

Mozambique

Country Operational Plan

(COP) 2016

Strategic Direction Summary (SDS)

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Goal Statement

The goal of the United States Government (USG) for the President's Emergency Plan for AIDS Relief (PEPFAR) in Mozambique is to achieve control of the HIV epidemic through rapid adoption and application of evidence-based policies and interventions to drive progress and save lives, implemented through a partnership that best supports host country leadership, ownership and sustainability.

PEPFAR will achieve this goal by working with the Mozambican National HIV and AIDS Program, the National AIDS Council (*Conselho Nacional de Combate ao HIV e SIDA-CNCS*), the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), the Joint United Nations Programme on HIV and AIDS (UNAIDS), civil society, and the private sector to target high impact interventions to the populations at greatest risk in the areas with the highest HIV prevalence.

This support is focused on providing technical assistance, training, mentoring, and supportive supervision together with essential commodities and key system investments, including supply chain, human resources, and laboratory and strategic information support. This Strategic Direction Summary (SDS) details the objectives and activities for the USG \$337 million budget apportioned to PEPFAR-Mozambique.

Two recent events strengthened the opportunity for productive partnership between the USG and the Government of the Republic of Mozambique (GRM). In December 2015, the two governments signed a bilateral agreement which opened the possibility of direct government to government (G2G) support of Mozambique's HIV/AIDS response. In March 2016, the Mozambican Ministry of Health (MOH: *Ministério da Saúde-MISAU*) announced adoption of a new treatment threshold (CD4<500) and phased implementation of T&S. Mozambique's phased implementation of T&S began in August 2016 and will cover 60% of all people living with HIV (PLHIV) by the end of this Country Operational Plan 2016 (COP16). In COP17 all PLHIV in Mozambique will have early access to life-saving treatment.

PEPFAR-Mozambique will support the GRM to achieve ambitious targets to increase the number of people on anti-retroviral treatment (ART) from 899,598 total (GRM national estimate end of June 2016) to 887,293 adults and 82,058 children in PEPFAR-supported sites by the end of September 2017. To reach these targets, 4,938,747 people will be tested for HIV using modalities that have been most successful at finding HIV-positive people. Male circumcision, a critical prevention measure, will be scaled to reach 427,542 men. Adolescent girls and young women (AGYW) living in five high burden districts in Mozambique will benefit from the concentrated support of the Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) Initiative to help protect them and their male partners from acquiring or spreading HIV. PEPFAR will also continue to support orphans and vulnerable children (OVC) and to target services to vulnerable key and priority populations, recognizing that to support these populations means continuous advocacy for human rights and an end to gender-based violence (GBV).

PEPFAR-Mozambique activities will continue to follow the geographic prioritization and differentiated support models approved in COP15, with slight adjustments to maximize investments and assure continued progress toward epidemic control.

1.0 Epidemic, Response, and Program Context

1.1 Summary Statistics, Disease Burden and Country Profile

Mozambique is a predominantly rural country of approximately 27 million people challenged by a severe generalized HIV epidemic. National HIV prevalence is 11.5%, with substantial variation in regional prevalence ranging from 25.1% in Southern provinces to 3.7% in Northern provinces. In 2015, there were an estimated 1,623,827 PLHIV, with a higher prevalence among women (13.1% vs 9.2% in men) and especially among young women (aged 15-24 years) compared to young men.¹ Prevalence among adolescent girls and young women is estimated at 11.1%.² Of the estimated number of PLHIV, 51% are currently on ART. The HIV epidemic has contributed to a reduced life expectancy of 51 years, and there are approximately 1.8 million orphaned children.

Despite encouraging economic growth, estimated at over 7% over the last three years, the Human Development Index ranks Mozambique 180 out of 187 countries.³ Sixty percent of Mozambicans live on less than \$1.25/day; gross national income is \$600 per capita.⁴ Key health indicators indicate gradual improvement in health status; however, challenges remain. Although antenatal coverage, defined as at least one visit, is 91%, maternal mortality ratio remains high at 490/100,000 live births. Under-five child mortality is 90/1,000 live births, declining from 103/1,000 live births in 2010.⁵ Malaria, diarrhea, acute respiratory infections, and vaccine-preventable diseases are the main causes of child mortality, with malaria contributing to one third of deaths. Forty-three percent of children-under-the-age of 5 years are stunted.

The Gender Inequality Index synthesizes gender-based inequalities in three dimensions – reproductive health, empowerment, and economic activity – on which Mozambique ranks 135 of 155 countries. Mozambique has high rates of early marriage: 60% of women age 25-49 were married before age 20. About 40% of Mozambican women become pregnant before the age of 20. The adolescent pregnancy rate is 137.8 births per 1000 live births, with the risk of death among pregnant teenagers four times higher than for women above the age of 20. One-and-a-half percent of adult women have reached at least a secondary-level of education compared to 6% of their male counterparts.⁶

Key drivers of Mozambique's HIV epidemic are low coverage of ART, risky sexual behaviors, low rates of male circumcision, low and inconsistent condom use, mobility and migration, and survival sex work. Qualitative studies have highlighted the social and cultural factors that shape attitudes and behaviors towards risk, sexual relations, prevention, care seeking and use of services.

The 2009 AIDS Indicator Survey (*Inquérito Nacional de Prevalência, Riscos Comportamentais e Informação sobre o HIV e SIDA-INSIDA*) is the most current source of population level data about the epidemic.⁷ INSIDA estimates 433,000 HIV-sero-discordant couples in Mozambique, representing 10% of all cohabiting heterosexual couples. At least 58% of PLHIV did not know their HIV status.

¹ EPP SPECTRUM Version 5.03.2014; 2015 estimate (the estimate in Table 1.1.1 is for 2017)

² AIDS Indicator Survey INSIDA 2009

³ Human Development Report 2015, UNDP

⁴ World Bank 2014

⁵ Mozambique DHS 2011& UNICEF 2012

⁶ Human Development Report 2014, UNDP

⁷ A new survey is underway with final results expected in FY17

Condom use is limited but more common in urban populations. Among women age 15-49 who had sexual intercourse in the last 12 months, 8% reported using a condom during last intercourse (19% urban, 3% rural). The proportion increases to 16% among similar aged men (33% urban, 7% rural). Male circumcision (MC) is common in the northern provinces of the country, where it is performed for traditional and religious reasons. Nationally, MC prevalence is reported at 63%, with geographic variations ranging from 9% (Tete Province) to 95% (Niassa Province).

A Modes of Transmission Model conducted in 2013 shows that 29% of new infections were among sex workers, their clients and men who have sex with men (MSM), and 26% of new infections occur among people in stable sexual relationships, due in large part to high rates of sero-discordance and low rates of condom use among couples. People in multiple concurrent partnerships contributed to 23% of new adult infections. Mobile and migrant workers such as miners, agricultural workers, prison populations, the military, and truck drivers also constitute priority populations.⁸

Mozambique has lower national retention rates than many other African countries. Twelve month retention among PLHIV newly initiating ART was 66% at SAPR16. Rates are even lower in pregnant women, children under 15, and adolescents 15-19 (59%, 64% and 58% respectively at SAPR16). Innovative efforts are being planned and implemented at both facility and community levels to retain and track people on treatment.

The health sector struggles with limited funding and infrastructure and with a critical shortage of human resources to provide adequate health care. More than half of all Mozambicans must walk over one hour to reach the nearest health facility. Overall the ratio of population per hospital bed is 1 bed per 1,038 persons, with substantial variation across the country.⁹ Health facilities face a general dearth of basic amenities: 55% lack electricity, and 41% lack running water. Human resources for health (HRH) are severely constrained with 6.5 doctors, 28 nurses, and a total of 66 health care workers (HCW) per 100,000 people (MOH/MISAU, 2012). The accepted standard is 230 medical professionals per 100,000 people (WHO, 2006). Together with uneven geographic distribution and limited supervision, there are an inadequate number of trained and competent HCW in all cadres.

The GRM's ability to oversee policies and regulations and to coordinate numerous health actors is a challenge. Information systems and monitoring and evaluation (M&E) efforts are heavily supported by external funding and technical assistance (TA) and are not yet able to provide timely and accurate health data. Supply chain and commodities management is fragile and is an area where PEPFAR provides substantial TA. Development and capacity building of the National Health Information System and supply chain is a priority for COP16. The laboratory network to support HIV care and treatment (C&T) also requires significant investment to expand the capacity of diagnostics services and to strengthen currently fragile systems. Of the 1,438 health units in Mozambique, only 344 have laboratories.

Despite these challenges and despite the heavy burden of the HIV/AIDS epidemic, there has been remarkable progress. Since 2011, the number of people on ART has increased nearly threefold, with a

⁸ Military – Seroprevalence and Behavioral Epidemiology Risk Survey in the Armed Forces of Mozambique 2010

⁹ MISAU/MOH – DRH. Relatório Anual dos Recursos Humanos. Maputo, Abril 2014

dramatic increase since the launch of the MOH's national *HIV/AIDS Acceleration Plan 2013-2015*, with the rapid national expansion of health facilities offering ART from 255 in 2011 to 937 by the end of 2015, and with 202,672 adults newly initiated on ART in 2015 alone. By the end of December 2015, there were a reported 738,386 adults currently on ART.

There has also been remarkable progress in T&S (Option B+) for pregnant women attending antenatal care (ANC), which increased from 12% coverage of all HIV-infected pregnant women in 2012 to 91% in 2015. More HIV infected children are being identified and started on ART; the total number of children currently on treatment nationally was 70,138 at the end of June, 2016. This represents 65% of all estimated pediatric PLHIV in the country based on the revised SPECTRUM estimates released in 2016.

In February 2016, the MOH announced its decision to adopt the revised WHO guidelines released September 30, 2015. Mozambique initiated ART for all patients at CD4<500 in March 2016, and began phased rollout of T&S in August 2016. To support the new T&S treatment thresholds, Mozambique will move to three-month scripting for stable ART patients, increased availability of viral load monitoring, and reduced frequency for clinical checkups to decongest health facilities. The National HIV Strategic Plan (*Plano Estratégico Nacional de Resposta ao HIV e SIDA-PEN IV*), which was developed with assistance from PEPFAR, is now being implemented and will be updated based on the revised national HIV treatment policies for the period 2017-2019.

With COP16, Mozambique will increase momentum towards achieving saturation of PLHIV on treatment, with 39 of 78 PEPFAR-supported scale-up districts targeted for 80% ART coverage of all PLHIV in the next two years (in addition to the five attained districts that have already reached saturation). Based on these criteria, the MOH will exceed the targets laid out in the *HIV/AIDS Acceleration Plan*.

Calculated Risk. COP16 represents a calculated risk in investments by PEPFAR, particularly for commodities that are needed to implement T&S. While the team is confident that this plan includes the necessary budget to assure commodities for the anticipated increase in the number of persons on treatment in FY17, there is not confirmed funding to maintain an uninterrupted supply of ARVs in FY18.

Critical Additional Challenges in FY17. Mozambique faces three additional challenges in FY17. First, the region is experiencing the worst drought in 35 years. Food insecurity is anticipated to peak between October 2016 and March 2017, with 2.3 million people in Mozambique expected to need emergency humanitarian assistance in the first quarter of 2017. Second, ongoing conflict between Frelimo and the opposition group Renamo has intensified and affects large portions of central Mozambique, including priority T&S districts. Third, the country is in the midst of a severe fiscal crisis triggered by the withdrawal of support by IMF and foreign donors after discovery of \$2 billion in undisclosed loans. Annual inflation reached 25% in September 2016, spurred by currency devaluation and by the drought.

Table 1.1.1 Key National Demographic and Epidemiological Data (continued)

	Total		<15				15+				Source, Year	
	N	%	Female		Male		Female		Male			
			N	%	N	%	N	%	N	%		
Estimated Population Size of MSM	Maputo City - 10,121 Beira - 2,624 Nampula/Nacala - 3,069											MSM IBBS 2011
MSM HIV Prevalence	Maputo City - 8.2% Beira - 9.1% Nampula/Nacala - 3.7%											MSM IBBS 2011
Estimated Population Size of FSW	Maputo City - 13,554 Beira - 6,802 Nampula - 6,929											FSW IBBS 2011-2
FSW HIV Prevalence	Maputo City - 31.2% Beira - 23.6% Nampula - 17.8%											FSW IBBS 2011-2

Table 1.1.1 Key National Demographic and Epidemiological Data (continued)												
	Total		<15				15+				Source, Year	
			Female		Male		Female		Male			
	N	%	N	%	N	%	N	%	N	%		
Estimated Population Size of PWID	Maputo City - 1,684*** Nampula - 520***											PWID IBBS 2013
PWID HIV Prevalence		Maputo City - 50.3%*** Nampula - 36.8%***										PWID IBBS 2013
Estimated Size of Priority Populations - Prisoners	N/A											
Priority Populations Prevalence - Prisoners		24.00%										INS & UNDOC Report 2013
Estimated Size of Priority Populations - Adolescent Girls****	2,764,226											Census 2017
Priority Populations Prevalence - Adolescent Girls****		11.10%										INSIDA 2009

*15-49 year olds
**From Spectrum Files used for COP16 planning - MozREGIONmig2015.06.10 - CD4500 + TS, Version 5.31
***Preliminary Data Not Yet Officially Released
****15-24 year olds

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)

				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate	HIV Prevalence	Total PLHIV	On ART	Retained on ART 12 Months	Viral Suppression	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
	(#)	(%)	(#)	(#)	(#)	12 Months	(#)	(#)	(#)
Total population	27128530*	11.50%	1643065**	802659	528129	N/A	6630337	468870	220787
Population less than 15 years	12074668*	N/A	175,375**	64273	40865	N/A	N/A	N/A	1815
Pregnant Women	1087000*	15.20%	101,831**	99786	54882	N/A	1367536	77585	62088
MSM	Maputo City – 10,121 Beira – 2,624 Nampula/Nacala – 3,069	Maputo City – 8.2% Beira – 9.1% Nampula/Nacala – 3.7%	Maputo City - 830 Beira - 239 Nampula/Nacala - 114	N/A	N/A	N/A	N/A	N/A	N/A
FSW	Maputo City – 13,554 Beira – 6,802 Nampula – 6,929	Maputo City – 31.2% Beira – 23.6% Nampula – 17.8%	Maputo City – 4,229 Beira – 1,605 Nampula – 1,232	N/A	N/A	N/A	N/A	N/A	N/A
PWID	Maputo City – 1,684*** Nampula – 520**	Maputo City – 50.3%*** Nampula – 36.8%**	Maputo City - 847 Nampula - 191	N/A	N/A	N/A	N/A	N/A	N/A
Priority Pop Prisoners	N/A	24.00%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Priority Pop Adolescent Girls	2,764,226	11.10%	306,829	N/A	N/A	N/A	N/A	N/A	N/A
<p>* 2017 demographic projection estimate from Mozambique Census conducted in 2007 ** 2017 estimate from Spectrum Files used for COP16 planning - MozREGIONmig2015.06.10 - CD4500 + TS, Version 5.31 *** Preliminary Data Not Yet Officially Released</p> <p>Note : Prevalence number for the military cannot be shared with the general public due to military concerns regarding HIV prevalence as it relates to national security. However, prevalence data and other military data were shared with the country team to inform COP15 decisions and inclusion of the military as a priority population.</p>									

1.2 Investment Profile

National Health Budget. The GRM's total budget allocated to health in 2014, the most recent year for which data are available, was US \$635 million, representing 7.9% of the total national budget¹⁰. Forty-eight percent was dedicated to the central ministry level, 15.7% to the Provincial Directorates of Health (*Direcção Provincial de Saúde - DPS*), 16.5% to the District Services of Health, Gender, Children and Social Action (*Serviços Distritais de Saúde, Género, Criança e Acção Social - SDSGCAS*), 11.6% to central hospitals, 1% to the Central Medical Stores (*Central de Medicamentos e Artigos Médicos - CMAM*), and 1% to CNCS.¹¹

HIV Expenditures. The 2014 National AIDS Spending Assessment (NASA) showed a 28% increase in HIV expenditures from US \$260.3 million in calendar-year (CY) 2011 to US \$332.5 million in CY14 (74% PEPFAR). PEPFAR and GFATM finance the bulk of the HIV response. The GRM is the third-largest individual source of funding, with US \$16.2 million allocated to HIV in 2014. Despite having doubled from 2004 to 2014, domestic public HIV expenditure represented only 5% of overall HIV expenditures in 2014.

HIV Expenditure by Programmatic Area. NASA 2014 showed 16% of HIV expenditures were used for prevention programs, while C&T (including PMTCT) accounted for 36%.

Expenditure towards Health System Strengthening. In 2013, US \$292 million was invested in health systems (52% domestic public resources, 23% PROSAUDE and 24% from other external partners). According to NASA, in 2014 US \$137.6 million was spent in HIV-specific HSS funding, including expenditure for laboratories (US \$16.1 million); SI, surveys, and surveillance (\$24.2 million); and others not specified (US \$43.6 million).

Expenditure by Cost Category. The financing landscape changed significantly from 2014 to 2016, although most commodities for HIV continue to be financed by international partners. In 2014, 100% of ARVs were procured through international mechanisms such as Pooled Procurement Mechanism and Supply Chain Management System (SCMS) and financed by international donors, including PEPFAR (52%), the GFATM (45%), and UNITAID (3%). GFATM became the major financing mechanism during 2016 for key HIV/AIDS commodities like ARVs, CD4 and RTKs. UNITAID (implemented by CHAI) no longer funds pediatric ARVs, testing, and other diagnostics like PIMA CD4 and EID.

GRM pays HCW salaries (estimated at US \$12 million in 2011¹²) and costs related to implementation (facility maintenance, transport, etc.). According to the 2014 NASA, 40% of labor costs for HIV treatment in 2011 were supported by the state budget, with an additional 8% from Mozambique's Common Health Sector Common Fund (PROSAUDE).

It is estimated that 11% of the MOH recurrent expenses are allocated to HIV and TB. Other domestic spending from MOH covers lab reagents, materials and specific services. In addition to these

¹⁰ PEPFAR funds are not included in this total.

¹¹ UNAIDS GARPR 2015

¹² MISAU/MOH, Plano Estratégico para TB

allocations to the MOH, the GRM also allocated funding to the CNCS for the coordination of the national HIV response and to civil society organizations for community activities.

Planned Government Contributions. The GRM has committed to increase domestic public expenditure for HIV, TB and malaria to US \$53 million in 2017 (totaling US \$127 million between July 2015 and December 2017). The MOH increased its contribution by US \$28.4 million in 2015, which will raise the contribution of GRM to those three diseases in 2015-2017 to 20% of its health sector budget. The Ministry of Defense (Ministério da Defesa Nacional -MDN) will continue to invest in the military health care system in support of its armed forces.

Data Availability and Estimations. Overall health sector expenditures are estimated from the MOH annual execution budget reports (*Relatorios de Execução Orçamental*), complemented by estimations made by WHO and the United Nations Children's Fund (UNICEF). The MOH does not track or report spending by disease category. Reporting of HIV specific funding is based on the NASA, elaborated by CNCS, which details HIV expenditure by financing source, programmatic area, beneficiary population or geographical location. Data available covers the years 2004 to 2011. HIV funding for 2012 and 2013 was estimated using the FY2015 PEPFAR Expenditure Analysis, Official Development Assistance to Mozambique Database (ODAMOZ), and the Organization for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC) online data bases and donor reports.

Conclusion and Next Steps. Despite positive projections, the GRM will not be able to fully cover the costs of its response to HIV (and TB and Malaria). The estimated gap from June 2015 to December 2017 reaches US \$365 million, representing 36% of the Government's Health Sector Budget for the same period.

Over the past few years the GRM has increased investment in the health sector in total dollar terms; however the proportion of the total domestic budget allocated to health continues to fall well below the 15% commitment made in the Abuja Declaration. With significant increased state revenues from extractive industry gains expected within the next 15-20 years, the GRM can prepare to increase its investments in, and ownership of, the health sector, including the fight against HIV/AIDS. It is essential for the GRM, GFATM, and PEPFAR to work closely to create a clear and sustainable financing plan for anti-retroviral (ARV) drugs and other commodities and to execute timely disbursements. The MOH, with PEPFAR support, is completing a Health Financing Strategy, and discussions are underway between the MOH and the Ministry of Finance (*Ministério da Economia e Finanças - MINEF*) regarding implementation of innovative financing mechanisms.

Table 1.2.1 HIV Expenditure by Programatic Area in 2014, Mozambique

Program Area	Total Expenditure	% PEPFAR	% GF	% GRM	% Other
Clinical care, treatment and support	90.6	68%	20%	2%	10%
Community-based care, treatment, and support	7.9	92%	N/A	2%	6%
PMTCT	22.1	75%	10%	4%	11%
HTC	14.2	81%	12%	4%	3%
VMMC	17.6	99%	1%	0%	0%
Priority population prevention	5.0	44%	7%	7%	43%
Key population prevention	3.5	49%	7%	N/A	45%
OVC	6.2	84%	N/A	4%	12%
Laboratory	16.1	75%	2%	9%	13%
SI, Surveys and Surveillance	24.2	90%	N/A	5%	5%
HSS	43.6	89%	N/A	7%	4%
Total	250.9				
Missing:	81.6				
<i>Other prevention expenditure</i>	28.3	43%	17%	4%	35%
<i>National coordination and program m</i>	44.0	81%	2%	8%	9%
<i>Enabling environment & other social s</i>	9.4	35%	16%	22%	27%
TOTAL	332.5	74%	9%	5%	12%

* Includes VCT, PIT and blood safety (PMTCT testing included under PMTCT)

** Refers to preventino for vulnerable groups, accessible population and prevention for youth

*** National M&E, operacional research, surveillance, information technology, research

Source: National Aids Spending Assessment (NASA) for the period 2014 in Mozambique, Conselho Nacional de Combate ao HIV/SIDA (CNCS), September 2016.

Table 1.2.2 Procurement Profile for Key Commodities (through Sept. 2016)

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GRM	% Other
ARVs	\$117,635,707	27.80%	72.20%	0.00%	0%
Rapid test kits	\$11,801,866	4.80%	95.20%	0.00%	0%
Other drugs	\$33,140,972	9.30%	44.90%	45.80%	0%
Lab reagents	\$11,811,094	32.90%	67.10%	0.00%	0%
Condoms	\$2,413,735	0.00%	0.00%	13.00%	87.00%
Viral Load commodities	\$4,839,492	94.90%	5.10%	0.00%	0%
VMMC kits*	\$520,386	100.00%	0.00%	0.00%	0%
MAT	\$0	0.00%	0.00%	0.00%	0%
Total	\$182,163,252	25%	65%	9%	1%

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	# Co-Funded IMs receiving PEPFAR COP Funds for this Objective	PEPFAR COP Co-Funding Contribution (for this objective)	Objectives
USAID MCH	\$14,050,000	\$10,450,000	4	1	\$500,000	Strengthened quality and safety of priority medicines; Improved pharmaco-vigilance and rational use of drugs; Expand coverage and improve quality of community health activities; Training CHWs; Increased access to and use of voluntary FP contraceptive methods; Improved maternal and child survival.
USAID TB	\$4,500,000	\$300,000	1	1	\$1,600,000	Strengthened quality and safety of priority medicines; Improved pharmaco-vigilance and rational use of drugs..
USAID Malaria	\$28,500,000	\$16,220,000	3	0	\$0	Strengthened governance, supply chain; Improved maternal and child survival; Improved health behaviors.
USAID Family Planning	\$11,500,000	\$4,850,000	4	0	\$0	Strengthened quality and safety of priority medicines; Improved pharmaco-vigilance and rational use of drugs; Improved health behaviors; Commodities purchased including condoms, essential medicines, and diagnostics; Increased access to and use of voluntary FP contraceptive methods; Improved maternal and child survival.
USAID Nutrition	\$5,700,000	\$3,300,000	4	0	\$0	Include, but are not limited to: Increased capacity of MISAU to develop and implement nutrition-oriented policies and programs; Improved maternal and child survival; improved health behavior.
Peace Corps	\$7,135,131	\$0	0	0	\$0	Include, but are not limited to: increased capacity of MISAU, NGOs, community organizations, and CHWs to prevent and control HIV (non-PF resources pay for PC Health staff and operations); increased capacity of MINEDH to prepare secondary school students for academic success (non-PF resources pay for both staff and Education PCVs).
Total	\$71,385,131	\$35,120,000	4	2	\$2,100,000	

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP (FY17)						
Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total PEPFAR Non-COP IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
ACT (applied pipeline)	\$5,536,208	Unknown	3	3	\$78,746,096*	Pediatric diagnosis, care & treatment
DREAMS	\$13,572,731.35	Unknown	10	8	\$118,699,207*	HIV prevention in AGYW
DREAMS Innovation	\$1,332,753**	Unknown	3	0	N/A	Reduce HIV infections in AGYW by infusing new approaches
DREAMS Test & Start-Men	\$5,964,735	Unknown	6	5	\$110,408,707*	Accelerate enrollment and treatment for men in DREAMS districts
VMMC	\$16,410,814	Unknown	4	4	\$25,728,516	VMMC
Viral Load	\$0	N/A	N/A	N/A	N/A	N/A
Other PEPFAR Central Initiatives – Additional Commodities	\$14,314,594	Unknown	1	1	\$57,200,196	Essential commodities
Other Public Private Partnership	\$0	N/A	N/A	N/A	N/A	N/A
Total***	\$57,131,835	Unknown	15*	14*	\$243,346,370*	

* This amount reflects the total COP16 budget going to these IMs and includes funding that is not going to this objective.

**Estimated amount of funding, delays on award phase caused that grants have not yet been signed

***Co-funding numbers are not column totals due to duplication across different rows

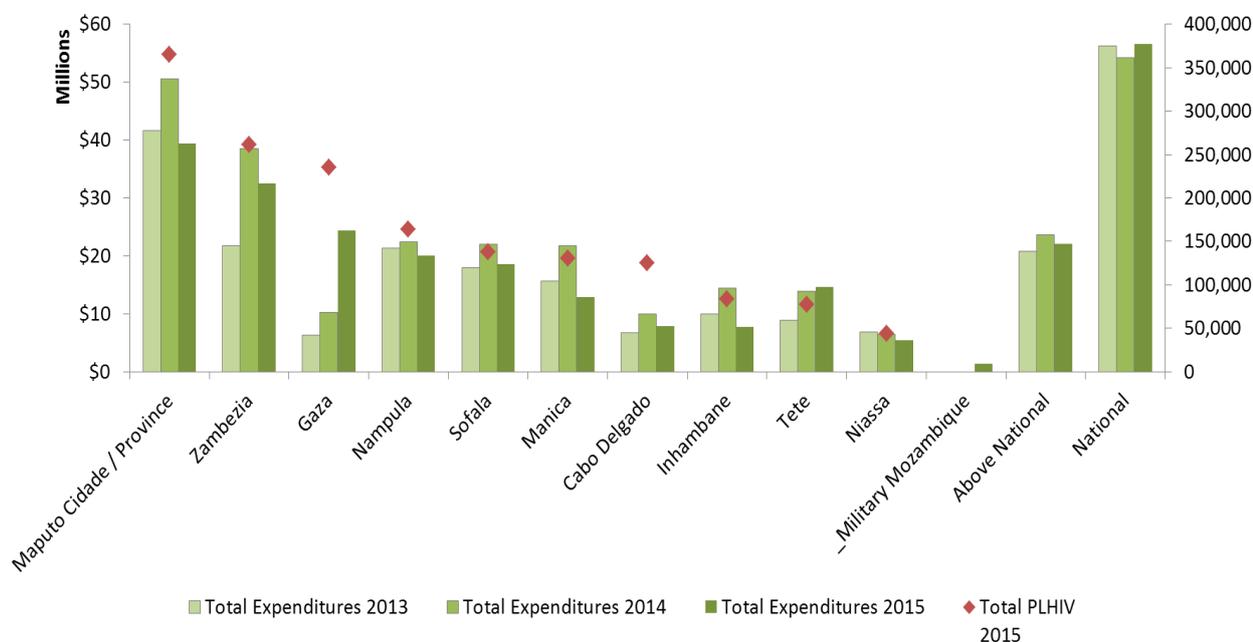
1.3 National Sustainability Profile

PEPFAR-Mozambique strove to make the completion of the Sustainability Index Dashboard (SID) as inclusive as possible. Consultations involved a series of nine meetings with key stakeholders including the MOH, multilateral partners, and civil society. Over 40 participants provided input, and the final product was vetted by the GRM during a day-long review. SID reviewers identified the following critical weaknesses: domestic resource mobilization, laboratory services, and civil society engagement. Both PEPFAR and the GFATM have been investing in the laboratory system in Mozambique including key activities such as the construction of the National Public Health Laboratory, procurement of diagnostic machines, and procurement of reagents for viral load (VL) diagnostic scale-up. PEPFAR and GFATM have also provided extensive support for sustainable health sector financing plans and increased civil society participation. All of these activities will continue to be supported in COP16. Key sustainability strengths include quality management, program planning and coordination, and utilization of performance data. Moving towards a sustainable response requires improving GRM’s allocative efficiency and oversight and stewardship. Some areas that scored dark green (“sustainable and requires no additional investment at this time”) or light green (“approaching sustainability and requires little or no investment”) do not align to the perception of country team members, perhaps because the instrument fails to capture either the quality or enough granularity of the requested indicators.

Given these fundamental systemic weaknesses in the health sector, PEPFAR-Mozambique has prioritized supply chain, health information systems, and HRH for investment in COP16.

1.4 Alignment of PEPFAR Investments Geographically to Disease Burden

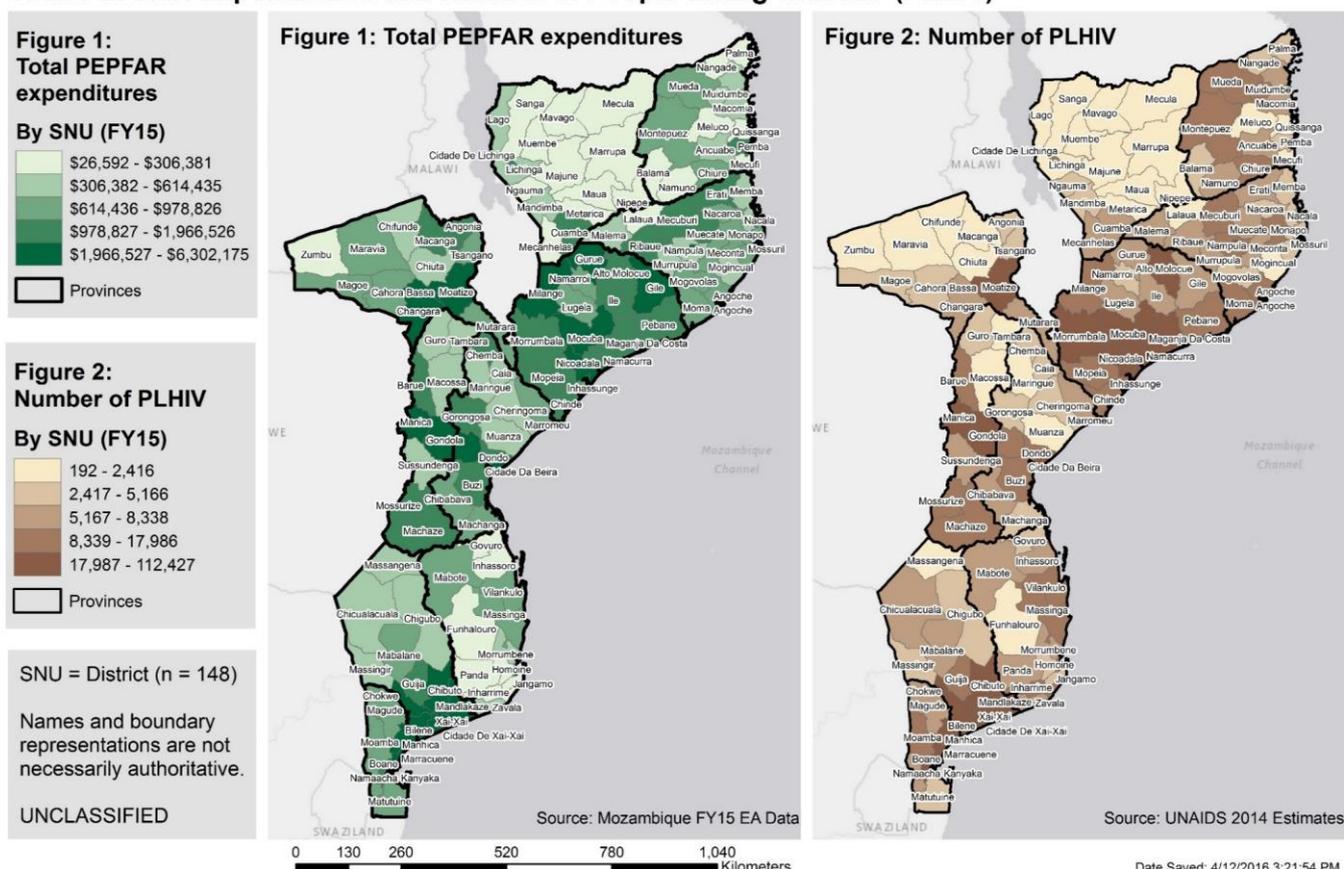
Figure 1.4.1: Total PEPFAR Expenditures and Total PLHIV by SNU by Fiscal Year



Overall, the PEPFAR program in Mozambique has made great progress in geographically targeting resources to the right places to ensure the highest degree of impact. In FY15, expenditures were geographically aligned with the HIV disease burden. The notable exception to this was Tete Province with 5% of total PLHIV and 6% of expenditures, representing a larger spend than Inhambane, Cabo Delgado, or Manica Province, all of which have larger numbers of PLHIV. From 2014 to 2015, the data show a proportionate increase (total provincial expenditure/total expenditure

by each year) in expenditures in Gaza and at the national level. Decreases occurred in Maputo Cidade/Province, Manica, and Inhambane. The total spend increased from 2013 to 2014 and again from 2014 to 2015, so comparing the total expenditure across years is not as useful as comparing proportions to total spend. The cost of doing business and the populations served varies slightly by Sub-National Unit (SNU) in Mozambique which could explain some of the variance between the above mentioned provinces.

Figure 1.4.2 PEPFAR Operating Unit
Total PEPFAR Expenditures and Number of People Living with HIV (PLHIV)



1.5 Stakeholder Engagement

Host Country Government. PEPFAR-Mozambique is committed to increased engagement with the Mozambican government on policy issues, data sharing, and strategic discussion to develop a shared vision for more substantial country ownership. USG leadership enjoy regular meetings with the Minister and Vice Minister for Health and frequent policy and program consultations with the national directors of Planning & Cooperation, Medical Assistance, Public Health, CMAM, Human Resources and heads of programs including STI, HIV/AIDS, TB, and Laboratory.

PEPFAR-Mozambique contributes to provincial planning processes and engages with Provincial Directorates for Health (*Direcção Provincial de Saúde - DPS*) to oversee program implementation and partner support at district and site level. This is accomplished through support for facility site visits and also by sharing QI cycle results, Site Improvement through Monitoring Systems (SIMS) reports and program results. PEPFAR-Mozambique has two national level government-to-government (G2G) cooperative agreements with the MOH and one with the National Institute of

Health (*Instituto Nacional Saúde*– INS). In addition, PEPFAR-Mozambique has six G2G at the provincial level.

PEPFAR-Mozambique also collaborates closely with the INS and the CNCS. Other ministries with which PEPFAR collaborates frequently include the Ministry of Gender, Child, and Social Action (*Ministério do Género, Criança e Acção Social* - MGCAS) and the Ministry of Education and Human Development (*Ministério da Educação e Desenvolvimento Humano* - MEDH) - both of which are critical to the OVC work, DREAMS and pediatric C&T initiatives. PEPFAR also engages with the MDN, the Ministry of Foreign Affairs and Cooperation (*Ministério dos Negócios Estrangeiros e Cooperação* - MINEC), Ministry of Defense (*Ministério da Defesa*), FADM (*Forças Armadas da Defesa de Moçambique*), and the Ministry of Finance (MINEF).

This level of engagement has enhanced PEPFAR's ability to participate in policy and planning in meaningful ways and allowed the USG to advocate on behalf of the MOH with other parts of GRM (especially MINEF and the Presidency).

Global Fund and Other External Donors. PEPFAR-Mozambique has engaged closely with GFATM throughout the development of COP16. The USG plays a key role in the management of GFATM grants via participation in the Country Coordinating Mechanism (CCM). The USG is the lead of the strategic supervision working group and sits on the CCM Executive Committee. Since 2015, PEPFAR-Mozambique has a full-time Global Fund Liaison who attends all GFATM meetings in country, communicates regularly with the Fund Portfolio Manager (FPM) in Geneva, coordinates USG technical assistance to the GFATM, and works to harmonize the PEPFAR and GFATM programs.

GFATM staff (including the FPM) and the PEPFAR strategic information, HSS and supply chain leads have participated in meetings in Maputo and Washington, DC, which were focused on improving collaboration and synchronizing programmatic strategies between PEPFAR and GFATM for the COP16 implementation period. PEPFAR-Mozambique held two in-person COP16 briefings for GFATM staff, a meeting between the FPM and the US Ambassador, and convened several technical calls focusing on specific programmatic areas during the COP planning period. The PEPFAR team shares all program plans with GFATM prior to finalization and solicits input on key strategic pivots.

In COP16 PEPFAR-Mozambique will continue to engage with GFATM to ensure both programs leverage their respective comparative advantages and eliminate duplicative activities. In particular, PEPFAR will share information and solicit feedback before and after technical assistance visits, quarterly reporting, and SID. PEPFAR will also continue to work closely with GFATM to coordinate commodities planning as Mozambique progresses through phased implementation of T&S.

Civil Society. For COP16 development, PEPFAR-Mozambique has been engaging with civil society since December 2015, through the Civil Society Platform for Health (Plataforma da Sociedade Civil - PLASOC), implementing partners and UNAIDS. PEPFAR and civil society members jointly developed an engagement plan highlighting key activities that will mark a close collaboration and partnership throughout FY16. Representatives of the PLASOC participated in the COP16 review conference call in August 2016.

PEPFAR-Mozambique's Civil Society technical working group will continue to meet with the PLASOC regularly throughout the COP16 implementation period to share information as well as to solicit input into key programmatic issues and policy decision points. In COP16 this will include consultations to assist with analysis of the roll out of T&S, to share guidance from the Office of the U.S. Global AIDS Coordinator (OGAC) on funding opportunities available to civil society, to discuss the final outcomes of the COP16 review, and to discuss PEPFAR's Human Rights agenda.

Private Sector. The U.S. Government Public-Private Partnership (PPP) Interagency Working Group in Mozambique meets quarterly to provide a forum for communication, collaboration, and discussion of best practices and opportunities for partnership building across U.S. Agency for International Development (USAID), State Political/Economic Section, Centers for Disease Control and Prevention (CDC), and Peace Corps (PC). This platform is PEPFAR's primary point of engagement with the private sector.

2.0 Core, Near-Core and Non-Core Activities

PEPFAR-Mozambique defined core, near-core, and non-core activities for program implementation by considering the activities required for achieving sustained epidemic control, the current country investment portfolio, and gaps/bottlenecks preventing program scale-up. PEPFAR is the primary funder for key activities in the national response, and core activities include combination prevention activities, aspects of community-based care, OVC and priority population prevention, and technical TA for commodity procurement and supply chain and information systems. For COP16, PEPFAR-Mozambique re-categorized nutrition support from near-core to core, given its importance to patient adherence to treatment. The current economic situation and severe drought, expected to continue through COP16 implementation, also informed this decision.

PEPFAR-Mozambique is the primary provider of TA to support C&T, which remains a core activity. The majority of C&T interventions are considered core activities with the exception of the following classified as near-core activities: diagnosis and treatment of sexually transmitted infections (STIs), cervical cancer, and Kaposi's Sarcoma; certain laboratory monitoring (e.g. liver function tests); expansion of TB diagnosis (training, GeneXpert scale-up); specific sample referral systems; and expansion of radiological diagnostic capacity (x-ray machines). COP16 will not fund any activities categorized as non-core. (See Appendix A for details of Core/Near Core/Non-Core activities).

3.0 Geographic and Population Prioritization

PEPFAR-Mozambique estimated PLHIV at the sub-national level using available epidemiological, programmatic, and demographic data in a stepwise process. This process mirrors the recent OGAC method that takes existing Sub-National Unit (SNU) Spectrum estimates and apportsions and disaggregates these down to the SNU level based on relative burden of disease as estimated from PMTCT programmatic data. First, official Spectrum files from 2015 (2014 estimates) were adjusted to reflect the move to CD4<500 in 2016 and T&S from 2017 onwards, and 2016 and 2017 PLHIV estimates were captured. Second, INSIDA 2009 Provincial HIV (age 15-49) estimates and provincial census projections were used to calculate the relative burden of disease in each province and used to push down Spectrum PLHIV regional estimates to the provincial level. Third, the MOH calendar year antenatal care (ANC) prevalence data and district census projections were used to calculate the relative burden of disease in each district and to attribute PLHIV burden down to the district level. (Please note that there are limitations to these estimates especially when extrapolated to the district level.)

In COP15, PEPFAR-Mozambique prioritized 77 (of 148) districts for scale-up based on high HIV burden.¹³ At the beginning of FY16, the estimated gap to achieve saturation in these districts was 495,243 persons¹⁴. The technical team recalculated the total number of PLHIV in each district nationally taking into consideration the most recent UNAIDS Spectrum estimates and the latest ANC program prevalence data and found that recategorizing districts would have resulted in minimal change (<5% of PLHIV). Given that the current list of prioritized districts was determined with the MOH and that more precise estimates of HIV burden by district are anticipated later in 2016, PEPFAR-Mozambique elected to make no changes to the overall prioritization of scale-up and sustained districts.

For pediatrics, the number of estimated children (<15 yrs) living with HIV decreased by 8% from 180,701 in 2014 (Spectrum 2014) to 165,585 in 2015 (Spectrum 2015)¹⁵. The estimated number of children eligible for ART under the MOH guidelines (issued March 2016) decreased from 128,924 to 77,202 (47% of pediatric PLHIV). District estimates for pediatric PLHIV were derived from the estimated adult prevalence rates and the estimated number of children in the district.

Technical teams conducted a saturation analysis to determine if districts deemed to be near saturation should be re-categorized as sustained (now “attained”). Districts with high-coverage and districts with low-coverage that are adjacent and appear to have a shared catchment area (based on patient health-seeking behavior) were brought into a single cluster. With this analysis, PEPFAR-Mozambique created two new clusters: *A Cluster of Inhambane* (ACOI), made up of Inharrime and Zavala, and *A Cluster of Maputo* (ACOM) made up of all seven districts in Cidade de Maputo. With this clustering, the overall number of scale-up districts was adjusted from 77 to 78, as one district of Cidade de Maputo, Katembe, then moved from sustained to scale-up. (See Figure 3.0.1 below which illustrates these clusters and coverage for each of these districts individually and clustered).

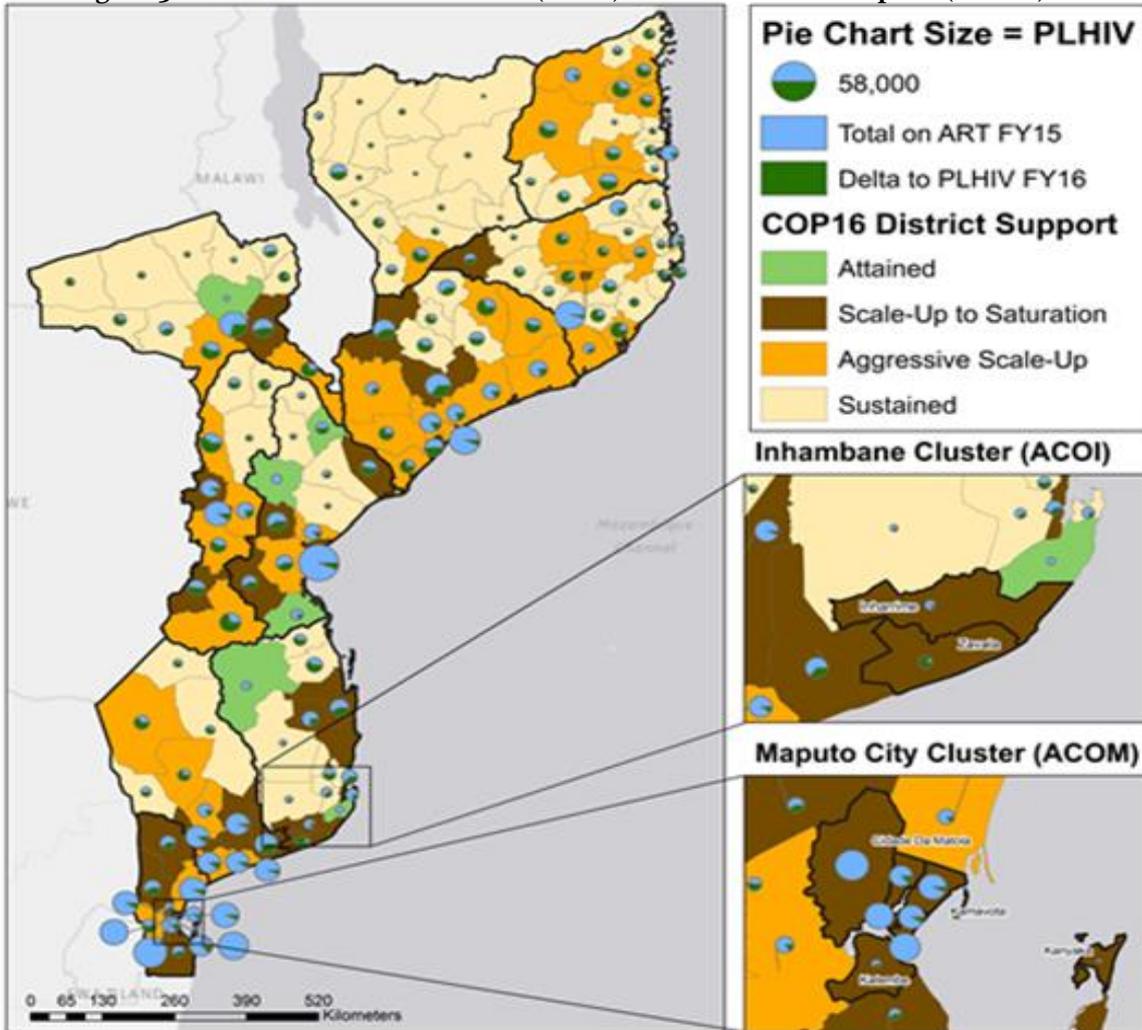
¹³ 86% of the PLHIV nationally reside in these districts.

¹⁴ MOH and PEPFAR data.

¹⁵ NB: Spectrum 2016 was recently released and estimated the number of children living with HIV at 110,042 in 2016.

PEPFAR-Mozambique developed targets using estimates of coverage at the cluster level for treatment, HIV counseling and testing (HTC), and voluntary medical male circumcision (VMMC). Targets for clusters were allocated to component districts proportional to FY15 achievements.

Figure 3.0.1: A Cluster of Inhambane (ACOI) and A Cluster of Maputo (ACOM)



In March 2016, MOH revised the threshold for ART eligibility to CD4 <500 and committed to phased implementation of T&S. MOH plans commit to roll-out of T&S in 36 districts by August 2017 and include all provincial capitals (except Cidade de Inhambane which was replaced with Maxixe as it has a higher burden and lower coverage of PLHIV), all five DREAMS districts, and nine additional districts chosen based on high burden of HIV and/or key populations. Together, these 36 districts represent 60% of PLHIV in Mozambique (947,353).

Phase 1 of T&S implementation began in August 2016 and included all provincial capitals (12 districts, including all sub-districts of Cidade de Maputo), covering 629,927 PLHIV (40% of all PLHIV). **Phase 2** will begin in February 2017 and will add eight of the next highest-burden districts in each province, covering an additional 195,099 PLHIV (52% of all PLHIV will be covered). **Phase 3** will begin in August 2017 and will add another nine districts, covering an additional 122,327 PLHIV and bringing the overall coverage of T&S to 60% of PLHIV in Mozambique. Following Phase 3, the GRM will roll out T&S throughout Mozambique. (Please see Appendix D for the T&S phased implementation plan.)

District targets were set using updated treatment guidelines and the potential to achieve saturation, as described in Section 4.1. The overall number of districts achieving saturation by FY18 was calculated using 80% as the threshold (vs. 73% in COP15). With established COP16 targets, it is expected that PEPFAR-Mozambique will reach epidemic control ($\geq 80\%$ ART coverage) by the end of FY18 in an additional 39 scale-up districts on top of the 5 which achieved epidemic control in FY15. Ten sustained districts will also reach epidemic control by the end of FY18.

Figure 3.0.2: Districts and Timeline for Test & Start Rollout

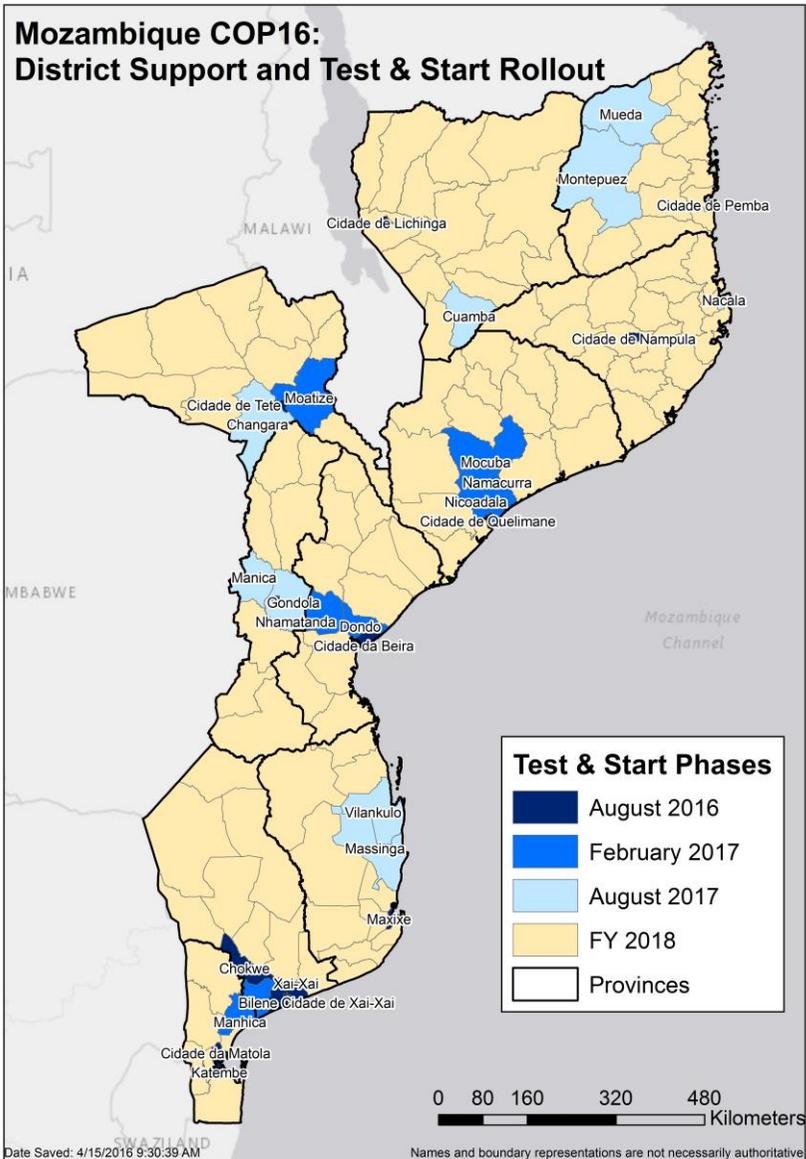
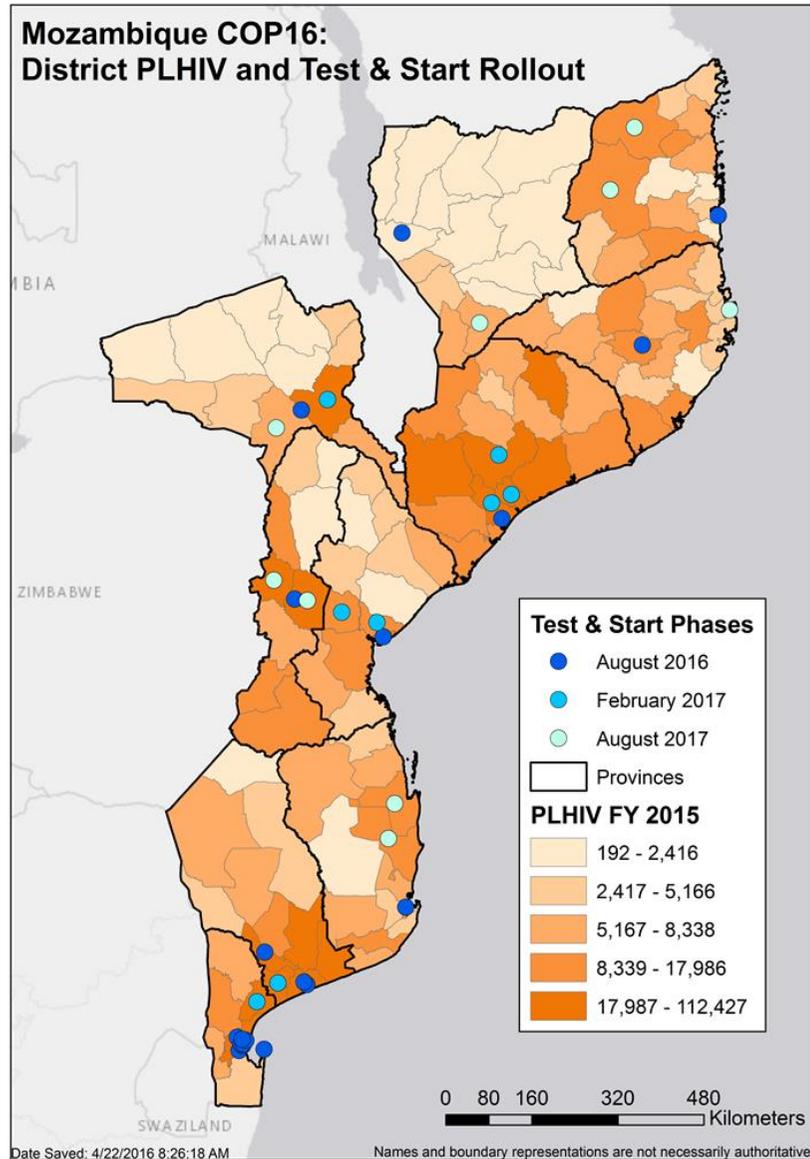


Figure 3.0.3: Test & Start Districts and PLHIV burden



4.0 Program Activities for Epidemic Control in Scale-up Locations & Populations

4.1 Targets for scale-up locations and populations

Development of overall treatment targets

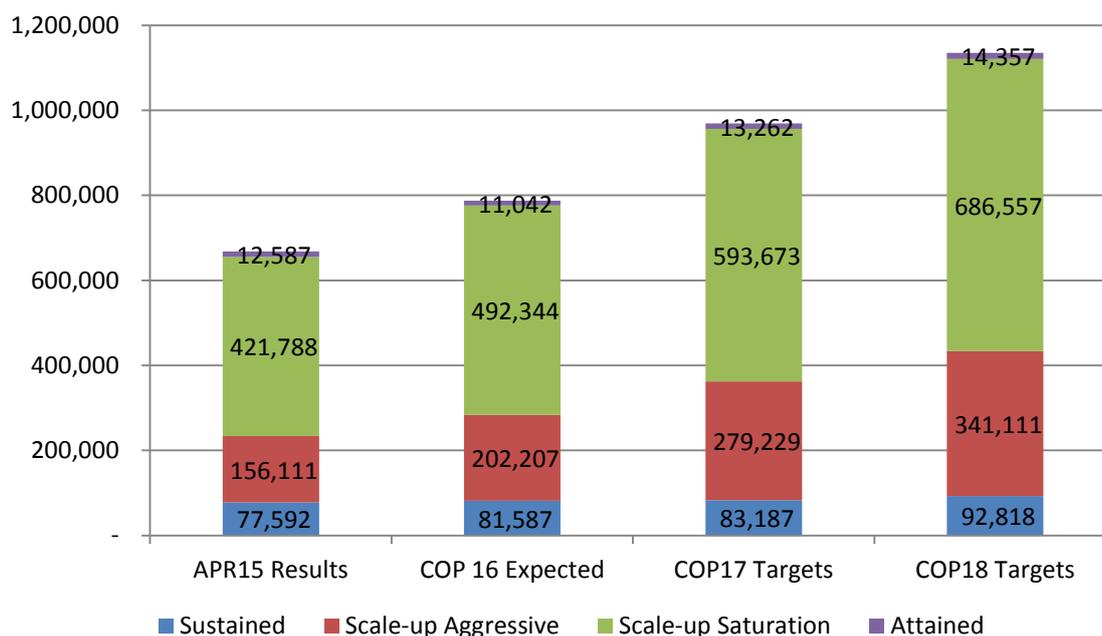
In order to maximize progress towards achieving UNAIDS 90-90-90 goals, PEPFAR-Mozambique prioritized activities to maximize ART coverage for all PLHIV in the highest burden districts. The team used the following data sources to determine COP16 targets in priority areas: 1) updated epidemiologic data, 2) updates to national guidelines, and 3) past achievements and feasibility of further acceleration of scale-up.

While the overall list of 78 scale-up districts did not change between COP15 and COP16 (except for the addition of Katembe as described in Section 3.o), current ART coverage and plans for phased implementation of T&S informed the development of targets and determination of which districts would be scale-up-to-saturation in COP16.

PEPFAR-Mozambique, together with the MOH, reviewed accomplishments during implementation of the national *HIV/AIDS Acceleration Plan* and roll-out of Option B+ to estimate feasible scale-up of T&S and concluded that approximately 20-35% growth of the total number of people on ART each year could be achieved in scale-up districts, with higher growth rates in T&S districts and in districts starting with lower coverage. PEPFAR targets do not exceed MOH province-level targets.

Based on these assumptions, 981,656 patients will be on ART in Mozambique by the end of 2017, of which 872,902 will be in scale-up districts, 83,187 will be in sustained districts, 13,262 will be in attained districts, and 12,305 will be in U.S. Department of Defense (DOD) supported sites. Figure 4.1.1 shows anticipated growth in current on treatment by district category (excluding DOD).

Figure 4.1.1: Treatment Targets and Coverage by Revised District Category



The greatest challenge for reaching these ambitious targets is retention of PLHIV on treatment. Strategies to improve retention are described in Sections 4.6, 4.8 and Appendix E.

Specific populations prioritized for intensive service provision in COP16 include children <15yrs, adolescent females, older men, persons at increased risk for TB/HIV, mineworkers, and key populations—including female sex workers (FSW), MSM, and PWID. ART initiation and retention in care among children <15yrs are especially challenging. In line with on-going efforts to increase pediatric coverage, aggressive targets were developed for this group as described below.

Pediatric Treatment Targets

Mozambique provides treatment for all children <5yrs and treatment for children 5-14yrs based on either a CD4 threshold of 500 cells/mm³ or WHO Stage III/IV disease. As discussed above, T&S for all (including children 5-14yrs) began in Phase I T&S districts (covering 40% PLHIV) in August 2016 and will continue to Phase II T&S districts (covering another 12% PLHIV) in February 2017.

FY17 targets for children <15yrs on ART were set as a proportion of the overall ART targets (8.7% overall) and were tightly constrained by the MOH's provincial level targets; the pediatric proportion ranged from ~7% of total targets in Tete and Cidade de Maputo to ~10% in Cabo Delgado and Sofala. The target for the total number of children on ART is 82,058 in FY17, a two-year increase of 30,575 or 59% from the APR15 TX_CURR result of 51,483. Based on the latest SPECTRUM model (released in June 2016), this is approximately 75% of all children living with HIV in Mozambique (110,042). The number of children on ART increased by 10,760 from APR13 to APR14 and by 12,113 from APR14 to APR15.

Key challenges to reaching this target are pediatric case identification, linkage to care, initiation of treatment, adherence and retention in care. Strategies for addressing these challenges are discussed in Section 4.9.

HIV Counseling and Testing Targets

PEPFAR calculated targets for adult and pediatric HTC in parallel. Linkage to treatment at the provincial level was estimated based on the historical ratio between number of new HIV diagnoses and new entrants into care less 10% to account for loss between C&T. Eligibility for treatment and entry of HIV infected persons in pre-ART to treatment were assumed to range from 56-100% and from 15-25%, respectively, depending on anticipated date of district implementation of T&S.

- Testing yield was based on district and testing modality-specific FY15 results.
- Since provider initiated counseling and testing (PICT) sites co-located with voluntary counselling and testing (VCT) has resulted in the identification of the highest number of new PLHIV, the team added VCT targets to 50 new sites, including every site deemed feasible in a scale-up district with PICT but no VCT.
- Index-case testing targets are based on 1.75 times the new on treatment target, based on the most common method of index case identification and assumptions about the number of partners and the treatment acceptance rate. Index-case targets were allocated 50% to facility-based testing and 50% to community based testing (CBT).
- CBT targets are solely comprised of index-case and KP targets.

For children aged <15yrs, PEPFAR-Mozambique estimated the number of HIV tests required to make targeted pediatric HIV positive diagnoses based on 50% of the positivity rate in the ANC matched at the district level.

Key Populations Targets

The KP population size was estimated using the Integrated Behavioral and Biological Survey (IBBS) and general population data. Since these estimates are only available in several large urban areas, for COP16, target districts were selected based on this data and expert opinion regarding KP hotspots. Targets for FSW and MSM testing targets were calculated at 40-50% of the relevant population size at district level, and prisoner targets were 100% of population size. KP district targets were not allowed to fall below historical achievement.

Voluntary Male Medical Circumcision Targets

Initial VMMC targets were set based on estimated numbers of circumcisions among adult men age 15-29 needed to reach 80% coverage in the minimum feasible timeframes: one year in Maputo City and Province, two years in Gaza, Sofala, and Zambezia, three years in Tete, and four years in Manica. Estimates were based on Project SOAR modeling but were adjusted upwards 70% for Sofala based on IMASIDA data. At a minimum, targets at the district and provincial level were set at the expected FY16 achievement. Particular attention was paid to aggressive targeting in DREAMS districts. The total VMMC target in Central and Northern provinces was calculated using the adult male target as 70% of the total target. In Cidade de Maputo and Maputo Province where estimated coverage at the end of FY16 was near 80%, the 10-14-year-old target was set at the number that would be needed to maintain current coverage levels in a maintenance program. A higher 10-14-year-old target was also used in Gaza where migrant labor among adult men is common.

Prevention of Mother to Child Transmission Targets

For PMTCT, revised district population estimates allocated to the SNU by fertility rates were used to set targets. The PMTCT program set ambitious targets for pregnant women tested for HIV (99%), HIV+ pregnant women on ART (99%), HIV-exposed infants tested (95% in Phase 1 T&S districts, 90% in other scale-up districts, and 80% in sustained districts), and HIV-infected infants linked to ART (95%). Specific activities to address challenges with early infant diagnosis (EID) implementation and plans to improve linkage and treatment of HIV-infected infants are discussed in Section 4.4.

Table 4.1.1 ART Targets in Scale-up Sub-national Units for Epidemic Control

SNU	[Specify SNUs for focus]	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART	Newly initiated (APR FY 17)	ART Coverage (APR 17)
					(APR FY17)	TX_NEW	
					TX_CURR		
Alto Molocue	ScaleUp Agg	10,523	4,122	3,646	4,964	1,667	47%
Ancuabe	ScaleUp Agg	6,546	3,341	2,042	3,381	708	52%
Angoche	ScaleUp Agg	8,832	3,113	3,968	3,506	1,016	40%
Barue	ScaleUp Agg	13,788	7,026	3,120	8,163	2,542	59%
Bilene	ScaleUp Agg	31,483	18,440	7,202	18,817	4,065	60%
Boane	ScaleUp Agg	22,765	10,154	2,708	13,584	5,461	60%
Buzi	ScaleUp Agg	8,935	4,270	1,056	5,483	2,067	61%
Caia	Attained	5,090	3,486	0	4,815	2,200	95%
Changara	ScaleUp Agg	11,124	6,057	1,761	7,342	2,496	66%
Chibabava	ScaleUp Sat	7,074	3,739	619	5,038	2,047	71%
Chibuto	ScaleUp Sat	26,341	17,065	2,353	18,783	5,131	71%
Chicualacuala	ScaleUp Agg	6,915	3,068	1,522	3,421	966	49%
Chinde	ScaleUp Agg	6,456	2,529	2,165	3,118	1,095	48%
Chiure	ScaleUp Agg	10,292	5,253	1,839	6,356	2,154	62%
Chiuta	Attained	1,046	1,212	0	1,400	491	134%
Chokwe	ScaleUp Sat	32,493	23,069	0	27,619	9,164	85%
Cidade Da Beira	ScaleUp Sat	76,701	40,539	5,825	55,818	23,387	73%
Cidade Da Matola	ScaleUp Sat	130,497	64,379	6,305	69,310	17,808	53%
Cidade De Chimoio	ScaleUp Sat	40,296	22,710	127	31,028	12,860	77%
Cidade De Lichinga	ScaleUp Sat	8,715	4,081	0	6,699	3,435	77%
Cidade De Nampula	ScaleUp Sat	38,603	19,867	3,258	24,134	8,240	63%
Cidade De Pemba	ScaleUp Agg	19,155	7,407	4,464	10,034	4,109	52%
Cidade De Quelimane	ScaleUp Agg	46,070	26,350	5,698	27,124	6,044	59%
Cidade De Tete	ScaleUp Sat	23,601	15,576	0	18,240	5,779	77%
Cidade De Xai-Xai	ScaleUp Sat	29,280	18,969	1,957	21,988	6,813	75%
Cuamba	ScaleUp Agg	7,760	3,285	952	4,654	2,026	60%
Dondo	ScaleUp Agg	20,767	9,924	3,287	13,706	5,767	66%
Gile	ScaleUp Agg	7,302	2,861	2,261	3,334	1,045	46%
Gondola	ScaleUp Agg	25,798	9,958	7,308	12,899	4,932	50%
Gorongosa	Attained	2,171	2,648	0	3,429	1,443	158%
Guija	ScaleUp Agg	16,088	7,138	3,643	9,653	3,942	60%
Inharrime	ScaleUp Sat	3,452	1,881	373	2,597	1,092	75%
Inhassunge	ScaleUp Agg	11,127	4,359	3,886	5,033	1,546	45%
Jangamo	Attained	1,954	1,755	0	2,197	881	112%
Kamavota	ScaleUp Sat	36,240	27,900	4,365	31,315	8,994	86%
Kamaxakeni	ScaleUp Sat	35,856	27,605	3,401	30,266	8,182	84%
Kampfumu	ScaleUp Sat	16,584	12,768	6,864	18,137	7,923	109%
Kamubukwana	ScaleUp Sat	33,385	25,702	2,452	27,621	7,059	83%
Kanyaka	ScaleUp Sat	648	499	91	570	171	88%
Katembe	ScaleUp Sat	2,712	2,088	222	2,262	591	83%

Table 4.1.1 ART Targets in Scale-up Sub-national Units for Epidemic Control

SNU	[Specify SNUs for focus]	Total PLHIV	Expected	Additional patients	Target current on	Newly	ART
			current on ART (APR FY 16)	required for 80% ART coverage	ART (APR FY17)	initiated (APR FY 17) TX_NEW	Coverage (APR 17)
<i>TX_CURR</i>							
Mabalane	ScaleUp Agg	4,785	2,123	1,084	2,871	1,173	60%
Mabote	Attained	2,935	2,729	0	3,656	1,609	125%
Machanga	Attained	4,332	2,888	0	3,881	1,570	90%
Machaze	ScaleUp Agg	12,976	5,009	2,833	7,786	3,778	60%
Macomia	ScaleUp Agg	5,488	2,122	1,825	2,508	811	46%
Maganja Da Costa	ScaleUp Agg	23,613	9,250	8,010	11,312	3,912	48%
Magude	ScaleUp Sat	7,121	3,513	0	4,942	2,131	69%
Malema	ScaleUp Sat	3,887	2,000	316	2,676	1,076	69%
Mandlakaze	ScaleUp Sat	15,357	10,903	1,510	11,151	2,429	73%
Manhita	ScaleUp Agg	36,514	18,014	0	22,784	8,373	62%
Manica	ScaleUp Sat	20,059	11,305	1,771	14,643	5,599	73%
Marracuene	ScaleUp Agg	18,335	8,178	1,000	10,884	4,342	59%
Marromeu	ScaleUp Sat	8,258	4,365	729	6,028	2,536	73%
Massinga	ScaleUp Sat	8,329	4,974	0	6,403	2,424	77%
Matutuine	ScaleUp Sat	4,593	2,266	0	3,184	1,371	69%
Maxixe	ScaleUp Sat	7,745	4,625	174	6,053	2,353	78%
Mecuburi	ScaleUp Agg	5,061	1,784	1,787	2,496	1,069	49%
Milange	ScaleUp Sat	14,248	8,149	0	10,120	3,601	71%
Moamba	ScaleUp Sat	8,320	4,105	0	5,794	2,510	70%
Moatize	ScaleUp Sat	12,856	8,485	0	10,928	4,140	85%
Mocimboa Da Praia	ScaleUp Agg	6,577	2,543	2,245	3,053	1,019	46%
Mocuba	ScaleUp Sat	19,316	12,107	287	13,680	3,994	71%
Moma	ScaleUp Agg	12,859	3,626	5,844	4,972	2,071	39%
Monapo	ScaleUp Agg	4,321	2,224	560	2,702	923	63%
Montepuez	ScaleUp Agg	9,450	3,654	2,760	4,371	1,448	46%
Mopeia	ScaleUp Agg	6,452	2,528	2,180	3,100	1,078	48%
Morrumbala	ScaleUp Agg	18,095	5,671	7,978	6,829	2,292	38%
Mossurize	ScaleUp Sat	8,804	4,962	402	6,427	2,458	73%
Muecate	ScaleUp Agg	3,508	1,237	950	1,718	729	49%
Mueda	ScaleUp Agg	16,245	6,281	5,130	7,484	2,459	46%
Muidumbe	ScaleUp Agg	9,399	3,634	3,263	4,488	1,581	48%
Mutarara	ScaleUp Agg	7,609	3,139	1,661	4,565	2,054	60%
Nacala	ScaleUp Agg	13,142	4,633	4,550	6,571	2,865	50%
Namaacha	ScaleUp Agg	6,371	3,143	0	3,705	1,191	58%
Namacurra	ScaleUp Agg	28,932	11,334	9,889	13,785	4,718	48%
Nampula	ScaleUp Agg	5,684	1,603	2,536	2,274	991	40%
Nhamatanda	ScaleUp Sat	11,778	6,651	75	9,422	4,102	80%
Nicoadala	ScaleUp Agg	33,453	13,105	10,835	16,539	6,055	49%
Nlhamankulu	ScaleUp Sat	22,266	17,142	5,375	21,347	7,633	96%
Pebane	ScaleUp Agg	26,149	8,195	10,861	9,843	3,287	38%
Sussundenga	ScaleUp Agg	7,652	3,899	649	5,050	1,931	66%
Vilankulo	ScaleUp Sat	10,419	5,678	987	7,276	2,734	70%
Xai-Xai	ScaleUp Agg	29,081	18,840	4,905	19,129	4,057	66%
Zavala	ScaleUp Sat	5,557	3,028	495	3,979	1,557	72%

Table 4.1.2 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY17)			Identified Positive (APR FY17)			Newly initiated (APR FY 17) <i>TX_NEW</i>		
	Total	Adult	Pediatrics	Total	Adult	Pediatrics	Total	Adult	Pediatrics
Pre-Art	N/A			N/A			69,558		
Facility-Based HIV Testing	3,683,285	2,909,430	773,855	362,293	327,691	34,602			
Antenatal Clinic 1st Test	830,368			57,083			51,995 (from ANC)		
Labor and Delivery	104,426			1,800					
Early Infant Diagnosis	80,543			4,771					
Infant Rapid	47,315			2,014					
Tuberculosis	17,132			8,663					
VMMC	334,234			4,344					
Facility Index-Case	246,291			36,447					
Other PITC	1,517,351			142,358					
Co-located VCT	505,625			104,813			188,817 (from all other newly diagnosed patients)		
Community-Based HIV Testing	305,841	149,195	156,646	42,078	31,686	10,392			
Community Index Case	246,291			36,447					
Key Populations	21,160			2,167					
Prisoner	9,204			1,013					
Non-DREAMS Adolescent Girls and Young Women	1,280			325					
DREAMS Additional Community	27,906			2,126					
Total	3,989,126	3,058,625	930,501	404,371	359,377	44,994	310,370	276,950	33,420

Table 4.1.3 VMMC Coverage and Targets by Age Bracket in Districts Targeted for VMMC in FY17

Province	District	Population Size Estimate		Est. Coverage*	VMMC_CIRC Targets		Targeted Coverage**
		(SNU)		(End FY16)	(FY17)		(End FY17)
		Total male population	Male population, age 15-29	Male population, age 15-29	Total male population	Male population, age 15-29	Male population, age 15-29
Zambezia	Alto Molocue	180,702	45,978	58%	7,483	5,238	69%
Manica	Barue	109,158	30,556	33%	7,092	4,964	48%
Gaza	Bilene	78,177	23,025	51%	1,918	982	55%
Maputo	Boane	74,739	21,111	93%	1,430	390	94%
Sofala	Buzi	90,200	24,406	76%	23,441	16,409	141%
Tete	Cahora Bassa	61,272	18,175	21%	6,086	4,260	43%
Sofala	Caia	70,336	16,862	16%	17,469	12,228	85%
Tete	Changara	96,764	27,055	14%	8,355	5,849	35%
Sofala	Chibabava	60,654	13,498	54%	7,169	5,018	90%
Gaza	Chibuto	98,925	26,381	42%	3,972	2,033	49%
Gaza	Chicualacuala	20,460	5,700	25%	3,316	1,697	54%
Zambezia	Chinde	64,830	15,014	42%	1,798	1,259	50%
Gaza	Chokwe	91,339	25,727	54%	3,054	1,563	60%
Sofala	Cidade Da Beira	231,684	81,575	63%	15,741	11,019	76%
Maputo	Cidade Da Matola	447,365	143,363	64%	8,340	4,078	67%
Manica	Cidade De Chimoio	158,700	51,205	38%	7,489	5,242	48%
Zambezia	Cidade De Quelimane	121,599	48,010	129%	12,695	8,887	147%
Tete	Cidade De Tete	107,128	34,985	34%	4,818	3,373	43%
Gaza	Cidade De Xai-Xai	59,452	19,835	69%	4,377	2,241	80%
Sofala	Dondo	86,689	28,995	73%	4,002	2,801	83%
Zambezia	Gile	97,694	23,013	82%	7,371	5,160	104%
Manica	Gondola	169,303	46,059	27%	10,924	7,647	43%
Sofala	Gorongosa	76,139	18,573	28%	16,616	11,631	88%
Gaza	Guija	42,648	11,109	41%	1,012	518	45%
Zambezia	Gurue	199,008	54,504	69%	10,950	7,665	82%
Zambezia	Ile	156,308	32,854	51%	12,779	8,945	77%
Zambezia	Inhassunge	48211	13,308	65%	2,771	1,940	80%
Maputo Cidade	Kamavota	166,042	50,773	83%	5,927	2,898	88%
Maputo Cidade	Kamaxakeni	113,382	39,474	49%	0	0	49%
Maputo Cidade	Kampfumu	53,880	17,612	171%	4,164	2,036	186%
Maputo Cidade	Kamubukwana	172,700	54,035	53%	3,166	1,548	55%
Gaza	Mabalane	18,553	5,096	29%	2,150	1,100	49%
Manica	Machaze	58,362	12,836	7%	4,943	3,460	33%
Zambezia	Maganja Da Costa	147,799	33,319	52%	10,973	7,681	75%
Gaza	Mandlakaze	82,718	20,593	41%	5,727	2,932	54%
Maputo	Manhira	121,556	33,398	82%	4,899	2,953	90%
Manica	Manica	140,963	43,046	42%	4,940	3,458	50%
Maputo	Marracuene	68,382	18,937	56%	4,561	3,387	73%
Sofala	Marromeu	85,611	23,274	71%	6,707	4,695	90%
Maputo	Matutuine	20,083	5,212	67%	1,420	1,074	87%
Zambezia	Milange	309,640	73,968	68%	16,871	11,810	83%
Tete	Moatize	168,679	44,658	9%	14,826	10,378	31%
Maputo	Moamba	33,017	9,408	71%	330	308	74%
Zambezia	Mocuba	187,383	49,888	86%	7,322	5,125	96%
Zambezia	Mopeia	75,865	17,217	51%	1,194	836	56%
Zambezia	Morrumbala	224,625	50,134	45%	15,297	10,708	66%
Manica	Mossurize	124,388	32,653	7%	10,573	7,401	29%
Tete	Mutarara	132,546	29,099	2%	15,249	10,674	38%
Zambezia	Namacurra	126,530	34,303	45%	8,725	6,108	62%
Sofala	Nhamatanda	136,829	38,706	47%	11,020	7,714	66%
Zambezia	Nicoadala	126,261	34,869	74%	7,194	5,036	88%
Maputo Cidade	Nhamankulu	77,739	27,691	136%	5,791	2,832	149%
Zambezia	Pebane	110,995	24,692	49%	7,722	5,405	70%
Gaza	Xai-Xai	114,278	32,011	41%	3,974	2,034	47%
Total		6,298,290	1,757,778		398,133	266,625	

*FY16 estimated achievement based on FY16 Q2 results adjusted by FY15 seasonal trend.

**Estimated VMMC coverage may exceed targets due to imperfect population estimates or migration for services.

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Province	District	Target Populations	Population Size Estimate (scale-up SNU)	Coverage Goal (in FY17)	FY17 Target
		<i>FSW</i>			
Cabo Delgado	Chiure	FSW	880	50%	440
Cabo Delgado	Cidade De Pemba	FSW	1,327	50%	664
Cabo Delgado	Mocimboa Da Praia	FSW	942	50%	511
Cabo Delgado	Montepuez	FSW	613	50%	307
Cabo Delgado	Palma	FSW	703	40%	273
Gaza	Bilene	FSW	316	40%	127
Gaza	Chokwe	FSW	661	40%	265
Inhambane	Cidade De Inhambane	FSW	1,309	50%	655
Inhambane	Massinga	FSW	437	50%	439
Inhambane	Maxixe	FSW	2,152	50%	1,076
Inhambane	Vilankulos	FSW	1,001	50%	629
Manica	Cidade De Chimoio	FSW	1,862	40%	745
Manica	Gondola	FSW	610	40%	494
Maputo Cidade	Kampfumu	FSW	913	40%	766
Maputo Cidade	Kamubukwana	FSW	2,677	40%	1,071
Maputo Provincia	Cidade Da Matola	FSW	6,820	40%	2,728
Maputo Provincia	Moamba	FSW	222	40%	89
Nampula	Angoche	FSW	693	40%	278
Nampula	Cidade De Nampula	FSW	8,615	45%	3,877
Nampula	Malema	FSW	378	40%	152
Nampula	Meconta	FSW	284	40%	562
Nampula	Moma	FSW	208	40%	84
Nampula	Nacala	FSW	3,350	45%	1,508
Niassa	Cidade de Lichinga	FSW	1,319	40%	528
Niassa	Cuamba	FSW	650	40%	260
Sofala	Cidade Da Beira	FSW	7,299	40%	2,920
Tete	Changara	FSW	1,134	40%	454
Tete	Cidade De Tete	FSW	1,360	40%	544
Tete	Moatize	FSW	327	40%	131
Zambezia	Cidade De Quelimane	FSW	1,580	40%	632
Zambezia	Mocuba	FSW	1,368	40%	548
Total			52,010	46%	23,757

		Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
<i>MSM</i>					
Cabo Delgado	Chiure	MSM	197	50%	99
Cabo Delgado	Cidade De Pemba	MSM	881	50%	441
Cabo Delgado	Mocimboa Da Praia	MSM	234	50%	117
Cabo Delgado	Montepuez	MSM	383	50%	192
Cabo Delgado	Palma	MSM	206	40%	82
Gaza	Bilene	MSM	166	40%	66
Gaza	Chokwe	MSM	294	40%	118
Inhambane	Cidade De Inhambane	MSM	310	50%	155
Inhambane	Massinga	MSM	91	50%	46
Inhambane	Maxixe	MSM	457	50%	229
Inhambane	Vilankulos	MSM	229	50%	115
Manica	Cidade De Chimoio	MSM	1,249	40%	500
Manica	Gondola	MSM	154	40%	62
Maputo Cidade	Kampfumu	MSM	630	40%	252
Maputo Cidade	Kamubukwana	MSM	1,751	40%	700
Maputo Provincia	Cidade Da Matola	MSM	4,657	40%	1,863
Maputo Provincia	Moamba	MSM	122	40%	49
Nampula	Angoche	MSM	411	40%	164
Nampula	Cidade De Nampula	MSM	2,654	50%	1,327
Nampula	Malema	MSM	231	40%	92
Nampula	Meconta	MSM	180	40%	72
Nampula	Moma	MSM	146	40%	58
Nampula	Nacala	MSM	928	50%	464
Niassa	Cidade de Lichinga	MSM	885	40%	354
Niassa	Cuamba	MSM	424	40%	170
Sofala	Cidade Da Beira	MSM	2,694	40%	1,078
Tete	Changara	MSM	654	40%	262
Tete	Cidade De Tete	MSM	900	40%	360
Tete	Moatize	MSM	203	40%	81
Zambezia	Cidade De Quelimane	MSM	1,071	40%	428
Zambezia	Mocuba	MSM	821	40%	328
Total			24,213	43%	10,324

Province	District	Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
		<i>Prisoners</i>			
Cabo Delgado	Cidade De Pemba	Prisoners	228	100%	228
Gaza	Cidade De Xai-Xai	Prisoners	388	189%	732*
Gaza	Mabalane	Prisoners	569	150%	853*
Inhambane	Cidade de Inhambane	Prisoners	302	100%	302
Inhambane	Inharrime	Prisoners	75	129%	97*
Manica	Cidade de Chimoio	Prisoners	1,871	100%	1,871
Maputo Provincia	Cidade de Matola	Prisoners	2,313	100%	2,313
Nampula	Cidade De Nampula	Prisoners	2,310	100%	2,310
Nampula	Muecate	Prisoners	100	100%	100
Sofala	Cidade de Beira	Prisoners	1,428	100%	1,428
Zambezia	Cidade De Quelimane	Prisoners	650	100%	650
Zambezia	Mocuba	Prisoners	253	100%	253
Total			10,487		11,137
Grand Total (FSW, MSM, Prisoners)			86,710		45,218

* In sites where APR15 results for prisoners were above estimates, we used the APR15 result as the COP16 target.

Table 4.1.5 Targets for OVC and Linkages to HIV Services

[Specify SNUs for focus]	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY17 Target)	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target)
		OVC_SERV	OVC_KNOWNSTAT*
Alto Molocue	13,795	4,422	No targets set for this indicator. Targets not required for COP 16.
Ancuabe	3,515	879	
Angoche	15,072	3,768	
Barue	16,041	4,010	
Bilene	28,852	7,136	
Boane	28,661	22,136	
Buzi	14,920	3,904	
Changara	17,114	4,278	
Chibabava	12,010	3,734	
Chibuto	25,500	6,307	
Chicualacuala	7,596	1,879	
Chinde	10,523	2,603	
Chiure	5,147	1,287	
Chokwe	29,525	7,302	
Cidade Da Beira	80,750	25,776	
Cidade Da Matola	119,767	29,622	
Cidade De Chimoio	33,247	8,312	
Cidade De Lichinga	24,101	5,961	
Cidade De Nampula	56,530	14,133	
Cidade De Pemba	8,146	3,894	
Cidade De Quelimane	41,456	15,364	
Cidade De Tete	24,226	8,041	
Cidade De Xai-Xai	21,785	5,388	
Cuamba	5,212	5,212	
Dondo	26,464	6,616	
Gile	11,429	3,400	
Gondola	32,466	8,117	
Guija	16,504	4,082	
Inharrime	5,390	3,434	
Inhassunge	12,899	3,190	
Kamavota	15,345	3,795	
Kamaxakeni	13,716	3,392	
Kampfumu	4,087	1,011	
Kamubukwana	16,475	4,075	
Kanyaka	905	224	

Table 4.1.5 Targets for OVC and Linkages to HIV Services

[Specify SNUs for focus]	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY17 Target)		Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target)
		OVC_SERV	OVC_KNOWNSTAT*	
Mabalane	5,109		1,264	No targets set for this indicator. Targets not required for COP 16.
MACHAZE	15,948		3,987	
Macomia	2,613		1,221	
Maganja Da Costa	32,971		8,243	
Magude	9,714		2,428	
Malema	7,449		2,688	
Mandlakaze	17,292		4,277	
Manhiça	48,452		11,984	
Manica	21,171		5,236	
Marracuene	23,929		5,982	
Marromeu	12,741		3,151	
Massinga	12,660		8,549	
Matutuine	5,859		2,574	
Maxixe	7,276		5,897	
Mecuburi	10,834		3,026	
Milange	20,005		5,001	
Moamba	9,658		3,609	
Moatize	18,253		4,851	
Mocimboa Da Praia	2,796		699	
Mocuba	29,760		7,440	
MOMA	22,868		5,656	
Monapo	7,705		1,926	
Montepuez	4,667		1,167	
Mopeia	9,462		2,656	
Morrumbala	28,985		7,330	
Mossurize	8,621		2,582	
Muecate	6,630		1,640	
Mueda	7,550		1,867	
Muidumbe	4,853		1,200	
Mutarara	11,305		5,189	
Nacala	20,900		5,169	
Namaacha	7,357		1,820	
Namacurra	35,068		8,767	
Nampula	10,270		3,649	
Nhamatanda	19,832		4,958	
Nicoadala	41,751		10,438	
Nlhamankulu	7,839		1,939	
Pebane	36,051		8,916	
Sussundenga	8,815		2,204	
Vilankulo	11,831		2,958	
Xai-Xai	29,627		7,328	
Zavala	8,974		2,690	
TOTAL	1,464,622		420,840	

4.2. Priority Populations Prevention

4.2.1 Key Populations

For COP16, PEPFAR-Mozambique will strengthen current investments in activities targeting KPs. FSW and MSM activities will occur at community and facility levels and will use a cascade approach to ensure linkages across the continuum of care¹⁶. Interventions will cover 30 districts, 28 of which are among the 78 scale-up districts¹⁷. The 22 health facilities that the MOH designated as “KP-friendly” will receive critical support and staff training in order to effectively reach these populations. USG will support IBBS (2nd round of IBBS on FSW), as well as update venue mapping and profiling and size estimation exercises. Results from these efforts will inform subsequent programming for KPs.

With HIV prevalence of 25%, prisoners are also considered a priority population. PEPFAR-Mozambique will support interventions for prisoners to include training of peer educators, demand creation for HTC, VMMC, TB and STI screening, and linkages to HIV C&T services. All prisons targeted for these interventions fall within scale-up districts.

PEPFAR-Mozambique will be conducting a limited pilot among people who inject drugs in Cidade de Maputo. This will include a comprehensive package of prevention, psychosocial support, and linkage to treatment, care and support. Preliminary data indicate that HIV prevalence among PWID ranges between 37%-50%, and population size estimates are 847 PWID in Cidade de Maputo and 191 for Cidade de Nampula.

4.2.2. Other Priority Populations

The military is also a priority population for PEPFAR-Mozambique, with significantly higher HIV prevalence than the general population. A Seroprevalence and Behavioral Epidemiology Risk Survey (SABERS) completed in early 2016 will provide more information on HIV among the military population. Preliminary results place the military epidemic in the north, and after further analysis the placement of specific interventions will be reorganized accordingly. Core prevention interventions include VMMC, HTC, and GBV, plus aggressive scale-up of ART through mobile and fixed sites. The military has also adopted T&S.

Mobile populations including long distance truck drivers and mineworkers are also an important high risk group. Prevalence among truck drivers (15%) and mineworkers (22%) is higher than the general population. Prevention activities targeting FSW at “hot spots” at the community level are expected to reach some of these priority populations.

¹⁶ Identify (KP Size and profile), Reach KPs, Test KPs, Continue Engaging HIV-negative KPs in Prevention, Enroll HIV-positive KPs in Care, Initiate on ART, Sustain on ART, Suppress Viral Load

¹⁷ The additional two districts are strategically important recognized KP hotspots.

4.2.3 Adolescent Girls and Young Women

Complementarity of COP 2016 with DREAMS Central Initiative

In Mozambique the HIV prevalence among AGYW age 15-24yrs is three times higher (11.1%) than their male counterparts in the same age group (3.7%). While the DREAMS proposal aligns with the GRM's *National HIV Strategic Plan*, a key difference is the geographic and sub-population focus. DREAMS will work in five districts in three provinces (Gaza, Zambézia, and Sofala) with the highest HIV prevalence among young women aged 15-24yrs (25%), which is over two times higher than the national estimate of 11.1% in this group.

The DREAMS Initiative includes evidence-based interventions with the potential to reduce HIV incidence among AGYW. Interventions focus on HIV negative AGYW who are in-school (10-19yrs); out-of-school AGYW (15-24yrs) who are HIV negative, pregnant/post-partum, or lactating; and socially vulnerable/hard to reach girls (10-24yrs) and their male sex partners. The core package of interventions includes HTC, social asset building, prevention of GBV, provision of post-violence care services, parenting and caregiver training, condom promotion and availability of comprehensive FP options including long-acting reversible contraceptives. Programmatically, DREAMS will link with both clinical and community GBV, OVC, VMMC, and PMTCT platforms in these five districts. Activities build on the clinical GBV platform by expanding post-GBV care services to 43 new health facilities in DREAMS districts for a total of 62. A comprehensive package for post-GBV care for children and adolescents will be expanded to non-DREAMS districts and integrated into the national GBV program supported through COP16. Linkages with the COP16 OVC platform are centered on savings groups, school-block grants, educational attainment, and care-givers' programming.

The programmatic pivot in both HTC and C&T for COP16 and the enhanced focus on reaching more male sex partners are central to the success of the DREAMS Initiative. As Mozambique rolls out T&S, the five DREAMS districts will provide an opportunity to pilot T&S for male sex partners. With the expansion of a reproductive health platform that will reach more AGYW, we will also reach male sexual partners and strengthen linkages to VMMC and referrals to C&T.

4.3 Voluntary Medical Male Circumcision

VMMC is provided as part of a comprehensive package of core and near-core activities. These activities include providing information on VMMC surgery, screening for STI, condom provision, promotion of safer sex practices through individual risk reduction counseling, and provision of reproductive health services for clients and accompanying family members. In FY16, the program made a shift towards targeting the 15-29 year old age group based on modeling data suggesting a more immediate impact on the HIV epidemic.

Currently, multiple activities support demand creation specifically targeting clients aged 15 to 29. Mobile clinics and partner-funded transportation for clients are used to facilitate access to services. In FY17, demand creation activities will continue to focus on the 15-29 target age group based on effectiveness data from FY16. In districts reaching 80% coverage in the target age group, the program will transition activities to a maintenance phase relying on circumcision of adolescents aged 10-14yrs. Modeling data suggests that VMMC coverage is approaching 80% in Cidade de Maputo and Maputo Province as of early FY16.

PEPFAR-Mozambique will coordinate with the MOH to decrease the intensity of PEPFAR support in districts which have achieved high VMMC coverage. The Shang Ring male circumcision device will be piloted along with a careful program evaluation. Maintenance of safety and quality during scale-up will be essential including strengthening of adverse event monitoring and reporting, exclusive utilization of dorsal slit surgical method for all patients younger than 15 years, and strengthening of Quality Assurance (QA) and Quality Improvement (QI) methods that function independently of implementing partners.

4.4 Preventing Mother-to-Child-Transmission

In the context of the rollout of B+, PMTCT activities have expanded to include treatment with ART initiation in newly diagnosed pregnant women in ANC. The GRM endorsed the global initiative for elimination of vertical transmission with the objective of reducing new HIV infections in children by 90% by 2015. Long-standing challenges at MCH facilities include low rates of facility-based deliveries (70% according to IMASIDA 2015), limited infrastructure, and limited human resources. Male involvement remains challenging. Cultural factors and stigma impede uptake of exclusive breast feeding. Mozambique has a high fertility rate (5.3 births per woman) and low levels of modern contraceptive use (27%)¹⁸. Finally, data quality overall is a challenge, as the national PMTCT M&E system is paper-based. PEPFAR supported the MOH to revise, improve and roll-out PMTCT/MCH registers which allow for longitudinal follow-up of pregnant and lactating women and linkage of mother/infant pairs. PEPFAR teams will continue monitoring and mentoring the HW in consistent and accurate use of the new registers.

Most women (93%) attend at least one ANC visit; however this often occurs late in pregnancy. Although ANC uptake drops off to approximately 55% by the fourth visit, ANC is an important venue for identifying HIV+ women. According to PEPFAR APR15 data, 96% of pregnant women who attend ANC visits know their status, and 93% of HIV+ women received ARVs. Eighty-six percent of all HIV+ women initiate ART at the ANC. HIV prevalence in ANC is 8% nationally. Male partner testing reached 34% in SAPR15, but it varies widely across the country. EID and linkage to treatment, retention of HIV positive women in care and appropriate utilization of VL monitoring are critical challenges, as confirmed by our SIMS data, and these areas will be a focus for PEPFAR partners in FY17. PEPFAR will continue to support the national quality improvement strategy for PMTCT that now also includes early retention and VL.

In FY15, 64% of exposed infants in PEPFAR sites received HIV testing in the first twelve months of life. Challenges are related to quality of samples, a fragile logistics system with lengthy turnaround times, and gaps in the instrument maintenance program. Near the end of 2015, laboratories faced shortages of PCR EID reagents and test kits (Abbott) as support for procurement transitioned from UNITAID to the GFATM. The situation was resolved by emergency procurement through PEPFAR but still resulted in an unacceptable multi-month delay. The PEPFAR team is investigating options for emergency procurement of EID and VL reagents if needed in the future, possibly through tapping into buffer stocks in neighboring countries.

Key strategies to address challenges in laboratory and program include: training health providers on quality sample collection, training lab technicians on use of new technology (Abbott and Roche), revising and strengthening the laboratory forecasting and logistic system, improving

¹⁸ IMASIDA 2015

sample transport and supporting rapid return of results to health facilities and caregivers. In addition, PEPFAR funded community workers will increase coordination with the health facility to maintain lists of children needing follow up. Training in presumptive diagnosis and treatment of HEI is ongoing.

The most critical challenge for PMTCT is retention on treatment among pregnant and lactating women along the entirety of the care cascade. Focused interventions to improve retention include intensified use of an individualized, longitudinal case management strategy utilizing mentor mothers and health educators to prevent lost-to-follow-up (LTFU), with an intensive focus on the immediate diagnosis and ART initiation phase, implementation of mothers2mothers support groups, and support to the Psychosocial Support and Positive Prevention Strategy. Community-based interventions will improve follow up for mother-baby pairs, increase male involvement and address the prevention and reduction of GBV including PEP, legal and psycho-social support.

4.5 HIV Testing and Counseling

The primary objective of the HTC program is to identify HIV positive individuals to achieve treatment targets. Secondary objectives include increasing identification of men who are HIV positive (as they are currently underrepresented in HIV care), ensuring linkage to care, and maintaining test quality.

PEPFAR-Mozambique's strategy focuses on high-volume, high-yield, scalable modalities and seeks to fully implement the MOH guideline for universal testing in specific high-yield clinical settings including inpatient, TB services, and emergency rooms. Symptom-based HIV testing will be offered in other settings such as triage and general provider clinics. Focused evaluation and QI will help to identify the highest yield sub-settings and ensure these are fully covered by PICT. Efforts will be made to co-locate VCT, the highest yield high-volume modality, in all feasible sites in scale-up districts not already covered. Co-located VCT is also a relatively successful modality for identifying male HIV positive individuals (45% of tested are male vs 31% in PICT). PEPFAR-Mozambique will work with the MOH to determine whether expansion of HIV testing to presumptive TB cases (in addition to confirmed cases) is indicated. In addition, index-case testing and KP outreach both of which are high yield modalities will be implemented in facility-based and community settings. Index-case testing will also be used as an opportunity to identify sero-discordant partners who would benefit from prevention counseling and treatment of the infected partner.

The PEPFAR-Mozambique Gender analysis (2016) emphasizes the need to test men who are at risk of becoming infected with HIV. In addition to existing VCT, MSM, prisoner, and VMMC testing programs used to identify HIV-positive males, PEPFAR-Mozambique will further explore workplace testing including minerworkers, testing of ill persons presenting to traditional healers, and incentivized peer referral for KPs as new or relatively underutilized testing modalities in Mozambique.

SIMS data indicate that linkages are a weakness in the HTC program. Strategies to ensure newly diagnosed PLHIV are enrolled in care include: reinforcement of post-test counseling, intensified coverage of peer educators to accompany clients and act as case managers, active referral into care whereby the counselor themselves escort newly diagnosed patients into care services, introduction of real-time defaulter tracing system to find and re-integrate diagnosed PLHIV into care services,

expansion of the HTC one-stop model, where the patient file is opened at the point of testing, prioritization of newly diagnosed PLHIV in the (usually long) lines to receive care services and revision of HTC M&E tools to incorporate linkage measurement. The HTC program will leverage the DREAMS Initiative to ensure any AGYW who are identified as HIV-positive receive appropriate services.

SIMS also highlights HIV testing quality as a programmatic weakness. To improve rapid HIV testing COP16 will: disseminate the national testing quality improvement guidelines in which the HIV rapid testing minimum standards are defined; provide HCW refresher training and ensure certification to perform HIV testing; and ensure that all facilities that receive the standardized specimen panel respond accordingly in collaboration with the INS, DPS, and implementing partners. Activities to assure quality of testing including use of dried tube specimens for external quality assessment (EQA), logbooks at service delivery sites, and provision of basic resources to maintain high quality testing will continue. Supportive supervision will continue in collaboration with central and provincial health authorities. PEPFAR-Mozambique is also working with the MOH to explore revision of the national HIV rapid testing algorithm to introduce a confirmatory test prior to initiating treatment to minimize the possibilities of false positives, particularly as T&S is rolled out.

Pediatric case identification continues to be a challenge beyond the early infant period. Starting with the largest health facilities in high prevalence areas, data will be collected on coverage and yield of routine testing in high risk medical departments serving children (inpatient, TB, high risk outpatient, and emergency). Partners will mentor and train health providers on routine testing, implement clinical quality improvement, and use data to improve performance. In other medical departments serving children (well child, sick child, and urgent care clinics), providers will receive additional training and mentoring on symptom-based testing. PEPFAR will continue to support scale-up of community and facility-based index-case and OVC testing. A pediatric HIV screening tool will be adapted and piloted both in health facilities and in community settings. COP16 will also intensify youth counseling and testing at adolescent friendly health units.

The National HTC guidelines were finalized during COP15 and dissemination will intensify during COP16. Guidelines include new strategies to target HTC to increase case finding, improve HIV testing quality, and strengthen linkages from HIV testing into care services.

4.6 Facility and Community-Based Care and Support

A comprehensive set of interventions to ensure the bidirectional linkages between facilities and communities is critical to decrease stigma, enhance patient detection, and improve patient retention and adherence. The community interventions framework will continue to implement client-oriented practices that improve the interaction between community and health systems to accelerate progress across the continuum of care.

For the first 90, the creation of an enabling environment for uptake of HIV testing and subsequently to ensure linkages to C&T services will be emphasized. Specific interventions include: the promotion and implementation of index-case testing for HIV and TB patients in the community; the expansion of male engagement to promote uptake of HIV testing including awareness for partner testing and ART initiation; and the use of community dialogues facilitated by PLHIV and local community radios to broadcast key HIV prevention and adherence related

messages.

For the second 90, interventions will aim to facilitate enrolment of diagnosed patients into care, to support rapid ART initiation and to expand the use of health educators that work both in the facility and in the community to follow patients through to care initiation.

For the third 90, activities that support medication adherence and retention in care will be implemented both at the facility and community. Interventions include the use of the M-health platform (e.g. using SMS or phone to remind patients about follow up appointments and other key messages). Using PLHIV as champions and advocates is critical to ensure successful implementation of interventions. Different models of peer PLHIV support will be used, including community ART support groups (*Grupos de Apoio a Adesão Comunitária*–GAAC), Mentor Mothers, Mothers-to-Mothers groups, adolescent and pediatric support groups, and *Pais e Cuidadores* (Parents and Caregivers). Additional interventions will include involving Community Health Agents, Health Educators, Community Health Workers (Agentes Polivalentes Elementares de Saúde - APES), traditional healers, traditional birth attendants, and community leaders to support adherence and retention. A combination of interventions including non -ART distribution sites and enhanced treatment literacy programs for those newly on treatment will be used to further address retention challenges.

4.7 TB/HIV

The twin epidemics of TB and HIV have consistently resulted in high TB/HIV co-infection rates (52%) and high HIV associated mortality in TB/HIV co-infected patients (134/100,000 compared to 67/100,000 for HIV negative TB patients). Recent policies have incorporated recommendations for universal HIV testing among TB patients, universal TB screening for HIV patients, and ART for co-infected patients. In PEPFAR supported sites, PITC for TB patients and ART initiation has been steadily improving over the recent years of program support, and the roll-out of “one-stop shops” for TB and HIV treatment has dramatically improved ART provision at a national level. In APR15, 98% of all TB patients had documented HIV status in the TB register, and 87% of all HIV-infected TB patients were initiated on ART (up from 95% and 68% in APR13 respectively).

Currently, TB case detection in Mozambique is at 39%. TB screening for HIV patients is not consistently implemented, and tools for monitoring completion of the TB Intensified Case Finding (ICF) cascade for PLHIV are limited. PEPFAR-Mozambique will provide TA to improve case detection through expansion of TB screening and case finding in PMTCT, antenatal clinics, HTC settings, ART clinics, and inpatient wards for adults and children in scale-up districts. To increase TB case detection, beginning in COP16 integrated TB screening and HIV testing will be offered to TB contacts and presumptive TB patients. Cough officers who conduct routine screening for patients will be expanded. Additionally, support will be provided to expand health workers’ ability to conduct TB surveillance in all high yield districts. Isoniazid preventive therapy (IPT), infection control measures and cotrimoxazole for TB/HIV patients will continue to be provided in all scale-up districts. A national TB survey supported by GFATM in 2016 will provide a better understanding of TB rates in the country.

Challenges identified in SIMS visits were the TB diagnostic evaluation cascade, IPT, and facility linkage to community. SIMS analyses have been shared and discussed with the provincial

directorates and partners, and follow up visits have been conducted in problematic clinics with intensified TA to targeted sites.

In 2015 the MOH adopted the new WHO recording and reporting forms for country-wide use and incorporated sex and age disaggregation. Clinical implementing partners (IPs) have ensured that data are used to inform the design of gender-specific approaches in service delivery. This work will be done both at the community and facility levels to ensure that TB is not seen as a man's disease and that infected women are not stigmatized.

Increased ART coverage to 100% and reduced lost-to-follow-up for co-infected military members will be reached through mobile treatment units and through delivery of GeneXpert MTB/RIF diagnostic capabilities at military medical sites.

PEPFAR partners will support monthly meeting between TB nurse/supervisor and pharmacy personnel to validate patient information and stock management.

4.8 Adult Care and Treatment

The goal of the adult treatment portfolio is to implement evidence-based interventions to increase early initiation ART, provide high quality services, ensure robust retention strategies and achieve epidemic control. The Mozambique ART program has scaled up rapidly since starting the implementation of the national *HIV/AIDS Acceleration Plan* in 2013, in addition to the adoption of universal ART for pregnant women and the national roll out of tenofovir based first-line regimens. Adult treatment coverage reached 49% – 36% in adult men and 58% in adult women – by December 2015. Prevailing challenges include low adult ART retention rates of 66% by 12 months on treatment, which is worse among adolescents and pregnant women; low male coverage; and slow roll-out of routine viral load (VL) monitoring.

PEPFAR IPs will continue to support the standard package of services defined in COP15 using a tiered approach, with the highest level of support in scale-up facilities (≥ 6 visits/year), decreased support and visit-frequency in sustained facilities (4 visits/year), and a minimal package of support which includes QI support and central TA in central-support facilities (2 visits/year), (See Section 5.1 and 5.2).

The following approaches will be implemented in all scale-up districts to improve ART initiation and treatment: strengthening linkages between community and health facilities through health educator outreach activities; expansion of quarterly patient file reviews to assess ART eligibility; implementation of strategies to increase male involvement; expansion of One-Stop-Shop models; early initiation of ART; diagnosis and treatment of ART related side effects; disclosure support; stigma reduction; and nutritional support.

In addition, core interventions to improve retention and VL suppression will be implemented, including: enhanced ART adherence support with particular focus on patients with detectable viral load; facility patient flow improvements; text message reminders and a tiered defaulter tracing cascade; preventive home visits for high-risk patients; and development of sample based approach to LTFU.

The results of the PEPFAR Gender Analysis have been incorporated in planning the adult treatment portfolio by specifically including districts with high estimated rates of HIV among AGYW to initiate implementation of T&S during COP16. Additional efforts will be made to provide post-GBV care services in scale-up districts as the health facility coverage of these services is currently less than 20%.

Changes to ART Service Delivery in COP16

In March 2016, the MOH committed to a phased implementation of T&S with nation-wide implementation by FY18. Six-month clinic visits and expansion of viral load monitoring are being implemented alongside T&S. Additional changes (including 3-month drug distribution and an enhanced retention package) are being implemented in a subset of sites and will expand based on early experience. *Please see Appendix D for a summary of the phased implementation timeline and coverage.*

- **Test and Start:** Phase 1 (which includes districts covering 40% of PLHIV) began in August following training sessions supported by PEPFAR IPs. Health facility readiness for T&S was assessed at baseline, and IPs have been assisting facilities in addressing problems that were identified. Patient outcomes, quality of care, and qualitative and quantitative aspects of implementation are being tracked; these data will be used to inform implementation of subsequent phases.
- **6-Month Clinic Visits for Stable Adult Patients:** Most ART patients in Mozambique (except those who are members of GAACs) are seen monthly. Implementation of T&S includes transitioning stable adult patients to 6-month visits (3-month visits for stable children over 5). This reduces the burden on both patients and providers and allows providers to focus more time on patients who are ill or initiating treatment.
- **Expansion of Viral Load Monitoring:** T&S districts will advance from Phase 1 VL implementation (focused on pregnant and breastfeeding women, children <5 years, and suspected treatment failure) to Phase 2 VL implementation (routine VL monitoring for all ART patients). Additional support to clinicians and decentralization of second-line drug committees are key to ensure appropriate management of ARV treatment failure cases. PEPFAR will also support minor infrastructure changes to accommodate high throughput or point-of-care (POC) VL machines, improved lab supply chain management, and a focus on improving overall lab efficiency (with the goal of minimizing lost samples, ensuring quality results, and improving lab turnaround times). Options for improving sample transport in Mozambique will be reviewed with the goal of establishing a cost-effective and reliable sample transport system.
- **3-Month Drug Distribution:** Monthly prescriptions are the standard of practice in Mozambique. Twenty-two sites (2 per province) began implementation of 3-month prescriptions for stable patients in July 2016. Subsequent expansion will take place once feasibility has been demonstrated.
- **Enhanced retention package:** 63 high volume sites in Phase 1 T&S districts covering 35% of SAPR16 TX_CURR have been targeted for the first phase of an enhanced retention package. Interventions include enhanced case-management and individual follow up at community level during the first 6-months on ART, pharmacy-based electronic patient management systems, systematic review of patient files (monthly) and intensive retention cQI. PEPFAR-Mozambique has developed a retention progress management framework with monthly indicators, a

monthly retention monitoring dashboard, and a follow-up action tracker. See Appendix E for details.

4.9 Pediatric Care and Treatment

Mozambique's pediatric ART eligibility criteria includes universal coverage for all children <5, coverage for children 5-14 with CD4<500 or meeting WHO stage III/IV criteria, and presumptive diagnosis and treatment of exposed infants. Additionally, the MOH is rolling-out pediatric T&S in concert with implementation for the adult population. PEPFAR will support effective implementation of the MOH guidelines on 3-month clinical visits for stable HIV+ children over 5 years of age. The MOH is considering adoption of new pediatric formulation for lopinavir/ritonavir.

Significant challenges to pediatric care and treatment include low retention (SAPR16 12 month ART retention rate were 64% for children <15 and 58% for adolescents 15-19) and slow roll-out of routine viral load monitoring. The latter is particularly important given the high rates of pediatric virologic failure (VF) (36%) and drug resistant mutations (95% among those with VF) reported by Vaz et al. (2016). Plans to address these are discussed in Section 4.8 (above).

SIMS data show that pediatric ART monitoring, adolescent support services, and pediatric facility referral to community care and support services need improvement. PEPFAR-Mozambique's Health Educator Strategy will provide case management services, including referral and disclosure support. PEPFAR will support renovation or prefab construction for several new youth-friendly health clinics (*Serviços Amigáveis Para Adolescentes e Jovens - SAAJs*) in T&S districts in FY17. SIMS also showed a handful of stock-outs of ARVs and cotrimoxazole; this will continue to be monitored and will be addressed through strengthening of the logistics and transportation system.

Approximately 29% of Mozambican girls experience sexual debut before age 15, and over half of the sexual violence cases reported at Maputo Central Hospital are in children under 15. PEPFAR will continue to improve the quality and availability of GBV services in PEPFAR-supported sites including screening and C&T (which includes psychosocial support as well as post-exposure prophylaxis and emergency contraception).

PEPFAR-Mozambique continues to support the National Quality Improvement Strategy, which includes pediatric indicators.

4.10 Orphans and Vulnerable Children

COP16 aligns the OVC portfolio with the C&T scale-up districts and improved targeting to reach OVC directly affected by, and infected with, HIV.

Key interventions include: rotation of OVC home visitors to the nearest ART sites to identify OVCs of PLHIV; index case testing of: OVC with malnutrition, cared for elders, school absentees, children of FSW, PLHIV and their family members (to identify PLHIV); and case management for positive pregnant and lactating women on Option B+ and exposed babies to enroll OVC. Emphasis continues to be on a family-centered socio-economic care and support model and improved coordination/collaboration with ART sites, including pediatrics and PMTCT, through strengthened community facility linkages and bi-directional referrals.

Core interventions include socio-economic activities critical to prevent and mitigate the impact of HIV/AIDS on children and ensuring their most basic needs are met. Near-core activities which cannot yet be undertaken by other partners or the government include activities that provide for a sustainable social infrastructure (i.e. social welfare cadres, community committees, youth clubs and safe spaces).

A strength-based case management approach ensures that the health needs of OVCs are addressed through building health and nutrition knowledge and skills among caregivers, facilitating access to HTC, and linkages to ART. Community-based (CBO) and faith-based (FBO) organizations proactively identify children for testing and treatment and refer those identified in ART sites to community-based social services. Early childhood development (ECD) platforms address developmental delays experienced by children infected, exposed to and affected by HIV by linking with and targeting mothers in PMTCT programs. Stable environments will be nurtured through economic strengthening focused on the expansion of savings groups plus improving parenting, strengthening access to social protection to reduce economic instability, protecting adolescents from GBV, and ensuring victims receive proper counseling and care. A special emphasis in conjunction with DREAMS will be focused on keeping adolescent girls HIV-free, using evidence-based interventions through education, linkages to sexual reproductive health and HTC, psychosocial support, socio-economic package, and parenting caregiver programs with emphasis on adult/child communication. Subgroups of girls at high risk for HIV infection will be proactively identified using community, church and traditional leaders. Cross-referral mechanisms for these girls will be strengthened with relevant sites.

Activities will be implemented in 78 scale-up districts within the catchment areas of ART sites and in coordination with other HIV stakeholders and MGCAS. COP15 concluded implementation in sustained districts focusing on strengthening the community based response. Transition from those areas had already been planned as part of the mechanisms close out. Further TA to community platforms is being provided through UNICEF where needed.

Above site activities include support to MGCAS to provide decentralized Social Action Technician and Infant Educator courses in partnership with the MOH training Institutes, data collection tools and systems designs for both GRM and CS, FBO/CBOs capacity building including community based structures working with OVC, and advocating for social policy for child and social welfare. Resources will be set aside to evaluate OVC interventions through outcomes and impact studies.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support locations and populations

All 195 health facilities in sustained and/or attained districts with ≥ 100 ART patients are included as sustained-support sites. Those health facilities with less than 100 ART, B+, or HTC positive patients were categorized as either central-support or non-support sites.

The main difference between the scale-up package and sustained response package is based on passive enrollment into treatment which is projected at 10% growth in FY16 and 5% in FY17. By FY17, a total of 96,449 out of an estimated 223,734 PLHIV (86% of whom are attributed to PEPFAR-supported sites) in sustained and attained districts will be on ART, with treatment coverage of 51% in these districts.

Sustained sites will receive clinical mentorship, QI support, and support for PMTCT. These sites will implement national treatment guidelines and will not start implementation of T&S until FY18. Some of these include large, high-volume sites with greater than 1,500 ART patients and merit a core package of quality services. However, there will be no demand creation activities in sustained or attained districts, and there will be less frequent visits from PEPFAR implementing partners (4 visits/year for sustained sites vs. 6-8 visits/year for scale-up sites). Details of the package of services across technical areas are provided in Table 5.1.1.

Table 5.1.1: Package of Services by Health Facility Category

District Category	Saturation and Aggressive Scale-up	Sustained or Attained	
Health Facility Category	Scale-Up	Sustained	Central-support
Visit Frequency	≥6/year	≥4/year	2/year
Site support approach	QI, Clinical mentoring and supportive supervision (HTC, pre-ART, T&S, PMTCT, TB/HIV)	QI, Clinical mentoring and supportive supervision	QI-lite Support
Education/ Demand Creation	Treatment literacy (Adult and Peds ART, PHDP, TB/HIV); Demand creation/education for VL and T&S (where applicable); Stigma reduction interventions; Community/facility mobilization; Roll-out of PMTCT and pediatric national communication strategies	Treatment literacy, Stigma reduction interventions	N/A
HTC	Index-case based testing; VCT expansion; pilots for identification of male positives (traditional healers, incentivized peer referral) under PEPFAR guidance; KP facility-based testing; PICT optimization; as needed support for implementation of GRM HTC guidelines; quality assurance support; improvement of M&E processes, e.g. age/sex disaggregation; national level commodity support	KP facility-based testing in select hotspots; PICT optimization; as needed support for implementation of GRM HTC guidelines; quality assurance support; improvement of M&E processes, e.g. age/sex disaggregation; national level commodity support	National-level commodity support; transition planning for ongoing investments, e.g. VCT
Pre-ART/ Care	Quarterly review of pre-ART patient files to identify ART eligible patients; Clinical mentorship for PHDP, STI diagnosis, cervical CA screening, OI diagnosis and treatment, FP/HIV, GBV, NACS	Clinical mentorship, PHDP	National-level commodity support; Last-mile /specimen transport; Warm line; QI-lite
ART	Clinical mentoring; Support for implementation of new guidelines CD4<500 and T & S (trainings, job aids, tools); one clinic visit every 6-months and 3-month drug-pick up schedule for stable patients; GBV; NACS; PHDP/OI management; National level commodity support; Last-mile/specimen transport; Warm line	Support for new guidelines; Clinical mentoring on treatment, PHDP, & OI management; National-level commodity support; Last-mile/specimen transport; Warm line	National-level commodity support; Last-mile /specimen transport; Warm line; QI-lite
Retention and adherence support	M-health communication to patients; GAAC support and expansion; Preventive home visits for patients high risk for LTFU; Community tracing of LTFU patients;	GAAC, Mentor mothers and pilot of M2M groups	GAAC
PMTCT	Clinical mentoring (C&T; partner testing; quality of testing; B+; EID; TB/HIV; CTX; IPT malaria; syphilis testing; cervical cancer screening; FP/HIV; GBV; NACS; retention; VL testing; early identification of TF suspects); PHDP package; syphilis tests; Mentor Mothers / Health Educators and M2M groups for retention support; National-level commodity support; Last-mile /specimen transport; Warm line	Clinical mentoring; PHDP package; syphilis tests; Mentor Mothers/ Health Educators and M2M groups for retention support; OI management; National-level commodity support; Last-mile /specimen transport; Warm line	National-level commodity support; Last-mile /specimen transport; Warm line; QI-lite

District Category	Saturation and Aggressive Scale-up	Sustained or Attained	
Pediatric/ Adolescent Care & Treatment	Clinical mentoring (focus on TB & malnutrition diagnosis/treatment, CTX; IPT TB, GBV; VL monitoring & early identification of TF suspects); Health Educators for intensive case management, including disclosure & retention support; Health Educators for case identification in high yield settings; Monthly teen clubs in all priority districts; Provincial pediatric teams; National-level commodity support; Last-mile/specimen transport; Warm line	Clinical mentoring; OI management; retention & adherence, National-level commodity support; Last-mile /specimen transport; Warm line	National-level commodity support; Last-mile /specimen transport; Warm line; QI-lite
TB/HIV	Clinical mentoring, Implementation of 3I's (Intensified case finding, Infection control, and IPT); Early ART for TB/HIV patients through one-stop shops; Integrated outreach services (HIV testing & TB screening); Expanded contact tracing; Systematic TB screening/HIV testing in high risk groups (miners, prisoners);	Clinical mentorship for implementation of 3I's and early ART for TB/HIV patients	National-level commodity support; Last-mile /specimen transport; Warm line; QI-lite
KP	Training and M&E support for KP friendly clinics; Feasibility and acceptability of medication-assisted therapy pilot for PWID under PEPFAR guidance; Roll-out of new National Guidelines for C&T of MSM and CSW's	Training and M&E support for KP friendly clinics in select hotspots	
OVC	Full OVC package with linkages to health facility. See Section 4.10 for additional details.	N/A	N/A
Lab	HIV- testing quality assurance; Support lab infrastructure for VL/EID/TB dx and address bottlenecks; Continued baseline CD4 and biannual CD4 support where VL not available; Continued support for Cr and Hgb based on treatment regimen; Support of specimen referral, results reporting, and lab supply chain; Support for decentralized EQA	HIV-testing QA; Hgb, Cr, and biannual CD4 where VL not available; Specimen-referral, results-reporting, and lab supply chain-support	Specimen-referral, results-reporting, and lab supply chain-support
SI	Support for routine M&E activities (data clerks, registers, training, and supervision); Electronic patient tracking system support for all ART facilities with > 500 patients; Develop a module for monitoring HIV exposed children	Support for routine M&E activities (data clerks, registers, training, & supervision); Electronic patient tracking system support for all ART facilities with > 500 patients	Procurement of registers and clinical forms
Routine M&E/ Evaluation of new strategies	Benefit of VCT expansion?; Qualitative assessment of male-friendly treatment service provision; Evaluate the root causes of low retention among PWBF and design strategies to address identified issues; Sample-based LTFU analysis; Routine data-collection on effectiveness of retention strategies (GAACs, APES, health educators, mentor mother strategy); Tablet based supervision and cQI		

Table 5.1.2 Additional Activities and Services in T&S Districts

Category	Activity
Visit Frequency	>8/year
Site support approach	<ul style="list-style-type: none"> • QI, Clinical mentoring and supportive supervision • Pre- and post-implementation assessment of selected sites
Demand Creation	<ul style="list-style-type: none"> • Demand creation/education for T&S • Male-engagement strategy implementation
HTC	<ul style="list-style-type: none"> • Training and development of materials for change in pre- and post-test counseling and linkage procedures to reflect new T&S guidelines • Increased focus on test quality including re-testing due to higher stakes
Pre-ART/ Care	<ul style="list-style-type: none"> • Community tracing of previous LTFU pre-ART patients
ART	<ul style="list-style-type: none"> • Support for implementation of new guidelines for T&S (trainings, job aids, tools) • Improved service delivery models to decongest clinics (6 month clinic appointments for all stable patients/quarterly drug pick-ups) • Expansion of electronic pharmacy patient management system
Retention and adherence support	<ul style="list-style-type: none"> • Pilots of alternative ART distribution models (e.g. non-ART clinics) • Continued pilot of mobile health clinics to support ART expansion
Pediatric/ Adolescent Care & Treatment	<ul style="list-style-type: none"> • Support for implementation of new guidelines for T & S (trainings, job aids, tools) • Pilot of quarterly visits for stable older children & adolescents • Adherence counseling prior to initiation of ART for adolescents • Renovations / pre-fab units for SAAJs and MCH one-stop-shop clinics (2 each per Phase 1 T&S district) • Pediatric loss to follow up analysis (of both pre-ART and ART patients) combined with a back-to-treatment campaign
TB/HIV	<ul style="list-style-type: none"> • Piloting HIV-testing in presumptive TB patients • Enhanced support for TB diagnosis among PLHIV
Lab	<ul style="list-style-type: none"> • Focused lab strengthening, including infrastructure, staffing, and specimen-referral improvements to accompany implementation of VL Phase 2 implementation (routine VL monitoring)
SI / Routine M&E	<ul style="list-style-type: none"> • Expansion of barcode-based electronic pharmacy patient management system for monitoring retention at high-volume sites (>2000 pts) • Pilot POC EPTS systems at very high-volume sites (>5000 pts) • Biometrics and/or unique IDs in facilities or testing sites to improve patient identification • Integrated Health Information System (HIS) that links people across the clinical cascade and from different service entry points
Evaluation of new strategies	<ul style="list-style-type: none"> • Process evaluation of Test and Start implementation and transition to differential service delivery mode Implementation of repeat-testing of HIV+ clients before starting ART • Yield of intensified contact tracing/ universal screening for presumptive TB, TB contacts, miners & prisoners • Assessment of alternative ART distribution points

Table 5.1.3 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts

Sustained Support Volume by Group	Expected result APR 16	Expected result APR 17	Percent increase (decrease)
Pregnant women with known HIV status	122,531	293,024	139%
HTS (only maintenance ART sites in FY 17)	599,283	891,698	49%
Current on ART	92,629	96,449	4%
OVC	-	-	-

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

PEPFAR-Mozambique has identified 181 health facilities as central-support sites. Of the 38 sites scheduled for transition in FY16 (per COP15 agreement), six have increased in patient volume to over 365 individuals on ART and follow 760 HIV positive patients. These sites will receive sustained-support. The remaining 32 will continue to be categorized as central-support. In addition, there are ten sites which will no longer receive direct PEPFAR support in COP16.

Centrally-supported sites will continue to receive two visits/year from IPs for mentoring and supervision; national level commodity support for all key HIV commodities; last mile support for RTK, ART, and lab commodities; support for specimen referral and results reporting; and QI-lite support (2 visits/yr).

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Closing Key Programmatic Gaps

Mozambique participated in the Systems Budget and Optimization Review (SBOR), which was a thorough review of its health systems investment portfolio. Through this process PEPFAR-Mozambique identified three critical systems gaps to achieving 90-90-90 and sustained epidemic control. These are supply chain, human resources for health (HRH) and strategic information (SI). The Mozambican supply chain system has limited capacity (human, technical and physical), which will be further challenged by the rollout of T&S. Also, Mozambique has one of the lowest ratios of HRH/population in the region, and, in spite of significant improvements in data availability (EPTS coverage has increased nearly threefold from 127 health facilities 2012 to 365 facilities in 2015.), information challenges are still significant barriers to achieving 90-90-90.

For COP16, investment in these three critical systems will allow the program to:

- Support Mozambique to build an integrated and efficient supply chain system capable of sustaining the throughput necessary to implement T&S and reach 90/90/90;
- Support training of key cadres of HRH critical to reaching 90/90/90, including public health logisticians, pharmacy technicians and laboratory technicians, and support HRIS expansion to improve efficiencies in allocation of human resources to high burden districts/sites; and
- Extend SI investments critical to improving patient quality of care (e.g. EPTS) rapidly to all DREAMS sites and to T&S districts.

In addition to investing in these three key systems, PEPFAR-Mozambique conducted a prioritization exercise, ranking in order of importance the investments which are critical to sustainability in financing, governance, institutional development and laboratory. Decisions about those investments are reflected in the tables below.

Table 6.1.1 Key Programmatic Gap #1: Inadequate supply chain to support program growth						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Strain on warehousing space and quality given the increased commodity need to achieve 90-90-90, T&S, and VL scale-up.	1. Warehouse and cold chain storage space is sufficient to manage the increase in volume from treatment, EID, and viral load scale-up	Secure central warehouse availability, strengthen controls and improve quality of warehousing practices and distribution systems in central and provincial warehouses for tests, treatment, and lab commodities, and support changes to warehouse policies and procedures required to manage increased volume.	OHSS	\$1,700,000	GHSC	8. Commodity Security and Supply Chain (3.59)
	2. Less than 3% expiries at central warehouses					
	3. Central warehouse inventory accuracy greater than 90%	Support the development and pilot implementation of an intermediate warehouse strategy aligned with the PELF and Global Fund warehouse rehabilitation efforts.	OHSS	\$400,000	GHSC	8. Commodity Security and Supply Chain (3.59)
More real-time logistics data availability and visibility required for appropriate management of commodities and quality forecasting and quantification with multi-month scripting and 90-90-90 program growth.	1. Human resources are adequate to submit and analyze data using appropriate information systems	Support activities and build capacity in MOH staff in quantification, forecasting, and supply planning including annual quantifications and quarterly supply plan updates and donor coordination (e.g. Global Fund) for medicines, tests, and lab commodities.	OHSS	\$750,000	GHSC	8. Commodity Security and Supply Chain (3.59)
	2. Greater than 70% forecast accuracy	Develop LMIS strategy and coordinated approach while continuing to maintain the use of existing LMIS including modifications required to align with service delivery model changes.	OHSS	\$1,400,000	GHSC	8. Commodity Security and Supply Chain (3.59)
	3. More than 80% of logistics reports are complete and submitted on time	Support the development of supply chain staff to manage, analyze, and make decisions based on logistics data for tests, treatment, and lab commodities including training, mentoring, and facilitating.	OHSS	\$550,000	GHSC	8. Commodity Security and Supply Chain (3.59)
The current supply chain is slow, fragmented, and inefficient, which is inadequate to appropriately support the needs of test and start, multi-month scripting, and 90-90-90.	1. Supply chain design is patient-focused	Provide commodity procurement services, support commodity importation/customs clearance, and provide lab commodity delivery direct to the labs.	OHSS	\$1,300,000	GHSC	8. Commodity Security and Supply Chain (3.59)
	2. ARV tracer stockout rate maintained at 5% or below despite growth in treatment sites and commodity need	Strengthen lab logistics management through strategic integration of lab logistics activities within the MoH, development of the lab logistics system given viral load scale-up, coordinated lab supply plan, donor coordination, implementation of an electronic stock card at provincial and district labs, supportive supervision, data analysis, stock planning, and monitoring equipment downtime and maintenance.	OHSS	\$900,000	GHSC	8. Commodity Security and Supply Chain (3.59)
	3. Appropriate supply chain knowledge and expertise exists throughout the supply chain	Strengthen last mile logistics through the design of systems approaches for medicine distribution, province and district supply chain management support and capacity building, technical assistance to implement lab sample logistics strategy, and coordinating the implementation of 3-month dispensing at the province and district level with the DPS and clinical implementing partners.	OHSS	\$1,100,000	GHSC	8. Commodity Security and Supply Chain (3.59)
	4. Lab specific supply chain issues are addressed at the appropriate organizational units(s) in MOH	Support strategy development, planning, and implementation of supply chain human resources to take over and manage a streamlined supply chain.	OHSS	\$450,000	GHSC	8. Commodity Security and Supply Chain (3.59)
		Develop and implement the second phase of a joint strategy with CMAM to reduce dependency on PEPFAR for operational support.	OHSS	\$100,000	GHSC	8. Commodity Security and Supply Chain (3.59)
TOTAL				\$8,650,000		

Table 6.1.2 Key Programmatic Gap #2: Human Resources for Health - Insufficient quantities of adequately trained HRH distributed according to program expansion needs						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Insufficient and poorly deployed stock of HRH	1. 90% of scale-up districts with a full staff complement	Strengthening HR policy and guidance, relevant to scale up implementation through technical assistance and data analysis.	OHSS	\$700,000	JHPIEGO	Human resources for health (6.83)
	2. Strengthened tracking of HRH (deployment, trainings (in service, pre-service), thereby optimizing targeting of trainings and use of resources					
		CONTINUING: Pre-service for additional technicians clinical officers currently enrolled	OHSS	\$20,000	CCS	Human resources for health (6.83)
		Pre-service training of 200 health technicians, MCH nurses and pharmacy technicians to increase health system capacity to adequately respond to HIV program scale-up needs.	OHSS	\$250,000	FHI 360	Human resources for health (6.83)
		CONTINUING: Pre-service for additional technicians in pharmacy, lab, and MCH nursing, currently enrolled.	OHSS	\$362,814	ARIEL	Human resources for health (6.83)
		CONTINUING: Pre-service for additional technicians in lab currently enrolled.	OHSS	\$30,000	EGPAF	Human resources for health (6.83)
Lack of standardized approaches to in-service training	1. Use of standardized systems to determine the competencies gap and guide in-service training	Support improvement of the MOHs in-service training including distance learning and distance mentoring activities, database integration and data analysis, as well as standardization and accreditation of courses and practicum sites.	OHSS	\$721,774	JHPIEGO	Human resources for health (6.83)
	2. Reduced spend on in-service training and increased use of distance learning/mentoring approaches	Support the harmonization of training package for KP, TB, and Health Educators.	OHSS	\$360,000	I-tech	Human resources for health (6.83)
		Coordinate the implementation of the National In-service Training Strategy.	OHSS	\$100,000	MOH	Human resources for health (6.83)
Lack of appropriately trained staff in key areas of lab necessary for T&S expansion	1. Trainings and standardized materials specific to address key T&S Lab strategies are in place	Establish national trainers and mentors program for molecular diagnostics and implement peer to peer mentoring for molecular testing (EID/VL).	HLAB	\$310,000	ASCP	10. Lab (3.24)
		Roll out VL/EID training, competency assessment and supervision program.	HLAB	\$275,000	INS /MOH/ ASCP	10. Lab (3.24)
		Training and certifications of LED microscope users and facility based equipment maintenance program. microscopes	HVTB	\$356,075	ASM/ INS/ ICAP	10. Lab (3.24)
TOTAL				\$3,585,663		

Table 6.1.3 Key Programmatic Gap #3: Unavailability of Sufficient and Granular Strategic Information to Support Effective HIV Programming

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
HMIS system does not contain sufficient, reliable, granular and disaggregated data for PEPFAR reporting and on-going geographic prioritization planning	1. National DHIS2 HMIS that can be used for planning the HIV response and reporting on the majority of PEPFAR indicators	SISMA (national DHIS 2 aggregate reporting system) roll-out and continued development and incorporation of additional modules.	HVSI	\$300,000	JEMBI (12681)	15. Performance Data (7.78)
	2. Interoperability of aggregate and individual-level systems	Open Health Information Exchange - HIE, and Master Facility List – MFL	HVSI	\$300,000	JEMBI (12681)	15. Performance Data (7.78)
	3. Inclusion of community-level data in national HMIS	Data quality management and harmonization efforts within SISMA for PEPFAR reporting.	HVSI	\$50,000	JEMBI (12681)	15. Performance Data (7.78)
		Adaptation of existing community-level data collection tools and processes (from the CAP, PCC, and CHASS projects).	HVSI	\$100,000	Clinical Services System Strengthening (CHASS) (13022)	15. Performance Data (7.78)
		Data quality assessment (DQA internal and external).	HTXS, MTCT	\$346,237	Ministry of Health (MOH) (17044)	15. Performance Data (7.78)
	4. Improved data quality	Data quality assessment (DQA internal and external), TA for DQA to MOH	HTXS, MTCT	\$312,500	Mozambique Strategic Information Program (M-SIP) (17169)	15. Performance Data (7.78)
		Data quality improvement for routine program data.	HTXS, MTCT	\$369,355	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)
ePTS that contains patient-level outcomes needed to determine progress on 90-90-90 targets is not scaled-up, linked to HMIS, or officially part of the flow of national health data	1. Functional, expanded, and integrated ePTS that allows tracking of patient-level outcomes and measurement of 90-90-90 targets	Development and implementation of OpenMRS modules for TB, MCH, pharmacy	HTXS	\$577,419	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)
	2. Reduced turn-around times for EID/VL/ GenXpert MTB Rif /TB Culture	Requirements and development of a Pilot openMRS POC systems.	HTXS	\$240,591	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)
		OpenMRS Helpdesk and Troubleshooting.	HTXS	\$144,355	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)
		Laboratory Information System development.	HTXS/HLAB	\$440,591	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)
		National Unique ID and Biometrics Development work.	HVSI	\$100,000	JEMBI (12681)	15. Performance Data (7.78)
		Continuous Quality Improvement (CQI) Database.	HTXS	\$288,710	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)
		Optimizing HTC modalities, linkage to care and HTC data, including HTC OpenMRS development	HVCT	\$200,000	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)
		Implement laboratory information systems (testing and logistics information) to facilitate timely results return and availability of data for M&E	HLAB	\$680,000	APHL	10. Lab (3.24)
		Development, Coordination and Evaluation of Integrated Health Information System (HIS) for T&S that links people from testing to care and other services, between facilities in the community, and within facilities.	HTXS, HVSI	\$1,069,892	UCSF SI Technical Assistance (12702)	15. Performance Data (7.78)

Table 6.1.3 Key Programmatic Gap #3: Unavailability of Sufficient and Granular Strategic Information to Support Effective HIV Programming (continued)

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Ongoing need for timely and accurate surveillance data to inform national HIV response planning and tracking progress towards epidemic control	1. Increased availability of up-to-date surveillance information that informs geographic and programmatic focus of the HIV response	Surveillance support activities (HDSS, mortality, IBBS, KPs mapping/size estimation, epidemiologic training. etc...)	HVSI	\$470,000	INS (13784)	13. Epi and Health Data (4.70)
		ANC/PMTCT sentinel surveillance and transition to use of routine data.	MTCT	\$200,000	INS (13784)	13. Epi and Health Data (4.70)
	2. Increased access to VL and EID testing for hard to reach areas Increased capacity for routine surveillance	Viral load and drug resistance surveillance	HTXS, HVSI	\$244,355	INS (13784)	13. Epi and Health Data (4.70)
		Combination Prevention Evaluation (CPE) platform/Chokwe HDSS.	HVSI	\$250,000	INS (13784)	13. Epi and Health Data (4.70)
		CISM HDSS Activities	HVSI	\$240,000	CISM - Manhica Research Center (13661)	13. Epi and Health Data (4.70)
		Surveillance IA - Activities that are core to understanding the course of the HIV/TB epidemic and all aspects of the HIV/TB	HVSI	\$300,000	UCSF SI Technical Assistance (12702)	13. Epi and Health Data (4.70)
		PMTCT/ANC Surveillance Data Reporting System	MTCT	\$400,000	UCSF SI Technical Assistance (12702)	13. Epi and Health Data (4.70)
		HIV Case-Based Surveillance Development and Implementation	HVSI	\$150,000	UCSF SI Technical Assistance (12702)	13. Epi and Health Data (4.70)
		Mortality Vital Statistics Surveillance and SISROH	HVSI	\$125,000	JEMBI (12681)	13. Epi and Health Data (4.70)
		INCAM Mortality Survey Preparations (implementation post-census)	HVSI	\$300,000	Measure Evaluation IV (7328)	13. Epi and Health Data (4.70)
		VL and drug resistance surveillance commodities	HTXS, HVSI	\$200,000	GHSCP (TBD)	13. Epi and Health Data (4.70)
		IMASIDA Report Translation, and Data Use and Report Writing Workshops	HVSI	\$350,000	ICF DHS 7 (18121)	13. Epi and Health Data (4.70)
TOTAL				\$8,749,005		

6.2 Critical Systems Investments for Achieving Priority Policies

PEPFAR-Mozambique identified HIV testing and re-testing, VL , EID and GenXpert testing platform expansion, and clinical lab testing transition support as areas where rapid change in both policy and practice will be required to achieve successful T&S implementation. Most laboratory investments are incorporated into the supply chain, human resources, and SI system investments. However others, which are equally critical to implementation of T&S, are uniquely characterized in laboratory system development and do not fit clearly into the other system areas. Please see Table 6.2.1 for these other laboratory system investments.

Table 6.2.2 details systems investments to support differentiated and new service delivery models necessary to roll out T&S.

Table 6.2.1 Test and Start laboratory systems						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Critical need for lab systems essential for implementing T&S	1. WHO guideline for HIV testing services implemented 2. Testing sites and personnel certified to conduct HIV rapid testing	Support implementation of HIV re-testing policy before treatment initiation	HVCT	\$75,000	FIND	2. Policies and governance (1.43)
	3. Quality management systems implemented in EID/VL, GeneXpert and CD4 lab	Strengthen programmatic implementation and expansion of rapid test quality improvement initiative to all 77 scale-up districts including certification, monitoring and evaluation systems.	HLAB	\$600,000	INS/MOH/FIND	10. Lab (3.24)
	4. Reference laboratories accredited	Strengthen laboratories in continuous QI and management systems. Provide support to assure PEPFAR-supported laboratories meet quality standards.	HLAB	\$950,000	INS/ASCP	10. Lab (3.24)
	5. Parallel PEPFAR lab supply chain integrated into MOH supply chain	Support policy and strategy for harmonization of lab supply chain by strengthening national quantification and maintain pipeline monitoring system at central laboratory.	OHSS	\$220,000	APHL	8. Commodity Security and Supply Chain (3.59)
	6. Increased number of HIV testing sites participating in EQA and achieving 100 % pass rates on proficiency tests	Increase coverage of national HIV rapid test EQA program and guide implementation of a decentralized EQA model.	HLAB	\$240,000	FIND	10. Lab (3.24)
	7. Reduced turn-around-times for EID/VL/Xpert MTB Rif/TB culture and increased quality of testing	Implement an integrated specimen referral system for EID, VL and TB samples, including district hubs to conduct barcode labelling, manage and track specimens and results.	HTXS, PDCS	\$1,198,763	INS/ASM/APHL	10. Lab (3.24)

Table 6.2.1 Test and Start laboratory systems

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
	8. Increased participation and performance in EQA	Expand coverage of National EQA program for CD4, EID/VL Xpert MTB Rif, TB smear microscopy and POCT.	HLAB	\$350,000	ASM	10. Lab (3.24)
	9. Increased finding of TB/HIV co-infected patients and improved patient outcome and epidemic control including miners. Increased POCT contribution to routine surveillance.	Validate and implement laboratory component of multi tests POCT and other platforms for VL and TB in programmatic and community contexts.	HVTB	\$192,473	FIND	10. Lab (3.24)
	10. Increased TB case finding by increased utilization of GeneXpert and implementation of Xpert MTB Rif algorithm for HIV positive TB suspects and MDR suspects and decreased morbidity and mortality of PLHIV	Establish capacity to test all patients initiating ART with enhanced TB diagnostic platforms. Increase utilization of GeneXpert.	HVTB	\$625,537	ASM/FIND/INS	10. Lab (3.24)
	11. Increase national capacity to conduct TB surveillance. Improve SI for national TB control program	Support laboratory component of National TB surveillance.	HVTB	\$96,237	INS	10. Lab (3.24)
	12. Increased utilization of GeneXpert and implementation of Xpert MTB Rif algorithm for HIV positive TB suspects and MDR suspects and decreased morbidity and mortality of PLHIV	Implement GxAlert to improve TB test reporting times and provide remote monitoring of GeneXpert equipment errors and reagent consumption	HVTB	\$115,484	ASM	10. Lab (3.24)
	13. Improved sample quality. Decrease rejection rates. Decrease turnaround times of lab results.	Develop capacity for training for sample collection, storage and packaging for all health care staff involved in sample collection and referral (nurses, lab techs and <i>Técnicos de Medicina Geral</i> etc). Provide supplies.	HTXS/ PDCS	\$294,739	INS/ASM	10. Lab (3.24)
	14. Strengthen laboratories in continuous QI and management systems. Provide support to assure PEPFAR-supported laboratories meet quality standards.	Quality management systems implemented in EID/VL, GeneXpert and CD4 labs; TB, HIV serology and CD4 Immunology Reference laboratories accredited	HLAB	\$950,000	INS / ASCP	10. Lab (3.24)
	15. Drug resistance capacity and BSL 3 Laboratory established at NPHRL	Strengthen drug resistance testing and surveillance capacity and a BSL 3 laboratory at new NHPRL and provincial public health laboratories	HLAB	\$300,000	INS	10. Lab (3.24)
TOTAL				\$6,208,233		

Table 6.2.2 New and efficient service delivery models						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Critical lab systems essential for implementing T&S	1. Guidelines following WHO T&S recommendations are followed and translated into appropriate and clear clinical guidance to the health facilities	Support for development and roll-out of new guidelines, convene regional and national workshop, evaluate VL and T&S implementation, provide supportive supervision to implementing sites.	HTXS, HBHC, PDTX	\$921,774	MOH DNSP	10. Lab (3.24)
	2. Testing is targeted to produce the most efficient yields and WHO guidance on re-testing in T&S pilot districts is implemented.	Pilot of presumptive TB, HIV-testing, expanded household contact tracing (development of tools, staff training, CHWs)	HVTB	\$577,156	FGH, ICAP, CHASS	10. Lab (3.24)
		Repeat testing on all HIV-positive persons (536,508 persons) out of those tested this year using UE of \$4.04	HTXS	\$992,910	Clinical IPs	10. Lab (3.24)
		Renovation costs for VL laboratories	HTXS	\$941,021	Clinical IPs	10. Lab (3.24)
		Establishment of physical space at district hubs for specimen referral/results reporting (~\$35,000 per district - including printing, freezers, personnel)	HTXS	\$444,613	Clinical IPs	10. Lab (3.24)
Need for ePTS that contains patient-level outcomes needed to determine progress on 90-90-90 targets and is scaled-up, linked to HMIS, or officially part of the flow of national health data	1. At the end of year 1, information necessary to scaling up T&S, VL, and 3 mo. drug distribution will be available to MOH and PEPFAR	Pilot use of peripheral non-ART health facilities for distribution of ART (pilot in test and start districts)	HTXS	\$721,577	Clinical IPs	
		Evaluation of T&S, VL, and 3-month drug-distribution implementation at the provincial level; evaluation of enhanced integrated HIS approach to patient monitoring	HTXS	\$673,656	Clinical IPs	Commodity Security and Supply Chain (3.59)
		Exploration of alternative modes of ART distribution	HTXS	\$348,118	CCS / EQUIP	Commodity Security and Supply Chain (3.59)
		Implementation of electronic FILA for monitoring patient drug pickups/LTFU, with target implementation as all clinics with > 2000 ART patients in T&S districts (computers/electronic device, database/ program, training of pharmacy staff).	HTXS	\$609,064	Clinical IPs	Commodity Security and Supply Chain (3.59)
		Technical assistance (short, medium, long term) for direct service delivery for differentiated models of treatment	HTXS	\$400,110	EQUIP	
TOTAL				\$6,629,999		

6.3 Proposed system investments outside of programmatic gaps and priority policies.

Table 6.3 Other Proposed Systems Investments							
Systems Category*	Activity	For each activity, indicate which of the following the activity addresses: 1) First 90 2) Second 90 3) Third 90 4) Sustained epidemic control	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score
HRH - Systems/Institutional Investments							
HR assessments and Information Systems	1. Mapping of lay and community staff to inform decision around used to this person to improve retention 2. Allocation and training of HRH for HIV C&T improved based in key and current information in the districts 3. MOH ownership in the use and quality assurance of information generated by the HRIS for decision making.	1-4	Continue to support the development and expansion of the HRIS at the Provincial, District and Facility levels.	\$620,164	OHSS	JHPIEGO	7. Human resources for health (6.83)
	4. Direct support to training institutions to train currently employed nurses at mid-level to advance to superior level (University)	2	Increase by 25% stock of superior nurses.	\$300,000	OHSS	TBD	7. Human resources for health (6.83)
	5. Support the pediatric department and residency training program at Maputo Central Hospital (MCH), to establish a center of excellence in pediatric care to ensure doctors and nurses are competent to care for children with HIV/TB.	4	Improve pediatric HIV, TB, and general care through nurse and physician professional development and training.	\$22,721	OHSS	UCSF	7. Human resources for health (6.83)
SUBTOTAL				\$942,885			
Inst & Org Development							
	1. DPS capacity building strategy: continuation and expansion of NASTAD work with DPS to support fiscal management capacity of DPSs. Establish capacity building monitoring system (performance based). Implement Partner monitoring and pivot monitoring.	4	Establishment of direct funding agreements with PEPFAR funded provinces.	\$1,004,105	OHSS	NASTAD	1. Planning and Coordination (7.33)
SUBTOTAL				\$1,004,105			

Laboratory							
National Health System and Service Delivery	1. Update obsolete four-year laboratory university level pre-service training to include HIV related diagnostics, and support implementation of newly revised medium-level training	1-4	Adoption of updated national laboratory training curriculum across all health training institutions in Mozambique	\$200,000	OHSS	ASCP	7. Human resources for health (6.83)
	2. Implement blood transfusion policy to guarantee safe blood supply and reduce transfusion related HIV transmission	1-4	Transfusion associated HIV infections averted. National Blood Service (SENASA) established in Maputo, Beira and Nampula. Electronic blood bank management system established at the National Reference Blood Center and provincial hospital blood banks. Quality management systems implemented.	\$690,000	HMBL	MOH BS / AABB	10. Lab (3.24)
Commodity Security and Supply Chain	1. Support training infrastructure and stock management systems at provincial warehouses and district deposits to improve storage. 2. Maintain electronic stock card management	4	Reduced losses of laboratory commodities due to expiry or poor storage	\$200,000	OHSS	APHL	8. Commodity Security and Supply Chain (3.59)
SUBTOTAL				\$1,090,000			
Strategic Information							
Monitoring and Evaluation	1. APR / SAPR / DATIM / MER indicator reporting	1,2,3,4	Devresults developed for site level reporting	\$76,000	HVSI	DevResults (14597)	15. Performance Data (7.78)
	2. Monitoring and evaluation staff for MOH	4	Staff supported and MOH M&E capacity strengthened	\$100,000	HVSI	EGPAF TA (14789)	15. Performance Data (7.78)
	3. Monitoring and evaluation staff for MOH	4	Staff supported and MOH M&E capacity strengthened	\$200,000	HVSI	Clinical Services System Strengthening (CHASS) (13022)	15. Performance Data (7.78)
	4. Triangulations of data sources, MOH coordination and HIS roll out	4	Reports provided	\$200,000	HVSI	INS (13784)	15. Performance Data (7.78)
	5. Expansion of MGCAS Aggregate M&E system, development of dashboard and reports, strengthening capacity to use data	4	Platform, information architecture, dashboard tools, indicators all developed and capacity transferred to MGCAS	\$350,000	HKID	Fortalecimento Do Sistema De Monitoria E Avaliacao Do MGCAS (17259)	15. Performance Data (7.78)
Surveillance	1. INS Data Management Unit & GIS support	4	INS Data Management Unit set up and staff hired/seconded	\$300,000	HVSI	INS (13784)	13. Epi and Health Data (4.70)
	2. INS Data Management Unit & GIS support	4	INS Data Management Unit set up and support / TA staff hired / seconded. Includes modeling incidence, KPs.	\$150,000	HVSI	UCSF SI Technical Assistance (12702)	13. Epi and Health Data (4.70)
	3. HIV Modelling and forecasting, costing, feasibility of the first 90 target and strategy assessment, full costing of ART services, T&S modelling	1,2,3	Models and reports developed for Mozambique specifically to understand these key issues related to epidemic control in Mozambique	\$150,000	HVSI	Palladium (14598)	13. Epi and Health Data (4.70)
SUBTOTAL				\$1,526,000			

*Reference Appendix C for a list of activity types that fit in each category.

7.0 Staffing Plan

In COP16, the PEPFAR interagency team reviewed its staffing profile to focus on strategic investments toward epidemic control within a limited M&O budget envelope. Agencies adjusted their CODB to reflect for expected increases in ICASS costs as well as projected increases in travel budgets to support SIMS implementation. In addition the team carefully reviewed staff budget code allocations to ensure that this data accurately captured time spend supporting various program areas.

All new/proposed and repurposed positions are geared towards effective support to the roll out of T&S, the achievement of 90-90-90 as outlined in the Goal Statement above and strengthened technical and programmatic oversight. For additional details on staffing, please refer to the COP16 staffing database.

CDC proposes three new positions: 1) Public Health Analyst: to help provide financial & fiduciary oversight of grantees. 2) Surveillance Specialist: to provide essential TA and capacity building to the MOH around HIV surveillance activities, including both national-level and clinical surveillance activities, 3) Deputy Branch Chief: to support Prevention Branch Chief in developing and formulating new prevention program and initiative, including VMMC, DREAMS, KPs, GBV, and HTC. The incumbent will also serve as the senior public health specialist within the branch and participate in external engagement and development of strategic direction for prevention portfolio. All but the Public Health Analyst will be filled by Locally Employed Staff. CDC staffing reflects five vacancies, four of which are Locally Employed (LE) staff and one is a Direct Hire. Hiring for the vacant positions is in progress.

USAID staffing reflects 13 vacancies of which eight are LE and five are either U.S. Direct Hires or USPSCs. Four of these vacant positions are Non-PEPFAR funded positions which will allocate a percentage of their time to PEPFAR work. Three of these positions are partially PEPFAR-funded positions. Six of these vacant positions are positions fully funded by PEPFAR. All positions are intended for the same purpose as identified in COP15 with no repurposing or new hire requests. Hiring for these vacant positions, focused on programmatic and technical oversight, is in progress.

DOD filled in October 2016 their vacancy for an HIV C&T Specialist. This is new position in COP16, previously approved via reprogramming in 2015.

State Department has two LE vacancies. The DREAMS Coordinator will support the implementation of DREAMS activities across agencies, engagement & coordination with external stakeholders and reporting to OGAC. The Senior PEPFAR Outreach and Communications Specialist is repurposed to a Data Manager who will focus on providing efficient support to the interagency team in meeting quarterly reporting requirements.

Peace Corps supports ten local staff (no direct hires) with PEPFAR funds. These funds, plus additional funding from PC appropriations, will support 77 health volunteers in COP16. Volunteers

will be placed with IPs, health facilities or communities in scale-up districts and will support activities that strengthen community-facility linkages.

Across all agencies, Host Country Nationals represent 75% of a total of 272 positions that support PEPFAR implementation. Agencies will dedicate a total of approximately 380 days per quarter to support the implementation of SIMS.

APPENDIX A: Core, Near-Core, Non-Core Activities

Table A.1 Program Core, Near-core, and Non-core Activities for COP16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	<ul style="list-style-type: none"> • HTC • C&T (Tx), post-violence care • Retention and linkages – M2M and mentor mothers, GAACS, health educators, PHDP • TB- screening, diagnosis and Tx • PMTCT – C&T, B +, partners testing, EID • HRH- in service training, distance learning, accreditation • Supply chain - LMIS • PoC evaluation for Genexpert in pregnant and breastfeeding women at community level for VL,EID and TB • Lab: lab diagnostics & reagent resupply; equipment maintenance, integrated specimen referral, VL & drug resistance testing; in-service training & certification. EQA for rapid testing; laboratory information & results reporting systems • OVC – case management approach • Key & Priority Populations: Military, AGYW, MSM, FSW, PWID • VMMC • Condoms • PrEP, PEP, GBV • Blood banks – QA • SI: SISMA, LTFU tracking, EPTS, data quality inputs, open MRS development HIV/TB/MCH 	<ul style="list-style-type: none"> • Couples testing, • Pre-ART – some lab tests, cervical cancer screening and Tx, STIs, Kaposi, therapeutic feeding • FP/HIV integration • Infection control • TB/HIV – MDR ward renovations • OVC – village savings, vocational training, household economic strengthening • Stigma & discrimination community level activities • Lab: Laboratory QI implementation 	
Sub-national level	<ul style="list-style-type: none"> • Supply Chain logistics, and operational support • Provincial support for in-service training, mgmt., supervision • Improved HCW deployment • LMIS, lab supply chain • Lab: Specimen referral system, in-service training & certification of lab staff in HIV and HIV-related testing, Laboratory information & results reporting systems 	<ul style="list-style-type: none"> • Warehouse rentals • LMIS inventory management • Laboratory network support; lab pre-service training • Social worker/para social worker training 	
National level	<ul style="list-style-type: none"> • Supply Chain: – LMIS, warehouse operations and quality management, Quantification & Supply planning, Lab supply chain, management; National product supply management. • LMIS, equipment & commodities, specimen referral, drug resistance testing, Laboratory information & results reporting systems • SI: SISMA, LTFU tracking, EPTS, 	<ul style="list-style-type: none"> • Care and Tx National guidelines • Commodity security • LMIS; Training & mentorship to MOH staff in lab logistics & tools for lab commodities quantification pipeline analysis & warehouse management (MACS); • Supply Chain: PELF 	

Table A.1 Program Core, Near-core, and Non-core Activities for COP16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
	<ul style="list-style-type: none"> data quality inputs, open MRS development HIV/TB/MCH • Surveillance: ANC, VL and drug resistance, AIS/DHS 	<ul style="list-style-type: none"> implementation • Pre-service training • TA for HRH policy • Drug quality control • Warehouse rental • Lab: EQA • LMIS for lab supply chain management; Lab quality improvement program • CS - PLHIV network capacity building • Social protection advocacy/policies • Blood safety - national guidelines • SI: IBBS, HIV mortality survey, VACS, combination prevention evaluation; strengthen systems at MOH • Health care financing and financial management: Strategy development & implementation 	
HTS	<ul style="list-style-type: none"> • Focused HTC activities (PICT, VCT and index case testing) in epi burden districts • RTK - procurement , supply, distribution • Quality improvement - HCW training, EQA • Reinforce linkages into Care and Tx • M&E processes including collection of sex/age disaggregated data 	<ul style="list-style-type: none"> • Demand creation: - Training of HCW, replication of PHDP materials • Quality improvement for HTC including GBV prevention • Reproduction/dissemination of materials including job aids, provider guidance, and patient information 	
Care and Treatment (C&T)	<ul style="list-style-type: none"> • Demand creation for C&T in scale-up districts • Pre-ART Package, Counseling, PHDP, WHO staging, CD4, CTX, screening for OIs, FP Integration, syphilis testing • Nutrition: Screening for NACS, NACS monitoring, job aids • TB/HIV: Screening including of risk groups: people with diabetes , malnourished, heavy smokers , previous TB, with linkage to treatment, Tx, HIV testing of TB and of presumptive TB cases Contact tracing, IPT, Cough officers, IC, Health Educators, MDR-TB, specific programs addressing miners and prisoners • ART: Clinical Mentoring, Tx monitoring (CD4, VL) Warm line, Job aids, In-service training, POC diagnostics, Pre-ART counseling for same-day initiation (lay counselor), 	<ul style="list-style-type: none"> • Pre-ART: STIs, Hb, Cr, LTFU, Cervical CA, Kaposi Sarcoma; Therapeutic food, TA for <i>Programa de Rehabilitacao Nutricional</i> Messaging, including for quantification of commodities • Nutrition: Nutrition education, therapeutic feeding, provincial/district supervision, QI for NACS, development of community service directories and establishment of counter-referral systems; procurement and distribution of materials and equipment for NACS • Integration of FP and HIV - materials, training HWs and service provision • TB/HIV: Outreach services 	

Table A.1 Program Core, Near-core, and Non-core Activities for COP16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
	<p>Pharmacovigilance Expand One-Stop model; T&S KPs.</p> <ul style="list-style-type: none"> • Treatment support & retention: Health Educators, Support Groups, GAACS, M2M, community ART distribution, Adherence counseling, Tx literacy, referrals, condoms, MCP, disclosure, Teen Club/SAAJs, Adolescent transition to Adult Care • Sex disaggregated data 	<p>in high TB and HIV burden sites Renovations to MDR-TB wards, expansion of TB diagnosis (lab); lab technician training, referral systems expansion of x-ray diagnosis, support electronic TB register</p> <ul style="list-style-type: none"> • PMTCT partner testing, disclosure • Treatment support & retention village savings/loans groups, Stigma reduction, Nutritional support 	
Prevention	<p>Key Populations – CSW, MSM, PWID, prisoners</p> <ul style="list-style-type: none"> • Reach-test-treat interventions • KP friendly clinics focusing on CSW and MSM • Advocacy <p>Priority Populations - Military, adolescent girls & young women, miners</p> <ul style="list-style-type: none"> • Reach-test-treat for miners <p>VMMC</p> <ul style="list-style-type: none"> • MC procedures focusing on epi-burden districts with <80% VMMC saturation and age stratum 15-29 years • Demand creation activities • HIV testing and counseling • Condom use and safer sex education <p>Gender and Gender-Based Violence</p> <ul style="list-style-type: none"> • Ensure availability of MOH post-GBV services package at ART sites • Provision of PEP for post-rape care • Screen for GBV to determine effects on Tx & Adherence • Engage men in developing positive health seeking behaviors; communication strategies <p>Other Prevention</p> <ul style="list-style-type: none"> • Condom procurement, promotion and distribution • PReP: • Occupational PEP • Blood safety: HIV quality assurance in blood banks 	<ul style="list-style-type: none"> • Social protection – advocacy for polices, harmful traditional practices, <ul style="list-style-type: none"> • Stigma & discrimination – HW training, community education (including KPs) & increased male involvement in health councils, mass media toolkit; • STIs: -update national guidelines and SOPs, adolescent SRH, Training of HWs • Infection control in health facilities through training in SOPs and supply of protective materials • Blood safety: Revision of 	

Table A.1 Program Core, Near-core, and Non-core Activities for COP16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
		<ul style="list-style-type: none"> national guidelines and rational use of blood components • Household economic strengthening 	
	Sex/Age disaggregated data		
OVC	<ul style="list-style-type: none"> • Case Management: Assessing child & family socio-economic status at Household level (across all areas: healthy, safe, stable, schooled) • Implementing special studies to identify gaps in programming impact • Healthy: Promotion of EID and confirmatory HIV testing • Strengthen adherence assessment, counselling and support into routine OVC Home visitors work • Referral of suspected malnutrition, nutritional education at household and community level • Facilitate uptake of and monitoring completion of referrals for Health, Food and Nutrition, TB/HIV, treatment and care services for all children and family members of index cases, SRH and FP services for ALHIV, including AYFS • Safe: Facilitating birth registration, succession planning • Positive Parenting focused on adult/child communication and protective and provider roles, HIV disclosure and child health • Support psychosocial health among children, their caregivers, teachers, through individual, home, group-based and relationship-based activities • Support community and national level child protection/GBV prevention and response activities, including emergency food and shelter for abuse survivors • Stable: Facilitate establishment of savings groups plus (including financial literacy) • Support access to and uptake of social protection for all eligible according to GRM PSSB, PASD and PASP criteria • Schooled: Facilitate access to primary and secondary education through temporary and targeted support through support with uniforms, school fees, exam fees • Temporary school block grants to promote enrollment and progression • Early childhood development (ECD) for children under five with strong 	<ul style="list-style-type: none"> • Case Management: Mapping services within targeted communities and developing service directories • Supporting the development of national management info. systems • Training in strength's based case management for Community OVC Volunteers within PEPFAR-supported catchment areas • Strengthening referral mechanisms and other systems for linking clinical, social and protection services • Safe: Strengthening government-managed case management systems to prevent and respond to child abuse and Support family placement and temporary permanency support for children • Strengthening community-based structures for mediation of child abuse and violence cases • Professional Development for social and para-social workers • M&E systems for National child protection/ social welfare efforts • Stable: Carry out market assessments to identify potential Income generating Activities with links to existing businesses / agricultural projects and markets/value chain development • Targeted food security for destitute families • Facilitate access to primary (and secondary education for girls) through long-term or open-ended subsidies • Zero-tolerance interventions to make classroom environments gender and HIV sensitive, 	

Table A.1 Program Core, Near-core, and Non-core Activities for COP16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
	<ul style="list-style-type: none"> linkages with PMTCT and pediatrics Long-term or open-ended school block grants or support for ECD centers, Positive parenting, Economic strengthening Sex disaggregated data 	<ul style="list-style-type: none"> and safe places for vulnerable children Support community school councils 	
Program/ System support	<ul style="list-style-type: none"> Laboratory: Lab diagnostics & reagent resupply, equipment & maintenance, specimen referral, VL & drug resistance testing; in-service training. EQA program; lab supply chain coordination; laboratory information & results reporting systems; HIV Rapid Testing Quality Improvement Initiative CSO - capacity building for Network for PLHIV Supply Chain: – LMIS , warehouse operations and quality management, Quantification & Supply planning, Lab supply chain management SI: SISMA, LTFU tracking, EPTS, data quality inputs, open MRS development HIV/TB/MCH Surveillance: ANC, VL and drug resistance, AIS/DHS HRH: In-service training 	<ul style="list-style-type: none"> Commodities: ARV, RTK, OI drugs, Lab reagents- VL, CD4 Laboratory: Lab quality improvement program; Laboratory supply chain logistics & management strengthening of MOH, Pre-service training for lab technicians; promote approval of national lab policy Supply Chain –hardware inputs for LMIS; PELF implementation strategic management and design, commodity security, commodity importation Support a phased transition of commodity management from SCMS to MOH Warehouse management. CMAM internal governance systems, drug quality SI: IBBS, HIV mortality survey, VACS, combination prevention evaluation; improve systems at MOH Health care financing and Financial management: Strategy development & implementation HRH: HRIS, pre-service training 	

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP16	Estimated Funding in COP17	# of IMs	Transition End date	Notes
No activities						
Totals						

APPENDIX B: Planned Spending & Resource Projections

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
\$26,672,869	\$310,403,040	\$337,075,909

B.2 Resource Projections: Methods and Inputs

Expenditure analysis (EA) data, costing studies, current partner work plans, and partner inputs were used to inform the COP budgeting. This year's applied unit cost methodology was improved by isolating the expenditure data of direct service delivery partners whom report results and are assigned targets and comparing this data with COP15 activity budgets. Based on the structure of the Mozambique clinical service delivery platform, applied unit expenditures in the prior years for Adult and Pediatric Care and Treatment and PMTCT were overestimated because they included expenditures from non-direct service delivery partners. Therefore, COP16 methodology utilized direct service delivery partner unit expenditures from EA15 expenditure data and created direct service delivery applied unit costs for COP16. This offered a better understanding of the actual partner spend at the site level to deliver care and treatment services and created a more efficient applied unit cost for allocation of resources.

A second methodological improvement which resulted in further efficiencies in the applied unit cost was the classification of cost categories (e.g. personnel, vehicles) as either fixed or variable related to achieving targets. Assumptions were then applied to the fixed cost categories, such an increase in travel/transport due to projected increases in the number of MOH ART sites. The final unit cost, combining the fixed and variable unit cost, was calculated based on the Data Pack targets (dated August 19, 2016) and the unit costs were applied to the IM specific COP16 targets (dated August 24, 2016) derived from Mozambique specific target setting tools which allocated targets to the facility level.

For Adult and Pediatric Care and PMTCT, program management was calculated separately from the unit cost to avoid inflation due to differences in program management and geography. Assumptions and changes from EA 2015 spend were documented. The final program management allocation should be included in the final COP16 unit cost if making comparisons to prior or future EA data.

For OVC and Key Populations (FSW, MSM, and Prisoners), where new programs are being established, the applied unit cost was developed using detailed budget and proposed targets.

DoD unit costs and targets were set using different methodology which is outlined in the PBAC.

The PBAC illustrates the target-based budget and above site-level activities and the applied unit cost calculations in detail.

The final applied COP16 applied unit costs (UC) for non-DoD agency targets are below.

	COP16 UC	COP16 Costed Targets	COP16 Target-Based Budget	Added Program Management	Final COP16 UC including Program Management
Costing: HTC_CBCT	\$11.77	260,152	\$3,061,989		\$11.77
Costing: HTC_PITC	\$2.30	2,448,427	\$5,631,382		\$2.30
Costing: HTC_VCT	\$4.82	628,452	\$3,029,139		\$4.82
Costing: KP_PREV_FSW	\$122.00	23,757	\$2,898,354		\$122.00
Costing: KP_PREV_MSM	\$108.00	10,324	\$1,114,992		\$108.00
Costing: OVC_SERV	\$49.00	382,531	\$18,744,019		\$49.00
Costing: PMTCT_ART	\$51.68	90,835	\$4,694,353	\$2,729,295	\$81.73
Costing: PMTCT_EID	\$59.07	80,102	\$4,731,625	\$1,141,130	\$73.32
Costing: PMTCT_STAT (Excluding Known Positive)	\$2.17	1,070,426	\$2,322,824	\$2,062,912	\$4.10
Costing: TX_CURR (1-15) (Patient Year)	\$78.41	70,195	\$5,503,990	\$2,010,175	\$107.05
Costing: TX_CURR (15+) (Patient Year)	\$78.41	735,077	\$57,637,388	\$19,978,382	\$105.59
Costing: TX_NEW (<1)	\$382.82	4,559	\$1,745,276	\$1,389,752	\$687.66
Costing: VMMC_CIRC	\$93.58	398,127	\$37,256,725		\$93.58

Notes: 1) VMMC_CIRC and TX_CURR 15+ include targets funded through central level initiatives; 2) HTC CBCT and OVC targets exclude DREAMS Initiative Year 2 targets.

APPENDIX C: Systems Investments for Section 6.0

Systems Investments for Section 6.o

Included Activities	Excluded Activities
Human Resources for Health (HRH): Systems/Institutional Investments	
Pre-service training; in-service training systems support and institutionalization; HRH performance support/quality; HRH policy planning and management; HR assessments and information systems; other HRH activities not classified as above	N/A
Human Resources for Health (HRH): Personnel Costs for Service Delivery	
In-service training; all HRH support at sites and community across all program areas	Other site-level investments such as purchase of vehicles, equipment and furniture, construction and renovation, and site-level recurrent categories such as ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, building rental and utilities
Governance	
Technical area-specific guidelines, tools, and policy; general policy and other governance; other governance activities not classified as above	N/A
Finance	
Expenditure tracking; efficiency analysis and measurement; health financing; costing/cost modeling; other health financing activities not classified as above	N/A
Systems Development	
Supply chain systems; health information systems (HIS); laboratory strengthening; other systems development activities not classified above	ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, freight for transport of commodities to sites and other supply chain costs incurred at the site-level
Institutional and Organizational Development	
Civil society and non-governmental organizations (NGOs); government institutions; social welfare systems strengthening; other institutional and organizational activities not classified above	N/A
Strategic Information	
Monitoring and evaluation; surveys; operations research; geographic mapping, spatial data, and geospatial tools; surveillance; other strategic information activities not classified above	N/A
Laboratory	
Quality management and biosafety systems; implementation and evaluation of diagnostics (POC and VL monitoring); laboratory information and data management systems; laboratory workforce; quality management system; sample referral systems; accreditations; technical assistance to assure or improve quality of laboratory services	Vehicles, equipment and furniture, construction and renovation for site labs, and recurrent categories from site labs such as lab reagents and supplies, travel and transport, building rental and utilities will not be included

APPENDIX D: Test & Start Phased Implementation

PHASE 1: PROVINCIAL CAPITALS (w/ Inclusion of Chokwe District)

Began in August 2016

No.	Province	District	PLHIV
1	Niassa	Cidade de Lichinga	8,715
2	Cabo Delgado	Cidade de Pemba	19,155
3	Nampula	Cidade de Nampula	38,603
4	Zambézia	Cidade de Quelimane	46,070
5	Tete	Cidade de Tete	23,601
6	Manica	Cidade de Chimoio	40,296
7	Sofala	Cidade da Beira	76,701
8	Inhambane	Cidade de Maxixe	7,745
9	Gaza	Area Xai-Xai ¹	58,361
10	Maputo Provincia	Cidade de Matola	130,497
11	Maputo Cidade	Cidade de Maputo ²	147,690
12	Gaza	Distrito de Chokwe ³	32,493

1 - Area Xai-Xai composed of Cidade de Xai-Xai and Xai-Xai District

2 - Cidade de Maputo includes all seven sub-districts in Maputo Cidade

Number of PLHIV captured in Phase 1 of "Test and Start" Introduction	629,927
Phase 1 coverage of national PLHIV	40%
Phase 1 coverage of PLHIV in 29 "Test and Start" Districts	66%

PHASE 2: 8 DISTRICTS

Provisionally scheduled for Feb 2017

No.	Province	District	PLHIV
12	Maputo Provincia	Distrito de Manhiça	36,514
14	Gaza	Distrito de Bilene Macia	31,483
15	Zambézia	Distrito de Namacurra	28,932
16	Zambézia	Distrito de Mocuba	19,316
17	Zambézia	Distrito de Nicoadala	33,453
18	Sofala	Distrito de Dondo	20,767
19	Tete	Distrito de Moatize	12,856
20	Sofala	Distrito de Nhamatanda	11,778

Number of PLHIV captured in Phase 2 of "Test and Start" Introduction	195,099
Phase 2 coverage of national PLHIV	12%
Phase 2 coverage of PLHIV in 29 "Test and Start" Districts	21%

PHASE 3: 9 DISTRICTS

Provisionally scheduled for August 2017

No.	Province	District	PLHIV
21	Manica	Distrito de Manica	20,059
22	Cabo Delgado	Distrito de Mueda	16,245
23	Manica	Distrito de Gondola	25,798
24	Cabo Delgado	Distrito de Montepuez	9,450
25	Nampula	Cidade de Nacala-Porto	13,142
26	Inhambane	Distrito de Vilanculo	10,419
27	Inhambane	Distrito de Massinga	8,329
28	Niassa	Distrito de Cuamba	7,760
29	Tete	Distrito de Changara	11,124

<i>Number of PLHIV captured in Phase 3 of "Test and Start" Introduction</i>	<i>122,327</i>
<i>Phase 3 coverage of national PLHIV</i>	<i>8%</i>

APPENDIX E: Strategic Plan for Improved ART Retention

1. Problem statement

Mozambique’s ART coverage of PLHIV is low at 53% nationally, and our retention in ART is one of the lowest in the region. Among patients who initiate treatment, only about 66% remain on treatment at the end of 12 months (Figure E.1.1). Although the loss to follow-up (LTFU) rate decreases after the first 12 months on treatment, the PEPFAR team estimates that over 20% of all patients on ART drop out of care in a given year. Despite the efforts of the MOH staff and of PEPFAR partners over the past several years, retention rates are not improving (Figure E.1.2).

Figure E.1.1: Almost Half of Patients LTFU by 24 Months

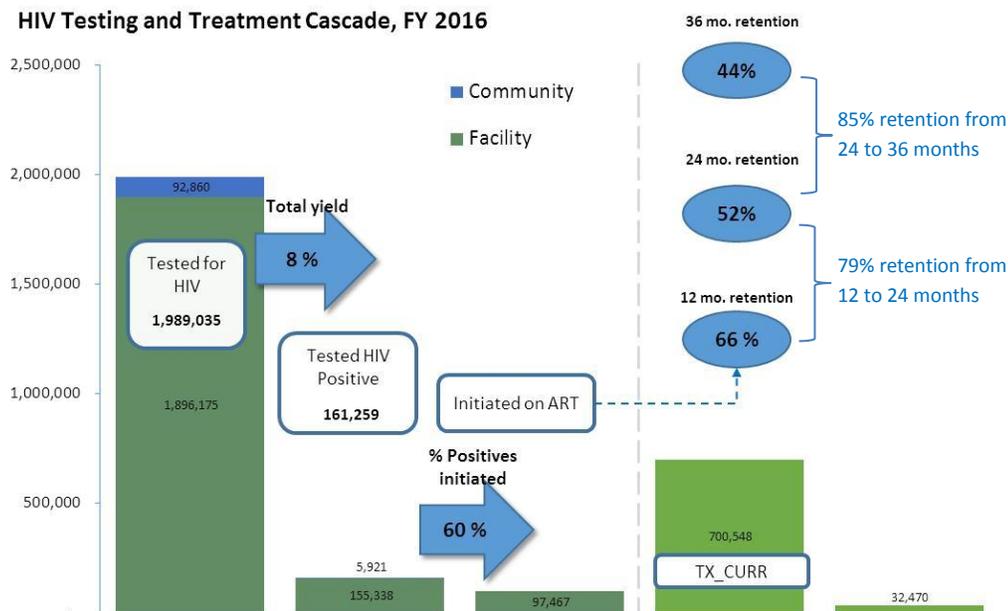
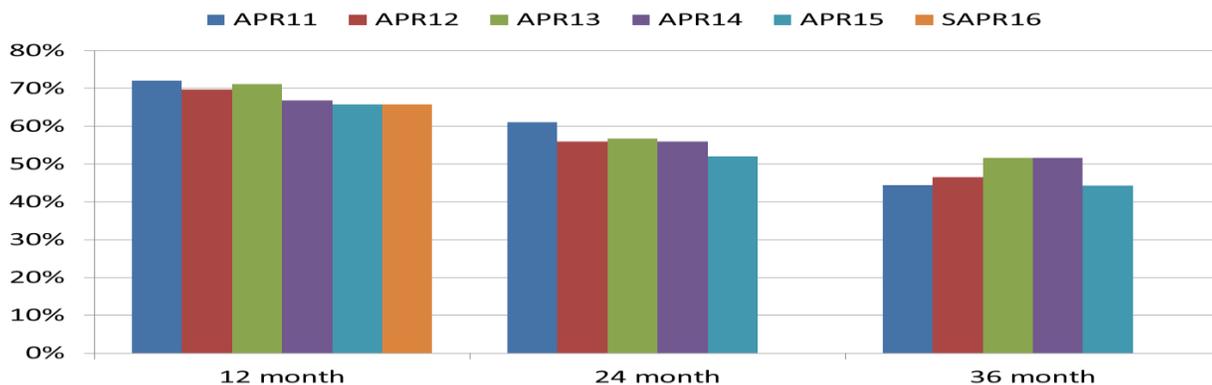


Figure E.1.2: 12, 24, and 36 Month Retention Over Time



2. Implementing Partner Meeting

On August 23, 2016, PEPFAR-Mozambique convened clinical and community implementing partners for a conference to discuss a focused retention strategy for FY17. Participants included 60 implementing partner staff from 9 implementing partners representing 3 agencies (CDC, USAID and DOD). The purpose of the meeting was to:

- Emphasize urgent need to improve retention as key to achieving treatment targets and national epidemic control,
- Validate proposed COP16 retention strategies based on partner experience,
- Solicit updates on current and proposed retention activities, and
- Establish plan to monitoring improvements in retention with indicators and targets for monthly progress management.

During the meeting, IPs and the PEPFAR team jointly addressed current and proposed actions needed to improve retention. We examined retention data by implementing partner (Figure E.2.1) and by patient population (Figure E.2.2). A consensus was reached in terms of where resources and efforts should be focused, as well as the indicators that would be tracked every month in order to closely monitor progress.

Figure E.2.1: 12 Month Retention by Partner (SAPR16)

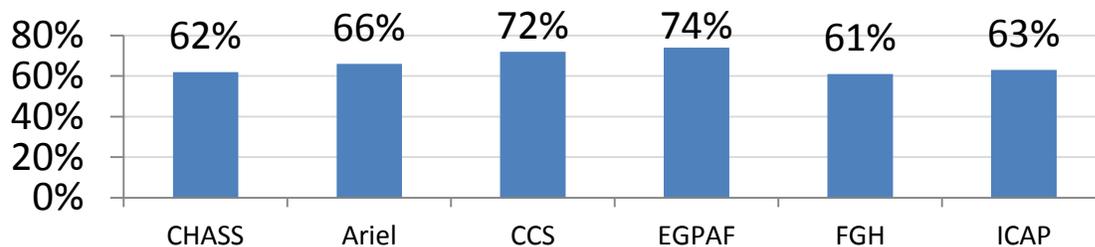
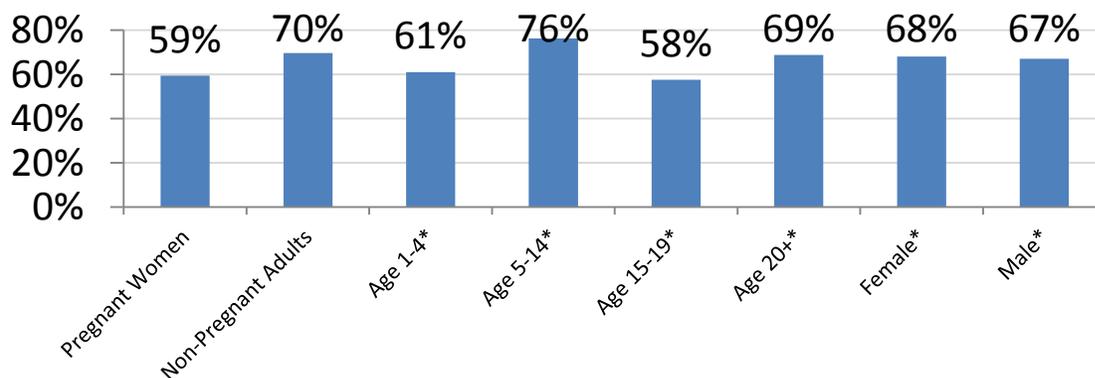


Figure E.2.2: 12 Month Retention by Subgroup (SAPR16)



**Sites with finer age / gender disaggregation only*

All partners agreed that early retention was a key bottleneck that required intensified focus in FY17, as loss to follow-up is highest during the first 6 months after treatment initiation. Although there exist some early retention strategies that benefit all groups, partner also highlighted some activities that were focused on specific populations at high risk for LTFU (Figure E.2.4). Partners noted specific concerns about the quality of some on-going adherence activities such as counseling & treatment literacy and acknowledged need for service quality improvement in FY17.

Figure E.2.3: Key Early Retention Areas by Subgroup



3. Plan for Improved Patient Retention

A core element of the discussion during the partner meeting was about focusing COP16 retention activities in high-burden areas where disproportionate impact would be possible. Based on that, a plan was established to prioritize high-volume ART sites. Sites were chosen based on the following criteria: (1) PEPFAR DSD site, (2) located within a Phase 1 Test & Start SNU, and (3) TX_CURR >1,000 at SAPR 16. Nineteen sites meeting these criteria were identified in Cidade de Maputo, so only the top 10 (all with TX_CURR >5,000) were chosen. The final 63 sites are listed in Table E.3.1 and mapped in Figure E.3.1.

These 63 sites cover:

- 35% of SAPR16 TX_CURR,
- 29% of SAPR16 TX_CURR <15,
- and 23% of SAPR16 HIV+ pregnancies.

Figure E.3.1: Location of 63 High Volume Sites for Intensive Retention Intervention

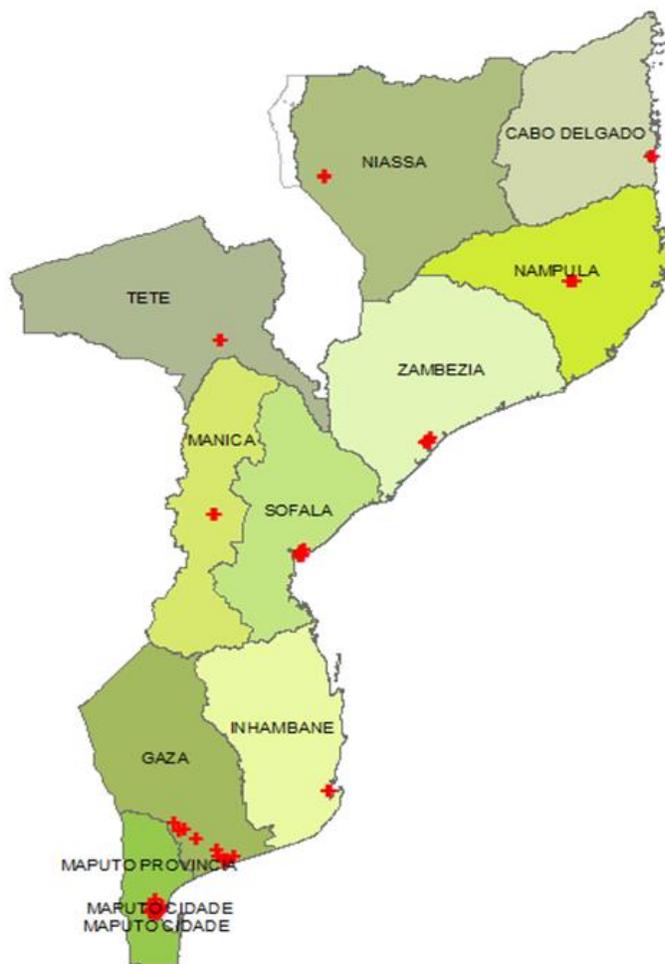


Table E.3.1: List of 63 High Volume Sites for Intensive Retention Intervention

District	Site	District	Site
Chokwe	Chokwe CSURB	Cidade De Nampula	1 de Maio CSURB
Chokwe	Chókwè HR	Cidade De Nampula	25 de Setembro CS II
Chokwe	Hókwè PS	Cidade De Nampula	Hospital Psiquiatrico Nampula HP
Chokwe	Manjangue (Barragem) CS II	Cidade De Nampula	Marrere CS I
Cidade Da Beira	Hospital Central da Beira HC	Cidade De Nampula	Mod Hospital (Hospital Militar de Nampula)
Cidade Da Beira	Macurungo PSA	Cidade De Nampula	Muhala PS
Cidade Da Beira	Manga Mascarenha CS III	Cidade De Pemba	B. Cariacó CS III
Cidade Da Beira	Manga Nhaconjo PS	Cidade De Pemba	Hospital Provincial de Pemba HP
Cidade Da Beira	Mod Hospital (Beira Hospital Militar)	Cidade De Pemba	Natite PS
Cidade Da Beira	Munhava CS III	Cidade De Quelimane	17 de Setembro CSURB
Cidade Da Beira	Ponta Gêa PS	Cidade De Quelimane	24 de Julho CSURB
Cidade Da Matola	Boquisso PS	Cidade De Quelimane	4 de Dezembro CSURB
Cidade Da Matola	Komgolote PSA	Cidade De Quelimane	Centro de Saude de Icidua
Cidade Da Matola	Machava HG	Cidade De Quelimane	Chabeco CSURB
Cidade Da Matola	Machava II CS	Cidade De Quelimane	Coalane CSURB
Cidade Da Matola	Matola Gare PS	Cidade De Quelimane	Namuinho CS III
Cidade Da Matola	Matola I CSURB	Cidade De Tete	Cs Nº 1 - Bairro Magaia CSURB
Cidade Da Matola	Muhalaze CS	Cidade De Tete	Cs Nº 2 - Bairro Matundo CSURB
Cidade Da Matola	Ndlavela PSA	Cidade De Tete	Cs Nº 3 - Bairro Manyanga CSURB
Cidade De Chimoio	1º Maio CS II	Cidade De Tete	Cs Nº 4 - Bairro Muthemba CSURB
Cidade De Chimoio	7 de Abril	Cidade De Xai-Xai	Centro de Saude Ngoabi
Cidade De Chimoio	Eduardo Mondlane CSURB	Cidade De Xai-Xai	Centro de Saude Patrice Lumumba
Cidade De Chimoio	Nhamaonha CS II	Cidade De Xai-Xai	Xai-Xai CS
Cidade De Lichinga	Chiuaula PS	Maxixe	Chicunque HR
Cidade De Lichinga	Lichinga Yes CSURB	Maxixe	Maxixe (Urbano) CS III
Cidade De Maputo	1º de Junho CS	Xai-Xai	Chicumbane HR
Cidade De Maputo	1º de Maio PS	Xai-Xai	Chongoene CS III
Cidade De Maputo	Albasine CS	Xai-Xai	Julius Nyerere PS
Cidade De Maputo	Alto-Maé CSURB		
Cidade De Maputo	Bagamoio CS III		
Cidade De Maputo	Centro de Saude do Chamanculo		
Cidade De Maputo	Jose Macamo CS		
Cidade De Maputo	Polana Caniço CS II		
Cidade De Maputo	Porto CSURB		
Cidade De Maputo	Xipamanine CSURB		

Emphasis will be placed on tailoring retention activities to specific populations (pregnant women, adolescents, young children, males), patient treatment experience (new on ART, stable on treatment), and geographic ART site (rural vs urban, etc.). Figure E.3.2 shows a draft logic model for the retention strategy.

Figure E.3.2: DRAFT LOGIC MODEL - COP16 Retention Interventions

Inputs	Activities	Outputs	Outcomes	
MISAU policies on retention	Health Facility Level -Counseling, psychosocial support & treatment literacy -Co-located HIV / TB treatment -Co-located HIV / ANC -Youth friendly services (SAAs) -6 month appointments for stable patients -3 month prescriptions for stable patients Bridging Health Facility and Community -Patient support groups, treatment buddies -Intensive community case management of patients starting ART -Standardized, tiered defaulter tracing (defaulter lists, SMS, phone calls, defaulter tracing) -GAACs -Alternative ART delivery sites (non-ART HF) -Mobile clinics -LTFU analysis and back-to-treatment campaign	% new pts receive counseling w/in 1 mo	% new patients return for 2nd visit within 1 month	
National health system (staff, HF, etc.)		% new patients enrolled in community support groups	TX_RET at 3 months >90%	
Supportive supervision, mentoring, & training		% patients enrolled in GAACs	TX_RET at 6 months >85%	
Site-level staff supported by IP (professional staff, lay workers)		% patients on 6 month appointments	TX_RET at 12 months >80%	
M-Health: EPTS, CommCare, electronic pharmacy management system		% patients on 3 month prescriptions	District reaches TX_CURR targets	
Tracing and re-engaging resources (bicycles, phones, airtime, etc.)				
M&E systems				
QI committee, QI collaborative		Community Level -Training & engagement of community members and leaders by CBOs on the adoption of healthy behaviors (service uptake, retention & adherence, role of men in PMTCT) -Village Savings & Loans	# trainings held & # participants	2 nd visit & 3 month retention among PLHIV referred
Funding			# meetings held & # participants	Reduced stigma
			# VSLs & # PLHIV enrolled	Improved economic livelihoods for PLHIV

Items highlighted in green are important for early retention

USG agencies and PEPFAR partners reached consensus on a progress management framework that includes monthly monitoring of 3 early retention indicators, monthly monitoring of 3-5 retention activity indicators, and use of a Follow-up Action Summary Tracker (FAST) to document and track corrective action status.

Indicators are still under development, and final decisions will be based on clinical value, EPTS data availability, and harmonization with national programs. Draft indicators include:

- % of newly enrolled patients that had a clinical appointment on the same day of diagnosis
- % of newly enrolled ART patients who returned for a second clinical appointment within 35 days of initiation
- % of newly enrolled ART patients retained at 3 months
- % of stable ART patients on 6 month clinical appointments
- % of stable ART patients on 3 month prescriptions

- % of ART patients enrolled in GAACs
- % of newly enrolled patients who receive counseling within one month per guidelines (*not currently available in EPTS*)
- % of newly enrolled patients enrolled in community support groups (*not currently available in EPTS*)

A monthly dashboard (Figure E.3.3) will be used to track overall performance, and site-level run charts (such as the one shown in Figure E.3.4) will be developed to benchmark performance across sites and to show improvement over time. Figure E.3.5 shows a mock follow-up action summary tracker (FAST).

Figure E.3.3: Mock-up of Monthly Retention Monitoring Dashboard

		% newly diagnosed patients with same day clinical consultator	% Diagnosed that started ART within first 15 days	% new patients returned for 2nd visit within 30 days	% newly initiated ART patients retained at 3 months	% patients on 6 month clinical appointments	% patients on 3 month prescriptions	% eligible patients enrolled in GAACs
Partner 1	44%	76%	69%	74%	37%	18%	45%	
Site 1	🟡 59%	🟢 79%	🟢 75%	🟢 80%	🟡 60%	🔴 8%	🟡 60%	
Site 2	🟡 62%	🟢 82%	🟢 91%	🟢 83%	🟡 40%	🔴 22%	🟡 43%	
Site 3	🔴 10%	🟢 68%	🟡 40%	🟡 60%	🔴 12%	🔴 23%	🔴 33%	
Partner 2	63%	63%	88%	83%	31%	59%	52%	
Site 18	🟡 56%	🟢 76%	🟢 90%	🟢 88%	🔴 20%	🟢 65%	🟢 76%	
Site 19	🟡 60%	🟢 67%	🟢 88%	🟢 77%	🔴 35%	🟡 58%	🔴 14%	
Site 20	🟢 74%	🟡 47%	🟢 85%	🟢 83%	🔴 38%	🟡 55%	🟢 66%	

Figure E.3.4: Mock-up of Site-Level Run Chart with Benchmarking (3 month retention)

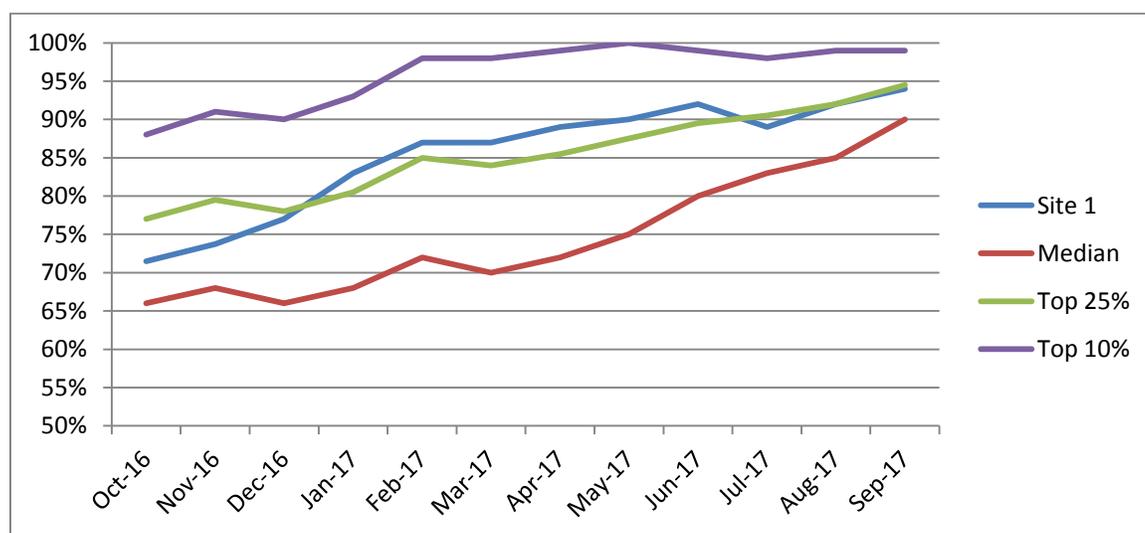


Figure E.3.5: Mock-up of Follow-up Action Summary Tracker (FAST)

Follow-up Action Summary Tracker (FAST)				
Partner Organization	Partner 1		Date	9/30/2016
Activity	PEPFAR Mozambique Recommendations	FAST Response Due	IP Person Responsible	Partner Response
Youth Friendly Services - What % newly initiated ART patients retained at 3 months are adolescent?	Multidisciplinary education and counseling intervention approaches for ages 15-19 are recommended. Please provide proposal. Create table with newly initiated ART patients retained at 3 months by age by site.	2 business days	Partner Staff A	FAST response will be completed within 2 business days.
Counseling, psychosocial support & treatment literacy - Are you implementing patient support groups, treatment buddies activities?	Offering peer support may be considered. The additional cost should be considered. Please provide proposal with additional costs included.	3 business days	Partner Staff B	FAST response will be completed within 3 business days.

4. Expected Impact on TX_RET Targets and on Overall Cohort Retention

ART retention is complex and multi-factorial, and many countries in the region are struggling. PEPFAR-Mozambique will implement this strategy in these 63 high volume sites both to improve coverage and outcomes for the 35% of patients covered here and to identify effective activities to expand to other sites.

SAPR16 results for 12 month retention in patients initiating ART were 66% overall, 59% for pregnant women, and 64% for children <15. APR15 results for 6 month retention were 75% overall, 59% in pregnant women, and 69% in children <15. (6 month retention is not routinely reported at SAPR). Based on these previous results and on the strategy described here, we set the following ambitious targets for FY17 (Table E.4.1):

Table E.4.1: FY17 Retention Targets Among Patients Initiating ART (TX_RET)

	3-month Retention	6-month Retention	12-month Retention		
	63 Enhanced Retention Sites*	Phase 1 Test & Start Districts	Phase 1 Test & Start Districts	Other Scale-Up Districts	Sustained & Attained Districts
Overall	90%	85%	80%	75%	70%
Pregnant Women	90%	85%	80%	75%	70%
Children (<15)	90%	85%	80%	75%	70%

PEPFAR TX_RET targets are for patients newly initiating ART, but retention in treatment and re-engagement for those who drop out are also important for patient outcomes, treatment coverage and epidemic control. The COP16 datapack applies a crude cohort retention rate to the number of patients on ART in the previous year (and assumes that no new patients drop out of care). This rate determines the number of new patients needed to start treatment (and thus to be tested & linked to care) for a given coverage level.

We anticipate that increasing retention in new patients (as described with the TX_RET targets) plus expanding activities that benefit existing patients (6 month appointments, 3 month drug distribution, GAACs, VSLs, etc.) will lead to an increase in this crude cohort retention rate from 77% overall (as estimated initially) to 82% in Phase 1 T&S districts, 80% in other scale-up districts, and 77% in sustained and attained districts.

APPENDIX F: Acronyms List

ACOI	A Cluster of Inhambane
ACOM	A Cluster of Maputo
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immuno-Deficiency Syndrome
AIS	AIDS Indicator Survey
ALHIV	Adolescents Living with HIV
ANC	Antenatal Care
APES	Agentes Polivalentes Elementares de Saúde/ Community Health Workers
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
AYFS	Adolescent and Youth Friendly Services
CASG	Community ART Support Groups / Grupos de Apoio a Adesão Comunitária–GAAC
CBO	Community Based Organization
CBT	Community Based Testing
CCM	Country Coordinating Mechanism
CD4	Cluster of Differentiation 4
CDC	Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CMAM	Central de Medicamentos e Artigos Médicos / Central Medical Stores
CNCS	Conselho Nacional de Combate ao HIV e SIDA / National AIDS Council
COP	Country Operational Plan
C&T	Care and Treatment
CY	Calendar-Year
CTX	Cotrimoxizole
DAC	Development Assistance Committee
DOD	Department of Defense
DPS	Direcção Provincial de Saúde / Provincial Directorates of Health
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
ECD	Early Childhood Development
EID	Early Infant Diagnosis
EQA	External Quality Assessment
FPM	Fund Portfolio Manager
FSW	Female Sex Workers
FY	Funding Year

G2G	Government-to-Government
GAAC	Grupos de Apoio a Adesão Comunitária / Community ART Support Groups
GARPR	Global AIDS Response Progress Report
GBV	Gender-Based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	Gross National Income
GRM	Government of the Republic of Mozambique
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HRIS	Human Resources Information System
HTC	HIV Counseling and Testing
IBBS	Integrated Behavioral and Biological Survey
ICF	TB Intensified Case Finding
INS	Instituto Nacional de Saúde / National Institute of Health
INSIDA	Inquérito Nacional de Prevalência, Riscos Comportamentais e Informação sobre o HIV e SIDA / AIDS Indicator Survey
IP	Implementing Partner
IPT	Isoniazid Preventive Therapy
KP	Key Populations
LMIS	Laboratory Management Information System
LTFU	Lost-To-Follow-Up
M&E	Monitoring and Evaluation
MACS	Management And Control System
MC	Male Circumcision
MCH	Maternal Child Health
MCP	Multiple Concurrent Partnership
MDN	Ministério da Defesa Nacional / Ministry of Defense
MDR	Multi-Drug Resistant
MEDH	Ministério da Educação e Desenvolvimento Humano / Ministry of Education and Human Development
MGCAS	Ministério do Género, Criança e Acção Social / Ministry of Gender, Child, and Social Action
MINEC	Ministério dos Negócios Estrangeiros e Cooperação / Ministry of Foreign Affairs and Cooperation
MINEF	Ministério da Economia e Finanças / Ministry of Finance
MISAU	Ministério da Saúde / Ministry of Health
MOH	Ministry of Health

MRS	Medical Report System
MSM	Men who have Sex with Men
NASA	National AIDS Spending Assessment
NGO	Non-Governmental Organizations
ODAMOZ	Official Development Assistance to Mozambique Database
OECD	Organization for Economic Cooperation and Development
OGAC	Office of the U.S. Global AIDS Coordinator
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PASD	Programa Apoio Social Directo / ENGLISH TRANSLATION
PASP	Programa da Acção Social Produtiva / ENGLISH TRANSLATION
PC	Peace Corps
PICT	Provider Initiated Counseling & Testing
PPP	Public-Private Partnership
PLASOC	Plataforma da Sociedade Civil / Civil Society Platform for Health
PLHIV	People Living with HIV
PROSAUDE	Mozambique's Common Health Sector Common Fund
PWID	People Who Inject Drugs
QI	Quality Improvement
SDS	Strategic Direction Summary
SDSGCAS	Serviços Distritais de Saúde, Género, Criança e Acção Social / District Services of Health, Gender, Children and Social Action
SIMS	Site Improvement through Monitoring Systems
SNU	Sub-National Unit
STI	Sexually Transmitted Infection
TA	Technical Assistance
T&S	Test and Start
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USG	United States Government
VL	Viral Load
VTC	Voluntary Counseling & Testing
VMMC	Voluntary Medical Male Circumcision

