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| Funding Request Form |
| Full Review |
| Allocation Period 2023-2025 |
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# **Summary Information**

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| Country(s) | Mozambique |
| Component(s) | TB/HIV |
| Planned grant start date(s) | 1 January 2024 |
| Planned grant end date(s) | 31 December 2026 |
| Principal Recipient(s) | Ministério da Saúde (Ministry of Health - MISAU)  Fundação para o Desenvolvimento da Comunidade (FDC)  Centro de Colaboração em Saúde (CCS) |
| Currency | USD |
| Allocation Funding Request Amount | 514 727 788 |
| Prioritized Above Allocation Request (PAAR) Amount | 116 944 572 |
| Matching Funds Request Amount  (if applicable) | 11 750 000 |

# Funding Request and Rationale

## Prioritized Request

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| Module # 1 | Differentiated HIV testing services |
| Interventions | * 1. **Health Facilities (HF)-based HIV testing (general population)**:  New,  Scale-up,  Continuation, or  Scale-down |
| * 1. **HF-based testing for key population (KP) program**:  New,  Scale-up,  Continuation, or  Scale-down |
| **1.3 Self-testing for key populations (KP):**  New,  Scale-up,  Continuation, or  Scale-down |
| **1.4 Self-testing outside of KP and adolescent, girls, and young women's (AGYW) programs**:  New,  Scale-up,  Continuation, or  Scale-down |
| **1.5 Community-based testing for KP**:  New,  Scale-up,  Continuation, or  Scale-down |
| **1.6 Community-based testing for AGYW, and their sexual partners**:  New,  Scale-up,  Continuation, or  Scale-down |
| **1.7 Community-based testing outside of programs of KP and AGYW**:  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and barriers addressed | **Population:** Adolescents and young people, pregnant and lactating women (PBW and their sexual partners, direct contacts of index case, key populations (KP) and vulnerable population, men >25 years).  **Locations:** Non-AJUDA sites, Sites in districts with high prevalence and low knowledge of HIV status prioritized.  **Barriers:** poor access to HIV diagnosis; low coverage in access to self-testing; issues in the coverage of HIV testing services in the community; gendered discrepancies in HIV testing with women testing more (26%) than men (14%)[[1]](#footnote-2), weaknesses in thequality of Counseling/Welcoming/Testing; weaknesses in the referral and counter-referral system between HTS-C and HF; weak communication of HIV testing as well as dissemination of testing services at community level; gaps in the training/updating of testing providers; weaknesses in the supply chain of RDT and consumables. |
| List of activities | 1.3.1 Use priority networks to reach the KP's for primary distribution of HIVST and fixed and/or occasional sexual partners (by secondary distribution): Peer Educators will stress with KP the importance of testing all secondary sexual partners). Plan and distribute the supply of HIVST by decentralized community-based outreach in places of concentration of KP (safe spaces, places of coexistence, "hot zones", "drug dens”, penitentiaries, LAMBDA, etc.) with the support of peer-educators and other CHWs, under the supervision of preventive staff from the health district directorate.  1.3.2 During demand creation, ensure messages to address the clients after carrying out the self-test: (i) if HIV- = refer to prevention services (condom use, non-sharing needle if PWUD, PrEP, VMMC); (ii) if HIV+ = refer to the HF or HTS-C to result confirmation. Establish a triangulation between peer educator and the HIV service in the Health Facility (HF).  1.3.3 Recruit and train peer educators that will act in the prevention package (testing, condom, PrEP). Activities of training and program implementation of KP pair educators related to HTS & ART, also in 1.2.1 (KP PE as navigators) 1.5.2 (HCT training package) 11.2.17. (M&E); 11.2.37 (PSS to LTFU); 11.2.38 (call & home visits); 11.2.39 (Adherence, segregation); 11.7.1 (Viral Load); 11.7.9 (Drug toxicity).  1.3.4 Include demand creation for HIVST in KP social platforms via digital/online tools (KP influencers, KP champions, WhatsApp groups, dating apps, trusted access platforms).  1.3.5 Strengthen the distribution of HIV self-tests kits to sexual partners and syringe sharing partners of PWID.  1.3.6 Ensure a smooth planning process for the last mile delivery of test kits in coordination with district managers and local GF partners (valid also for 1.4, 1.5, 1.6).  1.4.1 Offer/distribute HIVST in public/private pharmacies: implement automatic/electronic dispensers in 6 pharmacies in 3 regions; ensure reporting to the MoH. Select pharmacies according to their proximity to truck stops, neighborhoods frequented by SW or PWID, hotspots of MSM.  1.4.2 Offer HTS and/or HIVST in public and private workplaces, public institutions, social networks including the sexual network of AGYW, technical schools and universities.  1.4.3 Promote secondary distribution by community health workers (CHW), peer educators and lay counselors, by raising awareness of the need to involve sexual partners in testing and prevention.  1.4.4 Strengthen in the provider’s training the approach of confirming positive HIVST during pre-test counseling to clients.  1.4.5 Reinforce messages of combined prevention by implementers during the HIVST offering.  1.4.6 Engage community leaders and CHWs to disseminate and foster HIVST demand. Train CHWs to expand HIVST.  1.4.7 Make known the directory with information of the CHWs who distribute HIVST, for all populations.  1.4.8 Expand HIVST to all communities with HTS-C.  1.5.1 Ensure the supply of HTS in places of concentration of KP supported by peer educators (hot zones, places of coexistence, residences, drug dens, penitentiaries etc.).  1.5.2 Identify, recruit & train KP peer educators in HTS training package, including HF referral for HIV + cases to T&C and HIV- for the prevention package (including PrEP).  1.5.3 Capture direct contact of Index Case (IC) using lay counselors.  1.5.4 Train/refresh the lay counselors to support disclosure of HIV positivity for sexual partners & in screening for Intimate Partner Violence (IPV) and Index Case (IC) (all included in the HTS training package), stressing the issues of human rights regarding voluntariness, confidentiality, safety. Train counselors to reach KP sexual partners eliciting information in a non-judgmental manner.  1.5.5 Use social network-based strategies as part of HIV testing services with a focus on KP testing HIV+ and KP testing HIV- at high risk, to reach KP with poor access to HIV testing.  1.5.6 Strengthen contact tracing for syringes/needles users in case of IC PWUD, biological children under the age of 15, parents of IC adolescents under 15.  1.6.1 Expand the HTS in places of agglomerations and concentration of adolescents and young people (technical schools, universities, playing fields, parks, gardens, markets, festivals, bars and nightclubs). Ensure that out-of-school girls who tested positive, will be followed-up in communities for ART adherence by placing peer AGYW placed in the communities.  1.6.2 Create demand for HTS in 2ary schools and ensure referrals for SAAJ (friendly services for adolescents & young people) in HF  1.6.3 Implement a pilot of HIV testing in the schools (15+), in 2 provinces (high incidence), providing that the most at-risk AYP are reached with the full package. Ensure a holistic approach of SRH by fully evolving educators, and by promoting behavioral change by clearly defining how activities will lead to the expected outcomes (theory of change).  1.6.4 Create demand for HTS through holistic and coordinated packages that include TV and radio programs, social media, ambassadors, influencers, and the health system.  1.6.5 Capture direct contact of Index Case (IC) using lay counselors  1.6.6 **Intimate Partner Violence (IPV) tracing expansion:** Expand IPV tracing to all sites and communities where GBV services are offered (with a focus on non-AJUDA sites). Form testing providers within the scope of the expansion of GBV tracing.  1.6.7 Make adolescents & youngsters peer educators distribute HIVST in the community.  1.7.1 Capture sexual partners and biological children (under 15) of Index Case (IC) beyond the main partner through: (i) counselors’ training to reach all sexual partners (eliciting information in a non-judgmental manner); (ii) retesting HIV-negative sexual partners according to the guideline; (iii) ensuring regular screening (at least once a year) of IC contacts to identify new contacts; (iv) refreshing testing providers (clinicians, counselors, etc.) for disclosure and testing all, including the new ones;  1.7.2 Maximize the supply of HTS for men: Offer HTS in public, formal and informal workplaces to reach men; ensure the framing of HTS activities in male engagement activities (work sector); offer testing in the places where men live together (tents, bars, soccer fields, etc.).  1.7.3 Ensure HTS activities in brigades and mobile clinics: promote discussion groups on HTS and HIV stigma to influence changes in gender roles and attitudes towards testing and counseling  1.7.4 Train and refresh counsellors in the community to offer HTS. |
| Amount requested | Allocation: 31 433 229,24 USD |
| Expected outcome | Increase the number of PLHIV who know their status from 87% in 2022 to 95% and above by 2026, contributing to the achievement of UNAIDS global 2030 targets. |

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| Module # 2 | Prevention package for adolescent girls and young women (AGYW) and male sexual partners in high HIV incidence settings |
| Interventions | **2.1 Condom and lubricant programing for AGYW in high HIV incidence settings** -  New,  Scale-up,  Continuation, or  Scale-down |
| **2.2 Voluntary Medical Male Circumcision -**  New,  Scale-up,  Continuation, or  Scale-down |
| **2.3 HIV prevention communication, information and demand creation for AGYW in high HIV incidence settings**  New,  Scale-up,  Continuation, or  Scale-down |
| **2.4 Comprehensive sexuality education for AGYW and adolescent boys and young men (ABYM):**  New,  Scale-up,  Continuation, or  Scale-down |
| **2.5 Sexual and reproductive health services, including STIs, hepatitis, post-violence care for AGYW and male sexual partners in high HIV incidence settings**:  New,  Scale-up,  Continuation, or  Scale-down |
| **2.6 Pre-exposure prophylaxis (PrEP) programing for AGYW in high HIV incidence settings:**  New,  Scale-up,  Continuation, or  Scale-down |
| **2.7 Social protection interventions for AGYW in high HIV incidence settings:**  New,  Scale-up,  Continuation, or  Scale-down |
| **2.8 Removing human rights-related barriers to prevention for AGYW in high HIV incidence settings:**  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** Adolescent Girls and Young women; Sexual partners of adolescents; Adolescents boys, youth and adults 15+ who are male partners of AGYW at high risk  In general, the focus of this fund request will be to complement the interventions that are already in implementation from the previous GF grant. The 2022 HIV incidence estimation among AGYW 15-24 years based on the UNAIDS AGYW population estimation tool (per 100 person years) identified no (0) district with very high incidence (≥3%) 51 districts with high HIV incidence (1.0 – 2.999%); 103 districts with moderate incidence (0.3 – 0.9%); 7 districts with low incidence (<0.3Reaching the adolescents in school will be prioritized with intervention for behavior changes and to improve access to prevention package according to national guidelines and the the implementation of Out of school adolescents SOP.  AGYW geographic prioritization for this fund request focused on (i) high HIV incidence districts with no DREAMS and Viva+ programs (6 districts), (ii) an assessment of vulnerability factors (school drop-out rates, reported cases of gender-based violence (MOH), internally displaced persons, teenage pregnancy and security) and (iii) a saturation approach at Health Facility levels particularly in high incidence districts and some moderate incidence districts for HFs to be equipped with a functional stand-alone SAAJ sector (Adolescent Friendly Health Services sector) which works in coordination with community based programs for referrals to the Health Facility. The fund request proposes to continue AGYW implementation in 76 of the 78 districts in order to reinforce the expansion of services and ensure continuity of AGYW programming by implementers: Tsangano and Nacala-a-Velha districts will be substituted with Cahora Bassa and Ilha de Mozambique districts (within the same province). Overall, AGYW expansion is recommended in 3 high incidence districts with no DREAMS or Viva+ programs (Mabote, Chicualacuala, Mabalane) and in 3 moderate incidence districts (Massingir, Ilha de Moçambique and Cahora-Bassa). In total, this grant will cover 82 districts: 38 high incidence districts (46%), 43 moderate incidence districts (52%) and 1 low incidence district (1%). The one (1) low incidence district prioritized (Angónia) borders with Malawi and is a high mobility corridor with risk characteristics prone to the spread of HIV. It was prioritized for the 2024-2026 fund cycle to consolidate Viva+ interventions and contribute towards maintaining low HIV incidence.  The AGYW PSE tool allows a stratification of the AGYW population according to HIV related behavioral risk profile – sexually inactive, regular partner, non-regular multiple partner and key population (FSW). The tool will be applied in the 82 districts to estimate district level population size estimates of the AGYW population into low risk (no sex), moderate risk (regular partner) and high risk (non-regular multiple sex partners and key population (FSW)) to guide interventions.  **Location:** National Territory, HF not covered by PEPFAR funds  **Barriers/Gaps:** Lack of literacy, demand, and access to HIV combined prevention by the AGYW. Prevalence of misconception regarding the preventive measures like the VMMC andlack of integration of the MC in the routine surgical services. Low coverage of youth-friendly services affecting their utilization by adolescents and youth. Lack of communication interventions for social and behaviour change (CMSC) that contributed to minimal change in sexual behaviour. High level of stigma and discrimination in the care of adolescents and young people in access to services; There is inadequate knowledge and understanding of protection laws among populations and service providers and access to justice for redress of rights violations needs to be improved. Poor school retention of AGYW |
| List of activities | 2.1.1Make condoms and lubricant gel available in all places of concentration of adolescents and young people (youth associations, clubs, sporting events, among others). Building on steps taken during the current grant, the program will continue pursuing the expansion of the condom storing at community level including the acquision the containers the use of community available infrastructures such as NGO, Schools, Government structure, community leaders, teachers and other actors present at community level.  2.1.2 Empower adolescents and young people, particularly for the AGYW, to negotiate condoms (operationalization of the life skills manual/mentoring manual)  2.2.1 Demand promotion for CMMV among adolescent boys and young mem sexual partners of AGYW in HIV incidence Districts covered under this grant application.   * Use the leaders of opinion at community level (leaders, churches, mosques, businesses, schools among others, EPAs) to expand the Male Circumcision (MC) activities as HIV prevention measure. * To train and sensitize the technical staff of the Health Facility (HF) on the strategies of demand generation and referral of users eligible for the MC service. * Carry out campaigns of massification and mobilization of communities about the MC focusing the use of community radios disseminating messages targeting adolescents, in the areas covered of the target Districts. Use of cultural and sporting events also to ensure the message is widely disseminated and reach these boys and youth. * Strengthen identification and referral of adolescents and young people eligible for VMMC and link to other prevention services (PREP, STIs screening, condoms, testing) * Establish partnerships with masters of male initiation rites and negotiate the delivery of MC following medical standard standards.   + 1. Training providers in new HTS approaches and reinforcement of HTS monitoring during the VMMC activities * Train VMMC providers and ensure effective referral of negative cases to combined prevention services * Train transition unit providers (supported by PEPFAR partners and to be transferred under full MOH management) on the (updated) HTS approaches.   2.2.3 Strengthening surveillance of adverse events in transition HF   * Training the providers in diagnosis and follow-up of adverse events * Implement the Surveillance System of Infections and Adverse Events   2.2.4 Expansion of service coverage for the provinces not covered by PEPFAR resources.   * Expand VMMC services to PEPFAR's non-priority provinces: Inhambane and Nampula and implementation of VMMC activities in HF with surgical capacity. This activity will gradually adopt as routine surgical activity in those HF   2.3.1 Implementation of the SOP of adolescents and young people (the document guides community activities, community dialogues, peer approach among others)  2.3.2 To train activists and peer educators to deliver behavior changes messaging and promote services demand at schools and community level.  2.3.3 Exchange visit to other countries implementing successfully activities to improving access to the package of Adolescents and Youth through the strategic strengthening in relation to the references for the reach of 95/95/95 and the capture of data at the level of the Adolescents and Young users of the SAAJ – consolidation of the connection to the services  2.3.4 Develop a comprehensive demand creation program with high impact that synchronizes all actors in a 360º approach: health providers at health centers, schools and mobile clinics; CHW – door-to-door activities, interventions with the broader community (leaders, and influential figures, parents, husband, gender-specific and gender-mixed group sessions; community distribution prevention consumables; interpersonal communication activities for adolescents with peers, multimedia campaign, social networks with real-time chat and video projection followed by the debate at the community level.  2.3.5 To disseminate of existing SAAJs directorate and other community providers of AGYW services across the entire country to facilitate MISAU planning to expand and improve the services available for adolescents and young people and demand creation for SAAJ services.  2.3.6 Develop a single-family engagement package for changing social and cultural norms that constitute barriers to health, especially stigma and discrimination, adherence and retention to HIV/AIDS treatment, and acceptance of new approaches that contribute to health promotion  2.3.7 Expand behavior change interventions using virtual platforms, involving Mentor Boys  2.3.8 Implement a communication campaign for social change, harmful cultural norms and risky behaviors of Boys,, using Male Champions  2.4.1 Train teachers in tools/methodologies for integrating SRH themes into lesson plans (GBV, sexual harassment and exploitation, stigma and discrimination, disability)  2.4.2 Disseminate the IEC materials and make them available for adolescents and young people in Schools, Adolescent & youth-friendly services (SAAJ) and Youth Centers (adapt to age groups and gender). The peers’ educators will be the key mechanism to disseminate these materials and messaging activities.  2.4.3 Training the members of School Boards on the implementation of SRH Approach for Youth  2.4.4 Expansion and equipping of the School Health Corners as these have been vital for the adolescents in school to access prevention information delivered by their peers and the local where these adolescents access condoms; under 18 girls who engage in transactional sex and are still studying would benefit from well-functioning school health corners.  2.4.5 Mapping the conceptions, and the perception of boys regarding the social norms that dominate the gender relations in a given region aiming to have a clear picture of what are the needs of communication interventions pertaining these groups and better guide the activities implementation to prevent new HIV infections  2.5.1 Expand the number of specific youth-friendly services adding 40 additional services within the expansion’s areas according to the prioritization. Currently, 287 specific youth services and the adolescent services are integrated into other 690 health facilities distributed in 11 provinces. The new specific youth services will contribute in expanding AGYW access to the focused package delivered by health providers trained to deliver theses services.  2.5.2 Train Health Providers in the youth friendly services Package from the areas covered by the health facilities prioritized (annex: Prioritization of AGYW) for this grant  2.5.3 Expanding the coverage of adolescent and young mentor (AYM) activity to HF not covered PEPFAR support  2.5.4 Training of health providers in the Youth Quality Improvement (YQI) package including the clinical tutoring component and introduce the implementation of YQI in Youth Friendly services  2.6.1 PrEP and other services of SRH will be promoted and made available for adolescents and their sexual partners in all Health facilities and surrounding communities not supported by PEPFAR, especially among adolescents in high risk of exposure to HIV.  2.6.2 AGYW will be targeted with PrEP literacy messaging, demand creation and adherence using the peer’s educator and directed to access services at HF, mobile brigade, or SAAJ.  2.6.3 Implementation a pilot intervention to validate and evaluate the Vaginal Ring PrEP in the local context. PrEP offered as an additional prevention choice for AGYW at substantial risk of HIV infection as part of combination prevention approaches[[2]](#footnote-3) in 5 health facilities from 5 provinces namely Maputo Province, Maputo city, Gaza, Zambezia and Nampula. The estimation that 20% of AGYW will choose to use the vaginal ring was based on the survey conducted by MSF in 2022[[3]](#footnote-4)  2.6.4 Ensure the purchase of all inputs / consumables / RDT's related to PrEP  **Retention/Reintegration of adolescents and young people in school**  The activities included in this section will be implemented exceptionally in the situations of girls at high risk for HIV and where is not funded through e.g., the education / social welfare sector.  2.7.1 Continuous support to vulnerable adolescents and young people, in school supplies, didactic material and school uniforms, dignity kits  2.7.2 Print the government-approved menstrual management flipchart to better guide girls in their menstrual management  2.7.3 Creation of opportunities for access to Vocational and professional training and income generation for vulnerable Girls and Young Women at risk of HIV infection or affected, especially girls who are involved in "transactional sex"  2.7.4 Engagement and awareness of families for the economic empowerment of girls and young women, especially young girls involved in transactional sex  2.7.5 Visit to seek experience around the creation of Economic Empowerment Groups within the school for income generation and also about the experience in connecting Girls and Young Women with Empowered Mentors locally, as a way of motivation and stimulation of Girls and Young Women  2.7.6 Integrate girls who are victims of premature unions into school, identified by Paralegals  **Economic empowerment of young women**  2.7.7 Connecting vulnerable girls and young women benefiting from short-term vocational courses with local Empowered Mentors/providers as a way to ensure the continuity of application of learning for income generation  2.7.8 Provide starter kit for girls and young women trained  2.7.9 Promotion of business plans and opportunities for incubation program and technical assistance to Girls and Young Women beneficiaries of vocational, vocational or income generation courses  2.8.1 Train providers on non-AJUDA sites for VGB screening and use of the IMD (performance measurement instrument)  2.8.2 Expand services and offer the minimum package of post-care VBG (First Line Support; PEP; Emergency contraception; HIV screening and STIs; Reference for PrEP to eligible; Reference to other services (Activity supported by PEPFAR on the help sites)  2.8.3 Expand the implementation of the multisectoral GBV package with a focus on children, adolescents and young people;  2.8.4 Create/Train community social protection committees on the prevention, response and mitigation of GBV with special attention to sexual violence in children and adolescents, including in an emergency and/or humanitarian context (training should include the dissemination of reporting sites for GBV cases)  2.8.5 Community awareness of changing gender norms that perpetuate sexual violence against girls and adolescents  2.8.6 Promote and/or expand actions involving boys, adult men and young couples to change harmful social norms  2.8.7 Promote meetings with man-to-man groups at the community level  2.8.8 Develop a single-family engagement package for changes in social norms that constitute barriers to the health and education of adolescents and young people (Map/survey existing packages)  2.8.9 Dissemination of laws protecting the rights of adolescents (e.g., the Premature Unions Act, stigma index report (propose for HD group)  2.8.10 Conduct literacy and legal empowerment sessions for AGYW, ABYM.  2.8.11 Strengthen the link to prevention services (PREP, STIs screening, condoms, testing, circumcision, ART)  2.8.12 Expanding HIV-related human rights literacy and legal support through peer educators and paralegal for young women and adolescent girls  2.8.13 Integrate rights and legal literacy and paralegal support into ongoing programs for adolescent girls and young women |
| Amount requested | Allocation: 32 686 136,12 USD  PAAR: 6 222 970,79 USD |
| Expected outcome | Increase the percentage of high risk AGYW reached with HIV prevention programs defined package of services from 20% in 2024 to 95% by 2026 (the indicator is new and has no baseline)  Increase the percentage of high-risk AGYW (15-24) who say they used a condom the last time they had sex with a non-regular partner, of those who have had sex with such a partner in the last 12 months from 45% (baseline INSIDA 2021) to 75% (2026) |

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| Module # 3 | Prevention package for men who have sex with men (MSM) and their sexual partners |
| Interventions | **3.1 Pre-exposure prophylaxis (PrEP) programming for MSM:**  New,  Scale-up,  Continuation, or  Scale-down |
| **3.2 Condom and lubricant programing for MSM:**  New,  Scale-up,  Continuation, or  Scale-down |
| **3.3 Sexual and reproductive health services, including STIs, hepatitis, post-violence care for MSM:**  New,  Scale-up,  Continuation, or  Scale-down |
| **3.4 HIV prevention communication, information and demand creation for MSM**  New,  Scale-up,  Continuation, or  Scale-down |
| **3.5 Removing human rights related barriers to prevention for MSM:**  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** Men Who Have Sex with other Men  **Location:** Areas of High Concentration of the key population sites not covered under PEPFAR funds  **Barriers:** Low identification and reach of KP and their sexual partners and clients; Stigma and Discrimination. Weakness in GBV screening for KP; Poor human rights literacy; Deficit of prevention inputs.; Poor availability and initiation of PREP outside the Health Units. Poor use of multimedia and other channels to disseminate messages promoting correct and consistent condom use, information on the places of condom availability; Limited coverage of the prevention services of KP and its sexual partners and clients. Lack of complete and accurate data on the size, demography and geography of the key population hinders the design and implementation of quality interventions; Legal barriers that negatively impact human rights, including legalization of SW organizations, poor legal knowledge on the part of legal practitioners, health officials and personnel, and people in general, poor integration or marginalization of human rights as an essential component of the HIV response, persistence of stigma, discrimination and violence, poor adherence and quality of MSM’s human rights programs and weak coordination mechanisms.. Weakness in the implementation of robust outreach services, weak micro planning, weak cohort management and follow up of enrolled clients. |
| List of activities | 3.1.1 Recruit PrEP users who are MSM Peer educators and non MSM councilors and assign them as PrEP champions and from Man to Man implemented through community partners on high-risk communities (they work both at the community and Health facility) no additional salaries will be granted to them for being PrEP champions.  3.1.2 Offer PrEP in hotspots through mobile clinics to improve the reach of the eligible population.  3.1.3 Peer led activities to promote literacy, demand, access and adherence of PrEP by MSM at health facilities and at the hotspots through mobile clinics  3.1.4 Delivery of PrEP program, including planning, determining eligibility, and service delivery requirements in all health facilities not supported by PEPFAR  3.1.5 Adherence support through peer led, and health providers including mobile outreach.  3.1.6 Ensure the purchase of all inputs / consumables / TDR's related to PreP  3.2.1 Promotion and distribution of condoms and condom-compatible lubricants. Promotion and Promotion and distribution of condoms and condom-compatible lubricants. Promotion and Targeted distribution of condoms and condom-compatible lubricants using peers educators, ensure the condom availability in the places of high concentration of MSM. Information and communication on safer sex and condom use at community level, or through social media/web-based condom promotion.  3.2.2 Demand generation through peer outreach and other peer-based strategies.  3.2.3 Condom social marketing activities.  3.3.1 On the job training of providers in the full suite of KP services in the community and HF (prevention, HR and CT)  3.3.2 Reproduce Job Aid and allocate them to all HF points of care not supported by PEPFAR  3.3.3 Offer the screening, testing and treatment of asymptomatic STIs, including periodic serological testing for syphilis infection and treatment for hepatitis B  3.3.4 Routine STI check-ups and delivery of anal health care, including anal cancer screening and linkages.  3.3.5 Integration of HIV prevention and sexual and reproductive health services, including youth-friendly services for Young MSM  3.3.6 Provide MSM differentiated care and one-stop service  3.3.7 Create demand and offer PEP  3.3.8 Ensure the availability of peer educators. MSM: 1 Peer educator per 40  3.4.1 Targeted internet-based information, education, communication, including social media.  3.4.2 One-on-one and group risk reduction activities through peer educators at the community level  3.4.3 Train peer educators and lay counselors on the updated HIV Prevention Communication materials (currently being update with PEPFAR funds)  3.5.1 Produce data and information through a baseline report for KP from a human rights perspective that includes stigma, discrimination and violence and analyses the status of laws and policies, needs, progress, challenges, and recommendations, with support of technical assistance.  3.5.2 Train MSM organizations and movements on their rights from a human rights perspective and promote their participation in community interventions  3.5.3 Carry out an advocacy and communication plan for policy and law reform for MSM.  3.5.4 Conduct an anti-homophobia campaign.  3.5.5 Scale-up support to MSM organizations and movements from the perspective of their rights to participate in the design, elaboration, and implementation of legal and policy measures  3.5.6 Advocate for the legalization of MSM organizations.  3.5.7 Carry out a special module on the rights of MSM and integrate it in the manuals or legal tools created for the training of health personnel, prison officials, law enforcement officers and public order agents in general, judges, prosecutors and parliamentarians and train them on the rights of MSM.  3.5.8 Integrate module on rights of MSM in community responses including training of paralegals.  3.5.9 Consolidate and expand mechanisms for documenting and reporting human rights violations for MSM especially with regard to violence, stigma and discrimination, in public and private contexts, and strengthen coordination between formal mechanisms and community mechanisms for communication and reporting (health sector, public order, paralegals, community system and CSOs).  3.5.10 Produce and disseminate material IEC about human rights of MSM. |
| Amount requested | Allocation: 8 486 383,65 USD  PAAR: 1 272 589,10 USD |
| Expected outcome | * Percentage of HSH receiving a prevention package increase from 16,84% in 2022 to 57,58% at the end of 2026 * Decreased violence, stigma and discrimination against MSM |

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| Module # 4 | Prevention package for sex workers, their clients and other sexual partners |
| Interventions | **4.1 Condom and lubricant programming for sex workers:**  New,  Scale-up,  Continuation, or  Scale-down |
| **4.2 Pre-exposure prophylaxis (PrEP) programming for sex workers:**  New,  Scale-up,  Continuation, or  Scale-down |
| **4.3 Sexual and reproductive health services, including STIs, hepatitis, post-violence care for sex workers:**  New,  Scale-up,  Continuation, or  Scale-down |
| **4.4 HIV prevention communication, information, and demand creation for sex workers:**  New,  Scale-up,  Continuation, or  Scale-down |
| **4.5 Removing human rights related barriers to prevention for sex workers:**  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** Sex workers, and Their clients and other sexual partners  **Location:** Areas not covered by PEPFAR support with focus in the areas of concentration of FSW  **Barriers:** Low identification and reach of FSW and especially their sexual partners and clients; High stigma and Discrimination; Limited coverage of the prevention services of KP and its sexual partners and clients; Fragility in the screening of GBV in KP; Poor human rights literacy on the part of KP; Poor use of multimedia and other channels to disseminate messages promoting correct and consistent condom use, information on the places of condom availability; Poor knowledge, visibility/access of the female condom; Lack of complete and accurate data on the size, demography and geography of the key population hinders the design and implementation of quality interventions; Legal barriers that negatively impact human rights, including legalization of SW organizations, poor legal knowledge on the part of legal practitioners, health officials and personnel, and people in general, poor integration or marginalization of human rights as an essential component of the HIV response, persistence of stigma and discrimination, sexually exploited children, and poor coherence and quality of SW human rights programs and weak coordination mechanisms. |
| List of activities | 4.1.1 Conduct sensitization sessions led by the peers and health providers in the areas of concentration of key population in all prioritized geographical areas (not covered by PEPFAR support) to create demand and promote the correct and consistent use of condoms, including distribution  4.1.2 Condom and lubricant available in restaurants, pubs/bar highly frequented by key population  4.1.3 Increase the availability of condoms and lubricants in the HF and community Through expansion of storage capacity locally by Identifying community leaders who can store condoms and distribute within their communities.  4.2.1 Pilot of use of Vaginal Ring in FSW and AGYW, in prioritized facilities: Maputo Cidade, Maputo Provincia , Zambezia, Nampula  4.2.2 Reproduce and implement/operationalize the demand creation guideline and train the program stakeholders in the demand creation chain  4.2.3 Train lay providers in the full PrEP literacy package  4.2.4 Train/update the attendants of the communication platforms (SMS, BIZ / ALO VIDA/PENSA, etc.) in terms of PrEP;  4.2.5 Involve local leaders, community influencers, parents and caregivers, etc., to better create demand and buy-in of PrEP by the community.  4.2.6 Ensure the purchase of all inputs / consumables / RDT's related to PrEP  4.3.1 Refresh providers in the full suite of KP services in the community and HF (prevention, HD and CT)  4.3.2 Reproduce algorithms (JOB AID) and allocate them at all HF points of care  4.3.3 Screening, testing and treatment of asymptomatic STIs, including periodic serological testing for syphilis infection, delivery of cervical and anal cancer screening and linkages, emergency contraception, and PEP  4.3.4 Prevention, screening, testing and treatment for hepatitis B  4.3.5 Integration of HIV prevention and sexual and reproductive health services, including youth-friendly services  4.3.6 Integrate violence response services into HIV-related services for sex workers  4.3.7 Strengthen outreach system by improving peer ratio FSW 1 peer to 60 FSW  4.4.1 Use of social network groups to spread the IEC messages and demand creation for services among FSW  4.4.2 Implement virtual approach outreach  4.4.3 Targeted internet-based information, education, communication, including social media  4.5.1 Produce data and information through a baseline report for sex workers from a human rights perspective that includes stigma, 4.5.1 Train sex workers organizations and movements on their rights from a human rights perspective and promote their participation in community interventions  4.5.2 Carry out an advocacy and communication plan for policy and law reform for sex workers.  4.5.3 Conduct a campaign for the rights and dignity of sex workers.  4.5.4 Scale-up support to sex workers organizations and movements from the perspective of their rights to participate in the design, elaboration, and implementation of legal and policy measures  4.5.5 Advocate for the legalization of sex workers organizations.  4.5.6 Carry out a special module on the rights of sex workers and integrate it in the manuals or legal tools created for the training of health personnel, prison officials, law enforcement officers and public order agents in general, judges, prosecutors and parliamentarians and train them on the rights of sex workers.  4.5.7 Integrate module on rights of sex workers in community responses including training of paralegals.  4.5.8 Consolidate and expand mechanisms for documenting and reporting human rights violations for sex workers especially with regard to violence, stigma and discrimination, in public and private contexts, and strengthen coordination between formal mechanisms and community mechanisms for communication and reporting (health sector, public order, paralegals, community system and CSOs).  4.5.9 Produce and disseminate material IEC about human rights of sex workers.  4.5.10 Protect sexually exploited children |
| Amount requested | Allocation: 22 377 811,88 USD  PAAR: 1 350 631,00 USD |
| Expected outcome | * Percentage of SW receiving a prevention package increase from 22,27% in 2022 to 87,84% at the end of 2026 |

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| Module # 5 | Prevention package for transgender people and their sexual partners |
| Interventions | **5.1 Pre-exposure prophylaxis (PrEP) programming for TG:**  New,  Scale-up,  Continuation, or  Scale-down |
| **5.2 Condom and lubricant programing for TG:**  New,  Scale-up,  Continuation, or  Scale-down |
| **5.3 Sexual and reproductive health services, including STIs, hepatitis, post-violence care for TG:**  New,  Scale-up,  Continuation, or  Scale-down |
| **5.4 HIV prevention communication, information and demand creation for TG**  New,  Scale-up,  Continuation, or  Scale-down |
| **5.5 Removing human rights-related barriers to prevention for transgender people**  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** Transgender  **Location:** Areas of High Concentration of KP in sites not covered by PEPFAR funds  **Barriers:** Low identification and reach of KP and their sexual partners and clients; Stigma and Discrimination. Weakness in GBV screening for KP; Poor human rights literacy; Deficit of prevention inputs (quality, packaging, distribution chain, management chain, etc.); Poor availability and initiation of PREP outside the Health Units. Limited coverage of the prevention services of KP and its sexual partners and clients. Lack of complete and accurate data on the size, demography and geography of the key population hinders the design and implementation of quality interventions; Legal barriers that negatively impact human rights, including legalization of transgender people organizations, poor legal knowledge on the part of legal practitioners, health officials and personnel, and people in general, poor integration and marginalization of human rights as an essential component of the HIV response, persistence of stigma, discrimination and violence, and poor coherence and quality of transgender peoples’ human rights programs and weak coordination mechanisms. |
| List of activities | 5.1.1 Recruit PrEP users who are TG Peer educators and non-TG councilors and assign them as PrEP champions through community partners on high-risk communities (they work both at the community and Health facility) no additional salaries will be granted to them for being PrEP champions.  5.1.2 Offer PrEP in hotspots through mobile clinics to improve the reach of the eligible population.  5.1.3 Peer led activities to promote literacy, demand, access and adherence of PrEP by TG at health facilities and at the hotspots through mobile clinics.  5.1.4 Delivery of PrEP program, including planning, determining eligibility, and service delivery requirements in all health facilities not supported by PEPFAR  5.1.5 Adherence support through peer led, and health providers including mobile outreach.  5.1.6 Ensure the purchase of all inputs / consumables / TDR's related to PrEP  5.2.1 Promotion and distribution of condoms and condom-compatible lubricants.  5.2.2 Targeted condom distribution to TG, combined with dissemination of information and communication on safer sex and condom use at community level, or through peers, social media/web-based condom promotion.  5.2.3 Demand generation through peer outreach and other peer-based strategies.  5.2.4 Condom social marketing activities.  5.3.1 Refresh providers in the full suite of KP services in the community and HF (prevention, HD and CT)  5.3.2 Reproduce algorithms and allocate them at all HF points of care  5.3.3 Screening, testing and treatment of asymptomatic STIs, including periodic serological testing for syphilis infection, gonorrhea, chlamydia trachomatis.  5.3.4 Prevention, screening, testing and treatment for hepatitis B  5.3.5 Routine STI check-ups and Delivery of anal health care, including anal cancer screening and linkages.  5.3.6 Integration of HIV prevention and sexual and reproductive health services, including youth-friendly services especially for youth KP aiming to prevent HIV transmission.  5.3.7 Create demand and offer PEP  5.4.1 Targeted internet-based information, education, communication, including social media.  5.4.2 One-on-one and group risk reduction activities through peer educators at the community level  5.4.3 Train peer educators and lay counsellors on the updated HIV Prevention Communication materials (currently being updated with PEPFAR funds)  5.5.1 Train transgender peoples’ organizations and movements on their rights from a human rights perspective and promote their participation in community interventions  5.5.2 Carry out an advocacy and communication plan for policy and law reform for transgender people.  5.5.3 Conduct an anti-transphobia campaign.  5.5.4 Scale-up support to transgender peoples’ organizations and movements from the perspective of their rights to participate in the design, elaboration, and implementation of legal and policy measures  5.5.5 Advocate for the legalization of transgender peoples’ organizations.  5.5.6 Carry out a special module on the rights of transgender people and integrate it in the manuals or legal tools created for the training of health personnel, prison officials, law enforcement officers and public order agents in general, judges, prosecutors and parliamentarians and train them on the rights of transgender people.  Integrate module on rights of transgender people in community responses including training of paralegals.  5.5.7 Consolidate and expand mechanisms for documenting and reporting human rights violations for transgender people especially with regard to violence, stigma and discrimination, in public and private contexts, and strengthen coordination between formal mechanisms and community mechanisms for communication and reporting (health sector, public order, paralegals, community system and CSOs).  5.5.8 Produce and disseminate material IEC about human rights of transgender people.  5.5.9 Train health personnel on gender diversity and humanized treatment of transgender people  5.5.10 Produce and disseminate informative material on S&D including gendered stereotypes and beliefs associated to transgender  5.5.11 Conduct comprehensive formative research to understand and map the transgender community in the country |
| Amount requested | Allocation: 2.023.396,88 USD |
| Expected outcome | Percentage of Transgender receiving a prevention package increase from 0 in 2022 to 55% at the end of 2026 |

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| Module # 6 | Prevention package for people in prisons and other closed settings |
| Interventions | **6.1 Condom and lubricant programming for prisoners:**  New,  Scale-up,  Continuation, or  Scale-down |
| **6.2 Pre-exposure prophylaxis (PrEP) programming for prisoners:**  New,  Scale-up,  Continuation, or  Scale-down |
| **6.3 HIV prevention communication, information, and demand creation for prisoners:**  New,  Scale-up,  Continuation, or  Scale-down |
| **6.4 Sexual and reproductive health services, including STIs, hepatitis, post-violence care for prisoners:**  New,  Scale-up,  Continuation, or  Scale-down |
| **6.5 Removing human rights-related barriers to prevention for prisoners:**  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** People in prisons  **Location:** Prisons not covered under PEPFAR funds  **Barriers:** Legal barriers that negatively impact human rights, poor legal knowledge on the part of legal practitioners, prison’s health officials and personnel, prisoners, poor integration and marginalization of human rights as an essential component of the HIV response, persistence of stigma, discrimination and violence, and poor coherence and quality of prisons’ human rights programs, and weak coordination mechanisms. |
| List of activities | 6.1.1 Provide and ensure the availability of condoms and water-based lubricants at the Health Post located in the penitentiary’s institutions. During this grant (5 new prisons will be added increasing the prisons covered to 18) Peer educators and lay counsellors will be used to disseminate the information and communication on HIV prevention.  6.2.1 Map and train/refresh health technicians (prison employees) to expand the provision of HIV prevention services in prisons  6.2.2 Implement PrEP offer in all prisons. The peer educators and the lay counselors will promote literacy and demand and considering the eligibility those in need will be referred to the health post in the penitentiary or benefit from the visit of mobile clinic or sent to the satellite health facility.  6.2.3 Ensure the purchase of all inputs / consumables / TDR's related to PrEP  6.3.1 IEC material on safer sex will be made available for distribution as part of the prevention package. The peer dialogue session will be prioritized among the prisoners.  6.3.2 Lay counsellors training  6.4.1 Screening, testing and treatment for asymptomatic STIs, including periodic serological testing for syphilis infection  6.4.2 Provision of Contraception/family planning information and services  6.4.3 Post-violence counselling, referral, and linkages to post exposure prophylaxis (PEP)  6.5.1 Train Penitentiary agents and officials in the field of human rights of PLHIV, persons affected by TB and KVP that take into account the Mandela Rules.  6.5.2 Carry out an advocacy and communication plan for policy and law reform for prisoners.  6.5.3 Scale-up support to prisoners’ organizations and movements or their representatives from the perspective of their rights to participate in the design, elaboration, and implementation of legal and policy measures.  6.5.4 Consolidate and expand mechanisms for documenting and reporting human rights violations of prisoners especially with regard to violence, stigma and discrimination in prisons and redress for such violations.  6.5.5 Produce and disseminate material IEC about human rights of prisoners  6.5.6 Ensure dignified treatment, privacy and confidentiality in the provision of services for prisoners |
| Amount requested | Allocation: 3.302.636,24 USD |
| Expected outcome | Number of prisoners receiving a prevention package increase from 5.556 in 2022 to 8.623 at the end of 2026 |

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| Module # 7 | Prevention Package for People Who Use Drugs (PUD) (injecting and non-injecting) and their Sexual Partners |
| Interventions | **7.1 Pre-exposure prophylaxis (PrEP) programming for PUD:**  New,  Scale-up,  Continuation, or  Scale-down |
| **7.2 HIV prevention communication, information, and demand creation for PUD:**  New,  Scale-up,  Continuation, or  Scale-down |
| **7.3 Harm reduction interventions:**  New,  Scale-up,  Continuation, or  Scale-down |
| **7.4 Condom and lubricant programing for prisoners:**  New,  Scale-up,  Continuation, or  Scale-down |
| **7.5 Sexual and reproductive health services, including STIs, hepatitis, post-violence care PUD/PWID:**  New,  Scale-up,  Continuation, or  Scale-down |
| **7.6 Removing human rights related barriers to prevention for PUD**  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** People who use drugs and People who inject drugs  **Location:** Areas of High Concentration of the key population  **Barriers:** Legal barriers that negatively impact human rights, poor legal knowledge on the part of legal practitioners, health officials and personnel, and people in general, poor integration or marginalization of human rights as an essential component of the HIV response, persistence of stigma and discrimination and violence, and poor coherence and quality of PUD human rights programs, and weak coordination mechanisms. Lack of access to syringes. Violent police action in the places of concentration and hot zones of PUD and PWID that interferes with the provision of prevention services; Lack of complete and accurate data on the size, demography and geography of the key population hinders the design and implementation of quality interventions. |
| List of activities | 7.1.1 PrEP demand creation using PUD peers  7.1.2 Ensure the purchase of all inputs / consumables / TDR's related to PrEP  7.2.1 The use of peer educators will be the main strategy to ensure the dissemination of messages of prevention and demand creation for harm reduction and other health services.  7.2.2 IEC material will be made available to be used by the peer’s educators.  7.2.3 Integration visits to create demand for women PUD (who can simultaneously be sex workers) as due to stigma they have low or no access to health care  7.3.1 To be implemented following the previous country experience and the national guidelines, peer’s educators will be recruited and trained to distribute the harm reduction kits at the concentration, hot spots areas. The grant will cover the procurement of harm reduction kits to be available in 4 satellite community centers that are already functioning and the new 2 centers that will be implemented in the new grant period. The package for PWID is composed of Methadone, Naloxone, needles and syringe, and paraphernalia)  7.3.2 Offer the complete package for PWID (RH/equipment/materials/Methadone, Naloxone, Rapid Test Validation for drug problems, Methadone dispensing machine and manual dispensers).7.3.3 Integrate violence response services into HIV-related services for PUD and PWID  7.4.1 As part of the combined prevention Kit, condoms, including female condom, water-based lubricants, will be provided and promotion activities implemented targeting the hotspots, DIC and safe spaces.  7.5.1 The package includes services demand creation.  Reproduce job aid and allocate them at all HF points of care including safe spaces.  7.5.2 Screening, testing and treatment of asymptomatic STIs, including periodic serological testing for syphilis infection.  Routine STI check-ups and Delivery of anal health care, including anal cancer screening and linkages.  7.5.3 Diagnosis, screening, and treatment of both Hepatitis B and C  (The combined package will be delivered using the targeted peer educators (harm reduction) and through mobile clinics) Integration of HIV prevention and sexual and reproductive health services, including youth-friendly services especially for youth KP aiming to prevent HIV transmission.  7.5.4 Support screening, and treatment of HC from harm reduction service delivery platforms (3 sites in all country). Acquire and distribute RDT, cartridges, reagents for VL HC and drugs for the treatment of HC.  7.5.5 Offer the complete package for PWID (RH/equipment/materials/Methadone, Naloxone, Rapid Test Validation for drug problems, Methadone dispensing machine).  7.6.1 Produce data and information through a baseline report for PUD from a human rights perspective that includes stigma, discrimination and violence and analyzes the status of laws and policies, needs, progress, challenges, and recommendations, with support of technical assistance.  7.6.2 Train PUD organizations and movements on their rights from a human rights perspective and promote their participation in community interventions.  7.6.3 Carry out an advocacy and communication plan for policy and law reform for PUD.  7.6.4 Conduct a campaign for the human rights of PUD.  7.6.5 Scale-up support to PUD organizations and movements from the perspective of their rights to participate in the design, elaboration, and implementation of legal and policy measures.  7.6.6 Carry out a special module on the rights of PUD and integrate it in the manuals or legal tools created for the training of health personnel, prison officials, law enforcement officers and public order agents in general, judges, prosecutors and parliamentarians and train them on the rights of PUD.  7.6.7 Integrate module on rights of PUD in community responses including training of paralegals.  7.6.8 Consolidate and expand mechanisms for documenting and reporting human rights violations for PUD especially with regard to violence, stigma and discrimination, in public and private contexts, and strengthen coordination between formal mechanisms and community mechanisms for communication and reporting (health sector, public order, paralegals, community system and CSOs).  7.6.9 Produce and disseminate material IEC about human rights of PUD. |
| Amount requested | Allocation: 6.406.868,99 USD |
| Expected outcome | Percentage of PWID receiving a prevention package increase from 7,61% in 2022 to 49,87% 2026 |

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| Module # 8 | Prevention package for other vulnerable populations (OVP) |
| Interventions | **8.1 Condom and lubricant programming for OVP:**  New,  Scale-up,  Continuation, or  Scale-down |
| **8.2 Pre-exposure prophylaxis (PrEP) programming for OVP:**  New,  Scale-up,  Continuation, or  Scale-down |
| **8.3 Sexual and reproductive health services, including STIs, hepatitis, post-violence care for OVP:**  New,  Scale-up,  Continuation, or  Scale-down |
| **8.4 Removing human rights-related barriers to prevention for OVP:**  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** Long distance truck drivers, miners, Internally Displaced People (IDP), seasonal workers  **Location: Miners:** Manica, Gaza, Tete and Cabo delgado; **IDP:** Cabo Delgado, Sofala, Zambezia, Niassa and Nampula  **Barriers:** Legal barriers that negatively impact human rights, constant mobility, cultural barriers, Stigma and Discrimination; and poor coherence and quality of OVP human rights programs and weak of coordination mechanisms; Limited coverage of the prevention services for this populations; fragility in the screening of GBV; condom availability; poor knowledge, visibility/access of the female condom; Lack of complete and accurate data on the size, demography and geography of these population. Internally displaced women become exposed to employ transactional sex or sex work as a mitigation strategy given the absence of livelihood sources. |
| List of activities | 8.1.1 Provide and ensure the promotion and distribution of condoms and water-based lubricants using leaders, champions, peers in high concentrated locations of these groups  8.2.1 Referral of OVP to health facilities and when concentrated populations as Internal displaced populations with limited access to health services will be provided through mobile brigades potentially to be implemented in 4 provinces (Cabo Delgado, Nampula, Sofala and Tete).  8.2.2 Implement DSD for PrEP  8.3.1 Screening, testing and treatment for symptomatic STIs  8.3.2 Provision of Contraception/family planning information and services  8.3.3 post-violence counseling, referral, and linkages to post exposure prophylaxis (PEP)  8.4.1 Integrate module on rights OVP in community responses including training of paralegals.  8.4.2 Produce and disseminate material IEC about human rights of OVP. |
| Amount requested | Allocation: 14.945.225,14 USD |
| Expected outcome | Increased the percent of respondents who say they used a condom the last time they had sex with a non-marital,non-cohabiting partner, of those who have had sex with such a partner in the last 12 months |

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| Module # 9 | Prevention Program Stewardship |
| Intervention | **9.1 Prevention Program Stewardship:**  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** Key and vulnerable populations  **Location:** all the country  **Barriers:** Availability of preventive commodities in a timely manner, weak management in the provision of prevention commodities to the final consumer, lack of prevention data for decision-making (capture and documentation of good practices), weak coordination in relation to condoms supply chain, low literacy related to prevention (knowledge about prevention), management of stock outs |
| List of activities | **Routine monitoring**  9.1.1 Strengthen the monitoring system for the achievement of positive goals at the province, district, US and community level  9.1.2 Implement a harmonize micro planning strategy:  9.1.3 Print the tools of the micro planning strategy.  9.1.4 Training the services providers at HF and community health workers on the micro planning strategy  9.1.5 Implementation of the SOP linkage to HIV test and CT  9.1.6 Reproduce the SOP  9.1.7 Purchase phones and phone credits  9.1.8 Map to KP (all) size estimation at sub-national level  9.1.9 Acquisition of Tablets to collect Youth Quality Improvement information (AGYW) in selected SAAJ  **Training of providers**  9.1.10 Conduct training in the use of data collection/reporting PREP tools.  9.1.11 Providers training for GBV screening, first-line support and post-violence care- Basic care package for victims of violence in the areas that are not covered under the PEPFAR funding. (PEPFAR-supported activity):  9.1.12 Train clinical and community providers in the revised KP SOP (communities’ interventions)  9.1.13 PrEP Provider Training  **Program Supervision / Program management**  9.1.14 Supervision of the implementation of the new instruments – STI covering Health Facilities not covered under PEPFAR  9.1.15 Supervision and Monitoring of the sterilization quality improvement process  9.1.16 Annual meeting of Male Circumcision  **Review and reproduction of recording and data collection tools**   * + 1. Reproduction of instruments and their distribution – STI; PrEP, HTS/HIVST, VMMC   **Implement program-specific evaluations**  9.1.18 Assessment of the mobile population and IDP  9.1.19 Conduct assessments and monitoring of the link in sectors that do not use the HTS book  9.1.20 Evaluation of PreP implementation to complement the activity under PEPFAR that currently is being implemented in Maputo City and. adding 3 additional Provinces (Manica, Niassa, Cabo Delgado)  9.1.21 Conduct evaluation of HIVST implementation  9.1.22 Conduct assessment to verify the monitoring of the link of negative cases to prevention services (not only for PrEP, but also for other combined prevention services)  9.1.23 Create a platform for collecting/managing data on HIV and AIDS including condoms (output and outcome indicators) (CNCS).  9.1.24 Conduct 8 supervisory visits for all levels (CNCS): program supervision/program management  9.1.25 Conduct a study/research on preferences, barriers, attitudes, practices on condom use. Previous work was implemented by PLM and focused solely on Boane district. In 2024-2026 the research will be scaled to understand the nuances in different districts and provinces to be able to adjust the campaign material. i.e. the reduced use of Portuguese in the North may result in different messages, or the visuals may need to be more conservative in more rural areas, or be focused more on females as the decision makers. These adjustments will also allow for the fine-tuning of the brand to allow it to become a National Brand.  **Condom and lubricant programing**  9.1.27 Mass and digital media campaign on combination prevention at population level to promote the correct and consistent use of condoms and all prevention interventions.  9.1.28 Hire technical assistance to develop training packages in matters of demand creation and condom promotion (communication plan) for activists, teachers, religious leaders, community leaders, peer educators, mentors, etc.; Produce the training materials considering the total marketing approach and the preferences of the 3 market sectors  **IEC Material and Communication Strategies (including materials for people with disability)**  9.1.29 Produce communication materials for changing pandemic-related behavior and attitudes for religious leaders.  9.1.30 Develop specific literacy/IEC materials, and made them available, for the sex workers, Transgenders and their clients  9.1.31 Production and distribution of pocket IEC material  9.1.32 Reproduce and disseminate IEC material focusing on prevention of HIV/STI and prevention of GBV in KP  **Program Management**  9.1.33 Conduct community dialogues with religious leaders and leaders to publicize PrEP-related services  9.1.34 National expansion of PrEP to more HF within districts already in implementation, and to more districts  9.1.35 Implement a pilot intervention to offer PrEP at Community level  9.1.36 Intensify awareness about the existence of PrEP in the community and especially among high-risk groups  **Strengthening the supply chain of prevention consumables**  9.1.37 Ensure the purchase of all inputs / consumables / TDR's related to prevention  9.1.38 Increase the transport capacity and peripheral storage of the public sector through the implementation of peripheral warehouses (in the form of containers adapted for this purpose); priority should be given to location according to HIV seroprevalence, population density (general, vulnerable to key), local transport network, eg |
| Amount requested | Allocation: 4 158 256,23 USD  PAAR: 12 654 591,65 USD |
| Expected outcome | Condoms, lubricants, PrEP and updated STI treatment available on 100% of the sites that offer complete combined prevention |

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| Module # 10 | Elimination of mother-to-child transmission of HIV, syphilis and hepatitis B |
| Interventions | **10.1 Integrated testing of pregnant women for HIV, syphilis and hepatitis B:**  New,  Scale-up,  Continuation, or  Scale-down |
| **10.2 Prevention of incident HIV among pregnant and breastfeeding women (PBW)**  New,  Scale-up,  Continuation, or  Scale-down |
| **10.3 Postnatal Infant Prophylaxis: Enhanced prophylaxis offered to all children exposed to HIV**.  New,  Scale-up,  Continuation, or  Scale-down |
| **10.4 Early childhood diagnosis and follow-up HIV testing for exposed children**:  New,  Scale-up,  Continuation, or  Scale-down |
| **10.5 Retention support for pregnant and lactating women:**  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** PBW, children exposed to HIV, HIV infected children <5 years, parturient women, children exposed/infected by syphilis, sexual partners, PW infected by HB, children exposed to HB, AGYW, boys, young adolescents, men (BAYM), and the community. **Location:** All the provinces, priority for Niassa, Cabo Delgado, Nampula, Zambezia. Prioritization of districts non supported by PEPFAR with high prevalence and low knowledge of HIV status and with no undergoing SRH Projects focusing on AGYW (list attached).  **Barriers**: *Access:*Late start of the 1st ANC due to late confirmation of pregnancy negatively impacting triple EVT. Gap in syphilis testing, which impairs timely treatment for prevention of congenital syphilis. *Availability:* Insufficient DUO and RPR reagents. Stockouts of benzathine penicillin (BP) generated by increase in demand. PMTCT clinical standards not consistently implemented. Services for HIV, syphilis, and hepatitis B PMTCT are poorly known to communities. MCH instruments for triple EVT, not adjusted to the registration needs, making it impossible to report the key indicators internationally. Lack of ARV drugs in pediatric formulations for HIV exposed infant prophylaxis. Insufficient HIV retesting in breast-feeding women (BW) due to RDT-HIV insufficiency. Insufficient implementation of MM strategy in Non-AJUDA HF. Low retention of users in C&T without MM. *Lack of information* about seroconversion in BW (most cases of HIV VT occur in breastfeeding). *Cultural factors:* Poor retention of the mother/child pair in PVT care and treatment (C&T). |
| List of activities | 10.1.1 Implement early diagnosis of pregnancy and early testing for HIV, syphilis, and HB, including: DUO in the 1st Antenatal consultation (ANC), RDT for syphilis, HB in the 1st ANC, as well as in parturient woman and exposed children, Viral Load (VL) (or HBeAg) for HB to HBsAg+ adolescents, girls, young women (AGYW) and pregnant women (PW).  10.1.2 Acquire and make available: RDT DUO of HIV & syphilis, RDT for HBsAg for use in POC, RDT for HBeAg for use in POC  10.1.3 Acquire & make available near-POC equipment (GeneXpert), reagents and collection kits for HIV VL  10.1.4 Acquire & make available reagents & kits for collection for HBV VL for conventional platforms existing in labs of molecular biology.  10.1.5 HIV VL using near-POC (GeneXpert) platforms for PBW and HIV+ children <5 years.  10.1.6 Acquire and make available hemogram and biochemical reagents for PW treated with TDF for HB\*\*\*.  10.1.7 Acquire and make available reagents for RPR test to help diagnose congenital syphilis at birth (parturient woman & newborn).  10.1.8 Print & distribute data recording and reporting tools for PMTCT of HBV for MCH and SAAJ services:  10.1.9 Print Triple Elimination of Vertical Transmission (EVT) Pocket Guidelines; disseminate clinical norms for the triple EVT.  10.1.10 Inform, educate, and communicate to providers and the public about the availability of services for the prevention of Vertical Transmission of HBV.  10.1.11 Train, supervise and provide technical support of trainers and providers for testing and management related to EVT in sites non supported by PEPFAR.  10.1.12 Conduct campaigns for the dissemination of information related to the triple EVT in the community. Create demand through IEC and community dialogues. Develop and insert television and radio spots.  10.1.13 Define milestones, targets and activities for HIV, Syphilis and HB EVT after 2024 through a new National Operational Plan for Triple EVT of HIV, syphilis, and HBV, 2025 – 2029: hire consultants; conduct auscultation workshops etc.).  10.1.14 Review MCH/MTCT registry instruments (hire consultant; conduct auscultation workshops, and Pilot instruments)  10.1.15 Train the health providers at Provincial, district and Health facilities (HF) level and provide supervision and technical support on PMTCT of HBV.  10.1.16. Conduct supervision and technical support visits to the provinces and in 250 non-AJUDA HF  \*Integrated with other interventions.  10.2.1 Test/retest for HIV AGYW and PBW according to the national norms  10.2.2 Strengthen follow-up and HIV monitoring of PBW according to national norms through interventions of community awareness\*.  10.2.3 Make HIV prevention consumables available to PBW: Acquire and make available RDT HIV for retesting of BW\*\*; acquire and make available male/female condoms, lubricants, and PreP for PBW.  10.2.4 Train/retrain the health providers at district and HF level and provide supervision and technical support to the HF\*/\*\*.  10.2.5 Include prevention of incident HIV among PBW in the National Operational Plan for Triple EVT 2025 – 2029\*  10.2.6 Disseminate information related to the prevention of HIV among PBW through IEC and community dialogues. Develop, insert television, and radio spots  \*Integrated with other interventions in this module. \*\*in NON-AJUDA HF.  10.3.1 Enhance Postnatal Infant Prophylaxis to all children exposed to HIV and Early HIV Diagnosis/Testing for exposed children  Acquire and make available prophylactic AZT and NVP syrup for HIV exposed Infants (HEI).  10.3.2 Train/refresh and supervise CHWs (MM) for dissemination of information on post-natal HIV prophylaxis\*  10.3.3 Conduct supervision and technical support visits to the provinces and the HF; train/refresh health providers at district and HF level and provide supervision and technical support to the HF \*/\*\*.  \*Integrated with other interventions in this module. \*\*in NON-AJUDA HF.  10.4.1 Include early infant diagnosis & follow up HIV testing in the Triple EVT pocket Guidelines and in the National Operational Plan for Triple EVT 2025 – 2029\*  10.4.2 Implement clinical mentoring for correct implementation of EID\*  \*Integrated with other interventions.  10.5.1 Train/retrain the health providers at district and HF level and provide supervision and technical support to the HF.  10.5.2 Expand MM strategy in non-AJUDA HF (HF not supported by PEPFAR) with a large volume of activities. Allocate MM in the AJUDA HF (which already implements the MM approach) to ensure follow-up of CLHIV aged 0 -10 years.  10.5.3 Train and supervise MM; train/refresh health providers at district and HF level\*; provide supervision & technical support\*.  10.5.4 Reproduce Mentor Mothers (MM) recording tools, purchase MM kits, train/refresh and supervise MM on PMTCT\*/\*\*  10.5.5 Conduct an evaluation of the MM interventions to ensure the lessons learnt can be applied for expansion.  10.5.6 Conduct recruitment and initial training of new mentor mothers (MM)\*\*; do annual refreshment of existing MM\*\*  10.5.7 Hire MCH Nurses in the provinces to mentor the implementation of the MM strategy in the HF\*\*  10.5.8 Prepare MM recording tools and purchase MM kits\*\*  10.5.9 Include retention of PBW in the National Operational Plan for Triple EVT, 2025 – 2029\*  10.5.10 Conduct supervision and technical support visits to the provinces and the HF\*\*  \*Integrated with other interventions. \*\*Non-AJUDA sites only. \*\*\*Under the Treatment and Support Cost |
| Amount requested | Allocation: 22 239 349,34 USD  PAAR: 3 774 112,94 USD |
| Expected outcome | By 2026:   * Reduce new cases of congenital syphilis to <750 cases/100,000 live births; * Reduce incidence of HIV new infections to <750 cases/100,000 live births. * Reduced prevalence of HBsAg in 5-year-old children to <0.5%; * Reduce mother-to-child transmission rate of HIV to <5% * Increase coverage of EID: Exposed children tested with PCR <2 months (2022) = 75%[[4]](#footnote-5) to 95%. |

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| Module # 11 | Treatment, care, and support |
| Intervention | **11.1 HIV treatment and differentiated service delivery - Children (under 15 years old)**:  New,  Scale-up,  Continuation, or  Scale-down |
| **11.2 HIV treatment and differentiated service delivery – adults (≥15 years)-**  New,  Scale-up,  Continuation, or  Scale-down |
| **11.3 Integrated management of co-infections and comorbidities (adults and children) – NCDs, HPV, Hepatitis, Diabetes and Mental Health issues** –  New,  Scale-up,  Continuation, or  Scale-down |
| **11.4 Diagnosis and management of advanced disease (adults and children).**  New,  Scale-up,  Continuation, or  Scale-down |
| **11.5 Treatment monitoring – drug resistance**:  New,  Scale-up,  Continuation, or  Scale-down |
| **11.6 Treatment monitoring - viral load and antiretroviral (ARV) toxicity**:  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **HIV treatment and differentiated service delivery - Children (under 15 years old)**  **Population:** Children living with HIV(CLHIV) 0–15 years.  **Location:**  All HF with ART services (medicines delivery). NON-AJUDA HF (with no direct support from PEPFAR) and AJUDA HF with no funding for mentor mothers (MM).  **Barriers**:   * Budget gap: for ARV drugs and drugs for the treatment of opportunistic infections (OIs) in pediatric formulations; for training of HF providers in non-AJUDA HF in clinical and PSS care for ART transition of children to adolescents and from adolescents to adults. * Lack of staff: In non-AJUDA HF, no MM for follow-up of adherence and peer support to parents and caregivers; lack of human resources (including CHWs) and funds for tracing back patients. * Lack of tools. PSS package not adjusted to the degree of neurocognitive development of child/adolescent; lack of standardized tools to monitor neurocognitive development and to approach care transition. * Social issues: No children/adolescents’ empowerment for their own control of ART. Children 0-10 are more likely to discontinue ART after 6 months in C&T; as a result, viral suppression is still suboptimal among children, particularly in children <1 year and 5-9 years.   Lack of access to HIV services in rainy seasons, emergencies, and humanitarian crisis, mainly in HF with no direct support from the partner (non-AJUDA HF) causing high rates of patients lost to follow-up (LTFU). |
| **HIV treatment and differentiated service delivery – adults (≥15 years)**  **Population (according to the specific activity group):** PLHIV, KP, AGYW and their partners, PBW, men, patients on ART non-adherent and/or LTFU, families with PLHIV.  **Location:** All health facilities (acquire medicines; non-AJUDA sites (most activities). Districts with low awareness of HIV status (Shiny90 tools) for male engagement.  **Barriers (according to the specific activity group):** Lack of resources from the HNS to provide ART to 95% of PLHIV. Cultural gender issues: Low inclusion & low adherence of men: AIDS targets: male 73-83-89, female 88-91-90. Access: poverty, long distances, difficulty of transport. Social factors affecting adherence and retention in ART. Social issues and lack of resource to deal with adherence and retention issues to HIV C&T, as well as stigma and discrimination (S&D) in HF and Community contexts |
| **Integrated management of co-infections and comorbidities (adults and children) – NCDs, HPV, Hepatitis, Diabetes and Mental Health issues**  **Population:** PLHIV, KP, AGYW and their partners and PBW.  **Geography:** All the country, in sites/activities not supported by PEPFAR.  **Barriers:** Gaps in the diagnosis and management of NCDs; neoplasms (cervical cancer etc.); hepatitis B and C, metabolic and cardiovascular diseases. |
| **Diagnosis and management of advanced disease (adults and children)**  **Population:** PLHIV, KP, AGYW and their partners and PBW.  **Geographies:** Expansion to 29 (phase 1) and 50 (phase 2), reference hospitals for Advanced HIV Disease (AHD) listed in the Nota DNSP 687/002 of 24/03/23.  **Barriers addressed:** Screening, diagnosis, and management of advanced disease ineffective due to lack of adequate resources. Lack of involvement of gynecologists/obstetricians in C&T in AHD & cervical cancer |
| **Treatment monitoring - viral load and antiretroviral (ARV) toxicity**  **Population:** PLHIV.  **Location:** All the country for pharmacovigilance system and non-AJUDA sites for viral load monitoring.  **Barriers addressed:** lack of a strategic plan to monitor the resistance of ARVs; Limited access to health services including VL testing (e.g., working hours, stigma for KP, school hours for adolescent and youth, etc.), low ART literacy. Fragile, inadequate pharmacovigilance system. |
| List of activities | **Differentiated HIV treatment services**  11.1.1 Acquire ARV drugs (specific formulations for children) to ensure the 1st, 2nd.and 3rd line of ART, and drugs for the treatment of OIs, including for newborns, in accordance with current regulations.  11.1.2 Ensure the availability of ARVs and drugs for OIs in all ART sites, including HF with pediatric wards.  **Differentiated service delivery models**  11.1.3 Empower providers in the updated package of community Difference Service Delivery (DSD) in the context of an emergency or humanitarian crisis.  11.1.4 Ensure the effective implementation of the DSD in the non-AJUDA HF (integrated mobile brigades including the offer of ARVs by CHWs (APEs) in the HF without direct support from the partner (non-AJUDA HF)  **Differentiated adherence and treatment support**  11.1.5 Empower (and support cost training in non-AJUDA sites) care providers in the package of clinical care and PSS for transition of pediatric and adolescent services.  11.1.6 Reproduce and distribute didactic/support materials and tools for monitoring the transition strategy.  **Activity for Orphans and Vulnerable Children (OVC)**  11.1.7 Implement approaches for HIV screening in OVC, linkage to C&T, with Psychological and Social Support (PSS) and follow-up of adherence.  11.1.8 Develop guidelines for health providers including OVC identification, standard operational testing for HIV, screening, referral triangulation among HF/ community / social services, procedures for economic support activities, training for HF and community providers, screening, recording tools for M&E.  11.1.9 Make trained health providers and CHWs to implement the standardized OVC package and monitor implementation.  **Differentiated HIV treatment services**  11.2.1 Acquire and make available ARV drugs of the 1st, 2nd, and 3rd lines, including PBW in accordance with WHO recommendations.  11.2.2 Acquire and make available TDF 300mg for PW with HB.  11.2.3 Acquire and make available Benzathine Penicillin (BP) needles, and syringes for PW and sexual partners with syphilis.  **Differentiated Adherence and Treatment Support**  11.2.4 Implement preventive and reintegration activities through calls and home visits. Improve Adherence to treatment, follow-up, and reintegration of LFTU: (i) by implementing the NID system, (ii) by employing peer educators as navigators in the HF for steering the users among the ART-related services.  11.2.5 Improve adherence among KP, by recruiting, training, and deploying KP peer educators as navigators to support KP accessing services, including VL testing; sensibilize all peer educators and counselors in the HF on KP and vulnerable people. The service will be fully integrated in order not to segregate KP in the HFs. Peer educators will work with communities and Health Facilities starting from HIV testing, along a continuum of care aimed to support HIV+ vulnerable and key subjects.  11.2.6 Map CHWs who carry out preventive and reintegration visits, community leaders, religious and traditional medicine practitioners (TMP) and set up a database for existing and trained CHWs. Train untrained CHWs in the MoH’ s PSS package.  11.2.7 Implement the "Welcome" package to patients LTFU and reintegrated into the HF; ensure privacy and confidentiality in the provision of PSS and PP / Mental Health for patients from the priority HF (higher volume) looking for alternative solutions (fiber cabinet, prefabricated, etc.).  11.2.8 Monitor the provision of PSS and PP: Carry out the evaluation of the implementation of the PSS Guideline in ART services.  11.2.9 Conduct a Quantitative Study on the screening of Mental Illness in PLHIV (following recommendation of the GF funded “*Por que parou*” study)  **Stigma and discrimination reduction**  11.2.10 Expand GBV support services: post-violence counselling, clinical investigations, PSS including mental health services.  Improve NCD/coinfections screening and management:  11.3.1 Acquire and make available medical and lab equipment and reagents, and furniture.  11.3.2 Train/retrain: (i) clinicians in C&T of NCDs, coinfections, and anal cancer; (ii) train clinicians, counsellors CHWs for screening and referring or treating according to their competences, patients with symptoms of depression and mental diseases; train psychologists in mental illness relevant to PLHIV (refreshments)  11.3.3 Scale up of CETA (Common Elements Treatment Approach) integrated in PSS in 99 HF that have ART services, to improve retention of PLHIV with mental diseases.  11.3.4 Integrate HB, cardiovascular diseases, and diabetes screening within platforms for PLHIV aimed at early detection and treatment, including POC RDT for HBV.  11.3.5 Organize referral and treatment systems for cervical cancer and for anal cancer on the model of cervical cancer.  11.3.6 Work out, reproduce and distribute data recording and reporting tools.  11.3.7 Purchase drugs and therapeutic aids for HBP, diabetes, cancers, hepatitis and mental health.  11.3.8 Support prevention, screening, and treatment of cervical cancer in women of reproductive age (20-49): Acquire and distribute (i) LEEP for referral hospitals and probes for PHC HF, (ii) reagents for HPV testing using existing lab platforms; (iii) Acetic Acid for the realization of the VIA, (iv) gynecological lamps, speculums, and thermal ablation equipment. Train staff in HPV testing; conduct supervision for HPV testing. Reproduce/distribute recording tools. Support referral of eligible women to hospitals. \*  11.3.9 Support screening, and treatment of HB(PLHIV and their partners, focus for KP, mobile/migrant populations). Acquire and distribute RDT, cartridges, and reagents for measuring VL for HB, drugs for the treatment of HB.  \*GF funds will be used for cervical cancer C&T in 250 sites not supported by PEPFAR funds  **Improved screening, diagnosis, and management of AHD:**  11.4.1 Expand the implementation of the AHD package to include 122 HF: Acquire, distribute, and maintain (i) conventional machines for CD4 testing; (ii) reagents for CD4 (including Visitect), TB LAM and CrAG; (iii) drugs for the treatment of conditions associated with AHD (Amphotericin, including liposomal Amphotericin, Fluconazole, Flucytosine); supply, maintain and expand chemotherapy sites [including drugs and items for Kaposi Sarcoma (KS)].  11.4.2 Empower providers in the AHD package (including diagnosis, C&T of KS.  11.4.3 Supervise from the central level – through the sub-recipients. Supervise the provincial level for the HF implementing AHD.  11.4.4 Reproduce and distribute recording tools (logbooks, AHD sheet, CD4 requisition)  11.4.5 Train clinicians from Gynecology and Obstetrics sectors of reference hospital in AHD.  11.4.6 Make follow-up/reintegration calls of clients with contra-referred AHD from the reference HF to the health center.  11.4.7 Develop and implement an integrated home and palliative care package under the responsibility, leadership, and coordination of civil society with the involvement of the MoH  11.4.8. Engage Peer educators and other CHW in the follow up of patients discharged from the hospital (adherence treatment, home care) and in the quick referral of patients with clinical evidence of ADH  **Structure a complete surveillance system for resistance to HIV-1 ARVs**  11.5.1 Develop, lay out, reproduce, distribute a strategic plan for surveillance of HIV-1 ARV resistance (HIVDR), including the operational roadmap. Organize workshops for the strategic plan of resistance to ARVs and for their dissemination; develop guidelines and guiding documents for HIVDR. Develop surveillance strategies to monitor acquired resistance and pretreatment in children and adults. Take stock of the implementation of the Plan.  11.5.2 Empower providers in monitoring ARV resistance; provide technical support and supervision; introduce and expand genotyping for resistance detection within clinical practice, in priority groups (PBW and adolescents). Establish and strengthen laboratory capacity for surveillance of resistance to HIV-1 ARVs (HIVDR)  11.5.3 Acquire laboratory equipment for HIV-1 sequencing for public health labs, reagents, and consumables; perform maintenance and calibration of lab equipment that tests samples under the HIVDR.  11.5.4 Strengthen HIVDR data analysis for HIV-1 prevention and treatment  11.5.5 Prepare and publish periodic bulletins; hold meetings to disseminate and discuss the results of HIVDR.  **Viral Load (VL) Monitoring:**  11.6.1 Train CHWs and lay personnel (APEs, counselors, peer educators, MM etc.) in VL (refreshments, supervision, follow-up, and monitoring); follow-up CHWs with the involvement of civil society.  11.6.2 Develop and disseminate messages about HIV and VL to the general population through text messages (sms). Disseminate VL communication material for the monitoring of ART, for the reduction of transmission to partners and vertical transmission, through radios and lectures in the community.  11.6.3 Implement the VL literacy package for the patient; continue the dissemination of the "U = U" campaign (radio-television spots).  **Strengthen the pharmacovigilance system:**  11.6.4 Active monitoring: Increase awareness on drug adverse effects (DAE) among clinicians by sending refreshing information on DAE through SMS (including detailed information when a new drug is introduced),  11.6.5 Implement on-the job-training, clinical supervision, and mentoring in ART sites, with priority for high volume HF.  11.6.6 Expediting and aggregating the reports of DAE; providing timely feedback to the providers through the existing institutions (National and Provincial Therapeutic Committees) and online mechanisms.  11.6.7 Set up and implement a Pregnancy registry / birth defect surveillance system to monitor the safety of ARV in PW  11.6.8 Train CHWs and lay personnel (counsellors, peer educators, etc.) in ARV toxicity focusing on common adverse effects. |
| Amount requested | Allocation: 305 384 719,12 USD  PAAR: 10 000 000 USD |
| Expected outcome | * Increased HIV VL coverage from 64% (2022) to 100% (2026) * Increased HIV VL suppression from 71,95% (2022) to 88,12% (2026). * Increased the coverage of children on ART from 72,4% (2022) to 94% (2026). * Increased coverage of adults on ART from 82% (2022) to 93% (2026). * Increased coverage of cervical cancer screening using HPV-DNA in WLHIV from 0 (2022) to 50% (2026) * Expand AHD basic package implemented from 40 HF (in 2022) to 162 HF in 2026 * Continuity of HIV services provision in emergency, rainy season or humanitarian crises; increased retention of patients in C&T. * Surveillance system for monitoring HIV-1 resistance to ARVs in place; * Program's treatment and prevention strategies improved. * Adverse drug effects are better identified, reported, and managed with positive effects on patient’s wellbeing, adherence and retention. |

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| Module # 12 | Reducing Human Rights related Barriers to HIV/TB Services |
| Interventions | **12.1 Eliminating stigma and discrimination in all settings**:  New,  Scale-up,  Continuation, or  Scale-down |
| **12.2 Legal literacy (“Know Your Rights”)**:  New,  Scale-up,  Continuation, or  Scale-down |
| **12.3 Ensuring non-discriminatory provision of health care**:  New,  Scale-up,  Continuation, or  Scale-down |
| **12.4 Increasing access to justice**:  New,  Scale-up,  Continuation, or  Scale-down |
| **12.5 Ensuring rights-based law enforcement practices**:  New,  Scale-up,  Continuation, or  Scale-down |
| **12.6 Improving laws, regulations and polices relating to HIV and HIV/TB**:  New,  Scale-up,  Continuation, or  Scale-down |
| **12.7 Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity:**  New,  Scale-up,  Continuation, or  Scale-down |
| **12.8 Community mobilization and advocacy for human rights** -  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:**  Health and other public authorities, health professionals, policy makers, duty bearers (particularly law enforcement officials), PLHIV, KVPs, People affected by TB, CSOs, CBOs, FBOs, private sector, traditional authorities.  **Locations:** National  **Barriers:** Persistent stigma and discrimination in all contexts, specially within the health system, constitute a barrier to access to health services and negatively impact on treatment, care and retention. Fragmentation of human rights programs and inadequate coordination mechanisms jeopardizes the effectiveness and efficiency of human rights interventions in the context of HIV. Lack of specialized human rights human resources and inadequate staffing of the human rights program hinders coordination and quality of interventions. Discrimination in law enforcement and poor access to justice services, particularly the poor. Low coverage and quality of legal and paralegals systems. HIV-related gender discrimination; harmful gender norms and violence against women, girls and identity and gender minorities. Poor knowledge of the laws at both ends, namely, rights holders such as PLHIV, KVP, people with TB and population in general on the one hand, and duty bearers such as HCW and public servants, on the other hand. HIV-related laws and policies are not aligned with some core content of human rights, while others contain barriers or are not duly enforced, including those related to legalization of CSOs and movements; weak community mobilization for the defence of human rights; weak production of evidence on human rights; gender discrimination and gender-based violence discourage uptake of health services; weak involvement of PLHIV, PC and the vulnerable in interventions to fight stigma, discrimination and violence. Insufficient knowledge of legislators and agents responsible for interventions in the area of human rights; lack of legal tools for adoption and implementation of measures; poor coverage of legal services including GBV Integrated Care Centres; poor access to health care equitably in an emergency and humanitarian context. Insufficient coordination mechanisms amongst and between institutional and community-based stakeholders. Poor monitoring and evaluation system; poor quality of Human Rights interventions continues to undermine the effectiveness of investments, and poor coordination between different institutions and community systems negatively affects program implementation. |
| List of Activities | **Private, Domestic and Community**  12.1.2 Disseminate results of PLHIV and PC stigma index.  12.1.3 Integrate the results of the HIV and TB stigma and discrimination indexes into the respective operational plans to combat these diseases.  12.1.4 Follow up implementation of stigma and discrimination index for people affected by HIV and TB.  12.1.6 Provide psychosocial and mental health support services in the community to reduce self-stigma.  12.1.7 Develop and disseminate IEC materials on stigma and discrimination (including in sign language) in all, private, community and in public spaces.  12.1.8 Carry on research, increase awareness and knowledge interventions on rights of persons with disabilities and its relationship to HIV and TB.  12.1.9 Train the community on Stigma and Discrimination through dialogues, theater, lectures, engaging men and women and people belonging to gender and sexual minorities.  12.1.10 Train community actors, including community leaders, religious leaders and Traditional Medicine Practitioners (PMTs) in sign language.  **Educational settings**  12.1.13 Develop guidelines and integrate them in educational deontological codes that describe duties of school professionals and with attention to the student community in general on disease prevention, gender promotion and Human Rights in PLHIV, Key and Vulnerable Populations, TB, and disseminate it.  12.1.14 Carry out modules and train teachers and school professionals at all levels of education in the country, including higher education in matters of Health, HIV, TB, Human Rights, stigma reduction, gender awareness, ethics and deontology and expand training to assistants of education.  12.1.15 Offer support services for psychological counseling to students, staff on issues of gender, HIV, Key and Vulnerable Populations.  12.1.16 Ensure technical assistance for the assessment and adjustment of curricula regarding matters on Health, HIV and TB, gender, stigma and discrimination and HR in educational institutions.  12.1.17 Hold a symposium and academic presentations on human rights in the context of HIV and TB, key and vulnerable populations and promote and organize academic debates involving all social strata on the issue of human rights in key and vulnerable populations in educational centers including higher education.  **Workplace**  12.1.18 Assess, make recommendations, and strengthen existing mechanisms to combat stigma and discrimination in the context of HIV and TB, as well as strengthen reporting, accountability, and redress mechanisms for victims of violations of labor rights in the context of TB and HIV.  12.1.19 Conduct a qualitative assessment on stigma and discrimination in the workplace with support from technical assistance.  12.1.20 Raise awareness and train, employers and employees, workers' unions, employers' associations, including labor inspectors.  12.1.21 Revise policies and strategies that promote a healthy environment free of stigma and discrimination in the workplace.  **Emergencies and humanitarian settings**  12.1.22 Development, update and implementing a strategy for access to services without discrimination in emergency and humanitarian contexts involving CBOs and crises management committees.  12.1.23 Train staff and CBOs working in emergency and humanitarian settings on access to services without discrimination in emergency and humanitarian contexts.  12.1.25 Strengthen governmental prevention mechanisms, address, monitor and report violence against populations in emergency and humanitarian settings.  12.1.27 Develop and disseminate information on human rights, stigma and discrimination among populations affected by emergency and humanitarian situations.  12.2.1 Scale-up “Know your rights” program through the design and implementation of campaigns on human rights linked to HIV and TB with legal and communication technical assistance.  12.2.2 Preparation and implementation of training manuals for CSO and movements on a) users' rights to health related to HIV and TB services, b) human rights and HIV -general-, c) human rights and TB -general- d) international (United Nations) and regional (African Union) instruments and mechanisms of human rights with special emphasis on engagement with these mechanisms;  12.2.3 With the support of technical assistance, revise the legal training program specially designed for paralegals that includes coordination mechanisms with the different implementers.  12.2.4 Conduct and expand periodical training on rights for CSOs, CBOs, PLHIV and TB networks, people with disabilities, peer educators and paralegals throughout the national territory.  12.2.6 Conducting national dialogues and exchanges with countries with effective experiences on legal literacy.  12.3.1 Improve quality standards for access to health services and health care without discrimination by strengthening the Technical Working Groups responsible for human rights and HIV and the Technical Working Group on Human Rights and TB, and scale-up/consolidate coordination mechanisms between them, as well as strengthening co-management mechanisms and the integration of community organizations for support and quality control through formal agreements.  12.3.2 Updating the system, strengthening and ensuring the proper functioning of the accountability mechanisms that include, medical ethics mechanisms both for institutional health bodies at all levels as well as for health professionals, mechanisms for reporting and monitoring complaints on violations of health rights based on stigma and discrimination, mechanisms for accountability and reparation in cases of stigma and discrimination and other violations of users' rights in the health system, including the user office in the Health Units, and creating mechanisms for consultation and user engagement.  12.3.3 Review the Patient’s Safety Protocols with support of technical assistance.  12.3.5 Support implementation of existing communication package for Health Units non-AJUDA and elaborate, update, and disseminate materials (IEC) on the rights of users in accessing health services.  12.3.6 Continue and scale-up training of health professionals and health public servants in matters of stigma and discrimination, human rights related to HIV and TB in pre-and in-services training, including on rights of Key and Other Vulnerable Populations rights.  12.3.7 Expand the scope of human rights intervention through training health providers in sign language, use and production of evidence regarding the link between disability, HIV and TB.  12.3.8 Re-organize HIV service provision to ways that avoid singling out via special queues and rooms that allows for the disclosure of people’s positive HIV status to others which can lead to S&D and people’s drop out of treatment  12.3.9 Revise HTS, treatment, care, and child to mother transmission health care protocols to ensure human rights and gender compliance and ensure integration of recommendations into these protocols  12.3.10 Conduct a human rights assessment on performance of health care workers on HTS, treatment, care and child to mother transmission  12.4.1 Mapping, integrating paralegals in the institutional and community response to HIV and TB.  12.4.2 Strengthening, expanding paralegal system that considers the emergency and humanitarian contexts, and advocates for their institutionalization.  12.4.3 Promote establishment and strengthen existing collaboration with the Bar Association, the Ombudsman, and the National Commission for Human Rights.  12.4.4 Ensure community legal assistance for victims of discrimination and other violations of rights related to HIV and TB,  12.4.6 Increase support for strategic litigation that includes cases in the national context (domestic law) as well as the international context (international and regional human rights mechanisms) with support of technical assistance.  12.4.7 Continue support for alternative and community dispute resolution, including engagement of traditional and religious leaders in the context of HIV and TB and revitalize community courts.  12.5.1 Continue to roll out a program for access to justice that includes the development of SOPs for different sectors of law enforcement (judges, prosecutors, lawyers, police, prisons’ officials), continue to update existing legal tools, and strengthen coordination mechanisms that include the designation of focal points both in the judiciary system and in the public order system.  12.5.2 Promoting the integration of modules on HIV and TB rights in the training curriculum (pre-service) of public order agents and health system inspectors with support of technical assistance.  12.5.3 Advocate for the integration of module on HIV, TB and Human Rights for judges and prosecutors and roll out trainings of this module with support of technical assistance.  12.6.1 Update legal environment assessment with special emphasis on a) situation analysis, b) progress, c) challenges and d) recommendations.  12.6.2 Ensure implementations of Legal Environment Assessment recommendations through provision of technical support for law reform.  12.6.3 Finalize and revise the Operational Plan for a comprehensive human rights response to adjust to comprehensive human rights response in the contexts of HIV and TB.  12.6.4 Conduct a Thematic Report on HIV and TB with the National Commission for Human Rights with special attention to the Right to Health, the Right to Equality and the Prohibition of Discrimination.  12.6.5 Train parliamentarian in specific matters of PLHIV, persons affected by TB and KVP that include a non-binary gender perspective.  12.6.7 Create a national platform and provide for spaces for debates and discussions for the participation of civil society and relevant government ministries and departments in policy and legislation reform needed to create an enabling environment for an effective HIV and TB response  **Individual**   * + 1. Develop gender-specific communication campaigns against S&D, including self-stigma, in the context of HIV (through mass media, social media, mHealth platforms, audio-visual, influential leaders and ambassadors)   Community   * + 1. Engage, train and sensitize community, religious and opinion leaders on gender-based violence, gender norms and traditional practices that increase the vulnerability of key and vulnerable populations to HIV and TB infection     2. Support grassroots movements, including women’s groups, in raising awareness concerning HIV and TB rights, S&D in vulnerable populations, monitoring violations, and advocating for change.     3. Introduce and test community-led empowerment methodologies to promote more harmonious and violence-free relationships in families and communities, such as Gender Action Learning System (GALS)     4. Expand the Community Dialogues platform into a comprehensive package that includes and promotes communication skills for a culture of dialogue, tolerance and peaceful resolution of differences in domestic and community life to overcome the various forms of GBV     5. Identify, map good practices and strengthen community initiatives that support hosting and referring GBV survivors     6. Establish alliances and cooperate with masters of purification rites, initiation rites (of both girls and boys) and religious leaders (including leaders of neo-Pentecostal churches) to negotiate the inclusion of gender equity values and practices, comprehensive sexual education, and rights in the knowledge transmission that they provide/ and purification rites   Institutional   * + 1. Advocate, strengthen and develop capacity building for gender statistics that include the multiple gender identities in general (MGCAS) and related to HIV and TB S&D in MISAU and INE in particular     2. Strengthen multisectoral approaches to gender issues, including the consolidation of integrated support for victims of violence   12.7.10 Ensure leadership of MISAU’s gender unit in the gender intervention processes of HIV and TB programmes (technical assistance, monitoring and supervision)  12.7.11 Monitor HIV and TB-related violations against women, girls, transgender, disable people, and young people.  12.7.12 Reinforce the implementation of MISAU’s guidelines on stigma, discrimination and confidentiality, as well as the humanization and quality of care policy  12.7.13 Conduct a comprehensive HIV Gender Assessment and use findings to inform more targeted programming to address gender inequality  12.7.14 Build capacity and support community committees in monitoring protocols in the organic units that offer services, paying attention to gender-related vulnerabilities  12.7.15 At Integrated Care Centers for GBV victims:   * + Develop and implement an official and harmonized to communicate the victim’s reception at any entry door   + Guarantee trained occasional experts in legal medicine in all points receiving GBV victims to increase chances of reliable evidence in court cases   + Develop and reinforce guidelines for health management and supervision of independent CAIs (outside the health centers)   **Police**  12.7.16 Expand police services for victims of violence and provide them with a response capacity to complaints and distress messages  12.7.17 Expand existing and create new private and dignified assistance rooms for GBV at police stations as a way to bring services closer to the community;  12.7.18 Update the GBV guidelines to police officials to include new content (including pro-activity when GBV perpetrators or victims are police officers);  12.7.19 Expand the use of the InfoViolência platform to other sectors in the multisectoral response to GBV and support it to guarantee that it continues to be a reference in GBV statistics in the country;  12.7.20 Support the effective functioning of the emergency line  12.7.21 Acquire motorbikes to respond to the limitations of reaching remote locations in the context of intensified awareness-raising and community dialogues on GBV  12.8.1 Conduct a mapping of national institutions, CSOs, CBOs and movements, regional and international human rights mechanisms, develop guidelines for the engagement with these mechanisms and revise it periodically with support of technical assistance.  12.8.2 Create and update a chronogram of national policy and legislation processes for engagement in these processes, and with international human rights mechanisms.  12.8.3 With support of technical legal and communication assistance, make proposals and advocate for the adoption of policy and legislative measures to improve policy and legal environment related to HIV and TB that bears account of recommendations of the Legal Environment Assessment.  12.8.4 Support CSOs providing technical assistance in the engagement with regional and international human rights mechanisms, including the elaboration of shadow reports |
| Amount requested | Allocation: 7 649 073,86 USD  PAAR: 11 867 381,55 USD |
| Expected outcome | * Improved coordination and cooperation of the HIV, health and human rights response within the national response mechanism and among government, civil society organizations, the private sector and development partners * Percentage of people living with HIV who report having experienced stigma and discrimination in the general community decreases from 10% (Stigma Index 2023) to 7% by 2026. * Decrease of at least 2 % of people living with HIV and key population who reported experiencing physical and/or sexual violence by 2026 * Increase to 50 % of legislators, judges, magistrates and law enforcement official with knowledge and capacity to apply standards and guidelines related to human rights in the contexts of HIV, including KVP * Increase to 75 % of health care workers with knowledge and capacity to apply standards and guidelines related to human rights in the contexts of HIV, including KVP * Increase to 80 % by of people living with HIV and key and vulnerable population members reporting greater knowledge of their rights and where and how to obtain redress when their rights are violated * Increased proportion of PLHIV who sought justice services in the face of violation of their rights from baseline 12,5% (PLACE, 2018) to 80% * Increase number of new laws, regulations, policies that specify human rights protections for PLHIV and KVPs. * Decrease number of existing laws, regulations, policies that present barriers to accessing HIV services |

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| Module # 13 | Tuberculosis Diagnosis, Treatment and Care |
| Intervention | **13.1 TB screening and diagnosis -** Change in Programming from current grant:  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** TB patients and their contacts  **Location:** National. This module will focus on strengthening the TB screening, diagnosis and notification cascade throughout the entire country, from the community to the health facility level. Community TB activities including community-based TB case finding, contact tracing, treatment support for active TB and TPT, are currently supported through the NTP/Global Fund partner CCS and by the USAID supported LTBR project. While these projects are active in each province, there are still 24 districts without a community TB partner. With funding from the core allocation, TB matching funds, and other partner support this community package of TB activities will be expanded to every district. There will be particular focus on activities in the Central and Southern regions where there is a higher prevalence of TB among the general population and higher HIV rates in the general population, and high-risk groups (Miners, Prisoners, TB contacts, PLHIV, highly mobile population, health workers). Investment in the northern provinces will target internally displaced individuals. The TB Laboratory Diagnostic Network will be strengthened through rapid WHO approved molecular testing for TB in each district, primarily with the GeneXpert platform at facility level and in smaller facilities and into the community with TrueNat. In large health facilities, HIV clients with advanced disease will be targeted for implementation of the HIV Advanced Disease package, which includes urine TB LAM testing. The NTP will further expand rapid molecular testing for drug resistance testing for Isoniazid and Fluoroquinolones using Xpert XDR. Regional TB reference labs will continue to play a major role in TB culture, phenotypic drug resistance testing particularly for the new DR-TB medications and will be piloting targeted sequencing for drug resistance testing both for clinical purposes, and for DST surveillance. Under this grant, the NTP will initiate the implementation of the new TB screening algorithm which includes the Digital X-Ray with Computer Assisted Detection (CAD) aiming to reach high risk groups.  **Barriers:** The outbreak of the COVID-19 pandemic reversed the gains achieved over the years in TB cases reporting. Prior to COVID-19 TB AF notifications had been increasing by 15% annually but plateaued from 2019 to 2021, translating into a loss of an estimated seventeen thousands of TB notifications[[5]](#footnote-6). While access to community TB screening and contact tracing has improved with two primary partners implementing activities, there is still no coverage for all districts, and the package of services could be further strengthened. Facility level TB screening is variable and needs to be strengthened – some facilities have MOH or partner supported cough officers, others do not. Some clinicians do excellent TB screening and testing for adults and children, others do not. Due to changes on WHO screening, testing, and treatment guidelines some of the current TB algorithms and guidelines need to be updated.  Collaboration between the Public and Private Sector remains a challenge, less than 1% (0.16%) of reported cases come from the private sector, showing the need to improve collaboration and create partnerships/cooperation agreements between these two sectors. In an initial phase, there should be a MoU or disclosure of TB services in the private sector and development of technical capacity for screening, diagnosis and follow-up of patients with TB among technicians in private clinics.  Mozambique still has low coverage of a TB laboratory network, only 28% of the Heath Units have a TB laboratory and only half of these have GeneXpert. Only 71% of all existing Health Units can reach a laboratory with GeneXpert within a feasible distance of 50 km using the current sample transport system, highlighting inadequate access to rapid molecular testing for TB, but challenges persist in maintaining the GeneXpert equipment with one third of modules non-functional prior to the recent start of the HyperCare contract with Cepheid. Although TB AF and BC notifications show a growing trend, the percent of TB BC cases remains below 50% (42% in 2022) due to multiple factors in the diagnostic cascade. This includes a notable proportion of samples that are saliva and low quality, long turnaround time for TB testing especially samples referred for Xpert, over reliance on clinical diagnosis, inadequate access to rapid molecular testing for TB, poorly maintained Xpert network, insufficient coverage of health units with technical capacity and material for collecting pediatric samples (induced sputum, gastric aspirate and stool for Xpert), few sites using TB LAM, and low dXR and CAD coverage. One of the major challenges faced is the management of laboratory information, with the training of technicians and laboratory logistics managers in the completion and sending of LMIS reports using the Web/Link system. There is low technical capacity and material for preparation of proficiency panels for laboratory tests; Lack of maintained calibration of the main equipment of the accredited test. In the last 3 years there has been an improvement in the performance of the sites that perform the tests through microscopy. However, there was a slight decrease in the performance of the sites that performed tests using the Xpert MTB Rif technique. Across the entire cascade there is a need for a comprehensive quality improvement strategy anchored by a strong M&E platform for TB which is further discussed in module 18. There is also a need to further strengthen treatment support for clients including mental health screening and treatment, diabetes screening and treatment, and adequate supervision and in-service training for all cadres of workers from community, to lab, to facility, district, province and national level staff. Women tend to be bacteriologically underdiagnosed due to the challenges of TB diagnosis in PLHIV, pregnant and post-partum women and genital TB. In Mozambique, NTP is lacking data for genital TB[[6]](#footnote-7). Evidence demonstrates that women are prioritized to see doctors and nurses. This means that men are likely to have less access than women[[7]](#footnote-8). |
| List of activities | **Case finding**  13.1.1 Hiring cough offices who can support TB screening in screening/waiting areas, particularly at high-volume entry points, and facilitate the liaison between child health services and TB-related services (i.e., sampling and diagnostic services, clinics) for pediatrics and adults;  13.1.2 Hiring activists for community contact tracing of index TB cases will also be strengthened.  13.1.3 Perform monthly days of coughing.  13.1.4 Mass media campaign nas rádios e televisão  13.1.5 Producing IEC materials on tuberculosis literacy and sample collection.  13.1.6 Initial Training cough officer on tuberculosis screening  13.1.7 Initial Training activists on tuberculosis and MDR/TB  13.1.8 Refreshment for cough officer on tuberculosis screening  13.1.9 Refreshment for activists on tuberculosis and MDR/TB  13.1.10 Provision of work kits for activists to carry out technical support visits and monitoring of community activities.  13.1.11 Celebration of Tuberculosis Day  13.1.12 Strengthen the integration of TB screening at the different entry points (maternal and child health services, nutrition and HIV care and treatment, pediatric screening, and hospitalization). Job aids will be distributed to support TB screening in children and will be allocated to lay providers (cough officers) at ports of entry and waiting areas to support screening and facilitate linkage between services (sampling sites, referrals, laboratory, TB clinics).  13.1.13 Implement systematic IEC campaigns for TB awareness raising and communities’ mobilization to access TB services (community dialogue, monthly day of coughing and annual tuberculosis day; media campaign using community radios)  13.1.14 Provide TB activist working kits to conduct TB community screening activities.  13.1.15 Sensibilization of PMT for screening and refer TB cases.  13.1.16 Expand diagnosis capacity:  13.1.17 Produce IEC materials on tuberculosis literacy and sample collection for health providers and community health workers.  13.1.18 Establish provincial capacity through Public Health Laboratories and Clinical Laboratories to provide dashboards through proficiency testing and Blind Re-observation as a mechanism to ensure 100% coverage of testing sites across the country.  13.1.19 Improve diagnosis of genital TB (which has been identified as an important cause of infertility in settings with high TB incidence)  13.1.20 Expand availability of Health Facilities with GeneXpert technology, from 174 to at least 280 by 2025, in order to increase access in 90% of U.S. to a viable distance of 10 and 50 km from the U.S. with GeneXpert; and of 60 TrueNat for molecular diagnosis of TB  13.1.21 Procure microscopy supplies (reagents and supplies), GeneXpert (MTB/XDR), including mucoestrators nr. 6 and 8 for sputum induction.  13.1.22 Hire maintenance and calibration services of equipment (GeneXpert, TrueNat) for the laboratories of the National Health System  13.1.23 Hire connectivity services for GeneXpert equipment (e.g., GxAlert)  13.1.24 Procure Refrigerators and Cold Boxes for storage and referencing of TB samples, including pediatric samples.  13.1.25 Hire technical assistance to develop training package for the clinicians and provide training sessions to Improve clinicians’ capacity to read and interpreting X-rays and provide support materials  13.1.26 Equip the US with digital RX with artificial intelligence reading software.  13.1.27 Purchase and installation of solar panels  13.1.28 Solar panels maintenance  13.1.29 Improve bacteriological confirmation:  13.1.30 Phased implementation of TB testing using stool samples from 4 to 11 provinces.  13.1.31 Provided training in sample collection, including pediatric sample collection procedures, feces samples (covering sample collection, storage, and transportation and processing). Training shall be aimed at both clinical and laboratory staff.  13.1.32 Strengthening sample transportation system from the community to the reference Health Facility  13.1.33 Conduct training of laboratory technicians in preventive maintenance and processing of sputum and fecal samples using GeneXpert MTB RIF/XDR;  13.1.34 Training in iLED Microscopy and Rapid TB Tests- using TB-LAM;  13.1.35 Training in molecular diagnosis of TB using TrueNat and sample collection and referencing.  13.1.36 Training for the preparation of tuberculosis proficiency panels for antibiotic sensitivity testing (DST) in tuberculosis reference laboratories.  13.1.37 Conduct technical support visits and monitoring of the implementation of the TB LAM, XDR test and use of other samples in the diagnosis of TB using GeneXpert, Microscopy and TrueNat;  13.1.38. Conduct clinical and laboratory coordination workshops by region  **Treatment and care**  **-Improve adherence and quality of care for TB treatment:**  13.2.1 Adjust the protocols, ensure availability of pediatric formulations and implement the DS-TB 4 months regimen for children under 15 years of age, as recommended by the WHO guidelines;  13.2.2 Provide scales and altimeters for correct weighing and nutritional classification, to support physicians in dosing and preparing medications, investigating adverse reactions, and monitoring treatment until treatment completion to improve the quality of follow-up.  13.2.3 Implement differentiated models (DOTC, family approach) in care for TB patients and contacts;  13.2.4 Provide psychosocial support for all DS-TB patients and transportation subsidy for children under 5 years;  13.2.5 Training Health provide to Strengthen capacity to screen mental disorders;  13.2.6 Implement consented follow-up, using cellular phone to monitor, follow-up and reintegrate patients in treatment;  13.2.7 Develop interventions (IEC, audio-visual, engagement with community leaders and influential figures) to eliminate TB gendered stigma at community level  13.2.8 Conduct integrated TB package training for clinicians (comprehensive package training).  13.2.9 Update the manual for the management of tuberculosis in children (0-9 years) and adolescents (10-19 years), as well as the clinical support job aids to align the interventions carried out with the latest version of the consolidated WHO guidelines on tuberculosis – Module 5: management of tuberculosis in children and adolescents Operational Manual)  13.2.10 Update general TB guideline including Quality Improvement guidelines.  13.2.11 Update, reproduce and distribute the Psychosocial Support Manual for the Management of Patients with Tuberculosis  13.2.12 Include private service providers (for-profit) in training on the comprehensive tuberculosis package including on Quality Improvement training.  13.2.13 Hire technical assistance to develop training package for clinicians (pediatric TB)  **Integration Non communicable and mental disease**  13.2.14 Implement bidirectional screening for TB/Diabetes Mellitus (implement TB screening in diabetic patients and implement the national diabetes screening algorithm in TB patients).  13.2.15 Conduct a study to determine the prevalence of TB in patients with diabetes. |
| Amount requested | Allocation: 27 726 231,31 USD  PAAR: 30 756 837,81 USD |
| Expected outcome | * Increase treatment coverage from 85% to 90% * Maintain a treatment success rate above 90% * Increase in bacteriological confirmation rate from 43% in 2022 to 50% in 2026 * 90% of presumptive patients who seek the health unit have TB * Improvement in the management of the logistics chain (avoiding waste, stock breaks) |

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| Module # 14 | Drug-resistant (DR)-TB diagnosis, treatment and care |
| Intervention | **14.1 DR-TB diagnosis/drug susceptibility testing (DST)** -  New,  Scale-up,  Continuation, or  Scale-down |
|  | **14.2 DR-TB treatment, care and support** -  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** Patients with MDR TB  **Geographies:** National  **Barriers:** Although ongoing interventions show some positive results including an increase in the DR-TB treatment success rate to 75% with the introduction of new all oral regimens and shortened treatments piloted under the SHOORT Study, challenges persist mainly in the search for lost cases. The country continues to miss opportunities to identify about 70% of the 4800 annual MDR TB patients nationally, but of those that are diagnosed 80-90% are bacteriologically confirmed and almost all were diagnosed with RR-TB by Xpert. Among negative treatment outcomes high mortality rates (12%) and loss to follow-up (8.4%) are the main outcomes of concern.  Other barriers to DR-TB diagnosis and successful treatment include: inadequate TB screening overall and inadequate number of clients identified with presumptive TB; low coverage of the molecular diagnostic network including DST (many presumptive TB clients only get access to smear microscopy testing and this will never be diagnosed with DR-TB); under performance and few TB reference laboratories; weak technical capacity in the management of patients with multidrug-resistant TB; inadequate psychosocial support and routine monthly monitoring throughout treatment; poor contact tracing and low uptake of TPT for DR-TB contacts. The occurrence of adverse reactions to treatment, the administration of long MDR TB treatment regimens, associated with limited access to basic needs, including adequate nutrition in quantity and quality, interferes with patients' adherence to treatment. Women tend to be underdiagnosed due to the challenges of TB diagnosis in PLHIV, pregnant and postpartum women. Early pilots in monthly subsidies for DR-TB patients for transport and food are promising but have limited geographic reach. The country is planning to adopt BPaLM (or Levo) and BpaL six-month regimens as recently recommended by the WHO. The country also has not prioritized rapid molecular testing for INH and FQ for all bacteriologically confirmed TB cases, but a recent workshop and the procurement of 10-color GeneXpert machines and Xpert XDR cartridges with plans to implement this at the provincial capitals will address this gap. Phenotypic DST and targeted sequencing for DST will be critical to identify resistance to other new DR-TB drugs including BDQ, DLM, LZD, CFZ, CS, Pretomanid and carbapenems.  Additional barriers in the diagnostic cascade include challenges in accurately forecasting and distributing lab commodities and DR-TB medications which are expensive and low volume, but stock outs are devastating. The current last mile distribution system is not well suited to the needs of the TB response (pharmaceuticals and lab commodities). The AMOSTRA sample transportation system has been primarily designed for VL samples but does transport TB samples. TB sample transport as part of AMOSTRA and general continues to have some barriers: AMOSTRA does fully and timely respond to TB sample collection requirements particularly for TB culture and phenotypic drug resistance testing that requires transport to regional reference labs. Sample quality remains an issue, due to poor patient instruction on sample collection, sample storage in remote locations, and sample transportation conditions. There is a deficient management of laboratory supplies at health facility level, incurring in stock out of supplies at this level. The laboratory information system does not capture relevant information from TB patients, such as treatment resistance in real time, monitoring of samples through the transportation network, and monitoring of Turn Around Times.  A study[[8]](#footnote-9) carried out in the country shows that about 60% of patients with TB suffer catastrophic costs related to transport and food insecurity, which constitutes a barrier both for diagnosis and for adherence to treatment. To respond to this challenge, the NTP started the implementation of social incentives to all patients with multi-resistant tuberculosis in Maputo, Inhambane and Zambezia provinces, through a community partner, to minimize the referred costs, while MoH is still articulating with the National Institute of Social Action to hand over the implementation of this intervention.  The following activities will address the gaps in DR-TB diagnosis and treatment.  **Improve the approach to screening and diagnosis of drug-resistant tuberculosis.**  14.1.1 Train technicians and laboratory logistics managers to complete and submit LMIS reports using the Web/Link system  14.1.2 Procure supplies for stool testing, drug susceptibility testing (DST), TB LAM, Truenat and genomic sequencing (whole genome sequencing and next-generation sequencing)  **Increase and expand availability and use of molecular diagnostic technology.**  14.1.3 Leverage from NFM3 provided equipment and expand the laboratory capacity by creating demand for additional numbers and proper use of GeneXpert equipment (see national radiology strategy)  14.1.4 Create a surveillance system for resistant tuberculosis that allows the rapid identification of cases and associates them with care and treatment (strengthen current surveillance systems GxAlert, DISA, for patient identification and timely start of treatment). (See INS genomic expansion plan 2022-2024)  14.1.5 Ensure that diagnostic and treatment algorithms are sufficiently sensitive and tailored to women’s needs including in pregnant women to strengthen DS and DR-TB diagnosis and treatment.  **Quality of care and adherence**  14.2.1 Adoption of short regimens for the treatment of multidrug-resistant tuberculosis (BPal, BPalm e Short) as per WHO new guidelines and national operation research  14.2.2 Procurement of pediatric formulations for treatment of resistant TB.  14.2.3 Improve adherence to TB treatment by expanding the availability of pillbox to ensure better control of the patient's intake of medicines (frequency and dosage), storage and adherence to treatment.  14.2.4 Offer community DOT to all MDR TB patients through activists and APEs.  14.2.5 National training on psychosocial support package  14.2.6 Provincial trainings psychosocial support package  14.2.7 Provide transportation subsidy for MDR-TB patients.  14.2.7 Procure nutritional supplements for MDR-TB patients  14.2.8 Screening and follow-up of mental illnesses in patients with TB to improve adherence.  14.2.9 Conduct operational research on the implementation of new regimens for the treatment of MDR TB;  14.2.10 Create a surveillance system for adverse reactions to treatment.  14.2.11 Review the approach and monitor side effects and drug interactions (aDSM (active drug safety monitoring)  14.2.12 Update, print and distribute the manual for the clinical and programmatic management of DR-TB to align it with the latest WHO guidelines on the management of drug-resistant TB.  14.2.13 Hire technical assistance to assess the frequency of mental disorders in patients with tuberculosis.  14.2.14 TB Sequels evaluation  14.2.15 Initial train clinicians and lay health workers to deliver a comprehensive package of TB services.  14.2.16 Refresher training of clinicians in the treatment of tuberculosis/tuberculosis DR-TB, including side effects and comorbidities, in line with the new WHO guidelines.  **Improve the Quality of Care**  14.2.17 Expand quality improvement in 50% (300) of health facilities with a TB management unit focused on TB and DR TB care for children, adolescents and adults (implement MQ evaluation package in 9 provinces)  14.2.18 Training the health workers in Implement Quality Improvement Package (conduct mentoring in all health facilities with Tuberculosis management units, adopting an annual cascade training of health providers, from central to provincial level)  14.2.19 Conduct technical support visits (supervision visits) within the scope of continuous improvement, prioritizing sites with low performance, low participant rate and new sites  14.2.20 Quality Improvement annual meeting |
| Amount requested | Allocation: 6 759 799,31 USD  PAAR: 7 110 931,04 USD |
| Expected outcome | * Early diagnosis of MDR and XDR TB cases to break the chain of transmission of resistant TB * 50% of all patients with rr/MR tuberculosis diagnosed. * Less than 5% loss of follow-up in patients with DR-TB * Increase treatment success rate from 75% to 90% * Well-established provincial EQA programs in all 11 provinces of Mozambique |

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| Module # 15 | Prevention of TB/DR-TB |
| Interventions | **15.1 Preventive treatment** -  New,  Scale-up,  Continuation, or  Scale-down |
| **15.2 Infection prevention and control (IPC) -**  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** General and high-risk population, health/TB unit personnel, high-risk settings, TB/HIV-TB patients, TB contacts  **Location:** National  **Barriers:** Mozambique recently updated their national TPT guidelines, including the use of new shorter regimens such as 3HP which is now the first line TPT regimen in the four Southern Provinces. As part of this process eligibility for household contacts increased from <5 to <15 years old, and as a result the country has seen a major increase in the number of children starting TPT. Community TB partners are raising TPT awareness and working to refer eligible household contacts for TPT. The country is introducing Levofloxacin for DR-TB Preventive Therapy. TPT coverage (the percentage of PLHIV that have completed a TPT regimen or are actively on TPT) has increased from ~50% two years ago to 90% at AJUDA sites with EPTS. TPT completion rates for PLHIV have also increased to 88% for the most recent cohort, with many provinces over 90%. Almost all new HIV positive clients at AJUDA sites are screened for TB, and 94% start TPT.  Despite these advances, many barriers to TPT uptake and completion persist. The cost of 3HP and challenges with procurement, short shelf life impede national implementation. The country is considering 3HR as a short and less expensive alternative and a formulation that already exists in the country. Challenges in contact tracing persist, in addition to poor coordination between the TB sector and consultations of children at risk (CCR) to link traced contacts to TPT. Mozambique is currently evaluating if children that are household contacts of a TB index case should be started on TPT and followed in CCR, or in the NTP. Six months of INH is a long, unfriendly regimen and is still currently the standard of care in 7 provinces. The limited availability of TB CHWs in all districts contributes to the poor follow-up of contacts after the start of the TPT, and inadequate documentation about TPT completion. TPT instruments are outdated and do not easily accommodate all the new TPT regimens and recommendations. Parents of healthy children eligible for TPT often are reluctant to start a healthy child on TPT – data from four provinces in central Mozambique suggest 30% of eligible children do not start TPT. Inadequate knowledge about TPT in the community and among household contacts, and the fact families are asked to take their children to a health center, which is frequently a long distance from their home remain major barriers to care. There is also inadequate TB screening, use of TPT in other high-risk and immunocompromised populations such as those with diabetes, smokers, miners, and health care workers. Remain barriers around IPC and specific knowledge about TB transmission amongst TB patients and their families about cough hygiene, collection and disposal of sputum. At a facility level PPE stock management remains a challenge. The health system T infrastructure in most cases are inadequate with facilities with inadequate ventilation and limited availability of communication material on infection control. During provider training sessions not much emphasis is given to infection control measures or policies. While sites are supposed to have active IPC plans and focal points, in practice these are often outdated and under-utilized. |
| List of activities | **Screening/testing for TB infection**  15.1.1. Train health providers and activists and community (hired in the TBTF module) for screening of DS and DR TB contacts and enroll the eligible in TPT, using short regimens and Levofloxacin, respectively.  15.1.2 Implement TPT communication package (distribution of IEC material, radio spots and awareness raising at Health Facilities entrance doors, community dialogues, patient home visits and monthly cough days) to increase TPT literacy among parents and caregivers to improve TPT acceptability and inclusion  15.1.3 Strengthening sample transportation system from the community to the reference Health Facility  15.1.4 Implement awareness-raising campaigns aimed at affected communities about TB and the importance of preventive TB treatment for eligible contacts addressing gender challenges that reinforce stigma and discrimination.  **Preventive treatment**  15.1.5 Conduct a study on challenges and acceptability of TPT in children from the perspective of caregivers and health professionals (hire consultant);  15.1.6 Expand the implementation of short TPT regimes to 7 provinces using 3HR and maintain 3HP in the remaining 4 provinces;);  15.1.7 Implement a differentiated mixed model, in the health unit and in the community (for children with difficulties access Health Facilities). In this intervention, a multidisciplinary team composed of a clinician and an activist travel to the community on monthly coughing day;  15.1.8 Conduct outreach interventions in search and follow-up of missing and lost TB contacts through telephone calls to ensure the completeness of the TPT.  15.1.9 Align contact tracing and case finding to gender differences paying attention to where best to find men, women, and transgender people  15.2.1 Conduct training/retraining in TB infection control in all health facilities  15.2.1 Develop/update health protocol for movement of TB patients, waiting area, sample collection and communication.  15.2.3 Provision of protective equipment for laboratories and health facilities.  15.2.4 Using mass communication to improve knowledge and practices for TB infection control.  15.2.5 Develop, display, distribute and educate infection control measures to be practiced by patients at home and community level.  15.2.6 Buy fans to direct air in consultation rooms |
| Amount requested | Allocation: 3 410 355,83 USD  PAAR: 749 888,80 USD |
| Expected outcome | * 90% of TPT coverage * 90% of TPT competition * Evidence from the perspective of caregivers and health professionals on the challenges and acceptability of TPT to inform the decision. * 90% of TB HF practicing TB infection control measures. * 90% of TB patients aware and practicing infection control at an individual and family level |

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| Module # 16 | TB/HIV |
| Interventions | **16.1 TB/HIV - Screening, testing and diagnosis** -  New,  Scale-up,  Continuation, or  Scale-down |
| **16.2 TB/HIV Collaborative interventions** -  New,  Scale-up,  Continuation, or  Scale-down |
| **16.3 TB/HIV Treatment and Care** -  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** PLHIV, TB patients, Key and vulnerable populations  **Places:** National, AJUDA and non AJUDA sites  **Barriers:** Nationally almost 100% of notified TB clients have a known HIV status (a very small portion of clients chose to refuse HIV testing) and 96% of TB/HIV co-infected clients are on ART. Despite this strong performance, many barriers exist in optimizing TB screening testing and diagnosis for PLHIV (Note – TPT for PLHIV was discussed in the previous module TB Prevention). Routine TB screening in PLHIV actively on ART is only documented for 81% over the last six months at AJUDA sites. This is complicated by the fact that almost 20% of clients active in ART have not had a facility based clinical consultation in the last six months – this is currently the only way TB screening is captured and digitized for PLHIV. The quality of TB screening for PLHIV is also low, dXR and CAD are not currently available for the vast majority of PLHIV though this is slowly changing. The TB screen positivity rate is low, about 2-3% for clients stable on ART and 8-9% for those new on ART whereas targets should be closer to 5% and 12-15% respectively, Providers do not always provide a full symptom screen and some have weak clinical suspicion in general for TB at the level of the Health Units despite the fact that TB remains the leading cause of death in PLHIV in Mozambique. There are growing differentiated delivery models for ARV dispensing including in pharmacies, communities, GAC groups, mobile brigades, but high-quality TB screening is not yet comprehensively offered and documented at every ARV dispensing encounter. |
| List of activities | 16.1.1 Expand coverage of the one stop model through.  16.1.2 Training of healthcare professionals in TB/HIV collaborative package  16.1.3 Strengthening integration of TB screening in the service package of all community health agents, enabling them to identify signs and symptoms of tuberculosis.  16.1.4 Integrate TB screening and diagnosis in HIV services, Sexual Reproductive Health and maternal health to increase the number of women reached.  16.1.5 Develop sensitization to the double stigma and discrimination for PLHIV that also have TB, and consider other kinds of vulnerability such as being KP or transgender  **Improving the quality of TB/HIV services**  16.2.1 Train providers of TB activities in the HF in HIV services management.  16.2.2 Conduct clinical mentoring to improve the quality of HIV services for TB patients along the HIV cascade of care.  16.2.3 Deploy medical officers to provide services to TB patients, including TB/HIV coinfected patients.  16.2.4 Reproduce and allocate recording tools: TPT Daily Record Book and Monthly TPT Summary.  16.2.5 Expand properly equipped TB/HIV One-Stop Units. Massify community screening of TB cases for PLHIV.  16.2.6 Purchase and distribute 3HP for TPT.  16.2.7 Develop formative research on the context of vulnerability regarding gender and KP for PLHIV and TB to inform programing  16.3.1 Carry out 2 annual visit to evaluation (intermediate and final) in at least 4 health facility that implement Quality Improvement package per year. 2 visits to the central level and 2 from the province to HF implementing the Quality Improvement |
| Amount requested | Allocation: 12 625 733,13 USD  PAAR: 246 404,07 USD |
| Expected outcome | * Reducing the burden of TB in PLHIV * 99% of reported patients have been tested for HIV. * At least 96% of TB/HIV co-infected patients on antiretroviral treatment * Improvement of the quality of care provided in the collaborative activities of HIV/TB and identified layers of vulnerability for both diseases. |

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| Module # 17 | Key and vulnerable populations TB screening, diagnosis, and treatment care cascade |
| Interventions | **17.1 Miners (including artisanal miners) and former miners and their communities -**  New,  Scale-up,  Continuation, or  Scale-down |
| **17.2 Prison population**:  New,  Scale-up,  Continuation, or  Scale-down |
| **17.3 Enhanced TB Screening Diagnosis and Treatment for Displaced Populations and Resettlement Centres** -  New,  Scale-up,  Continuation, or  Scale-down |
| **17.4 KVP – Others: Health Workers**:  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Miners**  **Population:** High-risk, marginalized, vulnerable mining population  **Location:** National  **Barriers**: Mine workers have limited access to health services due to migration, gender norms that discourage men from seeking health care, limited availability of services aimed at reaching these populations, and precarious work and hiring regimes that prevent miners from moving in search of healthcare for fear of losing jobs. The coverage of Community assistance to reach these populations is limited. Some Mozambican miners are artisanal in provinces such as Tete, Manica, Cabo Delgado and other Mozambican miners, particularly those from the South, work in South African mines. A recent regional World Bank TB in the mining sector project is closing down, and some of the initiatives need to be sustained. The World Bank project and a regional Global Fund project did support procurement of some dXR and CAD and GeneXpert equipment and some activities to improve TB screening, diagnosis and treatment in miners, but dXR and CAD is still not routinely used to screen Mozambican miners. These projects also started a pilot cross-border referral system mostly for miners going to South Africa crossing at Ressano Garcia, but the geographic scope of this activity was limited. Integrated screening for hypertension, diabetes, hearing loss, other occupational lung diseases remain limited. |
| **Prisoners**  **Population:** Inmates, their families and prison staff  **Location:** National  **Achievement:** TB screening for new prisoners on their arrival. Routine screening to incarcerated population. Increase of TB services coverage within prisons  **Barriers:** Inmates populations have limited access to TB services in prisons; Insufficient mastery of TB signs and symptoms by prison guards and health focal points (Further barriers mentioned in the intervention 6.1).   * Low access to TB services in prisons. * Insufficient mastery of TB signs and symptoms by prison guards and health focal points. * Low coverage of a laboratory network of prisons. * Poor health coverage. * Overcrowding and poor ventilation of penitentiary facilities that does not allow separation of prisoners with tuberculosis increasing infection transmission risks. * Limited used TPT for contacts and low access to dXR and CAD for TB screening in prisons * Inadequate screening of household contacts for newly arrived prisoners diagnosed with TB |
| **Displaced population**  **Population:** Displaced population  **Location:** National, but particularly in the Central and Northern Provinces  **Barriers:** Mozambique is a country prone to disasters. The country suffers, on average, 1.17 disasters1 of great magnitude per year and is seen as being one of the three regions most exposed to natural disasters in Africa. In the last 30 years, at least 14% of the population has been affected by a drought, a flood, or a tropical storm and more than half of the events that result in disasters (53%) have occurred in the last two decades[[9]](#footnote-10). These disasters result in: Destruction of health infrastructures with loss of files, medicines, and others; Internal displacement of the population, including TB patients who lose not only their medication but also their identification cards; Crowding of people in transitory accommodation centers, increasing the risk of transmission and making it difficult to identify diagnosed TB patients lost due to natural disasters. In addition to natural disaster vulnerability, Mozambique is recurrently affected by armed conflict. Conflicts in Cabo Delgado Province have caused the displacement of more than [800,000 people.](https://www.unhcr.org/news/briefing/2021/6/60c312e94/insecurity-northern-mozambique-continues-forcibly-displace-thousands.html)[[10]](#footnote-11), and there is a challenge to reach these populations with TB services. Mozambique also hosts more than 28,500 refugees and asylum seekers, of which around 9,500 reside in Maratane settlement while the remaining 19,000 reside in urban areas of Mozambique[[11]](#footnote-12). Refugees and migrants are a population that still has great difficulty in accessing health services and social protection systems, in addition to often presenting other health conditions such as malnutrition. For TB patient contacts, thereisnon-regular screening at community level. Long distances to reach Health Units, frequent migrations and movement of these individuals combined with lack of transportation support are additional barriers to accessing TB services. |
| **Health workers**  **Population:** Population working in institutional and non-institutional/community-based health facilities  **Location:** National  **Barriers:** For Health Workers there isnon-regular TB screening and underutilization of screening opportunities such as TB screening days. Stigma and discrimination related to Tuberculosis remains an inhibitive factor limiting access to TB services across all high risk and vulnerable populations. There is little access to dXR and CAD to increase the quality of TB screening for this high-risk population, Limited sex disaggregated data, analysis and of gender relevant information crossing |
| List of activities | **Miners**  **Case detection**  17.1.1 Map medium and small-scale mine/handicraft companies  17.1.2 Conduct community and systematic tuberculosis screening in miners, former miners, and their communities  17.1.3 Conduct mobile tuberculosis screening brigades in remote communities of artisanal miners using mobile clinics.  **Diagnosis**  17.1.5 Purchase and install 5 CAD X-ray equipment for medical examination centers, as per the allocation plan.  17.1.6 Train healthcare professionals to read and interpret chest X-rays according to ILO standards for the diagnosis of pneumoconiosis.  **Care and Treatment**  17.1.7 Expand the use of Cross-Border Referral System from Maputo to other 3 provinces (Inhambane, Manica, and Tete)  17.1.8 Conduct joint supervision to raise awareness and provide Occupation Health Services deliver to miners and prisoners.  **Prevention**  17.1.9 Develop and disseminate IEC material with key messages.  **Inmates**  **Case detection**  17.2.1 Conduct systematic tuberculosis screenings in at least 90% of inmates.  17.2.2 Train peer educators such as cough officer/activists to perform tuberculosis screening and DOT in correctional facilities.  **Diagnosis**  17.2.3 Integrate PEs into the sample collection and transport system.  **Care and Treatment**  17.2.4 Purchase airtime for follow-up calls to link patients with TB services after release from prison  17.2.5 Ensure dignified treatment and privacy for inmates in TB consultations both inside the prison and in health centers outside prisons  **Prevention**  17.2.6. Design and reproduce specific IEC material for prisoners.  **Displaced Populations**  **Case detection**  17.3.1. Perform systematic TB screening in populations in resettlement centers and in refugees’ camps/settlements.  **Diagnosis**  17.3.2. Ensure availability of Sampling and transport system to outreach displaced population  **Care and Treatment**  17.3.4. Train resettlement center members to implement the DOT  **Prevention**  17.3.5. Develop and disseminate IEC material on the prevention and control of tuberculosis infections  **Health Workers**  **Case detection and diagnosis**  17.5.1 Training of health professionals in relation to Occupational Safety and Health Standards, including infection prevention and control (Adjust health workers and community health workers)  17.5.2 Systematic TB screening of Health works including the Community activists with use of dXR and CAD when appropriate.  **Prevention**  17.5.6 Establish a Health Professionals Week to raise awareness about TB infection and create demand for TB screening |
| Amount requested | Allocation: 4 424 105,19 USD |
| Expected outcome | * 90% of key and vulnerable population (inmates, miners, prisoners). * Patients undergoing TB treatment identified at the Transitory Accommodation Centers and reintegrated into care and treatment * Contingency plans/guideline approved * Cross-border Routing System extended to Inhambane, Manica and Tete Province * Health workers from 180 target health facilities screened symptomatically and through x-ray every year |

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| Module # 18 | Removing human rights and gender related barriers to TB services |
| Interventions | **18.1 Eliminating TB-related stigma and discrimination** -  New,  Scale-up,  Continuation, or  Scale-down |
| **18.2 Ensuring people-centered and rights-based TB services at health facilities**-  New,  Scale-up,  Continuation, or  Scale-down |
| **18.3 Ensuring people-centered and rights-based law enforcement practices -**  New,  Scale-up,  Continuation, or  Scale-down |
| **18.4 Legal literacy (“Know-Your Rights”)**-  New,  Scale-up,  Continuation, or  Scale-down |
| **18.5 Increasing access to justice** -  New,  Scale-up,  Continuation, or  Scale-down |
| **18.6 Monitoring and reforming policies, regulations and laws** -  New,  Scale-up,  Continuation, or  Scale-down |
| **18.7 Addressing needs of people in prisons and other closed settings**-  New,  Scale-up,  Continuation, or  Scale-down |
| **18.8 Reducing TB-related gender discrimination, harmful gender norms and violence**:  New,  Scale-up,  Continuation, or  Scale-down |
| **18.9 Community mobilization and advocacy, including support to TB survivor-led groups**:  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** Hard to reach, vulnerable/marginalized and general population  **Places:** National  **Barriers:** Persistent stigma and discrimination in all contexts, specially within the health and prisons systems, constitute a barrier to access to health services. Lack of knowledge and information on specific TB human rights issues. Fragmentation of human rights programs and inadequate coordination mechanisms jeopardizes the effectiveness and efficiency of human rights interventions in the context of TB and HIV/TB. Lack of specialized human rights human resources and inadequate staffing of the human rights program hinders coordination and quality of interventions. Discrimination in law enforcement and poor access to justice services, particularly the poor. Low coverage and quality of legal and paralegals systems. TB-related gender discrimination; harmful gender norms and violence against women, girls. Poor knowledge of the laws at both ends, namely, rights holders and duty bearers. TB-related laws and policies are not aligned with some core content of human rights. Weak community mobilization for the defense of human rights; Insufficient knowledge of legislators and policy makers in the area of human rights; lack of legal tools for adoption and implementation of measures; poor coverage of legal services; poor access to health care equitably in an emergency and humanitarian context. Insufficient coordination mechanisms amongst and between institutional and community-based stakeholders. Poor monitoring and evaluation system; poor quality of Human Rights interventions continues to undermine the effectiveness and efficiency of investments. subjugations, gendered understandings of TB that stigmatize women as the source of the disease due to sexual misconduct. |
| List of activities | 18.1.1 Hold a National Workshop to disseminate the results of the Stigma and Discrimination Index in people affected by tuberculosis and the 2020 Communities, Rights and Gender (CRG)TB Assessments in Mozambique  18.1.2 Train community health workers, paralegals, and traditional, religious and community educators on TB and human rights, including how to combat TB-related stigma and discrimination  18.2.1 Strengthen curriculum on TB-related human rights and ethics, integrate TB-related human rights and ethics information in pre- and in-service trainings for all TB programs and roll out training on human rights and ethics in health care facilities in districts hardest hit by TB.  18.3.1 Expand efforts to sensitize police and lawmakers on TB and human rights related barriers to access to services  18.4.1 Develop and disseminate patients’ rights materials specifically related to TB on the types of discrimination faced by individuals living with TB, including in workplaces with high TB risk.  18.5.1 Continue to expand capacity and scale of trained community paralegals to facilitate access to TB and HIV/TB services and identify cases for referral to legal assistance services.  18.6.1. Conduct a legal environment assessment specific for TB with special emphasis on a) situation analysis, b) progress, c) challenges and d) recommendations  18.6.2 Elaborate an advocacy plan for law and policy reform  18.6.3 Introduce in the NTP indicators to measure intended gender-related changes  18.6.4 Include, in TB advocacy, communication and social mobilization material, educative information about the gendered dynamics of TB risk and infection, debunking of popular myths related to gender and TB the right to quality care of all people, including gender minorities and key populations  18.6.5 Develop a study to further explore specific gendered TB themes not covered by the CRG to inform programming and implementation  18.7.1 Expand efforts to reduce TB-related stigma and discrimination to all prisons and support the NTP and its partners to ensure legal resources and knowledge for the Prison Health Technical Working Group  18.8.1 Provide on-the-job gender training and include gender topics in the curricula of health training institutions to sensitize health providers about TB and gender, stigma and discrimination  18.8.2 Introduce in the NTP indicators to measure intended gender-related changes  18.8.3 Include in TB advocacy, communication and social mobilization material educative information about the gendered dynamics of TB risk and infection, debunking of all people, including gender minorities and key populations  18.8.4 Develop a study to further explore specific gendered TB themes not covered by the CRG to inform programming and implementation  18.9.1 Include patient groups and organizations in the design, evaluation and modification of TB services to improve their patient-centeredness and quality |
| Amount requested | Allocation: 116.045,42 USD |
| Expected outcome | Paralegals trained and engaged in mitigating barriers to access to TB services with a focus on preventive and curative treatment  Gender TB stigma tackled and gender indicators for TB enlarged |

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| Module # 19 | RSSH: Monitoring and evaluation systems |
| Interventions | **19.1 Data quality** -  New,  Scale-up,  Continuation, or  Scale-down |
| **19.2 – Routine reporting** -  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** TB program (national, provincial, district and facility) staff, including community employees. PLHIV on ART, National Health Services Workforce  **Location:** National  **Barriers:**  TB Program: The NTP Monitoring and Evaluation System has been missing essential structure (including dashboards and data utilization as part of a continuous quality improvement effort) to allow better planning and contextual monitoring and evaluation activities. With growing demand, the monitoring and evaluation team has been focusing more on the data collection and quality. Missing standardized structure which would guide stakeholders on how to monitor and evaluate the implementation of the program and determine how well the program is being implemented against intended results, and whether its objectives and results are being met. Also, outlining the program’s proposed activities, with key performance indicators (KPIs), timelines, and other indicators that measure performance management would benefit from standardization. To better structure the system, the program plans to develop a structured M&E Plan based on landscape analysis which will provide clear guidance on the principal pillars of the system.  The program also has been struggling with data quality at all levels. The fragment data set and unavailability of clear data management flow has been contributing to the data issues the program faces. At this level, building a surveillance system based on the electronic patient data register has been defined as the main strategy to build on and improve data quality and availability. In summary, the following are the main barriers:   * Scaling up the electronic patient tracking system (EPTS) level data due to various challenges (platform not user friendly, unavailability of sufficient data collection devices, availability of human resources) * Low data quality that affects decision making (validation rules not applied, deficient data feedback) * Unavailability of structured Monitoring and evaluation Plan that would clearly guide the implementation of M&E Activities * Data availability due to (instability of the platform, fragmented data sources which does not communicate, not harmonized data collection) * Different data sources including from SISMA, SISTB, GxAlert/ASPECT, DISA, CMAM, Partners * Limited ability to analyze reported data using routine dashboards and interpreting the data for decision-making. * Lack of a comprehensive cQI strategy and discussion of TB data routinely at the facility level (which does happen for HIV on weekly or monthly basis with “Comite TARV”.   HIV Program:Though major strides have been made in recent years to improve monitoring and evaluation systems in the National HIV Program, major challenges remain, especially in the areas of Data Quality, Completeness, and Timeliness of Reporting.  Data Quality is a challenge due to the paper reporting systems that are the official sources for national data which result in major limitations in terms of disaggregation and ease of reporting.  The completeness of reporting, though much improved in the past year in the main HIV Monthly Report, still has major challenges not only due to human resource capacity but also to natural disasters and resulting instability.  Timeliness of Reporting also remains a challenge, both at the health facility level as well as at the DHIS2 management level. There is no established schedule for data review in the DHIS2 system, and due to issues with the hosting of the platform, it is virtually inaccessible during working hours when reporting is performed due to the high demand.  Finally, a cross-cutting issue is the sheer number of data tools that are now present in the HIV program.  Since the last application to Global Fund, 5 new instrument sets have been implemented, including STIs, PrEP, Self-Testing, Youth Mentor, and Advanced HIV Disease.  Coupled with the existing instruments, the volume of data registered by hand has increased substantially.  Despite these challenges, in the past year the HIV Program has participated in the following activities to support the improvement of these areas (though challenges persist):   * In collaboration with the DPS/DIS, the HIV Program has participated in an evaluation of the current electronic patient tracking system in order to better understand the challenges and advantages to using it as an official data source. * Challenge: Complexity of the review is delaying recommendations, no projected end date is currently established * Expansion of the monthly review indicators to include newly implemented instruments. * Challenge: Use of Excel for daily data analysis limits the integration of various areas and increases the time needed to complete simple analyses * Initial review of the Ficha Mestra (“MasterCard”) to update and improve the data capture for HIV+ beneficiaries in care. * Challenge: Lengthy discussions for the inclusion of new indicators and a pilot mean any national update will happen in 2024 at the earliest. * Previously, PEPFAR and MISAU conducted separate data quality assessment visits with separate teams. Such visits are now integrated. * Challenge: Though a good step in the right direction, the alignment needs to continue with Global Fund and other HIV program stakeholders and actors to ensure that challenges are commonly understood, consensus on solutions is reached and acted upon. * Continuation of the monthly calls with the provincial HIV offices to review data quality and discuss progress towards goals.   Challenge: Useful for general reviews, however many of the data quality issues identified during the call are present for various months in a row.  Need to develop/implement an approach that allows for more individual follow-up. |
| List of activities | **TB program**  19.1.1 Hire consultant to develop TB structured M&E plan with clear change path as per overarching theory of change and logical mode, including main Monitoring and Evaluation activities, indicator definitions and team responsibilities, data management plan.  19.1.2 Conduct landscape analysis to understand the components of the current M&E System  19.1.3 Align the data collection tools to inform the electronic registers.  19.1.4 Provide capacity building the implementation of the M&E System  19.1.5 Implementation of revised TB data collection tools (Refresher training; Printing of the new tools)  19.1.6 Scale-up the Implementation of electronic patient registers (Review, align and restructure the platform as per the new data collection tool; Procurement of electronic devices for data entry; Conduct facility level training of platform users; Conduct user training to community health worker on the use of patient register).  19.1.7 Improve data availability and visualization (Integration of fragmented data sources to a single platform; Create visual products to be shared with program team for decision making; Conduct trainings to the platform users up to the district level)  19.1.8 Cover provincial gaps in human resources to provide a more reliable provincial support in M&E Activities (Hire provincial M&E Officers; Procure equipment to improve their work).  19.1.9 Provide in job technical support (Conduct national level field supervision; Conduct provincial and district level field supervisions; Conduct Data Quality Assurance with programmatic improvement focus; Hold national and provincial monthly and quarterly data discussion meetings)  19.1.10 Include data analysis that responds gendered TB specificities  19.1.11 For cases of HIV co-infection, enlarge the categories to include transgender  **HIV Program**  19.1.12. Implement Prevention outcome monitoring tool (Prevention Outcome Monitoring Tool from Global Fund) **Alignment and Data Quality Improvement Efforts**  19.1.13 Align Data Quality Assessments related to HIV between the different donors and areas in MISAU  19.1.14 Data validation field visits (National and Provincial level) (FDC)  19.1.15 Conduct data quality assessment visits from the central to the provincial level (FDC)  **Need for updated electronic systems for an integrated national use**  19.1.16 Provide technical expertise for the development of potential electronic systems for the development/integration of a system for the national health system that would include all applicable health areas in the Health Facility  **HIV Program Use of paper records for reporting impacts efficiency and data quality**  19.2.11 Reproduction of Instruments for Report and Register (STI, HIV self-testing, HIV testing and counseling, patient records, adolescent and youth mentors/male champions/mentor mothers, advanced HIV disease, hepatitis B, psychosocial support, PrEP). We are budgeting for a total of 11,000 instruments reported each year, which will be divided as needed according to the different program areas  19.2.12 Advocate for the appropriation of electronic systems for follow-up of beneficiaries – no cost activity  19.2.13 Expansion of beneficiary level electronic systems for non-PEPFAR supported HF. Currently PEPFAR supports 651 HF with SESP, which covers approximately 85% of the people living with HIV on ART. The program is proposing to expand this coverage to an additional 20 of the largest volume HF with conditions for EPTS (electricity, space, accessibility). The expansion will be phased, preparation will happen in the first year, with 10 HF in the second year of the grant cycle adopting SESP, and the final year with the final 10 HF to be added. These HF will be targeted in Maputo Province (Fase 1 - 5 US), Gaza Fase 1 - 5 US), and Nampula (Fase 2 – 5 US) and Sofala (Fase 2 – 5 US).  19.2.14 Defining a standardized system for assignment of user identification codes for mobile / hard to reach Key Populations and AGYW (FDC)   * Hire a consultant to develop the system * Training of Trainers involving Senior M&E and Programmatic officers of main KP organizations * Training of M&E, Programmatic staff and Field Supervisors of KP implementing organizations * Printing of training material and daily use guidelines on unique identifying codification * Training of Activists, Counsellor, Peer Educators and their supervisors on the standardized package of service * Weekly planning meetings (Activists and Supervisor) * Monthly reporting update meetings (Activists and Supervisor) * Monthly reporting update meetings (SR and Supervisors) * Acquisition of IT equipment for Peer Educators, Counselors, Paralegals and supervisors to collect and introduce data into DHIS2   19.2.15 Printing of M&E data collection tools, Reference & counter reference tools (FDC)  **Continual Function and Use of National Reporting Systems**  19.2.21 Participation of technicians in DHIS2 International academies (FDC)  19.2.22 Carry out supervision from the central level to the provincial level (FDC)  **Improving human resource training access**  19.2.31 Incorporation of recent training packages on the Telesaude platform, including voice recording as part of the packages to ensure that the quality of training is faithful to the original package. This activity will have a consultant that will help coordinate a meeting for the finalization and recording of all the different activity packages.  **Information Reporting for Community Interventions and Private Sector**  19.2.41 Develop standardized instruments for data collection of community interventions. This will include a pilot, a consultant to support the pilot and finalization of the pilot, and a final dissemination meeting. The printing of these instruments will be covered under the activity 19.2.12  19.2.42 Technical semester meetings for progress updates (FDC) |
| Amount requested | Allocation: 3 875 908,36 USD  PAAR: 1 254 775,25 USD |
| Expected outcome | * Established means to provide critical information to the decision makers. * Provided timely update on the program implementation Improved quality and timely availability of routine data for effective decision-making by all stakeholders. * Improved analytical capacity of M&A managers and decision makers. * Improved data quality * Timely data availability * Structured Monitoring and Evaluation System * Evidence based decision making. * Improvement of data quality and completeness and timeliness of reporting, * Improved reporting systems for community interventions and private sector. |

|  |  |
| --- | --- |
| Module # 20 | Program management |
| Interventions | **20.1 Grant management -**  New,  Scale-up,  Continuation, or  Scale-down |
| **20.2 Coordination and management of national disease control programs -**  New,  Scale-up,  Continuation, or  Scale-down |
| Population, geographies and/or barriers addressed | **Population:** general population, PLHIV, TB patients, key and vulnerable population  **Location:** National  **Barriers:** lack of consistency, continuity and interoperability between demand creation and anti-stigma campaigns. In the continuum of care for HIV/AIDS, adherence and retention represent very important challenges and the last 95 of the 95/95/95 targets has not yet been achieved. Despite numerous efforts undertaken in the country for HIV control, there are still gaps in the cascade, particularly in diagnosis, initiation, and retention to ART among PLHIV. This may indicate that many of the strategies implemented thus far, focusing on the past 5 years, will need to be evaluated, potentially adapted and/or consolidated to reach the 95-95-95 targets, and eliminate HIV by 2030.  Despite the gains achieved through the implementation of electronic systems in supervision visits, the HIV Program, does not have specialized technical personnel, capable of ensuring not only the continuous functioning of the currently existing electronic systems but also expanding the use of technology to other areas that are deemed necessary, such as Clinical Mentoring and other interventions associated with improving the quality of care, and to enhance technical collaboration with implementation partners regarding the understanding and maximization of the use of existing patient tracking electronic systems in health facilities that receive external support (AJUDA Sites). Additionally, the program is not able to perform faster updates and resolution of technical problems, particularly when the team is using devices during programmatic activities in the field (supervision visits). |
| List of activities | 20.1.1 Operational costs  **Technical support for the STI/HIV Program**  20.2.1 Technical Assistance: one Health communication technical advisor; one C&T technical advisor; one senior Quality Improvement Manager technical advisor; one computer Officer Programmer advisor  20.2.2 Functioning of the Technical Support Unit for Key Populations  20.2.3 Consultants' fees  20.2.4 Office space including electricity, water and internet, fuel, office consumables  20.2.5 Provide framework to support to organizations on micro-planning with key population sub-groups  20.2.6 Map the organizations working with KP at national level  20.2.7 Design, disseminate and monitor implementation of service packages for key population of adolescents and youth in Mozambique  20.2.8 Provide a framework to conduct quarterly strategic review sessions of data on the implementation of key population outreach activities in the Country  20.2.9 Document the implementation of Programs with Key Populations in Mozambique  20.2.10 Provide a framework to support the and implementation of harm reduction program  20.2.11 Provide a framework to advocate for stigma and discrimination reduction in Key Populations  20.2.12 Standardize data collection instruments for key populations  20.2.13 Provide a framework to support advocacy strategy for key populations in Mozambique  20.2.14 Establish regional forums in the country to discuss data on outreach to key populations  20.2.15 Organize international forums to exchange TSU experience  **Prevention Technical Support Unity**  20.2.16 Hiring specialist to prepare the establishment of the prevention technical support unity 1. Specialist for prevention area 2. PMEL specialist 3. SBC specialist equipment for the Staff of Prevention Technical Support Unit  20.2.17 Supervision at national level to map and collect HIV prevention data (baseline/studies and implementation)  20.2.18 Workshop for the evaluation of the prevention package.  **Condom Management**  20.2.19 Improve the procedures for quantification and acquisition of condoms (annual quantification meeting)  20.2.20 Hire Project Last Mile technical assistance to scale from Boane up to Mocuba district and other local  20.2.21 Guarantee the functioning of the condom management team (salaries)  **Support for program activities**  20.2.12 Acquire mobile clinics to support activities during health emergencies  20.2.13 Hire 11 TB Technical advisers (1 per province for the 11 provinces, for 3 years period) to support NTP program to plan and accelerate the implementation of TB response interventions at provincial and district level, aiming to support the MoH cadre of personnel to reach mains goals in TB screening and case finding.  20.2.14 Strengthening the NTP management team at central level by appointing 5 technical advisers (for 3 years) to provide coaching/ mentoring and on the job support in the following areas (1) MDR TB to respond to the challenges of MDR TB case finding and clinical management of patients; (2) Monitoring and evaluation to support the NTP team in the implementation and response to the challenges of designing and operating electronic platforms and implementing programmatic activities in the area of monitoring and evaluation; (1) PSM Expert, to support the NTP management team on planning and handling of the logistics chain for medicines and laboratory products; (1) Technical adviser to support NTP on planning and accelerate implementation of Pediatrics and Community related activities. |
| Amount requested | Allocation: 6 446 522,77 USD  PAAR: 29 683 457,99 USD |
| Expected outcome | * Improved grant performance * Increase the efficiency of condom supply chain * Timely and effective roll out of planned community interventions |

## Rationale

* + 1. **Overall approach to how you selected and prioritized the requested interventions**

The interventions described in this application were selected through an inclusive process during the country dialogue that included a national consultation meeting, resulted from consultation meetings conducted in all 11 provinces of Mozambique. This country dialogue approved a report containing a list of priority areas for interventions and activities, based on identified gaps and lessons learned during the current grant implementation period.

After the country dialogue phase, technical working groups were created to develop the application, grouped in thematic areas related to disease programs and RSSH, namely HIV, TB, malaria, and RSHH. These technical working groups further refined the list of priority interventions and activities. Civil society organizations contributed to each of the four thematic groups with specific inputs about interventions and activities that should be included in the application.

To prioritize, the technical working groups used all the available program data, estimates supported or published by United Nations agencies (UNAIDS, WHO), surveys and studies conducted in the country (as Stigma Index, INSIDA, other IBBS), demographic data, programs reports, the National Strategic Plans for HIV and TB[[12]](#footnote-13)[[13]](#footnote-14) and the last guidelines for each area of the diseases.

All the process took in account the GF program essentials, efficiency, value for money and the funding landscape with the American Government fundings to identify the gaps and chose the interventions within allocation that can maximize the response.

**HIV prioritization**

The HIV modules and interventions were elaborated using information derived from the V HIV National Strategic Plan (2021-2025) and the lessons learned during the NFM3 implementation.

Specific geographies and interventions were informed by Spectrum data and other strategic information sources, always taken in account other partners investments and implementations, specially PEPFAR. Resource allocation across interventions was done to maximize impact, have greater coverage and avoid overlap.

1. **Differentiated HIV testing services and Prevention**

The low coverage of HIV diagnosis and prevention services are barriers to the HIV epidemic response, as well to reach the UNAIDS global targets, with INSIDA 2021 showing that 71.6% of people living with HIV are aware of their HIV status and very low coverage and knowledge of key prevention interventions, with 26.8% VMMC coverage nationally and only 6.6% and 7.6% of all women and men participating in the survey having heard of PrEP[[14]](#footnote-15).

In addition, it is essential to highlight that some sub-populations are disproportionally affected and at risk for HIV infection, in 2020, of the 98,000 estimated new infections in Mozambique, 39,000 (40%) were among young people 15-24y, with 28,000 (82%) being adolescent girls and young women (AGYW); key populations are also at high risk (see Context section). These reinforce the importance of strengthening and targeting HIV prevention and case identification for this subpopulation. The technical working group identified the barriers and challenges impacting delivery of testing and prevention services and listed priority interventions, including targeted and high yield testing modalities that address some of the structural challenges these population face (e.g., community-based testing, self-testing, index case testing) and the necessary funding.

This funding request will prioritize prevention interventions for KP and AGYW and look for the specific needs of this populations, as community service delivery, combined prevention offer, human rights and gender equity.

As Mozambique has a generalized HIV epidemic with high prevalence and gaps in prevention and knowledge of HIV status, interventions HIV prevention and case identification for AGYW have been proposed to cover as many high and medium incidence districts as possible, also taken in account not only PEPFAR geographic location, but the scope and coverage of their activities in the districts. The summary of the prioritization was described in the AGYW specific module and a more detailed report with annex information are attached.[[15]](#footnote-16)[[16]](#footnote-17)[[17]](#footnote-18) IBBS for KP was used and a population size estimation exercise was conducted.

The prevention interventions look for precision and efficiency, without leaving anyone behind.

1. **Elimination of mother-to-child transmission of HIV, syphilis and hepatitis B**

The Elimination of mother to child transmission (EMTCT) of HIV, Syphilis and Hepatitis B is considered a public health priority, globally and nationally. According to MOH MCH programmatic data, in 2022 only 17% of pregnant women (PW) started the antenatal care (ANC) with less than 12 weeks of gestational age. The introduction of pregnancy tests and IEC campaigns to create demand, aim to ensure early identification of pregnancy (currently confirmed by fetal heart beats and movement) and early linkage to ANC care and offer the complete triple EMCT package.

Incident infections among women during the pregnancy and breastfeeding period poses a risk for the mom and the baby’s health and life. In Mozambique, MTCT rate is 10% (2022, Spectrum V. 6.26) and about 24% of the pediatric infections in 2020 were related to maternal incident infection during the breastfeeding period. While virtually all PW are tested at ANC (99.7% of PW enrolled at ANC had a known HIV status in 2022), HIV testing during breastfeeding period is less systematic, this is mainly due to HIV test kits reporting and distribution gaps, as well as limited implementation of national guidelines due to limited infrastructure (e.g., privacy for testing at immunization clinics) and HRH availability. Retesting is a key intervention for the timely identification and treatment of HIV+ breastfeeding women and VTP care for exposed children (HEI).

Of the estimated HEI, 90% enrolled in the Child at Risk Consultation, and 89% collected PCR < 2 months, positivity rates are as follows: HEI < 2 months at 3% and HEI > 2month at 13%. Despite the improvements in the EID program, there are still gaps to ensure all HEI are linked with clinical follow-up and in a timely fashion. Delays with access to testing and continuous exposure during breastfeeding increases risks of new pediatric infections and delay access to life-saving ARV treatment.

The mentor mothers (MM) strategy is an essential strategy to address some of the key gaps for EMTCT, by providing peer support to reinforce HIV literacy, adherence and treatment continuation, however its limited geographic coverage impacts the strategy impact. We propose to expand and strengthen this strategy, by expanding to 299 non-AJUDA HF supported by CCS through Global Fund in 111 districts. Criteria for site selection followed the criteria: (i) HFs not supported by PEPFAR; (ii) high number of HIV+ PW; (iii) HFs with at least 30 exposed mother/baby pairs; (iv) presence of CCS supported initiatives with community involvement with a focus on PSS, TB, and male engagement. The MoH is currently preparing a comprehensive evaluation of the MM strategy. The analysis will focus on the different stages of the mother/child follow-up from pregnancy to the preadolescence

Within the current NFM3 grant, 507 MM have been hired for peer support in HFs and the community. The target group is HIV+ PW, HIV+ BW, and their HEI, parents & caregivers of children living with HIV (CLHIV) <10y. The defined ratio MM/client is 1:48, which has resulted in low coverage of CLHIV eligible for peer support (26% of the total of 2,067 eligible children < 10 years old), while proper coverage for PW and BFW (95% and 98%, respectively) (Quarterly Report, Q1, 2023, CCS). The technical group calculated that 253 new MM are needed to achieve a ratio of 1 MM: 25 HIV+ children <10 and 1 MM: 25 HIV+ mother/baby pairs. Moreover, services will be reorganized by sharing responsibilities, so that one MM supports the mother/baby pair, and another MM supports parents and caregivers of HIV+ children. The distribution of new MM per HF is detailed in the annexed CCS supported HF MM estimates worksheet.[[18]](#footnote-19)

For an effective implementation of the triple EMTCT plan, including the new Syphilis and Hepatitis B guidelines, there is a need to make essential inputs available (tests and treatment). The risk of developing chronic liver disease in adults is strongly associated with the age of exposure to Hepatitis B virus, and approximately 90% in babies who become infected under 1 year of age chronify the infection. The estimatedHBV prevalence of the general population was given at 5.0-8.7% in 2019.[[19]](#footnote-20) In addition, data referring to operational research carried out at the Chamanculo HC, in Maputo city, found 4% of the women at maternity ward had a positive HBsAg results, of these, 9.1% were HBeAg positive and 5.2% had CV-HB > 200,000 IU/ml. 36.6% of these women with Hepatitis B were co-infected with HIV. GF is the only partner that support the country to implement interventions related to Hepatitis B.

1. **Treatment and Care**

There have been improvements in the pediatric care and treatment, however some challenges persist, including limited infra-structure and HRH (e.g., limited availability of adolescent and youth services, limited availability of infrastructure allowing for privacy), impacting access to care and treatment continuation. Low percentage of children and adolescents living with HIV know their HIV status, there is multiple missed opportunities due to lack of prioritization for children at different entry points, poor identification of vulnerable population groups (orphan children, girls and adolescents, key population, children with disabilities) and limited linkage to support services specific to these groups.

The inconsistency in the availability and supply of some medicines and essential medical items/consumables for the handling and treatment of children in accordance with the norms recommended at the HF level (e.g.: Management of opportunistic infections and patients with advanced HIV disease, handling and treatment of healthy child and sick child in general) constitutes barriers to achieve the goals.

Regarding the Treatment and Care for adults, activities were selected and prioritized based on previously identified challenges and opportunities in the respective areas. The rule of thumb and first criteria is to complement PEPFAR coverage of technical areas and interventions and geographic footprint (support 645 HF through its implementing partners). Since PEPFAR targets health facilities (HF) and not geographical areas (provinces, regions, districts), the GF NFM4 grant activities are proposed to coverer all provinces, and the only geographical focus will be to target HFs not supported by PEPFAR (commonly known as "non-AJUDA" sites). The second criterion is the volume of patients on ART, which allows prioritization at HF level (as incidence and prevalence are not available at that level), we propose to target all HF with more than 336 patients on ART, which includes 270 HFs non-AJUDA at all 11 provinces. Choosing to support non-AJUDA sites will allow for more equity on quality-of-service delivery and support for PLHIV throughout the country, improving access conditions. Meanwhile, choosing to include only HFs with a substantial volume of patients will have the best cost-effective interventions and impact.

The prioritization takes in account achieve the second and third 95, with community and reducing human rights barriers interventions to improve adherence and retention of PLHIV in care and treatment. In addition, improved quality of services was included, with increased provision of care for NCD and advanced disease.

In addition, to improve quality of service delivery, QI interventions were also included into the proposal. The MOH QI Guidelines were launched in 2015 aiming to improve quality of care in response to the increased demand for ART services, including PDSA cycles and mentoring strategies. This strategy is currently implemented at 728 (43% of HF with ART services), covering about 87% of ART clients in the country and also include recipient of care and communities since 2021. In order to strengthen quality of services and harmonize approaches, we propose to expand QI methodologies to the 270 prioritized HF, including training, data review and discussion and mentoring visits and assessment.

The proposal includes interventions and activities to address NCD, Hepatitis B and C and syphilis among PLHIV. Data from African countries show an increased prevalence of NCD among individuals on ART, according to a meta-analysis[[20]](#footnote-21), the possibility of PLHIV presenting at least one NCD increased to 42.2% after 10 years in ART vs. 25.9% in the control group. There is limited data about NCD in PLHIV in the country or even in the region.[[21]](#footnote-22)[[22]](#footnote-23)[[23]](#footnote-24)[[24]](#footnote-25) Considering that, in Mozambique, the prevalence of hypertension and diabetes in the age group 15-64 was estimated, respectively, at 31.4%[[25]](#footnote-26) and 7.3%[[26]](#footnote-27), figures of hypertensive and diabetic PLHIV may be as high as 750,000 and 180,000. The financial burden associated with the treatment of these patients clearly exceeds the capacities of the MoH. It is unfeasible to reserve medicines provided by the GF for PLHIV and those provided by the State to HIV- patients with hypertension or diabetes. If medicines will be provided by the GF through the PAAR, hypertensive and diabetic PLHIV will have priority access to the drugs.

The burden of AIDS-associated cancers has shown a marked increase (KP)[[27]](#footnote-28). In Mozambique, cervical cancer is the most common cause of death from cancer among women, with an increase related to the HIV epidemic. In 2018, about 1,800 cervical cancers were attributable to HIV in Mozambique, 42% of the total estimated[[28]](#footnote-29). PEPFAR is funding activities for cervical cancer screening, referral, and treatment (LEEP, cryotherapy, thermocoagulation) in 646 HF covering 85% of the eligible women. Targeting the 270 priority HF will allow to ensure equitable access to early detection and treatment for cervical cancer. Anal cancer is the fourth most common cancer among PLHIV. Incidence is estimated to be 89 per 100,000 among MSM HIV+ and 18.6-35.6 per 100,000 among women HIV+. An inquiry on local symptoms through the routine clinical history could prompt an anorectal exploration, to refer the suspicious cases for surgical observation. This needs just gloves and lubricants. The screening for this type of cancer would be modelled on the referral system already in place for the CC.

Prevalence of HBsAg in the last decade was found at almost 10% among PLHIV not yet on ART (8.3% in 2012[[29]](#footnote-30) and 9,1% in 2017[[30]](#footnote-31) in Maputo City), and at 7.6% among PLHIV in ART in the Northern province of Cabo Delgado[[31]](#footnote-32); in 2011, a study in the central province of Tete among 679 blood donors found a seroprevalence of HBV at 10.6 %[[32]](#footnote-33). The estimated HBV prevalence on the general population was given at 5.0-8.7% in 2019[[33]](#footnote-34). However, a higher percentage of 12.2% was found, rather unexpectedly, among the young population in Maputo (aged 18-24) in 2015[[34]](#footnote-35). Mozambique started universal three-dose HBV vaccination in 2004, and coverage rates have remained above 95% since 2012.[[35]](#footnote-36).

The estimated HCV prevalence on the general population was given at 0,5-1,3%[[36]](#footnote-37). In 2016 a prevalence of HCV serology in persons with AHD of 1.15% was found in Maputo. In 2017 by MSF started a comprehensive service for PWUD, providing screening, clinical care, social support, and syringe‐needle distribution, via outreach activities and a community center. In 2020, opioid substitution therapy (OST) was added. This has been until now the only service of this kind in the country. HCV screening revealed an HCV prevalence at 8% among PWUD overall and at 25.2% among PWID[[37]](#footnote-38). Currently no treatment is available, but the country is going to receive daclatasvir and sofosbuvir (combined dose) through the current GF grant**.** Just scaling up of comprehensive services for PWUD and testing availability for HCV will make possible effective treatment including Pan genotypic regimen.

In Maputo city, a prevalence of syphilis was reported at 0.36% among 1380 youngsters aged 18-24 in 2011. Female made 76.8% of the sample. The prevalence was lower than the national values in this age group[[38]](#footnote-39). Among blood donors in Tete, the prevalence of syphilis was 1.2%.[[39]](#footnote-40) In 2022 79% of women enrolled in ANC were screened for Syphilis with a positivity rate of 2.2 % and higher positive case in Cabo Delgado (4.5%) and Zambezia (3.4), which also presented a low screening rate. We may calculate that about 18,000 babies, mainly in Zambezia, Nampula and Cabo Delgado were exposed to congenital syphilis women missed the prophylaxis[[40]](#footnote-41).

1. **Human Rights**

Despite strong national and international legal frameworks and commitments to the protection of human rights and recent notable progress in scaling up programs to reduce barriers in accessing and utilizing human rights-related HIV, TB services compared to 2017 (Mid-term review Global Fund Breaking Down Barriers Initiative), with global scores increasing from 0.91 to 2.24 in this area, Mozambique still faces challenges, assessed with the prevalence of stigma and discrimination in all contexts, being in 2013 the prevalence of PLHIV stigma and discrimination in the community was 56%. (Survey, 2013).

There continue to be significant gender dimensions to the HIV epidemic in Mozambique involving gender norms that challenge access, prevention, treatment and equity as well as gender-based discrimination and violence. Although major efforts are underway to address these challenges, progress has been slow, particularly with regard to efforts to shift socio-cultural practices that limit the agency and autonomy of adolescent girls and young women to access relevant programs and services. The health system is generally, and particularly community, family and sexual and reproductive health services seen as directed to women and children, fueling gender norms that regards men as weak when seeking health care. Despite the MoH approval of several instruments to engage men in healthcare services, practical implementation is still a challenge.

There are Interventions to address and remove gender-related barriers to health services, with a focus on adolescent girls and young women. However, too often the focus of such interventions is solely AGYW and women, making them aware and empowered by continuing to navigate in a broader social environment where no one understands and follows the rights she maters. Within its national HIV response, Mozambique is currently mounting a comprehensive response to gender inequality and gender-based violence, with the specific focus being adolescent girls and young women. There is recognition of key populations that are acutely vulnerable to HIV and TB. However, the response in the provision of care for such groups in not yet comprehensive and able to change the pattern of vulnerability of such groups. Additionally, stigma, discrimination and the general lack of an intersectional analysis of vulnerability exposes certain categories of KP to multiple layers of vulnerability.

Long-term capacity building as well as technical assistance remains an urgent need to ensure grant implementation and indeed the success of interventions, as the need to continue and strengthen all efforts to effectively mainstream human rights and gender issues in the response to HIV and TB.

According to the Legal Environment Assessment (LEA) report, the country is at the forefront of ratifying international instruments for the protection of human rights and in particular those related to HIV and AIDS and health, despite the fact that challenges prevail in any relevant instrument not ratified; as is the case with the optional protocols that allow national citizens access to the jurisdiction of international bodies, which limits the possibility of international jurisdictional protection in cases of violation of human rights. And in relation to the Specific Legislation: the HIV and AIDS Law 19/2014 “for the protection of the person, worker and job candidate living with HIV and AIDS”.

Challenges remain, as the lack of disclosure, especially at base level, lack of human rights and gender knowledge by service providers which fuel discrimination, stigma and ill-treatment of users; ignorance of the beneficiaries who work for the protection of the Target Group; lack of regulation of the law; generation of data, research and information that help to improve service provision and the production of legislation.

According to the report on the evaluation of Stigma and Discrimination in some health units in Maputo, Manica and Nampula carried out in 2020, the analysis of attitudes, knowledge and practices of providers revealed that 12% of the health personnel surveyed stated that they feel worried when they have to measure the temperature of a patient with HIV, 5.3% also stated that they are very worried when they touch the clothes of an HIV+ patient and 45% of the respondents feel worried when dressing the patient with HIV. For assistance to key populations, the same study revealed that 13.1% of respondents reported that they preferred not to provide services to MSM; 12.5% ​​to sex workers, 25% to IDPs and 7% to prisoners if they had a choice, considering that they put them at risk of disease. Also, laws against drug use limit the development of harm reduction interventions for injecting drug users. Poor conditions in prisons, specifically severe overcrowding and SERNAP's inability to provide for the basic well-being of detainees, limit both the availability and access to HIV interventions. Finally, harmful gender norms and gender inequality, along with severe poverty, continue to place adolescent girls and young women at high risk of HIV infection and also limit their ability to use HIV and other services when they need them.

Programmatic areas considered effective in removing human rights and gender-related barriers to HIV include: Eliminate stigma and discrimination in all settings; Ensuring the non-discriminatory provision of health care through training both at health training institutions as well as on-going on-the-job training; Ensuring rights-based law enforcement practices; Reduce HIV-related gender discrimination, harmful gender norms and violence against women and girls, transgender in all their diversity through in-depth liaison with community leaders and educators in order to incorporate gender equity as well as HIV and TB prevention in community and social education; Legal literacy (“know your rights”); Increase access to justice; Improving HIV-related laws, regulations and policies; Community mobilization and defense of human rights; Gender equity in planning and organization of the health system.

1. **Monitoring and Evaluation**

The Technical Working Group met and walked through the perceived barriers and challenges to improvements or successes in the Monitoring and Evaluation area. After the barriers were listed, the interventions that are transversal to public health programs were incorporated at RSS component. Specific interventions for the HIV and Tuberculosis program have been included in a module in this proposal.

1. **HIV/TB**

HIV is still one of the main drivers of the TB epidemic in Mozambique. The country shows a steady decline in the co-infection rate in newly diagnosed TB patients, although there are wide variations between provinces. The southern provinces namely Maputo City, Maputo Province and Gaza have a high co-infection rate of around 55%. While Inhambane and Sofala, provinces in the middle zone, have a co-infection rate of around 40%, it varies between 20% and 33% in the northern provinces.

HIV testing rates among reported TB cases and ART treatment in co-infected individuals are high, both above 95%. However, routine TB screening in this group and TPT onset and PLHIV completion rate are still low. National TB and HIV programs are working on a joint strategy to increase TB screening and TPT coverage in PLHIV.

Activities for improvement includes implementation of the fast strategy to improve TB screening at all ports of entry through cough officers; massify TB screening in chronic disease consultations, integration of TB screening into the service package of all community health workers.

**TB prioritization**

The NTP and CCM have led a process to elaborate this proposal based on national and global policies, strategies and guidelines and the data that is available in country from the Government, partners and UN agencies, specially WHO.

The strategic direction of the TB modules in this funding request were guided by the National Strategic Plan for TB Elimination 2023-2030 and the Joint Assessment[[41]](#footnote-42). The Global Strategy to end TB, and the country’s commitments as a part of the 2018 United Nation’s High-Level Meeting on TB. The latest country-level, other scientific research studies and GFATM performance reports were also used to inform investment decisions.

Mozambique aims to reach and serve the TB patients of the country with integrated, people-centered care and prevention, to maximize their detection and ensure their cure by standard treatment. The people-centered care will cover the following groups of priority patients: (1) People with TB not accessing the healthcare system; (2) People with active TB who seek healthcare but are either not diagnosed or not notified to the NTP; (3) People with TB who are notified, but still not successfully treated, (4) TB cases with no drug resistant status; and (5) Those with Drug resistant status but not on treatment. To make this possible, the country has prioritized the following three core strategies that encompass all the modules, to maximize impact: (1) Improve access to TB services; (2) Improve TB diagnosis, and notification to NTP and (3) Improve successful treatment completion.

This is adopted to push the country to achieve a larger proportion of the End TB Strategy targets and United Nations High-Level Meeting on TB targets by 2025, with the currently available resources. Other partner investments were also considered in prioritization. The investments in the NTP from the United States Government, World Bank and Stop TB Partnership will focus mostly on community engagement and key populations in selected provinces. The Global Fund investments will be prioritized in overall system strengthening and community mobilization in the rest of the provinces.

To prioritize and select the interventions and activities following approach was undertaken.

1) Created a landscape of the present program approaches, interventions and outcomes and the source of funding supporting the such interventions.

2. Assessed present situation in regards to program implementation results to the planned outcome and identified areas that lagged the most. Assessed further to identify the possible bottlenecks.

3) Analyzed the studies and assessments undertaken in country or in the region to specify best actions to overcome the bottlenecks.

4) The interventions identified were alignment with guidance from the WHO/UN/GFATM

5) Meetings and workshops were organized engaging the Technical Working Groups and stakeholders to discuss the proposal and collect inputs. CSO and communities’ representatives working on TB affected areas were also engaged in the proposal development.

6) A simple cost-effective analysis was done with the outcome targets as the value for money.

7) The cost analysis was associated with the impact on disease load in the country and its long-term sustainability,

8) Leverage resources from other potential sources of funding and costs haring or in-kind/logistic support like the private companies was considered.

Steps followed were as follows:

**Step1:** The NTP conducted a meeting of all NTP specialty teams and stakeholders introducing the new application form and the requirement thereof.

**Step 2:** Each of the NTP specialty team and other stakeholders were requested to work on the progress of the previous funding and identify the key achievements and challenges.

**Step 3:** Consultants were hired, including one international consultant with long experience in TB program management, proposal writing and donor relation. The consultants facilitated the process of information processing and identifying key areas where the program was lacking in impact and needed strengthening and thereby needed resource support.

**Step 4:** A meta-analysis was done of the achievement and challenges and cross-cutting issues were identified e.g, M&E feedback, patient psycho-socio-economic support, Socio-economic reasons for case finding and treatment adherence, and such others.

**Step 5:** Such analyzed information of program needs and demands created by the consultants was placed to the NTP teams and other stakeholders to review and edit with modifications including deletions and additions.

**Step 6:** Based on the responses from the teams, the consultants compiled and presented to the NTP the areas of interventions and activities thereof for further discussion by the NTP/CCM and stakeholders.

**Step 7:** The final input was provided to the NTP by the consultants as Modules. Interventions and activities for approval and to be included in the application form.

**B. Decision process for interventions selected for allocation versus those included in the PAAR**

Funding for the implementation of HIV and TB programs is limited and thus, the prioritization took into account value for money, that is, allocated resources to interventions and activities with which maximum impact can be achieved. Some criteria used to rank the priority were: intervention with potential large effect and that can be measured by data, equity, sustainability and reliability (assessed by existing experiences). Interventions that met more criteria were considered for allocation, while those with fewer criteria were placed on the Above Prioritized Allocation Request (PAAR). PAAR activities are necessary, but if not funded, they may not significantly affect project outcomes. Interventions proposed in the allocation will strengthen the project and sustain the gains made in NFM3.

Activities funded by other Global Fund grants such as RSS or C19RM were excluded from the allocation request or PAAR.

For both programs, the treatment and related activities were priority and were included in allocation.

Most of HIV program PAAR proposal are interventions that complement and potentialize what are proposed on allocation and are related to remove human rights barriers for key and vulnerable populations, social support to AGYW, M&E and program stewardship.

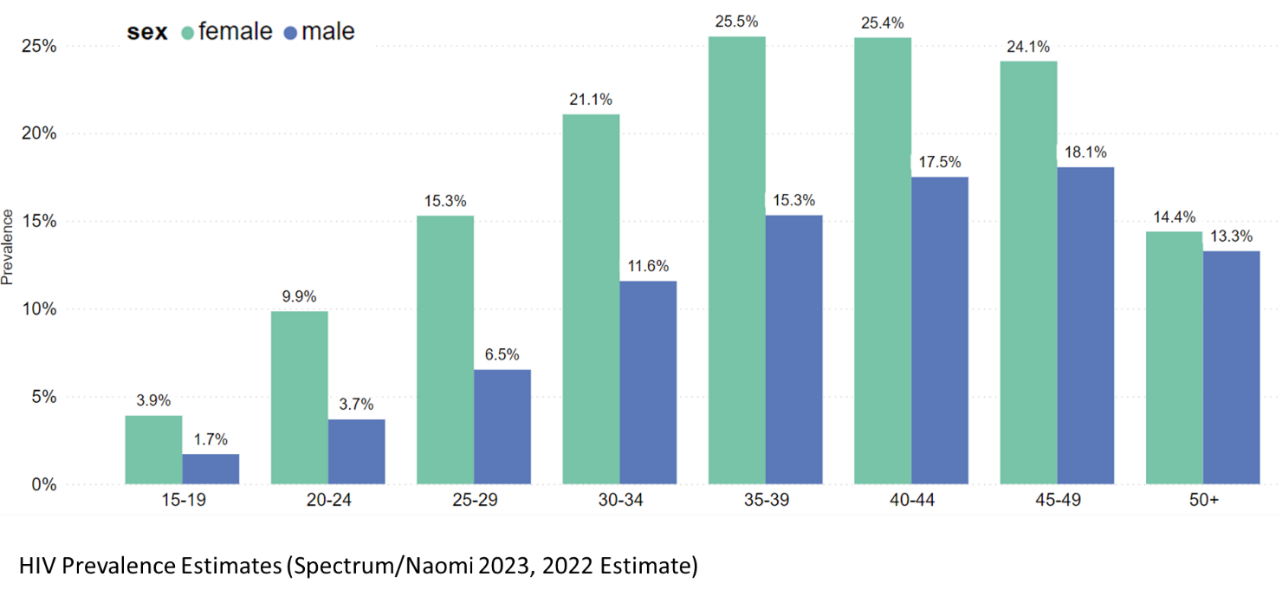
For TB program, most part of PAAR are complementary interventions for TB screening and diagnosis and program management.

## Context

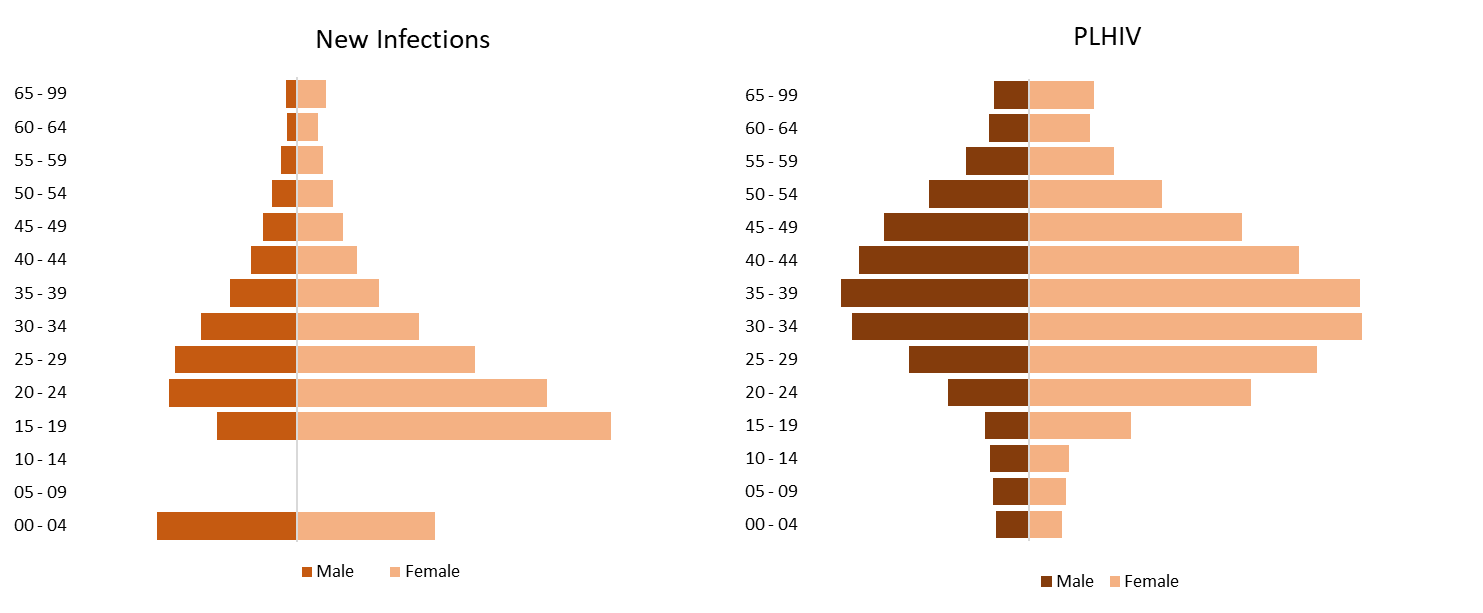
**Overview of the HIV Epidemic in Mozambique**

According to Spectrum estimates 2023, in 2022 Mozambique had 2.4 million [2.3 million - 2.6 million] people living with HIV (PLHIV), including 2.3 million adults [2.0 million - 2.5 million] and 150,000 children [125,000 - 170,000]. HIV prevalence is 12.5% among adults aged 15+ years (15% in women and 9.5% in men). Women face a disproportionate HIV burden throughout the life cycle, but the disparity is most pronounced among young women aged 20 -24 years, whose HIV prevalence is 3.1 times greater than their male peers (11.8% vs. 3.8%) (Figure 1 & 2). Demographic and economic inequities drive the epidemic and create barriers to access. Of Mozambique’s 31.6 million of people, 10.9 million are between the ages of 10 and 24, with many of the age group either unemployed or working in the informal sector (INE 2022). In 2015, 46.1% of the total population lived below the poverty line. The HIV response is guided by the V National Strategic Plan (PEN V) 2021-2025.

**Figure 1**. HIV prevalence in Mozambique, disaggregated by age and sex (Spectrum 6.26, 2023)

****

**Figure 2**. People Living with HIV and New Infections in Mozambique, disaggregated by age and sex (Spectrum 6.26, 2023)



There is significant geographic variance in Mozambique’s HIV epidemic (Figure 3 & 4). At the provincial level, adult HIV prevalence in 15+ is highest in Gaza (20.9%) and lowest in Manica (7.9%) (INSIDA 2021). At the district level excluding Maputo City, prevalence is highest in Quelimane (18.8%) and lowest in Macanga (1.2%) (Naomi 2023).

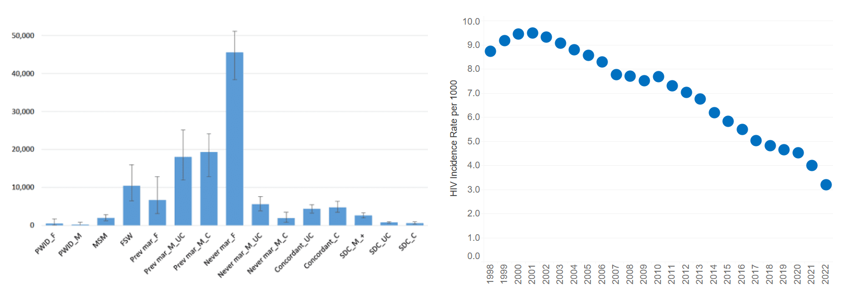
While Mozambique has a generalized HIV epidemic, it is characterized by distinct sub-epidemics that require targeted responses. PEN V defines key populations as sex workers (SW), men who have sex with men (MSM), people who inject drugs (PWID), transgendered people (TG), and prisoners. The plan also considers adolescent girls and young women (AGYW) aged 15-24 years, mobile and migrant workers (mine workers and truck drivers) and sero-discordant couples as vulnerable populations.16 Size estimates and prevalence data is below in Table 1.

**Table 1. Population size estimates and HIV prevalence for key and vulnerable populations in Mozambique[[42]](#footnote-43)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Population** | **Size Estimate** | **HIV Prevalence** | **Coverage of HIV prevention programs\*** |
| **Female Sex Worker** | 97,000 (2022) | 26.5% (2019-2020) | 82.7% (2022) |
| **Male Sex Worker** | No data | No data | No data |
| **Men who have sex with men** | 72,000 (2022) | 6.8% (2020-2021) | 40.4% (2022) |
| **People who inject drugs** | 9,100 (2022) | 45.8% (2014) | 38.5% (2022) |
| **Prisoners** | 21,301 (2022) | Total: 25.5% (2022) | 54.0% (2022) |
| Men: 25.4% (2022) | No data |
| Female: 31.5% (2022) | No data |
| **AGYW (aged 15-24 years)** | 3,375,366 (2022) | 8% (2021) | 26.2% (2022) |
| **Transgender-Men** | 3,600 (2022) | No data | No data |
| **Transgender-Women** | 4,000(2022) | No data | No data |
| **Transgender- All** | 7,600 (2022) | No data | 11.0% (2022) |
| \*Based on program data (FDC+PASSOS), 2022 | | | |  |

Adult HIV incidence has fallen from 1.55% in 2000 to 0.55% in 2022, as a result of effective treatment and prevention programs implemented by government and partners (Figure 3). The total number of new infections remains persistently high (97.000 in 2022). Almost 26.00 new infections in 2022 occurred among young women between the ages of 15 to 24 (Spectrum 6.26, preliminary data). The second population category with the highest number of new cases is 20-34 men, with 16.000 (Spectrum estimates). From the report Modes of HIV Transmission, Mozambique 2018, FSWs and MSM make up a very small proportion of Mozambique’s population (estimated at 1.08% of the adult female population, and 0.56% of the adult male population, respectively) yet these two groups are estimated to account for 11% of new infections.

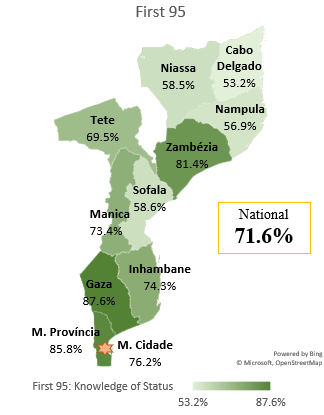
**Figure 3.** Number of new HIV infections (2018) (left) and adult (15-49) incidence (Spectrum 6.26, 2023) (right) in Mozambique



Low condom use is a major driver of new infections, with just 30% of women and 48% of men with 2 or more partners reported using one the last time they had sex with a non-regular partner (INSIDA 2021). In 2019, Mozambique developed a National Condom Strategy which aims to increase condom use to 61% (up from 46%), 51% (up from 31%) and 49% (up from 24%) among men who have sex with non-regular, paid, and multiple partners, respectively. To achieve this, the plan suggests that procurement costs will top $4 million by 2023. Last mile distribution to remote, rural areas is needed. In 2022, 205,961 male circumcisions were performed, with the main age group between 15-24 with 65% with the second largest group 20-24 with 17& of the total. Between 2020 and 2021 there was a reorientation of the circumcision program, moving the focus of procedures from the 10-14 age group to the 15-19.

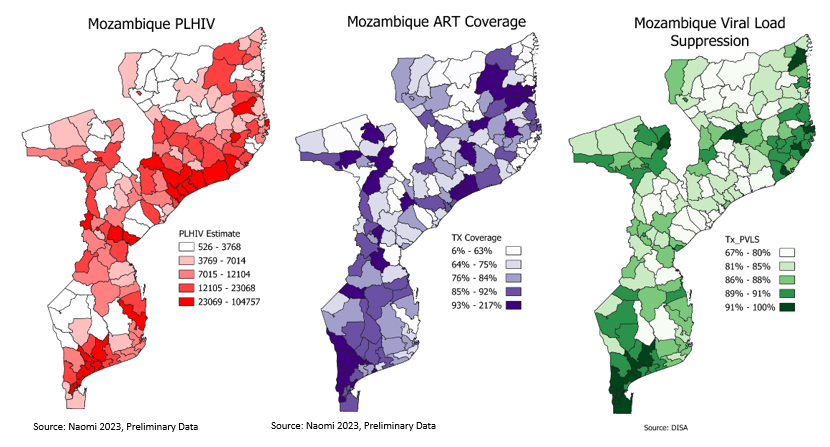
In terms of knowledge of status, which is the first 95, the north and center of the country have disproportionately lower rates than the south, with Sofala, Niassa, Cabo Delgado, Nampula al under 60% (INSIDA 2021) (Figure 4).

**Figure 4. Percentage of PLHIV who know their status, in Mozambique**



Antiretroviral therapy (ART) coverage, viral load testing and viral suppression are notably better in the southern parts of the county (Figure 5).

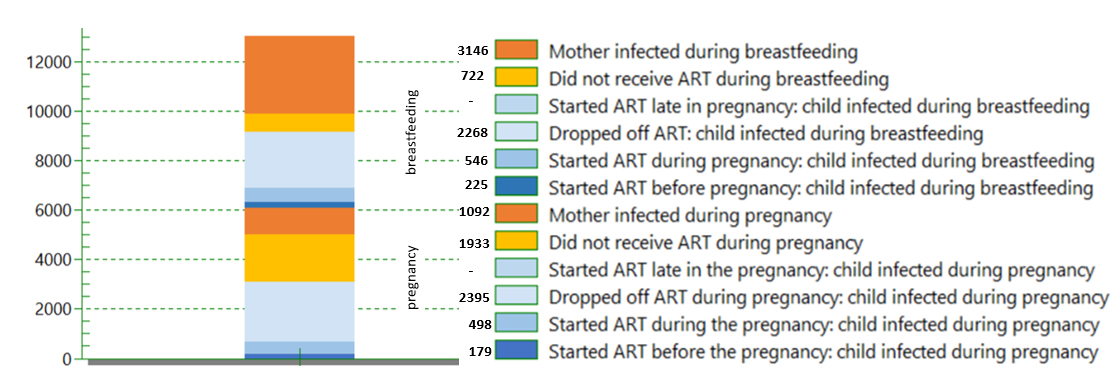
**Figure 5.** PLHIV (left), ART coverage (middle) and viral suppression (right) in Mozambique, 2023



There is an ongoing conflict in Cabo Delgado between a violent Islamic insurgency and Mozambican security forces, creating significant barriers to health services for people living there. To help address geographic inequities and to provide services in humanitarian settings, the National Control Program for STIs and HIV/SIDA have adopted a strategy for “mobile brigades” and a treatment passport that allows beneficiaries of HIV treatment to continue treatment in any health facility.

Mozambique has an accelerated plan to eliminate mother-to-child transmission (MTCT) of HIV and syphilis 2020-2024, aiming for HIV transmission of less than 5%, reduce the incidence of new HIV pediatric infections to less than 750 hepatitis transmissions per 100,000 live births, reduce the prevalence of hepatitis in children under 5 to less than .05%, less than 750 syphilis per 100,000 live births. Though the MTCT rate has declined from 28% to 10% from 2010 to 2022, it remains far from the accelerated plan goal of 5%. Coverage of ART among HIV-positive pregnant women is high, at 99.2% in 2022. For early retention among pregnant women, 93% of pregnant women are retained after 33 days, which 95% retained after 99 days (AJUDA Dashboard 2022). A stack-bar analysis shows MTCTs occur most commonly when mothers are infected during breastfeeding, followed by dropping out of ART during pregnancy. These two modes of transmission account for 24.2% and 18.4% of all new infections in children, respectively (Figure 6). Ten other modes make up the remaining 57.4% of vertical transmissions.

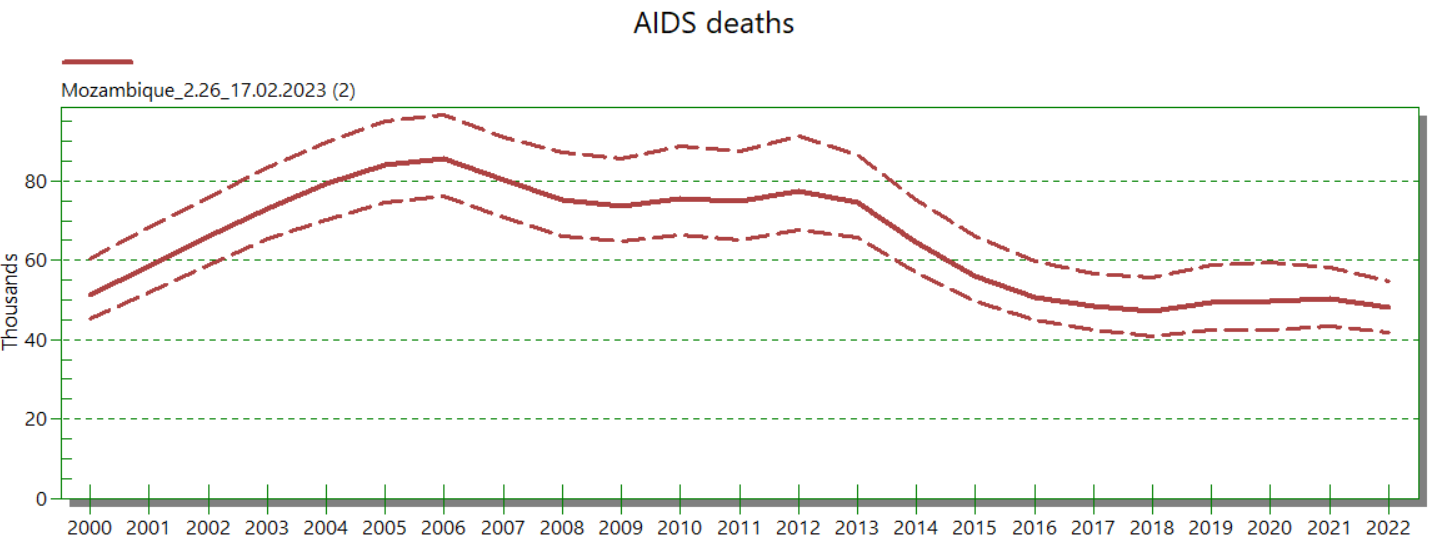
**Figure 6.** Number of new infections in children, by mode of mother-to-child transmission (Spectrum 6.26, 2022)



Among key populations, incidence is fueled by stigma, low testing, discrimination, violence, harassment and extortion, including from law enforcers who are inadequately sensitized. For instance, in Maputo 45.2% of MSM reported experience some form of discrimination in the last 12 months. In the 12 months before the survey, between 28.3% of the MSM in Nampula and 88.3% in Beira, had received condoms, lube, or pamphlets of information. Finally, between 89.2% of MSM in Quelimane and 65.0% in Nampula had tested previously, reveling a lack of frequent testing in this priority group. (IBBS MSM 2021). In Maputo 58.6% of FSW had suffered physical violence, while 24.2% had experienced sexual violence. A large majority of the FSW had received condoms, lube, or pamphlets in the last 6 months, with 85.8% in Quelimane as the lowest and 96.8% in Maputo the highest.

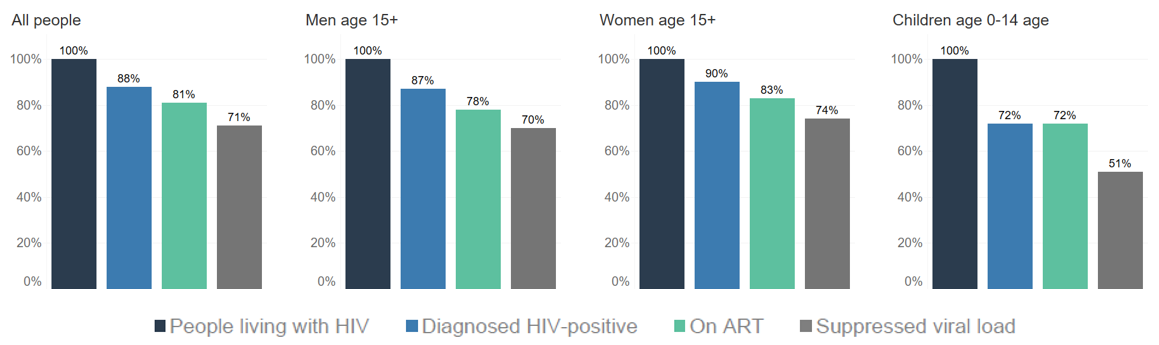
Mozambique has implemented rapid scale-up of ART, guided by a National Acceleration Plan and executed with robust collaboration among the Ministry of Health, PEPFAR and the Global Fund. The number of people on ART rose from 308,000 in 2012 to 1,981,568 in 2022. Test-and-treat has been policy since 2016. Successful treatment scale-up has led to a reduction in the number of AIDS-related deaths, from a peak of 85,000 in 2006, to 48,000 in 2022 (Figure 7). However, more must be done to achieve national targets.

**Figure 7**. Number of AIDS-related Deaths in Mozambique, 2000-2022 (Spectrum 6.26, 2023)



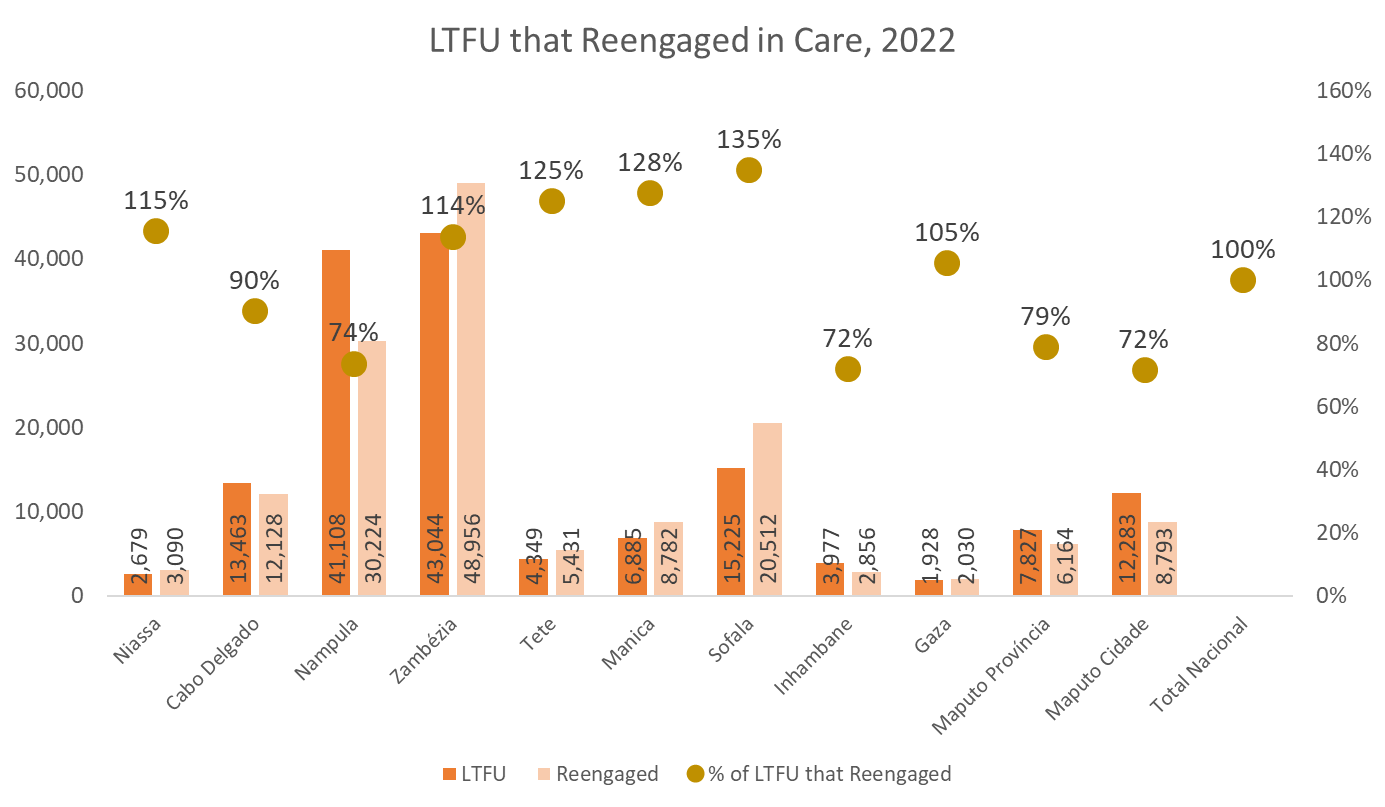
Mozambique remains below the 2025 95-95-95 treatment targets, which out of all PLHIV, require 95% to know their status, 90% to be on ART, and 86% to be virally suppressed. In 2022, 88% knew their status, 81% were on ART, and 71% were virally suppressed (Spectrum 6.26). In the last quarter of 2022, routine Ministry of Health data from SIS-MA (Mozambique’s DHIS2 Platform) shows just 82% of adult PLHIV are on ART. Disaggregated cascades reveal age and gender inequities (Figure 8, Spectrum 6.26, preliminary data). Men fare worse than women along the entire cascade, which is being addressed through a comprehensive male engagement strategy in the previous funding request. PEPFAR program data suggest viral suppression is just 71% among adolescent boys 10-14 and 76% among young men aged 15-19 years (AJUDA Dashboard), which is particularly concerning given the abovementioned sources of risk for AGYW. INSIDA 2021 data show that knowledge of HIV status is lower for adolescent men and young women aged 15-24 years, at 45.3% and 56.4% respectively, indicating a need for more targeted testing approaches.

**Figure 8.** Treatment cascades in Mozambique, disaggregated by age and sex, 2022



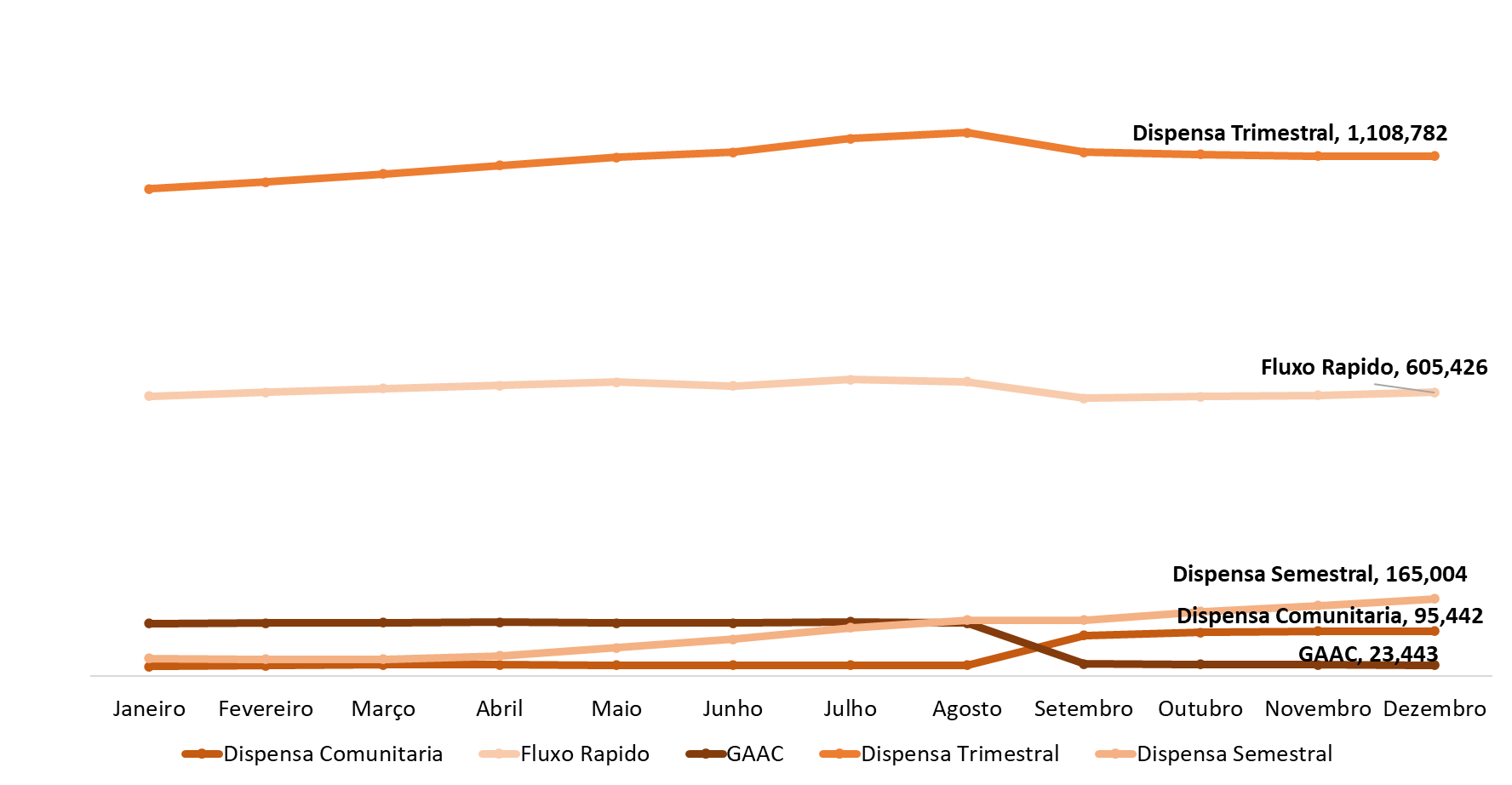
Poor retention is a major cause of treatment cascade ‘leaks. Economic migration/mobility, and poor relationships between the health system and patients, lead to repeated cycles of patient disengagement and re-engagement in HIV care. Despite this, there has been an increased focus in 2022 on reinitiating lost-to-follow-up beneficiaries, with the vast majority of the LTFU beneficiaries entering care again within the period (Figure 9). It is hypothesized that the above 100% reengagement due to previous years LTFU being brought back into care and treatment.

**Figure 9.** Reengagement of LTFU beneficiaries, 2022



Community adherence support groups (GAACs) have been active in Mozambique since 2008. Other differentiated service delivery (DSD) models have been rolled out in recent years to improve quality of care and retention, including one-stop and family visits, multi-month dispensing, and rapid flow (e.g., Fast-Track lanes). Due to the COVID epidemic, the inclusion criteria for DSD were opened and there was a massive uptake of three-month drug distribution. Currently more than half of the people living with HIV on ART are enrolled in at least one model: 1,108,782 in the 3-month MMD and 165,004 in the 6-month scheme (Figure 10).

**Figure 10.** Trend of number of beneficiaries on the five most population DSD models, 2022



Fear of stigma—including self-stigma, discrimination and violence—and disclosure are the major barriers to access for services for PLHIV.84 Individual stigma correlates negatively with recent HIV testing among men, underscoring gendered dimensions to stigma.85 Delays in seeking care have resulted in 25-30% of HIV patients presenting to health facilitates with advanced disease (CD4 <200) in a study from Beira by MSF. To respond to the need of increased CD4 monitoring for clinically advanced beneficiaries, an Advanced HIV Disease package was launched in 2022 at a selected number of sites, which will be expanded to a total of 74 sites in 2023.

**COVID impact on HIV/AIDS services**

COVID outbreak brought an almost immediate negative impact on HIV epidemics: HIV RDT & Viral Load, diagnosis and treatment start of HIV, as well as clinical consultations, all fell between March and June 2020. The MoH quickly reacted by boosting the spacing of ARV drug delivery in order to reduce patients’ overcrowding and exposition to COVID in the HFs. Quarterly Dispensing of ARVs grew from coverage of 32.9% to 62.1% of all patients on ART in just three months (March-June 2020)[[43]](#footnote-44). The Semi-Annual Dispensing of ARVs, promoted in a few selected HFs raised from 1% in March to 4% in December 2020[[44]](#footnote-45). The measures probably curbed the negative peak of patients failing treatment recorded in April, which was followed by a quick improvement in patients’ adherence to ART seen in the following months[[45]](#footnote-46). Thus, the answer to COVID epidemics showed a notable resilience of the health national system, and produced gains in efficiency regarding the way ART was delivered. On the negative side, there were inconsistencies and arbitrariness in the way patients were collocated in or retired from a specific differentiated model of service, not always responding to their needs and clinical conditions. This, in turn, may have affected adherence to ART, patients’ loss to follow up, and, eventually, mortality.

**Overview of the TB Epidemiology**

According to the 2022 Global TB Report, the country has an average estimated TB incidence of 116 000 cases annually. Of these, it is estimated around 25% are co-infected with HIV. The estimated proportion of MDR/RR TB is 3,5% in new and 11,2% in previously treated cases. Mozambique has estimated TB death rate of only 12%, meaning that Mozambique is one of only seven high TB burden countries to have already reached the milestone of a 35% reduction in TB deaths[[46]](#footnote-47). The average case notification in the last 5 years is 99,380 with constant increase. All those notified (100%) had their HIV status known. Case notification as per gender, 44% were females and 56% were males, and out of this, 12% were under 15 years old. The bacteriologically confirmed cases continue to be less than 50%, with 42% reported in 2022 from the total cases notified. MDR TB notification has been varying during the last 5 years, being 1441 notified during 2022 of which 55 XDR-TB cases were notified.

**TB case notification:**

Mozambique is 18th country on the list of the 22 countries, according to the World Health Organization (WHO) Global TB Report 2022.

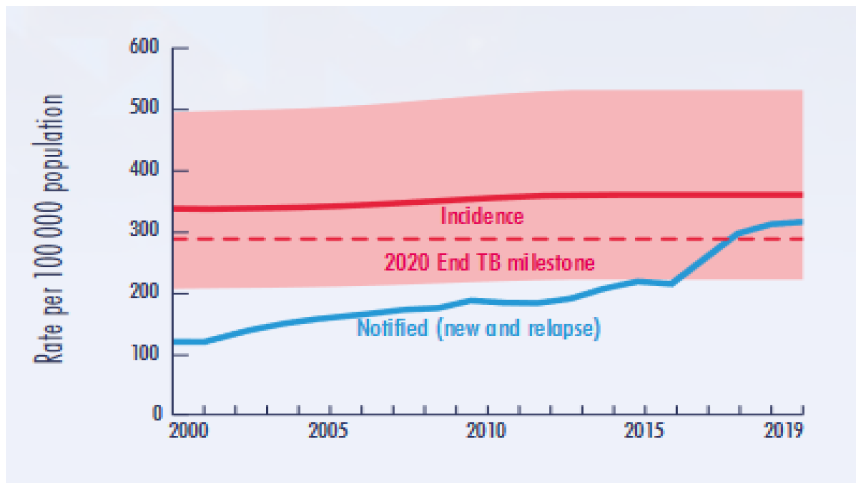
The Mozambique TB incidence rate has been stable for the last 5 years according to the World Health Organization (WHO) report, which is almost aligned with the National TB Prevalence Survey conducted in 2018 and published in 2022, indicating that the prevalence of TB in the adult population is 334/100,000 people and extrapolated to the general population it becomes 354 (233-475)/100,000 people and the incidence is 361/100,000, implying in 116,000 new cases each year.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mozambique** | | | | | | | | | | | | |
| **Year** | **2010** | **2011** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** |
| **TB Case Notification** | 46.174 | 47.452 | 50.827 | 56.220 | 60.340 | 61.559 | 73.470 | 86.515 | 93.546 | 97.111 | 97.093 | 98.485 |

Since 2018 to 2021 the case notification has plateaued around 93000-98000 cases per year. At the same time, the missing cases have reduced from 18907 in 2020, to 17515 in 2021, a decrease of 7%. This indicates the program has reached a critical level in reaching out to the community at large in identifying the missing cases and to move to address the estimated TB incidence rates[[47]](#footnote-48)[[48]](#footnote-49).

Based on the National TB prevalence survey, the extrapolated TB prevalence rate of (361/100000 - 95% CI, 223-532) population of TB all forms was lower than previously estimated by WHO (551 100,000 - 95% CI, 356-787) though within the earlier confidence bound. For bacteriological confirmed cases, 334 (502-774) per 100,000 adults (≥ 15 years) population in 2018 -2019. Although the prevalence was lower than previously estimated, Mozambique is still a High TB Burden County[[49]](#footnote-50).

**Figure 11. Incidence and notifications of TB cases**



The TB prevalence survey also depicted that the prevalence rate among men (474/100,000) was twice that of females (211/100,000), higher in urban settings (416/100,000 population) than in rural settings (287/100,000 population) and highest in the age group ≥ 65 years (1141/100,000). The survey additionally found a wide variation in the burden and drivers of TB among the regions.

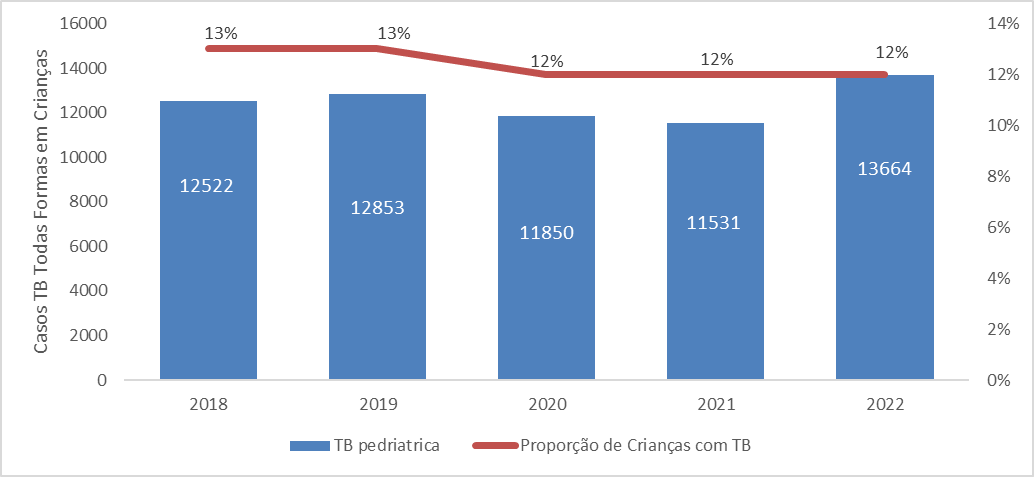
The program therefore needs to be sustained with additional efforts to scale up the case findings activities. The program hereby proposes to scale up the ongoing activities with addition of new innovative approaches to reach out to the key populations that are vulnerable, marginalized and hard to reach. The program also proposes to enhance the case finding activities with focus on children and TB contacts.

**Pediatric TB**

As per the WHO 2022 report TB in children (0-14yrs.) accounted for 12% of all cases. The MoH reported a 25% HIV-infection rate among registered adult and pediatric TB patients[[50]](#footnote-51). The incidence of TB is rising, with pediatric TB cases almost tripling in recent years[[51]](#footnote-52)[[52]](#footnote-53)[[53]](#footnote-54).

The case notification among the pediatric case is found to be following the similar trend of overall case finding. The figure below depicts that the case notification appears to be plateauing around 12000 since 2017 onwards[[54]](#footnote-55).

**Figure 12. Children proportion of TB cases**



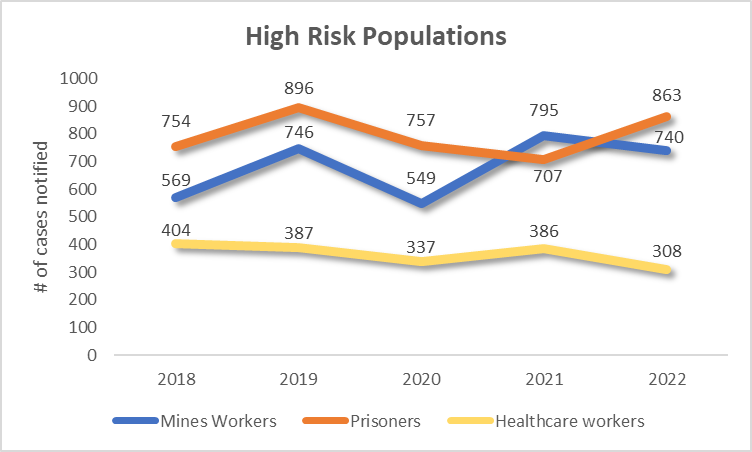
Diagnosis of extra-pulmonary TB like cervical lymph-node TB, a common manifestation in children in high HIV settings, is still inadequate due to the lack of biopsy facilities at the secondary-care health-facilities. Collecting samples in children under five years is equally challenging. As a result, the vast majority of pediatric TB cases are clinically diagnosed resulting in compromising the standard procedure.

Additionally, knowledge gap among the healthcare workers, especially in pediatric TB and GeneXpert MTB/RIF testing, may result into substandard care to the patients[[55]](#footnote-56)[[56]](#footnote-57).

**High risk populations**

Key populations are vulnerable to TB infection. During the National TB prevalence survey, 3 key populations were considered (mine workers, prisoners and health workers). The mining activity in Mozambique is composed of informal miners in the southern region and some formal Mines in low scale. Mozambique is bordering South Africa and Eswatini with high mining activities. The program has been implementing TB screening to mine and ex-mine workers with main focus to the southern region of Mozambique, through the Occupational Health Centre in Gaza and Maputo provinces. As known from world statistics, prison systems have been TB focus areas given their outdated and overpopulated facilities, poor ventilation and sanitation[[57]](#footnote-58).

**Figure 13. Notifications of TB cases in high-risk populations**[[58]](#footnote-59)



**Health care workers**

Health workers involved in caring for patients with TB and MDR-TB have at least a two-to-three-fold higher risk of contracting the disease than that of the general population. A study conducted at Maputo Central Hospital identified an annual incidence rate among health workers of 1676 per 100,000, consistent with the median incidence rate of 1180 per 100,000 reported in a meta-analysis of active TB among health workers in high-TB incidence countries[[59]](#footnote-60)[[60]](#footnote-61). In 2022, 11,603 health professionals were screened, of which 160 were diagnosed with TB. Furthermore, TB screening is passive and not systematic. Only professionals who present themselves at the worker's appointment are screened, which in turn has poor adherence. However, around 8000 community health workers (including APEs, PMTs, TB Community Activists and others) are not covered by this approach. Among the factors that contribute to low coverage include stigma, lack of confidentiality, and limited access to laboratory and X-ray services, especially for professionals working in remote health facilities. Recently, MISAU is developing an Occupational Health and Safety Standard for Health Professionals that is expected to improve TB control and prevention in health facilities. Therefore, it is urgent to reduce occupational exposure among health care workers within health facilities and at the community level.

**Miners and ex-miners**

In the last five years, Mozambique has achieved significant milestones in addressing TB in the mine sector. These include active case finding through TB community-based services across high-density population of miners and ex-miners, the operationalization of three occupational health centers in the Provinces of Gaza and Maputo for the systematic screening of TB in miners and ex-miners, especially those linked to mines in South Africa, in addition to the expansion of diagnostic capacity and sample transportation system might have played a critical role to enhance TB case detection and linkage to care. Additionally, to ensure cross-border continuity of TB care, a regional electronic platform has been developed which is in use in 10 health centers in the Province of Gaza.

Coordination between Mozambique and South Africa was strengthened at the high-level meeting between the labor and health sectors of the two counterparts in 2022. From 2018 to 2022, 26,759 miners and ex-miners were screened for TB and other pulmonary and occupational diseases, of which 2,830 were diagnosed, reported, and treated for TB. TB reporting in these groups showed a static trend except for 2020, which saw a 36% decrease compared to 2019, potentially caused by the restriction of travel to and from South Africa during the COVID-19 pandemic, followed by a rapid recovery in the following year with the lifting of restrictions and resumption of normal TB procedures.

Despite these achievements, there is a huge coverage gap among mine and ex-mine workers in the domestic mining industry, either formal or artisanal, that have limited access to TB services due to several factor including long distances, high mobility of artisanal miners and the location of the mining activity out of the reach of the facility catchment areas. As per the last Artisanal Mining Census (2022), there are 1577 centers of artisanal mining activity that engage almost 230,000 miners across the country. The risk of developing TB among these is as higher as the general population. Therefore, urge the development of a comprehensible and integrated approach to address the TB epidemic among these communities.[[61]](#footnote-62)

**Prisoners/Correctional service population**

From 2018 to 2022, NTP in coordination with Serviço Nacional Penitenciario (under the Ministry of Justice) have strengthened and implemented a set of interventions that comprehend the dissemination of key messages to raise awareness and generate demand for TB services; integrated TB, HIV, NCDs screening at the entrance and periodically throughout the term of the inmate and during TB campaigns; coordination between the penitentiary units and health facilities of reference for technical assistance, diagnostic services and training. Under this collaboration, the coverage of TB services has expanded beyond the provincial units toward district-wise facilities. Despite this progress, TB rates among this population (almost 1,500 per 100,000 Pop.) are still higher than the general population. Factors contributing to this low coverage include obsolete, poor ventilated and overcrowded facilities; low literacy and stigma related to TB. Additionally, the coverage is still below the satisfactory rates. Therefore, there is a need to improve the coverage of interventions to raise awareness, psychological and nutritional support, and advocacy for infrastructural refurbishment to enhance air-borne infection prevention and control.

**Other vulnerable groups**

Barracks occupants, military personnel, are also considered risk groups for TB. In this context, NTP carried out the awareness and screening campaign, at the request of the Ministry of Defense, which resulted in the screening for TB of 300 military personnel, of which 247 samples were taken and processed at the Laboratory of the Provincial Hospital of Pemba using GeneXpert, and of these 2 were positive for TB. Considering the risk for TB in this group, NTP proposes to expand the intervention over the next 3 years.

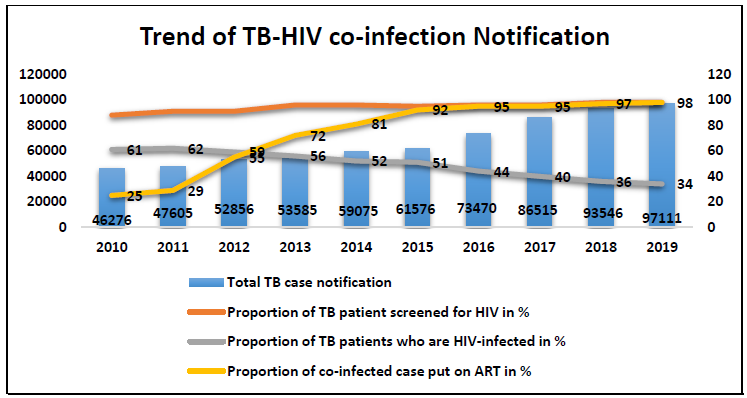
Similarly, NTP carried out TB screening in resettlement centers in Cabo Delgado, Nampula and in the Center of the Country (the latter resulting from natural disasters). Currently, just over 28,500 refugees and asylum seekers are registered in the country, of which around 9,500 reside in Maratane settlement while the remaining 19,000 reside in urban areas[[62]](#footnote-63). Given the high risk of natural disasters, there is a need to create satellite points in the centers, screening and ensure the continuity of TB services for people already diagnosed through mobile brigades and/or transitional health centers. In this context, NTP intends to consolidate the interventions carried out during cyclones (IDAI and FRED) and displaced populations in the Province of Cabo Delgado.

**TB-HIV**

According to the INSIDA report, HIV prevalence in Mozambique, among the general population (15 and 49 years old) is 12,5%. In addition, there are some geographic hotspots and subpopulations where HIV prevalence reaches 20% in some adult age groups in southern Mozambique[[63]](#footnote-64). As per the national TB prevalence survey, 2021, TB prevalence were much higher among people living with HIV (759/100,000)[[64]](#footnote-65).

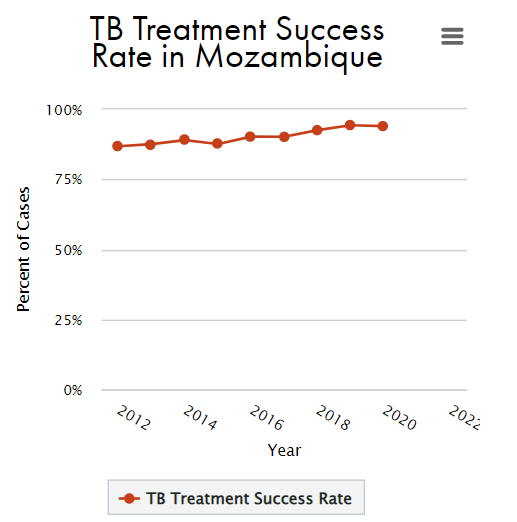
In Mozambique, addressing the TB and HIV epidemics is constrained by poor access to services, with 66% of the country’s population living in rural areas and only 36% of the people having access to a health facility within 30 minutes of their home. While community-based TB and HIV services do exist, they are often patchy and do not cover all rural areas. In areas where community-based services are limited or not available, people living with HIV and those falling ill with TB must find their own way to health facilities for screening, diagnosis and treatment, at significant financial cost. This means that a high proportion of people living with HIV are unaware of their status and that people with TB remain undiagnosed (or diagnosed after long delays) and untreated, which sustains TB transmission in their communities. Lack of access also means that people with TB and/or HIV are less likely to adhere to their daily treatment. When services are available, they are often not integrated, making it more costly and complicated for people to be screened for both TB and HIV[[65]](#footnote-66).

**Figure 13. TB/HIV coinfections**



HIV testing rates among notified TB cases and ART treatment in co-infected individuals are high, both over 95% (figure above). However, the routine TB screening, Tuberculosis Preventive Therapy (TPT) initiation and completion rate of PLHIV are still low[[66]](#footnote-67).

**Figure 14. TB treatment success rate**



TB treatment completion rate has been high and as per Global TB report 2022 the TB success rate among new and relapse cases is 94%. The challenge is to take the treatment as near as possible to the community to reduce the traveling time and other barriers to access the treatment services[[67]](#footnote-68).

As for the TB preventive treatment rate among children under five years, Global TB report 2022 mentions it at 89%. However, the reach of the children as contacts of TB patients and HIV is limited and not well documented.

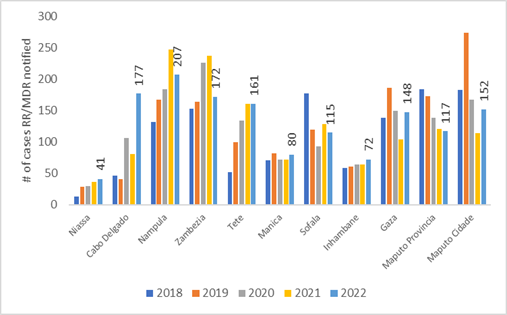
HIV is still one of the main drivers of the TB epidemic in Mozambique. The country shows a steady decline in the co-infection rate in newly diagnosed TB patients, although there are wide variations between provinces. The southern provinces namely Maputo City, Maputo Province and Gaza have a high co-infection rate of around 55%. While Inhambane and Sofala, provinces in the middle zone, have a co-infection rate of around 40%, it varies between 20% and 33% in the northern provinces. HIV testing rates among reported TB cases and ART treatment in co-infected individuals are high, both above 95% (Figure 2). However, routine TB screening in this group and TPT onset and PLHIV completion rate are still low. National TB and HIV programs are working on a joint strategy to increase TB screening and TPT coverage in PLHIV and the set of interventions envisaged includes: i) Implementation of the fast strategy: to improve TB screening at all ports of entry through cough officers; Massify TB screening in chronic disease consultations. To this end, there is a need to train health professionals in the search for signs and symptoms of tuberculosis; Integration of TB screening into the service package of all community health workers; Ensure continuity of implementation of collaborative TB/HIV activities.

**Drug resistance TB**

The graph indicates a steady rise of MDR-TB cases in Mozambique but there is a gap in those put-on treatment. This proposal aims at putting in efforts to address the issue and close the gap of identified versus those put-on treatment and strategies to enhance the treatment management and adherence. The prevalence of MDR TB in Moz is 3,5%, annually 4800 MDR TB cases develop TB but only 30% are diagnosed per year. Some diagnosed patients are lost before starting treatment.

Death rate is high (12%), lost on follow up rate is also high (8.4%)[[68]](#footnote-69)[[69]](#footnote-70)[[70]](#footnote-71).

**Figure 15. Percentage of RR/MDR Tb cases notified**

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**Partner and donor organizations of the NTP**

The NTP is supported by many cooperation organizations. The major donors are the Global Fund, United States Agency for International Development (USAID) and Center for Disease Control and Prevention (CDC) trough implementing agencies such, Columbia University Mailman School of Public Health (ICAP), Centro de Colaboração em Saúde (CCS), Elizabeth Glaser Paediatric AIDS Foundation (EGPAF), and Fundação Ariel Glaser contra o SIDA Pediátrico. As per the Global TB Report, 2022, 88% of the TB program funding was from domestic sources and only 12% of the funding was from the domestic sources.

**Awareness generation and Advocacy**

TB patients in Mozambique face many challenges to effectively preventing, diagnosing and treating tuberculosis.

Having TB is often seen as equivalent to the stigma associated with being HIV infected, or even a higher perceived stigma as seen in a study in Southern Mozambique. Barriers to treatment adherence vary from individual level factors (such as fear for side effects) to social (mainly stigma) and institutional factors (lack of timely attendance as a principal barrier)[[71]](#footnote-72).

Knowledge of TB is less pronounced among the general population and the further the place is or more isolated the communities are the more decrease in knowledge of TB. Perceptions of TB and MDR-TB that were related to myths and local traditions or rituals still dominate most parts of the rural or urban slum communities. In general, it has been observed in studies that the knowledge and understanding of HIV is better than that of TB.

Studies show individual reasons like, preference to see the traditional healer, concern about shame and stigma, lack of confidence in the health system, not wanting/not being able to follow the advice of the HCWs and side effects, as barriers to access and start treatment. All these results in significant section of the population not using the health services to get diagnosed and treatment and break the chain of transmission[[72]](#footnote-73).

There is a lack of proper systematic and sustained approach for communication and advocacy with community and national leaders to address myths, misinformation and stigma related to the disease. However, there are also certain health system issues that deter people from using the health services like timing of the opening and closing of facilities, behavior of the heath staff, delay in diagnosis, not proper counseling and out of pocket expenditures.

**Laboratory services**

TB program has established DR-TB testing facilities and introduced newer technologies for TB diagnosis but the coverage of such is still very limited and much needs to be done to decentralize the facilities and help get the diagnostic services as close to the people as possible.

The phase-wise scale-up of rapid molecular diagnostic services (Xpert RIF/MTB) in the current Global Fund grant helped to dramatically improve the notification rate RR/MDR-TB, from 1206 cases notified in 2018 to 1441 in 2022 an 19% increase[[73]](#footnote-74). The access to rapid molecular diagnostics further increased by regular sputum collection and transportation from non-Xpert to Xpert sites. However, the installation of the new GeneXpert machines has not yet facilitated finding people with MDR-TB as much as expected. There is a need to accelerate the installation of the GeneXpert machines and ensure continuous maintenance of those in service. A significant percentage of the eligible TB laboratories did not participate in EQA mainly due to inadequate control panels dispatched by the INS in the period under review. There is also a mismatch noted between the number of GeneXpert MTB + Rif+ cases reported (796) and the number of cases that had an LPA 2nd line test conducted (282) in the two reference laboratories.

With the introduction of GeneXpert MTB/XDR, training laboratory technicians in testing and correctly interpreting results will become critical. The diagnosis of TB using stool samples will contribute to the increase of diagnosed cases of children with TB, as this represents an important target group, but difficult to diagnose due to the nature of the samples, which are mostly paucibacillary.

The expansion of fluorescence microscopy in the diagnostic network associated with the high turnover of technicians makes training in iLED Microscopy essential in order to guarantee quality diagnosis in the laboratory network. The diagnosis of TB in patients with advanced HIV disease using the TB-LAM test is an important tool for the increase in cases diagnosed in this group of patients.

The implementation of testing with TrueNat in peripheral US must be accompanied by training in the use and preventive maintenance of the equipment. This training will be integrated into the TB sample collection and referencing package in order to guarantee the reception of quality samples in the laboratories, reducing sample rejection rates and contamination.

The training of reference laboratory technicians in the production of panels for Antibiotic Sensitivity Tests will allow for their production and distribution at a local level and since the LNRT is a candidate for Supranational Reference Laboratory.

With the introduction of new TB diagnostic technologies (GeneXpert MTB XDR, TrueNat, use of feces for diagnosing childhood TB, TB-LAM, etc.), there will be a need to monitor activities in laboratories in order to guarantee standardization of procedures and emission of reliable and quality laboratory results.

One of the great challenges faced is the management of laboratory information, with the training of technicians and laboratory logistics managers in completing and sending LMIS reports using the Web/Link system, this gap can be overcome since the central level will have information in real time of the stock of consumables, reagents and all US information. The National Institute of Health (INS) is an institution that seeks regional and international recognition. INS created the National Program for External Quality Assessment (PNAEQ) with the main objective of ensuring the continuous improvement of testing quality comparable to international standards in all testing sites in Mozambique. The uninterrupted participation in the External Quality Assessment Program should be considered a fundamental element in the continuous improvement process, as the program helps in identifying the presence of possible analytical errors, enabling the laboratory to implement corrective actions to eliminate the causes of these errors. In addition to the aforementioned benefit, it allows identifying the need for training, compares and validates test methods, however, it is a priority that all testing sites participate in a quality assurance program, thus ensuring that patients receive reliable and timely results, and that public health programs and actions are based on genuine results for decision making. The creation of Provincial Quality Assurance Programs (PPGQ) represents a strategy aimed at expanding access to programs that guarantee quality laboratory testing. To that end, there is a need to expand and strengthen these programs through centralization in the provincial Public Health Laboratories. Investment in the technical competence of those involved is a success factor for this activity.

**Monitoring and Evaluation**

The absence of clear Monitoring and Evaluation guideline further to the weak learning process in the program. Data Quality also is key to inform evidence-based decision making. The poor quality of data has been significantly affecting the ability of providing clear guidance on the program implementation.

Aggregated data combined with fragment data sources have been greatly contributing negatively to the quality of data that is used at the program level to manage their activities. Efforts have been taken to improve the quality; however, it is known that the use of aggregated data with multiple data points constitutes a great challenge to maintain the necessary quality standards. Based on the pilot of the Data Quality Assurance tool developed during the current grant, and extensive research that suggests the use of electronic patient level data, the program has decided to scale-up the country wide implementation of SIS-TB in the next grant. To improve the availability of data, the program plans to integrate fragmented data sources into one platform to allow triangulation and advanced analysis which can easily be shared. The program will also intensify field technical support, including data checks which will allow the identification of issues and support on solutions.

Currently, data is collected aggregated by facility, but, with considerable quality issues. The availability of accurate data is key to strengthening program activities. During the last 2 grants, M&E activities were not clearly defined at program level as these have been included through HSS. However, a considerable focus was made on 4 main points: provision of field technical support, the review of data collection tools, data quality assurance, and the implementation of electronic patient register. To have data available in a timely manner, the NTP intends to leverage the electronic patient register to establish a reliable surveillance platform. The NTP intends to focus on the same points as mentioned above, but focusing on improving data quality and use. Based on the pilot which involved 3 provinces, the NTP will escalate the implementation of electronic patient level register.

Apart from implementing the surveillance system, the country is also leveraging other digital innovations to improve data quality and availability, by using existing platforms for community data collection as well as integration of the various data sources, allowing decision makers and data users to have data in a timely manner to bust the use and evidence-based decision. These solutions have been piloted in the past by the TB program and have proved to be effective.

Enhancing digital inclusion in Mozambique is essential, given that access to reliable and affordable connectivity is a foundational step in maximizing the impact of deploying digital technologies. As per 2021 figures, 50.4% of the population has a cell phone, and nearly 34.2% use smartphones. Internet penetration stands at 21.2% in the country.

**Infection Control**

In recent studies it was found that Guidelines for diagnosis and treatment of TB patients were not present in all facilities. Staff instructed patients on sputum collection 91% of times, but only 4% observed it. Only 52% of the rooms assessed in health facilities had adequate ventilation. Three quarters of the health care workers had N95 respirators but only 36% knew how to use it correctly[[74]](#footnote-75).

Two significant factors were identified in the studies for non-compliance of the infection control measures by the health workers especially in the health setups. The first was the healthcare system, including infrastructure and the availability of necessary materials or equipment. The consultation and waiting rooms in some facilities were of inadequate space and not all windows could open. There is a conflict regarding the measure to use ventilation by opening doors and windows and maintaining patient privacy by closing doors during consultations. There is insufficient guidance as to how to apply TBIPC measures. Lack of necessary material or equipment such as respirators and other protective equipment also leads to non-practice of infection control protocol. This led to indifference and developing poor practice in respirator use.

Another reason for non-use of TBIPC was related to change of existing work practices. It is observed difficult to apply the required new practice such as using respirators consistently since many of the health care workers have not got into the habit of using the respirators and feel uncomfortable in using it all the time, they are in the health setup and also finds the respirators to be a barrier in communicating clearly with the patients[[75]](#footnote-76).

Studies also found that when the staff are subjected to TB training/re-training not much emphasis is given to the infection control and practices and neither the supervision or reviews highlight the infection control measures in the facilities. Much of the health staff are also not screened regularly to assess their status.

In the high-risk population, there is much awareness for the HIV and sexually transmitted disease infection prevention but very little about TB infection prevention and control.

At the patient and community level some studies that focus on the issue found that at home level the infection control measures were minimal at the best. Much of the patients hardly knew of the how to collect and dispose the sputum, cough hygiene and keeping distance from other family members. Information disseminated during the COVID outbreak did help to maintain the distancing and use of mask and cough hygiene, but such knowledge is understood by the community as protection for COVID only[[76]](#footnote-77).

**Human Rights**

The human rights situation in Mozambique worsened in 2021, largely because of the ongoing violence in the northern Cabo Delgado province. The humanitarian crisis in the province also deteriorated due to insecurity and violence, causing the displacement of over [800,000 people](https://www.unhcr.org/news/briefing/2021/6/60c312e94/insecurity-northern-mozambique-continues-forcibly-displace-thousands.html).[[77]](#footnote-78)

Mozambique does not currently have a national strategy for human rights. However, Mozambique is one of the countries in the Global Fund Breaking Down Barriers Initiative. The midterm evaluation, 2021, of the this initiative have demonstrated, that Mozambique, 1) progress on reducing HIV-related stigma and discrimination reflects a strong commitment to development of programs in this area, 2) training of health care workers on human rights and medical ethics has improved slightly in terms of scope and scale., 3) under the Global Fund grant, the government has taken on a significant role in the implementation of programs for sensitization of lawmakers and law enforcement officials.

Progress, however, remains limited, 4) legal literacy programs have expanded in both scope and scale, ranging from “Know Your Rights” radio spots and debates, dissemination of patients’ rights charters and widespread legal literacy activities for girls, young women, sex workers and others, 5) paralegal programs have expanded significantly, with three NGOs training and deploying paralegals to reduce human rights-related barriers to access to health care in 11 provinces, 6) young women and girls, as well as female sex workers, have been the focus of broad and sustained efforts to reduce the disproportionate burden of HIV. These efforts include the DREAMS program sponsored by PEPFAR and the Viva+ project from the Global Fund, 7) few specific programs on TB stigma and discrimination were identified during the mid-term assessment, and those that were identified were limited in scale, however recently initiated programs appear to be strengthening human rights components and expanding the range of individuals reached. For example, the ADPP implemented OneImpact project, working with the Stop TB Partnership, developed a program where individuals with TB can report issues they face related to stigma and discrimination, but the pilot project was only operating in four health facilities, all in Maputo. However, an expansion of the project, with support from Namati, was initiated in October 2020 in Gaza Province using quarterly broadcasts in four communities via local radio stations.

**Health Equity**

Contributors to health equity are boundless and extend into social, political, economic, and cultural domains. In Mozambique, access to health care facilities may be hindered by geographical distance, lack of transportation, employment requirements or internal displacement. Health care knowledge and awareness is obstructed by literacy, cultural differences, or limited access to technology (the ‘digital divide’).

Chronic illness progression is generally affected by insurance status, food insecurities, or environmental and living conditions such as working in mines and industrial set ups, or an inmate in the prison. More blatant assaults on human rights including barrier to access also represent health inequities.[[78]](#footnote-79) There are limited evidence and studies on this issue. As per one study, about 72.1% of women and 72.9% men use healthcare.

Population in a disadvantaged position living in rural areas have less probabilities of using healthcare for equal health compared to the individuals of a wealthier position and living in urban settings. With regard to quality care, 47.7% women and 46.8% men do not report quality problems. No differences for women’s wealth. Men in a disadvantaged position report less chances of accessing quality care compared to men of advantaged position. Also, women and men living in rural areas have less probabilities of accessing quality care. Finally, the majority of people who access healthcare paid 1 Mt during their visit.[[79]](#footnote-80)

**Gender Equality**

Mozambique ranked 185th out of 191 countries in the 2021-22 UNDP Human Development Index, and 136th out of 191countries in the UNDP Gender Inequality Index.[[80]](#footnote-81)

Extreme poverty and the HIV/AIDS epidemic have contributed to the precarious status of women and girls in the country. While there have been gains in the legal framework to prevent and sanction GBV, premature unions, promote and create an enabling environment for girls to access and maintain in school which led to gender parity in enrolment conflicts and climate shocks experienced since 2017 can shake or limit the impact of the country's gains. The displaced condition exacerbates the difficulty of continuing their studies and providing for their needs. Additionally, the restriction measures enacted by the Government to contain the spread of the COVID-19 pandemic exacerbate poverty, especially in the periphery of urban areas. Female-headed households have been the most affected by poverty (63% versus 52% of male-headed households), and women are the most excluded from decent work opportunities (they constitute only 4% of the workforce in the formal sector and the highest unemployment rates in the country affect urban women between 19 and 24 years of age)[[81]](#footnote-82). High maternal health risks (451,6 women deaths per 100 000 births), pressure to marry at a young age continue and unrecognized and unpaid women’s care work continue to limited economic prospects as well as GBV and accepted cultural norms place women at a high disadvantage. The country is facing the growth of non-communicable diseases with hypertension as one of the causes of premature mortality affecting more women (68%) than men (31%)[[82]](#footnote-83).

HIV prevalence among adults 15+ in the country is 12.1%, being higher among women with 15.1% against 9.0% among men[[83]](#footnote-84). Women are the group with the highest prevalence and incidence rates regardless of social class, level of education and geographical area. Men have low rates of HIV testing and treatment. Adolescents and young people of both sexes have very low viral suppression rates. Key populations face a higher risk of contracting HIV, and suffer stigma and discrimination and adult women are the most knowledgeable about their HIV status compared to adult men[[84]](#footnote-85).

Men's access to health services is still a challenge. On the one hand, this situation emerges from social norms and expectations that stereotype health care as a women's arena, contributing to dissuade men's interest and demand for health services. Aware of such challenge, the Ministry of Health has developed guidelines for men’s engagement however, effective implementation is still a challenge. The country’s overall policy is rooted on a gender binary understood from their anatomical sex and associated social roles (cis-gender). This perspective loses sight of gender diversity and fails to perceive and include categories such as transgender (except for some interventions in the health sector). This general framework makes it difficult to perceive and guarantee the promotion and monitoring of the rights of people who do not follow the normative pattern of gender but also of heterosexual sexuality.

Sex and gender desegregated data is still a general challenge as, not all sectors perform such desegregation or do not do so for all age categories. Additionally, data analysis rarely cross intersectional features of vulnerability which impacts on effective programming that leaves no one behind.

**Community Systems**

Mozambique formalized the creation of the Community Health Subsystem in 2021 through the elaboration of a subsystem strategy, approved by the Government of Mozambique.

In May 2022, it began the training of Community Health Agents (CHA), funded by the World Health Organization (WHO). The training is part of efforts to expand Universal Health Coverage and strengthen capacity to ensure the continuity of essential health services at the community level as part of Primary Health Care (PHC).

These efforts are part of the objectives of the Community Health Subsystem of Mozambique, to whose development the WHO contributed and contributes to the design of the CHA's training package and funding of the course, with about $33,000 (thirty-three thousand US dollars). The training is the first phase of the implementation of the Community Health Subsystem in Mozambique. A total of 18 CHAs were formed, constituting three categories for (a) case management, (b) disease surveillance, and (c) health promotion.

Other activities of the structuring and implementation in pilot regime of the Community Health Subsystem, are ongoing, since May 2022, financed by the Global Fund, through the financing mechanism C19RM ($4,770,203.61). The activities are specifically framed in the components of planning and governance, training and development of human resources, health information systems, quality, knowledge management and evidence generation and, functionality of the community subsystem, through the payment of remuneration and acquisition and distribution of medicine and work kits to PHC.

Evaluation of the pilot phase of the implementation of the Community Health Subsystem, UNICEF funded pilot phase research, which has been ongoing since May 2022 and aims to inform the implementation of the community subsystem strategy at the national level. The research used a combination of qualitative and quantitative methods and was carried out in six communities in the provinces of Cabo Delgado, Nampula, Zambezia, Manica and Maputo City.

Selection and training of PHC/CHA: the research revealed that 90% of the CHA trained were selected by indication of the community and that community leaders and health units were the main actors in the process. The training included content on structures, governance and coordination and leadership mechanisms, as well as addressing the core health care package and health information and surveillance systems. Only 60% of the participants reported having been discussed with which medications the CHA would work and how they would manage the material and record and report their activities. Similarly, only 60% of the trainers and trainees considered the training time sufficient for teaching and assimilation of the contents of the training. Therefore, some have suggested that the time of training be increased, to include theoretical training (4-6 months) and internship (6 months). More than 80% of the participants found the training package appropriate because it was based on the needs of the population and therefore has the potential to reduce flooding in the health units, given that the CHA/APE will offer the package of essential health care in the communities. Although most participants indicated that they knew the training curriculum, 37% did not have a copy.

The participants indicated several challenges faced during the training, namely (a) poor organization and linguistic revision of the manual, (b) lack of insertion of relevant training modules, (c) lack of medication and material for practical classes, such as sphygmomanometers and mannequins, (d) lack of didactic material and sufficient space for teaching (e) lack of information about ACS/APS medication kit and monitoring and evaluation instruments, (f) lack of professionalism of the trainees, highlighted by the delay and disrespect to the trainers.

Development and implementation of the Community subsystem strategy: most participants agree with the coordination mechanisms of the subsystem, but stress the need for improvement. The participants indicated the involvement of the communities and good communication with the reference health units as potential facilitators of the implementation of the community subsystem strategy. They indicated as barriers, the lack of communication and lack of clarity about the role of each actor, the distance between the health units of reference and the communities attached to it, difficulties in finding CHAs of higher level than the 7th class of schooling, the lack of financial incentives for the ASC and the weak supervision of the CHA.

Hiring, remuneration and distribution of ACS/APS| There is a desire of MISAU other key actors of community health to harmonize the categories of community workers, possibly two broad categories – APEs and ACS – and on the harmonization of their remuneration, based on the minimum wage practiced in the civil service in Mozambique.

In addition, a tool is being developed that will inform the priority in the allocation of community workers (PHC and CHA) by districts and communities, according to criteria that include the ratio of PHC per inhabitant (differentiated by urban and rural areas), districts with records of the three diseases and outbreaks (using as a proxy for outbreaks the occurrence of cholera) and vulnerability index to severe weather events. The tool produces numerical information, illustrated in tables and mapped by district using georeferencing.

The distribution will be phased in per year, with eligible districts and communities gradually included in the community subsystem, with the expectation of covering 40% of the country's population by 2025, as provided for in the Community Subsystem Strategy.

As part of the response to COVID-19, the municipality of Maputo has created community health posts, in which CHWs technically supported by various CSOs provide services, with funding from the World Bank. These community outposts, after the peak phases of COVID-19, have started to provide health promotion services that go beyond COVID-19 and can be leveraged to respond to future public health emergencies and disasters, including outbreaks and pandemics.

# **COVID-19 Impact for TB program**

On 22 March 2020, the Government of Mozambique officially declared the first positive COVID-19 case. As of 12 January 2021, Mozambique reported 21,361 positive COVID-19 cases including cases in every province. As per one study 17 147 new tuberculosis cases were potentially missed, 9 months after COVID-19 onset, resulting in a 15.1% (95% CI 5.9 to 24.0) relative loss in 2020. The greatest impact was observed in the southern region at 40.0% (95% CI 30.1 to 49.0) and among men at 15% (95% CI 4.0 to 25.0). The incidence of pulmonary tuberculosis increased at an average rate of 6.6% annually; however, an abrupt drop (15%) was also observed immediately after COVID-19 onset in March 2020.

**Overall performance of TB program in Mozambique**

Overall performance of TB program in Mozambique as per the GFATM reports if as follows[[85]](#footnote-86)[[86]](#footnote-87)[[87]](#footnote-88).

|  |  |  |  |
| --- | --- | --- | --- |
| **Reporting period** | **Dec-20** | **Dec-21** | **Jul-22** |
| **Average all indicator performance** | 81% | 76% | 89% |

The average all indicator performance has increased to 89%, indicating a good progress.

## Lessons Learned

**Lessons Learned HIV Program**

1. **Expansion of differentiated service models is needed to improve retention and reduce LTFU**

Differentiated service models are client-centred approaches that simplify and adapt HIV services across the entire care and treatment cascade. They reflect the preferences and expectations of various groups of PLHIV, reduce unnecessary burdens on the user and the health system, and redirect resources to those users who need it most. These models aim to improve the adherence and retention of users in care and treatment, reducing the frequency of trips or visits by the user to the HU, increasing the availability of clinicians in order to improve the quality of the provision of clinical services to unstable users. The expansion of MDS in 2020 resulted in an increase and maintenance of patients on ART, and it is hoped that further expansion would help reduce the lost to follow-up and improve retention.

1. **Importance of implementing literacy activities on the part of its beneficiaries.**

At the beginning of the implementation of the first version of the MDS guide, it was not accompanied by a comprehensive approach to literacy activities and demand creation, and in the middle of its implementation required the search for additional funds for the implementation of a campaign for the improvement literacy and demand creation.

1. **The implementation of Differentiated Models started without a robust mechanism for registering and reporting data to monitor its implementation.**

This gap has led to the implementation of ad hoc interventions to ensure the availability of MDS data. Thus, external evaluations are implemented annually to collect data for decision-making, however the coverage of the HU involved in each evaluation round falls short of the total number of HU that implement the MDS. Another data reporting mechanism is through the electronic patient follow-up system installed in US supported by PEPFAR. Although these US cover more than 86% of users, it is not under the direct control of MISAU. Thus, it is important at the beginning of the implementation of each approach, the definition of sustainable and robust monitoring and evaluation mechanisms.

1. **For the implementation and expansion of Advanced HIV disease it is necessary to have a robust distribution and monitoring system in place.**

The Advanced HIV Disease package was implemented first in 2022 in a select number of sites. The package includes testing and treatment for conditions related to low CD4 count, and as such the supply chain and availability of medications at some health facilities has not been up to national standards. With the expansion of the AHD package to the second phase of health facilities, a total of 74, the challenges from the first phase may be more pronounced. It is important to continue to reenforce the supply chain system to allow for improved access to critical medications.

1. **Greater coverage of HIV prevention programs among key and vulnerable populations is needed.**

Low service coverage has hampered the HIV response among key and vulnerable populations. Global Fund supported programs reach about 49,670 FSW, 10,775 MSM, 989 PWID and 5,556 in persons in prison in 2022. PEPFAR partners currently reach about 23,337 FSW, 13,296 MSM, 6,727 prisoners, and 1,620 PWID and 867 TG in 2022. In 2022, the Global Fund reached 325,467 AGYW, PEPFAR reached 258,445, and Rapariga Biz reached 271,304. As presented in Table 1 (page 74), this equates to a national coverage of HIV prevention programs of 32.6% for FSW, 37.6% for MSM, 18.6% for PWID, 57.7% for prisoners, and 26.2% for AGYW. Given that global guidance suggests countries should aim 95% coverage among key populations, and 75% among AGYW, current coverage of HIV prevention among key and vulnerable populations is therefore inadequate to achieve the desired impact— especially given the need for services across many districts, including more rural areas. In close collaboration with PEPFAR, this funding request aims to scale-up key and vulnerable population programs to increase scale, quality, and coverage in priority high-burden locations.

1. **Low condom use is linked to poor information and poor supply in remote rural areas.**

Mozambique’s National Condom Strategy has three main priorities: program stewardship, increased demand and improved supply. Consultations with a wide range of stakeholders point to four main challenges that need to be addressed in order to achieve the strategy’s goals: (1) Limited awareness and uptake of condoms across general and key populations; (2) Lack of data visibility at the last mile; (3) Challenges in distribution and storage of condoms to last mile and (4) Lack of access outside public health facilities.

1. **More targeted HIV testing services are needed to reduce over-testing and increase yield.**

In 2022, Mozambique performed 11,107,217 HIV tests with a yield of 3.6%. This inefficiency is particularly glaring for adolescents, among whom about 2,317,319 tests were performed with a yield of 3%. Further, 4% of those tested were people that had previously been diagnosed HIV-positive. This signals the need to reduce over-testing and retesting through a more targeted approach. Lessons have been learned from experiences with key populations as well as index testing. In 2022, Mozambique tested 163,471 key populations with very high yields among FSW (11%), MSM (15%), PWID (13%), mine workers (14%), and in prison (8%) (Figure 20). Index testing to sexual partners and mother or father of infant less than 15 year was the most efficient modality, with an HIV positivity rate of 22% and 28% respectively. This funding request prioritizes targeted testing to these populations, using index and self-test modalities (see self-test lesson below).

**Figure 11.** HTS positivity among key populations (left) and index clients (right) in Mozambique, 2022

|  |  |
| --- | --- |
|  |  |

1. **HIV self-testing is a viable strategy to reach men and young people, but counselling is needed.**

In 2022, Mozambique distributed 203,966 HIV self-test kits of those 34% were among adolescent, following by sex worker (19%), general population (18%) and men, 25+ years old (13%). Most of HIVSF beneficiaries had their last HIV test more than 12 months (29%), followed 28% between 4-12 months ago, and 16% never been tested for HIV in your life. These results suggest that HIV self-testing is a viable strategy to increase demand for HTS and reach men and young people in Mozambique, however, the increase in people being tested for HIV by an HIVST confirmatory should be monitored.

1. **Although Human Rights training at health facilities are become more inclusive, their limited scope and poor expansion to all health units jeopardizes its efficacy**

Human Rights programs remain limited and expansion of training of health providers on Stigma and Discrimination and Human Rights is needed. Only 234 health facilities were trained representing 14% of the ART sites, thus the training package was converted to the “Tele-saúde” platform to maximize access to training for health providers assigned to US offering ART services. About 50 health providers, 5 HF in Maputo City and Maputo Province, have also been trained in sign language. To maximizing community dialogues for key populations, a standardized tool for the activity has been developed. The charter of rights and duties of users is in the process of revision. Health providers have also been trained in care of gender-based violence victims in coordination with the Ministry of Gender and Home Affairs. There is urgent need to expand theses services to additional health facilities where ART is offered.

1. **National updates to pediatric treatment norms are essential for quality of care, but a detailed transition plan is needed.**

During the 2020-2023 grant term, the country had the need to change the norms for ART in children, to follow WHO global guidelines. The guidelines recommended the use of pDTG 10mg in children < 20kg, DTG 50mg in children from 20 – 29.9 kg and TLD from 30 kg onwards. These medications substantially improve quality of care for paediatric beneficiaries. However, this guideline was not accompanied by the immediate availability of the pDTG 10mg formulations and the respective dosages, which led to the need for adaptations to its implementation in the country. This adaptation was based on available medication in country while the transition was happening in the country. The phased transition may have led to waste of some older regimes, including LPVr 40/10mg. For future norm updates, the country must be prepared before initiating the process with both the medications and funding for trainings, supervision visits, and mentoring in order to avoid the identified issues in the last norms update.

1. **DUO testing for Vertical Transmission (mother to child) has moved the country towards vertical transmission elimination.**

The introduction of the DUO test for HIV and Syphilis reduced the missed opportunity for syphilis testing at the first ANC and allowed the identification of infected PW and their timely treatment, with coverage of Syphilis testing in PW having evolved from 46% in 2014 to 79% in 2022. There was also an increase in the treatment rate from 85% in 2019 to 95% in 2022.

Although challenges persist in offering HIV prevention care, progress has been made in reducing the vertical transmission rate from 17% in 2014 to 10% in 2022. Strategies such as mentor mothers and mother-to-mother groups have contributed to improving retention of HIV+ PW and mother-child pair to care and treatment, treatment adherence, and viral suppression. The introduction of enhanced prophylaxis with AZT and NVP in 2019 for 12 weeks, and the introduction of PCR testing at 9 months also contributed to the reduction of VT.

The development of quality improvement plans by the health facilities based on the performance of the indicators and the identification of the root cause of the problem associated with their poor performance, allowed the health units to implement specific interventions to respond to their main challenges in their context.

1. **Scale Up of Quality Improvement approaches improves beneficiary care in health facilities.**

The implementation of the PDSA Cycles reinforces the Health Facilities team's commitment to offering services according to national protocols, as it allows the HF teams to self-assess the quality of the services, they provide in the follow-up of HIV+ beneficiaries, help identify root causes of the problems that are compromising the quality of services and test solutions that can be implemented under US control.

The implementation of the Intensive Monitoring approach contributes cross-sectionally to improve the ownership of the action plan by the HF providers, as the team meets monthly to discuss progress and monitor the mechanisms for implementing the solutions described in the action plan.

In the approach of Engagement of the user and their communities, in the consultation meetings held in the community, the groups of pregnant women, breastfeeding women and adolescents participate less actively than in population-based meetings in which only they participate (focused of specific subgroups).

1. **There is need to make stronger alliances at community level for significant impact on gender norms**

The negative approach and framing of local practices and norms and intervention approaches that vilify respected institutions at community level (such as initiation rites) is not effective. Future approaches should secure partnerships, cooperation and use more positive language to engage with locally respectable institutions in order to promote and achieve the desired changes.

Interventions that solely focus on AGYW and women are ineffective as they only empower one specific group that has to continue living and interacting with a group that remains ignorant about issues related to rights and equity.

**Lessons learned TB program**

**1. Diagnosis, treatment and care of tuberculosis**

TB notification has steadily increased, as demonstrated on Context section. In addition, there have been advances in community referrals by activists or community health workers, intensified screening in health facility waiting areas (by cough officers), and expansion of diagnostic capacity through the deployment of diode microscopy. light emitter (LED) and GeneXpert machines have contributed to the increase in case reports. Despite the increase in the TB notification rate, the proportion of bacteriologically confirmed TB cases remains low, at 42% in 2022. Of the notified TB cases, only 46% of the total were diagnosed with rapid diagnosis in the same period. Some factors that contribute to low bacteriological confirmation include low quality samples due to multiple factors to be analyzed in the diagnostic cascade from sample collection to processing.

Similarly, to what happened globally, the outbreak of the COVID-19 pandemic set back the progress made in reporting TB cases in the country, with a reduction of 15% from 2019 to 2020.

According to UNHLM targets, in 2022, 34,300 cases of TB were estimated in children aged 0-14 years. The Ministry of Health notified 13,664 cases (12% of the total number of notified cases), which represent only 40% of the estimated cases. 13% of cases reported in 2022 in the 0-14 age group were bacteriologically confirmed. Insufficient coverage of health units with the technical and material capacity to collect pediatric samples (induced sputum and gastric aspirate), as well as the poor quality of the samples collected, constitute challenges for access to universal testing of presumptive TB children with Xpert MTB RIF ultra as the first diagnostic test. Despite the progress made with the increasing trend in TB case reporting over the last 5 years.

**2.** **Diagnosis, treatment and care of drug-resistant tuberculosis (DR-TB)**

The prevalence of MDR-TB in Mozambique is 3.5% among new cases and 11.2% among previously treated cases, and around 4800 cases of MDR-TB are estimated annually.

In the last three years, the country has evolved in terms of treatment coverage for these types of patients by around 2%, having gone from 28% in 2020 to 30% in 2022. We registered a significant improvement in the treatment success rate, with an increase of 65% in 2020 to 75% in 2022) thus reducing the proportion of patients who are lost to follow-up. Innovative interventions were carried out to achieve the results described above, such as the involvement of activists in the search for MDR TB cases through contact tracing of index cases and support in monitoring treatment at community level using Pillboxes for storage and storage of patient medications.

Additionally, in some provinces such as Inhambane (FG), Zambézia (USAID) social incentives were awarded in 2021 for all patients with MDR TB and this intervention was expanded in 2022 to the province and Maputo City. In these provinces, it was possible to verify that in the intermediate evaluation of patients, there was a reduction in patients lost to follow-up. Although ongoing interventions show some positive results, challenges persist mainly in the search for lost cases, the program continue to lose the opportunity to identify about 70% of patients with MDR TB in health services and community, high mortality rates still

prevail (12%) and loss to follow-up (8.4%).

To train providers to improve their competencies in clinical and programmatic management, aligned with WHO latest guidelines, still to incorporate into national guidelines, is critical to the success of treatment and overall program interventions. The high turnover of health professionals also leads to the continuous need for training providers, at the different levels of health care.

The high burden of drugs for TB DR-TB treatment remains a challenge, and its success requires, among others, operational research and adoption of treatment regimens that are more tolerable (short and with fewer drugs) and made available in order to ensure a better understanding of the patient and/or caregiver, facilitating the intake of drugs at the appropriate frequency and dosage (ex: use of pillbox), and contributing to improve the treatment adherence.

As part of the NTP accelerated response to reduce the burden of TB in the country, the Center of Excellence for Resistant and Pediatric TB (CoE), was inaugurated on April 2022, to provide quality TB care for hospitalized and ambulatory patients, HF training and generation of evidence to inform national policies and guidelines for TB control in the country. The treatment adherence challenges, that can be related to patient, drugs management system, or the pharmaceutical product (e.g., adverse reactions, drug interactions) are factors that negatively influence the treatment success, and require a system of surveillance and further investigation in our context through the conduct of research to better inform decision-making.

**3.** **Prevention of TB/DR-TB**

For some time now, the country has been implementing activities aimed at reducing the burden of TB among risk groups. One of the key interventions is offering TPT to contacts of patients with pulmonary tuberculosis, under 15 years of age, and to HIV-positive people who do not have signs and symptoms of tuberculosis.

Initially, the TPT was offered to contacts of an index case with TB under 5 years old, but after the WHO review, the country extended the TPT to children aged 5 to 14 years. In addition, in 2021, new preventive treatment regimens such as 3HP were adopted, which are currently implemented in 4 provinces in the southern region.

With the adoption of this short regimen and the implementation of the approach of starting TPT in the community through mobile brigades, the number of children submitted to TPT has registered a considerable increase, having gone from 27,393 in 2020 to 71,003 in 2022, however, problems of inclusion of children still persist. children for the TPT and its completion. However, despite the fact that the TPT has been adopted for contacts of patients with MDR TB using levofloxacin, the inclusion of these contacts is weak and we have challenges for their monitoring due to the lack of up-to-date instruments.

**4. TB/HIV**

HIV is still one of the main drivers of the TB epidemic in Mozambique. The country shows a steady decline in the co-infection rate in newly diagnosed TB patients, although there are wide variations between provinces. The southern provinces namely Maputo City, Maputo Province and Gaza have a high co-infection rate of around 55%. While Inhambane and Sofala, provinces in the middle zone, have a co-infection rate of around 40%, it varies between 20% and 33% in the northern provinces. HIV testing rates among reported TB cases and ART treatment in co-infected individuals are high, both above 95% (Figure 2). However, routine TB screening in this group and TPT onset and PLHIV completion rate are still low.

**5. Quality Improvement**

The PNCT has implemented several strategies for TB control in the country, however gaps persist in the quality of provision of screening, diagnosis, treatment and patient monitoring and prevention services. Tuberculosis quality improvement initiatives started in 2020 with the implementation of clinical tutorials in 44 Health Units. Clinical mentoring is currently implemented in 132 high-volume health units nationwide. Each province has tutors trained at the central level and makes 2 visits per quarter to the health units. Clinical competency and psychosocial support checklists are used for competency checks of front-line clinicians (adult and pediatric) as well as providers in the TB treatment sector. Different areas of competence are evaluated, namely screening and diagnosis, treatment of sensitive TB, treatment of resistant TB and treatment of pediatric TB. After the basic assessment of competences, the tutor draws up a training plan and continuous support to improve the mentee's competences.

During implementation (2020-2022) 99 provincial tutors were trained, clinical tutoring was carried out in 132 health units. This investment resulted in the improvement of the technical capacity of the health professionals in these HUs, in the improvement of the quality of the follow-up of patients with TB translated by the standardization of the performance of the follow-up consultations, improvement of the monitoring and clinical and laboratory follow-up of the patients.

The implementation of the quality improvement cycles started in 2021, and is in a pilot phase in 8 Health Units in the provinces of Maputo and the city of Maputo. 45 health professionals from provincial, district and health units in the 2 provinces were trained. After training, each Health Unit carried out a situational analysis and identified the worst performance indicators. There was a discussion and analysis of the root of the problems and brainstorming of possible solutions to the problems. Each health unit prepared a plan to improve the worst performance indicators. Intermediate and final assessments of each cycle were performed in the third and last month of each plan.

Recognizing it as a strategy that has the potential to leverage TB control in the country, the preparation of a National Quality Improvement Guideline is underway, which constitutes a document that standardizes implementation so that all key players at national level can coordinate, implement and monitor and evaluate the quality improvement package.

Regarding the quality of follow-up of patients with MDR TB, the country recently inaugurated the center of excellence for MDR TB, which intends to offer quality services for MDR TB by training providers to improve their skills, not only clinical, but also investigations for the implementation of operational research to generate evidence that can ensure the safe adoption of WHO recommendations and test new approaches identified to respond to the country's challenges.

Additionally, due to the high turnover of health professionals there is a continuous need to train providers in the clinical and programmatic components of TB and address the different co-morbidities most common in this type of patients and ensure psychosocial support.

**5. Laboratory services**

The laboratory represents a key element for the success of interventions made for TB control, which involves having a robust and functional diagnostic network and guaranteeing conditions for a quality diagnosis. One of the pillars for achieving this objective is the collection, conservation and adequate transport of samples, which makes it essential to acquire refrigeration and sample conservation equipment such as glaciers and colmans to reduce the number of contaminated and discarded samples and, consequently, loss of opportunity. of testing patients.

The implementation of TB testing using Truenat will allow for an expansion of diagnosis to remote regions (perpheral US), ensuring greater access for patients close to their communities of origin.

The introduction of GeneXpert MTB/XDR will be essential to reduce the response time in diagnosing patients with Isoniazid mono resistance and with FQ resistant, guaranteeing early treatment in this group. We will also be able to reduce the number of tests carried out in reference laboratories

The purchase of consumables, laboratory equipment and maintenance of equipment will allow for proper functioning, a flow of functional testing and continuous TB diagnostic services in laboratories.

With the introduction of GeneXpert MTB/XDR, Truenat will be instrumental in training laboratory technicians in testing and correctly interpreting results. The diagnosis of TB using stool samples will contribute to the increase of diagnosed cases of children with TB as this represents an important target group but difficult to diagnose due to the nature of paucibal samples.

The expansion of fluorescence microscopy in the diagnostic network associated with the high turnover of technicians makes training in iLED Microscopy essential in order to guarantee quality diagnosis in the laboratory network. Diagnosing TB in patients with advanced HIV disease using the TB LAM test is an important tool for increasing cases diagnosed in this group of patients.

With the introduction of new TB diagnostic technologies (Genexpert MTB XDR, Truenat, use of feces for diagnosing childhood TB, TB LAM, etc.), there will be a need to monitor activities in laboratories in order to guarantee standardization in procedures and issuing reliable and quality laboratory results.

One of the great challenges faced is the management of laboratory information, with the training of technicians and laboratory logistics managers in filling out and sending LMIS reports using the Web/Link system this gap can be overcome since the central level will have real-time information on the stock of consumables, reagents and all HU information.

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The National Institute of Health (INS) is a national reference institution that seeks regional and international recognition. INS created the National Program for External Quality Assessment (PNAEQ) with the main objective of ensuring the continuous improvement of testing quality comparable to international standards in all testing sites in Mozambique. The uninterrupted participation in the External Quality Assessment Program should be considered a fundamental element in the continuous improvement process, as the program helps in identifying the presence of possible analytical errors, enabling the laboratory to implement corrective actions to eliminate the causes of these errors. In addition to the aforementioned benefit, it allows identifying the need for training, compares and validates test methods,

However, it is a priority that all testing sites participate in a quality assurance program, thus ensuring that patients receive reliable and timely results and that public health programs and actions are based on genuine results for decision making. The creation of Provincial Quality Assurance Programs (PPGQ) represents a strategy aimed at expanding access to programs that guarantee quality laboratory testing. To that end, there is a need to expand and strengthen these programs through centralization in the provincial Public Health Laboratories. Investment in the technical competence of those involved is a success factor for this activity.

Improving the quality of testing should be considered an ongoing activity. The INS has provided proficiency testing twice a year to 81.6% of the sites that perform tuberculosis testing through microscopy and 100% through the Xpert MTB Rif technique. Based on the results of these schemes, locations in need of technical support are identified. Technical Support visits are crucial for improving the performance of health professionals and, consequently, of the laboratory system. In the last 3 years, there has been an improvement in the performance of sites that carry out testing through microscopy. However, there was a slight decrease in performance for sites that perform testing using the Xpert MTB Rif technique. Given the results, there is an urgent need to carry out technical support visits in order to carry out a deeper investigation of the possible causes that may be influencing the decline in performance and to strengthen the sites, maintain and strengthen these results. In addition to these challenges, there is a need to expand the coverage of proficiency programs, allowing more places that carry out testing to participate in this program, thus guaranteeing the quality of the reports. Decentralization, a process that consisted of creating provincial quality assurance programs to provide external quality assessment schemes with the aim of increasing the coverage of testing sites, was a gain, however, the need to maintain and strengthen these programs. However, it is essential to gain and transmit confidence in the execution of these activities through international recognition by confirming the existence of a level of technical competence.

**6. Key and vulnerable populations**

Country data revealed a higher burden of TB in key and vulnerable populations (KVP), including household contacts of index TB cases. The graph below shows the contribution of KVPs to TB notification over the years. About 30% of the remote population does not have access to health facilities, which also includes TB.

**7. Remove human and gender barriers to TB services.**

Addressing TB, HIV and gender and human rights challenges are closely linked. TB is a disease of poverty and inequality, and there are different factors related to human rights and gender that can undermine the effectiveness, accessibility and sustainability of TB programs and services, among which are: poverty, co-infection TB/HIV, gender inequalities and norms, stigma and discrimination, involuntary isolation, population mobility,

The “Stop TB” Strategy, proposed by WHO, proposes to eliminate the epidemic by 2035, with United Nations actions based on the Sustainable Development Goals (SDGs), which include a 90% reduction in deaths from the disease by 2030. The agenda of the SDGs promotes the elimination of poverty, equity, justice and human rights in order to provide better services to the most vulnerable populations. The Universal Declaration of Human Rights reaffirms that all basic rights must be guaranteed by the State.

In the survey on Communities, Right and Gender (GRG), carried out in 2020, in the country, the results showed that there is low knowledge about TB, limited geographic coverage of the health sector, widespread poverty and marginalization of vulnerable groups, high prevalence of stigma and discrimination. Complementary research to the CRG is currently underway in the country, as is the case of Barriers to accessing Tuberculosis services related to Human Rights at the level of Health Units and the Study of the Index of Stigma and Discrimination in people affected by Tuberculosis. With the results of these studies, it is expected to obtain information for the design of actions more adjusted to the Mozambican context.

In the meantime, guided by global documents and some local data, the country has been carrying out some interventions aimed at the provision of interventions that go beyond the availability of screening, diagnosis and provision of medical and drug treatment for patients, giving increasing attention to the respect and dignity of patients and their families. Some of these interventions are implemented at health facilities and community level, with support from partners such as CCS, Namati and ADPP. Through its interventions, it has been possible to access some of the violations of patients' rights and their respective legal referral.

Additionally, in order to improve treatment results, especially with regard to Multidrug-resistant Tuberculosis, interventions aimed at providing psychosocial support at the Health Unit and community level, for patients and their families, are privileged, according to three main pillars:

1. Informative support about the disease and treatment
2. Psychological and emotional support
3. material support

In this context, interventions in the Psychosocial Support Manual for the Management of Patients with Tuberculosis were prepared and are being implemented. Aspects such as the standardization and quality of provision of these services continue to be a challenge. Recently, the country carried out a study of the direct costs linked to the treatment of Tuberculosis, whose results showed higher unemployment rates in patients with Tuberculosis, compared to the average annual rate in the country; Tuberculosis was associated with the loss of the school year, food insecurity, job loss and social exclusion. These data reinforce the need to strengthen the social protection mechanisms for patients and their families, with their inclusion in the different packages of services provided in the Mozambican state.

**8. TB services and mental health**

Mental disorders are beginning to be a component to be considered in the treatment of patients with tuberculosis, since the disease and the drugs used in these situations are related to some common mental disorders such as anxiety and depression. The implementation of mental health approaches, aimed at responding to the demands of common mental disorders, is beginning to be highlighted in interventions by the National Tuberculosis Control Program in the country. To this end, in 2022, the country trained part of the mental health technicians in interventions to address common mental illnesses, alcohol abuse and suicide attempts, and all aspects related to its implementation are currently being evaluated, for subsequent expansion to other health units in the country.

**9. Monitoring and Evaluation**

* **Data collection and management:** using standardized data collection tools, training the TB technicians is a key to ensuring data quality and integrity. Utilizing electronic data systems for efficient data management and regular data audits and validation processes also contribute to maintaining data reliability. With the result shown during the partial implementation of electronic patient records, the NTP plans to leverage the use of electronic tools to build a surveillance system and reduce data issues occurring during the data entry process
* **Routine reporting and feedback:** Establishing regular reporting and feedback mechanisms is crucial for continuous monitoring and evaluation of TB activities. The need for timely reporting of program data to relevant stakeholders, such as national TB programs and funding agencies and building a robust system with clear monitoring and evaluation pillars is key to align and strengthen the monitoring and evaluation system. Building from a landscape analysis a monitoring and evaluation is key to structure the M&E activities, responsibilities and key aspects to provide clear updates to stakeholders, healthcare providers, program managers, and policymakers promotes accountability and supports evidence-based decision-making.
* **Data analysis and interpretation:** Analyzing and interpreting TB data effectively is essential for deriving actionable insights and informing program improvements. Using a data analysis and visualization platform (PAAD) has proved to help the NTP reduce time they take reviewing data discrepancies, providing the facility of narrowing down data points with issues and facilitating the correction of data. With the facility to triangulate data from different data sources, the platform has helped and facilitated complex analysis and building infographics easily. Data use sessions with focus to routine data would be the focus now to leverage the data analysis and interpretation to inform decision-making.
* **Evaluation studies and operational research:** Conducting evaluation studies and operational research provides valuable insights into the effectiveness and impact of TB interventions. The NTP will leverage the importance of integrating evaluation and research components into the TB program, utilizing findings to inform programmatic decision-making and policy development. The program will continue working on planned studies to bring more evidence and inform policy making. based on the great results of the prevalence survey, the country will start the preparation on the second study in 2026
* **Feedback loops and learning culture:** Creating feedback loops and fostering a learning culture within TB programs support continuous improvement. Establishing mechanisms for regular feedback to healthcare providers, sharing best practices and lessons learned across program sites, and creating platforms for knowledge exchange and peer learning. The NTP will learn from other programs and consider implementing a tailored feedback mechanism to help and provide constructive and adequate feedback to the health workers as well as collecting feedback from patients through community led monitoring activities.

**Supervision and supportive supervision:** Regular and supportive supervision of healthcare providers is essential for ensuring adherence to guidelines, addressing gaps in performance, and promoting continuous quality improvement. With a comprehensive supervision tool, the program was able to identify and pinpoint challenges in service delivery. Based on the result, the program was able to structure a tailored support package to respond to the needs of health workers. With the use of the standardized supervision tool, the program was able to provide constructive feedback and mentoring. NTP will use electronic supervision tool to help track supervision findings as well as informing actions to be taken facilitating information within the team.

**Data-driven decision-making:** Using data to drive decision-making is critical for improving the quality of TB services. The program has been improving in collecting, analyzing, and utilizing data to identify gaps, track progress, and inform programmatic changes, NTP will continue conducting programmatic data quality assurance (DQA) with special attention to data review, triangulating the different data sources. NTP will also use an electronic platform to conduct data quality assurance. Regular data review meetings and data feedback loops should be established to engage healthcare providers and managers in quality improvement efforts.

**Innovative TB interventions at community level**

MoH and partners coordination is key for an effective implementation of community activities. Between 2018-2023, TB related community interventions expanded the outreach and geographic coverage up to 123 districts in 10 provinces (73 districts supported by GF and 50 districts) funded by USAID. This geographic distribution of community partners it’s an important milestone to avoid duplication of effort and improve district coverage when compared to previous models of division of implementation sites. The systematic coordination among all stakeholders involved in TB response at community level, led to the development and approval of a standardized National Guideline for implementation of community activities, describing a package of key and complementary services to be implemented by all stakeholder working at community.

During the 2020-2023 period, new, innovative approaches for community interventions were implemented in a piloting scale with encouraging outcomes**: i)** Identification and training of TB Champions in Inhambane (2022) contributed to increased notification and greater acceptability of caregivers in taking children to US for TPT. TB Champions activities included: Conduct a conversation about TB involving other members of the community; Support the ACS in identifying presumptive TB cases in their community; To raise awareness among TB patients about the importance of TB contact tracing; To sensitize TB patients to allow their children from 0 to 14 years old to undergo TPT; Encourage patients to start and stay on treatment; Encourage active partner involvement in TB treatment. **ii).** Initiation and monitoring of the TPT in the Community (Q2 2022 and 2023) to cover children whose caregivers complain about the distance and lack of transport to take them to the Health Facility. This activity was carried out on the monthly cough days with involvement of health providers, community activists and paralegals. **iii).** Assignment of the basic subsidy to patients with MDR-TB and Pediatric in 3/7 provinces (2022 and 2023) to reduce catastrophic costs in the search for TB services and improve adherence to treatment. Other lessons learned from the implantation of community interventions include the effective reorganization of community activities to mitigate the effects of COVID-19 (Identification of presumptive TB cases in the HU pre-screening for COVID19; FAST implementation using ACS (scale of ACS in US); Reminder and support calls for DOTC patients; Calls for pre-abandonment, missing and lost follow-up; DOTC for patients who could not go to Health Facility.

## Focus of Application Requirements

As Mozambique is a lower income country with a high HIV and TB disease burden, this funding request is consistent with the focus of application’s requirements and has almost 50% of the allocation on TB and HIV specific interventions. The application includes interventions and activities that promote equity, responding to key and vulnerable populations needs, human rights and gender-related barriers, inequities and vulnerabilities in access to services.

The HIV and TB modules and interventions are aligned to the disease NSP and the latest HIV specific prevention and treatment guidelines.

Analysis of the program's context, using routine HIV and TB program data, program evaluations, epidemiological data, Spectrum estimates and other documents were used to prioritize and plan. The prioritized interventions also include activities that aim to remove human rights and gender related barriers and reduce inequities in access to HIV and TB services. This will allow the country to maintain and expand program coverage, strengthening the sustainability of community and health systems, maximizing the impact of available resources through greater efficiency, effectiveness and equitable use of these resources.

The FR took into account the synergies and complementarities with other sources of funding and investments, with emphasis on PEPFAR. In order to maintain gains and achieve value for money, for HIV the country team used NAOMI subnational data analysis was used for AGYW. The FR prioritized investments in HIV prevention for KP, AGYW and sexual partner priority area and priority HIV pre-exposure prophylaxis (PrEP), as recommended in the allocation letter.

A significant amount of the allocated funds has been directed towards supporting TB program essentials and critical interventions that target TB among key and vulnerable populations and aim to address TB-related issues such as TB and MDR-TB (Multidrug-resistant tuberculosis) diagnosis and treatment, community TB care, TB/HIV co-infection, engaging public and private care providers and removing human rights and gender barriers.

Part of the allocation amount has been dedicated to prioritizing RSSH interventions with a primary goal of enhancing the resilience and sustainability of the country's health systems.

## Matching Funds (if applicable)

* + 1. *Describe how integrating the Matching Funds will increase the impact and improve the outcome of the allocation for the Matching Funds area.*
    2. *Describe how programmatic and access conditions have been met.*

1. **Find and treat the missing people with drug-susceptible TB (DS-TB) and drug-resistant TB (DR-TB)**

Mozambique’s allocation letter spells out three programmatic conditions to access $4 million USD in catalytic matching funds to find and successfully treat the missing people with drug-susceptible TB (DS-TB) and drug-resistant TB (DR-TB):

* Scale up of innovative approaches to accelerate progress to find and treat the missing people with DS-TB and DR-TB, based on the country context and lessons learned;
* Alignment with priority interventions on TB screening and diagnosis outlined in the Global Fund’s TB Information Note; Monitoring of progress in finding and successfully treating the missing people with DS-TB and DR-TB, including through grant performance reporting.

Furthermore, Mozambique must invest a portion of its TB allocation that is greater than or equal to the amount of available Matching Funds, to find and treat people with DS-TB and DR-TB, focusing on specific interventions and/or populations to be agreed during country dialogue.

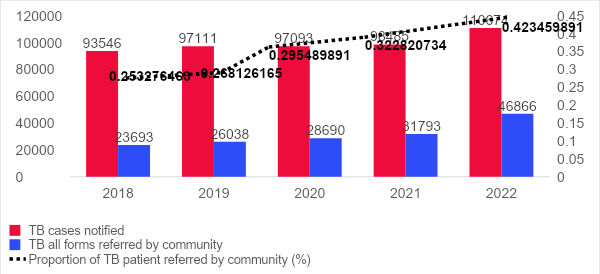
Mozambique has a good TB All Forms (AF) coverage rate of almost 85%, finding and starting treatment about 98,485 out of an estimated 116,000 incident TB cases in 2021. However, the TB bacteriologically confirmed coverage rate is much lower given that only 38% of pulmonary notified cases were bacteriologically confirmed in 2021. This suggests that there is a gap of about 15-20,000 bacteriologically confirmed TB cases annually in Mozambique (if we use a target of ~60%) and that there is an over reliance on clinically diagnosed TB. It is clear that the quality of TB diagnosis needs to be strengthened.

To find these missing bacteriologically confirmed TB cases Mozambique will leverage lessons learned from prior interventions, scale-up a number of promising strategies and introduce new innovations across the TB screening, diagnosis cascade. On the other hand, the diagnosis of multidrug-resistant tuberculosis continues to be a challenge, around 70% of the cases predicted annually are not diagnosed, and this low detection may be influenced by the low diagnostic confirmation. In 2021, 1366 cases were diagnosed and reported, which corresponds to 28% of the 4800 expected cases.

Overall, the TB All Forms treatment success rate is excellent at over 90%, and MDR-TB treatment success rates have increased notably in the last several years to 72% in 2021, and will continue to improve with shorter and more effective DR-TB treatment regimens and better patient follow-up and support. The core TB proposal highlights a number of critical activities for laboratory diagnosis including expansion and adequate maintenance of the GeneXpert network, and introduction of TrueNat testing to expand access to the network of WHO approved rapid molecular tests for TB. Combined with the new national AMOSTRA sample transport system this should provide universal access to rapid molecular TB tests with a rapid turnaround for all individuals with presumptive TB in Mozambique. This is critical for ensuring high quality molecular TB testing with additional rapid molecular drug resistance testing to ensure that the country finds the large number of missing DR-TB cases, including for mono-resistant Isoniazid. The regular allocation investments in these areas should count towards the matching requirement, specifically for new testing platforms like TrueNat.

Prior to COVID Mozambique was seeing a 10-15% annual increase in TB notifications. With the outbreak of the COVID-19 pandemic, the country’s TB notifications flat lined, and a recent paper estimated that the country would have notified another ~17,000 TB cases if COVID had not happened. Looking at the low quality of TB diagnosis, Mozambique plans to use the TB matching funds to primarily focus on expanding access to high quality TB screening and to appropriately identify a larger number of presumptive TB patients, collection of sample with quality, by enhancing technical capacity, and submit to rapid molecular tests for TB and for drug resistance. This is the only way to find more BC TB cases, and more DR-TB cases. The recent TB prevalence survey showed that 40% of patients with confirmed TB do not report symptoms of TB but have an abnormal chest X-ray (CXR) which was detected using CAD. The country has made substantial investments in dXR and CAD systems both in the current GF grant, C19RM grant, and with support from USAID, the World Bank and others. The NTP is actively updating TB screening algorithms to include the use of WHO and Global Fund recommended dXR and CAD for TB screening, particularly for priority populations such as PLHIV, TB contacts, HCWs, miners, prisoners etc. This matching fund proposal will also support the use of mobile vans with dXR, CAD, GeneXpert to screen prisoners, IDPs, miners in targeted areas, and the use of portable dXR and CAD systems, TrueNat as part of district level cough days. The program will leverage mass media campaigns to inform and advertise this activity within the community.

Part of the reason for the major increase in TB all forms notifications over the last decade has been the investment in a cadre of TB CHWs and a community TB strategy. This started with USAID supporting TB CHWs in just 4 provinces, in the 2000’s, but started to reach scale in 2018 with a GF grant to CCS to support TB CHWs and community TB activities in six additional provinces, with the World Bank supporting this in one additional province. While all eleven Mozambican provinces had a community TB partner over the last 5 years, whose combined efforts contributed up to 25-40% of notifications in their implementation districts, these partners did not support all districts nor all health facilities. With these $4m in matching funds Mozambique proposes to increase the number of districts that will have a TB community partner from about 123 districts currently, to all 155. This will increase the geographic and technical capacity reach of community TB activities, including TB screening, contact tracing, TPT referral for eligible contacts, and community-based treatment support for TPT, DS-TB, and DR-TB. As a result of this increased geographic expansion, the NTP expects to increase total BC TB notifications by 7,000 cases annually in these 24 districts. The following graph shows the increased contribution of community actors in TB notifications in all forms – the goal is for this to also ensure higher quality TB diagnosis with increased absolute numbers and rates of BC TB. TB CHWs can support higher quality sample collection (by providing guidance to clients about how to provide a good sample), sample transport from the community to the nearby health facility, which has access to the AMOSTRA project, and soon a fully functional GeneXpert network. If/when these samples test positive for BC TB, TB CHWs are also a critical component of finding the client, informing them of their result, and ensuring that they get to a health facility to be evaluated and to start TB treatment.



The TB Community package has been further strengthened by fostering stronger links between the TB CHWs and the health facility, especially the NTP and the CCR where children are started on TPT. At the facility level we have noted significant variability in the FAST strategy, with some facilities having GRM staff that work as part time cough officers, some sites having partner supported cough officers, and some sites having none of the above. As part of the standard Community TB package, we will work with district, facility staff and the community TB and other health partners to ensure a more uniform approach (this continues to evolve, and will be further developed during grant making in partnership with NTP, CCS, USAID/LTBR and the PEPFAR implementing partners), and that FAST activities are happening at all sites with quality, having an impact, and if needed will be provided by the community TB partner. The matching funds will also support the hiring of cough officers to cover the gaps observed throughout the country.

Over the last three years Mozambique has seen a major shift towards decentralized drug distribution for HIV medications, in part catalyzed by the COVID pandemic. As a result, many HIV clients are getting community, private pharmacy, or multi-month distribution of ARVs, and are having fewer facility based clinical consultations. This has reduced the frequency of TB screening in PLHIV, which has historically primarily been done at the facility level. With these matching funds we work with the MOH HIV program, our TB and PEPFAR partners to strengthen TB screening for all PLHIV and so that it is happening whenever ARVs are being dispensed and that effective M&E systems are in place to document it. This will include training HIV CHWs, pharmacists, mentor mothers, “Male champions”, Adolescent Mentors and other staff to ensure high quality TB screening in this high-risk group, and if indicated the use of dXR and CAD, particularly for newly diagnosed HIV clients. This will leverage investments in these different cadres of HIV CHWs, mentor mothers, male champions, and other providers in the HIV allocation.

With support from the GF and the NTP, CCS has started an initiative of using TB survivors’ “TB Champions” as a cadre of community members that educate their community about TB, screen individuals for TB, provide support for clients on TB therapy, and who form the basis of a much-needed TB civil society advocacy group. With matching fund financing the NTP proposes to expand this initiative from 14 to 97 districts.

Current NTP instruments do not capture the contribution of the private sector for TB notifications. While this is thought to be less of a source of TB notifications in Mozambique due to a limited network of private healthcare clinics mostly confined to provincial capitals, there are likely some TB cases that are being missed, or which are treated in the private sector. Updated NTP instruments, which will be rolled out next year, should better capture this contribution. Mozambique also has a large population of traditional healers, a formal network of over several thousand, and some studies suggest that up to 25-30% of patients with symptoms of TB first visit a traditional healer in Mozambique. In the Mozambican context we should consider both traditional healers (which can be considered part of the “community TB cadre” but more “private sector”), and some religious organizations along with larger for-profit companies such as Mozambique Leaf Tobacco etc. as “private” and not part of the formal public health system. These groups will be targeted for a public-private approach for TB screening, referral and diagnosis. Part of the community TB package will be to engage with the relevant private sector actors and companies in each district to increase access to TB screening and diagnostic services.

The table below describes specifically how the programmatic and access conditions have been met.

|  |  |
| --- | --- |
| **$4m TB Matching Fund Conditions** | **Mozambique TB Matching Fund Request Justifications** |
| Invest the same or more than $4m in the regular allocation for*: to find and successfully treat the missing people with drug-susceptible TB (DS-TB) and drug-resistant TB (DR-TB)* | Current Allocation for TB:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Module** | **Intervention** | **Activity/Commodity** | **Total cost related to TB case finding and applicable towards the TB MF** | **% for TB Case finding** | **Cost of Activity/Module** | | Tuberculosis Diagnosis, Treatment and Care | TB screening and diagnosis | Hiring activists for community contact tracing of index TB cases will also be strengthened  ACSs Salaries | USD$5,171. 992.36 | 40% | USD$2,068. 796.94 | | TB screening and diagnosis | Hire cough officer to support TB screening, case finding at the HF | USD$201,029,27 | 100% | USD$ 400 878 | | TB screening and diagnosis | Initial Training for CHW (activist) on TB and MDR-TB | USD$987,815.29 | 40% | USD$395,126.12 | | TB screening and diagnosis | Provided training in sample collection, including pediatric sample collection procedures, including feces (covering sample collection, storage, and transportation and processing). Training shall be aimed at both clinical and laboratory staff. | USD$904, 407.20 | 50% | USD$452,203.60 | |  | TB screening and diagnosis | Provide TB activist working kits to conduct TB community screening activities;  Kit Actores Comunitários ACS | USD$239, 265.58 | 40% | USD$239 265,58 | |  | TB screening and diagnosis | Mass media campaigns | USD$241,727.71 | 50% | USD$121 363,86 | |  | TB screening and diagnosis | Perform monthly days of coughing using Mobile TB services with existing Ministry of Health vans for monthly cough days | USD$322,505.87 | 100% | USD$322,505.87 | |  |  |  | **USD$8,427 .641.66** | **TOTAL** | **USD$4.000.000** | |
| Monitoring of progress in finding and successfully treating the missing people with DS-TB and DR-TB, including through grant performance reporting. | The narrative above lays out a rationale and proposes expected outcomes for the impact of the catalytic matching funds for TB. With these additional $4m in funding prioritized for strengthening TB screening and diagnosis of BC TB cases we proposed the following high-level indicators:   * Increase rates of BC TB from 54% in 2026 in regular allocation to 59% with these additional matching funds * Increase total cases TB BC notified by 7000 annually, of which 210 will be DR-TB cases * Increase the total number of presumptive TB patients identified as part of increased scope of symptom screen, dXR and CAD, Advanced HIV Disease Package, screening PLHIV and high-risk groups by 10% |

1. **HIV prevention for key populations, AGYW and sexual partners’ priority area: HIV pre-exposure prophylaxis (PrEP) priority component**

Since December 2022 the country has been implementing PrEP at 316 health facilities, where a total of 99.876 people has initiated PrEP. Of these 60,836 (61%) are females and 19% (39,040) classified as youth. Most of these PrEP recipients are aged 25 years and above. These numbers, though matutinary, highlight the need to further improve PrEP access and uptake in Mozambique to ensure maintaining the gains of HIV prevention.

The specific national PrEP supervisions and technical assistance visits had the following findings:

·       Low PrEP continuation;

·       Timid demand creation;

·       Low general PrEP knowledge;

·       Fear of stigma due to PrEP´s packaging being like ART packaging.

Therefore, the country mandated the scale up of PrEP to all Health facilities offering ART, simplification of PrEP eligibility criteria; expansion of targeted populations, implementation of On-Demand PrEP, introduction of Differentiated Service Delivery models and testing, to achieve improved uptake of PrEP.

Considering these new guidelines and latest statistics on HIV prevalence in Mozambique is 12,5% and vertical transmission through MTCT is 10%, there is a clear need to increase the uptake of PrEP among target groups such as adolescents and woman and men sexually active through the increasing the investment in HIV prevention.

Strategic efforts will focus on advocating to address barriers to accessing PrEP, monitoring and evaluation of PrEP programs, as well as development, designing and delivery of targeted demand creation; community engagement; peer-led and community-driven efforts to increase the use of PrEP, inclusion of PHCs in the dispensing of PrEP and capacity building of the clinical personnel that will offer PrEP.

The HIV prevention approach will be multifaceted with the engagement of different stakeholders and community engagement programs. With demand creation will come increased PrEP procurement and the associated Procurement and Supply Management activities for both PrEP and related commodities. Mozambique targets having put on PrEP near to 366.220 people by December 2026.

Through the PrEP Matching Fund Mozambique is eligible for an additional US$3.75 million to scale up PrEP for people at increased risk of HIV infection, if the financial matching condition of US$ 5.625 million is met, among other access and programmatic conditions. This matching fund will be critical for supporting the following focal areas in Mozambique’s PrEP programming: procurement and supply management of PrEP and PEP; introduction planning for new PrEP products; development, design, and delivery of targeted demand creation, community engagement, peer-led, and community driven efforts to build demand for PrEP; service delivery (including strengthening and expansion of service delivery models and exploration of innovative channels such as private sector and community-based approaches); strengthening PrEP M&E; advocacy and policy analysis to address barriers to access; and development or adaptation of technical and operational plans and guidelines. The PrEP matching fund will increase coverage of PrEP and PEP, while strengthening the systems required to adequately target, measure, and evaluate prevention services. This will include specific M&E and program evaluation activities to drive expansion of cost-effective delivery models to ensure the cost per person receiving any PrEP product does not exceed US$ 91.24.

The country initiated PrEP service delivery through Pilots in 2017 in Zambezia Province in sero-discordant couples in 13 districts and 29 HF where adherence and acceptability were evaluated. In 2018 a modeling exercise was done to evaluate cost effectiveness of targeting different priority populations for PrEP, with the results of this exercise in 2019 the pilot was expanded to phase 2 to Nampula and Manica province with a broader priority group namely Key populations, and AGYW at risk.

With the lessons learned from the Pilot, in August 2021 the country started the National implementation of PrEP, after:

1. Demand creation tools where updated;
2. A national PrEP guideline was developed;
3. New priority populations were included (miners, long distance truck drivers, military, pregnant and lactating woman);
4. M&E tools and system were harmonized, piloted, and included in NHIS (SISMA);
5. National, provincial and Health facility trainings were conducted.

| **PrEP MF Condition** | **Mozambique Funding Request** |
| --- | --- |
| 1:1.5  matching  and increased investment | PrEP budget exceeds previous cycle and total for PrEP (allocation of USD $3,75M plus USD $5,625M matching):   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Module** | **Intervention** | Activity/ commodity | **Cost of**  **Activity** **/ Module** | **% of total related to PrEP** | **Cost related to PrEP and countable toward PrEP MF** | | Prevention package modules | PrEP delivery | 9.1.10 implement PrEP vaginal ring implementation Pilot on AGYW and SW  9.1.39 PrEP Provider Training | $116,000 | 100% | $0.1M | | Prevention Program Stewardship | Prevention program stewardship | 9.1.2 On the job training Health providers and lay providers in 550 HF  9.1.2\_1 Development and implement electronic systems (Print registering tools for microplanning strategy HF and community and print Job AIDS)  9.1.4. Map KP size estimation trainers perdiem  9.1.10. Prevention outcome monitoring tool  9.1.11. Assessment of the mobile population and IDP  9.1.18. conduct study/ research on preferences, barriers, attitudes, practices on condom use, focusing on AGYW  9.1.20. media campaigns on combination preventions  9.1.25. reproduce and disseminate IEC material focusing on prevention of HIV/STI and prevention G BV  9.1.28. intensify awareness about the existence of PrEP in the community and especially among high-risk groups radio spots | $110 258,42    $150 392,48      $697 846,67  $783 086,36  $46 919,34    $51 037,12      318 364,69    214 956,93      792 873,92 | 100%      100%      100%     100%  100%    100%      100%     100%      100% | $110 258,42      $150 392,48      $697 846,67     $783 086,36  $46 919,34    $51 037,12      318 364,69     214 956,93      792 873,92 | | Prevention Package for all KP, OVP, and AGYW | Condom and lubricant programing for all KP, OVP, and AGYW | A) Condoms, lubricants, condom dispensing machines | A) $12.2M | A) 20% | A) $2.4M | | Prevention Package for all KP, OVP, and AGYW | PrEP | A) 1,883,532 bottle of TE  B) 40,000 PrEP rings | A) $7.5M  B) $0.5M | A) 100%  B) 100% | A) $7.5M  B) $0.5M | | Prevention Package for all KP, OVP, AGYW | PEP | A) 10000 bottles of TLD | A) $40,000 | A) 50% | A) $20,000 | |
| PSE (pop size estimate) | PSE for PrEP eligibles was updated in 2023 |
| Expansion of service delivery platforms | The country intends to expand service delivery platforms:  1.              Through the delivery of PrEP services on of KP mobile clinics and mobile brigades.  2.              Through the inclusion of Private Health Sectors in the dispensing of PrEP; |
| Innovative approaches to increase scale | 1.              Combined prevention service delivery;  2.              Virtual and mass media demand creation;  3.              multi-month dispensing;  4.              Simplification of PrEP criteria;  5.              Differentiated testing (HIVST);  6.              Community-based service delivery ( mobile clinics and brigades)  7.              Expansion of targeted groups (anyone who desires PrEP can access PrEP)  8.              Expansion service delivery in prisons;  9.              Pilot to implement prep at community level and private sector |
| Data systems | Paper based system is used to monitoring and evaluation the PrEP implementation.  The core indicator is:  Percentage of eligible who initiated oral antiretroviral PrEP during the reporting period, disaggregated by  -  Men who have sex with men  -  Transgender people  -   AGYW    Every month the aggregated data is reported through SIS-MA, disaggregated by  -  Health facility  -  District  -  Province |
| Program stewardship | 1.  Training new personnel.  2.  Mentoring ship of health providers.  3.  Implementation evaluations.  4.  Supervision visits;  5.  Hiring of HR;  6.  Pilots of DVR (CAB\_LA pilots is planned with PEPFAR funds and MSF); |
| Geographical and population risk data | National target is defined using population risk criteria:  •  Sexually active (anal or vaginal sex)  •  Multiple Sex Partners and no condom use at last sexual intercourse; STI (self-report)  •  Sex work  Also was considering the priority populations and risk eligibility such population size and HIV prevalence.  To estimate the number of people in need for PrEP  The PrEP IT software is used to define target |
| More than one PrEP product | 3 PrEP products included (TDF, 3TC; CAB-LA and Dapivirine vaginal ring), with new product introduction planning under “Prevention Program Stewardship” |
| Minimum target on PrEP products | 2024- 84 838  2025- 120 703  2026- 160 678  Total 366 220 |

1. **HIV prevention for key populations, AGYW and sexual partners priority area: HIV prevention for AGYW and sexual partners priority component**

Preliminary results from INSIDA 2021 show that the prevalence of HIV among AGYW between 15 and 24 years of age is around 3 times higher when compared to boys/Youth in the same age groups. On the other hand, reaching these with prevention services is still a challenge, especially for the most vulnerable girls and most at high risk of HIV infection.

The results of IMASIDA 2015 showed that there was a reduction in the comprehensive knowledge of HIV prevention in young people aged 15-24 years, from 35.7% in women and 33.7% in men in 2009, to 30.8% in women and 30.1% in men in 2015.

In Mozambique, there are several factors that influence the high prevalence of HIV in Girls and Young Women, compared to Boys, with structural factors being more critical, where barriers to accessing sexual and reproductive health and health services, as well as gender inequalities directly influence the aforementioned factors and constitute a barrier to preventing HIV infection.

Adolescents have low knowledge about HIV/STI/Sexual and Reproductive Health, limited access to information and services, and even when these services are available, there are barriers to their use and quality. The failure to respond effectively to this problem has resulted in the adoption of risky sexual behavior and consequently the exposure of Adolescents and Young People to HIV infection.

The country intends to use the catalytic funds to implement interventions targeting AGYW who are at high risk of HIV infection. The referred risk is associated to their economic condition which lead them to early initiation of risk Sexual activities, or forced into such a situation, combined with early unions that result in early pregnancy and continuous vulnerability, and which also exposes Girls and Young Women to Gender-Based Violence. The full realization of sexual and reproductive health and rights plays a crucial role in the economic empowerment of these Girls and Young Women and is necessary for them to stay healthy, participate in education and participate in economic life free of violence.

A mix of interventions will be oriented to reduce their vulnerability. This include economic empowerment activities as such: Connecting vulnerable girls and young women benefiting from short-term vocational courses with local Empowered Mentors/providers as a way to ensure the continuity of implementation of learning for income generation; Provide starter kit for girls and young women trained; Promotion of business plans and opportunities for incubation program and technical assistance to Girls and Young Women beneficiaries of vocational and professional training for income generation.

The implementation of boys and men engagement activities aim to get them involved and participating in activities such communication for behavior change regarding the prevention of HIV, promotion of demand to youth friendly services, and promotion of Sexual and Reproductive Health.

During the implementation of interventions, a positive change is sought in the conception of masculinity and in the attitude of and about boys during their growth. Specifically, the project will attempt to pursue the following changes: Demystify the “feminization” of HIV/AIDS; Demystify negative and harmful masculinities; Positive perception of issues related to gender equity and equality, seeking peer influence among men; Boys and Men accessing Health Services / SAAJ to seek health services (Counselling, HIV Testing, STI screening, PrEP, ART); Positive, cooperative, and non-dominant behavior in their relationship with girls/women; Boys and men`s taking action against gender-based violence and promoting assertive, non-violent communication; Reduce Gender-Based Violence, stigma, and discrimination in the community in relation to HIV.

Girls' education has a positive influence on their lives and is recognized as being an important and powerful tool to equip them within the family and community, according to their age group and risk level, with knowledge, skills, attitudes and values that enable them to realize: (i) their health, well-being and dignity; (ii) develop respectful social and sexual relationships; (iii) consider how their choices affect their own well-being and that of others; understand and ensure the protection of their rights throughout their lives. Therefore, an educated girl is more likely to delay the onset of sexual activity, marry later, thus avoiding early pregnancy and HIV infection. Consequently, it continues to be a priority for the country to deal with these determinants from the foundation of personality formation, hence the intervention in support with school uniforms, didactic and school material for vulnerable girls and at risk of HIV infection, as a way of keeping the Girl at school and ensure the continuity of her studies. In addition to the above mentioned, it is intended to reinforce the following: Integrate girls who are victims of premature unions into school, identified by Paralegals. Continuous support to vulnerable adolescents and young people, in school supplies, didactic material and school uniforms, dignity kits.

Girls and young women in this condition see their ability to choose reduced and forcing them to submit to any condition even outside their needs.

The mitigation of this impact is only possible with their empowerment. This grant intends to reinforce the following:

With the current grant the Country aim to continue improving access to quality health services, for AYP, including prevention, care and treatment of HIV, family planning, promotion of sexual and reproductive health, information and education as a strategy to ensure the adoption of healthy behaviors, so that AYP can make informed choices about their lives.

It is intended to use a mentoring and interpersonal approach, through Mentor Teachers, Education Assistants and Peer Educators, either in the classroom and/or in the School Health Corner, where they will be able to assist and support students with useful information and make references to youth-friendly services, thus creating demand for health services. It is important to emphasize that the SAAJ are available for Adolescents and Young People in and out of school.

The services in question are offered by Health Professionals trained to offer friendly services, in a private and welcoming environment, hence the need to equip them with a minimum of acceptable equipment.

|  |  |
| --- | --- |
| **Programmatic and Access conditions:**  **US$2.000.000** | **AGYW and their sexual Partners** |
| Invest a portion of the HIV allocation that is at least 1.5 times greater than the amount of available Matching Funds, in HIV prevention for key populations; |  |
| Maintain or increase the level of investment in HIV prevention activities from the country’s 2020-2022 HIV allocation, in its 2023-2025 HIV allocation. |  |
| The estimate of the population size for AGYW was made in the last three years or is planned and budgeted for year one of the HIV grant of the respective allocation period 2023-2025. | Last estimation 2022, AGYW: 3,375,366 (2022) |
| Expansion of service delivery platforms for key elements of the HIV prevention program is established or planned and budgeted for (e.g., HIV prevention provision in family planning/sexual and reproductive health services, community and community-led organizations, pharmacies and other private sector outlets, and online service provision). | |  |  | | --- | --- | | **Interventions for behavior change and demand creation settings** | Projected cost in USD | | 2.4.9 Develop a single-family engagement package for changing social and cultural norms that constitute barriers to health, especially stigma and discrimination, adherence and retention to HIV/AIDS treatment, and acceptance of new approaches that contribute to health promotion | 44,338.44 | | 2.3.7 Expand behavior change interventions using virtual platforms, involving Mentor Boys | 128,245.23 | | 2.3.8 Implement a communication campaign for social change, harmful cultural norms and risky behaviors of boys, using Male Champions | 86,565.53 | | **Comprehensive Sexuality education for AGYW** |  | | 2.4.5 Mapping the conceptions, and the perception of boys and adult men regarding the social norms that dominate the gender relations in a given region aiming to have a clear picture of what are the needs of communication interventions pertaining these groups and better guide the activities implementation to prevent new HIV infections | 5,067.25 | | **Social Protection**  **Retention/Reintegration of Girls Vulnerable at High risk of HIV Infection** |  | | 2.7.1 Continuous support to vulnerable adolescents and young people, in school supplies, didactic material and school uniforms, dignity kits | 161,401.31 | | 2.7.6 Integrate girls who are victims of premature unions into school, identified by Paralegals | 14,427.59 | | **Economic Empowerment** |  | | 2.7.4 Engagement and awareness of families for the economic empowerment of girls and young women, especially young girls involved in transactional sex | 136,815.76 | | 2.7.5 Visit to seek experience around the creation of Economic Empowerment Groups within the school for income generation and also about the experience in connecting Girls and Young Women with Empowered Mentors locally, as a way of motivation and stimulation of Girls and Young Women | 73,389.11 | | 2.7.8 Connecting vulnerable girls and young women benefiting from short-term vocational courses with local Empowered Mentors/providers as a way to ensure the continuity of application of learning for income generation | 469,189.87 | | 2.7.9 Provide starter kit for girls and young women trained | 879,731.00 | |
| Plan and budget inclusion of strengthening HIV prevention data systems. |  |
| Innovation or improvement of HIV prevention outcomes. | * Approach using virtual platforms to reach boys with prevention messages. * Use of buses to disseminate messages about prevention * Use of social networks and mobile phones network to disseminate prevention messages targeting adolescents * Digital soap operas for the dissemination of prevention messages * Implementation of the boy-to-boy interpersonal approach * Mentoring from teacher to student on HIV prevention, promotion of SRH and creation of demand for health services |
| Evidence of HIV/STI prevention program management and coordination that involves key stakeholders, especially priority populations and competent and crucial multi-sectoral stakeholders, in prevention program planning and decision-making | * Existence of Memoranda of Understanding between MINED, MGCAS, Health and Secretary of State for Youth that establishes responsibilities of the parties from the central level to the District level (Technical Coordination) * Adolescent acts as a peer educator both at school level and at community level * Participation of adolescents in the technical groups and be part of the decision-making process in the perspective of nothing for me without me. |

1. **Scaling up programs to remove human rights and gender related barriers**

Matching funds in the context of human rights are intended to be used in the same line that the current funding cycle.

Barriers related to human rights and gender are pervasive and interfere throughout the prevention and treatment process in Mozambique, keeping key and vulnerable populations away from primary health services and care, including HIV services.

In this program is added to the matching funds strategies and activities to improve, complement and integrate all populations: PLHIV, vulnerable people, key population and people with disabilities in access of all services. The perspective for the matching funds is aligned to the principals’ challenges in the country related to high levels of stigma and discriminations and the violation of human rights in all settings.

The use of paralegals, the capacity improvement of public and private service providers, such as policies, legal technicians, health care providers need to be aligned with the empowerment of communities by improving their knowledge about their rights and defining strategies to eliminate all forms of discrimination and gender-based violence in this context.

The advocacy to adopt international norms and adapt for Mozambican context is another important aspect to be prioritize with these funds.

The documentation from all sectors its necessary since the country needs a summarized and integrated annual Human rights report.

To address the requirements, the proposal maintain the level of investment for interventions in programs to reduce human rights-related barriers when compared with NFM3 grant. For the present proposal, the country programmed over 7 million dollars in under the allocation and 2 million dollars under matching funds amount. Also, the PAAR proposal request almost 12 million dollars to human rights and gender related interventions.

With the implementation and complementarity of these funds it is expected that in Mozambique the following objectives will be achieved:

* Improved leadership, coordination and accountability of human rights and gender responses to HIV;
* Elimination of stigma, discrimination and violence against people living with HIV and key and vulnerable populations;
* Greater access to justice and protection of human rights for people living with HIV and key and vulnerable populations;
* Improve access to affordable, acceptable, accessible and quality HIV services for people living with HIV and key and vulnerable populations;
* Reducing gender inequality and gender-based violence faced by women and girls in their diversity, people living with HIV and key and vulnerable populations.

All of these results must to be aligned with the following activities:

* Payment of paralegals and lawyers’ salaries and their trainings
* Dissemination of findings and recommendations of both, PLHIV Stigma Index and other studies and Stigma Index of persons affected by TB
* Meeting to Support networks to conduct dialogues and advocacy meetings with local leaders (district governments and community leaders)
* Production of radio and television spots- stigma and discrimination campaign in the context of prevention for Key and OVP and in the context of PLHIV.
* Influencing policies and practices through disseminating the results - advocacy at different level (district, provincial and national), advocacy meetings
* Training of community committees in HIV, TB and human rights including regular technical support
* Meeting to Support networks to conduct dialogues and advocacy meetings with local leaders (district governments and community leaders)
* Hiring consultants to carry out focused follow-up studies, e.g., for people with disabilities.
* Exchanges with of international experiences (e.g., in the context of sexual exploitation, reports of national human rights institutions, etc)
* Elaboration of human rights reports

# Maximizing Impact

[The 2023-2028 Global Fund Strategy[[88]](#footnote-89)](https://www.theglobalfund.org/media/11612/strategy_globalfund2023-2028_narrative_en.pdf) describes clear pathways for control and elimination of the three diseases at a global level. The [Review Criteria of the Technical Review Panel](https://www.theglobalfund.org/media/3048/trp_technicalreviewpanel_tor_en.pdf#page=15)1F1F[[89]](#footnote-90) will be used to help evaluate optimal program design.

## Ending AIDS, TB and Malaria

Global Fund strategy 2023-28 states, “Our vision is a world free of the burden of AIDS, tuberculosis and malaria with better, more equitable health for all”. The strategy further mentions, “Against

HIV, we will focus on closing HIV prevention and treatment coverage gaps through more equitable service delivery models, better tailored to people’s needs, with particular emphasis on key and other most vulnerable groups”, and “Against TB, we must tackle the all-too persistent vulnerabilities, barriers and gaps that limit access to and quality of TB prevention and treatment programs”.

The Global Fund supported programs in Mozambique play a significant role in advancing the primary goal of ending AIDS. These programs focus on comprehensive strategies aimed at prevention, treatment, care, and support for individuals and communities affected by HIV/AIDS. GF supports ARV to almost 50% of the PLHIV on ART. The grant supports HIV prevention interventions and activities, including procurement of condoms, lubricants, PREP regimens and PEP. The interventions prioritize prevention strategies to reduce new HIV infections. Adult HIV incidence has fallen from 1.55% in 2000 to 0.55% in 2022 and is estimate to be 0,36% in 2026 (Spectrum).

Rapid HIV tests, also supported by these grants, provide a diagnostic and entry-level basis for HIV treatment, as well as being an entry point for combined prevention strategies (including PrEP) for those who are not infected. The HIV rapid diagnostic test provided also guarantees the testing of pregnant and lactating women, and those diagnosed with HIV will benefit from treatment and support for adherence, as well as their children will have access to drug prophylaxis and EID, and this set of interventions results in the reducing mother-to-child transmission of HIV. Support for laboratory products has ensured that patients undergoing treatment and care receive drugs in accordance with WHO recommendations and have the VL suppression monitored by molecular tests.

GF supports anti TB drugs to almost 82% and 92% of patients on drug susceptible TB and on Drug Resistant TB, respectively. Diagnosis of TB and MDR TB are also supported, as well as supervised TB treatment, allowing for improved treatment success rates. The grant also supports TB prevention activities, including procurement of TB preventive drugs (INH). TB prevalence has remained stable, but reported cases have increased year on year (see Context section).

All modules, interventions and activities proposed are based on the premise of taking the services as close as possible to where the end users are, and take into account the needs of the key and vulnerable populations. Value for money is achieved in terms of effectiveness and economy.

The grant supports the strengthening of the health system, especially the improvement of the supply chain, laboratories, sample transportation system, continuous capacity development for health technicians and community agents and the health information system. GF also provides support to community system strengthening and to make no one left behind through interventions that promote human rights, gender and health equity.

**HIV Program Essentials**

The Mozambique Government, with partners as Global Fund and US government, has made important advances and has achieved its goals in relation to Program Essentials, but some barriers remain for the coverage of services offered to be complete.

1. HIV primary prevention: Condoms are available, but the quantity and availability in places where the most vulnerable population is found is not ideal. In this grant, it is planned the acquisition of condoms and lubricants and activities for the improvement in the supply chain, so that the end user has access to the inputs. PrEP and PEP are available, but demand and adherence are below the desired level. In the new grant, it is intended, with a focus on key and more vulnerable populations, to expand the units that offer PrEP, create demand and community supply of services. Harm reduction is also offered in Maputo, and in the next subsidy it is intended to expand and improve the service package offered for PWID. VMMC also offers and this grant pretends to cover the activities related to the HF that doesn’t have PEPFAR support.

2.HIV testing and diagnosis: Self testing is implemented and focused on KP (precise prevention), OVP and AGYW, but also Men, which is an important barrier to overcome to reduce the gap of the first 95. The proposal for the new grant has a pilot to implement the three-test algorithm. The introduction of a completely new approach, such as the three-test algorithm entails complex adjustments in the country's logistics and routine procedures. An approval of this strategic change needs, therefore, a thorough assessment by the MoH regarding its feasibility and effectiveness of implementation in the country context. If the three-test algorithm is approved, the subsequent steps involve identifying the test, reviewing the algorithm, procuring, purchasing, and ensuring the timely distribution of the consumables in all the country as well as the “cascade” training of all testing providers in the HFs and communities.

Most of the proposed activities aim to increase testing approaches in the community, by targeting priority populations, which are at greater risk of infection, bear problematic conditions of access to health services, and are difficult to reach (FSW, PWUD, MSM, recluses, migrant population, miners, adolescents and young people, men). For these reasons, there is a need to focus more on outreach and testing strategies in the community, specifically in places where key and vulnerable populations can be found.

3.Elimination of Vertical Transmission: ARVs are available for the treatment of pregnant women living with HIV and thus, the country has reached the target of having 95% of these women on treatment by 2022. The country increased the coverage of EID to 75% of the exposed children and in this grant, pretended to continuously increase access until reaching all exposed children.

4.Treatment and care: rapid ART initiation, WHO recommended regimens to treat HIV, CD4 and VL are available to PLHIV on the HF. This grant pretends to guarantee continuous treatment and care and increase the community support to adherence. Also, it pretends to increase the quality of care, including management of advanced disease and NCD on PLHIV.

5.TB/HIV: the country invested in integration. HIV testing and ART are available for people diagnosed with TB and TPT and TB diagnosis are available to PLHIV.

6.DSD: MMD is available at least for a 3-month period and its expansion was driven by the Covid-19 pandemic.

7.Human Rights: PEN IV includes four main categories of human rights-related interventions: reducing stigma and discrimination, legal literacy, reducing discrimination against women and HIV-related legal services. In line with the PEN, this proposal has interventions to reduce stigma and discrimination and a special focus on human rights and gender and the violation of the rights of the populations most affected by HIV.

**TB Program Essentials**

Although some barriers to full access persist, especially social issues, Mozambique has made progress on TB Program Essentials (PE).

All program essentials are implemented, but the degree of reach is different. It was only considered as implemented countrywide that all PLHIV with active TB started ART. Most of the PE (9) are considered implemented between 50 and 95% of the country health facilities.

1.TB screening and diagnosis:

The use of the Xpert stool test to strengthen diagnosis in children will start with a gradual implementation during the 2nd semester this year. TB screening using chest X-ray without CAD has been implemented in the general population. The access of TB services for key and vulnerable populations remains low due to different reasons like, stigma and discrimination, long distance to the Health Facilities, insufficient interventions for this group. Not all bacteriological confirmed patients are tested for Rifampicin resistance, due to the limited access to the molecular testes and limited sample transport system.

To improve this key area, the country intend to intensify TB screening at HF and community level with the activities proposed in the TB Modules, as, for example, implementing symptomatic screening campaigns using mobile X-rays with CAD for key and vulnerable populations and stool sample to improve the quality of diagnosis in pediatric population, reinforce the use of GeneXpert and TrueNat also in the remotely area, engaging the private sector (clinics, pharmacies, traditional medicine) in the TB case finding and referral, optimizing of the diagnosis algorithm using Xpert MTB/RIF, strengthening the transport of samples in all provinces.

2.TB Treatment and Care

The 4-month scheme for children under 15 years of age with a not severe form of tuberculosis is not yet implemented and the 6-month BPaL/BPaLM scheme is not yet adopted for the national guidelines.

To improve this key area, the country intends to update the National Guideline to include all the WHO recommendations and implement the short regime for sensitive TB.

3.TB Prevention

TB preventive treatment is available for all eligible people living with HIV (adults and children) and for all eligible household contacts of people with bacteriologically confirmed pulmonary TB. Short regimes like HR and 3HP are adopted. TPT coverage among child contacts under 15 years of age and PLHIV to be strengthened, but completion of TPT has to be improve.

To improve this key area, the country intends to strengthen contact investigation and TPT coverage in eligible child contacts under 15 years age and among PLHIV, strengthen the monitoring of subjects under TPT and reinforce the implementation of short regimes of TPT in the south region.

4.TB/HIV

HIV testing rates among notified TB cases and ART treatment in co-infected individuals are high, both over 95%. But to make it better, the country intends to strengthen the one-stop shop policy and reinforce TB/HIV coordination activities.

5.Cross-cutting areas

The M&E system has various constrains, mentioned in the Modules of section 1 and in the Context section. Other issues as not all TB patients screened are treated, long periods between the diagnose and treatment (especially for patients with DR-TB) and weaknesses in the supply of medicines and other consumables were mentioned before.

To improve this key area, the country intends to implement many interventions described in the previous sections of the FR, but can highlight: reorganize TB services and strengthen the collaboration with the laboratory, extend of the quality approach (Program Quality Efficiency and Improvement -PQE) to make the analysis of the TB cascade, strengthen collaboration with private companies, involve private pharmacies in the referral of presumptive TB subjects to TB sites, strengthen the community support for the distribution of medicines, home visits and recovery of defaulters, implement the smart pill dispensers for patients with PS-TB.

## Resilient and Sustainable Systems for Health

As Mozambique is a low-income country with a high disease burden—and therefore not facing donor transition now—sustainability considerations are more focused on epidemiological and programmatic sustainability.

To enable Mozambique to scale up coverage to a level that will provide for epidemic control, in this request critical systems investments are intensified in order to sustain the gains achieved by the HIV and Tb programs. In particular:

* + 1. Health products management systems: focusing on the quantification, storage and distribution of medicines and other commodities.
    2. Labs: strengthening lab systems in terms of optimized referral systems, infrastructures, and quality.
    3. Information Systems (strategic information): building frames that allow better collection and reporting of data to improve data quality
    4. Human Resources: essential for quality of care, invest in the number and quality of HR

Continuous involvement of the community systems is also crucial for the sustainability of the response since their contribution allows them to sustain achievements through local solutions.

The set of RSS support will strengthen and build sustainability and resilience in the areas mentioned above.

## Engagement and Leadership of Most Affected Communities

The hard-to-reach areas and the more exposed and the marginalized groups as defined by HIV PEN V (KP and vulnerable populations) have been reached through various channels and their support and active participation was sought.

This involves special initiatives set up for PLHIV affected by emergencies and natural disasters. The grant will focus on the least served regions (sites which do not receive PEPFAR technical, managerial, and financial support), where PLHIV have the worst conditions of access to testing and treatment, through a substantial boost of activities based on CHW and their organizations. Through the community contribution, a sizable increase is expected in the success of case finding, treatment initiation, and retention. CBO/CLO as recipients and subrecipients will have a role not just to implement community activities, but also in programmatic decisions through technical groups consisting of KP, PLHIV, AGYW and community-led monitoring. In this funding request the program strives to expand communities who actively take leadership roles in helping to find new missing cases by giving effective peer support for treatment and follow-up.

For people with TB in communities of high-risk populations, the program will increase the reach to them and enhance their active role and promote them to take up leadership roles to help finding cases and support the identified TB cases. Such communities have demonstrated to be more comfortable reaching out to their peers than anyone from outside. are involved and will increase their involvement in implementation.

Funding for community system strengthening is foreseen to strengthen the community system capacities and engagement in national, regional and local level decision-making bodies. The program will work to have representation from the people especially the previously treated TB/MDR TB patients, high risk population and general populations living in rural areas and urban slums, in the local, district and national level TB committees and their meetings and in the program planning and decision making. The program will work to get significant representation of the prisoners in the prison health/TB committees and meetings and in the Prison Reform Task Force. For the miners and other industrial workers. The program will work to see the miners and industrial workers are presented in the management committees for health of the mining/industrial companies.

Special attention is given to build community leadership within programs for key and vulnerable populations. Community activists, more often peer educators, who are young women themselves, will be enabled to deliver initial care, particularly for prevention, to AGYW, an approach which will be strengthened. These activists increase teenager’s literacy by sharing health information related to HIV and STI, create linkage to health services (such as YFS), distribute condoms to AGYW and advocate for their use. Within the new grant, it will be possible to maintain a closer link with KP-led organizations. In the current grant, there is an MSM-led organization that is implementing MSM programs, as well as five other non-MSM-led CSOs. A promising initiative has been the involvement of the MSM-led organization to support capacity-building of the other implementers. This model is going to be adopted for the sex worker’s programs and drug user’s programs. In fact, there is currently a proposal to work closely with the emerging network of PWID in Mozambique, as well as with four sex worker-led organizations.

## Health Equity, Gender Equality and Human Rights

**Global Fund-supported program(s) will maximize:**

**A. Equity in Health.**

Contributors to health equity are boundless and extend into social, political, economic, and cultural domains. In Mozambique, access to health care facilities may be hindered by geographical distance, lack of transportation, employment requirements or internal displacement. Health care knowledge and awareness is obstructed by literacy, cultural differences, or limited access to technology (the ‘digital divide’).  Chronic illness progression is generally affected by insurance status, food insecurities, or environmental and living conditions such as working in mines and industrial setups, or an inmate in prison. More blatant assaults on human rights including barriers to access also represent health inequities.[[90]](#footnote-91)

There is limited evidence and studies on this issue. As per one study, about 72.1% of women and 72.9% men use healthcare. Populations in a disadvantaged position living in rural areas have less probabilities of using healthcare for equal health compared to the individuals of a wealthier position and living in urban settings. With regard to quality care, 47.7% women and 46.8% men do not report quality problems. No differences for women’s wealth. Men in a disadvantaged position report less chances of accessing quality care compared to men of advantaged position. Also, women and men living in rural areas have less probabilities of accessing quality care. Finally, the majority of people who access healthcare paid 1 Mt during their visit.[[91]](#footnote-92)

The interventions supported by this funding request will maximize health equity by targeting activities to populations, geographies, and barriers where the diseases have the greatest impact. The technical working groups analyzed Mozambique data to identify equity issues related to key and vulnerable populations, Internal displaced populations, seasonal workers, prisoners and miners. Each of the geographic areas and populations identified are targeted for focus in the interventions proposed. Specific targets are set with respect to each group.

**B. Gender Equality.**

The interventions funded by the Global Fund will maximize gender equality through interventions at two levels: (1) approaches that respond to the specificities of different gender categories and the intersections of discrimination that these categories may be exposed to. For instance, women sex workers experience inequity because they are women and social esteem in receiving the health services they receive due to the prejudice associated with their profession. The second level, will encompass interventions with the potential to transform the instituted social gender dynamics that promote inequality.

**Gender-sensitive approaches**

The dominant social gender values in the country associate men with strength, control and self-sufficiency. As a consequence, seeking support and help in the health services (understood as a primarily female space and mostly used by women) is associated with weakness. Data indicates that men have less contact with health services. Therefore, we propose to expand the opportunities for men to access health care:

* By bringing health services to meet men for provision of ATS (including ATHIV) in their community, at home, at the workplace through health campaigns, mobile brigades, visits by EPAs. Services will also include prevention and treatment
* Promotion of community discussion groups, including male-only groups with themes including HTC, stigma, prevention and treatment to influence changes in gender roles and attitudes
* Evidence from other African settings shows that interventions that bring together male peer or friendship groups have potential for success. Thus, we propose 'peer networking' or 'peer group testing' interventions as potential approaches to HIV testing
* Adapt provision of TB care services to men categories (miners) that respond to their specific needs

The intersectionality of gender and disability places disabled girls and women in a more precarious situation for obtaining information, accessing services and health care. We therefore propose that knowledge of the specific HIV, TB and malaria related needs of persons with disabilities be expanded to ensure the systematic increase of girls and women with disabilities in seeking and accessing SRHR, GBV prevention programs and response services

Adherence to antiretroviral therapy (ART) is higher for women than for men. However, men have higher ART retention rates (60%) than women (40%). Women's close interaction with the health sector through antenatal care (ANC) and child care (CCR) may explain the high adherence. However, there is no consistent follow-up interaction to ensure retention of ART. Thus, we propose strengthening the link with the health facility after routine RCC consultations and sensitizing about the importance of her continuing with treatment to be able to see her children grow up, as the message on ART for prevention of mother-to-child transmission tends to be well taken up and followed.

Training and support for health providers to provide non-judgmental and stigmatizing care to adolescent girls, people with alternative gender identities, and female key populations. Access to legal and health services for survivors of GBV, including provision of Post-Exposure Prophylaxis (PEP).

**Gender transformative interventions**

The initiation rites are an important training vector for boys and girls, passing on social values, including those referring to gender roles and sexual education. Due to their historical and cultural roots, they are widely followed by the community because they promote values with which the communities most identify. As a transforming intervention, we propose the establishment of cooperation with the masters of the initiation rites of both girls and boys to negotiate the inclusion of new values and practices to be transmitted:

* The integration of condom-use in the messages about sexual life taught in the rites
* Promotion and sharing of communication techniques for a culture of dialogue, tolerance and peaceful resolution of differences in domestic life
* Dissociation of the physical differences of individuals from social differences, promoting horizontality between men and women
* Promote wider acceptance of sexual and gender diversity through giving visibility to traditional non-normative gender and sexual identities (examples of traditional medicine, female categories of men in mines)
* Negotiate mechanisms for ritual circumcision to follow the precepts of medical circumcision
* Legal literacy campaigns focusing on (i) gender equity and equality and (ii) rights and duties of the user in the health facility in order to respond to the challenges of sex workers, people with alternative gender identities.

**C. Human Rights**

In the previous funding cycle application, the funding request prioritized investment in the development of a consultative National HIV, TB and Human Rights Plan based on research, community mapping and evaluations. Highlighted in the policy context in the Background Section, PEN IV includes four main categories of human rights-related interventions: reducing stigma and discrimination, legal literacy, reducing discrimination against women and HIV-related legal services. The next iteration, PEN V, would expand the scope of the programs to remove human rights-related barriers to include all seven programs areas for HIV and thereby extend to TB, namely training of health care workers, sensitization of lawmakers and law enforcement and monitoring and reforming laws, policies and regulations. An M&E framework will be included in the plan. This demonstrates a time bound and concrete strategic action to complete this plan during the period of the new grant.

In the 2014 National AIDS Spending Assessment (NASA), Mozambique tracked and reported domestic investments in human rights programs ($56,808).[[92]](#footnote-93) The 2014 NASA also tracked and reported domestic investments in community mobilization ($118,199 in domestic public funds and $15,093 in domestic private funds) and advocacy ($1,790,024) - two social enablers.[[93]](#footnote-94) Preliminary data from the new NASA shows that $641,057 was spent on human rights in 2018, though all these resources came from external sources.[[94]](#footnote-95) Though there has been no specific funding for TB, it was expected since the two diseases are closely related and encompasses many similar target groups, that the effect will also be felt by the TB program.

In addition, the country wishes to emphasize that the programming to address human rights-related barriers in this funding request is based on the findings of baseline assessment, which is referenced several times in the narrative. The detailed costing in the baseline assessment has also been used to guide the resource allocation in this request (providing insight into what a comprehensive national program will look like and cost) as well as the specific activity costing in this request. Further, the performance framework for this grant includes several outcome indicators related to human rights, including key populations’ avoidance of healthcare due to stigma as well as people with TB who report stigma in community settings. The latter indicator is a new addition to the performance framework, demonstrating the intensified focus on TB stigma reduction.

The interventions in this proposal pretends to create an enabling and supportive environment for programs: Supporting the expansion of legal literacy and legal services, while increasing support for programming in other key areas, particularly the training of health professionals in human rights and medical ethics, in raising awareness of legislators and authorities, monitoring and reform of laws and policies. Ensure that the Technical Working Group on Human Rights, within the CNCS structure, is supported and continues to meet regularly to discuss and streamline multisectoral coordination and collaboration, as well as how to move forward with programs to eliminate barriers to access to HIV and TB services related to human rights.

## Sustainability, Domestic Financing and Resource Mobilization

**A. Challenges to Sustainability**

Total HIV spending in Mozambique increased from $508.5 million in 2017 to $545.4 million in 2021, a change of ~7% (2021 National AIDS Spending Assessment [NASA] report)[[95]](#footnote-96). Together, the Global Fund and PEPFAR accounted for approximately 83% of HIV expenditures in 2020. Government expenditures on HIV programming in 2018 were $12.1 million (2% of all expenditures) and were essentially devoted to program costs such as operations, human resources, logistics, limited equipment, and provider training.

The bulk (73%) of financial support provided to Mozambique as of 2018 was managed by international financing agent-purchasers (the majority of which were PEPFAR implementing partners (IPs). Only $135 million (25%) of international funding was managed by public financing agent-purchasers (FAPs) (i.e., GRM).

Mozambique's TB Program has been funded primarily through external funds. For example, in 2021, funding for the program came from the Global Fund 52%, USAID 27%, World Bank 9%, and domestic resources 12%.[[96]](#footnote-97) The largest donors have been the Global Fund (current grant 2021-2023), the World Bank (current grant 2017-2023) and other donors are USAID and partly PEPFAR. Over the past 3 to 4 years, about US$30 million per year has been allocated to TB control activities but the activities remain underfunded.

It is important to note that over 95% of facility-based HIV services are provided through a network of over 1,730 government-owned and -run health facilities. The private health sector remains small and concentrated in urban centers and caters to higher-income groups. The government covers recurring costs in public facilities (staff, maintenance, etc), and donor funds support predominantly technical assistance, community activities, lay cadres, limited amounts of direct service delivery (DSD) staff, as well as key inputs (medicines, diagnostics, logistics) and targeted systems support (data/health information, surveillance, supply chain, and laboratory systems).

The national HIV and TB response challenges identified in the 2020-2022 allocation remain valid and relevant to the current allocation and some have even worsened, mainly due to the impacts of climate change.

Although the programs have registered significant progress, the HIV and TB epidemics continue to be important public health threats in Mozambique, with **increasing resource** needs for control, which pose a threat to sustainability. As noted, resource needs have increased by 60% for HIV (to achieve PEN V 2021-2025) and by 25% for TB (to achieve the strategic vision to 2029) since 2020. Even with the maintenance or slight increase in allocation for Mozambique, but gaps remain. The Government of Mozambique’s contribution of $10 million to ART and HIV testing since 2019 is a sign of the country’s efforts to address this challenge.

**The sustainability of domestic resource mobilization** is challenged by the government’s difficulties with tax collection. There is considerable tax evasion, which may threaten the viability of efforts to secure additional funding through personal income tax and company tax. The stated preference of stakeholders for earmarked taxes (sin tax) is a way of addressing this challenge.

**Low absorption of donor funds** is another sustainability challenge, affecting the country’s ability to deliver on programs as well as its ability to attract future investment. This challenge affects some program areas more than others. For instance, absorption of Global Fund resources for RSSH stands still be very low. To address low absorption of resources for RSSH, a standalone grant will be established and a dedicated manager appointed.

**Domestic Financing and Resource Mobilization**

Domestic financing is one of the HIV and TB programs biggest challenges – if not the biggest. Given that the country has the second highest HIV burden worldwide and is on the three lists of the World Health Organization (WHO) for the high burden of tuberculosis (TB), TB/HIV and multidrug-resistant tuberculosis (MDR-TB), the ongoing reliance on external donors is an area of great concern. In the immediate- and short-term, the GRM is unlikely to have the fiscal capacity to cover the costs of the HIV and TB programs for three reasons: (1) the current implementation approaches are unaffordable; (2) recurrent and severe emergencies caused by climate events (e.g., floods and cyclones) and an insurgency in the northern part of the country are placing significant pressure on government finances; and (3) short-term economic prospects are not promising. Nevertheless, in the medium-term, it is hoped that the GRM will have sufficient fiscal space (due to growing energy exports) to gradually cover a larger percentage of commodity needs.

In short, the GRM's capacity to increase domestic contributions for the HIV and TB programs is currently limited, and the country will continue to require substantial international support to reach epidemic control for the two diseases. To increase domestic financing and resources mobilization the Ministry of Health developed a health financing strategy (subject to approval) which aims to define various mechanisms to raise financial resources to enhance fiscal space[[97]](#footnote-98). The strategy builds on several other initiatives, including a situation analysis, insurance landscape study, a National Health Accounts (NHA) exercise, and the three health financing scenarios in the Health Sector Strategic Plan PESS 2014-2019[[98]](#footnote-99).

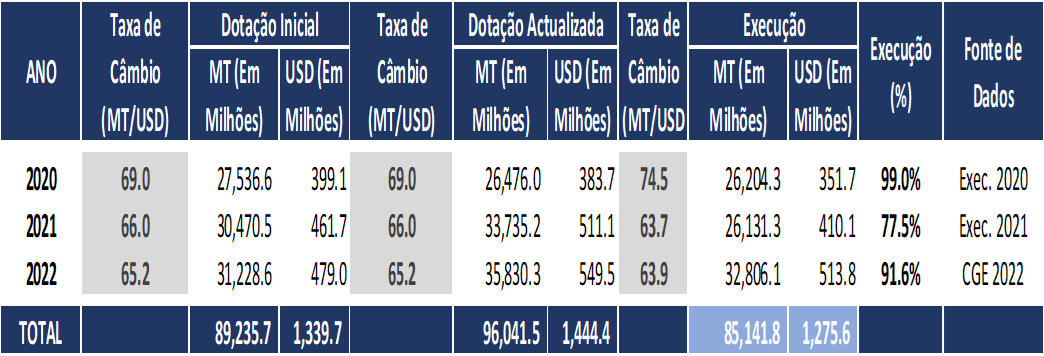
Nevertheless, careful transition planning to ensure sustainability once epidemics control has been achieved is under discussion with the leadership of the Ministry of Health.

**B. 2020-2022 co-financing commitments**

The Government of Mozambique is engaged to meet its co-funding commitments for programs on HIV, Tuberculosis, Malaria and on resilient and sustainable health systems, to access the full allocation of the Global Fund and ensure the sustainability of investments in health.

During the allocation period (2020-2022), the Government of Mozambique contributed a total amount of USD 1,275.6 million) in domestic resources to the health sector as shown in Table 2. below, which represents an amount above regarding the commitment made to the Global Fund to invest $112.65 million in domestic resources in the health sector.

**Table 2. Internal Component of the Health Sector – DI, DA and Execution 2020-2022**

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It should be noted that from 2020 to 2022 the Government of Mozambique increased the internal financing of the Health Sector from USD 351.7 million to MT 513.8 million in 2022, an increase above what it committed to make available until 2023. This fact demonstrates the Country's dedication to a sustainable response and an approach to the Government's priorities in the Health Sector.

**C. 2023-2025 co-financing commitments**

For the period 2024-2026, the Government of Mozambique is committed to investing more resources in HIV, tuberculosis, malaria and health systems strengthening programs.

1.Global commitments to health expenditures.

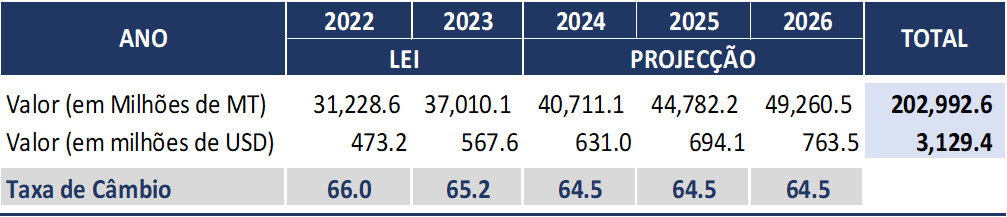
During the 2023-2025 allocation period, the country intends to increase the State Budget for Health from USD 567.6 million in 2023 to USD 763.5 million by 2026 (Table) , corresponding to a rate of increase of 34 .5%. It is intended that health represents 14.1% of all public expenditure, excluding General State Charges, in 2023 and 16.0% by 2026. The country understands the importance of allocating a strong percentage of public expenditure to the health sector and to create a solid foundation that underpins our internal contributions to national responses to HIV, TB and malaria, as well as to resilient and sustainable health systems.

1.Commitments on HIV, TB, malaria and resilient and sustainable health systems.

According to the Global Fund allocation letter of December 20, 2022, the country understands that 15% of the total allocation to Mozambique in the amount of USD 770,542,490 will only be accessible when the country assumes and fulfills a full internal financial commitment to HIV, TB, Malaria and Resilient and Sustainable Health Systems during the 2020-2022 allocation period that is equal to or greater than USD 112.65 million, and intends to do so during the 2023-2025 allocation period.

Our commitments to each of the diseases and the Resilient and Sustainable Health Systems (SSRS) are explained in the following table 3.

**Table 3. Internal Component of the Health Sector – Law 2022 and 2023, and Projection 2024-26**



## Pandemic Preparedness

Mozambique is considered the tenth (10th) country in the world, most vulnerable to the risk of natural disasters. In the last 30 years, at least 14% of the population was affected by drought, flood or tropical storm and more than half of the events that resulted in disaster (53%) occurred in the last two decades[[99]](#footnote-100). Extreme events, such as cyclones (IDAI, Kenneth, GOMBI and Freddy) and armed conflict in Cabo Delgado province. Consequences of natural and social unrest resulted in: Destruction of health infrastructures with loss of files, medicines and others; more than 744,000 people internally displaced due to military conflict; internal displacement of the population, including TB and HIV patients who lose not only their medicines but also their ID cards; crowding of people in Transitional Accommodation Centers, increasing the risk of transmission and making it difficult to identify TB patients diagnosed and lost due to natural disasters.

Mozambique, through the HIV and TB national programs, with GF and other partners support, has taken substantial efforts to improve data system and laboratory quality. In response to adverse context, highly affected by natural disasters, military conflict, and COVID-19 pandemic outbreak, the MoH and the national programs redirected its technical capacity and equipment to minimize the impact of the natural and humanitarian disaster, while securing continuity of provision of TB and HIV services. Mitigation and adaptation plan (contingency plan) implemented.

Specific investments in pandemic preparedness (e.g., laboratory systems, sample transport, surveillance and strength supply chain) are expected to be made through the RSSH component in this funding request. Also, Mozambique is applying for complementary funds to increase the resilience of the national health system to respond to an infectious disease outbreak under C19RM application.

# Implementation

## Implementation Arrangements

1. **Implementation arrangements which will maximize implementation effectiveness and optimize efficiency.**

For the new grants, the Mozambique CCM has decided to maintain the three current Principal Recipients: Ministry of Health, Fundação para o Desenvolvimento da Comunidade (FDC), and Centro de Colaboração em Saúde (CCS).

The Ministry of Health will continue to sub-grant Mozambique's 11 provinces, to enable smooth implementation at that level. It is difficult to manage funds from a central level for activities happening in the provinces in Mozambique. Lessons learned from current grant implementation show there is a need for intensified training and monitoring of these partners, to ensure they are able to use the guidelines that The Ministry has prepared on the use of grant funds, understanding performance-based funding, financial reporting tools, and how to do a Treasury plan. The decentralization of the government—which is currently underway—may present additional challenges for these implementation arrangements in the new grant.

The Ministry may also explore options of selecting new/different experienced sub-recipients for human rights, especially for the training of lawyers and magistrates, to minimize implementation delays.

In the new grant, The Ministry of Health will focus programmatically on the sites that don't have USG support, usually called non-AJUDA sites. PEPFAR works in the 628 AJUDA sites. Global Fund medicines and commodities will support all sites, including AJUDA. Given that non-AJUDA sites are mostly smaller, more rural facilities, strong community approaches to find, link and retain PLHIV are prioritized as part of the implementation arrangements. Similarly, for TB, an increasing community focus characterizes the proposed program, including implementation of the Community TB Service Package, working with TB volunteers, peer educators and other community-based organizations to deliver the program. These approaches are then reinforced by quality-of-care improvements at facilities, with a focus on training, technical assistance, and accountability (community-led monitoring of service provision).

For non-governmental PRs, working closely with government ministries has proven a critical success factor for effective program implementation in the past. These close partnerships are envisaged to continue in the new grant. This relationship like in working with the ministry of education also allows for personnel to be placed in the schools, doing monitoring and evaluation directly. Working closely with the national authorities is important for the successful implementation of key populations programs.

Another strategy that has worked well in the current implementation arrangements that is expected to continue is the model whereby non-governmental PRs do not implement programs directly, but rather, sub-grant to locally-based civil society SRs, who know the context and the community in which they work. This is key to program success in Mozambique for TB in particular, the approach of a “CSO consortium” has worked well and is planned to continue according to selected PRs.

There is also an intention to foster greater synergies and collaboration between the Ministry of Health and Ministry of Education, in order to bring the SAAJ model into schools, making onsite services available to learners.

**Role that community-based and community-led organizations in implementing programs supported by the Global Fund.**

Community-led AIDS responses are vital for addressing stigma and discrimination; providing treatment literacy and adherence support and prevention interventions; supporting differentiated service delivery; and reaching all people who need those services. People living with and affected by HIV are fundamental to the AIDS response, and their leadership is essential for achieving transformational ways of reaching and serving people. These organizations will have an important role in HIV service delivery at the community level complementing the public sector. In addition, they will implement and oversee community-led monitoring as failure to make progress across all societal enablers would undermine efforts to reach HIV prevention targets, the community-based and community-led organizations will lead the advocacy activities in order to create the societal enablers to maximize the impact of the programs supported by the Global Fund.

Community-based organizations will play a central role in the delivery of the proposed program. In the current grant, the PR responsible for finding missing people with TB in the community has worked with networks of people living with HIV, including two networks of women living with HIV, as well as faith-based communities. These organizations do home visits, contact tracing and collection of samples for TB diagnosis. Experience has shown this approach reduces stigma in the community.

For the new grant, the PR has the intention of working with TB and HIV patients, key populations, TB survivors and their family members, as a strategic shift, expanding the role of CBOs in implementation.

For key and vulnerable populations, the idea is for these programs to be community-led. For AGYW, the package is delivered by community activists who are young women themselves—a model which will continue. These activists share health information, create linkage to services, and distribute condoms to AGYW and advocate for their use. Another clear intention is to work more closely with key population-led organizations. In the current grant, there is one MSM-led organization implementing MSM programs, and about five other non-MSM-led CSOs. A promising initiative was to have this MSM-led organization build the capacity of the other implementers. There is a similar intention for the sex worker program and the drug user program, going forward. In particular, there is intent to work closely with the nascent network of people who inject drugs in Mozambique, as well as four known sex worker-led organizations in Maputo, Matola and Manica.

Overall, community-based and community-led organizations are essential partners in the implementation of Global Fund-supported programs in Mozambique. Their grassroots presence, deep understanding of local contexts, and ability to engage and mobilize communities are critical for achieving the desired health outcomes, reducing health disparities, and building resilient healthcare systems.

Community focus means carrying out the multiple activities included in the grant, by working with counselors and peer educators (general, as well as specific for each KP) for PSS and adherence, APEs (CHW directly hired by the NHS), activists, mentor mothers (MM), male champion, adolescent and youth mentors and the community-based organizations to deliver the program. The ubiquitous presence of CHWs in the HF and communities, where often they will conduct the same work responsibilities, will ensure all the ingredients are there for the activity impact. These approaches are then reinforced by quality-of-care improvements at facilities, with a focus on training, technical assistance, and accountability (community-led monitoring of service provision). CHW figures in non-AJUDA sites, particularly MM and peer educators for KP, will be expanded to ensure access and improve coverage of PBW and KP.

CBO and CLO will have a pivotal role to reach the KP's and their sexual partners for HTS, for capturing the sexual partners of index cases, and for the distribution of HIVST, through decentralized outreach in places of concentration of KP. HIVST will be part of a standardized outreach package and followed up by peer-educators, who will refer users for PrEP and/or to the HF for test confirmation; a triangulation system will be established between peer educator and the HIV service (by using the referral/counter referral community-HF system). Lay counselors will support disclosure of HIV status for sexual partners & screening for IPV. Community-based HTS for AGYW, and their sexual partners will be expanded in places with a high concentration of adolescents and young people (secondary schools, universities, playing fields) and referral systems from those locations to a SAAJ (youth friendly services) in HF will be set up. IPV tracing will be expanded to all communities where GBV services exist with a focus on non-AJUDA sites. CBO staff will support contact tracing for syringes/needles use in case of PWUD. They will promote discussion groups on HIV stigma to influence changes in gender roles and attitudes towards prevention and implement quality improvement interventions in community based YFS. Finally, CBO/CLOs will be engaged to address access barriers to PrEP, to increase the use of PrEP, to dispense PrEP, and to promote the expansion of service delivery models involving communities to relieve the HF’s workloads.

Community led organizations will also have a central role in the advocacy of human rights and anti-stigma strategies. Representing KP´s needs and concerns on key meetings and activities, as well as educating and supporting communities on their rights.

TB patients in Mozambique face many challenges to effectively preventing, diagnosing and treating tuberculosis. Barriers to treatment adherence vary from individual level factors (such as fear for side effects) to social (mainly stigma) and institutional factors (lack of timely attendance as a principal barrier)[[100]](#footnote-101). Perceptions of TB and MDR-TB that were related to myths and local traditions or rituals still dominate most parts of the rural or peri-urban communities. All these results in significant section of the population not using the health services to get diagnosed and treatment and break the chain of transmission[[101]](#footnote-102).

Mozambique has been implementing a standardized approach to TB service delivery at the community level since 2018, adopting the National Guideline for Community TB Activities. The 2022 results demonstrate that the community contribution is critical in finding new cases and promoting adherence to TB treatment and stigma reduction. In this funding request the program strives to expand the role of CSO and community health workers to actively take leadership roles in helping to find new missing cases and play an effective role during treatment and follow-up, and reduce gender barriers and stigma related to TB. GF investment will be used to expand the and strengthen the contribution of community structures to the NTP expected outcomes. Community health workers and community support structures will play a critical role to expand access to TB services and outreach vulnerable and hard to reach populations with packages of TB services. The NTP will work with Communities to strengthen Community health workers and community support systems to address TB services at community level in liaison with the health facility aiming to expand TB screening at different entry ports of health facilities, provide support and manage DR-TB patients at community level.

The list of planned interventions to be implement by CHW include, but is not limited to: i) Engage additional community health structures to act as gatekeepers of information on TB awareness raising and demand creators for TB services seeking; ii) Intensify contact tracing, reach out and engaging community-based NGO/CSOs to support to locate and find case’s families and friends for TB screening; iii) Enhance/create peer educator groups/networks. Identify, train and support present or previously treated TB patients to be the gatekeepers and influencers in the community to promote identification, treatment and prevention of TB symptomatic and cases; iv) Empowering communities to monitor and support patient treatment aiming at improving treatment success for all forms MDR TB; v) In close coordination with MoH, CSO organization will implement joint outreach activities and bi-directional referral mechanisms between health and community-led service delivery points; vi) Expand implementation of community-led monitoring initiatives, such as One Impact; vii) Establish and strengthen linkage of PHC with community structures at the ward level and Strengthen coordination at national, provincial and district level.

## Key Risks and Mitigation Measures

Risks and mitigating measures for Procurement of health products, management of health products and laboratory related activities; flow of data from service delivery points and financial and fiduciary concerns.

|  |  |  |
| --- | --- | --- |
|  | **Key Implementation Risks** | **Corresponding Mitigation Measures** |
| **Procurement of health products, management of health products and laboratory related activities** | Delays in shipping and Port clearance | * Plan to have at least 3-month buffer stock and contract with a warehouse of available storage and space. * Buffer stock and contract with warehouse of available storage and space, the country will: * Identify and/or hiring administrative person to respond to all GF needs at CMAM, supporting administrative procedures on issuing BIEF and green lights; * Carry out adequate supervision of country stock levels, pipeline and purchase orders, and provide regular updates on the list of available and required health products; * To respond to delays in port clearance, the country will use ENCOTERM DAP form all GF products. |
| Constraints in distribution of commodities to the health facilities | * A proper distribution well in place to be enacted quickly on receiving the commodity/s. The distribution plan to take into account the need-based approach for each health/TB facility. * Hiring of administrative personnel to provide technical assistance on the import of medicines, to be used by TB and CMAM * Ensure that medicines are sent in complete kits, particularly for MDR-TB * Create a smooth redistribution process of medicines and laboratory supplies within health facilities. * Use the Project Last Mile (PLM) experience in the Boane pilot to map critical access points for creating demand and increasing the availability of the Government's free condom |
| Laboratory related activities: weaknesses on sample transport | * Create an integrated and sustainable sample transport system * Capacity development of technicians from central and local laboratories |
| **Flow of data from service delivery points** | Paper based tools are the primary data source for all indicators collected at the facility and community level. The complexity of data collection tools and indicators, as well as the increase in the volume of patients receiving services has made paper-based data management a challenge. This creates challenges for health facility staff in aggregating results accurately and reporting those results via SIS-MA to above-site levels of the National Health System. | Mitigation Strategy 1: Official use of patient level electronic data capturing tools, where they exist, for supporting health facility reporting, data management and data quality improvement. |
| Mitigation Strategy 2: Conduct survey and assessment of existing patient-level electronic data capturing tools used across the various MOH health programs with a vision toward maximizing opportunities for consolidation and harmonization of information standards. |
| Mitigation Strategy 3: Development of a sustainability plan for development and maintenance of patient-level electronic data capturing tools that prioritizes government ownership and capacity building. |
| On-going challenges in the functionality and accessibility of the national reporting system, SIS-MA, which contributes to data reporting bottlenecks and inaccuracies | Mitigation Strategy: Assess the root causes affecting the functionality of SIS-MA at all levels and invest in both hardware and human resources to support sustainable improvements in performance and reliability. |
| The lack of a cohesive strategy around data and analytic systems prevents maximizing opportunities for data use. SIS-MA is a rich and detailed source for national indicator reporting and is built on DHIS2, which is recognized as a robust open-source data warehousing solution. That said, DHIS2 systems are ideally complemented with analytic solutions that are oriented toward development of dashboards and automated reports. The current SIS-MA does not allow APIs and lacks sub-system tools for automating the generation of structured datasets that could be used to power such national analytic systems. Moreover, if Mozambique is to realize its vision of transitioning to interoperable systems, a roadmap is needed for prioritization, budgeting, and definition of technical inputs. | Mitigation Strategy 1: Conduct assessment of sustainable analytic solutions to be used with SIS-MA for creation of national health dashboards. |
| Mitigation Strategy 2: Investigate opportunities for increased ability for authorized users to extract data from SIS-MA via either APIs or dedicated sub-system tools. |
| Mitigation Strategy 3: Develop costed interoperability roadmap |
| **Financial and fiduciary concerns** | Grant disbursal delayed | Request for available fund reallocation and refund. |
| Available funds prior identified and fund source/donor communicated with. |

Annex 1: Documents Checklist

Use the list below to verify the completeness of your application package.

This checklist only applies to applicants requested to apply using the Full Review application approach.

Refer to the [Full Review Instructions](https://www.theglobalfund.org/media/5743/fundingrequest_fullreview_instructions_en.pdf)[[102]](#footnote-103) for details, applicability and resources.

#### Documents Reviewed by the Technical Review Panel

|  |  |
| --- | --- |
|  | Funding Request Form |
|  | Performance Framework |
|  | Detailed Budget |
|  | Programmatic Gap Table(s) |
|  | Funding Landscape Table(s) |
|  | Prioritized Above Allocation Request (PAAR) |
|  | Health Product Management Template |
|  | Implementation Arrangement Map(s) |
|  | RSSH Gaps and Priorities Annex |
|  | Gender Assessment (if available) |
|  | Assessment of Human Rights-Related Barriers (if available) |
|  | Essential Data Table(s) |
|  | National Strategic Plans |
|  | Innovative Financing Documentation (if applicable) |
|  | Supporting Documentation Related to Sustainability and Transition (if available) |
|  | List of Abbreviations and Annexes |

#### Documents Assessed by the Global Fund Secretariat

|  |  |
| --- | --- |
|  | Funding Priorities from Civil Society and Communities Annex |
|  | Country Dialogue Narrative |
|  | CCM Endorsement of Funding Request |
|  | CCM Statement of Compliance |
|  | Additional documentation to support co-financing requirements |
|  | Sexual Exploitation, Abuse and Harassment (SEAH) Risk Assessment (optional) |

1. Greene, Margaret. 2019. Gender Assessment for USAID/Mozambique Country Development Cooperation Strategy (Final Report). Iris Group for Management Systems International (MSI)/Tetra Tech Company. pp 31. <https://pdf.usaid.gov/pdf_docs/PA00WGW3.pdf> [↑](#footnote-ref-2)
2. WHO updated recommendations on HIV prevention, infant diagnosis, antiretroviral initiation and monitoring. <https://www.ncbi.nlm.nih.gov/books/NBK569318/pdf/Bookshelf_NBK569318.pdf> [↑](#footnote-ref-3)
3. Assessment PrEP MSF MOZ 2022 [↑](#footnote-ref-4)
4. Ministério da Saúde. Relatório Anual Relatório das Actividades relacionadas ao HIV/SIDA 2022, Abril de 2023, page 48. [↑](#footnote-ref-5)
5. Manhiça I, et al. BMJ Global Health 2022;7:e007878 [↑](#footnote-ref-6)
6. MISAU. 2020. Communities, Rights and Gender Assessments in Mozambique. Pp.22. <https://stoptb.org/assets/documents/communities/CRG/TB%20CRG%20Assessment%20Mozambique%20DRAFT.pdf> [↑](#footnote-ref-7)
7. MISAU. 2020. Communities, Rights and Gender Assessments in Mozambique. Pp.41. <https://stoptb.org/assets/documents/communities/CRG/TB%20CRG%20Assessment%20Mozambique%20DRAFT.pdf> [↑](#footnote-ref-8)
8. Ghazy, R -A systematic review and meta-analysis of the catastrophic costs incurred by tuberculosis patients [↑](#footnote-ref-9)
9. PLANO DIRECTOR PARA A REDUÇÃO DO RISCO DE DESASTRES 2017-2030 [↑](#footnote-ref-10)
10. Human right Watch World report 2022 - <https://www.hrw.org/world-report/2022/country-chapters/mozambique> [↑](#footnote-ref-11)
11. Information available on UNHCR website: https://www.unhcr.org/countries/mozambique [↑](#footnote-ref-12)
12. PLANO ESTRATÉGICO NACIONAL DE RESPOSTA AO HIV e SIDA - PEN V (2021 - 2025) [↑](#footnote-ref-13)
13. PLANO ESTRATÉGICO NACIONAL PARA ELIMINAÇÃO DA TUBERCULOSE EM MOÇAMBIQUE, 2023-2030 [↑](#footnote-ref-14)
14. INSIDA 2021 [↑](#footnote-ref-15)
15. AGYW District Priorization 09.06.2023 [↑](#footnote-ref-16)
16. AGYW Package of Interventions [↑](#footnote-ref-17)
17. AGYW Preliminary Health Facility List 29.05.2023 [↑](#footnote-ref-18)
18. Planilha de estimativas de MM para US apoiadas pela CCS, 22.05.23 [↑](#footnote-ref-19)
19. Ministério da Saúde, Impacto na Saúde Pública da Abordagem Centrada na População para a Prevenção e Tratamento do VHB e do VHC em Moçambique, no date, page 5 [↑](#footnote-ref-20)
20. Jespersen NA, Axelsen F, Dollerup J, Nørgaard M, Larsen CS. The burden of non-communicable diseases and mortality in people living with HIV (PLHIV) in the pre-, early- and late-HAART era. HIV Med. 2021 Jul;22(6):478-490. doi: 10.1111/hiv.13077. Epub 2021 Feb 28. PMID: 33645000; PMCID: PMC8247855 [↑](#footnote-ref-21)
21. Peer N, Nguyen KA, Hill J, Sumner AE, Cikomola JC, Nachega JB, Kengne AP. Prevalence and influences of diabetes and prediabetes among adults living with HIV in Africa: a systematic review and meta-analysis. J Int AIDS Soc. 2023 Mar;26(3):e26059. doi: 10.1002/jia2.26059. PMID: 36924213; PMCID: PMC10018386 [↑](#footnote-ref-22)
22. Bigna JJ, Ndoadoumgue AL, Nansseu JR, Tochie JN, Nyaga UF, Nkeck JR, Foka AJ, Kaze AD, Noubiap JJ. Global burden of hypertension among people living with HIV in the era of increased life expectancy: a systematic review and meta-analysis. J Hypertens. 2020 Sep;38(9):1659-1668. doi: 10.1097/HJH.0000000000002446. PMID: 32371769 [↑](#footnote-ref-23)
23. Nansseu, Jobert Richie; Bigna, Jean Joel, Kaze, Arnaud D, Noubiap, Jean Jacques Incidence and Risk Factors for Prediabetes and Diabetes Mellitus Among HIV-infected Adults on Antiretroviral Therapy A Systematic Review and Meta-analysis Epidemiology 29(3): p 431-441, May 2018. | DOI: 10.1097/EDE.0000000000000815 [↑](#footnote-ref-24)
24. Relatório Final Avaliação dos Factores de Risco das Doencas Não Transmissiveis na População Moçambicana Steps 1,2,3 Moçambique 2014/2015 Maputo, 2017, page 22 [↑](#footnote-ref-25)
25. Relatório Final Avaliação Dos Factores De Risco Das Doencas Não Transmissiveis Na População Moçambicana Steps 1,2,3 Moçambique 2014/2015 Maputo, 2017, page 22 [↑](#footnote-ref-26)
26. Relatório Final Avaliação Dos Factores De Risco Das Doencas Não Transmissiveis Na População Moçambicana Steps 1,2,3 Moçambique 2014/2015 Maputo, 2017, page 23 [↑](#footnote-ref-27)
27. Lorenzoni C, Vilajeliu A, Carrilho C, Ismail MR, Castillo P, Augusto O, et al. (2015) Trends in Cancer Incidence in Maputo, Mozambique, 1991–2008. PLoS ONE 10(6): e0130469. doi:10.1371/journal.pone.0130469 [↑](#footnote-ref-28)
28. Supplement to: Stelzle D, Tanaka LF, Lee KK et al. Estimates of the global burden of cervical cancer associated with HIV. Lancet Glob Health 2020; published online Nov 16. http://dx.doi.org/10.1016/S2214-109X(20)30459-9. Page 40 [↑](#footnote-ref-29)
29. Carimo AA, Gudo ES, Maueia C, Mabunda N, Chambal L, Vubil A, Flora A, Antunes F, Bhatt N First report of occult hepatitis B infection among ART naïve HIV seropositive individuals in Maputo, Mozambique PLoS One. 2018 Jan 10;13(1):e0190775. doi: 10.1371/journal.pone.0190775. eCollection 2018 [↑](#footnote-ref-30)
30. Chambal L, Gudo ES, Carimo A, Corte Real R, Mabunda N, Maueia C, Vubil A, Zicai AF, Bhatt N, Antunes F, HBV infection in untreated HIV-infected adults in Maputo, Mozambique PLoS One. 2017; 12(7): e0181836. Published online 2017 Jul 31. doi: 10.1371/journal.pone.0181836 [↑](#footnote-ref-31)
31. Wandeler G, Musukuma K, Zürcher S, Vinikoor JM, Llenas-García J, Aly MM, Mulenga L, Chi BH, Ehmer J, Hobbins MA, Bolton-Moore C, Hoffmann CJ, Egger M; Hepatitis B Infection, Viral Load and Resistance in HIV-Infected Patients in Mozambique and Zambia PLoS One. 2016 Mar 1;11(3):e0152043. doi: 10.1371/journal.pone.0152043. eCollection 2016 [↑](#footnote-ref-32)
32. Stokx et al.: Seroprevalence of transfusiontransmissible infections and evaluation of the pre-donation screening performance at the Provincial Hospital of Tete, Mozambique. BMC Infectious Diseases 2011 11:141. [↑](#footnote-ref-33)
33. Ministério da Saúde, Impacto na Saúde Pública da Abordagem Centrada na População para a Prevenção e Tratamento do VHB e do VHC em Moçambique, no date, page 5 [↑](#footnote-ref-34)
34. Viegas EO, Tembe N, Macovela E, Gonçalves E, Augusto O, Ismael N, et al. (2015) Incidence of HIV and the Prevalence of HIV, Hepatitis B and Syphilis among Youths in Maputo, Mozambique: A Cohort Study. PLoS ONE 10(3): e0121452. doi:10.1371/journal.pone.0121452 [↑](#footnote-ref-35)
35. Ministério da Saúde, Impacto na Saúde Pública da Abordagem Centrada na População para a Prevenção e Tratamento do VHB e do VHC em Moçambique, no date, page 5 [↑](#footnote-ref-36)
36. Ministério da Saúde, Direcção Nacional de Saúde Pública- Programa Nacional de controlo de ITS/HIV e SIDA, Protocolo clinico e directrizes terapêuticas para Hepatites B e Hepatites C em Moçambique. Moçambique – 2019. page 6 [↑](#footnote-ref-37)
37. Loarec A, Gutierrez AG, Muvale G, et al. Hepatitis C treatment program in Maputo, Mozambique, the challenge of genotypes and key populations: a 5‐year retrospective analysis of routine programmatic data. Health Sci Rep. 2023;6:e1165. doi:10.1002/hsr2.1165 [↑](#footnote-ref-38)
38. Viegas EO, Tembe N, Macovela E, Gonçalves E, Augusto O, Ismael N, et al. (2015) Incidence of HIV and the Prevalence of HIV, Hepatitis B and Syphilis among Youths in Maputo, Mozambique: A Cohort Study. PLoS ONE 10(3): e0121452. doi: 10.1371/journal.pone.0121452. [↑](#footnote-ref-39)
39. Stokx et al.: Seroprevalence of transfusiontransmissible infections and evaluation of the pre-donation screening performance at the Provincial Hospital of Tete, Mozambique. BMC Infectious Diseases 2011 11:141 [↑](#footnote-ref-40)
40. Ministério da Saúde Relatorio Anual 2022 Telatório das Actividades relacionadas com HIV/SIDA, Maio 2023 [↑](#footnote-ref-41)
41. Strategic Vision of the National Tuberculosis Control Program Until 2024. Entire document. Online at https://bit.ly/2XCDgLW [↑](#footnote-ref-42)
42. Estimating population size and HIV burden among Key Populations in Mozambique, 2023 [↑](#footnote-ref-43)
43. Ministério da Saúde Relatório Anual 2020 Relatório Anual das Actividades Relacionadas ao HIV/SIDA Maio de 2020\* page 10-23 \*In fact issued in May 2021 [↑](#footnote-ref-44)
44. Ministério da Saúde Relatório Anual 2020 Relatório Anual das Actividades Relacionadas ao HIV/SIDA Maio de 2020 page 57 [↑](#footnote-ref-45)
45. Ministério da Saúde Relatório Anual 2020 Relatório Anual das Actividades Relacionadas ao HIV/SIDA Maio de 2020 page 12 [↑](#footnote-ref-46)
46. WHO (2019). TB incidence taking the prevalence survey data into account, for the year 2018 the estimated incidence was. Geneva: World Health Organisation. [↑](#footnote-ref-47)
47. https://tradingeconomics.com/mozambique/tuberculosis-case-detection-rate-all-forms-wb-data.html [↑](#footnote-ref-48)
48. https://worldhealthorg.shinyapps.io/tb\_profiles/?\_inputs\_&entity\_type=%22country%22&lan=%22EN%22&iso2=%22MZ%22 [↑](#footnote-ref-49)
49. The First National Pulmonary Tuberculosis Prevalence Survey in Mozambique Report August 2021 [↑](#footnote-ref-50)
50. https://worldhealthorg.shinyapps.io/tb\_profiles/?\_inputs\_&entity\_type=%22country%22&lan=%22EN%22&iso2=%22MZ%22 [↑](#footnote-ref-51)
51. [Pediatr Infect Dis J. 2019 Oct; 38(10): 999–1004.](https://www.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&retmode=ref&cmd=prlinks&id=31568138) [↑](#footnote-ref-52)
52. https://hub.tbdiah.org/dashboards/countries/mozambique [↑](#footnote-ref-53)
53. [AIDS Res Ther.](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7796582/) 2021; 18: 3., Published online 2021 Jan 9. doi: [10.1186/s12981-020-00325-9](https://doi.org/10.1186%2Fs12981-020-00325-9) Integrated TB and HIV care for Mozambican children: temporal trends, site-level determinants of performance, and recommendations for improved TB preventive treatment [↑](#footnote-ref-54)
54. The First National Pulmonary Tuberculosis Prevalence Survey in Mozambique Report August 2021 [↑](#footnote-ref-55)
55. The First National Pulmonary Tuberculosis Prevalence Survey in Mozambique Report August 2021 [↑](#footnote-ref-56)
56. Noé, A., Ribeiro, R. M., Anselmo, R., Maixenchs, M., Sitole, L., Munguambe, K., Blanco, S., Souef, P. L & García-Basteiro, A. L. (2017). Knowledge, attitudes and practices regarding tuberculosis care among health workers in Southern Mozambique. BMC Pulmonary Medicine. 17(1): 2-7. [↑](#footnote-ref-57)
57. Nyasulu P, Mogoere S, Umanah T, Setswe G. Determinants of Pulmonary Tuberculosis among Inmates at Mangaung Maximum Correctional Facility in Bloemfontein, South Africa. Tuberculosis Research and Treatment. 2015 ;2015:752709. DOI: 10.1155/2015/752709. PMID: 25866677; PMCID: PMC4381858. [↑](#footnote-ref-58)
58. *The First National Pulmonary Tuberculosis Prevalence Survey in Mozambique Report August 2021* [↑](#footnote-ref-59)
59. *https://*www.researchgate.net/publication/269717357 Healthcare Workers' Challenges in the Implementation of Tuberculosis Infection Prevention and Control Measures in Mozambique Article  in  PLoS ONE · December 2014 DOI: 10.1371/journal.pone.0114364 · Source: PubMed [↑](#footnote-ref-60)
60. Garcia, R.; Spiegel, J.M.; Yassi, A.; Ehrlich, R.; Romão, P.; Nunes, E.A.; Zungu, M.; Mabhele, S. Preventing Occupational Tuberculosis in Health Workers: An Analysis of State Responsibilities and Worker Rights in Mozambique. *Int. J. Environ. Res. Public Health* 2020, *17*, 7546. https://doi.org/10.3390/ijerph17207546 [↑](#footnote-ref-61)
61. Moyo D, Zishiri C, Ncube R, Madziva G, Sandy C, Mhene R, Siziba N, Kavenga F, Moyo F, Muzvidziwa O, Ncube P, Chigaraza B, Nyambo A, Timire C. Tuberculosis and Silicosis Burden in Artisanal and Small-Scale Gold Miners in a Large Occupational Health Outreach Programme in Zimbabwe. Int J Environ Res Public Health. 2021 Oct 20;18(21):11031. doi: 10.3390/ijerph182111031. PMID: 34769551; PMCID: PMC8583466. [↑](#footnote-ref-62)
62. https://www.unhcr.org/countries/mozambique [↑](#footnote-ref-63)
63. INSIDA Summary sheet [↑](#footnote-ref-64)
64. The First National Pulmonary Tuberculosis Prevalence Survey in Mozambique Report August 2021 [↑](#footnote-ref-65)
65. https://hub.tbdiah.org/dashboards/countries/mozambique [↑](#footnote-ref-66)
66. The First National Pulmonary Tuberculosis Prevalence Survey in Mozambique Report August 2021 [↑](#footnote-ref-67)
67. https://hub.tbdiah.org/dashboards/countries/mozambique [↑](#footnote-ref-68)
68. Stop Tb dashboard Mozambique - https://www.stoptb.org/static\_pages/MOZ\_Dashboard.html [↑](#footnote-ref-69)
69. Current Tropical Medicine Reports (2018) 5:264–272 [↑](#footnote-ref-70)
70. The First National Pulmonary Tuberculosis Prevalence Survey in Mozambique Report August 2021 [↑](#footnote-ref-71)
71. MOZAMBIQUE – A comprehensive community-based service delivery intervention for TB, ENGAGE-TB, Empowering communities to End TB, WHO [↑](#footnote-ref-72)
72. Barriers to access and adherence to tuberculosis services, as perceived by patients: A qualitative study in Mozambique,Published: July 10, 2019, <https://doi.org/10.1371/journal.pone.0219470> [↑](#footnote-ref-73)
73. https://hub.tbdiah.org/dashboards/countries/mozambique [↑](#footnote-ref-74)
74. Int J Tuberc Lung Dis 2015 Jan;19(1):44-9.  doi: 10.5588/ijtld.14.0337. Implementation of tuberculosis infection prevention and control in Mozambican health care facilities [↑](#footnote-ref-75)
75. [Health system influences on the implementation of tuberculosis infection prevention and control at health facilities in low-income and middle-income countries: a scoping review.](https://pubmed.ncbi.nlm.nih.gov/33975887/) BMJ Glob Health. 2021 May;6(5):e004735. doi: 10.1136/bmjgh-2020-004735. [↑](#footnote-ref-76)
76. Tuberculosis infection risk, preventive therapy care cascade and incidence of tuberculosis disease in healthcare workers at Maputo Central Hospital, [BMC Infect Dis.](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6485058/) 2019; 19: 346. Published online 2019 Apr 25. doi: 10.1186/s12879-019-3966-7 [↑](#footnote-ref-77)
77. Mozambique events of 2021 on Human Rights World Watch Report 2022 <https://www.hrw.org/world-report/2022/country-chapters/mozambique> [↑](#footnote-ref-78)
78. Breaking down the barriers to health equity, [Ther Adv Infect Dis.](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8855465/) 2022 Jan-Dec; 9: 20499361221079453. Published online 2022 Feb 16

    https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8855465/#:~:text=Contributors%20to%20health%20equity%20are,refugee%20status%2C%20or%20political%20factors. [↑](#footnote-ref-79)
79. Inequalities in the access to and quality of healthcare in Mozambique: evidence from the household budget survey, International Journal for Quality in Health Care, 2019, 31(8), 577–582 doi: 10.1093/intqhc/mzy218 Advance Access Publication Date: 2 November 2018 [↑](#footnote-ref-80)
80. UNDP Human Development Reports, 2021-22. pp. 274 <https://hdr.undp.org/system/files/documents/global-report-document/hdr2021-22pdf_1.pdf>. pp [↑](#footnote-ref-81)
81. Perfil de Igualdade de Género de Moçambique, 2022.pp.3 <https://mozambique.un.org/pt/210656-perfil-de-igualdade-de-g%C3%A9nero-de-mo%C3%A7ambique>. [↑](#footnote-ref-82)
82. Somerville, Claire & Khatia Munguambe. 2021. The Rise of Non-Communicable Disease (NCDs) in Mozambique: Decolonising Gender and Global Health. *Gender & Development* 29(1): 189–206 pp.199 <https://www.tandfonline.com/doi/full/10.1080/13552074.2021.1885220> [↑](#footnote-ref-83)
83. Spectrum v6.28, 2023 [↑](#footnote-ref-84)
84. Grupo Técnico Multisectorial. 02.05.2023Análise Situacional das Desigualdades do HIV, Moçambique, 2023 (Draft document) [↑](#footnote-ref-85)
85. MOZ-T-MOH: Performance Letter Progress Report covering the period 1 July – 31 December 2020 [↑](#footnote-ref-86)
86. MOZ-T-MOH P03\_Performance Letter\_3\_Jul\_Dec\_2021 [↑](#footnote-ref-87)
87. MOZ-T-MOH P03\_Performance Letter\_4\_Jan\_Jun\_2022 [↑](#footnote-ref-88)
88. 2023-2028 Global Fund Strategy - <https://www.theglobalfund.org/media/11612/strategy_globalfund2023-2028_narrative_en.pdf> [↑](#footnote-ref-89)
89. Review Criteria of the Technical Review Panel - <https://www.theglobalfund.org/media/3048/trp_technicalreviewpanel_tor_en.pdf#page=15> [↑](#footnote-ref-90)
90. Hojat LS. Breaking down the barriers to health equity. Ther Adv Infect Dis. 2022 Feb 16;9:20499361221079453. doi: 10.1177/20499361221079453. PMID: 35186290; PMCID: PMC8855465. [↑](#footnote-ref-91)
91. Inequalities in the access to and quality of healthcare in Mozambique: evidence from the household budget survey, International Journal for Quality in Health Care, 2019, 31(8), 577–582 doi: 10.1093/intqhc/mzy218 Advance Access Publication Date: 2 November 2018 [↑](#footnote-ref-92)
92. National AIDS Spending Assessment (NASA) for the Period 2014 in Mozambique 2016. Page 94. Online at https://bit.ly/2K6FRWx [↑](#footnote-ref-93)
93. National AIDS Spending Assessment (NASA) for the Period 2014 in Mozambique 2016. Page 94-95. Online at https://bit.ly/2K6FRWx [↑](#footnote-ref-94)
94. National AIDS Spending Assessment (NASA) for the Period 2018 in Mozambique (Provisional Data as of May 2020). Online at https://bit.ly/3cPPqWB [↑](#footnote-ref-95)
95. National AIDS Spending Assessment (NASA), 2021 Online at https://bit.ly/2K6FRWx [↑](#footnote-ref-96)
96. http://stoptb.org/resources/cd/MOZ\_Dashboard.html [↑](#footnote-ref-97)
97. Revenue-Raising Potential for Universal Health Coverage in Benin, Mali, Mozambique and Togo. Page 621. Online at https://bit.ly/35WwRxu [↑](#footnote-ref-98)
98. 416 Mozambique National Health Accounts 2012. Page x Online at https://bit.ly/2LoyH0D & Health Sector Strategic Plan PESS 2014-2019 (Portuguese). Page 119-120. Online at https://bit.ly/3adMHUE [↑](#footnote-ref-99)
99. Information avaiable on INGD (Instituto Nacional de Gestão e Redução do Risco de Desastres Moçambique) website: https://www.ingd.gov.mz/ [↑](#footnote-ref-100)
100. Mozambique – A comprehensive community-based service delivery intervention for TB, ENGAGE-TB, Empowering communities to End TB, WHO [↑](#footnote-ref-101)
101. Barriers to access and adherence to tuberculosis services, as perceived by patients: A qualitative study in Mozambique,Published: July 10, 2019, <https://doi.org/10.1371/journal.pone.0219470> [↑](#footnote-ref-102)
102. Full Review Instructions - <https://www.theglobalfund.org/media/5743/fundingrequest_fullreview_instructions_en.pdf> [↑](#footnote-ref-103)