Mozambique

HIV Thematic Report

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Contents

Acronyms

AIDS Acquired immune deficiency syndrome
ALHIV Adolescents Living with HIV
ARV Antiretroviral
ART Antiretroviral treatment
BFHI Baby-friendly Hospital Initiative
CD4 Cluster of differentiation 4
CHAI Clinton Health Access Initiative
EID early infant diagnosis
eMTCT Elimination of mother-to-child-transmission
HAART Highly Active Antiretroviral Therapy
HIV Human immunodeficiency virus
iCCM Integrated Community Case Management
INSIDA Inquérito Nacional de Prevalência, Riscos Comportamentais e Informação sobre o HIV e SIDA em Moçambique (National Survey on Prevalence, Behavioural Risks, and Information about HIV and AIDS in Mozambique)
MoH Ministry of Health
PCR Polymerase chain reaction testing
PMTCT Prevention of mother-to-child transmission (of HIV)
POCT Point-of-care technology
VAC Violence Against Children
WHO World Health Organization

Glossary

CD4: A type of white blood cell that fights infection. Measuring the number of CD4 cells in a sample of blood helps tell how strong an immune system is, indicates the stage of HIV infection, guides treatment, and predicts how the disease may progress.

PMTCT package: The prevention of mother-to-child transmission of HIV package includes counselling and testing; referral of pregnant women; antiretroviral treatment; promotion of institutional delivery; postnatal counselling; psychosocial support through mother support groups; referral to at-risk child consultation; and early infant diagnosis.

Polymerase chain reaction (PCR) testing: A PCR test can detect the genetic material of HIV and can identify HIV in the blood within two or three weeks of infection. The test is used in children below 9 months of age to determine their HIV sero-status (the antibody HIV test may detect maternal antibodies).

Point-of-care testing/technology (POCT): Defined as medical testing at or near the site of patient care. The driving notion behind POCT is to bring the test conveniently and immediately to the patient, thus increasing the likelihood that the patient, physician, and care team will receive the results in a timely manner.

SMS printer system: An SMS printer is a small, portable, stand-alone device for receiving and printing messages. The unit works with most network providers and can be supplied in many different configurations. In Mozambique, limited sample referral logistics, laboratory capacity, and reduced numbers of skilled health care workers has led to long turnaround times for critical early infant diagnosis results, significantly delaying treatment initiation, and ultimately contributing unnecessarily to child mortality.

I. EXECUTIVE SUMMARY

2016 was a difficult year for Mozambique as it faced a significant economic and financial crisis. In April it was revealed that the previous government had taken out approximately US$2billion of undisclosed debt. This led to a suspension of IMF support while bilateral donors put on hold the General Budget Support and Common Funds given their lack of confidence and trust in sound financial governance.

In addition, Mozambique remains heavily impacted by HIV/AIDS, having the eighth highest prevalence in the world, with more than 1 in 10 Mozambicans infected (UNAIDS, 2013). There has been a decrease in new infections, but the absolute number of people living with HIV has been rising and this trend is likely to continue as higher treatment coverage reduces mortality. Despite strong progress in access to ART and PMTCT services, still very few children who need treatment receive it.

In Mozambique, there are approximately 147,000 children under 15 living with HIV and adolescents and youth continue to face enormous vulnerability to HIV and AIDS. According to the INSIDA 2009 survey, HIV prevalence among young people 15–24 years was 7.9 per cent, and HIV prevalence among young women was almost three-times higher than that of young men of similar age (11.1 per cent women, 3.7 per cent men).

During 2016, in the area of Prevention of Mother to Child Transmission (PMTCT) and Paediatric HIV, UNICEF has made a significant contribution to policy development through studies on the most effective operational approaches for retention of mothers and children. This work is informing the National PMTCT communication strategy being developed with technical and financial support from UNICEF. The Strategy will guide all HIV partners, including PEPFAR, towards a common and focus approach to improve retention in HIV treatment. UNICEF also contributed to the scale up of ART across the country which enhanced the national programme such that 68 per cent of health facilities are now classified as ART sites. UNICEF's contribution has been to conduct readiness assessment of facilities that have been upgraded to ARV sites. In addition, UNICEF supported MOH to develop the National Communication Strategy for Retention in PMTCT and HIV Paediatric Treatment as well as the introduction for POC for EID. For HIV exposed infants, the main area of progress has been around POC technology which has enabled test results (PCR) to be available to the patient within 50 minutes.

Retention in PMTCT and HIV Treatment services remains low. The current retention rate for children on ART is 64 per cent at 12 months after initiation. For pregnant women, the rate is 59 per cent at 12 months after initiation of treatment.

The launch of the One UN Action for Girls programme ensured that an integrated engagement programming for adolescents was further strengthened at national level, with a particular focus in Zambézia and Nampula. In addition, the first results from the IMASIDA survey were disseminated, however, IMASIDA data on HIV prevalence and incidence is still not available due to delays in the supply of kits for testing dry blood spots.

UNICEF worked closely with the regional media hub, regional/global coverage on child marriage during the African Union (AU) Summit and on HIV programme innovation during the Durban conference.

II. STRATEGIC CONTEXT OF 2016

2016 was a difficult year for Mozambique as it faced a significant economic and financial crisis. In April it was revealed that the previous government had taken out approximately US$2billion of undisclosed debt. This led to a suspension of IMF support while bilateral donors put on hold the General Budget Support and Common Funds given their lack of confidence and trust in sound financial governance. The situation was compounded by a fall in commodity prices, a decline in foreign exchange inflows and significant currency depreciation and, as a result, the national budgets for 2016 and 2017 were reduced. UNICEF has remained very engaged and has continued to advocate that critical social services for children should not be affected and, when requested, has stepped in to ensure resources remain available

Mozambique also faced the worst "El Niño" drought in 35 years, with an estimated humanitarian impact of 1.5 million people and a projected scenario of 2.3 million by March 2017. In addition, the continuing political-military tensions have resulted in population displacement and disruption of basic social services in health and education in various districts of Zambézia, Manica, Sofala and Tete provinces. UNICEF is co-chairing the HCT and leading clusters providing humanitarian assistance in the areas of WASH, Nutrition, Education and Protection.

Mozambique remains heavily impacted by HIV/AIDS, having the eighth highest prevalence in the world, with more than 1 in 10 Mozambicans infected (UNAIDS, 2013). The first national household HIV/AIDS survey in 2009 (INSIDA) found that HIV prevalence in the population aged 15-49 was 11.5%, with more women infected than men (13.1% and 9.2% respectively). With regards to children, in 2009 there were 1.4% of children aged 0-11, with varying trends between different age groups. Among children under 1 year old (0-11 months), whose infection is attributed to their mothers, a prevalence of 2.3% was observed. Yet, as most of these children grow without access to treatment, they begin to succumb to the disease, which is reflected in the lower prevalence rate of 1.0% found among 5-9 year olds. From this point onward, there is an upward trend in prevalence, reaching 1.8% in the 12-14 year age group and then rising steeply until it peaks at age 25-29 for women (16.8%) and at age 35-39 for men (14.2%).

There has been a decrease in new infections, but the absolute number of people living with HIV has been rising and this trend is likely to continue as higher treatment coverage reduces mortality. UNAIDS (2012) estimates that new infections fell from 140,000 in 2001 to 130,000 in 2011, while the total number of people (of all ages) living with HIV rose from 850,000 to 1.4 million during this period. There have been impressive increases in the coverage of HIV testing (especially of women during antenatal consultations), anti-retroviral therapy (ART) and prevention of mother-to-child transmission (PMTCT), made possible by large-scale project-specific funding by donors. The survey data (DHS, INSIDA and MICS) show that the proportion of women aged 15-49 who were tested within the previous year and who received their results rose from less than 3% in 2003 to 15% in 2008, 17% in 2009 and 26% in 2011. The figures for men (aged 15-49) are lower, but have also risen, from 9% in 2009 (INSIDA) to 14.2% in 2011 (DHS).

Despite strong progress in access to ART and PMTCT services, still very few children who need treatment receive it. There has been a large increase in the proportion of HIV+ pregnant women receiving drugs for PMTCT: according to administrative data fewer than 3,000 patients were receiving ART in 2003 but by the end of 2012 this figure had risen to 300,000, with a coverage rate estimated at 52% for adults. Yet, the coverage rate for children is extremely low, at only 22% (MoH, 2013b).

PMTCT is a relatively simple intervention that grants all women attending antenatal care (ANC) the opportunity to know their sero-status and access antiretroviral medicines (ARVs) should they be HIV positive. In 2012, WHO recommended countries to consider another option, called 'Option B+'. This option calls for all HIV-positive pregnant women attending PMTCT services to begin antiretroviral treatment irrespective of the stage of their illness. This approach was adopted in Mozambique and in June

2013 Mozambique initiated nationwide implementation of these guidelines, calling for the use of Universal ART for pregnant and lactating mothers once tested HIV-positive, independent of their CD4 result. This regimen is being implemented in a phased approach, starting where ART is already being offered and through one stop approach service model. Where ART is not available, option A will continue.

In Mozambique, there are approximately 147,000 children under 15 living with HIV. There has been a significant improvement in the number of children under 15 years receiving ART, growing from less than 500 in 2004 to 37,712 in 2013. There has also been an increase in the number of sites providing antiretroviral therapy; and by September 2013, 523 health facilities provided treatment (207 more new health facilities in 2013 than in 2012), all of which were treating HIV-positive children, compared with 261 in 2011, 173 in 2009, and only 32 of 150 sites in 2006.

In terms of early infant diagnosis, Polymerase Chain Reaction (PCR, see glossary) testing has been expanded, reaching 600 health facilities collecting PCR samples in 2013, and 500 with SMS printers (see glossary) for the faster return of results, compared to 305 health facilities and 54 SMS printers in 2011.

Adolescents and youth continue to face enormous vulnerability to HIV and AIDS. According to the INSIDA 2009 survey, HIV prevalence among young people 15–24 years was 7.9 per cent, and HIV prevalence among young women was almost three-times higher than that of young men of similar age (11.1 per cent women, 3.7 per cent men). Young women have higher odds of HIV infection due to various factors, including age-disparate sex, not living with their sexual partner, not attending school, and having multiple partners. Not knowing one's HIV status and engaging in high-risk practices such as scarification/ tattooing predispose young people to the risk of contracting HIV, particularly among young girls. Given that Mozambique's population is very young, with adolescents and youth making up roughly a third of the country's population, any change in the behaviour and lifestyle of this age group would have a significant impact on the course of the epidemic.

The HIV and AIDS epidemic is the major contributor to the increasing number of orphaned and vulnerable children (OVC) in Mozambique. Currently there are estimated to be 2.1 million orphans in Mozambique, of whom 600,000 have been orphaned by AIDS. This does not take into account additional children who may be vulnerable due to the impact of HIV on their family.

In recent years, the Government has made significant efforts to build a protective environment for vulnerable children, resulting in an improved national policy framework relating to OVCs. The National Plan of Action for Children (2013–2019) outlines the main principles of intervention, targets, and priority actions, with particular emphasis on psychosocial support, legal assistance and placement in alternative care for orphans and vulnerable children.

III. RESULTS IN THE OUTCOME AREA

During 2016, in the area of Prevention of Mother to Child Transmission (PMTCT) and Paediatric HIV, UNICEF has made a significant contribution to policy development through studies on the most effective operational approaches for retention of mothers and children. This work is informing the National PMTCT communication strategy being developed with technical and financial support from UNICEF. The Strategy will guide all HIV partners, including PEPFAR, towards a common and focus approach to improve retention in HIV treatment

UNICEF also contributed to the scale up of ART across the country which enhanced the national programme such that 68 per cent of health facilities are now classified as ART sites. UNICEF's contribution has been to conduct readiness assessment of facilities that have been upgraded to ARV sites. UNICEF

supported three provinces in training more than 220 MCH nurses in ART treatment protocols for option B+ and paediatric treatment has also contributed to an increase of children on ART. Specifically the number of children under 15 years on treatment reached 70,138 at the end of June 2016.

In addition, UNICEF supported MOH to develop the National Communication Strategy for Retention in PMTCT and HIV Paediatric Treatment as well as the introduction for POC for EID. For HIV exposed infants, the main area of progress has been around POC technology which has enabled test results (PCR) to be available to the patient within 50 minutes. Depending on the result, many people return home on the same day with access to treatment. UNICEF together with CHAI supported application of POC technology in Mozambique, leading to the adoption of POC into national policy guidelines (2016) and roll-out is starting in two provinces.
Coverage of paediatric treatment remains at 39 percent as compared to 52 percent for adults1.

Retention in PMTCT and HIV Treatment services remains low. The current retention rate for children on ART is 64 per cent at 12 months after initiation. For pregnant women, the rate is 59 per cent at 12 months after initiation of treatment. Low retention in PMTCT services, particularly after birth, is negatively impacting number and percentage of HIV exposed children on ARV prophylaxis to prevent MTCT. The on-going work to develop a communication strategy is anticipated to improve retention rates, though finds do continue to point to challenging underlying determines (poverty and hunger) that constrain continued treatment. Additionally, the initiation of HIV+ infants in treatment is affected by long delays in the identification circuit of early infant diagnosis (which can have up to a three-month delay). Towards improving this situation, Point of Care Technology (POC) for early infant diagnosis and implementation of the national communication strategy for retention in PMTCT and HIV paediatric treatment form the basis of UNICEF support in 2017. However, the low quality and capacity of current data makes it difficult to accurately measure retention.

The launch of the One UN Action for Girls programme ensured that an integrated engagement programming for adolescents was further strengthened at national level, with a particular focus in Zambézia and Nampula. UNICEF also ensured that children and adolescents from organized platforms actively and genuinely participate in important decision-making fora, such as the adolescents' meeting organized in the context of the National Plan of Action for Children assessment and the Graça Machel consultation on SDGs. Through the flagship project SMS BIZ (U-Report platform), more than 63,000 registered adolescents and young people were engaged and counselled on SRH and HIV prevention related issues.

The first results from the IMASIDA survey have been disseminated, however, IMASIDA data on HIV prevalence and incidence is still not available due to delays in the supply of kits for testing dry blood spots. This lack of data represents a major constraint for planning, target setting and results-based programming of the HIV programme, at this important time as the country moves towards Test and Treat and the new Global Fund proposal is being developed.

UNICEF worked closely with the regional media hub, regional/global coverage on child marriage during the African Union (AU) Summit and on HIV programme innovation during the Durban conference.

To address data gaps, UNICEF has supported the development of new PMTCT/ MCH tools to capture longitudinal data that follows cohorts of pregnant women. Implementation of new tools started in May 2016. It is expected to have first ANC cohort analysis by December 2016 for provinces that started implementation.

[1] Based on estimation of number of individuals living with HIV

Monitoring and evaluation

The monitoring and evaluation system includes the following approaches:

Joint reviews: HIV related indicators are monitored through joint reviews with the government. These indicators have been incorporated into the performance matrix of the government's Five Year Plan, as well as the United Nations Development Assistance Framework (UNDAF).

Integrated Monitoring and Evaluation Plan (IMEP): UNICEF Mozambique has a results-based Integrated Monitoring and Evaluation Plan for the duration of the country programme, which is a mandatory planning and management tool for all country office monitoring, evaluation, and research activities. This tool is reviewed quarterly and amended, if deemed necessary. The IMEP is consistent with the UNDAF and PARP result matrices.

Annual and mid-year reviews: Within the framework of the IMEP, the country office carries out annual and mid-year reviews to compare achievements against planned results, activities, inputs, and outputs as described in the Annual Work Plans, jointly developed and agreed upon with counterparts.

Regular field monitoring visits: Regular monitoring visits to the sites of implementation are jointly carried out with counterparts. These field visits are indispensable for monitoring progress of activities and their continuous consistency with the Annual Work Plans. They are also crucial in ensuring that the disbursed financial resources are utilized as intended.

Added value of thematic contributions

Earmarking of funds by donors not only restricts the use of funds, but also increases transaction costs and reporting burdens. Given the flexibility of thematic funding, the Country Office was able to allocate resources to underfunded areas, ensuring that all elements of the programme in 2016 could be implemented to achieve maximum results.

IV. FINANCIAL ANALYSIS

Table 1 illustrates the planned budget for SPO2 for 2016; the information, in USD, is disaggregated by Programme Area and funding type.

Programme Area	Funding Type[1]	Planned Budget[2]
02-01 PMTCT and infant male circumcision	RR	
	ORR	
02-02 Care and Treatment of Children affected by HIV&AIDS	RR	
	ORR	
02-03 Adolescents and HIV/AIDS	RR	
	ORR	
02-05 HIV # General	RR	$479,012
	ORR	$467,336
Total Budget		**$946,348**

Table 1: Planned Budget for HIV and available funding (2016)

There were no thematic contributions received in 2016 for Strategic Plan Outcome 2.

Table 3 provides details of expenditure in 2016, disaggregated by programme area and resource type. All figures are on US Dollars.

Programme Areas	Expenditure Amount*			
	Other Resources - Emergency	Other Resources - Regular	Regular Resources	All Programme Accounts
02-01 PMTCT and infant male circumcision	$8	303,808	321,761	**$625,577**
02-02 Care and Treatment of Children affected by HIV&AIDS	$15	55,874	1,199,596	**$1,255,485**
02-03 Adolescents and HIV/AIDS	$1	11,879	48,890	**$60,770**
02-05 HIV # General	$8	203,960	424,073	**$628,041**
Total	**$32**	**575,521**	**1,994,320**	**2,569,873**

Table 2: Expenditure by programme areas

In 2016, UNICEF Mozambique utilized approximately $2.5 million for programme activities and interventions related to HIV interventions. The funds' utilisation is summarised below in Table 4.[2]

In 2016 the following results were achieved specifically **with thematic funds**:

Programme Areas	Expenditure Amount*			
	Other Resources - Emergency	Other Resources - Regular	Regular Resources	All Programme Accounts
02-01 PMTCT and infant male circumcision	$0	$10,064	$0	**$**10,064
Total	$0	$10,064	$0	**$**10,064

Table 3: Summary of Financial Implementation in 2016 (in US Dollars)

Table 5 below illustrates the total funds utilized to deliver nutrition programming in 2016.

Specific Intervention Codes	Total Utilized (USD)
02-01-05 Infant feeding, nutrition and nutritional support in HIV/AIDS	518,406
02-01-06 Viral load monitoring	9,346
02-02-01 Infant and child HIV diagnosis (PITC)	-1
02-02-03 Paediatric ART	1,009,755
02-03-06 Address barriers to accessing HIV services by adolescents	-6,024
02-05-01 HIV # General systems	39,921
02-05-02 HIV and sexuality education	456,794
02-05-05 Risk informed conflict sensitive HIV programming	2,126
02-05-08 HIV and AIDS monitoring and bottleneck analysis	40
08-01-01 Country programme process	69,388

[2] ibid

08-01-06 Planning # General	15,271
08-02-01 Situation Analysis or Update on women and children	503
08-02-05 Other multi-sectoral household surveys and data collection activities	945
08-02-06 Secondary analysis of data	-464
08-02-07 Data dissemination	110
08-02-08 Monitoring # General	2,909
08-03-01 Cross-sectoral Communication for Development	9,312
08-03-02 Communication for Development at sub-national level	153,668
08-03-03 C4D # training and curriculum development	36,012
08-05-01 Supply # General	4,088
08-06-02 Building global/regional/national stakeholder evaluation capacity	59,341
08-09-01 Innovation activities	868
08-09-06 Other # non-classifiable cross-sectoral activities	14,369
08-09-07 Public Advocacy	141,581
08-09-08 Engagement through media and campaigns	8,036
08-09-11 Emergency preparedness and response (General)	9,832
Total	**2,559,212**

Table 4: Major interventions using by specific intervention codes (2016)

VI. FUTURE WORK PLAN

For 2017, the Country Office will continue to build on its successes in HIV prevention and Table 6 provides details of the 2016 planned budget for and the financial resources available, along with the any financial shortfall or surplus.

Programme Area	Funding Type	Planned Budget	Funded budget	Shortfall
02-01 PMTCT and infant male circumcision	RR	5,000	5,000	
	ORR			
02-02 Care and Treatment of Children affected by HIV&AIDS	RR	858,907	858,907	
	ORR	1,033,776	813,776	220,000
02-03 Adolescents and HIV/AIDS	RR	30,000		30,000
	ORR	280,000	30,000	250,000
02-05 HIV # General	RR			
	ORR			
TOTAL		2,207,683	1,707,683	500,000

Table 6: Planned budget and available resources for 2016

VI. EXPRESSION OF THANKS

Thematic funds remain a critical source of funding and allow the Country Office to respond to priorities and demands in a more flexible way than many other sources of funding. The CO is hopeful that thematic funds will be available to support critical HIV interventions in 2017 and beyond.

THE BEST POSSIBLE PRESENCE IN THE LIVES OF HIV CHILDREN

By Patricia Nakell, UNICEF Mozambique Communication Specialist

Maputo City – You wouldn't be blamed for not noticing Bernadina Gonçalves. Trailing behind the group of international dignitaries visiting the Polana Caniço Clinic that morning, the pediatrician remained a few steps behind, a shadow of a smile on her face, hands demurely clasped in front of her.

But beneath the unassuming demeanor is a highly skilled professional with what certainly must be one of the most difficult jobs in the world. Dr. Bernadina is a pediatrician working with HIV positive children in the outskirts of Maputo, in a country where 11.5% of 15 to 49-year-olds carry the virus, and where treatment is not always available to everyone.

In the past year alone, Dr Bernadina has cared for several patients patients, from newborns to 15-year-olds. Some have the constant support of a loving family, proper medication, food, and a near-normal life. Others are less fortunate.
Yet it is the positive that Dr. Bernadina prefers talking about.

"One of the best days of my week is when I visit the Casa da Alegria orphanage," she says, eye shining with emotion. "I have a very strong connection to the children there. Not all of them are HIV positive, but some of the older teens have been my patients since they were toddlers."

In fact, some of them are at the clinic today, putting on a performance for the visitors, and as soon as they are done with the song and dance, they rush to surround Dr. Bernadina, chatting with her and holding her hand. She is all smiles and the bond between them is obviously strong.

Dr. Bernadina patiently followed the delegation as they moved from one room to the next, though she must have had a pile of work waiting for her. The visit looked routine, but it was really anything but. The chair of the UNITAID Board was in the country to inaugurate the use of new point-of-care diagnostic devices that will shorten diagnosis time for HIV in babies, and may greatly improve the odds for the youngest patients.

"The earlier we have diagnosis, the earlier we can begin antiretroviral treatment," she says, "and immediate treatment can make an enormous difference for longevity and quality of life, especially for children." For the youngest, it is even a matter of life of death. Without antiretroviral treatment, half of HIV-positive babies die before reaching the age of two.

Some families bring their children for testing, but never come back for the results. Most come late, once the child has been sick for too many months, possibly after consulting a traditional healer.

"This is becoming better," admits Dr Bernadina. "Thanks to communication work, through community radios and TV, families have begun to understand the importance of bringing children to treatment quickly."

Dealing with this illness requires a holistic view, she insists. Proper timing and the right institutional treatment are important, but home care is almost as crucial, she says.
"Sometimes children are being cared for by elderly grandparents, who forget doctor's appointments or when pills have to be taken. Or they are too poor to afford more than one meal a day, and children will need to eat several times a day with their medication."
But beyond the obvious challenges of living with a potentially deadly disease, there is the emotional toll the infection takes on children.

“In some cases, children only learn of their infection when they become teenagers, which would be a difficult thing to deal with even for a mature adult. But for these youngsters, they don’t understand what they did wrong, or how to handle their fears. They may not understand why they need to continue swallowing 8 or 9 large pills every day for the rest of their lives, especially if they are feeling fine. They may be experiencing their first love. All of this complicates matters for them.”

The best thing for children is treatment that begins as early as possible, immediately, she says, but it is not enough.

“The unconditional support and love of parents and caregivers is just as important for the wellbeing of children with HIV,” says Dr. Bernadina.

Watching her as she interacts with the orphans of Casa da Alegria, who have no family of their own, it is clear that Dr. Bernadina Gonçalves comes as close to being the best possible presence in their lives as one could wish for.

UNICEF is supporting the Government in expanding the services of prevention of mother-to-child transmission (PMTCT), including Option B+ (simplified treatment protocols which improve retention and reduce the mother-to-child transmission rate), in Tete, Maputo, Niassa, Sofala and Zambézia provinces, through training sessions, supervision and monitoring of anti-retroviral (ARV) treatment for the nurses of the Mother and Child Health services (SMI). This contributed to significant progress in the country with a view to eliminating mother-to-child transmission of HIV. Services for the prevention of mother-to-child transmission of HIV are available in 82% (1,213) of the 1,485health units, offering ante-natal consultations throughout the country. Ninety-seven (97) percentof HIV-positive pregnant women are receiving prophylaxis for the prevention of mother-to-child transmission. Eighty-seven (87) percent of them have received ARV for PMTCT (Option B).

The main challenges faced in Mozambique are related to the retention and adherence to treatment for both prevention of mother-to-child transmission (PMTCT) and pediatric anti-retroviral treatment (ART). UNICEF is working on three key priorities in Mozambique: PMTCT, pediatric treatment and health care for adolescents with HIV.

Historically UNICEF also supported community involvement and the involvement of groups of adolescent peer educators in HIV prevention, counselling and testing, access to anti-retroviral treatment, as well as adolescent and youth friendly health services (SAAJ).

Dr. Bernadina is a pediatrician working with HIV positive children in the outskirts of Maputo, in a country where 11.5% of 15 to 49-year-olds carry the virus, and where treatment is not always available to everyone. © UNICEF Mozambique/2014/Patricia Nakell

IX. DONOR REPORT FEEDBACK FORM

Name of Report:

Reference number:

SCORING:	5 indicates “highest level of satisfaction” while 0 indicates “complete dissatisfaction”.

1. To what extent did the narrative content of the report conform to your reporting expectations?

5	4	3	2	1	0

If you have not been fully satisfied, could you tell us what we could improve on next time?

2. To what extent did the fund utilization part of the report conform to your reporting expectations?

5	4	3	2	1	0

If you have not been fully satisfied, could you tell us what we could improve on next time?

3. What suggestions do you have for future reports?

4. Any other comments you would like to share with us?