Republic of Mozambique

National AIDS Council

GARPR

(2012 Global AIDS Response Progress Report)

For the Period 2010 - 2011

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Partners: **GIZ**: Guenter Dietz, Marina Chichava. **CDC:** Peter Young, Paula Simbine, Zenóbia Machanguana, **FNUAP:** Amélia Zawangoni, Nuno Gaspar, Alex Nhambir. **OMS:** Abdou Moha. **ONUSIDA:** Raul de Melo Cabral, Abigail David. **UNICEF:** Dezi Mahotas, Luísa Brumana, Maaike Arts, Paula Libombo. **PMA:** Nádia Osman. **MEASURE:** Maria João Nazareth. **DANIDA:** Kierstn, Hermínia Xerinda. **USAID:** Mathew Rosental**,** Márcia Manteja. **PEPFAR:** April Kelley. **Pathfinder International**: Marcos Benedetti. **Lambda:** Danilo da Silva, Augusto Guambe. **EcoSIDA:**Natividade Bule, Balbina Santos**. FHI:** Xavier Cândido. **MOPCA:** Lídia Monjane. **MONASO:** Linda Chongo. **RENSIDA:** Júlio Mujojo, Amos Sibambo. **NAIMA**+: Sally Griffin.

GARPR report preparation team: **CNCS:** Páscoa Themba, Glória Fazenda Leite, Cecília Uamusse, Izídio Nhantumbo, Lourena Manembe, Cecília Martine and Sílvio Macamo; **MEASURE:** Meldina Valente; **UNAIDS:** Marta Bazima; **Consultants:** Rui Mapatse and Joel Samo Gudo.

Supervision and final review: Joana Mangueira and Diogo Milagre.

PREFACE

The Government of Mozambique signed in 2001 the Commitment Declaration towards the Global AIDS Response Progress Report (GARPR) previously known as UNGASS, and as such it undertook to report every two years the progress in the implementation of its National Program to Fight Against AIDS. Since then, the Government of Mozambique has been reporting domestically and to the international community the progress made in the national response to AIDS, and so far it has covered the periods 2001-2003, 2004-2005, 2006-2007 e 2008-2009.

Mozambique has been making history due to the success of its laudable approaches in the fight against HIV. After many years of titanic efforts, the number of new infections is now on the decline.

For all the segments and players engaged in the fight against HIV and AIDS in Mozambique this is a moment of pride given the progress the country has been making year after year. For the first time the country is in a position to report information of high scientific value both qualitatively and quantitatively. Each passing day, such information contributes to shed light to the intervention, while also imposing challenges.

For that reason, the prevailing enthusiasm should not lessen the need to speed up and enhance the response and the fulfillment of the set targets. Rather, it should serve to provide greater impetus to the efforts to face up the many challenges that still lie ahead, such as the fact that the data show that there is an increase of new infection in the central region of the country, which could be associated to the large development projects in the part of the country. It is important to foresee events and to even increase everybody's commitment towards the development of the country, by preparing the different stakeholders to engage in this battle, which can be won through the duly combined and harmonized actions and efforts at all levels.

It can now be noted that the prevention messages have been given a Mozambican flavour, with slogans such as: "*Andar fora é maningue arriscado*" (having affairs is just too risky) or "*Amores a mais é demais*" (too many lovers is just too much). However, there is still a lot to be done, as there is a need to confront openly the issue of sexuality, and to address the taboos and myths around sexual and reproductive health. Grass-roots authorities need to get more involved, such as the traditional healers and traditional leaders (local chiefs - *régulos*), neighbourhoods leaders, residential blocks leaders, etc.), community-based organizations and households so that it can be further understood how to deal with the issue of sexuality at the household level.

Weaknesses have been found in quantifying and in the distribution of both the male and female condom. With the assistance from local and international stakeholders there are now better approaches to deal with this issue, which is highly important, considering that the epidemic in Mozambique in essence results from unprotected sex.

Existing lifelong skills development programs are encouraging and constitute a source of inspiration to other nations that are also engaged in the fight against HIV and AIDS. Such programs and other targeting girls, give us more hope and the assurance that Mozambique is on the right track, as proven by scientific data showing that behaviour patterns among this group is improving. Nonetheless, much remains to be done, as HIV prevalence amongst girls is still very high, i.e. three times higher than that of boys of the same age.

While the country now has a lot of quality information that can help to understand better the epidemic than in the past, there are still some areas that require improvement, such as concerning the group of men who have sex with men, people who inject drugs and sex workers, where further studies are required to establish how to reach such groups and the kind of specificities that need to be incorporated into the current activities to secure their involvement towards an effective response to HIV and AIDS.

A study has been initiated on the prison population and it is hoped that this will lead to a better understanding of the dynamics of transmission amongst this group of people so that they can be better protected and to ensure that appropriate assistance is provided to those in need.

Mozambique is making progress towards the involvement of people with disabilities and there is now in place a testing and counselling program for people with hearing disability, but much still remains to be done.

The knowledge that we have acquired up to date about different approaches for prevention of HIV in our population, enable us to integrate different interventions in order to take advantages. Taking as an example, we are using male circumcision program as a window of opportunity for HIV testing.

Africa and Mozambique in particular is privileged to be undergoing an historical period that is shaping the development of nations, namely the era of Information Technologies. The pediatric anti-retroviral treatment program has experienced a step forward, as it was at the forefront in the use of text messages via mobile phones (SMS) to send test results to the users. This is an illustration of how Information Technologies, when properly used, can constitute a robust and comfortable vehicle leading to various destinations swiftly and safely.

The experience that Mozambique has gained over the years encourages the decentralization of treatment to the most peripheral health facilities by using Medical Technicians, some of whom have already received training and feel confident to administer ART on children.

The issue of nutrition amongst HIV infected patients is a very critical aspect in the fight against the HIV and AIDS epidemic. This requires a very particular attention, as it could undermine the whole effort and result in the wastage of the limited resources available. In a country with one of the highest rates of poverty in the world, the people affected by AIDS are also mostly poor, with nothing to eat. People undergoing treatment have to decide whether to take the medicines or not based on what they have available to eat at that moment. Adherence to treatment and care is considerably dependent on this in the country. Efforts are being made to address this matter, but it should be made clear that there is a long way to go.

Experience of over twenty years of combating AIDS in Mozambique points towards what really works with the few resources that the country has. The process of documenting good practices has unveiled remarkable achievements in some battles in which Mozambique has been engaged and this enhances the certainty that the country is on the right track. This constitutes a true *mozambicanization* of the response. There is a need to perfect the response documentation processes, as this will serve as a source of learning and inspiration for all stakeholders engaged in the fight against HIV and AIDS.

Successes and failures in the daily battles require a recording system that is commensurate with the results that are expected to be achieved. It is not possible to review and discuss the achievements and failures if these are not properly documented. A robust monitoring and evaluation system is a requirement for a robust response. Major progress has been made, but challenges still prevail related to the lack of skilled and motivated staff. More support from our partners is needed, to furnish institutions with state of the art equipment, robust programs and technical assistance for an effective information management.

Without the unfaltering support from the cooperating partners and from the implementation partners the country would not have reached where it is now. And in other to face the many challenges that lie ahead, it is important for the country to continue to strengthen its harmonization and coordination systems at all levels.

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

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-Natal Care/Clinic
ANEMO	National Association of Nurses of Mozambique *Associação Nacional dos Enfermeiros de Moçambique*
ARV	Anti-Retroviral Drugs
ART	Anti-Retroviral Treatment
ASC	AIDS Spending Categories
AVC	Stroke *Acidente Vascular Cerebral*
AZT	Zidovudine
BAU	On Stop Services Desk
BMI/Age	Body Mass Index for Age
BSS	Behaviour Surveillance Survey
CBO's	Community Based Organizations
CCR	HIV exposed child outpatient *Consulta da Criança de Risco*
CCTH	Community Counselling and Testing on Health
CDC	Centers for Disease Control and Prevention
CEP	Center for Population Studies
CNCS/NAC	*Conselho Nacional de Combate ao SIDA* National AIDS Council
CSB	Corn Soy Blend
CSO's	Civil Society Organizations
CTH	Counselling and Testing on Health
CTHU	Counselling and Testing on Health Unit
CTU	Counselling and Testing Unity
DBS	Dry Blood Spot
DFID	Department for International Development (United Kingdom)
DHS	Demografic and Health Survey
DOTS	Direct Observation Treatment Strategy
du-NVP	Single dose of Nevirapine
EAP	Strategy for the Acceleration of the Prevention of HIV Infection *Estratégia de Aceleração da Prevenção da Infecção pelo HIV*
EcoSIDA	Business People Against AIDS *Empresários Contra o SIDA*
EPP	*Estimates and Projections Packet*
FDC	Community Development Foundation *Fundação para o Desenvolvimento da Comunidade*
GARPR	Global AIDS Response Progress Reporting
GCPCD	Central Cabinet for Prevention and Combating Drugs *Gabinete Central de Prevenção e Combate à Droga*
GTM	Multi-sectoral Technical Group *Grupo Técnico Multi-sectorial*
HBC	Home Based Care
HbsAG	Hepatitis B Surface Antigen
HCV	Hepatitis C Virus
HIS	Health Information System

HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological and Behavioral Survey
IDU	Injecting Drug Users
IEC	Information, Education e Communication
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illnesses
IMO	International Migration Organization
INAS	National Institute for Social Support *Instituto Nacional de Apoio Social*
INE	National Institute for Statistics *Instituto Nacional de Estatística*
INS	National Institute for Health *Instituto Nacional de Saúde*
INSIDA	Population-Based Sero-Behavioral Survey *Inquérito Nacional de prevalência, riscos comportamentais e informação sobre HIV e SIDA*
IPT	Isoniazid Preventive Therapy
I-RARE	International Rapid Assessment, Response and Evaluation
KAPB	Knowledge, Attitudes, Practices and Beliefs Survey
LWF	Lutheran World Federation
M&E	Monitoring and Evaluation
MCH	Mother and Child Health
MDGs	Millennium Development Goals
MF	Ministry of Finance *Ministério das Finanças*
MIC	Ministry of Industry and Trade *Ministério da Indústria e Comércio*
MICS	Multiple Indicator Cluster Survey *Inquérito sobre Indicadores Múltiplos*
MIDEF	Ministry of Defense *Ministério da Defesa*
MINED	Ministry of Education *Ministério da Educação*
MINT	Ministry of Home Affairs *Ministério do Interior*
MISAU	Ministry of Health *Ministério da Saúde*
MJ	Ministry of Justice *Ministério da Justiça*
MJD	Ministry of Youth and Sports *Ministério da Juventude e Desportos*
MMAS	Ministry of Women and Coordination of Social Action *Ministério da Mulher e Acção Social*
MONASO	Mozambique Network of AIDS Services Organizations *Rede Moçambicana de Organizações de Serviços de SIDA*
MOPCA	Mozambican Palliative Care Association
MSM	Men who have Sex with Men
MTC	Ministry of Transports and Communication

	Ministério dos Transportes e Comunicação
MTFS	Medium-Term Fiscal Scenario
NASA	National AIDS Spending Assessment
NBTS	*Serviço Nacional do Sangue*
NCPI	National Commitments and Policy Instruments
NDH	National Directorate of Health
NER	Net Enrolment Ratio
NGO	Non-Governmental Organization
NHS	National Health Service
NPCS	Provincial AIDS Nucleus *Núcleo Provincial de Combate ao SIDA*
NRL	National Reference Laboratory
NVP	Nevirapine
OI	Oportunistic Infection
OIT	Opportunistic Infection Treatment
OVC	Orphans and Vulnerable Children
PACOV	Multi-Sectoral Plan for Orphans and Vulnerable Children *Plano Multi-sectorial para as Crianças Órfãs e Vulneráveis*
PARPA	Action Plan for the Reduction of Absolute Poverty *Plano de Acção para a Redução da Pobreza Absoluta*
PCR	Polymerase Chain Reaction
PDH	Provincial Directorate of Health
PEEC	Strategic Plan for Education and Culture *Plano Estratégico da Educação e Cultura*
PEN	National HIV and AIDS Strategic Plan *Plano Estratégico Nacional de Combate ao HIV e SIDA*
PEPFAR	President's Emergency Plan for AIDS Relief
PES	Social and Economic Plan *Plano Económico Social*
PGB	*Programa Geração Biz*
PGR	Attorney General Office *Procuradoria Geral da República*
PIMA	Integrated and Budgeted Monitoring and Evaluation Plan *Plano Integrado e Orçamentado de Monitoria e Avaliação*
PLHIV	People Living with HIV
PMC	Mental and Behavioral Problems
PMTCT	Prevention of Mother-to-Child Transmission
PNAC	National Action Plan for Children *Plano Nacional de Acção para as Crianças*
PNTS/ NBTP	National Blood Transfusion Program *Programa Nacional de Transfusão de Sangue*
PRN	Nutrional Reabilitation Program *Programa de Reabilitação Nutricional*
PSA	Food Subsidy Program *Programa Subsidio de Alimentos*
PSI	Population Services International
PWD	People With Desability
PWHD	People With Hearing Desability

QUALIMUN-Ser-HIV	Quality Assurance Programme for HIV Serology *Programa de Garantia de Qualidade para a Serologia do HIV*
RENSIDA	Mozambique Network of PLHIV associations Rede Nacional de Associações de Pessoas Vivendo com HIV
RUTF	Ready-to-Use Therapeutic Food
SDSMAS	Districs Services for Health, Women and Social Action Serviços Distritais de Saúde, Mulher e Acção Social
SENASA/	National Blood Transfusion Service
SETSAN	Technical Secretariat for Food and Nutrition Security *Secretariado Técnico de Segurança Alimentar e Nutricional*
SIRNM	National HIV/AIDS Response Information System for Mozambique *Sistema de Informação da Resposta Nacional ao HIV/SIDA Moçambique*
SNAPRI	National Service for Prisons *Serviço Nacional das Prisões*
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TB-MDR	Multi-drug Resistant Tuberculosis
TSA	Antibiotic Sensitivity Testing *Teste de Sensibilidade Antibiótica*
TTIs	Transfusion Transmitted Infections
UNAIDS	United Nations Joint Programme on HIV and AIDS United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session Declaration of Commitment on HIV and AIDS
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
US$	United States Dollar
USAID	United States Agency for International Development
WFP	World Food Program
WHO	World Health Organization
YFHS	Youth Friendly Health Services

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I. STATUS AT A GLANCE

Indicator	Comments on the changes	2004/2005	2006/2007	2008/2009	2010/2011
Objective 1: Reduce sexual transmission of HIV by 50% by 2015					
General Population					
1.1. 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. (IDS: 2003, INSIDA: 2009)	It has been maintained	22.3%* Male: 33%* Female: 20%*	22.3%* Male: 33%* Female: 20%*	34.8% Male: 33.7% Female: 35.7%	34.8% Male: 33.7% Female: 35.7%
1.2. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 (IDS: 2003, INSIDA: 2009)	Minor differences, as the preliminary 2008/2009 version was used	27.6%* Male: 26%* Female:28%*	27.6%* Male: 26%* Female:28%*	25.1% Male: 24.9% Female: 25.3%	24.9% Male: 24.8% Female: 25.0%
1.3. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months. (IDS: 2003, INSIDA: 2009, IDS: 2011)	It has been maintained	11,1% Male: 30.2% Female: 4.9%	11,1% Male: 30.2% Female: 4.9%	10,8% Male: 19.6% Female: 2.9%	15.3% Male: 29.5% Female: 2.8%
1.4. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse (IDS: 2003, INSIDA: 2009, IDS: 2011)	Age group has been expanded and changes introduced to the definition	17% Male: 19% Female:14.4%	17% Male: 19% Female:14.4%	23.6% Male: 22,4% Female: 24.7%	18.5% Male: 25.5% Female: 30.6%
1.5. Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results (INSIDA: 2009).	Differences found as the preliminary 2008/2009 version was used	Not reported in 2005	2.5%* Male: 3%* Female: 2%*	12.1% Male: 8.9% Female: 14.5%	13.6% Male: 8.9% Female: 17%

*- 2003 data

Indicator	Comments on the changes	2004/2005	2006/2007	2008/2009	2010/2011
1.6. Percentage of young people aged 15-24 who are living with HIV	It has been maintained	-	14.4% (2007)	Female = 14.1%	Data not available
Sex Workers					
1.7. Percentage of sex workers reached with HIV prevention programmes	New definition to specify the target group	Data not available	Data not available	Data not available	Data not available
1.8. Percentage of sex workers reporting the use of a condom with their most recent client	It has been maintained	Data not available	Data not available	Data not available	Data not available
1.9. Percentage of sex workers who have received an HIV test in the past 12 months and know their results	New definition to specify the target group	Data not available	Data not available	Data not available	Data not available
1.10. Percentage of sex workers living with HIV	New definition to specify the target group	Data not available	Data not available	Data not available	Data not available
Men who have sex with men (MSM)					
1.11. Percentage of men who have sex with men reached with HIV prevention programmes	New definition to specify the target group	Data not available	Data not available	Data not available	Data not available
1.12. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	It has been maintained	Data not available	Data not available	Data not available	Data not available
1.13. Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	New definition to specify the target group	Data not available	Data not available	Data not available	Data not available
1.14. Percentage of men who have sex with men who are living with HIV	New definition to specify the target group	Data not available	Data not available	Data not available	Data not available

Indicator	Comments on the Changes	2004/2005	2006/2007	2008/2009	2010/2011
Objective 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015					
2.1. Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	New Indicator	Data not available	Data not available	Data not available	Data not available
2.2. Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	It has been maintained	Data not available	Data not available	Data not available	Data not available
2.3. Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	It has been maintained	Data not available	Data not available	Data not available	Data not available
2.4. Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	New Indicator	Data not available	Data not available	Data not available	Data not available
2.5. Percentage of people who inject drugs who are living with HIV	New definition to specify the target group	Data not available	Data not available	Data not available	Data not available
Objective 3: Eliminate mother to child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths					
3.1. Percentage of HIV-positive pregnant women who receive anti-retrovirals to reduce the risk of mother-to-child transmission	Changes in the definition	6.7% (2005)	29.8% (2007) 8.3% (2006)	32.1% (2008) 45.8% (2009)	60.2% (2010) 66.0% (2011)
3.2. Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	New Indicator			30.9% (2009)	35.3% (2010) 40.9% (2011)
3.3. Mother-to-child transmission of HIV (modelled)	Changes in the definition	24.6% (2005)	-	31.0% (2008) 29.0% (2009)	23.1% (2010) 20.2% (2011)

Indicator	Comments on the Changes	2004/2005	2006/2007	2008/2009	2010/2011
Objective 4: Have 15 million People Living with HIV on Antiretroviral Treatment by 2015					
4.1. Percentage of eligible adults and children currently receiving antiretroviral therapy	It has been maintained	7.4% (2005) 13.7% (2006)	28.0% (2007)	30.0% (2008) 38.0% (2009)	52.4% (2010) 45.5% (2011)
4.2. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	It has been maintained	Data not available	Data not available	Data not available	74.0% (2010) 74.0% (2011)
Objective 5: Reduce tuberculosis deaths in People Living with HIV by 50% by 2015					
5.1. Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	It has been maintained	Not reported in 2005	3.9% (2006)	9.8% (2009)	8.3% (2010) 9.8% (2011)
Objective 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries					
6.1. Domestic and international AIDS spending by categories and financing sources	Minor differences, as the 2008/2009 preliminary version was used	107 496 637 (2004-05)	96 624 000 (2006)	146 425 000 (2008)	146 420 694 (2008)

Indicator	Comments on the Changes	2004/2005	2006/2007	2008/2009	2010/2011
Objective 7: Critical Enablers and Synergies with Development Sectors					
7.1. National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Change in the denomination and additional issues	82% (2005)	70%	75%	74%
7.2. Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.	New indicator	Data not available	Data not available	Data not available	0.6%
7.3. Current school attendance among orphans and non-orphans aged 10–14	It has been maintained	Orphans: 62.6%* Male: 72.6% Female: 54%	Orphans: 62.6%* Male: 72.6% Female: 54%	Orphans: 77.3% Non-orphans: 86.5% (2008)	Orphans: 66% Non-orphans: 79.3% (2009)
7.4. Proportion of the poorest households who received external economic support in the last 3 months	Changes in the definition	22%	22%	22%	Data not available

*- 2003 Data

II. Overview of the AIDS Epidemic

HIV Prevalence

HIV prevalence among adults in Mozambique is estimated on the basis of the National Survey on Prevalence, Behavioral Risks and Information about HIV and AIDS in Mozambique (2009 INSIDA[1]), and HIV epidemiologic surveillance in sentinel sites, held among pregnant women attending ante-natal care. A quarter of the 144 administrative districts and cities of Mozambique have sentinel posts (Centre: 15 sites; North: 11 sites; South: 10 sites). While fieldwork has been concluded for 2011 ANC surveillance, laboratory testing has not yet been completed, thus results are only available through 2009.

Prevalence among Pregnant Women

In 2009, epidemiologic surveillance was held in the same 36 sentinel posts as in 2004 and 2007. A total of 13 373 women agreed to be tested (approximately 300 women per sentinel site).

Table 1 – HIV median prevalence among pregnant women aged 15-49 attending ANC, by Age Group, Region, Location of the Site and Pregnancy in Mozambique 2001-2009

Characteristics	Median HIV prevalence[2]				
	2001	2002	2004	2007	2009
Age group					
15 – 19	8.6%	9.8%	12.4%	7.7%	8.2%
20 – 24	15.1%	15.1%	19.2%	16.2%	14.9%
25 – 29	14.9%	13.9%	16.3%	13.6%	18.5%
30 – 49	11.3%	14.2%	15.5%	13.0%	12.7%
Region					
South	15.2%	16.8%	20.0%	20.3%	22.2%
Centre	16.0%	15.4%	19.1%	15.4%	15.1%
North	6.0%	8.3%	10.1%	7.4%	7.9%
Location					
Urban	15.3%	18.0%	19.0%	18.7%	22.1%
Rural	9.0%	12.0%	12.7%	9.4%	9.5%
Gestation					
1st pregnancy	9.8%	9.4%	13.0%	10.0%	10.5%
2nd or additional gestations	14.3%	14.0%	17.9%	14.6%	16.6%
National	14.2%	13.7%	16.0%	13.2%	13.7%

Source: RVE 2009 V19-page 27

[1] Population Based Sero-Behavioral Survey (INSIDA 2009).
[2] Notice that the consistence on sentinel sites is from 2004 up to 2009. Before that there were changes on sentinel sites in 2002 and 2004.

The refusal rate was - 0.3%. Median prevalence among pregnant women was 13.7% at the national level, and varied from 22.2% in the south to 7.9% in the north. In Urban areas prevalence was 22.1%, while in suburban areas prevalence was 9.5%. The age group with the highest prevalence in 2009 was 25-29 years of age (18.5%).

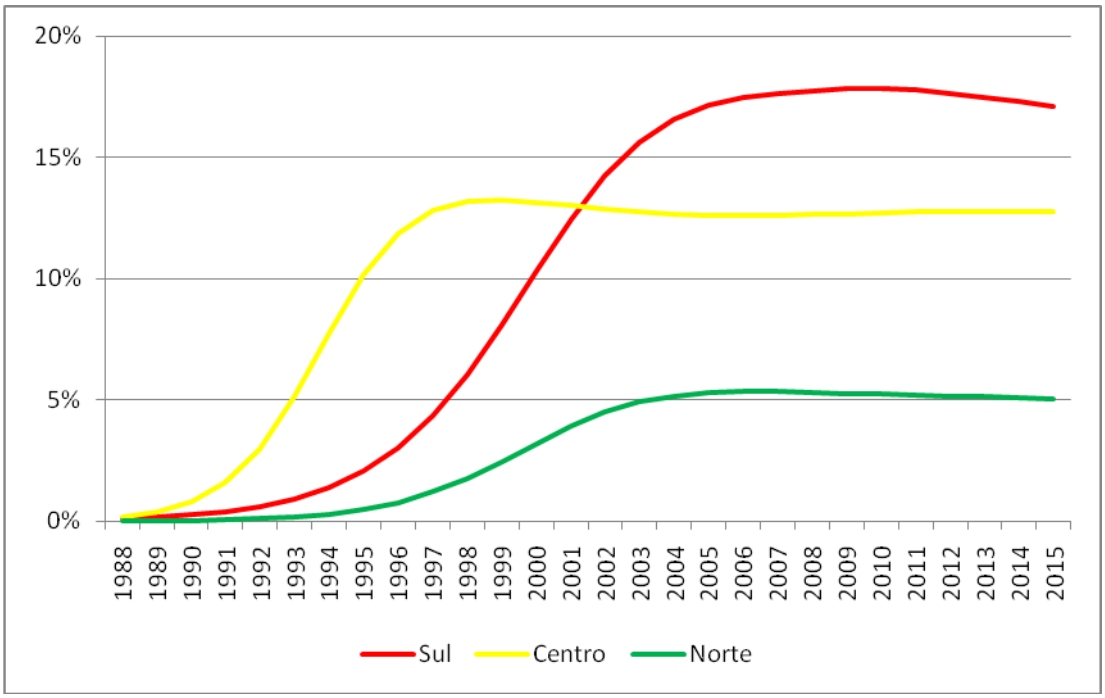
ANC prevalence estimates are summarized at the regional and national level using the median of the sentinel site prevalence estimates. Results of the last 4 rounds of sentinel surveillance are shown in Table 1.

A linear regression analysis was performed to assess trends in ANC prevalence among women aged 15-49. No significant change in prevalence was detected from 2002-2009, although the southern region registered an increase in this period, and urban sites had higher prevalence than rural sites in 2009.

Prevalence in Adult Population

According to the INSIDA, national prevalence was 11.5% in adults aged 15-49 in 2009. HIV prevalence was higher in women (13.1%) than in men (9.2%) and is highly variable between provinces, from 3.7% in Niassa to 25.1% in Gaza. The estimated HIV prevalence for adults in the southern region is 17.8%, in the central region it is 12.5% and in the northern region it is 5.6%.

Figure 1 – Projected HIV regional prevalence, 1988-2015



Source: RVE v19- page 45

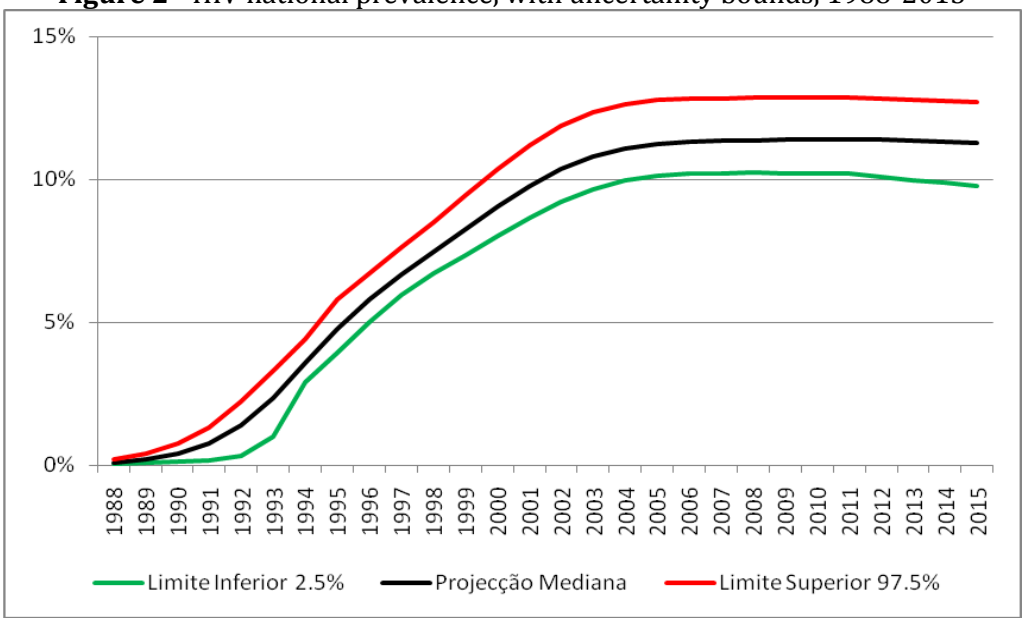
National prevalence is projected using an epidemic model which fits a projection to the INSIDA prevalence in the three regions (northern, central and southern) and the HIV prevalence of each sentinel post in each year that sentinel surveillance was conducted. The model weights the prevalence estimates by the population of each region where the sentinel sites are sited. The adult population is calculated using available census

projections that are based on the 2007 population census. As such, prevalence rates are calculated for each region and for the whole country. Projected prevalence rates are not disaggregated between rural and urban areas.

Regional Trends

Figure 1 shows the population HIV prevalence rates historic trends and future projections among the adult population, at regional level, from 1988 up to 2015. Similarly to what was noted in previous rounds, the three regions in the country show marked differences: the southern region has the highest prevalence levels, followed by the central region and the north.

Figure 2 - HIV national prevalence, with uncertainty bounds, 1988-2015



Source: RVE v19- page 45

Trend analysis on the projected HIV prevalence among adults at regional level, from 2001 up to 2009 (Figure 1), shows that the levels have stabilized in recent years and may have declined in the central region and more recently in the north. In the south, prevalence levels have grown between 2001 and 2007, having a growth desacceleration and possible stabilization between 2007 and 2009

National Trends

The analysis of the HIV prevalence rates historic trends among the adult population, at national level, from 1988 up to 2015 shows stabilization of the national prevalence (Figure 2).

GARPR Indicator #1.6: Percentage of young women and men aged 15–24 who are living with HIV

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

	All 15-24	Disaggregated Values 15-19	20-24
Numerator: Number of ANC clinic attendees (aged 15 -24) tested whose HIV test results are positive	843	255	588
Denominator: Number of ANC clinic attendees (aged 15-24) tested for their HIV infection status	5 999	2 738	3 261
Indicator Value Percent*	14.1%	9.3%	18.0%

*-Pooled prevalence percentage calculated as the numerator / denominator × 100. It should be noted that figures mentioned in the Table above correspond to females only.

According to the GARPR (UNGASS) method of measurement HIV prevalence among young women (15-24 years) attending antenatal clinics in 2009 is 14.1%. The HIV prevalence rate is higher among age group of 20-24 (18.0%) when compared to the age group of 15-19 years (9.3%)(Table 2).

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

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

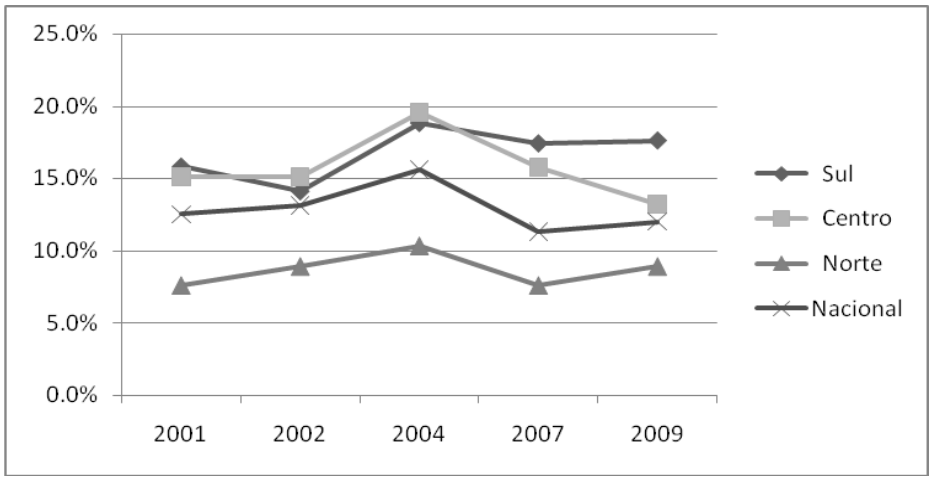
Ano	2001	2002	2004	2007	2009
National Prevalence	12.5%	13.1%	15.6%	11.3%	12.0%

[Source: MISAU/INS, 2009]. † Median of the site level prevalence percentages

According to Table 3, the HIV prevalence rate among young women (15-24 years) attending antenatal clinics reached a peak value in 2004 (15.6%) and showed a decrease in 2007 (11.3%), that was confirmed in 2009 (12.0%).

A linear regression analysis shows that, in the period 2002-2009 among female youth aged 15-24 years, at national level, there was not a significant reduction in the prevalence of HIV. At regional level, the northern region keeps on showing the lowest prevalence rate in the country in this age group. The central region shows a descending trend. Posts sited in urban areas present higher prevalences when compared to sites in rural areas, in the same age group, in 2009. This is illustrated in figure 3 which shows the median of HIV prevalence at each sentinel site among 15-24 year olds.

Figure 3 - Median HIV prevalence among women aged 15-24 years at all surveillance posts, by region, 2001-2009, Mozambique.



[Source: MISAU/INS, 2009]

III. National Response to the AIDS Epidemic

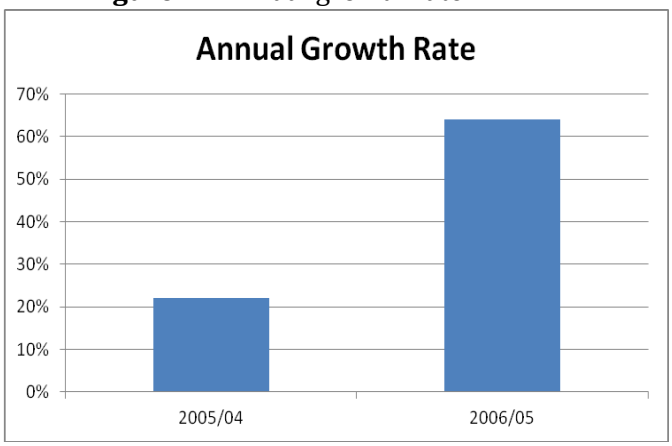
Part I. National Commitments and Action

Domestic and International Expenditure on HIV and AIDS

In Mozambique, the determination of the expenditures on HIV and AIDS (MEGAS) was introduced for the first time in the early 2008 covering the period 2004 - 2006, based on the use of the NASA methodology, which enables the thorough screening of expenditures funded by public, private and international sources. Through such exercise, national level expenditures were tracked through the collection of data on domestic, external and private expenditures from the major players in the national response.

Estimates show that between 2004 and 2006 the country spent a total of US$ 204 million, with a steep growth in that in 2006 the expenditure was double the 2005 expenditure while annual growth rates varied from 22% in 2004/2005 to 64% in 2005/ 2006. Over the same period, external sources of funding represented 82% of the expenditures on HIV and AIDS against 16% from public funds and just 2% from private sources.

Figure 4– Annual growth rate



To establish the expenditures for the period 2007/2008, NASA pursued the same methodology, in that expenditure data were obtained mainly from the records kept by primary sources of information. In some cases, the data had to be adjusted to the country's fiscal year, which is the same as the calendar year, but is different from the fiscal year adopted by some countries and international organizations. In other cases, it was necessary to make estimates on HIV and AIDS expenditures using costing techniques based on the best information available and adequate assumptions.

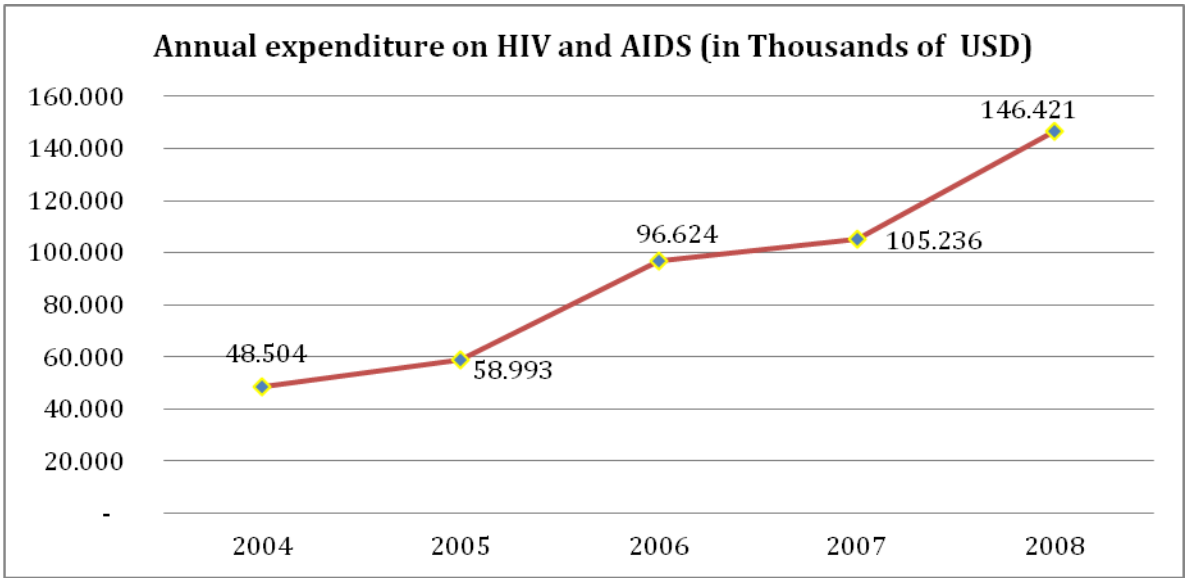
A constraint in this exercise is the fact that some organizations involved in the national response are not based in the country and hence it was not possible to get relevant information. Generally, the organizations tend not to disclose their expenditures related to the management and administration of HIV and AIDS related programs. Another constraint arises out of the fact that it is very difficult to make estimations, in the absence of baseline population surveys, of the household expenditures on HIV and AIDS related services and medicines.

Although these data were contained in the 2010 UNGASS report, here they appear with their final format, as the data in such report were provisional. Moreover, this is the most updated information available about the expenditure on HIV and AIDS in Mozambique.

Major Findings

As shown in Figure 5 and on Table 4, MEGAS estimates reveal that the expenditures on HIV and AIDS totalled US$ 251 million over the 2007/2008 period. The 2007/2008 estimated expenditure is 23% higher than what was recorded in the three preceding years (2004 - 2006).

Figure 5 – Annual expenditure on HIV and AIDS



Although the expenditure growth between 2006 and 2007 has been modest at just 9%, it accelerated to 39% between 2007 and 2008 confirming the trend of high growth rates as it was the case between 2004 and 2006.

Figure 5 clearly shows that the expenditures on HIV and AIDS increased three-fold between 2004 and 2008.

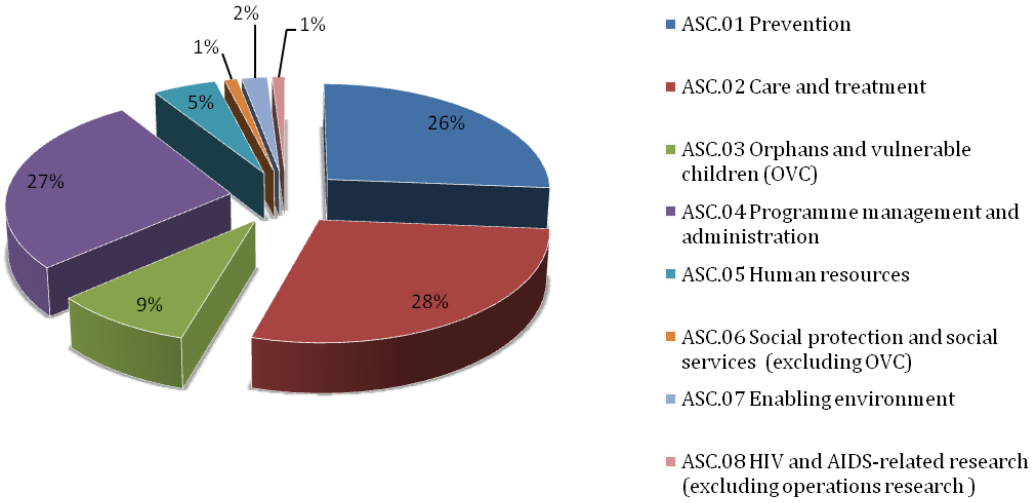
Table 4 – Total expenditures by areas and years (US$)

Category of Expenditure	2007	2008	2007-2008	Var 2007/2008 %
ASC.01 Prevention	26,133,742	40,242,840	66,376,582	54%
ASC.02 Care & Treatment	28,566,098	41,735,566	70,301,664	46%
ASC.03 Orphan & Vulnerable Children	9,239,784	12,593,144	21,832,928	36%
ASC.04 Program Management & Administration	32,822,701	36,085,951	68,908,652	10%
ASC.05 Human Resources	5,056,421	8,486,865	13,543,286	68%
ASC.06 Social Protection & Social Services (excluding OVC)	928,090	1,899,639	2,827,729	105%
ASC.07 Conducive Environment	1,810,620	2,497,158	4,307,778	38%
ASC.08 HIV and SIDA related research (excluding operational research)	678,132	2,879,532	3,557,663	325%
Total	**105,235,588**	**146,420,694**	**251,656,282**	**39%**

During the period under review (2007 and 2008), growth was recorded in all the 8 main categories of expenditure (ASC) and it should be noted that the highest growth, in excess of 65%, occurred in HIV and AIDS related Research (325%), Social Protection and Social Services (105%) and Human Resources (68%). The programmatic activities that benefit specific populations have increased between 46% and 54% whereas the expenditures related to Programs Management and Administration went up just 10%.

For the two years, as illustrated in Figure 6, three categories of expenditures: Prevention; Care and Treatment and Programs Management and Administration represented 81% of the total expenditures. Care and treatment is the expenditure category that absorbed more resources (28%).

Figure 6 – Proportion of Expenditure Categories out of the Total for 2007 and 2008



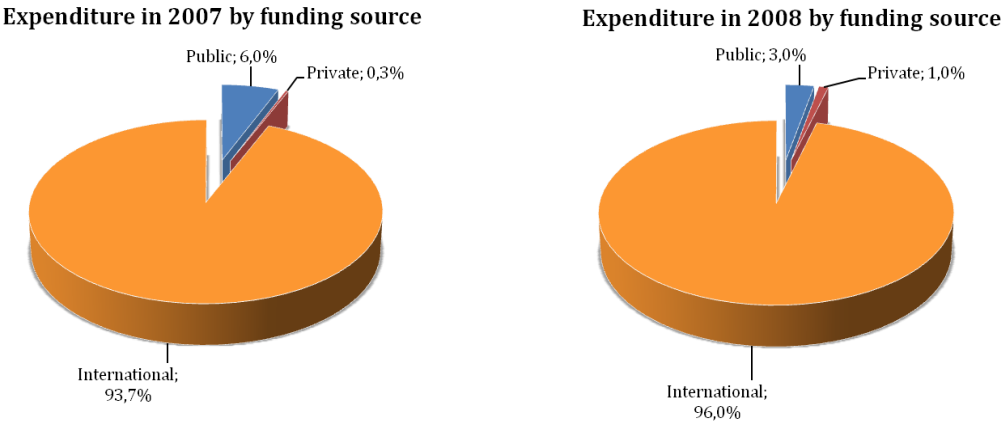
Expenditures with Human Resources for the two years stood at just 5 to 6% of the total expenditure.

The funding of HIV and AIDS programs in Mozambique comes from three sources, namely: Public, Private and External (International). As illustrated in Table 5 and Figure 7, the relative weight of direct external funding of HIV and AIDS increased from 94% in 2007 to 96% in 2008, against a decrease in the public funds from 6% to 3% while private funds remained unchanged at about 0.7 to 1%.

Table 5 – Sources of Funding (US$)

Sources of Funding	2007	%	2008	%
Public	5,967,118	6%	5,033,452	3%
Private	693,965	0.7%	1,479,443	1%
International	98,574,505	94%	139,907,799	96%
Total	**105,235,588**	**100%**	**146,420,694**	**100%**

Figure 7 – Expenditure by source of funding, (2007 & 2008)



The distribution of the various types of source of funding by category of expenditure is shown in Table 6 below.

Table 6 – Expenditure by source of funding and years (US$ thousands)

Expenditure Category	Public		Private		International	
	2007	2008	2007	2008	2007	2008
ASC.01 Prevention	1,959	1,123	294	787	23,880	38,332
ASC.02 Care & Treatment	1,648	1,358	85	133	26,832	40,245
ASC.03 Orphan and Vulnerable Children	0	0	55	9	9,185	12,584
ASC.04 Programs Management & Administration	2,252	2,252	60	258	30,511	33,576
ASC.05 Human Resources	4	140	168	220	4,884	8,127
ASC.06 Social Protection and Social Services (excluding OVC)	30	0	30	67	869	1,832
ASC.07 Conducive Environment	24	161	2	3	1,784	2,334
ASC.08 HIV and AIDS related Research (excluding operational research)	49	0	0	2	629	2,877
Total	**5,967**	**5,033**	**694**	**1,479**	**98,575**	**139,908**

Public Funds are concentrated on three categories of expenditures, namely: Prevention, Care and Treatment and Programs Management and Administration and play a lesser role in the other expenditure categories. Private funds have more than doubled between 2007 and 2008 although they continued to represent just about 1% of the total expenditure during these two years. Thus, the national response to HIV and AIDS is essentially financed by external sources.

External (international) funds when disaggregated show that Bilateral funds represented respectively 72% and 72.5% in 2007 and 2008, Multilateral funds 15% and 17% while NGOs and International Foundations represented 12% and 10% (Tables 7).

Table 7 – Desaggregated External Funds (main 3) (US$ thousands)

Expenditure Category	BILATERAL		MULTILATERAL		NGO & Fundations	
	2007	2008	2007	2008	2007	2008
ASC.01 Prevention	17,109	23,326	4,900	12,561	1,843	2,273
ASC.02 Care & Treatment	20,337	33,303	4,739	2,140	1,756	4,801
ASC.03 Orphan and Vulnerable Children	8,384	10,955	736	1,579	64	50
ASC.04 Programs Management and Administration	19,406	21,909	3,399	5,244	7,706	6,424
ASC.05 Humans Resources	3,185	6,263	1,152	1,573	548	291
ASC.06 Social Protection & Social Services (excluding OVC)	741	895	111	912	17	25
ASC.07 Conducive Environment	1,461	2,098	110	167	214	70
ASC.08 HIV and AIDS related Research (excluding operational research)	510	2,702	0	27	120	149
Total	**71,133**	**101,451**	**15,147**	**24,201**	**12,267**	**14,083**

Table 8 below shows that Bilateral Funds have increased 43% between 2007 and 2008; Multilateral Funds grew 60% while funds from NGOs and Foundations went up 15%. It is worth noting that the growth of Multilateral Funds was negative with respect to Care and Treatment whereas bilateral contributions increased in all expenditure categories. Resources from NGOs and Foundations were targeted preferably to Care and Treatment, Prevention, Social Services and Research.

Table 8 – Variation of the different types of external funds in 2007/2008

Expenditure Category	Var 2007/2008 %		
	BILATERAL	MULTILATERAL	NGOs & International Foundations
ASC.01 Prevention	36%	156%	23%
ASC.02 Care and Treatment	64%	-55%	173%
ASC.03 Orphan and Vulnerable Children	31%	114%	-22%
ASC.04 Programs Management & Administration	13%	54%	-17%
ASC.05 Human Resources	97%	37%	-47%
ASC.06 Social Protection and Social Services (excluding OVC)	21%	724%	54%
ASC.07 Conducive Environment	44%	52%	-67%
ASC.08 HIV and AIDS related Research (excluding operational research)	430%	78.114%	24%
Total	**43%**	**60%**	**15%**

Conclusions

Based on the data presented, it becomes clear that considerable amounts of resources are allocated annually to the national response to HIV and AIDS in Mozambique. Although the growth between 2006 and 2007 has been relatively small at just 9%, the growth recorded between 2007 and 2008 was quite high (39%), overtaking any growth experienced by the other public health programs in the country.

The non-existence of a National Response Strategic Plan with a valuation does not allow for the evaluation of the extent to which the expenditures incurred correspond to the defined priorities in financial terms.

The level of dependence on external funds to finance HIV and AIDS expenditures continued to go up in the years under review. In this connection, it is proper to raise concerns around the issue of sustainability of the programs to combat HIV and AIDS. As shown, expenditures funded by public funds came down between 2007 and 2008 also confirming the trend that had prevailed between 2004 and 2006.

The difficulty of establishing the expenditures paid by households remains a major constraint, and as such the actual weight of HIV and AIDS on the population does not come out clearly.

GARPR Indicator # 6.1: Domestic and International Expenditures with HIV and AIDS by categories and sources of funding are summarized in Table 9.

Table 9 – Expenditure category by type of source of funding and year (US$ thousands)

Expenditure Category	Public		Private		International		Total	
	2007	2008	2007	2008	2007	2008	2007	2008
Prevention	1,959	1,123	294	787	23,880	38,332	26,134	40,243
Care and Treatment	1,648	1,358	85	133	26,832	40,245	28,566	41,736
Orphans and Vulnerable Children	0	0	55	9	9,185	12,584	9,240	12,593
Programs Management and Administration	2,252	2,252	60	258	30,511	33,576	32,823	36,086
Humans Resources	4	140	168	220	4,884	8,127	5,056	8,487
Social Protection & Social Services (excluding OVC)	30	0	30	67	869	1,832	928	1,900
Conducive Environment	24	161	2	3	1,784	2,334	1,811	2,497
HIV & AIDS related Research (excluding operational research)	49	0	0	2	629	2,877	678	2,880
Total	**5,967**	**5,033**	**694**	**1,479**	**98,575**	**139,908**	**105,236**	**146,421**

National Commitments and Policy Instruments (NCPI)

STRATEGIC PLAN

The PEN III for the 2010-2014 period constitutes a reaffirmation of the commitment by Government of Mozambique to provide an effective national response to HIV and AIDS, in strict compliance with the global and regional commitments it has embraced.

This paper is more focused and is the outcome of various studies, such as the matching of HIV and AIDS related data. This is a strategy founded on the results-based management approach. The planned activities are evidence-based and approach of issues such as gender, disability, male circumcision were significantly improved in the PEN III compared to the PEN II.

Some government sectors are involved in the PEN III, such as the case of the Ministries of Health, Education, Women and Social Action, Youth and Sports, National Defence, Home Affairs and Labour. Out of these sectors it is worth noting that Health and Education have budget allocations but not the other sectors.

It is commonly accepted that the multi-sectoral approach is quite comprehensive. Key populations and other vulnerable groups are covered in the strategy, with the exception of a few cases such as people who inject drugs and men who have sex with men. Their exclusion derives from the fact that it is not yet consensual that such aspects are a priority based on the country's reality. The other reason is due lack of evidence on their sizes and information on the epidemic dynamics on these groups.

HIV programs have identified as some of the vulnerable groups and key populations sex workers, men who have sex with men, truck drivers, teachers, populations with high rate of mobility, informal traders, young girls and boys, women, prisoners, orphan and vulnerable children, the elderly, people with disability, the military, miners and police officers.

The civil society was involved in the development of the multi-sectoral strategy through two elected members who participated in the working groups established to that effect. The private sector also participated and was represented by EcoSIDA. The strategy is comprehensive and contains clear targets and objectives and monitoring and evaluation tools. It should be emphasized that this strategy was not budgeted through an exercise that would estimate the costing of each intervention area. Development partners have aligned and harmonized their HIV programs with the multi-sectoral strategy.

HIV and AIDS was mainstreamed into the major development plans of the country as shown for instance in the Strategy Matrix of the 2011-2014 PARP, which provides for the reduction of the prevalence rate amongst adults aged 19-49 from 11.5% in 2009 to 8.5% by 2014.

However, the country needs to assess the impact of HIV and AIDS on its social and economic development in order to better undertake its macroeconomic planning and the respective allocation of financial and human resources.

Generally, the country's strategic planning effort is good but the real issue is the difficulty of putting into practice the identified actions. Another major challenge that the country faces is resource mobilization.

CIVIL SOCIETY INVOLVEMENT

The government of Mozambique adopted a multi-sectoral approach to respond to HIV and AIDS centered on the broad involvement of the various sectors of society, through the coordination of the National AIDS Council, which is the coordination body.

The efforts by the civil society are commendable as it has been working to strengthen the national response to HIV and AIDS by reinforcing the existing platforms and establishing new forums. Presently, there is a civil society platform to operationalize the PEN III, and there is also an advocacy group to deal with public health issues and a Partners Forum where the civil society discusses the plans and strategies to combat HIV and AIDS, just to cite a few examples at central level.

The involvement of the civil society is felt at the highest level through two representatives that seat at the PEN III Steering Committee. This good coordination is praised by the majority of the civil society organizations.

The inclusion of the services rendered by the civil society in the national reports is clearly satisfactory. Most of the information pertaining to the prevention, care and ART programs is conveyed by the civil society organizations.

Concerning the civil society participation in the reports on HIV and AIDS the challenge of collecting and including information particularly from Community-Based Organizations (CBOs) still persists. Another challenge is related to the reinforcement of the local civil society organizations' commitment, for at times they lack the capacity, particularly in technical and financial terms to pursue the planned actions.

With respect to monitoring and evaluation, the civil society participation is open and it provides inputs at various levels. For example, the civil society takes part in annual joint evaluation. However, it is at the Partners Forum where the civil society has the opportunity to give its contribution to the planning based on the existing data. However is highlighted that CNCS should contribute on publicising and massification of national indicators in order to ensure that all actors feed the system.

It is acknowledged that the Civil Society Platform is inclusive, as it brings together representatives from the various groups. This arrangement allows for a greater harmonization of the actions.

Civil society organizations have been receiving financial support from bilateral partners. It should be noted that from the time CNCS ceased to play the role of financing agent, civil society organizations have been facing some difficulties to receive funding, on the one hand, and the world financial crises, on the other hand, is cited by the civil society as another hurdle to access to funding.

POLITICAL SUPPORT AND LEADERSHIP

Most government officials and other leaders in Mozambique at the Central, Provincial and District level are committed to the fight against HIV and AIDS. For example, the Head of State launched a strategy to fight against HIV and AIDS amongst the youth and advocated for greater intervention in the area of prevention and in combating stigma and discrimination on the occasion of the commemoration of the 1st of December.

Beside the campaigns and strategies launched in the pass by the Head of State, he is the patron of EcoSIDA, an organization fighting against HIV and AIDS in the Private sector. Other government officials are also committed on fight against HIV and AIDS at the central, district and provincial levels.

His Excellency, the Prime Minister chairs the National AIDS Council and his deputy is the Minister of Health. The Prime Minister chairs the high level CNCS meetings while the Minister of Health chairs the multi-sectoral technical meetings on HIV and AIDS. Still at the central level, Ministers within their institutions lead and talk to their staff during the campaigns aimed fostering the combat against this disease organized by entities working on HIV and AIDS issues. At the provincial level, government officials are replicating the Presidential Initiative to Combat HIV and AIDS.

The engagement of the government officials is both notable and commendable and the same applies to other leaders, particularly religious figures, who are fully committed to the national response to HIV and AIDS.

CNCS members are clearly defined as being five, including the Network of People Living with HIV (RENSIDA), and EcoSIDA, in representation of the private sector. Presently, the country's major challenge concerns the coordination of the donors to prevent parallel funds and the duplication of efforts in terms of programming and reporting.

The Government, the Private Sector and the Civil Society Organizations have put in place an interaction mechanism that provides for an annual joint evaluation meeting to review the progress and the challenges encountered in the course of the year. A major success indicator is that it was through this mechanism that was established that the indicators that gauge the level of response to AIDS in the country were agreed.

Other challenges include qualified human and financial resources, and also the infrastructures to set in motion the strategies and interventions to fight against AIDS across the country. There are still some challenges to achieve the targets agreed in the Abuja Declaration and in exploring domestic funding opportunities. Coordination among

donors in other to avoid parallel funds and duplication of efforts on programming and reporting is other critical challenge in country.

Political support is present and positive, judging by the active participation of leaders at the highest level. During the last two years it was possible to secure additional funds through the State Budget, and this resulted in financial allocations to programs aimed at fighting HIV in government departments.

HUMAN RIGHTS

Respect for human rights is fundamental to ensure that the strategies related to sensitive matters such as sexuality can bear fruit. To respect individual human rights, particularly of PLWHA, disenfranchised populations, high risk populations, women, people with disability and the elderly is indispensible to ensure the provision of services and information.

The legislation against discrimination is being disseminated in the country and this has to some extent contributed to enhance the protection and promotion of human rights. The existing legislation covers the following vulnerable groups: People Living with HIV and AIDS, Orphan and Vulnerable Children, People with Disabilities, Prisoners, Sex Workers, Women and Girls.

The country has been working on a more generalized legislation. For example, there is the Law 5/2002 that protects people living with HIV and AIDS in the workplace. The protection of the human rights of people living with HIV and AIDS became more encompassing with the passing of Law 12/2009, which protects the rights and combats discrimination and stigma against PLWHA.

Civil society organizations that provide free legal assistance have been playing a key role in the protection of the rights of PLWHA. Victims approach such organizations and they take the matter through the legal system.

Generally, there are not effective mechanisms to implement such laws. However, the Civil Society has been playing an important role in the dissemination of the laws and in other interventions such as the training of community-based paralegals. Nevertheless access to judicial services still deficient and a significant part of the population do not have ability and resources need to navigate in this system.

PREVENTION

Prevention continues to be a central area of focus and is sustained by evidences highlighted in the Prevention Acceleration Strategy. The attention of the investment is on the reduction of HIV prevalence amongst pregnant women. Prevention strategies are supported by a component of change in the social and individual character driven by the broad involvement of households and the communities.

In the area of prevention, the country adopted strategies that promote information, education and communication through clear and specific messages. Such strategies include messages on abstinence, faithfulness, getting to know about the HIV status,

delaying sex activity, prevention of mother to child transmission and the use of sterilized syringes.

Education on HIV has been an area of focus on the part of the government. Various activities are carried out to promote life-long skills for the youth. It should also be pointed out that education on HIV is part of the secondary education and teachers' training curriculum.

The outcome of the prevention policies efforts is felt through the downward trends in the incidence of cases of infection in the country. As an illustration, some of the achievements since 2009 include: the launching of the campaign to prevent multiple sexual partners, which brought positive results; massive expansion of testing in all contexts: CTHU, RUTF and CCTH; improvements in the management, stocking and availability of condoms at health facilities; strengthening and expansion of counselling and testing of pregnant women and the youth at YFHS; training of health staff in universal bio-safety precautions and availability of individual protection gear; improvement in the sensitization and adherence of health staff to testing, care and treatment; increased coverage of ART; introduction of HIV modules during the initial training and strengthening of the continuous training of health staff;

In this area some challenges still remain, namely: behaviour change; to bring down HIV incidence; ensure that the tools used in prevention, specifically IEC material, rapid HIV tests, condoms, medicines increasingly have better management and proper logistics; sensitization of the communities towards greater adherence to care; greater involvement and role played by high risk groups like MSM, sex workers, prisoners and others in HIV prevention activities associated to the reduction of stigma and discrimination amongst these groups both at the health facilities and within the communities.

The country has identified some specific needs for the HIV prevention programs, mainly through studies conducted to better understand the epidemic in the country. Debates have been organization with the aim of establishing the best ways of fighting the epidemic on the basis of the social and cultural dynamics. These efforts have culminated with the recommendation to "*mozambicanize* HIV and AIDS messages".

In addition to these efforts, it should be noted that HIV programs are being expanded. Within health facilities, there is a growing integration of HIV into primary healthcare, and related to that there is the integration and expansion of CTHU in the various services and programs at health facilities and also the RUTF and CCTH within the communities.

Prevention programs are being implemented regularly and with some degree of success. People in need agree that they have been having access to safe blood, condom use is promoted, there are HIV prevention program for out of school youths and in the workplace. There is also strong agreement that there is access to prevention of mother to child HIV transmission, HIV counselling and testing, information, education and communication to reduce the risk, reproductive health risks, including the prevention of sexually transmitted infections.

Most people with needs to reduce the negative impact on people who inject drugs and to reduce the risk of men who have sex with men are not being sufficiently covered by the prevention programs.

TREATMENT, CARE AND SUPPORT

Strategic interventions in the component of Treatment and Care are based on five areas of services provisions that are mutually interconnected and include the massive expansion of counselling and testing of the health status as a way of expanding the beneficiaries of health services and care.

The country has identified the key elements for a comprehensive package of HIV treatment, care and support services. Priorities in this regard are the reduction of the risk and vulnerability to HIV infection by screening and treating STI, HIV prevention at the health facilities and within the communities through the provision of the abovementioned integrated prevention services, provision of HIV treatment and care, mitigation of the consequences of HIV through food aid and nutritional counselling to people that are infected and their families.

The expansion of treatment, care and support services is carried out through the provision of an integrated package for HIV care at the already existing health facilities that have the conditions to that effect such as infrastructure, staff, pharmacy, laboratory; through the opening of new health facilities and new sites for ART; and through the training of technical staff and the delegation of tasks.

Most people in need have access in addition to the anti-retroviral therapy, to ART for patients with TB, to prophylaxis with cotrimoxazole for people living with HIV, early diagnosis of newborns, HIV testing and counselling of people with TB, treatment services at the workplace, nutritional care, and the treatment of paediatric AIDS.

However, there is also the need to improve access to HIV care and support in the workplace, including finding alternative work.

The government has been providing social and economic support to people living with HIV and AIDS under various forms, notably the support that is provided to people with formal employment who get food assistance worth 30% of their salaries. Through clearly defined criteria, some HIV positive employees receive this basic food basket.

In general, it can be considered that the efforts to implement HIV treatment, care and support programs are quite good, judging by what was done over the last two years, notably the setting up of new sites for ART; increase in the number of patients receiving ART and the respective coverage; implementation of strategies to retain patients under care; improvement of pre ART services; updating the targets for paediatric ART; development of new tools for ART monitoring and evaluation; authorization for the prescription of ART by nurses, including those in mother and child healthcare and by medicine agents.

Even through the efforts made are considered to be very good, some challenges still persist in this area, namely: i) availability of HIV medicines and tests and improvement in the logistics and management of the inputs; ii) to increase the access and coverage of ART, notably at paediatric level; iii) improvement in the adherence and retention of patients undergoing ART and care with the consequent reduction in the drop-outs; iv) staff training to prescribe ART; v) implementation of new monitoring and evaluation tools; vi) clinical tutorials to Medical Technicians and Agents, mother and child healthcare nurses and others.

MONITORING AND EVALUATION

The country has an Integrated and Budgeted Plan for Monitoring and Evaluation – PIMA that is aligned and harmonized with the M&E tools of the partners. The Monitoring and Evaluation System of the PEN III is aimed at the proactive follow-up of the HIV and AIDS epidemic evolution and the progression of the actions and interventions. The country has two M&E functional units based at the Ministry of Health and at the CNCS.

The M&E Plan includes the following components: data collection strategy that involves evaluation and research, drug-resistance surveillance, HIV surveillance, and routine programmatic monitoring. This plan also includes data analysis, data dissemination and the use of the strategy, clearly defined standard indicators and guidelines for the data collection tools.

There is a technical M&E multi-sectoral group operating at the central level that coordinates the M&E activities. The country has a central HIV related database. The health information system is functional from the central level down to the provincial and district levels, however it needs improvements.

M&E data are used to improve the programs, to develop the national response or its revision and for resource allocation. Challenges in the use of M&E data include the validation of the status of compliance with the set targets and of coverage of the services that are provided and the definition and prioritization of the strategies as well as the allocation of human and material resources.

Some training activities are contemplated and in 2011 M&E training was provided to 14 technical staff with the support from the development partners (UNAIDS and USAID-MEASURE Evaluation).

The M&E of HIV in the country is good, and succeeded in achieving landmark results like the strengthening of human and material resources for M&E, the development of the M&E plan for the health sector and for HIV and AIDS program, and the identification and definition of priorities in the context of the implementation of M&E programs.

Challenges in the area of M&E include the dissemination and implementation of the plan, the issue of human and material resources, the alignment of the indicators with key

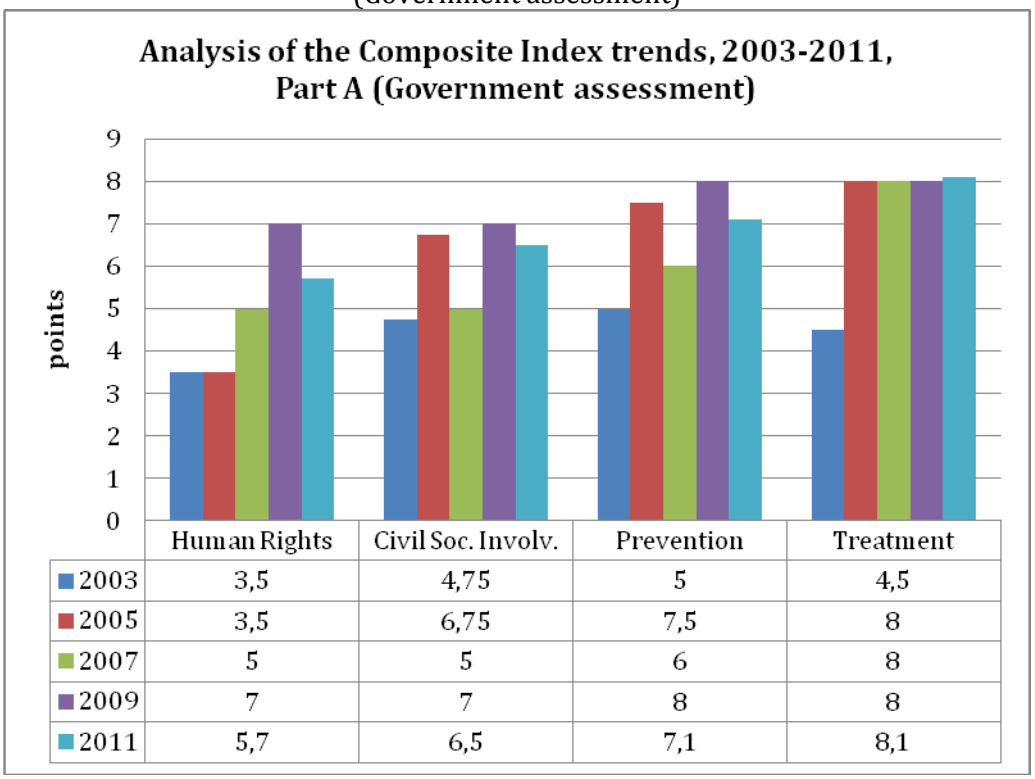
strategies and the process of harmonization and integration of the information generated by the various stakeholders.

ANALYSIS OF THE NCPI TRENDS FROM 2003 TO 2011

The Figures below show the trends unveiled by the key data from the Composite Index (NCPI) from 2003 to 2011.

Figure 8 reveals that in 2010 – 2011, from the point of view of the CNCS and government officials (Part A), they are quite satisfied with the Strategic Plan and this level of satisfaction is almost the same as in 2009. Regarding political support and prevention, there is no variation, however there is an increase compared to the exercise conducted in 2009. In terms of treatment there was no variation compared to 2009 and the level of satisfaction increased in relation to monitoring and evaluation when compared to 2009.

Figure 8 – Analysis of the Composite Index trends, 2003-2011, Part A (Government assessment)

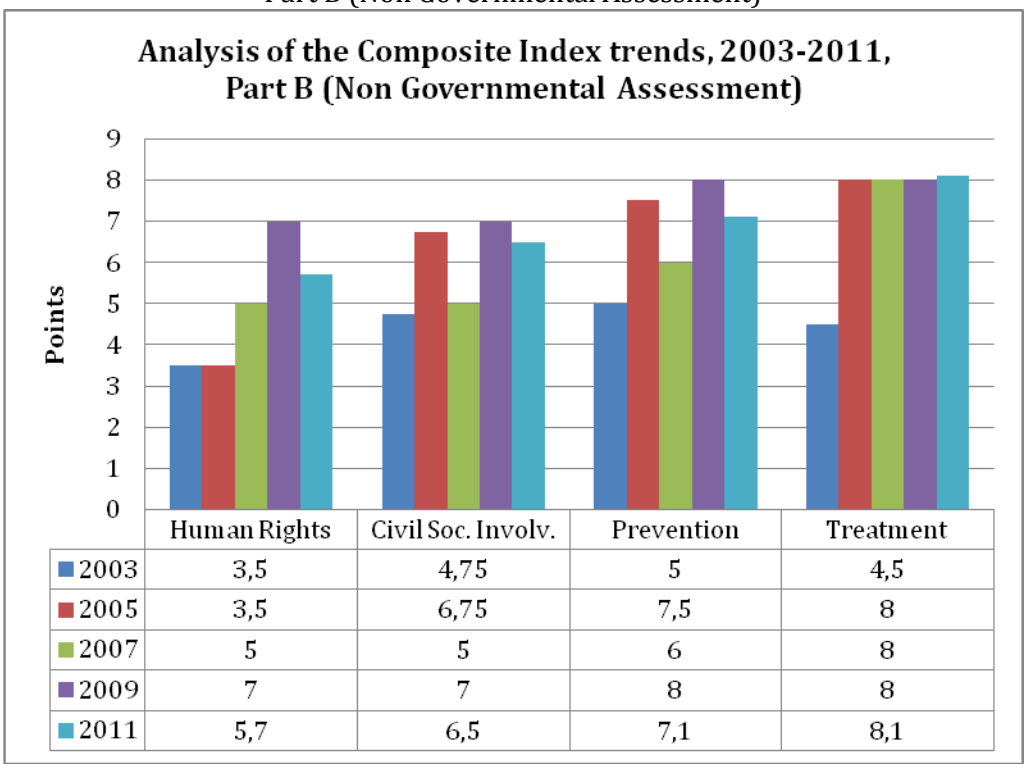


	Human Rights	Civil Soc. Involv.	Prevention	Treatment
2003	3,5	4,75	5	4,5
2005	3,5	6,75	7,5	8
2007	5	5	6	8
2009	7	7	8	8
2011	5,7	6,5	7,1	8,1

Figure 9 shows generally that in 2011, there was a reduction in the satisfaction of government partners compared to the 2009 exercise.

The differences are significant in relation to the aspect of Human Rights, Civil Society Participation and Prevention. But there was a certain improvement on aspects related to Treatment, Care and Support.

Figure 9 – Analysis of the Composite Index trends, 2003-2011, Part B (Non Governmental Assessment)



	Human Rights	Civil Soc. Involv.	Prevention	Treatment
2003	3,5	4,75	5	4,5
2005	3,5	6,75	7,5	8
2007	5	5	6	8
2009	7	7	8	8
2011	5,7	6,5	7,1	8,1

Private Sector Response to HIV and AIDS

The response to HIV and AIDS in the workplace is part of the multi-sectoral response and is aligned with the objectives of the national response as defined in the PEN III and contains interventions in the following areas: i) Prevention; ii) Advocacy to sensitize Management towards the mainstreaming of HIV and AIDS in the companies' plans; iii) Reduction of the stigma and discrimination of PLWHA in the workplace and dissemination of the legislation on the rights of PLWHA; iv) Facilitation of the access to services such as HIV Counselling and Testing, and Treatment and Care.

Concerning the response to HIV and AIDS at the workplace and by the private sector in particular, there was an increase in the number of companies with HIV and AIDS policies and programs and the activities are undertaken by the companies themselves and by other players like EcoSIDA, the PSI's SEDE Program, Trade Unions and Associations of PLWHA. Partnerships were strengthened with UNAIDS, ILO and IMO concerning HIV and AIDS issues in the workplace, notably in the area of M&E.

In order to strengthen the planning and coordination capacity and in a bid to decentralize the decision-making arrangements and resource management, the Coordination Group of the Response to HIV and AIDS in the workplace remained in operation, which in addition to the abovementioned organizations also includes the CNCS. A Monitoring and Evaluation Working Group for the response to HIV and AIDS in the workplace was constituted and it developed a manual for the M&E of the response to HIV and AIDS in the workplace with the aim of increasing the reporting level of the data from the private sector to feed the CNCS M&E data base of the national response. In order to try out the subsystem, a M&E pilot was rolled out in partnership with the CNCS, and with the support from UNAIDS and the ILO in the following provinces: Cabo Delgado, Tete, Zambézia, Manica and Sofala, and a total of 93 technical staff from private sector associations, companies, trade unions and from the CNCS. As an outcome of the pilot, there was an increase in the number of companies reporting information to the CNCS and providing greater visibility to the response to HIV and AIDS in the workplace.

Over this period, the collaboration between the private sector and government institutions, namely the Ministry of Labour (MITRAB) and the Ministry of Industry and Trade (MIC) was strengthened to broaden the sensitization towards the response to HIV and AIDS in the workplace. Thus, through the assistance from the ILO, 140 Labour Inspectors received training across all provinces of the country, and their primary responsibility shall be to inform companies about the legislation on HIV and AIDS in the workplace and to oversee compliance with the said legislation. At the MIC 30 staff from the One-Stop Services Desk (BAU) received training related to HIV and AIDS, as this is the sector in charge of licensing companies, so as to sensitize them to incorporate HIV and AIDS in their business plans.

Through a partnership with IMO, 50 staff from port companies in Maputo and Beira were trained on Gender, HIV and AIDS and Migration.

Access by workers to HIV Counselling and Testing was expanded through the establishment of mobile teams that provide such services to companies.

The table below shows the main outcomes of the private sector HIV and AIDS activities:

Sensitization of the Business Community

Indicators	2010	2011	TOTAL (2010-2011)
Sensitization meetings in companies	123	169	292
New companies implementing the roadmap	215	139	354
Number of new members	23	8	31

Sensitization

Indicators	2010	2011	TOTAL (2010-2011)
Sensitization sessions held	2,554	2,963	5,517
Employees reached by the sensitization sessions	22,675	36,593	59,268

Voluntary Counselling and Testing

Indicators	2010	2011	TOTAL (2010-2011)
Employees reached through HIV counselling and testing	26,548	30,903	57,451

Training/Capacity-Building

Indicators	2010	2011	TOTAL (2010-2011)
Peer Educators trainers that received training	161	72	233
Peer Educators trained	362	297	659
Policy Design Facilitators trained	54	36	90

HIV and SIDA Policies

Indicators	2010	2011	TOTAL (2010-2011)
HIV and AIDS working groups in place	68	57	125
HIV and AIDS policies developed	57	58	115

Availability of Education and Prevention Material

Indicators	2010	2011	TOTAL (2010-2011)
IEC material distributed	429,496	75,475	504,971
Male condoms made available	5,520,582	3,003,784	8,524,366
Female condoms made available	82,856	21,164	104,020

Part II. National Programs

Prevention Programs

Blood Safety

In Mozambique, following the country's independence in 1975, and based on the Resolution n.º 325/77 of 11 August of the Ministry of Health (regulating blood donations and setting forth the State Duties and the Donors' Rights) and Decree 14/88 of 30 November (strengthening the provisions of the Resolution n.º 325/77 of 11 August), the National Blood Transfusion Program (PNTS) was established in the Ministry of Health which as of now has about 149 Blood Banks in the whole country and distributed across central, provincial, general and district hospitals and health centres. The PNTS, which work specifically towards the mobilization of donors, in coordination with the Mozambican Association of Blood Donors and the Mozambique Red Cross, is presently responsible for the collection, processing, storage and free distribution of blood to both public and private health facilities.

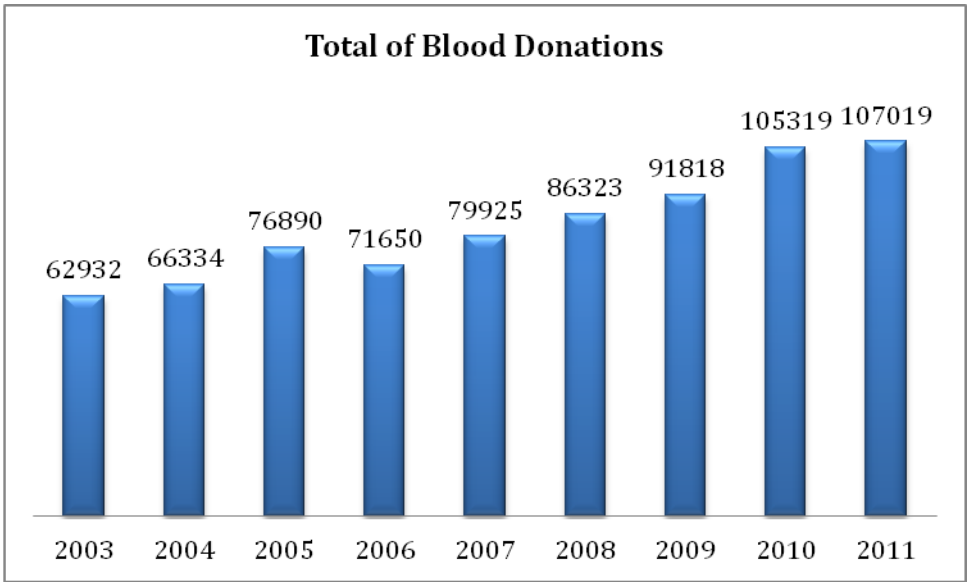
As blood cannot be manufactured or produced artificially, for its only source is the human body, the Resolution WHA 28.72 of 28th Assembly of the World Health Organization (WHO) calls on Member States to promote the development of National Blood Services through voluntary and unpaid donors. The Cabinet in Mozambique during its 45th Ordinary Session in December 2011 considered and approved the bill that establishes the National Blood Service (SENASA), as proposed by the Ministry of Health (MISAU) and which will subsequently be submitted to the National Assembly. SESANA aims to ensure the collection and availability of human blood and blood products in adequate quantity and quality for the needs of blood therapy of the National Health Service[3].

Outcomes

In Mozambique, blood donations can be made by individuals aged between 16 and 65. However, these individuals are screened so that low-risk donors can be selected. Blood is collected at the blood banks and also through mobile teams. From 2003 to 2011, the number of blood units collected increased from 66 932 per year to 107 019 per year, which represents an increase of about 14% from 2009 to 2011. Despite the increase in the number of blood donations during the past years, it is not yet sufficient to meet the country's blood demand. In 2011, 107 019 units were collected, but according to WHO estimates this number of blood units represents 53.5% of the country's blood requirements (~ 200 000 units/year) (Figure 10).

http://www.misau.gov.mz/misau/destaques/governo_aprova_proposta_de_lei_que_cria_servico_nacional_do_sangue.

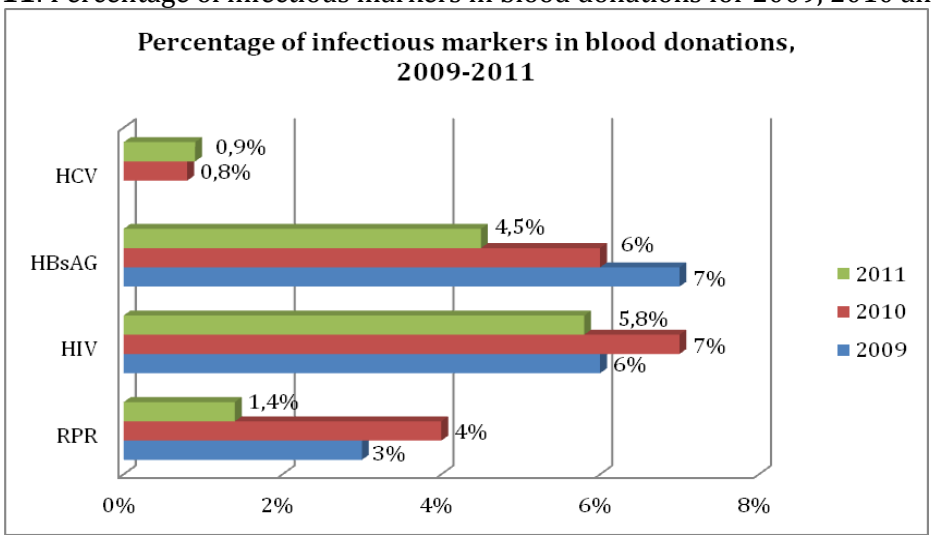
Figure 10 – Number of blood units collected at blood banks, 2003 – 2011



Source: PNTS, MISAU, 2012

The strengthening of the area of mobilization and recruitment of low-risk blood donors remain a priority area for the PNTS, given that blood safety starts with the selection of low-risk donors. From 2003 to 2011, the percentage of blood collected from voluntary donors has been increasing and exceeded the blood collected from donors that are relatives of blood recipients or who donate for the sake of replacement. Data from 2010 show that currently about 60% of blood donations were made by voluntary unpaid donors (benevolent donors) whereas 40% were donations from relatives of patients or for replacement. WHO advocates, as is also the goal of PNTS, that 100% of the donations should be from benevolent donors or at the very least a greater percentage should be from benevolent donors, as this would reduce the risk of transmission of infectious agents through blood transfusion.

Figure 11: Percentage of infectious markers in blood donations for 2009, 2010 and 2011.



Source: PNTS, MISAU. 2012

According to figure 11, the percentage of blood units testing positive for HIV dropped from 8.3% (2003) to 5.8% (2011). HIV prevalence in blood donations has been fluctuating between 6 and 7% over the last 3 years (2009-2011), with its peak in 2010 when it reached 7%. With a rate of donors for relatives that are patients and as replacement at 40% it will be very difficult to bring down HIV prevalence in donations to the desired levels, considering that HIV prevalence amongst the population at large stands at 11.5% (INSIDA 2009).

The percentage of blood units testing positive for syphilis increased between 2009 and 2010 and reduced significantly in 2011, from 3 to 4% and then to 1.4%, respectively. Concerning hepatitis B (HbsAG) there was drop from 7 to 4.5% from 2009 to 2011[4]. Tests for hepatitis C (HCV) in blood donations was introduced in 2010, and constitutes the least prevalent marker at less than 1% (0.8% in 2010 and 0.9% in 2011).

All blood banks and all health facilities performing the work of blood banks have a Standard Operating Procedure (SOP) to test for HIV; however, there is not in place as yet an external quality assurance system. The Immunology Department has been performing quality assurance in the country's laboratories and blood banks. In 2011, this was done in 34 of the existing 149 blood banks. In all, these 34 units have collected 74 274 blood units, which represents 69.4% of all blood units donated in 2011 (107 019) (Table 10).

The National Blood Transfusion Program currently tests 100% of the blood for Transfusion Transmitted Infections (TTIs). However, 30.6% of the blood units are not yet tested for adequate conditions of quality assurance.

Table 10 – Percentage of donated blood units tested for HIV in conditions of quality assurance from January to December in 2010 and 2011.

Measurement Method	Value: 2010	Value: 2011
Numerator: Number of donated blood units tested for HIV at blood screening centres/laboratories having: (1) observed the standard operating procedures, and (2) taken part in an external quality assurance scheme	77 111	74 274
Denominator: Total number of blood units donated	105 319	107 019
Indicator value: Percentage	**73.3%**	**69.4%**

[Source: National Blood Transfusion Program – DNAM/MISAU/Mozambique, 2012]

The percentage of blood tested with quality assurance increased from 35.5% in 2007 to 69.4% in 2011.

Progress Report of Blood Banks for 2010. MISAU/ PNTS.

Major Challenges

The main difficulties faced are in the area of mobilizing and recruiting blood donors, namely:

- Lack of incentives and motivation of blood donors, which results in the high rate of drop-outs by the voluntary donors;
- Lack of education material (pamphlets, posters and leaflets) to carry out sensitization and dissemination work concerning blood donation;
- Lack of adequate vehicles for the mobile teams;
- Failure to comply with the rights of donors as set out by the government.
- Shortage of staff to carry out the work of sensitizing and recruiting donors.

Proposed actions to increase the number of safe blood donations

- The government will allocate adequate resources to acquire vehicles, education material and to sensitize blood donors;
- Provide training and organize workshops on mobilization and recruitment not just at central and provincial hospitals but also in rural and district hospitals and at health centres;
- Improve the information systems at the blood banks, for example to ensure that forms in use by the PNTS are filled in adequately;
- Respect and compliance with the rights of blood donors and adoption of mechanisms to stimulate and acknowledge the action of donors;
- The PNTS will alongside the provincial bodies develop mobilization plans taking into consideration the school calendar, commemoration dates in a bid to increase benevolent donations and live up to any likely blood crises that could arise.

Prevention of Mother to Child Transmission

Mozambique is one of 16 countries in the world that contribute with 60% to the global number of pregnant women living with HIV, only after South Africa, Nigeria and Kenya in terms of the number of yearly infected pregnant women.

The prevention of mother to child transmission (PMTCT) and the access to paediatric ART were enhanced exponentially in Mozambique in recent years, but coverage has not reached the desired levels to produce a substantial impact.

The spectrum of PMTCT services is extended from pregnancy to the post-birth and breastfeeding period, including the administration of prophylaxis regimes, care and treatment of HIV infected women and their exposed children and as a whole this is known as the cascade of PMTCT services.

PMTCT is currently acknowledged as a priority in all initiatives related to Maternal, Neonatal and Child Health towards the achievement of the Millennium Development Goals 4, 5 e 6.

The government through the Millennium Development Agenda (2000) and the UNGASS Declaration of Commitment (2001) and more recently, in 2011, as it ratified high-level commitments is striving to improve drastically maternal and child survival rates by 2015, to reduce the number of new HIV infections to less than 5% and to achieve 90% coverage of the pregnant women with PMTCT services and increase the proportion of HIV positive mothers with access to ART to 30% by 2015. In this regard, innovative and strong actions are required to expand the coverage and to improve the quality of services so as to enable the country to eliminate HIV mother to child transmission.

To prevent HIV mother to child transmission, the United Nations recommend a comprehensive approach, consisting of the following four pillars: (1) primary HIV prevention amongst women of reproductive age, (2) the prevention of undesired pregnancies of women living with HIV, (3) prevention of HIV transmission by women living with HIV to their children, and (4) adequate care, treatment and support to mothers living with HIV and to their children and family.

Policies and program expansion

Antenatal care (ANC) is the main entry point to identify HIV positive women through the Mother and Child Healthcare services. According to 2008 data from the MICS, in the country 89% of the pregnant women make at least one ANC visit (MICS 2008), while just 58% have deliveries in maternities, with the assistance from qualified professionals.

Mozambique started to implement the PMTCT back in 2002, in 8 health facilities, and this became a nationwide program in 2004 and this was integrated into the Maternal and Child Healthcare services in 2006. By the end of 2010, the expansion of the PMTCT services had reached 909 (86%) of the 1 063 health facilities through ANC.

All the women, regardless of their HIV status need to have access to quality antenatal, delivery and post delivery care, including:

- Early access to antenatal care (ANC);
- Screening and treatment for anemia and sexually transmitted infections (STIs);
- Provision of prophylaxis against malaria;
- Vaccination against tetanus;
- Multivitamin and micronutrients supplements;

- Counselling and support for safe child feeding practices;
- HIV counselling and testing.

The existing options to prevent mother to child transmission currently in use in the country include the single dose of Nevirapine (du-NVP), NVP plus AZT and ART for life for the women in need of treatment to remain healthy plus a single dose of syrup Nevirapine and AZT for 4 weeks for the newborn.

Since the 2006 standards, new evidence have emerged about the following: adequate/optimum timing and the eligibility to start ART, the benefits of starting early anti-retroviral prophylaxis for the PMTCT during pregnancy, the effectiveness of anti-retroviral prophylaxis for the mother or for the newborn in reducing the risk of HIV transmission during breastfeeding. This has prompted the updating of the PMTCT standards by the WHO in 2009 given the additional benefits to the health of the mother, and the drop of the mother to child HIV transmission rate to <5% among people engaged in breastfeeding and <2% among the people that do not breastfeed and the survival from HIV.

MISAU approved the said guidelines for the country in 2010[5], introducing various key elements such as: benefits from starting early anti-retroviral prophylaxis for the PMTCT during pregnancy, from the start of the 2nd quarter (14 weeks of pregnancy), the adequate/optimum timing to start ART for eligible HIV positive pregnant women (estimated at 30-40% of the HIV positive pregnant women) that account for about 87% of the transmissions. The anti-retroviral prophylaxis for the mother or the child during breastfeeding is very effective in reducing the risk of HIV transmission. The implementation at the national level started in July 2011.

MISAU has adjusted the child feeding standards to the new PMTCT standards. Thus, the current standards recommend that the mothers living with HIV provide exclusive breastfeeding from birth up to 6 months, and to continue with breastfeeding and introduce complementary foods after the 6 months. After the 12 months, breastfeeding should continue until a nutritionally adequate and safe diet can be provided without breastfeeding.

All health facilities providing PMTCT services must ensure that HIV positive pregnant women and their children receive ARV prophylaxis and based on their child feeding option should proceed with or stop breastfeeding after the 6 months.

The child exposed to HIV will be monitored regularly during the HIV exposed child outpatient Appointments (CCR), and provided prophylaxis for opportunistic infections with Cotrimoxazole; the child's growth and psychomotor development will be evaluated regularly; feeding counselling will be provided and an early PCR (Polymerase Chain Reaction) diagnosis in the first opportunity at the health facility between the 1st an 9th month of life. All exposed children 9 months old or more that have not undergone the PCR-DNA before or whose PCR-DNA test has been negative must undergo the rapid test on the 9th month.

Children that test positive with the rapid test must perform the HIV PCR DNA to confirm the diagnosis. Children that test negative in the rapid HIV test on the 9th month and that are not breastfeeding for more than 2 months and without any symptom that could

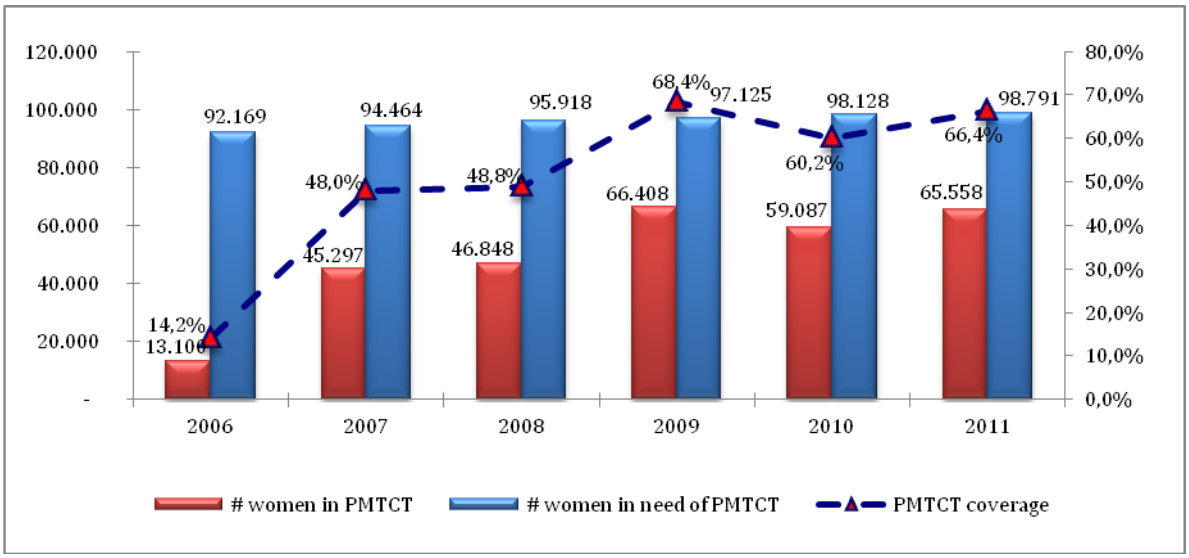
[5] Notice from the Ministry of Health No. 7820/GPS-3/DNS of November 2006

suggest HIV infection, are excluded from being HIV infected and it is recommended to stop the prophylaxis with Cotrimoxazole and be released from CCR.

"Mother to Mother Groups", comprising pregnant women and HIV positive mothers were established in Health Facilities in order to provide psychosocial support to its members so as to overcome obstacles and comply with the PMTCT recommendations. In 2011, the National Guidelines for the Mother to Mother Groups were approved and are expected to be rolled-out in 2012.

Implementation Outcomes

Figure 12 – PMTCT coverage trends from 2006 to 2011.



Source: MISAU, 2012 (spectrum 2011 + March 2012 updates)

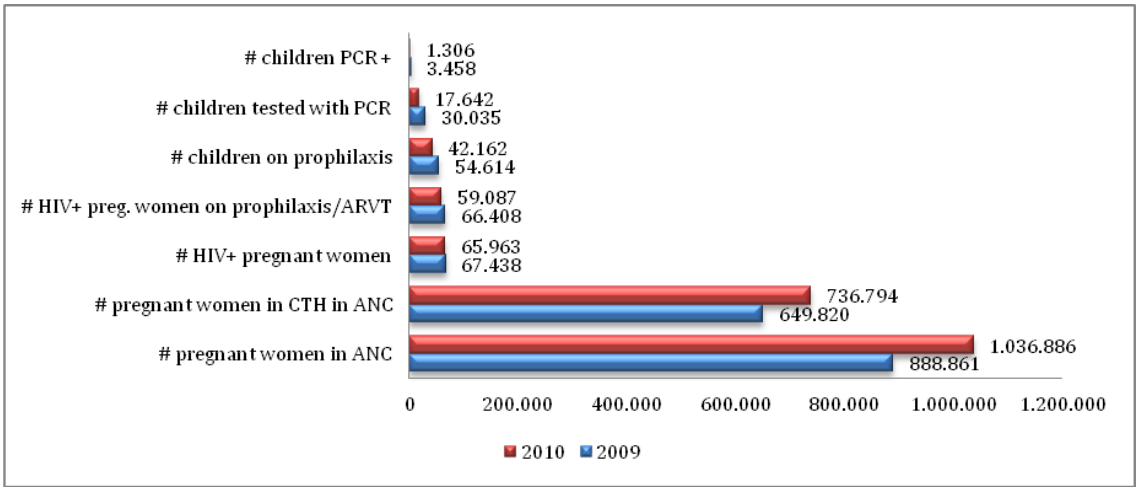
In 2010, some 98,128 pregnant women were estimated to be HIV positive, and 22,644 children below the age of five could have been infected and 87,040 children below the age of 15 might need ART.

According to data from the program, in the same year 736,794 pregnant women (64.6%) out of all the women present at the 1st ANC appointment received HIV counselling and testing, and 59,087 received anti-retroviral prophylaxis, totalling a coverage of 60.2% of all the pregnant women infected with HIV. With respect to exposed children, 42,162 (44%) received anti-retroviral prophylaxis.

Access to anti-retroviral treatment (ART) by pregnant women remains a major challenge in Mozambique. In 2010, some 6,944 pregnant women received ART and in 2011, such number rose to 8,643. If we consider that 30% of HIV positive pregnant women would eligible for ART (CD4<350/mm^3), corresponding to a total of 65,963 HIV positive pregnant women in 2010, we come to the conclusion that there is still a lot to be done.

In 2010, a total of 17,642 children were PCR tested within their first two months of life and out of these, 1,306 were tested PCR positive, representing a prevalence rate of 7,4% amongst those who got tested. In relation to the children that went through the HIV rapid tests aged below 18 months, 12,463 were tested and 2,476 found to be positive.

Figure 13 – Antenatal and post-natal cascade for the PMTCT, 2009-2010



Source: MISAU, 2012 (spectrum 2011 + March 2012 updates)

By the end of the 1st half of 2011, about 314 health facilities were collecting PCR samples that would be sent to four existing laboratories in the country (Maputo, Beira, Quelimane and Nampula) for processing.

MISAU collaborates with various implementation partners in the PMTCT program. With the view of ensuring good coordination amongst the technical and the implementation partners, MISAU has a technical working group on the PMTCT. The group meets regularly under the leadership of MISAU and discusses all the programmatic issues and policy standards, as well as the progress in the implementation, the challenges and lessons learnt. Over the last two years (2010 and 2011), the group was restructured to strengthen MISAU's capacity to implement and expand quality PMTCT towards universal access and full benefit of the prevention of mother to child HIV transmission to mother and child healthcare. Its focus is on the development/updating of strategies, standards and guidelines, training, monitoring and evaluation, dissemination and sharing of evidence-based knowledge on PMTCT and advocacy at all levels of implementation in Mozambique.

Major Challenges

The main challenges are related to the following:

- Insufficient access to ART by eligible pregnant women under ANC;
- Low coverage of institutional births with insufficient use of maternities;
- Low coverage of the PMTCT services;
- Low coverage of paediatric ARV and poor follow-up of exposed children in the Child at Risk medical appointment;
- Inconsistent adoption of safe child breastfeeding practices;
- Poor inclusion of the family, male partners and other people with decision-making power in the family;
- Insufficient quality assurance of the data in the area of monitoring and inadequate standardization of the indicators;
- Inadequate implementation practice of operational research and program evaluation.

Priorities

The strategic focus in this area is to ensure an adequate and comprehensive provision of quality PMTCT services to all women in reproductive age and their children and the follow-up at the family and community level to reinforce adherence to the program. Other actions worth highlighting are:

- Thematic integration of PMTCT/ART/IMCI in the pre-service training curricula of basic nurses for mother and child healthcare in order to increase access with quality.
- Community involvement (strengthening of the linkages between the National Health Service and the families and communities, building knowledge and dialogue around social and cultural practices);
- Start the ART on eligible pregnant HIV positive women;
- Strengthening of the integration of PMTCT with the components of Sexual and Reproductive Health, such as family planning and after childbirth care;
- Strengthening of counselling on safer child food particularly after childbirth;
- Definition of the modalities for the involvement of men, mothers-in-law and influential elderly people, traditional midwives and traditional healers, and improve coordination with the various sectors of the health facility to increase access to pMTCT for pregnant women and the regular follow-up of the exposed child in the CCR medical appointments. Food and nutritional assistance to women receiving pMTCT services and to the children as a key area because this contributes to increase adherence to the program;
- Strengthening of early diagnosis of exposed children and increase access to ART for HIV positive children.

GARPR Indicator # 3.1: Percentage of pregnant HIV positive women who receive antiretroviral drugs to reduce the risk of mother to child HIV transmission

Table 11 – Percentage of HIV positive pregnant women who receive antiretroviral drugs to reduce the risk of mother to child HIV transmission (2010/2011)

Measurement Method	Indicator Value	
	2010	2011
Numerator: Number of HIV positive pregnant women who received ARV over the last 12 months, to reduce mother to child transmission.	59,087	65,558
Denominator: Estimated number of pregnant women infected with HIV in the past 12 months.	98,127	98,791
Indicator Value: Percentage	60.2%	66.4%

[Source: MISAU, 2012]

There is an evident and remarkable increase in the percentage of women receiving ARV to reduce the risk of mother to child transmission. In effect, it used to be 14.2% and 48.0% in 2006 and 2007, respectively, and climbed to 68.8%, 60.2% and 66.4%, in 2009, 2010 and 2011, respectively.

In the Universal Access Report, was reported a total of 69,880 HIV-positive pregnant women receiving ARV prophylaxis or ART in 2010 based on programmatic data. In 2011

the pMTCT programme reported 70,270 HIV-positive pregnant women receiving ARV prophylaxis or ART. The Mozambican HIV epidemic is regionalized, which means it use Spectrum regional models to estimated the pMTCT needs and other indicators. The Spectrum model use surveillance data from pregnant women, census, and from the monitoring of programmes to estimate the number of births from HIV positives women and the pMTCT coverage. According to this projections, the number of births from HIV positive women in the south region is less then the number of thouse who benefited from this intervention according to the programme data. The Spectrum being a mathematical model, its evaluation depends on the maximum valor of programmatic coverage (100%), which means when it estimates the coverage will limit to thouse who benefited from the intervention in 100%, in each region. This calculation will result in a national pMTCT coverage estimate different from 2010 and 2011 programatic data. The table 12 below illustrate the differences in the two years. The outcome of this process is a lower programmatic coverage estimate compared to reported by the programa (60% against 71% in 2010, and 66% against 71% in 2011).

Table 12 – Comparison between pMTCT programme official data and projected data from the Spectrum model (2010/2011)

Programatic Data								
	2010				2011			
Region	North	Centre	South	National	North	Centre	South	National
Received pMTCT	12.876	17.552	39.452	69.880	14.816	22.629	32.825	70.270
HIV+ Preg. women	16.256	53.213	28.659	98.128	16.164	54.514	28.113	98.791
Coverage	79%	33%	138%	71%	92%	42%	117%	71%
Data from Spectrum Projections								
	2010				2011			
Region	North	Centre	South	National	North	Centre	South	National
Received pMTCT	12.876	17.552	28.659	59.087	14.503	22.629	28.113	65.245
HIV+ Preg. women	16.256	53.213	28.659	98.128	16.164	54.514	28.113	98.791
Coverage	79%	33%	100%	60%	90%	42%	100%	66%

This discrepancy of data is associated to quality of data, which is being reported in the main national processes like Health Sector Strategic Plan (PESS) and GARPR, as a major challenge. By the end of 2011 the data registry was not consonant wit the reality of the programme, due to lack of integration no the main system, manual counting system, limited technical knowledge on correct data entry and use of non standardized registry tools. These facts resulted in double or over-counting. For example pregnant women who received prophylactic scheam comprised by AZT and NVP, were reported in simple NVP indicator, as well as in the NVP and AZT indicator. These facts were largerly discussed in the recent pMTCT nacional assessment.

GARPR Indicator # 3.2: Percentage of HIV positive children born from HIV positive mothers

Table 13 – Percentage of HIV positive children born from HIV positive mothers (2010/2011)

Measurement Method	Indicator Value	
	2010	2011
Numerator: Estimated number of HIV infected children born from HIV positive pregnant women	17,642	40,396
Denominator: Estimated number of pregnant women eligible for pMTCT services over the last 12 months	98,128	98,791
Indicator Value*: Percentage	18.0%	40.9%

[Source: MISAU, 2012] *Indicator calculated through the Spectrum mathematic model.

The percentage of HIV positive children born from HIV positive mothers increased significantly from 18 to 41%, in 2010 and 2011, respectively.

GARPR Indicator # 3.3: Mother-to-child transmission of HIV (modeled)

Table 14 – Mother-to-child transmission of HIV (modeled) (2010/2011)

Measurement Method	Indicator Value	
	2010	2011
Numerator: Estimated number of children who will be newly infected with HIV due to mother-to-child transmission among children born in the previous 12 months to HIV-positive women	22,644	19,040
Denominator: Estimated number of HIV positive women who delivered in the previous 12 months	98,128	98,791
Indicator Value*: Percentage	23.1%	19.3%

[Source: MISAU, 2012] *Indicator calculated through the Spectrum mathematic model.

HIV Counselling and Testing

Health Counselling and Testing (ATS) is a fundamental component for HIV and AIDS prevention, as it is the entry point for care, treatment and psychosocial support and constitutes the basis for screening major chronic diseases, including HIV and AIDS and thus enables a better guidance of the individual towards a healthy life, behaviour change and access to treatment, care and support[6].

To assess the knowledge and coverage of the counselling and testing services, in the INSIDA respondents are asked if they know of sites where HIV tests are conducted and if they have ever been tested. Those that have already been tested were asked if they had been tested within the 12 months prior to the survey and if they had received the results of the test[7]. Of the respondents, 73% of the women and 72% of the men aged 15-49 knew the sites where tests are conducted, without a clear trend with regard to age. Women (87%) and men (88%) living in urban areas knew more sites where they could be tested compared to women and men from rural areas (66% and 63%, respectively). Just 37% of the women and 19% of the men aged 15-49 had already been tested (33% of the women and 17% of the men did receive the results). Only 17% of the women and 9% of the men aged 15-49 were tested and received the results over the last 12 months. Those in the 20 year old age group have greater probability of having been tested during the last 12 months than the other age groups.

Policy and Institutional Response

In 2008, the Ministry of Health approved and published two important documents that strengthen the country's counselling and testing strategy: *Guidelines for Counselling and Testing Initiated by the Provider in the Clinical Context;* and the Strategic/Operational Guide for the Implementation of Health Counselling and Testing Units (CTU). In 2009, as part of the strategy to expand widely the counselling and testing services, the Ministry of Health approved and published the *Guidelines for Health Counselling and Testing in the Community*. These documents set clear guidelines for these services and strengthen the role to be played at central, provincial and district level, and at health facilities, within the community, and by the implementing partners of these actions.

The MISAU's main focus in this area continues to be the expansion of the counselling and testing services in the National Health Service. This health promotion package proposes the continuation and expansion of HIV counselling and testing and the strengthening of the screening of diseases that could associated to HIV and further referral, when necessary, like in the case of Tuberculosis (TB) and Sexually Transmitted Infections (STIs). In addition, the package includes the screening for high blood pressure and health counselling for the prevention of malaria and diabetes, education of environmental health and orientation on sexual and reproductive health – especially in relation to early diagnosis of pregnancy and the promotion of institutional births.

[6] National Strategic Plan to Respond to HIV and AIDS, 2010-2014, Government of Mozambique, 2010.
[7] Inquérito Nacional de Prevalência, Riscos Comportamentais e Informação sobre o HIV e SIDA em Moçambique. MISAU, INE, 2009.

To expand these services with the desired quality, MISAU defined as priority activities:

i. Capacity building of health professionals and advisors on the new approach for counselling and testing services;
ii. Training of all the health professionals to perform quality rapid HIV tests;
iii. Use of the media to publicize counselling and testing services;
iv. Distribution of the policy and strategy guidelines on counselling and testing services for the implementation of counselling and testing at community level;
v. Development of education material.
vi. Holding of health events.

Overall Report of the Tenth Proficiency Panel (QUALIMUN-Ser-HIV-10)

The National Health Institute (INS) – MISAU – introduced in 2006 into the National Health Service a quality assurance program for HIV serology (QUALIMUN-Ser-HIV). The main objective of this program is to ensure quality HIV tests comparable to international standards in all laboratories of the National Health Service.

One of the activities of the Quality Assurance Program is the proficiency test. To this end, the National Health Institute sends periodically a panel of coded specimen for testing in various sites. The results from the testing sites are then sent to the INS for assessment. Each sites participating in this Program receives a confidential individual report on its proficiency.

Constitution of the Tenth Proficiency Panel

The tenth proficiency panel was sent to various parts of the country between November and December 2011. This panel comprised six (6) plasma dry tube specimen, of which three (3) were negative and three (3) were positive in terms of HIV-1&2 antibodies.

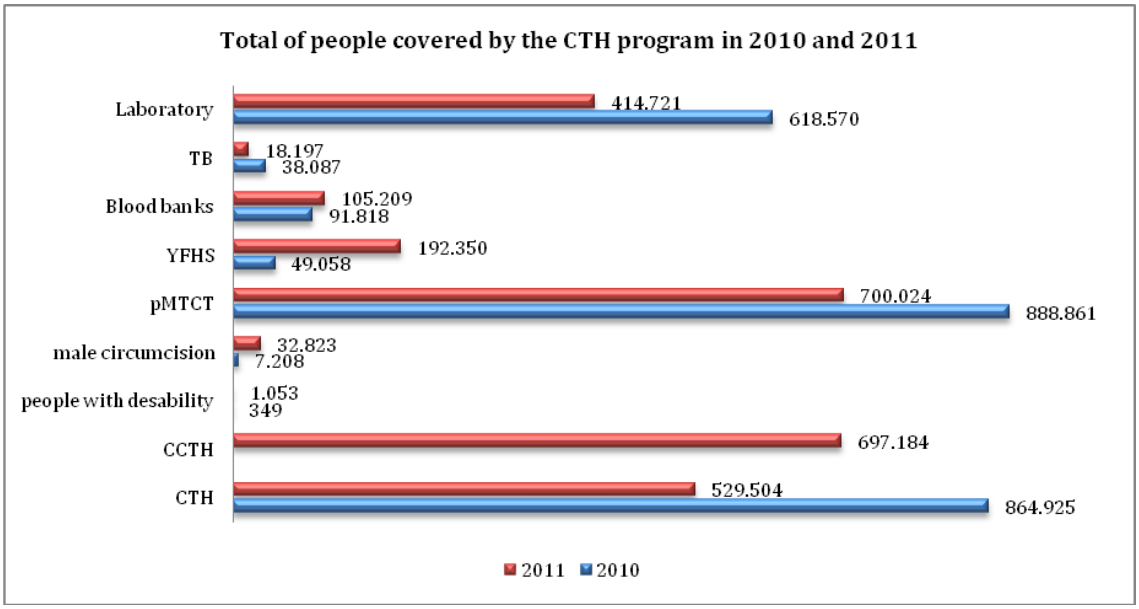
Participating sites

The tenth proficiency panel was sent to 240 testing sites by Mozambique's 11 provinces. Out of the sites that received the panel, 197 (82%) tested the specimen and responded in time.

Major Achievements:

In 2011 a total of 2,961,099 people were tested through the various healthcare services, such as laboratories, Tuberculosis treatment, blood banks, care services for adolescents and the youth, prevention of mother to child transmission, community counselling and testing services and counselling and testing services at health facilities. The prevention of mother to child transmission services recorded the highest number of people that received counselling and were tested. This service (pMTCT) associated to community counselling and testing represent almost half of the coverage with counselling and testing services in the country (figure 14).

Figure 14 – People (aged 15 or more) attended to in the various counselling and testing sites of the National Health Service in 2010 and 2011



Source: MISAU, 2012.

Community Counselling and Testing Services

Community Counselling and Testing for Health (CCTH) constitutes a strategy that seeks to contribute to increased access to health services at the community level based on innovative modalities. MISAU introduced this activity in order to promote integrated health prevention actions in the community, including activities related to HIV, in a bid to enhance their effectiveness and acceptance while also reducing the stigma that could arise from isolated actions.

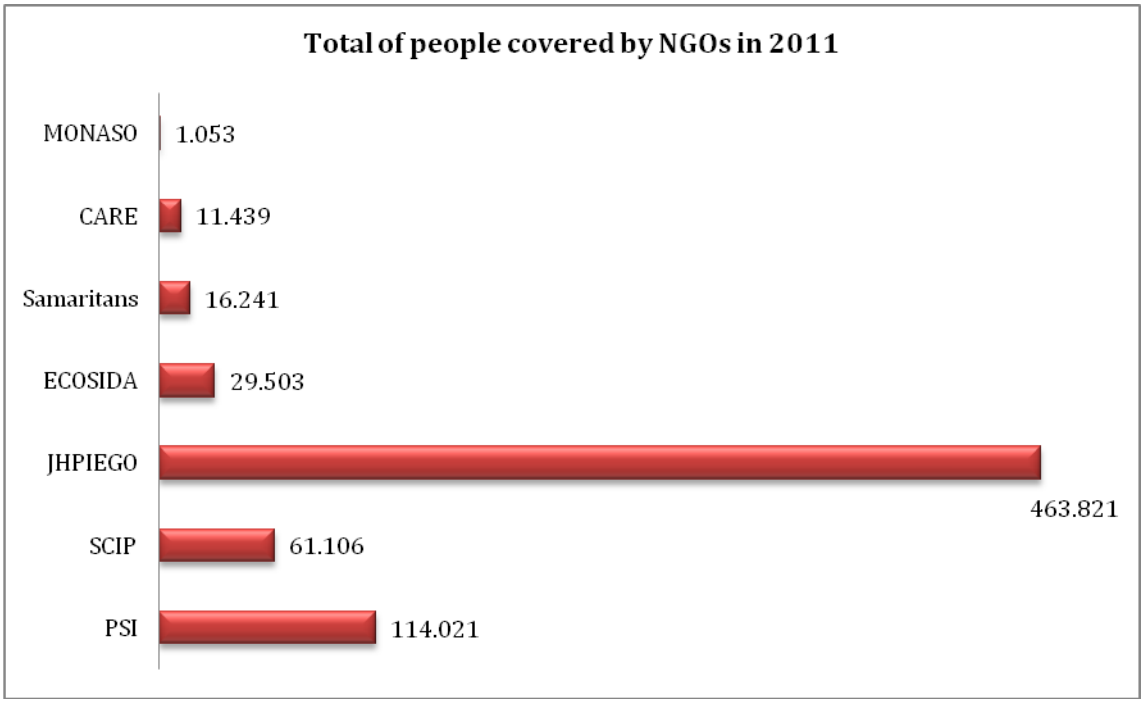
Prevention actions consist essentially of the provision of basic health-related education actions in the areas of Malaria, TB, HIV, Reproductive Health, High Blood Pressure, Skin Diseases, Nutrition and Personal and Environmental Hygiene/Sanitation, promotion of the early pregnancy diagnosis and institutional childbirth in an integrated way. These will be the responsibility of community members properly trained by the implementing partners and based on the use of material approved by MISAU. Special mention should be made about the role of the members from the local Civil Society Organizations (CSOs) in expanding the Health Counselling and Testing in the Community activities. In addition to the capacity building to achieve institutional and technical sustainability of the local organizations, CSO have been engaged in the actions aimed at securing a greater coverage of people.

Out of the 695,179 people that received counselling and were tested in 2011, through the ATSC services, the majority (66.7%) was covered by JHPIEGO, as illustrated in Figure 15 below, followed by PSI with 16.4%.

The Institute of Social Communication in partnership with the Provincial Directorates of Health, under the intergovernmental support, has been organizing community

mobilization sessions through multimedia approach (cinema, theatre and community talks), under the mobile units programme supported by UNICEF. During this sessions in 2011, 16,000 people benefited from community counselling and testing for health, conducted in the tents of the mobile units.

Figure 15 – People (aged 15 or more), attended to in the various ATSC units in 2011



Source: MISAU, 2012.

Counselling and Testing Services for People with Hearing Disability (PCDA)

People with disability (PWD) represent 7% of the Mozambican population[8], and for the first time through the PEN III they were identified as vulnerable groups in relation to HIV. The vulnerability factors to HIV infection by PWD are manifold including limited access to information and health services (information not adjusted to the needs of this group and health staff lacking capacity to attend to their specific needs), low schooling rate and consequent high rates of unemployment and poverty, stigma and discrimination and social exclusion.

In the country, comprehensive strategies on HIV and AIDS for PWD are very few or almost non-existent. In order to increase the access to counselling and testing services to this target group, the Ministry for Women and Social Action (MMAS), in partnership with MISAU and with the assistance from UNFPA, Pathfinder International, Population Service International, JHPIEGO and ASUMO, developed a strategy to expand the CCTH services to people with hearing disability in 2009[9].

[8] INE, *et al*. Living Conditions among People with Disabilities in Mozambique. 2009
[9] Strategy to Expand the Access to Counseling and Testing by People with Hearing Disability. MMAS, 2010

In this connection, 6 health providers from 2 referral Health Centres in sign languages and 8 people with hearing disabilities were trained on CCTH (and 5 were issued with certificates). After the training, the counsellors had a 4 week practical internship and subsequently joined the PSI and JHPIEGO teams. The activities on the ground started in August 2010 and consisted of the community mobilization for access and CCTH, the mapping of the main sites for counselling and testing and referral of people with hearing disability to the relevant Health Centres. The results achieved from August 2010 to December 2011 are summarized in the table below.

Figure 16 – Coverage of the Counselling and Testing Services by Sex to People with Hearing Disability in 2010 and 2011

Source: MMAS, 2012

From August 2010 to the end of 2011, a total of 1,402 people with hearing disability received counselling and were tested, and of these 46% were males and 54% females (Figure 16).

Out of those tested, 59 were found to be positive (4.2%), of which 12 were men and 47 women, corresponding to 1.69% of the tested population (79.45% of whom were women).

Talks are underway between MMAS and MISAU to roll out the strategy to other parts of the country, and to incorporate other health components in the strategy.

CTH for Male Circumcision

The Ministry of Health Small Surgeries and Male Circumcision (MC) Programme supported by partners started in 2009. Initial activities were limited to training of the initial team for the implementation of the pilot programme in Mozambique. This team was trained in Zambia, country which introduced the programme in 2006.

Five health facilities were identified, by MISAU after the initial training programme, for the implementation of the pilot phase, namely: Maputo Military Hospital, Boane Health Center, Chókwe Rural Hospital, Dondo Health Center, Manica District Hospital.

MISAU is being supported by JHPIEGO and PSI on the implementation of the programme. JHPIEGO is implementing the MC programme in the following health facilities: Maputo Military Hospital, Boane Health Center, José Macamo General Hospital, Mavalane General Hospital, Dhlavela Health Center, Dondo Health Center, Manica District Hospital and Chókwe Rural Hospital. On the other side PSI is implementing the MC programme in the following health facilities: Base Aérea da Beira Health Center, Nampula Military Hospital, Laulane Health Center and Khovo Medical Center.

From January 2010 up to December 2011, 40,280 attendants were counselled and male circumcision context. Out of these, 40,031 attendants (99%) were tested for HIV and 1,230 (3%) received an HIV positive result. Most of attendants tested were males from age group of 10-24 years, 31,888 (79%).

The elaboration of a strategic plan for male circumcision in Mozambique is one of the main challenges. The fact that all those who require a circumcision are recommended to be previously tested brings the need of the elaboration and implementation of a guiding document that will contribute for massification of counselling and testing services.

Challenges

The shortage of human resources constitutes one of the major challenges to achieve the desired results in the area of counselling and testing in Mozambique. Other challenges worth noting include:

- Poor quality of the testing services provided to users in all contexts (proficiency panel);
- Poor management of HIV rapid tests at all levels (Health Facilities, SDSMAS, DPS, MISAU);
- Inadequate implementation of the information monitoring and evaluation system;
- Insufficient coverage of the counselling and testing services at all levels;
- Variability of the sign language within the community of people with hearing disability;
- Dissemination of the counselling and testing services within the community of people with hearing disability;
- Development and distribution of support material that is adequate to people with hearing disability, particularly on SRH and HIV;
- Improve the technical capacity of the female counsellors to enhance their counselling skills and tests handling and the field work on counselling and testing services for people with hearing disability;
- Train the supervisors in sign language;
- Improve the supervision planning and retrain the health services providers already trained on counselling and testing for people with hearing disability.

Key Actions to Expand Universal Access to Counselling and Testing Services

- Ensure and strengthen technical support supervision, the ongoing monitoring and evaluation of the counselling and testing activities (CTHU, CTU and CCTH) by Health Facilities, SDSMAS, DPS and MISAU;
- Speed up the capacity building of the health staff for the integrated approach of counselling and testing, prioritizing on the job training;
- Define and clarify responsibilities in the management of rapid HIV tests at provincial level (Pharmacy and Laboratory);

- Expand and monitor counselling and testing services and avail timely rapid HIV tests to the various health facilities;
- Improve the quality of the testing by building the capacity of the health professionals and community counsellors on the issue of testing by using standardized modules;
- Put in place functional referral and counter-referral mechanisms for the patients receiving community level counselling and testing services to the Health Facilities;
- Sensitize and strength the use of recording tools for the control and management of rapid tests at providers level;
- Provincial level budgeting for the reproduction of the provincial instruments;
- Involve community leaders to sensitize the community to undergo testing;
- Establish a recording system for data on people with hearing disability at health facilities to consolidate counter-referral and set up a national data base on the health of people with hearing disability;
- Maximize the work of counsellors through the dissemination of SRH and HIV issues and information adapted to the needs of people with hearing disability and availability of more prevention tools;
- Retrain health services providers trained in sign language;
- Train the supervisors of the counsellors in sign language;
- Monitor and establish a system for continuous training in sign language for health services providers and supervisors;
- Sensitize family members and community-based groups to increase access and acceptance of the counselling and testing actions for people with hearing disability;
- Technical and continuous improvement of the counsellors with hearing disability to ensure quality;
- Establish support networks for people with hearing disability – means of transport, psychosocial support, fight against stigma;
- Expansion of the counselling and testing services for people with disability to other parts of the country.

GARPR Indicator # 1.5.: Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results.

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

Measurement Method	All 15-49	Disaggregated Values				
		Sex		Age		
		Male	Female	15-19	20-24	25-49
Numerator: Number of respondents aged 15-49 who have been tested for HIV during the last 12 months and who know their results	1 338	372	966	193	354	791
Denominator: Number of all respondents aged 15-49.	9 841	4 168	5 673	1 849	1 819	6 173
Indicator Value: Percentage	**13.6%**	**8.9%**	**17.0%**	**10.4%**	**19.5%**	**12.8%**

[Source: INSIDA, 2009]

Sexually Transmitted Infections (STI's)

Sexually transmitted infections (STIs) continue to a major public health issue of considerable significance in many parts of the world, including Mozambique.

As HIV and AIDS emerged, the control of STIs received renewed attention, particularly because of the strong correlation between the spread of conventional STIs and HIV transmission, and it has been found that ulcerative and non ulcerative STIs increase the risk of HIV transmission through sex.

The effective treatment of STIs contributes to keep them in check, as it prevents complications and other consequences from emerging, thus reducing the spread of such infections.

However, the initial high costs can be offset by the costs of an inadequate therapy, which include complications, relapse and subsequent transmission of the infection.

The National Program to Fight STIs/HIV/AIDS (PNC ITS/HIV/SIDA) has set as priorities to control STIs prevention, early detection and correct and timely treatment.

In the country, STIs prevention is not undertaken in isolation, and this is integrated into the HIV and AIDS prevention activities such as: sensitization campaigns, condom distribution, etc.

STIs are treated in all health facilities and integrated into the mother and child healthcare (MCH), Screening, General Medicine, and Friendly Services for Adolescents and the Youth (YFHS) and also in the mobile clinics operating predominantly along the rail and road corridors and in other areas.

At the primary level of focus, treatment is based on the Syndrome Approach.

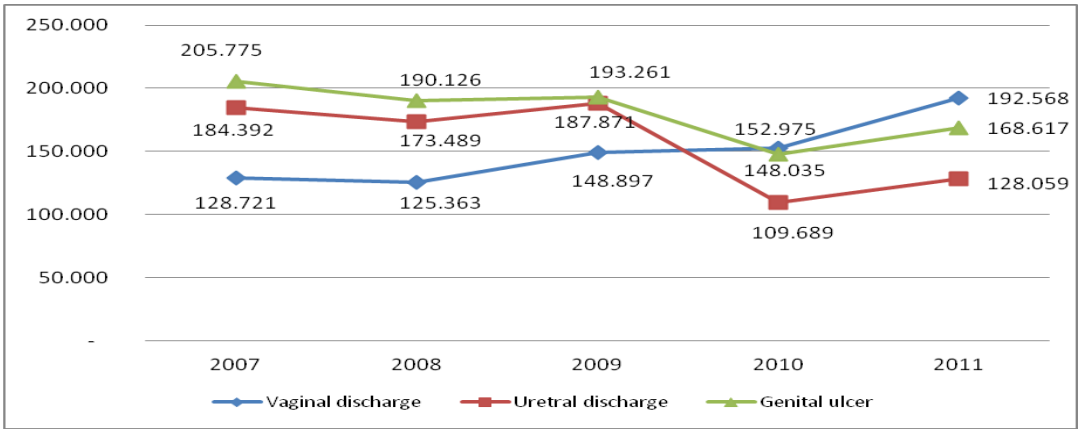
The Etiologic Approach is reserved for cases of resistance or to complicated cases and this occurs at referral hospitals.

SERVICES PACKAGE

i. Correct diagnosis by syndrome or laboratory test;
ii. Provision of an effective treatment during the first contact;
iii. Reduction of risky behaviour through counseling and education;
iv. Promotion and provision of condoms with a clear indication about correct and consistent use;
v. Reporting of cases and treatment through the contacts;
vi. Syphilis screening and treatment in pregnant women;
vii. HIV counseling and testing in all sites providing treatment for STIs.

Major Achievements

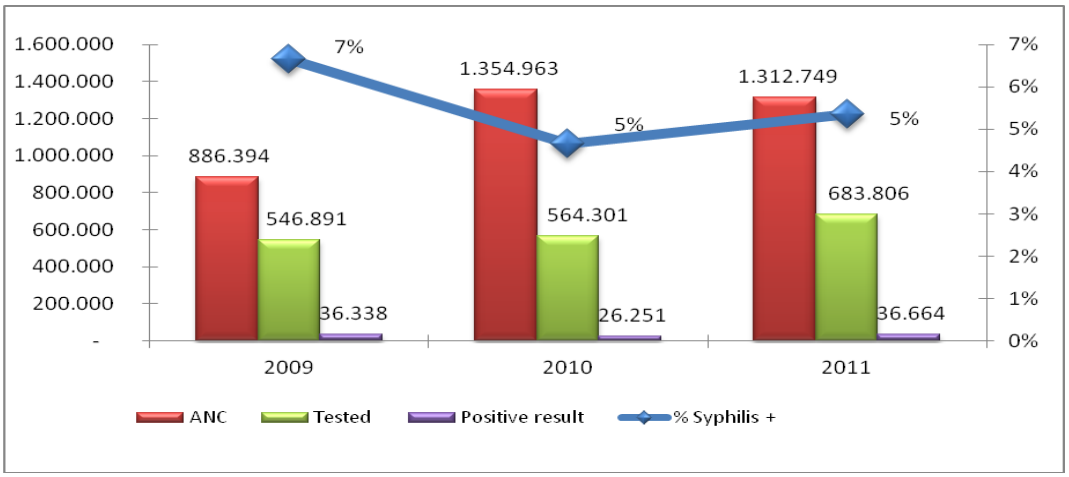
Figure 17– Evolution of reports cases from 2007 to 2011.



(Source: MISAU, 2012)

Recent data from National Program to fight STIs/HIV/AIDS[10] show that there has been some reduction in the reported cases of urethra discharge and genital ulcers from 184,392 reported cases in 2007 to 128.059 in 2011, and 205,775 reported cases in 2007 to 168,617 cases in 2011, respectively. However, from 2010 to 2011 the data reflect some rise, which is associated to the increase in the diagnosis capacity. Regarding the cases of leucorrhoea (vaginal discharge), there has been an upward trend from 2007 to 2011, with 128,721 and 192,568 reported cases, respectively (Figure 17).

Figure 18 – Appraisal of the syphilis situation from 2009 to 2011.



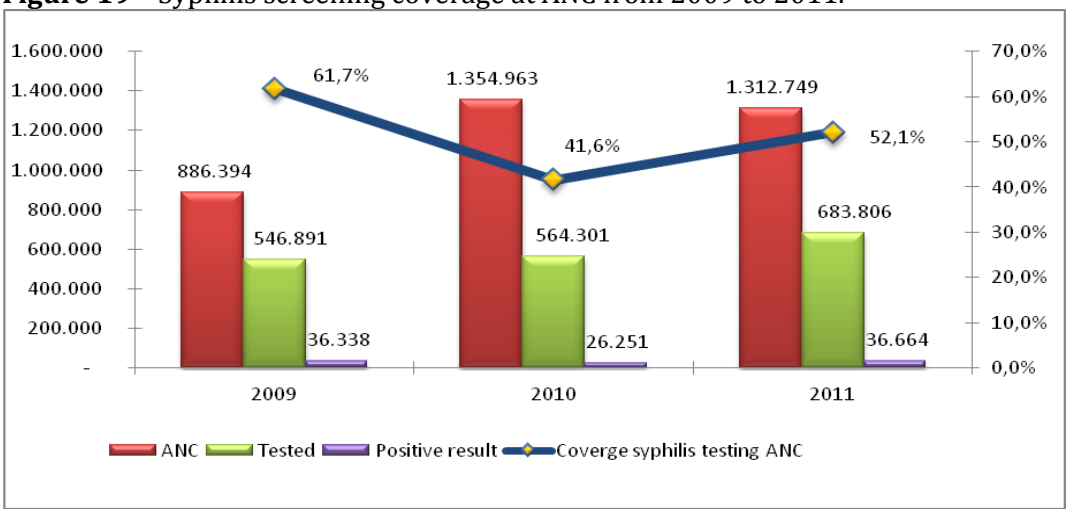
(Source: MISAU, 2012)

In 2009, 886,394 pregnant women attended antenatal care (ANC) consultations and of these 546,891 were tested for syphilis and 36,338 of them tested positive for *treponema pallidum* (the agent that causes syphilis). The women that tested positive for syphilis correspond to 7%, which was the highest percentage in the 3 years under review, as it had

[10] MiSAU. VI Reunião Nacional de ITS-HIV/SIDA

been 5% in 2010 and 2011 (Figure 18). The number of pregnant women assisted through the ANC went up between 2009 and 2011, as it moved from 886,394 to 1,312,749, respectively. This growth resulted from the increased access to health facilities and particularly to the improvement of the monitoring system with proper records being kept. This increase in the number of pregnant women in ANC was not monitored adequately as the diagnosis capacity increased, and to a certain extent this contributed to reduce the coverage rate of syphilis screening from 2009 to 2010, from 61.7% to 41.6%, as illustrated in figure 19, below.

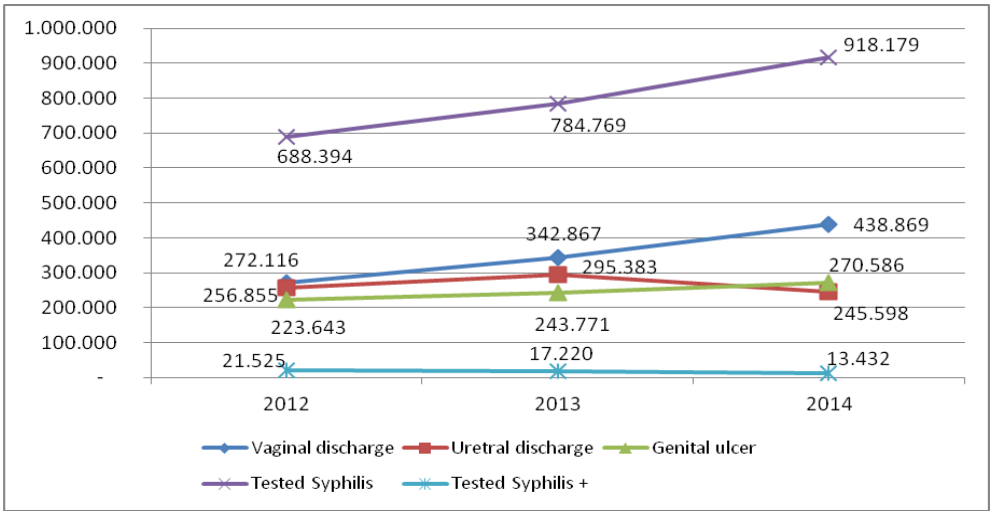
Figure 19 – Syphilis screening coverage at ANC from 2009 to 2011.



(Source: MISAU, 2012)

In order to reverse the situation described above, MISAU set realistic targets for the periods 2012 - 2014, to control STIs. It was estimated that syphilis testing will grow from 688,394 in 2012 to 918,179 in 2014. In terms of testing positive for syphilis it was estimated that there will be a drop in the number of cases of pregnant women testing positive for syphilis at the ANC from 21.525 in 2012 to 13,432 in 2014. In terms of reported cases of vaginal discharge and genital ulcers, it is envisaged that there will be increased capacity to record from 272,116 in 2012 to 438,869 in 2014, and from 223,643 in 2012 to 270,586 in 2014, respectively. With respect to urethra discharge, it is envisaged that the number of cases will drop from 256,855 in 2012 to 245,598 in 2014 (Figure 20).

Figure 20 – National targets for 2012, 2013 and 2014



(Source: MISAU, 2012)

Major Challenges

MISAU regards as major challenges in the National Program to Combat STIs/HIV/AIDS and control STIs the following: i) limited capacity for screening, diagnosis and reporting of contacts; ii) limited availability of medicines and consumables; iii) unavailability of STI algorithms in all diagnosis sites; iv) unavailability of M&E tools to record adequately STIs; v) Misinformation associated to the proliferation and sale of "medicines to treat STIs" in the informal market.

Treatment Programmes

Antiretroviral Treatment

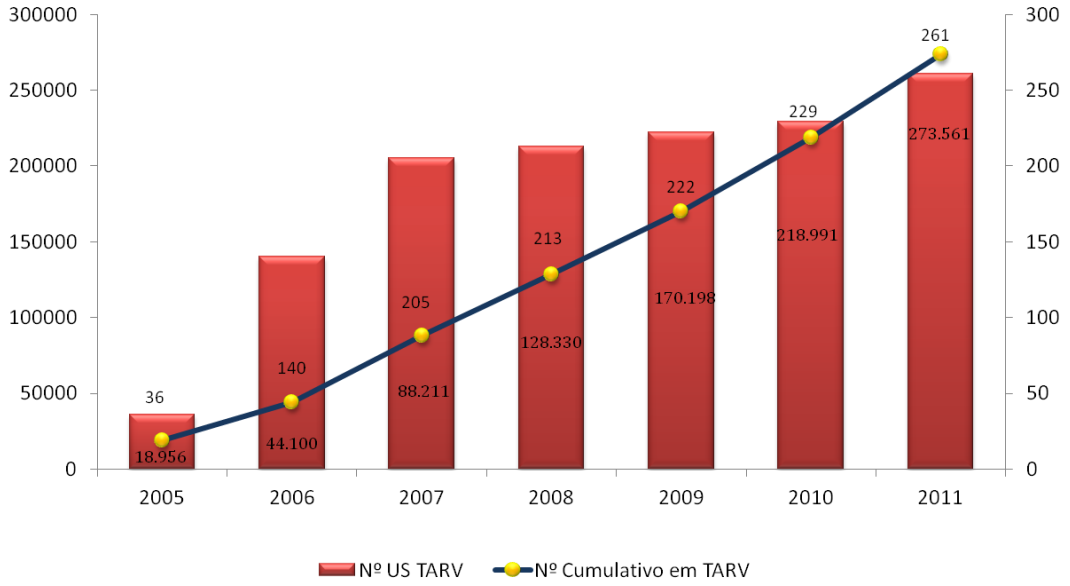
The provision of care and treatment associated to HIV in Mozambique started in 2003, and was aligned with the 2004-2008 National Strategic Plan for STIs, HIV and AIDS (PEN Saúde-PESS). Treatment was cited as one of the seven priority areas in the PEN II (2005-2009). In the National Strategic Plan for Health, the approach has always been to start do address comprehensively from the early stages the issue of long-term sustainability concerning the overall needs of the sector, using anti-retroviral treatment as a driving factor to balance the HIV approach in the health sector as a whole. The outcome was a comprehensive and balanced strategy stemming from prevention to diagnosis, care, treatment to the impact mitigation. In the same token and as a prerequisite it was decided that issues such as capacity at all levels would be taken on board so as to ensure treatment and consider the complexity of expanding the services.

Since the early stages of the national strategies in 2003, there has been considerable progress in the area of care and treatment. In 2003, there were just 3,314 people undergoing ARVT in Mozambique. In December 2011, there was a total of 273,561 (250,508 adults and 23,053 children) getting ARV (overall target for 2011). Close to 9% of all the patients are children below 15, and this coverage is below WHO directives that stipulate that out of the total patients under ARVT, 10 to 15% should be made up of the paediatric population.

Even though paediatric care and treatment were not specifically described or planned in the initial National Strategic Plan for Health, there has been remarkable progress in this area. Paediatric treatment was incorporated in MISAU's HIV program in 2005, alongside the development of guidelines and protocols, and technical working groups for paediatric HIV were established. In April 2011 new paediatric ARVT standards were published. But despite the progress made, Mozambique still has a long way to go in the area of paediatric care and treatment.

Geographic coverage of HIV services also expanded significantly. In 2003, ARVT used to be provided in just 12 urban sites in Maputo province and in Maputo city. By December 2011, all the districts in the country had at least one health facility providing ARVT services, bringing to a total of 261 the number of sites providing ARVT. Despite the significant expansion of the ARVT services, the coverage remains low in Mozambique. By the end of 2011, it was estimated that 250,508 adults and 23,053 children were undergoing treatment, which is approximately 51.7% of the adults and 19.7% of the children getting treated.

Figure 21 – Coverage trend of ART and number of health facilities involved from 2005 to 2011



Source: MISAU, 2012.

In terms of the percentage of adults and children at an advanced stage of HIV infection and receiving ARVT, Table 16 shows the latest results for 2010 and 2011.

<u>Indicator for the GARPR # 4.1.:</u> Percentage of HIV infected adults and children receiving anti-retroviral therapy

Table 16 – Percentage of adults and children at an advanced stage of HIV infection and receiving ART

Measurement Method	Indicator Value	
	2010	2011
Numerator: Number of adults and children at an advanced stage of HIV infection and currently receiving anti-retroviral therapy in accordance with the treatment protocol approved at the national level (or WHO / UNAIDS standards) by the end of the period under review	218,991	273,561
Denominator: Estimated number of adults and children at an advanced stage of HIV infection	417,621	601,384
Indicator Value: Percentage	52.4%	45.5%

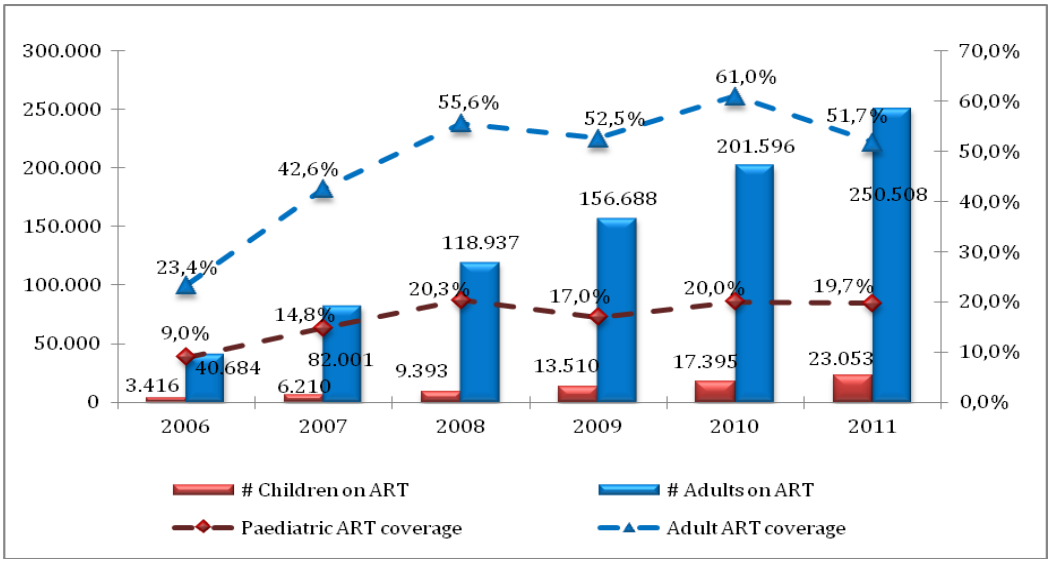
[Source: MISAU, 2012]

The third national HIV and AIDS strategy (PEN III)[11] was developed in 2009 and again assigns priority to AIDS care and treatment, and to prevention as one the four key components of the national response. Adult and paediatric HIV treatment is also considered to be a priority in other government papers prepared by MISAU. For example, AIDS treatment indicators are included as components of the second Strategy for the Reduction of Absolute Poverty, 2006-2009 (PARPA II) with specific targets, and these two of the 54 key monitoring indicators that reviewed twice a year as part of the "*Performance Assessment Framework*" monitored by the government and donors countries (the G19 donors that provide direct budget support to the government). This performance evaluation structure is aimed at assessing jointly the progress in the PARPA II implementation. Therefore, these areas are considered to be key to monitor the progress in the response to HIV and AIDS.

Adult ART

In relation to adult ART, Figure 21 highlights the expansion of services and the coverage between 2007 and 2011. By the end of 2011, MISAU's target of 241,240 adult patients undergoing ART was exceeded in approximately 9,268 patients, as 250,508 adults were actually under ART. Based on the estimates of treatment requirements calculated through the use of the Spectrum projections package, about 51.7% of the adults in need of treatment (484.404) were undergoing ART.

Figure 22 – Coverage trends of ART, 2006-2011



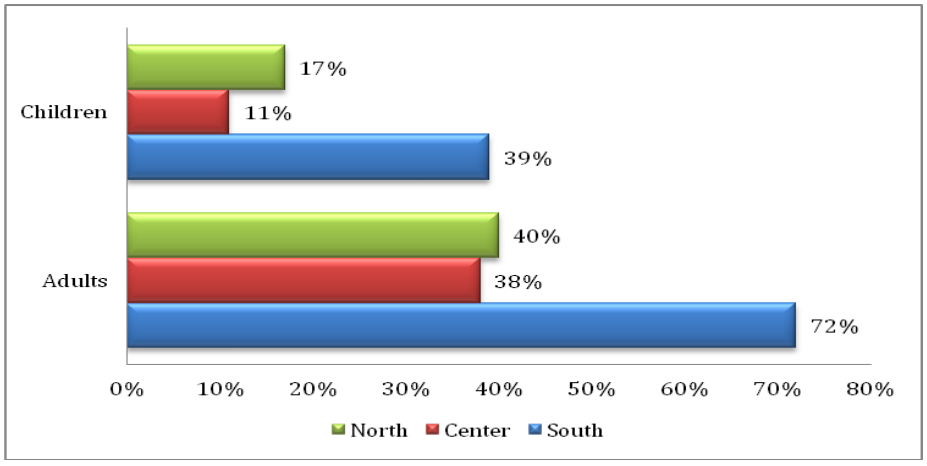
Source: MISAU, 2012 (spectrum 2011).

Although this has been a remarkable success for a national program providing treatment and care services for just six years, equity in the distribution of the coverage of ART through the various regions of Mozambique remains a matter of concern. As illustrated in Figure 22, the provinces from the central and northern regions have about half the

[11] Plano Estratégico Nacional de Resposta ao HIV e SIDA 2010 – 2014.

coverage with ART, compared to the Southern region, where the capital of the country is located.

Figure 23 – ART per region, in adults and children in 2011



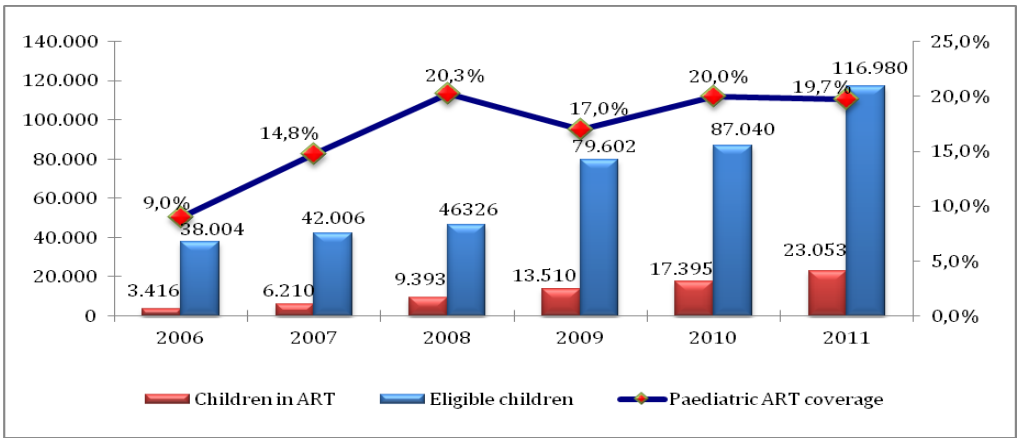
Source: MISAU, 2012 (spectrum 2011)

Paediatric ARVT

In Mozambique, paediatric ART is defined as a priority, in the same way as the improvement of the quality in the delivery of services in a bid to reduce treatment dropouts.

Based on the most updated projections, as illustrated in Figure 23, it was estimated that by 2010 there were 201,913 children aged below 15 living with HIV in Mozambique, of which 87,040 were eligible for ARVT. In 2011, the number of infected children increased slightly to 205.320, with about 116,980 eligible for ARVT. The factor that determined the growth in the number of children eligible for ARVT in 2011 was the implementation of new standards for paediatric ARVT, including the introduction of a more inclusive criterion to initiate paediatric ARVT. Despite the positive progress in increasing the number of children with access to ARVT, according to data from the program, given the proportion of children that need ARVT to save their lives in the first days after birth such figure remains insufficient. By the end of 2010 there were 17,395 children undergoing anti-retroviral treatment, representing an estimated coverage of 20% - an increase of 11% compared to 2006. However, a considerable deficit in the provision of services still remains. Even though the number of children ARVT went up 23,053 in 2011, the coverage of ARVT continues to be stagnated at around 19% over the past 4 years, due to the increase in the number of children eligible to treatment. The inability by the paediatric ARVT program to record this fast growth of the child population eligible to ARVT is a matter of serious concern, in view of the recent commitment made by the country towards universal access (>80% coverage) by the end 2015.

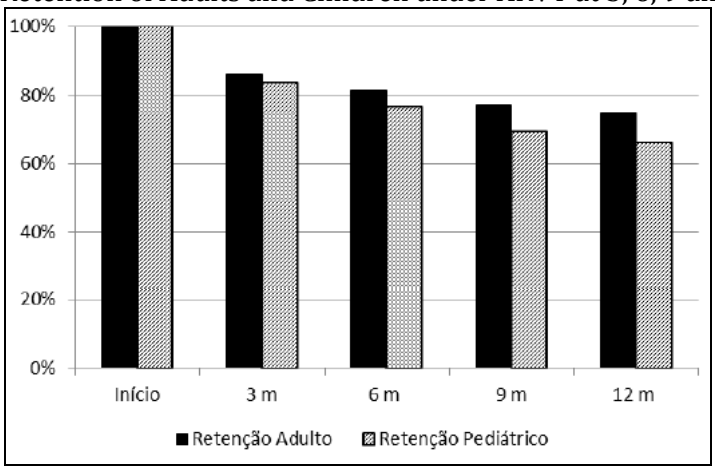
Figure 24 – Coverage trends of paediatric ARVT from 2006 to 2011



Source: MISAU, 2012 (spectrum 2011).

In order to achieve this challenging commitment, it will be necessary not just to build the capacity of the health system to identify and start ARVT of eligible children, but also to increase retention of the children under ARVT and reduce unwanted pregnancies and the rates of mother to child transmission through enhanced Maternal and Child Healthcare Services and the prevention of MTCT. The challenges of the losing track of the paediatric ARVT program were clearly documented in 2011 with the publication of the Report on Retention in ARVT of the Ministry of Health of Mozambique[12], which shows that just 66% of the children aged below 15 were still alive and under ARVT, against the global rate of 74%, 12 months after starting treatment (figure 24). A further study recently published and carried out over the period between 2004 and 2007, presents a retention rate of 79%[13](Table 17).

Figure 25 – Retention of Adults and Children under ARVT at 3, 6, 9 and 12 months



[12] Retention Analysis 12 months after patients started ARVT in June 2009. MISAU, September 2011.
[13] Auld AF, Mbofana F, Shiraishi RW, Sanchez M, Alfredo C, et al. (2011) Four-Year Treatment Outcomes of Adult Patients Enrolled in Mozambique's Rapidly Expanding Antiretroviral Therapy Program. PLoS ONE 6(4): e18453. doi:10.1371/journal.pone.0018453

Source: MISAU, 2011.

<u>Indicator for the GARPR # 4.2.:</u> Percentage of HIV infected adults and children undergoing ARVT 12 months after starting with the antiretroviral therapy

Table 17 – Percentage of HIV infected adults and children undergoing antiretroviral therapy

Measurement Method	Indicator Value	
	2010	2011
Numerator: Number of adults and children at an advanced stage of HIV infection that are still alive and undergoing treatment 12 months after starting ARVT	1,721	1,721
Denominator: Number of adults and children at an advanced stage of HIV infection that have started treatment within the period covered by the study (including dropouts, deaths and losing tracking)	2,326	2,326
Indicator Value: Percentage	74%	74%

[Source: MISAU, 2012]

Treatment and care services for children living with HIV are moving closer to people's homes, in the wake of a decentralization process that started in 2009, and also pursuant to the process of delegation of functions underway in the country. Moreover, MISAU has increased its efforts to expand early child diagnosis through the implementation of innovative technologies such the use of text message services (SMS) for the swift delivery of results of the PCR to the patient.

Following the introduction of the WHO standards in 2010, a positive development that led to the approval by MISAU of the revised paediatric standards early in 2011, resulting in a more aggressive process of initiating ARVT in children aged below 24 months, regardless of their CD4 count.

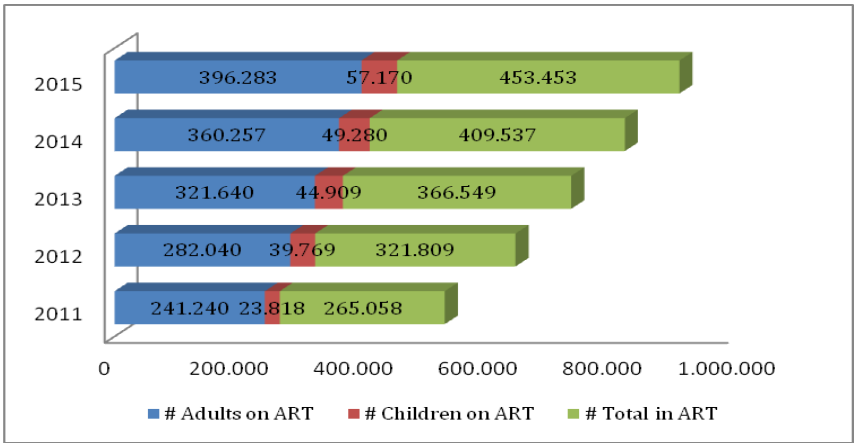
In this connection, MISAU initiated the implementation of the standards in the second half of 2011, with the training of trainers involving all provinces. The training material and the support material were adapted to incorporate the changes made to the 2011 National Policy Standards.

During the preparatory period of this report, the national health system consolidated the process of decentralization, including the improvement in the process of delegation of functions in the provision of paediatric services through the medical technicians from the health facilities at primary level. These technicians feel confident to initiate ARVT of children.

Following the review of the ARVT Standards and paediatric care, there was a need to adjust the existing targets, as the number of children in need of ARVT had increased so as to cover an additional number of children up to 24 months of age. This process took into

account the recently published data on the Demographic Impact of AIDS. The targets as defined were extended to the level of the health facilities (figure 25).

Figure 26 – Updated targets for the period 2011 -2015



Source: MISAU, 2012 (spectrum 2011).

ART Challenges

The main challenges include losing track and non adherence; the fact that there are few psychosocial activities and limited participation of the communities in matters linked to paediatric care and treatment. Children are dependent on their parents to seek care and treatment. There are reports of periodic stock outs of ARV drugs across the country. In other to the above, the following challenges can also be highlighted:

- Increase in the number of children under ARVT;
- Improved diagnosis and treatment of child TB;
- Ensure the availability of medicines and reagents for both adult and paediatric ARVT;
- Improve the integration of the ARVT/PMTCT/TB related services;
- Improve the follow-up of exposed children in the CCR and the link between the PMTCT and paediatric ARVT;
- Reduce the number of drop out from ARVT;
- Provide psychosocial support to infected patients;
- Expand prevention and counselling and testing services;
- Screen for TB all HIV positive patients;
- Develop a National Strategy for Psychosocial Support.

Prospects

Taking into account the abovementioned challenges, MISAU with the support from partners, defined the following actions as priorities:

- Development of a plan to accelerate paediatric ARVT;
- Development of a plan to accelerate PMTCT;
- Implementation of the GAAC;
- Implementation of new monitoring and evaluation tools for ARVT and health counselling and testing;
- Establishment of a technical group for planning and quantifying medicines and consumables;

- Development of guidelines to cater for high risk groups;
- Speeding up the standards for collaboration activities on TB/HIV.

Co-Management of Tuberculosis and HIV Treatment

Policy and Institutional Response

The mission of the National Tuberculosis Control Program (PNCT) is to improve the quality of the services and interventions in the primary healthcare system through the early detection and adequate treatment of patients. The overall objective of the National Strategic Plan for Tuberculosis in Mozambique (2008-2012) is to reduce the burden of Tuberculosis (TB) in the country, by reducing TB prevalence from 636/100 000 in 2006 to 390/100 000 by 2012; to reduce mortality rate due to TB from 12% in 2006 to 7% by 2012, increase the rate of case detection by means of positive skin smear of 50% in 2006 to 75% by 2012; and increase the success rate of treatment through the Direct Observation Treatment Strategy (DOTS) from 80% in 2006 to 85% by 2012.

WHO estimates (*WHO Global TB Control Report 2011*) indicate that Mozambique is ranked 19th among 22 countries with TB burden worldwide, with an estimated incidence rate of 330/100,000 (all forms), and an estimated prevalence, including HIV, of 491 cases/100,000.

Tuberculosis constitutes a serious Public Health problem in Mozambique and its association with HIV/AIDS constitutes one of the biggest challenges in the fight against this disease.

The number of TB cases associated to HIV continues to rise, as the people found to be HIV positive have 50% chance of developing TB along their lives. The prevalence of TB/HIV co-infection stands at 61% in the country.

To address the cases of Tuberculosis Multidrug-Resistant (MDR-TB) in the country is one of the priorities of the PNCT, as the diagnosis, treatment and follow-up of these cases in the country remains a major challenge.

DOTS Expansion

In the context of the strategy implementation for the control of Tuberculosis, all provinces have 100% coverage for institutional DOTS, which means that all health facilities in the periphery (health centres and/or health posts) are implementing components of the strategy, notably DOTS. With regard to Community DOTS, the country's 128 districts are implementing this strategy.

The community DOTS was introduced so as to cover all the geographic areas of the country and there are community volunteers actively engaged in the detection of TB cases. In 2010, of the expected 94,289 cases 42,123 suspicious cases were detected, corresponding to a detection rate of 45% and this rate increased to 48% in 2011. This growth results from the efforts by MISAU in partnership with volunteers and traditional healers involved in community DOTS. Some of the actions that contributed to the

[14] *PNCT/MISAU- Relatório de Actividades Desenvolvidas durante o ano 2011.*

achievement of the reported results were the increase in the diagnosis capacity through the capacity building of at least 5 health facilities without laboratories in each province to perform skin smear; and the training of 220 clinical staff, including Medical Doctors, Medical Agents, Nurses, Nurses for Mother and Child Healthcare in screening for Tuberculosis in patients that HIV positive .

Collaboration between HIV and TB programs

In Mozambique, TB-HIV co-infections are on the rise: in 2007, 47% of TB patients were HIV positive, whereas in 2011 these represented 63%. Mortality associated to TB-HIV co-infection is obstructing the achievement of the MDGs, concerning the treatment success rate[16].

Table 18 – Total number of TB patients tested for HIV, co-infected, receiving prophylaxis with cotrimoxazole, and undergoing ARVT, 2010-2011

Year	Total cases of Tuberculosis	Total cases of TB tested for HIV	Total cases of Tuberculosis that are HIV+	Total Cases of TB HIV+ under PTC (Cotrimoxazole)	Total cases of TB HIV+ under ART
2010	46,174	40,554	24,574	23,738	6,250
2011	47,452	41,896	26,538	24,095	7,661

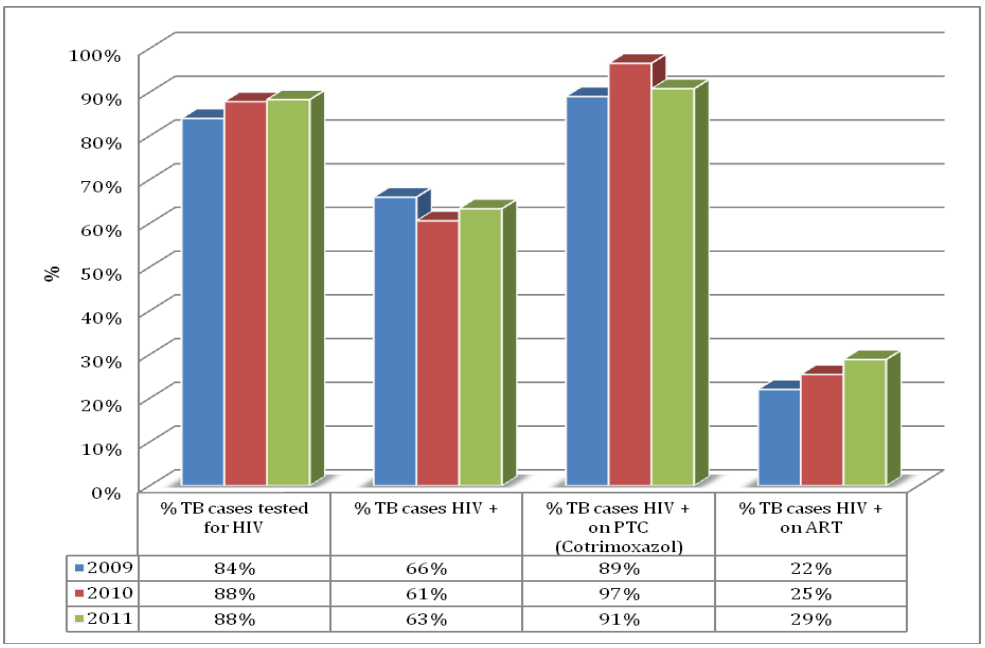
Source: PNCT/MISAU 2012

In the country and concerning the integration of TB/HIV, there has been an overall good progress in the activities. Out of the 40,554 patients with tuberculosis and tests for HIV in 2010, a total of 61% tested positive, and of these 25% started ART while 97% initiated preventive treatment with cotrimoxazole (PTC). In 2011, of the 41.896 cases tested for HIV, 63% tested positive, out of whom 91% are under prophylaxis with cotrimoxazole and 29% are undergoing ART. The widespread use of the questionnaire to screen for TB in HIV patients during consultations and the improved record keeping in the health facilities have contributed significantly to increase TB/HIV related activities, (Table 18 and Figure 27).

Integration is also made from HIV related services that screen for TB the patients that are HIV positive. Data from MISAU as shown in Figure 28 below indicate that there is an upward trend of cases of HIV positive patients being screened for TB; indeed, in 2009 a total of 24,330 patients were screened and the figure shot up to 112,606 patients in 2011. The number of HIV positive patients undergoing Isoniazid Preventive Therapy (IPT), also showed a rising trend and in 2009, a total of 2,429 cases were recorded, a figure that increased to 17,064 cases in 2011.

[15] PNCT/MISAU- 2010 Progress Report
[16] WHO REPORT 2009 Global Tuberculosis Control - Mozambique Profile

Figure 27 – Percentage of TB patients tested for HIV, co-infected, receiving prophylaxis with cotrimoxazole, and undergoing ART, 2009-2011

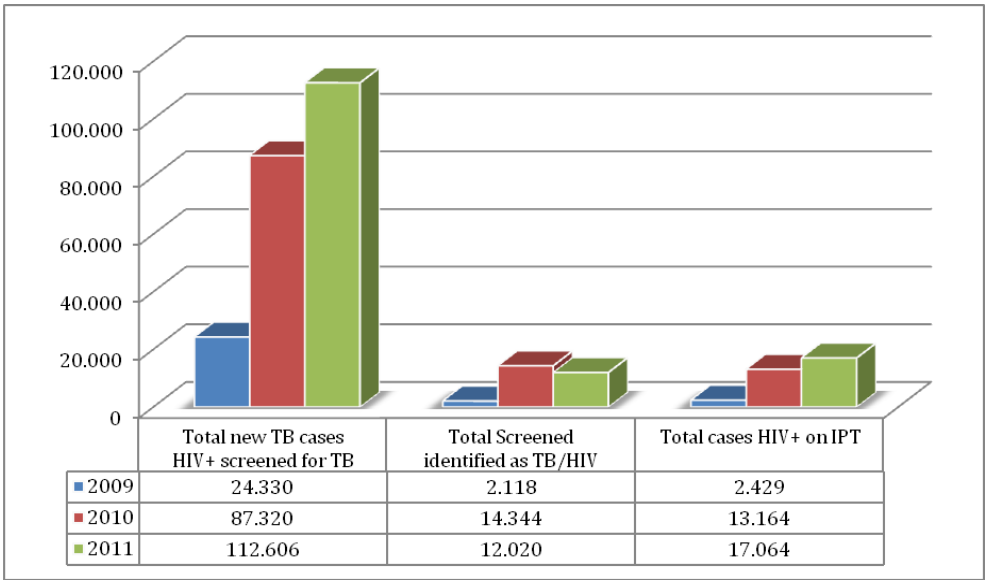


	% TB cases tested for HIV	% TB cases HIV +	% TB cases HIV + on PTC (Cotrimoxazol)	% TB cases HIV + on ART
2009	84%	66%	89%	22%
2010	88%	61%	97%	25%
2011	88%	63%	91%	29%

Source: PNCT/MISAU 2012

In 2010, out of the 87,320 cases of HIV positive patients that were screened for TB, 14,344 were confirmed as patients with TB/HIV co-infection in the pulmonary and extra pulmonary form. And out of these, 13,164 started IPT. In 2011 of the 112,606 cases of HIV positives patients that were screened for TB, 12,020 were confirmed as patients with TB/HIV co-infection, in the pulmonary and extra pulmonary form. Out of these, 17,064 started IPT.

Figure 28 – Number of HIV patients screened for TB, co-infected and under IPT, 2009-2011



	Total new TB cases HIV+ screened for TB	Total Screened identified as TB/HIV	Total cases HIV+ on IPT
2009	24.330	2.118	2.429
2010	87.320	14.344	13.164
2011	112.606	12.020	17.064

Source: PNCT/MISAU 2012

Multidrug-resistant TB

The management of cases of Multidrug-Resistant Tuberculosis (MDR-TB) in the country constitutes one of the priorities in the Tuberculosis Program, as the diagnosis, treatment and follow-up of cases of MDR-TB remain a major challenge. In 2010 and 2011, the program focused on training, with the involvement of clinical staff from all provinces of the country, to equip them with knowledge to rapidly identify suspicious cases and conduct diagnosis of MDR-TB. Based on data from the PNCT, out of the total 184 patients that were diagnosed, 144 cases of MDR-TB initiated treatment in the whole country during 2011 (Table 19) and, currently, 269 patients are under treatment across the country. However, the number of cases of MDR-TB treated in 2010 was far smaller than expected compared to 2009, and constitutes one of the causes of the paralysis of the culture and TSA services in the National TB (LNR) Referral Laboratory in that year.

Table 19 – Number of MDR-TB patients and the results of treatment from 2006 to 2011.

Year	Total N	Cured	Deaths	Dropout	Transfer	Under treatment	Mo information
2006	48	27	10	10	1	0	0
2007	97	47	28	14	1	0	7
2008	136	49	35	22	0	25	5
2009	137	0	28	16	1	88	4
2010	87	0	0	1	0	86	0
2011	144	33	30	20	3	269	3
Total	**649**	**156**	**131**	**83**	**3**	**468**	**19**

Source: PNCT/MISAU 2012

Challenges

1. Constant rotation of district supervisors, including the staff from the periphery trained in smear and/or microscopy.
2. Medicine and consumable stock outs such as reagents, glass slides and spittoons.
3. Non disbursement of funds from the Global Fund.

Way Forward

1. Proceed with the technical support visits to the provinces.
2. Increase the population coverage in the community DOTS strategy in the area of health, in all provinces of the country.
3. Ensure the operation of the 3 referral laboratories.
4. Regional training in program management for the district supervisors, including the district level chief Medical Doctors.

Indicator for the GARPR # 5.1: Percentage of estimated TB/HIV positive cases that received combined treatment for TB/HIV

Table 20 – Percentage of estimated incidental cases of TB & HIV positive patients that received treatment for TB and HIV

Measurement Method	Indicator Value	
	2010	2011
Numerator: Number of adults at an advanced stage of infection that are currently receiving antiretroviral therapy in accordance with the treatment protocol approved in the country (or WHO/UNAIDS standards) and that have started treatment for TB (in accordance with the PNC) within the reporting period.	6,250	7,661
Denominator: Estimated number of incidental cases of TB in people living with HIV	75,502	77,897
Indicator Value: Percentage	**8.3%**	**9.8%**

[Source: MISAU and WHO, 2012]

Table 20 above shows that the percentage of cases of TB/HIV dropped from 2009 to 2010 and increased again from 2010 to 2011, with 9.9%, 8.3% and 9.8%, respectively.

Care and Support Programmes

Home-based Care

With the increased access to ART, the reduction of patients very ill in bed, and a considerable increase in dropouts from ART or people failing to consistently report for treatment, the Home-Based Care Program (HBC) in Mozambique reformulated its national strategy that was approved in 2011 and it defines how the program is constituted, its operations, training tools, monitoring and supervision[17].

In keeping with the National Strategic Plan for Integrated Care, home-based care came about as a response to the need to ensure continuity of the care related to HIV/AIDS and other chronic diseases (cancer, diabetes, stroke, high blood pressure, renal failure) at the community level, in order to improve and prolong the health condition of the target population.

The home-based care approach comes to strengthen the linkages between the health facilities and the communities and constitutes a crucial resource for the provision of basic healthcare in an integrated fashion with the involvement of various stakeholders, such as: MISAU, in the design of framework policies, local and international non-governmental organizations as implementing and funding entities, community leaders, the private sector, and the community in general for the community involvement as a provider, for referral and follow-up of patients.

MISAU defines home-based care as the assistance given at the homes of people living with HIV/AIDS and suffering from other endemic diseases, and to their families, and this includes: i) education on health, prevention and counselling in connection with HIV/AIDS and other chronic diseases, ii) assessment and symptomatic care, iii) adherence to treatment, active search, prophylaxis of opportunistic diseases, and vi) a referral system between the national health system (SNS) and the community and other social sectors, in order to reduce HIV transmission and the complete care of the infected and affected population.

Despite the expansion and access to ART, across the country, to retain AIDS and other chronic diseases patients in the treatment has become a problem that the program seeks to address. Evidence shows that often times patients abandon treatment because of the fact that they feel better or cured; due to the lack of food; because of the side effects of the drugs, because of problems of transport when they live far from the health facility and when they have to go and work in their farms; take part in visits, family commemorations or family ceremonies; their perceived knowledge about the aetiology of diseases and the multiplicity of preferred health system in the wake of their beliefs, cultural values that they preserve and their cure mechanisms.

In 2010, in view of the issues mentioned above, MISAU defined a new approach for home-based care which is described in this paper, emphasizing three core areas, namely: i) adherence to treatment and active demand, ii) support in nutritional education; and iii) palliative care.

[17] National Strategic Plan for Integrated Care, Ministry of Health, October 2011

In Mozambique, Palliative Care (PC) was formally introduced in 2008 as a government strategy to address the issue of chronic diseases including HIV and AIDS, aimed at its inclusion in the already existing national structure for Home-Based Care. The emphasis is on the mitigation of suffering, with focus on the patient, not the disease, restoring and reaffirming interpersonal relations in the death process, where the major elements are compassion, empathy, humility and honesty.

With the establishment of the Mozambican Palliative Care Association (MOPCA), in 2009, collective efforts are being made, for the introduction of palliative care in the training curriculum and also for the provision of specific training for implementation professionals and care providers on palliative care. It has been working hard in terms of advocacy towards the legal recognition of the focus on care, thus creating hope for the operationalization of the national palliative care philosophy.

In the context of the implementation of the Home-Based Care there are programs that establish linkages aimed at the provision of food and nutritional assistance and for adherence to the medication. These actions are operationalized by volunteers that refer people and members of vulnerable families, (including orphans and vulnerable children) to the existing formal and informal services related to socioeconomic needs, such as the provision of food and/or money allowances through the Ministry for Women and Social Actions (MMAS); access to education, prevention and psychological support (disclosure and support in case of death). Volunteers are also trained to promote the respect for human rights and to address stigma and discrimination in the community.

In view of the need for a rapid expansion and the high demand for training, MISAU delegated in 2006, the responsibility of the training of trainers among the volunteers to ANEMO (National Association of Nurses of Mozambique).

Outcomes

In 2011, ANEMO, in the context of the implementation of the project known as "Chomchass" for the area of home-based care carried out two refresher training programs for trainers as had been planned, one in Maputo with the participation of 22 trainees and the other in Beira city also with 22 trainees. Of the 5 accreditations that had been planned, actually there were 7 accreditations in the provinces of Maputo, Inhambane and Sofala, covering 20 trainers, out of whom, 16 were accredited. One supervision mission had been planned, but 3 were conducted, 2 to Maputo and 1 to Sofala provinces. A refresher program was carried with the participation of four (4) expert trainers and the training coordinator, and this lasted for 10 days. The objective of the refresher program was to update these experts on home-based care and on the new approaches introduced to the program by MISAU[18].

In 2011, as part of its Social Assistance program MMAS made 267,756 regular unconditional money transfers to people living in poverty and unable to work (the elderly, people with disability, people that are chronically ill) from the 252,842 that had been planned, representing an execution rate of 105.90%. It also made 33,330 fixed term social

[18] Progress report for the period from June to September 2011. ANEMO, 2011.

transfers to the respective beneficiaries (people that are chronically ill, malnourished pregnant women, twin children, PWD, the elderly and victims of incidents) out of the 37,328 that had been planned, representing an execution rate of 89.29%. Assistance was also provided in the form of food, clothing, household tools, school material, psychosocial support, entertainment and medical assistance and the provision of medicines to 2,077 users of Social Facilities (Nurseries, Elderly Care Centres, Transit Centres and Open Community Centres) out of the 2,694 planned, corresponding to an execution rate of 77.10%, and opportunities were put in place for the self-reliance of 5,140 individuals (3,414 women and 1,726 men) living in poverty but able to work, as part of the Productive Social Action, through the implementation of 303 income-generation projects, out of the 347 planned, corresponding to an execution rate of 87.32%.

Within the framework of the collaboration activities between MISAU and MMAS there was a redefinition of the training program for the providers of home-based care and visits in the context of the integration of home-based care and visits to better cater for PLWHA and people with other chronic diseases and the provision of community-level care, trail o the program on the ground to get inputs or gather experiences concerning validation. With the support from FHI there is a program that is underway for the formulation of plans for joint training of activists on health and social action matters.

In 2009, MISAU launched the Basic Basket Program, targeted at PLWHA and Tuberculosis patients undergoing ARVT that were evaluated based on previously defined clinical criteria. In 2011, the Program was implemented with the support from the WFP in all provincial capitals and was expanded to 22 districts, covering 3,138 beneficiaries.

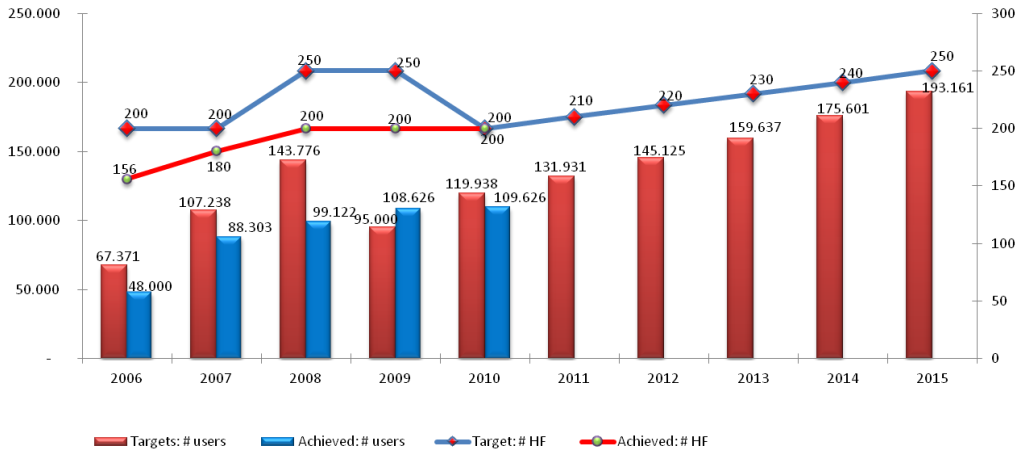
In 2011, an institutional protocol was entered into between MISAU and MMAS setting out the responsibilities of either party in the process whereby MISAU is responsible for the clinical component and MMAS is responsible for the social and nutritional component, including the Basic Basket Program.

In addition, the government introduced in 2010 the Nutritional Rehabilitation Program (PRN) and approved the Strategy to Combat Chronic Malnutrition, which will also reinforce the nutrition interventions in the home-based care component[19].

As shown in Figure 28 above, the activities under the Home-Based Care Program reduced in 2009, because of the lack of definition on the part of MISAU in relation to this Program, at a time when it was scoring success in the Anti-Retroviral Treatment (ART) Program. In the view of this, the targets were readjusted as from 2010. Moreover, this lack of definition resulted in instability in terms of the collection and submission of data from NGOs, SDSMAS, DPS and at the central level. According to central level managers of the home-based care, it is presumed that data are collected, collated and submitted from NGOs, SDSMAS up to the provincial level, and that there are bottlenecks between the provincial and central levels.

[19] Manual on Nutritional Treatment and Rehabilitation - Volume I. Ministry of Health, Nutrition Department, August 2010.

Figure 29 – Number of Health Facilities that provide Home-Based Care Services and the number of clients/users attended to between 2006 and 2010.



[Source: MISAU, 2012]

The financial crisis has affected sustainability and contributed to the reduction in the number of Community-Based Organizations (CBOs) that were funded for the implementation of the home-based care program and, in addition, the lack of definition on the part of MISAU on the route to follow have contributed to the current situation.

Challenges and Key Actions to Enhance Universal Access to Care and Support

In general, the decline in the activities experienced in 2008-2009 constitutes a major challenge for the restructuring and resources mobilization for the implementation of the Home-Based Care Program. Specifically, the challenges are:

- Sustainability of the Home-Based Care Program, in particular the funding to CBOs and NGOs;
- Continuous expansion of the home-based care coverage in tandem with the rapid expansion of ARVT;
- Functional and bi-directional referral system between the health centres and the communities;
- Inconsistent implementation of cost-effective interventions, such as prophylaxis with cotrimoxazole, integrated TB/HIV services;
- Integration of home-based care activities with the psychosocial support activities at the community level;
- Lack of a comprehensive mapping of the home-based care services to know what human resources are available for the implementation and care provision;
- Functional supervision, management and coordination structures at all levels;
- A standardized and functional M&E system for home-based care, linked to the National Information System (SIS).

Nutrition and HIV

There are important connections between HIV and AIDS and nutrition. There is a need for adequate nutrition to strengthen the immunological system, to manage opportunistic infections, to maintain healthy levels of physical activity and support optimum levels of quality living for people living with HIV (PLHIV). A good nutrition contributes to slowdown HIV and AIDS progression. The interventions in the area of nutrition can also help to optimize the benefits of Anti-Retroviral Treatment (ART) and to increase adherence to treatment and/or the prevention of mother to child transmission protocols[20].

The World Health Organization recommends that all the HIV care and treatment programs should include evidence-based interventions[21]. The collection of information on food intake and the survey on the nutritional status of PLHIV (weight and changes in weight, height, Body Mass Index (BMI) or arm circumference, symptoms and food intake) should be performed routinely. Food security and individual and household level also need to be assessed.

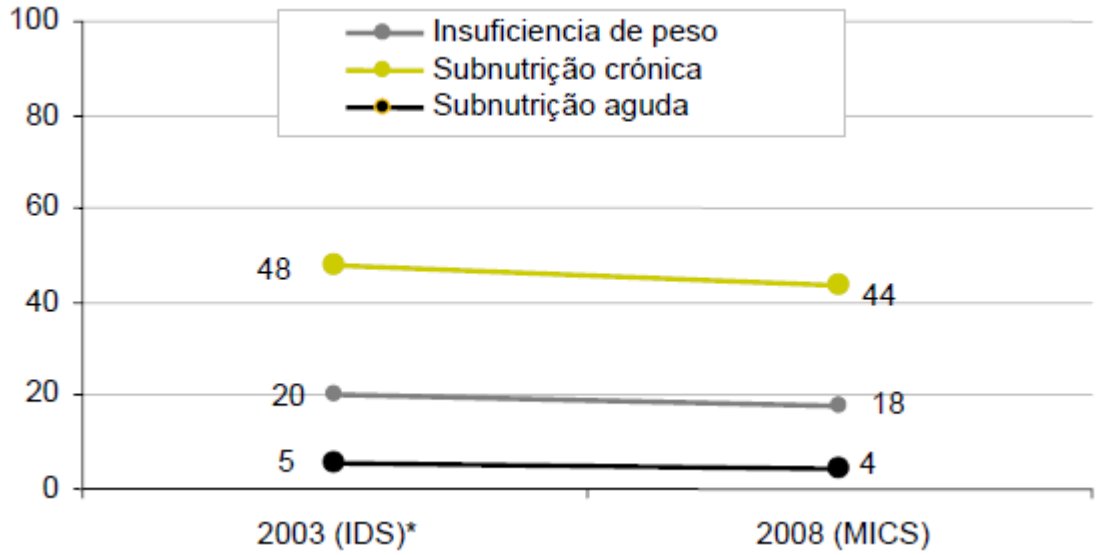
Data on the nutritional condition of PLWHA are scarce. The weight of patients is not measured systematically in all health facilities and height is taken in very rare occasions. Personal forms for adults do not have a specific space to record the height and BMI. The new forms will have space for these indicators. It is important to establish the BMI of patients, as this is used as a criterion to select the patients to the nutritional rehabilitation program, consisting of nutritional supplements or the Basic Basket.

Although the 2008 MICS showed some improvements in the nutritional condition of the under five children, the levels of child malnutrition, particularly chronic malnutrition, remain quiet high, according to WHO ratings. As illustrated in Figure 29, the percentage of chronically malnourished children stands at 44%, while in 2003 it was 48%. The percentage of children under the age of five with stunted growth dropped slightly, as it stood at 18%; the prevalence of acute malnutrition also reduced from 5% in 2003 to 4% in 2008.

The reduction in the rates of chronic malnutrition between 2003 and 2008 was the result of a steeper reduction that occurred in the rural areas, while the decline in the urban areas was not as high. Data from the 2003 IDS and 2008 MICS show that the rate of chronic malnutrition in urban areas has been dropping at an average of 0.4% per year (from 37% in 2003 to 35% in 2008), whereas the annual average reduction rate in rural areas was of 1% (from 52% to 47%).

[20] Banco Internacional para Reconstrução e Desenvolvimento, HIV e SIDA, Nutrição e Segurança Alimentar: O que podemos fazer, Uma síntese de princípios de orientação internacionais. 2008
[21] WHO, Priority interventions: HIV/AIDS prevention, treatment and care in the health sector, 2009

Figure 30 – Nutritional status of children under the age of five, 2003 and 2008.



Source: MICS 2008.

Policy and Institutional Response

The main government institutions in charge of nutrition and HIV are the Ministry of Health (MISAU) and the Technical Secretariat for Food and Nutritional Security (SETSAN). MMAS is the institutions responsible for Orphan and Vulnerable Children (OVC). MISAU has put in place a working group on nutrition, food and HIV.

The Ministry of Health developed Nutritional Guidelines for PLHIV (brochure for heath staff and program managers) and prepared a training package on the nutritional requirements of PLHIV for the health staff, activists involved in home-based care, and local NGOs. This package covers both adult and children patients. The development of simplified material for nutritional education activities particularly for adult patients is in the pipeline, and includes serial albums and posters with illustrations.

In addition, between 2010 and 2011, MISAU worked on the improvement of the integration of nutrition into the prevention of mother to child transmission, through the introduction of the nutrition component, especially Infant Food, following the new WHO recommendations, and in the mother to mother approach.

In 2011, MISAU published the Manual on Treatment and Nutritional Rehabilitation[22]. This Manual presents the steps and procedures for the treatment of patients suffering from acute malnutrition (moderate or serious) in a Hospital, Health Centre, Nutritional Rehabilitation Unit or any other facility providing such services. The Manual also contains some key points for community involvement in the identification and follow-up of these patients.

[22] Nutritional Treatment and Rehabilitation Manual. Volume I. MISAU, 2011.

According to the Manual, the Optimum Nutritional Status of a person is reflected by keeping vital processes of survival, growth, development and activity. Any deviation from the optimum nutritional status results in nutritional disruptions termed malnutrition. And this is defined as a pathologic status that results from the inadequate intake and/or absorption of nutrients by the body *(malnourishment or undernourishment)*, and from the excessive intake and/or absorption of nutrients *(over nourishment)*.

The different forms of malnutrition that can appear in isolation or in combination include:

- Acute malnutrition: manifested through stunted growth and/or bilateral edema;
- Chronic malnutrition: manifested through low height for the age;
- Micronutrients malnourishment: the most common form of micronutrients malnourishment is related to deficiency in iron, vitamin A, iodine and complex B vitamins.

Inadequate growth is diagnosed in a child when the child fails to gain weight in-between two consecutive weighing periods, over an interval of at least 1 month but not exceeding 3 months, which means horizontal or declining growth curve, based on the curve of the Child Health Card.

Acute malnutrition is caused by the inadequate food intake and/or recent illness, resulting in weight loss and/or bilateral edema.

Based on the clinical condition, acute malnutrition can be classified as light, moderate or serious. Acute malnutrition is manifested through the following clinical conditions:

i. Marasmus (serious weight loss);
ii. Kwashiorkor (bilateral edema);
iii. Kwashiorkor-marasmus, or serious weight loss with bilateral edema

The key nutritional indicators for the diagnosis of acute malnutrition are:

i. Arm circumference;
ii. Weight for the height for children aged 6 to 59 months;
iii. Body Mass Index for the age (BMI/Age) for children and adolescents aged between 5 and 15 years;
iv. Bilateral Edema (edema in both feet).

The indicators of weight for height and BMI/Age show how the weight and the height in children or adolescents compare with the weight and height of other children or adolescents in WHO standard population of the same sex.

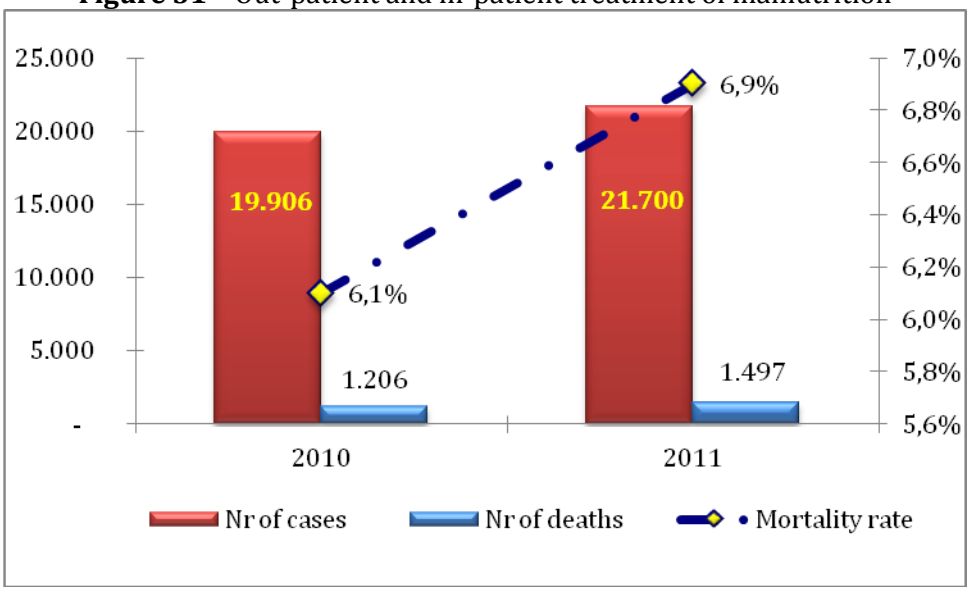
Interventions for PLHIV

The treatment of acute and serious malnutrition in HIV positive and HIV negative children is the same. The out-patient treatment of acute and serious malnutrition through the provision of Ready for Use Therapeutic (RUTF) supplied by and by the Clinton Foundation has already been introduced across the country for children that do not have complications. Out of the 216 health facilities that provide Anti-Retroviral Treatment (ART) for children, 146 provide out-patient treatment for acute and serious malnutrition with RUTF (Plumpy´ Nut). There has been community involvement that is expanding. HIV

positive children with acute and moderate malnutrition receive CSB++ or RUTF (where CSB is not available) to ensure quick rehabilitation.

The number of cases of malnutrition is on the rise in the country. Data from the Ministry of Health (figure 30) show that between 2010 and 2011, the number of cases treated both as out-patients and in-patients increased from 19,906 to 21,700. The number of deaths caused by malnutrition also increased from 1,206 to 1,497, which corresponds to a mortality rate of 6.1% and 6.9%, in 2010 and 2011, respectively.

Figure 31 – Out-patient and in-patient treatment of malnutrition



Source: MISAU, 2012.

The Basic Basket program introduced by the government in 2009 has already covered about 3,500 people in the 11 provincial capitals. In 2010, it expanded to more districts in the country in order to cover more eligible patients under ART. The Basic Basket consists of ten different food items, with a total weight of 28 kg, given out monthly, over a six-month period. After complying with the clinical criteria, in keeping with the biomedical assessment in place, patients move out of the program. PLHIV that are eligible receive a voucher at the health facility to be presented at a shop to collect the food items.

SETSAN developed a Manual on Standards concerning Food and Nutritional Insecurity and HIV and AIDS in 2006, providing guidelines for interventions in this area. This manual is being used by SETSAN in the training of NGOs and other stakeholders.

The Ministry of Health is implementing the Nutritional Rehabilitation Program (PRN), which covers the treatment of acute, moderate and serious malnutrition in HIV positive children. In 2010, this program expanded the treatment to children aged between 5 and 15, and as from 2011, MISAU is introducing in a phased manner the nutritional rehabilitation of chronically affected adults, (including PLHIV and with Tuberculosis) and pregnant and breastfeeding women, through the provision of CSB++ supplements. Currently, MISAU is finalizing Protocol II of the Nutritional Rehabilitation Program that covers adults with malnutrition.

It is worth pointing out that the community component of the Nutritional Rehabilitation Program includes a package on specific training, with support material, which includes the topic of nutritional counselling for PLHIV.

Between 2010 and 2011, training of trainers programs were carried out in all the provinces based on the MISAU's Nutritional Counselling Package for PLHIV.

MISAU is finalizing, together with its partners, the Nutritional Rehabilitation Manual for Adolescents and Adults (both for HIV positive and HIV negative people).

The World Food Program (WFP) is supporting the distribution of food supplements (Corn Soy Blend - CSB) to various target groups in seven provinces: pregnant and breastfeeding women (including HIV positive women) with moderate malnutrition, adults that are HIV positive and/or have Tuberculosis (TB) and with moderate malnutrition and exposed children (children at risk) with moderate malnutrition and/or stunted growth. In addition to this nutritional supplement, patients also receive food for their family, consisting of grains and pulses.

Supplements are used to enhance the nutritional condition of the patients and to improve adherence to treatment or to the PMTCT protocol. The distribution is made in collaboration with MISAU and jointly with various partners (including NGOs and the National Institute for Social Support - INAS). In the course of 2009 and on a monthly basis, an average of approximately 3,200 women and 3,900 children integrated in the maternal and child healthcare and close to 10,000 patients under ARVT and 3,600 being treated for opportunistic infections and TB are getting food assistance (CSB plus food basket for the family).

HIV affected households and OVC are eligible as either direct or indirect beneficiaries of the Food Subsidy Program or the Direct Social Support Program; both are run by MMAS and INAS. The WFP also provides food assistance to OVC and their families. In 2009, the WFP provided food assistance (grains and lentils/beans) to an average of 40,000 OVC monthly. The WFP also provides nutritional and food assistance to chronically ill people receiving home-based care. In 2009, the WFP provided such assistance to a monthly average of 14,500 people.

Conclusions and recommendations

There is a strong political will to improve the nutrition of PLHIV and with TB, and various interventions in this area are being implemented. However, there are a number of constraints: there is not as yet a comprehensive strategy on nutrition and HIV, the systems to assess the nutritional condition of PLHIV are weak; many interventions are being implemented at a small scale and there are not many linkages between the interventions.

To speed up and increase coverage and ensure quality in the nutrition related interventions for PLHIV, the following is recommended:

1. Develop a consensus and secure the support for the development of standards, protocols and operational plans concerning nutrition in the context of HIV jointly with the stakeholders from the government, civil society, NGOs, bilateral and UN agencies;
2. Develop a comprehensive strategy on nutrition and HIV for children and adults;
3. Develop a consensus and promote the setting up of a forum to coordinate the actions of all stakeholders and ensure the availability of the material required for nutrition related interventions targeted to PLHIV;
4. Build the capacity of the health workers from the health facilities and the community-based services providers in the area of nutrition and HIV, particularly with respect to the selection of patients based on anthropometric measurements, follow-up, monitoring and evaluation;
5. Strengthen counselling on nutrition for PLHIV, including the development and distribution toolkits;
6. Strengthen the linkages between the community and the health facilities to: i) streamline the identification and children and adults that are malnourished, improve the access to nutritional and HIV related services; and ii) improve the follow-up of out-patient children and adults suffering from malnutrition;
7. Strengthen the linkages between the food assistance programs, the income-generation programs, the food security programs and others to support the livelihood of PLHIV when they join the food assistance program;
8. Monitor the interventions related to food distribution and document the goals achieved and cost-effectiveness, and use such information for pertinent decision-making; and
9. Enhance MMAS's role in the nutrition interventions targeted to PLHIV.

Knowledge and Behavioural Change Programmes

Adolescents and young people

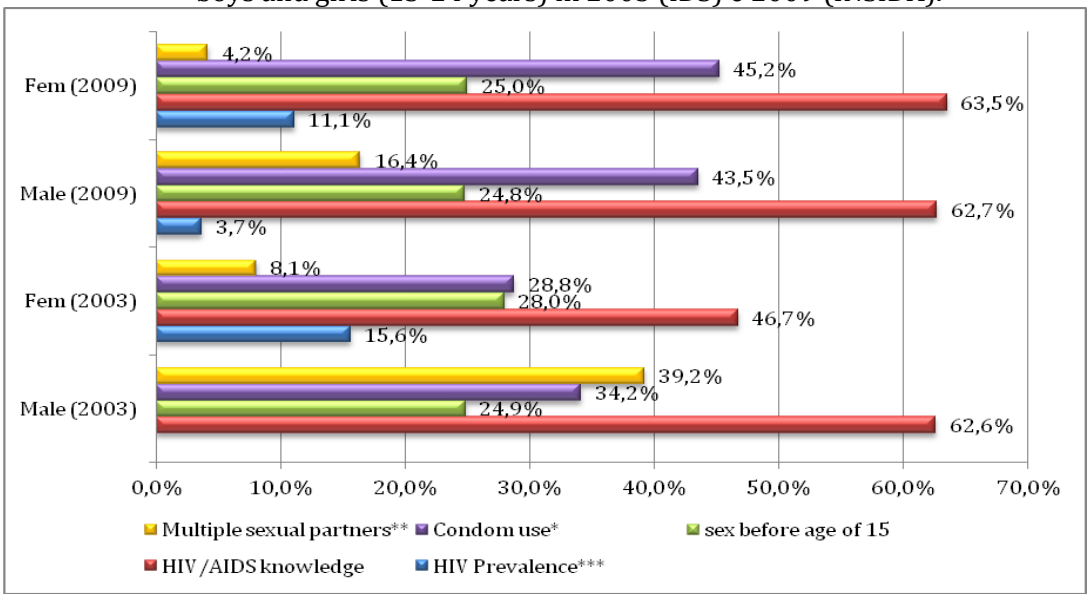
Every single day in the world nearly 3.000 adolescents and youth, with ages around 15 and 24 years are infected with HIV virus.

A little more than half of the people living with HIV in the World are women and girls. In sub-Saharan Africa, more women than men live with HIV and girls with ages between 15 and 24 years old are facing a risk 8 times greater than boys of contracting HIV[23].

In Mozambique the HIV prevalence rates in females, in the age group of 15-24, is estimated to be 3 times higher than in the same age group of male[24]. Several factors influence the increase of the risk and of the vulnerability of youth, particularly, among the girls. These include social and cultural aspects that perpetuate the unequal gender relations and violence based on gender, inter-generational sex involving girls and older sexual partners, multiple and concomitant partners, with little use or with inconsistency in the use of the condom[25].

A research made recently in Mozambique shows that boys, in general, have better knowledge and attitudes on Sexual and Reproductive Health and HIV/SIDA compared to girls. But in terms of behaviour change it is not clear if boys are better than the girls[26].

Figure 32 - Comparison between the knowledge, attitudes and behaviour changes, among boys and girls (15-24 years) in 2003 (IDS) e 2009 (INSIDA).



Caption: *-use of condom in the last sexual intercourse; **-2 or + partners in the last 12 months; ***-15.6 % in RVE 2004. Knowledge of at least 2 HIV prevention methods (use of condom + to limit the number of partners to only one not infected). Sources: IDS 2003, INSIDA 2009 and NSPIII 2010.

[23] UNAIDS, 2010 GLOBAL REPORT.
[24] INSIDA 2009.
[25] Government of Mozambique, 2009. National Multiple-pronged Action Plan on Gender and HIV and AIDS, 2010-2015
[26] In-depth Review of Geração Biz Programme, Mozambique. Preliminary Report. 10/2/2012

The youth and adolescents continue being the most vulnerable to HIV in the country. Given that the Mozambican population is very young, and makes up around one third of the population, any change in the behaviour and in the way of life of this age group would have a significant impact in the course of the epidemic. A comparative analysis of the IDS (2003) and INSIDA (2009) data on the knowledge, attitudes and changes of behaviour, shows that in 2003 boys had more knowledge on HIV compared with girls, but that this scenery has changed in 2009, where both have almost the same level of knowledge. Regarding the beginning of the sexual life before the age of 15 in 2003 girls used to begin earlier (28 %) compared to boys (24,9 %), but this trend has changed in 2009, where they both begin their sexual life almost at the same time. About the use of condom the girls had a slight disadvantage (28,8 %) in 2003, comparing with the boys (34,2 %), but that this disadvantage was already surpassed in 2009, where 45,2 % of the girls reported to have used condom in the last sexual intercourse against 43,5 % of the boys. Regarding multiple sexual partners the boys surpass the girls in both periods, but with a tendency of improvement (figure 31).

These results show that the government is focusing its answer on the girl and these efforts are achieving the expected results. But that there is still much to be done, since the above illustrated, prevalence is still very high in this population group.

Institutional e Political Context

When the National Strategic Plan of Response to the HIV and AIDS, 2010-2014 (NSPIII), analyzes the "Structural Factors of Risk and Vulnerability" associated to the HIV and AIDS, identifies the the youth as a group of elevated importance, since it constitutes considerable part of the population most exposed to the risk of infection, being the highest tax of HIV prevalence in the age group between 20 and 24 years (18.3 %). Around half of the young Mozambicans are sexually active before they reach the age of 16. The women in Mozambique make up nearly 52 % of the total population, 72.2 % of which lives in rural areas, with extremely low indexes of human development (such as an illiteracy rate of nearly 68 %)[27].

The NSPIII in the scope of its Strategic Vision establishes that the component of prevention is still the area of central approach and is being supported in evidences highlighted in the Strategy for the Acceleration of Prevention. And it highlights that the investment goes for the reduction of HIV prevalence in 15-24 years old pregnant women, from 11.3 % registered in 2007 to 8.5 % in 2014[28].

The Government of Mozambique has approved the Strategy for the Acceleration of Prevention in 2008. The strategy establishes the mechanisms of a progressive and sustainable reduction of the incidence of HIV in the country and indicates the priority actions to achieve this purpose. The strategy recognizes increased vulnerability of the Adolescents and The Youth in the context of the epidemic.

The Government of Mozambique is committed with adolescent and young person related issues. The National Youth Policy established by the National Youth Council already incorporates programmes that secure the access of the youth to information and services of sexual and reproductive health (SSR).

[27] NSPIII 2010

[28] NSPIII 2010

The Ministry of Education (MINED) has established the "corners of counselling" and information on HIV in the schools of the whole country, where the adolescents and the youth who attend school can obtain information and advice from educators, on HIV prevention, access to condoms and transferences to the SAAJ, among other services.

Radio Mozambique, the Institute of Social Communication, the National Television of Mozambique and the Forum of the Community Radios – FORCOM, with the support of UNICEF have actively involved 1.410 children, adolescents and young people in the production and presentation of children's programmes for the child of the media (RM, TVM and FORCOM) with contents that include all the rights of the children in 11 provinces, including HIV prevention. In 2011, 4 handbooks of training and of production of radio programmes on HIV prevention (with focus on simultaneous multiples partners and stigma), Prevention of Violence and Abuse against Children and survival and child development were also produced. In the same period, 10 FORCOM trainers were trained to be quality trainers to produce programmes for children and adults, 6 radio producers' trainings were carried out, in 6 community radios.

In terms of the community, in 2011 UNICEF has supported activities of social participative mobilization in 75 local authorities through programmes of mobile multimedia unit with the Institute of Social Communication (ICS) and of theatre in the community, in partnership with the Theatre of Oppressed Group (GTO). Nearly 1.600.000 people of 190 localities were visited at least twice by these multimedia units and nearly 184.000 people in 275 localities have benefited at least three times from community theatre activities that promote breast-feeding, malaria, HIV prevention and prevention of cholera. In the same period, 8 videos on Health and Life (malaria, prevention of cholera and HIV, and promotion of immunization, breast-feeding and good hygiene practices) were produced by the ICS.

The Ministries of Youth and Sports (MJD), MINED, the Ministry of Health (MISAU) and partners (FNUAP and Pathfinder), have been managing a multiple-sector programme, called Geração BIZ Programme (PGB) to talk about HIV prevention among the adolescents, inside and out of the school, with ages from around 10-24 years old in the country, with connections to the SAAJ's. In 2010, this programme has reached 56 % of the total of estimated population of adolescents and young people (10 to 24 years old) in the country. This result, of 56 %, counted with the important contribution of the school base, which on average in the country has presented a covering of young schoolboys and girls of 81 %. The community base contribution was around 55 %. Another factor that has contributed has to do with the existent infra-structures, for the support of PGB Interventive actions, as seen in table 21, below. Notice that there was growth compared to 2009, having the schools included by the PGB increased from 694 to 783. The youthful associations that support the community base increased from 488, in 2009 to 674, in 2010. As for the clinical base of the total of 244 SAAJs, in 2009, to 335 in 2010.

The clinical base, in 2009 has served 292.842 young people, in 2010 the number of young people that benefited from the services had an increase in 71 %, reaching 500.619. 15 % of

the young people who benefited from these services were referred to the peer educators in community and school bases. In 2010, 22 % of the young people sexually attended in the SAAJ were tested. This sharp increase is higher compared to 2009, where the annual testing reached 60.728 young people.

Table 21 – Distribution of School Coverage by the PGB (2010)

Institution	EP2/EPC	Secondary School	Technical School	Youth Associations	Specific YFHS	Alternative YFHS
Total	512	235	36	674	109	226

Source: PGB 2010 Annual Report.

Main Achievements

- Preparation of the notebook on Best Practices in Prevention Programmes, focusing on Adolescents and young people in Mozambique;
- Creation of an Internet page for the notebook of Best Practices.
- The Youth and Adolescents Associations are represented in different work groups, in the Province Nuclei of the National Council of Fight against AIDS, securing the inclusion of the of young people's concerns in the prevention and mitigation strategies.

Main Challenges

- The civil society organizations need an improved coordination, to be more critical and interventive in their response;
- Few prevention programmes focused in the particular needs of the young people's and adolescent's groups, such as, those involved in activities of commercial sex and the disabled;
- Distribution of prevention materials, including condoms and information on prevention is still a challenge, especially to reach the most remote areas.

Main Actions aimed at Broadening Universal Access to HIV Prevention

- To strengthen the response against the feminization of HIV and the efforts for the reduction of violence based on the gender among adolescents and the youth and to improve men's commitment.
- To continue the efforts to reinforce the capacity of the intervenient principals to translate the evidence in the improvement of the strategies of prevention, plans and national budgets.
- To continue the efforts of strengthening of the nets of distribution of prevention materials.
- To improve the involvement of the youth in the prevention programmes.

GARPR indicator # 1.1.: Percentage of 15-24 years old boys and girls who not only has identified correctly the ways of preventing sexual transmission of HIV but also has rejected the main misconceptions on the transmission of the HIV

Table 22 – Percentage of 15-24 years old boys and girls who not only has identified correctly the ways of preventing sexual transmission of HIV but also has rejected the main misconceptions on the transmission of the HIV, by sex and age group

Measuring Method	All aged 15-24	Disaggregated Values			
		Sex		Age	
		Male	Female	15-19	20-24
Numerator: Number of cross-examined aged 15-24 who not only has identified correctly the ways of preventing sexual transmission of HIV but also has rejected the main misconceptions on the transmission of the HIV.	1 278	534	744	623	660
Denominator: Number of all cross-examined aged 15-24	3 668	1 584	2 084	1849	1819
Indicator's Value: Percentage	**34.8%**	**33.7%**	**35.7%**	**33.7%**	**36.3%**

[Source: INSIDA, 2009]

GARPR indicator # 1.2.: Percentage of 15-24 years old boys and girls who had sexual intercourse before 15 years

Table 23 – Percentage of 15-24 years old boys and girls who had sexual intercourse before 15 years, by sex and age group

Measuring Method	All aged 15-24	Disaggregated Values			
		Sex		Age	
		Male	Female	15-19	20-24
Numerator: Number of cross-examined 15-24 years old who has had sex before turning 15 years old.	914	393	521	466	437
Denominator: Number of all the cross-examined of 15–24 years old	3 668	1 584	2 084	1849	1819
Indicator's Value: Percentage	**29.4%**	**24.8%**	**25.0%**	**25.2%**	**24.0%**

[Source: INSIDA, 2009]

Most at Risk Populations (MARP's)

There are specific segments of the population that are under a high risk of exposition to the HIV resulting from socio-economic, cultural or behavioural factors. For example, people who trade sex, refugee, migrant, soldiers, prisoners, intravenous drugs users, men who have sex with men, and women specially in communities in which there is pronounced gender inequality. The prevalence data in populations in high risk in the country is very limited. The study of Evaluation and Quick Response (I-RARE) supplied preliminary data of HIV prevalence in 2008. HIV prevalence was 48 % (N-63) in people of both sexes who trade sex who used the counselling and testing services and of 43 % (N-43) among the drugs users that used the counselling and testing services. There is also data of HIV prevalence from the blood donors of the military service (35 % in 1997; 33,3 % in 1998; 48,7 % in 1999)[29].

Paid sex is an important vehicle of new infections in countries of concentrated HIV epidemic, and it can play an important role in countries of generalized epidemic, as it is the case of Mozambique. According to INSIDA 2009 9 % of the 15-49 years old men reported to have paid to have sexual intercourse in the 12 months prior to the inquiry. The use of condom in paid sexual intercourses is relatively low, with 28 % in total. The percentage of women and men who reported to have had sexual intercourse while drunk or under the effect of drugs is of 3 %[30].

The first steps of coordinated work at national and regional level, on high risk groups that need to be consolidated began in 2007. In 2008, with the approval of the Strategy for the Acceleration of Prevention the high risk sub-group was created, which takes as one of its objectives the improvement of co-ordination between the institutions under the guardianship of GAR for drawing and harmonization of instruments (policies, strategies) that ease the interventions on these groups. It defines the Strategy, that Women, Children and Adolescents, Members of the Defence and Security Force, Health Care Professionals, Teachers, Prisoners, High Competition Athletes, Miners, Prospectors, Sailors and Sex Workers, are those who must deserve priority of the Government for immediate interventions.

Men who have Sex with Men (HSH)

Data related to population of HSH in Mozambique is still scarce. There are no finished studies that indicate the size of this population, much less their areas of concentration or demographic characteristics. It is predicted that throughout 2012, the Integrated Biological and Behavioural Survey, will be able to present estimates of the population of HSH in Mozambique that will contribute to make us focus the prevention programmes to the most pressing needs, as well as to inform this indicator in the future.

Nevertheless, the Association Lambda, in partnership with other organizations, is developing actions of HIV prevention among HSH since 2009 in the following provinces:

[29] National Strategic plan of HIV and AIDS Response, 2010-2014. Government of Mozambique. 2010.
[30] National Survey on Prevalence, Behavioral Risks and Information on HIV and AIDS in Mozambique. MISAU, INE, 2009.

Maputo City, Maputo Province, Nampula, Cabo Delgado, Inhambane and Sofala. The Lambda prevention programme is structured in two main components:

i. Component of education for health, implemented through peer educators enabled for the effect. These promote sensitizing actions for the change of behaviour in the social networks and places of socialization of HSH, distribution of male condoms and water based gel lubricant, educative material on HIV, Human rights and Sexuality and they also carry out referrals to health services or other social services;
ii. component of access to services, composed by the counselling and testing services in Health, Psychological Support, Legal Support and connection with other social services available in each context.

At the moment, Lambda has got 64 peer educators distributed by the above mentioned provinces.

In 2010, operating only in Maputo, Sofala and Nampula, the actions of Lambda have helped 1.521 people, whether with education activities in health, or even with access to prevention inputs, or with referrals to support services.

In 2011, the services expanded for the provinces of Cabo Delgado and Inhambane. This year, the actions of Lambda have reached 1.585 new HSH in five provinces. Besides these new contacts (i.e. HSH that were reached by Lambda's educative actions for the first time), the peer educators approached 3.513 old contacts.

In this extent, in 2011, 29.668 condoms and 21.367 *sachets* of water based lubricants were distributed. Also 505 HSH were referred to health services, and other services of social support.

In 2009, the first qualitative research on the structural vulnerabilities and risks of HIV infection among HSH took place in the city and province of Maputo. This research was published in 2010 and has demonstrated that this population has a high rate of ignorance of the risks of infection, high prevalence of partnerships and bisexual relations, have weak access to services that attend to their specific situation and is subject to recurrent situations of discrimination, including in the health services.

Percentage of men who has sex with men who did the HIV test in the last 12 months and know their results

There are no specific counselling services in Mozambique and health testing for HSH. In 2010, Lambda, with the support of the partners, has developed training for counsellors of the service of Counselling and Health Testing in the Community (CCTH) in Maputo. This was the first strategy implemented to adapt these services to the specifics and needs of the HSH population.

Subsequently, this action was expanded to Cabo Delgado, Nampula, Inhambane and Sofala. In these provinces, at the moment they have HTCC trained counsellors enabled to assist

the HSH population. In 2011, 947 HSH have benefited from the counselling and testing service and they now know their HIV-status.

More recently, Lambda and its partners has been supporting the Ministry of Health in the reformulation of the HTCC guide books so as to adapt them to the needs of the specific populations, including HSH. In the same path, the HTCC registration cards are being modified so as to present dispersed results by specific population. We believe that the moment this will be available, this indicator will be answered with greater precision.

Percentage of men who have sex with men who live with HIV

As it is described above, there are no specific counselling and testing services, not even of cares and treatment of HIV for HSH. The only available data at the moment originates from the CCTH initiative for HSH carried out by Lambda and partners. In 2011, 42 HSH who live with HIV were identified through these counselling and testing actions, which were referred to the health services for cares and treatment among the 947 tested ones.

In 2012, it is expected that the data of the Integrated Biological and Behavioural Survey (IBBS) is published. This research will be able to present trustworthy estimates of the size of the HSH population who lives with HIV in our country, in order to develop specific programmes.

GARPR Indicator # 1.11.: Percentage of HSH that are reached by HIV and AIDS Prevention Programs

GARPR Indicator # 1.12.: Percentage of HSH that declared to have used condom in the last anal sexual intercourse with partner of the same sex

GARPR Indicator # 1.13.: Percentage of HSH that requested the HIV test, were tested and received their results in the last 12 months

GARPR Indicator # 1.14.: Percentage of HSH living with HIV

Currently, there is no available data for these indicators.

Commercial sex workers

In Mozambique the Prevention Programmes aimed at sex workers has been expanded in coverage and range of interventions. Currently, there are actions of prevention being developed in the main cities and development corridors in the provinces of Cabo Delgado, Nampula, Tete, Sofala, Manica, Inhambane, Gaza, Maputo Province and Maputo City.

Though several implementing agents of these actions systematically collect data on monitoring on the prevention activities developed near this target group, it is not possible to represent in terms of percentage the covering of these actions, on account of the absence of data on the size of this population in several intervention sites. It is expected that by late 2012 the publishing of the final results of the Integrated Biological and

Behavioural Survey (IBBS) of the HIV and ITS among Sex Workers, which will contribute to a more thorough knowledge of the reality of the HIV epidemic among this group, as well as to provide trustworthy estimates on the size of this population.

In general, Government partners (OBC's and ONG's) who implement HIV prevention activities among sex workers have develop prevention programmes that are carried out in two basic components:

i. health education at community level, through peer educators that disseminate correct information on the ways of transmission and HIV prevention, they distribute informative and prevention materials (masculine and feminine, water based lubricating condoms) and they also refer to the health centres;
ii. Widening of access to health services, through the establishment of friendly and discrimination free services for sex workers.

The chart 24 below, presents data that illustrate the dimension of these interventions.

Table 24 - Activities of HIV prevention in sex workers from 2009 to 2011

Year	# of contacts with sex workers through peer educators	# of material distributed IEC	# of distributed masculine condoms	# of distributed feminine condoms
2009	34.678*	35.548*	278.285*	20.074*
2010	52.988**	88.251**	887.658**	83.755**
2011	40.940***	13.331***	352.255***	42.007***

*Data related with provinces of Nampula, Tete, Sofala, Manica, Maputo Province and Maputo City
**Data related with provinces of Nampula, Sofala, Manica, Maputo Province and Maputo City
*** Data related with provinces of Cabo Delgado, Nampula, Sofala, Manica, Inhambane, Maputo Province, Maputo City

On the interventions for reduction of the structural vulnerability factors, it important to mention that work articulated among peer educators, sanitary units and police stations in what refers to the follow up of cases of violence against the sex workers.

In 2010 and 2011, the 100 % Life Project (implemented by Pathfinder, PSI, Province Directorate of Health and UNFPA) has carried out sensitization courses for the police force as a strategy of implementing integrated attendance schemes for sex workers victims of violence. Altogether, 187 policemen from Nampula, Sofala, Manica, Maputo Province and Maputo City received training and renewed the commitment of continuing to give necessary assistance to the sex workers victims of violence, in an integrated way with referrals to the health units for the sexual violence cases. Besides, the peer educators of the project were enabled in the area of human rights and violence and have started to integrate this topic among their education activities in health, with support of an IEC material drawn specially for this purpose, called “Sex Workers: we have rights!”.

Percentage of commercial sex workers who live with HIV

Though it is universally known that the group of the sex workers generally have high HIV prevalence rates compared to that of the general population, even in environments of generalized epidemic as it is the case of Mozambique, the country still does not have a epidemic surveillance system able to show the percentage of this group infected by HIV.

The study Integrated Biological and Behavioural Survey (IBBS), currently on going, will be able to contribute to present trustworthy data on the reality of the epidemic among this group. Such information will be able to contribute to the adaptation of the interventions aimed at this population in Mozambique.

In 2008, the I-RARE International Rapid Assessment, Response and Evaluation – I-RARE, a qualitative study carried out in harbour cities of the country, in spite of the limited sample, demonstrated what 48 % of the sex workers that they accepted announced of the study were infected by the HIV.

Other existent information on this topic in Mozambique are those originating from the registers of some health services that offer counselling and HIV testing to sex workers in the scope of the 100 % Life Project, an HIV prevention initiative among sex workers was implemented by the Province Directorates of Maputo City, Maputo Province, Sofala, Manica and Nampula of Health, by Pathfinder and by PSI. These data are limited, since there are deficiencies in the registration system information and are sub-representative of this population in Mozambique (figure 32).

GARPR indicator # 1.7.: Percentage of commercial sex workers who are being reached by HIV and AIDS Prevention Programs

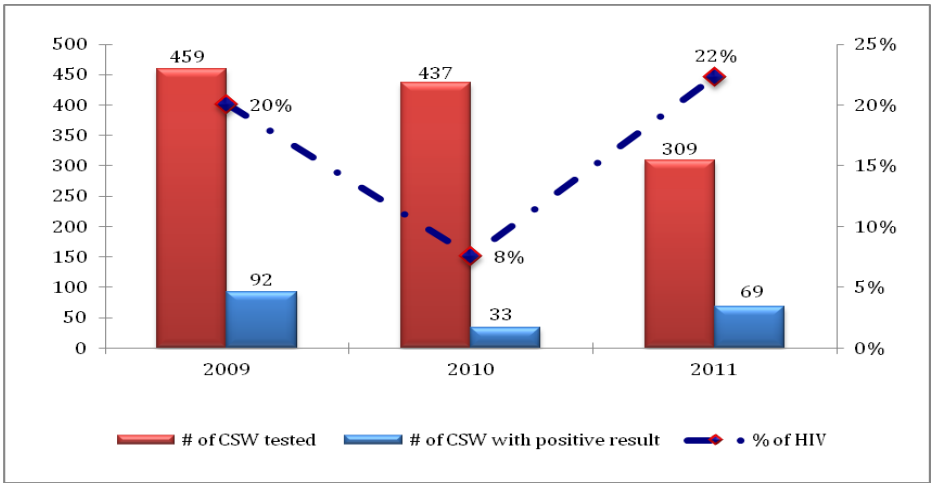
GARPR indicator # 1.8.: Percentage of commercial sex workers (men and women) who reported to have used the condom in the last sexual intercourse

GARPR indicator # 1.9.: Percentage of commercial sex workers who has asked for the HIV test, were tested and received the result in the last 12 months

GARPR indicator # 1.10.: Percentage of commercial sex workers who lives with HIV

Currently, there is no data available for these indicators.

Figure 33 – HIV prevalence in Sex Workers of 5 provinces from 2009 to 2011



Source: 100% Life Project

More recently, MISAU began the discussion for the alteration of the data registration cards in counselling and testing services, in which has started to include a field for the indication of the population in higher risk being tested. After the complete implementation of this new system of information, it is possible that more trustworthy data will be produced, contributing so to a more loyal portrait of the reality of the epidemic among this group.

Prisoners

The Ministry of the Justice, through the National Service of Prisons (SNAPRI), has been developing in partnership with the UNFPA, UNODC, CDC and Pathfinder International, different actions for the population of prisoners, the officials of the prison system and even for their relatives. Among the implemented strategies, the strategy of education of couples begun in the context of the Inclusion Project in 2008, has being continued by other partners, having already reached a great number of the reclusive population with actions of sensitization through discussions, through the making of IEC material available, referrals to the health centres inside the prison establishments and other activities just like it is displayed in the table below

In the context of the Inclusion Project, implemented in partnership with UNFPA and Pathfinder International, during the 2009-2011 period, the MINJUST went on with the expansion and strengthening of the peer education strategy in the biggest prison centres of the country covering 7 facilities of the country, that together they cover nearly 40 % of the prison population of the country. Another action that was joined to this one, with a different target group in mind, was the creation and introduction of the Nuclei of Health in all the institutions under the MINJUST, these nuclei whose actions have as their main target the official of the Justice sector, with the objective of giving an answer to the longings of the Strategy of fight against HIV and AIDS in the public function, where it is estimated that approximately 19 % of the officials are infected by HIV[31]. For it to work well

[31] A research study requested by the Ministry of the Public Function.

30 officials were trained at central level of each institution and prepared plans of work with the respective monitoring instruments.

In the context of the partnership with the UNODC, the MINJUST in the period of reference of the present report, aiming at building the capacity of the leadership of the prison facilities of the whole country and some partner organizations, carried out three regional seminars on prison health and its relation with the health in the community.

Another great achievement of this partnership with UNODC, was the drawing and start of the Study for Evaluation of the Situation of HIV/ITS/TB and Need of Health in Prison Environments in Mozambique, first study with national representation in the country with objective to enlarge and to systematize the information on HIV, AIDS, ITS and existent TB in the country and to support in the drawing of programmes based on evidences and more structured. This study will be done in 7 (seven) provinces with a sample of 3.000 people among prisoners and officials, having the pilot study already taken place in the end of 2011.

Table 25 - Activities of HIV prevention in convicts from 2009 to 2011

Indicators	UNFPA/P.I 2009-2011
Number of prisoners reached in face to face counselling	8,560
Number of prisoners reached in the events	23,364
Number of trained peer educators– Prisoners (80%) and officials (20%)	207
Number of peer educators	126
Material of IEC distributed for the prisoners	2,974
Number of referrals done by the Peer educators	2,922
Number of Trained officials of the Ministry	25

Source: Inclusion Project

Table 25 above the achievements in the scope of the inclusion project implemented in partnership with the UNFPA and Pathfinder International in the period between 2009 and 2011.

Main Challenges

- Limited Resources for interventions gone to the populations in greater risk;
- Most of the studies show a high level of knowledge of the masculine condom, but its use is still inconsistent among the populations in greater risk, especially among the partners of people involved in behaviours of high risk;
- Need of approaching varied and concomitant behaviours of sexual risk and of drugs, including the anal and vaginal sex without protection, and sex with multiple partners. For example, the sex workers use alcohol and drugs (mainly marijuana) to face their work and some drugs users sell the sex to obtain drugs;
- Deficient availability of water based lubricant gel for HSH and sex workers; need of increasing the knowledge on the gel and the correct forms of its use;
- To increase the offer of health services, especially for diagnosis and treatment of the ITS. There is necessary the development of health services that are sensitive to

the specifics of health in populations in greater risk (for example, the attention for the anal ITS), and that they offer service to these groups, that are free of discrimination and prejudice;

- Human rights –violence and discrimination constitute effective barriers among the populations in greater risk, for the access to prevention and health care services. In this context, it is necessary to promote the connections between the Prevention Programmes turned to these groups with the initiatives of protection and securing the human rights, so that in collaboration processes they may increase their efficiency;
- Complexity in the implementation of ongoing and solid interventions, both of prevention and of cares, aimed at movable population groups like miners and truck drivers of long course, among others.

Main actions necessary to expand Universal Access to HIV Prevention for populations in greater risk

- Greater inclusion of the populations in greater risk in health policies and programmes: the issue of TB among prisoners and the issue of family planning for the sex workers in reproductive health policies are some of the aspects to bear in mind;
- Greater access to the services of HIV control: should be increased, through the sensitizing the people about the needs of these particular populations and promotion and expansion of the use of the services among the populations in greater risk, like for example the night-shift clinics already implemented in the city of Maputo, Nacala-Porto and Nampula, as well as in Inchope;
- To produce methodologies for joining the treatment, of health care that bear in mind the specifics of the populations in greater risk;
- To increase the access to condoms and to other ways of prevention. There are places in which the condoms are not easily found, like for instance in prison environments, where it is not allowed to have it. For many HSH and drugs users, the condoms are not easily accessible, weather it is for the unavailability of prevention services especially for these groups, or maybe because of the logistics related problems experienced in the provision condoms in the whole country. Also it is not possible to make syringes and equipment of injection available for the drugs users, which can constitute another barrier for the prevention practices.

Education based on skills for the life in schools

In accordance with the National Inquiry of Prevalence, Behavioural Risks and Information on the HIV and AIDS in Mozambique (INSIDA 2009), among adolescents of 12-14 years who never got married, who at the present date attend school to girls' the percentage of girls with security at school is greater (86 %) than the boys' percentage (78 %). Girls have reported a high percentage of boys (53 %) who harass the girls. On the other side, girls and boys have reported a notable percentage of teachers (23 %) that harass students.

The same inquiry reports that among young people of both sexes, of the age group 15-24 years old, which sometime attends the school, but which are currently not attending it, are mostly made out of women and fewer men, with 67 % and 46 %, respectively. And the percentage of women and men who at the moment not attending school has a trend to increase with the age: of 36 % for the women of the age group of 15-17 years old to 87 % for those of 23-24 years old and of 21 % for the men of age group of 15-17 years to 81 % for those of 23-24 years of age. Among the women, the reasons mostly quoted for not attending school are: marriage (43 %), lacking of money to pay the school (15 %), pregnancy (14 %) and, to take care of the children (7 %). In the men, the most quoted reasons were: lack of money to pay the school (37 %), needing of work (16 %), helps in the crop field and marriage (8 % each). Some additional factors are connected with the school net, namely the distance from house to the school and the lack of vacancies.

Political e Institutional Response

The Strategy of Fight against HIV e SIDA in the Ministry of Education (MINED) in Mozambique is integrated in the Strategic Plan of Education and Culture (PEEC), in line with the National Strategic Plan of Fight against HIV e AIDS (NSPII) guided on the basis of a cross-cutting principle (for all the subsystems and levels) and uses a Strategy of Communication, which gives guidance on the type of messages for the different age groups[32].

The general objective of the Education sector response regarding HIV and AIDS is to secure that the officials and pupils will have skills for life and that they may benefit from actions of mitigation of the impact of the epidemic.

The sector is occupied by four strategic acting areas:

i. *MINED as the employer:* seeks to develop prevention actions and of minimizing the impact of HIV and AIDS to the teachers, manager and officials of the sector.

[32] Ministry of Education and Culture. Directorate of Special Programmes. In response to MEC on HIV and SIDA. 2007

ii. *MINED as the educator:* seeks to develop actions of prevention and of minimizing the impact of HIV and AIDS in the pupils and students of the sector, including support for orphans and vulnerable children.

iii. *MINED as system:* seeks to develop an effective institutional framework that allows the MEC to respond appropriately to the HIV and AIDS so that it can carry out its central mission of education, in spite of the impact of the epidemic.

iv. *MINED as part of the national response:* seeks to develop effective relations with the government and not government partners to resist the epidemic.

Curriculum Approach

The HIV and AIDS contents are treated as a crosscutting subject form in the curriculum of the Basic and Secondary Teaching and Teachers' Formation.

Approach intra and extracurricular

The national **prevention** programmes are:

i. *Basic packet* for the Basic Teaching (8-16 years): provides educative materials and playful activities for intra and extracurricular programs in the schools of the Primary Teaching of the 1st Cycle – 1st 5th grade (EP1) and Primary Teaching of the 2nd cycle – 6th 7th grade (EP2) and it trains teachers in teaching methodologies on skills for the life.

ii. *A World Without Secrets*: programmes of radio made by children for 8-16-year-old children. This programme has as objectives to encourage an oNSPdialog between children and other members of the community about the sexual and reproductive health and HIV/SIDA and other crosscutting subjects to promote the development and appropriation of skills for the life. It is broadcasted once a week in Portuguese in the Radio Mozambique (RM), in the provincial transmitters of the RM in the whole country, and in some Community Radios in all the provinces.

iii. *Programme of Sexual and Reproductive Health of the Adolescents and Young people* – Geração Biz: is a Multiple-sector Programme of Sexual and Reproductive Health (SSR) of the Adolescents and Young people destined to the age group of the 10 to 24 years. The respective objective is to supply, the adolescents and the youth, with information and health services for them to create skills for a good management of their sexual and reproductive life, preventing themselves against ITS's and HIV and to be able to live with their HIV status. This Programme is implemented in schools (by teachers and pupils), youth associations and health units. MINED, does the interventions in teaching institutions. Mainly in schools of the secondary level, the secondary school. This has got two cycles, the first one that goes from the 8th to 10th (ES1) and the second that goes from the 11th to 12th (ES2).

The national programmes of **mitigation and institutional reinforcement** are:

i. *Capacity building of Managers of the Schools in HIV and AIDS*: this intervention is done through the capacity building of managers of the schools in order to strengthen their skills for the insertion of the contents of the HIV and AIDS in the planning of the activities of the school, so contributing to prevention and mitigation of this epidemic. The adaptation of the contents was already done and these were already integrated in the Programme of Full Capacity Building of Schools Managers.

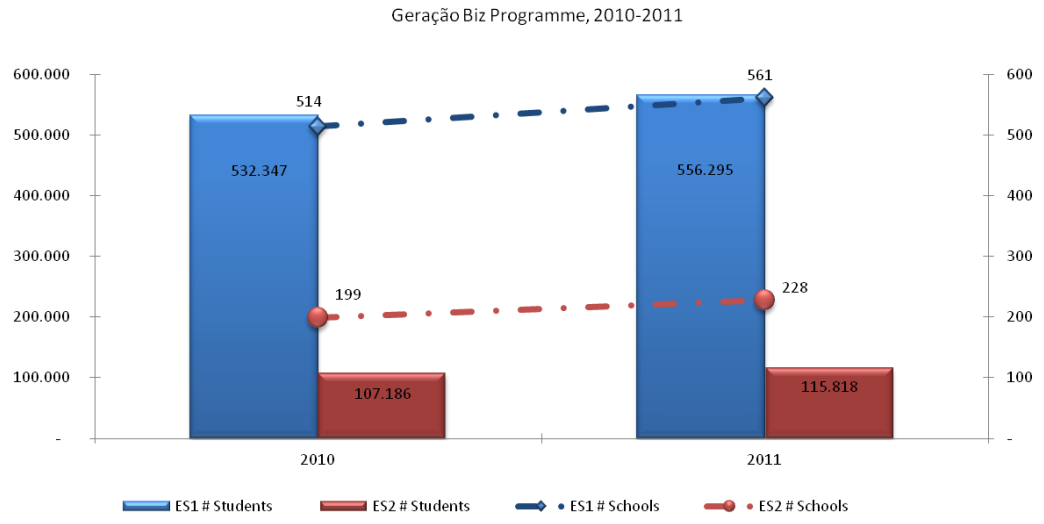
ii. *Programme of Support to Orphaned and Vulnerable Children*: it aims at securing that the orphaned children and vulnerable children have access to education and receiving the necessary support, in order to keep them in the schools and improve its use. This programme is being carried out in partnership with Ministry of Woman and Social Welfare and Ministry of Justice (National Directorate of Notary Registry). The support is channelled to the schools through existent mechanisms in the programme of Direct Support to the Schools: it channels financial resources for materials acquisition for the target group.

iii. *Programme of Social Assistance for Officials and Agents of the State of the Ministry of Education*: it is a programme that aims at giving support to the workers of the Education sector with chronic and degenerative diseases including the HIV. It has because of moving mission, educating, assisting socially, seek the social well-being and the health of the officials and agents of the State and their household, making access to client easy.

Main Achievements:

Geração Biz which is a multi-sector programme implemented in all the provinces for the Ministry of Education, Ministry of Youth and Sports and the Ministry of Health. The peer educators are supported, under the auspices of this programme, in order to provide sexual and reproductive education to their peer in higher, primary, secondary and technical education. In 2010, 783 schools were covered from the 825 expected with 109 counselling corners that provide access to the information, discussions, condoms for the students and referrals to the Friendly Health services for the Adolescent and Young person (Figure 34 and table 26)[33].

Figure 34 - Total of schools and students covered by the Geração BIZ Programme, in 2010 and 2011.



Source: MEC, 2012.

[33] Ministry of Education – Directorate of Planning. Statistical Survey of "the 03rd of March". Evolution of the Number of Schools and enrolled students.

In 2010 in these services 500,619 young people received assistance against 292,842 in 2009, representing a growth in the order of 71%.

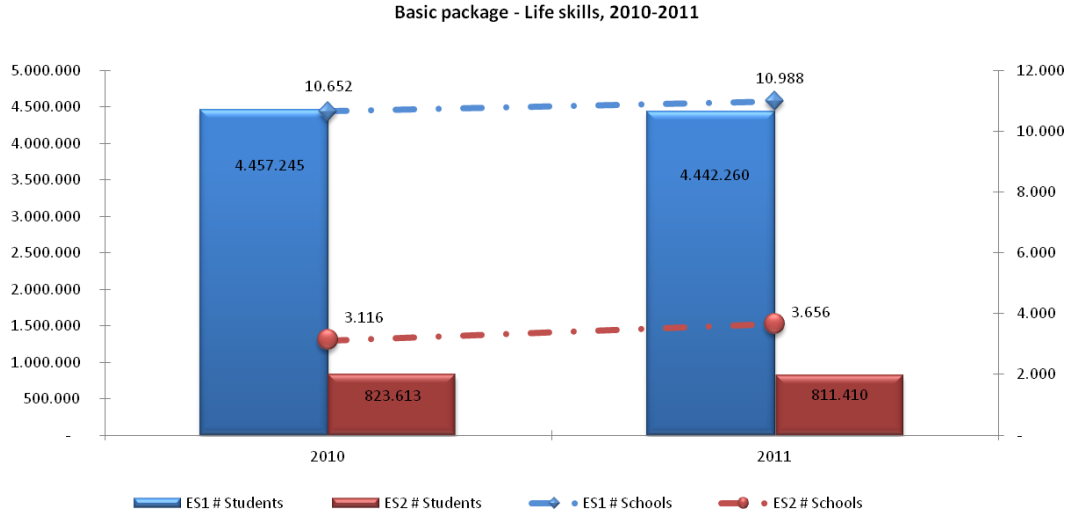
Table 26 – Distribution of Coverage of Schools by PGB (2010)

Institution	EP2/EPC	Secondary School	Technical. School	Youths Associations	Specific SAAJ	Alternative SAAJ
Total	512	235	36	674	109	226

Source: 2010 Annual Report of PGB.

The basic package program (Basic Package) is implemented in 7,560 elementary schools nationwide, about half of existing schools (Figure 34). The program facilitates the development of activities to equip children with the necessary skills for life. More than 4 million students were targeted by the program in 2010 and 2011. Through this program, students have access to books and other educational materials on HIV and AIDS.

Figure 34 - Total number of schools and students covered by the Basic Package in 2010 and 2011.



Source: MEC, 2012.

Under the program of skills for life (Basic Package Program), the MINED with the support of UNICEF, NWETI and RENSIDA and in 2011 completed the Manual for School Clubs and radio Programs and held three regional training of trainers involving focal points of the provincial associations of RENSIDA in the northern, central and southern regions (59 participants). The trainers led by N'weti and RENSIDA and subsequently trained more than 100 new activists in 7 districts with Child Friendly Schools bringing the number of schools covered by more than 600, involving more than 240,000 children in activities of school clubs. In general, the program of life skills in schools came in 2011 to cover more than 2,000 schools in 79 districts, involving more than 1,400,000 children.

Main Challenges:

MINED currently has a comprehensive strategy to combat HIV and AIDS and programs developed for its implementation.

Thus, the main challenges are:

I. Consolidation of national programs. This will require a significant increase in terms of trained human resources at all levels of the sector (including teachers) and financial resources.
II. Implementation of HIV and AIDS Programs at Workplace.
III. Development of a strategy to combat alcohol and other drugs in the school community.
IV. Development of an intervention strategy for students of the night shift.
V. Improve coordination with partners involved in schools under the combat of HIV and AIDS.

Sexual Behaviour

According to NSPIII, confirmed by the analysis study of the modes of HIV transmission and the National Response to Combat to HIV and AIDS conducted in 2008 and published in 2009, heterosexual transmission of HIV accounts for about 90% of new infections HIV in adults. These documents indicate that new infections were the result of individuals who claimed to have had only one sexual partner in the last 12 months (42-47%) of the discordant couples, individuals with multiple partners (24 -29%), people who do sex work (2 %) and their clients (7%), regular partners of clients who do commercial sex (10%), men who have sex with other men (5%), injecting drug users (3%), injection equipment (2%), and blood transfusions (<1%), transmission from mother to child (2.2%).

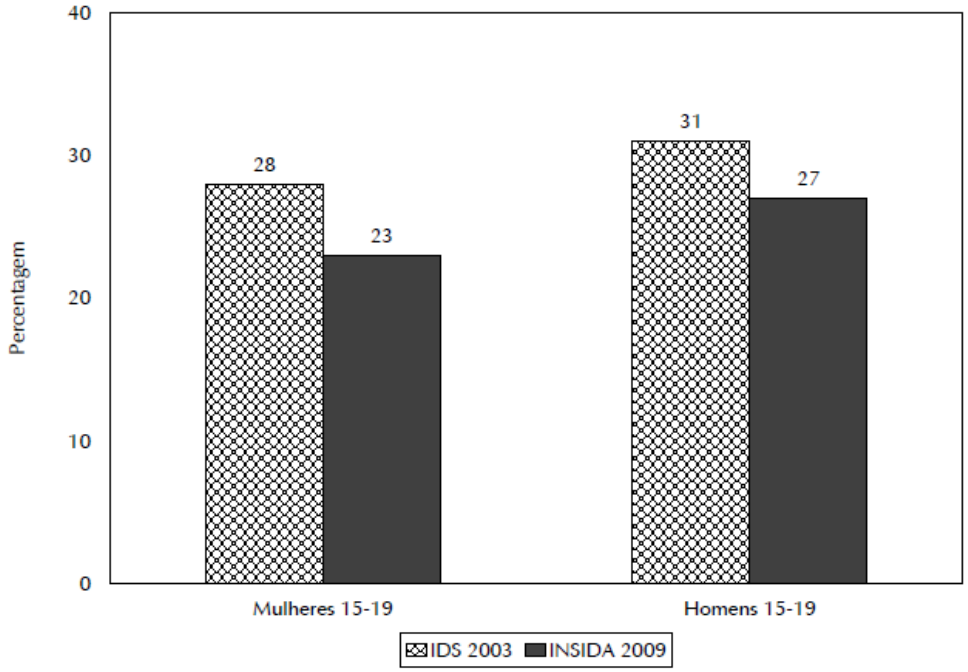
Inter-generational sex remains common in the country: MICS 2008 found that 13.5% of young women between 15-19 years and 17% aged 20-24 reported having had sex with men 10 years older than them, 12 months before the study. There is indication that condom use is increasing, particularly among youth and adolescents: MICS 2008 found that 42.9% and 46.5% of adolescents and young women, between 15-19 years and 20-24 years, respectively, reported using condoms with a partner and non-marital non-cohabiting in their last sexual intercourse, compared with the data produced by the IDS 2003, when 26% of women aged 15-24 reported using a condom with a non-regular partner in their last intercourse. However, condom use among the adult population within the country is far from satisfactory and remains inconsistent.

Previous research by INSIDA the 2009 show the high number of sexual partners, especially among men in specific areas of Mozambique (PSI, 2008). A qualitative research showed that, in Mozambican society, having multiple sexual partners is seen as the norm for men but not women (N'weti 2009, PSI, 2009). The interest in reducing multiple sexual partners culminated with the official launch of the national communication campaign “andar fora é maningue arriscado” (to have extra affairs is very risky) in March 18, 2010, which aims at the prevention of HIV infection by reducing multiple sexual partners.

In countries where the main mode of HIV transmission is heterosexual sex, early onset of sexual activity increases the period of infection risk for young people. Hence, delaying the beginning of sexual behaviour as a way to prevent HIV infection is a key to behavioural intervention in young people.

Twenty-six percent of women aged 20-49 years had sex before exact age 15 years. Young people aged 15-19 who have never had sex were asked why. Most girls and boys report that the reason was because they were too young to start having sexual intercourse. Only 2% of young women and 3% of young men said that they had initiated sexual life as a way to prevent HIV infection.

Figure 35- Young people aged 15-19 who had sex before the age of 15 years, IDS INSIDA 2003 and 2009.



Source: INSIDA 2009.

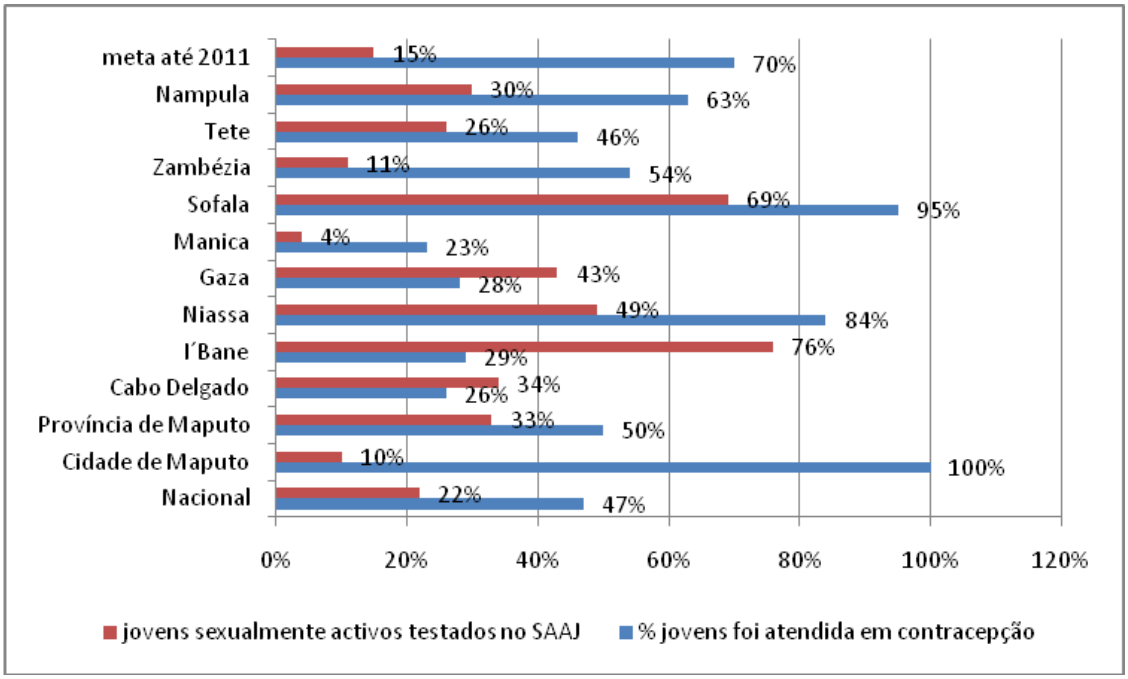
The ratio of young women aged 15-19 who had sex before the age of 15 years showed a slight reduction out of 28% recorded by IDS in 2003 to 23% by INSIDA registered in 2009 (Figure 35). A similar reduction is observed in men, from 31% in 2003 to 27% in 2009. Higher proportion of young people 15-17 years report the early onset of sexual intercourse compared to young people 18-19 years. As expected, only 13% of young women who never married reported having had sex before exact age 15 years compared with 30% of young married women. In men, there are no differences based on marital status.

Main results

The Program for Sexual and Reproductive Health of Adolescents and Young (Biz Generation - PGB) is a Multi-sectoral Program of Sexual and Reproductive Health (SRH) of Adolescents and Young for the age groups from 10 to 24 years. This aims to provide teenagers and young people, information and health services to develop skills to good management of their sexual and reproductive lives, preventing themselves from SDI's and HIV and be able to live with HIV status. This program is implemented in schools (by teachers and students activists), youth associations and health units. The program is implemented mainly in secondary schools.

Under the PGB in 2010 the contraceptive services attended 47% of young, against a target of 70% for the period 2010/2011 (Figure 36). The same figure shows that against a target of 15% established for the period 2010/2011, were tested throughout the country in 2010 22% of young people in Care Services for Adolescents and Youth (YFHS).

Figure 36 - Percentage of tests and contraceptives provided in YFHS in 2010



Source: Annual Report of Activities of the PGB 2010.

Table 27 illustrates a correlation between the average rates, with the sexually active young people, presented by the community and school-based KAP, applied by the PGB and the rate obtained by INSIDA. It can be seen that regarding the use of condom at last sexual intercourse, they are higher than those shown in INSIDA. But with regard to testing, it needs to be improved. Considering that the percentage of young people in KAPB who answered the question of testing is half the percentage shown in the study. We found however, that if we take young people who have done testing in SAAJs the national average was 22%, which demonstrates that the service is being offered and accessed by the youth. Yet (average) KAPB did not reflect this increase, one of the strategies to be adopted should be to offer a comprehensive package of care to adolescents and youth seeking SAAJs services. At the same time the strategy of peer educators, should enhance the information about this component, so that there is improvement in information and effective service search. What has actually shown is that from the moment when the young is accessed in SAAJ, the availability and performance of testing happens automatically. Hence, increasing access of young people to health services will be an important step to improve this rate

Table 27 - Comparison of average percentage rates in the population aged 15-24 years, about condoms use and HIV testing

Variables	KAPB (PGB)	Rate Established	INSIDA (average)
% of young people at school who used condom in the last sexual intercourse	50%	>30%	37%
% of young people at school tested	10%	>15%	23%
% of young people used condom in the last sexual intercourse	40%	>30%	37%
% of young people out of school tested	10%	>15%	23%

Source: Annual Report of PGB 2010 Activities

This analysis is directly related to the quality axis, hence the need to make a correlation with the population which was achieved in 2010.

As illustrated in Table 28 below, 60% of the population accessed were adolescents (<19 years), and in the age group 10-14, the percentage was 22% and from15 to 19.4% at age 20 24 was 28% covered. Also there is an access of 11% of youth aged 25 years. For the characterization of this coverage, there is a balance in relation to all young males and females accessed by PGB, which were respectively 1,550,232 boys and 1,394,079 girls.

Table 28 - Data disaggregated by sex and age, activists and young people achieved

Activists	Basic School		Community Based	
	Men	Women	Men	Women
10 -14	140	95	3	39
15-19	879	1024	179	209
20-24	258	239	589	392
>24	0	0	0	0
Non Identified	2.432		2.899	
Total	1277	1.358	771	640
	School Target		Community Target	
10 -14	173.093	149.265	122.563	224.908
15-19	387.730	333.212	223.777	185.378
20-24	277.080	216.902	183.241	142.638
>24	92.789	72.744	89.959	69.032
Non Identified	260.453		552.032	
Total	930.692	772.123	619.540	621.956

Source: Annual Report of PGB 2010 Activities.

Regarding the training of activists, a training plan prioritizing the expansion to new posts was anticipated in 2010. This plan was established based on the ratio of the population of 10 to 24 years in the districts, and the need for activists to both school and community based, considering the gender balance.

Young people's access to condoms was maintained in 2010 and it was possible to meet the needs of condoms of 16% of sexually active young people, based on the care services provided at the YFHS. A total of 6,430,853 male condoms were provided.

The guarantee of both coverage and quality of results is structured from the institutional capacity building. In 2010, as set out in transition planning as a priority encompassed the process of continuous training of technicians involved in the implementation of the PGB, at all levels.

Table 29 - Distribution of trained technicians in PGB in 2010

	Male	Female
Care Providers	118	177
Teachers	15	19
Technicians Trained	382	302
Other Trainings held	506	239

Source: Annual Report of PGB 2010 Activities.

Within the set for structuring and strengthening of institutional capacity in the process of sustainability 295 health care providers, 34 activists teachers, 684 technicians and managers of provincial, district and central level were trained. At this stage the trainings targeted central and provincial teams, as a contribution to theirs replica at district level, as the process of decentralization and expansion states (Table 29).

Indicator of GARPR# 1.3.: Percentage of women and men aged 15-49 who had sex with more than one partner in the last 12 months

Table 30 - Percentage of women and men aged 15-49 who had sex with more than one partner in the last 12 months

Measuring Method	2009	2011
Numerator: Number of respondents aged 15-49 who reported having had sex with more than one sexual partner in the last 12 months	1,156	3,949
Denominator: Number of all respondents aged 15–49	10,667	25,841
Value do Indicator's: Percentage	**10.8%**	**15.3%**

(Source: INSIDA 2009 & IDS 2011)

It is noticed there has been a slight decrease in this indicator, which was 11.1% in 2003, 10,8% in 2009 and 15.3% in 2011 (Table 30).

<u>Indicator GARPR# 1.2.:</u> Percentage of both young men and women aged 15-24 who had sex before the age of 15

Table 31 - Percentage of both young men and women of 15-24 years old they had sexual intercourse before the age of 15

Measuring Method	All 15-24	Disaggregated Values			
		Sex		Age	
		Male.	Fem.	15-19	20-24
Numerator: Number of respondents aged 15-24 who reported having had intercourse before the age of 15	914	393	521	465	448
Denominator: Number of respondents aged 15-24	3,668	1,584	2,084	1,849	1,819
Value do Indicator's: Percentage	**24.9%**	**24.8%**	**25.0%**	**25.1%**	**24.6%**

(Source : INSIDA, 2009)

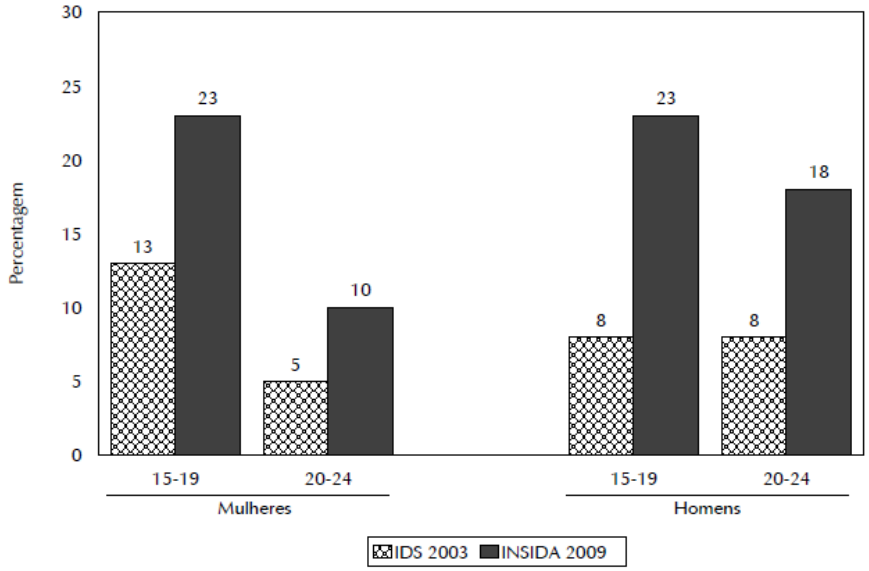
There was a slight decrease in the percentage of youth who had sexual intercourse before the age of 15, 27.6% in 2006 to 24.9% today (Table 31). In terms of gender distribution, the differences remain, but very light in contrast to 2003 (women 28% vs. men 26%).

Condom Use

It is estimated that the transmission is responsible for about 90% of new HIV infections in adults. Individuals who reported having had one sexual partner in the last 12 months, contributed largely to the number of new infections in 2008 (42-47%). This is due in part to the fact that they are the most populous group. The new HIV infections occur through HIV status discordant couples (i.e. a partner who contracted HIV for more than 12 months), non-condom use in stable relationships, and possibly, multiple secret sexual partners, not revealed in surveys or studies. It is estimated that the behaviour of multiple partners (MP) were responsible for 24-29% of all new infections in 2008. These include those who have MP and its partners have stable monogamous, which unwittingly became part of a sexual network.

According to the report of epidemiological surveillance 2009, the number of new infections in people older than 15 years in 2011 is about 275 per day.

Figure 37 - Use of condoms at first intercourse among young aged 15-24, IDS INSIDA 2003 and 2009.



Source: INSIDA 2009.

The male condom as a method of preventing HIV and AIDS among adults aged 15-49, improved in 2003 (IDS) to 2009 (INSIDA). 53% of women knew about condoms as a method of HIV prevention in 2003, while in 2009, 70% knew condom use. Among men the improvement is less significant, since the level of knowledge about condoms as a prevention method increased only 71% in 2003 to 73% in 2009.

The figure 37 compares the use of condoms among young women and men reported in IDS in 2003 and in INSIDA 2009, revealing a consistent increase in all age groups, although the overall proportion remaining relatively low.

Political Institutional Context

A Strategy for Accelerating the Prevention of HIV Infection (SAP), establishes the condom as one of its eight priority areas. And it presents it as their main findings: i) weak and / or non- use of condoms, linked to issues of disagreement between spouses, cultural and religious barriers and the dominance of man over his wife, ii) the fragility of the management and distribution of male condoms, especially in rural areas, iii) the sale of condoms reduces the access to it; iv) weak disclosure and access to female condoms; v) inappropriate messages to the reality of socio-cultural values, including non-segmentation of the communication per age groups.

Under the operation of the SAP the following were established as a component of the strategic objectives of Condoms: i) enhance the correct and consistent use of male and female condoms (media, IEC materials, awareness campaigns in communities, etc.), ii) improve the logistics capacity management and distribution of condoms at all levels (availability and access).

Coordination actions for the use of condoms in the country are performed by the Multi-Sectoral Working Group on Condom, which operates regularly and is led by the NAC in coordination with the Ministry of Health (MISAU), and constituted by the Ministry of Women and Social Action (MMAS), Ministry of Defence (MDN), Ministry of Interior (MINT), UNFPA, PSI-Mozambique, USAID, the Dutch Embassy, Project Deliver ECoSIDA, Women's Forum and the MONASO. This group aims to reach consensus on the implementation of initiatives that provide guarantees in the areas of forecasting, procurement, distribution and promotion of condom use as one of the intervention for the prevention and reduction of the frequency of STI / HIV and AIDS in the country, and unwanted pregnancy. MISAU has responsibility for procurement and distribution of condoms in public institutions.

The distribution of male and female condom is done in two main channels: a network of public health sector (where condoms are free) and the commercial sector (where condoms are distributed by PSI, which uses a system of subsidized prices).

In the network of public health sector, the different segments, including the public, private sector and civil society, using the mechanism established by the Government, where requests are made through NAC (central level) and Provincial Nucleolus (provincial level). However, being necessary to strengthen the integrated logistics and distribution of condoms, logistics staff and program training in ongoing at all levels on how to forecast their needs and thus predict when, how and where amounts should be requested. This training aims to improve the logistics capacity and management of the distribution of condoms at all levels through better coordination among stakeholders (public, private sectors and civil society) and creating technical and logistical capacity to meet growing demand of condoms

The distribution problems at all levels of the system, have been identified and were found locally during supervision visits. In several places, it appears that, given the lack of preparation of personnel to do the calculation and needs to make their order, the distribution turns out to be a system made by "pushing" rather than by the "pulling" system.

Due to lack of capacity to manage the supply chain, and poor knowledge of the procedures for making orders with regard to applications, the amount of condoms that actually reaches users, is still limited.

In the past, condoms were included in the kits of essential drugs and distributed by the "classical pathway" to the districts. However, since the needs in kits and medicaments have increased, there was no space available for the inclusion of condoms in the vehicle which make the distribution. For this reason, in some cases that have been reported condoms are becoming accumulated in the warehouses.

The promotion of male condoms is done by the following organizations operating in the country: UNFPA, CARE, LEPRA, MSF, HOPE, FDC, Pathfinder, ISCOS, LWF, World Vision, FHI and Medical del Mundo. And just UNFPA, Pathfinder and PSI are involved in promoting the female condom.

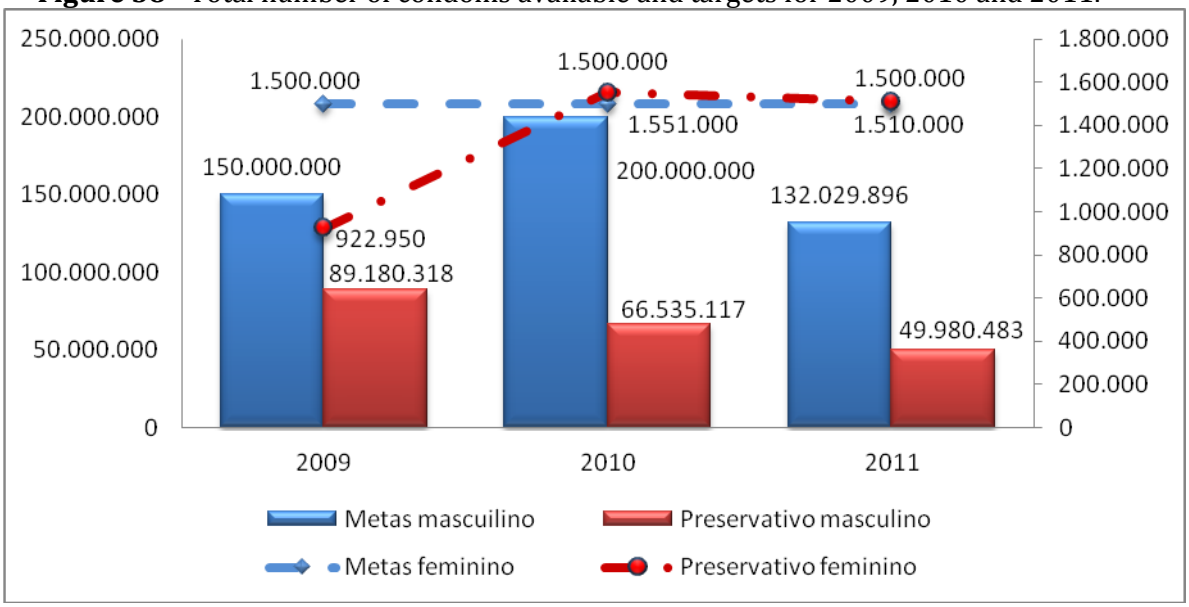
Main Results

Figure 38 shows a significant reduction in the availability of condoms in the country from 2009 to 2011. Interestingly, this reduction represents about 25% from 2009 to 2010 and from 2010 to 2011. The probable reasons are confined in low demand, weak distribution systems and reducing the availability of funds, which finance this activity, and half of which come from outside donations

The same figure on the other hand shows an abrupt reduction targets from 2010 to 2011, from 200 million condoms estimated to132 million condoms, respectively. The explanation is that the estimates prior to 2011, were not based on thorough knowledge of the calculation methodology. This knowledge was only acquired in the first half of 2011 in a training course conducted by the NAC with support from USAID, as referenced below.

Still on the same graph with respect to the female condom the goal projected for the years 2009, 2010 and 2011, is the same as 1.5 million female condoms. In 2009 the target was not met, but within two years was exceeded by 51,000 condoms in 2010 and 10,000 female condoms in 2011 (Figure 38).

Figure 38 - Total number of condoms available and targets for 2009, 2010 and 2011.



Source: NAC, 2012.

In 2010 the literature review of the various studies conducted in the area of male and female condoms was conducted to identify the main socio-cultural factors that affect their use, and logistical barriers that prevent or hinder access to condoms. In the same year two meetings were held to plan the needs of condoms, based on target groups and development corridors, and results the needs for female and male condoms for the year 2011 were quantified.

NAC together with its partners in this area in 2011 made two visits to the provinces of Cabo Delgado and Niassa, whose results were as follows: i) Assured the functionality of condoms distribution chain (male and female) at Provincial level, focusing District, based on communiqué produced for this purpose; ii) Disseminated the single instrument of data collection within the distribution system; iii) reinforced the call for submission of reports / number of condoms distributed to SE-NAC on quarterly basis iv) Enhanced the need for ownership and accountability of those involved in distribution of condoms at the local level; v) Discussed at the local level, the best method of condom promotion, with greater emphasis on women, including the social mobilization.

Also in 2011, the first three training of trainers were held in the three regions of the country, on the calculation of condom needs, data collection, logistics management, whose results were as follows: i) Trained 70 staff, among which Technicians of the NPCS, DPS / CMAM, including Civil Society Organizations working in the field of condoms ii) Improved insight into the quantitative variations and sources of data used for calculating needs; iii) Enhanced the spread of Circular nr .01/NAC/2006, referring to the flow of condom distribution and coordination at local level.

Challenges

This area faces major challenges in terms of logistics and distribution. The training of human resources and building capacity in logistics and distribution chain will have a positive impact on the management and distribution of condoms, at central, provincial and district levels, thus improving the management and service delivery programs. However; the following challenges also are to be highlighted:

- Strengthen the role of leadership (MISAU/NAC);
- Improve monitoring and evaluation system at central, provincial and district levels (establishing mechanism of periodic data collection in public, private sectors and civil society);
- Replicate to the local level, training of personnel involved in the logistics process for knowledge and proper use of tools for collecting data, and support human and material resources.;
- Improve the capacity of distribution (transport), especially from the Provincial level to the District;
- Improve the capacity and logistics management of condoms at all levels, through better coordination among stakeholders;
- Respond proactively and continuously the increasing demand for condoms, including the demand of female condoms for some women's organizations and women themselves;
- Oversee the quality of condoms distributed in the country.

Key actions for the promotion of condoms

- Train promoters of the female condom;
- Improve communication and messaging on the condom, to ensure that these messages are appropriate to local cultural realities as well as ensure that during the dissemination of messages, attention is paid to different types of people and age groups;
- Produce and disseminate appropriate communication materials in connection with the condom.

Main actions for the distribution of the condom

- Improving the process of logistics and management in the storage tanks of condoms, at central, provincial and district levels;
- Create an institution responsible for the distribution of condoms, whether be it inside or outside the health system;
- Develop and approve an interim plan of distribution, with the support of partners;
- Create technical capabilities in the areas of logistics and scheduling in order to meet the growing needs of the female condom;
- Develop tools and mechanisms to improve the control and monitoring of the distribution of condoms, especially for organizations that operate outside of health facilities.

<u>Indicator do GARPR # 1.4.:</u> Percentage of women and men aged 15–49 who had more than one sexual partner over the last 12 months who reported the use of condom during the last sexual intercourse

Table 27– Percentage of women and men aged 15–49 who had more than one sexual partner over the last 12 months who reported the use of condom during the last sexual intercourse, per sex and age group

Verification Methods	2009	2011
Numerator: Number of all respondents aged 15-49 who said have had more than one sexual partner over the last 12 months who reported having used condom during the last sexual intercourse	76	41
Denominator: Number of all respondents aged 15-49 who reported having had more than one sexual partner over the 12 months	320	219
Value of Indicators: Percentage	**23.6%**	**18.5%**

[Source: INSIDA, 2009 and 2011]

This indicator increased from 17% in 2003 to 23.6% in 2009 and declined further to 18.5% in 2011. The increase recorded occurs in both sexes, but with a higher proportion in females (Table 27).

Drug Use

In Mozambique the activities to prevent and combat trafficking and consumption of illegal drugs is coordinated by the Central Office for the Prevention and Combating Drugs (GCPCD), which is under the supervision of the Prime Minister's Office, where take part the Ministry of Education (MINED) The Ministry of Health (MISAU), Ministry of Youth and Sports (MJD), Ministry of Women and Social Action (MMAS), Ministry of Interior (MINT), Department of Justice (MJ), Ministry of Transport and Communications (MTC) Ministry of Industry and Commerce (MIC), Ministry of Finance (MF) and the Attorney General's Office (PGR). In 2010 the Government concluded the elaboration of the new "National Strategy for Prevention and Fight against Drugs", as well as related instruments, such as: "Plan for Prevention and Fight against Drugs" and "Plan of Implementation of National Strategy for Prevention and Fight against Drugs.

Prevention to Consumption and Illicit Traffic of Drug
Preventive activities are divided into primary, secondary and tertiary.

In the context of primary **prevention activities**, the GCPCD in coordination with its partners carry out the following activities: i) mobilization and organization of anti-drug activists, ii) the creation and revitalization of anti-drug clubs, iii) lectures on drugs.

Therefore, 2010 recorded a total of 35,523 anti-drug activists, against 31,960 in 2009, reached a total of 1418 revitalized and/or created clubs, and performed 3,721 lectures which benefited 755,312 youth and adults. In this context in collaboration with the Program of Basic Package ability for life of the MEC, messages were broadcast around the country aimed at preventing the use of illicit drugs, through the radio program on Radio Mozambique, "World without Secrets, school Radio. In cultural and sporting events, particularly in the holidays, there were intensively publicized throughout the country, messages related to HIV and AIDS and its link with alcohol and other drugs. The dissemination of these messages was promoted by the activists of the Centres for Prevention and Fight against Drugs and Program Busy Generation (Geração Biz) MISAU held a total of 10,158 lectures that addressed the various issues related to drugs. This activity had as main targets secondary school students, users of Health Unities, captives, prisoners and police.

In the context of **secondary prevention**, activities consist of interventions to prevent establishment or increase of the state of dependence between people who have experienced or made occasional use of drugs, in order to prevent its progression once initiated consumption of psycho-active substances. In this context, the different health units with psychiatric services and mental health provide care to patients with mental and behavioural disorders due to use of psychoactive substances.

In 2010 a total of 3062 patients with mental and behavioural disorder due to psychoactive substance use were treated in Psychiatric Services and Mental Health, being 77% male and

23% female. The number of visits this year greatly surpassed the year 2009 where 1,889 patients were treated.

Table 33 - Patients with PMC as a result of substance consumption

Psychoactive Substance	Patients with PMC		
	2009	2010	2011
Alcohol	1.014	1.267	1.429
Tobacco	45	392	150
Cannabis sativa	219	541	484
heroine	48	20	40
Cocaine	26	160	73
Volatile Solvent	00	0	18
Other stimulants including caffeine	00	18	00
Multiple	291	587	903
Hypnotic	51	67	100
Hallucinogens	05	10	00
Non-specific substance	190	0	00
TOTAL	**1.889**	**3.062**	**3.197**

Source: Annual Reports 2010 and 2011 of the Mental Health Program

According to Table 33, the main cause of demand for services for mental and behavioural problems (PMC) continues to be the harmful consumption of alcoholic beverages. Secondly we find the consumers of multiple substances where alcohol and cannabis sativa are the two drugs most associated. And last is the third is cannabis

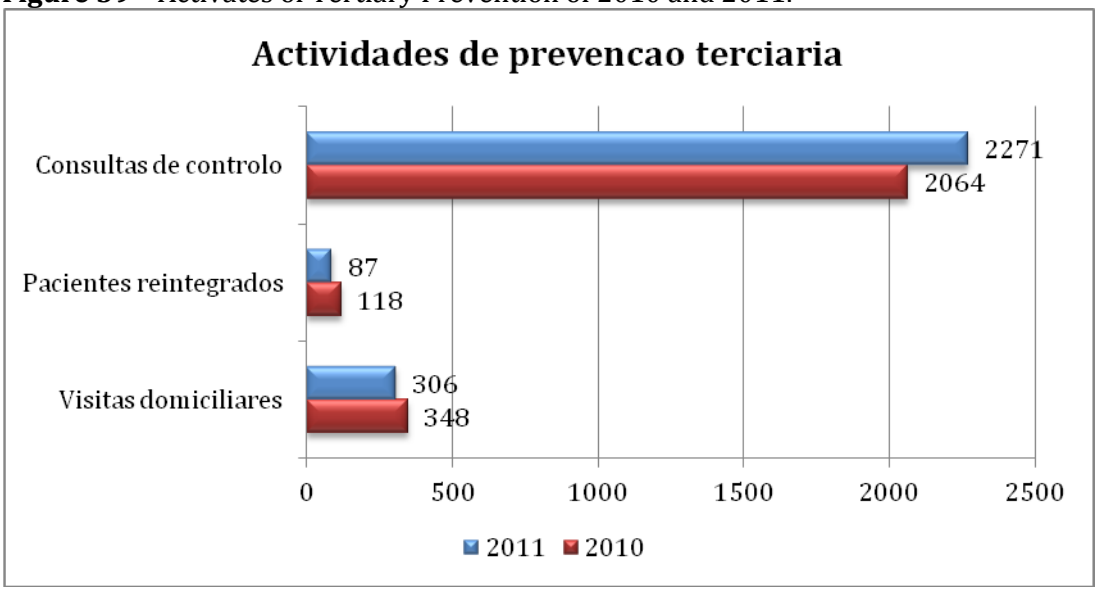
In 2010 there was a considerable increase in patients seeking treatment services due to consumption of tobacco, cannabis sativa, cocaine, other stimulants and multiple substances (alcohol and tobacco).

Tertiary prevention aims essentially to avoid relapse, aiming at the reintegration of the individual in society, allowing you new opportunities for engagement in school, groups of friends, family, work, among other sectors.

Thus the MiSAU in collaboration with MMAS and community organizations performs the following activities: monitoring of patients who were discharged from hospital at the level of external consultations, family and social reintegration and home visits to patients with mental disorders and behaviour resulting from consumption of alcohol and other drugs.

The number of reintegrated patients dropped from 118 in 2010 to 87 in 2011, and the number of home visits also decreased from 2010 to 2011, from 348 to 306, respectively. On the other hand there was a significant rise in the number of queries to control 2064 2271 2010 to 2011 (Figure 39).

Figure 39 – Activates of Tertiary Prevention of 2010 and 2011.



Source: Annual Report of 2010 and 2011 of Mental Health

Conclusion

In 2010 there was an increase of patients with mental and behavioural disorders due to psychoactive substance use compared to previous years. About 41% of patients had the harmful use of alcohol which remains the leading cause of demand for services and mostly male.

It should be noted that the expansion of services of Psychiatry and Mental Health in the country, and greater community awareness about the relationship between health and drug use are two factors that influence to increase the number of patients.

Perspectives

i. Nuclei form more anti-drugs clubs, among other places, especially in residence and schools, to increase the capacity of intervention in the arena of prevention and combating drug trafficking and consumption of illegal drugs;
ii. Continue with the intensification of the dissemination of anti-drug messages in the villages, using local languages and the use of various techniques for disseminating information;
iii. Expand the capacity to care and treatment of drug addicts in health facilities;
iv. Create databases to begin implementation of the Strategic Plan for Prevention and Fight against Drugs, after its approval;
v. Intensify activities leading to support for national and international partners, for activities to prevent and combat drugs.

<u>Indicator of GARPR # 2.1.:</u> Number of syringes distributed per person who injects drugs per year by needle and syringe programmes

<u>Indicator of GARPR # 2.2.:</u> Percentage of people who inject drugs who report the use of a condom at last sexual intercourse

<u>Indicator of GARPR # 2.3.:</u> Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected

<u>Indicator of GARPR # 2.4.:</u> Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results

<u>Indicator of GARPR # 2.5.:</u> Percentage of people who inject drugs who are living with HIV

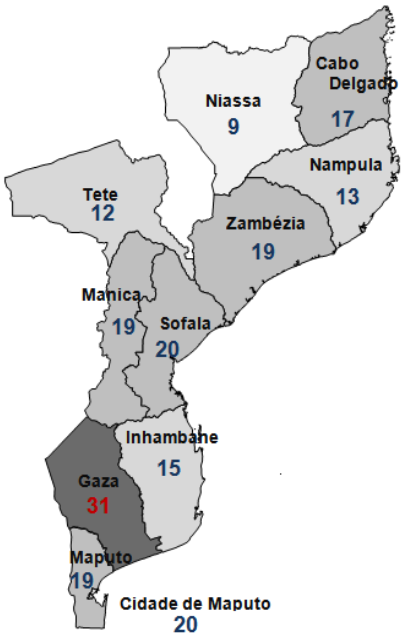
Currently, are not available for these indicators

Support for children affected by HIV

The Government of Mozambique defines orphans as children who have lost one or both parents. 12% of children surveyed by the Multiple Indicator Cluster Survey 2008 were orphans, out of whom 11% were orphans from one parent and 1% was double orphans. Another 6% were considered "vulnerable".

The number of orphans is much higher in areas with high HIV prevalence, particularly in the southern provinces compared with provinces in the centre and north (Figure 40). In addition to that, most vulnerable children live in urban areas compared with rural areas (20 and 16% respectively).

Figure 40 – Orphan and Vulnerable Children per province



The total number of orphans aged 0-17 was expected to increase over the period 2000 to 2015. In 2011 it was estimated that the number of maternal orphans was 936,000, and 424,000 due to AIDS and 512 000 due to other causes.

In Mozambique, 12% of children under 18 are orphans of mother, father or both. As expected, the prevalence of orphans increases with age of the child, from 3% (8% in 2003, IDS) among children aged 0-4 up to 29% (31% in 2003, IDS) aged between 15 to 17. Orphan hood is more common in children living in urban areas than those in rural areas (15% vs. 11%).

Combined with a previous analysis of Demographic and Health Survey 2003 which found that orphaned girls between 15 and 17 years old are more likely than non-orphans to have initiated sexual intercourse and those female maternal orphans are more likely than non-orphans to have been married, and the implication being the particular vulnerability of adolescents, particularly girls.

Orphan hood is also associated with the HIV status of children. According to INSIDA 2009, HIV prevalence is 3.2% in children orphaned by mother, father or both parents, compared to 1.3% among non-orphaned children.

Orphans and Vulnerable Children (OVCs) are more likely to live in poor households headed by women, and/or by a person without formal education. Some households are headed by children, or the child must act as the main provider of basic needs due to illness or disability of the adult family members. Children have limited income and resources and thus always have to rely on risk strategies for survival, such as early marriage, transactional sex and hazardous child labour. Children also have limited access to resources such as health, food, legal services, financial and psychological assistance. In addition to these challenges as a result of AIDS, OVC's always live stigma and social discrimination and potentially face exclusion in their communities. The VOC's are also prone to discrimination in the allocation of resources as they are not direct biological

descendants of the household head. The inheritance claimed by family members always results in the theft of property of the child head of household.

Political and Institutional Context

The second strategy for Poverty Reduction in Mozambique 2005-2009 (PARPA II) includes goals pertaining to VOC, such as developing and strengthening social safety nets for the poorest citizens (including orphans and vulnerable children) and ensure that the ratio of school attendance and the ratio of malnutrition among orphans and vulnerable children is equal to the ratio of non-orphaned children. PARPA II includes the goal of providing a minimum of three to six identified basic services (health, nutrition, education, and psychosocial support, legal and financial support) to 30% of households with OVCs.

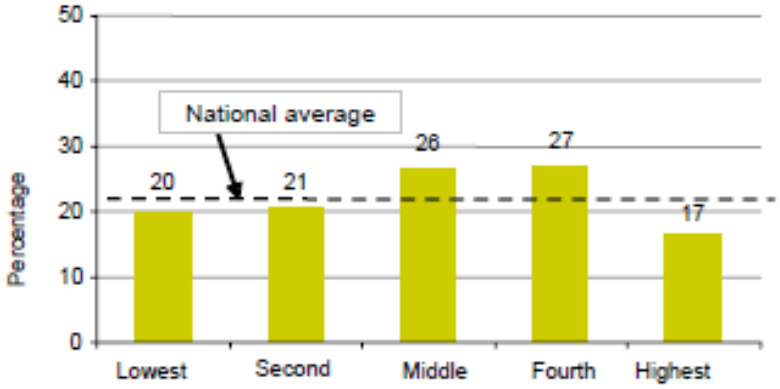
Mozambique has taken some steps towards meeting the needs of most vulnerable children in the country. The National Action Plan for Children (PNAC 2006-2010), which aims to ensure the protection of civil rights, human rights and protection of children through the development and coordination of activities of major stakeholders. The Multi-sectoral Plan for Orphans and Vulnerable Children (Pacov, 2006-2010) addresses the specific needs of this growing population. The Government defines the provision of at least three of such services as a minimum standard of care for OVCs. Both plans also state the commitment of the Government to extend the services of birth registration for VOC, essential for reducing vulnerability. The Social Protection Act, passed in 2007, calls for the provision of basic social security for poor people and children in difficult situation

<u>Indicator of GARPR # 7.4.:</u> Percentage of households who received external economical support over the last 3 months

Currently, there is no data available for this indicators .

The Survey Multiple Indicator 2008 found that only 22% of households with orphans and vulnerable children receive some outside support, most of this comes through Education (20% of VOC's), with 2% to receive material or financial assistance and less than 1% receive medical support. Another worrying statistic is that only 20% of children in the poorest quintile receiving free external support, compared with 27% of children who are in the fourth poorest quintile (Figure 41).

Figure 41 – Orphan and Vulnerable by AIDS whose households received free basic external support for child care, by wealth quintile, 2008



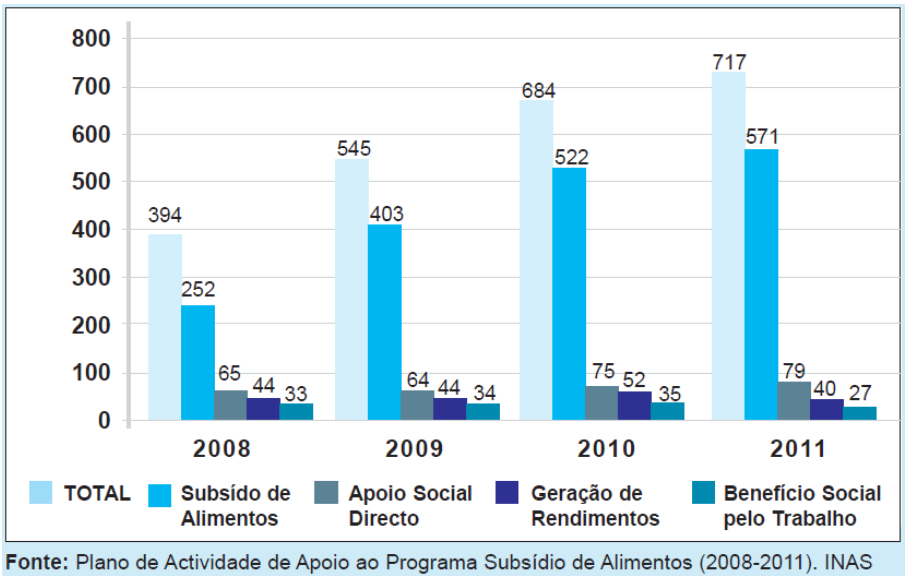
Source: MICS, 2008.

Another issue to consider in the context of programs that address the VOC is that, as previously discussed, many children live with adults who take care of them. However, a study conducted in Mozambique in 2006 found that an orphan and vulnerable child costs an average of $ 21 per month and care for a person living with HIV is $ 30, while an elderly man had, for months on average a yield equivalent to only U.S. $ 12.1. Obviously, for a senior an adult to meet this cost is a major challenge.

Main Results

The total resource envelope available for the Social Sector in 2011 is 1,432 million MT (while in 2010 it was 1029 million MT). The value, in both studies, is more or less 1% of total State Budget. This amount does not include the District Services OF Health, Women and Social Action (which equals the total of 1222 million MT, where we believe that a small percentage corresponds to the Ministry of Women and Social Action and its respective Provincial Directorates). For 2011, the amount of the sector is to include Social Protection Programs Conducted by the INAS. However, over the years comparison is difficult because in the previous years it did not happen. From 2008, INAS will count on outside support of four partners (the Netherlands, DFID, UNICEF and ILO) strengthening the internal funds of the Food Subsidy Program (PSA) (Figure 42). The proportion of internal and external resources to the INAS corresponds on average to 70% and 30% respectively

Figure 42 – Evolution of the Budget of the Social Protection Programs (PSA + other programs) (10^3), 2008 – 2011

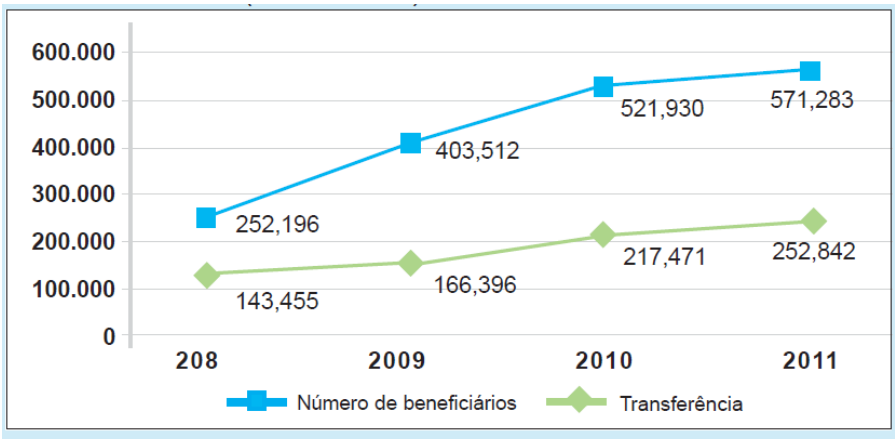


Fonte: Plano de Actividade de Apoio ao Programa Subsídio de Alimentos (2008-2011). INAS

Source: Schedule of Support Activity for the Food Subsidy Program (2008-2011), INAS

This information does not appear clearly in the State Budget before 2011, perhaps because the partner's support destined to the PSA appeared within the funds to the INAS and/or its provincial directorates. Anyhow, it is worth noting that the social protection programs absorb almost half the amount off the entire sector – which is very positive, as an indication that a major slice of the funds goes directly to the beneficiaries of the social protection programs. In 2011, these programs comprise about 0.5% of the State Budget, a slight reduction in relative terms, when compared to 2010 (0.6%). Looking more closely to the PSA, one may understand that the number of beneficiaries also grows along the years, following the growth of the transfers. But the amount of the transfers remains the same since 2008 (figure 43).

Figure 43 – Evolution of the number of beneficiaries and transfers of the PSA (2008-2011)



Fonte: Plano de Actividade de Apoio ao Programa Subsídio de Alimentos (2008-2011). INAS

Source: Schedule of Support Activity for the Food Subsidy Program (2008-2011), INAS

In 2010 the MMAS carried out some activities which consisted of the following:

- Location & Family Reunification Program: Of the 3,500 planned, 1,197 destitute children were documented, and of the 2,500 planned 1,517 were reunited with their families, of which 1,143 with their own families and 374 in foster families, which corresponds to 34.2% and 60.7% of the targets, respectively.
- Pre-School Education Program: Of the 1,900 planned, 1,869 children were attended to, which corresponds to a rate of accomplishment of 98.8%. Also functioning were 182 private kindergartens of the planned 170, and 663 community infant schools of the planned 570, which attended to a total of 16,079 children of the planned 15,000 and 51,364 of the planed 55,000 children, respectively, which corresponds to a rate of accomplishment of 107.2% and 93.4%. In respect to capacity-building, 323 tutors of the Community Infant Schools and Kindergartens were enabled, in issues pertaining to attending to pre-school age children.
- Attending to Children in Difficult Situation: of the 27,000 planned, 30,760 children were attended to in the 176 shelter centers existing in the country, corresponding to a rate of accomplishment of 113.9%; equally, of the 500 planed, 949 children were attended to in 36 public nurseries and 1,588 in 30 private nurseries of the 1,900 children planned, which corresponds to a rate of accomplishment of 189.8% and 83.6% respectively.
- Also given assistance at community level, 253,770 children in difficult situation of the planned 301,341, which corresponds to 84.2%. These children availed of multifaceted support consisting of foodstuffs, school materials, sundry equipment kits, poverty certificates, mosquito nets, clothing, etc., throughout the country.

Also worth mentioning the following activities:

- 22% of the families with external orphans receive some external support;
- During fiscal 2010 237,200 OVC received support from the USG ;
- The Multi-sectorial Technical Group for Vulnerable and Orphaned Children, comprised by the civil society and development partners, carries out regularly a revision of the PACOV. Additionally, all 11 provinces and 54 districts have established similar workgroups;
- In partnership with USAID, MAS is developing the minimum standards for care & support for the OVC;
- In partnership with Save the Children, MMAS developed guidelines for the establishment and functioning of children protection committees;
- There exist currently about 531 community committees to support the OVC;
- A OVC' database is currently being developed at MMAS;
- The number of OVC who received support from UNICEF-assisted DPMAS / NGOs in 2011 was 212,096.

Main challenges

- Define standards of quality for the six services provided to the most vulnerable children;
- Improve the MMAS' capacity at national, provincial and district levels and set limits on the number of officers, their qualifications and budget allocations;
- Setting-up of a comprehensive monitoring for reporting on the number of children reached both by the civil society as well as the government.

This number does not include all civil society organizations; only those programs financed by the USG

[50] This number does not include all the civil society organizations; only programs funded by USG www.pepefar.gov/countries/mozambique/index.htm

Main actions necessary for the extension of the Universal Access to Care for the OVC

- To strengthen the capacity of the families and communities in responding to the necessities of the OVC and in providing their access to the basic services. The Government policy promotes community-based care, instead of institutional care for the OVC;
- To strengthen psycho-social support, improve infancy development programs and emphasize gender-sensitive programming efforts;
- To ensure that the Food Subsidy Program transforms itself into a reliable mechanism for social assistance, reaching the most vulnerable children;
- To implement the child subsidy for the family ensemble supporting the COV as a measure of mitigation against the impact of HIV as part of the Basic Social Protection strategy;
- To work out a new five-year National Child Action Plan (2012-2016), which must integrate the objectives and actions proposed in the PACOV framework. This plan must be aligned with the Millennium Development Objectives which coincidentally have their fulfillment deadline 5 years from now, and aligned also with PARPA, currently in the making;
- PNAC must have a realistic budget that takes into account the resources available in the country (CFMP) as well as the possibility of mobilizing additional resources, as well as the contribution which may be given by the OSCs;
- To ensure the functioning of the coordinating organs provided for in the PNAC and that these be involved and take part in the process of working out the new PNAC in order to ensure the appropriation and institutional undertaking; the children must be adequately involved in the process of elaboration of the new PNAC as well as in the monitoring and evaluation of the same. It must be ensured that a child-friendly version of the new PNAC exists;
- To preserve the principle of integration of the PNAC in the planning instruments and Government monitoring (PES and PES Balance Sheet);
- In the new PNAC, to give new emphasis to the objectives related with access to health, education, leisure and entertainment, to protection including against violence, the abuse and child-labour, which are those in which the progress attained is far from the planned targets. The issue of orphaned and vulnerable children must also be given a very special attention;
- To strengthen the MMAS' capacity in human and material resources, in order that it may perform efficiently its leadership role in the PNAC;
- The institutions responsible for regulating the several approved laws protecting the rights of children, must take up actions with a view to render these laws operational.

School Attendance among orphans and non-orphans

Data from the 2008 Multiple Indicator Inquiry (MICS 2008) show that 81% of primary-school age children (6-12 years) are attending school (net rate of school attendance). The gender difference is 2%, with 82% boys and 80% girls. Net attendance rates for rural areas are lower (79%) compared to urban areas (89%).

One in every five children in secondary education age (13-17 years) are attending that level (net rate of attendance for secondary education). The difference between the rural areas (10%) and urban areas (38%) in secondary school attendance is broader than that in primary school.

Forty four percent of pupils attending primary school are older than 12 years. Late entrance to school allied to the rate of recurrence, is the contributing factor to the high percentage of pupils above official age for the respective levels. MICS found that 35% with entrance age to primary school do not attend school. The non-attendance percentage is higher in the rural areas (39%) than in urban areas (27%) and between female children (38%) than male children (33%). Attendance rates are lower when it comes to orphans of both parents.

Attendance rates by children aged 10-14 years whose father and mother have died stands at 77%, which is lower if compared with that of children (in the same age bracket) whose parents are alive and who live with at least one parent (87%). The difference between orphans of father and mother and the non-orphans is bigger in the urban areas (82% against 92% respectively), than in the rural areas (77% against 84% respectively).

According to the National Prevalence Inquiry, Behavioral Risks and HIV/AIDS information in Mozambique (INSIDA 2009), of children in age bracket 10 to 14 years, 66% of those most vulnerable attend school, compared to 79% of those least vulnerable. This situation is not much different from that found in IDS in 2003, when 63% of the most vulnerable children attended school, against 78% of the least vulnerable.

The difference in school attendance between most and least vulnerable children depends on gender and their place of residence. Among males, there is no difference between vulnerable and non-vulnerable (80% for both), while for females only 53% of the most vulnerable attend school, compared to 79% of the least vulnerable. In urban areas, 68% of the most vulnerable children attend school, compared to 86% of the least vulnerable. In rural areas the difference is similar: 65% of the most vulnerable children attend school compared to 77% of the least vulnerable.

Main Results

According to data from the Education Ministry (MINED) from 2007 to 2011 the number of orphan and vulnerable children attending school has been increasing along the years, from 628,933 to 776,775 respectively. Although a decrease has been registered from 2010 to 2011, from 810,161 to 776,775 respectively (table 34). As the above studies show, within this group of children the boys as a rule of thumb show more school attendance than girls and the orphans of

father show better attendance than the orphans of mother, and this last group show better attendance than the group of children who lost both parents.

Table 34 – **Number of orphaned pupils by gender, EP1 & EP2, 2007-2011**

Ano	Orphans of fathers		Orphans of Mothers		Orphans of Both	
	H	M	H	M	H	M
2007	176.435	147.632	94.994	84.113	67.746	58.013
2008	213.900	181.986	113.301	101.924	80.990	71.227
2009	218.894	190.027	116.783	108.834	86.330	78.075
2010	224.414	196.533	117.461	109.801	84.835	77.117
2011	216.513	191.088	112.730	106.321	78.252	71.851

Source: MINED ("03 March" Statistical Survey), 2011

In 2011, through the Program for the Promotion of Social Justice the MMAS carried out the following activities:

- Of the 1,026 planned, 1,128 children were reunited, of which 869 (412 girls and 457 boys) with their own families and 259 (138 girls and 121 boys) with foster families, corresponding to an 109% achievement rate;
- 360 orphan and vulnerable children were integrated in professional training courses;
- Of the 340,324 planned, assistance was provided to 280,436 orphan and vulnerable children at community level, corresponding to an achievement rate of 82.4%. These children availed of multifaceted support consisting of foodstuffs, school materials, sundry domestic utensils' kits, clothing, mosquito nets, poverty certificates, in all provinces;
- 2,505 children (1,124 girls and 1,378 boys) – including youths with disabilities, were forwarded for inclusive education, which represents an accomplishment rate of 205.3%;
- 307 children (119 girls and 188 boys) integrated in special schools were attended to, representing a rate of 83.4%;
- 89 (37 girls and 52 boys) visually impaired children were seen at the Visual Deficiencies' Institute, representing a rate of 108.5%.

Main Challenges

- Significant inequalities persist in terms of access to education, based i.e. on the gender, the level of poverty, the level of education of the parents, and the child's area of residence;
- Double orphans have a rate of enrollment in school lower than that of other groups; more data on the attendance of OVC compared with non-orphans is necessary;
- HIV-related stigma and discrimination still persist at community level. This can lead to the exclusion of the most vulnerable children with the excuse of 'no-more-vacancies' or due to discrimination at the school.

Main actions for the extension of Universal Access by Orphan and Vulnerable Children to Education

- Families caring for OVC need to be aware of the rights of all children of access to education;
- To ensure that MINED has enough resources to accommodate all children in all provinces, possibly through the reintroduction of the Education Subsidy for the OVC; to improve the school infrastructure; and to avail of enough qualified teachers;
- To continue emphasizing the implementation of activities by the MINED and MMAS, related with HIV-related stigma and discrimination;
- More emphasis in the coordination between MINED and MMAS at local level, with a view to ensure that the OVC' school attendance rates be on a par with those of non-orphans;

- Facilitate OVC' access to secondary education, through improvement of access to poverty certificates.

According to Table 35 bellow, an increase in school attendance by orphan children may be noticed in the country, from 63.6% in 2003 to 65.9% in 2009.

GARPR Indicator # 7.3: Current school attendance between orphan and non-orphan children in age bracket 10 – 14 years.

Table 35 - Current school attendance between orphan and non-orphan children in age bracket 10 – 14 years.

Measuring Methods	All 10 – 14	Gender	
		Male	Female
O R P H A N S			
Numerator: Number of children who lost both parents and who attend school	85	50	35
Denominator: Number of children who lost both parents	129	63	66
Indicator Value: Percentage	**65.9%**	**79.4%**	**53.0%**
N O N – O R P H A N S			
Numerator: Number of children whose parents are alive, who live with at least one parent, and who attend school	1,798	973	823
Denominator: Number of children whose parents are alive, who live With at least one of the parents	2,268	1,221	1,046
Indicator Value: Percentage	**79.3%**	**79.7%**	**78.7%**
[Source: INSIDA, 2009]			

Elderly people

In its introductory note, the Law defending the rights and fighting against stigmatization and discrimination of people living with HIV acknowledges that the pandemic affects all groups, regardless of age, race or gender, and also establishes as a group of people living in a state of vulnerability with HIV / AIDS, the aged persons who, besides other rights constitutionally consecrated and in other legal devices, have the right to be supported by their families or sheltered in shelter centers in case of need.

On the other hand, both the policy for the aged person and its implementation strategy, as well as the national plan for the aged person underline as priorities: a) the making of studies to evaluate the impact of HIV in the third age; b) active of the aged person in the HIV prevention and combat programs; c) to provide counseling and psychological support to third-age people who lost their children.

In relation to NSPIII, worked out with the participation of civil society organizations, it bears pointing out as a great step forward the inclusion of aged persons as one of the groups most at risk who, like other groups must avail of services and information about the primary and secondary HIV-prevention, as well as access to treatment.

Main Results

Despite the inclusion of aged persons as a risk group in the different laws and national policies, there does not exist data about prevalence of HIV in this group. In its analysis of the epidemiological profile of the country, PENII kept silent with regard to the age bracket above 50 years of age. All data are centered in the age bracket from 15 to 49 years of age, a fact that makes it impossible to grasp the real dimension about how the pandemic is affecting aged persons, how many third age people are infected, how many are receiving ARV treatment and how many have been tested. With a view to improve and render the information more inclusive, NSPIII foresees the introduction of ages above 49 years in the statistical data.

However, with the accomplishment of INSIDA in 2009, it was possible for the first time to gather data of prevalence in aged persons. INSIDA inquired a total of 1,370 persons ranging in age from 50 to 64 years, of which 54% were women. With relation to general knowledge, defined as encompassing knowledge about HIV and AIDS and which rejects the most common misconceptions about the transmission and prevention of HIV, 17.3% of the women and 29.6% of the aged men answered correctly, slightly less than the percentage of the total show of the study of 30.1% in women and 34.3% in men. The recent sexual activity in this age group is important, it being that the proportion of women who engaged in sexual relations during the past year was 17.7% and 15.9% of men. The report showed that 17.1% of the aged men reported 2 or more sexual partners during the past 12 months, and that only 1.4% of them made use of a condom. On the other hand, only 0.2% of women in the same age group reported having had 2 or more sexual partners during the past 12 months. It is interesting to point out that, during the past 12 months, 2% of the aged men inquired reported having paid their partner in exchange for sexual favors.

The Ministry of Women and Social Action (MMAS) established the Social Justice Promotion program, whose objective it is to attend to aged persons at the public Old-Age Support Centers and at the Community ONSPCenters. For 2011, it established as goals: i) to attend to 460 aged persons at the public centers for old-age support; ii) to attend to 399 aged persons at the community oNSPcenters; iii) work out and approve the 2nd PNAD.

Main Results

In 2011, through its Social Justice Promotion program, the MMAS carried out the following activities:

- Attended to 349 aged persons (1747 men and 175 women) at 13 public Old-Age Support Centers existing in the country, corresponding to a rate of accomplishment of 75.9%;
- Assistance given to 369 (163 men and 206 women) aged persons at 14 private Old-Age Support Centers existing in the country;
- Attended to 3,614 aged persons at 16 ONSPCenters existing in the country, corresponding to 106.3%;
- Started the working out of the 2nd PNAD 2011-2019, having the respective Terms of Reference been approved and launched the bid for contracting technical support.

Main Challenges

The main HIV-related challenges relative to aged persons are:

- The lack of data about the impact of the illness on aged persons, as a result of the non-compartmentalization of the information in relation to the age groups: young, adult and aged;
- The counseling and testing services are not prepared structurally to receive the aged person, supply the necessary information and, above all, to make that person feel confident enough to oNSPup and start talking;
- The conception of sensitization and education programs for prevention is more focused towards younger age bracket groups;
- The great scarcity of organizations that work to promote and defend the rights of the aged persons.

Main Recommendations

- It is urgent to compartmentalize the data on the prevalence of HIV taking into the age brackets: Youth [15-24 years]; adults [25-49 years]; aged persons [above 50 years];
- The counseling and testing units must be prepared to deal with persons of all age groups, through the training of young counselors guided towards working with younger people and older counselors to work with aged persons;
- In the conception of sensitization and education programs for the prevention and treatment of HIV / AIDS of a national scope, it is necessary to consult and sound with the organizations that work in the area of the defense of the aged persons' rights, in order as to allow the existence of messages addressed to the third age.

IV. Documenting of Good Practices in Mozambique

IV.1 In 2009, the National Council for the Fight Against AIDS (NAC) initiated a process of documenting "Good Practices" in the scope of the interventions in the areas of prevention, treatment and mitigation of the impact of the HIV / AIDS in Mozambique. The objective of this process is to strengthen the exchange of experiences among the different actors of the National Response to HIV/AIDS, thus helping in the motivating and enabling others and finally to improve the quality of the HIV/AIDS projects and/or programs.

The first action of this process was the production of the "Good Practices" brochure, based on a pilot-project implemented in the Manica, Sofala and Inhambane Provinces. And in 2010, an institutional film about good practices was also produced. The information on "Good Practices" results from the assessment by the local jury of 9 projects in the area of prevention, undertaken in the 3 provinces mentioned above, at the rate of 3 projects per province.

Elaboration of Best Practices Brochure

The brochure serves as an instrument of learning for the whole country, explaining "Good Practices" in a simple and accessible manner and based on evidence. Thus, the production of the brochure comprised the undertaking of the following activities:

i. Elaboration of the Terms of Reference;
ii. Presentation of the tender to the implementation partners in the provinces (communication fora) for the submission of bids;
iii. Constitution of a multi-sector jury (civil society, public & private);
iv. Evaluation of the bids and rewarding the winners by the Provincial Nucleus for the Fight Against AIDS (NPCS) of the following projects related to the 'area of prevention':
    a. Kwaeza – utilizes theater with focus on the "theater of the oppressed" methodology to pass sensitization messages about HIV/AIDS;
    b. AJUDECO – utilizes debates about issues related to HIV/AIDS;
    c. Maçaquese Community Radio – utilizes the Community Radio to promote debates & programs on HIV/AIDS-related issues;
    d. LeMusica – passes HIV/AIDS sensitization messages through music;
    e. Pembemuca – utilizes lectures with involvement of the community leaders to pass its HIV / AIDS sensitization messages;
    f. Positivo – passes HIV/AIDS sensitization messages through music;
    g. PROVIDA – utilizes lectures and workshops with involvement of the community leaders to pass its HIV / AIDS sensitization messages;
    h. PANBHONZI – carries out sensitization of young university students who work interactively with other youngsters (peer education), utilizing the 'bridges of hope' methodology. It is a project based in the Beira City Catholic University;
    i. Christian Network against HIV/AIDS – sensitizes through lectures and HTC. Its target group are prison inmates.
v. Visits to the field and documentation by the NPCS;
vi. Joint elaboration of texts by the NPCSs and key-actors;
vii. Systematization of the document

Production of the Institutional Film

Starting from the experience gained in producing the brochure, the NAC conceived the production of a film about the efforts of the civil society in its response to HIV/AIDS, which could

be illustrative of what is being done throughout the country. Thus was born the film "Hidden Voices of Loving the Fellow-Creature".

The actions that embody the film are framed in the domains of prevention, treatment and mitigation of the impact, anchored in community nuclei as a form to fundament its sustainability in the 11 provinces of the country.

Given that the NPCSs had identified the projects with good practices, the production of the film comprised the carrying out of the following activities:

I. Elaboration of the Terms of Reference;
II. Presentation of a project, by Province, by the NPCSs;
III. Engagement of a Mozambican filming company to produce the film;
IV. Production of the guide;
V. Visits to the field and production of the film, by the engaged company and NPCS, in the following projects:

a) – Solidarity Corner: mitigation area, support to orphaned and vulnerable children (OVC), distribution of school materials;
b) – ADPP Total Epidemic Control: prevention area, carries out counseling & testing activities in community health (HTC-C) & condom distribution;
c) – Voci-Volti (Health & Support to Vulnerable Families): mitigation area, carries out support activities to orphaned children and their families as well as distribution of the basic basket;
d) – PANBHONDZI: prevention area, carries out sensitization of young university students who work interactively with other youngsters (peer education), utilizing the 'bridges of hope' methodology. It is a project based in the Beira City Catholic University;
e) – Luz da Vida: treatment area, carries out ARV treatment with a view to prolong the life of the PLHA and mitigation area, where it carries out home care activities;
f) – Semeando Saúde/Padre Úsera: treatment area, is involved in the prolongation of life through natural medicine with a focus on medicinal plants, garlic-based syrups, honey and ointments for the treatment of sarcomas based on aloe-vera;
g) – Pembemuca: mitigation area, gives support to OVC through their integration in foster families, basket distribution and basic school materials and home care;
h) – Centro Juvenil Contra SIDA: prevention area, carries out sensitization of youngsters on HIV/AIDS issues, with focus on Sexual and Reproductive Health;
i) – Hospital de Caramelo: treaqtment area, offers ARV Treatment;
j) – Arca de Salvação: prevention area, carries out sensitization of adolescents on HIV/AIDS issues and is active in the area of mitigation, where it does vocational training on PLHA, in laying-hen breeding techniques, tailoring and batik, support to OVC & distribution of school material, building of houses to accommodate the PLHA in order to improve the conditions of their lives;
k) – MEMO: prevention area, provides Counseling and Testing in Community Health (HTC).

vi) Film editing.

Challenges & Prospects

Dissemination of the brochure and the film about "Good Practices" on HIV/AIDS in Mozambique, with a view to present the transformations that "Good Practices" may induce in society, this is, once the brochure and the film published and disseminated it is hoped to improve the capacity of the key-actors (people who organize projects) and thus encourage the rise of "Good Practices" throughout the country. This exercise shall be performed throughout this year 2012.

IV.2 The National Civil Society Conference held in 2008 under direction of the MONASO, served as a foundation, since it produced the Declaration of the Conference, which gave rise to various activities which culminated with the process of documenting of Good Practices.

The justification for this process is that more than 1,400 NGOs work with HIV/AIDS in Mozambique, coming from diverse regions and facing different challenges when working in the prevention of new infections, offering treatment and care, and in the reduction of the stigma and discrimination of the PLHA. This work is carried out in different manners and in accordance with specific contexts and problems, but some of the organizations involved are more successful than others. Some organizations succeed in making a significant difference in respect to the HIV epidemic, and that the harvesting of Good Practices originating from these organizations shall help in affording new ideas and leads.

The process of documenting of Good Practices began with a survey in all 11 provinces in the country, involving 74 organizations and 14 associations, lead by a group of consultants. In this process were identified organizations and associations that showed activities that resulted in avoided infections, care, treatment, improved support and reduction in the stigma and discrimination, while at the same time sharing information about the aspects that made their activities effective.

The documentation was structured in 4 areas, namely: i) HIV prevention; ii) treatment & care; iii) mitigation; and iv) stigma & discrimination.

In the area of prevention, the organizations were documented by sub-areas or objectives:

I. Most at risk population – ABEVAMO Association, active in the Maputo Province;
II. Multiple local and integrated approaches for the general population – WIWANANA, active in two districts in Cabo Delgado province;
III. Increase the knowledge about HIV among youngsters – PANBHONDZI, a project based in the Beira Catholic University, and is active in Sofala province;
IV. Communicate about HIV through art – Centro Cultural Ephato Na Conga (Rhino Boys), active in Nampula province;
V. Modifying traditional practices – AERMO (Mozambique Herbalists' Association), active in Inhambane province;
VI. Religious leaders break the silence – KUBHTCIRANA, active in 5 districts in Manica province.

In the area of care and treatment, only one organization was identified, and it was documented based on the following object:

I. To encourage adhesion to ARV treatment – ASKUT, active in the Sofala province.

In the area of mitigation, the organizations were also documented by sub-areas or objectives:

I. Use education to ensure the future of the orphans – AMOTREVO, active in Maputo province;
II. Ensure a home for orphans and vulnerable children – REENCONTRO, active in Maputo & Gaza provinces;
III. Encourage the self-efficacy of the people living with HIV/AIDS (PLHA) – CHITETEZO, active in Tete province.

In the area of stigma & discrimination, the organizations were also documented by sub-areas or objectives:

I. Live in a positive and visible manner – Kuvumbana Association, active in the Gaza province;
II. Help the young in revealing HIV-positivity at home – A Chama da Vida, active in Gaza province.

Challenges and Perspectives

The HIV epidemic is in constant evolution and our problems understanding must be deepened. For this reason it is important that we keep on talking, on debating, on analyzing and on sharing experiences about why some problems do prevent more infections, why some activities do reach the same objectives, but with less money, and why some programs are ethically and morally better than others.

IV.3 Geração Biz Program (PGB) is a national, multi-sector and outreach sexual and reproductive health (SSR) and HIV prevention program. It was founded in Mozambique nearly 12 years ago (in 1999) incorporating actions with the Ministries of Health, Education, and Youth and Sports, and Youth associations, with the support of the United Nations represented by FNUAP, Denmark, Norway and Sweden, and with technical back-up of Pathfinder International.

The teenagers and youth always constitute nearly 32 % of the population in Mozambique, the biggest group of 15-24 years age group, which represent the main PGB target group.

In 12 years of its intervention PGB has proved to be a school for the social, academic and professional development of thousands of pair educators and public workers. Along the time the program has liberated the local communities from sex taboos, education and the role of the youth in the society. Nowadays PGB also deals with more broad issues, such as the youth participation, gender empowerment and Human Rights.

PGB registers as historical landmarks: i) thousands of reached with behavior change messages regarding HIV and AIDS; ii) quality services in the area of sexual and reproductive health for the youth from all the places; iii) it reduced the average of pregnancy cases in schools in 78,4 %; iv) it administered HIV tests to more than 600.000 young people; v) it created and supported more than 400 youth associations; vi) it enabled more than 16.000 couples educators in social and professional skills. For this and other reasons it was considered by the World Bank as a "Good Practice" and the Government of Mozambique calls it a "national model".

IV. Main Challenges and Necessary Actions to Reach the Objectives

MAIN REPORTED CHALLENGES IN 2009	ACHIEVED PROGRESS TO DATE
POLITICAL AND FINANCIAL SUPPORT	
The strong dependence in extern financing raises HIV and AIDS programs sustainability issues in Mozambique.	In order to reduce dependence on external aid resources, advocacy has been being undertaken at national and international political level. However, NASA has been proving that the national approach to HIV is still strongly dependant (about 82 %) on the external aid.
NASA institutionalization	The second NASA, for the years of 2007 and 2008, was carried out during 2009 and beginning of 2010, with the NAC active leadership. With the objective to define the bases for NASA institutionalization, students of the Faculty of Economy and NAC personnel have participated in the exercise. Although the informers had been sensitized through several channels, there persists a weak answer in the supply of timely data of the expenses. This phenomenon has resulted in a delay in the total process conclusion, having taken more than five months to complete data collection. Therefore, NASA institutionalization must be approached in a two sided perspective and not only that of the Government.
National Strategic Plan of Combat to the HIV and AIDS Budgeting in Mozambique, as a resource mobilization strategy	At present it is only possible to get expenses information, information about the needs and funds availability for HIV and AIDS in the country continues to be a challenge.
HUMAN RIGHTS	
The Law 5/2000 approved in 2002 protects people living with HIV in the work place, but does not address discrimination as punishable offense, therefore the application of this law remains weak	The Rights Defense and Combat to Discrimination and Stigmatization of People Living with HIV and AIDS Law – law n. 12/2009 was adopted in 2009. Some previous experiences carried out in Mozambique, demonstrated that the laws application, such as the non discrimination Law of PLHIV in the work place, was weak, since there was not a corresponding Regulation. For this reason, it is recommended that a Regulation for the law n. 12/2009 is created.
A broad law against stigma and discrimination was passed and it continues waiting for the Parliament approval	
CIVIL SOCIETY	
The involvement of the civil society in planning, monitoring and vigilance of the answer to HIV, needs to be continuously intensified.	The civil society is represented in different national co-ordination structures, such as the NAC Directive Council, Reference Group for Prevention, the Country Co-ordination Mechanism for the Global Fund, Partners Forum, besides the improving dialog with different Government sectors involved in the answer to HIV.
Need of interventions expansion at all levels of the national answer	The civil society and NAC, are concerned with the expansion and quality of interventions they launched brochures and movies about the good practices in 2010 and 2011.

MAIN REPORTED CHALLENGES IN 2009	ACHIEVED PROGRESS TO DATE
CIVIL SOCIETY	
The management and financial support mechanisms must be clarified and need to be well known by the civil society organizations, in order that they can improve its funds access capacity to the realization of its activities.	SE-NAC at central and provincial level did not receive official information about funding opportunities made available by the partners for dissemination to the implementing agents in 2011. These funding windows, apparently, were straightly put at the disposal of the implementing agents. The access mechanisms to these funds are not clear and everything indicates that the implementing agents have not equal opportunity for competing. Additionally, it was noted that the availability of these funds do not answer to the priorities of each province or district since not always the NPCS and Local Governments are consulted to give their opinion about the projects to be funded.
SAFETY IN BLOOD TRANSFUSION	
The coverage is limited to the same measure of the access to health services in Mozambique. In general, the coverage is limited by an estimate of 40-50 %, with many remote and rural areas with limited or null access to health services.	MISAU has been making an effort to increase the coverage of blood bank services in the country, passing from 135 in 2007 to 149 blood banks in 2011. Also an increase was noted in the number of collected blood unities from 79.925 in 2007 to 107.019 in 2011. Likewise, the quality guarantee passed from 35, 5 % to 69, and 4 %, respectively.
Many emergence blood transfusions are performed out of the sanitary unities with blood banks.	
Some times, sanitary unities without blood banks perform blood transfusion without test possibility.	
VERTICAL TRANSMISSION PREVENSION	
To reduce the attendance losses (follow up) of women and children due to stigma and discrimination fear, insufficient human resources to find clients that gave up and family and community insufficient support	The net of sanitary unities that offer services of PMTCT has been expanding progressively of 386 in 2007, for 909 in 2011, representing a covering of 86 % of 1.063 sanitary unities with services of CPN.
	Creation of "mother-to-mother groups", pregnant women groups and of HIV positive mothers at Health Post level, which provides psychosocial support to help members to overcome the obstacles and to join the PMTCT recommendations. In 2011 National Guides were approved for the Mother to Mother Groups and its expansion is to start in 2012.
To increase the number of pregnant women receiving ARVT for their own health;	A growing number of pregnant women received ARVT in the last years: about 950 (7 % of the pregnant women who received ARV for PMTCT) in 2006, increased to 6 388 (14 %) in 2008, and 8.643 (22 %) in 2011.
Qualified and sufficient human resources guarantee what should exist;	, Most of PMTCT services were concentrated in the sanitary unities (US) of the provincial capitals from the beginning of this program in 2002. At present, the PMTCT interventions are integrated in the

To strengthen the co-ordination between PMTCT and other programs of prevention and treatment of HIV	services of woman and child health in all the districts, including the periphery US.

MAIN REPORTED CHALLENGES IN 2009	ACHIEVED PROGRESS TO DATE
VERTICAL TRANSMISSION PREVENTION	
Low ARVs coverage for children and weak follow-up of the children exposed in the consultation of Child in Risk;	The anti-retroviral preventive medicine for the mother or child during the breastfeeding is very efficient in the reduction of transmission of HIV risk. Its implementation at national level begun in July of 2011. Children exposed to HIV are followed regularly in Child at Risk Consultations (CCR), with the supply of preventive medicine of opportunistic infections with cotrimoxazole, regular evaluation of the growth and of psycho-driving development, counseling on food and precocious diagnosis with PCR in the first opportunity that is in the Sanitary Unity between the 1st and 9th month of life. All the exposed children with the age equal or superior to 9 months, who did not undergo the PCR-ADN before or those who had negative PCR-ADN test must undergo the quick test at 9 months.
To increase institutional childbirth for HIV positive women and to ensure the preventive medicine after birth for women and the newborn babies in non institutional childbirth places	Reduced institutional childbirth coverage– 58 % according to the MICS 2008 results - number of children who received preventive medicine with anti-retroviral is still limited, being that, in 2009 and 2010, there were 41.266 (58,7 % of the women tested positive HIV in the same period) and 59.087 (60,2 %), respectively.
To ensure good practices of childlike food for children exposed to HIV, both before the age of 6 months, and afterwards;	MISAU adapted the standards of childlike food in the context of HIV and of PMTCT with the international standards. So, the national directives recommend that HIV positive mothers undertake exclusive breastfeeding till 6 months, followed of stopping breastfeeding, if the substitution food of breastfeeding is acceptable, viable, accessible, sustainable and safe.
To strengthen monitoring and evaluation, including the availability of M&E instruments that incorporate all the program aspects and of the PMTCT capacity at all levels in the use of these instruments for the improvement of the given services	MISAU contributes with several partners and donors organizations to the PMTCT implementation. In order to ensure good co-ordination between the technical partners and of implementation, the MISAU disposes of a technical PMTCT work group. The group meets regularly under the leadership of the MISAU and discusses all the prescriptive programmatic and political issues, as well as the implementation progresses, challenges and learned lessons.
COUNSELING AND TESTING	
To increase the access to HTC for couples and families, with particular attention to the support to divergent couples	The number of attendants in several AT unities in Health increased from around 560 000 in 2008 to 602 171, in 2009. This year, 528 347 of the attended people were tested.
To enlarge PICT in clinics paying special attention to TB, ITS's and pediatric clinics.	

To expand the access of precocious diagnosis of HIV through households counseling and testing specially in areas of high predominance	Around quarter a million people took the HIV test through Community AT in 2009.

MAIN REPORTED CHALLENGES IN 2009	ACHIEVED PROGRESS TO DATE
COUNSELING AND TESTING	
To improve policies for more access to counseling and testing among People at Risk.	The main MISAU focus in this area to be the expansion of HTC services in the National Health Service. In order to increase these services with the expected quality, the MISAU in collaboration with the Ministry of Women and Social Work prepared the next instruments:
	THE MISAU approved in 2008 –the Guide on Counseling and Testing Initiated by the Provider in the Clinical Context; and the Operational-Strategic Guide for the Implementation of the Unities of the Counseling and testing in Health (UHTC).
	THE MISAU has launched in 2009 the Directives for Health Counseling and Testing in the Community.
	. THE Ministry of Women and Social Works has launched in 2010 the Strategy of Access Enlargement of Counseling and Testing for People With Hearing Deficiency.
	THE MISAU from 2006 has been implementing the Proficiency Panel for quality insurance in test places.
To increase the number of counselors in HTC places, as well as in clinics, placing trained counselors for several tasks.	The Community Counseling and Test in Health (HTCC) is a strategy that aims to contribute to the increase of the access to the community Health Services, through innovatory patterns, including activities related to HIV, in order to increase effectiveness and its acceptability and to reduce the stigma that could be produced with isolated actions.
To enlarge the ATIP in the sanitary unities, paying special attention to TB, ITS's and pediatric clinics.	
PREVENTION	
To strengthen evidences in the determinants of the epidemic and of the current answer	The following studies that are expected to improve the prevention intervention area of HIV in the country are in course: • Studies on condoms availability; • Integrated Biological and Behavioral Survey - IBBS for the HSH group and sex workers; • Demographic inquiry and of Health of 2011; • Epidemiologic vigilance, round 2011.

To reinforce the capacity of the main stakeholders to translate evidences in strategies, plans and national prevention budgets	During the year of 2011, the NAC in partnership with the National Journalists Trade Union and MISA Mozambique, and with the GIZ support, organized a national workshop of capacity building for Journalists and Communication Assistants in matters related to HIV and AIDS with the objective to improve the approach on HIV and AIDS in the organs of social communication, and to improve the strategic co-ordination of the intervention of the social communication in the combat to HIV and AIDS. Similar Workshops were carried out at the provincial level.

MAIN REPORTED CHALLENGES IN 2009	ACHIEVED PROGRESS TO DATE
PREVENTION	
To reinforce the national prevention strategy of HIV and to expand a holistic approach for culturally and socially sensitive communication, based on the current communication strategy, with the budget clearly defined for communication	In 2010 at central level they were developed campaigns with not advisable messages the Multiple Competing Partnership (PMC), excessive consumption of alcohol and drugs. The Concomitant Multiple Partners campaign was equally launched, "**To have outside partners is very risky**" the first phase started with the slogan**, "Too much loves is too much**".
expansion of efficient prevention measures	In the context of Prevention Acceleration Strategy a series of interventions have been implemented in the last 2 years, such as National Awareness Campaigns about Multiple Concomitant Partners, IEC to the youth and teenagers in schools and out of the schools, major expansion of condoms distribution,
School Headmasters training in teaching methodologies of life skills and importance of life skills for the pupils	An interventions assessment of the Geração Biz Program in its 12 years of existence published in 2011, indicate that it has been giving the following contribution in the struggle against HIV and AIDS in the country: i) thousands of young people reached with messages of behavior change regarding the HIV and AIDS; ii) quality services in the area of sexual and reproductive health for the young people of all the places; iii) it reduced the average of pregnancy cases in schools in 78,4 %; iv) it administered HIV tests to more than 600.000 young people; v) it created and supported more than 400 youth associations; vi) it enabled more than 16.000 couples educators in social and professional skills.
	THE MINED in the context of its Schools Managers Capacity Building program in HIV and AIDS, adapted contents and these were already integrated in the Integral Capacity building Program of the School Managers.

UNIVERSAL ACCESS TO CONDOM	
The feminine condoms are not generally available in the public or private sector, and few ONG's distribute them	Female condoms distributed in 2010: 1.551.000; 2011: 1.510.000 Planned for 2010: 1.500.000; 2011: 1.500.000
The capacity of carrying out a continuous analysis of the chain of distribution of condoms, in order to allow that timely decisions are taken; Supply of a continuous technical support, at all levels, in order to improve the capacities of prevision of the necessities, of requests preparation and of distribution;	THE NAC with the USAID support carried out in 2011 the first three capacity building of trainers, in three regions of the country, on calculation of necessities of condoms, data collection, and logistics management.
To strengthen the co-ordination between several actors of the process (public and private sectors and youth associations);	THE NAC in 2010 in the context of strengthening partnerships with the Civil Society carried out the formation of thirty (30) trainers for the feminine condom promotion.
To increase the demand for the correct and solid use of the masculine and feminine condom.	In 2010 the bibliographical revision was carried out of several studies already carried out in the area of the masculine and feminine condoms for the identification of the main social and cultural factors that affect its use, and of logistic barriers that obstruct or hinder access to the condoms.

MAIN REPORTED CHALLENGES IN 2009	ACHIEVED PROGRESS TO DATE
PREVENTION PROGRAMS WITHIN THE RISK POPULATION	
The partners together with the NAC, MISAU and other Mozambique agencies need prioritize groups of populations at risk within the context of Mozambique. The HIV prevention activities not need only to focus in the general prevention, but also they need to include prevention strategies aimed to the populations at risk.	Among the National Reference Group for Prevention, a work sub-group was created to discuss in structured form, on the answer to HIV among people at risk. The group is composed by members of government institutions and international and local partners involved in designing policies, strategies and / or in the interventions implementation directed to the different groups at risk.

To conduct the sub-national data collection and estimates separated by age and sex referring to the HIV prevalence among the MARPs groups.	In 2009, the first qualitative study happened on the structural vulnerabilities and risks of infection for the HIV between HSH in the city and province of Maputo.
	The Integrated Biological and Behavioral Survey is under way, in 2012 it will present estimates of the HSH population in Mozambique that will contribute in order that we focus the prevention programs in the most pressing necessities, as well as will inform this indicative in the future.
There is the need of health services development that are sensitive health specifications of people at risk (for example, the attention for the anal ITS), and that supply service to these groups, free of discrimination and prejudice	In 2011, 29.668 condoms and 21.367 were distributed lubricants sashes to the water base. Also 505 HSH were referenced to health services, and other services of social support.
The Communication efforts for Change of Behavior need to include specific and material interventions that are directed to the people at risk	In 2011, the services were expanded to the provinces of Cabo Delgado and Inhambane. This year, the Lambda actions reached 1.585 new HSH in five provinces. Besides these new contacts (i.e. HSH that were reached by the Lambda educative actions for the first time), the couples educators carried out 3.513 approaches to already existing contacts.
ANTIRETROVIRAL THERAPY IN ADULTS	
The ARV educative programs to ensure adhesion are still weak.	The challenge of the losses in the continuation in the pediatric ARV program was clearly documented in 2011 with the publication of the Report on Retention in ARV of the Ministry of Health of Mozambique, which indicate that only 66 % of children with less than 15 years of age were still alive and in ARV, 12 months after the beginning of the treatment.
The Human resources constraints in the whole sector continues to be the main challenges for the expansion of the services at the central and provincial levels, both in terms of numbers and in capacity, in terms of management and implementation.	During the period of preparation of this report, the National Health Service consolidated the process of decentralization, including the process improvement of delegation of functions in the pediatric services provision with resource to the **Medical Technicians** in the sanitary unities of the primary level.

MAIN REPORTED CHALLENGES IN 2009	ACHIEVED PROGRESS TO DATE
ANTIRETROVIRAL THERAPY IN ADULTS	

To ensure a balance adapted between the urgency of the expansion, and the need of ensuring security and quality of interventions, particularly while the numbers of those who are in treatment increase significantly in the sanitary unities of the most peripheral level, initiated and followed by other health technicians, and the number of those that, after some time, pass to more complex regimes.	Care provision and treatment of HIV in Mozambique began in 2003, in alignment with the National Strategic Plan 2004-2008 for the ITs, HIV, and AIDS (National Economic Plan in Health). The treatment was quoted like one of seven priority areas in National Economic Plan II (2005-2009). In National Economic Plan in Health, the approach was always of starting to treat from the form a broad sustainable way in the long term with the general necessities of the sector, using the anti-retroviral treatment as a driving factor in order to balance the HIV approach in the health sector as a whole. The result was a complete and balanced strategy that was covering from the prevention to the diagnosis, cares, treatment, and impact mitigation. Equally and as a pre-requisite, it was ensured which issues like the capacity at all levels should be treated to ensure the treatment and the complexity of the services expansion.
The logistics will continue to be a challenge while the expansion continues besides the current level, in terms of laboratory capacity, supply and management of medicines, and monitoring and evaluation.	Before the decentralization of the services, carried out in the last years, many sanitary unities of primary health care, faced enormous logistics challenges and of quality insurance of the provided care.
Collaboration between the Ministry of Health and community based organizations /NGOs in the area of the domiciliary care (CD) continues to be important for an appropriate treatment program, given the role which the domiciliary care plays in monitoring of the adhesion and of the nutritional psychosocial state in the essential installment and other supports to the patients and families.	With more ARV accessibility, reduction of the serious bedridden patients and a considerable desertions increase to the ARV and absences, the Domiciliary Care Program (CD) in Mozambique re-formulated its national Strategy approved in 2011 that defines how it's operational, formation instruments are constituted, monitoring and supervision.

EXPANSION OF UNIVERSAL ACCESS TO PEDIATRIC ARV

To increase the pediatric AIDS awareness in families and to increase the search of services for infected children, including the precocious childlike diagnosis	At the end of 2010 17.395 children were in antiretroviral treatment, representing an estimated coverage of 19, 5 % - an increase of 10, 5 % comparatively to 2006. However a considerable deficit in the services provision continues to exist.
	The treatment services and care for children living with HIV are being placed closer to house of the people as result of the decentralization process carried out from 2009, as well as the delegation process of current functions in the country. Further more, the MiSAU increased efforts in order that the use of the SMS influenced the precocious childlike diagnosis through the implementation of innovatory technologies such as the use of SMS for delivery of result from the PCR to a patient.
To enable the health personnel to use the algorithm of the Integrated Approach of the Childhood Diseases to identify the children with suspect infection	The Integrated Attention of the Childhood Diseases protocols (AIDI), were updated, in order to include HIV and AIDS, and its dissemination was effectuated in 2008.

MAIN REPORTED CHALLENGES IN 2009	ACHIEVED PROGRESS TO DATE
UNIVERSAL ACCESS EXPANSION TO PEDIATRIC ARV	
To include children in peripheral health facilities with few formed human resources: as soon as the Technicians (and possibly the nurses) are able to prescribe the pediatric ARV, capacity building needs to be facilitated and include practical experience and close accompanied training. The technicians will need to be guided through algorithms clearly established to ensure the quality of care and timely admission to the doctor or to the highest hospital, when needed. The peripheral hospitals also face constraints in terms of psychosocial support availability.	During the period of preparation of this report, the National Health Service consolidated the process of decentralization, including the process improvement of delegation of functions in the pediatric services provision with resource to the Medical Technicians in the sanitary unities at the primary level. The technicians feel more confident in initiating the ARV into the children.
To overcome the reluctance and lack of confidence between health workers in including children for the ARV: it is necessary to improve the accompanied training and regular support supervision	

Timely quality data provision on pediatric ARV and related information, for example, numbers of tested children and HIV positive, number of children who receive Cotrimoxazole, etc., especially at peripheral level.	In 2010, a total of 17.642 children were tested with PCR within the first two months of life and from these, 3.909 with PCR positive result, representing a predominance of 11,3 % between those who were tested. Regarding children tested with HIV quick test with less than 18 months of age, 12.463 were tested from which 2.476 were positive.
JOINT MANAGEMENT OF TUBERCULOSIS AND AIDS TREATMENT	
I track it of the tuberculosis in the places of ARV and other places of cares of HIV it must be strengthened.	A good progress of activities happens in general in the country concerning the TB/HIV integration. From 40.554 patients with tuberculosis tested for HIV in 2010, 61 % are positive of which 25 % started the ARV and 97 % have started the preventive treatment with cotrimoxazol. In 2011, of 41.896 cases tested for HIV, 63 % are positive, from which 91 % are undertaking preventive medicine with cotrimoxazol and 29 % are in ARV.
The increase of the Preventive Therapy implementation with Isoniazida (TPI) in the places of ARV	The number of HIV positive patients who have Preventive Therapy with Isoniazida (TPI), also registered the same growing trend, having registered in 2009 2.429 and 17.064 cases in 2011.
Diagnosis and patients' treatment of TB with X/MDR	According to the PNCT data, of the total of 184 patients diagnosed 144 cases of TB-MDR started the treatment in all the country during the 2011 year, and at present 269 patients are in treatments in all the Country.

MAIN REPORTED CHALLENGES IN 2009	ACHIEVED PROGRESS TO DATE
SUPPORT TO ORPHAN AND VULVERABLE CHILDREN	
To ensure that the Food Subsidy Program becomes an efficient mechanism of social work that includes most of the vulnerable children	22 % of the households with orphan and vulnerable children are receiving some external support.
	In 2010 the Ministry of Women and Social Works assisted 253.770 children in difficult situation of the 301.341 planned in terms of communities, which corresponds to a realization of 84,2 %. These children benefited of manifold support in food products, school materials, kits of different material, poverty certificates, mosquito nets, clothing, in the whole Country.
To expand the unconditional money transfers as an efficient measure of moderating the impact of HIV and AIDS in the most vulnerable population.	THE Ministry of Women and Social Works through its social assistance program in 2011 effectuated regular unconditional money transfers to 267.756 people in poverty situation and incapacitated for the work (old people, people with disabilities, people with chronic disease) of the 252.842 planned, representing a realization of 105,9 %.

To enable the Ministry of Women and Social Works at provincial and district levels in order to ensure a co-ordination of efficient implementation of the measures of social protection.	The Multi-Sector Technical Work Group in OVC, which includes development and civil society partners, does a regular review of the PACOV implementation progress. Besides that, in all the 11 provinces and in 54 districts similar work groups were created.
To enable the families and the communities to answer the needs of the OVC and organize arrangements for access to basic services. The politics of the Government promotes the care of the OVC based in the community, preferably the institutional care.	In partnership with the USAID, the Ministry of Women and Social Works is developing the least care standards and support for COV's
	In partnership with the Save the Children, the Ministry of Women and Social Works developed a guide for the establishment and functioning of child protection committees
	At present, there are nearly 531 community committees supporting the COV's
	There are at present 531 community committees to support OVC;
To ensure that an efficient instrument of monitoring should be established in order to assess the PARPA specific goal for the OVC.	The OVC data base is being developed by the Ministry of Women and Social Works;
Efficient co-ordination mechanisms even at decentralized level between the MEC and Ministry of Women and Social Works are necessary.	The co-ordination has been reinforced between the Ministry of Education, Services of Register and the Ministry of Women and Social Works, through the Multi-Sector Technical Work Group in OVC.
HOUSEHOLDS HEALTH CARE	
Food nutritional support strategies and at short and middle term	In 2011 the MISAU published the Nutritional Treatment and Rehabilitation Handbook. This Handbook indicates the steps and proceedings for treatment of patients classified with acute malnutrition (moderate or serious) in a Hospital, in a Health Center, in a Nutritional Rehabilitation Unity, or any other Unity that provides these care.
	The *Cesta Básica* program (CSB) introduced in 2009 had already covered about 3.500 people in the country. In 2010, it expanded to more districts, in order to attend eligible ARV patients.

MAIN REPORTED CHALLENGES IN 2009	ACHIEVED PROGRESS TO DATE
MONITORING AND EVALUATION	
There is the need of continuing monitoring and implementing studies on the vulnerable groups, adoption of new methods and effective strategies to stop the increase of HIV infection rate	There is a National Survey Plan that, among several issues, it orientates surveys realization in the area of HIV and AIDS to ensure a better understanding of the epidemic development. From these surveys we can list some, namely: - Studies on condoms availability; - The Integrated Biological and Behavioral Survey - IBBS, for the HSH group and sex workers and its launch is expected to be in 2012. - GARPR 2010/2011 in preparation process; - IDS 2011, released preliminary data, to be published in 2012; - Epidemiologic Vigilance, round 2011, report in the conclusion phase.
Preparation of a broad Monitoring and Evaluation operational plan	In the first Term of 2009 the M&E Integrated Plan was finished with Costs Quantification that includes 12 components of the M&E System. It also includes the contribution of different partners. The budgeted plan was also shared at the provincial level and incorporated in the provincial action plan of 2010 and of 2011. Each province identified the priority actions to be implemented for the area of M&E, at the provincial and district levels.
Revitalization of the multi-sector work group on Monitoring and Evaluation	In 2011, in the co-ordination context the multi-sector national answer in HIV and AIDS combat in Mozambique in the "Three Ones" framework principle (the Only One co-ordination organ of the national answer, the only One strategic plan of combat to the HIV and AIDS and the only One M&E system) the Monitoring and Evaluation System (SM&E) of the NSPIII, which aims to accompany in the proactive way the evolution of the epidemic of HIV and AIDS and progress of the actions and interventions was validated.
Strengthening the information flow between the provincial and district structures and the national routine information systems	During the year of 2011 there were carried out 8 (eight) support supervision visits to the provinces (with the exception of Tete, Sofala and Maputo Province) and in this context the supervision of the actions implemented in the context of the answer to the HIV and AIDS was done, with the main objective to enable, to deeNSPand to accompany the POP and PIMAP progress.
Harmonization and standardization of the Monitoring and Evaluation indicators, and of the monitoring tools and mechanisms	

Strengthening the survey and investigation through the development of an evaluation agenda and effective strategy for dissemination and application of the surveys observations.	The process of approximation between NAC, MCT and ONUSIDA began in 2010, in order to create a platform that creates mechanisms of monitoring and investigation plan updating taking into account the priorities defined in the NSPIII.

V. The support of the country development partners

The national answer to the HIV has been strongly supported by the partners of bilateral, multilateral cooperation and organizations of the civil society that strongly contribute in the implementation of strategic plans activities.

Mozambique has been benefiting from the support of the development partners for the implementations of the plans of AIDS combat (PEN).

The President's Emergence Fund for AIDS Relief (PEPFAR) of the Government of the United States of America, the Global Fund for combat of AIDS, Tuberculosis and Malaria, financing through the European Union, the United Nations and bilateral Agencies of Germany, Denmark, Canada, Sweden, United Kingdom and Ireland, do continue to contribute in crucial form to reach the results described in this report.

The Measurement of Expenses in AIDS report (NASA), 2008, reports that the financing levels of the cooperation partners and development continued increasing through the different mechanisms. The partners continue funding actions according to the priorities defined in the driving documents namely NSPIII. It is important to mention in this chapter that the investment in the component of human resources, witnessing the tendency of the partners in the support to a sustainable answer.

It is important to highlight that in spite of the significant economical progress reached by Mozambique in the last years, it continues to be one of the most poor countries of the World and one of the most affected by the epidemic in the sub-region and at Global level, increasing the economical weight of the Government in services provision to answer the demand created by the HIV.
As it is reported in the UNGASS 2010, the support from the development partners continues to be of extreme importance in order to ensure appropriate funding to the national answer. The NSPIII costing will allow the analysis of the implementation cost of the national strategy to 2014. The support of the partners will ensure that the country should have the possibility to reach the marks of the Universal Access to the prevention, treatment and care, at the light of the Political Declaration of High Level of June of 2011. A predictable and supported financial support, from the development partners, will continue to be a need in Mozambique for many years, in all the main development areas. The partners have been supporting the Government in the search of options of financing in order to increase its contribution through the State budget. This measure aims to reaching one of the marks defined at the light of the Political Declaration of New York, particularly in what refers to the shared responsibility in the national approaches.

The integration necessity of HIV actions, as a trans-boundary issue in the Fiscal Scenario of Middle Term that describes with clarity the available funds for the answer to the HIV, is gaining more and more importance and integration of this action is noticeable in the plans and priorities of NAC.

The Fiscal Scenario will provide a safe environment for funding HIV, and it would allow the interconnection of the available resources for the different plans. In this context, the Development Partners, also would like to see the Mozambican Government increasing the funds

of the State attributed for support to the NAC, (national co-ordination multi-sector organism of high level), in the struggle against HIV and AIDS.

HIV continues to be a development issue and requires adjusted interventions and in order to ensure the integration of all in order that all active forces of the society should give their contribute. The co-ordination between the partners and the Government has been improving along the years favoring actions that capitalize the efforts of all both at central level as at decentralized level.

The partners have been supporting the processes of current decentralization in the country and in particular the HIV decentralization approach. This action will allow strengthening the interrelation between NAC and other public sectors namely the Health (MISAU) at central and decentralized level.

The development partners do continue supporting the Ministry of Health in the efforts that it is carrying out to integrate the treatment and care of AIDS patients with other relevant programs, as well as to secure that financing for HIV and AIDS, is included as integrant part of the State budget and not as a special budget for financing of vertical programs.

One of the main challenges in Mozambique continues to be the weakness of the information systems. The development partners must support the reinforcement of strong and coordinated systems for data collection and interpretation, in order to ensure that the power and the NAC decision capacity could provide leadership to guide the HIV and AIDS programs.

To guarantee that the access to the treatment should be every time bigger, the partners must continue advocating an integrated and balanced approach of the national approach, which gives priority to the prevention included in a continuity of prevention, care and treatment. They must continue supporting the NAC and the implementation partners in integrating new HIV and AIDS evidences.

The NAC financing through the common funds continue to be crucial to allow the implementation of the key actions of co-ordination of the answer. This fund does not substitute however the need of more and more sustainable local mechanisms to finance activities of co-ordination of the answer according to the NAC mandate.

It is important to mention that the efforts of development partners to harmonize their requisites and to adapt them to the Government priorities and structures, they need to be maintained, reinforced and monitored, in order to lead to a national approach to the most efficient and sustainable HIV.
The partners have been fulfilling a crucial role in the process of NAC institutional Development as a way of addressing the resultant demand of its mandate. The support is notable in the reinforcement of the co-ordination mechanisms and of the structures and support systems.

As it was indicated in this document the epidemic continues to be one of the great threHTC to the country development and the 2009 INSIDA results demonstrates the fact.

The current efforts seem not to be sufficient, especially in the South of the country where the prevalence is very high. The Mozambique development partners need to continue having a significant role in the support to the Government, to face the challenges specified in this report, in order to stop and revert the HIV epidemic. The results of the impact report show tendencies of a new increase of the number of infections in the central zone from 2015, which reinforce the need of adjusted actions defined on basis of evidences.

VI. Monitoring and Evaluation Environment

This section of the GARPR report reviews the current Information System of the Mozambique National Appoach to the HIV/AIDS (SIRNM) based on twelve components that are important for the successfull functioning of a national system of Monitoring and Evaluation.

It equally analyses the progress made in the implementation of the twelve components of PIMA (Integrated Plan of M&E) which operatioalizes the SIRNM from 2009-2010. The PIMA is an extension of the Principle "The ONE national system of the HIV M&E" (the third of the Three "ONES" Principles), which means to have a PIMA for all the activities of M&E of the HIV during a period of defined time. The PIMA includes implemeting activities not only for the Government of Mozambique through the Executive Secretariate (SE)-NAC, at National and Provincial level, but also those being implemented by the different development partners, umbrella organizations, and NGOs with interventions in the context of HIV.

Component 1: Organizational Structures with HIV Monitoring and Evaluation Functions
In assessment of this comonented it has been noted a progress has been made in this component which identifies a maturation of coordination's structures on M&E countrywide, driven by the decentralization process in line with the realignment of functions of NAC, Governmental body responsible for Monitoring and Evaluation on the fight against AIDS.

An assessment of the progress related to the technical capacity of this coordination body in the operationalization of the main actions defined in the PIMA, and it was noticed that in spite of some registered improvement in this component concerning consolidation of the existent structure, there are still gaps regarding the existent human resources and definition of their profiles in order to answer the demand and the specific needs of this area.

A timely review of the guidind documents was recommended in order to ensure implementation of what has been planned within the expected timeframe. Specific reference was made to the review and preparation of the PIMA as on of the key documents.

In this component, it was also recommended by the assessment, the need for institutionalization of the Multi-sector Technical Group (GTM) to strengthen the capacity of the area of M&E in the specific issues of production of evidences, epidemiologic data, projections and estimates among others.

Preparation of the M&E System of the NSPIII is under way which, is the basis for monitor and evaluate the progress in accordance with the targets and indicators defined in the strategy as well as to visualize the evolution of the epidemic in Mozambique.

The 2012-14 PIMA is the component of the SM&E and it will allow the operationalization of the actions defined in the system. It is important here to refer in this component the integration of M&E sub-system indicators of the private sector as integrant part of the national response.
The submission of information from the key sectors to the NAC has been substantially improving; note that the Ministry of Health as the responsible of a series of key indicators for the HIV has been substantially contributing for SIRNM with its data base information.

The HIV programs coordinated by the Ministry of Woman and Social Affairs (MMAS) have been equally contributing with data referring to the support to the OVC and mitigation of the impact and income generation activities for women affected by HIV. International partners have been supporting the development of data base for the HIV programs in the public sector. The Ministry of Youth and Sports and the Ministry of Education have a specific data base for the youth in school and out of school. This data base contributes with specific information to the adolescents and youth in the componet of sexual and reproductive health and HIV/AIDS.

In the 2010 UNGASS report, it was noticed that an evaluation done by the NAC was indicating NGOs with a more technical qualified staff to manage and use Monitoring data; situation that continues for the biennium 2010-2012.

The annual progress reports show that the lack or limited technical capacity of the community based organizations (OCB) or less advanced ONG has been limiting its contribution in feeding the national system.

The private sector has been showing improvements in the establishment priorities for monitoring of the interventions related to HIV in their enterprises, feeding in systematic way the private sector sub-system.

Challenges

With the operationalization of NSPIII and decentralization of actions of the national response, the biggest challenge continues to be the operationalization of the M&E system in order to capture and integrate information of the different subsystems of the public sector, private sector and the civil society.

Corrective actions to overcome the challenges

- To re-define and to disseminate the NAC role in the co-ordination of M&E actions of HIV/AIDS in Mozambique
- To coordinate training actions in M&E not only at the level of the NAC but also at the level of other sectors involved in the approach (at the central and decentralized level)
- To reinforce the necessity of all the partners to report to the NAC/NPCS as co-ordination organ
- To keep on supporting the public sector in the establishment of M&E sub-system of HIV in the respective plans and programs

Component 2: Human capacity for the Monitoring and Evaluation

In this component progresses were noted in the PIMA implementation through the Unity of M&E centrally and the NPCS. This action counted with the technical support of the partners in the preparation of the provincial PIMA to orient the actions at the provincial and district level.

As it was previously reported the PIMA, Multi-sector budgeted Plan, has in view on its component 2, to reinforce the human capacity for the M&E activities, focused in the definition of needed Human resources (HR), development of HR plan, training in M&E and technical back-up provision.

According to the PIMA assessment, less than 20 % of the planned actions for this component was implemented which clearly indicates the need of urgent actions with objective to cover the gaps of needed human resources for M&E both in number and in its capacity.

At the national level, the team dedicated to the M&E in the NAC, is composed by five staff; a M&E Manager, a data and systems officer and three M&E officers.

At the decentralized level, each NPCS has at least one M&E assistant, having re-defined the role of the data base assistant in the context of the re-definition/realignment of the functions of the NAC. From 2009, the NAC recruited monitoring and evaluation assistants at the provincial level, which provide technical back-up for some Provincial Nucleus and partners.

It is worthy to mention in this component that the implementation of actions in view the development of a basic M&E curriculum for HIV, that aims to support actions of development of capacities in M&E, increase of technical knowledge in M&E and establishment of a uniform training base for M&E area. It is expected that the curriculum is available in 2012, to allow actions of the NAC/NPCS technicians training and implementation partners.

Challenges

- Conclusion and implementation of the national curriculum in M&E for capacity building;
- Implementation of the mission of regular supervision from the central level to the provincial and district levels;
- Improvement of the co-ordination of the technical back-up;

Corrective actions to overcome the challenges:

- The UNAIDS and MEASURE Evaluation will continue to support technically the development and implementation of the curriculum.
- To carry out the seminars of capacity building and of supervision of the planned program, in order to strengthen the M&E officers/assistants and implementation partners at provincial and district levels.
- Technical back-up plan to the developed NAC and of the knowledge of the partners

Component 3: Partnership to plan, coordinate, and manage the HIV monitoring and evaluation system

As it was previously reported the Multi-sector Technical Group (GTM) formed in 1999, composed by members of the NAC and national partners and donors, meets in a monthly basis at the NAC offices. This group includes entities as the NAC, the Ministry of Health (MISAU), National Institute of the Health (INS), National Institute of Statistic (INE), Center of Studies of the Population (CEP); Faculty of Medicine of the University Eduardo Mondlane; the Ministries of Planning and Development, Education, Justice, Interior, and Agriculture, and other government

sectors. Besides that, international organizations, such as USG, CDC, PHI, PSI, ONUSIDA, UNICEF, FNUAP, Measure, DANIDA, GTZ and others participate offering technical back-up to the GTM. Due to the great dimension of the group, several subcommittees were created, to deal with issues like studies and special surveys, and vigilance, including the GTM.

In 2010-2011, the GTM analyzed the results of the epidemiology vigilance 2009 round, it finished the INSIDA disseminated the INSIDA results, and prepared the HIV estimates,

In 2010-2011, the GTM updated the projections of impact, incorporating the results of the epidemiological vigilance round of 2009. The demographic impact and the round 2009 results were approved in 2011.

Challenges

- Functioning of the different subcommittees of the GTM&E;
- Integral and solid participation of the members of the GTM
- Improvement of the co-ordination between the partners of M&E at central, provincial and district level;
- Weak reports presentation by the implementing partners at the provincial and district levels.

Corrective actions to overcome the challenges

- Institutionalization of the GTM
- Creation / reinforcement of the provincial GTM
- To keep on supporting the Work Group in M&E of the provinces in co-ordination of efforts in order to reach the harmonization of the national system of M&E;
- To include in the Memorandum of Understanding with the partners, a chapter to oblige the implementation partners to present reports to the National System of M&E, to the provincial and district levels.
- To involve non regular partners / non members in a structured way in order to catch capture their contribution mainly at provincial and district level.

Component 4: National M&E plan in HIV

The orientation process of Monitoring and Evaluation of the NSPIII is conducted in the participatory manner with the technical support of the National Multi-sector Working Group of Monitoring and Evaluation to allow the development of a National Multi-sector Framework of Monitoring and Evaluation. It also identifies a set of 38 basic indicators, which include the agreed indicators for Monitoring and Evaluation of the UNGASS (GARPR) Declaration. It also defines the data sources for the indicators and another relevant information; the systems that need to be operationalized to ensure the flow, storage, analysis, dissemination and correct use of data and the role of each stakeholder.

The indicators are collected through existent routine information systems, including SIS of the Ministry of Health, as well as through inquiries, studies and surveys conducted with established

periodicity. The data for these indicators are available at the national and provincial level and, some are available at the district level.

In 2011, in the context of the co-ordination of the national multi-sector approach in the combat to HIV and AIDS in Mozambique in the "Three Ones" principle (the ONE co-ordination coordination body of the national response, the ONE strategic plan of combat to HIV and AIDS and the ONE M&E system) the Monitoring and Evaluation System (SM&E) of the NSPIII was validated, which aims to accompany in the proactive form the evolution of the epidemic of HIV and AIDS and progress of the actions and interventions.

Challenges

- To implement national inquiries, such as the DHS, INSIDA and others, in a systematic and regular form, in order to document the knowledge, the behavior and the national prevalence;
- To coordinate the actions of survey between the protection institutions;
- Updating the survey plan.

Corrective actions to overcome the challenges

- To update the national M&E framework, in accordance with NSPIII, 2010-2014;
- To improve the co-ordination between the institutions of inquiry;
- To carry out joint planning between the different institutions are make part of the inquiry group, namely the MISU/INS, NAC, INE, MCT, CDC;
- Regular and systematic Monitoring of the National Approach progress.

Component 5: National Annual budgeted plan of HIV Monitoring and Evaluation

The M&E integrated multi-sector and budgeted plan of HIV is a form of fulfillment of the "Three Ones" principle, through which all the M&E activities are implemented in a coordinated way. This plan also includes actions to be carried out by the Government at the central and provincial levels, and also the activities to be implemented by the partners, nets of organizations, and NGOs working in the area of HIV.

In summary, the budgeted plan is an operationalization tool of the National M&E System of the National response to the HIV, incorporating 12 components of the National M&E System, in Mozambique.

The budgeted plan was shared also at the provincial level and incorporated in the provincial plan of action of 2010 and 2011. Each province identified the priority actions to be implemented for the area of M&E, at the provincial and district levels.

Challenges

- To monitor the implementation of the budgeted plan in a quarterly basis.
- To obtain updating of the financing of the partners.
- To improve participation of the partners during the quarterly review of the budgeted plan.

Corrective actions to overcome the challenges

- To update and implements the PIMA on basis of the presuppositions of NSP III 2010 - 2014.
- To strengthen the co-ordination mechanism, in order to improve the PIMA implementation in its entire 12 component.
- To ensure the implementation and to do the follow-up of the PIMA at all levels.
- To advocate for the importance of M&E in terms of institutions.

Component 6: Advocacy, Communication and Culture for HIV Monitoring and Evaluation

In the period in question the M&E strengthened the process of dissemination and publication of reports, studies and surveys at all the levels on the driving factors of the epidemic, the strategies and epidemiological situation, which contributes greatly to the strengthening in the decision making and definition of priorities in the combat to the HIV in the country.

The M&E started to take a place of distinction in the mandate of the NAC framework, having advocacy strengthened the M&E component during the realignment process.

The great challenge persists in the need of development of actions of advocacy, in the direction of compelling the partners to feed the M&E system of the national approach of combat to the HIV and AIDS. Nevertheless, an improvement was noticed in the communication between the NAC and the great implementation partners in 2010, having presented their 2011work plan.

In 2011 actions of advocacy were developed and capacity building at the level of the provinces in order to improve the understanding on the Data Base. In this sense, a technical support was created in the NPCS of Central and Southern regions as part of the actions carried out for the strengthening of the capacities in the area of M&E during the year 2011. Through the visits undertaken to the provinces it was concluded that the reactivation of the GTM&EP would be fundamental for the functioning of the Data Base, besides bigger programmatic knowledge contents.

Corrective actions to overcome the challenges:

- Continuous updating of the NAC website as one of the main forms of information dissemination;
- To advocate for the increase in value of the use of the information produced by M&E for definition of policies, strategies, planning for decision making;
- Revision of the review periods of the reports at all levels;
- Definition of the periodicity;
- To advocate for the creation of M&E careers in the public sector.

Component 7: Routine Monitoring of the HIV Program

The M&E sector of the NAC is responsible for the consolidation, analysis and dissemination of data with the objective to document the national approach (medical Information and routine non-medical). Nevertheless, each actor is responsible because of reporting back to the M&E of the NAC, as the coordinator of the national approach.

Non Medical Routine Information

One of the tasks of the NAC, area of M&E is the collection, analysis, preparation and dissemination of reports on non medical HIV and AIDS programs, which require time and significant resources.

Public sector

The key ministries of the national approach (Health, Education, Woman and Social Work, Youth, Planning, Finances, Interior, Defense) report back straightly to the NAC.

Private sector

At present, the private Sector is implementing the M&E sub-system in great part of the provinces of Mozambique; this is done through the EcoSIDA.

Corrective actions to overcome the challenges:

- The M&E strengthens in several sectors (public, private and civil society, including the NAC) to ensure that the data of the implementing entities should be reported back in the correct, integral and timely form;
- To promote advocacy or to identify mechanisms to secure that all the stakeholders do report back to the National System of M&E;
- To ensure the implementation of the plan of capacity building and respective materials for a trainer's capacity building in the context of the report system, and written directions simplified on the reports, for the implementing entities.
- To create mechanisms and models of reports centered in the capacity of data for systematic feedback;
- To implement effectively the forms for data collection and what are used by all institutions and partners;
- To develop the internal capacity building for improvement of the quality of data and of reports.

Component 8: Inquiries and Vigilance

There is a National Plan of Inquiries that, among several subjects, it orientates in the realization of the surveys in the area of the HIV and AIDS to ensure a better understanding of the development of the epidemic. From the surveys we can list some, namely:

- The Integrated Biological and Behavioral Survey - IBBS, for the HSH group, sex workers, miners and truck drivers and its publication is hoped to be in 2012.
- The funding of NSPIII in course and its term is in the middle of May of 2012;
- NASA 2009, 2010 and 2011 is planned, from June of 2012;
- GARPR 2010/2011 in preparation process;
- DHS 2011, publication of preliminary data, are going to be published in 2012;
- Epidemiological Vigilance, round 2011, report in the conclusion phase.

Corrective actions to overcome the challenges:

- To carry out the inquiries and planned studies and conclusion of those that is still in force;

- To update the National Agenda of Inquiry for the HIV and AIDS;
- To improve the management for a bigger publication of the inquiry results.

Component 9: National and Sub-national HIV Data Bases

Five data bases were identified as essential for Monitoring and Evaluation. They include:
1. National indicators Data Base
2. Projects and initiatives Data base
3. Results of activities for project and for initiative Data base
4. Survey Data base
5. Financial resources Data base

The important aspect of these data bases is that the information is contained in a uniformed format that is regularly up-to-date and accessible to all the partners.

Indicators of the NAC data base

The NAC data base includes indicators of the national approach of the HIV and is functional and is installed in the NAC in the national and provincial levels and, at this moment it is in the migration phase to the district level.

The people of M&E at provincial level (1 data base assistant, per province) is enabled to collecting data of the implementing entities and other partners and introducing them in the data bases at its level, such as, provincial, district, and Administrative Post. Henceforth, the decentralization will be going to hapNSPfor 40 priority districts in 2012, which means that there will be 40 district Focal Points. This number will be increasing annually and in the same proportion until all the districts of the country are completed.

The process of data collection is done with the help of a questionnaire previously prepared and identified for each net of organizations, where indicators referring to each net. Nevertheless, there are still difficulties for the acceptance of this important instrument by the actors. It important to mention that at this moment the process of updating of this instrument is happening, following what is stated in NSPIII.

It is important to say that there is a need for the partners to provide constant technical back-up to the NAC personnel at all the levels, as well as the continuous updating of the data base, whenever it considers itself necessary.

Indicators Data Base

The ESDEM data base that accommodates all the indicators is still works under the auspices of the National Institute of Statistic. The NAC Information System data base that accommodates all the indicators of HIV exports the data to the ESDEM and the updating is done whenever asked.

Challenges

- To equip the NPCS with equipment and information technologies.
- To ensure the existence and capacity building of the district Focal Points.

Corrective actions to overcome the challenges:

- Review and up-to-date of the forms of the data base, to accommodate the new list of indicators.
- Creation of compelling instrument for updating and feeding of the SIRNM;
- Need of installation of the data base at district level.

Component 10: Support Supervision and Data Auditing

The necessary elements of any system of data are the support supervision and the routine data auditing. The provincial and district structures generally have lack of sufficient human resources and means of transport to travel regularly for distant districts to supervise activities of HIV and data collection.

During the year 2010 there were carried out 2 supervision support visits out of 4 planned having included the provinces of Niassa, Zambézia, Manica, Gaza, Inhambane, Tete and Nampula with the main objective to enable, to deeNSPand to accompany the progress of POP and PIMAP. During the visits the weak monitoring was noted in the provinces due to delay in the funds expenditure for operational costs, difficult follow-up of POP and of the PIMAP, not alignment between the financial and programmatic areas that culminated in weak fulfillment of the work plans.

During the year 2011 there were carried out 8 (eight) supervision support visits to the provinces (with the exception of Tete, Sofala and Maputo Province) and in this context there was done the supervision of the actions implemented in the context of the approach to the HIV and AIDS, with the main objective to enable, to deeNSPand to accompany the progress of POP and PIMAP.

In 2011 a capacity building was conducted for strengthening the capacities in the area of monitoring and evaluation for the hubs of the central region.

Corrective actions to overcome the challenges
As part of the capacity building materials for the provincial and district officers of Monitoring and Evaluation, directions were drawn in writing and forms for supervision of the activities of the implementing entities.

- To carry out workshops for provincial officers of Monitoring and Evaluation in support supervision and data auditing.
- To carry out capacity building to district focal points in matters of M&E and data collection.
- To delegate in some organizations the support supervision, after institutional reinforcement.

Component 11: HIV Evaluation and Survey

The Ministry of Science and Technology has the mandate of the Government to coordinate the whole survey related to poverty, including the survey on HIV and AIDS.

In 2008, a national list of priorities for HIV survey in Mozambique and the first National Program of Survey in HIV was approved. The program has two main pillars: to support the production of qualitative inquiry and to support the dissemination of the results of the inquiry and the institutional survey capacity building.

The Ministry of Health is the highest implementing entity of the survey in HIV, through the National Institute of Health, also accommodating, the National Bioethics Committee. Other actors involved in HIV survey include ministries, universities and NGOs.

The main progress in the survey in the area of HIV, in 2010-2011, can be summarized in the following: conclusion of several great surveys and evaluation studies with national signification, including: i) the NASA (Measurement of Expenses in AIDS), 2008/2009; ii) Study of epidemiologic round of vigilance and of the Demographic Impact of HIV and AIDS, 2011; iii) national Survey of prevalence, behavioral risks and information on HIV and AIDS (INSIDA 2009); iv) National Strategic Plan of Combat to AIDS in Mozambique, 2010-2014; v) Annual Joint Evaluations (ACA 2010 and 2011); v) Integrated Biological and Behavioral Survey - IBBS, for the group of HSH, sex workers, miners and truck drivers; vii) financing the NSPIII; viii) GARPR 2010/2011; ix) IDS 2011.

The process approximation between NAC, MCT and ONUSIDA began in 2010, in order to create a platform that creates mechanisms of monitoring and updating of the plan of investigation taking into account the priorities defined in the NSPIII.

In the area of production of inquiries and studies the preparation of the updating of the national program of inquiries and operational studies began in 2011, activity that will have to be finished along the 2012 year. The process of preparation of the reports on the Demographic Inquiry of Health (IDS), Behavioral Sexual Survey (BSS) and estimates on the level of the impact of the HIV and AIDS in Mozambique has begun. In the same period the protocol was launched by USAID for the realization of the study on the High Risk Groups.

Challenges

- In spite of the efforts, there is still a need of more knowledge based on evidences in the areas of national prevalence, incidence in specific population groups, driving factors of the epidemic, more vulnerable populations, effectiveness of the programs;
- Insufficient co-ordination and dissemination of the survey and not solid;
- Insufficient capacity of use of the results of the survey in the planning and in the adjustments.

Corrective actions

- Development of a National Multi-sector Strategic Plan of HIV and AIDS Survey, of five years, as basis for a co-ordination and national institutional capacity building;
- To review, to update and to implement the National HIV and AIDS Survey Program in a participative way and aligned with the new priorities of the National Strategic Plan;
- To disseminate the Strategy and the National HIV and AIDS Survey Program in all the sectors to increase financing and use of the survey in development program of all the sectors;

- To develop the technical and financial support for the implementation of the priorities of survey and dissemination of results through the National HIV and AIDS Survey Program and the National Survey Fund;
- To strengthen the capacity of production and use of the survey at all levels, including the facilitation of the share of the knowledge between the investigators.

Component 12: Dissemination and Use of Data

It happens, and in an increasing way, a more participation of partners, government, private sector and civil society in the information supply on the actions carried out in the struggle against AIDS, result of the dissemination of information at the national and provincial levels.

It is a general responsibility of the NAC to provide data of easy understanding, useful and addressed to appropriate audiences. The products of information (reports) and the formHTC of use of data and of planning must be organized in order that supports the implementation and fulfillment of NSPIII.

Corrective actions to overcome the challenges:

- There is a great need of ensuring dissemination of the systems and formHTC of presentation of standardized reports;
- To carry out workshops for institutional reinforcement at provincial and district levels;
- Institutional reinforcement in terms of data analysis at district level. To continue producing regularly reports summarized for share at the provincial and district levels;
- Organization of regular meetings of co-ordination and joint planning;
- To develop a policy of "quick" data dissemination;
- To advocate regarding the continuous data use in decision making.

VII. Annexes

I ANNEX 1: Process of consultation / preparation of the Progress Report of the country about implementation monitoring of the Declaration of the Promise in HIV and AIDS for the 2011 year.

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

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

2) With contributions of the Ministries:

Education	Yes
Justice	Yes
Public Works	Yes
Defense	Yes
Interior	Yes
Work	Yes
Finance	Yes
Woman and Social Works	Yes
Youth and Sports	Yes
Civil Society Organizations	Yes
People Living with HIV	Yes
Private sector	Yes
Organizations of the United Nations	Yes
Bilateral	Yes
International NGOs	Yes
Universities	Not

3) Was the report discussed in extended forum? Yes

4) Were its results filed at central level? Yes

5) Are the data available for public consultation? Yes

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

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

Date: 31st of March of 2012

Signature: _____

Address: Rua António Bocarro, 106/114 – Maputo

Email: diogo.milagre@NAC.org.mz
Telephone: +258 21 495 604/5; +258 21 495 396; **Faxes**: +258 21 485 001 or +258 21 495 395.

ANNEX 2: National Commitment and Political Instruments

Country: Mozambique

Name of the Officer in Charge in the National Council of AIDS:

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

Address: Rua António Bocarro, 106/114 – Maputo

Email: diogo.milagre@NAC.org.mz

Telephone: +258 21 495 604/5; +258 21 495 396

Faxes: +258 21 485 001 or +258 21 495 395

Submission Date: 31 of March, 2012

ANNEX 3: National Financing Matrix— 2011

Country: Mozambique

Contact Person at National AIDS Authority
Name: Páscoa Themba **Title:** Responsible for the Planning Unity and M&E

Information of contact of the Authority/National AIDS Committee

Address: Rua António Bocarro, 106/114 – Maputo

Email: pascoa.themba@NAC.org.mz

Telephone: +258 21 495 604/5; +258 21 497 595

Faxes: +258 21 485 001 or +258 21 495 395

Report Presentation Cycle: 2007 and 2008 civil year

Local Currency: Meticais

Average currency Exchange with US dollar during the report presentation: 2007: 25,29
2008: 24,43

Methodology: The measurement of AIDS Expenditures provided data for the National Financing Matrix.

Excluded Expenditures: Some expenditure of some activities in some of the AIDS expenditure categories was not included in the National Financing Matrix due to the lack of information availability.

Budget Support: The Budget support of the BI- and Multi-lateral, that are integral part of Public Funding, is which exclusively includes the support to Central Budget. The Direct support, even when budgeted, to the MISAU and NAC sectors, was attributed to the respective funding sources at the level of its effective contribution along the year (pró-rate).

Expenditure Categories per type of funding and year (US$ thousands)

Expenses Categories	Public		Private		International		Total	
	2007	2008	2007	2008	2007	2008	2007	2008
Prevention	1.959	1.123	294	787	23.880	38.332	26.134	40.243
Treatment and Health Care	1.648	1.358	85	133	26.832	40.245	28.566	41.736
Orphans and Vulnerable children	0	0	55	9	9.185	12.584	9.240	12.593
Program Management and administration	2.252	2.252	60	258	30.511	33.576	32.823	36.086
Human Resources	4	140	168	220	4.884	8.127	5.056	8.487
Social Protection and social services (excluding COV)	30	0	30	67	869	1.832	928	1.900
Apropriate environment	24	161	2	3	1.784	2.334	1.811	2.497
Survey related to HIV and AIDS (Excluding operational survey)	49	0	0	2	629	2.877	678	2.880
Total	**5.967**	**5.033**	**694**	**1.479**	**98.575**	**139.908**	**105.236**	**146.421**

ANEXO 4: List of Participants in the GARPR Evaluation workshop

Ref.	Name	Title/Institution	Office contact	Celphone	E-mail
1	Agy Mecusseriza	CISLAMO			cislamo@yahoo.com.br
2	Alzira Ferreira	TEBA		824753975	
3	Amata Kwitera	JHU.CCP-PACTO		824008080	akwitera@jhuccp.org.mz
4	Amélia Olga A. Zawangoni	UNFPA		844000005	
5	António B. Mabjaia	TDMSA		823085030	amabjaia@tdm.mz
6	April Kelley	Embaixada dos EUA – PEPFAR	21 49 27 97 ext. 3011	84 32 27 320	kelleyal@state.gov
7	Arminda Maculuve	NAC		843200440	
8	Augusto Guambe	LAMBDA-MOZ		847040345	aguambe@lambda.org.mz
9	Balbina Santos	ECOSIDA	21 32 72 02	82 32 37 080	balbina.santos@ecosida.org.mz
10	Benedito Ngomane	NAC			benedito.ngomane@NAC.org.mz
11	Cacilda Machiana	MJD			cacildamachiana@yahoo.com.br
12	Carlos Sotomane	A Politécnica		829352286	csotomane@apolitecnica.ac.mz
13	Cecília Martine	NAC			
14	Cecília Uamusse	NAC		824132980	
15	Daniel Shodell	CDC-USG			shodelld@mz.cdc.gov
16	Delmira Petersburgo	JHU.CCP-PACTO		823053208	dpetersburgo@jhuccp.org.mz
17	Donata Galloni	Medicos com AFRICA CUAMM		829001730	
18	Egídio Langa	MISAU-PNC TB			egidiolanga76@gmail.com
19	Eleonor Hill	GIZ		825140018	eleonor.hill@giz.de
20	Ernesto Martins	Rádio Moçambique		827009437	
21	Esmeralda Xavier	NAC		822639570	
22	Ferdinando Alueib	TEBA DEV		823010678	
23	Filipe Mabutana	Rádio Moçambique			fmabutana@gmail.com
24	Francisca Sales	MMAS		823177930	
25	Francisco Mbofana	Instituto Nacional de Saúde			mbofana98@yahoo.com
26	Hélio Maguio	MISAU			heliomaguio84@yahoo.com.br
27	Humberto Manoca	ADPP			manocah@yahoo.com
28	Joel Samo Gudo	Consultor	21 492725/492967	843132280	joel.sgudo@escopil.co.mz
29	Laurinda Manuel	RENSIDA		845171110	
30	Lina Timana	UNESCO		829727840	
31	Linda Chongo	MONASO		823922420	advocacia@monaso.co.mz
32	Lourenço Lampião	NAC			lourenco.lampiao@NAC.org.mz
33	Luisa Brumana	HIV/AIDS Specialist-UNICEF	21 48 11 00 ext.416	82 85 72 532	lbrumana@unicef.org
34	Márcia Monjane Matenja	USAID		823053814	
35	Marco Hanitzsch	GIZ/NAC			marco.hanitzsch@giz.de

36	Marcos Benedetti	Pathfinder Internacional		843056256	mbenedetti@pathfinder.org
37	Maria Joao Nazareth	JSI/MEASURE EVALUATION		823031442	
38	Maria Violantenice	ICAP			violantenice@columbia.org.mz
39	Marina Chichava	PPF Secretariat -GIZ	21 48 76 45	82 71 06 450	marina.chichava@giz.de
40	Maronos C. Mhampa			849514867	
41	Marta Bazima	M&E Officer - UNAIDS	21 484 524 ext.	84 38 95 469	bazimam@unaids.org
42	Massimiliano Sani	Communication Specialist-UNICEF	21 48 1100		masani@unicef.org
43	Maurício Santos	NAC		828831480	
44	Natividade Bule	ECOSIDA		823053960	natividade.bule@ecosida.org.mz
45	Nazir Amade Ibrahimo	MISAU		823136000	naibrahimo@yahoo.com.br
46	Nuno Gaspar	NPO HIV and Gender – UNFPA		82 41 71 622	gaspar@unfpa.org
47	Páscoa Themba	NAC			
48	Paula Simbine	CDC		823223610	
49	Peter Young	CDC			youngp@mz.cdc.gov
50	Quenissone Amburete	MISAU-PNC HIV/SIDA		826540293	
51	Rui MapHTCe	Consultor		826923446	rmapHTCe@gmail.com
52	Rui Maquene	Handcap International		82 47 28 750	himozcdp2@tvcabo.co.mz
53	Sally Griffin	Coordinator	21 310328/82 3013902	82 65 19 261	coordenacao@naima.org.mz
54	Sansão Buque	MMAS		823265860	
55	Selma Lalá	STV-Moçambique em Acção		824932390	selma.lala@soico.co.mz
56	Shawn Wesner	Deputy PEPFAR Coordinator	21 49 27 97	84 30 13 899	wesnerse@state.gov
57	Sumaira Chowdhury	Protection Specialist - UNICEF	21 48 11 00 ext 472	82 74 74 351	sachowdhury@unicef.org
58	Tatiana Bocharnikova	MISAU-PNC HIV/SIDA		823073276	
59	Valeriana Rufino	PSI		828621980	vrufino@psi.org.mz
60	Ximena Andrade	WLSA			ximenafrancisca@gmail.com

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