNITIES</b>	
<ul style="list-style-type: none"> <li>▪ Ministry of Health to introduce community counselling and testing.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Partners have supported MISAU and CNCS in the establishment of community-based CT (CCT) services in Mozambique during 2006 and 2007. These services are being implemented in five provinces with strong support from international and national NGOs and Faith Based Organizations (FBOs) testing different models such as: CT services delivered at non-traditional locations (e.g. churches and mosques); satellite CT services at fixed locations (i.e. mobile CT teams providing services at health facilities where CT services are not yet available on a daily basis); CT campaigns at markets and other non-traditional locations; and home-based (door-to-door) CT services.</li> </ul>

MAJOR 2005 CHALLENGES	PROGRESS MADE UP TO DATE
<ul style="list-style-type: none"> <li>▪ National AIDS Council to make more efforts to support, encourage and capacitate civil society organizations (especially organizations of PLWHIV) in order to ensure that they play a more active role in all aspects of HIV and AIDS interventions.</li> </ul>	<ul style="list-style-type: none"> <li>▪ The PEN 2005/2009 and POA (Annual Operational Plan) 2007 and 2008 give specific emphasis to activities which support, encourage and capacitate civil society organizations (especially organizations of PLWHA).</li> </ul>
NUTRITION	
<ul style="list-style-type: none"> <li>▪ The Ministry of Women and Social Services and the Ministry of Agriculture to cooperate with Mozambique's development partners to implement initiatives aiming to improve food security.</li> <li>▪ The World Food Programme to provide support focusing specifically on the link between HIV and AIDS and nutrition.</li> </ul>	<ul style="list-style-type: none"> <li>▪ The government is implementing the Junior Farmer Field School (JFFS) Initiative supported by FAO and in collaboration with the Ministries of Agriculture, of Education and Culture, and of Women and Social Services.</li> <li>▪ Mozambique has a system for Food support, focusing on elderly people, who take care of orphaned children.</li> <li>▪ The Triple Threat Meeting was held in the end of 2005 to tackle this issue.</li> <li>▪ Mozambique have programme for distribution for supplementary food for people in TARV and women in PMTCT.</li> <li>▪ The Council of Ministers adopted the concept of a Basic Nutrition Package for people living with HIV, in March 2007.</li> </ul>
COORDINATION	
<ul style="list-style-type: none"> <li>▪ The National AIDS Council (CNCS) to be strengthened to assume its role as the government agency responsible for ensuring that the response to HIV and AIDS in Mozambique is truly multisectoral - that all government ministries are fully committed to the response to the epidemic, and that all the aspects of the multisectoral response are understood.</li> </ul>	<ul style="list-style-type: none"> <li>▪ CNCS has successfully built partnerships to ensure that all actors are abiding by the principles of the "Three Ones" by using the National Strategic Plan as the framework for implementation, utilizing one monitoring and evaluation plan, and supporting CNCS in its role as the national coordinator of the response. Coordination and communication is conducted through monthly meetings of all partners, and working groups have been developed to address capacity building needs in a number of programmatic areas.</li> </ul>

MAJOR 2005 CHALLENGES	PROGRESS MADE UP TO DATE
<ul style="list-style-type: none"> <li>▪ The CNCS needs strengthening to be able to assume the coordination responsibility as envisaged in the first of the United Nations' Three Ones. This needs to happen not only at national level but also at provincial and district level.</li> <li>▪ The roles of the two major coordination bodies, the Executive Secretariat of the CNCS and the Ministry of Health, need to be clarified.</li> <li>▪ CNCS to strengthen civil society and community based organisations not just by providing the financial resources but also by building their capacity to manage activities.</li> </ul>	<ul style="list-style-type: none"> <li>▪ CNCS is receiving financial support from Global Fund, PEPFAR, World Bank (MAP and TAP), from bilateral development partners (Ireland, Norway, Denmark, Sweden, United Kingdom and Canada), and from Clinton Foundation</li> <li>▪ At the central level coordination is consolidated, however efforts are needed to ensure better coordination at provincial and district level.</li> <li>▪ The PEN 2005/2009, POA (Annual Operational Plan) 2007 and 2008, and PEN SAUDE clarify the roles of these two entities.</li> <li>▪ Since 2002 the CNCS secretariat has made structural rearrangements to establish a unit for capacity building of civil society organizations.</li> <li>▪ CNCS is making efforts to strengthen its capacity to provide technical assistance, training and supervision to support civil society organizations. As a result, the number of training sessions and on-the-job training is increasing. Also the number of good quality proposals for financial aid and the quality of activities provided by the organizations has increased.</li> </ul>

## **VI. Support from the country's development partners**

Mozambique continues to receive strong support from its development partners in its response to the HIV/AIDS epidemic. Since 2005, considerable amounts of financial resources have been made available to Mozambique in support of its national HIV and AIDS response. Funds from the President's Emergency Plan for AIDS Relief (PEPFAR) of the United States' Government, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank's Multi-Country AIDS Programme (MAP) and the UN family, in addition to bilateral resources from Canada, Denmark, Ireland, Sweden and the United Kingdom, among others, have contributed to achieving the significant results depicted in this report. The recently completed National AIDS Spending Assessment (NASA) indicates that Mozambique has spent over 48.5 million USD in 2004, 58.9 million USD in 2005 and 96.6 million USD in 2006.

It is important to note that despite the significant economic progress made by Mozambique in recent years, it remains one of the poorest countries in the world and one of the most affected by the epidemic. Development partners should continue to increase its funding of the AIDS epidemic in Mozambique so that it has a chance to attain Universal Access targets for prevention, treatment and care. Predictable and sustainable financial support from its development partners will remain a necessity for Mozambique for many years to come in all areas key to development. A functioning Medium Term Expenditure Framework (MTEF) clearly depicting funding available for HIV and AIDS response would provide a secure environment for HIV and AIDS funding, and would allow the linking of available resources to plans.

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

The significant focus on HIV and AIDS as a development issue in Mozambique has provided the Ministry of Health and its Partners with the impetus and opportunity to strengthen the health system across the board. Development Partners should continue to support the Ministry of Health in its ongoing efforts to integrate HIV and AIDS care and treatment with other relevant programmes and to ensure that HIV and AIDS financing is fully included as a central part of the overall Government budget and is not treated as separate vertical programmes.

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

After the great achievements of the increased access to treatment in Mozambique, development partners should recognize the need for an appropriate balance between prevention, treatment and care. The establishment by the Board of CNCS of a National Prevention Reference Group, a high level forum led by the Minister of Health (see Chapter IV of this report, reaffirmed the necessity to

put emphasis on prevention measures in Mozambique. Another challenge that CNCS is facing is the fact that the national HIV strategies and frameworks are not costed.

In 2008, CNCS will count on a Grant Management Agent for granting of funds to civil society, private and public sectors so as to ensure quick disbursement of funds. Development partners support this pivotal initiative that will ensure increased funding to civil society, private sector and public sector.

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

As highlighted in this report, HIV and AIDS are one of the greatest threats to Mozambique's development. The results of the 2007 sentinel survey results demonstrate a stable epidemic nationally but one that shows great variation by province, with some provinces showing a dramatic increase in prevalence rates since the last surveillance done in 2004. The support of technical development partners in the analysis of these results will help the National response to be more focused and effective. Current efforts seem not to be sufficient, especially in the South of the country where the prevalence is rapidly growing. Mozambique's development partners need to continue to play a significant role in supporting the Government to address the specific challenges outlined in this report in order to halt and reverse the HIV epidemic.

#### **"Three Ones" in Action: Innovative Partnership and Coordination in Mozambique**

The National AIDS Council of Mozambique (CNCS) serves as the main coordinating body of the HIV and AIDS response, supporting interventions in prevention, advocacy, reduction of stigma and discrimination, mitigation, and research and investigation. The CNCS works in partnership with civil society, public sector institutions, the private sector, bi-lateral and multi-lateral partners to coordinate the response on national, provincial, and district levels. CNCS has successfully built partnerships to ensure that all actors are abiding by the principles of the "Three Ones" by using the national strategic plan as the framework for implementation, utilizing one monitoring and evaluation plan, and supporting CNCS in its role as the national coordinators of the response. Coordination and communication is conducted through monthly meetings of all partners and working groups have been developed to address capacity building in a number of programmatic areas.

Partners abide by a single code of conduct which guides the relationship between CNCS and its partners and joint review processes monitors progress on national implementation and the degree of compliance to the code of conduct. Bi-lateral and multi-lateral funding partners, including GFATM and the World Bank, abide by a joint MOU supporting a common fund. Partners utilize joint review processes, evaluations, and audits to satisfy their individual corporate requirements and when possible joint missions are conducted to reduce the administrative burden on the CNCS.

The coordination mechanisms developed have contributed to a better flow of information and coordination of different actors. Challenges still remain in coordination of technical assistance and the integration of vertical projects into a common fund framework. Due to the large number of actors involved in the HIV and AIDS response, communication flows also remain a challenge. Participation of civil society partners, especially associations of people living with HIV and AIDS, has been weak due to the process-oriented nature of partner discussions and competing priorities of CSOs as implementers. Strong coordination mechanisms with a dynamic leader must be in place for there to be a successful partnership amongst the varied actors. National AIDS Councils must be given political and technical authority to coordinate the national response. All partners-bi-lateral, multi-lateral, civil society, public and private sectors-must adhere to the principles of harmonization and alignment. Global initiatives must respect local context and structures.

[Source: Abstract Kigali Implementers Meeting, 2007]

## VII. Monitoring and Evaluation Environment

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

### Component 1: Organizational structures with HIV M&E functions

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

At the national level, staff dedicated to CNCS M&E unit within the department of Planning and M&E include three M&E officers and two data officers. The CNCS receives M&E technical support from several partners including UNAIDS, World Bank/GAMET and USAID/MEASURE Evaluation among others. The CNCS does not currently have dedicated information technology experts for programming, database design and maintenance, and computer-based communications. At the decentralized level, each CNCS provincial nucleus has a database officer whose primary responsibility is to enter data from the Programme Activity Reporting System and to supervise reporting from implementers. In 2007, the CNCS recruited Provincial M&E officers who provide M&E technical assistance to each provincial nucleus.

The new influx of human resources and technical assistance, coupled with the contracting of the Grant Management Agent (GMA) to manage day-to-day monitoring of civil society and public sector sub-grants at both the national and provincial levels should free the CNCS M&E unit and its Provincial counterparts to concentrate on their primary responsibility of coordinating the flow of information and analysis for guiding the national response.

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

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

In 2006, the CNCS M&E assessment established that most of the larger NGO partners and all of the NGO facilitating agents have staff capable of managing and using M&E data. Some of these have staff at the provincial level as well. However, smaller NGO partners lack such staff and expertise. The assessment also revealed that whereas private companies do not usually have M&E officers, larger companies have systems in place for monitoring HIV issues.

Remedial actions planned to overcome the challenges:

- Effectively manage and coordinate the human and technical expertise available for M&E at the national level, especially those within the CNCS, GMA, public sector, and large implementing partners.

<sup>19</sup> World Bank/UNAIDS, 2007: Organizing Framework for a Functional National M&E System

<sup>20</sup> CNCS, 2006: Public and NGO M&E Capacity Needs Assessment

## Component 2: Human Capacity for M&E

In 2006, CNCS commissioned an M&E capacity needs assessment of the public, private and civil society sectors . The recommendations from this study highlight the importance of taking advantage of the strengths of the three key sectors in M&E, while identifying critical capacity-building needs. A capacity building plan should be developed with partners and should also include capacity building for decentralized entities at the provincial and district levels.

At a minimum, capacity building for implementers should include:

- Planning, design management of HIV and AIDS programmes
- Aligning plans to the National HIV Strategic Plan and M&E Framework
- Data collection and reporting using national forms and procedures
- Data use for decision making

In addition provincial officers will require training in:

- The implementer registration system
- Collection and data entry of routine data
- Capturing data from other sources (MOH, and others)
- Data analysis and use for decision making
- Data dissemination

The capacity to perform M&E within the health system in Mozambique has received much attention . Among other things, these assessments have concluded that there is limited capacity to perform M&A activities at all levels from the district to the national - both in numbers and capabilities. However, many of the current staff possesses the technical capacity that can be built on to strengthen the system.

Remedial actions planned to overcome the challenges:

- Develop an on-the-job training and supervision programme to strengthen provincial level M&E officers.
- A mix of training with formalized education to strengthen the human capacity. To build permanent capacity in Mozambique, incorporate M&E courses into the training programs for public health professionals.

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

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

A national multisectoral M&E Technical Working Group, chaired by the CNCS has been intermittently active in the past. The group is highly inclusive, with representation from a wide range of implementing partners, donor partners and technical agencies. The group meets quarterly, though the working group has reportedly been most active during periods when a special task must be undertaken (planning the Annual Review, preparation of the UNGASS report, etc.). Due to the large

<sup>21</sup> Ibid.

<sup>22</sup> MOH/UCSF, 2004: Assessing the Need for Capacity Building for Monitoring and Evaluation in Mozambique and MOH/GFATM, 2007: M&E Self Assessment Workshop  
01/02/2008

size of the group, a number of sub-committees have been formed to deal with such issues as special studies and surveys, and surveillance.

Remedial actions planned to overcome the challenges:

- Reactivate the M&E technical working group to coordinate the efforts to achieve a harmonized national M&E system.

#### Component 4: National Multisectoral HIV M&E Framework

The National Multi-Sector M&E WG used a participatory process to develop a National Multi-Sector Monitoring and Evaluation Framework in order to guide the M&E of the progress made in the implementation of the National Strategic Plan. The framework identifies a core set of 27 indicators that include the indicators agreed for the M&E of the UNGASS declaration. It also defines the sources of data for the indicators and other relevant information; the systems that need to be put in place to ensure the correct flow, storage, analysis, dissemination and use of data ; and the role of each stakeholder.

CNCS now needs only to ensure that it is widely disseminated and used by all partners.

Of the 27 national indicators in the framework, ten are available only through the DHS or other similar population-based surveys, one through antenatal care HIV surveillance, and seven through other special surveys (one each from a school survey, workplace survey, national composite index, health facility assessment, implementer survey of management training needs, national AIDS spending assessment, and a survey of condom acquisition/distribution).

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

There are some weaknesses in the ability to collect indicators in the framework. Of the nine indicators collected through routine data systems, two cannot be accurately measured with the information systems as they are currently designed (ARV survival and proportion of children of HIV+ mothers who are born HIV+) and two more indicators are cannot be measured according to their strict definition using existing data systems (coverage of a complete course of PMTCT and number of individuals seen in youth-friendly services).

Data for those indicators that can be collected are available at national and provincial levels, but few are available at the district level. DHS data are routinely available every five years, and some of the special surveys have never been done (school survey, health facility assessment to measure the percentage of people receiving proper of STI diagnosis and treatment, and management training needs of implementers).

Remedial actions planned to overcome the challenges:

- The CNCS should work with partners to fill the gaps in the data for indicators in the M&E framework. For those indicators that have proven to be difficult or impossible to collect, consider redefining or replacing them with indicators that can be collected.
- Regularly review and revise the national M&E framework to allow for adjustments of data collection needs associated with NSP revisions.

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

In 2006, initial efforts were made by the CNCS to develop an integrated and costed M&E work-plan to mobilize partners and resources into a coordinated effort to harmonize and implement the national M&E system, but the effort stalled early in the process. The M&E work-plan simply identifies all of the activities that must be carried out in order to make the M&E system work, and then assigns a timeframe, budget and source of funds, and designates the lead agency for its execution.

Remedial actions planned to overcome the challenges:

- Develop a costed multisectoral HIV M&E work-plan for 2008-2009.

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

Advocacy and communication for M&E are very important to ensure knowledge of and communication to HIV M&E among policy makers, programme managers, programme staff, and other stakeholders.

Remedial actions planned to overcome the challenges:

- CNCS to develop a specific HIV M&E communication and advocacy plan that forms an integral part of the overall national HIV communication strategy: A communication plan to publicize non-medical HIV activities and output reporting system should be developed and implemented. This should target all implementers and partners.
- Advocacy and communication on the importance that implementers report regularly: The CNCS should develop and implement a national communications plan to encourage universal reporting.
- CNCS M&E unit and Provincial M&E officers to produce different information products for different *audiences* including an annual report, summaries for politicians and government policy-makers, and a simplified list of highlights for the media and the general public. Each time an information product is published the CNCS will consider the different clients and audiences for that product and produce a variety products for those segmented audiences. The annual report, for example, will include a "pullout" summary section for each Province. These Province-specific chapters can then be used during provincial and district reviews.

### Component 7: Routine HIV Programme monitoring

#### *Routine medical information*

HIV and AIDS-related medical interventions include counselling and testing services, PMTCT, ARV and OI treatment and prophylaxis, STI programmes, HIV/TB programmes and prevention and condom distribution carried out through the health-care system. All of these are under the responsibility of the Ministry of Health, which has developed a harmonized information system to provide key output data for key indicators relating to these interventions from all providers, both government and non-government. Data are available at district, provincial and national levels. Data from this system are reportedly reasonably accurate, complete and timely.

#### *Routine non-medical information*

Gathering, analyzing and reporting on non-medical HIV and AIDS programmes is one of the most important responsibilities of the CNCS, and one which will require significant time and resources. However, it is essential that this system work if both the supply and demand for HIV services are to

be mapped and coordinated. Until now, the non-medical M&E system has been focused on gathering information for grant management, with special attention to civil society.

The CNCS is responsible for designing a reporting system that can be used by *all* implementers (public, private and civil society) to report on their activities and outputs. It is also required to publicize and disseminate the system, train implementers, supervise the quality, completeness and accuracy of data, and analyze the information and report on the results.

#### Civil society organizations

The CNCS has developed and implemented a reporting system for civil society organizations that includes programme description (name, location, area of work, funds), targets, activities and outputs. Civil society organizations report their activities monthly to the CNCS at the level where there funding was provided (smaller projects report to the provincial nucleus, and large ones to the CNCS). Although the system was designed for reporting by all civil society organizations regardless of funding source, reporting is coming almost exclusively from CNCS-funded projects. The forms are simple, and relate project outputs to targets. This system has the potential to provide a wealth of information about the coverage and distribution of services.

Provincial nucleus database agents enter provincial data into the provincial activity database, and data are collated and sent to the CNCS on paper to be entered into the national activity/output database. Most implementers report only to their immediate funder. As a result, provincial nuclei are often not aware of civil-society activities in their respective provinces if funding has not come through the provincial nucleus itself. According to the CNCS annual report, only about one-third of implementers are reporting regularly for a variety of reasons, which include an inability to collect and collate data or the lack of transportation to get forms from outlying districts to provincial capitals.

#### Public sector

Public sector entities that have received funds to date are mostly national level ministries, although the CNCS is encouraging more decentralization of funding to local public sector entities. Reporting for the public sector has concentrated on financial and activity reporting (related to financial reporting). The CNCS has not yet implemented a public sector system for reporting project outputs. However, most public sector entities that received funds have internal output monitoring system, though these data are not systematically reported to the CNCS. Like civil society organizations, provincial level public sector entities only report to the provincial nuclei if their funding was directly awarded by the nucleus. Therefore, the provincial nuclei are mostly unaware of provincial level public sector activities funded through the central mechanism.

#### Remedial actions planned to overcome the challenges:

- Review the civil society reporting system and adapt it to include data needs for private and public sector projects. Basic elements should include:
  - All implementers should report to the CNCS at the appropriate level (district, provincial, or national) where the activities are implemented.
  - Intermediary entities may aggregate information, but disaggregated information should be made available to the database at the provincial nuclei and the CNCS.
  - A decree or regulation requiring mandatory reporting has been successful in a number of countries.
- Review and revise the forms and output indicators, and update the written reporting guidelines
- For small implementers, the CNCS should not only provide simplified reporting forms and guidelines, but simple tools such as registries for collecting day-to-day activity and output

information that can then be aggregated each month.

- Quickly develop a training plan and materials for a training of trainers on the reporting system, and a simplified written reporting guideline for implementers.

## Component 8: Surveys and Surveillance

The M&E system has several critical sources of information that must be integrated in order to have a complete picture of the epidemic and the response to it. These include surveys and surveillance, routine data on medical HIV services, and routine data on non-medical HIV services (programme activities of the multi-sectoral response).

### *Studies and Surveillance*

This includes both biological and behavioural surveillance, both of which are essential to assess the state and the drivers of the epidemic. In Mozambique the MOH measures HIV prevalence through routine antenatal care surveillance from 36 sites every two years. In 2007, the surveillance study will include viral resistance studies from four of the sites.

The antenatal surveillance data provide national and provincial estimates of prevalence in the general population by applying standard projection algorithms. Prevalence data have not been collected for the general population or in any specific vulnerable group. The male-female infection ratio is only a standard approximation, for example, as no systematic study has been done in men. A national prevalence survey which was planned for 2006 will be carried out in 2008/09

Behavioural surveillance survey (BSS) is a monitoring and evaluation tool designed to track trends in HIV and AIDS- related knowledge, attitudes and behaviours in subpopulations at particular risk of infection, such as sex workers, long distance truck drivers, secondary and primary school teachers, police officers, estate workers, fishermen, vendors, and border traders. BSS complement other sources of HIV prevalence and behavioural data such as population based surveys like the DHS, and sentinel surveillance in pregnant women, by focusing on populations which may be disproportionately affected by the epidemic rather than attempting to estimate the behaviours and prevalence of the general population. BSS consists of repeated cross-sectional surveys conducted systematically to monitor changes in HIV/sexually transmitted infection (STI) risk behaviours based on HIV and STI surveillance methods. These surveys use a time-location sampling methodology to maximize the inclusion of special populations of interest. To date, Mozambique has not implemented a Behavioural Surveillance Survey (BSS). In 2008, however, the Government in collaboration with the CDC and key national stakeholders will support the implementation of the first round of BSS in Mozambique.

Other studies done by partners on smaller population groups or geographic areas supplement this information. Most notable among these is PSI, which has done a number of studies focusing primarily on youth and condom use.

Other special surveys needed for a functioning M&E system include a Workplace Survey and surveys of condom availability and quality of services (through health facility assessments). The latter two have not been performed in Mozambique on a national scale, though some data are available through smaller surveys done by implementing partners. In addition, regular political and financial assessments are important, including the National Composite Policy Index (CNCS 2005) and the National AIDS Spending Assessment (CNCS 2005/6).

Remedial actions planned to overcome the challenges:

- To obtain a complete picture of the scope, distribution and drivers of the epidemic, conduct more detailed and frequent epidemiological and behavioural surveys. These should include both national and sub-national surveys, as well as surveys in vulnerable groups. Examples of these surveys include a national sero-behavioural survey, and BSS, among others.

#### Component 9: National and sub-national HIV databases

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

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

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

##### *Indicator database*

A national database that holds all indicator data called ESDEM exists at the National Institute of statistics. The CNCS Country Response Information System (CRIS) database that houses HIV indicators exports data to ESDEM.

##### *Implementers, projects and outputs/activities*

The CNCS currently has an excel-based registry of all HIV implementers funded by the CNCS that includes contact data, geographic location, type of project(s) and budget, among other data. A separate Access-based system registers activity and output data from civil society implementers that report to the central level. Provincial nuclei also have this database, and enter data from provincial level projects (that is, those funded through the provincial nuclei). Provincial data are aggregated, transferred to paper, and sent to the CNCS to be entered into the national database. Public sector and private sector implementers and their outputs are not included in the database.

All provinces should be able to track all activities and outputs in their respective provinces, and for the CNCS to do the same for the entire country. In this way, it will be possible for the CNCS and other donor and implementing partners to evaluate the coverage of interventions and to guide the allocation resources and set priorities.

During the revision of the system it is recommended that it include:

- Provision for attribution of outputs by funding agency. Allowing for funder attribution is one way to encourage donor partners who are outside the common fund to report through the system.
- Provision for modification of indicators as necessary. This flexibility should be foreseen in the system design.
- Ability to track and differentiate otherwise generic interventions (condom promotion or C&T, for example) targeting specific vulnerable groups, such as transport workers or sex workers.

##### *Financial resources database*

Resource tracking can also be integrated into the implementer database if the CNCS wishes. At a minimum, resources provided to the CNCS can be crossed with outputs and outcomes. Later, as trust is developed in the system, it may be possible to track non-CNCS resources as well.

### *Research database*

The M&E working group, CNCS and Ministry of Science and Technology is designing a web-based research database.

### Remedial actions planned to overcome the challenges:

- Once the programme activity and output reporting system has been reviewed and revised, and training for reporting has begun, the implementer and output databases should be reviewed and improved to provide data on all implementers, private, public and civil society sectors, all levels (district, provincial and national) and both CNCS-funded and non-CNCS-funded implementers.

## Component 10: Supportive supervision and data auditing

Necessary elements of any data system are supportive supervision and routine data auditing. Data is being gathered at all levels, but little quality control is required. Although CNCS and several other ministries perform routine internal consistency checks on data as they are put into the database, provincial and district structures often lack sufficient human resources and means of transportation to routinely travel to far-flung districts to supervise HIV activities, quality and data collection.

### Remedial actions planned to overcome the challenges:

- Review the Programme Activity reporting system and its related Registry of Implementers. Design a system to serve all sectors (civil society, private and public sectors).
- As part of the training materials for the provincial M&E officers, design written guidelines and forms for supportive supervision and data auditing of implementers.
- Train provincial M&E officers in on-site supportive supervision and data auditing.
- Organize annual and quarterly provincial and district participatory annual reviews in cascade to assess the completeness, accuracy and quality of data from the various implementers. These reviews do not substitute supportive supervision and data-auditing, but serve as a cost-effective complement.
- Conduct quarterly regional reviews for provincial stakeholders to review statistics, surveys, surveillance, and medical and non-medical programme activity information.

## Component 11: HIV Evaluation and Research

Important HIV and AIDS evaluation research has been conducted in Mozambique over the past 20 years, mainly by Ministry of Health (MOH) affiliated researchers, but more recently also by many other sectors. In principle each sector coordinates the research activities within its area, and until recently very little cross sectoral coordination or sharing of results have taken place. MOH has an established system for approving protocols through its Bio-Ethics Committee.

With the approval by the Council of Ministers in June 2006 of the new National Research Strategy, which clearly operationalizes the role of the Ministry of Science and technology (MCT) in coordinating all poverty related research, including HIV and AIDS research, in Mozambique, a more comprehensively coordinated and integrated research system will be developed.

Research is one of seven sub-strategies in The National AIDS Strategy (PEN II), and a coordinated multisectoral research systems approach is foreseen, involving CNCS, MCT, MOH, Ministry of Education, the Institute of Statistics (INE), public and private universities, and civil society in both production and dissemination of research relevant for the implementation of the PEN II. Several

important steps in the operationalization of both the Research sub-strategy in the PEN II and the MCT Strategy were taken in 2007 by MCT in collaboration with CNCS and key ministries and institutions:

**Mapping of HIV and AIDS evaluation and research** conducted between 1986-2007 was undertaken and identified 455 studies and other key documents relevant for the implementation of the PEN II. An earlier bibliography from 2002, which contained less than half of these studies, was incorporated in the new bibliography. Studies were collected from 152 key government and private institutions, NGOs, research institutes and bi-and multilateral partners at both central and provincial levels in 8 of the 11 provinces. The studies were grouped according to the 7 sub-strategies of the NAS: prevention, advocacy, stigma and discrimination, treatment and care, mitigation, research, and coordination. Most studies focus on prevention (38%), followed by coordination, monitoring and evaluation (22%), treatment (19%), mitigation (10%), advocacy (5%), research (3%), and stigma and discrimination (0.6%). An annotated bibliography was produced and will be made available in print in 2008. It will be widely distributed, discussed, and used as a basis for identification of gaps in knowledge related to the implementation of the NAS, and as such it is intended to be used in the development of a "national research platform".

**Multisectoral research capacity needs assessment** was done through interviews with 126 key stakeholders at central and provincial levels in 8/11 provinces. The assessment looked at production, systematization and use of research findings to inform policy and strategy formulation; production, retention and use of human resources; as well as research infrastructure and resources. Among many other things, the assessment shows that:

- much information exists but is spread out and difficult to access;
- it is necessary to coordinate and assess the information produced
- it is imperative to facilitate the development of more knowledge in order to improve the national response in the PEN II
- Ensure that knowledge gained is not only accessible to some but to all involved in the response to HIV and AIDS.

A HIV and AIDS Research Programme has been finalized after inputs from the key stakeholders and discussions in the NAC Board and approved by the Council of Ministers. The MCT with assistance from NAC and other sectors will launch the programme in early 2008. The programme sets up a national management and coordination structure for research production, capacity building and research dissemination.

A national workshop is expected to take place in early 2008 to share and validate the results of the mapping of HIV research, but also to identify priority research. The key challenge is to secure "buy in" and ownership from all stakeholders in developing a sufficiently flexible and responsive research program that will show timely and visible impact on the HIV situation in Mozambique.

#### Component 12: Data dissemination & use

This component is closely related to the advocacy and communication plan already discussed. Overall, data is not being analyzed or used for decision making until it reaches the national level. Moreover, Program managers receive limited feedback from the available data

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

Remedial actions planned to overcome the challenges:

- Standardized reporting systems and formats need to be developed to assure uniform, meaningful reporting from all provinces.
- Data analysis should be done at the district level (i.e., simple graphs or charts provided to the health posts and health centers).
- Produce summary reports on a regular basis and shared with the districts and provinces.

**Mozambique HIV Data Triangulation Project #1 2007-2008:** There is evidence that HIV prevalence continues to rise in Mozambique. While sentinel surveillance from ANC clinics provides valuable data on trends in HIV prevalence, there has been limited work to date to integrate all available sources of data on HIV infection. In order to tailor prevention activities to respond to actual sources of new infections, and in order for care and treatment programs to best address the needs of PLWH, an integrated picture of the epidemic which explores the subpopulations most at risk for infection is urgently needed. In relation to this identified need the CNCS and MOH are collaborating with partners such as CDC, UNAIDS and University of California, San Francisco (UCSF) to conduct an HIV data triangulation activity in Mozambique. This activity will be complemented by other activities like the Evaluation agenda setting activity and the Modes of transmission work.

*Project Formulation/Data Identification and Capture:* Analysts from the CNCS together with a UCSF team and other interested stakeholders defined the research question. *Research Question:* What are the national, regional and local drivers of the HIV epidemic and how has the national prevention effort responded to them.

*Data Analysis:* The UCSF team, in conjunction with CNCS, analyzed the data collected in the first phase of the project. Initial analysis included looking at differences in HIV prevalence (incidence) and risk behaviours between different geographic areas and subgroups of the population, and to establish trends in prevalence (incidence) and risk factors in those geographic areas and subgroups.

The second phase of data triangulation will move forward with triangulating the evidence around the working hypotheses including the incorporation of the 2007 ANC round, additionally data on syphilis, and continued synthesis of other identified sources.

*Stakeholders Triangulation Workshop:* UCSF conducted a workshop in November 2007 with analysts from the CNCS, MISAU, and interested stakeholder organizations such as CDC, UNAIDS, MISAU and the Multisectoral Working Group. During the workshop, participants reviewed and discussed the several working hypotheses. As a result of the workshop, some hypotheses will be expanded (e.g., effect of alcohol and not just injection drug use), others will be more specific (e.g., behaviours of men and youth will be split into separate hypotheses).

*Data Triangulation Workshop:* In February 2008, a data triangulation workshop will walk participants through the process of integrating diverse sources of data using actual data from the HIV epidemic in Mozambique. Participants will generate observations and working hypotheses on HIV infection, risk behaviours and vulnerabilities that lead to HIV infection from the data during the workshop. Based on these observations and hypotheses participants will be encouraged to develop prevention and treatment program recommendations to respond to the identified trends and risk factors.

*Report on the current state of the HIV epidemic in Mozambique:* UCSF and CNCS will develop a report that summarizes the current state of the epidemic in Mozambique, with a focus on recommendations for prioritizing HIV-related interventions.

## VIII. Annexes

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

- 1) Which institutions/entities were responsible for filling out the indicator forms?
  - a) NAC or equivalent Yes
  - b) NAP Yes
- 2) With inputs from Ministries:

Education	Yes
Health	Yes
Labour	No
Foreign Affairs	No
Women and Social Action	
Youth and Development	
Agriculture	
Civil society organizations	Yes
People living with HIV	Yes
Private sector	Yes
United Nations organizations	Yes
Bilaterals	Yes
International NGOs	Yes
Universities	
- 3) Was the report discussed in a large forum? Yes
- 4) Are the survey results stored centrally? Yes
- 5) Are data available for public consultation? Yes
- 6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

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Date: 31 January 2008

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**ANNEX 2: National Funding Matrix – 2007**

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Reporting Cycle: 2004, 2005 and 2006 calendar year

Local Currency: Meticais

Average exchange rate with US dollars during the reporting cycle:

**Methodology:** National AIDS Spending Assessments supplied the data for the National Funding Matrix. Full report is attached to the UNGASS report.

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

**Budget Support:** Budget support from an international source (e.g. a bilateral donor) is included under the Central/National and/or Subnational sub-categories under Public Sources of financing.

**ANNEX 3: National Composite Policy Index**

Country: Mozambique

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## ANNEX 5: List of References

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