

TB AND HIV

CONCEPT NOTE

CCM Mozambique, 31 October 2014

Investing for impact against tuberculosis and HIV

SUMMARY INFORMATION			
Applicant Information			
Country	Mozambique		
Funding Request Start Date	1 July 2015	Funding Request End Date	31 December 2017
Principle Recipient(s)	Ministry of Health of Mozambique & Fundação para o Desenvolvimento da Comunidade		
If the programs are to be managed as separate grants:			
Funding Request Start Date for HIV	1 July 2015	Funding Request End Date for HIV	31 December 2017
Principal Recipient(s) for HIV	Ministry of Health of Mozambique & Fundação para o Desenvolvimento da Comunidade		
Funding Request Start Date for TB	1 July 2015	Funding Request End Date for TB	31 December 2017
Principal Recipient(s) for TB	Ministry of Health of Mozambique & Fundação para o Desenvolvimento da Comunidade		

FUNDING REQUEST SUMMARY TABLE



A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

Introduction

Despite a number of longstanding health system challenges (including low clinician/population ratios and dilapidated health facility infrastructure) the national TB and HIV responses have been remarkably successful.

The National TB Program (NTP) is ensuring high rates of treatment completion and TB/HIV integration has been successfully implemented at policy, district management, and service delivery level, with high uptake of HIV testing in TB clinics, and early initiation of ART for co-infected patients. While case detection and notification for TB has lagged, and treatment outcomes for MDR-TB are poor, the NTP has identified strategies that will ensure significant improvement in these two measures.

There has been a remarkable increase in the total numbers and population coverage of key HIV services in Mozambique. The number of individuals receiving HIV testing/year has risen from 3.8 million in 2012 to 4.7 million in 2013 in a population of 23.5 million; this represents 20% of the population (106% of the national target for 2013). There are high rates of TB screening of HIV patients who are enrolled in care. There were 163,918 adults and 13,566 children initiated on ART in 2013¹, for a total enrolment of 497,455 adults and children on ART at the end of 2013, representing an overall coverage of 59% (based upon national eligibility criteria consistent with 2010 WHO guidelines. By June 30, 2014, total enrolment on ART has risen to 552,940. ²

PMTCT coverage for women who have institutional deliveries is high, and Option B+ has been rolled out widely over a short time period. The proportion of HIV-infected pregnant women who receive ARV drugs rose from 79% in 2012 to 83% in 2013³, but more importantly, the proportion of HIV-infected pregnant women that receive lifelong ART when enrolled in PMTCT has increased from 12% in 2012 to 81% as of June 2014².

In 2012, the Ministry of Health (MoH) called upon all key partners – including PEPFAR, GFATM, UNICEF, WHO, UNAIDS, CHAI- to develop an ambitious, detail oriented, evidence-based, geographically focused plan to achieve universal access in Mozambique by 2015. This plan, called, *Mozambique's Accelerated HIV/AIDS Response 2013-2015 (Acceleration Plan)*⁴, now extended to 2017, was designed as a concrete guide to implement interventions that would allow the national program to achieve and monitor progress towards 80% ART coverage, 50% reduction in the number of new HIV infections and MTCT rates <5%.

By analyzing district level epidemiology and cross-referencing ANC HIV prevalence rates with data from the 2009 AIDS indicator survey, the MoH designated 71 of Mozambique's 144 districts as priority districts based on the burden of HIV and unmet need for ART and PMTCT. These districts have been prioritized to receive the full package of evidence-based care, treatment and prevention interventions clearly described in the Acceleration Plan.

The MoH engaged all Provincial Health Directorates in partnership with provincial HIV/AIDS councils to develop province-specific Acceleration Plans using the objectives and interventions from the national plan. The MoH's key funding and technical partners in the HIV response, the largest of whom are PEPFAR and GFATM, used the Acceleration Plan to reorient financial and technical support to ensure the ambitious interventions and targets from the plan are achieved.

Based upon expected growth in ART enrollment of PLHIV as a result of intensified case finding supported through the HIV Acceleration Plan, an estimated 750,023 adults and children will be on ART in 2015, and 996,593 in 2017, which will represent 81% of ART eligible persons. Given the pace of new enrollment on ART in the past two years, the national program expects to reach these targets.

Through a renewed commitment to engage and strengthen the capacity of community health workers there will be increased efforts to support adherence and retention to ART and increase the success rate for TB case finding and treatment. The interventions detailed below will enable the country to reduce HIV and TB incidence, as well as mortality due to HIV and TB related causes. To account for the limited availability of human resources in the health sector, the GRM has adopted task sharing and the roles of revitalized cadres of community health workers and community activists are being expanded in concert

with care delivery models such as *Grupos de Apoio a Adesão Comunitária*/Community Adherence and Support Groups (GAAC). A shift towards more simplified ART regimens, and the imminent implementation of quarterly ART distribution to stable ART patients are some of interventions that will increase adherence and retention of ART patients.

Based on a GOALS modeling exercise conducted in 2014, if Mozambique achieves its 2017 ART targets (81% ART coverage) and its 2017 male circumcision targets, there will be a significant reduction in incidence as well as in mortality. These forecasted reductions will have the effect of significantly curbing the spread and impact of the HIV epidemic in Mozambique.

In parallel, Mozambique is also focused on effective interventions to support comprehensive HIV and TB prevention countrywide, while strategically targeting key and vulnerable populations in the 71 priority high impact districts. HIV prevention efforts have become more focused on those populations that contribute disproportionately to new HIV cases. Community-based population-specific prevention interventions have combined with targeted community-based HTC efforts, for greater efficiency and effectiveness.

There is a critical need for the National HIV/AIDS Program to ensure that sufficient quantities of ARV are guaranteed to maintain the hundreds of thousands of people on ART and to have ART available for the many people who continue to enter health facilities aware of their HIV status and eager for treatment. It is expected that there will be a national stock out by early 2016 if additional funding for ART is not obtained. This stock-out, will result in 565,919 people being taken off of ART in the first quarter of 2016. This cannot be allowed to happen, therefore, the majority of funding requested under this Concept Note is intended to cover the gap to sustain the current number of patients in treatment, and support the progressive growth and expansion of ART services, particularly in the 71 districts prioritized in the Acceleration Plan.

The significant increase in ART coverage and the subsequent decline in incidence and HIV-related mortality has been possible only because of a firm commitment by the GFATM to support the commodities and programmatic needs of Mozambique's HIV response. This application includes a large above-allocation request to procure ARVs. The funds beyond direct treatment services that are requested are for community-based implementation of ART retention services and focused and targeted HIV prevention services, as well as for community-based testing, including among key populations and young women. Improving retention is also essential as interventions to support adherence and retention are key to ensuring that reductions in mortality are maintained and that HIV incidence is reduced. Given the absolute numbers of newly infected people each year, the reorientation towards evidenced-based, high impact prevention activities must also continue.

PEPFAR provided \$277 million in 2013, and is expected to provide a similar amount in 2014, with a significant portion utilized for ARV purchase. A larger proportion is directed towards supporting the programmatic needs of an expanding HIV response as well as many of the health system strengthening activities that support the national response. Funds from a number of donors, including the GFATM (GFATM Round 8), PEPFAR and the World Bank have been awarded to support essential HSS interventions in the areas of supply chain and logistics, human resources for health, public financial management, monitoring and evaluation and community systems strengthening. These funds are beginning to bear fruit and the Government of Mozambique (GRM) seeks to avoid counter posing HSS and ART as competing priorities.

As a reflection of this financial reality and in alignment with the Acceleration Plan goal to curb the HIV epidemic, the three priorities for funding elaborated in this concept note are (in order of prioritization):

1. Procurement of ARVs for continued scale-up of ART towards universal access;
2. Support of evidence-based prevention interventions for key populations;
3. Evidence based community activities to support ART and TB treatment scale-up and retention while also improving treatment literacy and linkages between communities and the clinics that serve them.

This grant application for TB (July 2015-Dec 2017) incorporates the current Interim Funding grant that started on 1 July 2014. The consolidated grant will support the implementation of the National TB Strategic Plan 2014-2019. This plan focuses on four key areas:

1. Increasing case detection of TB and MDR-TB by expansion of laboratory network, and introduction of GeneXpert MTB/RIF, and scale-up of DST services;
2. Expansion of treatment of patients diagnosed with TB and MDR-TB;
3. Further scale-up of TB/HIV collaborative activities, in particular ART for TB patients and IPT;
4. Scale-up and integration of TB and HIV Community-care, in support of increasing case detection and achieving high treatment outcomes for TB and MDR-TB.

To adequately tackle the burden of these two diseases, Mozambique is making an expression of demand of the full projected funding gap for truly essential services to cover interventions designed to respond to both the HIV and TB epidemics. The decision of the CCM to maintain the disease split proposed by the GFATM Board was made on the basis of a programmatic gap analysis.

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including descriptions of the TB and HIV disease epidemiology and their overlaps, the health systems and community systems setting, and the human rights situation.

1.1 Country Disease, Health Systems and Community Systems Context

With reference to the latest available epidemiological information for TB and HIV, and in addition to the portfolio analysis provided by the Global Fund, highlight:

- a. The current and evolving epidemiology of the two diseases, including trends and any significant geographic variations in incidence or prevalence of TB and HIV. Include information on the prevalence of HIV among TB patients and TB incidence among people living with HIV/AIDS.
- b. Key populations that may have disproportionately low access to prevention, treatment, care and support services, and the contributing factors to this inequity.
- c. Key human rights barriers and gender inequalities that may impede access.
- d. The health systems and community systems context in the country, including any constraints relevant to effective implementation of the national TB and HIV programs including joint areas of both programs.

1.a) Epidemiology

HIV

In the most recent AIDS Indicator Survey (INSIDA, 2009), HIV prevalence in adults 15-49 years of age was estimated at 11.5%, with significant demographic and geographic variation.⁵ A new AIDS indicator survey will be conducted early. Recent estimations are that the number of people living with HIV is 1.6 million out of a population of 24.4 million,⁶ and the annual number of new infections was estimated as 120,000 in 2013.⁷ There was a rapid rise in HIV prevalence from the mid- 1990s until 2006; since that time, likely as a result of expansion of the national HIV response in both prevention and treatment uptake, HIV prevalence has stabilized and may have begun a decline (Figure 1).⁸ Recent GOALS modeling suggests that by the end of 2013 the country reached the 'tipping point', where the number of adults newly initiated on ART exceeds the number of new adult infections.

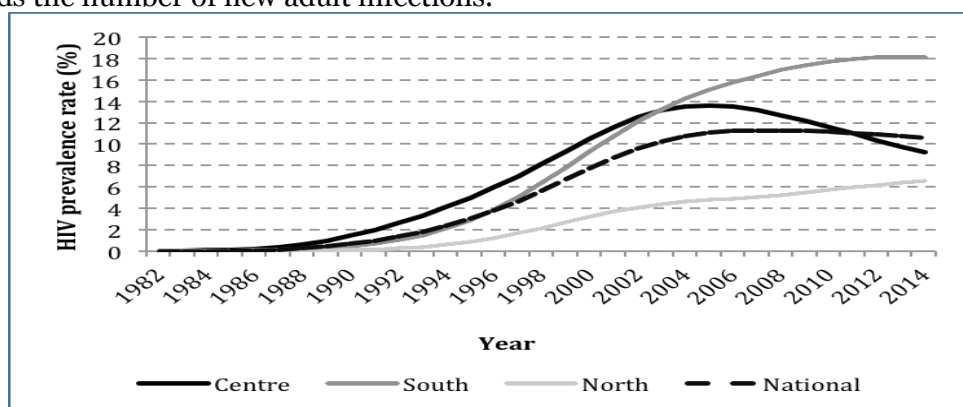


Figure 1: HIV prevalence rate by region and year, Mozambique 1982-2014

According to the INSIDA, HIV prevalence ranges from 3.7% in the northern province of Niassa to 25.1% in the southern province of Gaza (Figure 2). Prevalence in urban areas is generally twofold higher than in rural areas. HIV prevalence appears to be still increasing in the north, while prevalence in the central region is in decline (Figure 1). Large urban areas and the trade corridors from the country's coastal ports to the neighbouring countries of Zimbabwe, Malawi and South Africa have the highest HIV prevalence. Of particular concern is the burgeoning mining and natural gas industries in the northern and central provinces, which are expected to create economic, migration and housing conditions that promote rapid HIV and TB transmission, underlining the importance of intensified targeted prevention efforts.



Figure 2: HIV prevalence and Primary Transport Corridors in Mozambique

Women are disproportionately affected, with an estimated prevalence of 13.1% compared to 9.2% in men. The observed gender disparity (Figure 3) is most striking among 15-24 year olds, with HIV prevalence of 11.1% among young women - three fold higher than the 3.7% prevalence among young men of the same age- an effect thought to be primarily attributable to earlier sexual debut and trans-generational sexual transmission.

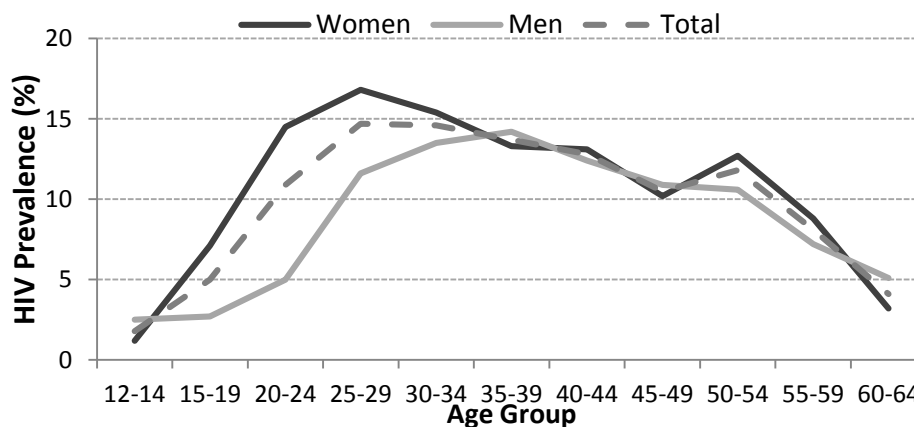


Figure 3: HIV prevalence (%) by age group and sex in Mozambique (INSIDA, 2009)

ANC coverage in Mozambique is 91%, but institutional delivery is only 54%, and maternal mortality is estimated at 408/100,000 live births,⁹ unchanged since 2003. Low institutional delivery impacts access to the full PMTCT package after an initial visit, as well as to entire continuum of care for reproductive, maternal, newborn and child health (RMNCH). HIV prevalence in ANC is estimated to be 15.8%,¹⁰ and HIV represents the leading indirect cause of maternal mortality. The high overall prevalence among pregnant women combined with a high mother-to-child transmission rate (estimated at 11.9% in 2013)⁷ results in a high burden of HIV infection among children. Spectrum epidemiologic models estimate an annual total of 12,000 new infant infections and a total of 190,000 children living with HIV in 2013⁷.

The HIV incidence rate reached its peak in 2001 (1.81%) and since then has decreased and reached 0.98% in 2013, but its distribution by region shows three different patterns of epidemic. In the north the epidemic is relatively new and the incidence rate shows signs of increase, probably due to the high rate of STIs, the high population size of people with multiple sexual partnerships, FSW and clients of FSW and low rate of condom use; in the center, the incidence has decreased since 2001 and is estimated to be the lowest rate in the country (0.56%); The southern region incidence rate seems to have stabilized at a high level, 1.85%.

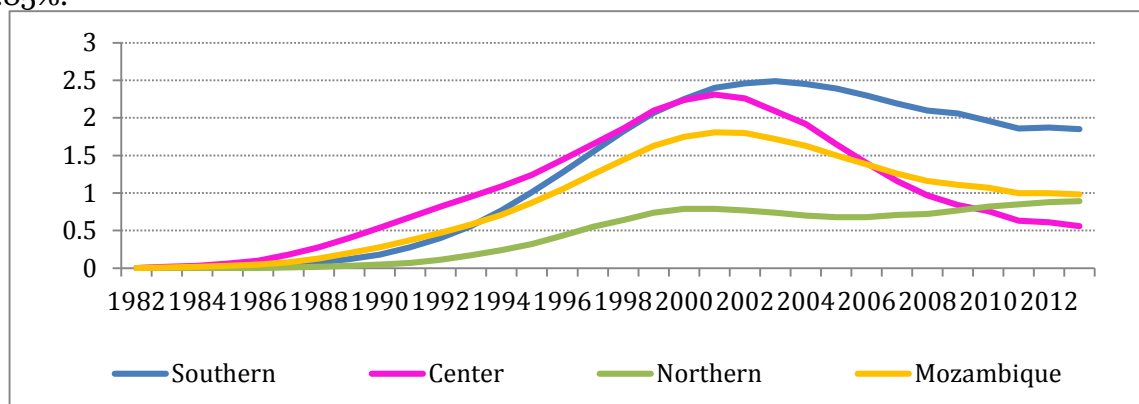


Figure 4. HIV incidence rate (%) among the 15 to 49 years old population by region and year.

A Modes of Transmission (MoT) study conducted in 2013¹¹ has provided important new information regarding the proportion of new infections occurring among various population groups. Data from this model estimate that 28.7% of new infections were among sex workers, their clients and men having sex with men, and that 25.6% of new infections occur among people in stable sexual relationships, due in large part to high rates of serodiscordance and low rates of condom use among couples. People in multiple partnerships contributed to 22.6% of new adult infections. Key and vulnerable populations in Mozambique that are particularly at risk for HIV infection include sex workers, MSM, prisoners, girls and young women, and mobile and migrant populations.

TB/HIV

HIV infection has been the major driver for the increase of TB notifications in Mozambique since the emergence of HIV in sub-Saharan Africa. Provider initiated testing and counseling has been scaled up since 2003 and reached 96% of TB patients in 2013. HIV prevalence among TB patients was 56% in 2013 and has been decreasing gradually over the past years.¹² This may reflect the impact of the scale-up of ART, which has reduced the incidence of TB among PLHIV.

HIV prevalence varies among TB patients between provinces, with Gaza having the highest prevalence (77%) and Niassa and Nampula the lowest (26% and 38% respectively). Data on trends of national HIV prevalence in patients with TB are shown in section 1.2. WHO estimates the mortality of PLHIV with TB at 177/100,000, more than three times higher than for HIV-negative TB patients (at 55/100,000)¹³. The NTP does not collect and report data on mortality stratified by HIV status.

TB

The WHO Global TB Report (2013)¹³ estimates the prevalence of TB in Mozambique to be 553/100,000 and to be gradually decreasing; mortality is 53/100,000 for HIV negative TB patients and decreasing (Figure 5); mortality of HIV infected TB patients 177/100,000; and incidence at 552/100,000. In 2012, the case detection rate for all forms of TB was estimated to be only 34%. All these indicators have wide confidence intervals and are based on computations and modeling that utilizes the available secondary data. A TB prevalence survey planned for 2015-2016 (co-funded by this grant) will provide more precise estimates of prevalence, incidence and case-detection rate. The current estimate is that case detection rate is low, in part due to limited access to PHC facilities (see HSS section).

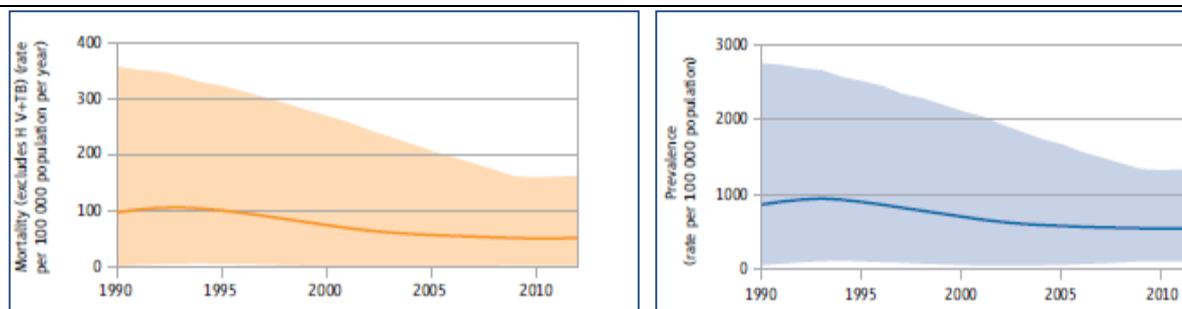


Figure 5: WHO Global TB Report 2013

Case notification/100,000 has increased slightly since 2009 (Table 1). In 2013, 53,272 patients were notified with TB, of whom 23,115 (43%) had new sputum smear-positive TB, 38% had sputum-smear negative pulmonary TB (PTB), and 10% had extra-pulmonary TB. The annual percentage of children aged < 15 years diagnosed with TB remains stable at 7-8% of the total patients notified. The NTP does not collect data on the gender breakdown of TB patients.

Year	Notification Rate/100,000 all forms	New smear-positive PTB	%	New smear-negative PTB	%	New Extra-pulmonary TB	%	Subtotal New patients	Re-treatment patients	%	Grand Total
2009	209	19.598	43	17.019	37	5.302	12	41.919	3.597	8	45.516
2010	206	20.097	44	16.408	36	5.621	12	42.126	4.023	9	46.149
2011	206	19.537	41	18.159	38	5.504	12	43.200	4.252	9	47.452
2012	214	20.951	41	19.797	39	5.542	11	46.290	4.537	9	50.827
2013	219	23.115	43	20.129	38	5.521	10	48.765	4.496	8	53.261

Table 1: Case-notifications for TB, 2009-2013, Mozambique

While the proportion of patients classified as new smear-negative PTB has been stable for the past five years, this may reflect under-diagnosis of TB among smear-negative persons with presumed TB, as diagnosis requires chest X-ray examinations which are not widely accessible. PLHIV and small children with PTB are more likely to be smear-negative and therefore more at risk of not being correctly diagnosed. The scale-up of access to GeneXpert diagnostics provides an opportunity for a more accurate diagnosis of PTB in PLHIV and small children, and is likely to increase the number of patients diagnosed with bacteriologic-confirmed TB in the near future. There will remain a group of patients (in particular PLHIV and small children) in whom sputum cannot be obtained and for whom X-ray examination is not available, and who need treatment without bacteriologic confirmation or X-ray result, based on clinical suspicion.

There is wide variation in TB burden across the 11 provinces (Figure 6). Maputo City and Province have the highest notification rates; there may in fact be higher TB burden due to more crowded living conditions, but there are likely higher rates of accurate diagnosis due to better access to diagnostic services than in more rural areas.

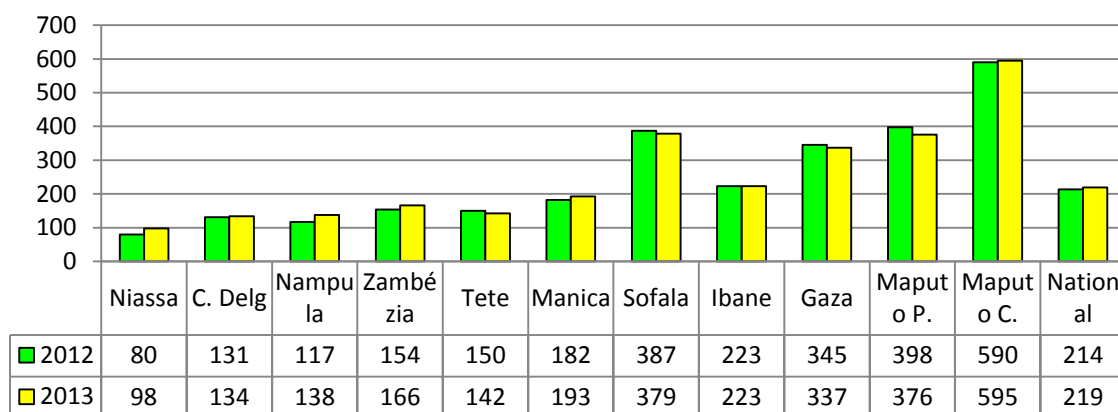


Figure 6: TB case notification rates/100,000 by province, 2013

The number of TB patients (all forms) notified (Figure 7) varies per province and is shown in the diagram below, reflecting the size of the population and the severity of the TB epidemic. The case detection rate is broken down per province, and shows wide variation from 27% to 95% in 2013. It should be noted, however, that the case detection rate provided in the WHO Global TB Report 2013 for the national level has a wide confidence interval (34% [25-50%]); this confidence interval is even wider when this number is used for calculations at provincial level and data need to be interpreted with caution.

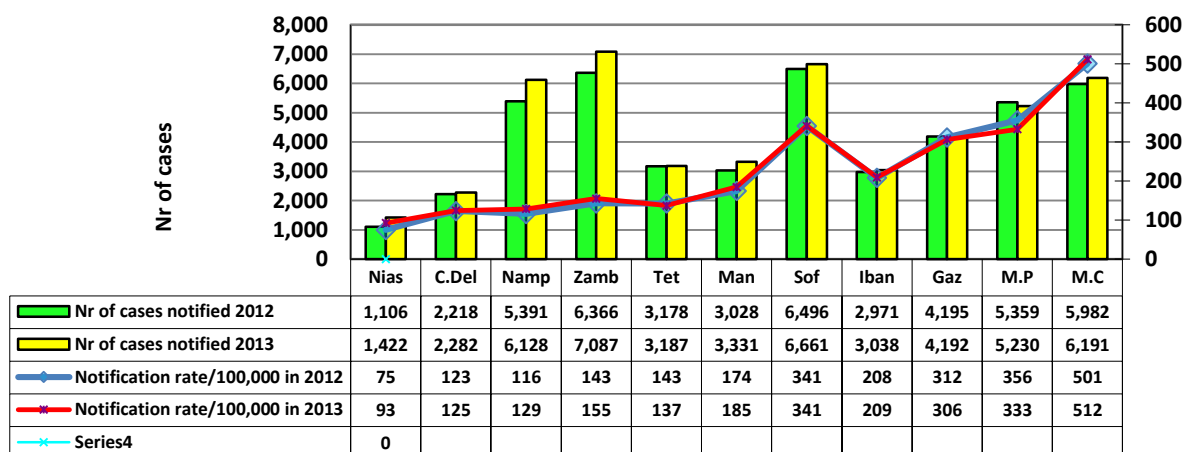


Figure 7: TB notifications per province, NTP, Mozambique

MDR-TB

The annual incidence of MDR-TB in Mozambique is estimated at 1,940 patients, of whom 1,400 are new patients and 540 are re-treatment patients¹³. Based on a drug resistance survey conducted in 2009, MDR-TB prevalence among new TB patients is estimated at 3.5% and 12% among retreatment patients¹⁴. The graph below shows the number of patients started on MDR-TB treatment since 2004 (Figure 8).

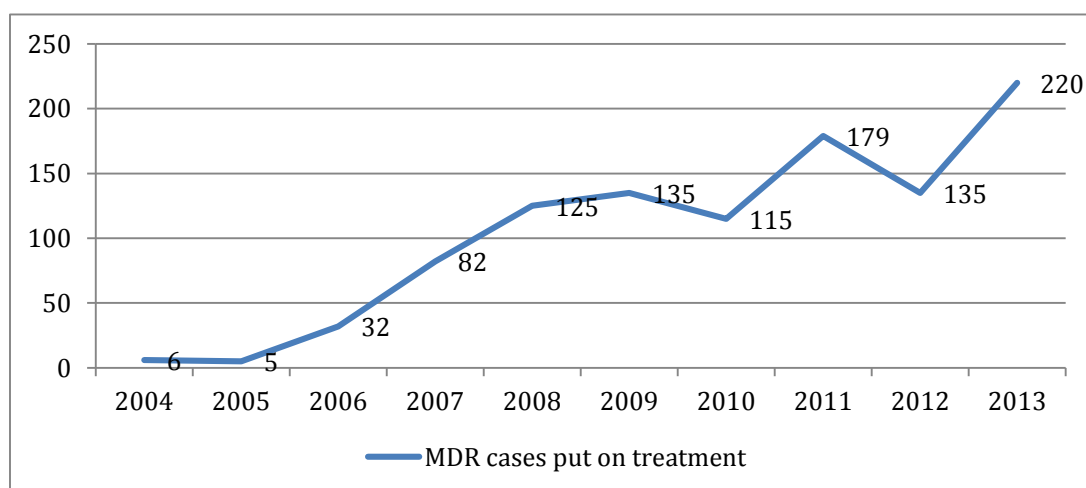


Figure 8: Number of patients started on MDR-TB treatment 2004-2013

84% of MDR-TB cases in Mozambique come from four provinces – Sofala, Gaza, Maputo Province, and Maputo City. This geographic concentration is explained, in part, by large numbers of migrant mine workers from these provinces that have worked in South African mines where MDR-TB is prevalent along with co-morbid silicosis and HIV (both risk factors for development of TB disease). A SADC initiative has now expanded into Mozambique, and is developing plans to provide treatment and care to this cross-border population when they are in Mozambique. The recent expansion of open pit coalmining in the northern and central regions has created new communities of mineworkers, with associated TB and HIV risks based upon internal migration.

The concentration of MDR-TB cases in three of these provinces may in part be an artifact of the current challenges in accessing laboratories capable of diagnosing MDR-TB. Currently C/DST is only available in the National TB Reference Laboratory in Maputo. The laboratories in Beira (serving the central region) and Nampula (serving the northern region) can perform GeneXpert and cultures, but have not yet been certified for DST by the National Reference Laboratory (NRL). This possible bias will be corrected with the introduction of a reliable sputum sample transportation system from all health facilities to an increasing number of laboratories with GeneXpert, and forwarding of samples with a GeneXpert rifampicin-resistant positive test result for drug sensitivity testing (DST) in the Maputo City laboratory, or in laboratories in Nampula and Beira when they become certified for DST confirmation of MDR-TB.

1.b) Key and vulnerable populations

HIV

Although Mozambique has a generalized HIV epidemic, certain populations shoulder a higher burden of disease. Key and vulnerable populations for HIV transmission in Mozambique include sex workers and their clients, MSM, mobile and migrant workers such as miners and agricultural workers and truck drivers operating between ports in Mozambique and neighbouring countries. Adolescent girls and young women are also considered vulnerable due to transactional or intergenerational sex. Similarly, certain populations are considered at higher risk of TB, including prisoners and prison staff, health workers and miners.

The disproportionate impact of the key populations on HIV incidence in Mozambique was demonstrated in the 2013 MoT study¹¹, which estimated that 28.7% of new adult infections in 2013 occurred among female sex workers, their clients and MSM. The relative contribution of these groups on overall HIV incidence in Mozambique is most pronounced in the central and northern regions of the country (Figure 9).

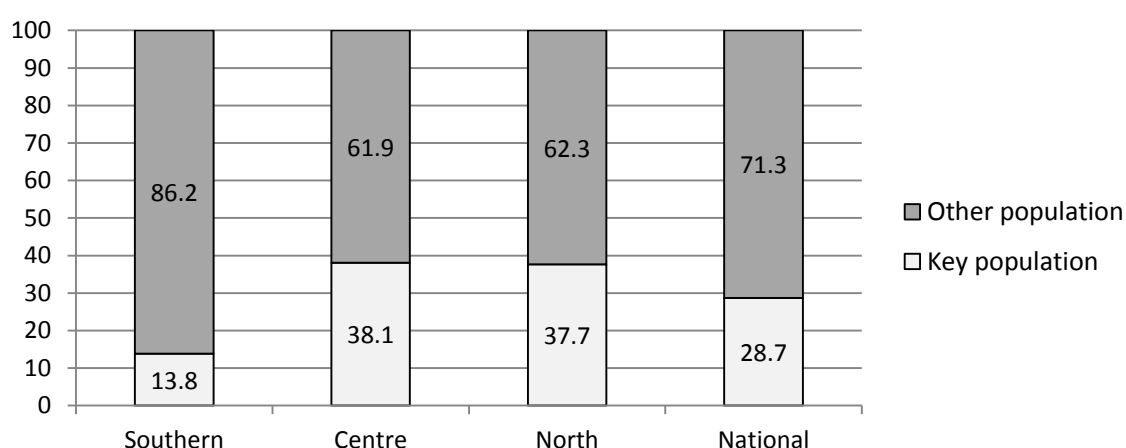


Figure 9: Proportional contribution of key populations on HIV incidence in Mozambique (MoT 2014)

The 2011 and 2012 IBBS results^{15,16} found HIV prevalence among female sex workers in Maputo, Beira and Nampula of 31.2%, 23.6% and 17.8%, respectively. Although overall prevalence found among MSM in the same cities was low at 8.2%, 9.1%, and 3.7%, respectively, the majority of MSM study participants were young, and therefore had a low cumulative risk of infection. HIV prevalence among MSM older than 25 was 33.8%, 32.1% and 10.3% respectively in the three cities. Similarly high prevalence, ranging

from 8.6% to 40.5%, was found in the 2012 IBBS among truck drivers, prison inmates, miners, and agricultural workers employed on farms bordering Mozambique in South Africa.^{17,18,19,20}

	MSM	FSW	Miners
Year, location	2011, Maputo, Beira, Nampula and Nacala	2012, Maputo, Beira and Nampula	2012, Ressano Garcia
Population size	Maputo: 1.5% Beira: 1.8% Nampula/Nacala: 1.3% of the 15+ male population	Maputo: 2% Beira: 5% Nampula: 4.5%	70 000 (35 000 formal and 35 000 informal)
HIV prevalence	Maputo: 8.2% Beira: 9.1% Nampula/Nacala: 3.7%	Maputo: 31.2% Beira: 23.6% Nampula: 17.8%	22.3

Table 2: Population estimates and HIV prevalence of selected KP and vulnerable populations

While important progress has been made in understanding the demographic, epidemiologic, and behavioral profiles of key and vulnerable populations and the relation to HIV prevalence, the data are not comprehensive or representative for the whole country. Follow-up studies that provide geographically representative results and data for monitoring trends are needed, as well as size estimates of key population groups.

Stigma and discrimination can discourage members of these key population groups from seeking healthcare services and can represent a significant challenge to accessing and treating FSW or MSM living with HIV or TB/HIV. In recognition of the health needs as well as vulnerability to HIV infection of these key populations, the MoH has implemented 13 'Key Population-Friendly' health facilities throughout the country and is planning to implement an additional 24, where universal treatment, independent of CD4 count, for HIV-positive FSW and MSM will be available. In addition, national guidelines for the integration of HIV prevention, care, and treatment for key populations within health facilities are being developed to provide more user-friendly and higher quality services for these groups. New legislation that establishes the right of every person living with HIV to access prevention, protection, and care and treatment services also addresses the unique barriers to services faced by these populations.

Miners

The IBBS study conducted with Mozambican miners in transit to the formal mining sector in South Africa found 22.3% of those tested as HIV infected (of whom 74.6% previously unaware of their status). Only 13.8% of miners report using condoms.

Long Distance Truck Drivers

One study of long distance truck drivers demonstrated 21.9 % HIV prevalence, with 83.7% reporting they did not know their status previously. Condom use was low and 27% indicated they had paid for sex in the prior year.

Incarcerated Populations

An estimated 24% of inmates of Mozambican prisons are infected with HIV, as well as 18.5% of prison staff. Inmates lack access to information on HIV and TB counseling and testing services, condom provision, diagnostic services, treatment and care. Health services are provided only intermittently and treatment regimens are frequently disrupted. Recidivism among prisoners is high: an estimated 25% of prisoners have been jailed previously.

Girls and young women (15-24 years)

HIV prevalence in girls and young women ages 15-24 years old is 11.1% and exceeds by threefold the 3.7% prevalence in men of the same age group; this is consistent with trans-generational sexual transmission. The INSIDA 2009 Report indicates increasing prevalence among young people in Inhambane, Cabo Delgado and Niassa⁵. Data indicates that young people are aware of sexual risk reduction but this has not consistently translated into behavioral change²¹.

Multiple and serodiscordant partnerships

The MoT (2013) study indicates that people with multiple sexual relationships contribute 25.6% of new infections, and serodiscordant couples 22.6%. Testing and counselling campaigns have insufficiently

focused on orienting HTC towards these groups. Condom use by those who have multiple sexual partnerships remains low (31% of women and 23% of men). Nearly half (46%) of the sexually active youth, both women and men, said they had used a condom in their last sexual relation.

Condom use is hampered by shortfalls in the supply and distribution of condoms in health facilities and community outlets. In 2012 the Government of Mozambique established the Multisectoral Coordination Working Group on Condoms to address supply, logistic management and condom distribution, including quantification. There is limited evidence that condom use has increased in recent years: data on PEPFAR-supported condom social marketing efforts shows that approximately 23 million condoms were sold in 2013, up from approximately 22 million the prior year.

TB in key and vulnerable populations

All key HIV-affected populations listed above also need to be considered a TB vulnerable population, particularly when diagnosed with HIV.

Miners

There are 35,000 Mozambican miners registered as working in the formal mining sector in South Africa; an estimated 35,000 others are working in South Africa in the informal mining sector²². The incidence of TB among this population is estimated at 4-5% per year²³. High HIV prevalence and silicosis (in the gold mines) are important risk factors for TB, in combination with the often crowded living conditions which favor transmission of TB infection. Mozambican miners patients returning home with TB are frequently diagnosed in Gaza Province. After a SADC initiative (2012) on TB in the mining sector, cross-border support projects and services have been developed in Mozambique for Mozambican miners and ex-miners. The project is supported by the World Bank and other donors, and provides for funds for TB and HIV screening, and provision of appropriate medical care, in partnership with the MOH/NTP. There is a World Bank-funded mapping exercise currently underway that will provide additional information.

There are 7800 miners registered with the Ministry of Labor as involved in the coal mining industry in Mozambique, with 35,000 registered as working in the formal mining sector in South Africa; an estimated 35,000 others are working in South Africa in the informal mining sector. The industry is relatively new and there are currently no data on the burden of TB (and HIV) in this population. The NTP currently assumes TB incidence of 2% in the open pit mining, fourfold higher than estimated for a similar aged cohort in the general population.

Incarcerated persons

In a recent survey (2013)¹⁹, 966 prisoners out of a prison population of 58,175 (1.5%) were diagnosed and reported with tuberculosis - a notification rate of 1,665/100,000 that is eight times greater than the general population rate¹². This likely is an underestimate; notification of TB patients in prisons is incomplete as not all prisons report this data. The prison population is a primary focus of the national TB response plan. USAID, through TB CARE I, is supporting the TB response in prisons.

TB in prisons is detected by screening on entry and through passive case-finding among resident prisoners. There is wide variation by province (Figure 10), probably related to issues with population density in prisons and infrastructure (ventilation), quality of care, and reporting. Not all prisons have NTP trained health staff on-site, hence there is likely to be under-diagnosis and reporting.

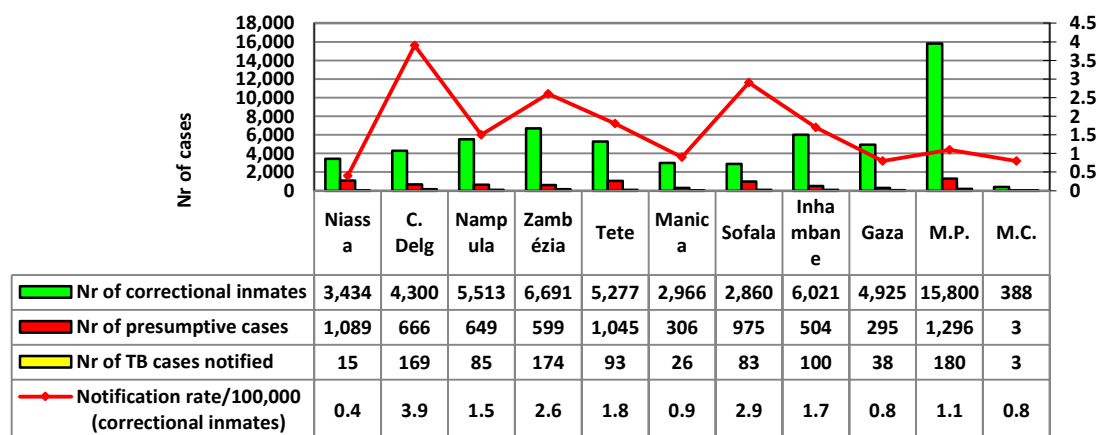


Figure 10: Case notification by province among prisoners, 2013, NTP

Health workers

Health workers are at increased risk of TB infection due to workplace exposure. In 2013, 144 health workers were notified (117 in 2012) and this is likely an underestimate due to insufficient occupational-based TB screening and perhaps due to unwillingness by health workers to report TB disease because of stigma and the association of TB with HIV infection. The NTP is planning to expand HIV and TB screening in the context of occupational health, and expects an increase in notifications, as well as better TB-IC in health facilities, which should reduce nosocomial transmission. It is assumed that numbers of HCWs notified with TB will rise slightly to 200 per year (among 38,500 workers), which translates to a notification rate of 519/100,000, compared to 219/100,000 in the general population.

Children

Children, particularly children under five years of age, are at increased risk of TB, because of their immature immune status, and particularly when exposed to an adult with infectious pulmonary TB and when the child is HIV infected. In addition, confirmation of the diagnosis of TB in small children is more difficult than in adults, as bacteriologic examination is often negative. NTP considers the 7-8% of annually notified TB patients being children 0-14 years too low given the observation in the field that health workers tend to diagnose TB in children in quite a late stage of disease progression. A further complication is that diagnosis of HIV infection in small children is lower than what may be expected, hence also TB among such children may be under diagnosed.

1.c) Human rights barriers and gender inequalities

The Government of Mozambique has provided a political and legal framework to protect human rights and reduce gender inequalities. Two laws protect the human rights of citizens affected by the HIV epidemic. Law No.5/2002 establishes the guiding principles seeking to guarantee that citizens who work or are seeking work are not discriminated in the workplace; Law No. 12/2009 establishes the right of every person living with HIV to access prevention, protection and care and treatment services. Law no. 19/2014 “Law for Protection of People, Workers and Employment Candidates Living with HIV/AIDS” was published in the Bulletin of the Republic on August 27, 2014²⁴; it was approved by the Assembly of the Republic on July 17, 2014, and it will come into force in November 2014. The law provides a framework for broad legal protection for PLHIV, including imprisoned populations, setting out rights and responsibilities of PLHIV, their communities, (prospective) employers and the state. The law confirms the right to privacy and confidentiality of serostatus for PLHIV, and specifies rights of various specific vulnerable groups of PLHIV, including orphans and vulnerable children, women, disabled PLHIV and prisoners. The law also spells out responsibilities and rights of health care professionals with respect to HIV, including practitioners of traditional medicine.

The first stigma index assessment was conducted in 2013 under the leadership of Network of People Living with HIV (RENSIDA) in coordination with the NAC.²⁵ Of PLHIV, 3.4% were denied access to a health service at least once in the last 12 months; and 4% said that health workers informed their status to other people without their consent.

Mozambique ranked 26 out of 136 countries globally in the Global Gender Gap Index of 2013²⁶, demonstrating greater gender equity compared to other countries in the region. However, important gender inequalities still exist that negatively impact health. Traditional gender roles and power relations reduce women’s ability to negotiate safer sex, economic and employment disparities contribute to a greater number of women engaging in sex work or trading sex for goods, and low access to health or sexual education leave young girls and women vulnerable.

There are a number of social and contextual factors which fuel gender imbalances. The illiteracy rate was estimated at 56% in 2008 in girls. Low and inconsistent condom use, along with high alcohol consumption, and early onset of sexual intercourse are common amongst people in the 15-24 age range; these combined with age-disparate sexual relations increase risk for girls. 19% of girls and 22% of boys aged 12-14 have already had a sexual intercourse⁹. Early marriage is a big problem, 48% of girls under 18 and 14% under 15 are married. Physical violence in the last 12 months was reported by 35.1% of girls aged 15-19 and 57.4% of those 20-24 years. Mozambique has the seventh highest child marriage prevalence rate in the world. On average, one out of two girls will be married before her 18th birthday²⁷.

In alignment with the HIV National Strategic Plan²⁸, the Ministry of Women and Social Affairs leads national mitigation action for families affected by HIV. This includes the protection of orphans and other vulnerable children as established in the National Plan of Assistance and Protection of Orphans and other Vulnerable Children; and the Multisectoral Mechanism for the Assistance and Protection of Women Victims of Violence, which establishes a joint mandate, along the Ministry of Health, to provide post-exposure prophylaxis to victims of sexual assault. Data on the prevalence of gender-based violence is not available. With respect to GBV, the DHS 2011 shows that 25% of women were victims of physical violence in the last 12 months. For 62% of the women who were victim of physical violence, the perpetrator frequently reported is the spouse / partner.

Uptake of ART as well as HCT has been low among men. PEPFAR implementing partners are piloting a number of interventions to encourage men to attend PHC with female partners, and youth-friendly clinics are re-designing their programming to attract more young men. Data shows that although men have high knowledge of where to go when desiring to be tested, the test rate among them is half that of women. Since HIV diagnosis is the first entry into the HIV care and treatment cascade, lack of desire to HIV test represent the first barrier to male access to HIV services. The difference in HIV test rates between male and females is in part due to the fact that women are tested, most of the times, during the ANC visit. Although HIV test is offered to all partners of pregnant women during the ANC visit, only a few men avail themselves of this service. The limited involvement of the men in their partners' pregnancy is another barrier to HIV services.

TB treatment is free of charge and accessible in the PHC network irrespective of any patient characteristic and uptake and access is wide. TB patients notified and managed by the NTP are generally from poorer strata and TB patients with disposable income are more likely to seek care in the private sector.

The NTP does not routinely disaggregate data by gender, and so it is difficult to make conclusions in relation to gender and TB based on surveillance data. However, a recent Knowledge Attitudes and Practices (KAP)²⁹ survey regarding TB documented the existence of misbeliefs that highlight that community and patient education activities need to be reassessed in order to address various (gender-based) community beliefs such as: transmission of TB through kissing, sharing of household utensils; sexual relations with a woman who has a recent miscarriage or abortion and did not undergo a purification ceremony; sexual relations with a widow who did not have a purification ceremony; not having done a purification ceremony after a member of the family died; sexual relations with a woman during menstruation. Community education and prevention materials will be modified and/or adjusted to respond to these issues. These beliefs can negatively effect on health care seeking behavior and stigmatization of women.

1.d) Health systems and community systems context; constraints, joint HIV/TB programs and planning

Health Systems

The National Health Service (NHS) is the main provider of health services, and operates a decentralized system throughout the 11 provinces, 144 districts and 30 urban municipalities. The MoH is responsible for health sector policy and strategic direction as well as supervises national referral hospitals. Provincial health directorates (DPS) are responsible for providing technical and policy oversight to districts and supervise provincial hospitals, and district health directorates oversee the health facilities in their catchment. There were a total of 1435 health facilities in 2012. Level I (98 health centers in urban areas, 820 health centers in rural areas, and 271 health posts) and Level II (26 rural hospitals and seven district hospitals) health facilities provide PHC services; they refer when necessary the patients to higher levels of care. Level III health facilities (seven provincial hospitals and four general hospitals) provide secondary level health services while Level IV health facilities (three central hospitals [Maputo, Beira, Nampula] and two specialized hospitals) provide tertiary level health services.

Mozambique's health infrastructure was devastated from decades of war, and despite significant rebuilding the health facility network remains inadequate for the size and distribution of the population. While regional differences persist, the inequity index, which reflects the distribution of primary health centres between worst-and best-provided provinces, has decreased from 5.8 in 1997 to 2.0 in 2011³⁰. There were 23,000 inhabitants/health center in 2007.

HRH remains a major constraint for program implementation. There is a severe shortage of healthcare workers³¹, with 5.6 clinicians, 26.3 nurses and 68.6 midwives per 100,000 population – compared to WHO recommended minimum standards of 20 clinicians and 100 nurses/100,000. The majority of clinic-based services are provided by non-physician staff, in particular by clinical officers (técnicos) and nurses. The Acceleration Plan also recommends expansion of task shifting and endorses a need for 1893 lay counselors by 2015 to achieve the goals of expanding testing, treatment and retention, up from the current 500 counselors. Despite a commitment to increasing access to and coverage of health services, as well as their efficiency and quality nationwide, high patient/facility, and low HCW/patient ratios impede equitable delivery of care. It is estimated that only 65% of the population live within 45 minutes of a health center.³²

At the health facility level, the MoH has been supportive of service integration efforts in order to increase the efficiency of primary care as well as to reduce the burden on patients who seek care. The NTP and the National HIV/AIDS Program have embraced the one-stop-model approach for provision of services for co-infected patients who are on both TB treatment and ART. By the end 2013 of 563 of 1350 clinics provided integrated TB and HIV care within which co-infected patients being treated for TB care can collect their ART and TB drugs at the same visit to the TB clinic (described in more detail in section 1.2). The cross-cutting health system challenges facing the national HIV and TB programs include:

- insufficient integration of prevention and treatment planning;
- challenges in expanding implementation of programs to all levels of the health system;
- limited outreach for integrated health service delivery and continuum of care at communities, particularly in isolated geographic areas;
- challenging logistics for commodity supply, including distribution, transport and warehousing/stock management and logistics data collection;
- limited use of information technology and data management, analysis and use for monitoring and planning purposes;
- poor quality of data and irregular reporting;
- chronic shortages of staff and insufficient skills development;
- weak community engagement and engagement of key and vulnerable populations;
- inadequate and unreliable health financing.
- insufficient integration of prevention, treatment *and supply* planning
- poor financial management capacity.

These challenges and the response of the national programs including Round 8 HSS grant to some of these challenges are discussed in Section 1.2.c.

Community based health-related services

Mozambique faces challenges in the provision of health services and reaching communities to deliver proper care. The MoH has begun to implement a number of strategies to increase coverage of health services through innovative community-based approaches. A number of initiatives for health service delivery take place at community level, either with direct government support or through local and international NGOs.

Agente Polivalente Elementar (APE) are an official health cadre, and serve as an extension of the primary health care facility to the community. APEs provide much of the preventive care in rural communities including community talks on key diseases and health conditions such as malaria, pneumonia and diarrhea, counselling on family-planning methods, promoting deliveries within health facilities, linking to nutrition programs, malaria prevention and improved health-seeking behaviours. APEs link the community to the National Health System (NHS) as the first step in the referral system. However, the APEs generally are stationary and do not perform home visits, and currently do not provide support for patients with TB or HIV. There are also a limited number of mobile health services being rolled out to bring clinical services to regions where the populace cannot reach health centres, on a reliable weekly or monthly schedule.

In addition to the formal health cadre of APE, the NHS relies heavily on community-based organizations to implement activities that complement health center-based and health center-outreach service provision. Community-based organizations are critical to the national response to HIV and TB due to

their ability to reach and mobilize community members, and change sociocultural and behavioural norms that inhibit people from accessing diagnosis, care and treatment.

Activistas are community members tasked with providing essential support for the community response to a number of health and wellness concerns, and have been utilized for many years for vaccination campaigns, and community education regarding proper use of bed nets. With the advent of the HIV epidemic, PEPFAR and GF-funded projects have been utilizing *activistas* to perform community based activities, including HIV prevention, behavior change communication, demand creation for HIV testing and positive prevention. In some cases *activistas* are peer educators (i.e., they are members of the population group they are reaching out to), and in other situations, they are community members who have been trained to sensitively work with key and vulnerable populations.

Fundação para Desenvolvimento da Comunidade (FDC), as the non-governmental PR for the Global Fund, provides financial and technical support, and coordinates the HIV activities of its sub-recipients, ADPP and ECOSIDA, and the ten CBOs of the FDC Consortium. The sub-recipients are geographically distributed and cover the priority districts throughout the country highlighted in the Acceleration Plan. FDC has standardized recruitment, training and supervision of remunerated *activistas*, as well as qualifications, responsibilities, workload, major activities and reporting schedules (Estrategia de Implementacao da FDC—atividades de HIV—Round 9 Phase 2). Additionally, all PEPFAR supported clinical implementing partners who support all 144 districts in Mozambique for HIV and TB/HIV related activities, support *activistas* to provide critical support in health facilities as well as improve community-clinical linkages. The work of these clinic-based *activistas* is coordinated with the work of the community-based *activistas* to provide a holistic network of support for patients in and out of the facilities. Two international NGO's (ADPP and FHI360 with USAID funding through TB CARE I) are supporting and managing district CSOs and community workers which provide activities as house-to-house visits in search of persons with presumed TB, their referral, and treatment adherence support. In 2013, 50 of 121 districts were covered by these services, contributing to detection of 10.2% of nationally notified patients.

Through the coordination role of FDC and other partners, during the past year the supervision of *activistas* has been increased, and a standardization of their roles and functions has occurred. Service packages have been established for each target group (young girls; women; sex workers; miners; truck drivers; work place), and the portfolio of tasks has increased. From 2015, *activistas* will be tasked with increasing demand for both TB and HIV awareness raising, safe sex and risk reduction education, community provision of HIV counselling and testing, TB case finding and referrals, PMTCT, treatment adherence through one-one interactions supported by targeted media approach and peer groups. *Activistas* will be the cornerstone for the new TB community strategy, in part by incorporating community DOT into their portfolio.

In addition, at the community level, the GRM has expanded the pilot of GAAC (community adherence support groups), as a community-based approach to supporting adherence and decongesting health facilities, with the expectation that GAAC will be implemented in association with all facilities providing ART and supported by the *activistas*.

Community systems strengthening:

The HIV National Strategic Plan 2009-2014 (PEN III), the Acceleration Plan for HIV (2013 – 2015) and the Tuberculosis National Strategy (2014-2018),³³ reinforced by the Quality Improvement and Humanization of Health Care Strategy (MISAU, 2011-2014)³⁴, the Health Promotion Strategy (MISAU, 2010)³⁵ and the Community Involvement Strategy (MISAU, 2004)³⁶ all recognize the importance of community engagement and participation, and reinforce the imperative that community health systems must be strengthened for attainment of better and more sustainable health outcomes. Furthermore, the national health system still relies heavily on community organizations to deliver the bulk of activities implemented at community level that complement health services provision.

The scope of civil society organizations (CSOs) in Mozambique in regard to the HIV response has traditionally been through supporting prevention, social behavior change, home-based care, reducing risk and vulnerability and impact mitigation interventions, marked by very weak linkage between the community services and the health systems. The recent plans, however, call for a vast expansion of CSO work and the alignment of CSO programs more towards contributing to care and treatment targets. Areas of current expansion for CSOs in Mozambique include: demand creation for services uptakes such HIV counseling and testing, male circumcision, PMTCT; timely TB diagnostics and treatment reinforcement

of the linkages between health services and community care through a referrals and counter referrals systems; patient centered care and patient rights and responsibilities; support for PLHIV to adhere to and continue TB treatment and ART; screening for TB patients; provision of treatment literacy education for HIV and TB; psychosocial support including mobilization and facilitation of community groups such as Mothers-to-Mothers and (GAACs).

Furthermore, more work is being done by CSOs in identifying and supporting key populations in the community and in conducting advocacy initiatives and community mobilization activities at central and local level as a complementary component to the service delivery package. There has been an increase in organizations involvement in defending women and children rights in the HIV national response and according to latest Global AIDS Response Program Report (GARPR), civil society was fully involved in the elaboration of the multisectoral HIV and AIDS National Strategic Plan 2009 - 2014 (PEN III), with two civil society representatives on the Steering Committee. Civil society also played a crucial role in the revision and dissemination of the laws that defend PLHIV rights (Lei n°19/2014 de 27 de Agosto).

As part of strengthening the collaboration between health facilities and community, the government, through the Community Involvement Strategy (MISAU, 2004) has been reinforcing linkages between community and health facility, by promoting the establishment and reinforcement of community structures such as the health community council, and co-management councils that facilitate linkages and interface.

Nonetheless, many CSO have limited organizational structures and still require skills building and organizational strengthening to assume even greater responsibilities Civil society still faces challenges in coordination and harmonizing of their activities, and some civil society organizations continue to require capacity building to implement appropriate interventions. CSO and networks of CSOs also face challenges, including capacity for management, leadership and governance, identifying and implementing their role and mandate, managing work plans and budgets, and monitoring and evaluation of advocacy efforts.

A platform for CSO coordination and common action has been created. The CSO Platform for Health, HIV, and Human Rights was launched in June 2014, whose main objective is to consolidate and strengthen civil society participation in the health, HIV and TB response at all levels. Some provincial CSO Platforms are operational; the national CSO Platform will revitalize the Platforms in the remaining provinces.

In addition, in part based upon advice from international partners including the Global Fund, there has been a re-orientation in Mozambique towards community-specific prevention approaches rather than large national campaigns. There are now sub-recipients in each province that focus on prevention for key and vulnerable populations. While the MoH has a role in establishing and supporting the overall prevention strategy, this reorientation is reflected in the role of FDC as the NGO PR, and its provincial sub-recipients.

1.2 National Disease Strategic Plans

With clear references to the **current** TB and HIV national disease strategic plan(s) and supporting documentation (including the name of the annexed documents and specific page reference), briefly summarize:

- a. The key goals, objectives and priority program areas under each of the TB and HIV programs including those that address joint areas.
- b. Implementation to date, including the main outcomes and impact achieved under the HIV and TB programs. In your response, also include the current implementation of TB/HIV collaborative activities under the national programs.
- c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints and barriers described in question 1.1 are currently being addressed.
- d. The main areas of linkage with the national health strategy, including how implementation of this strategy impacts the relevant disease outcomes.
- e. Country processes for reviewing and revising the national disease strategic plan(s). Explain the process and timeline for the development of a new plan and describe how key populations will be meaningfully engaged.

1.2.a: The key goals, objectives and priority program areas of the TB and HIV programs including those that address joint areas.

The National Health Strategy 2014 – 2019 (PESS)³⁷ is the guiding policy document for the MoH, including for the HIV and the TB programs. The PESS has adopted primary health care as the foundation for equitable health service delivery.³⁸

The HIV response in Mozambique had been guided by the National HIV Strategic Plan: PEN I (2000-2004), PEN II (2005-2009), and now by PEN III (2010-2014). While planning is underway for the development of PEN IV to cover 2015-2019, the objectives, strategies, targets, and implementation guidance specific to the national HIV response are already contained in more recent strategic documents include the National Accelerated Response to HIV 2013-2015 (Acceleration Plan) and the Plan for Elimination of Vertical Transmission of HIV³⁹ (which responds to the Global Initiative for Elimination of Vertical Transmission of HIV). These newer strategy documents shift the HIV response to evidence-based, high impact programming and emphasize geographically prioritized action in the areas (Figure 11) that will most effectively optimize the use of scarce resources to rapidly advance towards an AIDS free generation. The Acceleration Plan has been modified and extended to cover the period 2015-2017 and provides guidance to the HIV response while PEN IV is in development. The goals of the HIV Acceleration Plan, which guide the implementation plans of the MoH, FDC and all implementing partners and donors supported the national HIV and TB responses, are to:

1. Attain universal ART coverage for adults and children by 2017 (80% in AP 2013-2017)
2. Reduce the number of new infections by 50% by 2017
3. Reduce vertical transmission of HIV to less than 5% by 2017
4. Reduce HIV related mortality by 30% by 2017
5. Create a culture free of stigma and discrimination for those living with HIV and TB

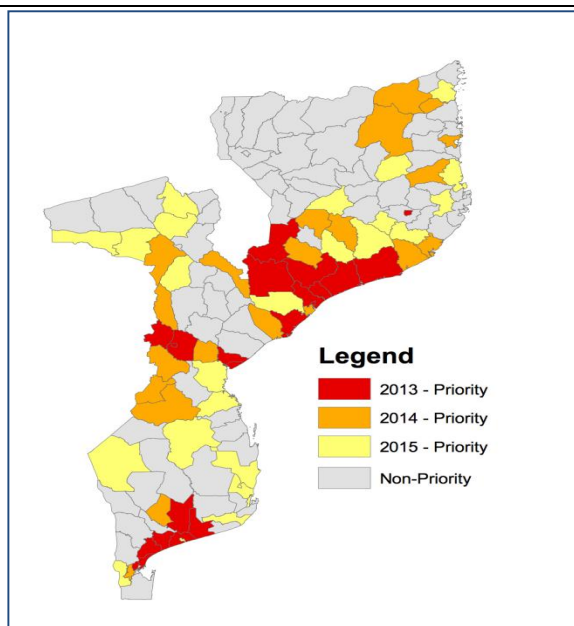


Figure 11: Acceleration Plan 71 priority districts

The Plan promotes specific strategies and priority program areas to target the 71 districts with the highest HIV prevalence. The policies, strategies and priority program areas adopted to reach these goals include massive treatment expansion through decentralization and a resultant increase in the number of health facilities offering ART from 310 to 707 in 2015 and 1072 in 2017, a comprehensive package of community interventions targeting key populations to reduce new HIV infections through access to primary prevention, care and treatment services; targeted HIV testing for key and other vulnerable populations (through PITC and testing at community level) which aim at increasing the number of people tested through advocacy by *activistas*; and increasing adherence to treatment through Community Adherence Support Groups (GAAC). Each province has developed province-specific Acceleration Plans based on the strategies and guidance delineated in the Acceleration Plan and the National HIV/AIDS Program conducts quarterly supervision to all provinces to monitor progress and support scale-up.

At the health facility level, newly implemented task-shifting strategies, including the two one-stop models-for TB/HIV, and for RMNCH/PMTCT/ Early Infant Diagnosis/ Universal ART), which will better ensure comprehensive care and increase access and retention to services. Newly modified guidelines establish immediate ART initiation for all HIV-infected pregnant and lactating women, for all children < 5 years of age, sero-discordant couples at RMNCH and for all TB/HIV co-infected patients. Sero-discordant couples outside of RMNCH continue with eligibility criteria consistent with the general population.

Improving quality of service delivery is guided by National Standardized Quality Improvement Strategy, which details health facility specific treatment targets, standardised multidisciplinary routine quarterly supervision, and a standardized, outcome-based monitoring and evaluation framework that evaluates data quality, consistency and veracity.

As a matter of routine, HIV program data is triangulated with data from the pharmacy and logistics sector in order to evaluate concordance between reported numbers of patients receiving treatment and reported volume of ARVs being dispensed. New technologies are being incorporated into the national response-notably the use of mobile-POC technology for EID as this service rapidly expands.

TB/HIV

Implementation of integrated TB/HIV services is guided by the National AIDS Strategy 2010-2014, the Acceleration Plan for the Response to HIV 2013-2015, (now extended to 2017) and the National Strategic Plan for TB 2014-2018 (NSP-TB), that outline specific HIV/TB interventions. In addition, programs are guided by the Guidelines for HIV/TB Collaborative Activities. The above guidelines and strategy documents support: a) intensified case finding through routine TB screening of all HIV positive patients in care (Acceleration Plan [AP] target 90% in 2015); b) early initiation of TB treatment in co-infected patients in order to reduce TB-related mortality (AP target 100%); c) isoniazid preventive therapy (IPT) is provided for PLHIV who do not have active TB (AP target 45%); d) testing and counselling of all TB patients (AP

target 99%); e) ART for TB patients (AP target 90%); within two weeks after the start of TB treatment (AP target 80%); f) cotrimoxazole (CPT) (AP target 100%); g) TB screening among HIV+ TB index family contacts (AP target 96%); h) GeneXpert testing of HIV+ sputum-smear negative presumed TB patients (AP target 50% where GeneXpert is available); i) TB infection control; j) TB screening for all HCWs.

The abovementioned national strategies support expansion of the One-Stop Model (OSM) approach. As of 2013, 563 of the 1350 health facilities providing TB treatment have initiated the OSM, with expansion to 700 facilities planned by 2017. The Acceleration Plan envisages that this one-stop model will be eventually expanded to all health facilities, in order to achieve 100% co-located TB/ART care. In addition in the context of the implementation of Option B+ for prevention of vertical transmission, male partners, as well as the children, can access ART at the same facility if found to be HIV positive.

The role of community systems is articulated in the national HIV and TB program strategies and in the Acceleration Plan. Additionally, four major strategy documents guide TB/HIV implementation: Quality Improvement and Patient Orientation of Health Care Strategy (MISAU 2011-2014)⁴⁰, Health Promotion Strategy (MISAU 2010)³⁵, the Community Involvement Strategy (MISAU 2004)³⁶, and the Plan for Community Involvement in Tuberculosis 2014-2018³⁶ (this plan complements the TB National Strategic Plan with more details on community care for TB). The activities laid out in these plans focus on increasing case finding for TB disease and HIV infection, ensuring the continuum of care between health services and community through community groups, peer educators, community health workers and *activistas*, contact tracing for TB disease and HIV infection, all intended to increase access and adherence to treatment, and service delivery at the community level. There is also an emphasis on strengthening prevention interventions. Promotion of male involvement through behaviour change strategies as women have challenges in continuing their own treatment, as well as of their children, if their male partner is not engaged are among the key interventions in the community service package. Community activities for HIV and TB are being aligned, assuring a fully integrated community-level approach to implementation of HIV and TB prevention and care activities³⁶. Based upon the findings of the Stigma Index Survey, issues related to recognizing and responding to stigma and discrimination will be included in all training curricula.

TB: The TB response in Mozambique is guided by the National Strategic Plan for TB, 2014-2018 (NSP-TB). The overall goals of the plan are to:

1. Reduce the incidence of TB from 544/100.000 persons in 2011 to 390/100.000 by 2018 (corresponding to a 28% reduction)
2. Reduce the mortality of TB from 49/100.000 in 2011 to 37/100.000 in 2018 (corresponding to a 24% reduction)

The plan sets out to achieve these goals by focusing on the following strategic targets: 1) increase in case notifications of all forms of TB by an additional of 6-12% /year, from 214/100.000 in 2012 to 343 cases /100.000 in 2018 (70% of expected cases); 2) expansion of access of eligible TB patients to ART to 90% in 2015 and 100% in 2018; 3) increase in the number of MDR-TB patients diagnosed and enrolled in care from 214 patients in 2012 to 1,194 in 2016 (50- 75% /year increase) and 1,648 in 2018 (30-15% /year increase); 4) improvement of the cure rate of MDR-TB from 30% in 2012 (2010 cohort) to 65% in 2018 (2016 cohort).

The recent Plan for Community Engagement in TB Control 2014-2018 strategy has two objectives: 1) increase of the number of patients diagnosed through community workers with TB, MDR-TB and HIV/TB co-infection; 2) improve and sustain high treatment success in PLHIV, and in particular patients with MDR-TB.

To meet these targets, the NTP is continuing the successful implementation of the DOTS strategy, and the following strategies and priority program areas:

1. Increase case-detection for all forms of TB by expansion of the laboratory network and increasing access to examination of sputum samples by Ziehl-Neelsen, LED-FM, GeneXpert and phenotypic C/DST [liquid and solid culture], as well as second-line drugs sensitivity testing. These will be combined with the introduction of quality assurance systems and an effective integrated lab sample transportation network (for both TB and HIV samples) to link peripheral health facilities to the laboratory network. The expansion of GeneXpert and testing of high-risk groups for MDR-TB (e.g. previously treated patients, contacts of MDR-TB patients, health workers, miners etc.) as well as PLHIV, children and presumed extra-pulmonary TB will increase the number of patients diagnosed with drug susceptible and rifampicin resistant TB. Training on MDR-TB and pediatric TB and

provision of diagnostic tools for pediatric TB diagnosis (nebulizers and gastric tubes) will raise the awareness and skills in diagnosing these forms of TB. Algorithms for diagnosis of MDR-TB and pediatric TB have recently been revised to incorporate GeneXpert. This case detection strategy will be supported by community care activities which should increase identification and referral of persons with presumed TB.

2. Access to ART for TB patients is expanded through expansion of the OSM model to 700 clinics.
3. Scale-up of MDR-TB treatment capacity to ensure that all patients diagnosed by GeneXpert with rifampicin resistance and phenotypic C/DST will start treatment quickly, with minimal delay between diagnosis and start of treatment. Patients diagnosed with GeneXpert-diagnosed rifampicin resistance (two positive results on different sputum specimen are needed for patients with low risk of drug resistance, such as patients never treated before or not exposed to a confirmed MDR-TB patient; one positive result for a patient at high risk of MDR-TB) will be started on a standard MDR-TB regimen, while awaiting confirmation of isoniazid resistance through phenotypic DST.
4. Treatment success for drug susceptible patients is already high and will be sustained, and supported by the recently developed TB/HIV community care strategy (“two diseases, one community, one patient, one community health worker”).

The low treatment success rate for MDR-TB patients will be improved by a combination of: a) admission of each patient in one of the MDR-TB centers for a period that is adequate to initiate MDR-TB treatment, ART if also HIV positive, conduct baseline blood chemistry (liver, kidney, thyroid function), audiometry, patient education and counselling, organization of ambulatory care, psychosocial and nutritional support (nutritional support is funded from other sources than this grant); b) good patient follow-up by the nearest health facility; c) training of health and community workers on MDR-TB management (side-effects monitoring and treatment); d) strict quarterly supervision of MDR-TB case management by provincial and district staff, data validation and recording, evaluation of interim and final treatment outcomes. An individual patient-based electronic TB Register will be developed and introduced for both drug-susceptible and drug-resistant tuberculosis, which facilitates surveillance and monitoring/evaluation.

The expansion of the lab network (LED-FM, GeneXpert, DST) will be done stepwise with careful attention to the most efficient placement of this new equipment as well as immediate implementation of quality assurance and maintenance, and data management (recording and reporting) to ensure high utilization and quality.

Laboratory expansion for TB microbiology					
Year	2013	2014	2015	2016	2017
Total functioning labs	315	390	450	510	600
# of ZN + LED microscopes	372	500	650	800	1200
# of ZN microscopes	310	390	450	510	600
# LED microscopes	62	110	200	290	420
# GeneXpert platforms	16	36	41	46	51
Culture	3	3	3	3	3
FLD DST	1	2	3	3	3
SLD DST	0	0	1	1	1

Table 3: Planned Laboratory Expansion – 2013-19

1.2 b. Implementation to date, including the main outcomes and impact achieved under the HIV and TB programs. In your response, also include the current implementation of TB/HIV collaborative activities under the national programs.

HIV

There has been a remarkable increase in the total numbers and population coverage of key HIV services. The number of individuals having HIV testing in the current year has risen from 3.8 million in 2012 to 4.7 million in 2013 (106% of the national target for 2013); 9.8% prevalence was noted in 2013.

The number of health facilities offering pediatric and adult ART has more than doubled, from 310 in 2012 to 647 as of June 2014. Along with the 647 facilities currently offering ART, there are an additional 41 health facilities receiving support via a mobile clinic “satellite” ART provision during fixed days in each month. Sites offering PMTCT services have increased from 1170 in 2012 to 1213 in June 2014. Of those

facilities providing PMTCT services, 623, as of June 2014, implement Option B+. The number of facilities that offer early infant diagnosis has risen from 597 in 2012 to 988 in June 2014.

The numbers of adults newly initiated on ART in 2013 was 163,918 (126% of target), with a cumulative 456,055 adults remaining on ART by the end of 2013. Adult ART coverage based upon national eligibility criteria (consistent with 2010 WHO guidelines) has risen from 44% in 2012 to 63% by the end of 2013. 41,400 children (80% of national target) were actively receiving ART at the end of 2013 (36% the ART eligible per national guidelines). In total there were 497,455 adults and children on ART, representing an overall coverage of 59% of eligible people living with HIV by the end of 2013, and a total of 552,940 as of June 2014. 616,113 children and adults are expected to be on ARV by the end of the year (Figure 12). The enrollment on ART as of June 2014 (Figure 13) demonstrates that the national program will reach its ambitious targets for 2014. Based upon expected growth in enrollment of PLHIV on ART plus the intensified case finding supported through the HIV Acceleration Plan, an estimated 750,023 adults and children will be on ART in 2015, and 996,593 in 2017, which will represent 81% of eligible persons. The National HIV/AIDS Program has not revised the CD4 eligibility upwards from 350.

One-year retention rate is 70%, and has remained stubbornly low. There is no 'unique identifier' for each PLHIV in care, and it currently is not possible to document the extent to which patients on ART identified as LTFU have self-transferred to a more convenient ART facility. Research from other settings has indicated that self-transfers may be a significantly-sized group.

Mozambique has recently begun implementing Phase 1 of its national viral load strategy. The strategy begins the roll-out of viral load testing by targeting ART patients with clinical or immunologic signs of treatment failure. Five viral load machines will be operational in five provinces by the end of 2014 and the MoH anticipates this phase will last two years. During that time, the logistical and operational challenges of rolling out viral load will be addressed in preparation for Phase 2, which is routine viral load testing for all ART patients.

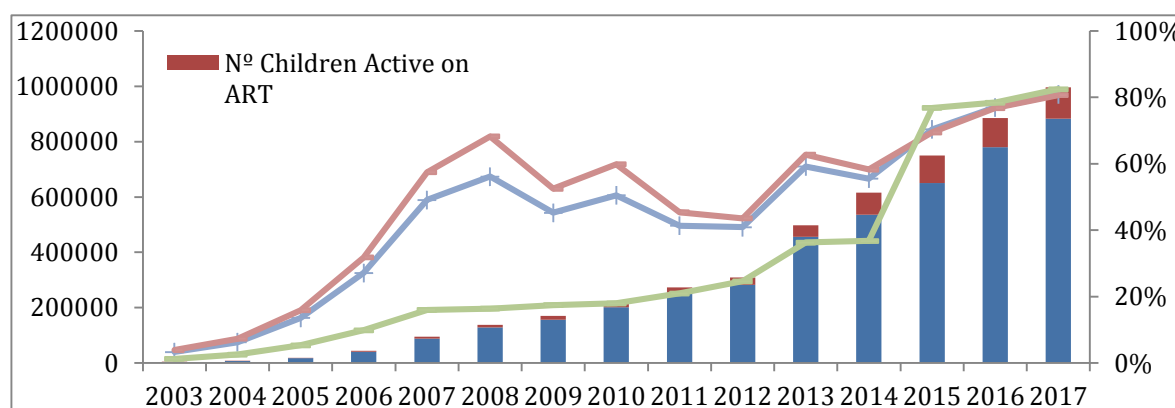


Figure 12: ART Enrolment 2003-2017 (projected)

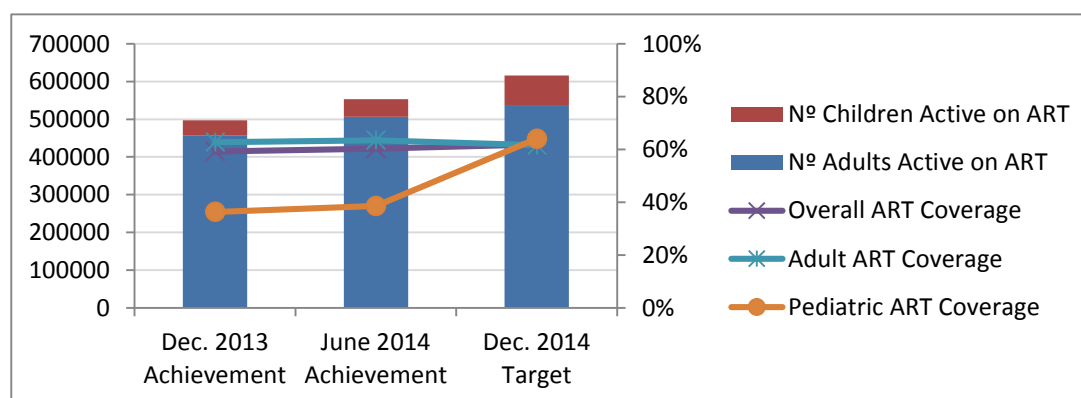


Figure 13: 2014 ART mid-year achievement vs. end year target

Coverage of PMTCT services (Figure 14) has increased from 72% in 2012 to 83% in 2013. Option B+ was introduced in June 2013; by six months later 50% of those HIV-infected pregnant women who received

any regimen were receiving ART (an increase from 12%), and by June 2014, 86% of all women receiving PMTCT were receiving ART.

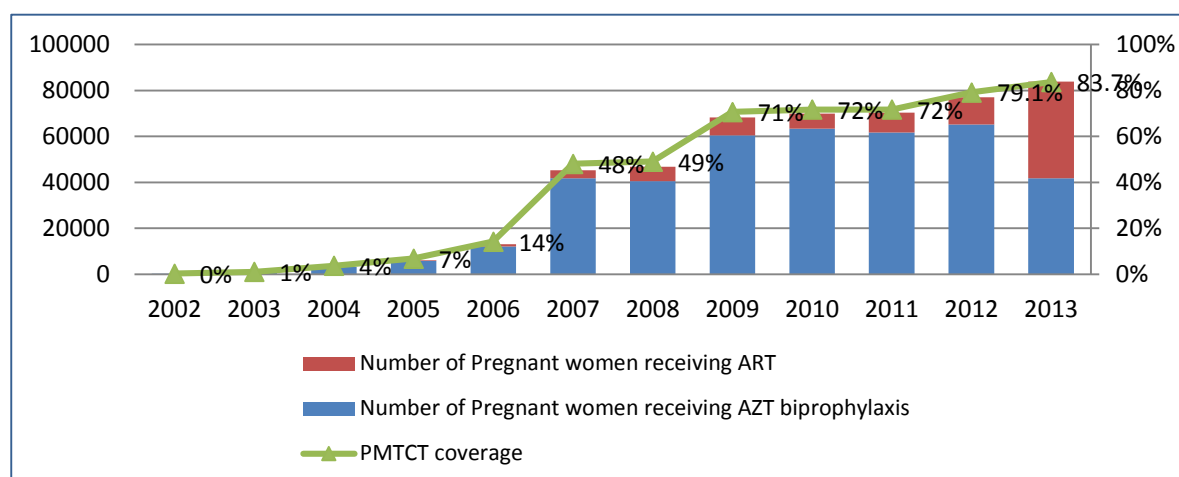


Figure 14: Coverage of PMTCT services by 2013

Male circumcision, although slow to scale-up, has reported an increase of more than 61% from 2012 to 2013 in the number of men who have been circumcised in that year (90,509 to 146,046). The national target is to attain 80% circumcision prevalence in men 12-49, although as of 2011 only 47% of men 15-49 were circumcised.⁴¹

In order to reduce barriers to ART initiation, the ART certification criteria for health facilities have been revised (safeguarding quality and minimum standards) and the number of counseling sessions required before patients start ART has been reduced from three to one. Introduction of Option B+ for PMTCT has been effectively implemented through the one-stop-shop model of services at RMNCH settings.

The approach to HIV prevention has been evolving, as increased information has become available regarding geographic and population group differences in HIV risk. The MoT and additional demographic information has focused prevention efforts as well as treatment efforts in priority provinces.

As part of Global Fund Round 9 proposal, the FDC Consortium, is strategically targeting girls and women with a comprehensive package of services in priority districts in nine provinces are currently covered by a specific package of services. The package being provided is centered on BCC and interpersonal communication and is based on existing evidence-based packages such as the “Go Girls initiative” that approach and address gender barriers and structural obstacles in order to empower girls towards protective and health seeking behavior. This community intervention package being implemented and will be adapted with this proposal to incorporate components such as TB, PMTCT and SRH to ensure a more comprehensive package for girls and women.⁴²

TB/HIV

HIV testing and counselling of TB patients has increased from 84% to 96% (2009 to 2013), and ART coverage in TB patients has increased from 22% to 80% (June 2014). Coverage of cotrimoxazole preventive therapy (CPT) for HIV-positive TB patients increased from 89% to 97%. 1350 of the 1,435 health facilities provide TB treatment; 647 also provide ART- 563 of which use the one-stop model approach. In 2013 the HIV program reported that 85% of newly registered PLHIV in care were screened for TB, and almost 50% of patients in care received TB screening at their latest clinic visit. IPT has been initiated in 48,330 PLHIV out of 277,173 PLHIV (17%) newly registered in HIV care in 2013. (HIV/AIDS Annual Report MOH 2013). In 2009 only 2,489 PLHIV were reported as started on IPT.

TB

Case notification has increased 17% over the past five years (from 45,516 to 53,261). Notification rates/100,000 have increased only minimally (from 209 in 2009 to 219 in 2013). Community organizations have increasingly become involved in supporting TB activities, including identification and referral of TB suspects, as well as in DOT and tracing patients. Through TB CARE I (funded by USAID), in 2013, 50 of the 141 districts are served by a TB community organization. In 2013 the NTP reported that 10.2% of all

notified patients were detected through referral by community organizations, and 0.4% by traditional healers. TB in children (0-14 years) is notified at 7-8% each year. This is considered low, based on observations during supervision.

TB treatment success rates have been consistently high for drug susceptible patients. In 2013 the NTP reported 87% treatment success among new patients with sputum-smear positive TB. Case fatality rates are declining slowly and reached 7% in 2013, which is influenced by late reporting, HIV prevalence and ART coverage. Lost-to-follow-up is consistently low at 3-4%.

USAID is providing technical assistance to the National TB Program to increase coverage of universal DOTS in prisons located in urban areas near district and provincial capital cities. Approximately 5 to 10% of prisoners that undergo screening are diagnosed with TB. Recently, four prisons (three regional and one provincial in Niassa) were visited to assess TB control interventions. Information collected from this assessment will be used to strengthen TB programming in prisons throughout the country.

MDR-TB treatment started in 2004. Between 2004 and 2013, a total of 1,034 patients were registered on treatment for MDR-TB. Culture (C) is available in the labs of Maputo (NRL), Beira, and Nampula; drug sensitivity testing (DST) is only available in the NRL Maputo. In 2012 the NTP reported that only 5% of notified retreatment patients were tested for MDR-TB, despite NTP policy that all should receive C/DST) - and 136 (60%) were diagnosed with MDR-TB. After introduction of GeneXpert MTB/RIF in early 2013, by June 2014, 16 platforms are operational; testing has substantially increased - 10,727 patients were tested, of whom 1,369 were MTB positive (NRL).

MDR-TB treatment outcomes to date are poor. From all patients started on treatment in 2011 (n=147) only 36% successfully completed treatment after 24 months of treatment, 33% were still reported on treatment, 16% were reported as died or lost to follow-up, and data for 12% was not available. Incomplete data impedes the ability to evaluate interim and final treatment outcome.

1.2.c: Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints and barriers described in question 1.1 are currently being addressed.

HIV

Despite high ANC coverage, only 50% of pregnant women have four or more ANC visits, and only 54% of pregnant women have an institutional delivery (DHS, 2011). With the introduction of Option B+, PMTCT coverage has increase significantly, with 86% of HIV-infected pregnant woman receiving PMTCT services, and of those women, 86% receiving ART. 20% of pregnant women will be too geographically distant to access ANC at the 707 health facilities that will be offering ART by 2015, so research on the main bottlenecks to access and retention for PMTCT and ART services is underway and results will be available later in 2014. Retention of HIV infected pregnant women on ART is an issue of great concern. Several evaluations are being undertaken of 3, 6, 12 and 24-month retention of pregnant and lactating women who have started on ART. The data from these evaluations will assist the MoH to adapt the program and develop strategies to improve retention for this critical population.

Pediatric ART coverage continues to lag behind adult ART coverage. Coverage of PITC in pediatric in- and out-patient wards remains low, and there is insufficient access to early infant diagnosis (EID), accompanied by gaps in linkage to care and early treatment. While there has been an impressive increase in the number of facilities providing EID, there are still challenges with sample and result logistics and coverage (54% population coverage in 2013 and among these, only 40% of samples collected were from infants < 2 months.). A minimum package of care for HIV-infected children has been developed and will be disseminated in the provinces, and there will be implementation of outreach activities focusing on fast-tracking the linkage of infants with positive PCR to care and early ART initiation. An EID electronic database has been developed and was disseminated in 2013 to provincial management teams, allowing them to monitor closely the program, including the samples and results logistics.

The MoH is currently identifying the main challenges and barriers to access and retention into pediatric treatment. The Pediatric Working Group is preparing a rapid assessment of the situation for these purposes in Q4 2014 with the support of UN, CDC and other implementing partners. It is expected that an action plan for acceleration of pediatric treatment in 2015 will result from this assessment. The pediatric treatment programme is working together with the PMTCT programme to optimize consistency of action at the RMNCH care services. A common ground that will be particularly explored in terms of demand

creation and retention is community action. Coordination with the CNCS communication/community working group is on-going.

Despite recent MoT results showing the importance of sero-discordance in the epidemic, the MOH has not yet been able to change ART eligibility to incorporate the recommendations from the WHO guidelines for sero-discordant couples. Revising ART eligibility to reflect these guideline would increase the number of eligible people needing ARV in 127 % in 2015; 123% in 2016 and 120 % in 2017, which is not feasible given financial constraints. Therefore this group is treated as general population.

Currently, it is envisaged that testing of partners (search and testing of index cases) will be done by counsellors at the community level; followed by integration of positive index cases in positive prevention sessions at community level; reference to the health facilities for assessment of positive index cases (for initiating ARTs or maintenance in pre ART); creation of community self-support groups of PLHIV composed of stable couples. This is a provisional approach and not the main focus of the community interventions, as described in specific packages of services for adult women, young women and girls and other vulnerable populations.

Patient retention in care and on ART remains a challenge. The national program has responded with a wide range of interventions that are expected to improve retention:

Site expansion

Poverty, distance, opportunity costs are significant structural causes for attrition. Given that there was little site expansion during the 2008-2012 period despite significant growth in patient volume, the rapid expansion of ART sites in priority districts in Mozambique has resulted in a decrease in the average distance a patient has to travel to obtain services, and decongestion of large, crowded clinics as patients seek services at newly opened facilities.

Quarterly drug distribution of ART

Due to insecurity regarding financing and availability of ART, until this month it has not been possible to ensure the Central, Provincial and District stocks of ARVs were sufficient to allow for quarterly distribution of ART for stable patients. As stock levels stabilize, there will be a move towards quarterly distribution of ARVs to stable ART patients. This represents an important improvement from the current policy of monthly distribution of ART for all patients on treatment, and by decreasing the burden on patients, should improve retention. Instead of 12 ART pick-up visits to ART facilities visits per year, stable ART patients would only need to make four health facility visits per year for ART pick-up. Additionally, by increasing the drug pick-up interval to three months, health facilities will significantly reduce monthly patient volume, thereby decongesting health facilities, including pharmacies, and allowing health facility staff more time to care for patients in need of services.

GAAC

Mozambique implemented a national pilot, based on the Tete Province experience, of Community Adherence and Support Groups (GAAC). A GAAC is a self-formed group of up to 6 adult ART patients who are enrolled at the same health facility and meet the following eligibility criteria: stable on ART for > 6 months, CD4 count > 200 cells/ml, no active WHO stage III or IV conditions and are > 15 years old. One GAAC representative of the group of six visits the health facility every month on a rotating basis, with each patient in the group traveling to the health facility every six months. The day before a clinic visit, group members meet to discuss the previous month's issues, conduct pill counts, and complete a form designed to relay essential information to the clinician. On the visit day, the GAAC representative has a CD4 count drawn, sees a clinician, conveys information about the other patients in the group using the standardized form, and collects medicine for the group. GAAC members reconvene the evening of the clinic visit to collect their month's supply of ART and discuss information provided by the health facility.

Analysis of the pilot results show retention rate in GAAC participants (n=6810) was 91% at 12-months as compared to 78% in the matched control group (n=6800). This striking difference has led the MoH to approve nationwide roll-out of the GAAC strategy in all ART facilities. This countrywide roll-out will begin in the third quarter of 2014.

This low cost intervention is a MoH initiative that is receiving support from PEPFAR partners in all health facilities in which it is being implemented, including for the logistics of creating and monitoring GAACs in

various health facilities as well as material support for the reproduction of the M&E tools required for GAAC-related data to be tracked and reported.

Community-based Peer and Outreach Workers

The expansion of the community strategy of utilizing province-based NGOs that recruit, train and deploy *activistas* will cover all priority districts, and provide community-based support for retention in care, in concert the interventions being incorporated into clinic-based care. This community strategy addresses structural and other barriers that impede high retention, including support to PLHIV on ART through community health workers and community groups, and is being expanded to all priority districts, and the scope will be expanded to include TB related support, including providing community TB-DOTS.

There are currently many different types of community health workers, operating under different program areas, funded by different donors implementing a wide array of important community –based activities throughout Mozambique. The MoH has decided that the responsibilities of those cadres looking after patients infected with TB or HIV would be consolidated and harmonized to allow for one person to carry out various roles.

With COP 14 funds PEPFAR intends to allocate approximately \$4 million dollars to train and support stipends for approximately 5000 CHW and distribute them nationally in priority districts to assist with demand creation, targeted HTC, treatment literacy, patient retention, CB-DOTS activities and the remainder of interventions described above.

SMS messaging

A pilot is currently taking place in Gaza and Sofala provinces.

Simplified ART Regimen

65% of all patients on 1st line ART are expected to be receiving a simplified, one pill, once per day ART regimen with improved side-effect profile (TDF/3TC/EFV)

Psychosocial support groups

These are population specific groups of PLHIV that convene regularly at health facilities and discuss common issues and concerns, including Cha Positivo, Café TARV, Mother to Mothers and KP Peer Groups. Many positive prevention messages are disseminated and discussed as well as key coping strategies and information about available resources.

The Day Hospitals, which were solely HIV clinics, have now been absorbed into general PHC as part of the MOH primary care strategy. While this has assisted in decentralization and improves access, additional attention is being addressed towards providers who are less familiar with the care and psychosocial needs of PLHIV. The challenges in reaching key and vulnerable populations are being addressed through an expansion of the revitalized community support strategy, in part delivered through *activistas*, and implemented by PR FDC and its associated sub-recipients.

Other activities focusing on adolescents, in particular adolescent girls, including adolescent peer groups engaged in community and school outreach interventions, are raising awareness and focus on reduction of stigma and discrimination among young people about HIV. The government is strengthening the capacity of the Ministry of Education (MINED) to incorporate cross-cutting issues (HIV, gender, school health and prevention of violence) in plans at all educational levels, and teacher training institutes are incorporating these issues into the curriculum.

Children and women's rights have been incorporated into the Criminal Code revision process. There has been development of national multisectoral and costed Plan of Action to Accelerate Prevention and Response to Violence against Children (2012-2017) in partnership with five key ministries (Ministries of Health, Education, Women and Social Action, Justice and Interior) the judiciary (Supreme Court and Provincial Courts) and civil society organizations.

Additional community based services by NGO are supported through PEPFAR funding, and in addition, a number of international NGOs also provide direct support from other donor sources. The community-based activities of these NGO are consistent with the approach of the MOH regarding the role of community services in the HIV and TB response.

TB

TB case-detection is reportedly low¹³. The coverage of TB diagnostic services within the health system is limited due to the absence of a reliable lab sample transportation system from health facilities to the nearest labs, and slow feedback of results, which result in long turn-around times of laboratory results. Testing for drug resistance is still very low; clinicians rarely request this testing, and there is poor performance by the laboratory service in bringing results back within a short time.

Given that primary health care only has 60% population coverage, community care delivery services have been used to counterbalance the poor health network coverage in Mozambique, especially for maternal health, TB, HIV and general community awareness. Lessons learned from these community projects are therefore applied to improve current TB interventions in the community. At the same time, availability of human resources and HR capacity are not optimal to perform early detection of TB as well as appropriate community support for patients on DOT. A study conducted in Beira City (in a high burden province) to evaluate delay in TB diagnosis revealed an average of 150 days, divided almost equally for the patient and health system factors, additionally, these patients had more than 2 visits to the health facility before they were diagnosed TB. Under these circumstances, it is clear that the role of community activities will be to expand TB screening to the populations that cannot easily access primary health care and capture the cases that are missed at health facility. Information from community activity supervision visits show that some TB patients detected through community volunteers had 4 or more visits to the health facilities for the same episode of symptoms.

Treatment success has been low for those MDR-TB patients for whom final treatment outcomes are available in the national TB register. The case fatality rate is high (15-29% in recent years- 2011 cohort¹²) and is likely due to late diagnosis and start of treatment, as well as delays in initiating ART for co-infected patients. 17-22% of patients are lost to follow-up. Currently, at the national level, the NTP is not able to conduct supervision on a regular basis, and the national database is outdated and there is not sufficient data quality assurance. As a consequence, the database cannot be relied upon to analyze the number of patients in care and their interim and final outcomes. The USG is providing technical assistance to the NTP to improve the data systems for case management to ensure these data input into TB drug quantification.

MDR-TB outcomes will be improved by expediting the diagnostic process (thus reducing diagnostic delay and patient mortality before treatment initiation), as well as early start of ART in HIV+ MDR-TB patients. GeneXpert is being introduced through support of USAID and other donors, in locations where utilization will be high, with sputum sample transportation from peripheral sites to GeneXpert sites with implementation of immediate feedback of test outcomes, referral systems linked to immediate clinical management, clinician and laboratory training, as well as ensuring equipment maintenance, power supply, and air conditioning. Confirmation of MDR-TB will be improved by expansion of first- and second line DST testing.

The NTP will recruit six additional medical officers at provincial level; and one medical officer and two M&E Officers at national level to strengthen quarterly supervision and M&E, specifically for MDR-TB, as well as provide on-the-job training. Specialized quarterly supervision on MDR-TB will allow the program to have reliable quarterly data, correct any issues of poor clinical management (e.g., side effects, regimen errors, drug interactions), give on the job training, discuss and correct any problems in patient adherence, conduct quarterly cohort analysis in the clinic, ascertain completeness of data and adherence to patient monitoring standards. Through this intervention the large majority of patients on MDR-TB treatment will be monitored and evaluated every quarter of their treatment schedule, thus allowing proactive solutions and interventions for improving treatment outcomes.

In collaboration with the NTP, USAID is supporting technical assistance to increase coverage of universal DOTS in prisons located in urban areas near district and provincial capital cities. Approximately 5 to 10% of prisoners that undergo screening are diagnosed with TB. Recently, four prisons (three regional and one provincial in Niassa) were visited to assess TB control interventions. Information collected from this assessment will be used to strengthen TB programming in prisons throughout the country.

Current responses to health system constraints to facilitate successful implementation of the national HIV, TB and malaria response

While the HIV and TB programs have been successful in managing and implementing a number of crucial disease interventions in the context of significant systems challenges, concerns have been raised, in part from international donors, that weaknesses in some key domains, if not addressed, would prevent the full realization of program goals, along with the appropriate fiscal controls. The Government of Mozambique has taken these concerns seriously. While some challenges, for example low health care worker/population ratios, require long-term interventions, significant progress has been made in the key health system building blocks that should reassure national and international partners of the seriousness of the governmental response, and of the feasibility of accomplishing the TB program targets, and the targets outlined in the HIV Acceleration Plan.

The Ministry of Health has been working collaboratively with development partners, and bilateral and multilateral donors, who have been providing capacity-strengthening support at central and provincial levels. Funding and technical support from these agencies has complimented GF resources, and has facilitated the implementation of a number of these health system strengthening (HSS) interventions.

The Ministry of Health has negotiated and signed the Global Fund Round 8 Agreement, which is exclusively dedicated to strengthening health systems. This R8 HSS grant includes support to financial management capacity, human resources (basic training for technicians of general nursing, MCH and statistics, strengthening of the Global Fund Program Management Unit, and Central Medicines and Medical Supplies [CMAM]), Laboratory (registration books), Supply chain and logistics of health products (improvements in planning, infrastructure and security systems, transportation) and Information systems (improvement in quality of information).

Subsequent to 2012 OIG audit, aspects of R8 HSS planned activities and expenditures were modified to specifically ensure that this funding would lead to improvements in the program and finance management gaps that were identified. The HSS R8 grant was re-activated with the 01 June 2013 signing of the current 3-year grant agreement for USD \$17,476,545.

As of September 2014, \$1.5 million has been disbursed and is being utilized by the PMU to pay for technical assistance, train MCH nurses and general nurses, and to procure equipment such as vehicles. The next disbursement for US\$8 million is expected in September 2014. With funds from other sources, as well as from R8 funds to date, a number of interventions have been implemented to support the management of GF funding and programming, as well as to ensure that the overall health system in Mozambique can well-support the implementation of HIV and TB program expansion. With these changes and the expected additional improvements funded by R8 HSS, MOH and civil society are well-poised to fully implement activities, and reach the targets under this Concept Note under the New Funding Mechanism.

Financial Management System (FMS)

A recent EU-financed review of the public financial management systems of the health sector verified that “clear progresses in performance since 2011, in different areas.”^a Although the independent review noted that there are still gaps, it confirmed that “a credible reform exists and a tendency of positive progress.” For example, the report cites national developments in payroll management, marked by an expansion of coverage of electronic systems of payment management (e-SISTAFE) across the government. The EU report also cites important progress in asset management as an important component of PFM.

The MOH has also developed a Financial Management Action Plan, and a tool for monitoring and conducting financial analysis (GMS) at the PMU. This tool facilitates the reconciliation of payments carried out by the means of the electronic system of public administration (e-SISTAFE). Technical staff has been recruited to manage Global Fund grants. The GMS enables the MOH to produce reports with ease and in accordance with the categories of costs, areas of intervention and the objectives defined in the agreements. The MOH has developed a Fiduciary Control Plan to mitigate the risks identified in the current financial management of the MOH. The Directorate of Administration and Finance (DAF) has created a unit responsible for accounting and reconciliation of accounts. After disbursements, all

^a Delegation of the European Union to the Republic of Mozambique- independent evaluation of budget support 16/09/2014

payments are sent daily to the Accounting and Reconciliation Unit for review and verification, which later reconciles the registries with the e-SISTAFE reports.

The PMU is currently developing (i) the financial management policy framework for GF grant implementation with a provincial adaptation of the DAF central manual; (ii) capacity building initiatives (central and provincial) including the posting of the TA^b and the preparation of a training plan for strengthening capacity at the central and provincial level, including trainings on GF and MOH financial policies and procedures; (iii) strengthening of UGEA procurement; (iv) a DAF decentralization plan; and (v) exclusion of the PR from the requirement of taxation on GF funds.

Human Resources for Health (HRH)

HRH needs within the National Health Service are principally guided by the National Plan for Health Human Resources Development 2008-2015 (PNDRHS)⁴³ and the Training Plan for the Acceleration Plan 2012-2015.⁴⁴ This plan reinforces the HRH-related interventions required that will support the reduction of maternal, neo-natal, and infant mortality and morbidity.

The National Strategic Plan for Health (Plano Estratégico do Sector de Saúde (PESS-III) for 2014 –2019) recognizes that the training system is slow to matriculate, graduate and absorb professionals, and that there is an unequal geographic distribution of the workforce. The PNDRHS highlights the quantitative deficit of pharmacy, lab technicians, nurses and other categories of health professionals as a threat to program success. The PESS plans for more efficient use of existing personnel that will be followed (2015 onwards) by significant increases in the numbers of trained HRH, coming ‘on-line’ just as the number of health facilities are increased during the period 2016-2018. These two approaches are consistent with the strategies of the HIV Acceleration Plan and the NSP-TB, “to do more and better”. For example, to address the shortfall in enrollment of children on ART⁴⁵, MCH nurses, generalist nurses and auxiliaries are now authorized to initiate such treatment⁴⁵.

The PNDRHS 2008-2015 provided a forecast of what number of health care workers would be needed, in order to meet the expected growth in population and necessary health utilization to meet disease targets, by 2014, by cadre. The MOH Training Plan 2008- 17 provided projections regarding the increased output of professional pre-service training institutions that would be necessary to meet the primary health care needs of the populace (consistent with PNDRHS). The Acceleration Plan 2013-17, also includes a revision of the MOH training estimates based upon increased needs due to HIV service expansion. The MOH training plan was implemented and sufficient support was obtained to increase pre-service training to meet these requirements- with the expectation that after several years of increased graduation of various health cadres those targets would be attained. PEPFAR has been a major contributor of funds to increase enrolment in health professional pre-service training programs.

The 2013 Department of Human Resources Annual Report⁴⁶ compares the numbers of various cadre of HRH documented in 2013 as compared to the projections prepared in 2008 for the PNDRHS. In most categories these 2013 results compared favorably with the accomplishments projected by that year. Maintaining the number of newly-graduated trainees over the next few years after 2013, it is likely that the original PNDHRS HRH 2015 targets will likely be achieved or surpassed. Since the ambitious Acceleration Plan increased HRH needs beyond what was originally projected for 2015, it was accompanied by a Training Acceleration Plan 2013-2015 that identified the need to train more laboratory and pharmacy staff and reduce the deficit in numbers of general & maternal and child health nurses based upon increased health facility utilization due to the Acceleration Plan. The Training Acceleration Plan also delineated the pre-service training for the period 2013-2014 looking at the training additional personnel in the different categories- for medical nurses, maternal and child health nurses and lab and pharmacy technicians.

The 2013 HRH Annual Report⁴⁶ identified 6,395 general nurses, corresponding to 71% of the 2015 objective. The report also identified 4,187 MCH nurses, which correspond to 70% of the 2015 objective. At current rates of increased pre-service training (approximately 900 per cadre of nurses), the number of nurses in the workforce in 2015 should be quite close to the 2015 goals.

There were 809 lab personnel in 2006, which has risen to 1358 in 2013, staffing 334 health facility laboratories. The PNDRHS⁴³ forecasted 1581 personnel in 2017 – hence the national program is well on

^bAide mémoire 26July-8August 2014 CT

its way to meet projected need for 2017. Regarding pharmacy technicians, there has been a significant increase (145%) of the pharmacy work force (from 721 in 2006 to 1210 in 2010), an average of 130 new technicians/year. This is consistent with the PNDRHS 2015 projections, although this is slightly underneath an optimal ratio of one pharmacy technician/health facility. It is expected that bar code system technology that is being implemented at facility pharmacies will reduce the time spent on dispensing and reduce pharmacy errors. Finally, a new cadre, statistical technician, has been created to register, analyze and give feedback on the information at all levels, improving on the quality of information produced in the health facilities.

Uneven placement of current and new HRH to more 'desirable' postings has added to service delivery challenges in some hard-hit, but remote districts. The MoH has mechanisms in place to mitigate the inequalities in placement of personnel. Upon graduation, the HR department of the MoH defines where the graduates will work, after consultation with the DPS. The DPS has the authority to redeploy staff within the province to ensure equitable distribution. These HR approaches are expected to minimize HR imbalances that might threaten the reaching Acceleration Plan and NTP targets.

In summary, the HRH targets that have been identified as necessary to meet the general health facility requirements, as well as the requirements of an ambitious HIV acceleration plan are well within reach in Mozambique. Historically HRH challenges have been a major limiting factor for program expansion and success - a combination of cross-training of existing staff and an increased output from pre-service training are factors that should reassure donors and citizens that HRH situation, particularly the gap in clinical, pharmacy and laboratory staff needed to provide TB and HIV care, is ameliorating.

Clinical Laboratories

The recently developed (draft) National Laboratory Strategic Plan (PENLab 2012)⁴⁷ is guiding laboratory systems strengthening. The strategic plan has noted insufficient computerization, deficient processes for the procurement of equipment, reagents and consumables, and a lack of standardized M&E and supervision. Implementation is underway to improve laboratory infrastructure (and this will be greatly assisted by the lab-related activities requested in the TB section of this concept note), workforce, and quality management systems and maintenance for all CD4, PCR, biochemistry and haematology machines, GeneXpert platforms and other lab equipment; and strengthening of the laboratory information management systems which includes the establishment of a central data base, and capacity building to analyse and use data for decision making. Diagnosis and bacteriologic confirmation of TB diagnosis for PLHIV will be greatly augmented by the planned or underway procurements for LED-FM, GeneXpert, and radiologic services funded by the TB Interim Funding grant of U\$27million (see section 3.1). These investments will be incorporated into this grant application from 1 July 2015 onwards. A specific GeneXpert scale-up plan⁴⁸ includes a diagnostic flow diagram for its use.

Supply Chain and Logistics of Health Products

In October 2013, the MOH approved a Strategic Plan for Pharmaceutical Logistics (PELF)⁴⁹ to address critical weaknesses in the procurement and supply chain management system. An implementation plan (PdI)⁵⁰ for the PELF was created in 2014 to describe and budget the costs for its implementation. The PdI describes the expansion of CMAM, which includes improvements across the board, the elimination of a level of the supply chain, and CMAM control of warehousing and distribution from the central level to sites (i.e., consolidation of fragmented authority of supply chain). The PdI covers a 10-year period up to 2024, with interim objectives at years 3 and 5.

The EU report^c also cites important progress in asset management as an important component of PFM, noting that the assessment team was "impressed with the high level of monitoring of progress within CMAM and the supply chain more generally" based on the logistics plan of action, where defined indicators are monitored on a quarterly and yearly-basis. Important improvements have also been made in inventory management: with USG support, CMAM exceeded its target to roll out the electronic system of inventory management for provincial warehouses (SIMAM) to new locations in 2013. These details are discussed in further detail in the supply chain strengthening section below.

^c Delegation of the European Union to the Republic of Mozambique- independent evaluation of budget support 16/09/2014

The hiring of procurement experts and acquisition of goods and services for each program has led to an improvement in the accomplishment of procurement procedures, consistent with the VPP procedures for procurement of medicines, tests and supplies generally, although the GF has required that procurement with GF funds be via the VPP (now the Pooled Procurement Mechanism).

Technical assistance through the SCMS and USAID | DELIVER PROJECT funded by the US Government continues to build CMAM and program capacity to improve the supply chain, particularly through quantification and forecasting, central warehouse management practices, and the logistics management and information system (LMIS), including the electronic software called SIMAM (Sistema de Informação de Medicamentos e Artigos Médicos). The implementation of SIMAM and the efforts to reinforce timely reporting have increased visibility of stock data from the central level to all provinces, some districts, and all ART sites. Challenges still remain for increasing timeliness and quality of reporting, and in use of the data for decision-making; supervision and quarterly provincial logistics meetings are addressing these challenges.

Central level storage capacity has been improved and is being further expanded by the rental and renovation of two new regional warehouses in Nampula, Northern Mozambique and in Beira in Central Mozambique with funding from the US Government. Both regional warehouses are will receive shipments from the ports at Nacala and Beira respectively directly from suppliers and can serve to train provincial medical depots (DPM). At the provincial level, physical capacity improvements in warehousing is carried out through funding from GF Round 8 HSS grant. Further improvement needs have been identified at district warehouses and included in this request.

Challenges regarding the capacity for storage at facility level are in part being addressed through the training and supervision for better stock management and proper quantification. The initial round of training nationwide was completed in August 2012. New personnel are being trained both through recently trained provincial trainers who can more closely work with facilities on-site, and through classroom-based training for provinces that have identified larger groups of untrained personnel. Stock management issues are also being addressed through quarterly provincial logistics meetings for all district medical officers and warehouse managers attend.

Health Management Information System (HMIS) and Monitoring and Evaluation

The M&E National Strengthening Plan (PNFSMA) is aligned with the PESS in its aim to provide quality information and to reduce fragmentation of M&E from separate programs such as TB and HIV. The malaria, TB and HIV programs have developed harmonized disease-specific M&E plans. The PESS endorses the M&E Plan priorities such as strengthening of internal and external coordination, strengthening of the capacity to produce quality data, improvements in the number and capacity of statistical technicians, and the promotion of better use of existing data (e.g., patient tracking systems).

Among the M&E plan priorities, the R8 HSS grant supports additional technical staff as well as IT equipment for the national needs in the area of information technology. This includes health statisticians to staff M&E positions at the central, provincial, district and health facility levels as well as HMIS Officers for each province to support the HMIS software system and provide training and mentoring for staff. Verification and transmission of data from district and provincial levels to central level has historically been challenging; this is strengthened through procurement of IT equipment, software and licences, recruitment of IT technicians to maintain hardware, provision of solar power installations in selected health centres without access to electricity, provision of internet connectivity and provision of conference calling facilities in all provinces, and staff training and maintenance of HMIS equipment.

HMIS for HIV and TB covers surveillance-based and routine information. The former includes activities designed to (i) enhance national vital registration systems, (ii) ensure the availability of critical data pertaining to both the general population (demographic surveys, IBBS, and TB prevalence surveys) and key populations contributing to the national TB and HIV epidemics (behavioral surveys) and (iii) ensure continued monitoring of TB and HIV drug-resistance in the country.

Among health information system (HIS) training priorities are (i) the improvement of the HIS management at all levels training of 449 technicians at district level (ii) the training of sufficient HR to realize expected HIS activities at all levels (that includes the training of HIS technicians in planning, HIS and M&E, the review of different forms used at HF and district levels, the development of the SIS-MA)

and (iii) to ensure that the IT infrastructure is in place for the institutionalization of the M&E at provincial & district levels.

Additional HIS tools^d will serve as a platform to obtain TB and HIV information. The patient tracking system (SESP)^e is utilized to register individual patient clinical data – once it is standardized, it will permit entry of patient-level data from any point in the health system. The SIS-ROH module complements SIS-MA, and collects hospital-based cause of death data for mortality rates analysis. Both SIS-MA and SIS-ROH are funded partially through the R8 HSS grant.

1.2.d: The main areas of linkage with the national health strategy, including how implementation of this strategy impacts the relevant disease outcomes.

The National HIV Strategy 2010-2014, the Acceleration Plan for HIV and AIDS Response 2013-2017 and the National Strategic Plan for TB 2014-2018 (NSP-TB) are aligned with the priorities laid out in the national economic and social planning framework and are in compliance with the national health sector strategy, PESS 2012-2019. The PESS 2014-2019 prioritizes a reduction in HIV, TB and malaria through a focus on service access, utilization and quality while emphasizing strengthening of the health system regarding improvements in supply chain management, health information systems and monitoring and evaluation. These documents provide the implementation guidance for the national program to reach the specific HIV and TB targets established in the PESS for the period 2012 to 2019. These health sector strategies lay out activities that will address many of the health system weaknesses that otherwise would threaten the ongoing success of the national HIV and TB responses. The plans also contribute to the PESS priority of strengthening community participation.

1.2.e: Country processes for reviewing and revising the national disease strategic plan(s). Explain the process and timeline for the development of a new plan and describe how key populations will be meaningfully engaged.

The National Strategic Plan on HIV and AIDS (PEN III – 2010-2014) covers the period until December 2014. The process to develop a new strategic plan for 2015-2019 has been initiated. A National Consultation Meeting on Prevention was held in June 2014⁵¹, and an independent Mid-term Review of PEN III was completed in July 2014⁵². The prevention consultation identified gaps in the current response for the most vulnerable populations in terms of behavior, demographic and geographic characteristics, as a step towards establishing a revised prevention agenda. The HIV Acceleration Plan has been revised and extended to 2017 and effectively guides the national HIV response while PEN IV is finalized.

During the life cycle of PEN III, Mozambique made significant progress in building evidence based data and knowledge on the drivers of the epidemic (DHS 2011, modes of transmission 2014), conducted special studies on key populations (FSW, MSM, long distance truck drivers, miners, agricultural workers on South African farms and incarcerated people); mapping of key and vulnerable populations, identification of obstacles for the implementation of an effective response and adopted international guidelines and good practices to prevent sexual transmission of HIV.

The review of PEN III⁵² noted that there has been significant progress in the national HIV response during the period of PEN III. There were a number of challenges during the implementation of PEN III that the review recommended should be addressed during the development of PEN IV. These include the need to align indicators to targets (not well aligned in PEN III) and establish clear targets for all area; increase attention to mitigation of cultural practices that amplify HIV vulnerabilities of girls and young women; increased efforts to increase paediatric HIV ART enrolment. Increased attention was recommended for the development and implementation of workplans at provincial and district levels, and that the coordination by CNCS would benefit from improvement. On the positive side, Mozambique was cited as the first country to update its targets from the Millennium Development Goals 2015 targets- and that this effort resulted in the Acceleration Plan; the IBBS for key populations have been accomplished; , and that programming for key and vulnerable populations has increased.

^d GF also recommends that a TB electronic data base particularly for MDR-TB

^e Sistema electrónico de seguimiento de pacientes

The lessons learnt from the implementation of PEN III identified in the mid-term review, recommendations from the National Consultation Meeting on Prevention, the results of the MOT study (2014) and the pending mid-term review of the Acceleration Plan will be used to inform the development of PEN IV, which should be completed by December 2014. The steering Committee for PEN IV development is being established with leadership of the National AIDS Council, and will include representatives of sectorial Ministries, provincial and district administrations, health sector, academia, private sector, CSOs and key populations as well as international partners. A national consultation will be organized late in 2014 to solicit the endorsement of PEN IV. The PEN IV will be in line with the national social and economic plans and health sector strategies.

The National TB Strategic Plan covers the period 2014-2018; the next revision will be based upon a review planned for early 2015. However, adjustments will be made to its implementation along the lines of the implementation modalities for the GF Concept Note, including the TB/HIV integration, coordination and particularly strengthening the community level work, which will be implemented by the concept note project starting date.

Based on recommendations by the TRP of the Global Fund on the current Interim Funding Grant, the NTP has developed a detailed community-TB care strategy to complement the limited description of this in the NSP; this strategy forms the basis of community care interventions under this grant application. The NSP will also be informed by an evaluation of CB-TB care activities conducted with funding from USAID through TB CARE I.

NTP is revising the National Strategy for Programmatic Management of Drug Resistant MDR-TB, the National Laboratory Strategic Plan, the GeneXpert Guidelines, MDR-TB Manual, and finalizing the revision of the national recording and reporting documents (in line with latest WHO guidance of 2013). A recent review of MDR-TB management in the country – supported by USAID - has provided advice on the scale-up of MDR-TB.

1.3 Joint planning and alignment of TB and HIV Strategies, Policies and Interventions

In order to understand the **future** plans for joint TB and HIV planning and programming, briefly describe:

- a. Plans for further alignment of the TB and HIV strategies, policies and interventions at different levels of the health systems and community systems. This should include a description of i) steps for the improvement of coverage and quality of services, ii) opportunities for joint implementation of cross-cutting activities, and iii) expected efficiencies that will result from this joint implementation.
- b. The barriers that need to be addressed in this alignment process.

In 2006 the Ministry of Health adopted TB/HIV collaborative activities as a national policy and strategy for both programs after successfully piloting TB/HIV collaborative activities during 2003-2005. Since then significant progress has been made in PITC for HIV within TB service sites, provision of cotrimoxazole and ART for co-infected patients, and implementation of the one-stop model for provision of TB treatment and ART in the TB clinic. These important collaborative activities are embedded in the national strategic plans of the programs (National AIDS Strategy 2010-2014, HIV Acceleration Plan 2013-2017 and TB National Strategic Plan 2014-2018).

Improved service coverage and quality

As described in greater detail in section 1.2, the strategic plans of both programs aim to sustain provider-initiated counselling and testing for TB patients (already 96% in 2013), CPT (97% in 2013) and improve ART coverage for TB patients (72% in 2013); improve quality and consistency of intensified case-finding (85% of newly registered patients in HIV care were screened for TB, and 50% for those already in care were screened at their last clinical consultation - 2013); improve uptake of IPT (44,800 persons out of 277,103 newly registered PLHIV without TB disease in 2013); and strengthen TB infection control measures in facilities. Early ART for diagnosed TB patients, and early diagnosis and appropriate treatment of TB (both drug susceptible as MDR-TB) in PLHIV identified through TB screening in HIV

care are key to reduce mortality. Both programs also plan to expand contact tracing of index patients, with screening for both TB and HIV testing among contacts.

Children lag behind adults in most key HIV and TB indicators including ART coverage (41% vs. 72%, MISAU 2013) and children <15 represent only 7% of all reported TB cases (3,890/53,261)¹². Each program has specifically prioritized improved performance and outcomes in children, with particular emphasis on expanded access to EID for HIV and bacteriologic TB diagnosis. Case finding among children of TB and/or HIV infected adults will be intensified through contact investigation conducted by health workers or community workers in families affected by both TB and HIV, training of clinicians and technicians, and TB screening in RMNCH clinics. At policy and planning levels there will be strengthened linkages with the maternal child health program.

The scale-up of the PMTCT program, implementation of Option B+, and the Early Infant Diagnosis program have already brought the HIV program in close collaboration with MCH. This needs to be leveraged to further reinforce combined active HIV and TB case finding at all portals of entry for women and children including at family planning, antenatal clinics, maternity, healthy and at-risk infant follow-up clinics, and immunization programs. MCH nurses working in these areas who are properly trained and capacitated to manage women and children with suspected and confirmed TB and HIV can make significant contributions to service coverage and quality in both areas.

An expanded, well-aligned community-level response is being implemented to also improve the coverage and quality of TB/HIV services. This proposal contains specific objectives and activities that will better integrate existing TB community programs centered on DOTS and HIV community programs for demand generation, case management, and defaulter tracing while simultaneously strengthening site-level community-clinical linkages and cooperation in strategic planning and results evaluation at each level of the health system.

Coordination

▪ *MultiSectoral Level*

The National AIDS Council (CNCS) is the national coordinating body for the national response to HIV. The CNCS is comprised of a national secretariat with branches in all provinces, and is tasked with coordination and stewardship at all levels, in assuring the mainstreaming of HIV in sectorial plans for government bodies as well as the engagement of employers regarding HIV-related workplace policies, strategies and actions. The CNCS chairs the Partnership Forum, which was established to coordinate HIV related programs. The Forum shares information through monthly meetings of a wide range of partners, particularly civil society organizations and representatives of key populations. The UN coordination and preparation for the Partnership Forum takes place in the Pre-Partners Forum, currently chaired by UNAIDS. The PEPFAR program in Mozambique holds monthly meetings with its implementing partners. There are also quarterly thematic meetings, sponsored by the PEPFAR team held jointly with the MOH and all implementing partners (including non-USG partners) to focus on specific areas of concern.

The PEPFAR Mozambique team and the MOH have close and frequent collaboration, both at senior leadership levels and technical levels. The USG PEPFAR team meets quarterly with the MOH's Permanent Secretary and all National Directors, in addition to ad-hoc meetings at the Ministerial-Ambassadorial level on PEPFAR issues. At the technical level, PEPFAR and the MOH have weekly collaboration, and have, over the past year, carried out joint field visits to the provinces to monitor the progress of provincial HIV Acceleration Plans, together with staff from the Provincial Health Directorates.

Multisectoral coordination arrangements for the TB program will need to be developed, utilizing the lessons learned from the structures and processes supporting HIV coordination.

▪ *MOH Central Level*

The Directorate for Planning and Coordination (DPC) provides the platform for coordination between the HIV, TB, malaria and HSS programs under the overall leadership of the Minister and senior staff of the Ministry. The DPC provides oversight and coordination of collaborative activities in support of the national TB and HIV strategic plans. The Project Management Unit (PMU) reports to the DPC and is responsible for the coordination of the programming supported by the Global Fund, and the PMU is in

charge of the programmatic and financial reporting from the Ministry to the GF, in coordination with the Department of Finance (DAF).

The MoH's TB/HIV Technical Committee serves to facilitate operational collaboration between the TB and HIV programs, which are located in different directorates (DNSP-Public Health/TB; DNAM-Medical Assistance/HIV). This committee is comprised of members from each program and representatives from donor and implementing partner organizations. This committee is responsible for overseeing joint activities, and is currently mostly focusing on technical and strategic issues. Its role in overseeing and reviewing scale-up of progress against targets will be strengthened to improve joint planning with provinces and districts to invigorate the provincial and district joint program meetings. The central level coordination meetings are held at least quarterly with an emphasis on data-driven decision-making, using interim reports from both programs.

The PMTCT program is located in the RMNCH Department, in DNSP. Coordination between the PMTCT and HIV programs is ensured through joint meetings that include representatives from each program and from partner organizations. However, there is still a need to strengthen the coordination between HIV program and other areas within the RMNCH Department. Donors and partners play an important role in the central-level coordination of activities by providing technical assistance to key working groups from both programs. Implementing partner technical staff and seconded advisors to MoH serve on working groups for the TB, HIV, and MCH/PMTCT programs, and thereby assist with communication and alignment of work. In addition, partner data, including PEPFAR program data, is also readily available for use by the MoH to supplement their routinely collected data from both the TB and HIV programs.

- Provincial Level

Management Committees (Comites de Gestão) that exist at the provincial level need to be strengthened to reflect the coordination that is occurring centrally. These provincial committees are being revitalized by the central MOH and they will include the current provincial focal points for the TB, HIV and PMTCT/RMNCH programs, technical advisors including staff from implementing partners, as well as representatives from relevant NGOs and CBOs working in the province. These committees will meet quarterly and discuss progress against targets, with a similar focus on the use of programmatic data to inform strategic planning and identify problem areas at the district and site level, that need to be corrected.

- District and Site Level

Coordination among MoH focal points for HIV and TB and PMTCT/RMNCH with civil society organizations, and clinical and community-level implementing partners needs reinforcement at the district and site level as well. While this may take different forms based on staff and provincial management decisions, the basic format of at least quarterly meetings using joint program data to evaluate program performance and make integrated strategic plans will be consistent. The involvement of clinical and community partners as part of co-management committees at the site level is crucial for improved integration of TB-HIV care, PMTCT-RMNCH/HIV and for improved community-clinical linkages for both programs.

- Community level

The current FDC standardized fieldwork architecture and working methods and guidelines for outreach work will be adjusted to accommodate the TB and HIV grant implementation and adopted by all SRs to maximize outreach capacity and efficient use of human resources. This standardized approach will leverage experience and comparative advantage of each SR, preserving appropriate differences in the package of care and curricula, while ensuring similar patterns of accountability among all members of the civil society organizations. Each SR will concentrate its work in defined geographic area with specific key and vulnerable population focus and community coverage.

As described above, the Community Council structure is engaged through the current FDC-led consortium; FDC and its SRs are tasked to provide much of the strengthening of these formal community structures.

Cross-cutting activities and opportunities for integration

Better alignment of the Mozambique TB and HIV programs of planning, operations, and monitoring and evaluation will reduce redundancies across the spectrum of program operations. Improved joint strategic

planning will facilitate alignment of program expansion targets and optimization of available human and financial resources. Recently the NTP developed a Community TB Care Strategy which embraces an integrated TB/HIV approach for community-based care. Both programs have identified the following cross-cutting activities that lend themselves to an integrated approach, resulting in more efficiency of program operations and improved outcomes:

Training

- Health care worker training for all cadres will be adapted ensuring that TB, HIV and family planning are adequately covered in the same trainings.
- Task shifting including adult and pediatric ART training for TB nurses as part of expansion of ART using the one-stop model, as well as for TB screening and HIV EID, and pediatric ART training for MCH nurses.

Community Activities

- Community health workers visiting patients in their homes will be empowered and trained to address HIV and TB issues including: education, screening, counselling and testing, TB contact and HIV index case tracing, treatment adherence support, and tracing of patients who fail to report for drug collections.
- Community leaders will be engaged more directly to support the *activistas* in the identification of LTFU and referrals of those suspected of TB/HIV
- Demand generation and patient literacy efforts for HIV and TB can be integrated at the community level to facilitate more unified and impactful advocacy efforts.
- The current network of HIV community organizations and health workers can be leveraged to incorporate TB activities as part of collaborative activities.

Medication/Supplies

- The TB program is transitioning the procurement and distribution of TB related drugs and commodities to CMAM, which already manages this role for the HIV and PMTCT programs.
- Management of essential supplies for HIV and TB care and prevention at facility level will be strengthened through joint supervision and monitoring by responsible program and CMAM staff (e.g. ART drugs, INH, CTM, TB drugs, HIV test kits).

Laboratory specimen transport networks

- Laboratory sample transportation systems/networks will be integrated for HIV and TB specimens where these exist, in particular between health facilities and laboratories, along with systems for results reporting.

Supervision

- TB supervision will now be integrated into the already integrated HIV and PMTCT supervision, using integrated supervision tools and M&E data collection.

Quality Improvement

- The HIV program already has in place a robust quality improvement pilot that includes TB and PMTCT-related indicators. This system will be adapted for use by the TB program to include areas such as diagnosis and management of MDR, and pediatric TB, as part of its implementation more widely beyond pilot facilities.

Monitoring and Evaluation

- Interoperability of electronic systems is being developed so that all TB/HIV/PMTCT information easily links into the national HIS. Reporting cycles have been synchronized, Results are reviewed quarterly via the joint technical committees to improve data-driven decision making and target-setting.
- Joint review of M&E data and strengthening of TB/HIV M&E tools where this is needed.

b. Barriers and Proposed Solutions for Successful Re-alignment

Central

- Barrier - HIV and PMTCT are in different directorates within the MoH from PMTCT, which challenges coordination
- Solution – Coordinated oversight from Planning and Coordination Department, with inclusion of the PMU and a strengthened TB/HIV Technical Committee.

Province and District

- Barrier – DPS and districts may have challenges to adapt existing Management Committees or institute new TB/HIV committees.
- Solution – The MoH will provide technical support to provinces and districts to facilitate reorganization.

Community

- Barrier - There are not sufficient numbers of community health workers to cover all communities
- Solution – The MOH and donors are supporting the expansion of CHW recruitment, funding for stipends, as well as their cross training
- Barrier – Poor understanding of community health worker roles and duties by healthcare workers with resulting gaps in mentoring and education
- Solution – TB/HIV integration at the site level will prioritize community-clinical linkages to improve appreciation of community component and increase access to education and mentoring for community health workers

Human Resources

- Barrier – HCW/patient ratios are low and task-shifting has added additional responsibilities for nurses and clinical officers. Additional integration of TB and HIV activities may further overburden health care workers.
- Solution - There are several initiatives being implemented to improve this in the short term including:
 - improved in-service training standardization and monitoring
 - increased managerial capacity for planning and allocation of human resources through recently developed HR information systems
 - implementation of distance learning to expand in-service training capacity while reducing costs
 - implementation of telephone and online platforms that allow for distance clinical mentoring and consultation

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

To achieve lasting impact against the diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources that are insufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the TB and HIV national programs and how this funding request fits within these, briefly describe:

- a. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).
- b. How the proposed Global Fund investment has leveraged other donor resources.
- c. For program areas that have significant funding gaps, planned actions to address these gaps.

Review of Total Health Expenditure

The health sector in Mozambique is financed by two main sources - domestic public funds from the state budget, and external funds mobilized through a common fund where partner-provided funds for the

health sector are pooled (PROSAUDE),^f as well as various programmes directly funded by bilateral agencies, multilateral organizations or international NGOs and philanthropies. The priorities of the health sector for the years to come are defined in the National Health Sector Strategic Plan, PESS (2015-2019), which estimated that USD 7.8 billion would be required to finance the health sector for this five-year period.

Formal expenditure for the health sector in Mozambique reached almost USD 500 million in 2012 and USD 928 million in 2013, representing a six-fold increase since 2010, and 87% from 2012⁵³. In 2013, health sector expenditure reached USD 18 per capita and general government expenditure on health accounted for 2.8% of GDP.^{54,55} According to the Annual Report on Health Expenditure from the Ministry of Health, 53% was expended on recurrent expenditure (including in-kind donations of drugs) and internal investments, while 47% of health sector expenditure was from vertical project funding and external investments in 2013.

Most of the health expenditure increase from 2012 to 2013 was due to an increase of vertical project funding and external investments (+ USD 251 million), and in domestic public expenditure (+ USD 183 million). Overall, it is estimated that 38% of health-related expenditure originated from the State budget and 7% from the common fund PROSAUDE. The rest (54%) originated from contributions from external partners for vertical project funding and external investments. Although no exact data is available on private expenditure, WHO estimates that about 6% of total health expenditure is out-of-pocket.

Review of HIV and TB expenditures

Trends in HIV and TB funding

As with the overall expenditures for health, expenditures for HIV and TB have steadily increased in the last decade. The latest data available indicates that HIV expenditure in Mozambique reached a record high of US\$ 260.3 million in 2011, representing an over five-fold increase from 2004, and a 22% increase from the US\$ 213.5 million reported in 2010.⁵⁶ Although no data is available on trends in TB expenditures, the OECD DAC database shows that international assistance for TB in Mozambique also increased from less than USD 1 million in 2007 to approximately USD 10 million in 2012.⁵⁷ In 2013, it is estimated that about USD 340 million was available for HIV and TB programming.⁵⁸

Following years of considerable scale up, resources available to the HIV and TB response are starting to level off despite continuing increases in the numbers of patients requiring and presenting for care and treatment⁵⁹. If this emerging trend continues, it will be challenging to meet the financial requirements for procuring drugs and providing essential services to people with TB and /or HIV.

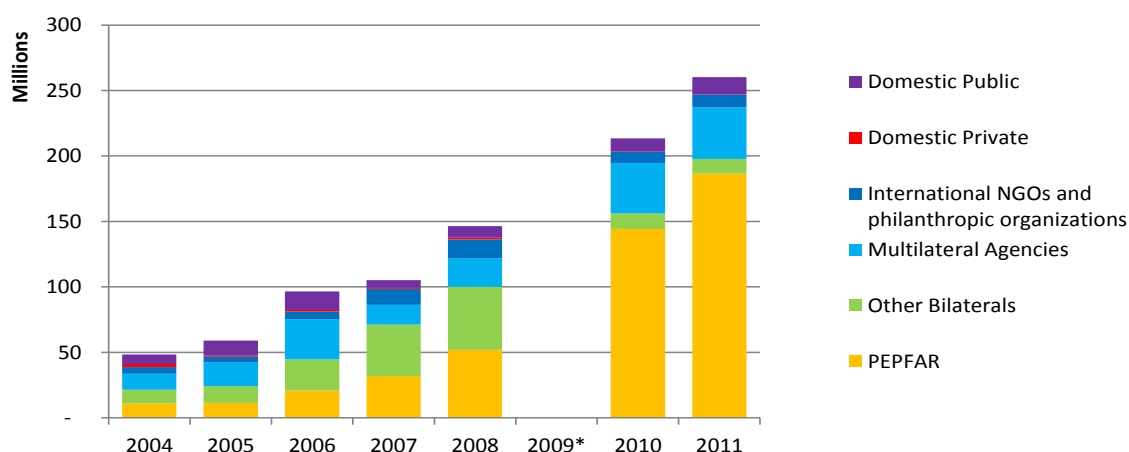
The flattening of available resources is predominately due to the levelling of international assistance, which represents an estimated 94% of resources for the two diseases (95% for HIV-related programmes) in 2013. Considering the financial constraints of several donor governments, and the shift of some donor agencies towards broader global health funding rather than disease-specific funding or funding reallocated towards other priority areas, the availability of international support to cover the increased needs is under threat.

Sources of funding for HIV and TB

The scale up of international funding for HIV was essentially due to the increased commitments of the United States government (primarily through PEPFAR) and the GFATM, which together represented about 85% (209 million) of HIV funding in 2011. In the same year, funding from other bilateral donors reached about USD 11.5 million, of which 8% was through PROSAUDE. The USG also provides approximately \$5-6M annually in funding for TB control efforts. Despite absolute values remaining steady, the share of resources for HIV that originated from all other donors decreased from 35% of funding in 2008 to 5% in 2011. In total the UN agencies and programmes allocated more than USD \$15 million a year for HIV and TB through 10 entities. International NGOs and philanthropic organizations also contributed significant resources for HIV and TB. According to the NASA, almost USD 10 million

^f PROSAUDE gathered contributions from various bilateral donors (CIDA Canada, Belgium, Denmark, The Netherlands, Ireland, United Kingdom, Switzerland, Spain, Italy) and UN agencies (UNICEF and UNFPA).

were spent from 23 organizations, including MSF (USD 4.3 million), Absolute Return for Kids (USD 1.4 million), Samaritan's Purse (USD 0.9 million), and Soul City Institute (USD 0.8 million).



(*) no data was collected for the years 2009 Source: CNCS, MEGAS 2010 & 2011 (2014)

Figure 1 – HIV expenditure by financing source (2004-2011)

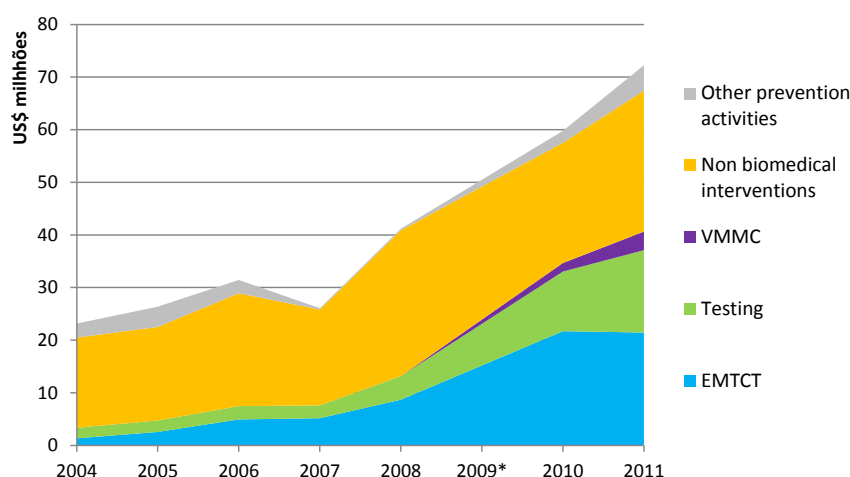
The State Budget represents the third largest individual source of funding with USD 21 million allocated to HIV and TB in 2013. Despite having doubled from 2004 to 2011, domestic public HIV expenditure represented only 5% of overall HIV expenditures in 2011 and about 11% for TB in 2013. It is estimated that about 11% of the Ministry of Health State Budget recurrent expenses is allocated to HIV and TB. Most of domestic public resources for HIV and TB (95% for HIV) cover salaries of health care workers. Data available suggests that about 15% of the MoH expenses on salaries can be attributed to providing HIV-related services [3]. Other domestic spending from the Ministry of Health covers reagents and material and specific services (3% each in 2011). In the absence of data to disaggregate recurrent expenses on infrastructure and related administrative costs, such expenditures were not taken into account.

The State budget for HIV is allocated to entities other than the MOH, including for the National AIDS Council (CNCS) for the coordination of the national response, and financing of civil society organizations for community activities. Such activities totalled USD 2.6 million in 2011. Following the closure of the Common Fund, which was specifically for HIV and allocated contributions from donors to CNCS, the Government of Mozambique increased its contribution and now fully funds the CNCS. In 2013, it allocated about USD 6.5 million to the CNCS.

Although most of the TB and HIV response is funded by external resources, service delivery is primarily within government and local NGOs, though often with technical support from international organizations. The NASA report shows that while 74% of HIV expenditure in 2010 and 2011 was distributed through international entities, 57% was executed for services that were delivered within public structures. Similarly, TB services are delivered within national structures. This reflects the well-integrated international assistance to national service delivery. The activities financed by the USG are all integrated into the functions of national entities and PROSAUDE catalyses funding from other donor governments for the Ministry of Health. The financial contribution from the Global Fund has also been integrated to the national service delivery.

HIV and TB expenditure by programmatic area

Results from NASA describe the use of resources by programmatic area. Trends show an evolution in priority areas. Consistent with the increase in people on ART, the expenditure for care and treatment increased considerably in the last 10 years: by 2011, most resources were used for care and treatment, followed by prevention, system strengthening and national coordination, and support to orphans and vulnerable children. Comparing to previous years, the proportion of resources used for prevention programmes reduced from 48% in 2004 to 28% in 2011, although the absolute amounts provided for prevention programming has continued to increase. Treatment and care as a proportion of the entire HIV expenditure increased from 24% in 2004 to 40% in 2011. With the adoption of the HIV Acceleration Plan and a focus on the prevention impact of treatment, the share of resources allocated to treatment may well continue to increase.



(*) no data was collected for the years 2009 Source: CNCS, MEGAS 2010 & 2011 (2014)

Figure 2: HIV prevention expenditure by main activities

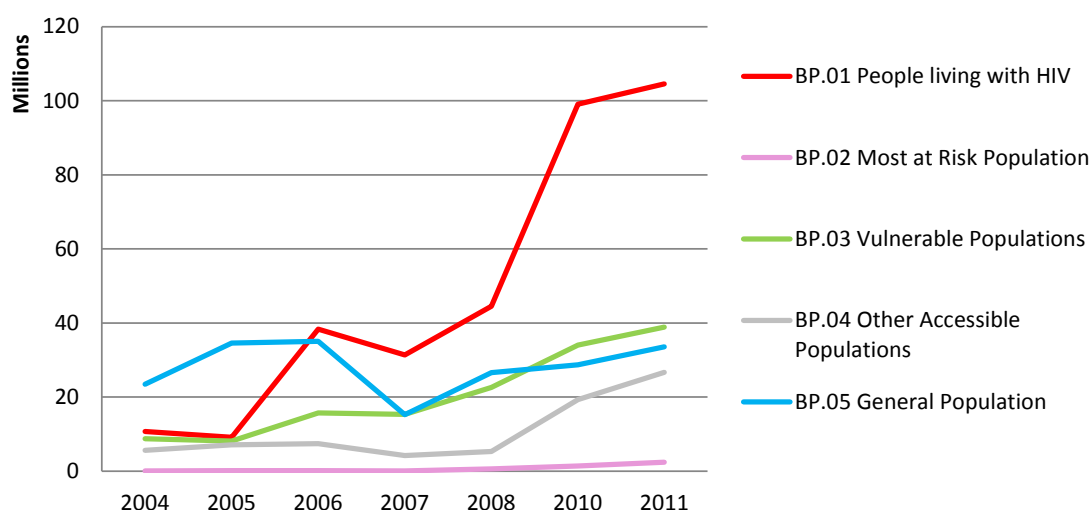
Over the years, there has also been a shift within prevention funding, with increasing resources allocated to evidence-based biomedical prevention interventions (included EMTCT, testing and MC). While biomedical prevention represented only 14% (USD 3.4 million) of prevention expenditures in 2004, they reached USD 40.6 million in 2011 and represented 51% of all prevention expenditures. Results of the PEPFAR Expenditure Analysis suggest that this trend might continue as PEPFAR alone contributed USD 32.2 million in 2012 and USD 59.3 million in 2013 to EMTCT, HTC and MC. This increase is primarily resulting from increased expenditure for MC, estimated at USD 3.5 million in 2011, USD 7.4 million in 2012 and USD 15.8 million in 2013.

The latest information available indicates that approximately USD 2.3 million worth of condoms were procured by UNFPA and then distributed through national distribution mechanisms in 2011, which is expected to continue. The most recent estimates (2013) are that 23 million condom units were sold in Mozambique. Nonetheless, reported use of condoms remains low.⁶⁰

Beneficiary populations of HIV expenditure

Despite increased emphasis regarding the need to focus on programmes for key populations, there has been a slight increase in resources addressing the needs of these population groups through 2011.⁸ Figure 3 describes the trends of overall HIV expenditure by direct beneficiary. In 2011, only 3% of prevention expenditures (USD 2.3 million) targeted key populations. The majority of prevention expenditures for key populations in 2011 targeted sex workers and their clients (USD 1.4 million), followed by people who inject drugs (USD 730,000), and MSM (USD 168,000). Another USD 688,000 could not be disaggregated to a specific population.

⁸ i.e. commercial sex workers & clients, men having sex with men, or injecting drug users



Note: no data was collected for the years 2009 Source: CNCS, MEGAS 2010 & 2011 (2014)

Figure 3 : HIV expenditure by beneficiary population, 2004-2011

Most prevention programmes targeting key populations are financed by PEPFAR (92% in 2011) and are implemented through international and national NGOs. Other projects for key populations were supported by UN agencies or other bilateral agencies. Total PEPFAR funding for KP and other vulnerable populations (OVP) in 2013 was USD 4.1 million, of which USD 2.2 million was allocated to KP and the remainder OVP. Funding in 2012 was similar and in both years represented less than 1.5% of PEPFAR budget and 1% of PEPFAR expenditure. The ongoing Round 9 phase 2 of the Global Fund will cover part of the gap (and will be incorporated into the funding period of the NFM, but additional resources are required to cover all three regions. Current PEPFAR investment covers all provinces other than Niassa, with focus in all main urban areas. In addition, PEPFAR supports the implementation of a comprehensive HIV/STI intervention package in 10 prison sites.

According to the NASA report, migrants, prisoners and truck drivers (all with relatively high prevalence and population size) were targeted by less than 2.5% of prevention expenditure in 2011 with USD 2.0 million (OVC in a separate category). As of 2011, 39% of these programmes were financed by PEPFAR, 34% by UN agencies and programmes, and 21% by the Swedish Development Agency. The majority of resources for vulnerable populations were distributed through UN agencies and national NGOs. According to PEPFAR EA for 2013, USD 3.8 million was spent on prevention programmes targeting other vulnerable populations.

The NASA report highlighted the limited funding specifically focused on critical enablers. Expenditure for HIV-related human rights or gender programming was USD 1.3 million in 2011, with support from donor governments (Netherlands, Belgium) and UN agencies. Information, education and communication (IEC), community mobilization and outreach activities have been recipients of significant funding, with USD 17.6 million in 2011, but the total appears to be declining. The majority of community centred mobilization interventions did not integrate TB and essentially targeted general population. USAID (through TB CAP and TB CARE I) has provided significant investments in community-TB care in the period 2005-2014.

Finally, funding for social services support to orphans mostly accounted for expenditure on programmes to support orphans and vulnerable children. OVC programmes benefit from significant funding from the USG, which spent USD 12.9 million in 2013 through NGOs and UN agencies. More than USD 20 million is budgeted by PEPFAR for OVC programs in 2014.

Expenditure towards the reinforcement of the health system

In the last five years there has been a significant scale up of investments for the overall strengthening of the health sector. In 2013, At least USD 292 million was invested, of which 52% was from domestic public resources, 23% from PROSAUDE and 24% from other external partners.

A significant portion of the HSS investments can be attributed directly to HIV and TB. According to NASA, USD 26.3 million in 2011 can be directly related to HIV specific funding. It included expenditure

for construction and rehabilitation of facility infrastructure and laboratories (USD 13.6 million), information systems (USD 7 million), drug systems (USD 2.9 million), and others not specified (USD 2.8 million). An additional USD 32 million was spent in 2011 for training of health care workers and staff from NGOs and community members on HIV related topics.

Expenditure by cost categories and financial gap

As of 2011, most commodities for the HIV response were financed by international partners. In 2014, all ARVs procured were procured through international mechanisms such as VPP and SCMS, and are financed by international donors. The same applied for the acquisition of rapid test kits, financed by the GFATM (57%), PEPFAR (39%), and CHAI (4%); The same sources covered the needs in reagents and other commodities for CD4 laboratory tests. Likewise, the acquisition of condoms also depends on international assistance. The aid dependency is less important for the acquisition of TB related commodities. In 2014, 33% of the TB drugs were purchased through CMAM from the State budget or PROSAUDE fund, while 60% originated from the GFATM, 4% from the USG, and 4% from the World Bank. In general, distribution of these commodities was through national distribution channels.

The procurement of key commodities for HIV and TB represents the largest component in the programmatic gap analysis. Table 1 represents the financial gap for key commodities. The most important gap for the next three years is for ARVs; predictions based upon funding from donors that is *likely* based upon prior year trends indicates that resources will be available to cover only 45% of the cost of ARV. The financial gap estimated below is based upon historical trends in funding from donors other than the GF. If funding from non-GF sources does not actualize, the financial gap for ARVs would exceed USD 300 million. Without additional resources for key commodities, the ability to meet treatment targets will be jeopardised.

		ARVs	Test Kits	CD4	Viral Load	TB
CY 2015	<i>Needs</i>	107.6	8.5	11.6	2.8	7.7
	<i>Available</i>	86.3	7.0	10.4	2.0	7.5
	<i>Gap</i>	21.3	1.5	1.2	0.8	0.2
CY 2016	<i>Needs</i>	125.4	8.1	14.6	6.1	9.1
	<i>Available</i>	28.1	0.2	10.9	2.0	6.3
	<i>Gap</i>	97.4	7.9	3.7	4.1	2.8
CY 2017	<i>Needs</i>	134.9	7.5	7.4	19.4	8.6
	<i>Available</i>	28.1	-	2.4	2.0	0.5
	<i>Gap</i>	106.8	7.5	5.0	17.4	8.1
TOTAL	<i>Needs</i>	367.9	24.1	33.7	28.3	25.4
	<i>Available</i>	142.5	7.2	23.7	6.1	14.3
	<i>Gap</i>	225.4	16.9	10.0	22.2	11.1

Source: Futures Groups and UNAIDS estimates based on available information and procurement plan (2014)

Table 1: Financial Gap for Key Commodities per calendar year (US\$ million)

The Government of Mozambique contributed to the HIV and TB responses through payment of salaries of health care workers and costs related to the running and managing the programme. About USD 12 million was spent on salaries of health care workers in 2011. According to NASA, 40% of labor costs for HIV treatment in 2011 were supported by the State budget, with an additional 8% from PROSAUDE. The remaining 52% was through USG funding (USD 14.3 million) and MSF (USD 2.3 million). Service delivery is integrated into the national health system but salaries are paid to doctors by some NGOs (and for some expatriate doctors employed by the MoH) are at levels above the national scale to cover the gaps in health workforce. Additionally, another USD 2.4 million was spent by the USG in 2011 for labor related expenses of national NGOs for home-based care.

Data availability and estimations

Overall health sector expenditures are estimated from the annual execution budget reports of the Ministry of Health (*Relatorios de Execucao Orçamental*), complemented by estimations made by WHO and UNICEF. The Ministry of Health does not track or report spending by disease category. Consequently other sources of data were used to track diseases specific expenditure. The ongoing National Health Accounts (NHA) will report such data but results will not be available in time to support

this proposal. The reporting of HIV specific funding is based on the National AIDS Spending Assessment, or MEGAS, elaborated by CNCS, which reports detailed HIV expenditure by financing source (including State budget), programmatic area, beneficiary population or geographical location. Data available covers the years 2004 to 2011. HIV funding for the years 2012 and 2013 were estimated using the latest PEPFAR Expenditure Analysis, available information on ODAMOZ and the OECD DAC online data bases and specific donor reports, and was complemented by projections on the basis of programmatic data. In the absence reports of specific TB expenditure, TB funding was estimated from available information on ODAMOZ and the OECD DAC online data bases, specific donor reports and the estimations of domestic public expenditure.

2.2 Counterpart Financing Requirements

Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

- a.** For TB and HIV, indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

Counterpart Financing Requirements	Compliant?	If not, provide a brief justification and planned actions
i. Availability of reliable data to assess compliance	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
ii. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
iii. Increasing government contribution to disease program	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

- b.** Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.
- c.** Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

According to information available (*ref.* section 2.1), about USD 36 million was spent for HIV, TB and malaria from the State budget in 2013, representing 15.4% of Government overall health expenditure in 2013. Actual government expenditure pays for salaries of health care workers, management of the HIV, TB and malaria programs, the costs of the National AIDS Council (CNCS) and provincial entities, as well as funding for civil society projects at the provincial level. The expenditures on salaries contributed to the provision of ART, TB treatment, EMTCT, MC, and HIV and TB screening.

If actual commitments are maintained and service delivery continues to expend, domestic public expenditure for HIV, TB and malaria will continue to increase, and could reach USD 53 million in 2017, totaling USD 126 million between July 2015 and December 2017. This would represent 18% of the

counterpart financing requirements, placing the Government far above the minimum threshold government contribution to disease program of 5%.

Furthermore, the Ministry of Health committed to increase its contribution to the three diseases by allocating an additional USD 28.4 million from the 2015 MoH budget, specifically to HIV, TB and malaria. Compared to 2014, this additional commitment translates into new resources from the State budget for HIV, TB and malaria, an increased percentage of MoH budget allocated to the three diseases, and a shift towards increased Government resource allocation as opposed to Common Fund resources.

These additional commitments will contribute to the implementation of the *Plano Económico e Social* (PES), including: increasing number of patients under ART, increased percentage of TB patients treated and undertaking the malaria pulverization campaign. This increase will raise the contribution of the Government to the three diseases in 2015-2017 to 20% of its health sector contribution. Its counterpart financing requirements for 2015-2017 will also jump to 25%.

Additionally, the Government will continue to invest in the reinforcement of the health system (infrastructure and human resources), which will indirectly respond to the needs of delivering treatment and care for HIV, TB and malaria.

In recent years, the Government revenue has steadily increased and could continue to do so in the near future. Similarly, the Government allocation to the health sector has increased in both absolute and relative terms. However, at the same time, government aid- through general budget support or sector specific aid is leveling off.

Consequently, despite positive projections, the Government of Mozambique will not be able to fully cover the costs of its response to HIV, TB and malaria. The estimated gap for the three diseases from June 2015 to December 2017 reaches USD 551 million, which represents 47% of the Government's Health Sector Budget for the same period.

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and outlines how the investment is strategically targeted to achieve greater impact on the diseases and health systems. While the investments for both the HIV and TB programs should be described, the applicant should also provide information on the expected impact and efficiencies achieved from planned joint programming for the two diseases including cross-cutting health systems strengthening as relevant.

3.1 Programmatic Gap Analysis

A programmatic gap analysis should be conducted for the six to twelve priority modules within the applicant's funding request. These modules should appropriately reflect the two separate disease programs in addition to crosscutting modules for both programs such as Health System and Community Systems Strengthening.

Complete a programmatic gap table (Table 2) for the quantifiable priority modules within the applicant's funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps in the narrative section below.

A. HIV/TB Programmatic Gap Analysis Table

The Programmatic GAP table (attached) presents the Gap for all quantifiable Modules. The difficult to quantify Modules for this proposal are described below:

Module: Prevention for general population

Under the prevention for general population the hard to quantified intervention is condom transportation and distribution. Condom supply for next 3 years is already secured by UNFPA. The PEN III review^h highlights the persistence of supply and distribution challenges, noting systemic failures in handling and delivering condom to the final beneficiaries and users. Currently, condom packages and boxes are considered the last items to be loaded onto the health commodities distribution vehicles, as they transport from the regional warehouses to health facilities and communities. The responses to respond to this challenge is funded through R9 FDC HIV grant in 9 provinces. With the expansion of the response to Inhambane, Cabo Delgado and Niassa, additional logistical support will be required. The Acceleration Plan has a target of 100% availability of condoms at health facilities by 2015, and with support from this funding request for logistics it will be attained.

Module: Community System Strengthening

Under Community Strengthening System the hard to quantified intervention is the Social mobilization, building community linkages, collaboration and coordination - Build a conducive environment at community level to enable a successful implementation of prioritized interventions. This intervention is targeting Community leaders, committees, and champions in 11 provinces and 71 priority districts. The implementation approach includes engaging multiple stakeholders at central and provincial level, to ensure adherence to rights and gender approaches, address stigma and discrimination; revise advocacy guidelines for community based advocacy; implementation of district sessions with community leaders, committees, and champions to ensure buy in on the intervention package of services for TB and HIV. Additional intervention includes the development of Standard Operation Procedures for community implementation to ensure that CSOs deliver complementary and standardized services that respond to the national strategies; produce a disseminate an annual booklet to compare the results of the community accountability tool, grant implementation results, and best practices; This module also includes investment on capacity building for 2 new sub-recipients and refresh training for 14 current sub-recipients already working on HIV to address TB.

Strengthen community monitoring and accountability capacity will also be part of this investment and planned interventions include revise the community accountability tools to assess progress in community health services delivery (ex: community score cards) for use in all communities; Train community facilitators to carry out community monitoring and accountability sessions; Conduct community and accountability monitoring session.

Module: Health information systems and M&E

Mozambique is proposing NFM support to strengthen both surveillance-based and routine monitoring and evaluation systems. This includes support for activities designed to enhance national vital registration systems to ensure the availability of critical data pertaining to both the general population as well as key populations disproportionately contributing to the national TB and HIV epidemics, and to ensure continued monitoring of TB and HIV drug-resistance. In addition, the routine health information system will be strengthened through ensuring the uninterrupted availability of paper-based M&E instruments at all TB and HIV service delivery points and through expansion and consolidation of existing and to-be- developed electronic medical records systems specific to the two disease areas.

The grant will fund: i) the first TB prevalence survey in the country, which is due to start in 2015. Co-funding will come from USAID and MOH Mozambique. The prevalence survey will provide a more accurate estimate of the TB and MDR-TB burden (the second drug resistance survey is funded from the Interim Funding grant) and guide future program policies and strategies; ii) annual national training in M&E; iii) annual TOT of provincial supervisors on data management, interpretation and quality assurance; iv) quarterly provincial M&E monitoring meetings; vi) procurement of the hardware for an electronic patient-based TB surveillance system; vii Routine reporting for TB and HIV programs.

^h CNCS, 2014 – Relatório de Avaliação intermédia do PEN III. Maputo, Julho de 2014.

Surveys

Surveys - Conduct 2016 & 2017 Integrated Bio-Behavioral Surveys (IBBS): MSM (2016) and Mobile Populations (2017). The IBBS is designed to measure HIV prevalence and risk behavior as well as to produce population size estimates to be conducted with support of Global Fund NFM. Other relevant information: 2016 and 2017 IBBS to be co-funded with PEPFAR. Mozambique proposes leveraging NFM funds to support implementation costs (i.e. personnel and training) and PEPFAR funds to support needed lab materials (i.e. HIV test kits, etc.). Global Fund Round 9 Phase 2 support already secured in support of 2014 and 2015 IBBS targeting FWS and miners.

Surveys - Conduct 2017 HIV drug resistance threshold survey, targeting Pregnant women attending ANC in 36 surveillance sites in 11 provinces. Mozambique will leverage established ANC surveillance platform to support proposed threshold survey (as done in 2013). Other relevant information: 2015 ANC surveillance activities including threshold survey already financed through PEPFAR and Global Fund Round 9 Phase 2.

Surveys - Conduct 2016 Demographic Health Survey (DHS), adopting a National and Sub-national representative cluster sample of Mozambican households. Mozambique requests NFM funding to support planned 2016 DHS survey which may serve as a reference for monitoring progress towards behavioral indicator targets included in the TB/HIV NFM performance framework. Other relevant information: Mozambique is currently investigating the possibility of integrating HIV testing in the 2016 DHS which would provide a complementary data source to measuring population-based HIV prevalence in Mozambique. Current 2016 DHS budget estimated at 4.2 million. This activity will be co-funded by an array of donors including Global Fund Malaria grant (if approved).

Routine reporting

Planned Routine reporting interventions includes - *Reproduction of data collection instruments* including paper-based charts, registries and monthly summary forms in 2016 and 2017. Instruments used to support ART/Pre-ART, PMTCT, HCT, STI and Key-Population services provided in 11 provinces. The HIV program has projected estimated instrument needs for paper-based tools based on historic consumption patterns and 2015-2017 HIV targets. Other relevant information: Global Fund Round 9 Phase 2 is currently supporting 25% of estimated need for instrument reproduction in 2015 and 2016. With the identified reduction in PEPFAR support for strategic information activities, Mozambique proposes augmenting Global Fund support for 2016 from 25% to 50% and extending support to 2017 via NFM for 50% of reproduction needs.

Module: Program management

Under the program management module the difficult to quantify intervention is related to policy planning, coordination and management. The set of interventions are Maintenance of equipment and insurance for central program unit vehicles and district supervisors' motorcycles; external audit; annual National Coordination Meeting for TB/HIV; biannual supervision from provinces to districts; Recruitment of 1 M&E staff and 1 medical officer at the national level; Annual National Coordination Meeting for TB/HIV including CSO organizations. Central regional trainings in TB program management.

B. Additional Programmatic Gap Analysis

The programmatic gap analysis and the funding request are based upon a number of changes in the approach of the national HIV program. These changes are a result of an analysis of the significant achievements to date, and a deeper understanding of how the national program can achieve even greater impact. In order to provide a context for the requests, the following section describes the re-orientation of the national HIV strategy.

B.1: Targeted HIV Counseling and Testing

Given relatively high HIV prevalence, HTC is widely available at health facility level (VCT and PITC) and/or community level (VCT and community-based testing). However, in recognition of historically inefficient testing approaches, the high burden of PLHIV who do not know their status, and the particularly high HIV prevalence among members of key and vulnerable populations, national policy has reoriented towards targeted testing approaches, aimed at increased efficiency of case finding among clients identified as at high risk for exposure to HIV. Based on recent performances in case finding,

HTC in facility settings (including PITC) will be expanded; while community testing will be re-focused towards geography and target populations with high expected yield of case finding. Testing based on an index case has been introduced and is currently being expanded throughout the HIV prevention, care, and treatment platform.

Targeted testing is expected to result in identification of a greater number of PLHIV who previously did not know their status, and will also reach the HIV negative member of sero-discordant couples in order to provide focused prevention services within those couples. The approach will focus on populations most likely to bear the burden of the HIV epidemic: contacts of index cases of PLHIV, inpatients as well as outpatients at high yield service delivery points, key populations (FSW [and clients], MSM, prisoners) and other vulnerable populations (migrant workers, 15-24 years old girls and young women). An increased emphasis will be placed upon ensuring effective linkages between HTC and facility-based care and treatment services, as well as with community-based prevention services. HTC interventions will aim to ensure that at least 90% of people diagnosed with HIV are enrolled in care services. Gaps in supply chain logistics also need to be addressed, with periodic last-mile stock disruption continuing to occur, as well as gaps in national procurement leading to thin buffer stocks. Quality assurance programs remain critical for continued support and expansion, in order to ensure correct results are provided to patients, with robust counselling to help clients accept their results.

PEPFAR, the primary bilateral donor to the HIV program, has similarly reoriented its approaches, and is in alignment with the changes at national level in Mozambique. PEPFAR support is particularly focused on early case finding, and closely linking HIV testing to steps to ensure enrolment in care. PEPFAR support is focus on using active referral methodologies, such as peer educators, peer navigators, escorting counselors, and case managers among priority target populations including key populations, adolescent girls, and active duty military personnel. National targets for HTC among key populations have been developed for the first time and PEPFAR support will contribute to approximately 65% of the national targets in 2015. PEPFAR is currently supporting HTC activities in 70% of the districts.

PEPFAR has been instrumental in supporting the delivery of commodities such as rapid HIV test kits and requisite materials used for testing, support the revision and rollout of new M&E tools (e.g. service delivery registers) as well as supporting the finalization of the counselling curriculum and content for HTC providers, with mass re-training. This will address a long-standing gap in the national program regarding quality of counseling. Activities to assure quality of testing will continue, including use of dried tube specimens for EQA, utilization of logbooks at service delivery sites, and provision of basic resources to help maintain high quality testing. Supportive supervision will continue to be addressed in direct collaboration with central and provincial health authorities.

In COP13 PEPFAR allocated a total of \$ 9.6million (\$3,2million of which is for procurement of rapid test kits) towards HTC activities. 42% of the total budget is to be allocated towards facility based HTC provision, mainly PITC - focusing on health services with the highest diagnostic yield (TB services, ANC, STI) and VCT activities in target areas with high HIV burden. 17% of the budget was allocated to community counseling and testing activities with a focus on case finding using strategies such as index case testing and providing local HTC access to key populations.

B.2: Community Based Services to Support Adherence and Retention

Adherence and retention continue to be major challenges. The national program is also reporting weak linkages between the services within health facilities (HCT, care and treatment, TB/HIV, RMNCH) and between health facilities and community interventions. As a result, opportunities to identify at risk clients or maintain patients in care are missed. Historically, the response to high loss to follow up has focused on finding patients who have not returned to care rather than proactively adopting measures to prevent poor adherence and retention.

In addition to a range of facility-based innovations to improve retention the use of routine early warning systems through the use of SMS and phone call reminders (described in Section 1) there are several community-based strategies that are increasingly being implemented. These include the Community Adherence and Support Groups (GAACs) that are now being rolled out to all facilities that provide ART. PEPFAR funded implementing partners are supporting the creation, maintenance and monitoring of the GAAC groups in the districts they provide implementation assistance.

PEPFAR and the national program through GFATM support have been rolling out the community-based platform, including peer educators, community health workers and *activistas*. FDC, the PR for community-based interventions already has 2400 *activistas* who work with specific communities (both geographic and key and vulnerable population based), to follow up with PLHIV who have missed an appointment or ART pick up and with support from the NFM an additional 1800 will be engaged. The new community TB strategy will expand the role of *activistas* to take on community DOT. The overall emphasis on community based, well-grounded community workers is consistent with the experience in Mozambique that communities are well organized and can be effectively mobilized, particularly valuable given the human resources for health challenges that are slowly ameliorating.

Finally, RENSIDA, a network of PLHIV, is coordinating the work of other PLHIV associations at provincial and district levels, aiming to increase adherence and retention to ART and PMTCT services.

B.3: Striking the Appropriate Balance of Treatment and Prevention Services

Results of clinical trials have demonstrated the efficacy of certain biomedical prevention interventions (for example voluntary medical male circumcision and ART for the elimination of vertically transmission of HIV in pregnancy), as well as documented the reduction in HIV-related mortality with the use of ART, and the dramatic reductions in HIV transmission on an individual level with the use of ART. Ecologic data points to declines in incidence on a population level with high ART coverage.

There has been a global shift of a greater proportion of prevention funding addressing biomedical prevention interventions, and an increased focus that structural and behavioral prevention efforts need to be evidence-based. The financial consequence of these trends is reflected in the funding envelopes of the two largest sources of bilateral and multilateral HIV funding. The proportion of prevention funding from the Global Fund and from PEPFAR for biomedical interventions has risen.

The number of PLHIV on ART continues to rise. In addition to the objective of ART expansion to reduce HIV-related mortality and morbidity, the Acceleration Plan has set ambitious ART coverage targets with the expectation that high ART coverage will result in a substantial reduction in HIV incidence. The proportion of overall funding now supporting ART has also risen for both PEPFAR and the GF.

3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request for TB and HIV, including both the proposed investment of the allocation amount and the request above this amount. Include the specific elements related to joint programming such as health systems and community systems strengthening. Describe how the request addresses the gaps and constraints described in sections 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

Mozambique is aware that the proportion of funding that is going towards prevention has reduced in the last 3 years, but the absolute dollar value of funds for prevention has not decreased. Under these circumstances, the country has a balanced approach in resources available for both treatment and prevention services.

However, Mozambique faces a looming funding gap in particular for procurement of ARVs for those patients already on treatment, and as well for those who continue to present to health facilities in need of ART. It is expected that there will be a national stock out by early 2016 if additional funding for ARV is not secured. Therefore, the majority of funds requested under this Concept Note is intended to cover the *gap* to sustain the current number of patients in treatment, and support the progressive growth and expansion of ART services, particularly in the 71 districts prioritized in the national HIV Acceleration Plan.

The Acceleration Plan prioritizes maintaining people currently on ART as well as an increase in the total enrolled on ART over the next several years. This will decrease mortality and morbidity, and as well have a complementary benefit of reducing community viral load and therefore HIV incidence. Mozambique is

also focused on effective interventions to support a comprehensive HIV and TB prevention and care countrywide, while strategically targeting key and vulnerable populations in 71 priority high impact districts.

Epidemiologic modeling projects significant decreases in HIV incidence and mortality if, indeed, Mozambique continues to achieve the targets established as part of the Acceleration Plan (see Figure 1).ⁱ By focusing on districts with the highest burden of disease, the epidemic impact of ART scale-up is maximized and sexual transmission of HIV, the principle mode of transmission in Mozambique, will be significantly curtailed. By additionally focusing prevention activities on those populations contributing disproportionately to the epidemic, Mozambique will further maximize use of the available resources towards the goal of epidemic control.

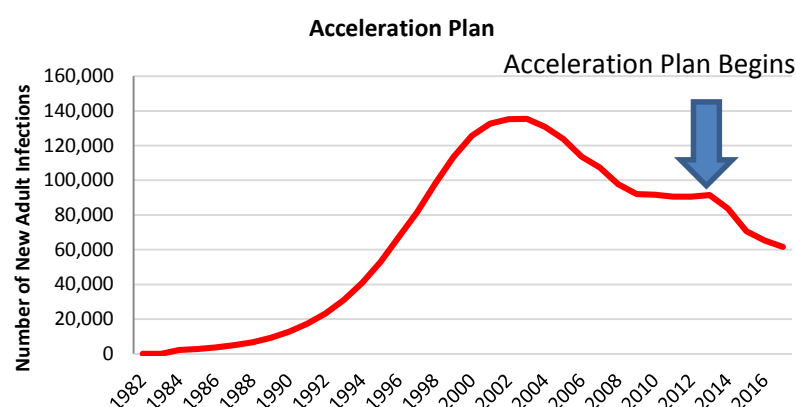


Figure 1. Impact of Achieving Acceleration Plan Targets ART on HIV incidence

Through renewed commitment to engage and strengthen the capacity of community health systems and reorienting community-based interventions to enhance HIV case finding through targeted testing, demand creation for clinical services, supporting ART retention and adherence while at the same time integrating community based DOTS activities to increase TB case finding and treatment success rates, Mozambique will efficiently and effectively utilize its large community platform to best support the goal of epidemic control.

To adequately tackle the burden of this two diseases Mozambique is making an expression of full demand of the projected funding gap to cover interventions designed to respond to both the HIV and TB epidemics. The decision of the CCM to maintain the disease split proposed by the GFATM Board was made on the basis of a programmatic gap analysis. Funds remaining in existing grants as of 1 July 2015 will be supplemented by the additional funding allocated to Mozambique. The budget of the MoH R9 HIV grant will be almost 100% spent or committed to procurements of ARV, RTK and related health commodities for 2015-2016 by 30 June 2015. This drives the needed start date for the NFM as new procurements will be needed to be ordered in Q3 of 2015. Table 1 below presents \$58,686,881 as the total amount available for allocation in the concept note period (1 July 2015 – 31 December 2017).

Table 1: Estimated funds available for HIV/TB Concept Note as of 1 July 2015

Funding Source	Amount
MOZ-911-G09-H	\$ 21,292,025
MOZ-911-G10-H	\$ 2,254,260
MOZ-708-G07-T	\$ 13,251,104
Additional HIV funding	\$ 3,636,533
Additional TB funding	\$ 18,252,959
Total available for allocation in CN	\$ 58,686,881

ⁱ GOALS modelling

Table 2: HIV and TB Interventions and Summary Budget

Module	Total Cost (US\$), July 2015-December 2017		
Intervention	ALLOCATED	ABOVE	TOTAL
Prevention - general population			\$18,094,226
Condoms as part of programs for general population	\$0	\$551,695	\$551,695
HIV testing and counseling as part of programs for general population	\$892,165	\$16,650,366	\$17,542,531
Prevention - Young females age 14-24			\$5,998,667
Behavioral change as part of programs for adolescent and youth	\$4,994,156	\$1,004,510	\$5,998,667
Prevention - Other vulnerable Populations			\$4,386,491
Behavioral change as part of programs for females age 25-49	\$2,865,153	\$568,251	\$3,433,404
Behavioral change as part of programs for miners	\$130,179	\$46,863	\$177,042
Behavioral change as part of programs for workplace	\$776,045	\$0	\$776,045
Prevention - sex workers and clients			\$2,780,474
Behavioral change as part of programs for sex workers and LDTD	\$1,225,666	\$1,554,808	\$2,780,474
Prevention - MSM and TGs			\$847,453
Behavioral change as part of programs for MSM and TGs	\$847,453	\$0	\$847,453
PMTCT			\$864,562
Prong 4: Treatment, care and support to mothers living with HIV and their children and families	\$864,562	\$0	\$864,562
HIV treatment, care and support			\$349,699,923
Antiretroviral Therapy (ART)	\$0	\$225,423,298	\$225,423,298
Other Interventions: Referral systems for laboratory samples and results	\$1,074,485	\$0	\$1,074,485
Pre-ART care	\$0	\$54,291,517	\$54,291,517
Prevention, diagnosis and treatment of opportunistic infections	\$0	\$29,847,552	\$29,847,552
Treatment adherence	\$1,502,172	\$2,076,465	\$3,578,637
Treatment monitoring	\$0	\$35,484,434	\$35,484,434
TB/HIV			\$4,978,270
Engaging all care providers	\$0	\$4,978,270	\$4,978,270
TB care and prevention			\$18,074,417
Case detection and diagnosis	\$5,804,971	\$44,225	\$5,849,196
Collaborative activities with other programs and sectors	\$995,387	\$221,374	\$1,216,761
Community TB care delivery	\$5,949,204	\$0	\$5,949,204
Engaging all care providers	\$89,889	\$79,647	\$169,536
Prevention	\$1,500,842	\$148,231	\$1,649,073
Treatment	\$3,056,075	\$184,572	\$3,240,647

MDR-TB			\$9,923,472
Case detection and diagnosis: MDR-TB	\$798,756	\$0	\$798,756
Prevention for MDR-TB	\$5,132,448	\$0	\$5,132,448
Treatment: MDR-TB	\$3,641,717	\$350,551	\$3,992,268
Procurement supply chain management (PSCM)			\$7,777,173
Operationalization of PSM system	\$0	\$214,273	\$214,273
PSM infrastructure	\$0	\$7,562,900	\$7,562,900
Health workforce			\$8,073,920
Health and community workers capacity building	\$0	\$2,626,200	\$2,626,200
Retention and distribution of health and community workers	\$0	\$1,126,080	\$1,126,080
Scaling up health and community workers	\$1,415,083	\$2,906,557	\$4,321,640
Community systems strengthening			\$454,560
Community-based monitoring for accountability	\$252,812	\$7,584	\$260,397
Institutional capacity building, planning and leadership development in the community sector	\$11,715	\$0	\$11,715
Social mobilization, building community linkages, collaboration and coordination	\$182,449	\$0	\$182,449
Health information systems and M&E			\$13,392,718
Routine reporting	\$2,362,930	\$4,233,172	\$6,596,102
Surveys	\$2,935,347	\$3,261,269	\$6,196,616
Vital registration system	\$600,000	\$0	\$600,000
Program management			\$9,697,863
Grant management	\$8,337,935	\$531,790	\$8,869,725
Policy, planning, coordination and management	\$414,856	\$413,282	\$828,138
Total Request in Concept Note	\$58,654,452	\$396,389,737	\$455,044,189

Table 3: Expression of Demand by Domain and PR- Jul 2015-Dec 2017⁶¹

Total Cost (US\$) July 2015-December 2017			
	ALLOCATED	ABOVE BUDGET	TOTAL
HIV*			
MoH	\$4,702,591	\$369,822,895	\$374,525,487
FDC	\$12,120,336	\$5,084,409	\$17,204,745
TB HIV			
MoH	\$0	\$4,978,270	\$4,978,270
FDC	\$0	\$0	\$0
TB**			
MoH	\$28,406,892	\$1,528,779	\$29,935,671
FDC	\$3,224,638	\$0	\$3,224,638

HSS***			
MoH	\$723,976	\$14,238,727	\$14,962,703
FDC	\$9,029,042	\$729,072	\$9,758,114
CSS			
MoH	\$0	\$0	\$0
FDC	\$446,976	\$7,584	\$454,560
TOTAL	\$58,654,452	\$396,389,737	\$455,044,189

*Includes M&E activities for the HIV program

**Includes M&E and program management activities for the TB program

***Includes general program management activities (GF Unit, FDC)

In the sections below, some budget totals reflect a grouping of several related activities- in these situations there will be one 'funding request' chart associated with several intervention/activity descriptions. The set of interventions outlined in the modular template are presented below in the sequence established through the modular template rather than in order of program priority.

HIV

The overarching goal of Mozambique's HIV response is to achieve epidemic control through scale-up of ART, elimination of mother to child transmission of HIV, and targeted prevention activities, an efficient targeted testing and counseling approach, improvement in diagnosis and treatment of STIs, with a special focus on key and vulnerable populations (FSW, MSM, adolescent and young adult woman, HIV+ male partners of HIV-negative pregnant women, and HIV-infected pregnant women). In parallel, Mozambique will continue to invest in the expansion of treatment with efficacious ART regimens and elimination of vertical transmission through expansion of Option B+, and ensuring increase in treatment adherence rates.

Most of the technical and financial support for programmatic care and treatment activities is provided through PEPFAR financed implementing partners who provide comprehensive support for HIV and HIV/TB related activities in all 11 provinces of Mozambique. As of the end of 2013, PEPFAR partners were providing technical and financial support to the health system in 144 districts, 567 ART facilities 964 PMTCT facilities and 864 HTC sites. PEPFAR support is fully aligned with the Acceleration Plan goals and objectives. PEPFAR partners provide support to ART facilities that account for approximately 85% of the national total and in COP 2013, approximately \$20 million was allocated to partners for adult clinical and community care activities and \$6 million for pediatric clinical and community care activities. \$36.7 million was allocated to adult treatment and \$7.4 million was allocated to pediatric treatment. Given an increased emphasis on the scale-up of treatment, the proportional allocation of care and treatment funds in relation to the overall PEPFAR portfolio will increase in 2014 to ensure that at least 57% of the PEPFAR budget is allocated to care and treatment activities.

Interventions include frequent mentoring, site visits, support implementing novel strategies for demand creation, linkages, retention and adherence and support for the implementation of the national quality improvement strategy. Allocation of district level teams comprised of experienced clinicians and nurses that can provide ongoing technical support to district and facility level staff as the Acceleration Plan scales. These district level teams have been placed in priority districts to ensure full Acceleration Plan scale-up in those districts. Additionally, most PEPFAR partners have district and/or provincial level sub-agreements that enable local health authorities to adequately plan and execute supervision plan, QI visits, and in-service trainings.

Most of the technical and financial support for prevention activities is provided through PEPFAR, through interventions that are consistent with the national prevention strategy. For this reason, the following details are provided regarding the PEPFAR contribution to prevention services for key and vulnerable populations.

The total PEPFAR funding for KP and OVP in fiscal year was USD 4.1 million, of which USD 2.2 million was allocated to KP (FSW, MSM, IDU, prisoners) and the remainder allocated to interventions for OVP (mobile and migrant, FSW clients, high risk youth). Current PEPFAR investment covers all provinces

with the exception of Niassa Province, with a focus in all main urban areas, transport corridors, and new development areas characterized by the existence of extractive mining industries. In addition, PEPFAR supports the implementation of a comprehensive HIV/STI intervention package in 10 prison sites.

Key Population and Other Vulnerable Populations interventions are oriented around HIV prevention and treatment, considering that both components are critical for members of these populations that both carry heavy HIV burden and remain at high risk of HIV acquisition. Vulnerable and hidden KP / OVP are reached through community peer platforms and offered an evidence-based package of HIV services focused on increasing the correct and consistent use of condoms as well as condom compatible lubricants; creating demand and increasing the uptake of HTC; and effectively linking clients to high quality, integrated health services. A major component towards increasing enrolment and retention in integrated health services is through the establishment and consolidation of KP-friendly services. These health facilities have undergone a special training and preparation program that allows for a de-stigmatized, welcoming environment; expanded M&E to allow for tracking of KP health services; and HIV treatment as prevention (test and treat) which is currently authorized at 14 pilot sites receiving PEPFAR support. PEPFAR support for the community HTC platform is oriented directly towards supporting peer outreach activities and engaging KP in the reach-test-treat-retain continuum of care.

The Government of Mozambique has adopted scale up of Voluntary Medical Male Circumcision (VMMC) as a key biomedical prevention intervention. Currently, VMMC is being scaled up in seven provinces based on HIV epidemiology and baseline rates of MC. PEPFAR allocated \$21,999,001 to support VMMC in COP13. In addition to support for training and implementation of widened VMMC programming, PEPFAR is providing technical support to the MOH for a better program monitoring and evaluation. The set of interventions outlined in the modular template are presented below in the sequence established through the modular template rather than in order of program priority. The modular template lists some program activities that are funded through other funding sources (and therefore not part of this NFM request) to reflect the comprehensiveness of the HIV and TB programs- while described in the modular template they are not included in the intervention descriptions below.

1: Reducing new infections by implementing targeted oriented set of prevention strategies in priority districts, through outreach to vulnerable population (infected and affected) and key populations with a comprehensive package of services:

As described in section 1, above, the results of the MoT (2014)¹¹ provide evidence that while Mozambique has a generalized HIV epidemic, certain key and vulnerable populations are particularly at risk of HIV acquisition and contribute disproportionately to HIV incidence. While there are prevention activities oriented towards the ‘general’ population that remain a component of the overall prevention strategy, there has been a reorientation of HIV prevention towards those specific key and vulnerable populations, as well as a reorientation of HTC towards case-finding. Under this NFM Mozambique aims to sustain previous investment and gains from the Global Fund and PEPFAR toward consistent outreach of vulnerable and key populations with comprehensive package of services, adapted from WHO and UNAIDS guidelines and best practices. Specific set of interventions aiming to reach key and vulnerable populations, Populations are described below.

1.a) Reducing the risk of HIV acquisition, in particular for women and girls

Context: The Global Fund Round 9 HIV grant implemented by FDC Consortium is strategically targeting girls and women with a comprehensive package of services, around 1.6 million young girls in 56 of priority districts in 9 provinces will be reached by specific package of services. The package for behaviour change, being provided, is centered on a BCC and interpersonal communication and is based on existing evidence-based packages such as the “Go Girls initiative” that approach and address gender barriers and structural obstacles in order to empower girls towards protective and health seeking behavior.

PEPFAR will support vulnerable children, boys and girls, to enroll in secondary schools and take advantage of vocational training opportunities, with a particular emphasis on young girls, who are highly vulnerable to sexual and reproductive health challenges. PEPFAR will support the enrolment and retention of young girls in schools, assistance through cash/in-kind transfers, complemented with a range of services that build a more holistic and safe environment that enables young girls to improve

their educational and financial opportunities, while at the same time protecting them from other risks, particularly early sexual debut, transactional sex, and their consequences such as unwanted pregnancy or unwanted infections, including HIV. PEPFAR support will ensure that young girls have access to HTC providers, SRH/FP counselors and providers, while their families benefit from Household Economic Strengthening interventions. PEPFAR will support these activities in 5 of Mozambique's 11 provinces.

Gap: This package of services for young girls will continue to be implemented through the civil society PR, FDC, and its sub-recipients. Interventions will be provided by *Activistas* with deep community roots, and supervised by the provincial sub-recipients. The supported services will include peer to peer education supplemented by targeted use of community media, provision or facilitation of access to condoms for at-risk young girls, targeted HIV counseling and testing, demand creation for PMTCT, STI diagnosis, referral and linkages to youth friendly and ANC services (for detailed content of the package of services refer to Package of Services for Girls and Young Women⁶², and Package of Services for Adult Women of Reproductive Age⁶³). This community intervention package being implemented will be adapted with this proposal to incorporate components such as TB, PMTCT and SRH to ensure a more comprehensive package towards girls and women. With these new funds the interventions and approaches will be strengthened and expanded until December 2017.

Module: Prevention Programs for adolescents and youth, in and out of school (young females 15-24) **(15-24)**

Allocation \$	Above Allocation: \$	Total \$
4.994.156	1.004.510	5.998.667

Note: in modular tool under *Prevention Programs for adolescents and youth, in and out of school*.

Intervention: Behavioural change as part of programs for adolescent and youth - outreach young girls (15-24 years-old) with comprehensive package of services to prevent HIV/TB, early and unintended pregnancies, GBV. **Allocation:** reach population in 57 districts train 22 new activists and refresher train 1060 existing activists; subsidies and materials; **Above:** expand coverage to an additional 14 districts to reach all 71 priority districts.

Target population and geographical scope: Reach 62.5% of estimated 2.615.723 vulnerable young girls in year 1; reach 49% of 2.687.975 in year 2 and 22% of 2.764.226 in year 3, in 71 priority districts

Implementation approach: Community based activists and peer educators will deliver a comprehensive package of services to prevent HIV/TB, early and unintended pregnancies and GBV. Referral of young girls to health services at community and health facility level for HIV counseling and testing, distribution of male and female condoms and reproductive health services (at health facility).

Prevention Programs for Adult Women (25-49)

Allocation \$	Above Allocation \$	Total \$
2.865.153	568.251	3.433.404

Note: in modular tool under *Prevention Programs for other vulnerable populations*.

Intervention: Behavioural change as part of programs for adult women – reach adult women (25-49 years-old) with comprehensive package of services to prevent HIV/TB, GBV in a context of a feminized epidemic. **Allocation:** reach target population in 57 districts; **Above:** expand coverage to an additional 14 districts to reach all 71 priority districts.

Target population and geographical scope: Reach 26% of 3.644.449 estimated vulnerable population in year 1; 20% of 3.757.970 in year 2; 9% of 3.873.104 in year 3, in 71 priority districts.

Implementation approach: Community based activists and health workers will deliver specific package of services, including referral of adult women (25-49 years) to health services at community and health facility level for HIV counseling and testing, screening of TB, provision of preventive commodities. In the case of HIV negative women whose partners do not know their status, in the package of services for women and girls, FDC will make adjustments to include outreach and referrals for HIV positive partners of targeted women and girls at community level. The community activist with this portfolio will

implement the risk assessment session with the women and girls. With permission from the participating woman, the activist will also visit their partner and conduct an awareness raising session, proceeding with permission to counseling and testing. Consistent condom use will be reinforced, at the next session, for all partners who are identified as sero-discordant from their index 'client', through this intervention. HIV+ partners will be referred to a health facility. Clients who are initiated on ART will be enrolled in adherence to ART interventions. For the follow-up of all positive cases (women and men) there is a specific group of dedicated activists who conduct individual sessions, providing guidance regarding ART and provide psychosocial support.

1.b) Outreach to key populations (FSW and MSM) with a comprehensive packages of prevention and treatment support service

Context: Providing services to marginalized, hard to reach and underserved populations is key to epidemic control. Under the GF R9 FDC HIV grant, in 2013, Mozambique conducted a mapping exercise, population size estimation and hot spot identification. The National Strategic Plan III Review (2014)⁵² shows promising results in engaging FSW and MSM in delivering peer to peer education for prevention among those populations at community level, and establishing linkages with 12 key population-friendly health facilities enabling FSW and MSM to access and use essential services in diagnose and treatment of STIs, HIV counseling and testing, including offering treatment to all HIV+ in this group.^j

FDC is the civil society PR that currently is funded to provide adherence and prevention related services to these populations, through direct implementation as well as through its subcontractors. *Activistas* based in these communities are supported through FDC and its subcontractors to provide these services through community outreach. The PR and its SR provide training and supervision to these *activistas* as well as document successful implementation. The interventions that comprise the package of services delivered to MSM, which will be updated and adjusted prior full roll out of this grant, include: training and capacity build of peer to peer educators, provision of water based lubricants and condoms, HIV testing and counseling, STI diagnosis and treatment.

As detailed above PEPFAR is engaged in this area as well, with investment covering targeted areas within 10 provinces and nationally within the penal system. Vulnerable and hidden key population are reached through community peer platforms and offered an evidence-based package of HIV services focused on both prevention and treatment services. Integration of HIV testing and linkages to key population-friendly health facilities are key features of the PEPFAR-supported response. Populations addressed included FSW, MSM, and prisoners; as well as other vulnerable populations including migrant and mobile populations, and high risk youth.

Gap: The set of interventions defined for FSW under GF R9 FDC grant are funded until June 2015, and will roll over to this NFM, to sustain coverage of 80% of the FSW total population^k from July 2015 to December 2017. The allocated amount will cover the programmatic gap for an effective coverage of FSW and addition investment required to scale up the number of health facilities with skilled trained providers to appropriately respond to the needs of FSW and MSM (24 new sites).

The requested amount to address MSM prevention and treatment needs is low. The MSM-related interventions are leveraging the USG-supported portfolio, and aims to expands the coverage of MSM to 11 provincial capital sites, progressively reaching at least 5260 MSM beneficiaries by the end of 2017.

Module: Prevention programs for sex workers and their clients (LDTD)

Allocation \$	Above Allocation: \$	Total \$
1.225.666	1.554.808	2.780.474

Intervention: Behavioural change as part of programs for sex workers and their clients (long distance truck drivers – LDTD) - outreach to FSW with a comprehensive package of prevention and treatment services. **Allocation:** reach population in 57 districts training 3 new and refresher train 173 existing

^j Projecto Vidas, 2014.

^k Targets denominator was estimated based on 2% of the total female population aged 15-49 years old.

activists; training of 360 health care providers on working with key populations (FSW & MSM); **Above:** expand coverage to an additional 14 districts to reach all 71 priority districts; procure lubricants for FSW.

Target population and geographical scope: Reach 80% of 125,203 estimated population of FSW in year 1; reach 90% of 128,919 estimated population of FSW in year 2, and reach 62% of 132,747 estimated population of FSW in year 3. Reach 27% of estimated 107,575 LDTD in year 1; reach 51% of 107,575 LDTD in year 2; and reach 42% of LDTD in year 3. Geographic Scope: Selected hot spots, transportation corridors and capital cities in 9 provinces.

Implementation approach: Adjust (to cover TB diagnosis and treatment) and full implementation of the existing package of services for FSW and clients (truck drivers) developed under R9 FDC HIV grant, which includes targeted and specific messages and peer to peer skills transfer aiming to: train and improve skills and knowledge of 205 and clients (truck drivers) peer educators to deliver the full package of services for FSW, adopting a rights and gender based approach; Strengthen the referral system to ensure that FSW and clients (truck drivers) reach the health facilities to get necessary services (HIV VCT, STI screening and treatment); develop job aids, flow charts, training modules and risk assessment tools to increase capacity of health care providers to identify and ensure access to ARV treatment of HIV+ FSW; develop tools to ensure and monitor linkages of FSW and clients (truck drivers) to HIV and other health services within health facilities (peer educators and community based lay counselors); create demand to community counseling and testing. Special effort will be made to include distribution of water-based lubricant to respond to the needs of key populations (MSM and FSW) being cared for at 24 'key population friendly' community and health facility venues.

Module: Prevention programs for MSM and TGs

Allocation \$	Above Allocation: \$	Total \$
847.453	0	847.453

Intervention: Behavioural change as part of programs for MSM– Outreach to MSM with comprehensive package of services, including access and linkages to selected health facilities with health personnel trained to address MSM needs (prevention and treatment).

Target population and geographical scope: Reach 12% of 52,594 MSM estimated population in year 1 and 2; reach 6% of estimated population in year 3. Focus in 9 cities located in priority districts.

Implementation approach: Engage, train and improve skills and knowledge of 111 peer educators to deliver the full package of services for MSM, including SBCC contents and access to health friendly services, promotion of safe sex practices among MSM; increase access to condom and water base lubricant use, prevent and promote STI treatment; promote adherence to HTC, HIV services and other health services, strengthen the referral system to ensure that MSM reaches the health facilities to get necessary services (HIV, VCT, STI screening and treatment). Engage peer educators to facilitate ART enrolment of at least 80% of MSM newly diagnosed HIV+ on ART services in targeted provinces.

1.c) Tackling a concentrated HIV and TB epidemic burden in migrant workers as well as their communities of origin, transit and destination

Context: 35,000 Mozambicans were officially registered as migrant and seasonal workers in neighboring South Africa and Swaziland. Another 35,000 unregistered Mozambicans are estimated to work in these mines. These migrants, and those working on farms in South Africa, often live part of the year in their provinces of origin, predominantly Gaza Province. Sociocultural, economic and political factors in both origin and destination regions influence the risk of HIV infection of regional labor migrants. This risk is exacerbated by inadequate access to HIV and TB prevention information, and other services for this population.

The USG currently supports a local organization - Thembaletu Development (TD) - to implement community-based HIV testing and counselling activities and referral to care and treatment for HIV and TB among current and ex-mineworkers, their families and those they interact with in Gaza Province. In partnership with IOM and other local partners, TD implements the project in the target districts of Bilene, Chibuto, Chokwe, Manjacaze and Xai Xai in Gaza.

In addition and complementarity, FDC has utilized funds from GF R9 grant to develop an overall community approach, which has been adapted to address the need of migrant population and surrounding communities. The community approach encompasses peer education, BCC through community media, provision of condoms, HIV testing and counseling, and referral and linkages to health facilities.

Gap: This community approach package will be updated to include TB and HIV treatment literacy and adherence to treatment messaging and skills building. The requested amount will enable to deliver sound coverage of about 22.0000 migrant workers, around 54% of the estimated size of these population groups through end 2017.

Module: Prevention programs for– mobile populations (miners)

Allocation \$	Above Allocation: \$	Total \$
130.179	46.863	177.042

Note: in modular tool under *Prevention programs for other vulnerable populations*.

Intervention: Behaviour change as part of programs for migrant population - outreach to migrant workers with comprehensive package of prevention of HIV and TB services in Southern Mozambique. **Allocated:** training of 28 activists to expand activities; subsidies and materials; **Above:** training of 9 activists to expand activities; subsidies and materials.

Target population and geographical scope: Reach 45% of an estimated 39.521 migrants in Year 1; reach 54% in Year 2; and cover 23% in Year 3. Geographic scope: Gaza Province.

Implementation approach: Adjust (to cover TB diagnosis and treatment) and fully implement the existing package of services for miners developed under R9 FDC HIV grant, which includes targeted and specific messages and peer to peer skills transfer aiming to: increase condom use; promote adherence to HTC, HIV services and other health services; increase HIV and TB treatment literacy among migrant workers in targeted communities and sites; strengthen the referral system to ensure that migrant workers reach the health facilities to get necessary services (HIV VCT, TB screening and treatment). The existing cadre of HIV community activists will benefit from refresher training for the added TB components.

1.d) Addressing workforce vulnerability to HIV and TB in a context of expansion of mining industry (new economic zones)

Module: Prevention programs for in the workplace

Allocation \$	Above Allocation: \$	Total \$
776.045	0	776.045

Note: in modular tool under *Prevention programs for other vulnerable populations*.

Intervention: Behavior change as part of programs for migrant population (workplace intervention) - reach company employees with comprehensive package of prevention of HIV and TB services.

Target population and geographical scope: Reach 17% of 163822 employees in Year 1, reach 34% and 24% in Year 2 and 3 respectively. Geographic scope: new economic zones (Maputo, Gaza, Inhambane, Tete, Manica, Sofala Cabo Delgado and Nampula Provinces).

Implementation approach: with full engagement of the Business Coalition Against HIV and AIDS (EcoSIDA), adjust (to cover TB diagnosis and treatment) and full implementation of existing workplace toolkit developed under R9 FDC HIV grant, which includes targeted and specific messages and peer to peer skills transfer aiming to: increase condom use; promote adherence to HTC, HIV services and other health services, increase HIV treatment literacy among company employees in targeted communities and sites; strengthen the referral system to ensure that company employees reach the health facilities to get necessary services (HIV VCT, TB screening and treatment). Build capacity for the companies (private sector) build up from workplace intervention toolkit in order to continue and finance the intervention.

1.e) Provision of commodities for all key prevention activities

Context: As a response to the generalized epidemic HTC is widely available at health facility level (VCT and PITC) and/or community level (VCT and community-based testing). Recognizing the particular risk for members of key and vulnerable populations, targeted testing approaches, aimed at increased efficiency of case finding, will be conducted with clients identified as at high risk for exposure to HIV (see modules on young women and girls, FSW, MSM, migrants and mobile populations above).

Gap: The procurement of RTKs is supported also by PEPFAR and the quantities included here are filling the gap in the national need.

Prevention programs: HIV testing

Allocation \$	Above Allocation: \$	Total \$
892.165	16.650.366	17.542.531

Note: Under module *Prevention programs for general population*

Intervention: Increase HTC for general and key and vulnerable populations (see modules above).

Allocation: Consumables for community testing. **Above:** Procurement of RTKs to fill national needs.

Target population and geographical scope: Test 5.706.004 persons in year 1, test 6.066.32 person in year 2 and test 6.068.795 in year 3¹ nationwide, with focus in the 71 priority districts and focus on targeting partners and family members of HIV index case: in community settings of high HIV prevalence and high population density to increase detection of HIV infection; HIV positive partners of pregnant women; HIV negative males to refer to VMMC services in areas with high HIV prevalence and low male circumcision (Zambezia, Manica, Sofala, Gaza, Maputo, and Maputo City); vulnerable population (young girls in community settings of high HIV prevalence); key populations (FSW, MSM, migrants).

Implementation approach: Purchase rapid test kits for HTC for all national HIV testing activities included PITC, VCT and community-based testing; Expand PITC availability in key entry points of health facilities (adult and children Triage, Emergency room, in-wards, MCH services and TB). HIV test is integrated in all packages of services above described for all key and vulnerable population targeted, at health facility and community level. With allocation funds, the MoH will procure HIV RTKs to cover the expected total need for test kits for all patients targeted for testing between July 2015 and December 2017 as well as of the procurement needs of reagents and supplies for EID to improve pediatric HIV diagnosis.

Context: There has been a progressive increase in condom use among both men and women who report more than one sexual partner during the last 12 months. This positive trend in condom use is hampered by shortfalls in the supply and distribution of condoms in health facilities and community outlets. The Acceleration Plan has a target of 100% availability of condoms at health facilities by 2015, and with support from this funding request for logistics it will be attained. Condom supply for next 3 years is already secured by UNFPA.

Prevention programs - Condoms

Allocation \$	Above Allocation: \$	Total \$
0	551.695	551.695

Note: Under module *Prevention programs for general population*

Intervention: Improve condom warehousing and distribution; condom promotion materials to be produced by MoH for all health facilities

Target population and geographical scope: General population (sexually active men and women 15-49) at national level; key populations at targeted sites (FSW/MSM/Miners/migrant workforce and LDTD); other vulnerable population in targeted sites (young women and partners 15-24 years);

Implementation approach: Ensure availability and accessibility of condoms in all national health facilities (waiting rooms, pharmacies, VCT sectors, toilets, consultation rooms). Condom provision to final beneficiaries is accounted under specific packages of services targeting specific populations. FDC

¹ Testing targets calibrated to targets for newly initiated on ART and total number of patients on ART.

will obtain condoms from provincial NAC warehouses and transport them to the implementation areas (districts and communities) for distribution to the end user by the activists. Strengthen condom transportation and distribution from provincial warehouses to community distribution centers; Strengthening coordination between principal recipient (FDC), sub recipients and other CSO's to ensure condom distribution and storage in community settings where FDC is not present (Niassa Province).

2: Reducing new HIV infections and AIDS mortality by expanding and sustaining access to quality PMTCT and ART services in prioritized, high impact districts, bringing care and treatment closer to the patient

2.a) Prevention of Mother to Child Transmission of HIV

Low institutional delivery (54%) impacts access to the full PMTCT package after an initial visit, as well as to entire continuum of care for reproductive, maternal, newborn and child health (RMNCH). Sites offering PMTCT services have increased from 1170 in 2012 to 1213 in June 2014. Of those facilities providing PMTCT services, 623, as of June 2014, implement Option B+. This will be leveraged to further reinforce combined active HIV and TB case finding at all portals of entry for women and children including at family planning, antenatal clinics, maternity, healthy and at-risk infant follow-up clinics, and immunization programs. MCH nurses working in these areas who are properly trained and capacitated to manage women and children with suspected and confirmed TB and HIV can make significant contributions to service coverage and quality in both areas.

The pediatric treatment programme is working together with the PMTCT programme to optimize consistency of action at the RMNCH care services. A common ground that will be particularly explored in terms of demand creation and retention is community action. The request under this module will cover for prevention of HIV infection among women of childbearing age - treatment for serodiscordant couples; prevention of vertical HIV transmission – through provision of most effective ARV prophylaxis for HIV infected women by expanding Option B+ to peripheral sites; and treatment, care and support for mothers living with HIV and their children and families as well as by increasing access to EID for HIV Exposed Infants (HEI).

Module: PMTCT *

Allocation \$	Above Allocation: \$	Total \$
864.562	0	864.562

*Note: Budget for Prong 1 and Prong 3 is included in ARVs and Test Kit procurement. The allocated amount reflects the investment for Prong 4.

Intervention: Prong1: primary prevention of HIV infection among women of childbearing age - Treatment for sero-discordant couples.

Target population and geographical scope: seropositive partners of sero-negative Pregnant Women and LW in all ART HF (2015: 707 HF, 2016: 889 HF, 2017: 1,072 HF)

Implementation approach: MoH is investing in partner testing at ANC, reinforcing communication skills of health workers to attract the partners of women who attend ANC by on-the-job training for MCH nurses to promote better quality counseling to pregnant women and couples in order to facilitate partner involvement as well as treatment literacy more broadly, using the new Psychosocial Guidelines and training material developed for MCH nurses. The strategies to reach the partners of women who attend the ANC include promotion and distribution of partner invitations and “partner friendly MCH services”, such as different services hours and prioritizing women that attend ANC with their partners.

Intervention: Prong 3: Preventing vertical HIV transmission - Provide most effective ARV prophylaxis for HIV infected women: expand Option B+ to peripheral sites.

Target population and geographical scope: 2015 80% PW, 2016: 87% PW, 2017: 90% PW

Implementation approach: Purchase of nevirapine and cotrimoxazole syrup for HIV exposed infants

Intervention: Prong 3: Preventing vertical HIV transmission - provide most effective ARV prophylaxis for HIV infected women (all regimens)

Target population and geographical scope: 2015 90% PW, 2016: 92% PW, 2017: 95% PW, National

Implementation approach: Purchase of AZT and NVP (2015: 10% all PW), (2016: 5% all PW), (2017: 5% all PW)

Intervention: Prong 4: Treatment, care and support for mothers living with HIV and their children and families (RTK and treatment in respective modules) as well as increase access to EID for HIV exposed infants (HEI) (within allocated of this module).

Target population and geographical scope: 1,414 HF by 2015, x 2016, x 2017

Implementation approach: Purchase of PCR DNA HIV kits; Transportation within districts, province and between provinces for PCR HIV samples.

2.b) Enrolling and retaining eligible HIV positive patients in treatment to reach Acceleration Plan targets:

Priority Module: Treatment, care and support

2.b.i HIV treatment, its monitoring and OI&STI care

Context: Mozambique has successfully scaled up the number of patients on ART, particularly during the last 2 years, in the context of implementation of the HIV Acceleration Plan, with PEPFAR support and GF R9 investment. Currently, 46,202 children are enrolled in treatment (37% of the ART eligible per national guidelines) and 506,738 adults are enrolled on ART (58% of the ART eligible per national guidelines). The pace of enrollment on ART is matching the expectations from the Acceleration Plan, and Mozambique is on track to reach the planned target that 750,023 children and adults will be on ART in 2015, and 996,593⁴ in 2017.

Gap: To fulfill this goal, the MoH will procure ARV to ensure drug availability for all patients targeted to be on treatment during the period July 2015 and December 2017, and ensure availability of OI and STI drugs for PLHIV for prophylaxis and treatment, as appropriate. Funds that may be available from other donors during that period should cover a portion of the total need (assumption is that PEPFAR will continue flatline- funding part of health commodity needs, please see scenarios in 3.3). A total amount required to cover the country's needs for this period is detailed below:

Antiretroviral Therapy (ART)

Allocation \$	Above Allocation: \$	Total \$
0	225.423.298	225.423.298

Intervention: Antiretroviral treatment (ART) - Scale up provision of ART using standardised efficacious and simplified ARV regimens to reach Acceleration Plan targets of 2017 to secure ART coverage of 80% of those eligible, reduce incidence significantly and decrease AIDS related mortality , please see scenario 3 section 3.3.

Target population and geographical scope: 80% of the HIV + adult and pediatric eligible for ART as of the end of 2017; 750,023 in Year 1, 885,165 in Year 2 and 996,593 in year 3.

Implementation approach: Procurement of TDF/3TC/EFV as well as other first and second line regimens.

Referral system for laboratory samples and results

Allocation Request \$	Above Allocation: \$	Total \$
1.074.485	0	1.074.485

Intervention: Referral systems for laboratory samples and results - strengthen timely management of lab sample and results referral systems for biochemistry, haematology, CD4, viral load and PCR tests

Target population and geographical scope: Health facilities providing HIV care, treatment and PMTCT services.

Implementation approach: Establish a network of sample transportation that is routine and reliable in all ART facilities; update health facility lab referral network in accordance with service expansion; scale up transport capacity (follow up with IPs-re: actual costs for transportation). Additional note: Timely receipt of results defined as results returned to patient within 2 weeks of sample collection.

Pre-ART Care

Allocation \$	Above Allocation: \$	Total \$
0	54,291,517	54,291,517

Intervention: Pre-ART - Perform creatinine, hemoglobin, CD4 for pre-ART patients

Target population and geographical scope: Patients enrolled in pre-ART and ART care.

Implementation approach: Procurement of biochemistry, hematology for all patients in care (pre-ART and ART) and CD4 reagents. Assumes 6-monthly HgB and creatinine monitoring for pre-ART and ART patients. The existing guideline recommends 6-monthly hemogram and biochemistry testing for pre-ART patients. A decision was made for the purposes of this application given the new treatment regimen that only CD4, HgB and creatinine would be monitored every 6-months.

Prevention, Diagnosis and treatment OI and STIs

Allocation \$	Above Allocation: \$	Total \$
0	29,847,552	29,847,552

Intervention: Screen HIV patients for cryptococcal meningitis

Target population and geographical scope: HIV+ adults with CD4 <100cells/mm³; district capital health facilities with >1000 patients on ART

Implementation approach: Procurement of cryptococcal antigen tests; Targets: (15% in Year 1, 30% in Year 2)

Intervention: Increase screening, diagnosis and treatment of STIs

Target population and geographical scope: Treat 1.107.806 STI cases in Year 1, treat 570.658 cases in Year 2 and 558.540 cases in Year 3. Geographic scope: general population including pregnant women in all health facilities with ANC services (1,368 HF); partners of index case identified with STIs in all health facilities at national level; key population referred to health facilities (FSW/MSM/mobile populations).

Implementation approach: Procurement of RTK syphilis and RPR reagents; Improve partner notification system by sending partner notices; Provision of STI treatment to 80% of notified partners.

Context: Laboratory testing is necessary to monitor the immunological and/or virologic status of patients, to facilitate staging for ART initiation, as well as for assessment of treatment success or failure (and need for intensified adherence interventions) and need for 2nd line ART. Consistent with WHO recommendations, viral load testing in particular is a more sensitive tool for assessment of treatment success or failure. VL testing in particular is not available widely.

Gap: The MoH will continue to strengthen the laboratory capacity to monitor patients, taking in account the 1st and 2nd line regimens implemented in the country. The requested amount will be invested in procurement of biochemistry 6 parameters, full blood count, urine dip sticks; and expansion of cryptococcal meningitis screening and prophylaxis (and procurement of cryptococcal antigen tests) based on the results of the ongoing CrAg pilot which began in March of 2014. By 2017, all ART facilities will have access to CrAg testing and fluconazole. The requested amount of will be used to procure CD4 and viral load reagents. For the first 2 years viral load expanded access will be focused on patients 'suspected' of treatment failure, while establishing the expertise and logistics networks required to scale-up routine viral load testing nationally as stipulated in the viral load strategy as part of Phase 2. Intensive adherence counselling will be an integral component of the package of services patients will receive when they are suspected of having treatment failure.

Treatment monitoring*

Allocation \$	Above Allocation: \$	Total \$
0	35.484.434	35.484.434

*Note: This aggregated budget covers for the interventions indicated below.

Intervention: Urine dipstick test

Target population and geographical scope: Patients enrolled in ART care; National

Implementation approach: Procurement of urine dipsticks. The existing guidelines recommend 6-monthly haematology and biochemistry testing. A decision was made for the purposes of this application given the new treatment regimen that only CD4, HgB and urine dipstick testing would be monitored every 6-months. Cost reflects full projected funding gap.

Intervention: Perform viral load on HIV patients receiving ART to be phased in in a step-by-step manner.

Target population and geographical scope: Patients enrolled in ART care; National

Implementation approach: Procurement of viral load reagents. In 2015 viral load testing will be used to prevent unnecessary transitions to second-line treatment while the laboratory network is fortified for routine viral load testing. In 2017 routine viral load testing for all ART patients will commence. We assume that there will be additional unit cost decreases by 2017. Routine viral load monitoring for patients on ART will allow for early identification of treatment failure if intensified adherence efforts after a detectable viral load are unsuccessful in re-suppressing HIV viral load.

Intervention: Nutritional support

Target population and geographical scope: HIV and/or TB malnourished adults, pregnant and lactating women and children that are initiating ART; National

Implementation approach: Acquisition of Plumpynut for the treatment of severe acute and malnutrition without complications and Acquisition of CSB or a similar product for the treatment of moderate acute malnutrition.

2.b.ii Community based adherence support

Context: Attrition from care programs remains a challenge and redoubled efforts are needed to improve rates of adherence and retention. Districts with low retention rates have been mapped⁶⁵. The combined effort of community health workers and facility-based health care providers is to reach patients at risk of attrition, and implement adherence and retention activities

Activistas, managed by PR FDC, either directly or through other NGO providers provide consented home visits, cell phone messaging, and patient and family treatment literacy education, are the cornerstone of adherence promotion interventions. Treatment literacy curriculums with broad engagement of community health workers and PLHIV are being developed and will be implemented. *Activistas* will also tracing patients who miss their clinic appointment and reengage them in care.

Treatment Adherence

Allocation \$	Above Allocation: \$	Total \$
1.502.172	2.076.465	3.578.637

Intervention: Treatment adherence - support treatment literacy. **Allocated:** Community-based adherence support in 57 priority district; refresher training for 187 activists; treatment literacy material for health facilities **Above:** Expansion of community-based adherence support to an additional 14 districts to cover all 71 priority districts, including community radio spots.

Target population and geographical scope: General population with specific focus on PLHIV, HIV+ pregnant women and family members.

Implementation approach: Develop, reproduce and distribute treatment literacy materials, purchase of radio-spots and provision of logistic, financial, technical and material support for community-based TB/HIV support groups and HIV network associations. Community mobilization for Community Adherence Groups (GAAC) to provide positive prevention and reinforce treatment retention to ART patients; facilitate creation of new and support existing peer-support groups to provide positive prevention and psychosocial support to PLHIV; provide SMS reminders for ART patients through existing treatment support call center; active follow up for defaulting patients by activists.

3. TB/HIV

The funding required to implement a broad spectrum of TB/HIV collaborative activities in the country, following WHO guidelines⁶⁶, is included largely in the HIV funding request which covers ART medicines and HIV testing; with cotrimoxazole funded by MOH budget; and costs of TB screening both from MOH and PEPFAR budget. TB infection control is included in the TB funding request, as well as from PEPFAR and USAID contributions. IPT for PLHIV is funded from the TB request for procurement of first-line TB

drugs. Coordination meetings between the TB and HIV programs and community care organizations at all levels are covered in the TB and HIV funding request budgets.

The major donor directly assisting the NTP and supporting TB/HIV activities is the United States Government (USG) through PEPFAR funding. The PEPFAR clinical partners support TB/HIV collaborative activities in all 11 provinces and all PEPFAR supported ART sites throughout Mozambique. Through regular mentoring focused on TB/HIV collaborative activities in both HIV and TB sectors, PEPFAR partners conduct clinical mentoring and quality improvement activities in all 467 supported ART sites. \$2.2 million was allocated in COP 13 to carry out these activities. Additionally, \$1.7 million was allocated to procure TB related laboratory reagents, portable X-Ray machines, N95 masks and to cover the financing gap for Isoniazid used to expand coverage of IPT. \$500,000 was allocated to provide TA to improve TB infection control practices and almost \$800,000 was allocated to finance health facility renovations related to TB infection control in PEPFAR supported ART sites and the laboratories in those sites.

The budget allocation for PEPFAR support in COP 2014 will likely remain the same, and the areas of intervention will remain focused on improving TB screening, diagnosis and treatment completion through focused TA, expanding the use of GeneXpert and LED microscopy, and expanding CB-DOTS respectively. Infection control (TA and minor renovations) will continue to improve through ongoing support by PEPFAR partners in all supported sites.

As part of the PEPFAR program, US CDC through the Federal University for Rio de Janeiro (FURJ), The American Society for Microbiology (ASM) and The Association for Public Health laboratories (APHL) is providing support to strengthen TB laboratory services with support from USAID through the follow-on mechanism of TB CARE I. Specifically, ASM is supporting the strengthening of the National Smear Microscopy External Quality Assessment (EQA) program, including expansion to include proficiency testing (PT) panels. APHL is supporting the implementation of an electronic Laboratory Information System (LIS) in the NRL. This is helping to improve the ability to store and manage laboratory data, facilitate retrieval of results, and the production of reports for the NTP. In addition to these activities, Clinton Foundation has focused on the implementation of an SMS system to ensure laboratory results are reaching health facilities in a timely manner.

The following presents the TB/HIV activities in the TB/HIV module and a summary of how the remaining TB/HIV activities are integrated into the HIV, TB, CSS and program management modules of this funding request.

3.a) Training of MOH staff on TB/HIV

Context: Many trainings are conducted by specific disease programs, instead of being integrated, thus creating unnecessary inefficiencies due to repetitive staff absence from work for training.

Training curricula for various MOH cadres will be reviewed and revised, TOT organized followed by cascade training of all levels of MOH health workers using an integrated TB/HIV curriculum with a priority of training healthcare providers working in facilities that offer both HIV and TB services, in order to facilitate implementation of one-stop-model and ART decentralization. During the three years of the grant a total of 2,730 MOH staff will be trained as Trainer (270) or trainee (2,500).

Module: TB/HIV Engaging all care providers

Allocation \$	Above Allocation \$	Total \$
0	4,978,270	4,978,270

Intervention: Engaging all care providers in implementation of integrated package of services through a cascade of training activities.

Target population and geographical scope: Health care workers in all regions.

Implementation approach: Review of integrated training curriculum; TOT and cascade training regionally and in-service training in all provinces.

3.b) Establish a standardized, integrated TB/HIV service package for community Activistas, provide training and support operational costs

Context: The Government of Mozambique, in close collaboration with funding and implementing partners and CBOs, are expanding the numbers and skills of community *Activistas*, who can manage the out-of facility components of both TB and HIV care through CB-DOTS, HTC, adherence support, and TB screening. Mozambique is further integrating its community platform to ensure that the natural synergies of joint disease management in the community are maximized.

The full financing request includes a total of 3,705 community-based *Activistas* to be supported through the FDC grant to support the national TB/HIV response. The service packages build on the HIV prevention packages developed for key affected and vulnerable population during Phase 2 of the FDC grant.

In modules for HIV prevention programs: The 2,746 *Activistas* working with key affected and vulnerable populations will benefit from training on an integrated TB/HIV service package that incorporates TB screening, referral and treatment in their set of delivered services. These *Activistas* will work in all 71 priority districts.

In the modules for TB community care delivery, 241 *Activistas* will deliver CB-DOTS, HIV counseling and testing, community sputum fixation, nutrition monitoring, screening for TB symptoms, contact tracing, adherence and patient support for both TB treatment and ART. These activists will work in 15 of the 71 priority district which have a high burden of TB (high notification rates), and/or 6 or more MDRTB cases notified annually.

In the HIV treatment adherence intervention: 241 *Activistas* will support HIV adherence activities, which will include screening for TB symptoms, contact tracing, adherence and patient support for both TB treatment and ART. These *Activistas* will work in all 71 priority districts.

The relevant modules contain the operation costs of technical assistance, training, IEC materials, and subsidies for the activists. The total investments request is \$18.2 million, \$15.4 million in allocated funding and \$2.8 million in above; the above allocated request targets expanding coverage to all 71 districts in the HIV Acceleration Plan, an additional 14 districts to the 57 covered in the allocated funding request.

3.c) Review and revision of service packages and data collection tools for TB/HIV activities conducted by CSOs.

Context: Many community organizations implement similar but non-harmonized service packages for TB/HIV activities and collect data on their operations, but use their own donor demanded formats. These tools will be essential to standardize service delivery and data collection across all implementers and produce reliable data reflecting the contribution of the community care organizations to case detection and improved treatment adherence to TB treatment and ART.

In modules Treatment, Care, and Support/Treatment Adherence intervention and Community Systems Strengthening/Social mobilization, building community linkages, collaboration and coordination intervention: National consultants will review the existing service packages and data collection tools, and in consultation with all stakeholders align the service packages and develop a standardized reporting tool; these tools will be printed and disseminated to all relevant activists.

3.d) Coordination of community care organizations with MOH at facility and district level.

Context: Implementers noted that communication and coordination between MOH and CSOs often leaves to be desired.

There will be monthly meetings between CSOs and MOH/NGO Health Facility community care coordinators, and of CSOs and MOH district management for ensuring optimal collaboration, quality of care and mutual accountability of community care operations towards the donor, MOH and other stakeholders.

3.e) Supervision

Context: Regular supervision of implementers by FDC is important and needs to be strengthened along with the expansion of community health care activities to 71 districts.

FDC central office will conduct 6-monthly supervision to contracted community organizations at the provincial level, and quarterly integrated supervision from provincial to district level CSOs. FDC will verify that contracted CSOs adhere to agreed procedures on output reporting and that their progress reports are in line with observations in the field.

3.f) Community systems strengthening:

Context: FDC and implementing CSOs often have lack of capacity for the implementation of Global Fund supported activities, resulting in lack of absorption of project funds and insufficient reporting of project deliverables.

In module community system strengthening/grant management interventions: FDC (PR for TB and HIV community care and support) and sub recipient organizations require capacity building on Global Fund grant management and implementation of the HIV/TB care package, including: a) management training, financial management, recording and reporting; b) technical expertise in TB and HIV; c) program supervision, recording and reporting and M&E; d) training of trainers in community health care interventions.

4. TUBERCULOSIS

USAID, through TBCARE I is providing direct support to the NTP regarding: support for training and supervision; coordination of the TB Task Working Group and other sub-working groups (laboratory, MDR-TB, DOTS); development of TB/HIV policies, strategies, and guidelines; implementation of GeneXpert; expansion of laboratory networks; support for community care interventions including treatment literacy, education, and advocacy; community-DOTS activities in 54 districts in 2014.

Besides the 53 districts covered by TB Care, there are other initiatives for community activities in Zambezia Province by FGH which is funded by CDC and World Relief totalling 63 districts (49% of the districts in country) with community activities focused specifically for TB. Other organizations such as VSO, Solidarmed, are implementing HIV/TB activities and their impact in TB activities is not measured yet by the NTP. It is established in the National Strategic Plan for community engagement in TB that NTP will map all the organization financing and implementing community activities, and measure their contribution to case detection and treatment success. In this Global Fund grant 15 priority districts for DOT where subsidised volunteers will be performing home based DOT, contact screening and sputum referral, as well as contact follow is under FDC grant. Additionally, under this grant another 57 districts will be performing TB/HIV activities, symptomatic active screening and sputum referral will be performed to ensure increased case detection, along with treatment support for TB/HIV patients.

USAID has indicated interest to continue support to NTP under the follow-on mechanism of TB Care I, which ends in December 2014.

4.a) TB care and prevention

Context: This grant application builds on and is a continuation of the U\$27million grant that NTP has received as interim funding. It sustains investments and activities already funded under the previous grant after the grant stops (June 2017). This grant will fund further expansion of the laboratory network, community care, MDR-TB diagnosis and treatment, pediatric diagnosis and treatment, introduction of an electronic TB Register, specialized training (MDR-TB, pediatric TB) regular supervision and coordination meetings. USAID is expected to continue funding community care, technical assistance through the new Challenge TB mechanism for the prevalence survey, laboratory strengthening, TB control in prisons, the electronic surveillance system etc. However, given that TB Care is ending at the end of 2014, 13 of 22 FDC priority districts for community TB care will overlap the TB Care I districts. The main reason for this overlap is it is of utmost importance to maintain funding for community activities in those districts that have had successful performance and where community activities may have great impact, factoring in the criteria of the burden of disease and population density.

The expectation is that the increase of the number of CHWs by integration of TB and HIV CHWs and the introduction of a comprehensive TB and HIV package of interventions will result in more identification and referral of persons with presumed TB to the nearest laboratory; or that the CHWs obtains a quality sputum sample and refers this to the nearest lab; and conducts follow-up on the lab results and the persons with presumed TB. The package of CHW would include: contact investigation through a household visit during which contacts are screened (symptom screening), referral for initiation of IPT or investigation for TB disease; tracking of lab result and patient.

Gap: The allocation funding for the TB program will be utilized to support implementation of the Laboratory Expansion Plan. Funds from the NFM application will be leveraged to expand and improve the laboratory sample transportation network and results reporting system that will support sample transport and results reporting for both diseases between health facilities and nearby laboratories. Integrated training of medical personnel on both HIV and TB will enhance Early Infant Diagnosis of HIV and TB among children in RMNCH settings, and enhance access to both pediatric HIV and TB treatment.

The following investments will be made: i) investments into expansion of the laboratory network and laboratory techniques (LED-FM, GeneXpert, C/DST) (following the goals set in the National Strategic Plan of the NTPC, the country decided to expand the use of the GeneXpert machines from 16 in 2013 to 101 in 2017 machines. The machines will be placed in districts with a high burden of TB, with a high number of patients retreatment and also according to the weight of HIV, as described in Guideline for use of the GeneXpert in Mozambique that follows as an appendix (see pages 53 and 54); quality assurance, sputum sample transportation will be sustained and expanded (procurement of equipment and lab consumables and supply management- US\$2.7m) ; ii) cough days will be organized in all districts, at which community members can present for examination for TB orientation and involvement of community workers in suspect identification and referral; iii) Training of lab staff and clinicians on GeneXpert and LED-FM; iv) Diagnostic tools for pediatric TB (nebulizers, gastric tubes); v) costs of technical assistance by the Supra National Reference Laboratory in Milano, Italy. SRL provides EQA for FLD and DST of second-line drugs, and other lab technical assistance towards certification. vi) laboratory sample transportation system.

Case detection and diagnosis

Allocation \$	Above Allocation: \$	Total \$
5.804.971	44.225	5.849.196

Note: in Module TB care and prevention.

Intervention: Case detection and diagnosis. **Allocation:** see activities below. **Above:** training for provincial and district lab staff.

Target population and geographical scope: NTP is operating countrywide

Implementation approach: Continuation of laboratory functions initiated under NFM Interim grant. This includes: a) ZN, LED-FM, GeneXpert and Culture/DST for both first- and second-line anti-TB drugs; b) Cough days in each district; c) Training of provincial and district laboratory staff; regional trainings on GeneXpert for lab staff and clinicians; procurement of lab reagents and PSM costs; procurement of pediatric lab diagnostic equipment. d) Contact tracing in the household members and neighbors of the index patient; Transportation of samples of contacts to the health facility twice a week; Reference contacts for early treatment of TB; Reference contacts that require other tests to diagnose TB Community HIV testing of the contacts; Referral of children under five years in contact with DOT patients to start prophylaxis with isoniazid; Follow up of the child in prophylaxis and referral in cases of adverse effects or onset of symptoms of TB.

Collaborative activities with other programs and sectors

Allocation \$	Above Allocation: \$	Total \$
995.387	221.374	1.216.761

Note: in Module TB care and prevention.

Intervention: Collaborative activities with other programs – nutritional supplements for pediatric and MDR TB cases. **Allocated:** Corn soya blend for pediatric TB and MDR TB patients; **Above:** Plumpy nut for pediatric and MDR –TB patients receiving TB treatment.

Target population and geographical scope: Pediatric TB and MDR-TB patients nationally.
Implementation approach: Treat pediatric TB patients and MDR –TB patients with moderately acute malnutrition and severely acute malnutrition with corn soya blend. Treat pediatric TB patients and MDR –TB patients with moderately acute malnutrition and severely acute malnutrition with F75, F100, and Plumpynut.

Community TB care delivery

Allocation \$	Above Allocation: \$	Total \$
5.949.204	0	5.949.204

Note: in Module TB care and prevention.

Intervention: Community TB care delivery

Target population and geographical scope: National Level.

Implementation approach: Train trainers at provincial level to provide integrated training on TB and TB/HIV. This will be done one time in the second year of this grant. The first time is done under the interim NFM grant.

Intervention: Community TB care delivery

Target population and geographical scope: Training 718 new activists for community DOTS in 15 high priority districts (chosen from pool of 900)

Implementation approach: The selection of priority districts was based on the need to improve treatment outcomes for MDR-TB, and to improve contact screening in high burden districts. Priority was given to districts with high burden of TB (high notification rates), or 6 or more MDRTB cases notified annually.

Community awareness, TB screenings and sputum referrals and contact tracing without DOT and TB patient follow up will be integrated into 57 districts, within HIV community activities, where FDC is already performing HIV activities such as awareness, community VCT, home based care and treatment support (funding for this is in module of each HIV key affected population).

4.b) Engaging all providers

Context: Knowledge on TB and HIV clinical management is often not at the required level of the National TB and TB/HIV Guidelines which have recently been updated with new guidance on GeneXpert testing and diagnosis and treatment of MDR-TB.

Gap: MOH is providing training to MOH and private clinicians on TB and TB/HIV, as well as to traditional healers.

Engaging all care providers

Allocation \$	Above Allocation: \$	Total \$
89.889	79.647	169.536

Note: in Module TB care and prevention.

Intervention: Engaging all care providers. **Allocated:** annual provincial coordination meeting for traditional healers. **Above:** Regional trainings on infant TB and training of clinical staff.

Target population and geographical scope: Private sector and Public sector health providers and Traditional Healers.

Implementation approach: Annual training for clinical staff on TB and TB/HIV twice yearly in each province. Deliver full or partial TB management (referrals for diagnosis and treatment); taking in account that cases detected in the private sector are notified to the NTP health facilities, prerequisite for drugs supply by the NTP; enforce notification system to capture cases detected in private sector. For traditional healers, provide annually training in each province to raise awareness of TB and TB/HIV and motivate them to refer patients with presumed TB to the health facility.

4.c) Treatment of patients with drug susceptible TB

Context: The NTP has initiated expansion of the laboratory network as a first priority for increasing case-detection. This has started with funds from the Interim Funding grant and needs to be complemented

and sustained with this grant application, in order to ensure that diagnostic and treatment services will be available and providing high quality services.

Gap: This grant will support: i) procurement and supply management of first-line TB medicines for adults and children. This includes a limited provision of TB drugs to private health care providers on the basis of information on diagnosed patients who are then also notified to NTP ii) training of Central Medical Stores staff on TB medicines; iii) Regional trainings on pediatric TB; iv) training on supply management for technicians; v) TOT training for provincial staff on training in TB and TB/HIV.

TB Treatment

Allocation \$	Above Allocation: \$	Total \$
3.056.075	184.572	3.240.647

Note: in Module TB care and prevention.

Intervention: TB Treatment. **Allocated:** First line treatment including PSM costs and PSM trainings at district level. **Above:** Regional trainings on logistics management and ToT courses for provincial staff to provide comprehensive training to district staff on implementation of DOTS and TB/HIV interventions.

Target population and geographical scope: all TB patients, focus in the priority districts.

Implementation approach: The funds provide for procurement of: first-line TB drugs, and isoniazid for IPT; Procurement and supply management by CMAM; training of CMAM staff on TB drugs management (twice per year); PSM training for health technicians (2x per year in each region); quarterly supervision by central level staff to all three regions (2x per year); quarterly supervision from provincial level to all districts; regional trainings on pediatric TB (2x per year). Support on ART adherence in patients on TB/HIV Community DOT and adherence to anti-TB tablets; Education of patients and contacts about TB infection and control at home; Provide HBC for patients under DOT; Follow-up of Patients and reference TB spectrum samples for examinations and controls; Referral of patients with adverse drug reactions.

4.d) TB Prevention

Context: Country policy is that IPT is prescribed for PLHIV in the absence of active TB disease, and for children under 5 years of age who are close contacts of a sputum-smear positive index patient. Uptake of IPT for PLHIV and eligible children is low. The NTP intends to expand IPT to both target groups.

Gap: Through integrated TB/HIV training and regular supervision, health workers will be supported to increase the number of PLHIV on IPT. Through community HIV/TB care activities families affected by HIV and TB will be visited in their homes by community workers, and be screened for TB. This will identify child contacts eligible for IPT. The numerator for children who are expected to be treated is aspirational. The denominator is based on the assumption that there is at least one child contact <5 per ss+ index patient notified. The budget pays for procurement and PSM of isoniazid tablets. Training on IPT is integrated in all TB/HIV training.

TB Prevention

Allocation \$	Above Allocation: \$	Total \$
1.500.842	148.231	1.649.073

Note: in Module TB care and prevention.

Intervention: TB Prevention. **Allocated:** procurement of health commodities and equipment; **Above:** Regional trainings on infection control.

Target population and geographical scope: All health facilities with priority for busy HIV clinics and general health centers and hospitals.

Implementation approach: Procurement of N95; fit test kits; construction of simple open air waiting shelters or other simple renovations; UVGI in well targeted places where natural ventilation is poor; ceiling fans; IB-IC measuring equipment (vaneometer, UV meter, smoke tubes), TB-IC training; regional trainings in TB-IC for HCWs. Health care worker surveillance will be maintained in all health facilities, and focus both on TB and HIV among health workers; organized by TB-IC programs such as initiated by JHIPIEGO and TB CARE I, and now in over 60 health facilities.

4e) MDR-TB case detection and diagnosis

Context: The number of patients projected as being diagnosed and started on treatment out of estimated incident patients, is increasing due to an anticipated increase of overall case-detection (see above) and expansion of access to testing using GeneXpert and C/DST. MDR-TB treatment coverage of estimated annual incident MDR-TB patients is expected to rise to 44% in 2017. If the TB prevalence survey shows different prevalence rates of TB than currently estimated - this may cause the number of estimated MDR-TB diagnosed and started on treatment to change. The data of a second Drug Resistance Survey (planned for 2017) may also result in an up- or downward adjustment of estimated MDR-TB incidence.

Gap: This grant provides funding for: i) costs of MDR-TB diagnostic tests (GeneXpert cartridges, and DST); ii) PSM for procurement of these tests and other consumables.

Case detection and diagnosis MDR-TB

Allocation \$	Above Allocation: \$	Total \$
798.756	0	798.756

Note: in Module MDR-TB.

Intervention: Case detection and diagnosis: MDR-TB

Target population and geographical scope: The target population comprises of all notified retreatment patients, as well as other eligible high risk

Implementation approach: Categories (health care workers, primary contacts, miners, prisoners, children, new smear positive cases who do not convert smear on 2nd month) which will be tested with GeneXpert and C/DST. Increasingly also new HIV+ persons with presumed TB will be tested with GeneXpert for MTB, of whom some will be diagnosed with MDR-TB. A sample referral system using courier services will be established to strengthen sputum referrals from the districts to GeneXpert sites for MDR-TB diagnosis.

4.f) MDR treatment

Context: Patients diagnosed with MDR-TB need to be started on the appropriate treatment as soon as possible, in the absence of any waiting list. With the expansion of GeneXpert and the laboratory network the number of patients diagnosed will increase substantially, as will the need for treatment. Current treatment success is poor (36% in 2011 cohort). Lack of knowledge on MDR-TB clinical management including side-effect management attributes to this.

Gap: This grant supports: i) procurement and supply management of second-line TB drugs for MDR- and XDR-TB patients; ii) specialized supervision by national and provincial staff on MDR-TB iii) Green Light Committee contribution; iv) international MDR-TB training; v) national MDR-TB training; vi) cascade training in all three regions vii) procurement of 20 audiometers

Treatment for MDR-TB

Allocation \$	Above Allocation: \$	Total \$
3.641.717	350.551	3.992.268

Note: in Module MDR-TB

Intervention: Treatment: MDR-TB. **Allocated:** Second-line treatment; audiometers; transportation incentives for MDR-TB patients; training of clinicians in PMDT and MDR-TB; GLC fees. **Above:** MDR-TB program supervision; additional training for health workers

Target population and geographical scope: Nationwide population is targeted, with priority to 6 high burden provinces.

Implementation approach: 1. Along with GeneXpert expansion and diagnosis of MDR-TB, treatment capacity will be expanded ensuring that every diagnosed patients can be started on treatment as soon as possible with minimal delay. 2. Patients are admitted initially for clinical evaluation (biochemistry, audiometry, HIV testing and counseling etc.) in 12 provincial MDR-TB treatment centers. When the patient is well oriented and on treatment (e.g. also ART) and ambulatory care organized, the patients will be discharged and continue ambulatory treatment at their nearest health facility to place of residence. Patient management may involve both health workers and community case workers. Quality of MDR-TB care will be strengthened by strictly quarterly evaluation of every patient on treatment

through patient card reviews during supervision, also ensuring correct and timely recording and reporting of MDR-TB data. The budget includes: quarterly supervision from national to provincial level, provincial supervision in 6 priority provinces, international training for 3 persons (per year), one national training of 5 days for 30 persons (year 2 and 3), procurement of second-line drugs and PSM costs, costs of 20 audiometers for baseline and audiogram monitoring, training of health workers (doctors, nurses, technicians). Standard costs of GLC affiliation is covered by this budget.

4.g) MDR prevention

Context: The establishment of a TB-IC workplan is hampered by the lack of reliable information on the actual situation of TB-IC in all health facilities.

Gap: Funds from this application will be utilized to map health facilities by conducting health facility assessments, assess TB-IC plans and work practices, and assist in the preparation and implementation of high quality and implementable TB-IC plans in hospitals and major health centers, ART clinics, and MDR-TB admission facilities. A portion of this expansion will be implemented with PEPFAR funding through JHPIEGO, and USAID funding through a new funding mechanism, entitled Challenge TB. There will also be procurement of three different sizes of N-95 masks and fit testing equipment; ii) UV meters, vaneometers, smoke tubes; iii) UVGI equipment and their maintenance; iv) ceiling fans for air mixing; v) funds for simple renovations for TB-IC such as open air sun/rain shielded waiting areas. vi) regional trainings on TB-IC.

Prevention for MDR – TB

Allocation \$	Above Allocation: \$	Total \$
5.132.448	0	5.132.448

Note: in Module MDR-TB

Intervention: Prevention for MDR-TB

Target population and geographical scope: TB-IC measures will be implemented in all MDR-TB admission facilities.

Implementation approach: TB-IC plans will be developed in combination with staff training for all staff. Implementation will be monitored through integrated supervision. Community-health workers will be oriented during training. Patients and family will be oriented on TB-IC measures in the household. Refurbishment and renovation will be done in prioritized high-risk areas in particular for care of MDR-TB patients.

5) Health System Strengthening – Procurement Supply Chain Management

5.a) LMIS

Context: CMAM's inventory and stock control reporting system, "SIMAM" (*Sistema de Informação de Medicamentos e Artigos Medicos/Information System for Medicines and Medical Supplies*), is used at 160 sites by the provincial and district warehouses and some hospitals. Due to the extent of the distribution of the system, CMAM staff cannot adequately support the staff and the equipment on a routine basis. Therefore, under financing from HSS Round 8, one of the activities is to establish service contracts to support the staff, equipment and software so that there is a reliable system in place to report stock levels and usage on a routine basis, thus leading to a country-wide stock control system. This activity is funded through 2016.

Gap: The proposal in the NFM is to extend this activity into 2017, and to add training activities, as new sites are included in the system, and to cover new staff, due both to new sites and to turnover and increase in staff using the system. This will allow for a more efficient procurement operation, to keep up with the country's demand for medical supplies and equipment

HSS-LMIS*

Allocation \$	Above Allocation: \$	Total \$
0	214.272	214.272

* Note: In module PSCM.

Intervention: Regional training to improve the management information system for drugs and logistics.

Target population: Provincial health workers from all provinces.

Implementation approach: Annual training for 145 participants on LMIS.

5.b) Infrastructure rehabilitation

Context: The Central Medical Stores of Mozambique (CMAM/Central de Medicamentos e Artigos Médicos) was allocated funds from HSS Round 8 in order to strengthen the medical supplies logistics systems. These activities are directly related to CMAM's PELF⁴⁹ (*Strategic Plan for Pharmaceutical Logistics*) that was approved by MoH in 2013. The PELF Implementation Plan (PDI)⁵⁰ recommends the elimination of one level in the supply chain (combine the current 11 provincial warehouses and 144 district warehouses into 20-30 intermediary warehouses.), along with initiation of CMAM supervision of the intermediary warehouses rather than provincial or district health directorates).

Funds from HSS R8 are supporting the HSS Grant, Round 8, are to renovate nine of the existing 11 provincial warehouses to bring the provincial warehouses, that will become some of the intermediary warehouses up to a standard of adequately storing pharmaceuticals and other sensitive health products, ensuring that the warehouse is secure, that operations to receive and distribute stock are efficient, and that the staff have an adequate working environment.

Gap: The proposal in the NFM is to complete the strengthening of intermediary warehouses. 10-20 of the current District Warehouses will be covered in the renovations, to transform these sites to be intermediary warehouses. The district warehouses to be upgraded into intermediary warehouses will be identified during 2015, with construction contracts to be issued in 2015 and 2016. As the PELF is implemented, commodities will be distributed directly from the three central warehouses to the 20-30 intermediary warehouses (with vehicles purchased under HSS R8) and from them to the health facilities. The proposal in the NFM is to strengthen the distribution from the intermediary warehouses to the more than 1,400 health facilities through the purchase of fifty closed pick-up trucks.

PSM infrastructure and fleet expansion*

Allocation Request \$	Above Allocation: \$	Total \$
0	7.562.900	7.562.900

*Note: In module PSCM.

Intervention: Warehouse rehabilitation and fleet expansion

Target population and geographical scope: National.

Implementation approach: Warehouse rehabilitation; acquire new vehicles for distribution of medical products (including car insurance and maintenance). Pay for insurance and fuel for one year.

6. Health workforce: Strengthening the human resource availability for HIV and TB programs, including recruitment and training of new staff for the TB services and ART sites; and on the job training and task shifting implementation:

Overall, Mozambique is historically hampered in its capacity to deliver effective and quality health services due to systemic and structural challenges affecting the health and community sectors. There is a limited and deficient health infrastructure, shortages of skilled human resources and low health worker/population ratio. Financial and management weaknesses and limited laboratory capacity are part of the key structural challenges affecting the health system. There are persistent weaknesses in establishing effective linkages with community structures to expand the continuum of health provision and care to the community level.

The Government of Mozambique is fully aware of those challenges and during the last decade has been committing its resources and mobilizing donors and stakeholders contribution, and in particular technical support from PEPFAR, to address the HSS and CSS constraints and gaps in order accomplish the national health outcomes in general as well as TB program targets, and the targets outlined in the HIV Acceleration Plan.

As noted in section 2 above, a significant portion of the HSS investments can be attributed directly to HIV and TB. The GFATM is one of the key partners contributing to address some of the critical HSS constraints. The R8 HSS grant includes cross cutting health system strengthening activities designed to

support the cross cutting needs of the disease specific programs without duplication, inclusive of the Malaria R9 grant recently rolling out as per July 2014.

Taking into account the on-going investments to improve HSS and CSS, this proposal aims to cover, with no duplication of activities covered by the R8 grant or other donors' contribution to health system strengthening, the gap for the effective delivery of TB and HIV services. The objective is to sustain the current pace of enrolment in ART and improve the diagnostic and community support needed to provide quality TB and HIV services in prioritized districts. As indicated in the modular template, additional investment in human resources training and on the job capacity building, strengthening of the laboratory capacity critical, mobilize and engage community structures to the grant are enablers to meet the HIV and TB treatment and prevention targets.

As in other modules, PEPFAR is the major bilateral donor and provider of technical support to optimize the deployment of HRH to scale up priority districts. PEPFAR's strategic approach is to:

1. Improve the planning and allocation of HRH to health facilities to support equitable distribution and prioritization of HIV services scale up;
2. Improve in-service training, management and supervision of HRH through the use technological enhancements and better management practices;
3. Improve the quality of nursing practice and its utilization

During 2013, 1,415 new health workers graduated with PEPFAR support, and an additional 4,561 are currently being supported to graduate in future years. By 2015, PEPFAR will have supported 7,410 additional health workers, contributing to the 140,000 target by expanding pre-service training through scholarships, and curricula development.

6.a) Training health and community work force

Scaling up health and community workers*

Allocation \$	Above Allocation:	Total \$
1,415,083	2,906,557	4,321,640

*Note: In module HSS- health and community workforce.

Intervention: Health and community workers capacity building - Training for Community HIV Counselling and Testing (CHCT) activists. **Allocated:** Refresher training of 258 existing CHCT activists to and payment of subsidies to cover 57 priority districts; **Above:** Expansion to additional 14 districts so all priority districts are covered; training and subsidies for 43 additional activists;

Target population and geographical scope: Training for 43 new CHCT activists To expand community health work current from 57 (with FDC presence) to 71 districts

Implementation approach: Refresher training for 43 CHCT activists in year 2. FDC will strengthen its capacity to deliver CHCT through specific activists trained by MoH.

Intervention: Above: Scaling up health and community workers - Provide scholarship support for national mid-level pre-service training of 6 classes of pharmacy technicians

Target population and geographical scope: Scholarship support for national mid-level pre-service training of 6 classes of pharmacy technicians. National

Implementation approach: These 30 student courses are implemented in 2 years in the MOH mid-level training institutions. The curriculum is composed of 3 semesters of in-class and practicum work and the last semester includes a rural internship. After completion of the course, the students conduct a theoretical and practical exam that includes an oral component. Graduates will be allocated to national health facilities (Plano de Formação 2011-2015)

Intervention: Above: Scaling up health and community workers - Provide scholarship support for national mid-level pre-service training of 4 classes of lab technicians

Target population and geographical scope: Lab technicians; National

Implementation approach: As above.

Intervention: Above: Scaling up health and community workers - Provide scholarship support for national mid-level pre-service training of health statisticians

Target population and geographical scope: 33 Health statisticians; National

Implementation approach: As above.

6.b) In-service training of health workforce

Health and community workers capacity building

Allocation \$	Above Allocation: \$	Total \$
0	2.626.200	2.626.200

*Note: In module HSS- health and community workforce.

Intervention: Health and community workers capacity building - Provide 4 week in-service trainings for 832 TB nurses and basic level clinical officers on HIV to support task-shifting and ART expansion

Target population and geographical scope: 832 TB nurses; National

Implementation approach: Curriculum includes 2 weeks of theory followed by 2 weeks of practical sessions and a pre/post-test. The main focus of the training is TB/HIV management for children and adults including HIV/TB prevention, diagnosis, care and treatment, palliative care, gender-based violence and post-exposure prophylaxis, opportunistic infections, MDR-TB, and prevention with positives. Each trainings is composed of 30 participants

Intervention: Health and community workers capacity building - provide in-service training on Option B+ to 510 basic and mid-level MCH nurses.

Target population and geographical scope: Basic and mid-level MCH nurses; National.

Implementation approach: Implementation approach: these on-the-job trainings are conducted in 4 weeks. 2 weeks of trainings is theoretical and 2 weeks are practical. Training includes a pre/post-test. The main focus of the training is TB/HIV management for children, pregnant and breastfeeding women, TB/HIV prevention, diagnosis, care and treatment, gender-based violence, post-exposure prophylaxis, opportunistic infections, MDR-TB, and prevention with positives. 30 nurses will participate in each training.

6.c) Recruitment and salaries of health staff

Retention health and community workers

Allocation \$	Above Allocation: \$	Total \$
0	1.126.080	1.126.080

*Note: In module HSS- health and community workforce.

Intervention: Retention and distribution of health and community workers - Support recruitment cost and salaries of 276 data clerks for sites implementing TB/HIV Electronic Patient Tracking System (EPTS)

Target population and geographical scope: 276 Data clerks, National

Implementation approach: Training will focus on core skills of data abstraction, data entry and quality control, use of EPTS for HF level patient monitoring and LTFU detection. Training will also include a module on ethical issues related to patient-level data and confidentiality. This cadre will conduct retrospective data entry using paper-based patient records in medium volume ART facilities (500-2,000 patients in ART)

7) Building linkages, standardized packages of services, coordination and accountability for community health work on TB and HIV

Module: Community Systems Strengthening

Community strengthening module and interventions aims to strengthening good governance and performance on community health related interventions through provision of systemic investment to disseminate the GF grant among health community work providers, strengthened the capacity of SR to deliver quality services, promote wide adoption and implementation of standardized package of services for specific key and vulnerable populations and ensure that the community work is contributing to the national strategies and goals. A great part of the funding request is being implemented through community organisations. Salaries and activist training costs are included in respective activity modules throughout the concept note. Community accountability mechanism will be supported under this grant as well as the country efforts towards development of common and effective patterns for community

health work. District, province and national coordination meeting will be supported and best practices of intervention of HIV and TB will be documented and shared. Specific activities under the CSS component are in CSS the modular template as follow:

Social mobilization, building community linkages

Allocation \$	Above Allocation: \$	Total \$
182.449	0	182.449

Intervention: Social mobilization, building community linkages, collaboration and coordination - Build a conducive environment at community level to enable a successful implementation of prioritized interventions

Target population and geographical scope: Community leaders, committees, and champions in 11 provinces and 71 priority districts

Implementation approach: Validation of respective packages of services (FSW, MSM, young girls, woman at a reproductive age, sero-discordant couples, TB/HIV, workplace, miners, LDTD, community DOTS), engaging multiple stakeholders at central and provincial level, to ensure adherence to rights and gender approaches, address stigma and discrimination; revise advocacy guidelines for community based advocacy; implementation of district sessions with community leaders, committees, and champions to ensure buy in on the intervention package.

Intervention: Social mobilization, building community linkages, collaboration and coordination - Strengthen standardized approaches to community health work

Target population and geographical scope: CSO Platform, CSO, NGOs, FBO, CBO and community health workers in all implementation sites.

Implementation approach: Develop SOP for community implementation to ensure that CSOs deliver complementary and standardized services that respond to the national strategies; produce a disseminate an annual booklet to compare the results of the community accountability tool, grant implementation results, and best practices; facilitate participation of SRs in robust national dialogue to standardize community health workers' classification, including incentives and compensation. This will support a long-term sustainable approach for community health work across the three diseases.

Capacity Building for SRs

Allocation \$	Above Allocation: \$	Total \$
11.715	0	11.715

Intervention: Institutional capacity building, planning and leadership development at community level - Strengthening SRs capacity to deliver quality community health services with linkages with health facility

Target population and geographical scope: 2 Selected SRs at Provincial and district level

Implementation approach: Capacity building for two selected SRs in institutional/organizational with focus on leadership, governance sustainability, program implementation cycle (Planning, M&E, Reporting), and financial management (accountability, reporting).

Community-based monitoring for accountability

Allocation \$	Above Allocation: \$	Total \$
252.812	7.584	260.397

Intervention: Community-based monitoring for accountability - Strengthen community monitoring and accountability capacity. **Allocated:** Activities in 57 priority districts; **Above:** Activities in 14 additional priority districts in order to cover all 71 priority districts.

Target population and geographical scope: CSO Platform at Central level, 11 CSO platforms at provincial level, and 71 district coordination forums in 71 priority districts.

Implementation approach: Revise the community accountability tools to assess progress in community health services delivery (ex: community score cards) for use in all communities; Train community facilitators to carry out community monitoring and accountability sessions; Conduct community and accountability monitoring session.

8) Health Information Systems and M&E

Module: Health Information Systems and M&E

Context: The NTP is revising its recording and reporting tools according to the 2013 WHO revised definitions. In addition it is developing an electronic TB register to be piloted in late in 2014. A nationwide scale-up is expected to begin in 2015 at district level. This system will allow data quality improvement as well as timely reporting.

Gap: Mozambique is proposing NFM support to strengthen both surveillance-based and routine monitoring and evaluation systems. This includes support for activities designed to enhance national vital registration systems to ensure the availability of critical data pertaining to both the general population as well as key populations disproportionately contributing to the national TB and HIV epidemics, and to ensure continued monitoring of TB and HIV drug-resistance. In addition, the routine health information system will be strengthened through ensuring the uninterrupted availability of paper-based M&E instruments at all TB and HIV service delivery points and through expansion and consolidation of existing and to-be-developed electronic medical records systems specific to the two disease areas. Finally, a series of activities focused on improving both the quality and use of data emanating from the health information system are proposed. In-country capacity will be augmented by training additional statisticians to assist the districts manage the data coming out of the various disease programs, as current capacity in this domain is limited. Standardized data quality assessments will be implemented. The grant will fund: i) the first TB prevalence survey in the country, which is due to start in 2015. Co-funding will come from USAID and MOH Mozambique. The prevalence survey will provide a more accurate estimate of the TB and MDR-TB burden (the second drug resistance survey is funded from the Interim Funding grant) and guide future program policies and strategies; ii) annual national training in M&E; iii) annual TOT of provincial supervisors on data management, interpretation and quality assurance; iv) quarterly provincial M&E monitoring meetings; vi) procurement of the hardware for an electronic patient-based TB surveillance system.

Routine Reporting - TB

Allocation \$	Above Allocation \$	Total \$
1.312.038	86.898	1.398.936

Intervention: Improvements data quality in routine TB reporting. **Allocated:** All activities below except; **Above:** Central level trainings on M&E.

Target population and geographical scope: Nationwide scale up is foreseen to begin in 2015 at district level. This system will allow data quality improvement as well as timely report.

Implementation approach: NTP Is revising recording and reporting tools according to the 2013 WHO revised definitions, In addition is developing an Electronic TB register to be both piloted in 4rd quarter of 2014. Scale up will be gradual, starting from high TB notification districts. 2) Data quality. Supervision costs are already covered by the Interim funding. Currents request will have to include purchase of computers and internet mobile devices.

TB Prevalence Survey

Allocation \$	Above Allocation \$	Total \$
2.935.347	0	2.935.347

Intervention: TB Prevalence Survey and operational research.

Target population and geographical scope: The start of the first prevalence survey in MOZ is planned for 2015.

Implementation approach: Conduct prevalence survey based on protocol and budget developed by technical partners in line with international guidance. It is planned for 2017. These surveys will allow to determine the real TB burden of TB and MDR-TB and guide program policies and strategies

Vital Registration System

Allocation \$	Above Allocation: \$	Total \$
600.000	0	600.000

Intervention: Vital registration system - Expand use of MoH death registry database (SIS-ROH) to all district hospitals by 2017.

Target population and geographical scope: SIS-ROH to be implemented in all 148 district hospitals by 2017.

Implementation approach: Funding requested to contract for assistance in implementation of SIS-ROH in remaining district hospitals where system is not currently in use. Funding will also cover costs for needed software upgrades and hardware for new installations. Other relevant information: An expanded SIS-ROH will provide an important data source to the national Vital Statistics Working Group, comprised of MOH, INE, MinJust, UEM, MOASIS, UNICEF, WHO. This includes data around TB/HIV related mortality which can be used to better understand the impact of and the effectiveness of the national response to HIV. The broader effort to support SIS-ROH expansion is being supported by WHO and CIDA (Canada).

Surveys HIV

Allocation \$	Above Allocation \$	Total \$
0	3.261.269	3.261.269

Intervention: Above: Conduct 2016 & 2017 Integrated Bio-Behavioral Surveys (IBBS): FSW and miners (2015), MSM (2016) and Mobile Populations (2017).

Target population and geographical scope: Miners and truck drivers concentrated in Tete, Gaza, Inhambane and along transport corridors in Mozambique.

Implementation approach: Conduct 2017 IBBS designed to measure HIV prevalence and risk behavior as well as to produce population size estimates to be conducted with support of Global Fund NFM. Other relevant information: 2016 and 2017 IBBS to be co-funded with PEPFAR. Mozambique proposes leveraging NFM funds to support implementation costs (i.e. personnel and training) and PEPFAR funds to support needed lab materials (i.e. HIV test kits, etc.). Global Fund Round 9 Phase 2 support already secured in support of 2014 and 2015 IBBS targeting FWS and miners.

Intervention: Above: Conduct 2017 HIV drug resistance threshold survey

Target population and geographical scope: Pregnant women attending ANC in 36 surveillance sites in 11 provinces.

Implementation approach: Mozambique will leverage established ANC surveillance platform to support proposed threshold survey (as done in 2013). Other relevant information: 2015 ANC surveillance activities including threshold survey already financed through PEPFAR and Global Fund Round 9 Phase 2.

Intervention: Above: Conduct 2016 Demographic Health Survey (DHS)

Target population and geographical scope: National and Sub-national representative cluster sample of Mozambican households

Implementation approach: Mozambique requests NFM funding to support planned 2016 DHS survey which may serve as a reference for monitoring progress towards behavioral indicator targets included in the TB/HIV NFM performance framework. Other relevant information: Mozambique is currently investigating the possibility of integrating HIV testing in the 2016 DHS which would provide a complementary data source to measuring population-based HIV prevalence in Mozambique. Current 2016 DHS budget estimated at 4.2 million. This activity will be co-funded by an array of donors including Global Fund Malaria grant (if approved).

Routine Reporting HIV

Allocation \$	Above Allocation \$	Total \$
1.050.891	4.146.275	5.197.167

Intervention: Routine reporting – **Above:** Reproduction of data collection instruments including paper-based charts, registries and monthly summary forms in 2016 and 2017.

Target population and geographical scope: Instruments used to support ART/Pre-ART, PMTCT, HCT, STI and Key-Population services provided in 11 provinces

Implementation approach: HIV program has projected estimated instrument needs for paper-based tools based on historic consumption patterns and 2015-2017 HIV targets. Other relevant information: Global Fund Round 9 Phase 2 is currently supporting 25% of estimated need for instrument reproduction in 2015 and 2016. With the identified reduction in PEPFAR support for strategic information activities,

Mozambique proposes augmenting Global Fund support for 2016 from 25% to 50% and extending support to 2017 via NFM for 50% of reproduction needs.

Intervention: Routine reporting – **Allocated:** Establish provincial and central-level EPTS data warehouse network through purchase of 12 servers, 12 PC workstations and 12 printers.

Target population and geographical scope: DPS offices in 11 provinces and HIV program office at central MoH.

Implementation approach: IT equipment to be procured and distributed to provincial and central offices. PEPFAR to provide support for the set-up and maintenance of system.

Intervention: Routine reporting – **Allocated:** Enhance routine data analysis and data use at Department of Health Information (DIS) through the contracting of epidemiologist

Target population and geographical scope: National

Implementation approach: Recruit technical assistant to support the epidemiological analysis at the Health Information Systems Department

9) Program Management

Module: Program management

9.a) Program Management NTP

Context: The team at national level is relatively junior in TB control and understaffed to take on the challenges of implementing the national strategic plan, with the interim and new funding model grant. Because of the many competing priorities program management and supervision has been a challenge.

Gap: This grant will provide funding for i) hiring of additional staff at central level (1 senior manager, 1 medical officer, 2 M&E officers); provincial level (6 medical officers); ii) semi-annual and quarterly supervision by national and provincial level respectively; iii) transport for national (one car) and district level (motorcycles) and running costs; iv) external audit costs; v) quarterly national TB/HIV coordination meetings; vi) annual provincial TB/HIV coordination meeting; vii) semi-annual annual training in program management; viii) annual national TB/HIV coordination meeting with provincial coordinators.

Policy Planning, Coordination and Management - TB

Allocation \$	Above Allocation \$	Total \$
414.856	413.856	828.138

Intervention: Policy Planning, Coordination and Management (NTP). **Allocated:** transport, motorbikes for district supervisors; external audit; annual national coordination meetings; salary for one additional senior manager for NTP. **Above:** recruitment of 6 MDR-TB staff for provincial level, 1 central level; annual provincial coordination meetings; supervision visits.

Target population and geographical scope: Management support - The continuation of two activities under GF interim proposal after December 2016:

Implementation approach: Maintenance and insurance for central program unit vehicles and district supervisors' motorcycles; external audit; annual National Coordination Meeting for TB/HIV; biannual supervision from provinces to districts; Recruitment of 1 M&E staff and 1 medical officer at the national level; Annual National Coordination Meeting for TB/HIV including CSO organizations. Central regional trainings in TB program management

9.b) Grant Management TB/HIV

Grant management at MoH and FDC

Allocation \$	Above Allocation \$	Total \$
8.337.935	531.790	8.869.725

Intervention: Incentives and salaries for human resources for the PRs: **Allocated:** FDC costs; salaries GF Unit at MoH **Above:** GF Unit at MoH supervision costs.

Target population and geographical scope: This include PR and SR central, Provincial and district staff. For the GF Unit based at MoH: Salaries for 8 staff.

Implementation approach: The grant management module covers incentives, salaries and supervision for program managers 3 Supervision - Central level team makes 3 trips per year to provinces (MoH). Under FDC the request also covers for Overhead (transportation, office materials, office equipment, and other non-HR overhead) for PR and SRs (new and old) and Annual grant audit. Purchase of furniture and equipment, motorcycles, computers, printers, etc. for use by new SR under FDC.

10) HSS analysis of Funding Request

The following table shows the HSS investments included in this Concept Note, which are spread across the modules both within and above allocation. The HSS investments comprise of \$2 million within allocation, and \$15.4 million in the above allocation request, as presented in the following table:

HSS activities in HIV-TB Concept Note		
HSS activity	Allocated	Above Alloc.
Vital registration system	\$600,000	
Training HIV/TB activists (CHWs)	\$1,415,084	\$270,145
Warehouse rehabilitation / fleet expansion		\$7,562,900
In-service training on task shifting		\$2,626,200
Recruitment and salary of data clerks		\$1,126,080
Training laboratory, pharmacy, statistician staff		\$2,636,412
DHS survey		\$422,898
MoH PMU Staff		\$771,234
Total	\$2,015,084	\$15,415,869

3.3 Modular Template

Complete the **modular template (Table 3)**. Note that the template allows access to modules that are specifically relevant to TB and HIV components, in addition to modules that are cross-cutting for both diseases.

To accompany the modular template, for both the allocation amount and the request above this amount, explain:

- The rationale for the selection and prioritization of modules and interventions for TB and HIV, including those that are cross-cutting for both diseases.
- The expected impact and outcomes of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

HIV

Mozambique is on track to reduce incidence, mortality and virtually eliminate vertical transmission of HIV by 2017 through strategic and evidence based planning, geographic prioritization and implementation of a combined set behavioral and biomedical set of integrated intervention, targeting specific key and vulnerable populations. However, at present, Mozambique is entirely reliant on donor funding to pay for its HIV commodities needs. The resources boom- in particular natural gas and extractive industries –is promising and there is optimism that state resources as well as per capita income will dramatically rise. However the drilling and exploration has not yet, and will not for some time, translate into significant revenue for the GRM. Until additional growth occurs, Mozambique will remain one of the poorest countries on earth and donor funding will remain the lynchpin of the health response.

Mozambique is presenting the full expression of need to the Global Fund for TB/HIV response. A significant component of this request is USD 225 million for ARV.

Recognizing the importance of balancing prevention and treatment of TB and HIV, and of strengthening the weak health and community systems in Mozambique, the CCM decided to maintain the amounts allocated by GF and expedite the implementation of the GF Round 8 HSS grant. The priority activities include community based prevention to address the challenges in the poor adherence to ART and to improve the community case finding of TB, strengthening the linkages between health facilities and community based organizations, logistics and information support, including capacity building of their staff. The key and vulnerable populations, sex workers and their partners, MSM, serodiscordant partners and people with multiple partnerships, as well as girls and young women are targeted with preventive action. Prevention and HSS/CSS activities aiming at expansion of the services within the allocated funding were identified and presented as second priorities for above the allocation request, should above the allocation funding become available.

Mozambique has been successful in rapidly identifying and putting more PLHIV on ART. This has resulted in the demand for ARVs exceeding the funding allocated in the HIV Round 9 grant to the extent that the funding allocated for the second phase of that grant will all be procured already by the first two quarters of 2015. As the allocation for HIV in this concept note is not sufficient to cover provision of additional ART—and considering the prevention activities as a high priority, the CCM has no option but to request provision of additional funding for ARVs from above the allocation funding. The full request for ART for July 2015 to December 2017 is USD 225 million. This funding, together with funding from PEPFAR estimated at USD 29 million annually, will support the 80% of eligible PLHIV who are expected to be on ART by the end of 2017. The pace of the past 2 years has been robust, and given the numbers of persons receiving new HIV diagnosis from HTC, the continued successful linkage and enrollment into care, and the ability of health facilities to accommodate these numbers, Mozambique is well positioned to reach its target for high treatment coverage.

Prioritization Scenarios

The desperate ART and commodity situation has compelled the CCM and the MoH to propose that a significant proportion of the request be for ARV. The prevention and retention support activities remain key as components of a balanced response to HIV, and further prioritization of the prevention programs beyond of what is proposed between the allocation and above allocation funding would not lead to significant savings to the full above-allocation request,. The importance of the funding for the retention and targeted HIV prevention activities would be even more crucial under an ART funding shortfall.

As mentioned in section 3.2, the country faces the funding situation provided in Table 1 for the period of the concept note. The MoH HIV grant will enter into the NFM allocation period (1 July 2015) with USD 2.2 million unexpended, which will be rolled over into the allocation for this next funding period. FDC the community PR will enter into the NFM allocation period with USD 21.2 from Round 9, which will be rolled into this next allocation period, and there will be USD 13.2 left with the MOH from TB R7 Interim. The proportionally larger sum for TB is reflective of the interim funding from the GF that was initiated only in 2014, though its period of performance would end in 2016 if it was not rolled into the NFM. In terms of ‘burn rate’, Mozambique is entering into the NFM period with seriously depleted resources, which highlights the inadequacy of the NFM allocation to date.

Table 1: Estimated funds available for HIV/TB Concept Note as of 1 July 2015

Funding Source	Amount
MOZ-911-G09-H	\$ 21,292,025
MOZ-911-G10-H	\$ 2,254,260
MOZ-708-G07-T	\$ 13,251,104
Additional HIV funding	\$ 3,636,533
Additional TB funding	\$ 18,252,959
Total available for allocation in CN	\$ 58,686,881

To illustrate the epidemic impact of various levels of financing on the HIV epidemic in Mozambique, three scenarios have been modeled based on the availability of financing for ARVs and packages of behavioral and community services:

1. No funding beyond the current allocation from the GF with the PEPFAR contribution to ARV procurement kept at 2014 levels (flatlined)

2. Sufficient above allocation funding to maintain patients who are on treatment as of December 2015 with flat lined PEPFAR resources for ARV procurement. This is a no growth ART scenario as of 12/2015.
3. Incentive and/or unmet quality demand funding sufficient to cover the \$225 million USD gap by 2017 with flat lined PEPFAR funding for ARV procurement

Using a detailed forecasting model conducted by the HIV quantification team, availability of ARVs was translated into number of people on ART and those data were inputted into the GOALS modeling software to determine the epidemic impact of various scenarios of ART availability.

Scenario 1

If the GFATM provides no additional funds, but PEPFAR maintains its 2014 ARV procurement budget of \$28million, ARV stock outs will begin in early 2016 and the national program will be forced to take approximately 565,919 adult and pediatric ART patients off ART by the end of 2016 and by the end of 2017 (NFM period) there would only be financing to support 212,741 patients on ART. If this scenario comes to bear, the number of new infections will begin to rise again and the HIV epidemic in Mozambique will begin to expand instead of contract. (See Scenario 1 in Figure 3) In this scenario there will be 77,230 new adult HIV infections in 2017 and 139,404 AIDS death in 2017.

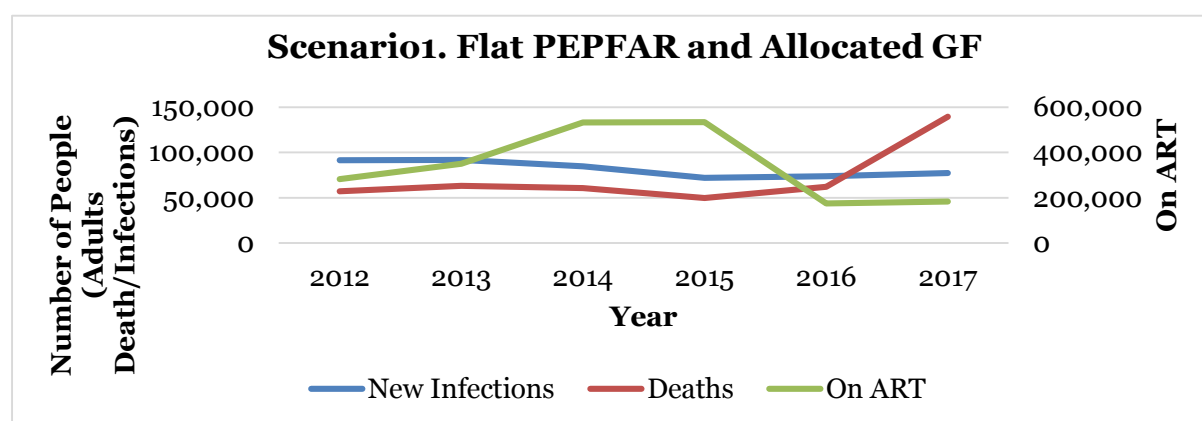


Figure 3: Scenario 1 – Flat PEPFAR and Allocated GF

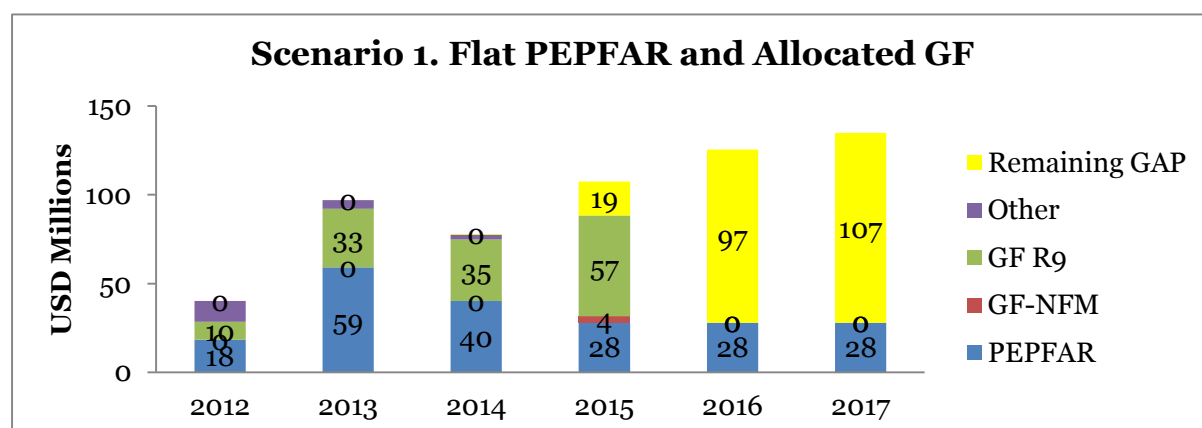


Figure 4 : Flat PEPFAR and Allocated GF

Scenario 2

If PEPFAR maintains its 2014 ARV procurement budget of \$28 million and the Global Fund provides sufficient above allocation funding to allow Mozambique to maintain the number of people on treatment as of December 2015 on ART, then Mozambique will be in a no growth scenario between December 2015 and December 2017. This will result in a real increase in incident infection when compared to a financing scenario that allows for continued scale up to reach the 80% 2017 target. In this scenario, there will be 69,590 new infections in 2017 and 32,310 AIDS deaths in 2017 (see scenario 2 in Figure 5 and 6). The above allocation amount for ARVs required for this scenario is \$174 million.

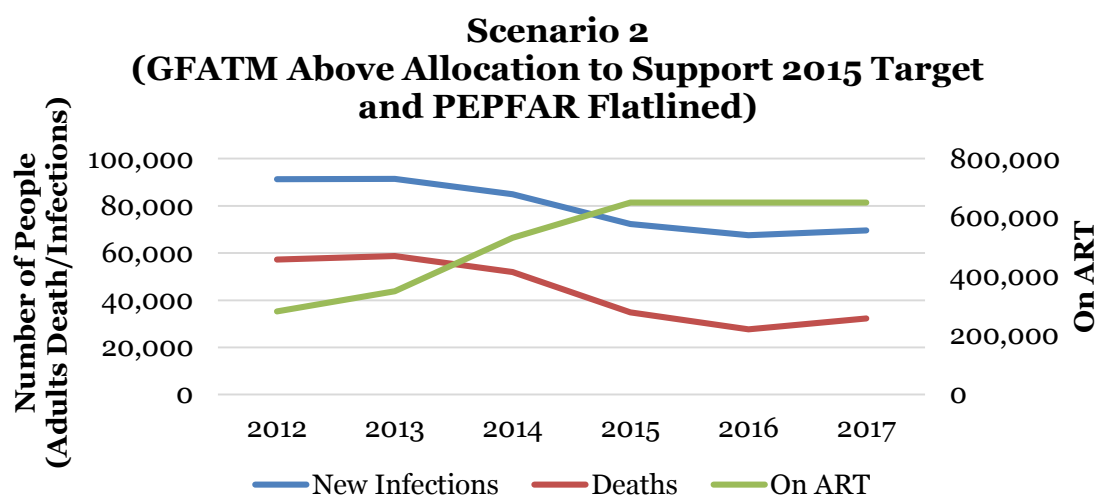


Figure 5: GFATM Above Allocation to Support 2015 Target and PEPFAR Flatlined

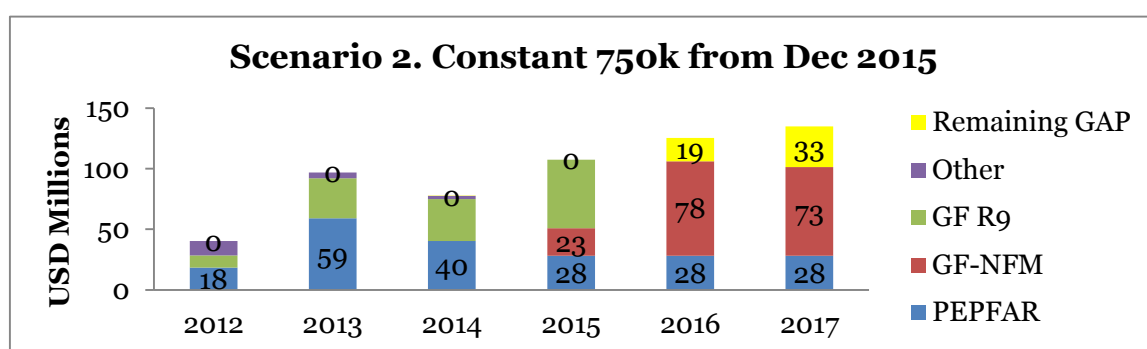


Figure 6: Scenario 2. Constant 750k from Dec 2015

Scenario 3

If, as Mozambique is requesting, the GFATM provides above allocation funding to cover the \$225 million ARV need, then Mozambique will succeed in increasing ART coverage to 81% by the end of 2017, reducing incidence significantly and dramatically decreasing AIDS related mortality. (See Figure 8 and 9. Scenario 3). In this scenario there will be 62,722 new adult HIV infection in 2017 and 21,768 AIDS deaths in 2017.

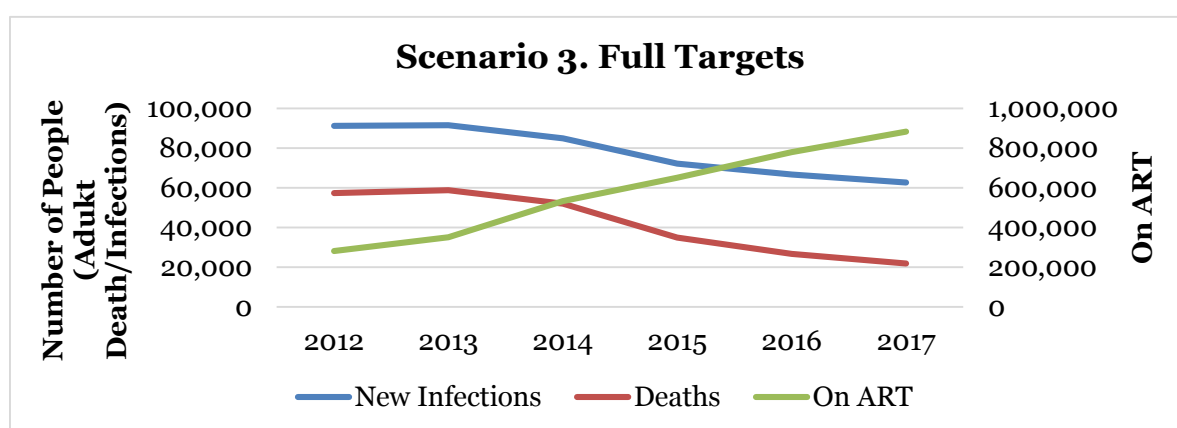


Figure 7: Scenario 3 –Full Targets

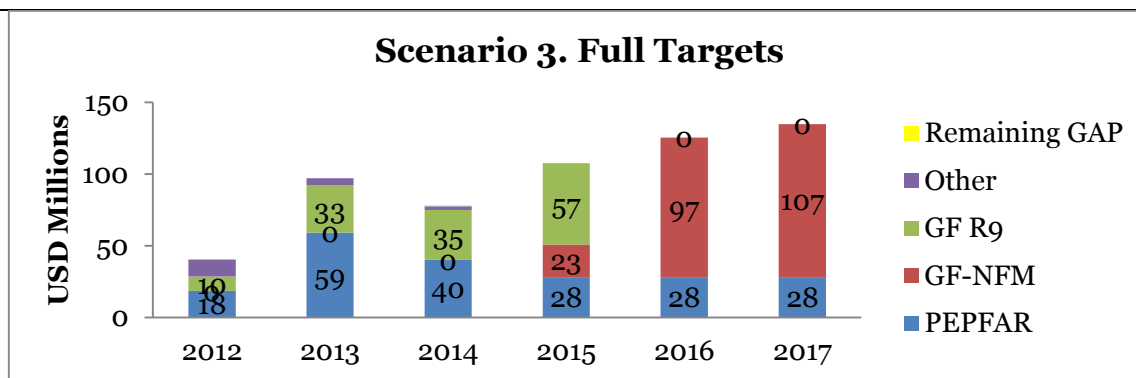


Figure 8 – Scenario 3 – Full Targets

As compared to a full funding scenario (Scenario 3), if the only funding available is the current allocation amount (Scenario 1) then 565,919 ART patients will be taken off ART by Q1 2016, an additional 21,455 new HIV infections will occur by 2017 and an additional 167,886 AIDS deaths will occur by 2017.

As compared to a full funding scenario (Scenario 3, if only enough funding is available to maintain treatment levels as of December 2015 achievement, (Scenario 2) an additional 7,640 new HIV infections will occur and there will be an additional 11,507 AIDS deaths.

The following graphs represent these comparisons graphically and provide a clear picture of the epidemic impact of the various scenarios.

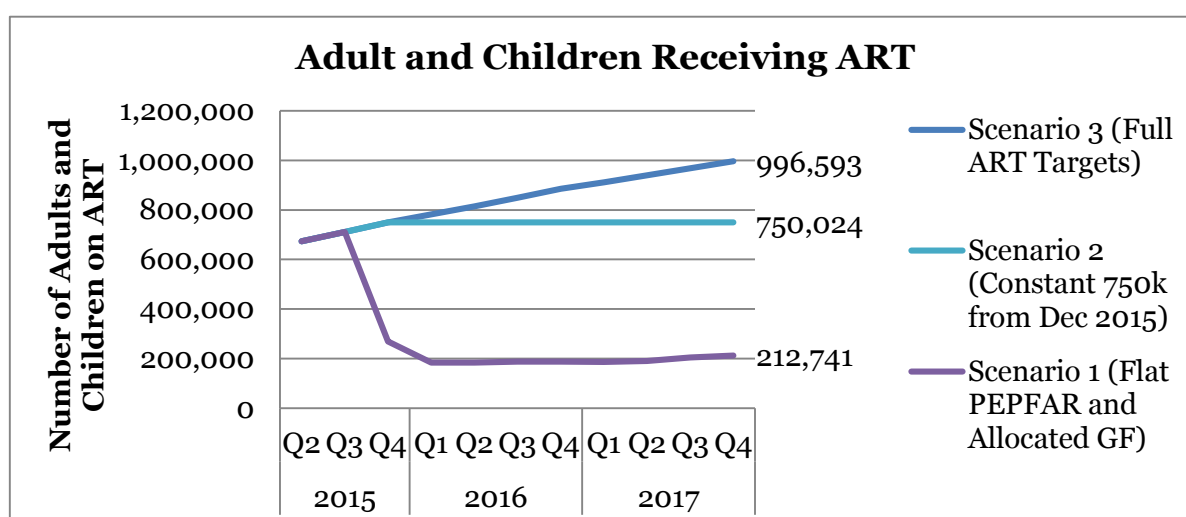


Figure 9: Adult and Children Receiving ART

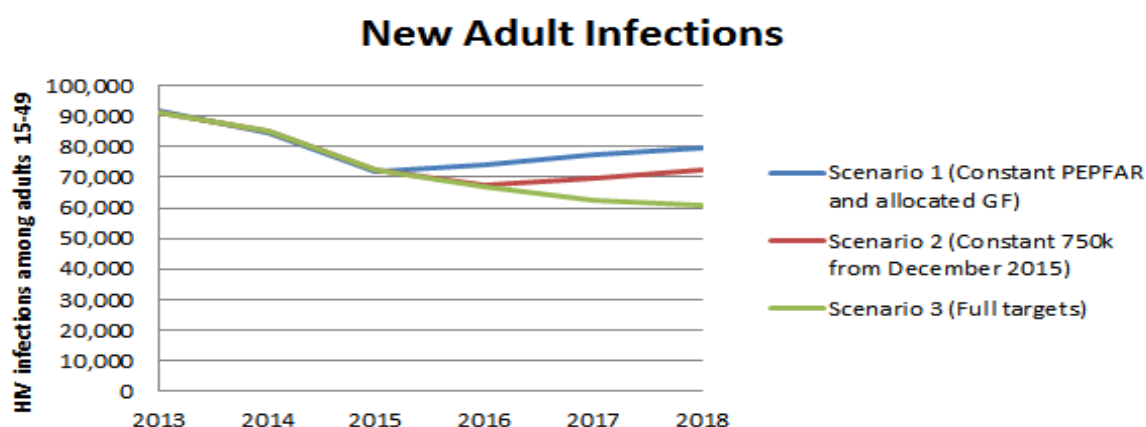


Figure 10: New Adult Infections

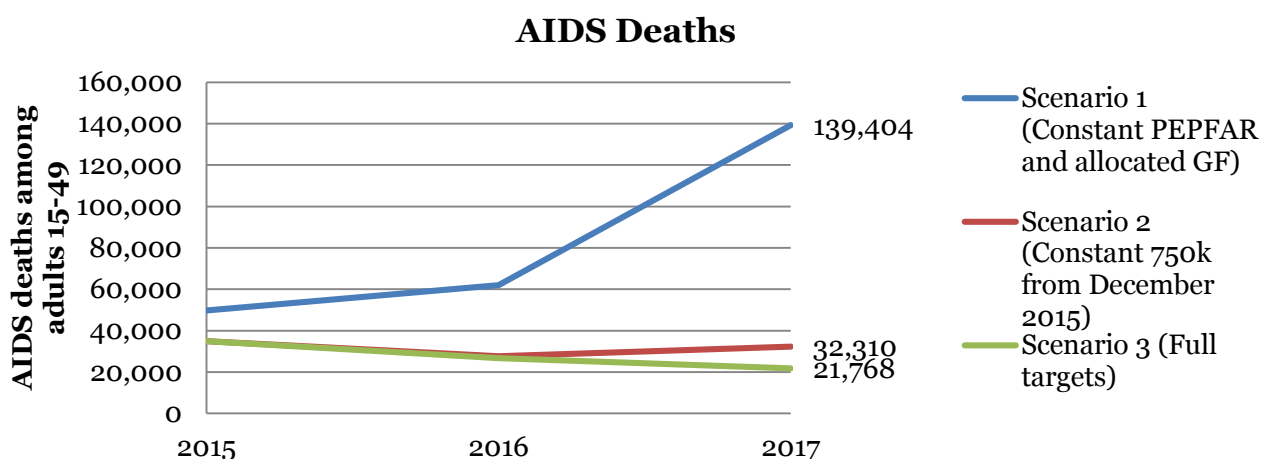


Figure 11: AIDS Deaths Among Adults 15-49

The epidemic impact of the various scenarios on new adult infections described above is clear. What is embedded in these models but not included in the graphs above is the profound impact that 80% treatment coverage for HIV-infected pregnant women will have to drive down vertical transmission of HIV-Mozambique will succeed in driving vertical transmission below 5%. If there are not sufficient ARVs in country to continue to increase coverage of ART for HIV-infected pregnant women, this achievable goal will not be attained.

HIV/TB

In this modular template TB/HIV is selected as a module in which interventions and targets are described for scale-up of TB/HIV care provision. As described earlier, the budgets for many of these interventions are placed in the HIV grant (ART, HIV testing and counseling), TB grant (procurement of isoniazid for IPT in PLHIV, TB infection control). CPT provision is funded by the MOH budget.

Under the intervention of Engaging All Care Providers, funds are placed in above allocation budget lines for MOH for integrated trainings of MOH health workers. In FDC budget there are integrated trainings for community activists on TB/HIV, as well as for expanding the numbers of community health workers. These interventions should result in an increase of ART provision through task shifting and further decentralization of the one-stop model, increased uptake of IPT, identification and referral of persons with presumed TB, TB contact investigation and referral in families affected by both TB and HIV, improved adherence for ART and TB treatment, including MDR-TB. This combination package of interventions should result in a decrease of HIV associated mortality among TB patients and a decrease of TB mortality among PLHIV.

TUBERCULOSIS

The proposed TB interventions provide a comprehensive package that is primarily aimed at reducing prevalence, incidence and TB mortality. This is achieved by: increasing case detection of all forms of TB (through expansion of community care coverage, expansion of the laboratory network resulting in increased access to TB bacteriologic tests for regular and MDR-TB; improved skills and knowledge on management of pediatric TB and MDR-TB; improving treatment outcomes of in particular MDR-TB patients resulting in less TB case-fatality and reduction of risk of amplifying XDR-TB; improved prevention of TB by TB-IC, contact investigation and preventive therapy; screening of high risk groups for TB disease in particular PLHIV, and other vulnerable groups such as those who live in mining communities as well as families of miners, prisoners, health workers and miners (miners being a health facility responsibility).

In this modular template the principal modules selected as 'allocation are described below- these are prioritized as they are the most essential activities for the national program:

1. TB care and prevention

- Costs under diagnosis include continuation of laboratory functions initiated under NFM Interim grant; training of provincial and district laboratory staff and clinicians; as well as procurement of lab reagents and PSM costs.

- Costs under treatment are related to the following activities: procurement of first-line TB drugs and isoniazid for IPT; procurement and supply management by CMAM; supervision at all levels
- Costs under Prevention support the procurement of equipment; and IC interventions.
- Costs under Engaging All Providers include: Training
- Costs under Community TB care include: Training of trainers at provincial level to provide integrated training on TB and TB/HIV.

2) MDR-TB care and prevention

Under case detection and diagnosis of MDR-TB prioritized costs are for the expanded implementation of GeneXpert including sample transport systems, and training

Under treatment for MDR-TB six 6 high burden provinces are targeted. Expansion of treatment capacity is prioritized to ensure that every diagnosed patients can be started on treatment as soon as possible with minimal delay. Quality of MDR-TB care will be strengthened by strictly quarterly evaluation of every patient on treatment through patient card reviews during supervision, also ensuring correct and timely recording and reporting of MDR-TB data. Six additional medical officers will be recruited for the function of MDR-TB provincial coordinator in 6 high burden provinces. At national level 3 additional staff will be hired (one medical officer, 2 M&E staff).

Under prevention for MDR-TB the prioritized costs are for TB-IC measures

3) Health Information Systems and M&E

Under routine reporting costs are for the following activities are prioritized: revising and printing of recording and reporting tools and development of an Electronic TB register to be both piloted in 4rd quarter of 2014.

Under surveys costs are for the following activities: implementation of a first prevalence survey in MOZ in 2015 and 2016; implementation of a repeat Drug Resistance Survey in 2017. These surveys will allow to determine much more accurately the real TB burden of TB and MDR-TB and guide program policies and strategies.

SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

This section requests information regarding the proposed implementation arrangements for this funding request. Defining the implementation arrangements for the program including the nominated Principle Recipients (PRs) and other key implementers is essential to ensure the success of the programs and service delivery. For the concept note for TB and HIV, the Country Coordinating Mechanism (CCM) can nominate one or more PRs, as appropriate given the country context.

4.1 Overview of Implementation Arrangements

For TB and HIV (including HSS if relevant), provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:

- If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector PRs).
- If more than one PR is nominated, how co-ordination will occur between PR(s) for the same disease and across the two diseases and cross-cutting HSS as relevant.
- The type of sub-recipient management arrangements likely to be put into place and whether sub-recipient(s) have been identified.
- How coordination will occur between each nominated PR and its respective sub-recipient(s).
- How representatives of women's organizations, people living with the two diseases and other

key populations will actively participate in the implementation of this funding request.

a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector PRs).

Not applicable. The NFM TB and HIV grant implementation arrangement is a dual-track financing arrangement. The Ministry of Health (MoH) is the government PR and Fundacao para o Desenvolvimento da Comunidade (FDC) is the non-government PR for both the HIV and TB grants.

b. If more than one PR is nominated, how co-ordination will occur between PR(s) for the same disease and across the two diseases and cross-cutting HSS as relevant.

The existing coordination arrangement for the HIV R9 grant PRs is executed through the Partnership Forum chaired by the National AIDS Council (CNCS). The Forum convenes monthly to share information between the PRs and key stakeholders from civil society organizations and external partners. A Pre-Partners Forum, chaired currently by UNAIDS, coordinates UN system inputs to the Forum. For more focused consultations between the PRs, NAC organizes coordination meetings as necessary.

This arrangement is HIV specific, similar disease specific arrangements for TB are not yet in place since, until now, the MoH has been the sole PR for TB.

Coordination between the PRs across the two diseases and cross cutting HSS needs remain to be established. The CCM, together with the two PRs, will explore options for coordination between the PRs for the same disease and across the two diseases, which will include also the cross-cutting HSS coordination. These coordination arrangements will be established and functioning by 1st July 2015 and will be informed by a review and evaluation of the existing HIV coordination arrangements. Since a MOU between the MoH and FDC already exists for the HIV grant, expansion of that MOU is an option that will be explored in coordination with CCM.

c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipient(s) have been identified.

In the MoH, the Project Management Unit (PMU), housed in the Department of Planning and Coordination (DPC), will provide the coordination platform between the HIV, TB and Malaria programs, including Central Medical Stores (CMAM) and other entities involved in the grant implementation. The PMU will be in charge of the MoH programmatic and financial monitoring and reporting to the Global Fund on grant implementation by the respective program in coordination with Department of Finance (DAF). The implementation of the programs will take place through the HIV, TB and Malaria programs and the CMAM, with specific tasks assigned to other entities of the MoH, including the Pharmaceutical, Quality control, and Supply & Distribution Departments. The MoH leads and guides the implementation by health sector authorities and health facilities under the MoH's control at provincial and district levels, ensuring that the grant conditions are respected and that the national strategies for the health sector, TB, HIV and Malaria, and the Acceleration Plans for HIV Response continue to guide the grant implementation.

Regarding implementation by non-government PR, the FDC Board will provide the main coordination platform between the current HIV SRs. The SRs will continue to be: ADPP, ECOSIDA and FDC Consortium, which consists of 12 sub-recipient organizations (FDC PR⁶⁷ and SR⁶⁸ organogram annexed).

The SR selection for the non-government TB grant was launched using a standard, transparent application process, including advertisement in main national newspapers, and is being completed by an impartial FDC selection committee. These SRs will be provided with information and guidance on Global Fund grant management, their implementing responsibilities and will be informed of the coordination arrangements and reporting requirements of the Global Fund grant implementation. FDC will be in charge of programmatic and financial reporting to Global Fund on the implementation of both the HIV and TB grants in FDC portfolio.

The principal responsibilities of the selected SRs will be direct supervision and support to implementation of the activities by the activists in all districts except in those 56 districts where TB community activities are already implemented by other organizations' implementers. The FDC report⁶⁹ includes the structure for SRs and the standard service packages adjusted to the target populations which

the activists are expected to deliver, as well as the qualifications and terms of reference for the activists adjusted to the target populations.

The current FDC standardized field working architecture and working methods and guidelines for outreach work will be adjusted to accommodate the TB grant implementation and adopted by all SRs to maximize outreach capacity and efficient use of human resources. This standardized approach will leverage experience and comparative advantage of each SR, preserving inherent differences, while ensuring similar patterns of accountability among all members of the civil society organizations. Each SR will concentrate its work in defined geographic area with key and vulnerable population focus and community coverage.

The geographic coverage between the current SRs, ADPP and FDC Consortium, and the newly selected SRs for TB is being reviewed and revised to provide optimum coverage. ECOSIDA will ensure countrywide presence covering the HIV response for workplace activities. Coverage for TB activities in the workplace will be established in coordination with ECOSIDA. FDC will support the capacity strengthening of the selected SRs by recruiting staff to strengthen its own management and coordination capacities, providing training on annual basis, and provide financial support for program management and other critical needs identified by the SRs. Coordination with the provincial and district authorities will be reinforced by FDC and SRs' participation in the provincial and district management committees.

d. How coordination will occur between each nominated PR and its respective sub-recipient(s).

The MoH does not have any sub-recipients.

Coordination by FDC with its SRs takes place through regular meetings with SRs who also report quarterly on their progress to FDC, including quarterly financial reporting. This arrangement, which has been established for HIV grant implementation, will be extended to the TB grant implementation. PR support to SRs includes: strengthening of the SR capacities in planning and coordination; financial management and accountability; and improving coordination through holding regular technical meetings at central level.

Coordination at provincial level, established for health sector coordination, takes place in the provincial management committee which includes members of health administration and health facilities as well as the implementing NGOs and civil society organizations, thus bringing both PRs and the SRs at provincial level within the same coordination mechanism, reinforcing the integrated approach to health sector and community level coordination and monitoring. Sub-committees for coordination of TB and HIV grant implementation, including cross cutting HSS support, will be established.

Similar arrangements will be established and reinforced at district level, which is particularly important for the integrated implementation of community level activities. These arrangements may be flexible and differ between the districts. The service packages for community health workers, activists and volunteers will be standardized and introduced through common training, and common monitoring arrangements will be established.

e. How representatives of women's organizations, people living with the two diseases and other key populations will actively participate in the implementation of this funding request.

One the main benefits of joint CN development has been stimulation of an inclusive national dialogue among the national authorities, the TB and HIV programs, partners in civil society, and other stakeholders. The aim has been to encourage the design of a concept note that addresses the response to the two diseases in a more strategic way, calling for more effective joint approaches, exploring synergies that exist in TB and HIV programs and the underlying health and community systems and cross-cutting areas. Country dialogue process reflects involvement of civil society in consultations, including the CNCS and implementers responsible for prevention and community outreach of the HIV acceleration plan and of the national TB strategy. Strategic direction and priorities of response have been agreed to and reflected accordingly.

The NGOs implementing GF grants, the civil society organizations and representatives of key populations have been involved in the Proposal Development Committee which has convened regularly to review the progress on concept note development. In addition they have been involved in the special workshop for

TB and HIV CN development, in Prevention workshop, in the provincial consultations, one in each three regions (north, centre, south), in the working groups drafting the CN, and in the national consultation (reports of the national and provincial consultations and main workshops annexed^{60,70}).

The implementation of the funding request will involve women's organizations, organizations and networks of people living with the two diseases and other key populations at national level as members of the CCM and FDC, through their involvement in the SRs and their implementing partners at local community level. The PRs and SRs are requested to ensure active involvement of these key populations, to establish peer groups and to engage the key populations as activists and volunteers in the community level work. The service packages for each group of implementers are being reviewed and revised to ensure integrated TB and HIV service delivery.

4.2 Ensuring Implementation Efficiencies

Complete this question only if the CCM is overseeing other Global Fund grants.

From a program management perspective, describe how the funding requested links to any existing Global Fund grants, or other funding requests being submitted by the CCM at a different time. In particular, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

This funding request is comprised of the full, consolidated expression of the demand for HIV and TB support from the Global Fund. It includes the undisbursed and unexpended amounts of current HIV and TB grants at the expected new grant launch date 1 July 2015. These grants are the HIV grant of R9 phase2 and approved Interim allocation, the TB R7 grant and interim allocation. The request links to the R8 HSS grant which includes cross cutting health system strengthening activities designed to support the cross cutting needs of the disease specific programs without duplication. The concept note also links to the simultaneous development of the Concept Note for Malaria, which includes the undisbursed amounts of the Malaria R9 grant at the launch date of the new grant 1 July 2014.

The current grants have been analysed to ensure that the scale- up of the activities in the NFM CN are in synergy with the National HIV and TB Strategies and Acceleration Plans, and are harmonized with community based activities in the districts covered by other implementers. The Mid Term Review of the National HIV Strategy 2010-2014 (PEN III)⁵² provides recommendations that are reflected in the CN. The review noted that there has been significant progress in the national HIV response during the period of PEN III. There were a number of challenges during the implementation of PEN III that the review recommended should be addressed during the development of PEN IV. These include the need to align indicators to targets (not well aligned in PEN III) and establish clear targets for all area; increase attention to mitigation of cultural practices that amplify HIV vulnerabilities of girls and young women; increase efforts to raise pediatric HIV ART enrolment. Increased attention was recommended to development and implementation of workplans at provincial and district levels, and that the coordination by CNCS would benefit from improvement. On the positive side, Mozambique was cited as the first country to update its targets from the Millennium Development Goals 2015 targets- and that this effort resulted in the Acceleration Plan; the IBBS for key populations have been accomplished; , and that programming for key and vulnerable populations has increased.

The Mid Term Review of the HIV Acceleration Plan has been initiated, desk review will be completed by 15 October, to be followed by report on site visits, in order to provide further information about the Acceleration Plan implementation, which has been extended to 2017, as well provide the basis for potential adjustments to this NFM concept note during its grant negotiation period. The review of the TB program, starting at the end of August, will also provide information regarding other adjustments that can be made during the grant negotiation period.

Considering the concerns on operationalization of the HIV acceleration plan, particularly the capacity to implement and the service quality that the Technical Review Panel and the Grant Approval Committee expressed at the time of approval of the grant R9 Phase 2, the CN demonstrates the success of the national program in meeting many of its targets and in implementing improvements in program management,

with reference to data from the system, studies and reports on the implementation of the acceleration plan, in advance of the results of its mid- term evaluation.

The Ministry of Health (MoH) and The Foundation for Community Development (FDC) are the Primary Recipients (PRs) for the grant. Under each module there are interventions implemented by both PRs so as to have linkage between community and health sector activities. The MoH will primarily focus on the biomedical interventions implemented at health facilities throughout the country whereas FDC and its SRs will focus on activities at the community level. Activities of both components are aligned to ensure full synergy and complementarity, including with the malaria concept note, with particular attention to community level activities implemented by the community health workers, activists and volunteers. The service packages for each category of implementers are being reviewed and harmonized.

The TB and HIV concept note accommodates the needs of the disease specific programs, including the needs for civil society/community interventions and engagement, which are embedded in the proposal, and are designed to ensure close coordination between the implementing partners at all levels, and in particular to ensure the continuum of care at local level. Preliminary assessment of the human resource and training needs was conducted during the CN development and a comprehensive human resources training program drafted to ensure the synergy and no duplication.

The Monitoring and Evaluation and joint supervision arrangements were agreed to during the CN development process. The M&E Plan will be developed. The joint supervision is described in section 1.3. The HSS R8 grant implementation, which includes planned and initiated information system and reporting improvements (SISMA), will enhance the quality of data and reporting, and consequently the efficiency of the program implementation. The planned and ongoing strengthening of procurement and supply management under the R8 HSS grant, including improvements of the logistics and warehousing, aims to gradually improve the supply of quality products for the HIV and TB programs. Additional support to warehousing and logistics at district level is included in this concept note.

The request reflects complementarity of funding through PROSAUDE pooled funds and direct bilateral support from other donors and technical support agencies provided to the health sector in Mozambique, including from the US Government, other bilateral donors, World Bank and the UN system, and international non-governmental organizations. The coordination mechanisms for health sector support include the Health Partners Group, the UN Country Team and Partners' Forum chaired by CNCS.

The annual health sector meetings led by the Minister of Health provide the platform for sharing information and providing guidance for partners. The areas for joint planning include health system strengthening, regarding the infrastructure, logistics and commodity support and provision of technical assistance through secondments, as well as direct implementation support from NGOs. Duplication of the activities is avoided through joint workplanning at central and local level between PRs and implementing agencies. Sharing of the information in regular meetings provides also opportunities to learn from experiences, harmonize approaches and further reduce potential duplication.

4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery

For both TB and HIV complete the table below for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.

PR 1 Name	Ministry of Health	Sector	Government
Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?	X Yes <input type="checkbox"/> No		
Minimum Standards	CCM assessment		

1. The Principal Recipient demonstrates effective management structures and planning	In the Ministry of Health the Project Management Unit under the Department of Planning and Coordination coordinates planning, management and reporting on the GF grant which is being implemented by the HIV/AIDS program in the Department of Medical Assistance and the TB and PMTCT programs in the Department of Public Health. The Departments and the Programs guide the implementation by the health facilities at the provincial and district level.
2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)	MoH does not have sub-recipients. The implementation of the grants and the financial flows from Global Fund through the Ministry of Finance to Ministry of Health and further to the implementing entities in provinces and districts is described in section 2.
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	The GF OIG audit identified critical issues in financial control of the MoH.. Action has been taken to improve the financial control through strengthening of the MoH financial management systems
4. The financial management system of the Principal Recipient is effective and accurate	GF OIG audit identified critical management issues in financial control of the MoH. (OIG report annexed). Action has been taken to improve financial management
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	Following the OIG audit report MoH has established and started implementing the plan of action for improving Central Medical Stores and PSCM system including implementation of MACS
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions	Following the OIG audit report the MoH has established and started implementing the plan of action for health products' distribution and transportation
7. Data-collection capacity and tools are in place to monitor program performance	Data collection and tools in the MoH use standardized system SISTAFE which is being expanded to cover all health facilities
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	Routine reporting system is in place. The OSDV report of July 2014 identified challenges in recording and reporting in several health units and health administrations and provincial level. MoH will address the issues
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	The quality control system established in MoH includes strengthening pharmaceutical quality control and implementation of the quality control plan.

4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery

For both TB and HIV complete the table below for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.

PR 2	FDC	Sector	NGO
Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?		X Yes <input type="checkbox"/> No	
Minimum Standards		CCM assessment	
10. The Principal Recipient demonstrates effective management structures and planning		Yes. FDC has a central Management Unit in Maputo City and 5 local branches: 1 regional in Nampula Province to assist Niassa, Cabo Delgado and Zambézia; 1 branch in Manica, 1 in Sofala, 1 in Tete and 1 regional branch in Maputo province to assist SR in Inhambane, Gaza and Maputo province. All provincial branches have programmatic staff (Coordinator and M&E Officer) and Administrative and Financial Officers. At the central branch the team is comprised of quality control, data manager and M&E officers; a health, HIV specialist and program manager and the necessary administrative staff.	
11. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)		Yes. FDC has financial and administrative manuals specific for this grant and a unified financial system for SRs and the FDC. FDC developed programmatic intervention packages specific to each of the target groups	
12. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud		Yes. The internal control system is structured with the segregation of functions and authorization levels are well differentiated. The disbursement to the SR is made after validation of past expenditure. There are specific internal and external audits for each SR including for FDC.	
13. The financial management system of the Principal Recipient is effective and accurate		Yes. Annual external audits indicate positive findings regarding the control system, and indicate areas of improvement that are being implemented.	
14. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products		Yes. Test kits and condoms will be stored in the health units. FDC will not create a parallel storage system. FDC will improve the storage capacity of the health units with refrigerators.	
15. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions		Yes. Transport of tests kits is adequately budgeted for in this proposal (+R9 contribution). However FDC is waiting for MOH to determine quantities of test kits and condoms to be transported from each quarter to all implementation sites.	
16. Data-collection capacity and tools are in place to monitor program performance		Yes. For each target group package of intervention data collection and M&E tools have been developed and approved by GF. With the integration of activities related to TB indicators new information to the data collection instruments will be added.	
17. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately		YES. The FDC has a system of routine data collection for all its SRs. For improvement of actual manual system, FDC is developing an online system for collecting the same information allowing better centralized control, increased	

	assistance to SR and a higher level of validation of information.
18. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	The quality control officer is responsible for the periodic audit of M&E activities proposing actions to improve the tools and processes of M&E. FDC conducted a ToT for each SR in order to improve locally the ability of SR in the use of instruments of M&E. FDC expanded its presence in all provinces with an M&E officer to assist each SR on monthly basis.

4.4 Current or Anticipated Risks to Program Delivery and PR(s) Performance	
<p>a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, PR(s) and key implementers' capacity, past and current performance issues.</p> <p>b. Describe the proposed risk mitigation measures (including technical assistance) included in the funding request.</p> <p>c. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, PR(s) and key implementers' capacity, past and current performance issues.</p> <p>d. Describe the proposed risk mitigation measures (including technical assistance) included in the funding request.</p>	
<p>a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, PR(s) and key implementers' capacity, past and current performance issues.</p> <p>The Global Fund Inspector General's report of 2012⁷¹ (Audit of Global Fund Grants to the Republic of Mozambique, GF-OIG-11-018, 27 August 2012) assessed issues related to GF grant management and cross cutting health system performance. The report identified weak capacity in the Ministry of Health as the root cause of the shortcomings in financial program management and supply chain management. The quality of service delivery was found impacted by insufficient numbers of human resources. The OIG report points out the need to strengthening of MoH internal financial control systems; improving local disbursement control; adherence to workplans and budget; and improving PRs compliance and reporting to CCM. (22 critical and 12 important recommendations in the OIG report). Consequent to the OIG report, the R 8 HSS grant was revised in order to address the weaknesses. The implementation of the revised grant has started with first disbursement of USD 1.5 million, and the disbursements of USD 8 million are expected to start shortly.</p> <p>An identified risk is the insufficient PR and SR capacity for grant management and for implementation of the activities, which is regularly assessed by the Global Fund based on PR reporting. The reporting by the PRs, The Ministry of Health for R9 HIV and TB grants—as well as for the R8 HSS grant-- and the FDC for R9 HIV grant has indicated that the performance of the MoH has been at the level of A1 to B1 over the phase1 of the HIV grant and at B1 over the phase1 of the TB grant, the latter having shown slow absorption capacity. HSS R8 grant implementation has been extremely slow until now.</p>	

FDC performance in the beginning of the HIV R9 grant was graded at C, but has then improved to B1. The slow start was due to the SR's low performance in 2011-12, which has been improving after the decision was taken to reduce the number of SRs from 7 to 3, the FDC Consortium (which includes 10 sub-SRs), ADPP, ECOSIDA). FDC has only in July 2014 been selected as PR for TB, so there is no performance reporting yet. FDC is in the process of selecting and developing the capacities of the SRs for TB.

Key challenges and issues, in line with OIG report, were articulated in the Global Fund Country Team portfolio analysis in 2014 (GF CT report 19.06.2014⁷²) and in the CT pre-assessment of the TB program in July 2013. The GF Country Team's portfolio analysis points out the lack of the strategy to cover the HIV response for community response beyond 2014 as the National HIV Strategy expires at the end of 2014, and for health sector beyond the HIV Acceleration Plan period ending 2015. It also points out the separation of community based HIV prevention from treatment and prevention in health facilities as a major challenge for coordinated national response.

The major risk to the sustainability of the HIV and TB response is the continuing high dependency on external funding for HIV and TB programs, particularly now that as a result of the rapid acceleration of HIV and TB response, increased funding will be required to maintain the spectacular progress in ART coverage over the last two years. Mozambique, one of the poorest countries in the world is also among the countries most severely affected by the HIV and TB epidemics and will need external support for years to come. At the same time, the country will have to considerably increase domestic financing of health sector, including for the HIV and TB response, in view of likely stagnation or decline in external financing support.

The weaknesses in the health systems, unless strengthened and financed, may seriously affect the successful acceleration of the HIV and TB response. Health facilities, including laboratories, the procurement and supply system, including warehouses and management of drug and commodity supply and logistics, have been identified as in need of critical interventions to improve. Scarce health human resources, quality of health services, poor reporting and information management and data quality have been identified as major risks for successful implementation of the accelerated response.

The recent OSDV report of July 2014 confirms the discrepancies between data sources centrally available and the observed reality in the field, with at times large differences between reports and records at facility level.

Health services at community level managed by international and national NGOs depend largely on community health workers, activists and volunteers, linking with insufficiently staffed primary health care facilities. Insufficient support to the community based organizations is a risk to sustainability of many prevention activities and continuum of care, to improving the human rights and reducing the stigma and discrimination, and addressing gender inequalities and gender based violence, engagement of key populations and addressing the specific problem of young girls.

Both the TB and HIV National Programs are very ambitious, particularly, in terms of expansion to treatment services. In this context, the challenges in supply and distribution systems, infrastructure capacity, information systems, human resources and implementers' management capacities are to be addressed (section 3).

b. Describe the proposed risk mitigation measures (including technical assistance) included in the funding request.

The mitigation undertaken after the OIG report includes development of action plans for the Ministry to address the system weaknesses in Public Finance Management and Procurement and Supply

Management. CCM has strengthened grant oversight, including field visits to observe PR and SR performance and capacity development in response to the GF performance reports.

The government has taken the expressed challenges seriously and is in the process of addressing these to maximize the impact of the two programs on these overlapping epidemics, by better targeting of resources and by scaling up both services, and achieving efficiencies particularly by addressing health system constraints that are affecting both programs. An analysis of priority cross-cutting HSS areas such as human resources, the supply chain for both HIV and TB (including laboratory-related commodities) and health information systems has been conducted and priority needs and gaps identified, including the need for technical support. The priority activities are incorporated in section 3: program proposal.

As mentioned in previous sections (1.1.d & 1.2.c), a number of health system strengthening activities that are underway to address gaps that both the Government of Mozambique as well as the OIG have identified. The OIG has issued sets of multiple recommendations regarding financial management systems. The 1st set is i) to ensure the linkage between PMU and other directorates, ii) to align GF grants to government planning and budget cycles, (iii) the PMU to acquire the FMS, PSM, and M&E capacity, (iv) to ensure constant communication with the GF Secretariat; the 2nd set requires strengthening of systems for financial and programmatic reporting through action plans; the 3rd set looks at the accounting and reporting activities of the DAF (MoH) while the 4th set looks at the salary and other HR expenses through MoH strengthening of controls over HR payments. The 5th set is about the expenditure for travel and field activities with a 6th set looking at the planning and budgeting whereby MoH should ensure that detailed work plans (PROSAUDE funds) and the last set looks at audit, with the management of the MoH following up action of audit recommendations.

Among the priorities set up in the OIG report and acknowledged by the Government of Mozambique are improvements in the FMS area- which include: i) the establishment of the Accounting Reporting Unit (ARU) at the central and provincial levels through TA with the training of technicians in DAF, (ii) enhanced financial monitoring and oversight in the provinces and recruitment of staff; (iii) the reparation of a fixed asset register at central and provincial levels and supporting the provinces in implementation external audit findings, regular supervision and monitoring, and (iv) the strengthening of auditors and logistic and office support.

The OIG report also highlighted the need to strengthen linkages and coordination between TB and HIV programs at all levels has been initiated, including development and dissemination of TB/HIV integrated guidance, joint trainings, integrated supervisions, joint TB/HIV coordination meetings, joint TB/HIV data, integrated laboratory services and integrated service delivery (such as the TB/HIV one stop-shop model expansion). Also, the human resource needs of the HIV and TB programs will be included in the Health Sector Human Resources Plan, including estimates of how many new staff will be recruited for the TB services and ART sites and how many staff will be trained for all categories, and how task-shifting is implemented.

Joint planning, budgeting and implementation have been part of the consolidated NFM CN development. The aims of the TB program have been incorporated: TB case detection and improved case notification, including among vulnerable populations (children, miners, prisoners, etc.); MDR-TB: strengthening of all aspects from diagnostic to clinical management, to patient tracking, to reporting. The strategy that will be put in place is based on guidance from recent WHO/USAID mission addressing the system constraints, such as human resources capacity. The recommendations from the mission include: planning the expansion of laboratory network and diagnostic services for TB coordinating this with HIV laboratory expansion; planning the infrastructure improvements for infection control; developing a plan for human resource capacity building; ensuring the implementation of the prevalence

survey; strengthening management at all levels including supervision, capacity building and training, to demonstrate its capacity to implement and absorb funds.

Specifically in TB/HIV activities the CN considers mitigation of the risks by: increasing TB screening among HIV-positive people; Increasing the proportion of HIV-positive patients on ART; strengthening infection control measures; Increasing the number of HIV-positive people provided with IPT; increasing the number of health facilities which provide one-stop-shop services for TB/HIV patients; strengthening the recording & reporting system and M&E of TB/HIV interventions.

In the prioritization of the cross-cutting HSS activities, the key system challenges of implementing the ambitious scale-up plans of both HIV and TB (such as human resources capacity) have been analyzed for their funding gaps to ensure that sufficient system capacity is available within the health system for implementation of the scale-up. Community system strengthening activities are included in disease components (and not as a stand-alone section). Efficiency in implementation is sought through a harmonized and coordinated approach across TB and HIV community activities. MoH programs, in particular HIV and TB programs aim to set a deadline by which all the indicator requirements for the SISMA will be defined. The MoH will proceed to a prioritization of indicators. A review with all programs and partners is planned in order to identify key data needed with leadership from the MoH; HIV program plans to move to one electronic patient tracking system, and to ensure the system is being implemented in the whole country and agreed to with by the partners.

NTP will ensure also continuation of regular anti-TB drug resistance surveys. The process of quarterly data validation at health facility will be strengthened and systematically supervised by provincial TB Program Manager on a regular basis. The Program will gradually build a systematic performance analysis per district and even per facility at district level including regular feedback to increase notification rate and to train health staff to take every single opportunity to test patients who attend the health facility. At central level both general TB data base and the MDR database face important issues of data quality (excel files are being sent from provinces, those are not protected and may be corrupted, incomplete). This will be addressed immediately to maintain data integrity. NTP will also follow-up on the gradual integration of TB data into the HMIS and define the indicators and information requirements based on the updated NTP strategies, and build its capacity to be able to develop more analytical reports which reflect in particular the joint analysis of TB/HIV data and indicators. The improved reports will include the monitoring of the key program indicators, including outcomes and output with clear recommendations for actions to improve program management.

Technical assistance is being provided by long-term assignments by USG/PEPFAR/CDC to the Ministry of Health entities (PMU/HIV/TB/CMAM) and short term assignments at request by the MoH as necessary. The UN agencies provide short-term technical support to the government for specific assignments. International NGOs acting as implementers of donor-supported programs provide management and technical support both at central and local levels.

CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

<input type="checkbox"/>	Table 1: Financial Gap Analysis and Counterpart Financing Table
<input type="checkbox"/>	Table 2: Programmatic Gap Table(s)
<input type="checkbox"/>	Table 3: Modular Template
<input checked="" type="checkbox"/>	Table 4: List of Abbreviations and Attachments
<input checked="" type="checkbox"/>	CCM Eligibility Requirements
<input checked="" type="checkbox"/>	CCM Endorsement of Concept Note

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