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NATIONAL AIDS SPENDING ASSESSMENT (NASA) FOR THE PERIOD 2014 IN MOZAMBIQUE

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Technical Note

National Aids Spending Assessment (NASA) for the period 2014 in Mozambique

Conselho Nacional de Combate ao HIV/SIDA (CNCS), September 2016.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral
ASC	AIDS Spending Category
BB	Blood Bank
BP	Beneficiary Population
CBO	Community Based Organizations
CCM	Country Coordinating Mechanism
CDC	Centre for Disease Control
CFM	Caminhos de Ferro de Moçambique
CNCS	National AIDS Council
CSO	Civil Society Organizations
HTC	HIV Testing and Counseling
CTCH	Counseling and Testing in Community Health
CTHIV	Counseling and Testing in Health Initiated by the User
CTIP	Counseling and Testing Initiated by the Provider
DoD	Department of Defense
EMTCT	Elimination of Mother-to-Child Transmission
FDC	Foundation for Community Development
FA	Financing Agent
FS	Financing Source
GoM	Government of Mozambique
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HRG	High Risk Group
HIV	Human Immunodeficiency Virus
HIV+	Human Immunodeficiency Virus Positive (HIV positive)
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
NASA	National AIDS Spending Assessment
MSM	Men who have Sex with Men
MINEC	Ministry of Education and Culture
MISAU	Ministry of Health
MJD	Ministry of Youth and Sports
NDT	Not Disaggregated per Type

Abbreviations

NGO	Non-Governmental Organization
NHA	National Health Accounts
OVC	Orphan and Vulnerable Children
PAN	Provincial AIDS Nucleus
PEN	National Strategic Plan to fight HIV and AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PEPFAR EA	President's Emergency Plan for AIDS Relief Expenditure Analysis
PF	Production Factors
PID	People Injecting Drugs
PLWH	People Living with HIV
PMTCT	Prevention for Mother-to-Child Transmission
PST	Prevention of Sexual Transmission
RCS	Reinforcement of the Community System
RHS	Reinforcement of the Health System
RO	Religious Organizations
RTT	Resource Tracking Tool
SB	State Budget
ST	Service Provider
STI	Sexually Transmitted Infections
SW	Sex Workers
ART	Anti-Retroviral Therapy (ART)
TB	Tuberculosis
UIT	User Initiated Testing
UN	United Nations Organization
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activity
UNICEF	UNICEF UN Children's Fund
USAID	USAID United States Agency for International Development
USA	United States of America
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
IOM	International Organization for Migration

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Summary of Expenditures on HIV in Mozambique 2014

	2010		2014		Variation 2010-2014	
	US$ million	%	US$ million	%	US$ million	%
Expenditure in HIV and AIDS						
Total expenditure	213,5	100%	332,5	100%	119,0	56%
Total expenditure per capita >15 years (US$)	21,8		25,2			
Total expenditure per person living with HIV (US$)	195,4		225,2			
Expenditure in prevention per capita >15 years (US$)	5,2		6,7			
Expenditure in treatment per person in treatment (US$)	450,1		180,2			
Total expenditure in HIV in percentage of GDP (%)	2,3		2,1			
Expenditure in HIV and AIDS per province						
North Region	45,2	21,2%	46,6	14,0%	1,4	3%
Cabo Delgado	9,7	4,5%	12,2	3,7%	2,5	26%
Niassa	12,0	5,6%	8,2	2,5%	-3,8	-31%
Nampula	23,5	11,0%	26,2	7,9%	2,7	11%
Center Region	63,3	29,6%	111,3	33,5%	48,1	76%
Tete	10,0	4,7%	19,6	5,9%	9,6	96%
Zambezia	24,3	11,4%	44,1	13,3%	19,9	82%
Manica	12,4	5,8%	17,9	5,4%	5,5	45%
Sofala	16,6	7,8%	29,7	8,9%	13,0	78%
South Region	82,8	38,8%	106,7	32,1%	24,0	29%
Inhambane	13,1	6,1%	13,0	3,9%	-0,1	-1%
Gaza	22,1	10,4%	34,0	10,2%	11,9	54%
Maputo City	29,4	13,8%	32,0	9,6%	2,6	9%
Maputo Province	18,2	8,5%	27,8	8,4%	9,6	53%
Expenditure at national level	13,9	6,5%	67,7	20,4%	53,8	387%
Not disaggregated	8,4	3,9%	0,1	0,0%	-8,2	-98%

[1] Conselho Nacional de Combate ao HIV/SIDA

	2010		2014		Variation 2010-2014	
	US$ million	%	US$ million	%	US$ million	%
HIV expenditure by financing source:	213,5	100%	332,5	100%	119,0	56%
Domestic public	10,1	4,7%	16,2	4,9%	6,1	60%
Domestic private	0,2	0,1%	2,2	0,7%	2,0	853%
International		95,1%	314,1	94,5%	111,0	55%
HIV expenditure by financing agent:	213,5	100%	332,5	100%	119,0	56%
Public sector	49,1	23%	97,9	25%	48,8	99%
Private sector	5,6	3%	14,5	2%	8,9	160%
International purchasing organization	158,8	74%	220,1	74%	61,3	39%
HIV expenditure by service provider:	213,5	100%	332,5	100%	119,0	56%
Public sector providers	127,1	60%	173,8	52%	46,7	37%
Private sector providers - national	38,8	18%	40,0	12%	1,3	3%
Private sector providers - international	40,2	19%	111,7	34%	71,6	178%
Bilateral and multilateral entities	7,0	3%	6,9	2%	-0,1	-1%
HIV expenditure by programmatic area:	213,5	100%	332,5	100%	119,0	56%
PREVENTION (28% of total expenditure)	**59,8**	**100%**	**88,8**	**100%**	**29,0**	**49%**
Prevention of Mother to Child Transmission (PMTCT)	21,7	36%	22,1	25%	0,4	2%
HIV Testing and Counselling (HTC)	11,3	19%	9,7	11%	-1,7	-15%
Voluntary Medical Male Circumcision	1,6	3%	17,6	20%	15,9	979%
Other prevention expenditure, non-biomedical	22,8	38%	31,0	34%	8,2	36%
Other prevention expenditure, biomedical	2,3	4%	8,5	10%	6,2	272%
CARE AND TREATMENT (43% of total expenditure)	**98,6**	**100%**	**116,5**	**100%**	**17,9**	**18%**
Antiretroviral Therapy (ART)	60,4	61%	77,3	66%	16,9	28%
Other expenditure for Care and Treatment	38,2	39%	39,1	34%	0,9	2%
OTHER HIV EXPENDITURE (29% of total expenditure)	**45,5**	**46%**	**127,2**	**109%**	**81,8**	**180%**
National coordination and system strengthening	25,3	26%	91,9	79%	66,5	263%
Incentives/training of human resources	12,8	13%	19,6	17%	6,8	54%
Enabling environment	6,9	7%	8,5	7%	1,5	22%
Others	0,4	0%	0,2	0%	-0,2	-49%
HIV expenditure by beneficiary population:	213,5	100%	332,5	100%	119,0	56%
People living with HIV	99,1	46,4%	115,9	34,8%	16,8	17,0%
General population	28,7	13,4%	52,3	15,7%	23,6	82,3%
Most-at-risk populations	1,4	0,6%	3,5	1,0%	2,1	151,7%
Vulnerable and accessible population	53,3	25,0%	60,9	18,3%	7,6	14,3%
Not-targeted interventions	31,0	14,5%	99,8	30,0%	68,8	222,1%
HIV expenditure by production factors:	213,5	100%	332,5	100%	119,0	56%
Current expenditure	187,2	87,7%	289,5	87,1%	102,3	54,7%
Capital expenditure	11,8	5,5%	21,8	6,6%	10,0	85,3%
Not broken down by type	14,6	6,8%	21,2	6,4%	6,7	45,7%

Executive Summary

The measurement of spending on HIV and AIDS in Mozambique indicates that, in 2014, it reached a record $332.5 million, representing a 56% increase over the amount for 2010 ($213.5 million) and corresponding to 2.1% of the country's GDP. The expenses recorded in 2014 represented an expense of $25.2 per adult (> 15 years old).

In Mozambique, the response to HIV and AIDS in 2014 continued to be mainly supported by foreign aid. Indeed, international funding sources accounted for 94.5% of total expenditures in similar proportion recorded in 2010 and 2011. The domestic public resources were 4.9% ($16.2 million) while domestic private resources comprised about 0.7% ($2.2 million) in 2014. The increase in spending in the national response to HIV and AIDS in the last four years was mainly due to increased support by the United States Government and the Global Fund. Funding from other multilateral organizations declined by 7% since 2010.

Thus, in 2014, the contribution of the Government of the United States, totaling $247.0 million, represented 74.3% of total calculated expenses; and the Global Fund to Fight HIV, Tuberculosis and Malaria (GFATM)—the second most important contribution—reached $30.9 million, representing 9.3% of the total. Other international contributions came from other international funds, which include other bilateral funding (governments), totaling $15.5 million (4.7%), other multilateral organizations, with $11.1 million (3.3%) and nongovernmental international and philanthropic government, with $9.7 (2.9%).

Financial agents and service providers are also key actors in the national response to HIV. The agents decide which services to provide; the providers supply the services. Data for the period under review shows that international procurement organizations play an important role in deciding the programmatic allocation of resources; and they account for 66% of spending. On the other hand, the provision of services is made mainly by national entities, with the public entities representing 52% of the total spending and domestic private entities, 12%.

The analysis of expenses per AIDS spending category shows that the main priority in 2014 was care and treatment ($116.5 million), followed by strengthening of systems and program coordination ($91.9 million), prevention ($88.8 million), and others ($35.4 million). These areas accounted for 35%, 38%, 27% and 11%, respectively, of total spending on AIDS in 2014.

Compared to 2010, spending on care and treatment increased by 18% and spending on prevention programs grew 49% from 2010 to 2014. The greatest progress was recorded in spending on the strengthening of systems and coordination of programs, which quadrupled in that period (i.e., over $66.5 million). However, there has been a reduction in spending on mitigation programs, both in absolute terms and relative to total spending on AIDS per year. Spending to support orphans and vulnerable children decreased by 36% between 2010 and 2014, descending to $6.2 million in 2014, i.e., only 2% of all spending on HIV and AIDS (against 50% in 2010).

The progression of spending on prevention was mainly due to expansion of the male circumcision program, funded by the US government, which started in 2010 with $1.6 million and reached $17.4 million in 2014 (i.e., 20% of spending prevention). Spending on other non-biomedical prevention programs also increased at the rate of 36% in the same period, reaching $31 million (or 35% of spending on prevention) in 2014. While spending on prevention of MTCT remained at $22.1 million (or 25% of spending on prevention), spending on counseling and testing decreased by 15% between 2010 and 2014, accounting for 12% of spending on prevention in 2014.

The spending for the prevention of sexual transmission accounted for 15% of spending on HIV and AIDS. In addition to the male circumcision program, spending for prevention of sexual transmission included information, education and communication for behavior change ($9.3 million), social marketing and distribution of condoms ($8.6 million) and community mobilization ($6.1 million). Spending on prevention programs for high risk populations totaled $3.4 million and, for young people in or out of school, $1.7 million, or 7% and 2%, respectively, of the spending on prevention of sexual transmission.

Spending on prevention of sexual transmission per adult (inhabitants over 15 years) was $3.8 at national level, $1.6 in the north, $3.8 in the center, and $6.3 in the south. In comparison, the national strategic plan to fight AIDS for 2015-2019 (PEN IV) estimates that it will be $6.5 per adult for the prevention of sexual transmission.

Available data suggests a better alignment in the allocation of spending for prevention by region and in the regional distribution of new infections in 2014 compared to 2010. Expenditure for prevention of sexual transmission increased significantly in the central and southern regions, from $4 million and $9 million in 2010 to $22 million in each region in 2014. In contrast, spending for the northern region fell from $8 million in 2010 to $6 million in 2014. Thus, the central and southern regions absorbed respectively 43% and 44% of spending for the prevention of vertical transmission and recorded 40% and 41% of new infections in the population of 15-49 age group.

Despite this improvement in the regional distribution of expenditures, the provincial distribution of spending on prevention of sexual transmission has sharp variations and can improve. In 2014, the provinces of Zambezia, Cabo Delgado, Inhambane and Manica registered respectively 19%, 8%, 7% and 8% of new infections in the population above 15 years of age, but received only 15%, 3%, 4 % and 6% of spending on prevention of sexual transmission. On the other hand, Sofala, Tete and Gaza Provinces that have 10%, 4% and 13% of new infections consumed 14%, 8% and 16% of spending on prevention of sexual transmission. This general conclusion does not change when adjusting this analysis to population size or incidence rate.

Overall, expenditures were made in program areas that have proven to have a greater impact on reducing sexual transmission (e.g., male circumcision, treatment, prevention in high-risk populations). However, the distribution of these expenditures for population benefit and region could have a major impact on controlling the epidemic. For example, it appears that 52% of spending allocated to male circumcision benefited small boys less than 15 years old. If these expenses represent valuable investments in the medium term, their short--term benefit for reducing sexual transmission is very limited.

Similarly, while spending on g high-risk populations increased significantly by 2014, only 12% of these expenditures were made in the northern region. With only $403,000 spent on high-risk populations (or 7% of spending on prevention of sexual transmission), spending in the north seems to be at variance with epidemiological and behavioral data indicating that commercial sex accounted for 20% of new infections through sexual transmission.

With regard to spending on prevention of vertical transmission, the study results reveal that, despite not having recorded an increase in the volume of spending between 2010 and 2014, efficiency improved due to better regional allocation of resources and economies of scale. Reduced spending on the north and south and increased spending in the center where 51% of HIV-positive pregnant women needing PMTCT programs reside. The center accounted for 48% of spending on PMTCT (against 36% in 2010). As a result, the northern region which has 17% of HIV-positive pregnant women saw the proportion of PMTCT resources reduced from 29% in 2010 to 21% in 2014. There were also gains from improved technical efficiency in PMTCT programs with savings from economies of scale and the consequent reduction in unit costs. Nationally, spending per woman in PMTCT decreased from $956 in 2010 to $233 in 2014, but with large variations between provinces, e.g., $93 in the city of Maputo and $355 in Niassa Province.

In 2014, international funds represented 97% of expenditure for care and treatment. Antiretroviral medicines and laboratory reagents are essential to ART and represent 62% of spending on care and treatment. These are fully financed by foreign aid. This reality calls for new attention to the excessive dependence on external financing of the national response to HIV and AIDS, especially since antiretroviral therapy cannot be stopped.

The 18% increase in funding for care and treatment noted above is reflected positively in the increasing number of people who get ART services, which more than doubled in 2010-2014. This difference in growth suggests gains in allocative (geographic and programmatic) and technical efficiency (doing more with less) in providing services. As with spending on prevention, the expenditures by region for care and treatment show a better allocation of resources for geographical needs, considering the number of people living with HIV. This

improvement resulted from the increase of spending on treatment in the central region that grew 46% in four years to reach US 46.5 million in 2014. Thus, the region received 40% of the expenditures on care and treatment, against 44% in the south and 16% in the north.

The breakdown of spending on inputs for care and treatment show that the consumption of ARVs and reagents more than doubled between 2010 and 2014, reflecting the increase of ART beneficiaries. In contrast, other current costs for care and treatment decreased by $17.8 million, representing 34% of spending on care and treatment in 2014. These results suggest a better combination and use of factors of production that achieved economies of scale and gains in efficiency.

The results of the National AIDS Spending Assessment (NASA) for 2014 records, for the first time, higher expenditure levels on program areas other than prevention or treatment and care. These expenses amounted to $127 million and can be classified into two main program areas: coordination and strengthening of systems ($120.2 million) and social services ($7.1 million).

Most of the above mentioned expenses contributed to the strengthening of health and community systems ($47.8 million), which competed in the provision of prevention, care and treatment. After 2010, spending on these activities increased by 68%, mainly with funding from the US Government and implementation by international private entities. Other expenses were allocated to the development of strategic information ($24.2 million) and the coordination of the response ($15.4 million). In addition, there were expenses for program management and administration of funds amounting to $28.6 million in 2014, a figure that nearly tripled in 2011. Of this, most (88%) corresponds to the central program-management expenditures.

In general, the 2014 data show that the proportion of resources dedicated to social service activities tends to reduce over time, mainly due to the increased amount of resources assigned for care and treatment and the need to expand prevention activities. The expenses for social service activities have included support services for orphans and vulnerable children ($6.2 million) and mitigation services for people living with HIV ($0.9 million).

Comparing the major categories of NASA and the estimated costs for the PEN IV (2015-2019), it appears that the value of spending in 2014 is close to the estimated costs for 2015, but is less than the expanded costs projected by 2019. The 2015 estimates are only 6% higher than the costs recorded in 2014, while the 2019 estimates correspond to a 48% increase over the 2014 expenses.

A more detailed analysis of expenses and PEN IV costs indicates that the financial gap until 2019 is mainly due to expansion of ARV treatment, in particular the cost of ARVs, laboratory tests, and other costs required for the full sequence of treatment. The real financial gap will be even higher considering that the projections for PEN IV did not consider the new treatment protocol that intends to start ART early (CD4 / uL <500) and the strategy of progressively treating people living with HIV, regardless of their CD4 level. Another important finding is the discrepancy in the volume of spending on program support that is proportionally higher in 2014 than estimates for 2015.

Conclusions and Recommendations

Closing the financial gap will involve increasing the level of available resources and continuing to improve efficiency allocating resources (expenditure) by geographical area and by programs, which could have greater impact and target the populations most affected by HIV. In the response to HIV, the implementing partners should also gain in technical efficiencies through greater economies of scale or define ways to reduce unit costs without reducing the quality of services provided.

To reduce the heavy dependence on foreign aid and ensure the sustainability of HIV and AIDS programs in Mozambique, new financing mechanisms need to be defined, including increased contributions by the state budget.

To have the greatest impact on reducing incidence, it is necessary to maintain and expand interventions to reduce transmission of HIV, develop a better geographic distribution of spending on prevention of sexual and mother-to-child transmission, align spending with the provinces where most infections occur, and increase spending on prevention, especially targeting the most vulnerable people or those at risk of contracting HIV.

The level of spending on ART and PMTCT made at the level of community-service providers suggests an insufficient allocation for essential community-support activities to ensure the creation of demand for and retention in treatment services. The strengthening of community activities that can improve retention levels; and adherence to treatment is recommended.

The geographical allocation of spending on prevention and treatment was improved, though, additional efficiencies may be obtained through better economies of scale in programs for male circumcision, increased technical efficiency in training, or, reduced spending at central program-management.

The response to HIV and AIDS mobilizes significant funds to strengthen health and community systems. While these investments are essential to ensure the supply of goods and services, mobilization through other financing schemes to strengthen health systems could release specific resources for the growing need to buy ARVs and reagents.

Anyway, NASA has identified very low values for spending to create synergies between diverse HIV-related programs. Considering the HIV epidemic and the vulnerability of young girls in Mozambique, the assessment recommends increasing the allocation of resources to integrate the actions against HIV in programs for education, protection and social services, human rights, and gender.

1.1. Context

The Government of Mozambique has developed plans for prevention, treatment, care and support to reduce further transmission of HIV and respond to the growing demand for HIV services. Over the past years, the government invested substantial resources in providing such services and increasing the funding for prevention and care beyond that provided by other health programs.

To ensure a coordinated and properly resourced response, it is essential to monitor the resources and expenditures for HIV and AIDS in various sectors. In this context, Mozambique held various resource--tracking exercises for HIV to identify systematically the sources of funding and the cost of HIV and AIDS programs in each sector (prevention, care, support and treatment).

In 2005, a pilot study on AIDS Spending Assessment (NASA) was carried out within the monitoring and evaluation framework of the National AIDS Council (CNCS). After the study, the government agreed to carry out a complete NASA to identify exhaustively the actual cost of HIV and AIDS programs financed by public, international and private sources. In 2008, CNCS, strategic ministries, and multilateral and bilateral organizations, therefore, carried out a comprehensive NASA to identify the costs in 2004, 2005 and 2006 (CNCS 2008). New measurements of expenditures were made for 2007-2008 and 2010-2011 to continue regular monitoring of the costs of HIV and AIDS as planned to monitor the national response and better assess (in principle, biannually) the level of priority for each area according to expenditures. NASA 2010-2011 detailed the spending for each province (CNCS 2010 and CNCS 2014b).

This report refers to NASA for 2014, one year before PEN IV ended.

1.2. Objectives

The overall goal of NASA is to contribute to the strengthening of national evaluation of spending on the national response to HIV and AIDS in Mozambique in 2014. More specifically, the measurement objectives were to:

- Monitor the allocation of HIV and AIDS funds from origin to the last point of service for different financial sources (public, private or external), providers, beneficiaries (target groups) and inputs (production factors);
- Catalyze and facilitate actions to enhance the country's capabilities to identify effectively the expenditures related to HIV in 2014; and
- Synthesize the data into strategic information for decision-making and national strategic planning. Some key issues that are covered by the study of NASA are:

  What values are actually disbursed and used in each component of the multisectoral response to HIV and the priority interventions for HIV?

  Where do the funds to fight HIV and AIDS go to? Who are the main providers and recipients of services?

  What is the allocation of expenditures on AIDS in relation to the objectives and goals outlined in the National Strategic Plan (CNCS, 2015)?

1.3. Scope

The evaluation focused on the monitoring of national expenditure in response to HIV in 2014. Data collection covered domestic, external and private spending in response to HIV and AIDS, including funds channeled through the government. The assessment did not cover out-of-pocket expenditure related to HIV and AIDS. To disaggregate data at the provincial level, this measurement kept the methodology started in the last NASA for 2010 and 2011. To do so, required visits to some provinces to collect complementary data.

2.1. Approach

The Spending Assessment in HIV and AIDS (NASA) for monitoring resources is a comprehensive and systematic methodology used to determine the flow of resources for the fight against HIV and AIDS. That instrument monitors actual expenditures (public, private and international) and those in the health sector and in other sectors (social mitigation, education, labor and justice) that make up the National Response to HIV and AIDS.[2]

In addition to establishing a system of continuous financing of information on HIV financing, NASA promotes the development of standardized reporting of progress monitoring indicators to achieve the target of the Declaration of New York Policy of 2011.

NASA follows a monitoring-expenditure system that involves the systematic collection of data about the flow of funds from different sources for financial service providers through various transaction mechanisms. The transactions involve all elements of the cash flow, the transfer of resources from a financial source to a service provider, who uses the money to budget items to produce functions (or interventions) in response to HIV and AIDS for the benefit of specific groups or for non-specific populations (or the general population). NASA uses vertical descent techniques (top-down) and up (bottom-up) to get and consolidate information. The vertical top-down approach monitors the sources of funds from donor reports, commitment reports, state budgets whereas the bottom-up approach monitors costs from the records of the costs of service providers, records of level of units, and the records of expenses by governmental departments.

In cases where data is missing, techniques are used to estimate actual costs based on internationally accepted standards to estimate actual expenditures retrospectively from prior costs. Detailed costs of inputs are estimated indirectly from the basket of services provided and the number of outputs.

As part of this methodology, NASA employs tables and double-entry matrices to represent the origin and destination of resources, thus avoiding double counting of expenses through the reconstruction of resource flows for all transactions of HIV and AIDS.

2.2. NASA Classifications

The NASA classifies spending on HIV and AIDS according to a standardized tool that is based on concepts and nomenclatures of sectoring, financing and production internationally agreed. Therefore, pertinent official statistics can be readily used and specific estimates collated according to the international standards that are easily integrated into a comparative framework.

In NASA, financial flows and expenses related to the response to HIV and AIDS are organized in three dimensions finance, service, and consumption with each dimension further divided into two categories. The framework for the NASA system thus has six categories in total:

Funding

1. **Financial Sources (FS)** are entities that provide funds to financial agents;

2. **Financial Agents (FA)** are entities that collect financial resources to fund service provision programs and also to make decisions related to the program.

Service Provision

3. **Service providers (SP)** are entities that are engaged in the production, supply and provision of services related to HIV and AIDS;

4. **Production factors (PF)** are the inputs used to supply goods and services;

Consumption

5. **The AIDS Spending Categories (ASC)** are interventions and activities related to HIV and AIDS that are offered to the beneficiaries;

6. **The Benefiting Populations (BP)** are direct beneficiaries of the interventions carried out.

The 2014 NASA disaggregated expenditures for each of the 11 provinces, including most of the expenditures made at national level.

2.3. Data Collection and Processing

2.3.1. NASA Task Force

The AIDS spending measurement was performed by the NASA Task Force, the working group that had the technical responsibility to collect and process data, record and clean the data in the appropriate system, technically validate the data, carry out analyzes, and produce reports.

The NASA task force worked under the leadership of the National AIDS Council (CNCS). The composition of the Task Force varied during different stages of the exercise. In total, it had 18 members, including the National AIDS Council (4), UNAIDS (1), and 13 national consultants (a senior consultant, two mid-level consultants and ten junior consultants). Most of the members took part in the data collection while three consultants and an UNAIDS employee processed, validated and analyzed the data. The report was prepared by Benjamin Gobet and Joaquim Durão, UNAIDS specialist and consultant, respectively.

2.3.2. Harmonization between NASA and PEPFAR EA

To report expenditures from the funding of the Government of the United States, the NASA Task Force closely collaborated with PEPFAR Expenditure Analysis (PEPFAR EA) to harmonize the analysis of expenditures.

The PEPFAR EA information system is based on NASA and the National Health Accounts (NHA) and was developed by PEPFAR to track the spending on HIV funds distributed to their partners. PEPFAR EA was developed to support the management of PEPFAR resources and facilitate the report of the US Government spending for the NASA and the National Health Accounts.

This study represented the second harmonization exercise between the two methodologies, which has improved the level and quality of information on expenditures financed by the US. To accomplish this work for the first harmonization exercise, the Task Force's work was based on the methodological note by UNAIDS and the PEPFAR office in Mozambique.[2]

[2] "NASA excludes above-national expenditure" refers to the expenditures that PEPFAR reports as resources for Mozambique but that are actually made in the US and are thus not accounted for in the study.

To transpose PEPFAR EA results to be aligned with NASA classifications and methods, it was necessary to:

1. Adjust the crosswalk between NASA and EA classifications;

2. Reconstruct financial transactions with the NASA ratings per PEPFAR funding partner, considering the following variables: funding mechanism, geographic location, program area, and production factors;

3. Manually disaggregate spending by program area using financial data reported in PEPFAR EA plus other programmatic data. This has improved the breakdown of costs for antiretroviral treatment, the prevention of vertical transmission, and the prevention of sexual transmission among the general population;

4. Reclassify the expenditure on Program Management and on Health System Strengthening reported in PEPFAR EA according to NASA classification.;

5. Estimate the service providers and the beneficiary populations, which are not reported in PEPFAR EA. These estimates were made on the basis of available programmatic data and “the details of the PEPFAR Country Operational Plan for calendar year 2014;

6. Avoid duplication by validating the data reported by PEPFAR EA against other data collected by the NASA Task Force. A validation exercise was done with PEPFAR to ensure that expenditures reported in NASA reflect the cost of US funding.

With the transposition of PEPFAR EA data into NASA’s classifications, the NASA results do not exactly reflect the PEPFAR EA results and expenditures reported by the US Government. The main reason for this difference is the reporting of drugs and reagents because the NASA reports the consumption of medicine and reagent registered by the Central Drugs whereas PEPFAR EA reports the purchase price of drugs and reagents during the analyzed year. Another difference arises because NASA excludes above-national expenditure, which totaled $23.6 million in 2014.

Compared with the first exercise for 2010 and 2011, improvements can be noted in the breakdown of spending by program area, per production factor and per population benefits. The estimation of service providers - defined on the basis of the reports of implementing partners during the PEPFAR EA - also improved.

2.3.3. Data Sources and Quality

In collaboration with the National AIDS Council, the team of consultants identified and mapped all financial sources, financial agents, service providers, and categories of expenditure on HIV and AIDS.

Most of the main sources of data (detailed records of expenses) were obtained from the primary sources of NASA, especially the harmonization work between NASA and PEPFAR EA. Secondary sources were only used when primary sources were unavailable, e.g., for aggregate expenditure data by NGOs for which there was no detailed financial data upon which to disaggregate the expenditures by type of intervention, geographical area and production factors. Other techniques for determining costs were used to estimate some of the costs of activities related to HIV and AIDS using the most appropriate methods.

In 2014, NASA captured data from 195 institutions (i.e., 125 international, 49 private, and only 20 public). Expenses calculated based on estimates represent only 27% of total expenditures; and 88% of expenditures were collected in a "top-down" approach while 73% of expenditures were certified or adjusted by primary sources.

Table 1: Entities included in the measuring and type of information collected and analyzed

How many entities are included in the study?

Type of Entities	Number of entities	% od entities
International Entities	125	64%
Private Entities	49	25%
Public Entities	20	10%
Others (CCM)	1	1%
Total	**195**	**100%**

What is the level of certification of reported data?

Source of Information	% of Transactions	% of Expenditure
Certified by primary source	44%	62%
Adjusted from primary source	20%	11%
Estimates or imputation	35%	27%
Not available	0,2%	0,1%
Personal communications	0,1%	0,1%
Grand Total	**100%**	**100%**

How were the data/expenditure captured?

Data Collection	% of Transactions	% of expenditure
Bottom up	10%	8%
Top down	88%	88%
Top down and Bottom up	3%	4%
Grand Total	**100%**	**100%**

What type of data/expenses were collected?

Type of Data	% of Transactions	% of Expenditure
Budget	0%	0%
Estimates (PxQ)	36%	26%
Expenses reported	64%	74%
Grande Total	**100%**	**100%**

Appendix 2 contains the list of institutions visited to collect data on expenditure on HIV and AIDS and specifies the situation of the data collected. Institutions were grouped in the following categories: public, private, and external. Private spending included only the payment of individual sources of services or drugs as well as the expenses incurred by corporations.

2.3.4. Data Collection

A first documentary review of the main budget reports and institutional expenditure for 2014 was held at the beginning of the year. This review was accompanied during seven months of data collection from June 2015 to December 2016.

The data-collection forms were adjusted for different types of entities interviewed, including bilateral and multilateral agencies, and public-sector and civil-society organizations. CNCS sent letters with a copy of the data collection form to various ministries, NGOs, companies and bilateral and multilateral organizations to introduce NASA and request formal access to the necessary data. Later, the Task Force released the electronic version of the form.

To complement the data collected at the central level, visits were organized to four provinces Tete, Nampula, Sofala and Cabo Delgado to identify additional expenses that would not be reported to the central level. Data collected at the central level were broken down by province.

Table 2: Stages of MEGAS 2014

Activities	Period
Official launch and training of the Taskforce	June
Data collection at central level	July/November
Data collection at Provincial level (Tete, Nampula, Sofala, Cabo Delgado)	November
Data processing	July/November
Entry of data at the Resource Tracking Tool	December/January
Data cleaning and validation	February
Preliminary analysis and data assessment	February/March
Report drafting	April-May

Considering the importance of the amount of data from some organizations (e.g., UNICEF, WFP, UNFPA, FDC), data were collected in the formats available in organizations' systems and transferred to NASA's format and classification. These works were followed by validation exercises. The resources funded by PEPFAR have been reported using a specific methodology, detailed in section 3.3.2.

2.3.5. Data Processing

The data collected on expenditure were first launched in Excel® spreadsheets, checked and balanced. All information obtained or collected was checked in the greatest detail possible to ensure the validity of data sources, records, agents and providers and to avoid double counting. The data were then transferred to the NASA Resource Tracking Tool (RTT) (resource monitoring software), which is designed to facilitate data processing for NASA. The instrument guides the registration step-by-step and contains verification of compliance of ratings and totals This facilitates the monitoring of the confrontation of data between the various rating axes. The databases resulting from RTT were then exported to Excel® to produce tables and graphs for analysis.

2.4. Estimates

NASA's methodology allows the disaggregation of data to demonstrate the costs incurred by service providers, and to identify the categories of beneficiaries receiving services. However, for some activities such as health services, the available data did not reveal how much was spent, and there was need to make estimates.

Expenditures were estimated for antiretroviral treatment (salaries and ARVs), prevention of vertical transmission (salaries and ARVs), laboratory tests (salaries and reagents), counseling and testing (salaries and reagents), STI treatment (salaries and consumption of drugs), central supply chain (salaries and operating expenses) and condoms. The estimates were based on the determination of unit prices of services and the number of services provided (recipients).

In the case of the wages related to the provision of anti-retroviral treatment, changes were introduced in 2014 to the procedures followed by the measurements taken in previous years, in order to better align with the methodologies recently developed to project the costs of PEN IV. This approach considers the expansion of care and treatment, with the participation of more peripheral health units, and the consequent shifting tasks to be done by nurses, clinical officers, or other medical technicians instead of by doctors. Also, expenditures to provide pediatric and adult treatment were estimated separately.

Table 3: Estimates of the wage cost per patient on ART in 2014 shows the average distribution of professional time, the various professional categories involved in the delivery of antiretroviral treatment services for each meeting.

Table 3: Estimates over salary expense per patient in ART in 2014

Pediatric ART

Type of Staff	Percentage (%) treated per	Minutes	Time distributed	US$ / minute
Generalist physician	40	10	4	0,211
Medical assistant	60	10	6	0,054
Nurse	0	5	0	0,042
Chemistry staff	100	5	5	0,047
Laymen counselors	100	120	120	0,000
Average unit expenditure pediatriatics				**1,402**

Adult ART

Type of Staff	Percentage (%) treated per	Minutes	Time distributed	US$ / minute
Generalist physician	15	10	1,5	0,211
Medical Assistants	65	10	6,5	0,054
Nurses	20	8	1,6	0,042
Chemistry staff	100	2	2	0,047
Laymen counselors	100	120	120	0,000
Average expenditure of adults				**0,830**

The estimated contribution of specific donors to different HIV programs was of equal proportion to the contribution in the total expenditure incurred in the period and for this particular expense.

Most ministries lack information on expenditure for HIV and AIDS. Therefore, it is difficult to draw firm conclusions about the financial flows for HIV and AIDS for certain sectors. However, on the basis of information provided by financial sources and service providers, the study attempts to report some sectoral spending on HIV and AIDS.

The common fund (PROSAUDE) was treated as "Financing Scheme".

The exchange rate at the end of the year for the US dollar and metical for the year of the study was used (31.50 MZN).

2.5. Improvement in the Data Quality

One of the goals of NASA exercises is gradually improving the quality of data and then the information used in each new exercise.

In the 2014 exercise, the fifth to be held, it was possible to identify and report expenditures of the Santo Egídio organization (Project DREAM), from the companies Vale Mozambique and Mozambique Leaf Tobacco, and household costs, limited to condoms. It was also possible to obtain data to estimate spending on the public distribution of condoms.

In parallel, the breakdown of US Government spending data was improved both by program area, breakdown to three digits categories, as the factors of production and service providers. For evidence, the so-disaggregated data were crossed with other available data, including the programmatic.

With regard to spending in the health sector, there was an improvement and uniformity in the estimates of the state budget's and PROSAUDE's spending on civil servants' salaries.

The year 2014 was also the first to have more disaggregated information, which, thus, enabled an analysis of spending by production factors.

2.6. Limitations of Assessment

Despite the improvements mentioned above, the screening of spending on HIV and AIDS had some limitations:

Absence of data:

- Some organizations (public and private) did not report data;
- Lack of studies on expenditure of family aggregates;
- Traditional medicine was not included;
- Purchase and distribution of condoms funded per family aggregates only include Jeito condoms;
- Expenditure on the provincial coordination of programs for HIV funded while government expenditures by the Ministry of Health were not captured.

Data quality and coverage of expenses:

- Some data were reported in aggregate (mainly for the production factors);
- An important part of the expenditure was only obtained from the "top down" without being able to validate the actual expense of spending to the provider level;
- Poor quality of programmatic data on the distribution of condoms;
- Some spending reported at central level or management of the programs could have been broken down by program area;
- An important part of the expenses for beneficiary populations of communication and behavior change is not disaggregated by age or sex;
- It was not possible to disaggregate the consumption of ARV between first and second line treatment.

Delays in the implementation of the study:

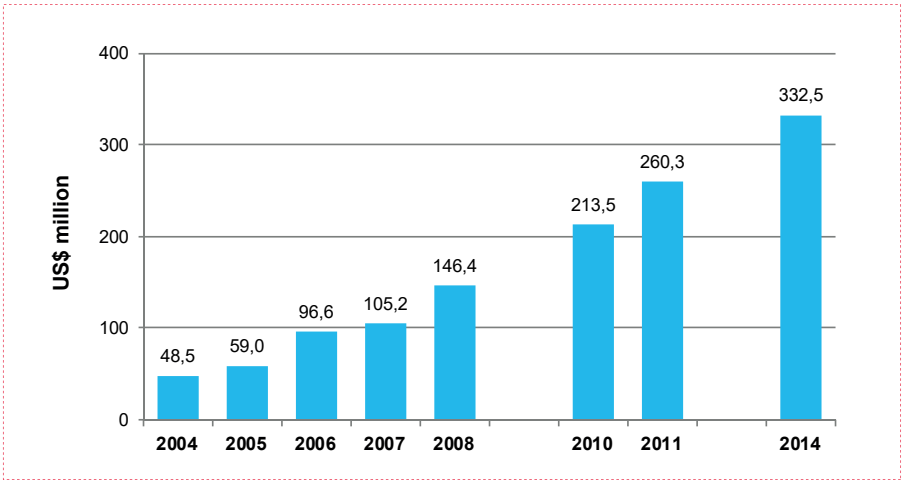
- Lack of respect for deadlines and timetables;
- Letters with permits were sent too late;

3.1. Trends of Expenditure in HIV and AIDS

The Government of Mozambique has introduced comprehensive initiatives for prevention, treatment, care and support to reduce HIV transmission, and meet the demand for HIV services. Within the period analyzed, the resources invested in these HIV and AIDS initiatives continued to exceed the funding of most other public health programs.

The measurement of the spending in 2014 on HIV and AIDS in Mozambique indicates that it has reached a new record $332.5 million, almost seven times more than in 2004 (see Figure 1). The 2014 expenditure corresponds to a 28% growth of the amount calculated for 2011.

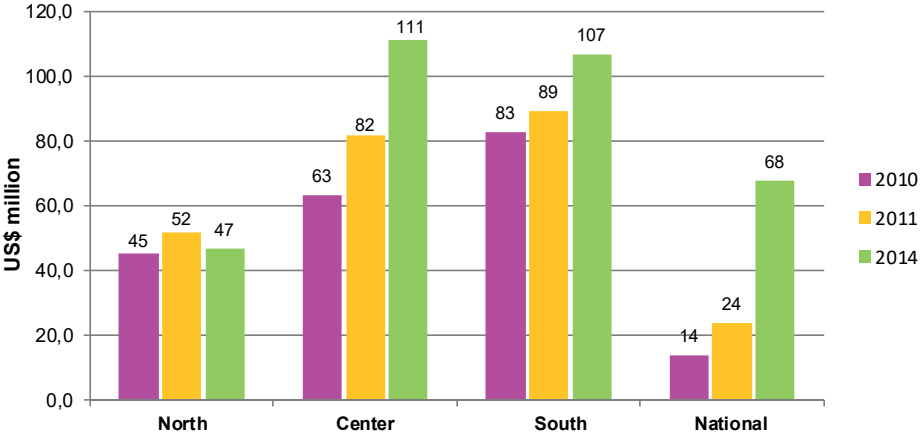
Figure 1: Total HIV expentiure - 2004-2014 (US$)



Source: CNCS, 2008 ; CNCS, 2010 ; CNCS, 2014b

The information obtained allows us to evaluate, with better precision, the territorial distribution of spending on HIV and AIDS. In 2014, most spending was done in the central region (33%), followed by the southern region (32%) and northern region (14%). The remaining expenses (20%) were performed?? at the national (central) level. Compared to 2010, the resources in the north barely grew, but increased significantly in the central and southern regions of the country while national expenditure also recorded strong growth.

Figure 2: Distribution of HIV expenditure per region - 2004-2014 (US$)

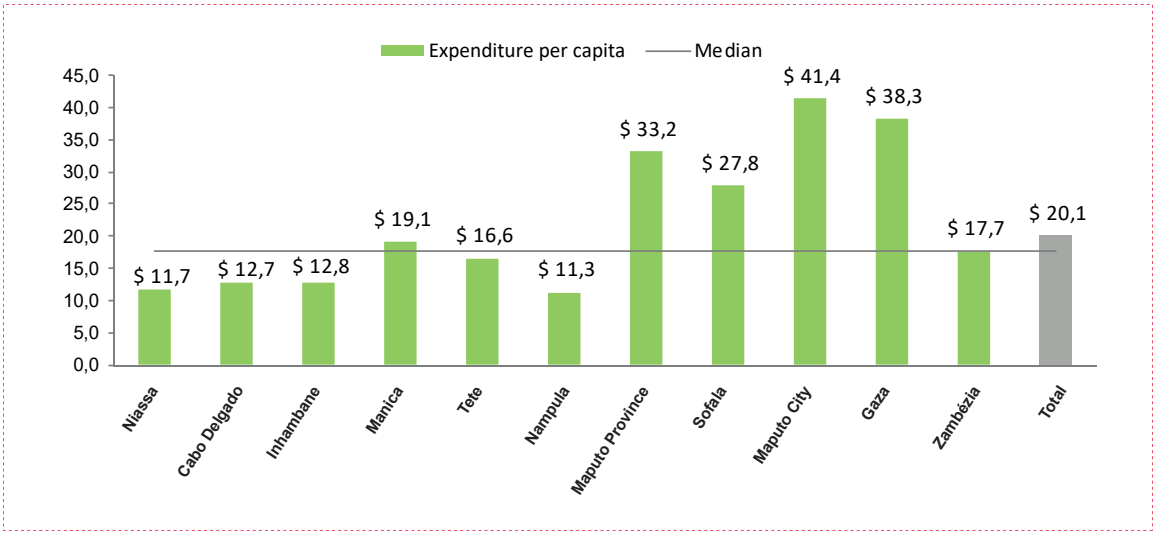


Compared to 2011, spending on HIV and AIDS decreased in the provinces of Niassa and Nampula, representing respectively 2% and 8% of total spending in 2014 (Figure 3,). In all other provinces, spending in 2014 increased compared to 2011, especially in Zambezia and Gaza, which accounted, respectively, for 13% and 10% of total expenditure in 2014.

Figure 3: **Distribution of HIV expenditure per Provinces (million US$)**

Since, in 2014, it was possible to disaggregate all spending by province, the comparison of the provincial per capita spending for the the population over 15 years is shown in Figure 4. The national average stood at $25.2, with a median of $17.7, which is the expenditure of Zambezia Province.

Figure 4: **Expenditure per capita and per Province, 2014 (US$)**



3.2. Financial Flows and Funding Modalities

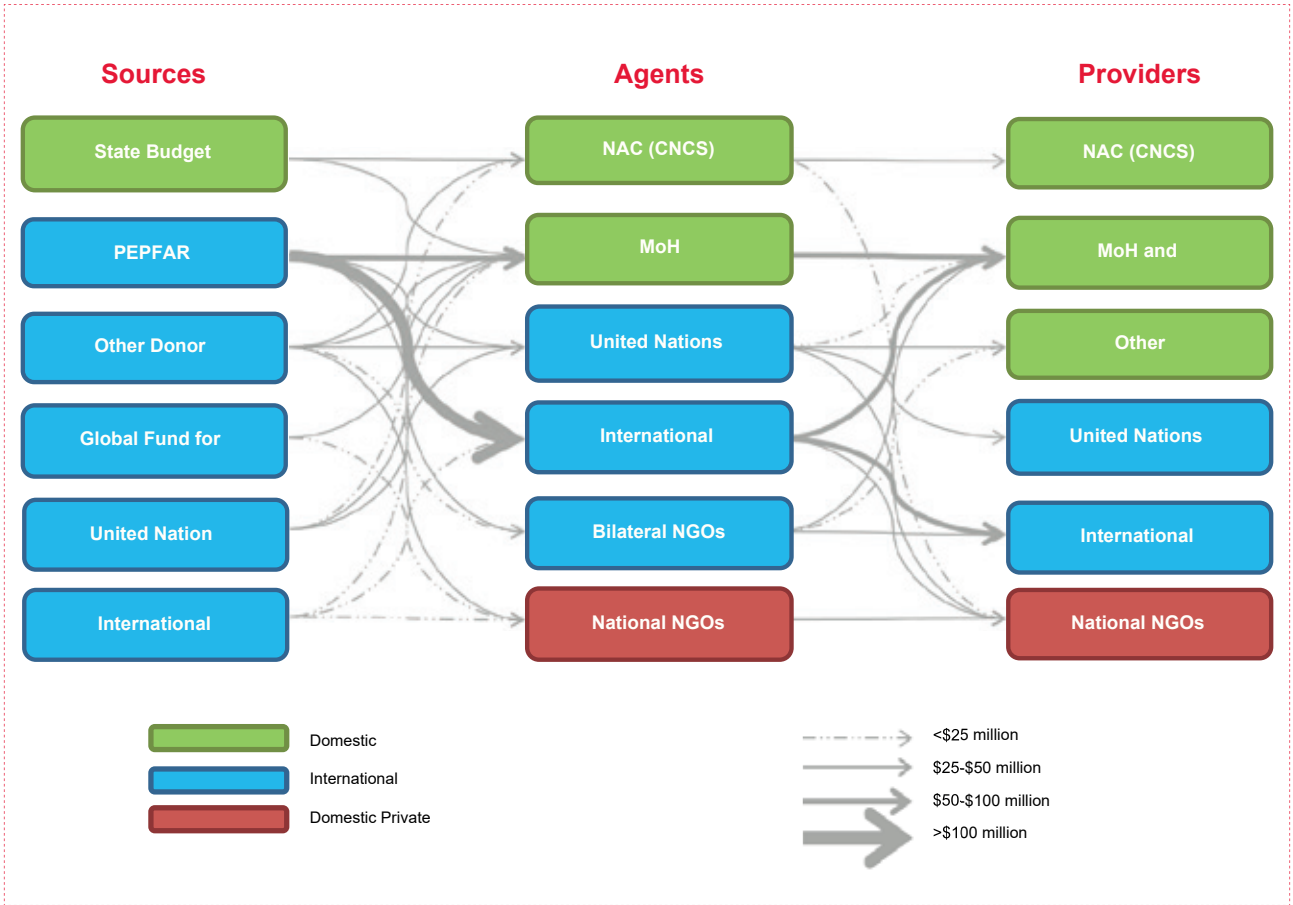
3.2.1. Funding Flows: From the Sources to Service Providers

As mentioned in the chapter on methodology, the entities involved in the national response to HIV and AIDS are classified as financial sources, financial agents or service providers according to the nature of the intervention; and the same entity may carry out all three roles. Financial sources are entities that provide funds to financial agents to use or distribute. Financial agents are important entities in the national response to HIV because they collect funds collected from various financial sources and transfer the money to providers to buy or pay for health care or other services or goods to handle activities related to HIV and AIDS. In this sense, the service providers for the Fight Against HIV are entities or people that engage directly in production, provision and delivery of services in exchange for a payment for their contribution.

The relationship between the entities that embody the transactions in 2014 is schematically represented in Figure 5, using NASA's general classifications.

As can be seen, the financial architecture is complex, with multiple levels of intermediation and a combination of direct financial contributions, funding for a common fund, support for public or private, central or decentralized activities, and the direct implementation of programs for OSCs or by implementing partners. Associations and civil society organizations mobilize resources through the state budget (ministries, local governments), multilateral and bilateral organizations or other NGOs. The two most important flows are related to the funding of PEPFAR and the Global Fund, which, in 2014, represented 83.6% of spending on HIV and AIDS in Mozambique.

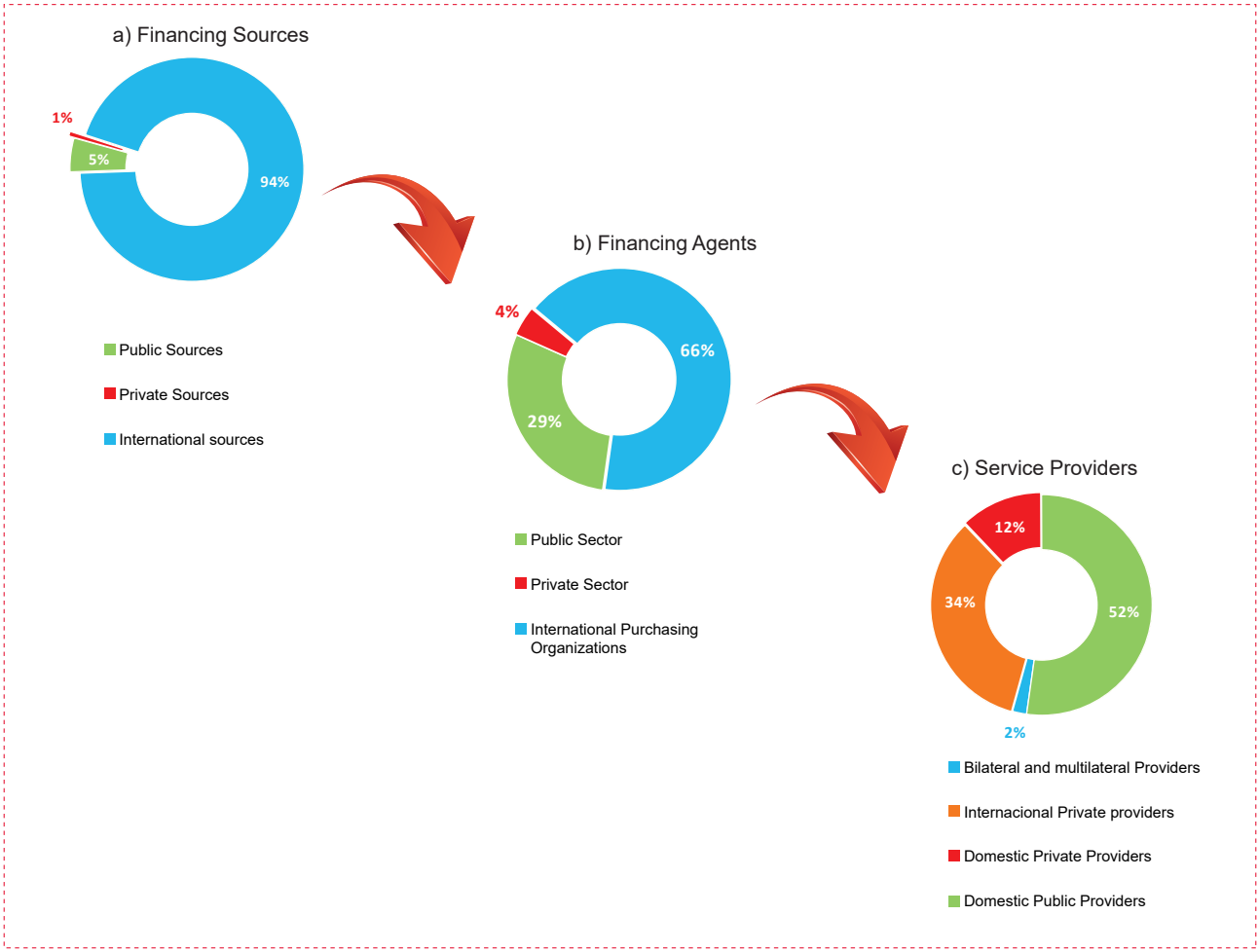
Figure 5: Main Flows of Funding in Response to HIV, 2014



The sources, agents and providers may be public, private or international. Understanding the flow of funds between these different entities and how the financial agents distribute this money to service providers helps donors to adjust future allocations in line with priorities.

For HIV and AIDS programs, 95% of the funds come from international donors whereas, by value, 52% of the activities are run by national public authorities (Figure 6), The same chart shows beyond doubt that, as agents, international procurement organizations, play an important role in deciding the programmatic allocation of resources since, in 2014, they accounted for 66% of spending.

Figure 6: Flow of Funds of National Response in 2014

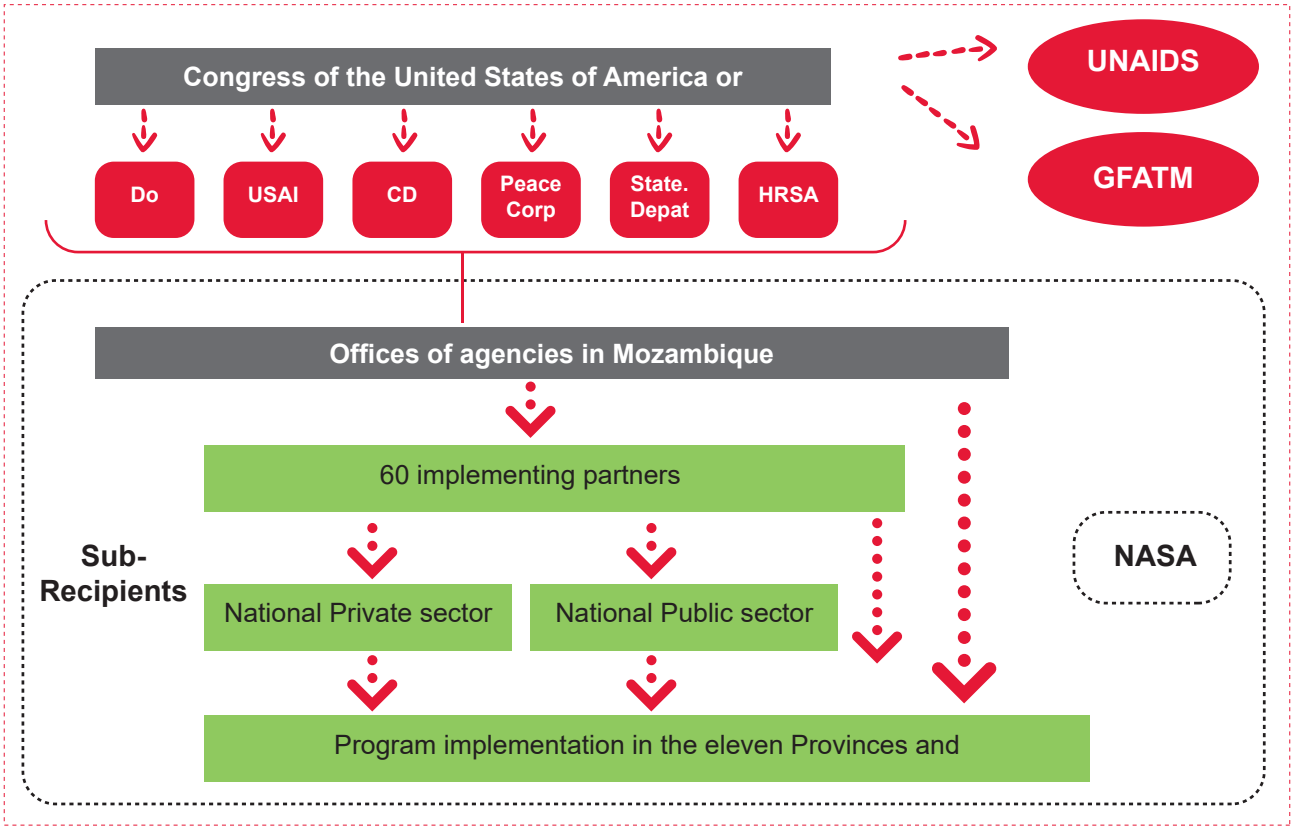


PEPFAR disbursements are direct support to programs. The funds are initially channeled to US agencies, which then distribute the money to the 60 implementing partners. Of the resources allocated to implementing agents, most (77%) were for international organizations, including international NGOs and international nonprofit organizations that received 66% of PEPFAR funds. In addition, 21% of funds were for public sector agents in 2014, up from 10% in 2011. In turn, these implementing partners reallocated resources to providers of goods and services. Of the service providers, the health sector was the main recipient of HIV and AIDS related resources, totaling 51% of expenditures (47% for hospitals and health units alone). Other recipients include Mozambican civil society organizations (9%) and Mozambican private companies (2%). The rest of the expenses were directly undertaken by international NGOs (26%) and other international for-profit bodies (11%).

The financing of the Global Fund for HIV, TB and Malaria is the second largest funding mechanism for HIV programs in Mozambique. In 2014, the major recipients were the Ministry of Health and FDC (Foundation for Community Development), which spent the funds allocated by GFATM. The CCM also consumed a small

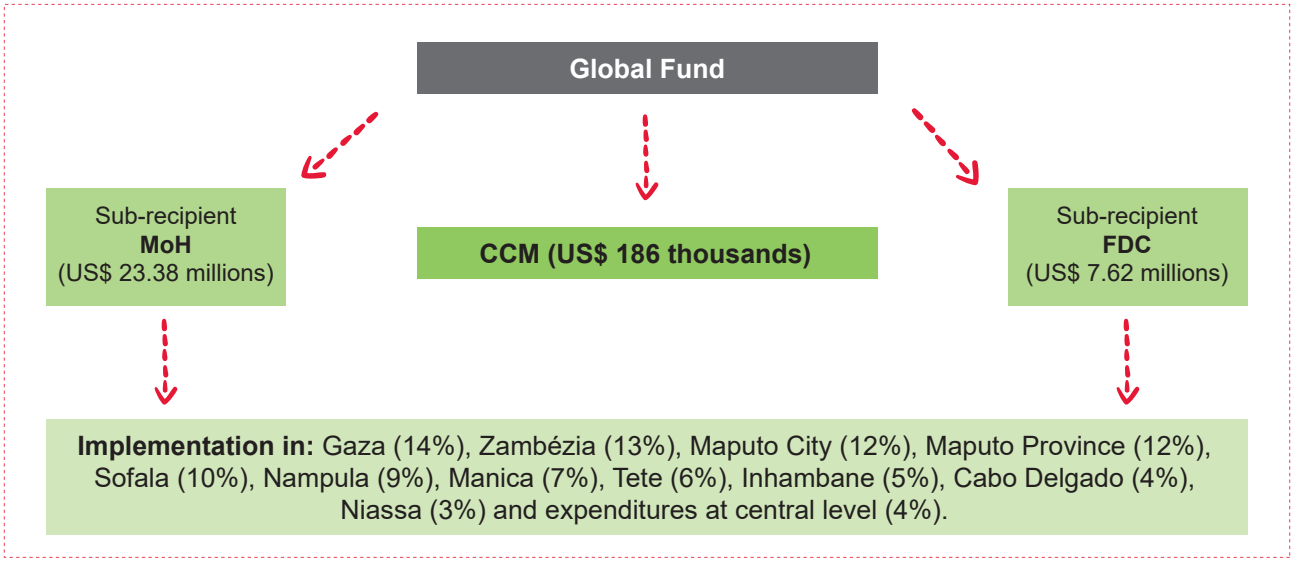
amount of resources. Of the funds allocated to the country in 2014, 75% were distributed to the Ministry of Health and 24.5% to the FDC. The MoH spends the allocated funds at the provincial level and in health facilities. Besides running part of the funds directly, FDC transfers funds to sub-recipients operating in different provinces.

Figure 7: Funding Flows of PEPFAR in Mozambique - 2014



Note: The part bordered with dashed lines represents the flows identified in NASA
Source: PEPFAR EA, Ooman et Al (2007), e Victoria Fan et al (2013)

Figure 8: Funding Flows of the Global Fund in Mozambique - 2014



In the health sector, the Ministry of Health manages a common fund (PROSAUDE), which is used by donors as a mechanism for sectorial budget support. This is a big advantage. It benefits MoH by reducing the number of parallel funded programs, thus increasing efficiency. It also gives the MoH power to decide how to use the funds. Pooling of funds is recommended by OECD as an efficient funding mechanism. In 2014, external contributions to PROSAUDE reached $83.6 million. Its main donors the governments of Canada, Ireland, the Netherlands and the United Kingdom contributed $10 million.

The Ministry of Health is responsible for the use of PROSAUDE resources, which are allocated for the payment of wages, goods and services and the provision of health services related to HIV and AIDS. In the estimates of expenditures made on health, PROSAUDE was treated as a "financing scheme" without trying to reallocate spending back to the entities that had contributed financial support.

Table 4: Summary of External Disbursements for PROSAUDE - 2010, 2011 and 2014 (US$)

Funders of PROSAUDE	2010	2011	2014
Belgium	2 739 398	2 644 170	
Canada	8 698 173	9 331 260	31 508 271
Catalunha	671 652		
European Commission	8 265 475	7 932 510	
United Kingdom	11 335 800	10 899 000	11 132 143
Denmark	6 584 469	7 077 741	5 143 945
Spain	4 082 251	3 966 255	1 342 300
Finland	4 898 565		
France	4 082 251		
The Netherland	9 525 253	9 254 595	10 738 400
Ireland	18 490 938	17 848 147	16 107 570
Italy	1 088 600	1 057 668	671 150
Switzerland	3 543 124	5 136 612	6 050 419
UNFPA	500 000	500 000	350 000
UNICEF	1 200 000	1 200 000	600 000
Total	**85 705 949**	**76 847 958**	**83 644 198**

Source: *MISAU - Financial Reports 2010, 2011 and 2014*

Table 5: Funding by the State Budget – thousands US$

SB Expenditure	2010	2011	2014
Health	8.011	10.635	10.125
CNCS	1.919	2.580	4.358
State-other	46	52	124
NGOs	**53**	**5**	**1.455**

Except for contributions from Caminhos de Ferro de Moçambique, public funds availed by the state budget obey the legal procedures for the administration of state funds. Of these public funds, the government-run health services spent $10.1 million, CNCS, ($4.4 million, and civil society, $1.5 million, in 2014).

The following sections conduct a detailed analysis of the constitutive elements of these flows, taking into account the role played in the response to HIV and AIDS in 2014 and in comparison to previous years whenever appropriate.

3.2.2. Funding Sources

Over the years, the composition of the funding mechanisms of the national response to HIV and AIDS in Mozambique has evolved. This section describes the portfolio of funding mechanisms in Mozambique by 2014.

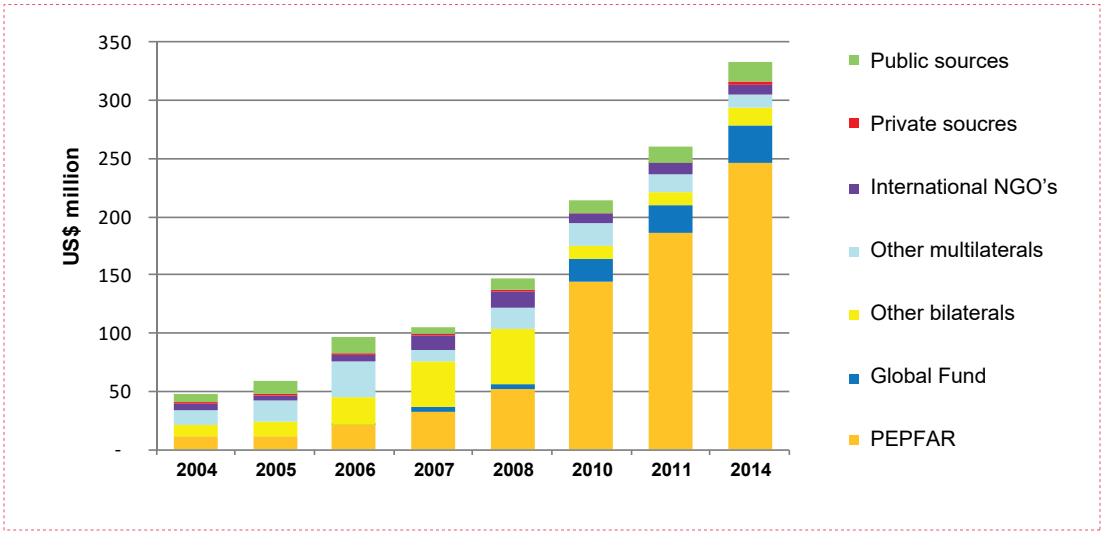
Table 6: Expenditure in HIV and AIDS per financing sources (2014)

Financial Sources	2010		2011		2014	
	US$	%	US$	%	US$	%
FS.01 Public Sources	10 144 596	4,8%	13 410 509	5,2%	16 197 217	4,9%
FS.02 Private Sources	235 048	0,1%	229 775	0,1%	2 239 452	0,7%
FS.03 International Sources	203 113 942	95,1%	246 656 411	94,8%	314 066 363	94,5%
Total	213 493 586	100,0%	260 296 695	100,0%	332 503 032	100,0%

Of national spending on HIV and AIDS in 2014, external financial sources accounted for 94%, public funds, 5%; and private sources, 1% (Table 6). Private sources include private entities and account for a small fraction of expenditures incurred by families and people living with HIV aggregates.

Figure 9 shows the evolution of the financing sources of spending on HIV and AIDS over the years, in conformity with the assessments made, and indicates the important role of international financing sources in the national response. The omitted years correspond to the years in which spending assessments were not carried out.

Figure 9: Evolution of HIV expenditure by financing source



Source: CNCS, 2008 ; CNCS, 2010 ; CNCS, 2014b

3.2.2.1. Domestic Public Financial Sources

The State Budget (SB) is an important financial source for the health sector's response to HIV and AIDS. The government's contribution to total expenditure on health has increased steadily in recent years. In 2014, the volume of domestic public resources for HIV and AIDS stood slightly above $16 million, increasing by 60.2% over 2010. However, the proportion of spending on HIV supported by the state budget fell from 5.1 % of total expenditure in 2011 to 4.9% in 2014, which is similar to the proportion reached in 2010.

3.2.2.2. Domestic Private Financial Sources

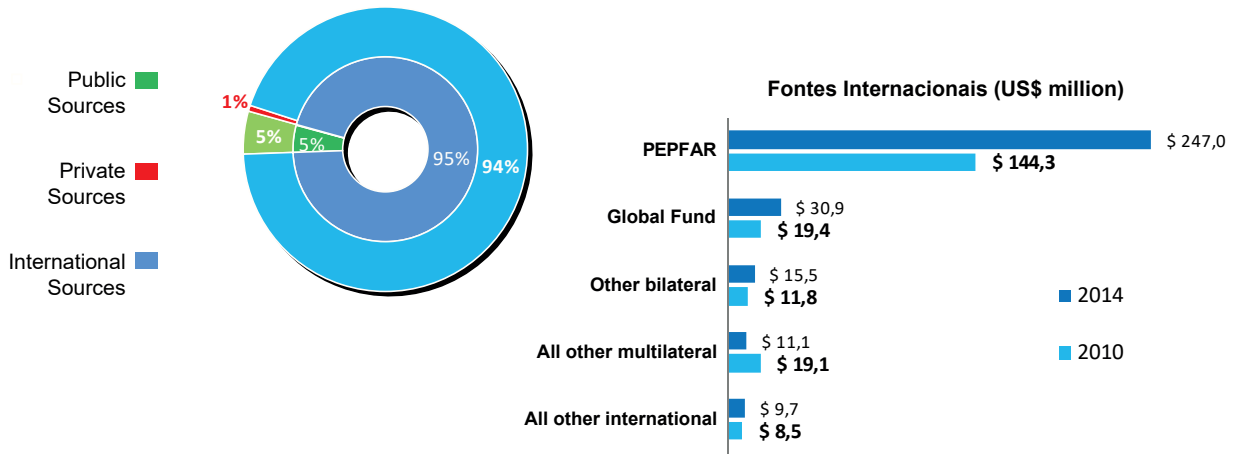
Spending coming from private sources in the fight against HIV and AIDS reached $2.2 million in 2014, compared to $230,000 in 2010 and 2011. The out-of-pocket expenditures incurred in 2014 (representing 77% of private sources) are primarily responsible for the observed growth. Nevertheless, for people living with HI, NASA did not identify all of their expenses for prevention, care, treatment and other expenses related to HIV and AIDS.

The evaluation includes the for-profit institutions and other private entities that have reported data for the period of analysis. The for-profit institutions with most important level of expenditure were the AGIR Association, TEBA and Mozambique Leaf Tobacco. Despite many requests, large companies in the extractive industry, except Vale, did not provide information and are, therefore, excluded from this study.

3.2.2.3. International Financial Sources

The increase in funds allocated to HIV and AIDS programs in Mozambique was only possible with an unprecedented increase in external resources, which in 2014 were almost seven times the amount invested in 2004. Even between 2011 and 2014, the resources increased by 27%.

Figure 10: Distribution of expenditure in HIV and AIDS, per international funding source (2010 & 2014)



Note: the inner circle refers to expenditure in 2010 and the outer circle expenditure in 2014

So, like many developing countries highly affected by HIV, Mozambique's national response to the pandemic is largely sustained by external assistance from bilateral agencies, international and multilateral organizations and international NGOs for assistance and philanthropy.

In 2014, the largest contribution came from the United States Government, a total of $247 million - about 74% - of the total expenses in the national response to HIV and AIDS (Figure 10). The second most important contribution came from the Global Fund to Fight HIV, Tuberculosis and Malaria, which totaled $30.9 million, representing 9.3% of the total. The Other Bilateral Funds, including funding from governments, financed $15.5 million (4.7%) while other multilateral organizations, including UN agencies, contributed $11.1 million (3.3%). All Other International funders, including non-profit organizations and international charities, contributed $9.7 million (2.9%). Table 7 details the international financial sources.

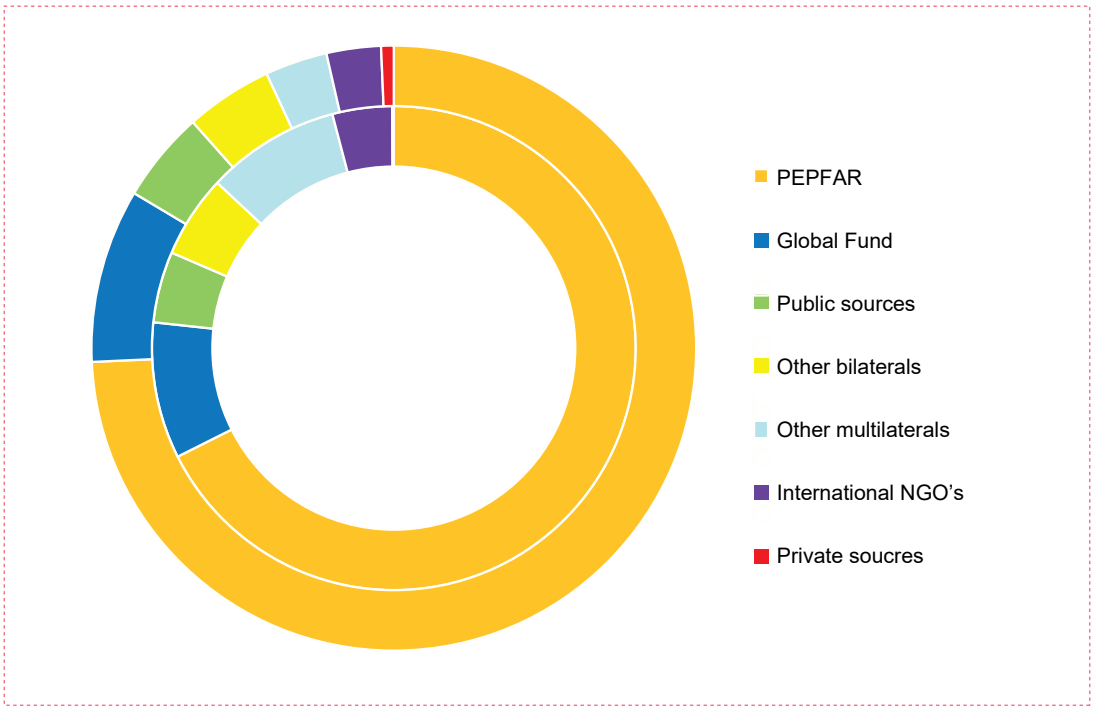
Table 7: Expenses in HIV per international financing sources

International Financial Sources	US$	%
FS.03 International Sources	**314 066 363**	**100,00%**
FS.03.01 Direct bilateral contributions	262 454 305	83,57%
FS.03.01.03 Belgian Government	1 723 208	0,55%
FS.03.01.04 The Government of Canada	1 455 654	0,46%
FS.03.01.05 The Government of Denmark	61 612	0,02%
FS.03.01.07 The Government of France	140 861	0,04%
FS.03.01.10 The Government of Ireland	15 851	0,01%
FS.03.01.11 The Government of Italy	451 404	0,14%
FS.03.01.14 The Government of the Netherlands	6 903 478	2,20%
FS.03.01.16 The Government of Norway	412 033	0,13%
FS.03.01.19 The Government of Sweden	791 787	0,25%
FS.03.01.20 The Government of Switzerland	947 836	0,30%
FS.03.01.21 The Government of the United Kingdom	362 374	0,12%
FS.03.01.22 The Government of the United States of America	246 956 061	78,63%
FS.03.01.99 Other governments/bilateral agencies n.c.o	2 232 146	0,71%
FS.03.02 Multilateral Agencies	**41 938 240**	**13,35%**
FS.03.02.02 European Commission	1 229 300	0,39%
FS.03.02.04 International Labour Organization (ILO)	23 000	0,01%
FS.03.02.07 Global Fund Against HIV, TB and Malaria	30 873 522	9,83%
FS.03.02.08 UNAIDS Secretariat	1 644 188	0,52%
FS.03.02.09 UN Children's Fund (UNICEF)	2 011 619	0,64%
FS.03.02.11 United Nations Development Program (UNDP)	152 473	0,05%
FS.03.02.17 United Nations Population Fund (UNFPA)	1 698 427	0,54%
FS.03.02.18 World Bank (WB)	880 023	0,28%
FS.03.02.19 World Food Program (WFP)	13 236	0,00%
FS.03.02.29 World Health Organization (WHO)	77 488	0,02%
FS.03.02.99 Other multilateral funds n.c.o	3 334 964	1,06%
FS.03.03 Non profit organizations and international foundations	**9 368 162**	**2,98%**
FS.03.03.20 Doctors Without Borders	5 210 053	1,66%
FS.03.03.24 SIDACTION	4 546	0,00%
FS.03.03.33 World Vision	396 079	0,13%
FS.03.03.34 International Planned Parenthood Federation	49 603	0,02%
FS.03.03.99 Other non profit international organizations n.e.c	3 707 881	1,18%
FS.03.04 International profit organizations	**305 656**	**0,10%**

Over the years, the funding structure of the response to HIV and AIDS in Mozambique has undergone some changes that reduced or sustained the contribution of some external funding. This intensified the aid dependence on a few donors.

While financing by the Global Fund remained at 9% (for 2010, 2011 and 2014), PEPFAR increased from 68% (2010) to 74% (2014). Other international funds (bilateral, multilateral and NGO) reduced from 18% (2010) to 11% (2014). Public contributions remained at 5% and the private contributions stood at 1% in 2014. These changes in the volumes of financing are shown in Figure 11.

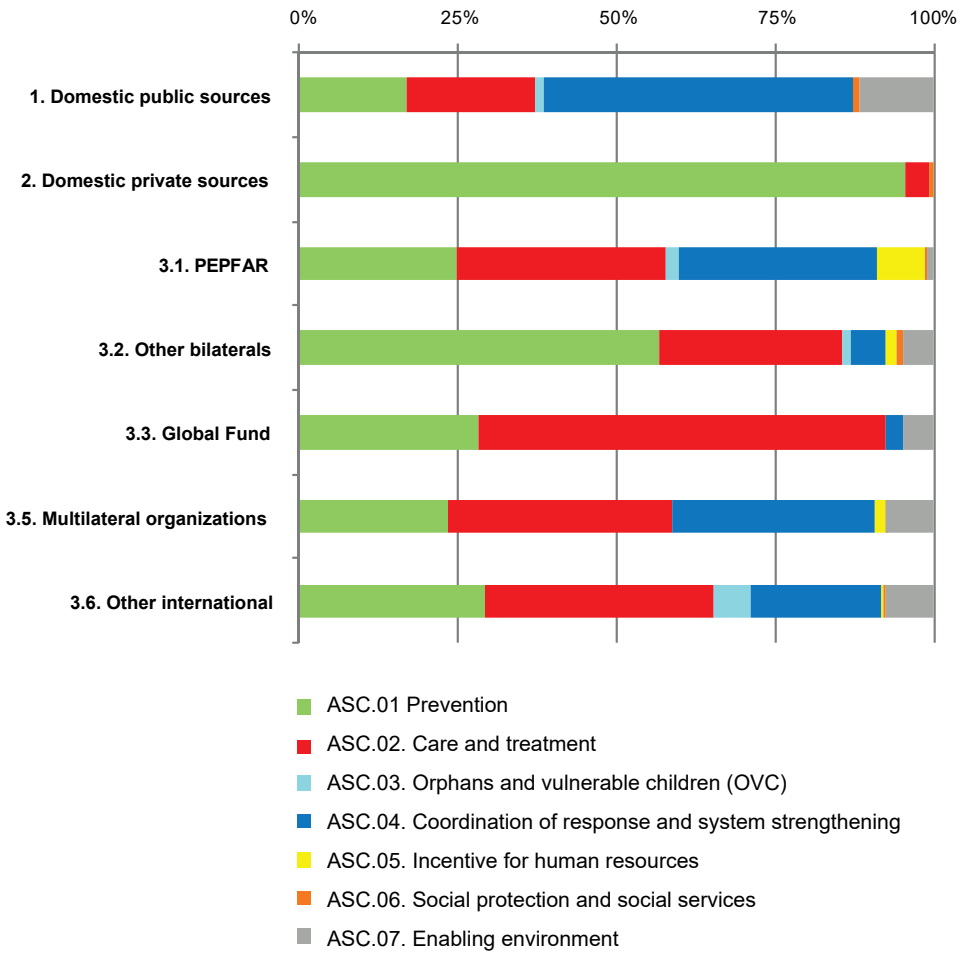
Figure 11: Distribution of the different sources of funds for HIV (2010 and 2014)



Note: Outer circle is for 2014, and the inner circle, 2010.

The programmatic priorities of resource allocation vary from one funding source to another (Figure 12). The costs of PEPFAR funding covered seven programmatic categories of NASA: care and treatment (33%), coordination of the response and system enhancement (31%), prevention (25%), incentives for human resources (8%), orphans and vulnerable children (OVC) (2%), and favorable environment (1%). In contrast, GFATM's resources were allocated to care and treatment (64%), prevention (28%), favorable environment (5%), and coordination of the response and system reinforcement (3%). Excluding the USG, the contributions of other bilateral donors, attributed more than half of their spending on prevention (57%) and the remainder on care and treatment (29%) and on coordination of the response, system reinforcement and favorable environment (about 5% each). The remaining contributions from other bilateral donors included social protection services (2.2%) and incentives for human resources (1.6%).

Figure 12: Priorization of programmatic areas per funding sources, 2014



3.2.3. Funding Agents

Although financing sources decide on the availability of resources for the national response, financial agents can decide which type of activity or product to finance or buy.

In 2014, the main financial agents of anti-HIV activities and AIDS in Mozambique are, in order of importance, the international organizations (66%), the public sector (29%), and the private sector (4%) (Figure 6).

The main public financial agents the Ministry of Health (MoH) and the National AIDS Council (CNCS) play an important role in deciding the activities to fight HIV and AIDS that need funding. The relative weight of the Ministry of Health increased from 21% in 2010 to 27% in 2014, with the CNCS remaining at about 2% in both years.

International organizations and international philanthropic NGOs received and distributed the bulk of total resources (46.7%), equivalent to $155 million in 2014 versus $151 million in 2011 (54% of the total). The resources allocated by international NGOs account for almost half of the expenditure, which confirms the NGOs' importance in the response to HIV and AIDS.

Table 8: Total HIV expenditure per financing agent (2010, 2011 and 2014)

Financial Agents	2010		2011		2014	
	US$	%	US$	%	US$	%
Public	49 195 057	23%	64 778 535	25%	97 932 654	29%
Ministry of Health	44 392 476	21%	57 664 830	22%	89 806 166	27%
CNCS	4 361 454	2%	6 396 249	2%	7 675 202	2%
Other public entities	441 127	0%	717 456	0%	451 286	0%
Private	5 562 499	3%	3 918 553	2%	14 469 295	4%
Family aggregates		0%		0%	1 730 343	1%
Other private companies	5 562 499	3%	3 918 553	2%	12 738 952	4%
International	158 736 030	74%	191 599 607	74%	220 101 083	66%
Bilateral agencies	15 217 498	7%	22 896 627	9%	26 727 611	8%
Multilateral agencies	28 250 017	13%	18 036 367	7%	11 675 822	4%
International NGOs	115 268 515	54%	150 666 613	58%	155 199 608	47%
Other international entities		0%		0%	26 498 042	8%
Total	**213 493 586**	**100%**	**260 296 695**	**100%**	**332 503 032**	**100%**

Source: *NASA 2010&2011 (2014) e NASA 2014 (2016)*

3.2.4. Service Providers

Most spending on HIV and AIDS in Mozambique are carried out by national public bodies, which absorbed 52% ($173.6 million) in 2014 (Figure 6 and Table 9). Most of the remaining expenses were made by private providers who used 46%, leaving 34% to international organizations and 12% to national ones. Bilateral and multilateral providers accounted for 2% of expenditures in 2014.

Expenditures in the health sector (hospitals and health centers) totaled $150 million in 2014 (45%) against the $108 million in 2010 (51%).

Table 9: Total HIV expenditure per service provider (2010, 2011 and 2014)

Service Provider	2010		2011		2014	
	US$	%	US$	%	US$	%
Public seervice provider	127 142 019	60%	144 159 606	55%	173 575 632	52%
Hospitals	72 053 606	34%	80 727 312	31%	48 869 862	15%
Ambulatory	36 022 508	17%	47 823 710	18%	101 157 180	30%
CNCS	3 316 739	2%	6 631 596	3%	4 964 580	1%
Other public	15 749 166	7%	8 976 988	3%	18 584 010	6%
Private service provider	78 376 040	37%	110 250 732	42%	152 028 877	46%
Non-for-profit	78 195 082	37%	109 851 184	42%	117 675 408	35%
Private International	*42 600 167*	*20%*	*73 088 904*	*28%*	*83 894 478*	*25%*
Private national	*35 594 915*	*17%*	*36 762 280*	*14%*	*33 780 930*	*10%*
For-Profit	180 958	0%	399 548	0%	34 084 568	10%
Other private		0%		0%	268 901	0%
Bilateral and multilateral entities	7 958 500	4%	5 886 357	2%	6 713 009	2%
Bilateral	957 137	0%		0%	1 061 064	0%
Multilateral	7 001 363	3%	5 886 357	2%	5 651 945	2%
Other not elswhere classified	17 027	0%		0%	185 514	0%
TOTAL	**213 493 586**	**100%**	**260 296 695**	**100%**	**332 503 032**	100%

Source: *MEGAS 2010&2011 (2014)*

PROSPECTS OF FINANCING THE RESPONSE TO HIV AND AIDS

In the immediate future, the architecture of the response to HIV and AIDS financing in Mozambique will probably not be substantially modified. It is expected that the volume of foreign aid is sufficient to meet the growing needs.

The Government of the United States, through PEPFAR, is the first source of external funding for HIV globally. This position was enhanced in 2015 and 2016. According to the Operational Plans for Countries (OPC), the budget for PEPFAR to Mozambique increased by 26% between 2014 and 2016 fiscal years, reaching $330 million in its OPC 15.*

In 2015, the Global Fund for HIV, TB and Malaria (GFATM) has committed to fund $175.7 million for HIV in the 2015-2017 period. The current principal recipients of the Global Fund include the Ministry of Health and civil society (FDC and its sub-recipients), which benefited from disbursements for HIV activities in Mozambique in the amount of $85.0 million.**

However, overall, since 2013, resource volumes availed by the two main sources of funding have been stable. Thus, the aforementioned increases resulted from reallocations of funds to (from??) other countries for the benefit of Mozambique. Consequently, foreign aid for HIV in Mozambique is unlikely to continue to increase as it did last decade.

In 2015, the Mozambican government created a new budget line for activities related to HIV and AIDS in the Ministry of Health, to which got MZN 715.7 million (equivalent to $22.7 million at the time of preparation of the budget law).*** This budget was for the purchase of materials and equipment and complemented the resources allocated to the management of HIV Program and the National AIDS Council and also for financing CSOs on HIV and AIDS service provision. This budget line was not retained in the budget law for 2016.

* PEPFAR, Country Operational Plan FY 2013; PEPFAR, Country Operational Plan FY 2014; PEPFAR, Country Operational Plan FY 2015.

** The Global Fund, Disbursements (as of 01 February 2016)

*** MEF, Acompanhamento da Lei Orçamental 2015, Despesa de nível Central (2014)

3.3. Programmatic Description of Expenses in HIV and AIDS

NASA classifies activities and interventions on HIV and AIDS in eight major spending categories. In 2014, the main spending categories were: care and treatment ($116.5 million), national coordination and system strengthening ($91.9 million) and prevention ($88.8 million) (Table 10).

Table 10: HIV Expenditure per AIDS spending category (ASC) in 2014

AIDS Spending Category (ASC)	US$	%
ASC.01 Prevention	88 791 123	27%
ASC.02. Care and treatment	116 476 416	35%
ASC.03. Orphans and vulnerable children (OVCs)	6 160 782	2%
ASC.04. Coordination of response and system strengthening	91 880 444	28%
ASC.05. Incentive for Human Resources	19 605 318	6%
ASC.06. Social protection and social services	914 176	0,3%
ASC.07. Enabling environment	8 460 634	3%
ASC.08. HIV-related research	214 138	0,1%
TOTAL	**332 503 032**	**100%**

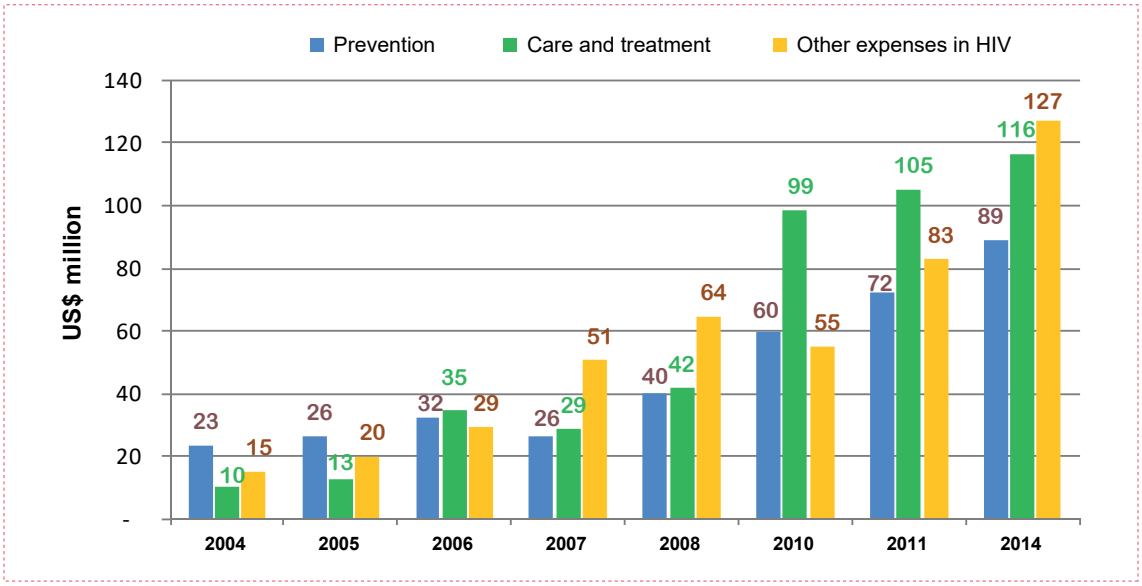
Other expenses for HIV and AIDS in 2014 were: incentives for human resources ($19.6 million); favorable environment ($8.5 million); orphans and vulnerable children ($6.2 million); social services ($914,000); and last research ($214,000). The value for research was low because most of the spending financed by the United States Government was reported in the category of expenditure: ASC.04 for national coordination and system strengthening. Altogether, these five expense categories totaled $35.4 million in 2014.

Figure 13 shows the evolution of individualized HIV and AIDS spending on prevention, care and treatment.

Spending on prevention, care and treatment grew continuously over the years though spending on prevention increased 3.8 times compared to 2004, and 1.5 times compared to 2010. For care and treatment, the increase between 2004 and 2014 was spectacular, reaching 11.5 times, and between 2010 and 2014 increased 1.5 times.

The other expenses, which comprise the remaining six categories of expenditures, show a mixed trend. They fell between 2008 and 2010 and rose sharply between 2011 and 2014. Moreover, between 2011 and 2014, they contributed to the rapid growth of expenses for coordinating and strengthening the system.

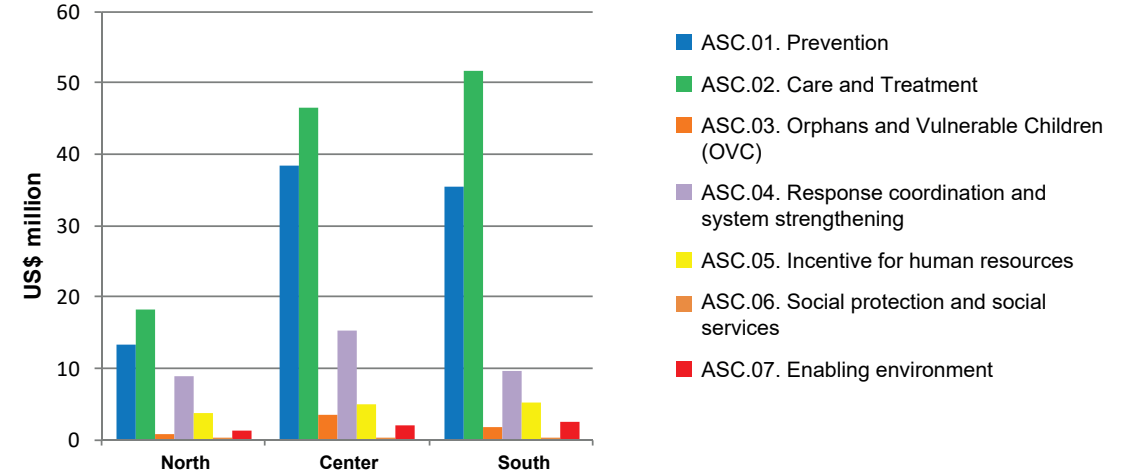
Figure 13: Trend of expenditures in main programmatic areas (2004-2014)



Source: CNCS, 2008 ; CNCS, 2010 ; CNCS, 2014b

Figure 14 shows the regional distribution of major AIDS spending categories, excluding national expenditure. The north, central and south absorbed, respectively, $47.6 million (17.6%), $111.3 million (42.1%) and $106.7 million (40.3%). Prevention programs in the north, central and south absorbed 29%, 34% and 33%, respectively, while care and treatment accounted for 39%, 42% and 48%, respectively. In the three regions, spending on care and treatment were greater than those of prevention. Notably, the costs for national coordination and system strengthening was higher in the central area ($15 million) while the northern area invested less money ($9 million) but proportionally more (19%) in this programmatic area.

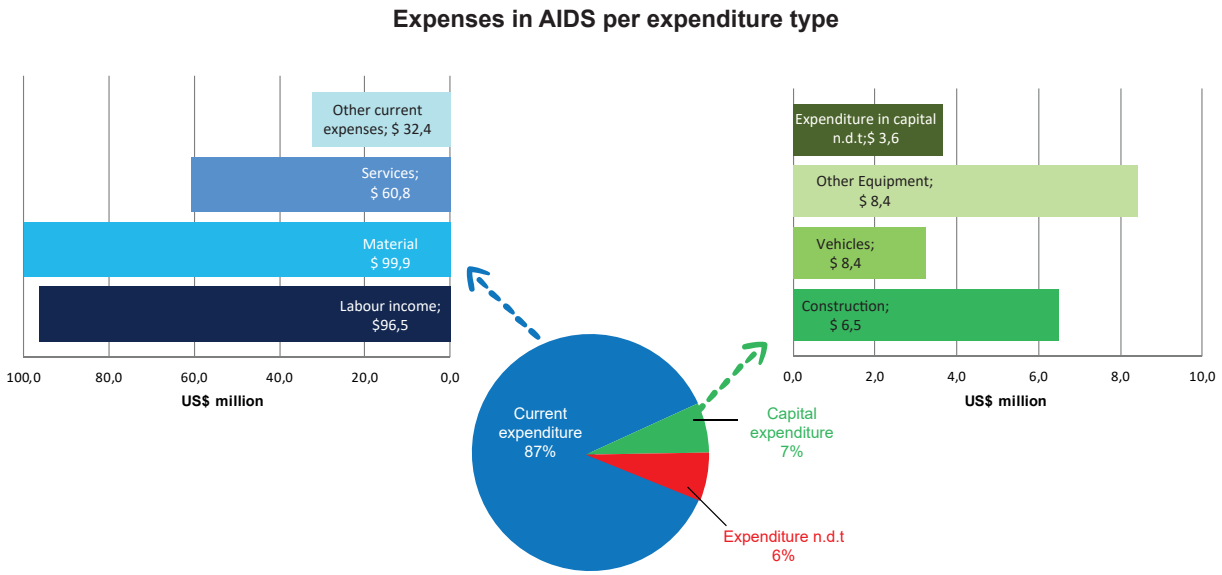
Figure 14: Expenditure in main programmatic areas per region (2014)



To carry out the program activities referred to above, production factors current expenses and capital expenditures were consumed. In 2014, current expenditures accounted for 87% of total spending. Capital expenditures absorbed 7%, and other expenses, 6%.

Capital expenditures are distributed between building ($6.5 million), vehicles ($3.2 million) and other equipment ($8.4 million). Capital expenditures not-disaggregated-by-type totaled $3.6 million in 2014.

Figure 15: Expenditure in HIV and AIDS per production factor



With regard to capital expenditures, Zambezia Province benefited the most ($4.9 million), followed by Tete ($2.7 million) and Maputo City ($2.5 million). Three provinces Nampula, Sofala and Gaza consumed about $2 million each. Manica consumed $1.6 million, and Maputo Province, $1.3 million, while Inhambane and Cabo Delgado got less than $1 million each. Niassa benefited the least in terms of capital investment ($344,000).

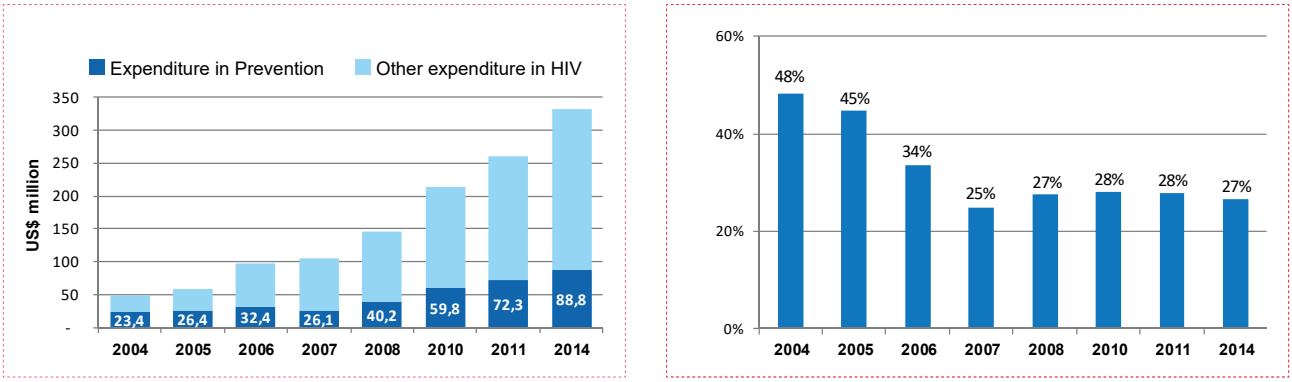
Table 11: **Total HIV expenditure per type of imput and per province, 2014, US$**

Provinces	Current Expenditure	Expenditure in Capital	Expenditure not disaggregated	TOTAL
Cabo Delgado	11 127 609	426 310	617 512	12 171 431
Gaza	30 543 582	2 070 973	1 391 641	34 006 196
Inhambane	11 381 629	734 913	835 392	12 951 934
Manica	14 870 873	1 566 368	1 475 583	17 912 824
Maputo City	28 567 531	2 481 443	936 718	31 985 692
Maputo Province	25 231 020	1 258 078	1 310 754	27 799 852
Nampula	22 334 008	2 263 499	1 631 774	26 229 281
Niassa	7 572 700	344 978	293 463	8 211 141
Sofala	24 899 298	2 181 242	2 575 346	29 655 886
Tete	16 048 795	2 694 171	894 882	19 637 848
Zambezia	37 902 449	4 917 262	1 315 667	44 135 378
National level	58 897 744	841 016	7 925 628	67 664 388
Not disaggregated by Prinvice	123 560		17 605	141 165
Grand Total	**289 500 798**	**21 780 253**	**21 221 965**	**332 503 016**

3.3.1. Expenditure on HIV Prevention

Since 2004, expenditures on prevention increased in from $23.4 million to $88.8 million in 2014, representing 27% of total expenditures in 2016.

Figure 16: **Expediture and percentage of expenditure with prevention, 2004 - 2014**



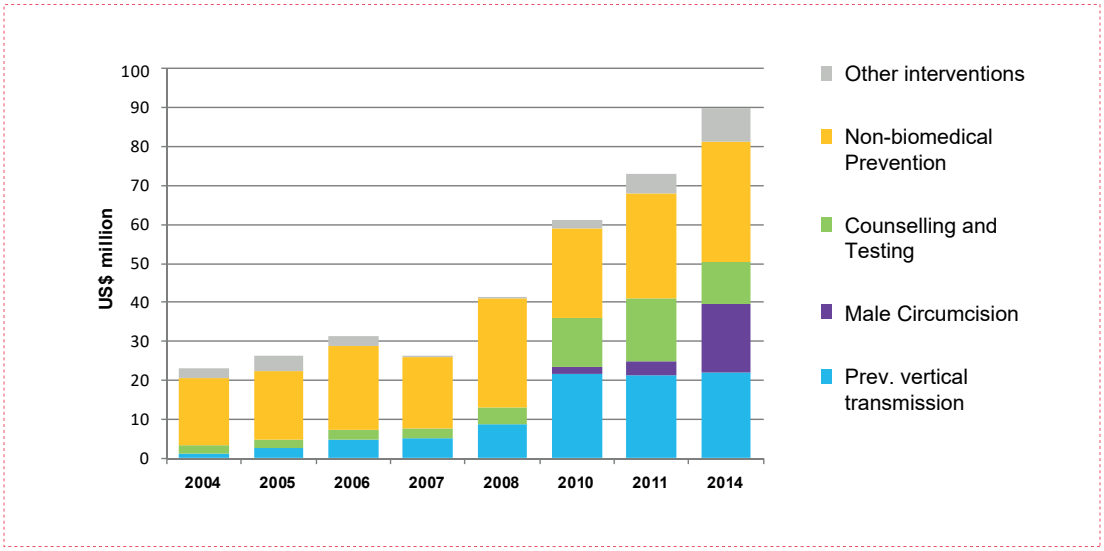
Source: CNCS, 2008 ; CNCS, 2010 ; CNCS, 2014b

Although, in absolute terms, spending on prevention programs increased, the proportion of resources directed to prevention fell from 48% in 2004 to 28% in 2010 and 2011, and 27% in 2014.

This trend is explained by the increased financial burden of care and treatment in the response to HIV and AIDS and by the evidence about the impact of treatment on reducing the incidence. The importance of coordination and response-system reinforcement also increased, contributing to the reduction in the relative weight of prevention in total spending.

The development of expenditures on prevention in its main components (Figure 17 - 2011 and 2014) shows a stabilization in spending for the prevention of vertical transmission and for non-biomedical prevention, a contraction in counseling, and testing and a huge expansion in male circumcision

Figure 17: Expenditure with prevention, main components, 2004 - 2014

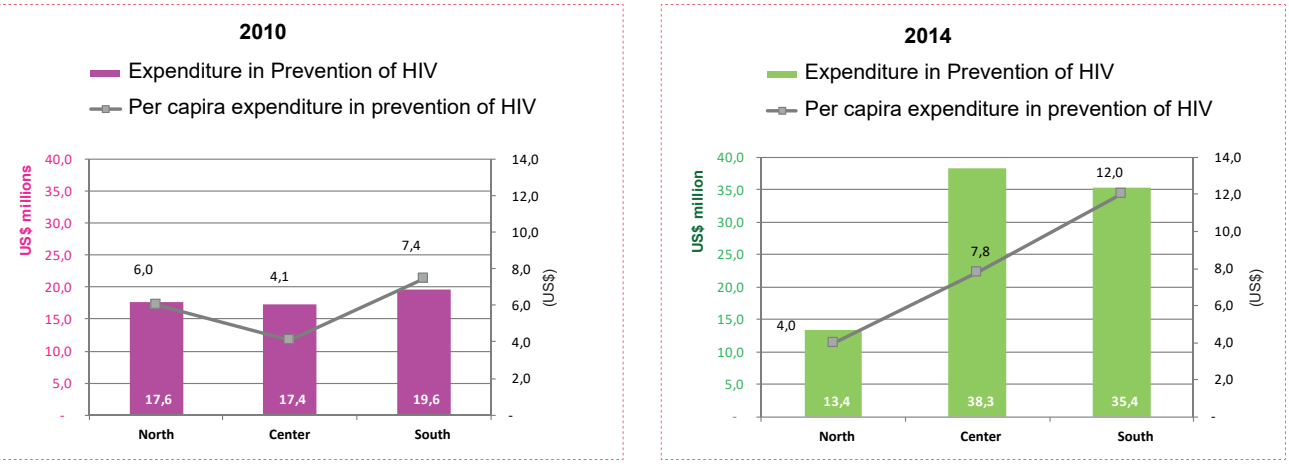


Source: CNCS, 2008 ; CNCS, 2010 ; CNCS, 2014b

In 2014, spending on prevention in the south and center reached was nearly the same while the north absorbed only about a third of that level (Figure 18).

From 2010 to 2014, spending increased significantly in the center and south. Absolute expenditures more than doubled in the center, grew 80% in the south, but decreased 24% in the north. Per capita expenditures followed the same trend although to a lesser extent in the center (+90%) and south (+62%) while, in the north, they fell 33%.

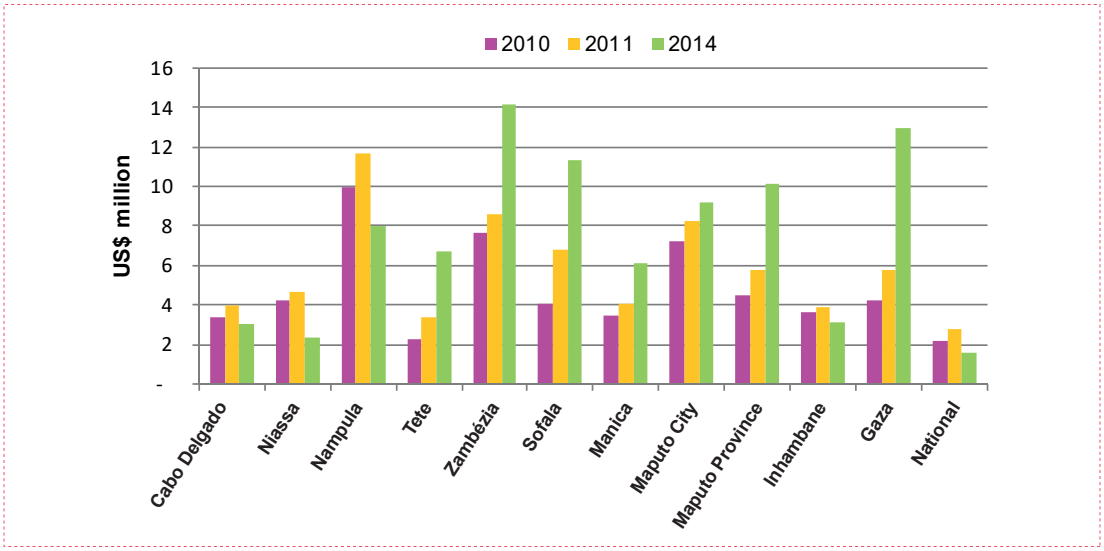
Figure 18: Expenditure in prevention per region and per capita, 2010 and 2014



Source: CNCS, 2008 ; CNCS, 2010 ; CNCS, 2014b

Despite the overall growth, the distribution of spending on prevention by province shows different developments (Figure 19). in both Nampula and Niassa provinces, spending fell by $1.9 million; in Cabo Delgado, it fell by $307,000; and Inhambane by nearly $3 million. In all other provinces, spending on prevention grew between 2010 and 2014, with the biggest percentage increases in Gaza, Tete, Sofala and Maputo.

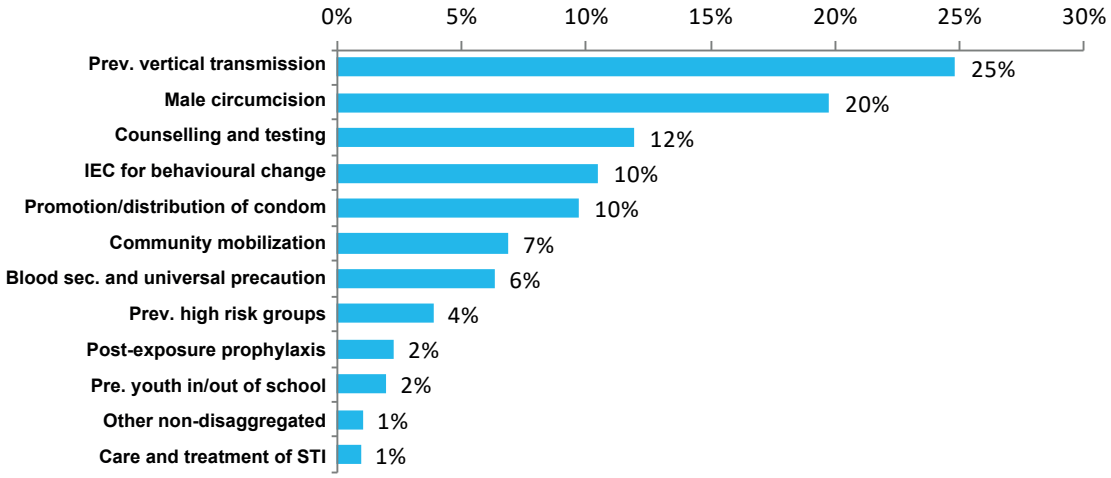
Figure 19: Expenditure in prevention per province, 2010, 2011 and 2014



For 2014, the spending for HIV prevention programs were disaggregated by intervention (Table 12). This is the direct result of improvements in the collection and disaggregation of information.

In 2014, an analysis of spending on prevention by component indicates that 55% of expenditures were dedicated to prevention of sexual transmission (male circumcision, IEC for behavior change, promotion of condom distribution, community mobilization, prevention of high-risk populations, PEP, young people in and out of school, other prevention programs (not disaggregated), and care and treatment of STIs). These interventions are crucial to reducing the number of new infections and deserve a more detailed analysis.

Figure 20: Distribution of expenditure in prevention per intervention, 2014



By region and category, spending on prevention on HIV and AIDS shows that PMTCT is one of the interventions which absorbed an important part of the 2014 resources in all three regions. In 2011 to 2014, male circumcision saw the greatest increase and is an important part of the expenditures in the central and southern regions. Other expenditures for the prevention of sexual transmission in the center and south are double those in the north. In general, the allocation of resources for programs linked to high-risk populations is very low in the three regions.

Figure 21: Expenditure in prevention per region and intervention, 2014

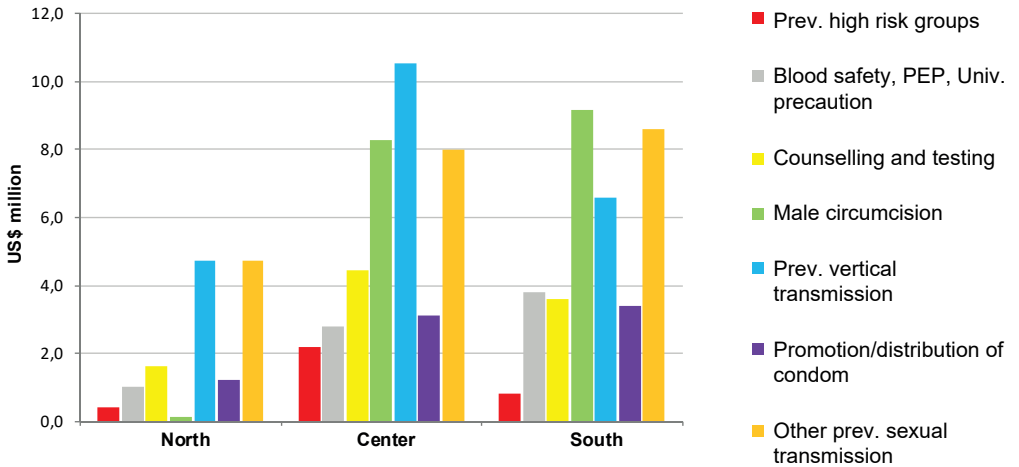


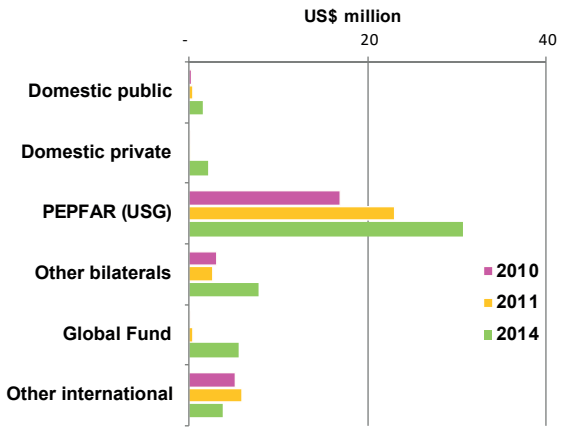
Table 12: Detail of expenditures in HIV prevention, 2010 – 2011 - 2014

Expenditure in Prevention	2010		2011		2014	
	US$	%	US$	%	US$	%
ASC.01.01 Communication for behavioral change	6 104 552	10,21%	8 157 014	11,29%	5 740 955	6,47%
ASC.01.02 Community mobilization	2 700 134	4,52%	4 350 057	6,02%	6 106 704	6,88%
ASC.01.03 Counseling and testing (ATS)	11 335 095	18,96%	15 654 099	21,66%	9 668 184	10,89%
ASC.01.04 Prevention for vulnerable or accessible populations	3 011 855	5,04%	2 780 988	3,85%	2 837 108	3,20%
ASC.01.05 Prevention, youths at school	2 781 247	4,65%	2 835 703	3,92%	1 359 763	1,53%
ASC.01.06 Prevention, youths out of school	422 870	0,71%	935 593	1,29%	366 318	0,41%
ASC.01.07 Prevention for PLWHIV	142 807	0,24%	444 002	0,61%	466 468	0,53%
ASC.01.08 Prevention for sex workers and their clients	748 684	1,25%	1 399 822	1,94%	2 858 937	3,22%
ASC.01.09 Prevention for men who have sex with men	72 916	0,12%	95 090	0,13%	205 742	0,23%
ASC.01.10 Prevention for people who inject drugs	409 397	0,68%	317 278	0,44%	357 498	0,40%
ASC.01.11 Prevention at work place	634 581	1,06%	385 644	0,53%	2 101 678	2,37%
ASC.01.12 Social marketing of condoms	5 797	0,01%		0,00%	5 513 784	6,21%
ASC.01.13 Distribution of male condoms					2 125 661	2,39%
ASC.01.14 Distribution of female condom					90 473	0,10%
ASC.01.16 Prevention and treatment of STIs	566 629	0,95%	862 443	1,19%	832 940	0,94%
ASC.01.17 Elimination of vertical transmission (ETV)	21 701 663	36,30%	21 444 945	29,68%	22 062 943	24,85%
ASC.01.18 Male circumcision	1 627 531	2,72%	3 531 622	4,89%	17 565 051	19,78%
ASC.01.19 Blood Safety	734 450	1,23%	984 315	1,36%	2 753 147	3,10%
ASC.01.21 Universal precaution	244 976	0,41%	1 546 340	2,14%	2 872 352	3,23%
ASC.01.22 Post-exposition prophylaxis	728 271	1,22%	1 425 234	1,97%	2 009 154	2,26%
ASC.01.98 Prevention n.d.t	5 812 719	9,72%	5 110 465	7,07%	896 263	1,01%
Total	**59 786 174**	**100,00**	**72 260 654**	**100,00**	**88 791 123**	**100,00**

Prevention of Sexual Transmission

As proposed above, in the categorized interventions such as prevention of sexual transmission, it appears that the increase in spending on prevention of sexual transmission between 2010 and 2014 (+$25.7 million) was due to the increase of funding from the US government (+ $13.7 million), the Global Fund (+$5.5 million) and other bilateral donors (+$4.7 million). The investment by other multilateral entities fell by 45% between 2010 and 2014, i.e., $1.5 million less. The US government's contribution of the growth resulted from the increased support for male circumcision (+ $15.8 million), community mobilization (+ $3.1 million) and post-exposure prophylaxis (+ $1.3 million). Half of the spending with post-exposure prophylaxis was for cases of sexual violence. In the same period, spending funded by PEPFAR for activities related to behavioral change fell by $7.0 million.

Figure 22: **Expenditure on prevention of HIV sexual transmission by source and year**



Between 2010 and 2014, the Global Fund's contribution increased by $5.5 million for communication programs for behavioral change.

For the provision of services related to the prevention of sexual transmission, the role of providers changed gradually, with a substantial increase in the public sector, which, between 2010 and 2014, more than doubled in value while increasing its proportion from 26% to 44% for the prevention of sexual transmission. Though domestic private entities increased spending by 60%, the proportion of expenditures made through domestic private entities for the prevention of HIV sexual transmission fell from 47% to 37% between 2010 and 2014. The private international entities increased their total expenditures for prevention of sexual by 34% between 2010 and 2014, but proportionally their contribution fell from 25% to 17% because overall expenditure for prevention of sexual transmission grew sharply (Figure 23).

Figure 23: **Expenditures allocated to prevention of HIV sexual transmission by year and service provider**

The increase in the relative importance of the public sector in 2014 is inextricably linked to the growth of male circumcision in public health facilities, though with full financial support from PEPFAR. As mentioned, PEPFAR has absorbed 20% of spending on prevention of sexual transmission.

In the south and center, spending for the prevention of sexual transmission shows similarities in the programmatic breakdown of the level of expenditures by categories, whereas the north spent less on every category (Figure 24). In fact, proportionately, most spending occurs in the south (44%) and center (43%) in line with the new infections recorded in those areas, 41% and 40%, respectively (Figure 25). Male circumcision stands out as the most important measure, followed by communication for behavioral change and the distribution of condoms.

Comparing the evolution of the distribution of expenditure on sexual-transmission activities with the incidence of HIV/AIDS in each region, it appears that 2014 improved the geographical distribution of resources compared to 2010. In 2010, the center and the south had higher incidences but less spending than the north, whereas, in 2014, the volume of spending in each region is more correlated with the incidence of HIV/AIDS in each region.

Figure 24: Expenditure in prevention of sexual transmission per type of intervention and region - 2014

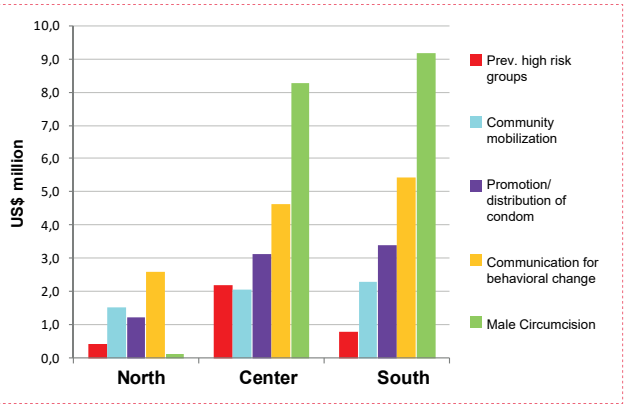
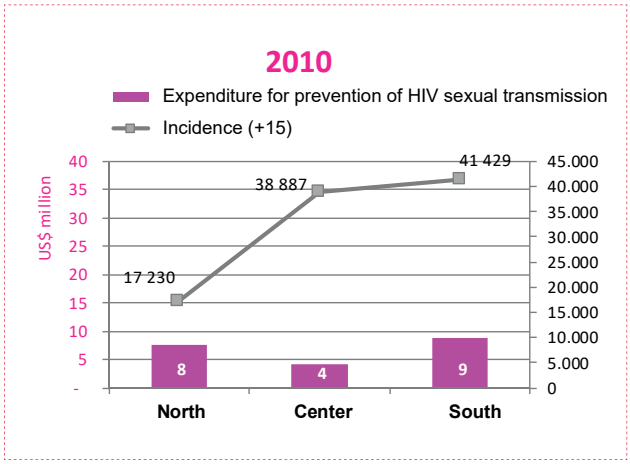
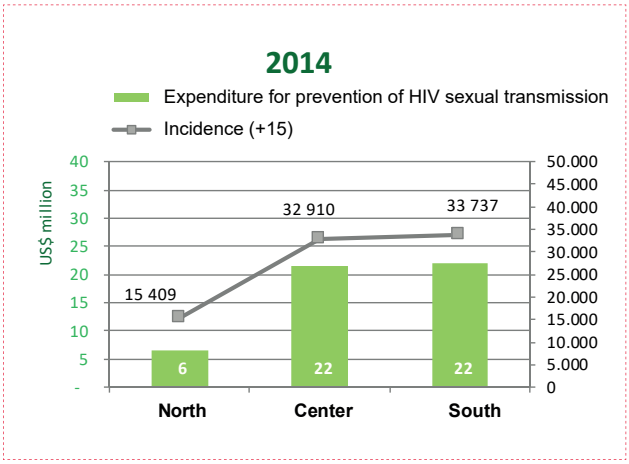


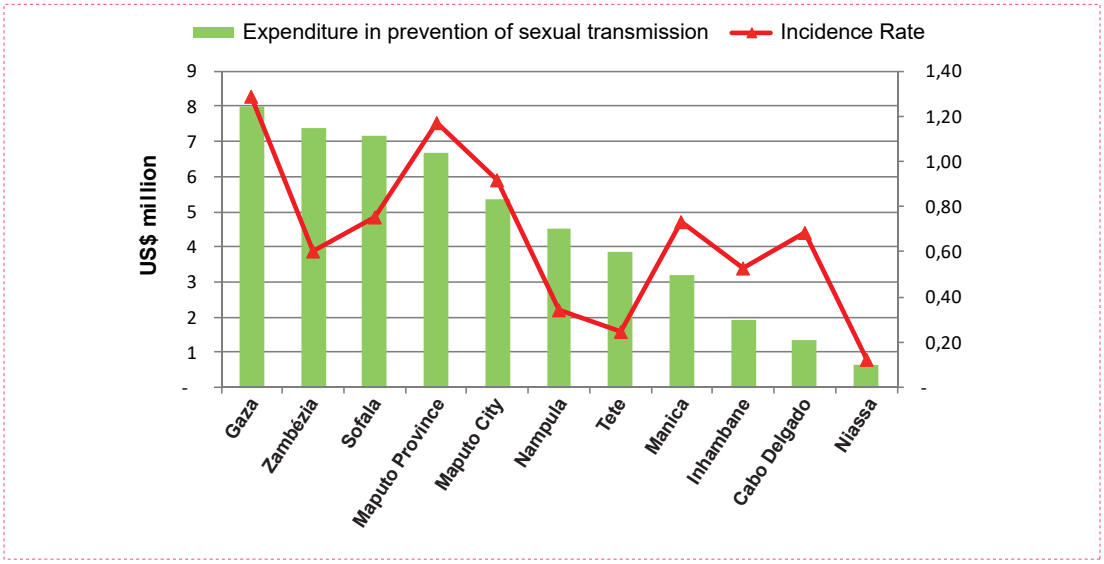
Figure 25: Expenditure for prevention of sexual transmission and incidence per region, 2010 and 2014





In analyzing the provincial distribution of spending for the prevention of sexual transmission compared to the incidence rate, it appears that the trend toward a balance between regions, disguises big differences between provinces, e.g., though the provinces of Cabo Delgado, Inhambane and Manica had high incidence rates, they were neglected in 2014 and received much less than the other provinces.

Figure 26: **Proportion of expenditure in prevention of sexual transmission and incidence rate per province - 2014**



On the other extreme, Nampula, Zambezia and Sofala proportionally spent more compared to the incidence rate. In Nampula and Zambezia, the size of their populations may be one reason. Zambezia benefited from 15% of spending on prevention of sexual transmission and recorded 18% of new infections.

Table 13: **Expenditure in prevention of sexual transmission, *per capita* and per province, 2014**

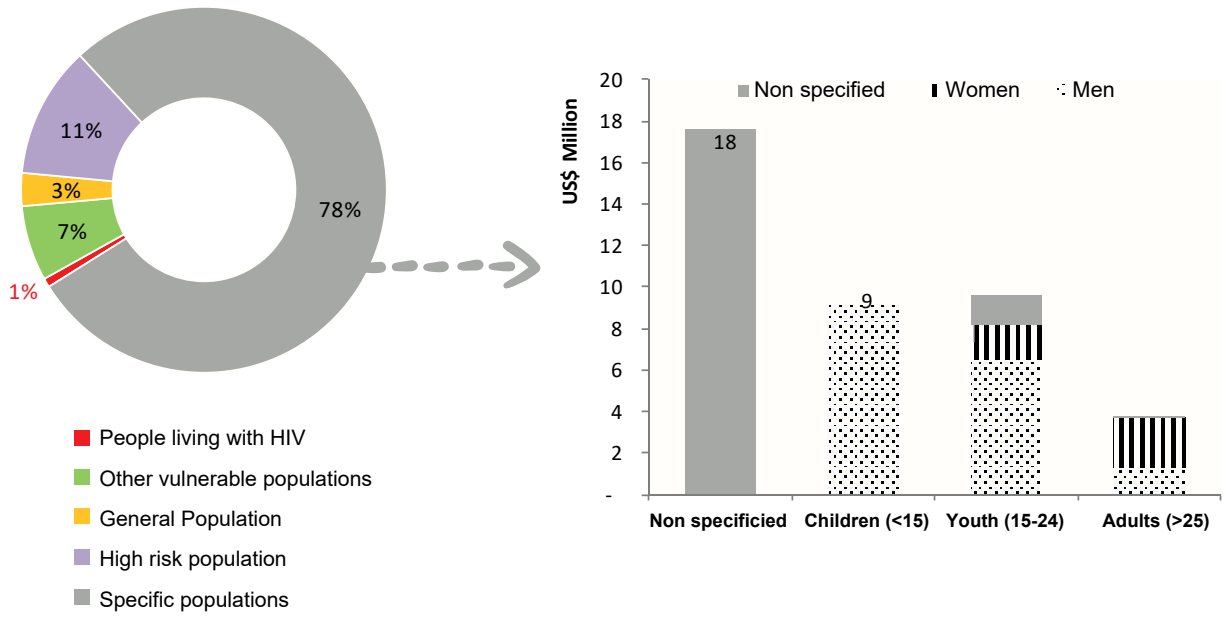
Geographic Distribution	Expenditure		New Infections (+15)		Incidence Rate	Population (+15)	Expenses per capita (+15)
	US$	%	Number	%			US$
Northern region	6 486 317	13%	15 409	19%	0,4	3 978 949	$1,6
Cabo Delgado	1 329 213	3%	6 575	8%	0,7	956 173	$1,4
Niassa	651 670	1%	853	1%	0,1	702 205	$0,9
Nampula	4 505 434	9%	7 981	10%	0,3	2 320 571	$1,9
Central region	21 590 572	43%	32 910	40%	0,6	5 685 176	$3,8
Tete	3 857 849	8%	2 932	4%	0,2	1 184 673	$3,3
Zambezia	7 378 013	15%	15 106	18%	0,6	2 497 507	$3,0
Manica	3 183 723	6%	6 864	8%	0,7	938 023	$3,4
Sofala	7 170 987	14%	8 008	10%	0,8	1 064 973	$6,7
Southern region	21 944 279	44%	33 737	41%	1,0	3 509 467	$6,3
Inhambane	1 935 495	4%	5 365	7%	0,5	1 011 064	$1,9
Gaza	8 006 500	16%	11 464	14%	1,3	888 493	$9,0
Maputo Province	6 656 912	13%	9 834	12%	1,2	837 880	$7,9
Maputo City	5 345 372	11%	7 074	9%	0,9	772 030	$6,9
Total	**50 021 168**	**100%**	**82 056**	**100%**	**0,6**	**13 173 592**	**$3,8**

In 2014, of from the expenditure for prevention of sexual transmission, 78% was for the general population, 11% for specific populations, 3% for vulnerable populations, 7% for high risk populations, and 1% for people living with HIV and AIDS (Figure 27).

From the 78% spent to prevent sexual transmission among the general population, 44% ($18 million) could not be disaggregated by gender or age, 23% ($9 million) was for children (<15 years), and 24% ($9.6 million) was for young people (i.e., young males (68%), young women (17%), and young people not disaggregated by gender (15%). Within the expenditure for prevention of HIV sexual transmission ($18 million), only 10% ($4 million) specifically targeted young girls and women.

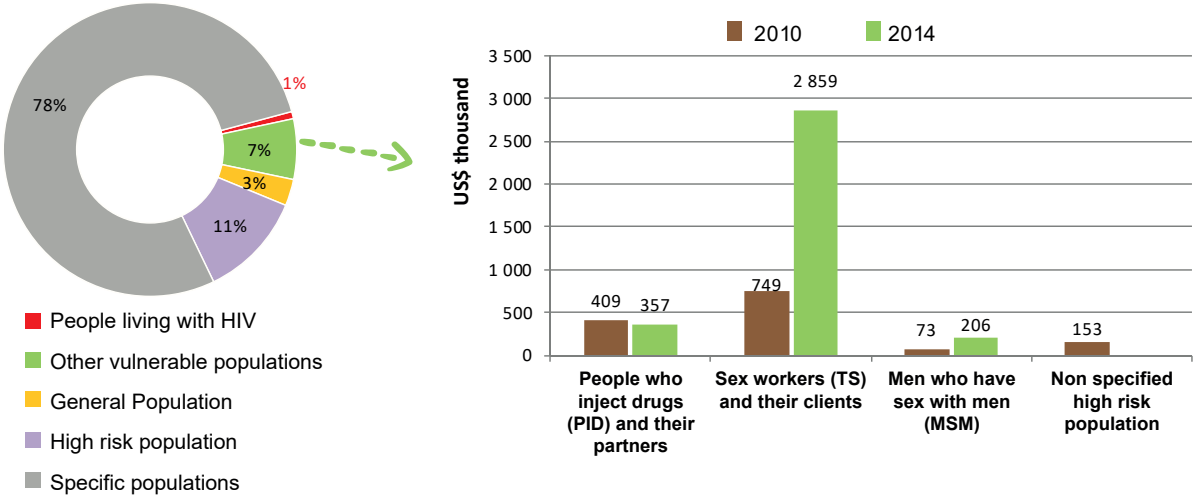
Expenditures for the general population not disaggregated by gender or age were for condoms ($7.7 million), community mobilization ($5.8 million), and communication for behavioral change ($2.6 million).

Figure 27: **Expenditure in prevention of sexual transmission for beneficiary populations (general population), 2014**



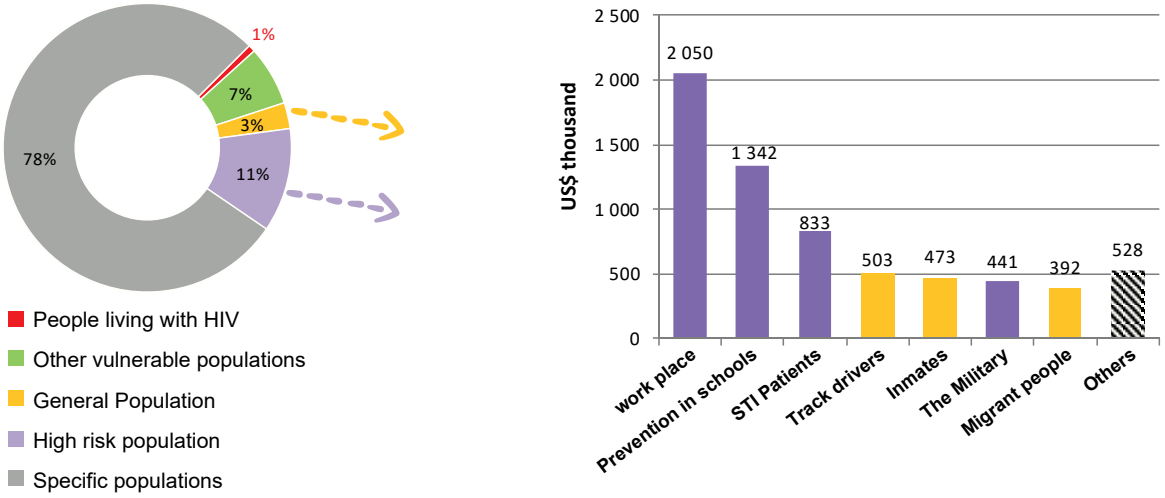
In 2014, high-risk populations consumed only 7% of spending, of which, 84% was allocated to prevention programs benefiting sex workers and their clients though, in 2013, this group accounted for 18% of new infections (Figure 28). Though this group of beneficiaries saw spending increase almost four times between 2010 and 2014, reaching $2.8 million. This amount is still woefully inadequate, particularly when compared to the projections of the PEN IV, which considers $6 million to be needed in 2019 (in total $21 million between 2015 and 2019) to reach 60% of sex workers and their clients. Compared to total spending on HIV and AIDS, this is but a scant expansion in resources though it might reduce new infections significantly. According to the impact estimates in PEN IV, achieving such coverage could help to prevent 16% of new infections nationwide and up to 32% of new infections in the north (Korenrump et al. 2015).

Figure 28: **Expenditure in prevention of sexual transmission and beneficiary population (high risk population), 2014**



To prevent sexual transmission in 2014, the other vulnerable and specific populations together absorbed 14% of expenditures ($6.6 million) (Figure 29). The beneficiaries of prevention in the workplace benefited most, consuming 31% of spending ($2 million), followed by students (prevention in schools) and patients with STI, which absorbed, respectively, 20% ($1.3 million) and 13% ($0.8 million) in 2014. Each of the remaining beneficiary populations had rather similar spending levels, with each consuming between 6% and 8% in 2014.

Figure 29: **Expenditure in prevention of sexual transmission and beneficiary populations (specific and vulnerable population), 2014**



The evaluation data show that, among the overall spending on prevention of sexual transmission by province, expenditure targeting children accounted for 32% in Gaza, 29% in Maputo City, 27% in Sofala, 25% in Zambezia and 25% in Maputo (Table 14). However, in Niassa, Inhambane, and Cabo Delgado provinces, there are no records of the expenditures to prevent sexual transmission among children. These three provinces do not have male circumcision programs.

Expenditures on programs to prevent sexual transmission by or to adult males are primarily distributed for male circumcision programs, followed by prevention in the workplace, activities promoting behavioral change in the general population, programs for migrants, soldiers and long-haul truck drivers.

Table 14: Proportion of exenditure for prevention of HIV sexual transmission per age groups and per province, 2014

Provinces	Adults	Children	Not disaggregated
Cabo Delgado	47%	0%	53%
Gaza	44%	32%	24%
Inhambane	41%	0%	59%
Manica	52%	11%	38%
Maputo City	36%	29%	35%
Maputo Province	40%	25%	35%
Nampula	26%	0%	73%
Niassa	38%	0%	62%
Sofala	48%	27%	24%
Tete	66%	6%	28%
Zambezia	47%	25%	28%
Total	**44%**	**20%**	**36%**

Male Circumcision

Regarding male circumcision, 52% of the spending in 2014 benefited children (under 15 years) in 2014 (Table 15). Although this is an investment for the future, in the short term it will have little impact on reducing new infections since children accounted for only 8% of new infections in 2014. On the other hand, the sexually active age group (adults and young people over 15 years old) consumed, by value, 45% of services, whereas adults used only 8%.

Table 15: Expenditure for male circumcision per age groups and province, 2014

Region/Province	Adults (>25)	Youth (15-24)	Boys (<15)	n.d.a*	TOTAL
North	12 322	38 545	10 277	52 824	113 968
Cabo Delgado				16 536	16 536
Nampula	12 322	38 545	10 277	28 526	89 670
Niassa				7 762	7 762
Center	745 104	3 557 319	3 720 579	239 167	8 262 169
Manica	121 808	609 232	295 298	31 786	1 058 124
Sofala	234 519	1 017 610	1 649 785	71 116	2 973 030
Tete	59 627	259 708	216 846	29 200	565 381
Zambézia	329 150	1 670 769	1 558 650	107 065	3 665 634
South	561 069	2 958 715	5 372 050	258 394	9 150 228
Gaza	190 532	1 630 418	2 540 446	91 972	4 453 368
Inhambane				18 519	18 519
Maputo City	214 073	554 933	1 236 838	79 582	2 085 426
Maputo Province	156 464	773 364	1 594 766	68 321	2 592 915
Total	**1 318 495**	**6 554 579**	**9 102 906**	**550 385**	**17 526 365**

** Not disaggregated by age*

The distribution of spending by province shows that, in 2014, Cabo Delgado, Niassa and Nampula in the north and Inhambane in the south spent little or nothing on male circumcision. The negligible spending on male circumcision in the north and in Inhambane can be justified since, there, traditional circumcision is a very common cultural practice. In the three other southern provinces, the expenses were always above the targets whereas the remaining four provinces were about on target. The provinces of Gaza (25%) and Zambezia (21%) spent the most on male circumcision and also benefited most from the 2014 capital investment (Figure 31).

In 2016, capital expenditure (investment) represents 24% of total expenditures on male circumcision while salaries absorbed another 25%. Capital investment and salaries thus correspond to half of the expenditures on male circumcision.

Figure 30: Proportion distribution of expendures for male cirucumcision and targets per province, 2014

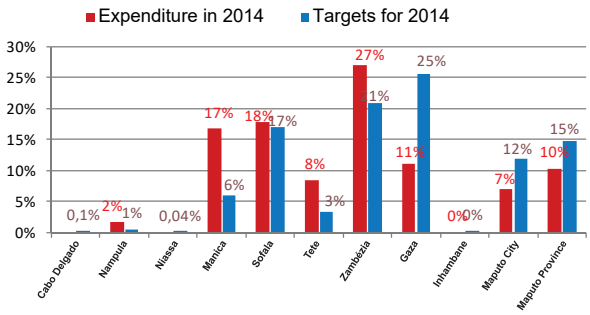
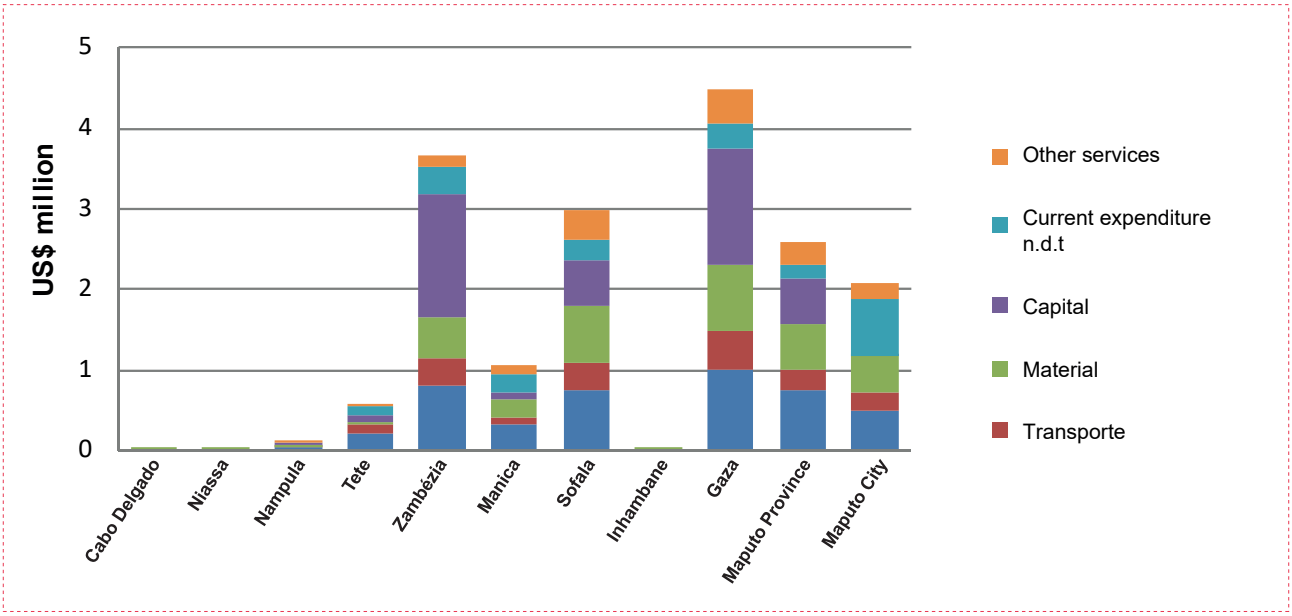


Figure 31: Expenditure on male circumcision per production factor and per province, 2014



The 2014 Report of the National STI and HIV Program stresses the need to strengthen the creation of demand to achieve the targets for male circumcision This will require greater investment at the community level and should be done without cutting necessary expenses in health facilities. In 2014, the expenditures on male circumcision by health units represented only 4% of total expenditures.

The per unit expenditure (i.e., for one circumcised person) is quite high, reaching a national average of $108, compared to $45.32 in other countries in the region - Cost per male circumcision using the PrePex device adjusted for complications indicates that there is also scope to improve efficiency by through economies of scale to reach more people with the same amount of resources (Avenir Health 2016).

In general, increased spending on prevention of sexual transmission is necessary. Despite increases in funding for ART and male circumcision ART and male circumcision programs have not yet reached the coverage necessary to achieve effective significant reduction of new infections. In fact, the CM coverage remains low in the central and southern regions. Moreover, treatment has low retention levels and, hence, inadequate suppression of the patient's viral load. These deficiencies impede attempts to reduce new HIV infections.

Condoms

Compared to past NASA, information gathered about the public distribution and social marketing of condoms has improved although it was impossible to disaggregate the beneficiary populations. The information used to estimate the costs of public distribution was provided by the Provincial Nucleus for the Fight against HIV and AIDS in collaboration with the Provincial Depots drugs and the MoH. Most condoms were distributed by the provincial deposits, and the remainder were assumed to have been distributed by the reproductive health program.

The main sources of funding in 2014 were the Government of the Netherlands (61%) and out-of-pocket expenditures by households (19%).

The Netherlands Government bore most of the social marketing costs for condoms ($5.5 million in 2014) while families purchased $1.7 million worth of Jeito condoms (the most popular brand) in stores.

The public distribution of condoms for $1.6 million was supported primarily by the contributions from the US Government and the United Nations Fund for Population Activity (UNFPA).

The evaluation data suggests a good alignment between spending on condoms and the regional distribution of new infections through sexual transmission. Since 2014, the south and center both had about 31,000 new infections and both spent $3.8 million on condoms. Compared to the south and center, the north had about half as many new infections and also spend a third as much.

By province, the distribution of expenditures on condoms compared to new infections through sexual transmission suggests room for improvement. Clearly, Zambezia, with 18% of new infections and 11% of spending, and Gaza, with 13% of new infections and 7% of spending contrast with Maputo City, with 9% of new infections and 14% of spending, or Tete, with 4% of new infections and 9% of the resources. These extreme cases are examples.

Figure 34: Percentage distribution of expenditure with condoms and new infections due to sexual transmission per province, 2014

Table 16: Funding sources for condoms, US$, 2014

Funding Sources	US$	%
The Government of Netherlands	5 425 562	61%
Households	1 730 343	19%
United States Government	835 095	9%
UNFPA	754 624	8%
Other international organizations	138 616	2%
State Budget	3 481	0%
Total	**8 887 721**	**100%**

Figure 32: Expenditure with condoms, 2014

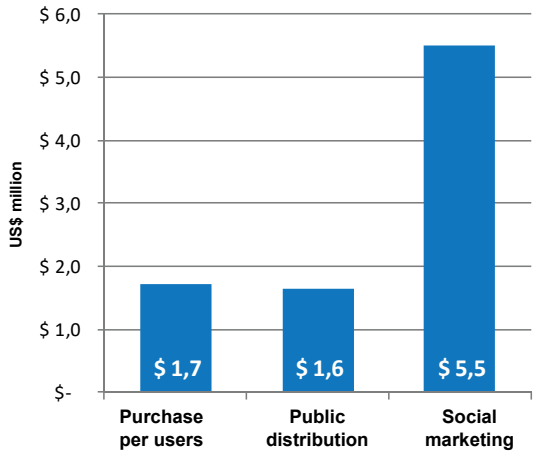


Figure 33: Expenditure with condoms and new infections per sexual transmission, per region, 2014

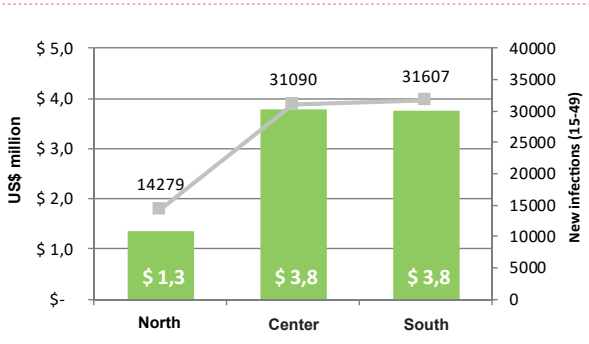
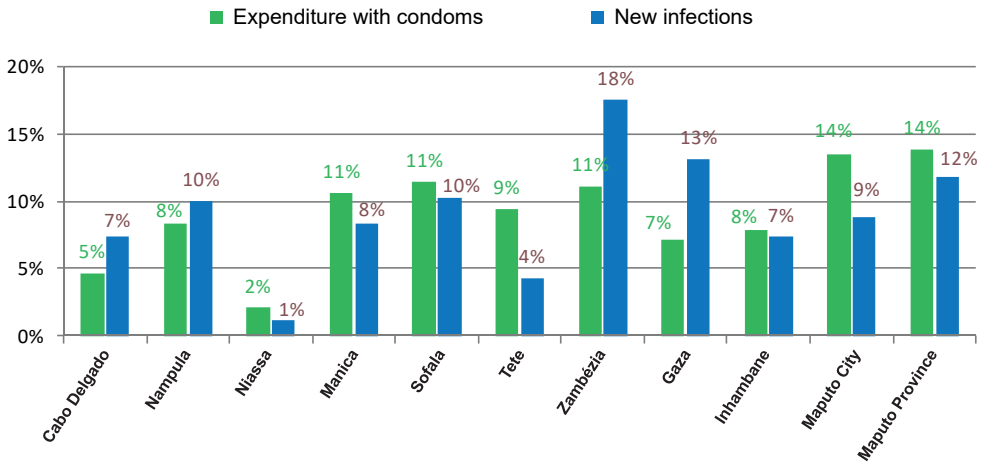


Figure 34: **Percentage distribution of expenditure with condoms and new infections due to sexual transmission per province, 2014**

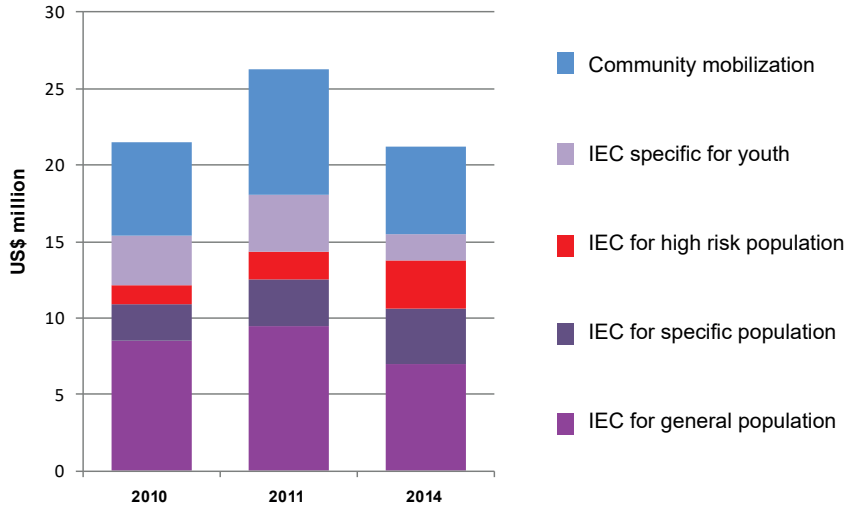


Activities aimed at behavioral change

For purposes of this analysis, the activities aimed at behavioral change include information, education and communication (IEC) to mobilize communities and change behavior in the general, specific, young and high--risk populations.

Spending on behavioral change fell 19% from $26.2 million in 2011 to $21.2 in 2014, the latter being close to the $21.5 million spent in 2010.

Figure 35: **Expenditure aimed at behavioral change per type of intervention**



In 2014, community mobilization absorbed 27% ($5.7 million) of spending for behavioral change, while 73% ($15.5 million) was allocated to IEC and directed at various population groups. Of this, 45% ($7 million) was for activities forthe general population, 20% ($3.2 million) for high-risk populations, 23% ($3.6 million) for other accessible populations, and 11% ($1.7 million) for young people.

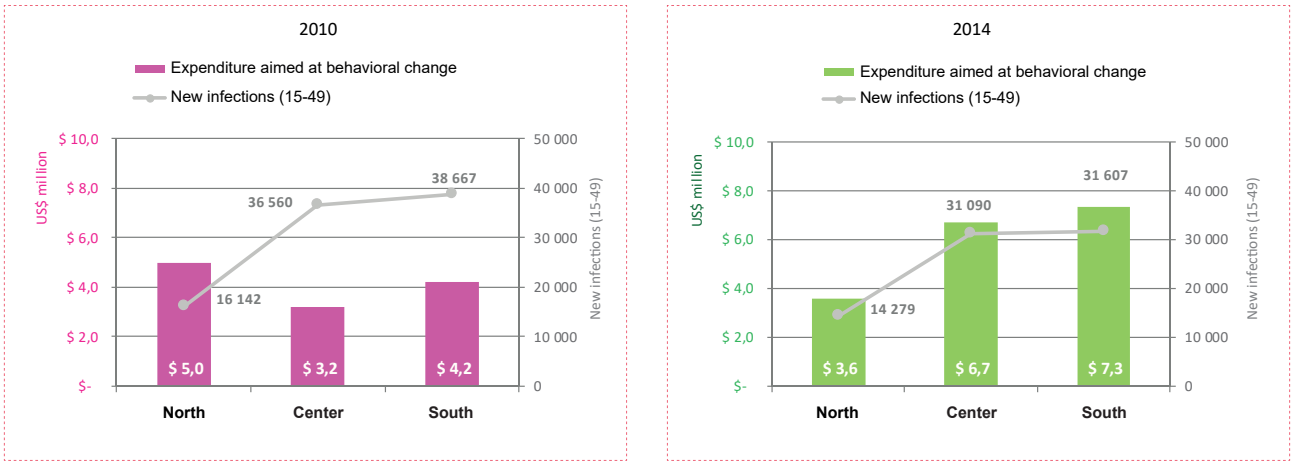
Between 2011 and 2014, expenditures on IEC for behavioral change in the general population and IEC activities for young people shrank whereas expenditures on prevention for high-risk populations increased substantially, particularly expenditures to change the behavior of sex workers and their clients.

In 2014, the activities aimed at behavioral change were mainly funded by foreign aid (95%). PEPFAR funded 48% of the expenditures, the Global Fund 23%, and all other international sources, 24%. Between 2010 and 2014, costs incurred by the US government were reduced by 29% (- $3.3 million) but were compensated for by the Global Fund's entry as a financial source in 2011. For example, in 2014, the Global Fund contributed $5 million.

In 2014, most of the expenditures aimed at behavioral change (74%) were for services provided by national private entities. Public providers accounted for 6% of the expenditure, international private organizations, 14%, and multilateral or bilateral agencies, 6%. The services provided by private national providers increased by 0% between 2010 and 2014 while those provided by international private agencies fell by 51%.

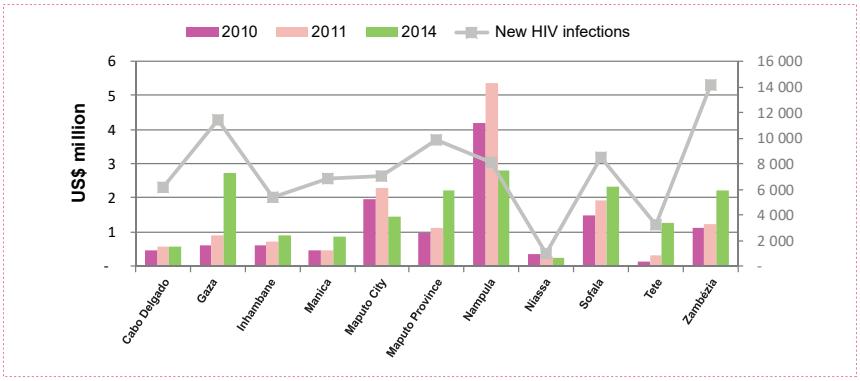
The set of interventions aimed at behavioral change and the distribution of resources (expenses) improved between 2010 and 2014 (Figure 36). Distortions recorded in 2014 were corrected because, as a proportion of national values, the volume of expenditure in each region is approximately the same as the number of new infections there.

Figure 36: **Expenditure aimed at behavioral change and new infections per region, 2010 and 2014**



Regarding the number of new infections in 2014, Figure 36 also shows a better distribution of expenditure per province except Zambezia where the amount spent is proportionately much smaller than the number of new infections.

Figure 37: **Expenses aimed at behavioral change and new infections per province, 2010, 2011 and 2014**

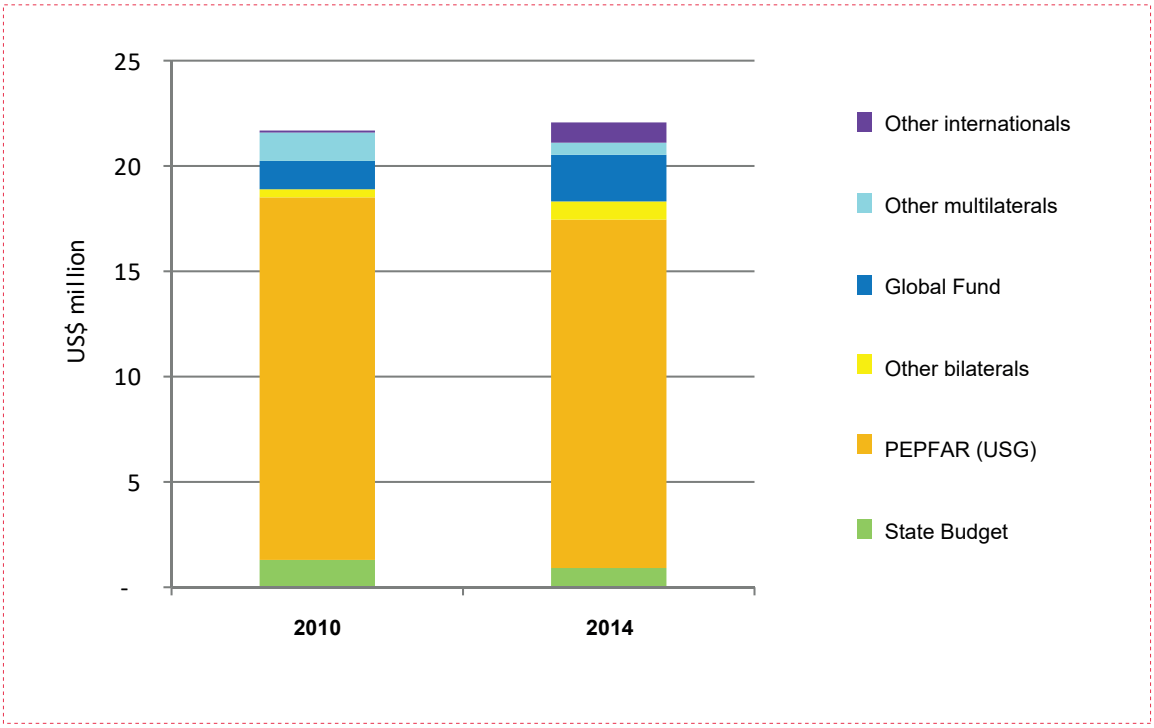


Prevention of Mother-To-Child Transmission (PMTCT)

Within the framework of the prevention of vertical HIV transmission, the country developed in 2013 the plan to eliminate HIV mother-to-child transmission. In 2014, according to Figure 38, $22.1 million was spent in PMTCT compared to $21.7 in 2010 and $21.4 in 2011, representing an increase of only 1.7% between 2010 and 2014. Although the annual expenditure in PMTCT maintained the same level in 2010 and 2011 and slightly increased in 2014, the number of women in PMTCT (Table 18) grew steadily, rising from 22,694 (2010) to 50,554 (2011) and then to 94,879 (2014).

Interventions in this field were mainly funded by the US Government with $16.5 million in 2014 compared to $17.2 in 2010, a 4% reduction . The second most important esource was the Global Fund, contributing $2.2 million in 2014 and$1.3 in 2010, increasing the funding by 73%. The state budget contributed $1 million in 2014. Other international and bilateral organizations increased expenditures from 2010 to 2014.

Figure 38: **Expenditure in prevention of Mother-To-Child Transmission per funding source, 2010 and 2014**



In 2014 the PMTCT activities were mainly carried out by institutions in the public sector (80% of expenditure), followed by national and international NGOs (12%). In 2014, Options A for HIV-positive pregnant women continued to be available in many health facilities. However, most of these women benefited from Option B + (ART).

To provide services related to PMTCT in 2014, the counseling and testing of pregnant women consumed 30% of the expenses, the provision of antiretroviral prophylaxis 20%, prenatal, birthing and post-natal care for mothers, 17%, child care (13%) and testing (11%).

Figure 39: **Expenditure in PMTCT per type of Providers, 2014**

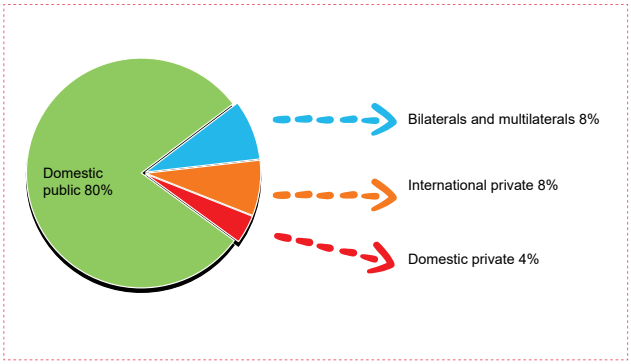


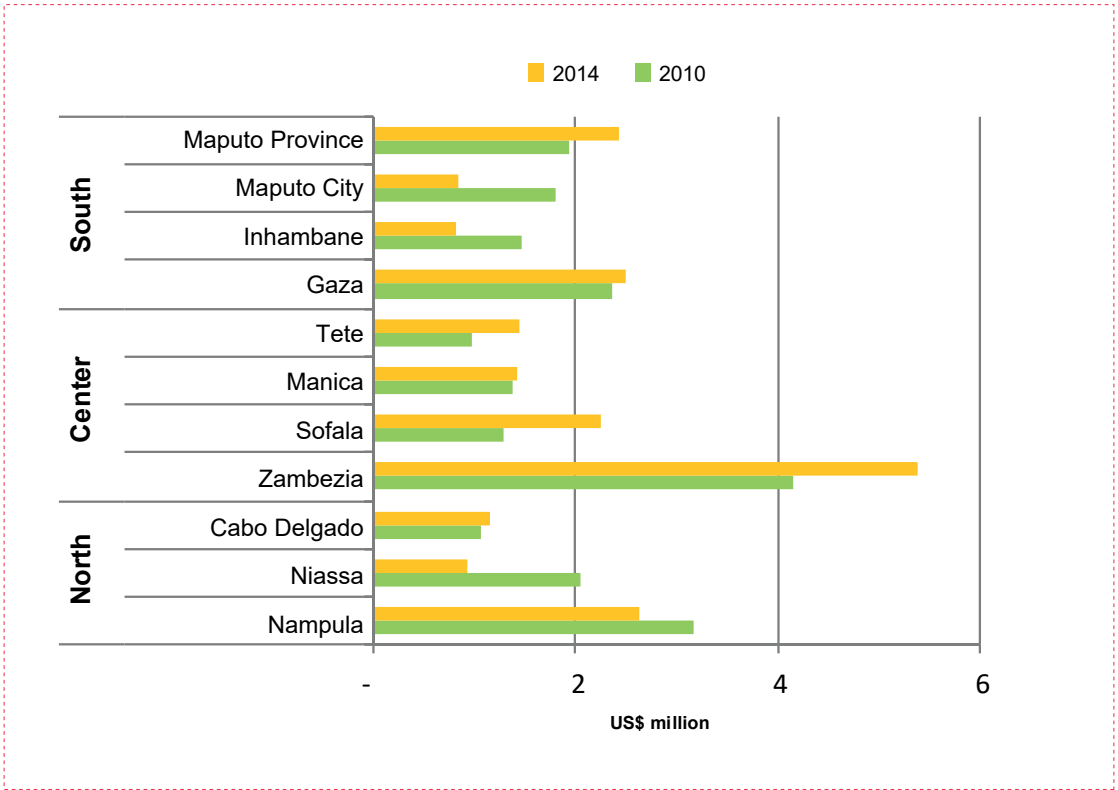
Table 17: **Expenditure in PMTCT per type of intervention, 2014**

Interventions in PMTCT	ASC Code	US$	%
Counseling and testing in HIV of pregnant women	ASC.01.17.01	6 690 865	30%
Testing of exposed children	ASC.01.17.99	2 381 247	11%
Antiretroviral prophylaxis for HIV positive mother and the baby	ASC.01.17.02	4 383 996	20%
Care for exposed children, including safe food	ASC.01.17.03	2 975 124	13%
Care for the mother, including delivery integrated to PMTCT program	ASC.01.17.04	3 847 806	17%
Expenditure in PMTCT not disaggrated.	ASC.01.17.98	1 783 905	8%
Total PTV		**22 062 943**	**100%**

PMTCT expenditures continued to be the most important in the central region, using $7.8 million in 2010 and $10.5 million in 2014. In the north, expenditures decreased between 2010 and 2014 by 25%, and in the south, by 13%.

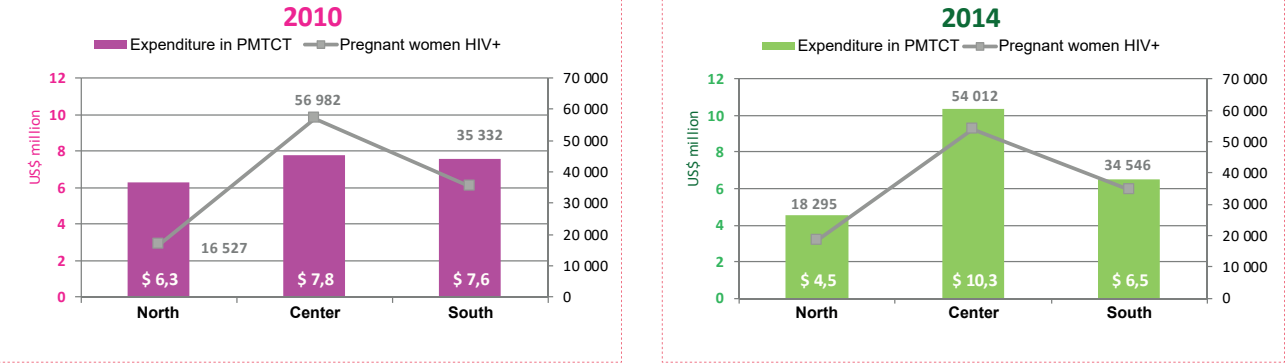
Without significant changes in total PMTCT expenditures, the data per province show a redistribution of expenditures from 2010 to 2014. The central provinces of Zambezia, Sofala and Tete show the most significant growth while reductions occurred in Maputo City, Inhambane and Niassa (Figure 40).

Figure 40: **Expenditure in PMTCT per province, 2010 and 2014**



Comparing the expenditures in PMTCT with the number of HIV-positive pregnant women shows a greater balance in 2014 compared to 2010. The central region has the largest number of HIV-positive pregnant women but spent proportionally less in 2010. The region's allocation of expenditure was corrected in 2014 (Figure 41).

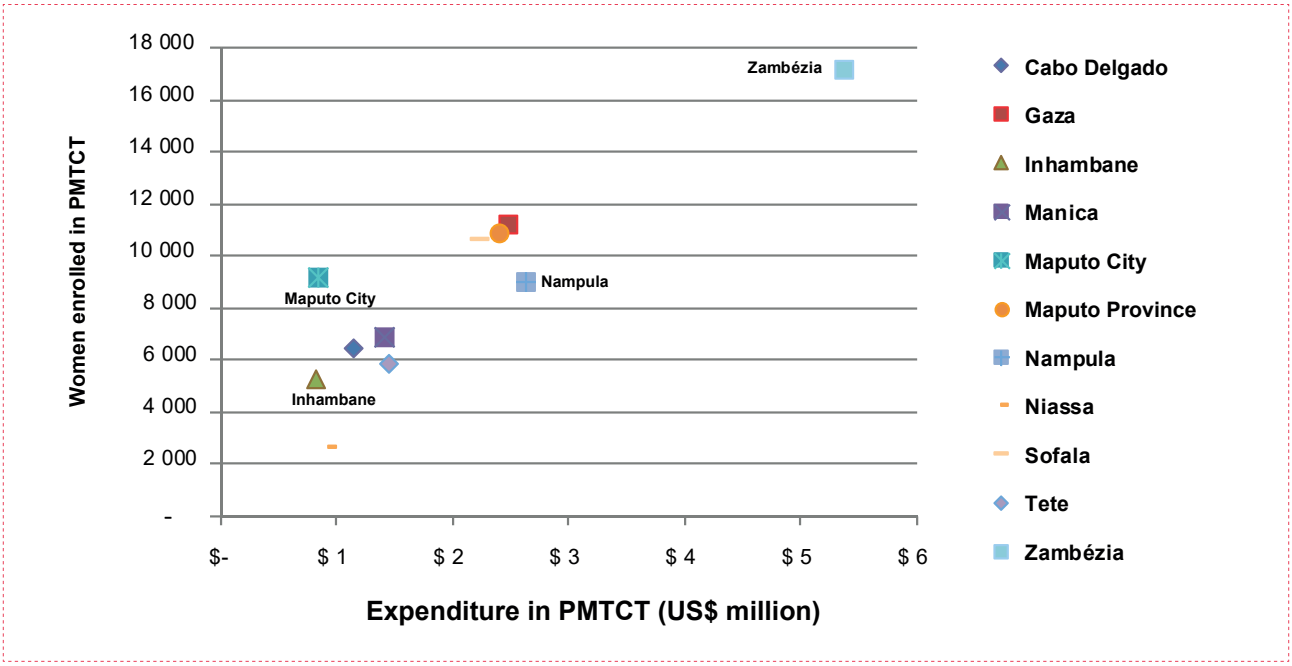
Figure 41: Expenditure in PMTCT (US$ million) and pregnant women HIV+ per region, 2010 and 2014



While there are big provincial variations, the expenditure per women in the North and Central in 2014 was around $260 while in the south, the average was $182. The unit cost to prevent the mother-to-child transmission varied from $93 in Maputo City to a maximum $355 in Niassa. This situation may be explained partly by the expansion of the ETV Plan that started in the south. As Option B+ is expanded throughout the country, the expenditures on PMTCT per woman will tend to fall.

Checking the data on expenditures for PMTCT versus the number of women in PMTCT demonstrates some correlation between the two variables in 2014. However, data from Maputo City show that, despite having the same level of expenditure as Inhambane and Niassa, twice the number of the women were reached. This shows that there is room for more efficiency in the allocation of resources for PMTCT.

Figure 42: Expenditure in PMTCT and women in PMTCT, per Province (2014)



The 2014 expenses for PMTCT were: salaries (37%), materials (34%), services (13%) and other operating costs (6%). Capital expenditures and investments absorbed 8% of the expenditure ($1.84 million) while non-disaggregated expenditures are only 2% of the expenditure in PMTCT.

Of the expenditures on salaries in PMTCT mainly for activities supporting provincial programs, bilateral donors paid 83%, followed the state budget, 11%, and other international donors, 5%.

For materials, multi¬lateral and other international agencies funded 35% and bilateral agencies, 66%. Of the materials for PMTCT, laboratory reagents represent 18% of expenditures and ARVs, only 3% (Option A). About three-quarters of the expenditures on services for PMTCT was for transport, which were almost fully funded by bilateral sources.

Figura 43: **Production factors per funding sources in PMTCT - 2014**

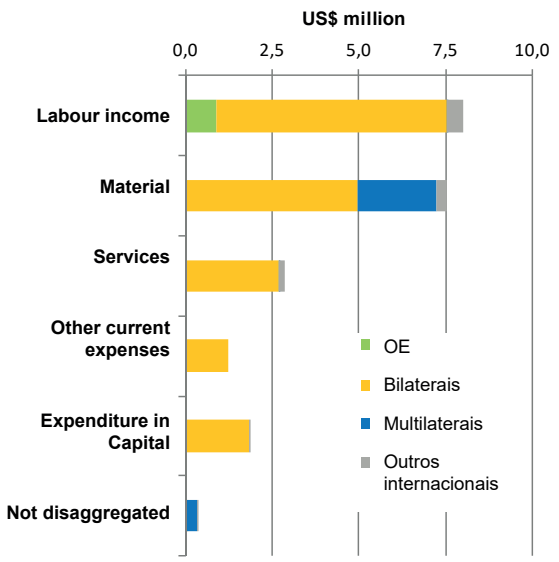


Table 18: **Distribution of expenditure and number of women reached in PMTCT programs per province and region**

Regions/Provinces	# Women in PMTCT			Expenditure in PTV (US$)			Expenses per woman in PMTCT (US$)		
	2010	2011	2014	2010	2011	2014	2010	2011	2014
North	4 350	11 921	18 074	$6 303 798	$6 205 255	$4 718 256	$1 449	$521	$261
Cabo Delgado	1 036	3 152	6 481	$1 074 261	$1 391 395	$1 157 356	$1 037	$441	$179
Niassa	200	1 070	2 627	$2 059 734	$2 160 545	$932 780	$10 299	$2 019	$355
Nampula	3 114	7 699	8 966	$3 169 803	$2 653 315	$2 628 120	$1 018	$345	$293
Center	5 372	12 747	40 470	$7 788 523	$8 515 051	$10 522 802	$1 450	$668	$260
Zambézia	3 100	7 340	17 063	$4 156 841	$4 024 265	$5 392 076	$1 341	$548	$316
Tete	704	2 331	5 880	$969 886	$1 379 707	$1 453 652	$1 378	$592	$247
Manica	598	1 032	6 908	$1 379 154	$1 337 296	$1 415 336	$2 306	$1 296	$205
Sofala	970	2 044	10 619	$1 282 642	$1 773 783	$2 261 738	$1 322	$868	$213
South	12 972	25 886	36 335	$7 587 095	$6 724 639	$6 597 459	$585	$260	$182
Inhambane	1 245	2 830	5 258	$1 478 034	$1 274 062	$822 073	$1 187	$450	$156
Gaza	3 443	7 793	11 113	$2 374 399	$2 334 791	$2 498 926	$690	$300	$225
Maputo City	5 245	9 210	9 170	$1 798 615	$1 578 646	$851 935	$343	$171	$93
Maputo Province	3 039	6 053	10 794	$1 936 047	$1 537 140	$2 424 525	$637	$254	$225
National/total	**22 694**	**50 554**	**94 879**	**$21 701 663**	**$21 444 945**	**$22 062 943**	**$956**	**$424**	**$233**
National level expenditure				**$22 247**		**$224 426**			

HIV Testing and Counseling (HTC)

For this analysis, AIDS spending categories or activities were grouped as detailed below:

- Testing as part of Blood Safety programs: ASC.01.19 blood safety
- Testing integrated in Mother and Child Health programs: ASC.01.17.01 testing in PMTCT programs
- HIV testing initiated by the user:ASC.02.01.01 provider initiated testing (PIT) and
- User initiating testing (UIT):

  ASC.01.03 counseling and testing;

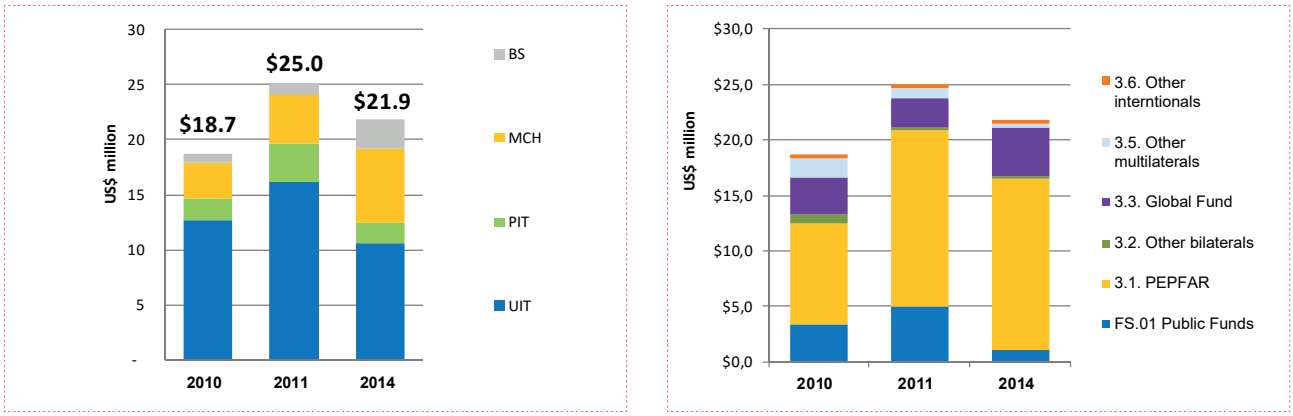
  ASC.01.04.01 HTC for vulnerable and accessible populations;

  ASC.01.11.01 HTC in the workplace.

Expenditures on counseling and testing are important interventions to reduce new infections and also to allow people to know their HIV status. Between 2010 and 2014, such expenditures increased from $18.7 million to $21.9 million, but remained lower than $25 million in 2011.

Between 2010 and 2014, these expenses grew was due to the significant increase in PEPFAR's contribution (69%), the Global Fund (28%) and also other internationals (46%). In the same period, domestic public expenditure fell by 67%, other bilateral, by 57%, and those of other multilaterals, by 82%. In fact, PEPFAR and the Global Fund represented 90% of expenditures in 2014, against 67% in 2010 and 74% in 2011.

Figure 44: **Expenditure in testing and counseling, per intervention and per financial source, 2010, 2011 and 2014**

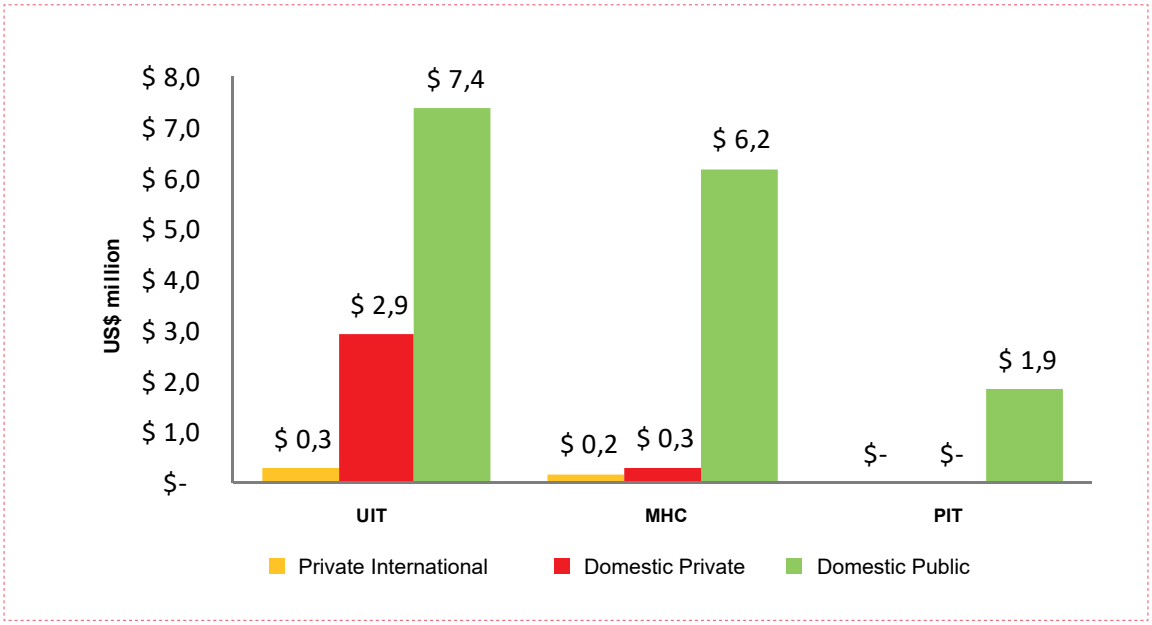


Expenditures for user initiated testing (UIT) and provider initiating testing (PIT) fell between 2010 and 2014, while expenditures for testing through MCH services doubled and those on Blood Safety almost tripled. The related weight of the expenditures on MCH and Blood Safety increased substantially in 2014, 31% and 13%, against 17% and 4% in 2010, respectively.

Expenditure on HTC in the area of Blood Safety was greatly influenced in 2014 by the investment in establishing the National Center for Blood Bank in Maputo City. For this reason, the description and analysis of expenditures per province excludes expenditures for blood safety.

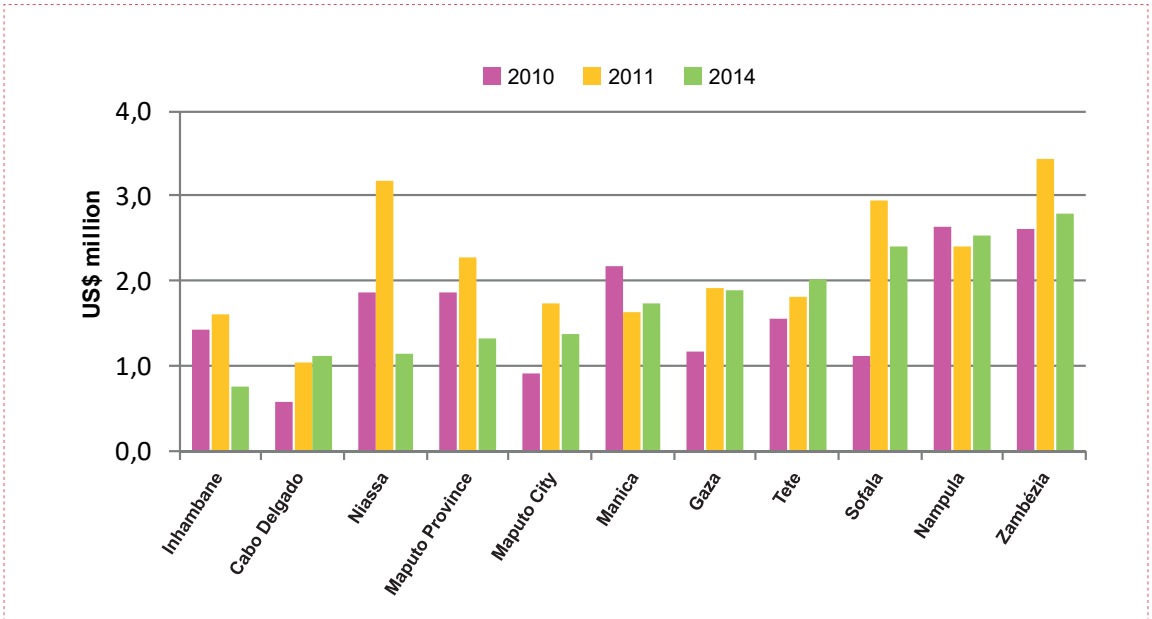
Having absorbed 81% of total expenditures, public providers were the main suppliers of HTC services. The private sector provided the remaining 19%. It is also possible that greater community involvement, via intervention of private providers, can improve efficiency in expenditure.

Figure 45: Expenditure in HTC per service provider and type of intervention, 2014



Between 2010 and 2014, expenditures on HTC increased in six provinces and decreased in five. Significant increases occurred in Sofala (115%), Cabo Delgado (100%) and Gaza (63%), while the reductions happened in Inhambane (-46%), Niassa (-38%) and Maputo Province (-28%).

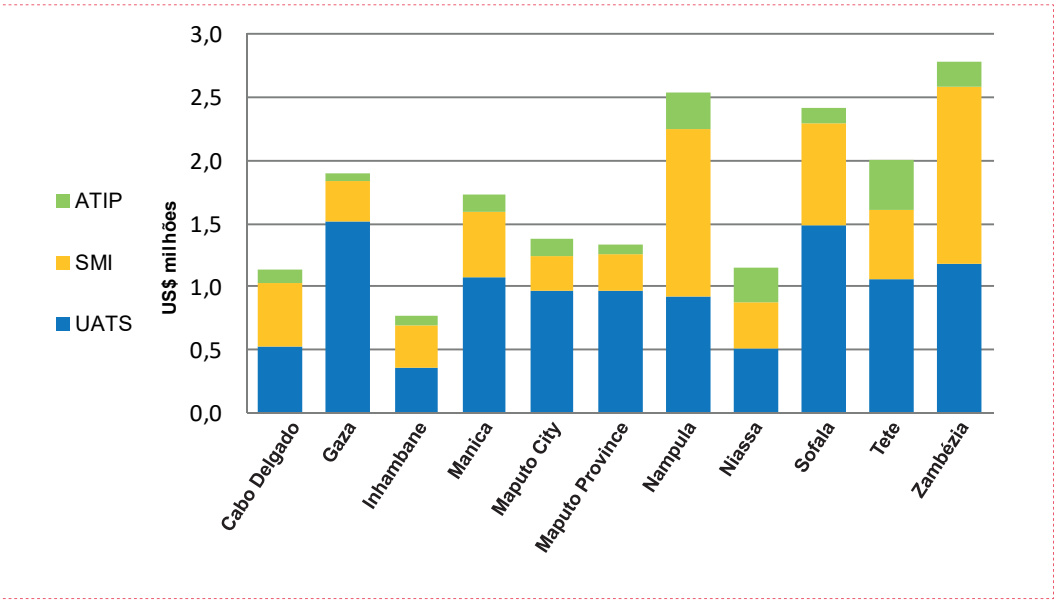
Figure 46: Expenditure in testing and counseling per province, 2010, 2011 and 2014



The distribution of expenditure per type of activity differed substantially between the provinces. In 2014, Nampula and Zambezia spent proportionately more on testing through PMCTC services (over 50% of total expenditures for HIV testing) while Cabo Delgado and Inhambane spent 45%. Other provinces spent more on UIT.

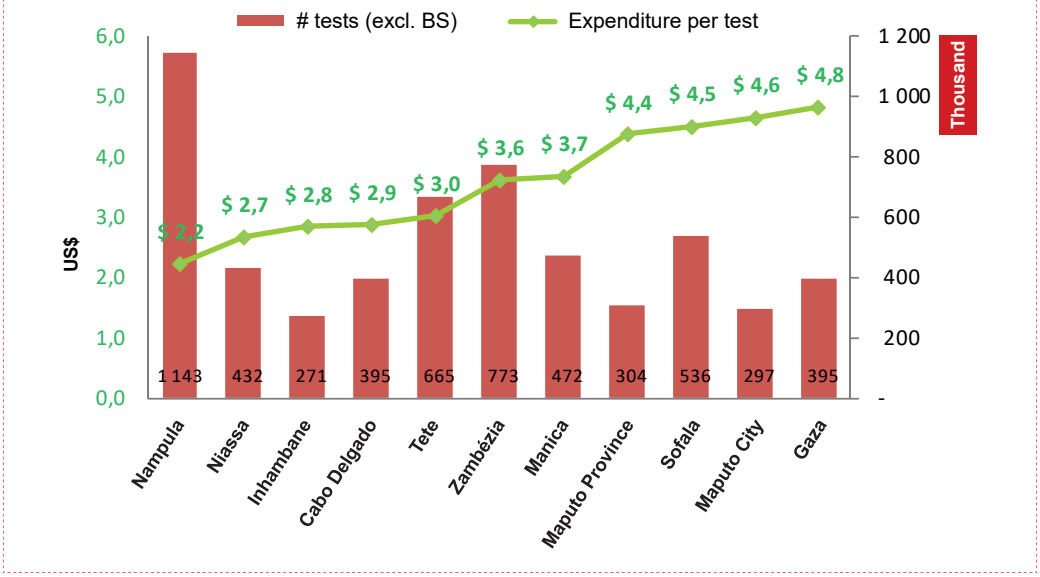
On the other hand, in 2014, Gaza Province consumed 80% of its HTC resources on UIT, followed by Maputo Province (73%) and Maputo City (71%). Manica and Tete consumed more than 50% for UIT.

Figure 47: Expenditure on HTC per type of intervention and per province, 2014



By province, the data reveal marked differences in the unit cost per test, ranging from $2.2 in Nampula to $4.8 in Gaza, i.e., more than twice as much. Even provinces that performed the same number of tests had very different unit costs, e.g., Cabo Delgado and Gaza. The variation in the combinations of the most frequent types of tests (PIT, UIT, PMTCT, etc.) and economies of scale could be an explanation.

Figure 48: Number of HIV tests carried out and unit expenditure per province, 2014



These data show that (i) further analysis is needed to understand the differences and, (ii) resources could be used more efficiently.

In 2014, excluding Blood Safety, the factors of production consumed in HTC service provision were mainly reagents and materials (39%) and salaries (30%), totaling 70% of the expenses. The other production factors have values that vary from $715,000 to $1.4 million.

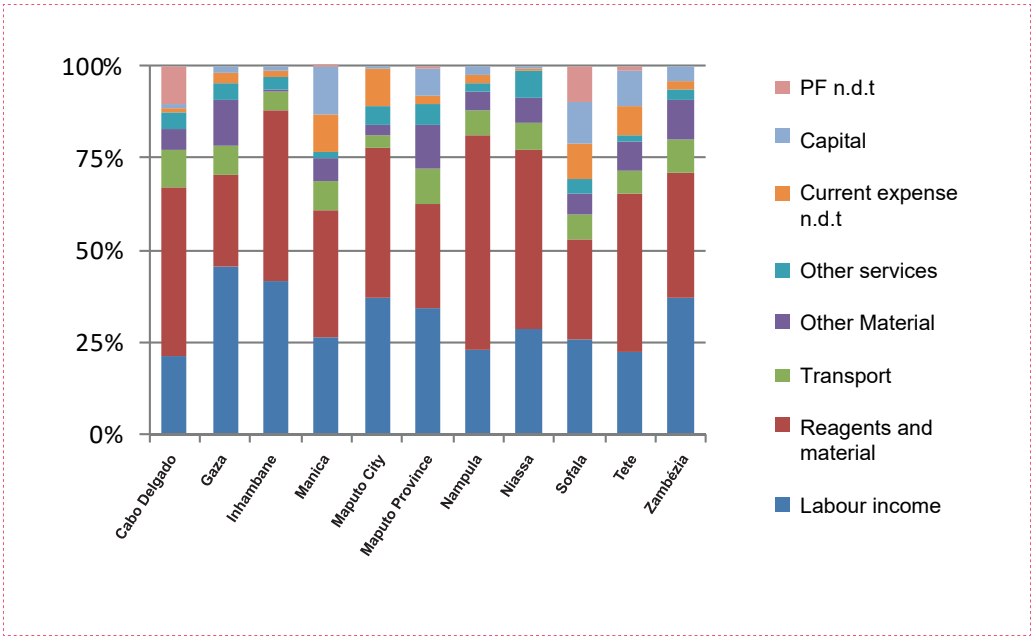
However, the proportional importance of the different production factors greatly changes in the provinces. Salaries and reagents and materials jointly comprise 80% of spending in Nampula but just over 50% in Sofala.

In 2014, capital expenditures benefit Maputo, Manica, Tete and Zambezia provinces. Expenses for transportation comprise similar proportions in all provinces.

Table 19: **Expenditures in HTC, excluding Blood Safety per production factors, US$, 2014**

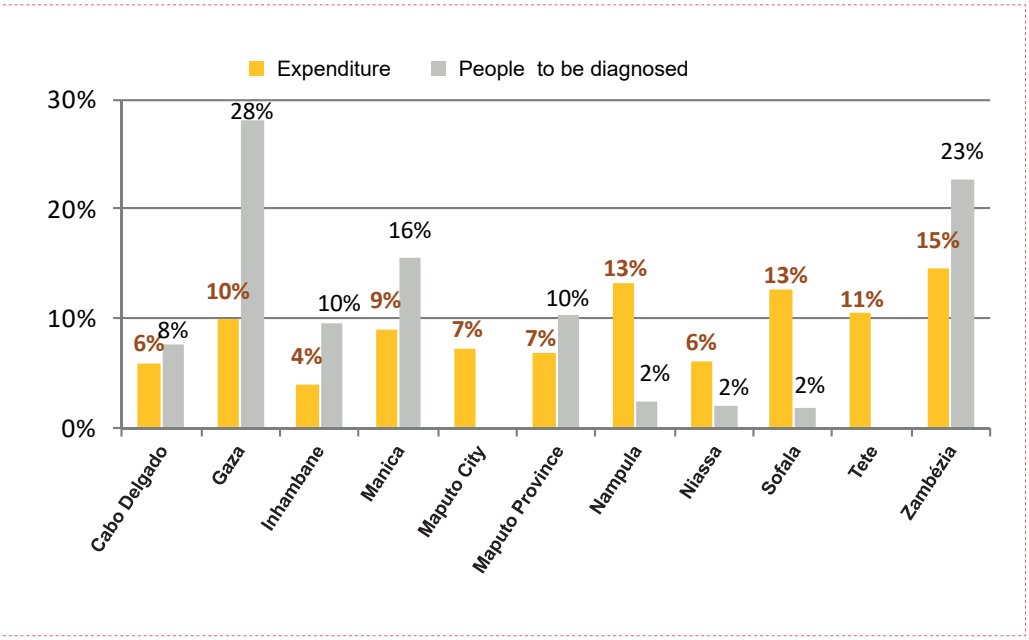
Production Factors	US$	%
Salaries	5 832 028	30%
Reagents and material	7 427 063	39%
Transport	1 420 314	7%
Other Material	1 396 363	7%
Other services	715 186	4%
Current expenses n.d.t	948 315	5%
Capital	1 023 263	5%
PF n.d.t	384 253	2%
Total PTV	**19 146 785**	**100%**

Figure 49: **Distribution of expenditure in HTC per production factors, per province, 2014**



As mentioned, the basic purpose of HTC is to ensure that people know their status and, in particular, to allow those who are HIV positive to be diagnosed and, thus, to contribute to an adequate lifestyle and prevent new infections. When comparing the proportion of expenditures on HTC per province in 2014 with the estimated percentage of people to be diagnosed, there seems to be no concordance between the expenditure made and the identified priorities. Gaza, Zambezia and Manica illustrate this: the proportion of expenditures is far below the proportion of the estimated cases to be diagnosed. Due to errors in programmatic or population data, Maputo City and Tete had coverage rates exceeding 100% and were, hence, why the proportions of people to be diagnosed are not displayed in Figure 50.

Figure 50: **Proportional distribution of expenditure in HTC per province and percentage of people to be diagnosed, 2014**



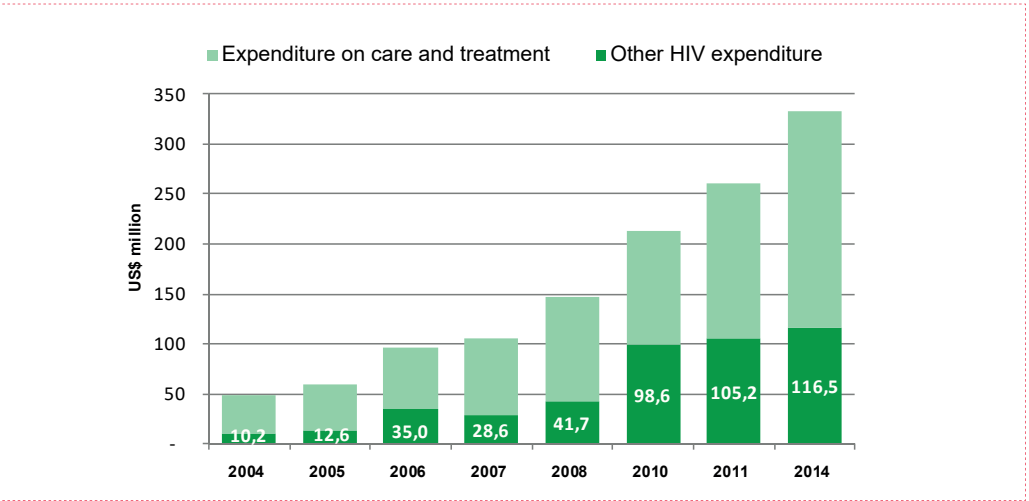
3.3.2. Care and Treatment

Care and Treatment grew more than 11 times between 2004 and 2014, having become the main category of expenditure in response to HIV and AIDS, representing 35% of total expenditures in 2014 compared to 2011 (40%). Since 2008, the expenses in this category have continuously grown.

The evaluation data show that also, as expected, in the case of Care and Treatment, the growth in expenditures was possible due to an increase of 15% between 2011 and 2014 of the contribution from international sources. Thus, in 2014, international funds represented 97% of expenses on care and treatment. This reality illustrates the extreme dependence on external financing for the national response to HIV and AIDS.

Two sources, PEPFAR and GFATM, funded 87% of the expenditures on care and treatment in 2014.

Figure 51: **Care and treatment in response against HIV**



Source: CNCS, 2008 ; CNCS, 2010 ; CNCS, 2014b

The care and treatment service providers are essentially from public sector, including hospitals, health centers and laboratories in all provinces (Figure 53). Throughout the country, public providers absorbed about 90% of the expenses and, in the provinces, this percentage ranged from 81% in Tete to 96% in Cabo Delgado. The international private providers are mainly international non-governmental organizations operating in the country and supplying important services in Maputo City, Tete and Zambezia - each with more than 10% of expenditures. In Sofala, they account for 6.5% of the expenses and, in other provinces, less than 5%. In Niassa in 2014, no international private providers operated, and the national private providers consumed 6% of the expenses on care and treatment. The national private providers were important in Nampula (11% of the expenses) followed by Gaza and Maputo provinces with about just over 6% each

Figure 52: Financial sources of care and treatment

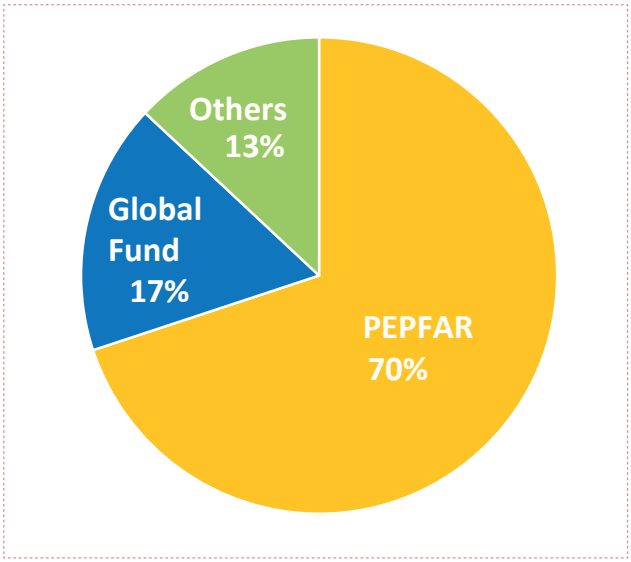
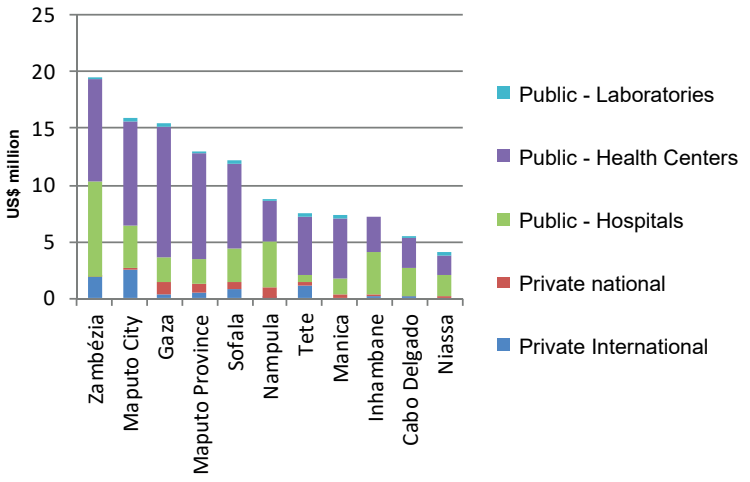


Table 20: Evolution of expenditure in care and treatment per financing sources, 2010, 2011 and 2014

Financial Sources	2010		2011		2014	
	US$	%	US$	%	US$	%
FS.01 Public Funds	5 119 707	5%	6 805 881	6%	3 275 115	3%
FS.02 Private Funds	148 855	0%	109 285	0%	85 853	0%
FS.03 International funds	93 292 419	95%	98 251 368	93%	113 115 448	97%
3.1. PEPFAR	60 995 947	62%	64 115 678	61%	81 449 267	70%
3.2. Other bilateral	3 006 779	3%	1 606 225	2%	4 489 926	4%
3.3. Global Fund	16 742 195	17%	20 111 039	19%	19 834 465	17%
3.4. Development Banks (grants)	596 200	1%		0%	835 413	1%
3.5. All other multilaterals	7 195 703	7%	2 889 798	3%	3 011 261	3%
3.6. All other internationals	4 755 595	5%	9 528 628	9%	3 495 116	3%
Grand Total	**98 560 981**	**100%**	**105 166 534**	**100%**	**116 476 416**	**100%**

Figure 53: Expenditures on care and treatment per provider and province, 2014



In 2014, the care and treatment services provided to the beneficiaries were predominantly ART, which absorbed 66% of all expenditures for care and treatment, and the laboratory monitoring of patients on ART which consumed 15%. The third most important expenditure is home care with 7% of all expenses on care and treatment.

Table 21: Expenditure in care and treatment per type of intervention, 2014

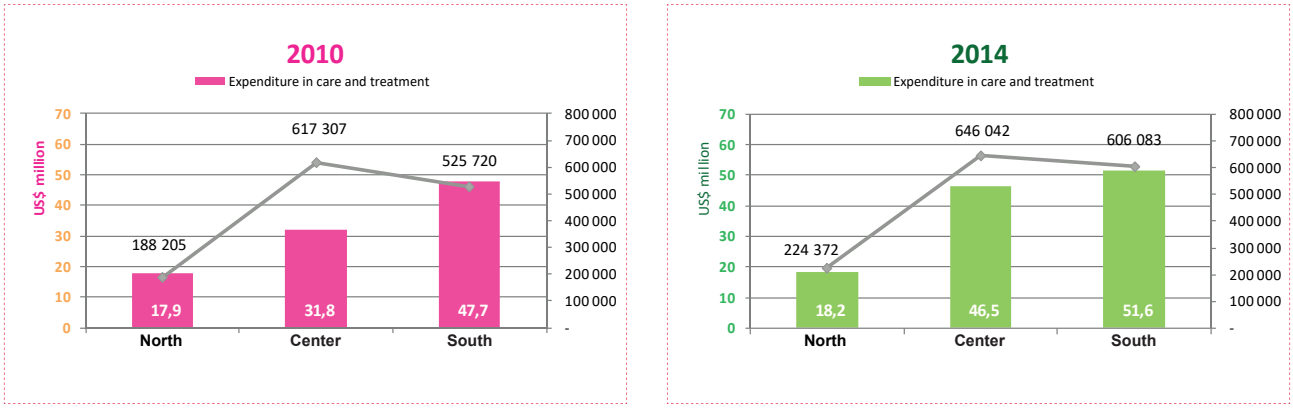
ASC.02. Care and treatment	US$	%
Adult ART	72 494 350	62%
Pediatric ART	4 780 224	4%
Opportunistic Infection and Pre-ART	5 645 681	5%
Laboratorial monitoring	16 064 549	14%
Nutritional support	2 678 632	2%
Home base care	7 940 863	7%
Testing initiated by the provider	1 856 408	2%
Non desaggregated treatment	5 015 702	4%
TOTAL	**116 476 409**	**100%**

Expenditure in antiretroviral therapy (Table 22) increased by 9% between 2011 ($71.2 million) and 2014 ($77.3 million), but decreased by 2 percentage points in the proportion of care and treatment when compared to 2011. Expenses in opportunistic infections decreased from $12 million (2011) to $5.6 million (2014), a reduction of 8%. The testing through the initiative of the provider also presented a reduction in expenditures to half between 2011 and 2014. The laboratory monitoring, on the other hand, increased by 156% from 6% in 2011 ($6.2 million) to 14% in 2014 ($16 million). The expenses in nutritional support in 2014 ($2.7 million) correspond to about half the level reached in 2010 ($5 million).

In this period, expenditures for home-based care presented few changes both in value and in their importance in relation to the care and treatment. Home-base care includes expenditures for patient tracking at the community in order to improve the retention of patients being cared for. Considering the recent scale of ART services and the current low retention rate, expenditures for home-based care were expected to increase.

Expenses for care and treatment per region show a better allocation of resources in relation to the geographical needs, judging from the number of people living with HIV. The redistribution that occurred between 2010 and 2014 in the central region corresponds to the highest prevalence of people living with HIV although, in 2014, the southern region continued to absorb more expenditures on care and treatment.

Figure 54: Expenditures on care and treatment per region and number of people living with HIV, 2010 and 2014



To provide care and treatment in 2014, goods and services absorbed 74% of the expenses, salaries, 19%, and capital expenditures, 3%. Expenditures related to the consumption of ARVs ($59.7 million) and reagents ($12.9 million) accounted for 62% of all expenses for care and treatment (Figure 55).

Figure 55: Expenditure in care and treatment per production factors, 2014

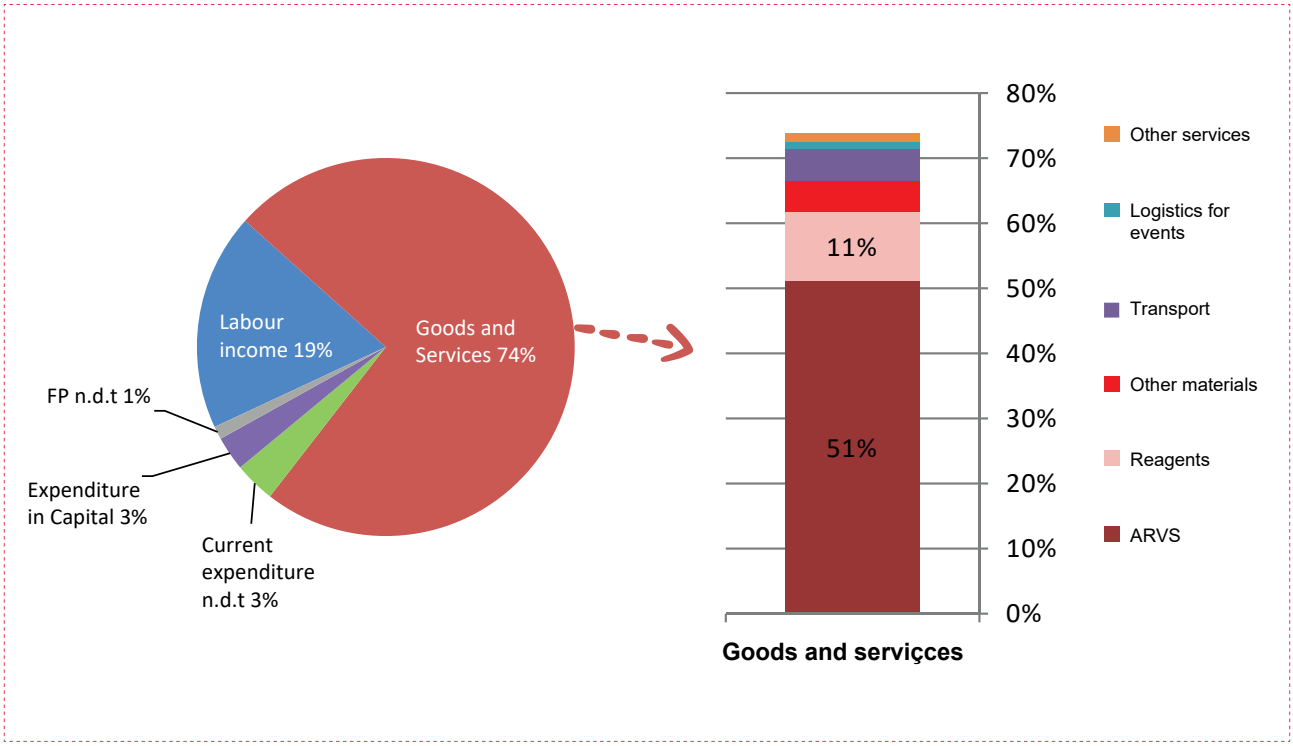
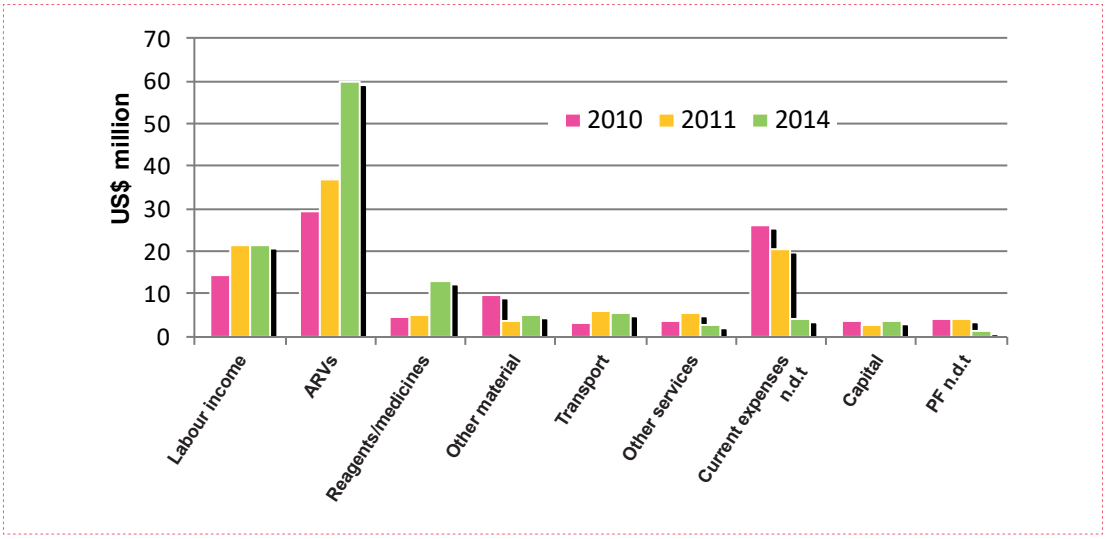


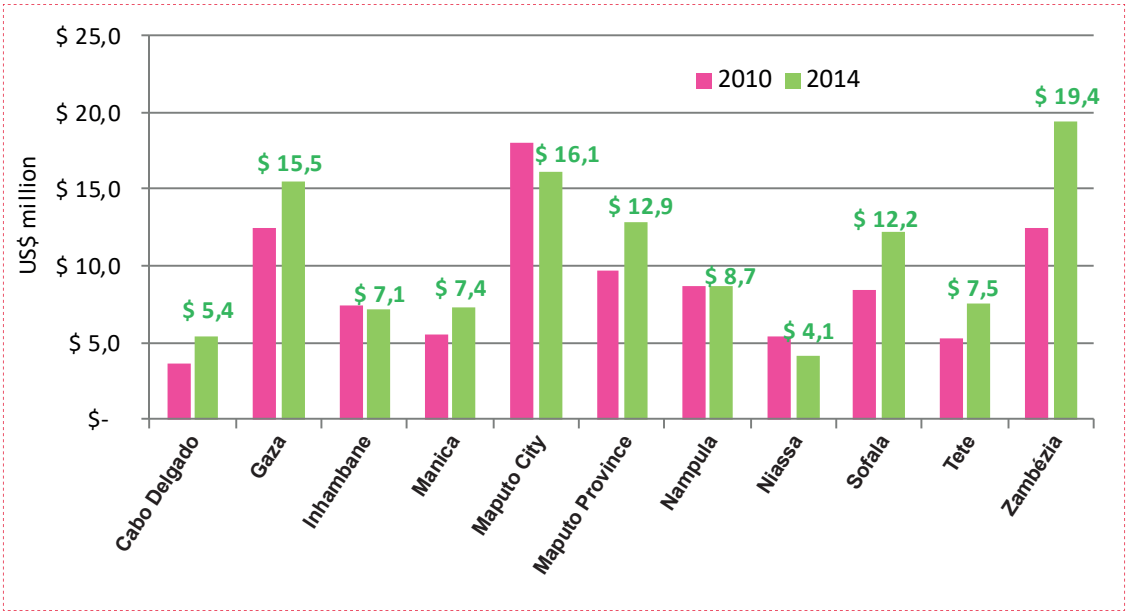
Figure 56 shows the evolution of the production factors consumed to provide care and treatment in 2010, 2011 and 2014. The quality of the information has improving because more and more current expenses are specified by type and production factors. Salary costs increased between 2010 and 2011; and they stayed level in 2014. Due to expanded coverage, the expenses for ARVs increased significantly despite the reduction in unit cost per patient. Between 2010 and 2014, current expenses continued to decrease.

Figure 56: Production factors for care and treatment, 2010, 2011 and 2014



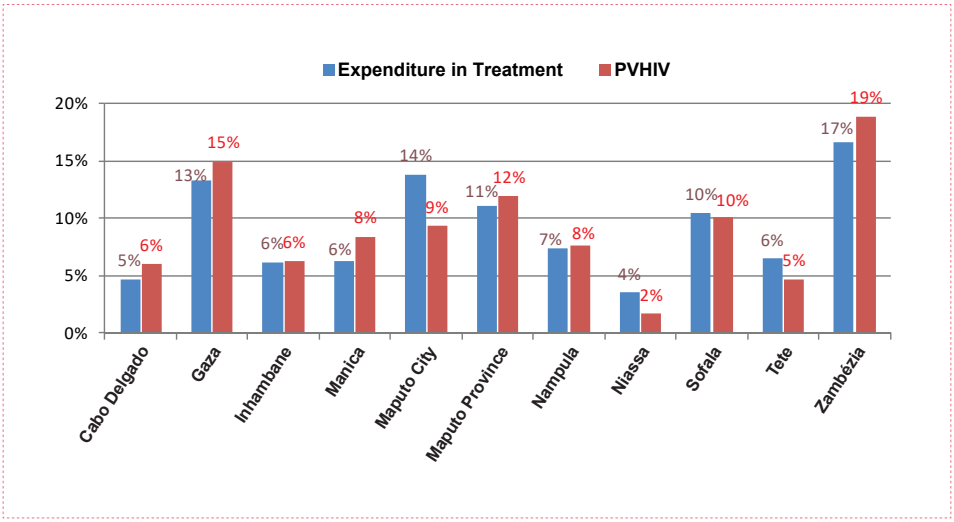
In 2014, Zambezia absorbed $19 million followed by Maputo City with $15 million and Gaza with $15 million (Figure 57). Maputo Province ($13 million) and Sofala ($12 million) spent more than $10 million while all other provinces remained below this threshold. Niassa and Cabo Delgado in the north spent less than $4 million and $5 million, respectively. Comparing 2010 and 2014, it appears that the expenses increased in all provinces except Niassa which decreased, and Inhambane, which maintained its level of expenses.

Figure 57: Expenditure in care and treatment per province, 2010 and 2014



In most provinces, the proportion of expenses incurred was at or below the proportion of people living with HIV, except in Maputo, Tete and Niassa where the expenses were higher (Figure 58). The 5% difference in Maputo City may be due to the problems already mentioned in the programmatic data, while Tete's 1% difference and Niassa's 2% difference may be due to the expansion of ART and consequent economies of scale.

Figure 58: Proportion of expenditure in care and treatment of people living with HIV per province, 2014



These improved distributions and use of resources are more visible when the unit expenditures per person benefitting from care and treatment per province are compared (Figure 59). This comparison shows that, between 2010 and 2014, per unit expenditures greatly decreased in all provinces. In fact, the national average cost decreased from $456 in 2010 to $199 in 2014. This fall is related to the achievement of the economies of scale as the ARV treatment program expanded.

In 2014, the provincial per unit costs ranged from a minimum of $154 in Manica, to a maximum of $331 in Niassa, and the median remained at $202.

Figure 59: Unit expenditure in care and treatment per province, 2010 and 2014

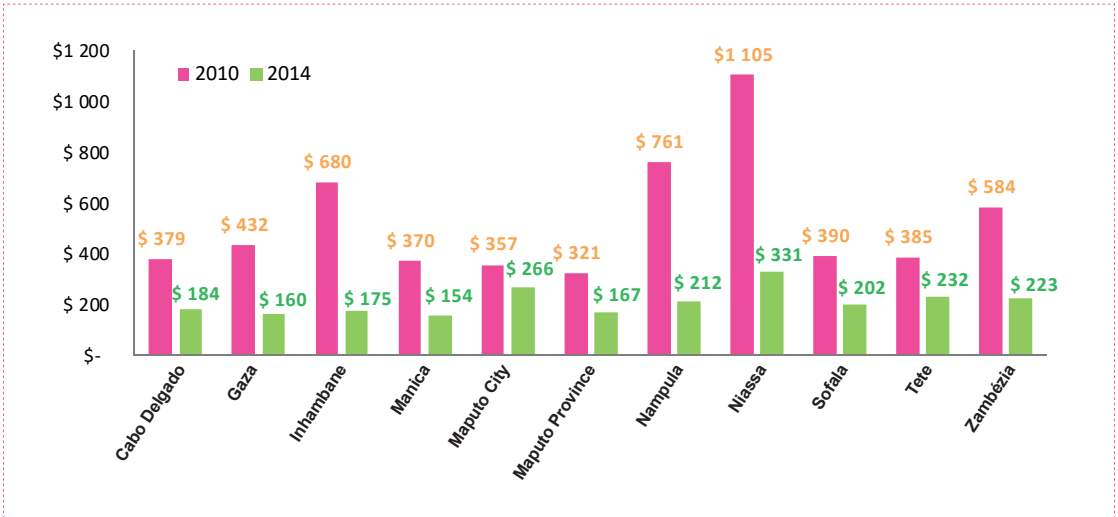


Table 22: Detail of expenditure for care and treatment

Services in care and treatment	2010		2011		2014	
	US$	%	US$	%	US$	%
ASC.02.01.01 Testing initiated by the provider (PITC)	2 027 421	2,1%	3 426 810	3,3%	1 856 408	1,6%
ASC.02.01.02 Opportunistic infections (IO) - Prophylaxis and treatment	12 897 310	13,1%	11 968 052	11,4%	5 645 682	4,8%
ASC.02.01.03 Antiretroviral Teraphy (ART)	60 385 864	61,3%	71 185 920	67,7%	77 274 574	66,3%
ASC.02.01.03.01 Antiretroviral Therapy - Adult	50 907 962	51,7%	58 488 437	55,6%	72 494 348	62,2%
ASC.02.01.03.02 Antiretroviral Therapy - Pediatric	6 472 579	6,6%	8 626 539	8,2%	4 780 226	4,1%
ASC.02.01.03.98 Antiretroviral Therapy Antiretroviral- n.d.age	3 005 323	3,0%	4 070 944	3,9%	-	0,0%
ASC.02.01.04 Nutritional support associated to ART	5 067 137	5,1%	1 354 689	1,3%	2 678 633	2,3%
ASC.02.01.05 Monitor laboratory especific to HIV	4 031 152	4,1%	6 195 380	5,9%	16 064 557	13,8%
ASC.02.01.07 Psychological support	124 320	0,1%	166 060	0,2%	-	0,0%
ASC.02.01.08 Paliative care for ambulatory patients	257 362	0,3%	-	0,0%	8 240	0,0%
ASC.02.01.09 Home-base care	7 345 984	7,5%	7 548 386	7,2%	7 940 860	6,8%
ASC.02.01.98 Ambulatory treatment	1 844 840	1,9%	1 167 898	1,1%	2 625 122	2,3%
ASC.02.98 Treatment n.d.t	4 579 591	4,6%	2 153 339	2,0%	2 382 340	2,0%
TOTAL	**98 560 981**	**100,0%**	**105 166 534**	**100,0%**	**116 476 416**	**100,0%**

3.3.3. Other Expenditures on HIV and AIDS

Coordination and strengthening of systems

Expenditures for the coordination and strengthening of systems, in a broad sense, including categories of expenditure ASC.04, ASC.05, ASC.07 and ASC.08, absorbed a total of $119.9 million in 2014, compared with $45 million in 2010 and $70.8 million in 2011, representing an increase of 1.6 times between 2010 and 2014.

In all those years, the national coordination and strengthening of systems (ASC.04) represented the largest proportion of the expenditure, ranging from 56% in 2011 ($ 45 million) to 77% in 2014 ($91.9 million). Expenditures related to the incentives for human resources (ASC.05) grew from $12.8 million in 2010 to $19.6 million in 2014, an increase of 53%. Expenditures toward a favorable environment (ASC.07) also increased about 22% between 2010 and 2014 from $6.9 million to $8.4 million.

The interventions included in each of the main categories of expenditure related to the coordination of the response, strengthening systems, research, and other expenses on HIV and AIDS (Table 23).

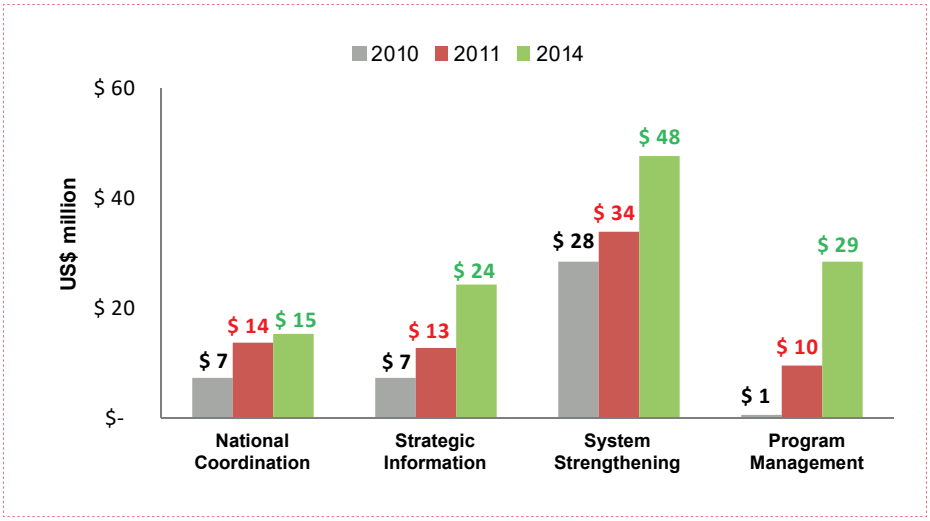
Table 23: Other expenses in HIV and AIDS, 2010, 2011 and 2014 (US$)

AIDS Spending Categories (ASC)	2010	2011	2014
ASC.04. National coordination and system strengthening	25 342 553	45 088 978	91 880 444
ASC.04.01 National program coordination and management	7 384 281	13 723 641	15 353 648
ASC.04.02 Administrative costs related to management and funds	609 477	235 586	28 609 409
ASC.04.03 Monitoring and Evaluation	4 027 367	7 326 361	13 308 963
ASC.04.04 Operation Research	41 664		568 757
ASC.04.05 Sero-surveillance		1 101 931	2 557 682
ASC.04.06 Surveillance on drug resistance	51 572	51 997	
ASC.04.07 Drug distribution system	2 023 511	884 839	11 824 649
ASC.04.08 Information technology	2 774 476	4 211 707	7 518 639
ASC.04.09 Patients'tracking	140 883	112 798	
ASC.04.10 Infrastructure construction and rehabilitation	7 839 652	5 759 192	10 639 966
ASC.04.98 Response coordination and system strengthening n.d.t	42 466	9 280 220	
ASC.04.99 Response coordination and system strengthening n.c.o	407 204	2 400 707	1 498 731
ASC.05. Incentives for human resources	12 769 816	18 800 141	19 605 318
ASC.05.01 Monetary incentives	23 832	25 414	
ASC.05.03 Training	11 103 750	17 198 672	16 482 017
ASC.05.98 Incentives for human resources ndt	1 642 234	1 576 055	3 123 301
ASC.07. Favorable environment	6 943 972	6 953 474	8 460 634
ASC.07.01 Advocacy	86 835	274 620	3 493 722
ASC.07.02 Human rights	132 209	172 254	170 804
ASC.07.03 Institutional development	5 383 227	6 092 468	4 250 877
ASC.07.04 HIV programs focusing on Gender	920 635	63 284	489 943
ASC.07.05 Programs to reduce gender-based violence		6 443	50 000
ASC.07.98 Favorable environment ndt	383 941	344 405	5 288
ASC.07.99 Favorable environment n.c.o	37 125		
ASC.08. Research	292 086	59 754	214 138
ASC.08.01 Biomedical research	10 733	52 402	
ASC.08.03 Clinical research	38 921		
ASC.08.04 Social science research	242 432	7 352	111 638
ASC.08.04 Research n.d.t			102 500
TOTAL	45 348 427	70 902 348	120 160 534

Other expenditures related to HIV and AIDS were regrouped for better analysis. This revised grouping shows clearly that the expenses related to the strengthening of systems are the most important and almost doubled between 2010 ($28 million) and 2014 ($48 million). Expenditures to collect information to improve the adoption of more consistent policies tripled between 2010 ($7 million) and 2014 ($24 million).

Expenditures for program management increased the most in this period, i.e., from $1 million in 2010 to $29 million in 2014. Such expenses include central management costs for the national response to HIV, including Supervision of program staff and technical assistance to program staff. These expenses mostly relate to the growing numbers of implementing partners working with the US government.

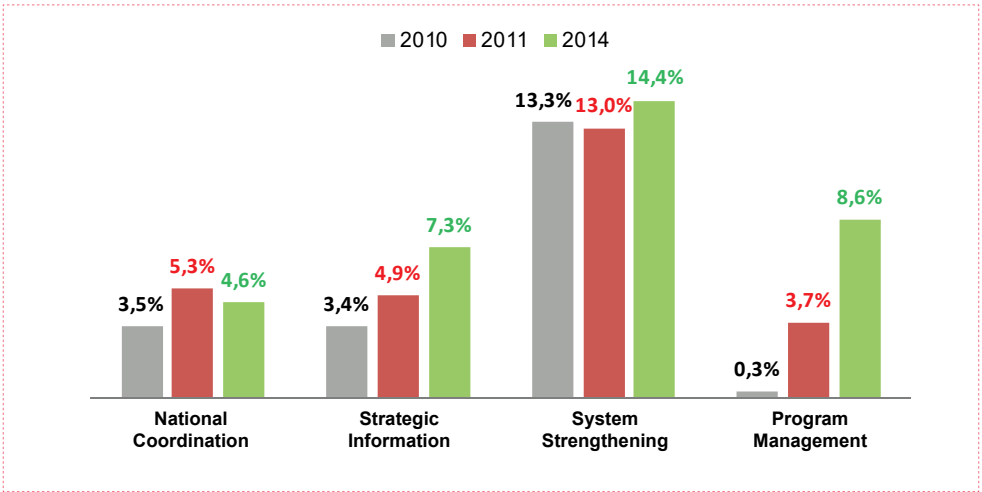
Figure 60: **Other expenses on HIV and AIDS for 2010, 2011 e 2014**



Note: for the expenditure ASC.07. Favorable environment, only expenditures in ASC.07.03 – Specific institutional support to HIV is considered

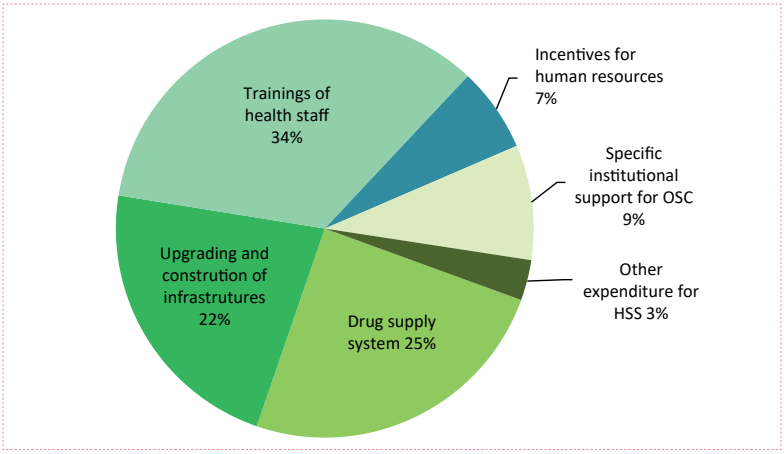
Seen from another perspective, the proportion of these other expenses related to HIV and AIDS has substantial changes in two groups compared to the total expenditures in each year (Figure 61). Expenses for program management increased from 0.3% in 2010 to 3.7% in 2011 and then to 8.6% in 2014. Expenses for information strategy also grew from 3.4% in 2010 to 4.9% in 2011 and then to 7.3% in 2014. The other two response coordination and system reinforcement maintained stable proportions, the first ranging from 3.5% (2010) to 5.3% (2011) and the second, from 13% (2011) to 14.4% (2014).

Figure 61: **Other expenditure related to HIV and AIDS as percentage of total HIV expenditures**



In 2014, expenditures to reinforce systems were focused on three types of interventions, namely, health staff training (34%); drug logistics (25%), and rehabilitation and construction of infrastructure (22%). Specific support to develop the capacity of civil society organizations absorbed 9% of the expenses in 2014; incentives for human resources, 7%; and other expenses for strengthening the health system, 3%.

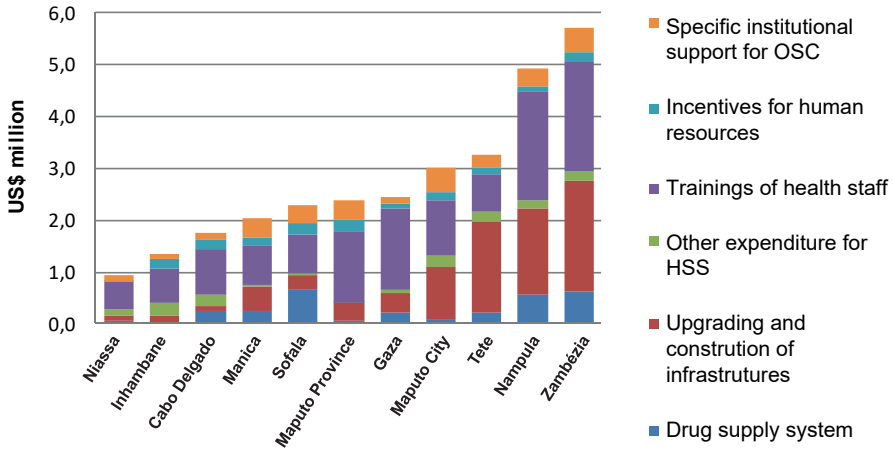
Figure 62: **Expenditure by interventions to strengthen systems in 2014**



Concerning the territorial distribution of expenditures to strengthen systems, 37% (US$17.7 million) of the expenses were national, including five interventions. As for national expenditures, drug logistical systems absorbed half of that amount ($8.8 million), the training of health staff 23% ($4 million), and infrastructure 23% ($2.3 million). Incentives for human resources used 8% ($1.5 million), and civil society capacity-building, 6% ($1.1 million).

Excluding national expenditures, the distribution of expenses to reinforce systems by province and type of intervention shows that provincial expenses to train health staff are are typically the largest category of expense in all provinces, ranging from 22% of total provincial expenses in Tete to 63% in Gaza. Expenditures to rehabilitate and construct infrastructure were concentrated in the provinces of Zambezia (absorbing 26% of all such expenditures), Tete (21%), Nampula (20%) and Maputo City (12%). In Cabo Delgado, such expenses account for only 5% of the province's expenses for system strengthening. Expenses for drug supply system were also important in Sofala (22%), Zambezia (20%) and Nampula (19%) provinces. Sofala also absorbed 20% of the provincial expenses to improve the drug supply system.

Figure 63: **Distribution of expenditures in system coordination and reinforcement per province and type of intervention, 2014**



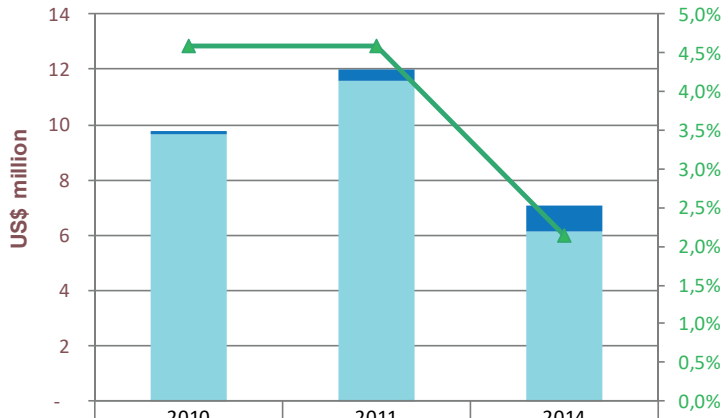
The distribution of expenses per province also shows that, comparing the less privileged province, Niassa, to the most benefited, Zambezia, the ratio of the amount of resources consumed is 1 to 6. The second most benefited province is Nampula, which together with Zambezia, are the country's most populous provinces.

Social services

In Mozambique, the HIV pandemic kills one or both parents and orphans many children, placing them in a vulnerable situation requiring special attention. Their vulnerability is especially grave since most of the population lives below the poverty line. Social protection and services in the form of support for people living with HIV are also important in the response to HIV and AIDS so as to mitigate its effects.

The evaluation data show that, between 2010 and 2014, the total cost of these two programs - social protection and social services and programs for orphans and vulnerable children (OVC) - decreased from $9.8 in 2010 to $7 million in 2014, after a $12 million peak in 2011. Expenditures on social services accounted for 5% of total expenses in 2010 but only 2% in 2014.

Figure 64: **Evolution of the expenditures in social services, by type of intervention, 2010, 2011 and 2014**

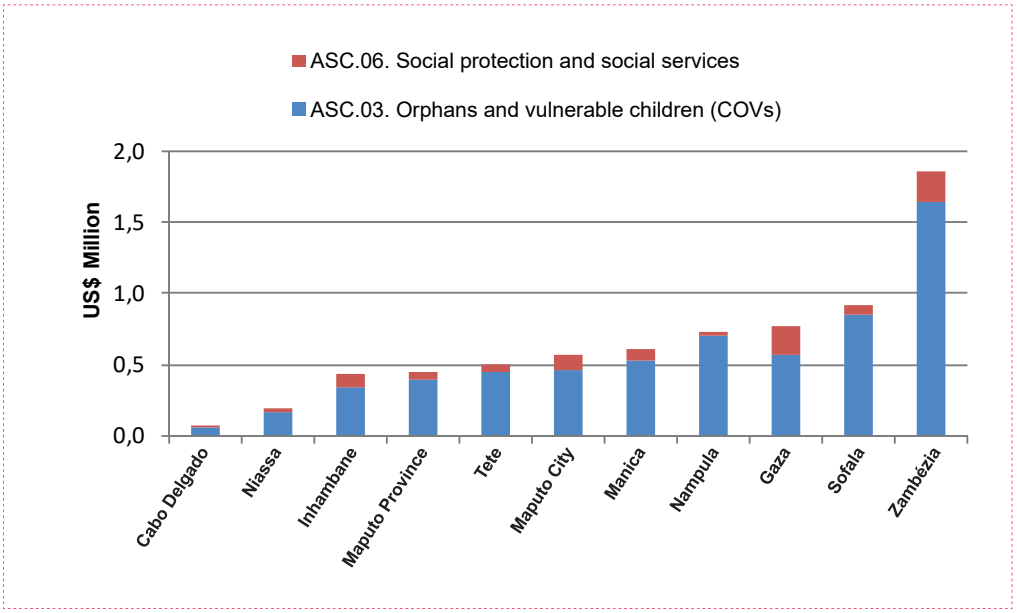


	2010	2011	2014
ASC.06. Social protection and social services	129 203	397 645	914 176
ASC.03. Orphans and vulnerable children (COVs)	9668 801	11569 514	6160 782
% of total expense in AIDS alocated to social services	5%	5%	2%

The distribution of expenditures on social services by province in 2014 shows that the four most benefited provinces (Zambezia, Sofala, Gaza and Nampula) consumed 60% of the executed expenditures. Expenditure for social services in those four provinces varied significantly. Expenditure for social services in those four provinces varied significantly. Zambezia benefited from double the expenditure of Sofala, the second most benefited province. The size of the population and the number of vulnerable people, including children, may explain this distribution.

Expenditures for social protection and services, though tiny, increased from $129,000 in 2010 to $914,000 in 2014. In 2014, these expenses were highest in Zambezia province (US$211,000), Gaza (US$198,000) and Maputo City (US$101,000). All other provinces spent less than $100,000; and Cabo Delgado, just $5,000.

Figure 65: Provincial distribution of expenses in social services, 2014



3.4. Adequacy of Expenses on HIV and AIDS with PEN IV

The National Plan to fight HIV and AIDS (PEN IV) covers 2015 to 2019. The plan was funded for a total estimated cost of $2,108 million. NASA 2014 analyzes the expenditures for the year prior to the beginning of PEN IV and shows that the level of expenses achieved is very close to the values projected for 2015.

In fact, the estimates for 2015 are only 6% higher than the costs calculated for 2014.

Figure 66: Total HIV expenditure in 2014 and projected cots of PEN IV (2015-2019)

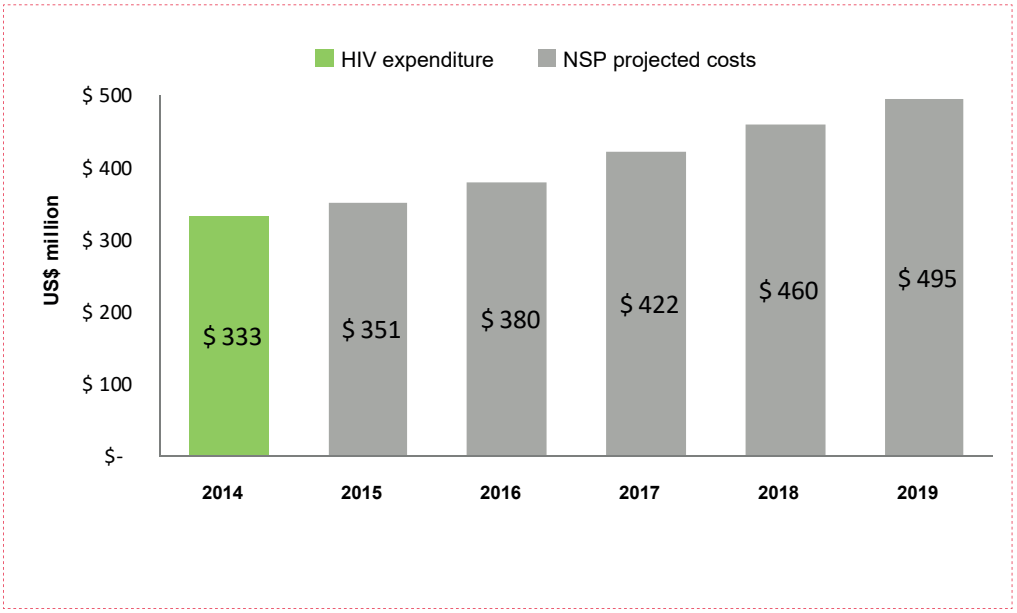


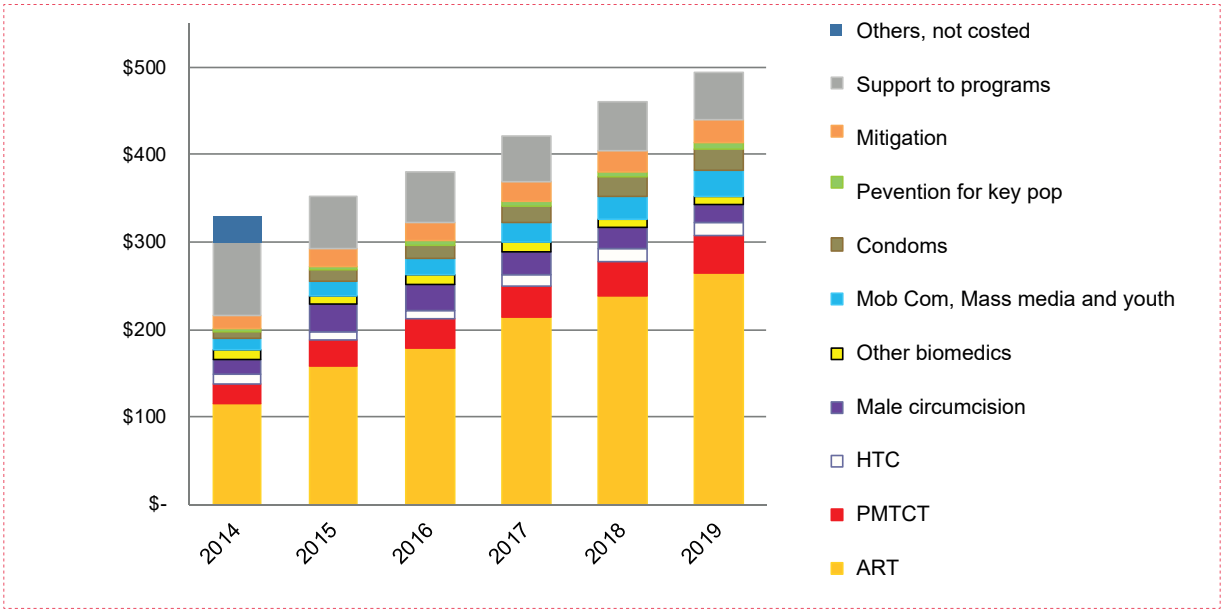
Figure 67 shows the breakdown of expenses in 2014 compared to the estimates made for the PEN IV and thus permits an assessment of how well the allocation of expenditures on HIV and AIDS conformed to the priorities defined in the PEN IV.

The costs of antiretroviral therapy are projected to double between 2014 and 2019. However, the growth will be even greater as a result of the change in the protocol (90-90-90 approach and CD4 / uL <500), which will lead to an increase of the number of people eligible for treatment. This category of expense will register the biggest gap in financing of the national response to HIV and AIDS, when compared to the funding level registered in 2014 (Figure 67).

Despite being less important in volume, the other categories of expenditure in the national response will continue to grow and will need more resources. The important thing is to ensure that the financial gap for ART is not overed by reducing support for prevention activities.

In 2014, expenditures for national coordination, system strengthening, and other administrative costs (support for programs) were much higher than the amounts planned in PEN IV for 2019 to support the programs. Much of this difference is due to the implementing partners' program-management costs. The big fall in expenditures between 2014 and the projections for 2019 may indicate that expenditure on support to programs has been too high or that the projected costs for these activities in 2019 are underestimated. A detailed analysis should be conducted to clarify this contingency and explore how to improve efficiency and reduce these costs.

Figura 67: Comparison between the expenditure in HIV in 2014 and the projected costs of the PEN IV (2015-2019) per program area



The national response depends greatly on external funds, mainly from just a few partners. This raises sustainability issues for HIV and AIDS programs in Mozambique, especially when the new antiretroviral treatment strategies are considered.

In the different components of the national response, the data collected in the assessment indicate that, compared to previous years, the trend in the territorial distribution of resources has been positive in relation to the estimated needs, thus indicating clear gains in economic and technical efficiency. In most of the interventions, a continued reduction in per unit costs for providing services allows more activities to be carried out with the same expenditure. However, differences that still persist in both per unit costs and the distributional balance of the territorial expenditures show that there is still room to improve the efficiency of the national response to HIV and AIDS.

While resources are being directed in a more balanced way for activities and beneficiary populations, thus potentially having more impact on reducing new infections, the resources for sexual-transmission--prevention activities fell, and expenditures assigned to community interventions related to ART remained clearly insufficient.

As supported by technical evidence, the strategic options already taken within the framework of the national response to HIV and AIDS will determine the increase in costs. In other words, the costs of the national response will grow; and more resources must be raised.

In this effort, the state budget should contribute more in line with needs in order to ensure the sustainability of the response to HIV and AIDS and develop additional and complementary funding mechanisms.

To have the greatest impact on reducing the incidence of HIV and AIDS, the allocation of resources for HIV prevention must be improved by:

- continuing to improve the geographic distribution of expenses for preventing sexual transmission and mother-to-child transmission by aligning the expenses with the provinces where most infections occur;
- increasing the expenses for prevention, especially targeting the populations most vulnerable or at-risk of contracting HIV, including young women, men and other high-risk populations. Despite being prioritized in PEN IV, young people have not benefited from enough resources;
- increasing the expenses on IEC programs and community ATS as an entry point to health services; and
- giving priority to adults (> 15 years old) in male circumcision programs to maximize the immediate impact of the prevention programs.

The level of expenditures on ART and PMTCT effected by the community-service providers suggests that allocation for the main community-support activities are insufficient to ensure retention in treatment. Community activities that may improve retention levels and adherence to treatment should be strengthened.

The geographical allocation of expenses in prevention and treatment improved though additional efficiencies may be achievable through economies of scale in male circumcision programs, increases in the technical efficiency of training, and reduction in central program-management expenses.

The assessment data show that the response to HIV and AIDS mobilizes significant funds to strengthen the health and community systems. While these investments are essential to ensure the supply of goods and services, other funding schemes must be mobilized to strengthen the health system thus releasing resources for the growing needs to purchase ARVs and reagents.

NASA shows very low values in expenses on activities with synergies with HIV. Considering the vulnerability of young girls in the HIV epidemic in Mozambique, more resources should be allocated for the integration of actions against HIV with those in education, protection and social services, human rights, and gender programs.

Appendix 1: Definition of terms

Beneficiary population: The beneficiary population is not a planned goal; it comprises people who benefited or were served through expenditures on goods and services and HIV and AIDS. The beneficiaries are the actual numbers of covered people, representing a result of the used resources regardless of the efficiency of resource use (effective coverage).

Capital expenditure: Records of the value of non-financial assets that are acquired, disposed of or have experienced a change in value during the period under study. The assets belonging to the health system include new acquisitions, major renovations and maintenance of tangible and intangible assets that are used repeatedly or continuously used in health-care-production processes, over periods longer than one year. The main categories of classification include buildings, capital equipment and transfer of capital. These categories may include major renovation, reconstruction or expansion of existing fixed assets since these interventions may improve and extend the previously expected lifetime of the good.

Civil Society Organization (CSO): The formal and informal networks and organizations which are active in the public sphere between the state and family. CSOs include a wide variety of associated forms such as churches, unions, trade unions, professional associations and community groups.

Current expenditure: Refers to the total amount, in cash or goods, of the resources payable to the service provider by a financing agent on behalf of the final user of the health services for the services rendered (including the delivery of goods) during the evaluation year.

Direct bilateral contributions: Allocations in the form of donations or nonrefundable financial cooperation that rich countries provide directly to recipient countries, whether as conditional or unconditional contributions, such as direct support to the beneficiary countries' state budget.

Fiduciary Risk: Risk that public funds are not used for the desired purposes, that there is no proper accountability for the funds, or that the expenditures do not get "value for money".

Financing agent: Entity that combines financial resources obtained from different financial sources and transfers them to buy or purchase health care or other services or goods. These entities finance programs or the provision of goods and services used to satisfy a need. The financing agents may join and directly pay or the resources consumed (especially by families) and they comprise entities that buy goods and services on behalf of the specific beneficiaries (mainly intermediaries such as insurance companies or donors).

Financial sources: Entities that provide funds to financing agents to be aggregated and distributed. An analysis of financial sources may be of particular interest in countries where funding in response to HIV and AIDS depends heavily on international funding sources or where sources are aggregated by a few managing entities.

Foreign entities for profit: For-profit entities, including multinational pharmaceutical and biotech companies, whose headquarters are located outside the country where the services or goods are provided.

General Budget Support (GBS): A form of program aid in which official development assistance (ODA) that is not linked to any specific project activities is directly channeled to partner governments using their own allocation systems, procurement and accounting.

General Common Fund (PROSAUDE): This is a new fund whose objective is to provide general support to PES and to the health sector activities defined in the Annual Operating Plan (AOP). In 2003, a provisional common fund was established. In January 2004, the GCF was created. It uses the government-funding-flow systems. This means that donors will transfer their contributions to the Ministry of Finance (MF), which adds these funds to the contribution by the Government of Mozambique (GoM) and transfers them to the PROSAUDE account.

International Funds: Funds from abroad executed in the current year. Bilateral and multilateral international grants as well as funds donated by institutions and individuals abroad are included to the extent they are used in the current period. The terminology used by NHA experts is the “rest of the world”.

Multilateral agencies: Organizations, institutions or public agencies or public/private international organizations that receive contributions from donor states and from other sources. The multilateral funding is thus a mechanism in which investments for assistance are aggregated by different donors and donated not necessarily in a one-to-one relationship between the donor and recipient countries. This usually occurs through international agencies of the UN system and development banks. The GFATM is a private/public multilateral organization.

Non-Governmental Organization (NGO): State-separated organizations that are designed to help others and do not pursue profit goals.

Non-wage labor income: Includes fees, subsidies and various forms of compensation earned by self-employed providers in self-employment that offer care and other services contributing to the National Response to HIV and AIDS.

Service Provider: Entity or people engaged directly in the production or provision of services, and who are responsible for a final product or subcontracting of a complex process involving several production units that may need to hire people and acquire material inputs and services in order to produce the planed final product A provider is accountable to the beneficiary of the service it provides and its quality although the provision does not imply a positive or desirable outcome. Providers include government and other public bodies, private organizations for profit and non-profit, corporate and non-corporate companies.

Public funds: All territorial government bodies, i.e., departments and agencies - central, state or local - that are involved in economic growth, technologic development, the promotion of well-being, and various activities, e.g., administration, defense, health, education and other social services.

Sector budget support: Support directed to a particular sector within the government budget.

Social contributions: include contributions from labour income other than wages, received by health or social-care staff. The exceptions include employers' social contributions, payments made to non-active workers, and payments in kind, i.e., supplies and services required for work.

Inputs and services: include all goods and subcontracted services used as inputs for the provision of health services, e.g., goods entirely used in the production process during which time they deteriorate and are lost, accidentally damaged, or diverted. Such goods include inexpensive durable goods (e.g., hand tools and other cheap goods), not machinery and equipment. A very important input is drugs. Donated materials and supplies should reflect the actual values so that the registered amounts equal the market prices and net subsidies, minus indirect taxes.

Wages: include all types of remuneration and compensation, e.g., payments for the recruitment or retention of workers (health or other) providing services related to HIV and AIDS, including extra payments of any kind, such as extra hours’ payments or night work, bonuses, various allowances and annual leave. Payments in kind include meals, drinks, special clothing, car parking, day care for children, transportation to and from service, and the value of interest forgone when loans are provided at a zero or reduced interest rates.

Appendix 2: List of institutions included in NASA

Order	Organization/Institution	Contacted	Recorded in NASA	Method of data collection*	Source	Agent	Provider
	NATIONAL PUBLIC SECTOR						
1	Parliament	✓	✓	↑		✓	✓
2	National Blood Bank Center		✓	↓			✓
3	Academic Community for Educational Development - CADE	✓	✓				
4	Maputo City Council	✓					
5	National Council to fight against HIV / AIDS – CNCS	✓	✓	↓ ↑		✓	✓
6	Mozambique Red Cross	✓					
7	Governor's Wife Office		✓	↓			✓
8	Quelimane Health Sciences Institute		✓	↓			✓
9	National Youth Institute	✓					
10	National Social Action Institute		✓	↓			✓
11	National Health Institute	✓	✓	↓			✓
12	Higher Institute for Health Sciences – ISCISA	✓	✓	↓			✓
13	Ministry of Defense	✓	✓	↓			✓
14	Ministry of Economy and Finance		✓	↓ ↑	✓	✓	✓
15	Ministry of Education and Human Development	✓	✓	↓			✓
16	Ministry of Justice and Religious Affairs (National Prison)	✓	✓	↓			✓
17	Ministry of Youth and Sports	✓					
18	Ministry of Health	✓	✓	↓ ↑		✓	✓
19	Ministry of Gender, Children and Social Welfare	✓	✓	↓			✓
20	Labor Ministry	✓	✓	↓ ↑		✓	✓
21	Ministry of Mineral Resources and Energy	✓	✓	↑		✓	✓
22	Portos e Caminhos de Ferro de Moçambique, EP – CFM	✓	✓	↑	✓	✓	✓
23	Telecomunicações de Moçambique -TDM, S.A.	✓	✓	↑	✓	✓	✓
24	Universidade Eduardo Mondlane		✓	↓			✓

Order	Organization/Institution	Contacted	Recorded in NASA	Method of data collection*	Source	Agent	Provider
	NATIONAL PRIVATE SECTOR						
25	Arquiplan		✓	↓			✓
26	Asna Construções		✓	↓			✓
27	Avani Hotails & Resorts, LDa	✓	✓	↓ ↑	✓	✓	✓
28	Cornelder (Beira)	✓					
29	Corredor de Desenvolvimento do Norte - CDN	✓	✓	↑	✓	✓	✓
30	Moçambique Leaf Tobacco Lda.	✓	✓	↑	✓	✓	✓
31	Mota Engil, Lda		✓	↑	✓	✓	✓
32	Teba	✓	✓	↑	✓	✓	✓
33	Tongaat Hulett - Açucareira de Moçambique, S.A.	✓	✓	↑	✓	✓	✓
34	Total	✓	✓	↑	✓		
35	União Geral das Cooperativas						
36	Vale Moçambique SA	✓	✓	↑	✓	✓	✓
	NATIONAL NON-PROFIT PRIVATE SECTOR						
37	Associação para a Defesa das Minorias Sexuais - LAMBDA	✓	✓	↑		✓	✓
38	Association of Women in Law - Muleide	✓	✓	↓ ↑		✓	✓
39	Ajuda de Desenvolvimento de Povo para Povo - ADPP	✓		↓			✓
40	Anemo	✓					
41	Aro Moçambique	✓					
42	Associação de Pessoas Vivendo com HIV/SIDA e Simpatizantes	✓					
43	Associação Moçambicana para o Desenvolvimento Concertado - AMDEC	✓	✓	↑		✓	✓
44	Associação Agir - Moçambique		✓	↑	✓	✓	
45	Associação Avante Mulher		✓	↑			✓
46	Associação Capaz		✓	↓			✓
47	Associação de Desenvolvimento de Povo para Povo - ADPP	✓	✓	↑			✓
48	Associação de Mineiros Moçambicanos - AMIMO	✓	✓	↓			✓

Order	Organization/Institution	Contacted	Recorded in NASA	Method of data collection*	Source	Agent	Provider
49	Associação Kindlimuka	✓	✓	↓			✓
50	Associação Moçambicana de Dadores de Sangue		✓	↓			✓
51	Associação Moçambicana Para Apoio e Desenvolvimento da Criança Orfã - REENCONTRO		✓	↓			✓
52	Associação Moçambicana para o Desenvolvimento da Familia - AMODEFA	✓	✓	↑	✓	✓	✓
53	Centro de Desenvolvimento Comunitário		✓	↓			✓
54	Chigwirizano		✓	↓			✓
55	Coalizão	✓	✓	↓			✓
56	Comunicação Para a Saúde - NWETI	✓	✓	↓			✓
57	Conselho das Religiões de Moçambique		✓	↑	✓	✓	
58	Conselho Islâmico de Moçambique - CISLAMO	✓					
59	Ecosida	✓	✓	↓	✓	✓	✓
60	Fórum Mulher	✓	✓				
61	Fórum Nacional de Rádios Comunitárias - FORCOM		✓	↓			✓
62	Fundação para o Desenvolvimento da Comunidade - FDC	✓	✓	↓ ↑		✓	✓
63	Igreja Evangélica Luterana		✓	↓			✓
64	Igreja Baptista de Dondo		✓	↓			✓
65	Kufunana		✓	↓			✓
66	Kupulumussana		✓	↓			✓
67	Kuyakana	✓					
68	Manhiça Research Center - CISM	✓	✓	↓			✓
69	Monaso	✓					
70	Movimento contra a TB	✓	✓	↑			✓
71	Movimento para o Acesso ao Tratamento em Moçambique - MATRAM	✓	✓	↑			✓
72	Organismo para o Direito Sócio-Integrado - KULIMA	✓	✓	↓			✓
73	Organização Kanimambo		✓	↓			✓
74	Phfuka U Hanya	✓	✓				✓
75	PIRCOM	✓		↑			

Order	Organization/Institution	Contacted	Recorded in NASA	Method of data collection*	Source	Agent	Provider
76	Rede Moçambicana de Líderes Religiosos Vivendo com HIV/SIDA - MONERELA	✓	✓	↓ ↑	✓	✓	✓
77	Rede Cristã Contra o HIV / SIDA	✓	✓	↓ ↑			✓
78	Rede de Comunicadores - RECAC		✓	↓			✓
79	Rede de Pessoas Vivendo com HIV	✓					
80	Rede Nacional Contra Droga - UNIDOS	✓					
81	Rede Umbrela		✓	↑	✓	✓	
82	Santo Egídio, Dream Program	✓	✓	↓ ↑		✓	✓
83	Tiyane Vavasate	✓					
84	Universidade Católica de Moçambique	✓	✓	↓			✓
85	Watana		✓	↓			✓
	MULTILATERAL ORGANIZATION						
86	World Bank	✓	✓	↓	✓		
87	United Nations Office on Drugs and Crime – UNODC	✓	✓	↑		✓	✓
88	United Nations Fund of Population Activities – FNUAP	✓	✓	↓ ↑	✓	✓	✓
89	Global Fund for HIV, TB and Malaria - GFATM	✓	✓	↓ ↑	✓		
90	United Nations Children's Fund – UNICEF	✓	✓	↓ ↑	✓	✓	✓
91	United Nations Educational, Scientific and Cultural Organization – UNESCO	✓	✓	↓ ↑	✓	✓	✓
92	International Organization for Migration – IOM	✓	✓	↑		✓	✓
93	International Labor Organization – ILO	✓	✓	↓ ↑	✓	✓	
94	World Health Organization – WHO	✓	✓	↓ ↑	✓	✓	✓
95	World Food Program – WFP	✓	✓	↓ ↑	✓	✓	✓
96	United Nations Development Program – UNDP	✓	✓	↓ ↑	✓	✓	✓
97	RCO / One UN	✓	✓	↓ ↑	✓		
98	UNAIDS Secretariat	✓	✓		✓	✓	✓
99	United Nations Hight Commissioner for refugees - UNHCR	✓					

Order	Organization/Institution	Contacted	Recorded in NASA	Method of data collection*	Source	Agent	Provider
100	UNITAID	✓	✓	↓ ↑	✓	✓	
101	UNWOMEN	✓					
102	International Funds for Agricultural Development - IFAD		✓	↑		✓	
	BILATERAL AGENCIES						
103	Government of German	✓	✓	↓ ↑		✓	✓
104	Government of Austria	✓					
105	Government of Belgium (BTC)	✓	✓	↓ ↑	✓		
106	Government of Flanders (Belgium)	✓	✓	↓ ↑	✓	✓	
107	Government of Denmark	✓	✓	↑	✓		
108	Government of Spain	✓	✓				
109	Autonomous Region of Catalonia (Spain)	✓	✓				
110	Government of Finland	✓	✓				
111	Government of France	✓	✓	↑	✓		
112	Government of Dutch	✓	✓	↓ ↑	✓		
113	Government of Ireland	✓	✓	↑	✓		
114	Government of Italy	✓	✓	↑	✓		
115	Government of Norway	✓	✓	↑	✓	✓	
116	Government of Sweden	✓	✓	↓ ↑	✓	✓	
117	Government of Swiss	✓	✓	↑	✓		
118	Government of Brazil	✓	✓				
119	Government of Canada	✓	✓	↓ ↑	✓		
120	Government of Japan	✓					
121	Government of UK	✓	✓	↓ ↑	✓		
122	Government of the United States of America - PEPFAR	✓	✓	↓ ↑	✓	✓	
123	Government of US – CDC		✓	↓		✓	
124	Government of US - U.S. Department of Defense (Defense)		✓	↓		✓	

Order	Organization/Institution	Contacted	Recorded in NASA	Method of data collection*	Source	Agent	Provider
125	Government of US - U.S. Department of State		✓	↓		✓	
126	Government of US - U.S. Peace Corps		✓	↓		✓	✓
127	Government of US - USAID		✓	↓	✓	✓	
128	PROSAUDE		✓	↓	✓		
129	European Union	✓	✓	↓ ↑	✓		
	OTHER INTERNATIONAL ORGANIZATIONS						
130	Abt Associates	✓	✓	↓		✓	✓
131	Africare		✓	↓	✓	✓	
132	Afrikagrupperna		✓	↑	✓	✓	
133	Agencia Andaluza de Cooperacion Internacional para el Desarrollo (AACID)		✓	↑	✓		
134	American Association of Blood Banks		✓	↓		✓	✓
135	American International Health Alliance Twinning Center		✓	↓		✓	✓
136	American Society for Microbiology		✓	↓		✓	✓
137	American Society of Clinical Pathology		✓	↓		✓	✓
138	Ariel Pediatrics AIDS Foundation		✓	↓ ↑		✓	✓
139	Association of Public Health Laboratories		✓	↓		✓	✓
140	Barcelona Center for International Health Research		✓	↓		✓	
141	Big Lottery		✓	↓ ↑	✓		
142	Cáritas	✓	✓				
143	Center for Collaboration in Health - Centro de Colaboração em Saúde - CCS	✓	✓	↓ ↑		✓	✓
144	Clinical and Laboratory Standards Institute		✓	↓		✓	✓
145	Columbia University Mailman School of Public Health		✓	↓		✓	✓
146	Deloitte Consulting Limited		✓	↓			✓
147	Douleur Sans Frontières	✓	✓	↑	✓	✓	✓
148	Elizabeth Glaser Pediatric AIDS Foundation		✓	↓		✓	✓
149	Federação Internacional da Cruz Vermelha e Sociedades do Crescente Vermelho	✓	✓				

Order	Organization/Institution	Contacted	Recorded in NASA	Method of data collection*	Source	Agent	Provider
150	Federação Internacional de Planeamento Familiar		✓	↑	✓	✓	
151	Federal University of Rio De Janeiro		✓	↓		✓	✓
152	Fhi 360	✓	✓	↓ ↑		✓	✓
153	Fondation Assistance Internationale		✓	↑	✓		
154	Foundation for Innovative New Diagnostics	✓	✓	↓		✓	
155	Fundação Aga Khan	✓	✓	↓ ↑			✓
156	Fundação Clinton	✓					
157	Fundação Clinton - CHAI	✓					
158	Fundação Ford	✓					
159	Fundo da Aliança Envangélica para Ajuda aos Pobres	✓	✓				
160	Gain Health (Nutrition)	✓	✓	↑	✓		
161	GAVI		✓	↓ ↑	✓		
162	Girl Child Right		✓	↓			✓
163	Global Health Communications		✓	↓		✓	✓
164	HACI - Iniciativa Africana para Apoio a COVs		✓	↑	✓	✓	
165	Handicap International	✓	✓	↑		✓	✓
166	Haurralde Fundation		✓	↑	✓		
167	HIV-AIDS and Children		✓	↓	✓		
168	ICF Macro		✓	↓			✓
169	Icrg (ONG)		✓	↓			✓
170	International Funds for Agricultural Development - IFAD		✓	↑		✓	
171	International Youth Foundation		✓	↓		✓	✓
172	International Center for Reproductive Health, Mozambique		✓	↓		✓	✓
173	Istituto Superiore di Sanità (Italy)		✓	↑	✓		
174	Italian Episcopal Conference		✓	↓ ↑	✓		
175	Jembi		✓	↓		✓	✓

Order	Organization/Institution	Contacted	Recorded in NASA	Method of data collection*	Source	Agent	Provider
176	Jhpiego		✓	↓		✓	✓
177	John Snow, Inc.	✓	✓	↓ ↑		✓	✓
178	Johns Hopkins University Bloomberg School of Public Health		✓	↓		✓	✓
179	Johnson & Johnson		✓	↓	✓	✓	
180	Luteran World Federation	✓	✓				
181	Management Sciences for Health		✓	↓		✓	
182	Médicos com África - CUAMM	✓	✓	↓ ↑	✓	✓	✓
183	Médicos Sem Fronteiras (Bélgica & Suiça)	✓	✓	↓ ↑	✓	✓	✓
184	Merck for Mother project - MSD		✓	↑	✓		
185	Misereor	✓					
186	Naima	✓	✓	↑		✓	
187	Namati Internacional		✓	↑	✓		
188	New York AIDS Institute		✓	↓		✓	
189	Open Society Initiative for Southen Africa - OSISA		✓	↑	✓	✓	
190	Oxfam Novib (African Transformation)	✓	✓	↑	✓	✓	
191	Partnership for Supply Chain Management	✓	✓	↓ ↑		✓	
192	Pathfinder International	✓	✓	↓ ↑		✓	✓
193	Population Services International - PSI	✓	✓	↓ ↑		✓	✓
194	Prosalus		✓	↑	✓	✓	
195	Repssi (Regional NGO)		✓	↓			✓
196	Right to Play	✓	✓				
197	Samaritans Purse	✓	✓	↓		✓	✓
198	Save the Children	✓					
199	Sidaction		✓	↑	✓		
200	SolidarMed		✓	↑		✓	✓
201	Soul City Institute		✓	↑	✓	✓	

Order	Organization/Institution	Contacted	Recorded in NASA	Method of data collection*	Source	Agent	Provider
202	Stephen Lewis Foundation		✓	↑	✓	✓	
203	Stiftung (Germany) - AIDS		✓	↑	✓		
204	Tearfund		✓	↑	✓	✓	
205	Técnica Engenheiros Consultores (TEC)		✓	↓ ↑			✓
206	Terre des Hommes - Alemanha	✓	✓	↓	✓	✓	
207	United States Pharmacopeia		✓				
208	University of California at San Diego		✓	↓			✓
209	University of California at San Francisco		✓	↓		✓	✓
210	University of Connecticut		✓	↓			✓
211	University of North Carolina at Chapel Hill, Carolina Population Center		✓	↓			✓
212	University of Washington - ITECH		✓	↓		✓	✓
213	University Research Corporation, LLC		✓	↓			✓
214	Vanderbilt University (Friends in Global Health)		✓	↓		✓	✓
215	Village Reach	✓	✓				
216	Vista Partners		✓	↓			✓
217	Viva Africa (ONG Belga de Sant' Egídio)		✓	↓			✓
218	VSO Moçambique	✓	✓	↓ ↑		✓	✓
219	World Vision International	✓	✓	↓ ↑	✓	✓	✓
	OTHER						
220	Country Coordination Mechanism	✓					

***Contacted organization/Institution without activity**

↑ **Top down data collection**

↓ **Bottom up data collection**

↓ ↑ **Top down and bottom up data collection**

Appendix 3: Service Providers (SP) and Location, 2014

Service Providers	Location												
	Cabo Delgado	Niassa	Nampula	Tete	Zambézia	Manica	Sofala	Inhamba-ne	Gaza	Maputo City	Maputo Province	National	Not disaggre-gated
Abt Associates				✓		✓	✓					✓	
Ajulsid							✓						
American Association of Blood Banks			✓				✓			✓		✓	
American International Health Alliance Twining Center											✓	✓	
American Society for Clinical Pathology			✓				✓			✓	✓	✓	
American Society for Microbiology			✓				✓			✓		✓	
Amodefa				✓	✓	✓	✓			✓	✓		
Ariel Pediatrics AIDS Foundation	✓										✓	✓	
Arquiplan			✓	✓	✓					✓			
ASNA Construções					✓								
Assembleia da República												✓	
Associação de Dadores de Sangue de Moçambique										✓			
Associação Moçambicana para o Desenvolvimento Concertado (AMDEC)											✓		
Associação Avante Mulher											✓		
Associação Capaz											✓		
Associacao de Desenvolvimento de Povo para Povo			✓		✓				✓		✓		
Associação Kanimambo										✓			
Associação de Mineiros de Moçambique									✓	✓	✓		
Association of Public Health Laboratories			✓								✓	✓	
AVANI Hotails & Resorts, Lda.	✓												
Caminhos de Ferro de Moçambique	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Catholic University of Mozambique												✓	
CCS - Center for Collaboration in Health - Centro de Colaboração em Saúde								✓		✓		✓	
Centro de Desenvolvimento Comunitário							✓						
Centro Nacional de Bancos de Sangue										✓			

Service Providers	Location												
	Cabo Delgado	Niassa	Nampula	Tete	Zambézia	Manica	Sofala	Inhamba-ne	Gaza	Maputo City	Maputo Province	National	Not disaggre-gated
Chigwirizano				✓									
CISM - Manhiça Research Center												✓	
Clinical and Laboratory Standards Institute			✓				✓			✓		✓	
CMAM - Central de Medicamentos e Artigos Medicos	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Coalizão					✓		✓	✓		✓	✓		
Columbia University			✓		✓					✓		✓	
Conselho Nacional de Combate ao SIDA												✓	
Conselho Nacional de Combate ao SIDA - Núcleo Provincial	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Corredor de Desenvolvimento do Norte			✓										
CUAMM (ONG - Médicos por África)							✓						
Deloitte Consulting Limited		✓					✓					✓	
Douler Sans Frontieres									✓				
DPMAS	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓	
DPS/MISAU	✓			✓	✓			✓			✓	✓	
DPSM											✓	✓	
Ecosida	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	
Elizabeth Glaser Pediatric AIDS Foundation	✓		✓						✓			✓	
Federal University of Rio de Janeiro												✓	
FHI360	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	
Forças Armadas de Defesa de Moçambique (FADEM)			✓	✓	✓		✓		✓	✓	✓	✓	
Forcom												✓	
Foundation for Innovative New Diagnostics	✓											✓	
Fundação para o Desenvolvimento da Comunidade	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Fundo das Nações Unidas para Actividades Populacionais					✓							✓	
Gabinete da Esposa do Governador									✓				
Girl Child Right						✓							

Service Providers	Location												
	Cabo Delgado	Niassa	Nampula	Tete	Zambézia	Manica	Sofala	Inhamba-ne	Gaza	Maputo City	Maputo Province	National	Not disaggre-gated
Global Health Communication												✓	
Governo da Alemanha (GIZ)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Handicap International										✓			
ICF Macro												✓	
ICRH(ONG)				✓									
Igreja Evangélica Luterana			✓										
Igreja Baptista de Dondo							✓						
Empresas privadas								✓					
Instituto de Ciências de Saúde de Quelimane					✓								
Instituto Nacional de Acção Social	✓												
Instituto Nacional de Saúde		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
International Youth Foundation										✓	✓		
International Center for Reproductive Health				✓									
ISCISA - Superior Institution of Health Sciences					✓								
ITECH, University of Washington	✓	✓	✓		✓	✓		✓	✓	✓	✓	✓	
Jembi												✓	
Jhpiego	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
John Snow, Inc.	✓		✓	✓		✓				✓	✓	✓	
Johns Hopkins University							✓		✓	✓	✓	✓	
Kufunana											✓		
KULIMA - Organismo para o Direito Sócio-Integrado						✓					✓		
Kupulumussana				✓									
Laboratórios	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		
Lambda													✓
Matram								✓	✓	✓	✓		
MC - Mecanismo de Coordenação do País												✓	

Service Providers	Location												
	Cabo Delgado	Niassa	Nampula	Tete	Zambézia	Manica	Sofala	Inhamba-ne	Gaza	Maputo City	Maputo Province	National	Not disaggre-gated
Médicos com África CUAMM							✓						
Médicos Sem Fronteiras da Bélgica				✓			✓			✓			
Médicos Sem Fronteiras da Suiça										✓		✓	
Ministério da Educação e Cultura	✓	✓					✓		✓	✓	✓		
Ministério da Justiça - Servico Nacional das Prisões			✓		✓			✓	✓				
Ministério da Mulher e Acção Social							✓						
Ministério do Trabalho		✓	✓		✓		✓			✓	✓		
Ministério dos Recursos Minerais e Energia										✓			
Ministério da Defesa Nacional		✓	✓	✓	✓	✓	✓			✓	✓		
Ministério da Saúde	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Ministério das Finanças				✓	✓	✓							
Moçambique Leaf Tobacco, Lda.		✓		✓	✓	✓							
Muleide													✓
Not for profit outpatient sites					✓			✓	✓	✓	✓		
N'WETI - Comunicação para a Saúde			✓						✓	✓	✓	✓	
N'WETI- Comunicação e Saúde									✓		✓		
OMS - Organização Mundial da Saúde					✓				✓			✓	
Organização das Nações Unidas contra o SIDA									✓			✓	
Organização Internacional das Migrações				✓			✓		✓		✓		
Organização Internacional do Trabalho				✓	✓	✓	✓						
Partnership for Supply Chain Management	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Pathfinder International			✓									✓	
Phfuka U Nhanya											✓		
Population Services International	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Programa Alimentar Mundial		✓	✓	✓	✓	✓	✓	✓	✓		✓		
Rede Moçambicana de Líderes Religiosos Vivendo com HIV/SIDA - MONARELA													✓

Service Providers	Location												
	Cabo Delgado	Niassa	Nampula	Tete	Zambézia	Manica	Sofala	Inhamba-ne	Gaza	Maputo City	Maputo Province	National	Not disaggre-gated
RECAC			✓	✓				✓	✓			✓	
Rede Cristã contra o HIV-SIDA								✓	✓				
Reencontro									✓				
REPSSI (Regional NGO)												✓	
Samaritans Purse								✓	✓			✓	
Santo Egídio, Dream Program					✓		✓		✓	✓	✓		
Sector público	✓	✓	✓		✓		✓	✓	✓	✓	✓		
SolidarMed	✓											✓	
TEBA								✓	✓	✓	✓	✓	
Técnica Engenheiros Consultores			✓	✓									
Telecomunicações de Moçambique	✓	✓	✓	✓	✓	✓	✓		✓	✓			
Tongaat Hulett - Açucareira de Moçambique, S.A,							✓						
U.S. Peace Corps		✓		✓	✓	✓		✓	✓				
UNESCO				✓	✓				✓	✓			
UNICEF- Organização das Nações Unidas para a Infância	✓		✓	✓	✓		✓		✓			✓	
Unidades Sanitárias	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
United Nations Office on Drugs and Crime	✓		✓		✓		✓	✓	✓	✓	✓	✓	
United States Pharmacopeia												✓	
Universidade de Ghent				✓									
Universidades			✓										
University of California at San Diego												✓	
University of California at San Francisco	✓		✓	✓	✓		✓	✓	✓		✓	✓	
University of Connecticut			✓									✓	
University of Eduardo Mondlane			✓									✓	
University of North Carolina at Chapel Hill, Carolina Population Center			✓			✓	✓						
University Research Corporation, LLC			✓			✓	✓				✓	✓	

Service Providers	Location												
	Cabo Delgado	Niassa	Nampula	Tete	Zambézia	Manica	Sofala	Inhamba-ne	Gaza	Maputo City	Maputo Province	National	Not disaggre-gated
Vale Moçambique, S.A.				✓									
Vanderbilt University					✓							✓	
Viva África (ONG Belga de Sant' Egídio)					✓		✓				✓	✓	
VSO Mozambique									✓	✓	✓	✓	
Watana			✓										
World Vision International			✓	✓	✓				✓			✓	

Appendix 4: Matrizes de Gastos em SIDA

Matrix of Costs in AIDS (ASC) – Financial Sources (FS), 2014

Categories of costs in HIV and AIDS (ASC)	Financial Sources					TOTAL
	FS.01 Public	FS.02 Private	FS.03.01 Bilateral	FS.03.02 Multilateral	FS.03.03 other international	
ASC.01. Prevention	2 735 860	**2 139 031**	**69 835 966**	**11 260 996**	**2 819 270**	**88 791 123**
ASC.01.01 Communication for behavior change	206 032	216 112	1 432 718	3 785 463	100 630	5 740 955
ASC.01.02 Community mobilization	118 199	15 093	5 619 340	300 428	53 644	6 106 704
ASC.01.03 Counseling and health testing (ATS)	297 966		8 386 711	903 692	79 815	9 668 184
ASC.01.04 Risk-reduction for vulnerable populations	84 010		2 279 103	443 506	30 489	2 837 108
ASC.01.05 Youth prevention in school	15 965		976 189	367 609		1 359 763
ASC.01.06 Prevention of young people out of school	214 544		7 684	114 090	30 000	366 318
ASC.01.07 Prevention for PLHIV	12 931		393 678	52 604	7 255	466 468
ASC.01.08 Programs for TS & customers			1 370 907	344 780	1 143 250	2 858 937
ASC.01.09 Programs for MSM			169 320	509	35 913	205 742
ASC.01.10 Programs for people who inject drugs			357 498			357 498
ASC.01.11 Prevention in the Workplace	148 203	177 483	308 545	1 467 447		2 101 678
ASC.01.12 Condom social marketing			5 513 784			5 513 784
ASC.01.13 Public distribution of male condoms		1 730 343	203 172	192 146		2 125 661
ASC.01.14 Public distribution of female condoms			47 425	43 048		90 473
ASC.01.16 Prevention and treatment of STIs	645 548		121 628	56 102	9 662	832 940
ASC.01.17 Elimination of mother-to-child transmission	958 530		17 364 272	2 794 518	945 623	22 062 943
ASC.01.18 Male Circumcision	26 596		17 400 744	125 847	11 864	17 565 051
ASC.01.19 Blood safety	7 336		2 710 473	32 065	3 273	2 753 147
ASC.01.21 Universal precaution			2 872 352			2 872 352
ASC.01.22 Post-exposure prophylaxis			2 009 154			2 009 154
ASC.01.98 Prevention ndt			291 269	237 142	367 852	896 263

Categories of costs in HIV and AIDS (ASC)	Financial Sources					TOTAL
	FS.01 Public	FS.02 Private	FS.03.01 Bilateral	FS.03.02 Multilateral	FS.03.03 other international	
ASC.02. Care and Treatment	**3 275 115**	**85 853**	**85 939 193**	**23 681 139**	**3 495 116**	**116 476 416**
ASC.02.01 outpatient treatment	3 275 115	85 853	84 453 927	23 681 139	2 598 042	114 094 076
ASC.02.01.01 Testing initiated by the provider	199 366		678 411	889 703	88 928	1 856 408
ASC.02.01.02 IO Treatment		4 240	5 641 442			5 645 682
ASC.02.01.03 Antiretroviral treatment	1 386 387		54 339 818	21 476 659	71 710	77 274 574
ASC.02.01.04 Nutritional support			2 664 920	6 159	7 554	2 678 633
ASC.02.01.05 Laboratory monitoring	1 509 373		12 489 101	1 303 343	762 740	16 064 557
ASC.02.01.08 Palliative care			8 240			8 240
ASC.02.01.09 Home care	179 989	81 613	7 466 087		213 171	7 940 860
ASC.02.01.98 Outpatient treatment ndt			1 165 908	5 275	1 453 939	2 625 122
ASC.02.98 Care and treatment ndt			1 485 266		897 074	2 382 340
ASC.03. Orphans and vulnerable children (OVCs)	**242 678**		**5 365 133**	**515**	**552 456**	**6 160 782**
ASC.03.01 Education for OVCs			1 385 301		31 027	1 416 328
ASC.03.02 Basic health services			1 696 777	515	210 223	1 907 515
ASC.03.03 Family support			1 265 517		7 402	1 272 919
ASC.03.04 Community support	232 757					232 757
ASC.03.05 Social and administrative services	9 921				948	10 869
ASC.03.06 Institutional care					1 828	1 828
ASC.03.98 OVC ndt					73 626	73 626
ASC.03.99 OVC not rated			1 017 538		227 402	1 244 940
ASC.04. Response coordination and system strengthening	**7 867 058**		**77 788 451**	**4 231 128**	**1 993 807**	**91 880 444**
ASC.04.01 National program coordination and management	3 543 067		8 753 086	2 357 742	699 753	15 353 648
ASC.04.02 Administrative costs related to management and funds	89 401		27 166 943	789 088	563 977	28 609 409
ASC.04.03 Monitory and Evaluation	892 962		11 966 419	430 941	18 641	13 308 963
ASC.04.04 Operation Research				7 168	561 589	568 757
ASC.04.05 Sero-surveillance	216 693		2 340 989			2 557 682

Categories of costs in HIV and AIDS (ASC)	Financial Sources					TOTAL
	FS.01 Public	FS.02 Private	FS.03.01 Bilateral	FS.03.02 Multilateral	FS.03.03 other international	
ASC.04.07 Drug distribution system	3 124 935		8 665 216	34 498		11 824 649
ASC.04.08 Information technology			7 518 271	368		7 518 639
ASC.04.10 Infrastructure construction and rehabilitation			9 901 488	588 631	149 847	10 639 966
ASC.04.99 Coordination of non-rated response			1 476 039	22 692		1 498 731
ASC.05. Incentives for human resources			**19 365 047**	**193 711**	**46 560**	**19 605 318**
ASC.05.03 Training			16 241 746	193 711	46 560	16 482 017
ASC.05.98 Incentives for human resources ndt			3 123 301			3 123 301
ASC.06. Social protection and social services	**184 812**	**14 568**	**678 789**	**13 000**	**23 007**	**914 176**
ASC.06.01 Social protection through monetary benefits		6 771				6 771
ASC.06.02 Gender Benefits	27 376	7 797				35 173
ASC.06.04 Income generation	77 087		154 304	13 000	23 007	267 398
ASC.06.98 Social protection services and social services not broken down by type.	72 610					72 610
ASC.06.99 Social protection services and social services n.c.o.	7 739		524 485			532 224
ASC.07. Favorable environment	**1 891 694**		**3 481 726**	**2 349 207**	**738 007**	**8 460 634**
ASC.07.01 Advocacy	1 790 024		424 354	655 684	623 660	3 493 722
ASC.07.02 Human rights	56 808		6 083		107 913	170 804
ASC.07.03 Institutional development			2 716 484	1 527 959	6 434	4 250 877
ASC.07.04 HIV programs focusing on Gender	39 574		334 805	115 564		489 943
ASC.07.05 Programs to reduce gender-based violence				50 000		50 000
ASC.07.98 Favorable environment ndt	5 288					5 288
ASC.08. Research				**208 543**	**5 595**	**214 138**
ASC.08.04 Social science research				106 043	5 595	111 638
ASC.08.98 Research activities related to HIV n.d.t.				102 500	0	102 500
TOTAL	**16 197 217**	**2 239 452**	**262 454 305**	**41 938 240**	**9 673 818**	**332 503 032**

Matrix of expenditure in AIDS Spending Categories (ASC) – Beneficiary Populations (BP), 2014

AIDS Spending Categories (ASC)	Beneficiary Populations							TOTAL
	BP.01. PVHIV	BP.02. Key pop	BP.03 Vulnerable groups	BP.04 Specific populations	BP.05 General population	BP.06 Not targetted	BP.99 Specific Population n.e.c.	
ASC.01. Prevention	**409 037**	**3 422 177**	**26 249 526**	**8 857 395**	**49 805 193**		**47 795**	**88 791 123**
ASC.01.01 Communication for behavior change					5 740 955			5 740 955
ASC.01.02 Community mobilization				50 870	6 055 834			6 106 704
ASC.01.03 Counseling and health testing (ATS)					9 668 184			9 668 184
ASC.01.04 Risk-reduction for vulnerable populations			1 419 521	766 651	650 936			2 837 108
ASC.01.05 Youth prevention in school				1 344 713	15 050			1 359 763
ASC.01.06 Prevention of young people out of school				223	366 095			366 318
ASC.01.07 Prevention for PLHIV	405 421		58 772		2 275			466 468
ASC.01.08 Programs for TS & customers		2 858 937						2 858 937
ASC.01.09 Programs for MSM		205 742						205 742
ASC.01.10 Programs for people who inject drugs		357 498						357 498
ASC.01.11 Prevention in the Workplace	3 616			2 050 267			47 795	2 101 678
ASC.01.12 Condom social marketing					5 513 784			5 513 784
ASC.01.13 Public distribution of male condoms					2 125 661			2 125 661
ASC.01.14 Public distribution of female condoms					90 473			90 473
ASC.01.16 Prevention and treatment of STIs				832 940				832 940
ASC.01.17 Elimination of mother-to-child transmission			22 062 943					22 062 943
ASC.01.18 Male Circumcision			21 826	16 860	17 526 365			17 565 051
ASC.01.19 Blood safety			2 686 464		66 683			2 753 147
ASC.01.21 Universal precaution				2 872 352				2 872 352
ASC.01.22 Post-exposure prophylaxis				922 519	1 086 635			2 009 154
ASC.01.98 Prevention ndt					896 263			896 263

AIDS Spending Categories (ASC)	Beneficiary Populations							TOTAL
	BP.01. PVHIV	BP.02. Key pop	BP.03 Vulnerable groups	BP.04 Specific populations	BP.05 General population	BP.06 Not targetted	BP.99 Specific Population n.e.c.	
ASC.02. Care and Treatment	**114 598 062**				**1 878 354**			**116 476 416**
ASC.02.01 outpatient treatment	112 215 722				1 878 354			114 094 076
ASC.02.01.01 Testing initiated by the provider					1 856 408			1 856 408
ASC.02.01.02 IO Treatment	5 645 682							5 645 682
ASC.02.01.03 Antiretroviral treatment	77 274 574							77 274 574
ASC.02.01.04 Nutritional support	2 678 633							2 678 633
ASC.02.01.05 Laboratory monitoring	16 064 557							16 064 557
ASC.02.01.08 Palliative care	8 240							8 240
ASC.02.01.09 Home care	7 918 914				21 946			7 940 860
ASC.02.01.98 Outpatient treatment ndt	2 625 122							2 625 122
ASC.02.98 Care and treatment ndt	2 382 340							2 382 340
ASC.03. Orphans and vulnerable children (OVCs)			**6 160 782**					**6 160 782**
ASC.03.01 Education for OVCs			1 416 328					1 416 328
ASC.03.02 Basic health services			1 907 515					1 907 515
ASC.03.03 Family support			1 272 919					1 272 919
ASC.03.04 Community support			232 757					232 757
ASC.03.05 Social and administrative services			10 869					10 869
ASC.03.06 Institutional care			1 828					1 828
ASC.03.98 OVC ndt			73 626					73 626
ASC.03.99 OVC not rated			1 244 940					1 244 940
ASC.04. Response coordination and system strengthening						**91 880 444**		**91 880 444**
ASC.04.01 National program coordination and management						15 353 648		15 353 648
ASC.04.02 Administrative costs related to management and funds						28 609 409		28 609 409
ASC.04.03 Monitory and Evaluation						13 308 963		13 308 963
ASC.04.04 Operation Research						568 757		568 757
ASC.04.05 Sero-surveillance						2 557 682		2 557 682

AIDS Spending Categories (ASC)	Beneficiary Populations							TOTAL
	BP.01. PVHIV	BP.02. Key pop	BP.03 Vulnerable groups	BP.04 Specific populations	BP.05 General population	BP.06 Not targetted	BP.99 Specific Population n.e.c.	
ASC.04.07 Drug distribution system						11 824 649		11 824 649
ASC.04.08 Information technology						7 518 639		7 518 639
ASC.04.10 Infrastructure construction and rehabilitation						10 639 966		10 639 966
ASC.04.99 Coordination of non-rated response						1 498 731		1 498 731
ASC.05. Incentives for human resources	**16 030**			**19 589 288**				**19 605 318**
ASC.05.03 Training	16 030			16 465 987				16 482 017
ASC.05.98 Incentives for human resources ndt				3 123 301				3 123 301
ASC.06. Social protection and social services	**823 884**		**80 604**	**9 688**				**914 176**
ASC.06.01 Social protection through monetary benefits	6 771							6 771
ASC.06.02 Gender Benefits	19 119		6 366	9 688				35 173
ASC.06.04 Income generation	193 160		74 238					267 398
ASC.06.98 Social protection services and social services not broken down by type	72 610							72 610
ASC.06.99 Social protection services and social services n.c.o.	532 224							532 224
ASC.07. Favorable environment	**5 050**	**66 490**			**639 207**	**7 749 887**		**8 460 634**
ASC.07.01 Advocacy						3 493 722		3 493 722
ASC.07.02 Human rights	5 050	66 490			99 264			170 804
ASC.07.03 Institutional development						4 250 877		4 250 877
ASC.07.04 HIV programs focusing on Gender					489 943			489 943
ASC.07.05 Programs to reduce gender-based violence					50 000			50 000
ASC.07.98 Favorable environment ndt						5 288		5 288
ASC.08. Research						214 138		214 138
ASC.08.04 Social science research						111 638		111 638
ASC.08.98 Research activities related to HIV n.d.t.						102 500		102 500
Total	**115 852 063**	**3 488 667**	**32 490 912**	**28 456 371**	**52 322 754**	**99 844 469**		**332 503 032**

Matrix – Costs in AIDS (ASC) – Service providers (SP), 2014

AIDS Spending Categories (ASC)	Service Provider				
	Bilateral and multilateral	International private	National private	Public	TOTAL
ASC.01. Prevention	**3 135 727**	**10 625 508**	**22 610 341**	**52 419 547**	**88 791 123**
ASC.01.01 Communication for behavior change	123 339	499 889	4 890 775	226 952	5 740 955
ASC.01.02 Community mobilization	268 076	796 331	4 287 218	755 079	6 106 704
ASC.01.03 Voluntary councelling and testing (HAT)		294 432	2 680 586	6 693 166	9 668 184
ASC.01.04 Risk reduction for vulnerable populations	559 131	17 985	1 477 763	782 229	2 837 108
ASC.01.05 Youth prevention at school	319 388	13 785	954 643	71 947	1 359 763
ASC.01.06 Youth prevention out of school			366 318		366 318
ASC.01.07 PVHIV prevention			466 468		466 468
ASC.01.08 Sex workers & clients programs		1 636 157	1 015 942	206 838	2 858 937
ASC.01.09 MSM programs		35 913	169 829		205 742
ASC.01.10 Programs for people injecting drugs			357 498		357 498
ASC.01.11 Work place prevention		32 854	1 583 798	485 026	2 101 678
ASC.01.12 Social marketing of condom		5 513 784			5 513 784
ASC.01.13 Male condom distribution for public and commercial sectors			1 855 177	270 484	2 125 661
ASC.01.14 Female condom distribution for public and commercial sectors			57 773	32 700	90 473
ASC.01.16 STIs Prevention and treatment				832 940	832 940
ASC.01.17 Elimination of mother-to-child transmission	1 865 793	1 723 671	886 286	17 587 193	22 062 943
ASC.01.18 Male circumcision			627 625	16 937 426	17 565 051
ASC.01.19 Blood safety			97 086	2 656 061	2 753 147
ASC.01.21 Universal precaution				2 872 352	2 872 352
ASC.01.22 Post exposure prophylaxis				2 009 154	2 009 154
ASC.01.98 Prevention ndt		60 707	835 556		896 263

AIDS Spending Categories (ASC)	Service Provider				
	Bilateral and multilateral	International private	National private	Public	TOTAL
ASC.02.01 Outpatient treatment	**209 846**	**7 464 861**	**4 817 720**	**103 983 989**	**116 476 416**
ASC.02.01 Outpatient treatment	209 846	5 154 043	4 808 744	103 921 443	114 094 076
ASC.02.01.01 Testing initiated by the provider				1 856 408	1 856 408
ASC.02.01.02 O treatment		2 644	4 240	5 638 798	5 645 682
ASC.02.01.03 Anti-retroviral treatment	209 846		262 181	76 802 547	77 274 574
ASC.02.01.04 Nutritional support		584 095	805 284	1 289 254	2 678 633
ASC.02.01.05 Laboratory monitoring		402 975		15 661 582	16 064 557
ASC.02.01.08 Palliative care			8 240		8 240
ASC.02.01.09 Home care		1 539 207	3 728 799	2 672 854	7 940 860
ASC.02.01.98 Outpatient treatment ndt		2 625 122			2 625 122
ASC.02.98 Care and treatment ndt		2 310 818	8 976	62 546	2 382 340
ASC.03. Orphans and vulnerable children (COVs)	**4 168**	**2 108 499**	**4 020 513**	**27 602**	**6 160 782**
ASC.03.01 Education for COVs	1 118	437 407	977 803		1 416 328
ASC.03.02 Basic health services		392 899	1 514 616		1 907 515
ASC.03.03 Family support	1 525	740 756	530 638		1 272 919
ASC.03.04 Community support			220 768	11 989	232 757
ASC.03.05 Social and administrative services			10 869		10 869
ASC.03.06 Institutional care			1 828		1 828
ASC.03.98 COVs ndt			58 013	15 613	73 626
ASC.03.99 Non-classified COVs	1 525	537 437	705 978		1 244 940
ASC.04. Response coordination and system reinforcement	**2 758 388**	**69 866 311**	**5 068 474**	**14 187 271**	**91 880 444**
ASC.04.01 National program coordination and management	1 834 125	8 629 113	96 993	4 793 417	15 353 648
ASC.04.02 Administrative costs related to management and funds	440 630	25 479 331	2 015 777	673 671	28 609 409
ASC.04.03 Monitoring and Evaluation	430 941	11 566 849	192 498	1 118 675	13 308 963
ASC.04.04 Operational research		568 757			568 757
ASC.04.05 Sero-surveillance		1 371 619	112 426	1 073 637	2 557 682

AIDS Spending Categories (ASC)	Service Provider				
	Bilateral and multilateral	International private	National private	Public	TOTAL
ASC.04.07 Drug distribution system	30 000	6 599 767		5 194 882	11 824 649
ASC.04.08 Information Technology		7 412 111	4 845	101 683	7 518 639
ASC.04.10 Infrastructure construction and rehabilitation		6 786 165	2 628 529	1 225 272	10 639 966
ASC.04.99 Coordination of non-classified response	22 692	1 452 599	17 406	6 034	1 498 731
ASC.05. Incentive for human resources	**36 750**	**17 641 367**	**564 427**	**1 362 774**	**19 605 318**
ASC.05.03 Training	36 750	14 616 096	485 480	1 343 691	16 482 017
ASC.05.98 Incentive for human resources ndt		3 025 271	78 947	19 083	3 123 301
ASC.06. Social protection and social services	**13 000**	**243 308**	**638 749**	**19 119**	**914 176**
ASC.06.01 Social protection through monetary benefits			6 771		6 771
ASC.06.02 Gender benefits			16 054	19 119	35 173
ASC.06.04 Income generation	13 000	38 602	215 796		267 398
ASC.06.98 Social protection services and social services non-divided by type			72 610		72 610
ASC.06.99 Social protection services and social services n.c.o.		204 706	327 518		532 224
ASC.07. Favorable environment	**560 896**	**3 780 664**	**2 323 548**	**1 795 526**	**8 460 634**
ASC.07.01 Advocacy	542 868	777 545	377 783	1 795 526	3 493 722
ASC.07.02 Human rights		66 490	104 314		170 804
ASC.07.03 Institutional development		2 601 824	1 649 053		4 250 877
ASC.07.04 HIV Programs focusing on Gender	18 028	334 805	137 110		489 943
ASC.07.05 Programs to reduce gender-based violence			50 000		50 000
ASC.07.98 Favorable environment ndt			5 288		5 288
ASC.08. Research	**179 747**			**34 391**	**214 138**
ASC.08.04 Research on social sciences	77 247			34 391	111 638
ASC.08.98 Research activities related to HIV n.d.t.	102 500				102 500
Total	**6 898 523**	**111 730 518**	**40 043 772**	**173 830 219**	**332 503 032**

Financing sources (FS) – Service Providers (PS), 2014

Financial Sources	Service Provider				
	Bilateral and multilateral	International private	Domestic private	Domestic public	TOTAL
FS.01 Public sources			**1 454 627**	**14 742 590**	**16 197 217**
FS.01.01 Territorial public funds			1 454 627	14 605 754	16 060 381
FS.01.99 Other public funds ndt				136 836	136 836
FS.02 Private Funds		**32 854**	**2 158 849**	**47 749**	**2 239 452**
FS.02.01 Profit Institutions		32 854	235 637	47 749	316 240
FS.02.03 Non-profit institutions			1 730 343		1 730 343
FS.02.99 Non-classified private funds			192 869		192 869
FS.03 International funds	**6 898 523**	**111 697 664**	**36 430 296**	**159 039 880**	**314 066 363**
FS.03.01 Direct bilateral contributions	2 735 418	102 473 911	27 265 983	129 978 993	262 454 305
FS.03.01.03 Government of Belgium		1 460 687	262 521		1 723 208
FS.03.01.04 Government of Canada	369 715		30 941	1 054 998	1 455 654
FS.03.01.05 Government of Denmark	959	60 653			61 612
FS.03.01.07 Government of France		140 861			140 861
FS.03.01.10 Government of Ireland	15 851				15 851
FS.03.01.11 Government of Italy		451 404			451 404
FS.03.01.14 Government of The Netherlands	27 931	5 464 123	1 411 424		6 903 478
FS.03.01.16 Government of Norway		412 033			412 033
FS.03.01.19 Government of Sweden	431 101	131 392	137 058	92 236	791 787
FS.03.01.20 Government of Switzerland		947 836			947 836
FS.03.01.21 Government of the United Kingdom		362 374			362 374
FS.03.01.22 Government of the United States of America	1 889 861	92 534 242	25 420 976	127 110 982	246 956 061
FS.03.01.99 Other Government		508 306	3 063	1 720 777	2 232 146

Financial Sources	Service Provider				
	Bilateral and multilateral	International private	Domestic private	Domestic public	TOTAL
FS.03.02 Multilateral Agencies	4 158 252	1 605 502	8 410 809	27 763 677	41 938 240
FS.03.02.02 European Commission	1 037 894	68 658		122 748	1 229 300
FS.03.02.04 ILO	23 000				23 000
FS.03.02.07 Global Funds for HIV, TB and Malaria	189 173	418 771	6 881 150	23 384 428	30 873 522
FS.03.02.08 UNAIDS	1 514 474		129 714		1 644 188
FS.03.02.09 UNICEF	896 993	124 154	749 938	240 534	2 011 619
FS.03.02.11 UNDP				152 473	152 473
FS.03.02.17 UNFPA	341 983		591 089	765 355	1 698 427
FS.03.02.18 World Bank				880 023	880 023
FS.03.02.19 WFP		12 867	369		13 236
FS.03.02.29 WHO	77 488				77 488
FS.03.02.99 Non-classified multilateral agencies	77 247	981 052	58 549	2 218 116	3 334 964
FS.03.03 International NGOs	4 853	7 618 251	753 504	1 297 210	9 673 818
FS.03.03.20 MSF		4 422 189	7 272	780 592	5 210 053
FS.03.03.24SIDACTION (mainly in French speaking countries)		4 546			4 546
FS.03.03.33 World Vision		396 079			396 079
FS.03.03.34 International Family Planning Federation			49 603		49 603
FS.03.03.99 Other international NGOs	4 853	2 795 437	696 629	516 618	4 013 537
Total	**6 898 523**	**111 730 518**	**40 043 772**	**173 830 219**	**332 503 032**

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