MOZAMBICAN NATIONAL INITIATIVE TO ACCELERATE ACCESS TO PREVENTION, CARE, SUPPORT, AND TREATMENT FOR PERSONS AFFECTED BY HIV/AIDS, TUBERCULOSIS AND MALARIA

SECTIONS I-III

Submitted to:

GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA
GLOBAL FUND SECRETARIAT

Submitted by:

COUNTRY COORDINATING COMMITTEE
MOZAMBIQUE
SEPTEMBER 25, 2002

***The* Global Fund to Fight AIDS, Tuberculosis and Malaria**

For the use of the Global Fund Secretariat: *Date Received:*   *ID No:*

PROPOSAL FORM

Before starting to fill out this proposal form, please read the *Guidelines for Proposals* carefully. When completing each question in the proposal form, please note the reference given to the corresponding section of the guidelines.

This form is divided into 4 main parts:

SECTION I is an executive summary of the proposal and *should be filled out only AFTER the rest of the form has been completed.*

SECTION II asks for information on the applicant.

SECTION III seeks summary information on the country setting.

SECTIONS IV to VIII seek details on the content of the proposal by different components.

How to use this form:

Please read ALL questions carefully. Specific instructions for answering the questions are provided.

Where appropriate, indications are given as to the approximate **length of the answer** to be provided. Please try, as much as possible, to respect these indications.

All answers, unless specified otherwise, should be provided in the form. If submitting additional pages, please mark clearly on the pages which section and numbered question this relates to.

To avoid duplication of efforts, we urge you to **make maximum use of existing information** (e.g., from programme documents written for other donors/funding agencies).

When **using tables**, all cells are automatically expanded as you write in them. Should you wish to **add a new row**, place the cursor on the outside of the cell at the bottom right-hand corner of the table and press ENTER.

To copy tables, select all cells in the table and press CTRL+C. Place cursor where you would like the new table to begin and press CTRL+V.

Please DO NOT fill in shaded cells.

Abbreviations

- AIFO Italian Association of Friends
- CISM Centre for Health Research, Manicha.
- EPI Expanded Programme on Immunisation
- HBC Home based care
- HIV Human Immunodeficiency Virus
- IMCI Integrated Management of Childhood Illnesses
- INS Institute of National Health
- ITN Insecticide-treated mosquito nets
- IEC Information, education, communication
- IHN Integrated Health Network
- INE National Institute for Statistics (Instituto Nacional de Estatística)
- IUATLD International Union against Tuberculosis and Lung Disease
- LEPRA British Leprosy Relief Association
- MOH Ministry of health
- MTCC Malaria Technical Co-ordinating Committee
- NGO Non-governmental Organisation
- NMCP National Malaria Control Programme
- NORAD Norwegian Agency for Development
- NAC National AIDS Council
- NGO Non-governmental organization
- NTLCP / NTCP National Tuberculosis Control Programme
- NRL Netherlands Leprosy Relief
- OI Opportunistic infection
- PARPA Poverty Reduction Plan
- PNI- DT National Integrated Plan for the Control of Communicable Diseases
- PMTCT Prevention of mother-to-child transmission
- RENSIDA Network of PLWHA Organisations
- STD Sexually transmitted disease
- TB Tuberculosis
- UNICEF United Nations Children's Fund
- USAID United States Agency for International Development
- WHO World Health Organisation
- VCT/VCCT Voluntary and (Confidential) Counseling and Testing
- VSO Voluntary Services Overseas

SECTION I: Executive summary of Proposal

Please note: The Executive Summary will be used to present an overview of the proposal to various members of the Secretariat, the Technical Review Panel and the Board of the Global Fund.

TO BE COMPLETED AFTER THE OTHER SECTIONS HAVE BEEN FILLED OUT

General information: *Table I.a*

Proposal title (Title should reflect scope of proposal)**:**	**Accelerated Access to Prevention, Care, Support and Treatment for PLWHA, Tuberculosis and Malaria**			
Country or region covered:	**MOZAMBIQUE**			
Name of applicant:	**MOZAMBIQUE Country Coordinating Mechanism**			
Constituencies represented in CCM (write the number of members from each Category)**:**	**2**	**Government – Health ministry**	**1**	**UN/Multilateral agency**
	4	**Government – Other ministries**	**1**	**Bilateral agency**
	2	**NGO/Community-based organizations**	**-**	**Academic/Educational Organizations**
	1	**Private Sector**	**1**	**Religious/Faith groups**
	1	**People living with HIV/TB/Malaria***		**Other** (please specify):
If the proposal is NOT submitted through a CCM, briefly state why:				

Specify which component(s) this proposal is targeting and the amount requested from the Global Fund:** *Table I.b*

			Amount requested from the GF (USD)					
			Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Component(s)	**X**	**HIV/AIDS**	12,718,750	16,974,082	22,155,327	26,349,619	31,140,995	109,338,777
	X	**Tuberculosis**	5,372,214	6,809,120	2,099,016	2,197,816	1,712,830	18,190,814
	X	**Malaria**	7,008,252	5,259,870	5,347,070	5,179,210	5,270,770	28,065,171
		HIV/TB						
		Total	25,099,216	29,043,072	29,601,413	33,726,645	38,124,595	155,594,941
Total funds from other sources for activities related to proposal (*)								

(*) It was difficult to obtain the Government and the donor pledges for these periods, in particular for the tuberculosis and malaria components. However all the known fundings for HIV are provided under section 21.4 and in Table 22.2a, however the pledges could not be split per year for most donors.

Please specify how you would like your proposal to be evaluated*** (mark with X):

The Proposal should be evaluated as a whole	
The Proposal should be evaluated as separate components	**X**

* According to national epidemiological profile/characteristics

** If the proposal is fully integrated, whereby one component cannot be separated from another, and where splitting budgets would not be realistic or feasible, only fill the "Total" row.

*** This will ensure the proposal is evaluated in the same spirit as it was written. If evaluated as a whole, all components will be considered as parts of an integrated proposal. If evaluated as separate components, each component will be considered as a stand-alone component.

Brief proposal summary (1 page)(please include quantitative information where possible):

- **Describe the overall goals, objectives and broad activities per component, including expected results and timeframe for achieving these results:**

Brief proposal summary (1 page)(please include quantitative information where possible):

The proposal aims to address the three diseases: HIV/AIDS, TB and Malaria by interlinking them with the cross cutting issues of :

- Health system strengthening
- Human resources development, increasing capacity for the efficient management and utilization of resources
- Improving services to rural areas, the poor and underserved.
- Monitoring and Evaluation

The HIV/AIDS Component (Expected outcome, key outputs and beneficiaries)

The Component´s goal is to reduce, and ultimately halt, the spread of HIV/AIDS and mitigate the impact on those infected and affected. The strategy is to provide a comprehensive programme of prevention, care, and support that builds upon existing community, governmental, and non-governmental activities and creates a response continuum that extends from the highest levels of government down to the individual household. The proposal is designed to support the Government of Mozambique its partners in their efforts to scale-up their multisectoral response to the AIDS epidemic. This component responds to the needs and priorities outlined in the NSP and the Mozambique Action Plan for the Reduction of Absolute Poverty (2001-2005), known as the PARPA. The HIV/AIDS component is organized under two mutually reinforcing sub-components: (1) Prevention and mitigation of the social impact of HIV/AIDS; and (2) Care, treatment, and support for persons with HIV/AIDS *(Detailed quantified objectives and expected outcomes and results table is presented as Annex I of Section I, which is at the end of this section).*

The Prevention and Mitigation sub-component has six objectives and includes a range of activities designed to address the multiple needs relating to prevention among young people, social mobilisation and the care of affected communities, particularly orphans and other children made vulnerable by HIV/AIDS. This will be achieved by working directly with those social groups most vulnerable to HIV/AIDS and by empowering local communities to cope with the challenges presented by HIV/AIDS. It is expected that by the end of the proposal cycle (2007):

- 50 percent (approx. 3 million) of adolescents and youth aged 10-24 will benefit from knowledge, skills and services to protect themselves from HIV infection,
- 82 million condoms will be procured so that together with contribution from other donors so as to ensure at least 80 percent of the condom needs of the adult population, 15-49 years.
- Over four million people will be reached through well-structured mass communication programmes on HIV/AIDS prevention, care and treatment;
- # % of the population will be sensitized on the gender dimension of the AIDS epidemic and # of women and girls will be provided with information and skills to protect themselves.
- Capacity will be strengthened and partnerships will be forged at all levels with the view to ensuring the care and protection of over 150,000 AIDS orphans and other children affected by HIV/AIDS.

Care, Treatment and Support for PLWHA: This sub-component approach aims to take to national scale an Integrated Health Network (IHN) for HIV/AIDS prevention and care. The IHN builds on existing health services to provide a comprehensive package of HIV/AIDS prevention and care that includes condom distribution, IEC activities, STD care, treatment of OIs, VCT, PMTCT interventions, and home-based care. 5o Integrated Health Network sites, each serving a target population of approximately 100,000, will be created or upgraded with support from the GFATM. The target sites were selected based on the estimated burden of HIV/AIDS per province. Within each province, the sites chosen for each implementation phase were chosen based on HIV prevalence, target population in reach of the potential sites, and readiness of public health infrastructure and NGOs to proceed rapidly with implementation. It is expected that by the end of the proposal cycle (2007):

- At least 90 percent of adults in all target districts will be made of the existence and location of VCT and PMTC services;
- At least 75 VCT centres (50 plus currently operating 25 centres) will be functional;
- The number of people receiving counseling and testing will reach over 80,000,
- At least 56 Day-Clinics will be operational and will have treated at least 56,000 persons for OI;
- 22 clinics will have developed capacity to administer ARV treatment and will be treating 20,000 (or 4 percent of those needing ARV treatment);
- The percentage of women accepting VCT testing in the maternities where services are offered will increase to 70 percent.
- At least 20,000 babies born to HIV positive mothers will receive Nevirapine according to national guidelines,
- 20,000 of PLWHA will receive home-base care, with 80% receiving at least three HBC visits a month,
- Knowledge of Integrated Network services among health staff will increase by 90 percent;
- Management systems will be strengthened at all levels to ensure an effective and efficient response.

The Tuberculosis Component (Expected outcome, key outputs and beneficiaries)

The Component aims to strengthen the current TB services to be able to expand efforts to reach 100 percent of the population. The Objectives of the TB intervention are to (1) to improve and expand case detection to 70 percent of new cases through sputum smear microscopy examinations by 2007; (2) increase the TB treatment success rate of registered smear positive cases to at least 85 percent. Its main strategy is to promote easier access to information for prevention; diagnosis; early and effective treatment and cure for each TB patient within an expanded framework. The foci of interventions include:

- Promoting/ maintaining high cure rates using DOTS
- Improved and expanded case detection
- Integration of TB activities into general health services, particularly with the HIV/AIDS programmes
- Provision of guidelines for all health providers on the proper management of respiratory diseases
- Home based care using community volunteers and traditional health care providers
- Involvement of private and non-governmental health providers.
- IEC and social mobilization
- Capacity building
- DOTS expansion to the most remote or peripheral areas.

The TB component seeks to ascertain availability of the five essential elements of the DOTS, while paying attention to HIV related and drug resistant forms of TB. It therefore includes strategies for maintaining political commitment in terms of human and financial resources; access to quality assured sputum microscopy; standardised short course chemotherapy for all TB cases under proper case management conditions; uninterrupted supply of quality-assured drugs and a recording and reporting system to enable outcome assessment. It approaches the TB problem on two fronts. It will work collaboratively with the other sectors in the integrated Networks and home-based care,but will also use its own initiative in extending case finding and access to treatment to the level of existing health posts. . It is expected that by the end of 2007:

- 70 percent of smear positive diagnosed by passive screening.
- 85 percent all new TB smear positive cases each year identified.
- Less than 10 percent of treatment default rate.
- 100 percent of cases reported to the public health services treated with DOTS.
- 100 percent timely and accurate quarterly reporting from DOTS health facilities.

The number of beneficiaries of the Tuberculosis Component are:

- 10 million people will benefit from IEC and case finding
- 55,000 TB patients within the catchment's areas of 149 existing health facilities, will benefit from case finding and treatment with DOTS.
- TB patients among prisoners, refugees and in the mining industries will benefit from case detection and treatment with DOTS
- Family members of TB patients and their household contacts

- The skills of the following will be upgraded with regard to management/expansion of TB services: NTCP provincial and district staff, 2400 Health post staff and volunteers, 11 existing provincial supervisors and 150 new or retired nurses to work at health centre/district hospital level.

The Malaria Component ((Expected outcome, key outputs and beneficiaries)

The overall goal of the malaria proposal is to reduce malaria morbidity and mortality by at least 25% in 10 selected districts from five provinces by 2007. The objectives of this component are (i) To expand the human and institutional capacity and build systems for malaria control programme at national, provincial and district levels, and scale up RBM implementation by introducing it into 10 districts of five provinces by 2007, (ii) To scale up Community Based Malaria Prevention And Treatment through ITNs use, early recognition of malaria symptoms and prompt treatment, and intermittent presumptive treatment in pregnancy (iii) To improve and expand effective malaria diagnosis and referral systems in health facilities in 10 selected districts to ensure effective case management and (iv) To provide preventive services through IRS to about 240,000 persons living in suburban areas in 10 districts. Activities designed to achieve this goal include training of community-based volunteers, mothers and child caretakers and health facilities staff how to recognise signs and symptoms of malaria and danger signs for which immediate medical help must be sought, conduct awareness campaign at community level to increase demand for and the use of ITNs and management of malaria at the community level using appropriate drugs and introduction of a new drug therapy at health facilities. Other activities include vector control in peri-urban areas of the target districts and capacity building at all levels to enable the NMCP respond to the scourge of malaria in Mozambique. Expected results include reduction in the morbidity and mortality associated with malaria especially among children below 5, pregnant mothers and people living with HIV/AIDS. Ultimately this program will contribute to the reduction of absolute poverty in the target communities. These results will be achieved over a 5-year period – 2003 through 2007.

The beneficiaries of the malaria component are shown in the table.

Province	District	Total Population	< 5years	Pregnant Women	No. of Families
Nampula	Nacala Velha	77 918	14 025	3 896	21 479
	Mussuril	89 457	16 102	4 273	23 507
	Monapo	226 968	40 855	11 349	57 165
Inhambane	Massinga	186 650	33 597	9 333	43 680
	Morrumbene	110 817	19 947	5 541	26 816
Tete	Changara	119 551	21 519	5 878	28 553
	Moatize	109 103	19 639	5 455	25 004
Sofala	Nhamatanda	137 930	24 827	6 897	30 320
	Dondo	117 719	21 190	5 886	25 917
Maputo	Magude	42 788	7 705	2 140	9 752
Grand Total		**1 218 901**	**219 406**	**60 648**	**292 193**

Benefits that are expected to accrue to the beneficiaries include reduction in absenteeism at work and school due to reduction in the number of malaria attacks, improved pregnancy outcome among pregnant mothers, improved survival rates of newborns due to higher birth weights, and better quality of life among PLWHAs. Others include job opportunities for the community members who will be involved in program activities and increased income due to higher productivty at the household level.

If there are several components, describe the synergies, if any, expected from the combination of different components (By synergies, we mean the added value the different components bring to each other, or how the combination of these components may have effects beyond the effects of each component taken individually):

The collaboration between the NAC and the MOH, and the institutional strengthening of both institutions would impact positively on the national health system and its response to HIV/AIDS and communicable/endemic diseases control.

The Global Fund process will catalyse the establishment of the Health Common Fund, and speed up the abolition of the existing fragmented financial arrangements for donor support within the MOH.

The comprehensive review of human resources requirements for the health sector's response to HIV/AIDS..

The efficiency savings from the joint training of different cadres of health providers for service provision in the Integrated Health Network model.

Cross-cutting issues like improved lab diagnosis, home based care, social mobilization, advocacy, IEC activities and surveillance systems will support TB, HIV/AIDS and malaria activities for increased synergy and impact. They will improve efficiency in the health sector and reduce costs.

GOAL	To reduce, and ultimately halt, the spread of HIV/AIDS and mitigate the impact on those infected and affected	
SUB-COMPONENT I : Prevention and Mitigation of the Social Impact of HIV/AIDS		
Objective/Broad Activity	*Summary of Expected Outcomes and Results/Outputs*	Responsible partners
***Objective** 1: Prevention among Young People*	50% (approx. 3 million) of young men and women between the ages of 10 and 24 have access to knowledge, skills and services to protect themselves from HIV infection.	
Activity 1: Youth-Friendly Health Services	• 44 Youth-Friendly will be established and supported in five provinces ; • 220 health workers will be trained • 4,250 peer educators (850/year) will be trained to educate and counsel youth. • Ministry of Health capacity will be strengthened	Ministry of Health in partnership with NGOs (AMODEFA, Pathfinder International, CARE and GOAL)
Activity 2: Community-based youth programme	• 1,100,000 young people, in particular out-of-school youth, will received information and skills • 185 youth corners will be established benefiting more than 300,000 young men and women. • Approx. 100 youth associations will receive institutional and technical support • Ministry of Youth capacity will be strengthened.	Ministry of Youth and Sports in partnership with NGOs (AMODEFA, Pathfinder International, CARE and GOAL)
Activity 3: School-based programme	• 1,800,000 children (primary and secondary) will be reached • 14,500 school teachers will be trained on HIV/AIDS and use of new materials/curriculum on HIV/AIDS life skills and information • 50,000 school children will be counselled • 2,665 peer educators and counsellors will be trained • Parents and community leaders will be mobilized.	Ministry of Education in partnership with NGOs (ADPP, Pathfinder International, CARE, GOAL)
Objective 2: **Condom promotion and distributiont**	There will be increased availability of condoms (in 100% of public service delivery points and other strategic locations) and promotion to increase awareness among four million men and women.	
Activity: Promotion and Distribution	• 82 million additional condoms will be distributed • Four million people will be reached through IEC • 1000 sex workers and partners will participate in operations research on acceptability of female condoms	Ministry of Health
Objective 3: Communication for Positive practices	Over four million people reached through multi-media communication campaign to increase awareness on prevention, reduce stigma and discrimination; promote gender equity and create demand for services.: .	
Activity 1: Partnership with media	• At least 50% of broadcaster and other media workers of five provinces will receive training • Well-researched and structured radio programmes on HIV/AIDS will be developed and aired to reach audience of more than 4 million • Partnership developed between media and other stakeholders.	National AIDS Council through NGO: Media Partnership Support (MPS)
Activity 2: Empowerment of women & male involvement	• 216 000 women and girls will be mobilized through the Circle of Interest initiative • 216 000 men will be gender sensitised with a view to increase male and reduce violence against women and girls.	OMM (Mozambican Women's Organisation)
Objective 4: Orphans and Vulnerable Children	Capacity will be strengthened at all levels to ensure the care and protection of orphans and other vulnerable children (OVCs) (contribute to meet national programme targets of 150,000 OVCs)	
Activities	• 100 district-level programme managers trained • 1310 service providers (teachers, health workers,) sensitised • 215 OVCs committees established and supported • 2365 community mobilizers equipped with counseling skills, (links with Home-based care) • Grants to NGOs for direct support to needy children • Facilitate links with existing services, including food distribution.	Ministry of Women & Social Action thru NGO ADPP and other NGOs
Objective 5 Support to PLWHA	PLWHA will be better organized and equipped to effectively advocate for the respect and fulfillment of their rights and support prevention and care activities	
Activities	• PLWHA associations will be provided with institutional and technical skills • Newly-created PLWHA Network will be supported and experience sharing promoted.	National AIDS Council through CARE (in collaboration with RENSIDA)
SUB-COMPONENT II: Care, Support and Treatment (Integrated Health Networks)		

Objective 6: To increase knowledge, skills, and motivation for utilization of IHNs	▪ Individual knowledge of existence and location of VCT services increases up to over 90% at the end of 5 year in all the districts where IN site exists. ▪ Individual knowledge of the availability of prevention of mother-to-child-transmission increases to over 90% at the end of 5 year in all the districts where IN site exists.	
Activity: IEC activities to promote use of Integrated Network sites	▪ 5000 opinion leaders and 5000 peer educators trained in all 50 sites. ▪ Opinion leaders and peer educators disseminate messages widely to their communities. ▪ Public service announcements developed in Portuguese and at least 6 local languages promoting and educating communities about Integrated Network services.	MOH and NGOs
Objective 7: To increase the number of persons who know their HIV status	▪ VCT centers are opened at the scheduled rate until a total of 75 are functioning at the end of the 5th year. ▪ The number of people receiving counseling and testing reaches over 80,000 by year 5 of the intervention	
Activity: Training of counselors and supervisors and installation of VCT centers	▪ At least 3 counselors and 1 supervisor are trained for each new VCT center. ▪ VCT centers are equipped with materials for testing, Q/A, IEC, and data management systems to insure best quality services. ▪ Monitoring and evaluation systems are set up so that by the end of the 5 year period, at least 75% of persons attending VCT receive services following national standards	MOH, NGOs, CDC and other partners
Objective 8: **P**revention and treatment of AIDS and opportunistic infections	▪ Day clinics will be opened according to the national plan. These clinics will number 56 and will have treated 56,000 persons for OI at the end of the 5-year period. ▪ At the end of 5 years, 22 of these clinics will also have developed the capacity to administer ARV treatment and will be treating 20,000 (or ~4% of those people needing ARV treatment)	
Activity: Establishment of day clinics	▪ One physician, one medical assistant and one nurse will be trained per day clinic for a total of 150 clinical staff in all 50 day clinics. In a subset of 20 sites, staff will be trained in ARV treatment administration. ▪ The percent of appropriate referrals from the clinic for home-based-care will increase to 70% in the 5th year, as this component develops. ▪ Training of health care workers on appropriate diagnosis and treatment of STIs will reach 85% in year 5. ▪ Involvement of associations of PLWHA will increase to at least one association per site at the end of year 5.	MOH, NGOs, and other partners.
Objective 9: Prevention vertical transmission	▪ The percentage of women accepting VCT testing in the maternities where services are offered increases to 70 percent. ▪ The number of babies born to HIV+ mothers and of HIV+ mothers who receive Nevirapine according to national guidelines increases to 20,000 in year 5. ▪ Peer support groups for PMTCT are created in every site.	
Activity: Implementation of PMTCT services	▪ Antenatal clinic health staff trained for counseling and administration of ARV medicines increases to a total of 150 in year 5 (3 per site). ▪ Antenatal clinics train at least one person to provide VCT services in the premises to a total of 50 in year 5.	MOH, NGOs, and other partners.
Objective 10: basic medical care and psychosocial support in PLWHA homes	▪ The number of PLWHA enrolled in home-based care programs increases to over 20,000 in year 5, and over 80% of these persons receive services according to national guidelines. ▪ The number of PLWHA receiving at least 3 HBC visits in the last month increases to 80% in year 5.	
Activity: Develop HBC services for PLWHAs	▪ The number of accredited HBC organizations increases so that there is at least one organization per site in year 5. ▪ 100 volunteers per site are trained for a total of over 5,000 volunteers trained at the end of year 5. ▪ At least one nurse supervisor is trained per site for a total of 50 over 5 years. ▪ The quality of service is insured by volunteer and nurse supervisors, according to national guidelines for care and referral.	MOH, NGOs, and other partners.
Objective 11: To increase MOH capacity	▪ Knowledge of IN services among health staff increases to 90% at the end of year 5. ▪ At least 95% of sites report no disruption in stock of medicines in year 5. ▪ Monitoring of HIV resistance is fully implemented in year 2.	

Activity: Supervision, monitoring and evaluation of the Integrated Networks.	▪ Advisory council board is organized at the central level and meets on a quarterly basis. ▪ 100% of management and technical staff at central and provincial levels are hired during the first 6 months. ▪ Data management and information systems are developed and in place within the first 6 months of start of the program. ▪ At the end of year two, all sites are reporting to provincial and central level data on the performance of the integrated network, on each component according to specific M&E plans. ▪ During the second year, an evaluation of service provision is performed by the central level team, to provide recommendations for improvement.	MOH, NGOs, CDC, and other partners.

SECTION II: Information about the applicant

Table IIa serves to help you know which questions you should answer in this Section, reflecting the different types of application mechanisms and proposals.

For further guidance on who can apply, refer to Guidelines para. II.8–33

Table IIa

Application mechanism	Type of proposal	Questions to answer
National CCM	Country-wide proposal *(Guidelines para. 14–15)*	1–9
Regional CCM	Coordinated Regional proposal from multiple countries reflecting national CCM composition *(Guidelines para. 24–25)*	1–9 and 10
	Small Island States proposal with representation from all participating countries but without need for national CCM *(Guidelines para. 24 and 26)*	
Sub-national CCM	Sub-national proposal *(Guidelines para. 27)*	1–9 and 11
Non-CCM	In-country proposal *(Guidelines para. 28–30)*	12 – 16
Regional Non-CCM	Regional proposal *(Guidelines para. 31)*	12 – 15 and 17

Proposals from countries in complex emergencies will be dealt with on a case-by-case basis (Guidelines para. 32)

Country Coordinating Mechanism (CCM), (Refer to *Guidelines paragraph 72–78)*

Table IIb

Preliminary questions	(Yes/No)
a). Has the CCM applied to the Fund in previous rounds?	Yes
b). Has the composition of the CCM changed since the last submission?	No
c). If composition of CCM has changed, briefly outline changes (e.g., list of new members or sector representatives)**:**	

1. **Name of CCM** (e.g., CCM Country name, National Committee to fight AIDS, TB and Malaria, etc):

- Mozambique Country Co-ordination Mechanism (MCCM).

2. **Date of constitution of the current CCM** (The date the CCM was formed for the purpose of the Global Fund application. If the CCM builds on or uses existing processes – which is encouraged – please explain this in Question 3)**:**

-04 March 2002

3. **Describe the background and the process of forming the CCM** (including whether the CCM is an entirely new mechanism or building on existing bodies, how the other partners were contacted and chosen, etc.), (1 paragraph):

- Mozambique joined the discussions that led to the preparation by the Transitional Working Group (September – December 2001) of the documentation that governs the Global Fund. In February 2002 a meeting with partners involved in at least one of the three disease components was held to brief them on the process and (new) arrangements by the Global Fund. In this meeting partners were advised to take the information back to their constituencies and propose their representatives to the CCM then in the process of composition. Therefore, the members of Mozambique CCM have been nominated by those whom they represent. Other meetings

followed to deepen the understanding of the CCM's functions, as well as its multi-sector coverage.

3.1. If the CCM is or includes an already existing body, briefly describe the work previously done, programmes implemented and results achieved (1 paragraph):

- No, the CCM does not include an existing body.

4. **Describe the organizational processes** (e.g., secretariat, sub-committee, stand-alone; describe the decision-making mechanism. Provide Terms of Reference, operating rules or other relevant documents as attachments), (1 paragraph):

The CCM formed technical groups to facilitate its work. It is the decision- making organ for all questions related to the Global Fund. It functions with institutional support from the National Aids Council (NAC) and the MOH, with whom the technical working groups for the three disease components are affiliated. The Technical Groups, in their turn, provide the analytical base for the work of the CCM, while being subject to the guidance of CCM. NAC also functions as the Secretariat of the CCM, ensuring that decisions made are appropriately recorded, communicated and executed; and to ensure timely preparation and submission of required reports.

5. **Describe the mode of operation of the CCM (**e.g., frequency of meetings, functions and responsibilities of the CCM. Provide the minutes or records of previous meetings as attachments), (1 paragraph):

The Mozambique CCM met monthly for the first 6 months and thereafter meetings continued on a quarterly basis. Extraordinarily CCM will also meet at the call of the Chair, whenever deemed necessary. The functions of Mozambique CCM comprises the following: Assess the validity of project/proposals in the light of technical advice provided by the technical working groups; ensure transparency and impartiality in the assessment and approval of projects; certify that proposals satisfy the priorities set in national policies and strategies for the three diseases; assure rational and efficient allocation of resources to programmes within the framework of existing mechanisms for fund management; ensure the existence and functioning of mechanisms for monitoring and evaluation based on indicators proposed in the programmes; and provision of financial oversight and disbursement control.

6. **Describe plans to enhance the role and functions of the CCM in the next 12 months, including plans to promote partnerships and broader participation as well as communicating with wider stakeholders, if required** (1 paragraph):

The CCM will be engaging in

- Studying and reviewing its implementation plan for the Global Fund programme in anticipation of a successful proposal
- Advocacy for resource mobilization for HIV/AIDS, TB and Malaria from the HIPC;
- Facilitation of the dialogue on the public sector review, with the aim of impacting on public sector wages, which is critical for the successful propagation of the war on HIV/AIDS, TB and Malaria;
- Advocacy for the speed implementation of the capacity building and institutional strengthening programmes of the MOH and NAC;
- Facilitation of the dialogue on the creation of the Health Common Fund;
- Strengthening of inter and intra-sectoral partnership as well as partnerships with NGOs and Civil Society organizations at all levels;
- Identification of existing best practices in the three programme areas for emulation in the rest of the country;
- District and Community level involvement in decision making;
- Joint planning of community level and home based care initiatives.

Members of the CCM (*Guidelines para. II.16 – 22)*:

Please note: All representatives of organizations included in the CCM must sign this page to be included in the original, hard-copy proposal sent to the Secretariat. The signatures must reach the Secretariat before the deadline for submitting proposals.

Please print additional pages if necessary, including the following statement:

FOR REASONS OF LOGISTICS, PLEASE NOTE THAT THE ORIGINAL SIGNED COPIES OF THIS SECTION ARE ATTACHED TO THE TRANSMITAL LETTER.

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation"

Table II.7

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
UNICEF	Marie Pierre Poirier	Representative		
Main role in CCM				
Member – Representative of Multi-lateral Partners				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
NORAD	Lise Stensrud	Counselor		
Main role in CCM				
Member – Representative of Bi-lateral Donors				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Education	Dr. Telmina Pereira	Vice-Minister		
Main role in CCM				
Member				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Planning and Finance	Dr. Armindo Matos	Finance Senior Inspector		
Main role in CCM				
Member				

* E.g. People living with HIV/ TB/ malaria, NGOs/ Community-based organisation, Private Sector, Religious/ Faith groups, Academic/ Educational Sector, Government Sector.

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
NAIMA (International NGO Coalition)	Gorik Ooms	MSF Head of the Mission		
Main role in CCM				
Member – Representative of International NGOs				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Entrepreneurs Against HIV/AIDS	Jeanne Stephens	Director - Austral Consult		
Main role in CCM				
Member – Representative of Business Organizations				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
MONASO – Network of National NGOs	Emília Adriano	Executive Director		
Main role in CCM				
Member – Representative of National NGOs				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
RENSIDA – Network of PLWHA Organizations	Júlio Mujojo	Executive Secretary		
Main role in CCM				
Member – Representative of PLWHA Organizations				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Mozambique Christian Council	Rev. Marcos Macamo	Director for Ecumenical Services		
Main role in CCM				
Member – Representative of Faith Based Organizations				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Youth and Sports	Joaquim Alfredo Ajane	National Director		
Main role in CCM				
Member				

7.1 Provide as attachment the following documentation for private sector and civil society CCM members:

- **Statutes of organization** (official registration papers)
- **A presentation of the organization, including background and history,scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

7.2 *If a CCM member is representing a broader constituency, please provide a list of other groups represented.*

8. Chair of the CCM and alternate Chair or Vice-Chair

Table II.8

	Chair of CCM	**Alternate Chair/Vice-Chair**
Name	Dr. Francisco Ferreira Songane	Janet Rae Mondlane
Title	Minister of Health	Executive Secretary of the National Aids Council
Address	Av. Eduardo Mondlane, nº1008, 8th Floor - Maputo	Rua António Bocarro , Nº106 – 114, Maputo
Telephone	258 1 31 33 89	258 1 49 53 96
Fax	258 1 42 71 33	258 1 48 50 01
E-mail	ffsongane@teledata.co.mz	janet@virconn.com
Signature		

9. Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

Table II.9

	Primary contact	**Second contact**
Name	Janet Rae Mondlane	Rosa Marlene Manjate
Title	Executive Secretary of the National Aids Council	Head of Department – Ministry of Health
Address	Rua António Bocarro , Nº106 – 114, Maputo	Av. Eduardo Mondlane, nº1008, 2th Floor - Maputo
Telephone	258 1 49 53 96	258 1 43 09 70
Fax	258 1 48 50 01	258 1 43 09 70
E-mail	janet@virconn.com	mmanjate@dnsdee.imoz.com

10. For <u>coordinated regional proposals</u> and <u>Small Island States proposals</u> describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve *(Guidelines para. II.24),* (1 paragraph):

10.1. For coordinated regional proposals, provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment (e.g, letter of endorsement from Chair/Alternate of CCM or equivalent documentation).

11. Sub-national Proposal from Large Countries

11.1. Explain why a sub-national CCM mechanism has been chosen(1 paragraph):

11.2. Describe how this proposal is consistent and fits with nationally formulated policies and/or how it fits with the national CCM plans *(Guidelines para. II.27),* (1 paragraph):

11.3. Provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment *(Guidelines para. II.27),* (e.g, letter of endorsement or equivalent documentation).

Non-CCM applicant

12. Name of applicant:

13. Representative of organization applying:

Table II.13

	Representative	**Alternate**
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

14. Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

Table II.14

	Primary contact	**Secondary contact**
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

15. Description of applying organization

15.1. Indicate what type of organization the applicant is (mark with X):

Table II.15.1

	Non-Governmental Organization (NGO) or network of NGOs
	Community based Organization (CBO) or network of CBOs
	Private Sector
	Academic/ Educational Sector
	Faith-based Organization
	Regional Organization
	Other (please specify):

15.2. Provide as attachment the following documentation:

- **Statutes of organization** (official registration papers)
- **A presentation of the organization, including background and history, scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

16. Justification for applying outside the CCM

16.1. Indicate reasons for not applying through the CCM (Explain clearly the circumstances, conditions and reasons; *Guidelines para. II.28–29*), (1–2 paragraphs):

16.2. Have you been in contact with the CCM in your country or other relevant governmental agencies (e.g. Ministry of Health, National AIDS Council)**? If so, what was the outcome? If not, why?**

16.3 Include letters from supporting organizations (e.g. human rights groups, NGO networks, bilateral or multilateral organizations, etc) supporting your reasons for not applying through a CCM as attachment.

17. For regional proposals from Regional Organizations or International Non Governmental Organizations, describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve *(Guidelines para. II.24),* (1 paragraph):

17.1. Provide signed letters of endorsement from the national CCMs or, if there is none, from other relevant national authority for the countries covered by the proposal as attachment.

SECTION III: General information about the country setting

*Please note: For **regional proposals**, the information requested in this section should reflect the situation in all countries involved, either in an aggregated form or by individual country.*
*For **sub-national proposals**, the information requested should reflect the situation in the particular sub-national area within the overall country context.*

18. Describe the burden or potential burden of HIV/AIDS, TB and /or Malaria: *(Describe current epidemiological data on prevalence, incidence or magnitude of the epidemics; its current status or stage of the epidemics; major trends of the epidemics disaggregated by geographical locations and population groups, where this data is available and/or relevant; Guidelines para. III.37 – 38), (1 – 2 paragraphs per disease covered in proposal):*

HIV/AIDS

Mozambique has one of the highest HIV prevalence rates in the world. According to the data from the 2000 sentinel surveillance (INE/MOH 2000)[1], 12.2% of the adult population (15-49 years) is HIV positive. As of that year, over 1.1 million Mozambicans of all ages were living with HIV/AIDS of whom approximately 10% were children infected through vertical transmission. More than 60,000 children were orphaned due to AIDS. Further, the projections indicate that throughout 2001, more than 500 people became infected with HIV each day in Mozambique, the majority youth under 29 years.

The epidemic is particularly severe in the central provinces of Tete, Manica, and Sofala with the average HIV prevalence rate exceeding 19%**,** and in the southern Gaza Province with more than 16 %of the population infected.

The principal mode of transmission among adults is unprotected sexual relations where women are the most vulnerable. Nearly 57% of the Mozambican adults (15-49 years) living with HIV/AIDS are women. The gender disparity is even more striking within the age group of 20-24 years where women living with HIV outnumber men by four to one.

It is projected that the HIV prevalence rate among the adult population will increase to 16% by the year 2007, the number of people living with HIV will rise to nearly 1.8 million, unless the trend is drastically reversed. The number of new AIDS cases will increase from the 61,000 in 2000 to 170,000 by the year 2010, which will cause a tremendous impact on the already overburdened health services. By the end of the decade, the epidemic will lower life expectancy from the anticipated 50.3 years to 36.5. With the rapidly increasing death rate, the epidemic will leave behind more than 900,000 maternal orphans.

Inter-relationship between AIDS and TB and other diseases

It has been estimated that in a population with 10% HIV prevalence, approximately 40% of TB cases can be attributed to HIV infection. In addition it has been reported that 50% of HIV persons will have developed TB in their lifetime in sub-Saharan Africa.

Nationally the HIV prevalence among TB patients is about 32%, with a range between 2% and 53% in different areas. Where HIV testing is carried out on in-patients suffering from diseases related to internal medicine in the major referral hospitals, 40-50% of the test results are positive. In addition, more than 75% of patients in wards of TB referral hospitals are HIV positive. HIV may also have changed the clinical and resistance picture of TB, compounding the difficulties of diagnosis and treatment. A comprehensive programme of testing and counselling and collaboration between the TB and HIV/AIDS services is however not yet in place in most facilities.

TUBERCULOSIS

[1] Demographic Impact of HIV/AIDS in Mozambique. Ministério da Saúde, Ministério do Plano e Finanças, INE, Centro de Estudos de População, 2002. The results of the Demographic Impact of HIV/AIDS in Mozambique are based on the HIV rates from the 2000 epidemiological surveillance round. The application of the AIM - AIDS Impact Model - produced the projections of demographic impact of HIV/AIDS.

Mozambique was added to the list of high-burden countries following a revision of TB incidence estimates for 1999. Information from the Department of Epidemiology shows TB as the third leading cause of hospitalization, after acute respiratory infections and malaria. There are 21.000 TB cases per year and 30-32% are co-infected with HIV. The estimated annual risk of TB infection is 1.7%, empirically corresponding to about 94 new smear positive cases per 100,000 inhabitants /year. With a population of 17 million, the expected number of smear positive TB cases in Mozambique is close to 17,000 per year. In 2000, 13,257 smear positive TB patients were registered. The estimated incidence is around 254/100,000 inhabitants. Of 21,329 tuberculosis patients registered in year 2000, 8% were re- treatment cases. The actual tuberculosis case detection rate of smear positive in Mozambique is 84%.The World Health Organization (WHO) and International Union against Tuberculosis and Lung Disease (IUATLD) have recommended performing routine surveillance of MDR-TB in Mozambique in order to enhance the monitoring and guiding of tuberculosis treatment in NTCP. Until 1997 National Reference Laboratory drug resistance studies have only been performed in a few main cities. In 1999 a country wide study done using a WHO/IUATLD methods demonstrated a 3.5% prevalence of combined MDR (primary and in patients previously treated). Treatment coverage and treatment success rates are high: in 2000, DOTS coverage was reported to be 100%, and success under DOTS was 71% for 1999, up from 67% for the 1997 cohort.

MALARIA

Malaria is endemic and accounts for the highest incidence of disease in Mozambique. Children under five years of age and pregnant women are the most vulnerable groups. Although prevalence data are not available for the whole country, it is known that in some areas 90% of the children under five are positive for plasmodium falciparum infestation. The disease accounts for up to 44% of all out-patient consultations and 57.6% of all paediatric admissions at the Rural and General Hospitals. Malaria is the leading cause of death in paediatric in-patient wards in Mozambique; 32% (617/1954) in 1998, 42% (764/1734) in 1999and 40% (498/1242) in 2000.

Malaria and malaria-associated anaemia also contribute to the high rate of maternal mortality observed (1,500 per 100,000 births) in the country. Through anaemia and haemorrhage-related complications, malaria is the leading cause of low birth weight in newborns. According to the official epidemiological reports received by the Ministry of Health in 2001, about three million cases of malaria were reported among a total estimated population of 17 million.

National meetings held in 2000 and 2001 concluded from research data that chloroquine is no longer effective as the first-line treatment in Mozambique. The Ministry of Health finalised a new drug policy for combination therapy in August 2002 and new guidelines will be finalised shortly.

19. Describe the current economic and poverty situation *(Referring to official indicators such as GNP per capita, Human Development Index (HDI), poverty indices, or other information on resource availability; highlight major trends and implications of the economic situation in the context of the targeted diseases; Guidelines para. III.39), (1–2 paragraphs*):

Despite considerable progress since the 1992 Peace Agreement, Mozambique remains one of the poorest countries in the world. According to the most recent UN Human Development Inde, Mozambique ranks 157 out of 162 countries. GNP per capita is US$230 (1999); external debt as apercentage of GNP stands at 148.7% (2000); and 69.4% of the population live below the poverty line (1997).

The incidence of poverty is higher in the rural areas (71.3%), where 79.7% of the population lives, than in the urban areas (62%). Some 65% of the population below the poverty line is illiterate, governed by traditional rules and values, where gender inequality is one of the salient features of traditional power structures. The causes of poverty in Mozambique include a variety of historical and current factors: (1) low rates of economic growth throughout the early nineties; (2) poor education levels, especially amongst women; (3) high household dependency rates; (4) low agricultural productivity, particularly in the small-holder sector; (5) lack of employment opportunities and; (6) infrastructural constraints, particularly in rural areas.

While GDP grew by 7.5% from 1996 to 2001, Mozambique remains highly vulnerable to external shocks. The devastating floods of 2000 and 2001 resulted in a fall of GDP from 10.1% in 1999 to 2.1% in 2000. Mozambique remains highly vulnerable to climatic changes often with tremendous impact on the people, livestock, property and the physical infrastructure. In 2000 and 2001 the floods caused considerable disruption

and devastation. Currently, Mozambique is one of the Southern African countries affected by the drought. An estimated 500,000 are facing starvation.

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Table1.1 Key Development Indicators

INDICATOR	VALUE	YEAR
Population size	16.8 million	1999
Annual population Growth Rate	2.4%	1997
Life Expectancy at Birth (years)	43.5 years	1999
GNP per capita	US$210	1999
External Debt as % of GNP	148.7%	2000
Poverty headcount ration (% of Population below poverty line)	69.4%	1997
Proportion of rural population under poverty	71%	1997
Proportion of urban population under poverty	62%	1997
Proportion of underweight children (under 5 years)	26%	2000
Net primary enrolment	19.8%	1998
Ratio of girls to boys in primary education	75.6%	2000
Infant Mortality Rate	146	1997
Under five mortality rate	246	1997
Maternal mortality rate	158	1998
% of population relying on traditional fuels for energy use	95.9%	2000
Prevalence of HIV/AIDS	12.2%	2000
Adult literacy	43.3	2000
Adult literacy – male	60%	2001
Adult literacy – female	29%	2001

20. Describe the current political commitment in responding to the diseases (indicators of political commitment include the existence of inter-sectoral committees, recent public pronouncements, appropriate legislations, etc.; *Guidelines para. III.40),* (1–2 paragraphs):

There is ample evidence of government support for HIV/AIDS, TB and Malaria intervention programmes. This is evidenced by the government's policy directives, financial commitments, participation in, and assenting to international and Regional (SADC) declarations in the three areas as reflected below.

Policy Directives

The Government's poverty reduction strategy (PARPA 2001-2005) is committed to combating HIV/AIDS as well as fighting tuberculosis and malaria, increasing the extent and quality of health care; bridging the equity gaps; ensuring equitable financial arrangements that protect the poor and enhanced efficiency (**See attached**). Strategies for Tuberculosis, Malaria and other preventable diseases, aimed at improvement of equity and quality of care in order to reduce maternal and child mortality rates are in the government's action plan oriented to poverty reduction. Government has shown continued commitment to the needs of women, children and the poor by establishing a Ministry of Women & Social Action.

The health sector has approved a National Strategic Plan for health that comprises a sector wide approach, bringing together partnerships for multi-sector interventions to fight HIV/AIDS, TB and malaria

Evidence of the increased leadership and political commitment to an expanded response to HIV/AIDS include:

- Formation of a **National AIDS Council (NAC)** led by the Prime Minister and composed of members from the Government and Civil Society in May 2000 to guide and co-ordinate the fight against STD/HIV/AIDS
- An increase in resources committed, with Government allocating more than $15,000,000 for three years to provide additional funds for HIV/AIDS
- Appointment of Provincial HIV/AIDS co-ordinators (NAC) in March 200, leading to the developing and costing of Provincial HIV/AIDS Plans
- Formulation by 15 line ministries of operational HIV/AIDS plans for their respective sectors

- Consistent reference by political leaders to HIV/AIDS as a major threat to the development of the country. The President called the epidemic a national emergency in September 1999 when he launched the National Strategic Plan for HIV/AIDS.
- Passage by Parliament in 2001 of a law protecting the rights of people living with HIV/AIDS in workplace
- Evidence of greater involvement of people living with AIDS, including current efforts to create a national umbrella of PLWA (RENSIDA).
- Facilitation by the GoM of the coming together of the various stakeholders - ASOs under MONASO; Private Sector under the Business Against AIDS Group, Forum of faith-based organizations, etc.
- Government endorsement the Declaration of Commitment on HIV/AIDS adopted by the General Assembly of the UN in June 2001.

Government's commitment to the control and eradication of TB has been long standing. The Government established the **Mozambique National Tuberculosis Control Program (NTCP)** in 1977, two years after Country's independence. The NTLCP has since had strong overall political commitment from Government, as well as technical commitment from the Ministry of Health. It's responsibilities include planning, and co-ordinating activities nation-wide, provision of manuals and guidelines, training or preparing new appointed staff to be involved in the NTLCP, managing anti-TB drugs and analysing statistics for input into policy and decision-making.

The National Malaria Commission was created to co-ordinate actions across Ministries and sectors and includes other relevant ministries such as Education, Agriculture and Environment. The National Malaria Commission expresses the political commitment of the Government to tackle the malaria problem. The **Malaria Technical Co-ordinating Committee** (MTCC) is composed of members from MoH, WHO, UNICEF, INS, CISM, USAID, IMCI. The purpose of this committee is to create a critical mass of scientists, technical experts and managers from those agencies to support operational efforts of the NMCP. This committee will be the focal point for operational decisions in support of the implementation of the National Malaria Control Strategy.

The UN WORKING GROUP ON HEALTH plays a sound role of advocacy and mobilization of resources in support of the Government of Mozambique, in implementing the RBM Initiative.
Strategic Documents and Actions

Comprehensive strategic documents have been developed for HIV/AIDS, TB and Malaria. The three diseases are afforded the highest priority in the MOH's 2002-2006 plan of action, within the development of the Health Sector SWAps programme.

21. Financial Context

The National Control Programs for Tuberculosis, Malaria and the National AIDS Council have been increasingly benefiting from government's funds and debt relief initiative. Due to the concomitance with other health, social and economic burdens, however, the government's contribution is still far behind the real demands. Some financial gaps are covered by enhanced international support. However, the magnitude of these communicable diseases underscores the need for additional funds from both government and international partnerships.

21.1. Indicate the percentage of the total government budget allocated to health*:

In 1997, 6.3 % of the total government budget was allocated to health. Private out-of pocket spending has never been assessed thoroughly

21.2. Indicate national health spending for 2001, or latest year available, in the Table III.21.2*:

Amounts are in USD Table III.21.2*:

(*)	**1997**	**1998**	**1999**	**2000**	**2001 (**)**	**2002 (**)**
Total spending	82,239,373	96,559,911	121,375,737	147,612,454	185,038,497	205,805,151
Spending per capita	5,0	5,7	7,0	8,3	10,2	11,1
% External funding	61,8	62,0	55,4	51,7	53,3	55,6

Expenses in % of GDP	2,3	2,4	2,8	3,4	3,7	3,8

Soucre : Work in progress - Health Expenditure Review - MOPF / MOH July 2002

(*) Constant prices 1997 - Exchange rate 11.297 mz = 1 USD in 1997

(**) Estimations.

21.3 Specify in Table III.21.3, if possible, earmarked expenditures for HIV/AIDS, TB and/or Malaria (expenditures from the health, education, social services and other relevant sectors)**:**

Table III.21.3

Total earmarked expenditures from government, external donors, etc. Specify Year: 2002	**In 1000 US dollars:**
HIV/AIDS	16,036
Tuberculosis	1, 600
Malaria	6,000
Integrated communicable disease programme	1,097
Total	**24,733**

Note: The National Integrated Plan for the Control of Communicable Diseases (called PNI-DT) is an integrated approach and focuses on the control of the main prevalent diseases (tuberculosis, leprosy, malaria and HIV/AIDS). Expenses for this programme are not disaggregated per disease. The data in the above table does not include the value of the drugs that are procured through a pooling mechanism at the National Directorate of Health. A sizeable proportion of these funds is managed directly by the funding agencies (WHO, UN agencies, bilateral and NGOs) and by sub-contracting national and international organisations.

21.4. Does the country benefit from external budget support, Highly Indebted Poor Countries (HIPC) initiatives[*], Sector-Wide Approaches? If yes, how are these processes contributing to efforts against HIV/AIDS, TB and/or malaria? (1–2 paragraphs)[**]:

The country benefits from the Highly Indebted Poor Countries (HIPC) initiatives. The following figures have been provided by the Ministry of Planning and Finance for the priority areas linked to the health sector and the HIV/ AIDS epidemic control. A portion of the funds allocated to the sectoral ministries are also used for sectoral HIV/AIDS activities.

1000 of USD

Value of debt relief .	**2000**	**2001**	**2002 (Estimates)**
Total	178,915	200,106	161,624
% of GDP	4,8	5,7	4,4
% Health	11,0	2,3	21,1
% HIV/AIDS	0,2	3,3	5,2
% Education	38,1	56,2	35,6
% Social Welfare	3,5	1,4	1,9

The sector wide approach in the Health sector is being developed. There is a Health Common Fund in the Ministry of Health, which government and donors are working on in the Directorate of Planning and Cooperation. Consultations and preliminary studies for this effort are ongoing. The report of one of the studies been supported by DFID, NORAD and the Swedish Corporation will be available at the end of September. The funds of some of the bilaterals as shown in the table below, is already being disbursed through this mechanism. This fund however is not yet fully operational, and its take off date is likely to be mid 2003. All the stakeholders are sparing no effort to meet this target. There is also a Finance Unit in the Directorate of National Health through which most UN programmes in the MOH like EPI, TB, RH etc are funded, through the use of dedicated bank accounts. The intention is to phase out this arrangement when the Common fund described above is operational. There are also two pool funds in the MOH, for provincial non wage expenditure and drugs respectively.

[*] HIPC is a debt-relief initiative for highly indebted poor countries through the World Bank

[**] Optional for NGOs

Table showing important funds managed by the MOH in USD

Category	Average Yearly Turnover	Source of funding	Fund Management at MOH
Wage and personnel expense costs	16-18 millions	State Budget	National Directorate of Administration and Management
Non-Wage related recurrent costs	About 15 millions	State budget and External Budget Support (Swiss, Norway, Ireland and soon EU)	National Directorate of Administration and Management
Drug pool	About 42 millions – increasing	State budget and External Budget Support (Swiss, Norway, Ireland, Holland, DFID, Denmark and soon EU)	National Directorate of Health - Finance section
Communicable disease programs Malaria / Tuberculosis / HIV /AIDS	About 2,1 millions	State and External funding (Norway, UNAIDS, UNDP, UNICEF, EU, WHO and NGOs)	National Directorate of Health - Finance section
"Common Fund" (Estimates) The Common Fund will be operational starting by March 2003. Until now this fund is called the "Fund for the Development of the Health Strategic Plan"	1 million in 2002. Will increase rapidly	External funding (Ireland, DFID, Denmark, Holland, Finland and soon EU)	National Directorate of Administration and Management

There is an operational HIV/AIDS Common Fund in the NAC. To date some donor and government resoucres have been put into this fund and disbursed to institutions to implement HIV activities. NAC has financial officers at central and provincial level, these officers were trained on NAC's financial management system with support from USAID. About 80% of the external funding and 65% of the State budget allocated to the NAC are channelled through the HIV/AIDS Common Fund. Funding agencies include: Ireland, DFID, UNICEF, UNDP, African Development Bank. The Netherlands, Denmark, EU, France and Norway are planning to support the NAC Common Fund soon. The World Bank MAP II (Loan 2003-2007) is likely to be disbursed through the common fund.

Table showing important funds managed by the NAC in USD

	1999	2000	2001	2002	2003	2004	2005
Domestic (public and private)	0	1,3	3,9	3,5	5,0	5,5	5,5
External (*)	0	0,03	0,575	0,865	1	2,0	2
Total		**1.33**	**4.47**	**4.36**	**6**	**7'5**	**7'5**

(*)= This contains only known pledges, so the figure is likely to increase as future pledges are confirmed.

Within the above context, there is evidence that common funds have contributed to HIV/AIDS, TB and Malaria in Mozambique.

22. National programmatic context

22.1. Describe the current national capacity (state of systems and services) that exist in response to HIV/AIDS, TB and/or Malaria (e.g., level of human resources available, health and other relevant infrastructure, types of interventions provided, mechanisms to channel funds, existence of social funds, etc.), (*Guidelines para. III.41 – 42*), (2–3 paragraphs):

The health services are inadequate in terms of coverage and quality of care mainly due to lack of infrastructure and limited managerial and other human resources needed to deliver quality services. There are still serious imbalances among and within the 11 provinces because of concentration of resources in the provincial capital cities, leaving some rural areas underserved. Access to health care is defined in Mozambique as living within 20 kilometres of a health facility. Yet even by that broad standard, less than 40% of the population have access. Quality of care is often poor: long queues at health facilities, short attendance time, under-the-table payments and drug shortages are among the most frequently cited examples. Other problems include over-prescription, poor patient compliance and frequent cold chain breakdowns. Low salaries, poor supervision capacity, high turnover of health workers, unqualified staff, poor working environment and inadequate in-service training all contribute to the low motivation and high absenteeism of health workers.

The health sector is financed both by the government budget (covering about 31% of total health expenditure) and external aid. Internal cost recovery is still negligible. The share of the government budget allocated to the health sector in 1997 was 6.3%, which represents an increase by 18% from 1994 to 1997. Instruments to pool external resources have been introduced in areas of technical assistance and drugs, as has joint auditing of donor funds. See the Attachment on size and distribution of health personnel and infrastructure.

The human resource base has been complemented with expatriate health personnel, including 48 Cubans, 23 Russians/Ukranians, 3 Nigerian Technical Aid Corpers etc. The existence of identifiable sources of competent manpower from these bilateral and multilateral sources at an affordable cost, and to which UN Volunteers, US Peace Corps and British VSO could be added enhances sustainability. This is because it provides a means of getting adequate manpower in the short to medium term to run innovative and ambitious programmes while allowing for the time to recruit and train Mozambican personnel.

22.2. Name the main national and international agencies involved in national responses to HIV/AIDS, TB and/or Malaria and their main programmes[**]:

PRIMARILY HIV/AIDS *Table III. 22.2a*

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programs** (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify time period) **Millions USD**
MOH	Government	HIV activities	Integrated funds for Directorate of National Health
Belgium	Bilateral	Medicines for opportunistic infections	2.4 (02-04)
Denmark	Bilateral	Reproductive health, gender and family education; research in malaria; primary health care and training	11.0 (02-04)
France	Bilateral	Support to national STD/Aids program. Laboratory strengthening, computing of blood banks	1.09 (02-04)
Germany	Bilateral	Support national aids program, capacity building in management, prevention and control of STD/HIV/AIDS in central region, support in the implementation of the national strategic plan	7.13 (02-04)
Netherlands	Bilateral	Social marketing of condoms, sectoral support through medicine supply	0.917 (02-04)
Portugal	Bilateral	Sanitary support, training and peer education programme, professional training on antiretroviral therapeutic	1.12 (02-04)
Spain	Bilateral	Implementation of a VCT, capacity building at district level	4.3 (02-04)
Ireland	Bilateral	NAC common fund and capacity building, support to be incorporated in ongoing activities (health, education and agricultural)	17.75 (02-04)
Italy	Bilateral	Support the epidemiological and microbiological program for communicable diseases	18.763 (02-04)
UK	Bilateral	Condom procurement, 4 multisectoral community based project aimed at supporting diagnosis, treatment, prevention of malaria and HIV/AIDS	63.5 (02-06)
Finland	Bilateral	Support to pharmaceutical pool for distribution of condoms, disposable materials, antibiotics and HIV test kits	3.709 (02-05)
European commission	Bilateral	Prevention for vulnerable groups(miners, refugees, truck drivers, etc, policy/advocacy, production of educational material, radio/TV broadcast	40.81 (02-06)
UNDP	Multilateral	HIV support in current country programme	9 (02-06)
UNFPA	Multilateral	HIV support in current country programme	2,6 (02-06)
UNICEF	Multilateral	HIV support in current country programme	25 (02-06)

[**] For NGOs, specify here your own partner organizations

UNESCO	Multilateral	HIV support in current country programme	3,5 (02-06)
WHO	Multilateral	Vector control & experts Protection, Epidemics Health Education, case management, finances	USD 840,000 (2002-2003)
WFP	Multilateral	HIV support in current country programme	8,5 (02-06)
UNIDO	Multilateral	HIV support in current country programme	0,1 (02-06)
USAID	Bilateral	Procurement of condoms, support to NGOs	9,45 (02-03)
World Bank	Loan MAP II	Community initiatives, capacity building, develop private sector, support to NAC and MOH	50 (03-07)

MALARIA *Table III. 22.2b*

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programs** (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify time period)
MOH	Government	Programme management, finances	Integrated funds for Directorate of National Health
UNICEF	Multilateral	Community based activities (ITNs and community based treatment, Epidemics Health education, finances	USD 6 000 000 (2002-2004, 2years)
World Bank	Multilateral	Vector control Infrastructure and equipment supply	-
USAID (JSI, HIA and EHP)	Bilateral	Integrated vector control, Personal protection Case Management and Community based activities (IMCI)	-
DFID/ UNICEF	Bilateral	Personal protection Epidemic & emergency aid	-
AUSAID	Bilateral	Integrated Vector control	-
African Development Bank	Bilateral	ITNs	USD 500,000
WVI	NGO	Community Based Malaria Activities and Post-Emergency ITN Distribution	
PSI	NGO	Social Marketing of ITNs and Insecticide Treated Kits	
SCF/US and LWF	NGO	Emergency and Post-Emergency Response and ITN/Re-Treatment Kit Distribution and Malaria Participatory Education	
Instituto Nacional de Saude (INS)	Government	Malaria Research	
Centro de Investigação de Saúde de Manica (CISM)	Government	Malaria Research	

University Eduardo Mondlane	Academic	Malaria Research	
Mozal	Private	Malaria control programme among workers	USD 1,500,000
Sygenta	Private	Training of personnel in IRS	
Bayer	Private	Training	

TUBERCULOSIS *Table III. 22.2c*

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programs** (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify time period)
MOH	Government	Programme management, finances	Integrated funds for Directorate of National Health
WHO	Multilateral	Technical support and training in-country and abroad	
NORAD	Bilateral	Drugs, financial support for training and supervision activities, including topping-up for National Tuberculosis Control Programme (NTCP) staff at national and regional levels	National Integrated plan for communicabl e disease
AIFO	NGO	Support to the implementation in the provinces of Maputo, Gaza, Inhambane, Nampula and Manica	1,600,000 USD for leprosy and TB for 2002
LEPRA	NGO	Support to the implementation in the province of Nampula	
NRL	NGO	Support to the implementation in the provinces of Nampula and Niassa	
TLMI	NGO	Support to the implementation in the province of Cabo Delgado	

22.3. Describe the major programmatic intervention gaps and funding gaps that exist in the country's current response to HIV/AIDS, TB and/or Malaria (*Guidelines para. III.41 – 42*), (2–3 paragraphs):

The current HIV/AIDS strategic plan ends next year. Preparations are ongoing with the support of the UNDP, World Bank and UNAIDS to revise the existing plan as well as to develop the next strategic plan. Programmatic and funding gaps in HIV/AIDS include provision for the replacement training of health personnel that would be lost due to HIV/AIDS, training of existing health personnel on HAART, provision of HAART, private sector involvement, costing and budgeting for HIV, and impact mitigation studies in the critical sectors of education, agriculture, transport, health and the financial sector, (including effects on savings and government revenue).

The MOH needs institutional strengthening, as part of the needed strengthening of the national health system. The lack of manpower that can carry out health economic, costing and budgeting activities affects both the TB and Malaria programmes.

The Malaria and TB programmes do not have national coverage. Their control activities are currently benefiting about 40 % of the population that are mainly urban. The other country partners mentioned above also operate in the urban areas and to a lesser extent rural areas, hence the need to scale up malaria and TB control and interventions to cover a proportion of the other 60% of the population living in peri-urban and remote rural areas.

The two programmes need strengthening in, infrastructure and human resource capacity development; management of reliable drug supplies; training of health care providers in appropriate case management, including diagnosis and treatment; quality assurance; development and strengthening of operational monitoring and evaluation to ensure sustainable programmes and microscopy at hospitals, health centres and reference laboratories.