

Mozambique Country Operational Plan 2019 Strategic Direction Summary



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1.0 Goal Statement

Despite Mozambique's substantial increases in the number of people who test positive for the human immunodeficiency virus (HIV) and the number of people living with HIV (PLHIV) currently on anti-retroviral treatment (ART), the inability to retain new clients on treatment has jeopardized country goals for achieving epidemic control, placing United States Government (USG) investment at risk. A program 'reboot' was needed to draw an immediate focus on retention and address this severe and chronic issue, which results in unacceptably high mortality amidst years of unsuccessful remediation and stalled progress.

The reboot process in Mozambique, based on a platform called Analyzing Joint Underperformance and Determining Assistance (AJUDA) – the Portuguese word for *help* – demonstrates that long-term retention can be achieved through a more rigorous and tailored monitoring approach, and a tailored response to the barriers clients face at facilities and in the community. Since AJUDA began, the adjusted one-month retention rate of 63 percent in September 2018 increased to 86 percent by April 2019 among the 127 high volume, low retention facilities accounting for 50 percent of all PLHIV. A more substantive accountability and action framework agreed to by PEPFAR, the Government of the Republic of Mozambique (GRM) and PEPFAR-funded partners has shown signs of improving critical aspects of HIV care and treatment and addressing barriers identified by defaulters as limiting their willingness to remain in treatment.

The 2019 Country Operational Plan (COP19) will feature AJUDA, a targeted surge in human resources deployment, and an inclusive civil society-led response to improve 12-month retention to rates that address the mortality and transmission issues that have plagued the national response hitherto. Having the appropriate ratio of clinical and lay staff to patients and population at risk of infection has proven essential in other countries in need of radical change to achieve epidemic control. Over \$70M of COP funding will be directed toward human resource optimization at facility and community levels. Also, a revamped service delivery package led by the GRM, which includes six month drug distribution and greater and more cost-efficient direct service support, will enable Mozambique to stay on pace with its ambitious treatment and viral suppression targets within a prioritized subset of facilities (from 1,326 in COP18 to 628 in COP19) that account for 90 percent of PLHIV. Furthermore, the expansion of Dolutegravir across all populations through a phased-approach will be a critical factor in enhancing retention and achieving viral load suppression.

COP19 is a particularly challenging year for the HIV program in Mozambique given two devastating cyclones in March/April 2019. Mozambique has also been suffering from instability due to extremist activity in Cabo Delgado, an area critical to epidemic control. Finally, the country is preparing for presidential elections in October 2019, which will lead to a period of transition of leadership. COP19 includes an additional \$10.7M in support specifically to address rebuilding and restoration of services to patients in the cyclone-affected areas, to keep pace with the plan to achieve epidemic control.

COP19 will build on recent gains made in viral suppression (66 percent in Q1FY17 to 78 percent in Q1FY19, for women) by maintaining fidelity to national guidelines on viral load (VL) testing, concentrated psycho-social and literacy support for patients who need it, and timely transfer of clients with treatment failure to second/third line regimens. PEPFAR Mozambique will continue its consolidation of prevention programming for greater value for money, this year with voluntary medical male circumcision (VMMC), while pivoting Key Populations (KPs) and Orphaned/Vulnerable Children (OVC) programming to better support the treatment cascade. Additional cost-saving measures in COP19 include controlling partner funds distribution for more effective outlay management, outsourcing last-mile logistics to specialists, and continued transition of program responsibilities to GRM institutions in line with PEPFAR sustainability objectives.

Finally this COP marks unprecedented contributions of civil society, multilateral agencies, and the GRM, who work in concert with PEPFAR Mozambique to identify novel community-oriented programming designed to hold facilities and clinical partners more accountable for quality HIV services, while improving patient literacy and strengthening local platforms to encourage treatment follow-up from within traditional networks.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Mozambique is a country of approximately 27.9 million people challenged by a generalized HIV epidemic¹. A national survey in 2015 estimated national HIV prevalence at 13.2 percent, with substantial variation in provincial prevalence that ranged from 5.2 percent in Tete Province to 24.4 percent in Gaza Province (2015, IMASIDA)². There were an estimated 2.2 million PLHIV in Mozambique, with a higher prevalence among women, 15.1 percent versus 10.2 percent among men (2018, Spectrum 5.751). HIV prevalence among adolescent girls aged 15-19 is estimated at 6.5 percent, and among young women aged 20-24 prevalence is estimated at 13.3 percent, compared to 1.5 percent and 5.3 percent among adolescent boys and young men, respectively. As of Q1 FY2019, 1.1M or approximately 50 percent of all PLHIV were estimated to be on ART. The HIV epidemic has contributed to a reduced life expectancy, estimated by the World Health Organization (WHO) in 2016 to be 58 years for men and 62 years for women³, and has resulted in an estimated 920,000 children orphaned by acquired immunodeficiency syndrome (AIDS)⁴.

Despite encouraging economic growth in 2015 of 6.6 percent, Mozambique's economy suffered a major blow following the report of nearly \$2 billion in government-backed hidden debt. This report

¹ "INE Destaques — Instituto Nacional de Estatística." <http://www.ine.gov.mz/>. Accessed 8 May. 2019.

² "The DHS Program - Mozambique AIS, 2015 - Final Report (English ..."
<https://dhsprogram.com/publications/publication-ais12-ais-final-reports.cfm>. Accessed 8 May. 2019.

³ "WHO | Mozambique - World Health Organization." <https://www.who.int/countries/moz/en/>. Accessed 8 May. 2019.

⁴ "Mozambique | UNAIDS." <http://www.unaids.org/en/regionscountries/countries/mozambique>. Accessed 8 May. 2019.

contributed to rapid inflation and a reduced gross domestic product (GDP), falling from \$16.9 billion in 2014 to \$11.0 billion in 2016.⁵ In 2015, the Human Development Index ranked Mozambique 180 out of 187 countries.⁶ The World Bank estimated 60 percent of Mozambicans in 2014 lived on less than \$1.25 per day, with the gross national income (GNI) per capita falling from \$620 in 2014 to \$480 in 2016.⁷ Seventy percent of Mozambicans are estimated to be poor and 37 percent destitute, with substantial variation by region and province.⁸

In addition to existing economic challenges, two significant cyclones hit Mozambique in March and April of 2019, producing torrential rains and strong winds across wide swaths of the country. Cyclone Idai, the first of the two cyclones, is now considered the worst natural disaster in southern Africa in nearly two decades. The catastrophic flooding triggered by the storm killed more than 600 people and nearly 1.9 million are in need of assistance. In Sofala, the most affected province, more than 90 percent of health centers were damaged or destroyed. Over 240,000 houses and 1.7 million acres of crops were damaged or destroyed, increasing the risk of food insecurity over the next several months and forcing many households to resettle on pieces of land with no existing infrastructure. Cyclone Kenneth was also extremely destructive, displacing over 21,000 people and causing over 40 deaths. Over 34,000 houses were damaged or destroyed and 200,000 people are in need of assistance.

Despite ongoing challenges, several key health indicators have improved over time. Antenatal care (ANC) coverage, defined as at least one ANC clinic visit, increased to 93 percent, with 70 percent of women delivering in a health facility.⁹ Under-five child mortality was 90/1,000 live births, declining from 103/1,000 live births in 2010.¹⁰ Malaria, 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 five years are stunted.

The Gender Inequality Index synthesizes gender-based inequalities in three dimensions—reproductive health, empowerment, and economic activity—on which Mozambique ranked 138 of 155 countries in 2017¹¹. Mozambique has high rates of early marriage; 60 percent of women age 25-49 were married before age 20, and 40 percent of Mozambican women become pregnant before the age of 20. The adolescent pregnancy rate is 137.8 births per 1,000 live births and the risk of death among pregnant teenagers is four times higher than for women above the age of 20. Only 1.5

⁵ World Bank, <https://data.worldbank.org/country/mozambique>.

⁶ Human Development Report, 2015, UNDP.

⁷ World Bank, 2014-2016 <https://data.worldbank.org/country/mozambique>.

⁸ Oxford Poverty and Human Development Initiative (2016). "Mozambique Country Briefing", Multidimensional Poverty Index Data Bank. OPHI, University of Oxford. Available at: www.ophi.org.uk/multidimensional-poverty-index/mpi-country-briefings/.

⁹ IMASIDA, 2015.

¹⁰ Mozambique DHS, 2011 & UNICEF, 2012.

¹¹ "Gender Inequality Index - | Human Development Reports - UNDP." <http://hdr.undp.org/en/composite/GII>. Accessed 8 May. 2019.

percent of adult women have reached at least a secondary-level of education compared to six percent of men.¹²

Population-level data from 2009 estimated 9.6 percent of all cohabiting heterosexual couples were serodiscordant and 61 percent of PLHIV did not know their HIV status. Among women age 15-49 who had sexual intercourse in the last 12 months, 13 percent reported using a condom during last intercourse (25 percent urban, 6.5 percent rural). The proportion increased to 16 percent among similar aged men (33 percent urban, seven percent rural). Male circumcision is reported at 63 percent, with geographic variations ranging from nine percent in Tete Province to 95 percent in Niassa Province.

Mozambique is facing another challenge due to the youth bulge. As of the 2017 census, 12.5 million or approximately 46.6 percent of the country's population is less than 15 years of age¹³. As these youth become sexually active, without comprehensive measures taken now that reduce the pool of HIV positive persons who are not on ART and virally suppressed, the opportunity to achieve epidemic control by 2020 will be lost. PEPFAR and GRM are acutely aware of this emerging challenge and are taking all actions with a sense of urgency.

A Modes of Transmission Model conducted in 2013 shows that 29 percent of new infections were among sex workers, their clients, and men who have sex with men (MSM), and 26 percent of new infections occur among people in stable sexual relationships, due in large part to high rates of serodiscordance and low rates of condom use among couples. People in multiple concurrent partnerships contributed to 23 percent of new adult infections. Mobile and migrant workers such as miners, agricultural workers, prison populations, the military, and truck drivers also constitute priority populations.¹⁴

Mozambique is challenged by a low national rate of retention in care and adherence to ART. The 12-month retention among PLHIV newly initiating ART in 2018 was 68 percent overall, including 67 percent among pregnant woman, 70 percent among children under 15 years old, and 68 percent among adults. Mozambique is aggressively implementing counter-measures and testing innovations at the facility and community level to retain and track PLHIV on treatment (see Appendix E).

The health system contends with substantial challenges that include stagnant domestic resource mobilization, insufficient infrastructure, and a critical shortage of human resources. In 2014, a study estimated that 90 percent of Mozambicans live in a primary health care area defined as over a one hour walk from a primary health care center.¹⁵ Overall, the ratio of population per hospital

¹² Human Development Report 2014, UNDP.

¹³ "Censo 2017 Brochura dos Resultados Definitivos do IV RGPH ..." <http://www.ine.gov.mz/iv-rgph-2017/mocambique/censo-2017-brochura-dos-resultados-definitivos-do-iv-rgph-nacional.pdf/view>. Accessed 8 May. 2019.

¹⁴ Military – Seroprevalence and Behavioral Epidemiology Risk Survey in the Armed Forces of Mozambique 2010.

¹⁵ Luis & Cabral, Geographic accessibility to primary healthcare centers in Mozambique, 2016.

bed is one bed per 1,038 persons, with substantial variation across the country.¹⁶ Human resources for health (HRH) are severely constrained with 7.8 doctors, 26.8 nurses, and a total of 100.2 health care workers (HCW) per 100,000 people.¹⁷ Together with uneven geographic distribution and limited supervision, there are an inadequate number of trained HCW in all cadres.

The GRM is responsible for HIV/AIDS-related service delivery, along with the development, implementation and oversight of policies and regulations. Information systems and monitoring and evaluation (M&E) efforts are heavily supported by external funding and are challenged by fragmented components and system patches that do not regularly provide timely and accurate health data. Supply chain and commodities management is an area where PEPFAR provides substantial technical assistance to keep pace with growing ART and commodity needs. The laboratory network to support HIV care and treatment also requires significant investment to expand diagnostic capacity; at present only 400 (27.8 percent) of 1,438 health units have laboratories.

Despite these challenges, there has been remarkable progress. Since 2011, the number of people on ART has increased threefold, with dramatic increases following the launch of the Ministry of Health's (MISAU) national *HIV and AIDS Response – Strategic Acceleration Plan for Mozambique 2013-2017* and the introduction of *Test and Start* in 2016. The number of health facilities offering ART increased from 255 in 2011 to 1,455 by 2018. Based on data from MISAU and PEPFAR, approximately 1.1M persons were estimated to be on ART at the end of 2018.¹⁸

¹⁶ MOH – DRH. Relatório Anual dos Recursos Humanos. Maputo, Abril 2014.

¹⁷ MOH/MISAU, 2016. WHO (2006) estimates 230 medical professionals per 100,000 people as a minimum threshold necessary to provide essential health interventions.

¹⁸ Mozambique APR17 POART.

Table 2.1.1: Host Country Government Results

	Total Population Size Estimate		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	28,861,863		6,482,747	22%	6,308,861	22%	2,969,337	10%	2,789,286	10%	5,608,922	19%	4,702,710	16%	2017 Data from Census (INE 2017)
HIV Prevalence (%)		13.2%		2.3%*		1.6%*		9.8%		3.2%		18.3%		14.6%	IMASIDA (AIS) 2015
AIDS Deaths (per year)	56,009		5,130		5,262		2,921		1,822		18,596		22,278		Spectrum v5.751, 2018
# PLHIV	2,222,789		85,837		87,433		236,031		100,046		1,010,714		702,727		Spectrum v5.751, 2018
Incidence Rate (Yr.)		5.45						1.36		0.65		6.36		7.3	Spectrum v5.751, 2018
New Infections (Yr.)	150,081		9,662		87,433		39,083		19,912		35,282		36,217		Spectrum v5.751, 2018
Annual births	1,091,569														Ministry of Health, SISMA 2018
% of Pregnant Women with at least one ANC visit		87.1%													IMASIDA (AIS) 2015

Pregnant women needing ARVs	108,756														Spectrum v7.751, 2018
Orphans (Total-maternal, paternal, double)	2,513,778														Spectrum v7.751, 2018
Notified TB cases (Yr.)	304032														Ministry of Health, PNCT 2018
% of TB cases that are HIV infected	11%														
% of Males Circumcised		62.8%				65%*				66.0%				60.9%	IMASIDA (AIS) 2015 * SOAR 2019, only provinces with VMMC program
Estimated Population Size of MSM*	41,393														Key Pop Size Estimation, 2018
MSM HIV Prevalence	2,800	7%													Key Pop Size Estimation, 2018
Estimated Population Size of FSW	93,523														Key Pop Size Estimation, 2018

FSW HIV Prevalence	21,866	23%														Key Pop Size Estimation, 2018
Estimated Population Size of PWID	13,514															Key Pop Size Estimation, 2018
PWID HIV Prevalence	5,193	38%														Key Pop Size Estimation, 2018
PWID HIV Prevalence		24%														
Estimated Size of Priority Populations Prevalence (specify)																

**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*

*Prevalence of children <2 years

* Some population data is 15+ vs 15-49

Table 2.1.2: 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*

Epidemiologic Data		HIV Treatment and Viral Suppression					HIV Testing and Linkage to ART Within the Last Year			
Total Population Size Estimate (2017 Data from Census (INE 2017)) (#)	HIV Prevalence (IMASIDA 2015) (%)	Estimated Total PLHIV 2018 (Spectrum v7.571) (#)	PLHIV diagnosed* (IMASIDA 2015) (%)	On ART (TX_CURR FY19 Q2) (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (HTS_TST FY19 Q2) (#)	Diagnosed HIV Positive (HTS_POS FY19 Q2) (#)	Initiated on ART (New on ART FY19 Q2) (#)	
Total population	28,861,863	13.2%	2,222,789	47%	1,089,714	49%	78%	4,237,750	176,574	152,349
Population <15 years	12,791,607	2.0%	173,270		64,192	37%	46%	580,167	9209	6,711
Men 15-24 years	2,789,286	3.2%	100,046		36,029	36%	64%	148,537	1787	1,068
Men 25+ years	4,702,710	14.6%	702,727		246,787	35%	79%	426,349	41839	42,440
Women 15-24 years	2,969,337	9.8%	236,031		142,884	61%	75%	405,414	9699	8,729
Women 25+ years	5,608,922	18.3%	1,010,714		538,133	53%	81%	1,051,264	58274	55,115
MSM*	41,393	6.76%	2,800	8.8%		3.5%				
FSW	93,523	23.40%	21,866	22.3%		12.6%				
PWID	13,514	38.40%	5,193	62.3%		42.2%				

Priority Pop Prisoners		24%								
<p>*% who self-reported HIV+ and were actually HIV+</p> <p>* VL data comes from DISA, not nationally representative and needs quality improvement</p> <p>* Key pops size estimation analysis</p> <p>** IBBS MSM and FSW 2011, PID 2014</p>										

Figure 2.1.3: National and PEPFAR Trend for Individuals Currently on Treatment

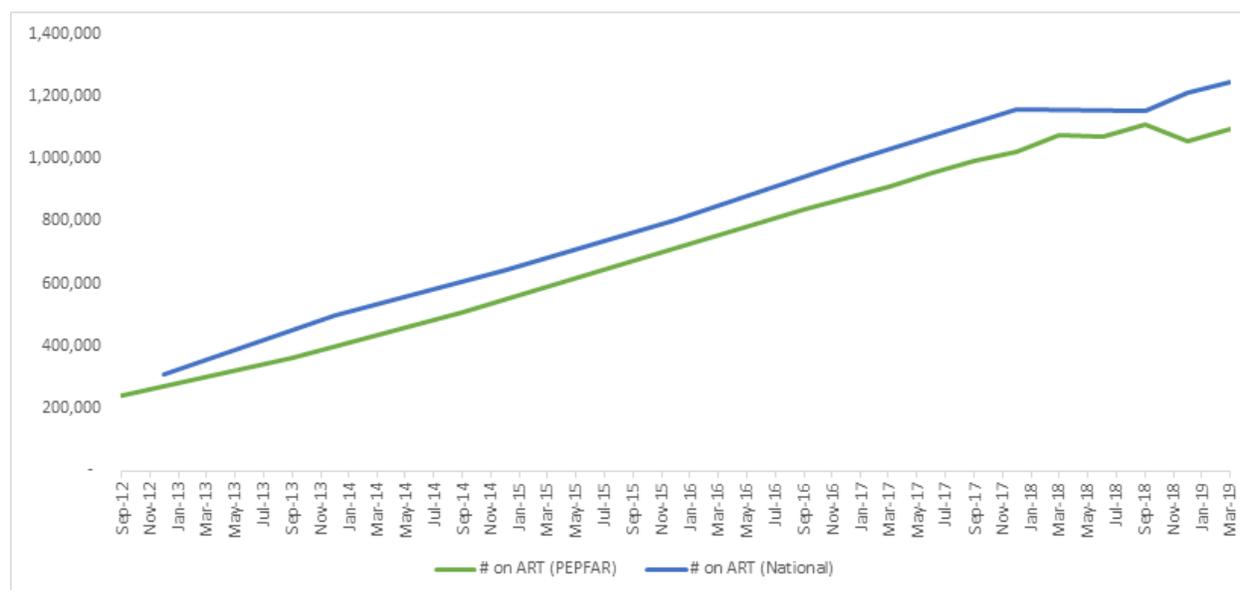
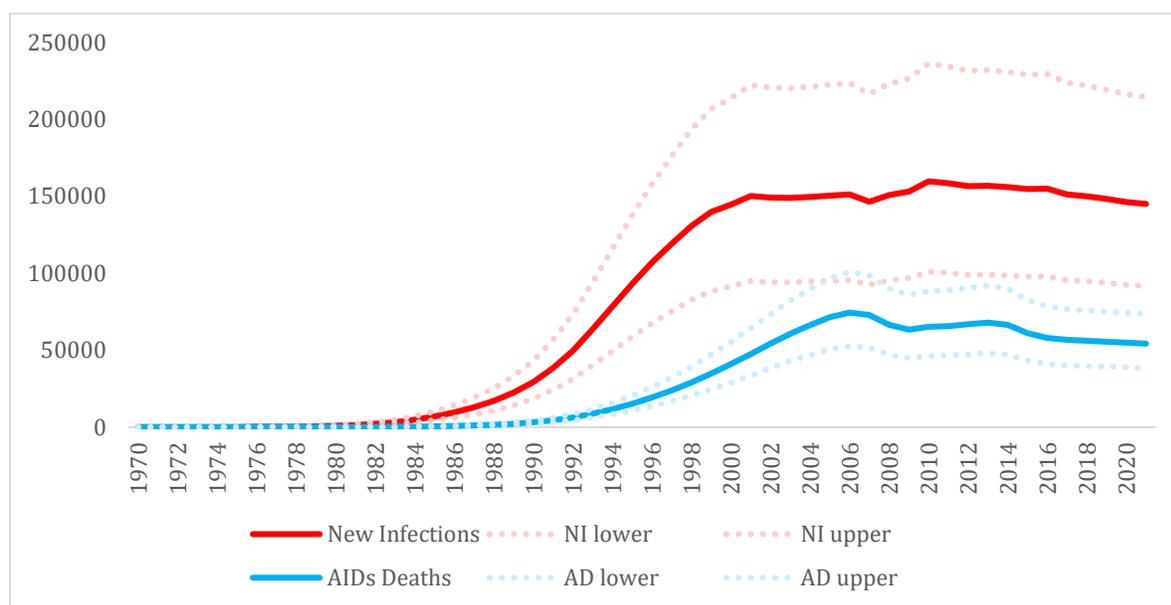


Figure 2.1.4: Trend of New Infections and All-Cause Mortality Among PLHIV



2.2 Investment Profile

National Health Budget

The GRM allocated 26.3 billion meticaïs (MTZ) (\$438 million USD) to health in the 2018 budget, the highest nominal amount ever allocated to the health sector. Relative to 2017, the health sector budget nominally increased by 24 percent, and accounts for 8.7 percent of the total budget. The health sector budget relies on 86 percent internal resources, and 14 percent external resources. Over the past decade, the GRM has increased of the total financing provided for health. Vertical donor

programs that do not directly finance the health sector budget represent between 1/3 and 1/2 of total expenditures per annum in the health sector. The largest 'vertical'-budget donor in Mozambique is PEPFAR. However, given increases in the overall health expenditures, approximately 67 percent of investment spending in 2018 was financed through external resources. MISAU central health services received the largest allocation in the 2018 budget (50 percent), followed by district health services (20 percent) and provincial health directorates (11 percent). The remaining 19 percent is allocated to specialized institutions of MISAU (central hospitals, training centers, health science institutes, etc.). Health sector recurrent spending accounts for 79 percent of the budget, with only 21 percent for investment spending. This is largely due to the reduction in donor funding, which has been inconsistent and declining. Donor contributions currently comprise 14 percent of the public sector health budget. In 2014, the health sector 'basket fund' called *Pro-Saude* financed \$84 million (25 percent) of funding that went to MISAU. Funding dropped to \$20 million in 2018, reflecting donor preference for alternative funding arrangements.

HIV expenditures

The 2017 Global AIDS monitoring report indicates that total HIV expenditures in 2016 amounted to \$330 million, a decrease from \$343 million in 2015 and \$333 million in 2014. PEPFAR and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) are the main source of funds for the HIV response, accounting for approximately 88 percent of HIV expenditures in 2016. Government expenditures in 2014 accounted for \$8.5 million in program costs (this figure does not include salary and benefits to HIV/AIDS service delivery providers, pharmacists, laboratory technicians, or other health care staff), approximately 2.5 percent of total expenditures on HIV, a reduction from \$16.2 million (five percent of HIV expenditures).

Expenditure by cost category

79 percent of the GRM health budget is dedicated to recurrent expenditures, consisting of salaries, procurement of goods and services, operating costs, transfers and financial operations. Only 21 percent of the health budget is spent in investment (capital expenditure) aimed at improving access to health services and quality of care. Between 2008 and 2016, internal investment showed nominal annual increases; meanwhile, over the same period, recurrent spending increased in real terms by more than 150 percent. During the same period, the investment to recurrent ratio decreased from 56 percent investment: 44 percent recurrent in 2008, to 12 percent investment: 88 percent recurrent in 2017, and slightly improved to 21 percent investment: 79 percent recurrent in 2018. As a result, the Mozambican health sector's capacity to improve the health system (increase access, improve infrastructure, etc.) is severely constrained by the limited amount of resources available for, and devoted to investment expenditure.

One hundred percent of antiretrovirals (ARVs) over the next GFATM implementation period 2018-2020 are procured by donors, principally by the GFATM (74 percent) and PEPFAR (26 percent). These are sourced through international pooled procurement mechanisms (Global Health Supply Chain Procurement and Supply Management (GHSC-PSM), GFATM Wambo). The country also

relies substantially on donors, particularly the USG, for other HIV commodities such as VL and early infant diagnosis (EID) reagents.

The GRM covers HCW salaries (estimated at \$140 million per annum) and costs related to implementation (facility maintenance, transport, provision of other essential commodities, operational costs). To date, 100 percent of ancillary health worker staff salaries (lay counselors, data clerks) are paid by donors.

Planned Government Contributions

The GRM has committed to spend \$10 million/annum on ARVs, a significant move towards reducing reliance on international partners for the HIV response. The government has also committed to increase domestic funding for health by \$25M USD annually between 2018-2020 in accordance with the GFATM counterpart agreement. However, its ability to meet this commitment is questionable in light of limited fiscal space caused by an excessive external debt burden. The GRM has also acknowledged their current limited capacity to finance additional human resources, or improve working conditions of existing resources, required for epidemic control (additional doctors, nurses, lab techs etc.).

Data availability and Estimations

Health sector expenditures are estimated from the annual MISAU budget reports (Relatório de Execução Orçamental) complemented by estimations made by the United Nations Children's Fund (health sector budget briefs). It is important to note that the health sector does not track or report spending by disease category. Reporting on HIV-specific expenditure is based on the National AIDS Spending Assessment (NASA) and the Global AIDS Monitoring Report, as tracked by Mozambique's National Council to Combat AIDS (CNCS), which details HIV funding and expenditure by source, programmatic area, and beneficiary population and geographical location. Data available covers the period running from 2004-2014.

Conclusion and Next Steps

The GRM will not be able to fully cover the costs of its response to HIV and will require substantial support from international partners for the medium term. This is due to two factors. First, the increased population as noted in the 2017 census and high HIV prevalence as estimated in the IMASIDA 2015 indicate that the country has significantly more people living with HIV than previously known (~2.2 million in lieu of ~1.6 million). Secondly, as stated above, the country is facing a severe fiscal crisis, which limits the government's ability to increase its contribution towards the response. However, the country's medium to long term economic prospects are bright. The extractive industry (natural gas) is expected to significantly contribute to state revenues in the next 10-15 years, which should allow the GRM to increase its contribution to the HIV response. As such, it is critical that PEPFAR, GFATM, and other donors support the planning to achieve

sustainable financing strategies to allow GRM to gradually become the primary funder of the HIV response.

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	53.6	72%	19%	6%	3%
<i>Other</i>	81	N/A	N/A	N/A	N/A
TOTAL	342	N/A	N/A	N/A	N/A
<p>* Includes VCT, PIT and blood safety (Preventing mother-to-child transmission (PMTCT) testing included under PMTCT) ** Refers to prevention for vulnerable groups, accessible population and prevention for youth *** National M&E, operational 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. NOTE: Updated data from NASA expected in mid-2019.</p>					

Table 2.2.2: Annual Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	\$72,394,763	19.94%	80.06%	0.00%	0.00%
Rapid test kits	\$12,494,800	33.09%	66.91%	0.00%	0.00%
Other drugs	\$7,218,364	13.86%	43.55%	42.59%	0.00%
Lab reagents	\$14,649,106	14.17%	85.83%	0.00%	0.00%
Condoms	\$4,697,046	43.56%	0.00%	4.31%	52.13%
Viral Load commodities	\$9,691,233	100.00%	0.00%	0.00%	0.00%
VMMC kits	\$764,682	100.00%	0.00%	0.00%	0.00%
MAT	\$-	0.00%	0.00%	0.00%	0.00%
Other commodities	\$-	0.00%	0.00%	0.00%	0.00%
Total	\$121,909,994				

Table 2.2.3: Annual USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	\$18,430,000	\$1,913,800	4	\$3,83,412*	Supply chain strengthening and procurement of essential commodities; training the expanding cadre of Community Health Workers (CHWs) to provide health promotion, prevention, and curative services at the community level; increasing healthy behaviors for maternal, newborn, and child health; provided technical assistance to improve health sector monitoring and evaluation and strengthen country health information system; strengthen and advance national health policy priorities, with a focus on maternal and child health, family planning and reproductive health, and HIV/AIDS and; strengthening GOM's ability to lead pharmacovigilance efforts nationwide
USAID TB	\$4,900,000	\$200,000	1		Strengthening GRM's ability to lead pharmacovigilance efforts nationwide
USAID Malaria	\$28,450,000	\$15,847,413	4		Supply chain and improved systems strengthening, improved the health status for women of childbearing age, particularly pregnant and lactating women and children under five year of age and; increased uptake of malaria prevention, testing, and treatment

					services. Co-funded mechanisms include: PSM
Family Planning	\$14,480,000	\$2,550,000	4		Increased access to and use of voluntary FP contraceptive methods; Commodities purchased including condoms, essential medicines, and diagnostics; Improved maternal and child survival; Improved health behaviors; strengthening GRM's ability to lead pharmacovigilance efforts nationwide.
USAID Nutrition	\$5,835,000	\$600,000	3		Increased capacity of MISAU to develop and implement nutrition-oriented policies and programs; Improved positive health and nutrition behaviors, particularly among HIV-positive pregnant women and mother.
NIH	N/A	N/A	N/A	N/A	N/A
CDC (Global Health Security)	N/A	N/A	N/A	N/A	N/A
Peace Corps	N/A	N/A	N/A	N/A	N/A
DOD Ebola	N/A	N/A	N/A	N/A	N/A
MCC	N/A	N/A	N/A	N/A	N/A
Total	\$72,070,000	\$21,111,213	N/A	\$383,412*	N/A

Table 2.2.4: Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP		
Funding Source	Total PEPFAR Non-COP Resources	Objectives
Cervical Cancer (Central Initiative)	\$5,026,819	<p>Cervical cancer in Mozambique continues to be one of the most common causes of cancer-related death among HIV+ women. Among all cancers in women, 31 percent are due to cervical cancer. PEPFAR Mozambique will scale up efforts in COP19 to ensure efficient implementation of cervical cancer screening and treatment services (called CECAP in Mozambique), in alignment with PEPFAR guidance.</p> <p>In order to reach the COP19 target of 228,837, PEPFAR Mozambique will support all AJUDA sites to strengthen and expand the provision of pre-cancer screening, visual inspection with acetic acid (VIA), cryotherapy, LEEP, and referral criteria for HIV positive women through an integrated approach to HIV services.</p> <p>PEPFAR Mozambique will work closely with the GRM to disseminate and implement the National Plan to Control Cancer, 2019-2029. PEPFAR will support nationwide trainings to ensure providers are adequately prepared to screen and treat HIV+ women in Mozambique. Plans for training of trainers at regional and provincial levels, with on-going supervision and technical assistance, will be offered at both the provincial and health facility levels for the SRH/MCH and HIV care providers. Specialist and non-specialists will be trained in LEEP to maximize coverage of services and equipment acquisition and optimization. In addition, demand creation, appropriate M&E system and eHUB for quality assurance, and referrals and counter referrals for appropriate case management will be ensured in order to meet the goal.</p>
Total	\$5,026,819	

2.3 National Sustainability Profile Update

Mozambique has been going through a period of austerity since the revelation of hidden debts and their subsequent impact on the GRM fiscal stability in 2015. In the midst of a generalized and growing epidemic, the GRM's capacity to respond has been constrained. In spite of these challenges, the country has advanced sustainability, with the most positive trends in the areas of Governance, Leadership, Accountability, and Strategic Information (SI). The overall sustainability index has not changed since it was completed in 2017.

Sustainability Index Dashboard (SID) Process

The Sustainability Index Dashboard is completed every two years via a collaborative, consultative process coordinated by The Joint United Nations Programme on HIV/AIDS (UNAIDS) and PEPFAR, with leadership from CNCS, the civil society platform for health (PLASOC), and MISAU. SID consultations occurred through a series of smaller meetings and one larger meeting involving over 50 participants representing government, multilateral partners, and civil society. The most recent SID (SID 3.0) was approved by the Minister of Health in November 2017.

Sustainability strengths:

- Program Planning and Coordination (8.62, dark green): CNCS and MISAU provide strong leadership in planning and coordinating the national HIV response. Challenges remain in having adequate financing and staffing to achieve objectives.
- Policies and Governance (7.27, light green): Mozambique has laws and policies in place that follow the most recent WHO guidelines that protect victims of domestic violence, and protect against discrimination. Nevertheless, there is a need to reinforce protection of KPs and of patient data and to address stigma.
- Performance Data (7.17, light green): MISAU, in coordination with donor partners, is strengthening its monitoring and evaluation platform, which provides critical strategic information to decision makers in a timely manner. Decision making at MISAU using data is showing improvement, particularly in areas of data interpretation and utilization.

Sustainability vulnerabilities:

- Laboratory Services (2.83, red): The laboratory system in Mozambique is challenged at all levels, and PEPFAR will continue to support the laboratory system with a focus on VL monitoring, quality control, increased technician capacity, data capturing, and administrative support to reduce long turnaround time of samples.
- Technical and Allocative Efficiencies (0.89, red): The GRM uses epidemiological models to define national targets and, prioritize programs and sub-national geographical areas, but the budget allocation process is not yet developed to the same granular level. PEPFAR and other donor partners will continue to provide technical assistance to identify innovative systems and mechanisms that may help to increase public investments for HIV.

In COP19, PEPFARs laboratory investments will shift towards consolidation of gains and institutionalization of national capacity. Mozambique will have a national network of VL laboratories with laboratories functional in 9 of 11 provinces by the end of FY2019. This will ensure that 70 percent of PLHIV will have access to VL and monitoring for viral suppression. The program will continue consolidating technical assistance to the national laboratory network in order to enhance partner management and increase accountability. GFATM also plans to contribute to addressing SID vulnerabilities in the laboratory area through financing of pre-service training, procurement of selected reagents and equipment and renovations of facility based infrastructure.

In COP19, PEPFAR will also continue to support MISAU in implementing the nationally approved electronic patient tracking system (EPTS). The program also intends to gradually transfer health information systems responsibility for EPTS management to provincial directorates. Investments aimed at improving budget allocation and tracking systems will be sustained, and the program will support MISAU to shift away from input based budgeting, to program based budgeting, which will strengthen the linkages between planning, budgeting, and budget execution monitoring.

GFATM financial support is expected to remain stable during COP19. Mozambique recently secured donor support to accelerate implementation of reproductive, maternal and child health priorities under the Global Financing Facility (GFF). On-budget support provided through the *Pro-Saude* common fund has incrementally increased but still remains considerably low.

USG collaborates with a range of local partners in Mozambique including non-governmental organizations (NGOs), faith based organizations and community based organizations. The program is transitioning responsibility for selected program components to local partners, whenever technically feasible. PEPFAR Mozambique has also established new partnerships with the National AIDS Commission (CNCS), the Ministry of Gender, Children and Social Action (MGCAS), sub-national provincial health directorates, and selected local authorities.

2.4 Alignment of PEPFAR investments geographically to disease burden

In order to maximize the impact of finite PEPFAR resources, an effort was made to concentrate PEPFAR investments in a smaller number of health facilities in COP19. A total of 628 AJUDA sites were prioritized based on having historically provided ART to 90% of Mozambique's patients on ART. The remaining 735 sites were classified as Centrally Supported. These two site-level classifications were used as the primary determination for level of investment and to define site level support packages. District level prioritization categories were also updated according to COP19 guidance based on ART saturation by age band.

The team defined three tranches of AJUDA sites: Phase 1 and 2, making up 50 and 35 percent of persons receiving ART (TX_CURR), respectively, and Phase 3, making up 5% of TX_CURR. Phase 1 and 2 sites are to receive intensive support in FY19 and Phase 3 sites, in FY20. Overall, Phase 1, 2, and 3 sites, currently make up 90% of TX_CURR. In COP19, AJUDA province and site support will be referred to as PEPFAR Site Support.

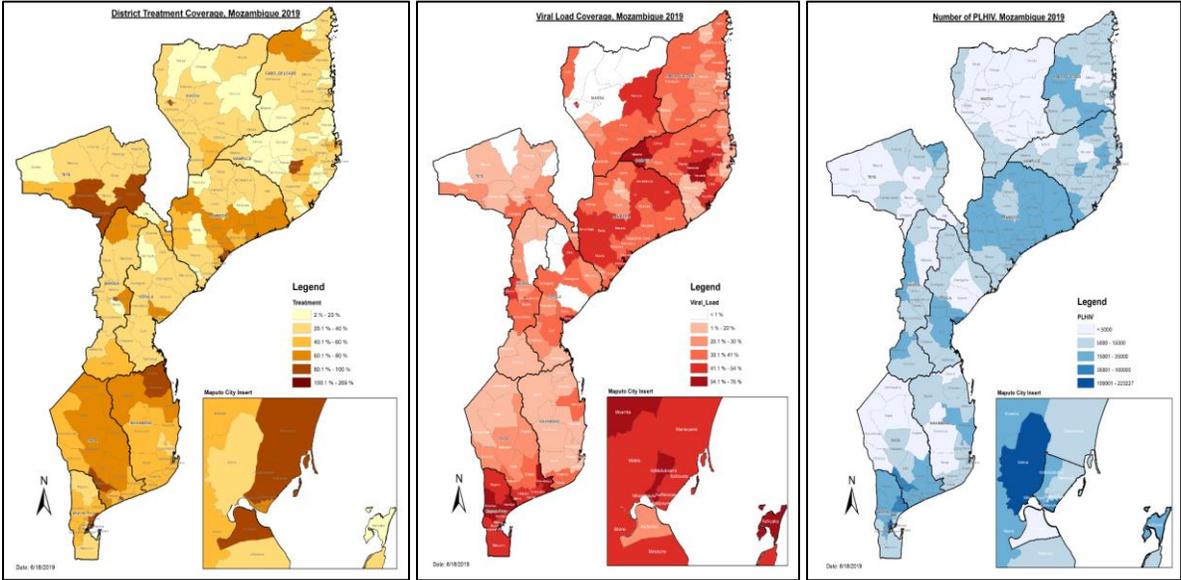
Site selection was driven primarily by size but informed by contextual factors. The initial FY19 Phase 1 sites were obtained by selecting the largest sites with the poorest 12-month retention, highest loss-to-follow up as a percent of TX_CURR, and inclusive of all sites that were already conducting enhanced retention monitoring. Phase 2 and Phase 3 sites were initially selected by sorting sites by descending TX_CURR and selecting the largest sites that made up 85 and 90 percent, respectively, of TX_CURR. In consultation with implementing partners and MISAU, this list was further refined to consider the number of districts supported, roads and their condition, and geographical factors such as rivers. Removal of sites was counterbalanced by addition of sites with an equal or greater number of TX_CURR so that the benchmarks of 85 percent TX_CURR coverage in FY19 and 90 percent in FY20 continued to be met. Contextual factors were also considered in the addition of sites, such as inclusion of a prison clinic as part of the KP program or proximity to existing AJUDA sites. The number of TX_CURR and associated sites that were classified as AJUDA versus central support are shown in Tables 2.4.1 and 2.4.2, respectively.

Province	PEPFAR Site Support	Central Support	Grand Total
Military Mozambique	15,060	0	15,060
Cabo Delgado	48,871	11,481	60,352
Cidade De Maputo	124,602	683	125,285
Gaza	137,813	9,462	147,275
Inhambane	62,662	14,784	77,446
Manica	69,576	8,459	78,035
Maputo	129,141	7,289	136,430
Nampula	69,882	15,001	84,883
Niassa	18,472	9,012	27,484
Sofala	76,186	11,381	87,567
Tete	46,076	12,887	58,963
Zambezia	178,800	20,032	198,832
Grand Total	977,141	120,471	1,097,612

Province	PEPFAR Site Support	Central Support	Grand Total
Cabo Delgado	44	80	124
Cidade De Maputo	28	5	33
Gaza	99	38	137
Inhambane	49	84	133
Manica	51	53	104
Maputo	57	42	99

Nampula	59	129	188
Niassa	18	73	91
Sofala	46	68	114
Tete	33	71	104
Zambezia	144	93	237
Grand Total	628	736	1,364

Figure 2.4.3 PLHIV and ART and VL coverage by health district, Mozambique, 2019



2.5 Stakeholder Engagement

Host country government

PEPFAR is committed to close engagement with the GRM on policy issues, alignment with national priorities, joint planning and implementation, data sharing, coordination and communication with various stakeholders, including implementing organizations, and strategic discussion to support attainment of country goals. Leadership from MISAU, CNCS, and PEPFAR led semi-annual and annual stakeholders’ meetings and helped to assure that policy decisions were fully communicated and resulted in action.

In 2017, following two years of COP planning in which PEPFAR Mozambique was much more deliberate in its engagement of key stakeholders, MISAU and CNCS leadership reached out to PEPFAR to form the Joint Steering Committee (JSC), to assure that this engagement between USG and GRM would not be limited to the COP only. The JSC focuses on discussion of strategic issues and coordination and alignment of PEPFAR, CNCS and MISAU in the national AIDS response. From late November through mid-February, the JSC met multiple times to discuss data and results, programmatic direction, and to make key decisions on policy and strategy in the period leading up

to and during COP19 planning. The COP19 in-country stakeholder retreat began on January 22, 2019 and spanned a two-week period of intense discussions among key stakeholders to finalize programmatic priorities and targets, and develop a united national plan. The GRM participated in the COP19 Johannesburg meeting, and continued its strong leadership in the planning process, even through the natural disasters of Cyclones Idai and Kenneth.

A key input for the COP19 planning process was the mid-cycle evaluation of the PEN IV (National Strategic Plan for control of HIV and TB) conducted in November 2018. The review was led by the CNCS, MISAU and coordinated jointly by WHO and UNAIDS. Preliminary results were shared and have informed the plans and direction of COP19.

PEPFAR has national level Government to Government (G2G) Cooperative Agreements with MISAU, the National Institute of Health (INS), and agreements with the Provincial Health Directorates (DPS), and provides district level sub-agreements and embedded technical advisors. PEPFAR staff are active participants in MISAU technical working groups, and engage with DPS to oversee program implementation and partner support through regular site visits and sharing of Quality Assurance and Quality Improvement results, Site Improvement through Monitoring Systems (SIMS) reports, and program results (Semi-Annual and Annual Reports).

PEPFAR also collaborates with the Ministries of Gender, Child, and Social Action; Education and Human Development; Defense; Foreign Affairs and Cooperation; and Economy and Finance (MEF).

GFATM and Other External Donors

PEPFAR engaged with GFATM and other key multilateral partners throughout the development of COP19. Members of the GFATM Country Coordinating Mechanism (CCM), UNAIDS, and WHO participated in the planning retreats and provided input on key elements. The Fund Portfolio Manager (FPM) attended PEPFAR specific planning meetings, including with technical staff, agency leadership, and also with MISAU and CNCS for coordination and planning for COP19.

The current GFATM grant, 2018-2020, is in the middle of second year of implementation. Current GFATM grants for this 2018-2020 period are:

1. MISAU joint HIV/TB grant totaling: \$254,124,911, with a majority of this funding going towards commodities, but also including some program areas such as health information system (HIS) support, laboratory, training, supervision, and monitoring, and human rights activities;
2. MISAU-TB grant totaling: \$41,858,657, supporting commodities, including tuberculosis preventative treatment (TPT), and some programmatic areas such as HIS activities, and training, supervision and monitoring;
3. Fundação para o Desenvolvimento da Comunidade HIV grant totaling: \$28,422,994 to support key population prevention activities and human rights interventions at community level; and,
4. Center for Collaboration in Health (CCS) HIV/TB grant totaling: \$30,295,168 to support HIV retention activities and TB case finding at community level, and human rights interventions.

Discussions are ongoing with technical staff and the FPM to coordinate and harmonize activities to avoid duplication. GFATM staff, including the FPM, SI advisor, and commodity/supply chain leads meet with PEPFAR during their periodic programmatic visits in Maputo. PEPFAR staff attend GFATM meetings in country, including CCM General Assembly and sub-group meetings, communicate with the FPM, coordinate USG technical assistance to the GFATM, and work to harmonize the PEPFAR and GFATM programs. In COP19, PEPFAR will continue to engage with GFATM to ensure both programs leverage their respective comparative advantages and eliminate duplication. PEPFAR will continue to share information and solicit feedback before and after technical assistance visits and quarterly reporting, and to work closely with GFATM to coordinate commodities planning.

The USG serves as the primary interlocutor between the Health Partners Group (HPG) and MISAU. This has deepened PEPFAR's strategic engagement with other bilateral and multilateral partners and has allowed shared responsibility for health systems support for endeavors such as emergency essential medicines procurement that work in tandem with ART.

Civil Society/Community

Civil society participated in all in-country consultations to prepare COP19, beginning with the evaluation of the PEN IV. They have been engaged through technical working group meetings, the stakeholder retreat in January 2019 (which included representatives from all provinces), and dialogues leading up to the COP19 Meeting.

Recognizing a need to improve civil society's engagement, a special training session was hosted by The Health Resources and Services Administration (HRSA)/National Alliance of State and Territorial AIDS Directors (NASTAD) in January 2019 to provide civil society with additional technical capacity to advocate for their needs and interests before the beginning of COP19 planning. As a result of this training, civil society developed a list of program priorities that were discussed and addressed during the COP19 meeting in Johannesburg. Civil society representatives to the meeting engaged directly with PEPFAR Mozambique leadership and secured a commitment to fund innovative community-oriented programming designed to hold facilities and clinical partners more accountable for quality HIV services, while improving patient literacy and strengthening local platforms by those serving those specific communities to encourage treatment follow-up from within traditional networks.

PEPFAR is committed to assuring inclusive geographic representation, engaging faith-based leadership from a variety of religions, and increasing the presence and voice of PLHIV, youth, and other key and priority populations in all stakeholder and partner meetings.

PEPFAR meets regularly with the Civil Society Platform for Health (PLASOC), a group representing a considerable number of HIV-focused NGOs and CBOs based in all provinces of the country. PEPFAR built capacity of civil society in 2018 by supporting trainings in data use and Gender and

Sexual Diversity (GSD). PEPFAR's Civil Society Engagement team continues to meet with PLASOC to share information, to solicit input into key programmatic issues and policy decision points, and to assure full participation in COP implementation.

2.5.4 Private Sector

The USG Public-Private Partnership (PPP) Interagency Working Group, which includes all agencies operating in Mozambique, provides a forum for coordination and sharing of best practices and opportunities for leveraging private sector resources to achieve shared development goals in Mozambique. The PPP Working Group engaged leadership from Exxon Mobile and Anadarko to discuss how they can support the HIV response. Private sector representatives from ECOSIDA, a chamber of commerce style organization in Mozambique, also participated in the COP retreat. Feedback from these forums and meetings was integrated into PEPFAR's program planning for COP19. G2G support to CNCS will help coordinate and monitor private sector workplace HIV/AIDS programs.

3.0 Geographic and Population Prioritization

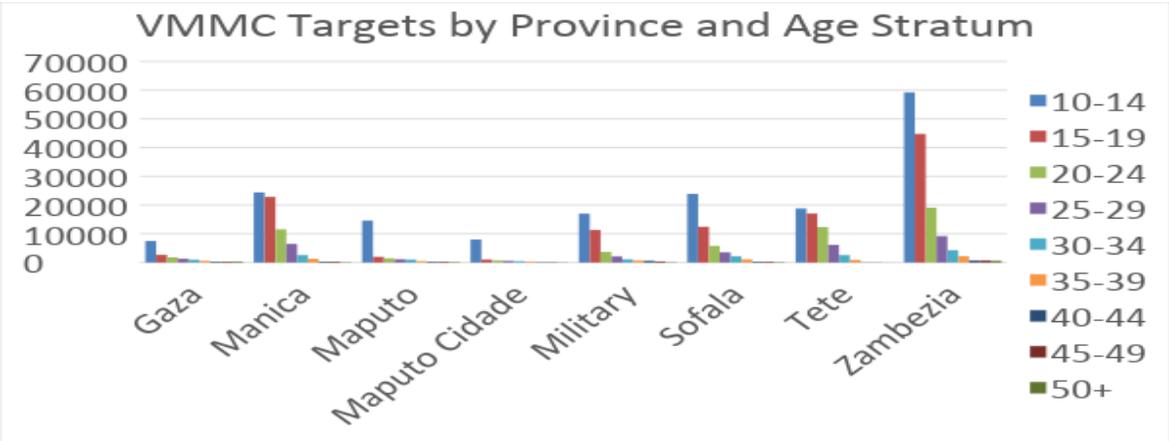
Voluntary Medical Male Circumcision (VMMC)

By the end of COP18, based on the Supporting Operational AIDS Research (SOAR) model, the VMMC program is expected to exceed 80 percent coverage among 10-29 year olds in 4 of 7 provinces in which the program is currently implemented. By the end of COP19, the program expects to add a fifth (Table 3.0.1) province with greater than 80 percent coverage. The most ambitious targets are in Zambezia where the population is large and coverage is still expected to be less than 80 percent at the end of FY19, followed by Manica and Tete where coverage is relatively low. As provinces and districts transition to higher coverage levels, the program will consolidate a maintenance program among 10-14 year olds. VMMC questions will be added to the *Population-based HIV Impact Assessment* (PHIA) to ensure that coverage of complete circumcision is truly high in the four provinces where traditional circumcision is thought to obviate the need for a VMMC program, namely Cabo Delgado, Niassa, Nampula, and Inhambane.

In COP19 Mozambique will conduct a national PHIA led by INS with support from the Centers for Disease Control and Prevention (CDC) and implemented by ICAP. The aim of the assessment is to gauge progress toward the UNAIDS 95-95-95 goal and will allow ascertainment of true VMMC coverage in all provinces for identification of areas with low coverage, targeting of resources, and planning for efficiencies. A central team is coordinating and planning the PHIA with Mozambique's country team.

Province	COP17 Coverage	COP18 Targeted Coverage	COP19 Targeted Coverage
Maputo City	85	91	101
Maputo Province	76	84	90
Gaza	74	80	89
Manica	46	60	83
Sofala	73	86	93
Tete	24	32	81
Zambezia	69	75	87

Figure 3.0.1: VMMC targets by province and age group



HIV Cascade Services

Treatment targets were determined at the district level based on estimates of treatment coverage and unmet need, as estimated through a combination of PEPFAR and HIVE data. In addition, data were reviewed on treatment coverage by age and sex. In the aggregate, targets are aggressive in comparison to prior years. As described in greater detail in section 4.0, these targets will be supported programmatically by an HRH surge with greater numbers of PEPFAR-funded staff providing direct services, and by scale-up of key interventions, including mobile brigades and a shift from 3-month to 6-month drug dispensation. Targets were set to be more aggressive in age-sex subpopulations with higher unmet need. In general, this resulted in more ambitious targets among adult men and adolescent girls and young women (Table 3.0.2). Programmatically, we expect to meet these higher targets among adult men by aggressively rolling out differentiated service delivery models such as multi-month scripting, introducing extended hours ART distribution through emergency rooms, community ART distribution through mobile brigades, and fully implementing other aspects of MISAU’s Male Engagement Strategy. Targets among adolescent girls and young women will be supported programmatically by high-fidelity implementation of the DREAMS program in 9 districts, and through national programs for adolescent girls and young women (AGYW), including support for adolescent health clinic (SAAJ) expansion and continuing to support existing SAAJs, consolidation of the mentor mother and peer educator programs,

support to gender-based violence (GBV) screening and post-GBV care, and expansion of differentiated service models applicable for adolescents, (i.e., family approach, adherence teen clubs, three months prescription, etc.).

Table 3.1: Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP19	# Current on ART (FY19 Q1)	# of SNU COP18 (FY19)	# of SNU COP19 (FY20)
Scale-up: Saturation	62,259 (3%)	357,217	16	4
Scale-up: Aggressive	1,966,885 (89%)	511,592	61	122
Sustained	-	159,796	60	0
Centrally Supported	164,678 (7%)	11,867	-	32
Attained	29,110 (1%)	-	3	0
New	-	-	14	0
Not Assigned	-	-	7	0

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

4.1 Finding the missing, getting them on treatment, and retaining them

All Populations

PEPFAR has worked closely with MISAU to develop and rapidly scale core strategies across the clinical cascade to accelerate progress towards achieving UNAIDS 95-95-95 goals in Mozambique. These strategies have further been refined to focus on identified demographic gaps in order to ensure no population segment is left behind.

During COP19, Mozambique will build on HIV testing “reboot” strategies implemented during COP18 (See Appendix E for more details). These shifts include the rapid introduction of national screening tools to improve the efficiency of provider-initiated counseling and testing (PICT), as well as the repurposing of existing lay counselors to strengthen linkage and early retention follow-up activities.

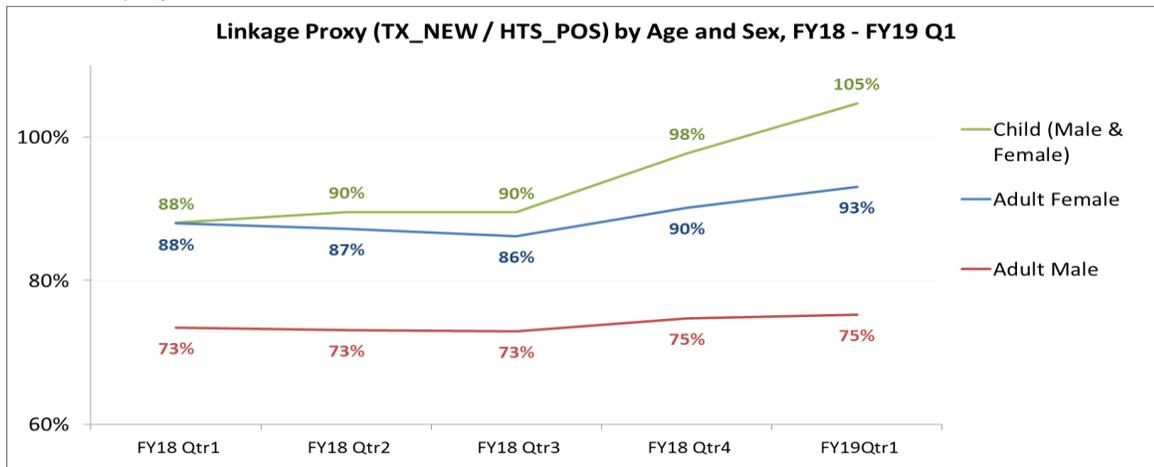
Testing targets for COP19 reflect an overall geographic shift towards supporting AJUDA sites and catchment areas where 90 percent of PLHIV reside, rather than reaching all sites within scale-up districts. This includes support for continuation of “focalized” PICT modalities using national screening tools and guidelines, as well as continuation of “passive” client-initiated counseling and testing (CICT/VCT) at all AJUDA sites. Facility-based index case contact testing will also continue to be expanded into all AJUDA sites, in partnership with MISAU, while community-based index

case contact testing will expand in 127 Phase I AJUDA site catchment areas, to contribute 45% of all case identification, after accounting for projected PMTCT, TB, and VMMC positive tests.

PEPFAR Mozambique will work closely with the National TB and HIV Programs to better leverage community-based TB and HIV index case contact investigations to include screening for active TB and HIV testing for household contacts to TB cases to improve TB and HIV active case finding during COP19.

As noted below in Figure 4.1, Mozambique has continued to improve its linkage rates, and will continue to strengthen linkages among men. Interventions such as traditional healer engagement and extended clinic hours may be of particular utility for men living with HIV.

Figure 4.1: Improvement in Linkage Proxy for Children, Women and Men, by Quarter, FY18-FY19 Q1



In addition to improving linkage rates, Mozambique continues to expand same-day HIV treatment enrollment. In April 2019, more than 90 percent of all new enrollees received same-day enrollment services. Beyond treatment initiation, ensuring patients are retained on and adherent to treatment is key to achieving epidemic control. With 1-month retention and 3-month retention at 86 percent as of April 2019, improving retention is the primary focus of the PEPFAR Mozambique portfolio. With MISAU leadership and additional collaboration with GFATM, PEPFAR continues to support the GRM’s six pillar strategy, which includes: (1) expansion and implementation of differentiated service delivery models; (2) strengthening national HIV quality improvement implementation efforts; (3) expanding and strengthening psycho-social services; (4) combating stigma and discrimination of PLHIV; (5) empowering communities to ensure sustainability; and (6) providing quality HIV testing services to facilitate linkage to care.

In COP19, a major focus will be on monitoring the fidelity of implementation of the interventions within the AJUDA logic model, which maps specific activities to each of the six pillars. An in-depth description of the AJUDA approach and the accompanying logic model can be found in Appendix E. The team will be working closely with MISAU to ensure that facility-based technical assistance

and mentorship leads to expected improvements in retention while simultaneously expanding collaboration with CNCS to ensure quality of community-based services and interventions.

Improved optimization of PEPFAR-supported health staff is essential, particularly given observations during AJUDA site visits of inefficient use of lay health care workers in facility settings. While administrative support, including chart organization, is critical to facility efficiency, lay workers will be an indispensable cadre to deliver the recently introduced community psycho-social support package. Patients identified as having an increased risk of adherence and retention challenges during the ART initiation process will receive preventive/supportive home visits in addition to the current facility-based counseling and loss-to-follow-up tracing activities. PEPFAR will work with GFATM and civil society to ensure that this service is provided as peer support by PLHIV whenever possible, and that lay staff time is prioritized for this activity in a proactive and culturally sensitive manner.

Dolutegravir (DTG) Transition Strategy

In addition to the activities described above, the transition from Efavirenz (EFV) to DTG-based regimens was planned to expand in COP18. As DTG is superior to EFV both in terms of side effect profile and time to VL suppression, this is an important intervention to improve both retention and viral suppression across populations. In 2019, Tenofovir-Lamivudine-Dolutegravir (TLD) expansion will occur in three phases as highlighted below.

Figure 4.2: Summary of Dolutegravir Transition Plan

Phase	Start Date	Criteria	Adult Men	PBW & Women of Reproductive Age	Post-Menopausal Women	Children >20kg
Phase 1	Mar/April 2019	NVP-based regimens	X	X	X	
		Other complex regimens	X	X	X	
		TB co-infected	X	X	X	
		PEP	X	X	X	X
		Pediatrics				X
Phase 2	Aug 2019	New ART initiates	X		X	
		Grade 3/4 adverse reactions	X	X	X	
		TLE-based regimens	X		X	
Phase 3	Nov 2019	TLE-based regimens		X		
		New ART initiates		X		

Case Identification for Key Populations

PEPFAR-support will continue community-based testing among KPs (female sex workers (FSW), MSM, and people who inject drugs (PWID)), as well as prison-based HIV testing in selected districts

with AJUDA sites.¹⁹ Implementing partners (IPs) will strengthen use of social media, peer referrals and index case testing, hotspot mapping, and KP-specific screening tools to identify eligible KP for HIV testing. IPs will follow national guidelines regarding frequency of KP testing, while also attempting to reach KPs who have never tested and those who do not test regularly. IPs will continue to expand “KP-friendly” services and peer-navigator approaches at “hotspot” health facilities to ensure improved follow-up support for effective linkage of KPLHIV into care and treatment.

Reaching Men

In COP18, MISAU launched a Male Engagement Strategy that highlighted specific interventions within the community, facility, and workplace²⁰. MISAU identified 60 priority districts based on low ART coverage, and has begun rolling out the strategy in three unique phases. The strategy includes core activities to improve the availability of male-friendly services, expand family-based care models, promote new social norms, and enhance communication and advocacy with male populations through male champions and community leaders. Mozambique expects to meet its adult male targets by aggressively rolling out differentiated service delivery models, such as multi-month scripting, introducing extended hours for ART distribution through emergency rooms, community ART distribution through mobile brigades, and fully implementing other aspects of MISAU’s Male Engagement Strategy. M&E tools are in development to measure impact in preparation for further expansion.

Prevention of Mother-to-Child Transmission

While Mozambique has achieved high testing (99 percent) as of Q1FY19 and ART coverage (98 percent) as of Q1FY19 for pregnant and lactating women (PLW), vertical transmission (VT) in Mozambique remains unacceptably high. In Q1FY19, vertical transmission under 12 months of age averaged 5.6 percent at PEPFAR supported sites. Mozambique’s Spectrum estimate for transmission at the national level is even more worrisome at 18 percent, reflecting both ongoing transmission and the need to further strengthen data on the quality of services delivered during ANC visits. Inadequate retention in care of PLW is a central driver of ongoing VT, contributing to a Q1FY19 viral suppression rate for PLW of 76 percent. Recent efforts to improve HIV program implementation in PMTCT via the AJUDA response have led to gains in short-term retention among PLW at priority sites. In September 2018, 1- and 3-month retention for pregnant women was 68 percent and 80 percent, respectively, and 54 percent and 68 percent, for breastfeeding

¹⁹ Geographic prioritization of KP activities for COP19 was based on a thorough review of available key population size estimation data, HIV testing and yield data, coordination with Global Fund and other non-PEPFAR planning, as well as contextual factors and input from civil society and the Ministry of Health.

²⁰ The male engagement strategy is available on the PEPFAR website as a supplemental document.

women. In April 2019, early retention improved to 86 percent and 90 percent, respectively for pregnant women, and 74 percent and 78 percent, for breastfeeding women (PEPFAR Data).

Poor retention in HIV care and treatment parallels late presentation for, and poor retention in, ANC. IMASIDA 2015 found that only 55 percent of pregnant women received four prenatal visits prior to delivery. The MISAU PMTCT program has prioritized activities to support early identification of pregnancy, which PEPFAR will support via its site level mentoring program in COP19.

Building on multi-pronged COP18 efforts, more than 24 months of PMTCT cohort monitoring, and lessons learned during site visits in the context of the AJUDA initiative, PEPFAR in COP19 will continue to support high fidelity site level implementation of PMTCT, including differentiated service delivery (DSD) models for eligible lactating women and “one-stop” care models for PLW and HIV exposed infants (HEI). PEPFAR will also continue to support the national implementation of the MISAU mentor mother strategy, ensuring that community and facility based mentor mothers are in place to provide high quality peer support to pregnant and lactating HIV positive women in all AJUDA sites in COP19. PEPFAR will support the national implementation of revised psychosocial support and positive prevention instruments tailored to support PLW. Newly diagnosed pregnant women will receive facility based preventive and pre-ART counseling, supportive home visits and phone calls, and defaulters will be identified on a weekly basis with community based follow-up. In COP19, PEPFAR will support limited implementation of MISAU’s national policy for mobile brigades, currently in development, in order to provide high quality primary care, ART access and PMTCT in remote communities in provinces with high VT. Support will be expanded depending on availability of additional funds for scale up.

Timely achievement of viral suppression during pregnancy and lactation are key priorities. VL result return to clinical charts and clinical use of results during pregnancy and lactation will be a renewed priority in COP19. If funds can be mobilized via a newly launched laboratory request for proposal (RFP) in COP19, PEPFAR will prioritize implementation of point-of-care (POC) VL for PLW. In order to eliminate maternal to child transmission of HIV, PEPFAR must strive for the ambitious goal of 100% viral suppression among PLW. Site-level efforts will focus on appropriate management of high VL to increase timely access to second line therapy for eligible PLW and intensive adherence in keeping with MISAU’s psychosocial support, positive prevention and VL guidelines to both prevent default and treatment failure and remediate it when it does happen.

As further detailed in the pediatric section, tailored services for adolescent pregnant women will be offered via expansion of one-stop shop SAAJ for first time pregnancies, as well as peer support models. PEPFAR will support MISAU in extending DTG treatment regimens to pregnant women aligned with the MISAU DTG scale-up plan, while supporting integration of HIV/family planning (FP) and increasing access to FP methods among HIV-positive women of reproductive age following appropriate informed consent. PEPFAR has also worked closely with the GRM to launch a

pharmacovigilance platform that will be in place before COP19 in order to monitor adverse events (AEs) and congenital abnormalities correlated with ART exposure.

Pediatric and Adolescent Populations

Pediatric ART coverage remains exceptionally low at 50 percent (MISAU 2018 Annual HIV/AIDS Activity Report) and pediatric case finding, linkage, and retention remain central priorities for MISAU and PEPFAR. PEPFAR remains committed to supporting the plan for accelerating HIV care for pediatric and adolescent populations. VL suppression among children and adolescents is catastrophic, at 45 percent in FY19Q1, reflecting an urgent need for improved ART regimens, better quality of care for children and adolescents and dedicated retention programming. Through revision of commodity orders and provider training, ongoing efforts to transition children off of ineffective nevirapine-based regimens onto effective regimens using lopinavir or dolutegravir will reach completion in COP19. Ensuring compliance with these regimens will require close mentorship guided by routine chart review. The transformation of PEPFAR's site level presence described in Appendix E will result in improved viral suppression for children and adolescents as well as adults when accompanied by pediatric-specific interventions such as adolescent health clinics, DREAMS (Section 4.2), and leveraging of the mentor mother, peace corps, and OVC platforms to improve pediatric treatment.

Testing and Linkage to Care

In COP19 PEPFAR IPs will continue to scale up revised pediatric PICT screening guidelines and implement PICT in high yield health sectors. PEPFAR will also support MISAU in ongoing expansion of ANC index case contact testing to increase targeted testing of children of HIV positive women with continued emphasis on linkage to care in all pediatric testing modalities.

Optimized ART and Quality Care

In COP19, PEPFAR will support MISAU in offering optimized pediatric ART regimens to all children and adolescents, including DTG as a first-line medication to children >20kg and lopinavir/ritonavir (LPV/r) pellets and granules to infants. PEPFAR will support the National Quality Improvement (QI) Strategy at the national, provincial and site levels and offer mentorship for clinicians serving pediatric and adolescent patients, with a focus on appropriate pediatric dosing, routine screening for TB and implementation of DSD models including family approach.

Adolescents

In COP19, PEPFAR will implement multi-sectoral programs to improve adolescent health and reduce HIV acquisition, and further improve and expand SAAJ in order to offer adolescent care and treatment in a teen-friendly, one-stop primary care setting. Comprehensive and age-appropriate services aimed at reaching adolescents, including pregnant adolescents, will be an important focus

in PEPFAR's work with AJUDA sites, in addition to expansion of peer driven support groups for adolescents, centered in retention and adherence.

Retention

In many clinics inadequate HRH leads to prolonged wait times, rushed poor quality care, and failure to complete prescribed activities, all of which contribute to poor retention. PEPFAR will increase HRH investments at site and community levels to improve retention for patients in treatment, including children and adolescents. Counselors and mentor mothers will provide intensive case management support for children under five years of age and their families; and peer educators and APEs will provide parallel services for children over five years of age, and adolescents. OVC providers will continue to target services to high-risk HIV-positive children and adolescents, prioritizing retention and adherence counseling. While also continuing to support pediatric defaulter tracing, the OVC program will increase collaboration with clinicians to provide wrap-around services to prevent LTFU for the highest-risk children and adolescents. PEPFAR clinical and community partners will fully implement revised psychosocial support tools, including tailored positive prevention and counseling services, support for diagnostic revelation, preventive home visits and defaulter tracing for pediatric and adolescent patients.

Viral Load Cascade

PEPFAR will support activities in the community and in health facilities to increase provider/patient demand for VL for children and adolescents. Training of providers through mentorship and on-the-job technical assistance offered via AJUDA and MISAU supervision will be essential in COP19 to ensure appropriate clinical utilization of VL, with rapid transition to second line therapy as needed. All too often in Mozambique viral load results never get into patient charts and provider's hands, leading to unacceptable levels of waste. Ensuring high viral loads are properly addressed is an integral part of the AJUDA response (Appendix E) requiring greater attention from both PEPFAR staff and implementing partners. To achieve the needed transformation in viral load utilization, all steps in the flow of viral load information will need to be remediated—from optimization of electronic systems to organization of patient records to implementation of SOPs for information flow to provider mentoring on use of viral load data. Additionally, identification of patients in need and linking them to quality, age-appropriate, enhanced adherence counseling are key components for COP19 to improve viral suppression rates among pediatric and adolescent patients in Mozambique

HRH Service Delivery Pivot

Early experience in the AJUDA response was instructive as to the importance of human resources, particularly at the site level, to quality care and treatment scale-up. In addition, patients' self-reported reasons for loss-to-follow-up, such as wait time and poor treatment by health providers, often pointed to deficiencies in number and quality of service delivery implemented by staff. A key shift during COP19 is a site level service delivery HRH pivot to address these gaps in service delivery

quality. Site-level staff needs were estimated using the staffing ratios and PEPFAR contribution assumptions. When known, adjustments were made for staff funded out of non-PEPFAR sources such as the government of Mozambique and the Global Fund. In total, PEPFAR will support 19,447 staff positions, 19,039 of which are based at the site level. This includes 280 clinicians, 126 pharmacy and laboratory technicians, 18,556 lay staff (including lay counselors, mentor mothers, and peer educators).

Simply providing additional staff is not sufficient to achieve ambitious PEPFAR targets. Close management is necessary to make sure that site-level staff have a well-defined and clear scope of work, the resources needed to do their jobs, and the oversight to ensure that they are performing as expected. In COP19, PEPFAR will fund site-level hospital managers for the first time in Mozambique. These 45 managers will sit in the largest sites in Mozambique (Tx_CURR \geq 5000). In order to ensure high-fidelity implementation, clinical partners are also expected to fund technical advisory teams at the district and provincial level. District teams will manage approximately 10 sites and be composed of two clinical advisors, a psychosocial support advisor, and a monitoring and evaluation advisor. In practice, these teams may operate at the sub-district level or cover multiple districts as required. It is expected that they would use their time strategically, focusing greater attention on sites with larger numbers of people on treatment or with greater needs, e.g. greater number of people lost to follow-up. Partners will also fund some advisors at the provincial level in the areas of pharmacy, lab, and health informatics.

An accountability framework with inclusion of consistent and routine performance evaluations of all HRH staff during this pivot will be a critical component of this surge approach. Partners will be required to conduct performance evaluations of all site level and community staff in order to ensure high quality performance is an output within this pivot. These performance evaluations will be implemented across all cadres including clinicians and lay cadre staff.

4.2 Prevention, specifically detailing programs for priority programming:

During COP19, Mozambique will refocus prevention activities for better epidemiologic alignment, including data-driven geographic prioritization and greater programmatic integration between OVC, DREAMS, and KP activities, and improved coordination with health facilities to support strong linkage and retention into care and treatment. VMMC service reductions at fixed sites in saturated districts will include: ceasing all dedicated demand creation efforts; transition of site leadership to MISAU; and maintenance of basic site capacity (overall 1 to 2 surgical beds).

AGYW Prevention

Prevalence of HIV in ANC among 15-24 years old in DREAMS districts ranked among the highest in Mozambique, ranging from 8 percent to 17 percent (APR FY18). Models of new HIV diagnoses among AGYW with ages 15-24 in DREAMS districts can assess changes over time. In Mozambique, the first round of modeling showed that new HIV diagnoses among AGYW declined by more than 25 percent in DREAMS districts since 2015.

In COP 19, DREAMS program allocation in the Planning Level Letter (PLL) is \$10,195,770 of which \$2,905,774 of the funding is allocated to Abstinence/Be Faithful Budget Code (HVAB) activities with a focus on HIV and violence prevention among 9-14 adolescent girls. DREAMS program implementation will be maintained at COP18 levels and with the same geographic reach in the following districts: Quelimane, Nicosadala, Beira, Chokwe, Xai-Xai, Chongoene, Limpopo, Matutuine, and Namaacha, located in four provinces (Gaza, Zambezia, Sofala, and Maputo Province). Because of the reboot exercise in COP18 implementation and geographic prioritization to AJUDA sites plan, DREAMS sites are aligned with the referred site prioritization.

In DREAMS sites, PEPFAR will continue to implement the core package of community-based and clinical services using the “one-stop-shop” youth and adolescent-friendly clinics model. Integrated services offered at these sites include: HIV counselling and testing, contraceptive method mix, post-violence care, prenatal care, as well as ART initiation, psychosocial support and drug distribution. Changes to the intervention package in COP19 include the addition of an HIV and violence prevention curriculum for all age groups.

PEPFAR will scale-up DREAMS activities focused on adolescent girls age 9-14, with age appropriate and evidence-based sexual violence and HIV prevention activities. PEPFAR will also increase the use of the *Girls Roster* methodology to systematically identify the most vulnerable AGYW, based on risk factors such as adolescent pregnancy, extreme poverty, early school drop-out, engagement in sexual risky behavior, and will improve linkages with the OVC program to expand the variety of services offered to adolescent girls aged 9-14. Among AGYW aged 15-24, PEPFAR will continue to implement a highly targeted set of approaches to reach the most vulnerable AGYW. This includes expanded support for survivors of gender-based and sexual violence, provision of contraceptive methods, AGYW-friendly HIV testing services (HTS) and sexually transmitted infection (STI) services, as well as active linkages to care for HIV positive AGYW.

In COP19 all IPs will use a standardized layering tool to ensure the completion of the full primary package of interventions, monitor the referral and counter-referral system, and report the AGYW_PREV indicator among DREAMS beneficiaries with greater fidelity.

GBV support services continue to be integrated across the HIV clinical cascade in all PEPFAR-supported health facilities in COP19. This includes:

1. Integration of post violence care into HTS, PMTCT, Pediatrics and ART services;
2. Improved early identification and linkages to care for post-GBV survivors;
3. Community engagement for improved identification and reporting of violence against children, sensitization of appropriate family communication, increased male engagement, reduced child marriage and other harmful gender norms; and
4. Technical assistance to MISAU to coordinate, monitor and evaluate the GBV response at all levels.

OVC Programming

The OVC program in Mozambique will complete a programmatic shift in COP19 to pivot towards prevention and retention-support activities focused on the highest-priority children and highest-risk adolescents, in the highest burdened areas. The OVC program will undergo a major geographic consolidation during COP19, focusing entirely on the catchment areas for priority AJUDA sites. PEPFAR will also transition OVC program implementation to local organizations through the procurement of new mechanisms, designed to reflect the latest PEPFAR guidance and global best practices in OVC programming.

In order to address the need for large-scale and effective adolescent prevention programming within high-incidence areas in Mozambique, while still offering comprehensive case management approaches to children and adolescents who are most in need of intensive support, PEPFAR has opted for a two-tiered OVC program design for COP19:

1. **Intensive Case Management:** Existing enrollment tools will be used to identify OVC under age 18 that are also HIV positive, survivors of sexual violence, children of FSWs or PWID, children of vulnerable HIV positive parents or caregivers, double orphans, or children living in child-headed households. These OVCs will be offered a comprehensive package of services that aims to ensure they are healthy, stable, educated and protected. The main entry points for selection and enrollment of OVC for this service package will be the SAAJ or HIV clinics (ART enrollment points) at priority (AJUDA) health facilities, mother-to-child-transmission (MTCT) sectors, community-based HIV testing platforms, GBV services, and other relevant referral points. Children, adolescents, and young people living with HIV (CLHIV & AYPLHIV) will receive additional support services, based on best practices from other PEPFAR countries, such as child and adolescent-friendly adherence clubs per MISAU DSD guidance, treatment literacy counseling, goal-setting, accompaniment of beneficiaries for drug pick-ups and viral load monitoring, and early childhood social and cognitive stimulation for CLHIV under age 5.
2. **Comprehensive Prevention Package:** In the 41 non-DREAMS districts, OVC enrollment tools will also identify children aged 9-14 who do not fall into the aforementioned categories, but who live within the catchment areas of priority (AJUDA) health facilities, meet other criteria for OVC enrollment, and who are eligible for sexual violence and HIV prevention activities. These at-risk adolescents will be systematically recruited and enrolled in educational sessions that use locally-tailored and evidence-based curriculums such as *Go Girls!*, *Sinovuyo* and *Coaching Boys into Men* to address vulnerability to HIV acquisition. Main entry points for these OVC would be community platforms, in coordination with community school councils, community child protection committees, and community health workers. This package will also include counseling and referrals for sexual and reproductive health (SRH) and other social services, disclosure counseling for CLHIV, AYPLHIV, and children of PLHIV, as well as accompanied referrals for post-GBV care. As needed, additional services will also be provided to these OVC,

in accordance with individual needs assessments, such as youth-led saving groups and educational subsidies.

Key Populations

PEPFAR's KP programming in COP19 will focus on improving the identification of HIV-positive KP, linkage to ART, and supporting adherence to treatment, with regular VL monitoring. PEPFAR will continue to reach FSWs, MSM, prisoners, and PWID with evidence-based and comprehensive prevention activities (KP_PREV), including informed demand generation for Pre-exposure prophylaxis (PrEP) where services are accessible and available for KP. Targets and programmatic plans for COP19 are designed to meet case identification and treatment goals for these populations. Index case contact testing, social media (*WhatsApp* groups and *Facebook* chatrooms), regular hotspot mapping, risk-based peer referrals, and use of KP lay counselors will collectively identify previously unreached and undiagnosed KP.

MISAU is actively engaged in leading the expansion of a "KP-friendly" service package in all eleven provinces of the country. PEPFAR will continue to support the implementation of this KP service package during COP19, including the training and mentorship of health providers and focal points in all relevant sectors. The KP service package includes KP-sensitive STI and HIV counseling and testing, as well as correct use of KP-specific data collection tools to track KP service provision via EPTS and HIV testing and linkage registers.

HIV-positive KP identified at the community-level will be linked to health services with the support of trained KP peer educators and/or lay counselors, who will offer accompanied referrals to "KP-friendly" public health facilities described above. At these sites, KP Peer Navigators will facilitate KP enrollment into ART, and will use a case-management approach to monitor and detect KP defaulters early, alerting Peer Educators of the need for KP-specific follow-up and/or community-based support to identify and overcome individual and contextual barriers to treatment adherence. Mozambique will also coordinate closely with the National HIV Program to make clinical services available for KP at the community level through mobile clinics. Community KP partners will work hand-in-hand with facility-based clinical partners to ensure that KP diagnosed in the community are appropriately initiated on ART.

Peer Navigators will work closely with MISAU's psycho-social support (APSS) focal points to ensure that all newly enrolled HIV positive KP receive effective treatment literacy support to understand the benefits of treatment adherence and viral suppression. Peer Navigators will help KP develop adherence plans, support goal-setting, and will provide practical advice on medication-taking cues, medication refills, clinical visits, viral load monitoring, side effect management, and organizational strategies relevant for the KP sub-population context.

Pre-Exposure Prophylaxis

During COP 19, PEPFAR will maintain the geographic reach and scale of PrEP services in the Provinces of Nampula, Manica and Zambezia. This will include offering PrEP for key populations and serodiscordant couples in Zambezia, as well as for young women age 18-24 in Manica and Nampula provinces. In selected health facilities, PrEP screening tools will be used to identify HIV negative HTS clients with elevated reported risk, and who meet other eligibility criteria. At these sites, PrEP-specific screening and counseling will be fully incorporated into HIV post-test counseling for multiple testing modalities, including community and facility-based index case contact testing, ANC, VCT, and community-based KP testing. Wherever couples are found to be serodiscordant, efforts will be made to ensure that the HIV-negative partner can make an informed decision about starting PrEP, including referrals to nearby PrEP initiation sites.

A one-stop model will be used for PrEP services to support retention; clients will be able to collect medication at either ANC or the HIV clinic without needing to visit the pharmacy²¹. APSS services, monthly follow-up phone calls, and regular adherence counseling using the PrEP toolkit will be part of the standard service package for all clients. Stable PrEP clients will be eligible for multi-month drug pickup after the third clinical appointment. Mozambique will also support the development of national guidelines for PrEP implementation, based on the results of the ongoing assessment.

Voluntary Male Medical Circumcision

In COP19, the VMMC program will continue to focus on reaching at least 80 percent coverage of 15-29 year old males, employing targeted demand creation activities to increase coverage, acceptability, and priority referral to services for this age band. An outreach strategy has been instrumental in accelerating progress in districts with slower growth and/or lower coverage; VMMC campaigns, surgical mobile units, and temporary sites will be expanded in COP19 in targeted areas.

Demand creation activities include non-coercive incentives and PEPFAR-supported transportation. A demonstration project is planned to evaluate VMMC acceptance rates with a compensation strategy in Gaza and Zambezia provinces for lost wages. The site optimization tool will be used to improve planning by allowing the reallocation of resources, including providers, surgical beds, and other items to sites that are in need of additional support and/or improved performance. In districts where modeling data suggest coverage of the target age group is at or above 80 percent, the program will consolidate a maintenance program for adolescents aged 10-14 years. The national HIV testing screening tools will be implemented with all VMMC clients during COP19, rather than universal testing of VMMC clients.

²¹ The operational model for PrEP, including sectors in which PrEP is offered, may be modified based on the results of the ongoing assessment, which will be completed by Q1 of COP19 and incorporated into national guidelines.

Emphasis will be placed on adverse event (AE) monitoring and reporting and strengthening of quality assurance and quality improvement activities with the leadership of MISAU. AE monitoring will ensure reporting consistency with MISAU and PEPFAR requirements, while simultaneously ensuring that clinical management of AEs remain under the purview of the MISAU.

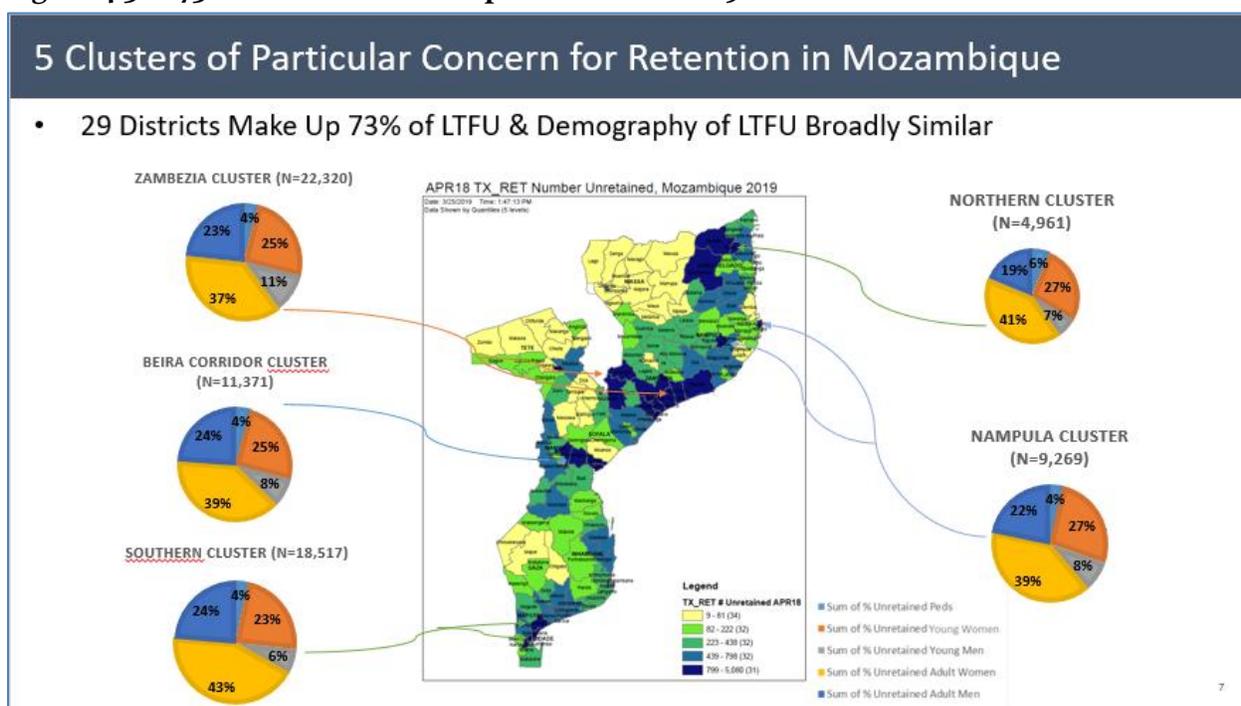
4.3 Additional country-specific priorities listed in the planning level letter

During COP17, PEPFAR introduced a system to monitor closely and manage partner performance toward target achievement, total expenditures, and quality of services. These efforts will continue during COP19 and will include in-house data reviews within and across program areas, as well as in-depth, multi-partner review meetings to share targets and best practices. Furthermore, continued support of the national guidelines and in particular, the National Quality Improvement Guidelines, will be prioritized in COP19. In addition to retention-specific site level data reviews and joint supervision work with MISAU teams through the AJUDA approach, SIMS 4.0 data will be triangulated with Monitoring, Evaluation, and Reporting (MER) and systems process indicators. These data will be reviewed with partners to identify sites that require facility level remediation plans in order to improve service delivery. Supplemental information to the standard SIMS questions will be collected and used to enhance program management capacity including utilizing a broad platform to enhance program implementation throughout the clinical cascade. In addition to AJUDA, Joint Supervision visits with MISAU teams, and SIMS visits, targeted direct technical assistance by USG staff aims to introduce as needed timely IP improvement plans developed jointly with district and/or provincial government authorities. Joint supervisory visits with partners, MISAU staff, and USG staff will be prioritized to assure high volume facilities are implementing activities as intended and reported data are of expected quality, while also ensuring improvement activities are scaled in vulnerable programmatic areas including retention and loss to follow up. During COP18 and COP19, joint supervision visits with CNCS teams will also be conducted using the SIMS 4.0 community tool and AJUDA Community Supervision tool to assess gaps in the quality of community activities and provide direct technical assistance to focus on improvement activities.

PEPFAR will continue to monitor key indicators at the site level on a monthly basis to facilitate early identification of performance issues so that rapid and intensive interventions from USG staff can be deployed. During COP18 and COP19, the Site-Action-List Tool (SALT) will be created to map MER indicators to monthly PEPFAR enhanced monitoring indicators, forming an early warning system for AJUDA sites that require more site level support. PEPFAR will continue to monitor all IPs' expenditures on a quarterly basis to ensure outlays are in line with approved spending levels and are congruent with target achievements. As needed, USG partner management staff will jointly develop Partner Performance Improvement Plans as remediation for partners whose target achievement, quality of services, implementation status, and/or expenditures do not meet expectations. Building off the National HIV Program's QI Strategy, the AJUDA approach will strengthen site level use of data to inform QI activities aimed at improving retention.

When designing programs at the provincial level, PEPFAR assured that emphasis was placed on provinces with high HIV burden. Particular emphasis will be placed on 29 districts in 5 specific geographies in Mozambique with the highest lost to follow up (LTFU; Figure 4.3.1). Phased implementation of important innovations were focused on these regions plans for additional support for high fidelity mentor mother programs, community ART distribution through using mobile brigades, male congregate setting testing, and PrEP. All involve some or all of these provinces, dependent upon funding levels, as detailed elsewhere in this document. These provinces are also prominently featured in partner management modifications.

Figure 4.3.1: 73% of loss to follow-up is clustered in 29 districts.



4.4 Commodities

PEPFAR Mozambique coordinates commodity investments closely with GFATM and regularly monitors commodity pipelines and funding to ensure appropriate stock levels in country to meet consumption demands. Commodity budgets are determined starting with current consumption levels and gradually working toward target achievement while taking retention into consideration. Supply plans are then updated quarterly to account for actual consumption levels and orders are adjusted accordingly to maintain 4-9 months of stock (based on consumption) and avoid over or under stocking. Discrepancies persist in TX_CURR and consumption data, but have improved from 19.8% in FY18Q2 to 6.5% FY19Q1, with variations by the province.

COP19 commodity investments align with priorities and are developed within the provided budget envelope. The anticipated COP19 investments in EID and viral load commodities are based on assumptions of price reductions from the global procurement ongoing during the COP

process, and will need to be re-examined once final prices are known. Pediatric ARV levels must be closely monitored for the remainder of calendar year 2019 to ensure sufficient stock with the phasing out NVP in favor of LVP/r. ARV levels in general will need to be closely monitored as the commodity requirements to achieve the COP19 targets exceed the funding available after the full GFATM commitment and Prioritized Above Allocation Request (PAAR), which is not confirmed at the writing of this document. It is also notable that the end of FY20 coincides with the end of a GFATM grant and early COP20 and/or GFATM transition funds will be needed to cover the period before the next GFATM grant. A shortfall in RTK funding is planned for COP19 given higher GRM targets than PEPFAR targets. Nutrition commodities will no longer be supported by PEPFAR and no other donor is offering this support.

4.5 Collaboration, Integration and Monitoring

During the COP18 implementation period, PEPFAR worked closely with external stakeholders to harmonize technical approaches and increase the impact of program implementation across the HIV clinical cascade. PEPFAR collaborated with GFATM on retention approaches in the community, prevention activities in DREAMS districts, health information systems expansion, optimization of KP programming, strategic planning for the national laboratory system, and supply chain strengthening. PEPFAR has collaborated closely with MISAU on technical approaches across the HIV clinical cascade, co-development of guidelines, draft plans for the DTG transition and Nevirapine phase-out plan.

CNCS engagement with PEPFAR has involved co-developing a scope of work on supporting their capacity to improve multi-sectoral coordination and monitoring of HIV response in Mozambique. This work has included co-development (along with PEPFAR, UNAIDS, WHO and civil society) of a set of community indicators for routine monitoring and a community supervision tool to assess the quality of community health services. PEPFAR is engaging with CNCS to take the lead in community systems strengthening to improve retention and adherence. Working closely with other external stakeholders, including UNAIDS, WHO, and civil society has been a priority during the COP19 planning. This engagement has focused on aligning efforts to build capacity for CNCS and provide an external evaluation of PEPFAR, MISAU, and other national level stakeholders, based on user experiences. Strengthening the community-level engagement of stakeholders is a key priority for COP19 to improve retention in HIV care and ensure DSD models, patient education and VL treatment literacy efforts are scaled appropriately. In COP19, PEPFAR will fund civil society's proposal for innovative community-oriented programming aimed to hold facilities and clinical partners more accountable for quality HIV services, while improving patient literacy and strengthening local platforms by those serving those specific communities to encourage treatment follow-up from within traditional networks.

Partner performance management continues to be a priority for PEPFAR and MISAU. Ensuring fidelity for core programmatic intervention packages in prevention, treatment, and retention is a key priority for both PEPFAR and MISAU. Regular data reviews within and across technical areas as well as in-depth, multi-partner review meetings to share targets and evolving best practices have

been conducted throughout the COP 18 implementation period. AJUDA and SIMS data have been used to identify site level remediation steps in order to avoid delays in service delivery. In addition to AJUDA and SIMS visits, targeted technical assistance by USG staff and additional joint supervisory visits with MISAU have created opportunities for gap analysis and development of improvement plans for timely response and in agreement with the partner, district, and/or provincial government authorities. Joint governance of provincial level engagement with MISAU stakeholders is a key focus in COP19 to ensure prioritization of key programmatic gaps in prevention, testing and retention.

System priorities continue to be identified, and activities are routinely monitored by cross-cutting working groups to ensure effective resource allocation. USG technical assistance will support the analysis of MISAU data for improved site-level information on the HIV cascade system, as well as HRH and physical infrastructure needs, including HRH modeling for existing and planned service delivery expansion. A standard HRH model for the service delivery pivot will be accompanied by a set of core indicators that will be the monitoring and evaluation framework with which to ensure accountability. This HRH site level pivot will be launched in close collaboration with GRM to ensure alignment and support of non-PEPFAR and PEPFAR supported sites to ensure stronger epidemic control. A consolidated and prioritized list of system investments will maximize program achievements within a fixed funding envelope.

Another point of enhanced coordination is better integration of logistics and transportation. In the near and medium term, continued support for supply chain, stock management, and transport of laboratory samples is required. In COP19, PEPFAR will improve the efficiency and yield on these investments by better harnessing accurate data on stock availability, including a shared e-platform on facility level stocks. Delivery routes optimization will allow for more frequent and dependable transportation of both commodities and laboratory samples.

In COP19, regular coordination on laboratory-related issues, with particular emphasis on VL monitoring, will continue across PEPFAR interagency teams. With completion of Test and Start roll out and increasing demand on the laboratory system for VL testing, PEPFAR will monitor, jointly with MISAU, for potential backlogs of VL samples and implement emergency backlog action plans to capacitate VL sample processing in country. Lab site readiness and commodity supply chain – including VL reagents, plasma implementation, and cold chain storage – will be priorities in COP19 to ensure a high quality, optimized laboratory network. Strategies to improve coordination and promote awareness on VL testing, sample transport, and results reporting will be implemented. At the health facility (HF) level, increased focus will be placed on VL results return in COP18 and COP19, ensuring patient VL results are placed in charts, understood by patients and utilized by clinicians for patient management.

Regarding health information systems and alignment of data, GFTAM focuses on health management information systems (HMIS), district health information system (DHIS), integration of systems in SIS-MA (a system which captures aggregate patient data to monitor performance at

the health facility, district, and provincial level) and the EPTS point of care system jointly developed by MISAU and Jembi. GFTAM will also work with PEPFAR and partners to ensure that implementation of the Community HMIS System and tools are aligned under MISAU and CNCS guidance. TB alignment issues at the community level and system related issues, i.e. the implementation of lab/specimen transportation and the results system under CCS, will be synchronized with PEPFAR/US partners' support.

Enhancing patient-friendly services, improving patient flow at the facility level, and optimizing provider workloads, are COP19 priorities. Scale up of DSD models is a core national priority and jointly with PEPFAR, with continued emphasis on expanding availability of multi-month scripting and six-month clinic visits for stable patients. Key strategies (including the family health approach to providing services and GAACs, both of which have been shown to improve retention) will be further scaled-up with more attention on fidelity to the six pillars for retention and adherence (see Appendix F). In COP19, there will be further expansion of community ARV distribution through integrated primary health care mobile brigades. Good stock management and continuous drug availability are central to expanding interventions that alter the current service delivery approach. Lay personnel charged with providing key services such as counseling, adherence support, and prioritization of LTFU will continue in COP19.

Coordination and performance management of partner implementation across the six key pillars for retention and adherence will occur in COP19. Investments in CNCS, clinical IP's and community partners in COP19 will increase community oversight of health facility performance via mobilization of village health committees, support for patient advocates and implementation of community scorecards. Monthly review jointly with MISAU teams on enhanced monitoring data at AJUDA sites will inform the trends in LTFU and VL suppression to jointly plan site level visits, supervision and direct technical assistance. In addition, through the increased prioritization of actualizing the weekly ART committee meetings at the site level, using MISAU-endorsed indicators across all three go's will be used to drive site level QI activities to drive programmatic improvements.

Entry Streams for ART Enrollment	Tested for HIV (APR FY20) HTS_TST	Newly Identified Positive (APR FY20) HTS_TST_POS	Newly Initiated on ART (APR FY 20) TX_NEW
Total Men (15+)	1,860,753	224,675	218,616
Total Women (15+)	3,533,397	358,205	339,473
Total Children (<15)	1,448,113	52,381	50,862
Total from Index Testing	1,029,566	230,014	-
Adults			
TB Patients	54,238	5,261	5,261
Pregnant Women	1,240,259	55,711	55,711
VMMC clients	191,383	3,368	3,368
Key populations	26,223	3,907	-

Priority Populations	-	-	-
Other Testing	3,882,047	514,633	493,749
Previously diagnosed and/or in care	-	-	-
Pediatrics (<15)			
HIV Exposed Infants	90,848	6,940	6,940
Other pediatric testing	1,357,265	45,441	43,922
Previously diagnosed and/or in care	-	-	-

Table 4.6.2: VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Boys 10-14 Years of Age					Men 15-29 Years of Age				VMMC_CIRC(in FY20)	
SNU	Population Size Estimate	Coverage End FY18	Expected Coverage End FY19	Expected Coverage End FY20	Population Size Estimate	Coverage End FY18	Expected Coverage End FY19	Expected Coverage End FY20	FY20 Expected VMMC_CIRC	Expected VMMC_CIRC age 15-29
MilitaryMoza mbique	DOD	DOD	DOD	DOD	DOD	DOD	DOD	DOD	37,124	17,174
Alto Molocue	25,154	57%	57%	81%	55,095	72%	79%	82%	15,739	10,459
Barue	12,828	70%	79%	80%	28,034	70%	94%	99%	1,937	1,741
Beira	45,267	112%	107%	85%	101,168	103%	119%	120%	20,701	7,945
Bilene	9,952	127%	129%	103%	24,329	81%	89%	99%	698	544
Boane	12,757	88%	96%	82%	33,400	101%	107%	106%	2,526	599
Buzi	14,146	79%	75%	80%	31,615	78%	89%	93%	6,050	2,666
Cahora Bassa	9,196	73%	85%	80%	20,467	63%	87%	94%	3,471	2,982
Caia	9,902	41%	50%	80%	22,131	33%	59%	81%	7,202	3,236
Changara	7,686	40%	49%	80%	17,106	46%	70%	80%	478	392
Chibabava	9,195	103%	99%	80%	20,550	117%	132%	130%	1,592	1,483
Chibuto	15,310	113%	103%	82%	37,429	60%	72%	88%	2,079	1,764
Chimoio	12,380	50%	57%	80%	27,055	51%	68%	80%	12,871	8,115
Chokwe	15,310	84%	71%	80%	37,429	62%	70%	82%	2,083	1,371
Derre	16,276	48%	47%	81%	35,650	53%	58%	82%	5,682	3,211
Dondo	13,863	98%	98%	80%	30,983	88%	99%	101%	1,873	1,753
Gile	16,276	67%	67%	81%	35,650	83%	94%	94%	25,012	13,896
Gondola	12,529	49%	54%	80%	27,382	69%	92%	93%	2,405	620
Gorongosa	9,478	46%	53%	80%	21,182	41%	67%	81%	5,283	2,586
Guija	5,869	153%	139%	110%	14,348	77%	90%	105%	1,295	1,067
Gurue	31,072	61%	59%	81%	68,059	73%	81%	82%	10,144	5,779
Ile	13,465	58%	72%	81%	29,491	65%	77%	82%	2,589	2,196
Inhassunge	9,618	68%	64%	81%	21,066	69%	79%	84%	4,249	1,424
Kamavota	3,427	83%	87%	81%	9,784	91%	97%	97%	413	0

Kamubukwana	6,942	61%	69%	81%	19,819	59%	62%	81%	1,186	860
Limpopo	9,821	82%	86%	80%	29,943	76%	82%	88%	402	283
Lugela	12,725	65%	63%	81%	27,871	58%	70%	82%	8,870	5,714
Machaze	9,546	29%	35%	80%	20,862	45%	62%	80%	5,300	4,245
Maganja DaCosta	16,276	54%	59%	81%	35,650	65%	71%	82%	6,955	4,419
Magude	6,147	120%	114%	94%	16,093	110%	124%	124%	3,438	968
Mandlakaze	11,610	121%	127%	101%	28,384	61%	74%	91%	1,513	1,002
Manica	20,882	51%	56%	80%	45,635	67%	80%	84%	7,577	4,093
Marromeu	10,468	90%	83%	80%	23,395	93%	105%	104%	827	707
Matola	95,100	54%	63%	81%	248,984	66%	71%	81%	14,573	2,906
Matutuine	4,523	64%	70%	81%	11,841	73%	89%	90%	1,546	262
Milange	22,194	42%	42%	81%	48,613	61%	65%	82%	18,028	8,422
Moamba	6,959	118%	161%	131%	18,218	86%	103%	109%	3,181	1,219
Moatize	21,960	27%	44%	80%	48,876	25%	43%	80%	18,345	12,256
Mocuba	28,113	72%	75%	81%	61,577	89%	92%	93%	15,777	11,592
Molumbo	1,060	42%	42%	81%	45,372	61%	65%	82%	8,423	5,921
Mopeia	10,949	58%	55%	81%	23,983	68%	76%	82%	3,808	2,492
Morrumbala	16,276	48%	47%	81%	35,650	53%	58%	82%	12,451	5,746
Mossurize	19,391	23%	25%	80%	42,377	29%	39%	80%	8,751	4,430
Mutarara	9,607	15%	24%	80%	21,384	23%	43%	80%	2,578	1,523
Namacurra	19,235	54%	64%	81%	42,131	60%	67%	82%	1,426	175
Nhamatanda	18,390	72%	69%	80%	41,100	66%	83%	89%	904	741
Nicoadala	23,674	83%	104%	86%	51,854	108%	133%	132%	15,443	7,891
Nlhamankulu	12,302	126%	142%	119%	35,123	155%	164%	163%	2,428	1,481
Pebane	17,756	104%	95%	82%	38,891	80%	91%	94%	18,461	10,753
Quelimane	19,235	96%	112%	92%	42,131	124%	137%	135%	21,252	10,631
Sussundenga	11,933	20%	36%	80%	26,077	25%	57%	80%	14,679	7,464
Tete	17,842	42%	54%	80%	39,712	40%	66%	80%	8,387	5,582
Xai-Xai	10,589	82%	86%	80%	25,888	76%	82%	88%	4,995	1,828
Total	822,461	n/a	n/a	n/a	1,946,837	n/a	n/a	n/a	405,000	218,609

Source: SOAR data for coverage, Population estimates from 2017 Preliminary Census with age ratios calculated using 2007 Census data

SNU	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY20)	FY20 Target
_Military Mozambique	N/A	N/A	23,247
Alto Molocue	108,414	0%	180
Angonia	154,510	0%	152

Barue	58,842	0%	152
Beira	169,627	3%	5,498
Bilene	47,840	0%	20
Boane	66,887	1%	792
Cahora Bassa	42,253	1%	300
Changara	40,817	0%	152
Chibuto	70,218	0%	320
Chimoio	118,467	1%	645
Chiuta	33,007	0%	152
Chokwe	76,339	5%	3,847
Chonguene	38,606	9%	3,357
Cuamba	84,070	1%	1,213
Erati	118,474	0%	152
Gondola	64,103	0%	152
Guija	29,846	4%	1,130
Guro	30,800	0%	152
Gurue	133,734	0%	512
Homoine	36,581	0%	20
Ile	59,989	0%	152
Inhambane	25,333	1%	152
Inharrime	39,276	0%	193
Inhassoro	17,873	1%	152
Jangamo	33,516	1%	300
Kamaxakeni	63,413	1%	318
Kampfumu	25,595	2%	559
Kamubukwana	102,139	0%	323
Lago	52,107	0%	152
Limpopo	48,316	26%	12,615
Maganja Da Costa	58,310	0%	152
Magoé	29,015	1%	152
Magude	20,238	1%	172
Malema	71,111	0%	20
Mandlakaze	44,673	0%	172
Manhiça	66,242	1%	452
Marracuene	73,253	0%	152
Massinga	72,588	0%	152
Matutuine	14,246	119%	16,988
Maxixe	39,360	1%	300

Mecanhelas	94,345	0%	172
Meconta	79,574	0%	172
Metarica	17,008	1%	172
Milange	196,779	0%	172
Moamba	26,653	1%	152
Moatize	109,164	0%	452
Mocuba	134,310	1%	1,280
Mocubela	35,226	0%	160
Mogovolas	131,999	0%	40
Monapo	131,454	0%	172
Morrumbala	120,808	0%	152
Morrumbene	43,968	0%	172
Mossurize	69,764	0%	173
Muecate	55,631	0%	172
Murrupula	68,384	0%	152
Nacaroa	46,279	0%	172
Namaacha	15,549	26%	4,101
Namacurra	76,937	0%	172
Nampula	236,134	0%	152
Nhamatanda	100,900	1%	879
Nicoadala	57,414	11%	6,190
Pemba	64,138	1%	811
Quelimane	111,165	19%	21,439
Rapale	55,514	0%	153
Ribaue	92,227	0%	172
Sussundenga	53,447	2%	1,283
Vanduzi	39,422	0%	172
Xai-Xai	45,480	20%	9,214
Zavala	49,624	0%	152
TOTAL	4,839,325	3%	124,600

Table 4.6.4: Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children (2018)	Target # of active OVC (FY20Target) OVC_SERV	Target number of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target) OVC*
Alto Molocue	196,519	7,515	6,542
Barue	114,567	3,999	3,479

Beira	261,152	17,801	15,487
Bilene	84,247	7,842	6,822
Boane	112,531	7,230	6,290
Buzi	105,388	5,758	5,010
Chibuto	123,985	10,423	9,068
Chimoio	207,614	3,669	3,192
Chiure	174,441	7,408	6,445
Chokwe	137,271	11,403	9,921
Chonguene	38,606	5,169	4,498
Dondo	100,409	4,978	4,331
Gondola	120,887	3,330	2,897
Gurue	238,607	7,606	6,617
Ile	59,989	4,111	3,577
Inhassunge	50,185	3,625	3,154
Kamavota	152,673	9,043	7,867
Kamaxakeni	85,330	10,423	9,070
Kamubukwana	143,983	13,477	11,732
Limpopo	89,688	9,228	8,026
Machaze	78,098	2,765	2,405
Maganja Da Costa	103,891	6,344	5,519
Mandlakaze	83,337	6,820	5,931
Manica	134,826	6,869	5,976
Marracuene	124,843	3,223	2,806
Massinga	130,178	10,399	9,048
Matola	754,693	55,908	48,639
Maxixe	61,073	5,456	4,747
Milange	350,627	4,756	4,138
Moatize	205,649	10,892	9,476
Mocuba	238,082	8,347	7,262
Molumbo	188,076	4,263	3,709
Moma	166,379	10,564	9,190
Monapo	230,557	7,734	6,728
Montepuez	137,513	6,523	5,675
Morrumbala	215,497	4,160	3,620
Mossurize	127,891	5,280	4,594
Namacurra	135,664	7,208	6,271
Nampula	236,134	9,897	8,095
Nhamatanda	187,258	6,144	5,345

Nicoadala	102,476	8,152	7,092
Nlhamankulu	52,866	23,634	20,562
Pebane	110,298	6,001	5,221
Pemba	104,818	5,769	5,019
Quelimane	198,317	7,336	6,383
Sussundenga	103,028	3,485	3,035
Tete	161,603	9,808	8,533
Vilankulo	105,725	7,637	6,644
Xai-Xai	74,863	7,615	6,616
Zavala	96,849	5,962	5,186
TOTAL	7,599,182	422,989	367,490
* Target number of active beneficiaries whose HIV status is known does not include known status among graduated beneficiaries			

4.7 Cervical Cancer Program Plans

Cervical cancer in Mozambique continues to be one of the most common causes of cancer-related death among HIV-positive women. Among all cancer in women, 31 percent of cases are cervical cancer. The availability of cancer-related data in Mozambique has improved in recent years, but does still not allow for many specific analyses and a solid M&E platform for cervical cancer screening and treatment needs to be developed in partnership with MISAU leadership. PEPFAR Mozambique will scale up efforts in COP19 to ensure efficient implementation of cervical cancer screening and treatment services (called CECAP in Mozambique), in alignment with PEPFAR guidance.

Cervical cancer services in Mozambique are offered through a “single visit approach,” adopted by MISAU to ensure women are appropriately screened and offered treatment or other options in the same visit. These services are integrated into Family Planning and Reproductive Health Services sector within a health facility.

In FY18, 443 PEPFAR-supported sites reported CXCA_SCRN and CXCA_TX indicators. Implementing partners reported a total of 10,596 women screening in FY18. This equates to 3.5 percent of HIV positive women on treatment (TX_CURR) age 25-49 at these 443 sites, and 2.3 percent of all HIV positive women on treatment (TX_CURR) age 25-49 in all PEPFAR-supported sites in Mozambique. While this reporting likely under-estimates actual coverage of cervical cancer screening and prevention activities because of changes in monitoring tools, there is clearly an urgent need to accelerate access to quality cervical cancer screening and prevention services in Mozambique.

In order to reach the COP19 target of 228,837 for screening HIV positive women for cervical cancer, Mozambique will rapidly strengthen and expand the provision of pre-cancer screening, visual

inspection with acetic acid (VIA), cryotherapy, loop electrosurgical excision procedure (LEEP), and referral criteria for HIV positive women through an integrated approach to HIV services. In COP19, PEPFAR Mozambique is investing more than \$5 million in cervical cancer prevention activities in all supported provinces.

Current practice per MISAU guidelines in Mozambique is for all HIV positive women to be screened for cervical cancer “independent of age.” Early initiation of cervical cancer screening may be justified in Mozambique by the early age of sexual debut. According to the 2015 IMASIDA, 25 percent of women had their first sexual contact before the age of 15. The risk of younger women for human papillomavirus (HPV) is demonstrated by the cervical cancer screening data. The risk of positive screen is 7.1 percent among women aged 20-24, nearly the same as that among women aged 25-29 and aged 30-34 (7.8 percent and 7.3 percent, respectively). Of all women screened for cervical cancer in PEPFAR-supported programs, 3.8 percent were aged 15-19. Even among these young women, 4.6 percent were positive.

PEPFAR Mozambique, IPs and the GRM must ensure that women who screen positive for advanced pre-cancerous lesions and invasive cervical cancer are offered prompt referrals for prevention and treatment. As such, in COP19, PEPFAR Mozambique will work closely with the GRM to disseminate and implement the National Plan to Control Cancer, 2019-2029. PEPFAR will support nationwide trainings to ensure providers are adequately prepared to screen and treat HIV positive women in Mozambique. Training of trainers at regional and provincial levels, with on-going supervision and technical assistance will be offered at both the provincial and health facility levels for the SRH/MCH and HIV care providers. Specialist and non-specialists will be trained in LEEP to maximize coverage of services and equipment optimization. PEPFAR will also continue supporting the MoH program through facilitating coordination, strengthening the monitoring and evaluation framework including tools to track registration and referral/counter referrals of patients requiring LEEP.

PEPFAR IPs are tasked in every province to ensure that at PEPFAR supported sites, human resources, physical infrastructure, clinical mentoring and supervision is in place to ensure complete CECAP programming for women living with HIV. PEPFAR will ensure that policies and guidelines are updated and aligned with WHO recommendations.

Investments in COP19 will also support purchase of cryotherapy and LEEP equipment including consumables where appropriate, in coordination with provincial governments and as defined in the Consolidation and Expansion Plan of the National Program for Prevention of Cervical and Breast Cancer, 2016-2021 and the National Plan.

4.8 Viral Load and Early Infant Diagnosis Optimization

COP19 will fully support VL and EID testing on conventional platforms in the existing national reference laboratory network. PEPFAR will also assume reagent, sample collection kit, and maintenance support for Mozambique’s 131 m-PIMA POC machines for EID testing in order to

expedite results return, facilitate early access to care for HIV positive infants, and improve retention.

The increase in demand for VL tests in FY19 to 1,0124,642 from 480,712 prompted the rapid expansion of laboratories, personnel, and instruments, which includes the strategically placed 131 m-PIMA POC instruments for EID. By the end of FY19 PEPFAR will have concluded the renovation or construction of five laboratories in Maputo City, Manica, Tete, Sofala, and Maputo Provinces. The addition of three laboratories will bring the conventional network to 16 laboratories and 29 instruments, including one high throughput, new generation instrument by the end of FY19. Laboratory investments have ensured that the HIV program has sufficient laboratory capacity to absorb aggressive scale up in VL coverage in COP19.

PEPFAR will support optimization of the national laboratory network in COP19 with a balanced distribution of new generation (higher throughput than conventional instruments), conventional, POC, and near POC instruments. While discussions continue to assess opportunities to multiplex current GeneXpert machines serving the national TB program, the new Global RFP for VL and EID reagents that will be available in COP19 could provide an opportunity to acquire new POC and near POC instruments through reagent rental agreement contracts to complement the current network. Such acquisitions could facilitate replacement of aging instruments with new generation, higher throughput equipment and acquisition of new POC or near-POC instruments for EID testing, and use of near-POC instruments for VL testing among PLW. A well-balanced distribution of high and low throughput instruments requires proper utilization at a capacity around 75 percent of manufacturers' throughput claims for 8 to 10 hour work shifts, in order to ensure sustained testing and eventual surges. As coverage of VL and EID testing improves and demand for tests increase over time, PEPFAR will coordinate with GRM the estimation of additional capacity needs to supplement the current network over the next few years. Network optimization relies heavily on Laboratory Information Systems (LIS) and geographic information systems (GIS) data, from which near real-time information is available for making decisions about optimal placement of instruments, based on program needs and cost-savings analysis. Network optimization also relies on LIS and GIS-generated data to manage sample referral, evaluate the performance of laboratories, forecast commodities, obtain backlog information, and perform general M&E of the VL and EID cascade. Moreover, the LIS implemented in Mozambique (DISA-Lab and DISA-Link) has drastically reduced average turn-around time (TAT) of results in FY19 and improved workflow in testing laboratories, as well as in health clinics. This LIS also provides tools for tracking samples and results and generates disaggregated data that is used for patient monitoring and to improve program performance. In COP19, PEPFAR plans to continue expansion of DISA-Link to district capitals and high volume health facilities. Our plans for optimizing the laboratory network for VL and EID testing also include creating efficiencies on the sample transport system to reduce costs and TAT, as well as ensure sample quality. As detailed in section 4.5, the PEPFAR program will prioritize VL result return and clinical utilization in COP19. In COP19, PEPFAR will continue to expand linkage between EPTS and DISA-link to improve assessment of VL coverage.

While LIS has provided important tools for managing the VL and EID program more efficiently, there are significant challenges affecting the program, such as inadequate laboratory and health facility infrastructure and power supply, limited human resources, lack of a consolidated sample referral system, and heavy dependence on external donors. PEPFAR and GRM will continue to collaborate to overcome those significant barriers for improving the laboratory network and facilitate ownership and sustainability of the VL and EID program.

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

*Calculations for targets for clinical services should be based on maintaining 80 percent ART coverage levels in the Attained districts. $[\text{Current Retention} + (\text{Passive HTS_POS} * \text{Linkage})] / \text{PLHIV} = 80 \text{ percent ART Coverage}$.

Attained Support Volume by Group		Expected result APR 19	Expected result APR 20
HIV testing (all populations)	<i>HTS_TST</i>	104,010	352,376
HIV positives (all populations)	<i>HTS_TST_POS</i>	3,615	39,920
Treatment new	<i>TX_NEW</i>	3,410	41,178
Current on ART	<i>TX_CURR</i>	6,756	107,835
OVC	<i>OVC_SERV</i>	23,731	23,771
Key populations	<i>KP_PREV</i>	4,256	1,816

Sustained Support Volume by Group		Expected result APR 19	Expected result APR 20
HIV testing in PMTCT sites	<i>PMTCT_STAT</i>	394,218	-
HTS (only sustained ART sites in FY18)	<i>HTS_TST/HTS_TST_POS</i>	1,249,792	-
Current on ART	<i>TX_CURR</i>	139,435	-
OVC	<i>OVC_SERV</i>	4,463	-

5.3 Establishing service packages to meet targets in attained and sustained districts

In COP19 PEPFAR Mozambique and GRM have collaborated to define the core service delivery package for HIV care and treatment services at AJUDA and central support sites (Table 5.3.2) as well as the core service delivery elements for programs not guided by HIV treatment targets (Tables 5.3.1).

Table 5.3.1: Service packages for programs whose geography is not driven by HIV treatment targets (PEPFAR supported activities not related to AJUDA facility based sites)*

Technical Area	Geography	Service Package
VMMC	<ul style="list-style-type: none"> • Program conducted in the following 7 provinces: Maputo City, Maputo Province, Gaza, Sofala, Manica, Tete, Zambezia • Distribution of targets determined by VMMC coverage estimates 	<ul style="list-style-type: none"> • High-quality VMMC for males aged 10 and older including follow-up care and AE management • Demand creation, mobile clinics as well as fixed sites • Transition to 10-14 year olds in the approximately 15 districts approaching saturation in 15-29 year olds • QA/QI • Strengthened systems for AE reporting
Key Populations	<ul style="list-style-type: none"> • Program conducted in 9 provinces; subset of priority site catchment areas in 31 districts; based on KP size and coverage estimates (e.g. Global Fund presence), as well as historic KP testing yield • Distribution of targets determined by KP prevalence and coverage estimates. • Target Populations: FSW, MSM, prison populations; and PWID 	<ul style="list-style-type: none"> • The KP prevention package includes multi-session educational and behavior change interventions, access to condoms and lubricants, provision of community-based HIV testing, linkage to health facilities, referrals for STI screening and treatment, follow-up support and adherence counseling, and referrals to other services (legal, social, health, etc.) • Identification of HIV+ KP through screening tools, linkages to care and treatment, and support to remain adherent to treatment, with regular VL monitoring • Activities in prisons will focus on HIV and TB screening upon entry as well as supporting the continuum of education and treatment services during incarceration, per HTC guidelines, and referral into care and treatment after release • PEPFAR Mozambique will also coordinate closely with the National HIV Program to make clinical services available for KP at the community level through mobile clinics • KP community partner will engage in sensitization and PrEP literacy in adherence counseling in provinces where PrEP is being provided to KP • Activities to better reach KP such as online platforms and use of peer educators • KP cascade monitoring will be a special focus, through monitoring of the newly approved HTS and treatment tools, and effective integration of KP indicators into

		<p>EPTS as well into health facility monitoring of PLHIV</p> <ul style="list-style-type: none"> • Supervision of KP program through joint MISAU/PEPFAR/IP site visits to ensure implementation. • Support, through clinical partners, implementation of the KP guidelines at the facility level, through trainings (in-service training, mentoring, clinical mentoring, technical support and supervision), and provision of support material (KP guidelines, screening algorithms and guides)
<p>DREAMS</p>	<ul style="list-style-type: none"> • Currently conducted in 4 provinces and 9 districts <ul style="list-style-type: none"> ○ Maputo Province <ul style="list-style-type: none"> ✓ Namaacha ✓ Matutuine ○ Gaza <ul style="list-style-type: none"> ✓ Chokwe ✓ Xai-Xai ✓ Chonguene ✓ Limpopo ○ Sofala <ul style="list-style-type: none"> ✓ Beira ○ Zambezia <ul style="list-style-type: none"> ✓ Quelimane ✓ Nicosadala 	<ul style="list-style-type: none"> • DREAMS programming in nine districts with Adolescent Girls and Young Women (AGYW) • Continue implementation of the core package of community-based and clinical services. Clinical services are provided in Youth and Adolescent Friendly clinics as one stop shop model. Services included are access to HIV counselling and testing, screening and treatment of STIs, provision of contraceptive method mix and post-violence care, ANC consultation as well as ART initiation and care at the same site (one stop model which includes drug distribution in the youth clinic) • Scale up the focus on adolescent girls 9-14 year olds by implementing age appropriate and evidence based HIV and Violence prevention interventions and leveraging OVC program to expand the variety of services offered • Maintain the package of services for most vulnerable 15-24 year olds, with a more holistic focus and a highly targeted approach within this age band • Use of the layering tool to ensure the completion of the full primary package of interventions, monitor the referral and counter-referral system and report of AGYW_PREV indicator with high fidelity of implementation of layering among DREAMS beneficiaries • Strengthen government policies and strategies to ensure comprehensive HIV and violence prevention in schools • Strengthen integration of GBV prevention in HIV cascade at key points (HIV testing,

		<p>HIV care and treatment, PMTCT/MCH services, etc.)</p> <ul style="list-style-type: none"> Ongoing implementation of PrEP for Young Women above 18 years old (serodiscordant couple with a HIV+ partner only) in the following DREAMS districts, Quelimane and Nicosadala.
OVC	<ul style="list-style-type: none"> Program conducted in 10 provinces; subset of priority site catchment areas in 50 districts; based on geographic pivot and CLHIV estimates 	<ul style="list-style-type: none"> Full package of home-based interventions and referrals offered to OVC, based on household vulnerability assessment, with increased focus on providing services, including counseling and testing, to CLHIV with family or socio-economic situations that cause barriers to retention and adherence on ART and threaten their health outcomes. Strengthen case management sensitivities for CLHIV and families affected by HIV including direct nutritional support and economic strengthening services Provision of primary sexual violence and HIV prevention services, which include counseling and referrals for SRH, disclosure counseling, referral to post GBV care, using Go Girls and Sinovuyo, whenever needed, additional services for AGYW will be provided such as youth led saving groups, referral to social action direct services and school enrollment and education subsidies
PrEP	<ul style="list-style-type: none"> PrEP with serodiscordant couples in Zambezia and KPs throughout Zambezia PrEP will be offered to at-risk young women aged 18-24 years old in Nampula and Manica provinces 	<ul style="list-style-type: none"> PrEP eligibility screening and counseling will be incorporated into HIV post-test counseling of people who demonstrate elevated risk, including at-risk young women aged 18-24 in Nampula and Manica provinces Integration of PrEP counseling into testing where couples are found to be serodiscordant including index case testing, VCT, and ANC, will ensure that the HIV-negative partner has the information necessary to make a decision about starting PrEP, including a referral to a site where PrEP can be initiated Training and mentoring of health facility staff to provide and monitor PrEP, perform adherence counseling, and manage AE

*This table serves as an overview. Definition of service package elements does not imply that these elements will be implemented uniformly or simultaneously throughout all sites, e.g. scale-up of

community ART distribution does not imply that it will be scaled up nationally, but rather precise timing and degree of implementation will be coordinated with MISAU.

Technical Area	PEPFAR Supported Sites (90% TX_CURR, 628 Sites)	Central Support (10% TX_CURR, 719 Sites)
Quality Improvement	<ul style="list-style-type: none"> • Joint USG/MISAU/DPS & DDS data driven performance management • IP-supported management and leadership at facility, provincial and district levels through direct supervision, intensive technical assistance and focused in-service trainings, scale pending budget availability • IP support for focused quality improvement activities (frequent visits from support/management team): <ul style="list-style-type: none"> ○ Normalize weekly ART Committee implementation and support use of data at site level to drive decision making ○ Enhanced monitoring via monthly reporting to MISAU/USG/IP ○ Support implementation of clinical, APSS and ATS mentorship program ○ Collaborative weekly change management model (PEPFAR/MISAU) ○ Support high fidelity implementation of the six pillars ○ Support facility level QI action plan ○ Establish quarterly provincial QI collaboratives for knowledge exchange, with provincial review of monthly/weekly performance and change management at AJUDA sites ○ Identify QI facility, provincial and district champions to support knowledge management and QI collaborative leadership ○ Inclusion of persons living with HIV in HF co-management committee meeting/ART committee 	<ul style="list-style-type: none"> • Share QA/QI tools for DPS to replicate trainings at central support sites • Central site participation in quarterly QI collaborative can be funded via MISAU's Cooperative Agreement or DPS coag funds, if prioritized by MISAU
HIV Testing	<ul style="list-style-type: none"> • Intensive mentoring for high fidelity facility-based and community-based index case testing and follow-up 	<ul style="list-style-type: none"> • Supervision and training for clinical staff at central support sites will not be included in PEPFAR IP budgets but may

	<ul style="list-style-type: none"> • Intensive mentoring on newly introduced national screening tools to prioritize symptomatic and high-risk individuals • Support for implementation of DSD for children, adolescents and adults • Intensive QI for pre- and post-test counseling, as per national guidelines • Targeted community-based testing and intensive linkage support among key populations, as well as clinical partner engagement in monitoring and providing technical support to HF regarding KP identification • Establish quarterly performance evaluations of all testing counselors • Assessment of direct service delivery of testing services • Ensure rational allocation and training of counselors to provide additional support to early retention activities 	<p>be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR</p> <ul style="list-style-type: none"> • Site-level HRH at central support sites will be determined by MISAU's COP19 funding
Linkage	<ul style="list-style-type: none"> • Site-level clinical mentorship on correct and consistent use of new HTC registers. (which includes linkage) • Support development and use of national SOPs for follow-up of non-linked PLHIV • Quarterly site-level linkage assessment with gap analysis and action planning; 	<ul style="list-style-type: none"> • Supervision and training for clinical staff at central support sites will not be included in PEPFAR IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR • Site-level HRH at central support sites will be determined by MISAU's COP19 funding
Retention	<p>Support for MISAU 6 pillars of retention:</p> <ul style="list-style-type: none"> • Differential Service Delivery (DSD) <ul style="list-style-type: none"> ○ Clinical mentorship and support for DSD implementation and scale up including multi-month drug dispensing, spaced consults (fluxo rapido), family approach, GAAC, adherence clubs, and one-stop models ○ Adoption and scale up of 6MDD within COP19 ○ Extended service hours, e.g. in emergency rooms, scale-up to be coordinated with MISAU ○ Scale up of IDART and IDART interoperability with EPTS to AJUDA sites to support multi-month drug dispensing 	<ul style="list-style-type: none"> • Roll out CNCS community/ psychosocial support package via G2G funding • MISAU will prioritize contracting psychologists to support APSS implementation at central support sites through MISAU's COP19 funding

	<ul style="list-style-type: none"> ○ Scale up of mobile brigades with community ARV distribution in 33 districts within 8 provinces ● Psychosocial support <ul style="list-style-type: none"> ○ Direct mentorship to strengthen the quality of psychosocial support including counseling, preventive calls, and home visits as well as dissemination of new APSS instruments ○ Programming for defaulter prevention and reintegration ○ Implementation and scale up of mentoring on psychosocial support package ○ Management mentorship for facility-level APSS supervisors ○ Implementation of APSS service package ○ Scale up SMS text reminders ○ HR footprint to support full APSS implementation ● Quality Improvement (see dedicated QI section) ● Stigma & Discrimination <ul style="list-style-type: none"> ○ Provide in-service training on human rights in the setting of HIV and KP via DPS coags and IP funding ○ Strengthen provincial PLHIV networks and civil society platforms through funds to CNCS ○ Reduce stigma among health providers through mentorship to ensure more comprehensive access to HIV quality services for all subpopulations ○ Strengthen local traditional leadership platform to support community dialogues on stigma and discrimination through funds to CNCS ● Community <ul style="list-style-type: none"> ○ Accountability platform for facility/community coordination via funds to CNCS <ul style="list-style-type: none"> ✓ Strengthen quality of community health committee ✓ Community-led monitoring of health facility performance ✓ Strengthen quality of HF co-management committee to 	
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	<p>ensure participation and engagement of community members</p> <ul style="list-style-type: none"> ✓ Direct mentorship of community actors to strengthen quality of counseling provided in the community ○ Support five core community activities: <ul style="list-style-type: none"> 1. High quality community health committee 2. High quality co- management committee 3. VSLs 4. High quality community radio messaging on normalizing positives 5. Support community based coordination with traditional healers ○ Joint supervision of community activities with MISAU, CNCS, USG teams ○ Direct support of nutrition assessment, counseling, and support (NACS) package ○ HIV Testing and Linkage (See dedicated sections) 	
<p>Additional Considerations for Adult Care and Treatment</p>	<ul style="list-style-type: none"> • Direct service delivery of clinical services AJUDA sites • Support routine screening and improved management of sexually transmitted infections, opportunistic infections (OI), malnutrition, and gender based violence (GBV) • Implementation of optimized ART regimens including DTG along with training and monitoring of fidelity (appropriate dosage and regimens) • Support implementation of male engagement strategy at targeted districts and sites based on MOH guidelines • Fully implement VL monitoring (including early identification of suspected treatment failure & prompt transition to second line when needed) • Provision of facility-based staff to ensure availability and flow of laboratory specimens and lab-results and improve use of laboratory results by clinical staff 	<ul style="list-style-type: none"> • Supervision and training for clinical staff at central support sites will not be included in PEPFAR IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR • Site-level HRH at central support sites will be determined by MISAU's COP19 funding • Last Mile Drug Delivery • IP support for VL/EID sample transport

<p>Additional Considerations for Pediatric Care and Treatment</p>	<ul style="list-style-type: none"> • Same as Adult Treatment (see above), plus site and community support by mentor mothers for HIV+ children <age 5, peer educators or activistas trained to support high risk HIV+ children >age 5 • Support for implementation of MISAU DSD models for children and adolescents • Support for implementation of optimized pediatric ART regimens, including DTG and LPV/r pellets and granules • Support for SAAJ, teen clubs and peer-facilitated support groups for adolescents • Support centers of excellence to strengthen clinicians' capacity to provide optimal pediatric HIV care and treatment services • Strengthen referral system between clinicians, mentor mothers, OVC teams, and CHW's to ensure individualized, patient-centered care 	<ul style="list-style-type: none"> • Last Mile Drug Delivery. • Supervision and training for clinical staff at central support sites will not be included in PEPFAR IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR • Site-level HRH at central support sites will be determined by MISAU's COP19 funding
<p>Additional Considerations for PMTCT/EID**</p>	<ul style="list-style-type: none"> • Facility and community based mentor mothers focused on peer support to promote retention and adherence of PLW, HEI and HII • Support for EID POC and conventional PCR testing in alignment with national MOH strategy • Ensure high fidelity implementation of VL testing, enhanced adherence support and second line switch for PLW • Expansion of mobile brigades to improve access to care for PLW in remote communities • Continued support for one stop model for PMTCT within ANC/CCR services • Continued support for Option B+ implementation 	<ul style="list-style-type: none"> • IP support for EID sample transport • Supervision and training for clinical staff at central support sites will not be included in PEPFAR IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR • Site-level HRH at central support sites will be determined by MISAU's COP19 funding
<p>Cervical Cancer</p>	<p>Cervical Cancer Screening and Prevention Activities</p> <ul style="list-style-type: none"> • Implementation of revised MISAU monitoring and evaluation CECAP tools • Training of MCH nurses and other clinical personnel in visual inspection with acetic acid (VIA), cryotherapy, LEEP and criteria for referral for surgical management • Strengthen referral and counter-referral system for treatment of preclinical and clinical lesions and follow-up after treatment • In alignment with DPS/MISAU national cervical CA scale up plan, support procurement of CECAP equipment • Support TA for cervical CA program implementation including supervision visits and capacity building at provincial, district and facility level 	<ul style="list-style-type: none"> • Supervision and training for clinical staff at central support sites will not be included in PEPFAR IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR • Site-level HRH at central support sites will be determined by MISAU's COP19 funding

	<ul style="list-style-type: none"> • Conduct awareness-raising activities with community health workers to increase the uptake of screening and treatment for cervical pre-cancer (demand creation) • Ensure minor renovations as necessary to ensure adequate private space in reproductive health clinic for pelvic examinations/VIA/cryo at identified sites • Support for CECAP nurses at large volume AJUDA sites with low CECAP target achievement 	
GBV	<ul style="list-style-type: none"> • Identify and train healthcare workers responsible for GBV services within every PEPFAR supported health unit, who can be points of contact for referrals within the HU or within the district • Together with HU staff, define location for post-GBV care services and ensure appropriate signage • Ensure that HU staff in ART/HTC/ANC/Auxiliary staff are sensitized to availability of GBV services and referral process to post-GBV care at HU • Establish post-GBV care services in all scale up ART sites and allocate the recommended post-rape kits; ensure GBV algorithms visible • Provide post-GBV care services as part of KP prevention package in all facilities that offer services for KPs • Reinforce demand creation to promote post-GBV services & PEP at community and facility level • Reproduce and distribute GBV IEC and other materials to ART sites 	<ul style="list-style-type: none"> • Supervision and training for clinical staff at central support sites will not be included in PEPFAR IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR • Site-level HRH at central support sites will be determined by MISAU's COP19 funding
TB/HIV***	<ul style="list-style-type: none"> • Implementation of 3Is (intensified case finding, infection control, and IPT), early ART for TB/HIV patients through one-stop shops, integrated outreach services during community index case testing (HIV testing & TB screening) • Support lay health workers who facilitate treatment initiation and support adherence among high risk drug sensitive and MDR-TB patients • Support implementation of TB treatment guideline revision • Support linkage of HIV patients to C&T services after completing TB treatment • Support systematic TB screening, TPT initiation and TPT completion for HIV+ patients 	<ul style="list-style-type: none"> • Sample transport for TB • Supervision and training for clinical staff at central support sites will not be included in PEPFAR IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR • Site-level HRH at central support sites will be determined by MISAU's COP19 funding

	<ul style="list-style-type: none"> • Implementation of FAST strategy, and continued support for cough officers approach • Promote use/scale-up of district based GeneXpert testing as the primary diagnostic test for all presumptive TB • Partner with NTP and HIV program to update TB Preventive Therapy (TPT) guidelines, job aids and instruments • Integrate TA and monitoring of TB care cascade in AJUDA visits • In order to improve the clinical and laboratory management of TB patients, IPs will use existing electronic data entry clerks to support digitization of TB case records at PEPFAR facilities that have existing electronic TB information systems 	
Viral Load / Lab	<ul style="list-style-type: none"> • Provincial level lab support coupled with site-level lab support to optimize VL and TB + result utilization • Demand creation/education for VL via CNCS funds • Support mentorship of laboratory staff • National HIV testing quality assurance for VL/EID/TB testing • Support for decentralized EQA • Support expansion of laboratory information System (LIS)/ DISA-Lab and DISA-Link for monitoring and optimizing VL cascade and generating lists of unsuppressed VL for patient follow-up • Support DISA-EPTS linkage • Strengthen VL results return and patient understanding of VL results 	<ul style="list-style-type: none"> • IP support for sample transport for VL • Supervision and training for clinical staff at central support sites will not be included in PEPFAR IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR • Site-level HRH at central support sites will be determined by MISAU's COP19 funding
M&E	<ul style="list-style-type: none"> • Support for routine M&E activities (data clerks, training, EPTS supervision and mentoring, participation in district data reviews) • Continued support for printing, reproduction and distribution of HIV instruments and forms • Routine data quality assurance and improvement activities (DQA, National Chart Cleaning, supervisory site visits, SIMS) for all quarterly indicators and enhanced monitoring of key interventions for retention 	<ul style="list-style-type: none"> • Annual reporting of HTS_TST, HTS_TST_POS, TX_CURR, TX_NEW, PMTCT_STAT, and PMTCT_ART via GRM reporting systems • Supervision and training for clinical staff at central support sites will not be included in PEPFAR IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR • Site-level HRH at central support sites will be

		determined by MISAU's COP19 funding
Informatics (HMIS)	<ul style="list-style-type: none"> • Support for EPTS system modifications, including EPTS point-of-care at select sites • Ongoing data quality review and resolution • Continue to implement pharmacy system scale up for drug management in collaboration with PEPFAR HMIS team (i.e., iDART) and continue to support pharmacy supply chain system (i.e., SIGLUS) • Continue implementation of linkage of external systems (i.e., pharmacy, laboratory, mhealth) with EPTS • Ensure alignment of HMIS systems with PEPFAR requirements and MISAU M&E platforms 	
Supply Chain	<ul style="list-style-type: none"> • Last mile medicines delivery • Last mile specimen transport • Viral load and EID conventional laboratory instrument provision, maintenance, repairs and reagent delivery to the labs • EID POC reagent delivery to district level • Commodity support for ARVs (adult, pediatric, and PrEP), RTKs, viral load (reagents and collection kits), EID (conventional and POC reagents and collection kits), VMMC, condoms, and TPT • SIGLUS implementation and support 	<ul style="list-style-type: none"> • Last mile medicines delivery • IP support for sample transport • Commodity support for ARVs (adult, pediatric, and PrEP), RTKs, viral load (reagents and collection kits), EID (conventional), VMMC, condoms, and Isoniazid

*This table serves as an overview. Definition of service package elements does not imply that these elements will be implemented uniformly or simultaneously throughout all sites, e.g. scale-up of community ART distribution does not imply that it will be scaled up nationally, but rather precise timing and degree of implementation will be coordinated with MISAU.

**Including EID lab support

***Including GeneXpert

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

The PEPFAR Mozambique team, in collaboration with the MISAU, undertook a thorough review of Table 6 activities as part of COP19 planning. The COP19 Table 6 builds on the previous year's portfolio, and phases out activities that were slated to end in FY19. Additionally, it further rationalized above site investments, and only activities essential to and or contributing to achieving epidemic control were proposed. All activities include clear milestones that allow for comprehensive assessment and monitoring.

Overall the budget for Table 6 activities decreased significantly, from \$28,473,864 in COP18 to \$18,848,204 in COP19. Above site investments have been substantially reduced since COP17, from \$43,712,447 in COP17 to \$18,848,204 currently. Substantial reductions were achieved between COP18 and COP19 through elimination of support for specific program areas (i.e., pre-service training, system development, etc.), completion of planned activities, or shifting line items to clinical partner budgets. Cost reduction strategies were driven by aggressive identification of efficiencies, shifting (wherever possible) responsibility for implementation away from international partners to local and/or government implementers, increasing PEPFAR staff provision of direct technical assistance, and minimizing development of new initiatives.

The above-site activities in COP19 squarely aim at improving the retention challenges that the Mozambican program is committed to addressing. They provide critical support across key areas including human resources for health, laboratory systems, and supply chain strengthening. A focus on efficiency (financial, programmatic and technical) informed the selection of activities in Table 6. For example, approaches to in-service training will shift away from off-site seminars to on-site approaches that will leverage PEPFAR supported distance training platforms. The program will invest in the national AIDS commission through a G2G grant to strengthen the national community platform. PEPFAR also proposes to leverage the national unique ID (NUIC) to improve de-duplication and improve patient tracking. The above-site investments align with key programmatic priorities, including DSD scale-up, quality improvement and TPT scale-up.

COP19 above site investments align with the key systems barriers identified in the SID, namely laboratory (25 percent of proposed investments), supply chain (20 percent of proposed investments) and strategic information (19 percent of proposed investments in COP19)

The COP19 above site portfolio is also closely aligned with the support provided to PEPFAR priority sites (identified in the COP19 pivot). Centrally supported sites will receive a differentiated and reduced package of services, essentially focused on support for commodity logistics (through a 4PL provider) and sample transportation.

This year's COP planning was marked by an excellent level of coordination with MISAU and other donors. Several planning meetings were held at technical and management levels, which allowed for engagement with key partners and aligning expectations in a budget constrained scenario. PEPFAR investments are increasingly better aligned with Government strategies and systems. Common standards and frameworks inform HIS investments, and PEPFAR is supporting the rollout of the NUIC. PEPFAR is strengthening the national community platform through the National AIDS commission and has also aligned its HRH and supply chain support with national strategies, namely the HR retention plan and the pharmaceutical logistics strengthening plan. PEPFAR is also scaling down its support for lay workers, and shifting this support to categories of staff with enhanced prospects for absorption in the government system (i.e., community health workers).

The activities in Table 6 have been developed with consideration of SMART targets and timelines. The benchmarks are realistic and are being used for quarterly program monitoring. Benchmarks were reviewed and improved during the COP development process.

7.0 Staffing Plan

The below contains a staffing profile of the five USG agencies implementing PEPFAR and their current staffing status.

There are currently a total of 266 positions for PEPFAR implementing agencies. Of these, 232 positions are filled (87 percent), 28 are currently vacant (11 percent), and 6 are newly proposed (currently vacant) planned positions (2 percent). From the 28 vacancies, 23 (82 percent) are slated for Host Country National (HCN) positions and 5 (18 percent) for US Direct Hires (USDH). Additionally, 212 positions (80 percent) are HCN, 51 (19 percent) USDH, 2 (1 percent) Local Resident American Citizen, and 1 (0.38 percent) Locally Hired Third Country National (TCN).

Currently, there are 202 USG positions which are fully or partially funded by PEPFAR. Of these positions, 94% allocate 100 percent of their time to PEPFAR, 76% allocate at least 30 percent of their time to PEPFAR, and 67% allocate more than 80 percent of their time devoted to PEPFAR activities.

Health and Human Services (HHS)/CDC

In COP19, CDC proposes no new positions. CDC has a total of 10 vacant positions, of which 7 are currently in recruitment, 2 are pending classification and 1 is already classified, and awaiting recruitment. Of the 10 vacant positions, 9 are slated for Host Country Nationals and 1 for a US Direct Hire. All recruitment efforts will follow CDC Agency-specific guidance for USDH positions as well as Embassy HR guidance for HCN positions.

Workspace and necessary equipment will continue to be provided at the CDC offices in the JAT Complex and eventually at the New Embassy Compound (NEC) in Maputo for all positions subject to revision.

United States Agency for International Development (USAID)

In COP19, USAID is requesting 6 new PEPFAR-funded positions to support localization efforts, bringing the total number of PEPFAR-funded positions to 81. These new positions will all be locally employed staff. Of these 6 positions, only 2 will be seated within the NEC, which is currently under construction.

USAID proposes to repurpose five positions, two of which have already been converted in COP18 implementation: 1) the Prevention Team Leader position from a USDH position to a locally employed staff position with the same title to provide technical and supervisory oversight of

USAID's HIV prevention portfolio and; 2) from M&E Specialist (LES) to Program Budget Analyst (LES) to strengthen USAID's oversight of program budget formulation and execution.

The remaining three positions proposed for repurposing in COP19 are: 3) the Supply System Strengthening Advisor (US personal services contractor (USPSC)) to an HIV Prevention Advisor (USPSC) to provide technical guidance and program analytics support for the HIV prevention portfolio; 4) the Health and Nutrition Linkages Advisor (USPSC) to Health Information Systems Specialist (LES) to support retention monitoring activities and scale up of electronic patient tracking systems; 5) the Logistics Project Specialist (LES) to Provincial Advisor (LES) to provide technical assistance, performance oversight, and financial monitoring oversight for the new G2G agreement in Tete Province.

USAID has eight vacancies, down from 16 one year ago. Two of these vacancies are USDH positions projected to be filled before the end of FY19; two are awaiting security clearance and two are in final stages of recruitment, and the final two will be advertised late FY19.

Peace Corps

In COP 19, Peace Corps proposes no new positions. Peace Corps has a total of 20 fully PEPFAR-funded positions in COP 19, all of which are filled by HCNs. Peace Corps staffing represents no change in COP19 in comparison to COP18.

Department of State

In COP19, State proposes no new positions. State has a total of 11 fully PEPFAR-funded positions at a 100 percent allocation, of which 9 HCNs, 1 is a PSA Eligible Family Member and 1 is a USDH. Of these 11 positions, 7 are filled and 4 are vacant.

The staffing structure for State remains the same in COP19 as compared to COP18, with the Community Grants positions now under the PEPFAR Coordination Office. Of the four vacancies, all are currently pending classification from the Regional HRO in Pretoria.

Department of Defense (DoD)

DOD has a total of 4 PEPFAR-funded positions, two filled and two vacant but with recruitment processes underway. The DoD PEPFAR program grew from three sites in COP 16 to 22 in COP 19, with a 20 percent increase in targets. Fifteen additional sites have been identified for gradual expansion. The current agency recruitment processes are for a Treatment Advisor and a Strategic Information Advisor which will respond to the growing need to manage the program activities and data.

APPENDIX A -- PRIORITIZATION

Table A1: Continuous Nature of SNU Prioritization to Reach Epidemic Control

Province	DATIM District Name	Year	Prioritization	<01		01-04		05-09		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+			
				Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
				Cabodelgado	Ancuabe	FY 17	ScaleUp Agg	28%	71%			18%	45%	10%	27%	12%	87%	21%	67%										
Cabodelgado	Ancuabe	FY 19 Q1	Sustained	28%	29%	28%	34%	23%	33%	8%	18%	5%	33%	12%	40%	17%	44%	27%	50%	28%	44%	32%	44%	39%	34%	59%	47%		
Cabodelgado	Ancuabe	FY 20	ScaleUp Agg	33%	33%	43%	40%	42%	39%	62%	56%	28%	9%	90%	91%	30%	54%	24%	50%	23%	57%	31%	81%	47%	13%	77%	81%	40%	
Cabodelgado	Balama	FY 17	Sustained	6%	23%			5%	19%	4%	11%	6%	42%	10%	33%									11%	14%	13%	11%		
Cabodelgado	Balama	FY 19 Q1	Sustained	10%	7%	13%	17%	7%	12%	6%	13%	4%	21%	7%	21%	11%	22%	11%	19%	15%	16%	15%	15%	15%	15%	8%	19%	8%	
Cabodelgado	Balama	FY 20	ScaleUp Agg	17%	17%	23%	21%	22%	20%	32%	29%	14%	7%	46%	46%	15%	28%	12%	26%	12%	29%	16%	41%	24%	6%	39%	41%	20%	
Cabodelgado	Chiure	FY 17	ScaleUp Agg	4%	34%			77%	60%	39%	31%	28%	145%	38%	119%									4%	9%	76%	9%	115%	
Cabodelgado	Chiure	FY 19 Q1	ScaleUp Agg	9%	14%	27%	38%	25%	30%	21%	15%	8%	27%	13%	37%	19%	43%	28%	51%	29%	46%	38%	43%	4%	9%	36%	56%	41%	

Cab o Delg ado	Chiure	FY 20	ScaleU p Agg	35 %	36 %	4 %	42 %	4 %	41 %	6 %	59 %	29 %	93 %	94 %	31 %	56 %	25 %	52 %	23 %	59 %	32 %	8 %	49 %	13 %	80 %	8 %	42 %		
Cab o Delg ado	Ibo	FY 17	Sustai ned	38 %	45 %			23 %	27 %	33 %	23 %	0 %	56 %	4 %	27 %									16 %	23 %	37 %	34 %		
Cab o Delg ado	Ibo	FY 19 Q1	Centra l Suppo rt	0 %	20 %	32 %	28 %	0 %	5%	0 %	15 %	0 %	9%	7 %	15 %	13 %	7%	7 %	16 %	12 %	12 %	3 %	12 %	19 %	22 %	22 %	15 %		
Cab o Delg ado	Ibo	FY 20	Centra l Suppo rt	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0%	
Cab o Delg ado	Macomi a	FY 17	ScaleU p Agg	16 %	82 %			11 %	52 %	3 %	17 %	6 %	68 %	20 %	50 %									20 %	30 %	34 %	34 %		
Cab o Delg ado	Macomi a	FY 19 Q1	Sustai ned	21 %	16 %	26 %	26 %	13 %	19 %	9 %	21 %	2 %	19 %	6 %	20 %	9 %	23 %	16 %	31 %	20 %	32 %	20 %	28 %	25 %	20 %	38 %	31 %		
Cab o Delg ado	Macomi a	FY 20	ScaleU p Agg	29 %	29 %	35 %	33 %	35 %	32 %	51 %	47 %	22 %	5 %	70 %	70 %	23 %	42 %	19 %	39 %	18 %	4 %	4 %	24 %	63 %	37 %	10 %	60 %	63 %	31 %
Cab o Delg ado	Mecufi	FY 17	Sustai ned	11 %	38 %			15 %	54 %	6 %	20 %	10 %	45 %	12 %	41 %									21 %	37 %	39 %	30 %		
Cab o Delg ado	Mecufi	FY 19 Q1	Sustai ned	25 %	33 %	21 %	21 %	25 %	10 %	14 %	28 %	3 %	7%	5 %	21 %	9 %	25 %	17 %	36 %	16 %	30 %	23 %	31 %	33 %	23 %	55 %	28 %		
Cab o Delg ado	Mecufi	FY 20	ScaleU p Agg	19 %	20 %	29 %	26 %	2 %	26 %	41 %	37 %	181 %	56 %	57 %	19 %	34 %	15 %	31 %	14 %	36 %	20 %	50 %	30 %	81 %	48 %	50 %	25 %		

Cab o Delg ado	Meluco	FY 17	Sustai ned	0 %	0%				22 %	32 %	4 %	11%	16 %	73 %	14 %	47 %							19 %	34 %	4 0 %	26 %	
Cab o Delg ado	Meluco	FY 19 Q1	Centra l Suppo rt	83 %	23 %	23 %	30 %	17 %	27 %	11 %	4%	8 %	25 %	4 %	21 %	6 %	28 %	16 %	39 %	14 %	41 %	29 %	34 %	29 %	21 %	51 %	24 %
Cab o Delg ado	Meluco	FY 20	ScaleU p Agg	20 %	20 %	29 %	27 %	2 9 %	27 %	41 %	39 %	18 4 %	58 %	58 %	19 %	35 %	16 %	32 %	15 %	37 %	20 %	52 %	31 %	8 4 %	50 %	52 %	26 %
Cab o Delg ado	Meluco	FY 17	Sustai ned	19 %	61 %			12 %	43 %	12 %	36 %	8 %	67 %	16 %	54 %								17 %	24 %	30 %	42 %	
Cab o Delg ado	Metuge	FY 19 Q1	Sustai ned	4 %	27 %	21 %	17 %	12 %	15 %	0 %	15 %	2 %	17 %	4 %	21 %	8 %	20 %	14 %	24 %	12 %	16 %	19 %	20 %	24 %	25 %	36 %	30 %
Cab o Delg ado	Metuge	FY 20	ScaleU p Agg	22 %	23 %	29 %	27 %	2 9 %	27 %	41 %	38 %	19 0 %	59 %	59 %	20 %	36 %	16 %	33 %	15 %	38 %	21 %	53 %	31 %	8 6 %	50 %	53 %	26 %
Cab o Delg ado	Mocimb oa Da Praia	FY 17	ScaleU p Agg	32 %	38 %			42 %	53 %	21 %	28 %	11 %	67 %	15 %	48 %								26 %	32 %	4 6 %	50 %	
Cab o Delg ado	Mocimb oa Da Praia	FY 19 Q1	Sustai ned	8 %	8%	15 %	25 %	24 %	25 %	19 %	20 %	3 %	20 %	5 %	23 %	8 %	29 %	17 %	38 %	21 %	32 %	29 %	31 %	36 %	29 %	65 %	47 %
Cab o Delg ado	Mocimb oa Da Praia	FY 20	ScaleU p Agg	28 %	28 %	36 %	34 %	36 %	33 %	52 %	48 %	23 7 %	74 %	75 %	25 %	45 %	20 %	41 %	19 %	47 %	26 %	6 6 %	39 %	10 7 %	63 %	67 %	33 %
Cab o Delg ado	Montepu ez	FY 17	ScaleU p Agg	23 %	31 %			26 %	36 %	12 %	18 %	16 %	80 %	16 %	59 %								19 %	30 %	51 %	43 %	

Cab o Delg ado	Montepu ez	FY 19 Q1	ScaleU p Agg	17 %	21 %	34 %	36 %	23 %	24 %	19 %	19 %	11 %	33 %	13 %	42 %	18 %	42 %	27 %	48 %	25 %	39 %	29 %	37 %	35 %	34 %	63 %	37 %
Cab o Delg ado	Montepu ez	FY 20	ScaleU p Agg	33 %	34 %	43 %	40 %	42 %	39 %	61 %	56 %	28 1%	87 %	88 %	29 %	53 %	24 %	4 9 %	22 %	56 %	31 %	78 %	46 %	12 7 %	75 %	79 %	39 %
Cab o Delg ado	Mueda	FY 17	ScaleU p Agg	14 %	21 %			23 %	32 %	12 %	17 %	6 %	53 %	11 %	41 %								18 %	25 %	24 %	24 %	
Cab o Delg ado	Mueda	FY 19 Q1	ScaleU p Agg	35 %	35 %	38 %	49 %	54 %	50 %	35 %	39 %	11 %	62 %	19 %	68 %	32 %	68 %	4 9 %	81 %	50 %	68 %	6 0 %	66 %	67 %	46 %	10 6 %	92 %
Cab o Delg ado	Mueda	FY 20	ScaleU p Agg	41 %	42 %	53 %	50 %	53 %	48 %	76 %	70 %	35 3 %	110 %	111 %	37 %	6 6 %	30 %	61 %	28 %	70 %	38 %	9 8 %	58 %	15 9 %	94 %	9 9 %	49 %
Cab o Delg ado	Muidum be	FY 17	ScaleU p Agg	16 %	27 %			2 9 %	47 %	8 %	13 %	8 %	92 %	14 %	50 %								20 %	28 %	26 %	20 %	
Cab o Delg ado	Muidum be	FY 19 Q1	ScaleU p Agg	41 %	55 %	6 0 %	61 %	4 9 %	58 %	21 %	55 %	20 %	101 %	31 %	76 %	29 %	57 %	4 6 %	71 %	45 %	60 %	52 %	68 %	70 %	51 %	12 0 %	93 %
Cab o Delg ado	Muidum be	FY 20	ScaleU p Agg	47 %	48 %	6 0 %	56 %	6 0 %	55 %	8 6 %	80 %	37 3 %	116 %	117 %	39 %	70 %	31 %	65 %	29 %	74 %	40 %	10 4 %	61 %	16 8 %	99 %	10 5 %	52 %
Cab o Delg ado	Namuno	FY 17	Sustai ned	17 %	20 %			10 %	12 %	9 %	9%	11 %	32 %	13 %	31 %								12 %	18 %	17 %	16 %	
Cab o Delg ado	Namuno	FY 19 Q1	Sustai ned	15 %	7%	16 %	12 %	5 %	8%	5 %	9%	7 %	19 %	8 %	17 %	8 %	17 %	14 %	25 %	12 %	17 %	14 %	15 %	17 %	13 %	17 %	9%

Cab o Delg ado	Namuno	FY 20	ScaleU p Agg	15 %	16 %	19 %	18 %	18 %	17 %	27 %	24 %	12 7 %	39 %	40 %	13 %	24 %	11 %	22 %	10 %	25 %	14 %	36 %	21 %	57 %	34 %	36 %	18 %
Cab o Delg ado	Nangade	FY 17	Sustai ned	9 %	10 %			34 %	41 %	11 %	14 %	0 %	51 %	16 %	47 %									23 %	35 %	38 %	32 %
Cab o Delg ado	Nangade	FY 19 Q1	Sustai ned	11 %	4%	19 %	14 %	14 %	19 %	9 %	7%	2 %	18 %	5 %	17 %	8 %	19 %	14 %	26 %	15 %	25 %	20 %	28 %	23 %	18 %	33 %	22 %
Cab o Delg ado	Nangade	FY 20	ScaleU p Agg	25 %	26 %	31 %	29 %	31 %	28 %	4 4 %	41 %	20 3 %	63 %	64 %	21 %	38 %	17 %	35 %	16 %	4 0 %	22 %	56 %	33 %	91 %	54 %	57 %	28 %
Cab o Delg ado	Palma	FY 17	Sustai ned	56 %	42 %			47 %	34 %	28 %	22 %	8 %	40 %	11 %	44 %									21 %	28 %	36 %	39 %
Cab o Delg ado	Palma	FY 19 Q1	Sustai ned	10 %	18 %	11 %	19 %	15 %	24 %	11 %	14 %	1%	10 %	3 %	12 %	8 %	21 %	17 %	29 %	15 %	27 %	21 %	17 %	27 %	15 %	4 6 %	18 %
Cab o Delg ado	Palma	FY 20	ScaleU p Agg	29 %	30 %	37 %	36 %	37 %	34 %	53 %	49 %	23 9 %	74 %	75 %	25 %	45 %	20 %	42 %	19 %	4 8 %	26 %	67 %	39 %	10 8 %	64 %	67 %	33 %
Cab o Delg ado	Pemba	FY 17	ScaleU p Agg	51 %	55 %			58 %	59 %	35 %	35 %	14 %	39 %	9 %	42 %									33 %	41 %	12 2 %	113 %
Cab o Delg ado	Pemba	FY 19 Q1	ScaleU p Agg	23 %	15 %	4 6 %	55 %	56 %	61 %	45 %	57 %	20 %	38 %	15 %	56 %	24 %	70 %	4 6 %	89 %	52 %	81 %	58 %	71 %	8 6 %	65 %	15 3 %	81 %
Cab o Delg ado	Pemba	FY 20	ScaleU p Agg	4 9 %	51 %	63 %	60 %	63 %	58 %	91 %	84 %	40 2 %	125 %	12 6 %	42 %	75 %	34 %	70 %	31 %	8 0 %	44 %	2 %	66 %	18 1 %	107 %	11 3 %	56 %

Cab o Delg ado	Quissan ga	FY 17	Sustai ned	20 %	19 %			16 %	15 %	4 %	7%	0 %	37 %	9 %	27 %								9 %	16 %	16 %	12 %		
Cab o Delg ado	Quissan ga	FY 19 Q1	Sustai ned	7 %	20 %	16 %	10 %	7 %	10 %	3 %	10 %	2 %	4%	2 %	11%	4 %	14 %	6 %	12 %	8 %	12 %	7 %	10 %	12 %	7%	17 %	12 %	
Cab o Delg ado	Quissan ga	FY 20	Centra l Suppo rt	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	
Gaza	Bilene	FY 17	ScaleU p Agg	32 %	34 %			45 %	47 %	42 %	43 %	17 %	57 %	12 %	61 %								31 %	55 %	93 %	58 %		
Gaza	Bilene	FY 19 Q1	ScaleU p Agg	22 %	30 %	6 %	73 %	76 %	85 %	71 %	81 %	31 %	46 %	17 %	64 %	29 %	72 %	4 %	8 %	87 %	4 %	85 %	4 %	72 %	47 %	68 %	11 %	107 %
Gaza	Bilene	FY 20	ScaleU p Agg	78 %	80 %	10 %	94 %	73 %	67 %	9 %	81 %	75 %	20 %	8 %	58 %	9 %	40 %	85 %	31 %	77 %	36 %	9 %	52 %	14 %	9 %	85 %	10 %	52 %
Gaza	Chibuto	FY 17	ScaleU p Sat	4 %	53 %			57 %	71 %	51 %	65 %	40 %	85 %	11 %	66 %								38 %	74 %	13 %	87 %		
Gaza	Chibuto	FY 19 Q1	ScaleU p Agg	30 %	39 %	59 %	76 %	79 %	82 %	8 %	79 %	46 %	39 %	15 %	50 %	23 %	57 %	34 %	72 %	45 %	86 %	4 %	83 %	51 %	67 %	12 %	121 %	
Gaza	Chibuto	FY 20	ScaleU p Agg	78 %	79 %	10 %	94 %	73 %	67 %	9 %	81 %	73 %	195 %	2 %	57 %	6 %	39 %	83 %	30 %	75 %	36 %	8 %	51 %	14 %	6 %	83 %	10 %	51 %
Gaza	Chicuala cuala	FY 17	ScaleU p Agg	36 %	74 %			50 %	96 %	5 %	33 %	35 %	70 %	13 %	94 %								38 %	59 %	10 %	59 %		
Gaza	Chicuala cuala	FY 19 Q1	Centra l Suppo rt	0 %	31 %	6 %	92 %	73 %	104 %	57 %	89 %	48 %	31 %	14 %	41 %	15 %	53 %	34 %	53 %	33 %	70 %	39 %	61 %	43 %	54 %	10 %	106 %	
Gaza	Chicuala cuala	FY 20	Centra l Suppo rt	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	0 %	0%	

Gaza	Chigubo	FY 17	Sustained	17%	20%			57%	74%	22%	26%	0%	97%	14%	126%								28%	66%	9%	2%	77%			
Gaza	Chigubo	FY 19 Q1	Central Support	13%	77%	11%	119%	13%	166%	8%	108%	47%	25%	0%	60%	10%	67%	37%	60%	4%	6%	77%	37%	105%	50%	58%	17%	3%	151%	
Gaza	Chigubo	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Gaza	Chokwe	FY 17	ScaleUp Sat	35%	35%			65%	66%	58%	66%	22%	70%	15%	77%									4%	4%	70%	15%	0%	98%	
Gaza	Chokwe	FY 19 Q1	ScaleUp Sat	62%	68%	11%	99%	11%	100%	76%	80%	32%	53%	25%	89%	38%	89%	57%	107%	58%	100%	57%	82%	63%	71%	14%	3%	109%		
Gaza	Chokwe	FY 20	ScaleUp Agg	92%	93%	11%	109%	85%	78%	3%	94%	4%	213%	6%	62%	7%	42%	91%	33%	82%	39%	9%	6%	55%	15%	9%	91%	3%	56%	
Gaza	Chongone	FY 17	new	52%	44%			57%	44%	31%	25%	11%	56%	10%	57%									23%	50%	6%	6%	47%		
Gaza	Chongone	FY 19 Q1	ScaleUp Agg	12%	15%	57%	78%	95%	98%	74%	101%	39%	44%	12%	50%	22%	58%	34%	73%	37%	74%	33%	67%	39%	61%	95%	100%			
Gaza	Chongone	FY 20	ScaleUp Agg	82%	85%	10%	99%	78%	71%	9%	4%	86%	5%	184%	7%	54%	9%	36%	78%	28%	71%	34%	83%	48%	13%	7%	79%	97%	48%	
Gaza	Guija	FY 17	ScaleUp Agg	23%	18%			83%	66%	58%	43%	17%	68%	17%	77%									39%	80%	13%	9%	85%		
Gaza	Guija	FY 19 Q1	ScaleUp Sat	12%	12%	8%	94%	82%	101%	6%	4%	68%	25%	50%	18%	63%	24%	72%	37%	90%	42%	97%	51%	95%	6%	0%	67%	0%	108%	
Gaza	Guija	FY 20	ScaleUp Agg	85%	85%	10%	98%	77%	71%	9%	4%	85%	2%	203%	4%	60%	1%	40%	87%	31%	78%	37%	92%	53%	2%	87%	0%	10%	8%	53%
Gaza	Limpopo	FY 17	new	97%	87%			8%	71%	70%	61%	30%	79%	15%	86%									42%	96%	14%	1%	105%		

Gaza	Limpopo	FY 19 Q1	ScaleUp Agg	18%	39%	68%	64%	66%	75%	70%	64%	33%	27%	11%	46%	16%	49%	31%	70%	32%	74%	32%	68%	41%	60%	87%	99%	
Gaza	Limpopo	FY 20	ScaleUp Agg	75%	76%	95%	89%	70%	64%	4%	77%	5%	181%	24%	3%	53%	8%	36%	77%	28%	70%	33%	82%	47%	5%	77%	6%	47%
Gaza	Mabalane	FY 17	ScaleUp Agg	90%	70%			66%	52%	24%	26%	11%	103%	14%	81%									36%	51%	9%	55%	
Gaza	Mabalane	FY 19 Q1	Sustained	56%	58%	101%	66%	84%	56%	92%	63%	38%	34%	16%	53%	25%	52%	40%	59%	38%	76%	44%	68%	53%	63%	0%	105%	
Gaza	Mabalane	FY 20	ScaleUp Agg	50%	50%	63%	60%	46%	44%	55%	52%	44%	116%	15%	7%	34%	9%	23%	50%	18%	45%	21%	53%	30%	87%	50%	62%	31%
Gaza	Mandlake	FY 17	ScaleUp Sat	70%	71%			84%	87%	70%	81%	43%	103%	16%	97%									51%	101%	2%	101%	
Gaza	Mandlake	FY 19 Q1	ScaleUp Agg	18%	30%	53%	65%	64%	82%	72%	84%	43%	31%	9%	39%	15%	44%	27%	56%	30%	57%	37%	59%	42%	64%	111%	110%	
Gaza	Mandlake	FY 20	ScaleUp Agg	75%	75%	94%	88%	69%	63%	83%	76%	65%	172%	23%	50%	102%	34%	73%	26%	6%	31%	78%	45%	12%	8%	73%	91%	45%
Gaza	Mapai	FY 17	new	66%	68%			41%	39%	38%	19%	13%	94%	12%	65%									25%	50%	82%	40%	
Gaza	Mapai	FY 19 Q1	Sustained	70%	0%	123%	51%	55%	99%	82%	56%	39%	42%	17%	52%	23%	66%	28%	70%	32%	73%	42%	70%	4%	4%	77%	3%	100%
Gaza	Mapai	FY 20	ScaleUp Agg	43%	43%	61%	57%	44%	39%	53%	50%	0%	111%	151%	33%	6%	22%	48%	17%	43%	20%	50%	29%	4%	48%	59%	29%	
Gaza	Massangena	FY 17	Sustained	74%	124%			40%	69%	29%	42%	5%	66%	5%	68%									25%	48%	9%	50%	
Gaza	Massangena	FY 19 Q1	Central Support	27%	0%	64%	71%	55%	74%	85%	88%	26%	38%	11%	38%	14%	51%	20%	56%	24%	66%	29%	81%	43%	76%	5%	95%	

Gaza	Massangena	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Gaza	Massingir	FY 17	Sustained	96%	63%		83%	54%	37%	28%	10%	112%	10%	92%								33%	48%	9%	43%	8%	
Gaza	Massingir	FY 19 Q1	Sustained	66%	27%	70%	115%	72%	75%	61%	66%	22%	51%	7%	46%	18%	51%	29%	61%	29%	57%	32%	51%	43%	46%	97%	66%
Gaza	Massingir	FY 20	ScaleUp Agg	40%	40%	50%	48%	36%	33%	43%	40%	323%	85%	113%	25%	50%	17%	36%	13%	32%	16%	38%	22%	4%	36%	45%	22%
Gaza	Xai-Xai	FY 17	ScaleUp Sat	59%	68%			57%	64%	72%	80%	37%	52%	11%	46%								33%	60%	158%	124%	
Gaza	Xai-Xai	FY 19 Q1	ScaleUp Sat	31%	39%	62%	65%	70%	100%	104%	113%	76%	47%	18%	46%	24%	70%	42%	100%	52%	107%	56%	104%	68%	108%	165%	148%
Gaza	Xai-Xai	FY 20	ScaleUp Agg	84%	106%	99%	78%	72%	4%	9%	86%	7%	213%	6%	62%	7%	42%	91%	33%	82%	39%	6%	55%	9%	91%	3%	56%
Inhambane	Funhaluro	FY 17	Sustained	30%	34%			102%	111%	103%	671%	20%	52%	8%	441%								51%	75%	7%	132%	
Inhambane	Funhaluro	FY 19 Q1	Sustained	25%	97%	90%	112%	110%	86%	4%	89%	26%	30%	3%	32%	15%	32%	15%	43%	23%	63%	23%	62%	45%	70%	2%	120%
Inhambane	Funhaluro	FY 20	ScaleUp Agg	33%	33%	45%	43%	52%	45%	77%	68%	410%	79%	98%	23%	9%	16%	39%	14%	38%	17%	45%	24%	71%	39%	9%	24%
Inhambane	Govuro	FY 17	Sustained	64%	52%			55%	45%	320%	257%	12%	23%	5%	307%								37%	32%	75%	24%	
Inhambane	Govuro	FY 19 Q1	Sustained	30%	74%	87%	144%	161%	200%	194%	139%	83%	58%	24%	75%	25%	99%	4%	135%	62%	118%	67%	98%	85%	75%	0%	83%
Inhambane	Govuro	FY 20	ScaleUp Agg	100%	110%	136%	129%	154%	141%	238%	217%	1039%	198%	244%	56%	2%	41%	8%	35%	4%	43%	111%	60%	8%	97%	2%	59%

Inhamba ne	Homoin e	FY 17	Sustained	7%	13%			40%	73%	139%	257%	14%	30%	6%	126%								19%	61%	76%	89%	
Inhamba ne	Homoin e	FY 19 Q1	Sustained	23%	8%	28%	53%	72%	78%	48%	116%	22%	19%	6%	22%	5%	24%	10%	43%	15%	51%	18%	63%	30%	61%	75%	114%
Inhamba ne	Homoin e	FY 20	ScaleUp Agg	38%	38%	45%	43%	51%	48%	80%	73%	9%	102%	5%	29%	63%	21%	51%	18%	48%	22%	58%	31%	91%	50%	63%	30%
Inhamba ne	Inhamba ne	FY 17	Sustained	23%	61%			34%	82%	76%	192%	19%	27%	4%	64%									16%	24%	95%	78%
Inhamba ne	Inhamba ne	FY 19 Q1	Sustained	9%	9%	34%	40%	41%	61%	72%	107%	22%	17%	8%	19%	10%	31%	16%	50%	22%	57%	20%	52%	35%	54%	83%	81%
Inhamba ne	Inhamba ne	FY 20	ScaleUp Agg	38%	39%	49%	47%	56%	52%	85%	80%	2%	118%	5%	33%	73%	24%	58%	21%	56%	26%	67%	36%	6%	58%	73%	35%
Inhamba ne	Inharrim e	FY 17	ScaleUp Sat	21%	21%			40%	42%	112%	114%	9%	22%	2%	78%								15%	40%	53%	56%	
Inhamba ne	Inharrim e	FY 19 Q1	Sustained	8%	47%	6%	69%	9%	96%	83%	73%	24%	34%	4%	32%	11%	39%	14%	65%	20%	65%	25%	64%	32%	70%	0%	107%
Inhamba ne	Inharrim e	FY 20	ScaleUp Agg	44%	44%	59%	56%	66%	61%	100%	93%	63%	121%	0%	34%	75%	25%	0%	21%	58%	27%	8%	37%	9%	60%	75%	36%
Inhamba ne	Inhassor o	FY 17	Sustained	28%	37%			67%	95%	120%	173%	13%	68%	8%	108%								41%	64%	5%	105%	
Inhamba ne	Inhassor o	FY 19 Q1	Sustained	8%	59%	4%	54%	111%	69%	7%	139%	26%	45%	15%	53%	23%	63%	34%	90%	4%	105%	4%	81%	79%	112%	5%	117%
Inhamba ne	Inhassor o	FY 20	ScaleUp Agg	47%	50%	6%	61%	73%	67%	112%	106%	6%	158%	5%	45%	8%	33%	79%	28%	75%	35%	9%	48%	2%	78%	8%	47%
Inhamba ne	Jangamo	FY 17	Attained	22%	26%			60%	74%	165%	20%	12%	33%	2%	149%								29%	71%	9%	115%	

Inhambane	Jangamo	FY 19 Q1	Sustained	8%	9%	46%	40%	67%	84%	37%	72%	9%	18%	3%	21%	5%	26%	12%	45%	17%	51%	21%	58%	30%	67%	8%	114%
Inhambane	Jangamo	FY 20	ScaleUp Agg	33%	35%	47%	44%	52%	49%	80%	75%	55%	108%	13%	30%	67%	22%	53%	19%	51%	24%	61%	33%	97%	53%	6%	32%
Inhambane	Mabote	FY 17	Attained	22%	24%			65%	69%	385%	403%	7%	39%	9%	322%									38%	52%	112%	78%
Inhambane	Mabote	FY 19 Q1	Sustained	33%	52%	43%	94%	131%	135%	106%	177%	28%	41%	13%	40%	18%	49%	26%	70%	35%	84%	47%	106%	71%	97%	140%	176%
Inhambane	Mabote	FY 20	ScaleUp Agg	64%	64%	83%	78%	93%	88%	141%	135%	769%	147%	181%	41%	90%	30%	73%	26%	70%	32%	83%	45%	131%	72%	91%	44%
Inhambane	Massinga	FY 17	ScaleUp Sat	21%	23%			37%	41%	287%	317%	8%	23%	3%	250%									23%	39%	59%	67%
Inhambane	Massinga	FY 19 Q1	ScaleUp Agg	33%	44%	46%	48%	86%	70%	87%	131%	51%	24%	7%	24%	15%	32%	27%	51%	33%	62%	45%	62%	72%	71%	159%	106%
Inhambane	Massinga	FY 20	ScaleUp Agg	50%	51%	63%	60%	71%	66%	110%	101%	729%	140%	3%	40%	87%	29%	70%	25%	67%	31%	79%	43%	126%	69%	87%	42%
Inhambane	Maxixe	FY 17	ScaleUp Sat	37%	38%			105%	108%	288%	295%	31%	54%	3%	108%									28%	54%	142%	148%
Inhambane	Maxixe	FY 19 Q1	ScaleUp Sat	39%	11%	50%	64%	95%	148%	151%	169%	63%	36%	7%	35%	11%	50%	24%	89%	35%	104%	39%	95%	61%	117%	137%	178%
Inhambane	Maxixe	FY 20	ScaleUp Agg	58%	58%	75%	72%	85%	79%	132%	122%	830%	159%	7%	45%	9%	33%	79%	28%	76%	35%	90%	48%	143%	79%	9%	48%
Inhambane	Morrumbene	FY 17	Sustained	30%	28%			63%	63%	213%	216%	23%	34%	6%	191%									23%	53%	67%	70%
Inhambane	Morrumbene	FY 19 Q1	ScaleUp Agg	34%	30%	34%	39%	55%	67%	64%	48%	34%	14%	8%	17%	6%	23%	15%	38%	20%	41%	23%	47%	31%	47%	94%	70%

Inhambane	Morrumbene	FY 20	ScaleUp Agg	43%	43%	52%	50%	58%	55%	91%	83%	628%	121%	149%	34%	75%	25%	60%	21%	57%	26%	68%	37%	109%	59%	75%	36%	
Inhambane	Panda	FY 17	Sustained	29%	28%			61%	62%	447%	475%	6%	39%	2%	544%									51%	59%	9%	65%	
Inhambane	Panda	FY 19 Q1	Sustained	44%	0%	73%	99%	68%	111%	76%	34%	22%	25%	5%	27%	4%	26%	16%	40%	20%	75%	22%	64%	38%	68%	96%	105%	
Inhambane	Panda	FY 20	ScaleUp Agg	40%	40%	51%	47%	57%	53%	87%	82%	529%	102%	125%	29%	63%	21%	50%	18%	48%	22%	57%	31%	91%	50%	63%	30%	
Inhambane	Vilankulo	FY 17	ScaleUp Sat	7%	8%			21%	24%	88%	102%	6%	21%	2%	67%								14%	19%	42%	34%		
Inhambane	Vilankulo	FY 19 Q1	ScaleUp Agg	17%	41%	50%	44%	93%	98%	108%	166%	39%	46%	11%	47%	19%	52%	35%	79%	39%	88%	44%	72%	57%	85%	9%	107%	
Inhambane	Vilankulo	FY 20	ScaleUp Agg	53%	55%	68%	64%	76%	70%	118%	108%	2%	151%	6%	42%	93%	31%	75%	27%	72%	33%	85%	46%	5%	74%	93%	45%	
Inhambane	Zavala	FY 17	ScaleUp Sat	7%	8%			23%	25%	76%	84%	5%	19%	3%	70%								12%	26%	41%	41%		
Inhambane	Zavala	FY 19 Q1	ScaleUp Agg	37%	27%	61%	62%	105%	141%	114%	114%	28%	35%	10%	38%	9%	47%	15%	65%	25%	67%	35%	75%	34%	72%	2%	142%	
Inhambane	Zavala	FY 20	ScaleUp Agg	59%	62%	75%	71%	84%	78%	129%	120%	769%	148%	18%	42%	91%	31%	73%	26%	70%	32%	8%	45%	13%	3%	73%	91%	44%
Manica	Barue	FY 17	ScaleUp Agg	53%	55%			74%	75%	45%	46%	23%	111%	34%	138%								62%	84%	4%	52%		
Manica	Barue	FY 19 Q1	ScaleUp Agg	6%	19%	22%	44%	21%	29%	13%	14%	12%	37%	13%	52%	28%	55%	32%	51%	30%	44%	33%	39%	32%	31%	39%	37%	
Manica	Barue	FY 20	ScaleUp Agg	57%	59%	72%	69%	44%	41%	52%	47%	335%	135%	18%	5%	46%	1%	32%	74%	25%	65%	29%	74%	40%	7%	67%	55%	44%

Manica	Chimoio	FY 17	ScaleUp Sat	43%	48%			47%	51%	38%	43%	23%	59%	17%	71%								40%	48%	76%	56%					
Manica	Chimoio	FY 19 Q1	ScaleUp Sat	63%	69%	128%	146%	109%	116%	87%	124%	78%	126%	66%	223%	12%	258%	16%	7%	279%	16%	3%	222%	14%	7%	166%	158%	148%	8%	22%	182%
Manica	Chimoio	FY 20	Attained	135%	138%	173%	163%	105%	98%	12%	112%	109%	443%	5%	150%	32%	9%	104%	24%	3%	81%	4%	94%	2%	132%	350%	220%	179%	143%		
Manica	Gondola	FY 17	ScaleUp Agg	58%	56%			47%	46%	4%	36%	15%	85%	27%	101%										42%	60%	55%	40%			
Manica	Gondola	FY 19 Q1	ScaleUp Agg	18%	56%	60%	61%	32%	43%	23%	32%	18%	66%	32%	85%	54%	98%	52%	79%	4%	6%	62%	42%	51%	47%	45%	62%	55%			
Manica	Gondola	FY 20	ScaleUp Agg	62%	63%	78%	74%	47%	44%	55%	50%	362%	147%	201%	50%	109%	34%	8%	0%	27%	71%	31%	0%	44%	116%	73%	59%	48%			
Manica	Guro	FY 17	Sustained	66%	81%			95%	107%	59%	70%	27%	135%	46%	170%									80%	112%	12%	4%	53%			
Manica	Guro	FY 19 Q1	Sustained	13%	0%	45%	65%	56%	38%	55%	47%	16%	57%	51%	79%	57%	99%	61%	69%	57%	67%	47%	62%	58%	44%	9%	6%	68%			
Manica	Guro	FY 20	ScaleUp Agg	50%	50%	65%	62%	40%	37%	46%	42%	274%	111%	2%	38%	82%	26%	61%	20%	53%	24%	0%	33%	88%	55%	45%	36%				
Manica	Macate	FY 17	new	65%	56%			100%	85%	28%	34%	16%	198%	76%	174%									74%	76%	9%	47%				
Manica	Macate	FY 19 Q1	Sustained	13%	0%	18%	21%	8%	3%	7%	4%	1%	17%	11%	28%	14%	26%	17%	21%	18%	14%	18%	13%	15%	15%	23%	15%				
Manica	Macate	FY 20	ScaleUp Agg	45%	46%	58%	55%	36%	33%	41%	38%	262%	106%	5%	36%	79%	25%	58%	19%	51%	23%	58%	32%	4%	53%	43%	34%				
Manica	Machaze	FY 17	ScaleUp Agg	64%	50%			79%	59%	4%	37%	18%	111%	37%	132%									34%	100%	56%	31%				

Manica	Machaze	FY 19 Q1	ScaleUp Agg	23%	44%	35%	63%	35%	26%	28%	16%	15%	47%	18%	58%	26%	67%	26%	68%	26%	60%	36%	65%	30%	58%	41%	54%		
Manica	Machaze	FY 20	ScaleUp Agg	6%	66%	81%	77%	50%	46%	58%	52%	35%	144%	19%	8%	49%	7%	34%	79%	26%	70%	31%	79%	43%	11%	4%	72%	58%	47%
Manica	Macossa	FY 17	Sustained	32%	17%			40%	22%	28%	16%	6%	34%	11%	41%									15%	23%	24%	16%		
Manica	Macossa	FY 19 Q1	Central Support	10%	12%	22%	26%	17%	13%	13%	14%	11%	21%	12%	32%	21%	37%	25%	36%	24%	29%	23%	23%	24%	24%	20%	32%	25%	
Manica	Macossa	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Manica	Manica	FY 17	ScaleUp Sat	29%	29%			36%	36%	25%	23%	21%	58%	14%	77%									36%	48%	52%	36%		
Manica	Manica	FY 19 Q1	ScaleUp Agg	10%	11%	29%	25%	21%	24%	16%	19%	14%	31%	13%	49%	30%	57%	32%	51%	32%	38%	30%	32%	30%	29%	41%	38%		
Manica	Manica	FY 20	ScaleUp Agg	50%	51%	4%	61%	39%	36%	45%	42%	30%	124%	17%	42%	92%	29%	8%	23%	6%	27%	8%	37%	9%	8%	62%	50%	40%	
Manica	Mossurize	FY 17	ScaleUp Sat	58%	75%			65%	86%	42%	57%	36%	176%	57%	169%									75%	137%	9%	61%		
Manica	Mossurize	FY 19 Q1	ScaleUp Agg	4%	0%	13%	17%	15%	15%	5%	17%	14%	15%	9%	25%	20%	36%	16%	37%	19%	39%	22%	35%	26%	31%	30%	33%		
Manica	Mossurize	FY 20	ScaleUp Agg	47%	48%	6%	56%	37%	34%	42%	39%	26%	109%	14%	9%	37%	81%	26%	6%	20%	53%	23%	6%	8%	6%	54%	4%	35%	
Manica	Sussundenga	FY 17	ScaleUp Agg	23%	23%			75%	76%	20%	27%	35%	131%	36%	160%									67%	86%	82%	50%		
Manica	Sussundenga	FY 19 Q1	ScaleUp Agg	11%	22%	37%	42%	21%	18%	10%	14%	11%	37%	20%	57%	33%	63%	42%	54%	33%	43%	27%	28%	35%	21%	33%	33%		

Manica	Sussundenga	FY 20	ScaleUp Agg	49%	50%	61%	58%	38%	35%	44%	40%	285%	116%	159%	39%	86%	27%	63%	21%	56%	25%	63%	35%	92%	58%	47%	37%	
Manica	Tambara	FY 17	Sustained	31%	33%			41%	42%	28%	29%	13%	64%	24%	75%									30%	43%	50%	23%	
Manica	Tambara	FY 19 Q1	Central Support	0%	0%	48%	38%	22%	31%	17%	35%	10%	60%	30%	50%	47%	66%	8%	42%	30%	58%	39%	35%	40%	51%	48%	36%	
Manica	Tambara	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Manica	Vanduzi	FY 17	new	60%	75%			50%	62%	38%	41%	5%	85%	19%	107%									47%	68%	85%	43%	
Manica	Vanduzi	FY 19 Q1	ScaleUp Agg	20%	17%	30%	23%	22%	21%	11%	14%	10%	30%	13%	39%	20%	46%	27%	45%	25%	32%	23%	24%	22%	20%	32%	30%	
Manica	Vanduzi	FY 20	ScaleUp Agg	52%	54%	66%	63%	41%	38%	47%	43%	301%	122%	7%	41%	91%	29%	67%	22%	59%	26%	67%	36%	96%	61%	9%	40%	
Maputo Cidade	Maputo City Cluster	FY 17	ScaleUp Sat	34%	37%			74%	81%	191%	205%	107%	129%	35%	127%									92%	136%	91%	73%	
Maputo Cidade	Kamavotora	FY 19 Q1	ScaleUp Sat	75%	150%	276%	302%	344%	379%	07%	454%	322%	266%	0%	326%	168%	303%	236%	370%	235%	345%	5%	264%	207%	210%	227%	222%	
Maputo Cidade	Kamavotora	FY 20	Attained	467%	467%	578%	546%	344%	321%	353%	327%	3258%	1201%	23%	342%	678%	186%	419%	122%	5%	127%	2%	150%	403%	218%	150%	110%	
Maputo Cidade	Kamaxakeni	FY 19 Q1	ScaleUp Sat	64%	57%	114%	131%	142%	192%	195%	226%	175%	158%	81%	141%	80%	136%	130%	177%	139%	192%	0%	152%	121%	126%	152%	155%	
Maputo	Kamaxakeni	FY 20	ScaleUp Sat	214%	214%	268%	256%	160%	151%	166%	153%	1843%	672%	910%	191%	381%	104%	235%	68%	182%	175%	84%	226%	122%	84%	61%		

Nam pular	Meconta	FY 17	Sustained	70%	73%			44%	16%	16%	24%	89%	36%	94%									29%	45%	36%	29%	
Nam pular	Meconta	FY 19 Q1	ScaleUp Agg	46%	64%	66%	70%	53%	91%	34%	53%	7%	41%	15%	59%	23%	63%	28%	72%	28%	52%	32%	50%	28%	38%	46%	36%
Nam pular	Meconta	FY 20	ScaleUp Agg	43%	43%	55%	52%	73%	66%	110%	98%	317%	105%	99%	36%	61%	30%	58%	27%	63%	36%	83%	50%	122%	77%	66%	37%
Nam pular	Mecuburi	FY 17	ScaleUp Agg	141%	115%			49%	39%	26%	20%	35%	163%	67%	133%								50%	56%	48%	27%	
Nam pular	Mecuburi	FY 19 Q1	Sustained	14%	21%	19%	17%	20%	22%	16%	30%	6%	20%	7%	27%	13%	28%	14%	23%	12%	19%	14%	14%	14%	13%	15%	6%
Nam pular	Mecuburi	FY 20	ScaleUp Agg	25%	25%	32%	30%	41%	38%	62%	56%	221%	73%	69%	25%	42%	21%	40%	19%	4%	25%	58%	35%	85%	54%	46%	26%
Nam pular	Memba	FY 17	Sustained	51%	84%			32%	51%	11%	18%	31%	110%	66%	106%								48%	46%	41%	22%	
Nam pular	Memba	FY 19 Q1	Sustained	2%	10%	10%	9%	13%	10%	13%	10%	2%	9%	6%	17%	11%	18%	13%	20%	12%	13%	12%	9%	20%	11%	13%	6%
Nam pular	Memba	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Nam pular	Mogincual	FY 17	Sustained	4%	33%			3%	26%	2%	16%	7%	40%	5%	31%								11%	11%	11%	6%	
Nam pular	Mogincual	FY 19 Q1	Sustained	0%	4%	0%	1%	0%	0%	0%	0%	0%	3%	0%	1%	1%	2%	1%	1%	0%	1%	1%	2%	0%	1%	1%	0%
Nam pular	Mogincual	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Nam pular	Mogovol as	FY 17	Sustained	114%	136%			42%	49%	18%	22%	47%	138%	39%	84%								34%	33%	31%	25%	

Nam pula	Mogovol as	FY 19 Q1	Sustained	56%	88%	34%	53%	30%	37%	20%	30%	9%	43%	16%	47%	20%	48%	29%	48%	25%	36%	25%	25%	31%	24%	34%	25%		
Nam pula	Mogovol as	FY 20	ScaleUp Agg	33%	35%	44%	42%	58%	53%	87%	80%	28%	9%	96%	90%	33%	56%	27%	53%	25%	58%	32%	75%	46%	111%	71%	0%	34%	
Nam pula	Moma	FY 17	ScaleUp Agg	9%	160%			48%	76%	12%	19%	38%	176%	54%	120%									40%	43%	25%	19%		
Nam pula	Moma	FY 19 Q1	ScaleUp Agg	31%	32%	29%	19%	22%	24%	11%	14%	10%	35%	16%	41%	18%	33%	19%	31%	20%	26%	15%	22%	22%	19%	26%	17%		
Nam pula	Moma	FY 20	ScaleUp Agg	31%	31%	38%	36%	50%	46%	75%	68%	27%	9%	92%	87%	32%	53%	26%	50%	24%	56%	31%	73%	44%	10%	7%	68%	58%	33%
Nam pula	Monapo	FY 17	ScaleUp Agg	54%	57%			30%	31%	10%	11%	7%	64%	18%	62%									25%	28%	28%	20%		
Nam pula	Monapo	FY 19 Q1	ScaleUp Agg	17%	23%	20%	21%	22%	18%	18%	21%	9%	15%	7%	19%	10%	24%	13%	24%	15%	20%	15%	18%	19%	13%	21%	14%		
Nam pula	Monapo	FY 20	ScaleUp Agg	26%	27%	33%	31%	43%	40%	6%	60%	23%	2%	77%	72%	26%	45%	22%	42%	20%	6%	26%	0%	37%	9%	57%	8%	27%	
Nam pula	Mossuril	FY 17	Sustained	53%	42%			38%	31%	32%	27%	30%	135%	51%	92%									35%	42%	23%	29%		
Nam pula	Mossuril	FY 19 Q1	Sustained	4%	8%	17%	18%	15%	10%	10%	10%	0%	13%	4%	14%	6%	13%	8%	17%	9%	15%	9%	10%	9%	8%	12%	8%		
Nam pula	Mossuril	FY 20	ScaleUp Agg	17%	17%	22%	20%	9%	26%	43%	39%	14%	3%	47%	44%	16%	27%	13%	26%	12%	28%	16%	37%	23%	54%	35%	30%	17%	
Nam pula	Muecate	FY 17	ScaleUp Agg	34%	50%			33%	46%	18%	24%	32%	130%	56%	98%									38%	36%	28%	31%		
Nam pula	Muecate	FY 19 Q1	ScaleUp Agg	38%	38%	4%	47%	59%	57%	52%	73%	21%	33%	18%	35%	16%	35%	20%	32%	26%	35%	22%	24%	23%	25%	30%	21%		
Nam pula	Muecate	FY 20	ScaleUp Agg	31%	31%	4%	39%	53%	49%	82%	73%	22%	5%	74%	70%	25%	43%	21%	41%	19%	45%	25%	58%	36%	6%	55%	47%	26%	
Nam pula	Murrupula	FY 17	Sustained	33%	62%			30%	53%	14%	25%	41%	162%	60%	112%									34%	39%	41%	21%		

Nam pula	Murrupu la	FY 19 Q1	Sustai ned	10 %	17 %	18 %	26 %	29 %	17 %	5 %	18 %	5 %	18 %	9 %	27 %	13 %	20 %	14 %	21 %	15 %	18 %	15 %	17 %	16 %	13 %	22 %	8%
Nam pula	Murrupu la	FY 20	ScaleU p Agg	23 %	24 %	29 %	28 %	38 %	36 %	59 %	52 %	21 %	69 %	65 %	24 %	40 %	20 %	38 %	18 %	42 %	23 %	55 %	33 %	8 %	51 %	4 %	25 %
Nam pula	Nacala	FY 17	ScaleU p Agg	70 %	79 %			53 %	58 %	34 %	35 %	19 %	99 %	24 %	103 %									39 %	55 %	65 %	44 %
Nam pula	Nacala	FY 19 Q1	ScaleU p Sat	71 %	48 %	9 %	82 %	8 %	90 %	71 %	80 %	13 %	44 %	18 %	74 %	32 %	90 %	57 %	94 %	52 %	79 %	6 %	73 %	74 %	54 %	97 %	47 %
Nam pula	Nacala	FY 20	ScaleU p Agg	56 %	57 %	72 %	69 %	9 %	87 %	14 %	41 %	7 %	138 %	9 %	47 %	8 %	39 %	75 %	36 %	83 %	47 %	10 %	66 %	15 %	102 %	87 %	49 %
Nam pula	Nacala- A-Velha	FY 17	Sustai ned	60 %	132 %			21 %	44 %	6 %	13 %	15 %	70 %	24 %	73 %									25 %	32 %	20 %	12 %
Nam pula	Nacala- A-Velha	FY 19 Q1	Sustai ned	33 %	44 %	37 %	51 %	20 %	40 %	14 %	16 %	4 %	28 %	12 %	43 %	18 %	48 %	24 %	43 %	27 %	36 %	29 %	35 %	4 %	26 %	35 %	20 %
Nam pula	Nacala- A-Velha	FY 20	ScaleU p Agg	39 %	39 %	51 %	47 %	6 %	62 %	10 %	92 %	6 %	105 %	99 %	36 %	61 %	30 %	58 %	27 %	63 %	36 %	83 %	50 %	12 %	78 %	6 %	38 %
Nam pula	Nacaroa	FY 17	Sustai ned	90 %	173 %			48 %	84 %	19 %	34 %	15 %	118 %	180 %										49 %	50 %	54 %	38 %
Nam pula	Nacaroa	FY 19 Q1	Sustai ned	20 %	25 %	22 %	29 %	20 %	25 %	7 %	15 %	7 %	24 %	13 %	26 %	15 %	33 %	17 %	26 %	19 %	21 %	12 %	17 %	12 %	11%	11 %	9%
Nam pula	Nacaroa	FY 20	ScaleU p Agg	25 %	25 %	32 %	30 %	43 %	39 %	63 %	59 %	22 %	75 %	70 %	26 %	43 %	21 %	41 %	19 %	45 %	25 %	59 %	36 %	87 %	55 %	47 %	27 %
Nam pula	Nampula	FY 17	ScaleU p Sat	47 %	67 %			46 %	64 %	37 %	51 %	27 %	96 %	30 %	45 %									42 %	59 %	56 %	51 %
Nam pula	Nampula	FY 19 Q1	ScaleU p Sat	54 %	66 %	111 %	107 %	126 %	141 %	1 %	147 %	32 %	62 %	22 %	106 %	4 %	128 %	75 %	155 %	71 %	129 %	8 %	117 %	11 %	103 %	9 %	94 %
Nam pula	Nampula	FY 20	ScaleU p Agg	80 %	82 %	10 %	96 %	13 %	122 %	20 %	183 %	50 %	165 %	15 %	57 %	9 %	47 %	91 %	43 %	100 %	56 %	13 %	79 %	19 %	122 %	10 %	59 %

Nam pula	Rapale	FY 17	ScaleUp Agg	49%	43%			47%	41%	21%	19%	8%	110%	41%	90%								31%	36%	33%	29%	
Nam pula	Rapale	FY 19 Q1	Sustained	21%	23%	13%	24%	17%	22%	11%	11%	5%	16%	7%	22%	9%	19%	12%	22%	13%	20%	15%	15%	15%	13%	17%	15%
Nam pula	Rapale	FY 20	ScaleUp Agg	28%	28%	36%	34%	47%	43%	71%	65%	255%	84%	80%	29%	49%	24%	46%	22%	51%	29%	67%	40%	98%	63%	53%	30%
Nam pula	Ribaue	FY 17	Sustained	21%	29%			12%	17%	8%	11%	4%	51%	12%	45%								14%	21%	18%	10%	
Nam pula	Ribaue	FY 19 Q1	Sustained	5%	18%	20%	23%	20%	29%	12%	29%	6%	21%	8%	26%	8%	23%	12%	25%	12%	18%	16%	14%	13%	12%	15%	7%
Nam pula	Ribaue	FY 20	ScaleUp Agg	28%	28%	34%	32%	45%	41%	68%	63%	236%	78%	74%	27%	45%	22%	43%	20%	47%	26%	62%	37%	91%	58%	9%	28%
Nias sa	Chimbonila	FY 19 Q1	Central Support	11%	13%	22%	21%	22%	15%	20%	19%	17%	24%	16%	37%	25%	41%	37%	41%	35%	32%	29%	27%	35%	22%	37%	25%
Nias sa	Chimbonila	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Nias sa	Cuamba	FY 17	ScaleUp Agg	16%	13%			22%	18%	15%	15%	4%	32%	8%	48%								18%	32%	36%	24%	
Nias sa	Cuamba	FY 19 Q1	ScaleUp Agg	12%	5%	33%	37%	22%	29%	26%	25%	14%	33%	17%	66%	25%	68%	39%	71%	42%	57%	36%	53%	47%	45%	50%	42%
Nias sa	Cuamba	FY 20	ScaleUp Agg	38%	39%	9%	46%	4%	41%	0%	55%	2%	100%	0%	35%	4%	27%	77%	23%	72%	28%	82%	41%	111%	69%	55%	47%
Nias sa	Lago	FY 17	Sustained	24%	24%			42%	39%	6%	35%	15%	34%	19%	65%								30%	41%	33%	21%	
Nias sa	Lago	FY 19 Q1	Sustained	5%	5%	17%	13%	14%	27%	19%	13%	21%	16%	13%	25%	13%	35%	35%	42%	22%	19%	24%	16%	26%	16%	21%	22%

Nias sa	Lago	FY 20	ScaleUp Agg	22%	23%	28%	27%	26%	24%	34%	32%	188%	55%	88%	19%	52%	15%	42%	13%	40%	16%	45%	23%	61%	38%	30%	26%
Nias sa	Lichinga	FY 17	ScaleUp Sat	26%	28%			52%	53%	55%	56%	25%	54%	17%	82%									43%	65%	0%	72%
Nias sa	Lichinga	FY 17	Sustained	24%	24%			39%	40%	44%	43%	27%	83%	34%	112%									49%	71%	65%	30%
Nias sa	Lichinga	FY 19 Q1	ScaleUp Sat	58%	96%	74%	90%	118%	136%	211%	165%	104%	122%	67%	195%	120%	252%	918%	261%	918%	234%	159%	191%	204%	172%	211%	197%
Nias sa	Lichinga	FY 20	Attained	95%	100%	126%	120%	115%	106%	156%	143%	1187%	348%	3%	120%	794%	266%	80%	250%	98%	285%	141%	384%	239%	0%	163%	
Nias sa	Majune	FY 17	Sustained	27%	38%			39%	54%	39%	53%	14%	71%	20%	81%									32%	51%	38%	23%
Nias sa	Majune	FY 19 Q1	Central Support	5%	9%	12%	15%	12%	11%	13%	9%	16%	9%	26%	13%	28%	20%	28%	19%	22%	16%	18%	19%	15%	20%	17%	
Nias sa	Majune	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Nias sa	Mandimba	FY 17	Sustained	6%	10%			9%	16%	6%	19%	5%	17%	4%	27%									9%	16%	11%	10%
Nias sa	Mandimba	FY 19 Q1	Sustained	0%	4%	23%	18%	22%	15%	11%	26%	6%	30%	16%	41%	18%	49%	22%	45%	27%	30%	21%	27%	23%	18%	30%	29%
Nias sa	Mandimba	FY 20	ScaleUp Agg	31%	31%	40%	38%	37%	34%	94%	45%	272%	80%	7%	28%	75%	22%	61%	18%	57%	23%	633%	88%	55%	4%	37%	
Nias sa	Marrupa	FY 17	Sustained	5%	9%			8%	15%	9%	16%	4%	35%	6%	43%									9%	24%	11%	12%
Nias sa	Marrupa	FY 19 Q1	Sustained	0%	6%	14%	14%	13%	15%	6%	10%	0%	25%	3%	34%	14%	28%	14%	25%	10%	22%	7%	16%	13%	5%	13%	8%
Nias sa	Marrupa	FY 20	Central	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Nias sa	Metarica	FY 17	Sustained	3%	12%			5%	21%	5%	22%	14%	62%	21%	80%								33%	44%	4%	26%		
Nias sa	Metarica	FY 19 Q1	Central Support	9%	12%	19%	21%	18%	15%	17%	19%	15%	23%	14%	36%	21%	39%	31%	39%	29%	31%	25%	26%	29%	21%	31%	24%	
Nias sa	Metarica	FY 20	ScaleUp Agg	33%	33%	46%	44%	43%	41%	0%	53%	308%	90%	14%	31%	4%	24%	6%	9%	20%	65%	25%	74%	37%	98%	61%	49%	42%
Nias sa	Muembe	FY 17	Sustained	34%	30%			58%	53%	61%	52%	10%	50%	16%	71%								27%	42%	32%	21%		
Nias sa	Muembe	FY 19 Q1	Central Support	7%	10%	16%	17%	16%	12%	15%	15%	12%	19%	12%	29%	18%	32%	27%	33%	25%	25%	21%	21%	25%	17%	27%	20%	
Nias sa	Muembe	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Nias sa	Ngauma	FY 17	Sustained	8%	7%			15%	12%	16%	13%	7%	28%	11%	37%								15%	23%	19%	11%		
Nias sa	Ngauma	FY 19 Q1	Sustained	7%	9%	16%	16%	15%	11%	14%	14%	12%	17%	11%	27%	17%	30%	26%	30%	24%	23%	20%	19%	24%	16%	26%	18%	
Nias sa	Ngauma	FY 20	ScaleUp Agg	21%	22%	27%	26%	24%	23%	34%	31%	5%	51%	82%	18%	48%	14%	39%	12%	37%	15%	42%	21%	57%	35%	28%	24%	
Nias sa	Nipepe	FY 17	Sustained	9%	10%			18%	21%	18%	19%	12%	53%	20%	62%								26%	34%	36%	19%		
Nias sa	Nipepe	FY 19 Q1	Central Support	0%	53%	20%	6%	3%	6%	3%	8%	13%	39%	17%	38%	20%	35%	25%	32%	26%	20%	13%	18%	5%	5%	11%	6%	
Nias sa	Nipepe	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Nias sa	Sanga	FY 17	Sustained	18%	14%			33%	26%	32%	26%	10%	43%	15%	59%								24%	37%	31%	18%		

Nias sa	Sanga	FY 19 Q1	Sustained	5%	6%	11%	11%	11%	8%	10%	10%	8%	12%	8%	18%	12%	20%	18%	20%	17%	16%	14%	13%	17%	11%	18%	12%	
Nias sa	Sanga	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Sofala	Beira	FY 19 Q1	ScaleUp Agg	24%	25%	38%	43%	36%	43%	36%	41%	25%	31%	22%	61%	30%	70%	47%	78%	4%	63%	47%	56%	52%	47%	75%	48%	
Sofala	Beira	FY 20	ScaleUp Agg	61%	62%	77%	73%	57%	53%	63%	58%	37%	9%	138%	2%	49%	7%	37%	87%	30%	82%	36%	97%	50%	9%	81%	71%	45%
Sofala	Buzi	FY 17	ScaleUp Agg	18%	24%			56%	72%	28%	43%	19%	105%	32%	141%									41%	80%	42%	28%	
Sofala	Buzi	FY 19 Q1	ScaleUp Agg	10%	6%	27%	23%	23%	36%	14%	24%	7%	25%	11%	46%	23%	43%	21%	41%	21%	30%	21%	25%	25%	20%	26%	17%	
Sofala	Buzi	FY 20	ScaleUp Agg	4%	48%	59%	56%	4%	40%	4%	44%	27%	0%	98%	13%	35%	76%	26%	62%	22%	59%	26%	9%	36%	9%	57%	51%	32%
Sofala	Caia	FY 17	Attained	25%	26%			4%	48%	4%	37%	20%	91%	31%	125%									32%	68%	4%	36%	
Sofala	Caia	FY 19 Q1	Sustained	17%	16%	33%	56%	20%	27%	19%	32%	17%	38%	15%	57%	21%	52%	25%	49%	25%	45%	22%	39%	29%	28%	36%	33%	
Sofala	Caia	FY 20	ScaleUp Agg	51%	53%	65%	62%	4%	45%	54%	49%	30%	4%	110%	14%	39%	6%	30%	9%	24%	6%	29%	77%	40%	2%	65%	57%	36%
Sofala	Chemba	FY 17	Sustained	25%	35%			4%	68%	52%	60%	11%	70%	17%	93%									19%	67%	28%	27%	
Sofala	Chemba	FY 19 Q1	Sustained	8%	13%	13%	25%	11%	15%	10%	16%	7%	17%	7%	29%	10%	30%	13%	32%	13%	26%	13%	22%	14%	18%	20%	18%	
Sofala	Chemba	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	

Sofala	Cheringoma	FY 17	Sustained	39%	121%			74%	206%	75%	174%	66%	275%	67%	285%								80%	156%	135%	136%	
Sofala	Cheringoma	FY 19 Q1	Sustained	0%	22%	12%	61%	32%	41%	17%	11%	13%	49%	18%	55%	17%	46%	24%	44%	18%	36%	13%	23%	20%	21%	31%	21%
Sofala	Cheringoma	FY 20	ScaleUp Agg	45%	45%	55%	53%	41%	37%	45%	41%	256%	93%	12%	33%	72%	25%	58%	20%	55%	24%	65%	34%	94%	54%	48%	30%
Sofala	Chibabava	FY 17	ScaleUp Sat	22%	27%			39%	45%	40%	37%	21%	86%	29%	96%								25%	73%	42%	27%	
Sofala	Chibabava	FY 19 Q1	Sustained	22%	13%	37%	27%	19%	33%	22%	18%	12%	43%	16%	50%	20%	51%	24%	55%	24%	45%	23%	38%	31%	26%	25%	14%
Sofala	Chibabava	FY 20	ScaleUp Agg	47%	48%	59%	56%	43%	40%	48%	44%	272%	99%	131%	35%	77%	27%	62%	22%	59%	26%	9%	36%	10%	58%	51%	32%
Sofala	Cidade Da Beira	FY 17	ScaleUp Sat	20%	47%			29%	65%	36%	44%	19%	42%	15%	53%								25%	33%	48%	32%	
Sofala	Dondo	FY 17	ScaleUp Agg	41%	42%			73%	72%	55%	43%	28%	120%	29%	154%								56%	87%	67%	62%	
Sofala	Dondo	FY 19 Q1	ScaleUp Agg	36%	55%	48%	67%	46%	42%	26%	32%	19%	47%	30%	87%	42%	85%	45%	75%	40%	59%	37%	45%	42%	42%	4%	40%
Sofala	Dondo	FY 20	ScaleUp Agg	62%	63%	78%	74%	58%	53%	4%	58%	358%	130%	17%	46%	101%	35%	82%	29%	78%	34%	91%	47%	131%	76%	67%	42%
Sofala	Gorongosa	FY 17	Attained	25%	36%			46%	65%	48%	56%	27%	82%	35%	103%								42%	61%	65%	37%	
Sofala	Gorongosa	FY 19 Q1	Sustained	11%	20%	12%	19%	17%	13%	17%	17%	11%	26%	9%	33%	14%	30%	17%	28%	18%	27%	16%	19%	14%	15%	24%	15%
Sofala	Gorongosa	FY 20	ScaleUp Agg	35%	36%	43%	41%	32%	30%	36%	32%	209%	76%	10%	27%	59%	20%	48%	17%	45%	20%	53%	28%	76%	44%	39%	25%
Sofala	Machangana	FY 17	Attained	59%	80%			103%	147%	80%	91%	19%	90%	31%	130%								38%	107%	46%	32%	

Sofala	Machanga	FY 19 Q1	Sustained	0%	18%	33%	37%	22%	37%	25%	32%	10%	26%	4%	40%	14%	39%	21%	46%	26%	44%	25%	41%	23%	25%	31%	22%
Sofala	Machanga	FY 20	ScaleUp Agg	22%	23%	30%	29%	22%	21%	25%	22%	135%	49%	65%	17%	38%	13%	31%	11%	29%	13%	35%	18%	50%	29%	26%	16%
Sofala	Maringue	FY 17	Sustained	16%	8%			34%	15%	38%	15%	24%	54%	40%	73%								34%	50%	56%	23%	
Sofala	Maringue	FY 19 Q1	Sustained	5%	6%	8%	11%	7%	7%	6%	7%	4%	7%	4%	12%	6%	13%	8%	13%	8%	11%	8%	9%	9%	8%	12%	8%
Sofala	Maringue	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Sofala	Marromeu	FY 17	ScaleUp Sat	32%	31%			61%	54%	61%	46%	23%	94%	28%	115%								36%	61%	52%	52%	
Sofala	Marromeu	FY 19 Q1	Sustained	15%	56%	26%	41%	8%	14%	11%	13%	6%	33%	9%	56%	18%	44%	19%	38%	19%	25%	18%	24%	22%	20%	23%	14%
Sofala	Marromeu	FY 20	ScaleUp Agg	41%	42%	51%	48%	38%	35%	42%	38%	24%	88%	117%	31%	9%	24%	56%	19%	53%	23%	62%	32%	9%	52%	6%	29%
Sofala	Muanza	FY 17	Sustained	45%	63%			92%	113%	94%	92%	48%	175%	56%	172%								70%	89%	111%	112%	
Sofala	Muanza	FY 19 Q1	Central Support	10%	15%	15%	28%	13%	17%	12%	18%	8%	19%	8%	33%	12%	34%	16%	35%	16%	29%	15%	24%	17%	20%	24%	20%
Sofala	Muanza	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Sofala	Nhamatanda	FY 17	ScaleUp Sat	22%	30%			35%	47%	24%	28%	19%	71%	25%	104%								36%	63%	40%	33%	
Sofala	Nhamatanda	FY 19 Q1	ScaleUp Agg	20%	20%	31%	34%	23%	33%	18%	23%	10%	28%	11%	51%	20%	52%	27%	54%	26%	44%	23%	34%	23%	32%	38%	35%

Sofala	Nhamatanda	FY 20	ScaleUp Agg	48%	49%	61%	58%	45%	42%	50%	46%	285%	104%	137%	37%	80%	28%	65%	23%	62%	27%	73%	38%	105%	61%	54%	34%
Tete	Angonia	FY 17	Sustained	7%	9%			22%	26%	24%	51%	41%	52%	29%	56%									51%	79%	61%	53%
Tete	Angonia	FY 19 Q1	ScaleUp Agg	0%	0%	15%	15%	10%	9%	11%	18%	11%	17%	16%	30%	20%	38%	31%	44%	26%	40%	26%	37%	25%	29%	26%	33%
Tete	Angonia	FY 20	ScaleUp Agg	42%	43%	55%	51%	31%	29%	32%	29%	179%	92%	141%	40%	94%	28%	8%	21%	52%	21%	9%	25%	57%	39%	25%	25%
Tete	Cahora Bassa	FY 17	Sustained	8%	7%			42%	38%	4%	42%	35%	120%	37%	157%									68%	80%	55%	42%
Tete	Cahora Bassa	FY 19 Q1	Sustained	0%	14%	27%	50%	40%	38%	41%	42%	34%	96%	39%	170%	98%	149%	110%	155%	98%	94%	63%	68%	61%	49%	58%	53%
Tete	Cahora Bassa	FY 20	ScaleUp Agg	61%	61%	80%	76%	46%	42%	47%	42%	300%	154%	237%	66%	157%	47%	114%	35%	88%	36%	82%	43%	96%	65%	43%	42%
Tete	Changara	FY 17	ScaleUp Agg	17%	16%			64%	56%	27%	41%	36%	190%	80%	210%									74%	79%	36%	45%
Tete	Changara	FY 19 Q1	Sustained	51%	27%	61%	62%	52%	64%	26%	24%	33%	107%	90%	214%	113%	179%	128%	139%	117%	92%	6%	65%	61%	46%	45%	67%
Tete	Changara	FY 20	ScaleUp Agg	69%	73%	92%	87%	53%	48%	53%	49%	312%	160%	246%	69%	163%	49%	118%	36%	91%	37%	85%	44%	100%	67%	4%	44%
Tete	Chifunde	FY 17	Sustained	12%	11%			59%	52%	56%	61%	67%	172%	68%	185%									108%	112%	98%	69%
Tete	Chifunde	FY 19 Q1	Sustained	6%	4%	13%	17%	12%	8%	9%	9%	11%	18%	15%	37%	26%	37%	35%	36%	30%	25%	22%	17%	19%	13%	19%	15%
Tete	Chifunde	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Tete	Chiuta	FY 17	Attained	13%	18%			32%	42%	27%	44%	30%	117%	63%	172%									57%	83%	43%	19%

Tete	Chiuta	FY 19 Q1	Sustained	0%	0%	18%	35%	23%	4%	19%	24%	15%	38%	26%	77%	35%	53%	39%	51%	39%	49%	32%	32%	19%	18%	24%	23%		
Tete	Chiuta	FY 20	ScaleUp Agg	33%	33%	45%	43%	26%	23%	27%	25%	14%	76%	11%	33%	77%	23%	56%	17%	4%	4%	17%	41%	21%	4%	8%	32%	21%	21%
Tete	Doa	FY 17	new	0%	0%			7%	13%	5%	13%	3%	33%	11%	42%									18%	27%	16%	9%		
Tete	Doa	FY 19 Q1	Sustained	0%	0%	14%	7%	7%	14%	3%	5%	3%	20%	10%	24%	17%	33%	19%	30%	16%	25%	13%	14%	11%	10%	11%	13%		
Tete	Doa	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Tete	Macanga	FY 17	Sustained	10%	10%			56%	56%	52%	62%	61%	148%	66%	189%									10%	5%	107%	8%	9%	58%
Tete	Macanga	FY 19 Q1	Sustained	0%	10%	18%	18%	14%	20%	6%	9%	14%	12%	13%	42%	29%	40%	45%	38%	28%	25%	27%	15%	19%	10%	16%	17%		
Tete	Macanga	FY 20	ScaleUp Agg	33%	33%	4%	37%	22%	21%	23%	21%	12%	64%	99%	28%	6%	20%	4%	15%	37%	15%	34%	18%	4%	0%	27%	18%	18%	
Tete	Magoe	FY 17	Sustained	6%	6%			38%	35%	26%	27%	35%	73%	24%	76%									4%	9%	51%	38%	23%	
Tete	Magoe	FY 19 Q1	Sustained	9%	10%	34%	38%	33%	36%	33%	26%	27%	68%	32%	87%	6%	71%	75%	91%	9%	74%	53%	45%	4%	0%	30%	42%	41%	
Tete	Magoe	FY 20	ScaleUp Agg	6%	64%	81%	77%	4%	43%	4%	43%	27%	139%	5%	60%	14%	43%	10%	31%	0%	32%	74%	39%	87%	59%	39%	38%		
Tete	Marara	FY 17	new	11%	9%			56%	46%	48%	47%	40%	101%	48%	135%									6%	8%	78%	61%	36%	
Tete	Marara	FY 19 Q1	Sustained	0%	0%	15%	42%	31%	21%	6%	14%	10%	37%	17%	62%	61%	41%	39%	70%	57%	40%	37%	32%	28%	32%	25%	32%		

Tete	Marara	FY 20	ScaleUp Agg	36%	36%	47%	44%	27%	25%	28%	25%	151%	77%	9%	34%	80%	24%	57%	17%	44%	18%	41%	21%	49%	33%	21%	21%
Tete	Maravia	FY 17	Sustained	5%	6%			30%	32%	29%	37%	29%	84%	35%	109%								49%	55%	42%	31%	
Tete	Maravia	FY 19 Q1	Sustained	0%	19%	10%	24%	17%	8%	17%	11%	0%	33%	5%	44%	14%	53%	38%	41%	34%	30%	45%	21%	23%	26%	22%	22%
Tete	Maravia	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Tete	Moatize	FY 17	ScaleUp Sat	7%	11%			33%	55%	44%	51%	46%	100%	44%	171%								70%	100%	66%	53%	
Tete	Moatize	FY 19 Q1	ScaleUp Sat	32%	12%	59%	64%	40%	48%	34%	37%	44%	76%	47%	180%	94%	201%	135%	166%	99%	120%	87%	80%	78%	71%	72%	78%
Tete	Moatize	FY 20	ScaleUp Agg	76%	78%	99%	94%	57%	52%	58%	53%	43%	223%	2%	96%	22%	69%	5%	50%	7%	52%	9%	62%	9%	94%	62%	61%
Tete	Mutarara	FY 17	ScaleUp Agg	4%	3%			31%	26%	20%	18%	18%	50%	19%	98%								31%	49%	37%	20%	
Tete	Mutarara	FY 19 Q1	Sustained	13%	0%	44%	37%	29%	17%	22%	21%	17%	27%	18%	88%	37%	71%	54%	67%	52%	65%	42%	42%	18%	29%	43%	30%
Tete	Mutarara	FY 20	ScaleUp Agg	47%	47%	60%	57%	34%	31%	34%	32%	191%	97%	0%	42%	10%	30%	73%	22%	56%	23%	52%	27%	61%	41%	27%	27%
Tete	Tete	FY 17	ScaleUp Sat	7%	8%			40%	44%	36%	39%	47%	93%	30%	126%								60%	73%	9%	42%	
Tete	Tete	FY 19 Q1	ScaleUp Sat	62%	52%	97%	127%	93%	95%	4%	87%	88%	167%	4%	365%	9%	389%	6%	396%	24%	263%	8%	168%	7%	130%	6%	137%
Tete	Tete	FY 20	ScaleUp Sat	114%	114%	143%	133%	81%	74%	83%	75%	987%	502%	773%	217%	515%	155%	373%	114%	288%	117%	8%	140%	315%	213%	9%	137%

Tete	Tsangan o	FY 17	Sustained	7%	5%			36%	27%	30%	27%	53%	127%	62%	172%								94%	99%	80%	46%		
Tete	Tsangan o	FY 19 Q1	Sustained	5%	4%	11%	19%	10%	8%	8%	10%	9%	20%	12%	41%	22%	41%	30%	40%	26%	28%	19%	19%	16%	15%	16%	16%	
Tete	Tsangan o	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Tete	Zumbu	FY 17	Sustained	11%	19%			62%	95%	59%	115%	82%	180%	94%	235%									126%	124%	133%	72%	
Tete	Zumbu	FY 19 Q1	Sustained	4%	3%	9%	12%	8%	5%	6%	6%	7%	13%	10%	26%	17%	26%	22%	26%	19%	18%	14%	12%	12%	9%	12%	11%	
Tete	Zumbu	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Zambézia	Alto Molocue	FY 17	ScaleUp Agg	25%	34%			28%	40%	14%	19%	15%	54%	16%	73%									27%	41%	46%	23%	
Zambézia	Alto Molocue	FY 19 Q1	ScaleUp Agg	10%	12%	17%	23%	15%	19%	8%	16%	7%	17%	13%	31%	18%	32%	18%	28%	15%	21%	15%	17%	15%	16%	19%	16%	
Zambézia	Alto Molocue	FY 20	ScaleUp Agg	26%	27%	33%	31%	28%	26%	39%	35%	221%	64%	92%	21%	50%	16%	4%	14%	39%	18%	48%	28%	72%	48%	39%	31%	
Zambézia	Chinde	FY 17	ScaleUp Agg	27%	37%			16%	22%	5%	7%	5%	39%	16%	34%									14%	20%	21%	10%	
Zambézia	Chinde	FY 19 Q1	Sustained	18%	15%	43%	49%	27%	30%	13%	15%	9%	32%	27%	42%	22%	44%	23%	42%	22%	29%	19%	27%	18%	20%	31%	22%	
Zambézia	Chinde	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Zam bézi a	Derre	FY 17	new	0%	23%			0%	29%	0%	3%	5%	52%	22%	55%								16%	19%	17%	8%	
Zam bézi a	Derre	FY 19 Q1	ScaleUp Agg	7%	12%	3%	9%	2%	3%	1%	1%	9%	8%	12%	4%	8%	6%	7%	4%	6%	4%	4%	5%	2%	3%	3%	
Zam bézi a	Derre	FY 20	ScaleUp Agg	21%	22%	27%	26%	23%	21%	32%	29%	18%	54%	77%	17%	42%	13%	34%	12%	33%	15%	4%	23%	61%	40%	33%	26%
Zam bézi a	Gile	FY 17	ScaleUp Agg	26%	32%			27%	33%	6%	8%	12%	100%	31%	99%								23%	29%	32%	20%	
Zam bézi a	Gile	FY 19 Q1	ScaleUp Agg	32%	36%	47%	39%	18%	24%	9%	15%	9%	51%	35%	61%	32%	44%	28%	32%	24%	24%	21%	21%	22%	21%	9%	25%
Zam bézi a	Gile	FY 20	ScaleUp Agg	41%	42%	51%	49%	43%	40%	0%	55%	7%	97%	0%	31%	76%	24%	61%	21%	0%	28%	73%	42%	0%	73%	59%	47%
Zam bézi a	Gurue	FY 17	Sustained	50%	53%			28%	30%	19%	20%	19%	83%	23%	85%								33%	44%	47%	24%	
Zam bézi a	Gurue	FY 19 Q1	ScaleUp Agg	5%	6%	8%	12%	14%	18%	17%	17%	12%	18%	14%	30%	20%	33%	21%	32%	23%	27%	18%	22%	22%	17%	26%	17%
Zam bézi a	Gurue	FY 20	ScaleUp Agg	30%	31%	37%	36%	31%	29%	4%	40%	7%	77%	0%	25%	0%	19%	8%	17%	47%	22%	58%	33%	87%	57%	47%	37%
Zam bézi a	Ile	FY 17	Sustained	22%	36%			23%	38%	13%	20%	11%	46%	17%	69%								28%	47%	43%	20%	
Zam bézi a	Ile	FY 19 Q1	ScaleUp Agg	25%	33%	29%	33%	16%	25%	11%	13%	5%	25%	18%	42%	16%	41%	26%	38%	20%	31%	23%	24%	23%	25%	23%	16%
Zam bézi a	Ile	FY 20	ScaleUp Agg	32%	33%	4%	38%	33%	31%	47%	43%	26%	76%	0%	25%	0%	19%	8%	17%	47%	22%	57%	33%	87%	57%	47%	37%
Zam bézi a	Inhassunge	FY 17	ScaleUp Agg	41%	52%			36%	46%	20%	26%	15%	42%	27%	68%								30%	57%	30%	22%	

Zam bézi a	Inhassunge	FY 19 Q1	ScaleUp Agg	27%	40%	48%	49%	33%	39%	33%	35%	22%	36%	40%	60%	43%	63%	46%	75%	35%	60%	33%	59%	32%	50%	45%	50%
Zam bézi a	Inhassunge	FY 20	ScaleUp Agg	51%	52%	64%	61%	53%	50%	75%	68%	429%	123%	177%	40%	97%	30%	78%	27%	76%	35%	93%	53%	140%	92%	75%	60%
Zam bézi a	Luabo	FY 17	new	23%	8%			30%	10%	5%	2%	13%	51%	35%	44%								18%	21%	25%	9%	
Zam bézi a	Luabo	FY 19 Q1	Sustained	4%	15%	18%	13%	9%	10%	4%	9%	6%	16%	13%	22%	15%	17%	12%	19%	12%	10%	9%	11%	9%	6%	13%	7%
Zam bézi a	Luabo	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Zam bézi a	Lugela	FY 17	Sustained	150%	145%			12%	11%	7%	6%	8%	74%	18%	59%								19%	31%	30%	16%	
Zam bézi a	Lugela	FY 19 Q1	Sustained	31%	41%	36%	34%	19%	25%	8%	15%	6%	40%	22%	62%	22%	46%	29%	49%	22%	35%	21%	23%	23%	24%	23%	24%
Zam bézi a	Lugela	FY 20	ScaleUp Agg	36%	36%	45%	43%	38%	35%	53%	49%	305%	88%	127%	28%	9%	22%	56%	19%	54%	25%	6%	38%	10%	66%	54%	43%
Zam bézi a	Maganja Da Costa	FY 17	ScaleUp Agg	48%	44%			32%	30%	13%	13%	10%	55%	22%	69%								23%	50%	35%	23%	
Zam bézi a	Maganja Da Costa	FY 19 Q1	ScaleUp Agg	35%	46%	42%	46%	25%	36%	15%	20%	8%	31%	32%	58%	30%	62%	34%	75%	25%	67%	25%	52%	28%	43%	36%	36%
Zam bézi a	Maganja Da Costa	FY 20	ScaleUp Agg	49%	50%	61%	58%	51%	47%	72%	66%	425%	122%	176%	39%	96%	30%	77%	26%	75%	35%	92%	53%	139%	91%	75%	60%
Zam bézi a	Milange	FY 17	ScaleUp Sat	14%	22%			24%	36%	16%	25%	13%	50%	15%	69%								29%	46%	51%	24%	
Zam bézi a	Milange	FY 19 Q1	ScaleUp Agg	15%	28%	44%	51%	35%	49%	33%	46%	20%	46%	35%	78%	45%	84%	57%	89%	59%	72%	55%	61%	62%	54%	71%	59%

Zam bézi a	Milange	FY 20	ScaleUp Agg	54%	56%	68%	64%	57%	53%	79%	73%	48%	6%	140%	20%	45%	110%	34%	88%	30%	86%	40%	105%	60%	158%	104%	85%	68%	
Zam bézi a	Mocuba	FY 17	ScaleUp Sat	20%	30%			25%	37%	15%	22%	15%	78%	27%	88%										28%	42%	55%	31%	
Zam bézi a	Mocuba	FY 19 Q1	ScaleUp Agg	29%	44%	41%	49%	38%	43%	22%	38%	19%	59%	36%	95%	48%	82%	49%	73%	42%	55%	40%	51%	40%	40%	41%	58%	50%	
Zam bézi a	Mocuba	FY 20	ScaleUp Agg	52%	53%	66%	63%	55%	51%	77%	71%	46%	3%	133%	2%	43%	5%	33%	4%	29%	82%	38%	10%	58%	15%	100%	82%	65%	
Zam bézi a	Mocubela	FY 17	new	44%	48%			25%	27%	4%	8%	23%	124%	43%	106%										29%	43%	42%	34%	
Zam bézi a	Mocubela	FY 19 Q1	ScaleUp Agg	20%	18%	56%	52%	21%	34%	11%	12%	28%	77%	63%	104%	54%	76%	50%	77%	41%	59%	40%	57%	45%	38%	0%	65%		
Zam bézi a	Mocubela	FY 20	ScaleUp Agg	48%	49%	61%	58%	51%	47%	71%	65%	47%	8%	137%	8%	44%	10%	8%	34%	87%	30%	85%	39%	10%	59%	6%	103%	4%	67%
Zam bézi a	Molumbo	FY 17	new	66%	48%			33%	23%	13%	9%	12%	74%	20%	73%										30%	37%	4%	20%	
Zam bézi a	Molumbo	FY 19 Q1	ScaleUp Agg	12%	8%	14%	13%	7%	12%	5%	8%	10%	16%	15%	20%	14%	19%	17%	18%	16%	17%	13%	12%	10%	8%	13%	7%		
Zam bézi a	Molumbo	FY 20	ScaleUp Agg	33%	33%	41%	39%	34%	32%	4%	44%	28%	3%	81%	117%	26%	6%	4%	20%	51%	18%	50%	23%	61%	35%	92%	61%	50%	40%
Zam bézi a	Mopeia	FY 17	ScaleUp Agg	25%	18%			22%	16%	16%	11%	7%	71%	25%	70%										21%	28%	24%	15%	
Zam bézi a	Mopeia	FY 19 Q1	Sustained	22%	22%	26%	19%	15%	15%	13%	9%	14%	37%	22%	43%	22%	33%	23%	33%	18%	26%	18%	22%	21%	15%	23%	15%		
Zam bézi a	Mopeia	FY 20	ScaleUp Agg	28%	29%	37%	34%	30%	28%	43%	39%	25%	5%	73%	5%	24%	57%	18%	6%	16%	45%	21%	55%	32%	83%	55%	45%	36%	

Zam bézi a	Morrum bala	FY 17	ScaleUp Agg	23%	34%			20%	30%	16%	21%	15%	58%	27%	57%								26%	38%	40%	18%		
Zam bézi a	Morrum bala	FY 19 Q1	ScaleUp Agg	15%	33%	27%	38%	28%	29%	23%	29%	16%	52%	39%	51%	33%	53%	35%	61%	36%	52%	37%	47%	36%	32%	47%	32%	
Zam bézi a	Morrum bala	FY 20	ScaleUp Agg	30%	31%	38%	36%	31%	29%	4%	41%	26%	76%	10%	24%	59%	19%	4%	16%	47%	22%	57%	33%	8%	6%	57%	4%	37%
Zam bézi a	Mulevala	FY 17	new	8%	8%			20%	20%	7%	9%	12%	31%	15%	44%								23%	24%	26%	16%		
Zam bézi a	Mulevala	FY 19 Q1	ScaleUp Agg	12%	19%	14%	13%	6%	9%	4%	4%	2%	19%	11%	27%	14%	16%	11%	14%	12%	13%	11%	13%	13%	7%	11%	9%	
Zam bézi a	Mulevala	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Zam bézi a	Namacurra	FY 17	ScaleUp Agg	33%	47%			34%	46%	14%	20%	12%	75%	31%	87%								24%	50%	38%	27%		
Zam bézi a	Namacurra	FY 19 Q1	ScaleUp Agg	59%	73%	62%	68%	40%	48%	29%	35%	24%	75%	53%	102%	51%	84%	42%	92%	35%	73%	33%	62%	43%	48%	9%	58%	
Zam bézi a	Namacurra	FY 20	ScaleUp Agg	57%	58%	73%	69%	61%	56%	85%	78%	4%	139%	20%	45%	9%	34%	8%	30%	6%	40%	5%	60%	15%	8%	104%	85%	68%
Zam bézi a	Namarro i	FY 17	Sustained	18%	253%			20%	28%	5%	7%	30%	145%	45%	113%								38%	46%	58%	23%		
Zam bézi a	Namarro i	FY 19 Q1	Sustained	0%	0%	8%	21%	21%	10%	10%	3%	8%	14%	12%	19%	15%	21%	22%	19%	24%	23%	23%	17%	20%	12%	20%	5%	
Zam bézi a	Namarro i	FY 20	Central Support	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Zam bézi a	Nicoadal a	FY 17	ScaleUp Agg	31%	37%			22%	26%	13%	16%	17%	103%	30%	85%								21%	30%	27%	19%		

Zam bézi a	Nicoadala	FY 19 Q1	ScaleUp Agg	23%	25%	36%	39%	21%	28%	18%	25%	12%	59%	33%	73%	31%	49%	29%	48%	24%	36%	20%	31%	22%	27%	31%	28%
Zam bézi a	Nicoadala	FY 20	ScaleUp Agg	46%	47%	59%	56%	49%	45%	8%	63%	398%	114%	165%	37%	9%	28%	72%	25%	70%	33%	6%	49%	13%	86%	70%	56%
Zam bézi a	Pebane	FY 17	ScaleUp Agg	20%	32%			27%	43%	10%	16%	12%	86%	37%	105%									29%	35%	41%	33%
Zam bézi a	Pebane	FY 19 Q1	ScaleUp Sat	51%	81%	63%	71%	42%	59%	18%	30%	22%	86%	67%	118%	55%	83%	58%	80%	53%	58%	47%	56%	6%	47%	73%	76%
Zam bézi a	Pebane	FY 20	ScaleUp Agg	56%	58%	72%	68%	6%	56%	4%	77%	49%	141%	203%	46%	111%	35%	9%	30%	87%	40%	6%	61%	16%	105%	6%	69%
Zam bézi a	Quelimane	FY 17	ScaleUp Agg	22%	29%			28%	36%	24%	31%	17%	72%	31%	86%									34%	50%	63%	42%
Zam bézi a	Quelimane	FY 17	ScaleUp Agg	22%	29%			28%	36%	24%	31%	17%	72%	31%	86%									34%	50%	63%	42%
Zam bézi a	Quelimane	FY 19 Q1	ScaleUp Sat	50%	57%	8%	104%	8%	111%	4%	106%	65%	123%	108%	181%	11%	174%	13%	187%	10%	151%	4%	139%	11%	121%	17%	157%
Zam bézi a	Quelimane	FY 20	ScaleUp Sat	8%	82%	10%	97%	85%	79%	9%	110%	95%	274%	394%	88%	21%	68%	17%	59%	16%	78%	6%	118%	31%	205%	16%	134%

*In FY17, was not possible to report all age/sex bands; Maputo City was treated as a cluster

*Age/sex bands were imputed for sites without EPST

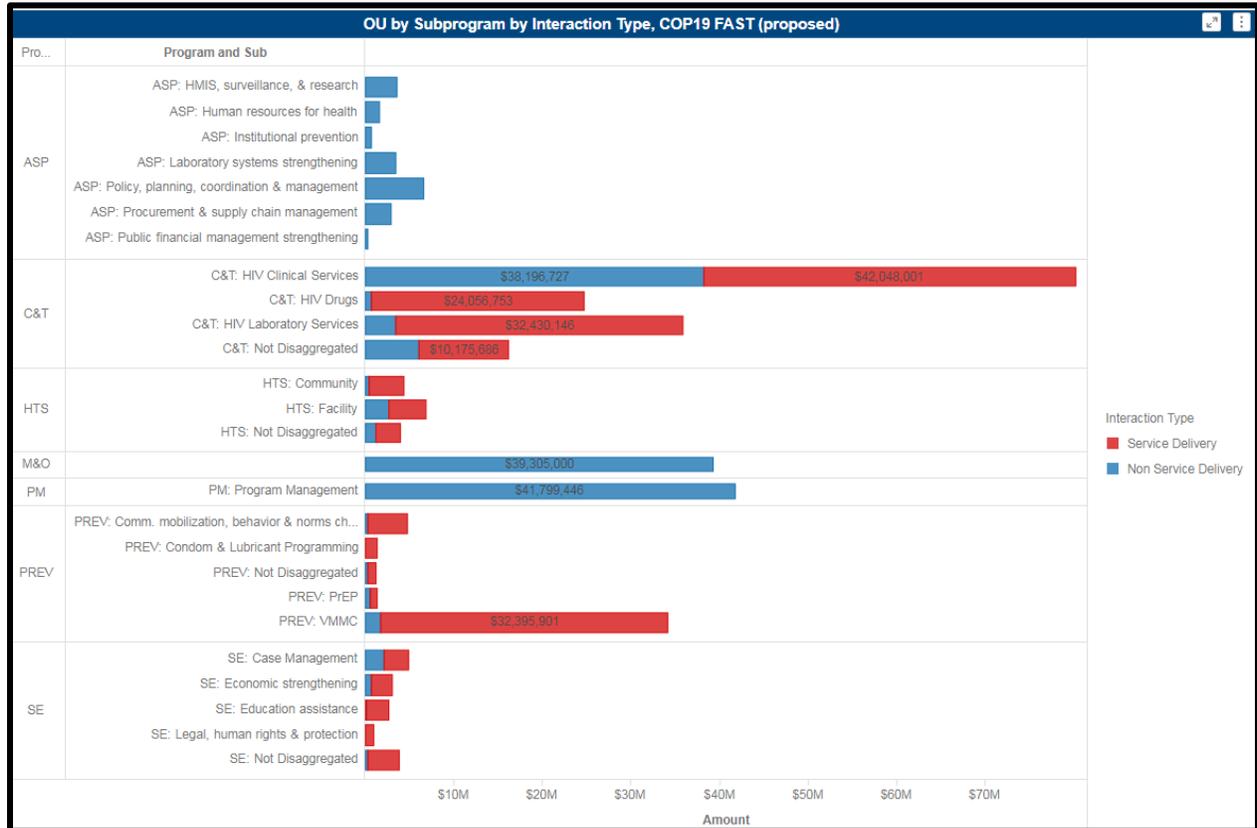
Table A.2: ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART	Additional patients required for 80% ART coverage	Target current on ART	Newly initiated (APR FY20)	ART Coverage (APR 20)
_Military Mozambique		14,516		20,039	5,781	
Attained	29,110	67,043	0	107,835	41,178	370%
Scale-Up Saturation	62,259	99,235	0	159,410	60,749	256%
Scale-Up Aggressive	1,966,885	965,166	0	1,505,066	548,202	77%
Sustained						
Central Support	161,894	34624	--	38883	4456	24%
Commodities (if not included in previous categories)	--					
Total	2,220,148	1,180,584	0	1,831,233	660,366	82%

APPENDIX B - Budget Profile and Resource Projections

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area, generated by the FAST tool



Initiative Type	Fiscal Year	2020
	Funding Agency	Amount
Planning Level	DOD	\$8,413,785
	HHS/CDC	\$151,904,897
	HHS/HRSA	\$2,450,000
	PC	\$3,221,063
	State	\$2,026,027
	State/AF	\$773,000
	USAID	\$161,160,095
Total		\$329,948,867

Fiscal Year	2020
Budget Code	Amount
CIRC	\$27,151,076
HBHC	\$25,192,115
HKID	\$13,596,486
HLAB	\$2,579,623
HMBL	\$ 0
HMIN	\$1,218,136
HTXD	\$26,271,484
HTXS	\$92,131,580
HVAB	\$2,976,597
HVCT	\$9,298,562
HVMS	\$22,304,473
HVOP	\$10,516,371
HVSI	\$5,212,496
HVTB	\$9,027,351
IDUP	\$ 0
MTCT	\$5,767,119
OHSS	\$6,013,255
PDCS	\$12,095,739
PDTX	\$10,876,150

B.2 Resource Projections

FAST tool development was an iterative and interagency process. The \$84 million budget decrease from COP18 required a re-thinking of priority investments and approaches. The operating unit (OU) decided to maintain level funding for Peace Corps, State Department, and DoD, so USAID and CDC engaged intensively with budget and program staff to identify more cost-efficient approaches to achieving results. The team used costed IP work plans and expenditure reporting

(ER) data to identify key cost and expenditure drivers. Significant cuts were made to non-earmarked areas, including HTS, HSS, lab, blood safety, and SI/Surveillance. Both agencies identified line items within management and operations (M&O) where savings will be achieved, despite anticipated increased costs due to the move into the NEC in 2020.

In consultation with GRM, USG identified key areas where clinical partners could transition responsibility to host government entities, typically at the provincial level. For example, for central support sites in-service training for public sector health providers, mentoring, and supervision will be wholly funded through G2G cooperative agreements. This shift resulted in increased funding for Provincial Health Directorates in COP19, a reduction in clinical partner budgets, and anticipated cost savings because host government agencies have lower program management and operating costs. Intensified site prioritization, dropping from 1,300 sites in COP18 to 628 in COP19 also yielded cost efficiencies.

APPENDIX C – Tables and Systems Investments for Section 6.o

Table 6-E (Entry of Above Site Programs Activities)								
Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	JHPIEGO CORPORATION	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	Institutionalization of in-service training	Lack of adequate and well trained staff.	COP 16	COP 20	50% of in-service training are distance learning, 25% are mixed in-person practicum at workplace and distance learning and 25% are in-person training
HHS/CDC	JHPIEGO CORPORATION	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Lack of adequate and well trained staff.	COP 16	COP 19	HRH data routinely available to partners and used in MOH program reports (production of annual HRH statistical compendium)
USAID	TBD	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Local organization (G2G, LINGO, civil society) capacity building for program sustainability.	COP 16	COP 21	90% of planned trainings and supervision visits conducted
HHS/CDC	Association of Public Health Laboratories, Inc. (THE)	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Critical lab systems essential for scaling up quality VL, EID and/or TB testing.	COP 17	COP 21	≥ 80% of district hubs with DISA link installed
HHS/HRSA	UNIVERSITY OF WASHINGTON	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	Institutionalization of in-service training	Lack of adequate and well trained staff.	COP 16	COP 19	2000

HHS/CDC	TBD	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 17	COP 20	50% of in-service training are distance learning, 25% are mixed in-person practicum at workplace and distance learning and 25% are in-person training
HHS/CDC	TBD	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 17	COP 20	HRH data routinely available to partners and used in MOH program reports (production of annual HRH statistical compendium)
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	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.	COP 16	COP 21	4
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	Training in supply chain systems	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.	COP 19	COP 19	5
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	More real-time logistics data availability and visibility required for appropriate management of commodities and quality forecasting and quantification with multi-	COP 16	COP 21	12

					month scripting and 90-90-90 program growth.			
USAID	TBD	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	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.	COP 18	COP 20	9
USAID	CONSELHO NACIONAL DE COMBATE AO HIV E SIDA	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 19	COP 20	30 districts
USAID	TBD	ASP: Policy, planning, coordination & management	OVC & care givers: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 19	COP 20	2 per prioritized provinces (5)
USAID	TBD	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 19	COP 21	2
HHS/CDC	TBD	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Critical lab systems essential for scaling up quality VL, EID and/or TB testing.	COP 16	COP 21	16 labs with DISA lab installed, EPTS - DISA connectivity established, more than 70% of district hubs with DISA link installed.
HHS/CDC	American Society For Microbiology	ASP: Laboratory	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Lack of adequate and well trained staff.	COP 17	COP 21	≥90 % lab staff achieving passing scores on competency tests, ≥90% labs achieving ≥ 4 stars on V/EIDL

		systems strengthening						scorecard, >90% achieving passing scores on PT.
HHS/CDC	American Society For Microbiology	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	Training in laboratory systems strengthening	Lack of adequate and well trained staff.	COP 17	COP 20	Xpert step down training conducted in 80% of provinces, greater than 55% utilization of Gene Xpert equipment achieved.
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Lack of adequate and well trained staff.	COP 16	COP 20	80% of labs received site visits and technical support visits.
HHS/CDC	TBD	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Critical lab systems essential for scaling up quality VL, EID and/or TB testing.	COP 16	COP 20	100% of VI/EID and 40% TB Xpert lab supervised at least once a year, M&E systems implemented in 100% of labs, inefficient sample referral, instrument distribution and utilization.
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Low coverage of EQA and CQI programs to guarantee quality HIV related testing.	COP 16	COP 21	100% VL/EID labs participating in PT programs; PT program for DBS and plasma samples, all PT programs for TB smear microscopy decentralized, PT programs for EID POC initiated in 2 provinces, electronic PT program management software implemented in 2 provinces.
HHS/CDC	AMERICAN SOCIETY OF CLINICAL PATHOLOGY	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	Lab accreditation	Critical lab systems essential for scaling up quality VL, EID and/or TB testing.	COP 16	COP 21	4 reference labs accredited, >80% of provincial and VL labs with at least > 3 star on SLMTA checklist.
HHS/CDC	American Society For Microbiology	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Low coverage of EQA and CQI programs to guarantee quality HIV related testing.	COP 17	COP 21	70% of PEPFAR supported HIV testing sites enrolled in PT programs and 95% of testing sites achieving passing scores in most recent EQA panel, RT CQI decentralized and implemented by the district.

HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	Lab accreditation	Critical lab systems essential for scaling up quality VL, EID and/or TB testing.	COP 17	COP 21	70% of HIV testers certified according to MOH revised HIV RT quality improvement guidelines, decentralization of SLMTA program in 7 provinces.
HHS/CDC	PROVINCIAL HEALTH DIRECTORATE ZAMBEZIA	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 16	COP 21	90% of planned trainings and supervision visits conducted.
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Critical lab systems essential for scaling up quality VL, EID and/or TB testing	COP 16	COP 21	90% of sites with well-established standardized referral system, using standardized assessment tool
HHS/CDC	PROVINCIAL HEALTH DIRECTORATE INHAMBANE	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 16	COP 21	90% of planned trainings and supervision visits conducted
HHS/CDC	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 18	COP 19	Provinces actively using GOALS and HIV Situation Room to set annual targets
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Ongoing need for timely and accurate surveillance data to inform national HIV response planning and tracking progress towards epidemic control	COP 18	COP 21	10

USAID	Management Systems International, Inc.	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Lack of adequate and well trained staff	COP 19	COP 21	Host-government conducts ongoing routine DQA with assistance (2 TA support staff). Data quality results are satisfactory at 85% of sites.
HHS/CDC	TBD	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 19	COP 21	2
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 18	COP 21	12
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Ongoing need for timely and accurate surveillance data to inform national HIV response planning and tracking progress towards epidemic control.	COP 18	COP 21	12
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Lack of adequate and well trained staff.	COP 19	COP 21	1
HHS/CDC	JEMBI HEALTH SYSTEMS	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient Data Use for monitoring retention of HIV positive patients.	COP 19	COP 21	2 EPTS requirements documents completed as certified.
HHS/CDC	JEMBI HEALTH SYSTEMS	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient Data Use for monitoring retention of HIV positive patients.	COP 19	COP 21	5 requirements documents completed as certified.
HHS/CDC	JEMBI HEALTH SYSTEMS	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient Data Use for monitoring retention of HIV positive patients.	COP 19	COP 21	100 support requests acted upon for closure of service delivery.
HHS/CDC	JEMBI HEALTH SYSTEMS	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Lack of adequate and well trained informatics staff.	COP 19	COP 21	6 informatics staff supporting MISAU HIV/TB program initiatives.

HHS/CDC	Vanderbilt University Medical Center	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient Data Use for monitoring retention of HIV positive patients.	COP 19	COP 21	5 EPTS requirements documents tested and certified.
HHS/CDC	Vanderbilt University Medical Center	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient Data Use for monitoring retention of HIV positive patients.	COP 19	COP 21	137 iDART systems deployed.
HHS/CDC	Vanderbilt University Medical Center	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient Data Use for monitoring retention of HIV positive patients.	COP 19	COP 21	345 lab/EPTS linkages & 84 pharmacy/EPTS linkages.
HHS/CDC	Vanderbilt University Medical Center	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient Data Use for monitoring retention of HIV positive patients.	COP 19	COP 21	5 requirements documents completed as certified.
HHS/CDC	FUNDACAO ARIEL CONTRA A SIDA PEDIATRICA	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Ensure quality of HIV testing program.	COP 19	COP 21	2500
HHS/CDC	JEMBI HEALTH SYSTEMS	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient Data Use for monitoring retention of HIV positive patients.	COP 19	COP 21	3 Provincial Hubs
USAID	Management Sciences For Health, Inc.	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Ongoing need for timely and accurate surveillance data to inform national HIV response planning and tracking progress towards epidemic control.	COP 19	COP 20	65%
HHS/CDC	JEMBI HEALTH SYSTEMS	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	HMIS systems	Insufficient Data Use for monitoring retention of HIV positive patients.	COP 19	COP 20	10 reports
USAID	TBD	ASP: Public financial management strengthening	Non-Targeted Pop: Not disaggregated	Training in public financial management strengthening	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 19	COP 21	2

USAID	TBD	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 19	COP 21	80%
HHS/CDC	UNICEF	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Children	Program and data quality management	Ongoing need for timely and accurate surveillance data to inform national HIV response planning and tracking progress towards epidemic control.	COP 18	COP 19	Results finalized and disseminated.
HHS/CDC	PROVINCIAL DIRECTORA TE OF HEALTH OF GAZA	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 16	COP 21	90% of planned trainings and supervision visits conducted.
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Surveillance	Ongoing need for timely and accurate surveillance data to inform national HIV response planning and tracking progress towards epidemic control.	COP 18	COP 19	Implementation and dissemination of results completed.
HHS/CDC	Vanderbilt University Medical Center	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate and poor distribution of staff.	COP 19	COP 21	100% of AJUDA sites visited to supervise site level HRH allocation.
HHS/CDC	National Alliance of State	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	Training in coordination and management of health systems	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 16	COP 18	Closeout and dissemination of results.
HHS/CDC	FUNDACION PRIVADA INSTITUTO DE SALUD	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	Program and data quality management	Ongoing need for timely and accurate surveillance data to inform national HIV response planning and	COP 16	COP 18	Closeout and dissemination of results.

	GLOBAL BARCELONA				tracking progress towards epidemic control.			
HHS/CDC	Direccao Provincial de Saude de Cabo Delgado	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Local organization (G2G, LNGO, civil society) capacity building for program sustainability.	COP 16	COP 21	90% of planned trainings and supervision visits conducted

APPENDIX D– Minimum Program Requirements

Mozambique specific minimum requirements for COP19 have all been met and are outlined below. Of note, detailed explanations of how these requirements will be achieved are discussed throughout the SDS document. The high level summary is listed below with explanations on areas that require more details on operationalizing meeting the minimum requirements outlined by the Office of the Global AIDS Coordinator (OGAC).

Minimum requirement #1: Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups

Mozambique has adopted a national Test and Start policy and has achieved full scale up of this policy as of December 2018.

Minimum requirement #2: Adoption and implementation of DSD including six- month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents

The National HIV program guidelines have developed an aggressive DSD plan that is already underway with specific national targets for achievement. This national DSD plan includes the following: national target: 30 percent of patients on any DSD model by March 2019 and 50 percent of patients on any DSD model by December 2019. To implement this policy, there were regional trainings held in December 2018 and HF trainings from December 2018 to March 2019. These trainings and plan include the following DSD models: six month scripting (Fluxo Rapido); three month drug distribution; family health approach; adherence clubs; and community ART distribution through mobile brigades.

In order to achieve a transition from 3 MDD to 6 MDD, PEPFAR has procured 90 pill bottles for ARVs and PEPFAR has created an aggressive 3MDD scale up plan which includes achieving implementation of an electronic pharmacy system at all phase 1 AJUDA sites by September 2019 coupled with learning exchanges between high performing partner CCS for 3MDD in Maputo City to enhance implementation of a standard approach of 3MDD at all phase 1 AJUDA sites. Furthermore, monthly monitoring of 3MDD for all phase 1 AJUDA sites has already begun and will be monitored jointly with MISAU to ensure scale up and 3MDD implementation with high quality. COP 18 will continue to scale 3MDD scale up at PEPFAR supported sites as well as ensure the AJUDA approach to ensure patients eligible for 3MDD are enrolled at the site level. COP 19 will include even further scale up of 3MDD at high volume sites with TX CURR >1000 with inclusion of electronic pharmacy system as well as interoperability between EPTS with electronic pharmacy system. 6MDD will also be implemented in COP 19 with joint operational planning with GRM and will ensure inclusion criteria such as site level space for drug storage, commodities availability and electronic pharmacy implementation at high impact sites will begin in COP 19.

Minimum requirement #3: Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens.

The GRM has adopted an aggressive TLD transition plan which includes removal of Nevirapine-based regimens during COP 18 and a three-phased scale up for TLD for the wider population of PLHIV in Mozambique.

Phase	Start Date	Criteria	Adult Men	PBW & Women of Reproductive Age	Post-Menopausal Women	Children >20kg
Phase 1	Mar/April 2019	NVP-based regimens	X	X	X	
		Other complex regimens	X	X	X	
		TB co-infected	X	X	X	
		PEP	X	X	X	X
		Pediatrics				X
Phase 2	Aug 2019	New ART initiates	X		X	
		Grade 3/4 adverse reactions	X	X	X	
		TLE-based regimens	X		X	
Phase 3	Nov 2019	TLE-based regimens		X		
		New ART initiates		X		

Minimum requirement #4: Scale up of index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence is established.

While sites are still struggling with high numbers of HIV patients lost to follow-up, facility-based HIV testing in those sites will be “passive” in nature. This includes provider-initiated testing using national screening algorithms, as well as support for client-initiated, in accordance with nationally-approved guidelines. Community-based “active” case finding surrounding these sites will be limited to index case contact tracing and targeted key populations outreach testing. However, once sites have adequately remediated systems to ensure high retention rates, they will transition to more aggressive testing in order to meet ambitious treatment targets. High-yield testing modalities such as index case testing will be aggressively scaled up in sites meeting retention thresholds.

Minimum Requirement #5: TB preventative treatment for all PLHIV must be scaled- up as an integral and routine part of the HIV clinical care package

TPT performance will be more closely monitored starting in COP 18. Weekly site level data has already shown improvements with increased focus on initiation and completion of TPT for eligible HIV positive patients. During COP18 and COP19, a TPT Taskforce will be established between the HIV and NTP programs with a scale up plan on how to improve TPT. Of note, GRM has recently

adopted a policy change whereby 3 month drug distribution of TPT will be available and implemented at health facilities implementing 3 month drug distribution of ARVs. This policy change will allow for further scale up of initiation and completion of stable HIV patients which is a population that has been identified with high eligibility rates for TPT. Weekly data review through the AJUDA approach including direct technical assistance with implementing partners and health facility staff will have prioritization on TPT initiation and completion.

Minimum Requirement #6: Direct and immediate (>95) linkage of clients from testing to treatment across age, sex and risk groups

Linkage has been steadily improving in Mozambique over the past six quarters, and is expected to continue increasing during COP19. Additional efforts as discussed in Section 4.1 are particularly needed for men who have lagged behind in linkage. All implementing partners engaged in facility or community-based HIV testing have received specific technical guidance on programmatic shifts required to improve linkage. These shifts will be reflected in revised COP18 and COP19 work plans, and include: reallocation of lay counselors for stronger tracking and follow-up of newly diagnosed positives through use of new national HIV testing and linkage registers, improved counseling protocols to reduce retesting among previously diagnosed positives and to improve de-duplication of reporting, as well as reductions in aggressive community-based testing targets. Linkage targets have been set at 95% or higher for all age, sex and risk groups for the remainder of COP18 and COP19.

Minimum Requirement #7: Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention

User fees do not apply to Mozambique

Minimum Requirement #8: Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80% access to annual viral load testing and reporting.

The VL/EID optimization activities in COP19 will take in consideration the national and regional demand for tests, the national laboratory network capacity, availability of POC and near-POC instruments, regional sample transportation systems, forecasting and distribution of reagents and consumables, availability, training, and supervision of staff, and the need for renovating or building infrastructure. The optimization will include the development of national plans for dealing with emergency situations, in which testing surges in some laboratories might occur due to equipment breakdown or natural disasters that might disable other facilities, in order to minimize backlogs and ensure that turnaround time of results are met. Moreover, the timely uptake of reliable results by health care professionals is the utmost importance for the program, in order to guide clinical decisions of patients on ART. Therefore, the VL and EID processes from test requests to results return will also be closely monitored and optimized on an ongoing basis.

A laboratory network and its supporting systems take years to build and require constant adjustments in order to maintain and improve efficiency. As new testing technologies emerge and instruments age, there is also a need to plan for replacing obsolete or low performing instruments with new platforms that will be able to handle the increasing demand of tests. In COP19, PEPFAR will use LIS coupled with GIS to propose, monitor, evaluate, and guide a well-balanced distribution of high and low throughput instruments. Results from the global RFP for VL and EID reagents, which Mozambique is part of, will guide decisions for placing potentially new testing platforms in health facilities (POC or near-POC) and laboratories (high throughput instruments) to meet national program and PEPFAR targets.

Minimum Requirement #9: Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity

PEPFAR Mozambique must work with HQ inter-agency subject matter experts to ensure tracking of TX_ML indicator per guidance.

Interagency SI and Program held many meetings with clinical and HIS partners to (1) clarify TX_ML MER reporting expectations, (2) discuss primary source availability and challenges for reporting, and (3) create requirements documentation, query definitions, and parameters for TX_ML reporting via EPTS – OpenMRS. Report was generated and pre-post tested to ensure accuracy. Main reporting challenges concern two areas: (1) primary source for reporting reason for defaulting and (2) cause of death. For reporting in Q2FY19, two main sources were identified – infoMovel mobile data capture reporting system and *cartao de buscas*, the primary paper-based form completed during defaulter tracing activities. A form for the latter was digitized in EPTS and partners reported using either one of these sources. Interagency consensus on primary source was reached following end of Q2 reporting period, and moving forward all partners will use the *cartao de busca* approach. Cause of death reporting limitation is mainly linked to Mozambique not having a viable death registry. PEPFAR is actively engaged in developing joint analytic plan for HIV-related mortality through triangulation of existing data sources in country (National Health Observatory (NHO) HIV Platform and Mortality Platform).

Minimum Requirement #10: Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management

Given ongoing issues with retention for children and adolescents, OVC program will be used to enhance pediatric and adolescent retention

In COP19, the PEPFAR Mozambique proposes a two-tiered service package for orphans and vulnerable children based on their HIV status and other key risks related to HIV. A combination of intensive case management and primary prevention services will allow for more intensive services

to be available for the most at-risk children and adolescents, while still providing quality prevention-focused services to an important subpopulation of youth; creating greater efficiencies and ensuring the right services are provided to the right OVC, at the right time.

Intensive case management activities will be used to support HIV prevention and/or retention support for OVC under age 18 that are HIV positive, sexual violence survivors, children of vulnerable HIV positive parents/caregivers, double orphans, children heads of household, children of KP, (or a combination of the above). This more intensive case management approach will use personalized care plans to ensure OVC are healthy, stable, educated and protected.

A key priority for OVC Partners will be improving the coverage of retention and adherence support activities for all eligible children and adolescents on ART. This will be accomplished through the close coordination with clinical and community IPs, starting with those AJUDA sites with poor pediatric retention.

The main entry points for OVC selection and enrollment in case management will be the health facilities (both adults and pediatric ART clinics, TB sector, CCR/sick child), PMTCT sites, community based platforms (both HIV and non-HIV specific) and GBV services. To support retention, children who are HIV positive and/or caregivers will receive additional adherence and retention counseling, accompaniment and monitoring of frequency of HF visits, and support addressing HIV-related stressors such as stigma, isolation and family support, and early childhood social and cognitive stimulation for CLHIV under 5 years of age.

Children ages 9-14 residing within AJUDA site catchment areas who do not fall in the categories listed above, but are out of school and hard to reach, will be eligible for primary sexual violence and HIV prevention services through systematic and tracked education sessions using evidence based curriculums such as *Go Girls!* and *Go Families!*, *Sinovuyo* and *Coaching Boys into Men*. Main entry points for this package of OVC services will be community platforms, in coordination with community school councils, community child protection committees, and community home visitors.

Minimum Requirement #11: Evidence of resource commitments by host governments with year after year increases

GRM investments towards health have increased substantially over the last year, with the state budget for health reaching its highest nominal amount ever (\$438 million) in 2018. The Government is also the main provider of health care and HIV care and treatment services, the bulk of which is provided through public health facilities staffed by civil servants. Mozambique is cognizant of its reliance on external support for the HIV response, and in 2019, the Government, through the Ministry of Finance, committed to invest \$10 million towards antiretroviral drugs and HIV commodities.

Minimum requirement #12: Evidence of agency progress towards local organizations partner prime funding

Local Mozambican NGOs including CSOs and FBOs have been contributing to the fight against HIV/AIDS since the inception of PEPFAR. Working with local organizations is essential to the PEPFAR Mozambique's program and a key element of our sustainability and self-reliance strategy. Currently approximately 14 percent of the PEPFAR investments in the country are through direct local partners and Mozambican government entities as prime partners. This proportion will rise to 16 percent by the end of COP19. Organizational capacity assessments, financial oversight and assuring transparency and accountability of PEPFAR resources that are channeled through the local partners and Mozambican government entities will remain a focus area during COP19 implementation.

For COP19, CDC has proposed a modest increase in the total funding available to G2G Partners and will continue direct agreements with MISAU and Instituto Nacional de Saúde to support policy development, clinical and laboratory services, infrastructure, reference laboratories, surveillance and population-based surveys. In addition, CDC will also continue direct agreements for financial and technical support to six high-burden Provinces and planning for direct support to Maputo City will be initiated. To ensure technical and financial integrity of all resources allocated to G2G, CDC has designated a team to work closely with the partners to enhance financial systems for improved tracking of expenditures and monitoring of program outcomes.

The majority of USAID's current funding to local organizations is through sub-recipient relationships with international organizations, which are prime partners. During COP18 and continuing into COP19, USAID will work towards increasing direct funding to local organizations as prime recipients of this funding. However, USAID will do this in a measured manner, taking into account Mozambique's contextual realities such as the absorptive capacity of local partners and the cultural acceptance of fraud, waste, and abuse specifically in local procurement and implementation (workshops, per diem abuse, etc.). In COP19, USAID will have up to 10 (ten) local partner awards including two new government-to-government (G2G) awards with provincial government (Niassa) and the Ministry of Gender, Children and Social Action (MGCAS). USAID will have three new service delivery awards targeting the Orphans and Vulnerable Children, pediatric adherence and retention, and behavior change and communication to reduce stigma and discrimination utilizing faith based leaders.

While a relatively small level of resources, Department of State PEPFAR Community Grants program will provide funding opportunities in COP19 to CSOs testing unique and innovative approaches in HIV programming, including prevention, retention and adherence.

Minimum requirement #13: Unique identifier scale up across all sites

Mozambique has an existing National health ID (NID) that is re-used to support PLHIV initiatives. MISAU introduced the NID in January 2018 and is an official, sixteen-digit client code generated at

the health facility level defined by country, province, district, facility, service, fiscal, and patient code combinations. Although unique at the time of its issuance, an individual could have multiple NIDs due to subsequent entry into an existing health facility (e.g., patient lost NID) or other health care facilities. PEPFAR's EPTS, with its scale to almost 90 percent of supported sites, captures the NID as its primary ID with options for multiple entry of other unique IDs (e.g., NUIT). Other PEPFAR supported systems, including laboratory, pharmacy, and community care also capture the NID and linking these data sources with the EPTS and POC will continue in COP19. Beginning in December 2018, Mozambique passed legislation for the electronic registration of a NUIC used for the civil registration of births and deaths and production of its official vital statistics. To date, over 200,000 births are electronically registered using the NUIC; with scale primarily situated in the Maputo Province area. Beginning in March 2019, PEPFAR HISS introduced the capability for electronically capturing the NUIC, as well. For COP19, PEPFAR will collaborate with MISAU, GFATM, and other partners to advance National IT architecture/centralization policies that improve the interoperability of health information systems using unique IDs and essential data, electronic exchange, and security standards. Expected investment benefits for scale include: facility-community tracking and reduction of silent transfers; authentication of patient-level records and elimination of duplicates; timely exchange and storage of information at varying levels of the National health information system (e.g., DHIS); and, the generation of new information derived from systems linkages for improved HIV/TB program management, case-based surveillance, and policy-making.

Minimum requirement Other: All VL test results should be in charts and available to patients.

Ensuring VL results are in patient charts and being used by providers to discuss the importance of adherence with patients is a key priority for COP18 and COP19. A VL results return weekly taskforce has been implemented to have weekly management meetings to assess progress on the progress of the VL life cycle which was presented at the Regional Planning meeting in Johannesburg. A VL results return tracker is being used to assess each phase of this life cycle from the time the VL test is ordered to the patient's understanding of the VL result. Monitoring of the VL cascade including VL test consumption will be reviewed quarterly to assess progress. Leads responsible for each VL life cycle problem intervention have been identified with an established accountability framework to ensure all steps in the VL life cycle are being managed towards ensuring the VL results are in the patient charts coupled with a focus on VL education sessions between providers and patients to ensure retention in care and adherence. The community aspect of utilizing VL demand creation materials including U=U (I=I in Portuguese) are scaled with a widespread understanding of the importance of undetectable VL = untransmissible. These education documents will be scaled across communities with poor VL suppression and high LTFU.

APPENDIX E: COP18 reboot

PEPFAR Mozambique's COP18 reboot is primarily focused in two technical areas: HIV testing services and retention. Per the COP18 PEPFAR PLL, the HIV testing portfolio needed to refocus its efforts and human resources to better support retention efforts. This included a reduction in the identification of new clients until issues surrounding retention are adequately addressed. The following provides a description of how PEPFAR Mozambique has addressed these two critical areas.

HIV Testing Services

Beginning in Q3FY19, PEPFAR Mozambique shifted all HIV testing implementation to ensure:

- Immediate alignment with COP19 PLL guidance;
- Immediate redirection of all PEPFAR-funded counselors to prioritize retention efforts;
- Revised COP18 and COP19 targets with minimum 10 percent adult yield from all testing modalities, excluding ANC²² and VMMC; and
- Revised COP18 and COP19 targets with minimum 31 percent adult yield from all index case contact testing (ICCT) modalities.

PEPFAR Mozambique worked closely with the MISAU's National HIV Program to prepare for a smooth roll-out of these changes, in alignment with national guidelines and priorities. Accelerated implementation of the following new national guidelines was a crucial part of this COP18 and COP19 HIV testing reboot:

1. **New Differentiated HIV Service Models**, which contains updated policies and standard operating procedures related to the use of national HIV testing screening tools for adults, adolescents and children; guidelines for enhanced post-test counseling and linkage; and guidelines for scale-up of efficient community and facility-based ICCT;
2. **New National HIV Testing and Linkage Registers**, which will improve de-duplication of known HIV positives persons who seek HIV testing, document KP testing in all health facilities and modalities, improve reporting of ICCT in all health facilities; improve detection and tracking of eligible index case contacts for testing; and improve systems for ensuring linkage into care and treatment and for documenting transfers of newly enrolled ART patients to other health facilities; and
3. **New Psychosocial Support Package**, which provides clearer operational guidelines as well as new supervision and mentoring tools for MISAU and IP-supported staff involved in

²² ANC, and ANC male partner testing, which have steady yields of approximately 4 percent.

pre-and post-ART initiation counseling, as well as retention support and lost-to-follow-up activities at the HF and community-level.

PEPFAR Mozambique developed and disseminated a country-specific *Technical Update on Integrated HIV Testing, Linkage and Retention* to explain these COP18 HIV testing shifts. This document, which was vetted by HIV testing IPs and approved by MISAU, provided specific guidance on how PEPFAR-supported implementing partners should immediately modify testing approaches to focus increased effort and resources to support linkage and retention, through the remainder of COP18. These changes will extend throughout COP19 implementation.

Immediate Actions & Technical Guidance for Testing for Q2-Q4 of COP18 and Continued in COP19:

1. All PEPFAR-supported personnel responsible for coordinating HIV testing at health facility or community-levels will convene an emergency planning meeting, led by an appropriately designated MISAU staff member (e.g. Clinical Director), involving all relevant supervisory staff covering HIV testing and care & treatment areas. The purpose of this initial planning meeting should be to review the status of implementation of the national guidelines referenced above, and to explore how to best leverage available PEPFAR-supported personnel (health providers, HIV testing counselors, and other lay workers based at the health facility and/or the community-level) to better support counseling and follow-up for improved linkage and retention. Specific high-priority improvements to be considered during this consultation include:
 - a. Support the implementation through the provision of technical assistance for the use of the HTC new registers; including mentorship on use of new tools and modified operating procedures/client flow to accommodate the new approaches.
 - b. Improved quality of group education, and pre- and post-test counseling; including screening for eligible contacts for index case testing, disclosure counseling, ART treatment literacy, and pre-initiation ART counseling for newly diagnosed positives.
 - c. Improved monitoring and follow-up of linkage into treatment; including use of available national registers to improve detection and de-duplication of retesting positives, improve documentation of patient contact-information , as well as supporting consented phone-based and/or home-based follow-up for those not yet linked into care. Specific testing modalities where additional linkage efforts are clearly needed include VMMC and blood bank.
 - d. Improved quality and consistency of regular ART treatment counseling; including enhanced mentoring, coaching and monitoring of health providers, and improved coordination between health providers and facility and community-based lay counselors to better identify and address barriers to retention at the individual and family-level.

- e. Improved focalization of HIV testing, in order to focus testing resources on the most high-risk and symptomatic individuals, including enhanced mentoring, coaching and monitoring of health providers for more consistent use of the nationally-recognized screening tools for adults, adolescents and children in some testing modalities, with the exception of those modalities indicated for universal testing, as described below.
 - f. Improved integration of community-based index case testing and community-based retention support activities, including cross-training of lay counselors to conduct home visits using available nationally-recognized guidance and tools.
 - g. Improved involvement of community leaders in providing social support for index case contact testing, disclosure of HIV status, linkage, and retention activities.
2. All PEPFAR-supported personnel responsible for coordinating HIV testing will develop clear action plans for these improvements. These plans should align with and supplement existing retention improvement action plans developed by the clinical care and treatment teams, support the implementation of the national guidelines referenced above, and guide the prioritization of all PEPFAR-supported counselors and lay workers active at the health facility and community-level. Specific technical objectives for these action plans should be determined at the site-level, but should aim to address the priority improvements listed above.
 3. Effective immediately, all PEPFAR-supported personnel responsible for coordinating HIV testing should fully participate in ongoing planning meetings organized by care & treatment teams at the district and health facility-levels (e.g., ART Committee Meeting), and should provide regular updates regarding implementation and results of the testing-specific shifts and action plans, and should also ensure that the HIV testing consumption reports are submitted on time.
 4. As part of the development and implementation of the testing-specific action plans, all PEPFAR-supported personnel responsible for coordinating HIV testing at the health facility or community-levels should undertake some form of “productivity assessments” of existing PEPFAR-supported lay counselors to determine the best way to leverage and/or re-allocate these human resources towards the efforts described above.

Approved Testing Modalities for PEPFAR-support During Q3-Q4 of COP18 & Continued in COP19:

1. **PICT:** PEPFAR-supported PICT should continue, but should be highly “focalized” using nationally-approved screening tools, as per the DSD guidelines, to prioritize symptomatic and high-risk individuals. This will require consistent use of these screening tools (not universal testing) for all clients attending “Triagem”, “Banco de Socorros”, “Consultas Externas”, “Consulta de Criança Sadia”, and for all VMMC clients (in PEPFAR language: Emergency, Other PITC & VMMC). As per national MOH guidelines, PEPFAR-supported PICT will continue to support universal HIV testing in “Servicos de SMI” for pregnant women and their male partners,

“Enfermaria”, “Banco de Sangue”, & “TB” (in PEPFAR language: PMTCT/ANC, Inpatient, & TB. Please note that for PEPFAR reporting, male partner testing from MCH will be reported as “Other PITC”.)

2. **CICT/VCT:** PEPFAR-supported VCT should continue in a “passive” manner, and referrals to VCT from the health facility and community-level should be “focalized”, in accordance with nationally-approved screening tools, as per the DSD guidelines. There should be no generic demand creation or referrals for testing without adequate screening, and frequency of testing should follow national guidelines. All PEPFAR-supported VCT counsellors should be instructed to enhance linkage and retention activities, as per the action plans outlined in the technical guidance above.
3. **ICCT:** In coordination with the National TB Program, facility and community-based HIV and TB ICCT will continue in COP18 for AJUDA Phase I high-volume health facility catchment areas. PEPFAR-supported implementing partners should expand community-based index case testing to ensure full coverage in these areas, starting October 1, 2019. For AJUDA Phase II & III sites, community-based lay workers conducting lost-to-follow-up activities should actively identify and refer index contacts for facility-based index testing. In addition, all community-based HIV index case contact follow-up should include active screening for TB and, if symptomatic, referrals for TB testing or field-based sputum collection, as per National TB Program guidelines. IPs must coordinate closely with HF staff to maximize coverage of HIV and TB ICCT for all eligible contacts, as per national guidelines. PEPFAR-supported counselors should prioritize reaching eligible contacts who are not willing and/or able to receive HIV and TB ICCT services at the health facility, and where appropriate consent for community-based follow-up is available. Effective community-facility linkage should be prioritized to ensure all HIV positive clients have access to ART initiation and to assess for eligibility for TPT and monitoring of treatment completion for all HIV positive clients and household contacts of active TB cases. Any confirmed multi-drug-resistant (MDR) TB index cases should be prioritized for follow-up and accompanied referrals, with guidance from TB staff at the nearest health facility.
4. **Community-based testing of key populations (HTS-C):** PEPFAR-support will continue with community-based testing among FSW, MSM, PWID, as well as prison-based testing among prison populations in districts with priority AJUDA sites. Implementing partners will refer to National Guidelines regarding frequency of KP testing, while also attempting to reach a higher percentage of KP who have never tested and those who do not test regularly. Implementing partners working with KP will continue to strengthen KP friendly services and “Peer Navigator approaches” within selected health facilities to improve linkages so that more routine testing of KP can be served using facility-based VCT modalities. The positivity of community based KP testing will be closely monitored, and approaches should be adjusted in areas where testing yield among KP are persistently below that of the general population.

Table 1: Annual Testing Trends, COP17- COP19, based on “Reboot” described above:					
Facility-Based²³			Community-Based²⁴	Total Tests	Change (%) from Previous Year
COP17 (APR)	Positive Tests	350,764	51,315	402,079	3%
	Total Tests	7,596,072	538,733	8,134,805	0%
	Yield	4.6%	9.5%	4.9%	3%
COP18 (Targets)	Positive Tests	361,455	98,684	460,139	14%
	Total Tests	6,881,304	497,476	7,378,780	-9%
	Yield	5.3%	19.8%	6.2%	26%
COP18 (Revised Estimates)	Positive Tests	525,699	86,607	612,306	52%
	Total Tests	7,628,876	524,621	8,153,497	0%
	Yield	6.9%	16.5%	7.5%	52%
COP19 (Targets)	Positive Tests	566,046	126,550	692,596	13%
	Total Tests	6,886,851	573,811	7,460,662	-8%
	Yield	8.2%	22.1%	9.3%	24%

Retention

In late FY16, recognizing that low retention rates were detracting from progress towards HIV epidemic control, PEPFAR Mozambique developed an approach to improve its concerning retention results. The team selected 63 high volume sites (approximately 27 percent of PEPFAR Mozambique’s TX_CURR at the time) to report on four early retention indicators on a monthly basis. These sites would also report HIV testing and treatment numbers at this same frequency. In addition to a focus on supplemental reporting, in COP 17, PEPFAR Mozambique co-developed the Retention 5 Pillar Strategy with the GRM in an effort to focus strategic efforts on retaining patients in HIV care.

The 5 pillars²⁵ include:

1. Scaling-up DSD models
2. Strengthening psychosocial support services
3. Improving quality of health services
4. Reducing stigma and discrimination of PLHIV
5. Increasing community engagement and participation

²³ For COP19, will include passive testing, targeted PICT and facility-based index case testing.

²⁴ For COP19, will include targeted community-based index case testing and key population testing.

²⁵ Recently, MISAU added a sixth pillar on HIV testing services and linkages, which has been incorporated into the AJUDA Logic Model.

After the COP 18 RPM, PEPFAR Mozambique launched a community of practice platform to facilitate discussions across PEPFAR partners to share best practices and promote knowledge management. Noting a need for enhanced alignment between program and systems teams with regards to retention activities, a USG Retention Task Force was created. The weekly inter-agency forum provided a space to prioritize key short-, medium-, and long-term outcomes, including supporting the expansion of electronic pharmacy systems for facilitating multi-month dispensing and improving EPTS content with an aim towards stronger data use to drive program improvements. The task force promoted systems- and program-level discussions, which directly led to weekly engagement with MISAU on HIS-specific activities and progress towards a more user-friendly EPTS. The task force also focused on moving key policy issues, including expansion of a 3MDD scale-up plan.

The task force's unilateral focus on retention was critical to channeling retention support efforts to MISAU. Since the task force was established, MISAU has launched differentiated service delivery models guidelines, new psycho-social support facility-based tools (including guidelines for preventive support and defaulter tracing), finalized a community-based psycho-social support package, and assumed the enhanced site-level retention monitoring as an official MISAU platform. The USG approach to improving stagnant retention numbers was founded upon national level engagement, liaising with host government counterparts and central IP staff, coupled with site-level performance monitoring.

Despite significant efforts, the results from this approach were not enough to strengthen progress in retention at the site-level. In September 2018, PEPFAR Mozambique identified some clear weaknesses that jointly contributed to the failure to improve retention rates. These gaps included:

- **Insufficient coordination with MISAU and National AIDS Council:** Given that the vast majority of the 1,400+ facilities in Mozambique are public sector sites, rapid and systemic changes at the site level require host government engagement and buy-in at all levels. Without joint planning and strategizing with provincial and district officials, IP recommendations for site-level adaptations were unlikely to be implemented with any fidelity and/or clear oversight;
- **Fragmented implementation of retention interventions:** Although standard operating procedures existed for generating defaulter lists, performing preventive home visits for new ART initiates, and offering early adherence counseling to all new clients, IPs did not systematically monitor implementation fidelity;
- **Lack of data review and action:** Despite monthly data collection, systematic and routine data analysis was not adequately performed. This insufficient analysis occurred both at the USG, IP, and site levels. Data collection and reporting had become a greater focus than data use;
- **Inadequate triangulation of SIMS data with MER results:** In FY18, 49 SIMS visits were performed. All sites passed, yet some persistently low CEEs, including staff performance management and stigma, were not adequately acted upon. Despite USG and IP staff

conducting numerous site visits, early warning signs documented through SIMS results were not identified;

- **Insufficient granular site-level analysis:** PEPFAR Mozambique’s understanding of retention challenges was not adequately grounded in first-hand accounts of implementation gaps and community and patient perspectives. Solving the retention puzzle would require a greater investment of USG staff time visiting facilities and communities as well as seeking a more profound understanding of granular site-level analysis; and
- **Lack of community M&E framework:** Despite a heavy investment in monitoring and reporting on facility-based interventions, community activities focused on reducing stigma and strengthening community systems (aligned to Pillars 4 and 5) are not adequately monitored. Performance management, quality of community services, and provision of regular technical assistance are all significant gaps in community programming.

In October 2018, PEPFAR Mozambique visited nine low performing sites using a standardized data collection instrument based on MISAU’s Supervision Tool (which is based off a previous version of SIMS). The assessments focused on a variety of thematic areas, ranging from psycho-social support and identification and tracing of defaulters to human resources and chart organization. The key findings from these visits were as follows:

Site-Level Diagnostic Visit Findings*				
DSD	APSS	QI	Stigma	Community
<ul style="list-style-type: none"> • Inadequate identification of eligible DSD clients and poor provider promotion of DSD models 	<ul style="list-style-type: none"> • Lack of fidelity to GRMAPSS guidelines • Fragmented implementation of preventive LTFU communication with new ART initiates and defaulter tracing • Unclear ToR for lay health workers 	<ul style="list-style-type: none"> • Poor care of high VL clients • Lack of privacy • Poor clinical chart organization • Insufficient viral load monitoring • Inconsistent clinical mentorship • Lack of uniformity and coverage of mentor mothers 	<ul style="list-style-type: none"> • Lack of core stigma reduction package • Insufficient community communication on HIV (e.g., community radio) 	<ul style="list-style-type: none"> • Inadequate coordination between CHWs and health facility staff • Lack of standardized community package

*High-level challenges and implementation gaps were consistent across all sites

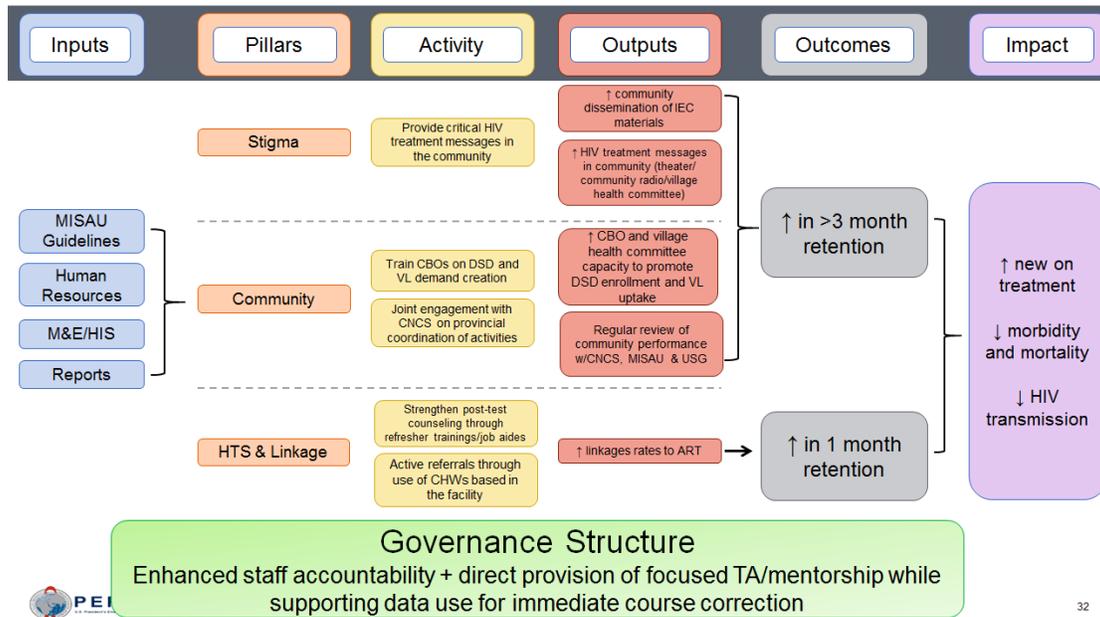
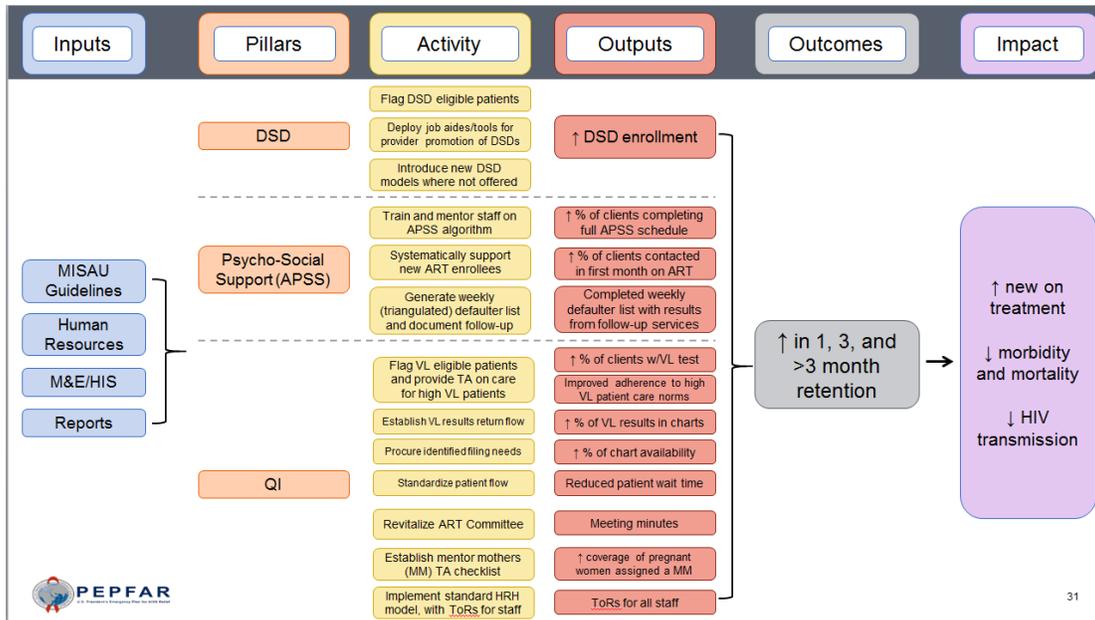
Despite a variety of challenges, some best practices were observed during these visits. In addition, a site visit to a high performing site was performed to document the unique approaches and interventions that were leading to positive outcomes.

In collaboration with MISAU and based on the aforementioned findings, the inter-agency team jointly developed the Addressing Joint Underperformance through Direct Assistance (AJUDA, meaning help in Portuguese) initiative. AJUDA is an intensified, focused, and harmonized retention approach, based on MISAU policies, guidelines, retention pillars, and best practices observed. AJUDA is expected to improve the quality of services for PEPFAR beneficiaries and strengthen site-level HIV treatment growth through targeted intervention and a fortified and standardized HRH

model, all managed through an enhanced governance structure to improve accountability and results. The initiative was initially launched to reach 127 underperforming health facilities (based on a discrete set of inclusion criteria), which comprise 50 percent of PEPFAR Mozambique's FY18 TX_CURR. During COP19 development, the initiative was expanded to cover all 628 PEPFAR-supported facilities.

There are four primary components that differentiate AJUDA from the previous approaches that unfortunately did not achieve the intended results. First, inadequate site-level HRH presence and thinly-spread district management teams led to inconsistent results across sites. In COP19, AJUDA sites will now have prescribed site-level PEPFAR-supported staffing ratios by cadre accompanied by scaled-down district management teams that focus on a far more limited number of sites than in previous years. Second, complementing the National HIV Program QI platform, AJUDA legitimizes and enforces the national guidelines on site-level quality improvement activities, which prioritize site-level data use and joint development of QI action plans. Furthermore, USG and MISAU site-level engagement is paramount to the success of the initiative. Rather than provide central-level direction to IPs and conduct a limited number of SIMS visits each year, AJUDA mandates USG staff to consistently either be in the field or speak directly to sites on a routine basis. Third, data analysis is fundamental to the quality improvement process and weekly and monthly dashboards will facilitate rapid and constructive data analysis for action. Fourth, AJUDA is a GRM-USG effort that includes harmonized facility and community tools, monthly inter-governmental leadership meetings to discuss progress, and joint formative supervision visits to monitor implementation fidelity.

With MISAU and CNCS participation, an AJUDA initiative logic model was developed that mapped directly to the retention pillars. The proposed interventions are intended to be rapidly implementable at relatively low-cost. Given that two of the pillars predominantly focus on community-based activities, the AJUDA initiative embraces a more holistic approach to addressing the systemic challenges experienced thus far in trying to remedy poor retention performance. While the logic model provides an overarching framework, the expectation is that the intervention focus will differ by sites. An in-depth analysis was performed to analyze current loss-to-follow-up data as well as geographic-, population-, and site-specific factors contributing to patient-reported reasons for missed appointments. This context will dictate which interventions will be more urgently required by site and where needed, based on unique site-level challenges, additional activities will be considered.



Accountability

To ensure a timely response to issues identified from weekly data and/or during site visits, individuals from USG, MISAU, IPs, and district officials have been assigned to unique sites. Site visit reports document specific names for follow-up, providing a heightened level of accountability. Consistent GRM engagement at all levels, which includes both MISAU and CNCS, allows for lessons learned and intervention priorities to be successfully shared across provinces and monitored.

Site Visit Approach

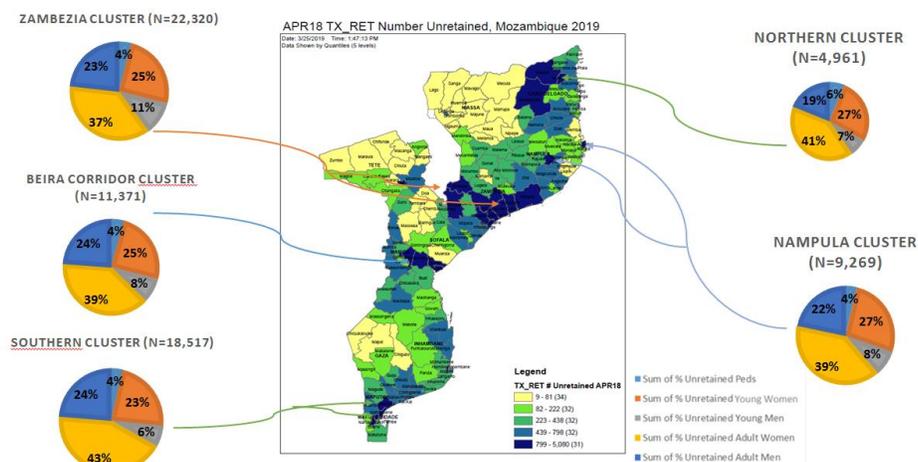
Given that USG site-level presence is a fundamental component of the AJUDA initiative, a standardized approach to site visits has been developed. Prior to all visits, staff review site-level data to pre-identify potential areas for improvement. All first visits are performed using a MISAU-USG developed retention-focused supervision tool, based on MISAU’s more expansive supervision tool that was initially modeled on SIMS. Data collection, analysis, and visualization are all in the process of being harmonized within the robust SIMS 4.0 data platform. While assessments are part of the site visit approach, the provision of direct technical assistance and clinical mentorship are key to rapid programmatic shifts. Staff with expertise in retention-related matters is expected to provide such assistance. Any follow-up visits may reapply the aforementioned retention-focused tool or may opt to provide clinical mentorship on specific retention-related technical areas. On a less routine basis (quarterly and/or semi-annually), MISAU-USG will perform supervision visits, utilizing the broader MISAU Supervision Tool to monitor progress across all thematic areas. SIMS 4.0 visits will also take place at AJUDA sites, in accordance with the soon to be revised SIMS 4.0 Assessment Prioritization List.

Loss-to-Follow-Up Trends

Following an intensive LTFU analysis, several key trends were identified. First, 29 districts, situated in five geographic clusters, represent more than 70 percent of the LTFU burden. This indicates that a targeted approach to a sub-set of the selected AJUDA sites may glean more immediate results. Second, within these districts, a very limited number of high volume sites comprise the majority of LTFU within a district. This again highlights the importance of carefully determining where additional resources and efforts should be placed. Third, while some similarities can be found across sites, reasons for LTFU differ by province (and by site). This suggests that key interventions within the logic model may not be identical across all sites. Understanding site-level barriers to retention and creating local solutions are paramount.

5 Clusters of Particular Concern for Retention in Mozambique

- 29 Districts Make Up 73% of LTFU & Demography of LTFU Broadly Similar



Weekly ART Committee

As noted earlier, AJUDA places its focus on the site. This extends to developing a more standardized format for site staff to collect and analyze data as well as use data for immediate action. In February 2019, MISAU-USG jointly created official guidance for site-level ART Committees. The guidance included an agreed set of indicators that sites are expected to collect and discuss on a weekly basis. IPs have been instructed to help revitalize these weekly meetings and support site-level staff in facilitating discussions. The standardized indicators cover a wide range of thematic areas and the weekly encounter provides a forum for site-level ownership of improvements and a shared vision for corrective actions. It ideally also builds the ability of clinical staff to lead quality improvement at the facility-level. Noting staff motivation has been a challenge, the AJUDA approach, which focuses on empowering site-level teams through weekly ART Committee meetings, enables site staff to learn from site data and then to shed light on opportunities for improvement promoting a team-based behavior change model of accountability and improved agency.

Data Use

The inability to make progress on retention indicators was not associated with a lack of data. It did, however, highlight that improvements were not likely going to be realized if analysis remained at an aggregate (i.e., national or provincial) level. The commitment to data use for action has been widespread – from site-level to national decision-makers and from IPs to USG staff. As noted above, MISAU recently finalized standardized indicators for sites to monitor on a weekly basis. All IPs have also agreed to weekly reporting that is shared with their respective agencies. On a monthly basis, the Site Action List (SALt) is populated to facilitate performance analysis and discussion with national decision-makers. An excerpt of the Excel-based SALt is shown below. The SALt is founded upon performance across ten key indicators, including treatment growth, early retention indicators (which are still being revised), and differentiated models of care coverage. A performance color-coded scale provides IPs, USG staff, and MISAU counterparts an early warning sign of concerning trends. The tool is *not* intended to diagnose the problem but rather signify where additional analysis is required (and likely a site visit to further interrogate the root cause of the problem).

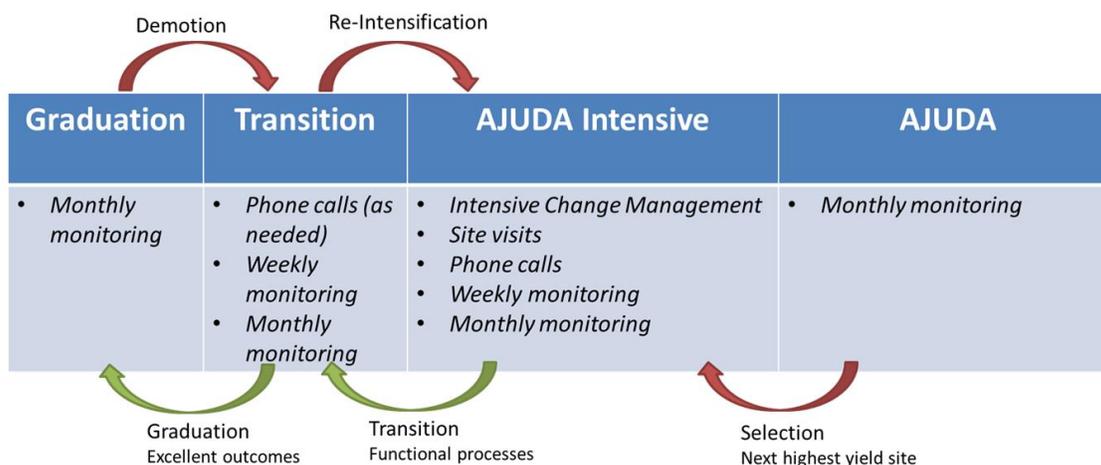
partner	province	health_facility	type_new	month	site_visit_yesno	impact_1_month
ARIEL	Cabo Delgado	1 de Maio CSURB	ER&MI	Jan	Yes	Apr
CCS	Gaza	17 de Setembro CSURB	ER127	Feb	(blank)	May
CHASS	Inhambane	1º de Junho CS	MI	Mar	1	(blank)
EGPAF	Manica	1º de Maio PS	(blank)	Apr		
	Maputo Cidade	1º Maio CS II		May		
	Maputo Provincia	24 de Julho CSURB		Jun		
	Nampula	25 de Setembro CS II		Jul		
	Niassa	4 de Dezembro CSURB		Aug		
	Sofala	7 de Abril PS		Set		
	Tate	7 de Abril PS		Out		

TX_CURR	TX_NEW	% LTFU (=LTFU/ TX_CURR)	% newly enrolled	# on DSD Models	# 6 month appts	1 month retention	3 month retention	% 6 month appts	% on 3MDD	% in GAAC	TX_CURR Growth				
			% newly enrolled in care on same day of HIV diagnosis	DSD_total_ patients	# of non-pregnant, non- breastfeeding adults (>15) active on ART whose next clinical consultation is scheduled 175-190 days after the date of the last clinical consultation	Sum of Overall 1 Month retention	Sum of Overall 3 month retention	% active ART patients with 6 month appointments	% active ART patients on multi- month scripting protocol	% active ART patients on GAAC	1-month TX_CURR % growth				
health_facility	partner	province	district	Sum of L1_TXC_T W_Total	NET_NE Total	%LTFU_CURR Total									
1 de Maio CSURB	ICAP	Nampula	Nampula	46790	24	22%	94%	63247	33418	75%	76%	37%	30%	3%	0%
17 de Setembro CSURB	FGH	Zambezia	Quelimane	47872	645	5%	86%	60450	19579	73%	91%	23%	45%	4%	1%
1º de Junho CS	CCS	Maputo Cidade	Kamavota	0	0	0%	91%	92423	46416			27%	9%	17%	
1º de Maio PS	CCS	Maputo Cidade	Kamaxakeni	0	0	0%	82%	119936	23510			12%	38%	11%	
1º Maio CS II	CHASS	Manica	Chimoio	0	0	0%	90%	40027	11909			11%	25%	1%	
24 de Julho CSURB	FGH	Zambezia	Quelimane	32559	-1221	48%	85%	9178	5731	59%	85%	9%	1%	5%	-4%
25 de Setembro CS II	ICAP	Nampula	Nampula	63157	2506	-19%	92%	55618	23427	72%	72%	23%	24%	8%	4%
4 de Dezembro CSURB	FGH	Zambezia	Quelimane	21765	-4112	174%	80%	11296	9793	61%	88%	25%	1%	3%	-19%
7 de Abril	CHASS	Manica	Chimoio	0	0	0%	90%	12637	1434			2%	16%	3%	
7 de Abril CS	FGH	Zambezia	Pebane	14098	0	16%	96%	5800	1131	57%	66%	10%	0%	39%	0%
Albasine CS	CCS	Maputo Cidade	Kamavota	0	0	0%	91%	45937	16172			15%	12%	16%	
Alto-Maé CSURB	CCS	Maputo Cidade	Kampifumu	0	0	0%	75%	87671	42872			25%	19%	8%	
Alto-Maé CSURB	CCS	Maputo Cidade	Kampifumu	0	0	0%	77%	1105	567			11%	1%	10%	
Anchilo CS I	ICAP	Nampula	Nampula	10413	-7307	595%	85%	2939	1859	49%	60%	24%	2%	11%	-70%

Site Coverage

The AJUDA initiative is applicable to all 628 sites that PEPFAR supports in COP19. The ability for the PEPFAR team to simultaneously focus on all sites is limited and thus the team has developed an approach to USG site-level focus. This entails having a set number of underperforming sites receiving intensive oversight and visits that eventually transition and/or graduate to a less intensive management model. This process is guided by a predetermined set of performance metrics and is intended to allow for the USG team to consistently ensure that its limited number of staff can focus energy on sites with persistent underperformance. Only sites with intensive AJUDA support and those in transition from intensive support will be required to submit weekly data. This site list is not static and will likely capture around 150 sites. All sites with EPTS, however, will report monthly on a sub-set of indicators. Site performance assessment for movement along this continuum will be conducted at least quarterly.

AJUDA Site Life Cycle



PMTCT and Pediatric-Focused Support in AJUDA

The overall AJUDA approach is applicable to all populations who receive HIV care and treatment services at PEPFAR-supported health facilities. However, the nuances of PMTCT and pediatric HIV programs in Mozambique were considered in AJUDA, from site selection to the operationalization of the three primary components of AJUDA. Sites were selected based on high vertical transmission rates (PCR positivity) and those with poor pediatric retention performance.

The core of the PMTCT program is reinforced in AJUDA to ensure the one-stop-model for ANC/PMTCT is implemented with fidelity as per MISAU's guidelines, including couples testing, VL testing, result return and clinical use and the full MISAU psychosocial support package. AJUDA supports early linkage to EID testing for HEI and timely linkage to treatment and all AJUDA sites report monthly on core performance steps in the PMTCT cascade.

Pediatric AJUDA interventions are closely aligned with PMTCT interventions and include technical assistance to guarantee case identification through use of the PCR algorithm and rapid testing algorithms for children of HIV positive women who are under ten years of age. Where children and adolescents are symptomatic, AJUDA promotes use of the revised pediatric PICT screening guidelines to implement PICT in high-yield health sectors.

During AJUDA visits, partner advisors are engaged to ensure ongoing mentoring to clinicians providing pediatric ART to ensure personalized, high quality pediatric ART and care including nutrition screening and support, correct ART regimens and dosage, use of VL to monitor treatment, timely identification of treatment failure and the switching to and monitoring of 2nd line treatment.

AJUDA visits also verify that mentor mothers serving PLW and young children as well as peer educators working high risk children > age 5 have clear scopes of work, adequate supervisory frameworks, and consistent support to provide systematic high quality psychosocial support at the facility and community level concordant with MISAU guidance.

As previously mentioned, weekly site-level meetings led by MISAU clinicians are used to discuss selected PMTCT and pediatric indicators using the MOH guidance recently approved.

Human Resources Optimization Pivot

A surge in human resources towards direct service delivery at the facility level is a critical pivot during this reboot. Previously the technical assistance model has not resulted in high quality HIV care service delivery highlighting the need for a pivot at the facility level in regards to human resources. Ensuring direct service delivery of providers including clinicians, nurses and senior managers is the fundamental pivot to ensure HRH staff consistently focus on delivering high quality HIV care at the health facility level. In fact, MISAU HRH surge will also be implemented at the central sites to widen the scope towards national epidemic control. This HRH pivot will involve implementing a strong accountability framework whereby the performance of HR staff providing direct service delivery is being monitored and evaluated to ensure high quality HIV care

delivery. The management of these HR staff is the platform in which accountability will be embedded into health facility care with the ultimate goal to strengthen the quality of HIV services and thus improve the likelihood of retaining patients in care and promotion of adherence to ART.

APPENDIX F– Impact of Cyclones Idai and Kenneth

Cyclone Idai

What happened?

Tropical Cyclone Idai made landfall over Mozambique between March 14 and 15, producing torrential rains and strong winds across the country, as well as in neighboring Malawi and Zimbabwe. Cyclone Idai is now considered the worst natural disaster in southern Africa in nearly two decades. The catastrophic flooding triggered by the storm has killed more than 600 people and nearly 1.9 million are in need of assistance. Immediately following the storm, over 130,000 people were living in 136 accommodation centers; that number has since dropped drastically as affected populations either return home or settle on a new plot of land that is less likely to flood in the future. Over 240,000 houses and 1.7 million acres of crops were damaged or destroyed, increasing the risk of food insecurity over the next several months and forcing many households to resettle on pieces of land with no existing infrastructure.

Specifically in the health sector, within the 38 districts identified by the Office of Coordination for Humanitarian Assistance (OCHA) as affected by Cyclone Idai, at least 93 facilities were significantly damaged and one destroyed. PEPFAR and MISAU teams reported extensive damage to infrastructure, laboratory equipment, patient records, and HIV commodities. Health facilities in affected areas reported a 30 percent absenteeism rate among health providers two weeks after the cyclone. The 38 affected districts represent over 275,000 PLHIV on treatment and over 570,000 total PLHIV.

The most affected province was Sofala, where a total of 43 health centers have been assessed. Some key findings include:

- 86 percent of HFs were damaged (one fully destroyed)
- 60 percent of HFs were without energy/electricity
- 58 percent of HFs were without tap/public water
- 58 percent of HFs reported patient registers were destroyed

Of note prior to the Cyclone, Sofala had the highest LTFU numbers nationally and the Beira corridor highlighted a specific geography of highly mobile patients and districts with low treatment literacy and VL suppression.

Commodities availability remains a consistent challenge, particularly among pediatric regimens. The pediatric medication Kaletra was destroyed during the cyclone given its dependence on a cold chain. Sofala assessment results from April highlight the expanse of the problem:

- 27 percent (12) of HFs reported insufficient stock of ARVs for Adults

- 58 percent (25) of HFs reported insufficient stock of Pediatric ARVs
- 60 percent (26) of HFs reported insufficient stock for post-exposure prophylaxis
- 56 percent (24) of HFs reported insufficient stock of corn soy blends

Although most health facilities have re-opened, providing high quality HIV prevention and treatment services remains a challenge, especially in Sofala province. A significant number of clinical staff and lay workers lost family members, homes, clothing, and their livelihoods. This impacts mental health and absenteeism, as well as greatly disrupts community services such as index case HIV testing and contact tracing of ART defaulters. Accommodation centers are serviced either by a small fixed health post or intermittent mobile health brigades. To date, limited chronic care services, including HIV, have been readily available within these centers. In addition, patients who are being relocated to uninhabited plots of land are currently without a home and mode of transportation to access services at the nearest health facility, making community based provision of HIV services even more urgent.

Immediate Response

Soon after the cyclone passed, PEPFAR Mozambique worked closely with MISAU to jointly develop and implement a site assessment tool at more than 105 sites to document the impact of the storm and identify immediate programmatic needs. In addition to documenting cyclone damage, site visits have focused on how MISAU and IPs can rapidly ensure continuity of HIV care services—at both facility and community levels—to meet the evolving needs of PLHIV affected by the storm.

MISAU, in collaboration with PEPFAR Mozambique, released a “Basic Package of Services” shortly after Cyclone Idai made landfall to minimize the gap in provision of health services, including HIV prevention, care, and treatment services. The purpose of this guidance was to ensure core HIV services were offered during the emergency response, when chronic-diseases like HIV often become secondary to highly infectious and diarrheal diseases. PEPFAR Mozambique oriented all healthcare providers within health facilities and accommodation centers on this minimum package of care, along with a shortened version of the paper-based ARV pharmacy distribution system. Furthermore, PEPFAR Mozambique built off an existing hotline called *Lignha Verde* to provide information to patients who present in accommodation centers or health facilities without documentation such as a clinical card.

PEPFAR Mozambique Disaster Relief Plan – Cyclone Idai

The damage caused by Cyclone Idai in the four central provinces is of significant concern to PEPFAR Mozambique and will negatively impact years of hard work and efforts made to progress the country toward epidemic control. Thousands of PLHIV have lost family members, their homes, and personal belongings. Food and safe drinking water are the day-to-day focus for families. In provinces already suffering from poor retention performance and inconsistent service quality prior to the natural disaster, the national HIV program faces a serious uphill battle as additional obstacles

have arisen. Fewer transportation options, damaged and poorly stocked health facilities, and insufficient food and clean water all impede patients from easily accessing life-saving ART.

There is clear intent among displaced individuals to eventually return to their place of origin. In 32 of the 41 displacement sites assessed by the International Office of Migration three weeks after the cyclone, the majority of displaced persons planned to return to their place of origin. In 15 of the 41 sites, the majority of individuals expected to be displaced for more than three months, while in 17 sites, expectations were between one and three months.

Based on the COP 19 funds approved for cyclone response, PEPFAR Mozambique developed a clear disaster response plan to mitigate the negative effects of the cyclone and support health facilities and government officials to ensure HIV services remain available. The response takes into account funding commitments by GRM and other bilateral and multilateral donors, and is founded upon three primary tenants:

1. Increase direct service delivery support at affected health facilities and communities
2. Normalize HIV services at affected health facilities, laboratories, and accommodation/transition centers
3. Scale-up community ARV distribution thru mobile brigades and APEs in cyclone affected areas

1. *Increase direct service delivery support at affected health facilities and communities*

Given heightened absenteeism, improvised service delivery within damaged health facilities, and significant destruction to historical patient records, the provision of routine facility-level HIV services can be relatively complex. To address this concern, PEPFAR Mozambique will increase its direct service delivery footprint to more rapidly support the host government's efforts as VMMC and HIV services slowly adapt to new and evolving circumstances. From clinical providers and laboratory technicians to HIV counselors and data entry clerks, PEPFAR Mozambique will provide sites with additional human resources support, as identified through site assessments and on-going discussions with IPs.

In addition to human resource needs within health facilities, community health workers play a critical role in delivering HIV and other health-related messages in their communities in post-disaster settings. With community workers more prone than clinical providers to being affected by the cyclone given their limited resiliency to economic shocks, absenteeism is a more significant issue within this cadre. This is compounded by an elevated number of defaulting patients and a more dispersed population than before. Displaced populations face numerous challenges in accessing ART, including individual challenges such as transport and loss of income, health service challenges such as disruption to services and drug supplies, and social challenges such as stigma and lack of social support. These challenges, together with the existence of competing health priorities such as cholera, malnutrition, and tuberculosis, have raised concerns about poor

adherence to ART in the post-cyclone environment. To ensure strong community support, bolstering the number of community health workers will be essential.

Most vulnerable affected families require immediate assistance to recover in the post-cyclone environment. OVC services in most affected districts will focus on locating beneficiaries and implementing intensive case management and psychosocial support, with a focus on HIV positive CLHIV.

2. *Normalize ART services at affected health facilities, laboratories, and accommodation/transition centers*

With physical trauma-related incidents now limited, the revitalization of routine HIV services is critical, including rehabilitation of damaged AJUDA sites and re-establishment of damaged information and supply chain systems. Within the list of damaged facilities, 40 are AJUDA sites PEPFAR Mozambique is focusing on for more effective service delivery for 90% of TX_CURR. Of these 40, MISAU has received commitments from other donors to rehabilitate 11, leaving 29 that require structural repairs to resume the full range of HIV services at pre-cyclone levels.

The success of PEPFAR's programming is reliant upon the availability of up-to-date, accurate data to drive real-time decision making. Establishing EPTS and iDART systems is essential for continuous program monitoring and reporting to ensure facilities and partners are improving treatment services and retention. PEPFAR Mozambique will repair EPTS and iDART infrastructure that was damaged during the cyclone, which will involve replacing computers and rehabilitating EPTS rooms, as needed, so they meet MISAU minimum standards. Furthermore, assessments conducted in accessible AJUDA facilities revealed water damage destroyed registers and filing cabinets in affected facilities. Therefore, in addition to restoring relevant information systems, printing new registers and ensuring proper filing systems are critical for PEPFAR's continued understanding of the epidemic and ability to collect and respond to available data.

Two VL reference laboratories had its entire information technology hardware destroyed, which is critical for the accurate and timely VL results return to patients and service providers. These two laboratories in Beira serve all the central and northwest regions of the country and are critical for providing timely viral load testing for HIV patients. While building structural repairs are already underway with non-PEPFAR funds, PEPFAR Mozambique will need to fund replacement of IT equipment. These two laboratories are critical components of the national VL testing network, which heavily rely on LIS for proper management of test requests and results delivery. Some laboratory services, including viral load, may require extra-ordinary interventions to allow PLHIV to receive this important services. With the three viral load machines in Sofala all currently out of use (which provided services to Sofala, Manica, and Tete provinces), emergency sample referral has been initiated to another province. Results registered through the DISA system have also encountered some challenges as some facilities remain without electricity or with damaged

hardware. As such, additional coordination with the contracted private sample transport provider is crucial.

Simultaneously, displaced individuals living in accommodation/transition centers may need additional education and support on how they can maintain their HIV care services during these uncertain times. While community workers have been trained on the provision of a community package for emergency situations, which incorporates messages around hygiene and gender-based violence, community workers need to be equally prepared to facilitate access to HIV treatment services in non-traditional living situations. This may require additional forms of psycho-social support and/or referrals to near-by health facilities. In addition, as displaced individuals return to their previous home locales, effective communication among community health workers for maintained support will be both challenging and critical for retention and adherence.

In addition, re-initiation of regular meetings, including the weekly ART Committee meeting, and reinstatement of national HIV QI guidelines at the site level, are paramount. Along with MISAU and health facility staff, IPs will work with sites to establish interim methods to ensure that sites can adequately report HIV treatment program progress.

3. Scale-up community ARV distribution and VMMC services through mobile brigades and APEs

Mobile brigades are currently a GRM-operated health service in some districts around the country to provide maternal and child health and immunization services. To expand the service package, PEPFAR Mozambique has complemented this model with HIV services in Cabo Delgado Province. This approach will be expanded to 33 districts in eight additional provinces in COP19. While mobile brigades are not currently present in all provinces, USG leadership is working closely with MISAU to determine how to ensure these mobile units are both available and able to provide this comprehensive package of services with an effort to prioritize community ARV distribution through mobile brigades in cyclone-affected areas in Sofala province. In addition to mobile brigades for ARV distribution, PEPFAR Mozambique will procure trailers for provision of VMMC services in hardest hit areas where rehabilitation of facilities will take a significant amount of time.

The expansion of mobile brigades may not be a long-term sustainable solution for community provision of ARV services. Therefore, MISAU has recently provided oral agreement to expand community ARV distribution through the government's recognized community lay worker cadre (known as APE, in Portuguese). To date, there are approximately 3,700 registered APEs and the training associated with transitioning from a PEPFAR-supported community worker to an official APE takes six months. PEPFAR Mozambique will support MISAU on the development of guidelines and supervision for community ARV distribution and will target implementation in areas most affected by the cyclones.

Cyclone Kenneth

What happened?

On April 25, a cyclone with wind strength equivalent to a Category 4 hurricane made landfall in Mozambique. The greatest damage was sustained in Cabo Delgado, the northernmost province in the country. Sustained rains over the week following the cyclone contributed to additional infrastructure damage. Preliminary government estimates indicate that 249,984 people in Cabo Delgado in nine districts were affected, with 41 deaths (6 May 2019). PEPFAR Mozambique currently supports 128 facilities in the province, and in the six districts affected by the cyclone 19 of 37 health units have reported cyclone damage, with three health units reported as inoperable. Some of the 37 facilities are inaccessible or without means of communication, and several facilities remain without power or potable water.

Immediate Response

On 2 May 2019, PEPFAR Mozambique staff members traveled to Cabo Delgado to assess Cyclone Kenneth's impact and to meet with key GRM and United Nations officials. This initial review of health facility damage led PEPFAR Mozambique leadership to deploy additional staff members to Pemba.

PEPFAR Mozambique staff were instrumental in establishing an emergency outbreak surveillance platform, fighting the cholera outbreak subsequent to the cyclone, and launching a cholera vaccination campaign. PEPFAR Mozambique also quickly mobilized to re-establish primary care and HIV services in most affected districts, based on a health facility rapid impact assessment conducted in collaboration with MISAU. Immediate response activities included the following:

Pemba

- Completed health facility cyclone impact assessments at all PEPFAR supported facilities
- Reviewed stock supply levels of antiretroviral medications and other pharmaceuticals
- Assigned clinical providers to health clinics within two accommodation centers to ensure MISAU-approved emergency clinical service package is being offered to displaced populations (approximately 30-60 patients are treated each day in both sites)
- Trained community health workers to use household-level screening tool to identify any person with chronic disease (including HIV and Tb) and refer them to clinical care in order to ensure continuity of access to anti-retroviral and Tb medications
- Reestablished routine reporting on volume of clinical service and pharmaceuticals delivered at facilities supported by PEPFAR
- Vehicles purchased with PEPFAR funds have been re-purposed for use by the Ministry of Health and provincial government to facilitate access to cyclone-affected facilities

Quissanga, Ibo, Macomia

- Completed health facility cyclone impact assessments at most of the PEPFAR supported facilities

- Reviewed stock supply levels of antiretroviral medications and other pharmaceuticals
- Replenished supplies of clinical registers, patient files, and clinical reference guidelines (Macomia)
- Identified pharmaceutical supply chain gaps that have been exacerbated by cyclone damage
- Vehicles purchased with PEPFAR funds have been re-purposed for use by the Ministry of Health and provincial government to facilitate access to cyclone-affected facilities

PEPFAR Mozambique Disaster Relief Plan – Cyclone Kenneth

Based on COP 19 funds approved for cyclone response, PEPFAR Mozambique developed a clear disaster response plan to mitigate the negative effects of the cyclone and support health facilities and government officials to ensure HIV services remain available. The response takes into account funding commitments by GRM and other bilateral and multilateral donors, and focuses largely on infrastructure and re-establishment of information systems.

In facilities where significant damage was sustained, in addition to structural elements that need restoration, it is understood that basic office furniture, paper products, and storage equipment in these facilities also need to be replaced to due water and wind damage. Facility repairs include roofing, minor carpentry of windows and door repair, facility cleaning, disinfection and painting for facilities.

In addition, re-establishing EPTS and iDART systems is essential for continuous program monitoring and reporting to ensure facilities and partners are improving treatment services and retention. PEPFAR Mozambique will repair information technology infrastructure that was damaged during the cyclone, which will involve replacing computers and rehabilitating EPTS rooms, as needed, so they meet MISAU minimum standards.

APPENDIX G – Acronyms

AE	Adverse Event
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
AJUDA	Analyzing Joint Underperformance and Determining Assistance
ANC	Antenatal Clinic
APSS	Apoio Psicossocial
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
AYPLHIV	Adolescents and Youth Living with HIV
CCM	Country Coordinating Mechanism
CCS	Center for Collaboration in Health
CDC	Centers for Disease Control and Prevention
CHWS	Community Health Workers
CICT	Client-initiated Counseling and Testing
CLHIV	children living with HIV
CNCS	Conselho Nacional de Combate ao HIV/SIDA /National Council to Combat AIDS
COP	Country Operation Plan
DHIS	District Health Information System
DOD	Department of Defense
DPS	Directorates of Provincial Health
DQA	Data Quality Assurance
DREAMS	Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe
DSD	Direct Service Delivery
DTG	Dolutegravir
EFV	Efavirenz
EID	Early Infant Diagnosis
EPTS	Electronic Patient Tracking Systems
EQA	External Quality Assessment
ER	Expenditure Reporting
FDC	Fixed-dose Combination
FP	Family Planning
FPM	Fund Portfolio Manager
FSW	Female Sex Workers
G2G	Government-to-Government
GAACs	Grupos de Apoio a Adesão Comunitária / Community ART Support Groups
GBV	Gender-Based Violence

GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
GFF	Global Financing Facility
GHSC-PSM	Global Health Supply Chain Procurement and Supply Chain Management
GIS	Geographic Information Systems
GNI	Gross National Income
GRM	Government of the Republic of Mozambique
GSD	Gender and Sexual Diversity
HCN	Host Country Nationals
HCWs	Healthcare Workers
HEI	HIV Exposed Infants
HF	Health Facilities
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HPG	Health Partners Group
HPV	Human Papillomavirus
HRH	Human Resources for Health
HRSA	Health Resources and Services Administration
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
HVAB	Abstain/ Be Faithful Budget Code
IBBS	Integrated Behavioral and Biological Survey
ICAP	Colombia University's Mailman School of Public Health
ICCT	Index Case Contact Testing
INS	National Institute of Health
INSIDA	Inquérito Nacional de Prevalência, Riscos Comportamentais e Informação sobre o HIV e SIDA / AIDS Indicator Survey
IPs	Implementing Partners
JSC	Joint Steering Committee
KP	Key Populations
LPV/r	Lopinavir/ritonavir
LEEP	Loop Electrosurgical Excision Procedure
LIS	Laboratory Information Systems
LTFU	Loss to Follow-Up
M&E	Monitoring and Evaluation
M ₂ M	Mães para Mães / Mothers to Mother
MDR-TB	Multi-Drug-Resistant Tuberculosis
MER	Monitoring, Evaluation, and Reporting
MGCAS	Ministry of Gender, Children and Social Action
MINEF	Ministério da Economia e Finanças/Ministry of Finance
MISAU	Ministério da Saúde / Ministry of Health
MMS	Multi-month Scripting

MSM	Men Who Have Sex With Men
MTCT	Mother-to-child-Transmission
NASA	National AIDS Spending Assessment
NASTAD	National Alliance of State and Territorial AIDS Directors
NEC	New Embassy Compound
NGO	Non-governmental Organization
NID	National Health Identification
NUIC	National Unique Identification
NVP	Nevirapine
OCHA	Office of Coordination for Humanitarian Assistance
OGAC	Office of the Global AIDS Coordinator
OU	Operating Unit
OVC	Orphans and Vulnerable Children
PBFW	Pregnant and Breastfeeding Women
PCR	Proper Molecular Biology
PEPFAR	President's Emergency Plan for AIDS Relief
PHIA	Population-based Impact Assessment
PICT	Provider-initiated counseling and testing
PLASCO	Plataforma da Sociedade Civil / Civil Society Platform for Health
PLHIV	People Living with HIV
PLL	Planning Level Letter
PLW	Pregnant and Lactating Women
PMTCT	Prevention of Mother-to-Child Transmission
POC	Point-Of-Care
PPP	Public-Private Partnership
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
RFP	Request for Proposal
RTK	Rapid Test Kit
SALt	Site-Action-List Tool
SI	Strategic Information
SID	Sustainability Index Dashboard
SIMS	Site Improvement through Monitoring Systems
SNU	Sub-National Unit
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TA	Technical Assistance
TAT	Turn-around Time
TCN	Third Country National
TLD	Tenofovir/Lamivudine/Dolutegravir
TLE	Tenofovir/ Lamivudine/ Efavirenz
TPT	Tuberculosis Preventative Treatment
UNAIDS	Joint United Nations Programme on HIV and AIDS

USAID	United States Agency for International Development
USDH	US Direct Hire
VCT	Voluntary Counseling and Testing
VIA	Visual Inspection with Acetic Acid
VL	Viral Load
VMMC	Volunteer Medical Male Circumcision
VT	Vertical Transmission
WHO	World Health Organization
ZAP	Zambezia Action Plan