



MOZAMBIQUE NATIONAL AIDS SPENDING ASSESSMENT:

2017 AND 2018

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Abbreviations

AfDB	Africa Development Bank
AGYW	Adolescent girls and young women
AIDS	Acquired Immune Deficiency Syndrome
ASC	AIDS Spending Category
ART	Antiretroviral therapy
ARV	Antiretroviral
ASC	AIDS Spending Category
BP	Beneficiary Population
CHAI	Clinton Health Access Initiative
CMAM	Central Medical Stores (Central de Medicamentos e Artigos Medicos)
CNCS	National AIDS Council (Conselho Nacional de Combate ao HIV/SIDA)
COP	Country Operational Plan (PEPFAR)
CSO	Central Statistical Office
DCT	Data Consolidation Tool
DSD	Differentiated service delivery
DTG	Dolutegravir
EA	Expenditure analysis (PEPFAR data)
EID	Early infant diagnosis
ER	Expenditure Report (PEPFAR data)
EU	European Union
FE	Financing entity
FAP	Financing agent – purchaser
FSW	Female sex workers
GAM	Global AIDS Monitor (formerly GARPR)
GDP	Gross Domestic Product
GDI	Gross domestic income
GF	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GoM	Government of Mozambique
GTM	Multisectoral Technical Working Group (Grupo Técnico Multisectoral)
HIV	Human Immunodeficiency Virus
HTC	HIV testing and counselling
HSS	Health systems strengthening
INE	National Institute of Statistics (Instituto Nacional de Estatística)
MARF	Monitoring of AIDS Financial Resources
MINED	Ministry of Education and Human Development
MISAU	Ministry of Health
MEF	Ministry of Economy and Finance
MSM	Men who have sex with men
MZN	Mozambican metical (local currency)
NASA	National AIDS Spending Assessment
NDP	National Development Plan
NGO	Non-governmental organisation
NHA	National Health Accounts
NSP	National strategic plan for HIV/AIDS response
NSF	National Strategic Framework
OOP	Out-of-pocket payments
OVC	Orphans and vulnerable children
PEN-IV	National Multisectorial Plan on HIV and AIDS: 2015-2020. (Plano estratégico para o combate ao HIV/SIDA)
PEP	Post-exposure prophylaxis
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PF	Production factor
PID	People who inject drugs
PLHIV	People living with HIV

PMTCT	Prevention of mother-to-child transmission
PrEP	Pre-exposure prophylaxis
PS	Provider of services
PxQ	Price multiplied by quantity
REV	Financing revenues
RTT	Resource Tracking Tool (NASA)
SBC	Social behaviour change
SDM	Service delivery modality
SHA	System of Health Accounts
SCH	Financing schemes
SPES	Social protection and economic support
STI	Sexually Transmitted Infection
TB	Tuberculosis
TWG	Technical working group
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNGASS	United Nations General Assembly on HIV/AIDS
USD	United States dollar
USG	United States government
VMMC	Voluntary medical male circumcision
WB	World Bank
WHO	World Health Organisation

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Executive Summary

This National AIDS Spending Assessment (NASA) for 2017 and 2018 builds on previous NASAs in Mozambique, and thus provides valuable time-trend data and insights into national priorities, allocative decisions, equity and efficiencies in HIV spending.

The total HIV spending in Mozambique reached 508.5 million United States dollars (US\$) in 2017 and increased by 7% to US\$545.4 million. This equated to \$35.59 per capita (>15 years) and \$242 per PLHIV in 2017 (increased from \$25.2 and \$225.2 respectively in 2014). Since 2014, the total HIV spending had dramatically increased with annual average increases of 18% till 2017, which displays the country's commitment to the HIV response. However, these increases were driven by development partners' contributions (international financing entities), which made up 97% of total HIV spending in 2017 and 2018. The Mozambican Government's contributions from public revenue, while importantly increasing in 2018 by 13%, only made up 2% of the total HIV spending, while private financing entities contributed 1%, in both years. Hence the sources of revenue for the financing schemes were primarily direct foreign transfers (97% in both years).

The country's dependency on international financing entities for the HIV response is somewhat mitigated by the fact that large portions of the external funds are channeled through government financing schemes (73% and 69% in 2017 and 2018, respectively). Financing schemes are the main types of financing arrangements through which people obtain health services. For example, the large amount of funding from international financing entities that flows through the Mozambican Central Medical Stores (CMAM) for the procurement and distribution of ARVs, directly benefiting people living with HIV (PLHIV), is labelled as government financing schemes. There were 28% of funds in 2018 (increased from 23% in 2017) which were channeled through development partners with in-country offices (resident foreign agencies') schemes, which primarily went towards programme enablers and systems strengthening and prevention efforts.

Despite the larger portions of financing going through the direct foreign transfer schemes, the bulk (72% and 73% in 2017 and 2018 respectively) were managed by international financing agent-purchasers (the majority of which were the PEPFAR implementing partners who made all the key programmatic decisions regarding funds from the American Government). Only US\$ 130 million and US\$ 135 million (26% and 25% of total HIV funds) were managed by public financing agents-purchasers (FAPs). Since FAPs are defined as the economic units that collect revenue, pool financial resources, pay for the service provision, and take programmatic decisions (allocation and purchase modalities), these declining public FAP proportions could imply the government's reducing control over financing for the national response.

Consideration of the provincial burden of disease in terms of numbers of PLHIV showed a range from \$92 per PLHIV in Maputo Province to \$257 in Inhambane. There appeared to have been mostly an equitable distribution of funds based on

need in 2017 – mostly driven by the numbers of ART patients in each province – the ART unit of expenditure per person on ART ranged from \$170 in Maputo Province to \$239 in Niassa.

Public HIV service providers consumed an increasing portion of the HIV funds in the delivery of HIV services (34% in 2017 and 44% in 2018), while international NGOs consumed 11% and 13% in service delivery and local NGOs only 2% and 1% in each year. A large portion of HIV funds were spent by PEPFAR's implementing partners and their sub-recipients (which could not be disaggregated by type of organization), but lumped together they used 52% and 40% of total HIV funds in 2017 and 2018, respectively.

The care and treatment programme consumed the largest, but decreasing, portion of funds, from 48% in 2017 to 43% in 2018, followed by programme enablers and system strengthening (32% and 34%, respectively). Prevention spending increased over the period, from 11% to 13%, of which larger portions went to the Five Pillars of Prevention (80% of all prevention spending in 2018), while HTC also increased from 6% to 8% of total spend in 2018. These increases represent important efforts to achieve the 90-90-90 targets, which are still some way from being realized. The other NASA programme areas had very low spending (social protection and economic support, social enablers), with zero spending reported on development synergies. These enablers are important for ensuring the optimal uptake and impact of programmes, and additional efforts to support these may need to be considered.

The bulk of HIV services were facility-based delivery modalities (taking 57% and 62% of total spending in the two years), and very little (2% in both years) through community-based modalities. At the time of the NASA, differentiated models of service delivery had not been scaled up in Mozambique. These differentiated models might provide more efficient options, although research in the region indicates that they are not necessarily cheaper, but are more accessible and convenient for PLHIV and could potentially decongest public facilities and improve retention in care (Nichols *et al*, 2020, Guthrie *et al*, 2020).

PLHIV were the main beneficiaries of the HIV spending in Mozambique (39% in 2018), due to the larger portion being spent on care and treatment, while there was 40% that went on non-targeted interventions (mostly for the large programme enablers and systems strengthening spending). In 2018, 10% went towards the general population, 9% to vulnerable and accessible populations and only 2% for key populations. Considering the main modes of transmission, funding might need to be directed towards interventions which target the most at risk.

Consideration of the production factors (inputs) per intervention and their programme performance (outputs) illustrated that the ART programme had achieved valuable technical efficiencies (mainly through reducing ARV costs) and economies of scale with increasing volumes, hence leading to reduced units of expenditure per person on ART. Further saving could possibly be made through

differentiated models of service delivery - although these had not scaled up to a meaningful level in 2018.

The VMMC programme displayed possible inefficiencies in delivery due to reducing numbers of circumcisions being performed in 2018, leading to a greater unit of expenditure, driven partly by increasing operational and recurrent costs. These could be examined further and demand-creation efforts might be required, in order for economies of scale to be achieved.

The comparison of spending with the estimated resources needed for the PEN-IV in 2017 and 2018 shows potential funding gaps, when including only comparable interventions. It is possible that these gaps drove the efficiencies that were made, by forcing reduced spending, or they resulted in lower performance than was targeted. In the case of ART, the savings made caused the lower-than anticipated spending while still achieving the annual ART targets. Consideration of the prioritization of actual spending versus the anticipated shares required to achieve the PEN-IV targets, showed some alignment of spending with national priorities, and hence allocative efficiencies may have been achieved. However, there remained an under-prioritization of condoms and key population interventions, which the country could reconsider.

The NASA assessment is not intended to be a full programme evaluation methodology, so cannot delve into the details of reasons for seeming inefficiencies (either technical or allocative) but seeks to shine a light on areas that might need further examination.

The findings of this NASA have fed into the country's funding request to the Global Fund and into the PEN-V development and costing. They shall provide the data for the annual Global AIDS Monitor (GAM) report and PEPFAR's Country Operational Planning process. Additional formats and outputs will be generated to ensure the optimal utility of these data. Additionally, in order to further routinize and institutionalise the process to allow for the annual collection of HIV-related expenditure data (rather than survey-style NASAs every few years), the country could consider requesting all development partners to submit their expenditure data, according to a common classification system (such as the NASA categories), for CNCS to collate, analyse and present in different formats that would inform policy decision-making and programmatic planning timeously.

In conclusion, financing for HIV should be viewed within the broader movement towards universal health coverage, and therefore as contributing to health systems' development, as well as to broader multi-sectoral development. To this end, cross-sectoral and multi-stakeholder financing will be essential to maintain and expand the HIV response in Mozambique and to ultimately achieve universal health care coverage. However, given the uncertainty of international financing for HIV, exacerbated by the demands of COVID-19, Mozambique's HIV response is highly vulnerable to shocks from reducing development partners' contributions. It would therefore be important for the government to attempt to increase its public revenue

for HIV and to explore alternative, or innovative, funding options. A suggested innovative solution was the capitalizing on the national gas sector.

Table 1: Summary of Mozambican NASA Findings (US\$ millions, 2017-2018)

Summary of HIV Spending in Mozambique	2017		2018	
	US\$ millions	%	US\$ millions	%
Spending on HIV/AIDS				
Total spending	508.5		545.4	
Total spending per capita (US\$)	18.2		19.1	
Total spending per adult >15 anos (US\$)	34.2		35.6	
Total spending per PLHIV (US\$)	242.1		247.9	
Prevention spending per adult (US\$)	3.7		4.6	
ART spending per ART patient (US\$)	207.0		190.0	
Total HIV spending as a percentage of GDP (%)	0.0		0.0	
HIV spending by Financing Entities	508.5	0%	545.4	0%
Public FE	10.7	2.1%	12.1	2.2%
Private FE	5.1	1.0%	4.7	0.9%
International FE	492.7	96.9%	528.6	96.9%
HIV Revenues	508.5	0%	545.4	0%
Transfers from government domestic revenue	10.7	2%	12.1	2%
Compulsory prepayment	4.2	1%	4.1	1%
Other domestic revenues	0.8	0%	0.6	0%
Direct foreign transfers	492.7	97%	528.6	97%
HIV Schemes	508.5	0%	545.4	0%
Government schemes	371.6	73%	375.7	69%
Compulsory private insurance schemes	4.2	1%	4.1	1%
Household out-of-pocket	0.7	0%	0.5	0%
Not-for-profit organisation schemes (resident)	12.7	3%	13.3	2%
Resident foreign agencies schemes	119.1	23%	151.7	28%
Enterprises (for-profit) schemes	0.1	0%	0.2	0%
HIV Financing Agents-Purchasers	508.5	0%	545.4	0%
Public FAP	130.0	26%	134.8	25%
Private FAP	14.6	3%	10.9	2%
International FAP	363.8	72%	399.7	73%
HIV spending by Providers of Services	508.5	0%	545.4	0%
Public sector providers	173.0	34%	241.4	44%
Non-profit providers	9.7	2%	7.4	1%
Private for-profit	4.3	1%	4.1	1%
Multilateral country offices	3.4	1%	2.7	1%
INGOs	55.0	11%	69.0	13%
PEPFAR IP / service providers (lumped)	263.1	52%	220.7	40%
HIV spending per Service Delivery Modality	508.5	0%	545.4	0%
Facility-based service modalities	287.9	57%	337.2	62%
Home and community based service modalities	24.8	5%	10.8	2%
Modalities not disaggregated	32.4	6%	12.6	2%
Non applicable (ASC which does not have a specific SDM)	163.3	32%	184.4	34%
Modalities n.e.c.	-	0%	0.4	0%
HIV spending per Beneficiary Population	508.5	0%	545.4	0%
PLHIV	243.7	47.9%	212.7	39.0%
Key populations	3.4	0.7%	8.5	1.6%
Vulnerable & accessible populations	48.5	9.5%	47.1	8.6%
General population	52.3	10.3%	56.1	10.3%
Non targeted spending	160.6	31.6%	221.0	40.5%
HIV spending by Production Factors	508.5	0%	545.4	0%
Current expenditure	457.1	89.9%	512.8	94.0%
Capital expenditure	44.5	8.8%	32.2	5.9%
PF not disaggregated	6.9	1.4%	0.4	0.1%

Table 2: Mozambican regional HIV spending (US\$ millions, 2017-18)

HIV spending by regions & provinces	2017		2018	
	US\$ millions	%	US\$ millions	%
HIV spending per province	US\$ millions	%	US\$ millions	%
North Region	63.6	12.5%	29.2	5.4%
Cabo Delgado	18.7	3.7%	9.3	1.7%
Niassa	8.6	1.7%	4.8	0.9%
Nampula	36.3	7.1%	15.1	2.8%
Central Region	168.2	33.1%	77.7	14.2%
Tete	21.6	4.2%	10.8	2.0%
Zambézia	67.9	13.3%	26.8	4.9%
Manica	34.7	6.8%	17.9	3.3%
Sofala	44.0	8.7%	22.2	4.1%
South Region	135.4	26.6%	72.1	13.2%
Inhambane	28.3	5.6%	15.6	2.9%
Gaza	41.0	8.1%	19.1	3.5%
Maputo Cidade	33.1	6.5%	19.5	3.6%
Maputo Província	33.1	6.5%	18.0	3.3%
National level spending	141.3	27.8%	366.4	67.2%
Not disaggregated	10.4	2.0%	224.7*	41.2%
National level	130.8	25.7%	141.7	26.0%
Total HIV spending	508.5	100%	545.4	100%

*In 2018 the PEPFAR ER data were not disaggregated by province

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1. Introduction and background

At the 2016 High Level Meeting on Ending AIDS¹, countries, including Mozambique, committed to achieve the Fast Track target to end AIDS by 2030 (UNAIDS, 2020). To facilitate this, Target 8 states: “Ensure that HIV investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers”.

The Government of Mozambique (GoM) continues to implement its National Multisectorial Plan on HIV and AIDS – PEN-IV (2015-2020), along with various sectorial plans for comprehensive prevention, treatment, care and support initiatives. This process is coordinated by the national AIDS council: Conselho Nacional de Combate ao HIV/SIDA (CNCS).

In an environment of scarce resources, it is essential to systematically track HIV/AIDS expenditure across sectors (prevention, care and support and treatment), and financing sources. In order to measure progress towards this target, and ultimately to achieve universal access to HIV prevention, care and treatment, and support services, each country must be able to timeously identify the use of financial resources allocated to HIV/AIDS response. Thus, in line with the UNGASS Declaration of Commitment on HIV/AIDS, UNAIDS in collaboration with governments, has developed a system to estimate the resource flows and levels of spending for the response to HIV at the country level through the implementation of the National AIDS Spending Assessment (NASA).

The NASA methodology provides strategic information on the effective allocation of financial resources and their use in the different focus areas of the national multisectoral response, providing some insight into the degree of allocative efficiency. The NASA framework estimates the financing flows and expenditures from their origin (i.e. the financing entity) through the financing agent/purchaser to the service provider, and to their final destination (i.e. the interventions, their production factors and the beneficiaries of the goods and services) in all sectors. Importantly, the NASA 2020 framework added the vectors of financing revenue and financing scheme, to better understand the flow of HIV funds in the country and to identify issues of potential vulnerability or sustainability. Additionally, the new vector of service delivery modality allows for the comparison of efficiency between differentiated service delivery (DSD) – as far as available data allows. Comparing expenditure against its outputs, in a simple unit of expenditure analysis, also allows for further exploration of value for money and identification of areas of potential technical (in-) efficiencies – although without detailed programme evaluations, this level of analysis is somewhat limited.

The HIV/AIDS financing system is highly complex and dynamic and should follow four ethical principles: a) to work towards the prosperity of mankind; b) to respect the autonomy of the communities; c) to be prudent regarding policy making; and d) to guarantee financial transparency (UNAIDS, 2020). NASA therefore attempts to

¹ <https://hlm2016aids.unaids.org/index.php/en/home/>

provide insight and evidence as to whether these are being achieved by the HIV financing in a country.

Mozambique has a strong tradition of monitoring its HIV spending, and as early as 2005, the country piloted its first NASA as part of the key monitoring function of the CNCS. Following this pilot, the CNCS and other strategic ministries, multilateral and bilateral organizations undertook a comprehensive NASA in 2008 to track HIV expenditure for 2004, 2005 and 2006². Thereafter, NASAs for the years 2007-2008, 2010-2011 and 2014 have been conducted, as an essential component of ongoing monitoring of the national response.

In terms of utilisation of NASA data, the 2010 and 2011 results served as key inputs for the evaluation of the PEN III and into the funding request made to the Global Fund (GF) proposal in 2014. It was also the first time that provincial level data could be used to reflect the decentralised approach of the Mozambican Poverty Reduction Action Plan (PARP). The 2014 exercise importantly integrated programmatic and epidemiological data into the analysis, which generated an assessment of some measure of allocative and technical efficiencies of the HIV response. The results were used to project the financial gap of the PEN-IV implementation (as well as for PEN-III and PEN-IV) and to support funding applications to the Global Fund and the United States Government (USG) President's Emergency Plan for AIDS Relief (PEPFAR).

The NASA 2017 and 2018 results presented here allow for further provincial analysis - although 2018 data were limited by the new PEPFAR expenditure reporting (ER) data which no longer have a sub-national identifier – and explore alignment of funding to the PEN-IV national priorities (allocative efficiencies), the adequacy of funding and potential funding gaps, the financing architecture and flows highlighting areas of over dependence on external aid, value for money as well as identify areas of potential efficiency gains. These data fed into the development and costing of PEN-V, the annual reporting to Global AIDS Monitor (GAM), the country's GF application (preliminary NASA results informed the funding landscape), the PEPFAR Country Operational Plan (COP) process and other important sustainability planning and resource mobilization efforts.

1.1. Mozambique country context

Located in south-eastern Africa, Mozambique is a low-income country and borders Tanzania, Malawi, Zambia, Zimbabwe, South Africa and Mozambique. In 2018, the Mozambican population was projected to reach 27.8 million (National Institute of Statistics, INE. 2018³), of which two-thirds live and work in rural areas. The official language in Mozambique is Portuguese. Mozambique is also strategically located; four of the six countries it borders are landlocked, and hence dependent on Mozambique as a conduit to global markets. Therefore, Mozambique's economic,

² <http://www.unaids.org/en/dataanalysis/knownyourresponse/nasacountryreports#M>

³ <http://www.ine.gov.mz/estatisticas/estatisticas-demograficas-e-indicadores-sociais/projeccoes-da-populacao>

political, and social development are important to the stability and development of Southern Africa as a region. However, Mozambique faces vulnerabilities due to numerous factors, including the political crisis, climate-related humanitarian crises, and more recently, the COVID impact – all of which impact upon the availability of funding for the HIV response.

1.2. Mozambique's economic situation

Mozambique is endowed with ample arable land, water, energy, as well as mineral resources and newly discovered natural gas offshore; three, deep seaports; and a relatively large potential pool of labor. According to the Africa Development Bank (AfDB, 2020), Mozambique's economic activity slowed between 2016–18, to an average of 3.7%, compared with 6.7% in 2015. This reduction resulted mostly from a decline in public and foreign direct investment. Inflation dropped to 3.9% in 2018 and 3.4% in 2019, reversing the high level that had been reached in 2016 and 2017. Limited currency fluctuations since June 2017, stable food prices, and monetary tightening have supported the low inflation. The fiscal deficit remained fairly high, at 6.4% in 2019 (AfDB, 2020). Also in 2019, Cyclones Idai and Kenneth caused massive damage to infrastructure and livelihoods, further lowering economic growth and negatively affecting wellbeing of the population.

The COVID-19 pandemic presents a further setback on the country's economic prospects, and dims the short-term growth prospects. The crisis and measures introduced during the State of Emergency (March – Aug 2020) will have a heavy impact on economic activity, as social distancing and travel restrictions (domestically and globally) affect demand for goods and services. In September 2020, the Public Disaster Situation substituted the State of Emergency and in November, measures were further eased to lift travel restrictions and reactivate economic activity. Reduced demand and prices of commodities have slowed the pace of investment in gas and coal, two key industries for Mozambique. With this, economic growth is expected to decline to 1.3% in 2020, down from a pre-COVID forecast of 4.3%, with significant downside risks. Mozambique will likely experience reduced external aid and increased financing gaps in 2020 and 2021, in a context characterized by exposure to external shocks and limited fiscal space (World Bank, 2020).

1.3. HIV situation in Mozambique

In 2019, there were an estimated 2.2 million people were living with HIV (PLHIV) in Mozambique - the second highest number in the world - of which 150,000 are children (aged 0-14 years) (UNAIDS, 2019⁴). Among the adult population living with HIV (+15 years) 62% were women (1.3 million), and new HIV infections among women were 1.4 times of those among men (69,000 vs 49,000). The HIV prevalence among adults (15–49 years) was estimated at 12.4% and an estimated 130,000 people were newly infected with HIV per annum (also the second highest number of newly infected in the world). The primary mode of transmission is through

⁴ Mozambique HIV Fact Sheet: <https://www.unaids.org/en/regionscountries/countries/mozambique>

unprotected heterosexual intercourse (close to 90% of cases) and mother to child transmission. The number of AIDS-related deaths has been declining since 2010, with a 20% decrease from 63,000 to 51,000 in 2019 (UNAIDS, 2019).

The 90–90–90 Fast Track targets envision that, by 2020, 90% of PLHIV will know their HIV status, 90% of people who know their HIV-positive status will be accessing treatment and 90% of people on treatment will have suppressed viral loads. In 2019 in Mozambique: 77% of PLHIV knew their status, 60% were on treatment (1,300,000) and 45% were virally suppressed. This corresponds to significant gaps toward achieving the 90-90-90 targets given that 77% PLHIV were aware of their status, of which 77% of which were on ART, and finally 75% of which were virally suppressed. In 2019, the percentage of people living with HIV and tuberculosis who were being treated for both diseases was 83% (UNAIDS, 2019).

More than 95% of pregnant women living with HIV had accessed antiretroviral medicine to prevent transmission of the virus to their baby in 2019. Early infant diagnosis—the percentage of HIV-exposed infants tested for HIV before eight weeks of age—stood at 71%. However, the vertical transmission rate remains high at 14% - largely due to mothers who are infected with HIV while pregnant (12% of new infections) or breastfeeding (32% of new infections) (UNAIDS, 2019). In response, the country is scaling up routine testing throughout pregnancy and breastfeeding and has plans to expand the provision of pre-exposure prophylaxis (PrEP) to include pregnant and breastfeeding women.

2. The National AIDS Spending Assessment in Mozambique

2.1. Objectives and scope of the NASA in Mozambique

The overall goal of this NASA was to contribute to the strengthening of comprehensive tracking of actual spending (from key financing entities) on the national response to HIV and AIDS in Mozambique, for the years 2017 and 2018, with a level of analysis that will allow program management decisions and the measurement of progress of financing the operationalization of the PEN-IV.

Specific objectives of the assessment were:

1. To implement the new NASA 2020 framework for systematic monitoring of HIV financial flows at the national and provincial levels in Mozambique.
2. To apply the new NASA 2020 classifications, the NASA data collection tool (DCT), and the NASA Resource Tracking Tool (RTT).
3. To conduct an HIV spending assessment focusing on public and development partner (international) resources and including private (both for-profit and not-for-profit) entities known to be contributing to HIV activities *but excluding medical insurances and out-of-pocket payments (OOP)*.
4. To estimate the expenditure on STIs, and the assessment includes HIV/TB spending but *excludes TB* spending.

5. To identify and measure the flow of resources for HIV applying the latest NASA 2020 vectors and classifications, including:
 - a. financing entity (*FE*),
 - b. revenue (*REV*),
 - c. financing scheme (*SCH*),
 - d. financing agent-purchaser (*FAP*),
 - e. service provider (*PS*),
 - f. service delivery modality (*SDM*), function/ intervention (*ASC*),
 - g. cost components (factors of production, *PF*) and,
 - h. beneficiary populations (*BP*).
6. To prepare a report of expenditure trends that will inform the development of Sustainability Plans; evaluation of the PEN-IV and the development of PEN-V; the Global Fund funding request; PEPFAR's COP process; and to generate the financial matrix for the Global AIDS Monitor (GAM).

The findings presented here answer the following questions:

- ✓ What are the sources and amounts of funding for the HIV response in Mozambique? What financing schemes and mechanisms are being used to channel the funds?
- ✓ What is actually disbursed and spent in each component of the multisectoral HIV response? Are increased allocations of expenditure going to priority HIV interventions?
- ✓ Who manages the funds and takes the programmatic decisions?
- ✓ Where do HIV and AIDS funds go? What services are being provided and what service delivery modes are being used?
- ✓ Who are the main service providers and beneficiaries of these services? What is the allocation of HIV spending in relation to the objectives, targets and costing of PEN-IV? Are there potential risks to the sustainability of certain programmes?
- ✓ What is the allocation of HIV spending in relation to the geographic characteristics of the epidemic and modes of HIV transmission?
- ✓ Are sufficient resources invested to enhance capacity for scaling up human resources?
- ✓ Is international donor assistance aligned to national priorities?

2.2. NASA methodology and classifications

This NASA fully applied the new NASA 2020 framework with the updated vectors and classifications. The methodology was aligned with the NASA Guide⁵, and therefore based on standardised methods, principles, definitions and accounting rules. **Please refer to the detail of the approach in the Appendix 1.**

Importantly, the new NASA 2020 variables allow for an improved description and understanding of the financing flows in Mozambique. The nine vectors are defined as follows:

⁵ Guide to producing National AIDS Spending Assessments (NASA), UNAIDS 2012

FINANCING:

1. **Financing entity** is the economic unit providing the resources to the schemes;
2. **Financing schemes** are the modalities through which the population access the HIV services;
3. **Financing revenues** are mechanisms to provide resources to financing schemes;
4. **Financing agents**-purchasers are economic units that operate the schemes. They collect revenue, pool financial resources, pay for the service provision, and take programmatic decisions (allocation and purchase modalities).

PROVISION OF HIV SERVICES:

5. **Providers of services (PS)** are entities that engage in the production, provision, and delivery of HIV services.
6. **Production factors (PF)** are inputs/resources (labour, capital, natural resources, “know-how,” and entrepreneurial resources) used for the production of ASC.

USE/ CONSUMPTION:

7. **AIDS spending categories (ASC)** are HIV-related interventions and activities.
8. **Beneficiary segments of the population (BP)** are populations intended to benefit from specific activities (eg. key population groups such as men who have sex with men, injecting drug users, etc.)
9. **Service delivery modality (SDM)** is a new variable in NASA 2020 which indicates the modality of the service provided.

Estimations were applied only for calculating the spending on STI treatment and for the share of public MOH salary costs that could be attributed to the delivery of HIV services in public health facilities. In addition, the actual spending on ARVs by PEPFAR and Global Fund (GF) had to be attributed to provinces based on the volumes distributed to provinces. Based on the unit prices (P) and the provincial volumes (Q), the PEPFAR and GF spending on ARVs per province were estimated (PxQ formula). *Altogether*, these estimations constituted 24% of the data captured in this NASA. All other data (76%) were primary expenditure data collected from expenditure records and reports. Please refer to Appendix 1 for the details of the methods and estimations applied.

Some preparation of the PEPFAR 2017 data (from their Expenditure Analysis database) was required to extract their district level spending correctly, and is explained in Appendix 1, with our cross-walking/ matching of the PEPFAR categories to the NASA categories in Appendices 4-8.

In Mozambique, most expenditure reports and budgetary allocations are made in United States dollars (USD), and therefore this NASA collected and reported all expenditures in USD, as per the guidance of the GTM. The annual average

exchange rate used to convert Mozambican metical (MZN) were USD1: 63.584 MZN in 2017 and USD1: 60.326 MZN in 2018⁶.

3. Key NASA Findings

3.1. HIV Financing Flows in Mozambique

Table 3: NASA terms used in this section: definitions and examples

NASA Term	Definition	Example
Financing Entity (FE)	The economic unit (organisation, institution, company, government) providing the resources to the schemes.	Central governments, PEPFAR, Global Fund
Financing Revenues (REV)	Mechanisms to provide resources to financing schemes	Transfers from government domestic revenue, Social insurance contributions, Direct foreign financial transfers
Financing Schemes (SCH)	The main types of financing arrangements through which people obtain health services	Government schemes, Compulsory contributory health insurance schemes, External schemes (non-resident)
Financing Agents-Purchasers (FAPs)	The economic units that operate the schemes. They collect revenue, pool financial resources, pay for the service provision, and take programmatic decisions (allocation and purchase modalities)	MOH, CNCS, principal recipients, bilateral/multilateral agencies
Government entity or revenue or scheme	Government (public) source of funds, source of source, or architecture of financing flows (see Box 1 above)	Central government
Resident foreign agency	Development partner (donor) with offices in-country	USAID, SIDA
Resident non-profit organisations	Non-profit organisations with offices in-country	The Clinton Health Access Initiative
Vulnerable populations	People or groups that are vulnerable to HIV infection	Orphans and vulnerable children (OVCs), AGYW, truck drivers
Accessible populations	People that are located in an area where interventions can easily reach them	Children in schools, police/army officers

* Please refer to UNAIDS NASA 2020 Guidance and Classifications for definitions of all NASA terms.

The HIV response in Mozambique is heavily dependent on external aid, with international financing entities making up 97% of the total spending on HIV in both 2017 and 2018. The sources of revenue were therefore mostly direct foreign transfers (97% in both years) and only 2% were transfers from government domestic revenue. However, the majority of HIV financing (73% in 2017, 68% in 2018) flowed through **government schemes** – including Global Fund resources and PEPFAR’s contributions to ARVs managed by the public Central Medical Stores (CMAM). Financing Schemes (SCH) are defined as the main types of financing

⁶ World Bank, 2018. Annual average exchange rate.

arrangements through which people obtain health services. The next main scheme for HIV financing was the resident foreign agencies schemes – which are development partners’ agencies that have a local office in the country, and they made up 23% and 28% in each year respectively, while 3% and 2% were resident not-for-profit organisations schemes. Less than 1% were private medical insurance schemes and for-profit enterprises schemes in both years. There was no financing reported as coming through external non-resident schemes.

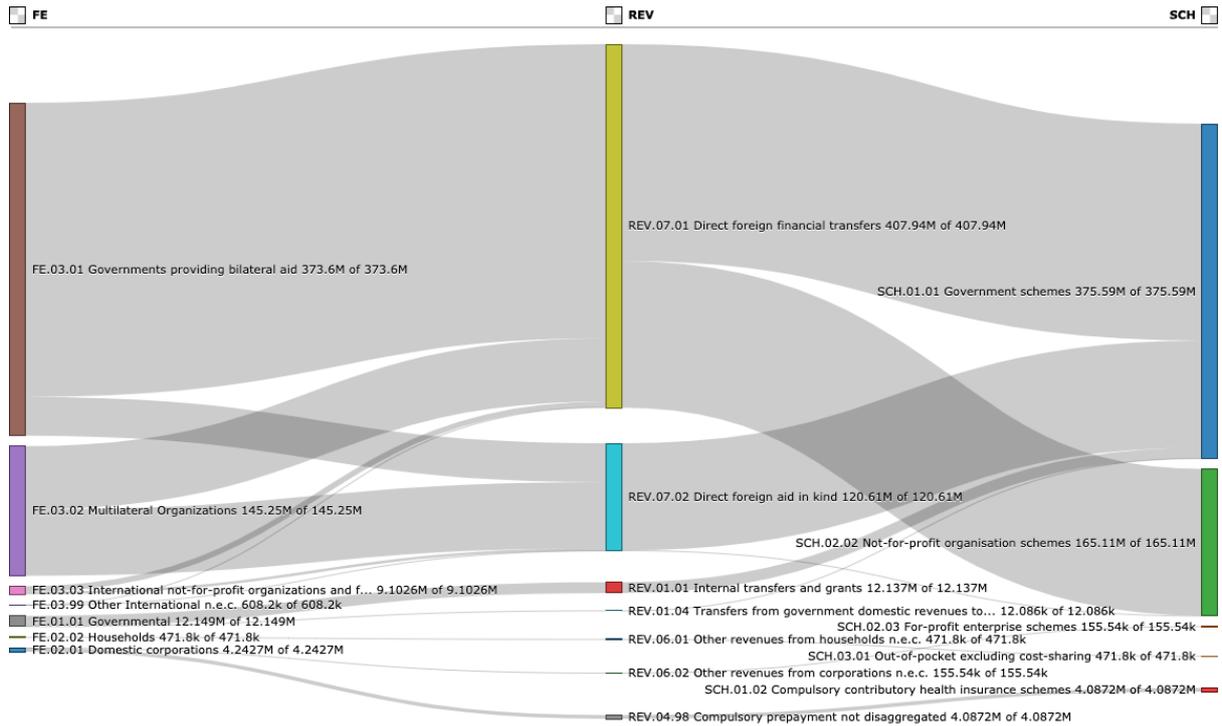
Table 4: Financing Schemes by their Financing Entities (US\$, %, 2017, 2018)

SCHEME and their Financing Entities	2017	2018	2017 %	2018 %
SCH.01.01.01 Central government schemes	371 616 160	375 696 882	73%	69%
FE.01 Public Entities	10 746 929	12 149 223	2%	2%
FE.03 International Entities	360 869 231	363 547 659	71%	67%
FE.03.01 Governments providing bilateral aid	234 365 170	221 710 432	46%	41%
FE.03.02 Multilateral Organizations	122 634 865	139 036 309	24%	25%
FE.03.03 International not-for-profit organizations and foundations	3 584 342	2 793 268	0.7%	0.5%
FE.03.99 Other International n.e.c.	284 853	7 649	0.1%	0.0%
SCH.01.02.02 Compulsory private insurance schemes	4 215 840	4 087 155	0.8%	0.7%
FE.02 Domestic Private Entities	4 215 840	4 087 155	0.8%	0.7%
SCH.02.02.01 Not-for-profit organisation schemes (excluding SCH.2.2.2)	12 717 353	13 329 539	3%	2%
FE.03 International Entities	12 717 353	13 329 539	3%	2%
FE.03.01 Governments providing bilateral aid	2 533 725	1 182 437	0%	0%
FE.03.02 Multilateral Organizations	9 426 239	5 237 187	2%	1%
FE.03.03 International not-for-profit organizations and foundations	757 389	6 309 360	0.1%	1%
FE.03.99 Other International n.e.c.	-	600 556	0.0%	0.1%
SCH.02.02.02 Resident foreign agencies schemes	119 105 740	151 682 574	23%	28%
FE.03 International Entities	119 105 740	151 682 574	23%	28%
FE.03.01 Governments providing bilateral aid	118 283 455	150 706 842	23%	28%
FE.03.02 Multilateral Organizations	822 284	975 732	0.2%	0.2%
SCH.02.03.01 Enterprises (except health care providers) schemes	110 652	155 545	0.0%	0.0%
FE.02.01 Domestic corporations	110 652	155 545	0.0%	0.0%
SCH.03 Household out-of-pocket payment	726 679	471 799	0.1%	0.1%
FE.02.02 Households	726 679	471 799	0.1%	0.1%
Grand Total	508 492 424	545 423 492	100%	100%

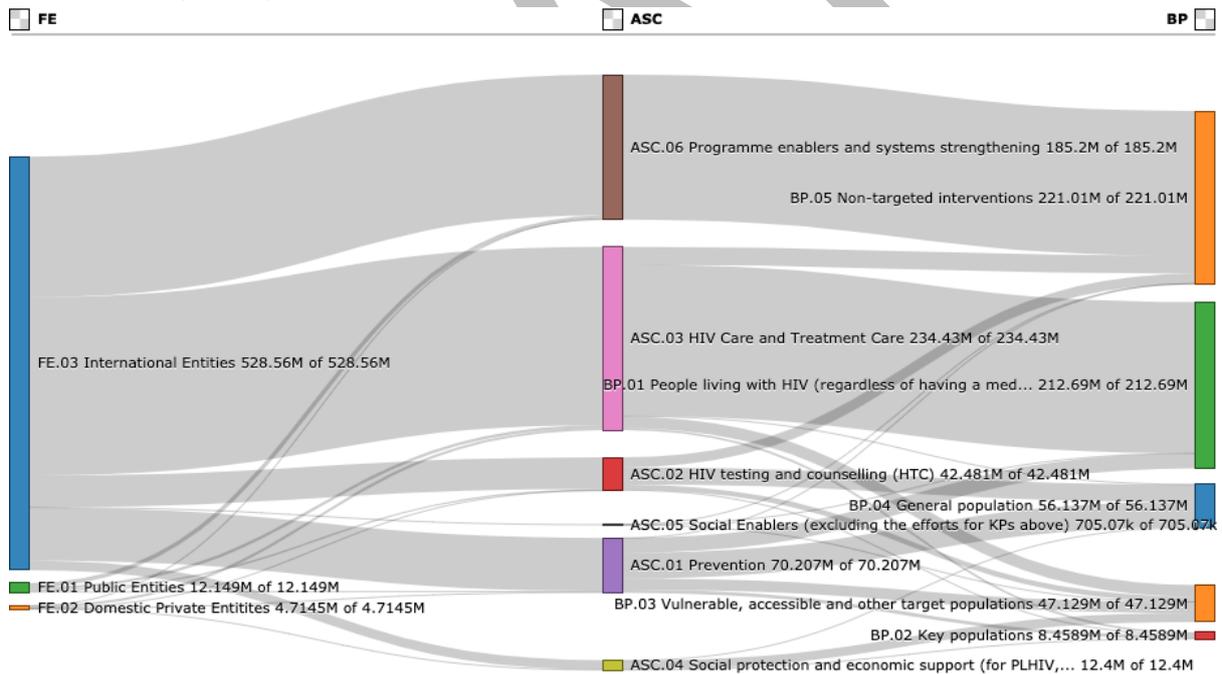
Table 4 indicates the financing schemes and their financing entities, and changes between the two years. There have not been any major changes generally in the proportional amounts, except that the reduction in government schemes in 2018 was primarily due to the reduction in funds from international bilateral entities that were channelled through public financing schemes. On the other hand, the increase in financing to the resident foreign agencies schemes was due to increased international bilateral entities’ financing going to these schemes. This seems to imply a trend (although measured over only two years) of bilateral financing entities moving funds from government schemes to resident foreign agency schemes, which highlights the vulnerability of the Mozambican HIV response, particularly the treatment programme, to changing donor commitments and priorities. This is further illustrated in the analysis of the financing agent-purchasers (FAPs), where the largest portion of HIV funds which were from PEPFAR were labelled as bilateral FAPs because the USG agency (USAID, CDC etc.) with their implementing partners (who were de-identified in the data provided for NASA) were the main decision-makers with regard to the services to be implemented and their purchase.

Figure 1: HIV Financing Flows in Mozambique (2018)

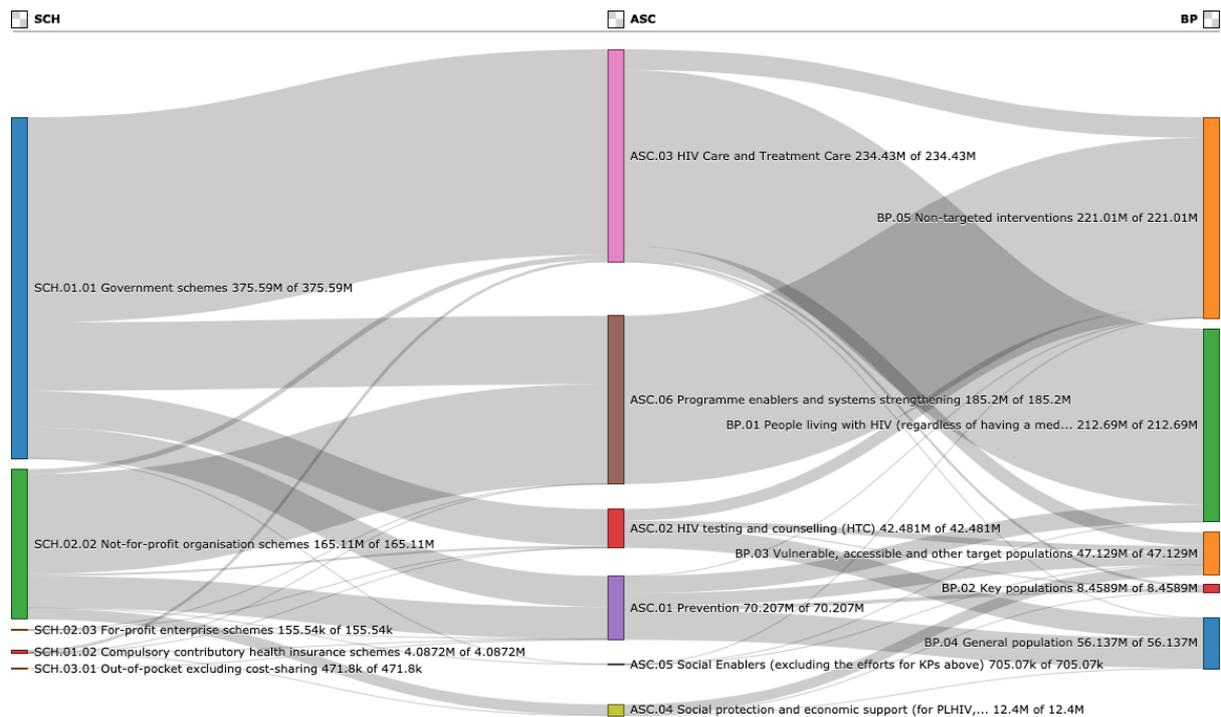
FE-REV-SCH (2018)



FE-ASC-BP (2018)



SCH-ASC-BP (2018)



FE-FAP-ASC (2018)

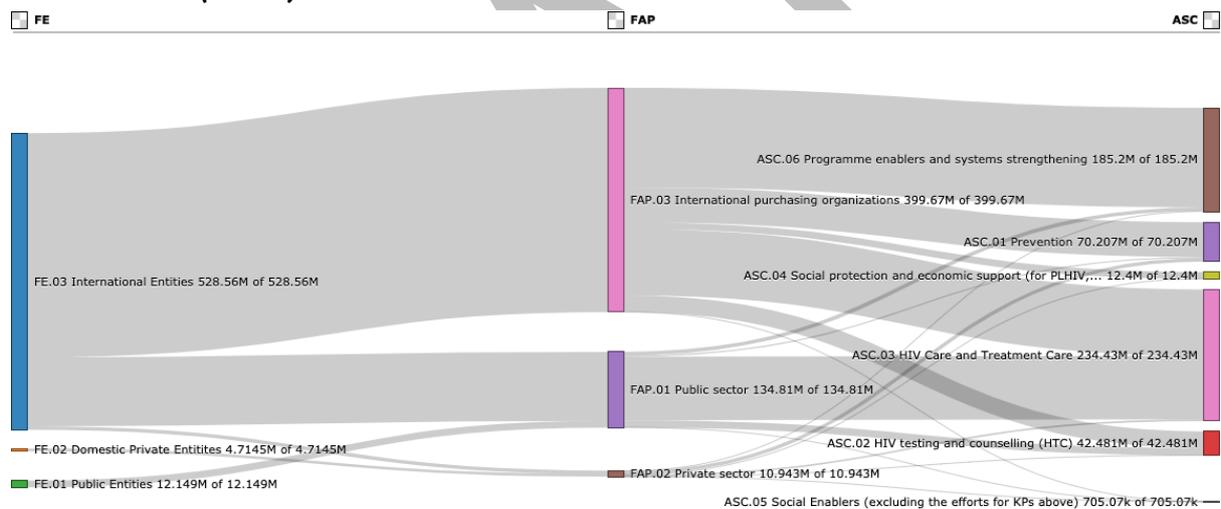


Figure 1 provides various diagrammatic representations of the flow of HIV financing in Mozambique, from revenues (REV) (which are mechanisms to provide resources to financing schemes) to financing entities (FE) (the economic units providing the resources to the schemes), via their schemes (SCH) which are the modalities through which the population access the HIV services, to the beneficiaries (BP), and visually represents the narrative above. With regards to which beneficiaries are benefiting from which schemes, Figure 1 indicates that 50% of the government scheme financing went to persons living with HIV (PLHIV) in 2018, 29% was non-targeted, 14% went to the general population, 6% to vulnerable and accessible populations, while 0.3% went towards key populations.

The financing from schemes' (donors with in-country offices) was primarily non-targeted in terms of beneficiaries (71% in 2018), and the remaining 29% benefitted vulnerable and accessible populations.

The HIV financing flowing through the resident non-profit organisations schemes were benefitting PLHIV (23%), key populations (14%), vulnerable and accessible populations (36%), general population (13%) and 13% were non-targeted. Although these financing schemes were a small proportion (2% of total HIV funds in 2018), they were more evenly distributed across the beneficiary populations, than the other two major schemes (Table 5).

Table 5: Financial Schemes and their Beneficiaries (US\$, %, 2017, 2018)

SCHEME and Beneficiaries	2017	2018	2017 %	2018 %
SCH.01.01.01 Central government schemes	371 616 160	375 696 882	73%	69%
BP.01 People living with HIV	239 632 861	187 941 950	47%	34%
BP.02 Key populations	904 688	1 244 349	0%	0%
BP.03 Vulnerable, accessible and other target populations	27 906 727	23 852 203	5%	4%
BP.04 General population	48 977 102	51 942 210	10%	10%
BP.05 Non-targeted interventions	54 194 781	110 716 169	11%	20%
SCH.01.02.02 Compulsory private insurance schemes	4 215 840	4 087 155	1%	1%
BP.01 People living with HIV	3 184 160	2 486 723	1%	0%
BP.03 Vulnerable, accessible and other target populations	941 680	1 510 432	0%	0%
BP.05 Non-targeted interventions	90 000	90 000	0%	0%
SCH.02.02.01 Not-for-profit organisation schemes (excluding SCH.2.2.2)	12 717 353	13 329 539	3%	2%
BP.01 People living with HIV	800 607	3 114 121	0%	1%
BP.02 Key populations	283 474	1 885 059	0%	0%
BP.03 Vulnerable, accessible and other target populations	1 067 446	4 839 606	0%	1%
BP.04 General population	2 548 961	1 742 249	1%	0%
BP.05 Non-targeted interventions	8 016 866	1 748 504	2%	0%
SCH.02.02.02 Resident foreign agencies schemes	119 105 740	151 682 574	23%	28%
BP.01 People living with HIV	51 355	19 145 167	0%	4%
BP.02 Key populations	2 232 010	5 329 509	0%	1%
BP.03 Vulnerable, accessible and other target populations	18 548 481	16 881 511	4%	3%
BP.04 General population	60 417	1 980 364	0%	0%
BP.05 Non-targeted interventions	98 213 476	108 346 023	19%	20%
SCH.02.03.01 Enterprises (except health care providers) schemes	110 652	155 545	0%	0%
BP.03 Vulnerable, accessible and other target populations	61 536	44 845	0%	0%
BP.05 Non-targeted interventions	49 116	110 700	0%	0%
SCH.03 Household out-of-pocket payment	726 679	471 799	0%	0%
BP.04 General population	726 679	471 799	0%	0%
Total	508 492 424	545 423 492	100%	100%

The financial schemes are discussed further under each of the other vectors presented below.

3.2. Overall trends in HIV spending in Mozambique (2004-2019)

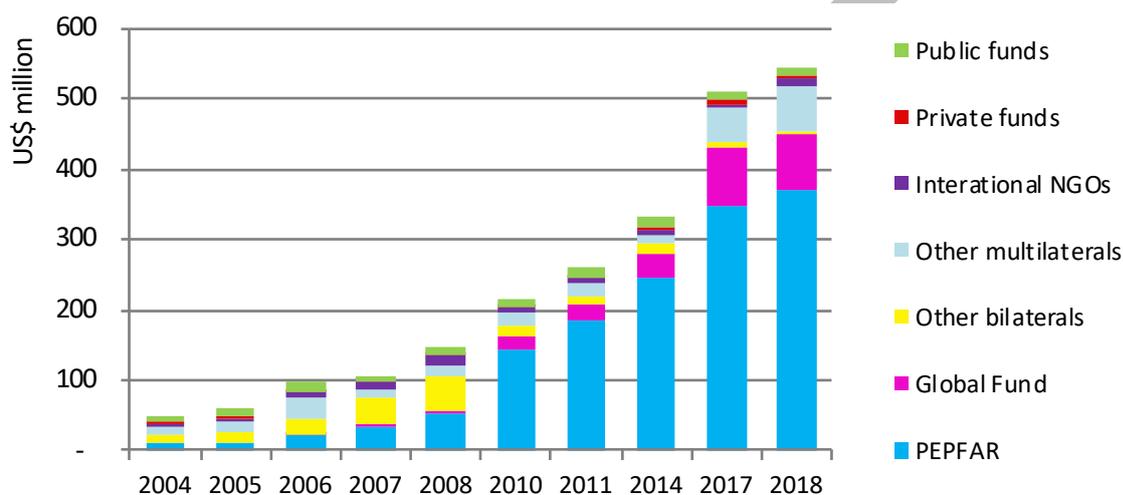
Key findings from this section:

- There has been an annual average increase in HIV financing in Mozambique of 18% per annum between 2014 and 2017.
- This rate of increase slowed to 7% increase between 2017 and 2018.
- Total HIV financing in 2018 was estimated at US\$ 545 million (4% of the gross domestic product).
- Increased HIV funding was driving primarily by increasing funding from international financing entities, and went mostly to increased spending on care and treatment activities.
- In 2018, US\$ 19 was spent per person in Mozambique (US\$ 36 per adult, or US\$ 248 per PLHIV).

The various NASAs undertaken in Mozambique over the years provide valuable insights into the financing trends for HIV/AIDS. Figure 2 shows HIV financing has been steadily increasing since 2004, with an annual average increase of 18% per

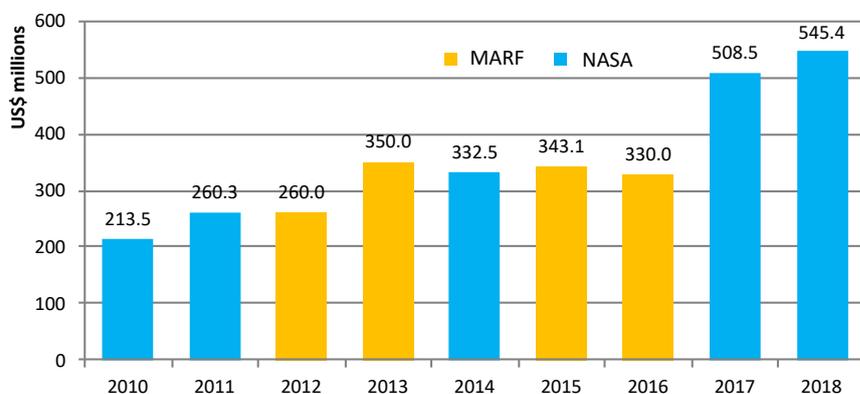
annum between 2014 and 2017 – driven primarily by increasing financing from international entities. This slowed to a 7% increase between 2017 and 2018, reaching a total of US\$ 545 million, which equated to 4% of the gross domestic product (GDP). Dividing this by the total population, the per capita spending in 2018 was US\$ 19 (increased from US\$ 13/14 in 2014, using new/old census total population figures), or US\$ 36 per adult (>15years) and US\$ 248 per PLHIV (increased from 2014 when the HIV spending per adult was US\$ 25 and the spending per PLHIV was US\$ 225).

Figure 2: HIV financing trends in Mozambique by Financing Entities (US\$ millions, 2004-2018)



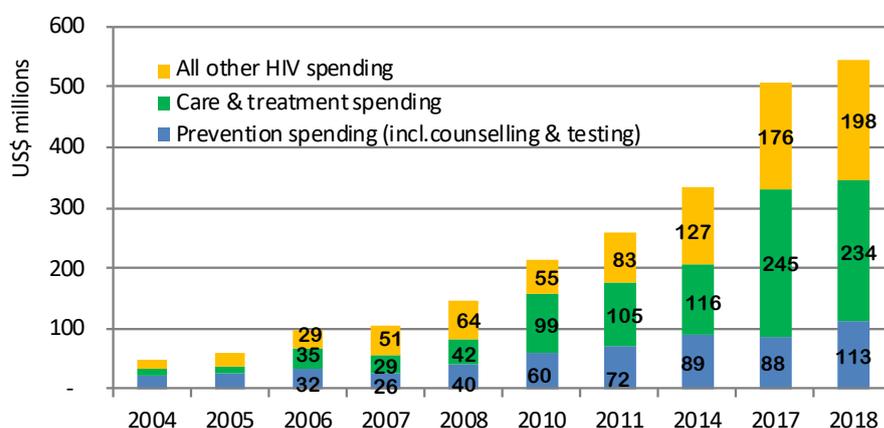
In the years where a full NASA was not undertaken in Mozambique, a 'lighter' Monitoring of AIDS Financial Resources (MARF) was undertaken for the years 2012-2013 (piloted) and 2015-2016. These are shown in Figure 3 where the 2016 estimates were much lower than this NASA's findings for 2017. The reasons for this are unknown, but may have been due to successful resource mobilization, primarily from the United States Government's increased its 2017 PEPFAR allocation.

Figure 3: NASA findings compared with MARF estimates (US\$ millions, 2010-2018)



The increases between 2014 and 2017 were largely driven by the increasing spending on care and treatment activities, from 27% of total spending in 2014 to 48% in 2017 and 43% in 2018. Proportional amounts for prevention decreased from 27% in 2014 to 17% in 2017 and slightly increased again to 21% (Figure 4).

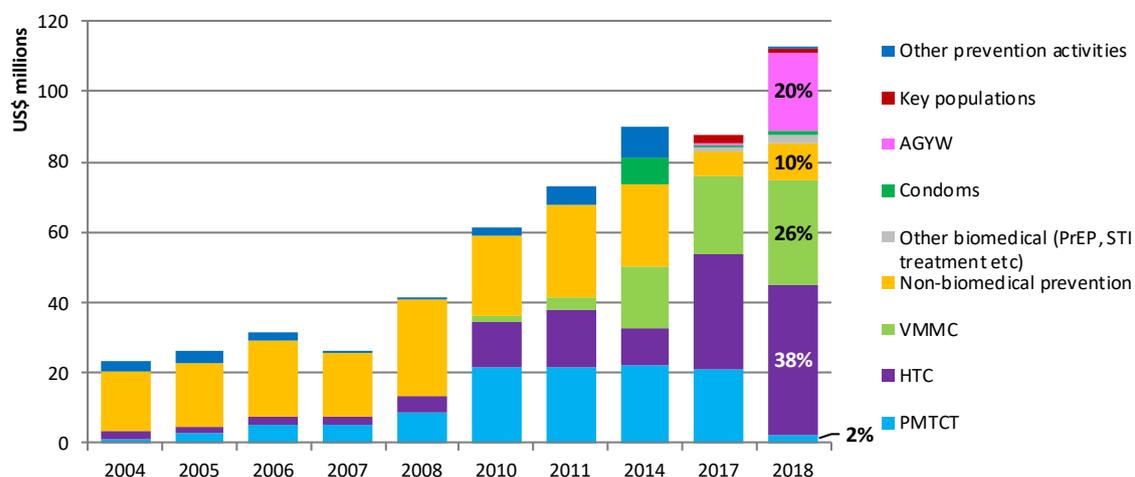
Figure 4: HIV spending per broad programmatic area (US\$ million, 2004-2018)



Note: In the new NASA 2020 framework, HIV testing and counselling (HTC) is no longer a sub-category of prevention, but has its own programmatic area. For comparison with the previous years, in the graph above, HTC has been included in the prevention category.

Examining the trends in spending on HIV prevention activities, Figure 5 shows the early focus on non-biomedical interventions, such as behaviour change and community mobilization, and the move towards the biomedical interventions, such as VMMC in more recent years, as well as the increased efforts to reduce infection among adolescent girls and young women (AGYW). The spending on PMTCT appears to have declined significantly in 2018, but this was largely due to the change in PEPFAR’s categorisation of their expenditure – in the 2018 expenditure reporting, PMTCT is no longer a standalone program category and is embedded in HIV clinical services category. Further details of each programmatic area in 2017 and 2018 are provided below.

Figure 5: Trends in HIV Prevention spending (US\$ millions, 2004-2018)



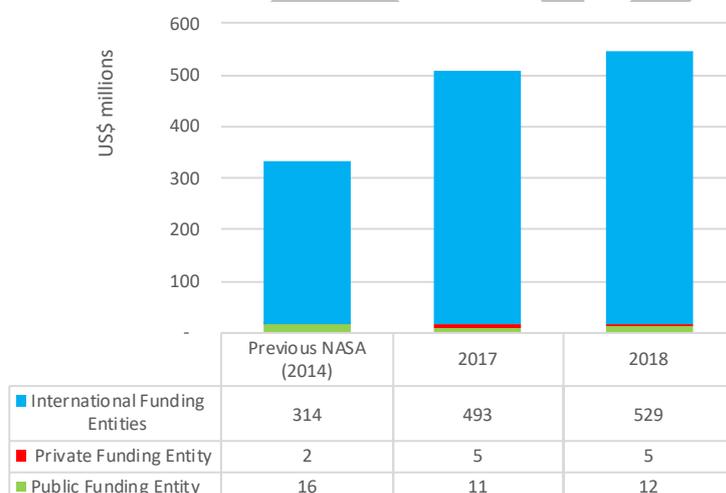
3.3. Financing entities and revenues for the HIV response (2017-2018)

Key findings from this section:

- In 2018, HIV financing in Mozambique was almost 1.5 times the size of the annual national health budget.
- Between 2017 and 2018:
 - public financing entities (sources) increased by 13%
 - international sources increased by 7%
 - private sources decreased by 7%.
- Of total HIV spending in 2017 and 2018:
 - PEPFAR made up 69% and 68% in each year
 - Global Fund made up 16% and 14%,
 - All the other multilaterals (summed) contributed 10% and 12%.

HIV expenditure in Mozambique increased by 7% between 2017 and 2018, from US\$ 508.5 million to US\$ 545.4 million (almost 1.5 times the size of the annual domestic health budget, noting that the HIV spending was not **only** health-related), of which 97% came from international financing entities (US\$ 529 million), 2% from public entities (US\$ 12 million) and 1% from private entities (US\$ 5 million), in both years (Figure 6). Between the two years, the public sources increased by 13%, international sources increased by 7% and private sources decreased by 7%.

Figure 6: Total HIV financing in Mozambique by Financing Entities (US\$ millions, %, 2017-2018)



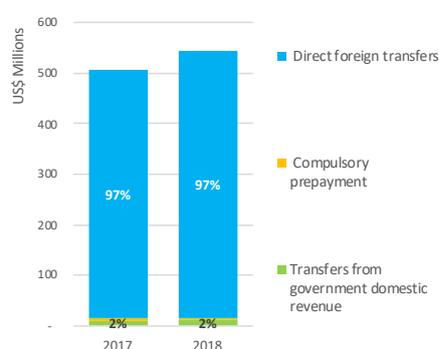
PEPFAR funding made up 69% and 68% of the total HIV spending in 2017 and 2018, respectively, Global Fund made up 16% and 14%, while all the other multilaterals (summed) contributed 10% and 12% (Table 6 provides the absolute amounts). Refer to Appendix 1 for details of all international financing entities included in the NASA sample.

Table 6: Total HIV financing in Mozambique by Financing Entities (US\$, %, 2017-2018)

Funding Entities	2017	2018	% 2017	% 2018
PEPFAR	349 135 001	370 190 650	69%	68%
Global Fund	82 493 387	78 545 201	16%	14%
Other bilateral FE	6 047 350	3 409 061	1%	1%
Other multilateral FE	50 390 001	66 704 026	10%	12%
INGOs and Foundations	4 626 585	9 710 833	1%	2%
Private FE	5 053 171	4 714 498	1%	1%
Public FE	10 746 929	12 149 223	2%	2%
Total	508 492 424	545 423 492	100%	100%

The financing revenues: 97% were direct foreign transfers (from international financing entities), 2% were transfers from government domestic revenue (for the public entities), while the private entities were compulsory prepayments (1%) (Figure 7).

Figure 7: Financing revenues for HIV (US\$, 2017-2018)



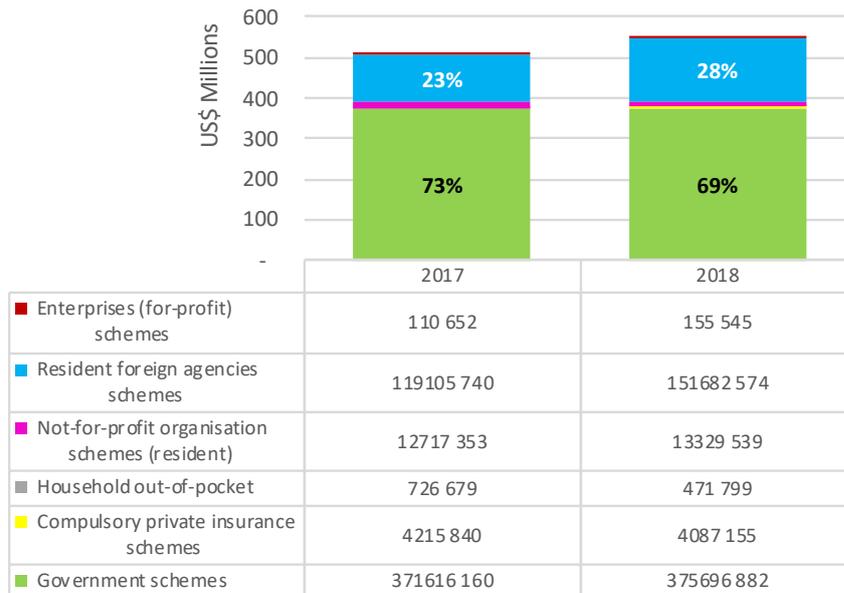
3.4. HIV financing schemes

Key findings from this section:

- In 2017 and 2018, 73% and 69% respectively, of HIV financing flowed through government financing schemes – mostly the international financing for ARVs distributed by CMAM.
- 23% and 28% flowed through resident foreign agencies schemes.

As explained in the financing flows section, the Financing Scheme indicates the main types of financing arrangements through which people obtain health services. Importantly, the largest portion of HIV financing (73% in 2017 and 69% in 2018) flowed through government schemes, mostly for the ARVs distributed by CMAM, while 23% and 28% flowed through resident foreign agencies schemes (Figure 8).

Figure 8: Financing schemes for HIV in Mozambique (US\$ millions, %, 2017-2018)



When considering which programmatic areas are being financed via these schemes, Figure 9 and Table 7 indicates the changing relationship between the two assessment years. In 2017, prevention, HIV testing and counselling, care and treatment, social enablers and research were funded primarily through government schemes (while keeping in mind that 97% of all these funds were from international financing entities), and social protection and economic support and programme enablers and systems strengthening were largely funded through resident foreign agency schemes. In 2018, the programme area with decreasing government schemes' financing was prevention from US\$ 44.6 million (82% of all prevention funding) to US\$ 34 million (48%). Government scheme financing for social enablers increased from US\$ 165 thousand in 2017 to US\$ 328 thousand (100%) to 48%). The resident foreign agency schemes dominated social protection and economic support (SPES) in both years, and formed 61% (US\$ 14.4 million) and 58% (US\$ 12.1 million) of SPES financing respectively.

Figure 9: HIV programme areas by their financing schemes (%), 2017-2018

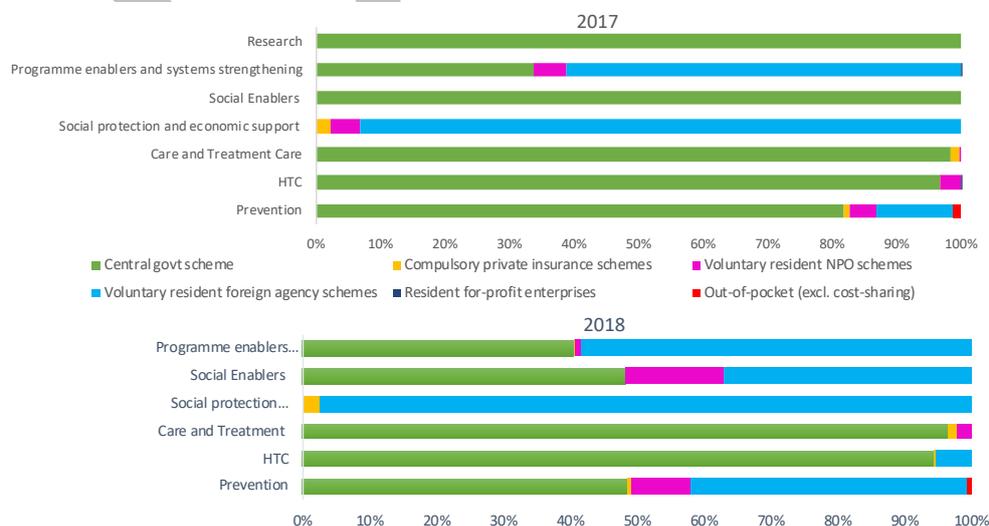


Table 7: Financing schemes x HIV programme areas in Mozambique (US\$, %, 2017-2018)

2017 HIV Programme Area	FINANCING SCHEME						Total (US\$)
	Central gov't scheme	Compulsory private insurance schemes	Voluntary resident NPO schemes	Voluntary resident foreign agency schemes	Resident for-profit enterprises	Out-of-pocket (excl. cost-sharing)	
Prevention	44 595 688	551 480	2 176 164	6 527 847	5 787	726 679	54 583 645
HTC	31 917 456	60 000	998 057	-	55 748	-	33 031 261
Care and Treatment Care	240 793 698	3 184 160	800 607	-	-	-	244 778 465
Social protection and economic support	-	330 200	725 659	14 363 691	-	-	15 419 551
Social Enablers	164 537	-	-	-	-	-	164 537
Programme enablers and systems strengthening	53 944 781	90 000	8 016 866	98 214 202	49 116	-	160 314 965
Research	200 000	-	-	-	-	-	200 000
Total	371 616 160	4 215 840	12 717 353	119 105 740	110 652	726 679	508 492 424
Sources % share	73%	1%	3%	23%	0.0%	0.1%	

2018 HIV Programme Area	FINANCING SCHEME						Total (US\$)
	Central gov't scheme	Compulsory private insurance schemes	Voluntary resident NPO schemes	Voluntary resident foreign agency schemes	Resident for-profit enterprises	Out-of-pocket (excl. cost-sharing)	
Prevention	34 057 512	540 756	6 227 295	28 918 241	16 393	471 799	70 231 996
HTC	40 118 529	60 000	10 347	2 263 637	28 452	-	42 480 965
Care and Treatment	226 016 330	3 066 199	5 343 393	-	-	-	234 425 922
Social protection & economic support	-	330 200	-	12 069 434	-	-	12 399 634
Social Enablers	327 925	-	99 800	252 349	-	-	680 074
Programme enablers & HSS	75 176 586	90 000	1 648 704	108 178 912	110 700	-	185 204 902
Total	375 696 882	4 087 155	13 329 539	151 682 574	155 545	471 799	545 423 492
Funding Entity % share	69%	1%	2%	28%	0%	0%	

Refer to section 3.1 for further insights into the beneficiaries of these financing schemes in Mozambique, and to Appendix 3 for detailed Scheme matrices and disaggregation.

3.5. Financing agent-purchasers of HIV services

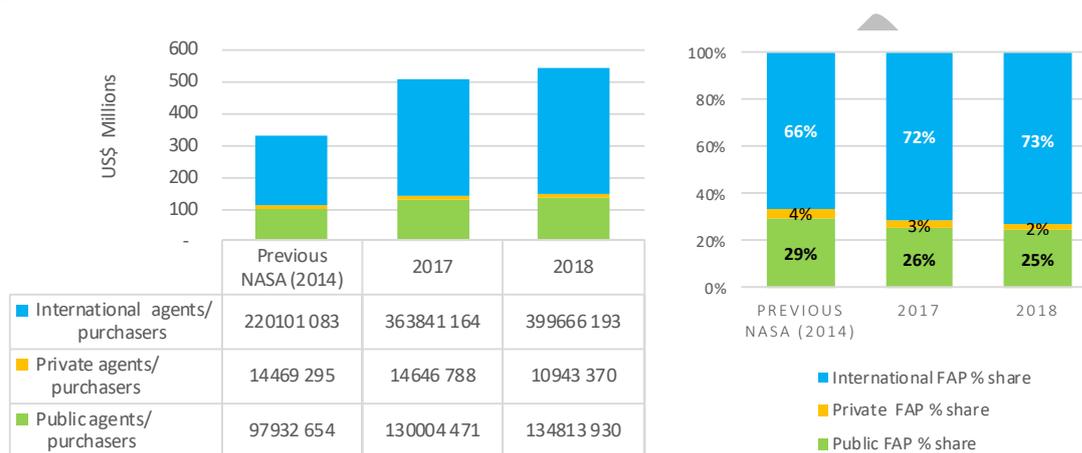
Key findings from this section:

- In 2017 and 2018, 72% and 73% of HIV funds were managed by international financing agents-purchasers (FAPs), while only 26% and 25% were managed by public FAPs.
- Funds from PEPFAR were labelled as bilateral FAPs because the USG agency (USAID, CDC etc.) with their implementing partners (who were de-identified in the data provided for NASA) were the main decision-makers with regard to the purchase and implementation of services.
- The declining proportion of funding being managed by public FAPs could imply a reducing public control over funding for the national response.
- Within the public FAPs, the Ministry of Health played the largest FAP role, followed by CNCS.
- Within the international FAPs, the PEPFAR implementing agencies/ partners played the greatest role.

The financing agent-purchasers (FAP) are economic units (institutions) that operate the schemes. They collect revenue, pool financial resources, pay for the service provision, and take programmatic decisions (allocation and purchase modalities) (UNAIDS, NASA 2020 framework). They are therefore critical in determining the prioritization and implementation of interventions, thus affecting both the allocative and technical efficiency of the national response. Figure 10 indicates that in 2017 and 2018, 72% (US\$ 363.8 million) and 73% (US\$ 399.7 million) of HIV funds were managed by international FAPs, while only 26% (US\$ 130 million) and 25% (US\$ 134.8 million) by public FAPs, and which had declined proportionally from 29% in 2014 (but increased in absolute terms from US\$ 97.9 million), according to the previous NASA findings. The declining proportion of funding being

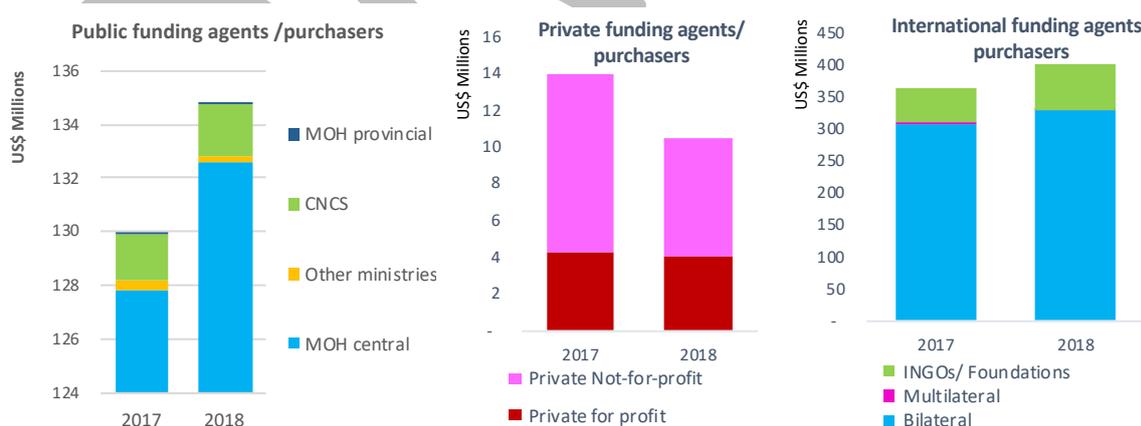
managed by public FAPs could imply the government’s reducing control over financing for the national response. However, it is important to note that the PEPFAR data did not provide details of their implementing partners managing the funds, and hence all their data were labelled with international bilateral FAPs. Since the PEPFAR Country Operation Planning (COP) process determines, to a large extent, the programmes and interventions, it was an acceptable assumption to have made.

Figure 10: Financing agent-purchasers for HIV services in Mozambique (US\$ millions, %, 2014-2018)



Further disaggregating the public FAPs, Figure 11 shows that the Ministry of Health played the largest FAP role, followed by CNCS. For the small portion managed by private FAPs, the bulk were non-profit FAPs, and for international FAPs, the bulk were bilateral FAPs (explained by the PEPFAR IPs being labelled as such).

Figure 11: Financing agent-purchasers disaggregated (US\$ millions, 2017-2018)



Regarding the FAPs selection of service providers (Table 8), public FAPs were financing primarily government organisations to deliver HIV services, while private FAPs selected NGOs, and international FAPs (the bulk of which were the PEPFAR funds) went to the PEPFAR IPs and their sub-recipients, whose type could not be identified in the EA and ER datasets provided by PEPFAR.

Table 8: Financing agent-purchasers' selection of service providers (US\$, %, 2017-2018)

FAPs and their HIV service provider types	2017	2018	2017 %	2018 %
FAP.01 Public sector	130 004 471	134 813 930	26%	25%
PS.01.01 Governmental organizations	129 965 058	134 791 171	26%	25%
PS.02.01 Non-profit providers	-	12 086	0%	0%
PS.02.02 Profit-making private sector providers	39 413	10 673	0%	0%
FAP.02 Private sector	14 646 788	10 943 370	3%	2%
PS.01.01 Governmental organizations	284 853	150 000	0%	0%
PS.02.01 Non-profit providers	9 419 416	6 234 417	2%	1%
PS.02.02 Profit-making private sector providers	4 215 840	4 087 155	1%	1%
PS.03.03 International NGOs and foundations	726 679	471 799	0%	0%
FAP.03 International purchasing organizations	363 841 164	399 666 193	72%	73%
PS.01.01 Governmental organizations	42 789 767	106 409 285	8%	20%
PS.02.01 Non-profit providers	280 456	1 192 137	0%	0%
PS.02.02 Profit-making private sector providers	-	34 943	0%	0%
PS.03.02 Multilateral agencies	3 378 701	2 731 257	1%	1%
PS.03.03 International NGOs and foundations	54 316 448	68 556 759	11%	13%
PEPFAR IPs and SRs	263 075 791	220 741 812	52%	40%
Total	508 492 424	545 423 492	100%	100%

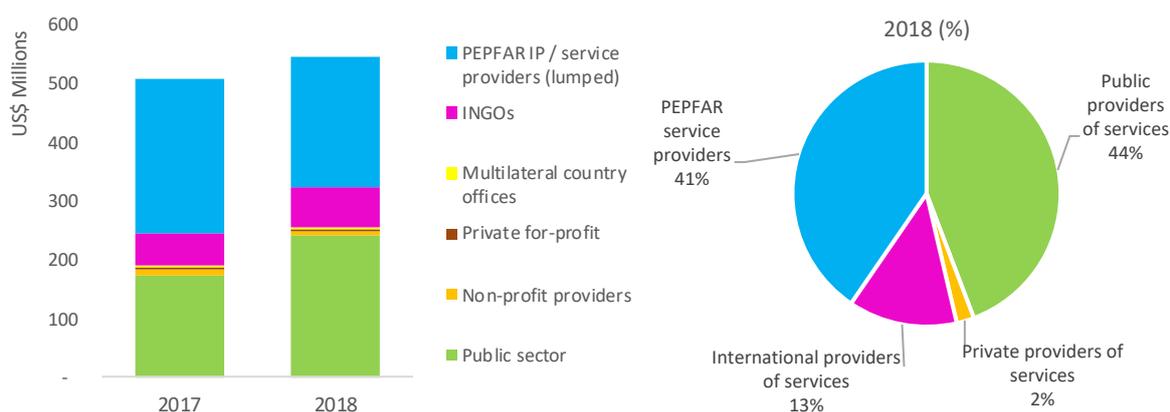
3.6. Providers of HIV services and their service delivery modalities

Key findings from this section:

- There was a 39% increase in HIV funding for public sector service providers, which received 44% of the total funding in 2018.
- Funding for PEPFAR implementing partners and their sub-recipients decreased by 16% between the two years.
- The bulk of the funding went to HIV services were facility-based: 57% in 2017 and increasing to 62% in 2018.

In 2018, 44% (US\$ 241.4 million) of all HIV financing in Mozambique went to public sector service providers, which had increased from 34% (US\$ 173 million) in 2017, while 41% (US\$ 220.7 million) went to the PEPFAR implementing partners and their sub-recipients in 2018 (decreased from US\$ 263.1 million, 52%, the previous year). There was 13% (US\$ 69 million) spent by international non-profit organisations in providing services (increased slightly from US\$ 55 million, 11%, in 2017) and a small 2% by private providers in both years (but decreasing from US\$ 13.8 million to US\$ 11.5 million) – of which three quarters was for local NGOs and the remaining quarter for private for-profit organisations. (Figure 12).

Figure 12: Spending by HIV service providers (US\$ millions, %, 2017-2018)



Within the spending by public sector providers, the bulk (96.6%) was by public hospitals and clinics, 2.4% by Ministry of Health central level, 0.8% by CNCS, and the remaining 0.2% by other ministries: education, labour, justice and others. (Table 9).

Table 9: Spending by HIV service providers (US\$ millions, %, 2017-2018)

HIV service providers	2017	2018	% 2017	% 2018
PEPFARs IPs and SRs	263 075 791	220 741 812	52%	40%
INGOs and Foundations (providing services)	55 043 127	69 028 558	11%	13%
Bilateral / multilateral agencies	3 378 701	2 731 257	1%	1%
For-profit providers (national)	4 255 253	4 132 771	1%	1%
Non-profit organisations (national)	9 699 872	7 438 640	2%	1%
Public providers:	173 039 678	241 350 456	34%	44%
Public hospitals and clinics	165 963 216	233 117 076	33%	43%
Schools and higher education centres	200 000	250 000	0.0%	0.0%
CNCS	1 725 596	1 940 249	0.3%	0.4%
MOH central	5 000 238	5 842 468	1.0%	1.1%
Ministry of Justice, Labour and other mini	150 629	200 663	0.0%	0.0%
Total	508 492 424	545 423 492	100%	100%

The types of HIV services being provided by the different service providers are shown in Table 10 below, while their production factors are provided in Table 11.

Table 10: Spending per HIV programme area by provider type (US\$, %, 2018)

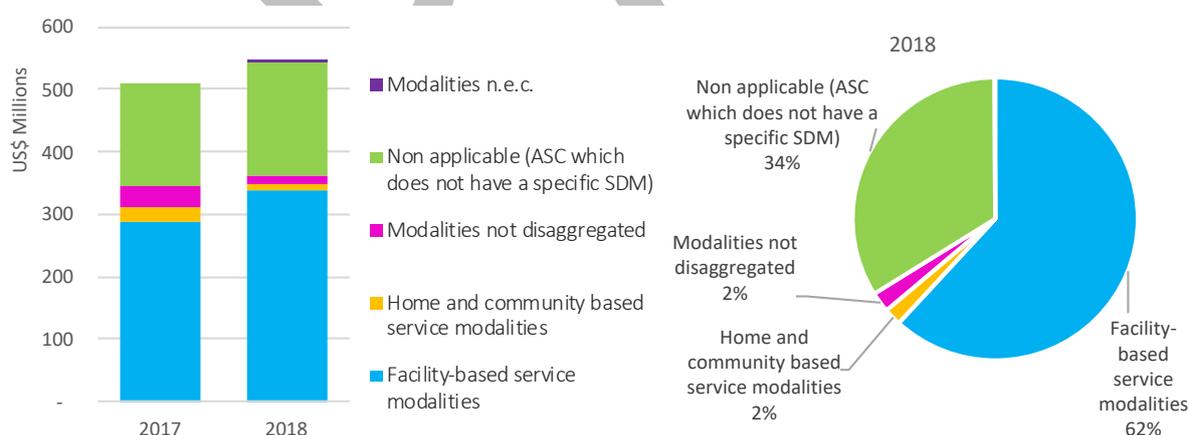
Programme area (US\$)	Public providers	Private providers	PEPFAR IP & service providers	International providers	Public provider %	Private provider %	PEPFAR IPs & SRs %	International provider %
Prevention	34 041 025	6 047 296	27 542 783	2 600 892	14%	52%	12%	4%
HTC	12 820 878	105 071	29 555 016	-	5%	1%	13%	0%
HIV Treatment Care	187 471 106	3 882 089	38 545 224	4 527 503	78%	34%	17%	6%
Social protection and economic support	-	330 200	11 663 206	406 228	0%	3%	5%	1%
Social Enablers	327 925	99 800	227 349	25 000	0%	1%	0%	0%
Programme enablers and systems	6 689 522	1 106 955	113 208 234	64 200 191	3%	10%	51%	89%
Total	241 350 456	11 571 410	220 741 812	71 759 814	100%	100%	100%	100%

Table 11: HIV service providers' spending by production factor (US\$, %, 2018)

Production factor (2018)	PUBLIC PS	NON-PROFIT PS	PROFIT-MAKING PS	MULILATERAL PS	INGOS / FOUNDATIONS PS	PEPFAR IP & PS
Current direct and indirect expenditures	239 153 335	7 434 742	3 779 279	2 670 473	45 999 636	213 803 399
Personnel costs	44 568 102	311 470	1 188 725	368 611	26 355 366	70 675 705
Operational / management current exp	57 514 475	29 349	659 276	141 601	410 605	67 933 093
Medical products and supplies (ARVs, labs, condoms, etc)	125 773 014	443 084	588 523	583 027	583 901	22 380 335
Contracted external services	-	-	-	43 000	298 153	-
Transportation related to beneficiaries	-	230 554	-	-	-	-
Housing/accommodation services for beneficiaries	-	230 554	-	-	-	-
Financial support for beneficiaries	25 895	-	-	105 512	-	947 386
Training related per diems/transport/other costs	3 538 369	6 624	331 756	158 957	16 118 638	6 764 468
Logistics of events, including catering services	338 665	99 800	-	279 324	348 185	-
Indirect costs	-	618	-	-	1 400	-
Current direct & indirect expenditures not disagg.	4 309 291	6 024 947	1 010 998	990 441	1 883 388	-
Current direct & indirect expenditures n.e.c.	3 085 524	57 742	-	-	-	45 102 412
Capital expenditures	2 197 121	3 897	-	19 484	23 028 922	6 938 414
Building	1 022 894	-	-	-	3 399 268	5 432 847
Vehicles	-	3 897	-	2 658	-	-
Other capital investment:	1 174 226	-	-	-	19 629 653	1 505 567
Capital exp n.e.c	-	-	-	16 826	-	-
Production factors not disagg.	-	-	353 492	41 301	-	-
Total	241 350 456	7 438 640	4 132 771	2 731 257	69 028 558	220 741 813

Examining the different service delivery modalities (SDMs), Figure 13 shows that the bulk of the services were facility-based: US\$ 287.9 million (57%) in 2017, increasing to US\$ 337.2 million (62%) in 2018, reflecting the increasing spending on ART delivery in facilities, as well as for HIV testing and counselling (HTC). Community-based delivery of services was reportedly low (2%), noting that differentiated models of ART delivery and HTC were not being scaled-up in the years of assessment. A third of the expenditure was for interventions which did not have a specific delivery modality (33.8%), mostly the programme enablers and system strengthening efforts.

Figure 13: HIV spending by service delivery modalities (US\$ millions, %, 2017-2018)



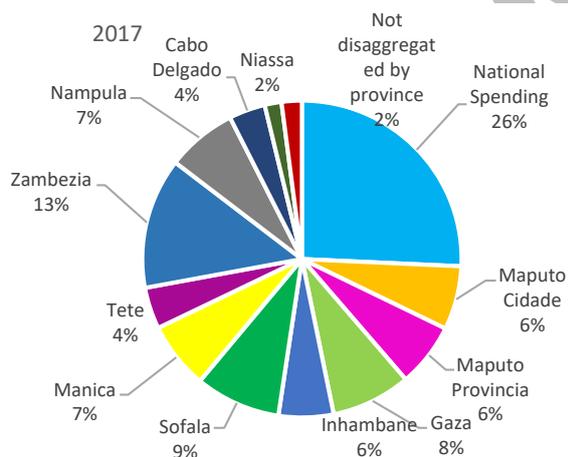
3.7. Provincial HIV financing

Key findings of this section:

- The provincial proportions of total HIV spending varied from 2% in Niassa to 13% in Zambezia, and with 26% labelled as national level spending in 2017.
- In 2017, the national average spending per PLHIV was \$242/PLHIV.
- The provincial HIV spending per PLHIV varied from \$92 in Maputo Province, to \$257 in Inhambane.
- Provincial level analysis could not be conducted for 2018 because of changes in PEPFAR's expenditure reporting format.

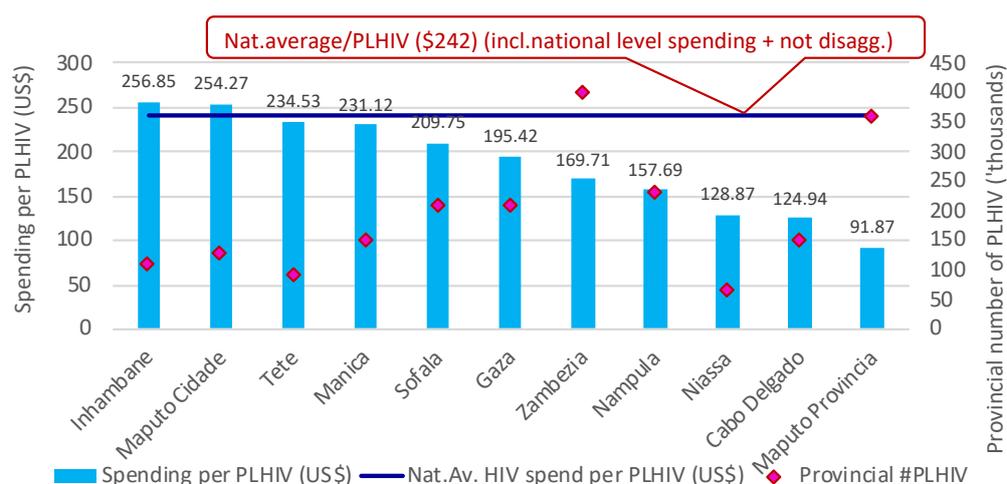
In 2017, the NASA was able to track the spending on HIV per province primarily because all PEPFAR's FY17 spending was split by 'sub-national unit' in their expenditure reporting format. Additionally, the spending on ARVs and other commodities was apportioned to provinces based on the volumes distributed by the Central Medical Stores (CMAM). The spending usually labelled as national level would be central ministries' spending, headquarters of development partners, and programme enablers that benefit the entire country. Figure 14) indicates that the proportions of the total HIV spending varied from 2% in Niassa to 13% in Zambezia, and with 26% labelled as national level spending.

Figure 14: Provincial shares of HIV spending (%), 2017



When taking into account the provincial numbers of PLHIV (as an indicator of geographic burden of disease), the provincial HIV spending per PLHIV varied from \$92 in Maputo Province, to \$257 per PLHIV in Inhambane. The national average spending per PLHIV (when including the national level and not disaggregated spending) was \$242/PLHIV in 2017 (Figure 15).

Figure 15: Provincial HIV spending per PLHIV (\$) in 2017



The provincial level analysis was not conducted for 2018 because PEPFAR IP’s new expenditure reporting format 2018 does not include a sub-national identifier. As a major source for of the total spending, an analysis of the remaining spending by province would not have produced meaningful results.

The following sections explore the spending on specific interventions within each program area, and the provincial activities.

3.8. HIV spending by programme area, financing entity, province and beneficiary

3.8.1. HIV programme area spending

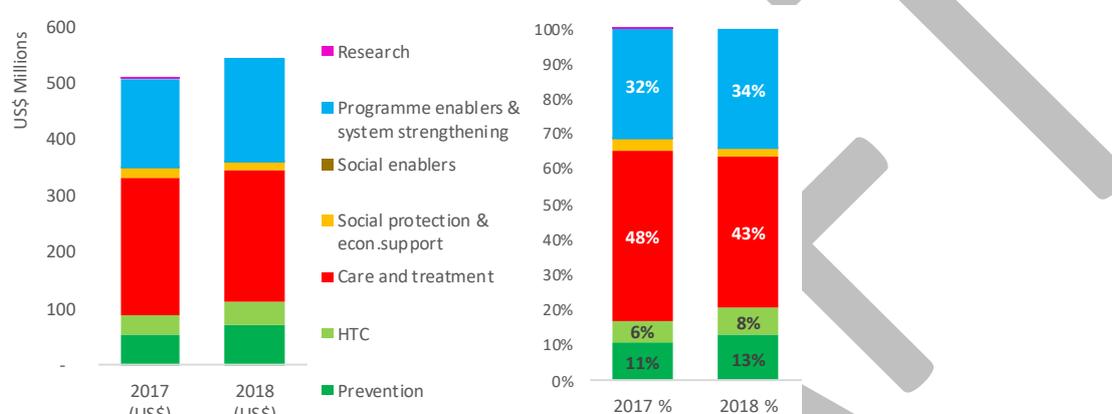
Key findings from this section:

- Care and treatment activities took the largest portion of HIV spending (48% and 43% in 2017 and 2018), followed by programme enablers and system strengthening activities (32% and 34%).
- Prevention activities (excluding HIV testing and counselling) received increasing amounts: 11% and 13%, in each year, while the HTS category also increased from 6% to 8% between the two years, illustrating the country’s commitment to the first of the 90-90-90 targets.
- Spending on the other programme areas was very low.
- The dependence on international financing makes all the HIV programme areas particularly susceptible to changes in external priorities and shocks, undermining the sustainability of the HIV response.

The spending on the HIV response in Mozambique reflects the country’s prioritization of care and treatment taking 48% and 43% of total HIV spending in 2017 and 2018 respectively, increased from 35% in 2014 (reported in the previous NASA – refer to earlier Figure 3). The nominal amount spent on all care and treatment activities (not only ART) decreased between 2017 and 2018, from \$244.8 million to \$234.4 million (4% reduction) (Figure 16). The next largest share of the HIV spending went to programme enablers and system strengthening activities, increasing from \$160.3 million to \$185.2 million between 2017 and 2018 (32% and

34% respectively). Prevention activities (excluding HIV testing and counselling, HTC) took increasing amounts: \$54.6 million (11%) in 2017 and \$70.2 million (13%) in 2018 (29% increase), and the HTS category also increased by 29% from \$33 million (6% of total spend) to \$42.5 million (8%) between the two years, also illustrating the country's commitment to the first of the 90-90-90 targets. After these four major areas of spending, there was very little spent on social protection and economic support (including OVC support), which took only 3% (\$15.4 million) in 2017 declining to 2% (\$12.4 million) in 2018, while the social enablers received less than 0.1% in both years and research zero (0%) in 2018. This was partly because efforts to improve surveillance systems and performance monitoring were included under the programme enablers category, and not in the research category.

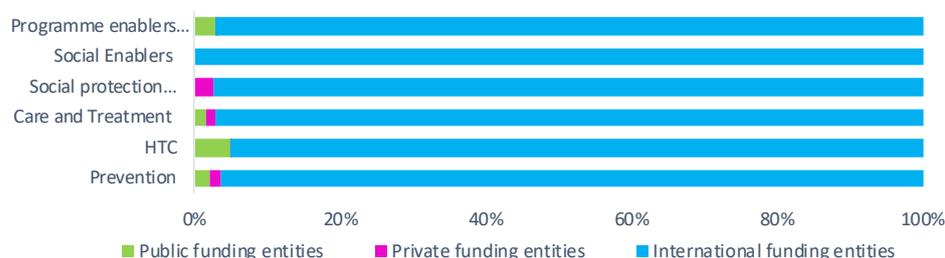
Figure 16: HIV spending by Programme Area (US\$ million, %, 2017-2018)



3.8.2. HIV programme area spending by financing entity

Examining the sources of financing and their programmatic areas of support, Figure 17 the heavy dependency on international financing entities for all the programmatic areas, recalling that public sources contributed 2% of the total HIV spending in both 2017 and 2018, and this is therefore reflected in all the programme areas.

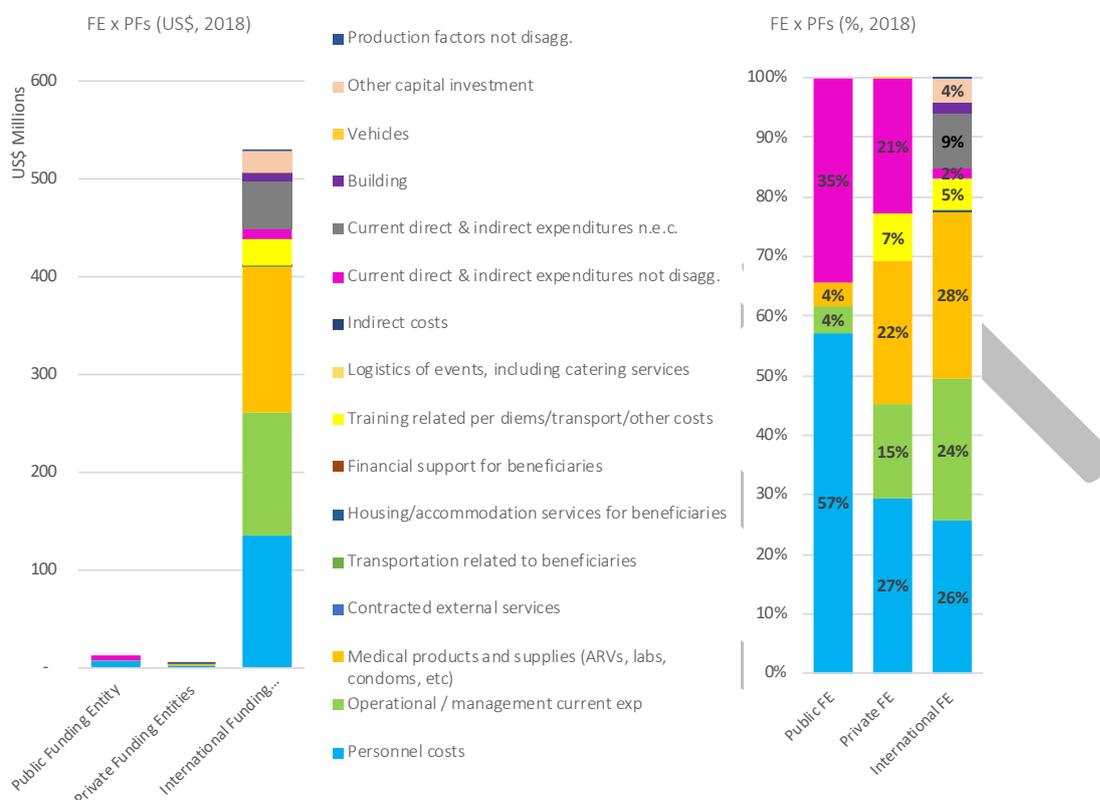
Figure 17: Proportional spending on HIV programme areas by Financing Entities (% , 2018).



Similarly, an analysis of the funding entities by their production factors (Figure 18) mostly displays the cost components of the international entities' financing, but also highlights that the small amounts of public financing are supporting mainly personnel salaries and other recurrent costs not disaggregated. Thus the critical production factors of ARVs, other medical supplies, the bulk of the salaries etc. are

being covered by external funding, on which the country's HIV response is therefore highly dependent.

Figure 18: Financing Entities' financing by production factors (US\$, %, 2017-2018)



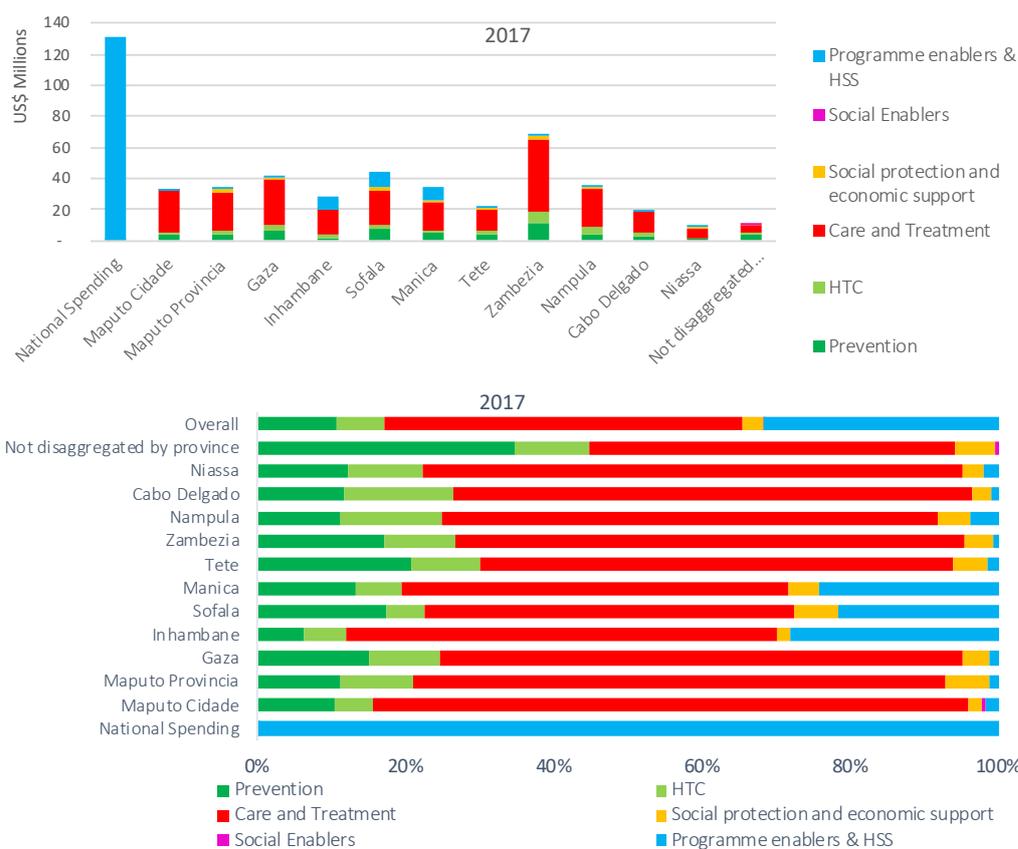
Even though larger portions are channelled through government financing schemes (as shown in section 3.4 above), the overall dependence on international financing entities makes all the HIV programme areas particularly susceptible to changes in external priorities and shocks (such as the impact of COVID-19), which would influence the availability of funding for the HIV response, undermining its sustainability.

3.8.3. HIV programme area spending by province

The provincial prioritisation of programme area varied only slightly in 2017⁷, with the largest portions going to care and treatment activities, followed by prevention and HTS activities. Almost all of the programmatic enablers occurred at the national level, although Inhambane, Sofala and Manica provinces also had around 20% of their spending on programmatic enablers – the bulk of which were UNITAID funds via the Clinton Health Access Initiative (CHAI) for laboratory strengthening. Figure 19 shows first the nominal amounts (where the provincial amounts are dwarfed by the national level spending) and then the proportional splits per province.

⁷ Spending in 2018 cannot be displayed by province due to the large portion of PEPFAR funds not disaggregated by sub-national identifiers.

Figure 19: Provincial HIV spending by programmatic areas (US\$ million, %, 2017)



3.8.4. HIV programme area spending by beneficiary

HIV spending in Mozambique benefitted mostly PLHIV (39% in 2018), driven by the large proportional spending on care and treatment, but an equally large share (41%) went to activities that were non-targeted in terms of beneficiaries. The general population benefitted from 10%, vulnerable and accessible populations from 9% and key populations only 2% in 2018 (Figure 20).

Figure 20: HIV spending by beneficiary groups (US\$ million, %, 2017-2018)

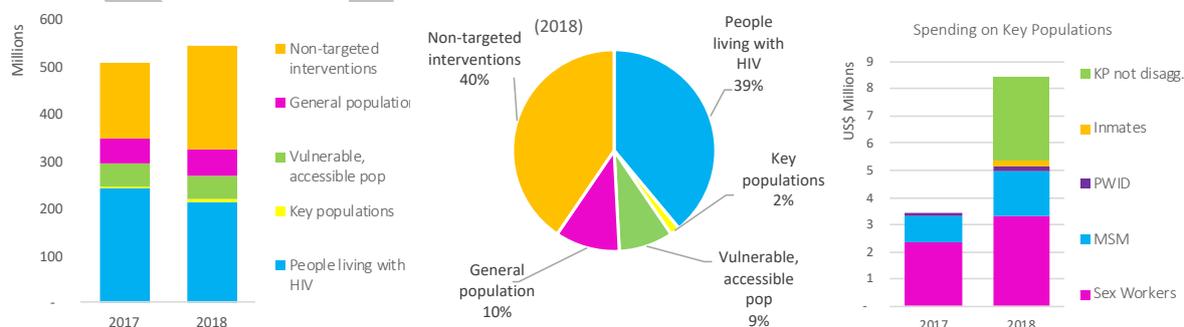
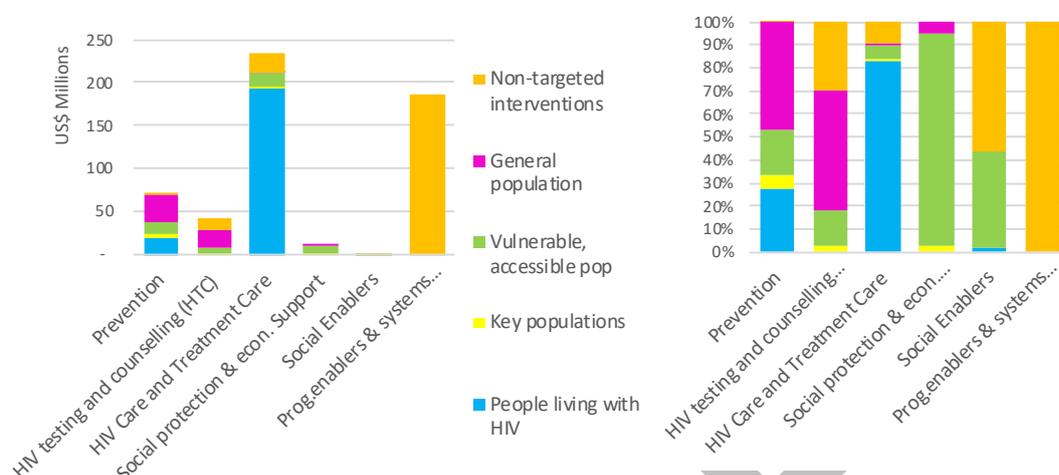


Figure 21 indicates the beneficiaries of the spending on each HIV programmatic area in 2018, both in nominal terms (figure on left) and proportional terms (figure on right). As would be expected, the care and treatment activities benefitted mostly PLHIV (83%), while prevention spending was targeted mostly towards the general

population (47%), with 20% towards vulnerable populations and 6% for key populations. HTC also targeted primarily the general population (52%), non-targeted (30%), vulnerable populations (15%) and key populations (3%). Programme enablers were entirely (100%) non-targeted.

Figure 21: Beneficiaries of spending on HIV programme areas (US\$ millions, %, 2018)



The following sections delve into each of the programme areas and provide insight into the specific interventions (AIDS spending categories), as well as into provincial variations in spending per output for certain interventions. Section 3.10 presents the production factors (cost components) of each of the programme area spending.

3.9. HIV spending on interventions (ASC) per programme area

3.9.1. Prevention activities

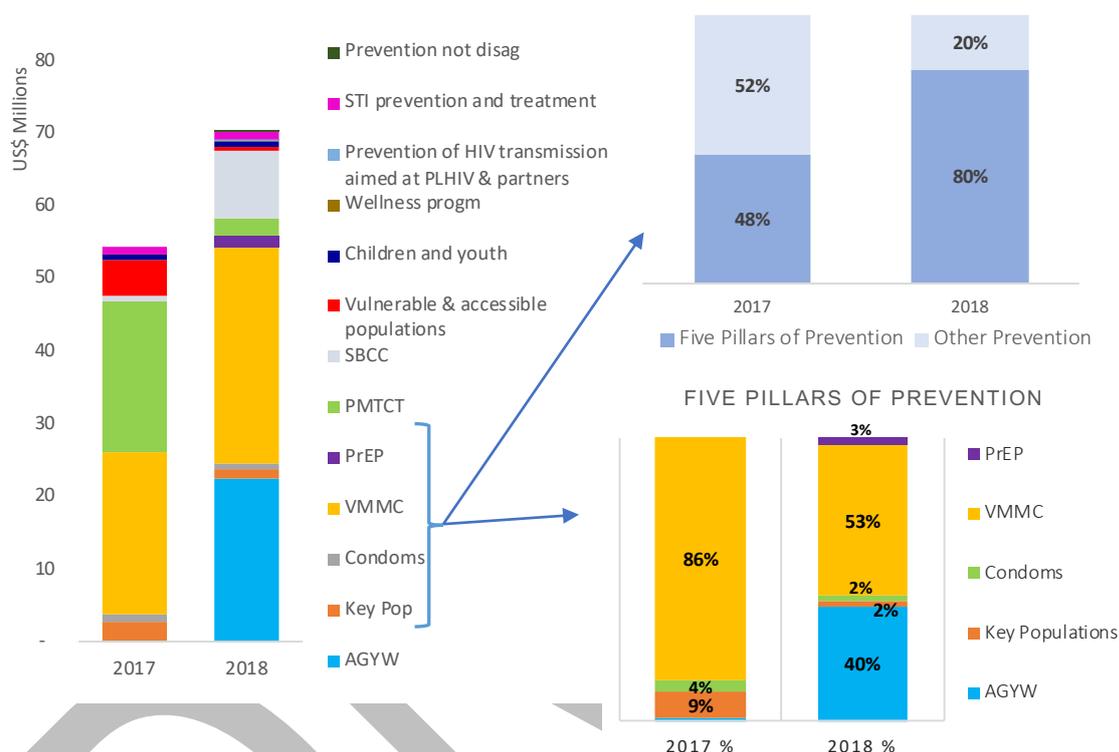
Key findings in this section:

- Prevention spending prioritized VMMC (86% in 2017 and 53% in 2018).
- There was increased spending for AGYW (40% in 2018).
- Comparatively little spending on PrEP (although increasing).
- The proportional spending on condoms and key populations decreased between 2017 & 2018.
- The average spending per circumcision nationally was \$70 (ranging between provinces from \$39 to \$219) in 2017.

Within the prevention programme area (see Figure 22 and Table 12 below), spending in Mozambique prioritized voluntary male medical circumcision (VMMC) with 41% and prevention of mother-to-child transmission (PMTCT) with 38% in 2017, but in 2018, this shifted to interventions for adolescent girls and young women (AGYW) with 32% and VMMC with 42%. The PMTCT spending appears to have dramatically decreased, but this is mostly driven by PEPFAR's new ER categories in 2018 which no longer distinguished their PMTCT spending within their HIV clinical services category. Also with the expansion of treatment for all, the ARV spending on pregnant women is now captured under the ART intervention, instead of under PMTCT. All other prevention interventions received very little

funding, with 2% or less in 2018. The spending on key populations halved from \$2.4 million (4%) in 2017 to \$1.2 million (2%) in 2018, while spending on vulnerable and accessible populations also dramatically reduced from \$5 million (9%) to \$0.6 million between the two years (also noting that there was some spending on testing for key populations, pregnant women and vulnerable populations captured under the HIV testing and counselling (HTC) programme area, section 3.4.2). Spending on condoms appeared low in both years, and reduced slightly from \$1.1 million to \$0.98 million in 2018 (Figure 22).

Figure 22: Spending on all prevention interventions (US\$ millions, 2017-2018) and Five Pillars (% , 2017-2018)



Given the increasing spending on AGYW, Mozambique's proportion of prevention spending that went towards the Five Pillars of Prevention (UNAIDS, 2017) increased from 48% to 80% of prevention spending, and increased from 5% to 10% of total HIV spending between 2017 and 2018, showing prioritization of those prevention interventions deemed to be the most impactful. However, as noted, in 2018 the Five Pillar spending was dominated by AGYW and VMMC, with very little going to the other interventions: PrEP (although increasing), condoms, and key populations. Figure 22 also shows these changing foci over the two years, and Table 12 provides the detailed absolute numbers.

Table 12: Spending on prevention – five pillars and other (US\$, 2017-2018)

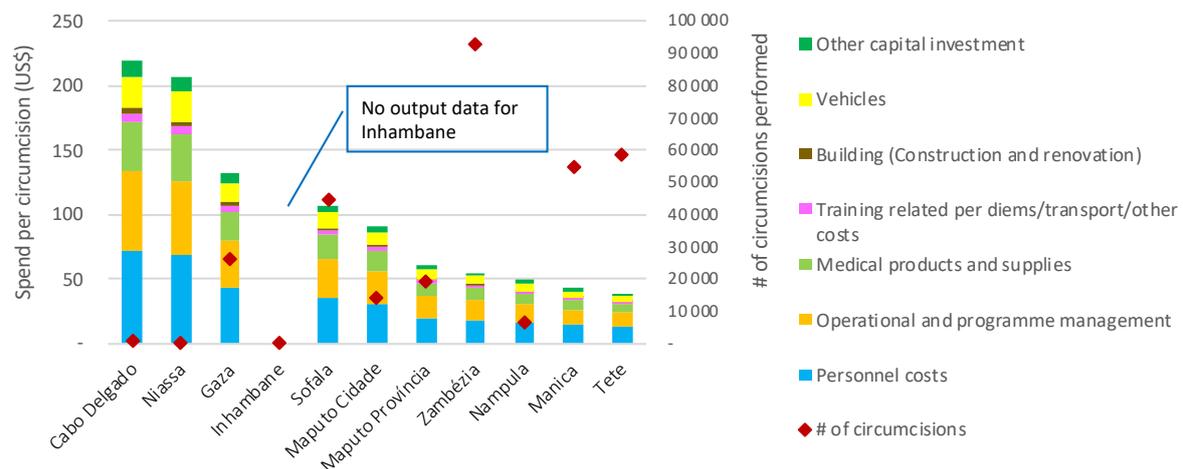
ASC.01 Prevention Spending	2017	2018
ASC.01.01 Five Pillars of Prevention	26 024 063	55 882 514
ASC.01.01.01 Prevention for adolescent girls and young women (AGYW) and their male partners in settings with high HIV prevalence	252 900	22 460 504
<i>ASC.01.01.01.02 Youth-friendly SRH services for AGYW - only if earmarked HIV funds are spent</i>	252 900	83 886
<i>ASC.01.01.01.04 Cash transfers, social grants and other economic empowerment as part of programmes for AGYW - only if earmarked HIV funds are spent</i>	-	546 469
<i>ASC.01.01.01.98 Programmatic activities for AGYW not disaggregated by type</i>	-	21 830 149
ASC.01.01.02 Services for key populations	2 382 886	1 183 234
<i>ASC.01.01.02.01 Programmatic activities for sex workers and their clients</i>	1 361 670	574 471
<i>ASC.01.01.02.02 Programmatic activities for gay men and other men who have sex with men (MSM)</i>	975 924	227 062
<i>ASC.01.01.02.04 Programmatic activities for People who Inject Drugs (PWID) including harm reduction programmes</i>	45 291	-
<i>ASC.01.01.02.05 Programmatic activities for inmates of correctional facilities or pre-trial detention centres (prisoners)</i>	-	184 300
<i>ASC.01.01.02.98 Services for key populations not disaggregated (exclusively for the five populations here described)</i>	-	197 400
ASC.01.01.03 Condoms (for HIV prevention) for the general population (excluding KPs and AGYW above)	1 118 720	981 732
<i>ASC.01.01.03.02 Social marketing of condoms for HIV prevention (excluding for KPs and AGYW)</i>	354 862	385 042
<i>ASC.01.01.03.04 Sale of condoms (purchased by individuals)</i>	763 858	488 080
<i>ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated</i>	-	108 609
ASC.01.01.04 Voluntary medical male circumcision (VMMC) for HIV prevention	22 269 558	29 800 035
<i>ASC.01.01.04.01 Voluntary medical male circumcision (VMMC) programmes</i>	284 853	-
<i>ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated</i>	21 984 705	29 800 035
ASC.01.01.05 Pre-Exposure Prophylaxis (PrEP)	-	1 457 009
<i>ASC.01.01.05.01 PrEP as part of programmes for AGYW</i>	-	655 658
<i>ASC.01.01.05.98 PrEP not disaggregated by key population</i>	-	801 351
ASC.01.02 Other Prevention activities	28 559 581	14 349 483
ASC.01.02.01 Prevention of vertical transmission of HIV infection (PMTCT)	20 869 984	2 383 207
<i>ASC.01.02.01.03 Reproductive health and family planning services as part of PMTCT programmes</i>	51 355	6 122
<i>ASC.01.02.01.98 PMTCT not disaggregated by activity</i>	20 818 629	2 377 085
ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations	579 483	9 220 810
ASC.01.02.03 Community mobilization for populations other than key populations	131 934	-
ASC.01.02.04 Programmatic activities for vulnerable and accessible populations	5 040 035	592 815
<i>ASC.01.02.04.01 Condom and lubricant promotion and provision as part of programmes for vulnerable and accessible populations</i>	-	44 286
<i>ASC.01.02.04.03 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations</i>	1 034 465	548 530
<i>ASC.01.02.04.98 Programmatic activities for vulnerable and accessible population not disaggregated by type</i>	4 005 570	-
ASC.01.02.05 Prevention for children and youth (excluding for AGYW in countries with high HIV prevalence)	787 567	690 912
<i>ASC.01.02.05.01 Prevention activities implemented in school</i>	-	293 915
<i>ASC.01.02.05.02 Prevention activities implemented out-of-school</i>	-	44 686
<i>ASC.01.02.05.98 Prevention activities for children and youth not disaggregated by type</i>	787 567	352 311
ASC.01.02.06 Prevention of HIV transmission aimed at people living with HIV and their partners (including sero-discordant couples)	-	183 150
<i>ASC.01.02.06.01 BCC for PLHIV and SDC</i>	-	62 137
<i>ASC.01.02.06.98 Programmatic activities for PLHIV and SDC not disaggregated by type</i>	-	121 013
ASC.01.02.07 Prevention and wellness programmes in the workplace	629	134 983
ASC.01.02.10 STI prevention and treatment programmes for populations other than key populations - only if funded from earmarked HIV budgets	1 149 950	935 938
<i>ASC.01.02.98 Prevention activities not disaggregated</i>	-	207 668
Total ASC.01 Prevention spending	76 572 349	73 780 085

Since VMMC was a large focus of the prevention spending, we examined the provincial VMMC spending and their numbers of circumcisions performed in 2017, and found wide variation in the expenditure per circumcision from \$39 in Tete to \$219 in Cabo Delgado – with some relationship to the volumes performed in the province: 58 thousand in Tete and only 330 reportedly in Cabo Delgado – but it is suspected that these numbers might be under-reported. There were no data for circumcisions in Inhambane.

The average spending per circumcision nationally was \$70 in 2017, and economies of scale have been achieved in the higher volume provinces: Zambézia, Manica and Tete, in comparison to the low volumes and high costs in Cabo Delgado and Niassa (Figure 23). However, these two provinces' high expenditure should be interpreted

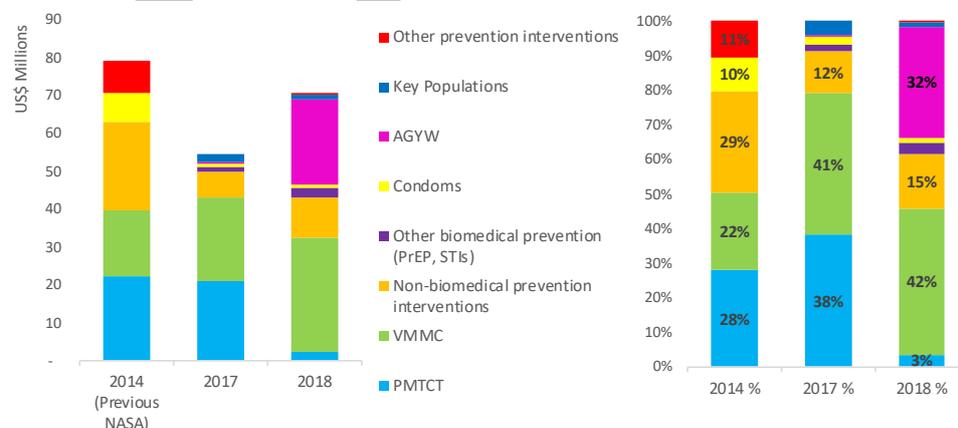
with caution as their output figures (of circumcisions performed) were possibly incorrect. The cost components (production factors) are shown and are explored further in Section 5.2, however, *proportionally*, the cost drivers were similar across the provinces.

Figure 23: Provincial spending per adult male circumcission by production factor (left axis) and numbers of circumcisions (right axis) (US\$, 2017)



Comparing this NASA’s findings of prevention spending in 2017 and 2018 with the previous NASA for 2014 is tricky because of the differing classifications. Figure 24 removes the HTC (which used to be included in the prevention programme area) and attempts to match the ‘non-biomedical’ and ‘other biomedical’ categories used in the previous NASA, to show changes between 2014 and 2017. Since an in-depth examination of the years 2015-2016 was not undertaken for this NASA, we cannot speculate on the reasons for these changes, except to note that although there have been decreasing absolute amounts going to prevention (partly due to the strong emphasis on testing for the first 90-90-90 target), there has been an increasing prioritisation of prevention spending on the five pillars (noting that these were not being emphasized in 2014).

Figure 24: Comparison with 2014 prevention spending (US\$ millions, %, 2014-2018)



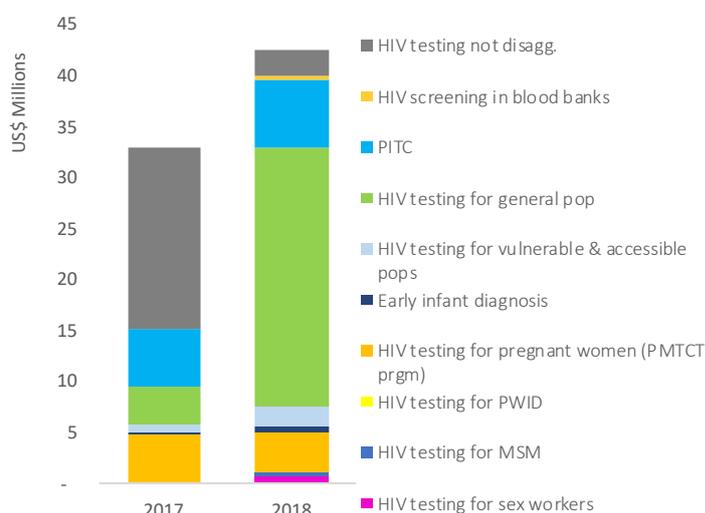
3.9.2. HIV testing and counselling

Key findings in this section:

- Spending on HTC increased in 2018, with a large portion for the general population.
- The national average spend per test was \$4.20 [\$3-\$8] in 2017.
- Personnel costs were the main cost drivers in the provinces with the higher spend per test.

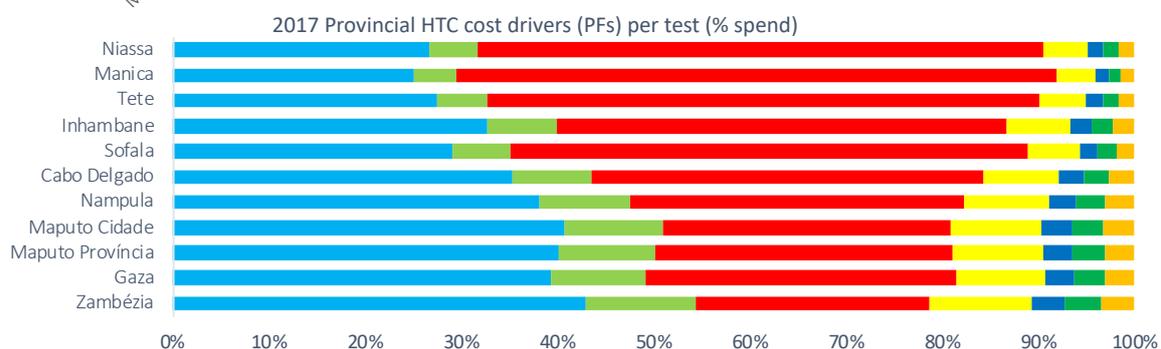
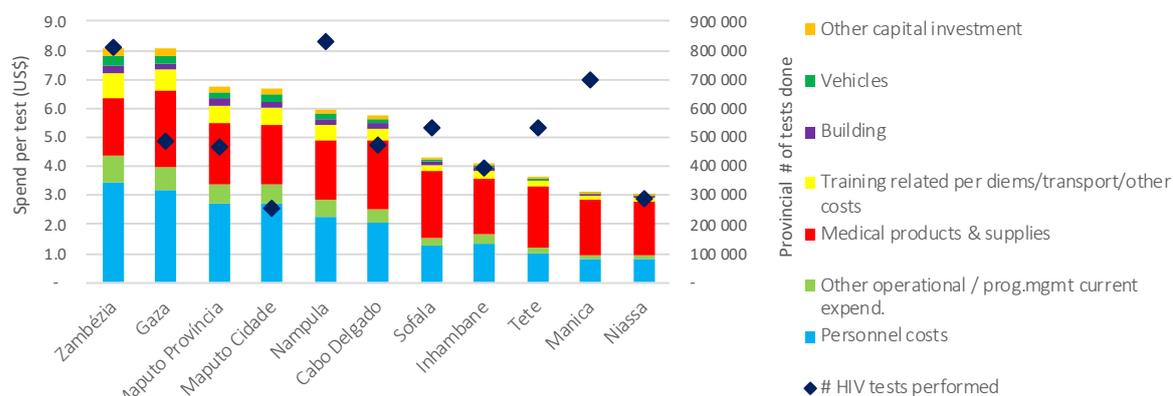
Within the HIV testing and counselling programme area, the spending was broken down, as far as possible, into testing for key populations, pregnant women, infants (early infant diagnosis, EID), vulnerable populations, blood banks and general population, showing a dramatic increase in the latter (Figure 25). However, the large portion of ‘HTC not disaggregated’ in 2017 was due to the old PEPFAR EA categories not being disaggregated by type of testing, and was most likely for general population testing. The new 2018 PEPFAR ER categories allow for more detail, hence the portion of ‘not disaggregated’ HTC decreased in 2018.

Figure 25: Spending on HIV testing and counselling (US\$ millions, 2017-2018)



Examining the cost drivers of the provincial variations in HTC spending per test, Figure 26 shows a range in spending per test from \$3 in Manica and Niassa to \$8 in Zambézia and Gaza, with a national average spend of \$4.20 per test in 2017. There does not appear to have been economies of scale achieved in Zambézia with the highest volume of tests performed (809 thousand), while Niassa had the lowest volume of tests (287 thousand) and yet the lowest unit/spend per test. Examining the production factors shows that personnel costs were the main cost drivers in the more expensive provinces (Zambézia, Gaza, Maputo Provincia and Maputo Cidade), while the test commodities (medical supplies) were the cost drivers in the provinces with lower spending per test (Niassa, Manica and Tete). Areas for efficiency gains should be explored further.

Figure 26: Provincial HTC spending by production factors province (left axis) and volumes of tests performed (right axis) (US\$, %, 2017)



3.9.3. Care and treatment activities

Key findings in this section:

- Spending on care and treatment activities declined between the two years, and the bulk went towards ART in 2018.
- The national average spend per person on ART was \$207 per annum [\$170-\$239].

Of the spending on all the care and treatment (C&T) activities, the largest portion (81%) went to ART in 2018, reaching \$189 million (Figure 27). In 2017, there was a large portion of C&T spending that was not disaggregated – these were mostly the PEPFAR categories of facility- or community-based care and treatment services from which ART specific spending could not be disaggregated. It is likely that the bulk of those funds were indeed for ART in 2017.

Figure 27: Spending on Care and Treatment interventions (US\$ million, %, 2017-2018)

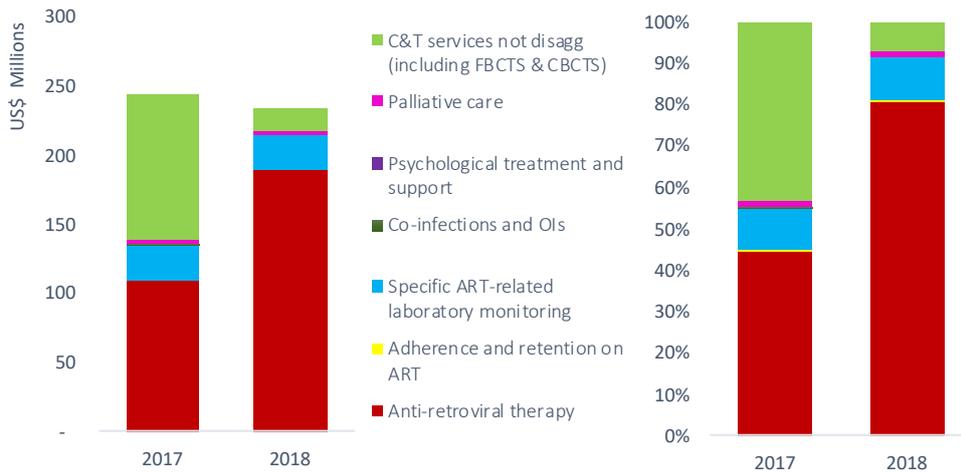
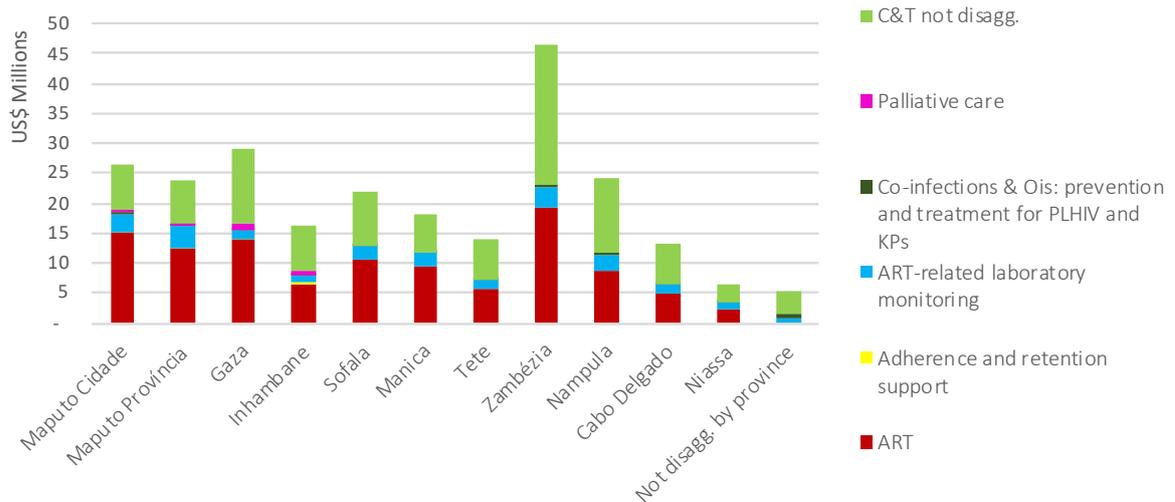


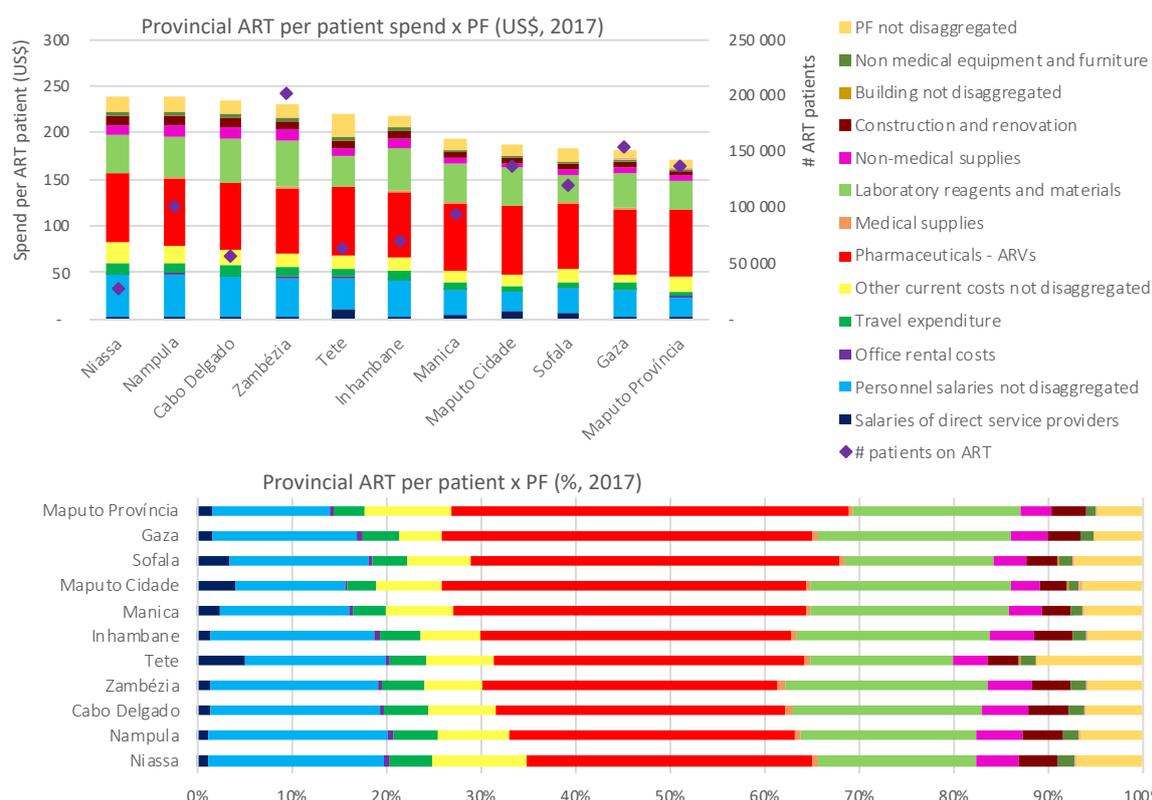
Figure 28 shows the total spending on C&T (more than ART only) per province in 2017, by the activities, indicating the highest total spent in Zambézia and the least in Niassa.

Figure 28: Provincial spending on Care and Treatment activities (US\$ millions, 2017)



The following Figure 29 presents only the ART spending (including laboratory costs) per ART patient per province, by their production factors, showing some variation around a national average of \$207 per patient, from \$170 in Maputo province to \$239 in Niassa, in 2017.

Figure 29: Provincial spending per ART patient by PF (left axis) and number of ART patients (right axis) (US\$, 2017)

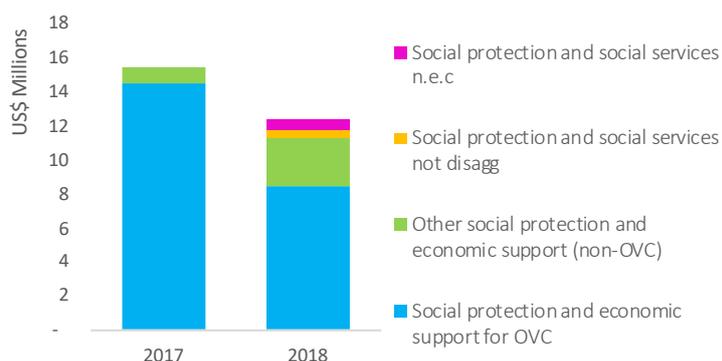


There appears to have been some economies of scale achieved, with an inverse linear relationship between the ART unit/spend and the volumes of persons on ART per province, where Maputo reached 137,000 ART patients (adults and children) with the almost lowest unit/spend, while Niassa reported 26,000 ART patients, with the highest unit/spend. The slight variation in units of expenditure were driven mostly by variation in personnel costs, while all other production factors remained more or less the same per person (ARVs, labs, non-medical supplies etc). Refer to Section 5.1 for the examination of the ART production factors and cost drivers.

3.9.4. Social protection and economic support spending

Spending on social protection and economic support in Mozambique only formed 3% and 2% of the total HIV spending in 2017 and 2018 respectively, and reduced by 20% between the two years from \$15.4 million to \$12.4 millions, of which most was for OVC support (94% on 2017 and 68% in 2018) (Figure 30).

Figure 30: Spending on social protection and economic support (US\$ million, 2017-2018)



3.9.5. Social enablers spending

Social enablers spending was extremely low in Mozambique, less than 0.1% in both 2017 and 2018, but increasing in the latter year from \$164 thousand to \$680 thousand), of which most reportedly went for human rights programmes (Table 13).

Table 13: Spending on social enablers (US\$, %, 2017-2018)

Social enablers (US\$)	2017	2018	2017 %	2018 %
Human rights programmes	125 000	680 074	76%	100%
Social enablers not disaggregated by type	39 537	-	24%	0%
Total S.Enablers spend (US\$)	164 537	680 074	100%	100%

3.9.6. Programme enablers and systems strengthening spending

Programme enablers and systems strengthening received increasing funding (+16%), from \$160.3 million in 2017 to \$185.2 million in 2018. Figure 31 and Table 14 shows the breakdown within this programme area, and that the largest shares (43% and 46%) went to programme administration and management, followed by public systems strengthening (32% and 43%) in 2017 and 2018 respectively. Most of this spending was at the national level, except for the laboratory strengthening project funded by UNITAID and implemented by CHAI in Sofala, Manica and Inhambane.

Figure 31: Programme enablers and systems spending (US\$ million, %, 2017-2018)

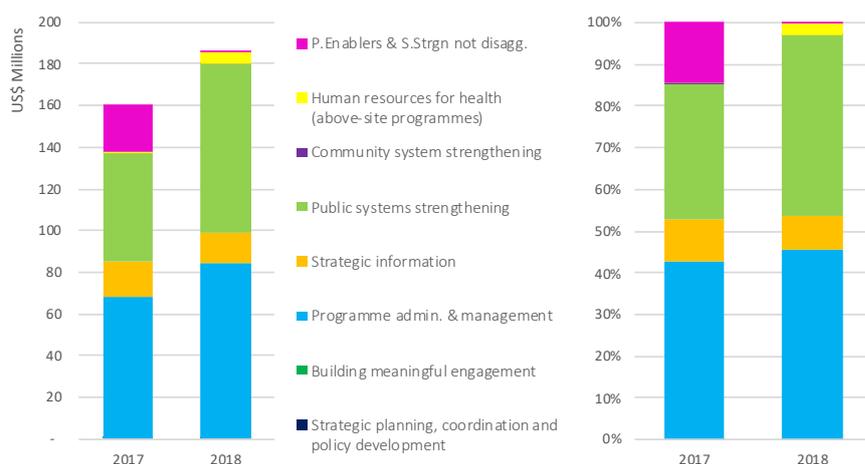


Table 14: Programme enablers and systems strengthening spending (US\$, %, 2017-2018)

Programme enablers and systems strengthening	2017	2018	2017 %	2018 %
Strategic planning, coordination and policy development	1 304	443	0%	0%
Building meaningful engagement	100	-	0%	0%
Programme admin. & management	68 622 120	84 581 114	43%	46%
Strategic information	16 298 796	14 466 347	10%	8%
Public systems strengthening	51 893 946	80 423 774	32%	43%
Community system strengthening	569 681	194 921	0%	0%
Human resources for health (above-site programmes)	48 670	5 518 284	0%	3%
P.Enablers & S.Strgn not disagg.	22 880 347	20 019	14%	0%
Total P.Enablers & S.Strengthening	160 314 965	185 204 902	100%	100%

3.9.7. Development synergies spending

This NASA found no spending in Mozambique in 2017 and 2018 that could be labelled as ‘development synergies’, which are those “investments in other sectors that can have a positive effect on HIV outcomes” (UNDP & UNAIDS, 2012), such as: formative education for health care workers, reducing gender-based violence, and promoting HIV-sensitive cross-sectoral development.

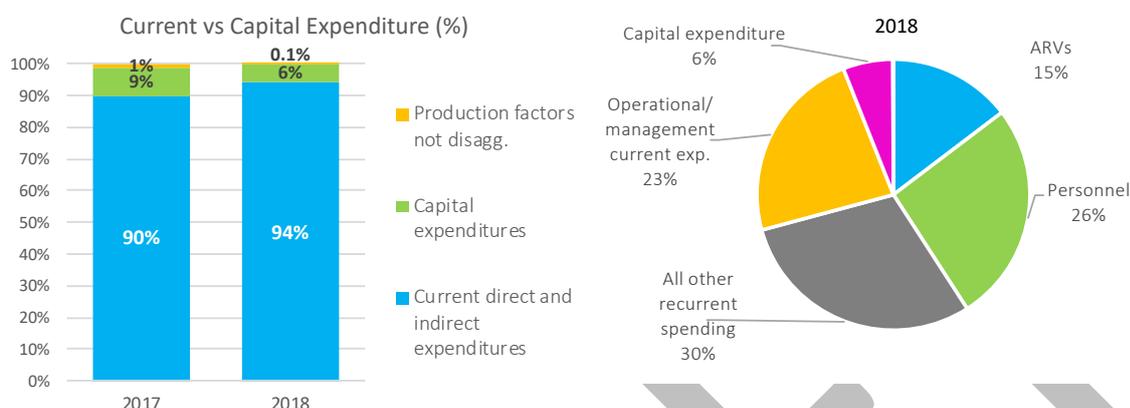
3.9.8. HIV-related research spending

Only \$200,000 was reportedly spent on HIV-related research in 2017 and none in 2018 in Mozambique. Although there were evaluations and applied research projects that took place, they were likely categorized as health system strengthening and therefore not captured here - particularly those funded by PEPFAR, since they do not have a research category in their new expenditure reporting categories.

3.10. Production factors of HIV/AIDS spending

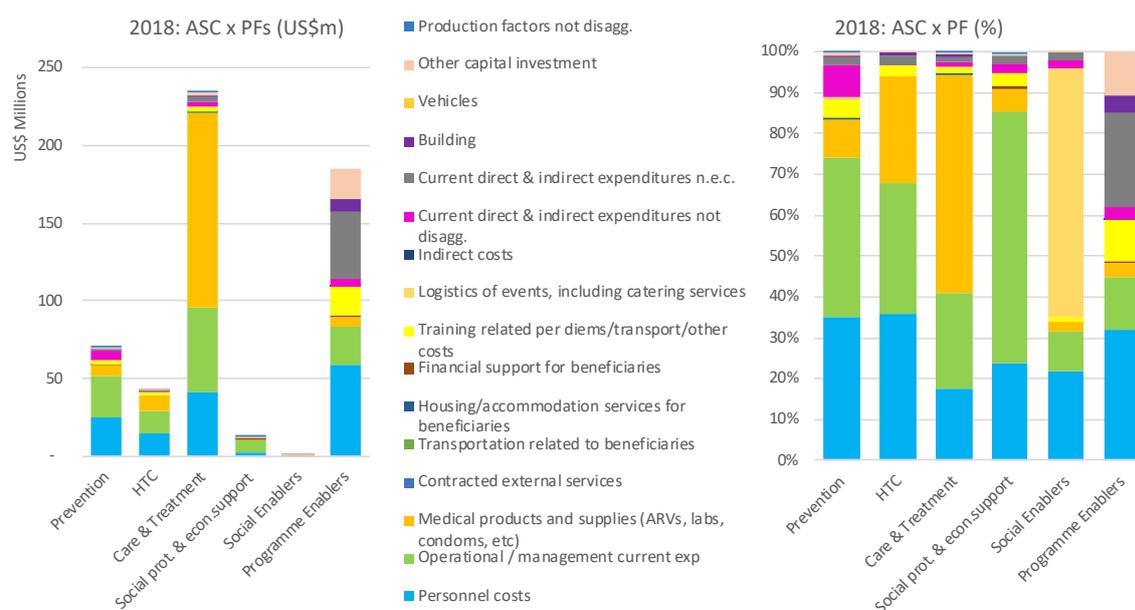
The production factors (PFs), or cost components, give some indication of the composition of spending on particular HIV interventions, and can highlight key cost drivers and possible inefficiencies (if comparators are available). The latter aspects are explored in more detail in Section 5 which considers the efficiency of spending.

Figure 32: HIV spending by production factor: capital versus recurrent spending (% , 2017-2018) and broad PF categories (% , 2018)



The bulk of HIV spending in Mozambique were recurrent expenditures (90% and 94% in 2017 and 2018 respectively). In 2018, personnel took 26% of the total, ARVs 15%, operational/management costs 23%, all other current 30% and capital only 6% (Figure 32). Of the capital spending, just over half (52% in 2018) went to laboratory and other medical equipment. Figure 33 and Table 15 provide greater disaggregation of the various PF categories, while the financing entity by their production factors was presented in Section 3.8.2 (Figure 17).

Figure 33: HIV production factors per programmatic area (US\$ million, %, 2018)



Examining the programmatic areas by their production factors (Figure 31) shows that in 2018 medical products (mostly ARVs) formed the largest part of care and

treatment (54%), while personnel costs for care and treatment were proportionally lower at 18% than for other areas. HTC personnel were 36% and HIV test kits were 26%; prevention personnel formed 35%, and was 32% for programme enablers, which also had a large portion of current spending that could not be disaggregated (23%). Social protection efforts (mostly for OVCs) had the largest portion (62%) of operational and management costs – noting that total spend on social protection was very low.

Table 15: HIV spending by production factors (US\$, %, 2017-2018)

Production factor (US\$)	2017	2018	2017 %	2018 %
Current direct and indirect expenditures	457 052 118	512 840 863	90%	94%
Personnel costs	153 305 328	143 467 980	30%	26%
Operational / management current exp	54 426 568	126 688 399	11%	23%
Medical products and supplies:				
<i>Antiretrovirals</i>	81 367 751	79 696 757	16%	15%
<i>STI drugs</i>	962 592	721 128	0.2%	0.1%
<i>Pharmaceuticals not disaggregated</i>	1 496 680	95 820	0.3%	0.0%
<i>Condoms</i>	2 144 631	550 972	0.4%	0.1%
<i>Lubricants</i>	-	62 892	0.0%	0.0%
<i>Medical supplies not disaggregated</i>	-	15 797 609	0%	3%
<i>HIV tests screening/diagnostics</i>	17 241 090	14 570 074	3%	3%
<i>VL tests</i>	6 846 939	14 060 270	1%	3%
<i>CD4 tests</i>	10 829 218	11 144 410	2%	2%
<i>Reagents not disagg.</i>	23 940 047	-	5%	0%
Non-medical supplies:				
<i>Food and nutrients</i>	5 585 923	702 776	1%	0%
<i>Promotion and information materials</i>	527 489	745 646	0.1%	0.1%
<i>Non-medical supplies not disaggregated</i>	14 432 660	12 007 000	3%	2%
<i>Office Supplies</i>	-	69 166	0%	0.0%
<i>Medical products and supplies not disaggregated</i>	-	127 363	0%	0.0%
<i>Contracted external services</i>	292 986	341 152	0.1%	0.1%
<i>Transportation related to beneficiaries</i>	-	230 554	0%	0.0%
<i>Housing/accommodation services for beneficiaries</i>	85 758	230 554	0.0%	0.0%
<i>Financial support for beneficiaries</i>	-	1 078 793	0%	0.2%
<i>Training related per diems/transport/other costs</i>	33 062 677	26 918 811	7%	5%
<i>Logistics of events, including catering services</i>	661 406	1 065 974	0.1%	0.2%
<i>Indirect costs</i>	6 182	2 018	0.0%	0.0%
<i>Current direct & indirect expenditures not disagg.</i>	49 836 192	14 219 065	10%	3%
<i>Current direct & indirect expenditures n.e.c.</i>	-	48 245 678	0%	9%
Capital expenditures	44 544 688	32 187 838	9%	6%
Building:				
<i>Laboratory and other infrastructure upgrading</i>	10 367 019	3 274 963	2%	1%
<i>Construction and renovation</i>	13 447 416	6 505 471	3%	1%
<i>Building not disaggregated</i>	96 029	74 575	0.0%	0.0%
Vehicles	7 826 382	6 555	2%	0.0%
Other capital investment:				
<i>IT (hardware and software)</i>	18 603	18 603	0.0%	0.0%
<i>Laboratory and other medical equipment</i>	4 350 376	16 818 805	1%	3%
<i>Non medical equipment and furniture</i>	7 716 540	5 029 219	2%	1%
<i>Other capital investment not disagg.</i>	718 565	442 819	0.1%	0.1%
<i>Capital exp n.e.c.</i>	3 756	16 826	0.0%	0.0%
Production factors not disagg.	6 895 617	394 793	1%	0.1%
Total	508 492 423	545 423 494	100%	100%

Given the large contributions to HIV financing in Mozambique from PEPFAR and the Global Fund, the following figures present each of their total expenditures by production factor, and further details of their ASC x PFs are provided in the appendices. It can be seen (Figure 34) that US\$ 72 million (92% in 2018) of the Global Fund money went towards medical supplies which were ARVs for the Care and Treatment programme. PEPFAR funding (Figure 35) was spread more evenly across more production factors, noting that ‘operational and management costs’ included transport and other recurrent operational costs, as well as their IP’s management costs.

Figure 34: Global Fund spending by production factors (US\$, %, 2017-2018)

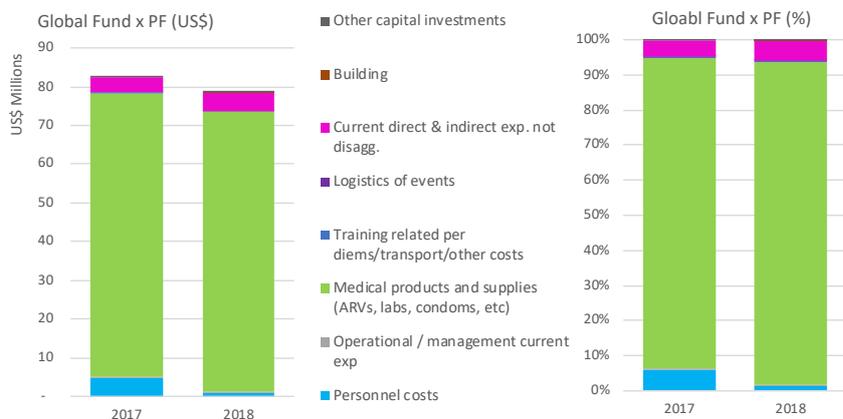


Figure 35: PEPFAR spending by production factors (US\$, %, 2017-2018)

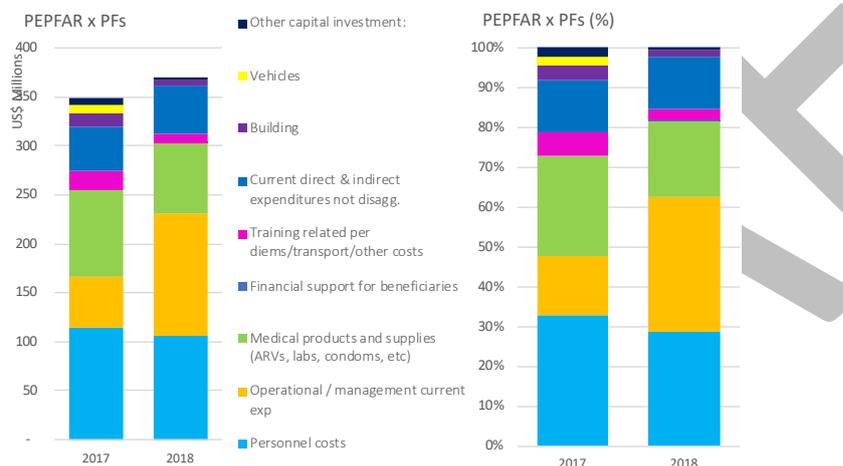


Figure 36: All Service Providers' spending by production factors (US\$, %, 2017-2018)

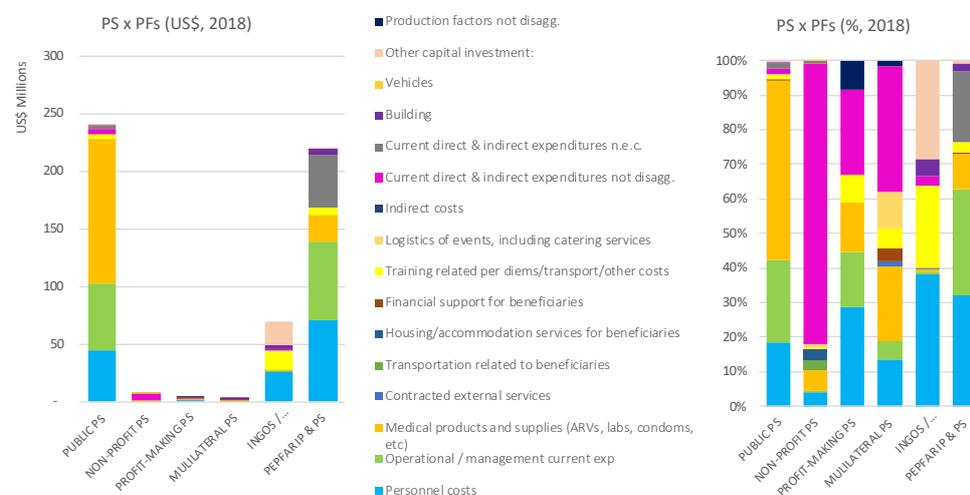


Figure 36 provides the production factors of the spending of the service providers, by their broad category types: public, non-profit, for-profit, multilaterals, INGOs

and PEPFAR IPs/ SRs (the latter all lumped together). Note that the production factors of a few specific interventions are explored in greater depth in Section 5, and further detailed tables in the appendices.

4. Comparison of spending and estimated costs of the PEN IV

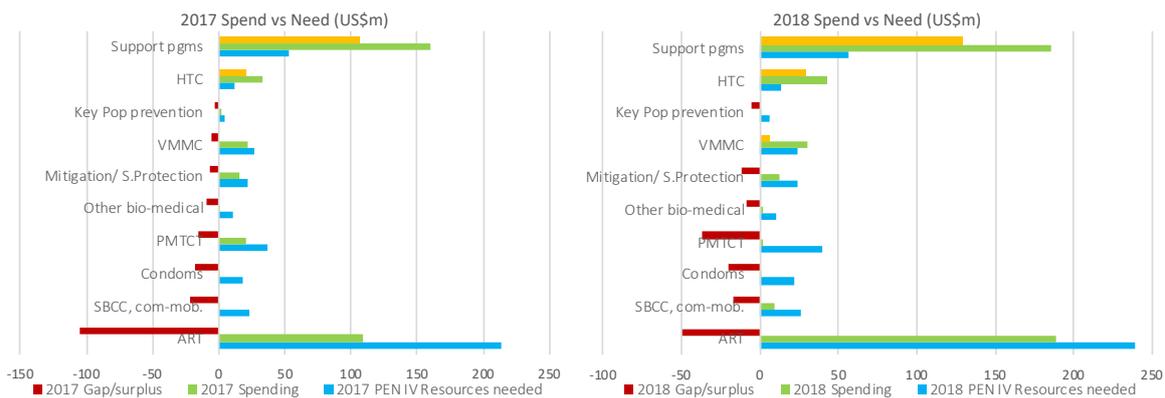
Key findings in this section:

- ART spending was less than PEN IV anticipated needed.
- Spending on SBCC, condoms, PMTCT, key populations and VMMC was very close to the costed need.
- There may have been a small funding surplus for HTC in both years (\$20-30 million), although HTC cost estimates may not have taken into account the increasing unit cost to reach those hard-to-reach.
- There was some alignment of spending prioritization with the PEN-IV proportional costs, with greater prioritization on ART, VMMC and HTC in 2018, and possible under-prioritization of condom provision and interventions for key populations.

As a simple measure of adequacy of funding and allocative prioritization, the spending per intervention, both nominal and proportional, is compared with the anticipated costs of PEN IV (for 2017 and 2018). Not all the interventions in the NASA or PEN-IV costs were directly comparable, therefore we compare costs and spending for specific (comparable) interventions in Figure 37. The comparison reveals that the spending on ART was less than anticipated as needed, less by US\$100 million in 2017 and US\$50 million in 2018, while managing to over achieve the targets used in the GOALS estimates for the PEN-IV. The spending was close to what was estimated as needed for certain interventions, with smaller potential possible gaps for SBCC, condoms, PMTCT, key populations and VMMC. The supposedly increasing gap for PMTCT was due to the expenditure being labelled differently in the PEPFAR 2018 expenditure reporting, which no longer differentiated the PMTCT spending, as well as the NASA PMTCT category no longer including the ARVs for pregnant woman – since these are now captured under ART.

There appears to have been a funding surplus for HTC in both years - however, the number of tests done were much higher than the targeted number used in the PEN-IV cost estimates. Additionally, the cost estimates may not have considered the increasing unit cost to reach the last 5-10% of the population and those hard-to-reach, and may have used only the basic cost for test commodities and not other costs related to delivery. Additionally, Sections 3.9.2 and 5.3 provide further examination of the cost drivers of HTC, to explore where inefficiencies might have occurred. There appears to have been ‘over-spending’ for “support programmes” - although it was unclear from the PEN-IV costing which activities were costed for this category, while the NASA social and programme enablers spending were captured here – therefore possibly causing a ‘false’ surplus.

Figure 37: PEN-IV estimated resources needed versus NASA spending (US\$ million, 2017-2018)



The expenditure on ART that was lower than estimated needed, even though reaching more people than were used in the cost estimates, and may have been due to efficiencies achieved or reducing prices of ARVs (refer to Section 3.12.1). Shortages of ARVs were not experienced during the study period, which implies there was adequate funding for ARVs. Additionally, when considering the proportional share of ART spending of the total spend, Figure 38 shows a greater and increasing share going to ART in 2018, which probably reflects the country's commitment to the 90-90-90 treatment targets. Further examination of the ART programme's performance and production factors may shed further light (Section 3.12.1).

Figure 38: Proportional comparison of PEN-IV costs with NASA spending (comparable activities) (% , 2017-2018)

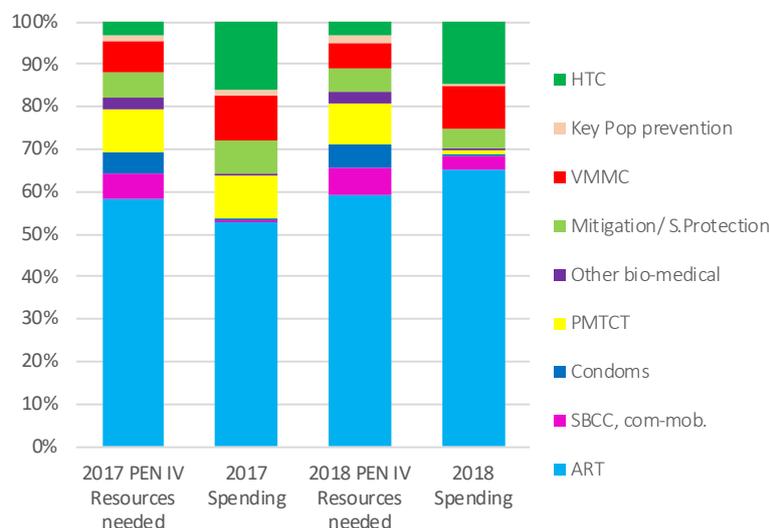


Figure 38 importantly shows some alignment of proportional prioritization in spending with the PEN-IV proportional costs, with greater prioritization on ART, VMMC and HTC in 2018 (all these programmes having achieved more than the targets used in the PEN-IV costing, Table 16), and possible under-prioritization of condom provision and interventions for key populations – compared to the estimated need. Given that key populations make up 11% of new infections (CNCS, Modes of HIV Transmission, Mozambique 2018), there appears to have been

inadequate spending on prevention interventions targeting these populations – only 2% of the total HIV spending in 2018. Stakeholders would be encouraged to examine these aspects when designing and funding PEN-V.

Table 16: PEN-IV Resource Needs Estimates – unit costs and targets applied & achieved

PEN-IV resource needs estimates (CNCS, Avenir Health)	Unit costs for PEN-IV cost (US\$)		Source	Targets / population to be reached		Actual Targets / population reached	
	2015	2019		2017	2018	2017	2018
Community mobilization	6.00	6.00	UNAIDS estimates (2015)	2 369 559	2 692 416		
Mass media	0.49	0.49	UNAIDS estimates (2015)	6 271 196	6 456 062		
Voluntary counseling and testing	3.34	3.34	UNAIDS estimates (2015)	2 405 150	2 475 502	7 866 465	9 787 397
Condom provision	0.25	0.25	UNAIDS estimates (2015)	72 981 761	84 048 676	Data not provided	
Youth - Cost per teacher trained	87.90	87.90	UNAIDS Estimates, 2014	368 955	379 691		
Youth - Cost of peer education for out of school youth	4.35	4.35	Programa da Geração Biz				
Workplace programs	6.30	6.30	Global Fund Concept Note				
Female sex workers	39.64	39.64	Global Fund Concept Note	69 541	75 064		
MSM reached with outreach and lubricants	64.61	64.61	Global Fund Concept Note	11 598	11 988	Data not provided	
PID - outreach and peer education per IDU targeted	79.86	79.86	UNAIDS Estimates, 2014	379	390		
STI management	1.43	1.43	UNAIDS Estimates, 2014				
Blood safety	5.40	5.40	UNAIDS Estimates, 2014				
Post-exposure prophylaxis	58.28	58.28	MISAU, CMAM (2015)				
Safe medical injection	0.23	0.23	RNM/Spectrum				
Universal precautions	300.00	300.00	RNM/Spectrum				
Male circumcision	93.43	49.54	UNAIDS Estimates, 2014	319 209	332 707	315 380	311 891
PMCT, Counseling - Pre-test	3.97	3.97	UNAIDS Estimates, 2014				
PMCT, Counseling - Post-test for HIV+	47.35	47.35	UNAIDS Estimates, 2014				
PMCT, Counseling - Post-natal (inc. breastfeeding)	53.10	53.10	UNAIDS Estimates, 2014				
PMCT, HIV testing - Mother	11.00	11.00	MISAU, PAH (2013)				
PMCT, HIV testing - PCR for infant after birth	5.88	5.88	MISAU, PESS (2013)				
PMCT, HIV testing - Infant after cessation of breastfeeding	1.32	1.32	MISAU, PESS (2013)				
PMCT, ARVs - Nevirapine, for infant	0.003	0.003	MISAU, PAH (2013)				
PMCT, ARVs - AZT	0.45	0.45	MISAU, PAH (2013)				
PMCT, ARVs - Triple treatment (TDF + 3TC + EFV)	0.43	0.43	MISAU, PAH (2013)	68 621	72 977	107 758	109 464
PMCT, ARVs - Triple treatment (AZT+3TC+NVP/EFV)	0.45	0.45	MISAU, PAH (2013)				
Service delivery (per mother)	11.51	11.51	MISAU, PAH (2013)				
Treatment, First line ART drugs (adults)	148.24	148.24	MISAU, CMAM (2015)				
Treatment, Second line ART drugs (Adults)	389.48	389.48	MISAU, CMAM (2015)				
Treatment, Lab costs for ART treatment	40.58	76.31	MISAU, CMAM (2015)				
Treatment, Cotrimoxazole prophylaxis	27.88	27.88	MISAU, CMAM (2015)	942 517	991 866	1 156 101	1 212 562
Treatment, TB prophylaxis	1.26	1.26	MISAU, CMAM (2015)				
Treatment, Nutrition supplements in first six months	17.30	17.30	MISAU (2015)				
Treatment, ARV drugs (Children)	124.48	124.48	MISAU, CMAM (2015)				
Treatment, Lab costs for ART treatment (Children)	29.00	29.00	MISAU, CMAM (2015)				
Treatment, delivery including OI treatment	16.62	16.62	UNAIDS Estimates, 2014				
Policy and Program Support	2015	2019	Total Per year, 2014-2019				
Program management (US\$ million)	4.14	4.14	Using NASA results 2010 as baseline				
Monitoring and evaluation (US\$ million)	19.08	17.77	Combined				
Training (US\$ million)	5.33	2.49	Combined				
Health systems strengthening (US\$ million)	27.99	25.74					
Community systems strengthening (US\$ million)	2.70	4.09					
OVC (US\$ million)	11.88	14.80					
Home-based care (US\$ million)	7.85	7.45					
Human Rights and Gender (US\$ million)	0.34	3.62					

5. Efficiency of HIV spending in Mozambique – outputs versus inputs

Key findings in this section:

- Mozambique appears to have achieved some technical efficiencies in spending per person on ART, and the savings made could fund another 47 thousand people on ART.
- VMMC may be suffering from lower than anticipated volumes which has increased their operational and recurrent costs, but the unit spend was in line with the estimated cost per circumcision used in the PEN-IV resource needs estimates.
- The spending per person tested appeared slightly higher than costed for PEN-IV, but new modalities of delivery, index-testing and reaching the hard-to-reach may have driven up the HTC delivery costs.
- The AGYW programme was only beginning to scale up in 2018, and hence no conclusions could be drawn as to its efficiency of spending.

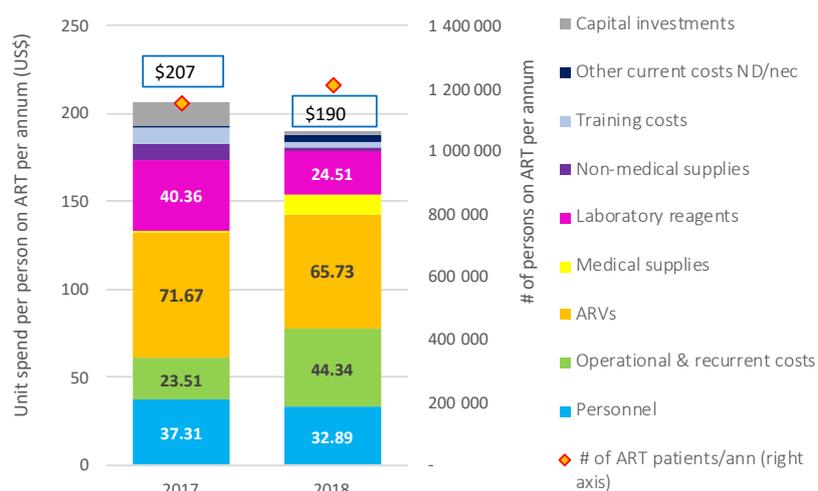
A comparison of expenditures (inputs) with the numbers of persons reached or served (outputs) by certain key interventions provides a unit of expenditure as a simple relative measure of in-/efficiencies when compared with the anticipated unit cost of those services (as applied in the costing of the PEN-IV). The unit spend per geographic area can also illustrate in-/equities in spending relative to need or burden of disease. This section explores the cost drivers (production factors) of the units of expenditure for ART, VMMC, HTC and AGYW, and explores changes over the two-year study period, as well as programme performance. A reminder of the change in PEPFAR expenditure reporting categories between the two years, which may have caused some of the strange changes in cost component amounts illustrated below, such as the increasing operational and programme management costs, in all the interventions presented here.

5.1. Spending per person on antiretroviral treatment (ART)

The spending per person on ART per annum reduced by 8% from \$207 in 2017 to \$190 in 2018 (Figure 39), but still higher than the PEN IV estimated unit cost for first line therapy of \$148 (Korenromp *et al*, 2015). The reduction in the unit of expenditure between the two study years was partially due to the reduction in the ARV component from \$72 to \$66 per person⁸ and partially due to the reduction in laboratory costs from \$40 to \$25 per person per annum. The personnel component also reduced slightly from \$37 to \$33, all implying technical efficiencies had indeed been achieved. However, the operational and recurrent costs increased from \$24 to \$44 (per person on ART per annum) – these could have been expected to reduce with the increasing volumes (from 1.16 million to 1.21 ART patients), through economies of scale. Table 17 below provides the details of the operational and programme management recurrent expenditure, showing the bulk are ‘other current not disaggregated’. The actual savings of \$8.9 million made in ART spending between 2017 and 2018 would have financed another 47 thousand people on ART. Further reductions in laboratory costs (mostly through reduced viral load test prices) and increasing the numbers of persons on Dolutegravir (DTG) formulations will further increase these savings.

Figure 39: Spending per ART patient, by production factor (US\$, 2017-2018)

⁸ The overall reduction in ARV spending was due to reduced unit price of Efavirenz/ Lamivudine/ Tenofovir reduced (12%) and Lamivudine/Zidovudine/Nevirapine (3%) between 2017 and 2018 – these two formulations made up the bulk of the ARV spending (99% and 91% in each year respectively).



Refer to Figure 28 in Section 3.9.3 which explores provincial cost drivers affecting the variations in their ART unit of expenditure per patient, and which found differences in personnel spending were the main causes of variation. Table 17 below provides the details of the ART PFs with a breakdown of operational and programme management recurrent expenditure, as far as the data allowed.

Table 17: ART spending by production factor (US\$, 2017-2018)

ART x PFs	2017	2018	Grand Total
⊗ PF.01.01 Personnel costs	43 138 810	39 879 670	83 018 479
⊗ PF.01.01.01 Direct service providers	5 091 007	39 879 670	44 970 676
PF.01.01.01.01 Labor costs - Direct service providers	5 091 007	36 671 883	41 762 889
PF.01.01.01.02 Fringe Benefits - Direct service providers		3 207 787	3 207 787
⊗ PF.01.01.98 Personnel not disaggregated	38 047 803		38 047 803
⊗ PF.01.02 Other operational and programme management current expenditures	27 180 307	53 763 532	80 943 839
⊗ PF.01.02.01 Office rental costs	1 110 156		1 110 156
⊗ PF.01.02.03 Travel expenditure	9 587 035	4 898 310	14 485 345
⊗ PF.01.02.98 Other current costs not disaggregated	16 483 117	41 042 465	57 525 582
⊗ PF.01.02.99 Other current costs n.e.c.		7 822 757	7 822 757
⊗ PF.01.03 Medical products and supplies	140 809 283	125 032 493	265 841 776
⊗ PF.01.03.01 Pharmaceuticals	82 859 029	79 696 757	162 555 786
PF.01.03.01.01 Antiretrovirals	81 367 751	79 696 757	161 064 508
PF.01.03.01.98 Pharmaceuticals not disaggregated		1 491 278	1 491 278
⊗ PF.01.03.02 Medical supplies	1 379 892	13 515 292	14 895 184
PF.01.03.02.02 Condoms	1 379 892		1 379 892
PF.01.03.02.98 Medical supplies not disaggregated		13 515 292	13 515 292
⊗ PF.01.03.03 Laboratory reagents and materials	46 654 662	29 717 328	76 371 990
PF.01.03.03.01 HIV tests screening/diagnostics	5 038 457	4 512 648	9 551 105
PF.01.03.03.02 VL tests	6 846 939	14 060 270	20 907 210
PF.01.03.03.03 CD4 tests	10 829 218	11 144 410	21 973 629
PF.01.03.03.98 Reagents and materials not disaggregated	23 940 047		23 940 047
⊗ PF.01.03.04 Non-medical supplies	9 915 700	2 103 116	12 018 816
PF.01.03.04.01 Food and nutrients	1 804 707		1 804 707
PF.01.03.04.02 Promotion and information materials		33 931	33 931
PF.01.03.04.98 Non-medical supplies not disaggregated	8 110 993	2 069 185	10 180 178
⊗ PF.01.04 Contracted external services	285 051	298 153	583 204
⊗ PF.01.08 Training-Training related per diems/transport/other costs	10 697 709	3 843 651	14 541 360
⊗ PF.01.98 Current direct and indirect expenditures not disaggregated	1 643 985	1 883 388	3 527 372
⊗ PF.01.99 Current direct and indirect expenditures n.e.c.		2 770 211	2 770 211
⊗ PF.02.01 Building	8 990 347	1 525 711	10 516 059
⊗ PF.02.01.02 Construction and renovation	8 894 318	1 451 136	10 345 454
⊗ PF.02.01.98 Building not disaggregated	96 029	74 575	170 605
⊗ PF.02.02 Vehicles	2 637 354		2 637 354
⊗ PF.02.03 Other capital investment	3 954 829	1 444 480	5 399 309
⊗ PF.02.03.02 Laboratory and other medical equipment		270 492	270 492
⊗ PF.02.03.03 Non medical equipment and furniture	3 564 573	731 169	4 295 742
⊗ PF.02.03.98 Other capital investment not disaggregated	390 256	442 819	833 075
Grand Total	239 337 676	230 441 289	469 778 965

5.2. Voluntary medical male circumcision (VMMC)

The numbers of voluntary medical male circumcisions performed in Mozambique declined slightly between 2017 and 2018, from 315 thousand to 312 thousand, while the unit of expenditure increased by 35% from \$71 to \$96 per circumcision – illustrating that no economies of scale had been achieved (Figure 40). Examining the cost components, the main driver of the increase were the operational and recurrent costs increasing by 172% from \$20 to \$54 per circumcision – possibly due, in part, to the changing PEPFAR ER categories in 2018. VMMC sites possibly need to maintain all their operational costs irrespective of the numbers of circumcisions, hence becoming more inefficient if the volumes are not being maintained or increased. Nevertheless, these operational costs should be explored further to ascertain if some savings could be made to improve the programme’s value-for-money. Importantly the capital investments declined over the period, implying initial set up costs will reduce with roll-out. The unit cost applied in the PEN-IV resource needs estimates was \$93, comparable with the unit/spend and confirming no potential savings had been made.

Figure 40: Spending per medical circumcision, by production factor (US\$, 2017-2018)

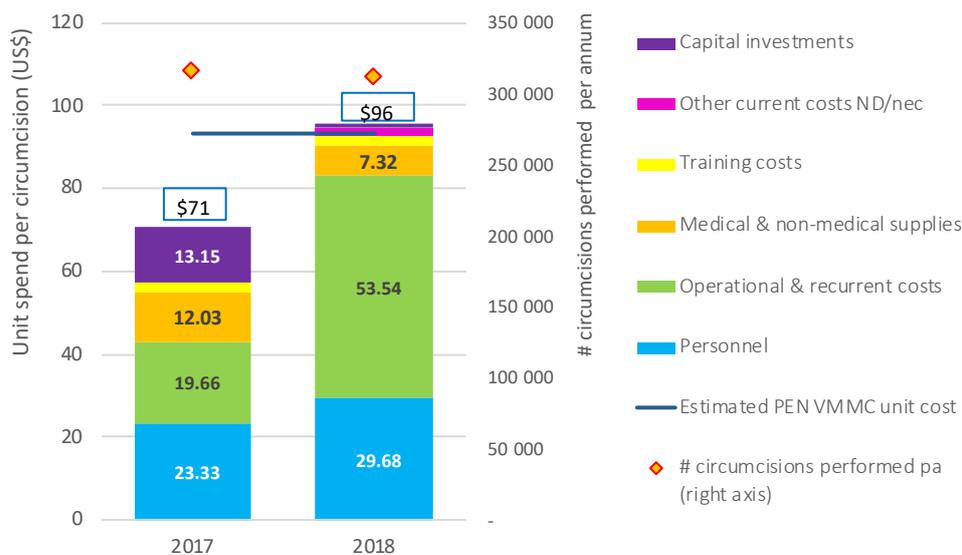


Table 18 below provides the details of the VMMC production factors, showing the breakdown of the operational and programme management recurrent expenditure.

Table 18: VMMC spending by production factor (US\$, 2017-2018)

VMMC x PF	2 017	2 018	Grand Total
⊗ PF.01.01 Personnel costs	7 324 998	9 257 731	16 582 729
⊗ PF.01.01.01 Direct service providers	102 547	9 257 731	9 360 278
PF.01.01.01.01 Labor costs - Direct service providers	102 547	7 864 526	7 967 073
PF.01.01.01.02 Fringe Benefits - Direct service providers		1 393 205	1 393 205
⊗ PF.01.01.98 Personnel not disaggregated	7 222 451		7 222 451
⊗ PF.01.02 Other operational and programme management current expenditures	6 172 405	16 697 453	22 869 858
⊗ PF.01.02.01 Office rental costs	436 354		436 354
⊗ PF.01.02.03 Travel expenditure	4 497 905	3 985 925	8 483 830
⊗ PF.01.02.98 Other current costs not disaggregated	1 238 146	8 281 255	9 519 401
⊗ PF.01.02.99 Other current costs n.e.c.		4 430 273	4 430 273
⊗ PF.01.03 Medical products and supplies	3 775 510	2 283 914	6 059 424
⊗ PF.01.03.01 Pharmaceuticals	1 802		1 802
⊗ PF.01.03.02 Medical supplies		1 086 700	1 086 700
⊗ PF.01.03.04 Non-medical supplies	3 773 708	1 197 214	4 970 922
⊗ PF.01.07 Financial support for beneficiaries		25 895	25 895
⊗ PF.01.08 Training- Training related per diems/transport/other costs	764 999	617 063	1 382 062
⊗ PF.01.99 Current direct and indirect expenditures n.e.c.		581 761	581 761
⊗ PF.02.01 Building	400 000		400 000
⊗ PF.02.01.02 Construction and renovation	400 000		400 000
⊗ PF.02.02 Vehicles	2 533 521		2 533 521
⊗ PF.02.03 Other capital investment	1 195 576	336 218	1 531 794
⊗ PF.02.03.03 Non medical equipment and furniture	1 146 365	336 218	1 482 583
⊗ PF.02.03.98 Other capital investment not disaggregated	49 212		49 212
⊗ PF not disaggregated	102 547		102 547
Grand Total	22 269 558	29 800 035	52 069 593

5.3. HIV testing and counselling

In the HTC programme, the numbers of tests performed per annum increased by 24% from 7.9 million in 2017 to 9.8 million in 2018, but the unit of expenditure did not decrease with the increasing volume, and actually increased slightly by 3% from \$4.20 to \$4.34 per test performed (Figure 41). The main driver of this were the operational, travel and recurrent costs, nearly tripling, from \$0.36 to \$1.38, which might be due to new modalities being applied to reach the hard-to-reach populations, or again, due to changing PEPFAR categorization in their expenditure reporting. Importantly, the cost of the HIV test kits and diagnostic costs have reduced from \$1.55 to \$1.03 per test, which should be leading to some savings in the programme. The unit spend was also higher than the estimated unit cost used in the PEN-IV costing (\$3.30), which also implies technical efficiencies many not have been achieved in the HTC programme, or that the increasing costs to reach the hard-to-reach were not factored into the PEN-IV costing. Additionally, the advent of index-case testing during PEN-IV, which is a management heavy testing approach, could also have contributed to the increase in unit spend in these years.

Figure 41: Spending per HIV test performed, by production factor (US\$, 2017-2018)

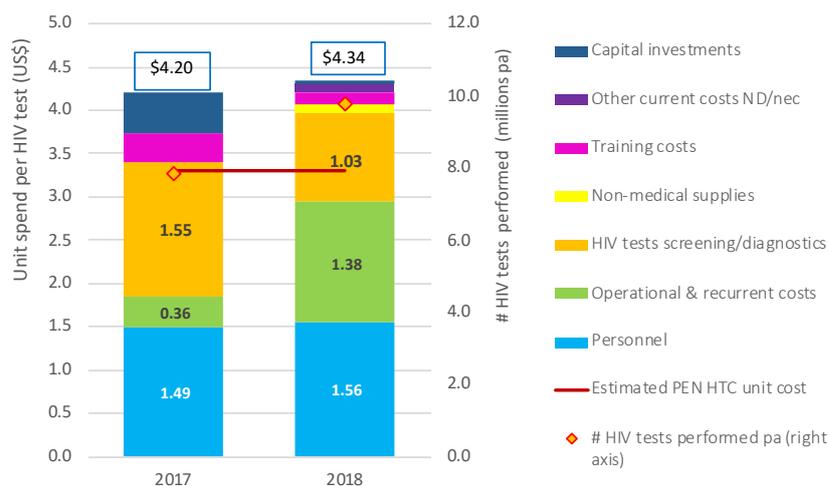


Table 19 below provides the details of the HTC production factors, showing the breakdown of the operational and programme management recurrent expenditure, the bulk of which were ‘other current not disaggregated’, due to data limitations of PEPFAR’s new ER category ‘programme management.

Table 19: HTC production factors (US\$, 2017-2018)

HTC x PF	2 017	2 018	Grand Total
⊗ PF.01.01 Personnel costs	11 724 393	15 235 025	26 959 418
⊗ PF.01.01.01 Direct service providers	1 988 440	15 230 732	17 219 172
PF.01.01.01.01 Labor costs - Direct service providers	1 988 440	13 561 931	15 550 371
PF.01.01.01.02 Fringe Benefits - Direct service providers		1 668 801	1 668 801
⊗ PF.01.01.98 Personnel not disaggregated	9 735 953	4 293	9 740 246
⊗ PF.01.02 Other operational and programme management current expenditures	2 820 145	13 544 169	16 364 314
⊗ PF.01.02.03 Travel expenditure	2 820 145	1 934 820	4 754 965
⊗ PF.01.02.98 Other current costs not disaggregated		9 650 048	9 650 048
⊗ PF.01.02.99 Other current costs n.e.c.		1 959 301	1 959 301
⊗ PF.01.03 Medical products and supplies	12 202 632	11 063 003	23 265 635
⊗ PF.01.03.03 Laboratory reagents and materials	12 202 632	10 057 427	22 260 059
PF.01.03.03.01 HIV tests screening/diagnostics	12 202 632	10 057 427	22 260 059
⊗ PF.01.03.04 Non-medical supplies		1 005 576	1 005 576
PF.01.03.04.98 Non-medical supplies not disaggregated		1 005 576	1 005 576
⊗ PF.01.08 Training- Training related per diems/transport/other costs	2 609 702	1 226 402	3 836 104
⊗ PF.01.98 Current direct and indirect expenditures not disaggregated		6 054	6 054
⊗ PF.01.99 Current direct and indirect expenditures n.e.c.		1 066 779	1 066 779
⊗ PF.02.01 Building	888 422	211 475	1 099 897
PF.02.01.02 Construction and renovation	888 422	211 475	1 099 897
⊗ PF.02.02 Vehicles	904 978		904 978
⊗ PF.02.03 Other capital investment	892 147	128 059	1 020 206
PF.02.03.03 Non medical equipment and furniture	892 147	128 059	1 020 206
⊗ Production factors not disaggregated	988 842		988 842
Grand Total	33 031 261	42 480 966	75 512 227

5.4. Adolescent Girls and Young Women (AGYW)

The AGYW interventions began to expand in 2018, reaching 509 thousand AGYW. Figure 42 shows the annual cost of \$44 per AGYW reached in 2018, the largest component (43%) being personnel costs, followed by operational and programme management costs (24%) and other recurrent costs not disaggregated or not elsewhere classified (n.e.c) (22%). It is difficult to say whether this is an efficiency

unit spend, with no comparators available, and given the early stages of implementation - it could be envisaged that with time, this unit spend should reduce as technical efficiencies and economies of scale are achieved. In Zambia, the estimated weighted average cost of \$29.20 per AGYW reached with a range package of interventions was applied for the revised NSP resource needs estimates.

Figure 42: Spending per AGYW reached, by production factor (US\$, 2018)

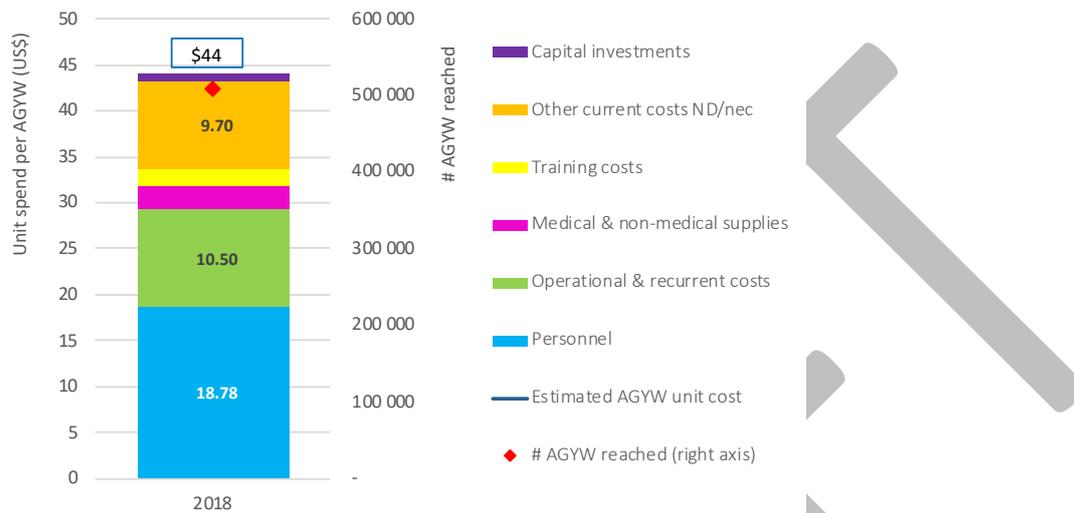


Table 20 below provides the details of the AGYW production factors, showing the breakdown of the operational and programme management recurrent expenditure, the bulk of which were other current not disaggregated, due to data limitations of PEPFAR’s new ER category ‘programme management’.

Table 20: AGYW production factors (US\$, 2017-2018)

AGYW x PF	2 017	2 018	Grand Total
⊗ PF.01.01 Personnel costs	65 206	9 564 776	9 629 982
⊗ PF.01.01.01 Direct service providers	65 206	8 627 255	8 692 461
⊗ PF.01.01.02 Program management personnel costs		937 521	937 521
⊗ PF.01.02 Other operational and programme management current expenditures		5 348 086	5 348 086
⊗ PF.01.02.03 Travel expenditure		1 331 788	1 331 788
⊗ PF.01.02.98 Other current costs not disaggregated		4 015 776	4 015 776
⊗ PF.01.02.99 Other current costs n.e.c.		522	522
⊗ PF.01.03 Medical products and supplies		1 357 940	1 357 940
⊗ PF.01.03.02 Medical supplies		598 538	598 538
⊗ PF.01.03.04 Non-medical supplies		747 316	747 316
PF.01.03.04.02 Promotion and information materials		37 303	37 303
PF.01.03.04.98 Non-medical supplies not disaggregated		710 013	710 013
⊗ PF.01.03.98 Medical products and supplies not disaggregated		12 086	12 086
⊗ PF.01.08 Training- Training related per diems/transport/other costs	32 603	851 244	883 847
⊗ PF.01.98 Current direct and indirect expenditures not disaggregated		4 867 980	4 867 980
⊗ PF.01.99 Current direct and indirect expenditures n.e.c.		69 952	69 952
⊗ PF.02.01 Building		240 019	240 019
⊗ PF.02.01.02 Construction and renovation		240 019	240 019
⊗ PF.02.03 Other capital investment	18 113	160 507	178 620
⊗ PF.02.03.03 Non medical equipment and furniture	18 113	160 507	178 620
⊗ Production factors not disaggregated	136 978		136 978
Grand Total	252 900	22 460 504	22 713 404

6. Summary, recommendations and conclusion

6.1. Key findings and recommendations

This National AIDS Spending Assessment (NASA) for 2017 and 2018 built on previous NASAs in Mozambique, and thus provides valuable time-trend data and insights into national priorities, allocative decisions, equity and efficiencies in HIV spending. The increasing total spending since 2014, with annual average increases of 18% till 2017, and a further 7% increase in 2018, displays the country's commitment to the HIV response. However, these increases were driven by development partners' contributions (international financing entities), which made up 97% of total HIV spending in 2017 and 2018, while the Mozambican Government's contributions from public revenue made up only 2%, and private financing entities only 1%, in both years. The public HIV financing appeared to have decreased between 2014 and 2017, by an annual average 11%, but then importantly increased by 13% in 2018. Hence the sources of revenue for the financing schemes were primarily direct foreign transfers (97% in both years).

The country's dependency on international financing entities for the HIV response is somewhat mitigated by the fact that large portions of the external funds are channeled through public financing schemes (73% and 69% in 2017 and 2018, respectively), particularly for the procurement and distribution of ARVs, which allows the government to manage and direct the treatment response which directly benefits PLHIV. There were 28% of funds in 2018 (increased from 23% in 2017) which were channeled through resident foreign agencies' schemes (development partners with in-country offices), which primarily went towards programme enablers and systems strengthening and prevention efforts.

Despite the larger portions of financing going through the direct foreign transfer schemes, the bulk (72% and 73% in 2017 and 2018 respectively) were managed by international financing agent-purchasers (the majority of which were the PEPFAR implementing partners who make all the key programmatic decisions regarding funds from the American Government). Only US\$ 130 million and US\$ 135 million (26% and 25% of total HIV funds) were managed by public financing agents-purchasers (FAPs). Since FAPs are defined as the economic units that collect revenue, pool financial resources, pay for the service provision, and take programmatic decisions (allocation and purchase modalities), these declining public FAP proportions could imply the government's reducing control over financing for the national response.

The HIV spending in Mozambique equated to \$35.59 per capita (>15 years) and \$242 per PLHIV in 2017 (increased from \$25.2 and \$225.2 respectively in 2014). Consideration of the provincial burden of disease in terms of numbers of PLHIV showed a range from \$92 per PLHIV in Maputo Província to \$257 in Inhambane. There appeared to have been mostly an equitable distribution of funds based on need in 2017 – mostly driven by the numbers of ART patients in each province – the ART unit of expenditure per person on ART ranged from \$170 in Maputo Província to \$239 in Niassa. Unfortunately, provincial expenditure data for 2018 was undermined by the PEPFAR data no longer being disaggregated by a sub-national identifier.

Public HIV service providers consumed an increasing portion of the HIV funds (34% in 2017 and 44% in 2018) in the delivery of HIV services, while international NGOs consumed 11% and 13% in service delivery and local NGOs only 2% and 1% in each year. A large portion of HIV funds were spent by PEPFAR's implementing partners and their sub-recipients (which could not be disaggregated by type of organization), but lumped together they used 52% and 40% respectively.

The care and treatment programme consumed the largest, but decreasing, portion of funds, from 48% in 2017 to 43% in 2018, followed by programme enablers and system strengthening (32% and 34%, respectively). Prevention spending increased over the period, from 11% to 13%, of which larger portions went to the Five Pillars of Prevention (80% of all prevention spending in 2018), while HTC also increased from 6% to 8%. These increases represent important efforts to achieve the 90-90-90 targets, which are still some way from being realized. The other programmes had very low spending, with zero spending reported on development synergies. These and social enablers are important for ensuring the optimal uptake and impact of programmes, and additional efforts to support these may need to be considered.

The bulk of services were facility-based delivery modalities, and very little (2%) through community-based modalities. At the time of the NASA, differentiated models of service delivery had not been scaled up in Mozambique. These differentiated models might provide more efficient options, although research in the region indicates that they are not necessarily cheaper, but are more accessible and

convenient for PLHIV and could potentially decongest public facilities and improve retention in care (Nichols *et al*, 2020, Guthrie *et al*, 2020).

PLHIV were the main beneficiaries of the HIV spending in Mozambique (39%), due to the larger portion being spent on care and treatment, while there was also 40% that went on non-targeted interventions (mostly for the large programme enablers and systems strengthening spending). In 2018, 10% went towards the general population, 9% to vulnerable and accessible populations and only 2% for key populations. Considering the main modes of transmission, funding might need to be directed towards interventions which target the most at risk.

Consideration of the production factors (inputs) per intervention and their programme performance (outputs) illustrated that the ART programme had achieved valuable technical efficiencies (mainly through reducing ARV costs) and economies of scale with increasing volumes, hence reducing units of expenditure per person on ART per annum. Further saving could possibly be made through the scale up of differentiated models of service delivery, and certainly from the patients' perspective in saving costs and time.

The VMMC programme displayed possible inefficiencies in delivery due to reducing numbers of circumcisions being performed in 2018, and hence a greater unit of expenditure, driven partly by increasing operational and recurrent costs, possibly due to slightly reducing volumes. These could be examined further and demand-creation efforts might be required, in order for economies of scale to be achieved.

The comparison of spending with the estimated resources needed for the PEN-IV in 2017 and 2018 shows potential funding gaps, when including only comparable interventions. It is possible that these gaps drove the efficiencies that were made, by forcing reduced spending, or they resulted in lower performance than was targeted. In the case of ART, the savings made caused the lower-than anticipated spending while still achieving the annual ART targets. Consideration of the prioritization of actual spending versus the anticipated shares required to achieve the PEN-IV targets, showed some alignment of spending with national priorities, and hence allocative efficiencies may have been achieved. However, there remained an under-prioritization of condoms and key population interventions, which the country could reconsider.

The NASA assessment is not intended to be a full programme evaluation methodology, so cannot delve into the details of reasons for seeming inefficiencies (either technical or allocative) but seeks to shine a light on areas that might need further examination.

6.2. Recommendations for improving and institutionalizing NASA

Mozambique is one of the few countries in the SADC region, along with Zimbabwe, that has routinely undertaken NASAs every few years, applying the model of an experienced contractor undertaking the assessment in close collaboration with CNCS and UNAIDS. In this way, the capacity within the country and CNCS has

been developed, and appears to have worked well and achieved some degree of institutionalization. Further consideration has been given to engaging an institution of higher education, which could ensure some continuity in service provider while also enabling skills transfer to students who could undertake the work as part of their assignments.

Further steps that could assist include:

- ❖ Increased awareness and understanding of NASA and promote its value-add, by increasing its use and referencing it in strategic discussions, which would encourage greater co-operation from respondents. Improving the utility of the NASA data could be done by creating specific outputs/ factsheets for specific audiences, or programmes, providing more indepth detail to inform their planning. The findings could also trigger research, or further exploration, into some of the issues raised here.
- ❖ Development of a robust, comprehensive and updated database of financing entities, financing agent-purchasers and service providers involved in the HIV response in Mozambique.
- ❖ Inclusion of key NASA / expenditure indicators in national plans. CNCS could coordinate an efficient tracking of HIV spending from financing entities to providers of services in Mozambique. The mechanism should routinely and systematically collect information for NASA, from all respondents who would be aware of NASA requirements and therefore include the preparation of their data in their annual plans.
- ❖ Creation of a simple, user-friendly expenditure reporting template, with resource tracking guidelines for respondents. An online portal that allows for the uploading of expenditure records, in excel or other formats, would reduce the reporting burden on respondents. This will reduce the time taken for data preparation and collection, improving its accuracy and timeliness.
- ❖ Strengthen financial information management systems of the Public sector, NGO and private sector, including standardized coding of their HIV spending by activity and by province. For example, the South African Treasury developed HIV codes for their Charter of Accounts which allows the departments to label their HIV spending in a standardized way.
- ❖ The Government could create a Vote output (specific budget) for public HIV mainstreaming spending in all ministries, which would enhance their expenditure reporting against the budget vote.
- ❖ There is also need to encourage (or enforce) the private-for-profit sector's reporting of HIV expenditure, and to mobilize additional support from this sector.

6.3. Conclusion

Since 2004, Mozambique has made important commitments to the collection and collation of these expenditure data for improved resource mobilisation, allocation, execution and tracking. This NASA report, once again, provided valuable data for monitoring the prioritization of the response and tracking the funding to the beneficiaries. Importantly, the new NASA 2020 framework has been applied and provided new vectors which allow for a deeper understanding of the financing architecture (through the financing revenue and scheme vectors) as well as the modalities through which services were delivered (the service delivery modality).

The report highlights, again, the country's dependence on external financing for its HIV response, and therefore its vulnerability to external (and internal) shocks or crises (further exacerbated by the global COVID pandemic) re-emphasizing that increased public revenue for HIV and AIDS and for improving the health care system is paramount. Not only are current levels of funding required to maintain the country's achievements, but additional funding is required to reach the remaining persons living with HIV who are not yet on treatment – just under one million persons in 2019 – and to retain them in care, achieve their viral suppression and reduce the mortality rate due to HIV. Concurrently, effective and targeted preventive measures to reduce the new infections (over 100 thousand in 2019), particularly amongst key populations, are required with concomitant funding.

The findings of this NASA have fed into the country's funding request to the Global Fund and into the PEN-V development and costing. They shall provide the data for the annual Global AIDS Monitor (GAM) report and PEPFAR's Country Operational Planning process. Additional formats and outputs will be generated to ensure the optimal utility of these data. Additionally, in order to further routinize and institutionalise the process to allow for the annual collection of HIV-related expenditure data (rather than survey-style NASAs every few years), the country could consider requesting all development partners to submit their expenditure data, according to a common classification system (such as the NASA categories), for CNCS to collate, analyse and present in different formats that would inform policy decision-making and programmatic planning timeously.

In conclusion, financing for HIV should be viewed within the broader movement towards universal health coverage, and therefore as contributing to health systems' development, as well as to broader multi-sectoral development. To this end, cross-sectoral and multi-stakeholder financing will be essential to maintain and expand the HIV response in Mozambique and to ultimately achieve universal health care coverage. Given the uncertainty of external financing for HIV, exacerbated by COVID-19 demands, Mozambique's HIV response is highly vulnerable to shocks from reducing development partners' contributions. It would therefore be important for the government to attempt to increase its public revenue for HIV and to explore alternative, or innovative, financing options. A suggested innovative solution was the capitalizing on the national gas sector.

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8. Appendices

Appendix 1: Methodology and estimations applied in this NASA

This Mozambican NASA (2017-2018) fully applied the new NASA 2020 framework with the updated vectors and classifications. The methodology was fully aligned with the NASA Guide⁹, and based on standardized methods, definitions and accounting rules. In the NASA2020 framework, the financial flows and expenditures related to the national response to HIV are grouped into three dimensions: finance, provision, and consumption/utilization. Each of these dimensions is broken down into several vectors, a total of nine. The classification of the three dimensions and nine vectors constitute the framework of the NASA 2020 and each are defined as follows:

❖ FINANCING

1. **Financing entities (sources) (FE)** refers to economic units providing the resources to the schemes (used by the agents).
2. **Financing revenues (REV)** are mechanisms to provide resources to financing schemes (used by the agents).
3. **Financing schemes (SCH)** are modalities through which the population access the services.
4. **Financing agent-purchasers (FAP)** are economic units that operate the schemes. They collect revenue, pool financial resources, pay for the service provision, and take programmatic decisions (allocation and purchase modalities).

❖ PROVISION OF HIV SERVICES

5. Providers of services (PS) are entities that engage in the production, provision, and delivery of HIV services.
6. Production factors (PF) are inputs/resources (labour, capital, natural resources, “know-how,” and entrepreneurial resources) used for the production of ASC.

❖ USE

7. AIDS spending categories (ASC) are HIV-related interventions and activities.
8. Beneficiary segments of the population (BP) are populations intended to benefit from specific activities (eg. key population groups such as men who have sex with men, injecting drug users, etc.)

⁹ Guide to producing National AIDS Spending Assessments (NASA), UNAIDS 2012

9. Service delivery modality (SDM) is a new variable in NASA 2020 which indicates the modality of the service provided.

NASA Multisectoral Strategic Information Working Group (GTM)

This NASA was conducted under the leadership of CNCS with the support of UNAIDS. The Multisectoral Strategic Information Technical Working Group (GTM) monitored the NASA process, ensuring compliance with objectives, ToRs and the chronogram. The GTM is a pre-existing working group that is composed of technical experts from CNCS, MISAU (HIV Program), INE, UNAIDS, and PEPFAR (USAID and CDC). The GTM importantly provided leadership, policy guidance and oversight of the NASA process and results.

NASA implementation occurred in the following phases:

1. Planning, mapping of Actors
2. Training of the NASA team of data collectors
3. Sampling and data collection
4. Quality control and data validation
5. Data analysis, validation of findings and report writing
6. Dissemination of findings

Several advocacy and sensitization meetings were held with partners to facilitate the process. The NASA teams obtained all necessary permissions from the national authorities to access relevant data and conduct the assessment. The letter of support for the mission is presented in Appendices 9 & 10.

NASA study design

The study design was a quantitative survey of the financing entities, financing agents/purchasers and service providers of HIV services in Mozambique.

Study population

A composite list of international, national and community-based organisations was generated from CNCS. The study was intended to include all financing entities for HIV, including:

- Public (all), international (all), private (not-for-profit and for-profit, but excluding private medical schemes)
- Data on national and provincial levels of expenditures were collected from the central levels and the headquarters of all involved organizations.
- Providers of HIV services in Mozambique – including public facilities; UN agencies, NGOs (local and international).

For each of these organisations/departments, the Directors, Programme Managers, Finance Directors, and Finance Officers were interviewed.

Note that this study did not interview persons living with HIV (PLHIV) since individual or household spending on HIV was not included in the scope of the study. The collection of out-of-pocket spending (OOPs) normally requires a large household survey, with cost and time implications that were beyond the scope of this NASA.

Sampling approach

To facilitate the sampling process, CNCS and the NASA TWG developed the register of all the stakeholders involved in HIV/AIDS to provide the sampling frame from which the majority of financing entities, financing agents/purchaser and key providers were selected for inclusion. The list of partners/stakeholders comprises all public, private-not-for-profit institutions, for-profit institutions (faith and non-faith based organisations) as well as civil society or non-governmental organisations. In addition, the list of organisations was expanded through the snowballing techniques during fieldwork.

Partners with the largest portfolio of services and expenditure were prioritized to ensure that at least 95% of all the HIV expenditure in the country was captured (mostly PEPFAR and GF), while also ensuring the selection of smaller but important service providers (who may have been the only providers of specific services such as those for the key populations).

Data collection

Primary data were collected through a nationwide survey, and all organisations in the mapping list were approached for their expenditure data. The majority of data were collected from the institutions' main offices in Maputo but included all their expenditure from all provinces. Data collection occurred over the period October 2019 to May 2020 with a break from mid-December 2019 to mid-January 2020.

NASA primary data were collected through face-to-face interviews as well as self-administered questionnaires, and the respondents' expenditure records were also obtained as part of the primary source for NASA. Data collectors assisted the respondents to complete the NASA forms. The assessment also used the secondary data through a desk review of key financial reports/documents, sources of funds, policies, annual programme performance reports, previous expenditure analysis reports, National Health Accounts, Estimates documents and audited reports.

Top-down and bottom-up approaches were employed during data collection, to triangulate the data in recreating the transactions. The top-down approach involved collecting data from financing entities and financing agents-purchasers while the bottom-up approach involved collecting data from the service providers. The data from the three levels were triangulated by comparing and consolidating them into one transaction, to avoid double counting. Thus, when a complete transaction was captured, all the data from the financing agents and providers indicating the same funding received from that source would be excluded to ensure that there is no double-counting from the source and provider perspectives.

In the case of all PEPFAR spending, the Co-ordinator provided their expenditure analysis (EA) and expenditure reporting (ER) data, and indicated that their IPs therefore did not need to be contacted. Where an organisation received funding other than PEPFAR, they were asked to only report their non-USG sources and thus we avoided double counting. We were unable to verify the EA and ER data at the service provider level, but these are the data publicly available on the PEPFAR website and have therefore been validated by the PEPFAR agencies.

The traditional NASA data collection tools, developed by UNAIDS, were used to collect quantitative data, using close-ended questions for HIV expenditure data. Data were collected using both soft and hard copies of the tools. However, PEPFAR provided their electronic expenditure reports (EA and ER datasets) that data collectors and consultants converted into the NASA format.

The local NASA expert was contracted as the NASA team lead, plus three data collectors, who were experienced through their involvement in previous NASA exercises, so received a refresher training. The international NASA expert provided them with an overview of the new NASA 2020 methodology, in the use of the NASA tools, as well as general interviewing and research skills.

Data capturing and processing

Data were either captured in hard-copies or electronic tools. The raw data were then prepared in excel and captured in the Data Consolidation Tool (DCT). The DCT is an excel-based spreadsheet that follows the nine vectors of the NASA methodology. The DCT serves to organize, clean, and verify the completeness of data, any missing, incomplete, or contradictory data were identified and addressed. The processing of the data first in Excel sheets also assisted the team in undertaking triangulation, ensuring complete transactions, maintaining the NASA principle of capturing only completed transactions, and thus reduced the chances of double counting.

Data Analysis

The data from DCT were imported into the NASA Resource Tool (RTT). The RTT software is a tool that allows the user to create the NASA set of matrixes, linking all the NASA vectors to the HIV spending amounts entered into the system. The use of RTT was useful in aggregating and analyzing the data, in creating financing flow diagrams, and it generated the full dataset in excel spreadsheets that were used to create graphical displays and tables.

Quality Control

- a) Data collectors received a refresher training for four days, and were introduced to the new NASA2020 principles, methods and classifications, with practical sessions on filling of the new tools.

- b) Data collected were cross-checked daily by the NASA Team Lead managing the project for completeness and accuracy.
- c) There was regular supervision by the NASA TWG and CNCS through face-to-face meetings and debriefing. Discussions about the data challenges, gaps, inaccuracies, coding issues helped the team to deal with any technical challenges, with the identification of possible solutions.
- d) Quality control was also undertaken by the international consultant who led the data analysis, and identified errors in coding or incorrect transaction capturing. She checked all captured data through a review of the RTT outputs, and ensured the quality and completeness of the data entered by the team, that each transaction had all the vectors labelled correctly, identified gaps, and requested corrective actions to be taken during the validation phase.
- e) Also, the RTT control board indicated where there were discrepancies that needed to be adjusted/ fixed. These were all corrected.
- f) In addition, UNAIDS arranged an external peer reviewer who undertook a mid-process review, checked preliminary analysis, and reviewed the draft and final reports. He identified errors in the application of the new SCH vector, which were corrected, and gave suggestions for improvements in the analysis and presentation of the data.
- g) The data validation was done in two stages for accuracy and consistency. The initial stage was by the NASA TWG to ensure the accuracy of the financial data as submitted by the various institutions. The individual institutions that provided large HIV expenditure datasets (MOH, CNCS, PEPFAR and GF) were also asked to check the preliminary outputs of their specific data - the programme and finance focal persons checked the data. A final set of RTT outputs was generated after including their comments to produce tables and graphs for the final report.

Overview of the data collected, gaps and quality of data sources

Data were collected using both top-down and bottom-up approaches, from the public, external and private sectors. The captured HIV spending data includes:

1. The bulk (over 99%) of government HIV financing, especially:
 - ✓ All Ministry of Health (MOH) **direct HIV spending**: ARVs, laboratories, test kits, condoms, and the HIV programme – from expenditure records.
 - ✓ MOH indirect, or shared, costs incurred in delivering HIV services: estimated as described below.

- ✓ Other ministries' HIV spending, where labelled as such, were captured.
2. International development partners: all PEPFAR, GF, UN agencies, and some smaller donors (bilateral and foundations). We believe we have captured 98% or more of international financing for HIV.
 3. Private sector: Two major private for-profit institutions, based in Maputo, provided their HIV expenditure data. Although difficult to estimate, we believe that at least 90% of private funding was captured.

Data collection was done at central level, from institutions with headquarters based in Maputo area, although with expenditures disaggregated per province as much as possible. Therefore, no travel to provinces was required. Due to time restrictions and delays in starting data collection, the NASA TWG and CNCS agreed that efforts would be focused on those institutions / organizations that would represent the bulk (98%) of all HIV expenditures and thus 57 institutions were identified. During data collections 8 institutions were excluded as 4 were not available, 3 were exclusive beneficiaries of USG funding and reported to PEPFAR and one was a funding mechanism. Another 8 institutions could not be contacted. Therefore, data were expected from 43 institutions comprising 29 international (67%) and 9 private national (21%). Only 4 public institutions were contacted.

Table 21: Data collection status

Institutions	No Responses	No activities	Responses	Linked to USG	Nr.	%
INTERNATIONAL	2	7	19	1	29	67%
Multilateral	1		12		13	
NGOs	1	7	7	1	16	
NATIONAL				1	1	2%
NGOs				1	1	
Private National	3	1	5		9	21%
For Profit	1		1		2	
NGOs	2	1	4		7	
PUBLIC	2		2		4	9%
Estatal	1				1	
Ministries	1		2		3	
Total	7	8	26	2	43	100%
	%	16%	19%	60%	5%	100%

When excluding the inactive organisations and those USG funded (who were already captured in the PEPFAR data) from the sampling frame, the response rate was 79%.

It should be noted that major projects and companies outside Maputo area did not report to NASA. As they were not registered or generally unknown in the HIV/AIDS field, it has been assumed that their contributions would have been small to the total HIV spending.

Overall, we believe the assessment has been successful in obtaining more than 95% of public and international funding, and captured most NGOs' activities. The response from the private sector was small and the total size of their contribution is unknown.

Assumptions and estimations

Overall, the NASA principle of capturing actual expenditure was adhered to for the majority (77%) of the data, and estimations were used for 23% of the data.

Table 22: Overview of the sources and types of data used in this NASA

Mozambique NASA	2016/17	2017/18
Overall type of NASA data:		
Expense reports	76%	77%
PxQ estimates	24%	23%
Transaction source type:		
Primary source certificate	75%	76%
Adaption of primary source	1%	1%
Estimation or imputation	24%	23%
ASC source type:		
Primary source certificate	75%	76%
Adaption of primary source	1%	1%
Estimation or imputation	24%	23%
BP source type:		
Primary source certificate	76%	77%
Adaption of primary source	21%	21%
Estimation or imputation	3%	3%
PF source type:		
Primary source certificate	75%	76%
Adaption of primary source	1%	1%
Estimation or imputation	24%	23%

* PxQ = unit prices multiplied by quantities used = costing technique to estimate the spending on opportunistic infections and STIs, ARVs distributed to provinces, as well as the Ministry of Health personnel costs allocated to HIV services. Refer to the appendix on assumptions applied.

The cases where some estimations had to be made and assumptions applied, were as follows:

a) **Activities at the Health Facility**

In Mozambique, there is no public accounting system that would enable the extraction of expenditures for specific health services delivered in public health facilities. Therefore, for HIV-related health services delivered in the public health facilities, there are no available data to demonstrate all the shared costs incurred by public service providers that could be attributed to HIV services. Data from the Health Information System only report the volume of activities/services and their beneficiaries (in aggregate).

In 2017, the common fund (PROSAUDE) was used to pay for salaries and common medicines (all other medicines excluding those related to HIV/AIDS, TB and Malaria); while in 2018, only salaries were covered by the fund. We treated PROSAUDE as "Basket/ pooled funding" and had to make assumptions about

specific sources for salaries and commodities, based on each financing entity's proportional contribution to the PROSAUDE10.

Therefore, expenditures were estimated for the antiretroviral treatment programme (salaries and ARVs), prevention of vertical transmission (salaries and ARVs), laboratory tests (salaries and reagents), counselling and testing (salaries and reagents), STI treatment (salaries and consumption of drugs), based on the volume of services provided and cost of the ingredients required to supply the service (PxQ).

The unit cost of wages was based on the combination of professionals that provided each type of services (source: expert information) and the time to perform a particular activity, informed by a Time and Movements Study.¹¹

b) **Commodities**

CMAM (Central Medical Stores) procures medicines and medical supplies funded by the Government State Budget, and undertakes the importation, storage and distribution of the main HIV commodities (ARVs, labs, OI treatment, STI treatment, condoms), as well as those funded and procured by Global Fund, PEPFAR and other donors. Therefore, the estimated contribution of specific financing entities to different HIV commodities was calculated based on the proportion of their contribution to the total expenditure incurred in the period and for that particular expense.

c) **Non-health public sector HIV spending**

For the other non-health public sector HIV spending, a similar challenge exists in that most ministries lack specific information on their expenditure for HIV services. Therefore, it is difficult to draw firm conclusions about the financial flows for HIV for certain public sectors. However, on the basis of information provided by financial entities that fund some activities of ministries, and their service providers, this NASA attempted to report some sectoral spending on HIV.

d) **The PEPFAR data**

PEPFAR data were provided in two different datasets: Expenditure Analysis (EA) data for 2017 and Expenditure Report (ER) for 2018. These reports were aligned with the PEPFAR financial years, however, for the purpose of NASA, were matched to the calendar years (the Mozambican financial year) as follows:

- EA 2017 (Oct 2016 to Sept 2017) = 2017
- ER 2018 (Oct 2017 to Sept 2018) = 2018

No further attempts were made to align more closely as the data would have been unrecognizable to PEPFAR, and other stakeholders, during validation.

¹⁰ Since 2016 the volume of funds of PROSAUDE reduced, and suspended from some donors, due to the debt crisis. Some commodities were purchased and imported in 2017. No funds were made available for medicines in 2018. Support for salaries and personnel related costs although shrinking was maintained in both 2017 and 2018.

¹¹ Um Estudo Sobre Tempos e Movimentos nos Cuidados de Saúde Primários em Moçambique, Thinkwell, 2018. Available: https://thinkwell.global/wp-content/uploads/2020/03/Avaliacao-PdA_Relatório-preliminar_V1.1.pdf

Note, both PEPFAR datasets were de-identified and did not have information on implementing partner (IP) or sub-recipients. Hence, the NASA Provider of services (PS) code could not be attributed to each transaction. Therefore, one PS code was applied to all the PEPFAR data (PS.03.99) and was labeled 'PEPFAR IPs & service providers'. Obviously, this was not ideal, but there was no way to split the expenditure between their IPs or providers without being inaccurate and misleading.

Each dataset (EA and ER) had to be dealt with differently, as follows:

2017 data from the PEPFAR Expenditure Analysis (EA) database

The 2017 EA data had district geographic (sub-national unit) identifiers for each program area, which were aggregated into provinces. However, the EA data had embedded its 'above site' programmes' spending in districts (such as Program Management, Strategic Information, Health System strengthening and Surveillance). The PEPFAR representative agreed that we could remove these from the district amounts, and label them as 'national level', where the remaining program area spending were attributed to their districts, as indicated.

The program areas were cross-walked to the closest NASA ASC, but the former were more aggregate categories and so further detail of sub-programs could not be extracted – for example, FBCTS and CBCTS include a range of care and treatment activities (not only ART) and hence had to be labelled as ASC.03.98 C&T ND (refer to appendix 1 for the crosswalk to ASCs). However, for the ARV component of ART, the CMAM (central medical stores) managed (importation, storage and distribution) of all ARVs procured with funding from PEPFAR, GF and other donors. Using the CMS actual expenditure records, the PEPFAR share of ARVs could be estimated (as explained above) and these were attributed to the ASC for either ART for adults or ART for paediatrics. Also based on the program area, the SDM and BP codes had to be assumed, based on most logical choice as no data were provided for these (see appendix 1). The EA cost categories were cross-walked to the closest NASA PF code (see appendix 2).

The EA data was provided per program area, split by cost component, in a table format (not flatfile transaction format like 2018 ER data). Hence the transactions had to be manually recreated in the DCT forms. These could then be imported into the RTT, but it was a time-consuming process (fortunately the 2018 ER data were easier to import).

2018 data from the PEPFAR Expenditure Report (ER) database

The new PEPFAR ER format has different program areas and sub-programs which were cross-walked as closely as possible to the NASA ASC. Also the ER data has their beneficiary and sub-beneficiary codes which are extremely useful for the NASA BP codes. Some ASC details had to be obtained from their beneficiary codes. For example, the ER no longer has a Key Population identifier in their sub-

programs but these can be identified as sex workers, MSM or PWIDs in their sub-beneficiary codes. This complicates the cross-walking which needs to consider 4 variables (PAXsubPAXBENxsubBEN). In addition, the SDM variable had to be intuitively selected based on the program and sub-program, since no indication was given in the ER data of the modality of delivery. The ER data provide adequate detail of the cost components (object and sub-object class) which were cross-walked to the correct NASA PF code. Refer to Appendix 3-5 for the crosswalks for the 2018 ER data.

Unfortunately, the new ER data no longer uses a geographic identifier (referred to in the old EA as sub-national unit, SNU). PEPFAR indicated that changes had been made to their geographic prioritization in 2018 and hence it would not be correct to apply the 2017 proportional split to the 2018 data. They requested that we not attempt to split it but present it as 'not disaggregated', which we have done.

Fortunately, the ER data were provided in a flat excel file format which enabled the recreation of transactions, to populate the DCT and RTT. After the necessary NASA variables had been created (cross-walked as described in appendices), and restructured to match the DCT, they were directly imported into the NASA RTT, which saved a lot of time.

Please refer to the appendices for the cross-walks for the two PEPFAR datasets.

- e) Because the PEPFAR EA and ER data included all their IPs' spending, if any additional data were collected from any of the PEPFAR IPs or service providers (for USG funds), these were excluded in the analysis to avoid double counting. **Respondents were requested to only report their non-PEPFAR funding to the NASA researchers.**
- f) Where details were not available on the beneficiaries of programme spending, the most obvious was selected, based on the ASC. For example,
 - i. Programme enablers and systems strengthening services of all organisations were assumed to be non-targeted interventions.
 - ii. For the training received by health workers (trained health workers, Peers Educators, opinion leaders) the beneficiary population was the population that receives the services that health workers were trained on, mostly PLHIV.
 - iii. Prevention of mother to child transmission (PMTCT) was assumed to benefit children to be born to HIV positive mothers. The spending on the ARVs for the mother was captured under ART and was attributed to ART patients (which could not be disaggregated by sex).

Limitations of the Study

Some limitations of the study should be noted:

- a) Generally, HIV costs for integrated and/or wellness programs from public sector other than health were difficult to identify since they did not have separate expenditures labeled as HIV-related. Though these costs are underestimated, they are likely to be a very small proportion of the entire response, considering the financial restrictions faced during 2017 and 2018.
- b) TB expenditures were not included in this survey.
- c) The private-for-profit sector's contribution was under-reported due to poor response, despite several attempts to collect these data. This may indicate that they did not have any HIV spending to report. As explained in the overview of data section, typically, the private sector's response has been found to be less than 2% in other East and Southern African countries (except where there is a strong private health insurance). It can be assumed that in Mozambique, any other private sector's contribution to total HIV envelop was relatively small and does not compromise this completeness of the assessment.
- d) Out-of-pocket payments (OOPs) were not collected as they were not in the scope of the project (due to time and cost constraints). Though most HIV services in Mozambique are rendered free to the beneficiaries, the collection of OOPs may be important for future NASAs, but would require additional resources and time to collect accurately through a large-scale household survey.

Appendix 2: Institutions from which data were collected

Ordem	Organização / Instituição
PUBLICAS	
1	Assembleia da República
2	Conselho Nacional de Combate ao HIV e SIDA - CNCS
3	Ministério da Economia e Finanças
4	Ministério da Saúde
5	Ministério do Trabalho
PRIVADAS	
6	Cornelder - Beira
7	TEBA
8	Técnica Engenheiros Consultores - TEC
9	ECOSIDA
MULTILATERAIS	
10	Escritório das Nações Unidas sobre Drogas e Crime - UNODC
11	Fundo das Nações Unidas para Actividades das Populações - FNUAP
12	Fundo Global de HIV, TB e Malária
13	Organização das Nações Unidas para a Infância - UNICEF
14	Organização das Nações Unidas para Educação, Ciência e Cultura - UNESCO
15	Organização Internacional de Migrações - OIM
16	Organização Internacional do Trabalho - OIT
17	Organização Mundial da Saúde - OMS
18	Programa Alimentar Mundial - PMA
19	Programa das Nações Unidas para o Desenvolvimento - PNUD
20	RCO / One - UN
21	Secretariado do UNAIDS/ONUSIDA
22	UNHCR
23	UNITAID
24	UNWOMEN
BILATERAIS	
25	Governo do Reino Unido
26	Governo dos Estados Unidos
27	Afrikagrupperna
28	Agencia Andaluza de Cooperación Internacional para el Desarrollo - AACID
ONGs - OCB	
29	Fundação Ariel Glaser contra o Sida Pediátrico
30	Big Lottery
31	Centro de Colaboração em Saúde - CCS
32	Federação Internacional de Planamento Familiar
33	FHI 360
34	Fundação Aga Khan
35	GAIN HEALTH - Nutrition
36	GAVI
37	Italian Episcopal Conference
38	Médicos com África - CUAMM
39	Médicos Sem Fronteiras - Bélgica & Suíça
40	Douler Sans Frontieres
41	Partnership for Supply Chain Management ou PSM
42	Pathfinder International
43	Population Services International - PSI
44	Associação para a Defesa das Minorias Sexuais - LAMBDA
45	Association of Women in Law - Muleide
46	Fundação para o Desenvolvimento da Comunidade - FDC
47	Santo Egídio, Programa DREAM
48	VSO Moçambique
49	World Vision International
50	AJULSID
51	AMODEFA
52	Associação de Desenvolvimento de Povo para Povo
53	COALIZAO
54	Igreja Evangelica Luterana
55	Kufunana
56	Oxfam Novib (African Transformation)
57	SolidarMed

Appendix 3: NASA Matrices and Data Tables

Total HIV spending in Mozambique by financing entity (US\$ and %, 2017-2018)

US\$	Public Funding Entity	Private Funding Entity	International Funding Entities	HIV Total in US\$	Public FE %	Private FE %	International FE %
Previous NASA (2014)	16 197 217	2 239 452	314 066 363	332 503 032	5%	1%	94%
2017	10 746 929	5 053 171	492 692 324	508 492 424	2%	1.0%	97%
2018	12 149 223	4 714 498	528 559 771	545 423 492	2%	0.9%	97%

Bilateral HIV financing entities (US\$, 2017/17-2018)

Bilateral Funding Entities	2017	2018	2018% of bilaterals	2018% of total funding
FE.03.01.03 Government of Belgium	275 152	124 993	0.03%	0.02%
FE.03.01.05 Government of Canada	121 829	-	0.00%	0.00%
FE.03.01.06 Government of Denmark	106 600	69 650	0.02%	0.01%
FE.03.01.08 Government of France	-	65 233	0.02%	0.01%
FE.03.01.12 Government of Ireland	106 600	221 147	0.06%	0.04%
FE.03.01.13 Government of Italy	330 197	17	0.00%	0.00%
FE.03.01.16 Government of Luxembourg	5 306	-	0.00%	0.00%
FE.03.01.17 Government of Netherlands	1 546 190	1 771 220	0.47%	0.32%
FE.03.01.25 Government of Spain	20 301	22 624	0.01%	0.00%
FE.03.01.26 Government of Sweden	280 764	339 128	0.09%	0.06%
FE.03.01.27 Government of Switzerland	257 315	42 312	0.01%	0.01%
FE.03.01.28 Government of United Arab Emirates	-	183 150	0.05%	0.03%
FE.03.01.29 Government of United Kingdom	852 988	95 824	0.03%	0.02%
FE.03.01.30 Government of United States	349 135 001	370 190 650	99.1%	67.9%
FE.03.01.99 Other government(s)/other bilateral agencies n.e.c.	2 144 108	473 762	0.1%	0.1%
Bilateral sub-total	355 182 351	373 599 711	100.0%	68.5%

UN Agency HIV financing entities (US\$, 2017/17-2018)

Multilateral Funding Entities	2017	2018	2018% of multilaterals	2018% of total funding
FE.03.02.07 The Global Fund	82 493 387	78 545 201	54%	14%
FE.03.02.08 UNAIDS Secretariat	617 997	807 124	1%	0.1%
FE.03.02.09 United Nations Children's Fund (UNICEF)	1 611 395	11 494 662	8%	2.1%
FE.03.02.11 United Nations Development Programme (UNDP)	525 000	729 880	1%	0.1%
FE.03.02.13 United Nations High Commissioner for Refugees (UNHCR)	-	1 924	0%	0.0%
FE.03.02.17 United Nations Population Fund (UNFPA)	195 681	2 409 436	2%	0.4%
FE.03.02.99 Other Multilateral organizations n.e.c.	47 439 928	51 261 001	35%	9.4%
Multi-lateral sub-total	132 883 388	145 249 227	100.0%	27%

International NGOs and Foundations financing entities for HIV (US\$, 2017/17-2018)

International NGOs and Foundations	2017	2018	2018% of INGOs/ Foundations	2018% of total funding
FE.03.03.20 Médecins sans Frontières	3 584 342	6 258 563	64%	1.1%
FE.03.03.25 The Clinton Foundation	-	1 062 209	11%	0.2%
FE.03.03.34 International Planned Parenthood Federation	-	787 069	8%	0.1%
FE.03.03.99 Other International not-for-profit organizations and	757 389	994 788	10%	0.2%
FE.03.99 Other International n.e.c.	284 853	608 205	6%	0.1%
INGOs / Foundations / Other international sub-total	4 626 585	9 710 833	100.0%	2%

Provincial HIV spending (US\$, 2010-2017)

Province	2010	2011	2014	2017
Cabo Delgado	9 666 938	11 985 278	12 171 443	18 740 905
Niassa	11 977 888	12 806 972	8 211 144	8 634 390
Nampula	23 536 583	27 200 653	26 229 282	36 268 063
Tete	10 006 973	14 626 505	19 637 853	21 576 310
Zambézia	24 262 715	27 927 387	44 135 372	67 883 729
Manica	12 371 767	16 258 643	17 912 818	34 667 836
Sofala	16 632 076	22 968 087	29 655 887	44 048 108
Inhambane	13 075 235	11 712 271	12 951 935	28 253 817
Gaza	22 116 647	22 450 949	34 006 196	41 037 905
Maputo Cidade	29 372 592	32 720 482	31 985 699	33 055 119
Maputo Província	18 214 525	22 346 702	27 799 852	33 073 566
Nacional	13 907 475	23 824 232	67 664 387	130 834 396
Not disaggregated by part of the country	8 352 172	13 468 534	141 164	10 418 278
Grande Total	213 493 586	260 296 695	332 503 032	508 492 424

Revenues for HIV financing in Mozambique (US\$, 2017-2018)

REVENUE (US\$)	Transfers from government domestic revenue	Compulsory prepayment	Other domestic revenues	Direct foreign transfers	Total US\$
2017	10 746 929	4 215 840	837 331	492 692 324	508 492 424
2018	12 149 223	4 087 155	627 343	528 559 771	545 423 492

Financing schemes for HIV in Mozambique (US\$, 2017-2018)

SCHEME (US\$)	Government schemes	Compulsory private insurance schemes	Household out-of-pocket	Not-for-profit organisation schemes (resident)	Resident foreign agencies schemes	Enterprises (for-profit) schemes	Total (US\$)
2017	371 616 160	4 215 840	726 679	12 717 353	119 105 740	110 652	508 492 424
2018	375 696 882	4 087 155	471 799	13 329 539	151 682 574	155 545	545 423 492

Financing schemes x financing entities in Mozambique (US\$, %, 2017-2018)

	2017	2018	2017 %	2018 %
SCH.01.01.01 Central government schemes	371 616 160	375 696 882	73%	69%
FE.01 Public Entities	10 746 929	12 149 223	2%	2%
FE.03 International Entities	360 869 231	363 547 659	71%	67%
FE.03.01 Governments providing bilateral aid	234 365 170	221 710 432	46%	41%
FE.03.02 Multilateral Organizations	122 634 865	139 036 309	24%	25%
FE.03.03 International not-for-profit organizations and foundations	3 584 342	2 793 268	0.7%	0.5%
FE.03.99 Other International n.e.c.	284 853	7 649	0.1%	0.0%
SCH.01.02.02 Compulsory private insurance schemes	4 215 840	4 087 155	0.8%	0.7%
FE.02 Domestic Private Entities	4 215 840	4 087 155	0.8%	0.7%
SCH.02.02.01 Not-for-profit organisation schemes (excluding SCH.2.2.2)	12 717 353	13 329 539	3%	2%
FE.03 International Entities	12 717 353	13 329 539	3%	2%
FE.03.01 Governments providing bilateral aid	2 533 725	1 182 437	0%	0%
FE.03.02 Multilateral Organizations	9 426 239	5 237 187	2%	1%
FE.03.03 International not-for-profit organizations and foundations	757 389	6 309 360	0.1%	1%
FE.03.99 Other International n.e.c.	-	600 556	0.0%	0.1%
SCH.02.02.02 Resident foreign agencies schemes	119 105 740	151 682 574	23%	28%
FE.03 International Entities	119 105 740	151 682 574	23%	28%
FE.03.01 Governments providing bilateral aid	118 283 455	150 706 842	23%	28%
FE.03.02 Multilateral Organizations	822 284	975 732	0.2%	0.2%
SCH.02.03.01 Enterprises (except health care providers) schemes	110 652	155 545	0.0%	0.0%
FE.02.01 Domestic corporations	110 652	155 545	0.0%	0.0%
SCH.03 Household out-of-pocket payment	726 679	471 799	0.1%	0.1%
FE.02.02 Households	726 679	471 799	0.1%	0.1%
Grand Total	508 492 424	545 423 492	100%	100%

Financing schemes x financing agent/purchasers in Mozambique (US\$, 2017-2018)

2017	Public FAP	Private FAP			International FAP			Total	% SCH share
	Territorial Govt	Private households	Not-for-profit orgs	Corporations	Bilateral agencies	Multilateral agencies	INGOs/foundations		
Central govt scheme	130 004 471		284 853		189 945 698	192 822	51 188 315	371 616 160	73%
Compulsory private insurance schemes				4 215 840				4 215 840	1%
Voluntary resident NPO schemes			9 308 764			129 272	3 279 317	12 717 353	3%
Voluntary resident foreign agency schemes					115 727 038	3 378 701		119 105 740	23%
Resident for-profit enterprises			110 652					110 652	0.02%
Out-of-pocket (excl. cost-sharing)		726 679						726 679	0.14%
Total	130 004 471	726 679	9 704 269	4 215 840	305 672 736	3 700 795	54 467 632	508 492 424	100%
% FAP share	26%	0%	2%	1%	60%	1%	11%		

2018	Public FAP	Private FAP			International FAP			Total	% SCH share
	Territorial Govt	households	orgs	Corporations	Bilateral agencies	agencies	ns		
Central govt scheme	134 813 930		150 000		178 099 780	100 000	62 533 172	375 696 882	69%
Compulsory private insurance schemes				4 087 155				4 087 155	1%
Voluntary resident NPO schemes			6 078 872				7 250 667	13 329 539	2%
Voluntary resident foreign agency schemes					148 951 317	2 731 257		151 682 574	28%
Resident for-profit enterprises			155 545					155 545	0%
Out-of-pocket (excl. cost-sharing)		471 799						471 799	0%
Total	134 813 930	471 799	6 384 417	4 087 155	327 051 097	2 831 257	69 783 839	545 423 492	100%
% FAP share	25%	0%	1%	1%	60%	1%	13%		

Financing schemes x HIV programme areas in Mozambique (US\$, %, 2017-2018)

2017	FINANCING SCHEME						Total (US\$)
	Central govt scheme	Compulsory private insurance schemes	Voluntary resident NPO schemes	Voluntary resident foreign agency schemes	Resident for-profit enterprises	Out-of-pocket (excl. cost-sharing)	
Prevention	44 595 688	551 480	2 176 164	6 527 847	5 787	726 679	54 583 645
HTC	31 917 456	60 000	998 057	-	55 748	-	33 031 261
Care and Treatment Care	240 793 698	3 184 160	800 607	-	-	-	244 778 465
Social protection and economic support	-	330 200	725 659	14 363 691	-	-	15 419 551
Social Enablers	164 537	-	-	-	-	-	164 537
Programme enablers and systems strengthening	53 944 781	90 000	8 016 866	98 214 202	49 116	-	160 314 965
Research	200 000	-	-	-	-	-	200 000
Total	371 616 160	4 215 840	12 717 353	119 105 740	110 652	726 679	508 492 424
Sources % share	73%	1%	3%	23%	0.0%	0.1%	

2018	FINANCING SCHEME						Total (US\$)
	Central govt scheme	Compulsory private insurance schemes	Voluntary resident NPO schemes	Voluntary resident foreign agency schemes	Resident for-profit enterprises	Out-of-pocket (excl. cost-sharing)	
Prevention	34 057 512	540 756	6 227 295	28 918 241	16 393	471 799	70 231 996
HTC	40 118 529	60 000	10 347	2 263 637	28 452	-	42 480 965
Care and Treatment	226 016 330	3 066 199	5 343 393	-	-	-	234 425 922
Social protection & economic support	-	330 200	-	12 069 434	-	-	12 399 634
Social Enablers	327 925	-	99 800	252 349	-	-	680 074
Programme enablers & HSS	75 176 586	90 000	1 648 704	108 178 912	110 700	-	185 204 902
Total	375 696 882	4 087 155	13 329 539	151 682 574	155 545	471 799	545 423 492
Funding Entity % share	69%	1%	2%	28%	0%	0%	

Financing schemes x beneficiary groups in Mozambique (US\$, %, 2017-2018)

SCHEME and Beneficiaries	2017	2018	2017%	2018%
SCH.01.01.01 Central government schemes	371 616 160	375 696 882	73%	69%
BP.01 People living with HIV	239 632 861	187 941 950	47%	34%
BP.02 Key populations	904 688	1 244 349	0%	0%
BP.03 Vulnerable, accessible and other target populations	27 906 727	23 852 203	5%	4%
BP.04 General population	48 977 102	51 942 210	10%	10%
BP.05 Non-targeted interventions	54 194 781	110 716 169	11%	20%
SCH.01.02.02 Compulsory private insurance schemes	4 215 840	4 087 155	1%	1%
BP.01 People living with HIV	3 184 160	2 486 723	1%	0%
BP.03 Vulnerable, accessible and other target populations	941 680	1 510 432	0%	0%
BP.05 Non-targeted interventions	90 000	90 000	0%	0%
SCH.02.02.01 Not-for-profit organisation schemes (excluding SCH.2.2.2)	12 717 353	13 329 539	3%	2%
BP.01 People living with HIV	800 607	3 114 121	0%	1%
BP.02 Key populations	283 474	1 885 059	0%	0%
BP.03 Vulnerable, accessible and other target populations	1 067 446	4 839 606	0%	1%
BP.04 General population	2 548 961	1 742 249	1%	0%
BP.05 Non-targeted interventions	8 016 866	1 748 504	2%	0%
SCH.02.02.02 Resident foreign agencies schemes	119 105 740	151 682 574	23%	28%
BP.01 People living with HIV	51 355	19 145 167	0%	4%
BP.02 Key populations	2 232 010	5 329 509	0%	1%
BP.03 Vulnerable, accessible and other target populations	18 548 481	16 881 511	4%	3%
BP.04 General population	60 417	1 980 364	0%	0%
BP.05 Non-targeted interventions	98 213 476	108 346 023	19%	20%
SCH.02.03.01 Enterprises (except health care providers) schemes	110 652	155 545	0%	0%
BP.03 Vulnerable, accessible and other target populations	61 536	44 845	0%	0%
BP.05 Non-targeted interventions	49 116	110 700	0%	0%
SCH.03 Household out-of-pocket payment	726 679	471 799	0%	0%
BP.04 General population	726 679	471 799	0%	0%
Total	508 492 424	545 423 492	100%	100%

Financing agent-purchasers of HIV services in Mozambique (US\$ and US\$, 2017-2018)

FAP (US\$)	Public agents/ purchasers	Private agents/ purchasers	International agents/ purchasers	Total US\$	Public FAP % share	FAP % share	International FAP % share
Previous NASA (2014)	97 932 654	14 469 295	220 101 083	332 503 032	29%	4%	66%
2017	130 004 471	14 646 788	363 841 164	508 492 424	26%	3%	72%
2018	134 813 930	10 943 370	399 666 193	545 423 492	25%	2%	73%

HIV Financing entities and their agents/purchasers (US\$, 2017-2018)

2017	Public FAP	Private FAP	International FAP	Total	% FE share
Public funding entity	10 746 929	-	-	10 746 929	2%
Private funding entity	-	5 053 171	-	5 053 171	1%
International funding entity	119 257 542	9 593 617	363 841 164	492 692 324	97%
Total	130 004 471	14 646 788	363 841 164	508 492 424	
% FAP share	26%	3%	72%		
2018	Public FAP	Private FAP	International FAP	Total	% FE share
Public funding entity	12 149 223	-	-	12 149 223	2%
Private funding entity	-	4 714 498	-	4 714 498	1%
International funding entity	122 664 707	6 228 872	399 666 193	528 559 771	97%
Total	134 813 930	10 943 370	399 666 193	545 423 492	
% FAP share	25%	2%	73%		

HIV Financing agents/purchasers and their service provider types (US\$, 2017-2018)

FAPs and their HIV service provider types	2017	2018	2017 %	2018 %
FAP.01 Public sector	130 004 471	134 813 930	26%	25%
PS.01.01 Governmental organizations	129 965 058	134 791 171	26%	25%
PS.02.01 Non-profit providers	-	12 086	0%	0%
PS.02.02 Profit-making private sector providers	39 413	10 673	0%	0%
FAP.02 Private sector	14 646 788	10 943 370	3%	2%
PS.01.01 Governmental organizations	284 853	150 000	0%	0%
PS.02.01 Non-profit providers	9 419 416	6 234 417	2%	1%
PS.02.02 Profit-making private sector providers	4 215 840	4 087 155	1%	1%
PS.03.03 International NGOs and foundations	726 679	471 799	0%	0%
FAP.03 International purchasing organizations	363 841 164	399 666 193	72%	73%
PS.01.01 Governmental organizations	42 789 767	106 409 285	8%	20%
PS.02.01 Non-profit providers	280 456	1 192 137	0%	0%
PS.02.02 Profit-making private sector providers	-	34 943	0%	0%
PS.03.02 Multilateral agencies	3 378 701	2 731 257	1%	1%
PS.03.03 International NGOs and foundations	54 316 448	68 556 759	11%	13%
PEPFAR IPs and SRs	263 075 791	220 741 812	52%	40%
Total	508 492 424	545 423 492	100%	100%

HIV service providers' spending (US\$, %, 2017-2018)

HIV service providers	2017	2018	2017 %	2018 %
PEPFARs IPs and SRs	263 075 791	220 741 812	52%	40%
INGOs and Foundations (providing services)	55 043 127	69 028 558	11%	13%
Bilateral / multilateral agencies	3 378 701	2 731 257	1%	1%
For-profit providers (national)	4 255 253	4 132 771	1%	1%
Non-profit organisations (national)	9 699 872	7 438 640	2%	1%
Public providers:	173 039 678	241 350 456	34%	44%
<i>Public hospitals and clinics</i>	165 963 216	233 117 076	33%	43%
<i>Schools and higher education centres</i>	200 000	250 000	0.0%	0.0%
<i>CNCS</i>	1 725 596	1 940 249	0.3%	0.4%
<i>MOH central</i>	5 000 238	5 842 468	1.0%	1.1%
<i>Ministry of Justice, Labour and other ministries</i>	150 629	200 663	0.0%	0.0%
Total	508 492 424	545 423 492	100%	100%

HIV spending by programmatic areas (US\$, 2017-2018)

HIV Programme Area	2017 (US\$)	2018 (US\$)	2017 %	2018 %
Prevention	54 583 645	70 231 996	11%	13%
HTC	33 031 261	42 480 965	6%	8%
Care and treatment	244 778 465	234 425 922	48%	43%
Social protection & econ.support	15 419 551	12 399 634	3%	2%
Social enablers	164 537	680 074	0.03%	0.1%
Programme enablers & system strengthening	160 314 965	185 204 902	32%	34%
Research	200 000	-	0%	0%
Total	508 492 424	545 423 492	100%	100%

Financing entities for the HIV programmatic areas (US\$, %, 2018)

2017	Public FE	Private FE	International FE	Total (US\$)	ASC %
Prevention	939 626	1 283 946	52 360 073	54 583 645	11%
HTC	1 746 246	115 748	31 169 267	33 031 261	6%
Care and Treatment Care	3 306 249	3 184 160	238 288 057	244 778 465	48%
Social protection and economic support	-	330 200	15 089 351	15 419 551	3%
Social Enablers	-	-	164 537	164 537	0%
Programme enablers and systems strengthening	4 754 808	139 116	155 421 040	160 314 965	32%
Development synergies	-	-	-	-	0%
HIV-related research	-	-	200 000	200 000	0%
Total	10 746 929	5 053 171	492 692 324	508 492 424	100%
Sources % share	2%	1%	97%	100%	

2018	Public FE	Private FE	International FE	Total (US\$)	ASC %
Prevention	1 471 580	1 028 948	67 731 468	70 231 996	13%
HTC	2 019 136	88 452	40 373 377	42 480 965	8%
Care and Treatment	3 504 267	3 066 199	227 855 456	234 425 922	43%
Social protection & economic support	-	330 200	12 069 434	12 399 634	2%
Social Enablers	-	-	680 074	680 074	0%
Programme enablers & HSS	5 154 239	200 700	179 849 964	185 204 902	34%
Development synergies	-	-	-	-	0%
Research	-	-	-	-	0%
Total	12 149 223	4 714 498	528 559 771	545 423 492	100%
Funding Entity % share	2%	1%	97%	100%	

Provincial spending per HIV programmatic areas (US\$, 2017)

2017	National Spending	Maputo Cidade	Maputo Provincia	Gaza	Inhambane	Sofala	Manica	Tete	Zambezia	Nampula	Cabo Delgado	Niassa	Not disagg. by province	Overall
Prevention	37 308	3 430 305	3 743 325	6 197 233	1 790 187	7 651 629	4 612 279	4 508 864	11 602 248	4 120 398	2 216 790	1 049 420	3 623 659	54 583 645
HTC	-	1 699 550	3 178 590	3 920 468	1 636 966	2 297 713	2 173 802	1 962 924	6 544 074	4 966 730	2 737 069	879 628	1 033 747	33 031 261
Care and Treatment	-	#####	23 768 334	28 967 834	16 362 128	21 991 821	18 081 391	13 800 619	46 590 776	24 219 893	13 129 392	6 290 221	5 141 973	244 778 465
Social protection and economic support	-	596 350	2 031 950	1 474 703	542 817	2 653 096	1 403 791	991 022	2 774 559	1 626 407	488 525	256 969	579 363	15 419 551
Social Enablers	-	125 000	-	-	-	-	-	-	-	-	-	-	39 537	164 537
Programme enablers & HSS	130 797 088	569 831	351 366	477 668	7 921 719	9 453 850	8 396 573	312 880	372 073	1 334 636	169 129	158 153	-	160 314 965
Research	-	200 000	-	-	-	-	-	-	-	-	-	-	-	200 000
Total	130 834 396	#####	33 073 566	41 037 905	28 253 817	44 048 108	34 667 836	21 576 310	67 883 729	36 268 063	18 740 905	8 634 390	10 418 278	508 492 424
Provincial % share	26%	7%	7%	8%	6%	9%	7%	4%	13%	7%	4%	2%	2%	100%

HIV Financing schemes and their ASC (US\$, 2017-2018)

SCH x ASC	2017	2018	Grand Total
* SCH.01.01 Government schemes	371 616 160	375 696 882	747 313 041
* ASC.01 Prevention	44 595 688	34 057 512	78 653 200
ASC.01.01 Five Pillars of Prevention	22 269 558	29 957 046	52 226 604
ASC.01.02 Other Prevention activities	22 326 130	4 100 466	26 426 596
* ASC.02 HIV testing and counselling (HTC)	31 917 456	40 118 529	72 035 986
programme)	4 802 502	3 900 812	8 703 313
ASC.02.07 Early infant (and paediatric?) diagnosis (EID) of HIV	93 868	516 040	609 908
ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	798 187	690 390	1 488 577
ASC.02.09 Voluntary HIV testing and counselling for general population	2 761 233	25 464 000	28 225 233
ASC.02.10 Provider initiated testing and counselling (PITC)	5 528 790	6 690 924	12 219 714
ASC.02.11 HIV screening in blood banks	81 529	340 352	421 882
ASC.02.98 HIV testing and counselling activities not disaggregated	17 851 347	2 516 011	20 367 358
* ASC.03 HIV Care and Treatment Care	240 793 698	226 016 330	466 810 028
ASC.03.01 Anti-retroviral therapy	108 809 956	187 437 175	296 247 131
ASC.03.03 Specific ART-related laboratory monitoring	24 300 383	24 853 322	49 153 705
treatment for PLHIV and KPs	1 456 022		1 456 022
ASC.03.05 Psychological treatment and support service		102 544	102 544
ASC.03.98 Care and treatment services not disaggregated	106 227 337	13 623 289	119 850 626
* ASC.05 Social Enablers (excluding the efforts for KPs above)	164 537	327 925	492 461
ASC.05.02 Human rights programmes	125 000	327 925	452 925
ASC.05.98 Social enablers not disaggregated by type	39 537		39 537
* ASC.06 Programme enablers and systems strengthening	53 944 781	75 176 586	129 121 367
delivery level)	2 216 738	1 346 733	3 563 472
ASC.06.04 Strategic information	945 048	1 168 584	2 113 633
ASC.06.05 Public Systems Strengthenin	50 782 994	72 661 268	123 444 262
* ASC.08 HIV-related research (paid by earmarked HIV funds)	200 000		200 000
ASC.08.04 Socio-behavioural research	200 000		200 000
* SCH.01.02 Compulsory contributory health insurance schemes	4 215 840	4 087 155	8 302 995
* ASC.01 Prevention	551 480	540 756	1 092 236
ASC.01.02 Other Prevention activities	551 480	540 756	1 092 236
* ASC.02 HIV testing and counselling (HTC)	60 000	60 000	120 000
ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	60 000	60 000	120 000
* ASC.03 HIV Care and Treatment Care	3 184 160	3 066 199	6 250 359
transport) and monitoring	590 200	579 476	1 169 676
ASC.03.06 Palliative care	2 593 960	2 486 723	5 080 683
* KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds	330 200	330 200	660 400
ASC.04.02 Other social protection and economic support (non-OVC)	330 200	330 200	660 400
* ASC.06 Programme enablers and systems strengthening	90 000	90 000	180 000
ASC.06.04 Strategic information	90 000	90 000	180 000
* SCH.02.02 Not-for-profit organisation schemes	131 823 093	165 012 113	296 835 205
* ASC.01 Prevention	8 704 011	35 145 536	43 849 547
ASC.01.01 Five Pillars of Prevention	3 027 826	25 453 669	28 481 495
ASC.01.02 Other Prevention activities	5 676 184	9 691 867	15 368 052
* ASC.02 HIV testing and counselling (HTC)	998 057	2 273 984	3 272 040
ASC.02.01 HIV testing and counselling for sex workers		711 309	711 309
ASC.02.02 HIV testing and counselling for MSM		296 319	296 319
ASC.02.04 HIV testing and counselling for PWID		113 485	113 485
ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	9 215	1 152 871	1 162 086
ASC.02.09 Voluntary HIV testing and counselling for general population	988 842		988 842
* ASC.03 HIV Care and Treatment Care	800 607	5 343 393	6 144 000
ASC.03.01 Anti-retroviral therapy		1 582 398	1 582 398
transport) and monitoring	139 625		139 625
treatment for PLHIV and KPs	660 982		660 982
ASC.03.06 Palliative care		815 890	815 890
ASC.03.98 Care and treatment services not disaggregated		2 945 105	2 945 105
* KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds	15 089 351	12 069 434	27 158 785
ASC.04.01 Social protection and economic support for OVC	14 463 245	8 390 450	22 853 695
ASC.04.02 Other social protection and economic support (non-OVC)	626 106	2 615 287	3 241 393
ASC.04.98 Social protection activities not disaggregated		378 088	378 088
ASC.04.99 Social protection activities n.e.c		685 609	685 609
* ASC.05 Social Enablers (excluding the efforts for KPs above)		352 149	352 149
ASC.05.02 Human rights programmes		352 149	352 149
* ASC.06 Programme enablers and systems strengthening	106 231 068	109 827 617	216 058 684
ASC.06.01 Strategic planning, coordination and policy development	1 304		1 304
governance, policy reform and development processes	100		100
delivery level)	66 360 863	83 132 033	149 492 896
ASC.06.04 Strategic information	15 259 150	13 199 854	28 459 005
ASC.06.05 Public Systems Strengthenin	1 110 952	7 762 506	8 873 458
ASC.06.06 Community system strengthening	569 681	194 921	764 602
ASC.06.07 Human resources for health (above-site programmes)	48 670	5 518 284	5 566 954
ASC.06.98 Programme enablers and systems strengthening not disaggregated	22 880 347	20 019	22 900 366
* SCH.02.03 For-profit enterprise schemes	110 652	155 545	266 197
* ASC.01 Prevention	5 787	16 393	22 181
ASC.01.02 Other Prevention activities	5 787	16 393	22 181
* ASC.02 HIV testing and counselling (HTC)	55 748	28 452	84 200
ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	55 748	28 452	84 200
* ASC.06 Programme enablers and systems strengthening	49 116	110 700	159 816
ASC.06.01 Strategic planning, coordination and policy development		443	443
delivery level)	44 519	102 348	146 867
ASC.06.04 Strategic information	4 597	7 909	12 506
* SCH.03.01 Out-of-pocket excluding cost-sharing	726 679	471 799	1 198 478
* ASC.01 Prevention	726 679	471 799	1 198 478
ASC.01.01 Five Pillars of Prevention	726 679	471 799	1 198 478
Grand Total	508 492 424	545 423 492	1 053 915 916

HIV prevention spending (US\$, %, 2017-2018)

Prevention (US\$)	2017	2018	2017 %	2018 %
AGYW	252 900	22 460 504	0%	32%
Key Pop	2 382 886	1 183 234	4%	2%
Condoms	1 118 720	981 732	2%	1%
VMMC	22 269 558	29 800 035	41%	42%
PrEP	-	1 457 009	0%	2%
PMTCT	20 869 984	2 383 207	38%	3%
SBCC	579 483	9 220 810	1%	13%
Community mobilization	131 934	-	0%	0%
Vulnerable & accessible populations	5 040 035	592 815	9%	1%
Children and youth	787 567	690 912	1%	1%
Prevention of HIV transmission aimed at PLHIV & partners	-	183 150	0%	0%
Wellness progms	629	134 983	0%	0%
STI prevention and treatment	1 149 950	935 938	2%	1%
Prevention not disag	-	207 668	0%	0%
Total prevention spend	54 583 645	70 231 996	100%	100%
Five Pillars of Prevention	2017	2018	2017 %	2018 %
AGYW	252 900	22 460 504	1%	40%
Key Populations	2 382 886	1 183 234	9%	2%
Condoms	1 118 720	981 732	4%	2%
VMMC	22 269 558	29 800 035	86%	53%
PrEP	-	1 457 009	0%	3%
Total spend on 5 pillars of prevention	26 024 063	55 882 514	100%	100%
Prevention (US\$)	2017	2018	2017 %	2018 %
Five Pillars of Prevention	26 024 063	55 882 514	48%	80%
Other Prevention	28 559 581	14 349 483	52%	20%
Total Prevention	54 583 645	70 231 996	100%	100%

HIV testing and counselling (US\$, 2017-2018)

HTC	2017	2018
HIV testing for sex workers	-	711 309
HIV testing for MSM	-	296 319
HIV testing for PWID	-	113 485
HIV testing for pregnant women (PMTCT prgm)	4 802 502	3 900 812
Early infant diagnosis	93 868	516 040
HIV testing for vulnerable & accessible pops	923 150	1 931 713
HIV testing for general pop	3 750 075	25 464 000
PITC	5 528 790	6 690 924
HIV screening in blood banks	81 529	340 352
HIV testing not disag.	17 851 347	2 516 011
Total HIV testing & counselling spend	33 031 261	42 480 965

HIV care and treatment spending (US\$, %, 2017-2018)

Treatment (US\$)	2017	2018	2017 %	2018 %	% change '17-18
Anti-retroviral therapy	108 809 956	189 019 573	44%	81%	74%
Adherence and retention on ART	729 825	579 476	0.3%	0.2%	-21%
Specific ART-related laboratory monitoring	24 300 383	24 853 322	10%	11%	2%
Co-infections and OIs	2 117 005	-	1%	0%	-100%
Psychological treatment and support	-	102 544	0.0%	0.0%	0%
Palliative care	2 593 960	3 302 612	1%	1%	27%
C&T services not disag (including FBCTS & CBCTS)	106 227 337	16 568 394	43%	7%	-84%
Total treatment and care spend	244 778 465	234 425 922	100%	100%	-4%

HIV care and treatment activities by financing scheme (US\$, 2017-2018)

2017 Treatment activities	FINANCING SCHEME			Total (US\$)
	Central govt scheme	Compulsory private insurance schemes	Voluntary resident NPO schemes	
Anti-retroviral therapy	108 809 956	-	-	108 809 956
Adherence and retention on ART - support (nutrition/ transport), monitoring	-	590 200	139 625	729 825
Specific ART-related laboratory monitoring	24 300 383	-	-	24 300 383
Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	1 456 022	-	660 982	2 117 005
Palliative care	-	2 593 960	-	2 593 960
Care and treatment services not disagg.	106 227 337	-	-	106 227 337
Total	240 793 698	3 184 160	800 607	244 778 465
Funding Entity % share	98%	1%	0%	

2018 Treatment activities	FINANCING SCHEME			Total (US\$)
	Central govt scheme	Compulsory private insurance schemes	Voluntary resident NPO schemes	
Anti-retroviral therapy	187 437 175	-	1 582 398	189 019 573
Adherence and retention on ART - support (nutrition/ transport), monitoring	-	579 476	-	579 476
Specific ART-related laboratory monitoring	24 853 322	-	-	24 853 322
Psychological treatment and support service	102 544	-	-	102 544
Palliative care	-	2 486 723	815 890	3 302 612
Care and treatment services not disagg.	13 623 289	-	2 945 105	16 568 394
Total	226 016 330	3 066 199	5 343 393	234 425 922
Funding Entity % share	96%	1%	2%	

HIV social protection and economic support spending (US\$, %, 2017-2018)

Social protection and economic support	2017	2018	2017 %	2018 %
Social protection and economic support for OVC	14 463 245	8 390 450	94%	68%
Other social protection and economic support (non-OVC)	956 306	2 945 487	6%	24%
Social protection and social services not disagg	-	378 088	0%	3%
Social protection and social services n.e.c	-	685 609	0%	6%
Total Social Protection & Economic Support	15 419 551	12 399 634	100%	100%

HIV social enablers spending (US\$, %, 2017-2018)

Social enablers (US\$)	2017	2018	2017 %	2018 %
Human rights programmes	125 000	680 074	76%	100%
Social enablers not disaggregated by type	39 537	-	24%	0%
Total S.Enablers spend (US\$)	164 537	680 074	100%	100%

HIV programme enablers and systems strengthening spending (US\$, %, 2017-2018)

Programme enablers and systems strengthening	2017	2018	2017 %	2018 %
Strategic planning, coordination and policy development	1 304	443	0%	0%
Building meaningful engagement	100	-	0%	0%
Programme admin. & management	68 622 120	84 581 114	43%	46%
Strategic information	16 298 796	14 466 347	10%	8%
Public systems strengthening	51 893 946	80 423 774	32%	43%
Community system strengthening	569 681	194 921	0%	0%
Human resources for health (above-site programmes)	48 670	5 518 284	0%	3%
P.Enablers & S.Strgn not disagg.	22 880 347	20 019	14%	0%
Total P.Enablers & S.Strengthening	160 314 965	185 204 902	100%	100%

HIV programme enablers and systems strengthening spending by financing entity (US\$, 2018)

2018 P.Enablers & S.Strengthening	Government FE	Domestic corporations FE	Bilateral FE	Multilateral FE	Other international FE	Total
Strategic planning, coordination & policy devmt	-	443	-	-	-	443
Programme admin. & management	737 759	102 348	81 599 539	1 540 912	600 556	84 581 114
Strategic information	321 672	97 909	13 230 950	815 816	-	14 466 347
Public systems strengthening	4 094 807	-	13 704 926	62 624 041	-	80 423 774
Community system strengthening	-	-	17 500	177 421	-	194 921
Human resources for health (above-site programmes)	-	-	5 516 041	2 242	-	5 518 284
P.Enablers & S.Strgn not disagg.	-	-	20 019	-	-	20 019
Total P.Enablers & S.Strgn	5 154 239	200 700	114 088 976	65 160 432	600 556	185 204 902
As share of total FE spending	42%	2%	31%	45%	6%	34%

Spending per HIV programme area by provider type (US\$, %, 2018)

Programme area (US\$)	Public providers	Private providers	PEPFAR IP & service providers	International providers	Public provider %	Private provider %	PEPFAR IPs & SRs %	International provider %
Prevention	34 041 025	6 047 296	27 542 783	2 600 892	14%	52%	12%	4%
HTC	12 820 878	105 071	29 555 016	-	5%	1%	13%	0%
HIV Treatment Care	187 471 106	3 882 089	38 545 224	4 527 503	78%	34%	17%	6%
Social protection and economic support	-	330 200	11 663 206	406 228	0%	3%	5%	1%
Social Enablers	327 925	99 800	227 349	25 000	0%	1%	0%	0%
Programme enablers and systems	6 689 522	1 106 955	113 208 234	64 200 191	3%	10%	51%	89%
Total	241 350 456	11 571 410	220 741 812	71 759 814	100%	100%	100%	100%

HIV spending by service delivery modality (US\$, %, 2017-2018)

Service delivery modality	2017	2018	2017 %	2018 %
Facility-based service modalities	287 928 362	337 230 392	57%	62%
Home and community based service modalities	24 829 107	10 835 197	5%	2%
Modalities not disaggregated	32 449 514	12 610 634	6%	2%
Non applicable (ASC which does not have a specific SDM)	163 285 441	184 355 789	32%	34%
Modalities n.e.c.	-	391 481	0%	0%
Total spending by SDM	508 492 424	545 423 492	100%	100%

HIV programme area spending by service delivery modality (US\$, 2018)

Row Labels	2017	2018	Grand Total
ASC.01 Prevention	54 583 645	70 231 996	124 815 641
SDM.01 Facility-based service modalities	44 238 137	62 074 760	106 312 897
SDM.02 Home and community based service modalities	212 032	462 657	674 689
SDM.98 Modalities not disaggregated	9 658 165	7 303 099	16 961 264
SDM.03 Non applicable (ASC which does not have a specific SDM)	475 311		475 311
SDM.99 Modalities n.e.c.		391 481	391 481
ASC.02 HIV testing and counselling (HTC)	33 031 261	42 480 965	75 512 226
SDM.01 Facility-based service modalities	14 066 109	32 428 002	46 494 111
SDM.02 Home and community based service modalities		9 541 459	9 541 459
SDM.98 Modalities not disaggregated	18 901 722	206 143	19 107 865
SDM.03 Non applicable (ASC which does not have a specific SDM)	63 430	305 361	368 791
ASC.03 HIV Care and Treatment Care	244 778 465	234 425 922	479 204 387
SDM.01 Facility-based service modalities	229 624 116	230 509 902	460 134 018
SDM.02 Home and community based service modalities	11 169 582	815 890	11 985 472
SDM.98 Modalities not disaggregated	1 314 247	3 100 130	4 414 377
SDM.03 Non applicable (ASC which does not have a specific SDM)	2 670 520		2 670 520
ASC.04 Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds are used)	15 419 551	12 399 634	27 819 185
SDM.01 Facility-based service modalities		12 069 434	12 069 434
SDM.02 Home and community based service modalities	13 407 956		13 407 956
SDM.98 Modalities not disaggregated	1 738 435	330 200	2 068 635
SDM.03 Non applicable (ASC which does not have a specific SDM)	273 160		273 160
ASC.05 Social Enablers (excluding the efforts for KPs above)	164 537	680 074	844 610
SDM.01 Facility-based service modalities		148 294	148 294
SDM.02 Home and community based service modalities	39 537		39 537
SDM.98 Modalities not disaggregated		438 708	438 708
SDM.03 Non applicable (ASC which does not have a specific SDM)	125 000	93 071	218 071
ASC.06 Programme enablers and systems strengthening	160 314 965	185 204 902	345 519 867
SDM.02 Home and community based service modalities		15 192	15 192
SDM.98 Modalities not disaggregated	836 944	1 232 354	2 069 298
SDM.03 Non applicable (ASC which does not have a specific SDM)	159 478 021	183 957 356	343 435 377
ASC.08 HIV-related research (paid by earmarked HIV funds)	200 000		200 000
SDM.03 Non applicable (ASC which does not have a specific SDM)	200 000		200 000
Grand Total	508 492 424	545 423 492	1 053 915 916

HIV spending by beneficiary populations (US\$, %, 2017-2018)

Beneficiary population (US\$)	2017	2018	2017 %	2018 %
People living with HIV	243 668 984	212 687 961	48%	39%
Key populations	3 420 172	8 458 917	1%	2%
Vulnerable, accessible pop	48 525 869	47 128 597	10%	9%
General population	52 313 159	56 136 622	10%	10%
Non-targeted interventions	160 564 239	221 011 396	32%	41%
Total Beneficiary spend	508 492 424	545 423 492	100%	100%

HIV spending on key populations (US\$, %, 2017-2018)

KP intervention (US\$)	2017	2018	2017 % of each KP sub-total	2018 % of each KP sub-total
Sex workers sub-total:	1 361 670	1 285 780		
<i>SW Peer education</i>	6 506	-	0%	0%
<i>SW Community empowerment</i>	14 767	-	1%	0%
<i>HIV testing for SW</i>	-	711 309	0%	55%
<i>SW interventions not disagg.</i>	1 110 634	542 768	82%	42%
<i>Other SW intervention n.e.c</i>	229 763	31 703	17%	2%
MSM sub-total:	975 924	523 381		
<i>MSM Condoms & lub</i>	-	125 783	0%	24%
<i>MSM Behaviour change</i>	63 549	101 279	7%	19%
<i>HIV testing for MSM</i>	-	296 319	0%	57%
<i>MSM interventions not disagg.</i>	912 375	-	93%	0%
PWID sub-total:	45 291	113 485		
<i>HIV testing for PWID</i>	-	113 485	0%	100%
<i>PWID interventions not disagg.</i>	45 291	-	100%	0%
Inmates sub-total:	-	184 300		
<i>Inmates Interpersonal communication on HIV prevention</i>	-	5 300	-	3%
<i>Inmates empowerment & prevn. of stigma/discrimn.</i>	-	34 000	-	18%
<i>Inmates interventions not disagg.</i>	-	25 000	-	14%
<i>Other inmates intervention n.e.c</i>	-	120 000	-	65%

Beneficiaries of HIV programmatic spending (US\$, 2018)

HIV Programme Area (2018)	People living with HIV	Key populations	Vulnerable, accessible pop	General population	Non-targeted interventions
Prevention	19 145 167	4 270 529	14 015 795	32 768 775	31 730
HIV testing and counselling (HTC)	-	1 228 053	6 581 977	21 942 200	12 728 735
HIV Care and Treatment Care	193 528 885	2 582 247	14 868 741	780 947	22 665 102
Social protection & econ. Support	-	378 088	11 376 846	644 700	-
Social Enablers	13 908	-	285 238	-	380 927
Prog.enablers & systems strengthening	-	-	-	-	185 204 902
Total	212 687 961	8 458 917	47 128 597	56 136 622	221 011 396

HIV spending by production factor (US\$, %, 2017-2018)

Key production factors	2017	2018	2017 %	2018 %
ARVs	81 367 751	79 696 757	16%	15%
Personnel	153 305 328	143 467 980	30%	26%
All other recurrent spending	167 952 471	162 987 727	33%	30%
Operational/ management current exp.	54 426 568	126 688 399	11%	23%
Capital expenditure	44 544 688	32 187 838	9%	6%
Production factors not disagg.	6 895 617	394 793	1%	0%
Total	508 492 423	545 423 494	100%	100%

HIV spending by production factor – further disaggregated (US\$, %, 2017-2018)

Production factor (US\$)	2017	2018	2017 %	2018 %
Current direct and indirect expenditures	457 052 118	512 840 863	90%	94%
Personnel costs	153 305 328	143 467 980	30%	26%
Operational / management current exp	54 426 568	126 688 399	11%	23%
Medical products and supplies:				
Antiretrovirals	81 367 751	79 696 757	16%	15%
STI drugs	962 592	721 128	0.2%	0.1%
Pharmaceuticals not disaggregated	1 496 680	95 820	0.3%	0.0%
Condoms	2 144 631	550 972	0.4%	0.1%
Lubricants	-	62 892	0.0%	0.0%
Medical supplies not disaggregated	-	15 797 609	0%	3%
HIV tests screening/diagnostics	17 241 090	14 570 074	3%	3%
VL tests	6 846 939	14 060 270	1%	3%
CD4 tests	10 829 218	11 144 410	2%	2%
Reagents not disagg.	23 940 047	-	5%	0%
Non-medical supplies:				
Food and nutrients	5 585 923	702 776	1%	0%
Promotion and information materials	527 489	745 646	0.1%	0.1%
Non-medical supplies not disaggregated	14 432 660	12 007 000	3%	2%
Office Supplies	-	69 166	0%	0.0%
Medical products and supplies not disaggregated	-	127 363	0%	0.0%
Contracted external services	292 986	341 152	0.1%	0.1%
Transportation related to beneficiaries	-	230 554	0%	0.0%
Housing/accommodation services for beneficiaries	85 758	230 554	0.0%	0.0%
Financial support for beneficiaries	-	1 078 793	0%	0.2%
Training related per diems/transport/other costs	33 062 677	26 918 811	7%	5%
Logistics of events, including catering services	661 406	1 065 974	0.1%	0.2%
Indirect costs	6 182	2 018	0.0%	0.0%
Current direct & indirect expenditures not disagg.	49 836 192	14 219 065	10%	3%
Current direct & indirect expenditures n.e.c.	-	48 245 678	0%	9%
Capital expenditures	44 544 688	32 187 838	9%	6%
Building:				
Laboratory and other infrastructure upgrading	10 367 049	3 274 963	2%	1%
Construction and renovation	13 447 416	6 505 471	3%	1%
Building not disaggregated	96 029	74 575	0.0%	0.0%
Vehicles	7 826 382	6 555	2%	0.0%
Other capital investment:				
IT (hardware and software)	18 603	18 603	0.0%	0.0%
Laboratory and other medical equipment	4 350 376	16 818 805	1%	3%
Non medical equipment and furniture	7 716 540	5 029 219	2%	1%
Other capital investment not disagg.	718 565	442 819	0.1%	0.1%
Capital exp n.e.c.	3 756	16 826	0.0%	0.0%
Production factors not disagg.	6 895 617	394 793	1%	0.1%
Total	508 492 423	545 423 494	100%	100%

HIV financing entities' spending by production factor (US\$, %, 2018)

Cost component (2018)	Public Funding Entity	Private Funding Entities	PEPFAR	Global Fund	Other International Funding Entities	Total (US\$)
Personnel	6 945 476	1 282 032	106 173 381	1 041 320	28 025 771	143 467 980
ARVs	-	-	23 238 166	56 458 591	-	79 696 757
Labs & reagents	-	33 722	19 677 865	15 590 025	4 473 143	39 774 755
Operational costs	525 848	688 625	124 718 923	202 797	552 206	126 688 399
Other current expend.	4 677 899	2 352 729	87 277 682	5 221 568	23 683 094	123 212 973
Capital expend.	-	3 897	9 104 634	30 901	23 048 406	32 187 838
Expend. n.d.	-	353 492	-	-	41 301	394 793
Total HIV spend	12 149 223	4 714 498	370 190 651	78 545 201	79 823 920	545 423 494

HIV service providers' spending by production factor (US\$, %, 2018)

Production factor (2018)	PUBLIC PS	NON-PROFIT PS	PROFIT-MAKING PS	MULILATERAL PS	INGOS / FOUNDATIONS PS	PEPFAR IP & PS
Current direct and indirect expenditures	239 153 335	7 434 742	3 779 279	2 670 473	45 999 636	213 803 399
Personnel costs	44 568 102	311 470	1 188 725	368 611	26 355 366	70 675 705
Operational / management current exp	57 514 475	29 349	659 276	141 601	410 605	67 933 093
Medical products and supplies (ARVs)	125 773 014	443 084	588 523	583 027	583 901	22 380 335
Contracted external services	-	-	-	43 000	298 153	-
Transportation related to beneficiaries	-	230 554	-	-	-	-
Housing/accommodation services for beneficiaries	-	230 554	-	-	-	-
Financial support for beneficiaries	25 895	-	-	105 512	-	947 386
Training related per diems/transport	3 538 369	6 624	331 756	158 957	16 118 638	6 764 468
Logistics of events, including catering	338 665	99 800	-	279 324	348 185	-
Indirect costs	-	618	-	-	1 400	-
Current direct & indirect expenditures not disagg.	4 309 291	6 024 947	1 010 998	990 441	1 883 388	-
Current direct & indirect expenditures n.e.c.	3 085 524	57 742	-	-	-	45 102 412
Capital expenditures	2 197 121	3 897	-	19 484	23 028 922	6 938 414
Building	1 022 894	-	-	-	3 399 268	5 432 847
Vehicles	-	3 897	-	2 658	-	-
Other capital investment:	1 174 226	-	-	-	19 629 653	1 505 567
Capital exp n.e.c.	-	-	-	16 826	-	-
Production factors not disagg.	-	-	353 492	41 301	-	-
Total	241 350 456	7 438 640	4 132 771	2 731 257	69 028 558	220 741 813

HIV programme areas by production factor (US\$, %, 2018)

Production factor (2018)	Prevention	HTC	Care & Treatment	Social prot. & econ.support	Social Enablers	Programme Enablers
Current direct and indirect expenditures	69 280 877	42 141 432	231 159 278	12 257 643	678 276	157 323 357
Personnel costs	24 687 212	15 235 025	41 187 237	2 931 448	147 328	59 279 729
Operational / management current exp	27 249 088	13 544 169	54 380 627	7 637 405	67 897	23 809 213
Medical products and supplies (ARVs, labs, condoms, etc)	6 658 420	11 063 003	125 505 442	695 646	15 666	6 413 707
Contracted external services	43 000	-	298 153	-	-	-
Transportation related to beneficiaries	73 253	-	157 301	-	-	-
Housing/accommodation services for beneficiaries	73 253	-	157 301	-	-	-
Financial support for beneficiaries	190 459	-	-	76 755	-	811 579
Training related per diems/transport/other costs	2 796 579	1 226 402	3 859 252	393 150	6 442	18 636 986
Logistics of events, including catering services	624 510	-	-	-	413 816	27 648
Indirect costs	-	-	-	-	-	2 018
Current direct & indirect expenditures not disagg.	5 423 052	6 054	2 805 486	289 986	13 908	5 680 579
Current direct & indirect expenditures n.e.c.	1 462 050	1 066 779	2 808 481	233 253	13 218	42 661 898
Capital expenditures	909 819	339 534	2 970 192	84 951	1 798	27 881 544
Building	289 749	211 475	1 525 711	-	-	7 828 074
Vehicles	-	-	-	-	-	6 555
Other capital investment	620 070	128 059	1 444 480	68 125	1 798	20 046 915
Capital exp n.e.c.	-	-	-	16 826	-	-
Production factors not disagg.	41 301	-	296 452	57 040	-	-
Total	70 231 997	42 480 966	234 425 922	12 399 634	680 074	185 204 902

PEPFAR spending by programme area (US\$, 2017-2018) – refer to appendices 4-8 for crosswalk details

PEPFAR HIV program areas (US\$)	2017	2018
5 pillars of prevn	24 053 005	48 908 788
Other prevn	24 916 177	10 902 693
HTC	29 468 029	37 927 086
C&T	161 044 621	147 353 294
S.Protect & Econ.Supp	12 684 178	11 663 206
Social enablers	-	227 349
Prog.enablers & system strengthn	96 968 990	113 208 234
Total	349 135 001	370 190 650

PEPFAR spending by activity (US\$, 2017-2018) – refer to appendices 4-8 for crosswalk details

PEPFAR HIV activities (US\$)	2017	2018	2017 %	2018 %
Prevention for AGYW	-	17 543 135	0%	5%
Services for key populations	2 068 300	-	1%	0%
Condoms	-	108 609	0%	0%
VMMC	21 984 705	29 800 035	6%	8%
PrEP	-	1 457 009	0%	0%
PMTCT	20 612 240	2 245 141	6%	1%
SBCC	-	8 434 030	0%	2%
Program activities for vul & acces pop	4 005 570	-	1%	0%
STI prevention & treatment	298 367	223 522	0%	0%
HTC for KPs	-	1 110 766	0%	0%
HTC for pregnant women (PMTCT)	3 974 476	2 830 806	1%	1%
EID	77 690	164 308	0%	0%
HTC for vulnerable & accessible pops	660 569	1 621 032	0%	0%
HTC for general pops	2 258 194	24 817 916	1%	7%
PITC	4 578 274	4 535 488	1%	1%
HIV screening in blood banks	67 479	330 759	0%	0%
HTC not disagg.	17 851 347	2 516 011	5%	1%
ART	31 547 216	108 808 070	9%	29%
Specific ART-related lab monitoring	24 300 383	24 853 322	7%	7%
Co-infections & OI treatment & prevention	1 456 022	-	0%	0%
Psychological support	-	102 544	0%	0%
C&T not disagg.	103 741 001	13 589 358	30%	4%
Social protection and economic support for OVC	12 684 178	8 094 548	4%	2%
HIV-specific income generation projects	-	2 504 961	0%	1%
Social protection activities not disagg.	-	378 088	0%	0%
Social protection activities n.e.c	-	685 609	0%	0%
Human Right programmes	-	227 349	0%	0%
Programme admin & mgmt (ASD level)	59 227 407	80 810 657	17%	22%
Strategic information	14 861 236	13 161 038	4%	4%
Procurement and supply chain	-	7 451 419	0%	2%
Laboratory system strengthening	-	5 953 892	0%	2%
Financial and accounting systems strengthening	-	295 895	0%	0%
Capacity building for health workers	-	5 515 314	0%	1%
Programme enablers and systems strengthening not disagg	22 880 347	20 019	7%	0%
Total	349 135 001	370 190 650	100%	100%

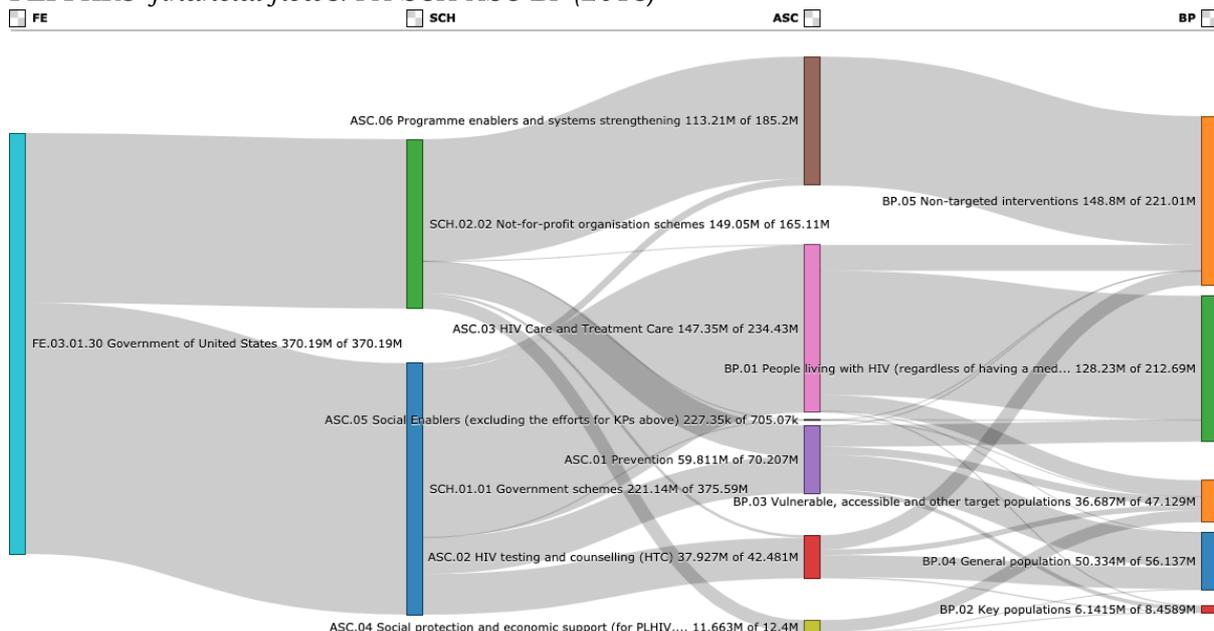
PEPFAR spending by production factors (US\$, %, 2017-2018)

Production factor (US\$)	2017	2018	2017 %	2018 %
Current direct and indirect expenditures	319 871 637	361 086 017	92%	98%
Personnel costs	114 068 863	106 173 381	33%	29%
Operational / management current exp	51 993 127	124 718 923	15%	34%
Medical products and supplies (ARVs, labs, condoms, etc)	88 303 660	70 927 254	25%	19%
Financial support for beneficiaries	-	973 281	0%	0%
Training related per diems/transport/other costs	20 606 794	10 105 242	6%	3%
Current direct & indirect expenditures not disagg.	44 899 193	48 187 936	13%	13%
Capital expenditures	29 263 364	9 104 634	8%	2%
Building	13 447 416	6 445 354	4%	2%
Vehicles	7 823 803	-	2%	0%
Other capital investment:	7 992 144	2 659 280	2%	1%
Total	349 135 001	370 190 651	100%	100%

PEPFARs' programme areas by production factors (US\$, 2018)

PEPFAR Production factor (2018)	Prevention	HIV Testing & Counselling	Care & Treatment	Social Protection	Social Enablers	Programme Enablers	Total
Current direct and indirect expenditures	59 019 099	37 587 553	144 900 497	11 595 081	225 551	107 758 236	361 086 017
Personnel costs	23 654 254	12 490 248	34 331 245	2 931 448	122 328	32 643 858	106 173 381
Operational / management current exp	26 828 832	13 544 169	53 811 351	7 637 405	67 897	22 829 269	124 718 923
Medical products and supplies (ARVs, labs, condoms)	4 765 452	9 377 646	50 128 438	323 070	15 666	6 316 982	70 927 254
Financial support for beneficiaries	84 947	-	-	76 755	-	811 579	973 281
Training related per diems/transport/other costs	2 243 037	1 108 711	3 859 252	393 150	6 442	2 494 650	10 105 242
Current direct & indirect expenditures n.e.c.	1 442 577	1 066 779	2 770 211	233 253	13 218	42 661 898	48 187 936
Capital expenditures	792 382	339 534	2 452 797	68 125	1 798	5 449 998	9 104 634
Building	240 019	211 475	1 451 136	-	-	4 542 724	6 445 354
Other capital investment:	552 363	128 059	1 001 661	68 125	1 798	907 274	2 659 280
Total	59 811 481	37 927 087	147 353 294	11 663 206	227 349	113 208 234	370 190 651

PEPFARs' financial flows: FA-SCH-ASC-BP (2018)



Global Fund spending by programme area (US\$, 2017-2018)

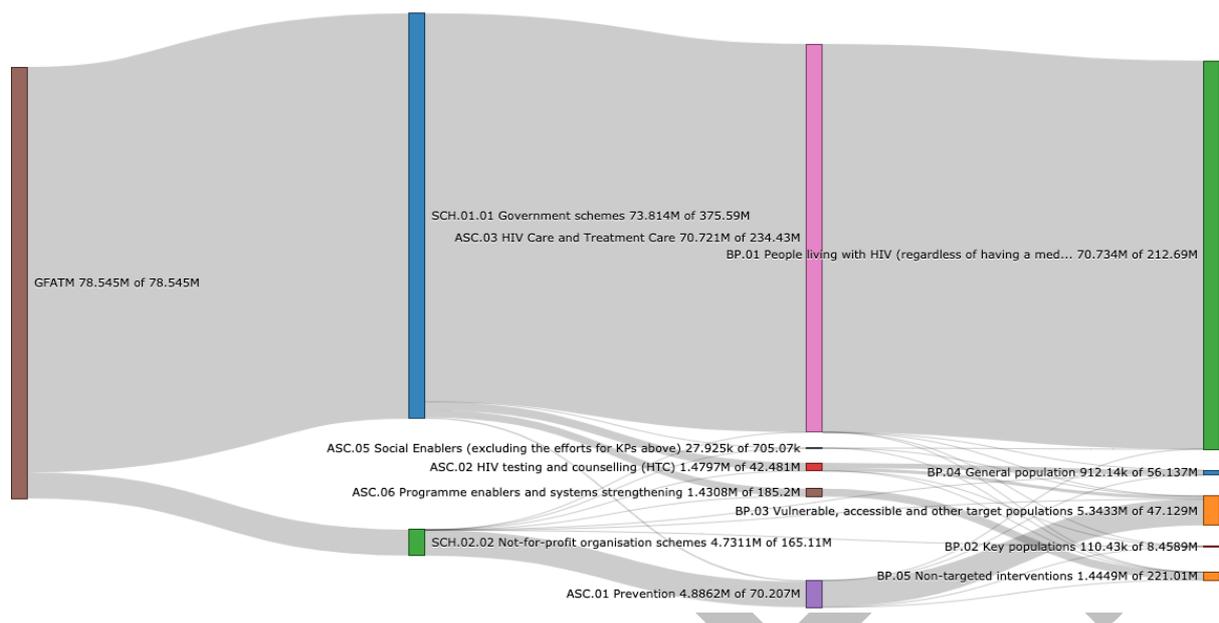
Global Fund by Programme Area (US\$)	2017	2018
5 pillars of prevention	283 474	4 728 450
Other prevn	1 334 462	157 752
HTC	1 527 755	1 479 696
C&T	73 325 611	70 720 542
S.Protect & Econ.Supp		
Social enablers	39 537	27 925
Prog.enablers & system strengthn	5 982 549	1 430 836
Total	82 493 387	78 545 201

Global Fund spending by activity (US\$, 2017-2018)

Global Fund HIV activities (US\$)	2017	2018	2017 %	2018 %
Prevention for AGYW	-	4 618 022	0%	6%
Prevention for key pops.	283 474	110 428	0%	0%
PMTCT	-	131 944	0%	0%
SBC	380 511	-	0%	0%
Community mobzn.	131 934	-	0%	0%
Prevention for children and youth	787 567	-	1%	0%
STI prevention and treatment	34 450	25 808	0%	0%
HTC for pregnant women (PMTCT)	184 381	460 528	0%	1%
EID	3 604	26 730	0%	0%
HTC for vulnerable and accessible populations	30 645	76 163	0%	0%
HTC for general population	1 093 602	174 291	1%	0%
PITC	212 392	737 853	0%	1%
HIV screening in blood banks	3 130	4 132	0%	0%
ART for adults	70 119 761	68 474 707	85%	87%
ART for paediatrics	2 405 242	2 211 904	3%	3%
Adherence and retention on ART	139 625	-	0%	0%
TB prevention, case finding, screening, diagnosis, tr	660 982	-	1%	0%
C&T not disagg.	-	33 931	0%	0%
Human rights programmes	-	27 925	0%	0%
Social enablers not disagg.	39 537	-	0%	0%
Programme admin. & mgmt (ASD level)	5 024 102	722 061	6%	1%
M&E	780 713	-	1%	0%
Management information systems	-	629 378	0%	1%
Procurement and supply chain	-	73 570	0%	0%
Institutional & organisational development	177 734	-	0%	0%
Public system strengthening not disagg.	-	5 827	0%	0%
Total	82 493 387	78 545 201	100%	100%

Global Fund's financial flows: FE-SCH-ASC-BP (2018)

FE Name SCH ASC BP



Global Fund spending by production factor (US\$, 2018)

Global Fund Production factor (US\$)	2017	2018	2017 %	2018 %
Current direct and indirect expenditures	78 625 132	78 514 301	95%	100%
Personnel costs	4 925 934	1 041 320	6%	1%
Operational / management current exp	222 694	202 797	0%	0%
Medical products and supplies (ARVs, labs, condoms, etc)	73 230 301	72 289 570	89%	92%
Training related per diems/transport/other costs	206 666	196 932	0%	0%
Logistics of events	39 537	38 665	0%	0%
Current direct & indirect exp. not disagg.	3 849 611	4 745 017	5%	6%
Capital expenditures	18 644	30 901	0%	0%
Building	-	10 387	0%	0%
Other capital investments	18 644	20 513	0%	0%
Total	82 493 387	78 545 201	100%	100%

Global Fund activities by production factor (US\$, 2018)

Production factor (2018)	Prevention (mostly AGYW)	HIV Testing & Counselling	Care & Treatment	Social Enablers	Programme Enablers	Total
Current direct and indirect expenditures	4 886 202	1 479 696	70 720 542	27 925	1 399 935	78 514 301
Personnel costs	-	-	-	-	1 041 320	1 041 320
Operational / management current exp	62 062	-	-	-	140 735	202 797
Medical products and supplies (ARVs, labs, condoms, etc)	206 118	1 362 005	70 720 542	-	904	72 289 570
Training related per diems/transport/other costs	-	117 691	-	-	79 241	196 932
Logistics of events	-	-	-	14 016	24 648	38 665
Current direct & indirect exp. not disagg.	4 618 022	-	-	13 908	113 087	4 745 017
Capital expenditures	-	-	-	-	30 901	30 901
Building	-	-	-	-	10 387	10 387
Other capital investments	-	-	-	-	20 513	20 513
Total	4 886 202	1 479 696	70 720 542	27 925	1 430 836	78 545 201

Global Fund spending by service provider type (US\$, %, 2017-2018)

GF Service providers(US\$)	2017	2018	2017 %	2018 %
Public sector providers	74 744 368	73 813 293	94%	94%
Non-profit organisations	7 747 555	4 731 109	6%	6%
Profit-making private providers	1 464	799	0%	0%
Total	82 493 387	78 545 201	100%	100%

Global Fund spending by PR and their activities (US\$, 2017)

Row Labels	FDC	MISAU	Grand Total
*ASC.01 Prevention	1 451 552	166 384	1 617 935
*ASC.01.01 Five Pillars of Prevention	283 474		283 474
ASC.01.01.02 Services for key populations	283 474		283 474
*ASC.01.02 Other Prevention activities	1 168 078	166 384	1 334 462
ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations	380 511		380 511
ASC.01.02.03 Community mobilization for populations other than key populations		131 934	131 934
ASC.01.02.05 Prevention for children and youth (excluding for AGYW in countries with high HIV prevalence)	787 567		787 567
ASC.01.02.10 STI prevention and treatment programmes for populations other than key populations - only if funded from earmarked HIV budgets		34 450	34 450
*ASC.02 HIV testing and counselling (HTC)	988 842	538 914	1 527 755
ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)		184 381	184 381
*ASC.02.07 Early infant (and paediatric??) diagnosis (EID) of HIV		3 604	3 604
ASC.02.08 HIV testing and counselling for vulnerable and accessible populations		30 645	30 645
*ASC.02.09 Voluntary HIV testing and counselling for general population	988 842	104 761	1 093 602
*ASC.02.10 Provider initiated testing and counselling (PITC)		212 392	212 392
*ASC.02.11 HIV screening in blood banks		3 130	3 130
*ASC.03 HIV Care and Treatment Care	800 607	72 525 003	73 325 611
*ASC.03.01 Anti-retroviral therapy		72 525 003	72 525 003
ASC.03.01.01 ART for adults		70 119 761	70 119 761
ASC.03.01.02 ART for paediatrics		2 405 242	2 405 242
ASC.03.02 Adherence and retention on ART - support (including nutrition and transport) and monitoring	139 625		139 625
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	660 982		660 982
ASC.03.04.01 TB prevention, case finding, screening, diagnosis, treatment and adherence for PLHIV and KPs	660 982		660 982
*ASC.05 Social Enablers (excluding the efforts for KPs above)		39 537	39 537
*ASC.05.98 Social enablers not disaggregated by type		39 537	39 537
*ASC.06 Programme enablers and systems strengthening	4 506 554	1 475 995	5 982 549
ASC.06.03 Programme administration and management costs (above service-delivery level)	4 328 820	695 282	5 024 102
*ASC.06.04 Strategic information		780 713	780 713
ASC.06.04.01 Monitoring and evaluation		780 713	780 713
*ASC.06.05 Public Systems Strengthening	177 734		177 734
ASC.06.05.03 Institutional & organisational development (health, social, educational etc)	177 734		177 734
Grand Total	7 747 555	74 745 832	82 493 387

Global Fund spending by PR and their activities (US\$, 2018)

Row Labels	Conselho Nacional de	FDC	MISAU	Grand Total
ASC.01 Prevention		6 069 574	434 564	6 504 138
ASC.01.01 Five Pillars of Prevention		4 901 496	110 428	5 011 924
ASC.01.01.01 Prevention for adolescent girls and young women (AGYW) and their male partners in settings with high HIV prevalence		4 618 022		4 618 022
ASC.01.01.02 Services for key populations		283 474	110 428	393 902
ASC.01.02 Other Prevention activities		1 168 078	324 136	1 492 214
ASC.01.02.01 Prevention of vertical transmission of HIV infection (PMTCT)			131 944	131 944
ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations		380 511		380 511
ASC.01.02.03 Community mobilization for populations other than key populations			131 934	131 934
ASC.01.02.05 Prevention for children and youth (excluding for AGYW in countries with high HIV prevalence)		787 567		787 567
ASC.01.02.10 STI prevention and treatment programmes for populations other than key populations - only if funded from earmarked HIV budgets			60 258	60 258
ASC.02 HIV testing and counselling (HTC)		988 842	2 018 609	3 007 451
ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)			644 909	644 909
ASC.02.07 Early infant (and paediatric?) diagnosis (EID) of HIV			30 334	30 334
ASC.02.08 HIV testing and counselling for vulnerable and accessible populations			106 807	106 807
ASC.02.09 Voluntary HIV testing and counselling for general population		988 842	279 051	1 267 893
ASC.02.10 Provider initiated testing and counselling (PITC)			950 245	950 245
ASC.02.11 HIV screening in blood banks			7 262	7 262
ASC.03 HIV Care and Treatment Care		800 607	143 245 546	144 046 153
ASC.03.01 Anti-retroviral therapy			143 211 615	143 211 615
ASC.03.01.01 ART for adults			138 594 469	138 594 469
ASC.03.01.02 ART for paediatrics			4 617 146	4 617 146
ASC.03.02 Adherence and retention on ART - support (including nutrition and transport) and monitoring		139 625		139 625
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs		660 982		660 982
ASC.03.04.01 TB prevention, case finding, screening, diagnosis, treatment and adherence for PLHIV and KPs		660 982		660 982
ASC.03.98 Care and treatment services not disaggregated			33 931	33 931
ASC.05 Social Enablers (excluding the efforts for KPs above)	13 908		53 553	67 461
ASC.05.02 Human rights programmes	13 908		14 016	27 925
ASC.05.02.06 Capacity building in human rights			14 016	14 016
ASC.05.02.98 Human rights programmes not disaggregated by type	13 908			13 908
ASC.05.98 Social enablers not disaggregated by type			39 537	39 537
ASC.06 Programme enablers and systems strengthening		4 619 641	2 793 744	7 413 385
ASC.06.03 Programme administration and management costs (above service-delivery level)		4 441 907	1 304 256	5 746 163
ASC.06.04 Strategic information			1 410 091	1 410 091
ASC.06.04.01 Monitoring and evaluation			780 713	780 713
ASC.06.04.04 Management information systems			629 378	629 378
ASC.06.05 Public Systems Strengthenin		177 734	79 397	257 131
ASC.06.05.01 Procurement and supply chain			73 570	73 570
ASC.06.05.03 Institutional & organisational development (health, social, educational etc)		177 734		177 734
ASC.06.05.98 Public system strengthening not disaggregated			5 827	5 827
Grand Total	13 908	12 478 664	148 546 016	161 038 588

Appendix 4: PEPFAR 2017 EA Program Area cross-walk to NASA ASC, SDM, BP

PEPFAR EA Program Area code	NASA ASC	NASA SDM	NASA BP
FBCTS	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
CBCTS	ASC.03.98 Care and treatment services not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.01.98 People living with HIV not broken down by age or gender
PMTCT	ASC.01.02.01.98 PMTCT not disaggregated by activity	SDM.98 Modalities not disaggregated	BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (undetermined HIV status) and new births
VMMC	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population
HTC	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.
OBP	ASC.03.04.98 Other OI prophylaxis and treatment not disaggregated by type (excluding TB and hepatitis)	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
LAB	ASC.03.03 Specific ART-related laboratory monitoring	SDM.01.99 Other facility-based n.e.c.	BP.01.98 People living with HIV not broken down by age or gender
OVC	ASC.04.01.98 OVC Services not disaggregated by activity	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
PP-PREV	ASC.01.02.04.98 Programmatic activities for vulnerable and accessible population not disaggregated by type	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PWID	ASC.01.01.02.04.98 Other programmatic activities for PWID not disaggregated by type	SDM.98 Modalities not disaggregated	BP.02.01.01 Adults (>18years) who inject drug users (PWID) and their sexual partners
SW	ASC.01.01.02.01.98 Programmatic activities for sex workers and their clients not disaggregated by type	SDM.98 Modalities not disaggregated	BP.02.02.01 Female sex workers and their clients
MSM	ASC.01.01.02.02.98 Programmatic activities for MSM not disaggregated by type	SDM.98 Modalities not disaggregated	BP.02.03 Gay men and other men who have sex with men (MSM)
MAT (for military only)	ASC.01.02.04.98 Programmatic activities for vulnerable and accessible population not disaggregated by type	SDM.98 Modalities not disaggregated	BP.03.21 Military

Appendix 5: PEPFAR 2017 EA cost category crosswalk to NASA PF

PEPFAR EA Cost component	NASA PF
In-Service Training	PF.01.08 Training- Training related per diems/transport/other costs
Construction & Renovation	PF.02.01.02 Construction and renovation
Vehicles	PF.02.02 Vehicles
Equipment & Furniture	PF.02.03.03 Non medical equipment and furniture
Other Investments	PF.02.03.98 Other capital investment not disaggregated
Personnel	PF.01.01.98 Personnel not disaggregated
Non-ARV Drugs & Reagents	PF.01.03.01.98 Pharmaceuticals not disaggregated
HIV Test Kits	PF.01.03.03.01 HIV tests screening/diagnostics
Condoms	PF.01.03.02.02 Condoms
Other Supplies	PF.01.03.04.98 Non-medical supplies not disaggregated
Food Supplements	PF.01.03.04.01 Food and nutrients
Building Rental & Utilities	PF.01.02.01 Office rental costs
Travel & Transport	PF.01.02.03 Travel expenditure
Other Recurrent Expenditures	PF.01.02.98 Other current costs not disaggregated
Labs (at site level)	PF.01.03.03.98 Reagents and materials not disaggregated

Appendix 6: PEPFAR 2018 ER Sub-program crosswalk to NASA ASC, SDM

ER Prog&Subpgm CONCAT	NASA ASC	Check BEN variables	SDM assumed
C&T HIV Clinical Services	ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT		SDM.01.01 Facility-based: Outpatient
C&T HIV Drugs	ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT		SDM.01.01 Facility-based: Outpatient
C&T HIV Laboratory Services	ASC.03.03 Specific ART-related laboratory monitoring		SDM.01.01 Facility-based: Outpatient
C&T Not Disaggregated	ASC.03.98 Care and treatment services not disaggregated		SDM.01.01 Facility-based: Outpatient
HTS Community-based testing	ASC.02.09 Voluntary HIV testing and counselling for general population	Unless for specific KP bens	SDM.02.98 Home and community based not disaggregated
HTS Facility-based testing	ASC.02.09 Voluntary HIV testing and counselling for general population	Unless for specific KP bens	SDM.01.01 Facility-based: Outpatient
HTS Not Disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated		SDM.98 Modalities not disaggregated
PREV Comm. mobilization, behavior change	ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations	Unless for specific KP bens	SDM.98 Modalities not disaggregated
PREV Condom & Lubricant Programs	ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	Unless for specific KP bens	SDM.98 Modalities not disaggregated
PREV Not Disaggregated	ASC.01.02.98 Prevention activities not disaggregated		SDM.98 Modalities not disaggregated
PREV PrEP	ASC.01.01.05.98 PrEP not disaggregated by key population	Unless for specific KP bens	SDM.98 Modalities not disaggregated
PREV VMMC	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated		SDM.98 Modalities not disaggregated
SE Case Management	ASC.04.99 Social protection activities n.e.c	Unless for OVC	SDM.98 Modalities not disaggregated
SE Economic strengthening	ASC.04.02.03 HIV-specific income generation projects		SDM.98 Modalities not disaggregated
SE Education assistance	ASC.04.01.01 OVC Basic needs (health, education, housing)	Unless for AGYW	SDM.98 Modalities not disaggregated
SE Legal, human rights & protection	ASC.05.02.02 HIV-related legal services		SDM.98 Modalities not disaggregated
SE Not Disaggregated	ASC.04.98 Social protection activities not disaggregated		SDM.98 Modalities not disaggregated
SE Psychosocial support	ASC.03.05 Psychological treatment and support service		SDM.98 Modalities not disaggregated
ASP HMIS, surveillance, & research	ASC.06.04.98 Strategic information not disaggregated by type		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Human resources for health	ASC.06.07.01 Capacity building for health workers, excluding those at community level		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Institutional prevention	ASC.02.11 HIV screening in blood banks		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Laboratory systems strengthening	ASC.06.05.02 Laboratory system strengthening		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Laws, regulations & policy environment	ASC.05.02.03 Monitoring and reforming laws, regulations and policies relating to HIV		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Not Disaggregated	ASC.06.98 Programme enablers and systems strengthening not disaggregated		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Policy, planning, coordination	ASC.06.03 Programme administration and management costs (above service-delivery level)		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Procurement & supply chain management	ASC.06.05.01 Procurement and supply chain		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Public financial management	ASC.06.05.04 Financial and accounting systems strengthening		SDM.03 Non applicable (ASC which does not have a specific SDM)
PM Program Management	ASC.06.03 Programme administration and management costs (above service-delivery level)		SDM.03 Non applicable (ASC which does not have a specific SDM)

Appendix 7: PEPFAR 2018 ER Beneficiary crosswalk to NASA BP

PEPFAR BenCONCAT	NASA BP	Check the PgArea
FM Not disaggregated	BP.04.01.02 Female adult population	UNLESS ASC treatment> BP.01.98 People living with HIV not broken
KP Not disaggregated	BP.02.98 "Key populations" not broken down by type	
NonT Adults	BP.04.01.98 General adult population (aged older than 24) not broken down by gender	UNLESS ASC treatment> BP.01.98 People living with HIV not broken down by age or gender
NonT Children	BP.04.02.98 Children (aged under 15) not broken down by gender	UNLESS ASC treatment> BP.01.98 People living with HIV not broken down by age or gender
NonT Not disaggregated	BP.05 Non-targeted interventions	UNLESS ASC treatment> BP.01.98 People living with HIV not broken down by age or gender
OVC Not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)	
PBFW Not disaggregated	BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their	
FM Young women & adolescent females	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence	
PRIPOP Military & other uniformed services	BP.03.21 Military	
PRIPOP Not disaggregated	BP.03.99 Other vulnerable, accessible and other target populations n.e.c.	
KP Men having sex with men	BP.02.03 Gay men and other men who have sex with men (MSM)	
NonT Young people & adolescents	BP.04.03.98 Youth (aged 15 to 24) not broken down by gender	
OVC Orphans & vulnerable children	BP.03.01 Orphans and vulnerable children (OVC)	
KP People who inject drugs	BP.02.01.01 Adults (>18years) who inject drug users (PWID) and their sexual partners	
KP Sex workers	BP.02.02.98 Sex workers, not broken down by gender, and their clients	
M Not disaggregated	BP.04.01.01 Male adult population	UNLESS ASC treatment> BP.01.98 People living with HIV not broken down by age or gender
M Young men & adolescent males	BP.04.03.01 Young men	UNLESS ASC treatment> BP.01.98 People living with HIV not broken down by age or gender
M Adult men	BP.04.01.01 Male adult population	UNLESS ASC treatment> BP.01.98 People living with HIV not broken down by age or gender
M Boys	BP.04.02.01 Boys	UNLESS ASC treatment> BP.01.98 People living with HIV not broken down by age or gender
All ASP systems strengthening activities	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)	

Appendix 8: PEPFAR 2018 ER Sub-object class crosswalk to NASA PF

PEPFAR ER Obj CONCAT	NASA PF	Check PGArea for HIVdrugs
Supplies Other supplies	PF.01.03.04.98 Non-medical supplies not disaggregated	
Training Training	PF.01.08 Training- Training related per diems/transport/other costs	
Contractual Other contracts	PF.01.02.99 Other current costs n.e.c.	
Fringe Benefits Fringe Benefits	PF.01.01.01.02 Fringe Benefits - Direct service providers	Unless Above service-delivery > PF.01.01.02.99 Program management
Personnel Salaries- other staff	PF.01.01.01.01 Labor costs - Direct service providers	
Subrecipient Subrecipient	PF.01.02.98 Other current costs not disaggregated	
Travel Domestic travel	PF.01.02.03 Travel expenditure	
Travel International travel	PF.01.02.03 Travel expenditure	
Construction Construction	PF.02.01.02 Construction and renovation	
Equipment Non-health equipment	PF.02.03.03 Non medical equipment and furniture	
Other Other	PF.01.99 Current direct and indirect expenditures n.e.c.	
Contractual Contracted interventions	PF.01.99 Current direct and indirect expenditures n.e.c.	
Supplies Health- non pharmaceutical	PF.01.03.02.98 Medical supplies not disaggregated	
Personnel Salaries- health care workers	PF.01.01.01.01 Labor costs - Direct service providers	
Equipment Health equipment	PF.02.03.02 Laboratory and other medical equipment	
Supplies Pharmaceutical	PF.01.03.01.98 Pharmaceuticals not disaggregated	UNLESS HIVdrugs > PF.01.03.01.01 Antiretrovirals
Other Financial Support for beneficiaries	PF.01.07 Financial support for beneficiaries	
Contractual Contracted health care workers	PF.01.01.01.01 Labor costs - Direct service providers	
Indirect charges Indirect charges	PF.01.99 Current direct and indirect expenditures n.e.c.	

Appendix 9: Permission letter for NASA process



REPÚBLICA DE MOÇAMBIQUE
CONSELHO NACIONAL DE COMBATE AO SIDA
SECRETARIADO EXECUTIVO

Exmo Senhor,
Zacarias Zindoga - Secretário Permanente
do Ministério da Saúde

Maputo

N/Ref. 47 /CNCS-GSE/19

Maputo, 7 de Outubro de 2019

Assunto: **Medição de Gastos em SIDA 2017 – 2018 (MEGAS)**

Exmo Senhor,

O CNCS, com apoio da ONUSIDA, implementa de três em três anos, um exercício voltado à medição dos gastos para a resposta ao HIV e SIDA em Moçambique. Trata-se de um levantamento que é desencadeado em alguns sectores, de forma amostral, para se aferir o volume de recursos que são investidos no país na resposta ao SIDA, as áreas onde esses recursos são usados, bem como as organizações que financiam a resposta no país.

Um dos principais objectivos deste exercício é determinar até que ponto os recursos existentes são gastos nas áreas prioritárias definidas no Plano Estratégico Nacional de Resposta ao HIV e SIDA e se não, que advocacia e negociação deverão ser feitas junto de diferentes parceiros para melhor alocação.

Por forma a permitir um levantamento que ofereça matéria substancial para subsidiar a análise e tratamento de dados, está prevista uma visita às organizações para a recolha de dados sobre as despesas, a partir de uma ficha padrão e entrevistas.

Assim, gostaríamos de aproveitar o ensejo para solicitar a V. Excia uma maior colaboração durante o processo de recolha de dados. Será enviado em breve, por correio electrónico, o formulário de recolha de dados contendo também uma nota explicativa sobre os objectivos do exercício, os dados necessários, bem como os resultados esperados.

Ciente da melhor colaboração que V. Excia emprestará a este exercício, subscrevemo-nos com a mais elevada consideração.

Atenciosamente,

Francisco Mbofana
Secretário Executivo do CNCS



Missão: Coordenar, facilitar, monitorar e avaliar a Resposta Multisectorial de Combate ao HIV e SIDA

Appendix 10: Credential letter for NASA team



REPÚBLICA DE MOÇAMBIQUE
CONSELHO NACIONAL DE COMBATE AO HIV/SIDA
SECRETARIADO EXECUTIVO

CREDECIAL

O Secretariado Executivo do Conselho Nacional de Combate ao HIV e SIDA (SE-CNCS), com o apoio da ONUSIDA vem implementado de três em três anos, um exercício voltado à medição dos gastos para a resposta ao HIV e SIDA em Moçambique. Trata-se de um levantamento que é desencadeado em alguns sectores, de forma amostral, para se aferir o volume de recursos investidos, as áreas onde esses recursos são usados bem como as organizações que financiam a resposta no país.

Nesse âmbito, está devidamente credenciado o Senhor **JOAQUIM RAMALHO DURÃO**, consultor, a realizar os trabalhos de recolha de informação no âmbito da implementação da medição de gastos em SIDA (MEGAS 2017-2018), junto das entidades e/ou pessoas que se julgarem relevantes neste processo. Agradecemos, toda e qualquer ajuda para o sucesso desta missão.

Por ser verdade, vai o presente documento, assinado por mim, Coordenador da Unidade de Administração do SE-CNCS e chancelada com carimbo em uso nesta instituição.

Maputo, Outubro de 2019

Atenciosamente,

Amário João Bicuane
Coordenador da Unidade de Administração CNCS

Missão: Coordenar, facilitar, monitorar e avaliar a Resposta Multisectorial de Combate ao HIV e SIDA

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