Mozambique

Country Operational Plan

COP 2021

Strategic Direction Summary

May 11, 2021

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1.0 Goal Statement

Over the past twelve months since the COVID-19 pandemic began, Mozambique has had to make many adjustments in its country response to HIV. COVID-19 has required certain types of activities to be paused for extended periods of time, while other areas have advanced ahead successfully, at times exceeding original plans and targets. This Country Operational Plan is one of restoration and recovery for PEPFAR Mozambique. As a result of COVID-19, we are accelerating programmatic activities and adapting our ways of working, we know this will make a tremendous difference for people living with HIV (PLHIV).

We have identified who and where to focus over the next 18 months and are consolidating and expanding COP20 interventions for prioritized demographic groups. The plan presented here includes, in addition to the full COP21 funding envelope, recently awarded additional American Rescue Plan Act (ARPA) funds of $20.5 million USD to help Mozambique get back on its feet and successfully prevent and control HIV and COVID-19.

For several years, Mozambique has struggled with the challenge of maintaining people on uninterrupted HIV treatment. We introduced the Analyzing Joint Underperformance and Determining Assistance (AJUDA) approach to address this and have seen that the comprehensive, multifaceted, client-centered approach has resulted in increases of people on treatment, despite COVID-19, largely because of improvements in retention. A concerted effort on data collection and review has allowed us to identify both geographic areas and sites that are performing poorly and service quality improvements needed to address program growth. Since we began implementing AJUDA, the overall number of PLHIV currently on treatment has grown at a rate of 10.7% even during COVID-19, a significant improvement compared to pre-AJUDA results. Particularly strong gains were seen most recently in Nampula and Sofala provinces where net gains in treatment were 9.7% and 6.5% in Q1 respectively. Lessons learned from these approaches are already being propagated to other areas.

COVID-19 has prompted changes in the HIV program to meet patients with services when and where they were needed, including rapid expansion of access to differentiated service delivery (DSD) models such as multi-month scripting and mobile brigades. Three-month drug dispensing was consolidated and expanded during COVID-19, and the proportion of stable patients on multi-month drug dispensing programs grew to 70% nationally. The Government of the Republic of Mozambique is committed to expanding these modalities and has seen good results for certain populations such as 375 migrant miners in Gaza who receive a 12-month prescription as they are absent from their homes for most of the year. Mobile brigades are being successfully used in cases where access to health services is extremely limited. Government supported community health workers (APEs in Mozambique) are also being deployed to provide community delivery of ARVs. To this end, we are supporting the training of 610 APEs in COP20 programs and another 720 in COP21. A program to expand easier access to ARVs in urban centers through semi-private pharmacies (subsidized by the government) in 75 pharmacies across all 11 provinces in COP20.

But while treatment numbers improved, the identification and linkage of new patients to treatment has been hampered by restrictions in community activities such as index case testing (ICT). This effective modality is, essential to find the HIV infected people who have not yet begun treatment, especially men who, as long as they are feeling healthy, are not reaching out for health services. In COP21, we will focus on adolescent girls and young women and men through various interventions designed to reach them through prevention, and to link them to and retain them in treatment programs. This includes efforts to expand our DREAMS and male circumcision efforts, and to restore robust index case testing, particularly in the community. For better detection and linkage of HIV infected pregnant and lactating women and infants, we will expand EID point of care testing to an additional 21 facilities where the volume of testing justifies this addition. We will continue to improve viral load testing platforms to increase coverage and reduce turn-around and facilitate the use of results for effective clinical management of patients. Another important change in COP21 is the rollout of advanced HIV disease care to facilities in all provinces, providing support for the identification of advanced disease patients and referral and treatment in selected referral hospitals in each province to better support these patients.

Community outreach activities have been negatively impacted by COVID-19. Activities such as DREAMS clubs and safe spaces for adolescent girls and young women, and Mentor Mothers for pregnant and lactating women and mothers of young children were halted for many months. In Mozambique, as around the world, we know that there has been an increase in gender-based violence, and Mozambique tragically lost one of our beloved community activists to this last year. We are deeply committed to reaching adolescent girls and young women, as well as women and children, and COP21 includes adapted and accelerated programs for DREAMS and orphans and vulnerable children, to provide essential support to survive and thrive. We will maintain the PEPFAR footprint in 32 districts and focus on improving services in all layers and completion rates and reporting. Strengthening the layering database will allow us to better understand the impact of the program.

Mozambique's epidemic is driven by young men, and the young women whom they infect. In COP20 we introduced intensive youth case management, and in COP21 we are expanding those services. We also launched specific campaigns to bring men to treatment with a private sector-like marketing campaign to change the image of what it means to live with HIV, which will also combat stigma and discrimination. COP20 also saw the introduction of more intensive engagement with faith leaders and the launch of an interfaith steering committee that will agree on messages or approaches to provide hope and support for the men, women, families and children to combat stigma and discrimination and help to achieve epidemic control; and this important work will continue in COP21.

Male circumcision is another area that experienced setbacks from COVID-19, services were paused on April 1, 2020 and only resumed in the third quarter of FY20. COP21 includes aggressive targets to reach men between the ages of 15 and 39, to help stop the spread of new infections. In COP20 PEPFAR Mozambique will begin the gradual transition of VMMC services to MISAU, by transferring the complete operations of 6 VMMC facilities supported by CDC in the provinces of Maputo city

(HG Mavalane and HG Jose Macamo), Sofala (CS Munhava and CS Chamba), Maputo province (CS da Manhica) and Gaza (CS de Xa-xai).

The investment that PEPFAR has made over the past several years in Mozambique's healthcare system has proven to be pivotal in the face of the COVID-19 pandemic. The strength and capacity of Mozambique's system has helped to avoid a large COVID-19 outbreak and to quickly roll out effective services for SARS-CoV-2 testing and results return. Nevertheless, Mozambique's health systems need continued support, in particular with electronic systems for everything from patient care to pharmacy support, human resources planning and allocation, laboratory services, infrastructure and supply chain. COP21 will provide support to continue decentralizing patient management information systems, so that each province is able to track facilities progress in clinical management of patients. We will continue to support and expand the footprint of interoperability and integration of information systems to include pharmacy, supply chain, lab information (including sample transport), HIV testing and community outreach with patient management systems, so that we can have a better understanding at all levels about where losses or gaps exist. Ultimately, these data and information help the Government of the Republic of Mozambique and PEPFAR Mozambique improve the quality and coverage of services. We will continue to support the addition of human resources and, when indicated, the re-allocation of healthcare workers, so that resources are better distributed according to need. We will also support the development of community health service extension platforms acceptable to MISAU such as the APEs. We will also continue to support the development and optimization of the laboratory network, so that the country can utilize the resources available from government and partners in the most efficient way, including the use of multiplexing, near POC and POC testing and medium and high throughput for viral testing in various settings and using various sample types. This will help Mozambique not only to tackle the next accelerated phase of the HIV treatment scale up, but also be ready to adapt and respond to viral pandemic threats such as COVID-19.

No program can function without commodities, drugs and supplies. PEPFAR Mozambique will continue to purchase adult and pediatric ARVs, laboratory reagents and other essential supplies that are the backbone of the reaching PEPFAR's testing, treatment and viral suppression goals. In COP21, PEPFAR Mozambique will continue the innovative outsourcing of drug distribution and lab sample transport to the private sector. These approaches put the Government of the Republic of Mozambique in the driver's seat in a role of oversight and planning, leaving the delivery to the last mile to the private sector. Information systems will allow providers at all levels to have eyes on stock availability and use, reducing stocks outs and ensuring life-saving medicine is in the hands of patients.

Violent extremism in Cabo Delgado province and surrounding areas in Northern Mozambique has escalated precipitously over the course of 2020 and into 2021, leading to more than 700,000 people displaced from their homes. Mozambique is focusing efforts to stabilize HIV services for internally displaced persons (IDPs) living with HIV, including mobile brigade expansion, expanded peer support for PLW and young children, and systematic efforts to identify IDPs living with HIV and reintegrate them into care. We are maximizing synergies with other donor and USG investments

to provide coordinated humanitarian efforts to ensure that IDPs have food, water and shelter and that the communities receiving them can absorb their needs.

PEPFAR Mozambique staff and Implementing Partners have been instrumental in supporting the GRM policy development, monitoring its implementation, and ensuring wide dissemination of key information to all respective communities. To maintain this critical support role, PEPFAR Mozambique is applying for $20,050,000 in America Rescue Plan Act (ARPA) funding, which represents 5% of the COP21 Planning Level Letter budget (of $401M). The proposed activities underwent a substantive inter-agency review process, with agency leadership identifying only those interventions that clearly aligned with ARPA COVID-19 Appropriation Guidance and complemented other on-going USG, GRM, and multilateral investments in the country. All funds associated with the proposed activities will be expended during COP21.

Overall, PEPFAR Mozambique's proposal is predicated around the following key tenets:

- Align with ARPA guidance and COVID-19 mitigation strategies
- Leverage existing health system investments
- Respond to HIV program priorities and enhance patient-centered models and services
- Limit to what may be feasibly implemented in a timely and effective manner
- Coordinate with other donor and government efforts, in particular Global Fund's C19RM application
- Facilitate improved monitoring and evaluation of COVID-19, HIV, and TB/HIV activities, through monthly and quarterly review of standard PEPFAR MER and customized indicators
- Prevent, prepare for, and respond to COVID-19 in our PEPFAR supported health facilities and/or for our HIV/AIDS healthcare workers and clients via:
  - Infection Prevention and Control (IPC)
  - Vaccination Support
  - Testing
  - Clinical Management
- Mitigate COVID-19 impact on PEPFAR programs and beneficiaries through the following:
  - Expanded logistics and laboratory support
  - Repair of Program Injury for pregnant women, children, adolescents, key populations and orphans and vulnerable children

Finally, at the center of all this work are the people of Mozambique who are living with HIV, key and vulnerable populations, and the many voices of civil society. With the rollout of expanded and innovative community-led monitoring during the pandemic, as well as innovative use of distance technology, we have engaged, listened, and learned. We support continued strengthening of community-led monitoring, and community activists, to help improve the quality of services in healthcare centers, and in communities, for the good of all.

We have set as a target seeing 1.86 million Mozambicans on treatment (treatment coverage of 87%) by the end of COP21[1], which will be a huge step forward toward 95-95-95 and achieving epidemic control.

We present this plan as the joint effort representing the country team of the Government of the Republic of Mozambique, civil society, multilateral and international partners, and the interagency United States Government PEPFAR Mozambique team. Estamos juntos, and sure that together, we will achieve epidemic control. Forca!!

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Mozambique has a population of approximately 32.5 million people with 14.4 million (44%) under 15 years of age. The national Indicators of Immunization, Malaria and HIV/AIDS survey (IMASIDA) in 2015 estimated 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]. IMASIDA data indicate that Mozambique is still challenged by a generalized HIV epidemic. As of 2020, 2.1 million people are estimated to be living with HIV in Mozambique, with a higher prevalence among women at 13.8 percent versus 8.8 percent among men (2020, Spectrum v6.06). HIV prevalence among adolescent girls (ages 15-19) is estimated at 3.3 percent, and among young women (ages 20-24) prevalence is estimated at 9.3 percent, compared to 1.6 percent and 3.7 percent among adolescent boys and young men, respectively. A population-based HIV impact assessment (PHIA) is underway, with preliminary results expected by January 2022.

As of Q1 FY2021, 1.4M or approximately 66 percent of all PLHIV were estimated to be on antiretroviral therapy (ART). While Mozambique has made progress toward the Joint United Nations Programme on HIV and AIDS (UNAIDS) 95-95-95 goal with 82% of PLHIV aware of their status, 81% of those who know their status on ART, and 88% viral suppression among those with a viral load (VL) test, major gaps remain among adolescent boys and young men (15-29) at 72-54-84.

Estimates suggest that Mozambique has 98,328 new HIV infections annually where 28.7%, or 28,253 of new HIV infections are among adolescent girls and young women (AGYW; ages 15-24 years) compared to 11.4%, or 11,217 among men in the same age group (Table 2.1.1.1).

The ongoing COVID-19 pandemic has taken a significant toll on the health and wellbeing of the Mozambican population. As of April 15, 2021, nearly 4.7 million diagnostic tests have been conducted, 68,870 cases have been reported, and 794 deaths due to COVID-19 have been

[1] This reflects a treatment coverage rate of 87 percent

[2] "INE Destaques — Instituto Nacional de Estatistica." http://www.ine.gov.mz/. Accessed 8 May. 2019

registered. Seroprevalence estimates from studies conducted in 13 major cities throughout 2020 ranged from 0.07-7.4%, indicating that many cases are going undetected. Provision and access to community and facility-based health services have been affected, resulting in reductions of up to 30% in complete childhood vaccination rates by province.[3]

The HIV epidemic has contributed to reduced life expectancy of 54 years for men and 61 years for women in 2019. An estimated 1.1 million children have been orphaned by AIDS.[4] Despite encouraging economic growth in recent years, Mozambique's economy contracted during the COVID-19 pandemic, resulting in 0.5% reduction in gross domestic product (GDP) in 2020.[5] In 2020, UNDP ranked Mozambique 181 out of 189 countries on the Human Development Index.[6] The World Bank estimated 62.9% of Mozambicans in 2014/15 lived on less than $1.9 USD per day[7], with the gross national income (GNI) per capita falling from $620 in 2014 to $460 in 2018.[8] Seventy percent of Mozambicans are estimated to be poor and 37 percent destitute, with substantial variation by region and province.[9]

Despite ongoing challenges, several key health indicators have improved over time prior to the COVID-19 pandemic. Antenatal care (ANC) coverage, defined as at least one ANC clinic visit, increased from 85 percent in 2003 to 93 percent in 2015, with 70 percent of women delivering in a health facility.[10] Malaria, acute respiratory infections, and vaccine-preventable diseases are the main causes of child mortality, with malaria contributing to one-third of deaths, and forty-three percent of children-under-the-age of five years are stunted. However, under-five child mortality was 90/1,000 live births in 2019, declining from 103/1,000 live births in 2010.[11]

The Gender Inequality Index synthesizes gender-based inequalities in three dimensions—reproductive health, empowerment, and economic activity—on which Mozambique ranked 127 of 162 countries in 2019.[12] Mozambique has high rates of early marriage; 53 percent of women (ages 20-24) were married before the age of 18. The adolescent birth rate is 148.6 births per 1,000 women

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[3] UNICEF, 2021, *Os impactos da COVID-19 nas crianças em Moçambique.* https://www.unicef.org/mozambique/media/2521/file/Os%20impactos%20da%20COVID-19%20nas%20crian%C3%A7as%20em%20Mo%C3%A7ambique.pdf. Accessed 27 Apr 2021.

[4] "Mozambique | UNAIDS." http://www.unaids.org/en/regionscountries/countries/mozambique. Accessed 27 Apr 2021.

[5] African Development Bank, 2021. https://www.afdb.org/en/countries/southern-africa/mozambique/mozambique-economic-outlook. Accessed 27 Apr 2021.

[6] Human Development Report, 2015, UNDP

[7] World Bank (2018). Strong but not broadly shared growth. Mozambique -poverty assessment-. http://documents1.worldbank.org/curated/en/248561541165040969/pdf/Mozambique-Poverty-Assessment-Strong-But-Not-Broadly-Shared-Growth.pdf. Accessed 27 Apr 2021.

[8] World Bank, 2014-2016 https://data.worldbank.org/country/mozambique

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

[10] IMASIDA, 2015 available at: https://dhsprogram.com/pubs/pdf/AIS12/AIS12.pdf.

[11] Mozambique DHS, 2011 & UNICEF, 2012.

[12] "Gender Inequality Index - | Human Development Reports - UNDP." http://hdr.undp.org/en/composite/GII. Accessed 28 Apr 2021.

aged 15-19. Only 14 percent of women aged 25 and above have at least some secondary-school education level compared to 20 percent of men.[13]

Similar to other African countries, Mozambique is experiencing a substantial increase in the proportion of Mozambicans who are adolescents or young adults. As of the 2017 census, 12.5 million (approximately 46.6 percent) of the country's population was less than 15 years of age.[14] 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 2030 will be lost. PEPFAR Mozambique and the Government of the Republic of Mozambique (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). Additionally, the model estimated that 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. Individuals 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.[15]

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 Q1 FY21 was 79 percent. PEPFAR Mozambique is aggressively implementing countermeasures and testing innovations at the facility and community level to retain and track PLHIV on treatment.

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.[16] Overall, the ratio of population per hospital bed is one bed per 1,038 persons, with substantial variation across the country.[17] 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.[18] Together with uneven geographic distribution and limited supervision, there are an inadequate number of trained HCW of all cadres.

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[13] Human Development Report 2020, Mozambique Country Profile, UNDP. http://hdr.undp.org/en/countries/profiles/MOZ Accessed 28 Apr 2021.

[14] "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.

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

[16] Luis & Cabral, Geographic accessibility to primary healthcare centers in Mozambique, 2016.

[17] MISAU – DRH. Relatório Anual dos Recursos Humanos. Maputo, Abril 2014.

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

The GRM is responsible for HIV/AIDS-related service delivery, along with the development, implementation and oversight of policies and regulations. The GRM information systems and monitoring and evaluation (M&E) efforts, heavily supported by external funding, are challenged by fragmented components and system patches that do not provide timely and accurate health data. PEPFAR augments the GRM supply chain and commodities management to keep pace with growing ART and commodity needs. The laboratory network for HIV care and treatment also requires significant investment to expand diagnostic capacity; at present only 462 (27.2 percent) of 1,699 health units have laboratories.

Despite these challenges, progress in the number of people on ART has been remarkable, with threefold increases following the 2011 launch of MISAU's national *HIV and AIDS Response – Strategic Acceleration Plan for Mozambique 2013-2017* and the 2016 introduction of *Test and Start*. The number of health facilities offering ART increased from 255 in 2011 to 1,554 by Q1 FY2021.[19] Based on data from MISAU and PEPFAR Mozambique, approximately 1.4M persons were estimated to be on ART after Q1 FY2021.

[19] Mozambique FY21, Q1 MER

Table 2.1.1 Host Country Government Results														
	Total		**<15**				**15-24**				**25+**			***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	31,847,925	100%	7,077,274	22%	7,150,802	22%	3,259,162	10%	3,278,203	10%	5,893,368	19%	5,189,116	16%	NAOMI Q3 2021
HIV Prevalence (%)		6.7%		0.9%		0.9%		6.1%		2.6%		18.1%		12.7%	NAOMI Q3 2021
AIDS Deaths (per year)	37,096		2,954		3,027		2,224		1,453		12,432		15,006		Spectrum v6.06, 2021
# PLHIV	2,130,428		61,310		62,507		199,705		84,606		1,065,253		657,047		NAOMI Q3 2021
Incidence Rate (Yr.)		0.33%		0.08%		0.08%		0.92%		0.35%		0.55%		0.46%	Spectrum v6.06, 2021
New Infections (Yr.)	98,328		5,655		5,818		28,253		11,217		26,637		20,749		
Annual births	1,264,304														Spectrum v6.06, projection year 2021
% of Pregnant Women with at least one ANC visit		93%													IMASIDA (AIS) 2015

Pregnant women needing ARVs	95,027														Spectrum v6.06, projection year 2021
Orphans (maternal, paternal, double)	1,879,480.00														Spectrum v6.06, projection year 2021
Notified TB cases (Yr.)	75,155														PEFPAR data from DATIM, 2020
% of TB cases that are HIV infected	34,4%														PEFPAR data from DATIM, 2020
% of Males Circumcised	6,096,284	77,9%							2,773,772	84,6%			3,322,512	64%	Spectrum v6.06, projection year 2021
MSM	38,473														KP size estimates, 2020
FSW	86,232														
PWID	12,366														

Table 2.1.2 95-95-95 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 (#)	**HIV Prevalence (%)**	**Estimated Total PLHIV (#)**	**PLHIV diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	31,847,925	6.7%	2,130,428	1,737,825	1,354,408	64%	86%	6,319,795	282,629	*266,553*
Population <15 years	14,228,076	0.9%	123,817	66,698	89,976	73%	63%	833,924	15,338	*16,411*
Men 15-24 years	3,278,203	2.6%	84,606	49,633	25,826	31%	77%	596,939	14,059	*11,163*
Men 25+ years	5,189,116	12.7%	657,047	541,286	355,821	54%	87%	1,017,423	87,581	*83,043*
Women 15-24 years	3,259,162	6.1%	199,705	142,174	128,824	65%	81%	1,809,399	52,736	*49,527*
Women 25+ years	5,893,368	18.1%	1,065,253	938,034	753,962	71%	88%	2,062,109	112,916	*106,409*
MSM	41,393	6.8%	2,800	8.8%	1,264			9,663	1,943	506
FSW	93,523	23.4%	21,866	22.3%	5,546			22,057	6,187	2,831
PWID	13,514	38.4%	5,193	62.3%	125			526	165	88
Priority Pop (Prisoners)		24.0%			1,107			10,238	1,227	554

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

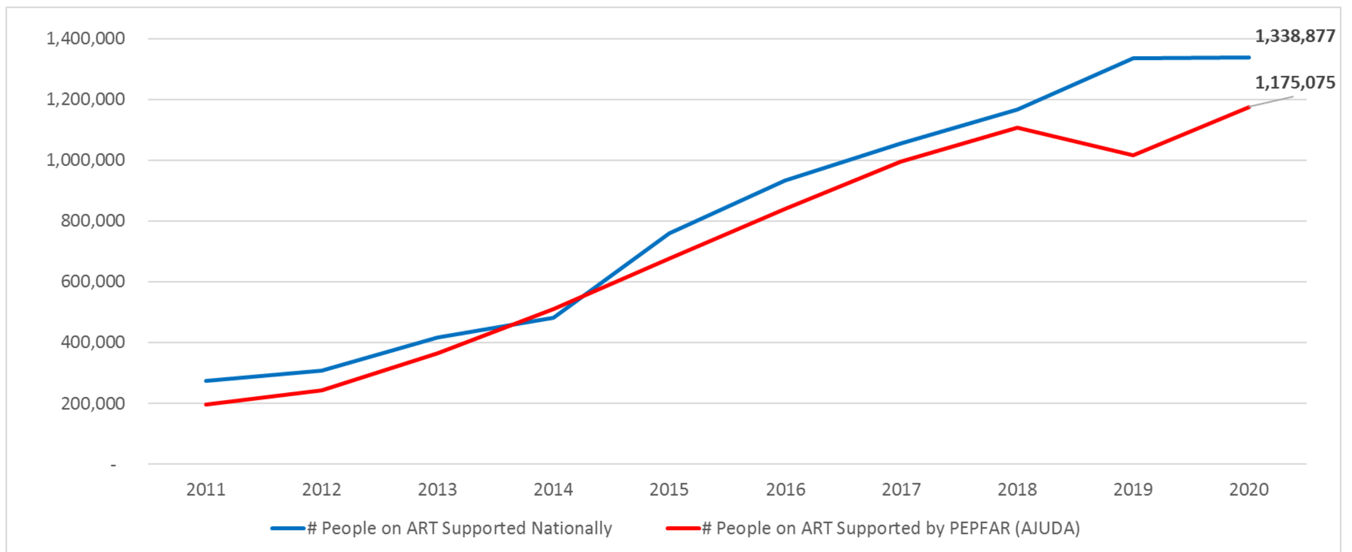


Figure 2.1.4: Trend of New HIV Infections and All-Cause Mortality Among PLHIV

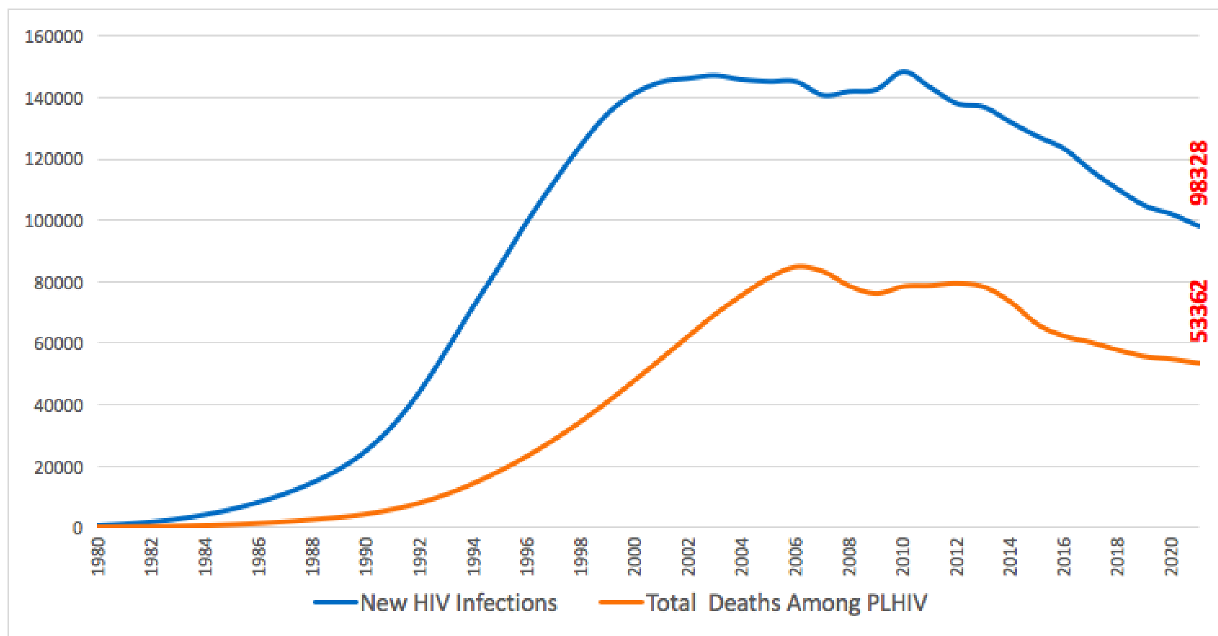


Figure 2.1.5: Progress on retaining individuals from FY20Q2 to FY21 Q1 (4 Quarters)

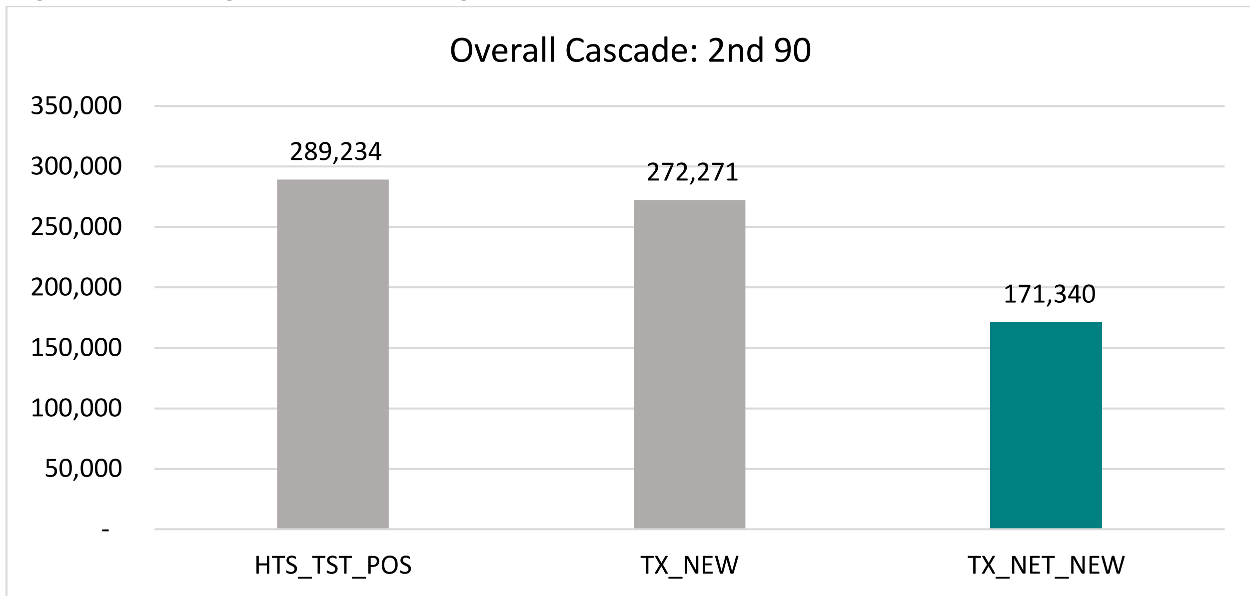


Figure 2.1.6: Proportion of clients lost in life-long ART in FY21Q1 (Based on TX_ML, Panorama)

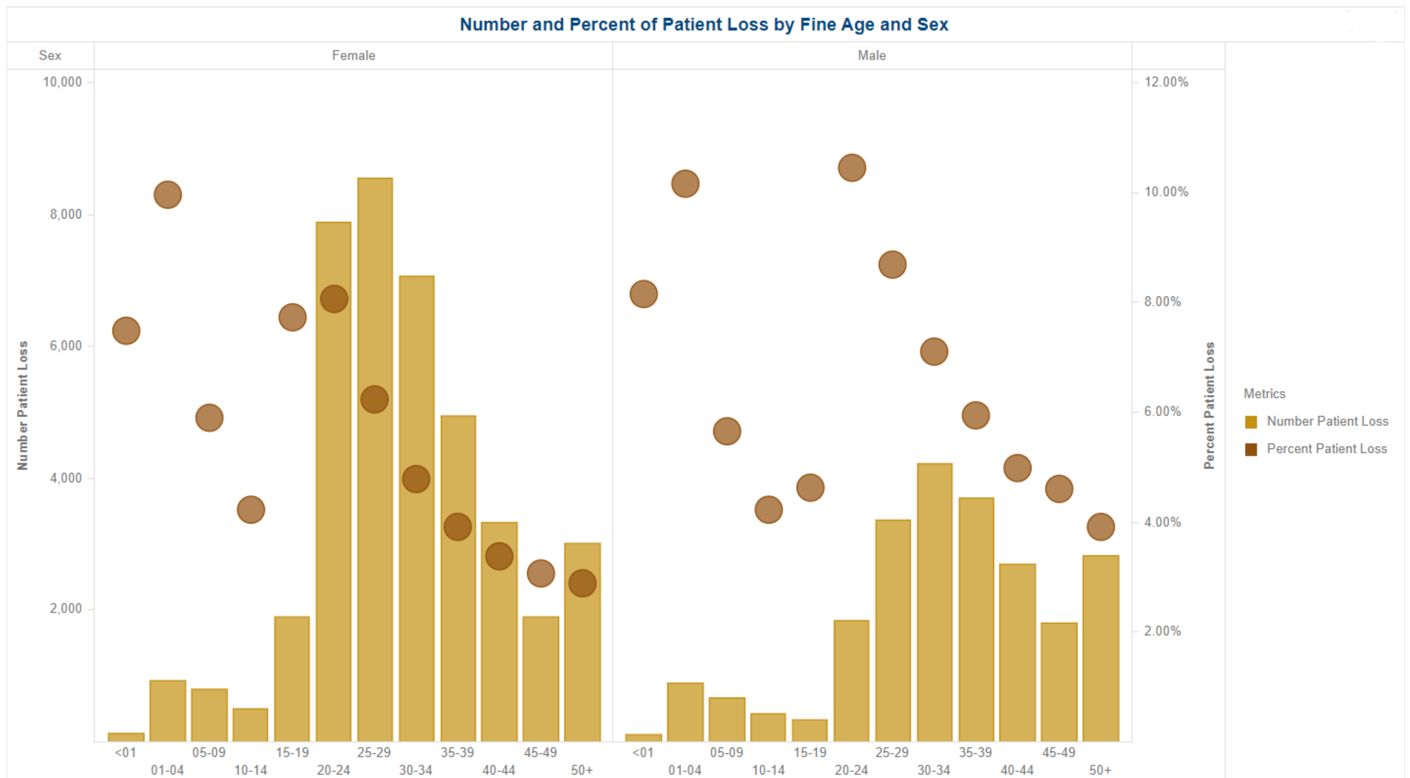


Figure 2.1.7: Epidemiologic Trends and Program Response for Mozambique

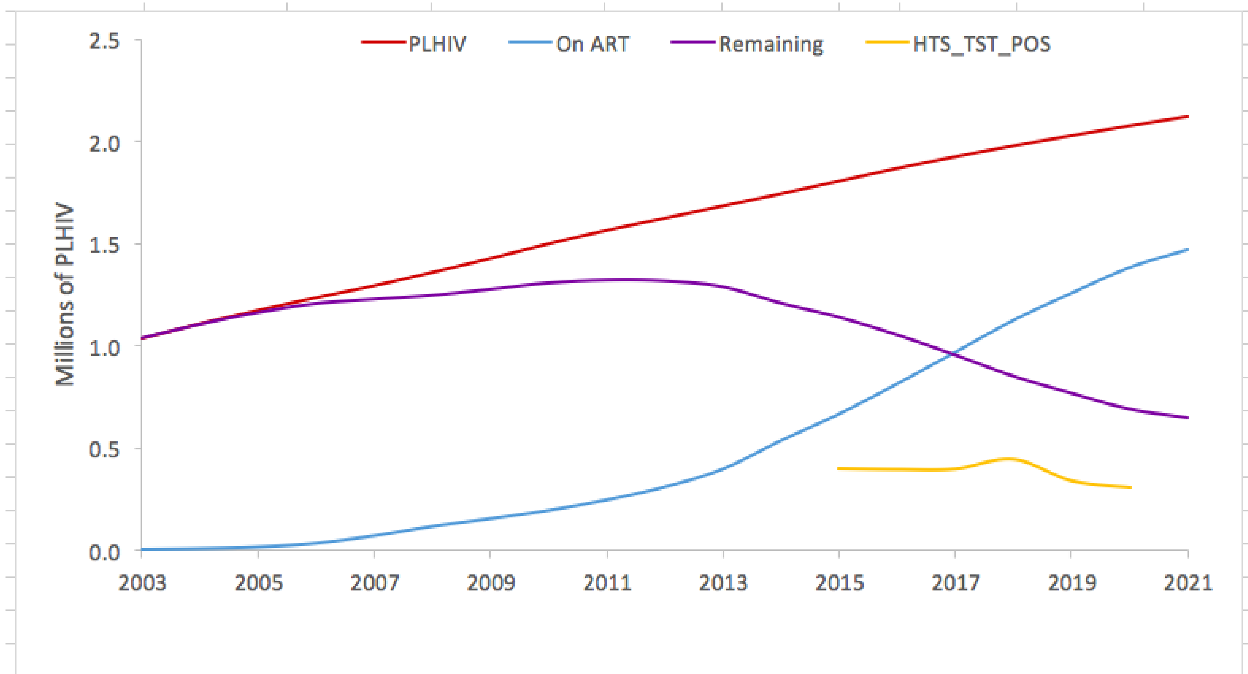
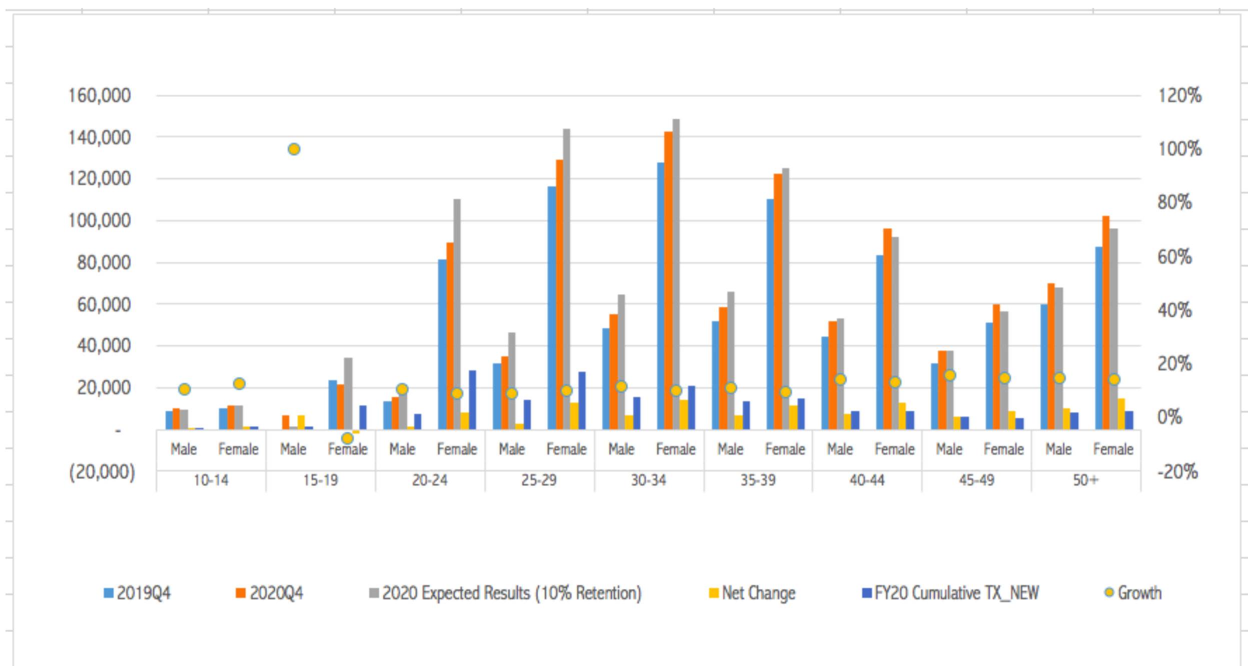


Figure 2.1.8: Net change in HIV treatment by sex and age bands 2019 Q4 to 2020 Q4



2.2 Consolidating Gains from COP20, Including Focus on Client Retention

During COP21, PEPFAR Mozambique will work with the GRM to improve retention among all persons receiving HIV care. The 12-month retention among PLHIV newly initiating ART in FY21 Q1

was 79 percent overall. In order to address challenges and program gaps identified, PEPFAR Mozambique, in coordination with the GRM, will support implementation of new activities and interventions during COP21.

Advanced disease

In Mozambique, no rigorous research data is available to describe the prevalence of advanced HIV disease; based on available electronic record CD4 data in Q4 FY20, the proportion of patients with advanced HIV disease varies among the provinces, with estimates in three provinces as high as one third of all patients based on their first CD4 test result (Table 2.2.1). Though decreasing in prevalence, low CD4 at ART initiation remains a problem that should be urgently addressed. For this fiscal year and in COP21 PEPFAR Mozambique is providing technical support to the GRM in order to develop advanced disease guidelines, provider training packages, and job aids. PEPFAR Mozambique, through implementing partner cooperative agreements, has also participated in central level training of trainers and will facilitate cascade trainings at district and health facility levels for effective screening and management of patients with advanced disease.

The advanced disease diagnostic and therapeutic package is composed of (i) CD4 screening and referral, (ii) co-trimoxazole prophylaxis, (iii) screening for active tuberculosis (TB) with urine lipoarabinomannan assay (LF-LAM) and GeneXpert MTB/RIF Ultra, and (iv) screening for cryptococcal disease, followed by prophylactic or therapeutic fluconazole. Facility-level implementation of this package will begin in late COP20 (FY21), based upon anticipated arrival of Global Fund-procured advanced disease commodities. The GRM has indicated its expectation that PEPFAR Mozambique should support implementation of the complete advanced disease package in a subset of central, provincial, and general hospitals, as well as the intermediate advanced disease package in referral district health facilities that have a robust outpatient HIV sector. All AJUDA sites will perform advanced HIV disease screening through CD4 screening and TB LAM (with cryptococcal screening subsequent to CD4 result).

Further evaluation and clinical management will be addressed through referral to the nearest facility offering the necessary advanced disease services. Where possible, clinical management should be offered at the site where the advanced disease was first identified. For some patients, this may be the basic primary care level facility where they were first seen. If a health facility does not have CD4 laboratory capacity, samples will be referred to the closest facility with this capacity.

In addition to diagnostic screening capacity at the primary health care facility level and indicated clinical management through a referral network, PEPFAR Mozambique also has committed resources to ensure that specialized advanced disease clinicians will be available at the province-level to offer technical assistance, supervision, and mentorship to PEPFAR Mozambique implementing partner clinicians who provide adult and pediatric advanced disease care at any AJUDA-supported facility within that particular province.

Table 2.2.1: Proportion of patients with CD4 < 200 cells/mm^3 at ART initiation, Q4 FY20

Province	CD4 ≤ 200 cells/mm^3
Niassa	Data not available
Zambézia	33%
Cabo Delgado	35%
Nampula	32%
Tete	30%
Maputo City	29%
Maputo Province	27%
Sofala	27%
Gaza	23%
Inhambane	22%
Manica	21%
FY20 Quarter 4, MOZART[20]	

Improving mental health

Research has shown that mental illness is a barrier to retaining HIV positive patients in care. Identification of patients with untreated mental illness has been recommended to improve clinical management and outcomes of this subpopulation. During COP19, the Common Elements Treatment Approach (CETA) program for diagnosis and treatment of symptoms of mental illness was introduced in five health facilities in Sofala Province. CETA involves application of a mental health symptom screening instrument that has been validated through randomized trials for use in low- and middle-income resource contexts that may rely upon non-mental health providers to deliver HIV care. The transdiagnostic instrument (and the accompanying treatment intervention) seeks to integrate screening, care, and treatment for depression, traumatic stress, substance abuse, and anxiety into existing HIV psychosocial and treatment platforms.

[20] MozART is a national patient level database generated quarterly from all sites with OpenMRS.

Observations from the Sofala sites demonstrated that 50% of PLHIV enrolled in treatment screened positive for clinically significant mental health symptoms. CETA's transdiagnostic methodology allows for treatment of any of these mental health challenges through a single approach. While the Sofala model in COP19 relied upon lay counselors to perform the diagnostic and therapeutic interventions, in May 2021, the approach will be as follows: screening will be performed by psychosocial counselors at all 22 selected health facilities in 11 provinces across Mozambique, but treatment will be provided by licensed clinical psychiatric technicians from the MISAU´s Department of Mental Health. The sites were selected based on the presence of key criteria at the health facility level [namely: (i) psychiatric technicians and psychologists available to provide all mental health services; (ii) adequate and private physical space for mental health consultation; (iii) historically low treatment retention rates].

MISAU has indicated that any expansion of the CETA model should be fully integrated into existing psychosocial support (APSS) programs and national guidelines, of which the 2nd edition was launched recently. For example, CETA central partner staff will provide technical assistance to develop an APSS screening instrument that reflects the elements of the validated CETA instrument. Funds for this activity will be provided through PEPFAR Mozambique Implementing Partners to include provision of technical support to MISAU at the central level for development of national guidelines, health facility materials, standard operating procedures, provider job aids, cascade trainings and relevant training materials. PEPFAR Mozambique Implementing Partners will also support hiring a limited number of psychologists and mid-level psychiatric technicians to provide treatment for any patients who have evidence of mental health symptoms at selected sites after screening is completed. PEPFAR Mozambique plans to expand to one additional site per province in COP21.

Building on the national male engagement strategy through strategic marketing and youth case management

Though the MISAU Male Engagement Strategy was officially launched in 2017 followed by implementation in selected districts during COP18, the number of men identified, linked, and retained in antiretroviral (ARV) therapy remains too low to reach the UNAIDS 95-95-95 goals. Approximately 330,000 men (15+ years) are estimated to never have been linked to care or are currently not retained in care. Additionally, individuals who have been lost-to-follow-up for greater than 12 months are historically hard to trace and re-engage in care. Reaching epidemic control requires returning known HIV+ men to care. Once they return, providers and program implementers must prioritize treatment literacy in order to emphasize the value and simplicity of new HIV therapy regimens (namely dolutegravir-based regimens) available in differentiated models of service delivery.

In COP21, PEPFAR Mozambique, in alignment with the MISAU National Male Engagement Strategy, will continue to pursue three additional strategies to improve engagement with this hard-to-reach subpopulation. These strategies are: (i) strategic marketing, (ii) youth case management, and (iii) leveraging the unique platform and contributions of faith-based organizations.

Strategic marketing

In Mozambique, approximately 150,000 men who are HIV+ have never received an HIV+ diagnosis. An additional 188,000 men, who received an HIV+ diagnosis, were never linked or have abandoned the treatment program. Epidemic control requires that these HIV+ men are identified, linked, or returned to care. Fortunately, Mozambique now has a new value proposition for HIV treatment, offering new and varied differentiated service delivery models, and providing new and more effective drug regimens. These new patient-centered services must be strategically communicated if they are to achieve desired uptake. In close collaboration with S/GAC and the MenStar Coalition, PEPFAR Mozambique has created a campaign that rebrands HIV services for men in a way that talks directly to their motivators and barriers to treatment adherence. The strengthening of this brand is predicated on wide stakeholder (particularly PLHIV themselves) and other PEPFAR Mozambique partner engagement. The campaign is designed to normalize community dialogue on HIV, reduce provider stigma through supportive inter-personal communication training to health care workers, and highlight that PLHIV can lead healthy and fulfilling lives. The campaign is guided by PLHIV, following significant formative research into the barriers men face in linking and staying in treatment as well as multiple workshops to seek a greater understanding into the journey of men living with HIV. On-going PLHIV input has also been formalized in the Marketing Advisory Committee (MAC), which consists of PEPFAR Mozambique representatives, clinical Implementing Partners (IPs), civil society, PLHIV, and the GRM. The MAC, which brings together a diverse array of perspectives, has been instrumental thus far in providing strategic guidance to campaign development.

Youth engagement and targeted support

Program and research data suggest that the majority of young HIV+ men are sexually active, asymptomatic, and have limited interactions with the health system.[21] According to UNAIDS 2020, 57% of all estimated new infections occur among young adult men (ages 20-29) and adolescent girls and young women (AGYW; ages 15-24). Additionally, over 60% of all estimated new HIV infections among AGYW come from young adult men (ages 20-29). To address these findings, PEPFAR Mozambique, in coordination with the GRM, will expand its targeted support to this age group at 90 facilities (an additional 25 from the COP20 sites) with high reported treatment interruption rates among AGYW and adolescent boys and young men (ages 15-29). These facilities are spread across all 11 provinces, with at least one expansion site in every province. The following activities will be layered and delivered simultaneously at all 90 sites:

Youth Case Management

This strategy targets individual adolescent and young adult men (age 15-29) and adolescent and young adult women (ages 15-24). A trained youth manager, who functions at the health facility level, completes an intake process which includes conducting a needs assessment, assigning a peer mentor, arranging a preventive home visit, and inclusion of the client in an age-appropriate support

[21] GOALS (Age-Sex Model) UNAIDS,2019
Directrizes para Engajament do Homens aos Cuidados de Saúde, 2018

group. As needed, case managers can arrange for referrals for complementary community-based support.

Peer Mentorship
Full-time hired PLHIV peers organize regular meetings and support individualized adherence plans for clients. Peer Mentors also focus on social dynamics, such as supporting disclosure, addressing stigma, discrimination, violence, human rights, promoting treatment literacy, and assisting with clinic navigation. Additional mentorship support can occur through regular age and sex-specific support group meetings.

Group Support
As part of the implementation of differentiated service delivery models for adolescents and youth, PEPFAR Mozambique is working to support the implementation of adolescent teen and young adult clubs. Adolescents and young adults living with HIV lead group sessions, which serve the purpose of sharing experiences, encouraging disclosure, reducing stigma and discrimination, improving self-esteem, enhancing patients' coping skills and psychosocial functioning, and supporting medication adherence and improved retention in HIV care. These sessions are coordinated with clinical care.

Faith-Based Interventions

Faith communities often have a deeply established and trusted community presence. Faith-based organizations (FBOs) and faith communities, as respected partners, are key for reaching PLHIV at earlier stages in their disease progression and providing critical support for continuity of HIV care. Many FBOs increasingly recognize that alarming rates of sexual violence against adolescent girls and young women and inaccurate perceptions around HIV are further fueling HIV transmission. As trusted influencers, strategic collaboration with faith leaders is expected to help make the achievement of sustained HIV epidemic control a reality. In COP20, a training package and set of communication materials were developed and faith leaders across the country were trained to deliver high-quality interventions in their communities. In COP21, this activity will be expanded to two additional provinces, providing full national coverage. A religious leaders committee will be supported, with the aim of creating a platform that will provide guidance and technical assistance to the implementing FBOs as well as contribute to refining the approach in coordination with the GRM.

2.3 Investment Profile

National Health Budget

Despite the detrimental effects of the COVID-19 pandemic on the national economy, with the country witnessing its first economic contraction in 28 years (-1.3% growth) and a 22% reduction in

domestic revenue collection, the GRM flatlined the health sector budget from its 2019 levels, by allocating 27.98 billion meticais (roughly $427 million dollars) to health in the 2020 budget.

This allowed for payment of a COVID-19 risk subsidy to all front line and at-risk health workers, equivalent to 30% of monthly base pay.

The government also embarked on an aggressive resource mobilization campaign, securing approximately $500 million in additional financing from the International Monetary Fund (IMF), World Bank, and other multilateral institutions. The GRM also secured temporary debt relief for sovereign obligations.

Health sector spending is on an upward trajectory, having increased by 32% since 2017. The 2020 health sector budget accounts for 8.9 percent of the overall state budget. The health sector budget is essentially internally funded, with on-budget external resources contributing 15 percent. When compared to the 2008 ratio (48 percent internal in 2008 versus 54 percent in 2020), it is evident that the Government has steadily increased its contribution to the health sector. It is important to note that the above-referenced ratios of external financing do not reflect off budget-resources. Vertical donor programs that do not directly finance the health sector budget ("off 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. Approximately 79 percent of the health sector budget covers recurrent expenditures, and 21 percent is dedicated to investment expenditures. Not surprisingly, 71 percent of investment expenditures are externally (donor) financed, an increase of 4 percent relative to 2019.

Health sector spending in Mozambique remains highly centralized. Since 2008, the majority of health resources have been executed at a central level, with central level institutions receiving an average of 59 percent of the overall health budget. The 2020 budget allocated 61 percent of health resources to central level institutions (i.e. the Mozambique Ministry of Health [MISAU], central hospitals, central medical stores), 17 percent to the provincial level (i.e. provincial health directorates, provincial hospitals) and 22 percent to the district level (district health directorates).

HIV expenditures

Currently, Mozambique is conducting a national AIDS spending assessment (NASA). The most recent Global AIDS Monitoring Report indicates that total HIV expenditures in 2016 amounted to $545 million, an increase from $343 million in 2015 and $333 million in 2014. PEPFAR Mozambique and the Global Fund are the main source of funds for the HIV response, accounting for approximately 83 percent of HIV expenditures in 2020. Government expenditures in 2020 accounted for $65 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), which comprises approximately 12.5 percent of total expenditures on HIV, an increase from $16.2 million (5 percent of HIV expenditures) in 2019.

Expenditure by cost category

79 percent of the GRM´s health budget is dedicated to recurrent expenditures (salaries, procurement of goods and services, operating costs, transfers, and financial operations). Only 21 percent of the health budget is spent on investment (capital expenditure) aimed at improving access to health services and quality of care. As a result, resource limitations severely constrain Mozambican health sector capacity to increase health care access and improve infrastructure.

Donors will procure one hundred percent of antiretrovirals between 2021-2023 (equivalent to the current Global Fund allocation period). Global Fund will procure 78 percent and PEPFAR Mozambique will procure 22 percent. These antiretrovirals are sourced through international pooled procurement mechanisms [Global Health Supply Chain Procurement and Supply Management (GHSC-PSM), and Global Fund Wambo]. The GRM also relies on donors, particularly the United States Government (USG), for other HIV commodities such as viral load and early infant diagnosis (EID) reagents.

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

Planned Government Contributions

The GRM had committed to spend $10 million/annum on commodities for HIV ($5 million for ARVs and $5 million for test kits), a significant move towards reducing reliance on international partners for the HIV response. However, this contribution did not materialize due to a reduction in government revenues. The government has also committed to maintain domestic funding for health constant until 2022, in accordance with a World Bank (GFF) funding agreement, as well as a condition for Global Fund support. However, the GRM´s ability to meet this commitment is at risk in light of significant reduction in domestic revenues caused by the COVID-19 pandemic. The GRM has also acknowledged its current limited capacity to finance additional human resources or improve working conditions, required for quality health care service delivery.

Data availability and Estimations

Health sector expenditures are estimated from 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, beneficiary population, and geographical location. Available data spans 2004-2020.

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, population growth (as noted in the 2017 census) and high HIV prevalence (as estimated in IMASIDA 2015) suggest that Mozambique could have significantly more people living with HIV than previously known (~2.1 million in lieu of ~1.6 million). Second, as stated previously, Mozambique is facing a severe fiscal crisis, caused by three factors, namely excessive debt (equivalent to 125% of GDP), economic contraction caused by COVID-19 pandemic, and a growing insurgency in the northern region of the country. The medium to long term economic outlook is mixed – the extractive windfall is increasingly distant due to conflict and market trends, but the country has significant untapped potential in other areas (agriculture, logistics, mining). As such, it is critical that PEPFAR Mozambique, Global Fund, and other donors support planning to achieve sustainable financing strategies to allow the GRM to gradually become the primary funder of the HIV response.

Table S1. Mozambique Investment Profile (Budget Allocation) for HIV Programs, 2021

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	$	%	%	%	%
Care and Treatment	$311,593,900	0%	22%	78%	0%
HIV Care and Clinical Services	$206,688,259	0%	31%	69%	0%
Lab Services incl. Treatment Monitoring	$48,497,159	0%	0%	100%	0%
Care and Treatment (Not Disaggregated)	$56,408,482	0%	8%	92%	0%
HIV Testing Services	$25,664,591	0%	43%	57%	0%
Facility-Based Testing	$11,534,451	0%	22%	78%	0%
Community-Based Testing	$7,397,008	0%	64%	36%	0%
HIV Testing Services (Not Disaggregated)	$6,733,132	0%	56%	44%	0%
Prevention	$65,618,250	0%	25%	75%	0%
Community mobilization, behavior and norms change	$7,574,468	0%	74%	26%	0%
Voluntary Medical Male Circumcision	$13,889,499	0%	0%	100%	0%
Pre-Exposure Prophylaxis	$5,890,069	0%	3%	97%	0%
Condom and Lubricant Programming	$1,792,203	0%	100%	0%	0%
Opioid Substitution Therapy	$39,091	0%	100%	0%	0%
Primary Prevention of HIV & Sexual Violence	$15,601,611	0%	23%	77%	0%
Prevention (Not Disaggregated)	$20,831,309	0%	24%	76%	0%
Socio-economic (incl. OVC)	$23,294,812	0%	31%	69%	0%
Case Management	$5,665,171	0%	0%	100%	0%
Economic Strengthening	$7,032,284	0%	0%	100%	0%
Education Assistance	$2,911,245	0%	0%	100%	0%
Psychosocial Support	$120,438	0%	0%	100%	0%
Legal, Human Rights, and Protection	$5,131,466	0%	96%	4%	0%
OVC (Not Disaggregated)	$2,434,208	0%	91%	9%	0%

Above Site Programs	$40,215,792	0%	50%	50%	0%
Human Resources for Health	$3,090,525	0%	37%	63%	0%
Institutional Prevention	$0				
Procurement and Supply Chain Mgmt	$13,276,377	0%	77%	23%	0%
HMIS, Surveillance, and Research	$16,120,641	0%	43%	57%	0%
Laboratory Systems Strengthening	$5,194,337	0%	0%	100%	0%
Public Financial Mgmt Strengthening	$450,289	0%	9%	91%	0%
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$2,083,623	0%	91%	9%	0%
Laws, Regulations and Policy Environment	$0				
Above Site Programs (Not Disaggregated)	$0				
Program Management	$66,632,464	0%	16%	84%	0%
Implementation Level	$66,632,464	0%	16%	84%	0%
Total (incl. Commodities)	**$564,246,257**	**6%**	**24%**	**71%**	**0%**
Commodities Only	**$143,068,908**	**0%**	**45%**	**55%**	**0%**
% of Total Budget	*25%*				
Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available.					

Table S2. Mozambique Investment Profile (Budget Allocation) for HIV Commodities, 2021 Budget

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	$	%	%	%	%
Antiretroviral Drugs	$64,476,288	0%	63%	37%	0%
Laboratory Supplies and Reagents	$38,540,393	0%	10%	90%	0%
CD4	$0				
Viral Load	$30,899,798	0%	0%	100%	0%
Other Laboratory Supplies and Reagents	$7,640,596	0%	52%	48%	0%
Laboratory (Not Disaggregated)	$0				
Medicines	$5,700,165	0%	58%	42%	0%
Essential Medicines	$942,972	0%	94%	6%	0%
Tuberculosis Medicines	$2,710,675	0%	13%	87%	0%
Other Medicines	$2,046,517	0%	100%	0%	0%
Consumables	$11,066,256	0%	70%	30%	0%
Condoms and Lubricants	$1,518,342	0%	100%	0%	0%
Rapid Test Kits	$8,347,411	0%	73%	27%	0%
VMMC Kits and Supplies	$1,124,003	0%	0%	100%	0%
Other Consumables	$76,500	0%	100%	0%	0%

Health Equipment	$2,440,420	0%	75%	25%	0%
Health Equipment	$1,142,202	0%	77%	23%	0%
Service and Maintenance	$1,298,218	0%	73%	27%	0%
PSM Costs	$20,845,387	0%	32%	68%	0%
Total Commodities Only	**$143,068,908**	**0%**	**45%**	**55%**	**0%**
Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available.					

Table 2.3.1 Annual USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources CoFunding PEPFAR IMs	# CoFunded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$20,854,000	$4,356,000	7	-	Focus on end-to-end supply chain strengthening, including procurement of essential commodities for maternal and child health. Funds will bolster the medical commodities delivery systems, focusing on ensuring the accessibility and availability of maternal and child health commodities. Strengthen the GRM's pharmaceutical systems and support G2G in strengthening the medical commodities supply chain.
USAID TB	$6,500,000	$559,000	3	-	Support G2G in providing capacity building and strengthening the training, supervision and procurement of medical supplies. Support for a seconded TB medication focused advisor to the Central de Medicamentos e Artigos Médicos (CMAM) and the transition of all TB medications to CMAM oversight.
USAID Malaria	$28,070,000	$16,435,000	2	$230,272	Increase the availability of essential health supplies by strengthening supply chains, commodity procurement, and creating more supportive environments for commodity security. Funds will support forecasting, procurement, warehousing and distribution of key malaria commodities, including commodities for diagnosis, prevention, and treatment of malaria. The PEPFAR Mozambique Co-Funding contribution will support trainings of trainer

					sessions for religious leaders to disseminate key messages to segmented audiences in their communities and create a referral and counter referral system between health units and religious leaders.
USAID Family Planning	$18,320,000	$3,815,000	7	-	Increase access to and use of voluntary family planning (FP) contraceptive methods; procure and deliver commodities for family planning and reproductive health. Design and produce high quality, evidence-based SBCC resources for local and community-based partners that provide FP. Funds will bolster the medical commodities delivery systems, focusing on ensuring the accessibility and availability of family planning commodities and strengthen the GRM's pharmaceutical systems.
USAID Nutrition	$6,867,000	$663,000	3	-	Support the supply chain for nutrition commodities. Nutrition resources will improve the management of nutrition commodities throughout the system and in target provinces. Funds will bolster the medical commodities delivery systems, focusing on ensuring the accessibility and availability of nutritional commodities.
Other (PEPFAR)	n/a	n/a	n/a	$1,450,663	Improve USAID/Mozambique's monitoring, evaluation and learning systems and improve capacity building of local partners.
CDC (Global Health Security)	n/a	n/a	n/a	n/a	
DOD (Ebola)	n/a	n/a	n/a	n/a	
Millennium Corporation Challenge (MCC)	n/a	n/a	n/a	n/a	
Other					

Total	80,611,000	25,828,000		1,680,935	

2.4 National Sustainability Profile Update

Mozambique has confronted multiple challenges over the past few years. On the fiscal front, the country has been traversing a period of austerity, with limited external donor support. In 2019, windfall, one-time, capital gains taxes from two large oil and gas transactions provided the government with much needed fiscal relief. Nevertheless, the country faces a generalized and growing HIV epidemic as well as a COVID-19 epidemic, which remains challenging to manage. Mozambique conducted the last sustainability assessment in 2019, and the country has made notable progress across all domains since the assessment.

Sustainability Index Dashboard (SID) Process

The Sustainability Index Dashboard is completed every two years via a collaborative, consultative process coordinated by UNAIDS and PEPFAR Mozambique, 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, collected in 2019) was approved by the Minister of Health in September 2019.

Sustainability strengths (2019)

- Quality Management (8.76, dark green): MISAU has developed and rolled out a number of quality management/quality improvement tools to improve the HIV response.
- Policies and Governance (8.30, light green): The country has approved tenofovir-lamivudine-dolutegravir (TLD) as a new adult regimen and is making the new treatment regimen available nationwide in a phased manner. Mozambique has laws and policies in place that follow the most recent WHO guidelines that protect victims of domestic violence and protect against discrimination.
- Human Resources: (7.26, light green): MISAU, in coordination with donor partners, has rolled out a data driven human resource allocation system, which deploys staff to health facilities with the highest need. The country has also invested in the human resource information system, which is recognized as one of the best in the region, and which provides reliable data on HRH allocation.

Sustainability vulnerabilities (2019)

- Laboratory Services (3.93, yellow): Although the sustainability score improved relative to the previous SID (2.83, red), the laboratory system in Mozambique remains challenged at all levels. PEPFAR Mozambique continues to support the laboratory system with a focus on expansion of VL coverage. PEPFAR Mozambique finances 100% of VL commodities and is committed to

guaranteeing access to VL for all PLHIV in Mozambique. Other challenges faced include low technical capacity, poor data management and long result turn-around times.

- Commodity security and supply chain (4.95, yellow): The GRM has struggled to keep pace with an increasingly complex and data driven supply chain. The current system is inefficient, poorly resourced, and heavily dependent on donors. The sustainability index score for this domain fell from 6.18 (SID 3.0) to 4.95. Mozambique remains heavily reliant on donor support for ARV's and test kits, as well as supply chain operational support. The Government has committed to allocate $10 million/year for ARV's. PEPFAR Mozambique and other donor partners will continue to provide technical and financial assistance to identify innovative systems and mechanisms that may help improve the effectiveness of the national supply chain.

In COP21, PEPFAR Mozambique's 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 FY2021. This will ensure that 90 percent of PLHIV will have access to VL and monitoring for viral suppression. The program will complete and implement recommendations from the lab optimization exercise, maintain technical assistance for the national laboratory network, and expand Data Intensive Systems Applications (DISA) link coverage from 233 facilities to 325 facilities by the end of COP21.

In COP21, PEPFAR Mozambique will also continue to support MISAU with implementation of the pharmaceutical logistics strengthening plan, with a specific focus on intermediate warehouses. By the end of COP21 PEPFAR Mozambique will support MISAU and Central de Medicamentos e Artigos Médicos (CMAM) to complete implementation of the "commando unico" reform, which aims at consolidating the supply chain to improve efficiency and end-to-end visibility. PEPFAR Mozambique will also expand support for third party distribution of medicines to improve effectiveness of the supply chain, as well as improve site level availability of ARVs. PEPFAR Mozambique will also support rollout of alternative ART distribution models (community, private sector pharmacies) and multi month scripting. Finally, PEPFAR Mozambique will continue to advocate for increased domestic contributions for ARVs and test kits.

Global Fund financial support, under the new grant (2021-2023) funding cycle, will increase by 30%, a much-needed boost for the national response. Domestic contributions are expected to remain stable during COP21. Mozambique is reengaging with on-budget support donors and the International Monetary Fund and expects to secure additional financial assistance in 2021. On-budget sector support provided through the *Pro-Saude* common fund is expected to remain constant.

USG collaborates with a range of local partners in Mozambique including non-governmental organizations (NGOs), faith-based, 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 all 11 sub-

national provincial health directorates and will consolidate and expand partnerships with existing local partners (National Institute of Health [INS], MISAU, CNCS and CMAM).

2.5 Alignment of PEPFAR investments geographically to disease

In COP19, in order to maximize the impact of finite PEPFAR resources, an effort was made to concentrate PEPFAR Mozambique investments in a smaller number of health facilities. A total of 628 sites (out of 1,365 sites) with direct clinical IP support were prioritized based on having historically provided ART to 90% of Mozambique's patients on ART (referred to as AJUDA sites). The remaining 737 sites were classified as Sustainability Sites to continue receiving PEPFAR Mozambique support through government-to-government cooperative agreements, both national and provincial. In addition, core services such as antiretroviral therapy and lab sample transport continued to be funded by PEPFAR Mozambique at all ART sites in the country. In this way, PEPFAR Mozambique struck a balance between focused intervention for maximum impact and equity.

AJUDA site selection was driven primarily by size but informed by contextual factors. Initial FY19 Phase 1 sites were identified by selecting the largest sites with the poorest 12-month retention and 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 the 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.

Clinical IPs began working intensively in these sites in a phased manner under the auspices of the "AJUDA response." In FY19 and 20, the roll-out of intensive clinical IP support to Phase 1, 2, and 3 sites was accomplished. As in COP20, in COP21, these phases are no longer operationally distinct, but rather all 620 sites[22] receive the same support package. In COP21, in addition to ongoing focused support at AJUDA sites, PEPFAR Mozambique will increase IP support at provincial referral hospitals in order to ensure functional referral services for advanced HIV disease as well as treatment capacity for advanced pre-cancerous cervical lesions. As of FY21 Q1, there were 934 sites reporting TX_CURR as sustainability sites (with 628 reporting as AJUDA sites), making a total of 1,554 ART-providing sites that receive PEPFAR Mozambique support. In light of its mandate to provide a basic package of services to all Mozambican PLHIV, MISAU may expand the number of Sustainability Sites if and when ART services are expanded to new sites.

[22] 9 sites closed in Cabo Delgado Province and 1 site in Gaza Province split into 2, adding 1 additional site.

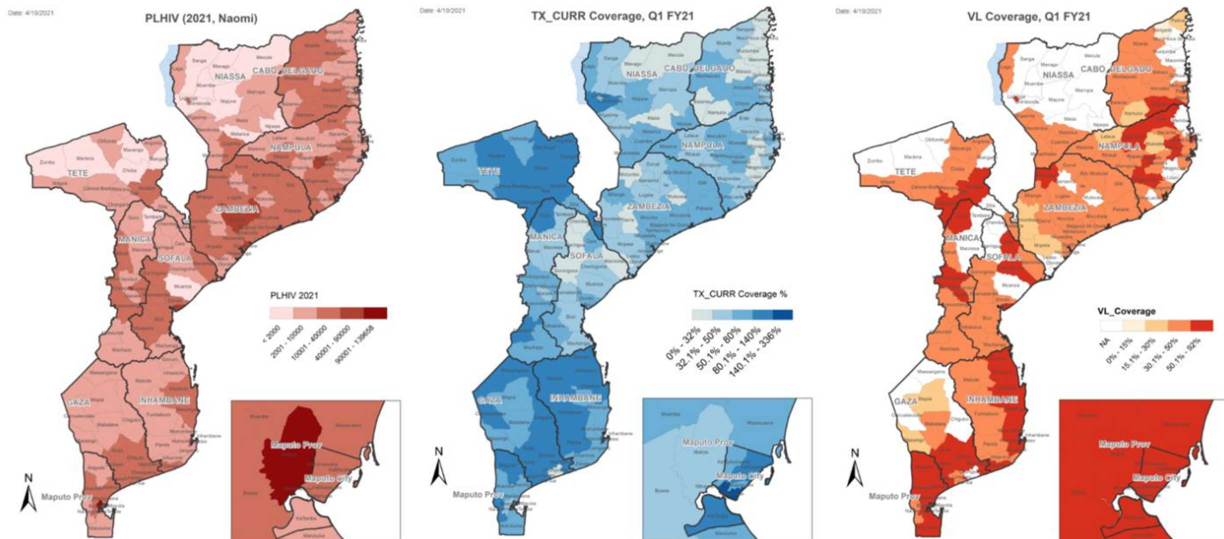
AJUDA site designations can and should respond to changes in the distribution of the HIV epidemic. During the COP21 planning period, an analysis was conducted of current HIV treatment services (TX_CURR) to ensure that the COP20 AJUDA and Sustainability site assignments were still optimized. Nine prior AJUDA sites in Cabo Delgado have been closed because of ongoing violence in the region and one AJUDA site in Gaza split in two. As such, in COP21, PEPFAR Mozambique will support 620 AJUDA sites representing 86.3% of TX_CURR nationally and serving 1,211,589 PLHIV.

AJUDA sites are sites in which clinical IPs provide a comprehensive package of primary-care HIV services designed to support the clinical care cascade. These site designations have focused the efforts of clinical IPs in a way that maximizes impact. However, in designating some sites as AJUDA and some as Sustainability, it is not to say that clinical IPs play no role in Sustainability sites, simply that they do not provide the comprehensive primary-care HIV package. The AJUDA selection algorithm was driven by TX_CURR achievement, which is closely tied to the distribution of people living with HIV. The following areas of HIV programming use geographical distribution strategies distinct from the AJUDA site selection logic:

1. As a preventive intervention, voluntary male medical circumcision (VMMC) operations are guided by a quantification of how many people could benefit from the intervention rather than simply the numbers of people on treatment for HIV; in this case, as measured by the numbers of uncircumcised men aged 15-29.
2. While allocation of primary-care services should be guided by the geographic distribution of beneficiaries, allocation of higher-level services such as cervical cancer or advanced disease treatment may instead leverage the organization of existing referral networks.
3. Although informed by the distribution of PLHIV, key population targeting is guided by a joint consideration of the distribution of key populations themselves and HIV prevalence within those specific populations.
4. Systems interventions like ART supply chain and lab sample transport are more efficiently and effectively run by a single entity. In these cases, PEPFAR Mozambique IPs support the entire country though the frequency of service will align with the frequency of demand.

It is neither accurate to say that PEPFAR Mozambique IPs only work in AJUDA sites, nor that if PEPFAR Mozambique IPs work in a given site, then provision of the entire package of primary care HIV treatment services is necessarily appropriate or strategic. The AJUDA designation guides deployment of PEPFAR Mozambique's primary-care HIV treatment package, which is our largest and most strategically important package, but is not our only package of services. Treatment for advanced precancerous cervical lesions, for instance, is often provided at tertiary care centers, which by design do not provide longitudinal primary healthcare services or do so minimally. Similarly, HIV testing in inpatient wards of tertiary care centers is strategically important and supported regardless of AJUDA designation; after discharge such patients are referred to the health facility closest health center to their residence for ongoing management.

Figure 2.5.1: Percent PLHIV by SNU, total PLHIV by SNU, Coverage of total PLHIV with ART and Viral Load Coverage by SNU



2.6 Stakeholder Engagement

Host country government

PEPFAR Mozambique 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 achievement of country goals. Leadership from MISAU, CNCS and PEPFAR Mozambique led stakeholders' meetings has helped to assure that policy decisions were fully communicated and resulted in action. For the PEPFAR Mozambique quarterly results meetings, CNCS has been organizing and facilitating access to the meetings from each of their Provincial offices, as a secure space for local community-based organizations (CBOs) to virtually attend the meetings being held in Maputo. CNCS also has steering committees and regular meetings with wide stakeholder participation. And in this past year, there has been in increased focus on fighting stigma and in getting men back into treatment.

Throughout the year, national leadership from the Ministry of Health and the National AIDS Committee meet regularly with PEPFAR Mozambique interagency leadership to make key decisions on policy and strategy both for COP planning as well as implementation. These "Directors' Meetings" happen at least quarterly, and more frequently during the COP preparation period. The COP21 in-country virtual stakeholder retreat began on January 26, 2021 and spanned a 2-week period of intense discussions among key stakeholders to finalize programmatic priorities and targets and develop a united national plan, prior to the COP21 pause. Following the re-start, another

2 weeks followed of stakeholder consultations, culminating in the GRM participation in the virtual COP21 approval meeting. PEPFAR Mozambique has national government-to-government (G2G) Cooperative Agreements with CNCS, MISAU, INS, and Directorates of Provincial Health (DPSs). PEPFAR Mozambique also provides district level sub agreements and embedded technical advisors. PEPFAR Mozambique staff are active participants in MISAU technical working groups and engage with DPSs to oversee program implementation and partner support through regular site visits, sharing quality assurance and quality improvement (QA/QI) results, Site Improvement through Monitoring Systems (SIMS) reports, and program results (Semi-Annual and Annual Reports). PEPFAR Mozambique also collaborates with the Ministries of Gender, Child, and Social Action (MGCAS), Education and Human Development (MINEDH), Defense (FADM), Foreign Affairs and Cooperation (MINEC), and Economy and Finance (MINEF).

Global Fund and Other External Donors

PEPFAR Mozambique engaged with Global Fund (GF) and other key multilateral partners throughout the development of COP21. Members of the Global Fund Country Coordinating Mechanism (CCM) participated in COP21 virtual planning retreats and provided input on key elements. The Fund Portfolio Manager (FPM) attended PEPFAR Mozambique's specific planning meetings, including with technical staff, agency leadership, and with MISAU and CNCS for coordination and planning for COP21. PEPFAR Mozambique staff also participated in the Global Fund National Dialogue Meeting and in Global Fund Technical Working Groups and Global Fund workshops to assist in developing the proposals for the new Grants to optimize both PEPFAR Mozambique's & GF's support to combating HIV & TB in Mozambique.

The new Global Fund grants, 2021-2023, have just started implementation during the COP21 planning discussions. The current Global Fund grants for this 2021-2023 period are a significant increase from the previous 3 years, recognizing the fact that Mozambique has the 2nd largest epidemic in sub-Saharan Africa. The approved grants are:

1. MISAU joint HIV/TB grant totaling: $382,706,224 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: $48,779,616, supporting commodities, including tuberculosis preventative treatment (TPT), some programmatic areas such as health information system (HIS) activities, and training, supervision, and monitoring.

3. Fundação para o Desenvolvimento da Comunidade HIV grant totaling: $83,256,060 to support key population prevention activities, AGYW and DREAMS-like activities, and human rights interventions at community level; and,

4. Center for Collaboration in Health (CCS) HIV/TB grant totaling: $59,170,102to 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 ensure that PEPFAR Mozambique & GF are fully aligned. Global Fund staff, including the FPM,

strategic information (SI) advisor, and commodity/supply chain leads meet with PEPFAR Mozambique during their periodic programmatic visits in Maputo. PEPFAR Mozambique staff attend Global Fund meetings in-country, including CCM General Assembly and sub-group meetings, communicate with the FPM, coordinate USG technical assistance to the Global Fund, and work to harmonize the PEPFAR Mozambique and Global Fund programs. In COP21, PEPFAR Mozambique will continue to engage with the Global Fund to ensure both programs leverage their respective comparative advantages and eliminate duplication. PEPFAR Mozambique will continue to share information and solicit feedback before and after technical assistance visits and quarterly reporting, and to work closely with the Global Fund to coordinate commodities planning.

Civil Society/Community

As a fundamental stakeholder of the Mozambican national HIV/AIDS response, civil society was actively engaged in all in-country consultations to develop COP21. In addition to routine quarterly meetings to present and discuss program data from COP20 implementation, PEPFAR Mozambique invited civil society organizations (CSOs) to participate in all national, international, and multilateral stakeholder meetings. Civil society representatives led thematic-specific technical working groups that informed the COP21 proposal. In addition, due to the COVID-19 pandemic which forced the PEPFAR Mozambique team to conduct all meetings virtually, it actually increased participation by CSOs across the country, since in prior years only a select few CSO members outside of Maputo were funded to join the in-person meetings. Furthermore, additional funding from GF also became available to support more CSOs' engagement with CNCS and the national response and continue to build CSO capacity. PEPFAR Mozambique also supported the Community-led Monitoring (CLM) roll-out. There was a major pivot in the Community Grants portfolio to have all CSOs provide support to CLM. This has been a multi-faceted process with UNAIDS, CNCS, and CSOs supporting the national model and roll out.

As with prior COP development cycles, PEPFAR Mozambique engaged civil society through the Civil Society Platform for Health (PLASOC), a group representing HIV-focused NGOs and CBOs based in all provinces of the country. PEPFAR Mozambique's Community Grants allocated one grant in COP20/ FY21 to PLASOC for capacity building. Following recommendations of civil society and multilateral partners in the COP21 consultations, PEPFAR Mozambique will provide grant support for a second year to PLASOC in the same amount for COP21/FY 22. PLASOC used this support to hire a new executive secretary and to provide more robust advocacy support and engagement with CNCS & MISAU, as well as to improve communication with civil society in all 11 provinces. The PEPFAR Mozambique team also supported additional advocacy efforts and engagement on fighting stigma, getting men back to treatment, and engagement with faith-based organizations. PLASOC´s leadership mobilized its constituents to ensure the participation of a vast variety of organizations, including representatives of people living with HIV, and key and vulnerable populations. Faith-based organizations were also in-attendance represented by COREM (Conselho das Religiões de Moçambique), a council that brings together several religious congregations that are present in Mozambique. HIV-related stigma and discrimination reduction, faith-based organizations engagement, HIV health literacy, and community-based monitoring were

widely debated, resulting in a list of priority programmatic activities for PEPFAR Mozambique to support in COP21. Concurrently, civil society selected representatives to attend the COP21 virtual planning and approval meetings, in which they were able to engage directly with PEPFAR Mozambique leadership and present their priorities for COP21 implementation.

PEPFAR Mozambique 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 the stages of its programming development, implementation, and monitoring. Throughout COP20 and COP21 implementation, PEPFAR Mozambique will continue to meet regularly with PLASOC and civil society representatives and will create opportunities for supporting trainings in data use. PEPFAR Mozambique's Civil Society Engagement team will continue 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.

Based on the priorities and issues raised by civil society in the virtual planning meeting, PEPFAR Mozambique adjusted the plan to provide dedicated funds for civil society and key population capacity building and made programmatic changes to increase the number of EID POCs, establish targets for transgender populations, and deepen engagement with faith communities.

Private Sector

The U.S. Government 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 Mobil and Anadarko to discuss how they can support the HIV response. Private sector representatives were also invited to the COP21 virtual meetings. Feedback from these forums and meetings was integrated into PEPFAR Mozambique's program planning for COP21. G2G support to CNCS will help coordinate and monitor private sector workplace HIV/AIDS programs. PEPFAR Mozambique will collaborate with the private sector in COP21 by making ART accessible through private sector pharmacies, and last mile distribution of HIV commodities.

3.0 Geographic and Population Prioritization

COP21 planning was driven by a recognition not only that programs should be prioritized, i.e. more intensive focus going to some places and populations than others, but also that they should be tailored, i.e. different interventions being applied to different places and populations. Analysis of the clinical cascade by age-sex disaggregation revealed different problems in different populations; case identification was a serious challenge among children and adolescent boys and young men (ABYM aged 15-29); loss to follow-up was particularly problematic among ABYM and AGYW. Program packages described in detail in Section 4 address both the higher magnitude of care challenges in certain populations and their particular needs. For instance, the youth and young adult case management program is designed to combat high rates of loss-to-follow-up in that

population and will be expanded in COP21. The budget of the DREAMS program, addressing needs of AGYW, was scrupulously maintained at the COP20 level, which was 3.5-fold higher than COP19. Rather than add to the number of districts, which had expanded from 9 to 32 in COP20, PEPFAR Mozambique will focus on consolidation of services in those 32 districts in COP21.

Treatment targets were allocated according to unmet need as determined through a combination of the Naomi model and PEPFAR Mozambique data. The targeting process considered unmet need at the provincial and district levels as well as within groups defined by sex by 5-year age band. These efforts ensured that the most aggressive targets went to the geographies and populations with the largest gaps to epidemic control.

Similarly, VMMC targets were allocated according to the gap to 80% coverage among 15-29-year-old men, the group where VMMC is expected to have the largest impact on HIV transmission. This resulted in allocation of the highest targets to the provinces of Manica and Tete, where the VMMC program is relatively new, and to Zambezia, where the population is large. Maputo City, Maputo Province, and Gaza, where the estimated coverage is higher, received lower targets. VMMC questions have been 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.

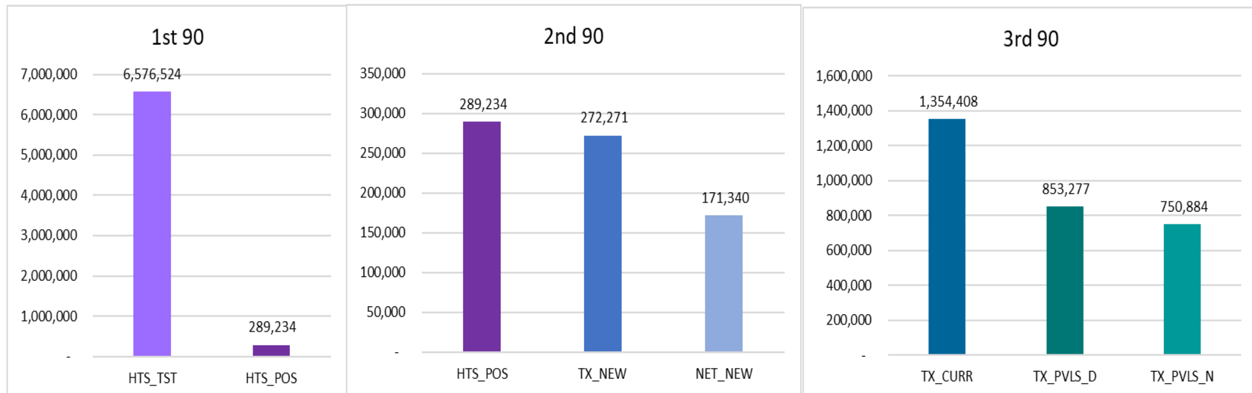
Owing to vertical transmission rates that in FY21 Q1 vary from 1-2% in Gaza and Maputo City and Province to over 5% in Nampula and Cabo Delgado, the PMTCT program dedicates intensified programmatic resources in Northern provinces where transmission remains highest. As in COP20, in COP21, a dedicated partner addressing PMTCT is funded exclusively to work in high transmission districts in the Northern provinces of Cabo Delgado, Nampula, and Zambezia. PEPFAR Mozambique is working with MISAU to ensure that the early introduction of point-of-care (POC) VL testing for pregnant women is also oriented toward highest vertical transmission facilities with appropriate laboratory capacity.

Table 3.0.1: Current Status of ART saturation

Prioritization Area*	**Total PLHIV/% of all PLHIV for COP21**	**# Current on ART (FY21 Q1)**	**# of SNU COP20 (FY21)**	**# of SNU COP21 (FY22)**
Attained	11,316 (0,5%)	38,016	1	1
Scale-up Saturation	N/A	N/A	0	0
Scale-up Aggressive	2,026,511 (95,1%)	1,304,966	128	128
Sustained	N/A	N/A	N/A	N/A
Central Support	92,601 (4,4%)	39,844	32	32

4.0 Client Centered Program Activities for Epidemic Control

Figure 4.0.1: Overview of 90/90/90 Cascade, 2020Q2-2021Q1 (4 Quarters)



4.1 Finding the missing and getting them on treatment

Case finding is the gateway to effective epidemic control, and bridges HIV prevention and HIV treatment efforts. To accelerate progress towards achieving UNAIDS' 95-95-95 goals, an effective, targeted, smart, and efficient case finding program is needed in Mozambique. This includes identifying those most at-risk for on-going transmission as well as those at highest risk of HIV infection through scale-up and continued prioritization of index partner and family testing while ensuring attention to privacy and safety.

While Mozambique has improved its targeted testing programs for index cases for adults, more work needs to be done to optimize case finding for men and children. UNAIDS data show significant gaps in the 1st 90 (61%) and 2nd 90 (42%) among males 15+ years. In 2020, MISAU established national targets for the number of positive new cases identified for the first time, rather than simply targets for numbers of individuals tested, indicating a shift towards more focused testing for case identification. MISAU recognizes the effectiveness of community and facility-based index case testing for achieving this goal.

Therefore, in COP21, Mozambique will: (1) scale-up community-based index case testing to all 620 AJUDA sites, including follow-up for male partners from ANC, and thorough community-level screening of all eligible children and adolescents; (2) provide maternal retesting services in all PEPFAR Mozambique-supported health facilities; (3) introduce lay counselor-led, proactive screening in waiting areas of high-volume sites, using national HIV testing screening algorithms; (4) implement highly targeted male congregate testing in high-incident areas; and (5) generate informed demand for self-testing, as per national policies, in coordination with the Global Fund.

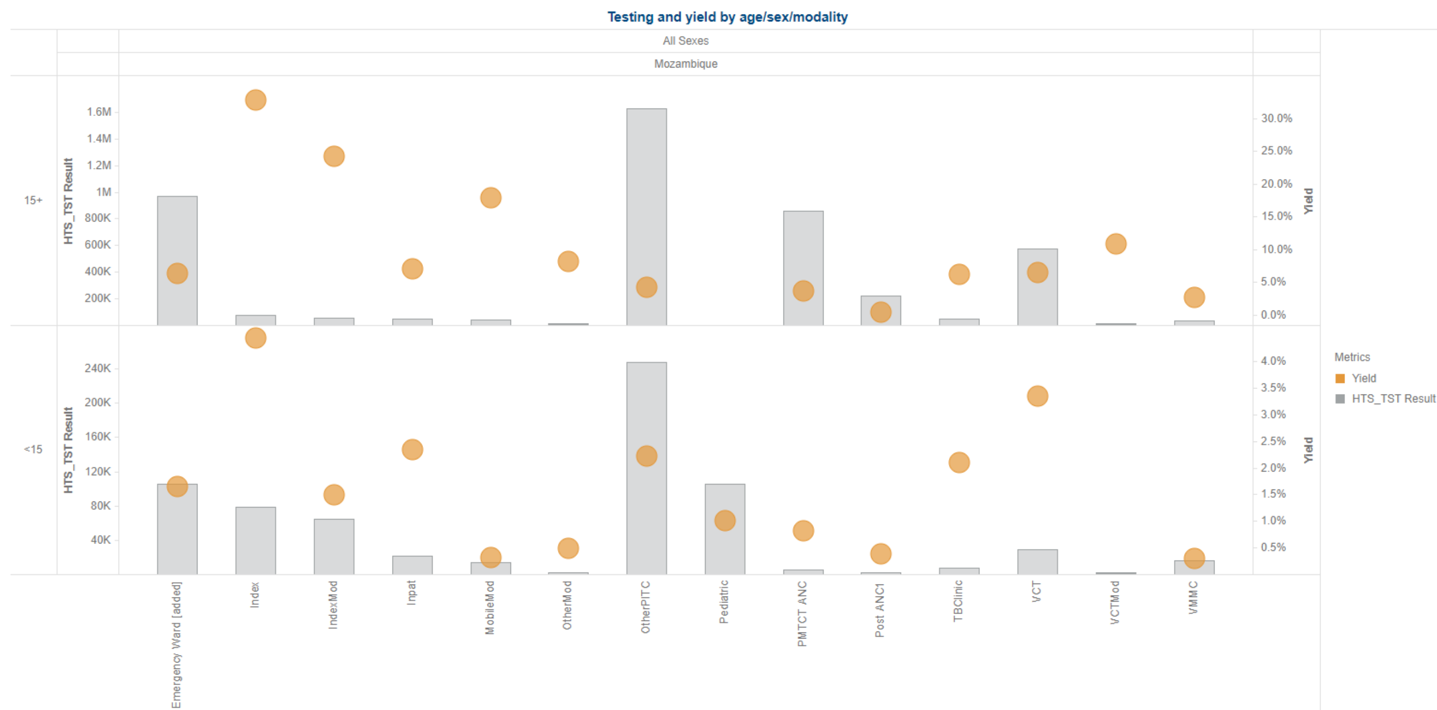
These interventions will find and reach children, adolescents, and HIV+ adults, adding them to treatment and moving the country towards epidemic control.

Testing targets for COP20 and COP21 reflect a more focused approach that was established during the COP19 planning process, in collaboration with MISAU. By the end of COP21, PEPFAR Mozambique expects that index case testing will contribute nearly one-third of all new HIV+ diagnoses. Policies in Mozambique provide a strong framework for voluntary partner disclosure and mitigation of the risks of intimate partner violence (IPV) related to index case testing. MISAU policy prohibits direct communication with index case sexual contacts and requires index case client consent for community-level support for partner disclosure or index case contact testing. During COP21, PEPFAR Mozambique will support the implementation of the new MISAU-approved IPV screening and safe and ethical index case testing training package, which help to monitor adverse events and establish minimum standards for index case testing at the site-level.

During COP21, PEPFAR Mozambique will continue to work closely with the National TB and HIV Programs to better leverage community-based HIV index case testing to include screening for active TB and accompanied referrals to the health facility for confirmatory TB testing.

Mozambique has continued to improve its linkage rates and will address on-going linkage challenges among multiple sub-populations. While not all directly related to linkages activities, all of the following should positively impact reported linkage and retention rates, especially for OVC as this is an excellent opportunity to identify other children that may either be at high-risk, fallen out of treatment and **link** them back into Care and Treatment services: (1) expansion of OVC case management to offer enrollment to 90% of CLHIV on ART at OVC-supported sites; (2) scaling-up of adolescent mentoring at high volume, low performing AJUDA sites; (3) extending MISAU's three-pronged male engagement strategy, male-friendly services and promotion of DSD services (including extended clinic hours, community ARV distribution by APEs (Agentes Polivalentes Elementares de Saúde);); (4) community treatment literacy activities to engage community influencers and religious leaders; and (5) expansion of the EID POC network to improve linkage to care for infants.

Figure 4.1.1: Testing Volume and Yield by Modality and Age/Sex, 2020Q2-2021Q1



4.2 Continuity of treatment and ensuring viral suppression

Treatment Continuity

With MISAU leadership and additional collaboration with Global Fund, PEPFAR Mozambique 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 support 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. PEPFAR Mozambique will increase investments at site and community levels to improve treatment continuity for patients, including children and adolescents. For COP21, the priority will be to provide client-centered care, targeting the needs for specific groups with disproportionate continuity of care challenges.

For AGYW (15-24 years) and adolescent boys and young men (ABYM; 15-29 years), PEPFAR Mozambique will support the expansion of the adolescent mentoring and youth case management program from 65 to 90 sites. The intervention offers one-on-one peer mentorship to support individualized adherence plans, group support sessions, and a flexible basket of services and referrals through a counselor-administered case management program. The additional 25 sites will be strategically selected based on poor continuity of care performance among the targeted age bands.

To complement the aforementioned case management program, the implementation of MISAU's three-pronged male engagement strategy (facility, community, and workplace) will be further rolled out at AJUDA sites within the MISAU prioritized districts. Facility- and community-based efforts should provide men additional support throughout their treatment experience. Workplace programming will be specifically focused on sites and communities where large private sector operators are based.

For pediatric populations, the OVC program will continue its pivot to focusing on children/adolescents living with HIV (in order to meet the COP21 mandate of offering OVC services to 90% of C/ALHIV on ART at OVC-supported sites). Expanded Mentor Mothers programming will be offered in four provinces with high vertical transmission (Nampula, Cabo Delgado, Sofala, and Manica) to improve retention among CLHIV as well as PLW and adolescents. In COP21, PEPFAR Mozambique will continue supporting MISAU in offering optimized pediatric ART regimens to all children and adolescents, including Dolutegravir (DTG)-50 as a first-line medication to children >20kg. The transition from lopinavir/ritonavir (LPV/r) granules for infants and young children to DTG10 will begin early in FY22 and promises to accelerate viral suppression in infants and young children given high efficacy and ease of storage and administration.

Regardless of age/sex, PEPFAR Mozambique will continue to support MISAU's expansion and increased uptake of differentiated service delivery models. At the facility, this includes multi-month scripting (3MMD, 6MMD and 12MDD), expansion of extended hours (either through shift work or shifted hours), one-stop shops for new ART initiates, and promotion of integrated family-based consultations. At the community level, this includes promoting community ART groups (GAACs), using APEs for ARV distribution in all provinces, exploring national expansion of mobile brigades beyond the current four provinces based on provincial authorities' priorities, and supporting the implementation of ARV distribution through private pharmacies and health professionals.

Improved services for PLHIV with Advanced HIV Disease are also a pillar of COP21 planning. In COP21, PEPFAR Mozambique will support implementation of an advanced HIV disease service package at a central or provincial hospital in each province as well as support to at least one outpatient facility to be equipped to provide ambulatory care for advanced disease in each province. Advanced HIV disease screening will take place at all sites, although the scale of this intervention continues to be fully dependent on the procurement of adequate commodities through the Global Fund grant.

PEPFAR Mozambique will also support mental health programming at three large AJUDA sites in each province. Using a standardized screening tool and an adapted Common Elements Treatment Approach (CETA) model, PEPFAR Mozambique will hire a limited number of mental health professionals to meet increased demand for mental health services.

The U=U campaign, supported by WHO, along with the stigma reduction campaign PEPFAR Mozambique launched in COP20, and various treatment literacy activities focused on community

and religious leaders will all complement the noted interventions happening both at the facility- and community-levels.

To ensure that implementation matches expectations, PEPFAR Mozambique will continue to support the National Quality Improvement (QI) Strategy at the national, provincial and site levels and offer mentorship for clinicians.

Viral Load Suppression

PEPFAR Mozambique will support activities in the community and in health facilities to increase provider/patient demand for viral load results. Increasing viral load demand will require targeted community sensitization efforts. In COP21, PEPFAR Mozambique will support further dissemination of U=U campaign messages as well as integrate viral load themes into its faith-based interventions and broader strategic marketing campaign. Training of providers through ongoing mentorship and on-the-job technical assistance will be essential in COP21 to ensure appropriate clinical utilization of VL results. In COP20, clinical and lay health worker training modules have been revised to include prioritization of the viral load cascade in all patient interactions. Unfortunately, viral load coverage has decreased during the COVID-19 pandemic as clinic visit frequency was reduced. In FY21 Q1, PEPFAR Mozambique reported a slight increase to 63%, a level that still remains lower than the reported 65% coverage levels in the previous three quarters.

To achieve the needed transformation in viral load utilization, steps in the flow of viral load information will need to be remediated—from improved turnaround time (TAT) through expansion of DISA-Link hubs to optimization of electronic systems to organization of patient records to implementation of standard operating procedures (SOPs). Currently, all VL testing laboratories and instruments are connected to the national laboratory information system (DISA LIS) and all test requests are referred through this system. Accurate VL results are reported instantly to health facilities through the LIS, expediting overall TAT. VL results are also uploaded to the central laboratory database (OpenLDR), from which reports containing VL results and patient demographic information are generated automatically weekly and monthly. These frequent reports are sent automatically to PEPFAR Mozambique supported health facilities in which respective patients seek treatment and are also shared with implementation partners. These reports complement the individual patient results that are automatically generated by the LIS and allow stakeholders to easily track and manage patients with unsuppressed VL, as well as for stakeholders to perform program monitoring. The OpenLDR also allows for interactive and real-time data analyses on the VL dashboard, from which IPs and health care providers can access facility-level data of TAT and patients with unsuppressed VL, disaggregated by age, sex, or PBFW. The interconnectivity of OpenLDR and EPTS (electronic patient tracking system)/OpenMRS that is planned for an additional four provinces in COP21 (on top of the three provinces supported in COP20) will not only improve data entry of patients results, which will increase the reported VL coverage in Mozambique, but also will alleviate workflow at health facilities (HFs), as manual entry of VL results on EPTS will no longer be necessary. In COP21 we are also planning to expand the DISA LIS to EID and for VL tests on POC instruments (multiplexing). Currently, the manual entry

of EID results generated by POC instruments into databases has been incomplete and inaccurate, demanding labor-intensive data cleaning procedures. With the initial implementation of DISA-POC in 70 health facilities in COP20, PEPFAR Mozambique plans to expand the number of HFs with this system in COP21, to capture timely and accurate data that will allow the PEPFAR Mozambique team to guide program implementation and monitor the efficacy of PMTCT strategies. The DISA-POC LIS will also upload data into the OpenLDR automatically, from which health facility/patient level and program reports will be generated, as well as be accessible through an EID dashboard. Additionally, identification of patients in need and linking them to quality, age-appropriate, enhanced adherence counseling are key components for COP21 to improve viral suppression rates among pediatric and adolescent patients in Mozambique.

PEPFAR Mozambique launched POC VL for vulnerable sub-populations in COP20 in coordination with MISAU and has budgeted to expand access to same day viral load results in COP21 with a phase 2 in implementation provisionally planned to begin in Q3 of FY21.

Figure 4.2.1 Number and Percent Contribution of Clients Receiving MMD by Age/Sex, 2021Q1

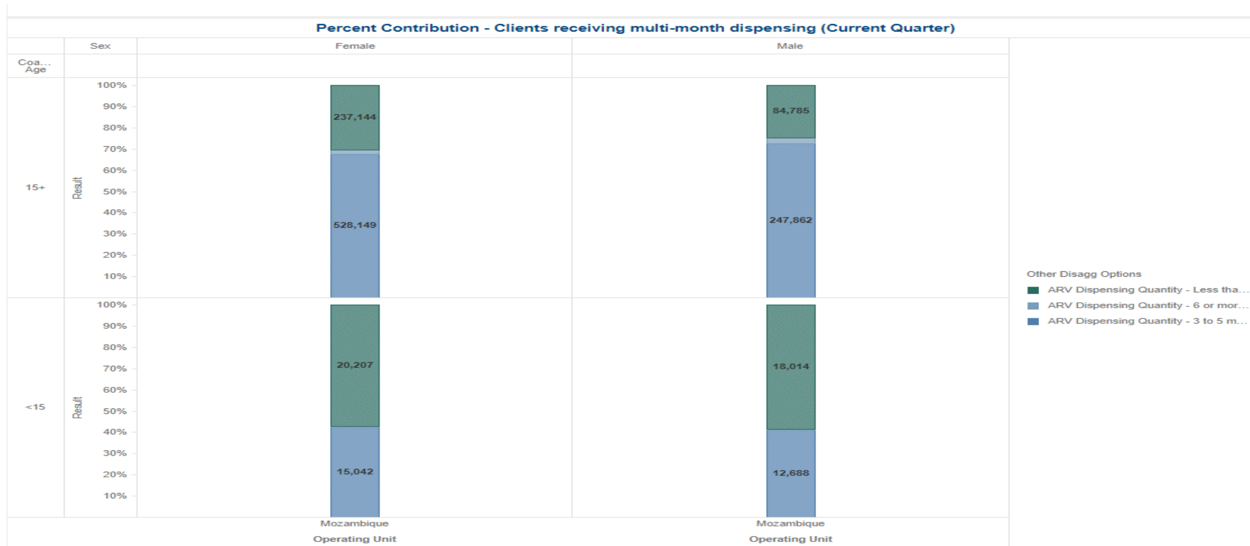
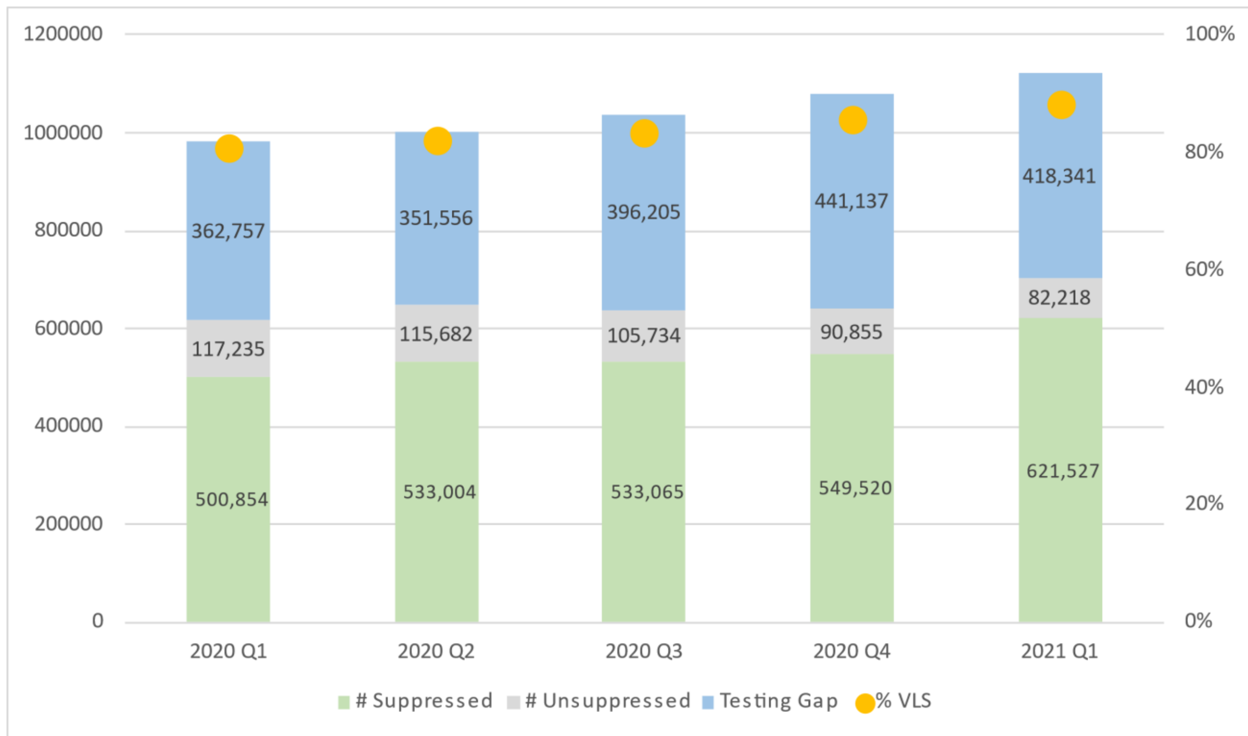


Figure 4.2.2 Viral Load Outcomes, 2020Q1-2021Q1 (EPTS sites only)



4.3 Prevention, specifically detailing programs for priority programming

During COP21, PEPFAR Mozambique will continue to 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 into and retention in care and treatment.

AGYW Prevention

Since its inception in 2015, the DREAMS program has driven drastic reductions in new HIV infections among adolescent girls and young women in the nine sites where it is being implemented.

In Mozambique, modeling of new HIV infections in nine DREAMS districts (Quelimane, Nicoadala, Beira, Chokwe, Xai-Xai, Chongoene, Limpopo, Matutuine, and Namaacha) indicates that incidence among AGYW has declined by more than 25 percent since 2015.[1] Nonetheless, HIV prevalence within these districts, as measured by testing yield at first ANC among 15-24 year-olds, continues to rank among the highest in Mozambique, at 10.4% as of December 2019. In COP21 the geographic implementation will be maintained in the same 32 districts as in COP20, namely: Limpopo, Xai-Xai, Chongoene, Chokwe, Beira, Quelimane, Nicoadala, Matutuíne, Namaacha and new districts – Matola city, Nampula, Chimoio, Marracuene, Boane, Namacurra, Manhiça, Mocuba, Pebane, Milange, Erati, Maganja da Costa, Moamba, Mocubela, Montepuez, Maxixe, Inhassunge, Ile, Gile, Guija, Lugela, Magude and Caia, representing eight provinces (Gaza, Sofala, Zambezia, Manica,

Nampula, Inhambane, Cabo Delgado and Maputo province). DREAMS program received a substantial increase in funding from $10.1 million in COP19 to $35 million in COP20 when the number of districts was expanded from 9 to 32; this budget will remain flatlined for COP21.

Within the existing 32 DREAMS districts, plans for COP21 will expand coverage to approach saturation, as per S/GAC guidelines. PEPFAR Mozambique has reached an agreement with MISAU, MINEDH, CNCS, and Global Fund to ensure maximum coverage of AGYW with comprehensive programming in the overlapping districts with the aim of reaching saturation. A final Memorandum of Understanding (MOU) is being developed and is expected to be finalized by May 2021.

In DREAMS sites, PEPFAR Mozambique will continue to implement the layered package of community interventions and clinical services at the "one-stop-shop" adolescent and youth friendly clinics. Integrated services offered at these sites include HIV counselling and testing, contraceptive method mix with emphasis on dual protection, post-violence care, prenatal care, as well as ART initiation, and psychosocial support. In COP21, the DREAMS package will continue to include pre-exposure prophylaxis (PrEP) provision for AGYW 15-24 as initiated in COP20. Sexually transmitted infection (STI) enhanced diagnosis and treatment in all districts will also be initiated. The STI protocol results will inform future STI diagnostic policy development for AGYW. Socioeconomic strengthening interventions with a clear path to both self-employment and wage employment will continue to address the deep economic disadvantages facing AGYW in a comprehensive manner and will be rolled out in all 32 districts. A basic financial literacy package will be rolled out as part of the primary package. The menstrual hygiene package will continue to be rolled out in cooperation with MINEDH and MISAU.

PEPFAR Mozambique will continue to use 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, and engagement in sexual risky behavior. Additionally, linkages with the OVC platform will continue to be strengthened to eligible DREAMS beneficiaries to guarantee access to either HIV and violence primary prevention services for adolescent girls aged 9-14, or for the 10-17 who do not need a case management plan.

In addition to interventions above mentioned, COP21 will feature a renewed focus on targeting adolescent boys and young men with interventions including HIV testing and counseling (HTC), VMMC, and ART services as well as education sessions on gender norms, sexual reproductive health, and masculinity.

In COP21, all IPs will continue to use an operable layering tool to ensure the completion of at least the full primary package of interventions, monitor the referral and counter-referral system of active AGYW, and report the AGYW_PREV indicator among DREAMS beneficiaries with greater fidelity in accordance with their age and needs. To ensure the most vulnerable girls are identified, all partners conduct a vulnerability assessment in order to screen and to offer enrollment in DREAMS services (see table of interventions by age band below).

Table 4.3.1: DREAMS Interventions by Age Groups			
	9-14	**15-19**	**20-24**
Individual Primary Interventions	• Social Asset Building ○ Life skills sessions ○ HIV prevention sessions ○ Violence prevention sessions • Basic financial literacy • Services for teenagers ○ 5 sessions of Sexual Reproductive Health (SRH) & personal hygiene in Serviços Amigos dos Adolescentes e Jovens (SAAJ)	• Provision and promotion of condoms/contraception • HIV testing • HIV prevention sessions • Violence prevention sessions • Basic financial literacy	• Provision and promotion of condoms/contraception • HIV testing • HIV prevention sessions • Violence prevention sessions • Basic financial literacy
Individual Secondary Interventions Primary package of interventions for sexually active AGYW marked with *	• Education subsidies • Supply and promotion of condoms * • HIV testing * • Clinical and community-based post-violence care services ○ Post Exposure Prophylaxis (PEP) ○ Psychosocial support • Other services	• Social asset building ○ Life skills Sessions • Education subsidies • Clinical and community-based post-violence care services ○ PEP ○ Psychosocial support • Combined socio-economic approaches ○ Youth loan and savings groups ○ Employment sessions (for eligible	• Social asset building ○ Life skills Sessions • Clinical and community-based post-violence care services ○ PEP ○ Psychosocial support • Combined socio-economic approaches ○ Youth loan and savings groups ○ Employment sessions (for

	○ Contraceptive mixture* ○ ITS tracking and treatment* ○ Pregnancy test and ANC consultation* ○ Linkage to ART ○ Alcohol and drug abuse/mental health support	participants who are 15 or older, out of school, and who meet the selection criteria) ● Other services ○ Contraceptive mixture ○ Screening and treatment of STIs ○ Pregnancy testing and ANC consultation ○ Linkage to ART ○ Alcohol and drug abuse/mental health support ○ Test and consultation on uterine cancer (if HIV+) ○ PrEP	eligible participants who meet the selection criteria) ● Other services ○ Contraceptive mixture ○ Screening and treatment of STIs ○ Pregnancy testing and ANC consultation ○ Linkage to ART ○ Alcohol and drug abuse/mental health support ○ Test and consultation on uterine cancer (if HIV+) ○ PrEP
Contextual Level Interventions	● Parenting programming for DREAMS beneficiaries' parents/caregivers ● Community mobilization and social norms changes (including men) ● Intervention directed to the male partners of AGYW via linkage to HTS, VMMC, Treatment (note: these interventions are not funded with DREAMS funds)		

In COP21, DREAMS will support the implementation of the strategic action plan that will be developed as a result of the 2020 Violence Against Children and Youth Study (VACS). The plan will be designed in collaboration with the GRM, INS and UNICEF. DREAMS implementation will continue to focus on primary prevention interventions among 9-14-year-olds through evidence-based interventions known to delay sexual debut and to prevent HIV infection and violence. The program will implement interventions for adolescent girls' that provide the foundation to develop healthy relationships, the ability to resist coerced and unwanted sex and to obtain support in the event of coerced sex and development of life skills.

GBV prevention and response will continue to be part of the services offered through DREAMS integrated across the HIV services in COP21. Support is offered for identification, disclosure, and referral of AGYW who have faced GBV through:

- Integration of post violence care into dedicated adolescent friendly clinics (SAAJ) services;
- Improved early identification and linkages through confidential and safe services and in the community;
- Improved identification and reporting of violence against children, sensitization for appropriate family communication, norm-changing approaches to revert gender inequitable norms, reduce/end child marriage and other harmful practices; and
- Technical and financial assistance to MISAU to coordinate, monitor and evaluate the GBV response at all levels.

To address the specific needs of youth, the health systems infrastructure needs to be improved. Health centers with SAAJ, and dedicated and trained staff can offer a full range of services at these one stop shop models of service, that include HIV counseling and testing, ART provision and psychosocial support, STI screening and treatment, contraceptives methods, PrEP, GBV screening and post violence care as well as Prenatal/Postnatal care.

These dedicated adolescent-friendly services can also respond to demand created in communities and schools. The construction of SAAJs is the most cost-effective intervention given that with the same amount of funding from the prior year, the health center benefits from 3 additional consultation and two waiting rooms, thus improving its capacity to respond more effectively and with the desired quality to the needs of adolescents and youth. In COP21 we propose the construction of an additional 35 SAAJ across the 32 DREAMS districts, improving the coverage of adolescent friendly services in AJUDA sites.

In addition, in COP21, services from the core package will continue to be provided in school settings through school health corner and schoolgirl clubs. School health corner services will include HIV and violence prevention, screening for GBV, provision and distribution of contraceptive methods (limited to condoms and pills), demand creation for HIV testing and referrals. A total of 15 dedicated spaces called school health corners will be rehabilitated/constructed in selected schools.

OVC Programming

The OVC program in Mozambique completed 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. PEPFAR Mozambique will complete this programmatic pivot during COP20 and consolidate in COP21. Additionally, the PEPFAR Mozambique program will transition OVC program implementation to new local organizations in Maputo, Gaza, Inhambane, Tete, Nampula and Cabo Delgado provinces, through the introduction of new, locally led OVC mechanisms, designed to reflect the latest PEPFAR Mozambique guidance and global best practices in OVC programming.

The OVC program will work with the maternal and child health (MCH) program to address specific IDP issues in Cabo Delgado province, focusing primarily on psychosocial support and village savings and loans to caregivers. OVC Implementing Partners will also work with community leaders and identify IDP children who are HIV positive to enroll them in the program.

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 Mozambique has opted for a continuation of the two-tiered OVC program design for COP21.

OVC Comprehensive Program

This will be offered to eligible beneficiaries through Intensive Case Management and a range of services addressing household vulnerability, over longer periods of time. Existing enrollment tools from the HIV Sensitive Case Management package will be used to identify OVC under age 18 that are also HIV positive, survivors of sexual violence, HIV exposed infants who interrupted treatment at PMTCT, biological children of HIV+ mothers, children of female sex workers (FSWs), children without parental care, double orphans, children living in child-headed households, and/or pregnant adolescents. These priority OVC sub-populations will be offered a comprehensive package of services to ensure they are healthy, stable, educated, and safe. The main entry points for selection and enrollment of OVC for this service package will be the SAAJ or ART enrollment points within AJUDA health facilities, mother-to-child-transmission (MTCT) sectors, community-based HIV testing platforms, GBV service points, and other relevant community or facility-based referral points. Children, adolescents, and young people living with HIV (CLHIV & AYPLHIV) will receive additional support services, such as the YCM support group experiences collected during COP20, 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. For children and adolescent beneficiaries of the OVC program, nutritional support will be provided in different formats. Through community activists, upon screening and identification of needs, children and caregivers will be referred to health facilities nutritional rehabilitation programs in case of severe and moderate malnutrition as per national guidance. Additionally, through the Ministry of Gender, Children and Social action social protection scheme, delivered by Instituto Nacional de Accao Social (INAS), eligible beneficiaries can access food baskets or other social grants. Whenever possible, the OVC programs will seek emergency resources to mitigate severe malnutrition situations and effects from environmental disasters.

The OVC program will also continue the good practice of data triangulation to ensure monitoring of viral suppression among CLHIV through MOUs with clinical partners and work with HFs to enroll these beneficiaries into the program.

OVC Preventive Program

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/or 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, economic strengthening, disclosure counseling for CLHIV, AYLHIV, and children of PLHIV, as well as accompanied referrals for post-GBV care. As needed, additional services will also be provided to these OVC according to individual needs assessments, such as youth-led saving groups and educational subsidies.

Key Populations

Targets and programmatic plans for COP21 were designed to increase the reach of KP and to meet case identification and treatment goals for these populations. In response to concerns of CSO and feedback from OGAC in relation to the insufficient coverage of service for key populations, the Country team, has reworked the approach to KP target setting by establishing target coverage goals, accounting for the presence of FDC/Global Fund. As a result, the joint PEPFAR Mozambique/GF KP coverage targets were set to reach 53% (FY 22) and 80% (FY 23) of KPs nationally. For PEPFAR Mozambique, the targets established will contribute to an increase of 50% of KP reached from FY21 to FY 22. Under MoH and NAC leadership the geographical coverage for KP services between PEPFAR Mozambique and GF has been agreed to assure that there is no overlap in the support to the KP program. PEPFAR Mozambique is covering districts where GF is not present with the exceptions of the major cities (urban centers) where both GF and PEPFAR Mozambique are supporting the activities while coordinating to avoid overlap and duplication. PEPFAR Mozambique and GF have already established a few coordination platforms (e.g., regular meetings, regular exchange of information) for program coordination, implementation and targeting purposes. As such, the COP21 targeting process builds on the experiences of an excellent collaboration between PEPFAR Mozambique and GF. During COP21, PEPFAR Mozambique will continue to focus on improving the identification of HIV-positive KP, linkage to ART, as well as supporting adherence and retention to treatment, with regular VL monitoring. PEPFAR Mozambique will continue to reach FSWs, MSM, Transgender individuals (TG), Prisoners, and people who inject drugs (PWID) with evidence-based and comprehensive prevention activities (KP_PREV), including demand creation and service provision of PrEP. Due to limited availability of resources, PEPFAR Mozambique will continue to support the demand creation, testing and referral of care and treatment services only for PWID in Maputo City while discussions will be held with key stakeholders including MISAU to define the future scope of PWID support. Through social media (WhatsApp groups and Facebook chatrooms), regular hotspot mapping, risk-based peer referrals, and use of KP lay counselors, PEPFAR Mozambique 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 Mozambique clinical partners will continue to support the implementation of the KP service package during COP21. In addition, PEPFAR Mozambique will support the training and mentorship of health providers and focal points in all relevant sectors. MISAU with PEPFAR Mozambique support will actively engage with clinical partners to assure the correct use of KP-specific data collection tools to track KP service provision across the cascade 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. The community implementing partner will monitor each KP referred from case identification through to the viral load status. The KP Program will continue to 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 clinical partners to ensure that KP diagnosed in the community are appropriately initiated and maintained on ART. In the case of HIV-negative KP the program will offer the adequate prevention package, including referral for PrEP.

Peer Navigators within health facilities will work closely with clinical partners to ensure that all newly enrolled HIV positive KP receive effective psychosocial support ensuring retention 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.

To address the specific needs of KP and based on gaps in services that were identified, particularly for TG, PEPFAR has been supporting MISAU in updating the National KP Guidelines with a specific package for TG. In addition, for COP21, PEPFAR has established targets for TG population in selected provinces, based on a proportion of overall population, using the PLACE study (2017) as reference, since there are not many sources of information available that can provide a more accurate size estimation for TG. PEPFAR will continue to work with MISAU and IPs to better estimate the size of the TG population for future programming.

Pre-Exposure Prophylaxis

During COP21, PEPFAR Mozambique will consolidate PrEP national roll out and will scale up for some additional districts, offering PrEP for key populations, serodiscordant couples, adolescents, and young women at substantial risk 15+ and for PBFW. During COP discussions, it was agreed that MISAU would determine which facilities would be offering PrEP, so the exact facilities will be proposed by MISAU, initially considering high-volume sites and then expanding to include peripheral sites. PrEP screening tools will be used to identify those eligible for PrEP among targeted

population groups; clients tested HIV negative and who meet eligibility criteria will be offered PrEP services. 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 discordant, 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-shop model will be used for PrEP services to support retention; clients will be able to collect medication at either ANC or the HIV clinic. Regular adherence counseling using the PrEP toolkit will be part of the standard service package for all clients. PEPFAR Mozambique will also support the development of national guidelines for PrEP implementation. Open MRS EPTS will include a PrEP module and iDART and EPTS will capture PrEP medications. MISAU approved information, education and communication (IEC) materials and demand creation tools are available and will support the consolidation of national roll out.

Voluntary Male Medical Circumcision

As per PEPFAR guidance, in COP21 the VMMC program will focus on clients aged 15 and above due to safety reasons. In COP21, the VMMC program will 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. Consistent with PEPFAR Mozambique guidance, the national VMMC program will no longer support VMMC for children below 15 years of age, except in the limited setting of Shang Ring implementation. All PEPFAR Mozambique VMMC targets are among males equal or greater than 15 years of age. Six VMMC sites will be transitioned to MISAU and will have direct MISAU support, with PEPFAR Mozambique only supporting the provision of all supplies, while MISAU will have targets and will be reporting results.

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 COP21 in targeted areas. Demand creation activities include non-coercive incentives and compensation such as transportation vouchers. A Human Centered Design (HCD) approach, that will focus on interpersonal communication to address the barriers to VMMC, will be implemented in all VMMC districts through Community VMMC mobilizers.

The modeling data for coverage and saturation does not factor internal migration for services from neighboring districts. The targets were set using historical performance and program knowledge. In districts where modeling data suggest coverage of the target age group is at or above 80 percent, the program will support a sustainable transition of the referred districts or sites from PEPFAR Mozambique partners to Government management. PEPFAR Mozambique will keep technical, logistical and financial support.

Planning for efficient and effective VMMC interventions is paramount. The VMMC site optimization tool will continue to be used to improve planning by allowing the reallocation of

resources, including providers, surgical beds, and other items to sites that need additional support and/or improved performance.

The national HIV testing screening tools are in use in all VMMC sites. The VMMC program will strengthen referral of clients testing positive for HIV at VMMC sites. HIV negative clients, whenever appropriate (based on the age band for which PrEP is being offered in the program), will be referred to PrEP services. All VMMC sites will continue to regularly use the MISAU national HIV testing screening and referral tools and, in addition, keep record of those clients referred to care and treatment. During COP21, Mozambique will introduce the Shang Ring device as an alternative for the surgical methods in Maputo and Zambézia provinces, targeting 1000 beneficiaries. The introduction of the device in the aforementioned provinces will inform the Mozambican Government and USG for the scale up of the use of the device during COP21.

Emphasis will continue to 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 Mozambique requirements, while simultaneously ensuring that clinical management of AEs remain under the purview of the MISAU.

Gender-based violence

Throughout COP21, PEPFAR Mozambique partners are expected to continue providing high quality post-GBV care services and integrate post-GBV services into the PEPFAR Mozambique clinical cascade, to address GBV as a risk factor for HIV infection and poor adherence to HIV treatment. Additionally, to improve identification of GBV survivors and referrals to post-GBV services. To support service implementation PEPFAR Mozambique partners are expected to do the following at PEPFAR Mozambique-supported sites:

- Establish post-GBV care services and allocate the recommended post-rape kits
- Ensure availability of the most updated GBV algorithms and drugs for children, adolescents, and adults in line with MISAU guidelines
- Coordinate with the GBV MISAU Department and partners through the MISAU-led GBV technical working group
- Ensure that there is a staff member responsible for the GBV program that is familiar with the GBV Provincial Multisectoral Mechanism and the points of contact for referrals to psycho-social support, police, social welfare services, forensic and legal services within the HF and/or the district
- Identify and properly train healthcare workers responsible for provision of post-GBV services to offer quality services and accurately report and complete forms and registers
- Ensure facility and community providers responsible for providing support to GBV survivors are adequately trained in LIVES support
- Provide regular mentoring and supervision to ensure quality counseling and services
- Sensitize HF staff (HCW/Auxiliary staff) regarding post-GBV care services within HF and referral processes

- Ensure that the locations where post-GBV services will be provided within HF are defined (ex: SAAJ; APSS; Maternity: one-stop GBV center, etc.)
- Support implementation of GBV QA; M&E and the GBV screening tool as per MISAU guidelines
- Provide post-GBV care services as part of KP prevention package in all AJUDA sites that offer services for KPs
- Report on GBV progress at every IP monthly meeting and through periodic PEPFAR Mozambique reporting
- Reproduce and distribute GBV IEC and other materials
- Reinforce demand creation to promote GBV prevention and response at community and facility level
- Train all community providers in GBV LIVES (1st Line of Support) such as OVC, DREAMS, KP case managers and mentors in supporting age-appropriate, gender sensitive disclosure of GBV

Table 4.3.2: Target Populations for Prevention Interventions to Facilitate Epidemic Control

SNU	PP_PREV		KP_PREV		AGYW_PREV		
	Population Size Estimate (scale-up SNUs)	FY22 Target	Population Size Estimate (scale-up SNUs)	FY22 Target	Population Size Estimate (scale-up SNUs)	FY22 Target	
						Any DREAMS Service	Completed Primary Package
_Military Mozambique	N/A	40,048	N/A	-	-	-	-
Alto Molocue	N/A	-	N/A	394	-	-	-
Ancuabe	N/A	-	N/A	387	-	-	-
Beira	N/A	3,666	N/A	2,963	57,610	7,049	5,640
Bilene	N/A	50	N/A	416	-	-	-
Boane	N/A	1,743	N/A	782	17,272	3,244	2,595
Caia	N/A	900	N/A	-	15,288	1,732	1,385
Changara	N/A	-	N/A	111	-	-	-
Chibabava	N/A	-	N/A	122	-	-	-
Chibuto	N/A	50	N/A	-	-	-	-
Chimoio	N/A	4,769	N/A	2,757	39,866	9,173	7,338
Chiure	N/A	-	N/A	1,103	-	-	-
Chokwe	N/A	1,574	N/A	-	21,471	2,932	2,345
Chongoene	N/A	1,067	N/A	318	11,267	1,955	1,564
Cidade da Matola	N/A		N/A	-	-	-	-

Cuamba	N/A	-	N/A	561	-	-	-
Dondo	N/A	-	N/A	218	-	-	-
Erati	N/A	1,931	N/A	-	32,214	3,714	2,971
Gile	N/A	1,885	N/A	-	21,133	3,625	2,900
Gondola	N/A	-	N/A	241	-	-	-
Guija	N/A	1,088	N/A	-	8,676	1,997	1,597
Gurue	N/A	-	N/A	450	-	-	-
Ile	N/A	1,202	N/A	-	19,321	2,313	1,850
Inhambane	N/A	-	N/A	2,131	-	-	-
Inharrime	N/A	50	N/A	50	-	-	-
Inhassoro	N/A	-	N/A	503	-	-	-
Inhassunge	N/A	955	N/A	-	8,584	1,837	1,469
Kamavota	N/A	-	N/A	399	-	-	-
Kamaxakeni	N/A	-	N/A	726	-	-	-
Kampfumu	N/A	-	N/A	1,716	-	-	-
Kamubukwana	N/A	-	N/A	614	-	-	-
Lichinga	N/A	-	N/A	789	-	-	-
Limpopo	N/A	1,427	N/A	374	14,357	2,647	2,118
Lugela	N/A	1,049	N/A	-	17,403	2,017	1,614
Mabalane	N/A	-	N/A	220	-	-	-
Maganja Da Costa	N/A	1,693	N/A	-	14,036	3,255	2,604
Magude	N/A	356	N/A	-	5,165	587	470
Mandimba	N/A	-	N/A	294	-	-	-
Mandlakaze	N/A	50	N/A	-	-	-	-
Manhiça	N/A	2,078	N/A	-	17,594	3,900	3,120
Manica	N/A	-	N/A	320	-	-	-
Marracuene	N/A	2,061	N/A	-	18,112	3,866	3,093
Massinga	N/A	-	N/A	398	-	-	-
Matola	N/A	8,950	N/A	9,321	91,603	17,212	13,769
Matutuine	N/A	8,379	N/A	-	3,381	16,942	13,554
Maxixe	N/A	810	N/A	982	12,954	1,558	1,246

Meconta	N/A	-	N/A	809	-	-	-
Metuge	N/A	-	N/A	445	-	-	-
Milange	N/A	6,284	N/A	353	56,477	12,085	9,668
Moamba	N/A	703	N/A	997	6,993	1,353	1,082
Mocuba	N/A	4,929	N/A	689	41,163	9,478	7,583
Mocubela	N/A	1,367	N/A	-	11,365	2,627	2,102
Mogovolas	N/A	-	N/A	283	-	-	-
Montepuez	N/A	-	N/A	1,086	-	-	-
Nacala	N/A	-	N/A	2,006	-	-	-
Nacala-A-Velha	N/A	-	N/A	285	-	-	-
Namaacha	N/A	961	N/A	-	3,893	4,095	3,276
Namacurra	N/A	2,499	N/A	340	22,066	4,805	3,845
Nampula	N/A	8,827	N/A	5,427	82,849	16,975	13,580
Nicoadala	N/A	1,724	N/A	480	19,749	3,315	2,652
Nlhamankulu	N/A	-	N/A	644	-	-	-
Pebane	N/A	2,070	N/A	-	19,766	3,980	3,184
Pemba	N/A	2,319	N/A	831	22,792	4,460	3,568
Quelimane	N/A	3,653	N/A	4,700	38,518	7,024	5,619
Tete	N/A	-	N/A	1,588	-	-	-
Vanduzi	N/A	-	N/A	214	-	-	-
Vilankulo	N/A	-	N/A	542	-	-	-
Xai-Xai	N/A	1,146	N/A	411	14,961	2,107	1,686
Zavala	N/A	50	N/A	-	-	-	-
TOTAL	**N/A**	**124,363**	**N/A**	**51,790**	**787,899**	**163,859**	**131,087**

*Please note population size estimates for PP and KP are not available at the district level
**Please note population size estimates for AGYW represent estimated number of vulnerable AGYW

Table 4.3.3 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
OU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage 2020**	***VMMC_CIRC (in FY22)***	**Expected Coverage (in FY22)**
Cabo Delgado	15-19	151,201	90%		0%

Cabo Delgado	20-24	128,982	91%		0%
Cabo Delgado	25-29	106,936	96%		0%
Cabo Delgado	30-34	78,250	109%		0%
Cabo Delgado	35-39	57,715	119%		0%
Cabo Delgado	40-44	47,212	115%		0%
Cabo Delgado	45-49	37,430	111%		0%
Cabo Delgado	50+	85,512	66%		0%
Cidade De Maputo	15-19	54,211	139%	1,950	115%
Cidade De Maputo	20-24	53,618	119%	600	96%
Cidade De Maputo	25-29	53,829	104%	300	81%
Cidade De Maputo	30-34	47,104	92%	150	69%
Cidade De Maputo	35-39	38,330	85%		62%
Cidade De Maputo	40-44	33,984	77%		55%
Cidade De Maputo	45-49	29,284	66%		0%
Cidade De Maputo	50+	76,592	34%		23%
Gaza	15-19	90,811	94%	3,331	85%
Gaza	20-24	83,845	68%	1,025	59%
Gaza	25-29	77,283	47%	512	40%
Gaza	30-34	57,843	38%	255	32%
Gaza	35-39	42,670	34%		28%
Gaza	40-44	33,055	34%		27%
Gaza	45-49	24,004	34%		0%
Gaza	50+	27,864	39%		31%
Inhambane	15-19	92,957	81%		0%
Inhambane	20-24	84,369	77%		0%
Inhambane	25-29	76,188	75%		0%
Inhambane	30-34	58,180	81%		0%
Inhambane	35-39	46,048	82%		0%
Inhambane	40-44	40,204	75%		0%

Inhambane	45-49	32,663	71%		0%
Inhambane	50+	42,184	74%		0%
Manica	15-19	129,730	83%	22,575	96%
Manica	20-24	112,577	65%	6,948	68%
Manica	25-29	94,234	43%	3,473	45%
Manica	30-34	68,962	30%	1,737	31%
Manica	35-39	50,980	21%		20%
Manica	40-44	40,609	17%		16%
Manica	45-49	30,008	15%		0%
Manica	50+	53,486	9%		9%
Maputo	15-19	112,187	105%	7,254	101%
Maputo	20-24	105,847	87%	2,232	80%
Maputo	25-29	101,488	79%	1,116	71%
Maputo	30-34	82,569	74%	558	66%
Maputo	35-39	62,393	74%		65%
Maputo	40-44	51,083	74%		65%
Maputo	45-49	40,484	70%		0%
Maputo	50+	81,117	47%		41%
Nampula	15-19	343,816	94%		0%
Nampula	20-24	297,740	93%		0%
Nampula	25-29	250,484	94%		0%
Nampula	30-34	188,741	104%		0%
Nampula	35-39	143,248	111%		0%
Nampula	40-44	124,316	101%		0%
Nampula	45-49	104,446	92%		0%
Nampula	50+	270,155	48%		0%
Niassa	15-19	119,364	82%		0%
Niassa	20-24	102,543	82%		0%
Niassa	25-29	83,548	89%		0%
Niassa	30-34	59,841	101%		0%
Niassa	35-39	44,043	111%		0%
Niassa	40-44	36,026	112%		0%
Niassa	45-49	27,950	109%		0%

Niassa	50+	57,135	73%		0%
Sofala	15-19	143,901	99%	10,025	95%
Sofala	20-24	126,148	79%	3,085	73%
Sofala	25-29	105,763	58%	1,543	54%
Sofala	30-34	77,408	45%	771	42%
Sofala	35-39	56,851	35%		31%
Sofala	40-44	45,915	28%		25%
Sofala	45-49	35,158	25%		0%
Sofala	50+	75,896	14%		12%
Tete	15-19	161,748	67%	24,056	66%
Tete	20-24	141,139	48%	7,403	41%
Tete	25-29	119,138	30%	3,700	25%
Tete	30-34	90,102	20%	1,851	17%
Tete	35-39	69,058	14%		10%
Tete	40-44	59,120	11%		4%
Tete	45-49	47,654	9%		3%
Tete	50+	104,172	5%		3%
Zambezia	15-19	342,928	94%	45,848	106%
Zambezia	20-24	298,541	79%	14,109	82%
Zambezia	25-29	248,849	70%	7,054	71%
Zambezia	30-34	180,495	67%	3,525	67%
Zambezia	35-39	133,344	65%		63%
Zambezia	40-44	107,799	64%		63%
Zambezia	45-49	82,366	62%		0%
Zambezia	50+	152,318	44%		43%

Table 4.3.4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY22Target) OVC_SERV Comprehensive	Target # of OVC (FY22Target) OVC_SERV Preventative	Target # of active OVC (FY22Target) OVC_SERV DREAMS	Target # of active beneficiaries whose HIV status is known (FY22 Target) OVC*
Cabo Delgado	N/A	2,111	4,539	2,275	1,149

Cidade De Maputo	N/A	10,717	25,048	0	5,643
Gaza	N/A	17,462	39,063	4,916	10,443
Inhambane	N/A	4,683	10,229	794	2,849
Manica	N/A	11,078	23,899	4,679	6,389
Maputo	N/A	12,076	28,822	12,403	6,814
Nampula	N/A	8,821	11,616	8,657	5,267
Niassa	N/A	0	0	0	0
Sofala	N/A	13,679	28,325	3,595	8,407
Tete	N/A	5,039	9,959	0	2,745
Zambezia	N/A	32,848	61,095	24,527	20,030
TOTAL	**N/A**	**118,514**	**242,595**	**61,846**	**69,736**

Preventing Mother to Child Transmission
Mozambique has, in recent years, consistently achieved high levels of HIV testing and ART coverage (100 percent) in ANC settings. The program has also made steady reductions in infant positivity over the past three years, with 3.8% of HIV exposed infants under 12 months at AJUDA sites infected in Q1 FY21. Spectrum v6.06 2021 estimates national vertical transmission (VT) at 12,07%. According to this Spectrum model, 6% of Mozambique's MTCT (mother-to-child-transmission) is attributable to incident infections in pregnant and lactating women, highlighting the need for access to PrEP for high risk pregnant and lactating women as well as timely identification and management of seroconversion. Inadequate adherence to and retention in care among PLW is a central driver of ongoing VT, contributing to a Q1FY21 viral suppression rate for PLW of 86 percent, albeit increased from 80% in Q1 of FY20. Viral load coverage for PLW is still suboptimal but is steadily improving and stands at 67% in Q1 of FY21 as opposed to 50% four quarters prior. Notably, gains in infant positivity has been sustained despite programmatic shifts in the setting of COVID-19, holding steady at 3.8% for the last three quarters. As the COVID-19 pandemic stabilizes, the resumption of intensive community-based support by Mentor Mothers and ongoing improvements in clinical care quality at AJUDA sites provide an opportunity for further reductions in infant positivity in COP21. As of Q1 FY21, only Nampula and Cabo Delgado had infant positivity above 5% (5.3% and 5.6% respectively).

Cabo Delgado (CDG) has been highly impacted by violent conflict and currently is home to large numbers of IDP's for whom continuity of care remains a challenge. In recent months more than 60,000 IDP's have fled from Cabo Delgado to Nampula. HIV+ refugees are particularly vulnerable to interruptions in HIV care and partners in both provinces are implementing evolving emergency plans to improve continuity of HIV and PMTCT care in these highly mobile and vulnerable

communities. Key Northern and Central provinces with infant positivity above the national average will receive ongoing intensified PMTCT investment in COP21.

In order to improve early infant diagnostic capacity and linkage to care as in COP20, in COP21 the PEPFAR Mozambique team will continue to support both EID testing existent platforms: conventional and m-PIMA POC. In COP21, we propose to further expand POC EID testing to an additional 21 AJUDA health facilities with high EID positivity and low linkage rates. Poor retention in HIV care and treatment parallels late presentation for, and poor retention in ANC. IMASIDA 2015 found that only 55% of pregnant women received four prenatal visits prior to delivery. In COP21 as in COP20, PEPFAR Mozambique's site level mentoring program will include support for early identification of pregnancy in alignment with MISAU PMTCT priorities. In COP20, PEPFAR Mozambique-expanded SAAJ (integrated adolescent care sites) to improve quality of care for teen mothers and introduced a tailored mentor mother strategy for teen mothers. Other interventions introduced in COP20 were PrEP for serodiscordant couples and AGYW, engagement of religious/community leaders, same day POC VL testing in PMTCT and intensified support by high performing PMTCT partners in higher VT sites. All activities will continue into COP21.

PEPFAR Mozambique will also continue to support the national implementation of MISAU's Mentor Mothers strategy, ensuring that community and facility-based Mentor Mothers are in place to provide high quality peer support to HIV positive PLW in all AJUDA sites in COP21. PEPFAR Mozambique will continue to support the national implementation of revised psychosocial support and positive prevention instruments tailored to support PLW as well as dissemination of new algorithm and job aids. Via the mentor mother strategy, 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 COP21, PEPFAR Mozambique will continue to expand the current footprint of mobile brigades to provide high quality primary care, ART access and PMTCT in remote communities in provinces with high VT.

Timely achievement of viral suppression during pregnancy and lactation are key priorities. VL results return to clinical charts and clinical use of results during pregnancy and lactation will be renewed priorities in COP21. As detailed in section 4.9, PEPFAR Mozambique introduced support for POC VL testing for PLW in COP20 and will expand access to same day test results in COP21. In order to eliminate maternal to child transmission of HIV, PEPFAR Mozambique must strive for the ambitious goal of 100% viral suppression among PLW. Site-level efforts will focus on ongoing appropriate implementation of DTG-based regimens, and appropriate management of high VL to increase timely access to second line therapy for eligible PLW. PEPFAR Mozambique Implementing Partners are expected to collaborate with government healthcare providers effectively at the site level to ensure that MISAU policies are fully implemented and that Mozambican PLW receive client-centered psychosocial support, positive prevention and timely VL testing with appropriate follow-up.

PEPFAR Mozambique has allocated funds to support the program costs of re-testing of HIV negative breastfeeding women at 4 and 9 months at high positivity sites. Broader PEPFAR Mozambique support for the maternal retesting platform will depend upon Global Fund support and rapid test kit (RTK) availability in FY22.

Pediatric and Adolescent Populations

Treatment coverage for children and adolescents remains low at 54% and 32% respectively, driven both by inadequate case finding and sub-optimal retention. In the setting of the COVID-19 pandemic, pediatric and adolescent VLC has remained stagnant at 66% in FY21Q1. Viral suppression has increased from 54% in FY20Q1 to 67% in FY21Q1.

Case finding

Index case testing for children continues to serve as the largest volume testing modality for pediatric case identification in Mozambique. The majority of case finding in adolescents continues to take place in ANC and emergency room settings, though provider-initiated testing and counseling (PITC) and ICT approaches have also been areas of focus. In COP20, poor linkage for adolescent boys is an area of focus, but ongoing work will be needed in COP21 to ensure that boys ages 10-19 are effectively linked to care via the support of counselors and adolescent mentors trained in linkage support. In COP21, PEPFAR Mozambique will continue to support high fidelity implementation of MISAU testing platforms for children and adolescents and increase investment in training and human resources to support community-based testing and referral from schools. PEPFAR Mozambique partners have accelerated community-based testing after a COVID-19 related pause during FY20 in community-based testing platforms.

Care and treatment

The number of HIV+ children on treatment has grown modestly over the past four quarters with 80,188 children on treatment at the end of Q1FY21 in comparison to 76,810 children on treatment four quarters prior. This growth was possible because of ongoing facility based testing and significant improvements in retention during a period in which community testing was significantly reduced in the setting of COVID-19 restrictions rates. In order to continue to improve the quality of services provided and to advance child and adolescent-friendly care models, PEPFAR Mozambique will continue to support expanded enrollment of children in differentiated service delivery models (i.e. family approach, teen clubs and multi month scripting), expansion of SAAJ, and implementation of extended hours (either through shift work or shifted hours) to accommodate school schedules. In COP21, PEPFAR Mozambique will also increase its site level investment in clinical human resources to ensure that more children and adolescents in high volume facilities in Mozambique can receive care from a dedicated healthcare worker with reinforced training in pediatric and adolescent HIV care. PEPFAR Mozambique and MISAU have agreed to work together to reinforce the mentor mother strategy for children and MISAU has extended the policy to allow mentor mother support to children below 10 years of age in COP21. This policy change from a focus on children 0-5 years of age extends peer-based community

support for the caregivers of a larger group of children. As detailed in section 1.3a, the OVC program is continuing a pivot toward support for C/ALHIV in COP21; PEPFAR Mozambique will continue to mandate well planned coordination between OVC and clinical partners to ensure effective wrap-around services for high--risk children, and that funding and activities are not duplicative. In COP20, MISAU and PEPFAR Mozambique are introducing a new cadre of age-appropriate HIV+ peer mentors for adolescents and youth ages 10-24 in 65 high volume and high loss sites in an effort to provide more effective psychosocial support to HIV+ adolescents and youth. In COP21, this adolescent mentoring program will be extended to 90 high priority sites.

Figure 4.3.1 PMTCT Cascade, 2020Q2-2020Q1 (4 Quarters)

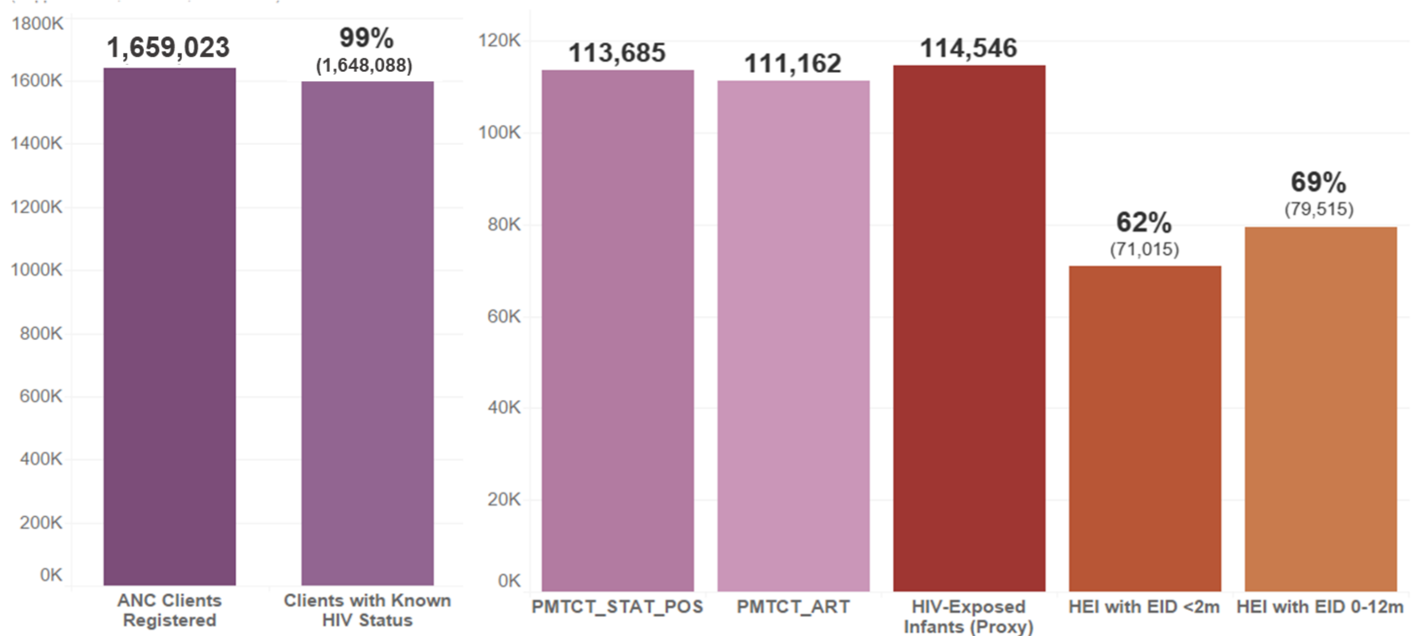


Figure 4.3.2 Prevention Continuum by Key Population Group, 2021 Q1

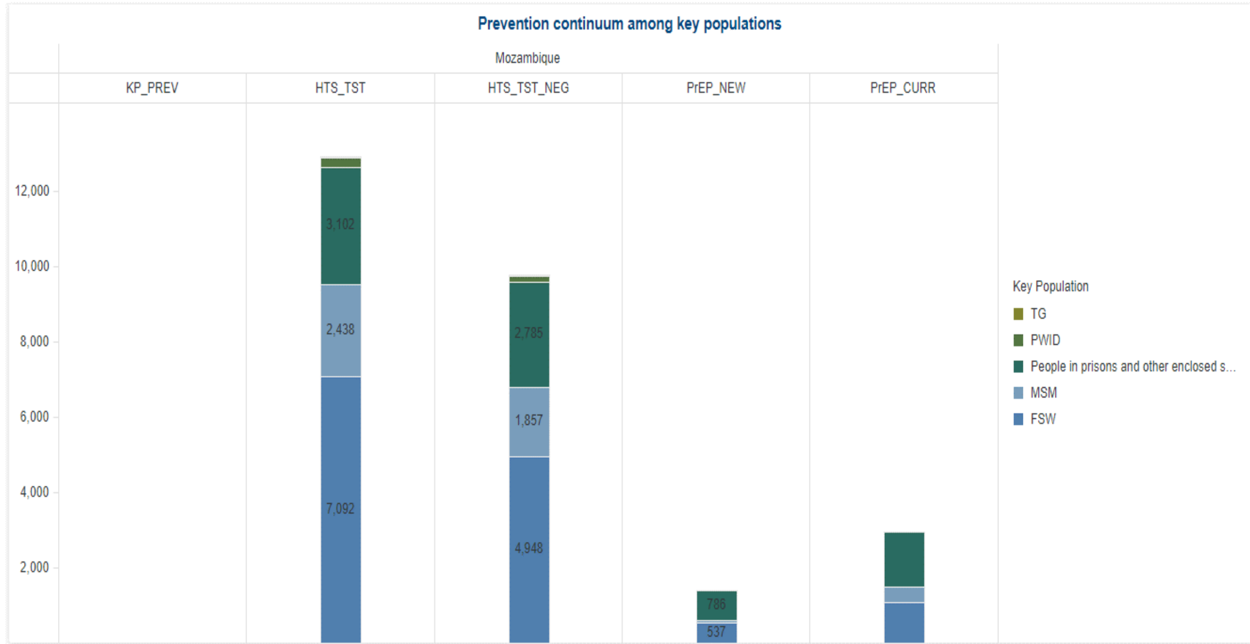
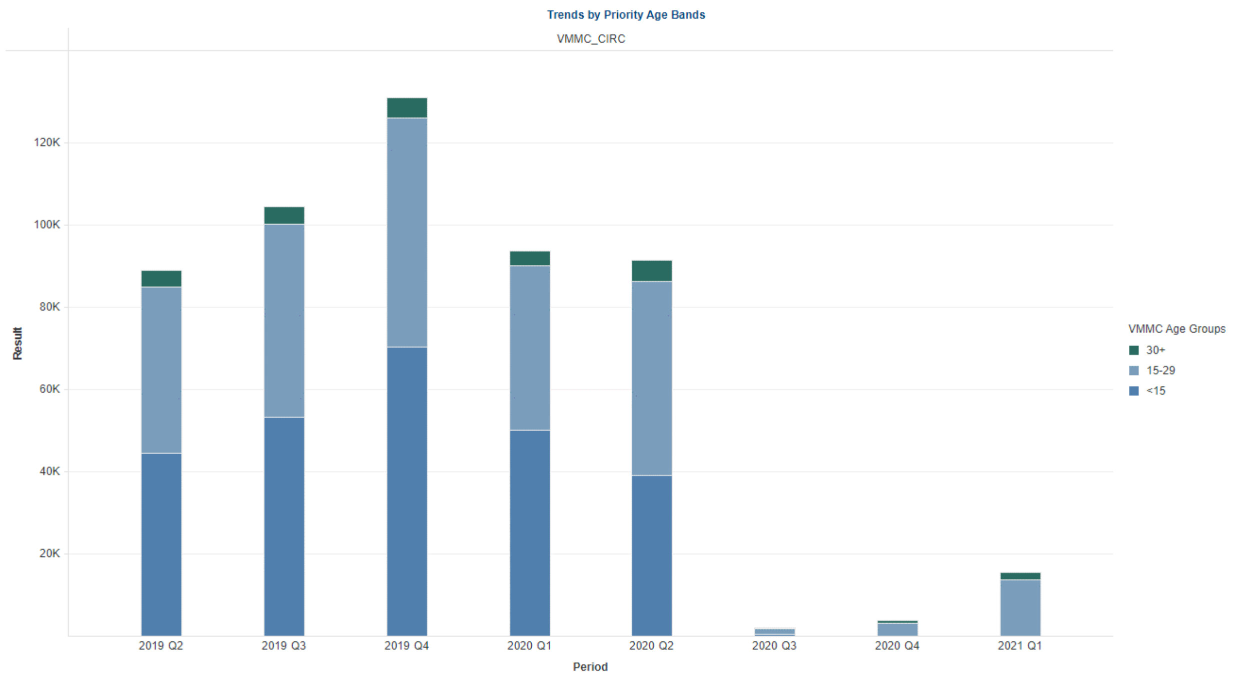


Figure 4.3.3 VMMC Quarterly Trends by Age (2019 Q2- 2021 Q1)



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

Table 4.4.1: Country-specific priorities listed in the planning level letter		
Program Topic	**Planning Level Letter Priority**	**Response**
Case Finding	Continue to scale evidence-based methods for increased case finding, such as index testing at both community and facility levels, self-testing, U=U campaigns, flexible testing days and hours, and targeted community-based testing to help close the gaps in HIV diagnoses among male and female adults (ages 15+) across all provinces, and especially for men in northern provinces.	PEPFAR Mozambique will expand in COP21 the community and facility index-based testing to all AJUDA sites, we will additionally continue optimizing the provider-initiated counseling and testing (PICT) through the effective use the MISAU approved HIV screening tools and continue allocating PICT dedicated counselors to support the providers on HIV testing. PEPFAR Mozambique will also support MISAU on the implementation of HIV self-testing distribution in COP21. We also intend to support the implementation of IPV screening and reporting systems in all AJUDA sites. We will implement HIV testing in congregate male settings and will continue working on improving HIV related literacy among our clients.
Linkage and Initiation of Treatment	Continue working on improving linkage for male and female clients 15-39. Reinforce evidence-based, peer-delivered linkage services for all clients following HIV diagnosis to include intensified post-test counselling and education, comprehensive service referral and linkage system that seeks to identify and address clients' personal challenges.	PEPFAR Mozambique, in COP20 and continuing in COP21, has articulated the necessity for routine exchange of sector-specific enrollment and linkage results between provincial authorities (based upon access to the national MISAU DHIS-2 platform) and PEPFAR Mozambique clinical Implementing Partners. With routine data sharing, COP21 will see an emphasis placed on addressing historically weak linkage seen among adolescent and young adult men. Additionally, PEPFAR Mozambique intends to improve use of the monthly retention and service-delivery dashboard known as the "AJUDA Dashboard." This site-level monthly report continues to be one of the most sensitive and earliest mechanisms that PEPFAR Mozambique has to recognize when ART initiation and early retention achievements are at risk.
	Work with IPs to ensure systematic monitoring and evaluation of enrollment in HIV care and ART	

	initiation outcomes, including monitoring of first drug pick-up, etc.	
Continuity of Treatment Services	Continue to expand and generate demand for client-centered services, including mobile and community ARV distribution, private pharmacy DDD models, integrated pharmacy pick-ups, and 6 MMD.	In COP21, PEPFAR Mozambique will continue to expand client-centered services, encouraging clinical partners and provincial authorities to best determine the appropriate mix of differentiated service delivery models within the allocated budget. Expedited by the change in clinical norms due to the COVID pandemic, PEPFAR Mozambique reports 69% of all active ART clients as receiving multi-month dispensation as of FY21 Q2. PEPFAR Mozambique expects to maintain 75 private pharmacies participating in ART distribution and expect to see a dramatic increase in the number of sites offering 6MDD and community ART distribution through health providers. The use of APEs for community ART distribution will also be expanded in COP21. Mobile brigades may be expanded to additional provinces based on provincial negotiations.
	Utilize CQI approaches to identify and address reasons for clients defaulting, differentiated by demographic and geographic considerations.	COP21 represents an opportunity to continue substantial integration and alignment of SIMS quality improvement and the AJUDA site-level remediation platforms. This effort, which first began in COP20, endeavors to bridge the strengths of rigorous quantitative CQI assessment tools (SIMS) with the gains that granular site management (AJUDA-specific instruments) have brought to Mozambique. PEPFAR Mozambique has incorporated 18 novel Core Essential Elements (CEE) into SIMS that reflect its objective of routinely and quickly identifying (and correcting) site-level workflow or service delivery issues that are impeding continuity in treatment. In COP21, PEPFAR Mozambique will focus attention on long-term treatment interruption (IIT greater than three months) as it remains a consistent, noticeable contributor to negative treatment growth, despite the gains in TX_CURR and early retention observed in COP19 and COP20 (particularly among men and in particular provinces). In light of COVID-19´s impact on safe access to health care facilities, distinguishing between COVID-19 related treatment interruption *vs.* common HIV-related reasons for treatment

		interruption will be critical to ensuring that "return-to-treatment" program interventions are addressed to the populations and geographies most in need.
	Consider deployment of CETA approaches to address mental health barriers to continuity of treatment.	In COP20, PEPFAR Mozambique, in coordination with MISAU (National HIV Program and Department of Mental Health), introduced a mental health screening and treatment program adapted from the Common Elements Treatment Approach (CETA) in 22 health facilities (two per province). All PEPFAR Mozambique-supported clinicians are trained to use the CETA-like model for screening, with referral to trained, licensed clinical mental health professionals for treatment. Based on successes and lessons learned in COP20, additional facilities will be incorporated into the mental health screening and treatment program in PEPFAR Mozambique-supported facilities in COP21.
	Ensure HIV treatment services are provided in Cabo Delgado by supporting the provincial and district levels and the tracing of internally displaced persons to relink to care. Consider leveraging partners with experience in conflict areas to support efforts.	In COP21, PEPFAR Mozambique will continue to build upon the novel platform that Cabo Delgado provincial authorities, PEPFAR Mozambique Implementing Partners, and humanitarian actors have established (i) to maximize identification of PLHIV among internally-displaced populations (among those displaced into host communities and those displaced into IDP camps), (ii) to reestablish linkage to care and access to ARVs, (iii) to integrate core HIV/TB services into mobile and community primary care delivery mechanisms. In COP21, a funding opportunity award may be made available to a new implementing partner with expertise in maintaining public health and clinical services in the context of a complex humanitarian emergency. In addition, during COP20 through established MISAU technical working groups, PEPFAR Mozambique has encouraged MISAU to consider simplifying the process through which a patient officially transfers care from one Cabo Delgado facility to another. MISAU has indicated that it is designing a new patient health passport which could make certain aspects of a patient medical record portable so that critical medical information about a displaced individual living with HIV is available to a clinician who is supporting

		the IDP community, even if the clinician does not have access to the original medical record.
	Validate TX_RTT reporting and ensure aligns with most recent MER guidance.	TX_RTT for FY2021 reporting is generated through a standardized OpenMRS EPTS query developed by HIS Implementing Partners, which applies the MER2.5 definition of TX_RTT. This query has been HIS certified and validated through an interagency DQA conducted in January 2021.
Viral Load Coverage and Suppression	Continue expanding VL coverage through continued optimization of the conventional VL and EID testing network.	The Diagnostic Network Optimization (DNO) is a continuous quality improvement process, which takes in consideration increasing demand creation, establishing a fast and frequent consolidated sample referral system, forecasting adequate instrument capacity for future demand, ensuring the appropriate number of trained staff are available, implementing adequate stock management and procurement systems to avoid stock outs of reagents, providing appropriate laboratory infrastructure, and establishing a comprehensive LIS to provide timely results and perform M&E of all steps of the VL and EID cascade. The PEPFAR Mozambique team is making improvements in all these areas and will be able to make targeted interventions to increase VL coverage in COP21.
	Optimize the interoperability and use of electronic monitoring tools for VL (VL dashboard, EPTS and DISA) to allow the monitoring of patients with high VL or failing TLD at the national level and generate and use high VL cascades at the site level.	The HIV program has had difficulty monitoring patients with unsuppressed VL due to limited use of the decentralized EPTS and absence of the patient ART identification number (NID) on test requisition forms. The absence of the NID on test requests makes the identification of patients inaccurate and labor intensive. However, the centralization of EPTS and the interoperability of EPTS and OpenLDR databases will permit the automated and accurate introduction of the NID on electronic test requests on the DISA LIS. Therefore, test results will be provided to the correct patients and automatically entered on EPTS electronically in real-time, as soon as VL results are available at the testing laboratory. This interoperability is being tested in Zambezia province in COP20 and will be expanded to additional provinces in COP21. Moreover, the generation of weekly VL results reports that are automatically sent to HFs with patients' VL results, as well as the VL dashboard provide easy access to patient's VL results facilitating the identification and tracking of patients with unsuppressed VL results. In

		addition, WWDisa, an online result viewing mechanism that supports smart phone, tablets and PC will be used to access VL results on timely manner.
	Implement measures that identify eligible individuals for VL test and to flag patients who are due for VL prior to their refill or who have high VL.	In COP21 PEPFAR Mozambique will continue to consolidate strategies aimed at improving timely identification of individuals who are eligible for Viral load testing. These include disseminating and supporting implementation of new viral load testing algorithms that are currently under revision; using electronic medical record systems to create weekly lists of patients that are eligible for VL; assigning dedicated staff within health facilities to review clinic charts of patients scheduled for a consultation and drug pick up in the pharmacy; ensuring implementation of MISAU psychosocial support (PSS) guidelines for phone call and home visit follow-up of patients who have a VL result >1000 copies/mL; setting weekly targets for number of VL tests done and monitoring performance during weekly ART committee meetings.
	Identify barriers for access to VL testing and suppression for pediatric, adolescent, and pregnant women and deploy remediation measures. Enhance partner management for these populations.	In COP20 the PEPFAR Mozambique team has been working with IPs to identify critical gaps pediatric HIV outcomes and action plans have been developed to support HF with interventions to improve VL testing and suppression for children and adolescents. Regular monthly meetings and data review are ongoing to monitor performance. Clinical mentorship in psychosocial support for MCH providers and the Mentor Mothers strategy has been implemented to improve VLC and VLS among PLW. There are ongoing discussions with MISAU for introduction of multiplexing for VL POC prioritizing PBFW and children less than 5 years old (see below).
Pediatrics	Improve pediatric case finding through increased index testing of all children and use of pediatric screening tools in OPD for other PITC.	In COP20, even with limited index testing due to COVID-19 restrictions particularly at the community level, facility-based index testing remained one of the most efficient modalities to identify CLHIV. In COP21 ongoing work will continue to be implemented to expand index case testing and expand PICT at OPD with the use of pediatric screening tools.

	Support the GRM to adopt and implement a policy authorizing CHW dispensing of ART, and for scaleup of 6-month MMD.	6 MMD is not currently approved by MISAU for children. However, children are eligible to receive community-based ART distribution by APEs and healthcare personnel Children are also eligible for care within mobile brigades
	Rapidly phase out of EFV and NVP (in FY 2021) and rapid scale up of DTG 50mg for all CLHIV >20kg and TLD for CLHIV >30kg. Once DTG 10 mg arrives, the remaining children should be rapidly optimized.	Phase I Pediatric ART optimization begun in October 2019, with the introduction of DTG based regimens for children > 50mg and phase II initiated in October 2020 for complete phase out of Efavirenz and Nevirapine-based regimens. This process is ongoing and as of Q1 FY 21, 89% of children were receiving optimized ARV regimens. The country is currently in preparation of the introduction of DTG10 mg that is expected to arrive mid-2022.
	Improve quality of pediatric services to ensure high VLS, including referral to quality EAC, viremia clinics, teen clubs, OVC programs, Mentor Mothers, etc. where appropriate with follow up VL to ensure suppression. Intensify partner management for pediatrics.	The PEPFAR Mozambique team has been supporting the Ministry of Health on several activities to improve the quality of pediatric care and treatment services, which includes mentorship of HCW providing pediatric ART to ensure ART optimization, timely VL management and treatment failure identification and scale up of DSD models such as the family approach and 3MDD. Additional wrap around activities to improve adherence and retention of children to treatment such as OVC support (through collaboration between OVC and clinical partners) and scaling up of Mentor Mothers support to children up to the age of 10 years old are ongoing. PEPFAR Mozambique invested in site level HRH to support pediatric HIV treatment. Regular monthly meetings and data review to monitor Pediatric performance as part of IP management is also an ongoing activity. These activities will continue in COP21.
	Improve quality of outcomes of TB services in children, including TB case identification for children newly initiated on ART and children with malnutrition. Increase the use of alternative sample types and diagnostic testing. Address clinical and supply	TB contact tracing and identification of children with TB is implemented. The Ministry of Health is designing a pilot to evaluate the implementation of stool samples as an alternative option for TB diagnosis in children, that if proven feasible in the Mozambican context will be scaled up in COP21. Training of

	chain barriers to pediatric TB treatment and TPT.	Clinicians on pediatric TB case management will continue to be performed in COP21.
	Improved screening and management of advanced HIV disease for children. Quantification for commodities for advanced disease, such as CD4, urine-LAM, and prophylactic medications, should include children and adolescents, and PEPFAR Mozambique should coordinate with Global Fund, the GRM and other stakeholders to ensure their procurement.	PEPFAR Mozambique supported development of an AHD package (guidelines and training materials) in collaboration with GF and the GRM and interventions targeting pediatric and adolescent populations are included and will be implemented in COP20 and maintained/scaled in COP21. PEPFAR Mozambique supports high fidelity implementation of TB and OI preventive therapy for children via TA, supervision and staff training.
PMTCT & EID	Continue to improve viral load coverage among PLW and EID testing. Deploy strategic use of POC technologies for implementation of same day VL POC for PLW (and children < 5) and EID (only if patients receive results during their facility visits).	Discussions with the Ministry of Health are ongoing to introduce VL multiplexing using m-PIMA and/or GeneXpert, in high volume sites in the highest HIV vertical transmission provinces in FY21 and continue in COP21.
	Improve tracking of pregnant women through Mother-baby pair programs and/or similar programs.	The Mentor Mothers strategy has been implemented to improve PLWs' adherence to PMTCT. Registries and monitoring tools are being developed to be used by the Mentor Mothers to improve tracking of mother and baby pairs to ensure effective linkage to Consulta de Criança em Risco (CCR) and EID.
	Intensify partner management for VLC/ VLS for PLW and EID coverage.	Regular monthly meetings and data review have been implemented to monitor VLC/VLS and EID and overall PMTCT and Pediatric HIV performance.

	Support MISAU to adopt DSD COVID-19 adaptations for PLW as routine operations in national guidelines.	No specific COVID-19 adaptation has been adopted as routine in the PMTCT national guidelines. 3 MDD has been recently approved for Lactating Women (LW) under specific criteria.
	Expand mentor mother-based ART distribution in conflict and disaster settings	Mentor Mothers based ART distribution has not been approved by the MISAU.
MenStar	Expand strategic marketing: Reinforce messaging and brand established in FY21 campaign, both at the mass/mid-media level as well as at the community level. Novel new approaches to reach men, including the use of advanced analytics, may be required to reach desired impact.	In May 2021, the campaign-focused on addressing stigma was launched, using a mix of mass and mixed-media, and including messages specifically targeted towards men.
TB	Deploy a comprehensive approach to eliminate the 30% gap of PLHIV not undergoing TB screening, including improved data quality, trainings and mentorship/supportive supervision to health care workers, patient literacy with communication (IEC) materials, and intensified partner management and data reviews.	PEPFAR Mozambique for COP20 continues to support the FAST strategy in all of the 625 health facilities. PEPFAR Mozambique is also committed to the development of an integrated literacy package for lay and health workers to increase demand for TB screening and diagnosis. The PEPFAR Mozambique team is working closely with the Ministry of Health and Implementing Partners to identify the root cause of the 30% gap and develop actions according to the findings. Inadequate or lack of TB screening registered on the official patient chart and screened positive, and a lab follow-up not registered were some of the gaps identified. Implementing Partners jointly with health facility staff conduct intensive clinical mentoring and supervision for TB/HIV activities in health facilities identified with these gaps. One of the primary challenges is that TB screening is currently only being captured on patient charts during a clinical consultation by a clinician. We are not capturing TB screening from lay workers, CHWs, or pharmacists. As part of COP21 our team is actively working with the HIS team on developing a module in

		iDART and iDART Lite to capture TB screening by public and private pharmacists during distribution of ART in MDD and DDD models. This may also be adapted for software applications supporting distribution of ART using mobile brigades and APEs. The idea is to document TB screening at all clinical consultations, and also whenever ART is being distributed to clients. Finally in COP21 PEPFAR Mozambique will work with the HIS team and clinical IPs to develop new EPTS reports that follow this cascade monthly to allow for near real time analysis (not just semesterly) to generate line lists of clients that are missing TB screening in the last 5-6 months, and line lists of clients that have a positive screen for TB in the last week to ensure that they are getting the appropriate work-up, and that relevant laboratory and CXR results get into the patient charts and are digitized in EPTS.
	Deploy CQI approaches to identify and address obstacles resulting in suboptimal TPT completion rates at 64% overall. Ensure client-centered approaches for ART are also applied to TPT.	PEPFAR Mozambique SI teams have updated three critical reports to support IPs efforts to strengthen this cascade. The first is to understand the number of TX_CURR that do not have documented TPT completion, and either need their records updated or to be started on TPT. The second is a line list to identify clients at a facility level that started TPT in the last seven months and that may have missed a TPT refill in the last week or may be eligible for TPT completion. This will help increase the number of clients that complete TPT and have this appropriately documented. The final updated line list will be launched in June and will list clients at a facility level in TX_CURR that do not have documented TPT completion. Together these CQI efforts, informed by these updated reports, will allow partners to pull these records, review them, update TPT completion if it's documented but not digitized, or flag these charts for TPT initiation at the next clinical consultation. These reports will help PEPFAR Mozambique and the MISAU achieve the COP21 MR of treating all eligible TX_CURR by the end of COP21.

		Overall TPT completion rates continue to climb and will likely be approaching 85% by the end of COP20. It's critical to have these TPT completion rates over 80% before starting a massive TPT mop-up campaign. We have seen significant progress over the last few semesters in the percentage of new on ART that have a negative symptom screen for TB that start TPT.
	Identify root causes and deploy remediation efforts to rapidly improve the 15% follow on diagnostic rate for ART patients with symptom positive TB screens.	PEPFAR Mozambique is committed to rapidly improve the 15% follow on diagnostic rate for ART patients with symptom positive TB screening by supporting a pilot presumptive TB follow-up registry, to better follow-up clients and to ensure that they get the appropriate laboratory follow-up, and make sure this information gets registered in the patient chart and digitizes into EPTS. Combined with the updated EPTS reports described in #1 above, intensive clinical mentoring on TB/HIV activity packages will also be implemented.
Advanced Disease Management	Make preparations needed for implementation of ADM services when commodities begin to arrive, including training package dissemination, update of national policy, needs assessment, clinical mentorship, laboratory capacity, development of SOPs, establishment of referral pathways, and monitoring and evaluation.	PEPFAR Mozambique staff have been closely involved in the development and finalization of MISAU's Advanced Disease (AD) national guidelines. In COP20, PEPFAR Mozambique has committed to train relevant central/provincial referral hospitals on AD service provision. In COP21, PEPFAR Mozambique will increase its contribution to AD services, supporting the introduction of MISAU´s complete AD package through pairing of central/provincial referral hospitals with high-volume health facilities to provide outpatient AD interventions (intermediate package) that may be necessary after acute inpatient management has been completed at tertiary facilities. In COP20 (and in COP21), PEPFAR Mozambique has committed to ensuring all 600+ AJUDA sites offer the basic AD package, which includes screening and referral for AD services. All AD commodities required by the MISAU basic, intermediate, or advanced package, have been procured through MISAU´s negotiation with the Global Fund. As such, PEPFAR Mozambique has no plans on procuring any specific commodities for AD activities. PEPFAR Mozambique will ensure quality implementation through on-site supervision and consistent mentoring for clinicians who will be screening, treating, and referring patients with advanced disease.

Cervical Cancer	Expand cryotherapy and LEEP services to new service delivery sites especially in Sofala, Manica, Military, and Zambezia.	Cryotherapy and LEEP capacity have been expanded in Sofala, Manica, Military and Zambezia. In COP21, PEPFAR Mozambique will expand LEEP access from 19-25 sites nationally.
	Work with MISAU to rapidly facilitate introduction of thermocoagulation for cervical cancer treatment in Mozambique to facilitate improved treatment access.	Thermocoagulation will be initially introduced in 50 sites in FY21 with plans for further expansion, to improve treatment capacity of cervix lesions with less than 75% of extension.
	Ensure that IPs and sites have a robust quality assurance system for VIA and begin implementation of HPV testing in pilot sites with this capability.	A national quality assurance program for cervical cancer prevention (CECAP) will be implemented in COP21.
OVC	Ensure that >90% or more of children and adolescents on ART with PEPFAR Mozambique support in OVC SNUs are offered the opportunity to enroll in the comprehensive OVC program.	In COP21, PEPFAR Mozambique partners will ensure an adequately funded and technically sound OVC program that strives to ensure that >90% of children and adolescents on ART at PEPFAR Mozambique-support health facilities in OVC program SNUs are offered the opportunity to enroll in the comprehensive OVC program
	OVC and clinical partners should continue to collaborate to systematically triangulate facility data with OVC program data to verify number of CLHIV, optimized ART regimens, and improve pediatric retention, VLC, and VLS. Clinical IPs should support this data sharing to enable monitoring of outcomes. OVC and clinical partners should implement existing MOUs, or put new MOUs in place, for all sites that are jointly served,	OVC and clinical partners have MOUs established in each Province and call for weekly coordination meetings at the health-facility level between OVC Case Managers, Linkage Facilitators, & Mentor Mothers to ensure adequate coverage and coordination of service delivery. Clinical data is being regularly triangulated at most sites, and this practice will be expanded during COP21. Mentor Mothers work closely with OVC Case Managers to ensure that PLHIV and their children continue to access optimized ART regimens and viral load testing. Those CLHIV struggling with ART continuity are supported with additional OVC social services, based on a needs assessment, and in coordination with Mentor Mothers

	clearly delineating responsibilities and coordination.	and clinical partners. In addition, OVC IPs will continue to create synergies with the DREAMS program through primary preventive for HIV and sexual violence.
KP	At minimum, maintain COP20 investments for KP programs (base and KPIF) to ensure high quality testing, linkage and treatment services. Continue working closely with clinical partners to improve linkages from community to clinical services.	COP21 investments for KP programming will be maintained at the COP20 level (base and KPIF), and will ensure high quality testing, linkage and care and treatment services for MSM, FSWs, PWID, TG, and Prisoner populations. PEPFAR Mozambique will continue working closely with community and clinical partners to improve linkages from community to clinical services, including demand creation for PrEP service expansion, monitoring of KP continuity on ART, viral load testing coverage and viral suppression.
	Provide technical assistance to MISAU health care workers to improve classification of KP using new fields on clinical records and to make health facilities in rural and suburban areas more KP-friendly.	In COP21, PEPFAR Mozambique will continue working with MISAU health care workers and PEPFAR Mozambique-supported clinical partners to ensure that KP clinical services are appropriately documented and disaggregated for improved program monitoring and data triangulation. PEPFAR Mozambique will expand the identification and training of "KP-Champion" health care workers to ensure KP-friendly services are available in more semi-urban health facilities within program districts.
DREAMS	Deploy intensified partner management to rapidly increase primary package completion for all ages and ensure quality scale up of DREAMS programs to new provinces and districts added in FY 2021. This should include improvements in routine data collection and monitoring the layering of services among AGYW.	Actions for improving IP performance at field level include curricula alignment, Data Layering Tool (DLT) system update, deployment of SI POCs in each IP to support SI teams, and stronger IP oversight to reinforce the DREAMS structure and accountability.
	Continue STI screening and treatment as part of the DREAMS package.	During COP20 DREAMS funds were used to support the MISAU in reviewing the STI screening and register tools. The MISAU has agreed for the tools to be rolled out in districts of DREAMS implementation. In collaboration with the INS and MISAU, DREAMS STI funds were used to implement a protocol to improve STI

		diagnostics among AGYW using rapid tests (not available in country) and GeneXpert (not available in country for STI). The protocol is expected to be implemented from June to October. The results of the study will provide information on (1) the prevalence of STI among AGYW who report risky sexual behaviors; (2) the use of rapid tests and GeneXpert for AGYW with and without report of STI symptoms; (3) how many AGYW would have been missed by the syndromic approach currently used in Mozambique if asymptomatic AGYW were not tested for STI; and (4) the acceptability of the rapid tests and GeneXpert for providers and AGYW. As part of COP21, funds were allocated to adapt programming based on the results of the study. Funds were allocated to support the MISAU to improve screening and treatment of STI among AGYW and their partners especially given the rollout of PrEP. All clinical IPs were allocated specific funds to support prevention, screening, treatment and reporting STI among youth.
	Increase engagement and retention of AGYW aged 20-24 years by scaling-up and expanding sustainable comprehensive economic strengthening interventions to all DREAMS districts.	A comprehensive SES package aimed at raising the employability level and job market entry of young women is being offered in 9 districts by an expert sub-contractor. The crucial component will be to build local IP capacity for a broader expansion in COP21 in the 32 districts.
	Increase the flexibility/adaptability of DREAMS programming, including post-violence clinical care services and community-based interventions, to sustain and build upon achievements by utilizing best practices and lessons learned from humanitarian settings to mitigate the effects of natural disasters, civil conflict, and the prolonged impacts of COVID-19 and other future pandemics.	Actions to modify/adapt the program have taken place particularly the delivery of virtual content in trainings, meeting in small groups and building IP capacity to prevent COVID-19, GBV and HIV through widespread messaging. Efforts are underway to collect information and establish program structure in order to assess the risk and vulnerabilities that AGYW face in conflict settings. The program is being tailored to their utmost needs. This will continue through COP21.

PrEP	Continue to expand PrEP access for KP, AGYW/DREAMS, serodiscordant couples, and in ANC, particularly through community-based PrEP services and differentiated service delivery models (e.g. MMD, virtual follow up) across all provinces.	In COP21, PrEP services will be made available for KP, AGYW/DREAMS beneficiaries, serodiscordant couples, and at-risk ANC clients in all supported districts in 11 Provinces, as part of the MISAU-led national PrEP acceleration plan. Community-based demand creation and referrals will be conducted by trained HTS counselors. Mobile clinics operating in KP hotspots will also conduct community-based clinical screening and enrollment as part of differentiated PrEP service delivery models in COP21.
	Ensure the use and dissemination of MISAU approved PrEP demand creation plan targeting all populations at risk.	Based on a demand creation training package that has been developed during COP20, in COP21 community IPs will be able to implement comprehensive demand creation approaches to increase uptake of PrEP in all provinces
	Ensure PrEP offered in all HFs in DREAMS districts and that DREAMS spaces support demand creation/education/support of PrEP More AGYW should be receiving PrEP in DREAMS districts versus non-DREAMS districts.	PrEP will be offered in all COP21 DREAMS districts
	Implementing Partners monitor PrEP adherence and provide adherence support to PLW.	Implementing Partners will monitor PrEP uptake and continuation, and provide the appropriate support to maintain all beneficiaries on PrEP during periods of elevated risk of HIV infection
	Continue working with the GRM to update policies, guidelines and IEC to deploy novel biomedical prevention products and delivery systems such as oral PrEP, long-lasting injectable PrEP, event-driven PrEP and the Dapivirine ring.	PEPFAR Mozambique will continue to support the GRM to update policies and guidelines to deploy novel biomedical prevention products and delivery systems such as oral PrEP, long-lasting injectable PrEP, event-driven PrEP and the Dapivirine ring as these become available.
VMMC	Adapt demand creation and service delivery for COVID-19, scale up in a	PEPFAR Mozambique will continue to scale up high quality and safe VMMC services to increase uptake of VMMC services through fixed and mobile

	deliberate, controlled fashion, and monitor sites for compliance with risk mitigation standards. Continue to modify demand creation and service delivery activities to achieve success for those 15+.	strategies. The program has adapted to the new COVID-19 operating environment by expanding socially distanced VMMC service protocols and demand creation strategies, including the use of community-radio testimonials and support for the AloVida toll-free hotline to answer potential VMMC clients' questions in local languages. Community referral agents have been trained on COVID-19 prevention measures and provided with appropriate PPE. PEPFAR Mozambique will continue to reach "late adopter" VMMC clients age 15+ in lower-coverage areas through one-to-one peer outreach and the introduction of individual transport vouchers.
	Support Implementing Partners on the effective use of voucher distribution for demand creation	PEPFAR Mozambique and partners support the introduction of different strategies to overcome existing barriers for uptake of VMMC services, e.g. transportation vouchers
Supply Chain	Provide national coverage of private sector last-mile distribution through PEPFAR Mozambique; shifting TA to focus on contract and performance management to pave the way for the GRM to replicate last mile distribution strategies.	In COP21 PEPFAR Mozambique will partner with a private sector 4PL for nationwide outsourced medicines distribution to the last mile, to ensure timely and cost-effective last mile delivery through a consolidated outsourced medicines distribution system.
	Strengthen end-to-end supply chain data availability, visibility, security, and use; particularly the routine triangulation of facility level stock data and program data by establishing a GRM Data Management Unit.	In COP21, we ensure the CMAM G2G agreement includes the establishment of the GRM Data Management Unit as one of the key reforms aimed at strengthening the reliability and sustainability of the medical product supply chain. This will ensure the sustainability of PEPFAR Mozambique investments in end-to-end supply chain data availability and use – such as management of SIGLUS, the electronic logistics management information system that provides visibility to commodities consumption and stocks at site level throughout Mozambique.
Lab	Improve laboratory systems by operationalization of the Diagnostic Network Optimization (DNO), in	As mentioned on the Viral Load Coverage and Suppression topic above, the DNO is a continuous quality improvement process, which among several areas, focuses on the availability of the current instruments network, both conventional and

	coordination with the TB Diagnostic Network Analysis (DNA), and establishment of a consolidated sample transport system.	POC or near-POC instruments, and on the demand needed to meet clinical program testing targets. The TB DNA will provide additional insight on the entire clinical and laboratory processes for TB diagnosis that is needed for the clinical management of patients. The current sample referral system (SRS) in Mozambique has been consolidated and serves different vertical programs, such as HIV, TB, clinical monitoring (CD4), and others. The SRS is managed by the clinical IPs in COP20 and varies in costs and strategy. In COP21, the PEPFAR Mozambique team will begin to transition the sample transportation system activity to a new expert IP that will focus exclusively on this activity, allowing clinical IPs to concentrate on service delivery and laboratory activities. The new SRS IP will absorb good practices and improvements already achieved by the current system and will take advantage of the Laboratory Information System for tracking specimens and to monitor transportation times from HFs to reference laboratories.
HMIS	Improve data integration through functional enhancements of EPTS. Transition of legacy DREAMS and GBV data collection systems to align with Mozambique's National HMIS guidelines. Consolidation of VMMC and HTC systems across partners and agencies	Continue to support MISAU in implementing the nationally approved HIV electronic patient tracking system (EPTS) through the inclusion of tools and MISAU requested reports needed for patient and program monitoring such as Melhoria de Qualidade and SISMA M&E Reports. The program intends to gradually transfer health information systems responsibility for EPTS management to provincial directorates through centralization activities. Interoperability and the ability to improve data integration improves the completeness and timeliness of data. In COP20, iDART, the health facility pharmacy system, iDART mobile, the mobile pharmacy system used in private pharmacies, and OpenMRS EPTS are interoperable. Interoperability between OpenMRS EPTS and DISA/Open LDR (laboratory) is in testing in one province and will be expanded in COP21. Interoperability between iDART pharmacy and SIGLUS, the electronic logistics management information system that provides visibility to commodities consumption and stocks at site level throughout Mozambique, is planned in COP21. Interoperability between systems will

		continue to be supported as enhancements are made systems, which at times requires enhancements to the interoperability connection between the systems. The DREAMS Layering Tool (DLT) and the GBV eIDM system will be transitioned to align with the Government of the Republic of Mozambique's National HMIS strategy, to support the transition of the system to MISAU for ownership and long-term sustainability. Data collected from disparate systems is problematic. It is an inefficient use of resources supporting duplicative systems, that are costly to maintain and support. Disparate systems introduce data quality issues as the meaning and contents of the data is not readily known or well-defined and makes having a national representative database challenging. An assessment will be conducted to determine the feasibility and cost to consolidate VMMC systems across partners and agencies. Paper based data collection and reporting introduces challenges to data quality. An assessment will be conducted to determine the feasibility and costs associated to develop a community and/or health facility-based system to support HTC/HTS activities.
HRH	Continue to optimize staffing investments and adjust staffing models to provide client-centered services. Expand local partner and private sector HRH capacity to build a more flexible and resilient workforce for HIV services.	USG Mozambique will continue using the Touch Foundation WISN based tool to conduct further analyses of the PEPFAR Mozambique HRH footprint with a view to optimally selecting, deploying and funding staff. Additionally, the interagency HRH team will commence discussions with Namibia and Tanzania to explore options for consolidating HRH investments in one or two partners (preferably local) so as to allow clinical IP's to focus on their core tasks.
Strategic Information	If funds are available, consider conducting SABERS survey of military population.	Funds were identified to conduct SABERS. This activity is included in COP21.
Management and Operations	If funds are available, support (up to 50% PEPFAR) an emergency response position to help coordinate ongoing and	In COP20, CDC Mozambique will hire a global health security advisor partially funded by PEPFAR. This position will be continued in COP21.

	emerging challenges related to conflict or natural disasters.	

4.5 Commodities

PEPFAR Mozambique coordinates commodity investments closely with the Global Fund and regularly monitors commodity pipelines and funding to ensure appropriate stock levels in country to meet consumption demands. Supply plans are 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.

COP21 commodity investments align with priorities and optimized regimens, are developed within the provided budget envelope, and represent a 14% decrease from the COP20 commodities budget. PEPFAR Mozambique commodity investments cover 100% of the viral load, EID, PrEP, and VMMC needs, while the ARV, TB, and RTK commodities depend largely on Global Fund investments. PEPFAR Mozambique funding covers 22% of the projected ARV financial need and 34% of the projected RTK need, and also assumes a $5 million contribution from the GRM for both RTKs and ARVs in FY22. In COP20, PEPFAR Mozambique funded 3HP, which was delayed due to production and quality issues, and is planned to arrive during FY22. Complementary quantities from the GF will ensure the expansion of this new TB preventive treatment. All funding gaps and potential commodity shortages depend heavily on coordination with the Global Fund.

4.6 Collaboration, Integration and Monitoring

Below we describe solutions to address challenges across the entire clinical cascade with specific consideration for:

4.6.a. Collaboration, Integration and Monitoring: Cross-technical collaborations and implementation

During COP19 & COP20 implementation, PEPFAR Mozambique engaged with CNCS to develop the scope of work for the new CNCS direct agreement (G2G), with a strong emphasis on sub-grants to civil society to conduct community-led monitoring of HIV services provided at facility and community levels. UNAIDS and several civil society organizations participated in the design of these community-led interventions. UNAIDS and civil society will continue to be substantively involved in implementation of the community-led monitoring approach, including the development of activities and indicators for monitoring progress during COP21 implementation.

In COP19 and into COP20, together with other multilaterals, civil society and the GRM, PEPFAR Mozambique provided direct technical assistance to the GRM on the process of developing the Global Fund grant applications for HIV & TB for 2021-23, including being active participants in assisting MISAU in the proposal development by each technical area. This was a key opportunity to maximize the collective efforts to control the HIV epidemic. In addition, PEPFAR Mozambique will collaborate closely with Global Fund in the 14 districts where both entities fund implementation of AGYW activities. Furthermore, PEPFAR Mozambique is also assisting the GRM to develop the COVID-19 supplemental applications to Global Fund. PEPFAR Mozambique will

ensure that it is fully aligned with PEPFAR's investments and that this funding mitigates the enormous impact that the COVID-19 pandemic has had on HIV service delivery.

4.6.b. Collaboration, Integration and Monitoring: Strengthening IP management

The COVID-19 pandemic has limited the ability of PEPFAR Mozambique teams across all agencies to conduct regular, focused technical assistance (TA) and Partner Management site visits to underperforming sites. Innovative approaches being implemented to maintain program oversight and support Implementing Partners in addressing and fixing site level challenges include use of video conferencing tools to jointly review performance data with provincial and site level teams. Monthly data "deep-dives" with both clinical IPs and the GRM allow for continued monitoring of site level implementation, oversight and accountability of PEPFAR Mozambique funded programs through a virtual platform. This analysis is conducted virtually monthly with all Implementing Partners using advanced data visualization tools consolidated in an inter-agency dashboard.

Additionally, the PEPFAR Mozambique teams are gradually resuming site visits to partner supported sites using an integrated SIMS-AJUDA tool. The visits are conducted jointly with Ministry of Health provincial and district staff and clinical partners, and there is strict adherence to recommended infection prevention measures. The resumption of visits is supported by the ongoing rollout of the COVID-19 vaccination campaign and continues to be informed by the evolving epidemiological profile of the COVID-19 pandemic in the country,

Specific improvement plans are elaborated following site visits to address identified areas of concern. Regular monitoring of these plans performed remotely through virtual platforms and through limited site visits ensure implementation and monitor progress towards improvement. CQI activities are developed in partnership with IPs and the GRM in order to address areas of low performance.

In order to effectively manage Implementing Partners and improve their accountability, USAID Mozambique made modifications to all PEPFAR Mozambique funded activities (as of October 2019) to comply with New Performance Based Requirements for PEPFAR awards that includes: a) High frequency technical data reporting for specific indicators; b) Changing the due date of the draft annual work/implementation plans to May 1st of each year, starting May 1, 2020; c) Incorporating greater performance accountability which stipulates that failure to make progress or meet targets and benchmarks may lead to revisions to the award, including instituting a Corrective Action Plan (CAP), or may result in a partial or full termination.

In addition, since October 2019, CDC with the support of the CDC Office of Grants Services now includes performance targets in the Notice of Awards for each Implementing Partner. This additional information provides clear guidance on COP expectations and accountability.

Based on COP21 guidance, effective financial monitoring will continue to take place to ensure that: 1) planned resources (including Human Resources for onsite regular TA) and spending is aligned with technical and geographic priorities as defined in the implementing partner work plan and 2) current spending or projected spending does not or will not exceed the approved operational plan budget. Financial monitoring will be done through rigorous monthly analysis of burn rates,

pipelines, and accruals of Implementing Partners and discussed during monthly partner management meetings.

4.6.c. Collaboration, Integration and Monitoring: Improving integration of key health system interventions

Health systems priorities continue to be identified, and activities are routinely monitored by cross-cutting working groups to ensure effective resource allocation. In COP20 PEPFAR Mozambique conducted an enhanced HRH prioritization and optimization analysis, which marries backward-looking HRH impact analysis with thorough Prioritization and Optimization Analysis (POA) outputs to produce a detailed COP21 Negotiation Analytics Pack to assist in our planning and ensure adequate staffing allocation and skills-mix by clinical and community partners based on HIV service delivery needs. In COP21, PEPFAR Mozambique will continue to monitor the staffing allocation and skills-mix at site level compared to MER results. In order to ensure appropriate HRH support in sites managed by MISAU, in COP20 PEPFAR Mozambique continued to work with MISAU's department of HR and Provincial Health Directorates to hire health cadres based on criteria defined during COP19, and this support will continue in COP21.

PEPFAR Mozambique will also provide technical assistance to MISAU to support transition to new data visualization technologies that will enhance use of HIV related data for program management. The scale up of EPTS, iDART, DISA and mHealth systems will continue along with EPTS centralization in four SNUs. PEPFAR Mozambique will continue to scale up VL lab capacity and productivity by operationalizing and building on the diagnostic network optimization analysis, to improve the sample referral system using a central partner and integrate multiplexing on POC platforms wherever possible. Another key component will be the expansion and maintenance of lab information systems.

Another key component of systems that will enhance and improve coordination is better integration of logistics and transportation. In COP21 PEPFAR Mozambique will continue to support the last mile distribution of ARV and other HIV commodities to all provinces, while providing CMAM with continued support for HIV commodities quantification and forecasting, stock management, as well as end-to-end supply chain data availability, visibility, security, and use. Lastly, in COP21 PEPFAR Mozambique will continue to work with a private sector mechanism for a phased scale up and implementation of the consolidated transport of laboratory samples. Continued delivery routes optimization will allow for more frequent and dependable transportation of both commodities and laboratory samples.

4.6.d Collaboration, Integration and Monitoring: Improving integration of quality and efficiencies in service delivery

COP21 priorities for improved service quality include strengthening patient-friendly services, improving patient flow and provider workloads within the health facility, and safe expansion of opportunities for community involvement during the prevailing COVID-19 pandemic. MISAU aims to achieve national coverage of all facility and community DSD models. DSD models available in Mozambique include multi-month scripting, six-month clinical consultations, extended hours

(either through shift work or shifted hours), one-stop shops, mobile brigades, APE ART distribution, family health approach, adherence clubs and GAACs[23]. These will be implemented to scale with specific attention to maintaining fidelity to MISAU's six pillars for retention and adherence. Specific interventions for sex, age, and demographic groups (mobile clinics for key populations; male-friendly services; strategic marketing; expansion of SAAJ[24], etc.) should be carefully monitored during implementation to reach the goal of improved quality of services. PEPFAR Mozambique, in coordination with the GRM, will invite greater community involvement through: (i) Implement community score cards in over ninety health facilities; (ii) pursue greater fidelity in the implementation of the health advocate program; (iii) expand CNCS-led community monitoring, supported by additional PEPFAR Mozambique Community Grants to community-based organizations; (iv) expand community ARV distribution through [25]APEs, clinical staff and integrated primary health care mobile brigades. Greater private sector involvement will be achieved through inclusion of more private pharmacies in the community DSD model platform for ARV distribution. High quality service delivery for these established and novel facility and community DSD models relies upon adequate stock management that ensures continuous availability of pharmaceuticals. Other services that will continue in COP21 include use of lay personnel to provide counseling, adherence support, and tracing of patients who have interrupted treatment. Site-level review of program implementation and service delivery will continue through SIMS assessments, as well as through leveraging existing provider mentorship and accountability platforms (supportive supervision, in-service training, and distance learning).

4.6.e Collaboration, Integration and Monitoring: Community: Community-Led Monitoring

Community-led monitoring trains, supports, equips, and pays members of directly affected communities to carry out routine monitoring of the quality and accessibility of HIV treatment and prevention services. Community-led monitoring models can involve quantitative and qualitative data collected via a wide variety of methods that reveal insights from communities about the problems and solutions to health service quality problems at the facility, community, sub-national, and national levels. Another key to the concept of community led monitoring—separating it from other modes of quality improvement—is the full integration of evidence-based advocacy into a cycle that brings new information to the attention of decision makers and holds them accountable for acting on that information. One of the key instruments used in this context is the Charter of Rights and Duties of the Patient. In COP21, PEPFAR Mozambique recognizes the need for monitoring the quality of services provided in health facilities, as a strategy for responding to violations of patients' rights and duties and improving services at the site level. In addition to improving the quality of services at the site level, community-led monitoring also works to address structural barriers and reduce attitudes related to the stigma and discrimination of patients.

PEPFAR Mozambique, through its internal community and civil society technical working group, has convened several meetings with civil society representatives for the discussion and planning of

[23] Grupos de Apoio e Adesão Comunitária
[24] Serviços Amigos dos Adolescentes e Jovens
[25] Agentes Polivalentes Elementares

concrete activities to be included in COP21 planning. The results of the various discussions were as follows: community-led monitoring must be conducted at both the community and the health facility level; the actions taken must be well documented and barriers solved (or addressed) in a timely manner; conditions for people to feel comfortable and safe to share information must be met; and representatives of PLHIV and key populations must be included in all phases of community-led monitoring activities. There is a need for national consensus in relation to the indicators to be collected, and the monitoring and evaluation plan of the data obtained to collect comparable and analyzable data that allow decisions to be made at the facility, local government and national level.

In COP21, the Department of State Community Grants (formerly Small Grants) under the PEPFAR Mozambique Coordination Office will allocate its entire Community Grants program budget for this activity, with the goal of funding 24 local organizations that will focus exclusively on community-led monitoring. Namati, a local Mozambican organization with experience on Community led monitoring models will continue providing technical assistance to community-based grantees. Development of technical criteria for eligible grantees and selection of grantees will be performed in collaboration with PLASOC (PLHIV), CNCS, UNAIDS, USG technical staff, and other relevant parties, as will selection of geography and focus for community-led monitoring activities. In keeping with the key principles of community monitoring, the monitoring will be done by PLHIV, KP, and other affected populations. Monitors will receive a living wage, and findings will serve as a basis to understand and then address and correct concerning finding and potentially scale promising/best practices. PEPFAR Mozambique will continue to support community led monitoring via funds to CNCS provided in COP20 currently funding 20 local organizations. CNCS will provide a grant or grants to additional community organizations for community-led monitoring. In COP21, PEPFAR Mozambique will continue its investment in Namati's current community monitoring platform and continue providing limited funds to Nweti to continue co-finance community score cards with the World Bank in 75 sites being supported in COP20. Despite the overall PEPFAR Mozambique budget reduction in COP21, financing for community led monitoring activities will increase in COP21 with $600,000 USD to support capacity building of civil society, including a special focus on key populations. The PEPFAR Mozambique Coordination Office Community Grants budget will also increase by $50,000 to increase the number of organizations receiving support.

4.6.f. Collaboration, Integration and Monitoring: Key barriers and measurable outcomes

For the prioritization of above site investments 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. During COP21 implementation, USG will address insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control, to allow improved data quality and inclusion of early retention data in national HMIS as well as timely and accurate data to inform national HIV response planning and monitor progress towards epidemic control.

To address the issues of poorly trained and insufficient human resources to achieve epidemic control, USG will focus on in-service training through use of distance learning/mentoring approaches.

One perceived key barrier is the lack of appropriate lab data systems needed for scaling up quality VL, EID and/or TB testing. USG will address it through investments in the expansion of DISA implementation and maintenance and DISA EPTS integration. The integration of EPTS and OpenLDR, coupled with the development of the VL dashboard will allow real-time data analysis of program activities. Moreover, the PEPFAR Mozambique team will work towards integrating laboratory and surveillance data systems, which will facilitate the efforts to reach epidemic control by focusing on areas of higher HIV prevalence and transmission. Another key component is continuous quality improvement of reference labs through the Strengthening Laboratory Management Towards Accreditation (SLMTA) program. In COP21, the PEPFAR Mozambique team will utilize mentors from the Association of Public Health Laboratories/American Society of Clinical Pathologists (APHL/ASCP) staff, one of the laboratory IPs, to support INS's SLMTA program. The SLMTA program is called FOGELA in Mozambique and has led multiple laboratories in many PEPFAR countries to earn international ISO 15189 accreditation. The SLMTA/FOGELA program is structured with workshops, followed by site visits by trained mentors and closes that cycle with assessments by independent auditors, using the Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA) checklist, which has WHO recognition. The program includes participation of laboratories in External Quality Assessment (EQA) and Proficiency Testing (PT) schemes, which are used to monitor the performance of laboratories. The mentors implement corrective actions during the scheduled site visits and guide laboratory managers to implement the ISO/SLIPTA checklist requirements of laboratory quality management systems. The PEPFAR Mozambique will continue to improve the quality of laboratory systems and services that guarantee accurate and reliable results through the SLMTA/FOGELA program in COP21.

PEPFAR Mozambique will also continue to provide TA to strengthen the quantification, collection, management and use of supply chain-related data for improved end-to-end visibility. Additionally, USG will support the expansion of MMD and the introduction of 3HP by developing policy, training materials, commodity consumption analysis, and routine supply plan updates.

4.6.g. Collaboration, Integration and Monitoring: Use of unique identifiers

Mozambique has an existing National Health Identifier (NID) that is used to support PLHIV initiatives. The NID is a health sector wide identifier specifically mandated by the Ministry of Health. MISAU introduced the NID in January 2013 and it is an official, nineteen-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 Mozambique's EPTS, with its scale to 92 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 Mozambique supported systems, including laboratory, pharmacy, and community care also capture the NID and linking these data sources with the EPTS will continue in COP21. It is a required field in the pharmacy system, iDART, to facilitate linkage between pharmacy and EPTS. It will be a required field in DISA to facilitate linking laboratory

results to EPTS. EPTS generates reports to identify duplicate NIDs and patients assigned multiple NIDS. In December 2018, Mozambique passed legislation for the electronic registration of a NUIC (Unique Civil Identification Number) used for the civil registration of births and deaths and production of its official vital statistics. To date, over 1.2 million births are electronically registered using the NUIC (compared to 400,000 last year), with scale situated nationally. Beginning in March 2019, PEPFAR Mozambique HIS introduced the capability for electronically capturing the NUIC, as well. For COP21, PEPFAR Mozambique in collaboration with MISAU, Ministry of Justice and other NUIC implementing donors (i.e., UNICEF, World Bank, WHO) advanced the registration of the NUIC in Zambezia province and facilitated introduction of the NUIC into the health sector. 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 policymaking. NUIC registration is currently occurring in 4 health facilities in Zambezia. For COP21, we will collaborate with UNICEF to continue registration activities in Zambezia but also add an additional province Sofala.

4.7 Cervical Cancer Program Plans

Cervical cancer is the first cause of cancer-related death among HIV positive women in Mozambique; yet it is preventable and treatable. PEPFAR Mozambique will continue to scale up efforts in COP21 to ensure efficient implementation of cervical cancer screening and treatment services in alignment with PEPFAR global guidance and MISAU policies. Cervical cancer prevention (CECAP) services in Mozambique are offered through a single visit approach (screen and treat), adopted by MISAU to ensure women are appropriately screened and offered treatment or referral in the same visit. At the health facility level, cervical cancer prevention and care is integrated with reproductive health services, which are co-located with HIV care and treatment services in some health facilities. Patients with advanced pre-cancerous lesions and apparent invasive cancer lesions are referred to secondary and tertiary hospitals where they have access to LEEP and surgical management.

PEPFAR Mozambique rapidly scaled cervical cancer programs in COP19 / FY20, screening 213,668 HIV+ women in a total of 638 sites and achieving 102% of PEPFAR Mozambique's annual national screening target. Despite these gains, the quality of screening and linkage to treatment remain a challenge. In COP19 / FY20, 68% of women who screened VIA+ had access to treatment. In COP21, PEPFAR Mozambique will invest a total of $5.5M to deepen its support for cervical cancer programming in Mozambique. The COP21 cervical cancer investment will focus on direct support to MISAU's national cervical cancer program for policy development and supervision as well as assist in procurement, planning and implementation of thermoablation to treat precancerous lesions. MISAU endorsed thermoablation in January 2021. Thermoablation is a highly effective treatment modality, with treatment devices that are battery operated, mobile and without complex supply chain requirements. Themoablative technologies offer an opportunity for rapid expansion of treatment access. MISAU has endorsed a roadmap that will allow phase 1 implementation in COP20 with the support of PEPFAR ambition funding, and further expansion in COP21.With

PEPFAR Mozambique funds, clinical Implementing Partners will invest in essential infrastructure and commodities for CECAP and support personnel providing CECAP services as well as relevant TA and supervision. In COP21, LEEP access will expand from 19 to 25 sites nationally with PEPFAR Mozambique support.

Table 4.7.1: ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY21)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY22) TX_CURR**	**Newly initiated (APR FY22) TX_NEW**	**ART Coverage (APR 22)**
_Military Mozambique	N/A	24,048	N/A	28,829	5,712	N/A
Attained	11,316	40,000	*<80% coverage reached*	43,562	5490	385%
Scale-Up Saturation	N/A	N/A	N/A	N/A	N/A	N/A
Scale-Up Aggressive	2,026,511	1,506,109	115,100	1,733,159	306,035	86%
Sustained	N/A	N/A	N/A	N/A	N/A	N/A
Central Support	92,601	48,966	25,115	54,882	8,965	59%
Total	**2,130,428**	**1,619,123**	**85,219**	**1,860,432**	**326,202**	**87%**

4.8 Viral Load and Early Infant Diagnosis Optimization

COP21 will continue to fully support VL and EID testing on conventional platforms in all ART sites nationally within the existing national laboratory network as well as utilizing the m-PIMA POC instruments for EID. In COP21, PEPFAR Mozambique will support expansion of the EID POC testing network to improve linkage to care for infants in the setting of COVID-19 at high volume AJUDA sites

Multiplexing

To further increase access and improve VL testing coverage for PLW, MISAU approved multiplexing VL/TB on GeneXpert and VL/EID on m-PIMA instruments in COP20. This strategy will allow VL testing for PLW and children <5y/o in the same facilities where GeneXpert or m-PIMA instruments are located and there is excess testing capacity beyond TB and EID testing, ideally allowing PLW and children <5y/o in multiplexing facilities to receive a VL result on the same day as their consultation. Phase 1 for multiplexing implementation should launch in COP20 and acceptability and impact on patient outcomes will be closely evaluated. COP21 budgeting allows for expanded same day POC VL testing in COP21 during a phase 2 that will begin in Q3.

TB DNA modeling scenarios are underway and will provide the basis for a cost-benefit analysis, in which the acquisition of additional GeneXpert instruments could be considered for meeting patient demand. The acquisition of additional instruments will be prioritized through reagent rental agreement contracts, but in absence of this modality, the upfront purchase of instruments could be considered when well-justified.

All ART sites across the country are covered by either conventional or POC instruments, ensuring access to VL and EID testing. The PEPFAR Mozambique team is working with MISAU to implement improvements and create efficiencies in processes and procedures for expediting VL and EID results, performed on conventional and POC instruments. These improvements will continue through FY22 and include the integration of m-PIMA instruments in the Laboratory Information System (LIS / DISA), which will improve data accuracy and facilitate program management. In order to improve linkage of patients from diagnosis to ART, as well as facilitate patient management, same-day test results on POC instruments will be prioritized at HFs with greater programmatic need in FY22. The POC/near-POC testing prioritization will be based on areas with higher numbers of vertical transmission of HIV and unsuppressed VL.

Funding

PEPFAR Mozambique funds in COP21 will cover 100% of VL testing needs and include the multiplexing strategy on POC or near POC instruments; provisional budgets include an allowance for the increased cost of POC testing in comparison to conventional platforms.

Donor transitions

Unitaid IP's (CHAI and EGPAF) transitioned out of support for the m-PIMA EID POC platform in COP20 during which time relevant contracts were transitioned to PEPFAR Mozambique. Currently all m-PIMA instruments are covered under a maintenance contract or extended warranty, but these contracts require renewal in COP21. PEPFAR Mozambique has made a commitment to expanding the EID POC testing network to at least 21 sites, though at the time of this writing is still negotiating a vendor pricing contract that will allow for finalization of expansion plans.

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

In COP20 PEPFAR Mozambique and the GRM collaborated to define the core service delivery elements for programs not guided by HIV treatment targets (Tables 4.9.1) as well as the core service delivery package for HIV care and treatment services at AJUDA and Sustainability sites (Table 4.9.2).

Table 4.9.1: Service packages for programs whose geography is not driven by HIV treatment targets		
Technical Area	**Geography**	**Service Package**
VMMC	• Program conducted in the following 7 provinces: Maputo City, Maputo Province, Gaza, Sofala, Manica, Tete, Zambezia • Distribution of targets determined by VMMC coverage estimates	• Offering of HIV testing services (HTS). Testing services should be targeted to highest risk beneficiaries based on use of HTS screening tools • Screening and treatment for STIs • Male circumcision (surgical or device removal of the foreskin) for males 15 years and older • Identifying and implementing active referral and linkages of HIV-positive men to HIV care and treatment and STI services • Demand creation targeting males 15 years and older including non-coercive compensation and extended hours services (either through shift work or shifted hours) • Optimal AE monitoring and reporting

Key Populations	• Program conducted in 11 provinces; subset of priority site catchment areas in 48 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, TG, prison populations; and PWID.
	• Clinical partners are responsible for facility-based screening and testing of KP and making sure that there is an effective linkage to the care and treatment services.
		• HIV prevention educational and behavior change interventions,
		• Counseling and testing for HIV
		• Identification of HIV+ KP through screening tools, linkages to care and treatment, adherence counseling and retention support, VL monitoring, referrals for STI screening and treatment, and referrals to other services (legal, social, health, etc.)
		• Through the clinical partners, implementation of the KP guidelines at the facility level, through training (in-service training, clinical mentoring, technical support, and supervision), dissemination of KP guidelines, screening tools, and algorithms.
		• KP cascade monitoring through monitoring of the newly approved HTS and treatment tools, and effective integration of KP indicators into EPTS as well into health facility monitoring of PLHIV
		• Clinical services provided for KP at the community level through mobile clinics including:
		  o PrEP
		  o HIV self-testing
		  o Screening for TB

		○ Screening for Cervical Cancer and Prostate cancer ○ Family planning methods • Offer of PrEP. In addition, KP community partner will engage in sensitization and PrEP demand creation as well as literacy in adherence counseling in provinces where PrEP is being provided to KP • Post-exposure prophylaxis (PEP) as per MISAU guidelines • GBV package • Condoms and lubricants • In prisons 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 • Provision of community-based HIV counseling and testing, prevention package and referral of PWID to clinical services
DREAMS	• DREAMS has expanded and is implemented in 32 districts in 8 provinces. DREAMS activities are restricted to sites within DREAMS districts with direct clinical IP support and their catchment areas. No expansion outside the selected provinces will occur as the focus is to reach saturation in the implementing districts. Please	• Improve diagnosis and treatment of STIs among AGYW and their partners. • Maintain the package of services for most vulnerable 15-24-year-old, with a more holistic focus and a highly targeted approach within this age band

see the list of DREAMS districts for COP21 below.

Cabo Delgado	Pemba
Gaza	Guija Chokwe Limpopo Xai-Xai Chongoene
Inhambane	Maxixe
Manica	Chimoio
Maputo Prov	Marracuene Boane Manhica Moamba Magude Matutuine Namaacha
Nampula	Nampula Erati
Sofala	Beira Caia
Zambezia	Namacurra Mocuba Pebane Milange Maganja da Costa Mocubela Inhassunge Ile Gile Lugela Quelimane

- Improve economic opportunities for AGYW; Strengthen government policies and strategies to ensure comprehensive HIV and violence prevention in schools.
- Support creation of an action plan following the results of the VACS study
- Strengthen integration of GBV prevention at key points in the HIV cascade (HIV testing, HIV care and treatment, PMTCT/MCH services, etc.)
- Ongoing implementation of PrEP for high-risk AGYW above 15 years in all the DREAMS districts

	Nicoadala	
OVC	• Program conducted in 10 provinces; subset of priority site catchment areas in 50 districts; based on geographic pivot and CALHIV estimates	• 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, supporting adherence and retention among CALHIV in care treatment services, and supporting the Pediatric Program with the introduction of new treatment regimens to ensure viral suppression among the targeted group. • Referral and support to families with poor socio-economic situations to address barriers to ensure retention and adherence on ART. • Strengthen case management services for CALHIV and families affected by HIV including referrals to 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, and using Go Girls and Sinovuyo. • When necessary, additional services for AGYW will be provided such as youth led savings groups, referral to social action direct services and school enrollment and education subsidies

PrEP	• In COP21, efforts will be allocated to the consolidation of PrEP expansion and additional sites will also start PrEP expansion from 3 to 11 provinces	• PrEP eligibility screening incorporated into HIV post-test counseling • PrEP will be offered to serodiscordant couples, key populations, and Pregnant and Breastfeeding Women (PBFW) and adolescents aged 15+ and the military at substantial risk. Demand creation interventions including the utilization of the approved MISAU IEC package • Training and mentoring of health facility staff to provide and monitor PrEP, perform adherence counseling, and manage AE • Support the dissemination and roll out of national guidelines, and norms and implementation of new monitoring tools

Table 4.9.2: Service packages to support HIV treatment in clinical IP supported sites and sustainability sites*		
Technical Area	**Clinical IP Supported Sites (90% TX_CURR, 628 Sites)**	**Sustainability Sites (10% TX_CURR, 719 Sites)**
Quality Improvement	• Consolidate the implementation of the HIV quality improvement strategy through support MISAU and DPS in planning, implementing and monitoring QI activities; support the health facilities to identify the causes of poor performance results including other unmeet patient needs, planning and implementation of corrective interventions and intensive monitoring; greater focus on improving the quality of care for DSD patients, clinical mentoring and identification of best	• 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 co-ag funds, if prioritized by MISAU

	practices and expansion. Additionally, improve recipients of care involvement in the identification of corrective interventions to improve quality of care at health facilities	
HIV Testing	• Implement facility and community-based index case testing in all 620 AJUDA sites, including follow-up for male partners from ANC, community-based testing and intensive linkage support among key populations, and thorough community-level screening of all eligible children and adolescents. • Provide maternal retesting services in high vertical transmission sites, as determined by provincial level data as well as available budget. • Introduce lay counselor-led, proactive screening in waiting areas of high-volume sites, using national HIV testing screening algorithms. • Implement highly targeted male congregate testing in high-incidence areas, based on available budget. • Generate informed demand for self-testing, as per national policies, in coordination with the Global Fund • Establish quarterly performance evaluations of all testing counselors	• Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by the GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP21 funding
Linkage	• Site-level clinical mentorship on correct and consistent use of new HTC registers (which include linkage)	• Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but

	• Support the dissemination and use of national SOPs for follow-up of non-linked PLHIV • In coordination with provincial authorities based on access to DHIS-2, quarterly site-level linkage assessment with gap analysis and action planning	may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by the GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP21 funding

Treatment Continuity	Support for MISAU 6 pillars of retention:
	• Differentiated Service Delivery (DSD)
	  • Support a province-led process to select and scale-up an optimal blend of facility-based and community-based DSD models (including multi-month drug dispensing, spaced consults (*fluxo rapido*), family approach, GAAC, adherence clubs, one-stop models, and community ARV distribution models through mobile brigades) within the available budget allocated through PEPFAR Mozambique Implementing Partners and/or provincial government funds
	  • Clinical mentorship and support for DSD implementation and scale up
	  • Expansion of 6MMD
	  • Community-based ART distribution via Agentes Polivalentes Elementares (APEs) in all provinces
	  • Private pharmacy ART distribution extended to entire Farmac network spanning 10 provinces
		• Roll out CNCS community/ psychosocial support package via G2G funding

	• Extended service hours via shifts, e.g. in emergency rooms, scale-up to be coordinated with MISAU • Complete scale up of iDART and iDART interoperability with EPTS to AJUDA sites to support multi-month drug dispensing • Psychosocial support • 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 • HR footprint to support full APSS implementation • Strengthen existing MISAU mental health system by increasing referrals and mental health treatment capacity of psychologist cadre • Quality Improvement (see dedicated QI section) • Stigma & Discrimination • Combat stigma through national media campaign • Provide in-service training on human rights in the setting of HIV and KP via DPS cooperative agreements 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 • Support development and implementation of health communication training package for FBO's and religious leaders focused on prevention and treatment literacy as well as stigma reduction • Community • Strengthen platform for facility/community coordination • Strengthen quality of community health committee • Community-led monitoring of health facility performance • Strengthen quality of HF co-management committee to ensure participation and engagement of community members • Implementation of treatment literacy strategy including messages on prevention, treatment, and U=U • Central development and adaptation of materials	

	• Community radio • Community mobilization • Social media	
Additional Considerations for Adult Care and Treatment	• Support routine screening and improved management of sexually transmitted infections, opportunistic infections (OI), malnutrition, and gender-based violence (GBV) • Support implementation of basic, intermediate, and complete advanced disease package at selected sites based on agreement with MISAU • Support implementation of male engagement strategy • 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	• Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by the GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP21 funding • IP support for VL/EID sample transport
Additional Considerations for Pediatric Care and Treatment	Same as Adult Treatment (see above), plus: • Support implementation of MISAU PICT screening algorithm for children and adolescents and routine testing in pediatric wards, TB sector and maternal and childcare services for all children and adolescents • Allocate dedicated counselors to high-volume pediatric entry points, including at Pediatric wards from central and provincial hospitals to ensure screening, testing, including index case testing to identify children and referral of CLHIV	• Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS/G2G cooperative agreements, if jointly agreed upon by the GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP21 funding

	• Support to pediatric ART optimization via site level mentorship and pediatric training cascade. Anticipate elimination of NVP formulations in COP20 and introduction of DTG10 for children under 20kg in COP21 • Improve stock management of pediatric ART via pharmacy mentorship • Optimize and scale mentor mother strategy for CLHIV <10 • Support and monitor disclosure support for children, adolescents, and their families • Ongoing expansion of 3MMD. Expand 6MMD • Support expansion of support groups for children and adolescents and for their parent or caregivers • Ongoing implementation of OVC program pivot to reach more children and adolescents living with HIV • Implement clinician shift schedules to offer consultations accommodating school schedules • Support VL activities to allow timely VL test requisition, timely results return and identification of children and adolescent with treatment failure • Support implementation of multiplexing VL&EID POC for children under 5yo in coordination with MISAU prioritizing high positivity sites and provinces	

	• Implement pediatric package for advanced disease in central, provincial and district hospitals and ambulatory centers to ensure treatment availability in all provinces for adults, children and PLW with AHD	

Adolescent treatment	Same as Adult Treatment (see above) plus:
	• Support implementation of prevention activities in non-DREAMs districts
	  ○ Implement and expand the access to PrEP for adolescents at high risk > 15 years
	  ○ Support implementation of self-testing for adolescents and youth
	• Train and allocate dedicated age-appropriate peer mentors for adolescents and youth aged 10-24 at 65 high-volume sites launched in COP20 as well as 25 additional COP21 expansion sites
	• Train and monitor implementation of dedicated teen Mentor Mothers
	• Support implementation of adolescents led group sessions
	• Support provision of comprehensive package of services for adolescents and youth in Hf with and without specific YFS
		• Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique IP budgets but may be supported via MISAU or DPS/G2G cooperative agreements, if jointly agreed upon by the GRM and PEPFAR Mozambique
		• Site-level HRH at central support sites will be determined by MISAU's COP20 funding

Additional Considerations for PMTCT/EID**	Same as Adult Treatment (see above) plus:	• IP support for EID sample transport • Supervision and training for clinical staff at central support sites will not be included in

	• Continue to fully scale MISAU mentor mother strategy by employing facility and community-based Mentor Mothers at all AJUDA sites • In coordination with MISAU, implement tailored mentor mother package for teen PLW, using age-appropriate Mentor Mothers • Support PrEP and PrEP adherence support for serodiscordant couples and AGYW • Support implementation of revised psychosocial support and positive prevention tools tailored to support PLW as well as dissemination of new algorithms and job aids. • Expand implementation of MISAU's national policy to integrate HIV services into mobile brigades to provide high quality primary care, ART access and PMTCT in remote communities in provinces with high VT. • Implement retesting policy for breastfeeding women at 4- and 9-months prioritizing sites with higher VT and burden of new infant infections; expand program support based in alignment with RTK availability • Support for EID POC and conventional EID PCR testing in alignment with national MISAU strategy • Support implementation of multiplexing VL&EID POC for PLW in coordination with MHH prioritizing high positivity sites and provinces	PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS/G2G cooperative agreements, if jointly agreed upon by the GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP20 funding

	• Continued support for one stop model for PMTCT within ANC/CCR services • Continued support for Option B+ implementation using DTG based regimens, aligned with the MISAU DTG scale-up plan, • Support integration of HIV/family planning (FP) and increasing access to FP methods among HIV-positive women of reproductive age following appropriate informed consent	
Cervical Cancer	• Increase screening and treatment access via support for CECAP HR, infrastructure and commodities. • Support training in visual inspection with acetic acid (VIA), cryotherapy, thermoablation, LEEP and criteria for referral for surgical management • In alignment with DPS/MISAU national cervical CA scale up plan, support procurement of CECAP equipment, supporting the roadmap for introduction of thermoablation jointly developed by PEPFAR Mozambique and MISAU • Strengthen referral and counter-referral system for treatment of preclinical and clinical lesions and follow-up after treatment • Increase LEEP access and quality via expansion of LEEP enabled treatment sites and site level QA/supervision at centers receiving referral for LEEP • Support site level quality assurance for screening and treatment	• Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS/G2G cooperative agreements, if jointly agreed upon by the GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP20 funding

	• Support TA for cervical CA program implementation including supervision/QA visits and capacity building at provincial, district and facility level • Support demand creation and awareness-raising activities with community health workers to increase the uptake of screening and treatment for cervical pre-cancer and engage in community-based demand creation activities for CECAP • Ensure minor renovations as necessary to ensure adequate private space in reproductive health clinic for pelvic examinations/VIA/cryo at identified sites • Support procurement of pathology reagents for biopsy and LEEP specimens • Support MISAU in relevant guideline and policy development at central level	
GBV	• Ensure that facility staff in ART/HTC/ANC/Auxiliary 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 levels	• Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by the GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP20 funding

TB/HIV	• TPT-scale up: improve TB screening, identification and start treatment for Latent TB • Improving screening for TB among all eligible PLHIV and ensure those that screen positive are appropriately worked up for TB with the appropriate tests and clinical evaluation • Identify all PLHIV still eligible for TPT, start them on treatment by February 2022 and increase TPT completion rates. • Implement demand creation package for TPT • Continuation of INH integration into 3MDD • Introduction of 3HP regimen for TPT • Defaulter tracing of patients who are "LTFU" without evidence of TPT completion • Implementation of FAST strategy, which includes ongoing support for cough officers • Active pharmacovigilance for INH and 3HP adverse events • Integrated TB/HIV community package: Community tracing for screening and testing of household contacts of co-infected index clients • Implement TB LAM at facilities through HIV advanced disease package	• Sample transport for TB • Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by the GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP20 funding

	• Promote use/scale-up of district-based GeneXpert testing as the primary diagnostic test for all presumptive TB • In order to improve the clinical and laboratory management of TB patients, use existing electronic data entry clerks to support digitization of TB case records at PEPFAR Mozambique facilities that have existing electronic TB information systems • Support use of digital chest radiographs as part of the TB screening algorithm at sites that are receiving new machines	
Viral Load / Lab	• Provincial and site level lab support to optimize VL and TB results return and utilization • Support national laboratory quality assurance for HIV/VL/EID/TB tests • Site level training and competency assessment for HIV/VL/EID/TB/CRAG and CD4 tests • Support for decentralized EQA/PT program • Support decentralization of FOGELA/SLMTA program • Support expansion of laboratory information System (LIS)/ DISA-Link and DISA-POC for monitoring and optimizing VL and EID cascades • Support OpenLDR-OpenMRS/EPTS linkage and automated data transfer of VL results	• IP support for sample transport for VL • Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by the GRM and PEPFAR Mozambique

	• Expand EID POC network to improve infant linkage	
M&E	• 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 • Data quality initiative including quarterly audits, with consequences for falsified data	• Quarterly reporting of HTS_TST, HTS_TST_POS, TX_CURR, TX_NEW, TX_PVLS, PMTCT_STAT, and PMTCT_ART via the GRM reporting systems • Reporting of TX_PVLS by MISAU is expected to begin in FY21Q2 • Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by the GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP20 funding
Informatics (HMIS) *Note: the systems referenced here are all electronic systems and not paper based*.	• Support for EPTS system modifications and the EPTS Clinical App including the addition of modules to support program and patient monitoring • Support for EPTS system in prisons • Support for EPTS centralization to improve data quality and MISAU ownership • Support for the VMMC and GBV systems • Support for the DREAMS Layering Tool system	• N/A

	• Support for iDART pharmacy and iDART mobile • Support for clinical, VMMC and PrEP apps • Ongoing data quality review and resolution • Continue to implement pharmacy system scale up for drug management in collaboration with PEPFAR Mozambique HMIS team (i.e., iDART) and continue to support pharmacy supply chain system (i.e., SIGLUS) • Continue implementation of interoperability of external systems (i.e., pharmacy, SIGLUS, laboratory, mhealth) with Open MRS EPTS • Ensure alignment of HMIS systems with PEPFAR Mozambique requirements and MISAU M&E platforms • Continue to scale registration of the national unique identifier (NUIC) to improve patient identification	
Supply Chain	• Last mile medicines delivery through either IP or a centralized contract • Last mile specimen transport through either IP or a centralized contract • Viral load and EID conventional laboratory instrument provision, maintenance, repairs, and reagent delivery to the labs • Commodity support for ARVs (adult, pediatric, and PrEP), RTKs, viral load (conventional and select POC reagents and	• Last mile medicines delivery through either IP or a centralized contract • Last mile specimen transport through either IP or a centralized contract • Viral load and EID conventional laboratory instrument provision, maintenance, repairs, and reagent delivery to the labs • Commodity support for ARVs (adult, pediatric, and PrEP), RTKs, viral load

	collection kits), EID (conventional and POC reagents and collection kits), VMMC, and TPT (3HP) • SIGLUS implementation and support	(conventional and select POC reagents and collection kits), EID (conventional and POC reagents and collection kits), VMMC, and TPT (3HP)

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

The above site activities proposed for COP21 build on the previous year's portfolio, and only include activities essential to and or contributing to achieving epidemic control. All activities include clear milestones that allow for comprehensive assessment and monitoring.

Despite the OU budget reduction, the budget for above site activities increased as a result of key one-time activities funded with the ARPA plus up. Above site investments have been consistently reduced as a percentage of the overall budget, however in COP21 the budget increased to 6% comparing to 4% in COP20. Substantial reductions were achieved between COP18 and COP20 through elimination of support for specific program areas (i.e., pre-service training, system development, etc.), completion of planned activities, and consolidation that continued in COP21 planning. Cost reduction strategies continue to be driven by aggressive identification of efficiencies, shifting (wherever possible) responsibility for implementation away from international partners to local and/or government implementers, increasing PEPFAR Mozambique staff provision of direct technical assistance, and minimizing development of new initiatives.

The above-site activities in COP21 squarely aim at providing client centered HIV care that the Mozambican program is committed to delivering. They provide critical support across key areas including health information systems, laboratory systems, supply chain strengthening, and infrastructure. A focus on efficiency (financial, programmatic, and technical) informed the selection of above site activities. The above-site investments align with key programmatic priorities, including DSD scale-up, quality improvement and TPT scale-up.

COP21 above site investments align with the key systems barriers identified in the SID, with the bulk of resources targeted at areas with red or yellow scores in SID scores. Additionally, key system areas received ARPA funds to mitigate COVID-19 impact on PEPFAR programs and beneficiaries and support program recovery from the impacts of COVID-19. These include Supply Chain (29 percent of proposed investments), Health Information System (32 percent of proposed investments), Laboratory (17 percent of proposed investments) and Human Resources for Health (14 percent of proposed investments). Limited resources were allocated to Institutional capacity building and Policy (all together 5 percent of proposed investments).

Despite the challenges posed by COVID-19 pandemic, this year's COP planning was marked by efforts to continue to have an excellent level of coordination with MISAU and other donors. Limited, but critical planning meetings were held at technical and management levels, which allowed for engagement with key partners and aligning expectations. PEPFAR Mozambique investments are increasingly better aligned with Government strategies, policies, and systems. Common standards and frameworks inform HIS investments, and PEPFAR Mozambique is supporting the rollout of the NUIC (Unique Civil Identification Number) in collaboration with UNICEF, WHO and the World Bank. PEPFAR Mozambique 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 Mozambique has implemented the HRH pivot, and scaled back support for lay workers, and shifting this support to categories of staff with enhanced prospects for absorption in the government system (i.e., facility-based staff (medical technicians, nurses, psychologists, etc.). PEPFAR Mozambique has also aligned its HRH compensation scale to government salary scales.

The program is maintaining strategic investments in surveys, research, and evaluation, which will all contribute to improving program efficiencies. The case base surveillance pilot will help improve quality improvement through an assessment of retention, quality, and impact of programs. The HDSS Polana Canico project, using community-based surveillance platforms, will contribute to improved understanding of quality and efficiency of programs. Key Population size estimations will provide improved data that will increase the efficiency of programs focused on key populations.

All above site activities have SMART targets and timelines. The benchmarks are realistic and are routinely used for quarterly program monitoring. Benchmarks were reviewed and improved during the COP development process.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

The text below includes the staffing profile of the five USG agencies comprising PEPFAR Mozambique and their current staffing status.

There are currently a total of 265 positions for PEPFAR Mozambique implementing agencies. Of these, 232 positions are filled (88%), 5 positions are planned new requests (2%) and 28 positions are currently vacant (11%). Of the 28 vacant positions, 18% are slated for US Direct Hires (USDH), 4% are slated for US Personal Services Contractor (USPSC) and 79% are slated for Host Country National (HCN) positions.

Currently, most of the USG positions (264) are fully funded by PEPFAR Mozambique and allocate 100 percent of their time to PEPFAR. Only one position is partially PEPFAR Funded.

The total COP21 OU CODB budget is $42,624,483.00, an increase of 6% from COP20.

Peace Corps

In COP21, Peace Corps proposes one new LE staff position. This position is aimed at establishing monitoring systems, coordinating data flows, conducting staff development in monitoring reporting and evaluation (MRE), leading PCV trainings in MRE, and providing leadership and coordination for timely and reliable data for analysis and reporting according to Peace Corps guidance and the requirements of US government funded partnerships especially PEPFAR. This position will work closely with the PEPFAR/HIV Coordinator to ensure documentation is captured

from Post's PEPFAR work including grants projects. The M&E Coordinator's functions will include preparing reports for donors and Peace Corps Washington and using the information to inform and improve programming and training in PC Mozambique

Peace Corps has a total of 16 fully PEPFAR-funded positions in COP21, all of which are filled by LE staffing. Peace Corps COP21 staffing structure represents a reduction of 4 staff in comparison to COP20, as a result of closing of our Nampula office due to security reasons. Our COP21 CODB is 8% less than in COP20 which is due to the already mentioned closure of our Nampula office and overall reduction in Volunteer costs due to fewer Volunteers.

Health and Human Services (HHS)/CDC

CDC will not request any new positions to support the PEPFAR Mozambique portfolio in COP21. CDC has a total of 6 vacant positions, one of which is a USDH, and 5 of which are Host Country Nationals (HCN). One HCN position has been made an offer and 4 are pending classification for recruitment. The USDH vacancy is in recruitment. All recruitment efforts will follow Embassy HR guidance for HCN positions and CDC HRO guidance for the USDH position.

Workspace and necessary equipment will be moved to the New Embassy Compound (NEC) in Maputo by July 2021. CDC has a Cost of Doing Business 6.4% higher than COP20. The reason for the increase is to cover for a HCN salary increase of 4% that was approved last FY and corresponding WGI (step increases). Furthermore, Retirement payouts were also included for staff that are not offered continuation contracts and/or opt to retire if have reached retirement age.

United States Agency for International Development (USAID)

USAID has 80 PEPFAR-funded positions, of those 80 there are 11 that are partially PEPFAR-funded. In COP21, USAID is requesting to add two new PEPFAR-funded positions to respond to current program priorities efforts, bringing the total number of PEPFAR-funded positions to 82. These new positions will all be locally employed staff and include: 1) Prevention Advisor (LE Staff) to strengthen the prevention portfolio specifically on the analysis, technical support and implementation of the HIV testing programs; 2) Project Management Assistant (LE Staff/Human Resources/Budget) to serve as the office liaison with the HR office to accommodate increasing demand for human resources management, and to provide additional PEPFAR Mozambique budget/financial management support.

USAID has 13 vacancies. The recruitment of these vacancies is in process and eight of the 13 vacancies have been advertised, of which: four have already been selected and the candidates are awaiting security clearances and the remaining four are in different recruitment stages and the majority in the interview phase. One of the USDH positions has recently become vacant, projected to be filled before the end of fiscal year. The final four positions will also be advertised by the end of fiscal year.

USAID proposes for COP21 Cost of Doing Business a total of $14,840,506 which is 6% higher than COP20. The increase in CODB is the result of the addition of two new positions, increase in the LES compensation plan and a slight increase in ICASS costs due to the move to the NEC.

Department of State

In COP21, State proposes no new positions. In COP19, the PEPFAR Mozambique Coordination Office updated its staffing profile to remove the USDH Global Fund Liaison position. To fill the staffing void with the removal of this position, it should be noted that a new position was approved in COP20 to create 1 new PEPFAR Mozambique funded position (Multilateral Advisor) to lead the USG team to complete activities for the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) as indicated by the partnership between the USG and the Global Fund. This position is currently pending recruitment which will occur in COP20 and the position should be filled by COP21. The position will provide strategic inputs into other multilateral relationships, especially with the Joint United Nations Program on HIV/AIDS (UNAIDS), the World Health Organization (WHO) and other UN agencies.

State has a total of 13 fully PEPFAR-funded positions at a 100 percent allocation, of which 11 are LE staff, 1 is a PSA Eligible Family Member and 1 is a USDH. Of these 13 positions, 10 are filled and 3 are vacant. All three of the vacant positions are in the process of active recruitment through Human Resources at Post.

State CODB increased in COP21 9% due to the increased number of districts in the DREAMS program proposed in COP20. The increase in CODB is the result of additional trainings (increased attendees, translation and interpretation needs, etc.), potential travel and the expansion of the DREAMS Ambassador program.

Department of Defense

DOD has a total of 4 PEPFAR-funded positions. All 4 positions were filled in COP20. DOD proposes a COP21 Cost of Doing Business (CODB) level that is 7% higher than COP20 due to the adjustments in the Staff Salaries as to relate closer to the new Mission-approved salary and staff step increases. The recruitment of new staff last year also resulted in the increase to the Management Meetings/Professional Development costs for DoD, as well as Staff Program Travel. The Non-ICASS Administrative costs were adjusted to reflect a more accurate agency reality.

APPENDIX A - PRIORITIZATION – scroll to next page

APPENDIX B – Budget Profile and Resource Projections

COP21 Planned Spending in alignment with planning level letter guidance.

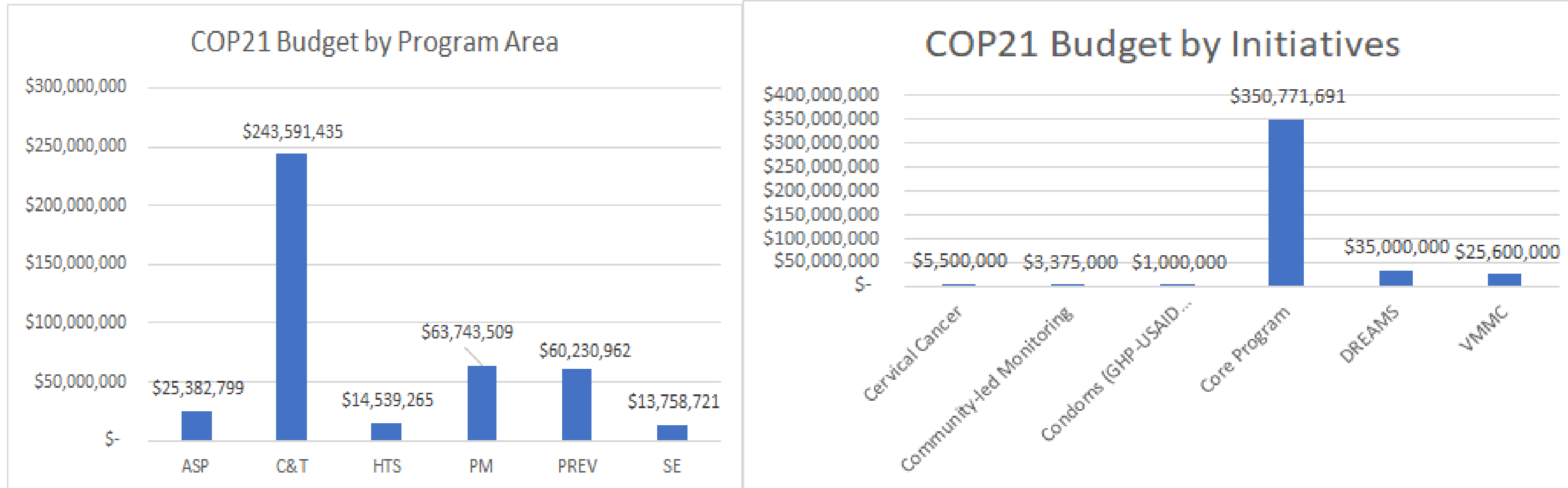
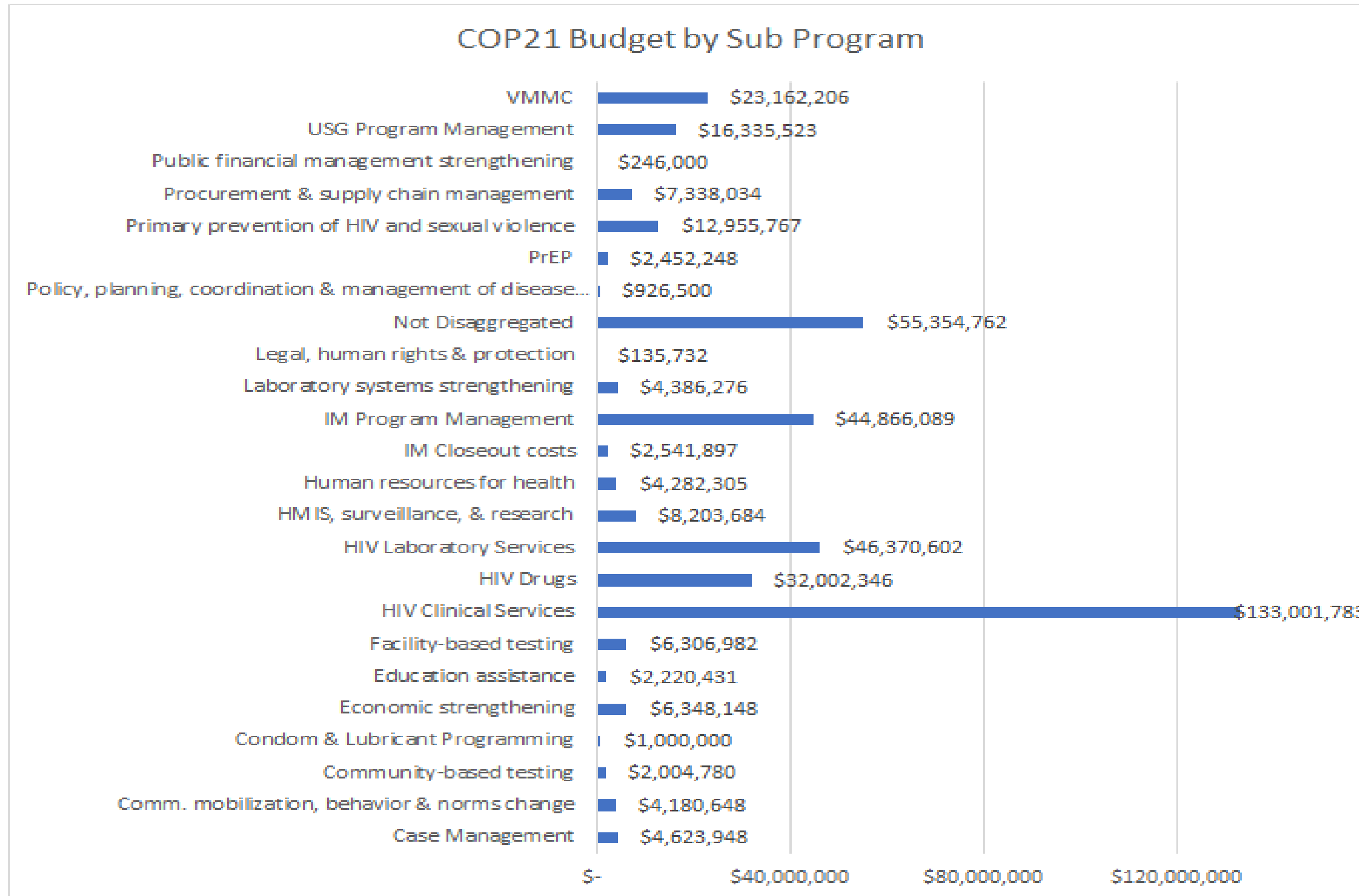


Table B.1.2 COP21 Total Planning Level **Note: These amounts include COP21 funds of $401,196,691 and ARPA funds of $20,050,000**			
Funding Agency	**Applied Pipeline**	**New Funding**	**Total Spend**
DOD	$1,390,245	$6,778,396	$8,168,641
HHS/CDC	$-	$197,407,342	$197,407,342
HHS/HRSA	$-	$3,364,539	$3,364,539
PC	$2,833,408	$-	$2,833,408
State	$-	$827,587	$827,587
State/AF	$1,672,858	$644,485	$2,317,343

USAID	$2,274,121	$113,215,203	$115,489,324
USAID/WCF	$-	$90,838,507	$90,838,507
Grand Total	**$8,170,632**	**$413,076,059**	** **$421,246,691**



B.2 Resource Projections

PEPFAR Mozambique took a methodical approach to planning the investment of COP21 funds, which represented a 4% budget decrease as compared to COP20 (when including the additional $5M of Ambition Funds). Recognizing that difficult trade-offs were inevitable, the team diligently engaged with stakeholders to ensure aligned priorities, including numerous discussions with the GRM, civil society, multilateral organizations, and headquarter-based USG staff. To ensure adherence to stakeholder input and leverage the full expertise of the diverse PEPFAR Mozambique team, agency leadership provided high-level direction while inter-agency technical staff reviewed and adjudicated every budget line from COP20. This process led to assessing all budget elements to find efficiencies, preserve funding for the most essential programs, and even increasing funding in cases when strategic. This approach allowed for the expansion of activities based on in-country priorities, including advanced HIV disease services, additional youth case management sites, more flexibility with implementation of differentiated service delivery models, and civil society capacity building, among others. In addition, despite the overall budget cut, national government-to-government support, community-led monitoring, and site-level direct service delivery staff were maintained at their COP20 levels. Cuts were applied to many technical areas, with health systems intervention areas often receiving cuts in excess of 12%. The systematic and careful review of each activity, which included internal activity-based budgeting exercises, allowed for priorities to be funded in spite of the challenging budget environment.

To reduce potential duplication, the USG team coordinated closely with the GRM and Global Fund to identify programs and commodities that are included in the Global Fund grant. In consultation with the GRM, USG expanded the COP20 efforts to transition additional responsibility (and funding) to provincial government health institutions.

APPENDIX C– Minimum Program Requirements

The following table notes the status of each minimum program requirement.

Topic/Technical Area	Minimum Requirement	Status
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[26]	Full national adoption of Test and Start in all ART facilities. FY21 Q1 linkage rate is 95%; however, additional work is needed to ensure 95% linkage rate across all age, sex, and risk groups.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children ≥4 weeks of age and weigh ≥3kg, and removal of all NVP- and EFV-based ART regimens.	As of March 2021, TLD consumption was 99% among all adults and 94% of all pediatric patients were on an optimized regimen. NVP destruction is planned in FY21. Introduction of DTG 10 for CLHIV <20kg planned for January 2022.
	3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	As of FY21 Q1, TX_MMD was 70%. In FY21, DDD through private pharmacies will be launched at 75 sites across ten provinces. Other DSD models, including extended hours, community ART distribution through health providers and lay staff (APEs), mobile brigades, and KP mobile clinics are designed to improve ART coverage for different demographic and risk groups. Pregnant women are not eligible for most DSD models except mobile brigades.

[26] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

	4. All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into HIV clinical care package at no cost to the patient.	Preliminary estimates from a new monthly TPT report for March 2021 sites suggest that 39% of TX_CURR have documented TPT completion, 16% are actively in treatment for TPT and 3% are not currently eligible for TPT. Therefore, 42% of TX_CURR (507,000) do not have documented TPT completion and need their records updated or are still eligible for TPT. We expect to update patient charts or start these remaining clients on TPT by February 2022 in a focused TPT mop-up campaign in collaboration with MISAU and Implementing Partners. This will be facilitated by a new line list facility level report released in June 2021. Partners also have improved systems to ensure high TPT completion rates. Cotrimoxazole is fully integrated into the HIV clinical care package at no cost to the patient.
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	The Diagnostic Network Optimization was completed in FY20. Mozambique currently has the laboratory capacity for ~75% coverage of viral load testing. VL results, from collection to validation, are carefully tracked in the national LIS, with a FY20 Q1 turnaround time of 18 days (note: time for results delivery to the client is not tracked in LIS). EID capacity is robust and meets current needs.
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be offered testing for HIV.	Index Testing: Scale-up of community- and facility-based index testing to all clinical IP sites in COP21. Self-Testing: National guidelines on self-testing released during FY20 Q1. PEPFAR Mozambique will support demand creation activities, complementing Global Fund

		resources that will procure self-test kits in COP20. Self-testing distribution has started. IPV: IPV pilot results were used to inform national index testing model, including screening for IPV. MISAU has conducted a national training on IPV and IPs are now preparing for provincial-level trainings. COP20 activities include certifying counselors in IPV and reinforcing existing IPV monitoring systems ICT Policy: MISAU updated policy in FY20 Q1 to increase age of index testing to include adolescents up to 14 years of age. National screening tools were altered and reprinted to align with this policy change.
Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices).	Based on the Zambezia PrEP evaluation, MISAU provided concurrence for the COP20 scale-up of PrEP for PBFW, adolescents 15+, serodiscordant couples, and key populations. The age for PrEP eligibility was lowered from 18 to 15 years of age.
	2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case management for vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-	The OVC program reports to S/GAC on a semi-annual basis. In FY20, PEPFAR Mozambique surpassed its OVC_SERV target (103%). PEPFAR Mozambique reported 95% OVC_STAT within the comprehensive package. Also, 99% of C/ALHIV OVC beneficiaries are confirmed to be enrolled in ART, as confirmed by case management within OVC program catchment areas.

	14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.	Mozambique does not have user fees for HIV and HIV-related services.
	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, agency agreements, and national policy.	Continuation of joint site visits and scale up of enhanced granular site management approach. This will include integrated CQI and action plans with IPs and the GRM to improve overall site standards.
	3. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Under the leadership of CNCS, Mozambique will continue to implement its stigma campaign, set to launch in May 2021. The campaign's key messages have been harmonized with the WHO-funded U=U campaign initiated in FY20 and bolstered by the COP20 faith-based interventions that are reaching key religious influencers and their congregants.
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	USAID increased proportion of total funding going to local partners. CDC proportion uncertain due to TBDs but likely to increase given modest local funding preference.
	5. Evidence of host government assuming greater responsibility of the HIV response including	The GRM supports the health system (salary payments for HRH, maintenance of HF). No funds were provided for ARV's in 2021 due to fiscal challenges

	demonstrable evidence of year after year increased resources expended.	
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Electronic Patient Tracking System at 608/628 sites tracks treatment interruption due to mortality. COMSA is a prospective surveillance system that follows a sample of ~1M Mozambicans for mortality by cause
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	National eCRVS and unique identifier registration system exists. Implementation began in December 2018 and 4,951,514 people have a unique identifier currently through 163 conservatories and 307 hospitals. A pilot to register 1,000 children and introduce the unique identifier registration in the health sector at select health facilities started in COP20 in coordination with leading eCRVS donors, the Ministry of Justice and MISAU.

APPENDIX D – Acronym List

AE	Adverse Event
ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
AJUDA	Analyzing Joint Underperformance and Determining Assistance
ALHIV	Adults Living with HIV
ANC	Antenatal Clinic
APES	Agentes Polivalentes Elementares de Saúde
APSS	Apoio Psicossocial
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
AYPLHIV	Adolescents and Youth Living with HIV
CCM	Country Coordinating Mechanism
CCR	Consulta de Criança em Risco
CCS	Center for Collaboration in Health
CDC	Centers for Disease Control and Prevention

CETA	Common Elements Treatment Approach
CHWS	Community Health Workers
CLHIV	Children living with HIV
CMAM	Central de Medicamentos e Artigos Médicos
CNCS	Conselho Nacional de Combate ao HIV/SIDA /National Council to Combat AIDS
COP	Country Operation Plan
COREM	Conselho das Religiões de Moçambique
CRAM	Centro de Referência do Alto-Maé
DHIS	District Health Information System
DISA	Data Intensive Systems and Applications
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
eCRVS	Electronic Civil Registration and Vital Statistics

EID	Early Infant Diagnosis
EPTS	Electronic Patient Tracking Systems
EQA	External Quality Assessment
ER	Expenditure Reporting
FDC	Fundação para o Desenvolvimento da Comunidade
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
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

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
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
iDART	Intelligent Dispensing of Antiretroviral Treatment
INAS	Instituto Nacional de Accao Social
INS	National Institute of Health

INSIDA	Inquérito Nacional de Prevalência, Riscos Comportamentais e Informação sobre o HIV e SIDS / AIDS Indicator Survey
IPs	Implementing Partners
IPV	Intimate Partner Violence
KP	Key Population
KPIF	Key Population Investment Fund
LPV/r	Lopinavir/ritonavir
LEEP	Loop Electrosurgical Excision Procedure
LE	Locally Employed
LIS	Laboratory Information Systems
LTFU	Loss to Follow-Up
LW	Lactating Women
MAG	Marketing Advisory Group
M&E	Monitoring and Evaluation
M2M	Mães para Mães / Mothers to Mother
MCC	Millennium Corporation Challenge
MDD	Month Drug Distribution

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
NEC	New Embassy Compound
NGO	Non-governmental Organization
NID	National Health Identification
NUIC	National Unique Identification
NVP	Nevirapine
OGAC	Office of the Global AIDS Coordinator
OTZ	Operation Triple Zero
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
PLASOC	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
POA	Prioritization and Optimization Analysis
POC	Point-Of-Care
PPP	Public-Private Partnership
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
RTK	Rapid Test Kit

SI	Strategic Information
SAAJ	Serviços Amigos dos Adolescentes e Jovens
SID	Sustainability Index Dashboard
SIGLUS	Sistema de Informação de Gestão Logística das Unidades Sanitárias
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
TLD	Tenofovir/Lamivudine/Dolutegravir
TPT	Tuberculosis Preventative Treatment
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	UNICEF United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
USDH	United States Direct Hire
VACS	Violence Against Children Survey

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