

Approved



Mozambique

Country Operational Plan

FY 2014

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.



Operating Unit Overview

PEPFAR FY 2014 Country Operational Plan Executive Summary FY 2014 PROGRAM OVERVIEW – Towards an AIDS Free Generation

As part of our two year Country Operational Plan (COP), 2014 funds will support the global priorities set forth in the AIDS-Free Generation (AFG) policy to: provide antiretroviral treatment (ART) for six million people; perform 4.7 million voluntary medical male circumcision (VMMC) procedures; provide antiretroviral (ARV) prophylaxis to 1.5 million HIV-infected pregnant women to prevent mother-to-child transmission (PMTCT). At the same time, the USG is supporting the Government of Mozambique's (GRM) National Accelerated Response to HIV/AIDS (the Acceleration Plan) to: increase the percentage of eligible adults and children with advanced HIV infection who receive antiretroviral therapy to 80%; increase the percentage of HIV-positive pregnant women who receive ARVs to 90%; and increase the percentage of adult males circumcised in target provinces to 39% by 2015. The Acceleration Plan, developed in collaboration with the PEPFAR Mozambique team, prioritizes high-impact interventions and geographic areas, and focuses on a continuum of response by addressing key and vulnerable populations.

In less than two years of implementation of the HIV Acceleration Plan, there has been a remarkable increase in the total numbers and population coverage of key HIV services in Mozambique, with significant PEPFAR support. The number of adults initiated on ART in 2013 was 163,918 (126% of target). In total there were 497,455 adults and children on ART, representing an overall coverage of 68% (based upon national eligibility criteria consistent with 2010 WHO guidelines and SPECTRUM 2012 estimates). 456,055 adults were on ART by the end of 2013. ART coverage of eligible adults has risen from 47% in 2012 to 72% by the end of 2013. 41,400 children were receiving ART at the end of 2013, with 13,566 initiated in 2013. This represents 41% of ART eligible children. Coverage of PMTCT Option B+ (test and treat lifelong ART) for pregnant women at PEPFAR-support sites followed this same trend, showing an increase from 14% in 2012 among those receiving some type of ARV prophylaxis to 44% in 2013. Between 2012 and 2013, PEPFAR increased the number of VMMC procedures performed by 64%.

Based upon expected growth in ART enrollment of PLHIV as a result of intensified case finding supported through the HIV Acceleration Plan, an estimated 750,023 adults and children will be on ART in 2015, and 996,593 by the end of 2017, the latter representing 90% of ART eligible persons based on UNAIDS SPECTRUM model 2014. Given the pace of new enrollment on ART in the past two years, the national program expects to reach these targets despite infrastructural and human resources for health (HRH) challenges. The GRM has re-oriented the national HIV program to focus on 71 high priority districts that have been identified based on high HIV prevalence and population size to increase program efficiency.

Through a renewed investment to increase the number and strengthen the capacity of community-based activists, there will be increased effort to support adherence and retention to ART and increase the success rate for TB case finding and treatment. The role of revitalized cadres of community health workers and community activists is being expanded in concert with care delivery models such as Community Adherence Clubs (GAAC), as well as the shift towards more simplified ART regimens, to support increased adherence and retention.

The combined set of interventions detailed below will enable the country to reduce HIV and TB incidence,



as well as mortality due to HIV and TB related causes. The focus on supporting current persons on ART with adherence support, as well the plan to increase ART enrollment over the next several years, will continue to reduce mortality and morbidity, and have a complementary benefit of reducing HIV incidence.

In parallel, Mozambique is also focused on effective interventions to support comprehensive HIV and TB prevention countrywide, while strategically targeting key and vulnerable populations in the 65 priority high impact districts. HIV prevention efforts have become more focused on those populations that contribute disproportionately to new HIV cases. Community-based population-specific prevention interventions have combined with targeted community-based HTC efforts, for greater efficiency and effectiveness.

As a result of the recent FY 2014 COP review process in August 2014, the PEPFAR Mozambique team has further focused our efforts, identifying 470 total sites that PEPFAR will fully support, of which 422 are ART sites, 436 are PMTCT sites, 427 are HIV testing and counseling (HTC) facility sites, and 54 are HTC community sites which will receive full support with 2014 funds to more rapidly achieve epidemiological control. As a result of this exercise, PEPFAR will no longer fully support a significant number of ART sites (145 ART sites will be maintenance only) and reduce or stop PEPFAR support to PMTCT and HTC sites in lower prevalence areas (423 PMTCT sites will be maintenance only and 195 PMTCT sites will no longer receive PEPFAR support, 195 HTC facility sites will be maintenance only and 149 HTC facility sites will no longer receive PEPFAR support, and 44 HTC community sites will no longer receive PEPFAR support) to allow these resources to be re-programmed towards efforts in higher prevalence areas with high HIV burden.

In January, the GRM altered its treatment targets, because the MOH surpassed its treatment targets due to the incorporation of universal access for TB/HIV co-infected patients, universal PMTCT Option B+ for pregnant women, and universal treatment access for children under-five into the 2014 Spectrum model. Consequently, the national target required to achieve 80% treatment coverage by 2015 increased. The Ministry of Health's (MOH) CY 2014 target was revised from 500,539 to 616,112, of which 59,863 are pregnant women, Option B+. The CY 2015 target increased from 610,163 to 750,023, of which 82,540 are pregnant women, Option B+. With the revised targets, the ART coverage rate is at 60% at the end of CY 2013, and will reach 71% by the end of CY 2014 on the trajectory toward 80% by end of CY 2015. The PEPFAR Mozambique team used the revised targets as the basis for our COP targets, activities, and budgets.

While these successes are impressive, the USG remains vigilant about the health and community systems required to support such rapid scale-up and aims to balance our investments between service delivery and support to health and community systems.

This year's COP represents result-driven and target-based budget allocations through the application of PEPFAR Expenditure Analysis and other unit cost data to PEPFAR's contribution towards national targets. Our interventions target priority districts identified in the Acceleration Plan and ensure strong linkages between counseling and testing, care, treatment, and PMTCT for a robust continuum of response. In the final stage of the COP 2014 budget allocation process, teams scrutinized mechanism level pipelines and continue to make steady progress in ensuring alignment with OGAC guidelines.

The overall budget is strategically aligned to the priorities of an AFG and the priorities outlined in the COP Planning Letter and supports the 57% care and treatment earmark. Overall funding for treatment, VMMC



and PMTCT represents 52% of our budget. Treatment, including 11% allocated for ARV drugs, represents 33% of the funds for ART for 649,017 adults and children, of which 603,184 receive full support (DSD). For PMTCT, 11% is dedicated for ARV prophylaxis for 77,529 pregnant women, of which 66,290 receive full support (DSD). 95% of these pregnant women are targeted to receive Option B+. For VMMC, 9% of 2014 funds were allocated to circumcise 296,298 men. For counseling and testing, 4% is dedicated to test and counsel 4,181,538 individuals, of which 3,691,212 receive full support (DSD). For Care, 10% is allocated to the care of almost one million HIV infected adults and children – including 10% for orphans and vulnerable children. Other priority prevention focus on Key Populations (1%) and condom programming (1%). Activities to strengthen health and community systems to support AFG goals represent 4% of 2014 funds. Overall funding for HIV commodities represents 11% of the FY 2014 funds, which is a decrease from prior FY.

COUNTRY CONTEXT

Mozambique is a predominantly rural country of approximately 25 million people where the impact of HIV and other major preventable diseases (e.g. malaria, tuberculosis and waterborne diseases) contribute to Mozambique's relatively low life expectancy of 51 years and United Nations Human Development Index ranking of 178 out of 187 countries.

HIV Epidemiology: Mozambique faces a severe, generalized HIV epidemic that has adversely affected growth and development in the country, and has taxed a fragile health system. The prevalence of HIV among Mozambicans aged 15-49 is 11.5% (2009 national seroprevalence survey), with prevalence among women higher than men (13.1% vs. 9.2%). Young women (aged 15-24 years), particularly in Sofala and Gaza provinces, are disproportionately affected at rates five and six times higher in comparison to men. Prevalence among children aged 0-11 years is 1.4%. Regional prevalence varies substantially from 19.8% in southern provinces to 3.7% in northern provinces. An estimated 1.6 million Mozambicans are living with HIV in 2014, with an additional 821,000 orphaned children directly affected by the epidemic. From the 2010 DHS, almost every Mozambican (98.5%) has heard of HIV, although only one-third of the adult population has comprehensive knowledge of the disease. Key drivers of Mozambique's HIV epidemic are low coverage of ART, risky sexual behaviors, low rates of male circumcision, low and inconsistent condom use, mobility and migration, and sex work.

Systems: Eighty-two percent of Mozambicans live on less than two dollars per day. With limited health infrastructure, more than half of all Mozambicans walk over one hour to reach the nearest health facility. Health facilities face frequent commodity shortages and a general dearth of basic amenities: 55% lack electricity and 41% lack running water. Likewise, human resources for health (HRH) are severely constrained in Mozambique. With only 5.3 doctors, 24.6 general nurses and a total of 86 health care workers per 100,000 population, and 429 social workers in the country, Mozambique faces some of the most critical HRH shortages in the world. There are an inadequate number of trained and competent health care workers in all cadres, including an uneven geographic distribution of health providers, who often lack the skill set necessary for their position and have limited supervision. The GRM's capability to



oversee its policies and regulations and to coordinate all health actors is weak, resulting in poor overall supervision and coordination. Information systems and monitoring and evaluation (M&E) efforts are generally unable to provide timely and accurate health system data.

Health and HIV Financing: The GRM is investing USD 495 million of its own domestic financing to the health sector in CY 2014, up from USD 300 million in 2013. HIV expenditure in Mozambique reached a record high of US\$ 260.3 million in 2011, representing an over five-fold increase from 2004, and a 22% increase from the US\$ 213.5 million reported in 2010. Conversely, external budget support to the health sector from general budget support (GBS) and health sector support (Prosaude) has decreased from representing 42% of the overall health budget to only 22% in 2014 (the total budget is USD 635M, including domestic and external budget support). PEPFAR funds are not included in this total. Despite the positive trend of increased GRM investment in total dollar terms, the proportion of the total domestic budget allocated to health (9.1%) has flatlined and continues to stagnate below the 15% Abuja Declaration. Of the USD 635 million, 48% is dedicated to the central MOH, 15.7% to the provincial directorates (DPS), 16.5% to the district health, women and social action (SDSMAS), 11.6% to central hospitals, 1% to the Central Medical Stores (CMAM), and 1% to the National AIDS Council (CNCS). Routine budget and expenditure data on investment of public resources in initiatives linked to specific diseases like HIV is difficult to measure. However, efforts are underway to begin program based budgeting at the MOH. A National AIDS Spending Assessment (NASA) was done for 2010 and 2011, and preliminary results show USD 213 million in in CY 2010 (68% PEPFAR financing) and USD 260 million in CY 2011 (72% PEPFAR financing). Costing of the Acceleration Plan, using the original targets, demonstrated a need of USD 277 million in CY 2015. However, the revised national targets have created an increased gap that is not yet fully known, but should be confirmed in the coming months as part of the Global Fund New Funding Model (NFM) application. HIV activities not included in the Acceleration Plan will also be costed and consolidated to form an overall HIV investment case for the Global Fund NFM. The country is at a critical moment where the GRM can, and must, capitalize on the Acceleration Plan successes to recruit additional internal financing. With increased state revenues thanks to extractive industry gains, the GRM must increase its investments in and ownership of the health sector, including the fight against HIV/AIDS. It is also ever more important for the GRM, GF, and PEPFAR to work closely to create a clear and sustainable financing plan, in particular for ARV drugs, and execute timely disbursements to ensure the scale-up of treatment at the pace the GRM is anticipating.

PEPFAR FOCUS IN FY 2014

PROGRAM PRIORITIES:

- 1) Expand and increase quality of care and treatment services to improve treatment outcomes. With FY 2014 funds, the USG will support expansion of care and treatment in 65 priority districts identified as a result of the COP 14 review in August. The focus will be on 422 ART sites in these priority districts to reduce unmet need and increase coverage of treatment and care services for PLHIV in these districts through support for universal ART for HIV-infected TB patients by expanding the one stop model to



these priority districts by 2015, expansion of PMTCT one stop models of universal ART for HIV positive pregnant women, active index case finding and early infant diagnosis to support universal access for children under-five, mobile clinics in two provinces, community ARV drug distribution in four provinces, and access to early treatment through pre-ART and clinical training, mentoring and supervision. In addition to improving quality and access, the USG will support efforts to improve retention, which remains a significant problem in Mozambique. According to APR 2014, retention remains approximately the same at 67% at 12-months and 52% after 36 months on ART. In FY 2014, new and continuing activities to improve retention include: roll-out of peer educators at all ART sites to manage patient defaulter tracking systems and processes; expansion of the number of eligible ART patients in community adherence and support groups annually by 10% from 5% (APR13) to 20% by 2015; community distribution of ARV drugs in four provinces; quarterly ARV drug prescriptions for patients stable on ART; support for scale-up of daily tenofovir/emtricitabine (TDF/FTC) to reach 67% of all patients as outlined in the National plan; and implementation of mobile clinics in two provinces.

- 2) Support Elimination of mother-to-child transmission (EMTCT) through Mozambique's PMTCT Acceleration Plan. Mozambique has endorsed the Global Initiative for the EMTCT and PMTCT Option B+ (lifelong ART), and in this context, the country has revised targets with the intent to reduce MTCT to less than 5% by 2015. The USG continues to support the MOH to scale-up for PMTCT Option B+ to improve and maintain maternal health, and to prevent sexual transmission to partners. In a phased approach, PEPFAR Mozambique has supported the MOH in Option B+ implementation with immediate initiation upon diagnosis (test and treat lifelong ART) for pregnant women at 423 priority sites with co-located ART and PMTCT services. Mozambique will continue to support partner testing and initiation of ART among HIV-infected men in sero-discordant couples, initiate broader FP/HIV integration, commence treatment for pregnant, postpartum and lactating women, and HIV-exposed infants, and maintain support and care for women living with HIV and their families. Retention and linkages are also critical areas of focus for COP 2014. Funding is allocated for intensified peer educator support for case management and individual attention to prevent loss-to-follow-up in the immediate diagnosis and ART initiation phase. In addition this model allows for strong community involvement to improve follow up for mother-baby pairs. Community adherence and support groups strategies that have been established in adult ART will be piloted in PMTCT settings. Quality in the PMTCT program is linked to expansion of the current National QA/QI strategy and COP14 includes support for B+ evaluation.
- 3) Scale up VMMC and interventions for Key Populations. The PEPFAR VMMC program in Mozambique supports the national VMMC Strategy, which aims to achieve 80% national coverage by 2017, by performing two million procedures within key provinces that have high prevalence of HIV and low prevalence of MC (10-49 year old males). High impact prevention activities for VMMC and most-at-risk populations are a priority within both the Acceleration Plan and within our 2014 COP. As the only partner in Mozambique contributing towards VMMC, PEPFAR funds have supported 227,529 procedures through FY 2013. Between 2012 and 2013, PEPFAR increased the number of VMMC procedures performed by 64%, with a 211,721 procedures to be performed by APR 2014. With FY 2014 funds, we aim to support 735,548 procedures through FY 2015. The USG will likely remain the only supporter of VMMC in Mozambique through 2015, and therefore there will be a financing gap for 245,718 circumcision procedures by 2015. Currently, PEPFAR supports 33 fixed sites for VMMC, plus two mobile units with two beds each. In FY 2014, the USG will expand to nine more sites and expand transport networks to provide access to established fixed sites that have saturated demand



within the local community. Two additional pre-fabricated (pre-fab) units will be installed, and it is anticipated that an additional 22 fixed sites will be renovated and prepared for VMMC service delivery. Advocacy to introduce surgical field hospitals will continue. As VMMC is scaled up, so will efforts to improve linkages between VMMC and treatment and care services for men identified as HIV-positive.

- 4) Support AFG service-delivery platform through procurement of HIV commodities and technical assistance for a strong supply chain system. Commodities security and a strong supply chain system are critical to the achievement of AFG targets in the national Acceleration Plan. The PEPFAR Mozambique team is requesting USD 41 million for HIV commodities – of which USD 28.3 million is for ARV drugs – to meet rapid scale-up targets, and \$12.6 million for the supply chain system to ensure that procured products reach their intended beneficiaries. HIV commodities funding can be found in the HIV and Medicines Diagnostic. Supply chain funds will focus on: national forecasting, quantification, supply planning and resource coordination; implementation of the national pharmaceutical logistics strategic plan (PELF), a priority noted in the FY 2014 COP guidance letter; improving supply chain operations and infrastructure; and strengthening pharmaceutical quality assurance and quality control. We expect this will lead to: more efficient public sector health commodity procurement, improved public sector warehousing and distribution at all levels (to ensure greater availability of ARVs, RTKs and lab commodities and reduced stock outs), improved availability, quality, use and visibility of logistics data at all levels and for procurement and supply plans, improved rational use of medicines and more effective pharmaceutical services, and strengthened medicines regulatory authority capacity.
- 5) Support AFG service-delivery platform through targeted health systems strengthening activities. In addition to support for the supply chain system and procurement of HIV commodities, COP 2014 health system investments align with the Acceleration Plan activities to meet VMMC, EMTCT, and ART targets. Under the Acceleration Plan, the number of health facilities providing full ART services is planned to increase to 707 by 2015, requiring infrastructure, the supply chain, and human resources for health investments. Priority service delivery support activities include human resources, laboratory, and strategic information. As part of our COP 2014, we have reduced our support to infrastructure and renovations and will advocate for the GRM to fund renovations as part of its Acceleration Plan, particularly since the Ministry's budget for infrastructure increased dramatically in 2014. COP 2014 funds will continue to strengthen human resources in three ways: more human resources for health in strategic cadres such as pharmacy and laboratory technicians, more efficient and impactful allocation and utilization of available human resources, and in-service training activities required for service delivery in the Acceleration Plan.

PARTNERSHIP, SUSTAINABILITY, AND FY 2015 TRAJECTORY

- 1) Maximize GRM Political and Institutional Leadership and Capabilities. GRM leadership has continued to confront challenges in the health and HIV sectors and has made gains in its ownership of the HIV response. Over the past year, our partnership has resulted in positive movement in a number of areas. As is evidenced by the tremendous progress in the HIV sector over the past year, the GRM is demonstrating its ability to implement its national Acceleration Plan. The GRM also successfully developed and costed its five-year Health Sector Strategy, which will result in more harmonized activities and targets across health programs (disease specific and health systems) in



order to ensure measurable and coordinated outcomes. The MOH also began to absorb a greater number of previously donor funded employees (non-USG funded) into its permanent staff, paying their wages with internal funds and developed a Human Resources Absorption Plan outlining how the GRM will absorb the pool of health care workers outside of the national health system within the next five years. The GRM has also increased its state allocation to the health sector from 2012 to 2014 by nearly 300% in total dollar terms, which is a positive trend. Recognizing these gains, we also note needed improvements. Broad criticism of both the Health Sector Strategy and Acceleration Plan development process includes the limited involvement of civil society and the exclusion of community-based activities implemented by CSOs. PEPFAR Mozambique continues to encourage the inclusion of civil society in GRM planning due to their role as implementers, service providers, advocates for voiceless and marginalized populations, and change agents in their communities. Regarding GRM financing, the share of the GRM budget allocated to the health sector still falls short of the Abuja Declaration (15%) at a level of 9.1%, a level that has been relatively flat over the past few years despite the significant growth in the GRM public revenue and overall budget. The USG will continue to support the GRM in evidence-based decision making and will continue to advocate for increased investment within the health sector, and specifically in HIV, which is the greatest cost driver of the health sector. Increased government financial commitment will ensure that USG efforts are part of a sustainable plan for strengthening the overall public health sector. Key to this effort will be USG support to the MOH to develop a robust health sector financing strategy in 2014. Our team continues to foster and strengthen institutional capacity and capabilities of staff within the Ministry of Health (MOH), the National AIDS Council, the Ministry of Women and Social Action, and the Ministry of Defense. In this COP, the USG continues to support significant technical assistance (TA) to the GRM to improve their capabilities, with a particular focus on TA needs that support the Acceleration Plan at central and provincial levels and enhance the MOH's capacity to successfully implement Global Fund resources.

- 2) Improve PEPFAR sustainability through increased direct funding and support to local institutions. The PEPFAR Mozambique program aims to promote country ownership and improve sustainability and effectiveness through increasing direct funding to local institutions, both government and non-government. The Partnership Framework Implementation Plan outlined a sustainability and transition strategy which includes efforts to strengthen Mozambican institutions and increase direct funding to local institutions (the GRM, local universities, and local NGOs). Over last year, the USG relationship with civil society demonstrated marked improvements, with the USG awarding four new direct agreements with grassroots civil CSOs and holding a COP 2014 consultation with civil society in partnership with the Global Fund Country Coordinating Mechanism (CCM). In COP 2014, PEPFAR direct funding to local institutions, including government, NGOs and universities, total USD 38 million (14%), up from USD 28.6 million (11%) in FY 2013. Direct funding to local NGOs increased to USD 29.4 million (11%), up from USD 19.5 million (7%) in 2013. In line with our Integrated Country Strategy, the PEPFAR Mozambique program remains steadfast in its support to civil society organizations (CSOs) to achieve an AFG, with a focus to strengthen local partners' capacity. All agreements with local institutions will be coupled with intensive capacity building at organizational and individual levels to strengthen the systems needed to manage direct USG



agreements, while concurrently providing rigorous oversight and auditing to demonstrate our intense focus on fiscal and results accountability.

- 3) Trajectory in FY 2015. With high unmet HIV service delivery needs, high HIV disease burden, and low level of external support for HIV programs beyond the USG PEPFAR program, Mozambique is a high priority country designated as a Long Term Strategy (LTS) country under PEPFAR and a priority country by the Global Fund. Strong Ministry of Health leadership has developed a concrete, evidence-based Acceleration Plan that is showing results, and has the potential for broad and significant impact in reducing the number of new adult infections by 50% by 2015. The USG team worked in close collaboration with the Ministry of Health and other principal recipients and the Country Coordinating Mechanism to develop a robust HIV/TB Concept Note (CN) for the Global Fund New Funding Mechanism (NFM). This CN requests significant additional (above indicative) funding, primarily for ARVs and related commodities, to support the continued scale-up of HIV treatment and care in priority districts. However, despite being a high priority by the USG and the Global Fund, the resource envelopes of the two are likely not going to be sufficient to cover the growing financial gaps required for the scale-up to achieve an AFG. The country is at a critical moment where the GRM can, and must, capitalize on its success to recruit additional internal financing to support its plan. The country's public revenue is significantly increasing, and the GRM has demonstrated that it can, and will, increase its allocations to sectors. Given this context, the USG believes that there is opportunity for the GRM to make a more substantial contribution to the Acceleration Plan. The USG will use the HIV investment case and proposal for the Global Fund NFM to begin a dialogue and agree to out-year trajectories of the complementarity of USG, Global Fund, and GRM investments to reach an AFG in Mozambique. The "willingness to pay" requirement of the Global Fund NFM provided an opportunity to begin this dialogue; the Ministry of Finance committed to increase domestic resources by \$28M for HIV, TB and malaria in 2015. The PEPFAR Mozambique team is also committed to analyzing how it funds the national program through a more in depth look at our Expenditure Analysis data so that we may gain efficiencies and re-orient financing investments that enable us to continue to increase coverage of key HIV services.

Central Initiatives and Other Considerations

- 1) Gender Based Violence Initiative (GBVI): The GBVI plan, a joint U.S. Government, Government of Mozambique, and civil society led document, has three objectives: (1) expand and improve coordination and effectiveness of GBV prevention efforts; (2) improve policy implementation in response to GBV; and (3) improve the availability and quality of GBV services. The GBVI supports the goals of the National Plan to Prevent and Combat Violence against Women (2008–2012) as well as the National HIV Strategy (2010–2014). In line with the principles of the PEPFAR Partnership Framework and reflected in current U.S. Government HIV activities in Mozambique, sustainability is an essential component of the GBVI plan. Mozambique is one of three countries participating in the GBVI initiative with Year 2 activities currently under way. GBVI funds are currently implemented by 21 partners, including the Ministry of Health as well as the Ministry of Women and Social Action.
- 2) Medical Education Partnership Initiative (MEPI): Mozambique benefits from the MEPI program. The MEPI program in Mozambique, with approximately USD nine million in central funds, aims to improve



the quality of Mozambican medical school faculty at the University of Eduardo Mondlane and two new medical schools, Unizambeze and Unilurio. MEPI's primary focus is the residency program for physicians as a strategy to strengthen faculty through postgraduate medical training, and operational, epidemiological, translational and clinical research training, ultimately building the medical school's capacity to develop a greater number of skilled physicians. MEPI also aims to enhance relationships among the Medical Universities, Medical Council and the MOH to jointly address the short and long term Medical Human Resources country needs. MEPI implementers routinely meet with the USG team to ensure alignment of activities and look for synergistic opportunities.

- 3) Food and Nutrition: Mozambique was awarded USD five million (USD four million PMTCT; USD one million Care and Treatment) in central level funding and is current implementing activities for scale-up of nutrition and counseling support (NACS) within Care and Treatment and PMTCT service delivery as part of the Partnership for HIV free survival.
- 4) VMMC: In March 2013, Mozambique was awarded USD 4,849,200 of central funds to support an additional 32,241 VMMC procedures. This funding will be used to achieve FY 2014 targets.
- 5) Public Health Evaluations (PHE): Mozambique currently benefits from central level PHE funding for five ongoing PHE studies and has requested additional centrally awarded funds for one study in FY2013.