PEPFAR COP/ROP 2021 Virtual Planning Meetings -- MOZAMBIQUE

WEDNESDAY, APRIL 21 – THURSDAY, APRIL 22, 2021 -- 07:00 – 11:00 DC // 13:00 – 17:00 Mozambique

Presentations can be found in:
SharePoint in Mozambique > HQ Collaboration > COP2021 > 2-Day Virtual Meeting Materials or https://mz.usembassy.gov/our-relationship/pepfar-us-presidents-emergency-plan-for-aids-relief-2/country-operational-plan/

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DAY 2: THURSDAY, APRIL 22, 2021

TIME	SESSION	CAPTURE QUESTION/RESPONSE AND ANY ACTION OR FOLLOW UP NEEDED	Notetaker
7:00-7:15 DC 13:00-13:15 Moz 15 mins.	**Morning Check-In** Updates on any actions needed from Day 1 and reflection on critical issues for follow up.	Q&A Follow up/Action Items 1. Jason Bowman • Welcome everyone to day 2 of COP virtual meeting • Thank everyone for the incredible conversations/discussions yesterday. • Will kick off today where we left off yesterday and move on to technical discussions many wish we alluded to yesterday including infant diagnosis, key populations, programming, HIV testing, index testing, Dreams and OVC • We'll start with discussions started yesterday and continue this morning briefly, re: discussion on teams plan on differentiated service delivery models, and then a question I want to pose, going back and looking at the presentations from yesterday, for colleagues from PLASOC and Civil Society organizations around CLM. What is happening there? In reviewing the slides, interested in hearing more about where we are at the national level in terms of finalizing our framework and matrix. 2. Rachel Idowu – Speaking on behalf of C&T (Direct Service Delivery) 3. Jason Bowman • If team or our colleagues from ministry can comment on the differentiation of pregnant women from sort of lactating women. I worry with our mother to child transmission rates. By not allowing such a population to have access to services that may be more tailored to their needs are is possibly what is helping drive some of the high persistent rates of mother to child transmission?	Baddy

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		• What is the policy space? And is there differentiation around women who are known positive at the time they got pregnant as opposed to sort of newly initiating women? And do we see differences and retention in those groups? • It's not just MMD, it's sort of the complete package almost of differentiated service delivery. And then on the specific topic of the DSD models, I appreciate the continued expansion. And I know there's costs associated with that, and I'm comfortable with sort of the plan, knowing that we should be pressing these things as we can, and especially as we start to determine things are working and clients are satisfied, and finding flexibility in that space as we implement to expand them. 4. <u>Asia - Heath Gap</u> • Would love to hear how much ARPA funding is being used to scale up DSD and for which problems and where • I want to hear from the team what they feel like is working because there are some interventions at the community level where it seems like availability by the end of cop 20 is pretty limited. For example, there aren't mobile brigades in every province, they're only in four out of 11. And then we see expansion is anticipated. But I would want to know the quantification of that. And is ARPA focusing more on scaling out, extended hours or like, where's it being focused? • Is there any initial data about viral load suppression about patient satisfaction from the pilot of private pharmacy distribution, that would indicate that the team should slam on the gas there? Is this expansion not massive? And shouldn't the hypothesis be on the table that further expansion is needed, particularly in the context of COVID. I believe the data indicate 13%, mother to child transmission rates now in Mozambique.	

		• Dr. Aleny mentioned high rates of women not coming back for care, my understanding from those data during the COVID experimentation with MMD, during pregnancy, is that it wasn't caused by the MMD, or caused by their HIV status. That was poor overall retention. It's not that women getting prescriptions every month will encourage them not to come to care. They're not going to not come to care because they get medicine, fewer times, they're going to potentially feel like they're trusted more and have more energy to focus on other things like preventing malaria and making sure they have enough nutrition to have a healthy pregnancy. • Emphasizes on how sad and dangerous it is to have no MMD available for a vast majority of most Moz women who happened to be pregnant during a critical period that they fall out of care, which is bad for their health, yes, also contributes to onward transmission. This can be fixed through extending hard available DSD models to them. They deserve equal treatment just like any other Mozambican 5. <u>Stan Wei:</u> • Response to Asia on scale up plan and about what she perceives as a small scale of some of the pieces like mobile brigades. First to acknowledge that we all agree that DSD models are critical, and that I think all of us, the Ministry of Health, PEPFAR folks all want to see these scaled up. And one of the complexities of this, is that not everything is determined at this moment in the cop planning process, that in the cost planning process, the most critical outputs of this process are, are the fast, in the data pack the targets, and the mechanism level budgets. • In subsequent months, we go into the detailed work planning process, where even though there's some guidance in the past	

		about what goes into the work plans, it's a much more detailed process that engages stakeholders at the provincial level to figure out, what makes the most sense in each province, and that that level of detail is not determined here. • We should acknowledge that the best DSD model will vary from province to province, places that are more rural maybe mobile brigades are more important, but in Maputo city maybe that's not worth the investment. Maybe it's the private pharmacies, which there are many more of in the urban centers. We don't want to have a one size fits all. And we don't aspire to make those decisions at the central level for the provinces but done in conversation with them. It's a conversation with the provincial health authorities about what they think will work best for their patient populations, 6. Jason Bowman • What we want to set as part of COP is the money and targets in the right place to allow for expansion in the treatment cohort. Rolling out DSD is going to be a critical part of that. Also when we get into the workplan drafting piece, is have some very standardized language around the access and availability to all these different spaces and the flexibility in those work plans to allow sort of all the different models to be potentially deployed in the right way, but with the consultation, with the provincial health authorities in the end, what makes the most sense in their environment. 7. Dr Mbofana - CNCS: • The HIV program does not operate in isolation. It is not fair for the HIV program to harm another program. The pregnant woman according to the WHO recommendations has to come somehow to the health unit. If we want good results in the HIV program, this woman may have consequences for not having come to the	

		health unit. When we are making contributions, we must not forget that the HIV program operates in a system and we agree that our interventions must be based on the person. This HIV positive pregnant woman has HIV related needs but also has needs related to prenatal care. I don't think we want to discuss this, to give it three months, we're opening space for the women to not show up and infant mortality is still an issue in Mozambique. So, it is unacceptable to accept 3-month treatment. The HIV program does not operate in isolation. The government will not accept this. 8. <u>Dra. Aleny - MISAU</u> • This decision was piloted in the country. COVID was the right time to offer 3-month treatment to pregnant women. The PMTCT is part of the pre-natal consultation. If the recommendation for pre-natal consultations is 8 visits to the health unit considering the 1st, 2nd, and 3rd trimester of a pregnancy, we have to respect what was recommended. If during the COVID experience we responded accordingly, but there was an increase in delivery complications, an increase in maternal mortality during this period, and deliveries outside of health unit, this is not good for the system. These are indicators that are evaluated and are indicators that evaluate the development of the country. In addition, what is good is that we were able to negotiate with colleagues from the MCH, that these women, at least during the lactation period, can be in 3-month treatment. Because the rate of vertical transmission, is no happening in pregnancy or during delivery, but during the lactation period. • That was a discussion within the Ministry of Health. We had to come up with the solutions. What was to happen to pregnant women after we started doing the distribution and this came from the MCH program. They told us clearly that there were	

		complication during delivery, complications outside of health facility because there was no follow up of pregnant within health facility. 9. Asia - Heath Gap • During the period of three months MD for HIV positive pregnant women, was there any evidence of increased rates of vertical transmission? 10. Jessica Cowan: • Our team was incredibly worried that we would see a big rise in our positivity data from AJUDA sites. And positivity has been at 3.8% for three consecutive quarters. We stopped progressing, but we didn't get worse for infants tested under 12 months of age. And then our preliminary data for Q2 puts us at 3.0%. What Dr. Aleny is raising, really important questions about how antenatal care needs to be provided in Mozambique? I think it's pretty hard to distinguish causality, did three-month drug distribution caused this drop in ANC attendance and bad outcomes? Or was it the rapid flow that all women were put on in COVID, and the fear throughout the population about going to facilities? In many ways, this trial of three months drug distribution for pregnant women was very, very much confounded by the COVID pandemic. And I find it difficult to draw clear conclusions. But in terms of transmission, there was no evidence of negative impact in PEPFAR data. 11. Jason Bowman • Need to have a different follow up on this conversation. Dr. Aleny and Dr. Mbofana we have quite a bit of data within PEPFAR, on this topic across a large number of our countries, and we would be happy to share that with you if that's helpful and continue the dialogue on a technical level. This is a very complex issue about ensuring the health of the entirety of a woman. What we have	

		very available is the number of countries that are offering three months to pregnant women, which is a large number of countries. But I think these questions around efficacy of that will take a little more time • Would be helpful. Maybe internally in that management structure of CLM we could set it would be it would be great. I would love to hear an update and hopefully bringing closure all these pieces in the sort of the management and systems space, and by in early June that those things have maybe been resolved. • PEPFAR team that maybe we can have a huddle between sort of myself it's an HQ team and the CSO groups and just hear update on CLM because it is such a critical component going forward and how we how we think about and inform the program. 12. Dr Mbofana - CNCS: • The message that we are sending, is not that these things have not worked in other contexts. Evidence always must be contextualized. We have this knowledge that things can work elsewhere. What we are saying is that it is not enough for the program to decide based on the evidence that the program has, because other programs may complain that our approach is not favoring other programs. Evidence alone is not enough for decision making. Our colleagues in maternal and child health are concerned about this. As part of our discussions, let us be flexible. There is no lack of interest, we are talking about our context that needs to be considered. HIV program cannot be a program that will interfere with other programs. 13. Jason Bowman • Many of the decisions, if not all of the decisions the ministry makes, and we certainly appreciate that the context is critically important and how that would work in Mozambique is not the same as other countries. If there is interest from the ministry, to	

		see how this could be contextualized and done in a few facilities, to monitor and, and, and see, collaboration across different aspects of the ministry that focus on maternal child health and other areas that impact a pregnant woman, PEPFAR would be very interested in supporting that if there's room for discussion. 14. Nidze Guiloviça – Speaking on communication campaigns • Document to be share in case of further discussion.	
7:15-8:05 DC 13:15-14:05 Moz 50 mins.	**Strategies to close the gap in the 1st 90** Presentation (20 minutes) • Plans for safe and ethical expansion of effective case finding, • Adult versus pediatric index testing, • Index testing of biological children up to 19 years of age, • RedCap Assessments and remediation efforts. Stakeholder feedback and discussion (30 minutes)	Q&A **Jason:** Excited to see initial proposal in the increase in large ANC1 testing. Happy to see continued focus on peds. Data on 15-24 yr olds. Difference between women and men reinforces the need to improve treatment and viral load suppression. Need to link young women to prevention programs. **Magdalena WHO**: WHO published effective timepoints for maternal retesting. Late in pregnancy is most effective time for retesting. **Jason:** Q: Concerned re scores in Redcap are averaging around 20. Significant room for improvement on quality. Would like to hear from team on timelines re expectations from Ips for remediation and analysis? Comment on oversight plan from USG? **Inacio:** A: Main limitation to screen intimate partner violence. MOH collaborated and GBV national registers reviewed. This will help overcome this limitation. Training occurred last week at prov level including Ips. and additional training will occur in the next quarter. **Question in the chat:** Index testing cascade: Data on acceptance and refusal rates? **Inacio:** A: We do not have data on the refusal rates. **Jason:** Q:Data on acceptance rates?	Charlotte

		A: In chat: About 81% **Jason:** Data pack assumptions. Quality of HIV testing is foundation to everything down stream. Vision around counselling and linkage surrounding the individual and talking to them about index and contacts. Quality of their Sensitive to IPV – need to have a safe index campaign. Ensuring that these components are working efficiently but also ethically. Index testing is an important approach for finding men but maintaining safety and continuity is important. Redcap – encourage moving on institutionalized and remediated pieces. **Stan Wei:** Agree that the balance is important between index testing and personal autonomy. Also important is the contacts right to refuse testing.	
		Follow up/Action Items • In next few months at monthly follow up between OGAC and country team track Redcap analysis - remediation and follow up.	

8:05-8:55 DC 14:05-14:55 Moz 50 mins.	**EID and POC** Presentation (20 minutes) • EID coverage at 2-months and 12-months, geographic variability, • Efforts to optimize lab networks for rapid diagnosis, reducing turnaround time ensuring results reach patients, • Contribution of POC, near POC, and traditional platforms, • Programs addressing follow-up with women and babies to ensure they return for follow-on testing and clinical services. Stakeholder feedback and discussion (30 minutes)	Q&A <u>EID</u> **Asia Russel: what is the MM coverage in non AJUDA sites? What will it be by end of FY21?** Jessica Cowan: Hi Asia, Global Fund actually supports mentor mother programming at non AJUDA sites. Perhaps Kirsi has this data? Kirsi: Asia - through the Global fund HIV grant implemented by NGO CCS, mentor mothers program will be implemented in 128 districts. I do not have the number of facilities included. **Asia Russel: Thank you. Is that expected during calendar year 2021?** Kirsi Viisainen: it is starting in 2021 with a rate of expansion over the grant period. <u>POC</u> **Jason Bowman: PEPFAR years ago moved to not procuring instruments but doing everything with comprehensive agreements around reagents, I am wondering if the team has insight or thoughts around this instrument agreements, what is that space look like, if there have been conversations around it? The budgetary implications? Do we know what the volumes sort of reagent purchase for the individual, you know, the per test cost, the standard needed, and order for the companies to agree to sort of that volume to place the machines?** Steven Hawkins: After discussions with folks in DC, the present mPima machines are not under these global arrangements in Mozambique or even other international, we talked to them to see if spectrums' machine could be put in this arrangement (with some negotiations in global level). But I don't have the number on what the surcharges would be.	Neusa

		Tom: Steve is correct - we don't have an international agreement for mPima yet. But aggregating these possible numbers in COP plans across countries helps provide leverage when negotiating with manufacturers. Artur: Just to complement on what Steve mention, for this kind of agreement the manufactures request a minimum of purchase volume for reagents to compensate the placement of the instrument. Unfortunately, I doubt that the manufactory will agree on this, especially for these low volume of sites. As mentioned, the daily capacity on instruments is six tests a day, and we're looking at the facilities with the four tests a week or more. The volumes are not there to facilitate this type of arrangement. **Jason Bowman: We can continue to follow up perhaps have a quick call with George and CDC HQ to pull the pieces together to understand as it will have very big resource implications. There is shyness around the procurement of those machines because of the experiences around them. I think you presented a strong argument for expansion of POC. We do need to figure out with HQ: What is that space in the budget, what is the tradeoff if we could find resources and then can we get sort of an estimate, and potentially finding spaces in the ARPA funds as well.** Asia Russell: We have hope that these resources can be identifiable in the budget, recognizing that Global Fund Emergency Response Mechanism will be available and together with ARPA constitutes additional resources. This is a super important intervention, we appreciate the flexibility and exploring unexpanded reach a point of care to more HIV exposed instance. Jessica Cowan: CDC HQ said that ARPA funds could be used for procurement for POC implement machines and we appreciate confirmation on OGAC policy in this issue. As we think about what is possible before closing the fast.	

		Jason Bowman: I agree there is sort of what is that balance, around access to point of care and sort of the benefit that it confers and turn the lifelong benefit as well, to the individual, it would be interested to ear from the team. How do we think that could close the gap, what are the things that could have be done at those spaces where we know we're not going to get coverage rapidly through point of care? Jessica Cowan: We need to have Lab System and programming excellent supportive, programming for pregnant, lactating women and their infants, as well as optimized laboratory systems. In many provinces do see a big difference in testing coverage between point of care and conventional sites. But we also see provinces where there is no difference, which is proof to me that programs can run well enough even in rural communities, that we can test infants without PLC. Regarding the Linkage: It's very difficult to create the effective linkage in mPima programming. An increase for POC investment in PEPFAR is viable as we are focus on infant's survival. We are seeking a balanced proposal that will strategically increase the patient centered testing platform at sites with higher volume and where is more needed. That is the proposal that we put on the table. Aleny Couto: POC EID improved our program, this means that something that in two years' time we had only 66% of our coverage were in front diagnose on those population less than two months now we are talking about 83%. So I am standing up with within my team here and with the even with PEPFAR team and with the Asia civil society that this is something that is needed in the country. Artur: The main purpose is to make the linkage more efficient, reaching out all the positive children in our test, if we can do this with PEPFAR program that will be great. Just make clear that this will be a modest expansion. The conventional network is very important and we need to make improvements to make this program work better, and the linkage and coordination between lab, clinic and community is important to get this.	

		Tom: If helpful, the HQ lab group has allowed POC machine procurement to advance this agenda, though they require countries to do a comprehensive diagnostic network optimization to ensure it's being used wisely. Thankfully - Mozambique has already done that! Mozambique has been well ahead of many other countries in outlining where the labs are, where the need for tests are, and where existing POC machines and sample transport routes are. **Asia Russell: What is the next step?** Jason Bowman: We need to have a further conversation with our Lab HQ team, to find out exactly what are the spaces in terms of procurement of instruments vs the reagents. I still need to understand what is the trade off that could happen if we find space in the ARPA funds. Follow up/Action Items • Desire/consensus across HQ in the EID space to look at potential increase of coverage of POC • Also need to see that space in the budget and the possible tradeoff of using the ARPA funding. • Follow up on what are the spaces in terms of procurement of instruments vs the reagents.	
8:55-9:00 DC 14:55-15:00 Moz 5 mins.	**Brief Break**		N/A

9:00-9:50 DC 15:00-15:50 Moz 50 mins.	**Key and Vulnerable Populations** Presentation (25 minutes) • Strategies to reach KP and ensure high quality, stigma-free services, • Incorporation of KPIF investments into core PEPFAR programming, • Prevention interventions, including PrEP. Stakeholder feedback and discussion (25 minutes)	Q&A **Lindsay Bonanno:** • Comment: A clarification from the previous slide - KPIF ends 30 September 2021, not 2022 (as mentioned on the slide 10). **Jason:** **Thank you for the presentation, I know there are quite comments from yesterday's presentation and from Civil Society in particular and I will ask one question and handover to finish the yesterday questions from Roberto and additional questions for today:** 1. **I am curious about treatment interruption and how we are able to monitor the treatment interruption to the KP. Coverage around viral load, and if we do have data about interruption treatment I would like to know what we have learned and know in terms of the whys for specific KP needs.** **Roberto:** Thank you for the opportunity, I speak on behalf of the constitution of the key population of Civil Society but I am part of the Key Population Organizations_LAMBDA, I would start with the presentation that I should have done yesterday, where we had to share, we did not have the opportunity to share due to the time. It would take a few minutes and then start the questions. • Yesterday we brought in the role of our vision to guarantee retention and improve the quality of services, the need to reduce the number of clients for each peer educator because in the current situation they have a goal and spend their lives running and have little time to work. follow-up to the beneficiaries. This thinking about adjusting quality / quantity in our intervention and this will complement the increase in the number of existing peer educators and above all looking at the prisons. • On the other hand, there is a curriculum in the training of peer educators, but in our opinion this instrument does not have a complete training to meet the needs of users and the suggestion is that we must	Maria

		offer more tools that can allow the provision of quality services that are expected. • We also hope that specific services will be offered to the transgender population, because we have seen this community neglected in existing programs and we recognize that there is not much knowledge about this population, but this population exists and there is a need for basic services. • Need to make inputs available, but they also need inputs for harm reduction and we would like you to consider yourself at COP21. • Yesterday we talked about PrEP and we like to hear Dr. Aleny's intervention, but we bring the need for a literacy campaign because the level of knowledge of our peer educators / health providers is still below the desired level and it is difficult to convince the key population about the PrEP campaign. • A suggestion is the need to offer PrEP injectable and we feel that it can have greater adherence and results. • In prophylaxis we have been having post exposure, but despite existing rules, there are still many barriers for people to have access to, and we hope that at COP21 there will be flexibility in adhering to post exposure prophylaxis. • Yesterday we also saw the whole issue of improving services, but we are concerned with financing because about 4.12% of the funds made available abroad have gone to the key population and in Africa there are about 2% but in Mozambique it doesn't even reach 2%, the level of financing compared to the world in general is very low and does not seem fair and the non-increase in the level of financing will make the levels of adherence and retention of this population continue at undesirable levels. • Another issue, the level of transition for local partners and we hear that we are going to reach high levels of transition, but in COP21 we can only go up to 39% but in 2022 this is the door and we are in doubt	

		regarding this transition. The biggest barrier is the capacity that these organizations have to implement, due to gaps in their ability to manage these programs. And KPIF was our hope for KP involvement, but more than 75% was not applied to support KP organizations and how will they be able to benefit from this transition process? **Recommendations:** • Adopt another training model, at this moment there are the IPs that implement and also work for the building capacity, we would like that at COP21 there were other alternatives for direct capacity building and leave the IPs only for implementation. • Another aspect is Stigma and discrimination has been the biggest barrier for services, the PASSOS project has reduced the levels of stigma considerably, but we suggest that strategically review the training curricula, for example PEPFAR training is trained 15-20 people, the GF trains 20-30 people for the implementation and at the end of the implementation period financed the CSOs has no way to continue, we suggest revising the curricula so that everyone leaves with complete information about key population so that when all training: for example, the doctor, all health providers, the police are trained to offer friendly services to the key population. • We suggest improving the legal environment. Unfortunately, some rules create barriers to the key population (e.g. Law 3/97), create obstacles for people who use drugs, for example, and PEPFAR could support in advocacy in order to work on the review of these materials and overcome these barriers. • Yesterday we heard about a campaign on calling men (stigma and discrimination campaign), but we would also like to have health units that bring friendly services, however it is important to provide stigma and discrimination campaigns not only for men but transgender women to have more key population adhering to health services.	

		Jason: • Thank you for those points and I think, these are all valid points and some not only for COP planning but valid points even besides COP21 planning. • The points raised around the quality of the program we need to work on and they are independent of COP planning. • The feedback on meeting supporting training and specially for those newer intervention such as PrEP, they are valid points that we need to work on and have conversations as part of COP planning. • On the local partner transition, we have heard loud and clear the concerns from CS about building capacity to give potential to lead these programs. We may need to go back as USG Team and conclude on how potentially ramp up some of those interventions in terms of local building capacity. • In terms of benchmarks, the 40% and 70% those have always been global benchmarks across all of PEPFAR and there is a broad understanding that there is different capacities across every Country in which we work, with the eventual goal that those majority of PEPFAR resources have been programmed directly to the local organization to implement as they know and ty to the context much better. There are some new answers around on it, we usually pull out the commodities on that conversation because we do the virtual global procurement mechanism in many countries and it is significant amount of budget. But the message was clearly heard about need/desire to the Local organizations to take over the KP awards and implement. But they can speak to that. • In some of the technical pieces, on the transgender issue community we should be proposing targets on this community as their needs maybe different and we may be challenged on the data as their targets can be measured by IBBS/Size estimation/Localization and maybe team can comment on that.	

		• On the regulatory space around this new interventions for PrEP and others like biomedical interventions, maybe the Team or Ministry can comment on what is currently licensed and approved for use in Country, do we have a timeline on that and if we don't what is the policy level we can have to work on. • For stigma it is being permissive and it is something to continuing to invest in for a long time, the Justice sector amongst of our beneficiaries and then through the General population approach in terms of communication of PLHIV • Global Fund is also have additional resources, there is a lot being asked but some of THIS we can do on what is already in the plan/Framework, there are some budget implications and some commodities request, there is a need to coordinate well on how this can happen. Maybe the team will probably want to say something at this point. **Nuno:** Thank you for your questions and comments. • A: There is a need to acknowledge the huge improve in performance in particularly the raise of awareness of stigma and discrimination, there is still a lot to cover, but there was considerable improvement on these, the Ministry is recently updating the KP Directive to include the trangender package and this is some of the improvements that can be highlighted as this was a population underserved despite this the KP have been provided with needed services corresponding their needs. • A: The recommendations from Roberto, some are in the document shared and the team is working on them and will provide responses ASAP. We agree in most of the requests and we also have the same objective to provide high quality services for KP ans support MoH and HIV Council in this objective. • A: In terms of treatment question: we can share the Proxy data later, the performance is good, but we can provide more comprehensive data after if needed.	

		• A: Regarding Capacity building, this is a recurring question and we understand, Shadit can talk about this. • A: In terms of stigma and discrimination, PASSOS has made a lot of improvements and the environment had changed due to their advocacy and bring retention on treatment and the high level intervention was during COVID-19, where there was more of GBV which were rapidly responded and for legal environment question I will revert to Paula to comment on that. **Shadit:** • A: About Capacity building for Local Organizations and consequent transition, the allocation of some funds for KP, we recognize that the plan to transition took some time but, in terms of where they are, this is happening since last year for capacity building, we have been using one of the mechanisms for financial management capacity and this started last week and we expect to have more webinars to CSOs to improve their cpacity to engage with USG/USAID • A: For transition component we are already proposing direct funding, of course is not much but it corresponds to 15% of the total budget to KP. We expect to have a program in 2022 on the 1st semester being implemented directly by KP Local organizations. We already started a process and consultation with main stakeholders and LAMBA/MoH were involved and this 15% is part of this design and it is going to be concluded in October 2022. • A: More details can be provided through PASSOS implementing partners and specific capacity building interventions and all these details will be also provided to respond the document with recommendations. **Dra. Aleny:** Muito obrigada! • A: I have to echo Roberto's intervention, the KP projects started in 2011 and then we started to have projects from then on and only in 2016 did we have an expansion guideline and from there is still a lot to be consolidated and there are only 54% of sites that offer services for KP	

		and even in these places we did not get a holistic coverage, as it doesn't look at the whole cascade, but this transition can be good if we want them to take the lead, but it is also necessary to have a clear plan as this tariff will be done in a way to make a faithful continuation of the KP program. • A: MoH is also reviewing the key population package and will include the transgender population but it is still a very open question and the question of inclusion in the curriculum is still being discussed, and it would be done with the ICAP but it involves more staff because it implies a general revision of the curriculum. • A: As for the PrEP package, we are working through the University of Colombia in order to have a literacy package for PrEP, even the pilot was misinterpreted and there were even civil society organizations making edits on what were the pamphlets and it must be emphasized that MoH does not promote the non-use of condoms, which is why we ask civil society to help in the elimination of correct and true information. **Paula Simbine:** • A: Regarding the legal environment, we clearly hear and understand the concerns presented by CSOs • A: There are joint exercises with UNDP, GF, etc to advocate on those issues presented, we know that this take time, this is something that is welcome and it involves Ministry of Interior, Justice. And we are trying to advocate and lobby and make ministry of Interior and Justice understand the gaps that still exist in the law, for example to decriminalize the drug consumption to avoid embarrassing some of this drug consumers to look for health services. We will consider all these contributions and respond to the recommendations document submitted. **Asia Russel:**	

		• It is important to have a timeframe to provide some of the responses in writing.	
		Follow up/Action Items: **Jason:** • Of course it is a long term conversation, but for the purpose of COP21 planning Team may need to provide responses to the request that Roberto has shared very early next week (maybe Monday) • Provide space for some follow on conversations early next week (maybe Tuesday) maybe can ask for a HQ representation but maybe can be tricky for me to participate considering Uganda VPM discussions on Monday and Tuesday • Discuss if there are additional resources that may be addressed for those raised pieces by CS • There is a real desire from the CSOs to take this responsibility and we need to see what are the funds that can be made available and plans for building capacity	
9:50-9:55 DC 15:50-15:55 Moz 5 mins.	**Brief Break**	N/A	N/A

9:55-10:35 DC 15:55-16:35 Moz 40 mins.	**DREAMS and OVC** Presentation (20 minutes) • COP20 DREAMS expansion status update, • Description of program activities during COVID-19, • How is DREAMS linking with OVC and clinical programs? • How is OVC linking with DREAMS, KP programs, and clinical programs? • PrEP Stakeholder feedback and discussion (20 minutes)	Q&A **Nicky Matthews- VSO Mozambique** Q: do you have any disaggregated data for girls with disabilities? A: Thanks for the question in girls with disabilities. Yes, we do have data on girls living with disabilities and what disabilities they have. Disabilities are considered a vulnerability factor for girls. However, die to privacy and protocol we are not able to share the data **Nicky Matthews:** Q: Do you have an idea of the % of total DREAMS participants perhaps that you can share? A: We could. Would you like to send me an email? **Jason:** • I wish we could have more time to dive in DREAMS and OVC conversation, but we have very limited time. But I would like to highlight particularly for DREAMS that there is a mountain of work that the team is capably to provide and can work on to prepare for COVID space and have the program in a good position and I am sure that this has been taking over. • We know the critical need to address the prevention services to adolescent girls and this has been discussed during our POART discussions and we may continue having those discussions in the next meetings and as we are going to the work planning we can continue to follow up on the implementation issues.	Iva/Maria

		Follow up/Action Items **Jason:** Continue having discussions on critical need to address the prevention services to adolescent girls.	
10:35-10:50 DC 16:35-16:50 Moz 15 mins.	**Day 2 Review and Finalization** Summary and identification of critical actions needed to finalize COP submission.	Q&A N/A	Joyce
		Follow up/Action Items **Jason Bowman** • PEPFAR-Team will share detail information provided in advance for the meeting on the 30thth of April • Written response about recommendations from Civil Society and Key Population (KP) • Further dialogue early next week about those specifics • How can these things be addressed by our program where possible • We also know there is a desire/consensus about EID • Increase in coverage • Look at proposal - how we find the money for it? • What instrument procurement and licensing piece? • Money not available for 6 months • How do we budget for it? • Tweaking needed in some of the tools • These are captured in the tracker on pepfar.sharepoint.com	

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		• If there are Questions about those components, the team is happy to assist • Check-in next week (electronically or on a call if needed) • Final version of draft SDS due Apr 30, 2021 • Civil Society, Multilateral organizations need to provide feedback on this quickly • May 11, 2021 - Briefing to OGAC leadership of overall plan • Make sure everything is tied up by then	
10:50-11:00 DC 16:50-17:00 Moz 10 mins.	**Closing of Meeting** • Brief closing remarks to the team from the USG Front Office • Brief closing remarks to the team from a representative from Mozambique government	Q&A N/A	Joyce
		Follow up/Action Items **Jason Bowman** • Thanks everyone for your time during this two-day meeting • We were able to have great dialogue • This is very unusual time, not similar to JBG experience • Many thanks to Civil Society, the Stakeholders and the Government of Mozambique for the partnership and Multilateral team for continuing working with us • PEPFAR Team for all the hard work **Dr. Mbofana – CNCS Executive Secretary** • It has been two days of great discussion • Trying to get solutions on areas where things are not clear	

		• The Government and main stakeholders support results to be able to improve health and wellbeing for our population • We always have the channel open to continue discussion and making things clear for progress that contribute to improvement of matters • Our position needs to be understood that we always have the concern to improve • We need to work together and would like to thank PEPFAR Team, implementing partners, Civil society, and Multilateral organizations for the participation and ideas working towards HIV response towards 2030 goal • We are available to make any comments necessary from our end **Abigail Dressel, Deputy DCM in Maputo** • Jason has done an amazing job, incredible leadership on this call • Thank you, Dr Mbofana, IPs, Civil Society, PEPFAR, Global organizations and UN Partners for their commitment to move this program forward • PEPFAR team here in Mozambique and throughout the US Government • As PEPFAR team, we will continue working on concerns identified over next couple of weeks • And to find ways forward • Jacky will follow up in writing • As Dr. Mbofana noted, we are all working towards the same goal **Jason Bowman** • Thank you everyone, Interpreters have been incredible, logistics team and everyone!	

End of Day 2

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